Commonwealth of Virginia Department of Medical Assistance Services

2021 External Quality Review Technical Report—Medallion 4.0

Table of Contents

Glossary of Acronyms

42 CFR	Title 42 of the Code of Federal Regulations
AACE	American Association of Clinical Endocrinology
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
BMI	Body Mass Index
BR	Biased Rate
CAHPS®,[1]	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CCC	Children with Chronic Conditions
CCC Plus	Commonwealth Coordinated Care Plus
CDC	Centers for Disease Control and Prevention
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
CMHRS	Community Mental Health Rehabilitative Services
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus Disease 2019
CPT	Current Procedural Terminology
CRMS	Care Management Solution
CY	Calendar Year
D-SNP	Dual-Eligible Special Needs Plan
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disability
DMAS	Department of Medical Assistance Services
DOC	Department of Corrections
DPP	Diabetes Prevention Program
ED	Emergency Department
EDV	Encounter Data Validation

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

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
FMEA ..... Failure Mode and Effects Analysis
FPL ..... Federal Poverty Level
HCBS ..... Home and Community-Based Services
HCPCS ..... Healthcare Common Procedure Coding System
HEDIS®,[2] ..... Healthcare Effectiveness Data and Information Set
HHS ..... United States Department of Health and Human Services
HIPAA ..... Health Insurance Portability and Accountability Act of 1996
HIV ..... Human Immunodeficiency Virus
HMO ..... Health Maintenance Organization
HSAG ..... Health Services Advisory Group, Inc.
IACCT ..... Independent Assessment Certification and Coordination Team
ICT ..... Intensive Community Treatment
ID ..... Identification
IDSS ..... Interactive Data Submission System
IIH ..... Intensive In-Home Services
IS ..... Information Systems
ISP ..... Individual Service Plan
LIFC ..... Low-Income Families With Children
LO ..... Licensed Organization
LOB ..... Line of Business
LTSS ..... Long-Term Services and Supports
MCE ..... Managed Care Entity
MCO ..... Managed Care Organization
MES ..... Medicaid Enterprise System
MHSS ..... Mental Health Skill-Building Services
MITA ..... Medicaid Information Technology Architecture
MLTSS ..... Managed Long-Term Services and Supports
MMIS ..... Medicaid Management Information System
MODRN ..... Medicaid Outcomes Distributed Research Network

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

MOUD.....Medications for Opioid Use Disorder
MRRV.....Medical Record Review Validation
MUE.....Medically Unlikely Edit
MY ..... Measurement Year
NCQA..... National Committee for Quality Assurance
NDC ..... National Drug Code
NPI.....National Provider Identifier
NR.....Not Reported
NVSS ..... National Vital Statistics System
O/E.....Observed/Expected
OB/GYN .....Obstetrics and Gynecology
OBOT.....Office-Based Opioid Treatment
OBRAF.....Obstetrical Risk Assessment Form
OSR .....Operational Systems Review
OTP.....Opioid Treatment Program
OUD..... Opioid Use Disorder
PAHP .....Prepaid Ambulatory Health Plan
PCCM..... Primary Care Case Management
PCP..... Primary Care Provider
PDF..... Portable Document Format
PDI..... Pediatric Quality Indicator
PDSA .....Plan-Do-Study-Act
PHE.....Public Health Emergency
PIHP..... Prepaid Inpatient Health Plan
PIP .....Performance Improvement Project
PM .....Performance Measure
PMPM .....Per Member Per Month
PMV ..... Performance Measure Validation
PRTF.....Psychiatric Residential Treatment Facility
PSR.....Psychosocial Rehabilitation
PTP.....Procedure-to-Procedure
PWP..... Performance Withhold Program
QAPI ..... Quality Assessment and Performance Improvement
QI.....Quality Improvement
QS.....Quality Strategy
SARS-CoV-2 .....Severe Acute Respiratory Syndrome Coronavirus 2
SBIRT.....Screening, Brief Intervention, and Referral to Treatment
SFY.....State Fiscal Year
SHCN.....Special Health Care Needs

SMART	Specific, Measurable, Attainable, Relevant, Time-bound
SNF	Skilled Nursing Facility
SUD	Substance Use Disorder
T-MSIS	Transformed Medicaid Statistical Information System
TDT	Therapeutic Day Treatment
TGH	Therapeutic Group Home
TPL	Third Party Liability
VA	Virginia
VCU	Virginia Commonwealth University
VDH	Virginia Department of Health
VDSS	Virginia Department of Social Services
VHHA	Virginia Hospital & Healthcare Association
VNPC	Virginia Neonatal Perinatal Collaborative
WIC	Women, Infants and Children

1. Executive Summary

Overview of 2021 External Quality Review

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

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

DMAS administers the Medallion 4.0 program, which includes the Virginia Medicaid program and the FAMIS program, the Commonwealth's CHIP. DMAS contracted with six privately owned MCOs to deliver physical and behavioral health services to Medicaid and CHIP members. The MCOs contracted with DMAS during CY 2021 are displayed in Table 1-1.

Table 1-1—Medicaid Medallion 4.0 MCOs in Virginia

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

Scope of External Quality Review Activities

To conduct this assessment, HSAG used the results of mandatory and optional EQR activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by CMS. The purpose of these activities, in general, is to improve states' ability to oversee and manage MCOs they contract with for services, and help MCOs improve their performance with respect to quality of, timeliness of, and access to care. Effective implementation of the EQR-related activities will facilitate the Commonwealth's efforts to

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019.* Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Nov 29, 2021..

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

Methodology for Aggregating and Analyzing EQR Activity Results

For the 2021 EQR technical report, HSAG used findings from the EQR activities conducted from January 1, 2021, through December 31, 2021. From these analyses, HSAG derived conclusions and made recommendations about the quality of, access to, and timeliness of care and services provided by each DMAS MCO and the overall statewide Medallion 4.0 program. For a detailed, comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each MCO, please refer to the results of each activity in sections 4 through 9 of this report. Detailed information about each activity's methodology are provided in Appendix B of this report. Table 1-2 identifies the EQR mandatory and optional activities included in this report.

Table 1-2—EQR Activities

Activity	Description	CMS EQR Protocol
Mandatory Activities		
PIPs	The purpose of PIP validation is to validate PIPs that have the potential to affect and improve member health, functional status, or satisfaction. To validate each PIP, HSAG obtained the data needed from each MCO's PIP Summary Forms. These forms provided detailed information about the PIPs related to the steps completed and validated by HSAG for the 2021 validation cycle.	*Protocol 1.* Validation of Performance Improvement Projects
PMV	HSAG conducts the PMV for each MCO to assess the accuracy of PMs reported by the MCOs, determine the extent to which these measures follow 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, 2020, through December 31, 2020.	*Protocol 2.* Validation of Performance Measures
Compliance With Medicaid and CHIP Managed Care Regulations	This activity determines the extent to which a Medicaid and CHIP MCO is in compliance with federal standards and associated 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, 2020, through June 30, 2021.	*Protocol 3*. Review of Compliance with Medicaid and CHIP Managed Care Regulations

Activity	Description	CMS EQR Protocol
Validation of Network Adequacy	The network adequacy validation activity validates MCO network adequacy using DMAS' network standards in its contracts with the MCOs. DMAS established time and distance standards for the following network provider types: primary care (adult and pediatric), OB/GYN, behavioral health, specialist (adult and pediatric), hospital, pharmacy, pediatric dental, and additional provider types that promote the objectives of the Medicaid program.	*Protocol 4.* Validation of Network Adequacy *(Pending Final Protocol)*
Optional Activities		
EDV	HSAG conducts EDV, which includes an IS review/assessment of DMAS' and the MCOs' IS and processes to examine the extent to which DMAS' and the MCOs' IS infrastructures are likely to collect and process complete and accurate encounter data. HSAG also completes an administrative profile, which is an analysis of DMAS' electronic encounter data completeness, accuracy, and timeliness. This activity evaluates the extent to which the encounter data in DMAS' EPS database are complete, accurate, and submitted by the MCOs in a timely manner for encounters.	*Protocol 5.* Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan
CAHPS Analysis	This activity assesses member experience with an MCO and its providers and the quality of care members receive. **FAMIS CAHPS Survey**—HSAG administers the CAHPS 5.1H Child Medicaid Health Plan Survey to FAMIS members receiving healthcare services through FFS or managed care. HSAG analyzes the CAHPS survey data and generates a FAMIS Program Member Satisfaction Report for DMAS.	*Protocol 6.* Administration or Validation of Quality of Care Surveys
Calculation of Additional PMs	This activity calculates quality measures to evaluate the degree to which evidence-based treatment guidelines are followed, where indicated, and to assess the results of care. HSAG calculates one PM (selected by DMAS) for the Medicaid population stratified by geographic region and key demographic variables (race, gender, age, etc.).	*Protocol 7.* Calculation of Additional Performance Measures

Activity	Description	CMS EQR Protocol
ARTS Measure Specification Development and Maintenance	HSAG identifies, when available, PMs from existing measure sets or develops PMs for the ARTS program.	*Protocol 7.* Calculation of Additional Performance Measures
Focus Studies	This activity provides information about the healthcare quality for a particular aspect of care across managed care in the Commonwealth or for subpopulations served by managed care within the Commonwealth. **Prenatal Care and Birth Outcomes Focus Study**—HSAG conducts a focus study that provides quantitative information about prenatal care and associated birth outcomes among Medicaid recipients. **Foster Care Focus Study**—HSAG conducts a Foster Care Focus Study to evaluate healthcare utilization among children in foster care under the Medallion 4.0 program. **Dental Utilization in Pregnant Women Data Brief**—HSAG produces a data brief describing dental utilization among pregnant women enrolled in the Medicaid or FAMIS MOMS programs.	*Protocol 9.* Conducting Focus Studies of Health Care Quality
Consumer Decision Support Tool	This activity provides information to help eligible members choose a Medicaid Medallion 4.0 MCO. The tool shows how well the different MCOs provide care and services in various performance areas. HSAG develops Virginia's Consumer Decision Support Tool (i.e., Quality Rating System) to improve healthcare quality and transparency and provide information to consumers to make informed decisions about their care within the Medallion 4.0 program. HSAG uses HEDIS and CAHPS data to compare MCOs to one another in key performance areas.	*Protocol 10.* Assist With Quality Rating of Medicaid and CHIP Managed Care Organizations, Prepaid Inpatient Health Plans, and Prepaid Ambulatory Health Plans
PWP	HSAG developed a methodology to calculate the MCO results for the PWP for DMAS. The 2021 PWP used HEDIS and non-HEDIS measures.	
QS Update	HSAG works with DMAS to update and maintain the Virginia 2020–2022 QS. QS maintenance incorporates programmatic	Medicaid and CHIP Managed Care QS Toolkit

Activity	Description	CMS EQR Protocol
	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.	

Virginia Managed Care Program Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from the preceding 12 months to comprehensively assess the MCOs' performance in providing quality, timely, and accessible healthcare services to DMAS Medicaid and CHIP members as required in 42 CFR §438.364. The overall findings and conclusions regarding quality, timeliness, and access for all MCOs were also compared and analyzed to develop overarching conclusions and recommendations for the Virginia managed care program. In accordance with 42 CFR §438.364(a)(1), HSAG provides a description of the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality of, timeliness of, and access to care furnished by the MCOs. Table 1-3 provides the overall strengths and weaknesses of the Medallion 4.0 program that were identified as a result of the EQR activities. Refer to Section 3 for a summary of each activity.

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

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

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

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

Table 1-3—Overall Medallion 4.0 Program Conclusions: Quality, Access, and Timeliness

EQRO Results	
Domain	**Conclusion**
Quality	**Strengths:** The compliance review identified that most MCOs maintained and implemented processes to ensure member information and member notices were understandable; accessible; distributed; and included, as appropriate, all

EQRO Results	
Domain	**Conclusion**
	required information, including member rights and processes to be followed. These MCO processes may have impacted the results of the member experience surveys where the *Rating of Health Plan* and *Rating of All Health Care* measure rates for most MCOs were statistically significantly higher than the 2020 NCQA child Medicaid national averages and one MCO for the adult Medicaid population. **Strengths:** Overall, MCO members were satisfied with the quality of care provided through their MCOs. MCO members rated their health plan higher in 2021 than in 2020. The member experience results were supported by improved PM rates in the Care for Chronic Conditions domain, including measures focused on the asthma medication ratio and discussing and assisting members with smoking and tobacco cessation. The results suggest that providers were providing quality care for chronic conditions such as asthma, and individuals were receiving help with cessation strategies for smoking and tobacco use. **Weaknesses:** The MCOs did not consistently update policies, procedures, processes, or member materials to include requirements in the 2020 Medicaid Managed Care Rule or in their contract with DMAS. In addition, the MCOs did not consistently follow approved methodologies for PIPs. These findings suggest that the MCOs may not have implemented processes to ensure all federal and DMAS requirements were met. **Weaknesses:** All MCOs' rates fell below the NCQA HEDIS Medicaid 50th percentile for two early detection measures, *Breast Cancer Screening* and *Cervical Cancer Screening*, and the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators. In addition, no MCOs' rates met the 50th percentile for the *Comprehensive Diabetes Care* measure indicator. MCO performance was also particularly low for the *Medical Assistance With Smoking and Tobacco Use Cessation* measure indicators. All measures within the Children's Preventive Care domain also fell below the 50th percentile. Although members may have adequate access to timely early diagnosis, preventive, and well visits, members are not completing these visits or receiving necessary preventive and early detection care. A factor that may have contributed to low performance was the temporary suspension of non-urgent services and in-person PCP appointments due to the COVID-19 PHE.
Access	**Strengths:** Overall, the results of the compliance review and PM results for some measure indicators, such as the children's measures for well-child visits and immunizations, identified that the MCOs implemented processes to ensure access to care and services and to ensure that the service delivery met the accessibility, cultural, ethnic, racial, and linguistic needs of members including those with physical and behavioral SHCN. **Strengths:** Overall, the MCOs evaluated and monitored the quality of, appropriateness of, and access to care for members with SHCN, ensuring that members had physical access, reasonable accommodations, and accessible equipment for members with disabilities.

EQRO Results	
Domain	**Conclusion**
	Weaknesses: All MCO rates fell below the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator, reflecting an opportunity for improvement. The low performance indicates members may be experiencing issues accessing providers for health services. The COVID-19 PHE had a significant impact on healthcare services. Many provider offices were closed and offered limited telehealth services. Families also deferred going to the doctor's office for routine, nonemergency care. Although members were receiving access to preventive care, the measure rates suggest that members were not always able to access providers for preventive services in a timely manner. These members may have had difficulties finding access to care, indicating potential overall or regional network adequacy issues, or this weakness may be a result of disparities in the population served. The PM findings are supported by member experience survey results, which reflect statistically significantly lower rates than the 2020 NCQA child Medicaid national averages in the *Getting Care Quickly* and *How Well Doctors Communicate* measures.
Timeliness	**Strengths:** Overall, the MCOs eased requirements and expanded access points during the COVID-19 PHE, including expanded use of telemedicine and services. The MCOs also eased processes to ensure claims edits were not triggered for emergency service claims. Members were able to access a PCP timely and receive appropriate treatment as necessary to stay healthy and reduce unnecessary ED utilization. **Strengths:** Overall, MCO performance within the Behavioral Health domain was strong, with all six MCOs' rates meeting or exceeding the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment*, *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total*, *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure indicators. The strong performance in the Behavioral Health domain measures indicates that Virginia and the MCOs have improved medication management and are appropriately managing care for patients hospitalized or who visit the ED with a mental health issue, potentially as a result of Virginia's focus on the ARTS benefit and the development of member-centric behavioral healthcare and services. **Weaknesses:** MCO members are not completing recommended screenings, which may indicate a lack of understanding of healthcare or recommended preventive schedules. All reportable measure rates for all six of the MCOs fell below the 50th percentile in the Women's Health domain, demonstrating opportunities for improvement for all MCOs for the *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Prenatal and Postpartum Care* measure rates. Factors that may have contributed to the declines include screening site closures and the temporary suspension of non-urgent services due to the COVID-19 PHE.

Quality Strategy Recommendations for the Virginia Managed Care Program

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

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

Program Recommendations	
Recommendation	**Associated 2020–2022 QS Goal and/or Objective**
To improve program-wide performance in support of Goal 4.3 and mitigate the barriers members experience related to access to care, HSAG recommends the following: • Require the MCOs to identify access-related PMs, such as *Child and Adolescent Well-Care Visits*, that fell below the NCQA Quality Compass national Medicaid HMO 50th percentile and focus QI efforts on identifying the cause and implementing interventions to improve access to care. • Require the MCOs to identify healthcare disparities within the access-related PM data to focus QI efforts on a disparate population.	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members **Objective:** Increase Child and Adolescent Well-Care Visits **Goal 4.6:** Improve Outcomes for Maternal and Infant Members **Objective:** Increase Child and Adolescent Well-Care Visits
To improve program-wide performance in support of Goal 4.4 and improve members' receipt of recommended care and services for better management of chronic conditions, HSAG recommends the following: • Require the MCOs to identify chronic health-related PMs that fell below the NCQA Quality Compass national Medicaid HMO 50th percentile and focus QI efforts on identifying the cause and implementing interventions to improve access to care. • Require the MCOs to identify healthcare disparities within the Care for Chronic Conditions domain PMs' data to focus QI efforts on a disparate population.	**Goal 4.4:** Improve Health for Members with Chronic Conditions **Objective:** Decrease Diabetes Poor Control **Objective:** Increase Control of High Blood Pressure

2. Overview of Virginia's Managed Care Program

Medicaid Managed Care in the Commonwealth of Virginia

The Department of Medical Assistance Services

DMAS is the Commonwealth of Virginia's single State agency that administers all Medicaid and FAMIS health insurance benefit programs in the Commonwealth. Medicaid is delivered to individuals through two models, managed care and FFS. As of December 2021, approximately 89.5 percent of Medicaid enrollees received their benefits through the managed care model, and approximately 10.5 percent of members participated in Medicaid through the FFS model. In 2021, the managed Medicaid populations in Virginia were organized into two programs: Medallion 4.0 and CCC Plus. Table 2-1 displays the DMAS annual enrollment by program.

Table 2-1—CY 2021 Average Annual Program Enrollment

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

DMAS contracted with six privately owned MCOs to deliver physical health and behavioral health services to Medicaid and CHIP members. The MCOs contracted with DMAS during CY 2021 are displayed in Table 2-2.

Table 2-2—MCOs in Virginia

MCO	Profile Description	MCO NCQA Accreditation Status
Aetna	Aetna Better Health of Virginia is the Medicaid/FAMIS Plus program offered by Aetna, a multistate healthcare benefits company headquartered in Hartford, Connecticut.	Accredited* through 04/01/24 LTSS Distinction through 04/01/24
HealthKeepers	HealthKeepers is a Virginia HMO affiliated with Anthem Blue Cross Blue Shield, a publicly owned, for-profit corporation that operates as a multistate healthcare company, headquartered in Indianapolis, Indiana.	Accredited* through 03/09/24 LTSS Distinction through 03/09/24
Magellan	Magellan is a Medicaid/FAMIS Plus program offered by Magellan Health, Inc., conducting business	Accredited* through 06/29/23 LTSS Distinction through 06/30/23

MCO	Profile Description	MCO NCQA Accreditation Status
	in Virginia since 1972, headquartered in Scottsdale, Arizona.	
Optima	Optima is the Medicaid managed care product offered by Optima Health. A subsidiary of Sentara, Optima is a not-for-profit healthcare organization serving Virginia and northeastern North Carolina, headquartered in Norfolk, Virginia.	Accredited* through 04/01/24 LTSS Distinction through 04/01/24
United	United is part of the UnitedHealth Group family of companies, headquartered in Minneapolis, Minnesota. United provides Medicaid managed care and nationally serves more than 6.6 million low-income and medically fragile people, including D-SNPs across 30 states plus Washington, D.C.	Accredited* through 06/22/23 LTSS Distinction through 06/22/23
VA Premier	VA Premier, founded in 1995, is jointly owned by the integrated, not-for-profit health system Sentara Healthcare, based in Norfolk, Virginia, and VCU Health Systems, based in Richmond, Virginia.	Commendable** Accreditation through 07/08/22 LTSS Distinction through 07/08/22

*Accredited: NCQA has awarded an accreditation status of "Accredited" for service and clinical quality that meet the basic requirements of NCQA's rigorous standards for consumer protection and QI.[2-1]

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

MCO Medallion 4.0 Enrollment Characteristics

Figure 2-1 through Figure 2-4 display the Medallion 4.0 program enrollment characteristics. Table 2-3 through

[2-1] National Committee for Quality Assurance. Advertising and Marketing Guidelines: Health Plan Accreditation. Available at: https://www.ncqa.org/wp-content/uploads/2018/08/20180804_HPA_Advertising_and_Marketing_Guidelines.pdf. Accessed on: Nov 30, 2021.

Table **2-7** display the MCO and Medallion 4.0 program overall enrollment characteristics.

Figure 2-1—Medallion 4.0 Program CY 2021 Eligibility Categories

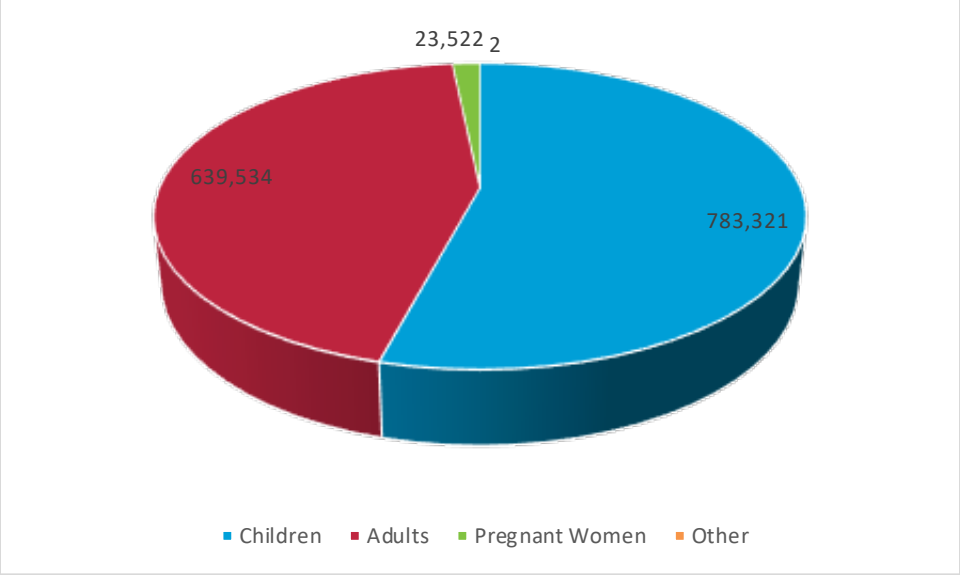


Table 2-3—Medallion 4.0 Program CY 2021 MCO Eligibility Categories

Category	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier	All
Eligibility							
Overall Total	191,415	440,733	94,284	283,491	148,316	288,140	1,446,379
Children	107,970	267,250	55,516	158,969	75,650	164,369	783,321
Adults	80,152	166,068	36,931	120,111	70,085	119,784	639,534
Pregnant Women	3,202	7,414	1,837	4,411	2,581	3,987	23,522
Other	1	1	0	0	0	0	2

Figure 2-2—Medallion 4.0 Program CY 2021 Categories by Race

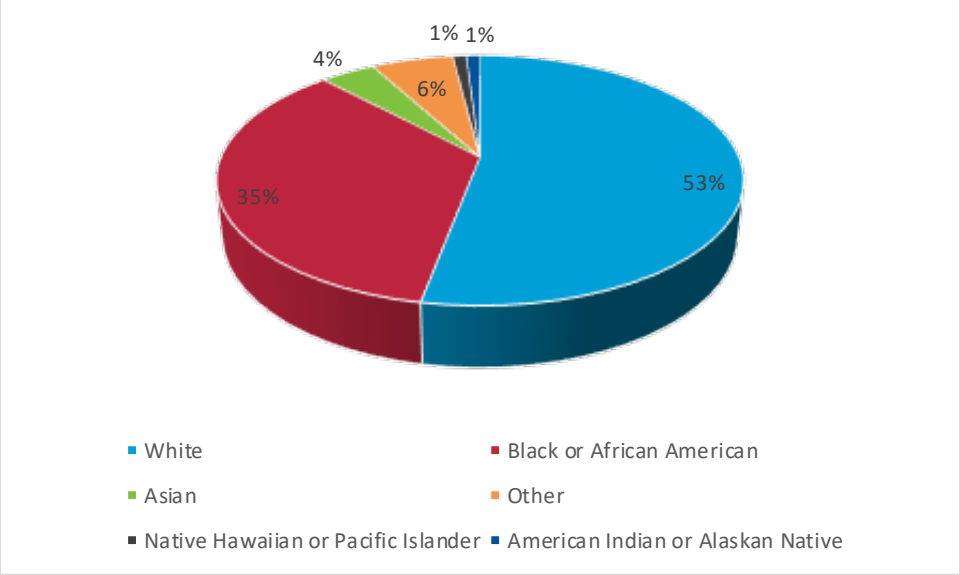


Table 2-4—Medallion 4.0 Program CY 2021 Categories by Race

Category	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier	All
Race							
White	53%	54%	52%	45%	59%	59%	53%
Black or African American	33%	35%	34%	46%	27%	31%	35%
Asian	4%	5%	3%	3%	5%	4%	4%
Other	8%	5%	9%	5%	7%	4%	6%
Native Hawaiian or Other Pacific Islander	1%	1%	1%	1%	1%	1%	1%
American Indian or Alaskan Native	1%	1%	1%	1%	1%	0%	1%

Table 2-5—Medallion 4.0 Program CY 2021 MCO Ethnicity Categories

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

Figure 2-3—Medallion 4.0 Program CY 2021 Percentage by Gender

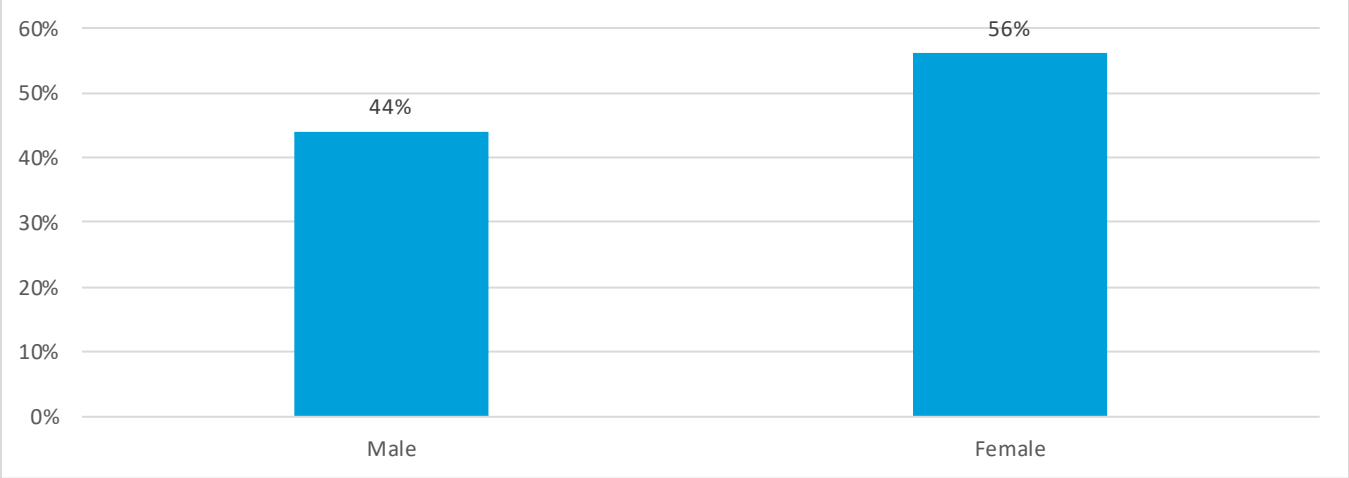


Table 2-6—Medallion 4.0 Program CY 2021 MCO Percentage by Gender

Category	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier	All
Gender							
Male	44%	44%	47%	43%	47%	44%	44%
Female	56%	56%	53%	57%	53%	56%	56%

Figure 2-4—Medallion 4.0 Program CY 2021 Enrollment by Age Group

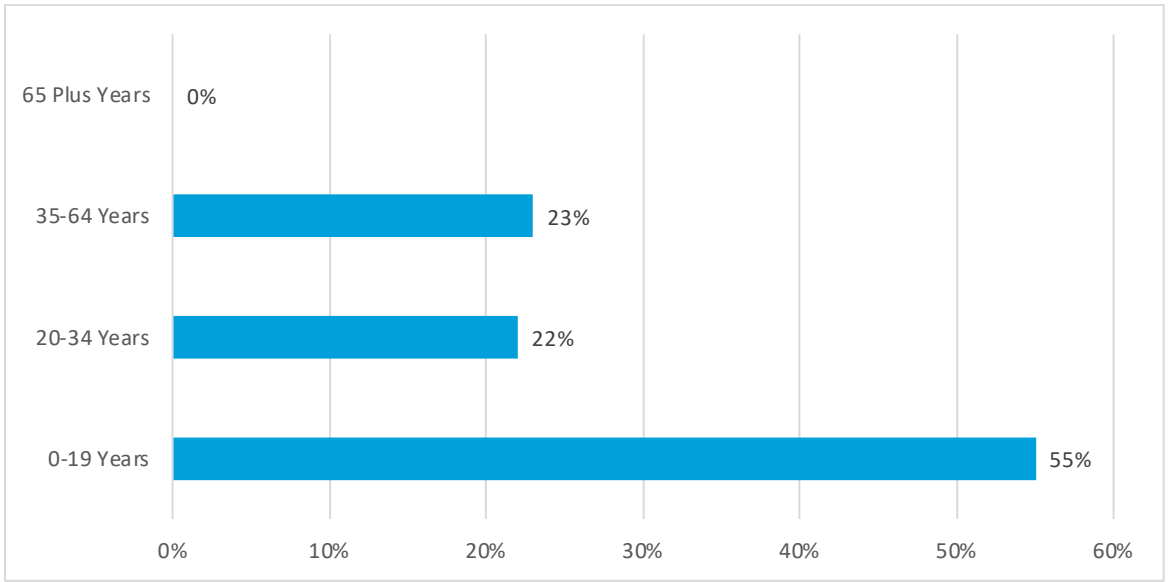


Table 2-7—Medallion 4.0 Program CY 2021 MCO Enrollment by Age Group

Category	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier	All
Age Groups							
0–19 Years	42%	61%	40%	57%	52%	58%	55%
20–34 Years	28%	19%	30%	22%	24%	21%	22%
35–64 Years	30%	19%	30%	21%	25%	22%	23%
65 Plus Years	0%	0%	0%	0%	0%	0%	0%

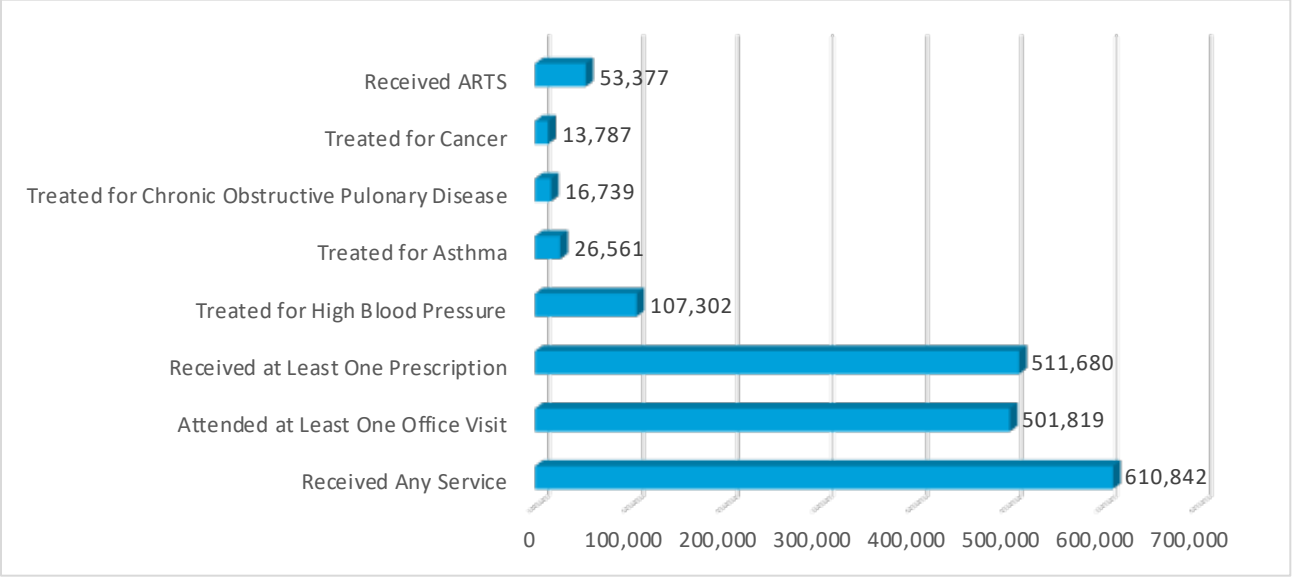
Data from 09/15/21 Enrollment Data at https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/.

Medallion 4.0 Program

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

Medicaid expansion coverage began in Virginia on January 1, 2019, and is administered through a comprehensive system of care. Medicaid expansion provides coverage for eligible individuals, including adults ages 19 through 64 who are not Medicare eligible, who have income from 0 percent to 138 percent of the FPL, and who are not already eligible for a mandatory coverage group (i.e., children, caretaker adults, pregnant women, individuals over the age of 65, and individuals who are blind or have a disability). As of September 15, 2021, 584,631 adults were newly enrolled in Medicaid as a result of Virginia's Medicaid expansion. Of those, 147,182 were also parents. Males accounted for 46 percent of the Medicaid expansion population and 54 percent were female. Figure 2-5 displays services received by Medicaid expansion members since January 2019. Enrollment and service data were obtained from the September 15, 2021 Medicaid Expansion data at: https://www.dmas.virginia.gov/data/medicaid-expansion-enrollment. All other data in Figure 2-5 and Figure 2-6 were obtained from the September 15, 2021 enrollment data at: https://www.dmas.virginia.gov/data/medicaid-expansion-access.

Figure 2-5—Medicaid Expansion Service Provision

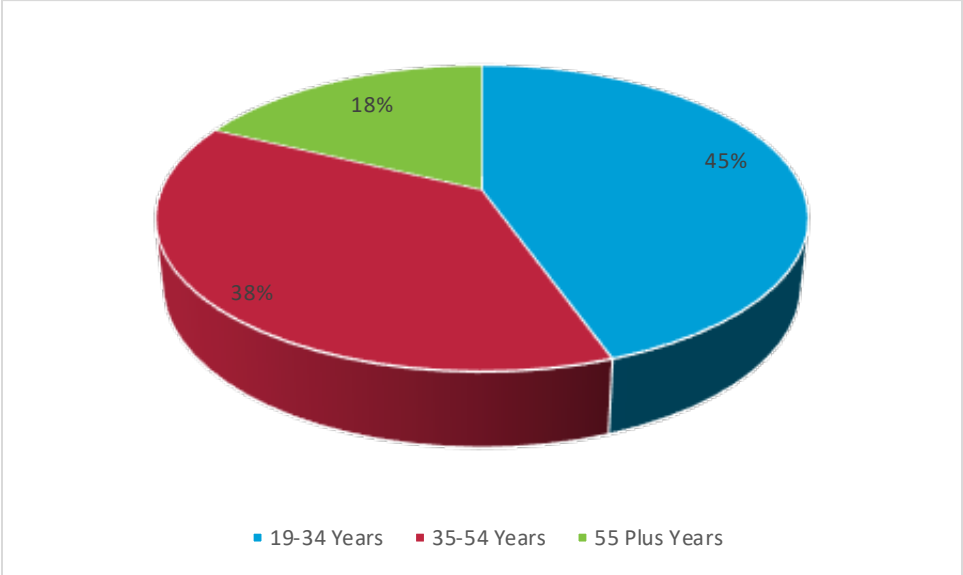


Notes:

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

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

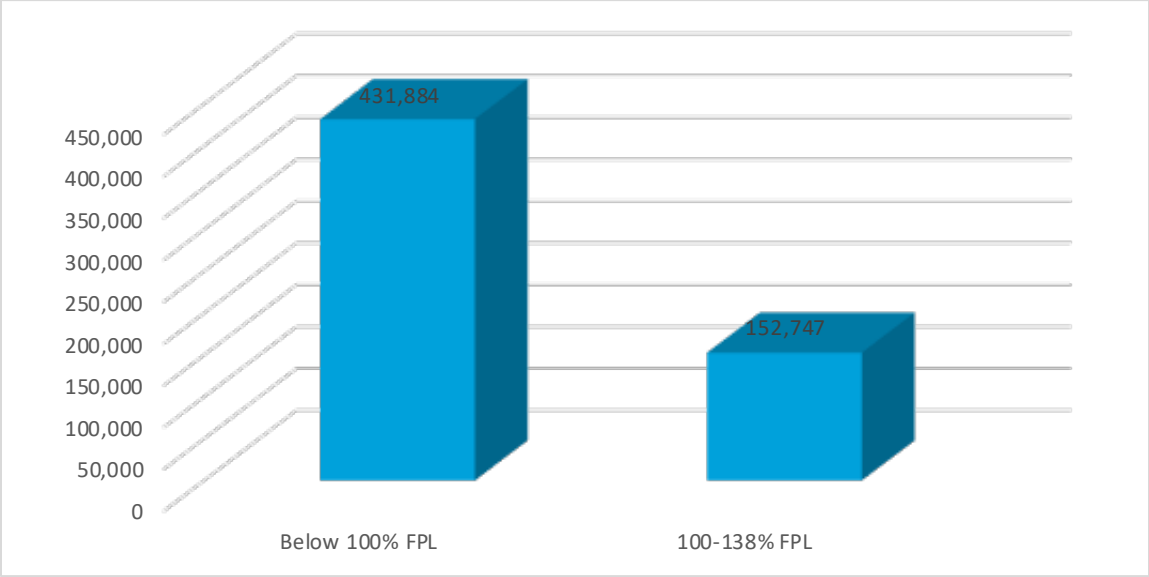
Figure 2-6—Medicaid Expansion Number of Members by Age Category



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

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

Figure 2-7—Medicaid Expansion Members by FPL Category



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

COVID-19 Response

The COVID-19 PHE had a significant impact on healthcare services. Many provider offices were closed and offered limited telehealth services. Families also deferred going to the doctor's office for routine, nonemergency care.

On May 20, 2020, DMAS announced that it had received federal approval for an emergency 1135 waiver giving DMAS the authority to take additional steps to ensure access to care for members and to address priority needs identified by healthcare providers.

The waiver allowed Virginia to streamline the process for healthcare providers to enroll in the Medicaid program and receive reimbursement for services to members. New staffing flexibilities granted under the waiver supported access to home health and hospice aides.

The emergency waiver completed the approval process for a new policy announced in March of 2020 that allowed Medicaid members to receive many critical health services and medical devices without waiting for authorization from DMAS or MCOs. The policy automatically extended some existing authorizations to prevent interruptions in medical services.

The ongoing COVID-19 pandemic, caused by SARS-CoV-2, became a PHE in January 2020 and was declared a pandemic in March 2020. The Commonwealth's PHE declaration expired on June 30, 2021.

Upon the expiration of the Commonwealth's PHE, DMAS began to unwind certain flexibilities and allowed providers to transition back to pre-COVID operations for a period of 60 days (August 29, 2021) in order to allow providers appropriate time to revert to normal procedures and policy requirements.

DMAS flexibilities were designed to maintain provider staffing, maximize access to care, and minimize viral spread through community contact to protect the most vulnerable populations. Table 2-8 describes some of the flexibilities and waivers allowed during the PHE that continued throughout 2021.[2-2]

Table 2-8—COVID-19 Flexibilities[2-3]

Support for Medicaid Members—Access to Services
No pre-approvals were required for many critical medical services and devices, and some existing approvals were automatically extended. Some rehabilitative services were permitted to be provided via telehealth.
Access to Appeals and State Fair Hearings
Deadlines were extended for members and applicants to file Medicaid appeals.
Appeals were processed as long as the Medicaid member or applicant gave appropriate verbal authorization of legal representation even if the paperwork for the appointment of representation was incomplete.
ARTS
OTPs administered medication as take-home dosages, up to a 28-day supply.
Member's home served as the originating site for prescription of buprenorphine.
Behavioral Health Services
TDT, IIH, MHSS, ICT, and PSR: • The service authorization request for new services used to track which members were continuing to receive these services, assessed the appropriateness of the services being delivered via different active, telehealth modes of treatment, and to determine if this was an appropriate service to meet the member's needs. • Face-to-face service requirements continued to be waived, documentation justified the rationale for the service through a different model of care. The goals, objectives, and strategies of the ISP were updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual related to COVID-19, as well as any newly identified problem. Documentation of this review was added to the individual's medical record as evidenced by the dated signatures of the qualified or licensed professional.
For youth participating in both TDT and IIH, TDT were not used in person in the home as this was considered a duplication of services. TDT was allowed to be provided through telehealth to youth receiving IIH (in person or via telehealth) as long as services were not duplicated and ensured treatment efficacy.
During the PHE, TDT, IIH, MHSS, ICT and PSR: Providers billed for one unit on days when a billable service was provided, even if time spent in billable activities did not reach the time requirements to bill a service unit. Providers billed for a maximum of one unit per day if any of the following applied:

[2-2] Department of Medical Assistance Services. Medicaid Memo: Developmental Disabilities (DD) and Commonwealth Coordinated Care (CCC) Plus Waivers: Provider Flexibilities Related to COVID-19, 08/11/20. Available at: https://dbhds.virginia.gov/assets/doc/EI/81020-HCBS-Flexibilities-Extension-Final.pdf. Accessed on: Nov 30, 2021.

[2-3] Department of Medical Assistance Services. COVID-19 Response. Virginia Medicaid is increasing access to care in response to COVID-19. Available at: https://www.dmas.virginia.gov/covid-19-response/. Accessed on: Dec 2, 2021.

Behavioral Health Services
• The provider was only providing services through telephonic communications. If only providing services through telephonic communications, the provider billed a maximum of one unit per member per day, regardless of the amount of time of the phone call(s). • The provider was delivering services through telephonic communications, telehealth, or face to face and did not reach a full unit of time spent in billable activities. • The provider was delivering services through any combination of telephonic communications, telehealth, and in-person services and did not reach a full unit of time spent in billable activities.
Behavioral Therapy (H2033)—Face-to-face service requirements continued to be waived, documentation justified the rationale for the service through a different model of care. The goals, objectives, and strategies of the ISP updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual to COVID-19, and any newly identified problem. Documentation of this review added to the individual's medical record as evidenced by the dated signatures of the licensed behavioral health provider.
Behavioral Therapy (H2033)—One service unit equaled 15 minutes. Effective June 11, 2020, behavioral therapy providers did not have a one-unit limit per day for audio-only communications.
Crisis Stabilization/Crisis Intervention Services—The appropriateness of a crisis response using telehealth (including telephonic) evaluated by the clinician and a determination made by the clinician responding to the crisis. Any therapeutic interventions including therapy, assessments, care coordination, team meetings, and treatment planning could occur via telehealth. Face-to-face service requirements continued to be waived, documentation justified the rationale for the service through a different model of care. The goals, objectives, and strategies of the ISP, updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual related to COVID-19 and any newly identified problem and documented according to the requirements in the CMHRS provider manual.
IACCT—IACCT assessments could occur via telehealth or telephone communication.
Psychiatric Inpatient, Facility Based Crisis Stabilization, PRTF, and TGH Levels of Care: • The requirement for service authorization remained in place. • Therapy, assessments, case management, team meetings, and treatment planning could occur via telehealth. • The plan of care updated to include any change in service delivery as well as any change in goals, objectives, and strategies, including impacts on the individual due to COVID-19.
Pharmacy
Drugs dispensed for 90 days subject to a 75 percent refill "too-soon" edit. Patients only received a subsequent 90-day supply of drugs after 75 percent of the prescription had been used (approximately day 68).
The agency made exceptions to their published Preferred Drug List if drug shortages occurred.
Suspended all drug co-payments for Medicaid and FAMIS members.
Support for Medicaid Providers—Streamlined Enrollment and Screening
Provider enrollment requirements were streamlined.

Support for Medicaid Providers—Streamlined Enrollment and Screening
Site visits, application fees, and certain background checks were waived to temporarily enroll providers in the Medicaid program.
Deadlines for revalidations of providers were postponed.
Out-of-state providers were permitted to be reimbursed for services to Medicaid members.
Telehealth policies—waiver of penalties for HIPAA non-compliance and other privacy requirements.
Facilities fully reimbursed for services rendered to an unlicensed facility (during PHE). This rule applied to facility-based providers only.
Electronic signatures accepted for visits that were conducted through telehealth.

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

Medicaid Enterprise System

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

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

One of the MES modules is a dynamic CRMS, the first phase of which was implemented in July 2020, that facilitates care coordination activities for all Medicaid enrollees. CRMS collects and facilitates the secure exchange of member-centric data, through data collection, data sharing, and performance management. CRMS will securely capture the member's health summary, improving the quality and safety of care, reducing unnecessary and redundant patient testing, aiding the MCOs with proactive care planning, and reducing costs.

Since July 2020, DMAS has received millions of records with dates from the beginning of the CCC Plus and Medallion 4.0 programs. This data exchange is the first step toward implementing a comprehensive CRMS that DMAS considers to be critical for supporting continuity of care when a member transitions across MCOs and programs.

Care Coordination

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

Care coordination in Medallion 4.0 is not mandatory for every member; however, it is strongly encouraged for the vulnerable populations. The vulnerable populations include children and youth with SHCN, adults with serious mental illness, members with SUD, children in foster care or adoption assistance, women with a high-risk pregnancy, and members with other complex or multiple chronic

conditions. Comprehensive health risk assessments are conducted for children and youth with SHCN and members in foster care and adoption assistance. The MCOs are required to develop and maintain a program to address and improve the care and access of services among members requiring assessments.

ARTS

In 2017, DMAS implemented the ARTS benefit and carved-in all services into the CCC Plus and Medallion 4.0 managed care contracts. The ARTS benefit focuses on treatment and recovery services for SUD, including OUD, AUD, and related conditions from SUD. The ARTS benefit expanded coverage of many addiction treatment and recovery services for Medicaid and CHIP members, including medications for OUD treatment, outpatient treatment, short-term residential treatment, and inpatient withdrawal management services. Outcomes are measured through reductions in SUD, OUD, and AUD ED utilization; reductions in inpatient admissions; increases in the number and type of healthcare practitioners providing SUD treatment and recovery services; and a decrease in opioid prescriptions. The ARTS benefit is a fully integrated physical and behavioral health continuum of care.

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

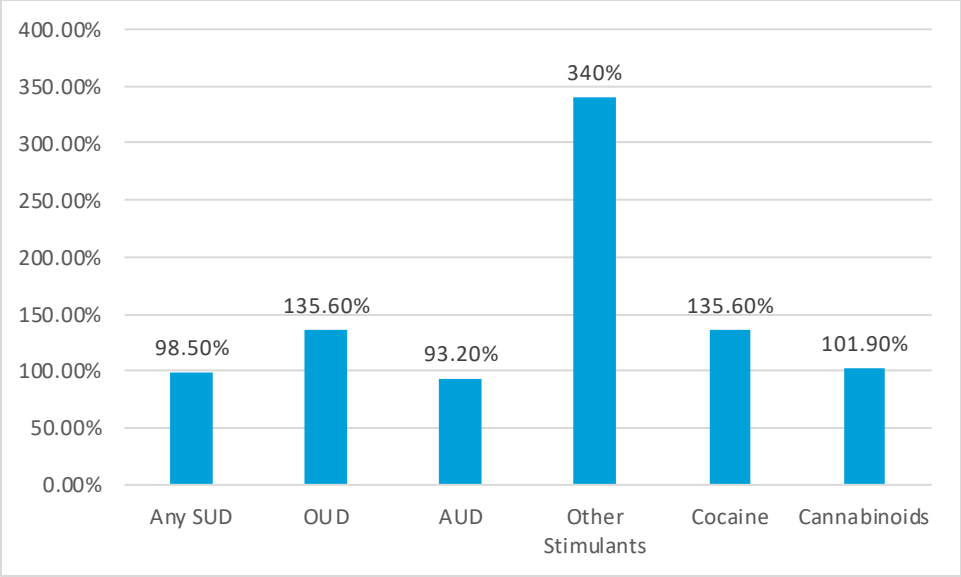
The following ARTS benefit information and findings were reported by VCU from the ARTS waiver evaluation.

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

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

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

Figure 2-8—Diagnosed Prevalence of SUD

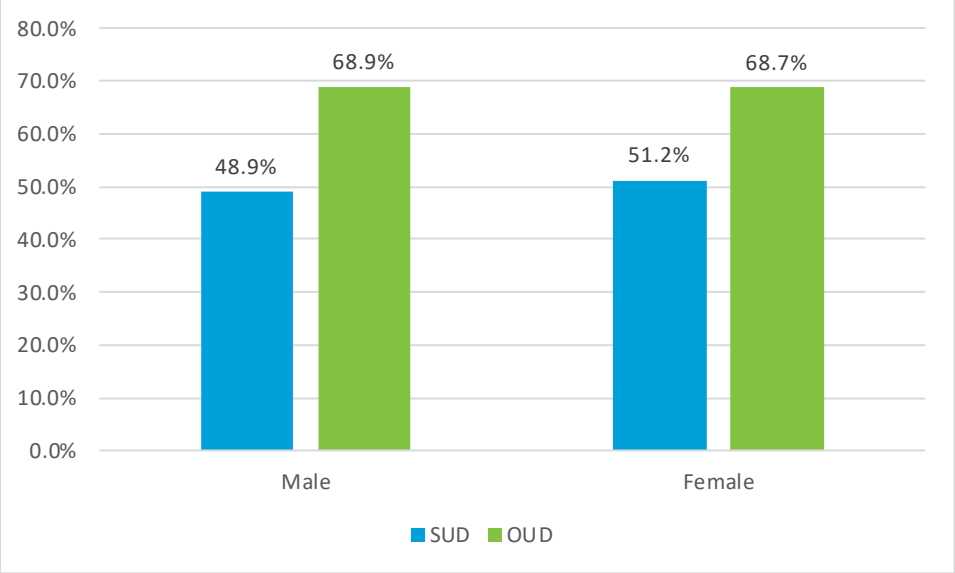


Note: Other Stimulants refers primarily to methamphetamines.

Member Characteristics

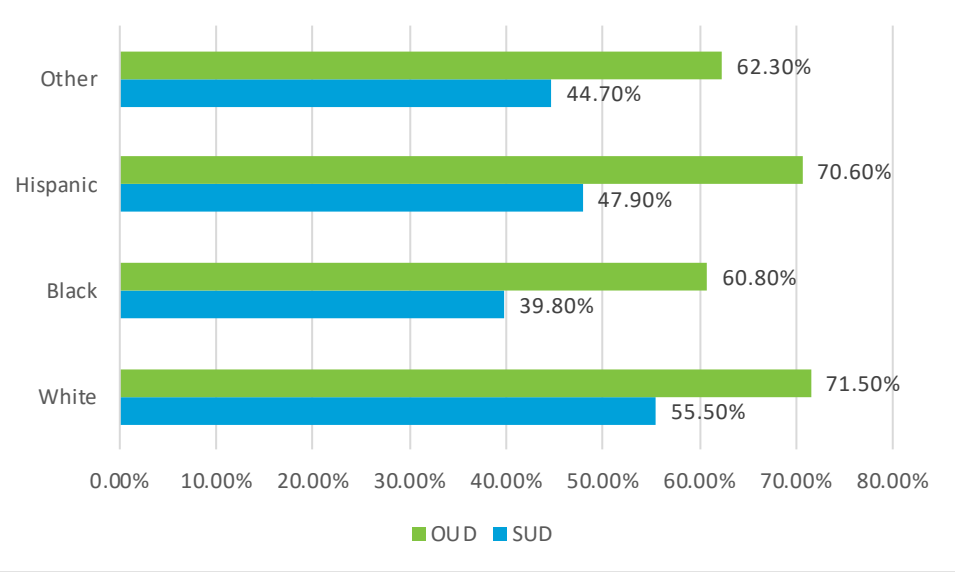
Members with a diagnosed SUD of any type represented 5.4 percent of the 1.78 million people in Virginia who were enrolled in Medicaid at some point in 2019. Figure 2-9 shows the prevalence, by gender, of members treated for SUD and OUD. Males were treated for an OUD at a higher rate than females. Females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

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



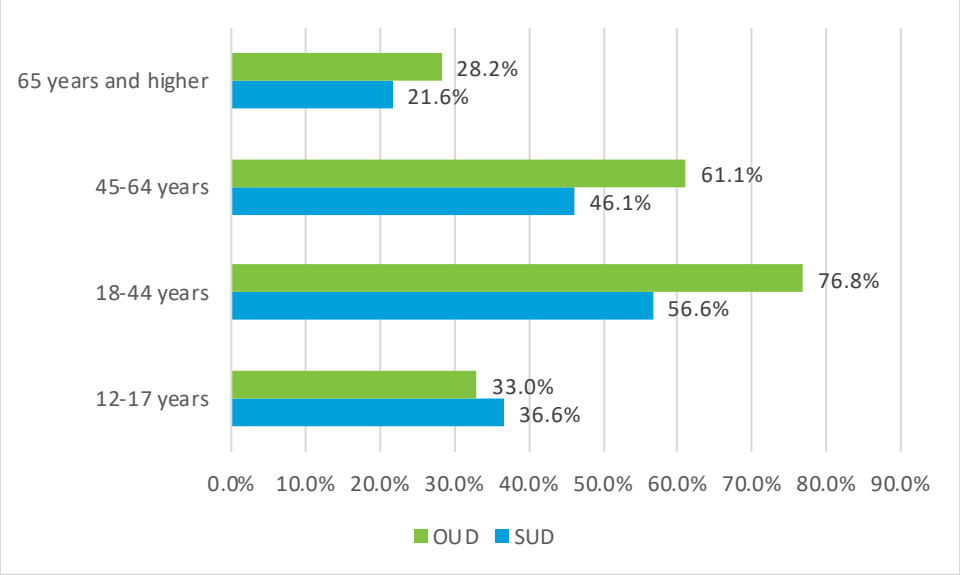
In reviewing the results published in the report, the prevalence of diagnosed SUD is lower among members identifying as Black (4.8 percent) and Hispanic (1.1 percent) compared to White members (6.3 percent). SUD and OUD treatment rates by race/ethnicity are depicted in Figure 2-10.

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



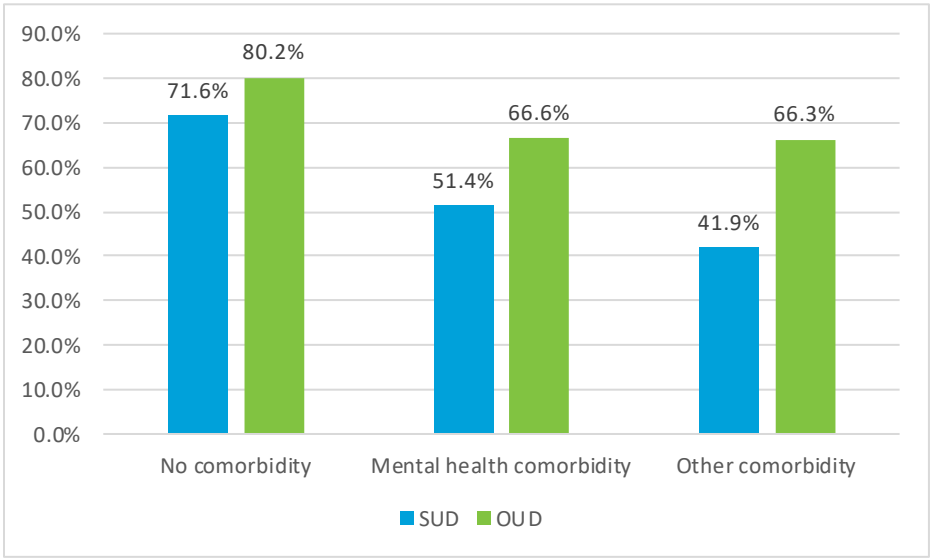
Variances in treatment rates for SUD and OUD were also identified by age group in the report. Members in the 45 to 64 age group had by far the highest diagnosed prevalence compared to other ages. Adolescents (ages 12 to 17) had the lowest diagnosed prevalence. Treatment for SUD and OUD by age are shown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

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



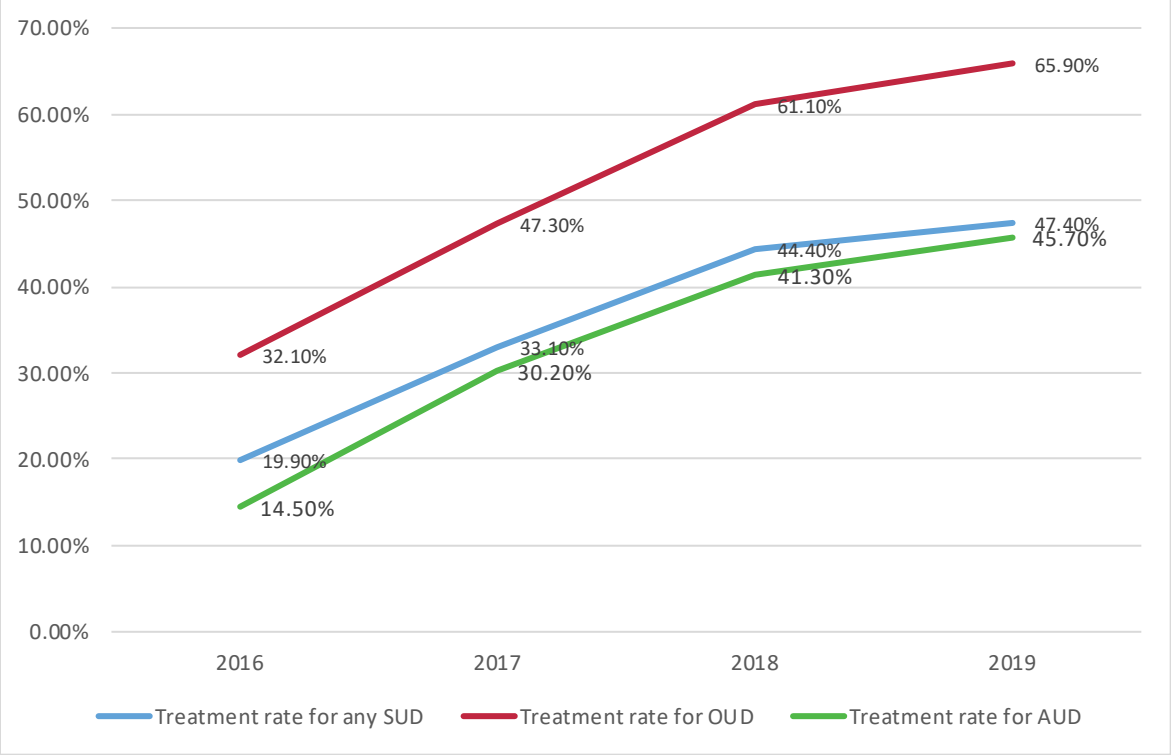
SUD are often accompanied by other co-occurring physical conditions and mental health disorders. Compared to all Medicaid members, those with SUD are more likely to have other comorbid conditions, including mental health disorders. Figure 2-12 shows the SUD and OUD treatment rates for members with diagnosed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

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



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

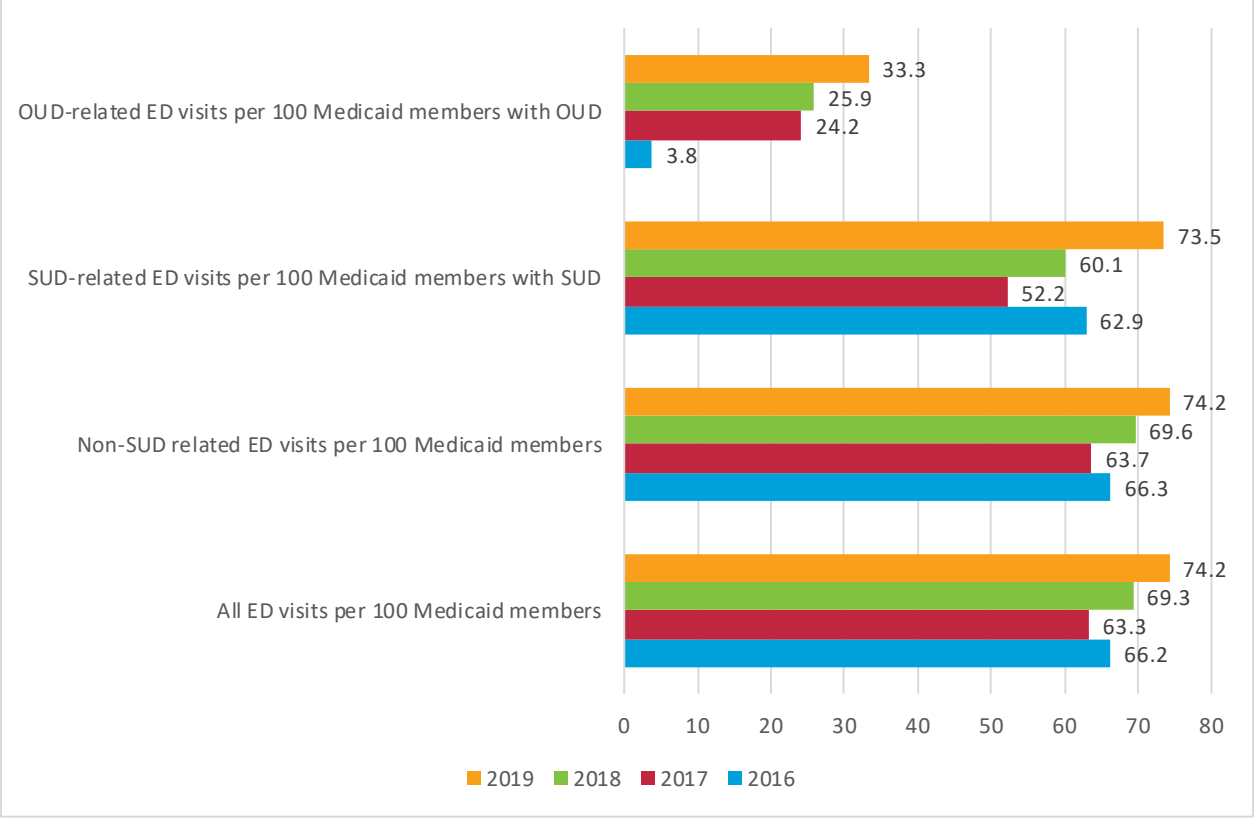
Figure 2-13—Change in Treatment Rates for SUD Among Base Members



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

The results in the report showed that following implementation of the ARTS benefit the likelihood of having an ED visit decreased by 9.4 percentage points (a 21.1 percent relative decrease) among members with OUD, compared to 0.9 percentage points among members with no SUD. A similar decline was noted in inpatient hospitalizations. Figure 2-14 shows the ED visits per 100 base Medicaid members.

