# Commonwealth of Virginia Department of Medical Assistance Services

## 2022 External Quality Review Technical Report—Commonwealth Coordinated Care Plus

**March 2023**



# Table of Contents

# Glossary of Acronyms

| | |
|---|---|
| 42 CFR | Title 42 of the Code of Federal Regulations |
| ABA | Applied Behavior Analysis |
| ACOG | American College of Obstetricians and Gynecologists |
| ADHD | Attention-Deficit Hyperactivity Disorder |
| Adult Core Set | CMS Core Set of Adult Health Care Quality Measures for Medicaid |
| AHRQ | Agency for Healthcare Research and Quality |
| AOD | Alcohol and Other Drug |
| ARTS | Addiction and Recovery Treatment Services |
| ASAM | American Society of Addiction Medicine |
| AUD | Alcohol Use Disorder |
| BBA | Balanced Budget Act of 1997 |
| BH | Behavioral Health |
| BMI | Body Mass Index |
| BR | Biased Rate |
| C-Section | Cesarean Section |
| CAHPS®,[1] | Consumer Assessment of Healthcare Providers and Systems |
| CAP | Corrective Action Plan |
| CC | Community Coaching |
| CCC Plus | Commonwealth Coordinated Care Plus |
| CDC | Centers for Disease Control and Prevention |
| CE | Community Engagement |
| CEG | Clinical Estimate of Gestation |
| Child Core Set | CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP |
| CHIP | Children's Health Insurance Program |
| CI | Confidence Interval |
| CIL | Center for Independent Living |
| CMH | Community Mental Health |
| CMHRS | Community Mental Health Rehabilitative Services |
| CMS | Centers for Medicare & Medicaid Services |
| CMU | Care Management Unit |
| COPD | Chronic Obstructive Pulmonary Disease |
| COVID-19 | Coronavirus Disease 2019 |
| CPT | Current Procedural Terminology |
| CRMS | Care Management Solution |
| CSB | Community Services Board |

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

CSS ..... Center for the Study of Services
CT ..... Computerized Tomography
CY ..... Calendar Year
D-SNP ..... Dual-Eligible Special Needs Plan
DBHDS ..... Department of Behavioral Health and Developmental Services
DD ..... Developmental Disability
DITP ..... Discrete Incentive Transitions Program
DMAS ..... Department of Medical Assistance Services
DNA ..... Deoxyribonucleic Acid
DOC ..... Department of Corrections
DSS ..... Department of Social Services
ED ..... Emergency Department
EDV ..... Encounter Data Validation
EDWS ..... Enterprise Data Warehouse System
EPS ..... Encounter Processing System
EPSDT ..... Early and Periodic Screening, Diagnostic and Treatment
EQR ..... External Quality Review
EQRO ..... External Quality Review Organization
FAMIS ..... Family Access to Medical Insurance Security
FAR ..... Final Audit Report
FFS ..... Fee-for-Service
FFY ..... Federal Fiscal Year
FIPS ..... Federal Information Processing Standards
FIT ..... Fecal Immunochemical Test
FOBT ..... Fecal Occult Blood Test
FPL ..... Federal Poverty Level
FQHC ..... Federally Qualified Health Center
FY ..... Fiscal Year
HbA1c ..... Hemoglobin A1c
HCBS ..... Home and Community-Based Services
HEDIS®,[2] ..... Healthcare Effectiveness Data and Information Set
HHS ..... United States Department of Health and Human Services
HIPAA ..... Health Insurance Portability and Accountability Act of 1996
HIV ..... Human Immunodeficiency Virus
HMO ..... Health Maintenance Organization
HPV ..... Human Papillomavirus
HSAG ..... Health Services Advisory Group, Inc.

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

I/DD ..... Intellectual and Developmental Disability
IACCT ..... Independent Assessment Certification and Coordination Team
ICT ..... Intensive Community Treatment
ID ..... Identification
IDSS ..... Interactive Data Submission System
IES ..... Individual Experience Survey
IIH ..... Intensive In-Home Services
IS ..... Information Systems
ISCA ..... Information Systems Capability Assessment
ISCAT ..... Information Systems Capabilities Assessment Tool
ISP ..... Individual Service Plan
LABA ..... Licensed Applied Behavior Analyst
LBA ..... Licensed Behavior Analyst
LCPA ..... Licensed Child Placement Agency
LIFC ..... Low Income Families With Children
LMHP ..... Licensed Mental Health Professional
LMHP-R ..... Licensed Mental Health Professional—Resident
LMHP-RP ..... Licensed Mental Health Professional Resident in Psychology
LMHP-S ..... Licensed Mental Health Professional—Supervisee
LMP ..... Last Menstrual Period
LO ..... Licensed Organization
LOB ..... Line of Business
LOCERI ..... Level of Care Review Instrument
LTSS ..... Long-Term Services and Supports
MBHO ..... Managed Behavioral Health Organization
MCE ..... Managed Care Entity
MCO ..... Managed Care Organization
MCP ..... Managed Care Plan
MES ..... Medicaid Enterprise System
MHP ..... Mental Health Provider
MHSS ..... Mental Health Skill-Building Services
MITA ..... Medicaid Information Technology Architecture
MLTSS ..... Managed Long-Term Services and Supports
MMIS ..... Medicaid Management Information System
MODRN ..... Medicaid Outcomes Distributed Research Network
MOUD ..... Medications for Opioid Use Disorder
MRI ..... Magnetic Resonance Imaging
MRRV ..... Medical Record Review Validation
MY ..... Measurement Year

| | |
|---|---|
| NA | Not Applicable |
| NASHP | National Academy for State Health Policy |
| NCHS | National Center for Health Statistics |
| NCQA | National Committee for Quality Assurance |
| NDC | National Drug Code |
| NF | Nursing Facility |
| 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 |
| 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 |
| PDSA | Plan-Do-Study-Act |
| PHE | Public Health Emergency |
| PIHP | Prepaid Inpatient Health Plan |
| PIP | Performance Improvement Project |
| PM | Performance Measure |
| PMV | Performance Measure Validation |
| PNC | Prenatal Care |
| PRTF | Psychiatric Residential Treatment Facility |
| PSR | Psychosocial Rehabilitation |
| PSV | Primary Source Verification |
| PWP | Performance Withhold Program |
| QAPI | Quality Assessment and Performance Improvement |
| QI | Quality Improvement |
| QS | Quality Strategy |
| RTC | Residential Treatment Center |
| SAFE | Secure Access File Exchange |
| SARS-CoV-2 | Severe Acute Respiratory Syndrome Coronavirus 2 |
| SBIRT | Screening, Brief Intervention, and Referral to Treatment |
| SFC | Smiles for Children |
| SFTP | Secure File Transfer Protocol |
| SFY | State Fiscal Year |

| | |
|---|---|
| SHCN | Special Health Care Needs |
| SIS | Supports Intensity Scale |
| SMART | Specific, Measurable, Attainable, Relevant, Time-Bound |
| SME | Subject Matter Expert |
| SNF | Skilled Nursing Facility |
| SUD | Substance Use Disorder |
| TANF | Transitional Aid to Needy Families |
| Tdap | Tetanus, Diphtheria Toxoids, and Acellular Pertussis |
| TDT | Therapeutic Day Treatment |
| TGH | Therapeutic Group Home |
| TPL | Third Party Liability |
| USPSTF | United States Preventive Services Task Force |
| VA | Virginia |
| VBP | Value-Based Purchasing |
| VCU | Virginia Commonwealth University |
| VDH | Virginia Department of Health |
| VDSS | Virginia Department of Social Services |
| WIC | Women, Infants and Children |

# 1. Executive Summary

## Overview of 2022 External Quality Review

Per 42 CFR §438.364, states are required to use an EQRO to prepare an annual technical report that describes the manner in which data from activities conducted for Medicaid MCOs, in accordance with the CFR, were aggregated and analyzed. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS).[1-1]

To meet this requirement, the Commonwealth of Virginia, DMAS, contracted with HSAG, as its EQRO, to perform the assessment and produce this report for EQR activities conducted during the period of January 1, 2022, through December 31, 2022 (CY 2022). In addition, this report draws conclusions about the quality of, timeliness of, and access to healthcare services that the contracted MCOs provide. Effective implementation of the EQR-related activities will facilitate Commonwealth efforts to purchase high-value care and to achieve higher performing healthcare delivery systems for their Medicaid and CHIP members.

DMAS administers the CCC Plus program. 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 2022 are displayed in Table 1-1.

**Table 1-1—Medicaid CCC Plus MCOs in Virginia**

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

## Scope of External Quality Review Activities

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

[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: Dec 15, 2022.

Effective implementation of the EQR-related activities will facilitate the Commonwealth's efforts to purchase high-value care and to achieve higher performing healthcare delivery systems for its Medicaid and CHIP members.

# Methodology for Aggregating and Analyzing EQR Activity Results

For the 2022 EQR technical report, HSAG used findings from the EQR activities conducted from January 1, 2022, through December 31, 2022. From these analyses, HSAG derived conclusions and made recommendations about the quality of, access to, and timeliness of care and services provided by each DMAS MCO and the overall statewide CCC Plus program. A comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each MCO are found in the results of each activity in sections 4 through 8 of this report and Section 9—Summary of MCO-Specific Strengths and Weaknesses. Detailed information about each activity's methodology is provided in Appendix B of this report. Table 1-2 identifies the EQR mandatory and optional activities included in this report.

**Table 1-2—EQR Activities**

| Activity | Description | CMS EQR Protocol |
|---|---|---|
| **Mandatory Activities** | | |
| **PIPs** | The purpose of PIP validation is to validate PIPs that have the potential to affect and improve member health, functional status, or satisfaction. To validate each PIP, HSAG obtained the data needed from each MCO's PIP Summary Forms. These forms provided detailed information about the PIPs related to the steps completed and validated by HSAG for the 2022 validation cycle. | *Protocol 1.* Validation of Performance Improvement Projects |
| **PMV** | HSAG conducts the PMV for each MCO to assess the accuracy of PMs reported by the MCOs, determine the extent to which these measures follow State specifications and reporting requirements, and validate the data collection and reporting processes used to calculate the PM rates. DMAS identified and selected the specifications for a set of PMs that the MCOs were required to calculate and report for the measurement period of January 1, 2021, through December 31, 2021. | *Protocol 2.* Validation of Performance Measures |
| **Compliance With Medicaid and CHIP Managed Care Regulations** | This activity determines the extent to which a Medicaid and CHIP MCO is in compliance with federal standards and associated state-specific requirements, when applicable. HSAG conducted full compliance reviews (called OSRs) that included all federal and state-specific requirements for the review period of July 1, 2021, through June 30, 2022. | *Protocol 3*. Review of Compliance with Medicaid and CHIP Managed Care Regulations |
| **Validation of Network Adequacy** | The network adequacy validation activity validates MCO network adequacy using DMAS' network | *Protocol 4*. Validation of Network Adequacy |

| Activity | Description | CMS EQR Protocol |
|---|---|---|
| | 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. | (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. | *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.<br>HSAG calculates one PM (selected by DMAS) for the Medicaid population stratified by geographic region and key demographic variables (race, gender, age, etc.). | *Protocol 7.* Calculation of Additional Performance Measures |
| **ARTS Measurement Specification Development and Maintenance** | HSAG identifies, when available, PMs from existing measure sets or develops PMs for the ARTS program. | *Protocol 7.* Calculation of Additional Performance Measures |
| **Focus Studies** | This activity provides information about the healthcare quality for a particular aspect of care across managed care in the Commonwealth or for subpopulations served by managed care within the Commonwealth.<br><br>**Medicaid and CHIP Maternal and Child Health Focus Study**—HSAG conducts a focus study that | *Protocol 9.* Conducting Focus Studies of Health Care Quality |

| Activity | Description | CMS EQR Protocol |
|---|---|---|
| | provides quantitative information about PNC and associated birth outcomes among Medicaid recipients.<br>**Child Welfare Focus Study**—HSAG conducts a Child Welfare Focus Study to evaluate healthcare utilization among children in foster care under the CCC Plus program.<br>**Dental Utilization in Pregnant Women Data Brief**—HSAG produces a data brief describing dental utilization among pregnant women enrolled in Medicaid. | |
| **Consumer Decision Support Tool** | This activity provides information to help eligible members choose a Medicaid CCC Plus 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 CCC Plus 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 develops 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 and to develop the 2023-2025 QS. QS maintenance incorporates programmatic changes such as DMAS' focus on care and service integration, a patient-centered approach to care, paying for quality and positive member outcomes, and improved health and wellness. HSAG reviews the QS to ensure the most current Managed Care Rule and CMS Medicaid and CHIP Managed Care QS Toolkit requirements are met. | Medicaid and CHIP Managed Care QS Toolkit |

# Virginia Managed Care Program Findings and Conclusions

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

analyzed, and conclusions were drawn as to the quality of, timeliness of, and access to care furnished by the MCOs. Table 1-3 provides the overall strengths and weaknesses of the CCC Plus program that were identified as a result of the EQR activities. Refer to Section 3 for a summary of each activity.

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

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

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

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

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

| Program Strengths | | |
|---|---|---|
| **Domain** | | **Conclusion** |
| + | **Quality** | **Strength:** Overall, MCO members were satisfied with the quality of care provided through their MCOs. MCO members rated their health plan, the specialist seen most often, and the ability to get needed care high, similar to the scores achieved in 2021 and in 2020. The CCC Plus program's 2022 CAHPS top-box scores were statistically significantly higher than the 2021 NCQA adult Medicaid national averages for the *Rating of Health Plan* and *Rating of Specialist Seen Most Often* measures, demonstrating strength in members' perceptions of the quality of care provided through the CCC Plus program.<br><br>The member experience results were supported by improved PM rates related to metabolic monitoring for children and adolescents on antipsychotics, as three of six MCOs met or exceeded the 50th percentile for all *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure indicators. The results suggest members are receiving quality care in the CCC Plus program.<br><br>**Strength:** Overall, the MCOs are providing quality care for members identified as smokers. This is supported by the MCOs' demonstrated strength in the PM rate results in members' use of preventive and well-care services such as tobacco cessation programs. The MCOs demonstrated strength for the *Medical Assistance With Smoking and Tobacco Use Cessation* measure, with five of six MCOs meeting or exceeding the 50th percentile for the *Discussing Cessation Medications* and *Discussing Cessation Strategies* measure indicators, and all six |

| Program Strengths | | |
|---|---|---|
| **Domain** | | **Conclusion** |
| | | MCOs meeting or exceeding the 50th percentile for the *Advising Smokers and Tobacco Users to Quit* measure indicator.<br><br>**Strength:** Overall, the MCOs demonstrate quality of care for diabetes chronic conditions testing. Five of six MCOs met or exceeded the 50th percentile for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure indicator rates.<br><br>**Strength:** Behavioral health and OUD treatment is also a demonstrated strength for the MCOs. Three of six MCOs met or exceeded the 50th percentile for two of the three *Use of Opioids From Multiple Providers* measure indicator rates. The results indicate quality behavioral health services through active monitoring of opioid prescriptions.<br><br>The MCOs demonstrated the provision of quality care with all six MCOs meeting or exceeding the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicator rates.<br><br>In addition, 2021 compliance reviews of the MCOs supported a strong implementation of the ARTS benefit, with few grievances or appeals filed with the MCOs, indicating member access to needed behavioral and SUD treatment and services. |
|  | **Access** | **Strength:** The CCC Plus program's 2022 CAHPS top-box scores were statistically significantly higher than the 2021 NCQA adult Medicaid national averages for the *Getting Needed Care* and *Getting Care Quickly* measures. These scores indicate that access to care is a strength in the CCC Plus program.<br><br>Member experience survey results indicate that adult and child members were able to access a PCP. Overall, access to care was evident as the MCOs' interventions have resulted in children and adolescents accessing well-care visits, oral healthcare, and receiving most screenings (exceptions are identified in the weakness section) according to the EPSDT or Bright Futures schedules.<br><br>**Strength:** Members' ability to access routine and preventive health care may have contributed to strong CAHPS scores in the *Getting Needed Care* and *Getting Care Quickly* measures. The MCOs demonstrated strength related to access to care, as five of six MCOs met or exceeded the 50th percentile related to the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM. |

| Program Strengths | | |
|---|---|---|
| **Domain** | | **Conclusion** |
| + | **Timeliness** | **Strength:** The MCOs demonstrated timeliness of follow-up care for behavioral health conditions as all six MCOs met or exceeded the 50th percentile for both *Follow-Up After Emergency Department (ED) Visit for Mental Illness* measure indicators. Overall, the MCOs eased requirements and expanded access points during the COVID-19 PHE, including expanded use of telemedicine and services, which may have impacted timely follow-up services after an ED visit for a mental health condition. |

| Program Weaknesses | | |
|---|---|---|
| **Domain** | | **Conclusion** |
| − | **Quality** | **Weakness:** The CAHPS member experience survey results may reflect an opportunity to improve quality of care in preventive care, chronic illness management, and management of opioid prescribing. The CCC Plus program's 2022 CAHPS top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national average for the *Rating of Health Plan* measure.<br><br>In addition, the CCC Plus program's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national average for the *Rating of All Health Care* measure. Members may have had difficulties finding access to care. Members also may have had concerns with accessing services during the COVID-19 PHE, which may have impacted their experience with their health plan and the care received through the CCC Plus program.<br><br>**Weakness:** Although some measures for preventive care for children were considered a strength, opportunities for improvement were identified in immunizations and nutrition and physical activity counseling. All six MCOs have opportunities for improvement related to the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total* measure indicator rates, as none of the MCOs' rates for these measure indicators met or exceeded the 50th percentile.<br><br>**Weakness:** Five of the six MCOs' rates fell below the 50th percentile for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator. Additionally, four of the six MCOs' rates fell below the 50th percentile for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed measure* indicators, reflecting areas of opportunity for improvement. |

| Program Weaknesses | | |
|---|---|---|
| **Domain** | | **Conclusion** |
| | | Members with chronic conditions may have access to care, yet are often challenged with managing their conditions, such as diabetes, according to evidence-based guidelines through the appropriate use of medications, diet and nutrition, or physical activity. A factor that may have contributed to low performance in the management of chronic conditions is the continued COVID-19 PHE. |
| – | **Access** | **Weakness:** The CCC Plus program's 2022 child Medicaid top-box scores were statistically significantly lower than the 2021 top-box scores for two measures: *Rating of Personal Doctor* and *Getting Needed Care*. Members may have had difficulties finding access to care or this weakness may be a result of disparities in the population served. The COVID-19 PHE may have also contributed to the lower CAHPS scores received. Members may have had concerns with accessing preventive care, early diagnosis services, and care for chronic conditions during the COVID-19 PHE, resulting in members feeling less positive about their personal doctor and the ability to receive needed care.<br><br>**Weakness:** Members' experience in accessing cancer screenings may have contributed to the lower *Rating of Personal Doctor* and *Getting Needed Care* measure scores. Cancer screenings for women and appropriate use of imaging studies for low back pain represent an area for opportunity Virginia-wide, as all reportable MCO rates fell below the 50th percentile for the *Cervical Cancer Screening* and *Use of Imaging Studies for Low Back Pain* measures. Additionally, five of six MCO rates fell below the 50th percentile for the *Breast Cancer Screening* measure. |
| – | **Timeliness** | **Weakness:** Compliance reviews of the MCOs supported a strong implementation of the ARTS benefit, with access to needed behavioral and SUD treatment and services; however, none of the MCOs met or exceeded the 50th percentile for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* measure indicator, reflecting an area of opportunity for improvement in timeliness of care. |

# Quality Strategy Recommendations for the Virginia Managed Care Program

The Virginia 2020–2022 QS is designed to improve the health outcomes of its Medicaid members by continually improving the delivery of quality healthcare to all Medicaid and CHIP members served by the Virginia Medicaid managed care programs. DMAS' QS provides the framework to accomplish

DMAS' overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP system. In consideration of the goals of the QS and the comparative review of findings for all activities, HSAG's Virginia-specific recommendations for QI that target the identified goals within the Virginia 2023–2025 QS are included in Table 1-4.

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

| Program Recommendations | |
|---|---|
| **Recommendation** | **Associated Virginia 2023–2025 QS Goal and/or Objective** |
| To improve program-wide performance in support of Objective 5.3 and improve outcomes for members with SUD, HSAG recommends DMAS:<br>• Require the MCOs to develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization.<br>• Require the MCOs to identify healthcare disparities (race, ethnicity, age group, geographic location, etc.) with the behavioral health follow-up PM data.<br>• Upon identification of a root cause issue, require the MCOs to implement appropriate QI interventions to improve use of evidence-based practices related to behavioral healthcare and services.<br>• Require the MCOs to identify best practices to conduct follow-up with members discharged from the ED and ensure follow-up visits within seven days and 30 days are completed. | **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorder<br>**Measure: 5.3.1.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment<br>**Objective: 5.4:** Improve Behavioral Health and Developmental Services for Members<br>**Measure 5.4.1.1:** Follow-Up After Hospitalization for Mental Illness |
| To improve program-wide performance in support of Objective 4.1 and 4.2 and improve preventive services and well-child visits for members under the age of 21 years, HSAG recommends DMAS:<br>• Require the MCOs to identify best practices for ensuring children receive all preventive vaccinations and well-child services according to recommended schedules.<br>• Require the MCOs to conduct a root cause analysis to identify barriers that their members are experiencing in accessing well-child and preventive care and services.<br>• Require the MCOs to identify best practices to improve care and services according to the Bright Futures guidelines. | **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members<br>**Measure 4.1.1.4:** Immunizations for Adolescents<br>**Objective 4.2:** Improve Outcomes for Maternal and Infant Members<br>**Measure: 4.2.1.4:** Well-Child Visits in the First 20 Months of Life |
| To improve program-wide performance in support of Objective 5.1 and improve outcomes for members with chronic conditions, HSAG recommends DMAS:<br>• Require that the MCOs conduct a root cause analysis to determine why members are not maintaining their diabetes care. | **Objective 5.1:** Improve Outcomes for Members With Chronic Conditions<br>**Measure: 5.1.1.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) |

| Program Recommendations | |
|---|---|
| • Upon identification of a root cause, require the MCOs to implement appropriate interventions to improve the performance related to proper diabetes management.<br>• Require the MCOs to identify best practices to improve care and services according to chronic care recommended guidelines. | |

# 2. Overview of Virginia's Managed Care Program

## Medicaid Managed Care in the Commonwealth of Virginia

### *The Department of Medical Assistance Services*

DMAS is the Commonwealth of Virginia's single State agency that administers all Medicaid and FAMIS health insurance benefit programs in the Commonwealth. Medicaid is delivered to individuals through two models, managed care and FFS. Table 2-1 displays the average annual program enrollment during CY 2022.

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

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

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

**Table 2-2—CCC Plus 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<br>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, | Accredited* through 03/09/24<br>LTSS Distinction through 03/09/24 |

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

| MCO | Profile Description | MCO NCQA Accreditation Status |
|---|---|---|
| | Indiana. | |
| Molina | Molina is a Medicaid/FAMIS Plus program offered by Molina Health, Inc., conducting business in Virginia since 1972. Molina is headquartered in Scottsdale, Arizona. | Accredited* through 06/29/23<br>LTSS Distinction through 06/30/23 |
| Optima | Optima is the Medicaid managed care product offered by Optima Health. A subsidiary of Sentara, Optima is a not-for-profit healthcare organization serving Virginia and northeastern North Carolina, headquartered in Norfolk, Virginia. | Accredited* through 04/01/24<br>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<br>LTSS Distinction through 06/22/23 |
| VA Premier | VA Premier, founded in 1995, is jointly owned by the integrated, not-for-profit health system Sentara Healthcare, based in Norfolk, Virginia, and VCU Health Systems, based in Richmond, Virginia. | Accredited* through 07/26/25<br>LTSS Distinction through 07/26/25 |

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

## MCO CCC Plus Enrollment Characteristics

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

[2-2] National Committee for Quality Assurance. Advertising and Marketing Guidelines: Health Plan Accreditation. Available at: https://www.ncqa.org/wp-content/uploads/2018/08/20180804_HPA_Advertising_and_Marketing_Guidelines.pdf. Accessed on: Dec 19, 2022.

Figure 2-1 displays the CCC Plus program CY 2022 eligibility categories.

**Figure 2-1—CCC Plus Program CY 2022 Eligibility Categories**

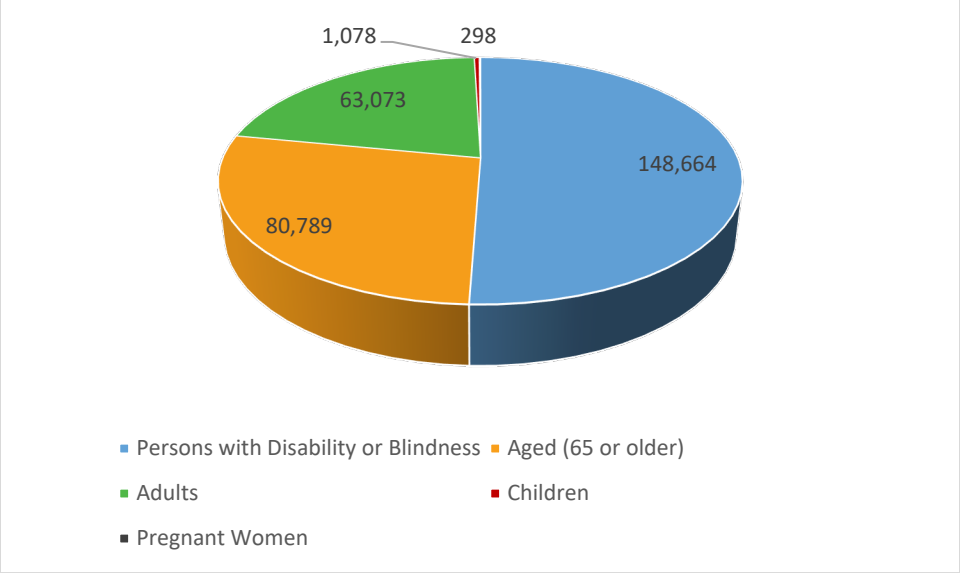



**Table 2-3—CCC Plus Program CY 2022 MCO Eligibility Categories[2-3]**

| Category | Aetna | HealthKeepers | Molina | Optima | United | VA Premier | All |
|---|---|---|---|---|---|---|---|
| **Eligibility** | | | | | | | |
| *Overall Total* | 45,254 | 83,448 | 28,522 | 47,644 | 39,041 | 49,993 | 293,902 |
| *Persons With Disability or Blindness* | 22,648 | 40,844 | 12,860 | 26,128 | 17,146 | 29,038 | 148,664 |
| *Aged (65 or older)* | 12,911 | 23,843 | 8,127 | 11,109 | 14,232 | 12,202 | 80,789 |
| *Adults* | 9,553 | 18,258 | 7,441 | 10,160 | 7,547 | 8,479 | 63,073 |
| *Children* | 91 | 439 | 49 | 204 | 59 | 236 | 1,078 |
| *Pregnant Women* | 51 | 64 | 45 | 43 | 57 | 38 | 298 |

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

Figure 2-2 displays the CY 2022 CCC Plus program categories by race.

**Figure 2-2—CCC Plus Program CY 2022 Categories by Race**

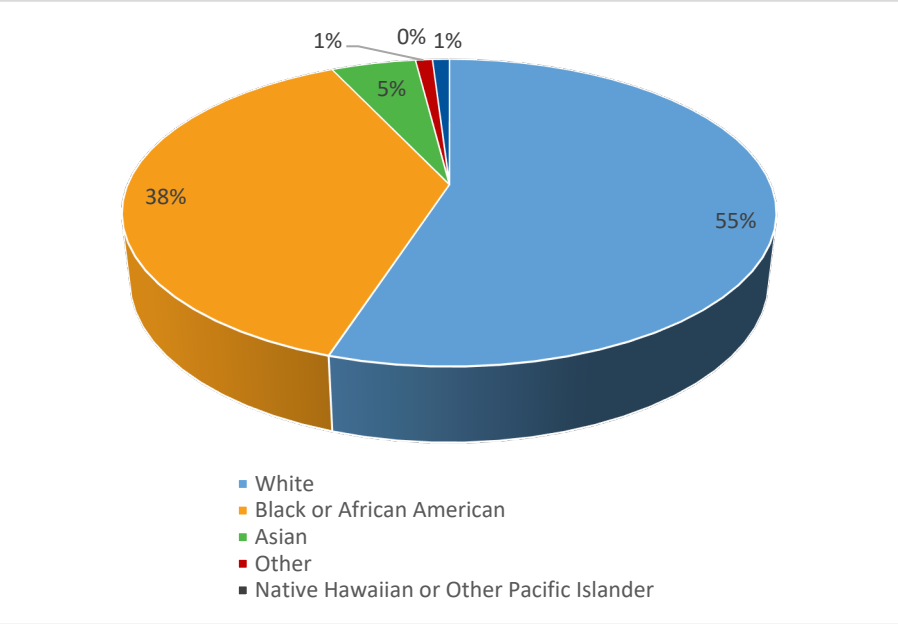



**Table 2-4—CCC Plus Program CY 2022 MCO Categories by Race[2-4]**

| Category | Aetna | HealthKeepers | Molina | Optima | United | VA Premier | All |
|---|---|---|---|---|---|---|---|
| **Race** | | | | | | | |
| *White* | 56% | 53% | 54% | 49% | 56% | 63% | 55% |
| *Black or African American* | 37% | 37% | 40% | 46% | 35% | 33% | 38% |
| *Asian* | 5% | 8% | 3% | 3% | 7% | 3% | 5% |
| *Other* | 1% | 2% | 2% | 1% | 1% | 1% | 1% |
| *Native Hawaiian or Other Pacific Islander* | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| *American Indian or Alaskan Native* | 1% | 1% | 1% | 1% | 1% | 0% | 1% |

[2-4] Ibid.

Figure 2-3 displays the CY 2022 CCC Plus program categories by ethnicity.

**Figure 2-3—CCC Plus Program CY 2022 Categories by Ethnicity**

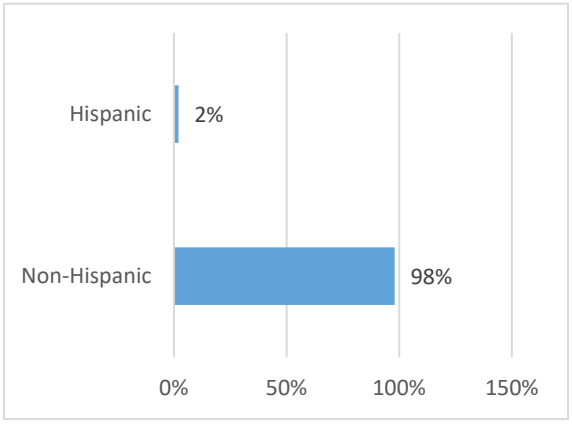



**Table 2-5—CCC Plus Program CY 2022 MCO Categories by Ethnicity[2-5]**

| Category | Aetna | HealthKeepers | Molina | Optima | United | VA Premier | All |
|---|---|---|---|---|---|---|---|
| **Ethnicity** | | | | | | | |
| *Non-Hispanic* | 99% | 98% | 98% | 98% | 98% | 99% | 98% |
| *Hispanic* | 1% | 2% | 2% | 2% | 2% | 1% | 2% |

[2-5] Ibid.

Figure 2-4 displays the CY 2022 CCC Plus program percentage of members by gender.

**Figure 2-4—CCC Plus Program CY 2022 Percentage by Gender**

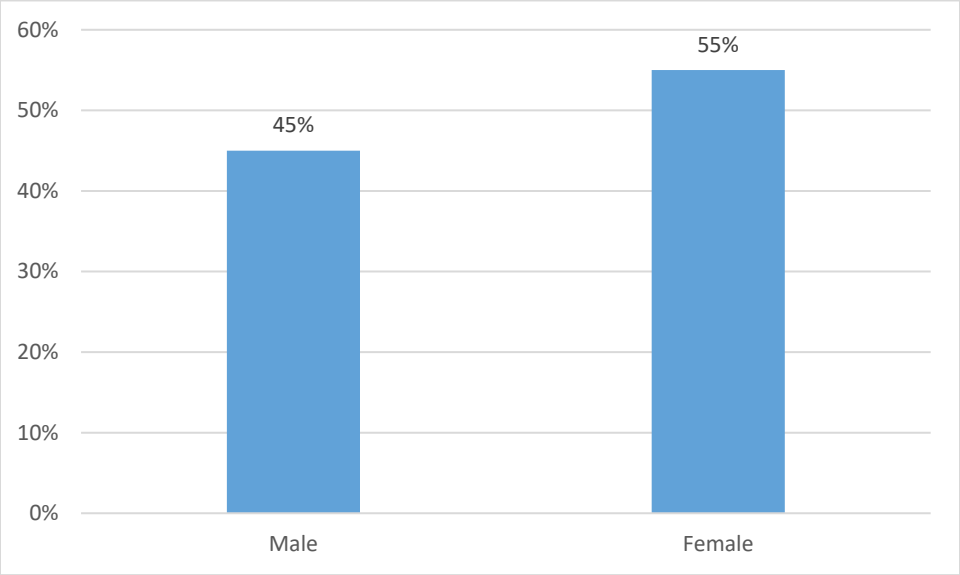



**Table 2-6—CCC Plus Program CY 2022 MCO Percentage by Gender[2-6]**

| Category | Aetna | HealthKeepers | Molina | Optima | United | VA Premier | All |
|---|---|---|---|---|---|---|---|
| **Gender** | | | | | | | |
| *Male* | 44% | 45% | 50% | 46% | 44% | 45% | 45% |
| *Female* | 56% | 55% | 50% | 54% | 56% | 55% | 55% |

[2-6] Ibid.

Figure 2-5 displays the CY 2022 CCC Plus program enrollment by age group.

**Figure 2-5—CCC Plus Program CY 2022 Enrollment by Age Group**

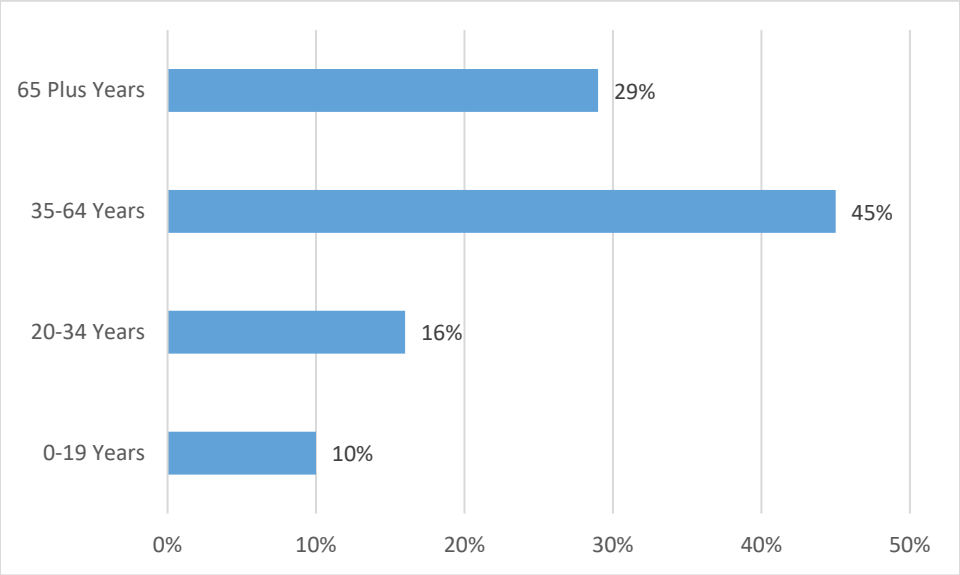



**Table 2-7—CCC Plus Program CY 2022 MCO Enrollment by Age Group[2-7]**

| Category | Aetna | HealthKeepers | Molina | Optima | United | VA Premier | All |
|---|---|---|---|---|---|---|---|
| **Age Groups** | | | | | | | |
| *0–19 Years* | 7% | 11% | 7% | 13% | 6% | 12% | 10% |
| *20–34 Years* | 15% | 16% | 18% | 18% | 13% | 15% | 16% |
| *35–64 Years* | 47% | 42% | 47% | 46% | 42% | 47% | 45% |
| *65 Plus Years* | 30% | 31% | 28% | 23% | 39% | 26% | 29% |

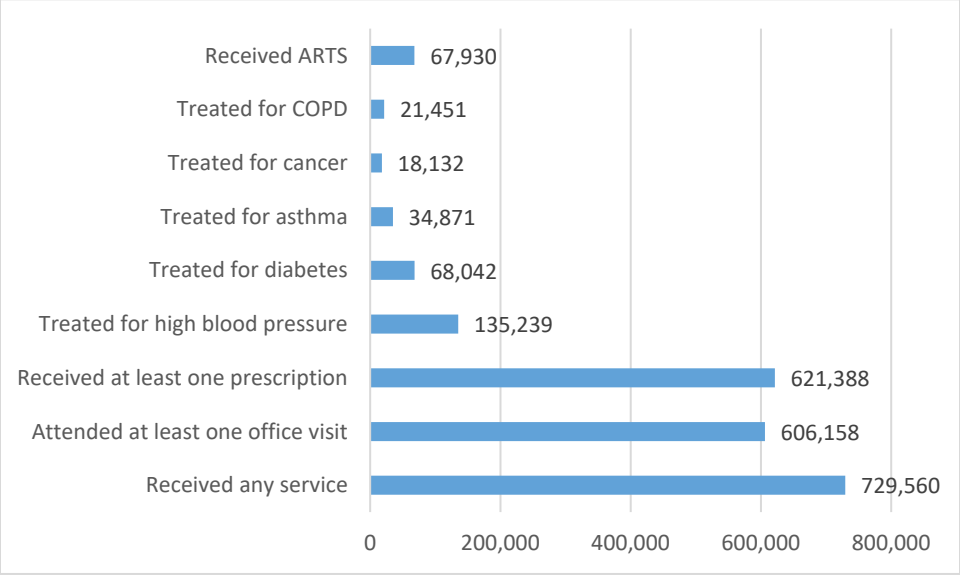
## CCC Plus Program

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

[2-7] Ibid.

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

**Figure 2-6—Medicaid Expansion Service Provision**




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

**Table 2-8—CY 2022 Medicaid Expansion Service Provision**

| Age Category | Number of Services Provided |
|---|---|
| *Received ARTS* | 67,930 |
| *Treated for COPD* | 21,451 |
| *Treated for Cancer* | 18,132 |
| *Treated for Asthma* | 34,871 |
| *Treated for Diabetes* | 68,042 |
| *Treated for High Blood Pressure* | 135,239 |
| *Received at Least One Prescription* | 621,388 |
| *Attended at Least One Office Visit* | 606,158 |
| *Received Any Service* | 729,560 |

*Data from 08/01/2022 Enrollment Data at https://www.dmas.virginia.gov/data/medicaid-expansion-enrollment/*

Figure 2-7 displays the CCC Plus program Medicaid expansion count of members by age category.

**Figure 2-7—CCC Plus Medicaid Expansion Number of Members by Age Category**

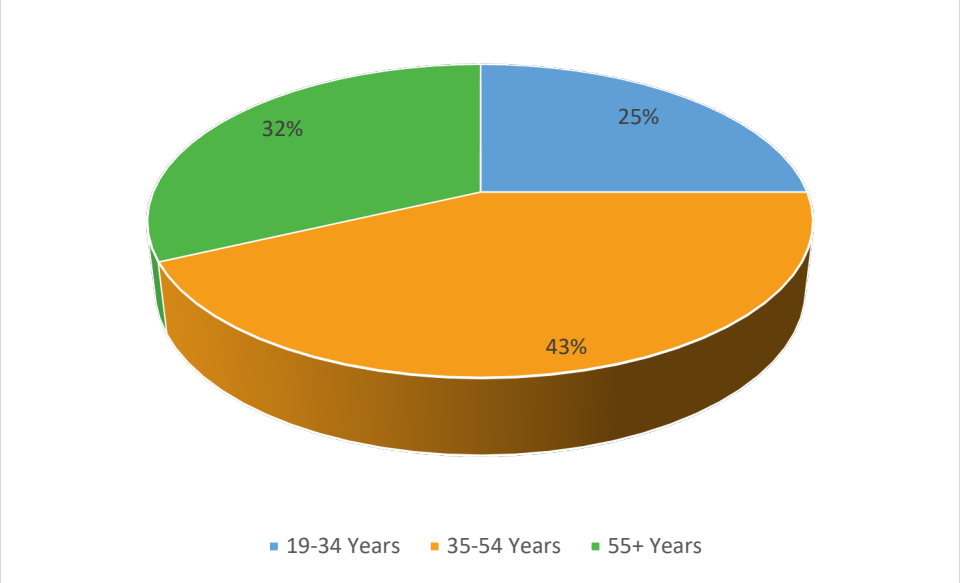



**Table 2-9—CCC Plus CY 2022 Medicaid Expansion Percentage by Age Category**

| Age Category | Percentage |
|---|---|
| *19–34 Years* | 31% |
| *35–54 Years* | 44% |
| *55+ Years* | 31% |

*Data from 08/01/2022 Enrollment Data at https://www.dmas.virginia.gov/data/medicaid-expansion-enrollment/*

Figure 2-8 displays the CCC Plus program Medicaid expansion count of members by FPL category.

