



Commonwealth of Virginia
Department of Medical
Assistance Services

2024 External Quality Review
Technical Report

April 2025

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Glossary of Acronyms

42 CFR	Title 42 of the Code of Federal Regulations
AAAs	Area Agencies on Aging
AAP	American Academy of Pediatrics
ADA	Americans With Disabilities Act
ADHC	Adult Day Health Care
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
BIS	Brain Injury Services
BMI	Body Mass Index
BR	Biased Rate
BRAVO	Behavioral Health Redesign for Access, Value and Outcomes Project
C-Section	Cesarean Section
CAHPS [®] , ¹	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CAQH	Council for Affordable Quality Healthcare
CC	Community Coaching
CCC	Children with Chronic Conditions
CCC Plus	Commonwealth Coordinated Care Plus
CCMC	Cardinal Care Managed Care
CDC	Centers for Disease Control and Prevention
CE	Community Engagement
CEG	Clinical Estimate of Gestation
Child Core Set	CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CHW	Community Health Worker
CI	Confidence Interval
CMH	Community Mental Health

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

CMHRS	Community Mental Health Rehabilitative Services
CMS	Centers for Medicare & Medicaid Services
CMU	Case Management Unit
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus Disease 2019
CPT	Current Procedural Terminology
CRMS	Care Management System
CSB	Community Service Board
CSS	Center for the Study of Services
CT	Computerized Tomography
CY	Calendar Year
D-SNP	Dual-Eligible Special Needs Plan
DAA	Direct-Acting Antiviral
DARS	Department for Aging and Rehabilitative Services
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disability
DMAS	Department of Medical Assistance Services
DNR	Do Not Report
DOC	Department of Corrections
DQA	Dental Quality Alliance
DSS	Department of Social Services
ED	Emergency Department
EDV	Encounter Data Validation
EDWS	Enterprise Data Warehouse System
EPS	Encounter Processing Solution
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FAMIS	Family Access to Medical Insurance Security
FAR	Final Audit Report
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FIPS	Federal Information Processing Standards
FIT	Fecal Immunochemical Test
FMEA	Failure Mode and Effects Analysis
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FTE	Full-time Equivalent
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
HPV	Human Papillomavirus
HRA.....	Health Risk Assessment
HSAG	Health Services Advisory Group, Inc.
IACCT.....	Independent Assessment Certification and Coordination Team
ID.....	Identification
IDSS	Interactive Data Submission System
IS	Information Systems
ISCA.....	Information Systems Capabilities Assessment
ISCAT.....	Information Systems Capabilities Assessment Tool
ISP	Individual Service Plan
JCC	Justice Care Coordination
LDSS	Local Departments of Social Services
LIFC.....	Low-Income Families With Children
LMP	Last Menstrual Period
LO.....	Licensed Organization
LOB	Line of Business
LOCERI	Level of Care Review Instrument
LRI.....	Legally Responsible Individuals
LTSS	Long-Term Services and Supports
MBHO.....	Managed Behavioral Health Organization
MCE	Managed Care Entity
MCO	Managed Care Organization
MCP	Managed Care Plan
MES.....	Medicaid Enterprise System
MHP	Mental Health Provider
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

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

MRRV	Medical Record Review Validation
MY	Measurement Year
NCHS	National Center for Health Statistics
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NEMT	Non-emergency Medical Transportation
NF	Nursing Facility
NIH	National Institutes of Health
NPI	National Provider Identifier
NR	Not Reported
NVS	Network Validation Survey
NVSS	National Vital Statistics System
OBAT	Office-Based Addiction Treatment
O/E	Observed-to-Expected
OB/GYN	Obstetrics and Gynecology
OBOT	Office-Based Opioid Treatment
OBQIP	Obstetric Quality Incentive Program
OBRAF	Obstetrical Risk Assessment Form
OSR	Operational Systems Review
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
P4Q	Pay for Quality
PACE	Program of All-Inclusive Care for the Elderly
PAHP	Prepaid Ambulatory Health Plan
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PDF	Portable Document Format
PQI	Pediatric Quality Indicator
PDSA	Plan-Do-Study-Act
PHE	Public Health Emergency
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIF	Provider Information Form
PIP	Performance Improvement Project
PM	Performance Measure
PMPM	Per Member Per Month
PMV	Performance Measure Validation
PNC	Prenatal Care
PPC	Prenatal and Postpartum Care

PRN	Provider Network
PSV	Primary Source Verification
PWP	Performance Withhold Program
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
QS	Quality Strategy
R	Reportable
RAP	Risk Assessment Profile
RPR	Rapid Plasma Reagin
RTC	Residential Treatment Center
SAFE	Secure Access File Exchange
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDOH	Social Determinants of Health
SFTP	Secure File Transfer Protocol
SFY	State Fiscal Year
SHCN	Special Health Care Needs
SMART	Specific, Measurable, Attainable, Relevant, Time-Bound
SME	Subject Matter Expert
SNF	Skilled Nursing Facility
SSA	Social Security Act
SUD	Substance Use Disorder
SUPPORT Act	Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act
SVR	Sustained Virologic Response
TANF	Transitional Aid to Needy Families
TB	Tuberculosis
TCM	Targeted Case Management
T-MSIS	Transformed Medicaid Statistical Information System
TPL	Third Party Liability
VA	Virginia
VBP	Value-Based Purchasing
VCU	Virginia Commonwealth University
VDH	Virginia Department of Health
VDSS	Virginia Department of Social Services
VP	Vice President
WIC	Women, Infants and Children

1. Executive Summary

Overview of 2024 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 CMS EQR Protocols.³

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, 2024, through December 31, 2024 (CY 2024). 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 facilitate Commonwealth efforts to purchase high-value care and to achieve higher performing healthcare delivery systems for their Medicaid and CHIP members.

DMAS is the single State agency that administers all Medicaid and FAMIS health insurance benefit programs and is the gold standard of health and human services. As of June 2024, more than 90 percent of Medicaid enrollees received their benefits through the managed care model, and less than 10 percent of enrollees participated in Medicaid through the FFS model.

DMAS contracted with five privately owned MCOs to deliver physical health and BH services to Medicaid and CHIP members. VA Premier and Optima combined into a single MCO effective July 1, 2023. The combined organization was re-branded as Sentara Health Plan as of the merger effective date. The Sentara Medicaid plan is titled Sentara Community Plan. Contracted MCO's were included in all EQRO activities. The MCOs contracted with DMAS during CY 2024 are displayed in Table 1-1.

Table 1-1—Cardinal Care MCOs in Virginia

MCO Name	MCO Short Name
Aetna Better Health of Virginia	Aetna
HealthKeepers, Inc.	HealthKeepers
Molina Complete Care of Virginia	Molina
Sentara Community Plan	Sentara
United Healthcare of the Mid-Atlantic, Inc.	United

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

³ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols*, February 2023. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Jan 8, 2025.

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 and launched the Cardinal Care MLTSS (formerly CCC Plus) and Cardinal Care Acute (formerly Medallion 4.0) programs.

The Cardinal Care program ensures 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 enables DMAS to ensure better continuity of care for members, operate with improved administrative efficiency, and strengthen the focus on the evolving needs of the populations served. The overarching program ensures 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 CMS EQR protocols cited earlier in the report. 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 facilitates 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 2024 EQR technical report, HSAG used findings from the EQR activities conducted from January 1, 2024, through December 31, 2024. 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 Cardinal Care program. For a detailed, comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each MCO, please refer to the results of each activity in sections 4 through 12 of this report and Section 13—Summary of MCO-Specific Strengths and Weaknesses. Details about each activity's methodology are provided in Appendix B of this report. Table 1-2 identifies the EQR mandatory and optional activities included in this report. DMAS does not exempt any MCOs from EQR.

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	<i>Protocol 1. Validation of Performance Improvement Projects</i>

Activity	Description	CMS EQR Protocol
	the steps completed and validated by HSAG for the 2024 validation cycle.	
PMV	HSAG conducts the PMV for each MCO to assess the accuracy of PMs reported by the MCOs, determine the extent to which these PMs follow Commonwealth specifications and reporting requirements, and validate the data collection and reporting processes used to calculate the PM rates. DMAS identified and selected the specifications for a set of PMs that the MCOs were required to calculate and report for the measurement period of January 1, 2023, through December 31, 2023.	<i>Protocol 2. Validation of Performance Measures</i>
Compliance With Medicaid and CHIP Managed Care Regulations	This activity determines the extent to which a Medicaid and CHIP MCO is in compliance with federal standards and associated Virginia-specific requirements, when applicable. HSAG conducted full compliance reviews (called OSRs) that included all federal and Virginia-specific requirements for the review period of July 1, 2023, through June 30, 2024.	<i>Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations</i>
	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.	<i>Protocol 4. Validation of Network Adequacy</i>
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	<i>Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan</i>

Activity	Description	CMS EQR Protocol
	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.	
CAHPS Analysis	This activity assesses member experience with an MCO and its providers and the quality-of-care members receive. FAMIS CAHPS Survey—HSAG administers the CAHPS 5.1H Child Medicaid Health Plan Survey to FAMIS members receiving healthcare services through FFS or managed care. HSAG analyzes the CAHPS survey data and generates a FAMIS Program Member Satisfaction Report for DMAS.	<i>Protocol 6.</i> 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.).	<i>Protocol 7.</i> Calculation of Additional Performance Measures
ARTS Measure Specification Development and Maintenance	HSAG identifies, when available, PMs from existing PM sets or develops PMs for the ARTS program.	
Focus Studies	This activity provides information about the healthcare quality for a particular aspect of care across managed care in the Commonwealth or for subpopulations served by managed care within the Commonwealth. Medicaid and CHIP Maternal and Child Health Focus Study—HSAG conducts a focus study that provides quantitative information about prenatal care and associated birth outcomes among Medicaid recipients.	<i>Protocol 9.</i> Conducting Focus Studies of Health Care Quality

Activity	Description	CMS EQR Protocol
	Child Welfare Focus Study—HSAG conducts a Child Welfare Focus Study to evaluate healthcare utilization among children in foster care under the Cardinal Care Acute (formerly Medallion 4.0) program. Dental Utilization in Pregnant Women Data Brief—HSAG produces a data brief describing dental utilization among pregnant women enrolled in the Medicaid or FAMIS MOMS programs.	
Consumer Decision Support Tool	This activity provides information to help eligible members choose a Medicaid Cardinal Care program. The tool shows how well the different MCOs provide care and services in various performance areas. HSAG develops Virginia's Consumer Decision Support Tool (i.e., Quality Rating System) to improve healthcare quality and transparency and provide information to consumers to make informed decisions about their care within the program. HSAG uses HEDIS and CAHPS data to compare MCOs to one another in key performance areas.	<i>Protocol 10. Assist With Quality Rating of Medicaid and CHIP Managed Care Organizations, Prepaid Inpatient Health Plans, and Prepaid Ambulatory Health Plans</i>
PWP	HSAG develops a methodology to calculate the MCO results for the PWP for DMAS. The 2024 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 Cardinal Care 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 Cardinal Care Program Conclusions: Quality, Access, and Timeliness

Program Strengths		
Domain		Conclusion
	Quality	Strength: DMAS selected four PIP topic areas for validation including <i>Ensuring Timeliness of Prenatal Visits, Tobacco Use Cessation in Pregnant Women, Ambulatory Care—Emergency Department Visits, and Transitions of Care—Patient Engagement After Inpatient Discharge</i>. Three of the five MCOs demonstrated strength in implementing performance improvement processes and received 100 percent validation scores across all evaluation elements for Steps 1 through 8, and were assigned a <i>High Confidence</i> level for all PIPs. These MCOs calculated and reported Remeasurement 1 data accurately, implemented targeted interventions that addressed the identified barriers, and developed sound methodologies for evaluating the effectiveness for each intervention.
		Strength: BH PMV also was a strength for DMAS and the MCOs. DMAS has focused significant effort and resources on advancing improvement in behavioral healthcare and outcomes through initiatives such as implementation of the ARTS benefit. PMV results demonstrated that all five MCOs' rates met or exceeded the 50th percentile for the <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Total</i> indicator, both <i>Initiation and Engagement of Substance Use Disorder</i>

Program Strengths	
Domain	Conclusion
	<i>Treatment</i> indicators, and the <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total</i> indicator. Strength: The MCOs also demonstrated strength in children's preventive care, with four of the five MCOs' rates meeting or exceeding the 75th percentile for the <i>Immunization for Adolescents—Combination 1 (Meningococcal; Tdap)</i> PM indicator. In addition to preventive care, the MCOs also showed strength in the <i>Asthma Medication Ratio—Total</i> PM indicator, with all five MCOs' rates meeting or exceeding the 50th percentile. In addition, three of the five MCOs' rates exceeded the statewide average for the <i>Breast Cancer Screening—Total</i> PM indicator in the Women's Health domain. Strength: The MCOs demonstrated strength in encounter data processes for both the Cardinal Care Acute and the Cardinal Care MLTSS programs. At least three MCOs were at or below 5 percent record omission and surplus rates when validated for professional record completeness, and at least one MCO for institutional encounters indicated that the professional and institutional encounters could mostly be identified in both the DMAS-submitted data and MCO-submitted data sources. Similarly, the validation of data element completeness for the Cardinal Care MLTSS and Cardinal Care Acute programs found that both the element omission and element surplus rates for all relevant key data elements were below 5.0 percent for two MCOs for professional encounters, one MCO for institutional encounters, and at least four MCOs for pharmacy encounters. This indicates that all relevant key data elements in the encounter records which could be matched between the DMAS-submitted and MCO-submitted data were largely complete. In addition, all relevant key data elements had element accuracy rates over 95.0 percent for at least four MCOs among the Cardinal Care Acute and Cardinal Care MLTSS pharmacy encounters. This indicates that records which could be matched between the DMAS-submitted and MCO-submitted data largely contained the same values. Strength: Overall, the FAMIS MOMS program demonstrated strength, with rates for the <i>Births With Early and Adequate Prenatal Care</i>, <i>Preterm Births (<37 Weeks Gestation)</i>, and <i>Newborns With Low Birth Weight (<2,500 grams)</i> study indicators outperforming the applicable national benchmarks for all three measurement periods (CYs 2020, 2021, and 2022). For the Medicaid for Pregnant Women program, rates

Program Strengths		
Domain	Conclusion	
	for the <i>Preterm Births (<37 Weeks Gestation)</i> and <i>Newborns With Low Birth Weight (<2,500 grams)</i> study indicators also outperformed the national benchmarks for all three measurement periods, despite having rates for the <i>Births With Early and Adequate Prenatal Care</i> study indicator that did not meet the national benchmark. Similarly, the FAMIS Prenatal Coverage program had the lowest rates of <i>Births With Early and Adequate Prenatal Care</i> but also had the lowest rates for the <i>Preterm Births (<37 Weeks Gestation)</i> and <i>Newborns With Low Birth Weight (<2,500 grams)</i> study indicators, which outperformed national benchmarks in CY 2021 and CY 2022. Of note, the Other Aid Categories rates for all three study indicators underperformed in comparison to the national benchmarks for all three measurement periods. In addition, women in the FAMIS Prenatal Coverage program had the highest rates for receiving contraceptives. This may be because approximately 90 percent of FAMIS Prenatal Coverage deliveries were to Hispanic, Any Race women, who had significantly higher rates of receiving contraceptives. Additionally, women in the FAMIS Prenatal Coverage program were only eligible for postpartum coverage for 60 days postpartum, which may be impacting the rates for this population. Strength: ARTS study findings demonstrated that identification of members with SUD continued to improve, in alignment with ARTS benefit goals. The <i>Cascade of Care for Members With OUD—High-Risk Members With OUD Diagnosis</i> indicator assessed identification of members with an OUD. Findings indicated that this rate increased from 5.1 percent to 5.6 percent from CY 2021 to CY 2022. Strength: The network adequacy validation task found that overall, the MCOs demonstrated strength through well-defined processes and procedures to ensure efficient, accurate collection of member and provider data to support network adequacy calculation and reporting. The MCOs also demonstrated dedicated efforts to identify gaps in provider networks throughout their service areas and to identify ways to improve the accessibility and timeliness of care for members.	
	Access	Strength: Three of the five MCOs demonstrated strength in access to care PMs, with rates meeting or exceeding the 75th percentile for the <i>Adults' Access to Preventive/Ambulatory Health Services—Total PM</i> indicator. These findings aligned with the phantom network analysis which found that across MCOs, the provider networks had few inactive providers for OB/GYN, PCP, and PEDIATRIC providers.

Program Strengths	
Domain	Conclusion
	Strength: The highlights of the 2022–23 Child Welfare Focus Study results identified priorities for the Virginia Medicaid program related to improving and monitoring healthcare utilization and timely access to care for members in child welfare programs and identifying health disparities. DMAS demonstrated strength in implementing policy changes and supported initiatives during the study period to improve utilization of and timely access to care among members in child welfare programs, including the following: As part of the SFY 2022–23 Cardinal Care Acute (formerly Medallion 4.0) Managed Care Services Agreement, effective July 1, 2022: – DMAS added language to improve continuity of and timely access to care for former foster care members, including ensuring that MCOs provide members who are aging out of foster care with a “health summary” consolidating key medical information, ensuring MCOs coordinate with the LDSS during the transition period, ensuring case management continues during the transition period, and ensuring MCOs document transition needs for children in foster care who will age out of foster care in their individualized care plan, if applicable. – DMAS added language requiring MCOs to participate in child welfare stakeholder collaboration workgroups, when requested. • On April 1, 2022, Governor Glenn Youngkin launched the Safe and Sound Task Force, which aims to work collaboratively across state and local agencies to address barriers related to safe and appropriate placements for children in foster care. DMAS participates in this task force and supports efforts to improve timely access to and utilization of medical and behavioral healthcare services for children in foster care. • DMAS and the Department of Behavioral Health and Developmental Services collaborated to launch Project BRAVO, a multiphase initiative to enhance BH services in Virginia. Under this initiative, Virginia Medicaid began covering additional BH services such as mental health intensive outpatient services, effective July 1, 2021, and multisystemic therapy, effective December 1, 2021. Strength: The policy changes included in the Managed Care Services Agreement, the Safe and Sound Task Force, and Project BRAVO may have had an impact on the Child Welfare Focus Study results. For example, this study demonstrated that children in foster care have higher rates of appropriate healthcare utilization than comparable controls (i.e., Medicaid peers not in child welfare programs) for the majority of study indicators in MY 2020, MY 2021, and MY 2022.

Program Strengths		
Domain	Conclusion	
		Among study indicators wherein children in foster care had higher rates, MY 2022 rate differences between children in foster care and controls were greatest among the following: - Dental study indicators (<i>Annual Dental Visit</i>; <i>Preventive Dental Services</i>; <i>Oral Evaluation</i>, <i>Dental Services</i>; and <i>Topical Fluoride for Children—Dental or Oral Health Services</i> by 14.9, 15.6, 15.6, and 9.8 percentage points, respectively) <i>Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics</i> indicator (by 17.1 percentage points) <i>Behavioral Health Encounters—CMH Services</i>, <i>Behavioral Health Encounters—Traditional Services</i>, and <i>Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up</i> indicators (by 15.3, 13.3, and 13.3 percentage points, respectively). Strength: The ARTS benefit also demonstrated strength for the Cardinal Care program, with several ARTS study indicators indicating that initiation of SUD treatment increased for every relevant indicator except <i>Preferred OBAT Compliance—Counseling From an OBAT Provider</i>. For example, 48.3 percent of members diagnosed with OUD initiated any OUD treatment (i.e., pharmacotherapy or other treatment) within 14 days of OUD diagnosis in CY 2022, and this rate increased by 4.0 percentage points from CY 2021 and by 9.0 percentage points from CY 2020. The rate change from CY 2020 to CY 2021 was driven by an increase in members initiating pharmacotherapy (by 6.2 percentage points), while the rate change from CY 2021 to CY 2022 was driven by increases in both pharmacotherapy and other OUD treatment initiation (by 3.0 and 3.5 percentage points, respectively).
	Timeliness	Strength: The MCOs also demonstrated strength with the compliance review results in developing and implementing the necessary policies, procedures, and processes to operationalize the requirements of their DMAS managed care contract and also demonstrating compliance with the expectations of the contract. All five MCOs achieved full compliance in three of the 17 standards reviewed, demonstrating strength and adherence to all requirements measured in the following standards: - Standard IV: Availability of Services - Standard IX: Confidentiality - Standard XIII: Health Information Systems The results of the SFY 2022–2023 Child Welfare Focus Study found that 86.8 percent of new foster care members had a visit with a PCP within 30 days after or 90 days prior to entering foster care during MY 2022, an increase of 0.6 percentage points from the prior year. These results indicate that most children in foster care were receiving timely

Program Strengths		
Domain		Conclusion
		access to primary care. Additionally, 47.2 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 during MY 2022. This rate improved by 3.2 percentage points from MY 2021. Additionally, this study found that 50.5 percent of new foster care members and 79.0 percent of new foster care members with a diagnosed BH condition had at least one visit with an MHP within 60 days of enrollment in the foster care program. Similarly, 67.1 percent of new foster care members and 93.1 percent of new foster care members with a BH diagnosis had a visit with an MHP within a year after enrollment in the foster care program. For newly enrolled members in the adoption assistance program, 44.3 percent of all members and 68.3 percent of members with a BH diagnosis had a visit with an MHP. Lastly, 78.9 percent of members who aged out of foster care had a BH diagnosis, and 45.8 percent of these members with a BH diagnosis had a visit with an MHP during MY 2022; this rate improved by 6.4 percentage points from MY 2021, also demonstrating a strength for the Cardinal Care program MCOs. Strength: The results of the ARTS benefit also demonstrated strength in timeliness of BH and substance use care and services. Among members who had an initiation visit with an OBAT provider, receipt of OUD medication within seven days of MAT initiation increased by 3.1 percentage points to 22.4 percent, and receipt of care coordination within 30 days of MAT initiation increased by 3.9 percentage points to 19.3 percent from CY 2021 to CY 2022.
Program Weaknesses		
Domain		Conclusion
	Quality	Weakness: Opportunities for improvement were identified in the PIP task. Not all MCOs addressed all requirements for data analysis and interpretation of results). One MCO did not include a statement about factors which threatened comparability, and one MCO did not provide the correct statistical testing results or indicator of the direction of change. Weakness: Opportunities were also identified in some of the PMV results. In the Children's Preventive Care domain, three of the five MCOs' rates fell below the 50th percentile for the <i>Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)</i> PM indicator. All five MCOs' rates also fell below the 50th percentile for the <i>Cervical Cancer Screening—Total</i> PM indicator in the Women's Health domain.

Program Weaknesses	
Domain	Conclusion
	Weakness: In addition, in the Care for Chronic Conditions domain, all five MCOs' rates fell below the 50th percentile for the <i>Medical Assistance With Smoking and Tobacco Use Cessation</i> PM indicators, also indicating opportunities for performance improvement. Weakness: Compliance review results also identified MCO weaknesses. The two standards with the greatest opportunity for improvement, with all five MCOs receiving performance scores under 90 percent, are listed below: - Standard II: Member Rights and Member Information - Standard X: Grievance and Appeal Systems These findings suggest that the MCOs did not consistently develop the necessary policies, procedures, and processes to operationalize the requirements of their contract and did not always demonstrate compliance with the contract requirements. Weakness: The EDV IS review activity found that some MCOs lacked sufficient comprehensive reports to monitor encounter data accuracy, completeness, and timeliness for the following: - Pharmacy and chiropractic encounters - Vision encounters - NEMT encounters Weakness: In addition, the EDV comparative analysis found that for record completeness of professional and institutional encounters, only one MCO had a rate over 5.0 percent (i.e., relatively poor performance) for both record omission and record surplus. For pharmacy encounters, two MCOs had a rate over 5.0 percent for both record omission and record surplus. These results indicate that the DMAS-submitted encounter records were incomplete when compared to MCO-submitted data. For professional and institutional encounters, at least four MCOs had both element omission and surplus rates that were above 5.0 percent (i.e., relatively poor performance) for at least one key data element. This indicates that at least one key data element in the DMAS-submitted encounter records was incomplete when compared to MCO-submitted data. For professional and institutional encounters, some of the MCOs had at least one element accuracy rate that fell below 95.0 percent. For

Program Weaknesses		
Domain		Conclusion
		pharmacy encounters, two MCOs had at least one element accuracy rate that fell below 95.0 percent. This indicates that at least one key data element in the DMAS-submitted encounter records was inaccurate when compared to the MCO-submitted data.
	Access	Weakness: For PMV, all five MCOs' rates demonstrated weakness, falling below the 50th percentile for the <i>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total</i> , <i>Colorectal Cancer Screening—Total</i> , <i>Use of Imaging Studies for Low Back Pain—Total</i> , and <i>Plan All-Cause Readmissions—Observed Readmissions PM</i> indicators in the Access to Care domain.
	Timeliness	Weakness: All five MCOs demonstrated an opportunity for improvement in the Behavioral Health domain, with rates that fell below the 50th percentile for the <i>Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total PM</i> indicator, which may result in increased ED or inpatient utilization. Weakness: The Child Welfare Focus Study also identified opportunities for improvement. During MY 2022, children in foster care had lower performance compared to controls for nine study indicators, of which three were statistically significant: <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i>, <i>ED Visits</i>, and <i>Overall Service Utilization</i>. For <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i>, the rate for children in foster care was 22.0 percentage points lower than the rate for controls in MY 2022. Additionally, while the rate difference was not statistically significant due to small denominators, the rate for children in foster care for the <i>Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment PM</i> indicator was 9.6 percentage points lower than the rate for controls, and there were similar findings in MY 2020 and MY 2021. Weakness: Among children in foster care, eight study indicator rates increased, while 18 study indicator rates decreased from MY 2021 to MY 2022; and from MY 2020 to MY 2022, two study indicator rates increased, while 13 study indicator rates decreased. The largest declines from MY 2021 to MY 2022 were for the <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i> indicator (by 28.6 percentage points), the <i>Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics</i> indicator (by 11.0 percentage points), and the <i>Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment</i> indicator (by 10.2 percentage points). However, eight of the rate declines from MY 2021 to MY 2022 for children in foster care were less than 3 percentage points.

Quality Strategy Recommendations for the Virginia Managed Care Program

The Virginia 2023–2025 QS is designed to improve the health outcomes of its Medicaid members by continually improving the delivery of quality healthcare to all Medicaid and CHIP members served by the Virginia Medicaid managed care programs. DMAS' QS provides the framework to accomplish DMAS' overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP system. In consideration of the goals of the QS and the comparative review of findings for all activities, HSAG's Virginia-specific recommendations for QI that target the identified goals within the Virginia 2023–2025 QS are included in Table 1-4.

Table 1-4—QS Recommendations for the Virginia Medicaid Managed Care Program⁴

Program Recommendations	
Recommendation	Associated Virginia 2023–2025 QS Goal, Objective, and Measure
Within the Access to Care and Women's Health domains, all five MCOs' rates fell below the 50th percentile for the <i>Cervical Cancer Screening—Total</i> PM indicator and the <i>Colorectal Cancer Screening—Total</i> PM indicator. To improve program wide performance in support of Goal 2: Promote Access to Safe, Gold-Standard Patient Care, Objective 2.1: Ensure Access to Care, HSAG recommends that MCOs consider whether there are health disparities within the plans' populations that contributed to less access to care. HSAG recommends that MCOs implement interventions to reduce barriers to care, including engaging with community providers and CHWs in planning educational materials and outreach activities. MCOs should also communicate with eligible members through multimodal approaches including outreach through phone calls and text messages to promote women's screenings. MCOs should also consider including incentives for PCPs to provide the needed services and to increase their access and outreach to eligible assigned members. MCOs should also monitor and implement interventions, if needed, for providers in communicating with members with scheduled reminders utilizing personalized outreach for overdue patients. DMAS should review MCO communication messages to ensure clear and concise information.	Goal 2: Promote Access to Safe, Gold-Standard Patient Care Objective 2.1: Ensure Access to Care Measure: 2.1.1.6: <i>Cervical Cancer Screening</i> Measure: 2.1.1.8: <i>Colorectal Cancer Screening</i>

⁴ Department of Medical Assistance Services. 2023–2025 Quality Strategy. Available at: <https://www.dmas.virginia.gov/media/ernmrksv/2023-2025-quality-strategy.pdf>. Accessed on: Jan 8, 2025.

Program Recommendations	
Within the Behavioral Health domain, four of the five MCOs' rates fell below the 50th percentile for both <i>Follow-Up After Hospitalization for Mental Illness</i> PM indicators. Additionally, at least four of the five MCOs' rates fell below the 50th percentile for both <i>Follow-Up After Emergency Department Visit for Mental Illness</i> PM indicators. All five MCOs' rates fell below the 50th percentile for the <i>Antidepressant Medication Management—Effective Acute Phase Treatment</i> PM indicator. To improve program wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4: Improve Behavioral Health and Developmental Services for Members, HSAG recommends that DMAS work with the MCOs to meet with hospitals to improve the understanding of the importance of follow-up care and discuss tips on scheduling patients in the hospital or ED. The MCOs should be encouraged to work with hospital discharge planners to gain insight into the challenges they face in setting up follow-up visits before member discharge. HSAG recommends that DMAS work with the MCO to collaborate with outpatient providers on solutions to these challenges. Additionally, HSAG recommends that DMAS encourage MCOs to establish processes for outpatient providers to send direct messages to patients with canceled visits or who do not show for scheduled appointments. HSAG recommends that MCOs ensure telehealth services for follow-up visits are covered, available, and that providers and patients are made aware of telehealth follow-up visit options. HSAG recommends that MCOs analyze mental health integration between providers, including primary care and mental health specialists. This, coupled with improved monitoring, has been shown to improve medication adherence.	Goal 5: 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 Measure 5.4.1.2: Follow-Up After Emergency Department Visit for Mental Illness Measure 5.4.1.8: Antidepressant Medication Management
Within the Children's Preventive Care domain, three of the five MCOs' rates fell below the 50th percentile for the <i>Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)</i> PM indicator. Additionally, all five MCOs' rates fell below the 50th percentile for the <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index</i> and <i>Counseling for Physical Activity</i> PM indicators. To improve program wide performance in support of Goal 4: Strengthen the Health of Families and Communities, Objective 4.1: Improve the Utilization of Wellness, Immunization, and Prevention Services for Members, HSAG recommends that DMAS work with the MCOs to	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 Measure 4.1.1.9: Weight Assessment and Counseling for

Program Recommendations	
address whether providers are recording any vaccinations patients receive outside of provider care, such as at a pharmacy. HSAG recommends that MCOs survey providers regarding barriers encountered for the cases wherein BMI was not measured or counseling was not provided such as lack of resources, time, or training to provide appropriate counseling.	<i>Nutrition and Physical Activity for Children/Adolescents</i>
The general child 2024 top-box score was statistically significantly lower than the 2023 NCQA general child Medicaid national average for <i>How Well Doctors Communicate</i>. To improve program wide member experience and program satisfaction and in support of Goal 2: Promote Access to Safe, Gold-Standard Patient Care, Objective 2.3: Promote Effective Communication and Care Coordination, HSAG recommends that the MCOs evaluate the process of care delivery to identify if there are any operational issues contributing to access to care for members, as well as identify and resolve dissatisfaction in customer and clinical services by addressing and providing solutions to customer service complaints. HSAG also recommends that the MCOs conduct root cause analyses of study indicators that have been identified as areas of low performance. In addition, HSAG also recommends that the MCOs continue to monitor the measures to ensure that significant decreases in scores over time do not continue to occur.	Goal 2: Promote Access to Safe, Gold-Standard Patient Care Objective 2.3: Promote Effective Communication and Care Coordination Measure 2.3.1.1: <i>How Well Doctors Communicate</i>

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 2024.

Table 2-1—CY 2024 Average Annual Program Enrollment^{5*}

Program	SFY 2024 Enrollment as of 07/01/2024*
Cardinal Care Managed Care Program	1,784,681
Fee-for-Service	237,846
Total Served	2,022,527

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

DMAS contracted with five privately owned MCOs to deliver physical health and BH services to Medicaid and CHIP members. The five MCOs contracted with DMAS on December 31, 2024, are displayed in Table 2-2.

Table 2-2—Cardinal Care 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. Aetna Better Health of Virginia is part of Aetna and the CVS Health family. Aetna has been serving Medicaid members for over 30 years.	Accredited* through 5/27/2027 LTSS Distinction through 5/27/2027
HealthKeepers	Anthem HealthKeepers is a Virginia HMO affiliated with Anthem Blue Cross and Blue Shield and the Anthem Insurance Companies, a publicly owned, for-profit corporation that operates as a multistate	Accredited* through 2/22/2027 LTSS Distinction through 2/22/2027

⁵ Department of Medical Assistance Services. Medicaid/FAMIS/PACE Enrollment. Available at: <https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/>. Accessed on: Jan 8, 2025.

MCO	Profile Description	MCO NCQA Accreditation Status
	healthcare company, headquartered in Indianapolis, Indiana. HealthKeepers provides managed healthcare services statewide under the Medicaid and Medicare programs, through the state insurance marketplace, and offers family and individual health plans.	
Molina	Molina Healthcare, Inc., headquartered in Long Beach, CA, provides managed healthcare services under the Medicaid and Medicare programs and through the state insurance marketplaces through its locally operated health plans.	Accredited* through 11/1/2026 LTSS Distinction through 11/01/2026
Sentara**	Sentara Community Plan, headquartered in Virginia Beach, provides managed healthcare services statewide under the Medicaid and Medicare programs, through the state insurance marketplace, and offers family and individual health plans.	Provisional Accreditation*** through 06/28/2025 LTSS Distinction through 4/01/2024
United	UnitedHealthcare Community Plan is part of the UnitedHealth Group family of companies, headquartered in Minneapolis, Minnesota. United provides Medicaid managed care, Medicare, commercial, insurance marketplace, and individual and family plans, 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 6/06/2026 Electronic Clinical Data Distinction LTSS Distinction through 6/06/2026

*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.⁶

**VA Premier merged with Optima during CY 2023 forming the Sentara Health Plan.

*** Provisional Accreditation is granted for one year to plans that have adequate quality improvement programs and meet many of NCQA standards. The plan needs to demonstrate progress before they can qualify for higher levels of accreditation.

MCO Cardinal Care Enrollment Characteristics

Figure 2-1 through Figure 2-5 display the Cardinal Care program enrollment characteristics. Table 2-3 through Table 2-7 display the MCO and Cardinal Care program overall enrollment characteristics. Data

⁶ National Committee for Quality Assurance. Advertising and Marketing Guidelines: Health Plan Accreditation. Available at: https://www.ncqa.org/wp-content/uploads/2018/08/20180804_HPA_Advertising_and_Marketing_Guidelines.pdf. Accessed on: Jan 8, 2025.

contained in these tables and figures are from DMAS' Cardinal Care Medicaid/FAMIS Enrollment dashboard.⁷

Figure 2-1—Cardinal Care Program CY 2024 MCO Eligibility Categories

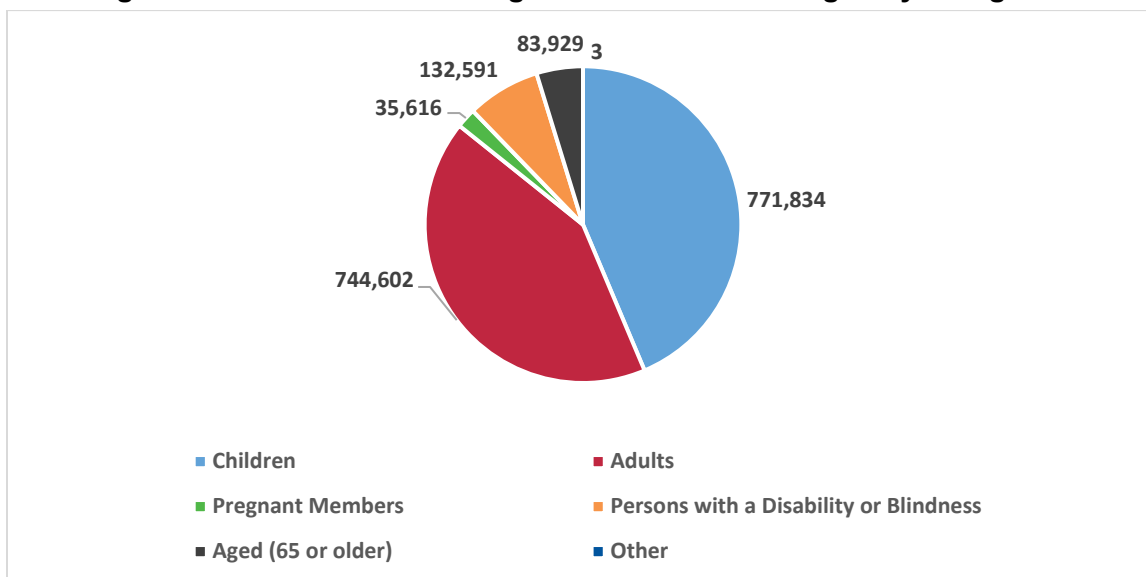


Table 2-3—Cardinal Care Program CY 2024 MCO Eligibility Categories^{8*}

Category	Aetna	HealthKeepers	Molina	Sentara	United	All**
Adults	127,022	208,677	66,141	247,236	95,526	744,602
Aged (65 and older)	14,425	25,323	7,125	19,930	17,126	83,929
Children	92,269	257,251	42,513	293, 318	86,483	771,834
Persons with a Disability or Blindness	21,274	37,436	10,515	46,257	17,109	132,591
Pregnant Women	6,012	10,820	3,166	10,564	5,054	35,616
Other	0	2	0	1	0	3
Overall Total	261,002	539,509	129,460	617,306	221,298	1,768,575

^{*}Point-in-time numbers. Categories are not intended to equal the total served.

^{**}Excludes fee-for-service and limited benefit populations.

⁷ Department of Medical Assistance Services. Medicaid/FAMIS/PACE Enrollment. Available at: <https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/>. Accessed on: Jan 8, 2025.

⁸ Ibid.

Figure 2-2—Cardinal Care Program CY 2024 Categories by Race⁹

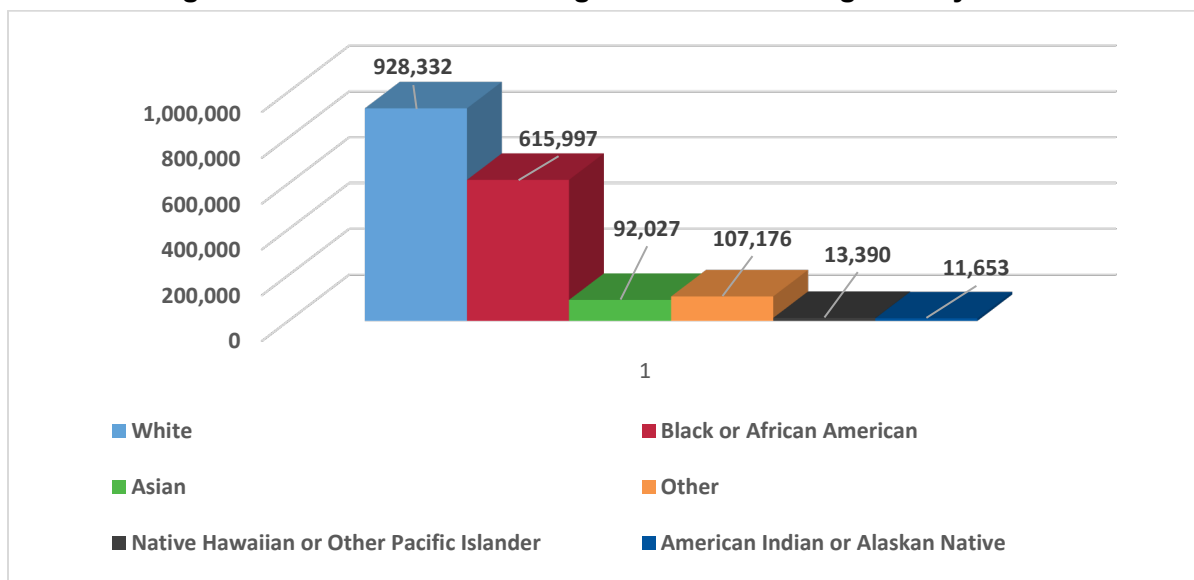


Table 2-4—Cardinal Care Program CY 2024 Categories by Race^{10*}

Category	Aetna	HealthKeepers	Molina	Sentara	United	All**
<i>White</i>	138,501	283,313	66,732	316,870	122,906	928,332
<i>Black or African American</i>	85,975	183,639	44,116	237,896	64,371	615,997
<i>Asian</i>	13,400	33,966	5,651	24,843	14,167	92,027
<i>Other</i>	19,433	30,668	11,107	29,503	16,465	107,176
<i>Native Hawaiian or Other Pacific Islander</i>	1,797	4,450	882	4,439	1,822	13,390
<i>American Indian or Alaskan Native</i>	1,896	3,473	972	3,745	1,567	11,653

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

**Excludes FFS and limited benefit populations.

⁹ Ibid.

¹⁰ Ibid.

Figure 2-3—Cardinal Care Program CY 2024 MCO Categories by Ethnicity¹¹

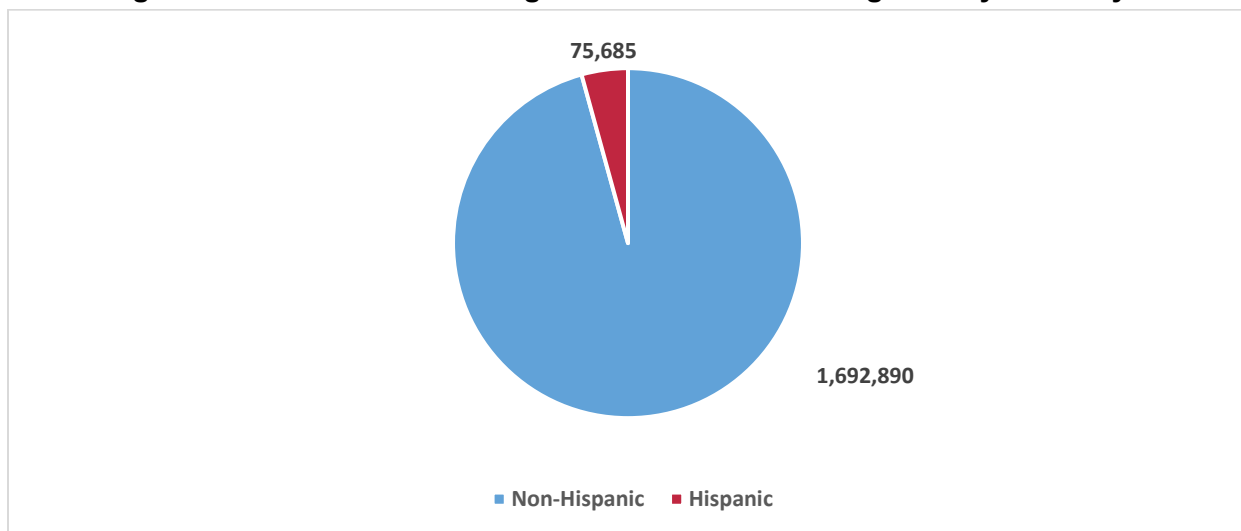


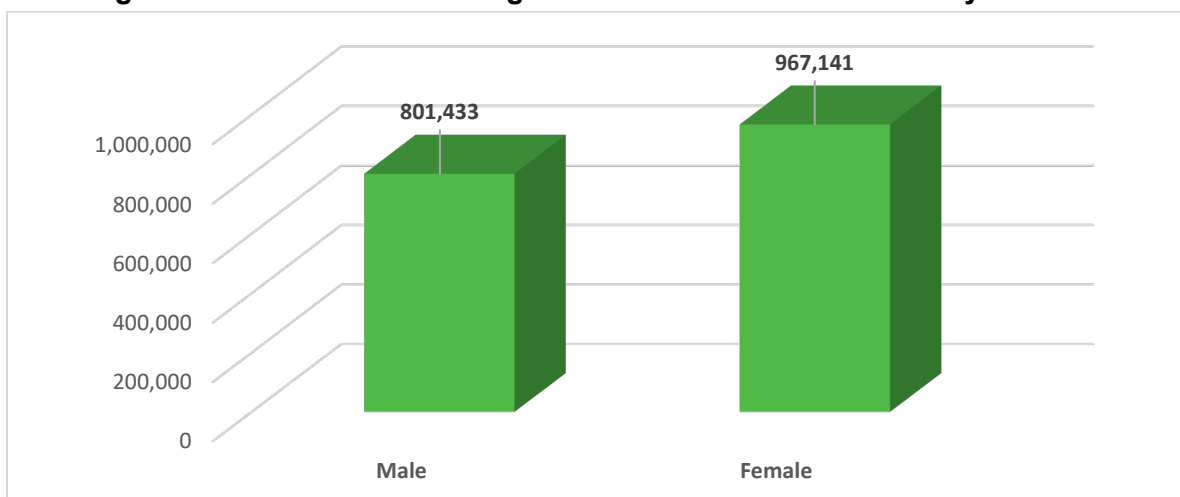
Table 2-5—Cardinal Care Program CY 2024 MCO Categories by Ethnicity^{12*}

Category	Aetna	HealthKeepers	Molina	Sentara	United	All**
Non-Hispanic	250,591	514,574	124,318	592,151	211,256	1,692,890
Hispanic	10,411	24,935	5,142	25,155	10,042	75,685

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

**Excludes FFS and limited benefit populations.

Figure 2-4—Cardinal Care Program CY 2024 MCO Enrollment by Gender¹³



¹¹ Ibid.

¹² Ibid.

¹³ Ibid.

Table 2-6—Cardinal Care Program CY 2024 MCO Enrollment by Gender^{14*}

Category	Aetna	HealthKeepers	Molina	Sentara	United	All**
Male	118,122	239,618	63,812	276,693	103,188	801,433
Female	142,880	299,891	65,648	340,612	118,110	967,141

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

***Excludes FFS and limited benefit populations.*

Figure 2-5—Cardinal Care Program CY 2024 MCO Enrollment by Age Group¹⁵

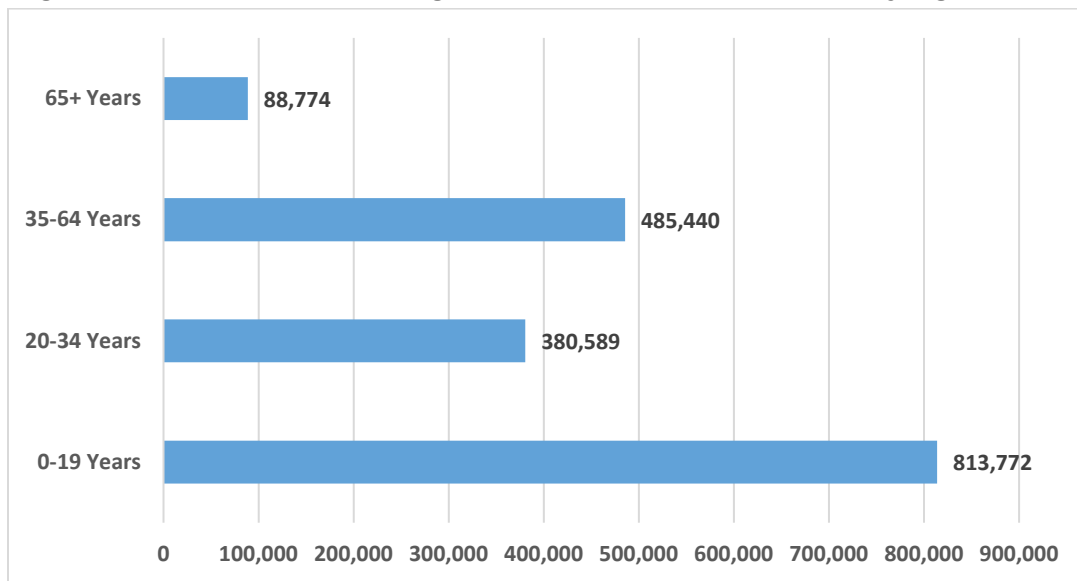


Table 2-7—Cardinal Care Program CY 2024 MCO Enrollment by Age Group^{16*}

Category	Aetna	HealthKeepers	Molina	Sentara	United	All**
0–19 Years	97,559	271,424	44,893	309,240	90,656	813,772
20–34 Years	62,997	107,987	34,478	126,630	48,497	380,589
35–64 Years	85,208	133,432	42,532	160,013	64,255	485,440
65+ Years	15,238	26,666	7,557	21,423	17,890	88,774

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

***Excludes FFS and limited benefit populations.*

¹⁴ Ibid.

¹⁵ Ibid.

¹⁶ Ibid.

Cardinal Care Program Medicaid Expansion

Beginning January 1, 2019, more adults living in Virginia gained access to quality, low-cost health insurance through Virginia's Medicaid expansion. The Medicaid expansion benefit plan includes all services currently covered by Medicaid for the existing populations as well as additional federally required adult preventive care and disease management programs. Medicaid expansion provides coverage for adults ages 19–64 years 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 (e.g., children, caretaker adults, pregnant women, individuals over the age of 65 years, and individuals who are blind or have a disability). Figure 2-6 through Figure 2-9 and Table 2-8 through Table 2-11 display the Medicaid expansion characteristics.

Figure 2-6—CY 2024 Medicaid Expansion Service Provision¹⁷

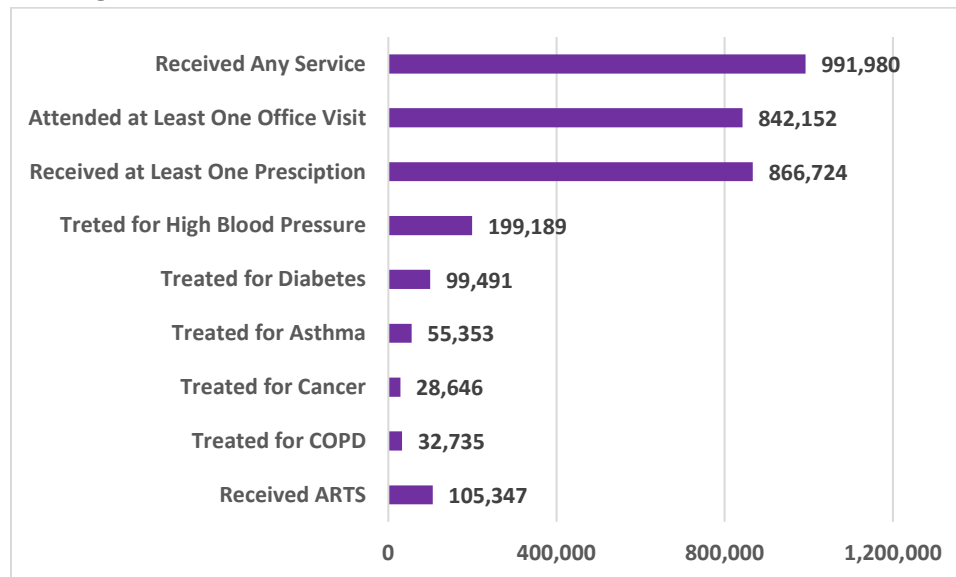


Table 2-8—CY 2024 Medicaid Expansion Service Provision^{18*}

Age Category	Number of Members Receiving Services
Received ARTS	105,347
Treated for COPD	32,735
Treated for Cancer	28,646
Treated for Asthma	55,353
Treated for Diabetes	99,491
Treated for High Blood Pressure	199,189

¹⁷ Department of Medical Assistance Services. Medicaid Expansion Access. Available at: <https://www.dmas.virginia.gov/data/medicaid-expansion-access/>. Accessed on: Jan 8, 2025.

¹⁸ Ibid.

Age Category	Number of Members Receiving Services
Received at Least One Prescription	866,724
Attended at Least One Office Visit	842,152
Received Any Service	991,980

Note: The number of members who received services is cumulative and includes members enrolled at any point from January 1, 2019, to October 1, 2024.

Enrollment Data from 10/2/2024 are available at <https://www.dmas.virginia.gov/data/medicaid-expansion-access/>

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

Figure 2-7—CY 2024 Cardinal Care Program Medicaid Expansion Percentage by Age Category¹⁹

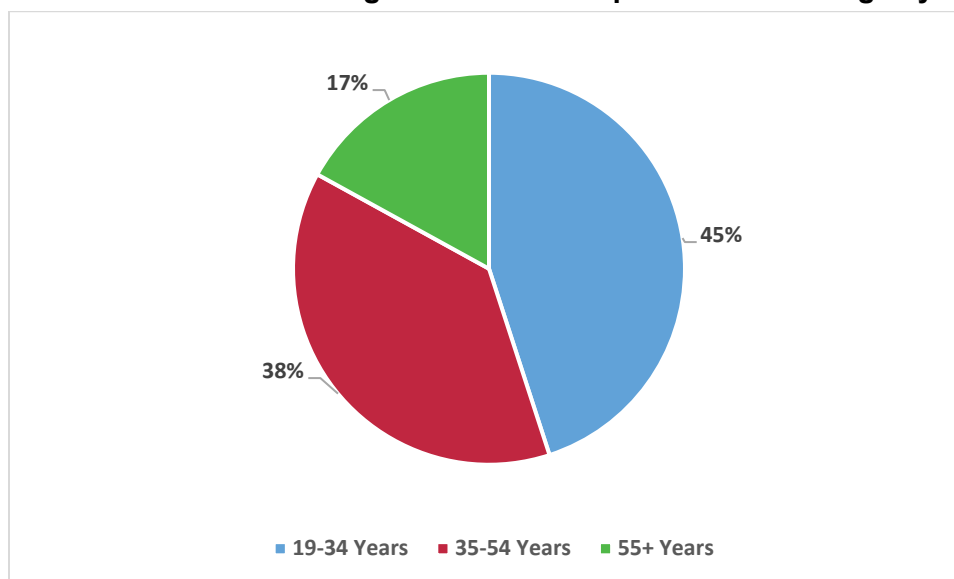


Table 2-9—CY 2024 Cardinal Care Program Medicaid Expansion Percentage by Age Category^{20*}

Age Category	Percentage
19–34 Years	45%
35–54 Years	38%
55+ Years	17%

Note: Excludes PACE enrolled members.

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

¹⁹ Department of Medical Assistance Services. Medicaid Expansion Enrollment. Available at: <https://www.dmas.virginia.gov/data/medicaid-expansion-enrollment/>. Accessed on: Jan 8, 2025.

²⁰ Ibid.

Figure 2-8—CY 2024 Cardinal Care Program Medicaid Expansion Enrollment by FPL Category²¹

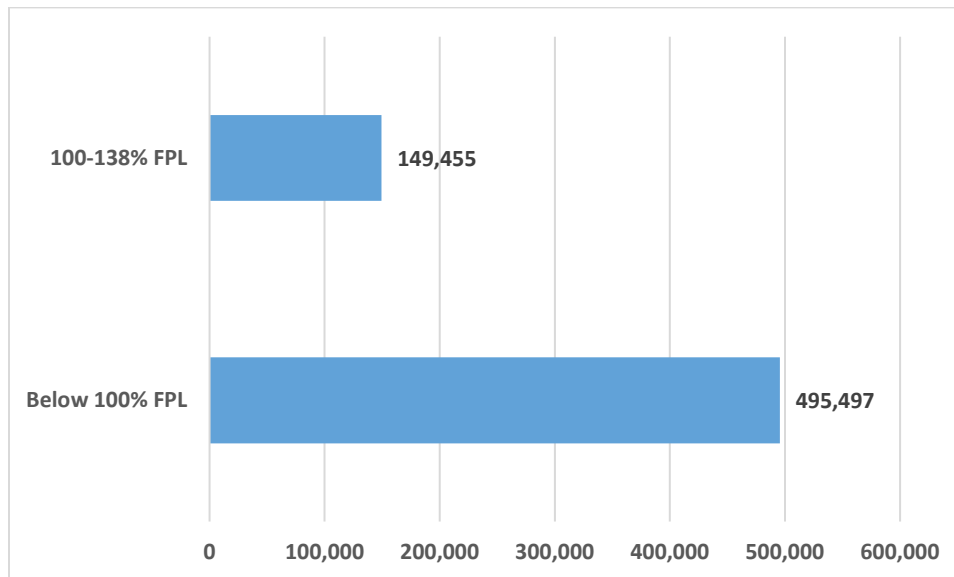


Table 2-10—CY 2024 Cardinal Care Program Medicaid Expansion Enrollment by FPL Category^{22*}

FPL Level	Number
Below 100% FPL	495,497
100–138% FPL	149,455

Note: The FPL is \$15,060 annually for a single person or \$25,820 annually for a family of three.

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

²¹ Ibid.

²² Ibid.

Figure 2-9—CY 2024 Cardinal Care Program Medicaid Expansion Enrollment by Medicaid Region²³

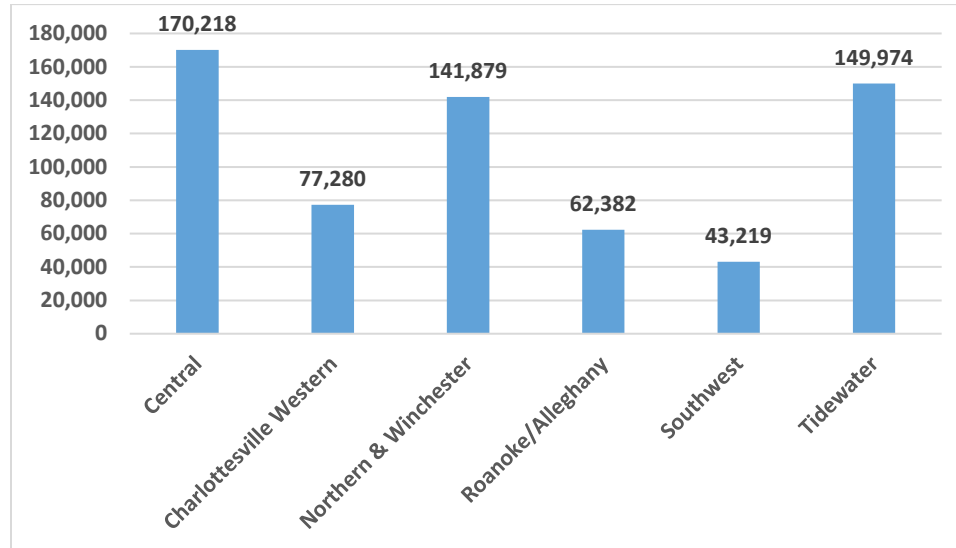


Table 2-11—Medicaid Expansion Enrollment by Medicaid Region^{24*}

Region	Number
Central Region	170,218
Charlottesville Western Region	77,280
Northern & Winchester Region	141,879
Roanoke/Alleghany Region	62,382
Southwest Region	43,219
Tidewater Region	149,974

Enrollment Data from 12/06/2023 are available at:

<https://www.dmas.virginia.gov/data/medicaid-expansion-enrollment/>

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

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.

²³ Ibid.

²⁴ Ibid.

On July 2, 2020, DMAS directed each MCO to increase payments to network physicians and nonphysician practitioners by 29 percent for certain services provided between March 1 and June 30, 2020. The services included primary care, preventive care, telehealth visits, and EPSDT screenings and treatments.²⁵ The flexibilities were designed to maintain provider staffing, maximize access to care, and minimize viral spread through community contact to protect the most vulnerable populations. Table 2-12 describes some of the flexibilities DMAS allowed during the PHE.

Table 2-12—COVID-19 Flexibilities

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

With the passage of the 2023 Consolidated Appropriations Act and associated omnibus bill that decoupled the continuous coverage requirement from the COVID-19 PHE, Virginia Medicaid enrollment processes returned to normal on April 1, 2023. DMAS began conducting eligibility determinations and renewals for all Medicaid and FAMIS members. DMAS is working with healthcare advocates and other partners to ensure eligible Virginians continue to receive high-quality healthcare coverage. As of July 31, 2024, Medicaid redetermination results included the following:²⁶

- 88,407 redeterminations needed (4.08 percent not yet completed)
- 459,939 coverage closed (21.23 percent)
- 1,618,035 coverage renewed and continued (74.69 percent)
- Of the members completing redetermination:
 - 37 percent were 0 to 18 years of age
 - 55 percent were 19 to 64 years of age
 - 8 percent were 65 years of age or older
 - 55 percent were female
 - 45 percent were male
 - 54 percent were White
 - 34 percent were Black or African American
 - 6 percent were some other race
 - 5 percent were Asian
 - 1 percent were Native Hawaiian or Pacific Islander
 - 1 percent were American Indian or Alaska Native

²⁵ Georgetown University McCourt School of Public Policy, Center for Children and Families. Redirecting Medicaid MCO Gains to Offset Network Provider Losses in the Time of COVID-19. Available at: <https://ccf.georgetown.edu/2020/07/27/redirecting-medicare-mco-gains-to-offset-network-provider-losses-in-the-time-of-covid-19/>. Accessed on: Jan 8, 2025.

²⁶ Virginia Department of Medical Assistance Services. Eligibility Redetermination Tracker. Available at: <https://www.dmas.virginia.gov/data/eligibility-redetermination-tracker/>. Accessed on: Jan 8, 2025.

- 96 percent were Not Hispanic or Latino
- 4 percent were Hispanic or Latino

Medicaid Enterprise System

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

MES supports DMAS to provide better and advanced data reporting and fraud detection. The separate MES modules represent each of the complex processes DMAS uses, individually updated to meet DMAS' needs without disrupting other modules. Several modules were live and providing benefits to DMAS and stakeholders. Remaining MES modules will transition all legacy MMIS functions, such as member enrollment data, claims adjudication, payment management, and health plan management to the new modular model.

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

One of the MES modules is a dynamic CRMS that facilitates care coordination activities for all Medicaid enrollees. CRMS collects and facilitates the secure exchange of member-centric data, through data collection, data sharing, and performance management. CRMS securely captures information related to the member's health summary, improving the quality and safety of care, reducing unnecessary and redundant patient testing, aiding the MCOs with proactive care planning, and reducing costs.

Since implementation, DMAS has received millions of records. 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.

Care Coordination

Care coordination is the centerpiece of the Model of Care in the Cardinal Care program. The Cardinal Care program 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 extended to all geographic areas, populations, and services within the managed care environment.

Training, Support, and Oversight of Care Coordination

The value of care coordination continued to demonstrate its worth with DMAS' most vulnerable members in the Cardinal Care (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 Virginia Department for Aging and Rehabilitative Services, the Virginia Association of Community Service Boards, the Alzheimer's Association, Association of AAAs, ENDependence Center of Northern Virginia, disAbility Law Center of Virginia, Eastern District of Virginia U.S. Attorney's Office, and Virginia Department of Housing and Community Development. In addition, DMAS Integrated Care collaborated with other DMAS units regarding needed educational opportunities related to the Cardinal Care Managed Care Waiver, screenings, BH, maternal and child health, and other areas as identified.

CMU continued to offer webinars twice a month for the Cardinal Care 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 Cardinal Care contract requirements. Many topics were related to waiver services and requirements, but there were also topics that were more general such as BH resources, crisis services, working with challenging members, etc.

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.
- Participation in workgroups along with other departments, agencies, and advocates/stakeholders to identify ways to improve care coordination in areas of specialized services and disease management.

The DMAS CMU continued to oversee care coordination provided through the MCOs and provided training and support to the MCOs' care coordinators. The MCOs' care coordinators were engaged in the training and support provided by the DMAS CMU and continued to fulfill the mission of the Cardinal Care (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 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.

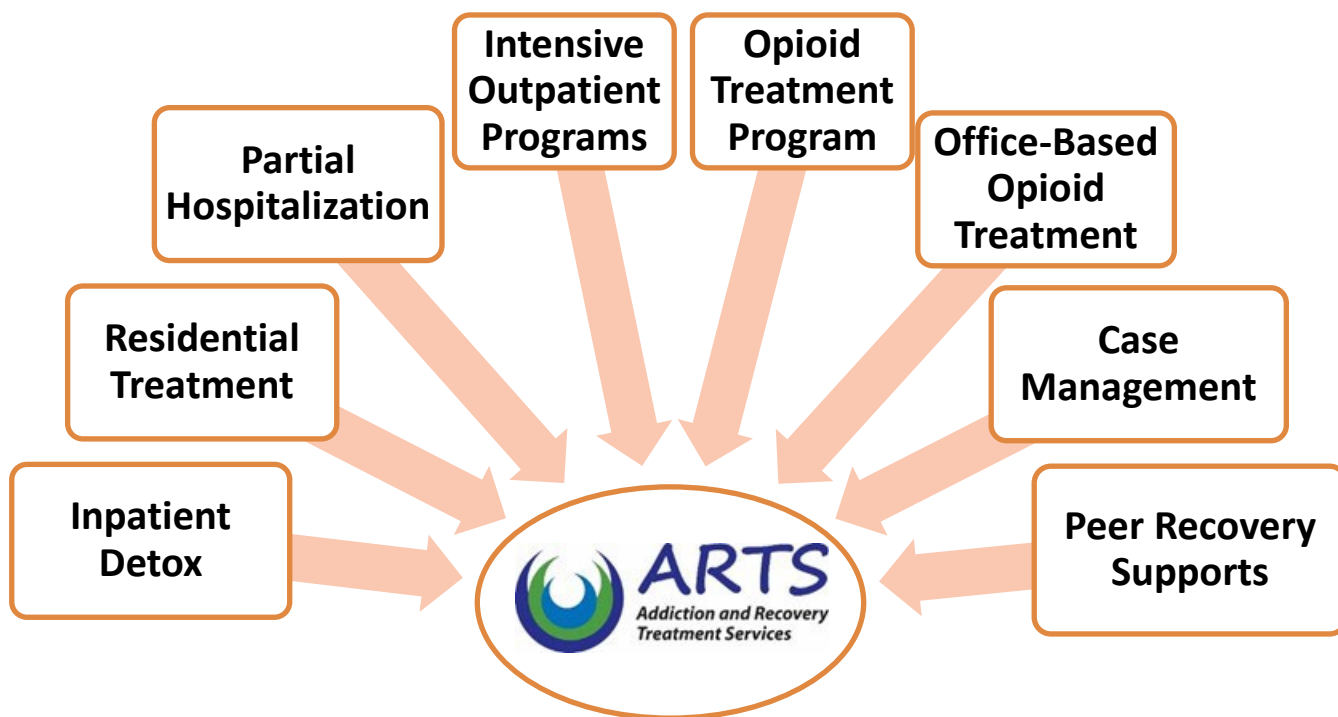
Training topics and meeting agendas were emailed to over 750 care coordinators each week, with an average of 500 participants on each call. Training topics included:

- DD Waivers and Cardinal Care MLTSS Care Coordination
- Building Blocks of CC—Part 1 Foundations
- Building Blocks of CC—Part 2 Filling Your Toolbox
- Easy Access to Health and Wellbeing with No Wrong Door Virginia
- Social Determinants of Health
- Virginia Medicaid Return to Normal Enrollment
- Motivational Interviewing for Care Coordinators
- DMAS Appeals
- Dementia—What is it?
- Virginia DARS
- Vocational Rehabilitation Services
- Community Service Boards
- ID and Dementia
- Depression and Dementia
- DARS—Overview of DARS and the Older Americans Act
- AAAs
- BIS TCM
- The Long-Term Care Ombudsman Program and Its Medicaid Managed Care Advocate Team: What's in it for you? Program Overview for Managed Care Coordinators
- Homeless Services Overview—Department of Virginia Housing and Community Development Homeless and Special Needs Housing Unit
- CCC Plus Waiver ADHC IES
- BIS TCM—Intake and Assessment Processes
- Reimbursing LRI for Personal Care
- Introduction to Disability Competency and Accessibility
- Overview of disAbility Law Center of Virginia—Protection and Advocacy
- ADA Requirements for Effective Communication in Health Care Settings
- Service Coordination for Tribal Members
- CCMC Continuity of Care for Members Enrolling in LTSS

ARTS²⁷

In 2017, DMAS implemented the ARTS benefit and carved in all services into the managed care contracts. The ARTS benefit focuses on treatment and recovery services for SUD, including OUD, AUD, and related conditions from SUD. The ARTS benefit expanded coverage of many ARTS services for Medicaid and CHIP members, including medications for OUD treatment, outpatient treatment, short-term residential treatment, and inpatient withdrawal management services. ARTS also increased provider reimbursement rates for many existing services and introduced a new care delivery model for treatment of OUD, the preferred OBAT provider. OBATs integrate MOUD with co-located behavioral and physical health by incentivizing increased use of care coordination activities. In addition, in accordance with requirements of Item 313, section ZZZ of the 2020 Appropriations Act, DMAS expanded the OBAT model effective March 1, 2022, to allow for other primary SUDs in addition to OUD.

ARTS outcomes are measured through reductions in SUD, OUD, and AUD ED utilization; reductions in inpatient admissions; increases in the number and type of healthcare practitioners providing SUD treatment and recovery services; and a decrease in opioid prescriptions. The goal is to ensure that members are matched to the right level of care to meet their evolving needs as they enter and progress through treatment. The ARTS benefit is a fully integrated physical health and BH continuum of care.



²⁷ 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, 2024.

DMAS worked with the Virginia Commonwealth University Department of Health Behavior and Policy to perform several evaluative efforts related to ARTS, including:

- A Midpoint Assessment of the ARTS benefit as required by CMS
- Qualitative interviews with key stakeholders
- Quantitative analysis of key metrics
- Assessment of progress towards meeting milestones

This collaborative process helps DMAS ensure that it is making progress towards achieving the goals for the ARTS benefit.

Approximately 154,854 individuals received ARTS benefits during SF 2024. 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).²⁸ The report was prepared by the VCU School of Medicine, Health Behavior and Policy. The primary objective of this report is to examine SUD prevalence, treatment utilization, and outcomes among Virginia Medicaid members during SFYs 2020, 2021, and the first two quarters of SFY 2022 (covering the period July 2019 through December 2022). The report states that the Commonwealth of Virginia has made substantial progress since the implementation of the ARTS benefit in 2017 in building a robust treatment infrastructure for Medicaid members, with the number of treatment providers, members using services, and treatment rates for those with SUD diagnoses increasing every year since 2017. The highlights of the results of the implementation of the ARTS benefit discussed in the report include:

Increased prevalence of SUD

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

²⁸ 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://healthpolicy.vcu.edu/media/school-of-population-health/hbp-2023/FinalARTSComprehensiveReport.4.27.23.docx.pdf>. Accessed on: Jan 8, 2025.

- MOUD treatment rates (the percentage of those with OUD diagnoses who were treated with one of three MOUD medications) increased from 64 percent in SFY 2020 to 78 percent in SFY 2021. While buprenorphine remains the most frequently prescribed MOUD treatment, use of methadone and naltrexone also increased.

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

Residential treatment and pharmacotherapy account for half of ARTS expenditures

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

Treatment gaps in transitions from emergency departments and residential treatment

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

Recently incarcerated at great risk for OUD and overdoses

- New Medicaid enrollees recently released from State prisons were four times as likely as other new Medicaid enrollees to receive an OUD diagnosis within six months of enrollment, and they were five times as likely to have had a fatal or nonfatal overdose.
- Once diagnosed with OUD, formerly incarcerated members tended to have higher rates of outpatient and MOUD treatment compared to other new Medicaid enrollees with OUD, and they were only slightly more likely to experience an overdose.

OUD-related overdose rates may have peaked

- OUD-related overdoses per 100,000 Medicaid members (fatal and nonfatal) increased 25 percent between SFY 2020 and SFY 2021.

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

- A more detailed quarterly analysis of overdose rates shows that while they rose precipitously through most of 2020, overdose rates have fluctuated since then. Also, overdose rates decreased during the first two quarters of SFY 2022.

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

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

Table 2-13—Providers of ARTS Services

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

Member Utilization of the ARTS Benefit

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

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

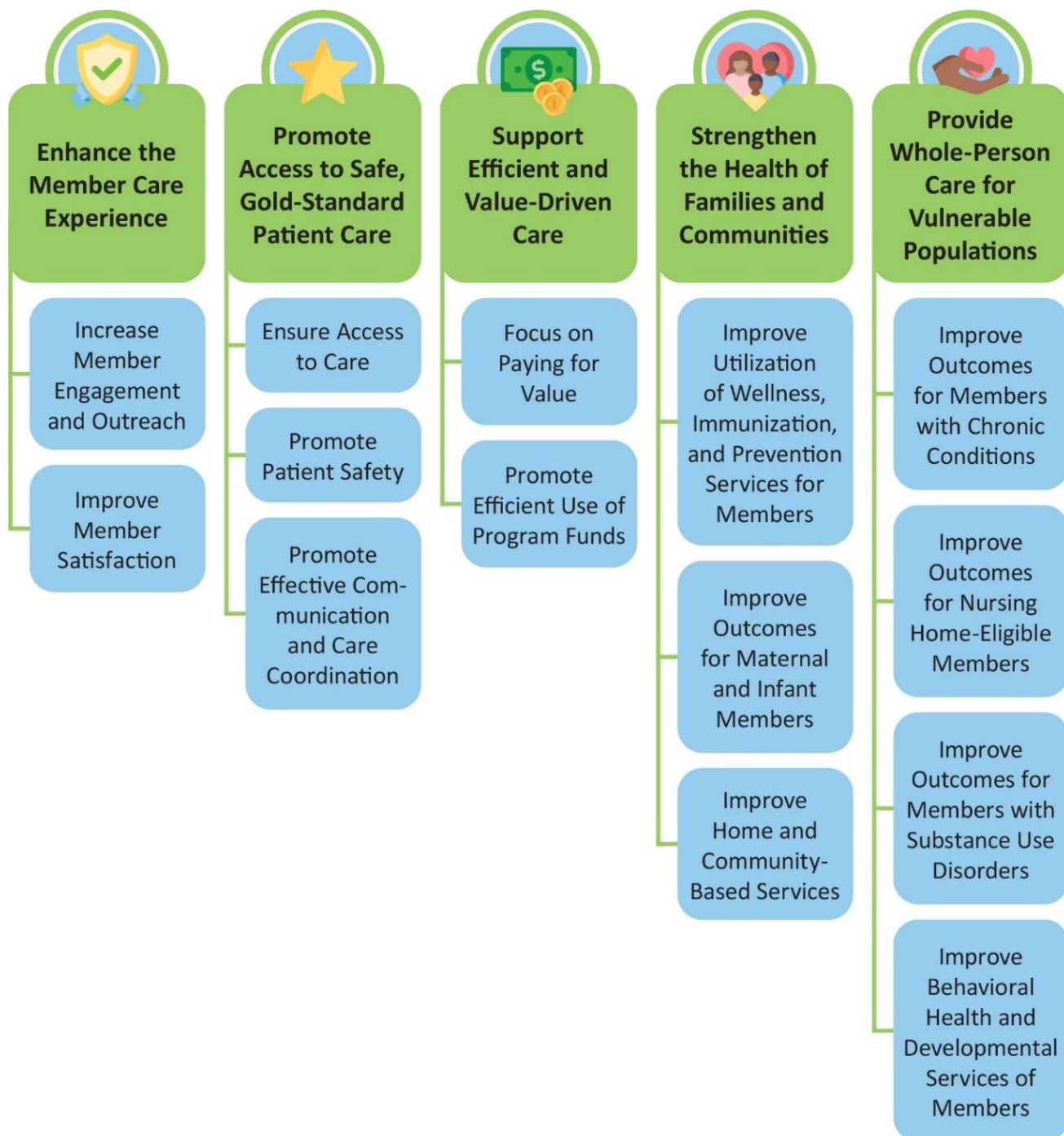
Between SFY 2020 and SFY 2021, the number of members with an ED visit increased. There were 45.4 SUD-related ED visits per 1,000 members in SFY 2021, a 5.6 percent increase from the prior year. Also, there were 9.7 OUD-related ED visits per 1,000 members in SFY 2021, a 15.5 percent increase from the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

Virginia's 2023–2025 Quality Strategy

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, and data-driven. DMAS conducts oversight of the MCOs to promote accountability and transparency for improving health outcomes.

Table 2-14 displays a sample of the initiatives DMAS implemented or continued during CY 2024 that support DMAS' efforts toward achieving the Virginia 2023–2025 QS goals and objectives.

Table 2-14—DMAS Quality Initiatives Driving Improvement

Virginia 2023–2025 QS Goal, Objective, and Metric	DMAS Quality Initiative
Goal 4.2: Improve Outcomes for Diagnosed Substance Use Disorders (DSU) Objective 4.2.1: Increase Diagnosed Substance Use Disorders Metric Metric 4.2.1: Monitor Diagnosed Substance Use Disorders	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 began in October 2023.
Goal 4.2: Improve Outcomes for Diagnosed Substance Use Disorders (DSU) Objective 4.2.3: Decrease Use of Opioids at High Dosage in Persons without Cancer Metric Metric 4.2.3: Use of Opioids at High Dosage in Persons Without Cancer	Through numerous efforts, including the SUPPORT Act Grant, DMAS has been working with stakeholders to identify ways to increase engagement and retention in substance use disorder 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.

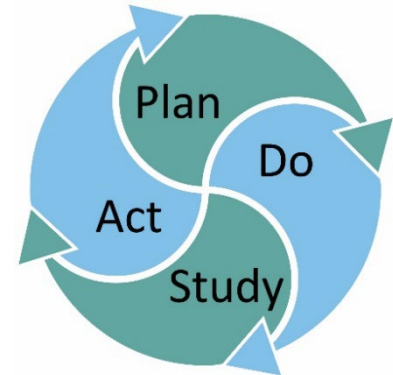
The MCOs' ongoing QAPI programs objectively and systematically monitor and evaluate the quality and appropriateness of care and services rendered, thereby promoting quality of care and improved health outcomes for their members.

Appendix D provides examples of the quality initiatives the MCOs highlighted as their efforts during CY 2024 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, and data-driven. 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, access, and timeliness of the Cardinal Care program.

Definitions

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

		
Quality CMS defines “quality” in the final rule at 42 CFR §438.320 as follows: “Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in 438.310[c][2]) increases the likelihood of desired outcomes of its enrollees through: its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement.”¹	Access CMS defines “access” in the final 2016 regulations at 42 CFR §438.320 as follows: “Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 438.68 (network adequacy standards) and 438.206 (availability of services).”²	Timeliness The 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 2024, the MCOs continued the DMAS-selected topics of *Ensuring Timeliness of Prenatal Care* (HEDIS PPC measure) and *Tobacco Use Cessation in Pregnant Women* as well as 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]—Patient Engagement After Inpatient Discharge* specifications). The MCOs progressed to reporting Remeasurement 1 data for CY 2023 and interventions, updating their PIP submission forms through Step 8 (Quality Improvement Strategies and Interventions). HSAG validated the Remeasurement 1 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 2024 final PIP validation score and overall confidence rating.

Strengths, Weaknesses, and Recommendations

Strengths	
	Three of the five MCOs received 100 percent validation scores across all evaluation elements for Steps 1 through 8 and were assigned a <i>High Confidence</i> level for all PIPs. These MCOs calculated and reported Remeasurement 1 data accurately, implemented targeted interventions that addressed the identified barriers, and developed sound methodologies for evaluating the effectiveness for each intervention.
Weaknesses and Recommendations	
	Weakness: Not all MCOs addressed all requirements for data analysis and interpretation of results (Step 7). One MCO did not include a statement about factors which threaten comparability, and one MCO did not provide the correct statistical testing results or indicator of the direction of change. Recommendations: The MCOs should ensure all documentation requirements are addressed. The MCOs must include a statement about whether there are factors which threaten comparability of the remeasurement period to the baseline period in the Step 7 narrative. If there are no factors, this should be documented. The MCOs should conduct accurate statistical testing and indicate the <i>p</i> value and the direction of change in the performance indicator(s) compared to baseline.

Table 3-1—PIP Performance Results

PIP Topic	Aetna		HealthKeepers		Molina*		Sentara		United Healthcare	
	Baseline Rate	R1 Rate	Baseline Rate	R1 Rate	Baseline Rate	R1 Rate	Baseline Rate	R1 Rate	Baseline Rate	R1 Rate
<i>Timeliness of Prenatal Care</i>	78.59%	77.13%	60.71%	61.40%	47.5%	55.2%	68.13%	66.18%	57.25%	62.10%

PIP Topic	Aetna		HealthKeepers		Molina*		Sentara		United Healthcare	
	Baseline Rate	R1 Rate	Baseline Rate	R1 Rate	Baseline Rate	R1 Rate	Baseline Rate	R1 Rate	Baseline Rate	R1 Rate
<i>Tobacco Use Cessation in Pregnant Women</i>	2.09%	2.68%	2.17%	1.04%	56.5%	70.6%	89.97%	90.30%	37.79%	52.25%
<i>AMB-ED Visits</i>	1,083.05 visits/ 1,000 member years	1,179.85 visits/ 1,000 member years	462.48 visits/ 1,000 member years	575.01 visits/ 1,000 member years	1132.40 visits/ 1,000 member years	698.35 visits/ 1,000 member years	1,000.32 visits/ 1,000 member years	1000.00 visits/ 1,000 member years	1,152.24 visits/ 1,000 member years	1,159.25 visits/ 1,000 member years
<i>Follow-Up After Discharge</i>	64.39%	66.75%	67.73%	71.21%	63.3%	75.2%	49.40%	50.67%	70.34%	73.10%

R=Remeasurement

*Molina reported rates to the first decimal place

MCO Comparative and Statewide Aggregate PMV Results

PMV Highlights

The PMV highlights are included in Table 3-2.

Table 3-2—PM Strengths and Weaknesses by Domain

Domain	Strengths	Weaknesses
Access to Care	Three of the five MCOs' rates met or exceeded the 75th percentile for the <i>Adults' Access to Preventive/Ambulatory Health Services—Total</i> PM indicator.	All five MCOs' rates fell below the 50th percentile for the <i>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total</i> , <i>Colorectal Cancer Screening—Total</i> , <i>Use of Imaging Studies for Low Back Pain—Total</i> , and <i>Plan All-Cause Readmissions—Observed Readmissions</i> PM indicators.
Behavioral Health	All five MCOs' rates met or exceeded the 50th percentile for the <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Total</i> , both indicators for <i>Initiation and Engagement of Substance Use Disorder Treatment</i> , and <i>Use of First-Line Psychosocial Care for Children and Adolescents</i>	All five MCOs' rates fell below the 50th percentile for the <i>Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total</i> PM indicator.

Domain	Strengths	Weaknesses
	on Antipsychotics—Total PM indicators.	
Children's Preventive Care	Four of the five MCOs' rates met or exceeded the 75th percentile for the <i>Immunization for Adolescents—Combination 1 (Meningococcal; Tdap)</i> PM indicator.	Three of the five MCOs' rates fell below the 50th percentile for the <i>Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)</i> PM indicator.
Care for Chronic Conditions	All five MCOs' rates met or exceeded the 50th percentile for the <i>Asthma Medication Ratio—Total</i> PM indicator.	All five MCOs' rates fell below the 50th percentile for the <i>Medical Assistance With Smoking and Tobacco Use Cessation</i> PM indicators.
Women's Health	Three of the five MCOs' rates exceeded the statewide average for the <i>Breast Cancer Screening—Total</i> PM indicator.	All five MCOs' rates fell below the 50th percentile for the <i>Cervical Cancer Screening—Total</i> PM indicator.

As part of performance measurement, the Virginia MCOs were required to submit HEDIS data to NCQA. To ensure that HEDIS rates were accurate and reliable, NCQA required each MCO to undergo an NCQA HEDIS Compliance Audit^{TM,29} conducted by a certified independent auditor.

Each MCO contracted with an NCQA LO to conduct the HEDIS Compliance Audit. HSAG reviewed the MCOs' FARs, IS compliance tools, and the IDSS files approved by each MCO's LO. HSAG found that the MCOs' IS and processes were compliant with the applicable IS standards and the HEDIS reporting requirements for the key Cardinal Care Medicaid PMs for HEDIS MY 2023.

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

- *Asthma Admission Rate (Per 100,000 Member Months)*
- *Blood Pressure Control for Patients With Diabetes*
- *Child and Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combination 3*
- *Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)—Total*
- *Eye Exam for Patients With Diabetes*
- *Follow-Up After Emergency Department (ED) Visit for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total*
- *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total*
- *Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—Total*

²⁹ HEDIS Compliance AuditTM is a trademark of NCQA.

- Heart Failure Admission Rate (Per 100,000 Member Months)—Total
- Hemoglobin A1c (HbA1c) Control for Patients With Diabetes
- Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment
- Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment
- Prenatal and Postpartum Care—Postpartum Care
- Prenatal and Postpartum Care—Timeliness of Prenatal Care

HSAG contracted with ALI Consulting Services, LLC, for assistance with validating the PMs. Using the validation methodology and protocols described in Appendix B, HSAG determined results for each PM. The CMS EQR Protocol 2 cited earlier in this report identifies two possible validation finding designations for PMs: *Reportable (R)*—PM data were compliant with HEDIS and DMAS specifications and the data were valid as reported, or *Do Not Report (DNR)*—PM data were materially biased. HSAG's validation results for each MCO are summarized in Table 3-3, with all rates validated as *Reportable (R)*.

Table 3-3—HSAG MCO PMV Results

Performance Measure	Aetna	Health Keepers	Molina	Sentara	United
Asthma Admission Rate (Per 100,000 Member Months)					
Asthma Admission Rate (Per 100,000 Member Months)	3.57	1.59	5.29	5.57	4.63
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control for Patients With Diabetes	62.04%	64.72%	47.45%	59.37%	68.37%
Child and Adolescent Well-Care Visits					
Total	48.71%	55.61%	44.63%	47.06%	55.64%
Childhood Immunization Status					
Combination 3	62.29%	67.88%	63.99%	66.18%	71.29%
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)					
40–64 Years	13.30	22.79	26.99	29.32	41.15
65+ Years	30.61	84.14	58.17	76.11	86.29
Total	14.96	30.68	28.23	34.15	50.23
Eye Exam for Patients With Diabetes					
Eye Exam for Patients With Diabetes	54.26%	58.15%	45.01%	53.53%	57.91%
Follow-Up After ED Visit for Mental Illness					
7-Day Follow-Up—Total	37.27%	40.28%	34.91%	39.33%	35.55%
30-Day Follow-Up—Total	51.35%	56.56%	51.07%	53.71%	49.66%
Follow-Up After ED Visit for Substance Use					
7-Day Follow-Up—Total	29.33%	27.13%	26.85%	27.82%	23.31%
30-Day Follow-Up—Total	41.12%	38.66%	38.43%	39.11%	35.68%
Heart Failure Admission Rate (Per 100,000 Member Months)					

Performance Measure	Aetna	Health Keepers	Molina	Sentara	United
40–64 Years	21.71	21.71	23.59	26.54	37.10
65+ Years	166.37	213.84	130.89	198.10	253.54
Total	28.04	31.64	25.32	33.26	58.18
Hemoglobin A1c (HbA1c) Control for Patients With Diabetes					
HbA1c Poor Control (>9.0%)*	37.71%	36.25%	40.39%	40.39%	28.47%
HbA1c Adequate Control (<8.0%)	52.80%	56.69%	51.09%	51.09%	61.80%
Initiation and Engagement of Substance Use Disorder (SUD) Treatment					
Initiation of SUD Treatment	53.81%	45.69%	56.17%	51.08%	48.51%
Engagement of SUD Treatment	22.74%	19.13%	23.99%	21.63%	18.00%
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	81.75%	76.40%	68.86%	66.18%	86.86%
Postpartum Care	75.67%	70.32%	68.37%	71.05%	82.97%

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

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

Data Integration—The steps used to combine various data sources (including claims and encounter data, eligibility data, and other administrative data) must be carefully controlled and validated. HSAG validated the data integration process used by the MCOs, which included a review of file consolidations or extracts, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. HSAG determined that the data integration processes for the MCOs were acceptable.

Data Control—Each MCO's organizational infrastructure must support all necessary IS; its quality assurance practices and backup procedures must be sound to ensure timely and accurate processing of data and to provide data protection in the event of a disaster. HSAG validated the MCO's data control processes and determined that the data control processes in place were acceptable.

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

MCO Comparative and Statewide Aggregate HEDIS Results

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

Each MCO contracted with an NCQA LO to conduct the HEDIS Compliance Audit. HSAG reviewed the MCOs' FARs, IS compliance tools, and the IDSS files approved by each MCO's LO. HSAG found that the MCOs' IS and processes were compliant with the applicable IS standards and the HEDIS reporting requirements for the key Cardinal Care Medicaid PMs for HEDIS MY 2023.

Table 3-4 displays, by MCO, the HEDIS MY 2023 PM rate results compared to NCQA's Quality Compass[®],³⁰ national Medicaid HMO percentiles for the HEDIS MY 2022 50th percentiles and the Virginia aggregate, which represents the average of five MCOs' PM rates weighted by the eligible population. Of note, gray-shaded boxes indicate MCO PM rates that were at or above the 50th percentile. Rates indicating better performance than the Virginia aggregates are represented in burgundy font.

Table 3-4—MCO Comparative and Virginia Aggregate HEDIS MY 2023 PM Results

Performance Measure	Aetna	Health Keepers	Molina	Sentara	United	Virginia Aggregate
Access to Care						
Adults' Access to Preventive/Ambulatory Health Services						
Total	73.61%	76.42%	60.79%	71.70%	73.82%	72.83%
Ambulatory Care—Emergency Department (ED) Visits						
Emergency Department (ED) Visits—Total*	744.85	674.25	698.35	680.21	698.48	689.26
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis						
Total	55.34%	56.18%	59.86%	60.91%	54.54%	57.79%
Colorectal Cancer Screening						
Total	34.71%	39.47%	23.79%	37.19%	37.64%	36.67%
Inpatient Utilization—General Hospital/Acute Care						
Total Discharges per 1,000 Member Months (Total Inpatient)	65.47	61.45	70.28	73.12	82.51	69.32
Total Average Length of Stay (Total Inpatient)	5.56	5.27	4.89	5.16	5.32	5.24
Total Discharges per 1,000 Member Months (Medicine)	28.74	27.49	31.31	38.46	42.93	33.85
Total Average Length of Stay (Medicine)	5.40	5.07	4.66	4.81	4.90	4.94
Total Discharges per 1,000 Member Months (Surgery)	16.70	15.47	15.91	16.77	19.44	16.58
Total Average Length of Stay (Surgery)	9.35	8.79	8.71	8.55	9.26	8.81
Total Discharges per 1,000 Member Months (Maternity)	26.51	25.90	30.11	24.59	28.64	26.00
Total Average Length of Stay (Maternity)	2.61	2.61	2.56	2.74	2.43	2.64
Plan All-Cause Readmissions						
Observed Readmissions*	11.99%	8.47%	14.14%	10.17%	10.12%	10.16%
O/E Ratio Total*	1.1099	0.8615	1.3560	0.9949	0.9660	0.9963
Use of Imaging Studies for Low Back Pain						

³⁰ Quality Compass[®] is a registered trademark of NCQA.

Performance Measure	Aetna	Health Keepers	Molina	Sentara	United	Virginia Aggregate
<i>Total</i>	64.77%	64.27%	61.14%	67.26%	67.83%	65.70%
Behavioral Health						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia						
<i>Total</i>	61.08%	64.12%	56.27%	62.69%	63.06%	62.39%
Antidepressant Medication Management						
<i>Effective Acute Phase Treatment</i>	52.23%	53.70%	44.53%	59.06%	56.34%	55.20%
<i>Effective Continuation Phase Treatment</i>	37.80%	39.05%	31.08%	44.55%	41.12%	40.65%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia						
<i>Total</i>	77.08%	76.36%	NA	77.54%	72.92%	76.11%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications						
<i>Total</i>	84.33%	80.57%	79.67%	81.70%	83.00%	81.79%
Diagnosed Mental Health Disorders						
<i>Total</i>	31.54%	29.10%	NA	30.80%	28.39%	30.06%
Diagnosed Substance Use Disorders						
<i>Alcohol Disorder—Total</i>	3.72%	2.52%	4.22%	2.64%	3.40%	2.90%
<i>Opioid Disorder—Total</i>	4.58%	3.25%	4.83%	3.53%	3.88%	3.68%
<i>Other or Unspecified Drugs—Total</i>	5.31%	3.68%	6.06%	4.13%	4.53%	4.29%
<i>Any Disorder—Total</i>	9.69%	6.94%	10.58%	7.54%	8.65%	7.91%
Follow-Up After Emergency Department Visit for Substance Use						
<i>7-Day Follow-Up—Total</i>	29.33%	27.13%	26.85%	27.82%	23.31%	27.27%
<i>30-Day Follow-Up—Total</i>	41.12%	38.66%	38.43%	39.11%	35.68%	38.86%
Follow-Up After ED Visit for Mental Illness						
<i>7-Day Follow-Up—Total</i>	37.27%	40.28%	34.91%	39.33%	35.55%	38.56%
<i>30-Day Follow-Up—Total</i>	51.35%	56.56%	51.07%	53.71%	49.66%	53.53%
Follow-Up After Hospitalization for Mental Illness						
<i>7-Day Follow-Up—Total</i>	31.13%	39.08%	33.93%	31.58%	33.37%	33.91%
<i>30-Day Follow-Up—Total</i>	55.02%	62.80%	55.90%	52.85%	55.26%	56.34%
Initiation and Engagement of Substance Use Disorder Treatment						
<i>Initiation of SUD Treatment</i>	53.81%	48.85%	56.17%	51.08%	48.51%	51.05%
<i>Engagement of SUD Treatment</i>	22.74%	19.13%	23.99%	21.63%	18.00%	20.93%
Metabolic Monitoring for Children and Adolescents on Antipsychotics						
<i>Blood Glucose Testing—Total</i>	56.77%	53.65%	56.79%	54.38%	62.31%	54.81%
<i>Cholesterol Testing—Total</i>	41.29%	32.93%	41.98%	37.80%	45.10%	36.87%
<i>Blood Glucose and Cholesterol Testing—Total</i>	39.57%	31.43%	40.12%	35.48%	43.92%	34.96%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics						
<i>Total</i>	70.29%	63.87%	66.67%	61.94%	64.10%	63.48%

Performance Measure	Aetna	Health Keepers	Molina	Sentara	United	Virginia Aggregate
Children's Preventive Care						
Child and Adolescent Well-Care Visits						
Total	48.71%	55.61%	44.63%	47.06%	55.64%	50.88%
Childhood Immunization Status						
Combination 3	62.29%	67.88%	63.99%	66.18%	71.29%	66.64%
Immunizations for Adolescents						
Combination 1 (Meningococcal; Tetanus, Diphtheria Toxoids and Acellular Pertussis [Tdap])	82.00%	86.13%	72.99%	83.70%	85.64%	84.20%
Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])	31.87%	36.25%	26.76%	34.06%	44.53%	35.30%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents						
Body Mass Index (BMI) Percentile Documentation—Total	77.37%	79.32%	65.45%	72.02%	77.62%	75.44%
Counseling for Nutrition—Total	65.69%	72.99%	58.15%	61.07%	69.10%	66.47%
Counseling for Physical Activity—Total	62.04%	64.48%	48.42%	55.96%	64.23%	60.09%
Well-Child Visits in the First 30 Months of Life						
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	64.51%	64.59%	52.21%	58.50%	61.48%	61.18%
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	72.49%	72.74%	65.66%	67.33%	74.69%	70.36%
Care for Chronic Conditions						
Asthma Medication Ratio						
Total	74.96%	72.91%	73.55%	75.11%	67.40%	73.68%
Blood Pressure Control for Patients With Diabetes						
Total	62.04%	64.72%	47.45%	59.37%	68.37%	61.74%
Eye Exam for Patients With Diabetes						
Total	54.26%	58.15%	45.01%	53.53%	57.91%	55.05%
Hemoglobin A1c Control for Patients With Diabetes						
HbA1c Control (<8.0%)	52.80%	56.69%	40.39%	51.09%	61.80%	53.65%
HbA1c Poor Control (>9.0%)*	37.71%	36.25%	51.09%	40.39%	28.47%	37.97%
Controlling High Blood Pressure						
Total	61.31%	65.69%	35.77%	56.45%	65.21%	59.87%
Medical Assistance With Smoking and Tobacco Use Cessation						
Advising Smokers and Tobacco Users to Quit	74.52%	72.73%	67.53%	76.92%	69.35%	72.41%
Discussing Cessation Medications	49.02%	49.09%	48.70%	58.82%	41.32%	49.22%
Discussing Cessation Strategies	41.13%	41.67%	38.22%	55.08%	37.19%	41.88%
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation						
Systemic Corticosteroid	87.87%	71.00%	78.08%	60.28%	77.33%	70.75%

Performance Measure	Aetna	Health Keepers	Molina	Sentara	United	Virginia Aggregate
<i>Bronchodilator</i>	92.85%	79.59%	85.13%	67.16%	86.13%	78.08%
Use of Opioids at High Dosage						
<i>Total*</i>	2.83%	3.59%	3.82%	5.52%	4.52%	4.40%
Use of Opioids from Multiple Providers						
<i>Multiple Prescribers*</i>	25.74%	20.12%	21.38%	18.64%	22.91%	20.71%
<i>Multiple Pharmacies*</i>	4.34%	2.95%	4.55%	3.07%	3.40%	3.29%
<i>Multiple Prescribers and Multiple Pharmacies*</i>	3.32%	1.87%	2.90%	1.97%	2.02%	2.15%
Women's Health						
Breast Cancer Screening						
<i>Total</i>	51.73%	55.07%	41.81%	46.06%	53.92%	50.14%
Cervical Cancer Screening						
<i>Total</i>	50.85%	53.77%	39.68%	48.42%	43.31%	49.37%
Prenatal and Postpartum Care						
<i>Timeliness of Prenatal Care</i>	81.75%	76.40%	68.86%	66.18%	86.86%	73.71%
<i>Postpartum Care</i>	75.67%	70.32%	68.37%	71.05%	82.97%	72.42%

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

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

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

 Indicates that the HEDIS MY 2023 rate was at or above the 50th percentile.

Strengths, Weaknesses, and Recommendations

Strengths	
	Within the Access to Care domain, three of the five MCOs' rates met or exceeded the 75th percentile for the <i>Adults' Access to Preventive/Ambulatory Health Services—Total PM</i> indicator. Aetna, HealthKeepers, and United demonstrated better performance than the Virginia Aggregate of 72.83 percent. Specifically, HealthKeepers led with a rate of 76.42 percent.
	Within the Behavioral Health domain, all five MCOs' rates met or exceeded the 50th percentile for the <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total PM</i> indicator. Aetna, HealthKeepers, Molina, and United demonstrated better performance than the Virginia Aggregate of 63.48 percent. Specifically, Aetna led with a rate of 70.29 percent.
	Within the Children's Preventive Care domain, four of the five MCOs' rates met or exceeded the 75th percentile for the <i>Immunization for Adolescents—Combination 1 (Meningococcal; Tdap) PM</i> indicator. HealthKeepers and United demonstrated better performance than the Virginia Aggregate of 84.20 percent. Specifically, HealthKeepers led with a rate of 86.13 percent.

Strengths	
	Within the Care for Chronic Conditions domain, all five MCOs' rates met or exceeded the 50th percentile for the <i>Asthma Medication Ratio PM</i> indicator. Aetna and Sentara demonstrated better performance than the Virginia Aggregate of 73.68 percent. Specifically, Sentara led with a rate of 75.11 percent.
	Within the Women's Health domain, two of the five MCOs' rates met or exceeded the 50th percentile for the <i>Breast Cancer Screening—Total</i> PM indicator. Aetna, HealthKeepers, and United demonstrated better performance than the Virginia Aggregate of 50.14 percent. Specifically, HealthKeepers led with a rate of 55.07 percent.
Weaknesses and Recommendations	
	Weakness: Within the Access to Care and Women's Health domains, all five MCOs' rates fell below the 50th percentile for the <i>Cervical Cancer Screening—Total</i> and <i>Colorectal Cancer Screening—Total</i> PM indicators. Cervical cancer was one of the most common causes of cancer death for American women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.³¹ Recommendations: HSAG recommends that MCOs consider whether there are health disparities within the plans' populations that contributed to lower access to care. HSAG recommends that MCOs implement interventions to reduce barriers to care, such as including community providers in planning educational materials and outreach activities. MCOs should also communicate to eligible members through multi-modal approaches including outreach through phone calls, text messages to promote women's screenings, and incentives to PCPs to provide the service and increase access and outreach to eligible assigned members. MCOs should also ensure that providers can communicate with patients with scheduled reminders and utilize personalized outreach for overdue patients. Communication messages should be clear and concise and include the procedure time.
	Weakness: Within the Behavioral Health domain, four of the five MCOs' rates fell below the 50th percentile for both <i>Follow-Up After Hospitalization for Mental Illness</i> PM indicators. Additionally, at least four of the five MCOs' rates fell below the 50th percentile for both <i>Follow-Up After Emergency Department Visit for Mental Illness</i> PM indicators. Finally, all five MCOs' rates fell below the 50th percentile for the <i>Antidepressant Medication Management—Effective Acute Phase Treatment</i> PM indicator. In 2019, nearly one in five adults ages 18 years and older in the U.S. had a diagnosed mental health disorder. Despite this, individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing

³¹ National Committee for Quality Assurance. Cervical Cancer Screening. Available at: <https://www.ncqa.org/hedis/measures/cervical-cancer-screening/>. Accessed on: Jan 8, 2025.

Weaknesses and Recommendations

	follow-up care to patients after psychiatric hospitalization can improve patient outcomes and decrease the likelihood of rehospitalization and the overall cost of outpatient care.³² Recommendations: HSAG recommends that MCOs meet with hospitals to improve understanding of the importance of follow-up care and discuss tips on scheduling patients in the hospital or ED. In turn, hospital discharge planners can provide insight into the challenges they face in setting up follow-up visits before discharge, and then MCOs can work with outpatient providers on solutions to these challenges. Additionally, MCOs should encourage outpatient providers to send direct messages to patients with canceled visits or no-shows. HSAG recommends that MCOs ensure telehealth services for follow-up visits are covered, available, and that providers and patients are made aware of telehealth follow-up visit options. HSAG recommends that MCOs analyze mental health integration between providers, including primary care and mental health specialists. This, coupled with improved monitoring, has been shown to improve medication adherence.
	Weakness: Within the Children's Preventive Care domain, three of the five MCOs' rates fell below the 50th percentile for the <i>Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)</i> PM indicator. Additionally, all five MCOs' rates fell below the 50th percentile for the <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index</i> and <i>Counseling for Physical Activity</i> PM indicators. Vaccines are a safe and effective way to protect adolescents against potential deadly diseases. Receiving recommended vaccinations is the best defense against vaccine-preventable diseases, including meningococcal meningitis, tetanus, diphtheria, pertussis (whooping cough) and HPV. These are serious diseases that can cause breathing difficulties, heart problems, nerve damage, pneumonia, seizures, cancer—and even death.³³ Recommendations: HSAG recommends that MCOs address whether providers are recording any vaccinations patients receive outside of provider care, such as at a pharmacy. MCOs should ensure that providers are scheduling and discussing vaccinations during the annual check-up visit. HSAG recommends that MCOs survey providers of the cases wherein BMI was not measured or counseling was not provided to identify barriers such as lack of resources, lack of time, or lack of training to provide appropriate counseling. MCOs should then determine the best methods to eliminate these challenges.
	Weakness: Within the Care for Chronic Conditions domain, all five MCOs' rates fell below the 50th percentile for all three of the <i>Medical Assistance With</i>

³² 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: Jan 8, 2025.

³³ National Committee for Quality Assurance. Immunizations for Adolescents. Available at: <https://www.ncqa.org/hedis/measures/immunizations-for-adolescents/>. Accessed on: Jan 8, 2025.

Weaknesses and Recommendations



Smoking and Tobacco Use Cessation—Discussing Cessation Strategies PM indicators.

Smoking and tobacco use are the largest causes of preventable disease and death in the U.S. Tobacco use causes disease in nearly every organ in the body. Quitting smoking and tobacco use can save lives and improve overall health. Comprehensive cessation interventions that motivate and help users to quit tobacco use can be very effective.³⁴

Recommendations: Coverage for smoking cessation treatment that is comprehensive, barrier-free, and widely promoted increases the use of these treatment services, leads to higher rates of successful quitting, and is cost-effective. HSAG recommends that MCOs analyze which demographic groups may have lower rates of cessation and consider how to reduce barriers for populations, like offering transportation or virtual services. Increasing promotion of these services can include local advertisements, collaboration with providers on marketing, or contacting patients who identify as smokers.

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 Cardinal Care Acute (formerly Medallion 4.0) program. During 2022, DMAS monitored the MCOs' implementation of federal and Commonwealth requirements and CAPs from the 2021 compliance reviews.

Operational Systems Review

Table 3-5 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	Sentara	United	Total Compliance Score
I.	438.56	Disenrollment: Requirements and Limitations*	66.7%	66.7%	100%	100%	100%	86.7%
II.	438.100 438.10	Member Rights* and Member Information	69.2%	69.2%	34.6%	84.6%	65.4%	64.6%

³⁴ National Committee for Quality Assurance. Medical Assistance With Smoking and Tobacco Use Cessation. Available at: <https://www.ncqa.org/hedis/measures/medical-assistance-with-smoking-and-tobacco-use-cessation/>. Accessed on: Jan 8, 2025.

Standard	CFR	Standard Name	Aetna	HealthKeepers	Molina	Sentara	United	Total Compliance Score
III.	438.114	Emergency and Poststabilization Services*	84.6%	100%	100%	100%	100%	96.9%
IV.	438.206	Availability of Services	100%	100%	100%	100%	100%	100.0%
V.	438.207	Assurances of Adequate Capacity and Services	75.0%	75.0%	50.0%	100%	75.0%	75.0%
VI.	438.208	Coordination and Continuity of Care	100%	90.9%	91.0%	100%	100%	96.4%
VII.	438.210	Coverage and Authorization of Services	91.3%	91.3%	87.0%	100%	95.7%	93.0%
VIII.	438.214	Provider Selection	95.5%	100%	95.5%	100%	95.5%	97.3%
IX.	438.224	Confidentiality	100%	100%	100%	100%	100%	100.0%
X	438.228	Grievance and Appeal Systems	87.2%	87.2%	84.6%	89.7%	89.7%	87.7%
XI.	438.230	Subcontractual Relationships and Delegation	40.0%	40.0%	80.0%	100%	100%	72.0%
XII.	438.236	Practice Guidelines	85.7%	57.1%	85.7%	100%	71.4%	80.0%
XIII.	438.242	Health Information Systems**	100%	100%	100%	100%	100%	100.0%
XIV.	438.330	Quality Assessment and Performance Improvement	100%	95.2%	100%	100%	100%	99.0%
XV.	438.608	Program Integrity	85.7%	78.6%	100%	100%	85.7%	90.0%
XVI.	Social Security Act; Section 1859	Model of Care	94.7%	97.4%	97.4%	92.1%	100%	96.3%
XVII.	441.50	EPSDT	67.6%	73.0%	94.6%	94.6%	86.5%	83.2%

Standard	CFR	Standard Name	Aetna	HealthKeepers	Molina	Sentara	United	Total Compliance Score
	SSA, Section 1902							
TOTAL SCORE			86.7%	87.0%	88.6%	95.8%	91.9%	90.0%

* 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 which 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	
	All five MCOs achieved full compliance in three of the 17 standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas: - Standard IV: Availability of Services - Standard IX: Confidentiality - Standard XIII: Health Information Systems These findings suggest that the MCOs developed the necessary policies, procedures, and processes to operationalize some of the requirements of its contract and demonstrated compliance with the expectations of the contract in these operational areas.
Weaknesses and Recommendations	
	Weakness: The areas with the greatest opportunity for improvement for the MCOs were related to the following, as all five MCOs received performance scores under 90 percent in the following standards: - Standard II: Member Rights and Member Information - Standard X: Grievance and Appeal Systems

Weaknesses and Recommendations

These findings suggest that the MCOs did not consistently develop the necessary policies, procedures, and processes to operationalize the requirements of their contracts and did not always demonstrate compliance with contract requirements.

Recommendations: HSAG recommends that the MCOs update policies, procedures, and operational documents to comply with federal and DMAS requirements of each element in all standards scored as *Not Met*. HSAG also recommends that the MCOs ensure that staff members are trained and knowledgeable about the requirements of the contract, and that they understand the policies and procedures that the MCOs use to meet federal and DMAS requirements.

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.

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 CMS EQR Protocol 4 cited earlier in this report. 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.