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



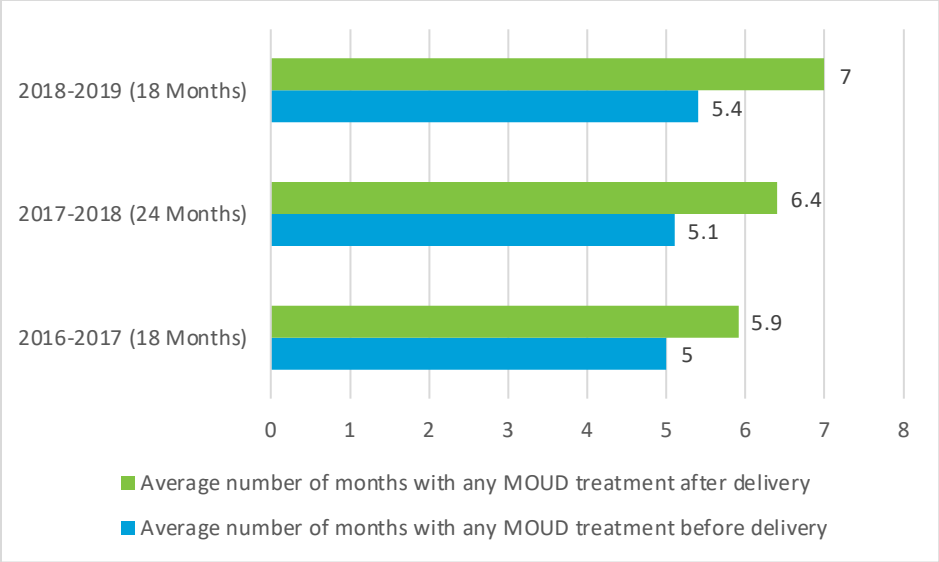
Note: Base members exclude members enrolled through Medicaid expansion to maintain comparability with prior years.

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

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

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

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



DMAS shared an article written by WTVR that highlighted a case study with positive outcomes from the ARTS program.[2-4] The case study describes a member's journey battling addiction. After having lost two of her children soon after they were born, the member soon became pregnant with her third child. The little girl growing inside of her was enough motivation for her to get sober. Through the ARTS benefit, the obstetrical and addiction service providers worked to meet the member where she was. Program providers had an understanding of the challenges that pregnant women and postpartum women with an addiction struggle with and work to reduce the challenges. The member successfully delivered a healthy baby girl.

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

[2-4] WTVR. "After losing 2 children during addiction, mother gives birth to miracle baby." Available at: https://www.wtvr.com/news/local-news/after-losing-2-children-during-addiction-mother-gives-birth-to-miracle-baby. Accessed on: Nov 30, 2021.

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

To enhance cross-state comparisons, VCU and DMAS participate in MODRN, a collaboration of state-university partnerships through AcademyHealth established for the purpose of comparing state Medicaid programs on key measures of SUD and OUD treatment access and quality of care. Table 2-9 displays characteristics of members receiving OUD treatment in Virginia compared to other states participating in MODRN.

Table 2-9—2018 OUD Treatment for Medicaid Members State Comparison

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

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

Member Experience With ARTS Services

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

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

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

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

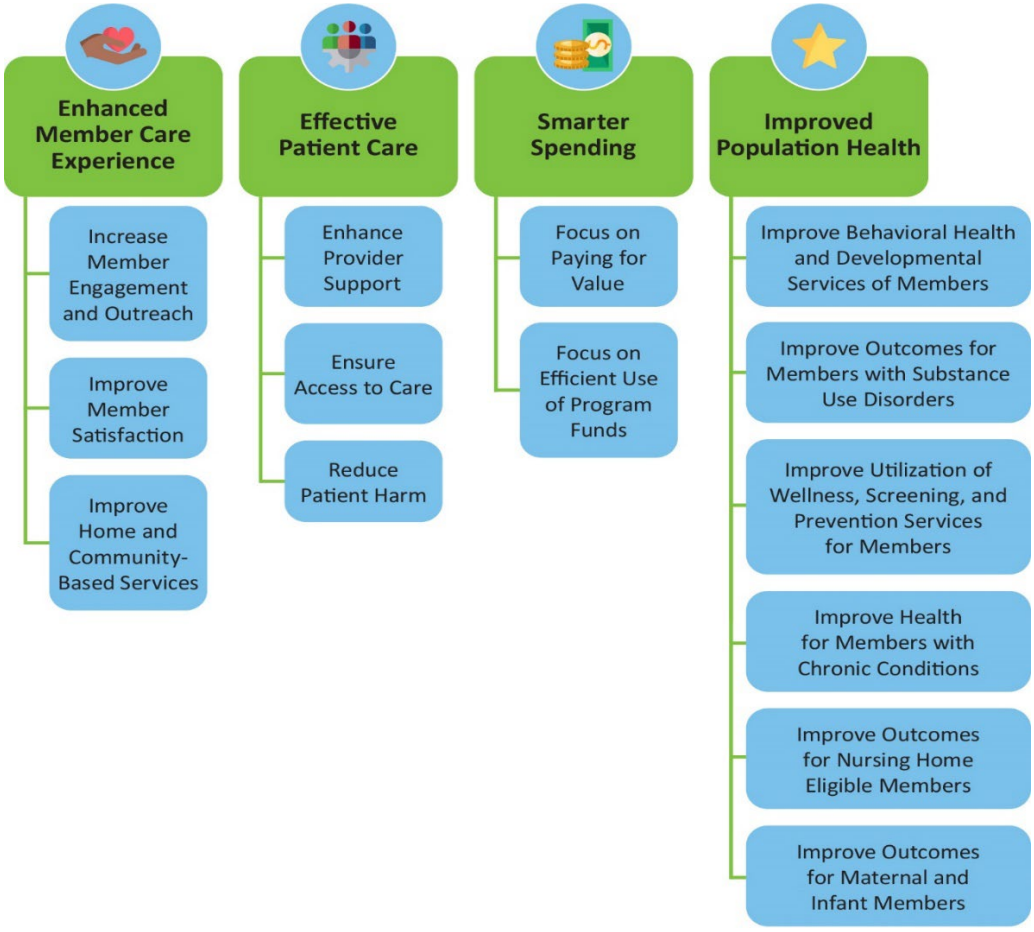
Virginia's 2020–2022 Quality Strategy

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

DMAS' QS objectives are to continually improve the delivery of quality healthcare to all Medicaid and CHIP recipients served by the Virginia Medicaid managed care and FFS programs. Virginia's 2020–2022 QS provides the framework to accomplish its overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP system. The QS promotes the identification of creative initiatives to continually monitor, assess, and improve access to care along with supporting the provision of quality, satisfaction, and timeliness of services for Virginia Medicaid and CHIP recipients.

Virginia's 2020–2022 QS is DMAS' guide to achieving Virginia's mission, vision, values, goals, and objectives. DMAS is committed to upholding its core mission and values, which have been consistent across all versions of the Virginia QS. Figure 2-16 displays Virginia's 2020–2022 QS aims and goals. Appendix F contains Virginia's 2020–2022 QS aims, goals, objectives, and metrics.

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



Quality Initiatives

DMAS considers its QS to be its roadmap for the future. The QS promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, the quality of care and services, member satisfaction, and the timeliness of service delivery for Virginia Medicaid and CHIP members. The Virginia QS strives to ensure members receive high-quality care that is safe, efficient, patient-centered, timely, value and quality-based, data-driven, and equitable. DMAS conducts oversight of the MCOs to promote accountability and transparency for improving health outcomes.

Table 2-10 displays a sample of the initiatives DMAS implemented or continued during CY 2021 that support DMAS' efforts toward achieving the Virginia 2020–2022 QS' goals and objectives.

Table 2-10—DMAS Quality Initiatives Driving Improvement

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

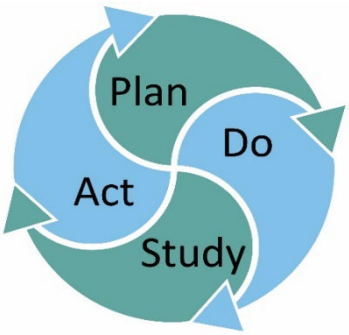
Virginia 2020–2022 QS Aim and Goal	DMAS Quality Initiative
Goal 4.6: Improve Outcomes for Maternal and Infant Members	Virginia QS. The DMAS maternity program, Baby Steps Virginia, actively partners with a variety of stakeholders including DMAS MCOs to improve quality maternity outcomes. All of these efforts have focused on eliminating racial disparities in maternal mortality by 2025, a key goal of Governor Ralph Northam and his administration. The program has five key subgroups including eligibility and enrollment, outreach and information, community connections, services and policies, and oversight, all with the aim to promote health equity and quality maternity outcomes. This year, teams have addressed a variety of topics such as Medicaid member outreach including a social media campaign, newborn screening education, WIC enrollment and services, MCO maternity care coordination, breastfeeding awareness, and flu vaccine access, all with the goal of advancing the holistic well-being of Medicaid and CHIP members.

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

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

Best and Emerging Practices

The Virginia 2020–2022 QS promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, the quality of care and services, member satisfaction, and the timeliness of service delivery for Virginia Medicaid and CHIP members. The DMAS QS strives to ensure members receive high-quality care that is safe, efficient, patient-centered, timely, value- and quality-based, data-driven, and equitable. DMAS conducts oversight of the MCOs to promote accountability and transparency for improving health outcomes.



Emerging practices can be achieved by incorporating evidence-based guidelines into operational structures, policies, and procedures. Emerging practices are born out of continuous QI efforts to improve a service, health outcome, systems process, or operational procedure. The goal of these efforts is to improve the quality of and access to services and to improve health outcomes. Only through continual measurement and analyses to determine the efficacy of an intervention can an emerging practice be identified. Therefore, DMAS encourages the MCOs to continually track and monitor the effectiveness of QI initiatives and interventions, using a PDSA cycle, to determine if the benefit of the

intervention outweighs the effort and cost. DMAS also actively promotes the use of nationally recognized protocols, standards of care, and benchmarks by which MCO performance is measured. Table 2-11 identifies DMAS' best and emerging practices. The MCOs' self-reported best and emerging practices are found in Appendix C.

Table 2-11—DMAS' Best and Emerging Practices

Best and Emerging Practices
DMAS collaborated with stakeholders on a variety of projects supporting pregnant and parenting people. Collaboration was geared toward furthering maternity program quality outcomes and engagement with a variety of partners such VDH, VDSS, DBHDS, VHHA, and VNPC. VDH and DMAS worked closely this year with state stakeholders to study requirements to operationalize a doula Medicaid benefit and execute a streamlined statewide doula certification process overseen by VDH. To realize these goals, both agencies actively collaborated with the Office of the Secretary of Health and Human Resources along with community members such as doula groups, VHHA, DMAS MCOs, VNPC, and other key statewide advocate groups supporting families. The final report is scheduled to be released in December 2020. DMAS also worked to promote quality outcomes in services for pregnant and parenting people experiencing substance use and misuse. The DMAS ARTS team partnered with VDH to facilitate a training needed to obtain a waiver to prescribe buprenorphine. Forty-three providers utilized this training across the state including OB/GYN providers, a target group for the series. In 2019, Virginia was one of eight states selected to participate in the National Academy of State Health Policy Maternal and Child Health Policy Innovations Program Policy Academy. Through this project, DMAS and VDH are partnering with VDSS and DBHDS on a statewide, collaborative effort to improve SBIRT services for pregnant and parenting people via two health system pilot sites.

3. MCO Comparative Information

Comparative Analysis of the MCOs by Activity

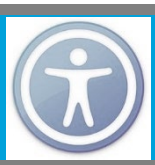
In addition to performing a comprehensive assessment of the performance of each MCO, HSAG compared the findings and conclusions established for each MCO to assess the quality, timeliness, and accessibility of the Medallion 4.0 program.

Definitions

HSAG used the following definitions to evaluate and draw conclusions about the performance of the MCOs in each of the domains of quality of, access to, and timeliness of care and services.

Quality

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



Access

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

Timeliness

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

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

MCO Comparative and Statewide Aggregate PIP Results

PIP Highlights

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

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** Two PIPs received a score of *Confidence*.
	Strength: Three MCOs selected more than one intervention (two) to test for its PIPs.
	Strength: Two interventions were *adopted*.
	Strength: Seven interventions were *adapted*.
Weaknesses	**Weakness:** One PIP received *Reported PIP results were not credible*. **Why the weakness exists:** It appeared that the PIP methodology was not executed as approved based on the documentation the MCO submitted. **Recommendation:** The MCOs should follow the approved methodology for the PIP and report the PIP's data in alignment with the approved methodology. If the MCO needs PIP technical assistance, it should contact HSAG.

MCO Comparative and Statewide Aggregate PMV Results

Monitoring of PMs allows for the assessment of the quality of, access to, and timeliness of care and services provided to Medicaid members. Validation of the MCOs' PM rates reported to the Commonwealth during the preceding 12 months is a mandatory EQR activity set forth in 42 CFR §438.358(b)(ii). Performance measure highlights are provided in Table 3-1.

PMV Highlights

Table 3-1—PM Strengths and Weaknesses

Domain	Strengths	Weaknesses
Children's Preventive Care	HealthKeepers displayed strong performance, with its rates exceeding the Virginia aggregate for the *Child and Adolescent Well-Care Visits—Total*, *Childhood Immunization Status—Combination 3, Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*, and *Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits* measure indicators.	All MCO rates fell below the 50th percentile for the four measures (*Child and Adolescent Well-Care Visits—Total*, *Childhood Immunization Status—Combination 3,* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits)* included in this domain.
Women's Health	HealthKeepers and Optima displayed strong performance, with their rates exceeding the Virginia aggregate for three of the four (75.0 percent) measure indicators.	All MCO rates fell below the 50th percentile for the three measures (*Breast Cancer Screening*, *Cervical Cancer Screening*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care)* included in this domain, reflecting an opportunity for improvement.
Access to Care	Four MCOs' rates demonstrated strong performance, exceeding the Virginia aggregate for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator.	All MCO rates fell below the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator, reflecting an opportunity for improvement.
Care for Chronic Conditions	All six MCOs' rates met or exceeded the 50th percentile for the *Asthma Medication Ratio—Total* measure indicator. Of note, the *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies* measure indicator was an area of strength for HealthKeepers, with its rate meeting or exceeding the 50th percentile.	None of the MCOs' rates met or exceeded the 50th percentile for the *Comprehensive Diabetes Care* measure indicator. MCO performance was particularly low for the *Medical Assistance With Smoking and Tobacco Use Cessation* measure indicators, as only one of the MCOs' measure rates meeting or exceeded the 50th percentile.
Behavioral Health	All six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication*	Four of the six MCOs' rates fell below the 50th percentile for the *Follow-Up After Hospitalization for Mental*

Domain	Strengths	Weaknesses
	Management—Effective Acute Phase Treatment, *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total*, *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measure indicators.	*Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators.

As part of performance measurement, the Virginia MCOs were required to submit HEDIS data to NCQA. To ensure that HEDIS rates were accurate and reliable, NCQA required each MCO to undergo an NCQA HEDIS Compliance Audit™,[3-1] conducted by a certified independent auditor.

Each MCO contracted with an NCQA LO to conduct the HEDIS audit. HSAG reviewed the MCO's FARs, IS compliance tools, and the IDSS files approved by each MCO's LO. HSAG found that the MCOs' IS and processes were compliant with the applicable IS standards and the HEDIS reporting requirements for the key Medallion 4.0 Medicaid measures for HEDIS MY 2020.

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

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

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

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

Table 3-2—HSAG MCO PMV Results

Performance Measure	Aetna	Health Keepers	Magellan	Optima	United	VA Premier
Asthma Admission Rate (Per 100,000 Member Months)						
Asthma Admission Rate (Per 100,000 Member Months)	1.88	1.70	3.14	3.13	1.97	2.60
Child and Adolescent Well-Care Visits						
Child and Adolescent Well-Care Visits—Total	43.39%	51.62%	32.97%	44.49%	47.22%	44.07%
Childhood Immunization Status						
Combination 3	59.61%	70.32%	55.96%	64.23%	66.91%	65.69%
Comprehensive Diabetes Care						
Hemoglobin A1c (HbA1c) Testing	84.43%	81.51%	77.13%	80.78%	84.43%	82.97%
*HbA1c Poor Control (>9.0%)**	45.50%	47.69%	60.58%	59.37%	44.04%	48.91%
HbA1c Control (<8.0%)	45.74%	44.77%	33.33%	35.28%	41.36%	40.63%
Eye Exam (Retinal) Performed	49.15%	37.96%	34.31%	38.44%	43.55%	49.88%
Blood Pressure Control (<140/90 mm Hg)	47.45%	50.61%	35.04%	38.20%	54.01%	53.28%
Follow-Up After Emergency Department Visit for Mental Illness						
7-Day Follow-Up—Total	40.52%	48.35%	40.29%	46.77%	39.09%	48.78%
30-Day Follow-Up—Total	54.99%	60.05%	51.08%	58.21%	47.95%	61.90%
Prenatal and Postpartum Care						
Timeliness of Prenatal Care	68.61%	77.62%	60.58%	74.45%	65.45%	74.45%
Postpartum Care	61.31%	70.32%	55.96%	65.45%	69.34%	66.91%

** 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 audit. HSAG reviewed the MCOs' FARs, IS compliance tools, and the IDSS files approved by each MCO's LO. HSAG found that the MCOs' IS and processes were compliant with the applicable IS standards and the HEDIS reporting requirements for the key Medallion 4.0 Medicaid measures for HEDIS MY 2020.

Table 3-3 displays, by MCO, the HEDIS MY 2020 measure rate results compared to NCQA's Quality Compass®,[3-2] national Medicaid HMO percentiles for the HEDIS MY 2019 50th percentiles and the Virginia aggregate, which represents the average of six MCOs' PM rates weighted by the eligible population. Of note, gray-shaded boxes indicate MCO PM rates that were at or above the 50th percentile. Rates indicating better performance than the Virginia aggregates are represented in burgundy font.

Table 3-3—MCO Comparative and Virginia Aggregate HEDIS MY 2020 Measure Results

Performance Measure	Aetna	Health Keepers	Magellan	Optima	United	VA Premier	Virginia Aggregate
Children's Preventive Care							
Child and Adolescent Well-Care Visits[1]							
Total	43.39%	**51.62%**	32.97%	44.49%	**47.22%**	44.07%	**46.57%**
Childhood Immunization Status							
Combination 3	59.61%	**70.32%**	55.96%	64.23%	**66.91%**	65.69%	**65.82%**
Well-Child Visits in the First 30 Months of Life[1]							
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	**55.76%**	**56.84%**	42.77%	**58.47%**	49.45%	51.15%	**54.35%**
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	70.62%	**76.58%**	58.72%	71.45%	70.32%	70.29%	**72.10%**

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

Performance Measure	Aetna	Health Keepers	Magellan	Optima	United	VA Premier	Virginia Aggregate
Women's Health							
Breast Cancer Screening[2]							
Breast Cancer Screening	38.66%	47.91%	NA	**58.27%**	36.07%	41.88%	**48.82%**
Cervical Cancer Screening[2]							
Cervical Cancer Screening	45.74%	**60.25%**	36.01%	**50.24%**	43.31%	47.45%	**50.09%**
Prenatal and Postpartum Care[2]							
Timeliness of Prenatal Care	68.61%	**77.62%**	60.58%	**74.45%**	65.45%	**74.45%**	**73.00%**
Postpartum Care	61.31%	**70.32%**	55.96%	65.45%	**69.34%**	**66.91%**	**66.52%**
Access to Care							
Adults' Access to Preventive/Ambulatory Health Services							
Total	**75.79%**	**75.60%**	62.01%	**72.95%**	67.65%	**73.55%**	**72.75%**
Care for Chronic Conditions							
Asthma Medication Ratio							
Total	69.62%	**73.33%**	65.35%	69.15%	**73.29%**	70.53%	**71.00%**
Comprehensive Diabetes Care							
Hemoglobin A1c (HbA1c) Testing[2]	**84.43%**	81.51%	77.13%	80.78%	**84.43%**	**82.97%**	**82.22%**
HbA1c Poor Control (>9.0%)[*,2]*	**45.50%**	**47.69%**	60.58%	59.37%	**44.04%**	**48.91%**	**50.30%**
HbA1c Control (<8.0%)[2]	**45.74%**	**44.77%**	33.33%	35.28%	**41.36%**	40.63%	**41.14%**
Eye Exam (Retinal) Performed[2]	**49.15%**	37.96%	34.31%	38.44%	**43.55%**	**49.88%**	**43.01%**
Blood Pressure Control (<140/90 mm Hg)[1]	**47.45%**	**50.61%**	35.04%	38.20%	**54.01%**	**53.28%**	**47.35%**
Controlling High Blood Pressure[1]							
Controlling High Blood Pressure	**50.85%**	**47.45%**	37.47%	43.31%	**52.07%**	**46.96%**	**46.91%**
Medical Assistance With Smoking and Tobacco Use Cessation							
Advising Smokers and Tobacco Users to Quit	70.53%	**71.43%**	65.61%	NA	NA	70.09%	**70.88%**
Discussing Cessation Medications	47.09%	**53.39%**	46.81%	NA	NA	43.22%	**48.43%**
Discussing Cessation Strategies	39.36%	**51.28%**	38.30%	NA	NA	34.19%	**40.49%**
Behavioral Health							
Antidepressant Medication Management							
Effective Acute Phase Treatment	**58.57%**	53.95%	**63.22%**	55.84%	55.41%	**59.61%**	**57.12%**
Effective Continuation Phase Treatment	**44.98%**	37.67%	**49.58%**	40.88%	39.74%	**44.32%**	**42.02%**
Follow-Up Care for Children Prescribed ADHD Medication[2]							

Performance Measure	Aetna	Health Keepers	Magellan	Optima	United	VA Premier	Virginia Aggregate
Initiation Phase	**52.58%**	44.63%	18.36%	37.37%	**50.31%**	**54.60%**	**45.20%**
Continuation and Maintenance Phase	**66.40%**	57.99%	12.24%	51.36%	58.33%	**68.72%**	**58.61%**
Follow-Up After Emergency Department (ED) Visit for Mental Illness[2]							
7-Day Follow-Up—Total	40.52%	**48.35%**	40.29%	**46.77%**	39.09%	**48.78%**	**45.34%**
30-Day Follow-Up—Total	54.99%	**60.05%**	51.08%	**58.21%**	47.95%	**61.90%**	**57.38%**
Follow-Up After Hospitalization for Mental Illness[2]							
7-Day Follow-Up—Total	35.14%	**42.74%**	27.69%	**41.05%**	35.57%	26.99%	**35.63%**
30-Day Follow-Up—Total	**58.19%**	**64.92%**	46.39%	**64.77%**	56.57%	44.79%	**56.84%**
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence[2]							
7-Day Follow-Up—Total	**14.04%**	13.61%	13.18%	**14.16%**	13.88%	**14.44%**	**13.92%**
30-Day Follow-Up—Total	**22.23%**	20.78%	**22.29%**	**22.32%**	21.44%	**22.54%**	**21.88%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics							
Total	**80.23%**	67.67%	65.57%	66.67%	**76.04%**	**71.47%**	**69.58%**

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

[1] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between MY 2020 and prior years; therefore, comparisons to benchmarks are not performed for this measure.

[2] Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2020 and prior years be considered with caution.

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

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

Indicates that the HEDIS MY 2020 rate was at or above the 50th percentile.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Within the Care for Chronic Conditions domain, all six MCOs met or exceeded the 50th percentile for the *Asthma Medication Ratio—Total* measure rate. Of note, the *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies* measure rate was an area of strength for HealthKeepers, with its rate meeting or exceeding the 50th percentile and exceeding the Virginia aggregate rate. The results suggest that individuals with persistent asthma are controlling their chronic condition and individuals are receiving help with cessation strategies for smoking and tobacco use.

Strength: MCO performance within the Behavioral Health domain was strong, with all six MCOs' rates meeting or exceeding the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment*,

Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total, *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure indicators. Within the Behavioral Health domain, HealthKeepers demonstrated the highest performance, meeting or exceeding the 50th percentile for 10 of the 11 (90.9 percent) measure rates. Of note, Optima and VA Premier met or exceeded the 50th percentile for nine of the 11 (81.8 percent) measure rates. The strong performance in the Behavioral Health domain measures indicates that Virginia and the MCOs have improved medication management and are appropriately managing care for patients hospitalized or who visit the ED with a mental health issue, potentially as a result of Virginia's focus on the ARTS benefit and the development of member-centric behavioral healthcare and services.

Weaknesses

Weakness: For all MCOs within the Children's Preventive Care domain, all measure rates (*Child and Adolescent Well-Care Visits—Total*, *Childhood Immunization Status—Combination 3*, *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits)* fell below the 50th percentile, indicating opportunities for improvement related to well-child/well-care visits and immunizations.

Why the weakness exists: Although children may have adequate access to timely preventive/well-child visits, members are not completing these visits or receiving necessary preventive immunizations. The lack of member participation in preventive/well-child visits and completion of immunizations may be a result of a disparity-driven barrier. Factors that may have contributed to the declines include site closures and the temporary suspension of non-urgent services due to the COVID-19 PHE.

Recommendation: HSAG recommends that the MCOs conduct a root cause analysis to determine why some children have not received well-child visits or immunizations according to the well-visit schedule. HSAG recommends that the MCOs analyze their data and consider if there are disparities within the MCOs' populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, HSAG recommends that the MCOs implement appropriate interventions to increase the number of children who receive a well-child visit or immunizations using interventions that address the root cause of the issue.

Weakness: All reportable measure rates for all six of the MCOs fell below the 50th percentile in the Women's Health domain, demonstrating opportunities for improvement for all MCOs' rates for the *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Prenatal and Postpartum Care* measures.

Why the weakness exists: Members are not completing recommended screenings, which may indicate a lack of understanding of healthcare or recommended preventive schedules. Members' lack of participation in screenings may also be a result of a disparity-driven barrier. Factors that may have

contributed to the declines include screening site closures and the temporary suspension of non-urgent services due to the COVID-19 PHE.

Recommendation: HSAG recommends that the MCOs conduct a root cause analysis or focus group to determine why women members are not receiving breast or cervical cancer screenings. HSAG recommends that the MCOs consider if there are disparities within the MCOs' populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, HSAG recommends that the MCOs implement appropriate interventions to improve access to and timeliness of cancer screenings.

Weakness: The Access to Care domain represented an area of opportunity for improvement, as all six of the MCOs' rates fell below the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure. The low performance indicates members may be experiencing issues accessing providers for health services.

Why the weakness exists: The COVID-19 PHE had a significant impact on healthcare services. Many provider offices were closed and offered limited telehealth services. Families also deferred going to the doctor's office for routine, nonemergency care. Although members are receiving access to preventive care, the measure rates suggest that members are not always able to access providers for preventive services in a timely manner. These members may have difficulties finding access to care, may have overall or regional network adequacy issues, or this weakness may be a result of disparities in the population served.

Recommendation: HSAG recommends that MCOs conduct a root cause analysis to determine why some adults are experiencing access to care issues. HSAG recommends that the MCOs identify the best practices of the MCOs that demonstrated strength in adults' access to care. HSAG recommends that the MCOs consider conducting a focus group to identify barriers that their members are experiencing in accessing care and services in order to implement appropriate interventions. If the COVID-19 PHE was a factor, HSAG recommends the MCOs work with its members to increase the use of telehealth services.

Weakness: The Care for Chronic Conditions domain represented an area of opportunity for improvement for all six MCOs, as none of the MCOs' rates met or exceeded the 50th percentile for the *Comprehensive Diabetes Care* measure indicators. MCO performance was particularly low for the *Medical Assistance With Smoking and Tobacco Use Cessation* measure indicators, as only one of the MCOs' measure indicator rates met or exceeded the 50th percentiles.

Why the weakness exists: Although members with chronic conditions may have access to care, these members are not consistently managing their conditions according to evidence-based guidelines through the appropriate use of medications, diet and nutrition, or physical activity. Members may also not be receiving referrals or assistance from providers to access all available resources focused on assisting individuals in quitting tobacco use. Factors that may have contributed to the declines include site closures and the temporary suspension of non-urgent services due to the COVID-19 PHE.

Recommendation: HSAG recommends that the MCOs conduct a root cause analysis or focus study to determine why members are not maintaining their chronic health conditions at optimal levels. Upon identification of a root cause, HSAG recommends that the MCOs implement appropriate interventions to improve the performance related to these chronic conditions. HSAG recommends that the MCOs consider conducting a focus group to identify barriers that their members are experiencing in accessing care and services in order to implement appropriate interventions

Compliance With Standards Monitoring

DMAS conducts compliance monitoring activities at least once during each three-year EQR cycle. During 2021, HSAG conducted MCO compliance review activities for the Medallion 4.0 program. DMAS monitored the MCOs' implementation of federal and Commonwealth requirements and CAPs from the 2021 compliance reviews.

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

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

	CFR	Standard Name	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier	Total Compliance Score
I.	438.56	Enrollment and Disenrollment: Requirements and Limitations*	100%	100%	100%	100%	100%	85.7%	97.6%
II.	438.100 438.224	Enrollee Rights* and Confidentiality	85.7%	100%	100%	100%	100%	100%	97.6%
III.	438.10	Member Information	100%	100%	95.2%	95.2%	100%	90.5%	96.8%
IV.	438.114	Emergency and Poststabilization Services*	100%	100%	100%	100%	100%	100%	100%
V.	438.206 438.207	Assurance of Adequate Capacity and Availability of Services	86.7%	80.0%	86.7%	66.7%	93.3%	66.7%	80.0%
VI.	438.208	Coordination and Continuity of Care	100%	100%	100%	100%	100%	100%	100%
VII.	438.210	Coverage and Authorization of Services	100%	100%	89.5%	100%	100%	100%	98.3%
VIII.	438.214	Provider Selection	100%	100%	100%	100%	100%	100%	100%
IX.	438.230	Subcontractual Relationships and Delegation	75.0%	100%	100%	75.0%	50.0%	75.0%	79.2%

	CFR	Standard Name	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier	Total Compliance Score
X.	438.236	Practice Guidelines	100%	100%	100%	100%	100%	100%	100%
XI.	438.242	Health Information Systems**	100%	100%	100%	100%	100%	100%	100%
XII.	438.330	Quality Assessment and Performance Improvement	100%	83.3%	100%	83.3%	100%	100%	94.4%
XIII	438.228	Grievance and Appeal Systems	86.2%	82.8%	89.7%	100%	93.1%	79.3%	88.5%
XIV.	438.608	Program Integrity	100%	100%	100%	100%%	100%	100%	100%
XV.	441.58 Section 1905 of the SSA	EPSDT Services	62.5%	62.5%	62.5%	87.5%	87.5%	62.5%	56.3%
TOTAL SCORE			**93.2%**	**92.6%**	**93.2%**	**94.4%**	**96.3%**	**88.9%**	**93.1%**

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

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

Each MCOs' total compliance scores ranged from a low of 88.9 percent to a high of 96.3 percent. Additionally, the MCOs achieved full compliance for Standard IV—Emergency and Poststabilization Services, Standard VI—Coordination and Continuity of Care, Standard VIII—Provider Selection, Standard X—Practice Guidelines, Standard XI—Health Information Systems, and Standard XIV—Program Integrity.

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

Strengths, Weaknesses, and Recommendations

Strengths

Strength: All MCOs were fully compliant with federal and Commonwealth requirements for six standards: Standard IV—Emergency and Poststabilization Services, Standard VI—Coordination and Continuity of Care, Standard VIII—Provider Selection, Standard X—Practice Guidelines, Standard XI—Health Information Systems, and Standard XIV—Program Integrity

Strength: Overall, the MCOs implemented process to ensure access to care and services and to ensure that the service delivery met the accessibility, cultural, ethnic, racial, and linguistic needs of members, including those with physical and behavioral SHCN.

Strength: Most MCOs maintained and implemented processes to ensure member information and member notices were understandable; accessible;

	distributed; and included, as appropriate, all required information, including member rights and processes to be followed.
	Strength: Overall, the MCOs implemented processes to provide for direct access to women's health services, out-of-network services, and second opinions; and informed members and providers, as applicable.
Weaknesses	**Weakness:** The MCOs did not consistently update policies, procedures, processes, and member materials to include requirements in the 2020 Medicaid Managed Care Rule or in their contract with DMAS. **Why the weakness exists:** The MCOs did not consistently implement processes to identify and apply changes in federal or Commonwealth requirements to policies, procedures, operational processes, and member information. **Recommendation**: The MCOs must review and update, as appropriate, member materials, online formularies, and provider directories to include all federal and DMAS contract requirements.
	Weakness: The MCOs did not consistently include DMAS requirements in subcontractor and delegated entity agreements. **Why the weakness exists**: The MCOs did not all have an implemented process to ensure its subcontractor and delegated entity agreements were reviewed and updated to ensure compliance with current federal and DMAS contract requirements. **Recommendation:** The MCOs must update its subcontractor and delegated entity agreements to include all CMS 2020 Medicaid Managed Care Rule and DMAS contract requirements. The MCOs must implement a process to ensure contract and delegated agreement updates are made when requirements change.
	Weakness: MCOs did not consistently include in notices of adverse benefit determination, grievance notices, or appeal notices to the member, all federal and Commonwealth requirements or all member rights. **Why the weakness exists:** The MCOs did not update their processes or content of member benefit determinations or notices to include all requirements specified in the CMS 2020 Medicaid Managed Care Rule. **Recommendation:** The MCOs must review and update, as appropriate, the medical management/utilization management, grievance and appeals policies, and notice templates to include all federal requirements and ensure that the member notices are in a format that is easily understood by the member.
	Weakness: The MCOs did not consistently apply the correct DMAS requirements for network adequacy according to provider types, regions, rural and urban. The MCOs did not consistently evaluate or monitor network providers regarding timely access to services, monitor providers regularly to determine compliance, and take corrective action if there was a failure to comply with DMAS requirements. **Why the weakness exists:** The MCOs' policies, procedures, and provider manual did not consistently include all or correct access standards for all provider types. The MCOs did not all have an implemented process to monitor accessibility against DMAS requirements.

Recommendation: The MCO must ensure it meets network requirements based on provider types, time and distance standards, rural, urban and region. The MCO must have mechanisms to ensure compliance by network providers regarding timely access to services, monitor network providers regularly to determine compliance, and take corrective action if there is failure to comply with requirements.

Network Capacity Analysis

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

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

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

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

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

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

MCO Comparative and Statewide Aggregate EDV Results

EDV Project Highlights

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

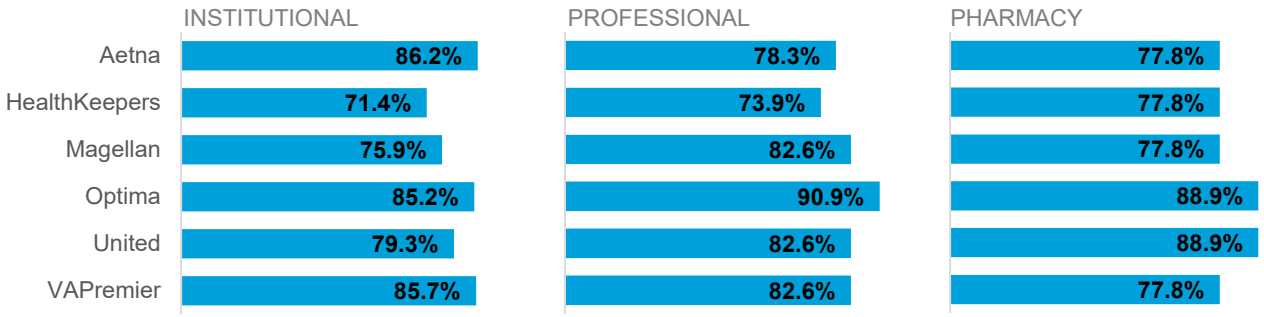
- **IS review** to assess each MCO's technical processes and capabilities.
- **Administrative profile analysis** to assess the quality, completeness, and timeliness of encounter data submitted to DMAS.

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

Quality

HSAG assessed the validity of values found across all commonly used data elements and data elements of particular interest to DMAS. HSAG considered rates of valid values of 99 percent to be sufficiently high for no concern. Figure 3-1 shows that across all data elements assessed; Optima met the valid value criteria for over 80 percent of data elements across all three encounter types. Meanwhile, less than 75 percent of data elements for HealthKeepers met the valid value criteria for institutional and professional encounters.

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



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

Completeness

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

- Large variation across the MCOs when populating the Servicing Provider Taxonomy Code data field for institutional encounters
  - Ranged from 0 percent (Optima) to 94.2 percent (VA Premier)
- Low completeness of header TPL paid amount for institutional encounters from Magellan and VA Premier

Timeliness

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

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

Plan	Institutional		Professional		Pharmacy	
Statewide	**94.9%**		**98.3%**	✓	**91.4%**	
Aetna	91.4%		98.6%	✓	94.3%	
HealthKeepers	89.7%		96.1%	✓	100%	✓
Magellan	99.6%	✓	98.0%	✓	98.7%	
Optima	100%	✓	99.2%	✓	100%	✓
United	93.8%		99.3%	✓	10.8%	
VA Premier	96.3%	✓	99.9%	✓	99.6%	✓

✓ Met submission standard

Strengths, Weaknesses, and Recommendations

Strengths

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

Strength: All six MCOs met the 30-day submission standard for professional encounters.

Weaknesses

Weakness: The IS review revealed several MCOs (HealthKeepers, Magellan, Optima, and VA Premier) could make improvements to their internal process for monitoring encounter data.

Why the weakness exists: While the MCOs create regular reports assessing the inbound encounter data, the reports HSAG reviewed focused primarily on a single snapshot of submission timeliness and acceptance rates.

Recommendation: HSAG recommends that the MCOs consider augmenting existing monitoring reports to include comparisons of existing metrics over time (e.g., week-to-week or month-to-month acceptance rates) and/or summary metrics on encounter data quality and completeness.

Weakness: Two MCOs (Aetna and United) did not meet the 30-day submission standards for two of the three encounter types.
Why the weakness exists: The IS review and administrative profile analysis did not identify the specific root cause of the weakness.
Recommendation: HSAG recommends that the MCOs seek to identify the root cause of any delays in submitting encounters to rectify any issues.

Weakness: HealthKeepers met the valid value criteria for less than 75 percent of data elements for institutional and professional encounters.
Why the weakness exists: The IS review and administrative profile analysis did not identify the specific root cause of the weakness.
Recommendation: HSAG recommends that the MCOs incorporate additional logic and referential checks to assess the validity of data elements.

Statewide Aggregate CAHPS Results

Member Experience Survey Highlights

Figure 3-2—CAHPS Strengths and Weaknesses

CAHPS Strengths

The top-box scores for two measures, *Rating of Health Plan* and *Rating of All Health Care*, for all MCOs (i.e., the Medallion 4.0 program) and one MCO were statistically significantly higher than the 2020 NCQA child Medicaid national averages.

One MCO's 2021 top-box score was statistically significantly higher than the 2020 top-box score for one measure, *Rating of Health Plan*, for the adult Medicaid population.

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

CAHPS Weaknesses

The top-box score for one measure, *Rating of Specialist Seen Most Often*, for all MCOs was statistically significantly lower than the 2020 NCQA adult Medicaid national average. One MCO's 2021 top-box scores were statistically significantly lower than the 2020 scores for *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Customer Service* for the adult Medicaid population.

The top-box scores for two measures, *Getting Care Quickly* and *How Well Doctors Communicate*, for all MCOs (i.e., Medallion 4.0 program) were statistically significantly lower than the 2020 NCQA child Medicaid national averages. Furthermore, the Medallion 4.0 program's 2021 top-box scores were statistically significantly lower than the 2020 top-box scores for two measures, *Rating of Specialist Seen Most Often* and *Getting Care Quickly*. Four MCOs had top-box scores that were statistically significantly lower than the 2020 NCQA child Medicaid

Table 3-6 and Table 3-7 present the 2021 top-box scores for each MCO and the Medallion 4.0 program (i.e., all MCOs combined) compared to the 2020 adult Medicaid CAHPS scores for the global ratings and composite measures. The 2021 CAHPS scores for each MCO and the Medallion 4.0 program were also compared to the 2020 adult Medicaid national averages.

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

	Rating of Health Plan		*Rating of All Health Care*		*Rating of Personal Doctor*		*Rating of Specialist Seen Most Often*	
	2020	2021	2020	2021	2020	2021	2020	2021
Medallion 4.0 Program	62.5%	62.5%	59.0%	55.8%	71.3%	68.0%	71.3%	64.8%
Aetna	54.6%	63.4%▲	47.5%	56.9%	67.7%	67.5%	65.3%	67.8%
HealthKeepers	61.8%	61.1%	64.0%	60.3%	76.1%	67.4%	71.0%+	59.3%+
Magellan	58.3%	62.1%	53.7%	48.0%	68.2%	64.4%	74.8%	68.1%+
Optima	72.5%	59.5%▼	69.3%+	53.2%+▼	80.9%+	63.5%+▼	73.2%+	61.5%+
United	65.0%	60.6%	59.1%	58.3%	69.5%	64.8%	72.4%+	63.8%+
VA Premier	61.3%	67.2%	54.5%	52.1%	62.2%	75.9%▲	72.7%+	71.8%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ Statistically significantly higher in 2021 than in 2020.
▼ Statistically significantly lower in 2021 than in 2020.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

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

	Getting Needed Care		*Getting Care Quickly*		*How Well Doctors Communicate*		*Customer Service*	
	2020	2021	2020	2021	2020	2021	2020	2021
Medallion 4.0 Program	83.3%	82.9%	82.1%	81.1%	94.6%	93.3%	88.8%	86.5%
Aetna	77.6%	84.3%	82.7%	82.6%	92.9%	93.8%	83.0%	90.3%+
HealthKeepers	85.3%+	84.3%	84.7%+	81.6%+	95.8%+	92.8%	91.2%+	86.6%+

	Getting Needed Care		Getting Care Quickly		How Well Doctors Communicate		Customer Service	
	2020	2021	2020	2021	2020	2021	2020	2021
Magellan	80.3%	86.7%	82.1%	81.8%+	91.8%	91.6%	90.5%	84.3%+
Optima	90.3%+	85.2%+	85.4%+	79.9%+	95.7%+	93.7%+	94.6%+	73.5%+▼
United	79.8%	77.5%	81.0%	76.7%+	93.1%	91.5%	87.1%	89.8%+
VA Premier	82.2%	79.5%+	76.2%	82.3%+	95.1%	94.6%	85.5%+	93.0%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▼ Statistically significantly lower in 2021 than in 2020.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Aetna's 2021 top-box score was statistically significantly higher than the 2020 top-box score for one measure, *Rating of Health Plan*. In addition, VA Premier's 2021 top-box score was statistically significantly higher than the 2020 top-box score for one measure, *Rating of Personal Doctor*.

Weaknesses

Weakness: The top-box score for one measure, *Rating of Specialist Seen Most Often*, for all MCOs (i.e., Medallion 4.0 program) was statistically significantly lower than the 2020 NCQA adult Medicaid national average. In addition, the scores for the *Rating of All Health Care* and *Customer Service* measures were statistically significantly lower than the 2020 NCQA adult Medicaid national average for Magellan and Optima, respectively. Optima's 2021 top-box scores were statistically significantly lower than the 2020 top-box scores for four measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Customer Service*.

Why the weakness exists: Based on the adult survey results, members indicated that they are not overly satisfied with the specialist they see most often, and Magellan members indicated that they are not overly satisfied with the healthcare they receive. Adult members are reporting more negative experiences with the healthcare services they are receiving and their specialists. Survey results also indicated that members have a lower level of satisfaction with Optima overall, including their healthcare services, personal doctors, and customer service, which may be associated with their perception of the ability to receive care or services.

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

Child Medicaid

Table 3-8 and Table 3-9 present the 2021 top-box scores for each MCO and the Medallion 4.0 program compared to the 2020 child Medicaid CAHPS scores for the global ratings and composite measures.[3-3] The 2021 CAHPS scores for each MCO and the Medallion 4.0 program were also compared to the 2020 NCQA child Medicaid national averages.

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

	Rating of Health Plan		*Rating of All Health Care*		*Rating of Personal Doctor*		*Rating of Specialist Seen Most Often*	
	2020	*2021*	*2020*	*2021*	*2020*	*2021*	*2020*	*2021*
Medallion 4.0 Program	73.8%	75.6%	74.1%	75.7%	76.4%	77.7%	82.4%	72.3%▼
Aetna	68.5%	69.8%	68.4%	69.4%	75.6%	74.9%	62.9%+	75.0%+
HealthKeepers	75.0%	77.0%	71.8%	75.3%	74.5%	77.4%	83.3%+	78.0%+
Magellan	55.8%	68.2%▲	70.3%+	70.3%+	69.1%+	74.8%	77.8%+	66.7%+
Optima	NR	80.3%	NR	81.8%+	NR	83.6%	NR	75.0%+
United	74.4%	65.8%▼	76.8%	71.1%	75.7%	74.2%	78.9%+	61.7%+
VA Premier	76.4%	77.0%	79.2%	76.4%	81.1%	76.4%	90.0%+	65.3%+▼

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ Statistically significantly higher in 2021 than in 2020.
▼ Statistically significantly lower in 2021 than in 2020.
"NR" indicates data were not reported.
Cells highlighted in orange represent rates that are statistically significantly higher than the 2020 NCQA national Medicaid averages.

Table 3-9—Comparison of 2020 and 2021 Child Composite Top-Box Scores

	Getting Needed Care		*Getting Care Quickly*		*How Well Doctors Communicate*		*Customer Service*	
	2020	*2021*	*2020*	*2021*	*2020*	*2021*	*2020*	*2021*
Medallion 4.0 Program	85.8%	84.6%	89.5%	86.0%▼	95.2%	93.7%	88.4%	87.0%
Aetna	85.6%	82.1%+	92.2%	83.0%+▼	96.8%	94.1%	91.4%+	73.9%+▼
HealthKeepers	83.0%	83.0%	89.1%	84.8%	95.4%	92.7%	87.8%+	91.6%
Magellan	82.8%+	79.5%+	91.3%+	86.3%+	92.7%+	92.3%+	90.4%+	75.4%+

[3-3] In 2020, HSAG excluded Optima's scores from the calculation of the Medallion 4.0 program top-box scores; however, for 2021, HSAG did not exclude Optima's scores from the calculation of the Medallion 4.0 program top-box scores. HSAG did not recalculate the 2020 Medallion 4.0 program top-box scores, so the scores are consistent with the 2020 Medallion EQR technical report.

	Getting Needed Care		Getting Care Quickly		How Well Doctors Communicate		Customer Service	
	2020	2021	2020	2021	2020	2021	2020	2021
Optima	NR	89.0%+	NR	91.2%+	NR	97.1%+	NR	93.5%+
United	79.1%+	72.9%+	80.1%	79.3%+	91.2%	91.8%	85.4%+	78.3%+
VA Premier	93.7%	90.6%+	93.0%	87.3%+	96.3%	93.4%	89.1%+	85.0%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▼ Statistically significantly lower in 2021 than in 2020.
"NR" indicates data were not reported.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

Summary of Strengths, Weaknesses, and Overall Conclusions

Strengths

Strength: The top-box scores for two measures, *Rating of Health Plan* and *Rating of All Health Care*, for all MCOs (i.e., Medallion 4.0 program) and Optima were statistically significantly higher than the 2020 NCQA child Medicaid national average. Magellan's 2021 top-box score was statistically significantly higher than the 2020 score for one measure, *Rating of Health Plan*. Furthermore, HealthKeepers' 2021 top-box score was statistically significantly higher than the 2020 NCQA child Medicaid national average for one measure, *Rating of Health Plan*.

Weaknesses

Weakness: The top-box scores for two measures, *Getting Care Quickly* and *How Well Doctors Communicate*, for all MCOs (i.e., Medallion 4.0 program) were statistically significantly lower than the 2020 NCQA child Medicaid national averages. Furthermore, the Medallion 4.0 program's 2021 top-box scores were statistically significantly lower than the 2020 top-box scores for two measures, *Rating of Specialist Seen Most Often* and *Getting Care Quickly*. VA Premier's 2021 top-box score for *Rating of Specialist Seen Most Often* was statistically significantly lower than the 2020 top-box score. United scored statistically significantly lower than the 2020 NCQA child Medicaid national average in *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*. In addition, United's rate for *Rating of Health Plan* declined from the prior survey year. The top-box scores for two measures, *Getting Care Quickly* and *Customer Service*, for Aetna were statistically significantly lower than the 2020 NCQA child Medicaid national averages and were statistically significantly lower than the 2020 top-box scores. HealthKeepers and Magellan had top-box scores that were statistically significantly lower than the 2020 NCQA child Medicaid national averages for at least one measure.

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

Furthermore, parents/caretakers of child members are reporting more negative experiences with communication among their child's doctors and their child's specialists. Aetna's, Magellan's, and United's child survey results indicate a lower level of satisfaction with customer service, which may be associated with their perception of the MCOs' ability to provide needed information.

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

FAMIS Program Statewide Aggregate Results

Table 3-10 presents the 2020 and 2021 FAMIS CAHPS top-box scores for the global ratings and composite measures. The FAMIS general child and Children with Chronic Conditions (CCC) 2021 CAHPS scores were compared to the 2020 NCQA national child Medicaid and CCC Medicaid averages.[3-4] In addition, a trend analysis was performed that compared the 2021 CAHPS scores to corresponding 2020 CAHPS scores.

Table 3-10—Comparison of 2020 and 2021 FAMIS Program General Child and CCC Top-Box Scores

	General Child		CCC	
Global Ratings	**2020**	**2021**	**2020**	**2021**
Rating of Health Plan	73.6%	72.9%	67.9%	72.6%
Rating of All Health Care	71.5%	72.8%	70.7%	66.2%+
Rating of Personal Doctor	76.0%	74.1%	75.7%	74.7%+
Rating of Specialist Seen Most Often	76.5%+	75.8%+	73.2%	77.8%+
Composite Measures	**2020**	**2021**	**2020**	**2021**
Getting Needed Care	89.0%	83.0%	89.6%	90.2%+
Getting Care Quickly	90.8%	83.6%+	92.2%	94.4%+
How Well Doctors Communicate	95.8%	95.7%	95.7%	95.5%+
Customer Service	85.7%+	83.1%+	85.6%+	76.2%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ Statistically significantly higher in 2021 than in 2020.

[3-4] For the NCQA national child Medicaid and CCC Medicaid averages, Quality Compass 2020 data were used with permission from NCQA. Quality Compass 2020 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.

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

MCO Comparative and Statewide Calculation of Additional PM Results

Project Highlights

DMAS contracted with HSAG in 2021 to develop a custom PM related to identifying members with prediabetes who were prescribed metformin and adhered to metformin during the measurement year. Table 3-11 displays the CY 2019 and CY 2020 prediabetes PM results stratified by Medicaid program, MCO, geographic region, and select demographics (i.e., age, gender, and race).

Table 3-11—Prediabetes PM Results

Rate Stratification	CY 2019 Results	CY 2020 Results
Rate 1—Prevalence of Prediabetes		
Virginia Total	4.68%	4.04%
Medicaid Program		
CCC Plus	6.66%	6.11%
Medallion 4.0	3.58%	3.35%
More Than One Medicaid Program	6.98%	6.52%
MCO		
Aetna	4.88%	4.06%
HealthKeepers	4.89%	4.29%
Magellan	4.51%	3.52%
Optima	4.50%	4.18%
United	4.58%	3.88%
VA Premier	4.30%	3.78%
More Than One MCO	6.37%	5.25%
Geographic Region		
Central	4.73%	4.03%
Charlottesville/Western	3.92%	3.67%
Northern & Winchester	4.88%	3.93%
Roanoke/Alleghany	4.24%	3.70%
Southwest	4.84%	4.20%
Tidewater	5.02%	4.43%
Age		
18–44 Years	3.01%	2.48%
45–60 Years	8.32%	7.63%
Gender		
Male	4.39%	3.56%

Rate Stratification	CY 2019 Results	CY 2020 Results
Female	4.83%	4.35%
Race		
White	4.46%	3.81%
Black/African American	4.97%	4.47%
Asian	5.82%	4.75%
Southeast Asian/Pacific Islander	4.02%	3.69%
Hispanic	2.74%	2.54%
More Than One Race/Other/Unknown	4.15%	3.19%
Rate 2—Metformin Use for Prediabetics		
Virginia Total	6.97%	7.37%
Medicaid Program		
CCC Plus	4.58%	4.53%
Medallion 4.0	8.77%	8.80%
More Than One Medicaid Program	8.89%	7.93%
MCO		
Aetna	7.61%	7.86%
HealthKeepers	6.80%	7.55%
Magellan	6.70%	6.80%
Optima	6.09%	6.52%
United	6.13%	5.88%
VA Premier	8.05%	8.40%
More Than One MCO	7.48%	8.90%
Geographic Region		
Central	6.93%	7.44%
Charlottesville/Western	9.04%	8.60%
Northern & Winchester	6.66%	6.78%
Roanoke/Alleghany	8.18%	9.08%
Southwest	8.48%	9.85%
Tidewater	5.34%	5.75%
Age		
18–44 Years	10.02%	10.86%
45–60 Years	4.40%	4.65%
Gender		
Male	4.77%	4.51%
Female	8.00%	8.76%
Race		
White	7.20%	8.18%
Black/African American	6.55%	6.43%
Asian	5.00%	6.86%
Southeast Asian/Pacific Islander	*	*

Rate Stratification	CY 2019 Results	CY 2020 Results
Hispanic	*	*
More Than One Race/Other/Unknown	10.55%	7.39%
Rate 3—Adherence to Metformin		
Virginia Total	42.17%	45.22%
Medicaid Program		
CCC Plus	55.32%	49.66%
Medallion 4.0	35.23%	44.03%
More Than One Medicaid Program	54.69%	45.83%
MCO		
Aetna	46.90%	50.40%
HealthKeepers	40.86%	42.49%
Magellan	35.29%	39.36%
Optima	39.16%	46.85%
United	38.96%	46.23%
VA Premier	45.45%	43.51%
More Than One MCO	46.34%	60.00%
Geographic Region		
Central	39.23%	44.44%
Charlottesville/Western	42.86%	42.86%
Northern & Winchester	41.51%	46.69%
Roanoke/Alleghany	48.31%	42.94%
Southwest	52.54%	47.34%
Tidewater	36.32%	46.71%
Age		
18–44 Years	38.02%	41.07%
45–60 Years	50.15%	52.77%
Gender		
Male	50.23%	50.34%
Female	39.92%	43.95%
Race		
White	47.21%	48.88%
Black/African American	35.14%	39.73%
Asian	46.15%	44.64%
Southeast Asian/Pacific Islander	*	*
Hispanic	*	*
More Than One Race/Other/Unknown	43.10%	48.68%

An em dash (—) indicates that a rate could not be calculated.

** 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.*

The Virginia total Prevalence of Prediabetes rates for CY 2019 and CY 2020 remained stable, with a rate ranging between 4 and 5 percent. Prediabetes, a condition in which an individual's blood sugar is higher than normal, yet not high enough to be classified as diabetes, affects approximately 88 million U.S. adults (age 18+ years) and the CDC estimates that only one in three of these individuals are aware that they have prediabetes.[3-5] According to a 2016 CDC estimate, 9 percent of adults in Virginia (among all payors) have been diagnosed with prediabetes, indicating that the prevalence of prediabetes may be underrepresented in the data used for measure calculation, as the CY 2020 rate was nearly half that of the CDC estimates.[3-6]

According to AACE, metformin therapy is suggested for the prevention of Type 2 diabetes mellitus for those diagnosed with prediabetes, those with a BMI over 35, those who are under 60 years of age, and for women who have previously had gestational diabetes.[3-7] Metformin was found to reduce the three-year risk of diabetes by 31 percent when used in association with a DPP and by 58 percent when additional lifestyle interventions were introduced (e.g., changes in diet, exercise).[3-8] However, research has found that providers are underutilizing metformin as a treatment option for prediabetes with one national study finding that less than 1 percent of US adults with prediabetes were prescribed metformin. The Virginia total rate of Metformin Use for Prediabetics was stable between CY 2019 and CY 2020, with rates higher among those 18–44 years of age, females, and the White race. The lowest rates of Metformin Use for Prediabetics were for members 45–60 years of age, males, and the Black/African American population. These rates indicate an opportunity for improvement given that known risk factors for Type 2 diabetes mellitus include those ages 45 and older and those in a high-risk population (e.g., Black/African American, Hispanic).[3-9] According to research, approximately 14 individuals would need to receive metformin over a three-year period to prevent one individual from being diagnosed with diabetes.[3-10] Thus, if the Black/African American population in Virginia were to receive metformin at the same rate as the statewide average, given their current adherence rate of 39.73 percent, then approximately 17 cases of diabetes could potentially be prevented for the Black/African American population.

As stated above, metformin therapy is suggested for individuals with prediabetes to prevent Type 2 diabetes mellitus. The Virginia total Adherence to Metformin rate increased between CY 2019 and CY 2020 to 45.22 percent; however, Virginia's adherence rates are lower than national adherence rates that range between 67 to 85 percent.[3-11] Similar to the rate of metformin use for prediabetes, adherence rates for the Black/African American population were between 5 and 9 percentage points below the other race categories, indicating an opportunity to understand the reasons for nonadherence and

[3-5] CDC. *Diabetes Report Card*. 2019. Available at: https://www.cdc.gov/diabetes/pdfs/library/Diabetes-Report-Card-2019-508.pdf. Accessed on: Dec 1, 2021.
[3-6] Ibid.
[3-7] Williamson J. Metformin's role in the prevention of type 2 diabetes in individuals diagnosed with prediabetes: A systematic literature review. *Cornerstone: A Collection of Scholarly and Creative Works for Minnesota State University*. 2020. Available at: https://cornerstone.lib.mnsu.edu/cgi/viewcontent.cgi?article=1976&context=etds. Accessed on: Dec 1, 2021.
[3-8] Hostalek U, Campbell I. Metformin for diabetes prevention: update of the evidence base. *Current Medical Research and Opinion*. 2021: 37(10): 1705-1717. Available at: https://doi.org/10.1080/03007995.2021.1955667. Accessed on: Dec 1, 2021.
[3-9] Williamson J. Metformin's role in the prevention of type 2 diabetes in individuals diagnosed with prediabetes: A systematic literature review. *Cornerstone: A Collection of Scholarly and Creative Works for Minnesota State University*. 2020. Available at: https://cornerstone.lib.mnsu.edu/cgi/viewcontent.cgi?article=1976&context=etds. Accessed on: Dec 1, 2021.
[3-10] Ibid.
[3-11] Christofides EA. Practical insights into improving adherence to metformin therapy in patients with type 2 diabetes. *Clinical Diabetes*. 2019:37(3):234-241. Available at: https://doi.org/10.2337/cd18-0063. Accessed on: Dec 1, 2021.

identify solutions to increase adherence rates overall (i.e., patient education and medication counseling).[3-12]

ARTS Measure Specification Development and Maintenance Results

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

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

Focus Studies

DMAS elected to continue the following clinical topics during the 2021 contract year: improving birth outcomes through adequate prenatal care (Birth Outcomes Focus Study), Perinatal Dental Utilization, and improving the health of children in foster care (Foster Care Focus Study). Based on methodological considerations, MCO-specific results produced for each focus study are available in the final activity reports.

MCO Comparative and Statewide Aggregate Consumer Decision Support Tool Results

DMAS contracted with HSAG in 2021 to produce a Consumer Decision Support Tool using Virginia Medicaid MCOs' HEDIS data and CAHPS survey results for the Medallion 4.0 MCOs. The Medallion 4.0 Consumer Decision Support Tool demonstrates how the Virginia Medicaid MCOs compare to one another overall and in key performance areas. The tool uses stars to display results for the MCOs, as shown in Table 3-12. Please refer to Appendix B for the detailed methodology used for this tool.

[3-12] Ibid.

Table 3-12—Consumer Decision Support Tool Results—Performance Levels

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

Table 3-13 displays the Medallion 4.0 2021 Consumer Decision Support Tool results for each MCO.

Table 3-13—2021 Consumer Decision Support Tool Results

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

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

Strengths, Weaknesses, and Recommendations

For 2021, the MCOs demonstrated similar performance within the *Keeping Kids Healthy* category, with five of the six MCOs achieving the High Performance or Highest Performance levels. The *Taking Care of Women, Living With Illness*, and *Overall Rating* categories showed large variations in performance between the MCOs for 2021, with star ratings ranging from one to five.

Strengths

Strength: Of note, HealthKeepers and VA Premier demonstrated strength when compared to the other MCOs by achieving High Performance or Highest Performance in three or more of the categories and never once performing below the Average Performance level.

Weaknesses

Weakness: Magellan demonstrated lowest performance among the MCOs, achieving Lowest Performance or Low Performance in five of the six categories and never once performing above the Average Performance level.

Why the weakness exists: Based on the results, Magellan scored low in the *Doctors' Communication, Keeping Kids Healthy, Living With Illness, Taking Care of Women*, and *Overall Rating* categories, indicating overall opportunities to improve members' overall care.