**Figure 2-8—CCC Plus Medicaid Expansion Members by FPL Category**

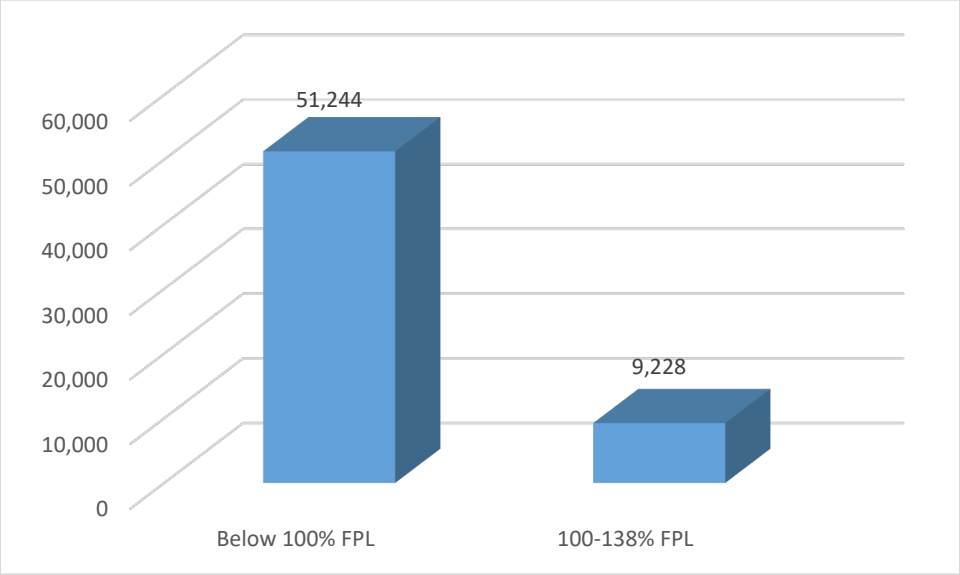



**Table 2-10—CCC Plus Medicaid Expansion Members by FPL Category**

| FPL Level | Number |
|---|---|
| *Below 100% FPL* | 51,244 |
| *100–138% FPL* | 9,228 |

*Data from 08/01/2022 Enrollment Data at https://www.dmas.virginia.gov/data/medicaid-expansion-enrollment/*

Figure 2-9 displays the CCC Plus program Medicaid expansion count of members by Medicaid region.

**Figure 2-9—CCC Plus Medicaid Expansion Members by Medicaid Region**

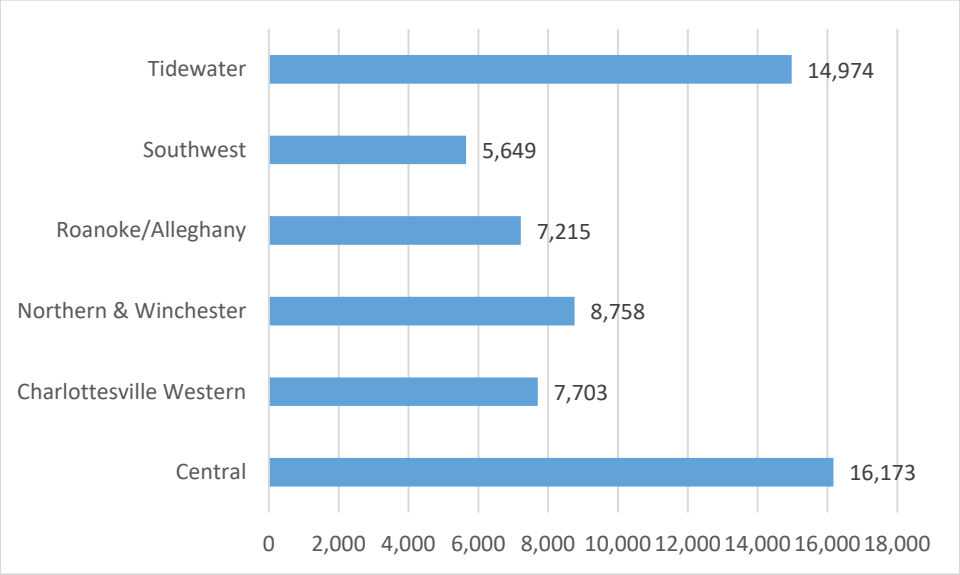



**Table 2-11—CCC Plus Medicaid Expansion Members by Medicaid Region**

| Region | Number |
|---|---|
| *Central Region* | 16,173 |
| *Charlottesville Western Region* | 7,703 |
| *Northern & Winchester Region* | 8,758 |
| *Roanoke/Alleghany Region* | 7,215 |
| *Southwest Region* | 5,649 |
| *Tidewater Region* | 14,974 |

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

**Table 2-12—CCC Plus Priorities**

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

## COVID-19 Response

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

On July 2, 2020, DMAS directed each MCO to increase payments to network physicians and nonphysician practitioners by 29 percent for certain services provided between March 1 and June 30, 2020. The services included primary care, preventive care, telehealth visits and EPSDT screenings and treatments.[2-11] DMAS also implemented flexibilities for care and services for members receiving LTSS. DMAS allowed flexibilities for specific face-to-face visit requirements and other HCBS. The flexibilities were designed to maintain provider staffing, maximize access to care, and minimize viral spread through community contact to protect the most vulnerable populations. Table 2-13 describes some of the LTSS flexibilities DMAS allowed during the PHE.[2-12]

**Table 2-13—LTSS Flexibilities to Support Access to Care**

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

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

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

[2-11] Georgetown University Health Policy Institute, Center for Children and Families. Redirecting Medicaid MCO Gains to Offset Network Provider Losses in the Time of COVID-19. Available at: https://ccf.georgetown.edu/2020/07/27/redirecting-medicaid-mco-gains-to-offset-network-provider-losses-in-the-time-of-covid-19/. Accessed on: Jan 3, 2023.

[2-12] Virginia Department of Medical Assistance Services. COVID-19 Response. Available at: https://www.dmas.virginia.gov/covid-19-response/. Accessed on: Dec 19, 2022.

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

HSAG recognizes that EQR-related activities in FY 2020–2021 and, to a lesser extent, FY 2021–2022 were conducted during the unprecedented COVID-19 PHE; therefore, results and recommendations, particularly in the access to care domain for both FY 2020–2021 and FY 2021–2022, should be considered with caution. Regardless, while some MCOs experienced lower scores across domains of care across these two reporting years, Virginia's Medicaid MCOs also found innovative and creative ways to address barriers and continued to provide services for Virginia's Medicaid members.

DMAS flexibilities were designed to maintain provider staffing, maximize access to care, and minimize viral spread through community contact to protect the most vulnerable populations. Table 2-14 describes some of the flexibilities and waivers allowed during the PHE that continued throughout 2021.[2-13]

**Table 2-14—COVID-19 Flexibilities and Waivers[2-14]**

| **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.<br>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. |
| **Behavioral Health Services** |
| TDT, IIH, MHSS, ICT, and PSR:<br>• 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.<br>• 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, |

[2-13] 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: Dec 19, 2022.

[2-14] 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 19, 2022.

| Behavioral Health Services |
| --- |
| 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:<br>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:<br>• 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).<br>• 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.<br>• The provider was delivering services through any combination of telephonic communications, telehealth, and in-person services and did not reach a full unit of time spent in billable activities. |
| Applied Behavior Analysis—Face-to-face service requirements for family adaptive behavior treatment continued to be waived, documentation justified the rationale for the service through a different model of care. The goals, objectives, and strategies of the ISP updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual to COVID-19, and any newly identified problem. Documentation of this review added to the individual's medical record as evidenced by the dated signatures of the LMHP, LMHP-R, LMHP-RP, LMHP-S, LBA, or LABA. |
| Applied Behavior Analysis—One service unit equaled 15 minutes. ABA service providers did not have a one-unit limit per day for audio-only communications. |
| Any therapeutic interventions including therapy, assessments, care coordination, team meetings, and treatment planning could occur via telehealth.<br>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:<br>• The requirement for service authorization remained in place.<br>• Therapy, assessments, case management, team meetings, and treatment planning could occur via telehealth.<br>• 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. |

| Behavioral Health Services |
|---|
| **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. |
| **Support for Medicaid Providers—Streamlined Enrollment and Screening** |
| Provider enrollment requirements were streamlined. |
| Site visits, application fees, and certain background checks were waived to temporarily enroll providers in the Medicaid program. |
| Deadlines for revalidations of providers were postponed. |
| Out-of-state providers were permitted to be reimbursed for services to Medicaid members. |
| Telehealth policies—waiver of penalties for HIPAA non-compliance and other privacy requirements. |
| Facilities fully reimbursed for services rendered to an unlicensed facility (during PHE). This rule applied to facility-based providers only. |
| Electronic signatures accepted for visits that were conducted through telehealth. |
| **Waivers** |
| Members who received less than one service per month not discharged from an HCBS waiver. |
| Any member with a significant change requesting an increase in support due to changes in medical condition and/or changes in natural supports must have an in-person visit. |
| Legally responsible individuals (parents of children under age 18 and spouses) provided personal care/personal assistance services for reimbursement. |
| Personal care, respite, and companion aides hired by an agency permitted to provide services prior to receiving the standard 40-hour training. |
| CE/CC provided through telephonic/video conferencing for individuals who had the technological resources and ability to participate with remote CE/CC staff via virtual platforms. |
| Residential providers permitted to not comply with the HCBS settings requirement at 42 CFR §441.301(c)(4)(vi)(D) that individuals were able to have visitors of their choosing at any time. |
| **Nursing Facilities** |
| Waived the requirements at 42 CFR §483.35(d) (with the exception of 42 CFR §483.35[d][1][i]), which required that an SNF and NF may not employ anyone for longer than four months unless they met the training and certification requirements under 42 CFR §483.35(d). |

## Medicaid Enterprise System

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

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

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

One of the MES modules is a dynamic CRMS that facilitates care coordination activities for all Medicaid enrollees. CRMS collects and facilitates the secure exchange of member-centric data, through data collection, data sharing, and performance management. CRMS securely captures service authorization information, including dates of the health risk assessment and the completion of the individualized care plan. CRMS also houses level of care and preadmission screening documentation improving the quality and safety of care, reducing unnecessary and redundant patient testing, aiding the MCOs with proactive care planning, and reducing costs.

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

## Care Coordination

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

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

## Training, Support, and Oversight of Care Coordination

The value of care coordination continues to demonstrate its worth with DMAS' most vulnerable members in the CCC Plus program. The DMAS CMU continued to provide training and support to the MCO care coordinators and oversee care coordination efforts provided through CCC Plus. CMU continued to offer webinars to the CCC Plus care coordinators on a regular and ongoing basis. Webinar topics were carefully selected, and SMEs were invited to cover certain topics that were helpful to the care coordinators in fulfilling the expectations of the CCC Plus contract requirements. Many topics were

related to waiver services and requirements but there were also topics that were more general such as behavioral health resources, or crisis services and working with challenging members, etc. These webinars were scheduled weekly or less frequently depending on unit resources and needs. High care coordinator participation continued with an average of 500 attendees or more per training session. The following is a list of the ongoing efforts and resources provided for the continued development and success of the care coordinators:

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

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

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

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

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

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

## ARTS[2-15]

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

[2-15] All data in this section were derived from a July 2021 report provided by DMAS titled, *Addiction and Recovery Treatment Services, Access, Utilization, and Quality of Care, 2016–2019*.

data sources, including Medicaid administrative claims, information on the supply of substance use treatment providers, and a survey of Medicaid members who used ARTS.

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

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

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

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

The report states that of the 1.78 million people who were enrolled in Medicaid at some point during 2019, 5.4 percent had a diagnosed SUD of any type. The diagnosed prevalence of other SUD among Medicaid members increased between 2016 and 2019. There were about 96,000 Medicaid members who had a diagnosis of SUD in 2019 compared to 37,000 members diagnosed with SUD in 2018. Of those, about 42,000 (44 percent) enrolled through Medicaid expansion. Table 2-15 shows the percent change between 2016 and 2019 of diagnosed prevalence of SUD.

**Table 2-15—Percent Change of Diagnosed Prevalence of SUD 2016–2019**

| Diagnosis | 2016 | 2019 | Percent Change 2016–2019 |
|---|---|---|---|
| *Any SUD* | 48,341 | 95,942 | 98.5% |

| | | | |
|---|---|---|---|
| *OUD* | 17,129 | 40,361 | 135.6% |
| *AUD* | 18,216 | 35,193 | 93.2% |
| *Other stimulants (primarily methamphetamines)* | 2,169 | 9,544 | 340% |
| *Cocaine* | 5,756 | 13,564 | 135.6% |
| *Cannabinoids* | 13,325 | 26,905 | 101.9% |

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

**Figure 2-10—Diagnosed Prevalence of SUD**

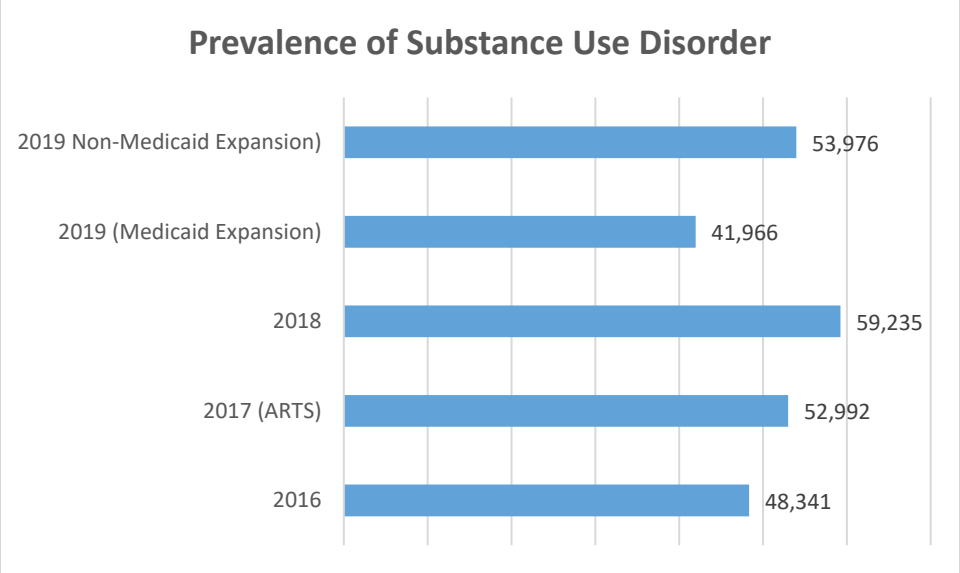


**Figure 2-11—Diagnosed Prevalence of OUD**

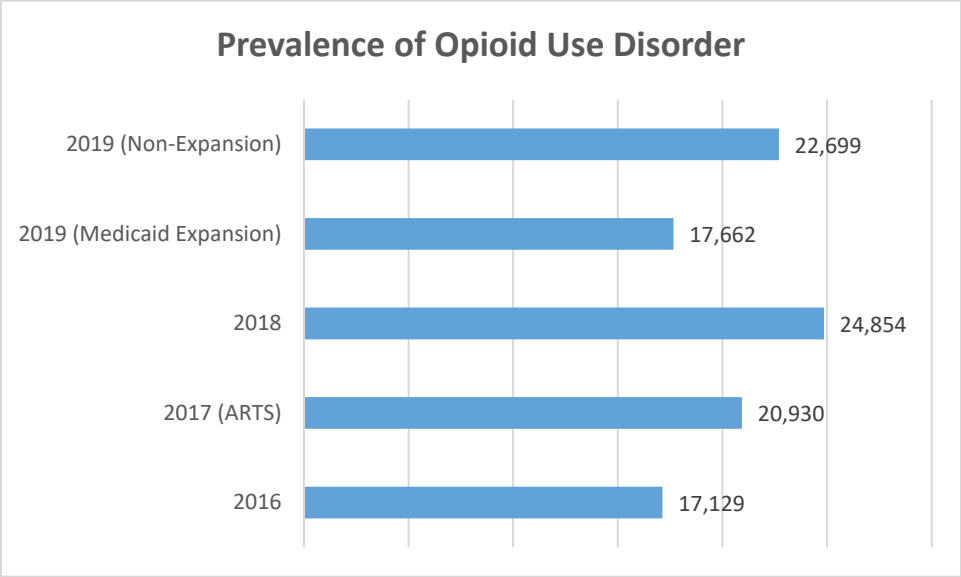
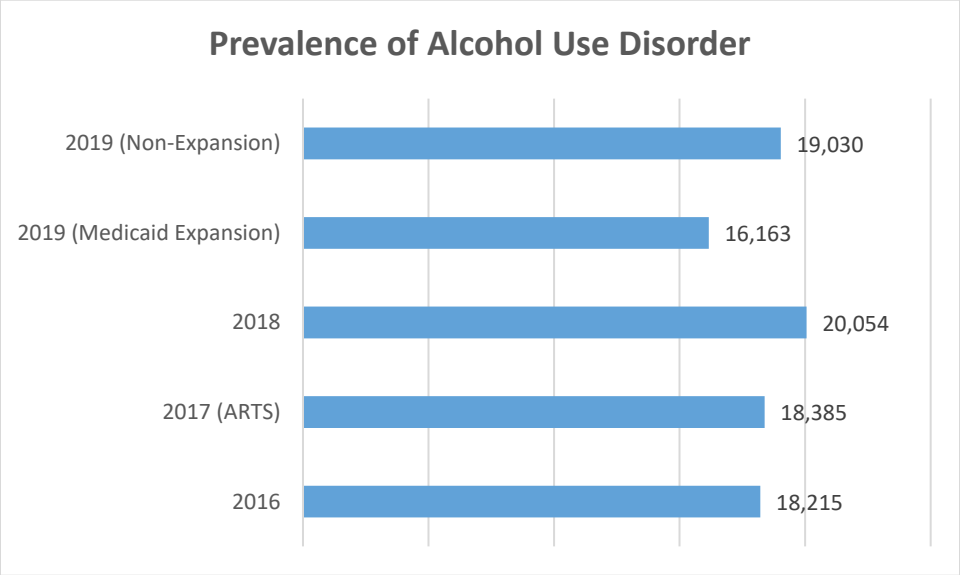



**Figure 2-12—Diagnosed Prevalence of AUD**




## Characteristics of Members Receiving ARTS Benefit

Among members enrolled in Medicaid expansion, 53.4 percent received treatment for a diagnosed SUD, while 72.8 percent received treatment for a diagnosed OUD—similar to the treatment rates for nondisabled adults who qualified through pre-expansion income eligibility levels. Only about 5 percent with SUD who were enrolled through foster care programs received any treatment, while there were too few foster care members with OUD to estimate a treatment rate. Table 2-16 shows the SUD and OUD treatment rates by member groups\.

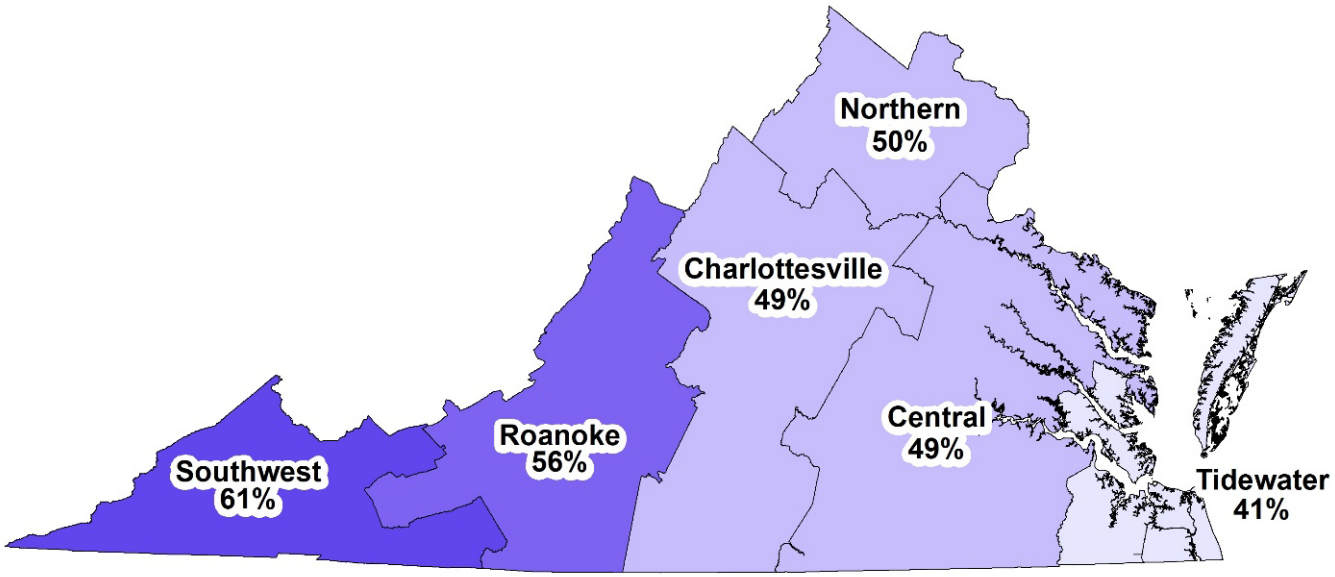
**Table 2-16—SUD and OUD Treatment Rates by Member Group**

| Member Group | SUD Treatment Rate[1] | OUD Treatment Rate |
|---|---|---|
| Medicaid expansion | 53.4% | 72.8% |
| Nondisabled adults | 52.7% | 72.8% |
| Disabled adults | 42.7% | 57.1% |
| Foster Care | 4.9% | Not Reportable |

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

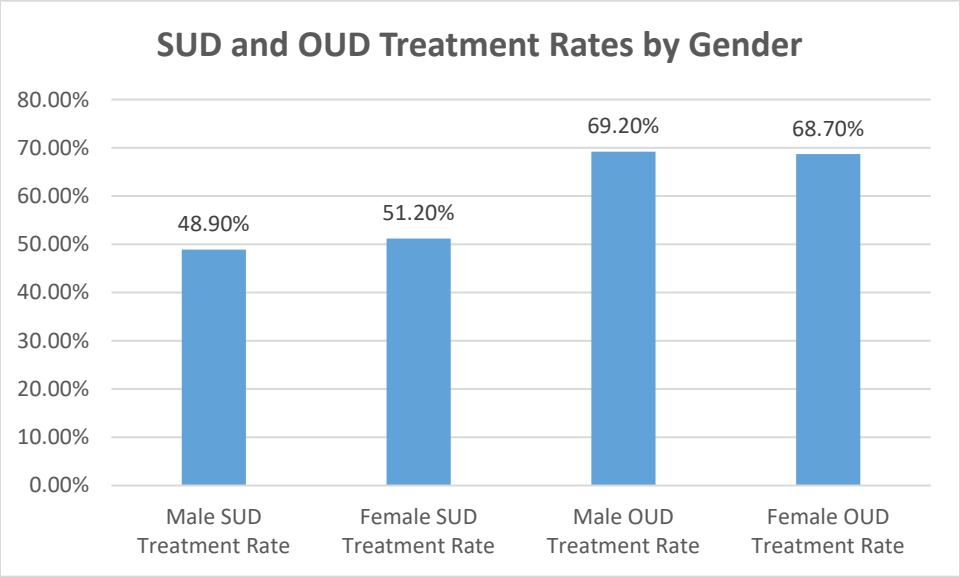
Among Virginia regions, the Southwest and Roanoke regions had the highest treatment rates for SUD (61 percent and 56 percent, respectively), and the Tidewater region had the lowest treatment rate (41 percent). Similar regional patterns were observed for OUD treatment rates.

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



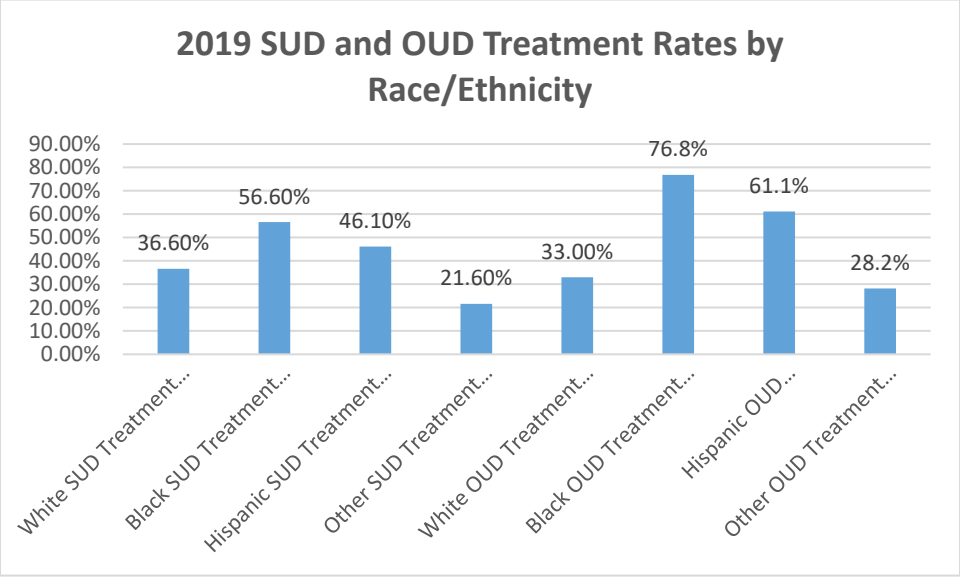

Members with a diagnosed SUD of any type represented 5.4 percent of the 1.78 million people in Virginia who were enrolled in Medicaid at some point in 2019. Figure 2-14 shows the prevalence, by gender, of members treated for SUD or OUD. Males were treated for an OUD at a higher rate than females. Females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

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




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

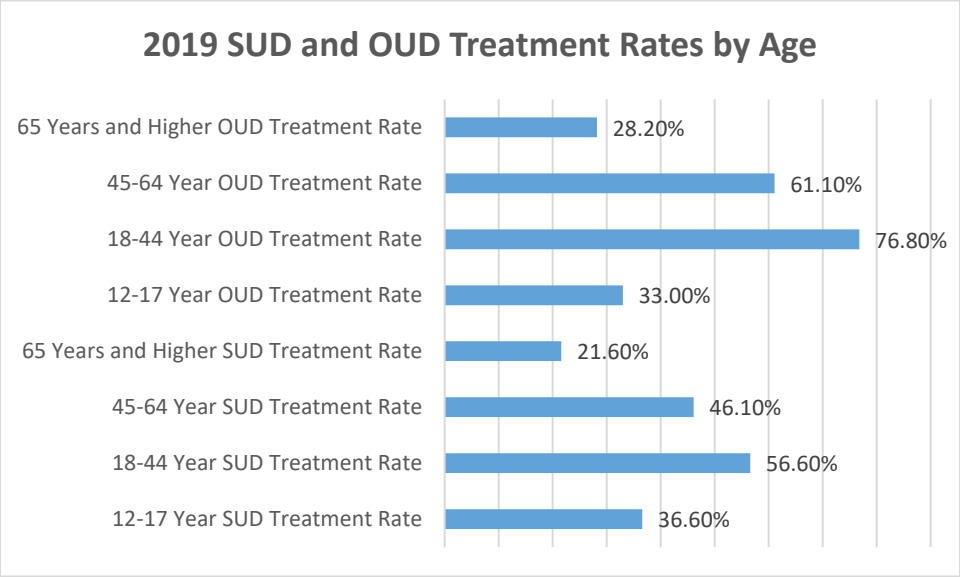
**Figure 2-15—2019 Treatment Rates for SUD and OUD by Race/Ethnicity**




Variances in treatment rates for SUD and OUD were also identified by age group in the report. Members in the 45 to 64 age group had, by far, the highest diagnosed prevalence compared to other

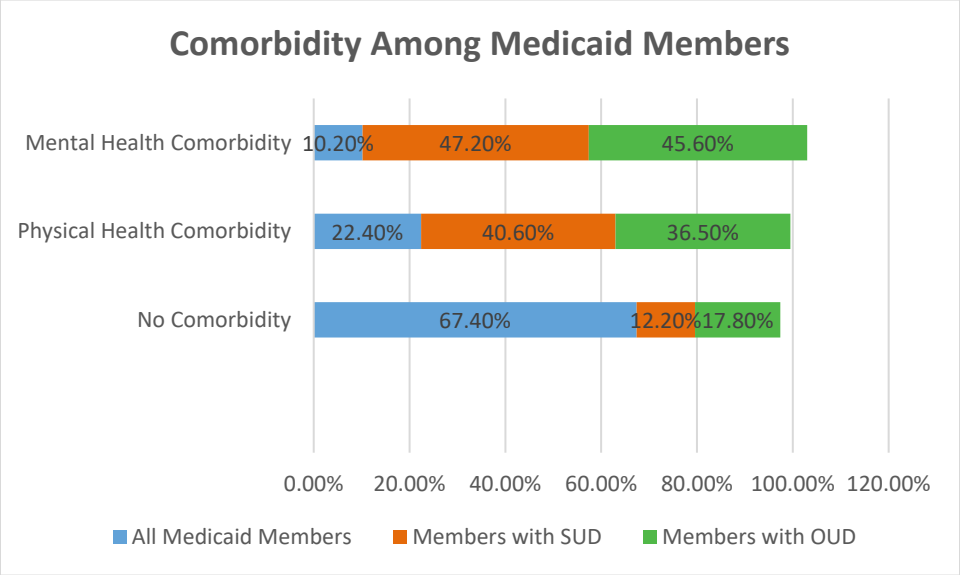
ages. Adolescents (ages 12 to 17) had the lowest diagnosed prevalence. Treatment rates for SUD and OUD by age are shown in Figure 2-16.

**Figure 2-16—Treatment Rates for SUD and OUD by Age**



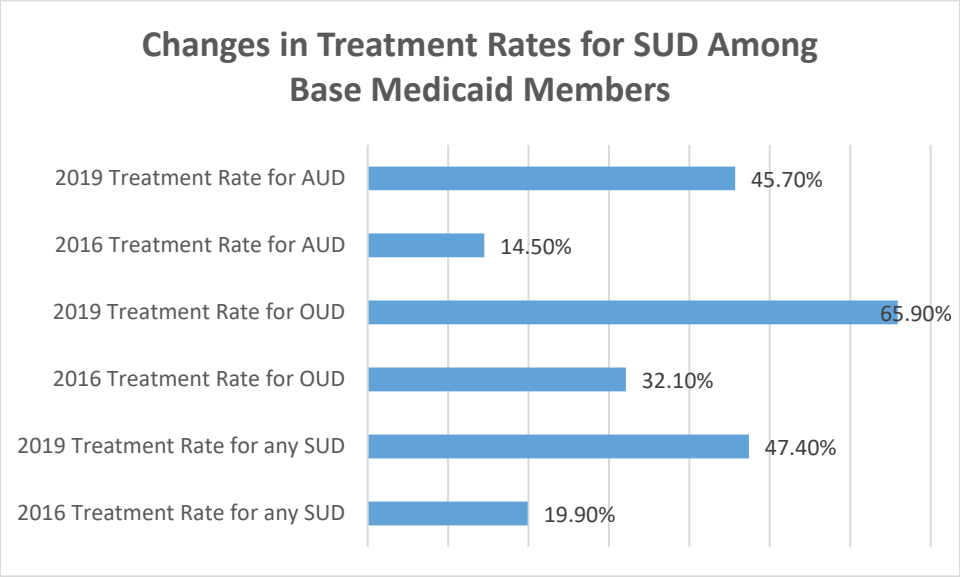

SUDs are often accompanied by other co-occurring physical conditions and mental health disorders. Compared to all Medicaid members, those with SUD are more likely to have other comorbid conditions, including mental health disorders. Among Medicaid members with SUD, 40.6 percent had a physical health comorbidity, while 47.2 percent had a mental health comorbidity. Only 12.2 percent of members with SUD had no comorbidities. Figure 2-17 shows the comorbidity rate of all Medicaid members, Medicaid members with diagnosed SUD, and Medicaid members diagnosed with OUD.

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



Treatment rates for any SUD, OUD, and AUD continued to increase each year since the implementation of the ARTS benefit. The treatment rate for any SUD increased by 138.3 percent between 2016 and 2019. During the same time frame, the treatment rate for OUD increased by 104 percent, and the treatment rate for AUD increased by 215.4 percent. The changes in treatment rates for SUD among the base Medicaid member, which excludes Medicaid expansion members, are shown in Figure 2-18.

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




The results in the report showed that following implementation of the ARTS benefit the likelihood of having an ED visit decreased by 9.4 percentage points (a 21.1 percent relative decrease) among members with OUD, compared to 0.9 percentage points among members with no SUD. A similar decline was noted in inpatient hospitalizations. Table 2-17 shows the number of ED visits per 100 base Medicaid members.

**Table 2-17—Number of ED Visits Per 100 Base Medicaid Members**

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

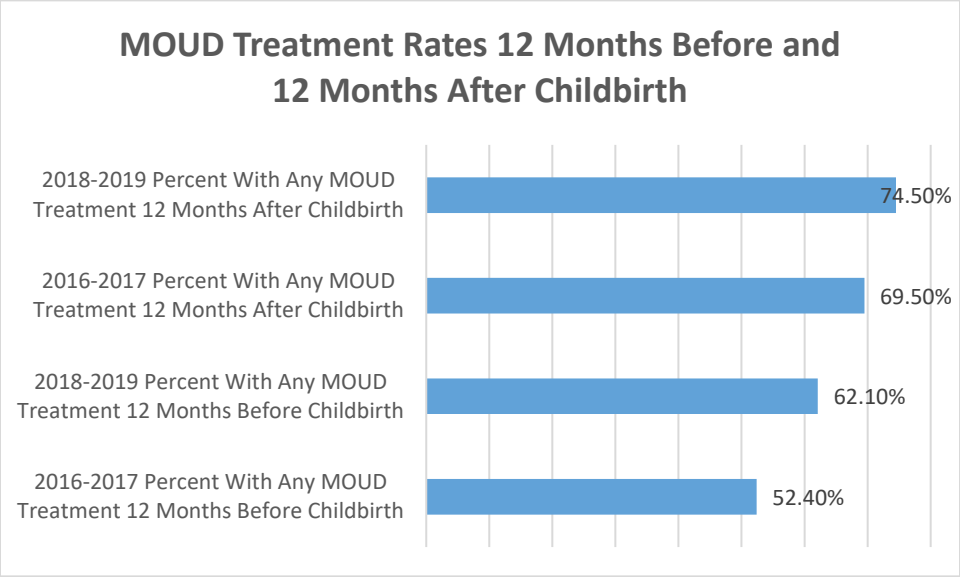
The report also states that use of services in 2019 increased greatly across all ASAM levels of care. In 2019, 46,520 members used a treatment service categorized with an ASAM level of care, a 79 percent

increase from 2018, and a 172 percent increase since 2017, the first year of ARTS. There were increases in utilization across all levels of service, but increases between 2018 and 2019 were especially notable for early screening and interventions, residential treatment services (ASAM 3), the use of OTP and Preferred OBOT providers, and the use of care coordination services at Preferred OBOTs:

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

The Virginia ARTS benefit expanded the treatment services available to Medicaid members, including pregnant individuals covered by Medicaid in the prenatal and postpartum period. MOUD treatment rates increased from 52.4 percent in 2016–2017 to 62.1 percent in 2018–2019, while the average number of months with any MOUD in the 12 months prior to delivery increased from 5 months in 2016–2017 to 5.4 months by 2018–2019. MOUD treatment rates were higher in the 12 months after delivery than the 12 months prior to delivery (69.5 percent in 2016–2017 to 74.5 percent in 2018–2019). The number of months of MOUD treatment increased from 5.9 months in 2016–2017 to 7.0 months by 2018–2019. Diagnosed MOUD treatment rates 12 months before and after childbirth are shown in Figure 2-19.

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




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

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

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

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

To enhance cross-state comparisons, VCU and DMAS participate in MODRN, a collaboration of state-university partnerships through AcademyHealth established for the purpose of comparing state Medicaid programs on key measures of SUD and OUD treatment access and quality of care. Table

2-18 displays characteristics of members receiving OUD treatment in Virginia compared to other states participating in MODRN.

**Table 2-18—2018 OUD Treatment for Medicaid Members State Comparison**

| Member Characteristic | Percentage of Members With OUD Diagnosis | |
|---|---|---|
| | Virginia | Other MODRN States* |
| **Age Group** | | |
| 12–20 | 1.2% | 1.5% |
| 21–34 | 35.1% | 41.9% |
| 35–44 | 28.7% | 29.4% |
| 45–54 | 19.3% | 16.9% |
| 55–64 | 15.7% | 10.3% |
| **Gender** | | |
| Female | 66.3% | 51.2% |
| Male | 15.7% | 10.3% |
| **Race/Ethnicity** | | |
| Non-Hispanic White | 79.1% | 76.2% |
| Non-Hispanic Black | 19.4% | 13.8% |
| Hispanic | 0.1% | 2.9% |
| Other/Unknown | 1.4% | 7.1% |
| **Eligibility Group** | | |
| Pregnant | 5.1% | 5.6% |
| Youth | 1.1% | 1.4% |
| Disabled Adults | 41.1% | 17.1% |
| Non-Disabled | 52.7% | 24.6% |
| Medicaid Expansion Adults | Not Applicable | 51.3% |
| **Living Area** | | |
| Urban | 69.0% | 73.3% |
| Rural | 31.0% | 26.4% |
| Missing Urban/Rural Category | 0% | 0.2% |

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

MOUD treatment rates increased to a much greater extent between 2016 and 2018 among Virginia Medicaid members compared to members in other MODRN states. Prior to the ARTS implementation in 2016, MOUD treatment rates were substantially lower in Virginia (33.6 percent) compared to other MODRN states (48.7 percent). MOUD treatment rates increased in both Virginia and other MODRN states between 2016 and 2018, but to a much greater extent in Virginia, following implementation of the

ARTS benefit. By 2018, MOUD treatment rates among Virginia Medicaid members were comparable to members in other MODRN states. Table 2-19 shows the rate of MOUD treatment among Virginia Medicaid members ages 12 to 64 years compared to Medicaid members in other MODRN states.

**Table 2-19—Rate of MOUD Treatment Among Virginia Medicaid Members Ages 12 to 64 Years Compared to Medicaid Members in other MODRN States**

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

## Member Experience With ARTS Services[2-16]

The ARTS member survey, adapted from a version of the CAHPS survey, included a number of questions assessing the patient's experience with ARTS, including Preferred OBOT, OTP, and other outpatient treatment providers, identified based on Medicaid claims data at the time of the survey sampling. The total number of survey respondents included 708 members. Results of the survey indicate that the majority of survey respondents have positive experiences with the treatment they were receiving. Of the survey respondents, 67.5 percent indicated that they were able to see someone as soon as they wanted, if needed. In addition, 83.6 percent of respondents indicated that providers explained things in a way they could understand, 84.5 percent indicated that providers showed respect for what the member had to say, and 90.1 percent indicated that the provider made them feel safe.

Regarding patient involvement in treatment or discontinuation of treatment, 84.8 percent of respondents were involved in treatment as much as they wanted to be, 73.7 percent of respondents indicated that they were provided information about different treatment options, 72.1 percent of respondents felt able to refuse a specific type of medicine or treatment, and 16.6 percent of respondents indicated that they stopped treatment against the advice of a doctor.

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

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

[2-16] All data in this section were derived from a July 2021 report provided by DMAS titled, *Addiction and Recovery Treatment Services, Access, Utilization, and Quality of Care, 2016–2019*.

## Health Disparities in SUD Treatment Services Among Medicaid Members[2-17]

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

As described in the report, availability of treatment providers tends to vary the most by rural/urban areas. Counties in large metropolitan areas (1 million or more people) are more likely to have waivered prescribers (79 percent), OTP providers (35 percent), and Preferred OBOT providers (54 percent) compared to rural areas. However, the number of waivered prescribers relative to the population tends to be higher in rural areas (16.2 prescribers per 100,000 people) compared to large metropolitan areas (10.8 prescribers per 100,000), indicating that urban areas potentially have greater problems with treatment capacity. Metropolitan counties with the lowest per capita income were more likely to have a waivered prescriber (92 percent), a higher relative number of waivered prescribers (19 per 100,000 people), and a Preferred OBOT provider (65 percent) relative to counties with the highest per capita income.

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

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

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

[2-17] Ibid.

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

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

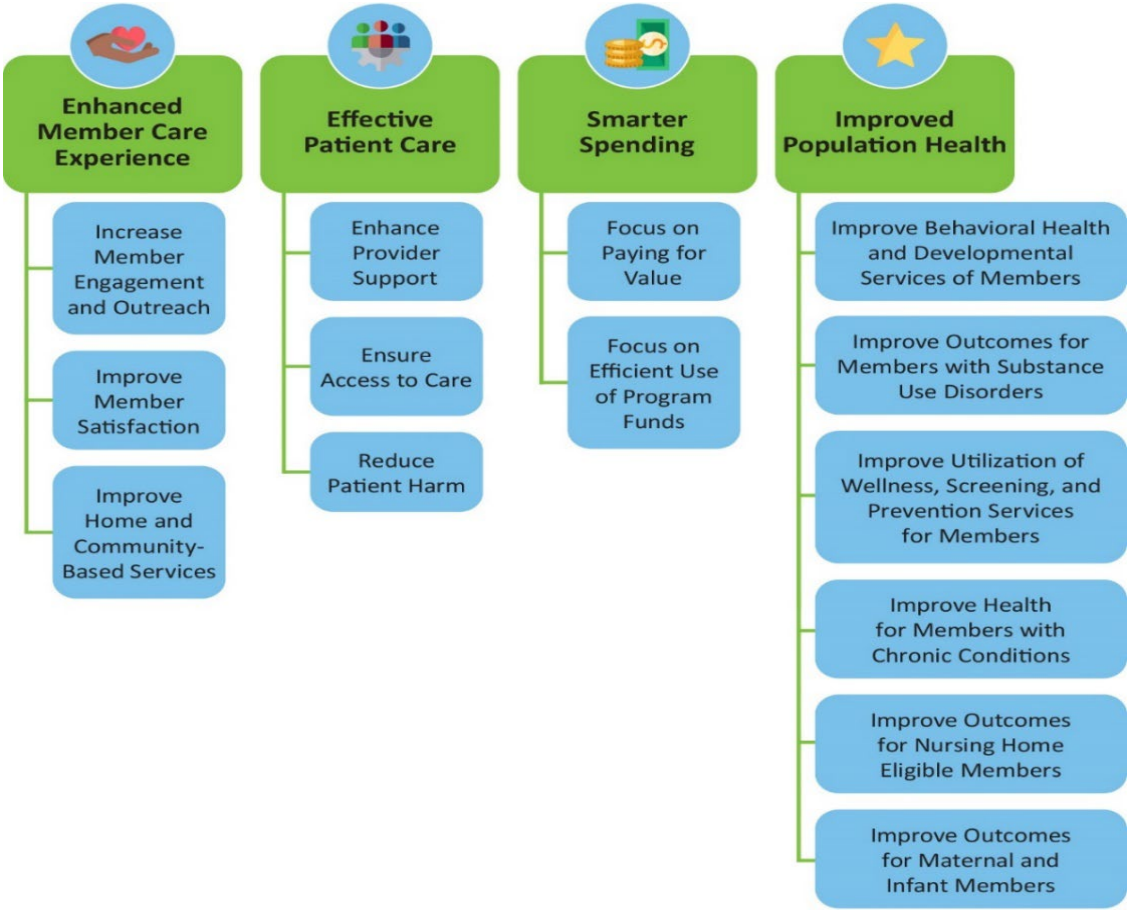
## Virginia's 2020–2022 Quality Strategy

In 2022, DMAS worked with its EQRO, HSAG, to review and update the fourth edition of its comprehensive Virginia 2020–2022 QS in accordance with 42 CFR §438.340. The QS updates did not meet the QS' definition of a significant change. During 2022, DMAS also worked with HSAG to develop the fifth edition of its comprehensive Virginia 2023–2025 QS. DMAS will implement the 2023–2025 QS in 2023.