NAV Highlights

Network Adequacy Indicator-Specific Validation Ratings

Based on the results of the ISCA combined with the virtual review and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCO's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for the MCOs according to Table 3-6.

Table 3-6—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	High confidence
50.0% to 89.9%	Moderate confidence
10.0% to 49.9%	Low confidence
Less than 10% and/or any <i>Not Met</i> element has significant bias on the results	No confidence

Based on the NAV audit combined with the detailed validation of each indicator, HSAG determined that all MCOs achieved a High Confidence validation rating, with the exception of indicators resulting in an Unable to Validate designation, which refers to HSAG's overall confidence that the MCOs used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

HSAG produced an aggregate that included program-level results and MCO-specific results which is available upon request.

Strengths, Weaknesses, and Recommendations

Strengths	
	Strength #1: Overall, the MCOs had well-defined processes and procedures in place to ensure the efficient and accurate collection of member and provider data to support network adequacy calculation and reporting.
	Strength #2: The MCOs demonstrated dedicated efforts to identify gaps in provider networks throughout their service areas and identify ways to improve the accessibility and timeliness of care for members.
Weaknesses and Recommendations	
	Weakness: Some MCOs were confused regarding whether certain provider types were required to be reported.
	Recommendations: HSAG recommends that the MCOs conduct an in-depth review of the list of required provider types to be reported for each standard to ensure accuracy in reporting.

MCO Comparative and Statewide Aggregate Secret Shopper Survey Results

Prenatal Care (PNC) Provider Secret Shopper Survey

In CY 2024, a phantom network analysis was conducted in place of the prenatal care secret shopper survey. Therefore, no results are available for the PNC shopper survey for CY 2024 as it was not performed.

Primary Care Provider (PCP) Secret Shopper Survey

In CY 2024, a phantom network analysis was conducted in place of the PCP secret shopper survey. Therefore, no results are available for the PCP secret shopper survey for CY 2024 as it was not performed.

MCO Comparative and Statewide Phantom Network Analysis Results

Phantom Network Analysis Project Highlights

HSAG identified PCPs and BH health providers from the MCO provider network files who were classified as providing services within the network categories included in the analysis. HSAG used the requirements described in the provider specification document. HSAG used the provider NPIs and State Provider Identifiers to identify all member claims from CY 2022 for any services rendered by any of the providers in the selected provider categories.

The population eligible for the phantom network analysis included providers actively enrolled with one or more Medicaid MCOs during CY 2022. Using DMAS-approved data request materials, the DMAS Enrollment Broker identified Cardinal Care Acute and Cardinal Care MLTSS providers potentially eligible for inclusion and submitted the provider data files to HSAG. The Enrollment Broker was asked to ensure that the provider data included out-of-state providers contracted to serve Medicaid managed care members (e.g., providers practicing in Kentucky, Maryland, North Carolina, Tennessee, West Virginia, or Washington DC).

For all MCOs, the provider networks for Cardinal Care Acute and Cardinal Care MLTSS consisted of exactly the same providers. To provide the most accurate assessment of active and non-active providers across the MCO, HSAG only assessed a single provider network for each MCO, but considered member visits with either Cardinal Care Acute, FAMIS, and Cardinal Care MLTSS members to indicate an active provider. An active provider was defined as a provider who submitted at least one claim for services provided to at least one Medicaid member during the measurement period.

Eligible providers were identified based on the primary taxonomy code identified using the NPPES NPI Registry and confirmed to have been contracted during CY 2022 through cross-referencing prior data submissions. HSAG restricted the analysis of the provider categories to those agreed upon with DMAS

Table 3-7 displays the total count and percentage of active versus non-active providers for each MCO. The MCO with the highest percentage of active providers was HealthKeepers at 78.9 percent, while the

lowest percentage of active providers was attributed to Molina, at 69.4 percent. There was a 9.5 percentage point difference between the highest and lowest rates of active providers among MCOs.

Table 3-7—Total Count and Percentage of Active versus Non-Active Providers by MCO

MCO	Total Number of Providers	Active Providers	Non-Active Providers
Aetna	15,790	11,062 (70.1%)	4,728 (29.9%)
HealthKeepers	24,046	18,981 (78.9%)	5,065 (21.1%)
Molina	15,541	10,786 (69.4%)	4,755 (30.6%)
Sentara	21,592	15,234 (70.6%)	6,358 (29.4%)
United	15,421	11,375 (73.8%)	4,046 (26.2%)

Note: Counts reflect number of unique NPIs.

As shown in Table 3-8 and Appendix B, the percentage of “phantom” or non-active providers varied from 10.8 percent of United’s PCP providers to 52.3 percent of Molina’s BH providers. For all MCOs, the BH provider category had the highest proportion of non-active providers, whereas the OBGYN category had the lowest percentage of non-active providers for Aetna, HealthKeepers, and Sentara. Among United’s providers, the PCP category had the lowest proportion of non-active providers.

Table 3-8—Percentage of Phantom or Non-Active Providers by MCO and Provider Category

Provider Category	Aetna	HealthKeepers	Molina	Sentara	United
Behavioral Health					
BH	44.3%	32.2%	52.3%	36.8%	46.1%
PSY	24.0%	16.9%	24.5%	24.8%	16.2%
Primary Care					
OBGYN	14.9%	13.8%	17.4%	23.3%	13.2%
PA/NP	35.7%	18.8%	32.8%	30.6%	26.7%
PCP	18.6%	15.5%	16.0%	25.6%	10.8%
PEDIATRIC	22.4%	15.9%	15.6%	24.3%	14.4%

Strengths, Weaknesses, and Recommendations

Strengths	
	Across MCOs, the provider networks had few inactive providers for OBGYN, PCP, and PEDIATRIC providers.
	The analysis of time/distance results of the MCOs’ provider network limited to only active providers demonstrated very small differences compared to the full provider networks.

Weaknesses and Recommendations



Weakness: This analysis presents one piece of understanding member access and provider availability and cannot fully demonstrate member access to providers.

Recommendations: To fully understand member access to providers, HSAG recommends that DMAS review these findings in conjunction with PMs and CAHPS measures to assess whether members are receiving high-quality care. HSAG recommends assessing the correlation between access to care PMs, phantom network analysis results, and member experience findings to determine whether high rates of phantom providers correlate with poor performance metrics or member experience metrics.

Weaknesses and Recommendations



Weakness: BH providers had the highest rate of phantom providers across all MCOs.

Recommendations: HSAG recommends conducting an appointment availability survey of the BH providers to determine if the high rate of phantom providers represents an access issue for members. With a new proposed rule from CMS requiring secret shopper surveys to monitor wait time requirements,³⁵ DMAS will begin conducting these surveys upon finalization of the proposed rule.

Conclusions

The purpose of the network adequacy phantom network analysis was to identify providers contracted with each MCO provider network who did not provide services to Medicaid members within the measurement period (i.e., providers who did not have encounters submitted in CY 2022), with the goal of better understanding each MCO's reported versus active provider network.

Overall, the percentage of phantom providers contracted with an MCO ranged from 10.8 percent of United's PCP providers to 52.3 percent of Molina's BH providers. Across all MCOs, BH providers had the highest percentage of phantom providers, which aligns with previous reports on phantom networks in other states. HealthKeepers and United had the lowest rates of phantom providers in their provider networks.

HSAG assessed differences between active and non-active providers and found minimal differences between the geographic regions, urbanities, languages spoken, and active status. Additionally, HSAG assessed the geographic locations of the phantom providers using the time and distance a member would travel to the nearest provider using the full network of providers and the active network of providers. Again, HSAG noted minimal differences in the travel time and distances for the providers. The phantom providers did not seem to be dramatically different from the active providers based on these categories. In fact, they seem to be distributed relatively proportionally to the active providers.

³⁵ Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS). Proposed Rule: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, May 5, 2023.

Lastly, HSAG assessed the patient load for the provider categories. In general, OBGYNs, PCPs, and PEDIATRIC providers were most likely to see more than 16 members over the course of the year. Pediatricians and OBGYNs were most likely to see more than 100 members over the year. Across all provider categories, Molina had the fewest providers seeing more than 100 members over the year. Sentara and HealthKeepers had the highest percentages of providers seeing more than 100 members across provider categories, and they also had the largest provider networks and the most members.

MCO Comparative and Statewide Aggregate EDV Results

EDV Highlights

During SFY 2022–2023, DMAS contracted with HSAG to conduct an EDV study which consisted of the following two activities for both the Cardinal Care MLTSS and Cardinal Care Acute MCOs:

- **IS review:** An assessment of DMAS' and the MCOs' IS and processes. The goal of this activity is to examine the extent to which DMAS' and the MCOs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's Capability in the CMS EQR Protocol 5 cited earlier in this report.
- **Comparative analysis:** An 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. The goal of this activity is to evaluate the extent to which the encounter data in DMAS' database (i.e., Enterprise Data Warehouse Solution [EDWS]/SAS[®],³⁶ data) are complete, accurate, and submitted by the MCOs in a timely manner. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5 cited above. HSAG included encounter data with dates of service from CY 2022 in the comparative analysis.

The following sections show the key results for the two programs: Cardinal Care MLTSS and Cardinal Care Acute.

Cardinal Care MLTSS

Record Completeness

HSAG evaluated the record-level data completeness of DMAS' Cardinal Care MLTSS encounter data by investigating the record omission (i.e., in MCO-submitted data but not in DMAS-submitted data) and record surplus (i.e., in DMAS-submitted data but not in MCO-submitted data) in DMAS' data compared to each MCO. Table 3-9 displays the Cardinal Care MLTSS MCOs' performance. Of note, lower record omission and surplus rates (i.e., green dots) indicate better performance.

³⁶ SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAS Institute Inc. in the USA and other countries. ® indicates USA registration.

Table 3-9—Summary for Record Omission and Surplus Rates for Cardinal Care MLTSS MCOs

Encounter Data Type	Aetna	Health-Keepers	Molina	Optima	United	VA Premier
Professional						
Institutional						
Pharmacy						
 Both <5.0%  Record Omission <5.0%  Record Surplus <5.0%  Both >5.0%						

Data Element Completeness

HSAG evaluated the element-level completeness of DMAS' Cardinal Care MLTSS encounter data by the element omission and element surplus rates for key data elements relevant to each encounter type. Table 3-10 displays an aggregated score for the percentage of key data elements that were below 5.0 percent for both the element omission and element surplus rates. A score of 100 percent indicates that all applicable key data elements for an encounter type had both element omission and surplus rates below 5.0 percent, which indicates relatively complete data for all key data elements.

Table 3-10—Percentage of Key Data Elements With Both Element Omission and Surplus Rates Below 5.0 Percent for Cardinal Care MLTSS MCOs

Encounter Data Type	Number of Key Data Elements	Aetna	Health-Keepers	Molina	Optima	United	VA Premier
Professional	17	82.4%	100.0%	82.4%	70.6%	94.1%	100.0%
Institutional	22	86.4%	95.5%	100.0%	86.4%	90.9%	90.9%
Pharmacy	9	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Data Element Accuracy

HSAG determined element-level accuracy by comparing the values of key data elements for Cardinal Care MLTSS encounter records with data present in both DMAS' and the MCOs' records. Table 3-11 shows an aggregated score for the percentage of key data elements with an element accuracy rate over 95.0 percent. A score of 100 percent indicates that all key data elements had an element accuracy rate over 95.0 percent, which indicates relatively accurate data for all key data elements.

Table 3-11—Percentage of Key Data Elements With an Element Accuracy Over 95.0 Percent for Cardinal Care MLTSS MCOs

Encounter Data Type	Number of Key Data Elements	Aetna	Health-Keepers	Molina	Optima	United	VA Premier
Professional	19	63.2%	89.5%	78.9%	57.9%	89.5%	89.5%
Institutional	24	75.0%	91.7%	58.3%	54.2%	75.0%	79.2%
Pharmacy	10	100.0%	100.0%	100.0%	80.0%	90.0%	100.0%

Strengths, Weaknesses, and Recommendations for Cardinal Care MLTSS MCOs

Strengths	
+	<u>IS Review Activity</u> Aetna and its subcontractors had relatively robust reports to monitor encounter data accuracy, completeness, and timeliness for encounters that Aetna and all four of its subcontractors collected. For vision encounters collected by its subcontractor, HealthKeepers and/or its subcontractor had relatively robust reports to monitor encounter data accuracy, completeness, and timeliness. Molina had relatively robust internal reports to monitor encounter data accuracy, completeness, and timeliness for encounters that Molina collected.
+	<u>Comparative Analysis</u> Record Completeness: Both the record omission and surplus rates were at or below 5 percent for three MCOs (HealthKeepers, Molina, and United) among professional encounters, two MCOs (Molina and United) among institutional encounters, and one MCO (VA Premier) among pharmacy encounters. This indicates that the professional, institutional, and pharmacy encounters could mostly be identified in both data sources (i.e., the DMAS-submitted data and the above-specified MCO-submitted data). Data Element Completeness: Both the element omission and element surplus rates for all relevant key data elements were below 5.0 percent for two MCOs (HealthKeepers and VA Premier) among professional encounters, one MCO (Molina) among institutional encounters, and all six MCOs among pharmacy encounters. This indicates that all relevant key data elements in the encounter records which could be matched between the DMAS-submitted data and the above-specified MCO-submitted data were largely complete. Data Element Accuracy: All relevant key data elements had element accuracy rates over 95.0 percent for four MCOs (Aetna, HealthKeepers, Molina, and VA Premier) among pharmacy encounters. This indicates that records which could be matched between the DMAS-submitted data and the above-specified MCO-submitted data largely contained the same values.
Weaknesses and Recommendations	
-	<u>IS Review Activity</u> Weakness: HealthKeepers, Molina, Optima, United, and VA Premier lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness for the following encounters: • Encounters that HealthKeepers collected, as well as HealthKeepers' pharmacy and chiropractic encounters. • Molina's vision encounters. • Encounters that Optima collected, as well as Optima's NEMT encounters. • Encounters that United collected, as well as United's pharmacy and NEMT encounters.

Weaknesses and Recommendations

	Encounters that VA Premier collected, as well as VA Premier's vision and NEMT encounters. Recommendations: HealthKeepers, Molina, Optima, United, and VA Premier and/or their subcontractors should consider building reports to monitor encounter accuracy, completeness, and timeliness through metrics such as encounter volume by submission month or encounter volume per member per month (PMPM) as well as reconciliation with financial reports.
	Comparative Analysis Record Completeness: For professional and institutional encounters, Aetna was the only MCO to have a rate over 5.0 percent (i.e., relatively poor performance) for both record omission and record surplus. For pharmacy encounters, Aetna and Optima were the only MCOs to have a rate over 5.0 percent for both record omission and record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the above-specified MCO-submitted data. Data Element Completeness: For professional and institutional encounters, respectively, four MCOs (Aetna, Molina, Optima, and United) and five MCOs (Aetna, HealthKeepers, Optima, United, and VA Premier) had both element omission and surplus rates that were above 5.0 percent (i.e., relatively poor performance) for at least one key data element. This indicates that at least one key data element in the DMAS-submitted encounter records was incomplete when compared to the above-specified MCO-submitted data. Data Element Accuracy: For professional and institutional encounters, all six MCOs had at least one element accuracy rate that fell below 95.0 percent. For pharmacy encounters, two MCOs (Optima and United) had at least one element accuracy rate that fell below 95.0 percent. This indicates that at least one key data element in the DMAS-submitted encounter records was inaccurate when compared to the above-specified MCO-submitted data. Recommendations: To improve the encounter data quality and completeness, DMAS should work with the MCOs to investigate the root cause(s) of the comparative analysis findings to determine whether the differences between DMAS' data and the MCOs' data were due to issues related to EDV study data extraction, or whether the differences indicate issues with the MCOs' encounter data that were submitted to DMAS. In general, the MCOs should submit complete encounter records to DMAS and ensure all key data elements contain complete and accurate information.

Cardinal Care Acute Record Completeness

HSAG evaluated the record-level data completeness of DMAS' Cardinal Care Acute encounter data by investigating the record omission (i.e., in MCO-submitted data but not in DMAS-submitted data) and record surplus (i.e., in DMAS-submitted data but not in MCO-submitted data) in DMAS' data compared to each MCO. Table 3-12 displays the Cardinal Care Acute MCOs' performance. Of note, lower record omission and surplus rates (i.e., green dots) indicate better performance.

Table 3-12—Summary for Record Omission and Surplus Rates for Cardinal Care Acute MCOs

Encounter Data Type	Aetna	Health-Keepers	Molina	Optima	United	VA Premier
Professional						
Institutional						
Pharmacy						
 Both <5.0%  Record Omission <5.0%  Record Surplus <5.0%  Both >5.0%						

Data Element Completeness

HSAG evaluated the element-level completeness of DMAS' Cardinal Care Acute encounter data by the element omission and element surplus rates for key data elements relevant to each encounter type. Table 3-13 displays an aggregated score for the percentage of key data elements that were below 5.0 percent for both the element omission and element surplus rates. A score of 100 percent indicates that all applicable key data elements for an encounter type had both element omission and surplus rates below 5.0 percent, which indicates relatively complete data for all key data elements.

Table 3-13—Percentage of Key Data Elements With Both Element Omission and Surplus Rates Below 5.0 Percent for Cardinal Care Acute MCOs

Encounter Data Type	Number of Key Data Elements	Aetna	Health-Keepers	Molina	Optima	United	VA Premier
Professional	17	94.1%	100.0%	94.1%	94.1%	94.1%	100.0%
Institutional	22	95.5%	95.5%	95.5%	95.5%	90.9%	86.4%
Pharmacy	9	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Data Element Accuracy

HSAG determined element-level accuracy by comparing the values of key data elements for Cardinal Care Acute encounter records with data present in both DMAS' and the MCOs' records. Table 3-14 shows an aggregate score for the percentage of key data elements with an element accuracy rate over 95.0 percent. A score of 100 percent indicates that all key data elements had an element accuracy rate over 95.0 percent, which indicates relatively accurate data for all key data elements.

Table 3-14—Percentage of Key Data Elements With an Element Accuracy Over 95.0 Percent for Cardinal Care Acute MCOs

Encounter Data Type	Number of Key Data Elements	Aetna	Health-Keepers	Molina	Optima	United	VA Premier
Professional	19	78.9%	89.5%	78.9%	73.7%	100.0%	94.7%
Institutional	24	83.3%	91.7%	70.8%	66.7%	83.3%	75.0%
Pharmacy	10	100.0%	100.0%	100.0%	80.0%	80.0%	100.0%

Strengths, Weaknesses, and Recommendations for Cardinal Care Acute MCOs

Strengths	
	<u>IS Review Activity</u> - Aetna and its subcontractors had relatively robust reports to monitor encounter data accuracy, completeness, and timeliness for encounters that Aetna and all four of its subcontractors collected. - For vision encounters collected by its subcontractor, HealthKeepers and/or its subcontractor had relatively robust reports to monitor encounter data accuracy, completeness, and timeliness. - Molina had relatively robust internal reports to monitor encounter data accuracy, completeness, and timeliness for encounters that Molina collected.
	<u>Comparative Analysis</u> Record Completeness: Both the record omission and surplus rates were at or below 5 percent for four MCOs (HealthKeepers, Molina, United, and VA Premier) among professional encounters and two MCOs (Molina and United) among institutional encounters. This indicates that the professional and institutional encounters could mostly be identified in both data sources (i.e., the DMAS-submitted data and the above-specified MCO-submitted data). Data Element Completeness: The element omission and element surplus rates for all relevant key data elements were below 5.0 percent for two MCOs (HealthKeepers and VA Premier) among professional encounters and all six MCOs among pharmacy encounters. This indicates that the key data elements in the encounter records which could be matched between the DMAS-submitted data and the above-specified MCO-submitted data were largely complete. Data Element Accuracy: All relevant key data elements had element accuracy rates over 95.0 percent for one MCO (United) among professional encounters and four MCOs (Aetna, HealthKeepers, Molina, and VA Premier) among pharmacy encounters. This indicates that records which could be matched between the DMAS-submitted data and the above-specified MCO-submitted data largely contained the same values.
Weaknesses and Recommendations	
	<u>IS Review Activity</u> Weakness: HealthKeepers, Molina, Optima, United, and VA Premier lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness for the following encounters: - Encounters that HealthKeepers collected, as well as HealthKeepers' pharmacy, chiropractic, and palliative encounters. - Molina's vision encounters. - Encounters that Optima collected, as well as Optima's NEMT encounters. - Encounters that United collected, as well as United's pharmacy and NEMT encounters.

Weaknesses and Recommendations

	Encounters that VA Premier collected, as well as VA Premier’s vision and NEMT encounters. Recommendations: HealthKeepers, Molina, Optima, United, and VA Premier and/or their subcontractors should consider building reports to monitor encounter accuracy, completeness, and timeliness through metrics such as encounter volume by submission month or encounter volume PMPM as well as reconciliation with financial reports.
	Comparative Analysis Record Completeness: For professional and institutional encounters, Aetna was the only MCO to have a rate over 5.0 percent (i.e., relatively poor performance)) for both record omission and record surplus. For pharmacy encounters, Aetna and Optima were the only MCOs to have a rate over 5.0 percent for both record omission and record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the above-specified MCO-submitted data. Data Element Completeness: For professional and institutional encounters, respectively, four MCOs (Aetna, Molina, Optima, and United) and all MCOs, had both element omission and surplus rates that were above 5.0 percent (i.e., relatively poor performance) for at least one key data element. This indicates that at least one key data element in the DMAS-submitted encounter records was incomplete when compared to the above-specified MCO-submitted data. Data Element Accuracy: Five MCOs (Aetna, HealthKeepers, Molina, Optima, and VA Premier) for professional encounters, all MCOs for institutional encounters, and two MCOs (Optima and United) for pharmacy encounters had at least one element accuracy rate that fell below 95.0 percent. This indicates that at least one key data element in the DMAS-submitted encounter records was inaccurate when compared to the above-specified MCO-submitted data. Recommendations: To improve encounter data quality and completeness, DMAS should work with the MCOs to investigate the root cause(s) of the findings from the comparative analysis to determine whether the differences between DMAS’ data and the MCOs’ data were due to issues related to EDV study data extraction, or whether the differences indicate issues with the MCOs’ encounter data that were submitted to DMAS. In general, the MCOs should submit complete encounter records to DMAS and ensure all key data elements contain complete and accurate information.

Statewide Aggregate CAHPS Results

Adult Medicaid

Table 3-15 and Table 3-16 present the 2024 top-box scores for each MCO and the Cardinal Care program (i.e., all Cardinal Care Acute and Cardinal Care MLTSS MCOs combined) compared to the 2023 adult Medicaid CAHPS scores for the global ratings and composite measures. The 2024 CAHPS scores for each MCO were also compared to the 2023 NCQA adult Medicaid national averages.³⁷

Table 3-15—Comparison of 2024 Adult Global Top-Box Scores

	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Cardinal Care Program	61.98%	58.84%	70.98%	70.03%
Aetna	60.79%	54.19%	64.55%	69.37%
HealthKeepers	65.67%	58.59%	69.54%	65.00% ⁺
Molina	67.16%	57.69%	75.39%	66.67%
Sentara	59.90%	61.76%	75.80%	75.00%
United	56.86%	55.37%	62.24%	69.05% ⁺

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

Cells highlighted in orange represent rates that are statistically significantly higher than the 2023 NCQA national Medicaid averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2023 NCQA national Medicaid averages.

Table 3-16—Comparison of 2024 Adult Composite Top-Box Scores

	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Cardinal Care Program	81.42%	81.07%	92.41%	87.73%
Aetna	80.49%	80.12%	92.17%	86.46%
HealthKeepers	78.69%	79.54% ⁺	91.72%	85.75% ⁺
Molina	78.02%	79.07%	94.43%	89.76%
Sentara	85.97%	83.55% ⁺	93.03%	90.52% ⁺
United	75.23%	78.60% ⁺	90.99%	82.98% ⁺

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

Cells highlighted in orange represent rates that are statistically significantly higher than the 2023 NCQA national Medicaid averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2023 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

Strengths	
	Molina's 2024 top-box scores were statistically significantly higher than the 2023 NCQA adult Medicaid national averages for <i>Rating of Health Plan</i> and <i>Rating of Personal Doctor</i> .

³⁷ Since Optima and VA Premier were merged into Sentara, trend results are unavailable for the Cardinal Care program and MCOs.

Strengths	
	Sentara's 2024 top-box scores were statistically significantly higher than the 2023 NCQA adult Medicaid national averages for <i>Rating of Personal Doctor</i> , <i>Rating of Specialist Seen Most Often</i> , and <i>Getting Needed Care</i> .
Weaknesses and Recommendations	
	Weakness: No overall weaknesses in the adult CAHPS survey results were identified. Recommendations: HSAG recommends that the MCOs continue to monitor the measures to ensure that significant decreases in scores over time do not continue to occur.

Child Medicaid

Table 3-17 and Table 3-18 present the 2024 top-box scores for each MCO and the Cardinal Care program compared to the 2023 child Medicaid CAHPS scores for the global ratings and composite measures. The 2024 CAHPS scores for each MCO were also compared to the 2023 NCQA child Medicaid national averages ³⁸

Table 3-17—Comparison of 2024 Child Global Top-Box Scores

	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Cardinal Care Program	72.95%	72.67%	76.18%	72.38%
Aetna	72.01%	70.77%	73.65%	64.67%
HealthKeepers	74.52%	73.38%	75.00%	74.63% ⁺
Molina	71.27%	66.98%	72.46%	73.68% ⁺
Sentara	72.19%	73.47% ⁺	79.26%	73.33% ⁺
United	72.28%	71.57%	72.06%	67.86% ⁺

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

Cells highlighted in orange represent rates that are statistically significantly higher than the 2023 NCQA national Medicaid averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2023 NCQA national Medicaid averages.

Table 3-18—Comparison of 2024 Child Composite Top-Box Scores

	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Cardinal Care Program	80.51%	84.49%	94.04%	87.63%
Aetna	79.81%	85.85%	91.32%	86.53%

³⁸ Since Optima and VA Premier were merged into Sentara, trend results are unavailable for the Cardinal Care program and MCOs.

	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
HealthKeepers	86.32%	85.75%	94.05%	91.63% ⁺
Molina	81.77% ⁺	79.63% ⁺	89.24%	86.40% ⁺
Sentara	77.35% ⁺	84.43% ⁺	95.94% ⁺	87.11% ⁺
United	73.07% ⁺	81.14% ⁺	91.31% ⁺	77.25% ⁺

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

Cells highlighted in orange represent rates that are statistically significantly higher than the 2023 NCQA national Medicaid averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2023 NCQA national Medicaid averages.

Summary of Strengths, Weaknesses, and Overall Conclusions

Strengths	
	No overall strengths in the child CAHPS survey results were identified.
Weaknesses and Recommendations	
	Weakness: Aetna's and Molina's top-box scores were statistically significantly lower than the 2023 NCQA child Medicaid national average for <i>How Well Doctors Communicate</i>. Weakness: United's top-box scores were statistically significantly lower than the 2023 NCQA child Medicaid national averages for <i>Getting Needed Care</i> and <i>Customer Service</i>.
	Recommendations: HSAG recommends that the MCOs evaluate the process of care delivery to identify whether there are any operational issues contributing to members' access to care, as well as identify and resolve dissatisfaction in customer and clinical services by addressing and providing solutions to customer service complaints. HSAG also recommends that the MCOs conduct root cause analyses of study indicators that have been identified as low performance areas. 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 that significant decreases in scores over time do not continue to occur.

FAMIS Program Statewide Aggregate Results

Table 3-19 presents the 2023 and 2024 FAMIS CAHPS top-box scores for the global ratings and composite measures. The FAMIS general child and CCC 2024 CAHPS scores were compared to the

2023 NCQA general child Medicaid and CCC Medicaid national averages.³⁹ In addition, a trend analysis was performed that compared the 2024 CAHPS scores to corresponding 2023 CAHPS scores.

Table 3-19—Comparison of 2023 and 2024 FAMIS Program General Child and CCC Top-Box Scores

	General Child		CCC	
	2023	2024	2023	2024
Global Ratings				
<i>Rating of Health Plan</i>	72.66%	71.30%	65.87%	72.65%
<i>Rating of All Health Care</i>	67.05% ⁺	63.79% ⁺	56.39%	57.29% ⁺
<i>Rating of Personal Doctor</i>	78.85%	73.56% ⁺	74.83%	73.08%
<i>Rating of Specialist Seen Most Often</i>	73.91% ⁺	66.67% ⁺	63.86% ⁺	64.91% ⁺
Composite Measures				
<i>Getting Needed Care</i>	83.35% ⁺	81.21% ⁺	76.24%	80.35% ⁺
<i>Getting Care Quickly</i>	90.72% ⁺	89.84% ⁺	87.70% ⁺	83.10% ⁺
<i>How Well Doctors Communicate</i>	93.66% ⁺	96.62% ⁺	92.24%	93.60% ⁺
<i>Customer Service</i>	95.00% ⁺	90.91% ⁺	89.35% ⁺	88.15% ⁺

⁺ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.

▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.

If no statistically significant differences were found, no indicator appears with the corresponding score.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2023 NCQA national Medicaid averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2023 NCQA national Medicaid averages.

Summary of Strengths, Weaknesses, and Overall Conclusions

Strengths	
	No overall strengths in the general child and the CCC CAHPS survey results were identified.
Weaknesses and Recommendations	
	Weakness: The general child 2024 top-box score was statistically significantly lower than the 2023 NCQA general child Medicaid national average for <i>How Well Doctors Communicate</i> .

³⁹ For the NCQA child Medicaid national and CCC Medicaid averages, Quality Compass 2023 data were used with permission from NCQA. Quality Compass 2023 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.

Weaknesses and Recommendations

Recommendations: HSAG recommends that the FAMIS Program include rating information from the CAHPS survey to emphasize patient-centered communication in provider communications throughout the year. HSAG also recommends that the FAMIS Program conduct a root cause analyses of study indicators that have been identified as low performance areas. 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 FAMIS Program 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 2024 to calculate the *Screening for Depression and Follow-Up Plan (CDF) PM* following the FFY 2024 CMS Core Set of Adult Health Quality Measures for Medicaid and Core Set of Children's Health Care Quality Measures for Medicaid and the Children's Health Insurance Program (CHIP) Technical Specifications and Resource Manuals.^{40,41} Table 3-20 and Table 3-21 display the CY 2024 CDF Child Core Set PM results and Adult Core Set PM results, respectively, stratified by Medicaid program, Medicaid delivery system, MCO, geographic region, and select demographics (e.g., gender and race).

Table 3-20—CDF Child Core Set PM Results

Stratifications	Num	Denom	Rate
Virginia Total	19,441	839,052	2.32%
Child Core Set Total (12–17 Years)	10,005	176,449	5.67%
Medicaid Program			
Medicaid [^]	8,407	153,349	5.48%
Separate CHIP	1,598	23,100	6.92%
Medicaid Delivery System			
Fee-for-Service	24	928	2.59%
Managed Care	9,258	160,759	5.76%

⁴⁰ Centers for Medicare & Medicaid Services. FFY 2024 Adult Core Set Measures Technical Specifications and Resource Manual. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf?t=1736123649>. Accessed on: Jan 8, 2025.

⁴¹ Centers for Medicare & Medicaid Services. FFY 2024 Child Core Set Measures Technical Specifications and Resource Manual. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf?t=1717523300>. Accessed on: Jan 8, 2025.

Stratifications	Num	Denom	Rate
More than One Delivery System	723	14,762	4.90%
MCO			
Aetna	526	14,604	3.60%
HealthKeepers	5,047	57,642	8.76%
Molina	386	5,532	6.98%
Sentara*	2,278	65,554	3.47%
United	908	15,295	5.94%
More than One MCO	113	2,132	5.30%
Geographic Region			
Central	753	42,483	1.77%
Charlottesville/Western	81	20,045	0.40%
Northern & Winchester	5,592	51,654	10.83%
Roanoke/Alleghany	63	16,028	0.39%
Southwest	S	S	S
Tidewater	3,509	35,954	9.76%
Unknown	S	S	S
Gender			
Male	5,239	93,100	5.63%
Female	4,766	83,349	5.72%
Unknown	0	0	NA
Race			
White	4,605	90,158	5.11%
Black/African American	3,466	59,114	5.86%
Asian	779	9,238	8.43%
Southeast Asian/Pacific Islander	147	1,919	7.66%
Hispanic	596	9,669	6.16%
More than One Race/Other/Unknown	412	6,351	6.49%

^aMedicaid is inclusive of Medicaid expansion CHIP.

* Rates for Sentara include members enrolled with Optima or VA Premier during CY 2023.

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.

NA indicates a small denominator.

Table 3-21—CDF Adult Core Set PM Results

Stratifications	Num	Denom	Rate
Virginia Total	19,441	839,052	2.32%
Adult Core Set Total	9,436	662,603	1.42%
Medicaid Program			
Medicaid^	9,131	651,493	1.40%
Separate CHIP	305	11,110	2.75%
Medicaid Delivery System			
Fee-for-Service	225	21,125	1.07%
Managed Care	8,010	546,703	1.47%
More than One Delivery System	1,201	94,775	1.27%
MCO			
Aetna	769	82,244	0.94%
HealthKeepers	2,690	159,207	1.69%
Molina	1,703	37,217	4.58%
Sentara*	1,499	195,177	0.77%
United	1,169	62,484	1.87%
More than One MCO	180	10,374	1.74%
Geographic Region			
Central	2,723	164,038	1.66%
Charlottesville/Western	494	80,217	0.62%
Northern & Winchester	3,217	162,319	1.98%
Roanoke/Alleghany	859	65,196	1.32%
Southwest	669	43,469	1.54%
Tidewater	1,474	147,336	1.00%
Unknown	0	28	NA
Age			
18–64 Years	7,179	589,900	1.22%
65+ Years	2,257	72,703	3.10%
Total (18+ Years)	9,436	662,603	1.42%
Age by Program			
18–64 Years—Medicaid^	6,874	578,790	1.19%

Stratifications	Num	Denom	Rate
18–64 Years—Separate CHIP	305	11,110	2.75%
65+ Years—Medicaid [^]	2,257	72,703	3.10%
65+ Years—Separate CHIP	0	0	NA
Gender			
Male and Unknown [†]	3,673	250,563	1.47%
Female	5,763	412,040	1.40%
Race			
White	4,455	323,795	1.38%
Black/African American	3,029	229,518	1.32%
Asian	1,138	42,628	2.67%
Southeast Asian/Pacific Islander	58	3,667	1.58%
Hispanic	264	19,171	1.38%
More than One Race/Other/Unknown	492	43,824	1.12%

[^]Medicaid is inclusive of Medicaid expansion CHIP.

^{*} Rates for Sentara include members enrolled with Optima or VA Premier during CY 2023.

NA indicates a small denominator.

^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.

[†] To avoid suppression, HSAG combined the Male and Unknown gender groups together

Overall, only 2 percent of Virginia Medicaid members received a screening for depression and, if positive, had a follow-up plan documented in CY 2023. Children ages 12 to 17 years received depression screenings at higher rates than adults in Virginia, with a rate approximately 4 percentage points higher than the rate for adults. For the MCOs, HealthKeepers had the highest rate for children, while Molina had the highest rate for adults. Both Aetna and Sentara adult and child members had the lowest rates of depression screenings compared to other MCOs. Adult and child members in the Northern & Winchester geographic region had the highest rates, while adult and child members in the Charlottesville/Western geographic region had the lowest rates. Of note, Asian and Southeast Asian/Pacific Islander child and adult members had the highest rates of depression screenings and follow-up plans compared to any other racial group members. Please note, this measure requires the use of age-appropriate, standardized, and validated depression screening tools. Therefore, it is possible that depression screenings and follow-up plans are happening; however, they may not be occurring using the appropriate tools, or the information may not be captured in administrative data.

ARTS Measurement Specification and Reporting

DMAS contracted with HSAG as its EQRO to develop and maintain custom PM specifications to evaluate the ARTS program. During 2024, HSAG calculated CY 2020, CY 2021, and CY 2022 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 OBAT 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 2024 contract year: improving birth outcomes through adequate PNC (Medicaid and CHIP Maternal and Child Health Focus Study), improving the health of children in foster care (Child Welfare Focus Study), and Dental Utilization in Pregnant Women Data Brief. Based on methodological considerations, MCO-specific results produced for each focus study are available in the final activity reports.

MCO Comparative and Statewide Aggregate Consumer Decision Support Tool Results

Tool Results

DMAS contracted with HSAG in 2024 to produce a Consumer Decision Support Tool using Virginia Medicaid MCOs' HEDIS data and CAHPS survey results for the Cardinal Care MCOs. The Cardinal Care Consumer Decision Support Tool demonstrates how the Virginia Medicaid Cardinal Care MCOs compared to one another in key performance areas. The tool uses stars to display results for the MCOs, as shown in Table 3-22. Please refer to Appendix B for the detailed methodology used for this tool.

Table 3-22—Cardinal Care Consumer Decision Support Tool—Performance Ratings

Rating	MCO Performance Compared to Statewide Average	
★★★★★	Highest Performance	The MCO's performance was significantly better than the Virginia Medicaid average using a 95% confidence interval.

Rating	MCO Performance Compared to Statewide Average	
★★★★	High Performance	The MCO's performance was significantly better than the Virginia Medicaid average using a 68% confidence interval.
★★★	Average Performance	The MCO's performance was not significantly different than the Virginia Medicaid average using either a 68% or a 95% confidence interval.
★★	Low Performance	The MCO's performance was significantly worse than the Virginia Medicaid average using a 68% confidence interval.
★	Lowest Performance	The MCO's performance was significantly worse than the Virginia Medicaid average using a 95% confidence interval.

Table 3-23 displays the Cardinal Care 2024 Consumer Decision Support Tool results for each MCO.

Table 3-23—2024 Cardinal Care Consumer Decision Support Tool Results

MCO	Accreditation Level	Overall Rating*	Doctors' Communication	Access and Preventive Care	Taking Care of Children	Women's Health	Behavioral Health	Living With Illness
Aetna	Accredited	★★★★	★★★	★★★	★★★	★★★★★	★★★★★	★★★★★
HealthKeepers	Accredited	★★★★★	★★★	★★★	★★★★★	★★★★★	★★★	★★★★★
Molina	Accredited	★	★★★	★	★	★	★★★	★
Sentara	Provisional	★★★	★★★★★	★★★★★	★	★	★★★	★
United	Accredited	★★★	★★	★★★	★★★★★	★★★★★	★★★	★★★

*This rating includes all categories, as well as how the member feels about his or her MCO and the healthcare received.

Strengths and Weaknesses

Strengths	
+	HealthKeepers demonstrated the strongest performance by achieving the Highest Performance level for the Overall Rating, Women's Health, Taking Care of Children, and Living With Illness categories; and Average Performance level for Doctors' Communication, Access and Preventive Care, and Behavioral Health categories.
+	Aetna also demonstrated strong performance by achieving the Highest Performance level for the Women's Health and Living With Illness categories; High Performance level for the Overall Rating and Behavioral Health; and Average Performance level for Doctors' Communication, Access and Preventive Care, and Taking Care of Children categories.

Weaknesses and Recommendations

	Molina demonstrated the lowest performance by achieving the Lowest Performance level for the Overall Rating, Access and Preventive Care, Taking Care of Children, Women’s Health, and Living With Illness categories, and never performing above the Average Performance level.
	Sentara also demonstrated low performance by achieving the Lowest Performance level for the Taking Care of Children, Women’s Health, and Living With Illness categories.

Performance Withhold Program

In 2024, DMAS contracted with HSAG to establish, implement, and maintain a scoring mechanism for the SFY 2024 PWP. The SFY 2024 PWP assessed CY 2023 PM data to determine what portion, if any, of the MCOs’ quality withhold would be earned back. For the SFY 2024 PWP, the MCOs could earn all or a portion of their 1 percent quality withhold based on performance for nine NCQA HEDIS measures/indicators (14 measures/indicators), one AHRQ PDI measure, and two CMS Adult Core Set measures. The SFY 2024 PWP was based on comparisons to the NCQA Quality Compass national Medicaid HMO percentiles for all HEDIS measures/indicators and receiving a Reportable audit result on the AHRQ PDI and CMS Adult Core Set PMs. For detailed information related to the PWP, please see the SFY 2024 PWP Methodology on DMAS’ website.⁴²

⁴² Health Services Advisory Group, Inc. *SFY 2024 Performance Withhold Program Methodology*. Available at: <https://www.dmas.virginia.gov/media/4gjbigmk/va-egro-sfy-2024-pwp-methodology-f3.pdf>. Accessed on: Jan 8, 2025.

4. Validation of Performance Improvement Projects

Overview

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

Objectives

As part of the Commonwealth's QS, each MCO is required to conduct PIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). As one of the mandatory EQR activities required under the BBA, HSAG, as the Commonwealth's EQRO, validated the PIPs through an independent review process. To ensure methodological soundness while meeting all State and federal requirements, HSAG follows validation guidelines established in the CMS EQR Protocol 1 cited earlier in this report.

Each PIP must involve:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or 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., 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 the 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 2024 submissions, the MCOs completed and validated for Steps 1 through 9 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 the 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 be *Met*.

In alignment with the CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the MCO adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. This validation rating is based on the scores for applicable evaluation elements in steps 1 through 8 of the PIP validation tool. The second validation rating is only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflects HSAG's

confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP validation tool. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a *Met* score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

1. Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)

- *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
- *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
- *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
- *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.

2. Overall Confidence That the PIP Achieved Significant Improvement (Step 9)

- *High Confidence*: All performance indicators demonstrated statistically significant improvement over the baseline.
- *Moderate Confidence*: One of the three scenarios below occurred:
 - All performance indicators demonstrated improvement over the baseline, and some but not all performance indicators demonstrated statistically significant improvement over the baseline.
 - All performance indicators demonstrated improvement over the baseline, and none of the performance indicators demonstrated statistically significant improvement over the baseline.
 - Some but not all performance indicators demonstrated improvement over baseline, and some but not all performance indicators demonstrated statistically significant improvement over baseline.
- *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator or some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated statistically significant improvement over the baseline.
- *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance indicators demonstrated improvement over the baseline.

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 2024 validation, the MCOs progressed to reporting Remeasurement 1 data for CY 2023, QI strategies, and interventions. The validation findings for each MCO are provided below.

Validation Findings

Aetna

In 2024, Aetna submitted its Remeasurement 1 data and interventions for the following PIPs for validation: *Ensuring Timeliness of Prenatal Visits*, *Tobacco Use Cessation in Pregnant Women*, *Ambulatory Care—Emergency Department Visits (AMB-ED)*, and *Transitions of Care—Patient Engagement After Inpatient 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 Statement, performance indicator measure, validation scores, and confidence level for each PIP.

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

Ensuring Timeliness of Prenatal Visits		
PIP Topic	Ensuring Timeliness of Prenatal Visits	
PIP Aim Statement	Do targeted interventions increase the percentage of deliveries that had a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Aetna Better Health of Virginia?	
Performance Indicator Measure	Percentage of deliveries that had a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.	
Description of Data Obtained	Administrative using claims and encounters and medical record review following HEDIS hybrid data collection specifications.	
Validation Scores	Overall Score: 100%	Critical Elements Score: 100%
Confidence Level	High Confidence in overall confidence of adherence to acceptable methodology and No Confidence in overall confidence that the PIP achieved significant improvement. All critical evaluation elements were Met, and 100 percent of all evaluation elements were Met across the first eight steps.	
Tobacco Use Cessation in Pregnant Women		
PIP Topic	Tobacco Use Cessation in Pregnant Women	
PIP Aim Statement	Do targeted interventions increase the percentage of pregnant women screened for tobacco use during at least one prenatal visit?	
Performance Indicator Measure	Percentage of pregnant women who are screened for tobacco use.	
Description of Data Obtained	Administrative data extracted from Inovalon Quality Spectrum.	

Tobacco Use Cessation in Pregnant Women		
Validation Scores	Overall Score: 100%	Critical Elements Score: 100%
Validation Status/Confidence Level	High Confidence in overall confidence of adherence to acceptable methodology and Moderate Confidence in overall confidence that the PIP achieved significant improvement. All critical evaluation elements were Met, and 100 percent of all evaluation elements were Met across the first eight steps.	
AMB-ED		
PIP Topic	Ambulatory Care—Emergency Department Visits	
PIP Aim Statement	Do targeted interventions decrease emergency department visits for the eligible population?	
Performance Indicator Measure	The member per month of ED utilization of the entire eligible population aligned with HEDIS AMB-ED measure specifications 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	High Confidence in overall confidence of adherence to acceptable methodology and No Confidence in overall confidence that the PIP achieved significant improvement. All critical evaluation elements were Met, and 100 percent of all evaluation elements were Met across the first eight steps.	
Transitions of Care—Patient Engagement After Inpatient Discharge		
PIP Topic	Transitions of Care—Patient Engagement After Inpatient 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 members who were hospitalized and had an ambulatory follow-up visit with a primary care provider or licensed provider 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	High Confidence in both overall confidence of adherence to acceptable methodology and overall confidence that the PIP achieved significant improvement. All critical evaluation elements were Met, and 100 percent of all evaluation elements were Met across the first eight steps.	

Aetna met 100 percent of the requirements in the Implementation stage, Steps 7 and 8. Aetna reported its Remeasurement 1 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 through Table 4-5 display the PIP intervention summaries.

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

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

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

Intervention	Intervention Status
A fax blast was sent to all three provider types: OB/GYNs, family practitioners, and general practitioners. The fax blast included provider talking points and member resources for tobacco use cessation.	Abandon
Case managers complete member screening for tobacco use.	Continued
Case manager notifies the provider that screening was completed on member. Provider will then consult member and submit the appropriate codes indicating that the screening and counseling have been completed.	Continued

Table 4-4—Intervention Summary for *AMB-ED*

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

Table 4-5—Intervention Summary for *Transitions of Care—Patient Engagement After Inpatient 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.	Continued

Strengths, Weaknesses, and Recommendations

Table 4-6—Aetna’s PIP Strengths, Weaknesses, and Recommendations

Strengths	
	Aetna received <i>Met</i> validation scores for 100 percent of all applicable evaluation elements validated for Steps 1–8 for each PIP. For the <i>Transitions of Care—Patient Engagement After Inpatient Discharge</i> PIP, the MCO implemented meaningful interventions which led to a statistically significant improvement in Remeasurement 1 compared to baseline. One PIP, <i>Tobacco Use Cessation in Pregnant Women</i> , showed non-statistically significant improvement in Remeasurement 1 compared to baseline.
Weaknesses and Recommendations	
	Weakness: HSAG identified that two of the four PIPs, <i>AMB-ED Visits</i> and <i>Ensuring Timeliness of Prenatal Care</i>, demonstrated a decline in the performance indicator in Remeasurement 1 compared to baseline. HSAG noted that Aetna provided raw data as attachments to the PIP submissions. Submitting raw data as an attachment is acceptable; however, Aetna should provide an overview of the data in the submission form. Recommendations: Aetna should revisit its causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. Aetna should use PDSA cycles to meaningfully evaluate the effectiveness of each intervention. Aetna should analyze intervention measure effectiveness data and provide a summary of the results for each intervention.

HealthKeepers

In 2024, HealthKeepers submitted its Remeasurement 1 data and interventions for the following PIPs for validation: *Ensuring Timeliness of Prenatal Visits*, *Tobacco Use Cessation in Pregnant Women*, *Ambulatory Care—Emergency Department Visits (AMB-ED)*, and *Transitions of Care—Patient Engagement After Inpatient 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 Statement, performance indicator measure, validation scores, and confidence level for each PIP.

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

Timeliness of Prenatal Care	
PIP Topic	<i>Timeliness of Prenatal Care</i>
PIP Aim Statement	Do targeted interventions increase the percentage of deliveries that had a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with the organization?
Performance Indicator Measure	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.

Timeliness of Prenatal Care		
Description of Data Obtained	Administrative using claims and encounters.	
Validation Scores	Overall Score: 93%	Critical Elements Score: 100%
Confidence Level	High Confidence in overall confidence of adherence to acceptable methodology and Moderate Confidence in overall confidence that the PIP achieved significant improvement. All critical evaluation elements were Met, and 93 percent of all evaluation elements were Met across the first eight steps.	
Tobacco Use Cessation in Pregnant Women		
PIP Topic	Tobacco Use Cessation in Pregnant Women	
PIP Aim Statement	Do targeted interventions increase the percentage of deliveries that were screened for tobacco use during at least one prenatal care visit?	
Performance Indicator Measures	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization who had screening for tobacco use within one of the first two prenatal visits. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization who had screening for tobacco use within one of the first two prenatal visits, and if the screen was positive for smoking, subsequently received counseling/advice for smoking cessation.	
Description of Data Obtained	Administrative using claims and encounters.	
Validation Scores	Overall Score: 73%	Critical Elements Score: 89%
Confidence Level	Low Confidence in overall confidence of adherence to acceptable methodology and No Confidence in overall confidence that the PIP achieved significant improvement. 89 percent of critical evaluation elements were Met, and 73 percent of all evaluation elements were Met across the first eight steps.	
AMB-ED		
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 total ED visits within the measurement period that did not result in an inpatient encounter per 1000 member months.	
Description of Data Obtained	Administrative data using claims and encounters.	
Validation Scores	Overall Score: 87%	Critical Elements Score: 100%
Confidence Level	Moderate Confidence in overall confidence of adherence to acceptable methodology and No Confidence in overall confidence that the PIP achieved	

AMB-ED		
	significant improvement. All critical evaluation elements were <i>Met</i> , and 87 percent of all evaluation elements were <i>Met</i> across the first eight steps.	
Transitions of Care—Patient Engagement After Inpatient Discharge		
PIP Topic	<i>Transitions of Care—Patient Engagement After Inpatient Discharge</i>	
PIP Aim Statement	Do targeted interventions increase the percentage of discharges that resulted in patient engagement (office visits, visits to the home, telehealth) provided within 30 days after discharge?	
Performance Indicator Measure	The percentage of member discharges where there was documentation of patient engagement/ follow up (e.g., office visits, visits to the home, or telehealth) provided within 30 days after discharge.	
Description of Data Obtained	Administrative data using claims and encounters.	
Validation Scores	<i>Overall Score: 93%</i>	<i>Critical Elements Score: 100%</i>
Confidence Level	<i>High Confidence</i> in both overall confidence of adherence to acceptable methodology and overall confidence that the PIP achieved significant improvement. All critical evaluation elements were <i>Met</i> , and 93 percent of all evaluation elements were <i>Met</i> across the first eight steps.	

HealthKeepers met 100 percent of the requirements in the Design stage, Steps 1 through 6. For the Implementation stage, Step 7, the MCO reported its Remeasurement 1 rate and the QI activities conducted; however, the MCO omitted documenting whether there were any factors which could threaten comparability of Remeasurement 1 to baseline. HealthKeepers completed a causal/barrier analysis, prioritized the identified barriers, and initiated interventions that have the potential to impact the performance indicators. Table 4-8 through Table 4-11 display the PIP intervention summaries.

Table 4-8—Intervention Summary for *Timeliness of Prenatal Care*

Intervention	Intervention Status
Send informative and educational text messages to members regarding timely prenatal visits as a reminder to make an appointment with their obstetrics provider.	Continued
Generated HEDIS tags in PointClickCare (Collective Medical) using identified Gap in Care report to alert care coordinators of HEDIS gaps and generate a return report from PointClickCare overlaying gaps with emergency room visits in real time.	Continued
Provide education to members on the value of prenatal visits by informing them of the doula benefit via flyers and text messages.	Continued
Developed a report that identifies members with SDOH needs, including pregnant members, for care coordinators/care managers to outreach the members and assist with addressing the identified SDOH needs.	Continued

Intervention	Intervention Status
Extended Pay for Quality Provider Incentive Programs for providers. This program allows the providers to earn incentives for closing gaps in care earlier in the year to allow for additional gap closures.	Adopted
Hired an additional OB practice consultant to increase participation in the OBQIP that incentivizes providers for improving maternal performance indicators, including timely prenatal care.	Adopted
Added the <i>Timeliness of Prenatal Care</i> measure to the Provider Incentive Category II program to encourage providers to use the correct codes for billing.	Continued

Table 4-9—Intervention Summary for Tobacco Use Cessation in Pregnant Women

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

Table 4-10—Intervention Summary for AMB-ED

Intervention	Intervention Status
The 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.	Continued

Table 4-11—Intervention Summary for *Transitions of Care—Patient Engagement After Inpatient 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 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.	Continued

Strengths, Weaknesses, and Recommendations

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

Strengths	
	HealthKeepers received <i>Met</i> validation scores for 100 percent of all applicable evaluation elements validated for Steps 1–6 for each PIP. The MCO implemented interventions, some of which had a positive impact on the performance indicators as evidenced by the statistically significant improvement achieved in the <i>Transitions of Care—Patient Engagement After Inpatient Discharge</i> PIP and non-statistically significant improvement in the <i>Timeliness of Prenatal Care</i> PIP.
Weaknesses and Recommendations	
	Weakness: HSAG identified that two of the PIPs, <i>AMB-ED</i> and <i>Tobacco Use Cessation in Pregnant Women</i>, had a statistically significant decline in performance at Remeasurement 1 compared to baseline. None of the MCOs included a statement about factors which threaten comparability of Remeasurement 1 to baseline. The MCO should provide intervention-specific process steps. Submitting raw data as an attachment is acceptable; however, HealthKeepers should provide an overview of the data in the PIP Submission Form. Recommendations: HealthKeepers must include a statement about whether there are factors which threaten comparability of the remeasurement period to the baseline period. If there are no factors, this should be documented. HealthKeepers should continue to develop active, innovative interventions that have the potential for impacting the performance indicator outcomes. HealthKeepers should revisit its causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. HealthKeepers should develop a process to evaluate the effectiveness of each individual intervention and report the intervention evaluation data annually. HealthKeepers should use PDSA cycles to meaningfully evaluate the effectiveness of each intervention.

Molina

In 2024, Molina submitted its Remeasurement 1 data and interventions for the following PIPs for validation: *Ensuring Timeliness of Prenatal Visits*, *Tobacco Use Cessation in Pregnant Women*, *Ambulatory Care—Emergency Department Visits (AMB-ED)*, and *Transitions of Care—Patient Engagement After Inpatient 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 Statement, performance indicator measure, validation scores, and confidence level for each PIP.

Table 4-13—PIP Aim Statements and Validation Results: Molina

Timeliness of Prenatal Care		
PIP Topic	Timeliness of Prenatal Care	
PIP Aim Statement	Do targeted interventions increase the percentage of deliveries that had a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Molina Complete Care of Virginia?	
Performance Indicator Measure	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Molina Complete Care as defined by the HEDIS <i>PPC</i> measure specifications.	
Description of Data Obtained	Administrative using claims and encounters.	
Validation Scores	<i>Overall Score</i> : 100%	<i>Critical Elements Score</i> : 100%
Confidence Level	<i>High Confidence</i> in both overall confidence of adherence to acceptable methodology and overall confidence that the PIP achieved significant improvement. All critical evaluation elements were <i>Met</i> , and 100 percent of all evaluation elements were <i>Met</i> across the first eight steps.	
Tobacco Use Cessation in Pregnant Women		
PIP Topic	Tobacco Use Cessation in Pregnant Women	
PIP Aim Statement	Do targeted interventions decrease the use of tobacco products or smoking in pregnant women?"	
Performance Indicator Measures	The percentage of pregnant members as defined by the HEDIS <i>PPC</i> measure specifications who have expressed interest in tobacco use cessation during the measurement period.	
Description of Data Obtained	Administrative using claims and encounters and pharmacy data.	
Validation Scores	<i>Overall Score</i> : 100%	<i>Critical Elements Score</i> : 100%
Confidence Level	<i>High Confidence</i> in overall confidence of adherence to acceptable methodology and <i>Moderate Confidence</i> in overall confidence that the PIP achieved significant improvement. All critical evaluation elements were <i>Met</i> , and 100 percent of all evaluation elements were <i>Met</i> across the first eight steps.	

Tobacco Use Cessation in Pregnant Women		
AMB-ED		
PIP Topic	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: 100%	Critical Elements Score: 100%
Confidence Level	High Confidence in both overall confidence of adherence to acceptable methodology and overall confidence that the PIP achieved significant improvement. All critical evaluation elements were <i>Met</i> , and 100 percent of all evaluation elements were <i>Met</i> across the first eight steps.	
Transitions of Care—Patient Engagement After Inpatient Discharge		
PIP Topic	Transitions of Care—Patient Engagement After Inpatient 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 with a patient engagement 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: 100%	Critical Elements Score: 100%
Confidence Level	High Confidence in both overall confidence of adherence to acceptable methodology and overall confidence that the PIP achieved significant improvement. All critical evaluation elements were <i>Met</i> , and 100 percent of all evaluation elements were <i>Met</i> across the first eight steps.	

Molina met 100 percent of the requirements in the Implementation stage, Steps 7 and 8. The MCO reported its Remeasurement 1 rate and the QI activities conducted. Molina completed a causal/barrier analysis, prioritized the identified barriers, and initiated interventions that have the potential to impact the performance indicators. Table 4-14 through Table 4-17 display the PIP intervention summaries.

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

Intervention	Intervention Status
Targeted member outreach by Healthcare Services and Quality Member Interventions Team, which	Continued

Intervention	Intervention Status
provides scheduling assistance, raises awareness regarding the importance of timely prenatal care and any additional support identified. Increase in member-centered campaigns and events with a focus on PPC measures. Leverages the use of vendors for contact information and data sources to support outreach.	
The Practice Transformation team was established to enhance collaboration with provider groups. Each provider group is assigned a dedicated specialist who shares data on patient rosters and outcomes. These specialists support providers by focusing on closing care gaps, offering education on timely prenatal appointments, providing scorecards, and encouraging engagement in clinic day activities.	Continued
Molina launched the utilization of the Lucina analytics platform across Health Services and Quality teams. This solution is used to identify, and risk stratify maternity members timely to allow for identification and management of those at highest risk for complications of pregnancy and preterm birth.	Continued

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

Intervention	Intervention Status
Member outreach. The MCO uses various tools to identify alternative methods of communication or contact information and will target all prenatal members after three attempts have been made by the Healthcare Service team.	Continued
Utilization of additional data sources and analytics. Molina launched the utilization of the Lucina analytics platform across Health Services and Quality teams. This solution is used to identify and risk stratify maternity members in a timely manner to allow for identification and management of those at highest risk for complications of pregnancy and preterm birth. This information is utilized by the Health Services team to support early engagement with members to support improved outcomes.	Continued
Development of the Practice Transformation team. The Practice Transformation team was established to enhance collaboration with provider groups. Each provider group is assigned a dedicated specialist who shares data on patient rosters and	Continued

Intervention	Intervention Status
outcomes. The specialists are able to share resources provided by our Health Services team (to include tobacco use cessation support). These specialists support providers by focusing on closing care gaps, offering education on timely appointments, providing scorecards, and encouraging engagement in clinic day activities associated with preventive measures. The data gathered through these efforts, as detailed in the interventions/evaluation chart below, help guide ongoing intervention strategies.	

Table 4-16—Intervention Summary for AMB-ED

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. A targeted meeting based on the list will include action items, actionable data, and resources to promote engagement and intervention activities.	Continued
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.	Continued

Table 4-17—Intervention Summary for Transitions of Care—Patient Engagement After Inpatient 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.	Continued

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

Strengths, Weaknesses, and Recommendations

Table 4-18—Molina’s PIP Strengths, Weaknesses, and Recommendations

Strengths	
	Molina received <i>Met</i> validation scores for 100 percent of all applicable evaluation elements validated for Steps 1–8 for each PIP. For three of the four PIPs, <i>AMB-ED</i>, <i>Timeliness of Prenatal Care</i>, and <i>Transitions of Care—Patient Engagement After Inpatient Discharge</i>, the MCO implemented meaningful interventions which led to a statistically significant improvement in Remeasurement 1 compared to baseline. <i>Tobacco Use Cessation in Pregnant Women</i> showed non-statistically significant improvement in Remeasurement 1 compared to baseline.
Weaknesses and Recommendations	
	Weakness: HSAG noted that Molina provided raw data as an attachment to the <i>AMB-ED</i> PIP submission, which is acceptable; however, Molina should provide an overview of the data in the PIP Submission Form. Recommendations: Molina should revisit its causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. Molina should use PDSA cycles to meaningfully evaluate the effectiveness of each intervention and determine whether they should be continued, expanded, revised, or replaced. Molina should analyze intervention measure effectiveness data and provide a summary of the results for each intervention as part of the PIP Submission Form.

Sentara

In 2024, Sentara submitted its Remeasurement 1 data and interventions for the following PIPs for validation: *Ensuring Timeliness of Prenatal Visits*, *Tobacco Use Cessation in Pregnant Women*, *Ambulatory Care—Emergency Department Visits (AMB-ED)*, and *Transitions of Care—Patient Engagement After Inpatient Discharge*. The topics selected by DMAS addressed CMS’ requirements

related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-19 displays the PIP Aim Statement, performance indicator measure, validation scores, and confidence level for each PIP.

Table 4-19—PIP Aim Statements and Validation Results: Sentara

Timeliness of Prenatal Care		
PIP Topic	Timeliness of Prenatal Care	
PIP Aim Statement	Do targeted interventions increase the percentage of deliveries who received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization?	
Performance Indicator Measure	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.	
Description of Data Obtained	Administrative using claims and encounters and medical record review following HEDIS hybrid data collection specifications.	
Validation Scores	Overall Score: 100%	Critical Elements Score: 100%
Confidence Level	High Confidence in overall confidence of adherence to acceptable methodology and No Confidence in overall confidence that the PIP achieved significant improvement. All critical evaluation elements were Met, and 100 percent of all evaluation elements were Met across the first eight steps.	
Tobacco Use Cessation in Pregnant Women		
PIP Topic	Tobacco Use Cessation in Pregnant Women	
PIP Aim Statement	Do targeted interventions increase the percentage of identified non-smoking pregnant members during the measurement period?	
Performance Indicator Measure	The percentage of maternal non-smokers for Sentara Health Plan Medicaid insured pregnant women.	
Description of Data Obtained	Administrative data using electronic health records	
Validation Scores	Overall Score: 81%	Critical Elements Score: 89%
Confidence Level	Low Confidence in overall confidence of adherence to acceptable methodology and Moderate Confidence in overall confidence that the PIP achieved significant improvement. 89 percent of the critical evaluation elements were Met, and 81 percent of all evaluation elements were Met across the first eight steps.	
AMB-ED		
PIP Topic	Reducing Utilization of Emergency Department (ED) Visits	
PIP Aim Statement	Do targeted interventions decrease the percentage of ED visits during the measurement period?	
Performance Indicator Measure	The rate of utilization of emergency department visits among Sentara Health Plan enrolled members.	

AMB-ED		
Description of Data Obtained	Administrative data using claims and encounters.	
Validation Scores	Overall Score: 100%	Critical Elements Score: 100%
Confidence Level	High Confidence in overall confidence of adherence to acceptable methodology and Moderate Confidence in overall confidence that the PIP achieved significant improvement. All critical evaluation elements were Met, and 100 percent of all evaluation elements were Met across the first eight steps.	
Transitions of Care—Patient Engagement After Inpatient Discharge		
PIP Topic	Transitions of Care—Patient Engagement After Inpatient 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 Sentara Health Plan enrolled members.	
Description of Data Obtained	Administrative data using claims and encounters	
Validation Scores	Overall Score: 87%	Critical Elements Score: 89%
Confidence Level	Low Confidence in overall confidence of adherence to acceptable methodology and High Confidence in overall confidence that the PIP achieved significant improvement. 89 percent of the critical evaluation elements were Met, and 81 percent of all evaluation elements were Met across the first eight steps.	

Sentara met 100 percent of the requirements in the Design stage, Steps 1 through 6. The MCO reported its Remeasurement 1 rate and the QI activities conducted. Sentara completed a causal/barrier analysis, prioritized the identified barriers, and initiated interventions that have the potential to impact the performance indicators. Table 4-20 through Table 4-23 display the PIP intervention summaries.

Table 4-20—Intervention Summary for *Timeliness of Prenatal Care*

Intervention	Intervention Status
Increase case management efforts and utilize the maternity assessment for pregnant Cardinal Care Acute members. The Partners in Pregnancy team receives a monthly member enrollment list from DMAS. Based on this list, the Partners in Pregnancy team outreaches members and completes a maternity assessment.	Continued
The MCO utilizes Ovia (a digital application) so members can have real-time access to pregnancy information at their own pace. The Ovia information	Continued

Intervention	Intervention Status
is posted on the Optima website for easy access. Ovia also provides the MCO with a monthly list of Cardinal Care Acute members who accessed the pregnancy topic in the application.	

Table 4-21—Intervention Summary for Tobacco Use Cessation in Pregnant Women

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

Table 4-22—Intervention Summary for AMB-ED

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	Continued

Intervention	Intervention Status
reminders about other options for care for members.	
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, education is provided to the member to mitigate high ED utilization, and referrals are generated as appropriate.	Continued
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.	Continued

Table 4-23—Intervention Summary for *Transitions of Care—Patient Engagement After Inpatient 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.	Continued
An assessment is initiated for each admission. The assessment is used to document TCC activity.	Continued
The care plan will be transitioned to the care coordinator after the member is discharged from the acute facility.	Continued
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.	Continued
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.	Continued
Members are identified as being in-patient through the daily review of Collective/Premanage reports. Once	Continued

Intervention	Intervention Status
identified, the TCC begins outreach to the hospital case manager telephonically to begin collaboration to ensure a successful discharge. The TCC focuses on medication reconciliation, PCP/specialist follow-up visits scheduled, education provided regarding health care issues, and continuous coordination of care. If TCC is unable to contact (UTC) the hospital discharge planner the attempts will be documented in the Care Management documentation platform.	

Strengths, Weaknesses, and Recommendations

Table 4-24—Sentara’s PIP Strengths, Weaknesses, and Recommendations

Strengths	
	Sentara received <i>Met</i> validation scores for 100 percent of all applicable evaluation elements validated for Steps 1–6 for each PIP. For Steps 7 and 8, two of the four PIPs received 100 percent compliance. For the <i>Transitions of Care—Patient Engagement After Inpatient Discharge</i> PIP, the MCO implemented meaningful interventions which led to a statistically significant improvement in Remeasurement 1 compared to baseline. Two PIPs, <i>Tobacco Use Cessation in Pregnant Women</i> and <i>AMB-ED</i> showed non-statistically significant improvement in Remeasurement 1 compared to baseline.
Weaknesses and Recommendations	
	Weakness: HSAG identified that one of the four PIPs, <i>Timeliness of Prenatal Care</i>, demonstrated a decline in the performance indicator in Remeasurement 1 compared to baseline. Additionally, Sentara did not provide appropriate <i>p</i> values for two of the PIPs, and one PIP did not address factors which threaten the comparability of Remeasurement 1 to baseline. Recommendations: Sentara should revisit its causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. Sentara should use PDSA cycles to meaningfully evaluate the effectiveness of each intervention. Sentara should analyze intervention measure effectiveness data and provide a summary of the results for each intervention as part of the PIP Submission Form. Sentara should use one of the HSAG-recommended statistical analysis tools to report the <i>p</i> value used to assess statistical significance between the remeasurement period and baseline data.

United

In 2024, United submitted its Remeasurement 1 data and interventions for the following PIPs for validation: *Ensuring Timeliness of Prenatal Visits*, *Tobacco Use Cessation in Pregnant Women*, *Ambulatory Care—Emergency Department Visits (AMB-ED)*, and *Transitions of Care—Patient Engagement After Inpatient Discharge*. The topics selected by DMAS addressed CMS’ requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-25

displays the PIP Aim Statement, performance indicator measure, validation scores, and confidence level for each PIP.

Table 4-25—PIP Aim Statements and Validation Results: United

Timeliness of Prenatal Care		
PIP Topic	Timeliness of Prenatal Care	
PIP Aim Statement	Targeted interventions supported by the Virginia UnitedHealthcare Cardinal Care Acute Plan and focused on member outreach and engagement will increase the percentage of women who receive a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment for the Cardinal Care Acute population	
Performance Indicator Measure	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.	
Description of Data Obtained	Administrative using claims and encounters.	
Validation Scores	Overall Score: 100%	Critical Elements Score: 100%
Confidence Level	High Confidence in both overall confidence of adherence to acceptable methodology and overall confidence that the PIP achieved significant improvement. 100 percent of the critical evaluation elements were Met, and 100 percent of all evaluation elements were Met across the first eight steps.	
Tobacco Use Cessation in Pregnant Women		
PIP Topic	Tobacco Use Cessation in Pregnant Women	
PIP Aim Statement	Targeted interventions supported by the Virginia UnitedHealthcare Cardinal Care Acute Plan and focused on member engagement increase the percentage of pregnant women (identified as tobacco users) who receive advice to quit smoking and/or who discussed or were provided cessation methods or strategies among pregnant women.	
Performance Indicator Measures	The percentage of pregnant women using tobacco who received smoking cessation services.	
Description of Data Obtained	Administrative using claims and encounters and telephone service center data.	
Validation Scores	Overall Score: 100%	Critical Elements Score: 100%
Confidence Level	High Confidence in both overall confidence of adherence to acceptable methodology and overall confidence that the PIP achieved significant improvement. 100 percent of the critical evaluation elements were Met, and 100 percent of all evaluation elements were Met across the first eight steps.	
AMB—ED		
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 period?	

Tobacco Use Cessation in Pregnant Women		
Performance Indicator Measure	The rate 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%
Confidence Level	High Confidence in both overall confidence of adherence to acceptable methodology and overall confidence that the PIP achieved significant improvement. 100 percent of the critical evaluation elements were Met, and 100 percent of all evaluation elements were Met across the first eight steps.	
Transitions of Care—Patient Engagement After Inpatient Discharge		
PIP Topic	Transitions of Care—Patient Engagement After Inpatient 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%
Confidence Level	High Confidence in both overall confidence of adherence to acceptable methodology and overall confidence that the PIP achieved significant improvement. 100 percent of the critical evaluation elements were Met, and 100 percent of all evaluation elements were Met across the first eight steps.	

United met 100 percent of the requirements in the Implementation stage, Steps 7 and 8. The MCO reported its Remeasurement 1 rate and the QI activities conducted. The MCO completed a causal/barrier analysis, prioritized the identified barriers, and initiated interventions that have the potential to impact the performance indicators. Table 4-26 through Table 4-27 display the PIP intervention summaries.

Table 4-26—Intervention Summary for *Timeliness of Prenatal Care*

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

Table 4-27—Intervention Summary for *Tobacco Use Cessation in Pregnant Women*

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

Table 4-28—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.	Continued
Care managers outreach identified members within 24–48 business hours following ED alert or discharge notification.	Continued
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.	Continued

Table 4-29—Intervention Summary for *Transitions of Care—Patient Engagement After Inpatient 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 HRAs completed following an inpatient stay and ensure PHAs are completed within 72 hours of discharge.	Continued
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.	Continued

Strengths, Weaknesses, and Recommendations

Table 4-30—United’s PIP Strengths, Weaknesses, and Recommendations

Strengths	
	United received <i>Met</i> validation scores for 100 percent of all applicable evaluation elements validated for Steps 1–8 for each PIP. The MCO implemented meaningful interventions which led to a statistically significant improvement in Remeasurement 1 compared to baseline in three of the four PIPs, <i>Transitions of Care—Patient Engagement After Inpatient Discharge</i> , <i>Timeliness of Prenatal Care</i> , and <i>Tobacco Use Cessation in Pregnant Women</i> .
Weaknesses and Recommendations	
	Weakness: HSAG identified that one of the PIPs, <i>AMB-ED</i>, demonstrated a decline in the performance indicator in Remeasurement 1 compared to baseline. Recommendations: United should revisit its causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. United should use PDSA cycles to meaningfully evaluate the effectiveness of each intervention. United should analyze intervention measure effectiveness data and provide a summary of the results for each intervention as part of the PIP Submission Form.

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 must include a statement about whether there are factors which threaten comparability of the remeasurement period to the baseline period in the Step 7 narrative. If there are no factors, this should be documented.
- The MCOs should use one of HSAG’s recommended statistical analysis tools to conduct statistical testing and indicate the *p* value as well as the direction of change in the performance indicator(s) compared to baseline.
- The MCOs should revisit their causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement.
- The MCOs should keep interventions focused on the prioritized barriers and consider making fundamental changes.
- When developing interventions, the MCOs should consider collaborating with external organizations and SMEs.
- The MCOs should use PDSA cycles to test interventions on a small scale before expanding to larger populations. The MCOs should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results quickly. The intervention evaluation results should drive next steps for interventions and determine whether they should be adopted, adapted, or abandoned, or whether continued testing is needed.
- The MCOs should discuss and address barriers to PIP progress with their internal teams and/or HSAG to determine methods on how to overcome any identified barriers.

- The MCOs should continue to reference the PIP Completion Instructions as additional steps of the PIP process are completed. This will help ensure that all documentation requirements have been addressed.
- The MCOs should apply lessons learned and HSAG's validation feedback to their PIPs and other QI projects.

5. Validation of Performance Measures

Overview

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

Objectives

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

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

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

Section 3, Table 3-3, displays, by MCO, the HEDIS MY 2023 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:

- **Administrative Data:** HSAG identified no concerns with Aetna's claims, eligibility, or provider data systems or processes.
- **Medical Record Review Process:** HSAG identified no concerns with Aetna's MRR processes.
- **Clinical Care and Delivery Data:** HSAG identified no concerns with Aetna's supplemental data systems and processes.
- **Data Management and Reporting:** HSAG identified no concerns with Aetna's procedures for data integration and PM production.

Strengths, Weaknesses, and Recommendations

Strengths	
	Within the Children's Preventive Care domain, Aetna displayed strong performance for the <i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i> and the <i>Well-Child Visits for Age 15 Months—30 Months—Two or More Well-Child Visits</i> PM indicators, with the MCO's rates meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 75th percentile.
	Within the Care for Chronic Conditions domain, Aetna displayed strong performance for the <i>Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation—Systemic Corticosteroid</i> and <i>Bronchodilator</i> PM indicators, with the MCO's rates meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 90th percentile.
	Within the Behavioral Health domain, Aetna performed strongly for both <i>Initiation and Engagement of Substance Use Disorder Treatment</i> PM indicators, with the MCO's rates meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 75th percentile.
Weaknesses and Recommendations	
	Weakness: The following HEDIS MY 2023 PM rates fell below NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Aetna: • <i>Use of Imaging Studies for Low Back Pain</i> • <i>Antidepressant Medication Management—Effective Acute Phase Treatment; Effective Continuation Phase Treatment</i> • <i>Use of Opioids from Multiple Providers—Multiple Prescribers and Multiple Pharmacies</i> Recommendations: To improve the rates for the PMs that fell below the 25th percentile, HSAG recommends that Aetna leverage its HEDIS and CAHPS Workgroup to conduct a segmentation analysis to identify potential disparities that are leading to lower quality care, focusing on characteristics of noncompliant members such as race, ethnicity, age, gender, and geography. Additionally, Aetna should consider providing scorecards and/or care gap reports to providers with low performance on these measures and encourage collaboration on identifying the best care protocols for these types of patients. Using evidence-

Weaknesses and Recommendations

based practices and monitoring metrics, Aetna can continuously improve and enhance quality.

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:

- **Administrative Data:** HSAG identified no concerns with HealthKeepers' claims, eligibility, or provider data systems processes.
- **Medical Record Review Process:** HSAG identified no concerns with HealthKeepers' MRR processes.
- **Clinical Care and Delivery Data:** HSAG identified no concerns with HealthKeepers' supplemental data systems and processes.
- **Data Management and Reporting:** HSAG identified no concerns with HealthKeepers' procedures for data integration and PM production.

Strengths, Weaknesses, and Recommendations

Strengths

	Within the Behavioral Health domain, HealthKeepers displayed strong performance for the <i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Total</i>, <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Total</i>, <i>Diagnosed Mental Health Disorders—Total</i>, both indicators for <i>Follow-Up After Emergency Department Visit for Substance Use</i>, <i>Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total</i>, both indicators for <i>Follow-Up After Hospitalization for Mental Illness</i>, and both indicators for <i>Initiation and Engagement of Substance Use Disorder Treatment</i> PM indicators, with the MCO's rates meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 50th percentile.
	Within the Children's Preventive Care domain, HealthKeepers displayed strong performance for the <i>Immunizations for Adolescents—Combination 1</i> PM indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 75th percentile.
	Within the Care for Chronic Conditions domain, HealthKeepers displayed strong performance for the <i>Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit</i> PM indicator, with the

Strengths	
	MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 90th percentile.
	Within the Woman's Health domain, HealthKeepers displayed strong performance for the <i>Breast Cancer Screening—Total</i> PM indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 50th percentile.
Weaknesses and Recommendations	
	Weakness: The following HEDIS MY 2023 PM rates fell below NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for HealthKeepers: • <i>Prenatal and Postpartum Care—Postpartum Care</i> • <i>Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment</i> Recommendations: To improve the rates for the PMs that fell below the 25th percentile, HSAG recommends that HealthKeepers identify strategies for addressing disparities based on the data deep dives being conducted by the Quality team to provide insight regarding the demographics of noncompliant members. HealthKeepers can leverage its current suite of maternal care programs to address different identified disparities. Additionally, HealthKeepers should consider providing scorecards and/or care gap reports to providers with low performance on these measures and encourage collaboration on identifying the best care protocols for these types of patients, including scheduling future visits and sending reminders.

Molina

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

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

- **Administrative Data:** HSAG identified no concerns with Molina's claims, eligibility, or provider data systems processes.
- **Medical Record Review Process:** HSAG identified no concerns with Molina's MRR processes.
- **Clinical Care and Delivery Data:** HSAG identified no concerns with Molina's supplemental data systems and processes.
- **Data Management and Reporting:** HSAG identified no concerns with Molina's procedures for data integration and PM production.

Strengths, Weaknesses, and Recommendations

Strengths	
	Within the Care for Chronic Conditions domain, Molina displayed strong performance for the <i>Asthma Medication Ratio—Total</i> and <i>Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation—Systemic Corticosteroid</i> PM indicators, with the MCO's rates meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 75th percentile.
	Within the Behavioral Health domain, Molina displayed strong performance for both <i>Initiation and Engagement of Substance Use Disorder Treatment</i> PM indicators, with the MCO's rates meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 75th and 90th percentile, respectively.
Weaknesses and Recommendations	
	Weakness: The following HEDIS MY 2023 PM rates fell below NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Molina: • <i>Breast Cancer Screening</i> • <i>Cervical Cancer Screening</i> • <i>Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment</i> • <i>Immunizations for Adolescents—Combination 1 and Combination 2</i> • <i>Use of Opioids from Multiple Providers—Multiple Prescribers and Multiple Pharmacies</i> Recommendations: To improve the rates for PMs that fell below the 25th percentile, HSAG recommends that Molina ensure that the above measures are included in the MY 2024 P4Q Program. Additionally, Molina should leverage its Direct Scheduling and Clinic Day programs to assist provider groups who have lower rates on the screening and immunization measures. Finally, Molina should conduct a segmentation analysis to identify potential disparities in noncompliant members, focusing on factors like race, ethnicity, age, gender, and geography.

Sentara

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

HSAG determined that Sentara 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:

- **Administrative Data:** HSAG identified no concerns with Sentara's claims, eligibility, or provider data systems or processes.

- *Medical Record Review Process*: HSAG identified no concerns with Sentara's MRR processes.
- *Clinical Care and Delivery Data*: HSAG identified no concerns with Sentara's supplemental data systems and processes.
- *Data Management and Reporting*: HSAG identified no concerns with Sentara's procedures for data integration and PM production.

Strengths, Weaknesses, and Recommendations

Strengths	
	Within the Behavioral Health domain, Sentara displayed strong performance for one indicator of the <i>Diagnosed Substance Use Disorders</i> measure, and both <i>Initiation and Engagement of Substance Use Disorder Treatment</i> PM indicators, with the MCO's rates meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 75th percentile.
	Within the Care for Chronic Conditions domain, Sentara displayed strong performance for the <i>Asthma Medication Ratio—Total</i> PM indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 75th percentile.
Weaknesses and Recommendations	
	Weakness: The following HEDIS MY 2023 PM rates fell below NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Sentara: • <i>Breast Cancer Screening</i> • <i>Cervical Cancer Screening</i> • <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care</i> • <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total and Counseling for Physical Activity—Total</i> • <i>Ambulatory Care—Emergency Department (ED) Visits</i> Recommendations: To improve the rates for PMs that fell below the 25th percentile, HSAG recommends that Sentara conduct a segmentation analysis to identify potential disparities in noncompliant members, focusing on factors like race, ethnicity, age, gender, and geography. Sentara should then leverage its maternal care programs to engage women in ways that help to address the barriers identified. Additionally, Sentara should consider providing scorecards and/or care gap reports to providers with low performance on these measures and encourage collaboration on identifying the best care protocols for these types of patients, including scheduling future visits and sending reminders.

United

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

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

- **Administrative Data:** HSAG identified no concerns with United's claims, eligibility, or provider data system or processes.
- **Medical Record Review Process:** HSAG identified no concerns with United's MRR processes.
- **Clinical Care and Delivery Data:** HSAG identified no concerns with United's supplemental data systems and processes.
- **Data Management and Reporting:** HSAG identified no concerns with United's procedures for data integration and PM production.

Strengths, Weaknesses, and Recommendations

Strengths	
	Within the Behavioral Health domain, United displayed strong performance for <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Total</i> , two of four <i>Diagnosed Substance Use Disorders indicators</i> , both indicators for <i>Initiation and Engagement of Substance Use Disorder Treatment</i> , and all three <i>Metabolic Monitoring for Children and Adolescents on Antipsychotics</i> PM indicators, with the MCO's rates meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 75th percentile.
	Within the Children's Preventive Care domain, United displayed strong performance for the <i>Child and Adolescent Well-Care Visits—Total</i> PM indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 75th percentile.
	Within the Care for Chronic Conditions domain, United displayed strong performance for the <i>Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)</i> PM indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 75th percentile; and the <i>Hemoglobin A1c Control for Patients With Diabetes—HbA1c (<8.0%)</i> PM indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 90th percentile.
Weaknesses and Recommendations	
	Weakness: The following HEDIS MY 2023 PM rates fell below NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for United: • <i>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total</i>

Weaknesses and Recommendations

- *Use of Opioids from Multiple Providers—Multiple Prescribers and Multiple Pharmacies*
- *Ambulatory Care—Emergency Department (ED) Visits*

Recommendations: To improve the rates for PMs that fell below the 25th percentile, HSAG recommends that United conduct a segmentation analysis to identify potential disparities in noncompliant members, focusing on factors like race, ethnicity, age, gender, and geography. United should also ensure these measures are included in the Clinical Quality Dashboard that it makes available to providers to help identify member needs and care gaps in real time and ensure that providers with low performance on these measures know how to access the dashboard. Additionally, United should collaborate with low-performing providers on these measures and help identify the best care protocols for these types of patients.

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, 2023, through June 30, 2024. To conduct the OSR, HSAG followed the guidelines set forth in the CMS EQR Protocol 3 cited earlier in this report.

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.

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

Table 6-1—OSR Standard Assigned CMS Categories

Standard	Quality	Access	Timeliness
I. Disenrollment Requirements and Limitations	✓	✓	
II. Member Rights and Member Information	✓	✓	
III. Emergency and Poststabilization Services		✓	
IV. Availability of Services		✓	✓
V. Assurances of Adequate Capacity and Services		✓	✓
VI. Coordination and Continuity of Care	✓	✓	✓
VII. Coverage and Authorization of Services		✓	✓
VIII. Provider Selection	✓	✓	✓
IX. Confidentiality	✓	✓	
X. Grievance and Appeals Systems	✓		
XI. Subcontractual Relationships and Delegation	✓	✓	
XII. Practice Guidelines	✓	✓	
XIII. Health Information Systems	✓	✓	
XIV. Quality Assessment and Performance Improvement	✓	✓	✓
XV. Program Integrity	✓	✓	✓
XVII. EPSDT	✓	✓	✓
XVI. Model of Care	✓	✓	✓

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 Cardinal Care OSR Standards and Scores

	Associated Federal Citation ¹		Compliance Reviews	Aetna		
	Medicaid	CHIP	Standard Name	2022	2023	2024
I.	§438.56	§457.1212	Disenrollment: Requirements and Limitations			66.7%
II.	§438.10 §438.100	§457.1207 §457.1220	Member Rights and Member Information			69.2%
III.	§438.114	§457.1228	Emergency and Poststabilization Services			84.6%
IV.	§438.206	§457.1230(a)	Availability of Services			100%
V.	§438.207	§457.1230(b) §457.1218	Assurances of Adequate Capacity and Services			75.0%
VI.	§438.208	§457.1230(c)	Coordination and Continuity of Care			100%
VII.	§438.210	§457.1230(d)	Coverage and Authorization of Services			91.3%
VIII.	§438.214	§457.1233(a)	Provider Selection			95.5%
IX.	§438.224	§457.1233(e)	Confidentiality			100%
X.	§438.228	§457.1260	Grievance and Appeal Systems			87.2%
XI.	§438.230	§457.1233(b)	Subcontractual Relationships and Delegation			40.0%
XII.	§438.236	§457.1233(c)	Practice Guidelines			85.7%
XIII.	§438.242	§457.1233(d)	Health Information Systems ²			100%
XIV.	§438.330	§457.1240	Quality Assessment and Performance Improvement Program			100%
XV.	§438.608	§457.1285	Program Integrity			85.7%
XVI.	Social Security Act; Section 1859	Social Security Act, Section 1859	Model of Care			94.7%
XVII.	§441.50; Social Security Act, Section 1902	Social Security Act, Section 1905	Early and Periodic Screening, Diagnostic, and Treatment			67.6%
			TOTAL SCORE			86.7%

¹ The OSR standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

² This standard includes a comprehensive assessment of the MCO's IS capabilities.

Strengths, Weaknesses, and Recommendations

Strengths	
	Aetna achieved full compliance in five of the 17 standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas: - Standard IV: Availability of Services - Standard VI: Coordination and Continuity of Care - Standard IX: Confidentiality - Standard XIII: Health Information Systems - Standard XIV: Quality Assessment and Performance Improvement Program These findings suggest that Aetna developed the necessary policies, procedures, and processes to operationalize some of the requirements of its contract and demonstrated compliance with most of the expectations of the contract.
Weaknesses and Recommendations	
	Weakness: The areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 90 percent: - Standard I: Disenrollment: Requirements and Limitations - Standard II: Member Rights and Member Information - Standard III: Emergency and Poststabilization Services - Standard V: Assurances of Adequate Capacity and Services - Standard X: Grievance and Appeal Systems - Standard XI: Subcontractual Relationships and Delegation - Standard XII: Practice Guidelines - Standard XV: Program Integrity - Standard XVII: EPSDT These findings suggest that Aetna did not consistently develop the necessary policies, procedures, and processes to operationalize the requirements of its contract and did not always demonstrate compliance with the contract. Recommendations: HSAG recommends that the MCO update policies, procedures, and operational documents to comply with federal and DMAS requirements of each element scored as <i>Not Met</i>. HSAG also recommends that the MCO ensure that staff members are trained and knowledgeable about the requirements of the contract, and that they understand the policies and procedures that the MCO uses to meet federal and DMAS requirements.

HealthKeepers

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

Table 6-3—HealthKeepers' Cardinal Care OSR Standards and Scores

	Associated Federal Citation ¹		Compliance Reviews	HealthKeepers'		
	Medicaid	CHIP	Standard Name	2022	2023	2024
I.	§438.56	§457.1212	Disenrollment: Requirements and Limitations			66.7%
II.	§438.10 §438.100	§457.1207 §457.1220	Member Rights and Member Information			69.2%
III.	§438.114	§457.1228	Emergency and Poststabilization Services			100%
IV.	§438.206	§457.1230(a)	Availability of Services			100%
V.	§438.207	§457.1230(b) §457.1218	Assurances of Adequate Capacity and Services			75.0%
VI.	§438.208	§457.1230(c)	Coordination and Continuity of Care			90.9%
VII.	§438.210	§457.1230(d)	Coverage and Authorization of Services			91.3%
VIII.	§438.214	§457.1233(a)	Provider Selection			100%
IX.	§438.224	§457.1233(e)	Confidentiality			100%
X.	§438.228	§457.1260	Grievance and Appeal Systems			87.2%
XI.	§438.230	§457.1233(b)	Subcontractual Relationships and Delegation			40.0%
XII.	§438.236	§457.1233(c)	Practice Guidelines			57.1%
XIII.	§438.242	§457.1233(d)	Health Information Systems ²			100%
XIV.	§438.330	§457.1240	Quality Assessment and Performance Improvement Program			95.2%
XV.	§438.608	§457.1285	Program Integrity			78.6%
XVI.	Social Security Act; Section 1859	Social Security Act, Section 1859	Model of Care			97.4%
XVII.	§441.50; Social Security Act, Section 1902	Social Security Act, Section 1905	Early and Periodic Screening, Diagnostic, and Treatment			73.0%
			TOTAL SCORE			87.0%

¹ The OSR standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

² This standard includes a comprehensive assessment of the MCO's IS capabilities.

Strengths, Weaknesses, and Recommendations

Strengths	
	HealthKeepers achieved full compliance in five of the 17 standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas: • Standard III: Emergency and Poststabilization Services • Standard IV: Availability of Services • Standard VIII: Provider Selection • Standard IX: Confidentiality • Standard XIII: Health Information Systems These findings suggest that HealthKeepers developed the necessary policies, procedures, and processes to operationalize some of the requirements of its contract and demonstrated compliance with most of the expectations of the contract.
Weaknesses and Recommendations	
	Weakness: The areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 90 percent: • Standard I: Disenrollment: Requirements and Limitations • Standard II: Member Rights and Member Information • Standard V: Assurances of Adequate Capacity and Services • Standard X: Grievance and Appeal Systems • Standard XI: Subcontractual Relationships and Delegation • Standard XII: Practice Guidelines • Standard XV: Program Integrity • Standard XVII: EPSDT These findings suggest that HealthKeepers did not consistently develop the necessary policies, procedures, and processes to operationalize the requirements of its contract and did not always demonstrate compliance with the contract. Recommendations: HSAG recommends that the MCO update policies, procedures, and operational documents to comply with federal and DMAS requirements of each element scored as <i>Not Met</i>. HSAG also recommends that the MCO ensure that staff members are trained and knowledgeable about the requirements of the contract, and that they understand the policies and procedures that the MCO uses to meet federal and DMAS requirements.

Molina

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

Table 6-4—Molina's Cardinal Care OSR Standards and Scores

	Associated Federal Citation ¹		Compliance Reviews	Molina		
	Medicaid	CHIP	Standard Name	2022	2023	2024
I.	§438.56	§457.1212	Disenrollment: Requirements and Limitations			100%
II.	§438.10 §438.100	§457.1207 §457.1220	Member Rights and Member Information			34.6%
III.	§438.114	§457.1228	Emergency and Poststabilization Services			100%
IV.	§438.206	§457.1230(a)	Availability of Services			100%
V.	§438.207	§457.1230(b) §457.1218	Assurances of Adequate Capacity and Services			50.0%
VI.	§438.208	§457.1230(c)	Coordination and Continuity of Care			91.0%
VII.	§438.210	§457.1230(d)	Coverage and Authorization of Services			87.0%
VIII.	§438.214	§457.1233(a)	Provider Selection			95.5%
IX.	§438.224	§457.1233(e)	Confidentiality			100%
X.	§438.228	§457.1260	Grievance and Appeal Systems			84.6%
XI.	§438.230	§457.1233(b)	Subcontractual Relationships and Delegation			80.0%
XII.	§438.236	§457.1233(c)	Practice Guidelines			85.7%
XIII.	§438.242	§457.1233(d)	Health Information Systems ²			100%
XIV.	§438.330	§457.1240	Quality Assessment and Performance Improvement Program			100%
XV.	§438.608	§457.1285	Program Integrity			100%
XVI.	Social Security Act; Section 1859	Social Security Act, Section 1859	Model of Care			97.4%
XVII.	§441.50; Social Security Act, Section 1902	Social Security Act, Section 1905	Early and Periodic Screening, Diagnostic, and Treatment			91.9%
			TOTAL SCORE			88.6%

¹ The OSR standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

² This standard includes a comprehensive assessment of the MCO's IS capabilities.

Strengths, Weaknesses, and Recommendations

Strengths	
	Molina achieved full compliance in six of the 17 standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas: • Standard I: Disenrollment: Requirements and Limitations • Standard III: Emergency and Poststabilization Services • Standard IV: Availability of Services • Standard IX: Confidentiality • Standard XIII: Health Information Systems • Standard XV: Program Integrity These findings suggest that Molina developed the necessary policies, procedures, and processes to operationalize some of the requirements of its contract and demonstrated compliance with most of the expectations of the contract.
Weaknesses and Recommendations	
	Weakness: The areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 90 percent: • Standard II: Member Rights and Member Information • Standard V: Assurances of Adequate Capacity and Services • Standard VII: Coverage and Authorization of Services • Standard X: Grievance and Appeal Systems • Standard XI: Subcontractual Relationships and Delegation • Standard XII: Practice Guidelines These findings suggest that Molina did not consistently develop the necessary policies, procedures, and processes to operationalize the requirements of its contract and did not always demonstrate compliance with the contract. Recommendations: HSAG recommends that the MCO update policies, procedures, and operational documents to comply with federal and DMAS requirements of each element scored as <i>Not Met</i>. HSAG also recommends that the MCO ensure that staff members are trained and knowledgeable about the requirements of the contract, and that they understand the policies and procedures that the MCO uses to meet federal and DMAS requirements.

Sentara

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

Table 6-5—Sentara's Cardinal Care OSR Standards and Scores

	Associated Federal Citation ¹		Compliance Reviews	Sentara		
	Medicaid	CHIP	Standard Name	2022	2023	2024
I.	§438.56	§457.1212	Disenrollment: Requirements and Limitations			100%
II.	§438.10 §438.100	§457.1207 §457.1220	Member Rights and Member Information			84.6%
III.	§438.114	§457.1228	Emergency and Poststabilization Services			100%
IV.	§438.206	§457.1230(a)	Availability of Services			100%
V.	§438.207	§457.1230(b) §457.1218	Assurances of Adequate Capacity and Services			100%
VI.	§438.208	§457.1230(c)	Coordination and Continuity of Care			100%
VII.	§438.210	§457.1230(d)	Coverage and Authorization of Services			100%
VIII.	§438.214	§457.1233(a)	Provider Selection			100%
IX.	§438.224	§457.1233(e)	Confidentiality			100%
X.	§438.228	§457.1260	Grievance and Appeal Systems			89.7%
XI.	§438.230	§457.1233(b)	Subcontractual Relationships and Delegation			100%
XII.	§438.236	§457.1233(c)	Practice Guidelines			100%
XIII.	§438.242	§457.1233(d)	Health Information Systems ²			100%
XIV.	§438.330	§457.1240	Quality Assessment and Performance Improvement Program			100%
XV.	§438.608	§457.1285	Program Integrity			100%
XVI.	Social Security Act; Section 1859	Social Security Act, Section 1859	Model of Care			92.1%
XVII.	§441.50; Social Security Act, Section 1902	Social Security Act, Section 1905	Early and Periodic Screening, Diagnostic, and Treatment			94.6%
			TOTAL SCORE			95.8%

¹ The OSR standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

² This standard includes a comprehensive assessment of the MCO's IS capabilities.

Strengths, Weaknesses, and Recommendations

Strengths	
	Sentara achieved full compliance in 13 of the 17 standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas: • Standard I: Disenrollment: Requirements and Limitations • Standard III: Emergency and Poststabilization Services • Standard IV: Availability of Services • Standard V: Assurances of Adequate Capacity and Services • Standard VI: Coordination and Continuity of Care • Standard VII: Coverage and Authorization of Services • Standard VIII: Provider Selection • Standard IX: Confidentiality • Standard XI: Subcontractual Relationships and Delegation • Standard XII: Practice Guidelines • Standard XIII: Health Information Systems • Standard XIV: Quality Assessment and Performance Improvement Program • Standard XV: Program Integrity These findings suggest that Sentara developed the necessary policies, procedures, and processes to operationalize most of the requirements of its contract and demonstrated compliance with most of the expectations of the contract.
Weaknesses and Recommendations	
	Weakness: The areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 90 percent: • Standard II: Member Rights and Member Information • Standard X: Grievance and Appeal Systems These findings suggest that Sentara did not consistently develop the necessary policies, procedures, and processes to operationalize the requirements of its contract and did not always demonstrate compliance with the contract. Recommendations: HSAG recommends that the MCO update policies, procedures, and operational documents to comply with federal and DMAS requirements of each element scored as <i>Not Met</i>. HSAG also recommends that the MCO ensure that staff members are trained and knowledgeable about the requirements of the contract, and that they understand the

Weaknesses and Recommendations

policies and procedures that the MCO uses to meet federal and DMAS requirements.

United

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

Table 6-6—United's Cardinal Care OSR Standards and Scores

	Associated Federal Citation ¹		Compliance Reviews	United		
	Medicaid	CHIP	Standard Name	2022	2023	2024
I.	§438.56	§457.1212	Disenrollment: Requirements and Limitations			100%
II.	§438.10 §438.100	§457.1207 §457.1220	Member Rights and Member Information			65.4%
III.	§438.114	§457.1228	Emergency and Poststabilization Services			100%
IV.	§438.206	§457.1230(a)	Availability of Services			100%
V.	§438.207	§457.1230(b) §457.1218	Assurances of Adequate Capacity and Services			75.0%
VI.	§438.208	§457.1230(c)	Coordination and Continuity of Care			100%
VII.	§438.210	§457.1230(d)	Coverage and Authorization of Services			95.7%
VIII.	§438.214	§457.1233(a)	Provider Selection			95.5%
IX.	§438.224	§457.1233(e)	Confidentiality			100%
X.	§438.228	§457.1260	Grievance and Appeal Systems			89.7%
XI.	§438.230	§457.1233(b)	Subcontractual Relationships and Delegation			100%
XII.	§438.236	§457.1233(c)	Practice Guidelines			71.4%
XIII.	§438.242	§457.1233(d)	Health Information Systems ²			100%
XIV.	§438.330	§457.1240	Quality Assessment and Performance Improvement Program			100%
XV.	§438.608	§457.1285	Program Integrity			85.7%
XVI.	Social Security Act; Section 1859	Social Security Act, Section 1859	Model of Care			100%
XVII.	§441.50; Social Security Act, Section 1902	Social Security Act, Section 1905	Early and Periodic Screening, Diagnostic, and Treatment			86.5%
			TOTAL SCORE			91.9%

¹ The OSR standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

² This standard includes a comprehensive assessment of the MCO's IS capabilities.

Strengths, Weaknesses, and Recommendations

Strengths	
	United achieved full compliance in nine of the 17 standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas: - Standard I: Disenrollment: Requirements and Limitations - Standard III: Emergency and Poststabilization Services - Standard IV: Availability of Services - Standard VI: Coordination and Continuity of Care - Standard IX: Confidentiality - Standard XI: Subcontractual Relationships and Delegation - Standard XIII: Health Information Systems - Standard XIV: Quality Assessment and Performance Improvement Program - Standard XVI: Model of Care These findings suggest that United developed the necessary policies, procedures, and processes to operationalize some of the requirements of its contract and demonstrated compliance with most of the expectations of the contract.
Weaknesses and Recommendations	
	Weakness: The areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 90 percent: - Standard II: Member Rights and Member Information - Standard V: Assurances of Adequate Capacity and Services - Standard X: Grievance and Appeal Systems - Standard XII: Practice Guidelines - Standard XV: Program Integrity - Standard XVII: EPSDT These findings suggest that United did not always develop the necessary policies, procedures, and processes to operationalize the requirements of its contract and did not consistently demonstrate compliance with the contract. Recommendations: HSAG recommends that the MCO update policies, procedures, and operational documents to comply with federal and DMAS requirements of each element scored as <i>Not Met</i>. HSAG also recommends that the MCO ensure that staff members are trained and knowledgeable about the requirements of the contract, and that they understand the

Weaknesses and Recommendations

	policies and procedures that the MCO uses to meet federal and DMAS requirements.

DMAS Intermediate Sanctions Applied

During 2024, DMAS conducted compliance monitoring activities and took corrective actions during SFY 2024. Table 6-7 contains the compliance actions taken.

Table 6-7—DMAS Compliance Actions

MCO/Vendor	Compliance Action
Optima (Sentara)	Optima (previously VA Premier) received a member on the 834-enrollment file with an effective date of January 1, 2022. A SNF admission (exception indicator 2) date of November 1, 2021, for this member was erroneously entered prior to the member's enrollment with Optima. DMAS received a request on July 7, 2023, from Optima to void the November 1, 2021, level 2 line as it was determined by Optima that this member had never resided in the SNF facility. The SNF line was voided by DMAS on July 7, 2023.
Optima (Sentara)	Untimely waiver portal entry (18 months) resulting in significant capitation overpayment.
HealthKeepers	Failure to submit a CAP.
Optima (Sentara)	Failure to complete a LOCERI assessment face to face.
Optima (Sentara)	On January 26, 2023, all health plans were given a timeline to clean up CRMS rejected data that remained outstanding for dates July 2020 through December 2022. The timeline for data quality clean-up was April 30, 2023. On September 25, 2023, a follow-up review revealed minimal to no progress of data quality clean-up. Rejected CRMS data are data that DMAS does not have, which has a direct impact on the Medical Transition Report and data analysis (e.g., DMAS website).
Optima (Sentara)	During the October 2023 review of the September case reviews, an Optima VP made an untimely NF line entry in the portal.
Aetna	On November 6, 2023, Aetna added a discharge date to a NF stay that began on 9/25/2020 and ended on 9/29/2020.

7. Network Adequacy Validation

Overview

DMAS contracted with HSAG to conduct NAV for the MCOs and DMAS. 42 CFR §438.350(a) requires states to have a qualified EQRO perform an annual EQR that includes NAV to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services. HSAG conducted NAV, validating the systems and processes, data sources, methods, and results in accordance with the CMS EQR Protocol 4 cited earlier in this report.

HSAG worked with DMAS to identify applicable quantitative network adequacy standards by provider and plan type to be validated. Information such as description of network adequacy data and documentation, information flow from MCOs to the State, prior year NAV reports, and additional supporting information relevant to network adequacy monitoring and validation were obtained from the State and incorporated into all phases of validation activities.

The purpose of NAV is to assess the accuracy of the state-defined network adequacy indicators reported by MCOs and to evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, systems and processes used, and to determine the overall validation rating, which refers to the overall confidence that acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as established by DMAS. If states elect to calculate network adequacy results for each MCO, the EQRO will validate the indicator-level results produced by the state, as if they were calculated by the MCO and validate the MCO's systems and processes, as well as source data provided to the state, to inform network adequacy analysis activities.

Description of Validation Activities

HSAG completed the following CMS EQR Protocol 4 activities to conduct the NAV:

- **Defined the scope of the validation of quantitative network adequacy standards:** HSAG obtained information from the State (i.e., network adequacy standards, descriptions and samples of documentation the MCOs submit to DMAS, a description of the network adequacy information flow, and any prior NAV reports), then worked with DMAS to identify and define network adequacy indicators and provider types, and to establish the NAV activities and timeline.
- **Identified data sources for validation:** HSAG worked with DMAS and the MCOs to identify NAV-related data sources and to answer clarifying questions regarding the data sources.
- **Reviewed information systems underlying network adequacy monitoring:** HSAG reviewed any previously completed ISCA's, then assessed processes for collecting network adequacy data that were not addressed in the ISCA, completed a comprehensive NAV ISCA by collecting an updated ISCAT from each MCO and DMAS, and interviewed MCO and DMAS staff members or other personnel involved in production of network adequacy results.
- **Validated network adequacy assessment data, methods, and results:** HSAG used CMS EQR Protocol 4 Worksheet 4.6, located in Appendix B, to document each MCO's and DMAS' ability to

collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its networks, and produce accurate results that support the MCOs' and State's network adequacy monitoring efforts. When evaluating the MCOs and DMAS for this validation step, HSAG assessed data reliability, accuracy, timeliness, and completeness; MCO and DMAS methods to assess network adequacy; and the validity of the network adequacy results the MCOs submitted. HSAG used CMS EQR Protocol 4 Worksheet 4.6 to summarize its NAV findings, which are documented in the individual MCO-specific sections of this report.

- **Communicated preliminary findings to each MCO and DMAS:** HSAG communicated preliminary NAV findings to each MCO and DMAS that provided findings, preliminary validation ratings, areas of potential concern, and recommendations for improvement. Each MCO and DMAS were provided the opportunity to correct any preliminary report omissions and/or errors.
- **Submitted the NAV findings to DMAS in the form of the NAV aggregate report:** HSAG used the DMAS-approved NAV aggregate report template to document the NAV findings and submitted the draft and final NAV aggregate report according to the DMAS-approved timeline.

MCOs

All MCOs servicing the Medicaid program were included in the NAV activity. Please see Table 1-1 for a list of the Cardinal Care MCOs in Virginia.

Network Adequacy Standards and Indicators Validated

States that contract with MCOs to provide Medicaid or CHIP services are required to develop quantitative network adequacy standards across a subset of provider types to set expectations for each contracted MCO's provider networks. States may elect to use a variety of quantitative standards including, but not limited to, minimum provider-to-member ratios, time and distance, percentage of providers accepting new patients, and/or combinations of these quantitative measures. Based on the state-defined network adequacy standards, the State and the EQRO defined the network adequacy indicators, which the EQRO then validated. The indicators are metrics used to assess adherence to the quantitative network adequacy standards required and set forth by the State. The DMAS-identified network adequacy indicators were to be validated for SFY 2024. Data were reported as of June 17, 2024.

Table 7-1 lists the network adequacy standards and the indicators HSAG validated.

Table 7-1—Network Adequacy Indicators Validated

Network Category Description	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance standard	Ratios
Physicians—PCP	2	15 Miles or 30 Minutes	30 Miles or 45 Minutes	At least one (1) FTE PCP, regardless of specialty type, for every 1,500 Members
Physicians—Pediatrics	2	15 Miles or 30 Minutes	30 Miles or 45 Minutes	At least (1) FTE pediatric PCP for every 1,500 Members under the age of eighteen (18)
Physicians—OBGYN	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Physician Assistants and Nurse Practitioners	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Behavioral Health Therapists and Counselors	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Pharmacy	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Eye Wear Supplier	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Chiropractor	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Occupational, Physical and Respiratory Therapists	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Nursing and Custodial Facilities	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Hospitals	1	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Dietary and Nutritional Providers	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Laboratories	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Specialist	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	

Network Category Description	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance standard	Ratios
Speech, Language and Hearing Providers	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
In Home Services				
Early Intervention	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Doula	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Home Health	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
LTSS	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
MHS	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	

Overview of NAV Results

Overall, the health plans had well-defined processes and procedures in place to ensure the efficient and accurate collection of member and provider data to support network adequacy calculation and reporting. The health plans demonstrated dedicated efforts to identify gaps in provider networks throughout their service areas and identify ways to improve the accessibility and timeliness of care for members. Opportunities for improvement are included in the MCO-Specific NAV Indicator Results section below and a few areas of compliance were found. However, the MCOs met the majority of study indicator results in this analysis.

MCO-Specific NAV Indicator Results

Aetna

HSAG determined that Aetna was compliant with network adequacy requirements for the Provider Ratios standard for all provider types. Compliance was determined based on the MCO meeting the State's Provider Ratio indicators. Results are presented by provider type in Table 7-2.

Table 7-2—Aetna Network Adequacy Provider Ratios Compliance

Provider Type	Ratio	Results	Compliance
PCP	1:1,500	1:41	<i>Met</i>
Pediatric PCP	1:1,500	1:60	<i>Met</i>

HSAG determined that Aetna was compliant with network adequacy requirements for the Time and Distance standard for 28 of 30 (93.33%) indicators. DMAS required at least 80 percent of members to have access to the providers within the associated time or distance parameters for PCPs and Pediatricians. DMAS required at least 75 percent of members to have access to the providers within the associated time or distance parameters for all other provider types. Compliance was determined based on the MCO meeting the State's Time and Distance indicators for both Urban and Rural classifications. Results are presented by provider type and urbanicity in Table 7-3, and noncompliant results are presented in Table 7-4.