Recommendation: HSAG recommends that Magellan review processes that may create barriers to communications with their doctors, children receiving regular checkups and shots, members getting the tests and checkups they need, and women getting tests for cancer and diseases and care before and after their babies are born. HSAG recommends implementing processes to receive direct feedback from members to ensure an understanding of the barriers and to use best practices to improve care and service delivery.

Performance Withhold Program

In 2021, DMAS contracted with HSAG to establish, implement, and maintain a scoring mechanism for the Medallion 4.0 PWP. Due to the impacts of the COVID-19 PHE on the MCOs' ability to collect and report data, as well as DMAS' ability to appropriately evaluate performance levels and improvement, DMAS determined that SFY 2021, which assesses CY 2020 PM data, would be a pay-for-reporting year for the PWP. The SFY 2021 PWP assesses CY 2020 PM data to determine what portion, if any, the MCOs will earn back from the funds withheld in SFY 2021 (i.e., the 1 percent of capitation payments withheld from July 1, 2020, through June 30, 2021). For the SFY 2021 PWP, the Medallion 4.0 MCOs could earn all or a portion of their 1 percent quality withhold based on sufficiently reporting the required measure rates for five NCQA HEDIS measures and one AHRQ PDI measure. The SFY 2021 PWP was based on whether the MCO reported valid HEDIS MY 2020 (i.e., CY 2020) measure rates to NCQA in the required reporting method (i.e., hybrid for the *Adolescent Well-Care Visits*, *Childhood Immunization Status*, *Comprehensive Diabetes Care*, and *Prenatal and Postpartum Care* measures; and administrative for the *Follow-Up After Emergency Department Visit for Mental Illness* measure) and whether the MCO received a "*Reportable (R)*" or "*Small Denominator (NA)*" audit designation for all HEDIS and AHRQ PDI measures. All MCOs met the requirements to earn back their entire 1 percent quality withhold for the SFY 2021 PWP. For detailed information related to the PWP, please see the *Medallion 4.0 Performance Withhold Program Methodology (Updated for COVID-19)* on DMAS' website.[3-13]

[3-13] Health Services Advisory Group, Inc. *Revised Medallion 4.0 Performance Withhold Program Methodology*. Available at: https://www.dmas.virginia.gov/media/2340/revised-medallion-40-performance-withhold-program-methodology.pdf. Accessed on: Dec 1, 2021.

4. Validation of Performance Improvement Projects

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.

Objective

As part of the Commonwealth's QS, each MCO is required to conduct PIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). As one of the mandatory EQR activities required under the BBA, HSAG, as the Commonwealth's EQRO, validated the PIPs through an independent review process. To ensure methodological soundness while meeting all Commonwealth and federal requirements, HSAG follows validation guidelines established in the CMS publication, *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[4-1] Additionally, HSAG's PIP process facilitates frequent communication with the MCOs. HSAG provides written feedback after each module is validated and provides technical assistance for further guidance. HSAG conducts webinar training prior to each module submission and progress check-ins while MCOs test interventions.

DMAS requires the MCOs to conduct two PIPs annually. The topics continued and completed in 2021 were:

- *Timeliness of Prenatal Care*
- *Tobacco Use Cessation in Pregnant Women*

The topics selected by DMAS addressed CMS requirements related to quality outcomes—specifically, the quality and timeliness of care and services.

For each PIP topic, the MCOs defined a Global and SMART Aim. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. HSAG provided the following parameters to the MCOs for establishing the SMART Aim for each PIP:

- **S**pecific: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **M**easurable: The indicator to measure the goal: What is the measure that will be used? What is the current data figure (i.e., count, percent, or rate) for that measure? What do you want to increase/decrease that number to?

[4-1] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Dec 3, 2021.

- **A**ttainable: Rationale for setting the goal: Is the achievement you want to attain based on a particular best practice/average score/benchmark? Is the goal attainable (not too low or too high)?
- **R**elevant: The goal addresses the problem to be improved.
- **T**ime-bound: The timeline for achieving the goal.

Approach to PIP Validation

In 2021, HSAG obtained the data needed to conduct the PIP validation from the MCOs' module submission forms. These forms provided detailed information about each of the PIPs and the activities completed.

The MCOs submitted Module 4 and Module 5 according to the approved timeline. After the initial validation of each module, the MCOs received HSAG's feedback and technical assistance and resubmitted the modules. This process allowed the MCOs an opportunity to address criteria that received a *Not Achieved* score, provide additional SMART Aim and intervention evaluation data, and potentially improve the PIP's confidence level.

The goal of HSAG's PIP validation is to ensure that DMAS and key stakeholders can have confidence that any reported improvement is related to and can be directly linked to the QI strategies and activities the MCO conducted during the PIP. HSAG's scoring methodology evaluates whether the MCO executed a methodologically sound PIP and confirmed that any achieved improvement can be linked to the QI strategies implemented by the MCO.

PIP Validation Scoring

During validation, HSAG determines if criteria for each module are *Achieved.* Any validation criteria not applicable (*NA*) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings from modules 1 through 5 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG will assign a level of confidence and report the overall validity and reliability of the findings as one of the following:

- ***High confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, the demonstrated improvement was clearly linked to the QI processes conducted and intervention(s) tested, and the MCO accurately summarized the key findings.
- ***Confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, and the MCO accurately summarized the key findings. However, some, but not all, QI processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- ***Low confidence*** = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the QI processes conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- ***Reported PIP results were not credible*** = The PIP methodology was not executed as approved.

Training and Implementation

HSAG trained the MCOs on the PIP module submission and validation requirements prior to the submission due dates. HSAG's rapid-cycle PIP validation process facilitates frequent communication with the MCOs. HSAG provides technical assistance throughout the process. At the onset, HSAG provides feedback to ensure that PIPs are well-designed. The MCOs also have opportunities for mid-course corrections. In addition to the PIP module training webinars that HSAG provides, the MCOs may seek ongoing technical assistance.

PIP Validation Status

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

Recommendations

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

Validation Findings

Aetna

In 2021, Aetna submitted the following topics for validation: *Ensuring Timeliness of Prenatal Care* and *Tobacco Use Cessation in Pregnant Women.* The topics selected addressed CMS' requirements related to quality outcomes—specifically, timeliness and quality of care and services. Table 4-1 displays the SMART Aim and results for each PIP.

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

SMART Aim Statement	By May 31, 2021, increase the percentage of HEDIS *Prenatal and Postpartum Care (PPC)* prenatal care visit rates among members aged 18–29 years in the Central VA region, from 41.8% to 49%.
Highest Rate Achieved	55.8%
Confidence Level	*Low confidence*

SMART Aim Statement	By May 31, 2021, decrease the rate of identified smokers among pregnant members in the Central VA region, from 32.6% to 29.86%.
Lowest Rate Achieved	32.0%
Confidence Level	*Low confidence*

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

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

Intervention	Intervention Status
Addiction & Pregnancy Support Flyer	Adapt
Telephonic Outreach to Pregnant Members	Abandon

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

Intervention	Intervention Status
American Cancer Society Newsletter	Abandon
Telephonic Outreach to Pregnant Smokers	Abandon

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

For Aetna's *Timeliness of Prenatal Care* PIP, although the SMART Aim goal was achieved, the MCO determined that it was not likely due to the interventions because of the small populations that were reached. For the *Tobacco Use Cessation in Pregnant Women* PIP, the SMART Aim measure results did not meet the goal.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** Aetna tested more than one intervention per PIP.
	Strength: Aetna provided the SMART Aim numerator and denominator data in the PIP resubmissions.
Weaknesses	**Weaknesses:** Aetna received *Low confidence* for both PIPs. **Why the weakness exists:** For the *Ensuring Timeliness of Prenatal Care* PIP, although the SMART Aim goal was achieved, the MCO determined that it was likely not due to the interventions. For the *Tobacco Use Cessation in Pregnant Women* PIP, the SMART Aim goal was not achieved. **Recommendation:** HSAG recommends that Aetna: • Focus on testing active and engaging interventions. • Ensure that interventions reach the maximum number of eligible members. • Provide additional SMART Aim measure data points in the resubmission.

HealthKeepers

In 2021, HealthKeepers submitted the following topics for validation: *Timeliness of Prenatal Care* and *Tobacco Use Cessation in Pregnant Women*. The topics selected addressed CMS' requirements related to quality outcomes—specifically, timeliness and quality of care and services. Table 4-4 displays the SMART Aim and results for each PIP.

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

SMART Aim Statement	By May 31, 2021, increase the percentage of members who have received timely prenatal care during the first trimester, on or before the enrollment start date or within 42 days of enrollment assigned to Dominion Women's Health, who were identified as pregnant and receiving a prenatal care visit, from 68.94% to 75%.
Highest Rate Achieved	95.0%
Confidence Level	*Low confidence*
SMART Aim Statement	By May 31, 2021, increase the percentage of members who have received tobacco cessation interventions plan-wide, who were identified as pregnant and were tobacco users screened for tobacco use, from 10.5% to 30%.
Highest Rate Achieved	58.0%
Confidence Level	*Low confidence*

For each PIP, HealthKeepers completed a process map and an FMEA to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by targeted interventions. Table 4-5 and Table 4-6 provide the interventions that HealthKeepers selected to test for the PIPs and the MCO's decision for each intervention.

Table 4-5—Intervention Summary for *Timeliness of Prenatal Care*

Intervention	Intervention Status
Personalized Case Management and Provider Collaboration	Abandon
Monthly Pregnancy Reporting	Abandon

Table 4-6—Intervention Summary for *Tobacco Use Cessation in Pregnant Women*

Intervention	Intervention Status
Personalized Case Management and Provider Collaboration	Abandon
Monthly Pregnancy Reporting	Abandon

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

For HealthKeepers' *Timeliness of Prenatal Care* PIP, the SMART Aim measure result was above the goal and remained above the goal for the duration of the PIP. The MCO determined that the interventions were not effective and could not be linked to the improvement. For the *Tobacco Use Cessation in Pregnant Women* PIP, the SMART Aim result started above the goal and steadily declined to below the goal after the interventions began.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: HealthKeepers tested more than one intervention per PIP.

Strength: HealthKeepers provided the intervention evaluation data in the PIP resubmissions.

Weaknesses

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

Why the weakness exists: The MCO did not link improvement in the SMART Aim measure results to interventions that were tested for the PIP.

Recommendation: HSAG recommends that HealthKeepers:

- If an intervention is not having an impact, quickly make modifications and continually review the data to assess for improvement.
- Provide additional SMART Aim measure data points in the resubmission.

Magellan

In 2021, Magellan submitted the following topics for validation: *Improve Timeliness of Prenatal Care* and *Reduce Tobacco Use in Pregnant Women*. The topics selected addressed CMS' requirements related to quality outcomes—specifically, timeliness and quality of care and services. Table 4-7 displays the SMART Aim and results for each PIP.

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

SMART Aim Statement	By May 31, 2021, increase the rate of members receiving a prenatal visit within their first trimester, on MCO enrollment date or within 42 days of MCO enrollment by 49.5 percentage points from 31.5% to 81% seen by top five selected providers meeting the PPC criteria.
Highest Rate Achieved	52.1%
Confidence Level	*Low confidence*
SMART Aim Statement	By May 31, 2021, increase the rate of pregnant women identified as smokers or tobacco users who receive smoking cessation treatments including medication and/or counseling by 5 percentage points from 94% to 99%.
Highest Rate Achieved	98.1%
Confidence Level	*Reported PIP results were not credible*

For each PIP, Magellan completed a process map and an FMEA to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by targeted interventions. Table 4-8 and Table 4-9 provide the interventions that Magellan selected to test for the PIPs and the MCO's decision for each intervention.

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

Intervention	Intervention Status
Prenatal Incentive Program	Abandon

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

Intervention	Intervention Status
Tobacco Cessation Incentive Program	Adapt

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

For Magellan's *Improve Timeliness of Prenatal Care* PIP, the SMART Aim measure result demonstrated improvement; however, the goal was not achieved. For the *Reduce Tobacco Use in Pregnant Women* PIP, the SMART Aim goal was not achieved, and it appeared that the remeasurement data were not comparable to the baseline.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** Magellan requested technical assistance from HSAG prior to the PIP resubmissions.
	Strength: Magellan provided intervention evaluation data in both PIP resubmissions.
	Strength: Magellan provided additional SMART Aim data in the *Improve Timeliness of Prenatal Care* PIP resubmission.
	Strength: Magellan planned to adapt the *Reduce Tobacco Use in Pregnant Women* PIP intervention to increase effectiveness.
Weaknesses	**Weaknesses:** The *Timeliness of Prenatal Care* PIP received *Low confidence*. **Why the weakness exists:** The SMART Aim goal was not achieved. **Recommendation:** HSAG recommends that Magellan: • Identify eligible members for the intervention using a method other than claims to avoid claims lag. • Obtain up-to-date member contact information. • Test more than one intervention per PIP.
	Weaknesses: Magellan did not improve the score for the *Reduce Tobacco Use in Pregnant Women* PIP with the resubmission. **Why the weakness exists:** The MCO provided an explanation regarding members for the intervention; however, it did not explain the reduction in the

SMART Aim eligible population. The SMART Aim measure should be calculated in alignment with the rolling 12-month methodology.

Recommendation: HSAG recommends that Magellan ensure understanding of the PIP methodology and data reporting requirements.

Optima

In 2021, Optima submitted the following topics for validation: *Timeliness of Prenatal Care* and *Tobacco Use Cessation in Pregnant Women*. The topics selected addressed CMS' requirements related to quality outcomes—specifically, timeliness and quality of care and services. Table 4-10 displays the SMART Aim and results for each PIP.

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

SMART Aim Statement	By May 31, 2021, increase in the percentage of timely prenatal visits among pregnant Optima health Medicaid insured women in the city of Norfolk, Virginia, by 10% (43.49% to 53.49%).
Highest Rate Achieved	58.5%
Confidence Level	*Confidence*
SMART Aim Statement	By May 31, 2021, decrease tobacco use among Optima Health Medicaid-insured pregnant women in the City of Norfolk, VA, by 8 percentage points (from 13.1% to 5.1%).
Lowest Rate Achieved	9.5%
Confidence Level	*Low confidence*

For each PIP, Optima completed a process map and an FMEA to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by targeted interventions. Table 4-11 and Table 4-12 provide the interventions that Optima selected to test for the PIPs and the MCO's decision for each intervention.

Table 4-11—Intervention Summary for *Timeliness of Prenatal Care*

Intervention	Intervention Status
Pregnancy Incentive Program	Adapt

Table 4-12—Intervention Summary for *Tobacco Use Cessation in Pregnant Women*

Intervention	Intervention Status
Survey to Identify Pregnant Optima Health Smokers	Adapt

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

For Optima's *Timeliness of Prenatal Care* PIP, the SMART Aim measure result was achieved with additional data points the MCO provided in the resubmission. For the *Tobacco Use Cessation in Pregnant Women* PIP, the SMART Aim goal was not achieved.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** Optima provided additional SMART Aim data in both PIP resubmissions.
	Strength: Optima achieved the SMART Aim goal in the *Timeliness of Prenatal Care* PIP resubmission and improved the score.
	Strength: Optima planned to adapt both interventions to increase effectiveness.
Weaknesses	**Weaknesses:** Optima received *Low confidence* for the *Tobacco Use Cessation in Pregnant Women* PIP. **Why the weakness exists:** The SMART Aim goal was not achieved. **Recommendation:** HSAG recommends that Optima: • Have a live person make telephone calls to members. • Test more than one intervention per PIP.

United

In 2021, United submitted the following topics for validation: *Timeliness of Prenatal Care* and *Tobacco Use Cessation in Pregnant Women*. The topics selected addressed CMS' requirements related to quality outcomes—specifically, timeliness and quality of care and services. Table 4-13 displays the SMART Aim and results for each PIP.

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

SMART Aim Statement	The Virginia UnitedHealthcare Medallion Plan will increase the percentage of women who receive a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment in the Northern & Winchester Region from 43.96% to 68.96% by May 31, 2021.
Highest Rate Achieved	51.9%
Confidence Level	*Low confidence*

SMART Aim Statement	The Virginia UnitedHealthcare Medallion Plan will increase the percentage of pregnant women (identified as tobacco users) who receive advice to quit smoking and/or who discussed or were provided cessation methods or strategies among pregnant women, from 19.85% to 24.85% by May 31, 2021.
Highest Rate Achieved	29.5%
Confidence Level	*Confidence*

For each PIP, United completed a process map and an FMEA to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by targeted interventions. Table 4-14 and Table 4-15 provide the interventions that United selected to test for the PIPs and the MCO's decision for each intervention.

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

Intervention	Intervention Status
Streamline Member Maternity Incentive Program Process	Adapt
Develop a Robust Provider OBRAF Submission	Adapt

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

Intervention	Intervention Status
Member Outreach Using Pharmacy Data as an Identifier	Adopt
Tobacco Cessation Counseling Information Submitted Through OBRAF	Adopt

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

For United's *Timeliness of Prenatal Care* PIP, the MCO provided additional SMART Aim data in the resubmission; however, the result did not achieve the goal. For the *Tobacco Use Cessation in Pregnant Women* PIP, the MCO provided additional SMART Aim data in the resubmission and the goal was achieved.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: United tested more than one intervention per PIP.

Strength: United provided additional SMART Aim data in both PIP resubmissions.

Strength: United planned to adopt the *Tobacco Use Cessation in Pregnant Women* PIP successful interventions.

Strength: United planned to adapt the *Timeliness of Prenatal Care* PIP interventions to increase effectiveness.

Weaknesses

Weaknesses: United received *Low confidence* for the *Timeliness of Prenatal Care* PIP.

Why the weakness exists: The SMART Aim goal was not achieved.

Recommendation: HSAG recommends that United:

- Ensure that interventions reach the maximum number of eligible members.
- Continue efforts to achieve further improvement and spread interventions to other populations.

VA Premier

In 2021, VA Premier submitted the following topics for validation: *Timeliness of Prenatal Care* and *Tobacco Use Cessation in Pregnant Women*. The topics selected addressed CMS' requirements related to quality outcomes—specifically, timeliness and quality of care and services. Table 4-16 displays the SMART Aim and results for each PIP.

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

SMART Aim Statement	By May 31, 2021, increase the percentage of timely prenatal care among members in the Roanoke region, from 55% to 65%.
Highest Rate Achieved	56.4%
Confidence Level	*Low confidence*
SMART Aim Statement	By May 31, 2021, decrease the percentage of pregnant members in the Roanoke region that did not receive counseling, medications, and advice on smoking cessation from 93% to 88%.
Lowest Rate Achieved	94.5%
Confidence Level	*Low confidence*

For each PIP, VA Premier completed a process map and an FMEA to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by targeted interventions. Table 4-17 and Table 4-18 provide the interventions that VA Premier selected to test for the PIPs and the MCO's decision for each intervention.

Table 4-17—Intervention Summary for *Timeliness of Prenatal Care*

Intervention	Intervention Status
Member Outreach Staff Target Moms Not in the Healthy Heartbeats Program. Provide Continuous Support and Guidance in Obtaining Prenatal Care.	Adapt

Table 4-18—Intervention Summary for *Tobacco Use Cessation in Pregnant Women*

Intervention	Intervention Status
Target Expectant Mothers and Provide Education, Support, and Guidance and Increase Participation in the Healthy Heartbeats Program	Abandon

VA Premier completed both PIPs and submitted Module 4 and Module 5 to HSAG for validation. HSAG assessed the SMART Aim measure results for improvement and whether interventions that were tested could be linked to demonstrated improvement. HSAG provided feedback and recommendations to VA Premier in the initial validation tools for Module 4 and Module 5 and VA Premier had an opportunity to resubmit the PIPs with corrections and additional data to potentially improve the 2021 PIP validation scores. VA Premier resubmitted the PIPs; however, it appeared that there were no updates.

For VA Premier's *Timeliness of Prenatal Care* PIP, the MCO did not provide additional SMART Aim data in the resubmission and the goal was not achieved. For the *Tobacco Use Cessation in Pregnant Women* PIP, the MCO did not provide additional SMART Aim data in the resubmission and the goal was not achieved.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: VA Premier planned to adapt the *Timeliness of Prenatal Care* PIP intervention to increase effectiveness.

Weaknesses

Weaknesses: VA Premier received *Low confidence* for both PIPs.

Why the weakness exists: The MCO resubmitted the PIPs; however, it appeared that there were no updates. The SMART Aim goal was not achieved.

Recommendation: HSAG recommends that VA Premier:

- If an intervention is not having an impact, quickly make modifications and continually review the data to assess for improvement.
- Provide additional SMART Aim measure data points in the resubmission.
- Test more than one intervention per PIP.

5. Validation of Performance Measures

Overview

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

Objectives

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

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

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 2020 measure rates that were used as the basis for the strengths and weaknesses described in the following MCO-specific evaluations.

MCO-Specific HEDIS Measure Results

Aetna

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

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

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

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Within the Care for Chronic Conditions domain, Aetna displayed strong performance within the *Asthma Medication Ratio—Total* measure, meeting or exceeding NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile. The results indicate that Aetna has established successful processes related to asthma medication for members with chronic conditions. The high level of performance in providing asthma care indicates that Aetna is ensuring that providers follow evidence-based clinical guidelines and that members are being encouraged to complete recommended care and services, thereby reducing adverse member outcomes and unnecessary ED utilization.

Strength: Within the Behavioral Health domain, Aetna's rates met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Antidepressant Medication Management—Effective Continuation Phase Treatment*, *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measure indicators. This suggests providers are following guidelines for follow-up monitoring for children prescribed ADHD or using psychosocial care as a first-line protocol for members prescribed antipsychotics. Aetna's strong performance in the Behavioral Health domain measures indicates the MCO has improved members' access to behavioral healthcare, potentially as a result of Virginia's focus on the ARTS benefit and the development of member-centric behavioral healthcare and services.

Weaknesses

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

- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*

- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* and *Eye Exam (Retinal) Performed*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Why the weakness exists: Although Aetna members may have adequate access to timely care and services, members are not completing timely visits, screenings, or recommended care for chronic conditions. The lack of member participation in recommended care and services may be a result of a disparity-driven barrier, a lack of understanding of care recommendations for optimal health, or the ability to access care and services in a timely manner. Screening declines may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed to the declines during this time include screening site closures and the temporary suspension of non-urgent services due to the COVID-19 PHE.

Recommendation: HSAG recommends that Aetna conduct a root cause analysis or focus study to determine why members are not consistently accessing and completing preventive screenings, childhood immunizations, and care and services for chronic conditions. HSAG recommends that Aetna analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, HSAG recommends that Aetna implement appropriate interventions to improve the receipt of recommended care and services that impact the health of its members.

HealthKeepers

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

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

- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with HealthKeepers' claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with HealthKeepers' eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with HealthKeepers' provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with HealthKeepers' medical record review processes.

- *Supplemental Data:* HSAG identified no concerns with HealthKeepers' supplemental data systems and processes.
- *Data Integration:* HSAG identified no concerns with HealthKeepers' procedures for data integration and measure production.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Within the Care for Chronic Conditions domain, HealthKeepers displayed strong performance within the *Asthma Medication Ratio—Total* measure, exceeding NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile. The result indicates that HealthKeepers has established successful processes related to asthma medication for members with chronic conditions. The high level of performance in providing asthma care indicates that HealthKeepers is ensuring that providers follow evidence-based clinical guidelines and that members are being encouraged to complete recommended care and services, thereby reducing adverse member outcomes and unnecessary ED utilization.

Weaknesses

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

- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Breast Cancer Screening*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Why the weakness exists: HealthKeepers' rates for several measure indicators in the Women's Health, Access to Care, and Care for Chronic Conditions domains falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentiles suggests a lack of access to care or understanding of recommended or needed care, or that a disparity may exist in access and availability of care. HealthKeepers' members with chronic conditions may have access to care; however, these members are not consistently receiving recommended screenings and care for chronic conditions. Screening declines may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed to the declines during this time include screening site closures and the temporary suspension of non-urgent services due to the COVID-19 PHE.

Recommendation: HSAG recommends that HealthKeepers conduct a root cause analysis to determine why members are not consistently receiving cancer screenings or recommended services for comprehensive diabetes care and care and services for chronic conditions. HSAG recommends that HealthKeepers analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, HSAG recommends that HealthKeepers implement appropriate evidence-based interventions to improve the receipt of recommended care and services that impact the health of its members and to reduce unnecessary ED use and inpatient utilization.

Magellan

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

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

- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with Magellan's claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with Magellan's eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with Magellan's practitioner data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with Magellan's medical record review processes.
- *Supplemental Data:* HSAG identified no concerns with Magellan's supplemental data systems and processes.
- *Data Integration:* HSAG identified no concerns with Magellan's procedures for data integration and measure production.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Within the Behavioral Health domain, Magellan's rates met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators. The strong performance on this Behavioral Health domain measure indicates that Magellan has improved member access to behavioral healthcare, potentially as a result of Virginia's focus on the ARTS benefit and the development of member-centric behavioral healthcare and services.

Weaknesses

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

- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Childhood Immunization Status—Combination 3*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Why the weakness exists: Several of Magellan's measure rates in the Children's Preventive Health, Women's Health, Access to Care, Care for Chronic Conditions, and Behavioral Health domains falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile suggests a lack of access to preventive care, screenings, care for chronic conditions, and behavioral healthcare. Magellan's members are not consistently scheduling or completing follow-up on recommended care or services or scheduling evidence-based care and services. With low performance across several domains, healthcare disparities may exist, and members may not have a comprehensive understanding of their healthcare needs or benefits. Magellan's members may need the tools to consistently manage their healthcare conditions according to evidence-based guidelines and preventive health schedules. Factors that may have contributed to the declines during this time include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The COVID-19 PHE also likely deterred individuals from seeking healthcare services.

Recommendation: HSAG recommends that Magellan conduct a root cause analysis or focus groups to identify the reasons why members are not accessing well care, preventive care, behavioral healthcare, and care for chronic conditions. HSAG recommends that Magellan analyze its data and results of any root cause analysis or focus groups to identify opportunities to reduce any disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of root causes, HSAG recommends that Magellan implement appropriate evidence-based interventions to improve the performance related to these low-scoring healthcare domains.

Optima

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

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

- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with Optima's claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with Optima's eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with Optima's practitioner data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with Optima's medical record review processes.
- *Supplemental Data:* HSAG identified no concerns with Optima's supplemental data systems and processes.
- *Data Integration:* HSAG identified no concerns with Optima's procedures for data integration and measure production.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Within the Care for Chronic Conditions domain, Optima displayed strong performance for the *Asthma Medication Ratio—Total* measure, meeting or exceeding NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile. The result indicates that Optima has established successful processes related to asthma medication for members with chronic conditions. The high level of performance in providing asthma care indicates that Optima is ensuring that providers follow evidence-based clinical guidelines and that members are being encouraged to complete recommended care and services, thereby reducing adverse member outcomes and unnecessary ED utilization.

Weaknesses

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

- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Why the weakness exists: Optima's performance on several measure rates in the Children's Preventive Care, Women's Health, Access to Care, and Care for Chronic Conditions domains falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile suggests a lack of access to preventive care, women's health, and care for chronic conditions. Optima's members are not consistently scheduling well-care visits or receiving childhood immunizations according to the recommended schedules. Chronic care measure results indicate that members may not be following up on evidence-based care and services. With low performance across several domains, healthcare disparities may exist, and members may not have a comprehensive understanding of their healthcare needs or benefits. Factors that may have contributed to the declines during this time include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The COVID-19 PHE also likely deterred individuals from seeking healthcare services.

Recommendation: HSAG recommends that Optima conduct a root cause analysis or focus groups to determine why children are not receiving immunizations according to recommended schedules. HSAG recommends Optima conduct a focus study to determine why women are not receiving timely prenatal and postpartum care. HSAG also recommends that Optima conduct similar processes and analyses of data to better understand barriers members experience in receiving care for chronic conditions. HSAG recommends that Optima consider whether there are disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause or causes, HSAG recommends that Optima implement appropriate interventions to improve access to and timeliness of preventive visits, screenings, and recommended services for members diagnosed with a chronic condition.

United

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

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

- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with United's claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with United's eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with United's provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with United's medical record review processes.
- *Supplemental Data:* HSAG identified no concerns with United's supplemental data systems and processes.

- *Data Integration:* HSAG identified no concerns with United's procedures for data integration and measure production.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Within the Care for Chronic Conditions domain, United displayed strong performance for the *Asthma Medication Ratio—Total* measure, meeting or exceeding NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile. The result indicates that United has established successful processes related to asthma medication for members with chronic conditions. The high level of performance in providing asthma care indicates that United is ensuring that providers follow evidence-based clinical guidelines and that members are being encouraged to complete recommended care and services, thereby reducing adverse member outcomes and unnecessary ED utilization.

Strength: Within the Behavioral Health domain, United's rates ranked at or above NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measure indicators. This suggests providers are following guidelines for follow-up monitoring or using psychosocial care as a first-line protocol for members prescribed antipsychotics. United's strong performance in the Behavioral Health domain measures indicates that the MCO has improved members' access to behavioral healthcare, potentially as a result of Virginia's focus on the ARTS benefit and the development of member-centric behavioral healthcare and services.

Weaknesses

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

- *Adult's Access to Preventive/Ambulatory Health Services—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Why the weakness exists: United's measure rates in the Women's Health, Access to Care, and Care for Chronic Conditions domains falling below the HEDIS MY 2019 25th percentile suggests a lack of access to preventive care, screenings, and care for chronic conditions. United's members are not completing timely visits, screenings, or recommended care for chronic conditions. The lack of member participation in recommended care and services may be a result of a disparity-driven barrier, a lack of understanding of care recommendations for optimal health, or the ability to access care and services in a timely manner. Screening declines may have coincided with the rapid increase of COVID-19

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

Recommendation: HSAG recommends that United conduct a root cause analysis or focus groups to determine why members are not accessing and completing preventive screenings or accessing care according to recommended schedules. HSAG also recommends that United conduct similar processes and analyses of data to better understand barriers members experience in receiving care for chronic conditions. HSAG recommends that United consider whether there are disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause or causes, HSAG recommends that VA Premier implement appropriate interventions to improve access to and timeliness of visits, screenings, behavioral healthcare, and recommended services for members diagnosed with a chronic condition.

VA Premier

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

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

- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with VA Premier's claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with VA Premier's eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with VA Premier's provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with VA Premier's medical record review processes.
- *Supplemental Data:* HSAG identified no concerns with VA Premier's supplemental data systems and processes.
- *Data Integration:* HSAG identified no concerns with VA Premier's procedures for data integration and measure production.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Within the Care for Chronic Conditions domain, VA Premier displayed strong performance for the *Asthma Medication Ratio—Total* measure, meeting or exceeding NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile. The result indicates that VA Premier has established successful processes related to asthma medication for members with chronic conditions. The high level of performance in providing asthma care indicates that VA Premier is

ensuring that providers follow evidence-based clinical guidelines and that members are being encouraged to complete recommended care and services, thereby reducing adverse member outcomes and unnecessary ED utilization.

Strength: Within the Behavioral Health domain, VA Premier's rates met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*, and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* measure indicators. The strong performance in the behavioral health antidepressant medication management measures and follow-up for care for children indicates that VA Premier has established strong access to behavioral healthcare, potentially as a result of Virginia's focus on the ARTS benefit and the development of member-centric behavioral healthcare and services.

Weaknesses

Weakness: The following HEDIS MY 2020 measure rates fell below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile and were determined to be opportunities for improvement for VA Premier:

- *Adult's Access to Preventive/Ambulatory Health Services—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Why the weakness exists: Although VA Premier members may have adequate access to timely care and services, members are not completing timely visits, screenings, or recommended care for chronic conditions. The lack of member participation in recommended care and services may be a result of a disparity-driven barrier, a lack of understanding of care recommendations for optimal health, or the ability to access care and services in a timely manner. Screening declines may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed to the declines during this time include screening site closures and the temporary suspension of non-urgent services due to the COVID-19 PHE.

Recommendation: HSAG recommends that VA Premier conduct root cause analyses or conduct focus groups to determine why members are not consistently

accessing and completing preventive screenings, childhood immunizations, and care and services for chronic conditions. HSAG recommends that VA Premier analyze its data and consider whether there are disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause or causes, HSAG recommends that VA Premier implement appropriate interventions to improve the receipt of recommended care and services that impact the health of its members and to reduce unnecessary use of ambulatory services, which can significantly reduce non-urgent ED visits.

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

Overview

This section presents HSAG's MCO-specific results and conclusions of the review of compliance with Medicaid and CHIP Managed Care Regulations conducted for the MCOs. It provides a discussion of the MCOs' overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. Also included is an assessment of how effectively the MCOs addressed the recommendations for QI made by HSAG during the previous year.

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

Objectives

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

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

Deeming

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

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

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

Table 6-1—Virginia OSR for All MCOs

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

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

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

Aetna

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

Table 6-2—Aetna's Medallion 4.0 OSR Standards and Scores for the Three-Year Period: SFY 2019–SFY 2021

Standard #	Standard Name	Total Elements	Number of Elements			Total Compliance Score
			D	*M*	*NM*	
I	Enrollment and Disenrollment	7	0	7	0	100%
II	Member Rights and Confidentiality	7	0	6	1	85.7%
III	Member Information	21	0	21	0	100%
IV	Emergency and Poststabilization Services	12	0	12	0	100%
V	Adequate Capacity and Availability of Services	15	0	13	2	86.7%
VI	Coordination and Continuity of Care	8	5	3	0	100%
VII	Coverage and Authorization of Services	19	2	17	0	100%
VIII	Provider Selection	5	2	3	0	100%
IX	Subcontractual Relationships and Delegation	4	1	2	1	75.0%
X	Practice Guidelines	3	1	2	0	100%

Standard #	Standard Name	Total Elements	Number of Elements			Total Compliance Score
			D	*M*	*NM*	
XI	Health Information Systems*	6	0	6	0	100%
XII	Quality Assessment and Performance Improvement	6	2	4	0	100%
XIII	Grievance and Appeal Systems	29	0	25	4	86.2%
XIV	Program Integrity	12	0	12	0	100%
XV	EPSDT Services	8	0	5	3	62.5%
Total Compliance Score		**162**	**13**	**138**	**11**	**93.2%**

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

Findings

Of the 162 elements, Aetna received *Met* scores for 138 elements and *Not Met* scores for 11 elements. Deeming was also applied to 13 elements using scores received from the MCO's NCQA accreditation survey. The MCO received an overall compliance score of 93.2 percent. These findings suggest that Aetna developed the necessary policies, procedures, and plans to operationalize most of the required elements of its contract and demonstrated compliance with most of the expectations of the contract.

Of note, Aetna achieved full compliance in 10 of the 15 standards reviewed, demonstrating strengths and adherence to all requirements measured in the areas of:

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

Strengths, Weaknesses, and Recommendations

During the Compliance With Standards review process, HSAG identified strengths and opportunities for improvement specific to Aetna. Examples of the strengths and weaknesses are as follows.

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

Strength: The MCO implemented processes to maintain and monitor its provider network related to the cultural, ethnic, racial, and linguistic needs of its members. In addition, the MCO evaluated and monitored the quality and appropriateness of care provided to members with SHCN.

Strength: The MCO implemented processes through customer services and the grievances and appeals area to assist members with submitting appeals. The MCO also maintained an "open door" system for compliance reporting and provided multiple reporting mechanisms for its staff, contractors, and members.

Weaknesses

Weakness: The MCO did not ensure policies, procedures, processes, and delegated agreements and subcontracts contained current federal and DMAS contract requirements. Examples included:

- The MCO's network adequacy policies and analysis did not align with federal and Commonwealth requirements for all provider types.
- The MCO developed a Virginia Addendum, but it was not consistently applied to the subcontractor and delegated entity agreements.

Why the weakness exists: The MCO may not have updated its policies to include the current DMAS contract requirements or the requirements in the 2020 Medicaid Managed Care Rule.

Recommendation: The MCO must update its policies and analysis procedures to include all current federal and Commonwealth requirements for all provider types. The MCO must also update its subcontractor and delegated entity agreements to include the Virginia-specific requirements.

Weakness: The MCO did not consistently send grievance resolution letters to members.

Why the weakness exists: The MCO did not monitor that grievance resolution letters were consistently sent to members.

Recommendation: The MCO must implement a process and establish monitoring to ensure that grievance resolution letters are sent consistently to members.

Weakness: The MCO did not consistently conduct a secondary review for coverage of services under the EPSDT benefit and notify the member that the secondary review was conducted. The MCO did not consistently inform members that although a service was carved out and therefore not covered under the member's MCO, it may be available through DMAS under the Medicaid State Plan and provide the appropriate contact information for the member to inquire with DMAS.

Why the weakness exists: The MCO did not have an implemented process that ensured a secondary review for EPSDT services that considered the EPSDT's correct or ameliorate criteria.

Recommendation: The MCO must implement a secondary review process for EPSDT services, include the reason for the denial of EPSDT services in its notice

of action to the member, and inform the member that the denied service may be available through DMAS under the Medicaid State Plan.

HealthKeepers

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

Table 6-3—HealthKeepers' Medallion 4.0 OSR Standards and Scores for the Three-Year Period: SFY 2019–SFY 2021

Standard #	Standard Name	Total Elements	Number of Elements			Total Compliance Score
			D	*M*	*NM*	
I	Enrollment and Disenrollment	7	0	7	0	100%
II	Member Rights and Confidentiality	7	0	7	0	100%
III	Member Information	21	0	21	0	100%
IV	Emergency and Poststabilization Services	12	1	11	0	100%
V	Adequate Capacity and Availability of Services	15	0	12	3	80%
VI	Coordination and Continuity of Care	8	5	3	0	100%
VII	Coverage and Authorization of Services	19	2	17	0	100%
VIII	Provider Selection	5	2	3	0	100%
IX	Subcontractual Relationships and Delegation	4	1	3	0	100%
X	Practice Guidelines	3	1	2	0	100%
XI	Health Information Systems*	6	0	6	0	100%
XII	Quality Assessment and Performance Improvement	6	2	3	1	83.3%
XIII	Grievance and Appeal Systems	29	0	24	5	82.8%
XIV	Program Integrity	12	0	12	0	100%
XV	EPSDT Services	8	0	5	3	62.5%
Total Compliance Score		**162**	**14**	**136**	**12**	**92.6%**

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

Findings

Of the 162 elements, HealthKeepers received *Met* scores for 136 elements and *Not Met* scores for 12 elements. Deeming was also applied to 14 elements using scores received from the MCO's NCQA accreditation survey. The MCO received an overall compliance score of 92.6 percent. These findings suggest that HealthKeepers developed the necessary policies, procedures, and plans to operationalize

most of the required elements of its contract and demonstrated compliance with most of the expectations of the contract.

Of note, HealthKeepers achieved full compliance in 11 of the 15 standards reviewed, demonstrating strengths and adherence to all requirements measured in the areas of:

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

Strengths, Weaknesses, and Recommendations

During the Compliance With Standards review process, HSAG identified strengths and opportunities for improvement specific to HealthKeepers. Examples of the strengths and weaknesses are as follows.

Strengths	**Strength:** The MCO focused efforts on sharing information and receiving feedback directly from providers and members. The MCO conducted monthly provider meetings to ensure providers were informed of policies and expectations including those focused on member rights and confidentiality. The MCO also conducted member focus groups that resulted in communication improvements such as a welcome kit to simplify initial materials members receive upon enrollment.
	Strength: The MCO consistently included all DMAS-specific contract requirements in subcontractor and delegated entity agreements. The MCO developed a Virginia-specific Medicaid Exhibit and included it consistently in the subcontractor and delegated entity agreements.
	Strength: The MCO developed and implemented an effective QAPI program that was focused on QI and measuring the results of quality initiatives to continue performance improvement.
Weaknesses	**Weakness:** The MCO's policies and procedures did not consistently contain all federal requirements related to adequate capacity and availability of services. The MCO also did not consistently monitor that its network included sufficient family

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

Why the weakness exists: The MCO may not have updated its policies to include the current DMAS contract requirements or the requirements in the 2020 Medicaid Managed Care Rule or monitor to ensure adequate capacity and availability of services. For example, although the MCO discussed a wide variety of provider types it considered to be family planning providers, policies, procedures, and network assessments did not include a definition or a process to ensure timely access.

Recommendation: The MCO must update its policies and procedures and ensure that all DMAS contract requirements and the requirements contained in the 2020 Medicaid Managed Care Rule are addressed, including defining provider types designated as family planning providers, and implementing processes to ensure adequate capacity and availability of services.

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

Why the weakness exists: The MCO did not demonstrate that it had implemented a process to identify and assess the quality and appropriateness of care furnished to members with SHCN.

Recommendation: The MCO's QAPI program must include a process to assess the quality and appropriateness of care furnished to members with SHCN.

Weakness: The MCO's appeal policy was not updated to include all requirements in the most current 2020 Medicaid Managed Care Rule such as the inclusion of all member rights. In addition, member grievance notices were not consistently in a format and language that was easily understood by the member or clearly stated the resolution so that it was easily understood by the member.

Why the weakness exists: The MCO did not review or update all policies and procedures to ensure compliance with the 2020 Medicaid Managed Care Rule. As a result, not all member rights were included. In addition, the MCO did not describe an implemented process to ensure that member notices would be easily understood by the member and contained the information necessary for the member to understand any additional member rights.

Recommendation: The MCO should develop a process to review or monitor grievance and appeal notifications to ensure that they are easily understood and include all requirements, including all member rights. The MCO should develop a process to ensure that internal processes align with the federal and Commonwealth requirements.

Magellan

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

Table 6-4—Magellan's Medallion 4.0 OSR Standards and Scores for the Three-Year Period: SFY 2019–SFY 2021

Standard #	Standard Name	Total Elements	Number of Elements			Total Compliance Score
			D	*M*	*NM*	
I	Enrollment and Disenrollment	7	0	7	0	100%
II	Member Rights and Confidentiality	7	0	7	0	100%
III	Member Information	21	0	20	1	95.2%
IV	Emergency and Poststabilization Services	12	0	12	0	100%
V	Adequate Capacity and Availability of Services	15	0	13	2	86.7%
VI	Coordination and Continuity of Care	8	3	5	0	100%
VII	Coverage and Authorization of Services	19	2	15	2	89.5%
VIII	Provider Selection	5	2	3	0	100%
IX	Subcontractual Relationships and Delegation	4	1	3	0	100%
X	Practice Guidelines	3	1	2	0	100%
XI	Health Information Systems*	6	0	6	0	100%
XII	Quality Assessment and Performance Improvement	6	2	4	0	100%
XIII	Grievance and Appeal Systems	29	0	26	3	89.7%
XIV	Program Integrity	12	0	12	0	100%
XV	EPSDT Services	8	0	5	3	62.5%
Total Compliance Score		**162**	**11**	**140**	**11**	**93.2%**

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

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

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

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

Findings

Of the 162 elements, Magellan received *Met* scores for 140 elements and *Not Met* scores for 11 elements. Deeming was also applied to 11 elements using scores received from the MCO's NCQA accreditation survey. The MCO received an overall compliance score of 93.2 percent. These findings suggest that Magellan developed the necessary policies, procedures, and plans to operationalize most of the required elements of its contract and demonstrated compliance with most of the expectations of the contract.

Of note, Magellan achieved full compliance in 10 of the 15 standards reviewed, demonstrating strengths and adherence to all requirements measured in the areas of:

- Enrollment and Disenrollment
- Member Rights and Confidentiality

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

Strengths, Weaknesses, and Recommendations

During the Compliance With Standards review process, HSAG identified strengths and opportunities for improvement specific to Magellan. Examples of the strengths and weaknesses are as follows.

Strengths	**Strength:** The MCO leveraged a multidisciplinary approach to engage disruptive members in continued care.
	Strength: The MCO assessed the quality and appropriateness of care provided to members with SHCN. The MCO also measured EPSDT services at the provider level and worked with providers to improve utilization of EPSDT services.
	Strength: The MCO implemented processes to prevent, detect, and remediate critical incidents.
Weaknesses	**Weakness:** The MCO did not provide machine-readable formats of its formulary or provider directory on its website. **Why the weakness exists:** The MCO did not verify that the required machine-readable formulary and provider directory requirements were met. **Recommendation:** The MCO must include a machine-readable file and format formulary on the MCO's website.
	Weakness: The MCO did not ensure that members had access to the required number of providers in each category as outlined in the contract. The MCO did not ensure the network included sufficient family planning providers to ensure timely access to these services. The MCO also did not monitor its network for adequate capacity to serve its members or ensure that there were enough providers in each region, depending upon its rural versus urban designation, during the time period under review. **Why the weakness exists:** The MCO did not have an implemented process to assess its network to ensure DMAS contract requirements were met or to ensure network sufficiency to ensure members had timely access to services. **Recommendation:** The MCO must implement a process to assess, monitor, and demonstrate that its network includes the required number of providers in each

category in its contract and sufficient providers to ensure timely access to covered services in each provider category, region, rural and urban.
Weakness: A review of denial case files, grievances, and appeals identified that the MCO did not consistently meet the time frame to mail the notice of adverse benefit determination to the member. The MCO's adverse benefit determination, grievance, and appeal notices did not consistently include all federal and DMAS contract requirements or member rights. **Why the weakness exists:** The MCO did not have an implemented process to monitor or review member adverse benefit determination, grievance, or appeal resolution notices to ensure that all required member rights were included. **Recommendation:** The MCO must develop a process to ensure that the grievance resolution notice to the member includes the reason for the decision and a clear explanation of any further rights available to the member.
Weakness: The MCO did not ensure members eligible for EPSDT services obtained all the care and services they needed, including medical and behavioral health needs and community-based resources. **Why the weakness exists:** The MCO did not have a documented or implemented process to identify the needs of EPSDT age members, or how they ensured that needed care, including medical and behavioral health services, and community-based resources were provided to its members. **Recommendation:** The MCO must implement a process to conduct follow-up to verify timely and appropriate treatment is received for medical and behavioral health needs, including necessary referrals, prior authorizations, and case management for members eligible for EPSDT services.

Optima

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

Table 6-5—Optima's Medallion 4.0 OSR Standards and Scores for the Three-Year Period: SFY 2019–SFY 2021

Standard #	Standard Name	Total Elements	Number of Elements			Total Compliance Score
			D	*M*	*NM*	
I	Enrollment and Disenrollment	7	0	7	0	100%
II	Member Rights and Confidentiality	7	0	7	0	100%
III	Member Information	21	0	20	1	95.2%
IV	Emergency and Poststabilization Services	12	0	12	0	100%
V	Adequate Capacity and Availability of Services	15	0	10	5	66.7%
VI	Coordination and Continuity of Care	8	3	5	0	100%

Standard #	Standard Name	Total Elements	Number of Elements			Total Compliance Score
			D	*M*	*NM*	
VII	Coverage and Authorization of Services	19	2	17	0	100%
VIII	Provider Selection	5	2	3	0	100%
IX	Subcontractual Relationships and Delegation	4	0	3	1	75.0%
X	Practice Guidelines	3	1	2	0	100%
XI	Health Information Systems*	6	0	6	0	100%
XII	Quality Assessment and Performance Improvement	6	2	3	1	83.3%
XIII	Grievance and Appeal Systems	29	0	29	0	100%
XIV	Program Integrity	12	0	12	0	100%
XV	EPSDT Services	8	0	7	1	87.5%%
Total Compliance Score		**162**	**10**	**143**	**9**	**94.4%**

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

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

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

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

Findings

Of the 162 elements, Optima received *Met* scores for 143 elements and *Not Met* scores for 9 elements. Deeming was also applied to 10 elements using scores received from the MCO's NCQA accreditation survey. The MCO received an overall compliance score of 94.4 percent. These findings suggest that Optima developed the necessary policies, procedures, and plans to operationalize most of the required elements of its contract and demonstrated compliance with most of the expectations of the contract.

Of note, Optima achieved full compliance in 10 of the 15 standards reviewed, demonstrating strengths and adherence to all requirements measured in the areas of:

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

Strengths, Weaknesses, and Recommendations

During the Compliance With Standards review process, HSAG identified strengths and opportunities for improvement specific to Optima. Examples of the strengths and weaknesses are as follows.

Strengths	**Strength:** The MCO's policies and procedures included the required accessibility standards, informed providers about the access standards, and assessed the network against the requirements.
	Strength: The MCO implemented processes to monitor, evaluate, and implement interventions to improve EPSDT services, including processes to monitor PCPs on fluoride varnish applications.
Weaknesses	**Weakness:** The MCO did not have a machine-readable provider directory file/link on the MCO website that functioned appropriately. **Why the weakness exists:** Although it appeared that the MCO had a machine-readable provider directory on its website, the MCO had not tested it to ensure that it functioned appropriately. **Recommendation:** The MCO must work with its vendor to ensure that the machine-readable provider directory file/link on the MCO website functions appropriately.
	Weakness: The MCO did not include all required provider types listed in the DMAS contract when describing the number of providers offered to members or to assess the network against the appropriate travel time and distance standards required in the contract. **Why the weakness exists:** The MCO did not include all required provider types or ratios in its policies or procedures or describe a process to assess the network against the contract travel time and distance standards. **Recommendation:** The MCO must update its policy and include all of the required provider types and describe the number of providers the MCO must offer to members. The MCO must update its policies to ensure that all time and distance requirements are documented correctly. The MCO must implement a process to measure and assess the network adequacy for all PCPs and specialists against the travel time and distance standards required in the DMAS contract.
	Weakness: The MCO's subcontractor and delegated entity agreements did not consistently include the Virginia-specific requirements. The MCO developed a Medicaid Addendum, but it did not consistently include it in the subcontractor and delegated entity agreements. **Why the weakness exists:** The MCO did not have an implemented process to ensure its subcontractor and delegated entity agreements were all reviewed or updated to include all current DMAS contract requirements.

Recommendation: The MCO must update its Medicaid Addendum to include the DMAS Medallion 4.0 contract requirements. The MCO must consistently include the Medicaid Addendum with subcontractor and delegated entity agreements.

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

Why the weakness exists: The MCO did not have an implemented process to ensure that denial notices for EPSDT-age members completed a secondary review for EPST requirements and, if denied, ensured that the denial notice included information on how the services may be available through DMAS.

Recommendation: The MCO must send a denial notice to the member upon denial of a secondary review for EPSDT requirements. Any such denial (non-covered, out-of-network, and/or experimental) must also state that EPSDT criteria were reviewed and the reason the requested service did not fit the criteria. Additionally, the MCO must inform members that, although a service is not covered under the member's managed care health plan, it may be available through DMAS under the Medicaid State Plan, and the appropriate contact information must be provided for the member to inquire with DMAS.

United

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

Table 6-6—United's Medallion 4.0 OSR Standards and Scores for the Three-Year Period: SFY 2019–SFY 2021

Standard #	Standard Name	Total Elements	Number of Elements			Total Compliance Score
			D	*M*	*NM*	
I	Enrollment and Disenrollment	7	0	7	0	100%
II	Member Rights and Confidentiality	7	0	7	0	100%
III	Member Information	21	0	21	0	100%
IV	Emergency and Poststabilization Services	12	0	12	0	100%
V	Adequate Capacity and Availability of Services	15	0	14	1	93.3%
VI	Coordination and Continuity of Care	8	2	6	0	100%
VII	Coverage and Authorization of Services	19	2	17	0	100%
VIII	Provider Selection	5	2	3	0	100%
IX	Subcontractual Relationships and Delegation	4	1	1	2	50.0%
X	Practice Guidelines	3	1	2	0	100%

Standard #	Standard Name	Total Elements	Number of Elements			Total Compliance Score
			D	*M*	*NM*	
XI	Health Information Systems*	6	0	6	0	100%
XII	Quality Assessment and Performance Improvement	6	2	4	0	100%
XIII	Grievance and Appeal Systems	29	0	27	2	93.1%
XIV	Program Integrity	12	0	12	0	100%
XV	EPSDT Services	8	0	7	1	87.5%
Total Compliance Score		**162**	**10**	**146**	**6**	**96.3%**

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

Findings

Of the 162 elements, United received *Met* scores for 146 elements and *Not Met* scores for six elements. Deeming was also applied to 10 elements using scores received from the MCO's NCQA accreditation survey. The MCO received an overall compliance score of 96.3 percent. These findings suggest that United developed the necessary policies, procedures, and plans to operationalize most of the required elements of its contract and demonstrated compliance with most of the expectations of the contract.

Of note, United achieved full compliance in 11 of the 15 standards reviewed, demonstrating strengths and adherence to all requirements measured in the areas of:

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

Strengths, Weaknesses, and Recommendations

During the Compliance With Standards review process, HSAG identified strengths and opportunities for improvement specific to United. Examples of the strengths and weaknesses are as follows.

Strengths

Strength: The MCO implemented strong monitoring and oversight processes including:

- Conducting frequent monitoring procedures to ensure staff members honored member rights.
- Monitoring its provider network for adequacy and accessibility according to appropriate Commonwealth requirements.
  Reviewing reports to ensure timely decisions on standard and expedited authorization requests and compliance with federal and DMAS contract requirements.
- Evaluating the quality and appropriateness of care provided to members with SHCN.

Strength: The MCO maintained policies and procedures to ensure member information was understandable, accessible, and produced and disseminated in accordance with information requirements.

Strength: The MCO implemented interventions to increase utilization of EPSDT services.

Weaknesses

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

Why the weakness exists: The MCO did not have an implemented process to ensure its subcontractor and delegated entity agreements were not all reviewed or updated to ensure that all current DMAS contract requirements were included.

Recommendation: The MCO must update its Medicaid Addendum to include the DMAS Medallion 4.0 contract requirements. The MCO must consistently include the Medicaid Addendum with its subcontractor and delegated entity agreements.

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

Why the weakness exists: The MCO had not consistently updated policies and procedures to include the 2020 Medicaid Managed Care Rule requirements.

Recommendation: The MCO must update its policies and procedures to address requirements included in the 2020 Medicaid Managed Care Rule such as removing the requirement that an oral appeal request must be followed with a written and signed request for an appeal.

VA Premier

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

Table 6-7—VA Premier's Medallion 4.0 OSR Standards and Scores for the Three-Year Period: SFY 2019–SFY 2021

Standard #	Standard Name	Total Elements	Number of Elements			Total Compliance Score
			D	*M*	*NM*	
I	Enrollment and Disenrollment	7	0	6	1	85.7%
II	Member Rights and Confidentiality	7	0	7	0	100%
III	Member Information	21	0	19	2	90.5%
IV	Emergency and Poststabilization Services	12	0	12	0	100%
V	Adequate Capacity and Availability of Services	15	0	10	5	66.7%
VI	Coordination and Continuity of Care	8	5	3	0	100%
VII	Coverage and Authorization of Services	19	2	17	0	100%
VIII	Provider Selection	5	2	3	0	100%
IX	Subcontractual Relationships and Delegation	4	1	2	1	75.0%
X	Practice Guidelines	3	3	0	0	100%
XI	Health Information Systems*	6	0	6	0	100%
XII	Quality Assessment and Performance Improvement	6	4	2	0	100%
XIII	Grievance and Appeal Systems	29	0	23	6	79.3%
XIV	Program Integrity	12	0	12	0	100%
XV	EPSDT Services	8	0	5	3	62.5%
Total Compliance Score		**162**	**17**	**127**	**18**	**88.9%**

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

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

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

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

Findings

Of the 162 elements, VA Premier received *Met* scores for 127 elements and *Not Met* scores for 18 elements. Deeming was also applied to 17 elements using scores received from the MCO's NCQA accreditation survey. The MCO received an overall compliance score of 88.9 percent. These findings suggest that VA Premier developed the necessary policies, procedures, and plans to operationalize most of the required elements of its contract and demonstrated compliance with most of the expectations of the contract.

Of note, VA Premier achieved full compliance in nine of the 15 standards reviewed, demonstrating strengths and adherence to all requirements measured in the areas of:

- Member Rights and Confidentiality

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

Strengths, Weaknesses, and Recommendations

During the Compliance With Standards review process, HSAG identified strengths and opportunities for improvement specific to VA Premier. Examples of the strengths and weaknesses are as follows.

Strengths	**Strength:** The MCO had a robust quality monitoring program for its member services staff to ensure respect of member rights and confidentiality. The MCO's member services department also provided a wide range of services to members via warm transfer processes.
	Strength: The MCO implemented processes to provide for direct access to women's health services, out-of-network services, and second opinions; and informed members and providers, as applicable. The MCO also implemented processes to ensure members received culturally competent services.
	Strength: The MCO implemented processes to ensure members eligible for EPSDT services received appropriate services, including medical and behavioral health services.
Weaknesses	**Weakness:** The MCO did not provide machine-readable file formats of the formulary and provider directories on its website. **Why the weakness exists:** The MCO's policies did not include the requirement for a formulary to be available on the MCO's website in a machine-readable format. A review of the MCO's website identified a formulary page at: https://www.virginiapremier.com/members/medicaid/pharmacy/. A searchable formulary and a PDF version were available; however, a machine-readable file and format was not located on the MCO's website. **Recommendation:** The MCO must include a machine-readable file and format formulary on the MCO's website.
	Weakness: The MCO did not have a process to follow up with providers to take corrective action when a provider does not meet appointment accessibility standards. The MCO did not appropriately apply its appointment access standards to the entire network.

Why the weakness exists: The MCO's policies, procedures, and provider manual did not include all or correct access standards to all provider types. The MCO did not have an implemented process to monitor accessibility against correct requirements.

Recommendation: The MCO must have mechanisms to ensure compliance by network providers regarding timely access to services, monitor network providers regularly to determine compliance, and take corrective action if there is failure to comply with requirements.

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

Why the weakness exists: The MCO did not have an implemented process to ensure its subcontractor and delegated entity agreements are all reviewed or updated to include all current DMAS contract requirements.

Recommendation: The MCO must include in its Medicaid Addendum all delegated entity requirements required by DMAS within the Virginia Medicaid Medallion 4.0 contract. The MCO must consistently include the Medicaid Addendum within its subcontractor and delegated entity agreements.

Weakness: The MCO's grievance and appeal policies and procedures did not contain all of the federal and DMAS contract requirements. The MCO's grievance and appeals policies and procedures did not consistently require the member's approval for an authorized representative or provider to act on his or her behalf when filing a grievance or appeal. The policies and procedures did not address informing the member of the right to request a State fair hearing. The MCO required oral requests for an appeal to be followed by a written appeal.

Why the weakness exists: The MCO did not update its policies and procedures to include all requirements specified in the 2020 Medicaid Managed Care Final Rule.

Recommendation: The MCO must update the Medical Management/Grievances and Appeals policy to include all federal requirements listed in this element.

Weakness: The MCO's appeal resolution notices to the member were not consistently sent, or when sent, did not consistently include all member rights.

Why the weakness exists: The MCO did not have an implemented process to ensure that appeal resolution notices are accurate, complete, and consistently sent to members.

Recommendation: The MCO must implement a process to ensure that appeal resolution notices are accurate, complete, and consistently sent to members.

Weakness: The MCO did not sufficiently inform providers about EPSDT services it is required to provide, adequately monitor service provision, and implement interventions to improve member participation in EPSDT services.

Why the weakness exists: The MCO's policies and procedures did not demonstrate how the MCO monitors, evaluates, and implements interventions to improve EPSDT participation.

Recommendation: The MCO must inform all PCPs about EPSDT services, including federal requirements, and DMAS EPSDT requirements. The MCO must monitor, evaluate, and implement interventions to improve EPSDT participation. The MCO must implement provider and member outreach activities and implement process improvement activities as necessary to improve member participation in EPSDT/well-child services.

DMAS Intermediate Sanctions Applied

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

7. Encounter Data Validation

Overview

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

HSAG's EDV study was comprised of two components:

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

Objectives

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

Statewide Results

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

General Recommendations

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

monitoring may be used to quickly identify the root cause of potential problem areas identified from CMS tools.

MCO-Specific Results

Aetna

Table 7-1 shows Aetna met the 30-day submission standard of 96 percent for professional encounters but fell below the standard for institutional and pharmacy encounters.

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

Encounter Type	Standard	Statewide	Aetna	
Professional	96.0%	98.3%	98.6%	✔
Institutional	96.0%	94.9%	91.4%	
Pharmacy	99.0%	91.4%	94.3%	

✔ Met submission standard

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

- **Institutional**: 86.2 percent
- **Professional**: 78.3 percent
- **Pharmacy**: 77.8 percent

Table 7-2—Percentage of Encounters With Valid Values

Data Element Name	Institutional		Professional		Pharmacy	
Member ID	99.0%		98.8%	✗	98.7%	✗
Header Service From Date	100%		100%		-	
Header Service To Date	100%		100%		-	
Detail Service From Date	100%		100%		-	
Detail Service To Date	100%		100%		-	
Date of Service	-		-		100%	
Billing Provider NPI	99.8%		99.7%		-	
Rendering Provider NPI	99.3%		99.7%		99.4%	
Attending Provider NPI	97.2%	✗	-		-	
Servicing Provider Taxonomy Code	83.8%	✗	98.9%	✗	-	
Referring Provider NPI	98.6%	✗	95.5%	✗	-	
Prescribing Provider NPI	-		-		96.3%	✗
Primary Diagnosis Codes	100%		100%		-	

Data Element Name	Institutional		Professional		Pharmacy	
Secondary Diagnosis Codes	100%		100%		-	
CPT/HCPCS Codes	100%		100%		-	
CPT/HCPCS Codes with PTP Edits	100%		100%		-	
Service Units	100%		100%		-	
Service Units with MUE	99.8%		99.3%		-	
Primary Surgical Procedure Codes	99.9%		-		-	
Secondary Surgical Procedure Codes	99.9%		-		-	
Revenue Codes	100%		-		-	
Diagnosis-Related Groups Codes	100%		-		-	
Type of Bill Codes	100%		-		-	
NDCs	99.3%		99.7%		99.7%	
HCPCS/NDC Combination	66.9%	✗	65.6%	✗	-	
MCO Received Date	100%		100%		100%	
MCO Paid Date	100%		100%		100%	
Header Paid Amount	100%		100%		100%	
Header TPL Paid Amount	99.8%		98.6%	✗	100%	
Detail Paid Amount	100%		100%		-	
Detail TPL Paid Amount	100%		100%		-	
Number of applicable data elements evaluated for validity	29		23		9	
Percentage of data elements meeting 99% or greater validity	86.2%		78.3%		77.8%	

✗ Did not meet 99 percent valid value criteria

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength: Overall, more than 80 percent of data elements analyzed for institutional encounters met the validity criteria. Additionally, the IS review revealed Aetna has a comparatively robust internal assessment and reporting of encounter data quality and timeliness.