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

Virginia's 2020–2022 QS is DMAS' guide to achieving Virginia's mission, vision, values, goals, and objectives. DMAS is committed to upholding its core mission and values, which have been consistent across all versions of the Virginia QS. Figure 2-20 displays Virginia's 2020–2022 QS aims and goals. Appendix F contains Virginia's 2020–2022 QS aims, goals, objectives, and metrics.

**Figure 2-20—Virginia's 2020–2022 QS Aims and Goals**




# Quality Initiatives

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

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

**Table 2-20—DMAS Quality Initiatives Driving Improvement**

| Virginia 2020–2022 QS Aim and Goal | DMAS Quality Initiative |
|---|---|
| **Aim 4:**<br>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 |

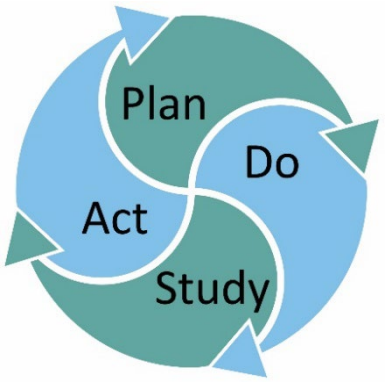
| Virginia 2020–2022 QS Aim and Goal | DMAS Quality Initiative |
|---|---|
| **Goal 4.6:**<br>Improve Outcomes for Maternal and Infant Members | Virginia QS. The DMAS maternity program, Baby Steps Virginia, actively partners with a variety of stakeholders including DMAS MCOs to improve quality maternity outcomes. All of these efforts have focused on eliminating racial disparities in maternal mortality by 2025, a key goal of the Governor and his administration.<br>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 2-21 identifies DMAS' best and emerging practices. The MCOs' self-reported best and emerging practices are found in Appendix C.

**Table 2-21—DMAS' Best and Emerging Practices**

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

# 3. MCO Comparative Information

## Comparative Analysis of the MCOs by Activity

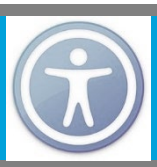
In addition to performing a comprehensive assessment of the performance of each MCO, HSAG compared the findings and conclusions established for each MCO to assess the quality, timeliness, and accessibility of the CCC Plus program.

### *Definitions*

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

### Quality

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



### Access

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

### Timeliness

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

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

# MCO Comparative and Statewide Aggregate PIP Results

## PIP Highlights

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

## Strengths, Weaknesses, and Recommendations

| Strengths | |
|---|---|
| + | All six MCOs developed methodologically sound projects that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project.<br>Four of the six MCOs received 100 percent validation scores and were assigned a *High Confidence* level for both PIPs. |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** Two of the six MCOs have opportunities for improvement related to accurate documentation of measure specifications followed for the PIPs. |
| | **Recommendations:** The MCOs should ensure that all initial validation feedback is addressed. The MCOs should ensure that the eligible population and performance indicator(s) are defined accurately according to the measure specifications. The MCOs should seek technical assistance to gain clarity on what corrections need to be made prior to the resubmission. |

# MCO Comparative and Statewide Aggregate PMV Results

To evaluate the MCOs' managed care performance in Virginia, DMAS used a subset of HEDIS and non-HEDIS measures to track and trend MCO performance and to establish benchmarks for improving the health of MCO populations. To evaluate the accuracy of reported PM data, HSAG conducted, on a subset of PMs and all quality withhold measures, non-HEDIS PMV for the measurement period of January 1, 2021, through December 31, 2021. Table 3-1 highlights the overall strengths and weaknesses identified by PM domain.

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

### *PMV Highlights*

The PMV highlights are included in Table 3-1.

**Table 3-1—PM Strengths and Weaknesses**

| Domain | Strengths | Weaknesses |
|---|---|---|
| **Access and Preventive Care** | Five of six MCOs' rates met or exceeded the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure. | All reportable MCO rates fell below the 50th percentile for the *Cervical Cancer Screening* and *Use of Imaging Studies for Low Back Pain* measures. |
| | | Five of six MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* measure. |
| **Behavioral Health** | All six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators. | All six MCOs' rates fell below the 50th percentile for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* measure indicator. |
| | All six MCOs' rates met or exceeded the 50th percentile for both *Follow-Up After ED Visit for Mental Illness* measure indicators. | |
| **Taking Care of Children** | Three of six MCOs' rates met or exceeded the 50th percentile for all *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure indicators. | All six MCOs' rates for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total* measure indicators fell below the 50th percentile. |
| **Living With Illness** | MCO performance within the Living With Illness domain was the highest for the *Medical Assistance With Smoking and Tobacco Use Cessation* measure, with five of six MCOs' rates meeting or exceeding the 50th percentile for the *Discussing Cessation Medications* and *Discussing Cessation Strategies* measure indicators, and all six MCOs' rates meeting or exceeding the 50th percentile for the *Advising Smokers and Tobacco Users to Quit* measure indicator. | Five of the six MCOs' rates fell below the 50th percentile for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator. |
| | Five of six MCOs' rates met or exceeded the 50th percentile for the | Four of the six MCOs' rates fell below the 50th percentile for the *Comprehensive* |

| Domain | Strengths | Weaknesses |
|---|---|---|
| | *Comprehensive Diabetes Care—HbA1c Testing* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure indicator. | *Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed* measure indicators. |
| **Use of Opioids** | Three of six MCOs' rates met or exceeded the 50th percentile for at least two of the three *Use of Opioids From Multiple Providers* measure indicators. | All six MCOs' rates fell below the 50th percentile for the *Use of Opioids From Multiple Providers—Multiple Prescribers* measure indicator. |

To ensure that HEDIS rates were accurate and reliable, DMAS required each MCO to undergo an NCQA HEDIS Compliance Audit.™[3-2] Each MCO contracted with an NCQA LO to conduct the HEDIS Compliance Audit. Additionally, HSAG reviewed the MCOs' FARs, IS compliance tools, and the IDSS files approved by each MCO's LO. HSAG found that the MCOs' IS and processes were compliant with the applicable IS standards and the HEDIS reporting requirements for the key CCC Plus Medicaid measures for HEDIS MY 2021.

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

- *Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)*
- *Comprehensive Diabetes Care*
- *Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence*
- *Follow-Up After ED Visit for Mental Illness*
- *Heart Failure Admission Rate (Per 100,000 Member Months)*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment*

**Table 3-2—HSAG MCO PMV Results**

| Performance Measure | Aetna | Health Keepers | Molina | Optima | United | VA Premier |
|---|---|---|---|---|---|---|
| ***COPD or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)**** | | | | | | |
| *40–64 Years* | 31.20 | 77.96 | 52.20 | 105.71 | 78.08 | 90.13 |
| *65+ Years* | 162.80 | 54.19 | 0.00 | 84.55 | 67.30 | 78.13 |
| *Total* | 58.52 | 70.45 | 47.18 | 103.03 | 73.77 | 87.17 |
| ***Comprehensive Diabetes Care*** | | | | | | |
| *HbA1c Testing* | 84.67% | 85.40% | 84.18% | 85.89% | 91.00% | 81.75% |
| *HbA1c Poor Control (>9.0%)** | 51.58% | 37.47% | 57.42% | 61.80% | 34.06% | 49.64% |
| *HbA1c Control (<8.0%)* | 42.09% | 54.50% | 36.25% | 32.60% | 57.18% | 41.61% |
| *Eye Exam (Retinal) Performed* | 45.26% | 53.04% | 36.50% | 48.18% | 69.59% | 45.99% |

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

| Performance Measure | Aetna | Health Keepers | Molina | Optima | United | VA Premier |
|---|---|---|---|---|---|---|
| *Blood Pressure Control (<140/90 mm Hg)* | 47.45% | 55.23% | 45.74% | 44.28% | 66.67% | 46.47% |
| ***Follow-Up After ED Visit for AOD Abuse or Dependence*** | | | | | | |
| *7-Day Follow-Up—Total* | 14.32% | 15.22% | 15.52% | 15.35% | 10.92% | 14.89% |
| *30-Day Follow-Up—Total* | 22.09% | 24.78% | 23.10% | 22.20% | 18.97% | 22.05% |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | | | |
| *7-Day Follow-Up—Total* | 46.99% | 46.82% | 44.34% | 45.24% | 46.76% | 42.40% |
| *30-Day Follow-Up—Total* | 61.33% | 63.68% | 57.23% | 60.28% | 60.88% | 60.18% |
| ***Heart Failure Admission Rate (Per 100,000 Member Months)**** | | | | | | |
| *18–64 Years* | 80.31 | 121.89 | 52.31 | 81.02 | 130.97 | 130.87 |
| *65+ Years* | 218.69 | 235.10 | 95.61 | 197.23 | 259.22 | 210.34 |
| *Total* | 99.94 | 146.80 | 54.79 | 90.29 | 170.25 | 144.46 |
| ***Initiation and Engagement of AOD Abuse or Dependence Treatment*** | | | | | | |
| *Initiation of AOD—Total—Total* | 44.10% | 46.08% | 47.88% | 44.67% | 44.34% | 44.83% |
| *Engagement of AOD—Total—Total* | 14.25% | 13.45% | 13.77% | 10.91% | 10.49% | 14.24% |

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

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

**Data Integration**—HSAG validated the data integration process used by the MCOs, which included a review of file consolidations or extracts, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. HSAG determined that the data integration processes for the MCOs were acceptable.

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

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

## MCO Comparative and Statewide Aggregate HEDIS Results

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

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

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

| Performance Measure | Aetna | Health Keepers | Molina | Optima | United | VA Premier | Virginia Aggregate |
|---|---|---|---|---|---|---|---|
| **Access and Preventive Care** | | | | | | | |
| ***Adults' Access to Preventive/Ambulatory Health Services*** | | | | | | | |
| *Total* | 87.06% | **90.86%** | 77.29% | 87.52% | **90.03%** | 86.53% | **87.82%** |
| ***Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis*** | | | | | | | |
| *Total* | 39.24% | 38.79% | **45.35%** | **55.49%** | 31.37% | **47.52%** | **43.59%** |
| ***Breast Cancer Screening*** | | | | | | | |
| *Breast Cancer Screening* | **46.10%** | **50.17%** | 38.92% | 45.23% | **53.95%** | 36.71% | **45.26%** |
| ***Cervical Cancer Screening*** | | | | | | | |
| *Cervical Cancer Screening* | 41.12% | **50.12%** | 39.90% | **47.93%** | **45.74%** | 40.88% | **45.25%** |
| ***Use of Imaging Studies for Low Back Pain*** | | | | | | | |
| *Use of Imaging Studies for Low Back Pain* | 66.95% | **71.31%** | **71.60%** | **73.00%** | **72.65%** | 68.34% | **70.53%** |
| **Behavioral Health** | | | | | | | |
| ***Adherence to Antipsychotic Medications for Individuals With Schizophrenia*** | | | | | | | |
| *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* | 65.31% | **67.87%** | 61.33% | 64.02% | **70.18%** | **71.94%** | **67.12%** |

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

| Performance Measure | Aetna | Health Keepers | Molina | Optima | United | VA Premier | Virginia Aggregate |
|---|---|---|---|---|---|---|---|
| ***Antidepressant Medication Management*** | | | | | | | |
| *Effective Acute Phase Treatment* | 64.08% | **66.65%** | 58.33% | 62.16% | **67.65%** | **71.38%** | **65.79%** |
| *Effective Continuation Phase Treatment* | 48.91% | **53.77%** | 42.50% | 46.44% | **51.64%** | **55.73%** | **51.01%** |
| ***Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*** | | | | | | | |
| *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* | **86.11%** | 65.06% | NA | **72.31%** | **72.22%** | 61.90% | **69.74%** |
| ***Follow-Up After ED Visit for AOD Abuse or Dependence*** | | | | | | | |
| *7-Day Follow-Up—Total* | 14.32% | **15.22%** | **15.52%** | **15.35%** | 10.92% | **14.89%** | **14.55%** |
| *30-Day Follow-Up—Total* | 22.09% | **24.78%** | **23.10%** | 22.20% | 18.97% | 22.05% | **22.57%** |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | | | | |
| *7-Day Follow-Up—Total* | **46.99%** | **46.82%** | 44.34% | 45.24% | **46.76%** | 42.40% | **45.40%** |
| *30-Day Follow-Up—Total* | **61.33%** | **63.68%** | 57.23% | 60.28% | 60.88% | 60.18% | **61.04%** |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | | | | |
| *7-Day Follow-Up—Total* | **33.88%** | **38.28%** | 20.80% | **35.70%** | **34.92%** | 19.16% | **31.38%** |
| *30-Day Follow-Up—Total* | **58.93%** | **63.57%** | 37.78% | **60.18%** | **58.44%** | 37.48% | **54.17%** |
| ***Initiation and Engagement of AOD Abuse or Dependence Treatment*** | | | | | | | |
| *Initiation of AOD—Total—Total* | 44.10% | **46.08%** | **47.88%** | 44.67% | 44.34% | 44.83% | **45.22%** |
| *Engagement of AOD—Total—Total* | **14.25%** | **13.45%** | **13.77%** | 10.91% | 10.49% | **14.24%** | **12.94%** |
| ***Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*** | | | | | | | |
| *Total* | NA | 36.84% | NA | 36.62% | NA | **50.00%** | **42.72%** |
| **Taking Care of Children** | | | | | | | |
| ***Child and Adolescent Well-Care Visits*** | | | | | | | |
| *Total* | 44.03% | **51.00%** | 32.22% | 44.78% | 39.97% | 43.54% | **45.17%** |

| Performance Measure | Aetna | Health Keepers | Molina | Optima | United | VA Premier | Virginia Aggregate |
|---|---|---|---|---|---|---|---|
| ***Childhood Immunization Status*** | | | | | | | |
| *Combination 3* | 37.50% | **55.08%** | NA | **54.65%** | NA | **61.97%** | **54.23%** |
| ***Immunizations for Adolescents*** | | | | | | | |
| *Combination 1 (Meningococcal, Tdap)* | 67.95% | **72.75%** | 58.16% | 69.19% | **76.99%** | **72.99%** | **70.70%** |
| *Combination 2 (Meningococcal, Tdap, HPV)* | 28.85% | **31.14%** | 25.53% | 30.07% | **37.17%** | **30.66%** | **30.52%** |
| ***Metabolic Monitoring for Children and Adolescents on Antipsychotics*** | | | | | | | |
| *Blood Glucose Testing—Total* | **53.03%** | 44.58% | **48.81%** | 39.09% | **47.78%** | **56.21%** | **47.17%** |
| *Cholesterol Testing—Total* | **37.12%** | 29.10% | **42.86%** | 30.24% | 31.11% | **38.70%** | **33.11%** |
| *Blood Glucose and Cholesterol Testing—Total* | **35.61%** | 27.86% | **40.48%** | 28.08% | 30.00% | **38.09%** | **31.74%** |
| ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*** | | | | | | | |
| *BMI Percentile—Total* | **70.32%** | **76.64%** | **68.61%** | 63.02% | **77.37%** | 58.64% | **68.17%** |
| *Counseling for Nutrition—Total* | **61.07%** | **68.13%** | 52.07% | 56.93% | **62.53%** | 48.18% | **58.87%** |
| *Counseling for Physical Activity—Total* | **54.74%** | **61.07%** | 45.74% | 47.45% | **58.15%** | 40.88% | **51.47%** |
| ***Well-Child Visits in the First 30 Months of Life*** | | | | | | | |
| *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* | NA | 25.93% | NA | **26.47%** | NA | NA | **26.28%** |
| *Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits* | **67.65%** | **68.84%** | NA | **70.48%** | NA | 64.00% | **65.74%** |
| **Living With Illness** | | | | | | | |
| ***Asthma Medication Ratio*** | | | | | | | |
| *Total* | **70.74%** | **70.11%** | 66.52% | 62.44% | 63.90% | **71.15%** | **67.98%** |
| ***Comprehensive Diabetes Care*** | | | | | | | |
| *HbA1c Testing* | 84.67% | **85.40%** | 84.18% | **85.89%** | **91.00%** | 81.75% | **85.23%** |
| *HbA1c Poor Control (>9.0%)* | 51.58% | **37.47%** | 57.42% | 61.80% | **34.06%** | 49.64% | **47.39%** |
| *HbA1c Control (<8.0%)* | 42.09% | **54.50%** | 36.25% | 32.60% | **57.18%** | 41.61% | **45.11%** |

| Performance Measure | Aetna | Health Keepers | Molina | Optima | United | VA Premier | Virginia Aggregate |
|---|---|---|---|---|---|---|---|
| *Eye Exam (Retinal) Performed* | 45.26% | **53.04%** | 36.50% | 48.18% | **69.59%** | 45.99% | **50.79%** |
| *Blood Pressure Control (<140/90 mm Hg)* | 47.45% | **55.23%** | 45.74% | 44.28% | **66.67%** | 46.47% | **51.04%** |
| ***Controlling High Blood Pressure*** | | | | | | | |
| *Controlling High Blood Pressure* | 49.39% | **58.15%** | 40.63% | 48.42% | **67.40%** | 47.69% | **53.24%** |
| ***Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*** | | | | | | | |
| *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* | **82.66%** | **82.51%** | 76.75% | 73.27% | **83.72%** | **85.80%** | **81.03%** |
| ***Medical Assistance With Smoking and Tobacco Use Cessation*** | | | | | | | |
| *Advising Smokers and Tobacco Users to Quit* | 79.34% | 78.76% | 77.27% | **81.20%** | 75.68% | **83.82%** | **79.34%** |
| *Discussing Cessation Medications* | 55.37% | **60.62%** | **57.41%** | **59.91%** | 50.78% | **58.38%** | **57.08%** |
| *Discussing Cessation Strategies* | 47.92% | **49.22%** | 47.51% | 48.28% | 46.67% | **52.87%** | **48.74%** |
| ***Pharmacotherapy Management of COPD Exacerbation*** | | | | | | | |
| *Systemic Corticosteroid* | **79.80%** | **70.49%** | **76.54%** | 46.87% | **77.81%** | 50.13% | **63.21%** |
| *Bronchodilator* | **88.24%** | **81.81%** | **88.48%** | 58.05% | **85.85%** | 59.54% | **73.30%** |
| **Use of Opioids** | | | | | | | |
| ***Use of Opioids at High Dosage*** | | | | | | | |
| *Use of Opioids at High Dosage* | **5.15%** | 9.44% | **4.79%** | **5.80%** | **5.22%** | **6.01%** | **6.84%** |
| ***Use of Opioids From Multiple Providers*** | | | | | | | |
| *Multiple Prescribers* | 24.70% | **20.23%** | **20.00%** | 25.92% | 21.56% | **19.24%** | **21.49%** |
| *Multiple Pharmacies* | 4.65% | **1.38%** | **1.45%** | 2.99% | **2.21%** | **1.77%** | **2.24%** |

| Performance Measure | Aetna | Health Keepers | Molina | Optima | United | VA Premier | Virginia Aggregate |
|---|---|---|---|---|---|---|---|
| *Multiple Prescribers and Multiple Pharmacies* | 3.34% | **0.92%** | **1.20%** | 2.46% | **1.48%** | **1.13%** | **1.58%** |
| **Utilization** | | | | | | | |
| ***Ambulatory Care—Total*** | | | | | | | |
| *Emergency Department (ED) Visits—Total** | 89.52 | 87.89 | 92.26 | **83.13** | 89.84 | **81.83** | **86.22** |
| ***Identification of AOD Services[1]*** | | | | | | | |
| *Total—Any Service—Total* | 17.19% | 14.52% | 22.89% | 13.18% | 15.17% | 13.85% | **15.06%** |
| ***Inpatient Utilization—General Hospital/Acute Care—Total[1]*** | | | | | | | |
| *Total Discharges per 1,000 Member Months (Total Inpatient)* | 13.45 | 16.85 | 16.14 | 22.36 | 18.32 | 20.31 | **18.45** |
| *Total Average Length of Stay (Total Inpatient)* | 7.65 | 7.61 | 6.83 | 7.36 | 7.48 | 6.93 | **7.32** |
| *Total Discharges per 1,000 Member Months (Medicine)* | 8.48 | 11.25 | 11.26 | 16.57 | 12.22 | 14.21 | **12.78** |
| *Total Average Length of Stay (Medicine)* | 5.99 | 6.33 | 5.69 | 6.68 | 6.40 | 5.73 | **6.21** |
| *Total Discharges per 1,000 Member Months (Surgery)* | 4.50 | 5.18 | 4.44 | 5.29 | 5.79 | 5.71 | **5.25** |
| *Total Average Length of Stay (Surgery)* | 11.18 | 10.67 | 9.96 | 9.90 | 9.98 | 10.17 | **10.32** |
| *Total Discharges per 1,000 Member Months (Maternity)* | 0.59 | 0.55 | 0.48 | 0.68 | 0.45 | 0.56 | **0.57** |
| *Total Average Length of Stay (Maternity)* | 4.02 | 3.75 | 4.30 | 3.22 | 3.11 | 3.21 | **3.53** |
| ***Mental Health Utilization—Total[1]*** | | | | | | | |
| *Any Services—Total* | 26.08% | 23.80% | 29.34% | 24.07% | 21.72% | 20.19% | **23.46%** |
| ***Plan All-Cause Readmissions**** | | | | | | | |
| *Observed Readmissions* | **10.59%** | 12.96% | **10.14%** | **11.04%** | **10.76%** | 11.85% | **11.65%** |
| *O/E Ratio—Total* | **0.85** | 1.04 | **0.86** | **0.89** | **0.88** | 0.98 | **0.95** |

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

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

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

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

*Indicates that the HEDIS MY 2021 rate was at or above the 50th percentile.*

## Strengths, Weaknesses, and Recommendations

| Strengths | |
|---|---|
| + | Within the Access and Preventive Care domain, the MCOs demonstrated strength related to access to care, as five of six MCOs' rates met or exceeded the 50th percentile related to the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator. |
| + | The MCOs demonstrated strength within the Behavioral Health domain related to the use of medication to treat mental health conditions, as all six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators. In addition, follow-up care for behavioral health conditions represented strength, as all six MCOs' rates met or exceeded the 50th percentile for both *Follow-Up After ED Visit for Mental Illness* measure indicators. Within the Behavioral Health domain, Aetna and HealthKeepers demonstrated the highest performance, with rates meeting or exceeding the 50th percentile for nine of the 13 (69.2 percent) measure indicators, respectively. |
| + | Within the Taking Care of Children domain, the MCOs demonstrated strength related to metabolic monitoring for children and adolescents on antipsychotics, as three of six MCOs' rates met or exceeded the 50th percentile for all *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure indicators. |
| + | MCO performance within the Living With Illness domain was the highest for the *Medical Assistance With Smoking and Tobacco Use Cessation* measure, with five of six MCOs' rates meeting or exceeding the 50th percentile for the *Discussing Cessation Medications* and *Discussing Cessation Strategies* measure indicators, and all six MCOs' rates meeting or exceeding the 50th percentile for the *Advising Smokers and Tobacco Users to Quit* measure indicator. Additionally, five of six MCOs' rates met or exceeded the 50th percentile for the *Comprehensive Diabetes Care—HbA1c Testing* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure indicators. HealthKeepers demonstrated the highest performance with 11 of the 13 (84.6 percent) measure rates meeting or exceeding the 50th percentile and 12 of the 13 (92.3 percent) measure rates exceeding the Virginia aggregate. |
| + | The MCOs demonstrated strength within the Use of Opioids domain, as three of six MCOs' rates met or exceeded the 50th percentile for two of the three *Use of Opioids From Multiple Providers* measure indicators. Moreover, Molina met or exceeded the 50th percentile for three of four (75.0 percent) measure rates that were compared to national benchmarks. |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** Within the Access and Preventive Care domain, cancer screenings for women and appropriate use of imaging studies for low back pain represent an area for opportunity Virginia-wide, as all reportable MCO rates fell below the 50th percentile for the *Cervical Cancer Screening* and *Use of Imaging Studies for Low Back Pain* measures. Additionally, five of six MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* measure. Molina demonstrated the |

| Weaknesses and Recommendations | |
|---|---|
| | lowest performance within the Access and Preventive Care domain, falling below the 50th percentile for all five (100 percent) measure rates within the domain.<br>Cancer screening can improve outcomes and early detection, reduce the risk of dying, and lead to a greater range of treatment options and lower healthcare costs.[3-4] Prolonged delays in screening related to the COVID-19 PHE may lead to delayed diagnoses, poor health consequences, and an increase in cancer disparities among women already experiencing health inequities.[3-5]<br>Evidence shows that unnecessary or routine imaging (X-ray, MRI, CT scans) for low back pain is not associated with improved outcomes. It also exposes patients to unnecessary harms such as radiation and further unnecessary treatment. Avoiding imaging for patients when there is no indication of an underlying condition can prevent unnecessary harm and unintended consequences to patients and can reduce healthcare costs.[3-6] |
| | **Recommendations:** HSAG recommends that the MCOs consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended cancer screenings and to make appropriate health decisions. HSAG recommends that the MCOs analyze their data and consider if there are disparities within the MCOs' populations that contributed to lower screening rates. Additionally, HSAG recommends the MCOs analyze the factors that contributed to the higher usage of imaging studies when not clinically appropriate for a particular age group, ZIP Code, etc. HSAG recommends that the MCOs implement appropriate interventions to increase the screening rates and reduce unnecessary imaging studies due to the low rates for the three measures. |
| – | **Weakness:** Within the Behavioral Health domain, for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* measure indicator, none of the MCOs' rates met or exceeded the 50th percentile, reflecting an area of opportunity for improvement.<br>Individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, decrease the likelihood of re-hospitalization and the overall cost of outpatient care.[3-7] |
| | **Recommendations:** HSAG recommends that the MCOs develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization. HSAG recommends that the MCOs consider if there are disparities within the MCOs' populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a |

[3-4] National Committee for Quality Assurance. Breast Cancer Screening. Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Dec 20, 2022.
[3-5] Centers for Disease Control and Prevention. Sharp Declines in Breast and Cervical Cancer Screening. https://www.cdc.gov/media/releases/2021/p0630-cancer-screenings.html. Accessed on: Dec 20, 2022.
[3-6] National Committee for Quality Assurance. Use of Imaging Studies for Low Back Pain. Available at: https://www.ncqa.org/hedis/measures/use-of-imaging-studies-for-low-back-pain/. Accessed on: Dec 20, 2022.
[3-7] National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness. Available at: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Dec 20, 2022.

| Weaknesses and Recommendations | |
|---|---|
| | root cause issue, HSAG recommends that the MCOs implement appropriate interventions to improve use of evidence-based practices related to behavioral healthcare and services. |
| − | **Weakness:** Within the Taking Care of Children domain, all six MCOs have opportunities for improvement related to the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total* measure indicator rates, as none of the MCOs' rates for these measure indicators met or exceeded the 50th percentile.<br>Vaccines are a safe and effective way to protect adolescents against potential deadly diseases.[3-8] The COVID-19 PHE is a reminder of the importance of vaccination. The identified declines in routine pediatric vaccine ordering and doses administered might indicate that children in the United States and their communities face increased risks for outbreaks of vaccine-preventable diseases. Continued coordinated efforts between health care providers and public health officials at the local, state, and federal levels will be necessary to achieve rapid catch-up vaccination.[3-9]<br>Assessing physical, emotional, and social development is important at every stage of life, particularly with children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-10] |
| | **Recommendations:** HSAG recommends that the MCOs identify best practices for ensuring children receive all preventive vaccinations and well-child services according to recommended schedules. HSAG recommends that the MCOs consider conducting a root cause analysis to identify barriers that their members are experiencing in accessing care and services in order to implement appropriate interventions to improve the performance related to the Taking Care of Children domain. |
| − | **Weakness:** Within the Living With Illness domain, five of the six MCOs' rates fell below the 50th percentile for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator. Additionally, four of the six MCOs' rates fell below the 50th percentile for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed* measure indicators, reflecting areas of opportunity for improvement.<br>Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. With support from health care providers, |

[3-8] National Committee for Quality Assurance. Immunizations for Adolescents. Available at: https://www.ncqa.org/hedis/measures/immunizations-for-adolescents/. Accessed on: Dec 20, 2022.
[3-9] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Dec 20, 2022.
[3-10] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Dec 20, 2022.

| Weaknesses and Recommendations | |
|---|---|
| | patients can manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, and being physically active.[3-11] |
| | **Recommendations:** HSAG recommends that the MCOs conduct a root cause analysis or focus study to determine why members are not maintaining their diabetes care. Upon identification of a root cause, HSAG recommends that the MCOs implement appropriate interventions to improve the performance related to proper diabetes management. |
| – | **Weakness:** All six MCOs' rates fell below the 50th percentile for the *Use of Opioids From Multiple Providers—Multiple Prescribers* measure indicator, reflecting an area for improvement.<br>Studies show that individuals who receive opioids from four or more prescribers or pharmacies have a higher likelihood of opioid-related overdose death than those who receive opioids from one prescriber or one physician.[3-12] |
| | **Recommendations:** HSAG recommends that the MCOs conduct a root cause analysis or focus study to determine why there is a higher proportion of members receiving prescriptions for opioids from multiple prescribers. Upon identification of a root cause, HSAG recommends that the MCOs implement appropriate interventions to help reduce the proportion of members who may be considered high risk for opioid overuse and misuse. |

## *Compliance With Standards Monitoring*

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

### Operational Systems Reviews

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

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

| Standard | CFR | Standard Name | Aetna | HealthKeepers | Molina | Optima | United | VA Premier | Overall Score |
|---|---|---|---|---|---|---|---|---|---|
| I. | 438.56 | Enrollment and Disenrollment: Requirements and Limitations* | 100% | 100% | 100% | 100% | 100% | 85.7% | 97.6% |
| II. | 438.100<br>438.224 | Member Rights* and Confidentiality | 85.7% | 100% | 100% | 100% | 100% | 100% | 97.6% |

[3-11] National Committee for Quality Assurance. Comprehensive Diabetes Care. Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Dec 20, 2022.
[3-12] National Committee for Quality Assurance. Use of Opioids From Multiple Providers. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-from-multiple-providers/. Accessed on: Dec 20, 2022.

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

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

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

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

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

HSAG also conducted components of an ISCA as part of the SFY 2022 PMV activities and the 2021 compliance review activities.

### Strengths, Weaknesses, and Recommendations

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

## *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 stipulates that states must establish time and distance standards for the following network provider types for the provider type to be subject to such time and distance standards:

- Primary care (adult and pediatric)
- OB/GYN
- 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 analyses to determine network adequacy and compliance with contract network requirements. DMAS is prepared to move forward with the mandatory EQRO network adequacy review once the CMS EQR protocol is finalized.

On November 13, 2020, CMS updated the Managed Care Rule to address state concerns and ensure that states have the most effective and accurate standards for their programs. CMS revised the provider-specific network adequacy standards by replacing time and distance standards with a more

flexible requirement of a quantitative minimum access standard for specified healthcare providers and LTSS providers. The new requirements include, but are not limited to:

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

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

## *Statewide Aggregate CAHPS Results*

### Member Experience Survey Highlights

**Figure 3-1—CAHPS Strengths and Weaknesses**

**CAHPS Strengths**

The CCC Plus program's 2022 top-box scores were statistically significantly higher than the 2021 NCQA adult Medicaid national averages for four measures: *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Getting Care Quickly*.

Optima's 2022 top-box scores were statistically significantly higher than the 2021 NCQA adult Medicaid national averages for five measures: *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. In addition, Optima's 2022 top-box score was statistically significantly higher than the 2021 NCQA child Medicaid national average for the *Customer Service* measure.

HealthKeepers', Optima's, and United's top-box scores were statistically significantly higher than the 2021 NCQA adult Medicaid national average for *Rating of Health Plan*.

### CAHPS Weaknesses

The CCC Plus program's, Aetna's, HealthKeepers', and Molina's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national average for the *Rating of Health Plan* measure. In addition, the CCC Plus program's, Aetna's, HealthKeepers', and VA Premier's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national average for the *Rating of All Health Care* measure. Aetna's 2022 top-box score was statistically significantly lower than the 2021 NCQA child Medicaid national average for *Rating of Specialist Seen Most Often*. In addition, HealthKeepers' 2022 top-box score was statistically significantly lower than the 2021 NCQA child Medicaid national average for *Rating of Personal Doctor.* Also, Molina's 2022 top-box score was statistically significantly lower than the 2021 NCQA child Medicaid national average for *Getting Needed Care*.

The CCC Plus program's 2022 child Medicaid top-box scores were statistically significantly lower than the 2021 top-box scores for two measures: *Rating of Personal Doctor* and *Getting Needed Care*. In addition, Aetna's 2022 child Medicaid top-box scores were statistically significantly lower than the 2021 top-box scores for three measures: *Rating of Specialist Seen Most Often, Getting Needed Care,* and *Getting Care Quickly*. Also, HealthKeepers' 2022 child Medicaid top-box score was statistically significantly lower than the 2021 top-box score for one measure, *Rating of Personal Doctor*.

Table 3-5 and Table 3-6 present the 2022 top-box scores for each MCO and the CCC Plus program (i.e., all MCOs combined) compared to the 2021 adult Medicaid CAHPS scores for the global ratings and composite measures. The 2022 CAHPS scores for each MCO and the CCC Plus program were also compared to the 2021 NCQA adult Medicaid national averages.

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

| | *Rating of Health Plan* | | *Rating of All Health Care* | | *Rating of Personal Doctor* | | *Rating of Specialist Seen Most Often* | |
|---|---|---|---|---|---|---|---|---|
| | *2021* | *2022* | *2021* | *2022* | *2021* | *2022* | *2021* | *2022* |
| CCC Plus Program | 64.7% | 66.6% | 58.7% | 58.8% | 71.8% | 70.5% | 70.0% | 72.6% |
| Aetna | 61.5% | 63.2% | 57.9% | 53.6% | 71.7% | 68.1% | 73.1% | 73.4% |
| HealthKeepers | 62.4% | 67.8% | 57.3% | 61.5% | 69.8% | 69.2% | 66.0% | 74.5% |
| Molina | 62.4% | 56.9% | 58.4% | 56.5% | 71.2% | 70.4% | 71.1% | 69.5% |
| Optima | 67.7% | 69.1% | 61.2% | 63.1% | 75.4% | 72.3% | 74.1% | 77.7% |
| United | 63.4% | 68.0% | 59.9% | 56.5% | 68.1% | 69.7% | 65.2% | 66.9% |
| VA Premier | 67.3% | 67.4% | 58.0% | 56.3% | 72.2% | 72.0% | 71.0% | 67.6% |

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

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

| | *Getting Needed Care* | | *Getting Care Quickly* | | *How Well Doctors Communicate* | | *Customer Service* | |
|---|---|---|---|---|---|---|---|---|
| | *2021* | *2022* | *2021* | *2022* | *2021* | *2022* | *2021* | *2022* |
| CCC Plus Program | 86.1% | 85.7% | 85.0% | 85.8% | 94.2% | 93.1% | 91.3% | 90.4% |

| | Getting Needed Care | | Getting Care Quickly | | How Well Doctors Communicate | | Customer Service | |
|---|---|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 |
| Aetna | 86.0% | 82.6% | 84.1% | 82.4% | 91.8% | 92.7% | 87.8% | 89.1% |
| HealthKeepers | 85.3% | 86.0% | 84.1% | 85.1% | 94.2% | 92.8% | 91.9% | 90.6% |
| Molina | 83.9% | 84.4% | 79.8% | 80.8% | 93.7% | 91.6% | 92.2% | 87.9% |
| Optima | 88.6% | 84.5% | 84.4% | 86.5% | 96.1% | 94.7% | 92.8% | 92.8% |
| United | 83.8% | 81.9% | 84.4% | 81.7% | 93.0% | 93.2% | 91.5% | 90.8% |
| VA Premier | 86.2% | 90.1% | 88.9% | 90.6% | 94.1% | 92.5% | 90.3% | 89.5% |

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

### Strengths, Weaknesses, and Recommendations

| Strengths | |
|---|---|
| + | The CCC Plus program's 2022 top-box scores were statistically significantly higher than the 2021 NCQA adult Medicaid national averages for four measures: *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Getting Care Quickly*. **[Quality, Timeliness, and Access]** |
| + | Optima's 2022 top-box scores were statistically significantly higher than the 2021 NCQA adult Medicaid national averages for five measures: *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. **[Quality and Timeliness]** |
| + | HealthKeepers', Optima's, and United's 2022 top-box scores were statistically significantly higher than the 2021 NCQA adult Medicaid national average for *Rating of Health Plan*. **[Quality, Access, and Timeliness]** |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** Overall weaknesses in the adult CAHPS survey were not identified. |
| | **Recommendations:** HSAG recommends the MCOs continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur. |

### Child Medicaid

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

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

| | Rating of Health Plan | | Rating of All Health Care | | Rating of Personal Doctor | | Rating of Specialist Seen Most Often | |
|---|---|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 |
| CCC Plus Program | 65.4% | 65.6% | 68.5% | 66.1% | 79.5% | 75.6%▼ | 74.8% | 72.3% |

| | Rating of Health Plan | | Rating of All Health Care | | Rating of Personal Doctor | | Rating of Specialist Seen Most Often | |
|---|---|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 |
| Aetna | 63.7% | 66.1% | 66.1% | 62.5% | 75.8% | 73.1% | 76.5% | 64.5%▼ |
| HealthKeepers | 65.7% | 65.9% | 68.3% | 63.9% | 79.5% | 72.3%▼ | 74.1% | 71.1% |
| Molina | 52.4% | 45.2%+ | 60.0%+ | 66.7%+ | 77.6% | 76.2%+ | 54.7%+ | 75.0%+ |
| Optima | 66.0% | 70.2% | 69.8% | 70.8% | 82.4% | 81.6% | 79.8% | 75.0% |
| United | 62.3% | 65.0% | 70.2% | 65.2%+ | 76.8% | 78.6%+ | 82.3%+ | 83.7%+ |
| VA Premier | 69.8% | 67.0% | 70.4% | 66.0% | 79.7% | 74.2% | 74.2% | 70.7% |

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

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

| | Getting Needed Care | | Getting Care Quickly | | How Well Doctors Communicate | | Customer Service | |
|---|---|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 |
| CCC Plus Program | 87.3% | 84.3%▼ | 89.7% | 87.6% | 93.9% | 93.8% | 89.4% | 87.2% |
| Aetna | 88.2% | 81.8%▼ | 91.2% | 82.9%▼ | 92.5% | 92.7% | 87.5%+ | 84.6%+ |
| HealthKeepers | 85.6% | 83.1% | 89.0% | 86.4% | 94.1% | 92.2% | 89.8% | 87.2%+ |
| Molina | 81.2%+ | 72.6%+ | 90.2%+ | 86.5%+ | 91.7%+ | 94.1%+ | 81.3%+ | 80.3%+ |
| Optima | 86.7% | 85.3% | 86.4% | 89.0% | 92.9% | 95.9% | 91.2%+ | 93.1%+ |
| United | 87.7%+ | 90.7%+ | 91.2%+ | 85.4%+ | 93.7% | 91.6%+ | 87.2%+ | 85.9%+ |
| VA Premier | 91.5% | 87.8% | 92.5% | 90.5% | 95.7% | 94.7% | 90.8%+ | 84.8%+ |

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

## Strengths, Weaknesses, and Recommendations

| Strengths | |
|---|---|
| + | Optima's 2022 top-box score was statistically significantly higher than the 2021 NCQA child Medicaid national average for the *Customer Service* measure. |

| Weaknesses and Recommendations | |
|---|---|
| − | **Weakness:** The CCC Plus program's, Aetna's, HealthKeepers', and Molina's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national average for the *Rating of Health Plan* measure. In addition, the CCC Plus program's, Aetna's, HealthKeepers', and VA Premier's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national average for the *Rating of All Health Care* measure. |
| | **Recommendations:** HSAG recommends that the MCOs conduct root cause |

| Weaknesses and Recommendations | |
|---|---|
| | analyses of study indicators that have been identified as areas of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that the MCOs continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur. |
| – | **Weakness:** Aetna's 2022 top-box score was statistically significantly lower than the 2021 NCQA child Medicaid national average for *Rating of Specialist Seen Most Often*. In addition, Aetna's 2022 child Medicaid top-box scores were statistically significantly lower than the 2021 top-box scores for three measures: *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Getting Care Quickly*. |
| | **Recommendations:** HSAG recommends that the MCOs conduct root cause analyses of study indicators that have been identified as areas of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that the MCOs continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur. |
| – | **Weakness:** HealthKeepers' 2022 top-box score was statistically significantly lower than the 2021 NCQA child Medicaid national average for *Rating of Personal Doctor*. In addition, HealthKeepers' 2022 child Medicaid top-box score was statistically significantly lower than the 2021 top-box score for one measure, *Rating of Personal Doctor*. |
| | **Recommendations:** HSAG recommends that the MCOs conduct root cause analyses of study indicators that have been identified as areas of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that the MCOs continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur. |
| – | **Weakness:** Molina's 2022 top-box score was statistically significantly lower than the 2021 NCQA child Medicaid national average for *Getting Needed Care*. In addition, The CCC Plus program's 2022 top-box scores were statistically significantly lower than the 2021 top-box scores for two measures: *Rating of Personal Doctor* and *Getting Needed Care*. |
| | **Recommendations:** HSAG recommends that the MCOs conduct root cause analyses of study indicators that have been identified as areas of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that the MCOs continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur. |

## Other Surveys Conducted

DMAS also conducted the following member experience surveys:

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

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

## MCO Comparative and Statewide Calculation of Additional PM Results

### Project Highlights

DMAS contracted with HSAG in 2022 to calculate the *Colorectal Cancer Screening (COL)* PM following the CMS *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set): Technical Specifications and Resource Manual for Federal Fiscal Year 2022 Reporting*.[3-13] Table 3-9 displays the CY 2021 *COL* PM results stratified by Medicaid managed care program, Medicaid delivery system, MCO, geographic region, and select demographics (i.e., age, gender, and race). Additionally, Table 3-9 includes the percentage of each colorectal cancer screening type received.