Table 7-3—Aetna Network Adequacy Time and Distance Compliance by Urbanicity

Provider Type	Urbanicity	Compliance
PCPs (Adult)	Urban	<i>Met</i>
	Rural	<i>Met</i>
Pediatricians	Urban	<i>Met</i>
	Rural	<i>Met</i>
OB/GYN	Urban	<i>Met</i>
	Rural	<i>Met</i>
Physician Assistants and Nurse Practitioners	Urban	<i>Met</i>
	Rural	<i>Met</i>
Behavioral Health Therapists and Counselors	Urban	<i>Met</i>
	Rural	<i>Met</i>
Chiropractor	Urban	<i>Met</i>
	Rural	<i>Met</i>
Pharmacies	Urban	<i>Met</i>
	Rural	<i>Met</i>
Occupational, Physical and Respiratory Therapists	Urban	<i>Met</i>
	Rural	<i>Met</i>
Nursing and Custodial Facilities	Urban	<i>Met</i>
	Rural	<i>Met</i>
Hospitals	Urban	<i>Met</i>
	Rural	<i>Met</i>
Dietary and Nutritional Providers	Urban	<i>Met</i>
	Rural	<i>Met</i>
Laboratories	Urban	<i>Met</i>
	Rural	<i>Met</i>
Specialist	Urban	<i>Met</i>
	Rural	<i>Met</i>
Speech, Language and Hearing Providers	Urban	<i>Met</i>
	Rural	<i>Met</i>

Table 7-4—Aetna Network Adequacy Time and Distance Noncompliance by Urbanicity

Provider Type	Urbanicity	Compliance
Eye Wear Suppliers	Urban	<i>Not Met</i>
	Rural	<i>Not Met</i>

During the NAV review period, HSAG determined the Time and Distance indicators in Table 7-5 were not required to be reported by DMAS, resulting in an *Unable to Validate* designation for each associated indicator.

Table 7-5—Aetna Network Adequacy Time and Distance *Unable to Validate* Indicators

Provider Type	Urbanicity	Indicator
Doula	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes
Early Intervention	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes
Home Health	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes
LTSS	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes
MHS	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes

Strengths, Weaknesses, and Recommendations

Strengths



Strength #1: Aetna conducted routine data quality validations against member and provider data to ensure accuracy in data transfers between systems.

Strength #2: Provider ratios for PCPs and pediatricians were well within the required indicators' ratio expectations.

Weaknesses and Recommendations



Weakness: Aetna required its providers to update their information every three years or as needed.

Recommendations: HSAG recommends that Aetna require its providers to send updated information on a more frequent schedule (e.g., monthly, quarterly, biannually). Accurate provider data are an integral part of network adequacy.

HealthKeepers

HSAG was unable to validate HealthKeepers' ratios for PCP and Pediatric PCP provider types in Table 7-6 due to the plan indicating they did not perform ratio calculations and reporting in alignment with DMAS requirements.

Table 7-6—HealthKeepers Network Adequacy Ratios *Unable to Validate* Indicators

Provider Type	Ratio
PCP	1:1,500
Pediatricians	1:1,500

HSAG determined that HealthKeepers was compliant with network adequacy requirements for the Time and Distance standard for 30 of 30 (100.00 percent) indicators. DMAS required at least 80 percent of members to have access to the providers within the associated time or distance parameters for PCPs and Pediatricians. DMAS required at least 75 percent of members to have access to the providers within the associated time or distance parameters for all other provider types. Compliance was determined based on the MCO meeting the State's Time and Distance indicators for both Urban and Rural classifications. Results are presented by provider type and urbanicity in Table 7-7.

Table 7-7—HealthKeepers Network Adequacy Time and Distance Compliance by Urbanicity

Provider Type	Urbanicity	Compliance
PCPs (Adult)	Urban	<i>Met</i>
	Rural	<i>Met</i>
Pediatricians	Urban	<i>Met</i>
	Rural	<i>Met</i>
OB/GYN	Urban	<i>Met</i>
	Rural	<i>Met</i>
Physician Assistants and Nurse Practitioners	Urban	<i>Met</i>
	Rural	<i>Met</i>
Behavioral Health Therapists and Counselors	Urban	<i>Met</i>
	Rural	<i>Met</i>
Eye Wear Suppliers	Urban	<i>Met</i>
	Rural	<i>Met</i>
Chiropractor	Urban	<i>Met</i>

Provider Type	Urbanicity	Compliance
	Rural	<i>Met</i>
Pharmacies	Urban	<i>Met</i>
	Rural	<i>Met</i>
Occupational, Physical and Respiratory Therapists	Urban	<i>Met</i>
	Rural	<i>Met</i>
Nursing and Custodial Facilities	Urban	<i>Met</i>
	Rural	<i>Met</i>
Hospitals	Urban	<i>Met</i>
	Rural	<i>Met</i>
Dietary and Nutritional Providers	Urban	<i>Met</i>
	Rural	<i>Met</i>
Laboratories	Urban	<i>Met</i>
	Rural	<i>Met</i>
Specialist	Urban	<i>Met</i>
	Rural	<i>Met</i>
Speech, Language and Hearing Providers	Urban	<i>Met</i>
	Rural	<i>Met</i>

During the NAV review period, HSAG determined the following Time and Distance indicators in Table 7-8 were not required to be reported by DMAS, resulting in an *Unable to Validate* designation for each associated indicator.

Table 7-8—HealthKeepers Network Adequacy Time and Distance *Unable to Validate* Indicators

Provider Type	Urbanicity	Indicator
Doula	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes
Early Intervention	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes
Home Health	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes
LTSS	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes

Provider Type	Urbanicity	Indicator
MHS	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes

Strengths, Weaknesses, and Recommendations

Strengths	
	Strength #1: HealthKeepers appropriately configured the Quest Analytics software to ensure accurate reporting. Data transfers to the software were validated and accurately uploaded to Quest Analytics. Strength #2: HealthKeepers continuously assessed quality of data extracts and monitored data loads regularly. HealthKeepers ensured record counts were consistent from Facets to Quest Analytics.
Weaknesses and Recommendations	
	Weakness: HealthKeepers required its providers to update their information every three years or as needed. Recommendations: HSAG recommends that HealthKeepers require its providers to send updated information on a more frequent schedule (e.g., monthly, quarterly, biannually). Accurate provider data are an integral part of network adequacy.

Molina

HSAG determined that Molina was compliant with network adequacy requirements for the Provider Ratios standard for all provider types. Compliance was determined based on the MCO meeting the State's Provider Ratio indicators. Results are presented by provider type in Table 7-9.

Table 7-9—HealthKeepers Network Adequacy Provider Ratios Compliance

Provider Type	Ratio	Results	Compliance
PCP	1:1,500	1:1	<i>Met</i>
Pediatric PCP	1:1,500	1:1	<i>Met</i>

HSAG determined that Molina was compliant with network adequacy requirements for the Time and Distance standard for 30 of 30 (100.00 percent) indicators. DMAS required at least 80 percent of members to have access to the providers within the associated time or distance parameters for PCPs and Pediatricians. DMAS required at least 75 percent of members to have access to the providers within the associated time or distance parameters for all other provider types. Compliance was determined based on the MCO meeting the State's Time and Distance indicators for both Urban and Rural classifications. Results are presented by provider type and urbanicity in Table 7-10.

Table 7-10—Molina Network Adequacy Time and Distance Compliance by Urbanicity

Provider Type	Urbanicity	Compliance
PCPs (Adult)	Urban	<i>Met</i>
	Rural	<i>Met</i>
Pediatricians	Urban	<i>Met</i>
	Rural	<i>Met</i>
OB/GYN	Urban	<i>Met</i>
	Rural	<i>Met</i>
Physician Assistants and Nurse Practitioners	Urban	<i>Met</i>
	Rural	<i>Met</i>
Behavioral Health Therapists and Counselors	Urban	<i>Met</i>
	Rural	<i>Met</i>
Eye Wear Suppliers	Urban	<i>Met</i>
	Rural	<i>Met</i>
Chiropractor	Urban	<i>Met</i>
	Rural	<i>Met</i>
Pharmacies	Urban	<i>Met</i>
	Rural	<i>Met</i>
Occupational, Physical and Respiratory Therapists	Urban	<i>Met</i>
	Rural	<i>Met</i>
Nursing and Custodial Facilities	Urban	<i>Met</i>
	Rural	<i>Met</i>
Hospitals	Urban	<i>Met</i>
	Rural	<i>Met</i>
Dietary and Nutritional Providers	Urban	<i>Met</i>
	Rural	<i>Met</i>
Laboratories	Urban	<i>Met</i>
	Rural	<i>Met</i>
Specialist	Urban	<i>Met</i>
	Rural	<i>Met</i>
Speech, Language and Hearing Providers	Urban	<i>Met</i>
	Rural	<i>Met</i>

During the NAV review period, HSAG determined the following Time and Distance indicators in Table 7-11 were not required to be reported by DMAS, resulting in an *Unable to Validate* designation for each associated indicator.

Table 7-11—Molina Network Adequacy Time and Distance *Unable to Validate* Indicators

Provider Type	Urbanicity	Indicator
Doula	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes
Early Intervention	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes
Home Health	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes
LTSS	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes
MHS	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes

Strengths, Weaknesses, and Recommendations

Strengths



Strength #1: Molina had established a robust process to maintain the accuracy and completeness of provider information through its quarterly PIFs and a three-year cycle for credentialing and recredentialing process.

Strength #2: Molina continuously assessed the quality of data extracts through validating data loads to the Quest Analytics software. Molina had automated processes that updated the provider records in QNXT from the DMAS PRN file.

Weaknesses and Recommendations



Weakness: Molina was missing some indicators for the Time and Distance Standard during the initial review of the results.

Recommendations: HSAG recommends that Molina review the reporting requirements for all Time and Distance indicators approved by DMAS for network adequacy to ensure accurate reporting.

Sentara

HSAG determined that Sentara was compliant with network adequacy requirements for the Provider Ratios standard for all provider types. Compliance was determined based on the MCO meeting the State's Provider Ratio indicators. Results are presented by provider type in Table 7-12.

Table 7-12—Sentara Network Adequacy Provider Ratios Compliance

Provider Type	Ratio	Results	Compliance
PCP	1:1,500	1:14	<i>Met</i>
Pediatric PCP	1:1,500	1:7	<i>Met</i>

HSAG determined that Sentara was compliant with network adequacy requirements for the Time and Distance standard for 30 of 30 (100.00 percent) indicators. DMAS required at least 80 percent of members to have access to the providers within the associated time or distance parameters for PCPs and Pediatricians. DMAS required at least 75 percent of members to have access to the providers within the associated time or distance parameters for all other provider types. Compliance was determined based on the MCO meeting the State's Time and Distance indicators for both Urban and Rural classifications. Results are presented by provider type and urbanicity in Table 7-13.

Table 7-13—Sentara Network Adequacy Time and Distance Compliance by Urbanicity

Provider Type	Urbanicity	Compliance
PCPs (Adult)	Urban	<i>Met</i>
	Rural	<i>Met</i>
Pediatricians	Urban	<i>Met</i>
	Rural	<i>Met</i>
OB/GYN	Urban	<i>Met</i>
	Rural	<i>Met</i>
Physician Assistants and Nurse Practitioners	Urban	<i>Met</i>
	Rural	<i>Met</i>
Behavioral Health Therapists and Counselors	Urban	<i>Met</i>
	Rural	<i>Met</i>
Eye Wear Suppliers	Urban	<i>Met</i>
	Rural	<i>Met</i>
Chiropractor	Urban	<i>Met</i>
	Rural	<i>Met</i>
Pharmacies	Urban	<i>Met</i>
	Rural	<i>Met</i>
Occupational, Physical and Respiratory Therapists	Urban	<i>Met</i>
	Rural	<i>Met</i>
Nursing and Custodial Facilities	Urban	<i>Met</i>
	Rural	<i>Met</i>

Provider Type	Urbanicity	Compliance
Hospitals	Urban	<i>Met</i>
	Rural	<i>Met</i>
Dietary and Nutritional Providers	Urban	<i>Met</i>
	Rural	<i>Met</i>
Laboratories	Urban	<i>Met</i>
	Rural	<i>Met</i>
Specialist	Urban	<i>Met</i>
	Rural	<i>Met</i>
Speech, Language and Hearing Providers	Urban	<i>Met</i>
	Rural	<i>Met</i>

During the NAV review period, HSAG determined the following Time and Distance indicators in Table 7-14 were not required to be reported by DMAS, resulting in an *Unable to Validate* designation for each associated indicator.

Table 7-14—Sentara Network Adequacy Time and Distance *Unable to Validate* Indicators

Provider Type	Urbanicity	Indicator
Doula	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes
Early Intervention	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes
Home Health	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes
LTSS	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes
MHS	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes

Strengths, Weaknesses, and Recommendations

Strengths	
	Strength #1: Sentara had established a robust process to maintain the accuracy and completeness of provider information through its quarterly confirmation of accurate provider data and a three-year cycle for credentialing and recredentialing process.
	Strength #2: Sentara continuously assessed the quality of data extracts by ensuring data records were fully loaded and integrated from the source systems to Quest Analytics software.
Weaknesses and Recommendations	
	Recommendations: No specific opportunities were identified related to the data collection and management processes that Sentara had in place to inform network adequacy standard and indicator calculations.

United

HSAG determined that United was compliant with network adequacy requirements for the Provider Ratios standard for all provider types. Compliance was determined based on the MCO meeting the State's Provider Ratio indicators. Results are presented by provider type in Table 7-15.

Table 7-15—United Network Adequacy Provider Ratios Compliance

Provider Type	Ratio	Results	Compliance
PCP	1:1,500	1:19	<i>Met</i>
Pediatric PCP	1:1,500	1:10	<i>Met</i>

HSAG determined that United was compliant with network adequacy requirements for the Time and Distance standard for 30 of 30 (100.00 percent) indicators. DMAS required at least 80 percent of members to have access to the providers within the associated time or distance parameters for PCPs and Pediatricians. DMAS required at least 75 percent of members to have access to the providers within the associated time or distance parameters for all other provider types. Compliance was determined based on the MCO meeting the State's Time and Distance indicators for both Urban and Rural classifications. Results are presented by provider type and urbanicity in Table 7-16.

Table 7-16—United Network Adequacy Time and Distance Compliance by Urbanicity

Provider Type	Urbanicity	Compliance
PCPs (Adult)	Urban	<i>Met</i>
	Rural	<i>Met</i>
Pediatricians	Urban	<i>Met</i>
	Rural	<i>Met</i>
OB/GYN	Urban	<i>Met</i>

Provider Type	Urbanicity	Compliance
	Rural	<i>Met</i>
Physician Assistants and Nurse Practitioners	Urban	<i>Met</i>
	Rural	<i>Met</i>
Behavioral Health Therapists and Counselors	Urban	<i>Met</i>
	Rural	<i>Met</i>
Eye Wear Suppliers	Urban	<i>Met</i>
	Rural	<i>Met</i>
Chiropractor	Urban	<i>Met</i>
	Rural	<i>Met</i>
Pharmacies	Urban	<i>Met</i>
	Rural	<i>Met</i>
Occupational, Physical and Respiratory Therapists	Urban	<i>Met</i>
	Rural	<i>Met</i>
Nursing and Custodial Facilities	Urban	<i>Met</i>
	Rural	<i>Met</i>
Hospitals	Urban	<i>Met</i>
	Rural	<i>Met</i>
Dietary and Nutritional Providers	Urban	<i>Met</i>
	Rural	<i>Met</i>
Laboratories	Urban	<i>Met</i>
	Rural	<i>Met</i>
Specialist	Urban	<i>Met</i>
	Rural	<i>Met</i>
Speech, Language and Hearing Providers	Urban	<i>Met</i>
	Rural	<i>Met</i>

During the NAV review period, HSAG determined the following Time and Distance indicators in Table 7-17 were not required to be reported by DMAS, resulting in an *Unable to Validate* designation for each associated indicator.

Table 7-17—United Network Adequacy Time and Distance *Unable to Validate* Indicators

Provider Type	Urbanicity	Indicator
Doula	Urban	Two within 30 miles or 45 minutes
	Rural	Two within 60 miles or 75 minutes
Early Intervention	Urban	Two within 30 miles or 45 minutes

Provider Type	Urbanicity	Indicator
Home Health	Rural	Two within 60 miles or 75 minutes
	Urban	Two within 30 miles or 45 minutes
LTSS	Rural	Two within 60 miles or 75 minutes
	Urban	Two within 30 miles or 45 minutes
MHS	Rural	Two within 60 miles or 75 minutes
	Urban	Two within 30 miles or 45 minutes

Strengths, Weaknesses, and Recommendations

Strengths	
	Strength #1: United had established robust processes to keep provider data up to date and accurate through its provider data audits, credentialing process, and telephone call campaigns to provider offices. Strength #2: United offered providers multiple options for provider data updates through multiple intake channels that allowed providers the opportunity to attest to data via My Practice Profile, Inbound Demographic Change Line, Roster Processing, and CAQH Provider Data Portal.
Weaknesses and Recommendations	
	Weakness #1: United did not use the correct time and distance standards to report network adequacy for respiratory therapy, dietary and nutrition, and physician assistants. Weakness #2: United did not include doulas or LTSS in the network adequacy report. Recommendation #1: HSAG recommends that United review the Time and Distance Standard settings for all categories prior to running the report to ensure compliance with DMAS requirements. Recommendation #2: HSAG recommends that United review the network adequacy report to ensure all required categories are included.

8. Phantom Network Analysis

Phantom Network Analysis

Overview

Each managed care organization (MCO) must maintain a network of providers that offers access to covered physical and behavioral healthcare services to meet the enrolled Medicaid members' needs, appropriate to the geographic area. When considering the adequacy of an MCO's network of providers, if a significant percentage of providers within the network are not rendering services to Medicaid members or accepting new patients, it may be challenging for members to adequately access care. In such cases where a provider may be contracted with an MCO but is not providing services to members, they may be considered "phantom" providers within the managed care networks. A previous report from Oregon Medicaid found that of providers listed in the provider directories, almost 60 percent did not see Medicaid patients during the study period.⁴³ A study from CMS of Medicare Advantage plans supports these findings by noting that over half of all provider directory listings contained at least one error.⁴⁴ Understanding the accuracy of the information in the provider directory in addition to the potential difference between the paper and the realized network is vital to assessing the MCO members' access to care. DMAS contracted with HSAG to conduct a phantom network analysis of the MCO's provider networks.

Since the time period of this analysis, DMAS has been working to enroll providers in the Provider Services Solution (PRSS) system, also known as the Provider Portal. This work ensures that providers are enrolled in compliance with the 20th Century Cures Act and updates the DMAS oversight of active providers in MCO provider networks. Information regarding provider enrollment and revalidation can be found on the DMAS website ([Provider Enrollment & Revalidation | Virginia Medicaid](#)).

Objectives

The purpose of the phantom network analysis was to identify providers contracted with each MCO's provider network who did not provide services to Medicaid members (i.e., providers who did not have encounters submitted in CY 2022). For each MCO, HSAG assessed the following metrics:

- Percentage of active versus non-active primary care and behavioral health providers
- Comparison of the demographics of active versus non-active providers (including, region, urbanicity, language, and acceptance of new patients)
- The median number of member visits per month per provider for active providers

⁴³ Zhu JM, Charlesworth CJ, Polsky D, and McConnell KJ. Phantom Networks: Discrepancies Between Reported and Realized Mental Health Care Access in Oregon Medicaid. *Health Affairs*. 2022;41(7):1013-1022.

⁴⁴ Centers for Medicare & Medicaid Services (CMS). Online Provider Directory Review Report. November 28, 2018. Available at: [Online Provider Directory Review Report \(cms.gov\)](#). Accessed on: Jan 8, 2025.

Provider types and specialties included in the study are as follows:

- Physical Health Primary Care Providers:
 - Obstetrics & Gynecology (OBGYN)
 - Physician Assistants/Nurse Practitioners (PA/NP)
 - Primary Care Physicians (PCP)
 - Pediatric (PEDIATRIC)
- Behavioral Health Providers:
 - Behavioral Health and Social Service Providers (BH)
 - Psychiatry (PSY)

Statewide Results

The purpose of the network adequacy phantom network analysis was to identify providers contracted with each MCO provider network who did not provide services to Medicaid members within the measurement period (i.e., providers who did not have encounters submitted in CY 2022), with the goal of better understanding each MCO's reported versus active provider network. Inactive providers may still render services to members but may not have submitted a claim during the study time period. This study demonstrates that the majority of providers across all studied provider types are actively providing services to Virginia Medicaid members.

Overall, the percentage of phantom providers contracted with an MCO ranged from 10.8 percent of United's PCP providers to 52.3 percent of Molina's BH providers. Across all MCOs, BH providers had the highest percentage of phantom providers, which aligns with previous reports on phantom networks in other states.⁴⁻⁴⁵ HealthKeepers and United had the lowest rates of phantom providers in their provider networks.

HSAG assessed differences between active and non-active providers and found minimal differences between the geographic regions, urbanities, languages spoken, and active status. Additionally, HSAG assessed the geographic locations of the phantom providers using the time and distance a member would travel to the nearest provider using the full network of providers and the active network of providers. Again, HSAG noted minimal differences in the travel time and distances for the providers. The phantom providers did not seem to be dramatically different from the active providers based on these categories. In fact, they seem to be distributed relatively proportionally to the active providers.

Lastly, HSAG assessed the patient load for the provider categories. In general, OBGYNs, PCPs, and PEDIATRIC providers were most likely to see more than 16 members over the course of the year. Pediatricians and OBGYNs were most likely to see more than 100 members over the year. Across all provider categories, Molina had the fewest providers seeing more than 100 members over the year. Sentara and HealthKeepers had the highest percentages of providers seeing more than 100 members across provider categories, and they also had the largest provider networks and the most members.

⁴⁵ Zhu JM, Charlesworth CJ, Polsky D, and McConnell KJ. Phantom Networks: Discrepancies Between Reported and Realized Mental Health Care Access in Oregon Medicaid. *Health Affairs*. 2022;41(7):1013-1022.

Study Limitations

Limitations of the CY 2022 Network Adequacy Phantom Network Analysis should be considered when interpreting results and outlining conclusions. Results may be affected by one or more of the considerations listed below:

- The provider data submitted by the DMAS Enrollment Broker did not have the contract start and end dates for the providers. HSAG was able to use data submitted to another activity (i.e., the Secret Shopper Survey activity during CY2022) to identify the network of providers contracted with the MCOs as of November 2022 and the providers contracted with MCOs as the data submission date for the phantom network analysis (i.e., January 2024). These providers were used as a proxy to identify the full provider network for the measurement period. However, there are limitations to this approach as providers may have been contracted with the MCOs during the measurement period but were not at the time of the data submission for the phantom analysis.
- The reporting of provider languages and the acceptance of new patients are self-reported data fields. As with any self-reported data fields, the reliability and completeness of these fields depend on the frequency that providers report this information and the requirements of the MCO regarding completeness of the data.
- Due to the nature of billing practices, it is possible that mid-level providers (i.e., NPs and PAs) were billing under supervising/attending providers' NPIs, thus making certain providers' capacity look much greater. While the claims indicate that NPs and PAs were submitting claims as rendering providers, the very large number of claims submitted by some PCPs and pediatricians combined with the higher rates of phantom NPs/PAs suggests that some mid-level provider services may have been billed under a supervising provider.
- The identification of active versus non-active providers was conducted at the individual provider level. If a provider offered services as part of a facility/organization and did not submit an individual NPI as either the rendering or billing provider NPI, the provider may have been miscounted as a phantom provider.
- Time and distance metrics represent a high-level measurement of the similarity in geographic distribution of providers relative to members. These raw, comparative statistics do not account for the individual status of a provider's panel at a specific location or how active the provider is in the Medicaid program.
 - Prior to calculating time and distance results, HSAG geocoded the provider and member data to assign latitude and longitude values to each record. A limited percentage (i.e., less than 1 percent) of records could not be geocoded primarily due to invalid ZIP Codes or missing ZIP Codes from the data and were subsequently excluded from time and distance analyses.
 - DMAS' member address data may not always reflect the members' place of residence (e.g., use of post office boxes) or be identifiable with mapping software (e.g., addresses reflecting local place designations rather than street addresses). While mapping software may assign members to geographic coordinates, these coordinates may not align with the members' exact residential location for records that do not use a standard street address.

General Recommendations

Based on the findings of the phantom network analysis, HSAG has provided the recommendations below:

- HSAG recommends that DMAS review these phantom network findings in the context of member complaints regarding access to these provider types. In a robust provider network, it may be expected that a few providers may not see members each and, in fact, this could be indicative of a robust network that meets the needs of the members. However, it is possible that there are providers enrolled with the MCOs that are not seeing the members which could indicate that the MCO's paper network is inflated compared to the actual network of providers offering services to the members.
- Since the BH providers had the highest rate of phantom providers, HSAG recommends an appointment availability survey of the BH providers to determine if high rate of phantom providers represents an access issue for members. With a new proposed rule from CMS requiring secret shopper surveys to monitor wait time requirements, DMAS will start to conduct these surveys upon finalization of the proposed rule.⁴⁶
- HSAG recommends that DMAS review these findings in conjunction with PMs and CAHPS measures to assess if members are receiving a high quality of care. HSAG recommends assessing the correlation between access to care PMs, phantom network analysis results, and member experience findings to determine if high rates of phantom provider correlate with poor performance metrics or member experience metrics.
- For this analysis to identify phantom providers, HSAG defined active providers as those who provided services to at least one member during the measurement year. This metric represents the minimum possible threshold for identifying active providers, thereby giving MCOs the best possible representation of an active network. HSAG recommends additional considerations for how different cut-points of active provider definitions might change the percentage of active providers across the MCOs. HSAG recommends considering different cut points across different provider categories based on the expected panel load for the providers, for example, a cut-off of five to 10 members may be appropriate for BH and PSY providers, whereas a high cut-off of 10 to 15 members may be more appropriate for primary care and women's health providers.

MCO-Specific Results

Aetna

HSAG assessed a total of 15,790 eligible providers across six defined provider categories for Aetna using the provider, member, and claims data files. As shown in Table 8-1, 70.0 percent (n=11,062) of the eligible providers were determined to be "active" (i.e., these providers had seen at least one member within the measurement period). Conversely, 30.0 percent (n=4,728) were determined to be non-active, or "phantom" providers (i.e., these providers had not seen at least one member during the measurement period).

Table 8-1—Active and Non-Active Providers by Provider Category

Provider Category	Active	Non-Active
Behavioral Health		
BH	1,998 (55.7%)	1,589 (44.3%)

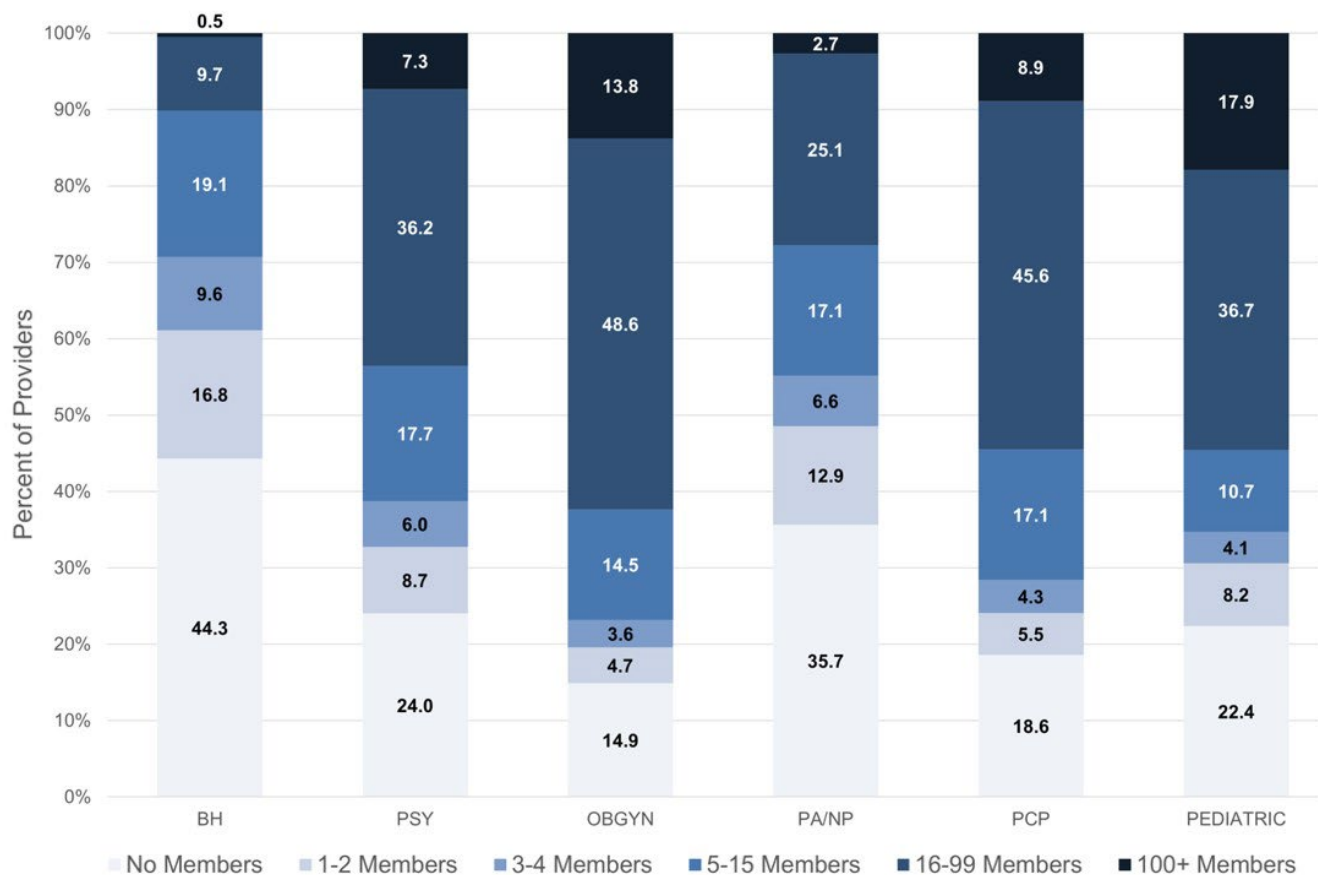
⁴⁶ Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS). Proposed Rule: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, May 5, 2023.

Provider Category	Active	Non-Active
PSY	518 (76.0%)	164 (24.0%)
Primary Care		
OBGYN	711 (85.1%)	124 (14.9%)
PA/NP	3,012 (64.3%)	1,670 (35.7%)
PCP	3,519 (81.4%)	805 (18.6%)
PEDIATRIC	1,304 (77.6%)	376 (22.4%)

Note: Counts reflect number of unique NPIs.

Figure 8-1 displays percentages of Aetna's active providers by the number of members for whom these providers provided services during CY 2022 by provider category. For Aetna's OBGYN, PCP, and PEDIATRIC providers, over one-half (62.4 percent, 54.5 percent, and 54.6 percent, respectively) of the providers were seeing at least 16 members. Conversely, 44.3 percent of Aetna's BH providers were not seeing any members.

Figure 8-1—Number of Members for Active Providers by Provider Category



Strengths, Weaknesses, and Recommendations

Aetna's data were assessed for quality and timeliness. Based on the analysis, the following strengths and weaknesses were identified.

Strengths	
	The majority (i.e., greater than 75 percent) of PSY, OB/GYN, PCP, and PEDIATRIC providers in Aetna's provider network were considered "active" and had provided services to at least one member in the network.
Weaknesses and Recommendations	
	Weakness: Over 35 percent of PA/NP and 44.3 percent of BH providers were considered non-active in Aetna's provider network. Why the weakness exists: This weakness may exist because providers are either not providing services to Medicaid members or because providers are billing services provided under other providers. Recommendations: HSAG recommends that Aetna conduct surveys of providers that are contracted but are not providing services to ensure they are actually providing services to Medicaid members. Additionally, Aetna may provide additional training to ensure all billing correctly reflects the servicing provider separate from the billing provider, as appropriate.

HealthKeepers

HSAG assessed a total of 24,046 eligible providers across six defined provider categories for HealthKeepers using the provider, member, and claims data files. As shown in Table 8-2, 78.9 percent (n=18,981) of the eligible providers were determined to be "active" (i.e., these providers had seen at least one member within the measurement period). Conversely, 21.1 percent (n=5,065) were determined to be non-active, or "phantom" providers (i.e., these providers had not seen at least one member during the measurement period).

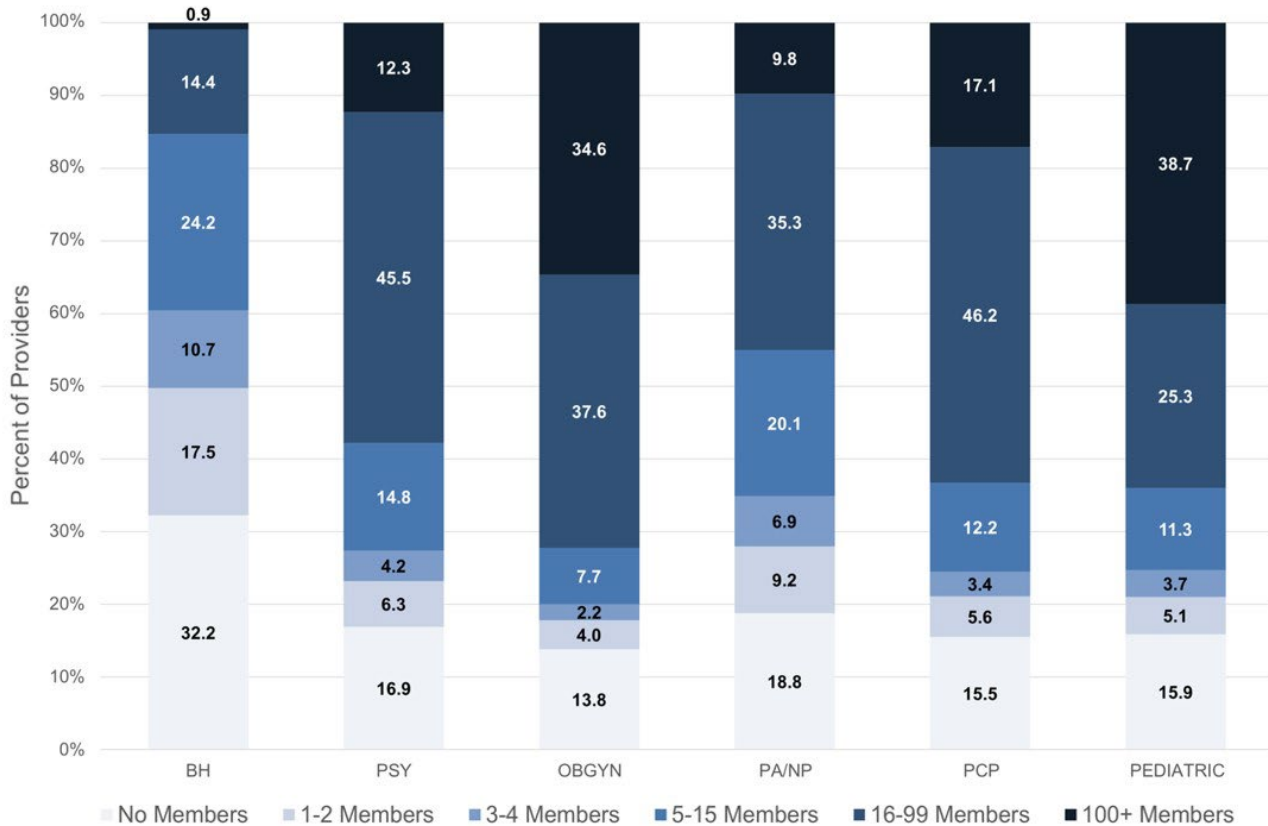
Table 8-2—Active and Non-Active Providers by Provider Category

Provider Category	Active	Non-Active
Behavioral Health		
BH	4,367 (67.8%)	2,078 (32.2%)
PSY	737 (83.1%)	150 (16.9%)
Primary Care		
OBGYN	926 (86.2%)	148 (13.8%)
PA/NP	6,296 (81.2%)	1,457 (18.8%)
PCP	4,876 (84.5%)	895 (15.5%)
PEDIATRIC	1,779 (84.1%)	337 (15.9%)

Note: Counts reflect number of unique NPIs.

Figure 8-2 displays percentages of HealthKeepers' active providers by the number of members for whom these providers provided services during CY 2022 by provider category. For HealthKeepers' OBGYN, PCP, and PEDIATRIC providers, over 60 percent (72.2 percent, 63.3 percent, and 64.0 percent, respectively) of the providers were seeing at least 16 members. Conversely, 32.2 percent of HealthKeepers' BH providers were not seeing any members.

Figure 8-2—Number of Members for Active Providers by Provider Category



Strengths, Weaknesses, and Recommendations

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

Strengths	
	The majority (i.e., greater than 75 percent) of PSY, OB/GYN, PA/NP, PCP, and PEDIATRIC providers in HealthKeepers' provider network were considered "active" and had provided services to at least one member in the network.
Weaknesses and Recommendations	
	Weakness: Over 32 percent of the BH providers were considered non-active in HealthKeepers' provider network.

Weaknesses and Recommendations



Why the weakness exists: This weakness may exist because providers are either not providing services to Medicaid members or because providers are billing services provided under other providers.

Recommendations: HSAG recommends that HealthKeepers conduct surveys of providers that are contracted but are not providing services to ensure they are actually providing services to Medicaid members. Additionally, HealthKeepers may provide additional training to ensure all billing correctly reflects the servicing provider separate from the billing provider, as appropriate.

Molina

HSAG assessed a total of 15,541 eligible providers across six defined provider categories for Molina using the provider, member, and claims data files. As shown in Table 8-3, 69.4 percent (n=10,786) of the eligible providers, were determined to be “active” (i.e., these providers had seen at least one member within the measurement period). Conversely, 30.6 percent (n=4,755) were determined to be non-active, or “phantom” providers (i.e., these providers had not seen at least one member during the measurement period).

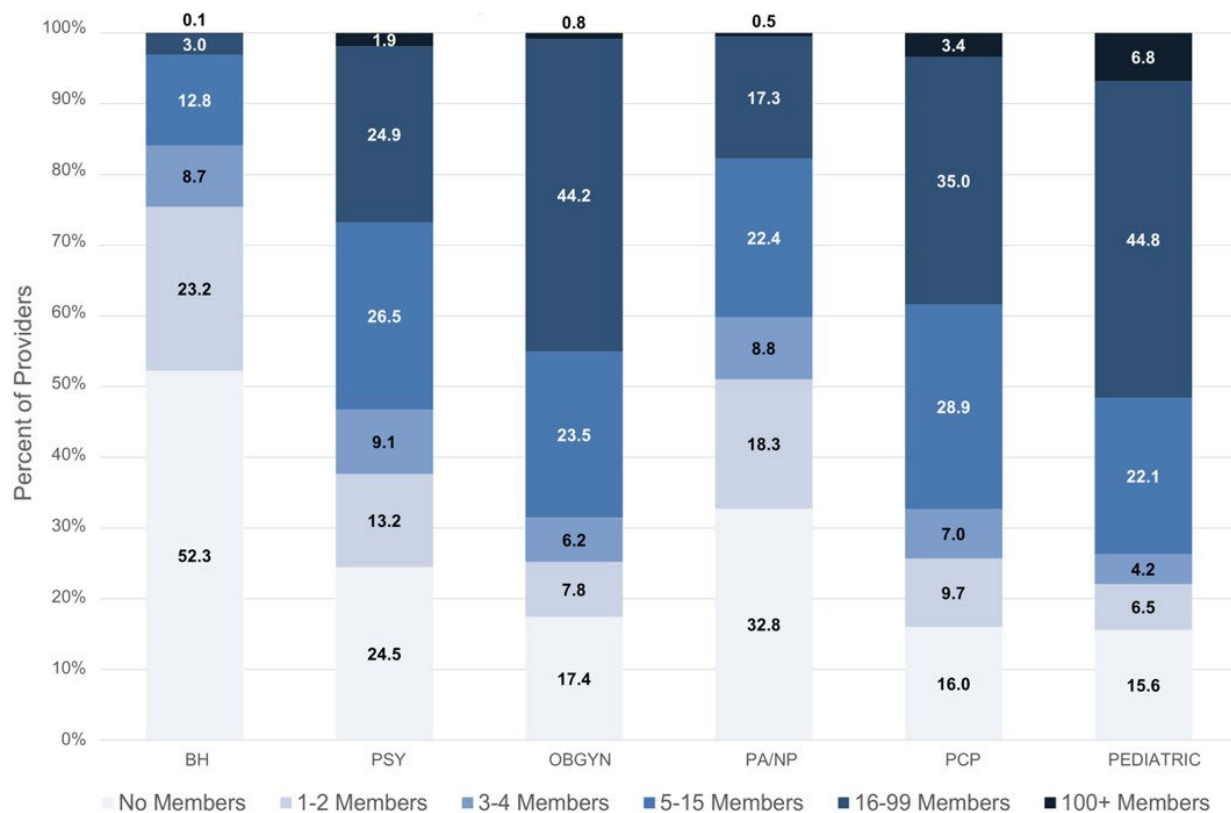
Table 8-3—Active and Non-Active Providers by Provider Category

Provider Category	Active	Non-Active
Behavioral Health		
BH	1,801 (47.7%)	1,974 (52.3%)
PSY	565 (75.5%)	183 (24.5%)
Primary Care		
OBGYN	696 (82.6%)	147 (17.4%)
PA/NP	3,309 (67.2%)	1,616 (32.8%)
PCP	3,390 (84.0%)	646 (16.0%)
PEDIATRIC	1,025 (84.4%)	189 (15.6%)

Note: Counts reflect number of unique NPIs.

Figure 8-3 displays percentages of Molina’s active providers by the number of members for whom these providers provided services during CY 2022 by provider category. For Molina’s PEDIATRIC providers, 51.6 percent of the providers were seeing at least 16 members. Conversely, 52.3 percent of Molina’s BH providers were not seeing any members.

Figure 8-3—Number of Members for Active Providers by Provider Category



Strengths, Weaknesses, and Recommendations

Molina’s data were assessed for quality and timeliness. Based on the analysis, the following strengths and weaknesses were identified.

Strengths



The majority (i.e., greater than 75 percent) of PSY, OB/GYN, PCP, and PEDIATRIC providers in Molina’s provider network were considered “active” and had provided services to at least one member in the network.

Weaknesses and Recommendations



Weakness: Over 52 percent of the BH providers and 32.8 percent of PA/NP providers were not considered active in Molina’s provider network.

Why the weakness exists: This weakness may exist because providers are either not providing services to Medicaid members or because providers are billing services provided under other providers.

Recommendations: HSAG recommends that Molina conduct surveys of providers that are contracted but are not providing services to ensure they are actually providing services to Medicaid members. Additionally, Molina may provide additional training to ensure all billing correctly reflects the servicing provider separate from the billing provider, as appropriate.

Sentara

HSAG assessed a total of 21,592 eligible providers across six defined provider categories for Sentara using the provider, member, and claims data files. As shown in Table 8-4, 70.6 percent (n=15,234) of the eligible providers were determined to be “active” (i.e., these providers had seen at least one member within the measurement period). Conversely, 29.4 percent (n=6,358) were determined to be non-active, or “phantom” providers (i.e., these providers had not seen at least one member during the measurement period).

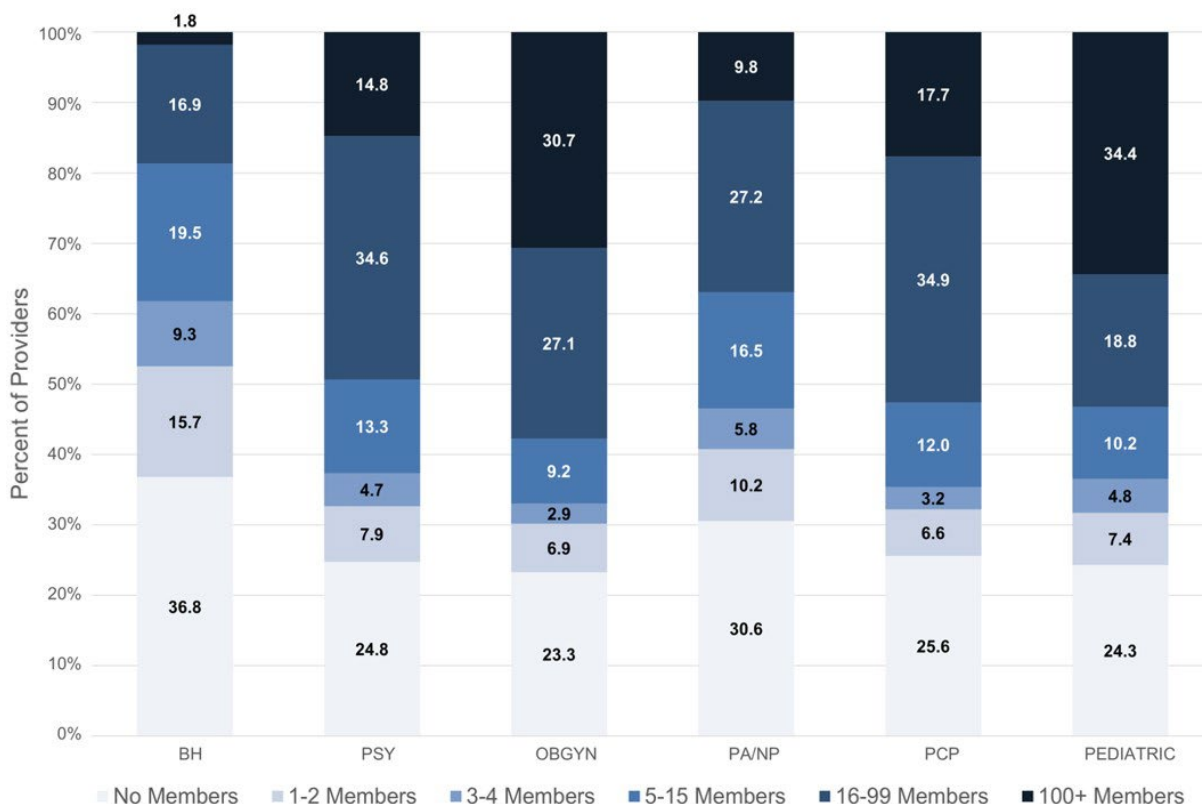
Table 8-4—Active and Non-Active Providers by Provider Category

Provider Category	Active	Non-Active
Behavioral Health		
BH	2,941 (63.2%)	1,709 (36.8%)
PSY	533 (75.2%)	176 (24.8%)
Primary Care		
OBGYN	804 (76.7%)	244 (23.3%)
PA/NP	5,153 (69.4%)	2,267 (30.6%)
PCP	4,315 (74.4%)	1,484 (25.6%)
PEDIATRIC	1,488 (75.7%)	478 (24.3%)

Note: Counts reflect number of unique NPIs.

Figure 8-4 displays percentages of Sentara’s active providers by the number of members for whom these providers provided services during CY 2022 by provider category. For Sentara’s OBGYN, PCP, and PEDIATRIC providers, over one-half (57.8 percent, 52.6 percent, and 53.2 percent, respectively) of the providers were seeing at least 16 members. Conversely, 36.8 percent of Sentara’s BH providers were not seeing any members.

Figure 8-4—Number of Members for Active Providers by Provider Category



Strengths, Weaknesses, and Recommendations

Sentara’s data were assessed for quality and timeliness. Based on the analysis, the following strengths and weaknesses were identified.

Strengths	
	The majority (i.e., greater than 75 percent) of PSY, OB/GYN, and PEDIATRIC providers in Sentara’s provider network were considered “active” and had provided services to at least one member in the network.
Weaknesses and Recommendations	
	Weakness: Over 36 percent of the BH providers and 30.6 percent of PA/NP providers were not considered active in Sentara’s provider network. Why the weakness exists: This weakness may exist because providers are either not providing services to Medicaid members or because providers are billing services provided under other providers. Recommendations: HSAG recommends that Sentara conduct surveys of providers that are contracted but are not providing services to ensure they are actually providing services to Medicaid members. Additionally, Sentara may provide additional training to ensure all billing correctly reflects the servicing provider separate from the billing provider, as appropriate.

United

HSAG assessed a total of 15,421 eligible providers across six defined provider categories for United using the provider, member, and claims data files. As shown in Table 8-5, 73.8 percent (n=11,375) of the eligible providers were determined to be “active” (i.e., these providers had seen at least one member within the measurement period). Conversely, 26.2 percent (n=4,046) were determined to be non-active, or “phantom” providers (i.e., these providers had not seen at least one member during the measurement period).

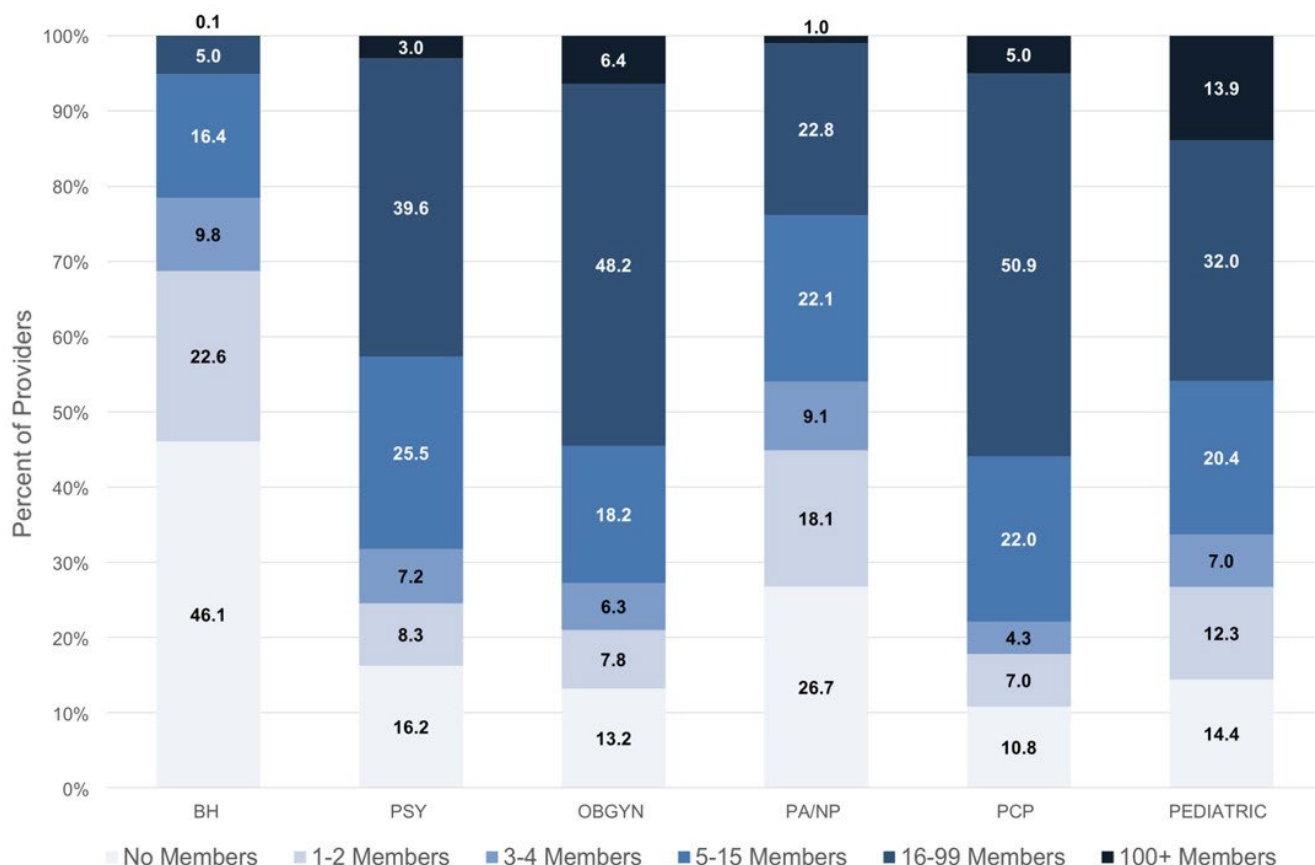
Table 8-5—Active and Non-Active Providers by Provider Category

Provider Category	Active	Non-Active
Behavioral Health		
BH	2,520 (53.9%)	2,156 (46.1%)
PSY	522 (83.8%)	101 (16.2%)
Primary Care		
OBGYN	625 (86.8%)	95 (13.2%)
PA/NP	2,879 (73.3%)	1,050 (26.7%)
PCP	3,552 (89.2%)	429 (10.8%)
PEDIATRIC	1,277 (85.6%)	215 (14.4%)

Note: Counts reflect number of unique NPIs.

Figure 8-5 displays percentages of United’s active providers by the number of members for whom these providers provided services during CY 2022 by provider category. For United’s OBGYN and PCP providers, over one-half (54.6 percent and 55.9 percent, respectively) of the providers were seeing at least 16 members. Conversely, 46.1 percent of United’s BH providers were not seeing any members.

Figure 8-5—Number of Members for Active Providers by Provider Category



Strengths, Weaknesses, and Recommendations

United's data were assessed for quality and timeliness. Based on the analysis, the following strengths and weaknesses were identified.

Strengths	
	The majority (i.e., greater than 75 percent) of PSY, OB/GYN, PCP, and PEDIATRIC providers in United's provider network were considered "active" and had provided services to at least one member in the network.
Weaknesses and Recommendations	
	Weakness: Over 46.1 percent of the BH providers and 26.7 percent of PA/NP providers were not considered active in United's provider network. Why the weakness exists: This weakness may exist because providers are either not providing services to Medicaid members or because providers are billing services provided under other providers. Recommendations: HSAG recommends that United conduct surveys of providers that are contracted but are not providing services to ensure they are

Weaknesses and Recommendations

	actually providing services to Medicaid members. Additionally, United may provide additional training to ensure all billing correctly reflects the servicing provider separate from the billing provider, as appropriate.

9. Encounter Data Validation

Overview

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

This section presents the MCO-specific results and conclusions of the SFY 2022–2023 EDV activities. It provides a discussion of the MCOs' overall strengths and recommendations for improvement related to encounter data completeness and accuracy. HSAG's EDV study comprised the following two components:

- IS review—assessment of DMAS' and the MCOs' information systems and processes. DMAS and the MCOs provided their responses to the questionnaires between July and August 2023.
- 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 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.

Of note, Optima and VA Premier merged under the name Sentara Health Plan before the study period; therefore, this section presents results for Optima and VA Premier separately.

Objectives

The MCOs contracted with Virginia DMAS to submit encounter data to DMAS. These encounter data are utilized for capitation rate setting, QI, program evaluation, program monitoring, CMS T-MSIS extract submissions, and other functions. The MCOs that do not meet certain standards relating to the accuracy, completeness, and timeliness of encounter data may face penalties or CAPs.

Cardinal Care MLTSS MCO-Specific Results

Throughout the comparative analysis section, lower rates indicate better performance for omission and surplus rates, while higher rates indicate better performance for accuracy rates.

Aetna

Using 5.0 percent and 95.0 percent as the cutoff values for the omission/surplus rates and accuracy rates, respectively, Table 9-1 displays the rates requiring Aetna's attention.

Table 9-1—Results Requiring Action From Aetna for Cardinal Care MLTSS

Measure	Claim Type	Data Element	Rate
Record Omission	Professional	Not Applicable	8.8%
Record Surplus	Professional	Not Applicable	11.6%
Record Omission	Institutional	Not Applicable	62.3%
Record Surplus	Institutional	Not Applicable	31.7%
Record Omission	Pharmacy	Not Applicable	37.8%
Record Surplus	Pharmacy	Not Applicable	38.1%
Element Surplus	Professional	Servicing Provider Taxonomy Code	16.1%
Element Surplus	Professional	Primary Diagnosis Codes	17.2%
Element Surplus	Professional	MCO Received Date	17.2%
Element Omission	Institutional	NDC	7.8%
Element Omission	Institutional	Drug Quantity	7.8%
Element Surplus	Institutional	Servicing Provider Taxonomy Code	86.6%
Element Accuracy	Professional	Detail Service From Date	84.8%
Element Accuracy	Professional	Detail Service To Date	84.8%
Element Accuracy	Professional	Billing Provider NPI	93.5%
Element Accuracy	Professional	Rendering Provider NPI	86.9%
Element Accuracy	Professional	Servicing Provider Taxonomy Code	58.3%
Element Accuracy	Professional	MCO Received Date	78.7%
Element Accuracy	Professional	MCO Paid Date	82.8%
Element Accuracy	Institutional	Detail Service From Date	60.5%
Element Accuracy	Institutional	Servicing Provider Taxonomy Code	19.7%
Element Accuracy	Institutional	Surgical Procedure Codes	93.6%
Element Accuracy	Institutional	Header TPL Paid Amount	92.7%
Element Accuracy	Institutional	MCO Received Date	55.3%

Strengths, Weaknesses, and Recommendations

Strengths



IS Review Activity

Aetna and its subcontractors had relatively robust reports to monitor encounter data accuracy, completeness, and timeliness for encounters collected by all four of Aetna's subcontractors. In addition, Aetna had relatively robust internal reports to monitor encounter data accuracy, completeness, and timeliness for encounters that Aetna collected.

Strengths	
	<u>Comparative Analysis: Data Element Completeness</u> Aetna excelled with all pharmacy key data elements having both element omission and surplus rates below 5.0 percent. This indicates that all relevant key data elements in the pharmacy records that could be matched between the DMAS-submitted and Aetna-submitted data were largely complete.
	<u>Comparative Analysis: Data Element Accuracy</u> All pharmacy encounter data elements had an accuracy rate greater than 95.0 percent. This indicates that records which could be matched between the DMAS-submitted and Aetna-submitted data largely contained the same values.
Weaknesses and Recommendations	
	<u>Comparative Analysis: Record Completeness</u> Weakness: For professional, institutional, and pharmacy encounters, Aetna had a rate that exceeded 5.0 percent (i.e., relatively poor performance) for both record omission and record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the above-specified Aetna-submitted data. Recommendations: Aetna should investigate the root cause(s) for the record omission and record surplus findings to ensure that complete encounter records are submitted to DMAS.
	<u>Comparative Analysis: Data Element Completeness</u> Weakness: Among the element-level completeness results for professional and institutional encounters, Aetna had six element omission and/or surplus rates that exceeded 5.0 percent, indicating that there were key data element(s) in the DMAS-submitted encounter records that were incomplete when compared to the above-specified Aetna-submitted data. Recommendations: Aetna should investigate the root cause(s) for the element omission and surplus findings to ensure the following data elements are submitted completely: - Professional encounters: <i>Servicing Provider Taxonomy Code</i> (16.1 percent surplus), <i>Primary Diagnosis Codes</i> (17.2 percent surplus), <i>MCO Received Date</i> (17.2 percent surplus) - Institutional encounters: <i>NDC</i> (7.8 percent omission), <i>Drug Quantity</i> (7.8 percent omission), <i>Servicing Provider Taxonomy Code</i> (86.6 percent surplus)
	<u>Comparative Analysis: Data Element Accuracy</u> Weakness: For professional and institutional encounters, Aetna had seven and five element accuracy rates, respectively, that fell below 95.0 percent. This indicates that there were key data element(s) in the DMAS-submitted encounter records that were inaccurate when compared to the above-specified Aetna-submitted data. Recommendations: Aetna should investigate the root cause(s) for the element accuracy findings to ensure the following data elements have accurate values:

Weaknesses and Recommendations

- Professional encounters: *Detail Service From Date* (84.8 percent accuracy), *Detail Service To Date* (84.8 percent accuracy), *Billing Provider NPI* (93.5 percent accuracy), *Rendering Provider NPI* (86.9 percent accuracy), *Servicing Provider Taxonomy Code* (58.3 percent accuracy), *MCO Received Date* (78.7 percent accuracy), and *MCO Paid Date* (82.8 percent accuracy)
- Institutional encounters: *Detail Service From Date* (60.5 percent accuracy), *Servicing Provider Taxonomy Code* (19.7 percent accuracy), *Surgical Procedure Codes* (93.6 percent accuracy), *Header TPL Paid Amount* (92.7 percent accuracy), and *MCO Received Date* (55.3 percent accuracy)

HealthKeepers.

Using 5.0 percent and 95.0 percent as the cutoff values for the omission/surplus rates and accuracy rates, respectively, Table 9-2 displays the rates requiring HealthKeepers' attention.

Table 9-2—Results Requiring Action From HealthKeepers for Cardinal Care MLTSS

Measure	Claim Type	Data Element	Rate
Record Surplus	Institutional	Not Applicable	13.0%
Record Surplus	Pharmacy	Not Applicable	13.2%
Element Surplus	Institutional	Secondary Diagnosis Codes	6.6%
Element Accuracy	Professional	Servicing Provider Taxonomy Code	76.0%
Element Accuracy	Professional	MCO Received Date	88.5%
Element Accuracy	Institutional	Secondary Diagnosis Codes	5.1%
Element Accuracy	Institutional	DRG	0.0%

Strengths, Weaknesses, and Recommendations

Strengths

	<u>IS Review Activity</u> For vision encounters collected by its subcontractor, HealthKeepers and/or its subcontractor had relatively robust reports to monitor encounter data accuracy, completeness, and timeliness.
	<u>Comparative Analysis: Record Completeness</u> For professional encounters, HealthKeepers had a rate below 5.0 percent for record omission and record surplus. This indicates that the professional records could mostly be identified in both data sources (i.e., the DMAS-submitted data and HealthKeepers-submitted data).
	<u>Comparative Analysis: Data Element Completeness</u>

Strengths	
	For professional and pharmacy encounters, HealthKeepers had a rate below 5.0 percent for all relevant element omission and element surplus. This indicates that all relevant key data elements in the professional and pharmacy records that could be matched between the DMAS-submitted and HealthKeepers-submitted data were largely complete.
	<u>Comparative Analysis: Data Element Accuracy</u> All pharmacy encounter data elements had an accuracy rate greater than 95.0 percent. This indicates that records which could be matched between the DMAS-submitted and HealthKeepers-submitted data largely contained the same values.
Weaknesses and Recommendations	
	<u>IS Review Activity</u> Weakness: For pharmacy encounters, HealthKeepers lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness. Recommendations: HealthKeepers and/or its pharmacy subcontractor should consider building reports to monitor encounter accuracy, completeness, and timeliness through metrics such as encounter volume by submission month or encounter volume PMPM.
	<u>IS Review Activity</u> Weakness: For chiropractic encounters, HealthKeepers lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness. Recommendations: HealthKeepers and/or its chiropractic subcontractor should consider building reports to monitor encounter accuracy, completeness, and timeliness through metrics such as encounter volume by submission month, encounter volume PMPM, as well as reconciliation with financial reports.
	<u>IS Review Activity</u> Weakness: HealthKeepers lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness for encounters that HealthKeepers collects. Recommendations: HealthKeepers should consider building reports to monitor encounter completeness through metrics such as encounter volume by submission month or encounter volume PMPM, as well as encounter accuracy, completeness, and timeliness through reconciliation with financial reports for encounters that HealthKeepers collects.
	<u>Comparative Analysis: Record Completeness</u> Weakness: Among the record-level completeness results for institutional and pharmacy encounters, HealthKeepers had a rate exceeding 5.0 percent for record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the above-specified HealthKeepers-submitted data.

Weaknesses and Recommendations	
	Recommendations: HealthKeepers should investigate the root cause(s) for the record surplus findings to ensure that complete encounter records are submitted to DMAS.
—	Comparative Analysis: Data Element Completeness Weakness: Among the element-level completeness results for institutional encounters, HealthKeepers had one element surplus rate that exceeded 5.0 percent, indicating that one key data element in the DMAS-submitted encounter records was incomplete when compared to the HealthKeepers-submitted institutional data.
	Recommendations: HealthKeepers should investigate the root cause(s) for the element surplus finding to ensure the following data element is submitted completely: Institutional encounters: <i>Secondary Diagnosis Codes</i> (6.6 percent surplus)
—	Comparative Analysis: Data Element Accuracy Weakness: Among the element-level accuracy results for professional and institutional encounters, HealthKeepers had four element accuracy rates that fell below 95.0 percent. This indicates that there were key data element(s) in the DMAS-submitted encounter records that were inaccurate when compared to the above-specified HealthKeepers-submitted data.
	Recommendations: HealthKeepers should investigate the root cause(s) for the element accuracy findings to ensure the following data elements have accurate values: - Professional encounters: <i>Servicing Provider Taxonomy Code</i> (76.0 percent accuracy) and <i>MCO Received Date</i> (88.5 percent accuracy) - Institutional encounters: <i>Secondary Diagnosis Codes</i> (5.1 percent accuracy) and <i>DRG</i> (0.0 percent accuracy)

Molina

Using 5.0 percent and 95.0 percent as the cutoff values for the omission/surplus rates and accuracy rates, respectively, Table 9-3 displays the rates requiring Molina's attention.

Table 9-3—Results Requiring Action From Molina for Cardinal Care MLTSS

Measure	Claim Type	Data Element	Rate
Record Surplus	Pharmacy	Not Applicable	14.0%
Element Omission	Professional	Procedure Code Modifiers	5.4%
Element Surplus	Professional	Referring Provider NPI	7.7%
Element Surplus	Professional	MCO Received Date	13.8%
Element Accuracy	Professional	Detail Service From Date	85.7%

Measure	Claim Type	Data Element	Rate
Element Accuracy	Professional	Detail Service To Date	85.5%
Element Accuracy	Professional	Servicing Provider Taxonomy Code	77.0%
Element Accuracy	Professional	Referring Provider NPI	70.5%
Element Accuracy	Institutional	Detail Service From Date	68.2%
Element Accuracy	Institutional	Attending Provider NPI	0.1%
Element Accuracy	Institutional	Servicing Provider Taxonomy Code	0.7%
Element Accuracy	Institutional	Referring Provider NPI	71.3%
Element Accuracy	Institutional	Primary Diagnosis Codes	91.9%
Element Accuracy	Institutional	Secondary Diagnosis Codes	41.0%
Element Accuracy	Institutional	DRG	43.6%
Element Accuracy	Institutional	Type of Bill Code	91.4%
Element Accuracy	Institutional	Header TPL Paid Amount	70.8%
Element Accuracy	Institutional	Detail TPL Paid Amount	77.7%

Strengths, Weaknesses, and Recommendations

Strengths



IS Review Activity

Molina had relatively robust internal reports to monitor encounter data accuracy, completeness, and timeliness for encounters that Molina collected.

Comparative Analysis: Record Completeness

For professional and institutional encounters, Molina had rates below 5.0 percent for both record omission and record surplus. This indicates that the professional and institutional records could mostly be identified in both data sources (i.e., the DMAS-submitted data and Molina-submitted data).

Comparative Analysis: Data Element Completeness

Molina excelled with all pharmacy key data elements having both element omission and surplus rates below 5.0 percent. This indicates that all relevant key data elements in the pharmacy records that could be matched between the DMAS-submitted and Molina-submitted data were largely complete.

Comparative Analysis: Data Element Accuracy

All pharmacy encounter data elements had an accuracy rate greater than 95.0 percent. This indicates that records which could be matched between the DMAS-submitted and Molina-submitted data largely contained the same values.

Weaknesses and Recommendations

	<u>IS Review Activity</u> Weakness: For vision encounters, Molina lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness. Recommendations: Molina and/or its vision subcontractor should consider building reports to monitor encounter accuracy, completeness, and timeliness via metrics such as encounter volume by submission month or encounter volume PMPM.
	<u>Comparative Analysis: Record Completeness</u> Weakness: Among the record-level completeness results for pharmacy encounters, Molina had a rate exceeding 5.0 percent for record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the above-specified Molina-submitted data. Recommendations: Molina should investigate the root cause(s) for the record surplus finding to ensure that complete encounter records are submitted to DMAS.
	<u>Comparative Analysis: Data Element Completeness</u> Weakness: Among the element-level completeness results for professional encounters, Molina had one element omission and two element surplus rates that exceeded 5.0 percent, indicating that there were key data element(s) in the DMAS-submitted encounter records that were incomplete when compared to the above-specified Molina-submitted data. Recommendations: Molina should investigate the root cause(s) for the element omission and surplus findings to ensure the following data elements are submitted completely: Professional encounters: <i>Procedure Code Modifiers</i> (5.4 percent omission), <i>Referring Provider NPI</i> (7.7 percent surplus), and <i>MCO Received Date</i> (13.8 percent surplus)
	<u>Comparative Analysis: Data Element Accuracy</u> Weakness: For professional and institutional encounters, Molina had four and 10 element accuracy rates, respectively, that fell below 95.0 percent. This indicates that there were key data element(s) in the DMAS-submitted encounter records that were inaccurate when compared to the above-specified Molina-submitted data. Recommendations: Molina should investigate the root cause(s) for the element accuracy findings to ensure the following data elements have accurate values: - Professional encounters: <i>Detail Service From Date</i> (85.7 percent accuracy), <i>Detail Service To Date</i> (85.5 percent accuracy), <i>Servicing Provider Taxonomy Code</i> (77.0 percent accuracy), and <i>Referring Provider NPI</i> (70.5 percent accuracy) - Institutional encounters: <i>Detail Service From Date</i> (68.2 percent accuracy), <i>Attending Provider NPI</i> (0.1 percent accuracy), <i>Servicing Provider Taxonomy</i>

Weaknesses and Recommendations

Code (0.7 percent accuracy), *Referring Provider NPI* (71.3 percent accuracy), *Primary Diagnosis Codes* (91.9 percent accuracy), *Secondary Diagnosis Codes* (41.0 percent accuracy), *DRG* (43.6 percent accuracy), *Type of Bill Code* (91.4 percent accuracy), *Header TPL Paid Amount* (70.8 percent accuracy), and *Detail TPL Paid Amount* (77.7 percent accuracy)

Optima

Using 5.0 percent and 95.0 percent as the cutoff values for the omission/surplus rates and accuracy rates, respectively, Table 9-4 displays the rates requiring Optima's attention.

Table 9-4—Results Requiring Action From Optima for Cardinal Care MLTSS

Measure	Claim Type	Data Element	Rate
Record Surplus	Professional	Not Applicable	26.4%
Record Surplus	Institutional	Not Applicable	17.3 %
Record Omission	Pharmacy	Not Applicable	15.1%
Record Surplus	Pharmacy	Not Applicable	39.5 %
Element Omission	Professional	Referring Provider NPI	34.2%
Element Surplus	Professional	Billing Provider NPI	11.0%
Element Surplus	Professional	Rendering Provider NPI	11.0%
Element Surplus	Professional	Procedure Code Modifiers	12.0%
Element Surplus	Professional	MCO Received Date	5.2%
Element Omission	Institutional	Servicing Provider Taxonomy Code	99.0%
Element Omission	Institutional	NDC	6.9%
Element Omission	Institutional	Drug Quantity	6.9%
Element Accuracy	Professional	Member ID	25.1%
Element Accuracy	Professional	Billing Provider NPI	63.5%
Element Accuracy	Professional	Servicing Provider Taxonomy Code	85.5%
Element Accuracy	Professional	Header TPL Paid Amount	85.1%
Element Accuracy	Professional	Detail TPL Paid Amount	86.6%
Element Accuracy	Professional	MCO Received Date	79.0%
Element Accuracy	Professional	MCO Paid Date	57.5%

Strengths, Weaknesses, and Recommendations

Strengths	
	<u>Comparative Analysis: Data Element Completeness</u> Optima excelled with all pharmacy key data elements having both element omission and surplus rates below 5.0 percent. This indicates that all relevant key data elements in the pharmacy records that could be matched between the DMAS-submitted and Optima-submitted data were largely complete.
Weaknesses and Recommendations	
	<u>IS Review Activity</u> Weakness: For NEMT encounters, Optima lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness. Recommendations: Optima and/or its NEMT subcontractor should consider building reports to monitor encounter accuracy, completeness, and timeliness through reconciliation with financial reports.
	<u>IS Review Activity</u> Weakness: Optima lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness for encounters that Optima collects. Recommendations: Optima should consider building reports to monitor encounter accuracy, completeness, and timeliness through reconciliation with financial reports for encounters that Optima collects.
	<u>Comparative Analysis: Record Completeness</u> Weakness: Among the record-level completeness results for professional, institutional, and pharmacy encounters, Optima had a rate exceeding 5.0 percent for record omission and/or record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the above-specified Optima-submitted data. Recommendations: Optima should investigate the root cause(s) for the record omission and surplus findings to ensure that complete encounter records are submitted to DMAS.
	<u>Comparative Analysis: Data Element Completeness</u> Weakness: Among the element-level completeness results for professional and institutional encounters, Optima had eight element omission and/or surplus rates that exceeded 5.0 percent, indicating that there were key data element(s) in the DMAS-submitted encounter records that were incomplete when compared to the above-specified Optima-submitted data. Recommendations: Optima should investigate the root cause(s) for the element omission and surplus findings to ensure the following data elements are submitted completely:

Weaknesses and Recommendations

	- Professional encounters: <i>Referring Provider NPI</i> (34.2 percent omission), <i>Billing Provider NPI</i> (11.0 percent surplus), <i>Rendering Provider NPI</i> (11.0 percent surplus), <i>Procedure Code Modifiers</i> (12.0 percent surplus), and <i>MCO Received Date</i> (5.2 percent surplus) - Institutional encounters: <i>Servicing Provider Taxonomy Code</i> (99.0 percent omission), <i>NDC</i> (6.9 percent omission), and <i>Drug Quantity</i> (6.9 percent omission)
—	<u>Comparative Analysis: Data Element Accuracy</u> Weakness: Among the element-level accuracy results for professional, institutional, and pharmacy encounters, Optima had 18 element accuracy rates that fell below 95.0 percent. This indicates that there were key data element(s) in the DMAS-submitted encounter records that were inaccurate when compared to the above-specified Optima-submitted data. Recommendations: Optima should investigate the root cause(s) for the element accuracy findings to ensure the following data elements have accurate values: Professional encounters: <i>Member ID</i> (25.1 percent accuracy), <i>Billing Provider NPI</i> (63.5 percent accuracy), <i>Servicing Provider Taxonomy Code</i> (85.5 percent accuracy), <i>Header TPL Paid Amount</i> (85.1 percent accuracy), <i>Detail TPL Paid Amount</i> (86.6 percent accuracy), <i>MCO Received Date</i> (79.0 percent accuracy), and <i>MCO Paid Date</i> (57.5 percent accuracy)

United

Using 5.0 percent and 95.0 percent as the cutoff values for the omission/surplus rates and accuracy rates, respectively, Table 9-5 displays the rates requiring United's attention.

Table 9-5—Results Requiring Action From United for Cardinal Care MLTSS

Measure	Claim Type	Data Element	Rate
Record Surplus	Pharmacy	Not Applicable	22.8%
Element Surplus	Professional	Servicing Provider Taxonomy Code	7.7%
Element Surplus	Institutional	Secondary Diagnosis Codes	6.5%
Element Surplus	Institutional	Type of Bill Code	5.1%
Element Accuracy	Professional	Header TPL Paid Amount	92.8%
Element Accuracy	Professional	Detail TPL Paid Amount	93.4%
Element Accuracy	Institutional	Secondary Diagnosis Codes	0.0%
Element Accuracy	Institutional	Surgical Procedure Codes	69.5%
Element Accuracy	Institutional	DRG	0.0%
Element Accuracy	Institutional	Type of Bill Code	92.1%
Element Accuracy	Institutional	Header TPL Paid Amount	80.3%

Measure	Claim Type	Data Element	Rate
Element Accuracy	Institutional	Detail TPL Paid Amount	85.9%
Element Accuracy	Pharmacy	MCO Paid Date	0.1%

Strengths, Weaknesses, and Recommendations

Strengths	
	<u>Comparative Analysis: Record Completeness</u> For professional and institutional encounters, United had rates below 5.0 percent for both record omission and record surplus. This indicates that the professional and institutional records could mostly be identified in both data sources (i.e., the DMAS-submitted data and United-submitted data).
	<u>Comparative Analysis: Data Element Completeness</u> United excelled with all pharmacy key data elements having both element omission and surplus rates below 5.0 percent. This indicates that all relevant key data elements in the pharmacy records that could be matched between the DMAS-submitted and United-submitted data were largely complete.
Weaknesses and Recommendations	
	<u>IS Review Activity</u> Weakness: For pharmacy encounters, United lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness. Recommendations: United and/or its pharmacy subcontractor should consider building reports to monitor encounter accuracy, completeness, and timeliness through metrics such as encounter volume by submission month or encounter volume PMPM.
	<u>IS Review Activity</u> Weakness: For NEMT encounters, United lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness. Recommendations: United and/or its NEMT subcontractor should consider building reports to monitor encounter accuracy, completeness, and timeliness through metrics such as encounter volume by submission month or encounter volume PMPM.
	<u>IS Review Activity</u> Weakness: United lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness for encounters that United collects. Recommendations: United should consider building reports to monitor encounter accuracy, completeness, and timeliness through metrics such as

Weaknesses and Recommendations	
	encounter volume by submission month or encounter volume PMPM for encounters that United collects.
—	<u>Comparative Analysis: Record Completeness</u> Weakness: Among the record-level completeness results for pharmacy encounters, United had a rate exceeding 5.0 percent for record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the above-specified United-submitted data.
	Recommendations: United should investigate the root cause(s) for the record surplus finding to ensure that complete encounter records are submitted to DMAS.
—	<u>Comparative Analysis: Data Element Completeness</u> Weakness: Among the element-level completeness results for professional and institutional encounters, United had three element surplus rates that exceeded 5.0 percent, indicating that there were key data element(s) in the DMAS-submitted encounter records that were incomplete when compared to the above-specified United-submitted data.
	Recommendations: United should investigate the root cause(s) for the element surplus findings to ensure the following data elements are submitted completely: - Professional encounters: <i>Servicing Provider Taxonomy Code</i> (7.7 percent surplus) - Institutional encounters: <i>Secondary Diagnosis Codes</i> (6.5 percent surplus) and <i>Type of Bill Code</i> (5.1 percent surplus).
—	<u>Comparative Analysis: Data Element Accuracy</u> Weakness: Among the element-level accuracy results for professional, institutional, and pharmacy encounters, United had nine element accuracy rates that fell below 95.0 percent. This indicates that there were key data element(s) in the DMAS-submitted encounter records that were inaccurate when compared to the above-specified United-submitted data.
	Recommendations: United should investigate the root cause(s) for the element accuracy findings to ensure the following data elements have accurate values: - Professional encounters: <i>Header TPL Paid Amount</i> (92.8 percent accuracy) and <i>Detail TPL Paid Amount</i> (93.4 percent accuracy) - Institutional encounters: <i>Secondary Diagnosis Codes</i> (0.0 percent accuracy), <i>Surgical Procedure Codes</i> (69.5 percent accuracy), <i>DRG</i> (0.0 percent accuracy), <i>Type of Bill Code</i> (92.1 percent accuracy), <i>Header TPL Paid Amount</i> (80.3 percent accuracy), and <i>Detail TPL Paid Amount</i> (85.9 percent accuracy) - Pharmacy encounters: <i>MCO Paid Date</i> (0.1 percent accuracy)

Virginia Premier Health Plan, Inc.

Using 5.0 percent and 95.0 percent as the cutoff values for the omission/surplus rates and accuracy rates, respectively, Table 9-6 displays the rates requiring VA Premier's attention.

Table 9-6—Results Requiring Action From VA Premier for Cardinal Care MLTSS

Measure	Claim Type	Data Element	Rate
Record Omission	Professional	Not Applicable	6.5%
Record Surplus	Institutional	Not Applicable	41.8%
Element Omission	Institutional	NDC	14.4%
Element Omission	Institutional	Drug Quantity	14.4%
Element Accuracy	Professional	MCO Received Date	81.9%
Element Accuracy	Professional	MCO Paid Date	77.0%
Element Accuracy	Institutional	Secondary Diagnosis Codes	43.2%
Element Accuracy	Institutional	Type of Bill Code	89.7%
Element Accuracy	Institutional	Header TPL Paid Amount	85.2%
Element Accuracy	Institutional	Detail TPL Paid Amount	93.9%
Element Accuracy	Institutional	MCO Received Date	65.2%

Strengths, Weaknesses, and Recommendations

Strengths	
	<u>Comparative Analysis: Record Completeness</u> For the pharmacy encounters, VA Premier had a rate below 5.0 percent for record omission and record surplus. This indicates that the pharmacy records could mostly be identified in both data sources (i.e., the DMAS-submitted data and VA Premier-submitted data).
	<u>Comparative Analysis: Data Element Completeness</u> VA Premier excelled with all professional and pharmacy key data elements having both element omission and surplus rates below 5.0 percent. This indicates that all relevant key data elements in the professional and pharmacy records that could be matched between the DMAS-submitted and VA Premier-submitted data were largely complete.
	<u>Comparative Analysis: Data Element Accuracy</u> All pharmacy encounter data elements had an accuracy rate greater than 95.0 percent. This indicates that records which could be matched between the DMAS-submitted and VA Premier-submitted data largely contained the same values.

Weaknesses and Recommendations

	<u>IS Review Activity</u> Weakness: For vision encounters, VA Premier lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness. Recommendations: VA Premier and/or its vision subcontractor should consider building reports to monitor encounter accuracy, completeness, and timeliness through reconciliation with financial reports.
	<u>IS Review Activity</u> Weakness: For NEMT encounters, VA Premier lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness. Recommendations: VA Premier and/or its NEMT subcontractor should consider building reports to monitor encounter accuracy, completeness, and timeliness through reconciliation with financial reports.
	<u>IS Review Activity</u> Weakness: VA Premier lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness for encounters that VA Premier collects. Recommendations: VA Premier should consider building reports to monitor encounter accuracy, completeness, and timeliness through reconciliation with financial reports for encounters that VA Premier collects.
	<u>Comparative Analysis: Record Completeness</u> Weakness: Among the record-level completeness results for professional and institutional encounters, VA Premier had a rate exceeding 5.0 percent for record omission and/or record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the above-specified VA Premier-submitted data. Recommendations: VA Premier should investigate the root cause(s) for the record omission and surplus findings to ensure that complete encounter records are submitted to DMAS.
	<u>Comparative Analysis: Data Element Completeness</u> Weakness: Among the element-level completeness results for institutional encounters, VA Premier had two element omission rates that exceeded 5.0 percent, indicating that there were key data element(s) in the DMAS-submitted encounter records that were incomplete when compared to the above-specified VA Premier-submitted data. Recommendations: VA Premier should investigate the root cause(s) for the element omission findings to ensure the following data elements are submitted completely: • Institutional encounters: <i>NDC</i> (14.4 percent omission) and <i>Drug Quantity</i> (14.4 percent omission)

Weaknesses and Recommendations



Comparative Analysis: Data Element Accuracy

Weakness: Among the element-level accuracy results for professional and institutional encounters, VA Premier had seven element accuracy rates that fell below 95.0 percent. This indicates that there were key data element(s) in the DMAS-submitted encounter records that were inaccurate when compared to the above-specified VA Premier-submitted data.

Recommendations: VA Premier should investigate the root cause(s) for the element accuracy findings to ensure the following data elements have accurate values:

- Professional encounters: *MCO Received Date* (81.9 percent accuracy) and *MCO Paid Date* (77.0 percent accuracy)
- Institutional encounters: *Secondary Diagnosis Codes* (43.2 percent accuracy), *Type of Bill Code* (89.7 percent accuracy), *Header TPL Paid Amount* (85.2 percent accuracy), *Detail TPL Paid Amount* (93.9 percent accuracy), and *MCO Received Date* (65.2 percent accuracy)

Cardinal Care Acute MCO-Specific Results

Throughout the comparative analysis section, lower rates indicate better performance for omission and surplus rates, while higher rates indicate better performance for accuracy rates.

Aetna

Using 5.0 percent and 95.0 percent as the cutoff values for the omission/surplus rates and accuracy rates, respectively, Table 9-7 displays the rates requiring Aetna's attention.

Table 9-7—Results Requiring Action From Aetna for Cardinal Care Acute

Measure	Claim Type	Data Element	Rate
Record Omission	Professional	Not Applicable	6.3%
Record Surplus	Professional	Not Applicable	14.0%
Record Omission	Institutional	Not Applicable	34.1%
Record Surplus	Institutional	Not Applicable	46.6%
Record Omission	Pharmacy	Not Applicable	31.9%
Record Surplus	Pharmacy	Not Applicable	32.3%
Element Surplus	Professional	Servicing Provider Taxonomy Code	26.8%
Element Surplus	Institutional	Servicing Provider Taxonomy Code	71.9%
Element Accuracy	Professional	Detail Service From Date	87.5%
Element Accuracy	Professional	Detail Service To Date	87.5%

Measure	Claim Type	Data Element	Rate
Element Accuracy	Professional	Rendering Provider NPI	87.7%
Element Accuracy	Professional	Servicing Provider Taxonomy Code	68.6%
Element Accuracy	Institutional	Detail Service From Date	85.8%
Element Accuracy	Institutional	Servicing Provider Taxonomy Code	82.8%
Element Accuracy	Institutional	MCO Received Date	94.8%

Strengths, Weaknesses, and Recommendations

Strengths	
	<u>IS Review Activity</u> Aetna and its subcontractors had relatively robust reports to monitor encounter data accuracy, completeness, and timeliness for encounters collected by all four of Aetna's subcontractors. In addition, Aetna had relatively robust internal reports to monitor encounter data accuracy, completeness, and timeliness for encounters that Aetna collected.
	<u>Comparative Analysis: Data Element Completeness</u> Aetna excelled with all pharmacy key data elements having both element omission and surplus rates below 5.0 percent. This indicates that all relevant key data elements in the pharmacy records that could be matched between the DMAS-submitted and Aetna-submitted data were largely complete.
	<u>Comparative Analysis: Data Element Accuracy</u> All pharmacy encounter data elements had an accuracy rate greater than 95.0 percent. This indicates that records which could be matched between the DMAS-submitted and Aetna-submitted data largely contained the same values.
Weaknesses and Recommendations	
	<u>Comparative Analysis: Record Completeness</u> Weakness: For professional, institutional, and pharmacy encounters, Aetna had a rate over 5.0 percent (i.e., relatively poor performance) for both record omission and record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the above-specified Aetna-submitted data. Recommendations: Aetna should investigate the root cause(s) for the record omission and record surplus findings to ensure that complete encounter records are submitted to DMAS.
	<u>Comparative Analysis: Data Element Completeness</u> Weakness: Among the element-level completeness results for professional and institutional encounters, Aetna had two element surplus rates that exceeded 5.0 percent, indicating that there were key data element(s) in the DMAS-submitted encounter records that were incomplete when compared to the above-specified Aetna-submitted data.

Weaknesses and Recommendations

	Recommendations: Aetna should investigate the root cause(s) for the record surplus findings to ensure the following data elements are submitted completely: - Professional encounters: <i>Servicing Provider Taxonomy Code</i> (26.8 percent surplus) - Institutional encounters: <i>Servicing Provider Taxonomy Code</i> (71.9 percent surplus)
—	Comparative Analysis: Data Element Accuracy Weakness: For professional and institutional encounters, Aetna had four and three element accuracy rates, respectively, that fell below 95.0 percent. This indicates that there were key data element(s) in the DMAS-submitted encounter records that were inaccurate when compared to the above-specified Aetna-submitted data. Recommendations: Aetna should investigate the root cause(s) for the element accuracy findings to ensure the following data elements have accurate values: - Professional encounters: <i>Detail Service From Date</i> (87.5 percent accuracy), <i>Detail Service To Date</i> (87.5 percent accuracy), <i>Rendering Provider NPI</i> (87.7 percent accuracy), and <i>Servicing Provider Taxonomy Code</i> (68.6 percent accuracy) - Institutional encounters: <i>Detail Service From Date</i> (85.8 percent accuracy), <i>Servicing Provider Taxonomy Code</i> (82.8 percent accuracy), and <i>MCO Received Date</i> (94.8 percent accuracy)

HealthKeepers

Using 5.0 percent and 95.0 percent as the cutoff values for the omission/surplus rates and accuracy rates, respectively, Table 9-8 displays the rates requiring HealthKeepers' attention.

Table 9-8—Results Requiring Action From HealthKeepers for Cardinal Care Acute

Measure	Claim Type	Data Element	Rate
Record Surplus	Institutional	Not Applicable	12.2%
Record Surplus	Pharmacy	Not Applicable	17.0%
Element Surplus	Institutional	Secondary Diagnosis Codes	15.7%
Element Accuracy	Professional	Servicing Provider Taxonomy Code	74.4%
Element Accuracy	Professional	MCO Received Date	89.7%
Element Accuracy	Institutional	Secondary Diagnosis Codes	0.9%
Element Accuracy	Institutional	DRG	0.0%

Strengths, Weaknesses, and Recommendations

Strengths	
	<u>IS Review Activity</u> For vision encounters collected by its subcontractor, HealthKeepers and/or its subcontractor had relatively robust reports to monitor encounter data accuracy, completeness, and timeliness.
	<u>Comparative Analysis: Record Completeness</u> For professional encounters, HealthKeepers had a rate below 5.0 percent for record omission and record surplus. This indicates that the professional records could mostly be identified in both data sources (i.e., the DMAS-submitted data and HealthKeepers-submitted data).
	<u>Comparative Analysis: Data Element Completeness</u> For professional and pharmacy encounters, HealthKeepers had a rate below 5.0 percent for all relevant element omission and element surplus. This indicates that all relevant key data elements in the professional and pharmacy records that could be matched between the DMAS-submitted and HealthKeepers-submitted data were largely complete.
	<u>Comparative Analysis: Data Element Accuracy</u> All pharmacy encounter data elements had an accuracy rate greater than 95.0 percent. This indicates that records which could be matched between the DMAS-submitted and HealthKeepers-submitted data largely contained the same values.
Weaknesses and Recommendations	
	<u>IS Review Activity</u> Weakness: For pharmacy encounters, HealthKeepers lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness. Recommendations: HealthKeepers and/or its pharmacy subcontractor should consider building reports to monitor encounter accuracy, completeness, and timeliness through metrics such as encounter volume by submission month or encounter volume PMPM.
	<u>IS Review Activity</u> Weakness: For chiropractic encounters, HealthKeepers lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness. Recommendations: HealthKeepers and/or its chiropractic subcontractor should consider building reports to monitor encounter accuracy, completeness, and timeliness through metrics such as encounter volume by submission month, encounter volume PMPM, as well as reconciliation with financial reports.
	<u>IS Review Activity</u>

Weaknesses and Recommendations	
—	Weakness: For palliative care encounters, HealthKeepers lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness.
	Recommendations: HealthKeepers and/or its palliative care subcontractors should consider building reports to monitor encounter accuracy, completeness, and timeliness through metrics such as encounter volume by submission month encounter volume PMPM, as well as reconciliation with financial reports.
—	<u>IS Review Activity</u> Weakness: HealthKeepers lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness for encounters that HealthKeepers collects.
	Recommendations: HealthKeepers should consider building reports to monitor encounter completeness through metrics such as encounter volume by submission month or encounter volume PMPM, as well as encounter accuracy, completeness, and timeliness through reconciliation with financial reports for encounters that HealthKeepers collects.
—	<u>Comparative Analysis: Record Completeness</u> Weakness: Among the record-level completeness results for institutional and pharmacy encounters, HealthKeepers had a rate exceeding 5.0 percent for record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the above-specified HealthKeepers-submitted data.
	Recommendations: HealthKeepers should investigate the root cause(s) for the record surplus findings to ensure that complete encounter records are submitted to DMAS.
—	<u>Comparative Analysis: Data Element Completeness</u> Weakness: Among the element-level completeness results for institutional encounters, HealthKeepers had one element surplus rate that exceeded 5.0 percent, indicating that one key data element in the DMAS-submitted encounter records was incomplete when compared to the HealthKeepers-submitted institutional data.
	Recommendations: HealthKeepers should investigate the root cause(s) for the element surplus finding to ensure the following data element is submitted completely: Institutional encounters: <i>Secondary Diagnosis Codes</i> (15.7 percent surplus)
—	<u>Comparative Analysis: Data Element Accuracy</u> Weakness: Among the element-level accuracy results for professional and institutional encounters, HealthKeepers had four element accuracy rates that fell below 95.0 percent. This indicates that there were key data element(s) in the DMAS-submitted encounter records that were inaccurate when compared to the above-specified HealthKeepers-submitted data.

Weaknesses and Recommendations

Recommendations: HealthKeepers should investigate the root cause(s) for the element accuracy findings to ensure the following data elements have accurate values:

- Professional encounters: *Servicing Provider Taxonomy Code* (74.4 percent accuracy) and *MCO Received Date* (89.7 percent accuracy)
- Institutional encounters: *Secondary Diagnosis Codes* (0.9 percent accuracy) and *DRG* (0.0 percent accuracy)

Molina

Using 5.0 percent and 95.0 percent as the cutoff values for the omission/surplus rates and accuracy rates, respectively, Table 9-9 displays the rates requiring Molina's attention.

Table 9-9—Results Requiring Action From Molina for Cardinal Care Acute

Measure	Claim Type	Data Element	Rate
Record Surplus	Pharmacy	Not Applicable	17.0%
Element Surplus	Professional	Referring Provider NPI	13.3%
Element Surplus	Institutional	Secondary Diagnosis Codes	7.5%
Element Accuracy	Professional	Detail Service From Date	85.3%
Element Accuracy	Professional	Detail Service To Date	85.2%
Element Accuracy	Professional	Servicing Provider Taxonomy Code	81.9%
Element Accuracy	Professional	Referring Provider NPI	73.3%
Element Accuracy	Institutional	Detail Service From Date	87.7%
Element Accuracy	Institutional	Attending Provider NPI	0.3%
Element Accuracy	Institutional	Servicing Provider Taxonomy Code	0.5%
Element Accuracy	Institutional	Referring Provider NPI	72.1%
Element Accuracy	Institutional	Secondary Diagnosis Codes	50.9%
Element Accuracy	Institutional	DRG	69.3%
Element Accuracy	Institutional	Type of Bill Code	90.5%

Strengths, Weaknesses, and Recommendations

Strengths	
	<u>IS Review Activity</u> Molina had relatively robust internal reports to monitor encounter data accuracy, completeness, and timeliness for encounters that Molina collected.
	<u>Comparative Analysis: Record Completeness</u> For professional and institutional encounters, Molina had rates below 5.0 percent for both record omission and record surplus. This indicates that the professional and institutional records could mostly be identified in both data sources (i.e., the DMAS-submitted data and Molina-submitted data).
	<u>Comparative Analysis: Data Element Completeness</u> Molina excelled with all pharmacy key data elements having both element omission and surplus rates below 5.0 percent. This indicates that all relevant key data elements in the pharmacy records that could be matched between the DMAS-submitted and the Molina-submitted data were largely complete.
	<u>Comparative Analysis: Data Element Accuracy</u> All pharmacy encounter data elements had an accuracy rate greater than 95.0 percent. This indicates that records which could be matched between the DMAS-submitted and the Molina-submitted data largely contained the same values.
Weaknesses and Recommendations	
	<u>IS Review Activity</u> Weakness: For vision encounters, Molina lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness. Recommendations: Molina and/or its vision subcontractor should consider building reports to monitor encounter accuracy, completeness, and timeliness via metrics such as encounter volume by submission month or encounter volume PMPM.
	<u>Comparative Analysis: Record Completeness</u> Weakness: Among the record-level completeness results for pharmacy encounters, Molina had a rate exceeding 5.0 percent for record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the above-specified Molina-submitted data. Recommendations: Molina should investigate the root cause(s) for the record surplus finding to ensure that complete encounter records are submitted to DMAS.
	<u>Comparative Analysis: Data Element Completeness</u> Weakness: Among the element-level completeness results for professional and institutional encounters, Molina had two element surplus rates that exceeded 5.0 percent, indicating that there were key data element(s) in the DMAS-submitted

Weaknesses and Recommendations

	encounter records that were incomplete when compared to the above-specified Molina-submitted data. Recommendations: Molina should investigate the root cause(s) for the element surplus findings to ensure the following data elements are submitted completely: - Professional encounters: <i>Referring Provider NPI</i> (13.3 percent surplus) - Institutional encounters: <i>Secondary Diagnosis Codes</i> (7.5 percent surplus)
	Comparative Analysis: Data Element Accuracy Weakness: For professional and institutional encounters, Molina had four and seven element accuracy rates, respectively, that fell below 95.0 percent. This indicates that there were key data element(s) in the DMAS-submitted encounter records that were inaccurate when compared to the above-specified Molina-submitted data. Recommendations: Molina should investigate the root cause(s) for the element accuracy findings to ensure the following data elements have accurate values: - Professional encounters: <i>Detail Service From Date</i> (85.3 percent accuracy), <i>Detail Service To Date</i> (85.2 percent accuracy), <i>Servicing Provider Taxonomy Code</i> (81.9 percent accuracy), and <i>Referring Provider NPI</i> (73.3 percent accuracy) - Institutional encounters: <i>Detail Service From Date</i> (87.7 percent accuracy), <i>Attending Provider NPI</i> (0.3 percent accuracy), <i>Servicing Provider Taxonomy Code</i> (0.5 percent accuracy), <i>Referring Provider NPI</i> (72.1 percent accuracy), <i>Secondary Diagnosis Codes</i> (50.9 percent accuracy), <i>DRG</i> (69.3 percent accuracy), and <i>Type of Bill Code</i> (90.5 percent accuracy)

Optima

Using 5.0 percent and 95.0 percent as the cutoff values for the omission/surplus rates and accuracy rates, respectively, Table 9-10 displays the rates requiring Optima's attention.

Table 9-10—Results Requiring Action From Optima for Cardinal Care Acute

Measure	Claim Type	Data Element	Rate
Record Surplus	Professional	Not Applicable	27.2%
Record Surplus	Institutional	Not Applicable	20.9%
Record Omission	Pharmacy	Not Applicable	9.3%
Record Surplus	Pharmacy	Not Applicable	24.6%
Element Omission	Professional	Referring Provider NPI	52.7%
Element Omission	Institutional	Servicing Provider Taxonomy Code	98.9%
Element Accuracy	Professional	Member ID	6.2%
Element Accuracy	Professional	Billing Provider NPI	38.5%

Measure	Claim Type	Data Element	Rate
Element Accuracy	Professional	Servicing Provider Taxonomy Code	71.8%
Element Accuracy	Professional	MCO Paid Date	58.6%
Element Accuracy	Institutional	Member ID	0.0%
Element Accuracy	Institutional	Billing Provider NPI	91.7%
Element Accuracy	Institutional	Secondary Diagnosis Codes	78.2%
Element Accuracy	Institutional	DRG	88.4%
Element Accuracy	Institutional	Type of Bill Code	89.5%
Element Accuracy	Institutional	MCO Paid Date	48.7%
Element Accuracy	Pharmacy	MCO Received Date	<0.1%
Element Accuracy	Pharmacy	MCO Paid Date	31.4%

Strengths, Weaknesses, and Recommendations

Strengths	
	Comparative Analysis: Data Element Completeness Optima excelled with all pharmacy key data elements having both element omission and surplus rates below 5.0 percent. This indicates that all relevant key data elements in the pharmacy records that could be matched between the DMAS-submitted and Optima-submitted data were largely complete.
Weaknesses and Recommendations	
	IS Review Activity Weakness: For NEMT encounters, Optima lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness. Recommendations: Optima and/or its NEMT subcontractor should consider building reports to monitor encounter accuracy, completeness, and timeliness through reconciliation with financial reports.
	IS Review Activity Weakness: Optima lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness for encounters that Optima collects. Recommendations: Optima should consider building reports to monitor encounter accuracy, completeness, and timeliness through reconciliation with financial reports for encounters that Optima collects.
	Comparative Analysis: Record Completeness Weakness: Among the record-level completeness results for professional, institutional, and pharmacy encounters, Optima had a rate exceeding 5.0 percent for record omission and/or record surplus. This indicates that the DMAS-

Weaknesses and Recommendations	
	submitted encounter records were incomplete when compared to the above-specified Optima-submitted data. Recommendations: Optima should investigate the root cause(s) for the record omission and surplus findings to ensure that complete encounter records are submitted to DMAS.
—	<u>Comparative Analysis: Data Element Completeness</u> Weakness: Among the element-level completeness results for professional and institutional encounters, Optima had two element omission rates that exceeded 5.0 percent, indicating that there were key data element(s) in the DMAS-submitted encounter records that were incomplete when compared to the above-specified Optima-submitted data. Recommendations: Optima should investigate the root cause(s) for the element omission findings to ensure the following data elements are submitted completely: - Professional encounters: <i>Referring Provider NPI</i> (52.7 percent omission) - Institutional encounters: <i>Servicing Provider Taxonomy Code</i> (98.9 percent omission)
—	<u>Comparative Analysis: Data Element Accuracy</u> Weakness: Among the element-level accuracy results for professional, institutional, and pharmacy encounters, Optima had 12 element accuracy rates that fell below 95.0 percent. This indicates that there were key data element(s) in the DMAS-submitted encounter records that were inaccurate when compared to the above-specified Optima-submitted data. Recommendations: Optima should investigate the root cause(s) for the element accuracy findings to ensure the following data elements have accurate values: - Professional encounters: <i>Member ID</i> (6.2 percent accuracy), <i>Billing Provider NPI</i> (38.5 percent accuracy), <i>Servicing Provider Taxonomy Code</i> (71.8 percent accuracy), and <i>MCO Paid Date</i> (58.6 percent accuracy) - Institutional encounters: <i>Member ID</i> (0.0 percent accuracy), <i>Billing Provider NPI</i> (91.7 percent accuracy), <i>Secondary Diagnosis Codes</i> (78.2 percent accuracy), <i>DRG</i> (88.4 percent accuracy), <i>Type of Bill Code</i> (89.5 percent accuracy), and <i>MCO Paid Date</i> (48.7 percent accuracy) - Pharmacy encounters: <i>MCO Received Date</i> (<0.1 percent accuracy) and <i>MCO Paid Date</i> (31.4 percent accuracy)

United

Using 5.0 percent and 95.0 percent as the cutoff values for the omission/surplus rates and accuracy rates, respectively, Table 9-11 displays the rates requiring United's attention.

Table 9-11—Results Requiring Action From United for Cardinal Care Acute

Measure	Claim Type	Data Element	Rate
Record Surplus	Pharmacy	Not Applicable	24.2%
Element Surplus	Professional	Servicing Provider Taxonomy Code	8.1%
Element Surplus	Institutional	Secondary Diagnosis Codes	15.6%
Element Surplus	Institutional	Type of Bill Code	26.9%
Element Accuracy	Institutional	Secondary Diagnosis Codes	0.0%
Element Accuracy	Institutional	Surgical Procedure Codes	72.3%
Element Accuracy	Institutional	DRG	0.0%
Element Accuracy	Institutional	Type of Bill Code	91.2%
Element Accuracy	Pharmacy	Drug Quantity	94.8%
Element Accuracy	Pharmacy	MCO Paid Date	<0.1%

Strengths, Weaknesses, and Recommendations

Strengths	
	<u>Comparative Analysis: Record Completeness</u> For professional and institutional encounters, United had rates below 5.0 percent for both record omission and record surplus. This indicates that the professional and institutional records could mostly be identified in both data sources (i.e., the DMAS-submitted data and United-submitted data).
	<u>Comparative Analysis: Data Element Completeness</u> United excelled with all pharmacy key data elements having both element omission and surplus rates below 5.0 percent. This indicates that all relevant key data elements in the pharmacy records that could be matched between the DMAS-submitted and United-submitted data were largely complete.
	<u>Comparative Analysis: Data Element Accuracy</u> All professional encounter data elements had an accuracy rate greater than 95.0 percent. This indicates that records which could be matched between the DMAS-submitted and United-submitted data largely contained the same values.
Weaknesses and Recommendations	
	<u>IS Review Activity</u> Weakness: For pharmacy encounters, United lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness. Recommendations: United and/or its pharmacy subcontractor should consider building reports to monitor encounter accuracy, completeness, and timeliness through metrics such as encounter volume by submission month or encounter volume PMPM.

Weaknesses and Recommendations	
	<u>IS Review Activity</u> Weakness: For NEMT encounters, United lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness.
	Recommendations: United and/or its NEMT subcontractor should consider building reports to monitor encounter accuracy, completeness, and timeliness through metrics such as encounter volume by submission month or encounter volume PMPM.
	<u>IS Review Activity</u> Weakness: United lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness for encounters that United collects.
	Recommendations: United should consider building reports to monitor encounter accuracy, completeness, and timeliness through metrics such as encounter volume by submission month or encounter volume PMPM for encounters that United collects.
	<u>Comparative Analysis: Record Completeness</u> Weakness: Among the record-level completeness results for pharmacy encounters, United had a rate exceeding 5.0 percent for record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the above-specified United-submitted data.
	Recommendations: United should investigate the root cause(s) for the record surplus finding to ensure that complete encounter records are submitted to DMAS.
	<u>Comparative Analysis: Data Element Completeness</u> Weakness: Among the element-level completeness results for professional and institutional encounters, United had three element surplus rates that exceeded 5.0 percent, indicating that there were key data element(s) in the DMAS-submitted encounter records that were incomplete when compared to the above-specified United-submitted data.
	Recommendations: United should investigate the root cause(s) for the element surplus findings to ensure the following data elements are submitted completely: - Professional encounters: <i>Servicing Provider Taxonomy Code</i> (8.1 percent surplus) - Institutional encounters: <i>Secondary Diagnosis Codes</i> (15.6 percent surplus) and <i>Type of Bill Code</i> (26.9 percent surplus)
	<u>Comparative Analysis: Data Element Accuracy</u> Weakness: Among the element-level accuracy results for institutional and pharmacy encounters, United had six element accuracy rates that fell below 95.0 percent. This indicates that there were key data element(s) in the DMAS-

Weaknesses and Recommendations

submitted encounter records that were inaccurate when compared to the above-specified United-submitted data.

Recommendations: United should investigate the root cause(s) for the element accuracy findings to improve the quality and completeness. United should focus on the following data elements to ensure they are submitted accurately and completely within the records:

- Institutional encounters: *Secondary Diagnosis Codes* (0.0 percent accuracy), *Surgical Procedure Codes* (72.3 percent accuracy), *DRG* (0.0 percent accuracy), and *Type of Bill Code* (91.2 percent accuracy)
- Pharmacy encounters: *Drug Quantity* (94.8 percent accuracy) and *MCO Paid Date* (<0.1 percent accuracy)

VA Premier

Using 5.0 percent and 95.0 percent as the cutoff values for the omission/surplus rates and accuracy rates, respectively, Table 9-12 displays the rates requiring VA Premier's attention.

Table 9-12—Results Requiring Action From VA Premier for Cardinal Care Acute

Measure	Claim Type	Data Element	Rate
Record Surplus	Institutional	Not Applicable	29.4%
Record Omission	Pharmacy	Not Applicable	6.8%
Element Omission	Institutional	Servicing Provider Taxonomy Code	87.7%
Element Omission	Institutional	NDC	14.5%
Element Omission	Institutional	Drug Quantity	14.5%
Element Accuracy	Professional	MCO Received Date	70.0%
Element Accuracy	Institutional	Secondary Diagnosis Codes	47.5%
Element Accuracy	Institutional	Surgical Procedure Codes	94.6%
Element Accuracy	Institutional	NDC	91.9%
Element Accuracy	Institutional	Drug Quantity	92.6%
Element Accuracy	Institutional	Type of Bill Code	87.8%
Element Accuracy	Institutional	MCO Received Date	55.5%

Strengths, Weaknesses, and Recommendations

Strengths	
	<u>Comparative Analysis: Record Completeness</u> For professional encounters, VA Premier had a rate below 5.0 percent for record omission and record surplus. This indicates that the professional records could mostly be identified in both data sources (i.e., the DMAS-submitted data and VA Premier-submitted data).
	<u>Comparative Analysis: Data Element Completeness</u> VA Premier excelled with all professional and pharmacy key data elements having both element omission and surplus rates below 5.0 percent. This indicates that all relevant key data elements in the professional and pharmacy records that could be matched between the DMAS-submitted and VA Premier-submitted data were largely complete.
	<u>Comparative Analysis: Data Element Accuracy</u> All pharmacy encounter data elements had an accuracy rate greater than 95.0 percent. This indicates that records which could be matched between the DMAS-submitted and VA Premier-submitted data largely contained the same values.
Weaknesses and Recommendations	
	<u>IS Review Activity</u> Weakness: For vision encounters, VA Premier lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness. Recommendations: VA Premier and/or its vision subcontractor should consider building reports to monitor encounter accuracy, completeness, and timeliness through reconciliation with financial reports.
	<u>IS Review Activity</u> Weakness: For NEMT encounters, VA Premier lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness. Recommendations: VA Premier and/or its NEMT subcontractor should consider building reports to monitor encounter accuracy, completeness, and timeliness through reconciliation with financial reports.
	<u>IS Review Activity</u> Weakness: VA Premier lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness for encounters that VA Premier collects. Recommendations: VA Premier should consider building reports to monitor encounter accuracy, completeness, and timeliness through reconciliation with financial reports for encounters that VA Premier collects.