Weaknesses

Weakness: Aetna did not meet the timeliness standard for institutional and pharmacy encounters.

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

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

HealthKeepers

Table 7-3 shows HealthKeepers met the 30-day submission standard of 96 percent and 99 percent for professional and pharmacy encounters, respectively, but fell below the standard for institutional encounters.

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

Encounter Type	Standard	Statewide	HealthKeepers	
Professional	96.0%	98.3%	96.1%	✓
Institutional	96.0%	94.9%	89.7%	
Pharmacy	99.0%	91.4%	100%	✓

✓ Met submission standard

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

- **Institutional**: 71.4 percent
- **Professional**: 73.9 percent
- **Pharmacy**: 77.8 percent

Table 7-4—Percentage of Encounters With Valid Values

Data Element Name	Institutional		Professional		Pharmacy	
Member ID	99.1%		99.1%		99.0%	
Header Service From Date	100%		100%		-	
Header Service To Date	100%		100%		-	
Detail Service From Date	100%		100%		-	
Detail Service To Date	100%		100%		-	
Date of Service	-		-		100%	
Billing Provider NPI	97.9%	✗	94.6%	✗	-	
Rendering Provider NPI	-		91.4%	✗	98.8%	✗
Attending Provider NPI	85.7%	✗	-		-	
Servicing Provider Taxonomy Code	60.2%	✗	66.6%	✗	-	
Referring Provider NPI	85.3%	✗	86.1%	✗	-	
Prescribing Provider NPI	-		-		80.4%	✗
Primary Diagnosis Codes	100%		100%		-	
Secondary Diagnosis Codes	100%		100%		-	
CPT/HCPCS Codes	100%		100%		-	
CPT/HCPCS Codes with PTP Edits	100%		100%		-	
Service Units	100%		100%		-	
Service Units with MUE	99.7%		99.8%		-	
Primary Surgical Procedure Codes	100%		-		-	

Data Element Name	Institutional		Professional		Pharmacy	
Secondary Surgical Procedure Codes	100%		-		-	
Revenue Codes	100%		-		-	
Diagnosis-Related Groups Codes	96.2%	✗	-		-	
Type of Bill Codes	100%		-		-	
NDCs	97.2%	✗	99.5%		99.8%	
HCPCS/NDC Combination	62.6%	✗	65.6%	✗	-	
MCO Received Date	100%		100%		100%	
MCO Paid Date	100%		100%		100%	
Header Paid Amount	100%		100%		100%	
Header TPL Paid Amount	94.6%	✗	95.7%	✗	100%	
Detail Paid Amount	100%		100%		-	
Detail TPL Paid Amount	100%		100%		-	
Number of applicable data elements evaluated for validity	28		23		9	
Percentage of data elements meeting 99% or greater validity	71.4%		73.9%		77.8%	

✗ Did not meet 99 percent valid value criteria

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength: HealthKeepers met the timeliness submission standard for both professional and pharmacy encounters.

Weaknesses

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

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

Recommendation: HSAG recommends HealthKeepers:

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

Magellan

Table 7-5 shows Magellan met the 30-day submission standard of 96 percent for institutional and professional encounters but fell below the standard for pharmacy encounters.

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

Encounter Type	Standard	Statewide	Magellan	
Professional	96.0%	98.3%	98.0%	✔
Institutional	96.0%	94.9%	99.6%	✔
Pharmacy	99.0%	91.4%	98.7%	

✔ Met submission standard

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

- **Institutional**: 75.9 percent
- **Professional**: 82.6 percent
- **Pharmacy**: 77.8 percent

Table 7-6—Percentage of Encounters With Valid Values

Field Name	Institutional		Professional		Pharmacy	
Member ID	98.7%	✗	98.7%	✗	98.9%	✗
Header Service From Date	100%		100%		-	
Header Service To Date	100%		100%		-	
Detail Service From Date	100%		100%		-	
Detail Service To Date	100%		100%		-	
Date of Service	-		-		100%	
Billing Provider NPI	97.5%	✗	99.8%		-	
Rendering Provider NPI	100%		99.6%		99.1%	
Attending Provider NPI	99.7%		-		-	
Servicing Provider Taxonomy Code	98.3%	✗	99.2%		-	
Referring Provider NPI	91.0%	✗	94.9%	✗	-	
Prescribing Provider NPI	-		-		89.3%	✗
Primary Diagnosis Codes	100%		100%		-	
Secondary Diagnosis Codes	100%		100%		-	
CPT/HCPCS Codes	100%		100%		-	
CPT/HCPCS Codes with PTP Edits	100%		100%		-	
Service Units	100%		100%		-	
Service Units with MUE	99.8%		99.2%		-	
Primary Surgical Procedure Codes	99.9%		-		-	
Secondary Surgical Procedure Codes	100%		-		-	
Revenue Codes	100%		-		-	
Diagnosis-Related Groups Codes	99.9%		-		-	
Type of Bill Codes	100%		-		-	
NDCs	97.3%	✗	99.4%		99.7%	

Field Name	Institutional		Professional		Pharmacy	
HCPCS/NDC Combination	62.4%	✗	62.2%	✗	-	
MCO Received Date	100%		100%		100%	
MCO Paid Date	100%		100%		100%	
Header Paid Amount	100%		100%		100%	
Header TPL Paid Amount	61.8%	✗	96.6%	✗	100%	
Detail Paid Amount	100%		100%		-	
Detail TPL Paid Amount	100%		100%		-	
Number of applicable data elements evaluated for validity	29		23		9	
Percentage of data elements meeting 99% or greater validity	75.9%		82.6%		77.8%	

✗ Did not meet 99 percent valid value criteria

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength: Magellan met the timeliness submission standard for both institutional and professional encounters. Over 80 percent of data elements assessed for professional encounters met the validity criteria.

Weaknesses

Weakness: The IS review revealed Magellan could improve its internal monitoring tools for assessing quality and timeliness of encounter data. In addition, Magellan had low header TPL paid amounts PMPM for institutional encounters compared to other MCOs.

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

Recommendation: HSAG recommends Magellan:

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

Optima

Table 7-7 shows Optima met the 30-day submission standard across all encounter types.

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

Encounter Type	Standard	Statewide	Optima	
Professional	96.0%	98.3%	99.2%	✓
Institutional	96.0%	94.9%	100%	✓
Pharmacy	99.0%	91.4%	100%	✓

✓ Met submission standard

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

- **Institutional**: 85.2 percent
- **Professional**: 90.9 percent
- **Pharmacy**: 88.9 percent

Table 7-8—Percentage of Encounters With Valid Values

Field Name	Institutional		Professional		Pharmacy	
Member ID	99.2%		99.1%		98.8%	✗
Header Service From Date	100%		100%		-	
Header Service To Date	100%		99.9%		-	
Detail Service From Date	100%		100%		-	
Detail Service To Date	100%		99.9%		-	
Date of Service	-		-		100%	
Billing Provider NPI	100%		99.0%		-	
Rendering Provider NPI	-		99.5%		100%	
Attending Provider NPI	99.8%		-		-	
Servicing Provider Taxonomy Code	0.0%	✗	87.5%	✗	-	
Referring Provider NPI	-		-		-	
Prescribing Provider NPI	-		-		100%	
Primary Diagnosis Codes	100%		100%		-	
Secondary Diagnosis Codes	100%		100%		-	
CPT/HCPCS Codes	100%		100%		-	
CPT/HCPCS Codes with PTP Edits	99.9%		100%		-	
Service Units	100%		100%		-	
Service Units with MUE	99.8%		99.7%		-	
Primary Surgical Procedure Codes	100%		-		-	
Secondary Surgical Procedure Codes	100%		-		-	

Field Name	Institutional		Professional		Pharmacy	
Revenue Codes	100%		-		-	
Diagnosis-Related Groups Codes	99.7%		-		-	
Type of Bill Codes	100%		-		-	
NDCs	95.4%	✗	99.9%		99.7%	
HCPCS/NDC Combination	66.0%	✗	74.8%	✗	-	
MCO Received Date	100%		100%		100%	
MCO Paid Date	100%		100%		100%	
Header Paid Amount	100%		100%		100%	
Header TPL Paid Amount	24.2%	✗	99.9%		100%	
Detail Paid Amount	100%		100%		-	
Detail TPL Paid Amount	100%		100%		-	
Number of applicable data elements evaluated for validity	27		22		9	
Percentage of data elements meeting 99% or greater validity	85.2%		90.9%		88.9%	

✗ Did not meet 99 percent valid value criteria

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses

Weakness: The IS review revealed Optima could improve its internal monitoring tools for assessing quality and timeliness of encounter data.

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

Recommendation: HSAG recommends Optima consider augmenting its automated data validation processes to contain quality and timeliness summary metrics as other MCOs have developed. This may be done in consultation with DMAS to align validation efforts across MCOs.

United

Table 7-9 shows United met the 30-day submission standard of 96 percent for professional encounters but did not meet the standard for institutional and pharmacy encounters. The pharmacy encounter data HSAG analyzed revealed that approximately 80 percent of encounters contained an invalid submission or payment date by listing a submission date prior to the payment date.

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

Encounter Type	Standard	Statewide	United	
Professional	96.0%	98.3%	99.3%	✔
Institutional	96.0%	94.9%	93.8%	
Pharmacy	99.0%	91.4%	10.8%	

✔ Met submission standard

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

- **Institutional**: 79.3 percent
- **Professional**: 82.6 percent
- **Pharmacy**: 88.9 percent

Table 7-10—Percentage of Encounters With Valid Values

Field Name	Institutional		Professional		Pharmacy	
Member ID	98.8%	✗	98.9%	✗	98.6%	✗
Header Service From Date	100%		100%		-	
Header Service To Date	100%		100%		-	
Detail Service From Date	100%		100%		-	
Detail Service To Date	100%		100%		-	
Date of Service	-		-		100%	
Billing Provider NPI	100%		99.8%		-	
Rendering Provider NPI	99.7%		99.9%		100%	
Attending Provider NPI	99.1%		-		-	
Servicing Provider Taxonomy Code	85.9%	✗	99.5%		-	
Referring Provider NPI	98.1%	✗	98.1%	✗	-	
Prescribing Provider NPI	-		-		100%	
Primary Diagnosis Codes	100%		100%		-	
Secondary Diagnosis Codes	100%		100%		-	
CPT/HCPCS Codes	100%		100%		-	
CPT/HCPCS Codes with PTP Edits	100%		100%		-	
Service Units	100%		100%		-	
Service Units with MUE	99.9%		99.6%		-	
Primary Surgical Procedure Codes	99.9%		-		-	
Secondary Surgical Procedure Codes	100%		-		-	
Revenue Codes	100%		-		-	
Diagnosis-Related Groups Codes	99.9%		-		-	
Type of Bill Codes	100%		-		-	
NDCs	98.4%	✗	99.0%		99.8%	

Field Name	Institutional		Professional		Pharmacy	
HCPCS/NDC Combination	63.4%	✗	63.2%	✗	-	
MCO Received Date	100%		100%		100%	
MCO Paid Date	100%		100%		100%	
Header Paid Amount	100%		100%		100%	
Header TPL Paid Amount	87.3%	✗	86.6%	✗	100%	
Detail Paid Amount	100%		100%		-	
Detail TPL Paid Amount	100%		100%		-	
Number of applicable data elements evaluated for validity	29		23		9	
Percentage of data elements meeting 99% or greater validity	79.3%		82.6%		88.9%	

✗ Did not meet 99 percent valid value criteria

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength: Over 80 percent of data elements assessed for professional and pharmacy encounters met the validity criteria.

Weaknesses

Weakness: United did not meet the timeliness standards for both institutional and pharmacy encounters.

Why the weakness exists: Approximately 80 percent of United pharmacy encounters reported a submission date prior to the payment date.

Recommendation: HSAG recommends United assess how submission and payment dates are populated on pharmacy encounters to determine the root cause for having submission dates prior to payment dates.

VA Premier

Table 7-11 shows VA Premier met the 30-day submission standard across all encounter types.

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

Encounter Type	Standard	Statewide	VA Premier	
Professional	96.0%	98.3%	99.9%	✓
Institutional	96.0%	94.9%	96.3%	✓
Pharmacy	99.0%	91.4%	99.6%	✓

✓ Met submission standard

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

- **Institutional**: 85.7 percent
- **Professional**: 82.6 percent
- **Pharmacy**: 77.8 percent

Table 7-12—Percentage of Encounters With Valid Values

Field Name	Institutional		Professional		Pharmacy	
Member ID	99.3%		99.1%		98.9%	✗
Header Service From Date	100%		100%		-	
Header Service To Date	100%		100%		-	
Detail Service From Date	100%		100%		-	
Detail Service To Date	100%		100%		-	
Date of Service	-		-		100%	
Billing Provider NPI	100%		99.9%		-	
Rendering Provider NPI	-		99.8%		99.4%	
Attending Provider NPI	99.5%		-		-	
Servicing Provider Taxonomy Code	82.8%	✗	84.3%	✗	-	
Referring Provider NPI	99.0%		98.4%	✗	-	
Prescribing Provider NPI	-		-		94.7%	✗
Primary Diagnosis Codes	100%		100%		-	
Secondary Diagnosis Codes	100%		100%		-	
CPT/HCPCS Codes	100%		100%		-	
CPT/HCPCS Codes with PTP Edits	99.7%		99.9%		-	
Service Units	100%		100%		-	
Service Units with MUE	99.6%		99.4%		-	
Primary Surgical Procedure Codes	100%		-		-	
Secondary Surgical Procedure Codes	100%		-		-	
Revenue Codes	100%		-		-	
Diagnosis-Related Groups Codes	98.7%	✗	-		-	
Type of Bill Codes	100%		-		-	
NDCs	96.2%	✗	99.9%		99.7%	
HCPCS/NDC Combination	70.1%	✗	47.2%	✗	-	
MCO Received Date	100%		100%		100%	
MCO Paid Date	100%		100%		100%	
Header Paid Amount	100%		99.9%		100%	
Header TPL Paid Amount	99.5%		97.5%	✗	100%	
Detail Paid Amount	100%		100%		-	
Detail TPL Paid Amount	100%		100%		-	

Field Name	Institutional		Professional		Pharmacy	
Number of applicable data elements evaluated for validity	28		23		9	
Percentage of data elements meeting 99% or greater validity	85.7%		82.6%		77.8%	

✗ Did not meet 99 percent valid value criteria

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength: VA Premier met the 30-day submission standards for all encounter types, and over 80 percent of data elements assessed for institutional and professional encounters met the validity criteria.

Weaknesses

Weakness: The IS review revealed VA Premier could improve its internal monitoring tools for assessing quality and timeliness of encounter data. In addition, VA Premier had low header TPL paid amounts PMPM for institutional encounters compared to other MCOs.

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

Recommendation: HSAG recommends VA Premier:

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

8. Member Experience of Care Survey

Overview

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

Objectives

The CAHPS surveys were conducted for Virginia's Medallion 4.0 Medicaid managed care population to obtain information on the levels of satisfaction of adult and child Medicaid members. For the Medallion 4.0 MCOs (Aetna, HealthKeepers, Magellan, Optima, United, and VA Premier), the technical method of data collection was conducted through administration of the CAHPS 5.1H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.1H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCOs.

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

MCO-Specific Results

Aetna

Table 8-1 and Table 8-2 present the 2020 and 2021 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. A trend analysis was performed that compared Aetna's 2021 CAHPS scores to its corresponding 2020 CAHPS scores. In addition, the 2021 CAHPS scores for Aetna were compared to the 2020 NCQA national adult and child Medicaid averages.

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

	2020	2021
Global Ratings		
Rating of Health Plan	54.6%	63.4%▲
Rating of All Health Care	47.5%	56.9%
Rating of Personal Doctor	67.7%	67.5%

	2020	2021
Rating of Specialist Seen Most Often	65.3%	67.8%
Composite Measures		
Getting Needed Care	77.6%	84.3%
Getting Care Quickly	82.7%	82.6%
How Well Doctors Communicate	92.9%	93.8%
Customer Service	83.0%	90.3%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ Statistically significantly higher in 2021 than in 2020.

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses

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

Why the weakness exists: NA.

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

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

	2020	2021
Global Ratings		
Rating of Health Plan	68.5%	69.8%
Rating of All Health Care	68.4%	69.4%
Rating of Personal Doctor	75.6%	74.9%
Rating of Specialist Seen Most Often	62.9%+	75.0%+
Composite Measures		
Getting Needed Care	85.6%	82.1%+
Getting Care Quickly	92.2%	83.0%+▼

	2020	2021
How Well Doctors Communicate	96.8%	94.1%
Customer Service	91.4%+	73.9%+▼

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ Statistically significantly higher in 2021 than in 2020.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses

Weakness: Aetna's top-box scores were statistically significantly lower than the 2020 top-box scores and NCQA child Medicaid national averages for two measures: *Getting Care Quickly* and *Customer Service*.

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

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

HealthKeepers

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

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

	2020	2021
Global Ratings		
Rating of Health Plan	61.8%	61.1%
Rating of All Health Care	64.0%	60.3%
Rating of Personal Doctor	76.1%	67.4%
Rating of Specialist Seen Most Often	71.0%+	59.3%+
Composite Measures		
Getting Needed Care	85.3%+	84.3%
Getting Care Quickly	84.7%+	81.6%+
How Well Doctors Communicate	95.8%+	92.8%
Customer Service	91.2%+	86.6%+

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

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses

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

Why the weakness exists: NA.

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

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

	2020	2021
Global Ratings		
Rating of Health Plan	75.0%	77.0%
Rating of All Health Care	71.8%	75.3%

	2020	2021
Rating of Personal Doctor	74.5%	77.4%
Rating of Specialist Seen Most Often	83.3%+	78.0%+
Composite Measures		
Getting Needed Care	83.0%	83.0%
Getting Care Quickly	89.1%	84.8%
How Well Doctors Communicate	95.4%	92.7%
Customer Service	87.8%+	91.6%

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in orange represent rates that are statistically significantly higher than the 2020 NCQA national Medicaid averages.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses

Weakness: HealthKeepers' 2021 top-box scores were statistically significantly lower than the 2020 NQCA child Medicaid national averages for two measures: *Getting Care Quickly* and *How Well Doctors Communicate*.

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

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

Magellan

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

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

	2020	2021
Global Ratings		
Rating of Health Plan	58.3%	62.1%
Rating of All Health Care	53.7%	48.0%
Rating of Personal Doctor	68.2%	64.4%
Rating of Specialist Seen Most Often	74.8%	68.1%+
Composite Measures		
Getting Needed Care	80.3%	86.7%
Getting Care Quickly	82.1%	81.8%+
How Well Doctors Communicate	91.8%	91.6%
Customer Service	90.5%	84.3%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses

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

Why the weakness exists: Based on the survey results, adult members have a lower level of satisfaction with their provision in healthcare overall, which may be associated with their perception of their ability to receive care or services.

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

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

	2020	2021
Global Ratings		
Rating of Health Plan	55.8%	68.2%▲
Rating of All Health Care	70.3%+	70.3%+
Rating of Personal Doctor	69.1%+	74.8%
Rating of Specialist Seen Most Often	77.8%+	66.7%+
Composite Measures		
Getting Needed Care	82.8%+	79.5%+
Getting Care Quickly	91.3%+	86.3%+
How Well Doctors Communicate	92.7%+	92.3%+
Customer Service	90.4%+	75.4%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ Statistically significantly higher in 2021 than in 2020.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses

Weakness: Magellan's 2021 top-box score was statistically significantly lower than the 2020 NCQA child Medicaid national average for one measure, *Customer Service*.

Why the weakness exists: Based on the survey results, parents/caretakers of child members have a lower level of satisfaction with Magellan overall, which may

be associated with their perception of their child's ability to receive care or services from customer service.

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

Optima

Table 8-7 and Table 8-8 present the 2020 and 2021 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively." A trend analysis was performed that compared Optima's 2021 adult Medicaid CAHPS scores to its corresponding 2020 CAHPS scores.[8-1] In addition, the 2021 CAHPS scores for Optima were compared to the 2020 NCQA national adult and child Medicaid averages.

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

	2020	2021
Global Ratings		
Rating of Health Plan	72.5%	59.5%▼
Rating of All Health Care	69.3%+	53.2%+▼
Rating of Personal Doctor	80.9%+	63.5%+▼
Rating of Specialist Seen Most Often	73.2%+	61.5%+
Composite Measures		
Getting Needed Care	90.3%+	85.2%+
Getting Care Quickly	85.4%+	79.9%+
How Well Doctors Communicate	95.7%+	93.7%+
Customer Service	94.6%+	73.5%+▼

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▼ Statistically significantly lower in 2021 than in 2020.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

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

[8-1] In 2020, Optima did not administer a separate survey to its child Medicaid population; therefore, results are NR.

Strengths

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

Weaknesses

Weakness: Optima's top-box score was statistically significantly lower than the 2020 NCQA adult Medicaid national average for one measure, *Customer Service*. In addition, Optima's 2021 top-box scores were statistically significantly lower than the 2020 top-box scores for four measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Customer Service*.

Why the weakness exists: Based on the survey results, adult members have a lower level of satisfaction with Optima overall, which may be associated with their perception of the ability to receive care or services from their personal doctors and customer service.

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

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

	2020	2021
Global Ratings		
Rating of Health Plan	NR	80.3%
Rating of All Health Care	NR	81.8%+
Rating of Personal Doctor	NR	83.6%
Rating of Specialist Seen Most Often	NR	75.0%+
Composite Measures		
Getting Needed Care	NR	89.0%+
Getting Care Quickly	NR	91.2%+
How Well Doctors Communicate	NR	97.1%+
Customer Service	NR	93.5%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
"NR" indicates data were not reported.
Cells highlighted in orange represent rates that are statistically significantly higher than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength: Optima's 2021 top-box scores were statistically significantly higher than the 2020 NCQA child Medicaid national averages for two measures: *Rating of Health Plan* and *Rating of All Health Care*.

Weaknesses

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

Why the weakness exists: NA.

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

United

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

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

	2020	2021
Global Ratings		
Rating of Health Plan	65.0%	60.6%
Rating of All Health Care	59.1%	58.3%
Rating of Personal Doctor	69.5%	64.8%
Rating of Specialist Seen Most Often	72.4%+	63.8%+
Composite Measures		
Getting Needed Care	79.8%	77.5%
Getting Care Quickly	81.0%	76.7%+
How Well Doctors Communicate	93.1%	91.5%
Customer Service	87.1%	89.8%+

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

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses

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

Why the weakness exists: NA.

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

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

	2020	2021
Global Ratings		
Rating of Health Plan	74.4%	65.8%▼
Rating of All Health Care	76.8%	71.1%
Rating of Personal Doctor	75.7%	74.2%
Rating of Specialist Seen Most Often	78.9%+	61.7%+
Composite Measures		
Getting Needed Care	79.1%+	72.9%+
Getting Care Quickly	80.1%	79.3%+
How Well Doctors Communicate	91.2%	91.8%
Customer Service	85.4%+	78.3%+

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

▼ Statistically significantly lower in 2021 than in 2020.

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

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses

Weakness: United's top-box score was statistically significantly lower than the 2020 NCQA child Medicaid national average for three measures: *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*. In addition, United's 2021 top-box score was statistically significantly lower than the 2020 top-box score for one measure, *Rating of Health Plan*.

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

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

VA Premier

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

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

	2020	2021
Global Ratings		
Rating of Health Plan	61.3%	67.2%
Rating of All Health Care	54.5%	52.1%
Rating of Personal Doctor	62.2%	75.9%▲
Rating of Specialist Seen Most Often	72.7%+	71.8%+
Composite Measures		
Getting Needed Care	82.2%	79.5%+
Getting Care Quickly	76.2%	82.3%+
How Well Doctors Communicate	95.1%	94.6%

	2020	2021
Customer Service	85.5%+	93.0%+

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

▲ *Statistically significantly higher in 2021 than in 2020.*

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength: VA Premier's 2021 top-box score was statistically significantly higher than the 2020 top-box score for one measure, *Rating of Personal Doctor*.

Weaknesses

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

Why the weakness exists: NA.

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

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

	2020	2021
Global Ratings		
Rating of Health Plan	76.4%	77.0%
Rating of All Health Care	79.2%	76.4%
Rating of Personal Doctor	81.1%	76.4%
Rating of Specialist Seen Most Often	90.0%+	65.3%+▼
Composite Measures		
Getting Needed Care	93.7%	90.6%+
Getting Care Quickly	93.0%	87.3%+
How Well Doctors Communicate	96.3%	93.4%
Customer Service	89.1%+	85.0%+

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

▼ *Statistically significantly lower in 2021 than in 2020.*

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses

Weakness: VA Premier's top-box score was statistically significantly lower than the 2020 top-box score for one measure, *Rating of Specialist Seen Most Often*.

Why the weakness exists: Based on the survey results, parents/caretakers of child members have a lower level of satisfaction with VA Premier's specialists, which may be associated with their perception of their child's ability to receive care or services from their child's specialist.

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

9. Focus Studies

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

Overview

DMAS continued to assess the following clinical topics for the 2021 contract year: improving birth outcomes through adequate prenatal care (Birth Outcomes Focus Study); Perinatal Dental Utilization; and improving the health of children in foster care (Foster Care Focus Study).

Improving Birth Outcomes Through Adequate Prenatal Care

The Birth Outcomes Focus Study was designed to address the following questions:

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

The Birth Outcomes Focus Study included four study indicators calculated among singleton births occurring during CY 2019 and paid by Virginia Medicaid: percentage of births with early and adequate prenatal care, percentage of births with inadequate prenatal care, percentage of preterm births (<37 weeks gestation), and percentage of newborns with low birth weight (<2,500g). Study results included all live births paid by Virginia Medicaid, and were assigned to one of four Medicaid programs (i.e., FAMIS MOMS, Medicaid for Pregnant Women, Medicaid Expansion, or Other Medicaid). Please note, study results are not limited to the women in the Medallion 4.0 program. Additionally, women may have changed service delivery systems or MCOs while pregnant; as such, analytic stratifications in this study reflect the service delivery system (i.e., managed care or FFS) and Medicaid program in which the woman was enrolled at the time of delivery. Table 9-1 presents study indicator results by Medicaid service delivery system within each measurement period, as well as whether each indicator's results were statistically significantly different from CY 2018 to CY 2019.

Table 9-1—Overall Study Indicator Findings Among Singleton Births by Medicaid Delivery System, CY 2017–CY 2019

Study Indicator	National Benchmark*	CY 2017		CY 2018		CY 2019	
		Number	Percent	Number	Percent	Number	Percent
FFS							
Births with Early and Adequate Prenatal Care	76.4%	5,366	70.5%	5,731	70.1%	5,227	65.4%^
*Births with Inadequate Prenatal Care***	NA	1,449	19.1%	1,516	18.6%	1,856	23.2%^
*Preterm Births (<37 Weeks Gestation)***	9.4%	810	10.3%	852	9.6%	880	10.2%
*Newborns with Low Birth Weight (<2,500 grams)***	9.5%	726	9.2%	779	8.8%	723	8.3%
Managed Care							
Births with Early and Adequate Prenatal Care	76.4%	16,487	73.0%	17,122	73.1%	20,036	74.6%^
*Births with Inadequate Prenatal Care***	NA	3,762	16.7%	3,851	16.4%	4,350	16.2%
*Preterm Births (<37 Weeks Gestation)***	9.4%	2,082	9.0%	2,316	9.3%	2,775	9.7%
*Newborns with Low Birth Weight (<2,500 grams)***	9.5%	2,047	8.8%	2,305	9.3%	2,613	9.1%

NA indicates there is not an applicable national benchmark for this indicator.
**The national benchmark for Births with Early and Adequate Prenatal Care is the Healthy People 2020 goal, excluding the 2019 update. The national benchmarks for Preterm Births and Newborns with Low Birth Weight were identified from NVS final data for 2018.*
***a lower rate indicates better performance for this indicator.*
^indicates the CY 2019 rate is statistically different from the CY 2018 rate.

With the exception of the *Newborns with Low Birth Weight (<2,500 grams)* study indicator, women enrolled in managed care had better outcomes than women in the FFS population in CY 2019. Of note, both the managed care and FFS rates for the *Newborns with Low Birth Weight (<2,500 grams)* study indicator exceeded the national benchmark in CY 2019. The CY 2019 rate for women in managed care demonstrated a significant improvement from CY 2018 for the *Births with Early and Adequate Prenatal Care* study indicator; however, the CY 2019 rate fell below the national benchmark. The CY 2019 rate for women in FFS demonstrated a significant decline in performance from CY 2018 for the *Births with Early and Adequate Prenatal Care* and *Births with Inadequate Prenatal Care* study indicators.

Table 9-2 presents the study indicator results by Medicaid program for each measurement period.

Table 9-2—Overall Study Indicator Findings Among Singleton Births by Medicaid Program, CY 2017–CY 2019

Study Indicator	National Benchmark	CY 2017		CY 2018		CY 2019	
		Number	Percent	Number	Percent	Number	Percent
FAMIS MOMS							
Births with Early and Adequate Prenatal Care	76.4%	1,233	78.3%	1,312	77.5%	1,626	78.3%
*Births with Inadequate Prenatal Care**	NA	212	13.5%	228	13.5%	292	14.1%
*Preterm Births (<37 Weeks Gestation)**	9.4%	121	7.5%	136	7.7%	168	7.7%
*Newborns with Low Birth Weight (<2,500 grams)**	9.5%	125	7.7%	131	7.4%	158	7.2%
Medicaid for Pregnant Women							
Births with Early and Adequate Prenatal Care	76.4%	16,681	72.9%	17,656	72.7%	18,459	72.6%
*Births with Inadequate Prenatal Care**	NA	3,859	16.9%	4,079	16.8%	4,454	17.5%
*Preterm Births (<37 Weeks Gestation)**	9.4%	2,039	8.6%	2,285	8.8%	2,485	9.2%
*Newborns with Low Birth Weight (<2,500 grams)**	9.5%	1,976	8.4%	2,229	8.6%	2,283	8.4%
Medicaid Expansion							
Births with Early and Adequate Prenatal Care	76.4%	—	—	—	—	1,509	72.9%
*Births with Inadequate Prenatal Care**	NA	—	—	—	—	353	17.1%
*Preterm Births (<37 Weeks Gestation)**	9.4%	—	—	—	—	275	12.2%
*Newborns with Low Birth Weight (<2,500 grams)**	9.5%	—	—	—	—	239	10.6%
Other Medicaid†							
Births with Early and	76.4%	3,939	68.7%	3,885	69.1%	3,669	69.3%

Study Indicator	National Benchmark	CY 2017		CY 2018		CY 2019	
		Number	Percent	Number	Percent	Number	Percent
Adequate Prenatal Care							
*Births with Inadequate Prenatal Care**	NA	1,140	19.9%	1,061	18.9%	1,107	20.9%
*Preterm Births (<37 Weeks Gestation)**	9.4%	732	12.4%	747	12.3%	727	12.6%
*Newborns with Low Birth Weight (<2,500 grams)**	9.5%	672	11.4%	724	11.9%	656	11.4%

**a lower rate indicates better performance for this indicator.*
—indicates Medicaid Expansion was not implemented until January 1, 2019; therefore, Medicaid Expansion study indicator results for CY 2017 and CY 2018 are not available.
† Other Medicaid includes births paid by Medicaid, but that do not fall into the FAMIS MOMS, Medicaid for Pregnant Women, and Medicaid Expansion programs.

Study indicator results were generally stable across the measurement periods for the FAMIS MOMS, Medicaid for Pregnant Women, and Other Medicaid programs. While the FAMIS MOMS program covers a limited number of women, these women had the highest rate of *Births with Early and Adequate Prenatal Care* and lowest rates of *Preterm Births (<37 Weeks Gestation)* and *Newborns with Low Birth Weight (<2,500 grams)* for all three measurement periods and exceeded the national benchmarks for all three measurement periods. Of note, the Medicaid Expansion and Other Medicaid program rates for the *Preterm Births (<37 Weeks Gestation)* study indicator fell below the national benchmark by a relative difference of 27 percent and 36 percent, respectively. Studies have shown that timely prenatal care is associated with fewer preterm births in the United States.[9-1] Given that Medicaid Expansion was first implemented on January 1, 2019, DMAS should continue to closely monitor this population to assess changes in outcomes over time. Women in the Medicaid Expansion program, unlike the Medicaid for Pregnant Women and FAMIS MOMS programs, are typically enrolled in the program before the start of their pregnancy due to federal Medicaid rules. For this reason, it is possible that improvements in outcomes will occur over time as Medicaid Expansion enrollees have the opportunity to benefit from continuous coverage before pregnancy and between pregnancies.

During 2021, HSAG initiated the sixth annual Birth Outcomes Focus Study, covering births occurring during CY 2020 and using a methodology similar to prior studies. Results from this study are scheduled to be released in 2022.

Dental Utilization in Pregnant Women Data Brief

As a supplement to the Birth Outcomes Focus Study, DMAS contracted with HSAG to provide annual data briefs on dental utilization among pregnant women covered through the Smiles for Children

[9-1] Centers for Disease Control and Prevention. Preterm birth. Available at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm. Accessed on: Dec 2, 2021.

program administered by DentaQuest.[9-2] During 2021, HSAG completed a Dental Utilization in Pregnant Women Data Brief that included all women 21 years of age or older with deliveries from January 1, 2020, through December 31, 2020 (i.e., CY 2020). Methodological or data-related factors may influence the identification of dental services utilized during the perinatal period (e.g., dental services may have been rendered prior to the perinatal period). Additionally, the study may have been impacted by the COVID-19 PHE, due to the recommendation from the American Dental Association on March 16, 2020, for dentists to postpone elective procedures and remain closed through the end of April 2020, except for emergency care.[9-3] Given these recommendations, as well as COVID-19 "shelter in place" guidelines across the United States, declines in dental utilization during CY 2020 may be attributed to the pandemic.

The distribution of deliveries among women receiving perinatal dental services varied widely by Medicaid program, managed care program, and delivery system. Table 9-3 presents the number and percentage of deliveries where perinatal dental services were received, stratified by the Medicaid program (i.e., FAMIS MOMS, Medicaid for Pregnant Women, Medicaid Expansion, LIFC, and Other Medicaid), managed care program (i.e., Medallion 4.0, CCC Plus, and FAMIS), and delivery system (FFS and Managed Care) as of the woman's date of delivery.

Table 9-3—Distribution of Women with Perinatal Dental Utilization by Medicaid Program, Managed Care Program, and Delivery System at Time of Delivery

Medicaid Program, Managed Care Program, and Delivery System at Time of Delivery	Count of Deliveries	Percentage of Study Population (n=30,674)	Count of Deliveries With Any Covered Dental Service	Percentage of Deliveries With Perinatal Dental Services Received
Any Program^	**30,674**	**100%**	**4,948**	**16.1%**
Medicaid Program				
Medicaid for Pregnant Women	20,477	66.8%	3,452	16.9%
Medicaid Expansion*	3,996	13.0%	569	14.2%
FAMIS MOMS	1,841	6.0%	279	15.2%
LIFC	2,820	9.2%	412	14.6%
Other Medicaid**	1,452	4.7%	232	16.0%
Medicaid Managed Care Program				
Medallion 4.0	22,081	72.0%	4,365	19.8%
CCC Plus	814	2.7%	164	20.1%
FAMIS	1,654	5.4%	266	16.1%
FFS	6,037	19.7%	149	2.5%

[9-2] The Smiles for Children program is administered by DentaQuest and covers most perinatal dental services for women ages 21 years and older. The latest DMAS program information is available at: http://www.dmas.virginia.gov/#/dentalpregnantwomen. Accessed on: Dec 2, 2021.

[9-3] Fontana J, Murawski T. COVID-19: Impact to dental utilization. Milliman White Paper. 2020. Available at: https://fdiworlddental.org/sites/default/files/2020-11/covid-19_impact_to_dental_utilization.pdf. Accessed on: Dec 2, 2021.

Medicaid Program, Managed Care Program, and Delivery System at Time of Delivery	Count of Deliveries	Percentage of Study Population (n=30,674)	Count of Deliveries With Any Covered Dental Service	Percentage of Deliveries With Perinatal Dental Services Received
Medicaid Delivery System				
Managed Care	24,549	80.0%	4,795	19.5%
FFS	6,037	19.7%	149	2.5%

^ Please note 88 members who were not enrolled on their date of delivery are included in the Any Program rate but are not included in any other stratification.
**The Medicaid Expansion category includes deliveries among women with Aid Categories 100, 101, 102, 103, 106, and 108, regardless of other benefit package information.*
***Other Medicaid includes all other births not covered by Medicaid for Pregnant Women, Medicaid Expansion, FAMIS MOMS, and LIFC. The Other Medicaid category program results exclude births to women in Plan First and the DOC programs, which are now included in the Not Enrolled category.*

Among the CY 2020 study population, most deliveries were to women covered by the Medicaid managed care delivery system (80.0 percent), with 19.5 percent (n=4,795) of those deliveries to women who received perinatal dental services. Conversely, while 19.7 percent of deliveries were covered by FFS, only 2.5 percent (n=149) of those deliveries were to women who received perinatal dental services. Within the managed care delivery system, 72.0 percent of deliveries were covered by the Medallion 4.0 program, with 19.8 percent (n=3,452) of these deliveries to women who had received perinatal dental services. Of note, the CCC Plus program had the highest percentage of deliveries where the woman received perinatal dental services (20.1 percent, n=164). Women enrolled in the Medicaid for Pregnant Women program accounted for the largest proportion of deliveries by Medicaid program (66.8 percent), with 16.9 percent (n=3,452) of these deliveries to women who received perinatal dental services.

Enhanced oral healthcare among pregnant women is important for both mother and baby. The Smiles for Children program provides pregnant women with a critically important opportunity to receive dental services during the prenatal and postpartum periods, and VDH offers guidance for providers offering dental services to pregnant women. In CY 2020, fewer than one in six eligible women (i.e., 16.1 percent) received dental services during or after pregnancy. Starting July 1, 2021, the Smiles for Children program expanded to provide an adult dental benefit to all members ages 21 and older enrolled in Medicaid or FAMIS, which may lead to an increase in dental utilization and rates as women enrolled in Medicaid may already be receiving dental care prior to conception.

Foster Care Focus Study

HSAG conducted the fifth annual Foster Care Focus Study during SFY 2019–2020, designed to determine the extent to which children in foster care received the expected preventive and therapeutic medical care under managed care service delivery compared to similar children not in foster care.

DMAS transitioned the Medallion 3.0 program to the Medallion 4.0 program during the year prior to the study period. Due to the program change, some children in foster care were transitioned to a different MCO during the study period. Additionally, the MCOs participating in Virginia Medicaid changed. Therefore, the current study assessed healthcare utilization among children in foster care compared to

utilization among children not in foster care ("non-foster children") who were enrolled with Medicaid MCOs[9-4] and compared findings to the previous year's study (SFY 2018–2019) to determine the extent to which MCOs reached Medallion 4.0 program goals.

To determine the extent to which children in foster care who were continuously enrolled with one or more MCOs throughout the study period utilized healthcare services, HSAG assessed 13 measures, representing 19 study indicators, across the following domains:

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

Table 9-4 presents study indicator results for the study population and the matched comparison group with *p*-values indicating whether the rate differences between foster and non-foster children are statistically significant.

Table 9-4—Overall Study Indicator Results for Foster Children and the Non-Foster Comparison Group

Measure	Foster Children Rate	Non-Foster Children Rate	*p*
Primary Care			
Children and Adolescents' Annual Access to PCPs	97.1%	93.4%	<0.001*
Oral Health			
Annual Dental Visit	86.9%	63.4%	<0.001*
Preventive Dental Services	81.7%	56.5%	<0.001*
Behavioral Health			
7-Day Follow-Up After Hospitalization for Mental Illness	38.7%	44.6%	0.26
30-Day Follow-Up After Emergency Department (ED) Visit for Mental Illness	92.6%	83.9%	<0.001*
Metabolic Monitoring for Children and Adolescents on Antipsychotics	40.8%	30.1%	0.003*
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	90.7%	67.7%	0.15
Initiation of Follow-Up Care for Children Prescribed ADHD Medication Within 1 Month	80.8%	78.9%	0.42
Initiation of Follow-Up Care for Children Prescribed ADHD Medication Within 2 Months	92.5%	88.6%	0.12

[9-4] Most children in foster care who received Medicaid benefits were transitioned from FFS programs to managed care no later than June 2014. Under Medallion 3.0 and Medallion 4.0, some children in foster care continued to receive Medicaid services on an FFS basis because they met exclusion criteria for managed care participation, such as utilizing Medicaid benefits as secondary insurance or receiving residential care services.

Measure	Foster Children Rate	Non-Foster Children Rate	*p*
Initiation of Follow-Up Care for Children Prescribed ADHD Medication Within 3 Months	95.0%	91.9%	0.06
Initiation of Follow-Up Care for Children Prescribed ADHD Medication Within 6 Months	98.3%	98.4%	0.61
Initiation of Follow-Up Care for Children Prescribed ADHD Medication Within 9 Months	100%	99.2%	0.28
Substance Use			
30-Day Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	S	S	0.62
Initiation of AOD Abuse or Dependence Treatment	44.4%	S	0.47
Engagement in AOD Abuse or Dependence Treatment	S	S	0.96
Reproductive Health			
Chlamydia Screening Among Women	27.7%	21.3%	0.20
Most Effective or Moderately Effective Method of Contraceptive Care	54.2%	41.3%	0.01*
Long-Acting Reversible Method of Contraceptive Care	10.6%	4.4%	0.003*
Respiratory Health			
Asthma Medication Ratio	85.7%	75.8%	0.82

* Indicates that the rates are statistically different between the foster and non-foster children.
S indicates that the rate has been suppressed due to a numerator or denominator less than or equal to 10.
P-values were calculated using logistic regression to predict numerator-compliance by foster status while controlling for demographic and health characteristics.
Denominators vary by study indicator; please refer to Appendix B for indicator-specific technical specifications.

Overall, this study demonstrated that foster children have higher rates of healthcare utilization than comparable non-foster children for most study indicators. Among the 19 study indicators, foster children demonstrated higher rates of healthcare utilization than non-foster children in 17 study indicators, seven of which were statistically significant. Among the 19 study indicators assessed in the current study, 12 indicators focused on behavioral healthcare utilization, which helped capture areas of healthcare that are particularly relevant to foster children. Of note, foster children were more likely than non-foster children to have a diagnosis of obesity or a metabolic syndrome, rheumatologic conditions, or congenital anomalies.

Study findings show that rate differences between the groups were greatest among dental measures, where the rates of foster children having annual dental visits and preventive dental services were over 20 percentage points higher than the rates for non-foster children.

During 2021, HSAG also initiated the sixth annual Foster Care Focus Study to assess utilization outcomes among members in foster care or adoption assistance programs (i.e., children in foster care, children in the adoption assistance program, and young adults formerly in foster care) for CY 2020 using a methodology similar to prior studies. Results from this study are scheduled to be released in 2022.

10. Summary of MCO-Specific Strengths and Weaknesses

HSAG used its analyses and evaluations of EQR activity findings from the preceding 12 months to comprehensively assess each MCO's performance in providing quality, timely, and accessible healthcare services to DMAS Medicaid and CHIP members as required in 42 CFR §438.364. For each MCO reviewed, HSAG provides a summary of its overall key findings related to quality, access, and timeliness based on the MCO's performance, which can be found in sections 4 through 9 of this report. In accordance with 42 CFR §438.364(a)(1), HSAG provides a description of the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality of, timeliness of, and access to care furnished by the MCOs. Table 10-1 through Table 10-6 provide MCO-specific strengths and weaknesses identified through the aggregation of the results of EQR activities. MCO-specific recommendations are found in sections 4 through 10 of the report.

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

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

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

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

Aetna

Table 10-1—Overall Conclusions for Aetna: Quality, Access, and Timeliness

EQRO Results for Aetna	
Domain	**Conclusion**
Quality	**Strengths:** Aetna had a comparatively robust internal assessment and reporting system for encounter data quality and timeliness. These robust systems and processes were evident in Aetna's PM results in the Care for Chronic Conditions domain; Aetna displayed strong performance within the *Asthma Medication Ratio—Total* measure, meeting or exceeding NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile. The results indicate that Aetna has established successful processes related to management of some chronic conditions. Aetna's processes ensure that providers follow evidence-based clinical guidelines and that members are being encouraged to complete recommended care and services, thereby reducing adverse member outcomes and unnecessary ED utilization.

EQRO Results for Aetna	
Domain	**Conclusion**
	Strength: The MCO implemented processes to maintain and monitor its provider network related to the cultural, ethnic, racial, and linguistic needs of its members. In addition, the MCO evaluated and monitored the quality and appropriateness of care provided to members with SHCN. The compliance review also identified that the MCO implemented processes through customer service to assist members with submitting grievances and appeals, and maintained an open door for staff, members, providers, and other stakeholders for compliance reporting. **Weaknesses:** Aetna's top-box scores were statistically significantly lower than the 2020 top-box scores and NCQA child Medicaid national averages for two measures: *Getting Care Quickly* and *Customer Service*, indicating lower member satisfaction. Based on the survey results, parents/caretakers of child members have a lower level of satisfaction with Aetna overall, which may be associated with their perception of their child's ability to receive access to care or services in a timely manner. Another factor that may have contributed to the lower satisfaction score was identified during the compliance review where it was found that members were not consistently informed that EPSDT services denied by Aetna as non-covered may be covered by DMAS.
Access	**Strengths:** The compliance review of Aetna identified that the MCO monitored its provider network to ensure providers provide physical access, reasonable accommodations, and accessible equipment for members with disabilities. These processes may have contributed to the results in the PM Behavioral Health domain, where Aetna's rates met or exceeded NCQA's HEDIS MY 2019 Medicaid HMO 75th percentile for the *Antidepressant Medication Management—Effective Continuation Phase Treatment*, *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measure indicators. This suggests providers are following guidelines for follow-up monitoring for children prescribed ADHD or using psychosocial care as a first-line protocol for members prescribed antipsychotics. Aetna's strong performance in the Behavioral Health domain measures indicates the MCO has improved members' access to behavioral healthcare, potentially as a result of Virginia's focus on the ARTS benefit and the development of member-centric behavioral healthcare and services. **Weaknesses:** Aetna members were not consistently completing timely screenings, receiving recommended care for chronic conditions, or receiving optimal care. The declines in preventive health and care for chronic health conditions may have been a result of the COVID-19 PHE. Aetna also did not align its network adequacy policies with federal and DMAS requirements, which may have also contributed to members' inability to access screening services and care for chronic conditions.
Timeliness	**Strengths:** Possibly as a result of DMAS' implementation of the ARTS benefit, Aetna met or exceeded NCQA's HEDIS MY 2019 Medicaid HMO 75th

EQRO Results for Aetna	
Domain	**Conclusion**
	percentile for some Behavioral Health domain measures including *Antidepressant Medication Management—Effective Continuation Phase Treatment*, which is dependent on timely receipt of care and services. This indicates that Aetna had effective care management processes to identify and work with members with diagnosed conditions to ensure follow-up care was received. **Weaknesses:** Aetna did not meet timeliness standards for institutional or professional encounters. This may have put some limits on identification of members in need of follow-up care. Aetna also did not consistently meet timeliness requirements for grievance resolution letters to members.

HealthKeepers

Table 10-2—Overall Conclusions for HealthKeepers: Quality, Access, and Timeliness

EQRO Results for HealthKeepers	
Domain	**Conclusion**
Quality	**Strengths:** HealthKeepers conducted monthly provider meetings and regular member focus groups to share updates and information, policy changes, and receive input and feedback for improvement. These efforts may have impacted the member experience survey rating for *Rating of Health Plan*, which was statistically higher than the 2020 NCQA adult Medicaid national average. **Weaknesses:** HealthKeepers' 2021 top-box scores were statistically significantly lower than the 2020 NCQA child Medicaid national average for *Getting Care Quickly and Customer Service*. The results indicate that parents/caretakers of child members have a lower level of satisfaction with Aetna overall, which may be associated with their perception of their child's ability to receive access to care or services in a timely manner. HealthKeepers did not have a defined process to identify members with SHCN or processes to monitor the quality and appropriateness of care furnished to members with SHCN.
Access	**Strengths:** Within the Care for Chronic Conditions domain, HealthKeepers displayed strong performance within the *Asthma Medication Ratio—Total* measure, exceeding NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile. The result indicates that HealthKeepers has established successful processes related to asthma medication for members with chronic conditions. The high level of performance in providing asthma care indicates that HealthKeepers ensures access to care and that providers follow evidence-based clinical guidelines. Members are being encouraged to complete recommended care and services, thereby reducing adverse member outcomes and unnecessary ED utilization. **Weaknesses:** Although contract requirements were met, HealthKeepers' performance rates indicated potential access to care issues with early detection

EQRO Results for HealthKeepers	
Domain	**Conclusion**
	screenings, preventive care, recommended care for chronic conditions, and well-care for children falling below NCQA's Quality Compass HEDIS Medicaid HMO 25th percentile. The results may also indicate a lack of understanding of recommended or needed care, or that a disparity may exist. Compliance review results also found that HealthKeepers did not have an implemented process to review EPSDT service requests against the EPSDT correct or ameliorate criteria.
Timeliness	**Strengths:** HealthKeepers did not have overall strengths in regard to timeliness. **Weaknesses:** HealthKeepers did not have defined processes to ensure members received EPSDT services or to inform members about the risks of childhood obesity, or the need for fluoride varnish and its availability in the PCP's office. HealthKeepers did not meet the timeliness standards or validity criteria for institutional and professional encounters, which may have limited the MCO's ability to identify timely members in need of EPSDT services.

Magellan

Table 10-3—Overall Conclusions for Magellan: Quality, Access, and Timeliness

EQRO Results for Magellan	
Domain	**Conclusion**
Quality	**Strengths:** Magellan compliance review results showed that the MCO promoted the delivery of services in a culturally appropriate manner and ensured access to members with physical and mental disabilities. Magellan also assessed the quality and appropriateness of care provided to members with SHCN. These processes were evident in the performance measurement results in the Behavioral Health domain, with a measure result ranked at or above NCQA's HEDIS MY 2019 Medicaid HMO 75th percentile. The strong performance on this measure indicates that Magellan has established successful processes related to medical assistance for members receiving behavioral health services. **Strengths:** The member experience of care survey showed that Magellan scored statistically significantly higher than the 2020 NCQA adult Medicaid national average for the *Rating of Health Plan* measure. This may be a result of how Magellan leveraged a multidisciplinary approach to engage disruptive members in continued care and the processes implemented to prevent, detect, and remediate critical incidents. **Weaknesses:** The member experience survey identified that members had a lower level of satisfaction with Magellan or their provision in healthcare overall, which may be associated with their perception of their ability to receive care or services from Magellan. The child member experience survey also found that members had had a lower level of satisfaction with Magellan overall, particularly

EQRO Results for Magellan	
Domain	**Conclusion**
	with Magellan's customer service. The MCO did not have a documented or implemented process to identify the needs of EPSDT age members, or how they ensured that needed care including medical and behavioral health services and community-based resources were provided to its members. These programs may positively impact member experience and help Magellan improve member satisfaction with the MCO and its provision of healthcare overall.
Access	**Strengths:** Within the Behavioral Health domain, Magellan's rates met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators. The strong performance on this Behavioral Health domain measure indicates that Magellan has improved member access to behavioral healthcare, potentially as a result of Virginia's focus on the ARTS benefit and the development of member-centric behavioral healthcare and services. In addition, Magellan exceeded the DMAS requirements for the number of providers, and the time and distance standards, which was an indication of access to care. **Weaknesses:** The compliance review found that Magellan did not have an implemented process to assess its network to ensure DMAS contract requirements were met or to ensure network sufficiency to ensure members received timely access to services. Magellan's rates for several PMs across several domains fell below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile, suggesting a lack of access and use of well and preventive care, behavioral health services, and chronic disease management. Magellan's members were not consistently scheduling or completing follow-up on recommended care or services or scheduling evidence-based care and services. These results align with the compliance review results, which identified that Magellan did not consistently ensure members eligible for EPSDT services obtained all the care and services they needed, including medical and behavioral health needs and referrals to community-based resources. The low performance across several PM domains and the results of Magellan's compliance review indicate that healthcare disparities may exist, and members may not have a comprehensive understanding of their healthcare needs or benefits. Factors that also may have contributed to the declines during this time include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The COVID-19 PHE also likely deterred individuals from seeking healthcare services.
Timeliness	**Strengths:** Magellan met the timeliness submission standard for both institutional and professional encounters. Over 80 percent of data elements assessed for professional encounters met the validity criteria. **Weaknesses:** A review of Magellan's compliance identified that the MCO did not have an implemented process to assess its network to ensure timely access to care and services.

Optima

Table 10-4—Overall Conclusions for Optima: Quality, Access, and Timeliness

EQRO Results for Optima	
Domain	**Conclusion**
Quality	**Strengths:** Optima's member experience survey results showed statistically significantly higher rates than the 2020 NCQA child Medicaid national average for two measures: *Rating of Health Plan* and *Rating of All Health Care*. These satisfaction results may relate to the MCO's performance measurement results in the NCQA HEDIS Behavioral Health domain, where Optima displayed strong performance for the *Asthma Medication Ratio—Total* measure, meeting or exceeding NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile. The result indicates that Optima has established successful processes related to asthma medication for members with chronic conditions. The high level of performance in providing asthma care indicates that Optima is ensuring that providers follow evidence-based clinical guidelines and that members are being encouraged to complete recommended care and services, thereby reducing adverse member outcomes and unnecessary ED utilization. **Weaknesses:** Optima's member experience survey top-box score was statistically significantly lower than the 2020 NCQA adult Medicaid national average for *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Customer Service*. Based on the survey results, adult members have a lower level of satisfaction with Optima overall, which may be associated with their perception of the ability to receive care or services from their personal doctors and customer service. **Weaknesses:** The member experience results may correlate to the findings of the PM rate results in the Children's Preventive Care, Women's Health, Access to Care, and Care for Chronic Conditions domains falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile, which suggests a lack of access to preventive care, women's health, and care for chronic conditions. Optima's members are not consistently scheduling well-care visits or receiving childhood immunizations according to the recommended schedules.
Access	**Strengths:** Optima's member experience survey results showed a statistically significantly higher rate than the 2020 NCQA adult Medicaid national average for *Rating of All Health Care*. The member experience results align with PM results in the Care for Chronic Conditions domain, where Optima met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Asthma Medication Ratio—Total* measure. The result indicates that Optima has established successful processes related to asthma medication for members with chronic conditions. The high level of performance in providing asthma care indicates that Optima is ensuring that providers follow evidence-based clinical guidelines and that members are being encouraged to complete recommended care and services, thereby reducing adverse member outcomes and unnecessary ED utilization. Compliance review results also showed that Optima focused efforts on access to care with the MCO

EQRO Results for Optima	
Domain	**Conclusion**
	implementing processes to monitor, evaluate, and implement interventions to improve utilization of EPSDT services. **Weaknesses:** The results of Optima's compliance review identified that Optima did not include all required provider types required in the DMAS contract, which may have impacted its assessment of time and distance standards compliance. These deficiencies may have impacted PM results since Optima's Care of Chronic Conditions domain measure results indicated that members may not be following up on evidence-based care and services. With low performance across several domains, healthcare disparities may have existed, and members may not have had a comprehensive understanding of their healthcare needs or benefits. Factors that may have contributed to the declines during this time include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The COVID-19 PHE also likely deterred individuals from seeking healthcare services.
Timeliness	**Strengths:** Optima was the only MCO that met the timeliness submission standard for all encounter types. Furthermore, over 80 percent of data elements assessed met the validity criteria for each encounter type. **Weaknesses:** Optima did not include all DMAS-required provider types or consider all required factors when describing and maintaining the number of providers offered to members or to assess the network against the appropriate travel time and distance standards required in the contract. These results may have impacted timeliness of care and service delivery.

United

Table 10-5—Overall Conclusions for United: Quality, Access, and Timeliness

EQRO Results for United	
Domain	**Conclusion**
Quality	**Strengths:** The compliance review results showed that United's QAPI program was focused on QI and measuring the results of quality initiatives to continue performance improvement. United implemented processes to evaluate the quality and appropriateness of care provided to members with SHCN. The MCO also implemented processes to monitor and evaluate critical incidents. These processes may have impacted United's PM results reflecting quality of care in the Care for Chronic Conditions domain. United displayed strong performance for the *Asthma Medication Ratio—Total* measure, meeting or exceeding NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile. The result indicates that United has established successful processes related to asthma medication for members with chronic conditions. The high level of performance in providing asthma care indicates that United is ensuring that providers follow evidence-based clinical guidelines and that

EQRO Results for United	
Domain	**Conclusion**
	members are being encouraged to complete recommended care and services, thereby reducing adverse member outcomes and unnecessary ED utilization. **Strength:** The compliance review also showed that United implemented robust compliance procedures that included regular meetings between the compliance officer, executive team, and various departments to maintain and monitor ongoing risk assessments, monitoring activities, and remediation work. **Weaknesses:** United's member experience survey top-box score was statistically significantly lower than the 2020 NCQA child Medicaid national average for three measures: *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*. In addition, United's 2021 top-box score was statistically significantly lower than the 2020 top-box score for one measure, *Rating of Health Plan*. Based on the survey results, parents/caretakers of child members have a lower level of satisfaction with United overall, which may be associated with their perception of their child's ability to receive access to care or services in a timely manner. The member experience survey results align with PM rates that show member's not accessing preventive care, screenings, and care for chronic conditions.
Access	**Strengths:** United monitored its provider network for adequacy and accessibility according to appropriate federal and Commonwealth requirements. United also monitored its provider network to ensure providers provided physical access, reasonable accommodations, and accessible equipment for members with disabilities. These monitoring processes may have resulted in improved access to care as evidenced in the results of PMs. Results indicate that United ensures providers follow evidence-based clinical guidelines and that members are being encouraged to complete recommended care and services, thereby reducing adverse member outcomes and unnecessary ED utilization. **Strengths:** Access to care was also found within the Behavioral Health domain, where United met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for two measure indicators. Indicator rates suggest that United has improved access to behavioral healthcare, potentially as a result of Virginia's focus on the ARTS benefit and the development of member-centric behavioral healthcare and services. **Weaknesses:** Some of United's measure rates in the Women's Health, Access to Care, and Care for Chronic Conditions domains were below the HEDIS MY 2019 25th percentile, which suggests a lack of access to preventive care, screenings, and care for chronic conditions. United's members were not completing timely visits, screenings, or recommended care for chronic conditions. The lack of member participation in recommended care and services may be a result of a disparity-driven barrier, a lack of understanding of care recommendations for optimal health, or the ability to access care and services in a timely manner. Screening declines may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed to the declines during this time include screening site closures and the temporary suspension of non-urgent services due to the COVID-19 PHE.

EQRO Results for United	
Domain	**Conclusion**
Timeliness	**Strengths:** The compliance review identified that United implemented interventions to increase utilization of EPSDT services, including processes to inform members and providers of the EPSDT-covered services. Outreach included educating members about childhood obesity and the dangers of lead exposure. **Strengths:** United's PM results within the Behavioral Health domain ranked at or above NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measure indicators. This suggests providers are following guidelines for follow-up monitoring or using psychosocial care as a first-line protocol for members prescribed antipsychotics. United's strong performance in the Behavioral Health domain measures indicates that the MCO has improved members' access to behavioral healthcare, potentially as a result of Virginia's focus on the ARTS benefit and the development of member-centric behavioral healthcare and services. These results are also supported by the compliance review results and United's processes to promote interventions and follow-up to increase timely access to care, follow-up, and recommended services. **Weaknesses:** United did not meet the timeliness standards for both institutional and pharmacy encounters. This may have impacted United's identification of members in need of preventive, early diagnosis, and evidence-based care, resulting in lower PM results in some measures.

VA Premier

Table 10-6—Overall Conclusions for VA Premier: Quality, Access, and Timeliness

EQRO Results for VA Premier	
Domain	**Conclusion**
Quality	**Strengths:** PM results showed that within the Care for Chronic Conditions domain, VA Premier displayed strong performance for the *Asthma Medication Ratio—Total* measure, meeting or exceeding NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile. The result indicates that VA Premier has established successful processes related to asthma medication for members with chronic conditions. The high level of performance in providing asthma care indicates that VA Premier is ensuring that providers follow evidence-based clinical guidelines and that members are being encouraged to complete recommended care and services, thereby reducing adverse member outcomes and unnecessary ED utilization. **Weaknesses:** The MCO did not implement 2020 Medicaid Managed Care Rule requirements of ensuring that members have access to machine-readable formats of its formulary and provider directory.

EQRO Results for VA Premier	
Domain	**Conclusion**
Access	**Strengths:** Compliance review results showed that VA Premier implemented processes to ensure members received culturally competent services. VA Premier also implemented processes to ensure that members had direct access to women's health services, out-of-network services, and second opinions. These processes may have had a positive impact on PM rates within the Behavioral Health domain, which met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators. The strong performance in the Behavioral Health domain antidepressant medication management measures has established strong access to behavioral healthcare, potentially as a result of Virginia's focus on the ARTS benefit and the development of member-centric behavioral healthcare and services. **Weaknesses:** A review of compliance of VA Premier identified that the MCO had not updated or implemented its policies and procedures regarding network adequacy or appointment accessibility to monitor and measure provider network accessibility. These findings are supported by the member experience survey results, which found that VA Premier's top-box score was statistically significantly lower than the 2020 top-box score for one measure, *Rating of Specialist Seen Most Often*. Based on the survey results, parents/caretakers of child members have a lower level of satisfaction with VA Premier's specialists, which may be associated with their perception of their child's ability to receive care or services from their child's specialist.
Timeliness	**Strengths:** A compliance review of VA Premier demonstrated that VA Premier had appropriate policies and procedures for a comprehensive QAPI program. VA Premier implemented processes to ensure members eligible for EPSDT services received appropriate services, including medical and behavioral health services. The results of PM validation indicated that the outreach processes implemented by VA Premier may have had a positive impact on PM results. Within the Behavioral Health domain, VA Premier's rates met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* measure indicators. The strong performance in the behavioral health follow-up for care for children indicates that VA Premier has established strong access to behavioral healthcare, potentially as a result of Virginia's focus on the ARTS benefit and the development of member-centric behavioral healthcare and services. **Weaknesses:** A compliance review identified that VA Premier did not appropriately apply its appointment access standards to the entire network; have processes to ensure that providers offer the same hours of operation for its Medicaid members as commercial or FFS members; or ensure that the provider network offers care and services 24 hours a day, seven days a week. These compliance review findings may have impacted the timeliness of care

EQRO Results for VA Premier	
Domain	**Conclusion**
	and service delivery resulting in several of VA Premier's rates falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile. Although VA Premier members may have adequate access to timely care and services, members are not completing timely visits, screenings, or recommended care for chronic conditions. The lack of timely member participation in recommended care and services may be a result of a disparity-driven barrier, a lack of understanding of care recommendations for optimal health, or the ability to access care and services in a timely manner. Screening declines may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed to the declines during this time include screening site closures and the temporary suspension of non-urgent services due to the COVID-19 PHE.