**Table 3-9—*COL* PM Results**

| Rate Stratification | CY 2021 Results |
|---|---|
| Virginia Total | 32.73% |
| **Medicaid Program** | |
| CCC Plus | 40.35% |
| Medallion 4.0 | 28.24% |
| More Than One Medicaid Program | 35.80% |
| **Medicaid Delivery System** | |
| Managed Care | 35.08% |
| FFS | 4.84% |
| More Than One Delivery System | 22.72% |
| **MCO** | |
| Aetna | 31.10% |
| HealthKeepers | 36.54% |
| Molina | 25.72% |
| Optima | 40.52% |

[3-13] Centers for Medicare & Medicaid Services. *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set): Technical Specifications and Resource Manual for Federal Fiscal Year 2022 Reporting*, March 2022 (Updated July 2022). Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-core-set-reporting-resources/index.html. Accessed on: Jan 3, 2023.

| Rate Stratification | CY 2021 Results |
|---|---|
| United | 31.36% |
| VA Premier | 37.96% |
| More Than One MCO | 39.01% |
| **Geographic Region** | |
| Central | 31.90% |
| Charlottesville/Western | 31.07% |
| Northern & Winchester | 32.15% |
| Roanoke/Alleghany | 32.62% |
| Southwest | 31.61% |
| Tidewater | 35.67% |
| **Age** | |
| 51–64 Years | 31.89% |
| 65–75 Years | 35.73% |
| **Gender** | |
| Male | 28.40% |
| Female | 36.07% |
| **Race** | |
| White | 31.40% |
| Black/African American | 35.79% |
| Asian | 34.32% |
| Southeast Asian/Pacific Islander | 31.55% |
| Hispanic | 49.04% |
| More Than One Race/Other/Unknown | 25.06% |
| **Screening Type** | |
| FOBT | 5.49% |
| Flexible Sigmoidoscopy | 0.91% |
| Colonoscopy | 26.56% |
| CT Colonography | 0.08% |
| FIT–DNA Test | 1.88% |

Colorectal cancer is the third leading cause of death among men and women in the United States with an estimated 52,580 people projected to die of colorectal cancer in 2022.[3-14,3-15] The USPSTF has found that there is a substantial benefit from screening for colorectal cancer using stool-based tests with high sensitivity, colonoscopy, flexible sigmoidoscopy, and CT colonography in adults 50 to 75

[3-14] U.S. Preventive Services Task Force. *Final recommended statement: Colorectal cancer: Screening*, May 18, 2021. Available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening#citation1. Accessed on: Dec 22, 2022.

[3-15] American Cancer Society. *Cancer Facts & Figures: 2022*. Available at: https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2022/2022-cancer-facts-and-figures.pdf. Accessed on: Dec 22, 2022.

years of age.[3-16] The *COL* Adult Core Set PM was calculated using administrative claims and encounter data for all members 51 to 75 years of age. The Virginia total *COL* rate for CY 2021 was 32.73 percent, with rates higher for the CCC Plus population than the Medallion 4.0 population (by approximately 12 percentage points) for those in the managed care population than the FFS population (by 30.24 percentage points). Rates by MCO varied, with Optima having the highest rate at 40.52 percent and Molina with the lowest rate at 25.72 percent. Additionally, colorectal cancer screening rates were higher among those 65 to 75 years of age, females, and the Hispanic race. Among the various screening types, colonoscopy was the primary screening type.

## *ARTS PM Specification Development and Maintenance Results*

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

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

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

## *Focus Studies*

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

[3-16] U.S. Preventive Services Task Force. *Final recommended statement: Colorectal cancer: Screening*, May 18, 2021. Available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening#citation1. Accessed on: Dec 22, 2022.

# MCO Comparative and Statewide Aggregate Consumer Decision Support Tool Results

## Tool Results

DMAS contracted with HSAG in 2022 to produce a Consumer Decision Support Tool using Virginia Medicaid MCOs' HEDIS data and CAHPS survey results for the CCC Plus MCOs. The CCC Plus Consumer Decision Support Tool demonstrates how the Virginia Medicaid CCC Plus MCOs compare to one another in key performance areas. The tool uses stars to display results for the MCOs, as shown in Table 3-10. Please refer to Appendix B for the detailed methodology used for this tool.

**Table 3-10—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 3-11 displays the CCC Plus 2022 Consumer Decision Support Tool results for each MCO.

**Table 3-11—2022 Consumer Decision Support Tool Results**

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

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

*— Indicates the CCC Plus MCO did not have enough data to receive a rating.*

### Strengths, Weaknesses, and Recommendations

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

## *Performance Withhold Program*

In 2022, DMAS contracted with HSAG to establish, implement, and maintain a scoring mechanism for the CCC Plus PWP. The SFY 2022 PWP was the first pay-for-performance year for the PWP and assessed CY 2021 PM data to determine what portion, if any, of the MCOs' quality withhold would be earned back. For the SFY 2022 PWP, the CCC Plus MCOs could earn all or a portion of their 1 percent quality withhold based on performance for four NCQA HEDIS PMs and two CMS Adult Core Set PMs. The SFY 2022 PWP was based on comparisons to the NCQA Quality Compass national Medicaid HMO percentiles for all HEDIS PMs and comparisons to CY 2019 rates for the CMS Adult Core Set PMs. For detailed information related to the PWP, please see the *CCC Plus SFY 2022 PWP Methodology* on DMAS' website.[3-17]

[3-17] Health Services Advisory Group, Inc. *SFY 2022 CCC Plus Performance Withhold Program Methodology*. Available at: https://www.dmas.virginia.gov/media/3053/ccc-plus-sfy-2022-pwp-methodology.pdf. Accessed on: Dec 22, 2022.

# 4. Validation of Performance Improvement Projects

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

## Objective

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

Each PIP must involve:

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

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

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

The goal of HSAG's PIP validation is to ensure that DMAS and key stakeholders can have confidence that the MCO executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably linked to the QI strategies and activities conducted by the MCO during the PIP.

# Approach to PIP Validation

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

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

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

## *PIP Validation Scoring*

HSAG used the following methodology to evaluate PIPs conducted by the MCOs to determine PIP validity and to rate the percentage of compliance with CMS EQR Protocol 1.
Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must achieve a *Met* score.

Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating of *Not Met* for the PIP. The MCO is assigned a *Partially Met* score if 60 percent to 79 percent of all evaluation elements are *Met* or one or more critical elements are *Partially Met*. HSAG provides general feedback when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*), HSAG assigns the PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*,

*Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

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

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

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

## *Training and Implementation*

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

## *PIP Validation Status*

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

## *Validation Findings*

### Aetna

In 2022, Aetna submitted the following new PIPs for validation: *Ambulatory Care—Emergency Department Visits* and *Follow-Up After Discharge*. The topics selected by DMAS addressed CMS'

requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-1 displays the PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

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

| **Ambulatory Care—Emergency Department Visits** | | |
|---|---|---|
| PIP Topic | Ambulatory Care—Emergency Department Visits | |
| PIP Aim Statement | Do targeted interventions decrease emergency department visits for the eligible population? | |
| Performance Indicator Measure | The percentage of members in the entire eligible population aligned with the HEDIS *AMB* measure specifications and who had more than one ED visit within the measurement period. | |
| Validation Scores | *Overall Score:* 88% | *Critical Elements Score:* 80% |
| Validation Status/Confidence Level | *Partially Met/Low Confidence in reported PIP results*: One or more critical evaluation elements were *Partially Met.* | |
| **Follow-Up After Discharge** | | |
| PIP Topic | Follow-Up After Discharge | |
| PIP Aim Statement | Do targeted interventions increase the percentage of members who were hospitalized and had an ambulatory follow-up visit with a primary care provider or licensed provider within 30 days of discharge? | |
| Performance Indicator Measure | The percentage of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge. | |
| Validation Scores | *Overall Score:* 100% | *Critical Elements Score:* 100% |
| Validation Status/Confidence Level | *Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all steps. | |

Aetna has not progressed to reporting baseline data and conducting QI activities and interventions. This information will be reported in the 2023 submission and will be included in the next annual EQR technical report. For the *Ambulatory Care—ED Visits* PIP, the MCO has an opportunity for improvement related to defining the numerator and denominator for the performance indicator measure. For the *Follow-Up After Discharge* PIP, the MCO performed well with no opportunities for improvement identified. Table 4-2 and Table 4-3 display the PIP intervention summaries.

**Table 4-2—Intervention Summary for *Ambulatory Care—Emergency Department Visits***

| Intervention | Intervention Status |
|---|---|
| To be determined (TBD) | TBD |

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

| Intervention | Intervention Status |
|---|---|
| TBD | TBD |

**Strengths, Weaknesses, and Recommendations**

| Strengths | |
|---|---|
| + | Aetna developed methodologically sound projects that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project. |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** For the *Ambulatory Care—Emergency Department Visits* PIP, the MCO received a *Low Confidence* rating related to a *Partially Met* validation score for a critical element for not defining the numerator and denominator correctly for the performance indicator. |
| | **Recommendations:** The MCO should seek technical assistance after receiving initial validation feedback to ensure that all necessary revisions are made correctly. The MCO should ensure it accurately documents any specifications followed for the PIP. |

## HealthKeepers

In 2022, HealthKeepers submitted the following new PIPs for validation: *Ambulatory Care—ED Visits* and *Follow-Up After Discharge*. The topics selected by DMAS addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-4 displays the PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

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

| Ambulatory Care—Emergency Department Visits | | |
|---|---|---|
| PIP Topic | Ambulatory Care—Emergency Department Visits | |
| PIP Aim Statement | Do targeted interventions decrease the percentage of ED visits that do not result in an inpatient encounter? | |
| Performance Indicator Measure | The percentage of ED visits per member months. | |
| Validation Scores | *Overall Score:* 100% | *Critical Elements Score:* 100% |

| Ambulatory Care—Emergency Department Visits | | |
|---|---|---|
| Validation Status/Confidence Level | *Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all steps. | |
| **Follow-Up After Discharge** | | |
| PIP Topic | Follow-Up After Discharge | |
| PIP Aim Statement | Do targeted interventions increase the percentage of inpatient discharges that had an ambulatory follow-up visit within 30 days? | |
| Performance Indicator Measure | The percentage of discharges reported in the denominator where the member had an ambulatory follow-up visit within 30 days of discharge to assess the member's health. | |
| Validation Scores | *Overall Score:* 100% | *Critical Elements Score:* 100% |
| Validation status/Confidence Level | *Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met,* and 80 to 100 percent of all evaluation elements were *Met* across all steps. | |

HealthKeepers has not progressed to reporting baseline data and conducting QI activities and interventions. This information will be reported in the 2023 submission and will be included in the next annual EQR technical report. For both topics, the MCO performed well with no opportunities for improvement identified. Table 4-5 and Table 4-6 display the PIP intervention summaries.

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

| Intervention | Intervention Status |
|---|---|
| TBD | TBD |

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

| Intervention | Intervention Status |
|---|---|
| TBD | TBD |

## Strengths, Weaknesses, and Recommendations

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

## Molina

In 2022, Molina submitted the following new PIPs for validation: *Ambulatory Care—Emergency Department Visits* and *Follow-Up After Discharge*. The topics selected by DMAS addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-7 displays the PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

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

| **Ambulatory Care—Emergency Department Visits** | | |
|---|---|---|
| PIP Topic | Ambulatory Care—Emergency Department Visits | |
| PIP Aim Statement | Do targeted member education and engagement intervention reduce the rate of ED visits that do not result in an inpatient stay? | |
| Performance Indicator Measure | The percentage of ED visits during measurement period . | |
| Validation Scores | *Overall Score:* 86% | *Critical Elements Score:* 80% |
| Validation Status/Confidence Level | *Partially Met/Low Confidence in reported PIP results*: One or more critical evaluation elements were *Partially Met*. | |
| **Follow-Up After Discharge** | | |
| PIP Topic | Follow-Up After Discharge | |
| PIP Aim Statement | Do targeted interventions increase the percentage of inpatient discharges for members 18–64 years of age that had an ambulatory follow up visit within 30 days of discharge? | |
| Performance Indicator Measure | The number of patients who have had an acute or nonacute inpatient discharge during the measurement year as defined by the HEDIS MY 2022 Technical Specifications. | |
| Validation Scores | *Overall Score:* 71% | *Critical Elements Score:* 60% |
| Validation Status/Confidence Level | *Partially Met/Low Confidence in reported PIP results*: One or more critical evaluation elements were *Partially Met.* | |

Molina has not progressed to reporting baseline data and conducting QI activities and interventions. This information will be reported in the 2023 submission and will be included in the next annual EQR technical report. For the *Ambulatory Care—ED Visits* PIP, the MCO has an opportunity for improvement related to defining the performance indicator measure, resulting in the score and validation status, as this was a critical evaluation element. For the *Follow-Up After Discharge* PIP, the MCO has opportunities for improvement related to defining the population and performance indicator measure, resulting in the score and validation status, as these were critical evaluation elements. Table 4-8 and Table 4-9 display the PIP intervention summaries.

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

| Intervention | Intervention Status |
|---|---|
| TBD | TBD |

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

| Intervention | Intervention Status |
|---|---|
| TBD | TBD |

**Strengths, Weaknesses, and Recommendations**

| Strengths | |
|---|---|
| + | Molina developed methodologically sound projects that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project. |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** For the AMD-ED PIP, the MCO received a *Low Confidence* rating related to a *Partially Met* validation score for a critical element for not defining the numerator and denominator correctly for the performance indicator. |
| | **Recommendations:** The MCO should ensure it accurately documents any specifications followed for the PIP. |
| − | **Weakness:** For the *Follow-Up After Discharge* PIP, the MCO received a *Low Confidence* rating related to *Partially Met* validation scores for a critical element for not defining the numerator and denominator correctly for the performance indicator and not referencing the measure specifications represented when defining the eligible population and performance indicator. |
| | **Recommendations:** The MCO should ensure it accurately documents any specifications followed for the PIP. The MCO should ensure it addresses all initial validation feedback and makes all revisions. |

## Optima

In 2022, Optima submitted the following new PIPs for validation: *Ambulatory Care—ED Visits* and *Follow-Up After Discharge*. The topics selected by DMAS addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-10 displays the PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

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

| Ambulatory Care—Emergency Department Visits | |
|---|---|
| PIP Topic | Ambulatory Care—ED Visits |
| PIP Aim Statement | Do targeted interventions decrease the percentage of ED visits during the measurement period? |

| Ambulatory Care—Emergency Department Visits | | |
|---|---|---|
| Performance Indicator Measure | Utilization of ED visits among Optima enrolled members. | |
| Validation Scores: | Overall Score: 100% | Critical Elements Score: 100% |
| Validation Status/Confidence Level | *Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all steps. | |
| **Follow-Up After Discharge** | | |
| PIP Topic | Follow-Up After Discharge | |
| PIP Aim Statement | Do targeted interventions increase the percentage of discharges for which the member had a 30-day follow-up visit (can include outpatient visits, telephone visits, transitional care services, and e-visits/virtual check-ins) during the measurement period? | |
| Performance Indicator Measure | The percentage of discharges for members 18 years of age and older who had patient engagement within 30 days after inpatient discharge. | |
| Validation Scores | *Overall Score:* 100% | *Critical Elements Score:* 100% |
| Validation Status/Confidence Level | *Met/High Confidence/Confidence in reported PIP results:* All critical evaluation elements were *Met,* and 80 to 100 percent of all evaluation elements were *Met* across all steps. | |

Optima has not progressed to reporting baseline data and conducting QI activities and interventions. This information will be reported in the 2023 submission and will be included in the next annual EQR technical report. For both topics, the MCO performed well with no opportunities for improvement identified. Table 4-11 and Table 4-12 display the PIP intervention summaries.

**Table 4-11—Intervention Summary for *Reducing Utilization of the Emergency Department for a Primary Diagnosis of COPD, Asthma, Bronchitis, or Emphysema***

| Intervention | Intervention Status |
|---|---|
| TBD | TBD |

**Table 4-12—Intervention Summary for *Improving Compliance in 30-Day Ambulatory Follow-Up After Discharge Appointments for Tidewater Regional Members***

| Intervention | Intervention Status |
|---|---|
| TBD | TBD |

**Strengths, Weaknesses, and Recommendations**

| Strengths | |
|---|---|
| + | Optima developed methodologically sound projects that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project. |

| Weaknesses and Recommendations | |
|---|---|
| – | **Weakness:** None identified. |
| | **Recommendations:** NA |

## United

In 2022, United submitted the following new PIPs for validation: *Ambulatory Care—ED Visits* and *Follow-Up After Discharge*. The topics selected by DMAS addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-13 displays the PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

**Table 4-13—PIP Aim Statements and Results: United**

| **Ambulatory Care—Emergency Department Visits** | | |
|---|---|---|
| PIP Topic | Ambulatory Care—ED Visits | |
| PIP Aim Statement | Do targeted interventions decrease overall ED visits that do not result in an impatient stay during the measurement year? | |
| Performance Indicator Measure | The percentage of ED visits that did not result in an inpatient stay during the measurement period. | |
| Validation Scores | *Overall Score:* 100% | *Critical Elements Score:* 100% |
| Validation status/Confidence Level | *Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all steps. | |
| **Follow-Up After Discharge** | | |
| PIP Topic | Follow-Up After Discharge | |
| PIP Aim Statement | Do targeted interventions increase the percentage of discharges where the member had a follow-up visit within 30 days of the discharge? | |
| Performance Indicator Measure | The percentage of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge. | |
| Validation Scores | *Overall Score:* 100% | *Critical Elements Score:* 100% |
| Validation Status/Confidence Level | *Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met,* and 80 to 100 percent of all evaluation elements were *Met* across all steps. | |

United has not progressed to reporting baseline data and conducting QI activities and interventions. This information will be reported in the 2023 submission and will be included in the next annual EQR technical report. For both topics, the MCO performed well with no opportunities for improvement identified. Table 4-14 and Table 4-15 display the PIP intervention summaries.

**Table 4-14—Intervention Summary for *Ambulatory Care—Emergency Department Visits***

| Intervention | Intervention Status |
|---|---|
| TBD | TBD |

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

| Intervention | Intervention Status |
|---|---|
| TBD | TBD |

**Strengths, Weaknesses, and Recommendations**

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

## VA Premier

In 2022, VA Premier submitted the following new PIPs for validation: *Ambulatory Care—ED Visits* and *Follow-Up After Discharge*. The topics selected by DMAS addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-16 displays the PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

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

| **Ambulatory Care—Emergency Department Visits** | | |
|---|---|---|
| PIP Topic | Ambulatory Care—ED Visits | |
| PIP Aim Statement | Do targeted interventions decrease ED utilization among eligible members enrolled in the Virginia Premier Health Plan during the measurement period? | |
| Performance Indicator Measure | The percentage of ED visits. | |
| Validation Scores | *Overall Score:* 100% | *Critical Elements Score:* 100% |
| Confidence Level | *Met/High Confidence/Confidence in reported PIP results:* All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all steps. | |
| **Follow-Up After Discharge** | | |
| PIP Topic | Follow-Up After Discharge | |

| Ambulatory Care—Emergency Department Visits | | |
|---|---|---|
| PIP Aim Statement | Do targeted interventions increase the percentage of discharges that have a follow-up visit within 30 days after an inpatient discharge during the measurement period? | |
| Performance Indicator Measure | Transitions of Care Measure, Patient Engagement After Inpatient Discharge. | |
| Validation Scores | *Overall Score:* 100% | *Critical Elements Score:* 100% |
| Confidence Level | *Met/High Confidence/Confidence in reported PIP results:* All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all steps. | |

VA Premier has not progressed to reporting baseline data and conducting QI activities and interventions. This information will be reported in the 2023 submission and will be included in the next annual EQR technical report. For both topics, the MCO performed well with no opportunities for improvement identified. Table 4-17 and Table 4-18 display the PIP intervention summaries.

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

| Intervention | Intervention Status |
|---|---|
| TBD | TBD |

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

| Intervention | Intervention Status |
|---|---|
| TBD | TBD |

**Strengths, Weaknesses, and Recommendations**

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

## *Recommendations*

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

- The MCOs should use QI tools such as a causal/barrier analysis, key driver diagrams, process mapping, and/or failure modes and effects analysis to determine and prioritize barriers, drivers, and/or weaknesses within processes. The use of these tools will help each MCO determine what interventions to initiate and test.
- The MCOs should develop active, innovative interventions that have the potential for impacting the performance indicator outcomes.
- The MCOs should develop a process or plan to evaluate the effectiveness of each individual intervention.
- The MCOs should use PDSA cycles as part of the improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful.
- The MCOs should revisit the causal/barrier analysis tools used at least annually to ensure the MCO remains on track and the identified barriers and opportunities for improvement are still relevant and applicable.

# 5. Validation of Performance Measures

## Overview

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

## Objectives

DMAS uses HEDIS, Child Core Set, and Adult Core Set data whenever possible to measure the MCOs' performance with specific indices of quality, timeliness, and access to care. HSAG conducts NCQA HEDIS Compliance Audits of the MCOs annually and reports the HEDIS results to DMAS as well as to NCQA. HSAG also conducts annual PMV of certain PMs such as the CMS Core Measure Sets, MLTSS PMs, and PMs 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 PMs is occurring.

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

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

In Section 3, Table 3-3 displays, by MCO, the HEDIS MY 2021 PM rates that were used as the basis for the strengths and weaknesses described in the following MCO-specific evaluations.

## MCO-Specific HEDIS Measure Results

### *Aetna*

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

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

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

## Strengths, Weaknesses, and Recommendations

| Strengths | |
|---|---|
| + | Within the Access and Preventive Care domain, Aetna displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM, meeting or exceeding NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 90th percentile. |
| + | Aetna's performance within the Behavioral Health domain identified three PM indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile or 90th percentile. The *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* PM indicators met or exceeded the 75th percentile, and the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* PM indicator met or exceeded the 90th percentile. |
| + | Aetna's performance within the Living With Illness domain identified four PM indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile or 90th percentile. The *Asthma Medication Ratio—Total* and *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid* PM indicators met or exceeded the 75th percentile, and the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PM indicator met or exceeded the 90th percentile. |
| + | Aetna displayed strong performance within the Utilization domain, ranking at or above NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Plan All-Cause Readmissions—O/E Ratio—Total* PM indicator. |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Aetna:<br>• *Ambulatory Care—ED Visits—Total*<br>• *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*<br>• *Breast Cancer Screening*<br>• *Cervical Cancer Screening* |

| Weaknesses and Recommendations | |
|---|---|
| | • *Use of Imaging Studies for Low Back Pain*<br>• *Childhood Immunization Status—Combination 3*<br>• *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*<br>• *Controlling High Blood Pressure*<br>• *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*<br>• *Use of Opioids From Multiple Providers—Multiple Pharmacies* and *Multiple Prescribers and Multiple Pharmacies*<br>• *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* |
| | **Recommendations:** HSAG recommends that Aetna conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Taking Care of Children, Use of Opioids, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Aetna analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. |

## *HealthKeepers*

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

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

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

## Strengths, Weaknesses, and Recommendations

| Strengths | |
|---|---|
| + | Within the Access and Preventive Care domain, HealthKeepers displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM, meeting or exceeding NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 90th percentile. |
| + | Within the Behavioral Health domain, HealthKeepers ranked at or above NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* PM indicator, and ranked at or above the 90th percentile for the *Antidepressant Medication Management—Effective Continuation Phase Treatment* PM indicator. |
| + | Within the Living With Illness domain, HealthKeepers displayed strong performance for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)*, and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PM indicators, which met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile. |
| + | Within the Use of Opioids domain, HealthKeepers ranked at or above NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Use of Opioids From Multiple Providers—Multiple Pharmacies* and *Multiple Prescribers and Multiple Pharmacies* PM indicators. |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for HealthKeepers:<br>• *Ambulatory Care—ED Visits—Total*<br>• *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*<br>• *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*<br>• *Cervical Cancer Screening*<br>• *Childhood Immunization Status—Combination 3*<br>• *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*<br>• *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*<br>• *Use of Imaging Studies for Low Back Pain*<br>• *Plan All-Cause Readmissions—Observed Readmissions—Total* |
| | **Recommendations:** HSAG recommends that HealthKeepers conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that HealthKeepers analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. |

## *Molina*

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

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

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

### Strengths, Weaknesses, and Recommendations

| Strengths | |
|---|---|
| + | Within the Taking Care of Children domain, Molina displayed strong performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total* and *Blood Glucose and Cholesterol Testing—Total* PM indicators, which met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile. |
| + | Within the Living With Illness domain, Molina ranked at or above NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* PM indicators. |
| + | Molina displayed strong performance within the Use of Opioids domain, ranking at or above NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Use of Opioids From Multiple Providers—Multiple Pharmacies* PM indicator. |
| + | Molina displayed strong performance within the Utilization domain, ranking at or above NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Plan All-Cause Readmissions—O/E Ratio—Total* PM indicator. |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Molina:<br>• *Ambulatory Care—ED Visits—Total* |

| Weaknesses and Recommendations | |
|---|---|
| | • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*<br>• *Breast Cancer Screening*<br>• *Cervical Cancer Screening*<br>• *Child and Adolescent Well-Care Visits—Total*<br>• *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed,* and *Blood Pressure Control (<140/90 mm Hg)*<br>• *Controlling High Blood Pressure*<br>• *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*<br>• *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*<br>• *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total* |
| | **Recommendations:** HSAG recommends that Molina conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Molina analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. |

## *Optima*

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

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

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

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

## Strengths, Weaknesses, and Recommendations

| Strengths | |
|---|---|
| + | Within the Access and Preventive Care domain, Optima met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 90th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator. |
| + | Within the Behavioral Health domain, Optima met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* PM indicators. |
| + | Optima displayed strong performance within the Utilization domain, ranking at or above NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Plan All-Cause Readmissions—O/E Ratio—Total* PM indicator. |

| Weaknesses and Recommendations | |
|---|---|
| − | **Weakness:** The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima:<br>• *Ambulatory Care—ED Visits—Total*<br>• *Breast Cancer Screening*<br>• *Cervical Cancer Screening*<br>• *Childhood Immunization Status—Combination 3*<br>• *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Blood Pressure Control (<140/90 mm Hg)*<br>• *Controlling High Blood Pressure*<br>• *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*<br>• *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*<br>• *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*<br>• *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*<br>• *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*<br>• *Use of Opioids From Multiple Providers—Multiple Prescribers*<br>• *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total*<br>• *Plan All-Cause Readmissions—Observed Readmissions—Total* |

| Weaknesses and Recommendations | |
|---|---|
| | **Recommendations:** HSAG recommends that Optima conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, Use of Opioids, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. |

## *United*

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

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

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

### Strengths, Weaknesses, and Recommendations

| Strengths | |
|---|---|
| + | Within the Access and Preventive Care domain, United displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator, which met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 90th percentile. |
| + | Within the Behavioral Health domain, United met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* PM indicators. |
| + | United's performance within the Living With Illness domain identified six PM indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile or 90th percentile. The *Pharmacotherapy* |

| Strengths | |
|---|---|
| | *Management of COPD Exacerbation—Systemic Corticosteroid* PM indicator met or exceeded the 75th percentile, and the *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Blood Pressure Control (<140/90 mm Hg),* and *Eye Exam (Retinal) Performed,* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PM indicators met or exceeded the 90th percentile. |
| + | United displayed strong performance within the Utilization domain, ranking at or above NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Plan All-Cause Readmissions—O/E Ratio—Total* PM indicator. |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for United:<br>• *Ambulatory Care—ED Visits—Total*<br>• *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*<br>• *Cervical Cancer Screening* |
| | **Recommendations:** HSAG recommends that United conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that United analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. |

## *VA Premier*

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

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

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

## Strengths, Weaknesses, and Recommendations

| Strengths | |
|---|---|
| + | Within the Access and Preventive Care domain, VA Premier displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM, which met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 90th percentile. |
| + | Within the Behavioral Health domain, VA Premier met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* PM indicator, and ranked above the 90th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* PM indicators. |
| + | Within the Taking Care of Children domain, VA Premier displayed strong performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* and *Blood Glucose and Cholesterol Testing—Total* PM indicators, which met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile. |
| + | Within the Living With Illness domain, VA Premier met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Asthma Medication Ratio—Total* PM indicator, and ranked above the 90th percentile for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PM indicator. |

| Weaknesses and Recommendations | |
|---|---|
| − | **Weakness:** The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier:<br>• *Ambulatory Care—ED Visits—Total*<br>• *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*<br>• *Breast Cancer Screening*<br>• *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*<br>• *Cervical Cancer Screening*<br>• *Childhood Immunization Status—Combination 3*<br>• *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*<br>• *Controlling High Blood Pressure*<br>• *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*<br>• *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*<br>• *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid* |

| Weaknesses and Recommendations | |
|---|---|
| | • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*<br>• *Use of Imaging Studies for Low Back Pain*<br>• *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*<br>• *Well-Child Visits in the First 30 Months of Life—Age 15 to 30 Months*<br>• *Plan All-Cause Readmissions—Observed Readmissions—Total* |
| | **Recommendations:** HSAG recommends that VA Premier conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. |

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


## Overview

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

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

## Objectives

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

[6-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Dec 27, 2022.

## *Deeming*

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

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

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

**Table 6-1—OSR Standard Assigned CMS Categories**

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

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

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

## *Aetna*

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

**Table 6-2—Aetna's CCC Plus OSR Standards and Scores**

| | CFR | Compliance Reviews | Aetna | | |
|---|---|---|---|---|---|
| | | Standard Name | 2019 | 2020 | 2021 |
| I. | 438.56 | Enrollment and Disenrollment | | | 100% |
| II. | 438.100<br>438.224 | Member Rights and Confidentiality | | | 85.7% |
| III. | 438.10 | Member Information | | | 100% |
| IV. | 438.114 | Emergency and Poststabilization Services | | | 100% |
| V. | 438.206<br>438.207 | Adequate Capacity and Availability of Services | | | 77.8% |
| VI. | 438.208 | Coordination and Continuity of Care | | | 100% |
| VII. | 438.210 | Coverage and Authorization of Services | | | 100% |
| VIII. | 438.214 | Provider Selection | | | 100% |
| IX. | 438.230 | Subcontractual Relationships and Delegation | | | 75.0% |
| X. | 438.236 | Practice Guidelines | | | 100% |

| | CFR | Compliance Reviews | Aetna | | |
|---|---|---|---|---|---|
| | | Standard Name | 2019 | 2020 | 2021 |
| XI. | 438.242 | Health Information Systems | | | 100% |
| XII. | 438.330 | Quality Assessment and Performance Improvement | | | 100% |
| XIII. | 438.228 | Grievance and Appeal Systems | | | 86.2% |
| XIV. | 438.608 | Program Integrity | | | 100% |
| XV. | 441.58 Section 1905 of the SSA | EPSDT Services | | | 62.5% |
| **TOTAL SCORE** | | | | | **92.2%** |

### Strengths, Weaknesses, and Recommendations

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

## *HealthKeepers*

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

**Table 6-3—HealthKeepers' CCC Plus OSR Standards and Scores**

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

| | CFR | Compliance Reviews | HealthKeepers | | |
|---|---|---|---|---|---|
| | | Standard Name | 2019 | 2020 | 2021 |
| VII. | 438.210 | Coverage and Authorization of Services | | | 100% |
| VIII. | 438.214 | Provider Selection | | | 100% |
| IX. | 438.230 | Subcontractual Relationships and Delegation | | | 100% |
| X. | 438.236 | Practice Guidelines | | | 100% |
| XI. | 438.242 | Health Information Systems | | | 100% |
| XII. | 438.330 | Quality Assessment and Performance Improvement | | | 66.7% |
| XIII. | 438.228 | Grievance and Appeal Systems | | | 82.8% |
| XIV. | 438.608 | Program Integrity | | | 100% |
| XV. | 441.58 Section 1905 of the SSA | EPSDT Services | | | 62.5% |
| **TOTAL SCORE** | | | | | **91.0%** |

### Strengths, Weaknesses, and Recommendations

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

## *Molina*

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

**Table 6-4—Molina's CCC Plus OSR Standards and Scores**

| | CFR | Compliance Reviews | Molina | | |
|---|---|---|---|---|---|
| | | Standard Name | 2019 | 2020 | 2021 |
| I. | 438.56 | Enrollment and Disenrollment | | | 100% |
| II. | 438.100 438.224 | Member Rights and Confidentiality | | | 100% |
| III. | 438.10 | Member Information | | | 95.2% |

| | CFR | Compliance Reviews | Molina | | |
|---|---|---|---|---|---|
| | | Standard Name | 2019 | 2020 | 2021 |
| IV. | 438.114 | Emergency and Poststabilization Services | | | 100% |
| V. | 438.206<br>438.207 | Adequate Capacity and Availability of Services | | | 77.8% |
| VI. | 438.208 | Coordination and Continuity of Care | | | 100% |
| VII. | 438.210 | Coverage and Authorization of Services | | | 95.9% |
| VIII. | 438.214 | Provider Selection | | | 100% |
| IX. | 438.230 | Subcontractual Relationships and Delegation | | | 100% |
| X. | 438.236 | Practice Guidelines | | | 100% |
| XI. | 438.242 | Health Information Systems | | | 100% |
| XII. | 438.330 | Quality Assessment and Performance Improvement | | | 100% |
| XIII. | 438.228 | Grievance and Appeal Systems | | | 86.2% |
| XIV. | 438.608 | Program Integrity | | | 100% |
| XV. | 441.58<br>Section 1905 of the SSA | EPSDT Services | | | 62.5% |
| **TOTAL SCORE** | | | | | **92.2%** |

### Strengths, Weaknesses, and Recommendations

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

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

## *Optima*

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

**Table 6-5—Optima's CCC Plus OSR Standards and Scores**

| | CFR | Compliance Reviews | Optima | | |
|---|---|---|---|---|---|
| | | Standard Name | 2019 | 2020 | 2021 |
| I. | 438.56 | Enrollment and Disenrollment | | | 100% |
| II. | 438.100<br>438.224 | Member Rights and Confidentiality | | | 100% |
| III. | 438.10 | Member Information | | | 95.2% |
| IV. | 438.114 | Emergency and Poststabilization Services | | | 100% |
| V. | 438.206<br>438.207 | Adequate Capacity and Availability of Services | | | 61.1% |
| VI. | 438.208 | Coordination and Continuity of Care | | | 100% |
| VII. | 438.210 | Coverage and Authorization of Services | | | 95.0% |
| VIII. | 438.214 | Provider Selection | | | 100% |
| IX. | 438.230 | Subcontractual Relationships and Delegation | | | 75.0% |
| X. | 438.236 | Practice Guidelines | | | 100% |
| XI. | 438.242 | Health Information Systems | | | 100% |
| XII. | 438.330 | Quality Assessment and Performance Improvement | | | 83.3% |
| XIII. | 438.228 | Grievance and Appeal Systems | | | 96.6% |
| XIV. | 438.608 | Program Integrity | | | 100% |
| XV. | 441.58<br>Section 1905 of the SSA | EPSDT Services | | | 87.5% |
| **TOTAL SCORE** | | | | | **92.2%** |

## Strengths, Weaknesses, and Recommendations

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

## *United*

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

**Table 6-6—United's CCC Plus OSR Standards and Scores**

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

### Strengths, Weaknesses, and Recommendations

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

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

## *VA Premier*

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

**Table 6-7—VA Premier's CCC Plus OSR Standards and Scores**

| | CFR | Compliance Reviews | VA Premier | | |
|---|---|---|---|---|---|
| | | Standard Name | 2019 | 2020 | 2021 |
| I. | 438.56 | Enrollment and Disenrollment | | | 85.7% |
| II. | 438.100<br>438.224 | Member Rights and Confidentiality | | | 100% |
| III. | 438.10 | Member Information | | | 90.5% |
| IV. | 438.114 | Emergency and Poststabilization Services | | | 100% |
| V. | 438.206<br>438.207 | Adequate Capacity and Availability of Services | | | 50.0% |
| VI. | 438.208 | Coordination and Continuity of Care | | | 100% |
| VII. | 438.210 | Coverage and Authorization of Services | | | 100% |
| VIII. | 438.214 | Provider Selection | | | 100% |
| IX. | 438.230 | Subcontractual Relationships and Delegation | | | 75.0% |
| X. | 438.236 | Practice Guidelines | | | 100% |
| XI. | 438.242 | Health Information Systems | | | 100% |
| XII. | 438.330 | Quality Assessment and Performance Improvement | | | 100% |
| XIII. | 438.228 | Grievance and Appeal Systems | | | 75.9% |
| XIV. | 438.608 | Program Integrity | | | 100% |
| XV. | 441.58<br>Section 1905 of the SSA | EPSDT Services | | | 62.5% |
| **TOTAL SCORE** | | | | | **86.2%** |

### Strengths, Weaknesses, and Recommendations

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

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

# DMAS Intermediate Sanctions Applied

During 2021, DMAS monitored the MCOs' implementation of federal and State requirements and CAPs from prior years' compliance reviews. Table 6-8 contains the compliance actions taken.

**Table 6-8—DMAS Compliance Actions**

| MCO/Vendor | Compliance Action |
|---|---|
| Aetna<br>CAP—19588 | During a quality review, it was discovered Aetna completed and submitted a level of care assessment dated 17 days after the respective member had passed away. Aetna had also failed to submit a discharge LOCERI.<br>Aetna created a job aid and conducted training specific to LOCERI. |
| HealthKeepers<br>CAP—19707 | A technology dependent member was authorized by HealthKeepers to receive private duty nursing without documentation of a primary caregiver. Furthermore, the member was left alone without a trained primary caregiver who accepted responsibility for providing care whenever nursing was not in the home.<br>HealthKeepers verified that all existing members had a trained caregiver and a backup caregiver. HealthKeepers also conducted retraining of all utilization management and quality staff on the importance of verifying the backup plan for each CCC Plus Technology Assisted Waiver member. |
| Molina<br>CAP—19473 | Molina failed to process NF claims for members enrolled in hospice within contractual timelines.<br>Molina conducted a claims review for members enrolled in hospice and implemented updated standard operating procedures for claim examiners to identify/process claims. |
| Optima<br>CAP—19687 | Optima inappropriately enrolled a member into the CCC Plus waiver.<br>Optima revised its internal enrollment change request form and process, added internal controls to ensure screenings are on file, and educated staff. |
| VA Premier<br>CAP—19472 | VA Premier failed to administer the CAHPS survey for Children with Chronic Conditions to the member population.<br>As a result, VA Premier addressed how it will adhere to reporting time frames outlined in the CCC Plus contract and technical manual. |

# 7. Member Experience of Care Survey

## Overview

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

## Objectives

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

## MCO-Specific Results

### *Aetna*

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

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

| | 2021 | 2022 |
|---|---|---|
| **Global Ratings** | | |
| *Rating of Health Plan* | 61.5% | 63.2% |
| *Rating of All Health Care* | 57.9% | 53.6% |
| *Rating of Personal Doctor* | 71.7% | 68.1% |
| *Rating of Specialist Seen Most Often* | 73.1% | 73.4% |

| | 2021 | 2022 |
|---|---|---|
| **Composite Measures** | | |
| *Getting Needed Care* | 86.0% | 82.6% |
| *Getting Care Quickly* | 84.1% | 82.4% |
| *How Well Doctors Communicate* | 91.8% | 92.7% |
| *Customer Service* | 87.8% | 89.1% |

## Strengths, Weaknesses, and Recommendations

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

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

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

| | 2021 | 2022 |
|---|---|---|
| **Global Ratings** | | |
| *Rating of Health Plan* | 63.7% | 66.1% |
| *Rating of All Health Care* | 66.1% | 62.5% |
| *Rating of Personal Doctor* | 75.8% | 73.1% |
| *Rating of Specialist Seen Most Often* | 76.5% | 64.5%▼ |
| **Composite Measures** | | |
| *Getting Needed Care* | 88.2% | 81.8%▼ |
| *Getting Care Quickly* | 91.2% | 82.9%▼ |
| *How Well Doctors Communicate* | 92.5% | 92.7% |

| | 2021 | 2022 |
|---|---|---|
| *Customer Service* | 87.5%+ | 84.6%+ |

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

### Strengths, Weaknesses, and Recommendations

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

| **Strengths** | |
|---|---|
| ⊕ | Aetna's 2022 top-box scores were not statistically significantly higher than the 2021 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no strengths were identified. |
| **Weaknesses and Recommendations** | |
| ⊖ | **Weakness:** Aetna's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*. |
| | **Recommendations:** HSAG recommends that Aetna conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that Aetna focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time. |
| ⊖ | **Weakness:** Aetna's 2022 top-box scores were statistically significantly lower than the 2021 top-box scores for three measures: *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Getting Care Quickly*. |
| | **Recommendations:** HSAG recommends that Aetna conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that Aetna focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time. |

## *HealthKeepers*

Table 7-3 and Table 7-4 present the 2021 and 2022 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures. A trend analysis was performed that

compared HealthKeepers' 2022 CAHPS scores to its corresponding 2021 CAHPS scores. In addition, the 2022 CAHPS scores for HealthKeepers were compared to the 2021 NCQA adult and child Medicaid national averages.