Weaknesses and Recommendations

	<u>Comparative Analysis: Record Completeness</u> Weakness: Among the record-level completeness results for institutional and pharmacy encounters, VA Premier had a rate exceeding 5.0 percent for record omission or record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the above-specified VA Premier-submitted data. Recommendations: VA Premier should investigate the root cause(s) for the record omission and surplus findings to ensure that complete encounter records are submitted to DMAS.
	<u>Comparative Analysis: Data Element Completeness</u> Weakness: Among the element-level completeness results for institutional encounters, VA Premier had three element omission rates that exceeded 5.0 percent, indicating that there were key data element(s) in the DMAS-submitted encounter records that were incomplete when compared to the above-specified VA Premier-submitted data. Recommendations: VA Premier should investigate the root cause(s) for the element omission findings to ensure the following data elements are submitted completely: • Institutional encounters: <i>Servicing Provider Taxonomy Code</i> (87.7 percent omission), <i>NDC</i> (14.5 percent omission), and <i>Drug Quantity</i> (14.5 percent omission)
	<u>Comparative Analysis: Data Element Accuracy</u> Weakness: Among the element-level accuracy results for professional and institutional encounters, VA Premier had seven element accuracy rates that fell below 95.0 percent. This indicates that there were key data element(s) in the DMAS-submitted encounter records that were inaccurate when compared to the above-specified VA Premier-submitted data. Recommendations: VA Premier should investigate the root cause(s) for the element accuracy findings to ensure the following data elements have accurate values: • Professional encounters: <i>MCO Received Date</i> (70.0 percent accuracy) • Institutional encounters: <i>Secondary Diagnosis Codes</i> (47.5 percent accuracy), <i>Surgical Procedure Codes</i> (94.6 percent accuracy), <i>NDC</i> (91.9 percent accuracy), <i>Drug Quantity</i> (92.6 percent accuracy), <i>Type of Bill Code</i> (87.8 percent accuracy), and <i>MCO Received Date</i> (55.5 percent accuracy)

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.⁴⁷ 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 Cardinal Care program (i.e., Cardinal Care Acute and Cardinal Care MLTSS MCOs) to obtain information on the levels of experience of adult Medicaid members and parents/caretakers of child Medicaid members. For the Cardinal Care program MCOs (Aetna, HealthKeepers, Molina, Sentara, and United), the technical method of data collection was conducted through administration of the CAHPS 5.1H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.1H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCOs.

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

MCO-Specific Results

Aetna

Table 10-1 and Table 10-2 present Aetna’s 2024 MCO-specific adult and general child Medicaid CAHPS top-box scores, respectively, for the global ratings and composite measures. In addition, the 2024 CAHPS scores were compared to the 2023 NCQA adult and general child Medicaid national averages.

Table 10-1—Comparison of 2024 Adult Medicaid CAHPS Results: Aetna

	2024
Global Ratings	
<i>Rating of Health Plan</i>	60.79%

⁴⁷ Since Optima and VA Premier were merged into Sentara, trend results are unavailable for the Cardinal Care program and MCOs.

	2024
Rating of All Health Care	54.19%
Rating of Personal Doctor	64.55%
Rating of Specialist Seen Most Often	69.37%
Composite Measures	
Getting Needed Care	80.49%
Getting Care Quickly	80.12%
How Well Doctors Communicate	92.17%
Customer Service	86.46%

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

Cells highlighted in orange represent rates that are statistically significantly higher than the 2023 NCQA national Medicaid averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2023 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

Aetna's 2024 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	Aetna's 2024 top-box scores were not statistically significantly higher than the 2023 NCQA adult Medicaid national averages for any measure; therefore, no strengths were identified.
Weaknesses and Recommendations	
	Weakness: Aetna's 2024 top-box scores were not statistically significantly lower than the 2023 NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified. Recommendations: HSAG recommends that Aetna monitor the measures to ensure that significant decreases in scores over time do not occur.

Table 10-2—Comparison of 2024 General Child Medicaid CAHPS Results: Aetna

	2024
Global Ratings	
Rating of Health Plan	72.01%
Rating of All Health Care	70.77%
Rating of Personal Doctor	73.65%
Rating of Specialist Seen Most Often	64.67%

	2024
Composite Measures	
<i>Getting Needed Care</i>	79.81%
<i>Getting Care Quickly</i>	85.85%
<i>How Well Doctors Communicate</i>	91.32%
<i>Customer Service</i>	86.53%

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

Cells highlighted in orange represent rates that are statistically significantly higher than the 2023 NCQA national Medicaid averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2023 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

Aetna's 2024 general child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	Aetna's 2024 top-box scores were not statistically significantly higher than the 2023 NCQA general child Medicaid national averages for any measure; therefore, no strengths were identified.
Weaknesses and Recommendations	
	Weakness: Aetna's 2024 top-box score was statistically significantly lower than the 2023 NCQA general child Medicaid national average for <i>How Well Doctors Communicate</i>. Recommendations: HSAG recommends that Aetna include rating information from the CAHPS survey to emphasize patient-centered communication in provider communications throughout the year. HSAG also recommends that Aetna conduct a root cause analysis of the study indicator that has been identified as an area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG recommends that Aetna continue to monitor the measure to ensure a significant decrease in the score over time does not continue to occur.

HealthKeepers

Table 10-3 and Table 10-4 present HealthKeepers' 2024 MCO-specific adult and general child Medicaid CAHPS top-box scores, respectively, for the global ratings and composite measures. In addition, the 2024 CAHPS scores were compared to the 2023 NCQA adult and general child Medicaid national averages.

Table 10-3—Comparison of 2024 Adult Medicaid CAHPS Results: HealthKeepers

	2024
Global Ratings	
Rating of Health Plan	65.67%
Rating of All Health Care	58.59%
Rating of Personal Doctor	69.54%
Rating of Specialist Seen Most Often	65.00% ⁺
Composite Measures	
Getting Needed Care	78.69%
Getting Care Quickly	79.54% ⁺
How Well Doctors Communicate	91.72%
Customer Service	85.75% ⁺

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

Cells highlighted in orange represent rates that are statistically significantly higher than the 2023 NCQA national Medicaid averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2023 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

HealthKeepers' 2024 adult Medicaid CAHPS scores were compared for statistically significant differences, and there were no differences observed.

Strengths	
	HealthKeepers' 2024 top-box scores were not statistically significantly higher than the 2023 NCQA adult Medicaid national averages for any measure; therefore, no strengths were identified.
Weaknesses and Recommendations	
	Weakness: HealthKeepers' 2024 top-box scores were not statistically significantly lower than the 2023 NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified. Recommendations: HSAG recommends that HealthKeepers monitor the measures to ensure that significant decreases in scores over time do not occur.

Table 10-4—Comparison of 2024 General Child Medicaid CAHPS Results: HealthKeepers

	2024
Global Ratings	
Rating of Health Plan	74.52%
Rating of All Health Care	73.38%

	2024
Rating of Personal Doctor	75.00%
Rating of Specialist Seen Most Often	74.63% ⁺
Composite Measures	
Getting Needed Care	86.32%
Getting Care Quickly	85.75%
How Well Doctors Communicate	94.05%
Customer Service	91.63% ⁺

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

Cells highlighted in orange represent rates that are statistically significantly higher than the 2023 NCQA national Medicaid averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2023 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

HealthKeepers' 2024 general child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	HealthKeepers' 2024 top-box scores were not statistically significantly higher than the NCQA general child Medicaid national averages for any measure; therefore, no strengths were identified.
Weaknesses and Recommendations	
	Weakness: HealthKeepers' 2024 top-box scores were not statistically significantly lower than 2023 NCQA general child Medicaid national averages for any measure; therefore, no weaknesses were identified. Recommendations: HSAG recommends that HealthKeepers monitor the measures to ensure that significant decreases in scores over time do not occur.

Molina

Table 10-5 and Table 10-6 present Molina's 2024 MCO-specific adult and general child Medicaid CAHPS top-box scores, respectively, for the global ratings and composite measures. In addition, the 2024 CAHPS scores were compared to the 2023 NCQA adult and general child Medicaid national averages.

Table 10-5—Comparison of 2024 Adult Medicaid CAHPS Results: Molina

	2024
Global Ratings	
<i>Rating of Health Plan</i>	67.16%
<i>Rating of All Health Care</i>	57.69%
<i>Rating of Personal Doctor</i>	75.39%
<i>Rating of Specialist Seen Most Often</i>	66.67%
Composite Measures	
<i>Getting Needed Care</i>	78.02%
<i>Getting Care Quickly</i>	79.07%
<i>How Well Doctors Communicate</i>	94.43%
<i>Customer Service</i>	89.76%

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

Cells highlighted in orange represent rates that are statistically significantly higher than the 2023 NCQA national Medicaid averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2023 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

Molina's 2024 adult Medicaid CAHPS scores were compared for statistically significant differences and there were no differences observed.

Strengths	
	Molina's 2024 top-box scores were statistically significantly higher than the 2023 NCQA adult Medicaid national averages for <i>Rating of Health Plan</i> and <i>Rating of Personal Doctor</i> .
Weaknesses and Recommendations	
	Weakness: Molina's 2024 top-box scores were not statistically significantly lower than the 2023 NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified. Recommendations: HSAG recommends that Molina monitor the measures to ensure that significant decreases in scores over time do not occur.

Table 10-6—Comparison of 2024 General Child Medicaid CAHPS Results: Molina

	2024
Global Ratings	
<i>Rating of Health Plan</i>	71.27%

	2024
Rating of All Health Care	66.98%
Rating of Personal Doctor	72.46%
Rating of Specialist Seen Most Often	73.68% ⁺
Composite Measures	
Getting Needed Care	81.77% ⁺
Getting Care Quickly	79.63% ⁺
How Well Doctors Communicate	89.24%
Customer Service	86.40% ⁺

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

Cells highlighted in orange represent rates that are statistically significantly higher than the 2023 NCQA national Medicaid averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2023 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

Molina's 2024 general child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	Molina's 2024 top-box scores were not statistically significantly higher than the 2023 NCQA general child Medicaid national averages for any measure; therefore, no strengths were identified.
Weaknesses and Recommendations	
	Weakness: Molina's 2024 top-box score was statistically significantly lower than the 2023 NCQA general child Medicaid national average for <i>How Well Doctors Communicate</i>. Recommendations: HSAG recommends that Molina include rating information from the CAHPS survey to emphasize patient-centered communication in provider communications throughout the year. HSAG also recommends that Molina conduct root cause analyses of the study indicators that have been identified as areas of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG recommends that Molina continue to monitor the measures to ensure that significant decreases in scores over time do not continue to occur.

Sentara

Table 10-7 and Table 10-8 present Sentara's 2024 MCO-specific adult and general child Medicaid CAHPS top-box scores, respectively, for the global ratings and composite measures. The 2024 CAHPS scores were compared to the 2023 NCQA adult and general child Medicaid national averages.

Table 10-7—Comparison of 2024 Adult Medicaid CAHPS Results: Sentara

	2024
Global Ratings	
<i>Rating of Health Plan</i>	59.90%
<i>Rating of All Health Care</i>	61.76%
<i>Rating of Personal Doctor</i>	75.80%
<i>Rating of Specialist Seen Most Often</i>	75.00%
Composite Measures	
<i>Getting Needed Care</i>	85.97%
<i>Getting Care Quickly</i>	83.55% ⁺
<i>How Well Doctors Communicate</i>	93.03%
<i>Customer Service</i>	90.52% ⁺

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

Cells highlighted in orange represent rates that are statistically significantly higher than the 2023 NCQA national Medicaid averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2023 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

Sentara's 2024 adult Medicaid CAHPS scores were compared for statistically significant differences and there were no differences observed.

Strengths	
	Sentara's 2024 top-box scores were statistically significantly higher than the 2023 NCQA adult Medicaid national averages for three measures: <i>Rating of Personal Doctor</i> , <i>Rating of Specialist Seen Most Often</i> , and <i>Getting Needed Care</i> .
Weaknesses and Recommendations	
	Weakness: Sentara's 2024 top-box scores were not statistically significantly lower than the 2023 NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified. Recommendations: HSAG recommends that Sentara monitor the measures to ensure that significant decreases in scores over time do not occur.

Table 10-8—Comparison of 2024 General Child Medicaid CAHPS Results: Sentara

	2024
Global Ratings	
Rating of Health Plan	72.19%
Rating of All Health Care	73.47% ⁺
Rating of Personal Doctor	79.26%
Rating of Specialist Seen Most Often	73.33% ⁺
Composite Measures	
Getting Needed Care	77.35% ⁺
Getting Care Quickly	84.43% ⁺
How Well Doctors Communicate	95.94% ⁺
Customer Service	87.11% ⁺

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

Cells highlighted in orange represent rates that are statistically significantly higher than the 2023 NCQA national Medicaid averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2023 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

Sentara's 2024 general child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	Sentara's 2024 top-box scores were not statistically significantly higher than the 2023 NCQA general child Medicaid national averages for any measure; therefore, no strengths were identified.
Weaknesses and Recommendations	
	Weakness: Sentara's 2024 top-box scores were not statistically significantly lower than the 2023 NCQA general child Medicaid national averages for any measure; therefore, no weaknesses were identified. Recommendations: HSAG recommends that Sentara monitor the measures to ensure that significant decreases in scores over time do not occur.

United

Table 10-9 and Table 10-10 present United's 2024 MCO-specific adult and general child Medicaid CAHPS top-box scores, respectively, for the global ratings and composite measures. In addition, the 2024 CAHPS scores were compared to the 2023 NCQA adult and general child Medicaid national averages.

Table 10-9—Comparison of 2024 Adult Medicaid CAHPS Results: United

	2024
Global Ratings	
Rating of Health Plan	56.86%
Rating of All Health Care	55.37%
Rating of Personal Doctor	62.24%
Rating of Specialist Seen Most Often	69.05% ⁺
Composite Measures	
Getting Needed Care	75.23%
Getting Care Quickly	78.60% ⁺
How Well Doctors Communicate	90.99%
Customer Service	82.98% ⁺

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

Cells highlighted in orange represent rates that are statistically significantly higher than the 2023 NCQA national Medicaid averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2023 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

United's 2024 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	United's 2024 top-box scores were not statistically significantly higher than the 2023 NCQA adult Medicaid national averages for any measure; therefore, no strengths were identified.
Weaknesses and Recommendations	
	Weakness: United's 2024 top-box scores were not statistically significantly lower than the 2023 NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified. Recommendations: HSAG recommends that United monitor the measures to ensure that significant decreases in scores over time do not occur.

Table 10-10—Comparison of 2024 General Child Medicaid CAHPS Results: United

	2024
Global Ratings	
Rating of Health Plan	72.28%

	2024
Rating of All Health Care	71.57%
Rating of Personal Doctor	72.06%
Rating of Specialist Seen Most Often	67.86% ⁺
Composite Measures	
Getting Needed Care	73.07% ⁺
Getting Care Quickly	81.14% ⁺
How Well Doctors Communicate	91.31% ⁺
Customer Service	77.25% ⁺

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

Cells highlighted in orange represent rates that are statistically significantly higher than the 2023 NCQA national Medicaid averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2023 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

United's 2024 general child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	United's 2024 top-box scores were not statistically significantly higher than the 2023 NCQA general child Medicaid national averages for any measure; therefore, no strengths were identified.
Weaknesses and Recommendations	
	Weakness: United's 2024 top-box scores were statistically significantly lower than the 2023 NCQA general child Medicaid national average for <i>Getting Needed Care</i> and <i>Customer Service</i>. Recommendations: HSAG recommends that United evaluate the process of care delivery to identify whether there are any operational issues contributing to access to care for members as well as identify and resolve dissatisfaction in customer and clinical services by addressing and providing solutions to customer service complaints. HSAG also recommends that United conduct root cause analyses of the study indicators that have been identified as areas of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG recommends that United continue to monitor the measures to ensure that significant decreases in scores over time do not continue to occur.

11. ARTS Measurement Specification and Reporting

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.⁴⁸ 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.⁴⁹ HSAG, in conjunction with DMAS, developed PMs using administrative data for the evaluation of DMAS’ ARTS benefit. The 2023 ARTS Measure Report presented the CY 2020, CY 2021, and CY 2022 ARTS measure rates for the eight measures described in Table 11-1.

Table 11-1—ARTS Measures

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

⁴⁸ Virginia DMAS. Addiction and Recovery Treatment Services (ARTS). Available at: <https://www.dmas.virginia.gov/providers/addiction-and-recovery-treatment-services>. Accessed on: Jan 8, 2025.

⁴⁹ 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: Jan 8, 2025.

Measure and Indicators

Cascade of Care for Members With HIV—Received HIV Care, Retained in HIV Care, and Received Antiretroviral Therapy

Findings

Table 11-2 presents the Virginia Medicaid total denominators (displayed as Denom) and rates for all study indicators for CY 2020, CY 2021, and CY 2022. 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, CY 2021, and CY 2022

Measure	CY 2020		CY 2021		CY 2022	
	Denom	Rate	Denom	Rate	Denom	Rate
Concurrent Prescribing of Naloxone and High-Dose Opioids						
<i>Concurrent Prescribing of Naloxone and High-Dose Opioids</i>	3,404	49.9%	3,306	51.4%	3,295	54.8%
Naloxone Use for High Risk of Overdose						
<i>Naloxone Use for Diagnosed Opioid Use Disorder</i>	26,263	35.1%	38,510	39.2%	46,784	42.3%
<i>Naloxone Use for History of Chronic Opioid Use</i>	2,663	66.6%	2,293	68.0%	2,211	71.7%
<i>Naloxone Use for Concurrent Benzodiazepine and Opioid Use</i>	3,140	57.5%	2,851	58.3%	2,743	60.3%
<i>Naloxone Use for History of Overdose</i>	1,956	37.6%	2,397	43.7%	2,293	46.7%
Treatment of Hepatitis C for Those With Hepatitis C and SUD						
<i>Treatment of Hepatitis C for Those With Hepatitis C and SUD</i>	3,809	29.1%	4,420	31.9%	4,709	33.2%
Treatment of HIV for Those With HIV and SUD						
<i>Treatment of HIV for Those With HIV and SUD</i>	1,104	64.9%	1,303	62.5%	1,362	62.7%
Preferred OBAT Compliance						
<i>Alcohol or Drug Screening: 8+ Screenings</i>	9,492	55.0%	12,788	69.6%	15,582	69.7%
<i>Counseling from an OBAT Provider</i>	9,492	94.2%	12,788	91.0%	15,582	89.6%
<i>Family Planning</i>	4,004	42.6%	5,220	44.1%	6,070	45.0%
<i>Prescription for Naloxone from OBAT Provider</i>	9,492	36.7%	12,788	37.6%	15,582	35.3%
<i>Prescription for Naloxone</i>	9,492	51.1%	12,788	54.4%	15,582	58.0%

Measure	CY 2020		CY 2021		CY 2022	
	Denom	Rate	Denom	Rate	Denom	Rate
Testing for HIV/Hepatitis C	9,492	20.8%	12,788	23.2%	15,582	31.0%
Initiation of Medication for OUD	9,492	20.6%	12,788	19.3%	15,582	22.4%
Concurrent Pharmacotherapy and Care Coordination	9,492	16.9%	12,788	15.4%	15,582	19.3%
RPR Testing	9,492	1.3%	12,788	1.5%	15,582	4.4%
TB Testing	9,492	3.3%	12,788	4.9%	15,582	5.0%
Cascade of Care for Members With OUD						
High-Risk Members With OUD Diagnosis	67,799	3.8%	87,229	5.1%	106,188	5.6%
Members Identified as Having OUD Who Initiated OUD Treatment: Pharmacotherapy	2,565	25.0%	4,485	31.2%	5,911	34.2%
Members Identified as Having OUD Who Initiated OUD Treatment: Other OUD Treatment	2,565	25.9%	4,485	25.8%	5,911	29.3%
Members Identified as Having OUD Who Initiated OUD Treatment: Both Pharmacotherapy and Other Treatment	2,565	11.4%	4,485	12.8%	5,911	15.1%
Members Who Initiated OUD Treatment Who Also Engaged in OUD Treatment	1,013	49.4%	1,983	40.7%	2,857	40.5%
Cascade of Care for Members With Hepatitis C						
Prevalence of Hepatitis C	873,579	0.2%	1,073,812	0.2%	1,228,543	0.2%
Received DAA Treatment for Hepatitis C	1,842	38.3%	1,871	46.1%	1,952	39.8%
Completed DAA Treatment for Hepatitis C	705	90.8%	862	91.3%	777	89.8%
Achieved SVR*	705	40.1%	862	42.8%	777	40.5%
Cascade of Care for Members With HIV						
Received HIV Care	4,938	41.3%	6,213	37.3%	7,198	36.6%
Retained in HIV Care	4,938	68.2%	6,213	66.1%	7,198	62.9%
Received Antiretroviral Therapy	4,938	63.9%	6,213	68.9%	7,198	68.6%

*As part of the SFY 2023–24 study, HSAG updated the specifications for this indicator and recalculated historical rates for trending. HSAG included the recalculated historical rates in this table to align with the rates presented in the SFY 2023–24 study; however, these rates will not align with the SFY 2022–23 study.

Conclusions

Study findings show that identification of members with SUD continued to improve, 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 5.1 percent to 5.6 percent from CY 2021 to CY 2022. However, this rate had previously increased from 3.8 percent to 5.1 percent from CY 2020 to CY 2021, indicating that improvement has slowed. Additionally, NIH reported that substance use has increased since the onset of the COVID-19 PHE,⁵⁰ so these findings may also reflect an increased incidence of SUD.

Several study indicators found that initiation of SUD treatment increased for every relevant indicator except *Preferred OBAT Compliance—Counseling From an OBAT Provider*. For example, 48.3 percent of members diagnosed with OUD initiated any OUD treatment (i.e., pharmacotherapy or other treatment) within 14 days of OUD diagnosis in CY 2022, and this rate increased by 4.0 percentage points from CY 2021 and by 9.0 percentage points from CY 2020. The rate change from CY 2020 to CY 2021 was driven by an increase in members initiating pharmacotherapy (by 6.2 percentage points), while the rate change from CY 2021 to CY 2022 was driven by increases in both pharmacotherapy and other OUD treatment initiation (by 3.0 and 3.5 percentage points, respectively). Among members who had an initiation visit with an OBAT provider, receipt of OUD medication within seven days of MAT initiation increased by 3.1 percentage points to 22.4 percent, and receipt of care coordination within 30 days of MAT initiation increased by 3.9 percentage points to 19.3 percent from CY 2021 to CY 2022. However, since CY 2020 the percentage of members receiving counseling from an OBAT provider following their initial visit declined by 4.6 percentage points. 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 was stable from CY 2021 to CY 2022 but remained notably lower than in CY 2020. For the *Cascade of Care for Members With OUD—Members Who Initiated OUD Treatment Who Also Engaged in OUD Treatment* indicator, 40.5 percent of members who had initiated OUD treatment engaged in OUD treatment for six months following OUD diagnosis during CY 2022, and this rate was 40.7 percent during CY 2021. However, for CY 2020, the rate was 49.4 percent, indicating an opportunity for improvement in engagement.

Seven study indicators assessed the receipt of naloxone, a medication to reverse opioid overdose, which can help reduce overdose deaths. Prescribing of naloxone improved in CY 2022 for six out of seven indicators, in alignment with ARTS benefit goals. These indicators suggest that most members who were receiving opioids through the healthcare system were receiving naloxone. In CY 2022, 54.8 percent of members prescribed high-dose opioids received naloxone, and since CY 2020 this rate has increased by 4.9 percentage points. Additionally, 71.7 and 60.3 percent of members with a history of chronic opioid use and concurrent benzodiazepine and opioid use, respectively, received naloxone, and these rates have increased since CY 2020 by 5.1 and 2.8 percentage points, respectively. However, naloxone receipt was notably lower among other members at high risk of overdose. Only 42.3 percent of members diagnosed with OUD received naloxone. Additionally, only 46.7 percent of members with a history of overdose received naloxone. However, rates of naloxone receipt for members diagnosed with OUD and members with a history of overdose have increased since CY 2020 by 7.2 and 9.1 percentage points, respectively. The rate of naloxone receipt among members receiving OBAT services was substantially higher at 58.0 percent, but still low compared to the rate for members receiving opioids through the healthcare system. However, the percentage of members receiving OBAT services who received naloxone from an OBAT provider declined by 2.3 percentage points from CY 2021 to CY

⁵⁰ 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: Jan 8, 2025.

2022, to 35.3 percent. DMAS requires OTPs and OBAT providers to co-prescribe naloxone with medication for OUD,⁵¹ and rates of naloxone receipt were generally higher than rates of pharmacotherapy. However, there may still be room for improvement given that all members included in the denominators for these indicators are at high risk of overdose.

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 show that rates for initiation of care were low and continuing to decrease, but rates for retention in care remained high. Rates of treatment for members with and without an SUD diagnosis were similar, indicating that SUD diagnosis is not a barrier to care. Additionally, most rates related to care for physical health conditions improved in CY 2022. Among members with SUD, 33.2 percent of members diagnosed with hepatitis C initiated antiviral therapy for hepatitis C, and since CY 2020 this rate has increased by 4.1 percentage points. Additionally, 62.7 percent of members diagnosed with HIV were dispensed an antiretroviral therapy medication within 30 days of their first HIV diagnosis; however, this rate declined by 2.4 percentage points from CY 2020 to CY 2021 and then remained stable from CY 2021 to CY 2022. In CY 2022, 89.8 percent of members who received DAA treatment completed it; however, only 39.8 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 2021 and CY 2022, the rate of initiating DAA treatment and achieving SVR declined by 6.3 and 2.3 percentage points, respectively, from CY 2021 to CY 2022. Among members diagnosed with HIV, only 36.6 percent received HIV care within 30 days of diagnosis, and since CY 2020 this rate has declined by 4.7 percentage points. Of the 36.6 percent of members who received HIV care, 62.9 percent were retained in HIV care for at least three months, and 68.6 percent received antiretroviral therapy within three months of their initial HIV diagnosis. Since CY 2020 the rate of members retained in HIV care for at least three months has also declined by 5.3 percentage points. Rates for members newly diagnosed with HIV were consistently lower than rates for members with chronic HIV.

Ten study indicators evaluated compliance with DMAS' requirements for OBAT providers. These indicators found that compliance greatly varied depending on the type of service. For example, all members receiving SUD treatment services from an OBAT provider must undergo random drug screenings at a minimum of eight times per year.⁵² The results of the *Preferred OBAT Compliance—Alcohol or Drug Screenings* indicator found that 69.7 percent of members received eight or more alcohol or drug screenings during CY 2022 after their initial visit with an OBAT provider, and another 17.7 percent of members received four to seven screenings. OBAT providers are also required to provide on-site screening or referral for screening for HIV and hepatitis C at initiation of care and then at least annually after that.⁵³ For the *Preferred OBAT Compliance—Testing for HIV/Hepatitis C* indicator, 31.0 percent of members who initiated SUD treatment with an OBAT provider received HIV or hepatitis C testing. OBAT providers have similar testing requirements for syphilis and TB; however, only 4.4 and 5.0 percent of members, respectively, received the expected tests. Missing lab data may have partially contributed to these low rates. Among the 10 study indicators evaluating compliance with OBAT provider requirements, five rates increased, four rates were similar, and one rate decreased from CY 2021 to CY 2022, indicating that compliance is generally improving or stable.

⁵¹ Virginia Department of Medical Assistance Services. Addiction Treatment Services / Medication Assisted Treatment Supplement. Available at: https://vamedicaid.dmas.virginia.gov/sites/default/files/2023-08/Opioid%20Treatment%20Services%20Supplement%20%28updated%208.2.23_Final.pdf. Accessed on: Jan 8, 2025.

⁵² Ibid.

⁵³ Ibid.

In addition to the total Virginia Medicaid rates, the 2023 ARTS Measure Report evaluated PM rates stratified by demographics, region, delivery system, eligibility group, managed care program, and MCO. Among rates stratified by age, members 12 to 21 years of age who were receiving high-dose opioids or who were at high risk of overdose were less likely to receive naloxone compared to members in other age categories, except for members who initiated care with an OBAT provider. Members 12 to 21 years of age receiving SUD treatment from an OBAT provider had a similar or higher rate compared to other age categories for *Prescription for Naloxone from OBAT Provider* and *Prescription for Naloxone*, respectively. Among members with an OUD diagnosis, members 12 to 21 years of age were also less likely to initiate pharmacotherapy or other OUD treatment in a timely manner, and were less likely to stay engaged in treatment. However, members 12 to 21 years of age receiving SUD treatment from an OBAT provider had the highest rate of timely initiation of medication for OUD among the age groups. Additionally, members 65 years of age or older were consistently less likely to initiate or be retained in hepatitis C and HIV care, and they were less likely to receive the expected services from OBAT providers. However, some of the services may not be completely captured in administrative data, since the Medicare-Medicaid crossover claims/encounters did not include Medicare Part C or Part D (e.g., prescriptions). Rates for male and female members were generally similar.

Rate differences among racial/ethnic groups varied across study indicators; however, rates for Asian members and Black/African American members tended to be lower than other racial/ethnic groups. Asian members prescribed high-dose opioids or with diagnosed OUD were less likely to receive naloxone than other racial/ethnic groups, and Asian members at high risk of OUD were least likely to be diagnosed with OUD. Additionally, Asian members were least likely to initiate and engage in HIV care. Among those with SUD, Black/African American members with hepatitis C or HIV were less likely to receive treatment for hepatitis C. Additionally, Black/African American members were less likely to initiate pharmacotherapy or other OUD treatment in a timely manner.

By region, 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 continued to have the highest rate of hepatitis C diagnoses. However, while the Southwest region also had the lowest rate for initiation of DAA treatment in CY 2021, this rate greatly improved in CY 2022. The Southwest region had the lowest rates for several other indicators for the *Cascade of Care for Members with OUD* measure during CY 2022 however, such as *High-Risk Members with OUD Diagnosis* and *Members Identified as Having OUD Who Initiated OUD Treatment: Both Pharmacotherapy and Other Treatment*.

Study indicator rates by delivery system varied, since the denominator for FFS members was typically small. However, FFS members had lower rates than managed care members for 89 percent of study indicators with sufficient denominator size for comparison. Many study indicators had large increases in their denominators driven by an increase in Medicaid Expansion members from CY 2020 to CY 2022, and this increase in Medicaid Expansion sometimes drove overall changes in rates. Also of note, dual eligible members were consistently less likely to initiate treatment for hepatitis C and HIV; however, this finding may reflect medications billed to Medicare or received in institutionalized settings, such as SNFs, not being captured in Medicaid administrative data.

For the MCOs, the rates for United were at least 10 percent lower than the Virginia Medicaid total population for 33.3 percent of indicators with sufficient denominator size for comparison, including the *Received DAA Treatment for Hepatitis C*, *Completed DAA Treatment for Hepatitis C*, *Members Identified as Having OUD Who Initiated OUD Treatment: Other OUD Treatment*, *Treatment of Hepatitis C for Those With Hepatitis C and SUD*, and *Treatment of HIV for Those With HIV and SUD* indicators.

Additionally, Molina had the highest rate of OUD diagnoses, yet it had the lowest rates for initiation of pharmacotherapy and engagement in OUD treatment.

Study Limitations

Study findings and conclusions may be affected by limitations related to the study design and source data. As such, caveats include, but are not limited to, the following:

- Study indicator results and the accuracy of demographic characteristics (e.g., region, MCO) may be influenced by the accuracy and timeliness of the administrative claims and encounter data used for calculations and must be interpreted within the broader context of the population. Furthermore, some services may not be captured well in administrative claims and encounter data, such as services covered by Medicare Part C and Part D for dually enrolled members, some counseling services, and medications provided in institutionalized settings (e.g., skilled nursing facilities). The administrative claims and encounter data also did not include denied pharmacy encounters. Therefore, study indicators that allow pharmacy claims/encounters to be either paid or denied may underestimate rates of actual utilization.
- Results for laboratory tests were often missing from the administrative data. For example, laboratory test results were not available for approximately 16 percent of members in the CY 2022 denominator for the *Cascade of Care for Members With Hepatitis C—Achieved SVR* study indicator; therefore, rates for this indicator may underestimate the percentage of members with hepatitis C who had initiated DAA treatment who achieved SVR. Additionally, the study could not assess other treatment outcomes, such as the percentage of members receiving HIV care who achieved viral load suppression.
- Several study indicators assessed the prescribing of naloxone, and these PMs rely on Medicaid pharmacy claims data. However, the Commonwealth of Virginia has a standing order to allow pharmacists to dispense naloxone without a prescription from a doctor. If members paid out of pocket at a pharmacy for naloxone, without submitting health insurance information, then these naloxone prescriptions would not be captured in the Medicaid administrative data. However, the out-of-pocket cost ranges from \$70 to \$150, and Virginia Medicaid covers naloxone at no cost to members.⁵⁴ Therefore, most members may still be motivated to submit health insurance information in these scenarios.
- Several study indicators utilize claims and encounter data prior to the period when the member must be continuously enrolled in Virginia Medicaid. For example, since naloxone has a shelf life of up to three years, the study indicators assessing prescribing of naloxone allow claims/encounters for naloxone up to three years prior to the measurement year, though the members in the denominator are not required to be continuously enrolled in Virginia Medicaid for that entire look-back period. Members are not required to be continuously enrolled for the entire look-back period because long continuous enrollment periods reduce the generalizability of the study indicator findings. Therefore, study indicators that utilize claims/encounters outside of the continuous enrollment period to assess an event may underestimate that event, if some of the events occurred while the member was not enrolled in Virginia Medicaid (i.e., the event will not be captured in the Virginia Medicaid administrative data).

⁵⁴ Virginia Department of Health. Frequently Asked Questions about Naloxone. Available at: <https://www.vdh.virginia.gov/content/uploads/sites/3/2019/09/Naloxone-FAQ-General-Public.pdf>. Accessed on: Jan 8, 2025.

- CY 2020, CY 2021, and CY 2022 findings may be impacted by the COVID-19 PHE. Therefore, HSAG recommends exercising caution when interpreting findings for these measurement years.
- Four study indicators assessed receipt of OUD treatment services from OBOT providers, since historically these providers were only reimbursed for services related to OUD. However, DMAS expanded coverage to allow other primary SUDs effective March 1, 2022, and subsequently renamed OBOT providers to OBAT providers.⁵⁵ Therefore, some members who met the denominator criteria for any Substance Use Care Coordination event for the *Preferred OBAT Compliance—Prescription for Naloxone From OBAT Provider*, *Preferred OBAT Compliance—Prescription for Naloxone*, *Preferred OBAT Compliance—Initiation of Medication for OUD*, and *Preferred OBAT Compliance—Concurrent Pharmacotherapy and Care Coordination* indicators may not have had an OUD diagnosis, and the OUD treatment services required for numerator compliance would not be appropriate for those members. However, the CY 2022 rates were generally consistent with CY 2021 rates, indicating that the impact of this change was minor.
- For the 2023 ARTS Measure Report, HSAG calculated CY 2022 rates and recalculated CY 2020 and CY 2021 rates with updated logic for identifying denied encounters. Therefore, CY 2020 and CY 2021 rates and denominators may differ from those previously reported in the *2022 ARTS Measure Report*. Measures requiring paid pharmacy claims/encounters (e.g., *Preferred OBAT Compliance—Prescription for Naloxone* and *Cascade of Care for Members With Hepatitis C—Received DAA Treatment for Hepatitis C*) changed the most; however, the conclusions regarding CY 2020 and CY 2021 results from the *2022 ARTS Measure Report* were not impacted by these changes.

⁵⁵ Virginia Department of Medical Assistance Services. Preferred Office-Based Addiction Treatment Manual Updates: April 2022. Available at: <https://www.dmas.virginia.gov/media/4590/obat-manual-2022-new-updates.pdf>. Accessed on: Jan 8, 2025.

12. Focus Studies

Overview

Medicaid and CHIP Maternal and Child Health Focus Study

The contract year 2022–23 Medicaid and CHIP Maternal and Child Health Focus Study addressed the following 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., prenatal and postpartum depression, emergency department [ED] utilization, postpartum contraceptive care) are associated with births paid by Virginia Medicaid?
- What health disparities exist in birth and maternal health outcomes for births paid by Virginia Medicaid?

HSAG calculated the following birth outcomes study indicators to assess the study questions for all singleton, live births paid by Virginia Medicaid during CY 2022:

- ***Births With Early and Adequate Prenatal Care***—The percentage of births with an Adequacy of Prenatal Care Utilization (APNCU) Index (i.e., the Kotelchuck Index) score greater than or equal to 80 percent (i.e., women who received at least 80 percent of expected prenatal visits).
- ***Births With Inadequate Prenatal Care***—The percentage of births with an APNCU Index score of less than 50 percent (i.e., women who received less than 50 percent of expected prenatal care visits).
- ***Births With No Prenatal Care***—The percentage of births with no prenatal care.
- ***Preterm Births (<37 Weeks Gestation)***—The percentage of births before 37 completed weeks of gestation.
- ***Newborns With Low Birth Weight (<2,500 grams)***—The percentage of newborns with birth weights less than 2,500 grams. This includes birth weights in the very low birth weight category (i.e., birth weights less than 1,500 grams) and the low birth weight category (i.e., birth weights between 1,500 and 2,499 grams).

Additionally, HSAG calculated the following maternal health outcomes study indicators to assess the study questions for all singleton, live births paid by Virginia Medicaid during CY 2022:

- ***Postpartum ED Utilization***—The percentage of postpartum women who utilized ED services within 90 days of delivery.
- ***Postpartum Ambulatory Care Utilization***—The percentage of postpartum women who utilized ambulatory care services within 90 days of delivery.

- **Prenatal Maternal Depression Screening**—The percentage of women who received a screening for depression during pregnancy.
- **Postpartum Maternal Depression Screening**—The percentage of postpartum women who received a screening for depression on or between seven and 84 days after delivery.
- **Utilization of Contraceptive Care for Postpartum Women**—The percentage of women who received a most or moderately effective contraceptive (MMEC) or a long-acting reversible contraceptive (LARC) within three and 90 days of delivery.

Study results included all live births paid by Virginia Medicaid, which were assigned to one of five Medicaid programs (i.e., Medicaid for Pregnant Women, Medicaid Expansion, FAMIS MOMS, FAMIS Prenatal Coverage, or Other Aid Categories). 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 2020, CY 2021, and CY 2022).

Table 12-1—Overall Birth Outcomes Study Indicator Findings Among Singleton Births by Medicaid Delivery System, CY 2020–CY 2022

Study Indicator	National Benchmark	CY 2020		CY 2021		CY 2022	
		Number	Percent	Number	Percent	Number	Percent
FFS							
Births With Early and Adequate Prenatal Care	76.4%	1,881	64.8%	2,320	60.2%	1,980	61.0%
<i>Births With Inadequate Prenatal Care*</i>	NA	562	19.4%	962	24.9%	715	22.0%
<i>Births With No Prenatal Care*</i>	NA	117	4.0%	176	4.6%	216	6.7%
Preterm Births (<37 Weeks Gestation)*	9.4%	334	11.0%	413	10.5%	359	10.9%
Newborns With Low Birth Weight (<2,500 grams)*	10.1%	280	9.3%	338	8.6%	313	9.5%
Managed Care							
Births With Early and Adequate Prenatal Care	76.4%	20,364	72.7%	21,460	74.3%	23,555	73.2%
<i>Births With Inadequate Prenatal Care*</i>	NA	4,089	14.6%	4,144	14.4%	4,739	14.7%
<i>Births With No Prenatal Care*</i>	NA	417	1.5%	509	1.8%	856	2.7%

Study Indicator	National Benchmark	CY 2020		CY 2021		CY 2022	
		Number	Percent	Number	Percent	Number	Percent
Preterm Births (<37 Weeks Gestation)*	9.4%	2,834	9.7%	2,914	10.0%	3,087	9.5%
Newborns With Low Birth Weight (<2,500 grams)*	10.1%	2,699	9.2%	2,736	9.4%	2,966	9.1%

*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 2022 for all study indicators. The FFS and managed care rates for the *Newborns With Low Birth Weight (<2,500 grams)* study indicator outperformed the national benchmark for all three measurement periods.

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 2020–CY 2022

Study Indicator	National Benchmark	CY 2020		CY 2021		CY 2022	
		Number	Percent	Number	Percent	Number	Percent
Medicaid for Pregnant Women							
Births With Early and Adequate Prenatal Care	76.4%	13,737	72.4%	11,493	73.9%	9,639	74.3%
<i>Births With Inadequate Prenatal Care*</i>	NA	2,839	15.0%	2,337	15.0%	1,899	14.6%
<i>Births With No Prenatal Care*</i>	NA	241	1.3%	239	1.5%	283	2.2%
Preterm Births (<37 Weeks Gestation)*	9.4%	1,750	8.9%	1,460	9.3%	1,139	8.7%
Newborns With Low Birth Weight (<2,500 grams)*	10.1%	1,699	8.6%	1,333	8.5%	1,153	8.8%
Medicaid Expansion							
Births With Early and Adequate Prenatal Care	76.4%	3,249	73.8%	5,031	77.5%	6,097	77.7%
<i>Births With Inadequate Prenatal Care*</i>	NA	578	13.1%	722	11.1%	854	10.9%

Study Indicator	National Benchmark	CY 2020		CY 2021		CY 2022	
		Number	Percent	Number	Percent	Number	Percent
<i>Births With No Prenatal Care*</i>	NA	90	2.0%	154	2.4%	183	2.3%
Preterm Births (<37 Weeks Gestation)*	9.4%	544	11.9%	733	11.2%	842	10.6%
Newborns With Low Birth Weight (<2,500 grams)*	10.1%	463	10.1%	707	10.8%	798	10.0%
FAMIS MOMS							
Births With Early and Adequate Prenatal Care	76.4%	1,564	76.8%	1,382	78.1%	1,391	77.4%
<i>Births With Inadequate Prenatal Care*</i>	NA	261	12.8%	219	12.4%	230	12.8%
<i>Births With No Prenatal Care*</i>	NA	11	0.5%	12	0.7%	27	1.5%
Preterm Births (<37 Weeks Gestation)*	9.4%	163	7.8%	161	9.0%	150	8.3%
Newborns With Low Birth Weight (<2,500 grams)*	10.1%	150	7.2%	145	8.1%	137	7.5%
FAMIS Prenatal Coverage							
Births With Early and Adequate Prenatal Care	76.4%	—	—	977	49.3%	2,791	58.0%
<i>Births With Inadequate Prenatal Care*</i>	NA	—	—	736	37.1%	1,243	25.8%
<i>Births With No Prenatal Care*</i>	NA	—	—	69	3.5%	276	5.7%
Preterm Births (<37 Weeks Gestation)*	9.4%	—	—	163	8.1%	370	7.6%
Newborns With Low Birth Weight (<2,500 grams)*	10.1%	—	—	123	6.1%	309	6.3%
Other Aid Categories†							
Births With Early and Adequate Prenatal Care	76.4%	3,695	66.9%	4,897	70.6%	5,617	70.4%

Study Indicator	National Benchmark	CY 2020		CY 2021		CY 2022	
		Number	Percent	Number	Percent	Number	Percent
<i>Births With Inadequate Prenatal Care*</i>	NA	973	17.6%	1,092	15.7%	1,228	15.4%
<i>Births With No Prenatal Care*</i>	NA	192	3.5%	211	3.0%	303	3.8%
Preterm Births (<37 Weeks Gestation)*	9.4%	711	12.3%	810	11.6%	945	11.7%
Newborns With Low Birth Weight (<2,500 grams)*	10.1%	667	11.5%	766	10.9%	882	10.9%

* a lower rate indicates better performance for this indicator.

— indicates no births to women in FAMIS Prenatal Coverage occurred during CY 2020 given that the program was implemented in July 2021.

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

† Other Aid Categories includes all other births not covered by the Medicaid for Pregnant Women, Medicaid Expansion, FAMIS MOMS, and FAMIS Prenatal Coverage 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 rates for the *Preterm Births (<37 Weeks Gestation)* and *Newborns With Low Birth Weight (<2,500 grams)* study indicators that outperformed the national benchmarks for all three measurement periods, despite having rates for the *Births With Early and Adequate Prenatal Care* study indicator that did not meet the national benchmark. Similarly, the FAMIS Prenatal Coverage program had the lowest rates of *Births With Early and Adequate Prenatal Care*, but had the lowest rates for the *Preterm Births (<37 Weeks Gestation)* and *Newborns With Low Birth Weight (<2,500 grams)* study indicators, which outperformed national benchmarks in CY 2021 and CY 2022. Of note, 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 2021 and CY 2022).

Table 12-3—Overall Maternal Health Outcomes Study Indicator Findings Among Singleton Births by Delivery System, CY 2021–CY 2022

Study Indicator	CY 2021		CY 2022	
	Number	Percent	Number	Percent
FFS				
Postpartum ED Utilization*	316	8.1%	310	9.4%
Postpartum Ambulatory Care Utilization	1,576	40.2%	1,359	41.1%
Prenatal Maternal Depression Screening	15	0.4%	19	0.6%
Postpartum Maternal Depression Screening	113	2.9%	86	2.6%
MMEC Within 3 Days of Delivery	—	—	143	4.3%
MMEC Within 90 Days of Delivery	—	—	610	18.5%
LARC Within 3 Days of Delivery	—	—	73	2.2%
LARC Within 90 Days of Delivery	—	—	251	7.6%
Managed Care				
Postpartum ED Utilization*	4,311	14.8%	5,619	17.2%
Postpartum Ambulatory Care Utilization	15,448	53.1%	19,708	60.5%
Prenatal Maternal Depression Screening	1,623	5.6%	1,913	5.9%
Postpartum Maternal Depression Screening	2,138	7.3%	2,735	8.4%
MMEC Within 3 Days of Delivery	—	—	3,726	11.4%
MMEC Within 90 Days of Delivery	—	—	13,802	42.4%
LARC Within 3 Days of Delivery	—	—	787	2.4%
LARC Within 90 Days of Delivery	—	—	4,389	13.5%

* a lower rate indicates better performance for this indicator.

— indicates the study indicator is new for CY 2022; therefore, rates are not available for CY 2021.

With the exception of the *Postpartum ED Utilization* study indicator, women in managed care had more favorable rates on the maternal health outcomes than women in FFS.

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–CY 2022

Study Indicator	CY 2021		CY 2022	
	Number	Percent	Number	Percent
Medicaid for Pregnant Women				
Postpartum ED Utilization*	2,175	13.9%	2,184	16.6%
Postpartum Ambulatory Care Utilization	8,301	52.9%	7,821	59.5%
Prenatal Maternal Depression Screening	709	4.5%	650	4.9%
Postpartum Maternal Depression Screening	1,147	7.3%	1,106	8.4%
MMEC Within 3 Days of Delivery	—	—	1,229	9.4%
MMEC Within 90 Days of Delivery	—	—	5,082	38.7%
LARC Within 3 Days of Delivery	—	—	247	1.9%
LARC Within 90 Days of Delivery	—	—	1,598	12.2%
Medicaid Expansion				
Postpartum ED Utilization*	905	13.8%	1,400	17.6%
Postpartum Ambulatory Care Utilization	3,265	49.9%	4,655	58.6%
Prenatal Maternal Depression Screening	387	5.9%	512	6.4%
Postpartum Maternal Depression Screening	485	7.4%	691	8.7%
MMEC Within 3 Days of Delivery	—	—	797	10.0%
MMEC Within 90 Days of Delivery	—	—	3,132	39.4%
LARC Within 3 Days of Delivery	—	—	172	2.2%
LARC Within 90 Days of Delivery	—	—	893	11.2%
FAMIS MOMS				
Postpartum ED Utilization*	191	10.7%	218	12.0%
Postpartum Ambulatory Care Utilization	855	47.9%	994	54.7%
Prenatal Maternal Depression Screening	S	S	52	2.9%
Postpartum Maternal Depression Screening	109	6.1%	142	7.8%
MMEC Within 3 Days of Delivery	—	—	128	7.0%
MMEC Within 90 Days of Delivery	—	—	597	32.9%
LARC Within 3 Days of Delivery	—	—	17	0.9%
LARC Within 90 Days of Delivery	—	—	205	11.3%
FAMIS Prenatal Coverage				
Postpartum ED Utilization*	158	7.9%	534	10.9%
Postpartum Ambulatory Care Utilization	888	44.2%	2,806	57.5%
Prenatal Maternal Depression Screening	S	S	84	1.7%

Study Indicator	CY 2021		CY 2022	
	Number	Percent	Number	Percent
Postpartum Maternal Depression Screening	53	2.6%	229	4.7%
MMEC Within 3 Days of Delivery	—	—	786	16.1%
MMEC Within 90 Days of Delivery	—	—	2,314	47.4%
LARC Within 3 Days of Delivery	—	—	169	3.5%
LARC Within 90 Days of Delivery	—	—	898	18.4%
Other Aid Categories[†]				
Postpartum ED Utilization*	1,198	17.1%	1,593	19.7%
Postpartum Ambulatory Care Utilization	3,715	53.0%	4,791	59.1%
Prenatal Maternal Depression Screening	489	7.0%	634	7.8%
Postpartum Maternal Depression Screening	457	6.5%	653	8.1%
MMEC Within 3 Days of Delivery	—	—	929	11.5%
MMEC Within 90 Days of Delivery	—	—	3,287	40.6%
LARC Within 3 Days of Delivery	—	—	255	3.1%
LARC Within 90 Days of Delivery	—	—	1,046	12.9%

* a lower rate indicates better performance for this indicator.

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

— indicates the study indicator is new for CY 2022; therefore, rates are not available for CY 2021.

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 values for the second smallest population were also suppressed, even if the values were 11 or more.

In CY 2022, women in the FAMIS Prenatal Coverage and FAMIS MOMS programs had the most favorable rates for *Postpartum ED Utilization*; however, women in the FAMIS MOMS program had the lowest rates of *Postpartum Ambulatory Care*. As discussed previously, all postpartum ED and ambulatory utilization increased from CY 2021 to CY 2022, which could be the result of utilization returning to pre-pandemic levels in CY 2022.

While women in the FAMIS Prenatal Coverage program had the lowest rates of depression screening, these women had the highest rates for receiving contraceptives. This is likely due to the fact that approximately 90 percent of FAMIS Prenatal Coverage deliveries were to Hispanic, Any Race women, who had significantly lower rates of receiving a depression screening and significantly higher rates of receiving contraceptives. Additionally, women in the FAMIS Prenatal Coverage program are only eligible for postpartum coverage for 60 days postpartum, which may be impacting the rates for this population.

Study Limitations

Study findings and conclusions may be affected by limitations related to the study design and source data. As such, caveats include, but are not limited to, the following:

- Study indicator and stratification results may be influenced by the accuracy and timeliness of the birth registry data and administrative Medicaid eligibility, enrollment, and demographic data used for calculations.
 - Additionally, study indicators rely on gestational estimate data from the birth registry. Reliability of these data, especially due to data collection practice variations in individual healthcare facilities, may have a disproportionate influence on regional study indicator results.
- COVID-19 may have impacted the CY 2020 study indicator results given the public efforts put in place during CY 2020 to mitigate the spread of COVID-19 (e.g., social distancing, stay at home orders). Additionally, researchers have found that women who were pregnant during the early stages of the COVID-19 pandemic had increased fears and stress about delivering in a hospital, especially when a support person could not be in the hospital for the delivery or go to prenatal visits with the mother. Further, COVID-19 may have also impacted women's ability to get timely and frequent prenatal care. As a result, caution should be exercised when comparing CY 2021 and CY 2022 study indicator results to those for CY 2020.
- Healthy People 2030 goals are presented for comparison to Virginia Medicaid results for the *Births With Early and Adequate Prenatal Care* and *Preterm Births (<37 Weeks Gestation)* study indicators. Caution should be used when comparing study results to national benchmarks, as the benchmarks were derived from birth records covered by all payer types and may not mirror birth outcomes among women with births paid by Title XIX or Title XXI.
- As many pregnant women new to Medicaid may not be enrolled in Title XIX or Title XXI benefits until their second or third trimester, use caution when interpreting study findings. Due to the multifactorial nature of birth outcomes and the need for pre-pregnancy interventions, a single delivery system or Medicaid program may not have had adequate time to contact new Medicaid members and subsequently impact birth outcomes.
- HSAG developed the maternal health outcomes study indicators; therefore, comparisons to national benchmarks cannot be made. Further, due to billing practices of providers (e.g., global billing), some study indicator results (i.e., maternal depression screening) are likely more representative of data completeness, rather than actual performance.
- Since the FAMIS Prenatal Coverage program began in July 2021, women included in the FAMIS Prenatal Coverage population at the time of delivery may not have been eligible for the program in time to receive timely or adequate prenatal care; therefore, exercise caution when interpreting study indicator rates for this population for CY 2021 and CY 2022. Further, given that the FAMIS Prenatal Coverage program only provides postpartum care for 60 days after delivery, exercise caution when interpreting the maternal health outcome study indicators that assess care received in the postpartum period given many of the indicators look at care beyond 60 days of delivery.

Please refer to the full *2022–23 Medicaid and CHIP Maternal and Child Health Focus Study Report* for full study results and limitations.⁵⁶

⁵⁶ Commonwealth of Virginia Department of Medical Assistance Services. 2022–23 Medicaid and CHIP Maternal and Child Health Focus Study Report. Available at: [2022–23 Medicaid and CHIP Maternal and Child Health Focus Study Report](#). Accessed on: Jan 8, 2025.

Child Welfare Focus Study

In contract year 2022–2023, HSAG conducted the eighth 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 2022 (i.e., January 1, 2022–December 31, 2022). While historically the Child Welfare Focus Study evaluated healthcare utilization among members in the study populations, for the 2021–22 and 2022–23 focus studies, DMAS requested that HSAG also evaluate timely access to care for members who transitioned into or out of the foster care program. For the timely access to care analysis, HSAG developed custom measures to determine the extent to which children newly enrolled in the foster care program and children who aged out of the foster care program were able to access healthcare services in a timely manner.

Additionally, DMAS requested that HSAG evaluate disparities in healthcare utilization and timely access to care based on demographic factors (i.e., age, sex, race, region, and MCO). Federal regulations require state Medicaid agencies to incorporate a plan to identify, evaluate, and reduce health disparities as part of their managed care state QS.⁵⁷ 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 health differences that are closely linked with social, economic, and/or environmental disadvantages.⁵⁸ The 2022–23 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.⁵⁹ 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,⁶⁰ 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.⁶¹ 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, children receiving adoption

⁵⁷ Centers for Medicare & Medicaid Services. CMS External Quality Review (EQR) Protocols. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf>. Accessed on: Jan 8, 2025.

⁵⁸ Commonwealth of Virginia DMAS. 2023–2025 Quality Strategy. Available at: <https://www.dmas.virginia.gov/media/ernmrksw/2023-2025-quality-strategy.pdf>. Accessed on: Jan 8, 2025.

⁵⁹ American Academy of Pediatrics. Health care issues for children and adolescents in foster care and kinship care. *Pediatrics*. Oct 2015;136:4. Available at: <https://publications.aap.org/pediatrics/article/136/4/e1131/73819/Health-Care-Issues-for-Children-and-Adolescents-in>. Accessed on: Jan 8, 2025.

⁶⁰ 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.

⁶¹ 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.

assistance, and former foster care members compared to utilization among similar members not in these programs who were also enrolled with Medicaid MCOs.

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 2023 Reporting or custom measure specifications. The healthcare utilization analysis assessed 20 measures, representing 32 study indicators, across six domains:

- 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 the matched controls. *P*-values indicate whether the rate differences between the study population and their controls are statistically significant.

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

Measure	Children in Foster Care Rate	Controls Rate	<i>p</i>
Primary Care			
<i>Child and Adolescent Well-Care Visits</i>	61.5%	52.9%	<0.001*
<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits</i>	65.1%	57.7%	0.16
<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>	77.9%	65.0%	0.002*
Oral Health			
<i>Annual Dental Visit</i>	68.6%	53.7%	<0.001*
<i>Preventive Dental Services</i>	63.3%	47.7%	<0.001*
<i>Oral Evaluation, Dental Services</i>	61.8%	46.2%	<0.001*
<i>Topical Fluoride for Children—Dental or Oral Health Services</i>	29.1%	19.3%	<0.001*
Behavioral Health			
<i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i>	35.6%	57.6%	0.01*
<i>Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up</i>	87.7%	74.4%	0.08
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing</i>	38.3%	31.3%	0.18
<i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i>	77.9%	60.8%	0.04*

Measure	Children in Foster Care Rate	Controls Rate	p
<i>Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up</i>	77.3%	75.0%	0.67
<i>Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up</i>	90.0%	90.1%	0.97
<i>Follow-Up Care for Children Prescribed ADHD Medication—Three-Month Follow-Up</i>	93.6%	93.4%	0.94
<i>Follow-Up Care for Children Prescribed ADHD Medication—Six-Month Follow-Up</i>	97.3%	97.4%	1.00
<i>Follow-Up Care for Children Prescribed ADHD Medication—Nine-Month Follow-Up</i>	97.3%	98.7%	0.65
Substance Use			
<i>Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment</i>	40.4%	50.0%	0.33
<i>Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment</i>	10.5%	13.6%	0.63
Respiratory Health			
<i>Asthma Medication Ratio</i>	82.5%	76.1%	0.43
Service Utilization			
<i>Ambulatory Care Visits</i>	86.8%	88.1%	0.08
<i>Emergency Department Visits</i>	26.9%	35.5%	<0.001*
<i>Inpatient Visits</i>	5.1%	4.2%	0.09
<i>Behavioral Health Encounters—Total</i>	65.4%	51.9%	<0.001*
<i>Behavioral Health Encounters—ARTS</i>	2.8%	1.5%	<0.001*
<i>Behavioral Health Encounters—CMH Services</i>	35.3%	20.0%	<0.001*
<i>Behavioral Health Encounters—RTC Services</i>	5.5%	4.1%	0.005*
<i>Behavioral Health Encounters—Therapeutic Services</i>	10.9%	6.0%	<0.001*
<i>Behavioral Health Encounters—Traditional Services</i>	61.2%	47.9%	<0.001*
<i>Overall Service Utilization</i>	89.7%	91.6%	0.005*

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

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.

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

Measure	Children Receiving Adoption Assistance Rate	Controls Rate	p
Primary Care			
<i>Child and Adolescent Well-Care Visits</i>	45.9%	47.3%	0.08
<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits</i>	0.0%	55.3%	0.11
<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>	79.2%	65.7%	0.17
Oral Health			
<i>Annual Dental Visit</i>	57.3%	54.3%	<0.001*
<i>Preventive Dental Services</i>	53.2%	49.5%	<0.001*
<i>Oral Evaluation, Dental Services</i>	52.1%	48.1%	<0.001*
<i>Topical Fluoride for Children—Dental or Oral Health Services</i>	23.3%	19.5%	<0.001*
Behavioral Health			
<i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i>	53.7%	59.7%	0.39
<i>Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up</i>	84.4%	79.3%	0.47
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing</i>	37.6%	33.2%	0.27
<i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i>	58.9%	53.3%	0.46
<i>Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up</i>	52.9%	62.9%	0.02*
<i>Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up</i>	68.9%	80.6%	0.001*
<i>Follow-Up Care for Children Prescribed ADHD Medication—Three-Month Follow-Up</i>	80.9%	87.0%	0.05*
<i>Follow-Up Care for Children Prescribed ADHD Medication—Six-Month Follow-Up</i>	91.4%	94.6%	0.14
<i>Follow-Up Care for Children Prescribed ADHD Medication—Nine-Month Follow-Up</i>	94.6%	96.5%	0.26
Substance Use			
<i>Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment</i>	42.3%	37.5%	0.60
<i>Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment</i>	7.7%	6.3%	1.00
Respiratory Health			
<i>Asthma Medication Ratio</i>	86.0%	71.0%	0.003*

Measure	Children Receiving Adoption Assistance Rate	Controls Rate	p
Service Utilization			
<i>Ambulatory Care Visits</i>	81.4%	82.9%	0.02*
<i>Emergency Department Visits</i>	17.7%	29.3%	<0.001*
<i>Inpatient Visits</i>	3.3%	2.3%	<0.001*
<i>Behavioral Health Encounters—Total</i>	45.7%	40.2%	<0.001*
<i>Behavioral Health Encounters—ARTS</i>	1.0%	0.9%	0.45
<i>Behavioral Health Encounters—CMH Services</i>	13.1%	13.4%	0.61
<i>Behavioral Health Encounters—RTC Services</i>	4.3%	2.6%	<0.001*
<i>Behavioral Health Encounters—Therapeutic Services</i>	5.3%	4.2%	0.001*
<i>Behavioral Health Encounters—Traditional Services</i>	43.2%	37.2%	<0.001*
<i>Overall Service Utilization</i>	84.0%	86.9%	<0.001*

* Indicates that the rates were statistically different between the children receiving adoption assistance 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.

Table 12-7—Healthcare Utilization Study Indicator Results for Former Foster Care Members and Controls

Measure	Former Foster Care Members Rate	Controls Rate	p
Primary Care			
<i>Child and Adolescent Well-Care Visits</i>	17.8%	16.6%	0.60
Oral Health			
<i>Annual Dental Visit</i>	29.1%	28.0%	0.80
<i>Preventive Dental Services</i>	21.7%	21.7%	1.00
<i>Oral Evaluation, Dental Services</i>	22.2%	22.0%	0.96
<i>Topical Fluoride for Children—Dental or Oral Health Services</i>	4.9%	3.5%	0.42
Behavioral Health			
<i>Antidepressant Medication Management—Effective Acute Phase Treatment</i>	27.8%	36.2%	0.20
<i>Antidepressant Medication Management—Effective Continuation Phase Treatment</i>	12.4%	16.2%	0.44
<i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i>	14.9%	32.1%	0.06
<i>Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up</i>	36.4%	43.8%	0.60
Substance Use			
<i>Follow-Up After ED Visit for Substance Use—30-Day Follow-Up</i>	18.4%	13.3%	1.00

Measure	Former Foster Care Members Rate	Controls Rate	<i>p</i>
<i>Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment</i>	44.0%	43.3%	0.91
<i>Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment</i>	13.7%	12.2%	0.74
Respiratory Health			
<i>Asthma Medication Ratio</i>	22.2%	60.0%	0.06
Service Utilization			
<i>Ambulatory Care Visits</i>	60.5%	66.6%	<0.001*
<i>Emergency Department Visits</i>	45.4%	39.1%	<0.001*
<i>Inpatient Visits</i>	9.9%	9.9%	1.00
<i>Behavioral Health Encounters—Total</i>	33.6%	28.3%	<0.001*
<i>Behavioral Health Encounters—ARTS</i>	7.3%	5.5%	0.02*
<i>Behavioral Health Encounters—CMH Services</i>	9.8%	5.1%	<0.001*
<i>Behavioral Health Encounters—RTC Services</i>	5.1%	2.7%	<0.001*
<i>Behavioral Health Encounters—Therapeutic Services</i>	2.0%	0.6%	<0.001*
<i>Behavioral Health Encounters—Traditional Services</i>	32.2%	27.0%	<0.001*
<i>Overall Service Utilization</i>	73.7%	75.0%	0.38

* Indicates that the rates were statistically different between the former foster care members and controls.

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.

The 2022–23 Child Welfare Focus Study highlights identified priorities for the Virginia Medicaid program related to improving and monitoring healthcare utilization and timely access to care for members in child welfare programs and identifying health disparities. DMAS continues to work with HSAG and the MCOs to address areas of opportunity to provide high quality care to Virginians. As context for the conclusions and recommendations, DMAS has implemented policy changes and supported initiatives during the study period to improve utilization of and timely access to care among members in child welfare programs, including the following:

- As part of the SFY 2022–23 Cardinal Care Acute (formerly Medallion 4.0) Managed Care Services Agreement, effective July 1, 2022:
 - DMAS added language to improve continuity of and timely access to care for former foster care members, including ensuring MCOs provide members who are aging out of foster care with a “health summary” consolidating key medical information, ensuring MCOs coordinate with the LDSS during the transition period, ensuring case management continues during the transition period, and ensuring MCOs document transition needs for children in foster care who will age out of foster care in their individualized care plan, if applicable.
 - DMAS added language requiring MCOs to participate in child welfare stakeholder collaboration work groups, when requested.
- On April 1, 2022, Governor Glenn Youngkin launched the Safe and Sound Task Force, which aims to work collaboratively across state and local agencies to address barriers related to safe and

appropriate placements for children in foster care. DMAS participates in the Task Force and supports efforts to improve timely access to and utilization of medical and behavioral healthcare services for children in foster care.

- DMAS and the Department of Behavioral Health and Developmental Services collaborated to launch Project BRAVO, a multi-phase initiative to enhance behavioral health services in Virginia. Under this initiative, Virginia Medicaid began covering additional behavioral health services such as mental health intensive outpatient services, effective July 1, 2021, and multisystemic therapy, effective December 1, 2021.

This study demonstrated that children in foster care have higher rates of appropriate healthcare utilization than comparable controls for the majority study indicators in MY 2022, MY 2021, and MY 2020. Among study indicators where children in foster care had higher rates, MY 2022 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 14.9, 15.6, 15.6, and 9.8 percentage points, respectively), the *Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics* indicator (by 17.1 percentage points), and the *Behavioral Health Encounters—CMH Services*, *Behavioral Health Encounters—Traditional Services*, and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* indicators (by 15.3, 13.3, and 13.3 percentage points, respectively). Rate differences between children in foster care and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2022, children in foster care had lower rates compared to controls for nine study indicators, of which three were statistically significant: *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*, *ED Visits*, and *Overall Service Utilization*. For *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*, the rate for children in foster care was 22.0 percentage points lower than the rate for controls in MY 2022, although children in foster care had a higher rate than controls during MY 2020 and MY 2021. For the *ED Visits* study indicator, the rate for children in foster care was 8.6 percentage points lower than the rate for controls, which could reflect better management of health conditions for children in foster care. For the *Overall Service Utilization* indicators, the rate difference between children in foster care and controls was less than 2 percentage points, and the rates for children in foster care were very high. Additionally, while the rate difference was not statistically significant due to small denominators, the rate for children in foster for the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* was 9.6 percentage points lower than rate for controls, and there were similar findings in MY 2020 and MY 2021.

Among children in foster care, eight study indicator rates increased, while 18 study indicator rates decreased from MY 2021 to MY 2022, and from MY 2020 to MY 2022, two study indicator rates increased, while 13 study indicator rates decreased. The largest declines from MY 2021 to MY 2022 were for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* indicator (by 28.6 percentage points), the *Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics* indicator (by 11.0 percentage points), and the *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* indicator (by 10.2 percentage points). However, eight of the MY 2021 to MY 2022 rate declines for children in foster care were by less than 3 percentage points. Among controls for children in foster care, 12 study indicator rates increased, while 16 study indicator rates decreased from MY 2021 to MY 2022, and from MY 2020 to MY 2022, 12 study indicator rates increased, while five study indicator rates decreased.

This study demonstrated that children receiving adoption assistance have higher rates of appropriate healthcare utilization than comparable controls for approximately half of the study indicators in MY 2022, MY 2021, and MY 2020. Study findings show that children receiving adoption assistance had higher rates than controls for all four Oral Health domain study indicators, *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, Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up, Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing, Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*, both *Initiation and Engagement of SUD Treatment* indicators, *Asthma Medication Ratio, Inpatient Visits*, and five 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 2022, children receiving adoption assistance had lower rates compared to controls 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, Child and Adolescent Well-Care Visits, Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*, all *Follow-Up Care for Children Prescribed ADHD Medication* study indicators, *Ambulatory Care Visits, ED Visits, Behavioral Health Encounters—CMH Services*, and *Overall Service Utilization*, of which six differences were statistically significant. 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 55.3 percentage points) and the *Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up* study indicator (by 11.7 percentage points). However, the denominator 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 was very small, so the rate is expected to fluctuate more. For five 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 11.6 percentage points lower than controls, which may indicate that health conditions for children receiving adoption assistance are being better managed.

Among children receiving adoption assistance, 16 study indicator rates increased, while 12 study indicator rates decreased from MY 2021 to MY 2022, and from MY 2020 to MY 2022, nine study indicator rates increased, while six study indicator rates decreased. The largest declines from MY 2021 to MY 2022 were for the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* study indicator (by 11.8 percentage points) and the *Behavioral Health Encounters—Traditional* study indicator (by 7.1 percentage points). 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 also decreased (by 50.0 percentage points); however, the denominator is very small for this study indicator, so rate changes across time are expected to be larger. Additionally, six of the rate declines among children in adoption assistance from MY 2021 to MY 2022 were by less than 3 percentage points. Among controls for children receiving adoption assistance, 15 study indicator rates increased, while 14 study indicator rates decreased from MY 2021 to MY 2022, and from MY 2020 to MY 2022, 13 study indicator rates increased, while four study indicator rates decreased.

This study demonstrated that former foster care members have higher rates of appropriate healthcare utilization than comparable controls for approximately half of study indicators in MY 2022, MY 2021, and MY 2020. Study findings show that former foster care members had higher rates than controls for *Child and Adolescent Well-Care Visits, Annual Dental Visit, Oral Evaluations, Dental Services, Topical Fluoride for Children—Dental or Oral Health Services, Follow-Up After ED Visit for Substance Use—30-*

Day Follow-Up, both *Initiation and Engagement of SUD Treatment* indicators, *ED 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 2022, former foster care members had lower rates compared to controls for all Behavioral Health domain study indicators, *Asthma Medication Ratio*, *Ambulatory Care Visits*, and *Overall Service Utilization*. The largest differences were for the *Asthma Medication Ratio* study indicator (by 37.8 percentage points), the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* study indicator (by 17.2 percentage points), the *Antidepressant Medication Management—Effective Acute Phase Treatment* study indicator (by 8.4 percentage points), and the *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* study indicator (by 7.4 percentage points).

Among former foster care members, all study indicator rates except the *Topical Fluoride for Children—Dental or Oral Health Services*, *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment*, *ED Visits*, *Behavioral Health Encounters—ARTS*, and the *Behavioral Health Encounters—RTC Services* study indicators decreased from MY 2021 to MY 2022. The largest declines from MY 2021 to MY 2022 were for the *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* indicator (by 12.2 percentage points) and the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* indicator (by 12.0 percentage points). The *Asthma Medication Ratio* indicator also decreased substantially (by 47.0 percentage points); however, the denominator is small, so rate changes across time are expected to be larger. Among controls for former foster care members, all study indicator rates decreased from MY 2021 to MY 2022 except for the *Annual Dental Visit*, *Preventive Dental Services*, *Topical Fluoride for Children—Dental or Oral Health Services*, *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up*, *Inpatient Visits*, *ED Visits*, *Behavioral Health Encounters—ARTS*, and *Behavioral Health Encounters—RTC Services* study indicators.

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 5 measures, representing 16 study indicators. Table 12-8 contains the timely access to care study indicator results for children newly enrolled in foster care, children newly enrolled in adoption assistance, and members who aged out of foster care.

Table 12-8—Timely Access to Care Study Indicator Results

Measure	Denominator	Numerator	Rate
<i>Timely Access to Care for New Foster Care Members—Timely Access to Primary Care for New Foster Care Members</i>	1,778	1,544	86.8%
<i>Timely Access to Care for New Foster Care Members—Timely Access to Dental Care for New Foster Care Members</i>	1,778	840	47.2%
<i>Timely Access to Care for New Foster Care Members—Timely Access to Primary Care or Dental Care for New Foster Care Members</i>	1,778	1,621	91.2%
<i>Timely Access to Care for New Foster Care Members—Timely Access to Primary Care and Dental Care for New Foster Care Members</i>	1,778	763	42.9%

Measure	Denominator	Numerator	Rate
<i>Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members—Timely Access to Behavioral Health Care for New Foster Care Members</i>	1,601	809	50.5%
<i>Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members—Timely Access to Behavioral Health Care for New Foster Members With a Behavioral Health Diagnosis</i>	643	508	79.0%
<i>Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members—Timely Access to Behavioral Health Care for New Foster Care Members</i>	1,368	918	67.1%
<i>Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members—Timely Access to Behavioral Health Care for New Foster Members With a Behavioral Health Diagnosis</i>	520	484	93.1%
<i>Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members—Timely Access to Behavioral Health Care for New Adoption Assistance Members</i>	812	360	44.3%
<i>Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members—Timely Access to Behavioral Health Care for New Adoption Assistance Members With a Behavioral Health Diagnosis</i>	356	243	68.3%
<i>Timely Access to Care for Members Who Aged Out of Foster Care—Timely Access to Primary Care for Members Who Aged Out of Foster Care</i>	152	103	67.8%
<i>Timely Access to Care for Members Who Aged Out of Foster Care—Timely Access to Dental Care for Members Who Aged Out of Foster Care</i>	152	45	29.6%
<i>Timely Access to Care for Members Who Aged Out of Foster Care—Timely Access to Primary Care or Dental Care for Members Who Aged Out of Foster Care</i>	152	109	71.7%
<i>Timely Access to Care for Members Who Aged Out of Foster Care—Timely Access to Primary Care and Dental Care for Members Who Aged Out of Foster Care</i>	152	39	25.7%
<i>Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care—Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care</i>	152	59	38.8%
<i>Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care—Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care With a Behavioral Health Diagnosis</i>	120	55	45.8%

The SFY 2022–23 study found that 86.8 percent of new foster care members had a visit with a PCP within 30 days after or 90 days prior to entering foster care during MY 2022, an increase of 0.6 percentage points from the year prior. Therefore, most children in foster care are receiving timely access to primary care; however, there may still be some room for improvement in meeting State guidelines. Additionally, 47.2 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 during MY 2022. This rate improved by 3.2 percentage points from MY 2021. Study indicators also assessed timely access to primary and dental care for members who aged out of foster care. Findings demonstrate that 67.8 percent of members who aged out of foster care in the year prior

to the MY had a visit with a PCP during MY 2022, and this rate decreased by 2.0 percentage points from MY 2021. Similar to new foster care members, only 29.6 percent of members who aged out of foster care had a visit with a dental practitioner during MY 2022, and most of these members also had a visit with a PCP. This rate decreased by 5.0 percentage points from MY 2021.

Additionally, the SFY 2022–23 study found that 50.5 percent of new foster care members and 79.0 percent of new foster care members with a diagnosed behavioral health condition had at least one visit with an MHP within 60 days of enrollment in the foster care program. Additionally, 67.1 percent of new foster care members and 93.1 percent of new foster care members with a behavioral health diagnosis had a visit with an MHP within a year after enrollment in the foster care program. For newly enrolled members in the adoption assistance program, 44.3 percent of all members and 68.3 percent of members with a behavioral health diagnosis had a visit with an MHP. Lastly, 78.9 percent of members who aged out of foster care had a behavioral health diagnosis, and 45.8 percent of these members with a behavioral health diagnosis had a visit with an MHP during MY 2022; this rate improved by 6.4 percentage points from MY 2021.

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 and timely access to care 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		
<i>Healthcare Utilization: Children in Foster Care</i>	15	57.7%
<i>Healthcare Utilization: Children Receiving Adoption Assistance</i>	15	57.7%
<i>Healthcare Utilization: Former Foster Care Members</i>	5	21.7%
<i>Timely Access to Care</i>	9	56.3%
Sex		
<i>Healthcare Utilization: Children in Foster Care</i>	5	19.2%
<i>Healthcare Utilization: Children Receiving Adoption Assistance</i>	4	15.4%
<i>Healthcare Utilization: Former Foster Care Members</i>	12	52.2%
<i>Timely Access to Care</i>	10	62.5%
Race		
<i>Healthcare Utilization: Children in Foster Care</i>	7	26.9%
<i>Healthcare Utilization: Children Receiving Adoption Assistance</i>	7	26.9%
<i>Healthcare Utilization: Former Foster Care Members</i>	4	17.4%
<i>Timely Access to Care</i>	2	12.5%

Disparity Type and Analysis	Count of Study Indicators	Percent of Study Indicators
Region		
<i>Healthcare Utilization: Children in Foster Care</i>	15	57.7%
<i>Healthcare Utilization: Children Receiving Adoption Assistance</i>	15	57.7%
<i>Healthcare Utilization: Former Foster Care Members</i>	11	47.8%
<i>Timely Access to Care</i>	10	62.5%
MCO		
<i>Healthcare Utilization: Children in Foster Care</i>	15	57.7%
<i>Healthcare Utilization: Children Receiving Adoption Assistance</i>	15	57.7%
<i>Healthcare Utilization: Former Foster Care Members</i>	6	26.1%
<i>Timely Access to Care</i>	5	31.3%

Children in Foster Care

Among children in foster care, 15 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, behavioral health 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, children in foster care who were 14 years of age and older also had significantly lower rates for the *Preventive Dental Services*; *Oral Evaluation*, *Dental Services*; and *Topical Fluoride for Children—Dental or Oral Health Services* indicators despite Virginia State guidelines that children in foster care should have dental examinations every six months while in foster care.⁶² Additionally, for the *ED Visits* and *Inpatient Visits* indicators, the rates for children in foster care 14 years of age and older were higher than the rates for controls as well as all other age categories. Five study indicators demonstrated disparities between males and females—female members had significantly higher rates for the *Inpatient Visits* indicator, while male members had significantly higher rates for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* and *Behavioral Health Encounters—Therapeutic Services* indicators.

Seven study indicators demonstrated disparities between racial groups—Black or African American members had significantly lower rates for the *Ambulatory Care Visits*, *Behavioral Health Encounters—ARTS*, and *Overall Service Utilization* indicators compared to other racial groups, while White members had significantly higher rates for the *Ambulatory Care Visits*, *Behavioral Health Encounters—ARTS*, *Behavioral Health Encounters—Traditional Services*, and *Overall Service Utilization* indicators. Finally, members in the Other racial group had significantly lower rates for the *ED Visits*, *Behavioral Health Encounters—CMH Services*, *Behavioral Health Encounters—Total* indicators. These disparities typically existed among controls as well. 15 study indicators had disparities across regions. Of note, members in the Roanoke/Alleghany region consistently had significantly lower rates for Oral Health domain study indicators, while members in the Southwest region had significantly better rates for

⁶² 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: Jan 8, 2025.

several of the Oral Health domain and *Behavioral Health Encounters* indicators compared to members in other regions. Findings also showed 15 study indicators with disparities between MCOs. Of note, members enrolled with Molina had lower rates for three of the four Oral Health domain study indicators as well as the *Ambulatory Care Visits* indicator compared to members enrolled with other MCOs.

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, 15 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 all indicators in the Oral Health domain, older children receiving adoption assistance had significantly lower rates compared to younger children. Four study indicators demonstrated disparities between males and females—female members had significantly higher rates for the *Inpatient Visits* indicator, while male members had significantly higher rates for the *Behavioral Health Encounters—Total*, *Behavioral Health Encounters—CMH Services*, and *Behavioral Health Encounters—Therapeutic Services* indicators.

Seven study indicators demonstrated disparities between racial groups—Black or African American members had significantly higher rates for the *Child and Adolescent Well-Care Visits*, *Oral Evaluation*, *Dental Services*, *Behavioral Health Encounters—CMH Services*, *Behavioral Health Encounters—RTC Services*, and *Behavioral Health Encounters—Traditional Services* indicators and a significantly lower rate for the *Ambulatory Care Visits* indicator compared to other racial groups, while White members had a significantly higher rate for the *Ambulatory Care Visits* indicator and significantly lower rates for the *Child and Adolescent Well-Care Visits*, *Oral Evaluation*, *Dental Services*, and *Behavioral Health Encounters—Traditional Services* indicators. Additionally, children receiving adoption assistance in the Other racial group had a significantly lower rate for the *Behavioral Health Encounters—Traditional Services* indicator. Some of these disparities were also seen among controls. There were also some disparities identified across regions and MCOs. For example, members in the Northern & Winchester region had significantly lower rates for well-child visits, three of the four indicators in the Oral Health domain, and three types of behavioral health encounters compared to members in other regions. Additionally, members enrolled with Aetna and Molina had significantly lower rates for well-child visits, all indicators in the Oral Health domain, and two types of behavioral health encounters compared to members enrolled with other MCOs.

Former Foster Care Members

Among former foster care members, five study indicators demonstrated disparities across age categories. Members 23 to 26 years of age were less likely to have an ED visit, behavioral health encounter with CMH services or any service, a follow-up visit after an ED visit for mental illness, or any service utilization type compared to members 19 to 22 years of age. Twelve indicators demonstrated disparities by sex, where male members consistently had lower rates of healthcare utilization compared to female members. Male members had significantly lower rates for the *Child and Adolescent Well-Care Visits*, *Annual Dental Visit*, *Preventive Dental Services*, *Oral Evaluation*, *Dental Services*, *Ambulatory Care Visits*, *ED Visits*, *Inpatient Visits*, *Behavioral Health Encounters—Total*, *Behavioral Health Encounters—ARTS*, *Behavioral Health Encounters—Traditional Services*, and *Overall Service Utilization* indicators.

Four study indicators demonstrated disparities by race/ethnicity. Of note, White members had significantly higher rates for the *Ambulatory Care Visits* indicator, while Black or African American members had significantly lower rates; however, Black or African American members had significantly higher rates for the *Behavioral Health Encounters—CMH Services* and *Behavioral Health Encounters—Therapeutic Services* indicators, while White members had significantly lower rates. Eleven study indicators demonstrated disparities by region. Of note, members in the Tidewater region had significantly lower rates for the *Ambulatory Care Visits*, *Annual Dental Visit*, *Preventive Dental Services*, *Oral Evaluation*, *Dental Services*, *Behavioral Health Encounters—ARTS*, *Behavioral Health Encounters—CMH Services*, *Behavioral Health Encounters—Traditional Services*, *Behavioral Health Encounters—Total*, and *Overall Service Utilization* indicators. Six study indicators demonstrated disparities by MCO; however, there were no overarching trends.

Timely Access to Care

Among new foster care members, older members were less likely to have a visit with a PCP and more likely to have a visit with a dental practitioner. Additionally, for new foster care members, older members were more likely to have an MHP visit among all members but less likely among members with a behavioral health diagnosis for both the 60-day and one-year time frames. Female members who aged out of foster care were more likely to have a visit with a dental practitioner than male members, and for both new foster care members and members who aged out of foster care, female members were more likely to have a visit with a PCP. The rate difference was particularly large for members who aged out of foster care and had PCP visits, where the rate for male members was 41.6 percentage points lower than the rate for female members. Members newly enrolled in foster care in the Northern & Winchester region were significantly less likely to have a PCP or MHP visit compared to members in other regions, and members newly enrolled in the adoption assistance program in Northern & Winchester were significantly less likely to have an MHP visit. There were no notable trends across indicators by race/ethnicity or MCO.

Study Limitations

Study findings and conclusions may be affected by limitations related to the study design and source data. As such, caveats include, but are not limited to, the following:

- Study indicator rates must be interpreted with caution given the denominator limitations. For example, the covariate balance between the stratification-limited study populations and the stratification-limited controls group may be disrupted when only one member in a matched pair qualifies for a stratification that was matched by propensity score. However, for the SFY 2022–23 study, all characteristics for which rates were stratified were exact-matched except for member sex, and HSAG found that most covariates were balanced within statewide male and female groups.
- Study indicator results and the accuracy of demographic characteristics (e.g., region, MCO) may be influenced by the accuracy and timeliness of the administrative claims and encounter data used for calculations and must be interpreted within the broader context of the population. Many study indicators are also based on CMS Core Set technical specifications, which may not comprehensively mirror the complete range of clinical practices recommended by AAP for members in the study population (e.g., an enhanced periodicity schedule customized to align with the needs of children in foster care). Furthermore, selected study indicators were originally developed by CMS to assess access to care or the degree to which care adhered to clinical guidelines. These measures were not necessarily developed to assess healthcare utilization. For example, most study

indicators do not assess the frequency of service utilization; they only assess whether or not a visit occurred. Findings should be interpreted with respect to the intent of the CMS Core Set technical specifications.

- The administrative claims and encounter data do not include denied pharmacy encounters. Therefore, study indicators for which the specifications include denied claims may underestimate pharmaceutical events (e.g., identification of members on antipsychotics for the denominator of the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* indicator). However, this limitation applies to all reported measurement years and populations, so trending and comparisons between populations are not affected.
- The study populations and controls were limited by several factors, including continuous enrollment and having a comparable match; therefore, study findings are not generalizable to other children in foster care, children receiving adoption assistance, or former foster care members; to other members not in these programs; or to other CMS Core Set measure calculations. However, despite the limitations of the denominators, study indicator results are generalizable to the full study population and controls.

Please refer to the full 2022–23 *Child Welfare Focus Study Report* for full study results and limitations.⁶³

Dental Utilization Focus Study

DMAS contracted with HSAG as its EQRO to assess dental utilization among pregnant women and adults covered by Virginia Medicaid or FAMIS MOMS through the Virginia Cardinal Care Smiles program administered by DentaQuest. During 2024, HSAG used dental encounter data to determine which dental services, if any, were utilized by pregnant women (during the member's preconception, pregnancy, or postpartum period) and adults during CY 2023. For the adult population, HSAG will also calculate the following DQA measures:

- *Adults With Diabetes—Oral Evaluation*
- *Ambulatory Care Sensitive Emergency Department (ED) Visits for Non-Traumatic Dental Conditions in Adults*
- *Follow-Up After ED Visits for Non-Traumatic Dental Conditions in Adults*

During 2024, HSAG calculated the CY 2023 rates and develop a formal report. The results are scheduled to be finalized in early 2025.

⁶³ Commonwealth of Virginia Department of Medical Assistance Services. 2022–23 Child Welfare Focus Study Report. Available at: [2022–23 Child Welfare Focus Study Report](#). Accessed on: Jan 8, 2025.

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 network adequacy with its process to conduct routine data quality validations against member and provider data to ensure accuracy in data transfers between systems. In addition, Aetna demonstrated provider ratios for PCPs and pediatricians that were well within the required indicators' ratio expectations.
	Aetna demonstrated strength in PIP processes, receiving <i>Met</i> validation scores for 100 percent of all applicable evaluation elements validated for Steps 1–8 for each PIP. For the <i>Transitions of Care—Patient Engagement After Inpatient Discharge</i> PIP, the MCO implemented meaningful interventions which led to a statistically significant improvement in Remeasurement 1 compared to baseline. One PIP, <i>Tobacco Use Cessation in Pregnant Women</i> , showed non-statistically significant improvement in Remeasurement 1 compared to baseline.
	Within the Children's Preventive Care domain, Aetna displayed strong performance for the <i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i> and the <i>Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits</i> PM indicators, with the MCO's rates meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 75th percentile. In addition, Aetna displayed strong performance within the Care for Chronic Conditions domain for the <i>Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation—Systemic Corticosteroid and Bronchodilator</i> PM indicators, with the MCO's rates meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 90th percentile. These results indicate that Aetna had processes in place to monitor care and services and ensure appropriate utilization so that members were connected to care.
	The EDV IS review activity identified that Aetna and its subcontractors had relatively robust reports to monitor encounter data accuracy, completeness, and timeliness for encounters that Aetna and all four of its subcontractors collected. The EDV comparative analysis for data element completeness also identified that for the Cardinal Care MLTSS program, Aetna excelled with all pharmacy key data elements having both element omission and surplus rates below 5.0 percent. This indicates that all relevant key data elements in the pharmacy records that could be matched between the DMAS-submitted and Aetna-submitted data were largely complete.

Strengths Related to Quality

	For the comparative analysis of data element accuracy, all Aetna pharmacy encounter data elements had an accuracy rate greater than 95.0 percent. This indicates that records which could be matched between the DMAS-submitted and Aetna-submitted data largely contained the same values.

Strengths Related to Access and Timeliness

	The phantom network analysis results demonstrated that the majority (i.e., greater than 75 percent) of PSY, OBGYN, PCP, and PEDIATRIC providers in Aetna's provider network were considered "active" and had provided services to at least one member in the network. The results indicate that members may have the ability to access care when needed for these types of services
	Within the Behavioral Health domain, Aetna performed strongly for both <i>Initiation and Engagement of Substance Use Disorder Treatment</i> PM indicators, with the MCO's rates meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 75th percentile. The results indicate that MCO processes to implement the ARTS benefit and ensuring access to behavioral health services are proving to be successful.
	Compliance review results identified that Aetna achieved full compliance in five of the 17 standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas: • Standard IV: Availability of Services • Standard VI: Coordination and Continuity of Care • Standard IX: Confidentiality • Standard XIII: Health Information Systems • Standard XIV: Quality Assessment and Performance Improvement Program These findings suggest that Aetna developed the necessary policies, procedures, and processes to operationalize the requirements and expectations of its contract in these operational and functional areas.

Weaknesses and Recommendations

	Weakness: The phantom network analysis demonstrated that over 35 percent of PA/NP providers and 44.3 percent of BH providers were not considered active in Aetna's provider network. Why the weakness exists: This weakness may exist because providers were either not providing services to Medicaid members or because providers were billing services provided under other providers. Recommendations: HSAG recommends that Aetna conduct surveys of providers that are contracted but are not providing services to ensure they are providing services to Medicaid members. Additionally HSAG recommends that Aetna consider providing additional training to ensure all billing correctly reflects the servicing provider separate from the billing provider, as appropriate.

Weaknesses and Recommendations	
	Weakness: Network adequacy validation found that Aetna required its providers to update their information every three years or as needed. Recommendations: HSAG recommends that Aetna require its providers to send updated information on a more frequent schedule (i.e., monthly, quarterly, biannually). Accurate provider data are an integral part of network adequacy and ensuring members have accurate information when seeking care and services.
	Weakness: HSAG identified that two of the four PIPs, <i>AMB-ED Visits</i> and <i>Ensuring Timeliness of Prenatal Care</i>, demonstrated a decline in the performance indicator in Remeasurement 1 compared to baseline. HSAG noted that Aetna provided raw data as attachments to the PIP submissions. Submitting raw data as an attachment is acceptable; however, Aetna should provide an overview of the data within the submission form. Recommendations: HSAG recommends that Aetna revisit its causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. HSAG recommends that Aetna use PDSA cycles to meaningfully evaluate the effectiveness of each intervention. HSAG also recommends that Aetna analyze intervention measure effectiveness data and provide a summary of the results for each intervention.
	Weakness: The following HEDIS MY 2023 PM rates fell below NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Aetna: • <i>Use of Imaging Studies for Low Back Pain</i> • <i>Antidepressant Medication Management—Effective Acute Phase Treatment; Effective Continuation Phase Treatment</i> • <i>Use of Opioids from Multiple Providers—Multiple Prescribers and Multiple Pharmacies</i> Recommendations: To improve the rates for the PMs that fell below the 25th percentile, HSAG recommends that Aetna leverage its HEDIS and CAHPS workgroup to conduct a segmentation analysis to identify potential disparities that are leading to lower quality care, focusing on characteristics of noncompliant members such as race, ethnicity, age, gender, and geography. Additionally, HSAG recommends that Aetna consider providing scorecards and/or care gap reports to providers with low performance on these measures and encourage collaboration on identifying the best care protocols for these types of patients. By using evidence-based practices and monitoring metrics, Aetna has an opportunity to continuously improve and enhance quality.
	Weakness: Results of the compliance review activity identified that Aetna's areas with the greatest opportunity for improvement were related to the following, as these standards received performance scores under 90 percent: • Standard I: Disenrollment: Requirements and Limitations • Standard II: Member Rights and Member Information • Standard III: Emergency and Poststabilization Services

Weaknesses and Recommendations	
	- Standard V: Assurances of Adequate Capacity and Services - Standard X: Grievance and Appeal Systems - Standard XI: Subcontractual Relationships and Delegation - Standard XII: Practice Guidelines - Standard XV: Program Integrity - Standard XVI: EPSDT These findings suggest that Aetna did not consistently develop the necessary policies, procedures, and processes to operationalize the requirements of its contract with DMAS. Recommendations: HSAG recommends that the MCO update policies, procedures, and operational processes to comply with federal and DMAS requirements of each element scored as <i>Not Met</i> during the compliance review. HSAG also recommends that the MCO ensure that staff members are trained and knowledgeable about the requirements of the contract, and that they understand the policies and procedures that the MCO uses to meet federal and DMAS requirements.
—	Weakness: The EDV comparative analysis for record completion found that for professional, institutional, and pharmacy encounters, Aetna had a rate over 5.0 percent (i.e., relatively poor performance) for both record omission and record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the specified Aetna-submitted data. Recommendations: HSAG recommends that Aetna investigate the root cause(s) for the record omission and record surplus findings to ensure that complete encounter records are submitted to DMAS.
—	Comparative Analysis: Data Element Completeness Weakness: The EDV data element completeness review found that among the element-level completeness results for professional and institutional encounters, Aetna had six element omission and/or surplus rates that exceeded 5.0 percent, indicating that there were key data element(s) in the DMAS-submitted encounter records that were incomplete when compared to the specified Aetna-submitted data. Recommendations: HSAG recommends that Aetna investigate the root cause(s) for the element omission and surplus findings to ensure the following data elements are submitted completely: - Professional encounters: <i>Servicing Provider Taxonomy Code</i> (16.1 percent surplus), <i>Primary Diagnosis Codes</i> (17.2 percent surplus), <i>MCO Received Date</i> (17.2 percent surplus) - Institutional encounters: <i>NDC</i> (7.8 percent omission), <i>Drug Quantity</i> (7.8 percent omission), <i>Servicing Provider Taxonomy Code</i> (86.6 percent surplus)

Weaknesses and Recommendations	
	<u>Comparative Analysis: Data Element Accuracy</u> Weakness: The EDV comparative analysis for data element accuracy found that for professional and institutional encounters, Aetna had seven and five element accuracy rates, respectively, that fell below 95.0 percent. These results indicate that there were key data element(s) in the DMAS-submitted encounter records that were inaccurate when compared to the specified Aetna-submitted data. Recommendations: HSAG recommends that Aetna investigate the root cause(s) for the element accuracy findings to ensure the following data elements have accurate values: - Professional encounters: <i>Detail Service From Date</i> (84.8 percent accuracy), <i>Detail Service To Date</i> (84.8 percent accuracy), <i>Billing Provider NPI</i> (93.5 percent accuracy), <i>Rendering Provider NPI</i> (86.9 percent accuracy), <i>Servicing Provider Taxonomy Code</i> (58.3 percent accuracy), <i>MCO Received Date</i> (78.7 percent accuracy), and <i>MCO Paid Date</i> (82.8 percent accuracy) - Institutional encounters: <i>Detail Service From Date</i> (60.5 percent accuracy), <i>Servicing Provider Taxonomy Code</i> (19.7 percent accuracy), <i>Surgical Procedure Codes</i> (93.6 percent accuracy), <i>Header TPL Paid Amount</i> (92.7 percent accuracy), and <i>MCO Received Date</i> (55.3 percent accuracy)
	Weakness: Aetna's 2024 top-box score was statistically significantly lower than the 2023 NCQA general child Medicaid national average for <i>How Well Doctors Communicate</i> in the CAHPS member experience survey. Recommendations: HSAG recommends that Aetna include rating information from the CAHPS survey to emphasize patient-centered communication in provider communications throughout the year. HSAG also recommends that Aetna conduct a root cause analysis of the study indicator that has been identified as an area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG recommends that Aetna continue to monitor the measure to ensure a significant decrease in the score over time does not continue to occur.

HealthKeepers

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

Strengths Related to Quality	
	PIP validation found that HealthKeepers received <i>Met</i> validation scores for 100 percent of all applicable evaluation elements validated for Steps 1–6 for each PIP. The MCO implemented interventions, some of which had a positive impact on the performance indicators as evidenced by the statistically significant improvement achieved in the <i>Transitions of Care—Patient Engagement After</i>

Strengths Related to Quality	
	<i>Inpatient Discharge</i> PIP and non-statistically significant improvement in the <i>Timeliness of Prenatal Care</i> PIP.
	PMV found that within the Children’s Preventive Care domain, HealthKeepers displayed strong performance for the <i>Immunizations for Adolescents—Combination 1</i> PM indicator, with the MCO’s rate meeting or exceeding NCQA’s Quality Compass HEDIS MY 2022 Medicaid HMO 75th percentile. Within the Care for Chronic Conditions domain, HealthKeepers also displayed strong performance for the <i>Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit</i> PM indicator, with the MCO’s rate meeting or exceeding NCQA’s Quality Compass HEDIS MY 2022 Medicaid HMO 90th percentile. In addition, within the Woman’s Health domain, HealthKeepers displayed strong performance for the <i>Breast Cancer Screening—Total</i> PM indicator, with the MCO’s rate meeting or exceeding NCQA’s Quality Compass HEDIS MY 2022 Medicaid HMO 50th percentile. These results indicate that HealthKeepers had processes in place to encourage members to receive preventive care, health screenings, and assistance in quitting tobacco use.
	The EDV IS review activity found that for vision encounters collected by its subcontractor, HealthKeepers and/or its subcontractor had relatively robust reports to monitor encounter data accuracy, completeness, and timeliness. In addition, the EDV comparative analysis for record completeness found that for professional encounters, HealthKeepers had a rate below 5.0 percent for record omission and record surplus. This indicates that the professional records could mostly be identified in both data sources (i.e., the DMAS-submitted data and HealthKeepers-submitted data). The comparative analysis for data element completeness found that for professional and pharmacy encounters, HealthKeepers had a rate below 5.0 percent for all relevant element omission and element surplus. This indicates that all relevant key data elements in the professional and pharmacy records that could be matched between the DMAS-submitted and the HealthKeepers-submitted data were largely complete. The comparative analysis for HealthKeepers’ data element accuracy also found that pharmacy encounter data elements had an accuracy rate greater than 95.0 percent. This indicates that records which could be matched between the DMAS-submitted and HealthKeepers-submitted data largely contained the same values.

Strengths Related to Access and Timeliness

+	The results of the phantom network analysis found that the majority (i.e., greater than 75 percent) of PSY, OBGYN, PA/NP, PCP, and PEDIATRIC providers in HealthKeepers' provider network were considered "active" and had provided services to at least one member in the network. These results indicate members had appropriate access to care and services.
+	Network adequacy validation found that HealthKeepers appropriately configured the Quest Analytics software to ensure accurate reporting. Data transfers to the software were validated by HealthKeepers and accurately uploaded to Quest Analytics. In addition, HealthKeepers continuously assessed quality of data extracts and monitored data loads regularly. HealthKeepers also ensured record counts were consistent from Facets to Quest Analytics.
+	PMV found that within the Behavioral Health domain, HealthKeepers displayed strong performance for the <i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Total</i> , <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Total</i> , <i>Diagnosed Mental Health Disorders—Total</i> , both indicators for <i>Follow-Up After Emergency Department Visit for Substance Use</i> , <i>Follow-Up After ED Visit for Mental Illness —30-Day Follow-Up—Total</i> , both indicators for <i>Follow-Up After Hospitalization for Mental Illness</i> , and both indicators for <i>Initiation and Engagement of Substance Use Disorder Treatment</i> PM indicators, with the MCO's rates meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 50th percentile. These results indicate that HealthKeepers has implemented strong processes for behavioral healthcare and follow-up for members using the emergency room or being discharged from an inpatient stay.
+	The compliance review of MCO compliance with federal and DMAS contract requirements found that HealthKeepers achieved full compliance in five of the 17 standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas: • Standard III: Emergency and Poststabilization Services • Standard IV: Availability of Services • Standard VIII: Provider Selection • Standard IX: Confidentiality • Standard XIII: Health Information Systems These findings suggest that HealthKeepers developed the necessary policies, procedures, and processes to operationalize these federal and DMAS contract requirements.

Weaknesses and Recommendations

-	Weakness: The phantom network analysis found that over 32 percent of the BH providers were not considered active in HealthKeepers' provider network.

Weaknesses and Recommendations	
	Why the weakness exists: This weakness may exist because providers are either not providing services to Medicaid members or because providers are billing services provided under other providers. Recommendations: HSAG recommends that HealthKeepers conduct surveys of providers that are contracted but are not providing services to ensure they are providing services to Medicaid members. Additionally, HSAG recommends that HealthKeepers provide additional provider training to ensure all billing correctly reflects the servicing provider separate from the billing provider, as appropriate.
—	Weakness: HealthKeepers required its providers to update their information every three years or as needed. Recommendations: HSAG recommends that HealthKeepers require its providers to send updated information on a more frequent schedule (i.e., monthly, quarterly, biannually). Accurate provider data are an integral part of network adequacy and ensure that members have accurate provider information when accessing care and services.
—	Weakness: HSAG identified that two of HealthKeepers' PIPs, <i>AMB-ED</i> and <i>Tobacco Use Cessation in Pregnant Women</i>, had a statistically significant decline in performance at Remeasurement 1 compared to baseline. None of the health plans included a statement about factors which threaten comparability of Remeasurement 1 to baseline. The MCO should provide intervention specific process steps. Submitting raw data as an attachment is acceptable; however, HealthKeepers should provide an overview of the data within the PIP Submission Form. Recommendations: HSAG recommends that HealthKeepers include a statement about whether there are factors which threaten comparability of the remeasurement period to the baseline period. If there are no factors, this should be documented. HSAG also recommends that HealthKeepers continue to develop active, innovative interventions that have the potential for impacting the performance indicator outcomes. HSAG also recommends that HealthKeepers revisit its causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. In addition, HSAG recommends that HealthKeepers develop a process to evaluate the effectiveness of each individual intervention and report the intervention evaluation data annually. HSAG recommends that HealthKeepers use PDSA cycles to meaningfully evaluate the effectiveness of each intervention.
—	Weakness: PMV found that the following HEDIS MY 2023 PM rates fell below NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for HealthKeepers: <i>Prenatal and Postpartum Care—Postpartum Care</i> <i>Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment</i> Recommendations: To improve the rates for the PMs that fell below the 25th percentile, HSAG recommends that HealthKeepers identify strategies for

Weaknesses and Recommendations	
	addressing disparities based on the data deep dives being conducted by the HealthKeepers Quality team to provide insight regarding the demographics of noncompliant members. HSAG recommends that HealthKeepers leverage its current suite of maternal care programs to address different identified disparities. Additionally, HSAG recommends that HealthKeepers consider providing scorecards and/or care gap reports to providers with low performance on these measures and encourage collaboration on identifying the best care protocols for these types of patients, including scheduling future visits and sending reminders.
—	Weakness: The review of compliance with federal and DMAS-specific contract requirements found that the areas representing HealthKeepers' greatest opportunity for improvement were related to the following, as these areas received performance scores under 90 percent: • Standard I: Disenrollment: Requirements and Limitations • Standard II: Member Rights and Member Information • Standard V: Assurances of Adequate Capacity and Services • Standard X: Grievance and Appeal Systems • Standard XI: Subcontractual Relationships and Delegation • Standard XII: Practice Guidelines • Standard XV: Program Integrity • Standard XVII: EPSDT These findings suggest that HealthKeepers did not consistently develop the necessary policies, procedures, and processes to operationalize the federal and DMAS contract requirements. Recommendations: HSAG recommends that the MCO update policies, procedures, and operational processes to comply with federal and DMAS requirements of each element scored as <i>Not Met</i> during the compliance reviews. HSAG also recommends that the MCO ensure that staff members are trained and knowledgeable about the federal requirements, DMAS contract requirements, and the policies and procedures that the MCO uses to meet federal and DMAS requirements.
—	Weakness: The EDV IS review activity found that HealthKeepers lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness for encounters that HealthKeepers collects. Recommendations: HSAG recommends that HealthKeepers consider building reports to monitor encounter completeness through metrics such as encounter volume by submission month or encounter volume PMPM, as well as encounter accuracy, completeness, and timeliness through reconciliation with financial reports for encounters that HealthKeepers collects.
—	Weakness: The EDV comparative analysis for record completion found that among the record-level completeness results for institutional and pharmacy encounters, HealthKeepers had a rate exceeding 5.0 percent for record surplus.

Weaknesses and Recommendations	
	This indicates that the DMAS-submitted encounter records were incomplete when compared to the specified HealthKeepers-submitted data. Recommendations: HSAG recommends that HealthKeepers investigate the root cause(s) for the record surplus findings to ensure that complete and accurate encounter records are submitted to DMAS.
—	Weakness: The EDV comparative analysis for data element completeness found that among the element-level completeness results for institutional encounters, HealthKeepers had one element surplus rate that exceeded 5.0 percent, indicating that one key data element in the DMAS-submitted encounter records was incomplete when compared to the HealthKeepers-submitted institutional data. Recommendations: HSAG recommends that HealthKeepers investigate the root cause(s) for the element surplus finding to ensure that the institutional encounters for the <i>Secondary Diagnosis Codes</i> (6.6 percent surplus) data element is submitted completely.
—	Weakness: The EDV comparative analysis for data element accuracy also found that among the element-level accuracy results for professional and institutional encounters, HealthKeepers had four element accuracy rates that fell below 95.0 percent. This indicates that there were key data element(s) in the DMAS-submitted encounter records that were inaccurate when compared to the specified HealthKeepers-submitted data. Recommendations: HSAG recommends that HealthKeepers investigate the root cause(s) for the element accuracy findings to ensure the following data elements have accurate values: - Professional encounters: <i>Servicing Provider Taxonomy Code</i> (76.0 percent accuracy) and <i>MCO Received Date</i> (88.5 percent accuracy) - Institutional encounters: <i>Secondary Diagnosis Codes</i> (5.1 percent accuracy) and <i>DRG</i> (0.0 percent accuracy)

Molina

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

Strengths Related to Quality	
+	PIP results showed that Molina received <i>Met</i> validation scores for 100 percent of all applicable evaluation elements validated for Steps 1–8 for each PIP. For three of the four PIPs, <i>AMB-ED</i>, <i>Timeliness of Prenatal Care</i>, and <i>Transitions of Care—Patient Engagement After Inpatient Discharge</i>, the MCO implemented meaningful interventions which led to a statistically significant improvement in Remeasurement 1 compared to baseline. <i>Tobacco Use Cessation in Pregnant Women</i> showed non-statistically significant improvement in Remeasurement 1 compared to baseline.

Strengths Related to Quality

	PMV found that within the Care for Chronic Conditions domain, Molina displayed strong performance for the <i>Asthma Medication Ratio—Total</i> and <i>Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation—Systemic Corticosteroid</i> PM indicators, with the MCO's rates meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 75th percentile. These results indicate that the MCO had established effective processes for medication management of members with respiratory conditions.
	The encounter data validation IS review activity found that Molina had relatively robust internal reports to monitor encounter data accuracy, completeness, and timeliness for encounters that Molina collected. The encounter data validation comparative analysis for record completion found that for professional and institutional encounters, Molina had rates below 5.0 percent for both record omission and record surplus. This indicates that the professional and institutional records could mostly be identified in both data sources (i.e., the DMAS-submitted data and Molina-submitted data). In addition, the encounter data validation comparative analysis for data element completeness found that Molina performed well with all pharmacy key data elements having both element omission and surplus rates below 5.0 percent. This indicates that all relevant key data elements in the pharmacy records that could be matched between the DMAS-submitted and the United-submitted data were largely complete. The encounter data validation comparative analysis for data element accuracy found that all pharmacy encounter data elements had an accuracy rate greater than 95.0 percent. This indicates that records which could be matched between the DMAS-submitted and the Molina-submitted data largely contained the same values.