Appendix A. Technical Report and Regulatory Crosswalk

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

Table A-1—Technical Report Elements

	Required Elements	Page Number
1	The state submitted its EQR technical report by April 30th.	Cover Page
2	All eligible Medicaid and Children's Health Insurance Program (CHIP) Plans are included in the report.	1-1
3a	Required elements are included in the report: Describe the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were **aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity.**	1-5
3b	Required elements are included in the report: An assessment of the **strengths and weaknesses of each MCO, PIHP, PAHP and PCCM entity** with respect to (a) quality, (b) timeliness, and (c) access to the health care services furnished by each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) furnished to Medicaid and/or CHIP beneficiaries. Contain specific recommendations for improvement of identified weaknesses.	Section 10
3c	Required elements are included in the report: Describe how the state can **target goals and objectives in the quality strategy**, under 42 CFR §438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid or CHIP enrollees.	1-8
3d	Recommend improvements to the quality of health care services furnished by each MCP.	Sections 4, 5, 6, 7, 8, and 9
3e	Provides state-level recommendations for performance improvement.	1-8
3f	Ensure methodologically appropriate, comparative information about all MCPs.	Section 3
3f	Assess the degree to which each MCP has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.	Appendix E
4	Validation of performance improvement projects (PIPs): A description of **PIP interventions** associated with each state-required PIP topic for the current EQR review cycle, and the following for the validation of PIPs: **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.**	
4a	Validation of performance improvement projects (PIPs): • **Interventions**	Section 4: Tables: 4-2, 4-3, 4-5, 4-6, 4-8, 4-9, 4-11, 4-12, 4-

	Required Elements	Page Number
		14, 4-15, 4-17, 4-18
4b	Validation of performance improvement projects (PIPs): • **Objectives;**	4-1
4c	Validation of performance improvement projects (PIPs): • **Technical methods of data collection and analysis;**	Appendix B
4d	Validation of performance improvement projects (PIPs): • **Description of data obtained; and**	4-2 – 4-13
4e	Validation of performance improvement projects (PIPs): • **Conclusions drawn from the data.**	4-3 – 4-13
5	Validation of performance measures: A description of **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.**	
5a	Validation of performance measure validation (PMV): • **Objectives;**	5-1
5b	Validation of performance measure validation (PMV): • **Technical methods of data collection and analysis;**	Appendix B
5c	Validation of performance measure validation (PMV): • **Description of data obtained; and**	3-4, 3-6
5d	Validation of performance measure validation (PMV): • **Conclusions drawn from the data.**	5-1 – 5-12
6	Review for compliance: 42 CFR §438.358(b)(1)(iii) (cross-referenced in CHIP regulations at 42 CFR §457.1250[a]) requires the technical report including information **on a review, conducted within the previous three-year period**, to determine each MCO's, PIHP's, PAHP's or PCCM's compliance with the standards set forth in Subpart D and the QAPI requirements described in 42 CFR §438.330. Additional information that needs to be included for compliance is listed below:	
6a	Review for compliance: • **Objectives;**	6-1
6b	Review for compliance: • **Technical methods of data collection and analysis;**	Appendix B
6c	Review for compliance: • **Description of data obtained; and**	Appendix B
6d	Review for compliance: • **Conclusions drawn from the data.**	6-3 – 6-20
7	**Each remaining activity** included in the technical report must include a **description of the activity** and the following information:	
7a	Optional activities: • **Objectives;**	7-1, 8-1, 9-1
7b	Optional activities:	Appendix B

	Required Elements	Page Number
	• **Technical methods of data collection and analysis;**	
7c	Optional activities: • **Description of data obtained; and**	Appendix B
7d	Optional activities: • **Conclusions drawn from the data.**	7-2 – 7-13, 8-1 – 8-14, 9-1 – 9-8

Appendix B. Technical Methods of Data Collection and Analysis—MCOs

This section of the report presents the approved technical methods of data collection and analysis, and a description of the data obtained (including the time period to which the data applied) for each mandatory and optional activity for the MCOs. It includes:

- Rapid-Cycle PIP Validation Approach
- Validation of Performance Measure Methodology
- Operational Systems Review Methodology
- Encounter Data Validation Methodology
- CAHPS Survey Methodology
- Calculation of Additional Performance Measures Methodology
- Focus Study Methodology
  - Birth Outcomes Focus Study
  - Dental Utilization in Pregnant Women Data Brief
  - Foster Care Focus Study
- Consumer Decision Support Tool Methodology
- Performance Withhold Program Methodology

Rapid-Cycle PIP Validation Approach

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

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

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

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

PIP Components and Process

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing a measure, determining interventions, testing interventions, and spreading successful changes. The core component of this approach involves testing changes on a small scale—using a series of Plan-Do-Study-Act (PDSA) cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies—so that improvement can occur more efficiently and lead to long-term sustainability. The duration of rapid-cycle PIPs is approximately 18 months.

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

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

During PIP validation, HSAG determines if criteria for each module are *Achieved*. As the PIP progresses, and at the completion of Module 5, HSAG uses the validation findings from modules 1 through 5 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG assigns a level of confidence and reports the overall validity and reliability of the findings as one of the following:

- *High confidence* = The PIP was methodologically sound, the SMART Aim was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the MCO accurately summarized the key findings.
- *Confidence* = The PIP was methodologically sound, the SMART Aim was achieved, and the MCO accurately summarized the key findings. However, some, but not all, quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- *Low confidence* = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes

conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.

- *Reported PIP results were not credible* = The PIP methodology was not executed as approved.

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

Validation of Performance Measure Validation Methodology

Overview

DMAS contracted with HSAG, as its EQRO, to conduct PMV for the MCOs. Title 42 of the Code of Federal Regulations (CFR) §438.350(a) requires states that contract with MCOs, prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), or primary care case management (PCCM) entities to have a qualified EQRO perform an annual external quality review (EQR) that includes validation of contracted entity performance measures (42 CFR §438.358[b][1][ii]). HSAG, in conjunction with ALI Consulting Services, LLC, conducted PMV for DMAS, validating the data collection and reporting processes used to calculate the performance measure rates by the MCOs in accordance with the CMS publication, *Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity,* October 2019.[B-3]

DMAS is responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP) in the Commonwealth of Virginia. DMAS refers to its CHIP program as Family Access to Medical Insurance Security (FAMIS). The Medallion 4.0 program provides services to the Medicaid and FAMIS populations. DMAS contracted with six privately owned MCOs to provide services to members enrolled in the Medallion 4.0 program for calendar year (CY) 2020. DMAS identified a set of performance measures that the MCOs were required to calculate and report.

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

Table B-1—CY 2020 Medallion 4.0 MCOs

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

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

MCO Name
Optima Health
UnitedHealthcare of the Mid-Atlantic, Inc.
Virginia Premier Health Plan, Inc.

Objectives

The primary objectives of the PMV process were to evaluate the accuracy of the performance measure data collected by the MCO and determine the extent to which the specific performance measures calculated by the MCO (or on behalf of the MCO) followed the specifications established for each performance measure. PMV results provided DMAS with MCO-specific performance measure designations to additional information for MCO quality withhold payments.

Description of Validation Activities

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

Pre-Audit Strategy

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

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

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

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

Technical Methods of Data Collection and Analysis

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

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

On-Site Activities

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

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

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

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

Post-On-Site Activities

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

HSAG prepared a separate PMV report for Medallion 4.0 for each MCO, documenting the validation findings. Based on all validation activities, HSAG determined the validation result for each performance measure. The CMS PMV protocol identifies possible validation results for performance measures, defined in Table B-2 below.

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

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

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

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

Performance Measure List for SFY 2021

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

Table B-3—Performance Measure List for SFY 2021

Performance Measure	Specifications	Method*
Asthma Admission Rate (Per 100,000 Member Months) (PDI 14)	AHRQ PDI	Admin
Child and Adolescent Well-Care Visits	HEDIS MY 2020	Admin
Childhood Immunization Status—Combination 3	HEDIS MY 2020	Hybrid
Comprehensive Diabetes Care	HEDIS MY 2020	Hybrid
Follow-Up After Emergency Department Visit for Mental Illness	HEDIS MY 2020	Admin
Prenatal and Postpartum Care	HEDIS MY 2020	Hybrid

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

Compliance With Standards Methodology

Requirement

Compliance reviews (Operational Systems Review or OSRs) are a mandatory activity that are used to determine the extent to which Medicaid and CHIP managed care plans (MCPs) are in compliance with federal standards. The U.S. Department of Health & Human Services (HHS) developed standards for managed care plans (MCPs), which are codified at 42 CFR §438 and 42 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.

Brief Overview

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

Document Request Packet

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

The following components are included in this packet:

Section I	Contact Information
Section II	Timeline
Section III	Standards and Review Information
Section IV	Virtual Review Agenda
Appendix I	Standard I—Enrollment and Disenrollment Tool
Appendix II	Standard II—Member Rights and Confidentiality Tool
Appendix III	Standard III—Member Information Tool
Appendix IV	Standard IV—Emergency and Poststabilization Services Tool
Appendix V	Standard V—Adequate Capacity and Availability of Services Tool
Appendix VI	Standard VI—Coordination and Continuity of Care Tool
Appendix VII	Standard VII—Coverage and Authorization of Services Tool
Appendix VIII	Standard VIII—Provider Selection Tool
Appendix IX	Standard IX—Subcontractual Relationships and Delegation Tool
Appendix X	Standard X—Practice Guidelines Tool
Appendix XI	Standard XI—Health Information Systems Tool
Appendix XII	Standard XII—Quality Assessment and Performance Improvement Tool
Appendix XIII	Standard XIII—Grievance and Appeal Systems
Appendix XIV	Standard XIV—Program Integrity Tool
Appendix XV	Standard XV—EPSDT Services

Table B-4—OSR Timeline

Section II—Timeline			
Task Description	**Start Date**	**End Date**	**Responsibility**
Submit to the HSAG SAFE site a Microsoft Excel list of all standard appeal requests for covered/authorization of services during the review period.	No later than July 6, 2021		MCO
Submit to the HSAG SAFE site an Excel list of all expedited appeal requests for covered/authorization of services during the review period.	No later than July 6, 2021		MCO
Submit to the HSAG SAFE site an Excel list of all standard grievances received during the review period.	No later than July 6, 2021		MCO

Section II—Timeline			
Task Description	**Start Date**	**End Date**	**Responsibility**
Submit to the HSAG SAFE site an Excel list of all expedited grievances received during the review period.	No later than July 6, 2021		MCO
Submit to the HSAG SAFE site an Excel list of all service authorizations (including approved and denied requests) during the review period.	No later than July 6, 2021		MCO
Submit to the HSAG SAFE site an Excel list of all delegation or subcontract agreements in effect during the review period.	No later than July 6, 2021		MCO
HSAG provides notification to the MCO of sample cases and agreements selected for review. • A separate sample will be selected by HSAG for each program (Medallion 4.0 and CCC Plus) • For each program a separate sample will be selected by HSAG of the following: 1. Overall cases 2. ARTS cases 3. EPSDT cases • Ten sample cases plus an over-sample cases selected by HSAG of the following case types: 1. Standard appeals 2. Expedited appeals 3. Standard grievances 4. Expedited grievances 5. Service authorization denials 6. Subcontractor and delegated entity agreements	No later than July 9, 2021		HSAG
MCO submits selected cases for review to the appropriate folders on the HSAG SAFE site.	No later than July 14, 2021		MCO
Submit to the HSAG SAFE site the MCO evidence of compliance documents for desk review.	No later than July 14, 2021		MCO
Perform virtual review.	To be populated with MCO-specific audit dates	To be populated with MCO-specific audit dates	HSAG/MCO/ DMAS
Review period	July 1, 2020	June 30, 2021	HSAG/MCO/ DMAS

Table B-5—OSR Process Instructions

Section III—Standards and Review Information
General Instructions and Notes
The MCO will need to designate subject matter expert staff members for each of the review areas during the interview portion of the OSR.

Section III—Standards and Review Information	
Standards Covered During the Operational Systems Review (OSR)	
Brief Description	HSAG will review the following standards as part of the OSR: I. Enrollment and Disenrollment (§438.56) II. Member Rights and Confidentiality (§438.10.00§438.100.00; §438.224) III. Member Information (§438.10) IV. Emergency and Poststabilization Services (§438.114) V. Adequate Capacity and Availability of Services (§438.206 and §438.207) VI. Coordination and Continuity of Care (§438.208) VII. Coverage and Authorization of Services (§438.210) VIII. Provider Selection (§438.214) IX. Subcontractual Relationships and Delegation (§438.230) X. Practice Guidelines (§438.236) XI. Health Information Systems (§438.242) XII. Quality Assessment and Performance Improvement (§438.330) XIII. Grievance and Appeal Systems (§438.228) XIV. Program Integrity (§438.608; §438.610) XV. EPSDT Services (1903 of the Social Security Act)
Document Request and Evaluation Tool	The Document Request and Evaluation Tool is the OSR tool that HSAG will use to assess the MCO's compliance with the standards being reviewed. The tools are organized according to the CMS 2016 Final Managed Care Rule categories, with the December 2020 updates applied. HSAG will review the MCO's compliance of the policies, procedures, or other written documents with federal and Commonwealth requirements **and the evidence of implementation of the requirements**. The MCO is the expert at identifying documentation that supports its compliance with federal and Virginia-specific requirements and should submit accordingly. Enter the name of the document that contains evidence of the MCO's compliance directly in the "Evidence as Submitted by the Health Plan" section of the tool. Please be very specific as to which document includes the information (i.e., for policies and procedures, include the policy name/number; for meeting minutes, include which committee and for which meeting date). Also, specify the exact page, section, attachment, etc., that provides evidence of compliance with the requirement. When submitting documents, please do not copy or cut a section or paragraph from one document and paste it into a separate document for submission. Reviewers need to see the entire policy or document to understand the context and the associated information. ***Highlight in yellow in the document submission the applicable information that demonstrates evidence of compliance with the standard.*** Please note that HSAG will review only the document portions highlighted and referenced according to page number, section, or attachment in the "Evidence as Submitted by the Health Plan" section of the tool for each element as evidence of the MCO's compliance with the standard/element. When uploading the referenced documents to the HSAG SAFE site folders, please name the file the same name as listed in the Evidence column. The Document Request and Evaluation Tool is provided in a Microsoft Word format that allows the MCO to enter information directly into the "Evidence as Submitted by the Health Plan" section of the tool. Please note that the preferred font for entering the information is Helvetica, size 11, black. Please do not enter,

Section III—Standards and Review Information	
	delete, or change information in any of the other sections of the tool (i.e., Requirements, Findings, Required Actions, and Score). The MCO must post all case/service lists in Excel format to the HSAG SAFE site folders (Operational Systems Review > CCC Plus > File Review > 1 – Universe File and Operational Systems Review > Medallion 4_0 > File Review > 1 – Universe File) no later than July 1, 2021. All requested MCO users have been granted access. Do not submit any documents via email as they may contain protected health information (PHI) or personally identifiable information (PII). Post all referenced documents to the appropriate folder (organized by standard) on the HSAG SAFE site folders site no later than July 1, 2021, and post all selected case files or documentation to the HSAG SAFE site folders no later than July 14, 2021.
Desk Review	
Brief Description	HSAG will conduct a desk review of the submitted documents, complete case file reviews, and conduct virtual interviews and systems demonstrations with MCO staff members to determine the MCO's compliance with federal and Commonwealth requirements.
Procedure	HSAG will conduct a desk review of the submitted documents prior to the virtual visit. HSAG will then conduct a virtual visit and interview MCO staff members to determine if the MCO is in compliance with the elements of each standard. MCO staff members should be prepared to discuss implementation of the standards during the virtual visit and answer the reviewer's questions. MCO staff members should be able to describe how policies and procedures are implemented. HSAG may request that certain documentation be submitted to the HSAG SAFE site folders by the close of the virtual visit date as evidence of implementation of processes described during the interview sessions.

Table B-6—OSR Agenda

Section IV—Virtual Review Agenda	
Day 1	
Time Period (EST)	**Sessions and Activities**
8:00–8:30 a.m.	Set-up
8:30–9:00 a.m.	Opening session: • Introduction – Participants include MCO staff, HSAG, and DMAS • MCO opening remarks and overview
9:00–10:00 a.m.	Standard V—Adequate Capacity and Availability of Services
10:00–11:00 a.m.	Standard VII—Coverage and Authorization of Services Standard IV—Emergency and Poststabilization Services
11:00–11:15 a.m.	*Break*
11:15 a.m.–12:00 p.m.	Standard VI—Coordination and Continuity of Care
12:00–1:00 p.m.	*HSAG reviewers—working lunch*
1:00–1:30 p.m.	Standard VIII—Provider Selection

Section IV—Virtual Review Agenda	
1:30–2:00 p.m.	Standard IX—Subcontractual Relationships and Delegation
2:00–3:00 p.m.	Standard XI—Health Information Systems
3:00–3:15 p.m.	*Break*
3:15–4:00 p.m.	Standard XIV—Program Integrity *HSAG document review time*
4:00–5:00 p.m.	*HSAG document review time–MCO follow-up on document requests*
5:00 p.m.	*End of day*
Day 2	
Time Period (EST)	**Sessions and Activities**
8:30–9:00 a.m.	Set-Up
9:00–10:00 a.m.	Standard II—Member Rights and Confidentiality
10:00–11:00 a.m.	Standard III—Member Information
11:00–11:15 a.m.	*Break*
11:15–11:45 a.m.	Standard I—Enrollment and Disenrollment
11:45 a.m.–12:15 p.m.	Standard X—Practice Guidelines
12:15–1:00 p.m.	*HSAG reviewers—working lunch*
1:00–2:00 p.m.	Standard XII—Quality Assessment and Performance Improvement
2:00–3:00 p.m.	Standard XIII—Grievance and Appeal Systems
3:00–3:30 p.m.	Standard XV—EPSDT Services
3:30–4:00 p.m.	*HSAG reviewers prepare closing summation*
4:00–4:30 p.m.	Closing session: • Summary of HSAG's preliminary findings
4:30–5:00 p.m.	*End of day*

Encounter Data Validation Methodology

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, DMAS requires its Medallion 4.0 contracted MCOs to submit high-quality encounter data. DMAS relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

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

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

HSAG conducted the EDV study for the following six Medallion 4.0 MCOs:

- Aetna Better Health of Virginia (Aetna)
- HealthKeepers, Inc. (HealthKeepers)
- Magellan Complete Care of Virginia (Magellan)
- Optima Health (Optima)
- UnitedHealthcare of the Mid-Atlantic, Inc. (United)
- Virginia Premier Health Plan, Inc. (VA Premier)

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

Information Systems Review

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

Stage 1—Document Review

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

Stage 2—Development and Fielding of Customized Encounter Data Assessment

To conduct a customized encounter data assessment, HSAG developed an MCO questionnaire customized in collaboration with DMAS to gather information and specific procedures for data

processing, personnel, and data acquisition capabilities. The questionnaire also included a review of supplemental documentation regarding other data systems, including enrollment and provider data. Lastly, the questionnaire included specific topics of interest to DMAS.

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

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

Stage 3—Key Informant Interviews

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

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

Administrative Profile

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

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

- Since this was the first time HSAG was to request encounter data from DMAS' EPS database, HSAG initially requested a set of test files from DMAS before DMAS extracted the complete set of data. The test data were smaller in size (e.g., encounters for one month) and allowed HSAG to detect any data extraction issues before the full data extract was submitted. In addition, the test data helped HSAG prepare the analyses in advance while waiting for the claim lag run-out to receive the complete data.

- After submitting the draft data submission requirements document to DMAS, HSAG scheduled a conference call with DMAS to review the document to ensure that all questions related to data preparation and extraction were addressed. Afterwards, HSAG submitted the final version of the data submission requirements document to DMAS for review/approval.

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

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

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

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

Encounter Data Completeness

HSAG evaluated the encounter data completeness through the following metrics:

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

Encounter Data Timeliness

HSAG evaluated the encounter data timeliness through the following metrics:

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

Field-Level Completeness and Accuracy

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

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

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

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

Key Data Elements	837P Encounters	837I Encounters	NCPDP Encounters	Criteria for Validity
Member ID [H]	✔	✔	✔	• In member file. Of note, if the Member IDs were 11 digits plus an alpha character (i.e., for newborns), HSAG evaluated whether the first 11 digits matched the first 11 digits for female members in the member file. • Enrolled in a specific MCO on the date of service • Member Date of Birth is on or before detail date of service
Header Service From Date [H]	✔	✔		• Header Service From Date ≤ Header Service To Date • Header Service From Date ≤ Paid Date
Header Service To Date [H]	✔	✔		• Header Service To Date ≥ Header Service From Date • Header Service To Date ≤ Paid Date
Detail Service From Date [D]	✔	✔	✔	• Detail Service From Date ≤ Detail Service To Date • Detail Service From Date ≤ Paid Date
Detail Service To Date [D]	✔	✔	✔	• Detail Service To Date ≥ Detail Service From Date • Detail Service To Date ≤ Paid Date
Billing Provider NPI [H]	✔	✔	✔	In provider data when service occurred
Rendering Provider NPI [H]	✔			In provider data when service occurred
Attending Provider NPI [H]		✔		In provider data when service occurred
Servicing Provider Taxonomy Code [D]	✔	✔		• In standard taxonomy code set • Match with the value in provider data
Referring Provider NPI [H]	✔	✔		In provider data when service occurred
Prescribing Provider NPI			✔	In provider data when service occurred

Key Data Elements	837P Encounters	837I Encounters	NCPDP Encounters	Criteria for Validity
Primary Diagnosis Codes [H]	✔	✔		In national ICD-10-Clinical Modification (CM) diagnosis code sets for the correct code year (e.g., in 2020 code set for services that occurred between October 1, 2019, and September 30, 2020)
Secondary Diagnosis Codes [H]	✔	✔		In national ICD-10-CM diagnosis code sets for the correct code year
CPT/HCPCS Codes [D]	✔			In national CPT and HCPCS code sets for the correct code year (e.g., in 2020 code set for services that occurred in 2020) AND satisfies CMS' Procedure to Procedure Edits[B-4]
Service Units [D]	✔	✔		Positive and below the maximum units of service according to CMS' MUE[B-5]
Primary Surgical Procedure Codes [H]		✔		In national ICD-10-CM surgical procedure code sets for the correct code year
Secondary Surgical Procedure Codes [H]		✔		In national ICD-10-CM surgical procedure code sets for the correct code year
Revenue Codes [D]		✔		In national standard revenue code sets for the correct code year
Diagnosis-Related Groups (DRG) Codes[H]		✔		In the list of all patients refined (APR) DRGs from DMAS [B-6]
Type of Bill Codes [H]		✔		In national standard type of code set
National Drug Codes (NDCs) [D]	✔	✔	✔	In national NDC code sets

[B-4] Centers for Medicare & Medicaid Services. PTP Coding Edits. Available at: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits. Accessed on: Oct 19, 2021. Currently, DMAS does not apply the Procedure to Procedure Edits in EPS.

[B-5] Centers for Medicare & Medicaid Services. Medically Unlikely Edits. Available at: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE. Accessed on: Oct 19, 2021. Currently, DMAS does not apply the MUE edits in EPS.

[B-6] Virginia Medicaid Department of Medical Assistance Services. Hospital Rates. Available at: https://www.dmas.virginia.gov/for-providers/rate-setting/hospital-rates/. Accessed on: Oct 15, 2021.

Key Data Elements	837P Encounters	837I Encounters	NCPDP Encounters	Criteria for Validity
HCPCS/NDC Combination [D]	✔	✔ (for type of bill codes starting with "13" or "83")		Met the criteria listed in 2020 Average Sales Price Drug Pricing files[B-7]
MCO Received Date (i.e., the date when the MCOs received claims from providers)	✔	✔	✔	MCO Paid Date ≥ MCO Received Date ≥ Detail Service To Date
MCO Paid Date [D]	✔	✔	✔	MCO Submission Date (i.e., the date when MCOs submit encounters to DMAS) ≥ MCO Paid Date ≥ MCO Received Date
Header Paid Amount [H]	✔	✔		Header Paid Amount equal to sum of the Detail Paid Amount
Header TPL Paid Amount [H]	✔	✔		Header TPL Paid Amount equal to sum of the Detail TPL Paid Amount
Detail Paid Amount [D]	✔	✔	✔	Zero or positive
Detail TPL Paid Amount [D]	✔	✔	✔	Zero or positive based on the TPL flag from the encounter data

[H] Conducted evaluation at the header level.

[D] Conducted evaluation at the detail level.

[B-7] Centers for Medicare & Medicaid Services. 2020 ASP Drug Pricing Files. Available at: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/2020-asp-drug-pricing-files. Accessed on: Oct 19, 2021. HSAG used this crosswalk to conduct the analysis. Currently, DMAS has a similar edit in EPS. However, it is based on a proprietary crosswalk from DMAS' pharmacy team.

CAHPS Survey Methodology

Technical Methods of Data Collection and Analysis

MCO CAHPS

For the Medallion 4.0 MCOs, the technical method of data collection was through administration of the CAHPS 5.1H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.1H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCO.[B-8] The mode of CAHPS survey data collection varied slightly among the MCOs. All MCOs used a mixed-mode survey methodology for their adult and child populations. Following NCQA's standard HEDIS timeline, adult members and parents/caretakers of child members enrolled in each of the MCOs completed the surveys between the time period of January to May 2021.

Each MCO was responsible for contracting with an NCQA-certified survey vendor to conduct CAHPS surveys of the MCO's adult and child Medicaid populations on the MCO's behalf. To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed to select members and distribute surveys.[B-9] These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis. Each MCO provided HSAG with its NCQA Summary Reports of adult and child Medicaid CAHPS survey results (i.e., summary report produced by NCQA of calculated CAHPS results) and raw data files for purposes of reporting.

The CAHPS 5.1H Surveys include a set of standardized items (40 items for the CAHPS 5.1H Adult Medicaid Health Plan Survey and 41 items for the CAHPS 5.1H Child Medicaid Health Plan Survey without 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 member experience.[B-10] 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 experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a top-box response or top-box score. For each of the four composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response

[B-8] HealthKeepers administered the CAHPS 5.1H Child Medicaid Health Plan Survey with the CCC measurement set to their child Medicaid populations, while the other MCOs administered the CAHPS 5.1H Child Survey without the chronic conditions measurement set. For purposes of this report, the child Medicaid CAHPS results presented for HealthKeepers represent the CAHPS results for their general child populations (i.e., general child CAHPS results).

[B-9] Aetna and HealthKeepers contracted with the Center for the Study of Services (CSS); and Magellan, Optima, United, and VA Premier contracted with SPH Analytics to conduct the CAHPS survey administration and analysis and reporting of survey results for their respective adult and child Medicaid populations.

[B-10] For purposes of this report, CAHPS survey results are not reported for the one individual item measure, *Coordination of Care*. Therefore, reported results are limited to the four global ratings and four composite measures.

choices fell into the following categories: "Never," "Sometimes," "Usually," or "Always." A top-box response or top-box score for the composite measures was defined as a response of "Usually/Always."

The 2021 CAHPS scores for each MCO and the statewide aggregate were compared to the 2020 NCQA Medicaid national averages.[B-11] A statistically significant difference was identified by using the confidence interval for each measure rate. Statistically significant differences are noted with colors. A cell was highlighted in orange if the MCO score was statistically significantly higher than the national average. However, if the MCO score was statistically significantly lower than the national average, then a cell was highlighted in gray.

Additionally, a trend analysis was performed for each MCO, where applicable, that compared its 2021 CAHPS scores to its corresponding 2020 scores to determine whether there were statistically significant differences. Scores that were statistically significantly higher in 2021 than in 2020 are noted with upward (▲) triangles. Scores that were statistically significantly lower in 2021 than in 2020 are noted with downward (▼) triangles. Scores in 2021 that were not statistically significantly different from scores in 2020 are not noted with triangles.

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

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. The CAHPS surveys were conducted per the Centers for Medicare & Medicaid Services' (CMS') CAHPS reporting requirements under the Children's Health Insurance Program Reauthorization Act (CHIPRA). 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., Children's Health Insurance Program [CHIP] members in FFS or managed care).

Based on NCQA protocol, child members included as eligible for the survey were 17 years of age or younger as of December 31, 2020. A mail-only methodology for data collection was utilized. Parents or caretakers of child members completed the surveys between the time period of March to June 2021. 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 5.1 Child Medicaid Health Plan Survey with the CCC measurement set includes a standardized set of 76 items that assess patient perspectives on care. To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed to select the general child and children with chronic conditions members and distribute the surveys. These

[B-11] Quality Compass 2020 data serve as the source for the 2020 NCQA CAHPS adult Medicaid and child Medicaid national averages.

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. An analysis of the CAHPS 5.1 Child Medicaid Health Plan Survey results was conducted using NCQA HEDIS Specifications for Survey Measures.[B-12]

For the FAMIS program, the survey questions were categorized into eight measures of member experience.[B-13] These measures included four global ratings and four composite measures. The global measures (also referred to as global ratings) reflected patients' 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* or *Getting Care Quickly*).

For each of the four global ratings, the percentage of respondents who chose the top experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a top-box response or top-box score. For each of the four composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into the following categories: "Never," "Sometimes," "Usually," or "Always." A top-box response or top-box score for the composite measures was defined as a response of "Usually/Always."

The FAMIS program's general child and CCC populations' survey findings were compared to 2020 NCQA CAHPS child and CCC Medicaid national averages.[B-14] A statistically significant difference was identified by using the confidence interval for each measure rate. Statistically significant differences are noted with colors. A cell was highlighted in orange if the lower bound of the confidence interval was higher than the national average. However, if the upper bound of the confidence interval was lower than the national average, then a cell was highlighted in gray.

NCQA requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result. However, for purposes of reporting the FAMIS CAHPS results, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Caution should be exercised when interpreting results for those measures with fewer than 100 respondents. CAHPS scores with fewer than 100 respondents are denoted with a cross (+).

Description of the Data Obtained/Time Period

The CAHPS survey asks members to report on and to evaluate their experiences with healthcare. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The CAHPS surveys were administered from January to May 2021 for the Medallion 4.0 MCOs, and from March to June 2021 for the FAMIS program.

The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. For the CAHPS 5.1H Adult Medicaid Health Plan Survey, a survey was

[B-12] National Committee for Quality Assurance. *HEDIS® Measurement Year 2020, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2020.
[B-13] For purposes of this report, CAHPS survey results are not reported for the one individual item measure, *Coordination of Care*, or the five CCC composite measures and items. Therefore, reported results are limited to the four global ratings and four composite measures.
[B-14] The source for the 2020 NCQA national child and CCC Medicaid averages for the general child population and children with chronic conditions population is Quality Compass® 2020 data.

assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 10, 19, 23, and 28. For the CAHPS 5.1H Child Medicaid Health Plan Survey without the CCC measurement, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 10, 22, 26, and 31. For the CAHPS 5.1 Child Medicaid Health Plan Survey with the CCC measurement set, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 25, 40, 44, and 49. Eligible members included the entire sample minus ineligible members. For the child population, ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), or they had a language barrier. For the adult population, ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), they had a language barrier, or they were mentally or physically incapacitated. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

Following the administration of the FAMIS CAHPS surveys, HSAG provided DMAS with an aggregate report of the general child and children with chronic condition populations' CAHPS survey results, representing the CAHPS survey results for the statewide FAMIS program in aggregate (i.e., FAMIS program members enrolled in FFS and managed care).

Calculation of Additional Performance Measures

Project Overview

DMAS contracts with HSAG to calculate one performance measure annually. This document provides an overview of the methodology for the CY 2019 and CY 2020 Prediabetes performance measure rate calculation.

Performance Measure

DMAS requested HSAG develop a custom measure related to identifying members with prediabetes who were prescribed metformin and adhered to metformin during the measurement year. Based on discussions with DMAS, HSAG developed the following custom measure specifications.

Definitions

- Index Prescription Start Date (IPSD)—The earliest prescription date for metformin during the measurement year.
- Treatment Period—The period of time beginning on the IPSD through the last day of the measurement year.
- Calculating number of days covered:
  - Drugs are defined as being the same or different based off the generic product name provided in the NDC list. Drugs with the same generic product name are considered the same drug and drugs with a different generic product name are considered different drugs.

  - If multiple prescriptions are dispensed on the same day, calculate the number of days using the prescription with the longest days' supply.
  - If multiple prescriptions for different medications are dispensed on different days, count each day within the treatment period only once.
  - If multiple prescriptions for the same medications are dispensed on different days, sum the days' supply, and use the total to count the number of days covered. For example, if a member had three metformin prescriptions dispensed on different days, each with a 30-day supply, sum the days' supply for a total of 90 days covered by metformin (even if there is overlap).
- Proportion of Days Covered (PDC)—The number of days a member is covered by at least one metformin prescription, divided by the number of days in the treatment period.

Eligible Population

Age

Members 18 to 60 years of age during the measurement year.

Continuous Enrollment

Members must be continuously enrolled for the measurement year.

Allowable Gap

Members can have at most one gap in enrollment of at most 45 days during the measurement year. If a member has more than one gap during the year or the gap exceeds 45 days, then the member is excluded from the measure.

Anchor Date

Member must be enrolled on December 31 of the measurement year.

Event/Diagnosis

None.

Exclusions

Exclude women who were pregnant (Pregnancy Code Set) during the measurement year from the eligible population.

Administrative Specifications

Rate 1: Prevalence of Prediabetes

Denominator

The eligible population.

Numerator

Identify all members in the denominator who had one or both of the following:

- A diagnosis of prediabetes (Prediabetes Code Set) during the measurement year
  - Note: Exclude members with a prediabetes diagnosis from the numerator who had any diagnosis of diabetes (Diabetes Code Set) during the measurement year or the two years prior to the measurement year
- At risk of prediabetes by having all three of the following:[B-15]
  - A diagnosis of being overweight/obese (Overweight-Obesity Code Set) during the measurement year
  - A diagnosis of hypertension (Hypertension Code Set) during the measurement year
  - A diagnosis of dyslipidemia (Dyslipidemia Code Set) at any point during the member's history through the end of the measurement year
  - Note: Exclude members at risk of prediabetes from the numerator who had any diagnosis of diabetes (Diabetes Code Set) at any point in the member's history through the end of the measurement year

Rate 2: Metformin Use for Prediabetics

Denominator

The numerator for Rate 1.

Numerator

Identify all members in the denominator who were dispensed metformin medication (Metformin Code Set) at any point during the measurement year.

Exclusions

Due to metformin contraindications, exclude members from the denominator with a diagnosis for severe kidney problems (Severe Kidney Problems Code Set), alcohol abuse (Alcohol Abuse Code Set), chronic hepatitis (Hepatitis Code Set), Cirrhosis (Cirrhosis Code Set), or metabolic acidosis (Metabolic Acidosis Code Set) at any point during the measurement year.

Rate 3: Adherence to Metformin

Denominator

The numerator for Rate 2.

[B-15] HSAG will assess the prevalence of billing for these conditions during the measure calculation process and work with DMAS to determine if any specification modifications are necessary (i.e., if no or few members have all three conditions, this can be limited to just two conditions).

Numerator

The number of members who achieved PDC of at least 80 percent for their metformin medication during the measurement year.

Step 1: Identify the IPSD.

Step 2: Determine the treatment period.

Step 3: Count the days covered by at least one metformin medication during the treatment period. If the days covered extends past the end of the measurement year (i.e., December 31), subtract the number of days covered from the total days covered (i.e., the days covered cannot be larger than the treatment period).

Step 4: Calculate the member's PDC using the following equation:

$$\left(\frac{Total\ Days\ Covered\ by\ Metformin\ in\ the\ Treatment\ Period}{Total\ Days\ in\ Treatment\ Period}\right) \times 100$$

Step 5: Round the PDC from step 5 to the nearest whole number using the 0.5 rule.

Step 6: Sum the number of members whose PDC was greater than or equal to 80 percent for their treatment period.

Informational Stratification

To determine if any Virginia providers are billing for the National Diabetes Prevention Lifestyle Change Program (DPP) and providing counseling to prediabetic members, HSAG will calculate an informational only measure using the specifications defined below.

Denominator

The numerator for Rate 1 (defined above).

Numerator

Identify all members in the denominator who participated in the DPP (DPP Code Set)[B-16] during the measurement year, as indicated by at least two claims on separate dates of service with a DPP code, and all members who received counseling services (Non-DPP Code Set) during the measurement year, as indicated by at least one claim with a non-DPP code. Three stratifications will be reported:

- DPP Counseling Participation
- Non-DPP Counseling Participation
- Total

[B-16] National DPP Coverage Toolkit. Coding and Billing. Available at: https://coveragetoolkit.org/coding-billing-for-the-national-dpp/. Accessed on: May 5, 2021.

Performance Period

HSAG calculated performance measure rates for CY 2019 and CY 2020 using data collected by DMAS and submitted to HSAG.

Data Collection

The prediabetes performance measure was calculated using administrative data sources, including demographic, enrollment, professional claims/encounters, institutional claims/encounters, and pharmacy data for Medicaid managed care eligible individuals from DMAS. DMAS will supply SAS® data sets extracted by claims' paid dates.[B-17] HSAG retrieved data files from DMAS' secure file transfer protocol (SFTP) site.

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 prediabetes measure rates. The lead analyst produced production programming code to generate the results and output for DMAS. In parallel with the work being performed by the lead analyst, the validation analyst created separate code and confirmed the rates generated by the lead analyst. The Associate 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 rate deliverable submission, HSAG reviewed the final output for appropriate formatting and numerical reasonability.

HSAG calculated a Virginia total rate and stratified results by Medicaid Program (i.e., CCC Plus and Medallion 4.0), MCO, and by managed care geographic region using Federal Information Processing Standards (FIPS) codes. In addition, rates were stratified by age, race, and gender. To align with NCQA's HEDIS *Technical Specifications for Health Plans, Volume 2*, HSAG did not report rates for any category that was based on fewer than 30 members. Table B-9 presents the prediabetes performance measure rate stratifications and values for Medicaid Program, MCO, geographic regions, age, and gender.

Table B-9—Medicaid Program, MCOs, Geographic Regions, Age, and Gender Stratification Values

Stratification	Value
Medicaid Program	CCC Plus, Medallion 4.0
MCOs	Aetna Better Health of Virginia (Aetna), HealthKeepers, Inc. (HealthKeepers), Magellan Complete Care of Virginia (Magellan), Optima Health (Optima), UnitedHealthcare of the Mid-Atlantic, Inc. (United), and Virginia Premier Health Plan, Inc. (VA Premier)

[B-17] SAS is a registered trademark of the SAS Institute, Inc.

Stratification	Value
Geographic Regions	Central, Charlottesville/Western, Northern & Winchester, Roanoke/Alleghany, Southwest, and Tidewater
Age	18–44, 45–60, and Total
Gender	Male, Female

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

Table B-10—Race Category Stratification Values

Stratification	Value
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

Birth Outcomes Focus Study Methodology

Purpose

DMAS contracted with HSAG to conduct a focus study that will provide quantitative information about prenatal care and associated birth outcomes among Medicaid recipients. The Birth Outcomes Focus Study addressed the following questions:

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

Study Design

Measurement Period

The study included all singleton births paid by Virginia Medicaid during CY 2019. Results for CY 2017 and CY 2018 were taken from a previously published report and included in the current study for trending purposes. However, CY 2019 is the first year that members part of Medicaid Expansion received services paid by Virginia. Therefore, caution should be exercised when comparing CY 2019 results to CY 2017 and CY 2018 results given that Medicaid Expansion members are only included in the CY 2019 results.

Eligible Population

The eligible population consisted of all live births during CY 2019 that were paid by Virginia Medicaid regardless of whether the births occurred in Virginia. Births paid by Virginia Medicaid were assigned to one of four Medicaid program categories based on the mother's program at the time of delivery:

- The FAMIS MOMS program uses Title XXI (Children's Health Insurance Program [CHIP] Demonstration Waiver) funding to serve pregnant women with incomes up to 205 percent [B-18] of the federal poverty level (FPL) and provides benefits similar to Medicaid through the duration of pregnancy and for 60 days postpartum.
- The Medicaid for Pregnant Women program uses Title XIX (Medicaid State Plan) funding to serve pregnant women with incomes up to 143 percent of the FPL.
- The Medicaid Expansion program uses Title XIX funding to serve women 19 years of age and older with incomes up to 138 percent of the FPL.
- The "Other Medicaid"[B-19] programs include births paid by Medicaid that do not fall within the FAMIS MOMS, Medicaid for Pregnant Women, or Medicaid Expansion categories.

To examine outcomes among all Virginia Medicaid-paid births, births were grouped into a study population and a comparison group based upon the timing and length of the mother's Medicaid enrollment:

- Study Population: women enrolled in FAMIS MOMS, Medicaid for Pregnant Women, Medicaid Expansion, or Other Medicaid programs on the date of delivery who were enrolled in any Medicaid program or a combination of programs for a minimum of 90 days prior to, and including, the date of delivery.
- Comparison Group: women enrolled in any of the four Medicaid programs (i.e., FAMIS MOMS, Medicaid for Pregnant Women, Medicaid Expansion, or Other Medicaid) on the date of delivery with continuous enrollment of 90 days or less in any Medicaid program prior to the date of delivery.

[B-18] A standard disregard of 5 percent FPL is applied if the woman's income is slightly above the FPL.

[B-19] The "Other Medicaid" category includes births paid by Medicaid that do not fall within the FAMIS MOMS or the Medicaid for Pregnant Women programs (i.e., the pregnancy aid categories).

Data Collection

From Medicaid member demographic and eligibility data provided by DMAS, HSAG assembled a list of female members between the ages of 10 and 55 years with any Medicaid eligibility during CY 2019 who were eligible for the focus study. This list was submitted to DMAS for linkage to VDH birth registry. Members eligible for the data linkage included Virginia Medicaid members with a live birth paid by Title XIX or Title XXI during the measurement period, regardless of whether the birth occurred in Virginia.[B-20] Deterministic and probabilistic data linkage methods were used by DMAS to match HSAG's list of potential study members to birth registry records.[B-21] DMAS returned a data file to HSAG containing the information from HSAG's original member list and selected birth registry data fields for matched members from both data linkage processes.

Indicators

HSAG calculated the following study indicators to assess the study questions for all singleton, live births paid by Virginia Medicaid during CY 2019:

- *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 inadequate prenatal care is also presented to demonstrate 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).
- *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 at less than 1,500 grams) and the low birth weight category (i.e., birth weights between 1,500 and 2,499 grams).

Results for each study indicator were calculated for all singleton births occurring during CY 2019. For national benchmark comparisons, HSAG used the Healthy People 2030 goals, using data derived from the CDC, National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS), for the *Births with Early and Adequate Prenatal Care* and *Preterm Births (<37 Weeks Gestation)* study

B-20 The Virginia birth registry contains records of live births; other pregnancy outcomes are not included in this study.

B-21 The deterministic data linkage sought to match potential study members with birth registry records using only the maternal SSN. The probabilistic data linkage used the Link Plus software program to probabilistically match study members with birth registry records using the following maternal information: last name, first name, SSN, residential street address, city of residence, and five-digit residential ZIP Code.

indicators.[B-22] HSAG used the Federal Fiscal Year (FFY) 2019 CMS Core Set benchmarks for the *Newborns with Low Birth Weight (<2,500 grams)* study indicator.[B-23]

Dental Utilization in Pregnant Women Data Brief Methodology

Overview

DMAS contracted with HSAG to conduct the 2020–21 EQR Task P: Dental Utilization in Pregnant Women Data Brief activity, which assesses dental utilization among pregnant women covered by Virginia Medicaid or FAMIS MOMS through the VA Smiles for Children program that is administered by DentaQuest. This document outlines HSAG's methodology for performing this analysis.

Data Sources

HSAG will use the member enrollment and eligibility, and claims/encounter data files provided by DMAS in July 2021 for the analysis.

Measurement Period

HSAG will assess the utilization of dental services during the prenatal and postpartum periods for women with deliveries from January 1, 2020, through December 31, 2020.[B-24]

Eligible Population

HSAG will identify women with a delivery during the measurement period using the member enrollment and eligibility, and claims/encounter data provided by DMAS. HSAG will identify deliveries using the *Deliveries Value Set* from the *Prenatal and Postpartum Care* measure in the Federal Fiscal Year (FFY) 2021 CMS Adult and Child Core Set of Health Care Quality Measures.[B-25]

[B-22] Healthy People 2030. Pregnancy and Childbirth. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Available at: https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth. Accessed on: Oct 19, 2020.

[B-23] Performance on the Child Core Set Measures, FFY 2019." *Child Health Care Quality Measures*, Centers of Medicare & Medicaid Services, Oct. 2020. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html. Accessed on: Oct 19, 2020.

[B-24] A women's pregnancy would begin during March 2019 for a live birth delivered on January 1, 2020. Therefore, all women with deliveries beginning in CY 2020 would have been eligible for the VA Smiles for Children program, contingent upon their enrollment in Medicaid or FAMIS MOMS.

[B-25] Centers for Medicare & Medicaid Services. Core Set of Adult and Child Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for Federal Fiscal Year 2021 Reporting, March 2021. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html. Accessed on: June 7, 2021.

HSAG will only include women 21 years of age and older at the time of conception through the end of the month following the 60th day after delivery. HSAG will estimate the time of conception as 280 days prior to the date of delivery.[B-26]

Study Indicators

HSAG will use the dental encounter data to determine which dental services, if any, were utilized during the member's pregnancy or postpartum period. Table B-11 outlines the study indicators HSAG will include in the analysis.

Table B-11—Dental Utilization Study Indicators

Study Indicators	Description/Values
Any Dental Service	Utilization of any dental services during pregnancy, based on the DentaQuest list of covered services[B-27, B-28]
Adjunctive Services[B-29]	Utilization of Adjunctive Services, including IV sedation and emergency services provided for relief of dental pain, determined by the following current dental terminology (CDT) codes: D9110, D9222, D9223, D9230, D9239, D9243, D9248, D9310, D9420, D9610, D9630, D9930, D9990, D9992, D9994, D9995, D9996, or D9999
Crowns	CDT codes D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2794, D2920, or D2931
Diagnostic Services	CDT codes D0120, D0140, D0150, D0170, D0220, D0230, D0240, D0250, D0251, D0270, D0272, D0274, or D0330
Endodontics	CDT codes D3110, D3120, D3221, D3310, D3320, or D3330
Periodontics	CDT codes D4210, D4211, D4341, D4342, D4346, D4355, or D4910
Preventive Services	CDT codes D1110 or D1208
Prosthodontics	CDT codes D5110, D5120, D5213, D5214, D5410, D5411, D5421, D5422, or D6930

[B-26] The VA Smiles for Children program covers most dental services for pregnant women aged 21 years and older through their pregnancy and postpartum period. Further information about the program is available at: https://www.dentaquest.com/getattachment/State-Plans/Regions/Virginia/Dentist-Page/VA-Smiles-For-Children-ORM.pdf/?lang=en-US.

[B-27] HSAG will only include paid claims and will exclude any zero-paid claims as part of the analysis.

[B-28] DentaQuest, LLC. Office reference manual Smiles for Children Commonwealth of Virginia Medicaid, FAMIS, FAMIS Plus, Dental Program. Available at: https://dentFaquest.com/getattachment/State-Plans/Regions/Virginia/Dentist-Page/va-smiles-for-children-orm.pdf/?lang=en-US. Accessed on: April 26, 2021.

[B-29] DentaQuest, LLC. Office reference manual Smiles for Children Commonwealth of Virginia Medicaid, FAMIS, FAMIS Plus, Dental Program. Available at: https://dentFaquest.com/getattachment/State-Plans/Regions/Virginia/Dentist-Page/va-smiles-for-children-orm.pdf/?lang=en-US. Accessed on: April 26, 2021.

Study Indicators	Description/Values
Restorative Services, including Crowns	CDT codes D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2794, D2920, D2931, D2940, D2950, D2951, D2952, or D2954
Surgery or Extractions	CDT codes D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7285, D7286, D7288, D7310, D7311, D7320, D7321, D7450, D7451, D7471, D7472, D7473, D7510, D7511, or D7880

Study Indicator Stratifications

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

Table B-12—Study Indicator Stratifications

Stratification	Description/Values
Medicaid Program	The Medicaid Program the woman was enrolled with on the date of delivery: • FAMIS MOMS (Eligibility category 005) • Medicaid for Pregnant Women (Eligibility categories 091, 097) • Medicaid Expansion (Aid categories 100, 101, 102, 103, 106, and 108) • LIFC (Aid category 081) • Other Medicaid (will include all other births not covered by FAMIS MOMS, Medicaid for Pregnant Women, Medicaid Expansion, and LIFC; will exclude births to women in Plan First [aid category: 080] and DOC [aid category: 109])
Medicaid Delivery System	• Fee-for-Service (FFS) • Managed Care
Managed Care Program	• Medallion 4.0 • CCC Plus • FAMIS
Perinatal Timing of Dental Service	The perinatal timing of the utilization of dental services. The following categories will be presented: • Prenatal period: the 280 days prior to the date of delivery • Postpartum period: through the end of the month following the 60 days after the date of delivery • Both: anytime during the prenatal and postpartum periods defined above

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

Foster Care Focus Study Methodology

Purpose

Beginning in state fiscal year (SFY) 2015–2016, DMAS contracted with HSAG to conduct an annual focus study that assesses healthcare utilization among foster care children receiving medical services through Medicaid MCOs.[B-30] The SFY 2019–2020 foster care focus study provided data to determine how the healthcare utilization among children in foster care compares to utilization among children not in foster care and receiving Medicaid managed care benefits.

Study Design

Measurement Period

The study included children in foster care for any length of enrollment between January 1, 2019, and December 31, 2019.

Eligible Population

The eligible population included all children enrolled in Medicaid under 18 years of age as of January 1, 2019, and who were enrolled in Virginia Medicaid under Aid Category "76" (Children in Foster Care) for any length of time during the January 1, 2019, to December 31, 2019, measurement year (MY).

HSAG identified all children enrolled in the foster care aid category at any point during the measurement period. The study indicators applied to different sub-groups of children in foster care, HSAG assigned each child to the following groups based on Medicaid enrollment; a child may be assigned to multiple groups:

- Foster care population: All children enrolled in the foster care aid category for any length of time during the measurement period.
- Continuously enrolled foster care population: All children in the foster care population continuously enrolled in managed care with any MCO or combination of MCOs from January 1, 2019, through December 31, 2019, with one or more gaps in enrollment totaling no more than 45 days.
- Study population: All children in the continuously enrolled foster care population who were matched to a comparable child not in foster care and receiving Medicaid managed care benefits.

Since this study compared healthcare utilization among children in foster care and their Medicaid peers not in foster care, HSAG identified a comparison group of children not in foster care and receiving Medicaid managed care benefits ("non-foster children"). HSAG used exact matching and propensity score-based matching to identify a group of non-foster children that is statistically similar to the

[B-30] Most children in foster care who received Medicaid benefits were transitioned from fee-for-service (FFS) programs to managed care no later than June 2014. Under Medallion 3.0, some children in foster care continued to receive Medicaid services on an FFS basis because they met exclusion criteria for managed care participation, such as utilizing Medicaid benefits as secondary insurance or receiving residential care services.

continuously enrolled children in foster care. Propensity score-based matching allowed for the construction of a comparison group similar to the treatment group (i.e., children in foster care) without the use of randomized selection. As such, the propensity score reduces bias and controls for multiple confounders. Children were matched using demographic characteristics, including age, gender, race/ethnicity, MCO enrollment, and selected health conditions (e.g., psychotic disorders, attention-deficit/hyperactivity disorder [ADHD]).[B-31] Once the matches were made, HSAG evaluated the similarity between the matched children in foster care (i.e., the study population) and the matched non-foster children (i.e., the comparison group) through a variety of tests and assessments.[B-32]

Data Collection

HSAG extracted information needed for the study from administrative claims and encounter data as well as member, provider, and enrollment data supplied by DMAS. In addition, DMAS supplied HSAG with dental encounter data from the Medicaid Dental Benefit Manager, DentaQuest, and behavioral health encounter data from Magellan. During July 2020, DMAS provided HSAG with data for claims and encounters paid through June 30, 2020, resulting in a six-month data runout from the end of the measurement period to data extraction.

Indicators

For consistency with other quality initiatives, healthcare utilization indicators are based on either the 2020 Child Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) or the HEDIS 2020 technical specifications.[B-33] However, HSAG modified the HEDIS continuous enrollment criteria to reflect the ability of children in foster care to move between MCOs during the measurement period. Additionally, indicators for the continuously enrolled foster care population and the study population will also be calculated for the non-foster children.

HSAG assessed 13 measures, representing 19 study indicators, across the following domains:

- *Primary Care*: One indicator in this category provided information on the degree to which foster children and comparable non-foster children utilized primary care services.
  - Children and Adolescents' Annual Access to PCPs
- *Oral Health*: Two indicators in this category provided information on the degree to which foster children and comparable non-foster children utilized oral health services.
  - Annual Dental Visit
  - Preventive Dental Services

[B-31] First, HSAG exact-matched groups of children on characteristics used for stratification. HSAG then used a Greedy 5 → 1 algorithm to select the "best" matches within the exact-matched groups, followed by the next "best" matches until no more matches can be made at a reasonable caliber. Specifically, this algorithm matched children in foster care with non-foster children using a propensity score rounded to the fifth decimal place until no more matches can be made. Then, matches were made on the propensity score rounded to the fourth decimal place, and so on down to one decimal place.

[B-32] HSAG evaluated covariate balance between the two matched groups using bivariate statistical testing (i.e., chi-square and two-sample *t*-tests), an assessment of standardized differences, and an omnibus test to evaluate statistical balance across all covariates simultaneously.

[B-33] HEDIS 2020 technical specifications align with indicator results reported to NCQA for the measurement period from January 1, 2019, through December 31, 2019.

- *Behavioral Health*: Twelve indicators in this category provided information on the degree to which foster children and comparable non-foster children utilized behavioral health services. A subsection encompassing three of the indicators provided information on healthcare utilization related to substance use disorders.
  - 7-Day Follow-Up After Hospitalization for Mental Illness
  - 30-Day Follow-Up After Emergency Department Visit for Mental Illness
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
  - Follow-Up Care for Children Prescribed ADHD Medication
    - One-Month Follow-Up
    - Two-Month Follow-Up
    - Three-Month Follow-Up
    - Six-Month Follow-Up
    - Nine-Month Follow-Up
- Substance Use Disorders
  - 30-Day Follow-Up After ED Visit for AOD Abuse or Dependence
  - Initiation and Engagement of AOD Abuse or Dependence Treatment
    - Initiation
    - Engagement
- *Reproductive Health*: Three indicators in this category provided information on the degree to which foster children and comparable non-foster children utilized reproductive health services.
  - Chlamydia Screening Among Women
  - Contraceptive Care
    - Most Effective or Moderately Effective Method
    - Long-Acting Reversible Method
- *Respiratory Health*: One study indicator in this category provided information on the degree to which foster children and comparable non-foster children utilized respiratory health services.
  - Asthma Medication Ratio

Comparative Analyses

HSAG performed appropriate statistical testing to assess whether the indicator rates are statistically different between the children in foster care (i.e., the study population) and their matched non-foster peers (i.e., the comparison group). HSAG used regression analyses to compare any differences in study indicator rates between the two populations. Matching on the propensity score demonstrated a "covariate balance" between the two matched groups. However, once the groups are subset at the study indicator level (i.e., excluding individuals who do not meet denominator criteria for a selected indicator) the indicator-specific groups may no longer be balanced. To control for any imbalance between groups at the study indicator level, HSAG evaluated outcomes using either a linear or logistic regression with observable covariates used as controls.

Deliverables

HSAG presented the focus study findings in a written report and supplied a copy of the analytic dataset to DMAS as an Excel workbook with an accompanying data dictionary. HSAG also produced a corresponding PowerPoint slide deck based upon the report for DMAS' use.

Consumer Decision Support Tool Methodology

Project Overview

DMAS contracted with HSAG to analyze MY 2020 HEDIS results, including MY 2020 CAHPS data from six Virginia Medallion 4.0 MCOs for presentation in the 2021 Virginia Medallion 4.0 Consumer Decision Support Tool. The Consumer Decision Support Tool analysis helps support DMAS' public reporting of MCO performance information.

Data Collection

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

Reporting Categories

The Medallion 4.0 Consumer Decision Support Tool reporting categories and descriptions of the measures they contain are:

- **Overall Rating:** Includes all HEDIS and CAHPS measures included in the 2021 Consumer Decision Support Tool analysis. This category also includes adult and child CAHPS measures on consumer perceptions of the overall rating of the MCO and their overall health care.
- **Doctors' Communication:** Includes adult and child CAHPS composites and items on consumer perceptions about how well their doctors communicate and the overall ratings of personal doctors. Additionally, this category includes a CAHPS measure related to medical assistance with smoking and tobacco use cessation.
- **Getting Care:** Includes adult and child CAHPS composites on consumer perceptions regarding the ease of obtaining needed care. This category includes HEDIS measures that assess adults' access to care, as well as appropriate follow-up for mental illness and alcohol or other drug (AOD) abuse or dependence.
- **Keeping Kids Healthy:** Includes HEDIS measures of how often preventive services and appropriate treatment are provided (e.g., child immunizations, well-child/well-care visits, attention deficit hyperactivity disorder [ADHD] medication follow-up care, and first-line psychosocial care for children and adolescents prior to prescribing antipsychotics).

- **Living With Illness:** Includes HEDIS measures that assess how well MCOs take care of people who have chronic conditions (e.g., diabetes and high blood pressure). In addition, this category includes HEDIS measures that assess medication management for people living with depression and asthma.
- **Taking Care of Women:** Includes HEDIS measures that assess how often women-specific services are provided (e.g., screenings for breast cancer and cervical cancer, and prenatal and postpartum care).

Measures Used in Analysis

DMAS, in collaboration with HSAG, chose measures for this year's Consumer Decision Support Tool based on a number of factors. In an effort to align with the Performance Withhold Program (PWP), the administrative HEDIS measures evaluated as part of the PWP were included in this analysis, as well as other administrative HEDIS and CAHPS survey measures required by the Medallion 4.0 Managed Care Contract for reporting. Per NCQA specifications, the CAHPS 5.1H Adult Medicaid Health Plan Survey instrument was used for the adult population and the CAHPS 5.1H Child Medicaid Health Plan Survey instrument was used for the child population.

Table B-13 lists the 41 measure indicators, 12 CAHPS and 29 HEDIS, and their associated weights. Weights were applied when calculating the category summary scores and the confidence intervals to ensure that all measures contribute equally in the derivation of the final results. Please see the Comparing MCO Performance section for more details.

Table B-13—Medallion 4.0 Consumer Decision Support Tool Reporting Categories, Measures, and Weights

Measures	Measure Weight
Category: Overall Rating [B-34]	
Adult Medicaid—Rating of Health Plan (CAHPS Global Rating)	1
Child Medicaid—Rating of Health Plan (CAHPS Global Rating)	1
Adult Medicaid—Rating of All Health Care (CAHPS Global Rating)	1
Child Medicaid—Rating of All Health Care (CAHPS Global Rating)	1
Category: Doctors' Communication	
Adult Medicaid—How Well Doctors Communicate (CAHPS Composite)	1
Child Medicaid—How Well Doctors Communicate (CAHPS Composite)	1
Adult Medicaid—Rating of Personal Doctor (CAHPS Global Rating)	1
Child Medicaid—Rating of Personal Doctor (CAHPS Global Rating)	1
Medical Assistance With Smoking and Tobacco Use Cessation	
Advising Smokers and Tobacco Users to Quit	1/3
Discussing Cessation Medications	1/3

[B-34] To calculate the Overall Rating category, all 41 CAHPS and HEDIS measures are included in the analysis. Please note that the CAHPS measures listed in the Overall Rating reporting category are exclusive to the reporting category.

Measures	Measure Weight
Discussing Cessation Strategies	1/3
Category: Getting Care	
Adult Medicaid—Getting Needed Care (CAHPS Composite)	1
Adults' Access to Preventive/Ambulatory Health Services	
20–44 Years	1/3
45–64 Years	1/3
65+ Years	1/3
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	1
Follow-Up After Emergency Department (ED) Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total	1
Follow-Up After Emergency Department Visit for Mental Illness	
7-Day Follow-Up—Total	1/2
30-Day Follow-Up—Total	1/2
Category: Keeping Kids Healthy	
Childhood Immunization Status—Combination 3	1
Well-Child Visit in the First 30 Months of Life	
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	1
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	1
Child and Adolescent Well-Care Visits	
3–11 years	1
12–17 years	1
18–21 years	1
Follow-Up Care for Children Prescribed ADHD Medication	
Initiation Phase	1/2
Continuation and Maintenance Phase	1/2
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	1
Category: Living With Illness	
Comprehensive Diabetes Care	
Hemoglobin A1c (HbA1c) Testing	1/5
HbA1c Poor Control (>9.0 Percent)	1/5
HbA1c Control (<8.0 Percent)	1/5
Eye Exam (Retinal) Performed	1/5
Blood Pressure Control (<140/90 mm Hg)	1/5
Controlling High Blood Pressure	1

Measures	Measure Weight
Asthma Medication Ratio—Total [B-35]	1
Antidepressant Medication Management	
Effective Acute Phase Treatment	1/2
Effective Continuation Phase Treatment	1/2
Category: Taking Care of Women	
Breast Cancer Screening	1
Cervical Cancer Screening	1
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	1
Postpartum Care	1

Missing Values

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

- *Not Reported (NR)*—MCOs chose not to submit data, even though it was possible for them to do so.
- *Biased Rate (BR)*—MCOs' measure rates were determined to be materially biased in a HEDIS Compliance Audit.
- *Not Applicable (NA)*—MCOs were unable to provide a sufficient amount of data (e.g., too few members met the eligibility criteria for a measure).