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

| | 2021 | 2022 |
|---|---|---|
| **Global Ratings** | | |
| *Rating of Health Plan* | 62.4% | 67.8% |
| *Rating of All Health Care* | 57.3% | 61.5% |
| *Rating of Personal Doctor* | 69.8% | 69.2% |
| *Rating of Specialist Seen Most Often* | 66.0% | 74.5% |
| **Composite Measures** | | |
| *Getting Needed Care* | 85.3% | 86.0% |
| *Getting Care Quickly* | 84.1% | 85.1% |
| *How Well Doctors Communicate* | 94.2% | 92.8% |
| *Customer Service* | 91.9% | 90.6% |

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

## Strengths, Weaknesses, and Recommendations

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

| **Strengths** | |
|---|---|
| + | HealthKeepers' 2022 top-box score was statistically significantly higher than the 2021 NCQA adult Medicaid national average for one measure, *Rating of Health Plan*. |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** HealthKeepers' 2022 top-box scores were not statistically significantly lower than the 2021 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified. |
| | **Recommendations:** HSAG recommends that HealthKeepers monitor the measures to ensure significant decreases in scores over time do not occur. |

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

| | 2021 | 2022 |
|---|---|---|
| **Global Ratings** | | |
| *Rating of Health Plan* | 65.7% | 65.9% |
| *Rating of All Health Care* | 68.3% | 63.9% |
| *Rating of Personal Doctor* | 79.5% | 72.3%▼ |
| *Rating of Specialist Seen Most Often* | 74.1% | 71.1% |
| **Composite Measures** | | |
| *Getting Needed Care* | 85.6% | 83.1% |
| *Getting Care Quickly* | 89.0% | 86.4% |
| *How Well Doctors Communicate* | 94.1% | 92.2% |
| *Customer Service* | 89.8% | 87.2%+ |

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

## Strengths, Weaknesses, and Recommendations

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

| **Strengths** | |
|---|---|
| + | HealthKeepers' 2022 top-box scores were not statistically significantly higher than the 2021 top-box scores or the NCQA child Medicaid national averages for any measure; therefore, no strengths were identified. |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** HealthKeepers' 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for three measures, *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. |
| | **Recommendations:** HSAG recommends that HealthKeepers conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that HealthKeepers continue to monitor the measures to ensure significant decreases in scores over time do not occur. |
| | **Weakness:** HealthKeepers' 2022 top-box score was statistically significantly lower than the 2021 top-box score for one measure, *Rating of Personal Doctor*. |

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

## *Molina*

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

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

| | 2021 | 2022 |
|---|---|---|
| **Global Ratings** | | |
| *Rating of Health Plan* | 62.4% | 56.9% |
| *Rating of All Health Care* | 58.4% | 56.5% |
| *Rating of Personal Doctor* | 71.2% | 70.4% |
| *Rating of Specialist Seen Most Often* | 71.1% | 69.5% |
| **Composite Measures** | | |
| *Getting Needed Care* | 83.9% | 84.4% |
| *Getting Care Quickly* | 79.8% | 80.8% |
| *How Well Doctors Communicate* | 93.7% | 91.6% |
| *Customer Service* | 92.2% | 87.9% |

### Strengths, Weaknesses, and Recommendations

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

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

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

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

| | 2021 | 2022 |
|---|---|---|
| **Global Ratings** | | |
| *Rating of Health Plan* | 52.4% | 45.2%+ |
| *Rating of All Health Care* | 60.0%+ | 66.7%+ |
| *Rating of Personal Doctor* | 77.6% | 76.2%+ |
| *Rating of Specialist Seen Most Often* | 54.7%+ | 75.0%+ |
| **Composite Measures** | | |
| *Getting Needed Care* | 81.2%+ | 72.6%+ |
| *Getting Care Quickly* | 90.2%+ | 86.5%+ |
| *How Well Doctors Communicate* | 91.7%+ | 94.1%+ |
| *Customer Service* | 81.3%+ | 80.3%+ |

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

## Strengths, Weaknesses, and Recommendations

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

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

| Weaknesses and Recommendations | |
|---|---|
| – | **Weakness:** Molina's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national average for two measures: *Rating of Health Plan* and *Getting Needed Care*. |
| | **Recommendations:** HSAG recommends that Molina conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that Molina focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time. |

## *Optima*

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

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

| | 2021 | 2022 |
|---|---|---|
| **Global Ratings** | | |
| *Rating of Health Plan* | 67.7% | 69.1% |
| *Rating of All Health Care* | 61.2% | 63.1% |
| *Rating of Personal Doctor* | 75.4% | 72.3% |
| *Rating of Specialist Seen Most Often* | 74.1% | 77.7% |
| **Composite Measures** | | |
| *Getting Needed Care* | 88.6% | 84.5% |
| *Getting Care Quickly* | 84.4% | 86.5% |
| *How Well Doctors Communicate* | 96.1% | 94.7% |
| *Customer Service* | 92.8% | 92.8% |

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

### Strengths, Weaknesses, and Recommendations

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

| Strengths | |
|---|---|
| + | Optima's 2022 top-box scores were statistically significantly higher than the 2021 NCQA adult Medicaid national averages for five measures: *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** Optima's 2022 top-box scores were not statistically significantly lower than the 2021 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified. |
| | **Recommendations:** HSAG recommends that Optima monitor the measures to ensure significant decreases in scores over time do not occur. |

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

| | 2021 | 2022 |
|---|---|---|
| **Global Ratings** | | |
| *Rating of Health Plan* | 66.0% | 70.2% |
| *Rating of All Health Care* | 69.8% | 70.8% |
| *Rating of Personal Doctor* | 82.4% | 81.6% |
| *Rating of Specialist Seen Most Often* | 79.8% | 75.0% |
| **Composite Measures** | | |
| *Getting Needed Care* | 86.7% | 85.3% |
| *Getting Care Quickly* | 86.4% | 89.0% |
| *How Well Doctors Communicate* | 92.9% | 95.9% |
| *Customer Service* | 91.2%+ | 93.1%+ |

*+ 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 2021 NCQA national Medicaid averages.*

## Strengths, Weaknesses, and Recommendations

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

| Strengths | |
|---|---|
| + | Optima's 2022 top-box score was statistically significantly higher than the 2021 NCQA child Medicaid national average for one measure, *Customer Service*. |

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

## *United*

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

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

| | 2021 | 2022 |
|---|---|---|
| **Global Ratings** | | |
| *Rating of Health Plan* | 63.4% | 68.0% |
| *Rating of All Health Care* | 59.9% | 56.5% |
| *Rating of Personal Doctor* | 68.1% | 69.7% |
| *Rating of Specialist Seen Most Often* | 65.2% | 66.9% |
| **Composite Measures** | | |
| *Getting Needed Care* | 83.8% | 81.9% |
| *Getting Care Quickly* | 84.4% | 81.7% |
| *How Well Doctors Communicate* | 93.0% | 93.2% |
| *Customer Service* | 91.5% | 90.8% |

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

### Strengths, Weaknesses, and Recommendations

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

| Strengths | |
|---|---|
| + | United's 2022 top-box score was statistically significantly higher than the 2021 NCQA adult Medicaid national average for one measure, *Rating of Health Plan*. |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** United's 2022 top-box scores were not statistically significantly lower than the 2021 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified. |
| | **Recommendations:** HSAG recommends that United monitor the measures to ensure significant decreases in scores over time do not occur. |

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

| | 2021 | 2022 |
|---|---|---|
| **Global Ratings** | | |
| *Rating of Health Plan* | 62.3% | 65.0% |
| *Rating of All Health Care* | 70.2% | 65.2%+ |
| *Rating of Personal Doctor* | 76.8% | 78.6%+ |
| *Rating of Specialist Seen Most Often* | 82.3%+ | 83.7%+ |
| **Composite Measures** | | |
| *Getting Needed Care* | 87.7%+ | 90.7%+ |
| *Getting Care Quickly* | 91.2%+ | 85.4%+ |
| *How Well Doctors Communicate* | 93.7% | 91.6%+ |
| *Customer Service* | 87.2%+ | 85.9%+ |

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

## Strengths, Weaknesses, and Recommendations

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

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

| Weaknesses and Recommendations | |
|---|---|
| − | measure; therefore, no weaknesses were identified. |
| | **Recommendations:** HSAG recommends that United monitor the measures to ensure significant decreases in scores over time do not occur. |

## *VA Premier*

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

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

| | 2021 | 2022 |
|---|---|---|
| **Global Ratings** | | |
| *Rating of Health Plan* | 67.3% | 67.4% |
| *Rating of All Health Care* | 58.0% | 56.3% |
| *Rating of Personal Doctor* | 72.2% | 72.0% |
| *Rating of Specialist Seen Most Often* | 71.0% | 67.6% |
| **Composite Measures** | | |
| *Getting Needed Care* | 86.2% | 90.1% |
| *Getting Care Quickly* | 88.9% | 90.6% |
| *How Well Doctors Communicate* | 94.1% | 92.5% |
| *Customer Service* | 90.3% | 89.5% |

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

### Strengths, Weaknesses, and Recommendations

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

| Strengths | |
|---|---|
| + | VA Premier's 2022 top-box scores were statistically significantly higher than the 2021 NCQA adult Medicaid national averages for two measures: *Getting Needed Care* and *Getting Care Quickly*. |

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

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

| | 2021 | 2022 |
|---|---|---|
| **Global Ratings** | | |
| *Rating of Health Plan* | 69.8% | 67.0% |
| *Rating of All Health Care* | 70.4% | 66.0% |
| *Rating of Personal Doctor* | 79.7% | 74.2% |
| *Rating of Specialist Seen Most Often* | 74.2% | 70.7% |
| **Composite Measures** | | |
| *Getting Needed Care* | 91.5% | 87.8% |
| *Getting Care Quickly* | 92.5% | 90.5% |
| *How Well Doctors Communicate* | 95.7% | 94.7% |
| *Customer Service* | 90.8%+ | 84.8%+ |

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

## Strengths, Weaknesses, and Recommendations

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

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

| Weaknesses and Recommendations | |
|---|---|
| − | **Weakness:** VA Premier's 2022 top-box score was statistically significantly lower than the 2021 NCQA child Medicaid national average for one measure, *Rating of All Health Care*. |
| | **Recommendations:** HSAG recommends that VA Premier conduct a root cause analysis of the study indicator that has been identified as the area of low |

| Weaknesses and Recommendations | |
|---|---|
| | performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that VA Premier focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time. |

# 8. Focus Studies

## Overview

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.

## *Prenatal Care and Birth Outcomes Focus Study*

The contract year 2020–2021 Prenatal Care and Birth Outcomes Focus Study addressed the following questions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## *Foster Care Focus Study*

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

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

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

[8-1] Virginia Department of Social Services. Adoption Assistance Screening Tool. Available at: https://dss.virginia.gov/files/division/dfs/ap/intro_page/forms/032-04-0091-06-eng.pdf. Accessed on: Dec 27, 2022.

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

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

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

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

8-2 American Academy of Pediatrics. Health Care Issues for Children and Adolescents in Foster Care and Kinship Care. *Pediatrics*. Oct 2015:136:4. Available at: https://publications.aap.org/pediatrics/article/136/4/e1131/73819/Health-Care-Issues-for-Children-and-Adolescents-in. Accessed on: Dec 28, 2022.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8-6 Choi SE, Simon L, Basu S, Barrow JR. *Changes in dental care use patterns due to COVID-19 among insured patients in the United States*. Journal of the American Dental Association. 2021. Available at: https://jada.ada.org/article/S0002-8177(21)00417-7/pdf. Accessed on: Dec 28, 2022.

8-7 Mehrotra A, Chernew M, Linetsky D, Hatch H, Cutler D, Schneider E. *The Impact of COVID-19 on Outpatient Visits in 2020: Visits Remained Stable, Despite a Late Surge in Cases.* The Commonwealth Fund. Available at: https://www.commonwealthfund.org/publications/2021/feb/impact-covid-19-outpatient-visits-2020-visits-stable-despite-late-surge. Accessed on: Dec 28, 2022.

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

## *Dental Utilization in Pregnant Women Focus Study*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

prenatal dental service was received had significantly higher rates (68.77 percent) compared to deliveries that received no dental services (56.30 percent).

Table 8-8 presents the total number of deliveries among continuously enrolled women and the number and percentage of deliveries with preventive dental services during the prenatal period, by birth outcome. Additionally, Table 8-8 presents the results of the Pearson's chi-square test with significance between the two rates for each birth outcome indicated by an up arrow (i.e., the Preventive Services group's rate is significantly higher than the No Preventive Services group's rate) or a down arrow (i.e., the Preventive Services group's rate is significantly lower than the No Preventive Services group's rate) on the Preventive Services group's rate.

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

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

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

Table 8-8 shows that there were statistically significant differences in the rates for deliveries that received preventive services versus those that did not receive any preventive services for three of the

birth outcomes: *Newborns With Low Birth Weight (<2,500 grams)*, *Births With Adequate Prenatal Care*, and *Postpartum Ambulatory Care Utilization*. Deliveries receiving preventive services had significantly lower rates of *Newborns With Low Birth Weight (<2,500 grams)* (7.06 percent) compared to deliveries that did not receive preventive services (9.18 percent). Deliveries receiving preventive services also had significantly higher rates of *Births With Adequate Prenatal Care* (79.07 percent) compared to deliveries that did not receive preventive services (74.74 percent). For *Postpartum Ambulatory Care Utilization*, the rate for deliveries receiving preventive services (69.76 percent) was significantly higher than the rate for deliveries with no preventive services (57.18 percent).

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

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

Overall, perinatal dental utilization and the receipt of preventive dental services varied by managed care region. Among women with continuous enrollment, utilization was highest in the Northern & Winchester region and lowest in the Roanoke/Alleghany region. Perinatal dental utilization was highest for deliveries among Asian, Non-Hispanic women (29.17 percent; n=271) and lowest among deliveries to women of Other/Unknown race (15.50 percent; n=106). The statewide patterns for race/ethnicity varied within each managed care region. It should be noted that women may have received services

[8-12] The American College of Obstetricians and Gynecologists. Oral health care during pregnancy and through the lifespan. Committee Opinion No. 569. *Obstet Gynecol* 2013;122:417–22. Available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/08/oral-health-care-during-pregnancy-and-through-the-lifespan. Accessed on: Dec 28, 2022.

[8-13] Oral Health Care During Pregnancy Expert Workgroup. 2012. *Oral Health Care During Pregnancy: A National Consensus Statement*. Washington, DC: National Maternal and Child Oral Health Resource Center. Available at: https://www.mchoralhealth.org/PDFs/OralHealthPregnancyConsensus.pdf. Accessed on: Dec 28, 2022.

[8-14] Virginia Department of Health, Dental Health Program. Oral Health During Pregnancy: Practice Guidance for Virginia's Prenatal and Dental Providers. Available at: https://www.vdh.virginia.gov/content/uploads/sites/30/2019/03/PracticeGuideforVirginiaPrenatalDentalProvidersWEB.pdf. Accessed on: Dec 28, 2022.

that DMAS did not cover (e.g., the services were covered by other public health initiatives);[8-15] however, the regional distribution of perinatal dental utilization may be indicative of regional differences in women's access to dental providers.

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

[8-15] Perinatal and Infant Oral Health Quality Improvement Expansion Program 2019 Final Progress Narrative. Richmond, VA: Virginia Department of Health. Available at: https://www.mchoralhealth.org/PDFs/H47MC28478.pdf. Accessed on: Dec 28, 2022.

# 9. Summary of MCO-Specific Strengths and Weaknesses

HSAG used its analyses and evaluations of EQR activity findings from the preceding 12 months to comprehensively assess each MCO's performance in providing quality, timely, and accessible healthcare services to DMAS Medicaid and CHIP members as required in 42 CFR §438.364. For each MCO reviewed, HSAG provides a summary of its overall key findings related to quality, access, and timeliness based on the MCO's performance, which can be found in sections 4 through 8 of this report. In accordance with 42 CFR §438.364(a)(1), HSAG provides a description of the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality of, timeliness of, and access to care furnished by the MCOs. Table 9-1 through Table 9-6 provide MCO-specific strengths and weaknesses identified through the aggregation of the results of EQR activities. MCO specific recommendations are found in sections 4 through 8 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 MCO.

**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.

## Aetna

**Table 9-1—Overall Conclusions for Aetna: Quality, Access, and Timeliness**

| Strengths Related to Quality | |
|---|---|
| + | Aetna demonstrated effective care management processes to ensure continued service delivery and monitoring processes for individuals receiving antidepressant medications. Quality care was also evident in monitoring results for individuals diagnosed with both physical and behavioral health conditions. Evidence of the quality of care was found in Aetna's performance within the Behavioral Health domain, which identified three PM indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile or 90th percentile. The *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* PM indicators met or exceeded the 75th percentile, and the *Cardiovascular Monitoring for People* |

| Strengths Related to Quality | |
|---|---|
| | *With Cardiovascular Disease and Schizophrenia* PM indicator met or exceeded the 90th percentile. |
| + | Aetna's PM results demonstrated quality with medication management and chronic illness screening. Aetna's performance within the Living With Illness domain identified four PM indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile or 90th percentile. The *Asthma Medication Ratio* and *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid* PM indicators met or exceeded the 75th percentile, and the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PM indicator met or exceeded the 90th percentile. |
| + | Aetna developed methodologically sound projects that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project. |
| **Strengths Related to Access and Timeliness** | |
| + | PM results for access and preventive care showed that adults had access to preventive and ambulatory care, with Aetna achieving a rate in NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 90th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator. This is an improvement from the prior year where Aetna scored in the 75th percentile. The 2021 compliance review results supported access to care with Aetna monitoring its network to ensure providers provided physical access, reasonable accommodations, and accessible equipment for members with SHCN. Aetna also ensured that the provider network met the cultural, ethnic, racial, and linguistic needs of its members. |
| + | Utilization management and ensuring members received access to follow-up care from primary care or appropriate specialty providers upon discharge from a facility was a strength for the MCO. Aetna displayed strong performance within the Utilization domain, with its rate ranking at or above NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Plan All-Cause Readmissions—O/E Ratio—Total* PM indicator. |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** Although contract requirements were met in the 2021 compliance review, Aetna's PM rates indicated potential access to care issues with early detection screenings, preventive care, recommended care for chronic conditions, and well-care for children falling below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile. These results may also indicate that members may have a lack of understanding of recommended or needed care, or that a disparity may exist. |

| Weaknesses and Recommendations | |
|---|---|
| | **Recommendations:** HSAG recommends that Aetna conduct a root cause analysis or focus study as it relates to PMs within the Access and Preventive Care, Taking Care of Children, and Living With Illness domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Aetna analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. |
| – | **Weakness:** The CAHPS member experience survey results align with some PM results in the early detection screening, preventive care, recommended care for chronic conditions, and well-care for children measures, with these rates falling below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile. Aetna's 2022 CAHPS top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*. Aetna's 2022 top-box scores also were statistically significantly lower than the 2021 top-box scores for three measures: *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Getting Care Quickly*. The member experience survey results may indicate that members have some challenges accessing care, or members do not perceive that they are receiving quality care. |
| | **Recommendations:** HSAG recommends that Aetna conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that Aetna focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time. These efforts may lead to improved screening, preventive, and chronic care PM rates, in addition to improving member experience survey scores. |
| – | **Weakness:** For the *Ambulatory Care—Emergency Department Visits* PIP, the MCO received a *Low Confidence* rating related to a *Partially Met* validation score for a critical element for not defining the numerator and denominator correctly for the performance indicator. |
| | **Recommendations:** HSAG recommends that Aetna seek technical assistance after receiving initial validation feedback to ensure that all necessary revisions are made correctly. HSAG recommends that Aetna ensure it accurately documents any specifications followed for the PIP. |

# HealthKeepers

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

| Strengths Related to Quality | |
|---|---|
|  | HealthKeepers demonstrated effective care management processes to ensure continued service delivery and monitoring for individuals receiving antidepressant medications. Quality care was also evident in PM results in PMs related to monitoring results for individuals diagnosed with both physical and behavioral health conditions. Evidence of the quality of care was found in HealthKeepers' performance within the Behavioral Health domain, which identified five PM indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile or 90th percentile. The *Antidepressant Medication Management—Effective Acute Phase Treatment*, *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*, and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PM indicators met or exceeded the 75th percentile. The *Antidepressant Medication Management—Effective Continuation Phase Treatment* PM indicator met or exceeded the 90th percentile. |
|  | Health Keepers demonstrated quality care with processes to monitor and manage opioid use. Within the Use of Opioids domain, HealthKeepers' rates ranked at or above NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Use of Opioids From Multiple Providers—Multiple Pharmacies* and *Multiple Prescribers and Multiple Pharmacies* PM indicators. |
|  | HealthKeepers developed methodologically sound PIP projects that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project. |
| **Strengths Related to Access and Timeliness** | |
|  | PM results for access and preventive care showed that adults had access to preventive and ambulatory care, with HealthKeepers achieving a rate in NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 90th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator. This is an improvement from the prior year where HealthKeepers scored in the 75th percentile. The 2021 compliance review results supported access to care with HealthKeepers monitoring its network to ensure providers provided physical access, reasonable accommodations, and accessible equipment for members with SHCN. HealthKeepers also ensured that the provider network met the cultural, ethnic, racial, and linguistic needs of its members. |
|  | HealthKeepers demonstrated both access to and timeliness of care within the Living With Illness domain. HealthKeepers displayed strong |

| Strengths Related to Access and Timeliness | |
|---|---|
| | performance for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* PM indicators, which met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile. The results may indicate that members were able to access recommended care and services related to chronic diseases. |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** Although contract requirements were met in the 2021 compliance review, HealthKeepers' PM rates indicated potential access to care issues with some early detection screenings, well-care for children, and follow-up care to reduce readmissions falling below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile. The results may also indicate members may have a lack of understanding of recommended care or the need for follow-up care after emergency or inpatient events. The PM results may also align with HealthKeepers' 2022 CAHPS top-box scores, which were statistically significantly lower than the 2021 NCQA child Medicaid national averages for three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. |
| | **Recommendations:** HSAG recommends that HealthKeepers conduct a root cause analysis as it relates to these measures within the Access and Preventive Care, Behavioral Health, Taking Care of Children, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that HealthKeepers analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. The work conducted within the PM may result in improved member experience survey results. |

# Molina

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

| Strengths Related to Quality | |
|---|---|
| + | Although not all PMs within the Taking Care of Children domain were considered strengths, such as the *Child and Adolescent Well-Care Visits—Total*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total* PM indicators, Molina displayed strong performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total* and *Blood Glucose and Cholesterol Testing—Total* PM indicators, which met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile.<br><br>In addition, within the Living With Illness domain, Molina showed strength in |

| Strengths Related to Quality | |
|---|---|
| | quality care by ranking at or above NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* PM indicators. |
| + | Molina demonstrated quality with processes used to monitor and manage opioid use. PM results within the Use of Opioids domain showed Molina ranked at or above NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Use of Opioids From Multiple Providers—Multiple Pharmacies* PM indicator. |
| + | Molina developed methodologically sound PIP projects that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project. |
| **Strengths Related to Access and Timeliness** | |
| + | Molina's PM results also displayed a strength in follow-up care from admissions. This was reflected in Molina's strong performance within the Utilization domain, ranking at or above NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Plan All-Cause Readmissions—O/E Ratio—Total* PM indicator. |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** Although contract requirements were met in the 2021 compliance review, Molina's PM rates indicated potential access to care issues with some early detection screenings, well and preventive care for children, recommended care for chronic conditions, and mental health and ED utilization follow-up falling below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO25th percentile. The PM results also may indicate that members may have a lack of understanding of recommended care guidelines or the need for follow-up care after ED use or inpatient events. |
| | **Recommendations:** HSAG recommends that Molina focus quality and performance improvement efforts on all PMs/indicators that fall below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile, including those PMs that are not included in the PWP. HSAG recommends that Molina conduct a root cause analysis as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Molina analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. |
| − | **Weakness:** Molina's 2022 CAHPS top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national average for two measures: *Rating of Health Plan* and *Getting Needed Care*. The member experience survey results align with some of Molina's rates in the |

| Weaknesses and Recommendations | |
|---|---|
| | Access and Preventive Care domain. |
| | **Recommendations:** HSAG recommends that Molina focus performance and QI efforts on all PM/indicators that are below the 25th percentile, including those that are not included in the PWP. HSAG also recommends that Molina conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that Molina focus initiatives on raising the statistically significantly lower scores and continue to monitor the PMs to ensure there are no significant decreases in scores over time. |
| − | **Weakness:** For the AMD-ED PIP, the MCO received a *Low Confidence* rating related to a *Partially Met* validation score for a critical element for not defining the numerator and denominator correctly for the performance indicator. |
| | **Recommendations:** HSAG recommends that Molina ensure it accurately documents any specifications followed for the PIP. |
| − | **Weakness:** For the *Follow-Up After Discharge* PIP, the MCO received a *Low Confidence* rating related to *Partially Met* validation scores for a critical element for not defining the numerator and denominator correctly for the performance indicator and not referencing the measure specifications represented when defining the eligible population and performance indicator. |
| | **Recommendations:** HSAG recommends that Molina ensure it accurately documents any specifications followed for the PIP. HSAG also recommends that Molina ensure it addresses all initial validation feedback and makes all revisions. |

# Optima

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

| Strengths Related to Quality | |
|---|---|
| + | PM results for access and preventive care showed that adults had access to preventive and ambulatory care, with Optima achieving a rate in NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 90th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator. This is an improvement from the prior year where Optima scored in the 75th percentile. The 2021 compliance review results supported access to care with Optima monitoring its network to ensure providers provided physical access, reasonable accommodations, and accessible equipment for members with SHCN. Optima also ensured that the provider network met the cultural, ethnic, racial, and linguistic needs of its members. |

| Strengths Related to Quality | |
|---|---|
| + | Optima demonstrated effective care management processes to ensure continued service delivery and monitoring for individuals receiving antidepressant medications. Evidence of the quality of care was found in Optima's performance within the Behavioral Health domain, which identified one PM measure indicator that met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile. The *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators met or exceeded the 75th percentile. |
| + | Optima developed methodologically sound PIP projects that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project. |
| **Strengths Related to Access and Timeliness** | |
| + | Utilization and ensuring members received access to follow-up care from PCPs upon discharge from a facility was a strength for the MCO. Optima displayed strong performance within the Utilization domain, ranking at or above NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator. |
| + | Member experience survey results showed Optima's strength in members' overall opinion of Optima, its customer service staff, and ability to access care. Optima's 2022 CAHPS top-box scores were statistically significantly higher than the 2021 NCQA adult Medicaid national averages for five measures: *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. Optima's 2022 CAHPS top-box score was also statistically significantly higher than the 2021 NCQA child Medicaid national average for one measure, *Customer Service*. |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** Although contract requirements were met in the 2021 compliance review, Optima's PM rates indicated potential access to care issues with early detection screenings, well and preventive care for children, recommended care for chronic conditions, mental health, and utilization measure indicator rates falling below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile. The results may indicate members may have a lack of understanding of recommended care or the need for follow-up care after emergency or inpatient events. |
| | **Recommendations:** HSAG recommends that Optima focus quality and performance improvement efforts on all PMs that fall below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile, including those measures that are not included in the PWP. HSAG recommends that Optima conduct a root cause analysis as it relates to the PM within the |

| Weaknesses and Recommendations | |
|---|---|
| | Access and Preventive Care, Behavioral Health, Taking Care of Children, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. |

# United

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

| Strengths Related to Quality | |
|---|---|
| + | PM results for access and preventive care showed that adults had access to preventive and ambulatory care, with United achieving a rate in NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 90th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator. This is an improvement from the prior year where United scored in the 75th percentile. United's 2022 CAHPS top-box score also was statistically significantly higher than the 2021 NCQA adult Medicaid national average for one measure, *Rating of Health Plan*, indicating members, overall, were satisfied with United's care and service delivery. The 2021 compliance review results supported access to care with United monitoring its network to ensure providers provided physical access, reasonable accommodations, and accessible equipment for members with SHCN. United also ensured that the provider network met the cultural, ethnic, racial, and linguistic needs of its members. |
| + | United demonstrated effective care management processes to ensure continued service delivery and monitoring to ensure that individuals adhered to behavioral health medication recommendations. Evidence of quality were found in United's PMs where two measure indicators were identified that met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile. This included the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*, and *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators. |
| + | United also demonstrated quality in its PMs within the Living With Illness domain, which identified six measure indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile or 90th percentile. The *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measure indicator met or exceeded the 75th percentile, and the *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Blood Pressure Control (<140/90 mm Hg),* and *Eye Exam (Retinal) Performed,* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure indicators met or |

| Strengths Related to Quality | |
|---|---|
| | exceeded the 90th percentile. |
| + | United developed methodologically sound PIP projects that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project. |
| **Strengths Related to Access and Timeliness** | |
| + | Utilization and ensuring members received access to follow-up care from PCPs upon discharge from a facility was a strength for the MCO. United displayed strong PM results within the Utilization domain, ranking at or above NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Plan All-Cause Readmissions—O/E Ratio—Total* measure indicator. |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** United had three measures that fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement. These measures included *Ambulatory Care—ED Visits—Total*, *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*, and *Cervical Cancer Screening*. |
| | **Recommendations:** HSAG recommends that United conduct a root cause analysis or focus study as it relates to these measures within the Access and Preventive Care and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that United analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. |

# VA Premier

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

| Strengths Related to Quality | |
|---|---|
| + | PM results showed that adults had access to preventive and ambulatory care, with VA Premier achieving a rate in NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 90th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator. This is an improvement from the prior year where VA Premier scored in the 75th percentile. The 2021 compliance review results supported access to care with VA Premier monitoring its network to ensure providers provided physical access, reasonable accommodations, and accessible equipment for members with SHCN. VA Premier also ensured that the provider network met the cultural, ethnic, racial, and linguistic needs of its members. |

| Strengths Related to Quality | |
|---|---|
| + | VA Premier demonstrated effective care management processes to ensure continued service delivery and monitoring for individuals receiving antidepressant medications. Evidence of the quality of care was found in VA Premier's PM rates within the Behavioral Health domain, as VA Premier met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure, and ranked above the 90th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators. |
| + | VA Premier demonstrated quality in its processes to monitor medication use and screening for diabetes when using certain medications. Within the Living With Illness domain, VA Premier met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Asthma Medication Ratio—Total* measure indicator, and ranked above the 90th percentile for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure. Results within the Taking Care of Children domain demonstrated similar results with VA Premier displaying strong performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* and *Blood Glucose and Cholesterol Testing—Total* measure indicators, which met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile. |
| + | VA Premier developed methodologically sound PIP projects that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project. |
| **Strengths Related to Access and Timeliness** | |
| + | Member CAHPS experience survey results demonstrated that VA Premier's adult members believed that they had access to needed care and were able to get care quickly. VA Premier's 2022 CAHPS top-box scores were statistically significantly higher than the 2021 NCQA adult Medicaid national average for two measures: *Getting Needed Care* and *Getting Care Quickly*. |
| **Weaknesses and Recommendations** | |
| − | **Weakness:** Although contract requirements were met in the 2021 compliance review, VA Premier's rates indicated potential access to care issues or a lack of member understanding of the need for early detection screenings, and well and preventive care for children, with recommended care for chronic conditions, mental health, and utilization measure indicator rates falling below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile. The results also may indicate members' lack of understanding of the need for follow-up care after emergency or inpatient events. |

| Weaknesses and Recommendations | |
|---|---|
| | **Recommendations:** HSAG recommends that VA Premier conduct a root cause analysis or focus study as it relates to these measures within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. |
| – | **Weakness:** VA Premier's 2022 CAHPS top-box score was statistically significantly lower than the 2021 NCQA child Medicaid national average for one measure, *Rating of All Health Care*. |
| | **Recommendations:** HSAG recommends that VA Premier conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that VA Premier focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time. |

# 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<br>2-1 |
| 3a | Required elements are included in the report:<br>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.** | 1-4 – 1-5 |
| 3b | Required elements are included in the report:<br>An assessment of the **strengths and weaknesses of each MCO, PIHP, PAHP and PCCM entity** with respect to (a) quality, (b) timeliness, and (c) access to the health care services furnished by each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) furnished to Medicaid and/or CHIP beneficiaries. Contain specific recommendations for improvement of identified weaknesses. | Section 9 |
| 3c | Required elements are included in the report:<br>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 – 1-9 |
| 3d | Recommend improvements to the quality of health care services furnished by each MCP. | Section 9 |
| 3e | Provides state-level recommendations for performance improvement. | 1-5 – 1-9 |
| 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):<br>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):<br>• **Interventions** | 4-4 – 4-12 |
| 4b | Validation of performance improvement projects (PIPs):<br>• **Objectives;** | 4-1<br>4-4 – 4-13 |

| | Required Elements | Page Number |
|---|---|---|
| | | Appendix B B-1 |
| 4c | Validation of performance improvement projects (PIPs):<br>• **Technical methods of data collection and analysis;** | Appendix B B-2 – B-3 |
| 4d | Validation of performance improvement projects (PIPs):<br>• **Description of data obtained; and** | 4-4 – 4-12<br>Appendix B B-3 |
| 4e | Validation of performance improvement projects (PIPs):<br>• **Conclusions drawn from the data.** | 4-4 – 4-13 |
| 5 | Validation of performance measures:<br>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):<br>• **Objectives;** | 5-1<br>Appendix B B-3 – B-4 |
| 5b | Validation of performance measure validation (PMV):<br>• **Technical methods of data collection and analysis;** | Appendix B B-4 – B-8 |
| 5c | Validation of performance measure validation (PMV):<br>• **Description of data obtained; and** | Appendix B B-5 – B-8 |
| 5d | Validation of performance measure validation (PMV):<br>• **Conclusions drawn from the data.** | 5-1 – 5-11 |
| 6 | Review for compliance:<br>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:<br>• **Objectives;** | 6-1<br>Appendix B B-9 |

| | Required Elements | Page Number |
|---|---|---|
| 6b | Review for compliance:<br>• **Technical methods of data collection and analysis;** | Appendix B<br>B-9 – B-11 |
| 6c | Review for compliance:<br>• **Description of data obtained; and** | 6-1 – 6-2<br>Appendix B<br>B-12 |
| 6d | Review for compliance:<br>• **Conclusions drawn from the data.** | 6-3 – 6-9 |
| 7 | **Each remaining activity** included in the technical report must include a **description of the activity** and the following information: | |
| 7a.1 | Optional activities: Member Experience of Care Survey<br>• **Objectives;** | 7-1<br>Appendix B<br>B-38 |
| 7b.1 | Optional activities:<br>• **Technical methods of data collection and analysis;** | Appendix B<br>B-38 – B-39 |
| 7c.1 | Optional activities:<br>• **Description of data obtained; and** | Appendix B<br>B-39 – B-40 |
| 7d.1 | Optional activities:<br>• **Conclusions drawn from the data.** | 7-1 – 7-14 |
| 7a.2 | Optional activities: Calculation of Additional PM Results<br>**Objectives;** | 3-22<br>Appendix B<br>B-14 |
| 7b.2 | Optional activities:<br>**Technical methods of data collection and analysis;** | Appendix B<br>B-14 |
| 7c.2 | Optional activities:<br>**Description of data obtained; and** | Appendix B<br>B-14 |
| 7d.2 | Optional activities:<br>**Conclusions drawn from the data.** | 3-22 – 3-23 |
| 7a.3 | Optional activities: Prenatal Care and Birth Outcomes Focus Study<br>**Objectives;** | 8-1 |

| | Required Elements | Page Number |
|---|---|---|
| | | Appendix B B-17 |
| 7b.3 | Optional activities: **Technical methods of data collection and analysis;** | Appendix B B-18 |
| 7c.3 | Optional activities: **Description of data obtained; and** | Appendix B B-18 |
| 7d.3 | Optional activities: **Conclusions drawn from the data.** | 8-1 – 8-4 |
| 7a.4 | Optional activities: Foster Care Focus Study **Objectives;** | 8-5 – 8-6 Appendix B B-25 – B-26 |
| 7b.4 | Optional activities: **Technical methods of data collection and analysis;** | Appendix B B-27 – B-28 |
| 7c.4 | Optional activities: **Description of data obtained; and** | Appendix B B-27 |
| 7d.4 | Optional activities: **Conclusions drawn from the data.** | 8-7 – 8-11 |
| 7a.5 | Optional activities: Dental Utilization in Pregnant Women Focus Study **Objectives;** | 8-11 – 8-12 Appendix B B-32 |
| 7b.5 | Optional activities: **Technical methods of data collection and analysis;** | Appendix B B-33 |
| 7c.5 | Optional activities: **Description of data obtained; and** | Appendix B B-33 |
| 7d.5 | Optional activities: **Conclusions drawn from the data.** | 8-12 – 8-16 |
| 7a.6 | Optional activities: Consumer Decision Support Tool **Objectives;** | 3-25 Appendix B B-41 |

| | Required Elements | Page Number |
|---|---|---|
| 7b.6 | Optional activities:<br>**Technical methods of data collection and analysis;** | Appendix B<br>B-41 |
| 7c.6 | Optional activities:<br>**Description of data obtained; and** | Appendix B<br>B-41 |
| 7d.6 | Optional activities:<br>**Conclusions drawn from the data.** | 3-25 – 3-26 |
| 7a.7 | Optional activities: Performance Withhold Program<br>**Objectives;** | 3-26<br>Appendix B<br>B-49 |
| 7b.7 | Optional activities:<br>**Technical methods of data collection and analysis;** | Appendix B<br>B-50 |
| 7c.7 | Optional activities:<br>**Description of data obtained; and** | Appendix B<br>B-50 |
| 7d.7 | Optional activities:<br>**Conclusions drawn from the data.** | 3-26 |

# Appendix B. Technical Methods of Data Collection and Analysis—MCOs

This section of the report presents the approved technical methods of data collection and analysis, and a description of the data obtained (including the time period to which the data applied) for each mandatory and optional activity for the MCOs. It includes:

- PIP Validation Approach and Methodology
- Validation of PM Methodology
- Assessment of Compliance With Medicaid Managed Care Regulations—Operational Systems Review Methodology
- MCO Comparative and Statewide Calculation of Additional PM Results
- Prenatal Care and Birth Outcomes Focus Study Methodology
- Foster Care Focus Study Methodology
- Member Experience of Care Survey Methodology
- Consumer Decision Support Tool Methodology
- Performance Withhold Program Methodology

## PIP Validation Approach and Methodology

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

### *Objectives*

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

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

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

## *Technical Methods of Data Collection*

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

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

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

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

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

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

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

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

### *Description of Data Obtained*

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

### *How Conclusions Were Drawn*

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

## Validation of Performance Measure Methodology

DMAS contracted with HSAG, as its EQRO, to conduct PMV for the MCOs. 42 CFR §438.350(a) requires states that contract with MCOs, PIHPs, PAHPs, or PCCM entities to have a qualified EQRO perform an annual EQR that includes validation of contracted entity PMs (42 CFR §438.358[b][1][ii]).

HSAG, in conjunction with ALI Consulting Services, LLC, conducted PMV for DMAS, validating the data collection and reporting processes used to calculate the PM rates by the MCOs in accordance with CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* October 2019 (EQR Protocol 2).[B-1]

DMAS is responsible for administering the Medicaid program and CHIP in the Commonwealth of Virginia. DMAS refers to its CHIP program as FAMIS. The CCC Plus program is an integrated managed care delivery model that includes medical services, nursing, personal care, and behavioral (mental) health services. DMAS contracted with six privately owned MCOs to provide services to members enrolled in the CCC Plus program for CY 2021. DMAS identified a set of PMs that the MCOs were required to calculate and report.

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

**Table B-1—CY 2021 CCC Plus MCOs**

| MCO Name |
|---|
| Aetna |
| HealthKeepers |
| Molina |
| Optima |
| United |
| VA Premier |

## *Objectives*

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

## *Technical Methods of Data Collection*

HSAG conducted the validation activities as outlined in CMS EQR Protocol 2. To complete the validation activities for MCOs, HSAG obtained a list of the PM that were selected by DMAS for validation.

[B-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 3, 2023.

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

HSAG conducted the validation activities as outlined in CMS EQR Protocol 2. To complete the validation activities for MCOs, HSAG obtained a list of the PMs that were selected by DMAS for validation.

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

## *Description of Data Obtained*

CMS EQR Protocol 2 identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data HSAG reviewed and how HSAG analyzed these data:

- **Roadmap and ISCAT—**The MCOs submitted a Roadmap for HSAG's review that was to be completed as part of the NCQA HEDIS Compliance Audit process. HSAG completed a thorough review of the Roadmap, which includes MCO operational and organizational structure; data systems and data reporting structure and processes; and additional information related to HEDIS Compliance Audit standards. Additionally, the MCOs completed and submitted an ISCAT for HSAG's review of the PMs. The ISCAT supplemented the information included in the Roadmap and addresses data collection and reporting specifics of non-HEDIS measures. HSAG used responses from the Roadmap and ISCAT to complete the pre-virtual on-site assessment of IS.
- **Medical record documentation—**The MCOs were responsible for completing the medical records review section within the Roadmap for the 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 MRV staff members, and policies and procedures outlining the processes for monitoring the accuracy of the abstractions performed by the review staff members. HSAG conducted over-read of 16 records from the hybrid sample for each PM. HSAG followed NCQA's guidelines to validate the integrity of the MRRV processes used by the MCOs and determined if the findings impact the audit results for any performance measure rate.
- **Source code (programming language) for PMs—**The MCOs that calculate the PMs using internally developed source code will be required to submit source code for each PM being validated. HSAG will complete a line-by-line review of the supplied source code to ensure compliance with the 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 PM calculation. If the MCOs outsourced programming for HEDIS measure

production to an outside vendor, the MCOs were required to submit the vendor's NCQA measure certification reports.

- **Supporting documentation—**HSAG requested documentation that provides additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, measure certification reports, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

## *How Data Were Aggregated and Analyzed*

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

- **Opening meetings**—These meetings included introductions of the validation team and key MCO staff involved in the calculation or reporting of the PMs. The purpose of the PMV, required documentation, basic meeting logistics, and queries to be performed will be discussed.
- **Review of ISCAT and Roadmap documentation**—This session was designed to be interactive with key MCO staff so that the validation team obtains a complete picture of all steps taken to generate responses to the ISCAT and Roadmap and can evaluate the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain if written policies and procedures were used and followed in daily practice.
- **Evaluation of enrollment, eligibility, and claims systems and processes**—The evaluation includes a review of the IS, focusing on the processing of claims, processing of enrollment and disenrollment data. HSAG conducted interviews with key staff familiar with the processing, monitoring, reporting, and calculation of the PMs. Key staff may include executive leadership, enrollment specialists, business analysts, customer operations staff, data analytics staff, and other front-line staff familiar with the processing, monitoring, and generation of the PMs. HSAG used these interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.
- **Overview of data integration and control procedures**—This session included a review of the IS and evaluation of processes used to collect, calculate, and report the PMs, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).
  - HSAG performed additional validation using PSV to further validate the data output files. PSV is a review technique used to confirm that the information from the primary source matches the data output file used for reporting. Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across 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 virtual on-site visit, HSAG summarized preliminary findings, discuss follow-up items, and revisit the documentation requirements for any post-virtual on-site activities.