Strengths Related to Access and Timeliness

	The phantom network analysis identified that the majority (i.e., greater than 75 percent) of psychiatry, obstetrics and gynecology, PCP, and pediatric providers in Molina's provider network were considered "Active" and had provided services to at least one member in the network. These results indicate that members should have access to care and services from these provider types when needed.
	The network adequacy validation found that Molina had established a robust process to maintain the accuracy and completeness of provider information through its quarterly PIFs and a three-year cycle for credentialing and recredentialing process. In addition, Molina continuously assessed quality of data extracts through validating data loads to the Quest Analytics software. Molina

Strengths Related to Access and Timeliness

	also had automated processes that updated the provider records in QNXT from the DMAS PRN file.
	PMV found that within the Behavioral Health domain, Molina displayed strong performance for both <i>Initiation and Engagement of Substance Use Disorder Treatment</i> PM indicators, with the MCO's rates meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 75th and 90th percentile, respectively. These findings suggest effective implementation of some ARTS benefit requirements.
	Molina achieved full compliance in six of the 17 standards reviewed during the compliance review of federal and DMAS contract requirements, demonstrating strengths and adherence to all requirements measured in the following areas: - Standard I: Disenrollment: Requirements and Limitations - Standard III: Emergency and Poststabilization Services - Standard IV: Availability of Services - Standard IX: Confidentiality - Standard XIII: Health Information Systems - Standard XV: Program Integrity These findings suggest that Molina developed the necessary policies, procedures, and processes to operationalize the federal and DMAS contract requirements for these standards.

Weaknesses and Recommendations

	Weakness: The phantom network analysis found that over 42 percent of the BH providers and 32.8 percent of physician assistants and nurse practitioner providers were not considered active in Molina's provider network. Why the weakness exists: This weakness may exist because providers are either not providing services to Medicaid members or because providers are billing services provided under other providers. Recommendations: HSAG recommends that Molina conduct surveys of providers that are contracted, but not providing services, to ensure they are providing services to Medicaid members. Additionally, HSAG recommends that Molina provide additional training to ensure all billing correctly reflects the servicing provider separate from the billing provider, as appropriate.
	Weakness: The network adequacy validation activity found that Molina was missing some indicators for the time and distance standard. Recommendations: HSAG recommends that Molina review the reporting requirements for all time and distance indicators approved by DMAS for network adequacy to ensure accurate reporting.
	Weakness: HSAG noted during the performance improvement project validation that Molina provided raw data as an attachment to the <i>AMB-ED</i> PIP submission

Weaknesses and Recommendations

—	which is acceptable; however, Molina should provide an overview of the data within the PIP Submission Form.
	Recommendations: HSAG recommends that Molina revisit its causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. HSAG also recommends that Molina use Plan-Do-Study-Act (PDSA) cycles to meaningfully evaluate the effectiveness of each intervention. for interventions and determine whether they should be continued, expanded, revised, or replaced. In addition, HSAG recommends that Molina analyze intervention measure effectiveness data and provide a summary of the results for each intervention as part of the PIP Submission Form.
—	Weakness: PMV found that the following HEDIS MY 2023 PM rates fell below NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Molina: • <i>Breast Cancer Screening</i> • <i>Cervical Cancer Screening</i> • <i>Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment</i> • <i>Immunizations for Adolescents—Combination 1 and Combination 2</i> • <i>Use of Opioids from Multiple Providers—Multiple Prescribers and Multiple Pharmacies</i> The findings suggest that the MCO has opportunities to improve processes to ensure members receive preventive screenings and recommended care and services and to monitor utilization of behavioral healthcare, services, and prescribing patterns.
	Recommendations: To improve the rates for PMs that fell below the 25th percentile, HSAG recommends that Molina ensure that the above measures are included in the MY 2024 P4Q Program. Additionally, HSAG recommends that Molina leverage its Direct Scheduling and Clinic Day programs to assist provider groups who have lower rates on the screening and immunization measures. Finally, HSAG recommends that Molina conduct a segmentation analysis to identify potential disparities in noncompliant members, focusing on factors like race, ethnicity, age, gender, and geography.
—	Weakness: The compliance review of federal and DMAS contract requirements found that the areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 90 percent: • Standard II: Member Rights and Member Information • Standard V: Assurances of Adequate Capacity and Services • Standard VII: Coverage and Authorization of Services • Standard X: Grievance and Appeal Systems • Standard XI: Subcontractual Relationships and Delegation • Standard XII: Practice Guidelines

Weaknesses and Recommendations	
	These findings suggest that Molina did not consistently develop the necessary policies, procedures, and processes to operationalize the federal and DMAS contract requirements. Recommendations: HSAG recommends that the MCO update policies, procedures, and operational documents to comply with federal and DMAS requirements of each element scored as <i>Not Met</i>. HSAG also recommends that the MCO ensure that staff members are trained and knowledgeable about the requirements of the contract, and that they understand the policies and procedures that the MCO uses to meet federal and DMAS requirements.
—	Weakness: The EDV IS review activity for vision encounters found that Molina lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness. Recommendations: HSAG recommends that Molina and/or its vision subcontractor consider building reports to monitor encounter accuracy, completeness, and timeliness via metrics such as encounter volume by submission month or encounter volume PMPM.
—	Weakness: The EDV comparative analysis for record completeness found that among the record-level completeness results for pharmacy encounters, Molina had a rate exceeding 5.0 percent for record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the Molina-submitted data. Recommendations: HSAG recommends that Molina investigate the root cause(s) for the record surplus finding to ensure that complete encounter records are submitted to DMAS.
—	Weakness: The EDV comparative analysis for data element completeness found that among the element-level completeness results for professional encounters, Molina had one element omission and two element surplus rates that exceeded 5.0 percent, indicating that there were key data element(s) in the DMAS-submitted encounter records that were incomplete when compared to the above-specified Molina-submitted data. Recommendations: HSAG recommends that Molina investigate the root cause(s) for the element omission and surplus findings to ensure the following data elements are submitted completely: Professional encounters: <i>Procedure Code Modifiers</i> (5.4 percent omission), <i>Referring Provider NPI</i> (7.7 percent surplus), and <i>MCO Received Date</i> (13.8 percent surplus)
—	Weakness: The EDV comparative analysis for data element accuracy for professional and institutional encounters found that Molina had four and 10 element accuracy rates, respectively, that fell below 95.0 percent. This indicates that there were key data element(s) in the DMAS-submitted encounter records

Weaknesses and Recommendations	
	that were inaccurate when compared to the above-specified Molina-submitted data. Recommendations: HSAG recommends that Molina investigate the root cause(s) for the element accuracy findings to ensure the following data elements have accurate values: - Professional encounters: <i>Detail Service From Date</i> (85.7 percent accuracy), <i>Detail Service To Date</i> (85.5 percent accuracy), <i>Servicing Provider Taxonomy Code</i> (77.0 percent accuracy), and <i>Referring Provider NPI</i> (70.5 percent accuracy) - Institutional encounters: <i>Detail Service From Date</i> (68.2 percent accuracy), <i>Attending Provider NPI</i> (0.1 percent accuracy), <i>Servicing Provider Taxonomy Code</i> (0.7 percent accuracy), <i>Referring Provider NPI</i> (71.3 percent accuracy), <i>Primary Diagnosis Codes</i> (91.9 percent accuracy), <i>Secondary Diagnosis Codes</i> (41.0 percent accuracy), <i>DRG</i> (43.6 percent accuracy), <i>Type of Bill Code</i> (91.4 percent accuracy), <i>Header TPL Paid Amount</i> (70.8 percent accuracy), and <i>Detail TPL Paid Amount</i> (77.7 percent accuracy)
—	Weakness: Molina’s 2024 top-box score was statistically significantly lower than the 2023 NCQA general child Medicaid national average for <i>How Well Doctors Communicate</i>. Recommendations: HSAG recommends that Molina include rating information from the CAHPS survey to emphasize patient-centered communication in provider communications throughout the year. HSAG also recommends that Molina conduct root cause analyses of the study indicators that have been identified as areas of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG recommends that Molina continue to monitor the measures to ensure that significant decreases in scores over time do not continue to occur.

Sentara

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

Strengths Related to Quality	
+	The PIP validation activity found that Sentara received <i>Met</i> validation scores for 100 percent of all applicable evaluation elements validated for Steps 1–6 for each PIP. For Steps 7 and 8, two of the four PIPs received 100 percent compliance. For the <i>Transitions of Care—Patient Engagement After Inpatient Discharge</i> PIP, the MCO implemented meaningful interventions which led to a statistically significant improvement in Remeasurement 1 compared to baseline. Two PIPs, <i>Tobacco Use Cessation in Pregnant Women</i> and <i>AMB-ED</i>, showed non-statistically significant improvement in Remeasurement 1 compared to baseline.

Strengths Related to Quality	
+	PMV results within the Behavioral Health domain found that Sentara displayed strong performance for the following PM indicators: <i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Total</i>, <i>Antidepressant Medication Management—Effective Continuation Phase Treatment</i>, <i>Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia—Total</i>, <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Total</i>, both indicators for <i>Follow-Up After Emergency Department Visit for Substance Use</i> and <i>Initiation and Engagement of Substance Use Disorder Treatment</i>, and <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total</i>, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 50th percentile. In addition, within the Care for Chronic Conditions domain, Sentara displayed strong performance for the <i>Asthma Medication Ratio—Total</i> PM indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 75th percentile. These results indicate that the MCO's members have appropriate access to care related to some behavioral healthcare and care for chronic conditions.
+	The EDV comparative analysis for data element completeness found that Optima, now operating as Sentara Health Plan, excelled with all pharmacy key data elements having both element omission and surplus rates below 5.0 percent. This indicates that all relevant key data elements in the pharmacy records that could be matched between the DMAS-submitted and Optima-submitted data were largely complete.
+	The EDV comparative analysis for record completeness of VA Premier, now operating as Sentara Health Plan, for the pharmacy encounters found that VA Premier had a rate below 5.0 percent for record omission and record surplus. This indicates that the pharmacy records could mostly be identified in both data sources (i.e., the DMAS-submitted data and VA Premier-submitted data). The EDV comparative analysis for data element completeness also found that VA Premier excelled with all professional and pharmacy key data elements having both element omission and surplus rates below 5.0 percent. This indicates that all relevant key data elements in the professional and pharmacy records that could be matched between the DMAS-submitted and VA Premier-submitted data were largely complete. The EDV comparative analysis for data element accuracy also found that all pharmacy encounter data elements had an accuracy rate greater than 95.0 percent. This indicates that records which could be matched between the DMAS-submitted and VA Premier-submitted data largely contained the same values.

Strengths Related to Access and Timeliness	
	The phantom network analysis found that the majority (i.e., greater than 75 percent) of psychiatry, obstetric and gynecological and pediatric providers in Sentara's provider network were considered "Active" and had provided services to at least one member in the network.
	Network adequacy validation results demonstrated that Sentara had established a robust process to maintain the accuracy and completeness of provider information through its quarterly confirmation of accurate provider data and a three-year cycle for credentialing and recredentialing process. In addition, Sentara continuously assessed quality of data extracts by ensuring data records were fully loaded and integrated from the source systems to Quest Analytics software.
	The compliance with federal and DMAS contract requirements review found that Sentara achieved full compliance in 13 of the 17 standards reviewed, demonstrating strengths and adherence to all requirements reviewed in the following areas: • Standard I: Disenrollment: Requirements and Limitations • Standard III: Emergency and Poststabilization Services • Standard IV: Availability of Services • Standard V: Assurances of Adequate Capacity and Services • Standard VI: Coordination and Continuity of Care • Standard VII: Coverage and Authorization of Services • Standard VIII: Provider Selection • Standard IX: Confidentiality • Standard XI: Subcontractual Relationships and Delegation • Standard XII: Practice Guidelines • Standard XIII: Health Information Systems • Standard XIV: Quality Assessment and Performance Improvement Program • Standard XV: Program Integrity These findings suggest that Sentara developed the necessary policies, procedures, and processes to operationalize the federal and DMAS contract requirements within these standards.
	Sentara's 2024 top-box scores were statistically significantly higher than the 2023 NCQA adult Medicaid national averages for three measures: <i>Rating of Personal Doctor</i> , <i>Rating of Specialist Seen Most Often</i> , and <i>Getting Needed Care</i> . These findings suggest a positive member experience when receiving services from the Sentara network providers.

Weaknesses and Recommendations	
—	Weakness: The phantom network analysis found that over 36 percent of the BH providers and 30.6 percent of PA/NP providers were considered inactive in Sentara's provider network.
	Why the weakness exists: This weakness may exist because providers are either not providing services to Medicaid members or because providers are billing services provided under other providers.
	Recommendations: HSAG recommends that Sentara conduct surveys of providers that are contracted but are not providing services to ensure they are providing services to Medicaid members. Additionally, Sentara may provide additional training to ensure all billing correctly reflects the servicing provider separate from the billing provider, as appropriate.
—	Weakness: PIP results identified that one of the four PIPs, <i>Timeliness of Prenatal Care</i>, demonstrated a decline in the performance indicator in Remeasurement 1 compared to baseline. Additionally, Sentara did not provide appropriate <i>p</i> values for two of the PIPs and one PIP did not address factors which threaten the comparability of Remeasurement 1 to baseline.
	Recommendations: HSAG recommends that Sentara revisit its causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. HSAG also recommends that Sentara use PDSA cycles to meaningfully evaluate the effectiveness of each intervention. In addition, HSAG recommends that Sentara analyze intervention measure effectiveness data and provide a summary of the results for each intervention as part of the PIP Submission Form. HSAG recommends that Sentara use one of the HSAG recommended statistical analysis tools to report the <i>p</i> value used to assess statistical significance between the remeasurement period and baseline data.
—	Weakness: The following HEDIS MY 2023 PM rates fell below NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Sentara: • <i>Breast Cancer Screening</i> • <i>Cervical Cancer Screening</i> • <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care</i> • <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total and Counseling for Physical Activity—Total</i> • <i>Ambulatory Care—Emergency Department (ED) Visits</i>
	Recommendations: To improve the rates for PMs that fell below the 25th percentile, HSAG recommends that Sentara conduct a segmentation analysis to identify potential disparities in noncompliant members, focusing on factors like race, ethnicity, age, gender, and geography. Sentara should then leverage its

Weaknesses and Recommendations

	maternal care programs to engage women in ways that help to address the barriers identified. Additionally, HSAG recommends that Sentara consider providing scorecards and/or care gap reports to providers with low performance on these measures and encourage collaboration on identifying the best care protocols for these types of patients, including scheduling future visits and sending reminders.
	Weakness: The compliance review of federal and DMAS contract requirements found that the areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 90 percent: - Standard II: Member Rights and Member Information - Standard X: Grievance and Appeal Systems These findings suggest that Sentara did not consistently develop the necessary policies, procedures, and processes to operationalize the requirements of its contract and did not always demonstrate compliance with the contract. Recommendations: HSAG recommends that the MCO update policies, procedures, and operational processes to comply with federal and DMAS requirements of each element scored as <i>Not Met</i>. HSAG also recommends that the MCO ensure that staff members are trained and knowledgeable about the requirements of the contract, and that they understand the policies and procedures that the MCO uses to meet federal and DMAS requirements.
	Weakness: The EDV IS review activity for NEMT encounters found that Optima, now Sentara Health Plan, lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness. Recommendations: HSAG recommends that Sentara and/or its NEMT subcontractor consider building reports to monitor encounter accuracy, completeness, and timeliness through reconciliation with financial reports.
	Weakness: The EDV IS review activity also found that Optima lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness for encounters that Optima collects. Recommendations: HSAG recommends that Sentara consider building reports to monitor encounter accuracy, completeness, and timeliness through reconciliation with financial reports for encounters that Optima collects.
	Weakness: The EDV comparative analysis for record completeness found that among the record-level completeness results for professional, institutional, and pharmacy encounters, Optima had a rate exceeding 5.0 percent for record omission and/or record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the above-specified Optima-submitted data. Recommendations: HSAG recommends that Sentara investigate the root cause(s) for the record omission and surplus findings to ensure that complete encounter records are submitted to DMAS.

Weaknesses and Recommendations

	Weakness: <u>Comparative Analysis: Data Element Completeness</u> Weakness: The EDV comparative analysis data element completeness among the element-level completeness results for professional and institutional encounters found that Optima had eight element omission and/or surplus rates that exceeded 5.0 percent, indicating that there were key data element(s) in the DMAS-submitted encounter records that were incomplete when compared to the above-specified Optima-submitted data. Recommendations: HSAG recommends that Sentara investigate the root cause(s) for the element omission and surplus findings to ensure the following data elements are submitted completely: - Professional encounters: <i>Referring Provider NPI</i> (34.2 percent omission), <i>Billing Provider NPI</i> (11.0 percent surplus), <i>Rendering Provider NPI</i> (11.0 percent surplus), <i>Procedure Code Modifiers</i> (12.0 percent surplus), and <i>MCO Received Date</i> (5.2 percent surplus) - Institutional encounters: <i>Servicing Provider Taxonomy Code</i> (99.0 percent omission), <i>NDC</i> (6.9 percent omission), and <i>Drug Quantity</i> (6.9 percent omission)
	Comparative Analysis: Data Element Accuracy Weakness: The EDV comparative analysis data element accuracy among the element-level accuracy results for professional, institutional, and pharmacy encounters found that Optima had 18 element accuracy rates that fell below 95.0 percent. This indicates that there were key data element(s) in the DMAS-submitted encounter records that were inaccurate when compared to the above-specified Optima-submitted data. Recommendations: HSAG recommends that Sentara investigate the root cause(s) for the element accuracy findings to ensure the following data elements have accurate values: - Professional encounters: <i>Member ID</i> (25.1 percent accuracy), <i>Billing Provider NPI</i> (63.5 percent accuracy), <i>Servicing Provider Taxonomy Code</i> (85.5 percent accuracy), <i>Header TPL Paid Amount</i> (85.1 percent accuracy), <i>Detail TPL Paid Amount</i> (86.6 percent accuracy), <i>MCO Received Date</i> (79.0 percent accuracy), and <i>MCO Paid Date</i> (57.5 percent accuracy) - Institutional encounters: <i>Member ID</i> (0.0 percent accuracy), <i>Billing Provider NPI</i> (90.4 percent accuracy), <i>Secondary Diagnosis Codes</i> (46.6 percent accuracy), <i>Procedure Code Modifiers</i> (92.6 percent accuracy), <i>DRG</i> (52.4 percent accuracy), <i>Type of Bill Code</i> (89.6 percent accuracy), <i>Header TPL Paid Amount</i> (55.5 percent accuracy), <i>Detail TPL Paid Amount</i> (79.2 percent accuracy), and <i>MCO Paid Date</i> (61.1 percent accuracy) - Pharmacy encounters: <i>MCO Received Date</i> (<0.1 percent accuracy) and <i>MCO Paid Date</i> (45.8 percent accuracy)
	Weakness: The EDV IS review activity for vision encounters found that VA Premier lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness.

Weaknesses and Recommendations	
	Recommendations: HSAG recommends that Sentara and/or its vision subcontractor consider building reports to monitor encounter accuracy, completeness, and timeliness through reconciliation with financial reports.
—	<u>IS Review Activity</u> Weakness: The EDV IS review activity for NEMT encounters found that VA Premier lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness.
	Recommendations: HSAG recommends that Sentara and/or its NEMT subcontractor consider building reports to monitor encounter accuracy, completeness, and timeliness through reconciliation with financial reports.
—	Weakness: The EDV IS review activity also found that VA Premier lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness for encounters that VA Premier collects.
	Recommendations: HSAG recommends that Sentara consider building reports to monitor encounter accuracy, completeness, and timeliness through reconciliation with financial reports for encounters that VA Premier collects.
—	<u>Comparative Analysis: Record Completeness</u> Weakness: The EDV comparative analysis for record completeness among the record-level completeness results for professional and institutional encounters found that VA Premier had a rate exceeding 5.0 percent for record omission and/or record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the above-specified VA Premier-submitted data.
	Recommendations: HSAG recommends that Sentara investigate the root cause(s) for the record omission and surplus findings to ensure that complete encounter records are submitted to DMAS.
—	<u>Comparative Analysis: Data Element Completeness</u> Weakness: The EDV comparative analysis for data element completeness among the element-level completeness results for institutional encounters found that VA Premier had two element omission rates that exceeded 5.0 percent, indicating that there were key data element(s) in the DMAS-submitted encounter records that were incomplete when compared to the above-specified VA Premier-submitted data.
	Recommendations: HSAG recommends that Sentara investigate the root cause(s) for the element omission findings to ensure the following data elements are submitted completely: Institutional encounters: <i>NDC</i> (14.4 percent omission) and <i>Drug Quantity</i> (14.4 percent omission)
—	<u>Comparative Analysis: Data Element Accuracy</u> Weakness: The EDV comparative analysis for data element accuracy among the element-level accuracy results for professional and institutional encounters also found that VA Premier had seven element accuracy rates that fell below 95.0

Weaknesses and Recommendations

percent. This indicates that there were key data element(s) in the DMAS-submitted encounter records that were inaccurate when compared to the above-specified VA Premier-submitted data.

Recommendations: HSAG recommends that Sentara investigate the root cause(s) for the element accuracy findings to ensure the following data elements have accurate values:

- Professional encounters: *MCO Received Date* (81.9 percent accuracy) and *MCO Paid Date* (77.0 percent accuracy)
- Institutional encounters: *Secondary Diagnosis Codes* (43.2 percent accuracy), *Type of Bill Code* (89.7 percent accuracy), *Header TPL Paid Amount* (85.2 percent accuracy), *Detail TPL Paid Amount* (93.9 percent accuracy), and *MCO Received Date* (65.2 percent accuracy)

* VA Premier merged with Optima during CY 2023 forming the Sentara Health Plan.

United

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

Strengths Related to Quality	
	PIP validation found that United received <i>Met</i> validation scores for 100 percent of all applicable evaluation elements validated for Steps 1–8 for each PIP. The MCO implemented meaningful interventions which led to a statistically significant improvement in Remeasurement 1 compared to baseline in three of the four PIPs, <i>Transitions of Care—Patient Engagement After Inpatient Discharge</i> , <i>Timeliness of Prenatal Care</i> , and <i>Tobacco Use Cessation in Pregnant Women</i> .
	PMV found that within the Behavioral Health domain, United displayed strong performance for the <i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Total</i>, <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Total</i>, <i>Diagnosed Mental Health Disorders—Total</i>, both PM indicators for <i>Initiation and Engagement of Substance Use Disorder Treatment</i>, all three <i>Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing</i>, <i>Cholesterol Testing</i>, and <i>Blood Glucose and Cholesterol Testing—Total</i> PM indicators, and <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total</i> PM indicators, with the MCO's rates meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 50th percentile. In addition, within the Care for Chronic Conditions domain, United displayed strong performance for the <i>Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)</i> PM indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 75th percentile; and the <i>Hemoglobin A1c Control for Patients With Diabetes—HbA1c</i>

Strengths Related to Quality	
	<i>Adequate Control (<8.0%)</i> PM indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 90th percentile.
+	The EDV comparative analysis for record completeness found that for professional and institutional encounters, United had rates below 5.0 percent for both record omission and record surplus. This indicates that the professional and institutional records could mostly be identified in both data sources (i.e., the DMAS-submitted data and United-submitted data). In addition, the EDV comparative analysis for data element completeness found that United excelled with all pharmacy key data elements having both element omission and surplus rates below 5.0 percent. This indicates that all relevant key data elements in the pharmacy records that could be matched between the DMAS-submitted and United-submitted data were largely complete.
Strengths Related to Access and Timeliness	
+	Phantom network analysis found that the majority (i.e., greater than 75 percent) of PSY, OBGYN, PCP, and PEDIATRIC providers in United's provider network were considered "Active" and had provided services to at least one member in the network.
+	NAV found that United had established robust processes to keep provider data up to date and accurate through its provider data audits, credentialing process, and telephone call campaigns to provider offices. In addition, United offered providers multiple options for provider data updates through multiple intake channels that allowed providers the opportunity to attest to data via My Practice Profile, Inbound Demographic Change Line, Roster Processing, and CAQH ProView.
+	Within the Children's Preventive Care domain, PMV found that United displayed strong performance for the <i>Child and Adolescent Well-Care Visits—Total</i> PM indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 75th percentile.
+	United achieved full compliance in 9 of the 17 standards reviewed during the compliance review of federal and DMAS contract requirements, demonstrating strengths and adherence to all requirements measured in the following areas: - Standard I: Disenrollment: Requirements and Limitations - Standard III: Emergency and Poststabilization Services - Standard IV: Availability of Services - Standard VI: Coordination and Continuity of Care - Standard IX: Confidentiality - Standard XI: Subcontractual Relationships and Delegation - Standard XIII: Health Information Systems - Standard XIV: Quality Assessment and Performance Improvement Program

Strengths Related to Access and Timeliness

- Standard XVI: Model of Care

These findings suggest that United developed the necessary policies, procedures, and processes to operationalize the federal and DMAS contract requirements within these standards.

Weaknesses and Recommendations



Weakness: The phantom network analysis found that over 46.1 percent of the BH providers and 26.7 percent of PA/NP providers were considered inactive in United's provider network.

Why the weakness exists: This weakness may exist because providers are either not providing services to Medicaid members or because providers are billing services provided under other providers.

Recommendations: HSAG recommends that United conduct surveys of providers that are contracted but are not providing services to ensure they are providing services to Medicaid members. Additionally, HSAG recommends that United provide additional training to ensure all billing correctly reflects the servicing provider separate from the billing provider, as appropriate.



Weakness: The NAV activity found that United did not use the correct time and distance standards to report network adequacy for respiratory therapy, dietary and nutrition, and physician assistants. In addition, United did not include douglas or LTSS in the network adequacy report.

Recommendations: HSAG recommends that United review the Time and Distance Standard settings for all categories prior to running the report to ensure compliance with DMAS requirements. HSAG also recommends that United review the network adequacy report to ensure all required categories are included.



Weakness: PIP validation identified that one of the PIPs, *AMB-ED*, demonstrated a decline in the performance indicator in Remeasurement 1 compared to baseline.

Recommendations: HSAG recommends that United revisit its causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement. HSAG also recommends that United use PDSA cycles to meaningfully evaluate the effectiveness of each intervention. In addition, HSAG recommends that United analyze intervention measure effectiveness data and provide a summary of the results for each intervention as part of the PIP Submission Form.



Weakness: The following HEDIS MY 2023 PM rates fell below NCQA's Quality Compass HEDIS MY 2022 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for United:

- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*

Weaknesses and Recommendations

	• <i>Use of Opioids from Multiple Providers—Multiple Prescribers and Multiple Pharmacies</i> • <i>Ambulatory Care—Emergency Department (ED) Visits</i> Recommendations: To improve the rates for PMs that fell below the 25th percentile, HSAG recommends that United conduct a segmentation analysis to identify potential disparities in noncompliant members, focusing on factors like race, ethnicity, age, gender, and geography. HSAG also recommends that United ensure these measures are included in the Clinical Quality Dashboard that it makes available to providers to help identify member needs and care gaps in real time. HSAG further recommends that United ensure that providers with low performance on these measures know how to access the dashboard. Finally, HSAG recommends that United collaborate with low-performing providers on these measures and help identify the best care protocols for these types of patients.
—	Weakness: The compliance review of federal and DMAS contract requirements found the areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 90 percent: • Standard II: Member Rights and Member Information • Standard V: Assurances of Adequate Capacity and Services • Standard X: Grievance and Appeal Systems • Standard XII: Practice Guidelines • Standard XV: Program Integrity • Standard XVII: EPSDT These findings suggest that United did not consistently develop the necessary policies, procedures, and processes to operationalize the federal and DMAS contract requirements. Recommendations: HSAG recommends that the MCO update policies, procedures, and operational documents to comply with federal and DMAS requirements of each element scored as <i>Not Met</i>. HSAG also recommends that the MCO ensure that staff members are trained and knowledgeable about the requirements of the contract, and that they understand the policies and procedures that the MCO uses to meet federal and DMAS requirements.
—	Weakness: The EDV IS review activity found that for pharmacy encounters, United lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness. Recommendations: HSAG recommends that United and/or its pharmacy subcontractor consider building reports to monitor encounter accuracy, completeness, and timeliness through metrics such as encounter volume by submission month or encounter volume PMPM.

Weaknesses and Recommendations	
	Weakness: The EDV IS review activity also found that for NEMT encounters, United lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness.
	Recommendations: HSAG recommends that United and/or its NEMT subcontractor consider building reports to monitor encounter accuracy, completeness, and timeliness through metrics such as encounter volume by submission month or encounter volume PMPM.
	Weakness: The EDV IS review activity found that United lacked a sufficient number of comprehensive reports to monitor encounter data accuracy, completeness, and timeliness for encounters that United collects.
	Recommendations: HSAG recommends that United consider building reports to monitor encounter accuracy, completeness, and timeliness through metrics such as encounter volume by submission month or encounter volume PMPM for encounters that United collects.
	Weakness: The EDV comparative analysis for record completeness found that among the record-level completeness results for pharmacy encounters, United had a rate exceeding 5.0 percent for record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the above-specified United-submitted data.
	Recommendations: HSAG recommends that United investigate the root cause(s) for the record surplus finding to ensure that complete encounter records are submitted to DMAS.
	Weakness: The EDV comparative analysis for data element completeness found that among the element-level completeness results for professional and institutional encounters, United had three element surplus rates that exceeded 5.0 percent, indicating that there were key data element(s) in the DMAS-submitted encounter records that were incomplete when compared to the above-specified United-submitted data.
	Recommendations: HSAG recommends that United investigate the root cause(s) for the element surplus findings to ensure the following data elements are submitted completely: - Professional encounters: <i>Servicing Provider Taxonomy Code</i> (7.7 percent surplus) - Institutional encounters: <i>Secondary Diagnosis Codes</i> (6.5 percent surplus) and <i>Type of Bill Code</i> (5.1 percent surplus)
	Weakness: The EDV comparative analysis for data element accuracy found that among the element-level accuracy results for professional, institutional, and pharmacy encounters, United had nine element accuracy rates that fell below 95.0 percent. This indicates that there were key data element(s) in the DMAS-submitted encounter records that were inaccurate when compared to the above-specified United-submitted data.

Weaknesses and Recommendations

	Recommendations: HSAG recommends that United investigate the root cause(s) for the element accuracy findings to ensure the following data elements have accurate values: - Professional encounters: <i>Header TPL Paid Amount</i> (92.8 percent accuracy) and <i>Detail TPL Paid Amount</i> (93.4 percent accuracy) - Institutional encounters: <i>Secondary Diagnosis Codes</i> (0.0 percent accuracy), <i>Surgical Procedure Codes</i> (69.5 percent accuracy), <i>DRG</i> (0.0 percent accuracy), <i>Type of Bill Code</i> (92.1 percent accuracy), <i>Header TPL Paid Amount</i> (80.3 percent accuracy), and <i>Detail TPL Paid Amount</i> (85.9 percent accuracy) - Pharmacy encounters: <i>MCO Paid Date</i> (0.1 percent accuracy)
	Weakness: United's 2024 top-box scores were statistically significantly lower than the 2023 NCQA general child Medicaid national average for <i>Getting Needed Care</i> and <i>Customer Service</i>. Recommendations: HSAG recommends that United evaluate the process of care delivery to identify if there are any operational issues contributing to access to care for members as well as identify and resolve dissatisfaction in customer and clinical services by addressing and providing solutions to customer service complaints. HSAG also recommends that United conduct root cause analyses of the study indicators that have been identified as areas of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG recommends that United continue to monitor the measures to ensure that significant decreases in scores over time do not continue to occur.

Appendix A. Technical Report and Regulatory Crosswalk

Table A-1 lists the required and recommended elements for EQR annual technical reports, in accordance with 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

Item #	Required Elements	Page Number
General Report Requirements		
1.	The state submitted its EQR technical report by April 30th .	Cover Page
2.	Include a clickable or hyperlinked table of contents for easy navigation throughout the report.	i – iii
3.	Produce a searchable PDF to enable stakeholders to review topics of interest and facilitate use of the reports for topic-specific analyses.	Entire Document
4.	Use the names of the managed care entities (MCEs) when referring to plan performance. Findings and comparisons should refer to MCEs by name to facilitate transparency and stakeholder understanding of specific plan performance.	Page 1-1 Entire Document
5.	All eligible Medicaid and Children’s Health Insurance Program (CHIP) plans are included in the report. <i>TIP: Identify the MCEs subject to EQR by plan name, MCE type, managed care authority, and population(s) served in an introduction, executive summary, or appendix. Explain MCE exclusions (overall or by mandatory or optional EQR activity) by providing context on MCE mergers, acquisitions, or terminations. §438.364(a).</i>	1-1
6.	The State must ensure that the EQR results in an annual detailed technical report summarize findings on access and quality of care , including: (1) A description of the manner in which the data from all activities conducted in accordance with § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, or PAHP <i>TIP: Include a description for all three activities noted under the regulation (1) how data were aggregated, (2) how they were was analyzed, and (3) how conclusions were drawn about the MCE’s ability to furnish services. These findings should reflect a comparison to the domains of quality, timeliness, and access to healthcare services.</i>	1-6 – 1-13
7.	For each EQR-related activity conducted in accordance with § 438.358: - Objectives; - Technical methods of data collection and analysis; - The data and a description of data obtained, including validated performance measurement, any outcomes data and results from quantitative assessments,	Appendix B

Item #	Required Elements	Page Number
	for each activity conducted in accordance with § 438.358(b)(1)(i), (ii) and (iv) of this subpart; and Conclusions drawn from the data	
8.	Include an assessment of each MCE's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries. TIP: - Include a chart outlining each MCE's strengths and weaknesses for each EQR activity and designate a quality, timeliness, and access domain. - Highlight substantive findings concerning the extent to which each MCE 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. - Consider using the Strengths-Weaknesses QAT Worksheet	Section 13
9.	The technical report must include recommendations for improving the quality of health care services furnished by each MCO, PIHP, or PAHP. TIP: - Include recommendations for each MCE. Recommendations should share the EQRO's understanding of why the weakness exists and suggest steps for how the MCE—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 MCE and/or state can identify the cause. - When determining recommendations, EQROs should consider whether the suggested actions are within the authority of the MCE (or state).	Section 13 13-2 – 13-5 13-7 – 13-10 13-12 – 13-15 13-18 – 13-22 13-24 – 13-27
10.	The technical report must include recommendations for how the state can target goals and objectives in the quality strategy , under §438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid or CHIP beneficiaries. TIP: 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 an MCE 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.	1-14 – 1-16

Item #	Required Elements	Page Number
11.	Ensure methodologically appropriate, comparative information about all MCEs, consistent with guidance included in the EQR protocols issued in accordance with § 438.352(e). TIP: - Aggregate findings across MCEs for each EQR activity and show comparisons. - Provide context for the individual MCE 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
12.	Include an assessment of the degree to which each MCE has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. TIP: - State the prior year finding and describe the assessment of each MCE'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 MCE or state. - Document assessments with the same specificity used when reporting on initial findings.	Appendix E
13.	Include the names of the MCOs exempt from external quality review by the State, including the beginning date of the current exemption period, or that no MCOs are exempt, as appropriate.	1-1
14.	EQR technical reports should share the EQRO's timeline for conducting EQR activities. For example, the report shared the measurement period for the performance measures validated by the EQRO. The report should then clarify when the EQRO received the performance measure data and conducted the validation. This will help the reader better understand the state's overall EQR timeline.	1-1 Appendix B
15.	The information included in the technical report must not disclose the identity or other protected health information of any patient. 42 CFR 438.364(d) TIP: - 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 MCEs 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
Performance Improvement Projects (PIPs) Report Requirements		
16.	The technical report must include information on the validation of PIPs that were underway during the preceding 12 months. TIP:	Section 4

Item #	Required Elements	Page Number
	<i>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 time-frame under review to a corresponding measurement or performance period such as state or federal fiscal year, or calendar year.</i>	
17.	The technical report must include a description of PIP interventions associated with each state-required PIP topic for the current EQR review cycle. Include information on the effectiveness of PIP interventions associated with each QAPI PIP to align with the 2023 EQR Protocols. To present this information, the state could include an MCP-level table describing each PIP's planned or implemented interventions, as well as the EQRO's recommendations for improving the interventions and any early insights on the success of the interventions. *The state may include a hyperlink if this information already exists in a separate document. As a reminder, if the reports include hyperlinks, these hyperlinks are considered part of the report and must be maintained. Resources to support reporting this information are the PIP validation reporting template. TIP: <i>For states with many MCEs 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 information in a cohesive way that allows for brevity in the sections that describe data analysis and conclusions.</i>	4-6 4-9 – 4-11 4-13 – 4-16 4-18 – 4-21 4-23 – 4-24
18.	Validation of performance improvement projects PIPs: Objectives TIP: <i>Provide the state or EQRO's objective for conducting the mandatory activity itself, including the general approach or methods of validation used by the EQRO. The state may also include the objective or aim statement for each PIP to satisfy this criterion for the PIP validation activity.</i>	4-1 Appendix B
19.	Validation of performance improvement projects PIPs: Technical methods of data collection and analysis TIP: <i>Provide a description of how data was obtained by the EQRO to conduct the validation activity. If a collection tool is used, providing an example of the format of the tool, or questions asked, in an appendix is a best practice. Further, describe how data is analyzed to connect the data requested to the analytical methods that eventually support the conclusions drawn with those data and analyses.</i>	4-2 Appendix B
20.	Validation of performance improvement projects PIPs: Description of data obtained;	4-4 – 4-5 4-8 – 4-9 4-12 – 4-13

Item #	Required Elements	Page Number
	TIP: Based upon the collection efforts identified in the Technical methods of data collection and analysis section, 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.	4-17 – 4-18 4-22 – 4-23 Appendix B
21.	Validation of performance improvement projects PIPs: Conclusions drawn from the data TIP: 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.	4-7 4-11 4-16 4-21 4-25
Performance Measure Validation		
22.	The technical report must include information on the validation of each MCE's performance measure required by 438.330(b)(2) or each MCE performance measure calculated by the State during the preceding 12 months. Include a list of the measures validated. TIP: - 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 time-frame under review to a corresponding measurement or performance period such as state or federal fiscal year, or calendar year.	Section 3
23.	Performance measure validation: Objectives TIP: 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.	5-1
24.	Performance measure validation: Technical methods of data collection and analysis TIP: 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.	5-1 Appendix B
25.	Performance measure validation: Description of data obtained;	5-1 Appendix B

Item #	Required Elements	Page Number
	TIP: Based upon the collection efforts identified in the Technical methods of data collection and analysis section, 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.	
26.	Performance measure validation: Conclusions drawn from the data TIP: 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.	5-2 – 5-8
Compliance Review		
27.	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 compliance with the standards set forth in Subpart D and the QAPI requirements described in 42 CFR §438.330. The technical report must provide MCE 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. TIP: - For each of the 11 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 MCEs across the three-year review period.	6-3 6-5 6-7 6-9 6-11 Appendix B
29.	Review for compliance: Objectives	6-1 Appendix B

Item #	Required Elements	Page Number
	TIP: 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.	
30.	Review for compliance: Technical methods of data collection and analysis TIP: 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.	6-1 Appendix B
31.	Review for compliance: Conclusions drawn from the data TIP: 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.	6-4 6-6 6-8 6-10 6-12 – 6-13
Validation of Network Adequacy		
32.	EQRO should compile the results for each MCE into the annual EQR Technical Report. In the report, the EQRO will provide its assessment of each MCE's ability to: collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support MCP and state network adequacy monitoring efforts. The EQRO's technical report to the state should follow the state's required format, and include the following elements, along with worksheets, tools, and other supporting documentation.	Section 7 7-4 – 7-5 7-7 – 7-8 7-9 – 7-10 7-12 – 7-13 7-14 – 7-15
33.	Validation of MCO, PIHP, or PAHP network adequacy during the preceding 12 months to comply with requirements set forth in § 438.68 and, if the State enrolls Indians in the MCO, PIHP, or PAHP, § 438.14(b)(1).	Section 7
34.	A description of the state's network adequacy standards for provider types covered by the state's MCEs, including minimum quantitative network adequacy standards, and the network adequacy indicators that were validated for each MCE (Worksheet 4.1 and Worksheet 4.2) ⁶⁴	7-3 – 7-4
35.	A list of the data and documentation validated by the EQRO (Worksheet 4.3)	7-4

⁶⁴ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicare.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf>. Accessed on: Nov 1, 2024.

Item #	Required Elements	Page Number
		Appendix B B-15
36.	A description of the EQRO's validation activities including: - The EQRO team members involved in the validation and other participants (MCE staff, vendors) - A summary of the validation strategy - Methods for collecting primary data - Data analysis methodology - Other considerations relevant to the network adequacy validation process	7-4 Appendix B
37.	Findings on the MCE's information systems capabilities and data integration, including documentation of the timing of the state's most recent ISCA and a description of what documentation was reviewed by the EQRO to support the validation of network adequacy (Worksheet 4.6)	7-1 7-4 – 7-5 7-7 – 7-8 7-9 – 7-10 7-12 – 7-13 7-14 – 7-15
38.	Analyses and conclusions for each network adequacy validation activity for each MCE. The EQRO should compile data across MCEs to create data tables with summary statistics for each MCE that include actual results and validation ratings (and analysis of patterns across MCEs), using the criteria established by the state in Activity 1	Section 7 7-4 – 7-5 7-7 – 7-8 7-9 – 7-10 7-12 – 7-13 7-14 – 7-15
39.	Recommendations for improving the reliability and validity of each MCE's process for monitoring network adequacy, including implications for the MCE's data systems, methods, and staffing (e.g., programming and analytic capacity) (Worksheet 4.8)	7-7 7-9 7-11 7-14 7-16
40.	When possible, the validation report should identify recommendations from the previous year's report submitted to the state , and discuss progress made on these recommendations over the past year based on information gathered during the validation process (Worksheet 4.8).	NA—First year reporting
41.	Review for NAV: Objectives TIP: 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.	7-1 Appendix B
42.	Review for NAV: Technical methods of data collection and analysis TIP: 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.	7-1 Appendix B

Item #	Required Elements	Page Number
43.	Review for NAV: Description of data obtained TIP: 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.	7-1 Appendix B
44.	Review for NAV: Conclusions drawn from the data TIP: 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.	7-7 7-9 7-11 7-14 7-16
All Other Optional Activities		
Each remaining optional activity included in the technical report must include a description of the activity and the following information: - Objectives - Technical methods of data collection and analysis - Description of data obtained - Conclusions drawn from the data.		
Phantom Network Analysis		
45.	Phantom Network Analysis: Objectives TIP: Provide the state or EQRO's objective for conducting the optional activity itself, including the general approach or methods of validation used by the EQRO.	3-19 8-1 – 8-2
46.	Phantom Network Analysis: Technical methods of data collection and analysis TIP: Provide a description of how data was obtained by the EQRO to conduct the 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
47.	Phantom Network Analysis: Description of data obtained TIP: Provide a description of how data was obtained by the EQRO to conduct the activity.	3-19 Appendix B
48.	Phantom Network Analysis:	3-20 – 3-22

Item #	Required Elements	Page Number
	Conclusions drawn from the data TIP: Having employed the process of data collection and validation using the types and nature of the data received, provide conclusions relevant to the optional activity.	8-2 8-6 8-7– 8-8 8-9 8-11 8-13 – 8-14
Encounter Data Validation		
49.	Encounter Data Validation: Objectives TIP: Provide the state or EQRO's objective for conducting the optional activity itself, including the general approach or methods of validation used by the EQRO.	9-1
50.	Encounter Data Validation: Technical methods of data collection and analysis TIP: Provide a description of how data was obtained by the EQRO to conduct the 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.	9-1 Appendix B
51.	Encounter Data Validation: Description of data obtained TIP: Provide a description of how data was obtained by the EQRO to conduct the activity.	9-1 Appendix B
52.	Encounter Data Validation: Conclusions drawn from the data TIP: Having employed the process of data collection and validation using the types and nature of the data received, provide conclusions relevant to the optional activity.	9-1 – 9-30
CAHPS		
53.	CAHPS: Objectives TIP: Provide the state or EQRO's objective for conducting the optional activity itself, including the general approach or methods of validation used by the EQRO.	10-1 Appendix B
54.	CAHPS: Technical methods of data collection and analysis TIP:	10-1 Appendix B

Item #	Required Elements	Page Number
	<i>Provide a description of how data was obtained by the EQRO to conduct the activity. If a collection tool is used, providing an example of the format of the tool, or questions asked, in an appendix is a best practice. Further, describe how data is analyzed to connect the data requested to the analytical methods that eventually support the conclusions drawn with those data and analyses.</i>	
55.	CAHPS: Description of data obtained TIP: <i>Provide a description of how data was obtained by the EQRO to conduct the activity.</i>	10-1 Appendix B
56.	CAHPS: Conclusions drawn from the data TIP: <i>Having employed the process of data collection and validation using the types and nature of the data received, provide conclusions relevant to the optional activity.</i>	10-1 – 10-11
ARTS Measurement Specification and Reporting		
57.	ARTS Measurement Specification and Reporting: Objectives TIP: <i>Provide the state or EQRO's objective for conducting the optional activity itself, including the general approach or methods of validation used by the EQRO.</i>	11-1 Appendix B
58.	ARTS Measurement Specification and Reporting: Technical methods of data collection and analysis TIP: <i>Provide a description of how data was obtained by the EQRO to conduct the activity. If a collection tool is used, providing an example of the format of the tool, or questions asked, in an appendix is a best practice. Further, describe how data is analyzed to connect the data requested to the analytical methods that eventually support the conclusions drawn with those data and analyses.</i>	Appendix B
59.	ARTS Measurement Specification and Reporting: Description of data obtained TIP: <i>Provide a description of how data was obtained by the EQRO to conduct the activity.</i>	Appendix B
60.	ARTS Measurement Specification and Reporting: Conclusions drawn from the data TIP:	11-3 – 11-7

Item #	Required Elements	Page Number
	<i>Having employed the process of data collection and validation using the types and nature of the data received, provide conclusions relevant to the optional activity.</i>	
Medicaid and CHIP Maternal and Child Health Focus Study		
61.	Medicaid and CHIP Maternal and Child Health Focus Study: Objectives TIP: Provide the state or EQRO's objective for conducting the optional activity itself, including the general approach or methods of validation used by the EQRO.	12-1 Appendix B
62.	Medicaid and CHIP Maternal and Child Health Focus Study: Technical methods of data collection and analysis TIP: Provide a description of how data was obtained by the EQRO to conduct the 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.	12-1 – 12-2 Appendix B
63.	Medicaid and CHIP Maternal and Child Health Focus Study: Description of data obtained TIP: Provide a description of how data was obtained by the EQRO to conduct the activity.	Appendix B
64.	Medicaid and CHIP Maternal and Child Health Focus Study: Conclusions drawn from the data TIP: Having employed the process of data collection and validation using the types and nature of the data received, provide conclusions relevant to the optional activity.	12-2 – 12-8
Child Welfare Focus Study		
65.	Child Welfare Focus Study: Objectives TIP: Provide the state or EQRO's objective for conducting the optional activity itself, including the general approach or methods of validation used by the EQRO.	12-10 Appendix B
66.	Child Welfare Focus Study: Technical methods of data collection and analysis TIP: Provide a description of how data was obtained by the EQRO to conduct the 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	Appendix B

Item #	Required Elements	Page Number
	<i>is analyzed to connect the data requested to the analytical methods that eventually support the conclusions drawn with those data and analyses.</i>	
67.	Child Welfare Focus Study: Description of data obtained TIP: Provide a description of how data was obtained by the EQRO to conduct the activity.	Appendix B
68.	Child Welfare Focus Study: Conclusions drawn from the data TIP: Having employed the process of data collection and validation using the types and nature of the data received, provide conclusions relevant to the optional activity.	12-10 – 12-24
Consumer Decision Support Tool		
69.	Consumer Decisions Support Tool: Objectives TIP: Provide the state or EQRO's objective for conducting the optional activity itself, including the general approach or methods of validation used by the EQRO.	3-37 Appendix B
70.	Consumer Decisions Support Tool: Technical methods of data collection and analysis TIP: Provide a description of how data was obtained by the EQRO to conduct the 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
71.	Consumer Decisions Support Tool: Description of data obtained TIP: Provide a description of how data was obtained by the EQRO to conduct the activity.	Appendix B
72.	Consumer Decisions Support Tool: Conclusions drawn from the data TIP: Having employed the process of data collection and validation using the types and nature of the data received, provide conclusions relevant to the optional activity.	3-38 – 3-39

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
- Network Adequacy Validation Methodology
- Phantom Network Analysis Methodology
- Encounter Validation Methodology
- Member Experience of Care Survey Methodology
- MCO Comparative and Statewide Calculation of Additional Performance Measure Results
- ARTS Measurement Specification and Reporting
- Medicaid and CHIP Maternal and Child Health Focus Study Methodology
- Child Welfare 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*, February 2023.(CMS EQR Protocol 1)⁶⁵ HSAG's PIP validation process includes two key components:

1. HSAG evaluates the technical structure of the PIP to ensure that the MCO designs, conducts, and reports on the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., Aim statement, population, sampling methods, performance indicator, 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, and

⁶⁵ 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.

the identification of 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, interventions, 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:

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

HSAG obtains the information and data needed to conduct the PIP validation from the MCO’s PIP Submission Form. This form provides detailed information about the PIP related to the steps completed and evaluated by HSAG.

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 be *Met*.

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the MCO adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. This validation rating is based on the scores for applicable evaluation elements in Steps 1 through 8 of the PIP validation tool. The second validation rating is only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP validation tool. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a *Met* score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

3. Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)

- *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
- *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
- *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
- *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.

4. Overall Confidence That the PIP Achieved Significant Improvement (Step 9)

- *High Confidence*: All performance indicators demonstrated statistically significant improvement over the baseline.
- *Moderate Confidence*: One of the three scenarios below occurred:
 - All performance indicators demonstrated improvement over the baseline, and some but not all performance indicators demonstrated statistically significant improvement over the baseline.
 - All performance indicators demonstrated improvement over the baseline, and none of the performance indicators demonstrated statistically significant improvement over the baseline.
 - Some but not all performance indicators demonstrated improvement over baseline, and some but not all performance indicators demonstrated statistically significant improvement over baseline.
- *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator or some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated statistically significant improvement over the baseline.
- *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance indicators demonstrated improvement over the baseline.

PIP Technical Assistance

HSAG provides ongoing PIP technical assistance to the MCOs and DMAS that includes training on how to complete the PIP Submission Form, quality improvement science tools, logically linking interventions that have the potential to impact the performance indicator outcomes with priority barriers, and evaluation of interventions to aid MCOs in making data driven decisions.

Validation of Performance Measure Methodology

DMAS contracted with HSAG, as its EQRO, to conduct PMV for the MCOs. 42 CFR §438.350(a) requires states that contract with MCOs, PIHPs, or PAHPs to have a qualified EQRO perform an annual EQR that includes validation of contracted entity performance measures (42 CFR §438.358[b][1][ii]). HSAG, in conjunction with ALI Consulting Services, LLC, conducted PMV for DMAS, validating the data collection and reporting processes used to calculate the performance measure rates by the MCOs in accordance with CMS EQR Protocol 2.

DMAS is responsible for administering the Medicaid program and CHIP in the Commonwealth of Virginia. DMAS refers to its CHIP program as FAMIS. The Cardinal Care program provides services to the Medicaid and FAMIS populations. DMAS contracted with five privately owned MCOs to provide services to members enrolled in the Cardinal Care program for CY 2023. 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 Cardinal Care MCOs and to determine the extent to which performance measures reported by the MCOs followed State specifications and reporting requirements. Table B-1 displays the Cardinal Care MCOs that were included in the PMV.

Table B-1—CY 2023 Cardinal Care MCOs

MCO Name
Aetna
HealthKeepers
Molina
Sentara
United

Objectives

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

Technical Methods of Data Collection

HSAG conducted the validation activities as outlined in CMS EQR Protocol 2. To complete the validation activities for MCOs, HSAG obtained a list of the performance measures that were selected by DMAS for validation.

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

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

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

Description of Data Obtained

CMS EQR Protocol 2 identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data HSAG reviewed and how HSAG analyzed these data:

- **Roadmap and ISCAT**—The MCOs submitted a Roadmap for HSAG’s review that was to be completed as part of the NCQA HEDIS Compliance Audit process. HSAG completed a thorough review of the Roadmap, which includes MCO operational and organizational structure; data systems and data reporting structure and processes; and additional information related to HEDIS Compliance Audit standards. Additionally, the MCOs completed and submitted an ISCAT for HSAG’s review of the performance measures. The ISCAT supplemented the information included in the Roadmap and addresses data collection and reporting specifics of non-HEDIS measures. HSAG used responses from the Roadmap and ISCAT to complete the pre-virtual site assessment of IS.
- **Medical record documentation**—The MCOs were responsible for completing the medical records review section within the Roadmap for the performance measures reported using the hybrid method. In addition, HSAG requested that the MCOs submit the following documentation for review: medical record abstraction tools and instructions, training materials for MRR staff members, and policies and procedures outlining the processes for monitoring the accuracy of the abstractions performed by the review staff members. HSAG conducted over-read of 16 records from the hybrid sample for each performance measure. HSAG followed NCQA’s guidelines to validate the integrity of the MRRV processes used by the MCOs and determined if the findings impact the audit results for any performance measure rate.

- **Source code (programming language) for performance measures**—The MCOs that calculate the performance measures using internally developed source code will be required to submit source code for each performance measure being validated. HSAG will complete a line-by-line review of the supplied source code to ensure compliance with the performance measure specifications required by DMAS. HSAG identified any areas of deviation from the specifications, evaluating the impact to the performance measure and assessing the degree of bias (if any). MCOs that do not use source code were required to submit documentation describing the steps taken for performance measure calculation. If the MCOs outsourced programming for HEDIS performance measure production to an outside vendor, the MCOs were required to submit the vendor's NCQA performance measure certification reports.
- **Supporting documentation**—HSAG requested documentation that provides additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, performance measure certification reports, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

How Data Were Aggregated and Analyzed

During the virtual site visit, HSAG collected additional information to compile PMV findings using several methods including interviews, system demonstration, review of data output files that identify numerator and denominator compliance, observation of data processing, and review of data reports. The virtual site strategies included:

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

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

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

How Conclusions Were Drawn

After the virtual site visit, HSAG reviewed final performance measure rates submitted by the MCOs to DMAS and followed up with each MCO on any outstanding issues identified during the documentation review and/or during the virtual 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 each MCO, documenting the validation findings. Based on all validation activities, HSAG determined the validation result for each performance measure. CMS EQR Protocol 2 identifies possible validation results for performance measures, defined in Table B-2.

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

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

According to CMS EQR Protocol 2, the validation result for each performance measure is determined by the magnitude of the errors detected for the audit elements, not by the number of errors detected within each audit element. It is possible for an audit element to receive a validation result of DNR when the impact of even a single error associated with that element biased the reported performance measure rate by more than 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 performance measure DNR.

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

Table B-3—Performance Measure List for SFY 2024

Measure Indicator Name	Measure Specification	Reporting Method*
<i>Asthma Admission Rate (Per 100,000 Member Months)</i>	AHRQ PDI	Admin
<i>Blood Pressure Control for Patients With Diabetes</i>	HEDIS	Hybrid
<i>Child and Adolescent Well-Care Visits</i>	HEDIS	Admin
<i>Childhood Immunization Status—Combination 3</i>	HEDIS	Hybrid
<i>Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)—Total</i>	Adult Core Set	Admin
<i>Eye Exam for Patients With Diabetes</i>	HEDIS	Hybrid
<i>Follow-Up After Emergency Department (ED) Visit for Mental Illness—7-Day Follow-Up—Total</i>	HEDIS	Admin
<i>Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total</i>	HEDIS	Admin
<i>Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total</i>	HEDIS	Admin
<i>Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—Total</i>	HEDIS	Admin
<i>Heart Failure Admission Rate (Per 100,000 Member Months)—Total</i>	Adult Core Set	Admin
<i>Hemoglobin A1c (HbA1c) Control for Patients With Diabetes</i>	HEDIS	Hybrid
<i>Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment</i>	HEDIS	Admin
<i>Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment</i>	HEDIS	Admin
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	HEDIS	Hybrid
<i>Prenatal and Postpartum Care—Postpartum Care</i>	HEDIS	Hybrid

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

Assessment of Compliance With Medicaid Managed Care Regulations

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

HSAG divided the federal regulations into 17 standards consisting of related regulations and contract requirements. Table B-4 describes the standards and associated regulations and requirements reviewed for each standard during the OSRs.

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

Standards	Associated Federal Citation ¹	
	Medicaid	CHIP
Standard I—Disenrollment: Requirements and Limitations	§438.56	§457.1212
Standard II—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220
Standard III—Emergency and Poststabilization Services	§438.114	§457.1228
Standard IV—Availability of Services	§438.206	§457.1230(a)
Standard V—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b) §457.1218
Standard VI—Coordination and Continuity of Care	§438.208	§457.1230(c)
Standard VII—Coverage and Authorization of Services	§438.210	§457.1230(d)
Standard VIII—Provider Selection	§438.214	§457.1233(a)
Standard IX—Confidentiality	§438.224	§457.1233(e)
Standard X—Grievance and Appeal Systems	§438.228	§457.1260
Standard XI—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)
Standard XII—Practice Guidelines	§438.236	§457.1233(c)
Standard XIII—Health Information Systems ²	§438.242	§457.1233(d)
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	§457.1240
Standard XV—Program Integrity	§438.608	§457.1285
Standard XVI—Model of Care	Social Security Act; Section 1859	Social Security Act, Section 1859
Standard XVII—Early and Periodic Screening, Diagnostic, and Treatment	§441.50; Social Security Act, Section 1902	Social Security Act, Section 1905

¹ The OSR standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

² This standard includes a comprehensive assessment of the MCO's information systems (IS) capabilities.

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 2024–2026, HSAG conducted a full review of the Part 438 Subpart D and QAPI standards for all MCOs to ensure compliance with federal requirements. The objective of each virtual site review was to provide meaningful information to DMAS and the MCOs regarding:

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

Technical Methods of Data Collection

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

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

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

For this protocol activity,	HSAG completed the following activities:
	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.
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 2024–2026 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.

For this protocol activity,	HSAG completed the following activities:
	• 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 <i>Not Met</i>). • HSAG distributed the final report to the MCO and DMAS.

Description of Data Obtained

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

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

How Data Were Aggregated and Analyzed

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

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

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

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

How Conclusions Were Drawn

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

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

Compliance Review Standard	Quality	Timeliness	Access
Standard I—Disenrollment: Requirements and Limitations	ü		ü
Standard II—Member Rights and Member Information			ü
Standard III—Emergency and Poststabilization Services			ü
Standard IV—Availability of Services		ü	ü
Standard V—Assurances of Adequate Capacity and Services		ü	ü
Standard VI—Coordination and Continuity of Care	ü	ü	ü
Standard VII—Coverage and Authorization of Services		ü	ü
Standard VIII—Provider Selection	ü	ü	ü
Standard IX—Confidentiality	ü		ü
Standard X—Grievance and Appeal Systems	ü		
Standard XI—Subcontractual Relationships and Delegation	ü		ü
Standard XII—Practice Guidelines	ü		ü
Standard XIII—Health Information Systems	ü		ü
Standard XIV—Quality Assessment and Performance Improvement Program	ü	ü	ü
Standard XV—Program Integrity	ü	ü	ü
Standard XVI—Model of Care	ü	ü	ü
Standard XVII—Early and Periodic Screening, Diagnostic, and Treatment	ü	ü	ü

Network Adequacy Validation Methodology

Validation Overview

DMAS contracted with HSAG to conduct NAV for the MCOs and DMAS. Title 42 of the Code of Federal Regulations (CFR) §438.350(a) requires states to have a qualified EQRO perform an annual EQR that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services.

The objectives of network adequacy validation (NAV) are to:

- Assess the accuracy of the DMAS-defined network adequacy indicators reported by the MCOs.
- Evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used.

Determine an indicator-level validation rating, which refers to the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by DMAS.

Technical Methods of Data Collection and Analysis

HSAG collected network adequacy data from the MCOs via a secure file transfer protocol (SFTP) site and via virtual NAV audits. HSAG used the collected data to conduct the validation of network adequacy in accordance with the Centers for Medicare & Medicaid Services (CMS) EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4).⁶⁶

HSAG conducted a virtual review with the MCOs. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, primary source verification (PSV), observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities performed for each MCO included the following:

- Opening meeting
- Review of the Information Systems Capabilities Assessment Tool (ISCAT) and supporting documentation
- Evaluation of underlying systems and processes
- Overview of data collection, integration, methods, and control procedures
- Network adequacy source data PSV and results
- Closing conference

⁶⁶ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: December 11, 2024.

HSAG conducted interviews with key MCO staff members who were involved with the calculation and reporting of network adequacy indicators.

Description of Data Obtained

HSAG prepared a document request packet that was submitted to each MCO outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess each MCO's information systems and processes, network adequacy indicator methodology, and accuracy of network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the MCOs to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained the following data and documentation from the MCOs to conduct the NAV audits:

- Information systems data from the ISCAT
- Network adequacy logic for calculation of network adequacy indicators
- Network adequacy data files
- Network adequacy monitoring data
- Supporting documentation, including policies and procedures, data dictionaries, system flow diagrams, system log files, and data collection process descriptions

How Data Were Aggregated and Analyzed

HSAG evaluated each MCO's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support the MCOs and States's network adequacy monitoring efforts.

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that the MCO used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators.

Based on the results of the Information Systems Capabilities Assessment (ISCA) combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCO's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care provided by the Medicaid MCOs, HSAG assigned each of the standards reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table B-7.

Table B-7—Assignment of NAV Audit Activities to the Quality, Timeliness, and Access Domains

NAV Standard	Quality	Timeliness	Access
Provider-to-Enrollee Ratios	✓	✓	✓
Time and Distance	✓	✓	✓

HSAG calculated each network adequacy indicators' validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol Worksheet 4.6, noted in Table B-8.

Table B-8—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of <i>Met</i> elements
B. Total number of <i>Not Met</i> elements
Score = $A / (A + B) \times 100$
Number of <i>Not Met</i> elements determined to have significant bias on the results.

The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table B-9, and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table B-9—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	High confidence
50.0% to 89.9%	Moderate confidence
10.0% to 49.9%	Low confidence
Less than 10% and/or any <i>Not Met</i> element has significant bias on the results	No confidence

Significant bias was determined based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- Requesting that the MCO provide a root cause analysis of the finding.
- Working with the MCO to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact, within HSAG's NAV Oversight Review Committee, to determine the degree of bias.
- Finalizing a bias determination within the HSAG NAV Oversight Review Committee based on the following threshold:

- The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or the impact was unable to be quantified and therefore was determined to have the potential for significant bias.

By assessing each MCO's performance and NAV reporting process, HSAG identified areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement. Table B-10 provides a list of network adequacy standards and indicators HSAG validated.

Table B-10—Network Adequacy Indicators Validated

Network Category Description	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance standard	Ratios
Physicians—PCP	2	15 Miles or 30 Minutes	30 Miles or 45 Minutes	At least one (1) full time equivalent (FTE) PCP, regardless of specialty type, for every 1,500 Members
Physicians—Pediatrics	2	15 Miles or 30 Minutes	30 Miles or 45 Minutes	At least (1) full time equivalent (FTE) pediatric PCP for every 1,500 Members under the age of eighteen (18)
Physicians—OBGYN	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Physician Assistants and Nurse Practitioners	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Behavioral Health Therapists and Counselors	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Pharmacy	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Eye Wear Supplier	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Chiropractor	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	

Network Category Description	Required Within Standard	Urban Time/Distance Standard	Rural Time/Distance standard	Ratios
Occupational, Physical and Respiratory Therapists	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Nursing and Custodial Facilities	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Hospitals	1	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Dietary and Nutritional Providers	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Laboratories	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Specialist	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Speech, Language and Hearing Providers	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
In Home Services				
Early Intervention	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Doula	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
Home Health	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
LTSS	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	
MHS	2	30 Miles or 45 Minutes	60 Miles or 75 Minutes	

Phantom Network Analysis Methodology

Overview

Each managed care organization (MCO) must maintain a network of providers that offers access to covered physical and behavioral healthcare services to meet the enrolled members' needs, appropriate to the geographic area. The Virginia Department of Medical Assistance Services (DMAS) contracted with Health Services Advisory Group, Inc. (HSAG), to conduct a phantom network analysis of the

MCO's provider networks. The purpose of this analysis was to identify providers contracted with the MCO provider networks who were not providing services to Medicaid members (i.e., providers who did not have encounters submitted in the past year). The MCOs included in this analysis were:

- Aetna Better Health of Virginia (Aetna)
- HealthKeepers, Inc. (HealthKeepers)
- Molina Complete Care of Virginia, LLC (Molina)
- Sentara Health (Sentara)
- UnitedHealthcare of the Mid-Atlantic, Inc. (United)

Purpose

HSAG identified primary care providers (PCP) and behavioral health providers from the MCO provider network files and who were classified as providing services within the network categories included in the analysis using the requirements described in the provider specification document (to be provided by DMAS). HSAG used the provider National Provider Identifiers (NPIs) and State Provider Identifiers to identify all member claims from calendar year (CY) 2022 for any services rendered by any of the providers in the selected provider categories.

Eligible Population

The population eligible for the phantom network analysis included providers actively enrolled with one or more Medicaid MCOs during CY 2022. Using DMAS-approved data request materials, the DMAS Enrollment Broker identified Cardinal Care Acute and Cardinal Care MLTSS providers potentially eligible for inclusion and submitted the provider data files to HSAG. The Enrollment Broker was asked to ensure that the provider data included out-of-state providers contracted to serve Medicaid managed care members (e.g., providers practicing in Kentucky, Maryland, North Carolina, Tennessee, West Virginia, or Washington DC).

- For all MCOs, the provider networks for Cardinal Care Acute and Cardinal Care MLTSS consisted of exactly the same providers. To provide the most accurate assessment of active and non-active providers across the MCO, HSAG only assessed a single provider network for each MCO, but considered member visits with either Cardinal Care Acute, FAMIS, and Cardinal Care MLTSS members to indicate an active provider. An active provider was defined as a provider who submitted at least one claim for services provided to at least one Medicaid member during the measurement period.

Eligible providers were identified based on the primary taxonomy code identified using the NPPES NPI Registry and confirmed to have been contracted during CY 2022 through cross-referencing prior data submissions. HSAG restricted the analysis of the provider categories to those agreed upon with DMAS. Provider types and specialties included in the study are as follows:

- Physical Health Primary Care Providers:
 - Obstetrics & Gynecology (OBGYN)
 - Physician Assistants/Nurse Practitioners (PA/NP)

- Primary Care Physicians (PCP)
- Pediatric (PEDIATRIC)
- Behavioral Health Providers:
 - Behavioral Health and Social Service Providers (BH)
 - Psychiatry (PSY)

Upon receipt of the data files, HSAG reviewed key data fields to assess potential duplication and completeness. Key data fields include, but are not limited to provider name, service street address, NPI, provider language, and provider acceptance of new patients.

Data Sources

To complete the phantom network analysis, HSAG used the following data sources:

- Claims/encounter data for CY 2022 for all providers contracted with the MCOs
- Member eligibility and enrollment data for CY 2022
- Provider network data for all MCOs from the Enrollment Broker
- Provider network data for all MCOs from CY 2022 PCP Secret Shopper Survey Data
- NPPES NPI Registry

Measurement Period

The assessment of member utilization used claims data from CY 2022, and providers network will be assessed using all MCO provider networks as of December 31, 2022.

Data Processing

HSAG assessed member utilization using claims data from CY 2022 and assessed the provider networks using all MCO provider networks from the Enrollment Broker, cross-referenced with the CY 2022 PCP Secret Shopper Survey Data. The MCO provider network data submitted by the DMAS Enrollment Broker did not contain contract start and end dates for the providers. To determine providers who had been contracted with the MCOs during the measurement period, HSAG only included providers contracted with the MCOs at the time of the data submission from the DMAS Enrollment Broker (i.e., January 26, 2024) and at the time of the CY2022 Secret Shopper Survey Data (i.e., November 1, 2022).

Out-of-state providers and provider locations in the Commonwealth of Virginia or within 15 miles of Virginia's borders who were contracted to service Medicaid managed care members (i.e., providers practicing in Kentucky, Maryland, North Carolina, Tennessee, West Virginia, or Washington DC) were also included in the analysis.

The 2023 Health Services Delivery Reference File was used to determine county urbanicity.⁶⁷ “Micro,” “Rural,” and “CEAC” areas were defined as rural, and “Metro” and “Large Metro” areas were defined as urban. A small proportion of records could not be geocoded (<0.01 percent) and were excluded from analyses.

Using the NPPES NPI Registry, HSAG identified each provider’s primary taxonomy code, which was evaluated for inclusion or exclusion in the analysis per the *Cardinal Care Managed Care NSRM and Methodology*. Members who were enrolled in a Virginia Medicaid managed care program at any time between January 1, 2022, and December 31, 2022, were included in the analysis. Using claims/encounter data, HSAG identified providers from the eligible population who rendered a service for an enrolled member within the same MCO.

For each MCO, HSAG assessed the following metrics:

- Percentage of active versus non-active primary care and behavioral health providers
- Comparison of the demographics of active versus non-active providers (including, region, urbanicity, language, and acceptance of new patients)
- The median number of member visits per month per provider for active providers

HSAG cleaned, processed, and used the data submitted to define unique lists of primary care and behavioral health providers for inclusion in the analysis. HSAG standardized and geocoded all member and provider addresses using Quest Analytics Suite software.

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*

⁶⁷ Centers for Medicare & Medicaid Services (CMS). Health Services Delivery Tables Reference File, Updated. December 06, 2022. Available at: <https://www.cms.gov/files/document/2023-hsd-reference-file-updated-12062022.xlsx>.

Health Insurance Program] Managed Care Plan: An Optional EQR-Related Activity, February 2023,⁶⁸ 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 Cardinal Care MLTSS MCOs and six Cardinal Care Acute MCOs displayed in Table B-11.

Table B-11—MCOs Included in the EDV

MCO Name	MCO Short Name
Cardinal Care MLTSS Program	
Aetna Better Health of Virginia	Aetna
HealthKeepers, Inc.	HealthKeepers
Molina Complete Care	Molina
Optima Health ¹	Optima
UnitedHealthcare of the Mid-Atlantic, Inc.	United
Virginia Premier Health Plan, Inc. ¹	VA Premier
Cardinal Care Acute Program	
Aetna Better Health of Virginia	Aetna
HealthKeepers, Inc.	HealthKeepers
Molina Complete Care	Molina
Optima Health ¹	Optima
UnitedHealthcare of the Mid-Atlantic, Inc.	United
Virginia Premier Health Plan, Inc. ¹	VA Premier

¹ As of January 1, 2024, Optima and VA Premier have merged under the name of Sentara Health Plan.

Information Systems Review

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

Stage 1—Document Review

HSAG initiated the EDV activity with a thorough desk review of documents related to encounter data initiatives/validation activities currently put forth by DMAS. Documents requested for review included

⁶⁸ 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.medicare.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: June 20, 2023.

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 2023.⁶⁹ 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 in SFY 2020–2021, two years prior to this EDV activity, 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.

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.

⁶⁹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: June 20, 2023.

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 file review 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-12. The analyses focused on an element-level comparison for each data element.

Table B-12—Key Data Elements for Comparative Analysis

Key Data Elements	Professional	Institutional	Pharmacy
Member ID	✓	✓	✓
Detail Service From Date	✓	✓	✓
Detail Service To Date	✓		✓
Header Service From Date		✓	
Header Service To Date		✓	
Billing Provider NPI	✓	✓	✓
Rendering Provider NPI	✓		
Attending Provider NPI		✓	
Servicing Provider Taxonomy Code	✓	✓	
Prescribing Provider NPI			✓
Referring Provider Number/NPI	✓	✓	
Primary Diagnosis Code	✓	✓	
Secondary Diagnosis Codes	✓	✓	
Procedure Code	✓	✓	

Key Data Elements	Professional	Institutional	Pharmacy
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.

For the Cardinal Care MLTSS program, HSAG stratified the results by the subcontractor types listed below for each MCO:

- Consumer-directed (CD) services
- Non-emergency medical transportation (NEMT)

- Pharmacy
- Vision

For the Cardinal Care Acute program, HSAG stratified the results, if appropriate, by the category of service (COS) listed in Table B-13.

Table B-13—Description of COS for Cardinal Care Acute

COS	Description
Institutional—Internal	Institutional encounters collected by the MCO but not from its subcontractor(s)
Institutional—Kaiser	Institutional encounters collected by Kaiser
Professional—CD Services	Professional encounters from MCO's CD services subcontractor
Professional—EMT (Kaiser)	Professional encounters from Kaiser's emergency medical transportation (EMT) subcontractor
Professional—Internal	Professional encounters collected by the MCO but not from its subcontractor(s)
Professional—Kaiser	Professional encounters collected by Kaiser
Professional—NEMT	Professional encounters from the MCO's NEMT subcontractor
Professional—NEMT (Kaiser)	Professional encounters from Kaiser's NEMT subcontractor
Professional—Vision	Professional encounters from MCO's vision subcontractor
Pharmacy	Pharmacy encounters
Pharmacy—Elixir Solutions	Pharmacy encounters collected by Elixir Solutions
Pharmacy—Kaiser	Pharmacy encounters collected by Kaiser

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 Cardinal Care program (i.e., Cardinal Care Acute and Cardinal Care MLTSS MCOs (Aetna, HealthKeepers, Molina, Sentara, and United) with their MCO and healthcare.

Technical Methods of Data Collection

MCO CAHPS

For the Cardinal Care program 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.⁷⁰ The mode of CAHPS survey data collection varied slightly among the MCOs. Aetna, HealthKeepers, Molina, United, and Sentara used an enhanced mixed-mode survey methodology that was pre-approved by NCQA for both their adult and child populations. In addition, Aetna and United included the option for adult and child members to complete the survey via the Internet, and Sentara included the option for adult members only to complete the survey via the Internet. Adult members and parents/caretakers of child members completed the surveys in 2024, following NCQA's data collection protocol.

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.⁷¹ 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 (39 items for the CAHPS 5.1H Adult Medicaid Health Plan Survey and 76 items for the CAHPS 5.1H Child Medicaid Health Plan Survey with the Children with Chronic Conditions measurement set) that assess members' perspectives on care. For the MCOs, the CAHPS survey questions were categorized into eight measures of experience. These measures included four global ratings and four composite scores. The global ratings reflected members' overall experience with their health plan, all health care, personal doctor, and specialist. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*).

For each of the four global ratings, the percentage of respondents who chose the top-box experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. For each of the four composite measures, the percentage of respondents who chose a positive, or top-box, response was calculated. CAHPS composite question response choices were "Never," "Sometimes," "Usually," or "Always." A top-box response for the composite measures was defined as a response of "Usually" or "Always." These percentages are referred to as top-box scores.

FAMIS CAHPS

For the FAMIS CAHPS surveys, the technical method of data collection was through administration of the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the CCC measurement set. In accordance with CMS' CHIPRA reporting requirements, the CAHPS survey was administered to a statewide sample of FAMIS members, representative of the entire population of children covered by Virginia's Title XXI program (i.e., CHIP members in FFS or managed care). To

⁷⁰ Aetna, HealthKeepers, Molina, Sentara, and United 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).

⁷¹ Aetna and HealthKeepers contracted with CSS; and Molina, Sentara, and United contracted with SPH Analytics to conduct the CAHPS survey administration, analysis, and reporting of survey results for their respective adult and child Medicaid populations.

support the reliability and validity of the findings, standardized sampling and data collection procedures were followed to select the general child and CCC members and distribute the surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instrument and the comparability of the resulting data.

Child members included as eligible for the survey were 17 years of age or younger as of December 31, 2023. A mail-only methodology for data collection was utilized. Parents/caretakers of child members completed the surveys between the time period of April to June 2024. The surveys were administered in English and Spanish. Members identified as Spanish speaking through administrative data received a Spanish version of the survey with the option to complete the survey in English. All other members received an English version of the survey with the option to complete the survey in Spanish.

The CAHPS surveys include a set of standardized items (40 items for the CAHPS Adult Medicaid Health Plan Survey, 41 items for the CAHPS Child Medicaid Health Plan Survey without the CCC measurement set, and 76 items for the CAHPS Child Medicaid Health Plan Survey with the CCC measurement set) that assess members' perspectives on care. The CAHPS survey questions were categorized into eight measures of member experience. These measures included four global ratings and four composite scores. The global ratings reflected members' overall experience with their health plan, all healthcare, personal doctor, and specialist. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*).

For each of the four global ratings, the percentage of respondents who chose the top-box experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. For each of the four composite measures, the percentage of respondents who chose a positive, or top-box, response was calculated. CAHPS composite question response choices fell into the following categories: "Never," "Sometimes," "Usually," or "Always." A top-box response for the composite measures was defined as a response of "Usually" or "Always." These percentages are referred to as top-box scores.

Description of Data Obtained

The CAHPS 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. Members completed the surveys in 2024, following NCQA's data collection protocol.

The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. For the CAHPS 5.1H Adult Medicaid Health Plan Survey, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 10, 19, 23, and 28. For the CAHPS 5.1H Child Medicaid Health Plan Survey with the CCC measurement set, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 25, 40, 44, and 49. Eligible members included the entire sample minus ineligible members. For the adult population, ineligible members met at least one of the following criteria: they were deceased, did not meet eligible population criteria, they had a language barrier, or they were mentally or physically incapacitated. For the child population, ineligible members met at least one of the following criteria: they were deceased, they did not meet eligible population criteria, or they had a language barrier. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

How Data Were Aggregated and Analyzed

HSAG compared the 2024 top-box scores for each MCO to the 2023 NCQA Medicaid national averages.^{72, 73, 74, 75} 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-14.

Table B-14—Assignment of CAHPS Measures to the Quality, Timeliness, and Access to Care Domains

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

⁷² For the NCQA Medicaid national averages, the source for data contained in this publication is Quality Compass 2023 data and is used with the permission of NCQA. Quality Compass 2023 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.

⁷³ National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023*. Washington, DC: NCQA, September 2023.

⁷⁴ NCQA national averages were not available for 2024 at the time this report was prepared; therefore, 2023 national data are presented.

⁷⁵ Since Optima and VA Premier were merged into Sentara, trend results are unavailable for the Cardinal Care Program and MCOs.

MCO Comparative and Statewide Calculation of Additional Performance Measure Results

Performance Overview

Virginia DMAS contracts with HSAG to calculate one performance measure as part of the Task J—Performance Measure Calculation activity. For the calendar year (CY) 2023 performance measure calculation activity, DMAS requested that HSAG calculate the *Screening for Depression and Follow-Up Plan* (CDF) performance measure using administrative data only. This section provides an overview of the methodology for the CY 2023 CDF performance measure rate calculation.

Performance Measure

For the CY 2023 performance measure calculation, HSAG calculated the CDF performance measure, which measures the percentage of members 12 years of age and older with an outpatient visit during the measurement year who were screened for depression on the date of the encounter or 14 days prior using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan was documented on the date of the encounter. HSAG followed the FFY 2024 CMS' *Core Set of Adult Health Quality Measures for Medicaid* and *Core Set of Children's Health Care Quality Measures for Medicaid* and the *CHIP Technical Specifications and Resource Manuals*.^{76, 77}

Performance Period

In 2024, HSAG calculated the CDF measure rates for CY 2023 using data collected by DMAS and submitted to HSAG.

Data Collection

The CDF 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.⁷⁸

HSAG used SAS software to perform all analytics. Upon receiving data, HSAG confirmed the reasonability and completeness of the data.

⁷⁶ CMS. FFY 2024 Adult Core Set Measures Technical Specifications and Resource Manual. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf>. Accessed on: Nov 7, 2024.

⁷⁷ CMS. FFY 2024 Child Core Set Measures Technical Specifications and Resource Manual. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf?t=1717523300>. Accessed on: Nov 7, 2024.

⁷⁸ 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 *CDF* measure rates. The lead analyst produced production programming code to generate the results and output for DMAS. In parallel with the work performed by the lead analyst, the validation analyst created 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 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 Federal Information Processing Standards (FIPS) codes. In addition, rates were stratified by age, race, and gender. Table B-15 presents the *CDF* performance measure rate stratifications and values for Medicaid Program, Medicaid Delivery System, MCO, geographic region, age group, and gender.

Table B-15—Medicaid Program, Medicaid Delivery System, MCO, Geographic Region, Age Group, and Gender Stratification Values

Stratification	Values
Medicaid Program [^]	- Medicaid (inclusive of Medicaid expansion CHIP) - All non-FAMIS aid categories - Separate CHIP (i.e., FAMIS) - Child Aid categories: 006, 007, 008, 009, 010, 014 - Adult Aid categories: 005, 110, 111
Medicaid Delivery System	- Fee-for-Service (FFS) - Managed Care
MCO	- Aetna Better Health of Virginia (Aetna) - HealthKeepers, Inc. (HealthKeepers) - Molina Complete Care of Virginia, LLC (Molina) - Sentara Health Plan (Sentara)* - UnitedHealthcare of the Mid-Atlantic, Inc. (United)
Geographic Regions	- Central - Charlottesville/Western - Northern & Winchester - Roanoke/Alleghany - Southwest - Tidewater

Stratification	Values
Age Groups	12–17 18–64 65 and Older
Age Group by Medicaid Program	12–17—Medicaid 12–17—Separate CHIP 18–64—Medicaid 18–64—Separate CHIP 65 and Older—Medicaid 65 and Older—Separate CHIP
Gender	- Male - Female

^aHSAG excluded members in a limited benefit program from the Medicaid Program stratification.

^{*}HSAG flagged members as enrolled with Sentara if they had any Optima or VA Premier enrollment during CY 2023. In the member-level file, HSAG identified members who were enrolled in VA Premier from January 1, 2023, to June 30, 2023.

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-16. Table B-16 presents the CDF performance measure race stratifications that were reported by HSAG with a crosswalk to DMAS' race categories.

Table B-16—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 and a numerator flag.

ARTS Measurement Specification and Reporting

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, 2023, during July 2023, resulting in a six-month data runout from the end of CY 2022 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-17.

Table B-17—ARTS Measures

Measure and Indicators
<i>Concurrent Prescribing of Naloxone and High-Dose Opioids</i>
<i>Naloxone Use for High Risk of Overdose—Naloxone Use for Diagnosed Opioid Use Disorder, Naloxone Use for History of Chronic Opioid Use, Naloxone Use for Concurrent Benzodiazepine and Opioid Use, and Naloxone Use for History of Overdose</i>
<i>Treatment of Hepatitis C for Those With Hepatitis C and SUD</i>
<i>Treatment of HIV for Those With HIV and SUD</i>
<i>Preferred 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</i>

Measure and Indicators
<i>Coordination, RPR Testing, and Annual TB Testing</i>
<i>Cascade of Care for Members With OUD—High-Risk Members With OUD Diagnosis, Members Identified as having OUD Who Initiated OUD Treatment, and Members Who Initiated OUD Treatment Who Also Engaged in OUD Treatment</i>
<i>Cascade of Care for Members With Hepatitis C—Prevalence of Hepatitis C, Received DAA Treatment for Hepatitis C, Completed DAA Treatment for Hepatitis C, and Achieved SVR</i>
<i>Cascade of Care for Members With HIV—Received HIV Care, Retained in HIV Care, and Received Antiretroviral Therapy</i>

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
 - Cardinal Care Acute, Cardinal Care MLTSS, and More Than One Managed Care Program
- MCO
 - Aetna; HealthKeepers; Molina; Optima; United; 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 in Table B-18.

Table B-18—Eligibility Group Definitions

Eligibility Group	Definition ⁷⁹
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.

⁷⁹ 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 ⁷⁹
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.
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 ≤ morphine milligram equivalents [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, CY 2021, and CY 2022, 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. HSAG did not identify comparable national benchmarks.

Medicaid and CHIP Maternal and Child Health Focus Study Methodology⁸⁰

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,

⁸⁰ Note: This methodology is presented as it appeared in the final report for this activity.

and Medicaid Expansion programs. The SFY 2022–23 (Contract Year 2) 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., prenatal and postpartum depression, emergency department [ED] utilization, postpartum contraceptive care) are associated with births paid by Virginia Medicaid?
- What health disparities exist in birth and maternal health 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 2022, regardless of whether the births occurred in Virginia. Births paid by Virginia Medicaid were assigned to one of five full-scope Medicaid program categories based on the mother's enrollment in the program at the time of delivery:

- The 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 133 percent of the FPL.
- The FAMIS MOMS program uses Title XXI (Children's Health Insurance Program [CHIP] Demonstration Waiver) funding to serve pregnant women with incomes up to 200 percent of the FPL and provides benefits similar to Medicaid through the duration of pregnancy and for the postpartum period.
- The FAMIS Prenatal Coverage program provides full coverage for pregnant women who meet income rules (up to 200 percent of the FPL) but do not meet immigration status rules for other coverage.
- The "Other Aid Categories" include births paid by Medicaid or CHIP that do not fall into the four main categories of Medicaid for Pregnant Women, Medicaid Expansion, FAMIS MOMS, or FAMIS Prenatal Coverage. Other Aid Categories include Low Income Families with Children (LIFC) (parents and caretaker adults), disabled individuals, Medicaid Children, Foster Children and Former Foster Youth, Adoption Assistance Children, FAMIS Children, presumptively eligible individuals, and others. Other Aid Categories excludes births to women in Plan First and incarcerated individuals.

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 2022. HSAG will submit the Finder's File to DMAS with instructions for conducting

two types of data linkages. DMAS will work with VDH to obtain the birth registry data and conduct the following data linkages:

- Use probabilistic data linking to match HSAG’s list of women eligible for the study to birth registry records.
- Match HSAG’s list of study-eligible members to birth registry records using social security numbers (i.e., deterministic data linking).

DMAS will return data files to HSAG containing the information from the Finder’s File and select birth registry data fields for matching members for each of the data linkage processes, as well as documentation regarding the linked data files. The data files DMAS submits to HSAG will only include information for live births (i.e., non-live births are excluded from the linked registry records). HSAG will include all probabilistically or deterministically linked birth registry records from births occurring during CY 2022 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-19 presents the study indicators that HSAG will calculate for this study limited to singleton births, defined using the Plurality field in the birth registry data.

Table B-19—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

Indicator	Denominator	Numerator
		– 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
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.
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.

Indicator	Denominator	Numerator
		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.
Utilization of Doula Services***	Number of single, live births paid by Virginia Medicaid during July 2022 to December 2022.	Number of women who utilized doula services during the prenatal period, at delivery, during the postpartum partum period, and total. HSAG will utilize codes and logic provided by DMAS to identify doula services.
Utilization of Contraceptive Care for Postpartum Women***	Number of singleton, live births to women 15 to 44 years of age paid by Virginia Medicaid during the measurement period.	Number of women who received a most effective or moderately effective method of contraception or a long-acting reversible method of contraception (LARC) within 3 and 90 days of delivery. This measure will be modified from the Contraceptive Care – Postpartum Women measure in

Indicator	Denominator	Numerator
		the CMS Core Set to use the vital statistics data.

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

* Estimated gestational age will be based upon the Clinical Estimate of Gestation (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 Last Menstrual Period (LMP) indicated on the birth certificate. Birth certification records missing both CEG and LMP values will be captured in a “missing gestational age” category

** SBIRT study indicators will be presented in the member level file only.

*** For study indicators that are new to this year’s analysis, HSAG will evaluate the feasibility of these approaches based on the data received and modify the indicators as needed with DMAS’ approval.

Where applicable, HSAG will compare the study indicators to national benchmarks. HSAG will use the Healthy People 2030 goals, using data derived from the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), and National Vital Statistics System (NVSS), for the *Births with Early and Adequate Prenatal Care and Preterm Births (<37 Weeks Gestation)* study indicators, and will use the Federal Fiscal Year (FFY) 2020 CMS Core Set benchmarks for the *Newborns With Low Birth Weight (<2,500 grams)* study indicator.

HSAG will also present CY 2022 birth outcome study indicator results compared to historical results (i.e., CY 2020 and CY 2021), when available. Since the FAMIS Prenatal Coverage program was included in the “Other Aid Categories” eligible population in last year’s study, HSAG will recalculate rates for the FAMIS Prenatal Coverage program and Other Aid Categories separately where applicable for CY 2021.

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 2023 study indicator rates by the categories listed in Table B-20, on the page below.-

Table B-20—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 (aid category 005 without citizen status A) - Other Aid Categories (will include all other births not covered by Medicaid for Pregnant Women, Medicaid Expansion, FAMIS MOMS, and FAMIS Prenatal Coverage; will exclude births to women in Plan First [aid category: 080] and incarcerated individuals [aid category: 109])

Stratification	Category Values
Delivery System at Delivery	• FFS • Managed Care
Managed Care Program at Delivery	• Cardinal Care Acute (will include FAMIS MOMS, FAMIS Prenatal Coverage, and FAMIS Children) • Cardinal Care MLTSS
Managed Care Organization (MCO) at delivery	• 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)
Length of Continuous Enrollment Prior to Delivery	• 30 Days • 31–90 Days • 91–180 Days • 180 Days
Trimester of Prenatal Care Initiation <i>Note: Defined from the birth registry data.</i>	• First Trimester • Second Trimester • Third Trimester • No Prenatal Care • Unknown
Managed Care Region of Maternal Residence <i>Note: Defined from the birth registry data using the county of residence at the time of delivery, grouped into regions using the Virginia managed care regions.</i>	• Central • Charlottesville/Western • Northern & Winchester • Roanoke/Alleghany • Southwest • Tidewater
Maternal Race/Ethnicity <i>Note: Defined from the birth registry data</i>	• White, Non-Hispanic • Black, Non-Hispanic • Asian, Non-Hispanic • Hispanic, Any Race • Other/Unknown

*Where appropriate, HSAG will compare the CY 2022 and CY 2021 results for Molina Complete Care of Virginia, LLC to the CY 2020 results for Magellan Complete Care of Virginia.

In addition to the study indicator results and trending, HSAG will present the study indicator results stratified by MCO (Cardinal Care Acute and Cardinal Care MLTSS combined), including MCO study indicator results stratified by demographics within the Findings Section of the report. HSAG will present program-specific (Cardinal Care Acute and Cardinal Care 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
 - FAMIS Prenatal Coverage
 - Other Aid Categories
- The comparison group will include women enrolled in any of the five programs (i.e., Medicaid for Pregnant Women, Medicaid Expansion, FAMIS MOMS, FAMIS Prenatal Coverage, 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 five 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.

Using the results from last year's focus study, HSAG reviewed whether there were differences in the distribution of race/ethnicity, region, and MCO among members in the study populations compared to members in the comparison groups. HSAG found, for example, that members in the comparison group were more likely to reside in the Northern/Winchester region, which may influence the study indicator rates. Therefore, for this year's focus study, HSAG will assess whether there are substantive demographic, geographic, or programmatic differences between the study populations and comparison groups and discuss any meaningful differences in the report.

Additional Population-Specific Stratifications

FAMIS MOMS

For the FAMIS MOMS study indicator results, HSAG will also stratify the CY 2022 results by:

- 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-20 for more information regarding these stratifications.

FAMIS Prenatal Coverage

For the FAMIS Prenatal Coverage study indicator results, HSAG will stratify the CY 2022 results by:

- Delivery system,
- MCO,
- Maternal race/ethnicity,
- Maternal age at delivery,
- Managed care region of maternal residence,
- Length of continuous enrollment prior to delivery, and
- Trimester of prenatal care initiation.

Please refer to the category values defined in Table B-14 for more information regarding these stratifications.

Postpartum ED Utilization Analysis

For the study indicator *Postpartum ED Utilization*, HSAG will perform the following additional analyses:

- Identify the most common primary diagnoses for postpartum ED visits
- Assess when postpartum ED visits occur within the postpartum period
- Stratify Postpartum ED Utilization rates by Kotelchuck Index score
- Stratify Postpartum ED Utilization rates by completion and timing of follow-up visits within the postpartum period

Additionally, HSAG will provide a supplemental Excel spreadsheet with information on postpartum ED visits, including the primary diagnosis code, dates, and provider information.

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), Newborns with Low Birth Weight (<2,500 grams), Postpartum ED Utilization, Postpartum Ambulatory Care Utilization, Prenatal Maternal Depression Screening, Postpartum Maternal Depression Screening, and Postpartum Contraceptive Care Utilization 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. 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.

Subgroup Analysis

HSAG will perform additional subgroup analyses on all Birth Outcomes and Maternal Health Outcomes measures included in the report. For measures where a substantial rate difference is identified among race, region, and MCO, HSAG will perform additional analyses to determine if the rate difference is related to other factors. For example, if the rate of *Prenatal Maternal Depression Screening* is higher in one region compared to other regions, HSAG would determine if another factor, such as race, contributed to the region having higher rates compared to other regions.

Partnership for Petersburg

To assist with the Partnership with Petersburg program, HSAG will also calculate all study indicator rates for members residing in Petersburg. For results with sufficient numerator and denominator sizes (i.e., 11 or greater), HSAG will include the results with narrative in the report.

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-21.

Table B-21—Member-Level Data File

Demographic Category	Category Values
Medicaid ID	• Medicaid ID
Date of Delivery	• Date
Singleton Birth Indicator	• Singleton • Multiple
Medicaid Program at Delivery	• Medicaid for Pregnant Women • Medicaid Expansion • FAMIS MOMS • FAMIS Prenatal Coverage • Other Aid Categories

Demographic Category	Category Values
Comparative Analysis Population Group	• Study Population • Comparison Group • Not Applicable (NA)
Delivery System at Delivery	• FFS • Managed Care
MCO at Delivery	• Aetna • HealthKeepers • Molina • Optima • United • VA 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 <i>Note: Defined from the birth registry data.</i>	• 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 <i>Note: Defined from the birth registry data using the county of residence at the time of delivery, grouped into regions using the Virginia managed care regions.</i>	• Central • Charlottesville/Western • Northern & Winchester • Roanoke/Alleghany • Southwest • Tidewater • Unknown/Missing
Petersburg Resident	• Yes • No
Maternal Race/Ethnicity <i>Note: Defined from the birth registry data as non-Hispanic race (i.e., White, non-Hispanic), with</i>	• White, Non-Hispanic • Black, Non-Hispanic • Asian, Non-Hispanic • Hispanic, Any Race • Other/Unknown

Demographic Category	Category Values
<i>Hispanic women of any race reported in the Hispanic category.</i>	
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 <i>Note: Defined from DMAS' demographic data.</i>	• 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	• Asthma • No Asthma • NA
Maternal Diabetes	• Diabetes • No Diabetes • NA
Maternal Gestational Diabetes	• 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

Demographic Category	Category Values
	• Very Low • Not Low • Missing
Method of Delivery <i>Note: Defined from the birth registry data.</i>	• C-Section Delivery • Vaginal Delivery • Missing
Postpartum ED Utilization <i>Note: Only ED services up to 90 days after delivery will be considered.</i>	• Yes • No
Postpartum Ambulatory Care Utilization <i>Note: Only ambulatory care services up to 90 days after delivery will be considered.</i>	• Yes • No
Received Prenatal SBIRT <i>Note: Only SBIRT evaluations received between the LMP and delivery date will be considered.</i>	• Yes • No
Received Postpartum SBIRT <i>Note: Only SBIRT evaluation received on or between 7 and 84 days after delivery will be considered.</i>	• Yes • No
Received Prenatal Maternal Depression Screening <i>Note: Only maternal depression screenings received between the LMP and delivery date will be considered.</i>	• Yes • No
Received Postpartum Maternal Depression Screening <i>Note: Only maternal depression screenings received on or between 7 and 84 days after delivery will be considered.</i>	• Yes • No
Received Doula Services in Prenatal Period	• Yes • No
Received Contraceptive Care within 3 Days of Delivery	• Yes • No
Received Contraceptive Care within 90 Days of Delivery	• Yes • No

Additionally, for members with postpartum ED utilization, HSAG will provide a supplemental Excel spreadsheet containing a row for each postpartum ED visit with all data elements listed in Table B-22.

Table B-22—Postpartum ED Visit-Level Data File

Data Element	Category Values
Medicaid ID	Medicaid ID
Date of Delivery	Date
First Date of Service	Date
Last Date of Service	Date
Primary Diagnosis	ICD-10 Diagnosis Code
Rendering Provider NPI	NPI
Billing Provider NPI	NPI

Deliverables

For the 2022–23 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.
- HSAG will supply a supplemental Excel spreadsheet that provides information on postpartum ED visits.
- 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 Methodology⁸¹

Objectives

DMAS has contracted with HSAG since SFY 2015–2016 to conduct a focus study that assesses healthcare utilization among members in child welfare programs receiving medical services through MCOs. The SFY 2022–2023 (Contract Year 2) Task 1.2 Child Welfare Focus Study assessed how

⁸¹ Note: This methodology is presented as it appeared in the final report for this activity.

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.
- **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 Cardinal Care Acute or Cardinal Care 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-23.

Table B-23—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)^
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)

Measure and Indicators
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

^aIndicates 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 Cardinal Care Acute or Cardinal Care 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-24.

Table B-24—Timely Access to Care Measure Indicators

Measure and Indicators
<i>Timely Access to Care for New Foster Care Members</i> —Timely Access to Primary Care for New Foster Care Members, Timely Access to Dental Care for New Foster Care Members, Timely Access to Primary Care or Dental Care for New Foster Care Members, and Timely Access to Primary Care and Dental Care for New Foster Care Members
<i>Timely Access to Care for Members Who Aged Out of Foster Care</i> —Timely Access to Primary Care for Members Who Aged Out of Foster Care, Timely Access to Dental Care for Members Who Aged Out of Foster Care, Timely Access to Primary Care or Dental Care for Members Who Aged Out of Foster Care, and Timely Access to Primary Care and Dental Care for Members Who Aged Out of Foster Care
<i>Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care</i> —Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care and Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care With a Behavioral Health Diagnosis
<i>Timely Access to Behavioral Health Care for New Foster Care Members</i> —Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members, Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members With a Behavioral Health Diagnosis, Timely Access to Behavioral Health Care

Measure and Indicators

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 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 for the Healthcare Utilization analysis, HSAG calculated p -values to determine the association between program status (e.g., membership in the foster care program) and numerator compliance. For indicators for which all contingency table cell sizes (i.e., the number of numerator-positive and numerator-negative members for each group) were greater than or equal to 5, HSAG calculated p -values using Chi-square tests. For indicators with small contingency table cell sizes, HSAG used Fisher's exact test because Fisher's exact test is more accurate than the Chi-square test when cell sizes are small. A p -value less than 0.05 was considered statistically significant.

For the Health Disparities analysis, the p -value for the demographic group's coefficient in the logistic regression model was used to identify statistically significant health disparities between the demographic groups and their reference groups. HSAG excluded comparisons for which disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).

For this report, a p -value less than 0.05 indicated a health disparity. When analyzing a given demographic group, HSAG classified the stratified rate in one of the following three categories based on the preceding analyses:

- Higher Rate

- The p -value for the coefficient in the logistic regression model was less than 0.05, indicating a health disparity, and the stratified rate for the demographic group was higher than the rate for the reference group.
- Lower Rate
 - The p -value for the coefficient in the logistic regression model was less than 0.05, indicating a health disparity, and the stratified rate for the demographic group was lower than the rate for the reference group.
- Similar Rate
 - The p -value for the coefficient in the logistic regression model was greater than or equal to 0.05. This means no health disparity was identified when the stratification was compared to the reference group.

Consumer Decision Support Tool Methodology

Objectives

DMAS contracted with HSAG to analyze MY 2023 HEDIS results, including MY 2023 CAHPS data from five Virginia MCOs for presentation in the 2024 Cardinal Care Consumer Decision Support Tool. The Consumer Decision Support Tool analysis helps support DMAS' public reporting of MCO performance information.

Data Collection

For this activity, HSAG received the MCOs' CAHPS member-level data files and HEDIS data from the MCOs. The CAHPS survey was most recently administered in 2023. The *HEDIS MY 2023 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS MY 2023 Technical Specifications for Health Plans, Volume 2* was used to collect and report on the HEDIS measures.

Reporting Categories

The Cardinal Care 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 2024 Consumer Decision Support Tool analysis. This category also includes adult and general child CAHPS measures on consumer perceptions of the overall rating of the MCO, MCO customer service, and their overall health care.
- **Doctors' Communication:** Includes adult, general child, and children with chronic conditions CAHPS composites on consumer perceptions regarding how well their doctors communicate and the overall ratings of personal doctors and specialists seen most often. This category also includes children with chronic conditions CAHPS composites and question summary rates related to family centered care and coordination of care for children with chronic conditions. Additionally, this

category includes a CAHPS measure related to medical assistance with smoking and tobacco use cessation.

- **Access and Preventive Care:** Includes adult, general child, and children with chronic conditions CAHPS composites on consumer perceptions regarding the ease of obtaining needed care and how quickly they received that care. Additionally, this category assesses a HEDIS measure related to adults' access to care and children with chronic conditions CAHPS question summary rates related to access to specialized services and prescription medications. Additionally, this category includes HEDIS measures on how well MCOs perform related to preventive screenings for colorectal cancer, as well as appropriate treatment for acute bronchitis/bronchiolitis and low back pain.
- **Women's Health:** Includes HEDIS measures that assess whether women-specific screenings are provided (i.e., screenings for breast cancer and cervical cancer) and if women receive care during and after their pregnancy (i.e., prenatal and postpartum care, and screenings and follow-up care for postpartum depression).
- **Behavioral Health:** Includes HEDIS measures that assess how often members remain on medications, appropriate care for members with substance use disorder (SUD), and follow-up services for mental illness and substance use. In addition, this category includes HEDIS measures that assess medication management for people living with depression, monitoring and screenings for children and adults on antipsychotics, and the use of psychosocial care as a first-line treatment for children on antipsychotics.
- **Taking Care of Children:** Includes HEDIS measures regarding how often preventive services and appropriate treatment are provided to child members (i.e., immunizations, well-child/well-care visits, attention deficit hyperactivity disorder [ADHD] medication follow-up care, and weight assessment and counseling for nutrition and physical activity).
- **Living With Illness:** Includes HEDIS measures related to the appropriate treatment for people who have chronic conditions (e.g., diabetes, high blood pressure, chronic obstructive pulmonary disease [COPD]). In addition, this category includes a HEDIS measure that assesses medication management for people with asthma.

Measures Used in Analysis

DMAS, in collaboration with HSAG, chose measures for this year's Cardinal Care 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 other administrative HEDIS and CAHPS survey measures required by the CCC Plus Technical Manual⁸² and the Medallion 4.0 Managed Care Contract for reporting. Per NCQA specifications, the CAHPS 5.1H Adult Medicaid Health Plan Survey instrument was used for the adult population and the CAHPS 5.1H Child Survey with Children with Chronic Conditions item set was used for the child population.

Table B-25 lists the 78 measure indicators, 31 CAHPS and 47 HEDIS, and their associated weights. Weights are applied when calculating the category summary scores and the confidence intervals to

⁸² Virginia Department of Medical Assistance Services. *CCC Plus Technical Manual*. Version 2.35.

ensure that all measures contribute equally to the derivation of the final results. Please see the Comparing MCO Performance section for more details.

Table B-25—Cardinal Care Consumer Decision Support Tool Reporting Categories, Measures, and Weights

Measures	Measure Weight
Overall Rating⁸³	
<i>Adult Medicaid—Rating of Health Plan (CAHPS Global Rating)</i>	1
<i>General Child Medicaid—Rating of Health Plan (CAHPS Global Rating)</i>	1
<i>Children with Chronic Conditions Medicaid—Rating of Health Plan (CAHPS Global Rating)</i>	1
<i>Adult Medicaid—Rating of All Health Care (CAHPS Global Rating)</i>	1
<i>General Child Medicaid—Rating of All Health Care (CAHPS Global Rating)</i>	1
<i>Children with Chronic Conditions Medicaid—Rating of Health Care (CAHPS Global Rating)</i>	1
<i>Adult Medicaid—Customer Service (CAHPS Composite)</i>	1
<i>General Child Medicaid—Customer Service (CAHPS Composite)</i>	1
<i>Children with Chronic Conditions Medicaid—Customer Service (CAHPS Composite)</i>	1
Doctors' Communication	
<i>Adult Medicaid—How Well Doctors Communicate (CAHPS Composite)</i>	1
<i>General Child Medicaid—How Well Doctors Communicate (CAHPS Composite)</i>	1
<i>Children with Chronic Conditions Medicaid—How Well Doctors Communicate (CAHPS Composite)</i>	1
<i>Adult Medicaid—Rating of Personal Doctor (CAHPS Global Rating)</i>	1
<i>General Child Medicaid—Rating of Personal Doctor (CAHPS Global Rating)</i>	1
<i>Children with Chronic Conditions Medicaid—Rating of Personal Doctor (CAHPS Global Rating)</i>	1
<i>Adult Medicaid—Rating of Specialist Seen Most Often (CAHPS Global Rating)</i>	1
<i>General Child Medicaid—Rating of Specialist Seen Most Often (CAHPS Global Rating)</i>	1
<i>Children with Chronic Conditions Medicaid—Rating of Specialist Seen Most Often (CAHPS Global Rating)</i>	1
<i>Children with Chronic Conditions Medicaid—Family Centered Care: Personal Doctor Who Knows Child (CAHPS Composite)</i>	1
<i>Children with Chronic Conditions Medicaid—Coordination of Care for Children with Chronic Conditions (CAHPS Question Summary Rates)</i>	1
<i>Medical Assistance With Smoking and Tobacco Use Cessation</i>	

⁸³ To calculate the Overall Rating category, all 78 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
<i>Advising Smokers and Tobacco Users to Quit</i>	1/3
<i>Discussing Cessation Medications</i>	1/3
<i>Discussing Cessation Strategies</i>	1/3
Access and Preventive Care	
<i>Adult Medicaid—Getting Needed Care (CAHPS Composite)</i>	1
<i>General Child Medicaid—Getting Needed Care (CAHPS Composite)</i>	1
<i>Children with Chronic Conditions Medicaid—Getting Needed Care (CAHPS Composite)</i>	1
<i>Adult Medicaid—Getting Care Quickly (CAHPS Composite)</i>	1
<i>General Child Medicaid—Getting Care Quickly (CAHPS Composite)</i>	1
<i>Children with Chronic Conditions Medicaid—Getting Care Quickly (CAHPS Composite)</i>	1
<i>Children with Chronic Conditions Medicaid—Access to Specialized Services (CAHPS Composite)</i>	1
<i>Children with Chronic Conditions Medicaid—Access to Prescription Medicines (CAHPS Question Summary Rates)</i>	1
<i>Adults' Access to Preventive/Ambulatory Health Services</i>	
<i>20–44 Years</i>	1/3
<i>45–64 Years</i>	1/3
<i>65+ Years</i>	1/3
<i>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis</i>	
<i>3 Months–17 Years</i>	1/3
<i>18–64 Years</i>	1/3
<i>65+ Years</i>	1/3
<i>Use of Imaging Studies for Low Back Pain</i>	
<i>18–64 Years</i>	1/2
<i>65–75 Years</i>	1/2
<i>Colorectal Cancer Screening</i>	1
Women's Health	
<i>Breast Cancer Screening</i>	1
<i>Cervical Cancer Screening</i>	1
<i>Prenatal and Postpartum Care</i>	
<i>Timeliness of Prenatal Care</i>	1
<i>Postpartum Care</i>	1
<i>Postpartum Depression Screening and Follow-Up⁸⁴</i>	

⁸⁴ Please note that HSAG will assess the ability to include this measure in the analysis once HEDIS data are available.