In developing scores and ratings for the reporting categories, HSAG handled the missing rates for measures as follows:

- Rates with an *NR* designation were assigned the minimum rate.
- Rates with a *BR* designation were assigned the minimum rate.
- Rates with an *NA* designation were assigned the average value.

For measures with an *NA* audit result, HSAG used the mean of non-missing observations across all MCOs. For measures with an *NR* or *BR* audit result, HSAG used the minimum value of the non-missing observations across all MCOs. This minimized the disadvantage for MCOs that were willing but unable to report data and ensured that MCOs did not gain advantage from intentionally failing to report complete and accurate data. If more than half of the plans had an NR, BR, or NA for any measure, then the measure was excluded from the analysis.

[B-35] This measure is not required in the Medallion 4.0 managed care contract; however, the *Medication Management for People With Asthma* measure was retired and DMAS allows for the use of this measure as a replacement in the Consumer Decision Support Tool.

For MCOs with NR, BR, and NA audit results, HSAG used the average variance of the non-missing observations across all MCOs. This ensured that all rates reflected some level of variability, rather than simply omitting the missing variances in subsequent calculations.

Additionally, HSAG replaced missing values where an MCO reported data for at least 50 percent of the indicators in a reporting category. If an MCO was missing more than 50 percent of the measures that comprised a reporting category, HSAG gave the MCO a designation of "Insufficient Data" for that category.

Comparing MCO Performance

HSAG computed six summary scores for each MCO, as well as the summary mean values for the MCOs as a group. Each score was a standardized score where higher values represented more favorable performance. Summary scores for the six reporting categories (Overall Rating, Doctors' Communication, Getting Care, Keeping Kids Healthy, Living With Illness, and Taking Care of Women) were calculated from MCO scores on selected HEDIS measures and CAHPS questions and composites.

1. HEDIS rates were extracted from the auditor-locked IDSS data sets and HSAG calculated the CAHPS rates using the NCQA CAHPS member-level data files. To calculate a rate for a CAHPS measure, HSAG converted each individual question by assigning the top-box responses (i.e., "Usually/Always," "9/10," and "Yes," where applicable) to a 1 for each individual question, as described in *HEDIS MY 2020 Volume 3: Specifications for Survey Measures*. All other non-missing responses were assigned a value of 0. HSAG then calculated the percentage of respondents with a top-box response (i.e., a 1). For composite measures, HSAG calculated the composite rate by taking the average percentage for each question within the composite.
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 CAHPS global rating measures, the variance was calculated as follows:

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

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

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

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

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

3. For MCOs with *NA* or *NR* audit results, HSAG used the average variance of the non-missing rates across all MCOs. This ensured that all rates reflected some level of variability, rather than simply omitting the missing variances in subsequent calculations.
4. HSAG computed the MCO composite mean for each CAHPS and HEDIS measure.
5. Each MCO mean (CAHPS or HEDIS) was standardized by subtracting the mean of the MCO means and dividing by the standard deviation of the MCO means to give each measure equal weight toward the category rating. If the measures were not standardized, a measure with higher variability would contribute disproportionately toward the category weighting.
6. HSAG summed the standardized MCO means, weighted by the individual measure weights to derive the MCO category summary measure score.
7. For each MCO k, HSAG calculated the category variance, CV_k as:

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

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

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

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

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

10. The statistical significance of each difference was determined by computing a confidence interval (CI). A 95 percent CI and 68 percent CI were calculated around each difference score to identify plans that were significantly higher than or significantly lower than the mean. Plans with differences significantly above or below zero at the 95 percent confidence level received the top (Highest Performance) and bottom (Lowest Performance) designations, respectively. Plans with differences significantly above or below zero at the 68 percent confidence level, but not at the 95 percent

confidence level, received High Performance and Low Performance designations, respectively. A plan was significantly above zero if the lower limit of the CI was greater than zero; and was significantly below zero if the upper limit of the CI was below zero. Plans that do not fall either above or below zero at the 68 percent confidence level received the middle designation (Average Performance). For a given measure, the formulas for calculating the CIs were:

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

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

A five-level rating scale provides consumers with an easy-to-read "picture" of quality performance across MCOs and presents data in a manner that emphasizes meaningful differences between MCOs. Table B-14 shows how the Medallion 4.0 Consumer Decision Support Tool results were displayed:

Table B-14—Medallion 4.0 Consumer Decision Support Tool–Performance Ratings

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

Performance Withhold Program Methodology

Project Overview

DMAS contracted with HSAG, as its EQRO, to establish, implement, and maintain a scoring mechanism, for the managed care Performance Withhold Program (PWP). For the PWP, Medallion 4.0 MCOs' performance is evaluated on five NCQA HEDIS measures and one AHRQ PDI measure. HSAG is responsible for collecting MCOs' audited HEDIS measure rates and the AHRQ PDI measure rates from DMAS. HSAG will validate the one AHRQ PDI measure in accordance with *External Quality Review (EQR) Protocol 2: Validation of Performance Measures: A Mandatory Protocol for External Quality Review (EQR)*, October 2019.[B-36]

[B-36] Department of Health and Human Services, Centers for Medicare and Medicaid Services. *EQR Protocol 2: Validation of Performance Measures: A Mandatory Protocol for External Quality Review (EQR)* 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jun 1, 2020.

Performance Measures

DMAS selected the following HEDIS measures and AHRQ PDI measure for the SFY 2021 PWP, as indicated in Table B-15.

Table B-15—SFY 2021 PWP Measures

Indicator	Measure Specification	Required Reporting Method
Child and Adolescent Well-Care Visits—Total	HEDIS	Administrative
Asthma Admission Rate (per 100,000 Member Months)	ARHQ PDI	Administrative
Childhood Immunization Status—Combination 3	HEDIS	Hybrid
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing	HEDIS	Hybrid
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	HEDIS	Hybrid
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	HEDIS	Hybrid
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	HEDIS	Hybrid
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	HEDIS	Hybrid
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	HEDIS	Administrative
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	HEDIS	Administrative
Prenatal and Postpartum Care—Timeliness of Prenatal Care	HEDIS	Hybrid
Prenatal and Postpartum Care—Postpartum Care	HEDIS	Hybrid

Performance Period

The SFY 2021 PWP assesses CY 2020 performance measure data to determine what portion, if any, the MCOs will earn back from the funds withheld in SFY 2021 (i.e., the 1 percent of capitation payments withheld from July 1, 2020 through June 30, 2021).

Data Collection

The HEDIS Interactive Data Submission System (IDSS) files for the PWP calculation will be audited as required by NCQA. The auditor-locked IDSS files containing the HEDIS measure rates will be provided to HSAG by the MCOs. Starting with the SFY 2020 PWP, DMAS will contract with HSAG, as their EQRO, to validate the AHRQ PDI measure in accordance with *EQR Protocol 2: Validation of Performance Measures: A Mandatory Protocol for External Quality Review (EQR)*, October 2019. Following the performance measure validation, HSAG will provide the true, audited rates for the AHRQ PDI measure to DMAS.

PWP Calculation

With receipt of audited HEDIS measure rates and validated AHRQ PDI measure rates (i.e., non-HEDIS measure rates), each measure will be scored prior to calculating the amount of the quality withhold, if any, each MCO will earn back. Table B-16 provides the HEDIS and non-HEDIS audit designations that will be eligible or ineligible to receive points in the PWP.

Table B-16—HEDIS and Non-HEDIS Audit Designations

HEDIS Audit Designation	Non-HEDIS Audit Designation
Eligible for Points in Medallion 4.0 PWP Analysis	
Reportable (R)	Reportable (R)
Small Denominator (NA)	
Ineligible for Points Medallion 4.0 PWP Analysis	
Biased Rate (BR)	Do Not Report (DNR)
Not Required (NQ)	Not Applicable (NA)
No Benefit (NB)	No Benefit (NR)
Not Reported (NR)	
Unaudited (UN)	

As indicated in Table B-16, only measure rates with a "*Reportable* (*R*)" (HEDIS and non-HEDIS rates) audit result (i.e., the plan produced a reportable rate for the measure in alignment with the technical specifications) or "*Small Denominator* (*NA*)" (HEDIS rates only) audit result (i.e., the plan followed the specifications but the denominator was too small to report a valid rate) will be included in the PWP calculation. Measure rates with the following audit results will receive a score of zero (i.e., the MCO will not be eligible to earn a portion of the quality withhold back for that measure):

- "*Biased Rate (BR)*" audit result for HEDIS measures or "*Do Not Report (DNR)*" audit result for non-HEDIS measures (i.e., the calculated rate was materially biased)
- "*Not Required (NQ)*" audit result for HEDIS measures or "*Not Applicable (NA)*" audit result for non-HEDIS measures (i.e., the plan was not required to report the measure)
- "*No Benefit (NB)*" audit result for HEDIS measures or "*No Benefit (NR)*" for non-HEDIS measures (i.e., the measure was not reported because the plan did not offer the required benefit)
- "*Not Reported (NR)*" audit result for HEDIS measures (i.e., the plan chose not to report the measure)
- "*Unaudited (UN)*" audit result for HEDIS measures (i.e., the measure was not audited)

SFY 2021 PWP

The SFY 2021 PWP will use the MCO's audited HEDIS MY 2020 and validated AHRQ PDI measure data. Table B-17 shows the percentage of withhold associated with each performance measure indicator.

Table B-17—SFY 2021 PWP Measure Weights

Indicator	Measure Weight*
Child and Adolescent Well-Care Visits—Total	16.67%
Asthma Admission Rate (per 100,000 Member Months)	16.67%
Childhood Immunization Status—Combination 3	16.67%
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing	3.33%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	3.33%
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	3.33%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	3.33%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	3.33%
Follow-Up After Emergency Department (ED) Visit for Mental Illness—7-Day Follow-Up—Total	8.33%
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	8.33%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	8.33%
Prenatal and Postpartum Care—Postpartum Care	8.33%

** Please note, the weights listed in the table are rounded values.*

Appendix C. MCO Best and Emerging Practices

Table C-1 identifies the MCOs' self-reported best and emerging practices.

Table C-1—MCOs' Best and Emerging Practices

MCO	Best and Emerging Practices
Aetna	**Aetna Better Health of Virginia Education Series on Chronic Health Conditions** The Education Series Program's primary focus was to empower Aetna's members with the necessary education on managing their chronic conditions and other health concerns. Educating members on chronic condition management which, in return, promoted an improved quality of life. The Education Series on Chronic Health Conditions allowed members to meet with a panel that consisted of staff from care management, pharmacy, community outreach, and behavioral health. The panel also includes a team of affiliated in-network providers, including behavioral health professionals, endocrinologists, pediatricians, obstetricians/gynecologists, social workers, immunization subject matter experts, non-profit organizations, and other appropriate health care professionals that educated members about chronic health conditions. Topics included diabetes management, depression, hypertension, substance abuse and asthma. **Mobile Mammography** In 2021, Aetna Better Health of Virginia's Quality Management department developed a pilot program to partner with an approved in-network health system to offer Aetna Better Health of Virginia members mobile breast cancer screenings. Data analysis conducted determined that Central Virginia, Western/Charlottesville and the Tidewater Regions as having the highest breast cancer rates among MCO membership. As a result, the MCO chose to pilot its mobile mammography in these three regions and partner with University of Virginia Health and Chesapeake Regional Health Systems. Members also had the opportunity to receive an incentive once the screening was completed. Transportation was scheduled in advance for those members that needed assistance. There have been delays in the launch date due to COVID-19, but the MCO anticipated that this initiative will launch successfully in the first quarter of 2022. **Ted E Bear M.D. Wellness Club** Aetna Better Health of Virginia's Ted E. Bear, M.D. Wellness Club was a program offered to members from newborns to 10 years of age. The program promoted and engaged parents to have their child/children complete an annual well-child check-up. The MCO incentivized each member that completed their annual well-child visit with a $10 Walmart gift card, teddy bear, coloring book, crayons, and bookmark. A well-child visit included a physical exam, shots (if applicable), and a growth and development check. Providers were asked to complete an incentive form at the time of the well-child visit that members returned to the MCO and received their incentives. The program was restructured make incentives more age appropriate. In addition to EPSDT, the program also supported the following HEDIS measures: • Childhood Immunization Status - (CIS) • Immunizations for Adolescents - (IMA) • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) • Child and Adolescent Well-Care Visits (WCV) • Well-Child Visits in the First 30 Months of Life (W30)

MCO	Best and Emerging Practices
HealthKeepers	• Partnering with care coordinators and case managers to address gaps in care by sharing monthly gaps in care report • Used of Health Crowd vendor started in 2021 that used focused outreach messaging based on member's gaps in care • Continued Critical Performance Steering Committee and workgroups collaboration • Continued collaboration with Medicaid risk team to develop provider education with opportunities for providers/office staff to obtain continuing medical education/continuing education unit credits • Continued leveraging Collective Medical to notify care coordinators via email or text when member had an emergency department visit • Continued behavioral health homes • Refocused improvement for behavioral health and pharmacy measures • Refocused efforts to improve child and women measures • Used Obstetrical practice consultants employed by Anthem to support and collaborate with obstetrical clinicians and office staff to increase obstetrical provider office understanding of member and provider programs for obstetrics. • Used Early, Periodic, Screening, Diagnostic and Treatment co-branding opportunities • Implemented post office visit survey text message to evaluate visit and address complaints/concerns in order to improve member satisfaction
Magellan	**Pay for Quality (P4Q) Program** Magellan chose a set of select, but critical, quality measures for 2021 that were included in this incentive program. The MCO will pay the primary care group of record a dollar amount per each compliant member after that provider achieves the 50th percentile benchmark for that measure for their assigned panel. **Clinic Day** Magellan partnered with community providers by holding clinic day events for its members. The Clinic Day offered a fun way to encourage members to: • Obtain the health services they needed • Improve health outcomes. • Improve HEDIS score/close care gaps. • Improve member/provider experience. Magellan's approach included identification of members in need of care, offering healthcare access to members by connecting them with PCPs and health education. All of these activities contributed to improved overall health outcome and experience. Magellan's partnered with providers by scheduling member appointments, arranging transportation service, and performing reminder calls. As a result, the MCO reduced administrative burden on provider office staff, decreased no-show rates, and improved member/provider experience.
Optima	• Weekly medical and behavioral care coordination /case management rounds with medical directors • Quarterly baby showers • Quarterly outreach Member Advisory Forums (currently virtual) • Dedicated Optima readmission prevention team with (CipherHealth) to conduct hospital and emergency department post-discharge follow-up calls to members to assist with any member-identified concerns (home health, medications, discharge instructions, etc.)

MCO	Best and Emerging Practices
	• Case management/care coordination care gap dashboard (Tableau) to assist in identifying and closing care gaps when engaging with members • Partners in Pregnancy (PIP) program • Performance Withhold Program monthly tracking grid • Multidisciplinary team approach to improvement in quality measures, meeting monthly • Vendor/partners in care: EMMI, CipherHealth, BiolQ, MDLive, Prealize, Integrated Eye Group (IEG), Ontrak, Lexus Nexus, Focus Care in-home assessments, Progeny, Accordant, Inogen • Focused Early, Periodic, Screening, Diagnostic and Treatment Care Coordination • Behavioral health member engagement program to improve follow-up visits with providers after emergency department visits • Focused vendors for Community Partners in member care: Urban Baby Beginnings, CHIP, Healthy Families, Southeast trans for medical/behavioral health/non-medical transportation • Focused Community Partners for improving social determinants of health (SDoH): United Us, Local Food Banks, Religious Organizations, Salvation Army, STOP Inc (rent, utility assistance), Virginia Department of Health Baby Care Programs, Local Shelters, Local Woman's Shelters, GED Program with financial voucher • Readmission High Risk Discharge Target and Intervention Committee • Power Hour for all staff to provide weekly educational sessions (examples: Asthma, COPD, Diabetes, Motivational Interviewing, Policy and Documentation updates, etc.) • Follow up post-discharge activities (Cipher) • Focused workgroups to impact DMAS Clinical Efficiency measures: – LANE – PPE – Readmissions • Staff training: – 2021 NCQA standards and HEDIS training for Medallion case management – Annual Medicare and Dual Special Needs Plan model of care/product training • Increased access for remote services for staff and members related to COVID • Automated EMMI campaigns (educational videos for members) - Postpartum • Monthly collaboration with Prealize for case studies and process improvements • MCO Collaboratives with Virginia Health Information (VHI) • Collaborative Stakeholder with Brock Institute at Eastern Virginia Medical School for Substance Use Disorder in Pregnant Moms and Parenting Women • DMAS/Optima COVID collaboration to improve member education and access to testing and vaccination • Collaborative partners with DMAS MCO Early Intervention Workgroup and DMAS MCO Foster Care Workgroup **Population Health:** • Newly Developed Population Health Department that encompassed population care, innovations portfolio management, and performance improvement teams • **Population Care Team:** • Provider-led

MCO	Best and Emerging Practices
	• Developed and implemented health plan-based gap closure interventions: – A1c and FIT at home testing kit programs – Diabetic eye exam campaign collaboration with community eye care provider group • **Innovation Portfolio Management Team:** – Developed and utilized a standardized process for innovation portfolio management: o Research, Evaluation & Contracting o Pilot and Validation o Scaling, Monitoring and Promotion o Operations and Optimization – Maintained current partnerships with vendors to facilitate and promote member self-care management – Continued exploration of emerging technology and partnerships to improve health outcomes for our members • **Performance Improvement Team:** – Created performance withhold program dashboard – Performance withhold program measure improvement reviewed monthly and as needed in interdepartmental collaborative meetings – In-home assessments for care gap closure – Establishment of standardized reports for all levels in the organization – Ensured that all team members in the organization had access to needed data to ensure improvement efforts were aligned – Establishment of a member and provider satisfaction improvement committee **Quality Improvement and Accreditation:** • Newly developed quality improvement and accreditation department that encompassed contractual and regulatory, NCQA / accreditation/ certifications, and HEDIS Teams • **Contractual and Regulatory Team:** – Reviews and reporting of Critical Incidents merged to one team. o Streamlined processes where possible. – Completed performance improvement projects. – Developed tracking grid for reporting requirements. • **NCQA / Accreditation / Certifications Team:** – Formalized annual NCQA standards training. – Developed plan for quarterly NCQA mock file audits. – Structured oversight of quality programs/committee governance. • **HEDIS Team:** – Implemented yearlong medical record retrievals, data abstractions, and overreads for gap closure. – Electronic medical record program – Daily review of quality improvement ancillary mailbox for gap closures from CCS and population health – Validating incentives for supplemental data

MCO	Best and Emerging Practices
	Emerging Practices for Medallion 4.0 and CCC Plus: • Vendor/Partners in care: Ontrak (BH), Lexus Nexus, Focus Care in-home assessments, Dario, Carenet • Interdepartmental committee evaluating enhanced member benefits for 2022 to improve SDoH • Additional automated EMMI campaigns (educational videos for members) • Interdepartmental collaboration for improved regulatory and internal reporting processes and data collection • Targeted behavioral health care coordination focusing on inpatient discharges, emergency room utilization and high-risk readmission member focus from behavioral health facilities. • Dedicated behavioral health transition of care coordinators. • Increased focus on SDoH and health equities with creation of a focused SDoH team collaborating with medical and behavioral utilization management/case management departments. • New electronic medical record system with increased capturing of SDoH.
United	• During the COVID-19 national public health emergency, United supported primary care providers and Federally Qualified Health Centers by accelerating funds aligned with the MCO's Community Plan Primary Care Professional Incentive (CP-PCPi) Program, including adding a Capacity Building Pathways component to the Program for provider investment in one of the following areas: – Telemedicine and digital engagement – Novel care strategies – Transitions of care – Collaboration with community organizations – Addressing social needs • United worked with community providers by holding clinic day events for Medicaid members and the community at-large. COVID vaccinations and immunizations were the focus, along with ensuring members obtained other health services as needed and to promote an improved member/provider experience. • United implemented telehealth visits (with both providers and care coordinators) in lieu of face-to-face visits during the COVID-19 PHE, allowing members to receive quality care coordination and services safely in their home. • United was focused on reducing health inequities. To that end, a cross-functional program fosters a holistic approach in reducing health disparities and enhancing the end-to-end consumer experience. Actions included: 1. Staff education 2. Provider education 3. Analysis of data outcomes looking for variation by age, gender, ethnicity, and geography to determine appropriate population specific interventions, and creation of action plans to address any identified disparities. • **Regional, Complex and Behavioral Health Rounds:** United's regional, complex and behavioral health rounds program consisted of care coordinators and representatives from pharmacy, behavioral health, utilization management, and external colleagues as needed. The weekly program addressed both immediate and long-term member needs,

MCO	Best and Emerging Practices
	provides support and resources to ensure member's needs were met and promotes quality outcomes. • **Long-Term Care to Community Rounds:** United's long-term care to community rounds program consisted of care coordinators and representatives from pharmacy, behavioral health, utilization management, and external colleagues as needed. The weekly meeting focused on addressing barriers to transition to the community including natural support, home and community-based services (Personal Care/Attendant Care/Private Duty Nursing), environmental modifications and durable medical equipment. • In addition to using member-level HEDIS and other quality measures, renewed focus with team on monitoring under-utilization of key services that were critical to supporting member needs (e.g., home and community-based services, behavioral health).
VA Premier	**Behavioral Health** • Behavioral Health Care Coordination Crisis Stabilization Provider Outreach Initiative - Care coordination effort to prevent inappropriate or further usage of service for crisis stabilization in the Central Region. The initiative focused on member's discharge planning, referrals to additional services (i.e.: behavioral health services, housing, etc.), and safety planning. • Behavioral Health Transition Care Coordination Initiative – Behavioral health care coordination team supported all members who had a behavioral health inpatient admission with the intent to reduce/eliminate readmissions by engaging members and linking them to community-based services and supports. • Behavioral health chronic care coordinators worked with the enhanced care coordination program that required targeted case managers employed with Community Service Boards (CSBs) to conduct seven-day follow-up with members discharged from acute care facilities. • Behavioral health inpatient reviewers sent notification at admission and discharge to member's care coordinator and/or transition coordinator to initiate discharge planning with inpatient facility to identify and resolve barriers for safe and effective discharge, while initiating community-based services, as needed, to reduce chance for member readmission. **Clinical Care Services** • Reorganized the transition of care (TOC) team and processes to provide higher level quality of care for our member • Targeted members prior to discharge within 72 hours of inpatient hospitalization. • Collaborated with the discharge planners at the facilities to ensure member's needs were met prior to discharge for a successful transition and to prevent readmission • Facilitated/collaborated with the nursing facility to ensure successful transition into community-based setting for CCC Plus members • Initiated skilled nursing facility rounds to decrease length of stay and to provide optimal transition back into the community • Used the Theory of Constraints (TOC) model to enhance collaboration with high-risk behavioral health member needs • Measured goals based on current readmission rates for Medallion 4.0 and CCC Plus and percentage of transitions

MCO	Best and Emerging Practices
	• Focus placed on SDoH, decreasing readmission rates, and increasing percentage of transitions. **Quality and Accreditation** • Practitioner Golden Globe Award (PGA) • Virginia Premier valued quality and safety, especially when coordinating and managing care for members. To promote, enhance, and salute excellence, the MCO sustained a physician recognition program. • Practitioners were recognized for their dedication to quality care, member safety, and improved member outcomes. Annually, the selected recipient was awarded a trophy and certificate for demonstrating commitment to quality and safety. • Quality NCQA internal auditing team • Used a corporate centralized team that managed every NCQA program and associated activities for all lines of business. A best practice model resulted as evidenced by achieving 100 percent on **every** standard and 100 percent on file audits: – Credentialing & Recredentialing – Denials – Case Management – Service Authorizations – Grievances (internal) – Appeals – Pharmacy • These accomplishments were achieved by ensuring consistent interpretation of standards, annual organizational training, monthly departmental collaborative meetings, and a standardized, quarterly auditing program with trended outcomes. As a result of audit outcomes, refresher training was developed and conducted as needed. • Conducted organizational provider virtual site visits • Due to the COVID-19 PHE, NCQA granted health plans the liberty to conduct virtual assessments as an acceptable form of survey. These types of visits enabled prompt service, productive follow-ups, and more specific scheduling. Virtual inspections were conducted between an organizational provider and the MCO using the video call function on a smartphone or tablet. **Virginia Premier utilized the following innovation to conduct virtual surveys:** • Google Earth – Allowed the MCO to review the exterior of a facility, building, or structure's accessibility, appearance, and adequacy. Google Earth allowed site surveyors to review the following independent of assistance from the organizational provider: – Adequacy of parking and building access – Physical appearance – Exterior signs – Handicap parking – Ability to safely approach a facility As a result of this innovative initiative, Virginia Premier conducted 239 virtual Organizational Provider Site Surveys in 2020 and 187 year-to-date for 2021. 100 percent of

MCO	Best and Emerging Practices
	providers received a passing score without any corrective action imposed. These providers were credentialed to provide needed services to members and help maintain network adequacy. **Member Outreach and Maternity Program** • Conducted outreach to pregnant and postpartum members at least monthly and screen for high-risk conditions and postpartum depression • Supplied new moms and families with healthy meals weekly • Provided source food vouchers for fresh fruits and vegetables in food deserts • Educated members on COVID-19, to include immunizations, via virtual social events, text messaging campaigns, and direct member contact • Administered contact free drop off for urgently needed supplies such as diapers, car seats, pack and plays, and formula for those awaiting Women, Infants and Children (WIC) appointments • Supplied members with free breast pumps, education, and support of breastfeeding and pumping • Facilitated quarterly virtual baby showers and Member Advisory Committee meetings • Enhanced virtual presence to remotely reach members • Hosted Facebook Live events (COVID-19, breastfeeding awareness) **Pharmacy** Pediatric Atypical Antipsychotic Program • Implemented clinical coordination program for those members aged 6-12 who were taking an atypical antipsychotic • Mailed care coordination letters to member's primary care providers and prescriber of atypical antipsychotic Ensured appropriate clinical monitoring of the member being completed and reported • Team meetings were held monthly to discuss program, suggest any improvements, and review data results **Hepatitis C Program** • Maintained clinical program to help adherence and therapy completeness • Specialty pharmacy provided member information to care coordinators on who filled Hep C therapy • Care coordinators outreached to members to educate on side effects and provided any additional support needed • Specialty provider sent quarterly and annual reporting, including SVR12 lab work, to show effectiveness of program

Appendix D. MCO Quality Strategy Quality Initiatives

Table D-1 through Table D-6 provide examples of the quality initiatives the MCOs highlighted as their efforts toward achieving the Virginia Quality Strategy's goals and objectives.

Aetna

Table D-1—Aetna's Quality Strategy Quality Initiatives

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	AAP SMS Soft Launch: Members will be sent approximately 1-3 messages each month. If a member is in multiple campaigns, ex. AWC, AAP, BCS, the messages will be staggered so that the member is not bombarded. The timeline can vary for each member, depending on when they are enrolled in the individual campaign.	**Metric 4.3.2:** (AAP) Adults' Access to Preventive/Ambulatory Health Services (Total)
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	AAP SMS Soft Launch: Members will be sent approximately 1-3 messages each month. If a member is in multiple campaigns, ex. AWC, AAP, BCS, the messages will be staggered so that the member is not bombarded. The timeline can vary for each member, depending on when they are enrolled in the individual campaign.	**Metric 4.4.5:** (CBP) Controlling High Blood Pressure
Aim 3: Smarter Spending **Goal 3.2:** Focus on Efficient Use of Program Funds	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	**Not a Quality Strategy Metric:** (AAB) Avoidance of Antibiotic Treatment for Acute Bronchitis
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when	**Metric 4.3.2:** ((AAP) Adults' Access to Preventive/Ambulatory Health Services (45-64)

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
	applicable), that will facilitate with educating members on managing various chronic conditions.	
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	**Metric 4.4.2:** (AMR) Asthma Medication Ratio (Total)
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	**Metric 4.4.5:** (CBP) Controlling High Blood Pressure
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	**Not a Quality Strategy Metric:** (PBH) Persistence of Beta-Blocker Treatment after a Heart Attack
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	**Not a Quality Strategy Metric:** (PCE) Pharmacotherapy Management of COPD Exacerbation - Bronchodilator
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with	**Not a Quality Strategy Metric:** (PCE) Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
	educating members on managing various chronic conditions.	
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	**Not a Quality Strategy Metric:** (CDC) Comprehensive Diabetes Care—Blood Pressure Control (<140/90)
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	**Not a Quality Strategy Metric:** (CDC) Comprehensive Diabetes Care - Attention for Nephropathy
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	**Not a Quality Strategy Metric:** (CDC) Comprehensive Diabetes Care - Eye Exams
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with	**Not a Quality Strategy Metric:** (SPC) Statin Therapy for Patients With Cardiovascular Disease

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
	educating members on managing various chronic conditions.	
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	Benefits of Quitting Tobacco Use Cessation in Pregnant Women: Flyer cobranded with the American Cancer Society to discuss the benefits of quitting smoking/tobacco cessation and the risks of smoking during pregnancy.	**Metric 4.6.2:** (PPC) Prenatal and Postpartum Care
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	BH Hospitalization Taskforce: To improve collaboration and support between UM, CM, and BH departments in working with members.	**Metric 4.1.1:** (FUH) Follow Up After Hosp For Mental Illness - 30 days
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	BH Hospitalization Taskforce: To improve collaboration and support between UM, CM, and BH departments in working with members.	**Metric 4.1.1:** (FUH) Follow Up After Hosp For Mental Illness - 7 days
	CVS Health Tags: Messages attached to Rx bags for flu vaccination.	**Not a Quality Strategy Metric:** (Flu) Flu Vaccinations for Adults Ages 18-64
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Diabetes and Cholesterol Member Mailer: Educational letter sent to members pertaining to diabetes and cholesterol medication management.	**Not a Quality Strategy Metric:** (CDC) Comprehensive Diabetes Care - Blood Pressure Control (<140/90)
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Diabetes and Cholesterol Member Mailer: Educational letter sent to members pertaining to diabetes and cholesterol medication management.	**Not a Quality Strategy Metric:** (CDC) Comprehensive Diabetes Care - Eye Exams
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Diabetes and Cholesterol Member Mailer: Educational letter sent to members pertaining to diabetes and cholesterol medication management.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care – Hemoglobin A1c (HbA1c) Testing
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Diabetes Mailer: Incentive for members that complete a yearly wellness and diabetic exam.	**Not a Quality Strategy Metric:** (CDC) Comprehensive Diabetes Care - Blood Pressure Control (<140/90)

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Diabetes Mailer: Incentive for members that complete a yearly wellness and diabetic exam.	**Not a Quality Strategy Metric:** (CDC) Comprehensive Diabetes Care - Eye Exams
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Diabetes Mailer: Incentive for members that complete a yearly wellness and diabetic exam.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care – Hemoglobin A1c (HbA1c) Testing
Aim 3: Smarter Spending **Goal 3.1:** Focus on Paying for Value	Emergency Department Visits Telephonic Outreach Visit: Call is made to member with 1 OP visit and 2+ ED visits.	**Metric 3.1.4:** (AMB) Ambulatory Care - Outpatient Visits/1000 MM (Total)
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	Ensuring Timeliness of Prenatal Care Quitting for Good: Flyer outlining unsafe habits during pregnancy.	**Metric 4.6.2:** (PPC) Prenatal and Postpartum Care - Timeliness of Prenatal Care
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	Ensuring Timeliness of Prenatal Care Telephonic Outreach: Call made to identified pregnant members to provide education and encourage 1st trimester prenatal care to reduce risk of preterm or low birth weights.	**Metric 4.6.2:** (PPC) Prenatal and Postpartum Care - Timeliness of Prenatal Care
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Metric 4.3.1:** (ADV) Annual Dental Visit (11-14 Yrs.)
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Metric 4.3.4:** (AWC) Adolescent Well-Care Visits
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members **Goal 4.3:** Improve Utilization of Wellness, Screening, and	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Metric 4.6.3:** (CIS) Childhood Immunization Status

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Prevention Services for Members		
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Metric 4.3.4:** (IMA) Immunizations for Adolescents
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Not a Quality Strategy Metric:** (LSC) Lead Screening in Children
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Metric 4.6.5:** (W15) Well-Child Visits in the first 15 Months of Life (6 or more visits)
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Not a Quality Strategy Metric:** (W34) Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Not a Quality Strategy Metric:** (WCC) Weight Assessment Counseling - BMI percentile (Total)
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Not a Quality Strategy Metric:** (WCC) Weight Assessment Counseling - for Nutrition (Total)
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Not a Quality Strategy Metric:** (WCC) Weight Assessment Counseling - Physical Activity (Total)

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Aim 3: Smarter Spending **Goal 3.1:** Focus on Paying for Value	Follow up After Discharge Keep Your Doctor in the Know: Letter mailed to identified members providing education of importance in engaging in follow up appointment within 30 days after hospital discharge.	**Metric 3.1.3:** (FUD) Follow Up After Discharge
Aim 3: Smarter Spending **Goal 3.1:** Focus on Paying for Value	Follow up After Discharge Outbound Call Logic: Outbound caller ID is updated to identify CM calls to members; Member received education from CM re: the importance of engaging in a 30-day post-discharge follow up visit with a PCP or specialist and is provided with assistance with making the appointment if needed	**Metric 3.1.3:** (FUD) Follow Up After Discharge
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	Higher Utilizer Rounds: Integrative round with UM, BH, MM, CM, Pharmacy, PSS representation to focus on stabilizing one member at a time who is a high utilizer of BH IP hospitalizations.	**Metric 4.2.2:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
Aim 3: Smarter Spending **Goal 3.1:** Focus on Paying for Value	Hospital Fax blast: The goal is to ensure that discharging physicians prescribe psychiatric medications that are on formulary, thereby avoiding delays and lack of continuity with medications.	**Metric 3.1.3:** Frequency of Potentially Preventable Readmissions
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Hospital Readmission Reduction Program: Clinical program focused on coordinating care between providers, Case Managers and Clinical Pharmacists as members are discharged from the hospital.	**Metric 4.4.2:** (PDI 14) Asthma Admission Rate 2-17 YO
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Hospital Readmission Reduction Program: Clinical program focused on coordinating care between providers, Case Managers and Clinical Pharmacists as members are discharged from the hospital.	**Metric 4.4.3:** (PQI 05) COPD and Asthma in Older Adults Admissions Rate
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Hospital Readmission Reduction Program: Clinical program focused on coordinating care between providers, Case Managers and Clinical Pharmacists as members are discharged from the hospital.	**Metric 4.4.1:** (PQI 08) Heart Failure Admissions Rate
Aim 4: Improved Population Health	Maternity Incentive Program: Incentive for members going to all prenatal appointments and postpartum check-up.	**Metric 4.6.1:** (PPC) Prenatal and Postpartum Care - Postpartum Care

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Goal 4.6: Improve Outcomes for Maternal and Infant Members		
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	Maternity Incentive Program: Incentive for members going to all prenatal appointments and postpartum check-up.	**Metric 4.6.2:** (PPC) Prenatal and Postpartum Care - Timeliness of Prenatal Care
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	MS Hold Line Flu Shot Message: When members call into plan, they will hear a recorded message reminding them to get their free flu shot.	**Not a Quality Strategy Metric:** (Flu) Flu Vaccinations for Adults Ages 18-64
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care - Attention for Nephropathy
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Not a Quality Strategy Metric:** (CDC) Comprehensive Diabetes Care - Blood Pressure Control (<140/90)
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care - Eye Exams
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care – Hemoglobin A1c (HbA1c) Testing
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.4.5:** (CBP) Controlling High Blood Pressure
Aim 4: Improved Population Health	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures	**Metric 4.6.3:** (CIS) Childhood Immunization Status - Combo 3

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Goal 4.6: Improve Outcomes for Maternal and Infant Members	specifically for our Care Management department.	
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.6.3:** (CIS) Childhood Immunization Status - Combo 10
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	(IMA) Immunizations for Adolescents
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.1.1:** (FUH) Follow Up After Hosp For Mental Illness - 30 days
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.1.1:** (FUH) Follow Up After Hosp For Mental Illness - 7 days
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Not a Quality Strategy Metric:** (Flu) Flu Vaccinations for Adults Ages 18-64
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.4.2:** (AMR) Asthma Medication Ratio (Total)
Aim 3: Smarter Spending **Goal 3.2:** Focus on Efficient Use of Program Funds	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Not a Quality Strategy Metric:** (MRP) Medication Reconciliation Post Discharge
Aim 4: Improved Population Health	PMMP Plan Education (Care Management): Pharmacy Advisor	**Metric 4.2.3:** (HDO) Use of Opioids at High Dosage

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Goal 4.3: Improve Outcomes for Members with Substance Use Disorders	led plan education for our Effectiveness of Care measures specifically for our Care Management department.	
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.4.1:** (PQI 08) Heart Failure Admissions Rate
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Not a Quality Strategy Metric:** (PQI 15) Asthma in Younger Adults Admission Rate
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.4.2:** (PDI 14) Asthma Admission Rate 2-17 YO
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Primary Health Care Model for Adults: Brochures outlining important health screenings to complete with PCP and/or specialist; gender specific.	**Not a Quality Strategy Metric:** (COL) Colorectal Cancer Screening
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Primary Health Care Model for Adults: Brochures outlining important health screenings to complete with PCP and/or specialist; gender specific.	**Metric 4.4.5:** (CBP) Controlling High Blood Pressure
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Primary Health Care Model for Adults: Brochures outlining important health screenings to complete with PCP and/or specialist; gender specific.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care - Blood Pressure Control (<140/90)
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Primary Health Care Model for Adults: Brochures outlining important health screenings to complete with PCP and/or specialist; gender specific.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care - Eye Exams
Aim 4: Improved Population Health	Primary Health Care Model for Adults: Brochures outlining important health screenings to	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care – Hemoglobin A1c (HbA1c) Testing

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Goal 4.4: Improve Health for Members with Chronic Conditions	complete with PCP and/or specialist; gender specific.	
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Primary Health Care Model for Adults: Brochures outlining important health screenings to complete with PCP and/or specialist; gender specific.	**Not a Quality Strategy Metric:** (Flu) Flu Vaccinations for Adults Ages 18-64
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Primary Health Care Model for Adults: Brochures outlining important health screenings to complete with PCP and/or specialist; gender specific.	**Not a Quality Strategy Metric:** (PSA) Non-Recommended PSA-Based Screening in Older Men
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Primary Health Care Model for Adults: Brochures outlining important health screenings to complete with PCP and/or specialist; gender specific.	**Not a Quality Strategy Metric:** (CCS) Cervical Cancer Screening
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Primary Health Care Model for Adults: Brochures outlining important health screenings to complete with PCP and/or specialist; gender specific	**Not a Quality Strategy Metric:** (CHL) Chlamydia Screening in Women - Total
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	Tobacco Use Cessation in Pregnant Women Telephonic Outreach: Calls made to identified pregnant smokers and inform members of available resources and options to engage in smoking cessation.	**Metric 4.6.2:** (PPC) Prenatal and Postpartum Care
Aim 4: Improved Population Health **Goal 4.3:** Improve Outcomes for Members with Substance Use Disorders	Weekly Overdose Outreach Project: Provides benchmark for how many members are in treatment (reports from Pre-Manage are reviewed weekly for recent ED admits for Drug or ETOH overdose, these members are outreached by BH Department to assure safety and encourage engagement in OP SA services).	**Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
Aim 4: Improved Population Health	Weekly Overdose Outreach Project: Provides benchmark for how many members are in	**Metric 4.2.4:** Initiation and Engagement of Alcohol and Other

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Goal 4.3: Improve Outcomes for Members with Substance Use Disorders	treatment (reports from Pre-Manage are reviewed weekly for recent ED admits for Drug or ETOH overdose, these members are outreached by BH Department to assure safety and encourage engagement in OP SA services.).	Drug Abuse or Dependence Treatment
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Well Woman Exam: Incentive for members that completes their Pap test and mammogram.	**Not a Quality Strategy Metric:** (BCS) Breast Cancer Screening
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Well Woman Exam: Incentive for members that completes their Pap test and mammogram.	**Not a Quality Strategy Metric:** (CCS) Cervical Cancer Screening
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Wellness Rewards Program: Program that incentivizes members for completing various screenings and yearly wellness exams.	**Not a Quality Strategy Metric:** (BCS) Breast Cancer Screening
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Wellness Rewards Program: Program that incentivizes members for completing various screenings and yearly wellness exams.	**Not a Quality Strategy Metric:** (CCS) Cervical Cancer Screening
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Wellness Rewards Program: Program that incentivizes members for completing various screenings and yearly wellness exams.	**Not a Quality Strategy Metric:** (CDC) Comprehensive Diabetes Care - Eye Exams
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Wellness Rewards Program: Program that incentivizes members for completing various screenings and yearly wellness exams.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care – Hemoglobin A1C (HbA1c) Testing
Aim 4: Improved Population Health	Wellness Rewards Program: Program that incentivizes members for completing various	**Not a Quality Strategy Metric:** (COL) Colorectal Cancer Screening

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Goal 4.3: Improve Utilization of Wellness, Screening, and Prevention Services for Members	screenings and yearly wellness exams.	
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Wellness Rewards Program: Program that incentivizes members for completing various screenings and yearly wellness exams.	**Not a Quality Strategy Metric:** (Flu) Flu Vaccinations for Adults Ages 18-64
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Wellness Rewards Program: Program that incentivizes members for completing various screenings and yearly wellness exams.	**Not a Quality Strategy Metric:** (PSA) Non-Recommended PSA-Based Screening in Older Men

HealthKeepers

Table D-2—HealthKeepers' Quality Strategy Quality Initiatives

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
Aim 1: Enhance Member Care Experience **Goal 1.1 :** Improve Member Satisfaction **Aim 2:** Effective Patient Care **Goal 2.2:** Ensure Access to Care	• Created a process for Care Coordinators to address Gaps in Care with members • Expanding text messaging and social media campaigns for member outreach • Tracking/trending SDOH needs of members to determine appropriate outreach for preventive care • Assessing for and reducing any disparities pertaining to race/ethnicity/language • Dedicated Case Managers to provide outreach to members who have had a recent ER visit to provide education	**Metric 1.2.3:** Rating of All Health Care **Metric 1.2.1:** Getting Care Quickly **Metric 2.2.3:** Getting Needed Care
Aim 1: Enhance Member Care Experience **Goal 1.1 :** Improve Member Satisfaction	Annually, Anthem Virginia completes a thorough evaluation of member experience by analyzing member complaints and appeals in conjunction with CAHPS member experience survey results. As a	**Metric 1.2.3:** Rating of All Health Care **Metric 1.2.1:** Getting Care Quickly **Metric 2.2.3:** Getting Needed Care

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
Aim 2: Effective Patient Care **Goal 2.2:** Ensure Access to Care	result, the following interventions were implemented: • Meetings held on a regular basis with transportation vendor • Corrective action plan put into place with transportation vendor • Provider offices can chat directly electronically with the prior authorization department to have questions answered. • Updates and additional clinical information can be submitted electronically to pre-authorization department • Added availability of provider telehealth to online physician directories • Added information to member website that has information on getting care that is easy to find, including Quick Start Guide • Network Operations Team enhanced servicing model to increase proactive engagement with providers. • Provider Orientation webinars held monthly to educate providers, highlighting appointment standards and importance of compliance with standards. • Telehealth and Nurse Line was available. Outreach specialists made calls to high risk members to make sure their needs were met. • Work with member communications group to determine the most meaningful way to display important information contained in member handbook • Pursuing digital communication capabilities for members and providers.	
Aim 1: Enhance Member Care Experience	• Evaluated QMR process and made internal changes to that	**Metric 1.3.1:** Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
Goal 1.3: Improve Home and Community-Based Services	ensure accuracy of process and reporting • Added staff to ensure reviews were done timely and to ensure access to care	Appropriate to Their Needs and Personal Goals
Aim 2: Effective Patient Care **Goal 2.1:** Enhance Provider Support	• Provider offices can chat directly electronically with the prior authorization department to have questions answered. • Updates and additional clinical information can be submitted electronically to pre-authorization department • Collaborated with Medicaid Risk Team to develop provider education opportunities for providers/office staff to obtain CMW/CEU credits • Network Operations Team enhanced servicing model to increase proactive engagement with providers. • Provider Orientation webinars held monthly to educate providers, highlighting appointment standards and importance of compliance with standards. • Telehealth and Nurse Line was available. Outreach specialists made calls to high risk members to make sure their needs were met.	**Metric 2.1.1:** Rating of Personal Doctor **Metric 2.1.2:** How Well Doctors Communicate
Aim 2: Effective Patient Care **Goal 2.2:** Ensure Access to Care	• Performed an analysis of primary care and behavioral health services along with specialty care practitioner appointment accessibility to ensure timely access to care for members. • Added availability of provider telehealth to online physician directories • Added information to member website that has information on getting care that is easy to find, including Quick Start Guide • Network Operations Team enhanced servicing model to	**Metric 2.2.3:** Getting Needed Care **Not Quality Strategy Metrics:** • Monitor Network Adequacy • Access and Availability Survey • After Hours Care Survey

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	increase proactive engagement with providers. • Provider Orientation webinars held monthly to educate providers, highlighting appointment standards and importance of compliance with standards. • Telehealth and Nurse Line was available. Outreach specialists made calls to high risk members to make sure their needs were met.	
Not a Quality Strategy Aim: **Not a Quality Strategy Goal:** Reduce Patient Harm	• Identifying and monitoring complaints and grievances and reported quality of care and service issues • Analyze and take action on issues related to quality of care and patient safety • Monitor and provide information to members and practitioners regarding hospital quality data reports on patient safety • Monitor process to determine if critical incidents and potential quality of care concerned are identified, investigated, tracked and reported and any necessary corrections have been implemented. • Credentialing and re-credentialing process in place to confirm practitioners' and providers' credentials and qualifications to practice as network providers and to perform services appropriately within their scope of practice • Establish and monitor implemented procedures for safety in pharmaceutical prescribing and medication management through various operational alerts • Quality of Care Database to track the resolution of quality of care and critical incident issues	No Quality Strategy Metrics provided

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	• Conduct a monthly Medical Advisory Committee (MAC), composed of network providers, representing primary care, Pediatrics, Psychiatry and Health Plan Medical Directors. The committee reviews and approves care management policies and guidelines, reviews and votes annually on our UM and CM program documents, provides critical input to Plan programs and initiatives, and reviews quality of care issues for referral to the plan's credentialing committee. • Developing a process for early identification of members with complex medical needs who may be eligible for additional services that will provide them with the highest quality of care by referring them to appropriate Commonwealth agencies as indicated. Case Management Team will work to ensure that members are given guidance and support while going through the process of applying for community based waiver services ensuring that safety and medical needs are met.	
Aim 3: Smarter Spending **Goal 3.1:** Focus on Paying for Value	• Clinical Efficiencies-DMAS	**Metric 3.1.2:** Frequency of Emergency Department Visits
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	• Utilize PreManage/Collective Medical reports to identify members with high utilization of ED and inpatient admissions to improve access to most appropriate levels of care/services • Health Plan staff collaboration within Quality and BH depts. at Health Plan to evaluate member (gap in care) missing services list and implement interventions & strategies.	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness **Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness **Metric 4.1.3:** Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	• Telehealth option that provides both medical (urgent care) and behavioral health services (psychology and psychiatry). HealthCrowd promotion/marketing. • Provider education to entire Anthem provider network to educate providers regarding HEDIS specifications. Includes both medical and behavior health HEDIS procedures and documentation requirements. • Field-based staff case management and/or non-clinical peer supports to locate and engage members to follow up with appointments and medications. • BH Provider Incentive Program-Partnership with select CMHCs to reward providers for improvements in selected HEDIS measures. • ADHD New Start Program-Analysis of pharmacy claims identify a new (first time) prescription for ADHD medications. Member IVR telephone New Start education, Member telephone IVR Follow Up Care education and education mailings. • ADHD Pharmacy - Prescriber Outreach- Retrospective drug utilization review (DUR), notifying most frequent Prescriber of ADHD recommendations with Pharmacy Care Notes (PCN). • Medication Synchronization-Enterprise Pharmacist: Allows pharmacy to override Refill Too Soon edit with a shorter day supply with a prorated copay so they can make one trip to the pharmacy for all refills- this will help with adherence.	
Aim 4: Improved Population Health	• Utilize PreManage/Collective Medical reports to identify	**Metric 4.2.2:** Follow-Up After Emergency Department Visit for

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
Goal 4.2: Improve Outcomes for Members with Substance Use Disorders	members with high utilization of ED and inpatient admissions to improve access to most appropriate levels of care/services • Health Plan staff collaboration within Quality and BH depts. at Health Plan to evaluate member (gap in care) missing services list and implement interventions & strategies. • Telehealth option that provides both medical (urgent care) and behavioral health services (psychology and psychiatry). HealthCrowd promotion/marketing. • Provider education to entire Anthem provider network to educate providers regarding HEDIS specifications. Includes both medical and behavior health HEDIS procedures and documentation requirements. • Field-based staff case management and/or non-clinical peer supports to locate and engage members to follow up with appointments and medications. • BH Provider Incentive Program-Partnership with select CMHCs to reward providers for improvements in selected HEDIS measures.	Alcohol and Other Drug Abuse or Dependence **Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening and Prevention Services for Members **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	• Care Compass HEDIS Alerts: Case managers, during regular contact with members, provide reminders of missed services and education on missed services. • HealthCrowd: Multi-model (IVR call, SMS, email, text) Informative/educational message to members regarding the 4 diabetes screenings & to remind them to make an appointment with their PCP.	**Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life Child and Adolescent Well Care Visits **Not a Quality Strategy Metric** Breast Cancer Screening **Not a Quality Strategy Metric** Cervical Cancer Screening **Not a Quality Strategy Metric** Chlamydia Cancer Screening

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	• Gaps in Care Reports: Data reports generated from HEDIS data set, and letters are sent to providers with list of members to follow-up to ensure services are completed. Returned medical records are data entered into the MRDB. • PQIP—The Provider Quality Incentive Program (PQIP or the Program) rewards our valued providers for the quality care they provide our Medicaid members. Using a system of Scorecard Measures, PQIP seeks to encourage efficient, preventive and cost-effective health care practices. Eligible PCPs who meet quality benchmarks and improvement and medical cost management targets will receive additional payments. • Provide information on new transportation vendor prominently on member website. • Partnering with Care Delivery Transformation (CDT) Team, Provider Relations, and Marketing to identify and educate providers with low quality scores. • Continuous HEDIS training for Case Managers/Care Coordinators. • Care Coordinators continue addressing gaps in care with members by using the Gap in Care Report. • Expanding HealthCrowd messaging campaigns. • Social Media ads Facebook/Instagram – monthly revolving topics. • Updated Coding Book for providers/CPT II Code cheat sheets. • American Cancer Society (ACS) collaboration.	**Not a Quality Strategy Metric** Children and Adolescents Access to Primary Care Practitioners

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	• Implementing Standing Order initiative for Breast Cancer Screenings. • Continue to investigate Mammogram Bus opportunities. • Tracking/trending SDOH needs of members to determine appropriate outreach for preventive care.	
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	• Anthem offers a Diabetes Disease Management Program to encourage member self-care efforts, health care education and provides effective intervention points. Diabetes Disease Management is offered to identify members by licensed clinicians. • Care Compass HEDIS Alerts: Case managers, during regular contact with members, provide reminders of missed services and education on missed services. • HealthCrowd: Multi-model (IVR call, SMS, email, Text) Informative/educational message to members regarding the 4 diabetes screenings & to remind them to make an appointment with their PCP. • Gaps in Care Reports: Data reports generated from HEDIS data set, and letters are sent to providers with list of members to follow-up to ensure services are completed. Returned medical records are data entered into the MRDB. • PQIP - The Provider Quality Incentive Program (PQIP or the Program) rewards our valued providers for the quality care they provide our Medicaid members. Using a system of Scorecard Measures, PQIP seeks to encourage efficient, preventive and cost-effective health care practices. Eligible PCPs who	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure **Not a Quality Strategy Metric** Comprehensive Management of Diabetes-all indicators

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	meet quality benchmarks and improvement and medical cost management targets will receive additional payments. • Healthy Rewards offers diabetic members $25 to complete the diabetic retinal eye exam every 12 months.	
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	• Develop FAQ for the National Call Center to educate/inform members of Doula services and benefits beginning Jan 2022. • Educate members on importance of postpartum visit. Internal prevention-based program that focuses on education and monitoring of pregnant women (during the prenatal/postpartum periods) and their newborns (through the first 90 days of life). This program, New Baby, New Life™- focuses on proactive outreach to both providers and members in an effort to address many of the barriers noted above. • Educate members on available transportation resources that may encourage member compliance. • Incentivize practitioners to schedule the postpartum visits and to encourage member compliance. • Incentivize members to schedule the postpartum visits and to encourage member compliance. • Maternal health education by telephone, text message, and by Smartphone app to pregnant and postpartum women. • Twice weekly messaging during the prenatal phase – Weekly postpartum calls – Weekly well child messaging – Interactive Voice Response (IVR) system and asked to	**Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care **Metric 4.6.3:** Childhood Immunization Status

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	complete the screener for high risk conditions – Pregnant/postpartum women are provided answers to their questions and directed to community and medical support if needed. • Identifying pregnant smokers via assessment and SDOH screener. • Developing a text messaging campaign to inform them of available resources and options to engage in smoking cessation. • Increasing participation in OBQIP provider incentive program. OB Practice Consultant will collaborate with Provider Relations to pitch program for interest.	

Magellan

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

Virginia Quality Strategy Aim and Goal	Magellan's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach.	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach.	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Not a Quality Strategy Metric** (AMR) Asthma Medication Ratio
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach.	**Not a Quality Strategy Metric** (BCS) Breast Cancer Screening **Not a Quality Strategy Metric** (CCS) Cervical Cancer Screening **Not a Quality Strategy Metric**

Virginia Quality Strategy Aim and Goal	Magellan's Quality Initiative	Performance Metric
Members		(COL) Colorectal Cancer Screening
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, educate them on CPT II codes, provide them support for member outreach.	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach. Partner with community/providers and host immunization campaign and provide incentives and school supplies	(**Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life **Not a Quality Strategy Metric** (IMA) Immunization for Adolescents **Not a Quality Strategy Metric** (LSC) Lead Screening in Children
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members **Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach.	**Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness **Metric 4.2.2:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence **Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, educate them on CPT II codes, provide them support for member outreach. Compliant members receive incentives from our partnered vendor on an agreed upon cadence Claims research for service date and bundle code issues. Providers are educated on the issues and updated.	**Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care **Metric 4.6.4:** Live Births Weighing Less than 2,500 Grams

Virginia Quality Strategy Aim and Goal	Magellan's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach.	**Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Hosting Clinic days in provider's offices to have an open day for appointments for members to get their services done.	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	• Hosting Clinic days in provider's offices to have an open day for appointments for members to get their services done. • Compliant members receive incentives from our partnered vendor on an agreed upon cadence • Members will receive a certificate based on their A1c outcomes • Vision Centers are incentivized to reach out to members, schedule them and complete the Dilated retinal eye exam • Blood Pressure cuffs sent to targeted members and telehealth visits are facilitated to capture required information • Members are sent home a HgA1c kit to complete	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	Hosting Clinic days in provider's offices to have an open day for appointments for members to get their services done.	**Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members **Goal 4.4:** Improve Health for Members with Chronic Conditions	MCC has partnered with MRx vendor partner to do outreach calls and identify barriers preventing members to be medication adherent	**Not a Quality Strategy Metric** (AMR) Asthma Medication Ratio **Not a Quality Strategy Metric** (SAA) Adherence to Antipsychotic medications for individuals with Schizophrenia **Not a Quality Strategy Metric** (AMM) Antidepressant Medication Management

Virginia Quality Strategy Aim and Goal	Magellan's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	Member outreach targeting kids before they turn two years old and helping them to schedule appointments to close the CIS measure gaps Compliant members receive incentives from our partnered vendor on an agreed upon cadence	**Metric 4.6.3:** Childhood Immunization Status
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach.	**Not a Quality Strategy Metric** (AMR) Asthma Medication Ratio
Aim: Focus on Screening and prevention **Goal:** Cancers are prevented or diagnosed at the earliest stage possible	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach.	**Not a Quality Strategy Metric** (BCS) Breast Cancer Screening **Not a Quality Strategy Metric** (CCS) Cervical Cancer Screening **Not a Quality Strategy Metric** (COL) Colorectal Cancer Screening

Optima

Table D-4—Optima's Quality Strategy Quality Initiatives

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
Aim 1: Enhance Member Care Experience **Goal 1.1: Improve Member Satisfaction** **Aim 2:** Effective Patient Care **Goal 2.2:** Ensure Access to Care *The quality initiative may impact other Quality Strategy aims and goals.*	• Outreach baby showers • Outreach member advisory forums (currently virtual) • Care coordination technician member outreach along with medical and behavioral care coordination/case management rounds with Medical Directors. • Dedicated Readmission Team with (Cipherhealth) to conduct hospital and ED post-discharge follow-up calls to members to assist with any member-identified concerns-(home health services,	**Metric 1.2.1:** Getting Care Quickly **Metric 1.2.3:** Rating of All Health Care **Metric 2.2.3:** Getting Needed Care

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
	medications, discharge instructions, etc.) • Case management/Care Coordination care gap dashboard (Tableau) to assist in identifying and closing care gaps when engaging with members • Partners in Pregnancy (PIP) Program • Vendor/Partners in care: EMMI, CipherHealth, BiolQ, MDLive, Prealize, Integrated Eye Group, (IEG), Ontrak, Lexus Nexus, Focus Care in home assessments, Progeny, Accordant, and Inogen. • Focused EPST Care Coordination • Behavioral health engagement program to improve follow-up visits with providers after ED visits. • Focused Community Partners for improving Social Dominants of Health (SDOH): United Us, Local Food Banks, Religious Organizations, Salvation Army, STOP Inc. (rent and utility assistance), VDH Baby Care programs, local shelters, local women's shelters, GED program with financial voucher • Readmission High Risk Discharge Target and Intervention Committee • Automated EMMI campaigns (educational videos for members)- Postpartum • Monthly collaboration with Prealize for case studies and process improvements • Collaborative Stakeholder with Brock Institute at Eastern Virginia Medical School for Substance use Disorder in	

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
	Pregnant Moms and Parenting Women • DMAS/Optima COVID collaboration to improve member education and access to testing and vaccination • Collaborative partners with DMAS and MCO EI Workgroup and DMAS MCO Foster Care Workgroup • Formation of Corporate Satisfaction Committee- with goal of improving the member and provider experience leading to satisfaction, advancing clinical excellence while providing compassionate member centered care	
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members **Goal 4.2**: Improve Outcomes for Members with Substance Use Disorders **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members **Goal 4.4:** Improve Health for Members with Chronic Conditions **Goal 4.6**: Improve Outcomes for Maternal and Infant Members *The quality initiative may impact other Quality Strategy aims and goals.*	• Diabetic Eye incentive program, call campaigns, mobile diabetic eye exam events • Enhanced Sentara Diabetes Class communication • Predictive analysis data integration into clinical workflows, engaging members in closing care gaps • In home assessments and quality gap closures • Collaboration with provider groups to assist with follow up and treatment visit scheduling • Emerging intervention- Partnerships with vendors to facilitate and promote member self-care management • Emerging intervention- Exploration of emerging technology and partnerships to improve health outcomes for our members • Predictive analytics to identify high risk members utilized for CMs to contact and provide asthma control education • Member level care gap data integration into clinical	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness **Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness **Metric 4.1.3:** Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication **Metric 4.1.4:** Monitor Mental Health Utilization **Metric 4.2.2:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence **Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.3.4:** Child and Adolescent Well-Care Visits **Metric 4.4.1:** PQI 08: Heart Failure Admission Rate **Metric 4.4.2:** PDI 14: Asthma Admission Rate (Ages 2–17) **Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
	workflows to inform/engage members in closing care gaps • Education resource utilization for educational videos • Outreach team calls identification of asthmatic members for CMs to contact • Outreach baby showers • Outreach member advisory forums (currently virtual) • Care coordination technician member outreach along with medical and behavioral care coordination/case management rounds with Medical Directors. • Dedicated Readmission Team with (Cipherhealth) to conduct hospital and ED post-discharge follow-up calls to members to assist with any member-identified concerns-(home health services, medications, discharge instructions, etc.) • Case management/Care Coordination care gap dashboard (Tableau) to assist in identifying and closing care gaps when engaging with members • Partners in Pregnancy (PIP) Program • Vendor/Partners in care: EMMI, CipherHealth, BiolQ, MDLive, Prealize, Integrated Eye Group, (IEG), Ontrak, Lexus Nexus, Focus Care in home assessments, Progeny, Accordant, and Inogen. • Focused EPST Care Coordination • Behavioral health engagement program to improve follow-up visits with providers after ED visits.	**Metric 4.4.5:** Controlling High Blood Pressure **Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life **Not a Quality Strategy Metric** Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescence (WCC) **Not a Quality Strategy Metric** Immunizations for Adolescents (IMA) **Not a Quality Strategy Metric** Plan All Cause Readmission (PCR)

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
	• Automated EMMI campaigns (educational videos for members)- Postpartum • Monthly collaboration with Prealize for case studies and process improvements	
Aim 1: Enhance Member Care Experience **Goal 1.1:** Improve Member Satisfaction **Aim 2:** Effective Patient Care **Goal 2.1:** Enhance Provider Support **Goal 2.2:** Ensure Access to Care **Aim 4:** Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members **Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders **Goal 4.4:** Improve Health for Members with Chronic Conditions *The quality initiative may impact other Quality Strategy aims and goals.*	• Care coordination technician member outreach along with medical and behavioral care coordination/case management rounds with Medical Directors. • Dedicated Readmission Team with (Cipherhealth) to conduct hospital and ED post-discharge follow-up calls to members to assist with any member-identified concerns-(home health services, medications, discharge instructions, etc.) • Case management/Care Coordination care gap dashboard (Tableau) to assist in identifying and closing care gaps when engaging with members • Behavioral health engagement program to improve follow-up visits with providers after ED visits. • Diabetic Eye incentive program, call campaigns, mobile diabetic eye exam events • Enhanced Sentara Diabetes Class communication • Predictive analysis data integration into clinical workflows, engaging members in closing care gaps • In home assessments and quality gap closures • Emerging intervention-Partnerships with vendors to facilitate and promote member self-care management	**Metric 1.2.1:** Getting Care Quickly **Metric 1.2.3:** Rating of All Health Care **Metric 2.1.1:** Rating of Personal Doctor **Metric 2.1.2:** How Well Doctors Communicate **Metric 2.2.3:** Getting Needed Care **Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness **Metric 4.2.2:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence **Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment **Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
	• Emerging intervention- Exploration of emerging technology and partnerships to improve health outcomes for our members Emerging interventions- • Vendor/Partners in care: Ontrak (BH), Lexus Nexus, Focus Care in home assessments, Dario, Carenet • Interdepartmental committee evaluating enhanced member benefits for 2022 to improve SDOH • Additional Automated EMMI campaigns (educational videos for members) • Interdepartmental collaboration for improved regulatory and internal reporting processes and data collection • Targeted Behavioral Health Care Coordination focusing on Inpatient discharges, Emergency Room utilization and high-risk readmission member focus from Behavioral Health Facilities. • Dedicated Behavioral Health Transition of Care Coordinators. • Increased focus on SDOH and health equities with creation of a focused SDOH team collaborating with Medical and Behavioral UM/CM departments. New EMR system with increased capturing of SDOH Optima Health understands that a "one size fits all" approach is not sufficient for member and community outreach. Therefore, we have created a program that uses both traditional and non-traditional means to reach our	

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
	member population and address unmet health-related social needs. We use a multi-modality platform for engaging our members, community partners, staff, and subcontractors. Our outreach and education program includes targeted communication and outreach by region, focusing on community-based organizations, continuing advocacy, and keeping members engaged by helping them understand the value of program benefits and services. Additionally, we support those members who may require unique communication solutions like TTY, Braille, interpretive services, or the use of community health workers to fully engage in their member benefits. We also use regular mail, member website and provide options for member engagement through social media, texting, and member email. Examples of Member Outreach Activities- • Member outreach – initial health screenings • Member Advisory Forums • Community member Advisory Forums • Maternity Care Outreach • Emergency Department Follow Up Initiative • Outreach for Homeless Members Examples of SDOH Activities- • Faith based initiatives • Partnering with organizations such as Veterans Helping Veterans, Tidewater Community College, Portsmouth Parks and Recreation, 100 Black Men, YMCA of the Eastern Shore, Lynchburg Boys and Girls	

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
	Club, Big Brothers and Big Sisters of Danville, and many more. • Optima Health, Read, learn, Grow literacy program • Developmental Screening Delays- connecting members to resources • Zero to Three • Home Visits – Ages and Stages Questionnaire • Healthy Savings – supporting food security and good nutrition • COVID Specific Activities Collaborating with Health care Providers Social Determinants Health Technology Initiatives developed and implemented by the MCO to meet goals and objective in the Virginia Quality Strategy also include, but are not limited to the following: • Quality Improvement Program • Quality Improvement Committee structure and governance • HEDIS performance monitoring and targeted improvement plan. • Population Health program including yearlong engagement with members to close gaps • Value-based purchasing • Member safety initiatives • Culturally and linguistically appropriate services (CLAS) competency provider training • Utilization management program • Reducing emergency department utilization • Patient utilization and safety (PUMS) program	

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
	• Behavioral Health/ARTS benefit • Member and Provider Outreach and Engagement This report and the various initiatives cover a multitude of departments which ultimately contributes to the quality outcomes for the MCO's member's and providers.	