## *How Conclusions Were Drawn*

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

HSAG prepared a separate PMV report for CCC Plus for each MCO, documenting the validation findings. Based on all validation activities, HSAG determined the validation result for each PM. CMS EQR Protocol 2 identifies possible validation results for PMs, defined in Table B-2.

**Table B-2—Validation Results and Definitions for PM**

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

According to CMS EQR Protocol 2, the validation result for each PM is determined by the magnitude of the errors detected for the audit elements, not by the number of errors detected within each audit element. It is possible for an audit element to receive a validation result of DNR when the impact of even a single error associated with that element biased the reported PM rate by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to an audit result of "Reportable" (R).

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

Table B-3 lists the PMs selected by DMAS, the method* (i.e., hybrid or admin) required for data collection, and the specifications that the MCOs were required to use.

**Table B-3—PM List for SFY 2022**

| Performance Measure | Specifications | Method* |
|---|---|---|
| *COPD or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)* | Adult Core Set | Admin |
| *Comprehensive Diabetes Care* | HEDIS MY 2021 | Hybrid |

| Performance Measure | Specifications | Method* |
|---|---|---|
| *Follow-Up After ED Visit for AOD Abuse or Dependence* | HEDIS MY 2021 | Admin |
| *Follow-up After ED Visit for Mental Illness* | HEDIS MY 2021 | Admin |
| *Heart Failure Admission Rate (Per 100,000 Member Months)* | Adult Core Set | Admin |
| *Initiation and Engagement of AOD Abuse or Dependence Treatment* | HEDIS MY 2021 | Admin |

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

# Assessment of Compliance With Medicaid Managed Care Regulations

Compliance reviews (Operational Systems Review or OSRs) are a mandatory activity that are used to determine the extent to which Medicaid and CHIP MCPs are in compliance with federal standards. HHS developed standards for MCPs, which are codified at 42 CFR §438 and 42 CFR §457, as revised by the Medicaid and CHIP managed care final rule issued in 2020. Federal regulations require MCPs to undergo a review at least once every three years to determine MCP compliance with federal standards as implemented by the state.

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

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

| Standard | Federal Requirements Included | Standard | Federal Requirements Included |
|---|---|---|---|
| Standard I—Enrollment and Disenrollment | 42 CFR §438.3(d)<br>42 CFR §438.56 | Standard VIII—Provider Selection | 42 CFR §438.12<br>42 CFR §438.102<br>42 CFR §438.106<br>42 CFR §438.214 |
| Standard II—Member Rights and Confidentiality | 42 CFR §438.100<br>42 CFR §438.224<br>42 CFR §422.128 | Standard IX—Subcontractual Relationships and Delegation | 42 CFR §438.230 |
| Standard III—Member Information | 42 CFR §438.10 | Standard X—Practice Guidelines | 42 CFR §438.236 |
| Standard IV—Emergency and Poststabilization Services | 42 CFR §438.114 | Standard XI—Health Information Systems* | 42 CFR §438.242 |

| Standard | Federal Requirements Included | Standard | Federal Requirements Included |
|---|---|---|---|
| Standard V—Adequate Capacity and Availability of Services | 42 CFR §438.206<br>42 CFR §438.207 | Standard XII—Quality Assessment and Performance Improvement | 42 CFR §438.330 |
| Standard VI—Coordination and Continuity of Care | 42 CFR §438.208 | Standard XIII—Grievance and Appeal Systems | 42 CFR §438.228<br>42 CFR §438.400 –<br>42 CFR §438.424 |
| Standard VII—Coverage and Authorization of Services | 42 CFR §438.210<br>42 CFR §438.404 | Standard XIV—Program Integrity | 42 CFR §438.602(b)<br>42 CFR §438.608<br>42 CFR §438.610 |

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

## Objectives

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

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

## Technical Methods of Data Collection

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

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

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

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

## Description of Data Obtained

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

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

## How Data Were Aggregated and Analyzed

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

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

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

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

## How Conclusions Were Drawn

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

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

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

# MCO Comparative and Statewide Calculation of Additional PM Results[B-2]

## *Project Overview*

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

## *Performance Measure*

For the CY 2021 PM calculation, HSAG will calculate the *COL* PM, which measures the percentage of members 51 to 75 years of age who had appropriate screening for colorectal cancer. HSAG will follow the CMS *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set): Technical Specifications and Resource Manual for Federal Fiscal Year 2022 Reporting*.[B-3]

## *Performance Period*

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

## *Data Collection*

The *COL* PM will be calculated using administrative data sources, including demographic, enrollment, professional claims/encounters, institutional claims/encounters, and pharmacy data for Medicaid eligible individuals from DMAS. DMAS will supply SAS® data sets extracted by claims' paid dates.[B-4] HSAG will retrieve data files from DMAS' SFTP site.

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

## *Measure Calculation*

HSAG will develop SAS program code to calculate the measure rates following the PM specifications. A lead analyst and validation analyst will independently calculate the *COL* PM rates. The lead analyst will

B-2 Note: This methodology is presented as it appeared in the final report for this activity.

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

B-4 SAS is a registered trademark of the SAS Institute, Inc.

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

HSAG will calculate a Virginia total measure rate and will stratify results by Medicaid program, Medicaid delivery system, MCO, and managed care geographic region using FIPS codes. In addition, rates will be stratified by age, race, and gender. Table B-7 presents the *COL* PM rate stratifications and values for Medicaid program, Medicaid delivery system, MCO, geographic region, age group, and gender.

**Table B-7—Medicaid Program, Medicaid Delivery System, MCO, Geographic Region, Age Group, and Gender Stratification Values**

| Stratification | Values |
|---|---|
| Medicaid Program | • CCC Plus<br>• Medallion 4.0 |
| Medicaid Delivery System | • FFS<br>• Managed Care |
| MCO | • Aetna<br>• HealthKeepers<br>• Molina<br>• Optima<br>• United<br>• VA Premier |
| Geographic Region | • Central<br>• Charlottesville/Western<br>• Northern & Winchester<br>• Roanoke/Alleghany<br>• Southwest<br>• Tidewater |
| Age Group | • 51–64<br>• 65–75<br>• Total |
| Gender | • Male<br>• 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. Table B-8 presents

the *COL* PM race stratifications that may be reported by HSAG with a crosswalk to DMAS' race categories.

**Table B-8—Race Category Stratification Values**

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

In order to understand the types of screenings for colorectal cancer that members are receiving, HSAG will also stratify the numerator-positive members by each type of colorectal cancer screening received. The colorectal cancer screening stratifications and descriptions are listed in Table B-9.

**Table B-9—Colorectal Cancer Screening Stratifications**

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

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

# Prenatal Care and Birth Outcomes Focus Study Methodology

## *Project Overview*

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

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

## *Study Design*

### Eligible Population

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

The FAMIS MOMS program uses Title XXI (CHIP Demonstration Waiver) funding to serve pregnant women with incomes up to 200 percent[B-5] of the FPL and provides benefits similar to Medicaid through the duration of pregnancy and for 60 days postpartum.

- The Medicaid for Pregnant Women program uses Title XIX (Medicaid State Plan) funding to serve pregnant women with incomes up to 143 percent of the FPL.
- The Medicaid expansion program uses Title XIX funding to serve adults 19 years of age and older with incomes up to 138 percent of the FPL.
- The LIFC program uses Title XIX funding to serve low-income adults with children under the age of 18 who are eligible for the TANF program based on their monthly income at the time of enrollment.
- The "Other Medicaid" programs include births paid by Medicaid that do not fall within the FAMIS MOMS, Medicaid for Pregnant Women, Medicaid expansion, or LIFC programs. Please note, births to women in Plan First or the DOC are excluded.[B-6]

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

B-6 Prior to the 2020–2021 Birth Outcomes Focus Study, births to women in the LIFC program, Plan First, and DOC were included in the Other Medicaid program. Therefore, HSAG will re-calculate historical (i.e., CY 2018 and CY 2019) Other Medicaid program rates to exclude births to women in LIFC, Plan First, and DOC.

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

## Data Collection

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

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

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

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

## Study Indicators

Table B-10 presents the study indicators that HSAG will calculate for this study limited to singleton births, defined using the Plurality field in the birth registry data.

**Table B-10—Study Indicators†**

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

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

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

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

Where applicable, HSAG will compare the study indicators to national benchmarks. HSAG will use the Healthy People 2030 goals[B-7] using data derived from the CDC, NCHS, and NVSS, for the *Births With Early and Adequate Prenatal Care* and *Preterm Births (<37 Weeks Gestation)* study indicators, and will use the FFY 2020 CMS Core Set benchmarks, if available, for the *Newborns With Low Birth Weight (<2,500 grams)* study indicator.[B-8]

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

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

B-7 Healthy People 2030. Pregnancy and Childbirth. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Available at: https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth. Accessed on: Dec 29, 2022.

B-8 If the FFY 2020 CMS Core Set benchmarks are not available at the time of producing the report, HSAG will use the FFY 2019 CMS Core Set benchmarks.

## Study Indicator Stratifications

HSAG will stratify the CY 2020 study indicator rates by the categories listed in Table B-11.

**Table B-11—Study Indicator Stratifications**

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

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

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

## *Comparative Analysis*

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

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

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

# Additional Population-Specific Stratifications

## *FAMIS MOMS*

For the FAMIS MOMS study indicator results, HSAG will also stratify the CY 2020 results by Medicaid delivery system, maternal race/ethnicity, maternal age at delivery, managed care region of maternal residence, length of continuous enrollment prior to delivery, and trimester of PNC initiation. Please refer to the category values defined in Table B-11 for more information regarding these stratifications.

## *Emergency-Only Benefits*

For the emergency-only benefits study indicator results, HSAG will stratify the CY 2020 results by maternal race/ethnicity, maternal age at delivery, and managed care region of maternal residence. Additionally, HSAG will compare the CY 2020 study indicators to the CY 2019 study indicator results for the women covered by emergency-only benefits. Please refer to the category values defined in Table B-12 for more information regarding these stratifications.

## *Member-Level Data File*

HSAG will produce a member-level data file and Microsoft Excel spreadsheet that DMAS can use for internal purposes. The member-level data file will include all data elements listed in Table B-12.

**Table B-12—Member-Level Data File**

| Demographic Category | Category Values |
|---|---|
| **Singleton Birth Indicator** | • Singleton<br>• Multiple |
| **Medicaid Program at Delivery** | • FAMIS MOMS<br>• Medicaid for Pregnant Women<br>• Medicaid Expansion<br>• LIFC<br>• Other Medicaid |
| **Comparative Analysis Population Group** | • Study Population<br>• Comparison Group<br>• Not Applicable (NA) |
| **Medicaid Delivery System at Delivery** | • FFS<br>• Managed Care |

| Demographic Category | Category Values |
|---|---|
| **MCO at Delivery** | • Aetna<br>• HealthKeepers<br>• Molina<br>• Optima<br>• United<br>• VA Premier |
| **MCO Enrollment** | • Not enrolled with an MCO prior to delivery (e.g., FFS)<br>• Enrolled with one MCO prior to delivery<br>• Enrolled with more than one MCO prior to delivery |
| **Continuous Enrollment** | • The number of days continuously enrolled in Virginia Medicaid |
| **Length of Continuous Enrollment Prior to Delivery** | • ≤ 30 Days<br>• 31–90 Days<br>• 91–180 Days<br>• > 180 Days<br>• Not continuously enrolled prior to delivery |
| **Maternal Gravidity**<br><br>*Note: Defined from the birth registry data.* | • The number of pregnancies, including the current pregnancy |
| **Trimester of Prenatal Care Initiation** | • First Trimester<br>• Second Trimester<br>• Third Trimester<br>• No Prenatal Care<br>• Unknown |
| **Managed Care Region of Maternal Residence**<br><br>*Note: Defined from the birth registry data using the county of residence at the time of delivery, grouped into regions using the Virginia managed care regions.* | • Central<br>• Charlottesville/Western<br>• Northern & Winchester<br>• Roanoke/Alleghany<br>• Southwest<br>• Tidewater<br>• Unknown/Missing |
| **Maternal Race/Ethnicity**<br><br>*Note: Defined from the birth registry data as non-Hispanic race (i.e., White, non-Hispanic), with Hispanic women of any race reported in the Hispanic category.* | • White, Non-Hispanic<br>• Black, Non-Hispanic<br>• Asian, Non-Hispanic<br>• Hispanic, Any Race<br>• Other/Unknown |

| Demographic Category | Category Values |
|---|---|
| **Maternal Age at Delivery** | • 15 Years and Younger<br>• 16–17 Years<br>• 18–20 Years<br>• 21–24 Years<br>• 25–29 Years<br>• 30–34 Years<br>• 35–39 Years<br>• 40–44 Years<br>• 45 Years and Older<br>• Unknown |
| **Maternal Citizenship Status**<br>*Note: Defined from DMAS' demographic data.* | • U.S. Citizen (Citizenship Status = "C", "N")<br>• Documented immigrant (Citizenship Status = "E", "I", "P", "R")<br>• Undocumented immigrant (Citizenship Status = "A")<br>• Other (Citizenship Status = "V") |
| **Emergency-Only Benefits** | • Emergency-Only Benefits<br>• NA |
| **Maternal Asthma**[B-9] | • Asthma<br>• No Asthma<br>• NA |
| **Maternal Diabetes**[B-10] | • Diabetes<br>• No Diabetes<br>• NA |
| **Maternal Gestational Diabetes**[B-11] | • Gestational Diabetes<br>• No Gestational Diabetes<br>• NA |
| **PNC Index** | • Adequate Plus PNC<br>• Adequate PNC<br>• Intermediate PNC<br>• Inadequate PNC<br>• Missing Info |

B-9 Identification of asthma will use administrative data sources; therefore, this stratification will not be applied to women without Medicaid enrollment prior to delivery.

B-10 Identification of diabetes will use administrative data sources; therefore, this stratification will not be applied to women without Medicaid enrollment prior to delivery.

B-11 Identification of gestational diabetes will use administrative data sources; therefore, this stratification will not be applied to women without Medicaid enrollment prior to delivery.

| Demographic Category | Category Values |
|---|---|
| **Gestational Age** | • Preterm: Less than 37 weeks<br>– Late preterm: 34–36 weeks<br>– Moderate preterm: 32–33 weeks<br>– Very preterm: 28–31 weeks<br>– Extremely preterm: <28 weeks<br>• Term: 37–41 weeks<br>– Late Term: 41 weeks<br>– Full Term: 39–40 weeks<br>– Early Term: 37–38 weeks<br>• Post Term: > 42 weeks |
| **Birth Weight** | • Moderately Low<br>• Very Low<br>• Not Low<br>• Missing |
| **Method of Delivery**<br>*Note: Defined from the birth registry data.* | • C-Section Delivery<br>• Vaginal Delivery<br>• Missing |
| **Birth in Administrative Data**<br>*Note: Defined using HEDIS MY 2020 Deliveries Value Set from the Prenatal and Postpartum Care measure and applied to DMAS' claims and encounter data.* | • Yes<br>• No |
| **High-Risk Pregnancies**<br>*Note: Defined using medications (e.g., progesterone) and diagnoses (e.g., prior high-risk pregnancy, preeclampsia, obesity, gestational diabetes) considered to be risk factors for high-risk pregnancies and applied to DMAS' claims and encounter data.* | • Yes<br>• No |

# Foster Care Focus Study Methodology[B-12]

## *Purpose*

DMAS has contracted with HSAG since SFY 2015–2016 to conduct a focus study that assesses healthcare utilization among foster care children receiving medical services through Medicaid MCOs. The SFY 2020–2021 (Contract Year 7) Task J.2 Foster Care Focus Study will assess how the

[B-12] Note: This methodology is presented as it appeared in the final report for this activity.

healthcare utilization among members in foster care or adoption assistance programs (i.e., children in foster care, children in the adoption assistance program, and young adults formerly in foster care) compares to utilization among members not in foster care or adoption assistance programs and receiving Medicaid managed care benefits.

## *Study Design*

### Measurement Period

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

### Eligible Populations

HSAG will identify the eligible populations for each foster care or adoption assistance program being assessed using the specific program's aid category to determine member enrollment at any point during the measurement period:[B-13]

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

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

- Continuously enrolled populations: All members in the eligible population continuously enrolled in a single managed care program (i.e., Medallion 4.0 or CCC Plus)[B-14] and a single aid category (e.g., continuously enrolled foster children must be continuously enrolled with aid category "76") with any MCO or combination of MCOs from January 1, 2020, through December 31, 2020, with one or more gaps in enrollment totaling no more than 45 days.
- Study populations: All children in the continuously enrolled population for which comparable members not in the foster care or adoption assistance programs and receiving Medicaid managed care benefits were identified.

[B-13] The Foster Children eligible population and Adoption Assistance Children eligible population are not mutually exclusive; a member may be included in both the Foster Children eligible population and Adoption Assistance Children eligible population.

[B-14] Based on analyses, HSAG and DMAS will determine whether members enrolled in CCC Plus will be excluded from the study or whether the analyses will stratify by managed care program.

Since this study will compare healthcare utilization among members in foster care or adoption assistance programs and their Medicaid peers not in foster care or adoption assistance programs, HSAG will identify a comparison group of members who are continuously enrolled through an aid category other than the foster care or adoption assistance programs (i.e., an aid category that is not "76", "72", or "70") and receiving Medicaid managed care benefits for each study population. HSAG will determine the most appropriate method to identify a group of members not in foster care or adoption assistance programs that is statistically similar to each continuously enrolled foster care or adoption assistance program population. Once the comparison groups have been identified, HSAG will evaluate the similarity between the study populations (i.e., members in foster care or adoption assistance programs ) and the comparison groups (i.e., members not in foster care or adoption assistance programs) through a variety of tests and assessments.[B-15]

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

## Data Collection

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

## Indicators

The unit of analysis for this study will be Medicaid members, and indicators will vary by population group (i.e., the eligible populations, the continuously enrolled populations, and the study populations described in the Eligible Populations section), as described in Table B-13. Indicators will be calculated for each foster care or adoption assistance program independently.

For consistency with other quality initiatives, healthcare utilization indicators are based on either the CMS Adult and Child Core Set Technical Specifications and Resource Manual for FFY 2021 Reporting or the HEDIS Measurement Year 2020 & Measurement Year 2021 Technical Specifications for Health Plans, where applicable.[B-16] However, HSAG will modify the HEDIS continuous enrollment criteria to reflect the ability of members in foster care or adoption assistance programs to move between MCOs during the measurement period. Additionally, indicators for the continuously enrolled populations and the study populations will also be calculated for the comparison groups. For sub-analysis indicators for former foster children originating from out of state, DMAS will provide custom measure specifications.

When identification of provider types is necessary for study indicator calculations, HSAG will work with DMAS to classify PCPs and MHPs as defined in the HEDIS MY 2020 technical specifications.

[B-15] HSAG will evaluate covariate balance between each eligible population's matched groups using bivariate statistical testing (i.e., chi-square and two-sample *t*-tests), an assessment of standardized differences, and an omnibus test to evaluate statistical balance across all covariates simultaneously.

[B-16] HEDIS Measurement Year 2020 & 2021 Volume 2 Technical Specifications for Health Plans align with indicator results reported to NCQA for the measurement period from January 1, 2020, through December 31, 2020.

Providers identified as PCPs may include, but are not limited to, pediatricians, family practice physicians, general practice physicians, internal medicine physicians, nurse practitioners, physician assistants, and FQHCs.

**Table B-13—Study Indicators**

| Indicator | Description and/or Category Values |
|---|---|
| **Eligible Populations—Demographic Characteristics of Medicaid Members in Foster Care or Adoption Assistance Programs[B-17]** | |
| **Sex** | Category Values: Female, Male, Other |
| **Age Category** | Category Values for Foster Care and Adoption Assistance: Infant [≤ 2 Years], Preschool [3 to 5 Years], Elementary School [6 to 10 Years], Middle School [11 to 13 Years], High School [≥ 14 Years]<br><br>Category Values for Former Foster Care: Young Adult [19 to 22 Years], Adult [23 to 26 Years] |
| **Race** | Category Values: White, Black or African American, Other<br><br>Race categories do not include consideration of ethnicity data. |
| **Region of Residence** | Category Values: Central, Southwest, Northern & Winchester, Roanoke/Alleghany, Tidewater, Charlottesville/Western<br><br>Region of residence will be defined based on members' county of residence as of December 31, 2020, using the Virginia managed care regions. |
| **MCO** | Category Values:<br>• Aetna<br>• HealthKeepers<br>• Molina<br>• Optima<br>• United<br>• VA Premier<br>Since the foster care population includes every member enrolled in foster care during the measurement year for any length of time, the latest MCO a member was enrolled with during the measurement year will be used. |

[B-17] Indicators in this category will be provided for all members in a foster care or adoption assistance program at any point during the measurement period for informational purposes only and will not be subject to continuous enrollment criteria.

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

| Indicator | Description and/or Category Values |
|---|---|
| | more than 45 days will be attributed to that MCO. Otherwise, a member continuously enrolled with more than one MCO or more than one gap in enrollment will be attributed to "Other." |
| **Health Characteristics** | Category Values: Diagnosed, Not Diagnosed (e.g., psychotic disorders, ADHD)<br><br>HSAG will identify health conditions for which prevalence differs between the continuously enrolled members in each foster care or adoption assistance program and the continuously enrolled members not in foster care or adoption assistance programs and present the proportion of members in each group who are diagnosed with each health condition. |
| **Study Populations—Healthcare Utilization Among Medicaid Members in Foster Care or Adoption Assistance Programs and Comparable Medicaid Members Not in Foster Care or Adoption Assistance Programs**[B-18] | |
| **Primary Care** | |
| **Child and Adolescent Well-Care Visits (WCV)** | Defined using the FFY 2021 Child Core Set technical specifications for the WCV indicator, with study-specific continuous enrollment modifications. |
| **Well-Child Visits in the First 30 Months of Life (W30)** | Defined using the FFY 2021 Child Core Set technical specifications for the W30 indicator, with study-specific continuous enrollment modifications. |
| **Oral Health** | |
| **Annual Dental Visit (ADV)** | Defined using the HEDIS MY 2020 technical specifications for the ADV indicator, with study-specific continuous enrollment modifications. |
| **Preventive Dental Services (PDENT-CH)** | Defined using the FFY 2021 Child Core Set technical specifications for the PDENT-CH indicator, with study-specific continuous enrollment modifications. |
| **Behavioral Health** | |
| **Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up** | Defined using the FFY 2021 Adult and Child Core Set technical specifications for the FUH–7-Day indicator, with study-specific continuous enrollment modifications. |
| **Follow-Up After ED Visit for Mental Illness (FUM)—30-Day Follow-Up** | Defined using the HEDIS MY 2020 technical specifications for the FUM–30-Day indicator, with study-specific continuous enrollment modifications. |

[B-18] Indicators in this category will be subject to continuous enrollment criteria and calculated for applicable programs based on age.

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

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

### *Comparative Analyses*

Following calculation of the Table B-13 indicator rates for the study populations and their comparison groups, HSAG will perform appropriate statistical testing to assess whether the indicator rates are statistically different between the members in the study populations and their respective comparison groups. HSAG anticipates using regression analyses to compare any differences in study indicator rates between the two populations. The statistical methods used to identify each comparison group should improve covariate balance between the two matched groups. However, once the groups are subset at the study indicator level (i.e., excluding individuals who do not meet denominator criteria for a selected indicator), the indicator-specific groups may no longer be balanced. To control for any imbalance between groups at the study indicator level, HSAG will evaluate outcomes using either a linear or logistic regression with observable covariates used as controls.

## Dental Utilization in Pregnant Women Data Brief Methodology[B-19]

### *Overview*

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

[B-19] Note: This methodology is presented as it appeared in the final report for this activity.

## Data Sources

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

## Measurement Period

HSAG will assess the utilization of dental services during the prenatal and postpartum periods for women with deliveries during CY 2021 (i.e., January 1, 2021, through December 31, 2021).[B-20]

## Eligible Population

If vital statistics data are received by August 5, 2022, HSAG will use vital statistics data to identify deliveries to women during CY 2021. If vital statistics data are not available, HSAG will identify women with a delivery during the measurement period using the member enrollment/eligibility and claims/encounter data provided by DMAS. HSAG will identify deliveries using the *Deliveries Value Set* from the *Prenatal and Postpartum Care* measure in the FFY 2022 CMS Adult and Child Core Set of Health Care Quality Measures.[B-21] HSAG will exclude non-live births from the deliveries using the *Non-Live Birth Value Set* for the *Prenatal and Postpartum Care* measure.[B-22]

HSAG will only include women 21 years of age and older at the time of conception through the end of the month following their 60th day postpartum. HSAG will use the vital statistics data to determine gestational age. In the absence of vital statistics data, HSAG will estimate the time of conception as 280 days prior to the date of delivery.[B-23]

[B-20] A women's pregnancy would begin during March 2020 for a live birth delivered on January 1, 2021. Therefore, all women with deliveries beginning in CY 2021 would have been eligible for the Virginia Medicaid SFC program, contingent upon their enrollment in Medicaid or FAMIS MOMS.

[B-21] Centers for Medicare & Medicaid Services. *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set): Technical Specifications and Resource Manual for Federal Fiscal Year 2022 Reporting*, March 2022 (Updated July 2022). Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html. Accessed on: Jan 10, 2023.

[B-22] Ibid.

[B-23] The Virginia Medicaid SFC program covers most dental services for pregnant women aged 21 years and older through their pregnancy and postpartum period. Further information about the program is available at: https://www.dentaquest.com/getattachment/State-Plans/Regions/Virginia/Dentist-Page/VA-Smiles-For-Children-ORM.pdf/?lang=en-US.

## *Study Indicators*

### Dental Utilization

HSAG will use the dental encounter data to determine which dental services, if any, were utilized during the member's pregnancy or postpartum period, using the following code sets:[B-24]

- Any Dental Service Code Set
- Adjunctive Services Code Set
- Diagnostic Services Code Set
- Endodontics Code Set
- Oral & Maxillofacial Surgery Code Set
- Periodontics Code Set
- Preventive Services Code Set
- Prosthodontics Code Set
- Restorative Code Set

#### Dental Utilization Stratifications

HSAG will stratify the CY 2021 dental utilization study indicator rates by the categories listed in Table B-14.

**Table B-14—Dental Utilization Study Indicator Stratifications**

| Stratification | Description/Values |
|---|---|
| Medicaid Program | The Medicaid program the woman was enrolled with on the date of delivery:<br>• FAMIS MOMS (eligibility category 005)<br>• Medicaid for Pregnant Women (eligibility categories 091 and 097)<br>• Medicaid expansion (aid categories 100, 101, 102, 103, 106, and 108)<br>• LIFC (aid category 081)<br>• 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])<br>• Not Enrolled |

[B-24] For detailed information related to the code sets used for this report, please refer to the *VA Task N_Dental Utilization in Pregnant Women Data Brief Code Set* Microsoft Excel file.

| Stratification | Description/Values |
|---|---|
| Managed Care Program | • Medallion 4.0<br>• CCC Plus<br>• FAMIS<br>• Not Enrolled |
| Medicaid Delivery System | • FFS<br>• Managed Care<br>• Not Enrolled |
| Perinatal Timing of Dental Service | The perinatal timing of the utilization of dental services. The following categories will be presented:<br>• Prenatal period: the start of the first trimester based on gestational age at time of delivery (or the 280 days prior to the date of delivery if only administrative data are available)<br>• Postpartum period: through the end of the month following the 60th day postpartum<br>  • Both: anytime during the prenatal and postpartum periods defined above |
| Continuous Enrollment During Dental Service | Dental service utilization occurred for members continuously enrolled in any Medicaid program for a minimum of 90 days prior to, and including, the date of delivery. |
| Age | The age of the woman on the date of delivery. The following age groups will be presented:<br>• 21–24<br>• 25–29<br>• 30–34<br>• 35–39<br>• 40 and Older |
| Race/Ethnicity | The race/ethnicity of the woman. The following race/ethnicity categories will be presented:<br>• White, Non-Hispanic<br>• Black, Non-Hispanic<br>• Asian, Non-Hispanic<br>• Hispanic, Any Race<br>• Other/Unknown |
| Managed Care Region of Residence | The region of the woman's residence at the time of delivery. The following regions will be |

| Stratification | Description/Values |
|---|---|
| | presented:<br>• Central<br>• Charlottesville/Western<br>• Northern & Winchester<br>• Roanoke/Alleghany<br>• Southwest<br>• Tidewater |

## *Birth Outcomes*

In addition to dental utilization rates, HSAG will perform a statistical analysis related to the association of the receipt of dental health services and birth outcomes. To determine the association between dental health services and each of the birth outcomes listed below, HSAG will use Pearson's correlation coefficient (r) and interpret the strength of the correlation based on the following guidelines, as displayed in Table B-15.

**Table B-15—Pearson's Correlation Coefficient (r) and Strength of Correlation Guidelines**

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

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

HSAG will include the following comparisons in the report:

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

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

Table B-16 presents details into the birth outcomes that HSAG will assess for this data brief.

**Table B-16—Birth Outcomes Analysis**

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

| Indicator | Denominator | Numerator |
|---|---|---|
| | | • A telephone visit (Telephone Visits Code Set) or online assessment (Online Assessments Code Set)<br>• Any one of the following<br>– An ED visit (ED Code Set)<br>– An ED procedure code (ED Procedure Code Set) with an ED POS code (ED POS Code Set) |
| Births With Early and Adequate Prenatal Care | Number of singleton, live births paid by Virginia Medicaid during the measurement period | Number of singleton, live births with an Adequacy of Prenatal Care Utilization Index (i.e., the Kotelchuck Index) score greater than or equal to 80 percent, which includes the Adequate Plus category (greater than or equal to 110 percent). |

# Member Experience of Care Survey Methodology

## *Objectives*

The primary objective of the adult and child CAHPS surveys was to effectively and efficiently obtain information on the levels of experience of adult and child Medicaid members enrolled in the CCC Plus MCOs (Aetna, HealthKeepers, Molina, Optima, United, and VA Premier) with their MCO and healthcare.

## *Technical Methods of Data Collection*

For the CCC Plus 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-25] The mode of CAHPS survey data collection varied slightly among the MCOs. Aetna, HealthKeepers, Molina, Optima, United, and VA Premier used an enhanced mixed-mode survey methodology that was pre-approved by NCQA for both their adult and child populations. In addition, Aetna and United included the option for adult and child members to complete the survey via the Internet, and Optima included the option for adult members only to complete the survey via the Internet. Following NCQA's standard

[B-25] Aetna, HealthKeepers, Molina, Optima, United, and VA Premier administered the CAHPS 5.1H Child Medicaid Health Plan Survey with the CCC measurement set to their child Medicaid populations. For purposes of this report, the child Medicaid CAHPS results presented for the MCOs represent the CAHPS results for their general child populations (i.e., general child CAHPS results).

HEDIS timeline, adult members and parents/caretakers of child members enrolled in each of the MCOs completed the surveys between the time period of January to May 2022.

Each MCO was responsible for contracting with an NCQA-certified survey vendor to conduct CAHPS surveys of the MCO's adult and child Medicaid populations on the MCO's behalf. To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed to select members and distribute surveys.[B-26] These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis. Each MCO provided HSAG with its NCQA Summary Reports of adult and child Medicaid CAHPS survey results (i.e., summary report produced by NCQA of calculated CAHPS results) and raw data files for purposes of reporting.

The CAHPS 5.1H Surveys include a set of standardized items (40 items for the CAHPS 5.1H Adult Medicaid Health Plan Survey and 76 items for the CAHPS 5.1H Child Medicaid Health Plan Survey with the Children with Chronic Conditions measurement set) that assess members' perspectives on care. For the MCOs, the CAHPS survey questions were categorized into eight measures of experience. These measures included four global ratings and four composite scores. The global ratings reflected members' overall experience with their health plan, all health care, personal doctor, and specialist. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*).

For each of the four global ratings, the percentage of respondents who chose the top-box experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. For each of the four composite measures, the percentage of respondents who chose a positive, or top-box, response was calculated. CAHPS composite question response choices were "Never," "Sometimes," "Usually," or "Always. A top-box response for the composite measures was defined as a response of "Usually" or "Always." These percentages are referred to as top-box scores.

## *Description of Data Obtained*

The CAHPS survey asks members to report on and to evaluate their experiences with health care. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The CAHPS surveys were administered from January to May 2022 for the CCC Plus MCOs.

The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. For the CAHPS 5.1H Adult Medicaid Health Plan Survey, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 10, 19, 23, and 28. For the CAHPS 5.1H Child Medicaid Health Plan Survey with the CCC measurement set, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 25, 40, 44, and 49. Eligible members included the entire sample minus ineligible members. For the adult population, ineligible members met at least one of the

[B-26] Aetna and HealthKeepers contracted with CSS; and Molina, Optima, United, and VA Premier contracted with SPH Analytics to conduct the CAHPS survey administration, analysis, and reporting of survey results for their respective adult and child Medicaid populations.

following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), they had a language barrier, or they were mentally or physically incapacitated. For the child population, ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), or they had a language barrier. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

## How Data Were Aggregated and Analyzed

HSAG performed a trend analysis of the results in which the FY 2022 top-box scores were compared to their corresponding FY 2021 top-box scores to determine whether there were statistically significant differences. Statistically significant differences are noted with directional triangles. Scores that were statistically significantly higher in FY 2022 than FY 2021 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in FY 2022 than FY 2021 are noted with black downward (▼) triangles. Scores that were not statistically significantly different between years are not noted with triangles.

Also, the 2022 top-box scores for each MCO and the statewide aggregate were compared to the 2021 NCQA Medicaid national averages.[B-27,B-28,B-29] Statistically significant differences are noted with colors. A cell is highlighted in orange if the MCO score was statistically significantly higher than the national average. However, if the MCO score was statistically significantly lower than the national average, then a cell is highlighted in gray. An MCO's score that was not statistically significantly different than the national average is not highlighted.

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

## How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to services provided by the MCOs, HSAG assigned each of the measures to one or more of these three domains. This assignment to domains is depicted in Table B-17.

[B-27] For the NCQA Medicaid national averages, the source for data contained in this publication is Quality Compass 2021 data and is used with the permission of NCQA. Quality Compass 2021 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass® is a registered trademark of NCQA.

[B-28] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2021*. Washington, DC: NCQA, September 2021.

[B-29] NCQA national averages were not available for 2022 at the time this report was prepared; therefore, 2021 national data are presented.

**Table B-17—Assignment of CAHPS Measures to the Quality, Timeliness, and Access to Care Domains**

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

# Consumer Decision Support Tool Methodology

## *Project Overview*

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

## *Data Collection*

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

## *Reporting Categories*

The CCC Plus Consumer Decision Support Tool reporting categories and descriptions of the measures they contain are:

- **Overall Rating**: Includes all HEDIS and CAHPS measures included in the 2022 Consumer Decision Support Tool analysis. This category also includes adult, general child, and children with

chronic conditions CAHPS measures on consumer perceptions of the overall rating of the MCO, MCO customer service, and their overall healthcare.

- **Doctors' Communication**: Includes adult, general child, and children with chronic conditions CAHPS composites on consumer perceptions regarding how well their doctors communicate and the overall ratings of personal doctors and specialists seen most often. This category also includes children with chronic conditions CAHPS composites and question summary rates related to family centered care for children with chronic conditions. Additionally, this category includes a CAHPS measure related to medical assistance with smoking and tobacco use cessation.
- **Access and Preventive Care**: Includes adult, general child, and children with chronic conditions CAHPS composites on consumer perceptions regarding the ease of obtaining needed care and how quickly they received that care. Additionally, this category assesses a HEDIS measure related to adults' access to care and children with chronic conditions CAHPS question summary rates related to access to prescription medications. Additionally, this category includes HEDIS measures on how well MCOs perform related to preventive screenings for breast cancer and cervical cancer, as well as appropriate treatment for acute bronchitis/bronchiolitis and low back pain.
- **Behavioral Health**: Includes HEDIS measures that assess how often members remain on medications, appropriate care for members with AOD abuse or dependence, and follow-up services for mental illness and AOD abuse or dependence.
- **Taking Care of Children**: Includes HEDIS measures regarding how often preventive services and appropriate treatment are provided to child members (e.g., immunizations, well-child/well-care visits, weight assessment and counseling for nutrition and physical activity, and metabolic monitoring for children and adolescents on antipsychotics).
- **Living With Illness**: Includes HEDIS measures related to the appropriate treatment for people who have chronic conditions (e.g., diabetes, high blood pressure, COPD). In addition, this category includes HEDIS measures that assess medication management for people with asthma and schizophrenia or bipolar disorder.

## *Measures Used in Analysis*

DMAS, in collaboration with HSAG, chose measures for this year's CCC Plus Consumer Decision Support Tool based on a number of factors. In an effort to align with the PWP, the HEDIS measures evaluated as part of the PWP are included in this analysis, as well as many measures required by the CCC Plus Technical Manual for Reporting.[B-30] Per NCQA specifications, the CAHPS 5.1H Adult Medicaid Health Plan Survey instrument was used for the adult population and the CAHPS 5.1H Child Survey with Children with Chronic Conditions item set was used for the child population.

Table B-18 lists the 64 measure indicators, 27 CAHPS and 37 HEDIS, and their associated weights.[B-31] Weights are applied when calculating the category summary scores and the CIs to ensure that all

B-30 Virginia Department of Medical Assistance Services. *CCC Plus Technical Manual*. Version 2.7.

B-31 The following measures have been removed from the 2022 Consumer Decision Support Tool analysis due to half or more of the MCOs having *Not Applicable (NA)* audit designations: *General Child Medicaid—Customer Service (CAHPS Composite)*, *Children with Chronic Conditions Medicaid—Customer Service (CAHPS Composite)*, *Children with Chronic Conditions Medicaid—Coordination of Care for Children with Chronic Conditions (CAHPS Question Summary Rates)*, *Children with Chronic Conditions Medicaid—Access to Specialized Services (CAHPS Composite)*, *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—3 Months–17 Years*, *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*.

measures contribute equally to the derivation of the final results. Please see the Comparing MCO Performance section for more details.

**Table B-18—CCC Plus Consumer Decision Support Tool Reporting Categories, Measures, and Weights**

| Measure | Measure Weight |
|---|---|
| **Overall Rating**[B-32] | |
| *Adult Medicaid—Rating of Health Plan (CAHPS Global Rating)* | 1 |
| *General Child Medicaid—Rating of Health Plan (CAHPS Global Rating)* | 1 |
| *Children with Chronic Conditions Medicaid—Rating of Health Plan (CAHPS Global Rating)* | 1 |
| *Adult Medicaid—Rating of All Health Care (CAHPS Global Rating)* | 1 |
| *General Child Medicaid—Rating of All Health Care (CAHPS Global Rating)* | 1 |
| *Children with Chronic Conditions Medicaid—Rating of Health Care (CAHPS Global Rating)* | 1 |
| *Adult Medicaid—Customer Service (CAHPS Composite)* | 1 |
| **Doctors' Communication** | |
| *Adult Medicaid—How Well Doctors Communicate (CAHPS Composite)* | 1 |
| *General Child Medicaid—How Well Doctors Communicate (CAHPS Composite)* | 1 |
| *Children with Chronic Conditions Medicaid—How Well Doctors Communicate (CAHPS Composite)* | 1 |
| *Adult Medicaid—Rating of Personal Doctor (CAHPS Global Rating)* | 1 |
| *General Child Medicaid—Rating of Personal Doctor (CAHPS Global Rating)* | 1 |
| *Children with Chronic Conditions Medicaid—Rating of Personal Doctor (CAHPS Global Rating)* | 1 |
| *Adult Medicaid—Rating of Specialist Seen Most Often (CAHPS Global Rating)* | 1 |
| *General Child Medicaid—Rating of Specialist Seen Most Often (CAHPS Global Rating)* | 1 |
| *Children with Chronic Conditions Medicaid—Rating of Specialist Seen Most Often (CAHPS Global Rating)* | 1 |
| *Children with Chronic Conditions Medicaid—Family Centered Care: Personal Doctor Who Knows Child (CAHPS Composite)* | 1 |
| *Medical Assistance With Smoking and Tobacco Use Cessation* | |
| *Advising Smokers and Tobacco Users to Quit* | 1/3 |
| *Discussing Cessation Medications* | 1/3 |
| *Discussing Cessation Strategies* | 1/3 |

B-32 To calculate the Overall Rating category, all 64 CAHPS and HEDIS measures are included in the analysis. Please note that the CAHPS measures listed in the Overall Rating category are exclusive to the reporting category.

| Measure | Measure Weight |
|---|---|
| **Access and Preventive Care** | |
| *Adult Medicaid—Getting Needed Care (CAHPS Composite)* | 1 |
| *General Child Medicaid—Getting Needed Care (CAHPS Composite)* | 1 |
| *Children with Chronic Conditions Medicaid—Getting Needed Care (CAHPS Composite)* | 1 |
| *Adult Medicaid—Getting Care Quickly (CAHPS Composite)* | 1 |
| *General Child Medicaid—Getting Care Quickly (CAHPS Composite)* | 1 |
| *Children with Chronic Conditions Medicaid—Getting Care Quickly (CAHPS Composite)* | 1 |
| *Children with Chronic Conditions Medicaid—Access to Prescription Medicines (CAHPS Question Summary Rates)* | 1 |
| *Adults' Access to Preventive/Ambulatory Health Services* | |
| *20–44 Years* | 1/3 |
| *45–64 Years* | 1/3 |
| *65+ Years* | 1/3 |
| *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* | |
| *18–64 Years* | 1/2 |
| *65+ Years* | 1/2 |
| *Use of Imaging Studies for Low Back Pain* | 1 |
| *Breast Cancer Screening* | 1 |
| *Cervical Cancer Screening* | 1 |
| **Behavioral Health** | |
| *Initiation and Engagement of AOD Dependence Treatment* | |
| *Initiation of AOD Treatment—Total* | 1/2 |
| *Engagement of AOD Treatment—Total* | 1/2 |
| *Follow-Up After EDED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total* | 1 |
| *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* | 1 |
| *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* | 1 |
| *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* | 1 |
| *Antidepressant Medication Management* | |
| *Effective Acute Phase Treatment* | 1/2 |
| *Effective Continuation Phase Treatment* | 1/2 |
| **Taking Care of Children** | |
| *Childhood Immunization Status—Combination 3* | 1 |
| *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* | 1 |

| Measure | Measure Weight |
|---|---|
| *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits* | 1 |
| *Child and Adolescent Well-Care Visits* | |
| *3–11 Years* | 1 |
| *12–17 Years* | 1 |
| *18–21 Years* | 1 |
| *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* | |
| *BMI Percentile Documentation—Total* | 1/3 |
| *Counseling for Nutrition—Total* | 1/3 |
| *Counseling for Physical Activity—Total* | 1/3 |
| *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* | 1 |
| **Living With Illness** | |
| *Comprehensive Diabetes Care* | |
| *HbA1c Testing* | 1/5 |
| *HbA1c Poor Control (>9.0%)* | 1/5 |
| *HbA1c Control (<8.0%)* | 1/5 |
| *Eye Exam (Retinal) Performed* | 1/5 |
| *Blood Pressure Control (<140/90 mm Hg)* | 1/5 |
| *Controlling High Blood Pressure* | 1 |
| *Asthma Medication Ratio—Total* | 1 |
| *Pharmacotherapy Management of COPD Exacerbation* | |
| *Systemic Corticosteroid* | 1/2 |
| *Bronchodilator* | 1/2 |
| *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* | 1 |
| *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* | 1 |

## *Missing Values*

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

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

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

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

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

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

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

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

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

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

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

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

3. For MCOs with *NA* or *NR* audit results, HSAG used the average variance of the non-missing rates across all MCOs. This ensured that all rates reflected some level of variability, rather than simply omitting the missing variances in subsequent calculations.
4. HSAG computed the MCO composite mean for each CAHPS and HEDIS measure.
5. Each MCO mean (CAHPS or HEDIS) was standardized by subtracting the mean of the MCO means and dividing by the standard deviation of the MCO means to give each measure equal weight toward the category rating. If the measures were not standardized, a measure with higher variability would contribute disproportionately toward the category weighting.
6. HSAG summed the standardized MCO means, weighted by the individual measure weights to derive the MCO category summary measure score.
7. For each MCO *k*, HSAG calculated the category variance, $CV_k$ as:

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

where: $j$ = 1,…,*m* HEDIS or CAHPS measures in the summary
$V_j$ = variance for measure j

$c_j$ = group standard deviation for measure j

$w_j$ = measure weight for measure j

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

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

where: $P$ = total number of MCOs

$CV_k$ = category variance for MCO *k*

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

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

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

## How Conclusions Were Drawn

A five-level rating scale provides consumers with an easy-to-read "picture" of quality performance across MCOs and presents data in a manner that emphasizes meaningful differences between MCOs.