Measures	Measure Weight
<i>Depression Screening</i>	1/2
<i>Follow-Up on Positive Screen</i>	1/2
Behavioral Health	
<i>Initiation and Engagement of Substance Use Disorder (SUD) Treatment</i>	
<i>Initiation of SUD Treatment—Total</i>	1/2
<i>Engagement of SUD Treatment—Total</i>	1/2
<i>Follow-Up After Emergency Department (ED) Visit for Substance Use—30-Day Follow-Up—Total</i>	1
<i>Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total</i>	1
<i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total</i>	1
<i>Adherence to Antipsychotic Medications for Individuals With Schizophrenia</i>	1
<i>Antidepressant Medication Management</i>	
<i>Effective Acute Phase Treatment</i>	1/2
<i>Effective Continuation Phase Treatment</i>	1/2
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total</i>	1
<i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total</i>	1
<i>Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia</i>	1
<i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i>	1
Taking Care of Children	
<i>Childhood Immunization Status—Combination 3</i>	1
<i>Immunizations for Adolescents—Combination 2</i>	1
<i>Well-Child Visits in the First 30 Months of Life</i>	
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	1
<i>Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits</i>	1
<i>Child and Adolescent Well-Care Visits</i>	
<i>3–11 Years</i>	1
<i>12–17 Years</i>	1
<i>18–21 Years</i>	1
<i>Follow-Up Care for Children Prescribed ADHD Medication</i>	
<i>Initiation Phase</i>	1/2
<i>Continuation and Maintenance Phase</i>	1/2
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i>	

Measures	Measure Weight
<i>BMI Percentile Documentation—Total</i>	1/3
<i>Counseling for Nutrition—Total</i>	1/3
<i>Counseling for Physical Activity—Total</i>	1/3
Living With Illness	
<i>Hemoglobin A1c (HbA1c) Control for Patients with Diabetes</i>	
<i>HbA1c Control (<8.0%)</i>	1/4
<i>HbA1c Poor Control (>9.0%)</i>	1/4
<i>Blood Pressure Control for Patients with Diabetes</i>	1/4
<i>Eye Exam for Patients with Diabetes</i>	1/4
<i>Controlling High Blood Pressure</i>	1
<i>Asthma Medication Ratio—Total</i>	1
<i>Pharmacotherapy Management of COPD Exacerbation</i>	
<i>Systemic Corticosteroid</i>	1/2
<i>Bronchodilator</i>	1/2

Missing Values

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

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

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

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

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

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

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

Comparing MCO Performance

HSAG computed seven 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 seven reporting categories (Overall Rating, Doctors’ Communication, Access and Preventive Care, Women’s Health, 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 2023 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, 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 confidence interval (CI). A 95 percent CI and 68 percent CI were calculated around each difference score to identify plans that were significantly higher than or significantly lower than the mean. Plans with differences significantly above or below zero at the 95 percent confidence level received the top (Highest Performance) and bottom (Lowest Performance) designations, respectively. Plans with differences significantly above or below zero at the 68 percent confidence level, but not at the 95 percent confidence level, received High Performance and Low Performance designations, respectively. A plan was significantly above zero if the lower limit of the CI was greater than zero; and was significantly below zero if the upper limit of the CI was below zero. Plans that do not fall either

above or below zero at the 68 percent confidence level received the middle designation (Average Performance). For a given measure, the formulas for calculating the CIs were:

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

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

How Conclusions Were Drawn

A five-level rating scale provides consumers with an easy-to-read “picture” of quality performance across MCOs and presents data in a manner that emphasizes meaningful differences between MCOs.

Table B-26 shows how the Cardinal Care Consumer Decision Support Tool displays results were displayed:

Table B-26—Cardinal Care Acute Consumer Decision Support Tool—Performance Ratings

Rating	MCO Performance Compared to Statewide Average	
★★★★★	Highest Performance	The MCO's performance was significantly better than the Virginia Medicaid average using a 95% confidence interval.
★★★★	High Performance	The MCO's performance was significantly better than the Virginia Medicaid average using a 68% confidence interval.
★★★	Average Performance	The MCO's performance was not significantly different than the Virginia Medicaid average using either a 68% or a 95% confidence interval.
★★	Low Performance	The MCO's performance was significantly worse than the Virginia Medicaid average using a 68% confidence interval.
★	Lowest Performance	The MCO's performance was significantly worse than the Virginia Medicaid average using a 95% confidence interval.

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 2024 PWP, MCOs’ performance is evaluated on nine NCQA HEDIS measures/indicators (14 measures/indicators), one AHRQ PDI measure, and two CMS Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) measures. The EQRO is responsible for collecting MCOs’

audited HEDIS measure/indicator rates, the AHRQ PDI measure rates, and CMS Adult Core Set measure rates from DMAS. The EQRO will derive PWP scores for each measure/indicator 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 2024. 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 10 PWP measurement domains. These are composed of nine HEDIS measures (five of which have additional indicators), one AHRQ PDI measure, and two CMS Adult Core Set measures. In total, data are drawn from 17 distinct measures/indicators for the PWP as indicated in Table B-27.

Table B-27—PWP Measures/Indicators

Domain	Measure/Indicator	Measurement Specification	Required Reporting Method
1	<i>Asthma Admission Rate (per 100,000 Member Months [MM])*</i>	AHRQ PDI	Administrative
2	<i>Child and Adolescent Well-Care Visits—Total</i>	HEDIS	Administrative
3	<i>Childhood Immunization Status—Combination 3</i>	HEDIS	Hybrid
4	<i>Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (per 100,000 MM)—Total*</i>	CMS Adult Core Set	Administrative
5	<i>Comprehensive Diabetes Care Composite⁸⁵ (3 measures)</i> <i>Blood Pressure Control for Patients With Diabetes—Total</i> <i>Eye Exam for Patients With Diabetes—Total</i> <i>Hemoglobin A1c (HbA1c) Control for Patients With Diabetes (2 Indicators)</i> <i>HbA1c Control (<8.0%)—Total</i> <i>HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)—Total*</i>	HEDIS	Hybrid
6	<i>Follow-Up After Emergency Department (ED) Visit for Substance Use (2 Indicators)</i> <i>7-Day Follow-Up—Total</i> <i>30-Day Follow-Up—Total</i>	HEDIS	Administrative
7	<i>Follow-Up After ED Visit for Mental Illness (2 Indicators)</i> <i>7-Day Follow-Up—Total</i> <i>30-Day Follow-Up—Total</i>	HEDIS	Administrative
8	<i>Heart Failure Admission Rate (per 100,000 MM)—Total*</i>	CMS Adult Core Set	Administrative

⁸⁵ Starting with HEDIS MY 2022, the Comprehensive Diabetes Care measure/indicator has been removed and three new measures/indicators have been established. For the purposes of the PWP, the measures/indicators are combined as a composite and weighted similar to the other measures/indicators.

Domain	Measure/Indicator	Measurement Specification	Required Reporting Method
9	- Initiation and Engagement of Substance Use Disorder (SUD) Treatment (2 Indicators) - Initiation of SUD Treatment - Engagement of SUD Treatment	HEDIS	Administrative
10	- Prenatal and Postpartum Care (2 Indicators) - Timeliness of Prenatal Care - Postpartum Care	HEDIS	Hybrid

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

Performance Period

The SFY 2024 PWP assesses CY 2023 performance measure data (i.e., the performance measures/indicators will be calculated following HEDIS MY 2023, AHRQ's PDI Technical Specifications [July 2022], and CMS FFY 2024 Adult Core Set Specifications that use a CY 2023 measurement period) to determine what portion, if any, the MCOs will earn back from the funds withheld in SFY 2024 (i.e., the 1 percent of capitation payments withheld from July 1, 2023, through June 30, 2024).⁸⁶

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/indicator 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 External Quality Review (EQR) Protocols: Protocol 2. Validation of Performance Measures*, February 2023.⁸⁷ Following the performance measure validation, the EQRO will provide the true, audited rates for the AHRQ PDI and CMS Adult Core Set measures to DMAS.

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 2024 PWP (i.e., the initial performance year). With receipt of audited HEDIS measure/indicator rates and validated CMS Adult Core Set measure rates (i.e., non-HEDIS

⁸⁶ 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 CMS' Adult Core Set.

⁸⁷ Department of Health and Human Services, Centers for Medicare and Medicaid Services. CMS External Quality Review (EQR) Protocols, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Jul 5, 2023.

measure rates), each measure/indicator will be scored prior to calculating the amount of the quality withhold, if any, each MCO will earn back.

Only measure/indicator rates with a “*Reportable (R)*” (HEDIS and non-HEDIS rates) audit result (i.e., the plan produced a reportable rate for the measure/indicator in alignment with the technical specifications) will be included in the PWP calculation. Measure/indicator rates with a “*Small Denominator (NA)*” (HEDIS rates only) status (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/indicator rates with any result other than a “*Reportable (R)*” audit result or “*Small Denominator (NA)*” status 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 2024 PWP

As indicated above, SFY 2024 PWP will use the MCOs’ audited HEDIS MY 2023 and validated CY 2023 AHRQ PDI and CMS FFY 2024 CMS Adult Core Set performance measure data. Table B-28 shows the percentage of withhold associated with each domain.

Table B-28—SFY 2024 PWP Measure Weights

Domain	Measure/Indicator	Domain Weight
1	• <i>Asthma Admission Rate (per 100,000 MM)*</i>	10%
2	• <i>Child and Adolescent Well-Care Visits—Total</i>	10%
3	• <i>Childhood Immunization Status—Combination 3</i>	10%
4	• <i>COPD or Asthma in Older Adults Admission Rate (per 100,000 MM)—Total*</i>	10%
5	• <i>Comprehensive Diabetes Care Composite (3 measures)</i> – <i>Blood Pressure Control for Patients With Diabetes—Total</i> – <i>Eye Exam for Patients With Diabetes—Total</i> • <i>HbA1c Control for Patients With Diabetes (2 Indicators)</i> – <i>HbA1c Control (<8.0%)—Total</i> – <i>HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)—Total*</i>	10%
6	• <i>Follow-Up After ED Visit for Substance Use (2 Indicators)</i> – <i>7-Day Follow-Up—Total</i> – <i>30-Day Follow-Up—Total</i>	10%
7	• <i>Follow-Up After ED Visit for Mental Illness (2 Indicators)</i> – <i>7-Day Follow-Up—Total</i> – <i>30-Day Follow-Up—Total</i>	10%
8	• <i>Heart Failure Admission Rate (per 100,000 MM)—Total*</i>	10%

Domain	Measure/Indicator	Domain Weight
9	<i>Initiation and Engagement of SUD Treatment (2 Indicators)</i> <i>Initiation of SUD Treatment</i> <i>Engagement of SUD Treatment</i>	10%
10	<i>Prenatal and Postpartum Care (2 Indicators)</i> <i>Timeliness of Prenatal Care</i> <i>Postpartum Care</i>	10%

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

Scoring Methods

The next several sections describe the PWP calculation method for the SFY 2024 PWP.

Measure/Indicator Partial Score

For SFY 2024, the AHRQ PDI and CMS Adult Core Set measure scoring will be based on whether the MCO reported valid CY 2023 measure rates in the required reporting method as indicated in Table B-27. Due to the planned transition to Cardinal Care, DMAS will attempt to set benchmarks for determining the Cardinal Care MCO performance scores for the AHRQ PDI and CMS Adult Core Set measures after the transition is complete.

As indicated in Table B-34, 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)

Table B-29—Audit Designations (AHRQ PDI and CMS Adult Core Set)

Audit Designation	
Eligible for Points	Ineligible for Points
<i>Reportable (R)</i>	<i>Do Not Report (DNR)</i>
	<i>Not Applicable (NA)</i>
	<i>No Benefit (NR)</i>

The performance scores for the HEDIS measures/indicators will be determined by comparing each rate to NCQA’s Quality Compass national Medicaid health maintenance organization (HMO) percentiles (referred to in this document as percentiles).

Table B-30 presents the possible scores for each HEDIS measure/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/indicator score, and no scores will be dropped.

Table B-30—PWP HEDIS Measure/Indicator Scoring

Criteria for Each Measure/Indicator	Score
MCO's rate is below the lower percentile threshold	0.00
MCO's rate is at or above the lower percentile threshold but below the upper percentile threshold	Between 0.00 and 1.00
MCO's rate is at or above the upper percentile threshold	1.00

For the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, and *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* indicators, the lower percentile threshold will be the 50th percentile and the upper percentile threshold will be the 66.67th percentile. For all other HEDIS measures/indicators, the lower percentile threshold will be the 25th percentile and the upper percentile threshold will be the 50th percentile. HEDIS measure/indicator rates that are below the lower percentile threshold will receive a score of zero (i.e., no portion of the quality withhold will be earned for this indicator). Measure/indicator rates that are at or above the upper percentile threshold will receive the maximum score for that measure/indicator (i.e., 1 point). If a measure/indicator rate is at or above the lower percentile threshold but below the upper percentile threshold, 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 measure/indicator level, each MCO's rate will be compared to the percentiles to determine how close the MCO's rate is to the upper percentile threshold. In future iterations of the PWP, the lower percentile threshold and upper percentile threshold may increase to encourage continued positive performance and quality improvement. The partial score for each measure/indicator will be derived using the following formula:

$$\text{Partial Point Value} = \left[\frac{(\text{MCO Rate} - \text{Lower Percentile Threshold})}{(\text{Upper Percentile Threshold} - \text{Lower Percentile Threshold})} \right]$$

For example, if the lower percentile threshold is 40 percent and the upper percentile threshold is 60 percent, and an MCO has a rate of 55 percent for a measure/indicator, then the partial point value is calculated as follows:

$$\text{Partial Point Value} = \left[\frac{(55 - 40)}{(60 - 40)} \right] = 0.75$$

Improvement Bonus

For the AHRQ PDI and CMS Adult Core Set measures, DMAS will determine an appropriate method of assigning improvement bonus points for future iterations of the PWP, if applicable.

For the SFY 2024 PWP, MCOs that failed to meet the 50th percentile in CY 2022 (i.e., HEDIS MY 2022 data) for a HEDIS measure/indicator may be eligible to earn an improvement bonus if a measure/indicator rate demonstrates substantial improvement from CY 2022.^{88,89} Substantial improvement will be defined as 20 percent of the difference between the lower and upper percentile thresholds. An improvement bonus of 0.25 points will be awarded for each measure/indicator, if the MCO was below the 50th percentile in CY 2022 and the following is true:

$$|MCO \text{ Current Rate} - MCO \text{ CY 2022 Rate}| \geq \left\lceil \left\lfloor \frac{(Upper \text{ Percentile Threshold} - Lower \text{ Percentile Threshold})}{5} \right\rfloor \right\rceil$$

For each MCO, HSAG will assess which measure/indicator rates are eligible for an improvement determination. HSAG will only determine improvement bonus eligibility if a measure/indicator meets the following criteria:

- The MCO current year rate demonstrated an improvement from the CY 2022 rate;
- The MCO reported the measure/indicator rate in both the current year and CY 2022;
- The MCO's reported measure/indicator rate was below the 50th percentile in CY 2022;
- The MCO reported the measure/indicator rate using the same reporting methodology in both years (e.g., the reporting methodology did not change from administrative in CY 2022 to hybrid in the current year); and
- NCQA did not recommend a break in trending for the measure/indicator due to a change in the technical specifications for the Medicaid product line.

If an MCO demonstrates substantial improvement for a measure/indicator rate and meets all of the criteria for improvement bonus determinations, then the MCO will receive an improvement bonus for that measure/indicator.

High Performance Bonus

For the SFY 2024 PWP, if an MCO demonstrates a strong performance trend over time for a HEDIS measure/indicator, the MCO will be eligible for a high performance bonus. For the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, and *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* indicators, the high performance value will be the 75th percentile. For all other HEDIS measures/indicators, the high performance value will be the 66.67th percentile. The high performance bonus will be awarded for measure/indicator rates that exceed the high performance value for both the current year and CY 2022.⁹⁰ Each measure/indicator rate that is awarded the high performance bonus will be eligible for a maximum high performance bonus of 0.25 points that will be added to the measure/indicator partial score described above (i.e., 1 point).

⁸⁸ HSAG will use the HEDIS MY 2022 Combined Aggregate files (i.e., the MCO's standard NCQA HEDIS submission) as a comparison to the HEDIS MY 2023 data submissions.

⁸⁹ To evaluate the improvement bonus for Sentara Health Plan (Sentara), HSAG combined the CY 2022 results for Optima Health (Optima) and Virginia Premier Health Plan, Inc. (VA Premier). Please refer to the Combining Data section for more information on how data were combined.

⁹⁰ To evaluate the high performance bonus for Sentara, HSAG combined the CY 2022 results for Optima and VA Premier. Please refer to the Combining Data section for more information on how data were combined.

For the AHRQ PDI and CMS Adult Core Set measures, DMAS will determine an appropriate method of assigning high performance bonus points for future iterations of the PWP, if applicable.

How Conclusions Were Drawn

Scoring Model Example

Table B-31 and Table B-32 provide examples of how measure/indicator partial scores will be determined by MCO. All data presented in the tables below (both measure/indicator rates and percentile values) are mock data and do not represent actual data or results.

**Table B-31—Measure/Indicator Partial Score Calculations—HEDIS Measures/Indicators
(Example Using Mock Data)**

Measure/Indicator	Current Year Rate	Lower Percentile Threshold	Upper Percentile Threshold	Measure/Indicator Partial Score
Child and Adolescent Well-Care Visits				
<i>Total</i>	55.55%	44.28%	54.26%	1.00
Childhood Immunization Status				
<i>Combination 3</i>	73.82%	65.45%	70.68%	1.00
Comprehensive Diabetes Care Composite				
<i>Blood Pressure Control for Patients With Diabetes—Total</i>	53.00%	50.23%	54.55%	0.64
<i>Eye Exam for Patients With Diabetes—Total</i>	42.68%	41.77%	52.00%	0.09
<i>HbA1c Control (<8.0%)—Total</i>	54.74%	44.11%	51.22%	1.00
<i>HbA1c Poor Control (<9.0%)—Total*</i>	50.70%	45.55%	38.66%	0.00
Follow-Up After ED Visit for Substance Use				
<i>7-Day Follow-Up—Total</i>	6.94%	6.25%	9.73%	0.20
<i>30-Day Follow-Up—Total</i>	11.04%	9.89%	15.25%	0.21
Follow-Up After ED Visit for Mental Illness				
<i>7-Day Follow-Up—Total</i>	46.22%	29.21%	35.49%	1.00
<i>30-Day Follow-Up—Total</i>	58.92%	43.17%	51.45%	1.00
Initiation and Engagement of SUD Treatment				
<i>Initiation of SUD Treatment</i>	42.26%	39.25%	41.99%	1.00
<i>Engagement of SUD Treatment</i>	11.16%	9.53%	11.01%	1.00

Measure/Indicator	Current Year Rate	Lower Percentile Threshold	Upper Percentile Threshold	Measure/Indicator Partial Score
Prenatal and Postpartum Care				
<i>Timeliness of Prenatal Care—Total</i>	78.01%	78.10%	83.76%	0.00
<i>Postpartum Care—Total</i>	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-32—Measure/Indicator Partial Score Calculations—AHRQ PDI and CMS Adult Core Set Measures

(Example Using Mock Data)

Measure	Audit Designation*	Met Reporting Requirements	Measure Partial Score
Asthma Admission Rate (per 100,000 MM)			
<i>Total</i>	R	Yes	1.00
COPD or Asthma in Older Adults Admission Rate (per 100,000 MM)			
<i>Total</i>	R	Yes	1.00
Heart Failure Admission Rate (per 100,000 MM)			
<i>Total</i>	NA	No	0.00

*Audit designations include: Reportable (R); Do Not Report (DNR); Not Applicable (NA); No Benefit (NR).

The measure/indicator partial scores for the HEDIS measures/indicators are calculated by first determining the applicable percentile level for the measure/indicator rate. For example, the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* indicator received a measure/indicator partial score of one point because the rate (46.22 percent) is above the upper percentile threshold (35.49 percent). For the AHRQ PDI and CMS Adult Core Set measures, the *Asthma Admission Rate—Total* measure receives a measure partial score of 1.00 because the audit designation was “Reportable (R).”

Table B-33 provides an example of how the improvement bonus scores will be determined by MCO based on performance for the current year and CY 2022 for the HEDIS measures/indicators. Improvement bonus determinations for the AHRQ PDI and CMS Adult Core Set measures will be evaluated for future iterations of the PWP.

Table B-33—Measure/Indicator Improvement Bonus Score Calculations—HEDIS Measures/Indicators

(Example Using Mock Data)

Measure/Indicator	CY 2022 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							

Measure/Indicator	CY 2022 Rate	Current Year Rate	Rate Difference	Substantial Improvement Value	Below 50th Percentile in Prior Year	Met Substantial Improvement	Improvement Bonus†
<i>Total</i>	50.85%	55.55%	4.70%	2.00%	Y	Y	0.25
Childhood Immunization Status							
<i>Combination 3</i>	71.29%	73.82%	2.53%	1.05%	N	Y	0.00
Comprehensive Diabetes Care Composite							
<i>Blood Pressure Control for Patients With Diabetes—Total</i>	53.25%	53.00%	-0.25%	0.86%	Y	N	0.00
<i>Eye Exam for Patients With Diabetes—Total</i>	44.27%	42.68%	-1.59%	2.05%	Y	N	0.00
<i>HbA1c Control (<8.0%)—Total</i>	57.41%	54.74%	-2.67%	1.42%	N	N	0.00
<i>HbA1c Poor Control (>9.0%)—Total*</i>	52.26%	50.70%	-1.56%	-1.38%	Y	Y	0.25
Follow-Up After ED Visit for Substance Use							
<i>7-Day Follow-Up—Total</i>	5.66%	6.94%	1.28%	0.70%	Y	Y	0.25
<i>30-Day Follow-Up—Total</i>	11.42%	11.04%	-0.38%	1.07%	Y	N	0.00
Follow-Up After ED Visit for Mental Illness							
<i>7-Day Follow-Up—Total</i>	45.12%	46.22%	1.10%	1.26%	N	N	0.00
<i>30-Day Follow-Up—Total</i>	59.67%	58.92%	-0.75%	1.66%	N	N	0.00
Initiation and Engagement of SUD Treatment							
<i>Initiation of SUD Treatment</i>	41.68%	42.26%	0.58%	0.55%	N	Y	0.00
<i>Engagement of SUD Treatment</i>	11.11%	11.16%	0.05%	0.30%	Y	N	0.00
Prenatal and Postpartum Care							
<i>Timeliness of Prenatal Care—Total</i>	77.62%	78.01%	0.39%	1.13%	Y	N	0.00
<i>Postpartum Care—Total</i>	60.58%	64.70%	4.12%	1.26%	Y	Y	0.25

†A measure/indicator is eligible for an improvement bonus if the measure/indicator rate was below the 50th percentile in CY 2022 and the measure/indicator rate demonstrated substantial improvement from CY 2022.

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

Table B-34 provides an example of how the high performance bonus scores will be determined, by MCO, based on performance for the current year and CY 2022 for the HEDIS measures/indicators.

Once the high performance bonus scores are determined, the measure/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 measure/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-34—High Performance Bonus Score Calculations—HEDIS Measures/Indicators
(Example Using Mock Data)

Measure/Indicator	CY 2022 Rate	CY 2022 High Performance Value	Current Year Rate	Current Year High Performance Value	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
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 measure/indicator, a lower rate indicates better performance.

Table B-35 shows the domain level score calculations for each MCO by determining the average of the measure/indicator level scores for each measure/indicator.

Table B-35—Domain Level Score Calculations
(Example Using Mock Data)

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

Measure/Indicator	Measure/ Indicator Level Score	Improvement Bonus	High Performance Bonus	Final Measure/ Indicator Score	Domain Level Score
<i>Postpartum Care—Total</i>	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/indicator 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* domain level score (0.33) was obtained by averaging the measure/indicator level scores for *7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* (0.45 and 0.21 respectively).

Table B-36 provides an example of how the percentage of the quality withhold is derived (i.e., overall withhold earned) based on the 10 domain level scores calculated above. The percentage of the quality withhold that the MCO is eligible to earn back is calculated by multiplying the domain level score with the applicable domain weight and then summing the domain 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-36—Percentage Withhold Earned
(Example Using Mock Data)

Domain	Domain Level Score	Domain Weight	Domain Withhold Earned	Overall Withhold Earned
<i>Asthma Admission Rate (per 100,000 MM)</i>	1.00	10.00%	10.00%	79.33%
<i>Child and Adolescent Well-Care Visits</i>	1.25	10.00%	12.50%	
<i>Childhood Immunization Status</i>	1.00	10.00%	10.00%	
<i>COPD or Asthma in Older Adults Admission Rate (per 100,000 MM)</i>	1.00	10.00%	10.00%	
<i>Comprehensive Diabetes Care Composite</i>	0.56	10.00%	5.58%	
<i>Follow-Up After ED Visit for Substance Use</i>	0.33	10.00%	3.30%	
<i>Follow-Up After ED Visit for Mental Illness</i>	1.25	10.00%	12.50%	
<i>Heart Failure Admission Rate (per 100,000 MM)</i>	0.00	10.00%	0.00%	
<i>Initiation and Engagement of SUD</i>	1.00	10.00%	10.00%	
<i>Prenatal and Postpartum Care</i>	0.55	10.00%	5.45%	

Please note that the numbers in the table have been rounded for display purposes. Calculations will be based off unrounded data.

Quality Withhold Funds Model

The quality withhold percentage is 1 percent of the total MCO capitation payments for the year. An MCO is eligible to earn the entire quality withhold by having 100 percent for the overall withhold (i.e., the MCO would not lose any quality withhold funds).

Table B-37—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-37, the one percent at risk amount for the example MCO is \$7,357,900.00. The MCO earned 79.33 percent of the quality withhold through the review of the HEDIS, AHRQ PDI, and CMS Adult Core Set measure/indicator rates, thus the MCO is eligible to receive \$5,836,654.18 of the quality withhold according to the following equation:

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

Combining Data

Due to the merger of Optima and VA Premier, HSAG combined results for Optima and VA Premier for CY 2022. HSAG employed the following methodology to combine the results:

The formula for computing the combined mean ($\bar{X}_c$) for each measure is:

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

where:

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

HSAG used the combined results of Optima and VA Premier to assess Sentara's improvement bonus and high performance bonus.

Appendix C. MCO Best and Emerging Practices

Table C-1 identifies the DMAS' self-reported 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 continued to work with DMAS' Healthcare Analytics Division to publish a public-facing version of the ARTS dashboard so that it could provide information similar to the external dashboard for mental health disorder services. This allowed the ARTS team more capability to do real time data analysis and quality assurance/improvement work.
Topic/Title: Partnership for Petersburg Description: 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.
Topic/Title: Newborn Bot Enrollment Description: The Newborn Enrollment process now incorporates newborn auto enrollment using an automated process in the form of a "newborn bot". The expectation is that the bot will process newborn enrollments from hospital through the Medicaid enrollment process. However, currently the bot is an attended bot. The newborn enrollment unit is moving toward an unattended bot which will be able to process more cases per day. Cases not processed through the bot are captured in an exception file which flags cases where there is a redetermination or where a case change has been made. Messaging for members remains the same for now for families to call CoverVA or work with LDSS to enroll their newborns.
Topic/Title: Development of MCH Dashboards Description: The Maternal and Child (MCH) Health Team has engaged in a collaborative effort with internal teams to design and implement sophisticated dashboards aimed at improving the review and analysis processes for MCH contract deliverables submitted by our Managed Care Organizations (MCOs). These dashboards provide high-level summary of MCOs self-report and claims data to get a picture of pregnant/postpartum enrollment numbers, members assigned as

Best and Emerging Practices
high risk, results of outreach and engagement efforts and utilization of services by high-risk members. Analysts track the results for trends and outliers. Analysts reach out to plans with questions and concerns. The information can also inform policy and programming changes needed.
Topic/Title: Baby Steps of Virginia Description: 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 sharing information on and fostering collaboration to improving maternal health outcomes and eliminating racial disparity in outcomes and maternal mortality. With the myriads of initiatives, workgroups, taskforces, new programs, etc. addressing maternal health, it is imperative to have a mechanism to keep partners and stakeholders informed. In addition to bimonthly virtual meetings, DMAS distributes bimonthly newsletters, an annual report, and ad hoc email blasts on key announcements.
Topic/Title: Community Doula Program Description: To date, 174 doulas have received state certification. Of the 174 state-certified doulas, 137 are approved and enrolled as Medicaid Doula Providers. There have been 226 doula-supported births to Medicaid members and over 437 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 community and provider engagement, data collection and analysis to evaluate benefit utilization, and increasing the network of doula providers. DMAS' dedicated doula program specialist, working with the contracted MCOs, provides technical assistance to Medicaid doula individual and group providers. The providers receive technical assistance with both enrollment and billing. The technical assistance augments quarterly doula informational sessions coordinated by our doula program specialist and the Virginia Department of Health doula certification coordinator. In an effort to expand the doula provider network, the Germanna Community College Doula Certification Program was launched in August 2024. This program developed by Germanna Community College in partnership with Rappahannock Health District, Mary Washington College, and the state departments of Health (VDH), and Medical Assistance Services (DMAS), utilizes local doula trainers, Germanna faculty/staff and the local hospital system for labor and delivery observation. Student scholarships were provided by three of DMAS' contracted Medicaid MCOs. This promising new approach of utilizing the community college system for doula state certification training offers greater access and accessibility to doula training throughout the state. The availability of state-certified Medicaid-approved doula providers within the Commonwealth means greater access to care and support for pregnant women with the goal of improving maternal and infant health outcomes.

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: Justice Program/Thrive Mobile Description: An adult and Juvenile system of care administrators, community health workers, peer support specialist working hand in hand with care managers and behavioral health team to provide wrap-around care for the Plan's justice-involved members. Description: Mobile phone to connect and engage members in the Justice program to assist with their health care to enable better health care outcomes. Each phone is preloaded with critical phone numbers, such as Member Services, transportation benefits, care manager contacts, 24/7 nurse line, Pyx health, MD live, etc. Topic/Title: Poly Poly Support (Petersburg) Description: The Plan implemented a pilot program that focuses on supporting members residing in Petersburg. The program identifies opportunities to balance the number of prescribers and pharmacies members use to fill medications. Topic/Title: Vheda Description: Remote patient monitoring program that serves medically complex populations, including members with diabetes, congestive heart failure, hypertension, chronic obstructive pulmonary disease, asthma, and high-risk pregnancy. Topic/Title: Flourish Health Description: Behavioral health treatment program that combines virtual psychiatric and therapeutic care with high-touch wraparound services, empowering members in the comfort of their home to achieve effective and long-lasting outcomes. Topic/Title: MDLive Description: Offers adult and child members 24/7 general non-emergent behavioral health care for adults and children in the comfort of their home.
HealthKeepers	Topic/Title: Pomelo Care Description: Pomelo Care is a program that address unmanaged risks during pregnancy. This program provides 24/7 personalized care, the application of evidence-based PH and BH interventions to decrease avoidable premature and cesarean deliveries and decrease the length of NICU stays through concentrated discharge planning for transitions home. Pomelo Care's integrated care teams treat underlying risk factors before they lead to adverse birth outcomes through progressive services such as remote patient monitoring via peripheral devices (asynchronous and synchronous), group prenatal services, virtual Doula support, and personalized hybrid care plans for rural members. Topic/Title: Concierge Care Description: Concierge Care, a Digital Fast Forward initiative, is a dynamic care management tool that delivers convenient and personalized condition management programming through an intuitive app that syncs with our Care Management

MCO	Best and Emerging Practices
	platforms. This digital solution includes embedded remote monitoring (condition specific) and gamified, interactive experience which generates value/impact for multiple stakeholders: Members have increased access to us to mitigate barriers and reach health goals more quickly, and tools/education that helps them self-manage and adopt healthy habits. Care Managers can more efficiently manage needs, drive behavioral changes and close gaps between member and all participants in their health care team/journey Providers can see results of patient engagement and track reported symptoms for more proactive intervention. Topic/Title: Community Pharmacy Total Care Description: Community Pharmacy Total Care is Anthem’s unique innovation in pharmacy services. This is a value-based program between Anthem and community based independent pharmacies. This program promotes clinical and community integration by utilizing the relationship between our members and their most available providers-local pharmacists. These pharmacists provide custom compliance packaging, medication refill synchronization, hand deliver medications, improving medication adherence. The member receives a personalized experience, accessibility is improved and HEDIS gaps are closed.
Molina	Topic/Title: Pay for Quality (P4Q) Program Description: For 2024, 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 bonus dollar amount to incentivize performance related to completion of preventative care opportunities including time sensitive follow up appointments. Service dates for this program follow the calendar year. Upon reaching the NCQA 50th percentile benchmark, providers will receive incentive payments for each member exceeding this threshold per measure. 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

MCO	Best and Emerging Practices
	• Meet and interact with Molina team members Topic/Title: Provider Network and Quality Practice Transformation 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, 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.
Sentara	Topic/Title: Tribal Care Coordination Description: Sentara Health Plan recognized adolescent suicide and adult substance use rates are the highest in the nation amongst Tribal populations. To provide additional assistance to our members in this population Sentara created a dedicated Tribal Care Coordination program targeted at reducing suicide rates in Tribal adolescent members and Substance Use rates in Tribal adult members. This program launched in February 2024. Our Tribal Coordinators are working with adolescents to complete suicide assessments that help identify individuals with suicidal ideations and/or past or recent suicide attempts. Once identified, our Tribal Coordinators work with the members to connect to providers, programs, and resources. The Tribal Coordinator works with those adult members at-risk or currently diagnosed with substance use disorder and assists with locating both Tribal and Health Plan providers, engaging in treatment and counseling, as well as identifying supportive services needed to ensure overall healthcare wellness. Topic/Title: Welcoming Baby Maternal Care Coordination Description: Sentara Health Plan recognized the increasing morbidity and mortality of maternal members nationwide. In January 2024, the health plan revised the maternal care management program to include wrap-around services

MCO	Best and Emerging Practices
	for this sub-population of members. The Welcoming Baby program consists of nurses and care coordinators as well as certified community educators to provide maternal education for healthy pregnancies, bereavement services for those experiencing fetal loss, assistance with social determinants of health, as well as behavioral health and substance use disorder concerns. The care management team completes a health risk assessment and a prenatal or postpartum supplemental assessment to provide a better picture of the needs of the member. Once the needs are identified, consultative referrals are sent internally for subject matter experts to begin to work with the members on individual concerns. The outreach team provides information regarding benefits and incentives that the member is eligible for, in addition to providing Baby Showers for members, community events and education, and recently began a father's support group. A maternal dashboard is in development to leverage data to identify where there may be maternal deserts to analyze and revise workflows on an ongoing basis. Each week, a maternity case is presented at rounds to the Welcoming Baby team and Medical Directors to ensure best practice is being utilized for members. This provides an arena for collaboration with other team representatives. Topic/Title: Justice Care Coordination Description: The Justice Care Coordination (JCC) program provides specialized care coordination for recently incarcerated individuals, supporting their successful reintegration into the community. The program ensures justice-involved members receive comprehensive outpatient services, including transportation assistance, housing support and facilitation of primary and specialty care appointments. Members are connected with substance use disorder (SUD) and/or opioid use disorder (OUD) support groups and can participate in programs to guide their path to sobriety. Peer recovery specialists are also available to our members for additional guidance. Topic/Title: Maternal Child Health Community Health Worker Outreach Program Description: Certified Community Health Workers & Marketing Specialist to support maternal health. Welcoming Baby Outreach, Watch Me Grow, Baby Showers and Maternal Child Health Ed. Series (MCH) Programming. Provide screening, education, one-on-one support, access to care, connections to community resources and internal clinical case management and care coordination. Telephonic and face to face support, incentives and materials. Specialized training to: • Outreach, screen, educate, refer to CM • Address social needs • Enhance health literacy • Support timeliness of prenatal and postpartum care • Assess mom/baby at postpartum/birth, screen and educate on postpartum depression, family planning well child visits, timely infant care, identify risk & refer to CM

MCO	Best and Emerging Practices
	• Baby Showers to connect, educate, provide resources to members, parents and caregivers • MCH Classes to educate and provide resources to staff and members, parents and caregivers Topic/Title: Notification and Monitoring of Durable Medical Equipment (DME) Recalls Description: QI Member Safety maintains a system for identifying, recording, and notifying members when applicable, of Durable Medical Equipment Recalls. Additionally, it is understood that communication with our members is a shared responsibility between the manufacturer, FDA, facilities, distributors, and providers. The Sentara Health Plan DME Recall Communication plan includes the identification of applicable DME Recalls and notifying Sentara Health Plan Clinical Care Services' teams, Medical Directors, members and providers affected by a Class I or Class II DME Recall when identified, as needed and as applicable. 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 and utilize SDOH data to drive member engagement. Topic/Title: Chronic Care Management Program Description: This program utilizes 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. This team assists members in finding and establishing a relationship with a Primary Care Provider, Transportation needs, and drives referrals to other inter-services offered through SHP. Topic/Title: Population Health - Preventive Screening Kits Description: The health plan collaborates with vendor partners to provide screening kits to members. 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. Topic/Title: Population Health – Digital Health Apps that help members track ovulation, cycle, pregnancy and navigate the early years of parenthood

MCO	Best and Emerging Practices
	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, 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 - 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. 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 of our members, enhance health literacy, improve health screenings, and reduce care gaps.
United	Topic/Title: Walnut Hill Food Pharmacy Description: Food insecurity's harmful impacts are amplified with medical conditions, such as diabetes. Food Pharmacy is an innovative service enabling PCPs to link patients at risk for food insecurity to nutritional food and education. We facilitated a partnership with Walnut Hill Pharmacy and Feed More food bank to deploy a 40-week food box program to 50 individuals with diabetes and food insecurity. To remain eligible, individuals must measure their A1C and body weight monthly. We will apply insights from this pilot to inform future food as medicine solutions to further support the populations we serve. Topic/Title: Community Link Health Alliance Description: Community Link Health Alliance (CLHA) is a network of social agencies. The main goal of the alliance is to address HRSN and improve overall community well-being. This relationship leverages a wide network of agencies, including 12 participating housing Continuums of Care, to engage difficult to reach members. Care coordination and closed-loop HRSN referrals are facilitated by a two-way member consent to allow bi-directional sharing of member information between partner organizations. The data sharing improves care coordination and

MCO	Best and Emerging Practices
	closed-loop referrals and addresses unmet needs, setting this standard as a new norm of Cardinal Care Managed Care (CCMC) MCO engagement. Topic/Title: Flourish Health Description: We prioritize community-based care for members in the least restrictive environment. To increase capacity for supporting members with SMI/SED in community settings and their caregivers, we partnered to bring Flourish Health to Virginia in July 2023. The Flourish Health First Episode Psychosis (FEP) and SED program for teens and young adults with SMI provides high-touch, in-person support with virtual therapeutic and psychiatric care. Topic/Title: Boost 200 Description: Virginia is currently experiencing a mental health crisis, with the demand for counseling services surpassing the capacity of the state's licensed behavioral health professionals. Boost 200 is a new initiative aimed at addressing this issue. It provides funding for the licensure-required supervision of motivated Master's-prepared Social Workers, Counselors, and Marriage and Family Therapists, helping them become Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), or Licensed Marriage and Family Therapists (LMFTs) in Virginia. To support this initiative and address the significant disparities in exam pass rates, UHC has provided funding to cover exam fees for Boost 200 participants. Topic/Title: Enhanced Clinical Quality Dashboard Description: We developed and implemented a Next Best Actions process, which offers clinicians and providers a prioritized snapshot of the most actionable steps a member can take to optimally support their health at any given time. We further enhanced this process through development and implementation within our clinical case management platform, which provides staff and providers the capability to monitor and track clinical quality measures and assist members in “real-time” to close gaps in care.

Appendix D. MCO Quality Strategy Quality Initiatives

Table D-1 through Table D-5 provide examples of the quality initiatives the MCOs highlighted as their efforts toward achieving the Virginia 2023–2025 QS's goals and objectives. Note: The narrative within the Quality Initiatives section was provided by the MCO and has not been altered by HSAG except for minor formatting.

Aetna

Table D-1—Aetna's QS Quality Initiatives

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
Goal 1: Enhance Member Care Experience Objective 1.1: Increase Member Engagement and Outreach	Description of Quality Initiative: <u>Outreach Call Center:</u> A member outreach team dedicated solely to educate members and assist with coordinating care to close gaps in care. Efforts are monitored by gap closure rates three months post outreach.	1.1.1.1: Number of Outreach and Engagement Activities Per Year
Goal 1: Enhance Member Care Experience Objective 1.1: Increase Member Engagement and Outreach	Description of Quality Initiative: <u>Outreach Call Center:</u> A member outreach team dedicated solely to educate members and assist with coordinating care to close gaps in care. Efforts are monitored by gap closure rates three months post outreach.	1.1.1.1: Number of Outreach and Engagement Activities Per Year
Goal 1: Enhance the Member Care Experience Objective 1.1: Increase Member Engagement and Outreach	Description of Quality Initiative: <u>Improved Website Structure:</u> Reviewed and restructured Plan website to assure quality materials and guidance are strategically placed on the website for increased member accessibility of resources. Ensuring user-friendly resource locations help improve member experience with locating needed resources and increases awareness of service/program options available to members. Additionally, the Plan monitors the utilization and outcomes of the member website as well as	1.1.1.1: Number of Outreach and Engagement Activities Per Year

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
	pharmacy and member service help desks.	
Goal 1: Enhance the Member Care Experience Objective 1.1: Increase Member Engagement and Outreach	Description of Quality Initiative: <u>Language Monitoring:</u> The Plan continues to conduct ongoing monitoring of its membership population monitoring to assess and evaluate members' language spoken. Continuous language monitoring allows the Health Plan to ensure member materials and services are sufficient to meet members' language needs and maintains alignment with	1.1.1.3: Monitor Member Language Counts
Goal 1: Enhance Member Satisfaction Objective 1.2: Improve Member Satisfaction	Description of Quality Initiative: <u>HEDIS and CAHPS Workgroup:</u> Multi-departmental workgroup that continuously looks for opportunities to improve member and provider satisfaction. The workgroup conducts deep dives into barriers related to members not having a PCP, members' ability to get urgent and routine appointments as needed, obtaining needed information from Member Services, and having access to highly rated or specialty providers. The workgroup focuses on initiatives that encourage same-day scheduling, increasing utilization of telehealth services, improving communications between providers and members, and increasing member use of patient-centered medical homes.	1.2.1.1: Enrollees' Ratings Q8 – Rating of all Health Care 1.2.1.2: Rating of Personal Doctor
Goal 2: Promote Access to Safe, Gold-Standard Patient Care Objective 2.3: Ensure Access to Care	Description of Quality Initiative: <u>Point Click Care:</u> Integrated platform that connects health systems, hospitals and FQHCs. The EMR health care system notifies Care Management staff of inpatient and emergency department visits, assists with transitions of care and care coordination with a variety of providers. The platform provides pertinent information including	2.1.1.3 Getting Needed Care

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
	diagnosis and discharge disposition. Additionally, the system serves as a valuable resource for obtaining new contact information, as member information frequently changes.	
Goal 2: Promote Access to Safe, Gold-Standard Patient Care Objective 2.1: Ensure Access to Care	Description of Quality Initiative: <u>MD Live:</u> A virtual care platform that offers members behavioral health services for addiction and common mental health conditions. Members have 24/7 access to services, such as talk therapy and psychiatry from the privacy of their home. <u>Thrive Mobile:</u> Offers members digital inclusion through mobile phones to support care management activities. Preloaded with critical phone numbers, such as Member Services, transportation benefits, 24/7 nurse line, Pyx health, MD live, Care Manager and PCP numbers. <u>Vheda:</u> Supports members with complex chronic conditions, such as congestive heart failure, diabetes, hypertension, asthma, chronic obstructive pulmonary disease, and high-risk pregnancy via remote patient monitoring, real-time analytics, and live outreach. Enrolled members receive an iPhone, and monitoring devices, such as BP cuff, scale, pulse oximeter and glucometer. <u>Waymark:</u> Offers PCP offices virtual technology and access to a community-based care team focused on increasing PCP relationships with hard-to-engage members. The program incorporates clinical and community interventions that close gaps in care and improve health outcomes by addressing rising-risk, behavioral health, maternity care, and high-risk members. Program	2.1.1.1: Getting Care Quickly Q6 2.1.1.3: Getting Needed Care

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
	components service physical and behavioral health needs, community-based peer support, and assists with transition of care from inpatient, ED, SNF, housing or incarceration.	
Goal 2: Promote Access to Safe, Gold-Standard Patient Care Objective 2.1: Ensure Access to Care	Description of Quality Initiative: <u>HEDIS and CAHPS Workgroup:</u> Multi-intradepartmental workgroup continuously looks for opportunities to improve member and provider satisfaction. Participants conduct root cause analyses and deep dive into barriers related to members not having a PCP, members' ability to get urgent and routine appointments as needed and having access to highly rated or specialty providers. The workgroup focuses on initiatives that encourage same-day scheduling, improving process of patient flow, embedding care managers in provider offices to ease administrative burden on provider office staff, increasing member awareness and utilization of telehealth services, improving communications between providers and members, and increasing member use of patient-centered medical homes.	2.1.1.1: Getting Care Quickly Q6 2.1.1.2: Respondent Got Non-Urgent Appointment as Soon as Needed 2.1.1.3: Getting Needed Care
Goal 2: Promote Access to Safe, Gold-Standard Patient Care Objective 2.2: Promote Patient Safety	Description of Quality Initiative: <u>Improved Critical Incident Report Process and Data Management:</u> Improved the Plan's process for tracking visibility of critical incident submissions and increased understanding and identification of critical incidents by Care Management staff. The Plan conducts ongoing education and training for providers and staff, implemented edits and additional fields to its reporting software application for improved submission and management of critical incident reporting. The Plan continues to	2.2.1.2: Monitor the Frequency of Reported Critical Incidents by Member Classification

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
	maintain 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: <u>Point Click Care:</u> Integrated platform that connects health systems, hospitals and FQHCs. The EMR health care system notifies Care Management staff of inpatient and emergency department visits, assists with transitions of care and care coordination with a variety of providers. The platform provides pertinent information including diagnosis and discharge disposition. Additionally, the system serves as a valuable resource for obtaining new contact information, as member information frequently changes. <u>Vheda:</u> Supports members with complex chronic conditions, such as congestive heart failure, diabetes, hypertension, asthma, chronic obstructive pulmonary disease, and high-risk pregnancy via remote patient monitoring, real-time analytics, and live outreach. Enrolled members receive an iPhone, and monitoring devices, such as BP cuff, scale, pulse oximeter and glucometer.	2.3.1.1: How Well Doctors Communicate
Goal 2: Promote Access to Safe, Gold-Standard Patient Care Objective 2.3: Promote Effective Communication and Care Coordination	Description of Quality Initiative: <u>BH/ARTS Preferred Provider Program:</u> Aetna-designed BH/ARTS Preferred Provider program for private and public providers that reduces administrative burdens for providers, allowing members to get access to care more quickly. <u>Behavioral Health Clinical Liaison Team:</u> A best-in-class model that provides integrated Utilization Management and Care Management	2.3.1.2: Service Authorizations

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
	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: <u>Aetna Value Incentive for Providers (AVIP):</u> Plan contracts with high-volume providers in value-based agreements that include performance metrics to increase members engaged with a primary care provider/patient centered medical home.	3.1.1.2: Frequency of Emergency Department Visits 3.1.1.3: Frequency of Potential Preventable Emergency Department Visits 3.1.1.4: Ambulatory Care 3.1.1.5: Ambulatory Care: Emergency Department (ED) Visits
Goal 3: Support Efficient and Value-Driven Care Objective 3.1: Focus on Paying for Value	Description of Quality Initiative: <u>Readmission Avoidance Program (RAP):</u> Identifies high-risk members for inpatient readmission utilizing inpatient RAP score and identifies members for referral to Care Management to engage at the intensive level of care for 30-days post discharge.	3.1.1.1: Frequency of Potentially Preventable Admissions 3.1.1.3: Frequency of Potentially Preventable Readmissions
Goal 3: Support Efficient and Value-Driven Care Objective 3.1: Focus on Paying for Value	Description of Quality Initiative: <u>Ambulatory Care – Emergency Department Visits Initiative:</u> Care Managers educate and remind members about the availability of 24/7 nurse line services and ED utilization during every contact.	3.1.1.2: Frequency of Emergency Department Visits 3.1.1.3: Frequency of Potentially Preventable Emergency Department 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: <u>Aetna Wellness on Wheels (AWOW):</u> Mobile health unit that works with a network of community partners to ensure essential health screenings, such as BMI and blood pressure screenings and education is made readily available in the heart of communities where typically such services are lacking due to educational, financial or transportation barriers.	4.1.1.1: Adults' Access to Preventive/Ambulatory Health Services

Virginia QS Aim and Goal	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: <u>Aetna Value Incentive for Providers (AVIP):</u> Plan contracts with high-volume providers in value-based agreements that include performance metrics to increase members engaged with a primary care provider/patient centered medical home.	4.1.1.1: Adults' Access to Preventive/Ambulatory Health Services 4.1.1.2: Child and Adolescent Well-Care Visits 4.1.1.3: Childhood Immunization Status 4.1.1.4: Immunizations for Adolescents 4.1.1.5: Flu Vaccinations for Adults 18-64 4.1.1.10: Chlamydia Screening in Women Ages 16 to 20 4.1.1.11: Lead Screening in Children
Goal 4: Strengthen the Health of Families and Communities Objective 4.2: Improve Outcomes for Maternal and Infant Members	Description of Quality Initiative: <u>Baby Showers:</u> English and Spanish virtual events for parents to be or recently became parents, educational discussion, and benefits review. <u>Pacify:</u> Tech-enabled full maternity management platform providing 24/7 virtual doula and lactation services to women to ease burden of access, address barriers and improve outcomes.	4.2.1.1: Prenatal and Postpartum Care: Postpartum Care 4.2.1.2: Prenatal and Postpartum Care: Timeliness of Prenatal Care
Goal 4: Strengthen the Health of Families and Communities Objective 4.2: Improve Outcomes for Maternal and Infant Members	Description of Quality Initiative: <u>Maternity Incentive:</u> Pregnant members can earn rewards for attending all recommended prenatal and postpartum appointments. <u>Timeliness of Prenatal Care PIP Intervention:</u> Care managers outreach members within 15 days of receiving monthly Maternal Care Report to educate members about the importance of completing and assisting with scheduling first trimester prenatal appointments. <u>Preeclampsia Prevention:</u> Provides high-risk pregnant members with a	4.2.1.1: Prenatal and Postpartum Care: Postpartum Care 4.2.1.2: Prenatal and Postpartum Care: Timeliness of Prenatal Care 4.2.1.3: Live Births Weighing Less than 2,500 Grams 4.2.1.5: Low-Risk Cesarean Delivery

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
	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: <u>Benefits of Quitting: Tobacco Use Cessation in Pregnant Women:</u> Health Plan and American Cancer Society cobranded flyer that educates members about the benefits of quitting smoking/ tobacco cessation and the health risks of smoking during pregnancy.	4.2.1.3: Live Births Weighing Less than 2,500 Grams 4.2.1.5: Low-Risk Cesarean Delivery
Goal 4: Strengthen the Health of Families and Communities Objective 4.2: Improve Outcomes for Maternal and Infant Members	Description of Quality Initiative: <u>Progeny:</u> Program focuses on improving NICU infant outcomes, decreasing the cost of NICU care, and increasing member and provider satisfaction. The program includes utilization and care management teams that monitor the baby telephonically from NICU admission and maintain consistent interaction with the hospital team through a care plan driven approach. The care management team connects with the family early in the hospital stay and continues to support them for the entire first year.	4.2.1.4: Well-Child Visits in the First 30 Months of Life
Goal 4: Strengthen the Health of Families and Communities Objective 4.3: Improve Home and Community Based Services	Description of Quality Initiative: <u>Non-Traditional Provider Education:</u> Quality Management staff educate providers about how to write corrective action plans through a dedicated section in each Provider Newsletter. Articles include education related to trended review findings and helpful best practices and resources to aid in improving health outcomes for waiver members.	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.

Virginia QS Aim and Goal	Aetna's 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: <u>Vheda</u>: Supports members with complex chronic conditions, such as congestive heart failure, diabetes, hypertension, asthma, chronic obstructive pulmonary disease, and high-risk pregnancy via remote patient monitoring, real-time analytics, and live outreach. Enrolled members receive an iPhone, and monitoring devices, such as BP cuff, scale, pulse oximeter and glucometer. <u>Waymark</u>: Offers PCP offices virtual technology and access to a community-based care team focused on increasing PCP relationships with hard-to-engage members. The program incorporates clinical and community interventions that close gaps in care and improve health outcomes by addressing rising-risk, behavioral health, maternity care, and high-risk members. Program components service physical and behavioral health needs, community-based peer support, and assist with transition of care from inpatient, ED, SNF, housing or incarceration.	5.1.1.1: PQI 08: Heart Failure Admission 5.1.1.2: PDI 14: Asthma Admission Rate (Ages 2-17) 5.1.1.3: PQI 05: COPD and Asthma in Older Adults' Admission Rate 5.1.1.4: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) 5.1.1.5: Controlling High Blood Pressure 5.1.1.6: Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years 5.1.1.7: Asthma Medication Ratio: Ages 5 to 18 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: <u>Aetna Value Incentive for Providers (AVIP)</u>: Plan contracts with high-volume providers in value-based agreements that include performance metrics to increase members engaged with a primary care provider/patient centered medical home. <u>Flourish Health</u>: Behavioral health treatment program that combines virtual psychiatric and therapeutic care with high-touch wraparound services, empowering members in	5.3.1.2: Follow-Up After Emergency Department Visit for Substance Use 5.3.1.4: Initiation of Engagement of substance Use Disorder Treatment

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
	the comfort of their home to achieve effective and long-lasting outcomes.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations Objective 5.4: Improve Behavioral Health and Developmental Services for Members	Description of Quality Initiative: <u>Flourish Health:</u> Behavioral health treatment program that combines virtual psychiatric and therapeutic care with high-touch wraparound services, empowering members in the comfort of their home to achieve effective and long-lasting outcomes.	5.4.1.1: Follow-Up After Hospitalization for Mental Illness 5.4.1.2: Follow-Up After Emergency Department Visit for Mental Illness 5.4.1.8: Antidepressant Medication Management 5.4.1.12: Adherence to Antipsychotic Medications for Individuals with Schizophrenia
Goal 5: Providing Whole-Person Care for Vulnerable Populations Objective 5.4: Improve Behavioral Health and Developmental Services for Members	Description of Quality Initiative: <u>Aetna Value Incentive for Providers (AVIP):</u> Plan contracts with high-volume providers in value-based agreements that include performance metrics to increase members engaged with a primary care provider/patient centered medical home. <u>MD Live:</u> A virtual care platform that offers members behavioral health services for addiction and common mental health conditions. Members have 24/7 access to services, such as talk therapy and psychiatry from the privacy of their home. <u>Thrive Mobile:</u> Offers members digital inclusion through mobile phones to support care management activities. Preloaded with critical phone numbers, such as Member Services, transportation benefits, 24/7 nurse line, Pyx health, MD live, Care Manager and PCP numbers.	5.4.1.1: Follow-Up After Hospitalization for Mental Illness 5.4.1.2: Follow-Up After Emergency Department Visit for Mental Illness 5.4.1.3: Follow-Up Care for Children Prescribed Attention- Deficit/ Hyperactivity Disorder (ADHD) Medication 5.4.1.5: Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics 5.4.1.6: Metabolic Monitoring for Children and Adolescents on Antipsychotics 5.4.1.8: Antidepressant Medication Management 5.4.1.10: Diabetes Screening for People with Schizophrenia or Bipolar disorder Who are Using Antipsychotic Medications

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
		5.4.1.11: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) 5.4.1.12: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

HealthKeepers

Table D-2—HealthKeepers' Quality Strategy Quality Initiatives

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
Goal 1: Enhance the Member Care Experience Objective 1.2: Improve Member Satisfaction	Description of Quality Initiative: Increase rating of <i>Personal Doctor</i> to meet the 50 th percentile or higher. - 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. - CAHPS 101 - Course made available to internal associates allowing them to become knowledgeable of the CAHPS® survey. - Revamp of Provider Education material - Elevance online learning course for Providers: <i>"What Matters Most: Improving the Patient Experience"</i> education material addresses communication gaps and offers innovative ways to communicate with patients.	1.2.1.2: Rating of Personal Doctor .

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
Goal 1: Enhance the Member Care Experience Objective 1.2: Improve Member Satisfaction	Description of Quality Initiative: Increase <i>Rating of all Healthcare</i> to meet the 50th percentile or higher. - 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. - CAHPS® 101 - Course made available to internal associates allowing them to become knowledgeable of the CAHPS® survey. - Revamp of Provider Education material - Elevance online learning course for Providers: <i>"What Matters Most: Improving the Patient Experience"</i> education material addresses communication gaps and offers innovative ways to communicate with patients.	1.2.1.1: Rating of all Health Care
Goal 1: Enhance the Member Care Experience Objective 1.2: Improve Member Satisfaction	Description of Quality Initiative: Increase <i>Rating of all Healthcare</i> to meet the 50th percentile or higher. - 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. - CAHPS® 101 - Course made available to internal associates allowing them to become knowledgeable of the CAHPS® survey.	1.2.1.1: Rating of all Health Care

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	Revamp of Provider Education material - Elevance online learning course for Providers: "What Matters Most: Improving the Patient Experience" education material addresses communication gaps and offers innovative ways to communicate with patients.	
Goal 2: Promote Access to Safe, Gold Standard Patient Care Objective 2.1: Ensure Access to Care	Description of Quality Initiative: Increase Rating of Getting Care Quickly to meet the 50th percentile or higher. - 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. - CAHPS® 101 - Course made available to internal associates allowing them to become knowledgeable of the CAHPS® survey. - Revamp of Provider Education material - Elevance online learning course for Providers: "What Matters Most: Improving the Patient Experience" education material addresses communication gaps and offers innovative ways to communicate with patients.	2.1.1.1: Getting Care Quickly
Goal 3: Support Efficient and Value-Driven Care Objective 3.1: Focus on Paying for Value	Description of Quality Initiative: Decrease by 10% Potentially Preventable Avoidable Admissions Created internal tracking and reporting to monitor the Clinical Efficiency Measures.	3.1.1.1: Decrease by 10% Potentially Preventable Avoidable Admissions

Virginia QS Goals and Objectives	HealthKeepers' 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: Increase the Child and Adolescent Well Care Visits measure rate to the 66.67th percentile or higher by 2025. 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. 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. PQIP Provider Incentive Program: Provider Incentive program that rewards our valued providers for the quality of care they provide our Anthem HealthKeepers Plus Members. The Program encourages efficient, preventive and cost-efficient health care practices by using a system of Scorecard Measures to employ pay-for-performance principles HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes.	4.1.1.2: Child and Adolescent Well-Care Visits

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for 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: Increase the Childhood Immunization Status measure rate to the 66.67 th percentile or higher by 2025 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 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. 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. PQIP Provider Incentive Program: Provider Incentive program that rewards our valued providers for the quality of care they provide our Anthem HealthKeepers Plus Members. The Program encourages	4.1.1.3: Childhood Immunization Status Combo 3 and 10 4.1.1.4: Immunizations for Adolescents Combos 2

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	efficient, preventive and cost-efficient health care practices by using a system of Scorecard Measures to employ pay-for-performance principles 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.	
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: Increase the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents rate to the 50th percentile or higher by 2025 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	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: Increase the Chlamydia Screening in Women Ages 16 to 20 rate to the 50th percentile or higher by 2025 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.	4.1.1.10: Chlamydia Screening in Women Ages 16 to 20

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
Goal 4: Strengthen the Health of Families and Communities Objective 4.2: Improve Outcomes for Maternal and Infant Members	Description of Quality Initiative: Increase the Timeliness of Prenatal Care and Postpartum rates to the 66.67th percentile or higher by 2025 Pomelo Care is a program that address unmanaged risks during pregnancy. This program provides 24/7 personalized care, the application of evidence-based PH and BH interventions to decrease avoidable premature and cesarean deliveries and decrease the length of NICU stays through concentrated discharge planning for transitions home. Pomelo Care's integrated care teams treat underlying risk factors before they lead to adverse birth outcomes through progressive services such as remote patient monitoring via peripheral devices (asynchronous and synchronous), group prenatal services, virtual Doula support, and personalized hybrid care plans for rural members. Concierge Care is an intuitive, consumer- facing digital experience that syncs with care management platforms enabling care managers to triage, monitor and engage pregnant members in a holistic, personalized way to achieve their health goals. Members are provided access to pre-natal and post-partum care as well as parenting support. By leveraging the digital experience and high-touch patient support, Concierge Care provides a personalized approach to care with digital tools, educational resources, care plans, messaging, and trackers. Centering Pregnancy Program allows a group setting with other parents for	4.2.1.1: Timeliness of Prenatal and Postpartum Care

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	discussion with your OB and nurse. Members can attend prenatal visits with other parents who are at the same or similar time in their pregnancies. New Baby New Life Program: This program provides quality 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. 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. Doula Program available to all Medicaid members reimbursing for prenatal, delivery and postpartum doula services. Referral from licensed	

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	provider required and incentive to doula for member to pursue services. 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. 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 Obstetric Quality Incentive Program (OBQIP) offers incentives to participating OB providers for providing increased access and improved quality of care and outcomes for maternity care members throughout all phases of their pregnancy. Life Skill Building: A partnership with select quality CMHRS providers in which an integrated care approach is utilized with identified complex	

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	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. Expanded the program to maternity members.	
Goal 4: Strengthen the Health of Families and Communities Objective 4.2: Improve Outcomes for Maternal and Infant Members	Description of Quality Initiative: Increase the Well Child Visits in the First 30 months of Life rates to the 50th percentile or higher by 2025 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. This is faxed/distributed to health care providers.	4.2.1.4: Well Child Visits in the First 30 months of Life

Virginia QS Goals and Objectives	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: Increase Diabetic measure rates to the 66.67th percentile or higher by 2025. 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. Community Pharmacy Total Care is Anthem's unique innovation in pharmacy services. This is a value based program between Anthem and community based independent pharmacies. This program promotes clinical and community integration by utilizing the relationship between our members and their most available providers-local pharmacists. These pharmacists provide custom compliance packaging, medication refill synchronization, hand deliver medications, improving medication adherence. The member receives a personalized experience, accessibility is improved and HEDIS gaps are closed. In Home Test and Home Lab Kits is a partnership with EQSI to implement in Home interventions to close gaps in care for HbA1c testing by targeting members not consistently screened. PQIP Provider Incentive Program: Provider Incentive program that rewards our valued providers for the quality of care they provide our Anthem HealthKeepers Plus Members. The Program encourages efficient, preventive and cost-efficient	5.1.1.4: Hemoglobin A1c (HbA1c) Control (<8.0%) 5.1.1.5: Controlling High Blood Pressure

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	health care practices by using a system of Scorecard Measures to employ pay-for-performance principles The Provider Quality Incentive Program (PQIP) Essentials structure rewards our valued primary care Providers (PCPs) for the quality of care they provide our Medicaid Members. The Program seeks to encourage efficient, preventive, and cost-effective healthcare practices by using a system of Scorecard Measures and financial incentives. Tytohome: Telehealth member kits provide basic medical devices to help PCP's/BH providers make a better assessment and diagnosis of members during telehealth visits. Specialty kits can offer support to members so that they can better manage their chronic conditions. Telehealth specific kits include high-risk pregnancy, asthma, behavioral health, blood pressure control, and diabetes kits. Kidney Care Program is a program with Care coordination outreach to members with diabetes or hypertension that have not had nephrology testing completed within the last year. The program is to prevent kidney disease. 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.	

Virginia QS Goals and Objectives	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: Increase the Asthma Medication Ratio measure rate to the 66.67th percentile or higher by 2025. The CPT Category II Incentive Program offers providers reimbursement for using select CPT Category II codes and corresponding diagnosis codes. The CPT Category II Incentive Program targets chronic conditions and the goal is to ensure providers are marking the correct diagnosis codes to get the most accurate health information for our members. Tytohome: Telehealth member kits provide basic medical devices to help PCP's/BH providers make a better assessment and diagnosis of members during telehealth visits. Specialty kits can offer support to members so that they can better manage their chronic conditions. Telehealth specific kits include high-risk pregnancy, asthma, behavioral health, blood pressure control, and diabetes kits. Community Pharmacy Total Care is Anthem's unique innovation in pharmacy services. This is a value based program between Anthem and community based independent pharmacies. This program promotes clinical and community integration by utilizing the relationship between our members and their most available providers-local pharmacists. These pharmacists provide custom compliance packaging, medication refill synchronization, hand deliver medications, improving medication adherence. The member receives a personalized experience, accessibility	5.1.1.7: Asthma Medication Ratio

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	is improved and HEDIS gaps are closed. Adherence and New Start Calls are completed by pharmacist and technicians for those taking asthma medications. Asthma New Stat Education Mailings are sent to adult and pediatric members who have diagnosis of persistent asthma and one controller medication claim. The letter encourages them on the importance of keeping appointments, knowing triggers and staying on their controllers. Asthma Medication Ratio Fax: Providers are sent a fax regarding members who fill rescue medications more often than controller medications. The fax includes an asthma prescription history and provides recommendations for ways to help improve asthma control.	
Goal 5: Providing Whole Person Care for Vulnerable Populations Objective 5.3: Improve Outcomes for Members with Substance Use Disorders	Description of Quality Initiative: Increase Substance Use Disorder measure rates to the 66.67th percentile or higher by 2025. BHQIP: BHQIP is a corporate run program administered by the Plan that rewards valued behavioral health outpatient providers for the quality care they provide to Anthem HealthKeepers Plus members. Using a system of quality of care and efficiency measurements and pay-for-performance principles, the program encourages efficient, preventive, and cost-effective health care practices. Providers who meet certain eligibility requirements and quality/access targets receive additional payments. Scoring is based on a point system in	5.3.1.1: Initiation and Engagement of Substance Use Disorder Treatment

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	which there is an opportunity to earn full or half credit with corresponding 10% and 5 % rates of improvement. Assigned Care Coordination-In partnership with large volume provider groups that serve our members across the state, an assigned Anthem HK+ care coordinator works collaboratively with a provider single point of contact utilizing an integrated whole person care approach to address BH, PH and SDOH needs of targeted high needs members. Member level gaps in care and claims data drive interventions while both parties work together to educate members and their families on available benefits. Behavioral Health Homes: In partnership with select CSBs we have established the blueprint for Behavioral Health Homes in Virginia. Members with serious mental illness and chronic physical health conditions are candidates for this specialized, integrated, and person-centered care model that is fueled by the exchange of health information, evidence-based practices, and care coordination among physical and behavioral health service providers where Nurse Educators play a central role. Each Behavioral Health Home has their own Dashboard – a user-friendly interactive document containing relevant information to the program, including member-specific data, initiative workflows and self-updating progress graphs. Scorecards based on claims that capture both utilization and outcome data are reviewed with participating providers on a quarterly basis.	

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	Embedded Care Coordination: 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 HK+ 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. Transition Care Coordination is designed to impact high needs populations. Transition care coordinators assist members using a high touch, whole health approach identifying and addressing SUD, BH, PH and SDOH needs. After serving in an extended bridge like role and ensuring a solid transition to the appropriate level of post-acute care, the member is then followed by the general care coordination team.	
Goal 5: Providing Whole Person Care for Vulnerable Populations	Description of Quality Initiative: Increase Follow Up measure rates to the 66.67th percentile or higher by 2025.	5.4.1.1: Follow-Up After Hospitalization for Mental Illness (FUH)

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
Objective 5.4: Improve Behavioral Health and Developmental Services for Members	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 needs. Data is reviewed quarterly to determine a provider's continued participation and support the ongoing development of an optimized network. Assigned Care Coordination-In partnership with large volume provider groups that serve our members across the state, an assigned Anthem HealthKeepers Plus care coordinator works collaboratively with a provider single point of contact utilizing an integrated whole person care approach to address BH, PH and SDOH needs of targeted high needs members. Member level gaps in care and claims data drive interventions while both parties work together to educate members and their families on available benefits. Behavioral Health Homes: In partnership with select CSBs we have established the blueprint for Behavioral Health Homes in Virginia. Members with serious mental illness and chronic physical health conditions are candidates for this specialized,	

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	integrated, and person-centered care model that is fueled by the exchange of health information, evidence-based practices, and care coordination among physical and behavioral health service providers where Nurse Educators play a central role. Each Behavioral Health Home has their own Dashboard – a user-friendly interactive document containing relevant information to the program, including member-specific data, initiative workflows and self-updating progress graphs. Scorecards based on claims that capture both utilization and outcome data are reviewed with participating providers on a quarterly basis. Embedded Care Coordination: 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	

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	and the benefits offered by Anthem HealthKeepers Plus. BHQIP is a corporate run program administered by the Plan that rewards valued behavioral health outpatient providers for the quality care they provide to Anthem HealthKeepers Plus members. Using a system of quality of care and efficiency measurements and pay-for-performance principles, the program encourages efficient, preventive, and cost-effective health care practices. Providers who meet certain eligibility requirements and quality/access targets receive additional payments. Transition Care Coordination is designed to impact high needs populations. Transition care coordinators assist members using a high touch, whole health approach identifying and addressing SUD, BH, PH and SDOH needs. After serving in an extended bridge like role and ensuring a solid transition to the appropriate level of post-acute care, the member is then followed by the general care coordination team.	
Goal 5: Providing Whole Person Care for Vulnerable Populations Objective 5.4: Improve Behavioral Health and Developmental Services for Members	Description of Quality Initiative: Increase Follow Up measure rates to the 66.67th percentile or higher by 2025. 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	5.4.1.2: Follow-Up After Emergency Department Visits for Mental Illness

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	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. Assigned Care Coordination-In partnership with large volume provider groups that serve our members across the state, an assigned Anthem HK+ care coordinator works collaboratively with a provider single point of contact utilizing an integrated whole person care approach to address BH, PH and SDOH needs of targeted high needs members. Member level gaps in care and claims data drive interventions while both parties work together to educate members and their families on available benefits. Behavioral Health Homes: In partnership with select CSBs we have established the blueprint for Behavioral Health Homes in Virginia. Members with serious mental illness and chronic physical health conditions are candidates for this specialized, integrated, and person-centered care model that is fueled by the exchange of health information, evidence-based practices, and care coordination among physical and behavioral health service providers where Nurse Educators play a central role. Each Behavioral Health Home has their own Dashboard – a user-friendly interactive document containing relevant information to the program, including member-specific data,	

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	initiative workflows and self-updating progress graphs. Scorecards based on claims that capture both utilization and outcome data are reviewed with participating providers on a quarterly basis. Embedded Care Coordination: 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 HK+ 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. BHQIP is a corporate run program administered by the Plan that rewards valued behavioral health outpatient providers for the quality care they provide to Anthem HealthKeepers Plus members. Using a system of quality of care and efficiency measurements and pay-for-performance principles, the program encourages efficient, preventive, and cost-effective health care practices.	

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	Providers who meet certain eligibility requirements and quality/access targets receive additional payments. Embedded Care Coordination Program: Anthem Inc, in partnership with DMAS and PointClickCare, is utilizing PreManage, a platform that connects all MCO's with hospital emergency room departments across the state via a two-portal interface allowing for the real-time sharing of member level information that our care coordinators use daily to drive member care. Via this portal Care Coordinators, ER staff and downstream providers share information, collaborate on care planning, and utilize actionable insights to improve outcomes for our members. Anthem Inc was identified as a forerunner in the initial full implementation and utilization of the product as well as playing a key role in the on boarding of downstream providers. Flourish: 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	

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	quality life in the community with a decrease in IP BH admission and ED utilization. Life Skill Building: 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 of time 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. Transition Care Coordination is designed to impact high needs populations. Transition care coordinators assist members using a high touch, whole health approach identifying and addressing SUD, BH, PH and SDOH needs. After serving in an extended bridge like role and ensuring a solid transition to the appropriate level of post-acute care, the member is then followed by the general care coordination team.	
Goal 5: Providing Whole Person Care for Vulnerable Populations Objective 5.4: Improve Behavioral Health and Developmental Services for Members	Description of Quality Initiative: Increase the Follow Up Care for Children Prescribed ADHD medication measure rate to the 66.67th percentile or higher by 2025. The CPT Category II Incentive Program offers providers reimbursement for using select CPT Category II codes and corresponding	5.4.1.3: Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	diagnosis codes. The CPT Category II Incentive Program targets chronic conditions and the goal is to ensure providers are marking the correct diagnosis codes to get the most accurate health information for our members. 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 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: Increase the Medical Assistance with Smoking and Tobacco Use Cessation measure rate to the 66.67th percentile or higher by 2025. 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 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	5.4.1.7: Medical Assistance with Smoking and Tobacco Use Cessation

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	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: Increase the Anti-Depressant Medication Management measure rate to the 50th percentile or higher by 2025. 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.	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: Increase the Adherence to Antipsychotic Medications of Individuals with Schizophrenia measure rate to the 50th percentile or higher by 2025. Antipsychotic Medication Adherence Standalone Provider Fax: Targets members who are nonadherent to antipsychotic or bipolar medications; less than 80% PDC.	5.4.1.12: Adherence to Antipsychotic Medications of Individuals with Schizophrenia

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	Member Outreach: Member Gap in Care outreach to refill medication, attend follow-up appointments and lab testing through Member email, telephone calls, and letters.	

Molina

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

Virginia QS Aim and Goal	Molina's 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: Molina Healthcare of Virginia is working with individual provider/ provider groups, conduct monthly meetings, send gaps in care reports, provide them support for member outreach, and assist with removing barriers to care. Molina Healthcare of Virginia partners with CVS to promote sharing of education materials to help members clearly understand the importance of timely medication refills and usage of asthma medications. Molina shares HEDIS tip sheets with providers evidencing ways to improve AMR HEDIS® scores. Tips include importance of referring members for Health Management interventions and coaching by contacting Health Care Services at Molina Healthcare.	5.1.1.7: (AMR) Asthma Medication Ratio
Goal 2: Promote Access to Safe, Gold-Standard Patient Care Objective 2.1: Ensure Access to Care	Description of Quality Initiative: Molina Healthcare of Virginia is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach, and assist with removing barriers to care. Target member list of members who have a gap for preventative screenings to help drive outreach efforts, promote	2.1.1.9: (BCS) Breast Cancer Screening 2.1.1.6: (CCS) Cervical Cancer Screening 2.1.1.8: (COL) Colorectal Cancer Screening

Virginia QS Aim and Goal	Molina's Quality Initiative	Performance Metric
	timely referrals and to create better outcomes. Molina Healthcare of Virginia has revised and revamped preventative screening 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 Member with Chronic Conditions	Description of Quality Initiative: Molina Healthcare of Virginia 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 Healthcare of Virginia 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.	5.1.1.4: (HBD) Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
Goal 4: Strengthen the Health of Families and Communities Objective 4.1: Improve Utilization of Wellness, Immunization, and Prevention Services for Members	Description of Quality Initiative: Molina Healthcare of Virginia is working with individual provider/ provider groups, conduct monthly meetings, send gaps in care reports, provide them support for member outreach, and assist with removing barriers to care. Description of Quality Initiative: Partner with network providers, VDH and schools to participate in immunization campaign, provide education and materials, incentives, and school supplies.	4.4.1.3: (CIS) Childhood Immunization Status 4.4.1.4: (IMA) Immunization for Adolescents
Goal 5: Providing Whole-Person Care for Vulnerable	Description of Quality Initiative:	5.3.1.2: (FUA) – Follow up after Emergency Department

Virginia QS Aim and Goal	Molina's Quality Initiative	Performance Metric
Populations Objective 5.3: Improve Outcomes for Members with Substance Use Disorders Objective 5.4: Improve Behavioral Health and Developmental Services of Members	Molina Healthcare of Virginia is working with BH provider groups to share data and identify opportunities for improvement such as using codes included in the current HEDIS® measure technical specifications to ensure services are captured appropriately and timely to improve outcomes and reduce readmission. Molina Healthcare of Virginia 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 follow-up referrals, monitor Point Click Care for diagnosis and discharge data. Target Pay for performance in progress to target BH providers for timely addressing BH quality measures in progress.	visit for Alcohol and other drug Dependence Treatment – 7 and 30 days total 5.3.1.4: (IET) – Initiation and Engagement for Alcohol and other drug Dependence Treatment 5.4.1.2: (FUM) - Follow up after Emergency Department visit for Mental Illness –7 and 30 days total
Goal 4: Strengthen the Health of Families and Communities Objective 4.2: Improve Outcomes for Maternal and Infant Members	Description of Quality Initiative: Molina Healthcare of Virginia is working with both OB/GYN and network provider groups to conduct monthly meetings, send gaps in care reports for members in the prenatal measure, educate them on the use of CPT II codes when bundling services to identify when a post-partum visit occurred, provide them support for member outreach, and assist with removing barriers to care. Compliant members receive Healthy Rewards Program 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.	4.2.1.1: (PPC) Postpartum Care 4.2.1.2: (PPC) Timeliness of Prenatal Care

Virginia QS Aim and Goal	Molina's Quality Initiative	Performance Metric
	Molina uses Lucina Analytics a data tool in conjunction with the pregnancy dashboard, which identifies of pregnancy early, which helps with getting members access to care more timely.	
Goal 4: Strengthen the Health of Families and Communities Objective 4.1:	Description of Quality Initiative: Molina Healthcare of Virginia 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 annual wellness screening rewards that are available via Molina Healthcare of Virginia's Healthy Rewards Program.	4.1.1.2: (WCV) Well child visit - Total
Goal 5: Providing Whole-Person Care for Vulnerable Populations Objective 5.1: Improve Outcomes for Member 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	5.1.1.4: (HBD) Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)

Virginia QS Aim and Goal	Molina's Quality Initiative	Performance Metric
	facilitated to capture required information. Members are sent home a HgA1c kit to complete.	
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	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 and assist with removing barriers to care.	4.1.1.2: (WCV) Well child visit – Total 4.1.1.3: (CIS) Childhood Immunization Status 4.1.1.4: (IMA) Immunization for Adolescents 4.2.1.4: (W30) – Well child visits in the first 30 months after birth
Goal 4: Strengthen the Health of Families and Communities Objective 4.1: Improve Utilization of Wellness, Immunization, and Prevention Services for Members	Description of Quality Initiative: Molina Healthcare of Virginia is working with individual provider/ provider groups by conducting monthly meetings, sharing of comprehensive gap reports, tactical strategies, provide support for member outreach and scheduling to new or existing patient to link members with providers as part of their care team, and coordination of care with our CM team with need is identified, and assist with removing barriers to care.	4.1.1.1: (AAP) Adults' Access to Preventive/Ambulatory Health Services
Goal 2: Promote Access to Safe, Gold-Standard Patient Care Objective 2.1: Ensure Access to Care	Description of Quality Initiative: MHI has partnered with CVS to conduct timely outreach calls and identify barriers preventing members from being adherent to medication.	2.1.1.13: (AMR) Asthma Medication Ratio 5.4.1.8: (AMM) Antidepressant Medication Management 5.4.1.12: (SAA) Adherence to Antipsychotic medications

Virginia QS Aim and Goal	Molina's Quality Initiative	Performance Metric
Goal 5: Providing Whole-Person Care for Vulnerable Populations Objective 5.4: Improve Behavioral Health and Developmental Services of Members		for individuals with Schizophrenia
Goal 4: Strengthen the Health of Families and Communities Objective 4.1: Improve 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 Healthcare of Virginia leverages the postpartum care outreach activities to also provide education on immunizations and well child checkups.	4.1.1.3: (CIS) Childhood Immunization Status

Sentara

Table D-4—Sentara's QS Quality Initiatives

Virginia QS Aim and Goal	Sentara's Quality Initiative	Performance Metric
Goal: 5 Providing Whole-Person Care for Vulnerable Populations Objective: 5.3 Improve Outcomes for Members with Substance Use Disorders	Description of Quality Initiative: Sentara Health Plan recognized adolescent suicide and adult substance use rates are the highest in the nation amongst Tribal populations. To provide additional assistance to our members in this population Sentara created a dedicated Tribal Care Coordination program targeted at reducing suicide rates in Tribal adolescent members and Substance Use rates in Tribal adult members. This program launched in February 2024. Our Tribal Coordinators are working with adolescents to complete suicide assessments that help identify individuals with suicidal ideations	5.3.1.4: Initiation and Engagement of Substance Use Disorder Treatment

Virginia QS Aim and Goal	Sentara's Quality Initiative	Performance Metric
	and/or past or recent suicide attempts. Once identified, our Tribal Coordinators work with the members to connect to providers, programs, and resources. The Tribal Coordinator works with those adult members at-risk or currently diagnosed with substance use disorder and assists with locating both Tribal and Health Plan providers, engaging in treatment and counseling, as well as identifying supportive services needed to ensure overall healthcare wellness.	
Goal: 4: Strengthen the Health of Families and Communities Objective: 4.2 Improve Outcomes for Maternal and infant members	Description of Quality Initiative: In July 2024, three (3) Maternal Nurse Navigators were deployed to 4 different facilities based on the volume of maternal members seen at those sites. Assessments and contact information are sent to the Welcoming Baby Care Managers to follow members post-discharge. Maternal Nurse Navigators also begin referrals to other care teams before discharge. They work closely with home visitation programs and Behavioral Health Nurse Navigators to provide services timely.	4.2.1.1: Prenatal and Postpartum Care: Postpartum Care
Goal: 4 Strengthen the Health of Families and Communities Objective: 4.2 Improve Outcomes for Maternal and infant members	Description of Quality Initiative: In July 2024, the maternal child health outreach team began a Father's Education and Support Group. This began to offer fathers education to better understand the maternal journey and to provide support to the family during the pregnancy.	4.2.1.1: Prenatal and Postpartum Care: Postpartum Care
Goal: 5 Providing Whole-Person Care for Vulnerable Populations Objective: 5.3	Description of Quality Initiative: The Justice Care Coordination (JCC) program provides specialized care coordination for recently incarcerated individuals, supporting their successful reintegration into the	5.3.1.4: Initiation and Engagement of Substance Use Disorder Treatment

Virginia QS Aim and Goal	Sentara's Quality Initiative	Performance Metric
Improve Outcomes for Members with Substance Use Disorders	community. The program ensures justice-involved members receive comprehensive outpatient services, including transportation assistance, housing support and facilitation of primary and specialty care appointments. Members are connected with substance use disorder (SUD) and/or opioid use disorder (OUD) support groups and can participate in programs to guide their path to sobriety. Peer recovery specialists are also available to our members for additional guidance.	
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 Justice Care Coordination (JCC) program provides specialized care coordination for recently incarcerated individuals, supporting their successful reintegration into the community. The program ensures justice-involved members receive comprehensive outpatient services, including transportation assistance, housing support and facilitation of primary and specialty care appointments. Members are connected with substance use disorder (SUD) and/or opioid use disorder (OUD) support groups and can participate in programs to guide their path to sobriety. Peer recovery specialists are also available to our members for additional guidance.	5.3.1.4: Initiation and Engagement of Substance Use Disorder Treatment
Goal: 3 Support Efficient and Value-Driven Care Objective: 3.1 Focus on Paying for Value	Description of Initiative: Reducing Emergency Department Utilization: PIP intervention involving providing education to members with the most Low-Acuity-Non-Emergency (LANE) visit; identifying providers with	3.1.1.5: Ambulatory Care: Emergency Department (ED) Visits

Virginia QS Aim and Goal	Sentara's Quality Initiative	Performance Metric
	the most LANE member visits and reminding them of members' needs for primary care; and identifying problems with transportation and mitigating barriers.	
Goal: 5 Providing Whole-Person Care for Vulnerable Populations Objective: 5.1 Improve Outcomes for Member with chronic Conditions	Description of Initiative: <i>Follow Up After Hospital Discharge:</i> PIP intervention involving educating members about the importance of engaging in a 30-day post-discharge follow-up visit with a PCP or specialist. Optima staff assist with scheduling appointment as needed.	Transitions of Care (TRC) - Patient engagement After Inpatient Discharge - documentation of patient engagement provided within 30 days after discharge.

United

Table D-5—United's QS Quality Initiatives

Virginia QS Aim and Goal	United's Quality Initiative	Performance Metric
Goal 1: Enhance the Member Care Experience Objective 1.1: Increase Member Engagement and Outreach Objective 1.2: Improve Member Satisfaction	Description of Quality Initiative: <u>Mobile App:</u> Members can view their ID card any time, search on the app to find a nearby network doctor and schedule an appointment, locate a pharmacy and find options for quick care such as a nearby clinic, urgent care center or ED. Members can get guidance by chatting with member advocates or talking to a registered nurse 24/7. <u>Language & Disability Access:</u> We continually determine the need for changes or additions to verbal and written member tools by collecting data on ethnicity and preferred written and spoken languages. LanguageLine interpretation services provide members with access to more than 240 languages to meet their communication needs. Our member	1.1.1.1: Number of Outreach and Engagement (O&E) Activities Per year 1.1.1.2: Monitor Language and Disability Access Reports 1.2.1.1: Rating of all Health Care 1.2.1.2: Rating of Personal Doctor

Virginia QS Aim and Goal	United's Quality Initiative	Performance Metric
	services call center and NurseLine use the 711 national telecommunications relay service (TRS) TTY line to facilitate communication with members who are hearing impaired. Our ASL Services interpreters are trained in sign language for medical terminology and in HIPAA laws for communication to maintain that the member and providers receive professional and confidential ASL interpretation. <u>Timeliness of Prenatal Care</u> <u>PIP:</u> Identifies healthy pregnant members with no prenatal care upon health plan enrollment. Prompt case management telephonic outreach is conducted to engage and assist members to complete prenatal care visits at recommended intervals. <u>Member/Provider Satisfaction:</u> UHC monitors provider and member satisfaction with services through various surveys, events, and forums – including CAHPS, Care Coordination and LTSS surveys, NPS surveys, Member Advisory Committees (MAC), Provider Advisory Committees (PAC), among others.	
Goal 2: Promote Access to Safe, Gold Standard Patient Care Objective 2.1: Ensure Access to Care Objective 2.2: Promote Patient Safety	Description of Quality Initiative: <u>Dr. Chat:</u> The UHC Doctor Chat App provides 24/7/365 virtual care for UHC 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. <u>Enhanced Clinical Quality Dashboard:</u>	2.1.1.1: Getting Care Quickly 2.1.1.2: Respondent Got Non-Urgent Appointment as Soon as Needed 2.1.1.3: Getting Needed Care 2.2.1.2: Monitor the Frequency of Reported Critical Incidents by Member Classification

Virginia QS Aim and Goal	United's Quality Initiative	Performance Metric
Objective 2.3: Promote Effective Communication and Care Coordination	Population Health Dashboard provides a snapshot of the overall health and well-being of our members. Case managers and providers can monitor and track clinical quality measures and assist members in “real-time” to close gaps in care. <u>CareBridge 24/7:</u> Members and their families can connect to a doctor or nurse practitioner for an immediate health concern via a simplified tablet 24/7. The tablet is used to share continuous information with CareBridge’s advanced practice clinicians, physicians, and geriatricians to assess and treat individuals in their home. <u>Integrated Behavioral Health Homes (IBHH):</u> 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 Measures and using comprehensive data sharing and technical support. <u>Member/Provider Satisfaction:</u> UHC monitors provider and member satisfaction with services through various surveys, events, and committees (Quality/Utilization Management). Results are analyzed and trends monitored in appeals and grievances, quality of care/quality of service (QOC/QOS), CAHPS and care management surveys to identify areas of opportunity for improvement.	2.3.1.1: How Well Doctors Communicate
Goal 3: Support Efficient and Value-Driven Care Objective 3.1: Focus on Paying for Value	Description of Quality Initiative: <u>Enhanced Clinical Quality Dashboard:</u> Population Health Dashboard provides a snapshot of the overall health and well-being of our members. Case managers and providers can	3.1.1.1: Frequency of Potentially Preventable Admissions

Virginia QS Aim and Goal	United's Quality Initiative	Performance Metric
Objective 3.2: Promote Efficient Use of Program Funds	monitor and track clinical quality measures and assist members in “real-time” to close gaps in care. <u>Follow up After Emergency Department Visit PIP:</u> Educating members about the proper use of the ED and alternative options for treatment for non-emergent issues. <u>Community Plan Primary Care Professional Incentive Program (CP-PCPi):</u> With the goal of achieving quality member outcomes, UHC educates providers in HEDIS specifications, providing up-to-date data of members experiencing gaps in care. Program measures were further aligned with state priority performance measures and the 2023-2025 Quality Strategy. UHC CPCs collaborate with providers and community entities to promote health fairs, clinic days, and other preventative care events to close gaps in care.	3.1.1.2: Frequency of Emergency Department Visits 3.1.1.3: Frequency of Potentially Preventable Readmissions 3.1.1.4: Ambulatory Care 3.1.1.5: Ambulatory Care: Emergency (ED) Visits 3.2.1.1: Monitor Medical Loss Ratio
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	Description of Quality Initiative: <u>Enhanced Clinical Quality Dashboard:</u> Population Health Dashboard provides a snapshot of the overall health and well-being of our members. Case managers and providers can monitor and track clinical quality measures and assist members in “real-time” to close gaps in care. <u>Member Engagement Bonus Program:</u> Providers participating in CP-PCPi program were provided the opportunity to earn bonuses for completing AAP and/or WCV visits in Q2 2023. <u>Follow up After Discharge PIP:</u> Educating members about the importance of engaging in a 30-day post-discharge follow-up visit with a	4.1.1.1: Adults’ Access to Preventive/Ambulatory Health Services 4.1.1.2: Child and Adolescent Well-Care Visits 4.1.1.3: Childhood Immunization Status 4.1.1.4: Immunizations for Adolescents 4.1.1.9: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents 4.2.1.1: Prenatal and Postpartum Care: Postpartum Care

Virginia QS Aim and Goal	United's Quality Initiative	Performance Metric
	PCP or specialist. UHC case managers assist with scheduling appointments as needed. <u>Timeliness of Prenatal Care</u> <u>PIP</u>: Identifies healthy pregnant members with no prenatal care upon health plan enrollment. Prompt case management telephonic outreach is conducted to engage and assist members to complete prenatal care visits at recommended intervals. <u>WCV Intervention</u>: Focus on members with the greatest language disparity on the importance of a Well Care Visit, through virtual education and incentives.	4.2.1.2: Prenatal and Postpartum Care: Timeliness of Prenatal Care 4.2.1.4: Well-Child Visits in the First 30 Months of Life
Goal 5: Providing Whole Person Care for Vulnerable Populations Objective 5.1: Improve Outcomes for Members with Chronic Conditions Objective 5.3: Improve Outcomes for Members with Substance Use Disorders Objective 5.4: Improve Behavioral Health and Developmental Services for Members	Description of Quality Initiative: <u>Complex Transitions of Care:</u> Partnership with large health systems to identify barriers impacting member transitions and sustainable health outcomes. Weekly integrated rounds meetings with care management teams, care managers, transitional care managers, health risk social needs (HRSN) leaders and associate directors to identify and member's discharge barriers, service recommendations and transition plan. <u>Enhanced Clinical Quality Dashboard:</u> Population Health Dashboard provides a snapshot of the overall health and well-being of our members. Case managers and providers can monitor and track clinical quality measures and assist members in "real-time" to close gaps in care. <u>HBD Intervention:</u> Focus on members with the greatest racial/ethnic disparity on the importance of controlling diabetes, through a diabetes education course and incentives.	5.1.1.1: PQI 08: Heart Failure Admission Rate 5.1.1.3: PQI 05: COPD and Asthma in Older Adults' Admission Rate 5.1.1.4: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) 5.3.1.2: Follow-Up After Emergency Department Visit for Substance Use 5.3.1.4: Initiation and Engagement of Substance Use Disorder Treatment 5.4.1.1: Follow-Up After Hospitalization for Mental Illness 5.4.1.2: Follow-Up After Emergency Department Visit for Mental Illness 5.4.1.7: Medical Assistance with Smoking and Tobacco Use Cessation

Virginia QS Aim and Goal	United's Quality Initiative	Performance Metric
	<u>Care Management Post-ED Outreach:</u> Enrollees discharging from an ED are assisted by case managers with scheduling follow-up appointments and aftercare resources. <u>Tobacco Use Cessation in Pregnant Women PIP:</u> Targeted intervention integrating pharmacy claims and other data sources to identify and capture more pregnant members who have had a history of current tobacco use into the case management process for member outreach for cessation counseling by case management RNs. <u>Integrated Behavioral Health Homes (IBHH):</u> 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 Measures and using comprehensive data sharing and technical support.	

Appendix E. Assessment of Follow-Up on Prior Recommendations

DMAS Follow-Up on Prior Year Recommendations for the Cardinal Care Acute (formerly Medallion 4.0) Program

Introduction

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

Recommendation – Cardinal Care MLTSS		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	Objective 5.	Measure(s): 5.1.1.5: Controlling High Blood Pressure
HSAG Recommendation: 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.		
DMAS' Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • DMAS included the measure Blood Pressure Control for Patients with Diabetes in its PWP which provides an incentive to MCOs to increase performance and close gaps.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed:		

Recommendation – Cardinal Care MLTSS

Measure: *Blood Pressure Control for Patients with Diabetes*

MY 2022: 55.31%

MY 2023: 61.74%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation – Cardinal Care MLTSS

Goal 5: Providing Whole-Person Care for Vulnerable Populations

Objective 5.4: Improve Behavioral Health and Developmental Services for Members

Measure(s):

5.4.1.1: Follow-Up After Hospitalization for Mental Illness

5.4.1.5: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

5.4.1.10: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

HSAG Recommendation: 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.

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 has improved its ability to track MCO required monthly data submissions

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

PMV results showed:

Recommendation – Cardinal Care MLTSS

Measure: *Follow-Up After Hospitalization for Mental Illness*

MY 2022: 7-Day: 29.00%; 30-Day: 52.02%

MY 2023: 7-Day: 33.91%; 30-Day: 56.34%

Measure: *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*

MY 2022: 37.18%

MY 2023: 63.48%

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

MY 2022: 82.49%

MY 2023: 81.79%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation – Cardinal Care MLTSS

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

Measure(s):

4.1.1.2: Child and Adolescent Well-Care Visits

4.1.1.3: Childhood Immunization Status

4.1.1.4: Immunizations for Adolescents

4.1.1.9: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

4.2.1.4: Well-Child Visits in the First 30 Months of Life

HSAG Recommendation: 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 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.

DMAS' Response

Recommendation – Cardinal Care MLTSS

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):

- Specific initiatives were not provided.

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

PMV results showed:

Measure: *Child and Adolescent Well-Care Visits Total*

MY 2022: 44.15%

MY 2023: 50.88%

Measure: *Childhood Immunization Status*

MY 2022: 64.63%

MY 2023: 66.64%

Measure: *Immunizations for Adolescents*

MY 2022: Combo 1: 79.96%; Combo 2: 30.96%

MY 2023: Combo 1: 84.20%; Combo 2: 35.30%

Measure: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*

MY 2022: BMI: 67.97%; Nutrition Total: 60.34%; Physical Activity Total: 51.75%

MY 2023: BMI: 75.44%; Nutrition Total: 66.47%; Physical Activity Total: 60.09%

Measure: *Well-Child Visits in the First 30 Months of Life*

MY 2022: Not measured in the Cardinal Care MLTSS program

MY 2023: First 15 Months: 61.18%; 15 Months – 30 Months: 70.36%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation – Cardinal Care MLTSS

Goal 5: Providing Whole-Person Care for Vulnerable Populations

Objective

Measure(s):

Measure 5.1.1.5: Controlling High Blood Pressure

HSAG Recommendation: 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

Recommendation – Cardinal Care MLTSS		
ensure implementation of interventions that address disparities and reflect identified opportunities for improvement.		
DMAS' Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): DMAS included the measure Blood Pressure Control for Patients with Diabetes 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: <i>Blood Pressure Control for Patients with Diabetes</i> MY 2022: 56.55% MY 2023: 61.74%		
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing the initiatives.		
HSAG Assessment: 		
Recommendation – Cardinal Care MLTSS		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	Objective 5.4: Improve Behavioral Health and Developmental Services for Members	Measure(s): 5.4.1.1: Follow-Up After Hospitalization for Mental Illness 5.4.1.5: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics 5.4.1.10: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
HSAG Recommendation: 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		

Recommendation – Cardinal Care MLTSS		
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.		
DMAS' Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): - DMAS included the measure Follow-Up After Emergency Department Visit for Mental Illness in its PWP which provides an incentive to MCOs to increase performance and close gaps. - DMAS will begin collecting data for the measure Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics and Diabetes Monitoring for People with Diabetes and Schizophrenia to begin monitoring MCO performance in the future.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: Follow-Up After Hospitalization for Mental Illness MY 2022: 7-Day: 29.00%; 30-Day: 52.02% MY 2023: 7-Day: 33.91%; 30-Day: 56.34% Measure: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics MY 2022: 37.18% MY 2023: 63.48% Measure: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications MY 2022: 82.49% MY 2023: 81.79%		
Identify any barriers to implementing initiatives: Barriers were not identified.		
HSAG Assessment: 		
Recommendation – Cardinal Care MLTSS		
Goal 4: Strengthen the Health of Families and Communities	Objective 4.1: Improve Utilization of Wellness, Immunization, and Prevention Services for Members	Measure(s): 4.1.1.2: Child and Adolescent Well-Care Visits 4.1.1.3: Childhood Immunization Status

Recommendation – Cardinal Care MLTSS		
	Objective 4.2: Improve Outcomes for Maternal and Infant Members	4.1.1.4: Immunizations for Adolescents 4.1.1.9: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents 4.2.1.4: Well-Child Visits in the First 30 Months of Life
HSAG Recommendation: 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 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.		
DMAS' Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): - DMAS included the measure Child and Adolescent Well-Care Visits in its PWP which provides an incentive to MCOs to increase performance and close gaps. - DMAS included the measure Childhood Immunization Status 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: <i>Child and Adolescent Well-Care Visits Total</i> MY 2022: 44.15% MY 2023: 50.88% Measure: <i>Childhood Immunization Status</i> MY 2022: 64.63% MY 2023: 66.64% Measure: <i>Immunizations for Adolescents</i> MY 2022: Combo 1: 96%; Combo 2: 30.96% MY 2023: Combo 1: 84.20; Combo 2: 35.30% Measure: <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</i> MY 2022: BMI: 67.97%; Nutrition Total: 60.34%; Physical Activity Total: 51.75%		

Recommendation – Cardinal Care MLTSS

MY 2023: BMI: 75.44%; Nutrition Total: 66.47%; Physical Activity Total: 60.09%

Measure: *Well-Child Visits in the First 30 Months of Life*

MY 2022: Not measured for the Cardinal Care MLTSS program

MY 2023: First 15 Months: 61.18%; 15 Months – 30 Months: 70.36%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation – Cardinal Care Acute

Goal 5: Providing Whole-Person Care for Vulnerable Populations

Objective 5.4: Improve Behavioral Health and Developmental Services for Members

Measure(s):

5.4.1.1: Follow-Up After Hospitalization for Mental Illness

5.4.1.2: Follow-Up After Emergency Department Visit for Mental Illness

HSAG Recommendation: To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4 and improve BH 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 ED visits for mental illness. HSAG also recommends that DMAS work with the MCOs to consider if there are disparities within the MCOs' populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Additionally, HSAG recommends that DMAS continue leveraging the CMS Improving Behavioral Health Follow-up Care Learning Collaborative1- materials to identify potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care.
- Continue work on the Follow-Up After Emergency Department Visit for Mental Illness measure through the PWP.

DMAS' Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- DMAS included the measure Follow-Up After Emergency Department Visit for Mental Illness in its PWP which provides an incentive to MCOs to increase performance and close gaps.

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

PMV results showed:

Measure: *Follow-Up After Hospitalization for Mental Illness*

MY 2022: 7-Day: 32.11%; 30-Day: 53.76%

Recommendation – Cardinal Care Acute		
MY 2023: 7-Day: 33.91%; 30-Day: 56.34% Measure: <i>Follow-Up After Emergency Department Visit for Mental Illness</i> MY 2022: 7-Day: 37.90%; 30-Day: 50.96% MY 2023: 7-Day: 38.56%; 30-Day: 53.53%		
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing the initiatives.		
HSAG Assessment: 		
Recommendation – Cardinal Care Acute		
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	Measure(s): 4.1.1.2: Child and Adolescent Well-Care Visits 4.1.1.3: Childhood Immunization Status 4.2.1.1: Prenatal and Postpartum Care—Timeliness of Prenatal Care 4.2.1.4: Well-Child Visits in the First 30 Months of Life
HSAG Recommendation: 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 improve access and timeliness of well-child visits and preventive healthcare for members under the age of 21 years, and the timeliness of pregnancy-related care, HSAG recommends that DMAS: • Work with the enrollment broker to address the data deficiencies identified during the PCP and prenatal care secret shopper surveys (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify the location address and appropriate provider type and provider specialty. DMAS may also consider requesting that the MCOs provide evidence of training offered, by the MCO, to providers' offices regarding the MCO plan names and benefit coverage. MCO evidence should demonstrate that the office staff responsible for scheduling appointments have been educated on the MCO names and benefit coverage, and that the offices have a plan in place for educating new staff in the event of staff turnover. Accurate provider information, including provider specialties and contact information, may result in improved access to care for members seeking well care, preventive healthcare, childhood immunizations, and pregnancy-related care. • Work with MCOs to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended well visits according to the EPSDT and Bright Futures schedule and to make appropriate health decisions. HSAG continues to recommend that DMAS monitor MCOs to ensure that the MCOs analyze their data and consider if there are disparities within the MCOs' populations.		
DMAS' Response		

Recommendation – Cardinal Care Acute

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- DMAS included the measure Child and Adolescent Well-Care Visits in its PWP which provides an incentive to MCOs to increase performance and close gaps.
- DMAS included the measure Childhood Immunization Status 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: *Child and Adolescent Well-Care Visits*

MY 2022: 48.66%

MY 2023: 50.88%

Measure: *Childhood Immunization Status*

MY 2022: 64.49%

MY 2023: 64.49%

Measure: *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

MY 2022: 77.10%

MY 2023: 66.64%

Measure: *Well-Child Visits in the First 30 Months of Life*

MY 2022: Not measured for the Cardinal Care Acute program

MY 2023: First 15 Months: 61.18%; 15 Months – 30 Months: 70.36%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation – Cardinal Care Acute

Goal 5: Providing Whole-Person Care for Vulnerable Populations

Objective 5.4: Improve Behavioral Health and Developmental Services for Members

Measure(s):

Measure 5.4.1.1: Follow-Up After Hospitalization for Mental Illness

Measure 5.4.1.2: Follow-Up After Emergency Department Visit for Mental Illness

HSAG Recommendation: To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4 and improve BH 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 ED visits for mental

Recommendation – Cardinal Care Acute		
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 Collaborative1- materials to identify potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care. Continue work on the Follow-Up After Emergency Department Visit for Mental Illness measure through the PWP.		
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): Specific initiatives were not provided.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: Follow-Up After Hospitalization for Mental Illness MY 2022: 7-Day: 32.11%; 30-Day: 53.76% MY 2023: 7-Day: 33.91%; 30-Day: 56.34% Measure: Follow-Up After Emergency Department Visit for Mental Illness MY 2022: 7-Day: 37.90%; 30-Day: 50.96% MY 2023: 7-Day: 38.56%; 30-Day: 53.53%		
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing the initiatives.		
HSAG Assessment: 		
Recommendation – Cardinal Care Acute		
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	Measure(s): Measure 4.1.1.2: Child and Adolescent Well-Care Visits Measure 4.1.1.3: Childhood Immunization Status Measure 4.2.1.1: Prenatal and Postpartum Care—Timeliness of Prenatal Care Measure: 4.2.1.4: Well-Child Visits in the First 30 Months of Life
HSAG Recommendation: 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		

Recommendation – Cardinal Care Acute

improve access and timeliness of well-child visits and preventive healthcare for members under the age of 21 years, and the timeliness of pregnancy-related care, HSAG recommends that DMAS:

- Work with the enrollment broker to address the data deficiencies identified during the PCP and prenatal care secret shopper surveys (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify the location address and appropriate provider type and provider specialty. DMAS may also consider requesting that the MCOs provide evidence of training offered, by the MCO, to providers' offices regarding the MCO plan names and benefit coverage. MCO evidence should demonstrate that the office staff responsible for scheduling appointments have been educated on the MCO names and benefit coverage, and that the offices have a plan in place for educating new staff in the event of staff turnover. Accurate provider information, including provider specialties and contact information, may result in improved access to care for members seeking well care, preventive healthcare, childhood immunizations, and pregnancy-related care.
- Work with MCOs to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended well visits according to the EPSDT and Bright Futures schedule and to make appropriate health decisions. HSAG continues to recommend that DMAS monitor MCOs to ensure that the MCOs analyze their data and consider if there are disparities within the MCOs' populations.

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):

- Specific initiatives were not provided.

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

Measure: *Child and Adolescent Well-Care Visits*

MY 2022: 48.66%

MY 2023: 50.88%

Measure: *Childhood Immunization Status – Combo 3*

MY 2022: 64.49%

MY 2023: 64.49%

Measure: *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

MY 2022: 77.10%

MY 2023: 73.71%

Measure: *Well-Child Visits in the First 30 Months of Life*

MY 2022: Not measured for the Cardinal Care Acute program

MY 2023: First 15 Months: 61.18%; 15 Months – 30 Months: 70.36%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:

Recommendation – Cardinal Care Acute



Recommendation – Cardinal Care Acute

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

Measure(s):

Measure 4.1.1.2: Child and Adolescent Well-Care Visits

Measure 4.1.1.3: Childhood Immunization Status

Measure 4.2.1.1: Prenatal and Postpartum Care—Timeliness of Prenatal Care

Measure 4.2.1.4: Well-Child Visits in the First 30 Months of Life

HSAG Recommendation: 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 improve access and timeliness of well-child visits and preventive healthcare for members under the age of 21 years, and the timeliness of pregnancy-related care, HSAG recommends that DMAS:

- Work with the enrollment broker to address the data deficiencies identified during the PCP and prenatal care secret shopper surveys (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify the location address and appropriate provider type and provider specialty. DMAS may also consider requesting that the MCOs provide evidence of training offered, by the MCO, to providers' offices regarding the MCO plan names and benefit coverage. MCO evidence should demonstrate that the office staff responsible for scheduling appointments have been educated on the MCO names and benefit coverage, and that the offices have a plan in place for educating new staff in the event of staff turnover. Accurate provider information, including provider specialties and contact information, may result in improved access to care for members seeking well care, preventive healthcare, childhood immunizations, and pregnancy-related care.
- Work with MCOs to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended well visits according to the EPSDT and Bright Futures schedule and to make appropriate health decisions. HSAG continues to recommend that DMAS monitor MCOs to ensure that the MCOs analyze their data and consider if there are disparities within the MCOs' populations.

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):

- Specific initiatives were not provided.

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

PMV results showed:

Recommendation – Cardinal Care Acute

Measure: *Child and Adolescent Well-Care Visits*

MY 2022: 48.66%

MY 2023: 50.88%

Measure: *Childhood Immunization Status – Combo 3*

MY 2022: 64.49%

MY 2023: 64.49%

Measure: *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

MY 2022: 77.10%

MY 2023: 73.71%

Measure: *Well-Child Visits in the First 30 Months of Life*

MY 2022: Not measured for the Cardinal Care Acute program

MY 2023: First 15 Months: 61.18%; 15 Months – 30 Months: 70.36%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation – Cardinal Care Acute

Goal 5: Providing Whole-Person Care for Vulnerable Populations

Objective 5.4: Improve Behavioral Health and Developmental Services for Members

Measure(s):

Measure 5.4.1.1: Follow-Up After Hospitalization for Mental Illness

Measure 5.4.1.2: Follow-Up After Emergency Department Visit for Mental Illness

Measure: 4.2.1.4: Well-Child Visits in the First 30 Months of Life

HSAG Recommendation: To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4 and improve BH 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 ED visits for mental illness. HSAG also recommends that DMAS work with the MCOs to consider if there are disparities within the MCOs' populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Additionally, HSAG recommends that DMAS continue leveraging the CMS Improving Behavioral Health Follow-up Care Learning Collaborative-materials to identify potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care.
- Continue work on the Follow-Up After Emergency Department Visit for Mental Illness measure through the PWP.