United

Table D-5—United's Quality Strategy Quality Initiatives

Virginia Quality Strategy Aim and Goal	United's Quality Initiative	Performance Metric
	UHC (Medallion and CCC Plus) has quality integrated into all facets of the health plan; aimed at ensuring quality services to members, ensuring members have appropriate access to care and improving health outcomes. In supporting the goals and objectives in the Virginia Quality Strategy, UHC conducts routine, diligent monitoring of rates for numerous quality measures; including those on the DMAS Quality Strategy Dashboard. Some core approaches that UHC has taken to support the Virginia Quality Strategy include, but are not limited to:	
Aim 1: Enhance Member Care Experience **Goal 1.1:** Improve Member Satisfaction **Aim 2:** Effective Patient Care **Goal 2.1:** Enhance Provider Support **Goal 2.2:** Ensure Access to Care	UHC's care coordination model and individualized care management plans for members ensure the integration of physical and behavioral health, incorporates medical management (pharmacy services) and unites with the needs for HCBS services and other supports. These care plans focus on member goals for positive health outcomes while aiming to improve appropriate use	**Metric 1.2.1:** Getting Care Quickly **Metric 1.2.3:** Rating of All Health Care **Metric 2.1.1:** Rating of Personal Doctor **Metric 2.1.2:** How Well Doctors Communicate **Metric 2.2.3:** Getting Needed Care

Virginia Quality Strategy Aim and Goal	United's Quality Initiative	Performance Metric
	of services and reduce inappropriate utilization. Embedded within UHC's care management planning and monitoring is a core focus on Social Determinants of Health; evaluating members' needs and ensuring a strong engagement and connection with community resources. UHC monitors provider and member satisfaction with services through various instruments and forums – including CAHPS, Care Coordination surveys, NPS surveys, provider surveys, and Member Advisory Committees (MACs) among others.	
Aim 2: Effective Patient Care **Goal 2.1:** Enhance Provider Support **Goal 2.2:** Ensure Access to Care	UHC diligently monitors and maintains network adequacy, so members have appropriate access to quality care. UHC strictly monitors to ensure we are meeting DMAS network adequacy standards and conducts routine evaluations of the quality of care provided by our valued provider partners. UHC ensures providers have the most current information on both core Medicaid/Medicare benefits as well as UHC's enhanced benefit offerings and resources to facilitate meaningful care conversations with members. UHC partners with providers and enables member support through such activities as: 1. Providing PCPs with detailed data on members experiencing gaps in care and engaging with providers in periodic reviews 2. Identifying emergency department visits through the emergency department Care	**Not linked to specific quality strategy metrics.**

Virginia Quality Strategy Aim and Goal	United's Quality Initiative	Performance Metric
	Coordination (EDCC) interface and working with emergency departments on adequate discharge plans and follow-up appointments 3. Coordinating transportation to provider appointments and other key non-medical appointments, and 4. Partnering with Federally Qualified Health Centers (FQHCs), health systems and other entities for member care and support of community events.	
Aim 3: Smarter Spending **Goal 3.1:** Focus on Paying for Value	UHC continually monitors to ensure it is operating as efficiently and effectively as possible in supporting its members and. There is also focus on medically unnecessary or potentially preventable spending for hospital admissions, hospital readmissions, and emergency department visits. UHC initiated and continues its Community Plan Primary Care Provider Incentive (CP-PCPi) Program which is a value-based incentive program with the goal of compensating primary care providers for performance for key member outcome measures. UHC assists in the identification of members who need preventive services so primary care providers can appropriately outreach and schedule appointments with these members.	**Metric 3.1.1:** Frequency of Potentially Preventable Admissions **Metric 3.1.2:** Frequency of Emergency Department Visits **Metric 3.1.3:** Frequency of Potentially Preventable Readmissions **Metric 3.1.4:** Ambulatory Care: Emergency (ED) Visits
Aim: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members **Goal 4.4:** Improve Health for Members with Chronic Conditions	Through a variety of methodologies UHC provides member education and outreach, with appropriate focus on sub populations with special ongoing or episodic needs. Many of these outreach programs are outlined in the performance measure validation section on HEDIS measure activities.	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.3.4:** Child and Adolescent Well-Care Visits **Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure

Virginia Quality Strategy Aim and Goal	United's Quality Initiative	Performance Metric
Goal 4.6: Improve Outcomes for Maternal and Infant Members	At a macro level, UHC continually reviews metrics globally to identify where outreach is most needed and to identify emerging trends statewide or regionally. At a micro level, each care coordinator has immediate access to known gaps at the individual member level when accessing their record for either proactive/planned care management activities or in responding to and supporting unplanned/reactive care events for the member. In addition, UHC has supported and encouraged the use of telemedicine throughout the PHE to assist members with continued access to care. UHC has worked to deploy enhanced virtual models to further assist members with various care needs and social needs and to maintain/improve member engagement and outcomes.	**Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care **Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life

VA Premier

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

Virginia Quality Strategy Aim and Goal	VA Premier's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	• Secret Shopper Survey-Quarterly. Provider Satisfaction Survey and Provider Access and Availability Survey-Annually. • Skilled Nursing Facility (SNF) rounds to decrease length of stay and to provide optimal transition back into the community. • Patient Utilization Management and Safety (PUMS) Program- PUMS is a safety program that targets overutilization. In cases involving buprenorphine use,	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness **Metric 4.1.5:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Not a Quality Strategy Metric** Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total—18–64 and 65+

Virginia Quality Strategy Aim and Goal	VA Premier's Quality Initiative	Performance Metric
	the member will automatically be in the PUMS program. • Enhanced Care Coordination Program- Behavioral Health Chronic Care Coordinators work with targeted case managers employed with CSBs to conduct 7 day follow up with members discharged from acute facilities. • Pediatric Atypical Antipsychotic Program-Clinical coordination program for those members aged 6-12 who are taking an atypical antipsychotic.	
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	• Provider Education Visits- educate providers on the importance of screenings and immunizations to promote health and wealth. • Watch Me Grow-Members age 0-24 months, whose parents enroll, receive text messages with reminders of upcoming well child visits and immunizations.	**Metric 4.3.4:** Child and Adolescent Well-Care Visits **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	**Healthy Heartbeats Program** Provide outreach to pregnant and postpartum members at least monthly and screen for high-risk conditions & postpartum depression.	**Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care **Metric 4.6.4:** Live Births Weighing Less than 2,500 Grams
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	**Chronic Care Management Programs** Nurses contact members at a minimum every 90 days to provide education, identify barriers and move the member toward achieving their goals. The Nurses work up to 12 months with members with Diabetes, Asthma, Coronary Artery Disease, Hypertension, Heart Failure, and Chronic Obstructive Pulmonary Disease.	**Metric 4.4.1:** PQI 08: Heart Failure Admission Rate **Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure

Appendix E. Assessment of Follow-Up on Prior Recommendations

From the overall findings of the Medallion 4.0 CY 2020 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Medallion 4.0 program. The recommendations provided to DMAS for the EQR activities in the *Calendar Year 2020 External Quality Review Technical Report* are summarized in Table E-1. Table E-1 also describes the interventions undertaken by DMAS to address the EQR recommendations, quality improvement achieved as a result of the interventions, and identified barriers to implementing the interventions focused on addressing the recommendations, if applicable.

Table E-1—Prior Year Recommendations and Responses—Medallion 4.0 Program Overall

Recommendation—Performance Improvement Projects		
Aim 4: Improve population health	**Goal 4.6:** Improve Outcomes for Maternal and Infant Members	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care
• As the MCOs continued to test interventions until the PIP's SMART Aim end date and prepared to submit the final Module 4s and Module 5s for validation, HSAG recommended that the MCOs: • Continue to monitor and report any impact COVID-19 has had on the MCO's PIPs. • Address all the feedback and recommendations that HSAG provided in the Module 4 plan pre-validation reviews and Module 4 intervention progress check-ins. After reviewing the feedback and/or recommendations, the MCO should contact HSAG with any questions. • Follow the approved methodology for the PIP and report the PIP's data in alignment with the approved methodology. If the MCO has questions about the approved methodology, it should review the approved Module 2 submission form and contact HSAG. • Identify and test innovative, actionable changes for the PIPs. If the interventions are not effective, the MCOs should make rapid modifications to the interventions and continue collecting data. If the MCO needs to identify additional potential interventions for the PIP, it should review its process map and FMEA completed in Module 3 to design changes to address gaps and high-priority failures in the process. • Continually monitor the monthly SMART Aim measure and intervention effectiveness measure data. If the outcomes are not improving over time, the MCO should adjust intervention testing. • Attend the Module 4 and Module 5 webinar training that HSAG will schedule prior to the submission of these modules for validation. • Request PIP technical assistance from HSAG as often as needed.		
DMAS' Response (Note—The narrative within the MCO's response section was provided by the DMAS and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website		

Recommendation—Performance Improvement Projects
• Designed a tableau based HEDIS dashboard (estimated to be published no later than January 2022) • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS Moms coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care 2019: NR 2020: 74.45%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improve population health	**Goal 4.6:** Improve Outcomes for Maternal and Infant Members	**Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life
• HSAG recommended that the MCOs conduct a root cause analysis to determine why some children have not received well-child visits or immunizations according to the well-visit schedule. • HSAG recommended that the MCOs analyze their data and consider if there are disparities within the MCOs' populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. • Upon identification of a root cause, HSAG recommended that the MCOs implement appropriate interventions to increase the number of children who receive a well-child visit or immunizations using interventions that address the root cause of the issue.		

DMAS' Response (Note—The narrative within the DMAS's response section was provided by the DMAS and has not been altered by HSAG except for minor formatting)
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard (estimated to be published no later than January 2022) • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs

Recommendation—Performance Measure Validation		
• Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS Moms coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV rates showed: **Metric 4.6.3:** Childhood Immunization Status Combo 3: 2019: NR 2020:65.82% **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life: 2019: NR 2020: First 15 Months: 54.35%; 15 Months – 30 Months: 72.10%		
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.		
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.		
Recommendation—Performance Measure Validation		
Aim 4: Improve population health	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Not included in the 2020–2022 Quality Strategy: • Cervical Cancer Screening • Breast Cancer Screening
• HSAG recommended that the MCOs conduct a root cause analysis or focus group to determine why women members were not receiving breast or cervical cancer screenings. • HSAG recommended that the MCOs consider if there were disparities within the MCOs' populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. • Upon identification of a root cause, HSAG recommended that the MCOs implement appropriate interventions to improve access to and timeliness of cancer screenings.		
DMAS' Response (Note—The narrative within the DMAS's response section was provided by the DMAS and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard (estimated to be published no later than January 2022) • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices		

Recommendation—Performance Measure Validation
• Received an extension of FAMIS Moms coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV rates showed: Cervical Cancer Screening 2019: NR 2020: 50.09% Breast Cancer Screening 2019: NR 2020: 48.82%
Identify any barriers to implementing initiatives: DMAS did not identify any barrier to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 1: Enhance Member Care Experience	**Goal 2.2:** Ensure Access to Care	**Metric 2.2.3:** Getting Needed Care
• HSAG recommended that MCOs conduct a root cause analysis to determine why some adults and children were experiencing access to care issues. • HSAG recommended that the MCOs identify the best practices of the four MCOs that demonstrated strength in adults' and children's access to care. • HSAG recommended that the MCOs consider conducting a focus group to identify barriers that their members were experiencing in accessing care and services in order to implement appropriate interventions.		
DMAS' Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard (estimated to be published no later than January 2022) • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS Moms coverage • Added new adult dental benefit		

Recommendation—Performance Measure Validation		
• Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): CAHPS results showed: **Metric 2.2.3:** Getting Needed Care 2020: 83.3% 2021: 82.9%		
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.		
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.		
Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.4:** Improve Health for Members with Chronic Conditions	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure
• HSAG recommended that the MCOs conduct a root cause analysis to determine why members were not maintaining their chronic health condition at optimal levels. • Upon identification of a root cause, HSAG recommended that the MCOs implement appropriate interventions to improve the performance related to these chronic conditions. • HSAG also recommended that the MCOs work closely with public health and the MCOs' provider network to coordinate available resources related to quitting smoking and tobacco use and obtaining access to smoking cessation medications*. * Note: Smoking cessation is not a covered service for Medicaid except for pregnant women and for the Medicaid Expansion population.		
DMAS' Response (Note—The narrative within the DMAS's response section was provided by the DMAS and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard (estimated to be published no later than January 2022) • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS Moms coverage • Added new adult dental benefit		

Recommendation—Performance Measure Validation
• Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) 2019: NR 2020: 50.30% **Metric 4.4.5:** Controlling High Blood Pressure 2019: NR 2020: 46.91%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness **Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness

- HSAG recommended that Magellan and VA Premier review their resources, interventions, and activities focused on follow-up care upon discharge for members receiving behavioral health services in the ED or an inpatient setting.
- HSAG recommended that the MCOs conduct a root cause analysis to determine barriers to follow-up with children prescribed ADHD medications.
- HSAG recommended that the MCOs consider if there were disparities within the MCOs' populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
- Upon identification of a root cause, HSAG recommended that the MCOs implement appropriate interventions to ensure appropriate follow-up on prescribing as well as ED and inpatient care to decrease inappropriate utilization.

DMAS' Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

DMAS is committed to promoting members. To address the EQRO recommendations, DMAS:

- Increased access to health coverage for lawful permanent residents
- Expanded Quality and Population Health Team
- Developed a dedicated QPH website and resources on the DMAS website
- Designed a tableau based HEDIS dashboard (estimated to be published no later than January 2022)
- Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs

Recommendation—Performance Measure Validation
• Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS Moms coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness 2019: NR 2020: 7-Day: 35.63%; 30-Day: 56.84% **Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness 2019: NR2020: 7-Day: 45.34%; 30-Day: 57.38%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey—Adult		
Aim 2: Effective Patient Care	**Goal 2.2:** Ensure Access to Care	**Metric 2.2.3:** Getting Needed Care
• HSAG recommended that the MCO conduct a focus group or other methods to receive direct information from members on their experience with access to care and receiving services, and the customer service they receive from the MCO. • Once the MCO gains an understanding of the member's experience, HSAG recommended that the MCO implement appropriate interventions to improve this experience when contacting the health plan and seeking care and services. • HSAG recommended that the MCO delve more deeply into those survey categories for which survey results are not only lower than the 2020 NCQA adult Medicaid national average but also where rates are declining.		
DMAS' Response (Note—The narrative within the DMAS's response section was provided by the DMAS and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard (estimated to be published no later than January 2022) • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices		

Recommendation—Member Experience of Care Survey—Adult
• Received an extension of FAMIS Moms coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric 2.2.3:** Getting Needed Care 2019: 83.3% 2020: 82.9%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Child		
Aim 2: Effective Patient Care	**Goal 2.2:** Ensure Access to Care	**Metric 2.2.3:** Getting Needed Care
• HSAG recommended that the MCOs conduct a focus group or use other methods to receive direct information from members on their experience with access to care and their interactions with the healthcare system. • Once an MCO gains an understanding of the member's experience, HSAG recommended that the MCO implement appropriate interventions to improve this experience when the member contacts the health plan or receives services from a personal doctor.		
DMAS' Response (Note—The narrative within the DMAS's response section was provided by the DMAS and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard (estimated to be published no later than January 2022) • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS Moms coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum		
Identify any noted performance improvement as a result of initiatives implemented (if applicable):		

Recommendation—Member Experience of Care Survey—Adult
CAHPS results show: **Metric 2.2.3:** Getting Needed Care 2020: 85.8% 2021: 84.6%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Response HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

MCOs' Follow-Up on Prior Year Recommendations

From the findings of each MCO's performance for the CY 2020 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Medallion 4.0 program. The recommendations provided to each MCO for the EQR activities in the Calendar Year 2020 External Quality Review Technical Report are summarized in Table E-2 through Table E-7. Table E-2 through Table E-7 also describe the interventions undertaken by the MCOs to address the EQR recommendations, quality improvement achieved as a result of the interventions and identified barriers to implementing the interventions focused on addressing the recommendations, if applicable.

Aetna

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

Recommendation—Performance Improvement Projects		
Aim 4: Improved Population Health	**Goal 4.6:** Improve Outcomes for Maternal and Infant Members	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care
• Provide the correct intervention description in the Module 4 plan. • Include all the details in the intervention process steps. • Update the Module 5 Intervention Determination Table with interventions that were not in Module 3. • Define the intervention effectiveness measure accurately. • Clarify that the intervention is focused specifically on the narrowed focus of the PIP. • Specify whether claims lag would impact receiving the intervention results. • Provide the data in the SMART Aim measure run chart correctly. • Address the Module 4 pre-validation review feedback for the intervention effectiveness measure.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):		

Recommendation—Performance Improvement Projects
• In response to HSAG's recommendations to avoid newsletter articles for PIP interventions, the Plan opted to collaborate with a high-volume OB/GYN provider to distribute the flyer to Aetna members. Unfortunately, the Plan ultimately had to forego the intervention due to organizational restrictions on provider and member outreach and requests per DMAS instructions at the height of the COVID-19 PHE and subsequent time constraints once those restrictions were removed. • The Plan confirmed that a claims lag existed for both Medallion PIPs. ***PPC PIP:*** • The PIP lead pulled the monthly membership file and filtered it to identify only those who fell within the targeted population (female members between the ages of 18-29 who resided in the Central Virginia region). The PIP lead then bumped the filtered members from the monthly membership against the monthly DMAS pregnancy report. • The Plan updated Module 5 to reflect the failure modes and interventions to address those failure modes as listed in the Intervention Determination Table in Module 3. • The Plan revised the denominator description to include members targeted with the intervention. Specifically, the Plan added the following verbiage: "and were successfully outreached by telephone." • The Plan also updated the denominator to include members who received addiction treatment and the flyer. • The Plan reviewed the run chart & data table and updated the write-up accordingly. We also entered the SMART Aim data table. • The Plan revised the denominator description to include members targeted with the intervention. Specifically, the Plan added the following verbiage: "and were successfully outreached by telephone." • The Plan also updated the denominator to include members who received addiction treatment and the flyer. ***PNS PIP:*** • The PIP lead generated a list of members using the monthly DMAS pregnancy List. The PIP lead generated a pharmaceutical report to identify those members who filled a prescription for smoking cessation medication. • The MCO updated Module 5 to reflect the failure modes and interventions to address those failure modes as listed in the Intervention Determination Table in Module 3 • The MCO revised the denominator definition to include the number of pregnant members in the Central VA Region who were identified as smokers and received the newsletter. The MCO also revised the denominator definition to include members targeted with the intervention. Specifically, the MCO added the following verbiage: "and were successfully outreached by telephone." • The Plan reviewed the run chart & data table and updated the write-up accordingly. We also entered the SMART Aim data table. • The Plan revised the denominator definition to include the number of pregnant members in the Central VA Region who were identified as smokers and received the newsletter. • The Plan also revised the denominator definition to include members targeted with the intervention. Specifically, the Plan added the following verbiage: "and were successfully outreached by telephone."
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement results from the initiatives implemented. PMV results showed: **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care 2019: 73.48% 2020: 68.61%

Recommendation—Performance Improvement Projects		
Identify any barriers to implementing initiatives: Due to the COVID restrictions set forth by DMAS, MCOs were prohibited to outreach members in person. Therefore, the Plan was unable to provide flyers to members face-to-face. The Plan was also unable to offer the flyer to providers for distribution due to organizational restrictions implemented for provider requests per DMAS instructions at the height of the COVID-19 PHE. In response to HSAG's recommendations to avoid newsletter articles for PIP interventions, the Plan opted to collaborate with a high-volume OB/GYN provider to distribute the flyer to Aetna members. Unfortunately, the Plan ultimately had to forego the intervention due to organizational restrictions on provider and member outreach and requests per DMAS instructions at the height of the COVID-19 PHE and subsequent time constraints once those restrictions were removed.		
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.		
Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.3**: Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.3.4:** Child and Adolescent Well-Care Visits
Aim 4: Improved Population Health	**Goal 4.4:** Improve Health for Members with Chronic Conditions	**Metric 4.4.4:** Comprehensive Diabetes Care, Hemoglobin A1c (HbA1c) Poor Control **Metric 4.4.5:** Controlling High Blood Pressure
• HSAG recommended that Aetna conduct a root cause analysis to determine why members were not consistently accessing and completing well-child visits, childhood immunizations, cancer screenings, behavioral health services, and care and services for chronic conditions. • HSAG recommended that Aetna analyze its data and consider if there were disparities within their populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. • Upon identification of a root cause, HSAG recommends that Aetna implement appropriate interventions to improve the receipt of recommended care and services that impact the health of its members and that may result in unnecessary use of the ED and inpatient settings.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): Prior to the PHE wellness visits and care for those members with chronic conditions was and remains an area in need of improvement. The MCO continued to develop new and monitor current initiatives and interventions. The MCO conducted analyses of its Medallion 4.0 population. These analyses were reported in an annual assessment to support NCQA accreditation requirements and drive member programs and quality improvement initiatives. A key finding for the measurement year 2020 was that disparities were noted for members residing in the City of Richmond and included the zip code where the MCO had the highest number of members. All SDoH		

Recommendation—Performance Measure Validation		
measures for Richmond failed to meet the threshold with the exception of Low Food Access and Low-Income Preschool Obesity. A subpopulation was targeted for intervention for the AMB PIP, where telephonic outreach was made to members with one outpatient visit and two or more emergency department visits. Also, the MCO had a hospital readmission reduction program, which was a clinical program focused on coordinating care between providers, case managers, and clinical pharmacists as members were discharged from the hospital.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement results from the initiatives implemented. PMV results showed: **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services 2019: 76.47% 2020: 75.79% **Metric 4.3.4:** Child and Adolescent Well-Care Visits 2019: NR 2020: 43.39% **Metric 4.4.4:** Comprehensive Diabetes Care, Hemoglobin A1c (HbA1c) Poor Control 2019: 48.42% 2020: 45.50% **Metric 4.4.5:** Controlling High Blood Pressure 2019: 47.45% 2020: 50.85%		
Identify any barriers to implementing initiatives: The MCO believed that the COVID-19 PHE significantly impacted members visiting the doctor for routine and follow-up care.		
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.		
Recommendation—Member Experience of Care Survey - Adult		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.1:** Getting Care Quickly **Metric 1.2.3:** Rating of All Health Care
HSAG recommended that Aetna focus quality improvement efforts on measure scores that were statistically significantly lower than the 2020 NCQA Medicaid national averages (i.e., Rating of Health Plan, Rating of All Health Care, Getting Needed Care, and Customer Service) for the adult population.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • The MCO conducted a rate comparison analysis for the aggregated survey as well as for each line of business to gain better insight into what membership contributed to low star ratings. • The analyses were presented and discussed in both the Quality Management Oversight Committee as well as the Service Improvement Committee to focus on those composites that fell below three stars.		

Recommendation—Member Experience of Care Survey - Adult
• Discussion identified opportunities to review appointment access and availability for pediatricians, improve connections between members and conveniently located providers, review specialist authorization process to identify drivers that could impact the effectiveness of care and improve member awareness of benefits offered by the MCO. • The MCO repurposed its CAHPS workgroup to include a rotation of MCO representatives to incorporate a fresh perspective on improvement opportunities. • The workgroup also implemented small break-out sessions to brainstorm opportunities to improve composite measures that fell below three stars. Specific improvement actions included: • Conducting a root cause analysis via fishbone diagram to identify key drivers of dissatisfaction • Educating providers about CAHPS in provider newsletters and the provider manual • Developing a series of internal educational snippet emails to educate staff members about CAHPS (i.e., purpose, survey timeframe, how regulatory bodies use the survey results, etc.). • Providing CAHPS education during Member Advisory Committee meetings regarding the importance of completing the survey. • Implementing a text messaging campaign preparing and educating members on the survey.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement results from the initiatives implemented. PMV results showed: **Metric 1.2.1:** Getting Care Quickly 2020: 82.7% 2021: 82.6% **Metric 1.2.3:** Rating of All Health Care 2020: 47.5% 2021: 56.9%
Identify any barriers to implementing initiatives: The MCO did not identify barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Adult		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.1:** Getting Care Quickly **Metric 1.2.3:** Rating of All Health Care
• Once the MCO gains an understanding of the member's experience, HSAG recommends that the MCO implement appropriate interventions to improve this experience when contacting the health plan and seeking care and services.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):		

Recommendation—Member Experience of Care Survey - Adult
• Through soliciting member feedback and reviewing grievances, appeals, potential quality of care concerns, and utilization data, the MCO was able to better understand the areas in which members voiced dissatisfaction. • Member feedback indicated dissatisfaction regarding the transportation vendor as well as providers who balance bill members. • The MCO addressed member dissatisfaction with its transportation vendor via quarterly joint operation committees that include discussion of member complaints and actions taken by the transportation vendor to reduce member complaints. • The MCO also conducted ongoing monitoring of member complaints related to transportation via monthly reports. • The MCO conducted provider education related to the rules surrounding balance billing Medicaid members and completed member education to improve knowledge about the requirement to present their identification cards to providers during the visit.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Through its efforts, the MCO demonstrated a 3 percent decline in transportation grievances. PMV results showed: **Metric 1.2.1:** Getting Care Quickly 2020: 82.7% 2021: 82.6% **Metric 1.2.3:** Rating of All Health Care 2020: 47.5% 2021: 56.9%
Identify any barriers to implementing initiatives: The MCO did not identify barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Adult		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.1:** Getting Care Quickly **Metric 1.2.3:** Rating of All Health Care
HSAG recommended that the MCO delve more deeply into those survey categories for which results were not only lower than the 2020 NCQA adult Medicaid national average but also where rates were declining.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): A deep dive into CAHPS survey categories indicated opportunities exist for the Rating of Health Care, Rating of Health Plan, Rating of Personal Doctor, Rating of Specialist, Getting Needed Care, How Well Doctors Communicate, and Coordination of Care. A qualitative analysis further indicated improvement needed in the following areas: • Access to care • Billing and Finance		

Recommendation—Member Experience of Care Survey - Adult
• Customer Service • Further Improvement in Transportation The MCO implemented the actions to improve within each of the categories.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Overall, Aetna Better Health demonstrated improvement in 21 of the 27 Medallion Adult measures compared to the 2020 reported rates, three of which were statistically significant. PMV results showed: **Metric 1.2.1:** Getting Care Quickly 2020: 82.8% 2021: 82.6% **Metric 1.2.3:** Rating of All Health Care 2020: 47.5% 2021: 56.9%
Identify any barriers to implementing initiatives: The MCO did not identify barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Child		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.1:** Getting Care Quickly **Metric 1.2.3:** Rating of All Health Care
Aim 2: Effective Patient Care	**Goal 2.1:** Enhance Provider Support	**Metric 2.1.1:** Rating of Personal Doctor
HSAG recommended Aetna focusing on quality improvement on measures that exhibited a decrease from 2019 to 2020 for the child population (i.e., Rating of Health Plan, Rating of Personal Doctor, Rating of Specialist Seen Most Often, and Getting Needed Care.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): Further analysis of CAHPS survey categories indicated opportunities in the following composite measures: • Rating of Health Plan Overall • Rating of Personal Doctor • Rating of Specialist • Customer Service • Getting Needed Care The MCO identified opportunities for improvement and initiated the following actions: • Educated providers on cultural and linguistic competence, member follow up, the importance of coordinating with care management, and rules regarding balance billing Medicaid members, educated		

Recommendation—Member Experience of Care Survey - Child		
representatives on member benefits and conducted monthly audits to ensure Member Services provides a high quality of service. • Due to the 2021 rates for Rating of Health Plan and Rating of Specialist being the only measures to demonstrate an increase from the 2020 reported rate, the MCO continued to review member feedback as well as internal processes to identify drivers that could impact member satisfaction and effectiveness of care.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement results from the initiatives implemented. PMV results showed: **Metric 1.2.1:** Getting Care Quickly 2020: 82.7% 2021: 82.6% **Metric 1.2.3:** Rating of All Health Care 2020: 47.5% 2021: 56.9% **Metric 2.1.1:** Rating of Personal Doctor 2020: 67.7% 2021: 67.5%		
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.		
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.		
Recommendation—Member Experience of Care Survey - Child		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.1:** Getting Care Quickly **Metric 1.2.3:** Rating of All Health Care
HSAG recommended that Aetna conduct a root cause analysis of study indicators that had been identified as areas of low performance.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
• Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • After reviewing the Child Survey results, the MCO identified some emerging patterns. • Those who rated their child's physical or mental health showed high satisfaction, and those that rated their child's health as poor showed low satisfaction. Subsequently, older adults who responded for themselves were the most satisfied with the MCO, but older adults who responded for children were the most dissatisfied. The inverse was true for younger adults. • The MCO will continue to identify opportunities for improvement and identify root causes of dissatisfaction and barriers to improvement to design targeted interventions or process improvements at the Health Plan level.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable):		

Recommendation—Member Experience of Care Survey - Child
Overall, Aetna Better Health demonstrated improvement in six of the Medallion Child measures compared to the 2020 reported rates. CAHPS results showed: **Metric 1.2.1:** Getting Care Quickly 2020: 82.7% 2021: 82.6% **Metric 1.2.3:** Rating of All Health Care 2020: 47.5% 2021: 56.9%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

HealthKeepers

Table E-3—Prior Year Recommendations and Responses—HealthKeepers

Recommendation—Performance Improvement Projects		
Aim 4: Improved Population Health	**Goal 4.6:** Improve Outcomes for Maternal and Infant Members	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care
HSAG recommended that HealthKeepers: • Ensure the targeted population is large enough to impact the SMART Aim. • Ensure the timing of completed prenatal visits will be sufficient to include women in the SMART Aim. • Define the intervention effectiveness measure accurately.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): HealthKeepers will adhere to the recommendations from HSAG.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note any performance improvement as a result of initiatives implemented. PMV results showed: **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care 2019: 76.16% 2020: 77.62%		
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.		
HSAG Assessment: HSAG determined that the MCO had not addressed the recommendations in the prior year's annual technical report.		

Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services
	Goal 4.4: Improve Health for Members with Chronic Conditions	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure
HSAG recommended that HealthKeepers conduct a root cause analysis to determine why members were not consistently receiving cancer screenings or recommended services for comprehensive diabetes care and care and services for chronic conditions.		

MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

HealthKeepers reviewed and continued to monitor the performance for cancer screenings and recommended services for comprehensive diabetes care and care and services for chronic conditions. Critical Performance Steering Committee workgroups were established to determine key drivers for performance and to establish interventions for improvement

Anthem Virginia addressed the barriers by implementing the following interventions:

<u>Diabetes</u>

- HealthKeepers offered a Diabetes Disease Management Program to encourage member self-care efforts, health care education and provides effective intervention points. Diabetes Disease Management was offered to identify members by licensed clinicians.
- Care Compass HEDIS Alerts: Case managers, during regular contact with members, provided reminders of missed services and education on missed services.
- HealthCrowd: Multi-model (IVR call, SMS, email, Text) Informative/educational message to members regarding the four diabetes screenings and to remind them to make an appointment with their PCP.
- Gaps in Care Reports: Data reports generated from HEDIS data set, and letters were sent to providers with list of members to follow-up to ensure services were completed. Returned medical records were data entered into the medical record data base.
- PQIP - The Provider Quality Incentive Program (PQIP or the Program) rewards HealthKeepers' valued providers for the quality care they provided Medicaid members. Using a system of Scorecard Measures, PQIP sought to encourage efficient, preventive and cost-effective health care practices. Eligible primary care providers who met quality benchmarks and improvement and medical cost management targets received additional payments.
- Healthy Rewards offered diabetic members $25 to complete the diabetic retinal eye exam every 12 months.
- Provided information on new transportation vendor prominently on member website.
- Partnered with Care Delivery Transformation (CDT) Team, provider relations, and marketing to identify and educate providers with low quality scores
- Conducted continuous HEDIS training for case managers/care coordinators
- Care coordinators continued addressing gaps in care with members by using the Gap in Care Report
- Expanded HealthCrowd messaging campaigns

Recommendation—Performance Measure Validation
• Used social media ads Facebook/Instagram – monthly revolving topics • Updated coding book for providers/Current Procedural Terminology CPT II code cheat sheets • Continued American Cancer Society (ACS) collaboration • Implemented standing order initiative for breast cancer screenings • Continued to investigate mammogram bus opportunities • Conducted tracking/trending SDoH needs of members to determine appropriate outreach for preventive care
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note any performance improvement as a result of initiatives implemented. PMV results showed: **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services 2019: 78.72% 2020: 75.60% **Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) 2019: 48.91% 2020: 47.69% **Metric 4.4.5:** Controlling High Blood Pressure 2019: 37.23% 2020: 47.45%
Identify any barriers to implementing initiatives: HealthKeepers believed that the following barriers were possible reasons for the decline: • Members may not have been aware that they were due for the exam or not know the importance of having an exam done • Members were apprehensive to go to the doctor/emergency room for any kind of issue • Many members tended to seek care only when they were sick • Successfully contacting members was difficult • Members sought emergency room treatment instead of preventive visits • Low dollar member incentives • Inappropriate provider coding or provider documentation for preventive visits • Members' lack of knowledge about their benefits • Member education about healthy living • Social determinants of health • Member may not have been aware of transportation benefit • Providers only seeing patients if sick • Primary providers not aware that their patient had not completed the exam • Primary providers not advising their patient to get the exam due to lack of reminder • Primary care providers not aware that their patient had not completed the exam and were not incentivized • COVID-19
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services
	Goal 4.4: Improve Health for Members with Chronic Conditions	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure
HSAG recommended that HealthKeepers 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 (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): Over the last five years, HealthKeepers had seen improvements in the following areas: • Literature review and supported by HealthKeepers HEDIS data to a limited extent, revealed disparities in the areas of prevention and screening, and maternal health. Initiatives included: • EPSTD corporate mailers were updated to improve reading ease and facilitate understanding • Development of a comprehensive infographic, Promoting Birth Equity, for maternal health practices (office staff and providers) to help practices: • Articulated practice-level factors that impacted birth equity, recognize that racial and ethnic biases existed in the maternal health care setting and used tools for defeating them • Demonstrated good communication skills — even while wearing a face mask, • Practiced patient-centered communication skills focused on listening respectfully and responding appropriately in the maternal health care setting • Raised awareness of maternal health care disparities among staff members and provided tools and guidance for improving birth equity. The resource will be available on mydiversepatients.com in 2021. • To help address disparities in CAHPS and facilitate positive patient experiences, HealthKeepers worked extensively on promoting the online educational program, Improving the Patient Experience, with practices, including newsletter articles, provider flyers and specific training resources • In October 2020, HealthKeepers hosted a Racial Trauma Forum for Providers. HealthKeepers partnered with Motivo, the first HIPAA-compliant platform connecting mental health therapists to clinical supervisors. The purpose of the event was to provide insight and guidance on the experiences of racial trauma, the impact of prolonged exposure to racial injustice for black and brown people, and the important role healthcare and mental healthcare professionals can play in identifying, treating, and addressing racial trauma. This webinar was designed for Anthem (HealthKeepers)/Amerigroup/Beacon providers who would like to gain a deeper understanding of the impact of racial trauma, share experiences, learn about self-care, and better support their patients/clients. Over 420 providers participated on the call.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The number of disparities, demonstrated through HEDIS and CAHPS data, continued to be low. It's felt HealthKeepers provider education and tools, associate education and increased awareness around the importance of cultural competency and improvements in member materials contributed to this success. PMV results showed:		

Recommendation—Performance Measure Validation
Metric 4.3.2: Adults' Access to Preventive/Ambulatory Health Services 2019: 78.72% 2020: 75.60% **Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) 2019: 48.91% 2020: 47.69% **Metric 4.4.5:** Controlling High Blood Pressure 2019: 37.23% 2020: 47.45%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 3: Smarter Spending	**Goal 3.1:** Focus on Paying for Value	**Metric 3.1.1:** Frequency of Potentially Preventable Admissions **Metric 3.1.2:** Frequency of Emergency Department Visits

- Upon identification of a root cause, HSAG recommended that HealthKeepers implement appropriate interventions to improve the receipt of recommended care and services that impact the health of its members and to reduce unnecessary ED use and inpatient utilization.

MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- HealthKeepers assessed the needs of its population annually in order to determine appropriate actions to meet the needs of its members. HealthKeepers assessed the needs of its population annually in order to determine appropriate actions to meet the needs of members. HealthKeepers' overall top three-inpatient diagnosis contain two maternal delivery diagnoses and one acute but severe condition requiring hospitalization. The top outpatient diagnosis was related to exposure to viral communicative diseases with second being hypertension, a chronic condition and third was a respiratory infection which could also coincide with the top reason. HealthKeepers implemented interventions to address the identified top three diagnoses for both inpatient and outpatient services:
- Maternal Care- My Advocate™ Program: An opt-in program maternal health education by telephone, text message, and by Smartphone app to pregnant and postpartum women. Twice weekly messaging during the prenatal phase.
- New Baby, New Life℠ was a comprehensive maternity management program that supported pregnant members during the prenatal and postpartum period and newborn members up to 90 days after discharge, including those hospitalized and discharged from neonatal intensive care units (NICU). Mothers of newborns were supported and encouraged to complete well-child checks through the first year of life. Depending on the health assessment and preferences of the member, HealthKeepers services included:
  - Health education materials
  - Interactive care and case management support

Recommendation—Performance Measure Validation
– Health assessment and development of a care plan for ongoing support – Facilitation of transfer to other internal programs, as needed – Coordination with governmental and community resources – Support understanding benefits of mother and newborn • OBQIP Program: Pay for Quality Provider Incentive Plan • FindCare.com – community resource referral • Obstetrical case management for higher risk pregnant women identified and stratified by high risk screener providing telephonic support through pregnancy and delivery and through 6-8 weeks postpartum. Obstetrical nurses provided pregnancy related education and benefits overview related to pregnancy and new baby. • Infectious Disease Support- Encouraged telehealth visits for members, educated on appropriate level of care needed for members. • Community Resources: HealthKeepers partnered with certain CVS pharmacies as optional locations where members received their flu vaccine outside of the primary care provider offices. Department of Health offered free Influenza vaccine throughout Influenza season. • COVID Resources- Case managers provided resources on where to obtain COVID testing and provided education on symptoms and treatments. Additionally, all case managers were able to provide community resources on wide variety of social issues as a result of community impact of the virus during this year. • Emergency Room Program- Outreach program to members identified as having an emergency room visit to help educate them on alternatives to emergency room care if appropriate such as urgent care facilities and the 24 hours Nurse Line, as well as identifying members for engagement in the Complex Case Management programs for all age groups. • EDCC (Emergency Department Care Coordination)-"Pre-managed" Emergency Department Care Coordination (EDCC) implemented by the Commonwealth. All MCOs were notified in real-time when their members access the emergency department. The project expedited intervention from care coordinators to improve transitions of care and assured needs were met for members. • Chronic Disease Management- Population Health Programs : COPD, Asthma, Hypertension and Case Management
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement as a result of initiatives implemented. PMV results showed: **Metric 3.1.1:** Frequency of Potentially Preventable Admissions 2019: NR 2020: NR **Metric 3.1.2:** Frequency of Emergency Department Visits 2019: NR 2020: NR
Identify any barriers to implementing initiatives: The MCO did not identify barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Adult		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.3:** Rating of All Health Care

HSAG recommended that HealthKeepers focus quality improvement efforts on measure scores that exhibited a decrease from 2019 to 2020, including Rating of Health Plan for the adult Medicaid population.

MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

HealthKeepers completed a thorough evaluation of member experience by analyzing member complaints and appeals in conjunction with CAHPS member experience survey results. This gave HealthKeepers a 360° view of the member experience. A drill down into the data revealed that the complaints about transportation represent 44 percent of total complaints. The two top sub-categories of all appeals were Personal Care Aid. HealthKeepers did not meet the goal for rating of the Health Plan, Getting Care Quickly and Getting Needed Care with the Adult CAHPS survey. All other measures were above goal.

Anthem Virginia addressed the barriers by implementing the following interventions:

- Transportation-
- Meetings held on a regular basis with transportation vendor.
- Corrective action plan put into place with transportation vendor.
- Member Appeals-
- Provider offices chatted directly electronically with the prior authorization department to have questions answered.
- Updates and additional clinical information submitted electronically to pre-authorization department.

<u>CAHPS</u>

- Added availability of provider telehealth to online physician directories.
- Member website had information on getting care that was easy to find, including Quick Start Guide.

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

The MCO did not note performance improvement as a result of initiatives implemented.

CAHPS results showed:

Metric 1.2.3: Rating of All Health Care

2020: 64.0%

2021: 60.3%

Identify any barriers to implementing initiatives:

The barriers identified during the analysis included:

<u>Complaints</u>

- For the MCO: Relationship with new delegated transportation vendor
- For Providers: Providers unaware they couldn't bill Medicaid members
- For Members: Members not aware of their responsibility for transportation

<u>Appeals</u>

- For Providers: Providers not submitting all of the information needed to process an initial utilization management request, such as personal care aid.

<u>Adult CAHPS</u>

- Access to primary care providers who provided primary care was an issue

Recommendation—Member Experience of Care Survey - Adult		
• Members not able to reach providers due to COVID-19 • MCO increased in membership related to COVID-19		
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.		
Recommendation—Member Experience of Care Survey - Adult		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.1:** Getting Care Quickly
Aim 2: Effective Patient Care	**Goal 2.2:** Ensure Access to Care	**Metric 2.2.3:** Getting Needed Care
HSAG recommended that HealthKeepers conduct a root cause analysis of study indicators that have been identified as areas of low performance.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): HealthKeepers completed a thorough evaluation of member experience by analyzing member complaints and appeals in conjunction with CAHPS member experience survey results. This gave HealthKeepers a 360° view of the member experience. A drill down into the data revealed that the complaints about transportation represent 44 percent of total complaints. The two top sub-categories of all appeals were Personal Care Aid. HealthKeepers did not meet the goal for rating of the Health Plan, Getting Care Quickly and Getting Needed Care with the Adult CAHPS survey. All other measures were above goal. Anthem Virginia addressed the barriers by implementing the following interventions: • Transportation- • Meetings held on a regular basis with transportation vendor. • Corrective action plan put into place with transportation vendor. • Member Appeals- • Provider offices chatted directly electronically with the prior authorization department to have questions answered. • Updates and additional clinical information submitted electronically to pre-authorization department. <u>Child CAHPs</u> • Lack of provider awareness of tools available and how to use • Members unaware of physician interaction regarding their care • Access to primary care providers who provided primary care was an issue • Members not able to reach providers due to COVID-19 • MCO increased in membership related to COVID-19		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement as a result of initiatives implemented. CAHPS results showed: **Metric 1.2.1:** Getting Care Quickly 2020: 84.7% 2021: 81.6%		

Recommendation—Member Experience of Care Survey - Adult
Metric 2.2.3: Getting Needed Care 2020: 85.3% 2021: 84.3%
Identify any barriers to implementing initiatives: HealthKeepers addressed the barriers by implementing the following interventions: <u>Transportation</u> • Meetings held on a regular basis with transportation vendor. • Corrective action plan put into place with transportation vendor. <u>Member Appeals</u> • Provider offices chatted directly electronically with the prior authorization department to have questions answered. • Updates and additional clinical information submitted electronically to pre-authorization department. <u>CAHPS</u> • Added availability of provider telehealth to online physician directories. • Member website had information on getting care that was easy to find, including Quick Start Guide.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Adult		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.1:** Getting Care Quickly
Aim 2: Effective Patient Care	**Goal 2.2:** Ensure Access to Care	**Metric 2.2.3:** Getting Needed Care
• HSAG also recommended that HealthKeepers continue to monitor the measures to ensure there are no significant decreases in rates over time.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): HealthKeepers addressed the barriers by implementing the following interventions: <u>Transportation</u> • Meetings held on a regular basis with transportation vendor. • Corrective action plan put into place with transportation vendor. <u>Member Appeals</u> • Provider offices chatted directly electronically with the prior authorization department to have questions answered. • Updated and additional clinical information submitted electronically to pre-authorization department. <u>CAHPS</u> • Added availability of provider telehealth to online physician directories. • Member website had information on getting care that was easy to find, including Quick Start Guide. • HealthKeepers continued to monitor the measures to ensure there was no significant decreases in rates over time.		

Recommendation—Member Experience of Care Survey - Adult
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement as a result of initiatives implemented. CAHPS results showed: **Metric 1.2.1:** Getting Care Quickly 2020: 84.7% 2021: 81.6% **Metric 2.2.3:** Getting Needed Care 2020: 85.3% 2021: 84.3%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Child		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.1:** Getting Care Quickly
Aim 2: Effective Patient Care	**Goal 2.2:** Ensure Access to Care	**Metric 2.2.3:** Getting Needed Care
HSAG recommended that HealthKeepers focus quality improvement efforts on measure scores that decreased from 2019 to 2020: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Getting Needed Care for the child Medicaid population.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): HealthKeepers addressed the barriers by implementing the following interventions: <u>Transportation</u> • Meetings held on a regular basis with transportation vendor. • Corrective action plan put into place with transportation vendor. <u>Member Appeals</u> • Provider offices chatted directly electronically with the prior authorization department to have questions answered. • Updated and additional clinical information submitted electronically to pre-authorization department. <u>CAHPS</u> • Added availability of provider telehealth to online physician directories. • Member website had information on getting care that was easy to find, including Quick Start Guide. • HealthKeepers continued to monitor the measures to ensure there was no significant decreases in rates over time.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable):		

Recommendation—Member Experience of Care Survey - Child
The MCO did not note performance CAHPS results showed: **Metric 1.2.1:** Getting Care Quickly 2020: 84.7% 2021: 81.6% **Metric 2.2.3:** Getting Needed Care 2020: 85.3% 2021: 84.3%
Identify any barriers to implementing initiatives: HealthKeepers addressed the barriers by implementing the following interventions: <u>Transportation</u> • Meetings held on a regular basis with transportation vendor. • Corrective action plan put into place with transportation vendor. <u>Member Appeals</u> • Provider offices chatted directly electronically with the prior authorization department to have questions answered. • Updates and additional clinical information submitted electronically to pre-authorization department. <u>CAHPS</u> • Added availability of provider telehealth to online physician directories. • Member website had information on getting care that was easy to find, including Quick Start Guide.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Child		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.1:** Getting Care Quickly
Aim 2: Effective Patient Care	**Goal 2.2:** Ensure Access to Care	**Metric 2.2.3:** Getting Needed Care
HSAG recommended that HealthKeepers conduct a root cause analysis of study indicators that have been identified as areas of low performance.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): HealthKeepers completed a thorough evaluation of member experience by analyzing member complaints and appeals in conjunction with CAHPS member experience survey results. This provided a 360° view of the member experience. A drill down into the data revealed that the complaints about transportation represented 44 percent of total complaints. The two top sub-categories of all appeals were Personal Care Aid. Anthem Virginia did not meet the goal for rating of personal doctor, getting care quickly, getting needed care, and customer service. All other measures were above goal.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable):		

Recommendation—Member Experience of Care Survey - Child
The MCO did not note performance improvement as a result of initiatives implemented. CAHPS results showed: **Metric 1.2.1:** Getting Care Quickly 2020: 84.7% 2021: 81.6% **Metric 2.2.3:** Getting Needed Care 2020: 85.3% 2021: 84.3%
Identify any barriers to implementing initiatives: HealthKeepers addressed the barriers by implementing the following interventions: <u>Transportation</u> • Meetings held on a regular basis with transportation vendor. • Corrective action plan put into place with transportation vendor. <u>Member Appeals</u> • Provider offices chatted directly electronically with the prior authorization department to have questions answered. • Updates and additional clinical information submitted electronically to pre-authorization department. <u>CAHPS</u> • Added availability of provider telehealth to online physician directories. • Member website had information on getting care that was easy to find, including Quick Start Guide
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Child		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.1:** Getting Care Quickly
Aim 2: Effective Patient Care	**Goal 2.2:** Ensure Access to Care	**Metric 2.2.3:** Getting Needed Care
HSAG recommended that HealthKeepers continue to monitor the measures to ensure there are no significant decreases in rates over time.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): HealthKeepers completed a thorough evaluation of member experience by analyzing member complaints and appeals in conjunction with CAHPS member experience survey results. This provided a 360° view of the member experience. A drill down into the data revealed that the complaints about transportation represented 44 percent of total complaints. The two top sub-categories of all appeals were Personal Care Aid. Anthem Virginia did not meet the goal for rating of personal doctor, getting care quickly, getting needed care, and customer service. All other measures were above goal		
Identify any noted performance improvement as a result of initiatives implemented (if applicable):		

Recommendation—Member Experience of Care Survey - Child
The MCO did not note performance improvement as a result of initiatives implemented. CAHPS results showed: **Metric 1.2.1:** Getting Care Quickly 2020: 89.1% 2021: 84.8% **Metric 2.2.3:** Getting Needed Care 2020: 83.0% 2021: 83.0%
Identify any barriers to implementing initiatives: HealthKeepers addressed the barriers by implementing the following interventions: <u>Transportation</u> • Meetings held on a regular basis with transportation vendor. • Corrective action plan put into place with transportation vendor. <u>Member Appeals</u> • Provider offices chatted directly electronically with the prior authorization department to have questions answered. • Updates and additional clinical information submitted electronically to pre-authorization department. <u>CAHPS</u> • Added availability of provider telehealth to online physician directories. • Member website had information on getting care that was easy to find, including Quick Start Guide
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Magellan

Table E-4—Prior Year Recommendations and Responses—Magellan

Recommendation—Performance Improvement Projects		
Aim 4: Improved Population Health	**Goal 4.6:** Improve Outcomes for Maternal and Infant Members	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care
HSAG recommended that Magellan: • Include the key driver the intervention is expected to address/impact. • Provide more details of the step-by-step data collection process. • Define the intervention effectiveness measure accurately. • Include how claims lag may impact having real-time data for intervention evaluation. • Provide the SMART Aim measure run chart correctly. • Ensure interventions tested for the PIP could impact the SMART Aim. • Explain major changes in the SMART Aim measure eligible population.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		

Recommendation—Performance Improvement Projects
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): **Improve Timeliness of Prenatal Care** Enroll Member in a Prenatal Incentive Program: Magellan care coordinators introduced members to the prenatal incentive program and enrolled members into the program. Upon enrollment, members received frequent monitoring by the care coordination team, educational and community resources, and financial incentives upon completing all prenatal visits. This intervention was selected because – compared to other interventions in the Failure Mode Priority Ranking, the failure "Member doesn't go to appointment" had the highest risk priority number (RPN) of 40 [Level of Severity – Very High (5); Likelihood of Detection – Low (2); Probability of Failure – Very High (5)]. Although there was another failure mode (wrong number or no contact information) with the same RPN, it was determined that an intervention to mitigate the failure mode of members not going to appointments would have a greater level of success and therefore be more likely to have a positive impact on the SMART Aim. Magellan therefore determined that this intervention should be prioritized. **Reduce Tobacco Use in Pregnant Women** Tobacco Cessation Incentive Program: Magellan care coordinators introduced member to smoking cessation incentive program and enrolled member into the program. Member received frequent monitoring by care coordination team, tobacco cessation resources, and financial incentive upon successful cessation. This intervention was selected because – compared to other interventions – in the Failure Mode Priority Ranking this failure had the highest risk priority number (RPN) of 100 [Level of Severity – Very High (5); Likelihood of Detection – High (4); Probability of Failure – Very High (5)]. All other failure modes scored a 75 RPN or less. Magellan therefore determined that this intervention focused on tobacco cessation for pregnant women should be prioritized.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): **Improve Timeliness of Prenatal Care:** The performance measure rate baseline rate (2/1/2019 – 1/31/2020) was 37 percent. A remeasurement (6/1/2020 – 5/31/2021) showed a rate of 34.2 percent. Reduce Tobacco Use in Pregnant Women: The performance measure rate baseline rate (2/1/2019 – 1/31/2020) was 94.5 percent. A remeasurement (6/1/2020 – 5/31/2021) showed a rate of 97.4 percent. PMV results showed: **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care 2019: 54.01% 2020: 62.01%
Identify any barriers to implementing initiatives: Improve Timeliness of Prenatal Care: Barriers were not identified in implementing the initiative. Reduce Tobacco Use in Pregnant Women: During intervention, Magellan found that many members did not join the incentive program for various reasons. Magellan did not have all the members' contact information so some members may not have known about the incentive program, some members were not interested in participating, some members were in "Do-Not-Call" list and Magellan was not able to contact them, and some members had already delivered a baby.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improve population health	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.3.4:** Child and Adolescent Well-Care Visits
	Goal 4.4: Improve Health for Members with Chronic Conditions	**Metric 4.4.4:** Comprehensive Diabetes Care, Hemoglobin A1c (HbA1c) Poor Control **Metric 4.4.5:** Controlling High Blood Pressure

- HSAG recommended that Magellan conduct a root cause analysis or focus groups to identify the reasons why members are not accessing well care, preventive care, behavioral healthcare, and care for chronic conditions.
- HSAG recommended that Magellan analyze its data and results of any root cause analysis or focus groups to identify opportunities to reduce any disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
- Upon identification of root causes, HSAG recommended that Magellan implement appropriate evidence-based interventions to improve access to, and timeliness of care and services across low-scoring healthcare domains.

MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Magellan acknowledged the need to conduct a root cause analysis to identify the reasons why members were not accessing well care, preventive care, behavioral healthcare, and care for chronic conditions. Magellan worked with the concerned department to make members aware of their assigned primary care provider and provided outreach support to the providers and reaching out on all HEDIS measures to educate members of preventive screenings and well visits.
- Magellan analyzed membership race and ethnicity at least annually to ensure that care and services met the needs of the population. Race and ethnicity were further analyzed by county to assess the areas where the MCO should be concentrating and expanding its network. CAHPS demographic data was used if internal data showed a high proportion of Unknown or Other membership.
- Providers were sent monthly gaps in care reports and educated on the importance of non-established members getting needed care on time. MCC also hosted monthly clinic days and concentrate on scheduling non established members for required visits.

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

The MCO did not identify results from the initiatives implemented.

PMV results showed:

Metric 4.3.2: Adults' Access to Preventive/Ambulatory Health Services

2019: 65.76%

2020: 62.01%

Metric 4.3.4: Child and Adolescent Well-Care Visits

2019: NR

2020: 32.97%%

Recommendation—Performance Measure Validation		
Metric 4.4.4: Comprehensive Diabetes Care, Hemoglobin A1c (HbA1c) Poor Control 2019: 59.37% 2020: 60.58% **Metric 4.4.5:** Controlling High Blood Pressure 2019: 27.74% 2020: 37.47%		
Identify any barriers to implementing initiatives: Magellan was able to identify the main cause for low scores was non established members (members not seen by the assigned primary care provider even once) and assigned primary care provider were unwilling to do any outreach to non-established members.		
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.		
Recommendation—Member Experience of Care Survey - Child		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.1:** Getting Care Quickly **Metric 1.2.2:** Enrollees' Ratings of All Health Care **Metric 1.2.3:** Rating of All Health Care
Aim 2: Effective Patient Care	**Goal 2.1:** Enhance Provider Support	**Metric 2.1.1:** Rating of Personal Doctor **Metric 2.1.2:** How Well Doctors Communicate
	Goal 2.2: Ensure Access to Care	**Metric 2.2.3:** Getting Needed Care
• HSAG recommended that Magellan focus quality improvement efforts on measure scores that were statistically significantly lower than the NCQA Medicaid national averages. • HSAG recommended that Magellan conduct a root cause analysis of study indicators that have been identified as areas of low performance. • HSAG recommended that Magellan focus on increasing response rates to the CAHPS survey for its child population so that there are more than 100 respondents for each measure.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Magellan acknowledges that quality improvement efforts are required to improve scores that were significantly lower than NCQA Medicaid national averages. Magellan educated providers through CAHPS tips sheet, discussions at Value based Program (VBP) meetings and provider newsletters. Magellan educated providers to prescribe refills for 90 days instead of 30 days. This timeframe made it easier for the member to pick up the medicine every three months than every month. • Magellan acknowledges the need to do a root cause analysis of study indicators that have been identified as areas of low performance. Magellan identified overscheduling of members was an important cause for the doctor not to spend enough time with members. Education was provided to providers to dedicate time to each member as needed. Magellan also identified that members had transportation issues to go to		

Recommendation—Member Experience of Care Survey - Child
pharmacy to pick up medicines. Magellan educated the providers on discussing the home delivery option with members for medicines. • Magellan acknowledges the need to increase response rates to CAHPS survey. Magellan believes in every member counts campaign and all employees were educated and engaged to increase knowledge of CAHPS, customer service techniques, and special awareness during survey period. Intranet articles were released throughout the year that MCC staff would have had access to along with two ILearn trainings.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note any performance improvement as a result of the initiatives implemented. CAHPS results showed: **Metric 1.2.1:** Getting Care Quickly 2020: 91.3% 2021: 86.3% **Metric 1.2.3:** Rating of All Health Care 2020: 70.3% 2021: 70.3% **Metric 2.1.1:** Rating of Personal Doctor 2020: 69.1% 2021: 74.8% **Metric 2.1.2:** How Well Doctors Communicate 2020: 92.7% 2021: 92.3% **Metric 2.2.3:** Getting Needed Care 2020: 82.8% 2021: 79.5%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Optima

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

Recommendation—Performance Improvement Projects		
Aim 4: Improved Population Health	**Goal 4.6:** Improve Outcomes for Maternal and Infant Members	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care
HSAG recommended that Optima: • Include the key driver and failure mode the intervention is expected to address/impact. • Include all the details in the intervention process steps. • Complete the evaluation plan in Module 4. • Define the intervention effectiveness measure accurately.		