Table B-19 shows how the CCC Plus Consumer Decision Support Tool displays results were displayed:

**Table B-19—CCC Plus Consumer Decision Support Tool—Performance Ratings**

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

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

# Performance Withhold Program Methodology

## *Objectives*

DMAS selected the following four HEDIS measures (11 measure indicators) and two CMS Adult Core Set measures (two measure indicators) for the PWP within the domains indicated in Table B-20.

**Table B-20—PWP Measures**

| Measure Indicator | Measure Specification | Required Reporting Method |
|---|---|---|
| **Behavioral Health** | | |
| *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* | HEDIS | Administrative |
| *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* | HEDIS | Administrative |
| *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total* and *Engagement of AOD Treatment—Total—Total* | HEDIS | Administrative |
| **Chronic Conditions** | | |
| *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)* | HEDIS | Hybrid |
| *COPD or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)—Total* | CMS Adult Core Set | Administrative |
| *Heart Failure Admission Rate (Per 100,000 Member Months)—Total* | CMS Adult Core Set | Administrative |

## Performance Period

The SFY 2022 PWP assesses CY 2021 PM data (i.e., the PMs will be calculated following HEDIS MY 2021 and CMS FFY 2022 Adult Core Set specifications that use a CY 2021 measurement period) to determine what portion, if any, the MCOs will earn back from the funds withheld in SFY 2022 (i.e., the 1 percent of capitation payments withheld from July 1, 2021, through June 30, 2022).

## Technical Methods of Data Collection and Description of Data Obtained

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

## How Data Were Aggregated and Analyzed

### PWP Calculation

The following sections provide a detailed description and examples of the PWP scoring and quality withhold funds model for the SFY 2022 PWP (i.e., the initial performance year). With receipt of audited HEDIS measure rates and validated CMS Adult Core Set measure rates (i.e., non-HEDIS measure rates), each measure will be scored prior to calculating the amount of the quality withhold, if any, each MCO will earn back.

Only measure rates with a "*Reportable (R)*" (HEDIS and non-HEDIS rates) audit result (i.e., the plan produced a reportable rate for the measure in alignment with the technical specifications) will be included in the PWP calculation. Measure rates with a "*Small Denominator (NA)*" (HEDIS rates only) audit result (i.e., the plan followed the specifications, but the denominator was too small to report a valid rate) will be excluded from the PWP calculation. Measure rates with any audit result other than "*Reportable (R)*" or "*Small Denominator (NA)*" will receive a score of zero (i.e., the MCO will not be eligible to earn a portion of the quality withhold back for that measure).

### SFY 2022 PWP

As indicated above, the SFY 2022 PWP is the initial performance period and will use the MCOs' audited HEDIS MY 2021 and validated CMS FFY 2022 Adult Core Set PM data. Table B-21 shows the percentage of withhold associated with each PM indicator.

**Table B-21—SFY 2022 PWP Measure Weights**

| Measure Indicator | Measure Weight |
|---|---|
| **Behavioral Health** | |
| *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* | 15% |

| Measure Indicator | Measure Weight |
|---|---|
| *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* | 20% |
| *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total* and *Engagement of AOD Treatment—Total—Total* | 15% |
| **Chronic Conditions** | |
| *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%),* HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)* | 20% |
| *COPD or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)—Total** | 15% |
| *Heart Failure Admission Rate (Per 100,000 Member Months)—Total** | 15% |

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

## *Scoring Methods*

The next several sections describe the PWP calculation method for the SFY 2022 PWP (i.e., the initial performance year).

### Indicator Partial Score

For SFY 2022 (i.e., the initial performance year), the performance scores for the Adult Core Set measures will be determined by comparing the rate for the current year to CY 2019 rates and calculating the relative difference.[B-33] Beginning with the SFY 2023 PWP and forward, DMAS will attempt to set benchmarks for the CMS Adult Core Set measures, based on available data from prior years, for determining CCC Plus MCO performance scores. However, this process will need to account for, and better understand, the future availability of such data and the impact of COVID-19 on such data in designated years before committing to such benchmarks. Table B-22 presents the possible scores for each CMS Adult Core Set indicator based on MCO performance. For both CMS Adult Core Set measures, a lower rate indicates better performance.

**Table B-22—PWP CMS Adult Core Set Indicator Scoring**

| Criteria for Each Indicator | Score |
|---|---|
| MCO's rate either declined or demonstrated a relative improvement of less than 2 percent from CY 2019 | 0.00 |
| MCO's rate demonstrated relative improvement of at least 2 percent but less than 4 percent from CY 2019 | 0.25 |

[B-33] Due to the impact COVID-19 will likely have on the CY 2020 rates, DMAS has elected to use the CY 2019 rates as a comparison to the current year rates.

| Criteria for Each Indicator | Score |
|---|---|
| MCO's rate demonstrated relative improvement of at least 4 percent but less than 6 percent from CY 2019 | 0.50 |
| MCO's rate demonstrated relative improvement of at least 6 percent but less than 8 percent from CY 2019 | 0.75 |
| MCO's rate demonstrated relative improvement of at least 8 percent from CY 2019 | 1.00 |

CMS Adult Core Set indicator rates that demonstrate a decline in performance from CY 2019 (i.e., the rate increases) or a relative improvement from CY 2019 of less than 2 percent will receive a score of zero (i.e., no portion of the quality withhold will be earned back for this indicator). Indicator rates that demonstrate at least 2 percent will receive at least 0.25 points up to a maximum of 1 point for relative improvement at or above 8 percent. The relative difference will be derived using the following formula, keeping in mind that a current year rate that is lower than the CY 2019 rate indicates an improvement in performance:

$$Relative\ Difference\ = \left[\frac{(MCO\ CY\ 2019\ Rate\ -\ MCO\ Current\ Year\ Rate)}{MCO\ CY\ 2019\ Rate}\right] \times 100$$

The performance scores for the HEDIS measures will be determined by comparing each rate to NCQA's Quality Compass national Medicaid HMO percentiles (referred to in this document as percentiles).

Table B-23 presents the possible scores for each HEDIS indicator based on the MCO performance for the current year. Rates will be rounded to two decimals prior to comparing to the percentiles and determining the measure score, and no scores will be dropped.

**Table B-23—PWP HEDIS Indicator Scoring**

| Criteria for Each Indicator | Score |
|---|---|
| MCO's rate is below the 25th percentile | 0 |
| MCO's rate is at or above the 25th percentile but below the 50th percentile | Between 0 and 1 |
| MCO's rate is at or above the 50th percentile | 1 |

HEDIS indicator rates that are below the 25th percentile will receive a score of zero (i.e., no portion of the quality withhold will be earned for this indicator). Indicator rates that are at or above the 50th percentile will receive the maximum score for that indicator (i.e., 1 point). If an indicator rate is at or above the 25th percentile but below the 50th percentile, the MCO will be eligible to receive a partial score (i.e., a partial point value that falls between 0 and 1). To calculate the partial points at the indicator level, each MCO's rate will be compared to the percentiles to determine how close the MCO's rate is to the 50th percentile. In future iterations of the PWP, the minimum performance level (i.e., 25th percentile) may increase to encourage continued positive performance and QI. The partial score for each measure will be derived using the following formula:

$$Partial\ Point\ Value = \left[\frac{(MCO\ Rate - 25th\ Percentile)}{(50th\ Percentile - 25th\ Percentile)}\right]$$

For example, if the 25th percentile is 40 percent and the 50th percentile is 60 percent, and an MCO has a rate of 55 percent for an indicator, then the partial point value is calculated as follows:

$$Partial\ Point\ Value = \left[\frac{(55 - 40)}{(60 - 40)}\right] = 0.75$$

## Improvement Bonus

For the CMS Adult Core Set measure indicators, DMAS will determine an appropriate method of assigning improvement bonus points for the SFY 2023 PWP, if applicable.

For the SFY 2022 PWP, MCOs that failed to meet the 50th percentile in CY 2019 (i.e., HEDIS 2020 data) for a HEDIS indicator may be eligible to earn an improvement bonus if an indicator rate demonstrates substantial improvement from CY 2019.[B-34] Substantial improvement will be defined as 20 percent of the difference between the 25th and 50th percentile. An improvement bonus of 0.25 points will be awarded for each indicator, if the MCO was below the 50th percentile in CY 2019 and the following is true:

$$|\ MCO\ Current\ Rate - MCO\ CY\ 2019\ Rate\ | \geq \left|\left[\frac{(50th\ Percentile - 25th\ Percentile)}{5}\right]\right|$$

For each MCO, HSAG will assess which indicator rates are eligible for an improvement determination. HSAG will only determine improvement bonus eligibility if an indicator meets the following criteria:

- The MCO current year rate demonstrated an improvement from the CY 2019 rate.
- The MCO reported the indicator rate in both the current year and CY 2019.
- The MCO's reported indicator rate was below the 50th percentile in CY 2019.
- The MCO reported the indicator rate using the same reporting methodology in both years (e.g., the reporting methodology did not change from administrative in CY 2019 to hybrid in the current year).
- NCQA did not recommend a break in trending for the indicator due to a change in the technical specifications for the Medicaid product line.

If an MCO demonstrates substantial improvement for an indicator rate and meets all criteria for improvement bonus determinations, then the MCO will receive an improvement bonus for that indicator.

## High Performance Bonus

For the CMS Adult Core Set measure indicators, DMAS will determine an appropriate method of assigning high performance bonus points for future iterations of the PWP, if applicable.

[B-34] In future iterations of the PWP, the improvement bonus will be based on improvement over the prior year; however, this methodology skips CY 2020 due to the impact of COVID-19 on MCO performance and measure results.

For the SFY 2022 PWP, if an MCO demonstrates a strong performance trend over time for a HEDIS indicator, the MCO will be eligible for a high performance bonus. The high performance bonus will be awarded for indicator rates that exceed the 66.67th percentile for both the current year and CY 2019.[B-35] Each indicator rate that ranks above the 66.67th percentile for the current year and CY 2019 will be eligible for a maximum high performance bonus of 0.25 points that will be added to the indicator partial score described above (i.e., 1 point).

## *How Conclusions Were Drawn*

### Scoring Model Example

Table B-24 and Table B-25 provide examples of how indicator partial scores will be determined, by MCO. All data presented in the tables below (both measure rates and percentile values) are mock data and do not represent actual data or results.

**Table B-24—Indicator Partial Score Calculations—HEDIS Measures**
**(Example Using Mock Data)**

| Indicator | Current Year Rate | 25th Percentile | 50th Percentile | Indicator Partial Score |
|---|---|---|---|---|
| **Behavioral Health** | | | | |
| ***Follow-Up After ED Visit for AOD Abuse or Dependence*** | | | | |
| *7-Day Follow-Up—Total* | 6.94% | 6.25% | 9.73% | **0.20** |
| *30-Day Follow-Up—Total* | 11.04% | 9.89% | 15.25% | **0.21** |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | |
| *7-Day Follow-Up—Total* | 46.22% | 29.21% | 35.49% | **1** |
| *30-Day Follow-Up—Total* | 58.92% | 43.17% | 51.45% | **1** |
| ***Initiation and Engagement of AOD Abuse or Dependence Treatment*** | | | | |
| *Initiation of AOD Treatment—Total—Total* | 42.26% | 39.25% | 41.99% | **1** |
| *Engagement of AOD Treatment—Total—Total* | 11.16% | 9.53% | 11.01% | **1** |
| **Chronic Conditions** | | | | |
| ***Comprehensive Diabetes Care*** | | | | |
| *HbA1c Testing* | 82.44% | 85.36% | 86.44% | **0** |
| *HbA1c Poor Control (>9.0%)** | 50.70% | 45.55% | 38.66% | **0** |

[B-35] In future iterations of the PWP, the high performance bonus will be based on sustained high performance over the prior year; however, this methodology skips CY 2020 due to the impact of COVID-19 on MCO performance and measure results.

| Indicator | Current Year Rate | 25th Percentile | 50th Percentile | Indicator Partial Score |
|---|---|---|---|---|
| *HbA1c Control (<8.0%)* | 54.74% | 44.11% | 51.22% | **1** |
| *Eye Exam (Retinal) Performed* | 42.68% | 41.77% | 52.00% | **0.09** |
| *Blood Pressure Control (<140/90 mm Hg)* | 53.00% | 50.23% | 54.55% | **0.64** |

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

**Table B-25—Indicator Partial Score Calculations—CMS Adult Core Set Measures**
**(Example Using Mock Data)**

| Indicator | CY 2019 Rate | Current Year Rate | Relative Difference | Indicator Partial Score |
|---|---|---|---|---|
| **Chronic Conditions** | | | | |
| ***COPD or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)**** | | | | |
| *Total* | 129.89 | 121.23 | 6.67% | **0.75** |
| ***Heart Failure Admission Rate (Per 100,000 Member Months)**** | | | | |
| *Total* | 135.31 | 119.24 | 11.88% | **1** |

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

The indicator partial scores for the HEDIS measures are calculated by first determining the applicable percentile level for the indicator rate. For example, the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* indicator received an indicator partial score of one point because the rate (46.22 percent) is above the 50th percentile (35.49 percent). For the CMS Adult Core Set measures, the indicator partial scores are derived by comparing the relative difference between the current year and CY 2019 (i.e., improvement less than 2 percent receives zero points; at or above 2 percent but below 4 percent improvement receives 0.25 points; at or above 4 percent but below 6 percent improvement receives 0.50 points; at or above 6 percent but below 8 percent improvement receives 0.75 points; and at or above 8 percent improvement receives 1 point). For example, the *COPD or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)—Total* indicator receives an indicator partial score of 0.75 because the relative difference (6.67 percent) was at or above 6 percent but less than 8 percent.

Table B-26 provides an example of how the improvement bonus scores will be determined by MCO based on performance for the current year and CY 2019 for the HEDIS measures. Improvement bonus determinations for the CMS Adult Core Set measures will be evaluated for future iterations of the PWP.

**Table B-26—Indicator Improvement Bonus Score Calculations—HEDIS Measures**
**(Example Using Mock Data)**

| Indicator | CY 2019 Rate | Current Year Rate | Rate Difference | Substantial Improvement Value | Below 50th Percentile in CY 2019 | Met Substantial Improvement | Improvement Bonus† |
|---|---|---|---|---|---|---|---|
| **Behavioral Health** | | | | | | | |
| ***Follow-Up After ED Visit for AOD Abuse or Dependence*** | | | | | | | |
| *7-Day Follow-Up—Total* | 5.66% | 6.94% | 1.28% | 0.70% | Y | Y | 0.25 |
| *30-Day Follow-Up—Total* | 11.42% | 11.04% | -0.38% | 1.07% | Y | N | 0 |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | | | | |
| *7-Day Follow-Up—Total* | 45.12% | 46.22% | 1.10% | 1.26% | N | N | 0 |
| *30-Day Follow-Up—Total* | 59.67% | 58.92% | -0.75% | 1.66% | N | N | 0 |
| ***Initiation and Engagement of AOD Abuse or Dependence Treatment*** | | | | | | | |
| *Initiation of AOD Treatment—Total—Total* | 41.68% | 42.26% | 0.58% | 0.55% | N | Y | 0 |
| *Engagement of AOD Treatment—Total—Total* | 11.11% | 11.16% | 0.05% | 0.30% | Y | N | 0 |
| **Chronic Conditions** | | | | | | | |
| ***Comprehensive Diabetes Care*** | | | | | | | |
| *HbA1c Testing* | 80.68% | 82.44% | 1.76% | 0.22% | Y | Y | 0.25 |
| *HbA1c Poor Control (>9.0%)** | 52.26% | 50.70% | -1.56% | -1.38% | Y | Y | 0.25 |
| *HbA1c Control (<8.0%)* | 57.41% | 54.74% | -2.67% | 1.42% | N | N | 0 |
| *Eye Exam (Retinal) Performed* | 44.27% | 42.68% | -1.59% | 2.05% | Y | N | 0 |
| *Blood Pressure Control (<140/90 mm Hg)* | 53.25% | 53.00% | -0.25% | 0.86% | Y | N | 0 |

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

*†A measure indicator is eligible for an improvement bonus if the indicator rate was below the 50th percentile in CY 2019 and the indicator rate demonstrated substantial improvement from CY 2019.*

Table B-27 provides an example of how the high performance bonus scores will be determined, by MCO, based on performance for the current year and CY 2019 for the HEDIS measures. Once the high performance bonus scores are determined, the indicator partial score, the improvement bonus score,

and high performance bonus score (i.e., 0 or 0.25) will be summed to obtain the final indicator score. High performance bonus determinations for the CMS Adult Core Set measures will be evaluated for future iterations of the PWP.

**Table B-27—High Performance Bonus Score Calculations—HEDIS Measures**
**(Example Using Mock Data)**

| Indicator | CY 2019 Rate | CY 2019 66.67th Percentile | Current Year Rate | Current Year 66.67th Percentile | High Performance Bonus | | |
|---|---|---|---|---|---|---|---|
| | | | | | CY 2019 | Current Year | Points Earned |
| **Behavioral Health** | | | | | | | |
| ***Follow-Up After ED Visit for AOD Abuse or Dependence*** | | | | | | | |
| *7-Day Follow-Up—Total* | 5.66% | 10.85% | 6.94% | 11.01% | N | N | 0 |
| *30-Day Follow-Up—Total* | 11.42% | 15.30% | 11.04% | 15.75% | N | N | 0 |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | | | | |
| *7-Day Follow-Up—Total* | 45.12% | 45.01% | 46.22% | 44.95% | Y | Y | 0.25 |
| *30-Day Follow-Up—Total* | 59.67% | 54.66% | 58.92% | 55.79% | Y | Y | 0.25 |
| ***Initiation and Engagement of AOD Abuse or Dependence Treatment*** | | | | | | | |
| *Initiation of AOD Treatment—Total—Total* | 41.68% | 47.00% | 42.26% | 48.04% | N | N | 0 |
| *Engagement of AOD Treatment—Total—Total* | 11.11% | 12.16% | 11.16% | 12.13% | N | N | 0 |
| **Chronic Conditions** | | | | | | | |
| ***Comprehensive Diabetes Care*** | | | | | | | |
| *HbA1c Testing* | 80.68% | 87.23% | 82.44% | 86.95% | N | N | 0 |
| *HbA1c Poor Control (>9.0%)** | 52.26% | 33.23% | 50.70% | 34.15% | N | N | 0 |
| *HbA1c Control (<8.0%)* | 57.41% | 53.48% | 54.74% | 54.51% | Y | Y | 0.25 |
| *Eye Exam (Retinal) Performed* | 44.27% | 57.16% | 42.68% | 58.02% | N | N | 0 |

| Indicator | CY 2019 Rate | CY 2019 66.67th Percentile | Current Year Rate | Current Year 66.67th Percentile | High Performance Bonus | | |
|---|---|---|---|---|---|---|---|
| | | | | | CY 2019 | Current Year | Points Earned |
| *Blood Pressure Control (<140/90 mm Hg)* | 53.25% | 56.12% | 53.00% | 57.89% | N | N | 0 |

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

Table B-28 shows the measure-level score calculations for each MCO by determining the average of the indicator-level scores for each measure.

**Table B-28—Measure-Level Score Calculations**
**(Example Using Mock Data)**

| Indicator | Indicator-Level Score | Improvement Bonus | High Performance Bonus | Final Indicator Score | Measure-Level Score |
|---|---|---|---|---|---|
| **Behavioral Health** | | | | | |
| ***Follow-Up After ED Visit for AOD Abuse or Dependence*** | | | | | |
| *7-Day Follow-Up—Total* | 0.20 | 0.25 | 0 | 0.45 | **0.33** |
| *30-Day Follow-Up—Total* | 0.21 | 0 | 0 | 0.21 | |
| ***Follow-Up After ED Visit for Mental Illness*** | | | | | |
| *7-Day Follow-Up—Total* | 1 | 0 | 0.25 | 1.25 | **1.25** |
| *30-Day Follow-Up—Total* | 1 | 0 | 0.25 | 1.25 | |
| ***Initiation and Engagement of AOD Abuse or Dependence Treatment*** | | | | | |
| *Initiation of AOD Treatment—Total—Total* | 1 | 0 | 0 | 1 | **1** |
| *Engagement of AOD Treatment—Total—Total* | 1 | 0 | 0 | 1 | |
| **Chronic Conditions** | | | | | |
| ***Comprehensive Diabetes Care*** | | | | | |
| *HbA1c Testing* | 0 | 0.25 | 0 | 0.25 | **0.50** |
| *HbA1c Poor Control (>9.0%)* | 0 | 0.25 | 0 | 0.25 | |
| *HbA1c Control (<8.0%)* | 1 | 0 | 0.25 | 1.25 | |
| *Eye Exam (Retinal) Performed* | 0.09 | 0 | 0 | 0.09 | |

| Indicator | Indicator-Level Score | Improvement Bonus | High Performance Bonus | Final Indicator Score | Measure-Level Score |
|---|---|---|---|---|---|
| *Blood Pressure Control (<140/90 mm Hg)* | 0.64 | 0 | 0 | 0.64 | |
| ***COPD or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)*** | | | | | |
| *Total* | 0.75 | NE | NE | 0.75 | **0.75** |
| ***Comprehensive Diabetes Care*** | | | | | |
| *Total* | 1 | NE | NE | 1 | **1** |

*NE indicates the measure is not eligible for an Improvement Bonus or High Performance Bonus, at this time.*

As shown above, the *Follow-Up After ED Visit for AOD Abuse or Dependence* measure-level score (0.33) was obtained by averaging the indicator-level scores for *7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* (0.45 and 0.21, respectively). Table B-29 provides an example of how the percentage of the quality withhold is derived (i.e., overall withhold earned) based on the six measure-level scores calculated above. The percentage of the quality withhold that the MCO is eligible to earn back is calculated by multiplying the measure-level score with the applicable measure weight and then summing the measure withhold earned values together. An MCO is not able to earn back more than 100 percent of its total withhold amount. If an overall withhold amount is greater than 100 percent (due to bonus points), the overall withhold earned will be reduced to 100 percent.

**Table B-29—Percentage Withhold Earned**
**(Example Using Mock Data)**

| Indicator | Measure-Level Score | Weight | Measure Withhold Earned | Overall Withhold Earned† |
|---|---|---|---|---|
| *Follow-Up After ED Visit for AOD Abuse or Dependence* | 0.33 | 15% | 4.95% | **81.20%** |
| *Follow-Up After ED Visit for Mental Illness* | 1.25 | 20% | 25.00% | |
| *Initiation and Engagement of AOD Abuse or Dependence Treatment* | 1.00 | 15% | 15.00% | |
| *Comprehensive Diabetes Care* | 0.50 | 20% | 10.00% | |
| *COPD or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)* | 0.75 | 15% | 11.25% | |
| *Heart Failure Admission Rate (Per 100,000 Member Months)* | 1.00 | 15% | 15.00% | |

†*Please note, the Measure Withhold Earned may not sum to the Overall Withhold Earned due to rounding.*

## Quality Withhold Funds Model

The quality withhold percentage is 1 percent of the total MCO capitation payments for the year. An MCO is eligible to earn the entire quality withhold by having 100 percent for the overall withhold as shown (i.e., the MCO would not lose any quality withhold funds).

**Table B-30—PWP Funds Allocation**
**(Example Using Mock Data)**

| MCO Name | Total Capitation Payment | Maximum At-Risk Amount (1% Withhold) | Percentage Withhold Earned | Final Withhold Earned Back Amount |
|---|---|---|---|---|
| **MCO** | $735,790,000.00 | $7,357,900.00 | 81.20% | $5,974,614.80 |

As shown in Table B-30, the 1 percent at risk amount for the example MCO is $7,357,900.00. The MCO earned 81.20 percent of the quality withhold through the review of the HEDIS and Adult Core Set measure indicator rates, thus the MCO is eligible to receive $5,974,614.80 of the quality withhold according to the following equation:

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

# Appendix C. MCO Best and Emerging Practices

Table C-1 identifies the MCOs' self-reported best and emerging practices. The narrative within the table was provided by the MCOs and has not been altered by HSAG except for minor formatting.

**Table C-1—MCOs' Best and Emerging Practices**

| MCO | Best and Emerging Practices |
|---|---|
| **Aetna** | **Topic/Title:** Moving On: Transitioning from Pediatrics to Primary Care Incentives<br>**Description:** Aetna Better Health of Virginia encourages young adult members to take the next steps in managing their healthcare needs and provide a resource for recommended screenings and adult vaccinations. Young adults aged 18-20 years that are preparing to transition from pediatric to adult primary care can earn a gift card for seeing primary adult health care.<br><br>**Topic/Title:** ARTS High-Utilizer Pilot Program<br>**Description:** An integrative pilot program that outreaches to members who are utilizing high levels of ASAM care and are often resistant to engage in the program or are unable to reach. Specific focus is placed on members identified as high utilizers of Addiction Recovery and Treatment Services based on three or more distinct admissions to inpatient or residential levels of care within the last six months.<br><br>**Topic/Title:** High Utilizers of Virginia (HUV) Program<br>**Description:** The Virginia Department of Behavioral Health and Development Services (DBHDS) in conjunction with Community Based Coordination Solutions (CBCS) launched a HUV program that emphasizes in-person engagement with individuals at time of program enrollment, engagement and coordination with local resources, 24/7/365 program access for enrollees, including crisis availability, close follow-up with participants after every provider encounter, close coordination with the collective medical tools, and customized care plans. The program is intended to improve enrollee care, decrease duplicative care efforts among providers, reduce mental health admissions, general hospital admissions, ED visits, and overall cost of care for and among participants.<br><br>**Topic/Title:** Member Services Post-Call Survey<br>**Description:** Offers members the opportunity to provide feedback through post-call survey following the completion of all customer service representative calls.<br><br>**Topic/Title:** Addressing Social Determinants of Health<br>**Description:** Aetna Better Health of Virginia also initiated the use of a social determinants of health (SDoH) software application to assist in identifying specific |

| MCO | Best and Emerging Practices |
|---|---|
| | needs in each region and using *FindHelp* to assist members in finding resources for health care inequities. |
| **HealthKeepers** | **Topic/Title:** Social Drivers of Health Program Provider Incentive Program (SDOHPIP)<br><br>**Description: Provider Incentive Program**<br>Effective July 2020, Anthem started a provider incentive program (SDOHPIP), collaborating with providers across the state. The goal of this program is to engage providers to address SDOH needs that research is showing impacts clinical needs. When these providers identify SDOH needs they can work with their patient to address the obstacle with the goal to make an impact on clinical care as well. This supports a holistic view of the member's needs. To do this we educate providers regarding SDOH needs, identify resources surrounding the provider's office, and incentivize the providers for documenting z codes corresponding to food and housing, assessing, referring, and following up on referrals to close the loop.<br><br>**Topic/Title:** Stepping-Stones Program<br><br>**Description:** HealthKeepers, Inc. recognizes that barriers in communication about, knowledge of, and access to available community resources impact members' quality of life. HealthKeepers also realizes that members need support from community-based organizations (CBOs) in addition to their health insurance plan. HealthKeepers wants to be the link that supports both the CBO partners and Anthem HealthKeepers Plus, Medallion and Anthem HealthKeepers Plus, Commonwealth Coordinated Care Plus (Anthem CCC Plus) members, and to bridge the communication gap. HealthKeepers, Inc. strives to support the community organizations that are making a difference in the lives of members each and every day, and this is why HealthKeepers is rolling out the Stepping Stones Program. The goal of Stepping Stones is to break barriers, support CBOs, and promote communication to empower the community and impact the quality of life for both Anthem HealthKeepers Plus members and the organizations that provide them with stepping stones to better lives.<br>• HealthKeepers, Inc. supports CBOs by identifying a CBO need and working to provide supportive funding for things such as a library for an employment agency, funds to purchase meals for a food bank, computers for a housing agency, or blankets and pillows for an emergency shelter.<br>• CBOs use the funds the best way for their organization and partner with HealthKeepers, Inc. to share HEDIS® information, use f *FindHelp*, and refer Anthem HealthKeepers Plus members for assistance as needed. The CBO follows up with HealthKeepers, Inc. to share how the support helped.<br>• *FindHelp*, The social care network, available at https://www.findhelp.org, connects anyone in need to free and reduced-cost programs in their local area. *FindHelp* provides free tools and free support to CBOs to manage their programs, respond to requests for services, and track/report on outcomes.<br><br>**Topic/Title:** SDOH *FindHelp* Partnership |

| MCO | Best and Emerging Practices |
|---|---|
| | **Description:** Anthem is engaged in a partnership with FindHelp to bring knowledge and community resource together for assisting members who have SDOH needs. FindHelp is an online community resources tool, which allows both member and associates to have access to FindHelp's expansive and updated list of resources for assisting members. This partnership allows Anthem to affect food security, housing, and employment needs for members in an efficient and uniform way. Utilizing this partnership allows Anthem and *FindHelp* to identify which partnerships are being referred more than others, which members are receiving referrals, which determinants are receiving referrals. This partnership allows Anthem and *FindHelp* to work together to create automatic note types within Anthem's system straight from the referrals website so that care coordinators and case managers receive a dated and timed record of the outreach in the documentation platform. This partnerships aids in the ability for the care coordinator or case manager to follow up with the member and ensure the referral was successful.<br><br>**Topic/Title:** Network Tables<br><br>**Description:** A network table is a group of volunteers trained to form a "network table" and access social networks in their community (social capital) to link supports, including relationships, goods and services to the specific need of a partner organization or friend (Anthem HealthKeepers Plus Member). Based on the project, network tables access their social capital and community networks to solve one specific challenge at a time (called a priority support) for a defined number of friends. The friend may be an individual or family being served by the partner organization that can benefit from access to the relational and social capital available in the community. The friend is identified and determined by the partner organization through a care coordinator, case manager, or other organizational representative. Network tables range from 8-12 volunteers. Network tables can work to solve the challenges of multiple friends simultaneously.<br><br>**Topic/Title:** Population Health Sprint<br><br>**Description:** HealthKeepers Inc. completed a population health sprint that was comprised of three separate work groups with representation from across the health plan in maternity, behavioral health, and physical health. Within these groups, measurable goals are being formulated along with objectives and interventions. By utilizing the Virginia population health analysis, the health plan can focus on not only the state specific priorities, but ensure equitable, whole person healthcare across membership.<br><br>**Topic/Title:** FUSE<br><br>**Description:** HealthKeepers Inc. has partnered with the FUSE team to discuss how the health plan can move towards further whole-person health/integration. Several general areas of opportunity have been identified with a detailed work plan expected that will outline suggestions and ideas for optimal integration. The |

| MCO | Best and Emerging Practices |
|---|---|
| | Virginia market will utilize the FUSE team in a consultant capacity for a period and continued to work with assigned regional vice president's and the governance board to ensure solid strategy leading to maximized outcomes. |
| **Molina** | **Topic/Title:** Pay for Quality (P4Q) Program<br>**Description:** Molina chose a set of select, but critical, quality measures for 2022 that were included in this incentive program. The MCO will pay the primary care group of record a dollar amount per each compliant member after that provider achieves the 50th percentile benchmark for that measure for their assigned panel.<br><br>**Topic/Title:** Clinic Day<br>**Description:** Molina partnered with community providers by holding clinic day events for its members. The clinic day offered a fun way to encourage members to:<br>• Obtain the health services they needed<br>• Improve health outcomes.<br>• Improve HEDIS score/close care gaps.<br>• Improve member/provider experience<br>Molina's approach included identification of members in need of care, offering healthcare access to members by connecting them with PCPs and providing health education. All these activities contributed to improved overall health outcome and experience. Molina's partner with providers to schedule new and/or existing member appointments, arranging transportation service, and performing reminder calls. As a result, the MCO reduced administrative burden on provider office staff, decreased no-show rates, and improved member/provider experience.<br><br>**Topic/Title:** Provider Network and Quality Partnership<br>**Description:** Molina's quality team in collaboration with the provider network team to identify and target providers in each region to build relationships, provider health plan education, and improve member health outcomes and overall patient satisfaction. |
| **Optima** | **Topic/Title:** Clinical Care Services<br>**Description:** Best Practices<br>• Weekly medical and behavioral care coordination/case management rounds with medical directors<br>• Quarterly baby showers<br>• Quarterly outreach member advisory forums (currently virtual)<br>• Dedicated Optima readmission prevention team with (CipherHealth) to conduct hospital and ED post-discharge follow-up calls to members to assist with any member-identified concerns (home health, medications, discharge instructions, etc.<br>• Case management/care coordination care gap dashboard (Tableau) to assist in identifying and closing care gaps when engaging with members |

| MCO | Best and Emerging Practices |
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| | • Partners in pregnancy (PIP) program<br>• Performance Withhold Program monthly tracking dashboard (Tableau)<br>• Multidisciplinary team approach to improvement in quality measures, meeting monthly<br>• Vendor/partners in care: EMMI, CipherHealth, BioIQ, MDLive, Prealize, Integrated Eye Group (IEG), Ontrak, Lexus Nexus, Focus Care in-home assessments, Progeny, Accordant, Inogen, Optum, Alere, Dario, Carenet<br>• Focused EPSDT care coordination<br>• Behavioral Health member engagement program to improve follow-up visits with providers after ED visits<br>• Dedicated behavioral health transition of care coordinators<br>• Focused vendors for community partners in member care: Urban Baby Beginnings, CHIP, Healthy Families, Southeast trans for medical/behavioral health/non-medical transportation, nurse family partnership<br>• Focused community partners for improving social determinants of health (SDOH): United Us, local food banks, religious organizations, Salvation Army, STOP Inc (rent, utility assistance), VDH baby care programs, local shelters, local woman's shelters, GED program with financial voucher<br>• Readmission high-risk discharge Target and Intervention Committee<br>• Power hour for all staff to provide weekly educational sessions (examples: Asthma, COPD, diabetes, motivational interviewing, policy, and documentation updates, etc.)<br>• Follow-up post-discharge activities (Cipher)<br>• Focused workgroups to impact DMAS clinical efficiency measures:<br>– LANE<br>– PPA<br>– Readmissions<br>• Staff training:<br>– NCQA standards and HEDIS training for Medallion case management<br>– Annual Medicare and Dual Eligible Special Needs Plan (DSNP) model of care/product training<br>– Change management and building resilience training<br>• Increased access for remote services for staff and members related to COVID<br>• Automated EMMI campaigns (educational videos for members) - postpartum<br>• Monthly collaboration with Prealize for case studies and process improvements<br>• MCO Collaboratives with Virginia health information (VHI)<br>• Collaborative stakeholder with Brock Institute at Eastern Virginia Medical School for Substance Use Disorder in Pregnant Moms and Parenting Women<br>• DMAS/Optima COVID collaboration to improve member education and access to testing and vaccination<br>• Collaborative partners with DMAS MCO EI Workgroup and DMAS MCO Foster Care Workgroup<br>• Targeted behavioral health care coordination focusing on inpatient discharges, Emergency room utilization and high-risk readmission member focus from behavioral health facilities. |

| MCO | Best and Emerging Practices |
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| | • Targeted case management for justice-involved members<br>• Quarterly behavioral health provider education launched through the "Now Let's Talk!" virtual platform<br>• Value-based agreements with providers to promote "Best In Class" outcomes for our behavioral health and substance abuse members<br>**Description:** Emerging Practices<br>• Collaboration with the Virginia Department of Health Diabetes Prevention Program to offer targeted services to members at-risk for diabetes<br>• Collaboration with Virginia Beach Department of Health Community Education Series to target pregnant members<br>• Vendor/partners in care: Ovia, Focus care in-home assessments<br>• Interdepartmental committee evaluating enhanced member benefits for 2023 to improve SDOH<br>• Interdepartmental collaboration for improved regulatory and internal reporting processes and data collection<br>• Increased focus on SDOH and health equities with creation of a focused SDOH team collaborating with medical and behavioral utilization management/case management departments<br>• New electronic medical record system with increased capturing of social determinants of health<br>• Chronic condition and social determinants of health risk factor monthly tracking dashboard (Tableau)<br>• Focused workgroup to target childhood vaccine hesitancy<br>• New doula benefit to augment member benefits and provide additional support during pregnancy and the post-partum period<br>• Post discharge meal benefit for members (Nations Food)<br>• Prosphire Consulting Group for enhancement of chronic condition management program<br>• Care plan alignment for chronic condition management<br>• Transition of care enhancement for Medicaid products<br>• Integrated behavioral health coaching for members identified through predictive analytics to be a potential risk for developing anxiety, depression, substance, or alcohol abuse along with those members identified as high-cost and high-needs members<br>• Culturally diverse integrated case management focused on adults and adolescents in the seven tribal communities across Virginia<br>• Targeted behavioral health case management for pregnant and parenting members with substance use disorders<br><br>**Topic/Title:** Quality HEDIS Team<br>**Description:**<br>• Implemented year-long medical record retrievals, data abstractions, and 100 percent overreads for gap closure<br>• Electronic medical record program |

| MCO | Best and Emerging Practices |
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| | • Daily review of quality improvement ancillary mailbox for gap closures from CCS and Pop Health<br>• Validating incentives for supplemental data<br><br>**Topic/Title:** Quality Accreditation Team<br>**Description:**<br>The NCQA internal mock file audits is used to maintain organizational readiness and verify that the management process documented in the records complies with NCQA Standards. Audits are conducted quarterly with random files selected. Annual audits are conducted on non-accredited delegates.<br>The quality accreditation team used the NCQA methodology of eight (8) and 30 file sampling process. The team reviews an initial sample of eight (8) files then review an additional sample of 22 files if any of the original eight files fail the review for a total of 30 records.<br><br>**Topic/Title:** Quality Regulatory Team<br>• Reporting for all critical incidents and quality of care/service grievances, within newly launched care management system for all lines of business (LOBs)<br>• Following QMR closure, team debriefs other departments such as care coordination, utilization management, etc. Opportunities for process improvement are identified and discussed<br>• Increased efficiency with flow of information between Optima Health and LTSS providers by having a dedicated QMR email and fax number<br><br>**Topic/Title:** Population Health – Performance Withhold Program Performance Improvement Workgroup<br>**Description:** Performance Withhold Program Performance Improvement workgroup consisting of key stakeholders across the organization established to collaborate, review, and discuss performance withhold program measure data trends, interventions, and barriers.<br><br>**Topic/Title:** Population Health - CAHPS Improvement Workgroup<br>**Description:** CAHPS Performance Improvement workgroup consisting of key stakeholders across the organization established to collaborate and discuss interventions to improve the bottom three CAHPS measures for both M4 and CCCP.<br>**Topic/Title:** Population Health – Interactive Voice Response (IVR) and Educational Video Campaigns<br><br>**Description:** Population Health - IVR and Educational Video Campaigns<br><br>**Topic/Title:** Population Health - Preventive Screening Kits |