Recommendation – Cardinal Care Acute

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):

The DMAS BH team continues to work on the following initiative to improve Medicaid funded behavioral health care across Virginia including the following efforts:

- DMAS has been instrumental in the planning and implementation of the Governor's Right Help, Right Now plan which aims to achieve the goal that all Virginians will, i) be able to access behavioral health care when they need it; ii) have prevention and management services personalized to their needs, particularly for children, youth and families; iii) know who to call, who will help and where to go when in crisis; and iv) have paths to reentry and stabilization when transitioning from a crisis. DMAS is an integral partner and stakeholder within this plan.
- In December, 2022, Governor Youngkin announced a six-pillar plan to transform Virginia's behavioral health system: the Right Help. Right Now. Plan. (RHRN). As plans developed under Pillar 3 (increasing community capacity) and Pillar 6 (service innovations), initiatives to redesign Medicaid legacy community mental health rehabilitative services (CMHRS)(Intensive In-Home, Therapeutic Day Treatment, Mental Health Skill Building, Psychosocial Rehabilitation and Targeted Case Management) for both adults and youth emerged as significant needs within the system. The current 2024-2026 biennium budget includes Item 288, XX which provides DMAS the authority to replace our CMHRS services and case management service. In collaboration with DBHDS and DHP, DMAS will be launching a two-year project (July 2024-June 2026) to replace our CMHRS services and case management service and this webinar is an opportunity to find about more about the project.
- A collaboration and partnership among health and human services state agencies in Virginia, came together to form 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. The Center and state agencies have developed an interagency agreement regarding Assertive Community Treatment and monitoring the fidelity of this service through the Tool for the Measurement of ACT (TMACT) Assessment as well as the development of a strategic plan to monitor the fidelity of High Fidelity Wrap Around services in Virginia.
- In addition, DMAS established a more robust outcome-based payment strategy that holds MCOs accountable for providing high quality behavioral health services to Virginia Medicaid members and researched additional behavioral health/crisis service utilization measures, including other state programs and commercial and Medicaid/Medicare metrics, that can be considered for inclusion in the performance withhold program (PWP) to assess MCO quality performance.

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

PMV results showed:

Measure: *Follow-Up After Hospitalization for Mental Illness*

MY 2022: 7-Day: 32.11%; 30-Day: 53.76%

MY 2023: 7-Day: 33.91%; 30-Day: 56.34%

Measure: *Follow-Up After Emergency Department Visit for Mental Illness*

Recommendation – Cardinal Care Acute	
MY 2022: 7-Day: 37.90%; 30-Day: 50.96% MY 2023: 7-Day: 38.56%; 30-Day: 53.53% Measure: <i>Well-Child Visits in the First 30 Months of Life</i> MY 2022: Not measured for the Cardinal Care Acute program MY 2023: First 15 Months: 61.18%; 15 Months – 30 Months: 70.36%	
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing the initiatives.	
HSAG Assessment: 	

MCOs' Follow-Up on Prior Year Recommendations

From the findings of each MCO's performance for the CY 2023 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Cardinal Care Acute program. The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting.

Aetna

Cardinal Care Acute

Table E-2—Prior Year Recommendations and Responses Cardinal Care Acute—Aetna

Recommendation—Performance Measure Validation		
Goal 4: Strengthen the Health of Families and Communities	Objective 4.1: Improve the Utilization of Wellness, Immunizations, and Prevention Services for Members Objective: Improve Outcomes for Maternal and Infant Members	Measure(s) 4.1.1.1: Adults' Access to Preventive/Ambulatory Health Services 4.1.1.3: Childhood Immunization Status 4.2.1.1: Prenatal and Postpartum Care: Postpartum Care 4.2.1.2: Prenatal and Postpartum Care: Timeliness of Prenatal Care
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: <i>Childhood Immunization Status—Combination 3</i> <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care</i>		

Recommendation—Performance Measure Validation

Adults' Access to Preventive/Ambulatory Health Services—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

Why the weakness exists: Based on the analysis health literacy rises to the top for these measures. Assuring members know and understand the importance of engagement and participation with treatment and care and the importance of preventative care. Due to the health literacy members lack of the understanding of utilizing PCPs for routine health care to prevent/avoid utilizing the ED for non-emergent needs. Additionally, vaccine hesitancy among parents is seen as a driver for low immunization/vaccination rates.

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 Status:**
 - Per HSAG's recommendation, Aetna Better Health of Virginia conducted a deep dive analysis to identify the top three counties, top races, and providers with members who have immunization care gaps to assist in focusing Plan efforts. Completing heat maps and utilization of Social Scape, an SDOH tool, helped the Plan identify specific areas of focus by county. Post identification of this data, the Plan's Outreach Team conducted direct calls to members to educate them about recommended vaccination schedules. Other initiatives that the Plan completes includes sending members an EPSDT mailers around the member's birthday month, which provide age-specific education about well visits, recommended immunization schedules, developmental milestones, and health safety. Through the support of Aetna's Community Development Team, Quality Provider Liaisons discuss with and encourage PCPs to hold childhood school immunization events to close care gaps. Ongoing initiatives include encouraging recommended vaccinations through SMS text messaging, Our Ted E. Bear M.D. Wellness Club promotes and encourages parents to have their child's well child check-up, which includes physical exam, immunizations, and growth and development. Upon joining the club, the child receives an age-appropriate enrollment gift. More recent initiatives include a new member video on immunization importance, which will be used in a variety of forums, such as baby showers, community events and websites. Our Pfizer immunization program will send mailers to members regarding immunizations, and a focused enterprise taskforce, across all Aetna markets will work to develop new and share successful interventions.
- **Prenatal and Postpartum Care:**
 - Per HSAG's recommendation, Aetna Better Health of Virginia conducted a deep dive analysis to identify the top three counties, top races, and providers with members who have prenatal and postpartum care gaps to assist in focusing Plan efforts. Completing heat maps and utilization of Social Scape, an SDOH tool, helped the Plan identify specific areas of focus by county. Initiatives include care managers reaching out to all identified pregnant women offering

Recommendation—Performance Measure Validation

support and resources to ensure timely prenatal and post-partum care visits. Our Let's Go Baby Book, maternity pack, and new mom's boxes are also provided. The Plan educates members and providers about health conditions, preventive care, free transportation benefit, and community resources. Members are invited to attend virtual baby showers that are provided in both English and Spanish, at which time members receive education and engage in discussion related to prenatal and postpartum care. The Plan also continues to incentivize pregnant members to attend prenatal and postpartum visits timely. Members are educated through our text messaging campaign about the importance of timely prenatal and post-delivery follow-up care. High-risk pregnant members received additional messaging related to blood pressure, blood sugar, and signs of pre-term labor. We have also worked to increase member and provider awareness of services we offer through qualified interpreters to help support and address communication barriers across cultures.

- **Adults' Access to Preventive/Ambulatory Health Services:**

- Per HSAG's recommendation, Aetna Better Health of Virginia conducted a deep dive analysis to identify Ambulatory care gaps. Completing heat maps and utilization of Social Scape, an SDOH tool, helped the Plan identify specific areas of focus by county. QM and CM leadership reeducated care managers about the 24-hour nurse line and the importance of communicating the availability of the nurse line clinical staff with each phone and face-to-face contact with members. Leadership monitors regular reports for documentation of task completion. The Plan also increased member notification about the importance of linking to services to assure seamless transitions, efficiency, maintaining continuity of care provides better outcomes and enhances the member experience. Providing education about program criteria, how to use program services and the method for contacting CM to opt in/out of programs. CM facilitates engagement through text messaging, letters, and telephonic/in-person outreach.

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

PMV results showed:

Measure: *Childhood Immunization Status – Combo 3*

MY 2022: 58.88%

MY 2023: 64.23%

Identify any barriers to implementing initiatives:

Identified provider barriers to implementing initiatives included difficulty obtaining documentation of results/services from PCPs or specialist providers and coding awareness.

Identified member barrier to implementing initiatives included health literacy and difficulty reaching members or members opting out or requesting to be added to the Do Not Call List.

HSAG Assessment:



Recommendation—Prenatal Care Secret Shopper Survey

Goal 1: Promote Access to Safe, Gold-Standard Patient Care

Objective 2.1: Ensure Access to Care

Measure(s):

2.1.1.1: Getting Care Quickly Q6

Recommendation—Prenatal Care Secret Shopper Survey		
Goal 4: Strengthen the Health of Families and Communities	Objective 4.2: Improve Outcomes for Maternal and Infant Members	4.2.1.1: Prenatal and Postpartum Care: Postpartum Care 4.2.1.2: Prenatal and Postpartum Care: Timeliness of Prenatal Care 4.2.1.3: Live Births Weighing Less than 2,500 Grams 4.2.1.5: Low Risk Cesarean Delivery
Weakness: The results of the prenatal care secret shopper survey identified that of the 258 provider locations surveyed, 55.8 percent could not be reached. Of the cases reached, 16.7 percent accepted Aetna, 15.8 percent accepted VA Medicaid, and 14.9 percent accepted new patients. Of the cases that were accepting new patients, none offered a second trimester appointment, and 66.7 percent offered a third trimester appointment. For cases that were offered a first trimester appointment, 20.0 percent were compliant with the seven-calendar-day standard. For cases that were offered a third trimester appointment, 16.7 percent were compliant with the three-business-day standard. Recommendation: 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.		
MCO's Response		
Why the weakness exists: Lack of provider knowledge related to contractual requirement for timely appointment availability and member perception of what constitutes urgent appointment criteria. Additionally, providers move and neglect to notify the Plan of updated demographics resulting in provider data and director inaccuracy. Identified barriers to implementing initiatives included technology limitations impact the ability to provide telehealth services, physician response to corrective action plan and requirements, new PCPs declining to join the network, and provider data and directory accuracy. 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 performed data clean-up efforts including conducting outreach calls to providers identified as having discrepancies or failing to meet standards. The Plan conducted a root cause analysis, which included evaluation of member complaints regarding accessibility of services to identify any patterns or trends for providers. Results indicated there was a decrease in complaints overall and identified no trends for specific OBGYN. The Plan continues its recruitment efforts to close gaps in access/coverage for network adequacy. To address provider non-adherence with appointment availability, the Plan published an article in its annual comprehensive provider newsletter that shared the access and availability survey results. The article included education related to the importance of practitioners adhering to all appointment availability requirements and the expectation of adherence. Additionally, the Plan increased network visibility and provider outreach with a gradual uptick in face-to-face visits and regular join operating committee		

Recommendation—Prenatal Care Secret Shopper Survey

meetings. The Plan also added a question to the after-hours survey that relates to whether the PCP is performing after hour visits telephonically. We also revamped our provider orientation materials regarding accessibility requirements. Provider Engagement developed a new corrective action plan process to work with providers to meet all critical performance goals. If a provider misses a critical performance goal for three consecutive months, Aetna Better Health of Virginia will issue a corrective action plan letter, requiring a written response from the provider. Additionally, the Plan will increase its appointment availability survey cadence with the survey vendor to conduct quarterly and allow for more real-time initiatives and interventions.

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

PMV results showed:

Measure: Member received first trimester appointment with OB/GYN within seven calendar days of member request

MY 2022: 42.0%

MY 2023: 47.6%

Measure: Member received second trimester appointment with OB/GYN within seven calendar days of member request

MY 2022: 45.5%

MY 2023: 57.6%

Measure: Member received third trimester appointment with OB/GYN within three business days of member request

MY 2022: 7.5%

MY 2023: 53.8%

Measure: Member received high-risk pregnancy appointment with OB/GYN within three business days of member request

MY 2022: 23.2%

MY 2023: 42.0%

Measure: Member received emergency appointment with OB/GYN immediately upon member request

MY 2022: 63.2%

MY 2023: 78.0%

Measure: Member received postpartum appointment with OB/GYN within 84 calendar days of member request

MY 2022: 100%

MY 2023: 100%

Identify any barriers to implementing initiatives:

Identified barriers to implementing initiatives included shortage of OB/GYN in various Virginia regions, technology limitations impact ability to provide telehealth services, and physician response to corrective actions plans and requirements, new OB/GYNs declining to join the network, and provider data and directory accuracy.

Recommendation—Prenatal Care Secret Shopper Survey

HSAG Assessment:



Recommendation—PCP Secret Shopper Survey

Goal 1: Promote Access to Safe, Gold-Standard Patient Care

Goal 4: Strengthen the Health of Families and Communities

Objective 2.1: Ensure Access to Care

Objective 4.1: Improve the Utilization of Wellness, Immunization, and Preventive Services for Members

Measure(s):

2.1.1.1: Getting Care Quickly Q6

4.1.1.1: Adults' Access to Preventive/Ambulatory Health Services

Weakness: The results of the PCP secret shopper survey identified that of the 418 provider locations surveyed, 56.0 percent could not be reached. Of the cases reached, 20.1 percent accepted Aetna, 19.0 percent accepted VA Medicaid, and 15.8 percent accepted new patients. Of the 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.

Recommendation: 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.

MCO's Response

Why the weakness exists: Lack of provider knowledge related to contractual requirements for timely appointment availability and member perception of what constitutes urgent appointment criteria.

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):

PCP Secret Shopper Survey

Per HSAG's recommendation, Aetna Better Health of performed data clean-up efforts including conducting outreach calls to providers identified as having discrepancies or failing to meet standards. Virginia strategically worked with key health systems to push for open panels where possible, particularly in areas where the county level panel percentage indicated opportunity. The Plan continues its recruitment efforts to close gaps in access/coverage for network adequacy. To address provider non-adherence with appointment availability, the Plan published an article in its annual comprehensive provider newsletter that shared the access and availability survey results. The article included education related to the importance of practitioners adhering to all appointment availability requirements and the expectation of adherence. Additionally, the Plan increased network visibility and provider outreach with a gradual uptick in face-to-face visits and regular join operating committee meetings. The Plan also added a question to the after-hours survey that relates to whether the PCP is

Recommendation—PCP Secret Shopper Survey

performing after hour visits telephonically. We also revamped our provider orientation materials regarding accessibility requirements. Provider Engagement developed a new corrective action plan process to work with providers to meet all critical performance goals. If a provider misses a critical performance goal for three consecutive months, Aetna Better Health of Virginia will issue a corrective action plan letter, requiring a written response from the provider.

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

PMV results showed:

Measure: *Emergency Care Appointment Request: Member received appointment immediately or was referred to the ER*

MY 2022: 69.0%

MY 2023: 80.6%

Measure: *Routine Care Appointment Request: Member received appointment within 30 calendar days*

MY 2022: 87.2%

MY 2023: 89.6%

Identify any barriers to implementing initiatives:

Identified barriers to implementing initiatives included technology limitations impact the ability to provide telehealth services, physician response to corrective action plan and requirements, new PCPs declining to join the network, and provider data and directory accuracy.

HSAG Assessment:



Recommendation—Member Experience of Care Survey – Adult 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

Objective 2.3: Promote Effective Communication and Care Coordination

Measure(s)

1.2.1.1: Enrollees' Ratings Q8- Rating of all Health Care

1.2.1.2: Rating of Personal Doctor

2.1.1.1: Getting Care Quickly Q6

2.1.1.2: Respondent Got Non-Urgent Appointment as Soon as Needed

2.1.1.3: Getting Needed Care

2.3.1.1: How Well Doctors Communicate

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.

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

Recommendation—Member Experience of Care Survey – Adult Medicaid

MCO's Response

Why the weakness exists: HSAG indicated that 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 and therefore identified no weaknesses.

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Per HSAG's recommendation to monitor the measures to ensure significant decreases in scores do not occur over time, Aetna Better Health of Virginia continues its multi-interdisciplinary HEDIS/CAHPS Workgroup to identify potential opportunities and develop new initiatives to address key drivers of Medicaid member experience. Root cause and deep dive analyses indicated the Plan's greatest opportunities encompass rating of personal doctor, rating of specialist seen most often, and member ability to make specialist appointments. Removing barriers to care can improve the health care experience for Aetna Better Health of Virginia members. In effort to remove barriers include a team of Quality Provider Liaisons working with assigned high-volume providers to encourage offering same day appointments and collaborating to implement process improvements to streamline patient flow, embedding care managers in provider offices to answer member questions, coordinate care, and ease administrative burdens on provider staff. The Plan developed member and provider materials to increase awareness of and utilization of telehealth services, improving communications between providers and members. Additionally, the Plan works closely with federally qualified healthcare centers (FQHC) to engage unengaged members and increase member use of patient-centered medical homes.

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

PMV results showed:

Measure: *Rating of All Health Care*

MY 2022: 53.49%

MY 2023: 59.33%

Measure: *Getting Needed Care*

MY 2022: 76.17%

MY 2023: 76.88%

Measure: *Getting Care Quickly*

MY 2022: 76.70%

MY 2023: 78.87%

Measure: *How Well Doctors Communicate*

MY 2022: 91.07%

MY 2023: 92.16%

Identify any barriers to implementing initiatives:

Identified barriers to implementing initiatives included providers low staffing resources resulting in longer wait time for routine appointments and time constraints for engaging with Plan.

HSAG Assessment:

Recommendation—Member Experience of Care Survey – Adult Medicaid



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 Objective 2.3: Promote Effective Communication and Care Coordination	Measure(s): 1.2.1.1: Enrollees' Ratings Q8-Rating of all Health Care 1.2.1.2: Rating of Personal Doctor 2.1.1.1 Getting Care Quickly Q6 2.1.1.2: Respondent Got Non-Urgent Appointment as Soon as Needed 2.1.1.3: Getting Needed Care 2.3.1.1: How Well Doctors Communicate

Weakness: Aetna's 2023 top-box scores were not statistically significantly lower than the 2022 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no weaknesses were identified.

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

MCO's Response

Why the weakness exists: HSAG indicated that Aetna's 2023 top-box scores were not statistically significantly lower than the 2022 top-box scores or NCQA child Medicaid national averages for any measure and therefore identified no weaknesses.

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Per HSAG's recommendation to monitor the measures to ensure significant decreases in scores do not occur over time, Aetna Better Health of Virginia continues its HEDIS/CAHPS Workgroup to identify potential opportunities and develop new initiatives to address key drivers of Medicaid member experience. Root cause and deep dive analyses indicated the Plan's greatest opportunities encompass rating of health plan, health care, personal doctor, and rating of specialist seen most often. Removing barriers to care can improve the health care experience for Aetna Better Health of Virginia members. In effort to remove barriers include a team of Quality Provider Liaisons working with assigned high-volume providers to encourage offering same day appointments and collaborating to implement process improvements to streamline patient flow, embedding care managers in provider offices to answer member questions, coordinate care, and ease administrative burdens on provider staff. The Plan developed member and provider materials to increase awareness of and utilization of telehealth services, improving communications between providers and members. Additionally, the Plan works closely with federally qualified healthcare

Recommendation—Member Experience of Care Survey – Child Medicaid	
centers (FQHC) to engage unengaged members and increase member use of patient-centered medical homes.	
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: Rating of Specialist MY 2022: 65.38% MY 2023: 70.13%	
Identify any barriers to implementing initiatives: Identified barriers to implementing initiatives included providers low staffing resources resulting in longer wait time for routine appointments and time constraints for engaging with Plan. Additionally, Cardinal Care Acute members typically respond with less favor, when compared to the Cardinal Care MLTSS population.	
HSAG Assessment: 	

Cardinal Care MLTSS

Table E-3—Prior Year Recommendations and Responses Cardinal Care MLTSS—Aetna

Recommendation—Performance Measure Validation		
Goal 2: Promote Access to Safe, Gold-Standard Patient Care Goal 4: Strengthen the Health of Families and Communities Goal 5: Providing Whole-Person Care for Vulnerable Populations	Objective 2.1 Ensure Access to Care Objective 4.2: Improve Outcomes for Maternal and Infant Members Objective 5.1 Improve Outcomes for Members with Chronic Conditions	Measure(s) 2.1.1.6: Cervical Cancer Screening 2.1.1.9: Breast Cancer Screening 2.1.1.12: Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis: Ages 18 and Older 4.2.1.2: Prenatal and Postpartum Care: Timeliness of Prenatal Care 5.1.1.6: Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years
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: <i>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total</i> <i>Breast Cancer Screening</i> <i>Cervical Cancer Screening</i>		

Recommendation—Performance Measure Validation

- *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*

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

Why the weakness exists: Based on the analysis health literacy continues to rise to the top for these measures. Assuring members know and understand the importance of engagement and participation with treatment and care and the importance of preventative care.

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):

- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis*
 - Post data analysis, the plan developed educational improvement opportunities to educate providers, including the Wednesday Wisdom, a monthly quick educational piece for providers and short educational CME courses for providers called “snacks.” Ongoing initiatives include member education related to the importance of preventive care.
- *Breast Cancer Screening*
 - New initiatives included community engagement through the launch of our AWOW program to provide education to members, incorporating additional, more insightful discussions among care manager and members regarding the importance of preventive care. Additionally, the plan has a Breast Cancer Awareness event schedule with community partners in October.
- *Cervical Cancer Screening*
 - Post data analysis, the plan implemented initiatives that encompasses community engagement through the launch of our AWOW program to provide education to members, incorporating additional, more insightful discussions among care manager and members regarding the importance of preventive care.
- *Prenatal and Post Partum Care – Timeliness of Prenatal Care and Postpartum Care*
 - New initiatives include care managers reaching out to all identified pregnant women offering support and resources to ensure timely prenatal and post-partum care visits. Our Let's Go Baby Book, maternity pack, and new mom's boxes are also provided. The plan educates members and providers about health conditions, preventive care, free transportation benefit, and community resources. Members are invited to attend virtual baby showers that are provided in both English and Spanish, at which time members receive education and engage in discussion related to prenatal and postpartum care. The Plan also continues to incentivize

Recommendation—Performance Measure Validation

pregnant members to attend prenatal and postpartum visits timely. Members are educated through our text messaging campaign about the importance of timely prenatal and post-delivery follow-up care. High-risk pregnant members received additional messaging related to blood pressure, blood sugar, and signs of pre-term labor. We have also worked to increase member and provider awareness of services we offer through qualified interpreters to help support and address communication barriers across cultures.

- *Use of Imaging Studies for Lower Back Pain*
 - Post data analysis, the plan developed educational flyers and pushed to provider offices demonstrating high rates of low back imaging. The plan will continue to push on a reoccurring basis through fax and hand delivering during in person visits by Quality Provider Liaisons and Network Relations Consultants.
- *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia*
 - New initiatives encompasses community engagement through the launch of our AWOW program to provide education to members, incorporating additional, more insightful discussions among care manager and members regarding the importance of preventive care, discussions among care managers and members regarding the importance of preventive care and education related to self-advocation for excellent care and treatment for their schizophrenia. The Plan is currently evaluating inpatient labs to determine if there is an identified gap due to bundled billing, which may identify members who in face have completed the monitoring.
- *Use of Opioids from Multiple Providers—Multiple Pharmacies and Multiple Prescribers and Multiple Pharmacies*
 - Post data analysis, the plan implemented an outreach campaign to providers identified as having high refill-to-fill ratios and/or a high number of opioid prescriptions greater than 7-day supply to provide education surrounding misunderstanding about the motivations for using diverted medications. Care managers initiate discussion with members about the risks of using multiple prescribers and complete continual assessments of appropriate uses of psychopharmacological medications and assessing members with identifying alternative pain management methods to lower their risk of developing opioid dependence. Additionally, care managers utilize tools such as pain assessments and their questionnaires. Care managers also educate members about responsible methods of disposing unused prescriptions to eliminate the potential for misuse. The plan's Pharmacy Lock-in Program limits members with six or more prescriptions for controlled substances in thirty days to one pharmacy. Text messaging campaigns encourage members to engage in care management as well as receiving pre/post refill reminders and education about the importance of taking medication appropriately. Our SUD Admission Discharge Program supports members returning home after intensive inpatient treatment and MDLive offers members a virtual platform to support behavioral and SUD needs through talk therapy and psychiatry.

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

PMV results showed:

Measure: *Breast Cancer Screening (BCS-E)*

2022: 48.29%

2023: 53.48%

Recommendation—Performance Measure Validation

Measure: *Cervical Cancer Screening (CCS)*

2022: 47.93%

2023: 50.12%

Measure: *Prenatal and Postpartum Care (PPC)*

2022: 71.82%

2023: 74.14%

Measure: *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)*

2022: 71.54%

2023: 76.09%

Identify any barriers to implementing initiatives:

Identified provider barriers to implementing initiatives included difficulty obtaining documentation of results/services from PCPs or specialist providers and coding awareness.

HSAG Assessment:



Recommendation—PCP Secret Shopper Survey

Goal 1: Promote Access to Safe, Gold-Standard Patient Care

Goal 4: Strengthen the Health of Families and Communities

Objective 2.1: Ensure Access to Care

Objective 4.1: Improve the Utilization of Wellness, Immunization, and Preventive Services for Members

Measure(s):

2.1.1.1: Getting Care Quickly Q6

4.1.1.1: Adults' Access to Preventive/Ambulatory Health Services

Weakness: The PCP secret shopper survey results found that of the 418 provider locations surveyed, 56.0 percent could not be reached. Of the cases reached, 20.1 percent accepted Aetna, 19.0 percent accepted VA Medicaid, and 15.8 percent accepted new patients. Of the 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.

Recommendation: 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.

MCO's Response

Recommendation—PCP Secret Shopper Survey

Why the weakness exists: Lack of provider knowledge related to contractual requirements for timely appointment availability and member perception of what constitutes urgent appointment criteria.

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):

PCP Secret Shopper Survey

Per HSAG's recommendation, Aetna Better Health of Virginia strategically worked with key health systems to push for open panels where possible, particularly in areas where the county level panel percentage indicated opportunity. The Plan continues its recruitment efforts to close gaps in access/coverage for network adequacy. To address provider non-adherence with appointment availability, the Plan published an article in its annual comprehensive provider newsletter that shared the access and availability survey results. The article included education related to the importance of practitioners adhering to all appointment availability requirements and the expectation of adherence. Additionally, the Plan increased network visibility and provider outreach with a gradual uptick in face-to-face visits and regular joint operating committee meetings. The Plan also added a question to the after-hours survey that relates to whether the PCP is performing after hour visits telephonically. We also revamped our provider orientation materials regarding accessibility requirements. Provider Engagement developed a new corrective action plan process to work with providers to meet all critical performance goals. If a provider misses a critical performance goal for three consecutive months, Aetna Better Health of Virginia will issue a corrective action plan letter, requiring a written response from the provider.

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

PMV results showed:

Measure: *Emergency Care Appointment Request: Member received appointment immediately or was referred to the ER*

MY 2022: 69.0%

MY 2023: 80.6%

Measure: *Urgent Care Appointment Request: Member received appointment within 24 hours*

MY 2022: 76.4%

MY 2023: 72.8%

Measure: *Routine Care Appointment Request: Member received appointment within 30 calendar days*

MY 2022: 87.2%

MY 2023: 89.6%

Identify any barriers to implementing initiatives:

Identified barriers to implementing initiatives included providers low staffing resources resulting in longer wait time for routine appointments and time constraints for engaging with Plan.

HSAG Assessment:



Recommendation—Member Experience of Care Survey – Adult 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 Objective 2.3: Promote Effective Communication and Care Coordination	Measure(s) 1.2.1.1: Enrollees' Ratings Q8- Rating of all Health Care 1.2.1.2: Rating of Personal Doctor 2.1.1.1: Getting Care Quickly Q6 2.1.1.2: Respondent Got Non-Urgent Appointment as Soon as Needed 2.1.1.3: Getting Needed Care 2.3.1.1: How Well Doctors Communicate
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. Recommendation: HSAG recommends that Aetna monitor the measures to ensure significant decreases in scores over time do not occur.		
MCO's Response		
Why the weakness exists: HSAG indicated that 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 and therefore identified no weaknesses. Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): Per HSAG's recommendation to monitor the measures to ensure significant decreases in scores do not occur over time, Aetna Better Health of Virginia continues its HEDIS/CAHPS Workgroup to identify potential opportunities and develop new initiatives to address key drivers of Medicaid member experience. Root cause and deep dive analyses indicated the Plan's greatest opportunities encompass rating of health care, personal doctor, specialist seen most often, getting needed care, and getting care quickly. Removing barriers to care can improve the health care experience for Aetna Better Health of Virginia members. In effort to remove barriers include a team of Quality Provider Liaisons working with assigned high-volume providers to encourage offering same day appointments and collaborating to implement process improvements to streamline patient flow, embedding care managers in provider offices to answer member questions, coordinate care, and ease administrative burdens on provider staff. The Plan developed member and provider materials to increase awareness of and utilization of telehealth services, improving communications between providers and members. Additionally, the Plan works closely with federally qualified healthcare centers (FQHC) to engage unengaged members and increase member use of patient-centered medical homes. Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: <i>Rating of All Health Plan</i>		

Recommendation—Member Experience of Care Survey – Adult Medicaid

MY 2022: 67.81%

MY 2023: 71.39%

Measure: *Rating of All Health Care*

MY 2022: 51.54%

MY 2023: 57.77%

Measure: *Rating of Personal Doctor*

MY 2022: 68.13%

MY 2023: 72.38%

Measure: *Getting Needed Care*

MY 2022: 80.48%

MY 2023: 82.49%

Measure: *How Well Doctors Communicate*

MY 2022: 93.79%

MY 2023: 93.80%

Identify any barriers to implementing initiatives:

Identified barriers to implementing initiatives included providers low staffing resources resulting in longer wait time for routine appointments and time constraints for engaging with Plan.

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

Objective 2.3: Promote Effective Communication and Care Coordination

Measure(s):

1.2.1.1: Enrollees' Ratings Q8- Rating of all Health Care

1.2.1.2: Rating of Personal Doctor

2.1.1.1: Getting Care Quickly Q6

2.1.1.2: Respondent Got Non-Urgent Appointment as Soon as Needed

2.1.1.3: Getting Needed Care

2.3.1.1: How Well Doctors Communicate

Weakness: Aetna's 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for *Rating of Health Plan*.

Recommendation: 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.

Recommendation—Member Experience of Care Survey – Child Medicaid

MCO's Response

Why the weakness exists: The Plan received low scores for several measures in measurement year 2022 when compared to measurement year 2021, which impacted the member rating of health plan. Survey results indicate positive member experience with specialists seen most often, but not with the ease of seeing the specialist or ease of getting urgent care.

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Per HSAG's recommendation to monitor the measures to ensure significant decreases in scores do not occur over time, Aetna Better Health of Virginia continues its HEDIS/CAHPS Workgroup to identify potential opportunities and develop new initiatives to address key drivers of Medicaid member experience. Root cause and deep dive analyses indicated the Plan's greatest opportunities encompass rating of health plan, health care, personal doctor, getting needed care, and getting needed care. Removing barriers to care can improve the health care experience for Aetna Better Health of Virginia members. In effort to remove barriers include a team of Quality Provider Liaisons working with assigned high-volume providers to encourage offering same day appointments and collaborating to implement process improvements to streamline patient flow, embedding care managers in provider offices to answer member questions, coordinate care, and ease administrative burdens on provider staff. The Plan developed member and provider materials to increase awareness of and utilization of telehealth services, improving communications between providers and members. Additionally, the Plan works closely with federally qualified healthcare centers (FQHC) to engage unengaged members and increase member use of patient-centered medical homes.

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

PMV results showed:

Measure: *Rating of All Health Plan*

MY 2022: 63.87%

MY 2023: 66.83%

Measure: *Rating of All Health Care*

MY 2022: 62.31%

MY 2023: 68.46%

Measure: *Rating of Personal Doctor*

MY 2022: 72.61%

MY 2023: 73.60%

Measure: *Getting Needed Care*

MY 2022: 81.71%

MY 2023: 86.50%

Measure: *Getting Care Quickly*

MY 2022: 85.55%

MY 2023: 90.16%

Identify any barriers to implementing initiatives:

Recommendation—Member Experience of Care Survey – Child Medicaid

Identified barriers to implementing initiatives included providers low staffing resources resulting in longer wait time for routine appointments and time constraints for engaging with Plan.

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
Objective 2.3: Promote Effective Communication and Care Coordination

Measure(s):
1.2.1.1: Enrollees' Ratings Q8- Rating of all Health Care
1.2.1.2: Rating of Personal Doctor
2.1.1.1: Getting Care Quickly Q6
2.1.1.2: Respondent Got Non-Urgent Appointment as Soon as Needed
2.1.1.3: Getting Needed Care
2.3.1.1: How Well Doctors Communicate

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*.

Recommendation: 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.

MCO's Response

Why the weakness exists: The Plan received low scores for several measures in measurement year 2022 when compared to measurement year 2021, which impacted the member rating of health care. Survey results indicate positive member experience with specialists seen most often, but not with the ease of seeing the specialist or ease of getting urgent care.

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Per HSAG's recommendation to monitor the measures to ensure significant decreases in scores do not occur over time, Aetna Better Health of Virginia continues its HEDIS/CAHPS Workgroup to identify potential opportunities and develop new initiatives to address key drivers of Medicaid member experience. Root cause and deep dive analyses indicated the Plan's greatest opportunities encompass rating of health plan, health care, personal doctor, getting needed care, and getting needed care. Removing barriers to care can improve the health care experience for Aetna Better Health of Virginia members. In effort to remove barriers include a team of Quality Provider Liaisons

Recommendation—Member Experience of Care Survey – Child Medicaid

working with assigned high-volume providers to encourage offering same day appointments and collaborating to implement process improvements to streamline patient flow, embedding care managers in provider offices to answer member questions, coordinate care, and ease administrative burdens on provider staff. The Plan developed member and provider materials to increase awareness of and utilization of telehealth services, improving communications between providers and members. Additionally, the Plan works closely with federally qualified healthcare centers (FQHC) to engage unengaged members and increase member use of patient-centered medical homes.

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

PMV results showed:

Measure: *Rating of All Health Plan*

MY 2022: 63.87%

MY 2023: 66.83%

Measure: *Rating of All Health Care*

MY 2022: 62.31%

MY 2023: 68.46%

Measure: *Rating of Personal Doctor*

MY 2022: 72.61%

MY 2023: 73.60%

Measure: *Getting Needed Care*

MY 2022: 81.71%

MY 2023: 86.50%

Measure: *Getting Care Quickly*

MY 2022: 85.55%

MY 2023: 90.16%

Identify any barriers to implementing initiatives:

Identified barriers to implementing initiatives included providers low staffing resources resulting in longer wait time for routine appointments and time constraints for engaging with Plan.

HSAG Assessment:



HealthKeepers

Cardinal Care Acute

Table E-4—Prior Year Recommendations and Responses Cardinal Care Acute—HealthKeepers

Recommendation—Performance Measure Validation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	Objective 5.1: Improve Outcomes for Members with Chronic Conditions	Measure(s): 5.1.1.4: <i>Eye Exam for Patients With Diabetes—Total</i>
Weakness: The following HEDIS MY 2022 PM rate fell at or below NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile and was determined to be an opportunity for improvement for HealthKeepers: <i>Eye Exam for Patients With Diabetes—Total</i> Recommendation: HSAG recommends that HealthKeepers conduct a root cause analysis or focus study for this PM within the Care for Chronic Conditions domain and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that HealthKeepers analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists. 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): Anthem completed a Root Cause Analysis of the MY2022 HEDIS results. The participants in the workgroup included representation from Quality, Health Care Management, Case Management, Long Term Services and Supports, Provider Relations, Behavioral Health including the plan Medical and Behavioral Health Directors. This workgroup analyzed the results for the measures that did not meet the goal. As recommended, the workgroup also reviewed current data that was drilled down by demographics for a more targeted approach. As a result of the Root Cause Analysis and review of the data, the following interventions were reviewed for effectiveness and/or implemented for improvement: - Continued to identify primary care providers with Diabetic Retinal Eye (DRE) exam machines. The Quality team distributed Gap in Care report to the LTSS and Non LTSS teams to contact members of those providers who needed a DRE exam to inform the member that the exam can be performed in the PCP office. - Continued with the CVS Health Tags intervention: Messaging to targeted patients via CVS prescription bags and/or Pharmacist/Technician verbal reinforcement. Messages are surrounding Condition Management, Preventive Services, and Plan Benefit Awareness. - Continued to Generate tags in the Collective Medical ER system to alert Care Coordinators of HEDIS gaps. Care Coordinator works with member to remind them to complete Diabetic Eye Exam. Identify any noted performance improvement as a result of initiatives implemented (if applicable):		

Recommendation—Performance Measure Validation

PMV results showed:

Measure EED: Eye Exam for Patients With Diabetes—Total

2022: 45.01%

2023: 58.15%

Identify any barriers to implementing initiatives: The MCO did not describe any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Prenatal Care Secret Shopper Survey

Goal 4: Strengthen the Health of Families and Communities

Objective 4.2: Improve Outcomes for Maternal and Infant Members

Measure(s):

4.2.1.1: Prenatal and Postpartum Care: Postpartum Care

4.2.1.1: Prenatal and Postpartum Care: Timeliness of Prenatal Care

Weakness: The results of the prenatal care secret shopper survey results identified that of the 333 provider locations surveyed, 28.5 percent could not be reached. Of the cases reached, 35.1 percent did not offer prenatal care services, 26.9 percent accepted HealthKeepers, 25.6 percent accepted VA Medicaid, and 23.9 percent accepted new patients. Of the cases that were accepting new patients, 61.1 percent offered a first trimester appointment, 20.0 percent offered a second trimester appointment, and 7.1 percent offered a third trimester appointment. For cases that were offered a first trimester appointment, none were compliant with the seven-calendar-day standard. For cases that were offered a second trimester appointment, 20.0 percent were compliant with the seven-calendar-day standard. For cases that were offered a third trimester appointment, none were compliant with the three-business-day standard.

Recommendation: HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that the MCO request a copy of the analytic flat files from the prenatal care secret shopper survey and use the files to provide updates or confirmation to DMAS that the data have been updated as appropriate. Additionally, HealthKeepers should review appointment availability and scheduling procedures, including panel capacity to accept new patients and provide an update to DMAS of its findings. Initiatives focused on improving the accuracy of the provider data may result in improved access to prenatal care and improved maternal and infant outcomes.

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

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—Prenatal Care Secret Shopper Survey

In 2022, Elevance began building a comprehensive proactive monitoring program of the provider directory. The Directory Accuracy program (PDA) leverages a proactive model using market based business rules with AI/ML where applicable to support automation of data corrections. The program was established in response to a common industry problem- not receiving timely and accurate provider data changes from our provider groups. The Provider Data Solutions organization- which has accountability and oversight of all provider systems and provider data maintenance – has change authority related to both program changes as well as management and maintenance of provider data.

- PDA applies methodology and scoring consistent with the CMS comprehensive audit criteria. PDA makes data driven decisions versus direct provider outreach by comparing internal directory data against multiple sources of data, applying business rules and a complex algorithm to identify incorrect data that requires updating. Data sources used vary based on the data element being monitored, and include claims, LexisNexis, NPES, ABMS, NUCC, and web data.
- The PDA audits all professional provider, ancillary and facility provider types in the online directory.
- Run a data program to measure the accuracy of the data consumed from the States demographic data.

Anthem will adhere to the recommendations and will 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. We will also review appointment availability and scheduling procedures, including panel capacity to accept new patients, and provide an update to DMAS of its findings.

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

PMV results showed:

Measure: Prenatal and Postpartum Care: Postpartum Care

MY 2022: 71.94%

MY 2023: 70.32%

Measure: Prenatal and Postpartum Care: Timeliness of Prenatal Care

MY 2022: 77.10%

MY 2023: 76.40%

Identify any barriers to implementing initiatives: The MCO did not describe any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—PCP Shopper Survey

Goal 4: Strengthen the Health of Families and Communities

Objective 4.1: Improve the Utilization of Wellness, Immunization and Prevention Services for Members

Measure(s):

4.1.1.1: Adults' Access to Preventive/Ambulatory Health Services

4.1.1.2: Child and Adolescent Well-Care Visits

Recommendation—PCP Shopper Survey

Weakness: The results of the PCP secret shopper survey results identified 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.

Recommendation: HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that the MCO request a copy of the analytic flat files from the PCP secret shopper survey and use the files to provide updates or confirmation to DMAS that the data have been updated as appropriate. Additionally, HealthKeepers should review appointment availability and scheduling procedures, including panel capacity to accept new patients, and provide an update to DMAS of its findings. Initiatives focused on improving the accuracy of the provider data may result in improved access to preventive, well, and chronic care visits.

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- In 2022, Elevance began building a comprehensive proactive monitoring program of the provider directory. The Directory Accuracy program (PDA) leverages a proactive model using market based business rules with AI/ML where applicable to support automation of data corrections. The program was established in response to a common industry problem- not receiving timely and accurate provider data changes from our provider groups. The Provider Data Solutions organization- which has accountability and oversight of all provider systems and provider data maintenance – has change authority related to both program changes as well as management and maintenance of provider data.
- PDA applies methodology and scoring consistent with the CMS comprehensive audit criteria. PDA makes data driven decisions versus direct provider outreach by comparing internal directory data against multiple sources of data, applying business rules and a complex algorithm to identify incorrect data that requires updating. Data sources used vary based on the data element being monitored, and include claims, LexisNexis, NPPEs, ABMS, NUCC, and web data.
- The PDA audits all professional provider, ancillary and facility provider types in the online directory.
- Run a data program to measure the accuracy of the data consumed from the States demographic data

Anthem will adhere to the recommendations and will 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. We will also review appointment availability and scheduling procedures, including panel capacity to accept new patients, and provide an update to DMAS of its findings.

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

Recommendation—PCP Shopper Survey

PMV results showed:

Measure: Adults' Access to Preventive/Ambulatory Health Services

MY 2022: 68.79%

MY 2023: 72.83%

Measure: Child and Adolescent Well-Care Visits

MY 2022: 48.66%

MY 2023: 50.88%

Identify any barriers to implementing initiatives: The MCO did not describe any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Member Experience of Care Survey – Adult Medicaid

Goal 1: Enhance the Member Care Experience

Objective 1.2: Improve Member Satisfaction

Measure(s):

1.2.1.1: Enrollees' Ratings Q8- Rating of all Health Care

Weakness: HealthKeepers' 2023 top-box score was statistically significantly lower than the 2022 NCQA adult Medicaid national average for *Rating of Health Plan*.

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

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

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):

On an annual basis, Anthem completes a thorough evaluation of member experience by analyzing member complaints and appeals in conjunction with Consumer Assessment of Healthcare Providers and Systems (CAHPS®) member experience survey results. In analyzing the three data types individually and then together, the plan has a comprehensive view of the member experience. The Service Quality Committee (SQC) reviews and analyzes the data and assists with the prioritization of opportunities to improve the member experience. This committee includes members of operational departments that can provide insight into reasons for member dissatisfaction and suggest interventions to improve member satisfaction. The Quality Management Committee (QMC) has the authority to approve the reported data, set goals, and allocate appropriately to support the interventions. Committee participants include leadership members from each operational department: Quality, Utilization Management, Behavioral Health (including the Behavioral Health Director),

Recommendation—Member Experience of Care Survey – Adult Medicaid

Credentialing, Network and/or Provider Relations, and Member Services and is chaired by the Medical Director. An analysis of the CAHPS Survey and member complaint data was presented to the Service Quality Committee. A Root Cause Analysis was completed to identify barriers and opportunities for improvement. As a result of the Root Cause Analysis and review of the data, the following interventions were reviewed for effectiveness and/or implemented for improvement:

- The Grievance and Appeal Teams presents trends in grievances and appeals on a quarterly basis to the data and key drivers, opportunities and existing interventions are discussed.
- To address transportation barriers, Anthem has an embedded onsite staff member from our transportation vendor to address transportation issues. Weekly meetings are held to review missed trips and discuss issues that are barriers to members getting their appointments.
- Continued use of the 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.
- CAHPS® 101 - Course made available to internal associates allowing them to become knowledgeable of the CAHPS® survey.
- Revamp of Provider Education material - Elevance online learning course for Providers: “What Matters Most: Improving the Patient Experience” education material addresses communication gaps and offers innovative ways to communicate with patients.

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

Measure: *Rating of Health Plan*

2022: 62.87%

2023: 58.17%

2024: 65.67%

Identify any barriers to implementing initiatives:

The MCO did not describe any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Member Experience of Care Survey – Child Medicaid

Goal: **Goal 1:** Enhance the Member Care Experience

Objective 1.2: Improve Member Satisfaction

Measure(s):
1.2.1.1: Enrollees’ Ratings Q8- Rating of all Health Care

Weakness: HealthKeepers’ 2023 top-box scores were not statistically significantly lower than the 2022 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no weaknesses were identified.

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

Recommendation—Member Experience of Care Survey – Child Medicaid	
MCO's Response	
Why the weakness exists: The MCO did not describe why the weakness exists. 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): Anthem will continue to monitor the CAHPS performance measures to ensure significant decreases in scores over time to not occur.	
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Measure: Enrollees' Ratings Q8-Rating of all Health Care 2022: 48.10% 2023: 58.59%	
Identify any barriers to implementing initiatives: The MCO did not describe any barriers to implementing the initiatives.	
HSAG Assessment: 	

Cardinal Care MLTSS

Table E-5—Prior Year Recommendations and Responses Cardinal Care MLTSS—HealthKeepers

Recommendation—Performance Improvement Projects		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	Objective 5.1: Improve Outcomes for Members with Chronic Conditions	Measure(s): 5.1.1.4: <i>Eye Exam for Patients With Diabetes—Total</i>
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. Recommendation: 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.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists. 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 Improvement Projects

Anthem will adhere to the recommendations from HSAG to ensure that data reported in the submission form are calculated and reported correctly as well as implement internal quality checks prior to submission of PIPs.

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

PMV results showed:

Measure: *Eye Exam for Patients With Diabetes—Total*

2022: 54.26%

2023: 55.05%

Identify any barriers to implementing initiatives: The MCO did not describe any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Performance Measure Validation

Goal 4: Strengthen the Health of Families and Communities

Goal 5: Providing Whole-Person Care for Vulnerable Populations

Objective 4.1: Improve the Utilization of Wellness, 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

Measure(s):

4.1.1.9: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

5.1.1.1: Heart Failure Admission

5.1.1.6: Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years

5.4.1.5: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

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*

Recommendation—Performance Measure Validation

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

Why the weakness exists: The MCO did not describe why the weakness exists.

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). The following interventions were implemented and/or continued as a result of the root cause analysis:

Ambulatory Care—ED Visits—Total

- The Utilization Management Team implemented a Case Management Trigger list to identify members to refer for Case Management/Cardinal Care MLTSS 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.

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total

- Provider Outreach-targets PCPs 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.

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia

Cervical Cancer Screening

- The CCS measure was added as a performance measure for the PQIP and PQIP Essentials programs.

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total

- Implemented customized clinical messaging based on pharmacy claims delivered via fax (providers) and mail (members). Clinical messages are delivered with an explanation about what steps are recommended to address gaps in care.

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. Targeting providers who are performing unnecessary x-rays of lower back for provider education of the measure. This measure is also added to the Provider Risk Adjustment education series.

Recommendation—Performance Measure Validation

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total

- Removed the measure from the PQIP program due to unclear compliance of the measure

Plan All-Cause Readmissions—Observed Readmissions—Total

- Continuation of the 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: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

2022: BMI: 67.97%; Nutrition Total: 60.34%; Physical Activity Total: 51.75%

2023: BMI: 75.44%; Nutrition Total: 66.47%; Physical Activity Total: 60.09%

Measure: Heart Failure Admission - Total

2022: 143.46

2023: 58.18

Measure: Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years

2022: 45.65%

2023: 57.59%

Measure: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

2022: 37.18%

2023: 63.48%

Identify any barriers to implementing initiatives: The MCO did not describe any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—PCP Shopper Survey

Goal 1: Enhance the Member Care Experience

Objective 1.2: Improve Member Satisfaction

Measure(s):

1.2.1.1: Enrollees' Ratings Q8- Rating of all Health Care

Weakness: The PCP secret shopper survey results found 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. For urgent visits, 25.0 percent of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standard.

Recommendation: 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

Recommendation—PCP Shopper Survey

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.

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

In 2022, Elevance began building a comprehensive proactive monitoring program of the provider directory. The Directory Accuracy program (PDA) leverages a proactive model using market based business rules with AI/ML where applicable to support automation of data corrections. The program was established in response to a common industry problem- not receiving timely and accurate provider data changes from our provider groups. The Provider Data Solutions organization- which has accountability and oversight of all provider systems and provider data maintenance – has change authority related to both program changes as well as management and maintenance of provider data.

- PDA applies methodology and scoring consistent with the CMS comprehensive audit criteria. PDA makes data driven decisions versus direct provider outreach by comparing internal directory data against multiple sources of data, applying business rules and a complex algorithm to identify incorrect data that requires updating. Data sources used vary based on the data element being monitored, and include claims, LexisNexis, NPPEs, ABMS, NUCC, and web data.
- The PDA audits all professional provider, ancillary and facility provider types in the online directory.
- Run a data program to measure the accuracy of the data consumed from the States demographic data.

Anthem will adhere to the recommendations and will 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. We will also review appointment availability and scheduling procedures, including panel capacity to accept new patients, and provide an update to DMAS of its findings.

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

2022: 59.50%

2023: 58.59%

Identify any barriers to implementing initiatives: The MCO did not describe any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Member Experience of Care Survey – Adult Medicaid		
Goal 1: Enhance the Member Care Experience	Objective 1.2: Improve Member Satisfaction	Measure(s): 1.2.1.1: Enrollees' Ratings Q8-Rating of all Health Care
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. Recommendation: HSAG recommends that HealthKeepers monitor the measures to ensure significant decreases in scores over time do not occur.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists. 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): Anthem will continue to monitor the measures to ensure significant decreases in scores over time do not occur.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Performance Measure Measure: Enrollees' Ratings Q8-Rating of all Health Care 2022: 59.50% 2023: 58.59%		
Identify any barriers to implementing initiatives: The MCO did not describe any barriers to implementing the initiatives.		
HSAG Assessment: 		
Recommendation—Member Experience of Care Survey – Child Medicaid		
Goal 1: Enhance the Member Care Experience	Objective 1.2: Improve Member Satisfaction	Measure(s): 1.2.1.1: Enrollees' Ratings Q8-Rating of all Health Care
Weakness: HealthKeepers' 2023 top-box scores were statistically significantly lower than the 2022 NCQA child Medicaid national averages for three measures: <i>Rating of Health Plan</i>, <i>Rating of All Health Care</i>, and <i>Rating of Personal Doctor</i>. 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		

Recommendation—Member Experience of Care Survey – Child Medicaid

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

Why the weakness exists: The MCO did not describe why the weakness exists.

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):

- On an annual basis, Anthem completes a thorough evaluation of member experience by analyzing member complaints and appeals in conjunction with Consumer Assessment of Healthcare Providers and Systems (CAHPS®) member experience survey results. In analyzing the three data types individually and then together, the plan has a comprehensive view of the member experience. The Service Quality Committee (SQC) reviews and analyzes the data and assists with the prioritization of opportunities to improve the member experience. This committee includes members of operational departments that can provide insight into reasons for member dissatisfaction and suggest interventions to improve member satisfaction. The Quality Management Committee (QMC) has the authority to approve the reported data, set goals, and allocate appropriately to support the interventions. Committee participants include leadership members from each operational department: Quality, Utilization Management, Behavioral Health (including the Behavioral Health Director), Credentialing, Network and/or Provider Relations, and Member Services and is chaired by the Medical Director. An analysis of the CAHPS Survey and member complaint data was presented to the Service Quality Committee. A Root Cause Analysis was completed to identify barriers and opportunities for improvement. As a result of the Root Cause Analysis and review of the data, the following interventions were reviewed for effectiveness and/or implemented for improvement:
- The Grievance and Appeal Teams presents trends in grievances and appeals on a quarterly basis to the data and key drivers, opportunities and existing interventions are discussed.
- To address transportation barriers, Anthem has an embedded onsite staff member from our transportation vendor to address transportation issues. Weekly meetings are held to review missed trips and discuss issues that are barriers to members getting their appointments.
- Continued use of the 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.
- CAHPS® 101 - Course made available to internal associates allowing them to become knowledgeable of the CAHPS® survey.
- Revamp of Provider Education material - Elevance online learning course for Providers: "What Matters Most: Improving the Patient Experience" education material addresses communication gaps and offers innovative ways to communicate with patients

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

Performance Measure

Measure Rating of Health Plan

2022: 73.00%

Recommendation—Member Experience of Care Survey – Child Medicaid	
2023: 73.42% 2024: 74.52% Measure Rating of All Healthcare 2022: 72.67 % 2023: 70.69 % 2024: 73.38% Measure Rating of Personal Doctor 2022: 70.14 % 2023: 74.10% 2024: 75.00%	
Identify any barriers to implementing initiatives: The MCO did not describe any barriers to implementing the initiatives.	
HSAG Assessment: 	

Molina

Cardinal Care Acute

Table E-6—Prior Year Recommendations and Responses Cardinal Care Acute—Molina

Recommendation—Performance Measure Validation		
Goal 4: Strengthen the Health of Families and Communities Goal 2: Promote Access to Safe, Gold-Standard Patient Care Goal 5: Providing Whole-Person Care for Vulnerable Populations	Objective 4.1: Improve Utilization of Wellness, Immunization, and Prevention Services for Members Objective 2.1: Ensure Access to Care Objective 5.1: Improve Outcomes for Members with Chronic Conditions Objective 5.4: Improve Behavioral Health and Developmental Services of Members Objective 4.2: Improve Outcomes for Maternal and Infant Members	Measure(s): 2.1.1.9: (BCS) Breast Cancer Screening 2.1.1.6: (CCS) Cervical Cancer Screening 4.1.1.1: (AAP) Adults’ Access to Preventive/Ambulatory Health Services 4.1.1.2: (WCV) Child and Adolescent Well-Care Visits 4.2.1.1: (PPC) Prenatal and Postpartum Care: Postpartum Care 4.2.1.2: (PPC) Prenatal and Postpartum Care: Timeliness of Prenatal Care 4.2.1.4: (W30) Well-Child Visits in the First 30 Months of Life

Recommendation—Performance Measure Validation		
		5.1.1.4: (HBD) Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) 5.1.1.5: (CBP) Controlling High Blood Pressure 5.4.1.2: (FUM) Follow-Up After Emergency Department Visit for Mental Illness 5.4.1.1: (FUH) Follow-Up After Hospitalization for Mental Illness Not a Quality Strategy Metric Measure: (BPD) Blood Pressure Control for Patients With Diabetes—Total Not a Quality Strategy Metric Measure: (EED) Eye Exam for Patients With Diabetes—Total
Weakness: The following HEDIS MY 2022 PM rates fell below NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Molina: • <i>Adults' Access to Preventive/Ambulatory Health Services—Total</i> • <i>Breast Cancer Screening</i> • <i>Cervical Cancer Screening</i> • <i>Child and Adolescent Well-Care Visits—Total</i> • <i>Childhood Immunization Status—Combination 3</i> • <i>Blood Pressure Control for Patients With Diabetes—Total</i> • <i>Eye Exam for Patients With Diabetes—Total</i> • <i>Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%) and HbA1c Poor Control (>9.0%)</i> • <i>Controlling High Blood Pressure</i> • <i>Follow-Up After ED for Mental Illness—30-Day Follow-Up—Total</i> • <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total</i> • <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care</i> • <i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i> Recommendation: HSAG recommends that Molina conduct a root cause analysis or focus study for these PMs within the Access to Care, Children's Preventive Care, Behavioral Health, Women's		

Recommendation—Performance Measure Validation

Health, and Care for Chronic Conditions domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Molina analyze its data and results of any root cause analysis or focus groups to identify opportunities to reduce any disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.

MCO's Response

Why the weakness exists: Within these identified domains, there are several factors impacting rates such as following:

- Access to Care: Social Determinates of Health (SDOH) needs impact access to transportation and other community resources; challenges with navigating the healthcare system; lack of awareness of available services.
- Children's Preventive Care: limited health literacy impacting understanding of care options; challenges coordinating preventive visits with other priorities; access challenges.
- Behavioral Health: heightened stigma leading to avoidance/delay in seeking care; challenges accessing care within short timeframe.
- Women's Health: limited health literacy around the importance of preventive screenings; beliefs; access to care in underserved areas; SDOH needs associated with transportation and childcare.

Care for Chronic Conditions: limited health literacy; challenges with ongoing monitoring and adherence to medications/recommendations; SDOH needs can exacerbate chronic conditions (food insecurity, transportation to appointments)

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):

- Leveraged use of Pay for Quality Program and Value Based Care Program as provider incentives.
- Development of a Practice Transformation Team to conduct focused provider outreach and education which supports providers with identifying members with gaps in care and the implementation of strategies to engage members in needed care.
- Distribution of monthly comprehensive scorecards.
- Offered the use of a direct scheduling platform collaboration to providers to eliminate administrative burden with scheduling, to include an online scheduling option and self-scheduling.
- Blood Pressure and Diabetes program to promote disease management, supplied blood pressure cuffs to provider offices to give to members to monitor and track blood pressure readings at home. Suggested healthy eating strategies with option to receive curated farm box, education and resource are shared.
- Diabetes Educator conducted member outreach and education at the Molina Healthcare of Virginia Petersburg Resource Center. A diabetes clinic is held on the second Tuesday of every month from 11 a.m. to 3 p.m. Services offered include blood glucose monitoring, nutrition, and carb counting, glucose monitoring set up, insulin dosage or insulin pump education, and foot care education.
- Prenatal and Postpartum care benefits available to reward for meeting scheduled appointments. Utilization of doula benefits. Implementation of telehealth option for prenatal and postpartum member support. Conducted virtual baby shower providing education on infant care and breast feeding, anxiety, depression, healthy weight for mom and baby, infant immunizations, tobacco

Recommendation—Performance Measure Validation

and substance abuse. Compliant members receive Healthy Rewards Program incentives for timely completion of their prenatal and postpartum visits.

- Increase in Clinic Days, while working with providers to target members with gaps in care and provide education. Utilized the direct scheduling option to support scheduling of the members and ease administrative burden of provider office.
- Behavioral Health (BH) clinical rounds to review and target BH gaps in care, leverage peer support to provide support to members who have experience BH constraints.
- Leveraged PointClickCare software daily and the use of an internal more real-time dashboard to identify members with BH diagnoses, hospital admissions, review discharge notes, and other pertinent information to create a targeted approach in timely member outreach.
- Enhanced member rewards to target HEDIS measures for gap closure.
- Increase in community event activities to target underserved areas.

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

PMV results showed:

Measure: *Child and Adolescent Well-Care Visits*

2022: 38.16%

2023: 44.63%

Measure: *Childhood Immunization Status – Combination 3*

2022: 44.00%

2023: 63.99%

Measure: *Blood Pressure Control for Patients with Diabetes*

2022: 39.66%

2023: 47.45%

Measure: *Eye Exam for Patients with Diabetes*

2022: 24.25%

2023: 45.01%

Measure: *Follow-Up After ED for Mental Illness – 30-Day Follow-Up - Total*

2022: 45.41%

2023: 51.07%

Measure: *Follow-Up After Hospitalization for Mental Illness – 7-Day Follow-Up and 30-Day Follow-Up - Total*

2022: 22.27% / 39.29%

2023: 33.93% / 55.90%

Measure: *Prenatal and Postpartum Care - Timeliness of Prenatal Care / Postpartum Care*

2022: 62.77% / 61.56%

2023: 68.86% / 68.37%

Identify any barriers to implementing initiatives:

- Practice not understanding appropriate billing practices to demonstrate when an exam closes a gap in care.
- Lack of provider awareness if a member has completed a gap or what visits are needed.
- Limited health literacy for the member to understand the importance of an eye exam, preventive care, and/or immunizations.

Recommendation—Performance Measure Validation

- Social Determinates of Health (SDOH) create challenges for members with transportation, childcare, prioritization of more immediate needs over an appointment. Lack of awareness of additional supports such as Medicaid transportation.
- Unable to reach members create challenges with member outreach and reminder calls. Requires leveraging other applications to identify potential contact information.

HSAG Assessment:



Recommendation—Prenatal Care Secret Shopper Survey

Goal 2: Promote Access to Safe, Gold-Standard Patient Care

Objective 2.1: Ensure Access to Care

Measure(s):
2.1.1.4: Monitor Network Adequacy by Region and Provider Types

Weakness: The results of the prenatal care secret shopper survey results identified Of the 314 provider locations surveyed, 36.6 percent could not be reached. Of the cases reached, 40.1 percent did not offer prenatal care services, 21.6 percent accepted Molina, 20.6 percent accepted VA Medicaid, and 20.6 percent accepted new patients. Of the cases that were accepting new patients, 23.1 percent offered a first trimester appointment, 36.4 percent offered a second trimester appointment, and 11.8 percent offered a third trimester appointment. For cases that were offered a first trimester appointment, 33.3 percent were compliant with the seven-calendar-day standard. For cases that were offered a second trimester appointment, 25.0 percent were compliant with the seven-calendar-day standard. For cases that were offered a third trimester appointment, none were compliant with the three-business-day standard.

Recommendation: 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, Molina should review appointment availability and scheduling procedures, including panel capacity to accept new patients, and provide an update to DMAS of its findings. Initiatives focused on improving the accuracy of the provider data may result in improved access to preventive, well, and chronic care visits.

MCO's Response

Why the weakness exists: Within these identified domains, there are several factors impacting rates such as following:

- Long wait times
- Data cleanup challenges with the provider directory

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):

- Dedicated individuals for updates/audits/review of provider directory (data cleanup efforts to ensure information is properly loaded)

Recommendation—Prenatal Care Secret Shopper Survey		
- CMs identifying a discrepancy within provider directory, the team communicates with the Network team to validate/update. - Use of provider directory vendor to provide support with data cleanup efforts.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: <i>Monitor Network Adequacy by Region and Provider Types</i> 2022: NR 2023: NR		
Identify any barriers to implementing initiatives: Data cleanup challenges		
HSAG Assessment: 		
Recommendation—PCP Secret Shopper Survey		
Goal 2: Promote Access to Safe, Gold-Standard Patient Care	Objective 2.1: Ensure Access to Care	Measure(s): 2.1.1.4: Monitor Network Adequacy by Region and Provider Types
Weakness: The results of the PCP secret shopper survey results identified of the 410 provider locations surveyed, 38.0 percent could not be reached. Of the cases reached, 23.9 percent did not offer primary care services, 56.3 percent accepted Molina, 54.3 percent accepted VA Medicaid, and 41.7 percent accepted new patients. 5.7 percent of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standard. Recommendation: HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that the MCO request a copy of the analytic flat files from the prenatal care and PCP secret shopper surveys and use the files to provide updates or confirmation to DMAS that the data have been updated as appropriate. Additionally, Molina should review appointment availability and scheduling procedures, including panel capacity to accept new patients, and provide an update to DMAS of its findings. Initiatives focused on improving the accuracy of the provider data may result in improved access to preventive, well, and chronic care visits.		
MCO's Response		
Why the weakness exists: - Long wait times - Data cleanup challenges with the provider directory		
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—PCP Secret Shopper Survey		
- Dedicated individuals for updates/audits/review of provider directory (data cleanup efforts to ensure information is properly loaded) - CMs identifying a discrepancy within provider directory, the team communicates with the Network team to validate/update. - Use of provider directory vendor to provide support with data cleanup efforts.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: <i>Monitor Network Adequacy by Region and Provider Types</i> 2022: NR 2023: NR		
Identify any barriers to implementing initiatives: Data cleanup efforts.		
HSAG Assessment: 		
Recommendation—Member Experience of Care Survey (Adult)		
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	Measure(s): 2.1.1.1: Getting Care Quickly 2.3.1.1: How Well Doctors Communicate Not a Quality Strategy Metric Measure: Customer Service
Weakness: Molina's 2023 top-box scores were not statistically significantly lower than the 2023 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.		
Recommendation: HSAG recommends that Molina monitor the measures to ensure significant decreases in scores over time do not occur.		
MCO's Response		
Why the weakness exists: None at this time. Continue with ongoing monitoring.		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): CAHPS workgroup to identify interventions, provide awareness across teams within the organization of current initiatives to prevent overlap and increase engagement in member experience of care activities.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable):		

Recommendation—Member Experience of Care Survey (Adult)		
PMV results showed: Measure: Getting Care Quickly 2022: 76.67% 2023: 79.07% Measure: How Well Doctors Communicate 2022: 93.68% 2023: 94.43% Measure: Customer Service 2022: 88.89% 2023: 89.76%		
Identify any barriers to implementing initiatives: No identified barrier to implementing interventions.		
HSAG Assessment: 		
Recommendation—Member Experience of Care Survey (Child)		
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	Measure(s): 2.1.1.1: Getting Care Quickly 2.3.1.1: How Well Doctors Communicate Not a Quality Strategy Metric Measure: Customer Service
Weakness: Molina's 2023 top-box scores were statistically significantly lower than the 2022 top-box scores and the 2022 NCQA child Medicaid national averages for four measures: <i>Getting Needed Care</i>, <i>Getting Care Quickly</i>, <i>How Well Doctors Communicate</i>, and <i>Customer Service</i>. Recommendation: HSAG recommends that Molina conduct root cause analyses of the study indicators that have been identified as areas of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG recommends that Molina continue to monitor the measures to ensure significant decreases in the scores over time do not continue to occur.		
MCO's Response		
Why the weakness exists: • SDOH needs (transportation issues, insufficient childcare, homelessness) • Lack of standardization of information provided to member • Limited awareness of services available 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): • Practice Transformation team developed to support Pay for Quality Program and align with Provider Relations team. The teams align to outreach with provider education around best		

Recommendation—Member Experience of Care Survey (Child)
practices, highlight incentives associated with performance, and resources around good communication. Review and analyze trends in grievance and appeals data and patterns of dissatisfaction associated with transportation vendor for opportunities for improvement and action plans.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Measure: Getting Care Quickly 2022: 76.67% 2023: 79.07% Measure: How Well Doctors Communicate 2022: 93.68% 2023: 94.43% Measure: Customer Service 2022: 88.89% 2023: 89.76%
Identify any barriers to implementing initiatives: No identified barriers to implementing interventions.
HSAG Assessment: 

Cardinal Care MLTSS

Table E-7—Prior Year Recommendations and Responses Cardinal Care MLTSS—Molina

Recommendation—Performance Improvement Projects		
Goal 3: Support Efficient and Value-Driven Care	Objective 3.1: Focus on Paying for Value	Measure(s): 3.1.1.5: (AMB-ED) Ambulatory Care: Emergency Department Visits
Weakness: For the <i>AMB-ED</i> PIP, Molina has an opportunity for improvement related to reporting correct data in the narrative summary of results. Recommendation: 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.		
MCO's Response		
Why the weakness exists: Additional quality check needed to validate data. 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 Improvement Projects		
Working with Clinical Data Analytics team for quality check prior to submission.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: <i>Ambulatory Care – ED Visits - Total</i> 2022: 1,132.40 2023: 698.35		
Identify any barriers to implementing initiatives: No barriers identified related to implementing an additional quality check prior to submission.		
HSAG Assessment: 		
Recommendation—Performance Improvement Projects		
Goal 3: Support Efficient and Value-Driven Care	Objective 3.1: Focus on Paying for Value	Measure(s): Not a Quality Strategy Metric Measure: Transitions of Care – Total Average
Weakness: For the <i>Follow-Up After Discharge</i> PIP, Molina did not address all documentation requirements for data analysis and interpretation of results		
Recommendation: The MCO should ensure it addresses whether there are factors that threaten the validity and comparability of the data annually.		
MCO's Response		
Why the weakness exists: Additional quality review needed.		
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): - Implementing additional quality review to ensure accuracy and compliance with all requirements. - Workgroup feedback on elements impacting PIP.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: <i>Transitions of Care - Total</i> 2022: 63.27% 2023: 74.32%		
Identify any barriers to implementing initiatives: No barriers identified related to implementing an additional quality check prior to submission.		
HSAG Assessment:		

Recommendation—Performance Improvement Projects



Recommendation—Performance Measure Validation

Goal 3: Support Efficient and Value-Driven Care Goal 2: Promote Access to Safe, Gold-Standard Patient Care Goal 4: Strengthen the Health of Families and Communities Goal 5: Providing Whole-Person Care for Vulnerable Populations	Objective 3.1: Focus on Paying for Value Objective 2.1: Ensure Access to Care Objective 4.2: Improve Outcomes for Maternal and Infant Members Objective 5.1: Improve Outcomes for Members with Chronic Conditions Objective 5.4: Improve Behavioral Health and Developmental Services for Members Objective 4.1: Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	Measure(s): 3.1.1.5: (AMB) Ambulatory Care: Emergency Department (ED) Visits 2.1.1.9: (BCS) Breast Cancer Screening 2.1.1.6: (CCS) Cervical Cancer Screening 4.2.1.1: (PPC) Prenatal and Postpartum Care: Postpartum Care 4.2.1.2: (PPC) Prenatal and Postpartum Care: Timeliness of Prenatal Care 4.1.1.2: (WCV) Child and Adolescent Well-Care Visits 5.1.1.5: (CBP) Controlling High Blood Pressure 5.4.1.1: (FUH) Follow-Up After Hospitalization for Mental Illness 4.1.1.4: (IMA) Immunizations for Adolescents 4.1.1.9: (WCC) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Not a Quality Strategy Metric Measure: (LBP) Use of Imaging Studies for Low Back Pain
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: <i>Ambulatory Care—ED Visits—Total</i> <i>Breast Cancer Screening</i>		

Recommendation—Performance Measure Validation

- *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

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.

MCO's Response

Why the weakness exists: Social Determinates of Health (SDOH) needs impact access to transportation, homelessness, and other community resources; challenges with navigating the healthcare system; lack of awareness of available services.

- Limited health literacy impacting understanding of care options; challenges coordinating preventive visits with other priorities; access challenges.
- Heightened stigma leading to avoidance/delay in seeking care for Behavioral Health (BH) services;
- Limited health literacy around the importance of preventive screenings; access to care in underserved areas; SDOH needs associated with transportation and childcare.
- Challenges with ongoing monitoring and adherence to medications/recommendations; SDOH needs can exacerbate chronic conditions (food insecurity, transportation to appointments)

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):

- Leveraged use of Pay for Quality Program and Value Based Care Program as provider incentives.
- Supplied blood pressure cuffs to provider offices to give to members to monitor and track blood pressure readings at home.
- Development of a Practice Transformation Team to conduct focused provider outreach and education which supports providers with identifying members with gaps in care and the implementation of strategies to engage members in needed care.
- Weekly clinical rounds with CMO, BH Medical Director to examine critical incidents, utilization trends across levels of care, and EPSDT services.

Recommendation—Performance Measure Validation

- Behavioral Health (BH) clinical rounds to review and target BH gaps in care to include leveraging peer support to provide support to members who have experience BH admissions/discharges, and ensure linkage/reminders of needed services.
- Leveraged PointClickCare software daily and the use of an internal more real-time dashboard to identify members with BH diagnoses, hospital admissions, review discharge notes, and other pertinent information to create a targeted approach in timely member outreach and gap closure.
- Engagement with community-based providers to support gap closure activities.
- Continual member outreach to provide education, ensure linkage to services, and support with scheduling needed services.
- Molina Healthcare of Virginia has partnered with neighboring Food Lion Supermarkets to assist members in providing healthy nutrition options for those affected by food desert regions.

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

PMV results showed:

Measure: *Prenatal and Postpartum Care – Timeliness of Prenatal Care and Postpartum Care*

2022: 63.79% / 41.38%

2023: 68.86% / 68.37%

Measure: *Child and Adolescent Well-Care Visits - Total*

2022: 36.02%

2023: 44.63%

Measure: *Follow-Up After Hospitalization for Mental Illness – 7 Day Follow Up - Total and 30-Day Follow Up - Total*

2022: 22.14% / 43.64%

2023: 33.93% / 55.90%

Identify any barriers to implementing initiatives:

- Practice not understanding appropriate billing practices to demonstrate when an exam closes a gap in care.
- Lack of provider awareness if a member has completed a gap or what visits are needed.
- Limited health literacy for the member to understand the importance of preventive care and/or immunizations.
- Social Determinates of Health (SDOH) create challenges for members with transportation, inadequate childcare, homelessness, prioritization of more immediate needs over an appointment. Lack of awareness of additional supports such as Medicaid transportation.
- Unable to reach members create challenges with member outreach and reminder calls.

HSAG Assessment:



Recommendation—PCP Secret Shopper Survey		
Goal 2: Promote Access to Safe, Gold-Standard Patient Care	Objective 2.1: Ensure Access to Care	Measure(s): 2.1.1.4: Monitor Network Adequacy by Region and Provider Types
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, 5.7 percent were compliant with DMAS' 24-hour appointment availability compliance standards. Recommendation: 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.		
MCO's Response		
Why the weakness exists: • Long wait times • Data cleanup challenges with the provider directory 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): • Dedicated individuals for updates/audits/review of provider directory (data cleanup efforts to ensure information is properly loaded) • CMs identifying a discrepancy within provider directory, the team communicates with the Network team to validate/update. • Use of provider directory vendor to provide support with data cleanup efforts.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: <i>Monitor Network Adequacy by Region and Provider Types</i> 2022: NR 2023: NR		
Identify any barriers to implementing initiatives: Data cleanup efforts.		
HSAG Assessment:		

Recommendation—PCP Secret Shopper Survey		
		
Recommendation—Member Experience of Care Survey (Adult)		
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	Measure(s): 2.1.1.1: Getting Care Quickly 2.3.1.1: How Well Doctors Communicate Not a Quality Strategy Metric Measure: Customer Service
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. Recommendation: HSAG recommends that Molina monitor the measures to ensure significant decreases in scores over time do not occur.		
MCO’s Response		
Why the weakness exists: None at this time. Continue with ongoing monitoring. Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): CAHPS workgroup to identify interventions, provide awareness across teams within the organization of current initiatives to prevent overlap and increase engagement in member experience of care activities.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: Getting Care Quickly 2022: 77.19% 2023: 79.07% Measure: How Well Doctors Communicate 2022: 91.00% 2023: 94.43% Measure: Customer Service 2022: 86.21% 2023: 89.76%		
Identify any barriers to implementing initiatives: No barriers identified.		
HSAG Assessment:		

Recommendation—Member Experience of Care Survey (Adult)		
		
Recommendation—Member Experience of Care Survey (Child)		
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	Measure(s): 2.1.1.1: Getting Care Quickly 2.3.1.1: How Well Doctors Communicate
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. Recommendation: HSAG recommends that Molina monitor the measures to ensure significant decreases in scores over time do not occur.		
MCO's Response		
Why the weakness exists: None at this time. Will continue with ongoing monitoring. Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): CAHPS workgroup to identify interventions, provide awareness across teams of current initiatives to prevent overlap, and increase engagement in member experience of care activities.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: <i>Getting Care Quickly</i> 2022: 77.19% 2023: 79.07% Measure: <i>How Well Doctors Communicate</i> 2022: 91.00% 2023: 94.43%		
Identify any barriers to implementing initiatives: No identified barriers at this time.		
HSAG Assessment: 		

Sentara

Cardinal Care Acute

Table E-8—Prior Year Recommendations and Responses Cardinal Care Acute—Sentara

Recommendation—Performance Measure Validation		
Goal 4: Strengthen the Health of Families and Communities	Objective 4.1: Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	Measure(s): 4.1.1.1: Adults' Access to Preventive/Ambulatory Health Services
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 Optima: <i>Adults' Access to Preventive/Ambulatory Health Services—Total</i> Recommendation: HSAG recommends that Optima conduct a root cause analysis or focus study for these PMs within the Access to Care, Behavioral Health, and Women's Health domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and results of any root cause analysis or focus groups to identify opportunities to reduce any disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists. 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 engagement with members to assist in managing care, making appointments, and scheduling transportation - Birthday card mailings that include a bookmarker that serves to remind members of the preventative health guidelines they should follow to achieve their personal best health - Provider Enablement provides data to VBC providers regarding preventative measures and discuss their performance/progress towards the goals - Network Management engagement - Includes appointment availability standards routinely in quarterly newsletters		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: <i>Adults' Access to Preventive/Ambulatory Health Services</i> 2022: 67.82% 2023: 71.70%		
Identify any barriers to implementing initiatives:		

Recommendation—Performance Measure Validation

Lack of appointment availability in outpatient settings.

HSAG Assessment:



Recommendation—Performance Measure Validation

Goal 5: Providing Whole-Person Care for Vulnerable Populations

Objective 5.4: Improve Behavioral Health and Developmental Services for Members

Measure(s):
5.4.1.3: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

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 Optima:

- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase*

Recommendation: HSAG recommends that Optima conduct a root cause analysis or focus study for these PMs within the Access to Care, Behavioral Health, and Women's Health domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and results of any root cause analysis or focus groups to identify opportunities to reduce any disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented and any activities still underway to address the finding that resulted in the recommendation):

- Clinical coordination program for those members aged 6-12 who are taking an atypical antipsychotic
- Care Coordination letters are sent to the member's Primary Care Provider (PCP) and prescriber of atypical antipsychotic
- The goal is to ensure appropriate clinical monitoring of the member is being completed and reported
- Team meetings are held monthly to discuss the program, suggest any improvements, and review data results

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

PMV results showed:

Measure: *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

2022: 37.48%

Recommendation—Performance Measure Validation

2023: 38.71%

Measure: *Follow-Up Care for Children Prescribed ADHD Medication— Continuation and Maintenance Phase*

2022: 49.03%

2023: 46.57%

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 4.2: Improve Outcomes for Maternal and Infant members

Measure(s):

4.2.1.1: Timeliness of Prenatal Care

4.2.1.2: Postpartum Care

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 Optima:

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care*

Recommendation: HSAG recommends that Optima conduct a root cause analysis or focus study for these PMs within the Access to Care, Behavioral Health, and Women's Health domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and results of any root cause analysis or focus groups to identify opportunities to reduce any disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

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):

Activities Still Underway:

- Prenatal Visit Incentive Program
- Postpartum Visit Incentive Program
- Healthy Pregnancy mailing, self-care guide and parenting magazine subscription
- Healthy Pregnancy mailing at 20 weeks gestation, dealing with stress while pregnant, and a preterm labor card
- Healthy Pregnancy mailing at 7 months including a letter, dealing with stress flyer, and early labor signs card

Recommendation—Performance Measure Validation

- Healthy Pregnancy mailing at 38 weeks gestation, dealing with postpartum depression, and an immunization with checkups magnet
- Regional Baby Showers are conducted virtually which allows more members to participate. Educational materials are disseminated to the members on the importance of prenatal/postpartum health.
- Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement
- Member Outreach Calls
- EMMI Manager utilization for educational videos
- Prealize (now Point-Click-Care) 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

Activities Implemented:

- Partners in Pregnancy is now Welcoming Baby. Benefits to assist members include:
 - \$75 grocery card every quarter while pregnant and for a year after for buying healthy food items
 - Help finding doctors for regular prenatal care
 - Case management for high-risk pregnancy

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

PMV results showed:

Measure: *Prenatal and Postpartum Care - Timeliness of Prenatal Care*

2022: 65.45%

2023: 68.86%

Measure: *Prenatal and Postpartum Care - Postpartum Care*

2022: 61.07%

2023: 71.78%

Identify any barriers to implementing initiatives:

- Conducted a data analysis of care gaps by region to determine if any possible trends in barriers existed, no trends were noted
- Barriers assessed with clinical team, childcare and transportation continue to be major barriers for this population; collaborating with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need
- Coding discrepancies with the Bundled coding in Inovalon not capturing all prenatal visits in data pull
- Social and economic barriers persist despite implementation of the Health Care Reform

HSAG Assessment:



Recommendation—Performance Measure Validation (Virginia Premier)		
Goal (2): Promote Access to Safe, Gold-Standard Patient Care	Objective (2.1, 2.2): Ensure Access to Care, Promote Patient Safety	Measure(s): 4.1.1.1: Adults' Access to Preventive/Ambulatory Health Services
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: <i>Adult's Access to Preventive/Ambulatory Health Services—Total</i>		
Recommendation: Since VA Premier merged with Optima, HSAG recommends that Optima consider conducting a root cause analysis or focus study for these PMs within the Access to Care, Children's Preventive Care, Behavioral Health, and Women's Health domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima also consider analyzing the data and consider whether there are disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists.		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): - Formalized Population Health Committee & workgroups established as part of the Quality Governance Structure - NCQA PHM Standards and Readiness tools were purchased to perform a comprehensive population health assessment to include but are not limited to SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities including race/ethnicity, age, zip code, etc. - Workgroups were established for each focus area of CAHPS to assess, research best practices, and pilot interventions to improve each area of focus - Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: <i>Adults' Access to Preventive/Ambulatory Health Services</i> 2022: 68.26% 2023: 71.70%		
Identify any barriers to implementing initiatives: - Lack of appointment availability in outpatient settings - Providers are still feeling the impact of the COVID-19 pandemic		
HSAG Assessment:		

Recommendation—Performance Measure Validation (Virginia Premier)



Recommendation—Performance Measure Validation (Virginia Premier)

Goal (4): Strengthen the Health of Families and Communities

Objective (4.1): Improve Utilization of Wellness, Immunization, and Prevention Services for Members

Measure(s):
2.1.1.6: Cervical Cancer Screening

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:

- *Cervical Cancer Screening*

Recommendation: Since VA Premier merged with Optima, HSAG recommends that Optima consider conducting a root cause analysis or focus study for these PMs within the Access to Care, Children's Preventive Care, Behavioral Health, and Women's Health domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima also consider analyzing the data and consider whether there are disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

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
- Incentivize members if screening is completed
- Implement targeted campaigns around cancer screenings

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

PMV results showed:

Measure: *Cervical Cancer Screening*

2022: 42.58%

2023: 48.42%

Identify any barriers to implementing initiatives:

No Barriers identified as measure improved

HSAG Assessment:



Recommendation—Performance Measure Validation (Virginia Premier)		
Goal (5): Providing Whole-Person Care for Vulnerable Populations	Objective (5.4): Improve Behavioral Health and Developmental Services for members	Measure(s): 5.4.1.1: Follow-Up After Hospitalization for Mental Illness
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: <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total</i>		
Recommendation: Since VA Premier merged with Optima, HSAG recommends that Optima consider conducting a root cause analysis or focus study for these PMs within the Access to Care, Children's Preventive Care, Behavioral Health, and Women's Health domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima also consider analyzing the data and consider whether there are disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists.		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): - The BH Care Coordination Team supports all members who have a BH inpatient admission with the intent to reduce/eliminate readmissions by engaging members and linking them to community-based services and supports. Behavioral Health Inpatient Reviewers send notification at admission and discharge to member's Care Coordinator (CC) and/or Transition Coordinator (TC) to initiate discharge planning with the inpatient facility to identify and resolve barriers for safe and effective discharge, while initiating community-based services, as needed, to reduce the chance for member readmission - Behavioral Health Inpatient Reviewers send notification at admission and discharge to member's CC and/or Transition Coordinator to initiate discharge planning with the inpatient facility to identify and resolve barriers for safe and effective discharge, while initiating community-based services, as needed, to reduce the chance for member readmission - A Performance Withhold Performance (PWP) team was established to monitor and track data trends with this measure and alert the organization when rates are dropping. - Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total</i> 2022: 22.67% 2023: 31.58% Measure: <i>Follow-Up After Hospitalization for Mental Illness—Total and 30-Day Follow-Up—Total</i>		

Recommendation—Performance Measure Validation (Virginia Premier)		
2022: 40.05%		
2023: 52.85%		
Identify any barriers to implementing initiatives: No Barriers identified. Measure improved significantly due interventions implemented		
HSAG Assessment: 		
Recommendation—Performance Measure Validation (Virginia Premier)		
Goal (4): Strengthen the Health of Families and Communities	Objective (4.1): Improve Utilization of Wellness, Immunization, and Prevention Services for Members	Measure(s): 4.2.1.1: Prenatal and Postpartum Care: Timeliness of Prenatal Care
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:		
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>		
Recommendation: Since VA Premier merged with Optima, HSAG recommends that Optima consider conducting a root cause analysis or focus study for these PMs within the Access to Care, Children's Preventive Care, Behavioral Health, and Women's Health domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima also consider analyzing the data and consider whether there are disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists.		
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): Activities Still Underway: - Prenatal Visit Incentive Program - Postpartum Visit Incentive Program - Healthy Pregnancy mailing, self-care guide and parenting magazine subscription - Healthy Pregnancy mailing at 20 weeks gestation, dealing with stress while pregnant, and a preterm labor card - Healthy Pregnancy mailing at 7 months including a letter, dealing with stress flyer, and early labor signs card - Healthy Pregnancy mailing at 38 weeks gestation, dealing with postpartum depression, and an immunization with checkups magnet - Regional Baby Showers are conducted virtually which allows more members to participate. Educational materials are disseminated to the members on the importance of prenatal/postpartum health.		

Recommendation—Performance Measure Validation (Virginia Premier)

- Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement
- Member Outreach Calls
- EMMI Manager utilization for educational videos
- Prealize (now Point-Click-Care) 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

Activities Implemented:

Partners in Pregnancy is now Welcoming Baby. Benefits to assist members include:

- \$75 grocery card every quarter while pregnant and for a year after for buying healthy food items
- Help finding doctors for regular prenatal care
- Case management for high-risk pregnancy

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

PMV results showed:

Measure: *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

2022: 76.89%

2023: 68.86%

Identify any barriers to implementing initiatives:

- Conducted a data analysis of care gaps by region to determine if any trends in barriers existed, no trends were noted
- Barriers assessed with clinical team, childcare and transportation continue to be major barriers for this population; collaborating with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need
- Coding discrepancies with the Bundled coding in Inovalon not capturing all prenatal visits in data pull
- Social and economic barriers persist despite implementation of the Health Care Reform

HSAG Assessment:



Recommendation—Performance Measure Validation (Virginia Premier)

Goal (4): Strengthen the Health of Families and Communities

Objective (4.1): Improve Utilization of Wellness, Immunization, and Prevention Services for Members

Measure(s):

4.2.1.4 and 4.5.6: 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

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:

Recommendation—Performance Measure Validation (Virginia Premier)
<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>
Recommendation: Since VA Premier merged with Optima, HSAG recommends that Optima consider conducting a root cause analysis or focus study for these PMs within the Access to Care, Children’s Preventive Care, Behavioral Health, and Women’s Health domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima also consider analyzing the data and consider whether there are disparities within the MCO’s populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
MCO’s Response
Why the weakness exists: The MCO did not describe why the weakness exists.
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): - Childhood Incentive Program established to incentivize member for obtaining preventative care - Health fairs throughout the state of Virginia - HEDIS Blitz conducted annually to close care gaps - Provider Education conducted statewide - Hired a dedicated full-time employee to support EPSDT (Early and Periodic Screening, Diagnosis and Treatment) - Partnership with the Virginia Department of Health to increase access to appointments and provide education - Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: <i>Well-Child Visits in the First 30 Months of Life</i> 2022: 51.41% 2023: 58.50% PMV results showed: Measure: <i>Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits</i> 2022: 62.30% 2023: 67.33%
Identify any barriers to implementing initiatives: No Barriers identified. Measure improved significantly due interventions implemented
HSAG Assessment: 

Recommendation—Prenatal Care Secret Shopper Survey (Optima)		
Goal (2): Promote Access to Safe, Gold-Standard Patient Care	Objective (2.1): Ensure Access to Care	Measure(s): 2.1.1.1: Getting Care Quickly
Weakness: The results of the prenatal care secret shopper survey results identified that of the 305 provider locations surveyed, 38.4 percent could not be reached. Of the cases reached, 28.2 percent did not offer prenatal care services, 30.9 percent accepted Optima, 30.3 percent accepted VA Medicaid, and 28.2 percent accepted new patients. Of the cases that were accepting new patients, 60.0 percent offered a first trimester appointment, 10.0 percent offered a second trimester appointment, and 22.2 percent offered a third trimester appointment. For cases that were offered a first trimester appointment, none were compliant with the seven-calendar-day standard. For cases that were offered a second trimester appointment, 50.0 percent were compliant with the seven-calendar-day standard. For cases that were offered a third trimester appointment, none were compliant with the three-business-day standard.		
Recommendation: HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that the MCO request a copy of the analytic flat files from the prenatal care and PCP secret shopper surveys and use the files to provide updates or confirmation to DMAS that the data have been updated as appropriate. Additionally, Optima should review appointment availability and scheduling procedures, including panel capacity to accept new patients, and provide an update to DMAS of its findings. Initiatives focused on improving the accuracy of the provider data may result in improved member access to care visits.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists.		
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): - SHP conducts an annual provider Access Survey on appointment availability to monitor compliance and understand areas of concern with timely access to care. - Set up focus groups (using SHP Access Survey data) with all non-compliant prenatal providers (n=15) to understand scheduling barriers that delay care. These focus groups will help identify opportunities for overcoming barriers and can direct education on timely access to care throughout the network. - Communicate appointment standards via emailed provider alerts, educational webinars, and digital newsletters. - Educate new and existing providers on appointment standards and demonstrate where to find standards, such as the online Doing Business with Sentara Health Plans guide or provider manual. - Communicated appointment standards via provider manuals which are posted on the health plan website. - SHP conducts an annual provider Access Survey on appointment availability and after-hours care to monitor compliance and understand areas of concern with timely access to care. Interventions are created based on any identified issues. - Providers are educated on how to update their provider directory status and information which includes if they are accepting new patients. - SHP will continue to recruit and contract with available providers.		

Recommendation—Prenatal Care Secret Shopper Survey (Optima)

- There is an indicator in the directory for accepting new patients, that can be used to identify if a provider is accepting new patients
- Network Management will evaluate the providers in the DMAS file that stated they do not participate in Medicaid, against their executed agreement. If the group/provider does participate with Medicaid (per their agreement), a Network Rep will make outreach and provide education to the provider based on the terms of their agreement. If the contract indicates that the provider is not participating with Medicaid, Network will notify Provider Operations to update our internal systems and remove that group/provider from the Medicaid products. If the provider is contracted for Medicaid but not accepting patients, Network will direct the provider to notify the health plan via our online provider update submission process. Provider Ops will make the necessary updates within our systems which will remove them from the directories.

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

PMV results showed:

Measure: *Getting Care Quickly*

2022: NR – Optima: 86.1% and VA Premier: 82.2%

2023: 83.55%

Identify any barriers to implementing initiatives:

No barriers identified.

HSAG Assessment:



Recommendation—Prenatal Care Secret Shopper Survey (Virginia Premier)

Goal (2): Promote Access to Safe, Gold-Standard Patient Care

Objective (2.1): Ensure Access to Care

Measure(s):
2.1.1.1: Getting Care Quickly

Weakness: The results of the prenatal care secret shopper survey results identified that of the 268 provider locations surveyed, 23.5 percent could not be reached. Of the cases reached, 36.6 percent did not offer prenatal care services, 33.7 percent accepted VA Premier, 33.2 percent accepted VA Medicaid, and 32.2 percent accepted new patients. Of the cases that were accepting new patients, 52.0 percent offered a first trimester appointment, none offered a second trimester appointment, and 7.7 percent offered a third trimester appointment. For cases that were offered a first trimester appointment, 30.8 percent were compliant with the seven-calendar-day standard. No cases were offered a second trimester appointment within the seven-calendar day standard. For cases that were offered a third trimester appointment, 50.0 percent were compliant with the three-business-day standard.

Recommendation: HSAG provides DMAS with the analytic flat files from the telephone survey. Since VA Premier merged with Optima, HSAG recommends that Optima consider conducting a root cause analysis and providing updates or confirmation that the MCO's merged network data have been updated as appropriate. Additionally, Optima should confirm the merged MCO's appointment availability and scheduling procedures with DMAS, including panel capacity to accept new patients.

MCO's Response

Recommendation—Prenatal Care Secret Shopper Survey (Virginia Premier)
Why the weakness exists: The MCO did not describe why the weakness exists.
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): • SHP conducts an annual provider Access Survey on appointment availability to monitor compliance and understand areas of concern with timely access to care. • Set up focus groups (using SHP Access Survey data) with all non-compliant prenatal providers (n=15) to understand scheduling barriers that delay care. These focus groups will help identify opportunities for overcoming barriers and can direct education on timely access to care throughout the network. • Communicate appointment standards via emailed provider alerts, educational webinars, and digital newsletters. • Educate new and existing providers on appointment standards and demonstrate where to find standards, such as the online Doing Business with Sentara Health Plans guide or provider manual. • Communicated appointment standards via provider manuals which are posted on the health plan website. • SHP conducts an annual provider Access Survey on appointment availability and after-hours care to monitor compliance and understand areas of concern with timely access to care. Interventions are created based on any identified issues. • Providers are educated on how to update their provider directory status and information which includes if they are accepting new patients. • SHP will continue to recruit and contract with available providers. • There is an indicator in the directory for accepting new patients, that can be used to identify if a provider is accepting new patients • Network Management will evaluate the providers in the DMAS file that stated they do not participate in Medicaid, against their executed agreement. If the group/provider does participate with Medicaid (per their agreement), a Network Rep will make outreach and provide education to the provider based on the terms of their agreement. If the contract indicates that the provider is not participating with Medicaid, Network will notify Provider Operations to update our internal systems and remove that group/provider from the Medicaid products. If the provider is contracted for Medicaid but not accepting patients, Network will direct the provider to notify the health plan via our online provider update submission process. Provider Ops will make the necessary updates within our systems which will remove them from the directories.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: <i>Getting Care Quickly</i> 2022: NR – Optima: 86.1% and VA Premier: 82.2% 2023: 83.55%
Identify any barriers to implementing initiatives: No barriers identified.
HSAG Assessment:

Recommendation—Prenatal Care Secret Shopper Survey (Virginia Premier)



Recommendation—PCP Secret Shopper Survey (Optima)

Goal (2): Promote Access to Safe, Gold-Standard Patient Care

Objective (2.1): Ensure Access to Care

Measure(s):
2.1.1.1: Getting Care Quickly

Weakness: The results of the PCP care secret shopper survey results identified that of the 412 provider locations surveyed, 31.3 percent could not be reached. Of the cases reached, 55.5 percent accepted Optima, 47.7 percent accepted VA Medicaid, and 41.3 percent accepted new patients. Of the provider locations accepting new patients, 31.0 percent and 27.1 percent offered a routine and urgent visit appointment, respectively. For urgent visits, 6.3 percent of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standard.

Recommendation: HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that the MCO request a copy of the analytic flat files from the prenatal care and PCP secret shopper surveys and use the files to provide updates or confirmation to DMAS that the data have been updated as appropriate. Additionally, Optima should review appointment availability and scheduling procedures, including panel capacity to accept new patients, and provide an update to DMAS of its findings. Initiatives focused on improving the accuracy of the provider data may result in improved member access to care visits.

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

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):

- SHP conducts an annual provider Access Survey on appointment availability and after hours care to monitor compliance and understand areas of concern with timely access to care.
- Set up focus groups (using SHP Access Survey data) with approximately 100 non-compliant PCPs to understand scheduling barriers that delay care. These focus groups will help identify opportunities for overcoming barriers and can direct education on timely access to care throughout the network.
- Communicate appointment standards and after hours care via emailed provider alerts, educational webinars, and digital newsletters.
- Educate new and existing providers on appointment standards and after hours care and demonstrate where to find standards, such as the online Doing Business with Sentara Health Plans guide or provider manual.
- Communicated appointment standards and after hours care via provider manuals which are posted on the health plan website.
- Providers are educated on how to update their provider directory status and information which includes if they are accepting new patients.
- SHP will increase monitoring of PCP panel status through a standing report.
- SHP will continue to recruit and contract with available providers.
- There is an indicator in the directory for accepting new patients, that can be used to identify if a provider is accepting new patients

Recommendation—PCP Secret Shopper Survey (Optima)

- Network Management will evaluate the providers in the DMAS file that stated they do not participate in Medicaid, against their executed agreement. If the group/provider does participate with Medicaid (per their agreement), a Network Rep will make outreach and provide education to the provider based on the terms of their agreement. If the contract indicates that the provider is not participating with Medicaid, Network will notify Provider Operations to update our internal systems and remove that group/provider from the Medicaid products. If the provider is contracted for Medicaid but not accepting patients, Network will direct the provider to notify the health plan via our online provider update submission process. Provider Ops will make the necessary updates within our systems which will remove them from the directories.

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

PMV results showed:

Measure: *Getting Care Quickly*

2022: NR – Optima: 86.1% and VA Premier: 82.2%

2023: 83.55%

Identify any barriers to implementing initiatives:

No barriers identified.

HSAG Assessment:



Recommendation—PCP Secret Shopper Survey (Virginia Premier)

Goal (2): Promote Access to Safe, Gold-Standard Patient Care

Objective (2.1): Ensure Access to Care

Measure(s):
2.1.1.1: Getting Care Quickly

Weakness: The results of the 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. 61.5 percent of the routine visit appointments offered were compliant with DMAS' 30-day appointment availability compliance standard. 25.9 percent of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standard.

Recommendation: HSAG provides DMAS with the analytic flat files from the telephone survey. Since VA Premier merged with Optima, HSAG recommends that Optima consider conducting a root cause analysis and providing updates or confirmation that the MCO's merged network data have been updated as appropriate. Additionally, Optima should confirm the merged MCO's appointment availability and scheduling procedures with DMAS, including panel capacity to accept new patients.

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

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—PCP Secret Shopper Survey (Virginia Premier)

- SHP conducts an annual provider Access Survey on appointment availability and after hours care to monitor compliance and understand areas of concern with timely access to care.
- Set up focus groups (using SHP Access Survey data) with approximately 100 non-compliant PCPs to understand scheduling barriers that delay care. These focus groups will help identify opportunities for overcoming barriers and can direct education on timely access to care throughout the network.
- Communicate appointment standards and after hours care via emailed provider alerts, educational webinars, and digital newsletters.
- Educate new and existing providers on appointment standards and after hours care and demonstrate where to find standards, such as the online Doing Business with Sentara Health Plans guide or provider manual.
- Communicated appointment standards and after hours care via provider manuals which are posted on the health plan website.
- Providers are educated on how to update their provider directory status and information which includes if they are accepting new patients.
- SHP will increase monitoring of PCP panel status through a standing report.
- SHP will continue to recruit and contract with available providers.
- There is an indicator in the directory for accepting new patients, that can be used to identify if a provider is accepting new patients
- Network Management will evaluate the providers in the DMAS file that stated they do not participate in Medicaid, against their executed agreement. If the group/provider does participate with Medicaid (per their agreement), a Network Rep will need to make outreach and provide education to the provider based on the terms of their agreement. If the contract indicates that the provider is not participating with Medicaid, Network will notify Provider Operations to update our internal systems and remove that group/provider from the Medicaid products. If the provider is contracted for Medicaid but not accepting patients, Network will need to direct the provider to notify the health plan via our online provider update submission process. Provider Ops will make the necessary updates within our systems which will remove them from the directories.

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

PMV results showed:

Measure: *Getting Care Quickly*

2022: NR – Optima: 86.1% and VA Premier: 82.2%

2023: 83.55%

Identify any barriers to implementing initiatives:

No barriers identified.

HSAG Assessment:



Recommendation—Member Experience of Care Survey (Adult) (Optima)

Goal (1): Enhance the Member Care Experience

Objective (1.1): Improve Member Satisfaction

Measure(s):
1.2.1.1: Rating of Health Plan

Recommendation—Member Experience of Care Survey (Adult) (Optima)		
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.		
Recommendation: HSAG recommends that Optima monitor the measures to ensure significant decreases in scores over time do not occur.		
MCO’s Response		
Why the weakness exists: The MCO did not describe why the weakness exists.		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): - The Quality Satisfaction Committee (QSC) was re-established to ensure timely fielding of surveys and interventions are implemented - Members receive reminders via social media, mail, & voice recordings to complete survey		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: <i>Rating of Health Plan</i> 2022: 72.50% 2023: 78.13%		
Identify any barriers to implementing initiatives: No barriers identified		
HSAG Assessment: 		
Recommendation—Member Experience of Care Survey (Adult) (Virginia Premier)		
Goal (1): Enhance the Member Care Experience	Objective (1.1): Improve Member Satisfaction	Measure(s): 1.2.1.1: Rating of Health Plan
Weakness: VA Premier’s 2023 top-box score was statistically significantly lower than the 2022 top-box score for one measure, <i>Rating of Health Plan</i> .		
Recommendation: HSAG encourages the merged Optima MCO to review the VA Premier results and implement actions to address member experience issues, as appropriate.		
MCO’s Response		
Why the weakness exists: The MCO did not describe why the weakness exists.		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): - The Quality Satisfaction Committee (QSC) was re-established to ensure timely fielding of surveys and interventions are implemented - Members receive reminders via social media, mail, & voice recordings to complete survey		

Recommendation—Member Experience of Care Survey (Adult) (Virginia Premier)

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

PMV results showed:

Measure: *Rating of Health Plan*

2022: 77.73%

2023: 78.13%

Identify any barriers to implementing initiatives:

No barriers identified

HSAG Assessment:



Recommendation—Member Experience of Care Survey (Child) (Optima)

Goal (1): Enhance the Member Care Experience

Objective (1.1): Improve Member Satisfaction

Measure(s):
1.2.1.1: Rating of Health Plan

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.

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

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- The Quality Satisfaction Committee (QSC) was re-established to ensure timely fielding of surveys and interventions are implemented
- Members receive reminders via social media, mail, & voice recordings to complete survey

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

PMV results showed:

Measure: *Rating of Health Plan*

2022: 72.50%

2023: 83.44%

Identify any barriers to implementing initiatives:

No barriers identified

HSAG Assessment:



Recommendation—Member Experience of Care Survey (Child) (Virginia Premier)		
Goal (1): Enhance the Member Care Experience	Objective (1.1): Improve Member Satisfaction	Measure(s): 1.2.1.1: Rating of Health Plan
Weakness: VA Premier's 2023 top-box scores were not statistically significantly lower than the 2022 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no weaknesses were identified		
Recommendation: HSAG encourages the merged Optima MCO to review the VA Premier results and implement actions to address member experience issues, as appropriate.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists.		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): - The Quality Satisfaction Committee (QSC) was re-established to ensure timely fielding of surveys and interventions are implemented - Members receive reminders via social media, mail, & voice recordings to complete survey		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: <i>Rating of Health Plan</i> 2022: 91.84% 2023: 83.44%		
Identify any barriers to implementing initiatives: - Virginia Premier's merger with Optima Health - Member participation much lower compared to previous surveys		
HSAG Assessment: 		

Cardinal Care MLTSS

Recommendation—Performance Measure Validation (Optima)		
Goal (3): Support Efficient and Value-Driven Care	Objective (3.1): Focus on Paying for Value	Measure(s): 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: <i>Ambulatory Care—ED Visits—Total</i>		

Recommendation—Performance Measure Validation (Optima)

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.

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

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):

- Legacy 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

2022: 1063.44

2023: 3836.51

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)

Recommendation—Performance Measure Validation (Optima)

HSAG Assessment:



Recommendation—Performance Measure Validation (Optima)

Goal (2): Promote Access to Safe, Gold-Standard Patient Care

Objective (2.1): Ensure Access to Care

Measure(s):
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, 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.

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

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
- Incentive provided to member for completing gap in care and obtaining preventative care
- Partnership ongoing with Network Education to distribute patient Gap Reports
- 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.

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

PMV results showed:

Measure: *Breast Cancer Screening*

2022: 44.76%

2023: 46.06%

Identify any barriers to implementing initiatives:

Timely access to Primary Care Provider (PCP)

HSAG Assessment:

Recommendation—Performance Measure Validation (Optima)



Recommendation—Performance Measure Validation (Optima)

Goal (2): Promote Access to Safe, Gold-Standard Patient Care

Objective (2.1): Ensure Access to Care

Measure(s):
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, 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.

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

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.

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

Measure: *Cervical Cancer Screening*

2022: 45.74%

2023: 48.42%

Identify any barriers to implementing initiatives:

Timely access to Primary Care Provider (PCP)

HSAG Assessment:



Recommendation—Performance Measure Validation (Optima)		
Goal (4): Strengthen the Health of Families and Communities	Objective (4.2): Improve Outcomes for Maternal and Infant Members	Measure(s): 4.2.1.1, 4.2.1.2: <i>Prenatal and Postpartum Care - Timeliness of Prenatal Care and Postpartum Care</i>
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: <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care</i>		
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.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists.		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): - Prenatal Visit Incentive Program - Postpartum Visit Incentive Program - Healthy Pregnancy mailing, self-care guide and parenting magazine subscription - Healthy Pregnancy mailing at 20 weeks gestation, dealing with stress while pregnant, and a preterm labor card - Healthy Pregnancy mailing at 7 months including a letter, dealing with stress flyer, and early labor signs card - Healthy Pregnancy mailing at 38 weeks gestation, dealing with postpartum depression, and an immunization with checkups magnet - Regional Baby Showers are conducted virtually which allows more members to participate. Educational materials are disseminated to the members on the importance of prenatal/post-partum health. - Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement - Member Outreach Calls - EMMI Manager utilization for educational videos		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: <i>Timeliness of Prenatal Care</i> 2022: 64.14% 2023: 66.18% Measure: <i>Postpartum Care</i> 2022: 53.03% 2023: 71.05%		

Recommendation—Performance Measure Validation (Optima)

Identify any barriers to implementing initiatives:

- Implementation of Telehealth visits and expanded telehealth codes not being captured for prenatal and postpartum visits
- Lack of awareness and knowledge of available preventive and maternal care services under the Affordable Care Act
- Social and economic barriers persist despite implementation of the Health Care Reform
- Untimely identification of the pregnancy and lack of understanding of the importance of prenatal and postpartum care
- Coding discrepancies with the Bundled coding in Inovalon not capturing all prenatal visits in data pull

HSAG Assessment:



Recommendation—Performance Measure Validation (Optima)

Goal (5): Providing Whole-Person Care for Vulnerable Populations

Objective (5.1): Improve Outcomes for Members with Chronic Conditions

Measure(s):
5.4.1: *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia—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 Optima:

- *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia—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.

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

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:

Measure: *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia—Total*

Recommendation—Performance Measure Validation (Optima)		
2022: 60.87%		
2023: 77.54%		
Identify any barriers to implementing initiatives:		
No barrier Identified; measure improved.		
HSAG Assessment:		
		
Recommendation—Performance Measure Validation (Optima)		
Goal (5): Providing Whole-Person Care for Vulnerable Populations	Objective (5.1): Improve Outcomes for members with Chronic Conditions	Measure(s): 5.1.1.4: <i>Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)</i>
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:		
<i>Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control (>9.0%)</i>		
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.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists.		
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):		
- EMMI Manager utilization for educational videos - HEDIS Blitz 4th QTR Push CM member outreach - Working with Retina Labs Vendor - Population Care Outreach efforts - Care Management Outreach efforts - Incentive Program for members w/Diabetes		
Identify any noted performance improvement as a result of initiatives implemented (if applicable):		
PMV results showed:		
Measure: <i>Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control (>9.0%)</i>		
2022: 52.31%		
2023: 40.39%		
Identify any barriers to implementing initiatives:		
No barrier Identified; measure improved. Inverted measure rate is supposed to be lower		

Recommendation—Performance Measure Validation (Optima)

HSAG Assessment:



Recommendation—Performance Measure Validation (Optima)

Goal (4): Strengthen the Health of Families and Communities	Objective (4.1): Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	Measure(s): 4.1.1.4: <i>Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)</i>

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 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, 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.

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

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):

- 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
- 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.
- 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.

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

PMV results showed:

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

2022: 29.97%

2023: 34.06%

Recommendation—Performance Measure Validation (Optima)

Identify any barriers to implementing initiatives:

No barrier Identified; measure improved.

HSAG Assessment:



Recommendation—Performance Measure Validation (Optima)

Goal (5): Providing Whole-Person Care for Vulnerable Populations

Objective (5.1): Improve Outcomes for Members with Chronic Conditions

Measure(s):
5.1.1.3 PQI 05: COPD and Asthma in Older Adults' Admission 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:

- *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, 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.

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

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):

- Member education on importance of taking prescribed medication

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

PMV results showed:

Measure: *Bronchodilator*

2022: 67.60%

2023: 67.16%

Measure: *Systemic Corticosteroid*

2022: 56.84%

2023: 60.28%

Identify any barriers to implementing initiatives:

- 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 (Optima)



Recommendation—Performance Measure Validation (Optima)

Goal (5): Providing Whole-Person Care for Vulnerable Populations	Objective (5.4): Improve Behavioral Health and Developmental Services for Members	Measure(s): 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: <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total</i>		
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.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists.		
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: <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i> 2022: 36.25% 2023: 61.94%		
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 (Optima)		
		
Recommendation—Performance Measure Validation (Optima)		
Goal (5): Providing Whole-Person Care for Vulnerable Populations	Objective (5.1): Improve Outcomes for Members with Chronic Conditions	Measure(s): Not a Quality Strategy Measure: Use of Imaging Studies for Low Back Pain
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: <i>Use of Imaging Studies for Low Back Pain</i>		
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.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists.		
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: <i>Use of Imaging Studies for Low Back Pain</i> 2022: 67.28% 2023: 67.26%		
Identify any barriers to implementing initiatives: No Barriers Identified.		
HSAG Assessment:		

Recommendation—Performance Measure Validation (Optima)



Recommendation—Performance Measure Validation (Optima)

Goal (5): Providing Whole-Person Care for Vulnerable Populations	Objective (5.3): Improve Outcomes for Members with Substance Use Disorders	Measure(s): <i>Not a Quality Strategy Measure: Use of Opioids from Multiple Providers—Multiple Prescribers</i>

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, 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.