Recommendation—Performance Improvement Projects
• Include how claims lag may impact having real-time data for intervention evaluation. • Ensure that the SMART Aim measure run chart data are reported correctly. • Ensure interventions tested for the PIP will impact the SMART Aim. • Report intervention evaluation measure results at least monthly.
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): Optima complied with all recommendations and feedback from HSAG within the PIP documents. This was evidenced within each PIP document and revision that was submitted to HSAG over the course of the PIP cycle. Feedback was addressed and expeditiously returned as requested or addressed at the next PIP cycle due date. **Clinical – Timeliness of Prenatal Visits PIP** As illustrated in Module 1 of this PIP, the key driver: "Identify pregnant Medicaid members who resided in the city of Norfolk and saw providers in the Norfolk locale" was expected to make an impact for this project. In Module 3, the number one subprocess identified was "Member doesn't understand the importance of prenatal care" – again helping identify effective interventions for this project. Module 4 contains all the details in the intervention process steps. Also had the evaluation plan as well as the effectiveness of the measures. Optima's claims lag was addressed in Module 2 which stated that "Optima Health estimated a 97 percent completion of claims within 30 days." The SMART Aim measure run chart and the monthly evaluation results in Module 4 were all reviewed and approved by HSAG upon previous submission. <u>Non-Clinical - Tobacco Cessation PIP:</u> As illustrated in Module 1 of this PIP, the Key driver: "Identification of tobacco use among Optima Health Medicaid-insured pregnant member" was expected to make an impact for this project. In Module 3, the FMEA showed that the number subprocess was "Identification of pregnant women who smoke" – confirming this need will make an impact. Module 4 contained all the details in the intervention process steps. Also had the evaluation plan as well as the effectiveness of the measures. Optima's claims lag was addressed in Module 2 which stated that "Optima estimated a 97 percent completion of claims within 30 days." The SMART Aim measure run chart and the monthly evaluation results in Module 4 were all reviewed and approved by HSAG upon previous submission.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not include performance improvement results as a result of the initiatives implemented. PMV results showed: **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care 2019: 72.99% 2020: 74.45%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing the initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.4:** Child and Adolescent Well-Care Visits
	Goal 4.6: Improve Outcomes for Maternal and Infant Members	**Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life

- HSAG recommended that Optima conduct a root cause analysis or focus groups to determine why children were not receiving well-care visits and immunizations according to recommended schedules.
- HSAG also recommended that Optima conduct similar processes and analyses of data to better understand barriers members experience in receiving care for chronic conditions.
- HSAG recommended that Optima consider whether there are disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
- Upon identification of a root cause or causes, HSAG recommended that Optima implement appropriate interventions to improve access to and timeliness of preventive visits, screenings, and recommended services for members diagnosed with a chronic condition.

MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

Optima understands that a "one size fits all" approach was not sufficient for member and community outreach. Therefore, the MCO created a program that used both traditional and non-traditional means to reach its member population and address unmet health-related social needs.

Optima used a multi-modality platform for engaging its members, community partners, staff, and subcontractors. Optima's outreach and education program included targeted communication and outreach by region, focusing on community-based organizations, continuing advocacy, and keeping members engaged by helping them understand the value of program benefits and services. Additionally, Optima supported those members who required unique communication solutions like TTY, Braille, interpretive services, or the use of community health workers to fully engage in their member benefits. Optima used regular mail, member website and provide options for member engagement through social media, texting, and member email.

<u>Comprehensive Diabetes Care (CDC)</u>

Current Interventions:

- Diabetic eye incentive program
- Diabetic eye exam call campaign
- Monthly video distribution
- Mobile diabetic eye exam events
- At-home HbA1c testing
- Enhanced Sentara diabetes lass communication
- Education resources training for case management teams
- Predictive analysis data integration into clinical workflows
- Member level care gap data integration into clinical workflows to inform/engage members in closing care gaps
- In-home assessment and quality gap closures

Recommendation—Performance Measure Validation
Emerging interventions • Partnerships with vendors to facilitate and promote member self-care management • Exploration of emerging technology and partnerships to improve health outcomes for Optima members Asthma Admission Rate • Used predictive analytics to identify high risk members utilized for case managers to contact and provide asthma control education • Used member level care gap data integration into clinical workflows to inform/engage members in closing care gaps • Provided education resource utilization for educational videos • Included outreach team calls identification of asthmatic members for case managers to contact
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Childhood Immunization Status (CIS)-When comparing Medallion 4- CY2019 (63.02%) to CY2020 (64.23%) for CIS-Combo 3 there was a slight increase of 1.9%. This increase was not statistically significant per Chi-squared testing and failed to meet any short or long-term goals. Although there was an increase, this rate is in the 10th percentile, when compared to the 2020 Quality Compass Benchmarks. Well-Child Visits in the First 30 Months of Life (W30)- For MY2020 NCQA revised the Specifications for Well Child/ Adolescent Visits. This is a first-year measure for M4. The current rate CY2020 (71.45%) is over the 50th Percentile when compared to the 2021 Quality Compass Benchmarks. Well Child Visits (WCV)-The current rate CY2020 (44.49%) is at the 50th Percentile when compared to the 2021Quality Compass Benchmarks. Comprehensive Diabetes Care (CDC)-When comparing Medallion 4- CY2019 (40.15%) to CY2020 (38.44%) for CDC Eye Exam there was a 4.35% decrease in rate. This decrease was not statistically significant and failed to meet any short or long-term goals. HbA1c<8.0% CY2020 (35.28%) had a decrease of 17%, and CBP CY2020 (38.20%) had a decrease of 29.35% decrease. Both of these decreases are significant per Chi-squared testing and both failed to meet any short or long-term goals. All 3 rates for CDC measure in Medallion 4 failed to meet the Long-Term Goal of NCQA Accreditation Benchmark 50th Percentile. PMV results showed: **Metric 4.3.4:** Child and Adolescent Well-Care Visits 2019: NR 2020: 44.49% **Metric 4.6.3:** Childhood Immunization Status 2019: 63.02% 2020: 64.23% **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life 2019: First 15 Months: 60.68%; 15 Months – 30 Months: NR 2020: First 15 Months: 58.47%; 15 Months – 30 Months: 71.45%
Identify any barriers to implementing initiatives: CIS; W30 and WCV • Decrease visits to Pediatricians due to Covid-19 PHE • Lack of childcare for parents, siblings not allowed in waiting areas due to COVID-19 restrictions • Knowledge/awareness deficit: • Language /communication barriers • Unaware of vaccination recommendations

Recommendation—Performance Measure Validation

- Concerns over overloading immune system and side effects or adverse reactions of vaccines
- Access Issues
- Cost
- Inappropriate/limited-service hours (limited days/hours; sessions begin late/end early)
- Fragmented care (no-shows, cancellations)
- Transportation issues

CDC

- Perceived control of disease process

Providers

- Not incorporating preventive care guidelines in each visit
- Lack of care coordination among multiple providers
- Unaware of noncompliant members with healthcare gaps/dismissive of gap in care letters
- Not enough providers
- Language/cultural
- Ability/knowledge of staff to assist members
- Providers wanting separate visits for issues instead of addressing two or three at a visit

Optima understands the barriers and challenges in each of the six regions and was uniquely positioned to successfully implement the Medicaid program. Proactive attention and focus on the unique properties of each region was a key component of its SDoH strategy. Below outlines some of the barriers and challenges in each region.

Tidewater Region-

In the urban areas of the Commonwealth of Virginia, Optima saw greater challenges with opioid use. Through Optima's Addiction and Recovery Treatment Services (ARTS) program and working with providers to help identify and enroll members in its lock-in program (PUMS), Optima worked with communities to combat this national epidemic.

Optima was also aware of the high infant mortality rate in Norfolk and have deployed its Partners in Pregnancy program in that area. Optima also referred pregnant members and members with newborns to the Comprehensive Health Investment Project (CHIP) of Virginia program and Urban Babies, which both provided home visiting services using a care management approach to promote wellness, minimize preterm births and low birthweight babies and improve children's health. Additionally, Hampton (8.6%) and Newport News (9.5%) had high percentages of babies born with a low birth weight and high infant mortality rates compared to US (8.1%) and Virginia (7.9%). Optima supported organizations like Smart Beginnings of Virginia Peninsula, which is an organization of health care workers, community leaders, teachers, and parents to work with parents to focus on minimizing preterm births and low birthweight babies.

Although obesity can sometimes be genetic, access to healthy food options, income/poverty, and other socio-economic factors are the cause of high obesity rates. Obesity rates were higher in Norfolk (30.7%), Portsmouth (36.6%), and Suffolk (33.1%) than Virginia (30.3%) and the USA (30.6%). Obesity leads to serious health conditions including hypertension, Type 2 diabetes, heart disease, stroke, sleep apnea/breathing problems, and others. Optima provided access to healthy foods through its Healthy Savings program and education about healthy alternatives through its health literacy program to its members.

Optima offered incentives to encourage increased prenatal and postpartum care of all pregnant women.

Central Region-

Overweight and obesity issues are well known in the Southwest and Central regions, where Optima also found high rates of prediabetes and diabetes. In addition to its care management interventions, Optima are also

Recommendation—Performance Measure Validation
offered enhanced benefits targeting weight management for its general membership, as well as specific interventions for members diagnosed with prediabetes and diabetes. Despite a decline in recent years, homelessness remained high in this area. Safe and affordable housing was difficult to find. Members frequently relocated Food insufficiency, literacy (including digital literacy), lack of transportation, and crime were other Northern/Winchester- Diverse population and language challenges Although the Northern/Winchester Region was home to the highest income counties in the Commonwealth, severe housing problems were found in Manassas City and Winchester City and food insufficiency. There were two additional needs: food insufficiency and mental health. Food pantries in the area have seen 200%-400% increases in their volume of clients with many of these pantries struggling to stay stocked in food for the communities they served. Mental health issues were also on the rise because of the drastic life changes, economic instability, and racial inequalities to name a few factors. Tensions in the home increased as well as families were learning to navigate the new normal with working and schooling from home. There has also been an unfortunate increase in domestic violence. Mental health facilities have reported growing waitlists as capacity in facilities have been reduced due to COVID-19. Optima is partnering with community organizations to address each of these issues. Charlottesville/Western- Limited transportation opportunities in difficult-to-reach locations. Optima worked with its transportation vendor to address this challenge and provide acceptable options. Safe and affordable housing was difficult to find With six of the 22 counties primarily rural, provider contracting and recruitment in rural areas was a common network development challenge due to the shortage of providers in rural areas. Roanoke/Alleghany- Adequate and timely transportation in rural areas was a challenge to members who live in those locales, such as the Southwest and Roanoke/Alleghany regions. Optima worked with these members and transportation providers to offer solutions. Optima also worked to expand telemedicine capacity in these rural areas to eliminate the need for transportation to a provider site when appropriate. Technology: expanded broadband, increased hot spot locations, technology centers, telehealth equipment (smart phones, laptops, hot spots), and Chromebooks for students. In the far southwest region of Virginia, there has been an increase in the number of children in foster care and children who are raised by their grandparents. There was some evidence that children in foster care have been removed from their families of origin due to sexual abuse or domestic violence. These children often have gaps in care, such as that provided through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) periodicity schedule. Optima's Outreach team and Care Managers worked with these families to ensure they access this care, addressing any barriers that existed. These young members may need mental health screening as well, and Optima collaborated with the Community Service Boards to schedule that service. Grandparents in these areas who were caring for their grandchildren may also need referral to resources to provide support and, at times, respite care. This region also experiences greater substance use and abuse, including high rates of tobacco use. Fewer provider groups to work with and limited access to specialists. Limited community resources in Alleghany. Food insufficiency, housing and literacy are additional challenges. Southwest-

Recommendation—Performance Measure Validation
Overweight and obesity issues are well known in the Southwest and Central regions, where Optima also find high rates of prediabetes and diabetes. In addition to its care management interventions, Optima are also offered enhanced benefits targeting weight management for its general membership, as well as specific interventions for members diagnosed with prediabetes and diabetes. Adequate and timely transportation in rural areas was a challenge to members who lived in those locales, such as the Southwest and Roanoke/Alleghany regions. Optima worked with these members and transportation providers to offer solutions. Optima are worked to expand telemedicine capacity in these rural areas to eliminate the need for transportation to a provider site when appropriate. Technology: expanded broadband, increased hot spot locations, technology centers, telehealth equipment (smart phones, laptops, hot spots), and Chromebooks for students. Substance abuse was prevalent. This region has a higher incident of opioid overdoses. Optima Health offered incentives for members and providers to encourage screening of all pregnant women.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Child		
Aim 1: Enhance Member Care Experience	**Goal 1.3:** Improve Home and Community-Based Services	**Metric 1.3.2:** Number and Percent of Individuals Who Received Services in the Scope Specified in the Service Plan
Aim 2: Effective Patient Care	**Goal 2.1:** Enhance Provider Support	**Metric 2.1.2:** How Well Doctors Communicate

- HSAG recommended that Optima focus quality improvement efforts on measure scores that exhibited a decrease from 2019 to 2020 (i.e., How Well Doctors Communicate for the child Medicaid population).
- HSAG recommended that Optima conduct a root cause analysis of study indicators that have been identified as areas of low performance.
- HSAG also recommended that Optima focus on increasing response rates to the CAHPS survey for its child population so that there are more than 100 respondents for each measure.

MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Established a member and provider satisfaction improvement committee
- Collaborated with network management team to communicate and educate within Medicaid providers

<u>Coordination of care</u>

- Informed, supported, reminded and facilitated providers about coordination of care expectations, timely notification requirements, and standards of care for post-visit follow up to all primary care providers. Explored options to encourage and support communications between specialists and primary care providers.
- Carefully assessed any parent or patient concerns associated with any health care received out-of-office, addressing, and clarifying as appropriate. Sought and obtained all associated records.
- Developed on-going and timely reminders/messaging to promote and improve communication and reporting between all provider types, ideally based directly on available data/information.

Recommendation—Member Experience of Care Survey - Child

- Assessed the status and consistency of coordination of patient care, communication, and information shared within and across provider networks. Assured prompt feedback, standards.
- Supported and facilitated a patient-centered care management approach within and across provider networks. Facilitated a complementary plan-based patient centered care management approach.
- Explored potential of aligning information flow/electronic health records to better integrate, support or facilitate patient care, care coordination and vital medical and personal information among providers.
- Encouraged providers to prompt patients AND patients to prompt providers, i.e., mutual interactions that reviewed and discussed care, tests and/or treatments involving other providers.
- Encouraged patients to bring a list of all medications, including dosage and frequency to all appointments. Encouraged providers to prompt patients to do the same for their appointments.

Getting Needed Care:

- Evaluated with HEDIS data, complaints, appeals and/or quality of care concerns, and communicated. Identified issues, prioritized and implemented improvement activities.
- Worked with providers to support patients in navigating health care and remove obstacles. Supported and encouraged providers to take innovative action to improve access. Examples include: Served patients quickly, treat urgent issues promptly, minimize wait times, follow-up about appointment times and test results. Another was to develop an in-depth referral/decision-making guide for primary care providers to prepare for/with patients explaining need, urgency, patient expectations and responsibilities, and preparations for seeing a specialist.
- Encouraged and guided parents/families when and how to use/access alternative care settings, e.g., web-based, tele-health, urgent care, and emergency care.
- Supported members and collaborated with providers to enhance access to care through innovative, proactive approaches within care management, chronic care, and quality management. Worked with providers to identify and resolve opportunities.
- Continually assessed, revisited, and simplified plan requirements/processes (i.e., utilization management) impacting access to care, tests, or treatment. Sought opportunities to improve processes and procedures.
- Reviewed and simplified precertification/auth/referral policies/procedures for both member and provider, including messages and communications. Cross-referenced with complaints, concerns, and quality of care issues. Improved and clarified processes and communications.

Getting Care Quickly:

- Correlated with HEDIS data, complaints, appeals and/or quality of care concerns, and communicate. Supported and encouraged providers to take innovative action to improve access.
- Supported members and collaborated with providers to enhance routine and urgent access to care through innovative, proactive approaches within care management, chronic care, and quality management. Worked with providers to identify and resolve opportunities.
- Discussed and engaged providers/staff on scheduling best practices, how to improve access to routine/urgent care. Considered scheduling routine appointments well in advance, e.g., 12 months. Provided tools, resources, support, and assessment.
- Supported, encouraged and assisted in approaches toward open access scheduling. Allowed a portion of each day open for urgent care and/or follow-up care.
- Contracted with additional providers for urgent and after-hour appointments/availability.
- Explored partnering with 24-hour urgent care or walk-in clinics.
- Educated providers and staff about MCO and regulatory appointment wait time requirements or standards (i.e., CAHPS, CMS, States, etc.) . Identified opportunities for improvement.

Recommendation—Member Experience of Care Survey - Child
• Provided members streamlined tools and resources (links, apps, etc.) about benefits, providers, referrals, scheduling appointments, etc. Identified options and hours available, and included alternatives, including practices with evening and weekend hours. Considered alternative sources of information, e.g., refrigerator magnets. • Explored and supported alternative telecommunication technologies to expand access to care: telephone, telehealth, telemedicine, and patient portals. • Encouraged use of nurse hotline/Nurse on Call lines or live chat via web for members to get health information and advice.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not provide any performance improvement results of the initiatives implemented. CAHPS results showed: **Metric 2.1.2:** How Well Doctors Communicate 2020: NR 2021: 97.1%
Identify any barriers to implementing initiatives: The MCO did not provide any barriers to implementing the initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

United

Table E-6—Prior Year Recommendations and Responses—United

Recommendation—Performance Improvement Projects		
Aim 4: Improved Population Health	**Goal 4.6:** Improve Outcomes for Maternal and Infant Members	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care
HSAG recommended that United: • Include all the details in the intervention process steps—the actual step-by-step process of the intervention that will be tested. • Prioritize interventions that will impact the SMART Aim. • Link interventions to priority failure modes from Module 3. • Link interventions to key drivers from the key driver diagram. • Provide clarification in the intervention evaluation plan. • Define the intervention effectiveness measure accurately.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): UHC completed and summitted Modules 1 - 5 for the Timeliness of Prenatal Care and Tobacco Use Cessation in Pregnant Women Medallion 4.0 PIPs and received validation feedback and recommendations from HSAG. UHC addressed all module feedback and recommendations provided by HSAG.		

Recommendation—Performance Improvement Projects
HSAG validated the modules and instructed UHC to resubmit Module 4 and Module 5 for the PIPs on September 30, 2021. The resubmissions allowed an opportunity to address HSAG's feedback from the initial validation, correct discrepancies that were identified in the documentation of the initial submission, provide additional SMART Aim measure data points and updates on interventions. For each PIP conducted, UHC defined a SMART Aim statement that identified the narrowed population and process to be evaluated, selected & prioritized interventions that could impact the SMART Aim, set a goal for improvement, developed an intervention evaluation plan and defined the intervention effectiveness measure indicator used to measure progress toward the goal. Two interventions were implemented for each PIP. UHC evaluated interventions and monitored results. Monitoring did not begin until June/July 2020. Trends in data and results were documented in the modules. UHC adapted two of the interventions with additional improvements for the Timeliness of Prenatal Care PIP and the Tobacco Cessation in Pregnant Women PIP and have adopted both interventions.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO continued to monitor results but did not provide any noted performance improvement as a result of the initiatives implemented. PMV results showed: **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care 2019: 69.59% 2020: 65.45%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.3.4:** Child and Adolescent Well-Care Visits

- HSAG recommended that United conduct a root cause analysis or focus groups to determine why members were not receiving well-child visits or preventive screenings or accessing care according to recommended schedules.
- HSAG also recommended that United conduct similar processes and analyses of data to better understand barriers members experience in receiving care for chronic conditions.
- HSAG recommended that United consider whether there were disparities within the MCO's populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
- Upon identification of a root cause or causes, HSAG recommended that United implement appropriate interventions to improve access to and timeliness of preventive visits, screenings, and recommended services for members diagnosed with a chronic condition.

MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

Recommendation—Performance Measure Validation
• As one of United's strategies for further evaluating this area, United examined members who were non-compliant for well-child visits or preventive screenings but had visited a primary care provider during the measurement period. • In addition to identifying chronic conditions through routine health risk assessments, on an ongoing basis, United conducted 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 were subsequently connected with enhanced care coordination and outreach activities. • On an ongoing basis United continued to evaluate data and identified areas of opportunity and strategies to address health disparities. • One example was where United performed an analysis of PPC HEDIS data of prenatal compliance, postpartum compliance, and prenatal/postpartum compliance by age, language, subpopulation, region, and behavioral health diagnosis; with one specific model conducting a deeper dive into select health districts in the Tidewater region. • Members in the Peninsula Health District showed a lower prenatal compliance than the overall Tidewater compliance. Members with a behavioral health diagnosis did not show significant differences from the non-behavioral health members. • United performed many interventions on an ongoing basis to improve access to and timeliness of preventive screenings and visits. A recent example includes United's analysis and identification of common barriers expressed by care coordinators with members accessing and receiving timely preventative visits, screenings, and services. As UHC identified members with chronic conditions through routine health assessments, United's enhanced complex care coordinators: • Ensured United's members had a primary care provider and/or specialist, and assisted the member with obtaining one if needed, • Assisted the member with scheduling appointments for each provider visit, • Arranged transportation if needed, • 4) Scheduled timely follow-up calls with the member post provider visit to provide additional evidenced-based education, assisted member with diagnostic-specific care, services and resources.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement as a result of initiatives implemented. PMV results showed: **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services 2019: 72.34% 2020: 67.65% **Metric 4.3.4:** Child and Adolescent Well-Care Visits 2019: NR 2020: 47.22%
Identify any barriers to implementing initiatives: During the COVID-19 national public health emergency, UHC determined members were primarily seeing providers for sick visits only with diminished focus on well-visits. United appreciated HSAG's recommendation and this continues to be an ongoing area of focus. Feedback from care coordinators that engaged with members indicated the most common barriers for connecting members with care included: • Office closures, limited support staff and clinician access (COVID-related)

Recommendation—Performance Measure Validation		
• Member hesitancy to return to provider office (COVID-related) • Ability to reach members UHC continued to evaluate data and identify strategies for barrier removal as part of United's ongoing processes.		
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.		
Recommendation—Member Experience of Care Survey - Child		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.3:** Rating of All Health Care
Aim 2: Effective Patient Care	**Goal 2.2:** Ensure Access to Care	**Metric 2.1.2:** How Well Doctors Communicate
• HSAG recommended that United focus quality improvement efforts on measure scores that were statistically significantly lower than the NCQA Medicaid national averages (i.e., Getting Care Quickly and How Well Doctors Communicate for the child Medicaid population). • HSAG recommended that United conduct a root cause analysis of study indicators that have been identified as areas of low performance. • HSAG recommended that United continue to monitor the measures to ensure there are no significant decreases in rates over time.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): Medallion 4.0 and CCC Plus adult and child surveys were reviewed. The areas identified as opportunities came from 5 questions that align to two larger topics. • Customer service • Customer service courtesy and respect – This was identified as a decline from the previous year. • Customer service provided information/ help • Physician/member communication • Doctor explained things • Doctor listened carefully • Doctor showed respect To address customer service, United ensured customer service representatives were able to accurately advise members of available alternatives for care and implemented a pop-up alert for repeat callers so the advocate could review and target call topics for the member. United also encouraged use of our nurse hotline for members to obtain health information and advice. To address physician/member communication, United surveyed providers on appointment availability. Outreach and education were provided to providers on scheduling best practices and how to improve access to routine/urgent care. United published an article in its monthly member newsletter on getting the most out of a provider visit. United additionally published an article in their monthly provider newsletter with survey findings and ways to improve patient-physician communication.		

Recommendation—Member Experience of Care Survey - Child
Medallion and CCC Plus adult and child surveys were reviewed for root causes. The areas identified as opportunities came from five questions that align to two larger topics. • Customer service • Physician/member communication On an ongoing basis, United continues to evaluate areas of opportunity and strategies to promote continuous improvement in this area. United continued to monitor all measures to ensure there were no significant decrease in rates over time.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement as a result of initiatives implemented. CAHPS results showed: **Metric 1.2.3:** Rating of All Health Care 2019: 76.8% 2020: 71.1% **Metric 2.1.2:** How Well Doctors Communicate 2019: 91.2% 2020: 91.8%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

VA Premier

Table E-7—Prior Year Recommendations and Responses—VA Premier

Recommendation—Performance Improvement Projects		
Aim 4: Improved Population Health	**Goal 4.6:** Improve Outcomes for Maternal and Infant Members	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care
HSAG recommended that VA Premier: • Define the intervention effectiveness measure accurately. • Report the intervention evaluation data for each month. • Provide more details in the intervention evaluation plan process description. • Report the SMART Aim measure results following the approved rolling 12-month methodology. • Include 12 months in the SMART Aim measurement periods. • Document the intervention title correctly. • Ensure the baseline data are comparable to the SMART Aim monthly remeasurements.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):		

Recommendation—Performance Improvement Projects		
Increase the timeliness of prenatal care in the Roanoke Region from 55 percent to 65 percent compliance by December 31, 2020. **Clinical PIP: Timeliness of Prenatal Care** The Smart Aim was to increase the timeliness of prenatal care in the Roanoke Region from 55 percent to 65 percent compliance by December 31, 2020. The intervention was to educate staff on the purpose and significance of the Healthy Heartbeats (HHB) prenatal program to increase participation which would lead to improved timely prenatal care. VA Premier assigned pregnant members to specific member outreach staff, and participation was indicated by a completed screening. The intervention was tested from 5/1/20 to 5/31/21.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Over the testing period, the HHB participation rate exceeded the target only two of the twelve months and fell short of the target by the end of the study. The *Timeliness of Prenatal Care* measure saw a slight improvement over the baseline but did not meet the target of 65 percent. PMV results showed: **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care 2019: 75.91% 2020: 74.45%		
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.		
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.		
Recommendation—Performance Measure Validation		
Aim 3: Smarter Spending	**Goal 3.1:** Focus on Paying for Value	**Metric 3.1.4:** Ambulatory Care: Emergency (ED) Visits
Aim 4: Improved Population Health	**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness **Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness **Metric 4.1.3:** Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication **Metric 4.1.4:** Monitor Mental Health Utilization **Metric 4.1.5:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
	Goal 4.2: Improve Outcomes for Members with Substance Use Disorders	**Metric 4.2.1:** Monitor Identification of Alcohol and Other Drug Services **Metric 4.2.2:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Recommendation—Performance Measure Validation		
		Metric 4.2.3: Use of Opioids at High Dosage in Persons Without Cancer **Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
	Goal 4.3: Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.1:** Percentage of Eligibles who Receive Preventive Dental Services **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.3.4:** Child and Adolescent Well-Care Visits
	Goal 4.4: Improve Health for Members with Chronic Conditions	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure
	Goal 4.6: Improve Outcomes for Maternal and Infant Members	**Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care **Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life

- HSAG recommended that VA Premier continue to conduct primary source validation of a sample of data from each provider office that provides supplemental data through electronic medical record feeds and to review and update any value set code mapping that is implemented, as needed.
- HSAG also recommended VA Premier explore potential data sources to impact the electronic clinical data system (ECDS) measures and enable future reporting, as VA Premier did not report the ECDS measures.

MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

Electronic Medical Record (EMR)

Virginia Premier has established Electronic Medical Record (EMR) access with 17 provider groups. The Quality HEDIS team work very closely with our Information Technology and Analytics teams to ensure mapping is implemented according to the value set directory that is published annually.

Virginia Premier worked with the analytics team to identify members with gaps in care and have implemented the following interventions to improve a member's care:

Recommendation—Performance Measure Validation
• Member Outreach through: – IVR calls – Person to Person calls – Text messaging – Email – Letters and Postcard notifications – Provider Education conducted across all regions to discuss the importance of members closing care gaps – Conducted assessments on all members, to monitor, educate, and recommend services based on member's health. – Conducted ASQs (Developmental Screening) on children under the age of three years, who may qualify for Early Intervention Program or other services such as physical therapy or speech therapy. – Care coordinators (CCs) were also assigned to contact members who needed education and reminders of dental care and vision. – Quality nurses contacted members to encourage and provide education on immunizations and assistance with closing care gaps by building a rapport with providers and giving out incentives to members. – VA Premier's high-risk teams assisted with monitoring and educating members on services who have been diagnosed with behavioral health or have chronic illnesses. – VA Premier's Watch Me Grow program was responsible for sending out text messages for member who chose to enroll, on reminders of upcoming well child visits and immunizations. – VA Premier developed a dedicated Quality Measures Improvement Committee. This committee included representatives from each operational area within the organization. This Committee's sole function was to discuss measure improvement opportunities which included monitoring, tracking, and trending of rates month-over-month and year-over-year. Measures were assigned to a business owner and interventions were tracked within an interventions grid and reviewed monthly for any updates or changes.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement as a result of initiatives implemented. PMV results showed: **Metric 3.1.4:** Ambulatory Care: Emergency (ED) Visits 2019: NR 2020: NR **Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness 2019: 7-Day: 40.07%; 30-Day: 61.68% 2020: 7-Day: 26.99%; 30-Day: 44.79% **Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness 2019: 2020: 7-Day: 48.85%; 30-Day: 61.55% **Metric 4.1.3:** Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication 2019: Initiation: 28.04%; Continuation and Maintenance: 49.15%

Recommendation—Performance Measure Validation
2020: Initiation: 54.60%; Continuation and Maintenance: 68.72% **Metric 4.1.4:** Monitor Mental Health Utilization 2019: NR 2020: NR **Metric 4.1.5:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics 2019: 78.62% 2020: 71.47% **Metric 4.2.1:** Monitor Identification of Alcohol and Other Drug Services 2019: NR 2020: NR **Metric 4.2.2:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence 2019: 7-Day: 11.82%; 30-Day: 20.36% 2020: 7-Day: 14.44%; 30-Day: 22.47% **Metric 4.2.3:** Use of Opioids at High Dosage in Persons Without Cancer 2019: NR 2020: NR **Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment 2019: NR 2020: NR **Metric 4.3.1:** Percentage of Eligibles who Receive Preventive Dental Services 2019: NR 2020: NR **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services 2019: 78.14% 2020: 73.55% **Metric 4.3.4:** Child and Adolescent Well-Care Visits 2019: NR 2020: 44.07% **Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) 2019: 45.50% 2020: 48.91% **Metric 4.4.5:** Controlling High Blood Pressure 2019: 48.42% 2020: 46.96% **Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care 2019: 67.88% 2020: 66.91% **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care 2019: 75.91% 2020: 74.45% **Metric 4.6.3:** Childhood Immunization Status Combination 3 2019: 65.94%

Recommendation—Performance Measure Validation
2020: 65.69% **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life 2019: First 15 Months: 64.48%; 15 Months – 30 Months: NR 2020: First 15 Months: 70.29%; 15 Months – 30 Months: 70.29%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 3: Smarter Spending	**Goal 3.1:** Focus on Paying for Value	**Metric 3.1.4:** Ambulatory Care: Emergency (ED) Visits
Aim 4: Improved Population Health	**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness **Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness **Metric 4.1.3:** Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication **Metric 4.1.4:** Monitor Mental Health Utilization **Metric 4.1.5:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
	Goal 4.2: Improve Outcomes for Members with Substance Use Disorders	**Metric 4.2.1:** Monitor Identification of Alcohol and Other Drug Services **Metric 4.2.2:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence **Metric 4.2.3:** Use of Opioids at High Dosage in Persons Without Cancer **Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
	Goal 4.3: Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.1:** Percentage of Eligibles who Receive Preventive Dental Services **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services

Recommendation—Performance Measure Validation		
		Metric 4.3.4: Child and Adolescent Well-Care Visits
	Goal 4.4: Improve Health for Members with Chronic Conditions	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure
	Goal 4.6: Improve Outcomes for Maternal and Infant Members	**Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care **Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life

- HSAG recommended that VA Premier conduct root cause or data analysis or conduct focus groups to determine why members were consistently receiving well visits, preventive screenings, behavioral healthcare, or care for chronic conditions according to recommended schedules.
- HSAG recommended that VA Premier consider whether there are disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
- Upon identification of a root cause or causes, HSAG recommended that VA Premier implement appropriate interventions to improve access to and timeliness of well and preventive visits, screenings, and recommended services for members diagnosed with a behavioral health or chronic condition, and follow-up assistance to ensure services are scheduled and received.

MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

Social Determinants of Health:

VA Premier members may be affected by many factors related to SDoH to include, but not limited to, employment, food security, housing stability, education, connection to social supports, health and healthcare, and other environmental factors. VA Premier was dedicated to ensuring its membership was assessed and provided the appropriate referrals and access to address all social determinants of health needs. In 2020, VA Premier developed a SDoH department to provide a greater focus on this pertinent area of healthcare delivery. The SDoH program identified members that contributed to lower performance for a particular race, ethnicity, age group, and region.

VA Premier worked with the analytics team to identify members with gaps in care and have implemented the following interventions to improve a member's care:

Member Outreach through

- IVR calls

Recommendation—Performance Measure Validation
• Person to person calls • Text messaging • Email • Letters and postcard notifications • Provider Education conducted with providers across all regions to discuss the importance of members closing care gaps • Members received education as to the importance of early treatment, and preventative measures • Leveraged technology to provide members access to more convenient timeframes, access to providers before or after school, weekends • Hired seven patient services coordinators to streamline workflow (early disease detection, increase survival rates, prevent further illness) • Activated key performance indicators for teams to measure user performance VA Premier developed a dedicated Quality Measures Improvement Committee. This committee included representatives from each operational area within the organization. This Committee's sole function was to discuss measure improvement opportunities which included monitoring, tracking, and trending of rates month-over-month and year-over-year. Measures were assigned to a business owner and interventions were tracked within an interventions grid and reviewed monthly for any updates or changes.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement that resulted from the initiatives implemented. PMV results showed: **Metric 3.1.4:** Ambulatory Care: Emergency (ED) Visits 2019: NR 2020: NR **Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness 2019: 7-Day: 40.07%; 30-Day: 61.68% 2020: 7-Day: 26.99%; 30-Day: 44.79% **Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness 2019: 2020: 7-Day: 48.85%; 30-Day: 61.55% **Metric 4.1.3:** Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication 2019: Initiation: 28.04%; Continuation and Maintenance: 49.15% 2020: Initiation: 54.60%; Continuation and Maintenance: 68.72% **Metric 4.1.4:** Monitor Mental Health Utilization 2019: NR 2020: NR **Metric 4.1.5:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics 2019: 78.62% 2020: 71.47% **Metric 4.2.1:** Monitor Identification of Alcohol and Other Drug Services 2019: NR 2020: NR **Metric 4.2.2:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Recommendation—Performance Measure Validation		
2019: 7-Day: 11.82%; 30-Day: 20.36% 2020: 7-Day: 14.44%; 30-Day: 22.47% **Metric 4.2.3:** Use of Opioids at High Dosage in Persons Without Cancer 2019: NR 2020: NR **Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment 2019: NR 2020: NR **Metric 4.3.1:** Percentage of Eligibles who Receive Preventive Dental Services 2019: NR 2020: NR **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services 2019: 78.14% 2020: 73.55% **Metric 4.3.4:** Child and Adolescent Well-Care Visits 2019: NR 2020: 44.07% **Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) 2019: 45.50% 2020: 48.91% **Metric 4.4.5:** Controlling High Blood Pressure 2019: 48.42% 2020: 46.96% **Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care 2019: 67.88% 2020: 66.91% **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care 2019: 75.91% 2020: 74.45% **Metric 4.6.3:** Childhood Immunization Status Combination 3 2019: 65.94% 2020: 65.69% **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life 2019: First 15 Months: 64.48%; 15 Months – 30 Months: NR 2020: First 15 Months: 70.29%; 15 Months – 30 Months: 70.29%		
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.		
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.		
Recommendation—Member Experience of Care Survey - Adult		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.1:** Getting Care Quickly

Recommendation—Member Experience of Care Survey - Adult

- HSAG recommended that VA Premier focus quality improvement efforts on the measure score that exhibited a statistically significant decrease from 2019 to 2020 (i.e., Getting Care Quickly for the adult Medicaid population).
- HSAG recommended that VA Premier conduct a root cause analysis of study indicators that have been identified as areas of low performance.
- HSAG recommended that VA Premier continue to monitor the measures to ensure there are no statistically significant decreases in rates over time.

MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

VA Premier had an established Quality Satisfaction Committee that focused on improvement of member and provider satisfaction results.

Quality Satisfaction Committee (QSC)

The QSC is a subcommittee of the Quality Improvement Committee (QIC) which met on a bi-monthly basis ensuring there was a coordination of activities, reduction/elimination in duplication of efforts and streamlined activities related to member and provider experiences. This included representatives from operational departments with a direct impact on accreditation, member healthcare outcomes and member and practitioner/provider experiences. There was oversight of organizational surveys to ensure the MCO was meeting regulatory timelines for completion and submission. This committee worked with departments to conduct barrier analyses to identify areas to improve experiences with the MCO or health care providers and worked with the departments develop strategic interventions to positively affect member and provider experience rates that fell below the benchmark. Outcomes were monitored and tracked over time and reported to the Committee. These outcomes were shared with members and providers at least annually.

VA Premier had an established Quality Satisfaction Committee that focused on improvement of member and provider satisfaction results.

Based on the NCQA Quality compass all plans percentile ratings, VA Premier scored lowest in the following measures:

- Getting Care Quickly
- Getting Needed Care
- Rating of Health Care

The following Interventions were put in place and will be monitored.

- Supported members and collaborated with providers to enhance routine and urgent access to care
- Discussed and engaged providers/staff on scheduling best practices, how to improve access to routine/urgent care.
- Encouraged members to use alternative telecommunication technologies to expand access to care: telephone, telehealth, telemedicine
- Encouraged use of nurse hotline/Nurse on Call lines or live chat via web for members to get health information and advice.
- Communicated and educated all areas of the MCO on CAHPS, sharing findings, initiatives, and outcomes.
- VA Premier will continue to review and monitor the measures to early detect statistically significant decreases in rates over time.

Quality Satisfaction Committee (QSC)

Recommendation—Member Experience of Care Survey - Adult		
In addition, VP's QSC was comprised of key stakeholders from all functional/operational areas. Survey scores were reviewed, and improvement implementation strategies were discussed, documented, and tracked. The QSC met bi-monthly to discuss opportunities for improvement. Quality Measures Improvement Committee (QMIC) VA Premier also developed a dedicated Quality Measures Improvement Committee. This committee included representatives from each operational area within the organization. This Committee's sole function was to discuss measure improvement opportunities which included monitoring, tracking, and trending of rates month-over-month and year-over-year. Measures were assigned to a business owner and interventions were tracked within an interventions grid and reviewed monthly for any updates or changes.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement resulting from the initiatives implemented. CAHPS results showed: **Metric 1.2.1:** Getting Care Quickly 2019: 76.2% 2020: 82.3%		
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.		
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.		
Recommendation—Member Experience of Care Survey - Child		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.1:** Getting Care Quickly
• HSAG recommended that VA Premier conduct a root cause analysis of study indicators that have been identified as areas of low performance. • HSAG recommended that VA Premier continue to monitor the measures to ensure there are no statistically significant decreases in rates over time.		
MCO's Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): Based on the NCQA Quality compass all plans percentile ratings, VA Premier scored lowest in the following measures: • Getting Care Quickly • Customer Service • Rating of a Specialist Due to the PHE many of the measures displayed lower results from 2020 to 2021. The following Interventions were put in place for improvement and will be monitored. • Supported members and collaborated with providers to enhance routine and urgent access to care • Discussed and engaged providers/staff on scheduling best practices, how to improve access to routine/urgent care. • Encouraged members to use alternative telecommunication technologies to expand access to care: telephone, telehealth, telemedicine		

Recommendation—Member Experience of Care Survey - Child
• Encouraged use of nurse hotline/Nurse on Call lines or live chat via web for members to get health information and advice • Provider service representatives worked with providers on discussing healthcare with parents and guardians • Quality Measures Committee review on interventions and monitoring • Provide on-going/periodic customer service training and feedback to associates • Member and provider newsletters contain language on rights to discuss with the provider communication on treatments and patient centered care • Gather and analyze patient feedback on their recent office visit VA Premier will continue to review and monitor the measures to detect statistically significant decreases in rates over time. Quality Satisfaction Committee In addition, VP's Quality Satisfaction Committee (QSC) was comprised of key stakeholders from all functional/operational areas. Survey scores were reviewed, and improvement implementation strategies were discussed, documented, and tracked. The QSC met bi-monthly to discuss opportunities for improvement. Quality Measures Improvement Committee (QMIC) VA Premier also developed a dedicated Quality Measures Improvement Committee. This committee included representatives from each operational area within the organization. This Committee's sole function was to discuss measure improvement opportunities which included monitoring, tracking, and trending of rates month-over-month and year-over-year. Measures were assigned to a business owner and interventions were tracked within an interventions grid and reviewed monthly for any updates or changes.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement as a result of initiatives implemented. **Metric 1.2.1:** Getting Care Quickly 2019: 76.2% 2020: 82.3%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implement initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Appendix F. 2020–2022 Quality Strategy Status Assessment

Evaluation Methodology Description

DMAS compares the baseline data for each measure along with the results from the Quality Strategy Tracking Table, as well as performance results from other initiatives outlined in the Virginia 2020–2022 QS and reported through each annual EQR-related deliverable (i.e., PIPs, compliance review, network adequacy validation) and the annual EQR, to evaluate the quality of the managed care services offered to Virginia Medicaid managed care members and, subsequently, the overall effectiveness of the existing Quality Strategy goals and objectives.

The methodology used by DMAS to evaluate the effectiveness of the Virginia 2020–2022 QS includes tracking and monitoring the MCOs' performance for the priority areas outlined in the DMAS Quality Strategy. DMAS annually tracks the progress of achieving the goals and objectives outlined in the Virginia 2020–2022 QS to further promote positive performance related to the quality of, and access to quality care and services provided by the DMAS contracted MCOs. Overall effectiveness of achieving the Virginia 2020–2022 QS goals and objectives will be determined in 2023 using rates from 2023. In CY 2021, DMAS tracked the aggregated annual results of performance measures included in the QS to measure improvement.

During the CY 2021 time frame, Virginia experienced unprecedented challenges due to the COVID-19 PHE. The PHE resulted in the implementation of innovative methods to ensure care delivery and receipt of early diagnosis, preventive and well care. To continue progress on achieving the Quality Strategy goals and objectives and in response to COVID-19, MCO care coordinators increased their outreach to members, ensuring access to services using telehealth medicine and automatically extending service authorizations and use of out-of-network providers when necessary.

It is noted that because of the COVID-19 PHE during MY 2020, many preventive services, including dental services, were negatively affected across the country as states followed orders to reduce the use of non-emergent services in order to slow the spread of COVID-19. MCOs developed processes to assist COVID-19 positive or exposed members with nonemergent transportation needs after discharge from the hospital and to ensure dialysis and chemotherapy appointments were not missed. In addition, MCOs initiated an outreach process to support discharge planning and post-acute care for all members who were pending or confirmed COVID-19 positive. To assist members with their pharmaceutical needs during the PHE, MCOs conducted outreach calls to high-risk members to ensure they received their medications on time.

Measure Alignment

DMAS has aligned most of the goals, objectives and quality metrics detailed in its Virginia 2020–2022 QS with MCO performance measure requirements outlined in the MCO's contract with the Commonwealth. Performance metrics align closely with the CMS Child and Adult Core Set measures and NCQA's revised HEDIS measures. DMAS also requires the MCOs to be NCQA accredited and to conduct HEDIS performance measure reporting using an NCQA licensed organization. In addition, DMAS requires MCOs to undergo performance measure validation with the EQRO for CMS Adult and Child Core Measure Set measures not included in HEDIS reporting. Table F-1 provides a summary of the MCOs' performance including rates that improved or declined from the baseline rate.

Table F-1—Virginia Medicaid 2020–2022 Quality Strategy Status Assessment

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	Increase Timely Access to Care	**Metric 1.2.1:** Getting Care Quickly Q6	CMS Adult Core Set: CPA-AD	81.1%	CAHPS benchmarks	✔	
		Increase Member Satisfaction	**Metric 1.2.2:** Enrollees' Rating of Health Plan	CMS Adult Core Set: CPA-AD	62.5%	CAHPS benchmarks	✔	
		Increase Member Satisfaction with Care	**Metric 1.2.3:** Rating of All Health Care	CMS Adult Core Set: CPA-AD	55.8%	CAHPS benchmarks	✔	
	Goal 1.3: Improve Home and Community-Based Services	Ensure Patient-Centered Care and Services	**Metric 1.3.1:** Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and Appropriate to Their Needs and Personal Goals	Quality Management Review (QMR)	91%♦	86%	✔	
		Ensure Access to Care	**Metric 1.3.2:** Number and Percent of Individuals Who Received Services in	Quality Management Review (QMR)	96%♦	86%	✔	

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
			the Scope Specified in the Service Plan					
Aim 2: Effective Patient Care	**Goal 2.1:** Enhance Provider Support	Maintain Provider Engagement	**Metric 2.1.1:** Rating of Personal Doctor	CMS Adult Core Set: CPA-AD	68.0%	CAHPS benchmarks	✔	
		Improve Health Communication	**Metric 2.1.2:** How Well Doctors Communicate	CMS Adult Core Set: CPA-AD	93.3%	CAHPS benchmarks	✔	
	Goal 2.2: Ensure Access to Care	Increase Access to Care	**Metric 2.2.3:** Getting Needed Care	CMS Adult Core Set: CPA-AD	82.9%	CAHPS benchmarks	✔	
Aim 3: Smarter Spending	**Goal 3.1:** Focus on Paying for Value	Decrease Potentially Preventable Admissions	**Metric 3.1.1:** Frequency of Potentially Preventable Admissions	VBP Reporting Team: Clinical Efficiencies Data	*	VBP/PWP Performance Target	✔	✔
		Decrease Emergency Department Visits	**Metric 3.1.2:** Frequency of Emergency Department Visits	VBP Reporting Team: Clinical Efficiencies Data	*	VBP/PWP Performance Target	✔	✔
		Decrease Potentially Preventable Readmissions	**Metric 3.1.3:** Frequency of Potentially Preventable Readmissions	VBP Reporting Team: Clinical Efficiencies Data	*	VBP/PWP Performance Target	✔	✔
		Decrease Emergency Department Visits	**Metric 3.1.4:** Ambulatory Care: Emergency (ED) Visits	NCQA HEDIS	50th: 40.96	NCQA Quality Compass 50th and 75th percentile	✔	✔

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
	Goal 3.2: Focus on Efficient Use of Program Funds	Ensure High-Value Appropriate Care	**Metric 3.2.3:** Monitor MLR annually by managed care program and aggregate total	Finance Team Reporting	85%	Minimum Loss Ration in Final Rule	✔	✔
Aim 4: Improved Population Health	**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	Increase Follow-Up Visits After Hospitalization for Mental Illness	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness	CMS Adult Core Set: FUH-AD	7-Day – Total: 35.63% 30-Day – Total: 56.84%	NCQA Quality Compass 50th and 75th percentile	✔	
		Increase Follow-Up Visits After Emergency Department Visit for Mental Illness	**Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness	CMS Adult Core Set: FUM-AD	7-Day – Total: 45.34% 30-Day – Total: 57.38%	VBP/PWP Performance Target	✔	
		Increase Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication	**Metric 4.1.3:** Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	CMS Child Core Set: ADD-CH	Initiation Phase: 45.20% Continuation and Maintenance Phase: 58.61%	NCQA Quality Compass 50th and 75th percentile	✔	✔
		Increase Mental Health Utilization	**Metric 4.1.4:** Monitor Mental Health Utilization	NCQA HEDIS MPT	12.41	NCQA Quality Compass 50th percentile	✔	
		Increase Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.	**Metric 4.1.5:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	CMS Child Core Set: APP-CH	69.58%	NCQA Quality Compass 50th and 75th percentile	✔	✔
	Goal 4.2: Improve Outcomes for	Increase Identification of Alcohol and Other Drug Services	**Metric 4.2.1:** Monitor Identification of	NCQA HEDIS IAD	2.21	NCQA Quality Compass 50th percentile	✔	

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
	Members with Substance Use Disorders		Alcohol and Other Drug Services					
		Increase Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	**Metric 4.2.2:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	CMS Adult Core Set: FUA-AD	7-Day – Total: 13.92% 30-Day – Total: 21.88%	VBP/PWP Performance Target	✔	
		Decrease Use of Opioids at High Dosage in Persons Without Cancer	**Metric 4.2.3:** Use of Opioids at High Dosage in Persons Without Cancer	CMS Adult Core Set: OHD-AD	50th: 5.12	NCQA Quality Compass 50th and 75th percentile	✔	
		Increase Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	**Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Total	CMS Adult Core Set: IET-AD	7.5%	VBP/PWP Performance Target♦♦	✔	
	Goal 4.3: Improve Utilization of Wellness, Screening, and Prevention Services for Members	Increase Percentage of Eligibles who Receive Preventive Dental Services	**Metric 4.3.1:** Percentage of Eligibles who Receive Preventive Dental Services	CMS Child Core Set: PDENT-CH	44.35%	CMS Child Core Set Benchmark	✔	✔
		Increase Adults' Access to Preventive/Ambulatory Health Services	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services	NCQA HEDIS AAP	72.75%	NCQA Quality Compass 50th and 75th percentile	✔	
		Increase Child and Adolescent Well-Care Visits	**Metric 4.3.4:** Child and Adolescent Well-Care Visits	CMS Child Core Set AWC-CH	46.57%	VBP/PWP Performance Target**	✔	✔

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
	Goal 4.4: Improve Health for Members with Chronic Conditions	Decrease Heart Failure Admission Rate	**Metric 4.4.1:** PQI 08: Heart Failure Admission Rate - Total	CMS Adult Core Set PQI08-AD	15%	VBP/PWP Performance Target♦♦	✔	
		Decrease Asthma Admission Rate	**Metric 4.4.2:** PDI 14: Asthma Admission Rate (Ages 2–17) (per 100,000 member months)	AHRQ Quality Indicators PDI 14	16.67%	VBP/PWP Performance Target♦♦		
		Decrease COPD and Asthma in Older Adults' Admission Rate	**Metric 4.4.3:** PQI 05: COPD and Asthma in Older Adults' Admission Rate - Total	CMS Adult Core Set PQI05-AD	15%	VBP/PWP Performance Target♦♦	✔	
		Decrease Diabetes Poor Control	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	CMS Adult Core Set HPC-AD	50.30%	VBP/PWP Performance Target**	✔	
		Increase Control of High Blood Pressure	**Metric 4.4.5:** Controlling High Blood Pressure	CMS Adult Core Set CBP-AD	46.91%	NCQA Quality Compass 50th and 75th percentile	✔	
	Goal 4.5: Improve Outcomes for Nursing Home Eligible Members	Decrease Use of High-Risk Medications in Older Adults (Elderly)	**Metric 4.5.1:** Use of High-Risk Medications in Older Adults (Elderly) (Medicare Rate)	NCQA HEDIS DAE	*	NCQA Quality Compass 50th and 75th percentile	✔	
	Goal 4.6: Improve Outcomes for	Increase Postpartum Care	**Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care	CMS Adult Core Set PPC-AD	66.91%	VBP/PWP Performance Target**	✔	✔

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
	Maternal and Infant Members	Increase Timeliness of Prenatal Care	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care	CMS Child Core Set PPC-CH	74.45%	VBP/PWP Performance Target**	✔	✔
		Increase Childhood Immunization Status	**Metric 4.6.3:** Childhood Immunization Status	CMS Child Core Set CIS-CH	65.82%	VBP/PWP Performance Target**	✔	✔
		Decrease Low Birth Weight Babies	**Metric 4.6.4:** Live Births Weighing Less than 2,500 Grams	CMS Child Core Set LBW-CH	9.9	CDC Wonder Data from CMS benchmarks	✔	✔
		Increase Well-Child Visits	**Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life	CMS Child Core Set W30-CH	First 15 Months: 54.35% 15 Months to 30 Months: 72.10%	NCQA Quality Compass 50th and 75th percentile	✔	✔

**The baseline measure rate is the final validated 2020 HEDIS, performance measure rate or CAHPS reported in the 2021 Annual Technical Report and posted to the DMAS website.*

***Target established in the CY2021 PWP Methodology.*

****The baseline measure rate is the final validated 2020 HEDIS rate reported in the 2022 Annual Technical Report and posted to the DMAS website.*

^The baseline measure rate is the final 2020 rate calculated by HSAG for the PWP.

^^The baseline measure rate is the final 2020 rate reported by DMAS for the Quality Management Review.

^^^The baseline measure rate is the final 2020 rate reported by the DMAS Finance Team

♦ *MY2019 HEDIS data was utilized*

♦♦ *2019 data was used to establish the target*

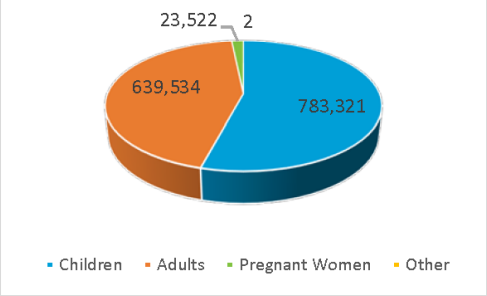
Appendix G. Medallion 4.0 Program 2021 Snapshot

Medallion 4.0 Program 2021 Snapshot

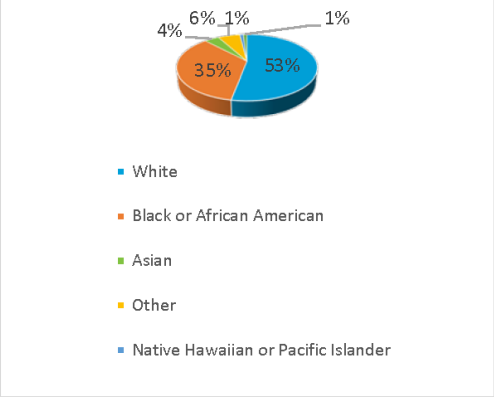
Medallion 4.0 Program Demographics

2021 average annual enrollment: 1,413,408.

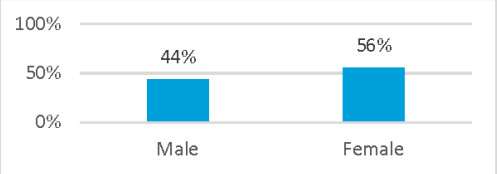
Eligibility Categories



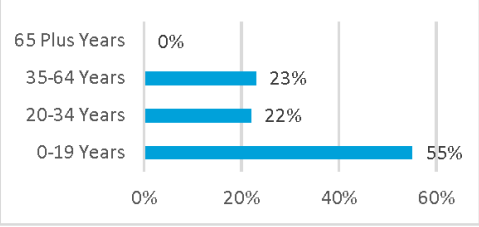
Categories by Race



Percentage by Gender



Enrollment by Age Group

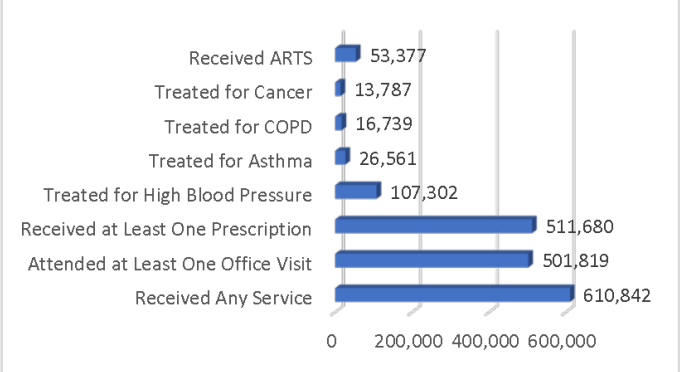


Medicaid Expansion

As of September 15, 2021, 584,631 adults were newly enrolled in Medicaid as a result of Virginia's Medicaid expansion. 147,182 expansion members were also parents

Male	Female	
46%	54%	
19–34 Years	**35–54 Years**	**55 Plus Years**
45%	38%	17%

Medicaid Expansion Service Provision



Performance Improvement Projects

Intervention Status
MCOs Adopted two successful interventions
MCOs Adapted seven interventions

Compliance with Standards Monitoring

MCOs' compliance scores ranged from 88.9% to 96.3%. All six MCOs received a 100% compliance score for the following standards:

Standards
Emergency and Poststabilization Services
Coordination and Continuity of Care
Provider Selection
Practice Guidelines
Health Information Systems
Program Integrity

Medallion 4.0 Program 2021 Snapshot

Performance Measure Validation

Strengths

Domain	Strengths
Children's Preventive Care	One MCO displayed strong performance, with its rates exceeding the Virginia aggregate for the *Child and Adolescent Well-Care Visits—Total*, *Childhood Immunization Status—Combination 3*, *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*, and *Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits* measure indicators.
Women's Health	Two MCOs displayed strong performance, with their rates exceeding the Virginia aggregate for three of the four (75.0 percent) measure indicators.
Access to Care	Four MCOs' rates demonstrated strong performance, exceeding the Virginia aggregate for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator.
Care for Chronic Conditions	All six MCOs' rates met or exceeded the 50th percentile for the *Asthma Medication Ratio—Total* measure indicator.
Behavioral Health	All six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment*, *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total*, *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measure indicators.

Weaknesses

Domain	Strengths
Children's Preventive Care	All MCO rates fell below the 50th percentile for the four measures (*Child and Adolescent Well-Care Visits—Total*, *Childhood Immunization Status—Combination 3*, and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits)* included in this domain.
Women's Health	All MCO rates fell below the 50th percentile for the three measures (*Breast Cancer Screening*, *Cervical Cancer Screening*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care)* included in this domain, reflecting an opportunity for improvement.
Access to Care	All MCO rates fell below the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator, reflecting an opportunity for improvement.
Care for Chronic Conditions	None of the MCOs' rates met or exceeded the 50th percentile for the *Comprehensive Diabetes Care* measure indicator. MCO performance was particularly low for the *Medical Assistance With Smoking and Tobacco Use Cessation* measure indicators, as only one of the MCOs' measure rates meeting or exceeded the 50th percentile.
Behavioral Health	Four of the six MCOs' rates fell below the 50th percentile for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators.

Encounter Data Validation

MCO Encounter Data Completeness
Encounter data completeness ranged from 71.4%–88.9%
MCO Statewide Timeliness Ranges
Institutional: 94.9%
Professional: 98.3%
Pharmacy: 91.4%

Medallion 4.0 Program 2021 Snapshot

Member Experience of Care

Strengths
The top-box scores for two measures, *Rating of Health Plan* and *Rating of All Health Care*, for all MCOs (i.e., the Medallion 4.0 program) and one MCO were statistically significantly higher than the 2020 NCQA child Medicaid national averages.
One MCO's 2021 top-box score was statistically significantly higher than the 2020 top-box score for one measure, *Rating of Health Plan*, for the adult Medicaid population.
One MCO's 2021 top-box score was statistically significantly higher than the 2020 score for one measure, *Rating of Health Plan*, for the child Medicaid population.

Opportunities for Improvement
The top-box score for one measure, *Rating of Specialist Seen Most Often*, for all MCOs was statistically significantly lower than the 2020 NCQA adult Medicaid national average.
The top-box scores for two measures, *Getting Care Quickly* and *How Well Doctors Communicate*, for all MCOs (i.e., Medallion 4.0 program) were statistically significantly lower than the 2020 NCQA child Medicaid national averages. Furthermore, the Medallion 4.0 program's 2021 top-box scores were statistically significantly lower than the 2020 top-box scores for two measures, *Rating of Specialist Seen Most Often* and *Getting Care Quickly*.

Prediabetes Calendar Year 2020 Performance Measure Calculation

Indicator	Prevalence	Metformin Use
Prediabetes	3.35%	Use: 8.80%; Adherence: 44.03%
Highest Region	Tidewater	Southwest
Lowest Region	Charlottesville/ Western	Tidewater
Male	2.48%	4.51%
Female	4.35%	8.76%
18-44 Years	2.48%	10.86%
45-60 Years	7.63%	4.65%
Race: Highest	Asian	White
Race	Southwest Asian/Pacific Islander	Black/African American

Focus Study Calendar Year 2019: Improving Birth Outcomes Through Adequate Prenatal Care

Program/ Delivery System	*Births With Early and Adequate Prenatal Care*	*Preterm Births (<37 Weeks Gestation)*	*Newborns With Low Birth Weight (<2500 grams)*
FFS Delivery System	65.4%	10.2%	8.3%
Managed Care	74.6%	9.7%	9.1%
FAMIS MOMS	78.3%	7.7%	7.2%
Medicaid for Pregnant Women	72.6%	9.2%	8.4%
Medicaid Expansion	72.9%	12.2%	10.6%

Focus Study Calendar Year 2020: Dental Utilization in Pregnant Women Data Brief

Medicaid Program or Delivery System	Percentage of Deliveries With Perinatal Dental Services Received
Any Program	16.1%
Medicaid for Pregnant Women	16.9%
Medicaid Expansion	14.2%
FAMIS MOMS	15.2%
LIFC	14.6^
Medallion 4.0	19.8%
FAMIS	16.1%
Fee-For-Service	2.5%

Focus Study State Fiscal Year 2020: Foster Care

Measure	Foster Children Rate	Non-Foster Children Rate
Children and Adolescents' Annual Access to PCPs	97.1%	93.4%
Annual Dental Visit	86.9%	63.4%
Preventive Dental Services	81.7%	56.5%
7-Day Follow-Up After Hospitalization for Mental Illness	38.7%	44.6%
30-Day Follow-Up After Emergency Department (ED) Visit for Mental Illness	92.6%	83.9%

Medallion 4.0 Program 2021 Snapshot

Measure	Foster Children Rate	Non-Foster Children Rate
Metabolic Monitoring for Children and Adolescents on Antipsychotics	40.85	30.1%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	90.7%	67.7%
Initiation of Follow-Up Care for Children Prescribed ADHD Medication Within 3 Months	95.0%	91.9%
Most Effective or Moderately Effective Method of Contraceptive Care	54.2%	41.3%
Long-Acting Reversible Method of Contraceptive Care	10.6%	4.4%
Asthma Medication Ratio	85.7%	75.8%

Consumer Decision Support Tool

MCO	Overall Rating*	Doctors' Communication	Getting Care
Aetna	✓✓✓	✓✓✓	✓✓✓
HealthKeepers	✓✓✓✓✓	✓✓✓	✓✓✓
Magellan	✓	✓✓	✓✓✓
Optima	✓✓✓✓	✓✓✓✓	✓✓✓
United	✓✓	✓✓	✓✓
VA Premier	✓✓✓✓✓	✓✓✓	✓✓✓

MCO	Keeping Kids Healthy	Living With Illness	Taking Care of Women
Aetna	✓✓✓✓✓	✓✓✓✓✓	✓
HealthKeepers	✓✓✓✓✓	✓✓✓	✓✓✓✓✓
Magellan	✓	✓	✓
Optima	✓✓✓✓	✓	✓✓✓✓✓
United	✓✓✓✓✓	✓✓✓✓✓	✓
VA Premier	✓✓✓✓	✓✓✓✓	✓✓✓✓

Key:
Highest Performance: ✓✓✓✓✓
High Performance: ✓✓✓✓
Average Performance: ✓✓✓
Low Performance: ✓✓
Lowest Performance: ✓