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

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:

Measure: *Use of Opioids from Multiple Providers—Multiple Prescribers*

2022: 25.63%

2023: 18.64%

Identify any barriers to implementing initiatives:

No barriers identified member use decreased.

HSAG Assessment:



Recommendation—Performance Measure Validation (Optima)		
Goal (4): Strengthen the Health of Families and Communities	Objective (4.1): Improve Utilization of Wellness, Immunization, and Prevention Services for Members	Measure(s): 4.2.1.4: Well-Child Visits in the First 30 Months of Life—Age 15 to 30 Months
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: <i>Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>		
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.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists.		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): - Childhood Incentive Program - 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.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: <i>Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i> 2022: 57.78% 2023: 67.33%		
Identify any barriers to implementing initiatives: No barriers identified. Measure improved		
HSAG Assessment: 		

Recommendation—Performance Measure Validation (Optima)		
Goal: (4) Strengthen the Health of Families and Communities	Objective (4.1): Improve Utilization of Wellness, Immunization, and Prevention Services for Members	Measure(s): 4.1.1.9: <i>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</i>
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: <i>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</i>		
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.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists.		
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.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total</i> 2022: 63.75% 2023: 72.02% Measure: <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Nutrition—Total</i> 2022: 52.55% 2023: 61.07% Measure 4.1.1.9: <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Physical Activity—Total</i>		

Recommendation—Performance Measure Validation (Optima)
2022: 42.58% 2023: 55.96%
Identify any barriers to implementing initiatives: No Barrier Identified
HSAG Assessment: 

United

Cardinal Care Acute

Table E-9—Prior Year Recommendations and Responses Cardinal Care Acute—United

Recommendation—Performance Measure Validation		
Goal 2: Promote Access to Safe, Gold Standard Patient Care Goal 4: Strengthen the Health of Families and Communities Goal 5: Providing Whole Person Care for Vulnerable Populations	Objective 2.1: Ensure Access to Care Objective 4.1: Improve Utilization of Wellness, immunization, and Prevention Services for Members Objective 5.1: Improve Health for Members with Chronic Conditions Objective 5.4 Improve Behavioral Health and Developmental Services for Members	Measure(s): 2.1.1.6: Cervical Cancer Screening 2.1.1.9: Breast Cancer Screening 4.1.1.1: Adults' Access to Preventive/Ambulatory Health Services Not a Quality Strategy Measure: Comprehensive Diabetes Care: Eye Exam for Patients with Diabetes 5.4.1.1: Follow-Up After Hospitalization for Mental Illness —7-Day Follow-Up
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: • <i>Adult's Access to Preventive/Ambulatory Health Services—Total</i> • <i>Breast Cancer Screening</i> • <i>Cervical Cancer Screening</i> • <i>Eye Exam for Patients With Diabetes—Total</i> • <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total</i>		
Recommendations: HSAG recommends that United conduct a root cause analysis or focus study for these PMs within the Access to Care, Care for Chronic Conditions, and Women's Health domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that United consider whether there are disparities within the MCO's		

Recommendation—Performance Measure Validation
populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
MCO's Response
Why the weakness exists: The MCO did not describe why the weakness exists.
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. UHC continues to evaluate data and identify areas of opportunity and strategies to address health care gaps. UHC received the following strengths related to quality on the 2023 EQR Technical Report: - United's performance within the Behavioral Health domain identified four PM indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile. Existing interventions continued: - We conduct risk scoring and uses other algorithms to identify and stratify members with chronic conditions, short-term care needs, long-term care needs or social supports. These members are subsequently connected with enhanced care coordination and outreach activities. - Emails, call campaigns and monthly letter reminders to members. - Continued partnership with clinics, health systems and other community partners for member care and support of community events. New interventions implemented: - Launched Population Health Dashboard to provide case managers and providers the ability to monitor and track clinical quality measures and assist members in "real-time" to close gaps in care. Transportation is arranged as needed as well as assistance in scheduling in-home & telehealth visits. - Increased member incentives for completing cervical cancer screenings, diabetic eye exams, and follow-up after hospitalization for mental illness. - Increased PCP and BH provider education on BH measures and timeframe requirements. - Implemented case management focus on prompt member follow-up after hospitalization for member illness. CMs contact members to confirm appointment is scheduled and arrange transportation as needed. - Increased provider education & engagement and enhanced provider incentives in CP-PCPi program to close opportunities specific to above measures. UHC educates providers in HEDIS specifications, providing up-to-date data of members experiencing gaps in care. Program measures were further aligned with state priority performance measures and the 2023-2025 Quality Strategy which include measures for maternal care, chronic care, preventive care. UHC CPCs collaborate with providers and community entities to promote health fairs, clinic days, and other preventative care events to close gaps in care. - Providers participating in CP-PCPi program were provided the opportunity to earn bonuses for completing AAP visits in Q2 2023. - Increased provider education of plan benefits and enhanced benefits for members. - Provided additional education around CPT codes and quality measures through uhcprovider.com.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed:

Recommendation—Performance Measure Validation

Measure: *Adult's Access to Preventive/Ambulatory Health Services—Total*

2022: 66.67%

2023: 66.62%

Measure: *Breast Cancer Screening*

2022: 46.46%

2023: 46.89%

Measure: *Cervical Cancer Screening*

2022: 46.47%

2023: 45.50%

Measure: *Eye Exam for Patients With Diabetes—Total*

2022: 44.53%

2023: 53.77%

Measure: *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*

2022: 36.59%

2023: 36.81%

Identify any barriers to implementing initiatives:

- PCP referrals for eye exams to ophthalmologist or optometrist at times resulted in unscheduled appointments and/or PCP obtaining results.
- Ensuring consistent practitioner appointment availability to schedule prompt follow-up after hospitalization for mental illness.
- Member and caregiver awareness of importance of preventative and follow-up care.
- Member awareness of transportation benefit to and from appointments.

HSAG Assessment:



Recommendation—PNC Secret Shopper Survey

Goal 2: Promote Access to Safe, Gold-Standard Patient Care

Goal 4: Strengthen the Health of Families and Communities

Objective 2.1: Ensure Access to care

Objective 4.2: Improve Outcomes for Maternal and Infant Members

Measure(s):

2.1.1.1: Getting Care Quickly

2.1.1.3: Getting Needed Care

4.2.1.2: Prenatal and Postpartum Care: Timeliness of Prenatal Care

Weakness: The results of the prenatal care secret shopper survey results identified that Of the 366 provider locations surveyed, 35.2 percent could not be reached. Of the cases reached, 26.5 percent did not offer prenatal care services, 40.5 percent accepted United, 32.5 percent accepted VA Medicaid, and 30.8 percent accepted new patients. Of the cases that were accepting new patients, 48.0 percent offered a first trimester appointment, 13.6 percent offered a second trimester appointment, and 15.4 percent offered a third trimester appointment. For cases that were offered a first trimester appointment, 16.7 percent were compliant with the seven-calendar-day standard. None of the second or third trimester appointments were compliant with DMAS' wait time standards of seven calendar days and three business days.

Recommendation—PNC Secret Shopper Survey

Recommendation: HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that the MCO request a copy of the analytic flat files from the prenatal care secret shopper survey and use the files to provide updates or confirmation to DMAS that the data have been updated as appropriate. Additionally, United should review appointment availability and scheduling procedures, including panel capacity to accept new patients, and provide an update to DMAS of its findings. Initiatives focused on improving the accuracy of the provider data may result in improved member access to care.

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

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):

- Internal quality reviews are additionally conducted via phone call campaigns to practitioner offices (Secret Shopper), defects from which an additional outreach validation is prompted to determine if system updates and/or corrective actions should be taken in UHC source systems; if so, updates are made to the applicable elements or practitioners are removed from directory display.
- Data remediation included demographic changes such as address changes, phone number, accepting patient status, and terminations. Provider demographic information is compared against USPS standardization rules to ensure accuracy.
- Additionally, multiple intake channels were created with the intent of allowing practitioners an opportunity to validate, or attest, to the demographic data on file with UHC every 90 days. Providers may also be contacted via phone or email to validate demographic data. Attestation data is tracked across all channels within an internal database and is archived for physician and facility.
- Revisions were made to provider manual regarding appointment requirements.
- Outreach and education continue to be provided to providers on scheduling best practices and how to improve access to routine/urgent care. We have fostered strong relationships with our providers via regular communications and collaboration and have addressed network adequacy concerns by communicating requirements such as those for after-hours availability.
- CP-HEPi: New physician incentive program to address maternity measures. This program offers CP-PCPi providers the opportunity to earn bonuses for helping to reduce health inequities endured by UHC Community Plan members based on racial, ethnic, or gender identity by increasing member engagement in their preventive health care.
- Our Population Health Dashboard provides case managers and providers the ability to monitor and track clinical quality measures and assist members in “real-time” to close gaps in care.

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

PMV results showed:

Measure: Getting Care Quickly

2022: 80.6%

2023: 82.9%

Measure: Getting Needed Care

2022: 76.8%

2023: 80.2%

Recommendation—PNC Secret Shopper Survey

Measure: Prenatal and Postpartum Care: Timeliness of Prenatal Care

2022: 80.54%

2023: 87.83%

Identify any barriers to implementing initiatives:

- Member awareness to alternatives of urgent care.
- Ensuring consistent practitioner appointment availability.
- Member and caregiver awareness of importance of preventative and follow-up care.
- Member awareness of transportation benefit to and from appointments.

HSAG Assessment:



Recommendation—PCP Secret Shopper Survey

Goal 2: Promote Access to Safe, Gold-Standard Patient Care

Objective 2.1: Ensure Access to care

Measure(s):

2.1.1.1: Getting Care Quickly

2.1.1.3: Getting Needed Care

Weakness: The results of the PCP secret shopper survey results identified that of the 455 provider locations surveyed, 33.8 percent could not be reached. Of the cases reached, 31.4 percent did not offer primary care services, 44.5 percent accepted United, 40.5 percent accepted VA Medicaid, and 34.2 percent accepted new patients. 12.5 percent of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standard.

Recommendation: HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG also recommends that the MCO request a copy of the analytic flat files from the PCP secret shopper survey and use the files to provide updates or confirmation to DMAS that the data have been updated as appropriate. Additionally, United should review appointment availability and scheduling procedures, including panel capacity to accept new patients, and provide an update to DMAS of its findings. Initiatives focused on improving the accuracy of the provider data may result in improved member access to screenings and preventive and chronic condition care.

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

UHC continues to evaluate data and identify areas of opportunity and strategies to address health care gaps. UHC received the following strengths related to quality on the 2023 EQR Technical Report:

- For the CAHPS survey, United's 2023 top-box score was statistically significantly higher than the 2022 top-box score and NCQA adult Medicaid national average for one measure, *Rating of Health Plan*. UHC is reviewing the initiatives that contributed to the positive score for this rating.
- Within the Children's Preventive Care domain, United displayed strong performance for the *Child and Adolescent Well-Care Visits—Total PM* indicator, with the MCO's rate exceeding NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile. These results indicate that

Recommendation—PCP Secret Shopper Survey

United network providers are providing care to children according to the EPSDT and Bright Futures schedules.

UHC conducted root cause analysis and focus studies. The following initiatives were implemented:

- Internal quality reviews are additionally conducted via phone call campaigns to practitioner offices (Secret Shopper), defects from which an additional outreach validation is prompted to determine if system updates and/or corrective actions should be taken in UHC source systems; if so, updates are made to the applicable elements or practitioners are removed from directory display.
- Data remediation included demographic changes such as address changes, phone number, accepting patient status, and terminations. Provider demographic information is compared against USPS standardization rules to ensure accuracy.
- Additionally, multiple intake channels were created with the intent of allowing practitioners an opportunity to validate, or attest, to the demographic data on file with UHC every 90 days. Providers may also be contacted via phone or email to validate demographic data. Attestation data is tracked across all channels within an internal database and is archived for physician and facility.
- Revisions were made to provider manual regarding appointment requirements.
- Outreach and education continue to be provided to providers on scheduling best practices and how to improve access to routine/urgent care. We have fostered strong relationships with our providers via regular communications and collaboration and have addressed network adequacy concerns by communicating requirements such as those for after-hours availability.
- Our Population Health Dashboard provides case managers and providers the ability to monitor and track clinical quality measures and assist members in “real-time” to close gaps in care.
- We educate our providers in HEDIS specifications, providing up-to-date data of members experiencing gaps in care. UHC CPCs collaborate with providers and community entities to promote health fairs, clinic days, and other preventative care events to close gaps in care.
- UHC continues to monitor measures to evaluate areas of opportunity and strategies to provide continuous improvement.

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

PMV results showed:

Measure: Getting Care Quickly (Adult)

2022: 80.6%

2023: 82.9%

Measure: Getting Care Quickly (Child)

2022: 76.1%

2023: 81.5%

Measure: Getting Needed Care (Adult)

2022: 76.8%

2023: 80.2%

Measure: Getting Needed Care (Child)

2022: 74.5%

2023: 79.8%

Identify any barriers to implementing initiatives:

- Member awareness to alternatives of urgent care.

Recommendation—PCP Secret Shopper Survey		
- Ensuring consistent practitioner appointment availability. - Member and caregiver awareness of importance of preventative and follow-up care. - Member awareness of transportation benefit to and from appointments.		
HSAG Assessment: 		
Recommendation—Member Experience of Care Survey (Adult)		
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 Objective 2.3: Promote Effective Communication and Care Coordination	Measure(s): 1.2.1.2: Rating of Personal Doctor 2.1.1.1: Getting Care Quickly
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.		
Recommendation: HSAG recommends that United continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists.		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): - UHC continues to monitor measures to evaluate areas of opportunity and strategies to provide continuous improvement and ensure there are no significant decrease in rates over time. We evaluate data and identify strategies for barrier removal as part of United's ongoing processes. - UHC regularly assesses the accuracy of marketing materials and how well new members understand their benefits, services, and materials upon enrollment, and uses commonly used medical and insurance terms in easy-to-understand language available in multiple languages. These materials enhance communication between health care professionals and members, while also facilitating member's ability to make informed healthcare decisions.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: Rating of Personal Doctor 2022: 81.1% 2023: 83.0% Measure: Getting Care Quickly 2022: 80.6% 2023: 82.9%		

Recommendation—Member Experience of Care Survey (Adult)

Identify any barriers to implementing initiatives:

UHC did not identify any barriers to implementing initiatives.

HSAG Assessment:



Recommendation—Member Experience of Care Survey (Child)

Goal 1: Enhance the Member Care Experience

Objective 1.2: Improve Member Satisfaction

Measure(s):

1.2.1.2: Rating of Personal Doctor

Weakness: United's 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for *Rating of Personal Doctor*.

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

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

UHC continues to evaluate data and identify areas of opportunity and strategies to address health care gaps. UHC received the following strengths related to quality on the 2023 EQR Technical Report:

- For the CAHPS survey, United's 2023 top-box score was statistically significantly higher than the 2022 top-box score and NCQA adult Medicaid national average for one measure, *Rating of Health Plan*. UHC is reviewing the initiatives that contributed to the positive score for this rating for the adult Member Experience Survey.
- Within the Children's Preventive Care domain, United displayed strong performance for the *Child and Adolescent Well-Care Visits—Total PM* indicator, with the MCO's rate exceeding NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile. These results indicate that United network providers are providing care to children according to the EPSDT and Bright Futures schedules.

UHC conducted root cause analysis to investigate process deficiencies, identify causes, and potential improvement strategies. The following activities remain active:

- Analyzed results and monitored trends in CAHPS and care management surveys.
- Increased awareness and communications within all areas of the health plan on CAHPS and increased engagement of contributors in our QI activities.
- Outreach and education continue to be provided to providers on scheduling best practices and how to improve access to routine/urgent care. We have fostered strong relationships with our providers via regular communications and collaboration.

Recommendation—Member Experience of Care Survey (Child)		
- UHC educates providers in HEDIS specifications, providing up-to-date data of members experiencing gaps in care. UHC CPCs collaborate with providers and community entities to promote health fairs, clinic days, and other preventative care events to close gaps in care. - UHC continues to monitor measures to evaluate areas of opportunity and strategies to provide continuous improvement and ensure there are no significant decrease in rates over time. We evaluate data and identify strategies for barrier removal as part of our ongoing processes.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Measure: <i>Rating of Personal Doctor</i> 2022: 76.8% 2023: 80.2%		
Identify any barriers to implementing initiatives: - Ensuring consistent practitioner appointment availability. - Member awareness of transportation benefit to and from appointments.		
HSAG Assessment: 		
Recommendation—Member Experience of Care Survey (Child)		
Goal 1: Enhance the Member Care Experience	Objective 1.2: Improve Member Satisfaction	Measure(s): Not a Quality Strategy Measure: Rating of Specialist Seen Most Often
Weakness: United's 2023 top-box score was statistically significantly lower than the 2022 top-box score and the 2022 NCQA child Medicaid national average for <i>Rating of Specialist Seen Most Often</i> .		
Recommendation: HSAG recommends that United conduct root cause analyses of the study indicators that have been identified as areas of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG recommends that United continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists.		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): UHC continues to evaluate data and identify areas of opportunity and strategies to address health care gaps. UHC received the following strengths related to quality on the 2023 EQRO Technical Report: - For the CAHPS survey, United's 2023 top-box score was statistically significantly higher than the 2022 top-box score and NCQA adult Medicaid national average for one measure, <i>Rating of Health Plan</i>. UHC is reviewing the initiatives that contributed to the positive score for this rating for the adult Member Experience Survey. - Within the Children's Preventive Care domain, United displayed strong performance for the <i>Child and Adolescent Well-Care Visits—Total PM</i> indicator, with the MCO's rate exceeding NCQA's		

Recommendation—Member Experience of Care Survey (Child)

Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile. These results indicate that United network providers are providing care to children according to the EPSDT and Bright Futures schedules.

UHC conducted root cause analysis to investigate process deficiencies, identify causes, and potential improvement strategies. The following activities remain active:

- Analyzed results and monitored trends in CAHPS and care management surveys.
- Increased awareness and communications within all areas of the health plan on CAHPS and increased engagement of contributors in our QI activities.
- Outreach and education continue to be provided to providers on scheduling best practices and how to improve access to routine/urgent care. We have fostered strong relationships with our providers via regular communications and collaboration.
- UHC educates providers in HEDIS specifications, providing up-to-date data of members experiencing gaps in care. UHC CPCs collaborate with providers and community entities to promote health fairs, clinic days, and other preventative care events to close gaps in care.
- UHC continues to monitor measures to evaluate areas of opportunity and strategies to provide continuous improvement and ensure there are no significant decrease in rates over time. We evaluate data and identify strategies for barrier removal as part of our ongoing processes.

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

PMV results showed:

Measure: *Rating of Specialist Seen Most Often*

2022: 67.9%

2023: 69.05%

Identify any barriers to implementing initiatives:

- Ensuring consistent practitioner appointment availability.
- Member awareness of transportation benefit to and from appointments.

HSAG Assessment:



Cardinal Care MLTSS

Recommendation—Performance Measure Validation

Goal 2: Promote Access to Safe, Gold-Standard Patient Care

Goal 3: Support Efficient and Value-Driven Care

Goal 4: Strengthen the Health of Families and Communities

Goal 5: Providing Whole-Person Care for Vulnerable Populations

Objective 2.1: Ensure Access to Care

Objective 3.1: Focus on Paying for Value

Objective 4.1: Improve the Utilization of Wellness, Immunization, and Prevention Services for Members

Objective 4.2: Improve Outcomes for Maternal and Infant Members

Measure(s):

2.1.1.6: Cervical Cancer Screening

2.1.1.12: Avoidance of Antibiotic Treatment for Acute

Bronchitis/Bronchiolitis: Age 18 and Older

3.1.1.4: Ambulatory Care

4.1.1.3: Childhood Immunization Status

4.1.1.4: Immunizations for Adolescents

4.2.1.1: Prenatal and Postpartum Care: Postpartum Care

Recommendation—Performance Measure Validation		
	Objective 5.1: Improve Outcomes for Members with Chronic Conditions Objective 5.4: Improve Behavioral Health and Developmental Services for Members	4.2.1.2: Prenatal and Postpartum Care: Timeliness of Prenatal Care 5.1.1.6: Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years 5.4.1.1: Follow-Up After Hospitalization for Mental Illness
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: <i>Ambulatory Care—ED Visits—Total</i> <i>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total</i> <i>Cervical Cancer Screening</i> <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care</i> <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total</i> <i>Use of Imaging Studies for Low Back Pain</i> <i>Child and Adolescent Well-Care Visits—Total</i> <i>Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)</i> <i>Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies</i>		
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.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists.		
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. UHC continues to evaluate data and identify areas of opportunity and strategies to address health care gaps. UHC received the following strengths related to quality on the 2023 EQR Technical Report: - 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'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. - 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.		

Recommendation—Performance Measure Validation

Existing Interventions continued:

- We conduct risk scoring and uses other algorithms to identify and stratify members with chronic conditions, short-term care needs, long-term care needs or social supports. These members are subsequently connected with enhanced care coordination and outreach activities.
- Emails, call campaigns and monthly letter reminders to members.
- Continued partnership with clinics, health systems and other community partners for member care and support of community events.
- Follow up After Discharge PIP: Educating members about the importance of engaging in a 30-day post-discharge follow-up visit with a PCP or specialist. UHC case managers assist with scheduling appointments as needed.
- Timeliness of Prenatal Care PIP: Identifies healthy pregnant members with no prenatal care upon health plan enrollment. Prompt case management telephonic outreach is conducted to engage and assist members to complete prenatal care visits at recommended intervals.
- Tobacco Cessation in Pregnant Women PIP: In alignment with DMAS' Quality Strategy's goal to prevent nicotine dependency, we identified a successful method to target and increase cessation support for members who are pregnant and smoke, thereby reducing the baby's risk for certain adverse outcomes
- WCV Intervention: Focus on members with the greatest language disparity on the importance of a Well Care Visit, through virtual education and incentives.

New Interventions implemented:

- Launched Population Health Dashboard to provide case managers and providers the ability to monitor and track clinical quality measures and assist members in "real-time" to close gaps in care. Transportation is arranged as needed as well as assistance in scheduling in-home & telehealth visits.
- Implemented case management focus on prompt member follow-up after hospitalization for member illness. CMs contact members to confirm appointment is scheduled and arrange transportation as needed.
- Increased member incentives and awareness to members for completing cervical cancer screenings, well child visits, prenatal and postpartum care, and child and adolescent immunizations.
- Increased provider education & engagement and enhanced provider incentives in CP-PCPi program to close opportunities specific to above measures. UHC educates providers in HEDIS specifications, providing up-to-date data of members experiencing gaps in care. Program measures were further aligned with state priority performance measures and the 2023-2025 Quality Strategy which include measures for maternal care, chronic care, preventive care. UHC CPCs collaborate with providers and community entities to promote health fairs, clinic days, and other preventative care events to close gaps in care.
- Providers participating in CP-PCPi program were provided the opportunity to earn bonuses for completing AAP visits in Q2 2023.
- Increased PCP and BH provider education on BH measures and timeframe requirements, use of OBRAF forms for pregnant members, CPT codes and antibiotic stewardship.
- Increased provider education of plan benefits and enhanced benefits for members.
- Additional provider education provided through uhcprovider.com.

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

PMV results showed:

Measure: *Ambulatory Care—ED Visits—Total*

2022: 1152.54

2023: 1159.25

Recommendation—Performance Measure Validation

Measure: *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*

2022: 30.42%

2023: 37.59%

Measure: *Cervical Cancer Screening*

2022: 45.50%

2023: 42.34%

Measure: *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

2022: 68.57%

2023: 71.95%

Measure: *Prenatal and Postpartum Care—Postpartum Care*

2022: 67.14%

2023: 68.29%

Measure: *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*

2022: 36.39%

2023: 33.93%

Measure: *Use of Imaging Studies for Low Back Pain*

2022: 67.19%

2023: 69.13%

Measure: *Child and Adolescent Well-Care Visits—Total*

2022: 39.30%

2023: 42.74%

Measure: *Immunizations for Adolescents—Combination 1*

2022: 65.18%

2023: 76.15%

Measure: *Immunizations for Adolescents—Combination 2*

2022: 25.89%

2023: 27.52%

Measure: *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies*

2022: 74.4%

2023: 76.7%

Identify any barriers to implementing initiatives:

- Challenges with global billing for OB/GYNs
- Ensuring consistent practitioner appointment availability to schedule prompt follow-up after hospitalization for mental illness.
- Member and caregiver awareness of importance of preventative and follow-up care.
- Member awareness of transportation benefit to and from appointments.

HSAG Assessment:



Recommendation—PCP Secret Shopper Survey		
Goal 1: Enhance the Member Care Experience Goal 2: Promote Access to Safe, Gold-Standard Patient Care Goal 4: Strengthen the Health of Families and Communities	Objective 1.2: Improve Member Satisfaction Objective 2.1: Ensure Access to care Objective 4.1: Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	Measure(s): 1.2.1.1: Rating of all Health Care 2.1.1.1: Getting Care Quickly 2.1.1.3: Getting Needed Care
Weakness: The PCP secret shopper survey results found 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. For urgent visits, 12.5 percent of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standard.		
Recommendation: 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.		
MCO's Response		
Why the weakness exists: The MCO did not describe why the weakness exists.		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): UHC continues to evaluate data and identify areas of opportunity and strategies to address health care gaps. UHC received the following strengths related to quality on the 2023 EQR Technical Report: - 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. - Within the Access and Preventive Care domain, United displayed strong performance for the <i>Adults' Access to Preventive/Ambulatory Health Services—Total</i> PM indicator, which met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile. UHC conducted root cause analysis and focus studies. The following initiatives were implemented: - Internal quality reviews are additionally conducted via phone call campaigns to practitioner offices (Secret Shopper), defects from which an additional outreach validation is prompted to determine if system updates and/or corrective actions should be taken in UHC source systems; if so, updates are made to the applicable elements or practitioners are removed from directory display. - Data remediation included demographic changes such as address changes, phone number, accepting patient status, and terminations. Provider demographic information is compared against USPS standardization rules to ensure accuracy. - Additionally, multiple intake channels were created with the intent of allowing practitioners an opportunity to validate, or attest, to the demographic data on file with UHC every 90 days. Providers may also be contacted via phone or email to validate demographic data. Attestation data is tracked across all channels within an internal database and is archived for physician and facility. - Revisions were made to provider manual regarding appointment requirements.		

Recommendation—PCP Secret Shopper Survey

- Outreach and education continue to be provided to providers on scheduling best practices and how to improve access to routine/urgent care. We have fostered strong relationships with our providers via regular communications and collaboration and have addressed network adequacy concerns by communicating requirements such as those for after-hours availability.
- Our Population Health Dashboard provides case managers and providers the ability to monitor and track clinical quality measures and assist members in “real-time” to close gaps in care.
- We educate our providers in HEDIS specifications, providing up-to-date data of members experiencing gaps in care. UHC CPCs collaborate with providers and community entities to promote health fairs, clinic days, and other preventative care events to close gaps in care.
- UHC continues to monitor measures to evaluate areas of opportunity and strategies to provide continuous improvement.

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

PMV results showed:

Measure: Rating of all Health Care (Adult)

2022: 56.5%

2023: 62.8%

Measure: Rating of all Health Care (Child)

2022: 65.2%

2023: 70.3%

Measure: Getting Care Quickly (Adult)

2022: 81.7%

2023: 81.7%

Measure: Getting Care Quickly (Child)

2022: 85.4%

2023: 87.1%

Measure: Getting Needed Care (Adult)

2022: 81.9%

2023: 84.5%

Identify any barriers to implementing initiatives:

UHC did not identify any barriers to implementing initiatives.

HSAG Assessment:



Recommendation—Member Experience of Care Survey (Adult)

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
Objective 2.3: Promote Effective Communication and Care Coordination

Measure(s):
1.2.1.1: Rating of all Health Care
1.2.1.2: Rating of Personal Doctor
2.1.1.1: Getting Care Quickly
2.3.1.1: How Well Doctors Communicate

Recommendation—Member Experience of Care Survey (Adult)
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.
Recommendation: HSAG recommends that United monitor the measures to ensure significant decreases in scores over time do not occur.
MCO's Response
Why the weakness exists: The MCO did not describe why the weakness exists.
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • UHC continues to evaluate data and identify areas of opportunity and strategies to address health care gaps. UHC received the following strength related to quality on the 2023 EQR Technical Report: 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. • UHC continues to monitor measures to evaluate areas of opportunity and strategies to provide continuous improvement and ensure there are no significant decrease in rates over time. We evaluate data and identify strategies for barrier removal as part of United's ongoing processes. • UHC regularly assesses the accuracy of marketing materials and how well new members understand their benefits, services, and materials upon enrollment, and uses commonly used medical and insurance terms in easy-to-understand language available in multiple languages. These materials enhance communication between health care professionals and members, while also facilitating member's ability to make informed healthcare decisions.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: Rating of all Health Care 2022: 56.5% 2023: 62.8% Measure: Rating of Personal Doctor 2022: 69.7% 2023: 69.8% Measure: Getting Care Quickly 2022: 80.8% 2023: 81.8% Measure: How Well Doctors Communicate 2022: 93.2% 2023: 93.5%
Identify any barriers to implementing initiatives: UHC did not identify any barriers to initiatives.
HSAG Assessment:

Recommendation—Member Experience of Care Survey (Adult)



Recommendation—Member Experience of Care Survey (Child)

Goal 1: Enhance the Member Care Experience Goal 2: Promote Access to Safe, Gold-Standard Patient Care	Objective 1.2: Improve Member Satisfaction Objective 2.3: Promote Effective Communication and Care Coordination	Measure(s): Not a Quality Strategy Measure: Rating of Health Plan 1.2.1.1: Rating of all Health Care 1.2.1.2: Rating of Personal Doctor 2.3.1.1: How Well Doctors Communicate Measure: Customer Service-Treated with courtesy and respect

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.

MCO's Response

Why the weakness exists: The MCO did not describe why the weakness exists.

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- UHC continues to evaluate data and identify root causes and areas of opportunity. UHC received the following strength related to quality on the 2023 EQR Technical Report: 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. UHC is reviewing the initiatives that contributed to the positive score for this rating for the Adult Member Experience Survey.
- UHC continues to monitor measures to evaluate strategies to provide continuous improvement and ensure there are no significant decrease in rates over time. We evaluate data and identify strategies for barrier removal as part of our ongoing processes.
- UHC regularly assesses the accuracy of marketing materials and how well new members understand their benefits, services, and materials upon enrollment, and uses commonly used medical and insurance terms in easy-to-understand language available in multiple languages. These materials enhance communication between health care professionals and members, while also facilitating member's ability to make informed healthcare decisions.

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

PMV results showed:

Measure: *Rating of Health Plan*

2022: 65.0%

2023: 62.5%

Recommendation—Member Experience of Care Survey (Child)

Measure: Rating of all Health Care

2022: 65.2%

2023: 70.3%

Measure: Rating of Personal Doctor

2022: 90.5%

2023: 89.4%

Measure: How Well Doctors Communicate

2022: 91.6%

2023: 92.0%

Measure: Customer Service-Treated with courtesy and respect

2022: 88.9%

2023: 100%

Identify any barriers to implementing initiatives:

UHC did not identify any barriers to implementing initiatives.

HSAG Assessment:



Appendix F. 2023–2025 Quality Strategy Status Assessment

Quality Strategy

In accordance with 42 Code of Federal Regulations (CFR) §438.340, the Virginia Department of Medical Assistance Services (DMAS) implemented a written quality strategy for assessing and improving the quality of healthcare and services furnished by the managed care organizations (MCOs) to Virginia Medicaid members under the 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 2024.

Table F-1—CY 2024 Average Annual Program Enrollment⁹¹

Program	SFY 2024 Enrollment as of 08/01/2024*
Cardinal Care Managed Care Program	1,784,681
Fee-for-Service	237,846
Total Served	2,022,527

**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 and launched the Cardinal Care MLTSS (formerly CCC Plus) and Cardinal Care Acute (formerly Medallion 4.0) programs.

The Cardinal Care program ensures 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 enables DMAS to ensure better continuity of care for members, operate with improved administrative efficiency, and strengthen the focus on the evolving needs of the populations served. The Cardinal Care program continues to offer members the same programs and services and does not reduce or change any existing coverage. The overarching program ensures 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

⁹¹ Department of Medical Assistance Services. Medicaid/FAMIS/PACE Enrollment. Available at: <https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/>. Accessed on: Jan 8, 2025.

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 five MCOs through September 30, 2024. The MCOs contracted with DMAS on December 31, 2024, 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—Cardinal Care MCOs in Virginia

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

Goals and Objectives

The Virginia 2023–2025 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—2024–2025 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
 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:	Objective 5.1: Improve Outcomes for Members with Chronic Conditions
	Objective 5.2: Improve Outcomes for Nursing Home Eligible Members

Goals	Objectives
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 ★

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 HEDIS 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®)⁹² 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.

⁹² CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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Progress

Progress was made Quality Strategy Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4: Improve Behavioral Health and Developmental Services for Members. Behavioral health performance measure validation was a strength for DMAS and the MCOs. DMAS focused significant effort and resources on advancing improvement in behavioral health care and outcomes such as through the implementation of the ARTS benefit. Results of performance measure validation demonstrated that all five MCOs' rates met or exceeded the 50th percentile for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Total*, both indicators for *Initiation and Engagement of Substance Use Disorder Treatment* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* PM indicators.

The MCOs also demonstrated progress in Quality Strategy Goal 4: Strengthen the Health of Families and Communities with four of the five MCOs' rates meeting or exceeding the 75th percentile for the *Immunization for Adolescents—Combination 1 (Meningococcal; Tdap)* PM indicator. In addition to preventive care, the MCOs also showed strength in the *Asthma Medication Ratio—Total* PM indicator with all five MCOs all five MCOs' rates meeting or exceeding the 50th percentile. In addition, three of the five MCOs' rates exceeded the statewide average for the *Breast Cancer Screening—Total* PM indicator in the women's health domain.

DMAS selected four PIP topic areas for validation including Ensuring Timeliness of Prenatal Visits; Tobacco Use Cessation in Pregnant Women; Ambulatory Care – Emergency Department Visits; and Transitions of Care – Patient Engagement After Inpatient Discharge. Progress in performance improvement project processes also was made. Three of the five MCOs demonstrated strength in implementing performance improvement process and received 100 percent validation scores across all evaluation elements for Steps 1 through 8 and were assigned a *High Confidence* level for all PIPs. These MCOs calculated and reported Remeasurement 1 data accurately, implemented targeted interventions that addressed the identified barriers, and developed sound methodologies for evaluating the effectiveness for each intervention.

The MCOs demonstrated progress in encounter data processes for both the Cardinal Care Acute and the Cardinal Care MLTSS programs. At least three MCOs were at or below five percent record omission and surplus rates when validated for professional record completeness and at least one MCO for institutional encounters indicating that the professional and institutional encounters could mostly be identified in both the DMAS-submitted data and the MCO-submitted data sources.

Similarly, the validation of data element completeness for the Cardinal Care MLTSS and the Cardinal Care Acute programs demonstrated progress finding that both the element omission and element surplus rates for all relevant key data elements were below 5.0 percent for two MCOs for professional encounters, one MCO for institutional encounters and at least four MCOs for pharmacy encounters. This indicates that all relevant key data elements in the encounter records which could be matched between the DMAS-submitted and those MCO-submitted data were largely complete.

In addition, all relevant key data elements had element accuracy rates over 95.0 percent for at least four MCOs among the Cardinal Care Acute and Cardinal Care MLTSS pharmacy encounters. This

indicates that records which could be matched between the DMAS-submitted and these MCO-submitted data largely contained the same values.

Overall, the FAMIS MOMS program demonstrated continued progress, 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 rates for the *Preterm Births (<37 Weeks Gestation)* and *Newborns With Low Birth Weight (<2,500 grams)* study indicators that outperformed the national benchmarks for all three measurement periods, despite having rates for the *Births With Early and Adequate Prenatal Care* study indicator that did not meet the national benchmark. Similarly, the FAMIS Prenatal Coverage program had the lowest rates of *Births With Early and Adequate Prenatal Care*, but had the lowest rates for the *Preterm Births (<37 Weeks Gestation)* and *Newborns With Low Birth Weight (<2,500 grams)* study indicators, which outperformed national benchmarks in CY 2021 and CY 2022. Of note, the Other Aid Categories rates for all three study indicators underperformed in comparison to the national benchmarks for all three measurement periods.

Women in the FAMIS Prenatal Coverage program had the highest rates for receiving contraceptives. This may be due to approximately 90 percent of FAMIS Prenatal Coverage deliveries were to Hispanic, Any Race women, who had significantly higher rates of receiving contraceptives. Additionally, women in the FAMIS Prenatal Coverage program were only eligible for postpartum coverage for 60 days postpartum, which may be impacting the rates for this population.

ARTS study findings demonstrated continued progress. Identification of members with SUD continued to improve, 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 indicated that this rate increased from 5.1 percent to 5.6 percent from CY 2021 to CY 2022.

The network adequacy validation task found that overall, the MCOs demonstrated strength through well-defined processes and procedures to ensure the efficient and accurate collection of member and provider data to support network adequacy calculation and reporting.

The MCOs also demonstrated dedicated efforts to identify gaps in provider networks throughout their service areas and to identify ways to improve the accessibility and timeliness of care for members.

Three of the five MCOs' demonstrated progress in access to care performance measure rates meeting or exceeding the 75th percentile for the *Adults' Access to Preventative/Ambulatory Health Services—Total PM* indicator. These findings aligned with the phantom network analysis which found that across MCOs, the provider networks had few inactive providers for OB/GYN, PCP, and pediatric providers.

The results of the 2022–23 Child Welfare Focus Study highlights identified priorities for the Virginia Medicaid program related to improving and monitoring healthcare utilization and timely access to care for members in child welfare programs and identifying health disparities. DMAS demonstrated progress in implementing policy changes and supported initiatives during the study period to improve utilization of and timely access to care among members in child welfare programs, including the following:

- As part of the SFY 2022–23 Cardinal Care Acute (formerly Medallion 4.0) Managed Care Services Agreement, effective July 1, 2022:

- DMAS added language to improve continuity of and timely access to care for former foster care members, including ensuring MCOs provide members who are aging out of foster care with a “health summary” consolidating key medical information, ensuring MCOs coordinate with the local departments of social services (LDSS) during the transition period, ensuring case management continues during the transition period, and ensuring MCOs document transition needs for children in foster care who will age out of foster care in their individualized care plan, if applicable.
- DMAS added language requiring MCOs to participate in child welfare stakeholder collaboration work groups, when requested.
- On April 1, 2022, Governor Glenn Youngkin launched the Safe and Sound Task Force, which aims to work collaboratively across state and local agencies to address barriers related to safe and appropriate placements for children in foster care. DMAS participates in the Task Force and supports efforts to improve timely access to and utilization of medical and behavioral healthcare services for children in foster care.
- DMAS and the Department of Behavioral Health and Developmental Services collaborated to launch Project BRAVO (Behavioral Health Redesign for Access, Value and Outcomes), a multi-phase initiative to enhance behavioral health services in Virginia. Under this initiative, Virginia Medicaid began covering additional behavioral health services such as mental health intensive outpatient services, effective July 1, 2021, and multisystemic therapy, effective December 1, 2021.

These policy changes may have had an impact on the study results. For example, this study demonstrated that children in foster care have higher rates of appropriate healthcare utilization than comparable controls for the majority study indicators in MY 2020, MY 2021, and MY 2022. Among study indicators where children in foster care had higher rates, MY 2022 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 14.9, 15.6, 15.6, and 9.8 percentage points, respectively), the *Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics* indicator (by 17.1 percentage points), and the *Behavioral Health Encounters—CMH Services*, *Behavioral Health Encounters—Traditional Services*, and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* indicators (by 15.3, 13.3, and 13.3 percentage points, respectively).

The ARTS benefit also demonstrated progress for the Cardinal Care program with several ARTS study indicators finding that initiation of SUD treatment increased for every relevant indicator except *Preferred OBAT Compliance—Counseling From an OBAT Provider*. For example, 48.3 percent of members diagnosed with OUD initiated any OUD treatment (i.e., pharmacotherapy or other treatment) within 14 days of OUD diagnosis in CY 2022, and this rate increased by 4.0 percentage points from CY 2021 and by 9.0 percentage points from CY 2020. The rate change from CY 2020 to CY 2021 was driven by an increase in members initiating pharmacotherapy (by 6.2 percentage points), while the rate change from CY 2021 to CY 2022 was driven by increases in both pharmacotherapy and other OUD treatment initiation (by 3.0 and 3.5 percentage points, respectively).

The MCOs also demonstrated progress with the results of the compliance reviews in developing and implementing the necessary policies, procedures, and processes to operationalize the requirements of their DMAS managed care contract and also demonstrating compliance with the expectations of the contract. All five MCOs achieved full compliance in three of the 17 standards reviewed, demonstrating strength and adherence to all requirements measured in the following standards:

- Standard IV: Availability of Services
- Standard IX: Confidentiality
- Standard XIII: Health Information Systems

In addition, the results of the SFY 2022–2023 Child Welfare focus study demonstrated continued progress finding that 86.8 percent of new foster care members had a visit with a PCP within 30 days after or 90 days prior to entering foster care during MY 2022, an increase of 0.6 percentage points from the year prior. These results indicate that most children in foster care were receiving timely access to primary care. Additionally, 47.2 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 during MY 2022. This rate improved by 3.2 percentage points from MY 2021.

Additionally, the SFY 2022–23 study found that 50.5 percent of new foster care members and 79.0 percent of new foster care members with a diagnosed behavioral health condition had at least one visit with an MHP within 60 days of enrollment in the foster care program. Similarly, 67.1 percent of new foster care members and 93.1 percent of new foster care members with a behavioral health diagnosis had a visit with an MHP within a year after enrollment in the foster care program. For newly enrolled members in the adoption assistance program, 44.3 percent of all members and 68.3 percent of members with a behavioral health diagnosis had a visit with an MHP. Lastly, 78.9 percent of members who aged out of foster care had a behavioral health diagnosis, and 45.8 percent of these members with a behavioral health diagnosis had a visit with an MHP during MY 2022; this rate improved by 6.4 percentage points from MY 2021, also demonstrating a strength for the Cardinal Care program MCOs.

The results of the ARTS benefit also demonstrated strength in timeliness of behavioral health and substance use care and services. Among members who had an initiation visit with an OBAT provider, receipt of OUD medication within seven days of MAT initiation increased by 3.1 percentage points to 22.4 percent, and receipt of care coordination within 30 days of MAT initiation increased by 3.9 percentage points to 19.3 percent from CY 2021 to CY 2022.

Opportunities

Opportunities for improvement were identified in the performance improvement project task. Not all MCO's addressed all requirements for data analysis and interpretation of results (Step 7). One MCO did not include a statement about factors which threatened comparability and one MCO didn't provide the correct statistical testing results or indicator of the direction of change.

Opportunities were also identified in some of the performance measure validation results. In the Children's Preventive Care domain, three of the five MCOs' rates fell below the 50th percentile for the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* PM indicator. All five MCOs' rates also fell below the 50th percentile for the *Cervical Cancer Screening—Total* PM indicator in the Women's Health domain.

In addition, opportunities exist in Quality Strategy Goal 5: Providing Whole-Person Care for Vulnerable Populations, all five MCOs' rates fell below the 50th percentile for the *Medical Assistance With Smoking and Tobacco Use Cessation* PM indicators. Also indicating opportunities for performance improvement.

Results of the compliance reviews also identified MCO opportunities for improvement in processes. The areas identified with the greatest opportunity for improvement, with all five MCOs receiving performance scores under 90 percent in the following Standards:

- Standard II: Member Rights and Member Information
- Standard X: Grievance and Appeal Systems

These findings suggest that the MCOs did not consistently develop the necessary policies, procedures, and processes to operationalize the requirements of its contract and did not always demonstrate compliance with the contract requirements.

The EDV IS review activity found that some MCOs lacked sufficient comprehensive reports to monitor encounter data accuracy, completeness, and timeliness for the following:

- Pharmacy and chiropractic encounters.
- Vision encounters.
- Non-emergency medical transportation (NEMT) encounters.

In addition, the EDV comparative analysis found that for record completeness of professional and institutional encounters only one MCO had a rate over 5.0 percent (i.e., relatively poor performance) for both record omission and record surplus. For pharmacy encounters, two MCOs had a rate over 5.0 percent for both record omission and record surplus. This indicates that the DMAS-submitted encounter records were incomplete when compared to the MCO-submitted data.

At least four MCOs, for professional and institutional encounters, had both element omission and surplus rates that were above 5.0 percent (i.e., relatively poor performance) for at least one key data element. This indicates that at least one key data element in the DMAS-submitted encounter records was incomplete when compared to the MCO-submitted data.

For professional and institutional encounters, some of the MCOs had at least one element accuracy rate that fell below 95.0 percent. For pharmacy encounters, two MCOs had at least one element accuracy rate that fell below 95.0 percent. This indicates that at least one key data element in the DMAS-submitted encounter records was inaccurate when compared to the MCO-submitted data.

For performance measure validation all five MCOs' rates demonstrated weakness falling below the 50th percentile for the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*, *Colorectal Cancer Screening—Total*, *Use of Imaging Studies for Low Back Pain—Total* and *Plan All-Cause Readmissions—Observed Readmissions* PM indicators in the access to care domain.

All five MCOs' demonstrated a weakness in the Behavioral Health domain with rates that fell below the 50th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-up—Total* PM indicator. These results may result in increased emergency department or inpatient utilization.

The Child Welfare focus study also identified opportunities for improvement. During MY 2022, children in foster care had lower rates compared to controls for nine study indicators, of which three were statistically significant: *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*, *ED Visits*,

and *Overall Service Utilization*. For *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*, the rate for children in foster care was 22.0 percentage points lower than the rate for controls in MY 2022. Additionally, while the rate difference was not statistically significant due to small denominators, the rate for children in foster care for the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* was 9.6 percentage points lower than rate for controls, and there were similar findings in MY 2020 and MY 2021.

Among children in foster care, eight study indicator rates increased, while 18 study indicator rates decreased from MY 2021 to MY 2022, and from MY 2020 to MY 2022, two study indicator rates increased, while 13 study indicator rates decreased. The largest declines from MY 2021 to MY 2022 were for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* indicator (by 28.6 percentage points), the *Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics* indicator (by 11.0 percentage points), and the *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* indicator (by 10.2 percentage points). However, eight of the MY 2021 to MY 2022 rate declines for children in foster care were by less than 3 percentage points.

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*.

Cardinal Care Program 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 Cardinal Care program 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* Global indicator.

Cardinal Care Program Child Survey

The Cardinal Care program's 2024 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.

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

PIP Topic Area
<i>Ensuring Timeliness of Prenatal Care</i> (HEDIS PPC measure)
<i>Tobacco Use Cessation in Pregnant Women</i>
<i>Ambulatory Care (AMB)—Emergency Department (ED) Visits</i>
<i>Follow-Up After Discharge</i> (following the <i>Transitions of Care—TRC</i>)

Validation of Network Adequacy

HSAG conducted the CMS EQR Protocol 4 activity in calendar year 2024. HSAG identified that to assess appointment availability, DMAS established minimum standards to ensure members’ needs were sufficiently met. DMAS monitored the MCO’s compliance with these standards through regular reporting requirements outlined in the DMAS Managed Care Technical Manual. In addition, DMAS required 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 required 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

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 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** ★. As a result of the delay in the MCO contract awards, HSAG did not conduct the prenatal care secret shopper survey during 2024.

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. As a result of the delay in the MCO contract awards, HSAG did not conduct the PCP secret shopper survey during 2024.

Compliance Monitoring

During 2024 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:

CFR	Standard
438.56	Disenrollment: Requirements and Limitations*
438.100 438.10	Member Rights* and Member Information
438.114	Emergency and Poststabilization Services*
438.206	Availability of Services
438.207	Assurances of Adequate Capacity and Services
438.208	Coordination and Continuity of Care

CFR	Standard
438.210	Coverage and Authorization of Services
438.214	Provider Selection
438.224	Confidentiality
438.228	Grievance and Appeal Systems
438.230	Subcontractual Relationships and Delegation
438.236	Practice Guidelines
438.242	Health Information Systems**
438.330	Quality Assessment and Performance Improvement
438.608	Program Integrity
Social Security Act; Section 1859	Model of Care
441.50 SSA, Section 1902	EPSDT

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, an aggregate technical report were prepared and included all required components as outlined in the CMS 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 first year of the VA 2024–2026 review period, DMAS continued to work diligently, in collaboration with the MCOs, to operationalize community engagement and 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 women 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

The MCO contract requires that the MCO consider the importance of 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 reduction of 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 varied memberships that includes but is not limited to analyzing significant health care disparities.

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 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 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 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 2024, DMAS contracted with HSAG to establish, implement, and maintain a scoring mechanism for the SFY 2024 PWP. The SFY 2024 PWP assessed CY 2023 PM data to determine what portion, if any, of the MCOs' quality withhold would be earned back. For the SFY 2024 PWP, the MCOs could earn all or a portion of their 1 percent quality withhold based on performance for nine NCQA HEDIS measures/indicators (14 measures/indicators), one AHRQ PDI measure, and two CMS Adult Core Set measures. The SFY 2024 PWP was based on comparisons to the NCQA Quality Compass national Medicaid HMO percentiles for all HEDIS measures/indicators and receiving a reportable audit result on the AHRQ PDI and CMS Adult Core Set PMs. For detailed information related to the PWP, please see the SFY 2024 PWP Methodology on DMAS' website.

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.

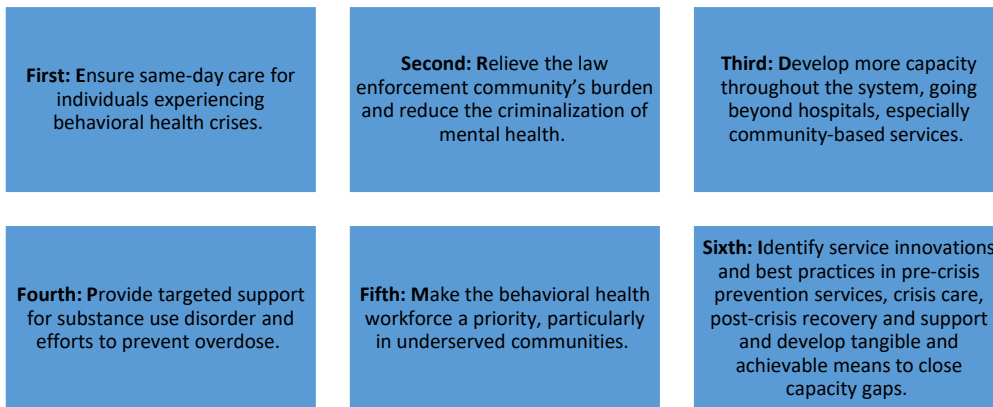
Quality Initiatives

Virginia developed a series of initiatives aligned closely to the Quality Strategy and designed to build an innovative, person-centered, coordinated system of care that addresses both medical and nonmedical drivers of health. These initiatives drive progress towards the Quality Strategy goals and objectives. These initiatives are discussed below.

Right Help, Right Now

Governor Glenn Youngkin created *Right Help, Right Now* to reform Virginia's behavioral health system and to support individuals in crisis. The goal of *Right Help, Right Now* is to support Virginians before, during, and after a behavioral health crisis occurs. The *Right Help, Right Now* plan aims to ensure that there will be same-day care delivered through mobile crisis units and crisis centers in order to reduce overcrowding at emergency departments. By doing so, there will be less strain on law enforcement who can instead better serve the communities where they are needed. This will also serve to reduce the criminalization of mental health in Virginia. The *Right Help, Right Now* plan includes specialized resources for individuals with substance use disorders or who have high risks of overdosing. Virginians should have immediate access to all the resources they need anytime and anywhere.

The “Right Help, Right Now” Six Pillars:



Youth Mental Health Strategy

Governor Glenn Youngkin unveiled the Youth Mental Health Strategy on the one-year anniversary of the *Right Help, Right Now* initiative. In 2023, according to Mental Health America, Virginia ranked 48th in the nation for youth mental health, which demands a collective and comprehensive approach to prioritize the health of the Commonwealth’s youngest and most vulnerable citizens. Children spend on average nearly five hours daily on social media; recent studies have suggested that children who spend more than a few hours per day on social media have double the risk of poor mental health.

Governor Glenn Youngkin is taking immediate action in year two of *Right Help, Right Now*. To better equip parents and support Virginia’s young people, Governor Glenn Youngkin, through budget proposals, legislation, and executive action, and the Youth Mental Health Strategy, will address critical components and harmful aspects of social media on Virginia’s youth. The strategy includes interventions in the following areas:

- Addictive and harmful aspects of social media on youth
- Inside Virginia schools—school-based mental health services for students
- In behavioral health care settings—family empowerment and rights

Additional Developmental Disabilities Waiver Slots

Governor Glenn Youngkin committed to enhance support for Virginians with developmental disabilities and their families. Included in the *Right Help, Right Now* initiative, Virginia is one step closer to the goal of providing enough priority one slots for everyone in urgent need of services by the end of the Governor’s term. Governor Glenn Youngkin announced an additional \$300 million over the biennium to fund enough priority one slots for every Virginian with a developmental disability on the waitlist for Medicaid Home and Community-Based Developmental Disability (DD) waiver slots.

These improvements give Virginians with disabilities the supports and services they need to live their best lives in their communities. Through these improvements, Virginians with disabilities are provided supports and services they need to live their best lives in their communities. Secretary of Health and Human Resources John Littel stated that they have heard from Virginians and their families about the important difference a DD waiver can have in their life of the life of a loved one. Whether it be paying for

in-home care or the kind of assistive technology that can help an individual avoid living in a hospital, nursing home, or other institution, these waivers can change lives. The waivers also cover services such as medical care, employment supports, assistance for community living, behavioral interventions, and other items like medical goods and assistive technology.

Baby Steps

DMAS and its contracted MCOs have undertaken a variety of initiatives aimed at improving quality outcomes in maternal health, a primary goal of the Virginia QS. The DMAS maternity program, Baby Steps Virginia, actively partners with a variety of stakeholders including DMAS MCOs to improve quality maternity outcomes. All of these efforts have focused on eliminating racial disparities in maternal mortality by 2025.

The program has five key subgroups including eligibility and enrollment, outreach and information, community connections, services and policies, and oversight, all with the aim to promote health 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 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 Cardinal Care Acute and the Cardinal Care 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—Cardinal Care MLTSS Prior Year Recommendations and DMAS Responses

Recommendation—Cardinal Care MLTSS		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	Objective 5.	Measure(s): 5.1.1.5: Controlling High Blood Pressure
HSAG Recommendation: 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.		
DMAS' Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): DMAS included the measure Blood Pressure Control for Patients with Diabetes 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: <i>Blood Pressure Control for Patients with Diabetes</i>		

Recommendation—Cardinal Care MLTSS

MY 2022: 55.31%

MY 2023: 61.74%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Cardinal Care MLTSS

Goal 5: Providing Whole-Person Care for Vulnerable Populations

Objective 5.4: Improve Behavioral Health and Developmental Services for Members

Measure(s):

5.4.1.1: Follow-Up After Hospitalization for Mental Illness

5.4.1.5: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

5.4.1.10: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

HSAG Recommendation: 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.

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 has improved its ability to track MCO required monthly data submissions

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

PMV results showed:

Measure: *Follow-Up After Hospitalization for Mental Illness*

Recommendation—Cardinal Care MLTSS

MY 2022: 7-Day: 29.00%; 30-Day: 52.02%

MY 2023: 7-Day: 33.91%; 30-Day: 56.34%

Measure: *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*

MY 2022: 37.18%

MY 2023: 63.48%

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

MY 2022: 82.49%

MY 2023: 81.79%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Cardinal Care MLTSS

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

Measure(s):

4.1.1.2: Child and Adolescent Well-Care Visits

4.1.1.3: Childhood Immunization Status

4.1.1.4: Immunizations for Adolescents

4.1.1.9: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

4.2.1.4: Well-Child Visits in the First 30 Months of Life

HSAG Recommendation: 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 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.

DMAS' Response

Recommendation—Cardinal Care MLTSS

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):

- Specific initiatives were not provided.

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

PMV results showed:

Measure: *Child and Adolescent Well-Care Visits Total*

MY 2022: 44.15%

MY 2023: 50.88%

Measure: *Childhood Immunization Status*

MY 2022: 64.63%

MY 2023: 66.64%

Measure: *Immunizations for Adolescents*

MY 2022: Combo 1: 79.96%; Combo 2: 30.96%

MY 2023: Combo 1: 84.20%; Combo 2: 35.30%

Measure: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*

MY 2022: BMI: 67.97%; Nutrition Total: 60.34%; Physical Activity Total: 51.75%

MY 2023: BMI: 75.44%; Nutrition Total: 66.47%; Physical Activity Total: 60.09%

Measure: *Well-Child Visits in the First 30 Months of Life*

MY 2022: Not measured in the Cardinal Care MLTSS program

MY 2023: First 15 Months: 61.18%; 15 Months – 30 Months: 70.36%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Cardinal Care MLTSS

Goal 5: Providing Whole-Person Care for Vulnerable Populations

Objective

Measure(s):

Measure 5.1.1.5: Controlling High Blood Pressure

HSAG Recommendation: 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

Recommendation—Cardinal Care MLTSS

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.

DMAS' Response

Describe initiatives implemented based on recommendations (include a brief summary of activities

that were either completed or implemented, and any activities still underway to address the finding

that resulted in the recommendation):

- DMAS included the measure Blood Pressure Control for Patients with Diabetes 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: *Blood Pressure Control for Patients with Diabetes*

MY 2022: 56.55%

MY 2023: 61.74%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Cardinal Care MLTSS

Goal 5: Providing Whole-Person Care for Vulnerable Populations

Objective 5.4: Improve Behavioral Health and Developmental Services for Members

Measure(s):

5.4.1.1: Follow-Up After Hospitalization for Mental Illness

5.4.1.5: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

5.4.1.10: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

HSAG Recommendation: 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

Recommendation—Cardinal Care MLTSS

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.

DMAS' Response

Describe initiatives implemented based on recommendations (include a brief summary of activities

that were either completed or implemented, and any activities still underway to address the finding

that resulted in the recommendation):

- DMAS included the measure Follow-Up After Emergency Department Visit for Mental Illness in its PWP which provides an incentive to MCOs to increase performance and close gaps.
- DMAS will begin collecting data for the measure Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics and Diabetes Monitoring for People with Diabetes and Schizophrenia to begin monitoring MCO performance in the future.

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

PMV results showed:

Measure: *Follow-Up After Hospitalization for Mental Illness*

MY 2022: 7-Day: 29.00%; 30-Day: 52.02%

MY 2023: 7-Day: 33.91%; 30-Day: 56.34%

Measure: *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*

MY 2022: 37.18%

MY 2023: 63.48%

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

MY 2022: 82.49%

MY 2023: 81.79%

Identify any barriers to implementing initiatives:

Barriers were not identified.

HSAG Assessment:



Recommendation—Cardinal Care MLTSS

Goal 4: Strengthen the Health of Families and Communities

Objective 4.1: Improve Utilization of Wellness,

Measure(s):

4.1.1.2: Child and Adolescent Well-Care Visits

Recommendation—Cardinal Care MLTSS

	Immunization, and Prevention Services for Members Objective 4.2: Improve Outcomes for Maternal and Infant Members	4.1.1.3: Childhood Immunization Status 4.1.1.4: Immunizations for Adolescents 4.1.1.9: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents 4.2.1.4: Well-Child Visits in the First 30 Months of Life

HSAG Recommendation: 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 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.

DMAS' Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- DMAS included the measure Child and Adolescent Well-Care Visits in its PWP which provides an incentive to MCOs to increase performance and close gaps.
- DMAS included the measure Childhood Immunization Status 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: *Child and Adolescent Well-Care Visits Total*

MY 2022: 44.15%

MY 2023: 50.88%

Measure: *Childhood Immunization Status*

MY 2022: 64.63%

MY 2023: 66.64%

Measure: *Immunizations for Adolescents*

MY 2022: Combo 1: 96%; Combo 2: 30.96%

MY 2023: Combo 1: 84.20; Combo 2: 35.30%

Recommendation—Cardinal Care MLTSS

Measure: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*

MY 2022: BMI: 67.97%; Nutrition Total: 60.34%; Physical Activity Total: 51.75%

MY 2023: BMI: 75.44%; Nutrition Total: 66.47%; Physical Activity Total: 60.09%

Measure: *Well-Child Visits in the First 30 Months of Life*

MY 2022: Not measured for the Cardinal Care MLTSS program

MY 2023: First 15 Months: 61.18%; 15 Months – 30 Months: 70.36%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Table F-6—Cardinal Care Acute Prior Year Recommendations and DMAS Responses

Recommendation—Cardinal Care Acute		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	Objective 5.4: Improve Behavioral Health and Developmental Services for Members	Measure(s): 5.4.1.1: Follow-Up After Hospitalization for Mental Illness 5.4.1.2: Follow-Up After Emergency Department Visit for Mental Illness
HSAG Recommendation: To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4 and improve BH 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 ED visits for mental illness. HSAG also recommends that DMAS work with the MCOs to consider if there are disparities within the MCOs' populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Additionally, HSAG recommends that DMAS continue leveraging the CMS Improving Behavioral Health Follow-up Care Learning Collaborative1- materials to identify potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care. - Continue work on the Follow-Up After Emergency Department Visit for Mental Illness measure through the PWP.		
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—Cardinal Care Acute

- DMAS included the measure Follow-Up After Emergency Department Visit for Mental Illness in its PWP which provides an incentive to MCOs to increase performance and close gaps.

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

PMV results showed:

Measure: *Follow-Up After Hospitalization for Mental Illness*

MY 2022: 7-Day: 32.11%; 30-Day: 53.76%

MY 2023: 7-Day: 33.91%; 30-Day: 56.34%

Measure: *Follow-Up After Emergency Department Visit for Mental Illness*

MY 2022: 7-Day: 37.90%; 30-Day: 50.96%

MY 2023: 7-Day: 38.56%; 30-Day: 53.53%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Cardinal Care Acute

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

Measure(s):

4.1.1.2: Child and Adolescent Well-Care Visits

4.1.1.3: Childhood Immunization Status

4.2.1.1: Prenatal and Postpartum Care—Timeliness of Prenatal Care

4.2.1.4: Well-Child Visits in the First 30 Months of Life

HSAG Recommendation: 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 improve access and timeliness of well-child visits and preventive healthcare for members under the age of 21 years, and the timeliness of pregnancy-related care, HSAG recommends that DMAS:

- Work with the enrollment broker to address the data deficiencies identified during the PCP and prenatal care secret shopper surveys (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify the location address and appropriate provider type and provider specialty. DMAS may also consider requesting that the MCOs provide evidence of training offered, by the MCO, to providers' offices regarding the MCO plan names and benefit coverage. MCO evidence should demonstrate that the office staff responsible for scheduling appointments have been educated on the MCO names and benefit coverage, and that the offices have a plan in place for educating new staff in the event of staff turnover. Accurate provider information, including provider

Recommendation—Cardinal Care Acute

specialties and contact information, may result in improved access to care for members seeking well care, preventive healthcare, childhood immunizations, and pregnancy-related care.

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

DMAS' Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- DMAS included the measure Child and Adolescent Well-Care Visits in its PWP which provides an incentive to MCOs to increase performance and close gaps.
- DMAS included the measure Childhood Immunization Status 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: *Child and Adolescent Well-Care Visits*

MY 2022: 48.66%

MY 2023: 50.88%

Measure: *Childhood Immunization Status*

MY 2022: 64.49%

MY 2023: 64.49%

Measure: *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

MY 2022: 77.10%

MY 2023: 66.64%

Measure: *Well-Child Visits in the First 30 Months of Life*

MY 2022: Not measured for the Cardinal Care Acute program

MY 2023: First 15 Months: 61.18%; 15 Months – 30 Months: 70.36%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Cardinal Care Acute

Goal 5: Providing Whole-Person Care for Vulnerable Populations

Objective 5.4: Improve Behavioral Health and Developmental Services for Members

Measure(s):

Measure 5.4.1.1: Follow-Up After Hospitalization for Mental Illness

Recommendation—Cardinal Care Acute		
		Measure 5.4.1.2: Follow-Up After Emergency Department Visit for Mental Illness
HSAG Recommendation: To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4 and improve BH 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 ED visits for mental illness. HSAG also recommends that DMAS work with the MCOs to consider if there are disparities within the MCOs’ populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Additionally, HSAG recommends that DMAS continue leveraging the CMS Improving Behavioral Health Follow-up Care Learning Collaborative1- materials to identify potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care. - Continue work on the Follow-Up After Emergency Department Visit for Mental Illness measure through the PWP.		
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): Specific initiatives were not provided.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: Follow-Up After Hospitalization for Mental Illness MY 2022: 7-Day: 32.11%; 30-Day: 53.76% MY 2023: 7-Day: 33.91%; 30-Day: 56.34% Measure: Follow-Up After Emergency Department Visit for Mental Illness MY 2022: 7-Day: 37.90%; 30-Day: 50.96% MY 2023: 7-Day: 38.56%; 30-Day: 53.53%		
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing the initiatives.		
HSAG Assessment: 		
Recommendation—Cardinal Care Acute		
Goal 4: Strengthen the Health of Families and Communities	Objective 4.1: Improve Utilization of Wellness, Immunization, and Prevention Services for Members	Measure(s): Measure 4.1.1.2: Child and Adolescent Well-Care Visits Measure 4.1.1.3: Childhood Immunization Status

Recommendation—Cardinal Care Acute		
	Objective 4.2: Improve Outcomes for Maternal and Infant Members	Measure 4.2.1.1: Prenatal and Postpartum Care—Timeliness of Prenatal Care Measure: 4.2.1.4: Well-Child Visits in the First 30 Months of Life
HSAG Recommendation: 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 improve access and timeliness of well-child visits and preventive healthcare for members under the age of 21 years, and the timeliness of pregnancy-related care, HSAG recommends that DMAS: • Work with the enrollment broker to address the data deficiencies identified during the PCP and prenatal care secret shopper surveys (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify the location address and appropriate provider type and provider specialty. DMAS may also consider requesting that the MCOs provide evidence of training offered, by the MCO, to providers' offices regarding the MCO plan names and benefit coverage. MCO evidence should demonstrate that the office staff responsible for scheduling appointments have been educated on the MCO names and benefit coverage, and that the offices have a plan in place for educating new staff in the event of staff turnover. Accurate provider information, including provider specialties and contact information, may result in improved access to care for members seeking well care, preventive healthcare, childhood immunizations, and pregnancy-related care. • Work with MCOs to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended well visits according to the EPSDT and Bright Futures schedule and to make appropriate health decisions. HSAG continues to recommend that DMAS monitor MCOs to ensure that the MCOs analyze their data and consider if there are disparities within the MCOs' populations.		
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): • Specific initiatives were not provided.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: Child and Adolescent Well-Care Visits MY 2022: 48.66% MY 2023: 50.88% Measure: Childhood Immunization Status – Combo 3 MY 2022: 64.49% MY 2023: 64.49% Measure: Prenatal and Postpartum Care—Timeliness of Prenatal Care MY 2022: 77.10% MY 2023: 73.71% Measure: Well-Child Visits in the First 30 Months of Life		

Recommendation—Cardinal Care Acute

MY 2022: Not measured for the Cardinal Care Acute program

MY 2023: First 15 Months: 61.18%; 15 Months – 30 Months: 70.36%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Cardinal Care Acute

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

Measure(s):

Measure 4.1.1.2: Child and Adolescent Well-Care Visits

Measure 4.1.1.3: Childhood Immunization Status

Measure 4.2.1.1: Prenatal and Postpartum Care—Timeliness of Prenatal Care

Measure 4.2.1.4: Well-Child Visits in the First 30 Months of Life

HSAG Recommendation: 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 improve access and timeliness of well-child visits and preventive healthcare for members under the age of 21 years, and the timeliness of pregnancy-related care, HSAG recommends that DMAS:

- Work with the enrollment broker to address the data deficiencies identified during the PCP and prenatal care secret shopper surveys (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify the location address and appropriate provider type and provider specialty. DMAS may also consider requesting that the MCOs provide evidence of training offered, by the MCO, to providers' offices regarding the MCO plan names and benefit coverage. MCO evidence should demonstrate that the office staff responsible for scheduling appointments have been educated on the MCO names and benefit coverage, and that the offices have a plan in place for educating new staff in the event of staff turnover. Accurate provider information, including provider specialties and contact information, may result in improved access to care for members seeking well care, preventive healthcare, childhood immunizations, and pregnancy-related care.
- Work with MCOs to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended well visits according to the EPSDT and Bright Futures schedule and to make appropriate health decisions. HSAG continues to recommend that DMAS monitor MCOs to ensure that the MCOs analyze their data and consider if there are disparities within the MCOs' populations.

DMAS' Response

Recommendation—Cardinal Care Acute

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):

- Specific initiatives were not provided.

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

PMV results showed:

Measure: *Child and Adolescent Well-Care Visits*

MY 2022: 48.66%

MY 2023: 50.88%

Measure: *Childhood Immunization Status – Combo 3*

MY 2022: 64.49%

MY 2023: 64.49%

Measure: *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

MY 2022: 77.10%

MY 2023: 73.71%

Measure: *Well-Child Visits in the First 30 Months of Life*

MY 2022: Not measured for the Cardinal Care Acute program

MY 2023: First 15 Months: 61.18%; 15 Months – 30 Months: 70.36%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Cardinal Care Acute

Goal 5: Providing Whole-Person Care for Vulnerable Populations

Objective 5.4: Improve Behavioral Health and Developmental Services for Members

Measure(s):

Measure 5.4.1.1: Follow-Up After Hospitalization for Mental Illness

Measure 5.4.1.2: Follow-Up After Emergency Department Visit for Mental Illness

Measure: 4.2.1.4: Well-Child Visits in the First 30 Months of Life

HSAG Recommendation: To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4 and improve BH 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 ED visits for mental

Recommendation—Cardinal Care Acute

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 materials to identify potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care.

- Continue work on the Follow-Up After Emergency Department Visit for Mental Illness measure through the PWP.

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):

The DMAS BH team continues to work on the following initiative to improve Medicaid funded behavioral health care across Virginia including the following efforts:

- DMAS has been instrumental in the planning and implementation of the Governor's Right Help, Right Now plan which aims to achieve the goal that all Virginians will, i) be able to access behavioral health care when they need it; ii) have prevention and management services personalized to their needs, particularly for children, youth and families; iii) know who to call, who will help and where to go when in crisis; and iv) have paths to reentry and stabilization when transitioning from a crisis. DMAS is an integral partner and stakeholder within this plan.
- In December, 2022, Governor Youngkin announced a six-pillar plan to transform Virginia's behavioral health system: the Right Help. Right Now. Plan. (RHRN). As plans developed under Pillar 3 (increasing community capacity) and Pillar 6 (service innovations), initiatives to redesign Medicaid legacy community mental health rehabilitative services (CMHRS)(Intensive In-Home, Therapeutic Day Treatment, Mental Health Skill Building, Psychosocial Rehabilitation and Targeted Case Management) for both adults and youth emerged as significant needs within the system. The current 2024-2026 biennium budget includes Item 288, XX which provides DMAS the authority to replace our CMHRS services and case management service. In collaboration with DBHDS and DHP, DMAS will be launching a two-year project (July 2024-June 2026) to replace our CMHRS services and case management service and this webinar is an opportunity to find about more about the project.
- A collaboration and partnership among health and human services state agencies in Virginia, came together to form 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. The Center and state agencies have developed an interagency agreement regarding Assertive Community Treatment and monitoring the fidelity of this service through the Tool for the Measurement of ACT (TMACT) Assessment as well as the development of a strategic plan to monitor the fidelity of High Fidelity Wrap Around services in Virginia.
- In addition, DMAS established a more robust outcome-based payment strategy that holds MCOs accountable for providing high quality behavioral health services to Virginia Medicaid members and researched additional behavioral health/crisis service utilization measures, including other

Recommendation—Cardinal Care Acute
state programs and commercial and Medicaid/Medicare metrics, that can be considered for inclusion in the performance withhold program (PWP) to assess MCO quality performance.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: <i>Follow-Up After Hospitalization for Mental Illness</i> MY 2022: 7-Day: 32.11%; 30-Day: 53.76% MY 2023: 7-Day: 33.91%; 30-Day: 56.34% Measure: <i>Follow-Up After Emergency Department Visit for Mental Illness</i> MY 2022: 7-Day: 37.90%; 30-Day: 50.96% MY 2023: 7-Day: 38.56%; 30-Day: 53.53% Measure: <i>Well-Child Visits in the First 30 Months of Life</i> MY 2022: Not measured for the Cardinal Care Acute program MY 2023: First 15 Months: 61.18%; 15 Months – 30 Months: 70.36%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing the initiatives.
HSAG Assessment: 

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 and data-driven.

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

Table F-7 includes the recommendations for the Quality Strategy.

Table F-7—Quality Strategy Recommendations

Program Recommendations	
Recommendation	Associated Virginia 2023–2025 QS Objective, and Measure
Within the Access to Care and Women’s Health domains, all five MCOs’ rates fell below the 50th percentile for the <i>Cervical Cancer Screening—Total</i> PM indicator and the <i>Colorectal Cancer Screening—Total</i> PM indicator. HSAG recommends that MCOs consider whether there are health disparities within the plans’ populations that contributed to lower access to care. HSAG recommends that MCOs implement interventions to reduce barriers to care, including engaging with community providers and community health workers in planning materials and outreach activities. MCOs should also communicate with eligible members through multi-modal approaches including outreach through phone calls and text messages to promote women’s screenings. MCO should also consider including incentives for primary care providers to provide the needed services and to increase their access and outreach to eligible assigned members. MCOs should also monitor and implement interventions, if needed, for providers in communicating with members with scheduled reminders utilizing personalized outreach for overdue patients. DMAS should review MCO communication messages to ensure clear and concise information.	Goal 2: Promote Access to Safe, Gold-Standard Patient Care Objective 2.1: Ensure Access to Care Measure: 2.1.1.6: Cervical Cancer Screening Measure: 2.1.1.8: Colorectal Cancer Screening
Within the Behavioral Health domain, four of the five MCOs’ rates fell below the 50th percentile for both <i>Follow-Up After Hospitalization for Mental Illness</i> PM indicators. Additionally, at least four of the five MCOs’ rates fell below the 50th percentile for both <i>Follow-Up After Emergency Department Visit for Mental Illness</i> PM indicators. All five MCOs’ rates fell below the 50th percentile for the <i>Antidepressant Medication Management—Effective Acute Phase Treatment</i> PM indicator.	Goal 5: Providing Whole-Person Care for Vulnerable Populations Objective 5.4: Improve Behavioral Health and Developmental Services for Members

Program Recommendations	
HSAG recommends that DMAS work with the MCOs to meet with hospitals to improve the understanding of the importance of follow-up care and discuss tips on scheduling patients in the hospital or ED. The MCOs should be encouraged to work with hospital discharge planners to gain insight into the challenges the discharge planners face in setting up follow-up visits before member discharge. HSAG recommends that DMAS work with the MCO to work with outpatient providers on solutions to these challenges. Additionally, HSAG recommends that DMAS encourage MCOs to establish processes for outpatient providers to send direct messages to patients with canceled visits or do not show for scheduled appointments. HSAG recommends MCOs ensure telehealth services for follow-up visits are covered, available, and that providers and patients are made aware of telehealth follow-up visit options. HSAG recommends MCOs analyze mental health integration between providers, including primary care and mental health specialists. This, coupled with improved monitoring, has been shown to improve medication adherence.	Measure 5.4.1.1: Follow-Up After Hospitalization for Mental Illness Measure 5.4.1.2: Follow-Up After Emergency Department Visit for Mental Illness Measure 5.4.1.8: Antidepressant Medication Management
Within the Children’s Preventive Care domain, three of the five MCOs’ rates fell below the 50th percentile for the <i>Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)</i> PM indicator. Additionally, all five MCOs’ rates fell below the 50th percentile for the <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index</i> and <i>Counseling for Physical Activity</i> PM indicators. HSAG recommends that DMAS work with the MCOs to address whether providers are recording any vaccinations patients receive outside of provider care, such as at a pharmacy. HSAG recommends that MCOs survey providers regarding barriers encountered for the cases where BMI was not measured or counseling was not provided such as lack of resources, lack of time, or lack of training to provide appropriate counseling.	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 Measure 4.1.1.9: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
The general child’s 2024 top-box score was statistically significantly lower than the 2023 NCQA general child Medicaid national average for <i>How Well Doctors Communicate</i>. HSAG recommends that the MCOs evaluate the process of care delivery to identify if there are any operational issues contributing to access to care for members as well as identifying and resolving dissatisfaction in customer and clinical services by addressing and providing solutions to customer	Goal 2: Promote Access to Safe, Gold-Standard Patient Care Objective 2.3: Promote Effective Communication and Care Coordination Measure 2.3.1.1: How Well Doctors Communicate

Program Recommendations	
service complaints. HSAG also recommends that the MCOs conduct root cause analyses of study indicators that have been identified as areas of low performance. 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.	

Quality Strategy Evaluation Methodology

Evaluation Methodology Description

Review Period

The evaluation period focuses on the 12-month performance period of January 1, 2024–December 31, 2024.

Goals and Objectives

The Virginia 2023–2025 Quality Strategy identified goals and objectives that focus on process as well as achieving outcomes. Virginia’s Quality Strategy identifies the following five goals and fourteen associated objectives:

- Goal 1: Enhance the Member Care Experience:
 - Objective 1.1: Increase Member Engagement and Outreach
 - Objective 1.2: Improve Member Satisfaction
- Goal 2: ★ Promote Access to Safe, Gold-Standard Patient Care ★
 - Objective 2.1: Ensure Access to Care
 - Objective 2.2: Promote Patient Safety
 - Objective 2.3: Promote Effective Communication and Care Coordination
- Goal 3: ★ Support Efficient and Value-Driven Care ★
 - Objective 3.1: Focus on Paying for Value
 - Objective 3.2: Promote Efficient Use of Program Funds
- Goal 4: Strengthen the Health of Families and Communities
 - Objective 4.1: Improve Utilization of Wellness, Immunization, and Prevention Services for Members
 - Objective 4.2: ★ Improve Outcomes for Maternal and Infant Members ★
 - Objective 4.3: Improve Home and Community-Based Services
- Goal 5: Providing Whole-Person Care for Vulnerable Populations
 - Objective 5.1: Improve Outcomes for Members with Chronic Conditions
 - Objective 5.2: Improve Outcomes for Nursing Home Eligible Members

- Objective 5.3: ★ **Objective 5.3: Improve Outcomes for Members with Substance Use Disorders** ★
- Objective 5.4: ★ **Objective 5.4: Improve Behavioral Health and Developmental Services of Members** ★

Evaluation

HSAG conducts a formal evaluation of the Quality Strategy to assess its overall effectiveness to improve healthcare delivery, accessibility, and quality in the populations served by the managed care program. For DMAS, HSAG's evaluation includes an assessment of managed care performance compared to national benchmarks; MCO target and improvement objectives; performance improvement initiatives; and an examination of strengths, opportunities for improvement, and recommendations to add, enhance, or modify quality initiatives aimed at improving service delivery, accessibility, and quality.

To evaluate the Quality Strategy, HSAG analyzes the following to determine performance and progress in achieving the goals of the DMAS Quality Strategy.

- HEDIS measures
- CAHPS surveys
- Core Set of Adult Health Care Quality Measures for Medicaid
- Core Set of Children's Health Care Quality Measures for Medicaid and CHIP
- State-specific measures
- Addressing health disparities
- Use of sanctions
- EQR activities, such as the following:
 - PIP validation
 - Network adequacy and availability validation
 - Compliance monitoring
 - Annual EQR technical reports
- MCO performance withholds of capitation payments
- Quality initiatives

The Quality Strategy evaluation provides critical information about the structure of the quality program and the process for improving health service quality, access, and timeliness, and whether the program is achieving its goals. When opportunities for improvement are identified, HSAG will work with DMAS and its contracted MCOs to identify the leading causes for stagnant or declining performance. HSAG also will work with DMAS to examine health policies that may impact, either positively or negatively, service delivery, accessibility, and quality of care and to refine its methodology and tools as needed based on lessons learned from the previous year's evaluation.

Evaluation Tool

To track the progress of achieving goals and objectives outlined in the 2023–2025 Quality Strategy, HSAG tracks annual results of contractual performance metrics that aligned with the performance measures included in the Quality Strategy to measure improvement. HSAG developed a Virginia Medicaid Goals Tracking Table. The table includes the metrics included in the 2023–2025 Virginia Quality Strategy and categorized by the State’s associated goals and objectives, along with baseline rates from measurement year (MY) 2020. The most recent MY rates are compared to baseline rates, targets, and improvement objectives.

Quality Strategy Evaluation Virginia Medicaid Goals Tracking Table

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
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	Increase by X percent the Cover Virginia Spanish language calls taken by Spanish-speaking bilingual staff	Maintain or increase these statistics by a minimum of 1%. NR
				Cover Virginia 2021: Calls Taken with Language Assistance Services: 50,902	Increase by X percent the Cover Virginia calls taken with language assistance by 2025	
				Cardinal Care Acute Call Center Language Calls 2021: 7,551	Increase by X percent the Cardinal Care Acute call center language calls taken by 2025	
				Cardinal Care MLTSS Call Center Language Calls 2021: 545	Increase by X percent the Cardinal Care MLTSS call center language calls taken by 2025.	
				2021 DMAS Website Translation Requests 2021: 3,489	Increase by X percent the translation requests taken by 2025	

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		1.1.1.2 Monitor Language and Disability Access Reports	DMAS	- Cardinal Care MLTSS: - Cardinal Care Acute:	Increase by X percent the Language and Disability Access report monitoring: Cardinal Care Program:	Maintain or increase these stats by a minimum of 1%. NR
		1.1.1.3 Monitor Member Language Counts	DMAS	- Cardinal Care MLTSS: - Cardinal Care Acute:	Increase by X percent the Member Language Counts reported : Cardinal Care Program:	Maintain or increase these stats by a minimum of 1%. NR
	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: - Cardinal Care MLTSS: 68.5% - Cardinal Care Acute: 75.7%	Increase the Cardinal Care annual CAHPS overall Rating of <i>All Health Care</i> to perform at or above the CAHPS 50th percentile by 2025: - Adult: - Child:	Use CAHPS benchmarks <i>Rating of All Health Care</i> Adult: 58.84% Child: 72.67%
				Adult: - Cardinal Care MLTSS: 58.7% - Cardinal Care Acute: 55.8%		

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		1.2.1.2 Rating of Personal Doctor	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: - Cardinal Care MLTSS: 79.5% - Cardinal Care Acute: 77.7% Adult: - Cardinal Care MLTSS: 72.8% - Cardinal Care Acute: 68.0%	Increase the Cardinal Care annual CAHPS overall Rating of <i>Personal Doctor</i> to perform at or above the CAHPS 50th percentile by 2025: - Adult: - Child:	Use CAHPS benchmarks <i>Rating of Personal Doctor</i> Adult: 70.98% Child: 76.18%
★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: - Cardinal Care MLTSS: 89.7% - Cardinal Care Acute: 86.0% Adult: - Cardinal Care MLTSS: 85.0%	Increase the Cardinal Care annual CAHPS overall Rating of <i>Getting Care Quickly</i> to perform at or above the CAHPS 50th percentile by 2025: - Adult: - Child	Use CAHPS benchmarks <i>Rating of Getting Care Quickly</i> Adult: 81.07% Child: 84.49%

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Cardinal Care Acute: 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: - Cardinal Care MLTSS: % - Cardinal Care Acute: % Adult: - Cardinal Care MLTSS: % - Cardinal Care Acute: %	Increase the Cardinal Care annual CAHPS overall Rating of <i>Got Non-Urgent Appointment as Soon as Needed</i> to perform at or above the CAHPS 50th percentile by 2025: - Adult: - Child:	Use CAHPS benchmarks Rating of <i>Got Non-Urgent Appointment as Soon as Needed</i> Adult: NR Child: NR
		2.1.1.3 Getting Needed Care	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	AHRQ CAHPS 2021 Child: - Cardinal Care MLTSS: 87.3% - Cardinal Care Acute: 84.6% Adult: - Cardinal Care	Increase the Cardinal Care annual CAHPS overall Rating of <i>Getting Needed Care</i> to perform at or above the CAHPS 50th percentile by 2025: - Adult: - Child:	Use CAHPS benchmarks Rating of <i>Getting Needed Care</i> Adult: 81.42% Child: 80.51%

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				MLTSS: 86.1% • Cardinal Care Acute: 82.9%		
	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 Cardinal Care MLTSS 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: • CCC Plus Waiver Members	Clarify difference from 3.1.1.11; increase numbers over 2022 benchmark, 1% minimum NR
		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	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:	Increase number over 2022 benchmark, 1% minimum NR

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Total: 2,393²	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: - Cardinal Care MLTSS: 93.9% - Cardinal Care Acute: 93.7% Adult: - Cardinal Care MLTSS: 94.2% - Cardinal Care Acute: 93.3%	Increase the Cardinal Care annual CAHPS overall Rating of <i>How Well Doctors Communicate</i> to perform at or above the CAHPS 50th percentile by 2025: - Adult: - Child:	Use CAHPS benchmarks <i>Rating of How Well Doctors Communicate</i> Adult: 92.41% Child: 94.04%
		2.3.1.2 Service Authorizations	DMAS https://www.dmas.virginia.gov/data/mco-service-authorization-performance/	MCO Reporting	Maintain or Increase by X% service authorizations adjudicated timely by 2025: Cardinal Care Program:	Increase number over 2022 benchmark, 1% minimum NR
★ 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	Decrease by 10% Potentially Preventable Admissions: Cardinal Care Program:	Based on CE benchmarks from DMAS website NR

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		3.1.1.2 Frequency of Emergency Department Visits	DMAS Clinical Efficiency Measure	Clinical Efficiency Measures	Decrease by 1% the Potentially Preventable, Avoidable, and/or Medically Unnecessary Emergency Department Visits: Cardinal Care Program:	Based on CE benchmarks from DMAS website NR
		3.1.1.3 Frequency of Potentially Preventable Readmissions	DMAS Clinical Efficiency Measure	Cardinal Care MLTSS Cardinal Care Acute	Decrease by 8% Potentially Preventable Readmissions Within 30 Days: Cardinal Care Program:	Based on CE benchmarks from DMAS website NR
		3.1.1.4 Ambulatory Care	NCQA HEDIS	HEDIS MY 2020 - Cardinal Care MLTSS: 77.45 - Cardinal Care Acute:	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:	Use HEDIS MY2022 percentile benchmark NR
		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 Cardinal Care MLTSS:	Decrease the HEDIS Ambulatory Care: Emergency Department (ED) Visit measure rate to perform at or above	Use HEDIS MY2022 percentile benchmark NR

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				- Cardinal Care Acute: HEDIS MY 2020 - Cardinal Care MLTSS: 77.45% - Cardinal Care Acute: NR Child Core Set - Cardinal Care MLTSS: - Cardinal Care Acute	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: 1-9 Years: 10-19 Years: - Total:	
		3.1.1.6 Days Without Minimum RN Hours	DMAS VBP Reporting Team	NF VBP Program 2019	NF VBP	Fair: 13.00-16.00

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
			CMS Payroll Based Journal	Cardinal Care MLTSS:	Decrease by X% the number of nursing facility y days without minimum RN hours. Cardinal Care Program:	Better: 5.00 – 12.00 Best: 0 – 4.00 NR
		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 Cardinal Care MLTSS:	NF VBP Increase by X% the number of days with total nurse staffing hours per resident day meeting minimum requirements. Cardinal Care Program:	Fair: 3.16 – 3.45 Better: 3.46 – 3.83 Best: 3.84+ NR
		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 Cardinal Care MLTSS:	NF VBP Decrease by X% Long-Stay Residents with a Urinary Tract Infection. Cardinal Care Program	Fair: 2.39– 4.36 Better: 1.31 – 2.38 Best: 0 – 1.30 NR
		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 Cardinal Care MLTSS:	NF VBP Decrease by X% the number of unplanned inpatient admissions or outpatient observations stays	Fair: 1.36 – 1.75 Better: 1.00 – 1.35 Best: 0 – 0.99 NR

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					that occurred among long-stay residents of a nursing home. • 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 • Cardinal Care MLTSS:	NF VBP Decrease by X% the number of outpatient ED visits that occurred among long-stay residents of a nursing home.	Fair: 0.64 – 0.95 Better: 0.39 – 0.63 Best: 0 – 0.38 NR
		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 • Cardinal Care MLTSS:	NF VBP Decrease by X% Long-Stay High-Risk Residents with Pressure Ulcers	Fair: 8.06 – 10.92 Better: 5.43 – 8.05 Best: 0 – 5.42 NR
	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/	• Cardinal Care MLTSS: • Cardinal Care Acute:	Maintain MLR XXXX	Maintain compliance with MLR requirements NR
Goal 4: Strengthen the Health of Families and Communities	Objective 4.1 Improve the Utilization of Wellness, Immunization, and Prevention	4.1.1.1 Adults' Access to Preventive/Ambulatory Health Services	NCQA HEDIS (AAP)	HEDIS MY 2020 • Cardinal Care MLTSS: 87.12%	Increase the HEDIS Adults' Access to Preventive/Ambulatory Health Services measure rate to perform at or above	Use HEDIS MY2022 percentile benchmark Adults' Access to Preventive/

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
	Services for Members			Cardinal Care Acute: 72.75%	the HEDIS 50th percentile by 2025: Cardinal Care Program:	Ambulatory Health Services 72.83%
		4.1.1.2 Child and Adolescent Well-Care Visits	NCQA HEDIS (WCV) Child Core Set: WCV-CH	HEDIS MY 2020 - Cardinal Care MLTSS: 39.86% - Cardinal Care Acute: 46.57% Child Core Set - Cardinal Care MLTSS: - Cardinal Care Acute:	Increase the HEDIS Child and Adolescent Well-Care Visits 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: 3-11 Years: 12-17 Years: 18-21 Years: - Total:	Use HEDIS MY2022 percentile benchmark <i>Child and Adolescent Well-Care Visits</i> Total: 50.88%
		4.1.1.3 Childhood Immunization Status	NCQA HEDIS (CIS) Combo 3 Child Core Set: CIS-CH	HEDIS MY 2020 - Cardinal Care MLTSS: 65.58% - Cardinal Care Acute: 65.82%	Increase the HEDIS Childhood Immunization Status measure rate to perform at or above the HEDIS 50th percentile by 2025:	Update to PWP target <i>Childhood Immunization Status</i>

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Child Core Set - Cardinal Care MLTSS: - Cardinal Care Acute:	- 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:	66.64% <i>Child and Adolescent Well-Care Visits</i> Total: 50.88%
		4.1.1.4 Immunizations for Adolescents	NCQA HEDIS (IMA) - Combo 1 - Combo 2 Child Core Set: IMA-CH	HEDIS MY 2020 Combo 1 - Cardinal Care MLTSS: 64.10% - Cardinal Care Acute: % Combo 2 - Cardinal Care MLTSS: 26.02% - Cardinal Care Acute: % Child Core Set	Increase the HEDIS Immunizations for Adolescents measure rate to perform at or 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:	Update to PWP target <i>Immunization for Adolescents</i> Combo 1: 84.20% Combo 2: 35.30% <i>Child and Adolescent Well-Care Visits</i> Total: 50.88%

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				- Cardinal Care MLTSS: - Cardinal Care Acute:	- 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 - Cardinal Care MLTSS: - Cardinal Care Acute:	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 50 th percentile by 2025: - Cardinal Care Program:	Use CAHPS benchmarks NR
		4.1.1.6 Topical Fluoride for Children	NCQA HEDIS (TFC) Child Core Set: TFL-CH CMS 416	HEDIS MY 2020 - Cardinal Care MLTSS: - Cardinal Care Acute: Child Core Set	Increase the HEDIS Topical Fluoride for Children measure rate to perform at or above the HEDIS 50th percentile by 2025:	Use HEDIS MY2022 percentile benchmark NR

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				- Cardinal Care MLTSS: - Cardinal Care Acute: CMS 416 2021	<i>Note: MY 2023 Year 1 measure – percentile rankings may not be available.</i> - 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: <i>Note: Need to determine target for a CMS 416 measure.</i>	
		4.1.1.7 Oral Evaluation, Dental Services	NCQA HEDIS (OED) Child Core Set: OEV-CH CMS 416	HEDIS MY 2020 - Cardinal Care MLTSS: - Cardinal Care Acute: Child Core Set - Cardinal Care MLTSS: - Cardinal Care Acute:	Increase the HEDIS Oral Evaluation, Dental Services measure rate to perform at or above the HEDIS 50th percentile by 2025: <i>Note: MY 2023 Year 1 measure – percentile rankings may not be available.</i> Cardinal Care Program	Use HEDIS MY2022 percentile benchmark NR

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				CMS 416 2021	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: <i>Note: Need to determine target for a CMS 416 measure.</i>	
		4.1.1.8 Sealant Receipt on Permanent First Molars	Child Core Set: SFM-CH CMS 416	Child Core Set - Cardinal Care MLTSS: - Cardinal Care Acute: 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: <i>Note: MY 2023 Year 1 measure – percentile rankings may not be available.</i> Cardinal Care Program Increase the CMS Child Core Set Sealant Receipt of	Use HEDIS MY2022 percentile benchmark NR

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Permanent First Molars measure rate to perform at or above the CMCS 50th percentile by 2025: Cardinal Care Program – Total: <i>Note: Need to determine target for a CMS 416 measure.</i>	
		4.1.1.9 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA HEDIS (WCC) CMS Child Core Set (WCC-CH)	HEDIS MY 2020 Cardinal Care MLTSS: - Blood Glucose Testing-Total: 41.33% - Cholesterol Testing—Total: 28.59% - Blood Glucose and Cholesterol Testing-Total: 27.05% - Cardinal Care Acute: NR Child Core Set	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	Use HEDIS MY2022 percentile benchmark <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i> BMI: 75.44% Nutrition: 66.47% Physical Activity: 60.09%

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				- Cardinal Care MLTSS: - Cardinal Care Acute:	Nutrition and Physical Activity for Children/Adolescents measure rate to perform at or above the CMCS 50th percentile by 2025: - Cardinal Care Program – Total: - 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 - Cardinal Care MLTSS: NR - Cardinal Care Acute: NR Child Core Set - Cardinal Care MLTSS: - Cardinal Care Acute:	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 <i>Note: HEDIS measure age is 16-24 Years.</i> Increase the CMS Child Core Set Chlamydia Screening in Women Ages 16-20 Years measure	Use HEDIS MY2022 percentile benchmark NR

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					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 - Cardinal Care MLTSS: NR - Cardinal Care Acute: NR Child Core Set - Cardinal Care MLTSS: - Cardinal Care Acute:	Increase the HEDIS Lead Screening in Children measure rate to perform at or above the HEDIS 50th percentile by 2025: - Cardinal Care Program 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:	Use HEDIS MY2022 percentile benchmark NR
	★ 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 Cardinal Care MLTSS: NR	Increase the HEDIS Prenatal and Postpartum Care: Timeliness of Prenatal Care measure rate to perform at or above the HEDIS 50th percentile by 2025:	Use PWP target <i>Prenatal and Postpartum Care: Timeliness of Prenatal Care</i> Timeliness: 73.71%

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				- Cardinal Care Acute: 66.52% Adult Core Set Postpartum Care - Cardinal Care MLTSS: - Cardinal Care Acute:	- 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:	Postpartum: 72.42%
		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 - Cardinal Care MLTSS: NR - Cardinal Care Acute: 73.00% Adult Core Set Timeliness of Prenatal Care - Cardinal Care MLTSS: - Cardinal Care Acute:	Increase the HEDIS Prenatal and Postpartum Care: Postpartum Care measure rate to 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	Use PWP target <i>Prenatal and Postpartum Care: Timeliness of Prenatal Care</i> Timeliness: 73.71% Postpartum: 72.42%

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					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:	Use national mean (9.9) from 2019 CDC Wonder data or most recent available NR
		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 - Cardinal Care MLTSS: 71.81% - Cardinal Care Acute: 72.10% Child Core Set - Cardinal Care MLTSS: - Cardinal Care Acute:	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: 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:	Use HEDIS MY2022 percentile benchmark <i>Well-Child Visits in the First 30 Months of Life</i> First 15 Months: 61.18% 15 – 30 Months: 70.36%

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					- 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: <i>Note: Lower rate is better.</i>	Use national mean (23.2%) from 2019 CDC Wonder data or most recent available NR
	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:	5% NR
		4.3.1.2 Number and Percent of Individuals Who Received Services in the Scope Specified in the Service Plan	QMR	FY22 Q1: 97.0% Q2: 100% Q3: 100%	Increase the number and percent of individuals who received services in the scopes specified in their service plan by 5% by 2025: Cardinal Care Program – Total:	5% NR

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
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 - Cardinal Care MLTSS: - Cardinal Care Acute:	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: <i>Note: Lower rate is better.</i>	Use PWP target <i>Heart Failure Admission Total</i> 58.18
		5.1.1.2 PDI 14: Asthma Admission Rate (Ages 2–17)	Adult Core Set: PQI15-AD	Adult Core Set - Cardinal Care MLTSS: - Cardinal Care Acute:	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: <i>Note: Lower rate is better.</i>	Use PWP target <i>Asthma Admission Rate</i> 4.63
		5.1.1.3 PQI 05: COPD and Asthma in Older Adults' Admission Rate	Adult Core Set: PQI105-AD	Adult Core Set - Cardinal Care MLTSS: 41.04% - Cardinal Care Acute:	Decrease the CMS Adult Core Set Asthma in Older Adults' Admission measure rate to perform at or above the CMCS 50th percentile by 2025:	Use PWP target NR

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Cardinal Care Program – Total: <i>Note: Lower rate is better.</i>	
		5.1.1.4 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	NCQA HEDIS (HPC) Adult Core Set: HPC-AD	HEDIS MY 2020 - Cardinal Care MLTSS: 51.42% - Cardinal Care Acute: 41.04% Adult Core Set - Cardinal Care MLTSS: - Cardinal Care Acute:	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:	Use PWP target <i>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)</i> Control: 53.65%

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		5.1.1.5 Controlling High Blood Pressure	NCQA HEDIS (CBP) Adult Core Set: CBP-AD	HEDIS MY 2020 - Cardinal Care MLTSS: 48.07% - Cardinal Care Acute: 46.91% Adult Core Set - Cardinal Care MLTSS: - Cardinal Care Acute:	Increase the HEDIS Controlling High Blood Pressure measure rate to perform at or above the HEDIS 50th percentile by 2025: - Cardinal Care Program 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:	Use HEDIS MY2022 percentile benchmark <i>Controlling High Blood Pressure</i> 59.87%
		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 - Cardinal Care MLTSS: 47.93% - Cardinal Care Acute: NR Child Core Set - Cardinal Care MLTSS:	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	Use HEDIS MY2022 percentile benchmark <i>Avoidance of Antibiotic Treatment for Acute Bronchitis</i> 57.79%

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Cardinal Care Acute:	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: 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 - Cardinal Care MLTSS: 63.62% - Cardinal Care Acute: 71.00%	Increase the HEDIS Asthma Medication Ratio: Age 5 to 18 Years measure rate to perform at or above the HEDIS 50th percentile by 2025:	Use HEDIS MY2022 percentile benchmark <i>Asthma Medication Ratio</i> 73.68%

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Child Core Set - Cardinal Care MLTSS: - Cardinal Care Acute:	- 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: Cardinal Care MLTSS: 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: Cardinal Care Program – Total: <i>Note: Lower rate is better.</i>	Use HEDIS MY2022 percentile benchmark NR
	★Objective 5.3 Improve Outcomes for Members with Substance Use Disorders	5.3.1.1 Monitor Identification of Alcohol and Other Drug Services	DMAS	- Cardinal Care MLTSS: - Cardinal Care Acute:	Increase the percentage of members with Identification of Alcohol and Other Drug Services by 5% by 2025.	5% NR

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		5.3.1.2 Follow-Up After Emergency Department Visit for Substance Use	NCQA HEDIS (FUA) Child Core Set: FUA-CH	HEDIS MY 2020 Cardinal Care MLTSS 7-Day: 11.44% 30-Day: 19.98% Cardinal Care Acute: 7-Day: 13.92% 30-Day: 21.88% Child Core Set Cardinal Care MLTSS: 7-Day: 30-Day: Cardinal Care Acute: 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:	Use PWP target <i>Follow-Up After Emergency Department Visit for Substance Use</i> 7-Day: 27.27% 30-Day: 38.86%
		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 - Cardinal Care MLTSS: - Cardinal Care Acute: Adult Core Set	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:	Use HEDIS MY2022 percentile benchmark NR

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				- Cardinal Care MLTSS: - Cardinal Care Acute:	- 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 Cardinal Care MLTSS: - Initiation: 46.41% - Engagement: 12.51% Cardinal Care Acute: - Initiation: - Engagement: Adult Core Set Cardinal Care MLTSS: - Initiation: - Engagement:	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 Engagement of Substance Use Disorder Treatment measure rate to perform at or above	Use PWP target <i>Initiation and Engagement of Substance Use Disorder Treatment</i> Initiation: 51.05% Engagement: 20.93%

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				- Cardinal Care Acute: - Initiation: - Engagement:	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 - Cardinal Care MLTSS: - Cardinal Care Acute:	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:	If not available, use 1% as a minimum performance improvement Use of Pharmacotherapy for Opioid Use Disorder NR
	★ 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 Cardinal Care MLTSS: 7-Day: 30.77% 30-Day: 54.12% Cardinal Care Acute: 7-Day: 35.63% 30-Day: 56.84% Adult Core Set	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	Use HEDIS MY2022 percentile benchmark <i>Follow-Up After Hospitalization for Mental Illness</i> 7-Day: 33.91% 30-Day: 56.34%

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Cardinal Care MLTSS: 7-Day: 30-Day: Cardinal Care Acute: 7-Day: 30-Day: 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 – 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 Cardinal Care MLTSS: 7-Day: 47.03% 30-Day: 62.83%	Increase the HEDIS Follow-Up After Emergency Department Visit for Mental Illness measure rate to perform at or above	Use PWP target <i>Follow-Up After Emergency Department Visit for Mental Illness</i>

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Cardinal Care Acute: 7-Day: 45.34% 30-Day: 57.38%	the HEDIS 50th percentile by 2025: - Cardinal Care Program 6 Years and Older - Within 7 Days - Within 30 Days	7-Day: 38.56% 30-Day: 53.53%
				Adult Core Set Cardinal Care MLTSS: 7-Day: 30-Day:	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	
				Cardinal Care Acute: 7-Day: 30-Day:		
				Child Core Set Cardinal Care MLTSS: 7-Day: 30-Day:		
				Cardinal Care Acute: 7-Day: 30-Day:	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:	

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					- 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 Disorder (ADHD) Medication	NCQA HEDIS (ADD) Child Core Set: ADD-CH	HEDIS MY 2020 Cardinal Care MLTSS: - Initiation: - Continuation: Cardinal Care Acute: - Initiation: 45.20% - Continuation: 58.61% Child Core Set Cardinal Care MLTSS: - Initiation: - Continuation: Cardinal Care MLTSS: - Initiation: - Continuation:	Increase the HEDIS Follow-Up for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication measure rate to perform at or above the HEDIS 50th percentile by 2025: - 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	Use HEDIS MY2022 percentile benchmark <i>Follow-Up for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication</i> NR

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					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 - Cardinal Care MLTSS: - Cardinal Care Acute:	Increase the percentage of members receiving mental health services by X% by 2025.	Use HEDIS MY2022 percentile benchmark NR
		5.4.1.5 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA HEDIS (APP) Child Core Set: APP-CH	HEDIS MY 2020 - Cardinal Care MLTSS: 43.71% - Cardinal Care Acute: 69.58% Child Core Set - Cardinal Care MLTSS: - Cardinal Care Acute:	Increase the HEDIS Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics measure rate to perform at or above the HEDIS 50th percentile by 2025: Cardinal Care Program – Ages 1-17 Years Increase the CMS Child Core Set Use of First-Line Psychosocial Care	Use HEDIS MY2022 percentile benchmark <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics Total</i> 63.48%

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					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 Cardinal Care MLTSS: - Blood Glucose Testing— Total: 41.33 - Cholesterol Testing— Total: 28.59% - Blood Glucose and Cholesterol Testing— Total: 27.05% Cardinal Care Acute: NR Child Core Set - Cardinal Care MLTSS:	Increase the HEDIS Metabolic Monitoring 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 Metabolic Monitoring for Children and Adolescents on Antipsychotics measure rate to perform at or above the CMCS 50th percentile by 2025:	Use HEDIS MY2022 percentile benchmark <i>Metabolic Monitoring for Children and Adolescents on Antipsychotics</i> Glucose: 54.81% Cholesterol: 36.87% Blood Glucose and Cholesterol Testing Total: 34.96%

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Cardinal Care Acute:	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 - Cardinal Care MLTSS: - Cardinal Care Acute:	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 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	Use CAHPS benchmarks <i>Medical Assistance with Smoking and Tobacco Use Cessation</i> Advising Smokers to Quit: 72.41% Discussing Cessation Medications: 49.22% Discussing Cessation Strategies: 41.88%

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					65 and Older	
		5.4.1.8 Antidepressant Medication Management	NCQA HEDIS (AMM) CMS Adult Core Set: AMM-AD	HEDIS MY 2020: Cardinal Care MLTSS: - Effective Acute Phase Treatment: 61.11% - Effective Continuation Phase: 48.29% Cardinal Care Acute: - Effective Acute Phase Treatment: 57.12% - Effective Continuation Phase: 42.02% Adult Core Set - Cardinal Care MLTSS: - Cardinal Care Acute:	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 65 and Older - Total - Effective Acute Phase Treatment	Use HEDIS MY2022 percentile benchmark <i>Antidepressant Medication Management</i> Acute Phase: 55.20% Continuation Phase: 40.65%

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					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 - Cardinal Care MLTSS: - Cardinal Care Acute:	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	If not available, use 1% as a minimum performance improvement <i>Screening for Depression and Follow-Up Plan</i> NR
		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: - Cardinal Care MLTSS: 77.18% - Cardinal Care Acute: NR Adult Core Set - Cardinal Care MLTSS: - Cardinal Care Acute:	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	Use HEDIS MY2022 percentile benchmark <i>Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications Total</i> 81.79%

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications measure rate to perform at or above the CMCS 50th percentile by 2025: - 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 - Cardinal Care MLTSS: - Cardinal Care Acute: Adult Core Set - Cardinal Care MLTSS: - Cardinal Care Acute:	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:	Use HEDIS MY2022 percentile benchmark <i>Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure</i> NR

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure rate to perform at or above the CMCS 50th percentile by 2025: - 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: - Cardinal Care MLTSS: 69.50% - Cardinal Care Acute: NR Adult Core Set - Cardinal Care MLTSS: - Cardinal Care Acute:	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	Use HEDIS MY2022 percentile benchmark <i>Adherence to Antipsychotic Medications for Individuals with Schizophrenia</i> 62.39%

Goal	Objective	Measure Name	Metric Specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					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 CY 2021.

*The baseline measure rate is the final validated 2021 HEDIS, PM rate or CAHPS reported in the 2021 Annual Technical Report and posted to the DMAS website.

**Target established in the CY 2021 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.

NR = Not Reported

★ 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.