| MCO | Best and Emerging Practices |
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| | **Description:** The health plan collaborates with two vendor partners to provide screening kits to members of both the CCC Plus and Medallion 4.0 product lines. Focus Care provides in-home assessments to these members as well as provides screening kits for A1c, diabetic retinal eye exams, kidney evaluation, and FIT kits for colorectal cancer screening for members that have gaps in these measures. Optima collaborates with another vendor, BioIQ, which automatically mails screening kits for A1c, KED, and FIT kits to all members with gaps in these measures. This is an effort to improve performance withhold program measures as well as improve overall population health and member satisfaction by making the preventative screenings easily accessible.<br><br>**Topic/Title:** Population Health - Newly Developed Population Health Department<br><br>**Description:** In 2021, Optima Health further developed the Population Health Department to focus solely on improving population health both through internal and external means and seek out best practices and technologies to target our high-risk members and providers. The department encompasses population care, innovations portfolio management, and performance improvement teams. In its first year, Population Health continued to grow and determine best practices as well as develop a future state. The department is currently planning a population health assessment to be completed in 2023.<br><br>**Topic/Title:** Member Advisory Committee Meetings<br><br>**Description:** The Member Advisory Committee meetings included a comprehensive communication method and approach to targeting the members to engage them in the member facing events. The goal being to elicit member feedback and improve the member experience. Members were engaged by email, mail, phone, social media, and the web.<br><br>The member planning committee primarily included the member outreach team and the communications team using a collaborative approach to increasing member participation, engagement, and member satisfaction. Meeting and member outcomes are reviewed, and member feedback is used to make decisions on member led and chosen content for future meetings. |
| **United** | **Topic/Title:** Sticks For Kicks<br><br>**Description:** To assist the Commonwealth with preventing infectious diseases, UnitedHealthcare (UHC) has implemented best practices to increase vaccination rates. One of our reward programs, Sticks for Kicks, offers incentives to members ages 5-18 for receiving certain vaccines. When members receive a qualifying “stick” (shot), they can earn a $50 gift card to buy “kicks” (shoes) and activewear at Foot Locker. If they receive any other qualifying vaccine, they can earn a second $50 Foot Locker gift card, up to a total of $100.<br><br>**Topic/Title:** FiveMedicine COVID Clinic<br><br>**Description:** UnitedHealthcare (UHC) collaborated with local organizations in the Tidewater region to improve vaccine access and decrease the spread of infectious |

| MCO | Best and Emerging Practices |
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| | diseases through a mobile clinic, including Virginia Department of Health, Southeastern Virginia Health System and Peninsula Health District. UHC partnered with FiveMedicine to host two clinic events for first and second COVID-19 vaccinations. To build awareness, UHC's care coordinators contacted members in the Tidewater area to encourage them to visit the clinic, answered questions, and arranged transportation. Many of these individuals manage chronic health conditions. During the two-day event, nearly 700 vaccines were administered to members of the community.<br><br>**Topic/Title:** Preventative Health Initiatives<br>**Description:** To improve health disparities and the health & well-being of underserved communities in the Commonwealth, UnitedHealthcare leverages an approach we designed and deploy in communities that combines localized data with community-level collaborations to improve health outcomes to drive meaningful change. This approach was most recently focused in Petersburgh, VA, but our overall approach includes creating unique and creative engagements with families through partnerships with community-based organizations including faith-based, non-profit, and trusted community mainstays to increase trust and sense of community.<br>• Annual Grandparents Day – UnitedHealthcare partners with Sesame Street Workshop to celebrate National Grandparents Day. The "*Grow Every Day, Every Way*" event features healthy snacks, games, activities, and giveaways along with UHC representatives to answer questions about healthy habits and managed care benefits. Most recently in Petersburg, VA, UHC's Chief Medical Officer gave over 100 attendees blood pressure devices and shared preventative health guidance. This fun, no-cost event supported Petersburg residents of all ages where they were, and featured the new resource "*Happy, Healthy, Hopeful: Stretching Our Food Dollars*" from Sesame Street to help families stay healthy and strong, every day and every way.<br>• Pop-Up Clinics – UnitedHealthcare partners with Color Health to provide preventative clinic services, including vaccinations, health screenings, and health education. By being flexible and meeting people where they are, we increase access, convenience, and participation. UHC will continue to identify and partner with local community organizations to educate the community, increase participation, support joint canvassing and awareness efforts, and build trust and credibility with the member population we serve.<br><br>**Topic/Title:** One Pass<br>**Description:** To improve physical and mental well-being for members, UHC offers an enhanced benefit to members ages 18 and older. Through this program, members gain access to more than 300 fitness locations in Virginia, including a digital library of more than 20,000 on-demand and livestream classes. As an emerging practice, UHC is expanding this program to our CCC Plus population in support of the transition to Cardinal Care. |

| MCO | Best and Emerging Practices |
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| | **Topic/Title:** Housing + Health<br><br>**Description:** UnitedHealthcare believes that creating sustainable programs that address and integrate all the key elements required for health (including social, behavior, and medical) requires innovative thinking, unconventional partnerships, and the ability to tailor and fund these programs for the most complex populations.<br><br>Housing + Health is a community and social health initiatives model that is aligned with our Community & State Population Health approach. Housing + Health operates with the mission to compassionately drive change by unifying the strengths of members and the community to make the housing and health systems achieve equitable outcomes for all. To achieve this mission, it focuses on creating data-driven and evidence-based solutions that help communities and individuals solve clear and specific housing challenges, curb health care costs for members, and improve health outcomes and self-sufficiency. Housing + Health works alongside community partners and health plan housing navigators to achieve positive outcomes. |
| **VA Premier** | **Topic/Title:** Complex Wellness Team/Program<br><br>**Description:** The Complex Wellness Program includes representation from care coordination, behavioral health, and the social determinants of health (SDOH) team via social workers. Virginia Premier's (VP) pilot began with VCU Health System in May 2022. In addition to the direct care stakeholders, the Complex Wellness Team includes medical directors, population health, pharmacy, utilization management, and quality. External partners include community service providers and VCU staff.<br><br>Members who are inpatient or have had an ED visit, with VP as primary payor, are assessed via inclusion criteria: **C**omorbidity/**A**dmission Type and Acuity/**P**lan/last **S**ix (6) months (CAPS) score, diagnosis, comorbidities, admission history, SDOH needs, open Care gaps, and medication adherence. Each member's "case" is reviewed by the stakeholder group to assess for potential medical, behavioral, and social impacts effecting health outcomes. This very targeted approach ensures that members with high-needs and high-supports receive the necessary interventions for full wrap-around care.<br><br>**Topic/Title:** Member Advisory Committee Meetings<br><br>**Description:** The Member Advisory Committee meetings include a comprehensive communication method and approach to targeting the members to engage them in the member facing events. The goal being to elicit member feedback and improve the member experience. Members are engaged by email, mail, phone, social media, and the web.<br><br>The member planning committee primarily includes the member outreach team and the communications team using a collaborative approach to increasing member participation, engagement, and member satisfaction. Meeting and member outcomes are reviewed, and member feedback is used to make decisions on member led and chosen content for future meetings. |

| MCO | Best and Emerging Practices |
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| | **Topic/Title:** Pediatric Atypical Antipsychotic Program<br>**Description:**<br>• Care coordination program for those members aged 6-12 years who are taking an atypical antipsychotic<br>• Care coordination letters are sent to member's PCP and prescriber of atypical antipsychotic<br>• Goal is to ensure appropriate clinical monitoring of the member is being completed and reported<br>• Team meetings are held monthly to discuss program, suggest any improvements, and review data results<br><br>**Topic/Title:** Hepatitis C Program<br>**Description:**<br>• Clinical program to help adherence and therapy completeness<br>• Specialty pharmacy provides member information to care coordinators on who fills Hep C therapy<br>• Care coordinators outreach members to educate on side effects and provide any additional support needed<br>• Specialty provider sends quarterly and annual reporting, including SVR12 lab work, to show effectiveness of program<br><br>**Topic/Title:** Vendor Management Organization (VMO) Team Structure<br>**Description:** The VMO established the following teams and processes to support the business by strategically delivering results through successful vendor partnerships, ultimately generating value for our members and customers.<br>• Strategic Sourcing: Assess and select best-in-class vendors that further Virginia Premier objectives and ensure minimal compliance, legal, financial and security risks.<br>• Non-Provider Contract Management: Execute and manage contracts that provide Virginia Premier with a vendor portfolio which allows for the safe, effective, and efficient delivery of services.<br>• Vendor Support: Implement and support the operational and regulatory requirements of select Virginia Premier vendor programs in partnership with assigned business owners.<br>• Vendor Oversight: Oversee and manage vendor financial and operational performance to help ensure Virginia Premier compliance and vendor obligation delivery.<br>• Vendor Systems and Support: Centralized support across all VMO teams, responsible for managing and supporting VMO contract & vendor systems and data.<br><br>**Topic/Title:** Behavioral Health Transitions of Care<br>**Description:** Behavioral health Transition care coordination initiative – Behavioral Health care coordination team supports all members who have a behavioral health |

| MCO | Best and Emerging Practices |
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| | inpatient admission with the intent to reduce/eliminate readmissions by engaging members and linking them to community-based services and supports. Behavioral health inpatient reviewers send notification at admission and discharge to members care coordinators and/or transition coordinator to initiate discharge planning with inpatient facility to identify and resolve barriers for safe and effective discharge, while initiating community-based services, as needed, to reduce chance for member readmission.<br><br>**Topic/Title:** Behavioral Health Chronic Care Coordination<br><br>**Description:** Behavioral health chronic care coordinators work with the enhanced care coordination program that requires targeted case managers employed with Community Service Boards (CSBs) to conduct seven-day follow-up with members discharged from acute care facilities.<br><br>**Topic/Title:** Continuity of Care<br><br>**Description:** Behavioral health inpatient reviewers send notification at admission and discharge to members care coordinator and/or transition coordinator to initiate discharge planning with inpatient facility to identify and resolve barriers for safe and effective discharge, while initiating community-based services, as needed, to reduce chance for member readmission.<br><br>**Topic/Title:** Peer Support Program<br><br>**Description:** In October 2022, VP will launch a peer recovery support program. Peer support is an evidenced-based practice that has proven outcomes in reducing the costs of admissions/readmissions, increasing the quality of life for individuals challenged with mental health (MH) and substance-use disorder (SUD). Certified peer support specialists, who have lived experience with MH, SUD, and/or trauma, and who are also trained, join along members who on their own path to recovery, wellness, and resiliency. Individuals engaged in peer support are often more engaged in treatment and navigate crises in a healthy way due to the support from peer support specialists.<br><br>**Topic/Title:** Annual Quality Summit<br><br>**Description:** Typically held the week of World Quality Week. The theme of the summit provides an opportunity to reflect on how corporate culture and conscience can help or hinder an organization to make decisions and 'do the right thing' for all stakeholders. The two-day interactive conference inclusive of speaker from the health plan senior leaders, DMAS, vendors and other quality leaders in the community who provide insight to how they contribute to quality.<br><br>This quality initiative is regarded as a best practice because it allows the quality staff to know and understand why the plan does what it does, how the work impacts members, other department, providers, practitioners, pharmacies, |

| MCO | Best and Emerging Practices |
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| | regulatory bodies, and the community as a whole. Topics of discussion include but are not limited to: member engagement, new strategic opportunities, cultural competency standards, health equity, and HEDIS medical record procurement/acquisitions.<br><br>**Topic/Title:** Quality HEDIS® Team<br><br>**Description:**<br><br>• Implemented year-long medical record retrievals, data abstractions, and 100 percent overreads for gap closure<br>• Electronic medical record program<br>• Daily review of quality improvement ancillary mailbox for gap closures from CCS and Pop Health<br>• Validating incentives for supplemental data |

# Appendix D. MCO Quality Strategy Quality Initiatives

Table D-1 through Table D-6 provide examples of the quality initiatives the MCOs highlighted as their efforts toward achieving the Virginia 2020–2022 QS's goals and objectives. Note: The narrative within the Quality Initiatives section was provided by the MCO and has not been altered by HSAG except for minor formatting.

## Aetna

**Table D-1—Aetna's QS Quality Initiatives**

| Virginia QS Aim and Goal | Aetna's Quality Initiative | Performance Metric |
|---|---|---|
| **Aim 3:** Smarter Spending<br>**Goal 3.1:** Focus on Paying for Value | *Follow up After Discharge:* PIP intervention involving educating members about the importance of engaging in a 30-day post-discharge follow up visit with a PCP or specialist. MCO staff assist with scheduling appointment as needed. | **Metric 3.1.3:**<br>(FUD) Follow Up After Discharge |
| **Aim 3:** Smarter Spending<br>**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:**<br>Frequency of Potentially Preventable Readmissions |
| **Aim 3:** Smarter Spending<br>**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:**<br>Frequency of Potentially Preventable Readmissions |
| **Aim 3:** Smarter Spending<br>**Goal 3.1:** Focus on Paying for Value | *ED Visits*<br>*Telephonic Outreach Visit:* PIP intervention involving conducting telephonic outreach to members identified as having one outpatient visits and two or more ED visits.<br><br>*Avoidable ED Visits NBA Campaign:* Promote health behavior changes and choices | **Metric 3.1.4:**<br>(AMB) Ambulatory Care—Outpatient Visits/1000 MM (Total) |

| Virginia QS Aim and Goal | Aetna's Quality Initiative | Performance Metric |
|---|---|---|
| | with one or more past visits to the ED for avoidable reasons through direct mail and interactive voice response microsite. | |
| **Aim 3:** Smarter Spending<br>**Goal 3.2:** Focus on Efficient Use of Program Funds | *Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions. | **Not a QS Metric:**<br>(AAB) Avoidance of Antibiotic Treatment for Acute Bronchitis |
| **Aim 3**: Smarter Spending<br>**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 QS Metric:**<br>(MRP) Medication Reconciliation Post Discharge |
| **Aim 4:** Improved Population Health<br>**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members | *Behavioral Health Hospitalization Taskforce:* To improve collaboration and support between utilization management, case management, and behavioral health departments in working with members.<br><br>*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:**<br>(FUH) Follow Up After Hosp for Mental Illness— 7 days<br>**Metric 4.1.1:**<br>(FUH) Follow Up After Hosp for Mental Illness— 30 days |
| **Aim 4:** Improved Population Health<br>**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members | *Higher Utilizer Rounds:* Integrative round with utilization management, behavioral health, medical management, case management, pharmacy, PSS representation to focus on stabilizing one member at a time who is a high utilizer of behavioral health inpatient hospitalizations. | **Metric 4.2.2:**<br>Follow-Up After ED Visit for AOD Abuse or Dependence |

| Virginia QS Aim and Goal | Aetna's Quality Initiative | Performance Metric |
|---|---|---|
| **Aim 4:** Improved Population Health<br>**Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders | *PMMP Plan Education (Care Management):* Pharmacy advisor led plan education for our effectiveness of care measures specifically for our care management department. | **Metric 4.2.3:**<br>(HDO) Use of Opioids at High Dosage |
| **Aim 4:** Improved Population Health<br>**Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders | *Weekly Overdose Outreach Project:* Provides benchmark for how many members are in treatment (reports from Pre-Manage are reviewed weekly for recent ED admits for drug or alcohol overdose, these members are outreached by behavioral health department to assure safety and encourage engagement in outpatient substance abuse services.). | **Metric 4.2.4:**<br>(IET) Initiation and Engagement of AOD Abuse or Dependence Treatment |
| **Aim 4:** Improved Population Health<br>**Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders | *Weekly Overdose Outreach Project:* Provides benchmark for how many members are in treatment (reports from Pre-Manage are reviewed weekly for recent ED admits for drug or alcohol overdose, these members are outreached by behavioral health department to assure safety and encourage engagement in outpatient substance abuse services.). | **Metric 4.2.4:**<br>(IET) Initiation and Engagement of AOD Abuse or Dependence Treatment |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *EPSDT Birthday Mailers:* Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care. | **Metric 4.3.1:**<br>(ADV) Annual Dental Visit (11–14 Yrs.) |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *AAP SMS:* Members are sent one to three messages each month. If a member is included in multiple text campaigns, messages are staggered as to avoid member abrasion. The timeline varies for when each member receives messages, | **Metric 4.3.2:**<br>(AAP) Adults' Access to Preventive/Ambulatory Health Services (Total) |

| Virginia QS Aim and Goal | Aetna's Quality Initiative | Performance Metric |
|---|---|---|
| | due to individual enrollment into the campaign.<br><br>*Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions.<br>*Wellness Rewards Program:* Program that incentivizes members for completing various cancer screenings and yearly wellness exams.<br><br>*Moving On Transitioning from Pediatrics to Primary Care:* Initiative incentivizing members aged 18-20 years who are transitioning from pediatrics health care to adult primary care. Eligible members receive a gift card for completing various services including, preventive care services, adult medical screenings, weight management, and recommended vaccines. | |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *AAP SMS:* Members are sent one to three messages each month. If a member is included in multiple text campaigns, messages are staggered as to avoid member abrasion. The timeline varies for when each member receives messages, due to individual enrollment into the campaign.<br><br>*Moving On Transitioning from Pediatrics to Primary Care:* Initiative incentivizing members aged 18-20 years who are | **Metric 4.3.2:**<br>(CBP) Controlling Blood Pressure |

| Virginia QS Aim and Goal | Aetna's Quality Initiative | Performance Metric |
|---|---|---|
| | transitioning from pediatrics health care to adult primary care. Eligible members receive a gift card for completing various services including, preventive care services, adult medical screenings, weight management, and recommended vaccines. | |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *EPSDT Birthday Mailers:* Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.<br><br>*Ted E. Bear M.D. Wellness Club:* Program encourages parents to ensure their child completes their well child visit. Child receives age-appropriate gift upon Program enrollment and parent receives gift card (amount varies based on child age group) upon completion of preventive service. | **Metric 4.3.4:**<br>(AWC) Adolescent Well-Care Visits |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *EPSDT Birthday Mailers:* Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.<br><br>*PMMP Plan Education (Care Management):* Pharmacy advisor led plan education for our effectiveness of care measures specifically for our care management department. | **Metric 4.3.4:**<br>(IMA) Immunizations for Adolescents |

| Virginia QS Aim and Goal | Aetna's Quality Initiative | Performance Metric |
|---|---|---|
| | *Ted E. Bear M.D. Wellness Club:* Program encourages parents to ensure their child completes their well child visit. Child receives age-appropriate gift upon Program enrollment and parent receives gift card (amount varies based on child age group) upon completion of preventive service. | |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *EPSDT Birthday Mailers:* Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.<br><br>*Ted E. Bear M.D. Wellness Club:* Program encourages parents to ensure their child completes their well child visit. Child receives age-appropriate gift upon Program enrollment and parent receives gift card (amount varies based on child age group) upon completion of preventive service. | **Not a QS Metric:**<br>(LSC) Lead Screening in Children |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *EPSDT Birthday Mailers:* Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.<br><br>*Ted E. Bear M.D. Wellness Club:* Program encourages parents to ensure their child completes their well child visit. Child receives age-appropriate gift upon program enrollment and parent receives gift card | **Not a QS Metric:**<br>(W34) Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life |

| Virginia QS Aim and Goal | Aetna's Quality Initiative | Performance Metric |
|---|---|---|
| | (amount varies based on child age group) upon completion of preventive service. | |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *EPSDT Birthday Mailers:* Parents of child members receives a reminder for child to have wellness visits with PCP and obtain recommended immunizations. Monthly mailing based on child's birthday and gaps in care.<br><br>*Ted E. Bear M.D. Wellness Club:* Program encourages parents to ensure their child completes their well child visit. Child receives age-appropriate gift upon program enrollment and parent receives gift card (amount varies based on child age group) upon completion of preventive service. | **Not a QS Metric:**<br>(WCC) Weight Assessment Counseling—BMI percentile (Total)<br>**Not a QS Metric:**<br>(WCC) Weight Assessment Counseling—for Nutrition (Total)<br>**Not a QS Metric:**<br>(WCC) Weight Assessment Counseling— Physical Activity (Total) |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *CVS Health Tags:* Messages attached to prescription bags educating members about the importance of flu vaccination<br><br>*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.<br><br>*PMMP Plan Education (Care Management):* Pharmacy advisor led plan education for our effectiveness of care measures specifically for our care management department.<br><br>*Primary Health Care Model for Adults:* Gender specific educational brochures about the importance of completing recommended health | **Not a QS Metric:**<br>(COL) Colorectal Cancer Screening<br>**Not a QS Metric:**<br>Non-Recommended PSA-Based Screening in Older Men |

| Virginia QS Aim and Goal | Aetna's Quality Initiative | Performance Metric |
|---|---|---|
| | screenings with PCP and/or specialist.<br><br>*Wellness Rewards Program:* Program that incentivizes members for completing various screenings and yearly wellness exams.<br><br>*Moving On Transitioning from Pediatrics to Primary Care:* Initiative incentivizing members aged 18-20 years who are transitioning from pediatrics health care to adult primary care. Eligible members receive a gift card for completing various services including, preventive care services, adult medical screenings, weight management, and recommended vaccines. | |
| **Aim 4:** Improved Population Health<br>**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.<br><br>*Well Woman Wellness Rewards:* Incentive for members that completes their pap test and mammogram. | **Not a QS Metric:**<br>(CCS) Cervical Cancer Screening |
| **Aim 4:** Improved Population Health<br>**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.<br><br>*Moving On Transitioning from Pediatrics to Primary Care:* Initiative incentivizing members aged 18-20 years who are transitioning from pediatrics health care to adult primary care. Eligible members receive a gift card for completing | **Not a QS Metric:**<br>(CHL) Chlamydia Screening in Women —Total |

| Virginia QS Aim and Goal | Aetna's Quality Initiative | Performance Metric |
|---|---|---|
| | various services including, preventive care services, adult medical screenings, weight management, and recommended vaccines. | |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *Mobile Mammography:* Collaboration with Virginia Health Systems offering female members mobile units for mammograms.<br><br>*Well Woman Wellness Rewards Program:* Program that incentivizes members for completing various screenings and yearly wellness exams. | **Not a QS Metric:**<br>(BCS) Breast Cancer Screening |
| **Aim 4:** Improved Population Health<br>**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.<br><br>*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:**<br>(PQI 08) Heart Failure Admissions Rate |
| **Aim 4:** Improved Population Health<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | *Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions.<br><br>*PMMP Plan Education (Care Management):* Pharmacy advisor led plan education for our effectiveness of care | **Metric 4.4.2:**<br>(AMR) Asthma Medication Ratio (Total) |

| Virginia QS Aim and Goal | Aetna's Quality Initiative | Performance Metric |
|---|---|---|
| | measures specifically for our care management department. | |
| **Aim 4:** Improved Population Health<br>**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.<br><br>*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:**<br>(PDI 14) Asthma Admission Rate 2–17 Years |
| **Aim 4:** Improved Population Health<br>**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:**<br>(PQI 05) COPD and Asthma in Older Adults Admissions Rate |
| **Aim 4:** Improved Population Health<br>**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.<br><br>*Asthma Value Based Care Pilot:* Collaboration and alignment between CVS retail patient care capabilities with Aetna Better Health member needs to impact asthma care of cost by decreasing emergency room/inpatient/ambulatory visits from asthma exacerbations | **Not a QS Metric:**<br>(PQI 15) Asthma in Younger Adults Admission Rate |
| **Aim 4:** Improved Population Health | *PMMP Plan Education (Care Management):* Pharmacy advisor led plan education for our effectiveness of care | **Not a QS Metric:**<br>(PQI 15) Asthma in Younger Adults Admission Rate |

| Virginia QS Aim and Goal | Aetna's Quality Initiative | Performance Metric |
|---|---|---|
| **Goal 4.4:** Improve Health for Members with Chronic Conditions | measures specifically for our care management department.<br><br>*Asthma Value Based Care Pilot:* Collaboration and alignment between CVS retail patient care capabilities with Aetna Better Health member needs to impact asthma care of cost by decreasing emergency room/inpatient/ambulatory visits from asthma exacerbations | |
| **Aim 4:** Improved Population Health<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | *Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions.<br><br>*Diabetes and Cholesterol Member Mailer:* Educational letter sent to members pertaining to diabetes and cholesterol medication management.<br><br>*Diabetes Mailer:* Incentive for members that complete a yearly wellness and diabetic exam.<br><br>*PMMP Plan Education (Care Management):* Pharmacy advisor led plan education for our effectiveness of care measures specifically for our care management department.<br><br>*Primary Health Care Model for Adults:* Gender specific educational brochures informing about the importance | **Metric 4.4.4:**<br>(CDC) Comprehensive Diabetes Care—HbA1c Testing |

| Virginia QS Aim and Goal | Aetna's Quality Initiative | Performance Metric |
|---|---|---|
| | of completing recommended health screenings with PCP and/or specialist.<br><br>*Wellness Rewards Program:* Program that incentivizes members for completing various screenings and yearly wellness exams.<br><br>*Moving On Transitioning from Pediatrics to Primary Care:* Initiative incentivizing members aged 18-20 years who are transitioning from pediatrics health care to adult primary care. Eligible members receive a gift card for completing various services including, preventive care services, adult medical screenings, weight management, and recommended vaccines. | |
| **Aim 4:** Improved Population Health<br>**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.<br><br>*Primary Health Care Model for Adults:* Gender specific educational brochures informing about the importance of completing recommended health screenings with PCP and/or specialist. | **Metric 4.4.4:**<br>(CDC) Comprehensive Diabetes Care— Eye Exams |
| **Aim 4:** Improved Population Health<br>**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:**<br>(CDC) Comprehensive Diabetes Care— Attention for Nephropathy |

| Virginia QS Aim and Goal | Aetna's Quality Initiative | Performance Metric |
|---|---|---|
| **Aim 4:** Improved Population Health<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | *Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions.<br><br>*PMMP Plan Education (Care Management):* Pharmacy advisor led plan education for our effectiveness of care measures specifically for our care management department.<br><br>*Primary Health Care Model for Adults:* Gender specific educational brochures about the importance of completing recommended health screenings with PCP and/or specialist.<br><br>*Moving On Transitioning from Pediatrics to Primary Care:* Initiative incentivizing members aged 18-20 years who are transitioning from pediatrics health care to adult primary care. Eligible members receive a gift card for completing various services including, preventive care services, adult medical screenings, weight management, and recommended vaccines. | **Metric 4.4.5:**<br>(CBP) Controlling High Blood Pressure |
| **Aim 4:** Improved Population Health<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | *Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions. | **Not a QS Metric:**<br>(PBH) Persistence of Beta-Blocker Treatment after a Heart Attack |

| Virginia QS Aim and Goal | Aetna's Quality Initiative | Performance Metric |
|---|---|---|
| **Aim 4:** Improved Population Health<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | *Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions. | **Not a QS Metric:**<br>(PCE) Pharmacotherapy Management of COPD Exacerbation— Bronchodilator |
| **Aim 4:** Improved Population Health<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | *Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions. | **Not a QS Metric:**<br>(PCE) Pharmacotherapy Management of COPD Exacerbation— Systemic Corticosteroid |
| **Aim 4:** Improved Population Health<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | *Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions.<br><br>*Diabetes and Cholesterol Member Mailer:* Educational letter sent to members pertaining to diabetes and cholesterol medication management.<br><br>*Diabetes Mailer:* Incentive for members that complete a yearly wellness and diabetic exam.<br><br>*PMMP Plan Education (Care Management):* Pharmacy advisor led plan education for our effectiveness of care measures specifically for our care management department. | **Not a QS Metric:**<br>(CDC) Comprehensive Diabetes Care—Blood Pressure Control (<140/90) |

| Virginia QS Aim and Goal | Aetna's Quality Initiative | Performance Metric |
|---|---|---|
| | *Primary Health Care Model for Adults:* Gender specific educational brochures about the importance of completing recommended health screenings with PCP and/or specialist. | |
| **Aim 4:** Improved Population Health<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | *Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions. | **Not a QS Metric:**<br>(CDC) Comprehensive Diabetes Care—Attention for Nephropathy |
| **Aim 4:** Improved Population Health<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | *Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions.<br><br>*Diabetes and Cholesterol Member Mailer:* Educational letter sent to members pertaining to diabetes and cholesterol medication management.<br><br>*Diabetes Mailer:* Incentive for members that complete a yearly wellness and diabetic exam.<br><br>*Wellness Rewards Program:* Program that incentivizes members for completing various screenings and yearly wellness exams. | **Not a QS Metric:**<br>(CDC) Comprehensive Diabetes Care—Eye Exams |
| **Aim 4:** Improved Population Health | *Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO | **Not a QS Metric:**<br>(SPC) Statin Therapy for Patients with Cardiovascular Disease |

| Virginia QS Aim and Goal | Aetna's Quality Initiative | Performance Metric |
|---|---|---|
| **Goal 4.4:** Improve Health for Members with Chronic Conditions | staff and non-profit organization guest speakers to help members better manage their chronic conditions. | |
| **Aim 4:** Improved Population Health<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | *Maternity Incentive Program:* Incentive for members going to all prenatal appointments and postpartum check-up. | **Metric 4.6.1:**<br>(PPC) Prenatal and Postpartum Care— Postpartum Care |
| **Aim 4:** Improved Population Health<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | *Ensuring Timeliness of Prenatal Care Telephonic Outreach:* Outreach conducted to identified pregnant members to provide education and encourage 1st trimester PNC to reduce risk of preterm or low birth weights.<br><br>*Tobacco Use Cessation in Pregnant Women Telephonic Outreach:* Outreach to identified pregnant smokers and inform members of available resources and options to engage in smoking cessation.<br><br>*Ensuring Timeliness of Prenatal Care Quitting for Good:* Flyer outlining unsafe habits during pregnancy.<br><br>*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:**<br>(PPC) Prenatal and Postpartum Care—Timeliness of Prenatal Care |
| **Aim 4:** Improved Population Health<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | *EPSDT Birthday Mailers:* Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing | **Metric 4.6.3:**<br>(CIS) Childhood Immunization Status<br>**Metric 4.6.3:** |

| Virginia QS Aim and Goal | Aetna's Quality Initiative | Performance Metric |
|---|---|---|
| | based on child's birthday and gaps in care.<br><br>*PMMP Plan Education (Care Management):* Pharmacy advisor led plan education for our effectiveness of care measures specifically for our care management department.<br><br>*Wellness Rewards Program:* Program that incentivizes members for completing various screenings and yearly wellness exams.<br><br>*Ted E. Bear M.D. Wellness Club:* Program encourages parents to ensure their child completes their well child visit. Child receives age-appropriate gift upon program enrollment and parent receives gift card (amount varies based on child age group) upon completion of preventive service. | (CIS) Childhood Immunization Status—Combo 3<br>**Metric 4.6.3:**<br>(CIS) Childhood Immunization Status—Combo 10 |
| **Aim 4:** Improved Population Health<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | *EPSDT Birthday Mailers:* Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.<br><br>*Ted E. Bear M.D. Wellness Club:* Program encourages parents to ensure their child completes their well child visit. Child receives age-appropriate gift upon program enrollment and parent receives gift card (amount varies based on child age group) upon completion of preventive service. | **Metric 4.6.5:**<br>(W15) Well-Child Visits in the first 15 Months of Life (6 or more visits) |

# HealthKeepers

**Table D-2—HealthKeepers' QS Quality Initiatives**

| Virginia QS Aim and Goal | HealthKeepers' Quality Initiative | Performance Metric |
|---|---|---|
| **Aim 1**: Enhance Member Care Experience<br>**Goal 1.1:** Improve Member Satisfaction<br>**Aim 2:** Effective Patient Care<br>**Goal 2.2:** Ensure Access to Care Member Care Experience<br>Access to Care | *Network Adequacy Assessment:* Assessed the adequacy of the MCO's network by reviewing data from the following reports: Member Experience report pertaining to complaints, Health Disparities and CLAS Evaluation report from our MHC Distinction, Availability report, Accessibility report and Calendar Year Out of Network utilization requests (approved and denied) and Utilization Data. As a results of the analysis, non- compliant providers were educated by letter reminding them of appointment standards.<br><br>*Provider Education:* Providers continued to receive educations on the standards monthly during Provider orientation meetings. Providers were educated via provider newsletter about HealthKeepers adoption of prior authorization app in Availity. A provider continuing medical education online course was added to the provider website to promote the continuing medical education class "Telehealth: Building a Sustainable Model". Added availability of provider telehealth to online physician directories to educate members regarding accessibility to PCP telehealth.<br><br>*Member Education:* Educated members regarding accessibility to alternatives to emergency room, such as nurse line and | **Metric 1.2.1:**<br>Getting Care Quickly<br>**Metric 2.2.3:**<br>Getting Needed Carey Strategy |

| Virginia QS Aim and Goal | HealthKeepers' Quality Initiative | Performance Metric |
|---|---|---|
| | urgent care centers and telehealth. | |
| **Aim 4:** Improved Population Health<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | *Improving Maternal and Child Services:*<br>Conducted an evaluation of HealthKeepers Population Health Management Strategy that focused on clinical, cost/utilization, and program feedback from members.<br>In 2021, a 'snapshot' of the July membership indicated approximately 1.08 percent of the plan's membership was comprised of maternity and/or perinatal women. Timely PNC helps promote healthy birth outcomes for both mother and baby. A focus on improving this measure therefore had a positive impact not only for the 1.08 percent of perinatal women in the plan membership but extended the benefit to essentially twice that amount when considering their newborns. This measure had been identified as a state priority to improve maternal health outcomes for women.<br><br>Approximately 2.11 percent of MCO members were in the denominator for the PM indicator Combo 10 Childhood Immunization Status. Assuring members were vaccinated prevented morbidity and mortality caused by serious illnesses in the younger population.<br><br>The HEDIS work group which consisted of the HEDIS team and corporate quality directors analyzed trends and determined barriers for HEDIS measures. The Anthem Virginia HEDIS Root Cause Analysis (RCA) work | **Metric 4.6.2:**<br>Prenatal and Postpartum Care: Timeliness of Prenatal Care<br>**Metric 4.6.3:**<br>Childhood Immunizations Status Combo 10 |

| Virginia QS Aim and Goal | HealthKeepers' Quality Initiative | Performance Metric |
|---|---|---|
| | group also reviewed the data trends to determine barriers for the measures.<br><br>Opportunities identified included educating parents regarding the need for all immunizations and educating members regarding the need for prenatal visits. As a result of the analysis, HealthKeepers, Inc implemented the following interventions:<br><br>• PPC: Doula program available to all Medicaid members reimbursing for prenatal, delivery and postpartum doula services. Referral from licensed provider required and incentive to doula for member to pursue services.<br>• Increased participation in OBQIP to increase prenatal and postpartum visits. Incentive in OBQIP was increased.<br>• Stepping-Stones (partner with CBOs and shared grant funds and provided resources to provide to clients).<br>• Monthly SDOH report that looked at pregnancy assessment and if member had social needs as well.<br>• Worked with transportation vendor on improving reliability of transportation.<br>• Educated providers on the importance of reminding members of follow-up appointments. | |
| **Aim: 4** Improved Population Health<br>**Goal: 4.4** Improve Health for Members with Chronic Conditions | *Improving Supportive Care and Disease Management:* Conducted an evaluation of the Population Health Management Strategy that focused on clinical, | **Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) HbA1c Poor Control<br>**Metric 4.4.5:** |

| Virginia QS Aim and Goal | HealthKeepers' Quality Initiative | Performance Metric |
|---|---|---|
| | cost/utilization, and program feedback from members.<br><br>*Reviewed Data:*<br>In 2021, a 'snapshot' of the July membership indicated approximately 6.54 percent of the plan's membership had a diagnosis of diabetes. Controlling HbA1c levels is known to reduce the long-term risk of microvascular complications in people with diabetes. Focusing on improving the CDC (Blood Pressure 140/90) measure helped improve the lives of members with diabetes by reducing the cardiovascular risk related to high blood pressure. A focus on these measures also aligned with the state's quality strategy to improve care and outcomes for members with chronic diseases.<br><br>*Conducted Root Cause Analysis:*<br>The HEDIS work group which consisted of the HEDIS team and corporate quality directors analyzed trends and determined barriers for HEDIS measures. The Anthem Virginia HEDIS Root Cause Analysis (RCA) work group also reviewed the data trends to determine barriers for the measures.<br><br>*Implemented Interventions:*<br>Opportunities identified included educating parents regarding the need for all immunizations and educating members regarding the need for prenatal visits. As a result of the analysis, HealthKeepers Inc. implemented the following interventions: | Controlling High Blood Pressure |

| Virginia QS Aim and Goal | HealthKeepers' Quality Initiative | Performance Metric |
|---|---|---|
| | • mPulse text campaign<br>• Gap in Care reports distributed internally by case management.<br>• Hypertension adherence program through pharmacy.<br>• Mail order delivery of prescriptions.<br>• Pay for Quality Provider Incentive Program - non PQIP providers who could earn incentives for closing gaps in care.<br>• IngenioRx outreach | |
| **Aim: 3:** Smarter Spending<br>**Goal 3.1:** Focus on Paying for Value | *Improving Cost/Utilization:*<br>Conducted an evaluation of the population health management strategy that focused on clinical, cost/utilization, and program feedback from members.<br><br>In the trended analysis of the ambulatory care. ED visits measure, HealthKeepers Inc. saw a considerable drop in the per thousand calculation of emergency room visits year-over-year. The MCO believed that this could have been attributed to members avoiding the emergency room during the PHE due to the risk of coming in contact with the virus, in addition to extreme wait times that have occurred during this time period. The MCO also focused on providing other alternatives to care other than the emergency room, including urgent care facilities, encouraging members to contact their PCP after hours, and to use telehealth. For and inpatient utilization measure, (ALOS) Covid-19 attributed to the increase. Case management will continue to monitor inpatient stays by | **Metric 4.4.4:**<br>Ambulatory Care: EDED visits (AMB)<br>**Not a QS Metric:**<br>Inpatient Utilization measure, (ALOS) (IPU) |

| Virginia QS Aim and Goal | HealthKeepers' Quality Initiative | Performance Metric |
|---|---|---|
| | focusing on team education with case reviews, and case management rounds.<br><br>*Member Education:*<br>Opportunities identified for emergency room visits included educating members regarding alternatives to emergency room care when appropriate, reaching out to members who were high utilizers of the emergency room to assist them in alternative care, as well as addressing health the condition that was causing the visits.<br><br>*Early Discharge Planning:*<br>Opportunities identified for average length of stay reduction included beginning discharge planning upon admission, earlier collaboration between the health plan, case management and utilization management with hospital discharge planners and additional collaboration with sub-acute facilities, home health and durable medical equipment companies to ensure services were able to meet the needs of the MCO's member population.<br><br>*Implemented Interventions*<br>As a result of the analysis, HealthKeepers Inc. implemented the following interventions:<br><br>• Utilization management department/staff and plan's medical director implemented a process to decrease length of stay admissions.<br>• Prominent information placed on the landing page of the member website with alternatives to emergency room utilization. | |

| Virginia QS Aim and Goal | HealthKeepers' Quality Initiative | Performance Metric |
|---|---|---|
| | • Dedicated case managers identified to outreach to those members on the ED care coordination list to provide support, education about appropriate use of the emergency room, alternate providers and follow up with PCP.<br>• Revisions were made to the identifiers for complex rounds in effort to recognize those potential members sooner who had challenges at discharge. This helped to establish a transition in care plan prior to discharge.<br>• Enhanced the use of the collective medical system to identify and outreach to members who had utilized the emergency room for non-emergent visits.<br><br>*Effective Care Coordination:* Emergency room visits and longer than required hospital stays continued to be a focus due to the quality-of-life issues they raise. Effective care coordination between the health plan and the providers was essential in delivering optimal outcomes. | |
| **Aim 2:** Effective Patient Care<br>**Goal 2.2:** Ensure Access to Care<br>**Aim 4:** Improved Population Health<br>**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members<br>**Aim 4:** Improved Population Health | *Collaboration with Behavioral Health to Close Gaps; Telehealth Investment Fund Initiative:* With HealthKeepers Inc. allocated funds, the Virginia Medicaid market partnered with select providers to enhance their market position by increasing member access to care through innovative digital and technology solutions. Select providers were offered up to five telehealth offerings (Telehealth OS-Provider Platform, | **Metric 2.2.3:** Getting Needed Care<br>**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness<br>**Metric 4.1.2:** Follow-Up After ED Visit for Mental Illness<br>**Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) |

| Virginia QS Aim and Goal | HealthKeepers' Quality Initiative | Performance Metric |
|---|---|---|
| **Goal 4.4:** Improve Health for Members with Chronic Conditions<br>**Aim 4:** Improved Population Health<br>**Goal 4.4:**<br>Improve Outcomes for Maternal and Infant Members | Virtual Visit Platform, Digital Solutions Kiosk Program, eConsults, Telehealth Member Kits). Participating behavioral health providers elected to utilize the Telehealth OS Platform, Kiosk program and member kits. The kiosks increased access to care via telehealth, eliminated language barriers and improved health equity for multi-cultural patients. The telehealth member kits provided basis medical devices to help PCP's/behavioral health providers make a better assessment and diagnosis of members during telehealth visits. Specialty kits offered support to members so that they could better manage their chronic conditions. Telehealth specific kits included high-risk pregnancy, asthma, behavioral health, blood pressure control, and diabetes kits. | **Metric 4.4.5:**<br>Controlling High Blood Pressure<br><br>**Metric 4.6.2:**<br>Prenatal and Postpartum Care: Timeliness of Prenatal Care |
| **Aim 4:** Improved Population Health<br>**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members<br>**Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders | *Provider Incentive Programs:* Implemented provider incentive programs that rewarded qualifying providers for quality and cost-effective care provided to members:<br>• BHQIP: OP BH Providers<br>• BHFIP: Inpatient BH Facilities<br>• SUDFIP: Inpatient and RTC ARTS providers<br>• SDOHPIP | **Metric 4.1.1:**<br>Follow-Up After Hospitalization for Mental Illness<br>**Metric 4.1.3:**<br>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication<br>**Metric 4.2.4:**<br>Initiation and Engagement of AOD Abuse or Dependence Treatment<br>**Not a QS Metric:**<br>Follow-Up After High-Intensity Care for Substance Use Disorder at 7 Days<br>**Not a QS Metric:**<br>30,60,90-day Readmission Rates<br>**Not a QS Metric:**<br>SDOH |

# Molina

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

| Virginia QS Aim and Goal | Molina's Quality Initiative | Performance Metric |
|---|---|---|
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *Communicate and Share with Providers:*<br>The MCO worked with individual provider/ provider groups, conduct monthly meetings, sent gaps in care reports, provided support for member outreach. | **Metric 4.3.2:**<br>(AAP) Adults' Access to Primary Care (Preventive/Ambulatory Health Services) |
| **Aim 4:** Improved Population Health<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | *Communicate and Share with Providers:*<br>The MCO worked with individual provider/ provider groups, conduct monthly meetings, sent gaps in care reports, provided support for member outreach. | **Metric 4.4.2:**<br>Asthma Admission Rate (Ages 2–17)<br>**Metric 4.4.3:**<br>Asthma Admission Rate (Ages 2–17) |
| **Aim 4:** Improved Population Health<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | *Communicate and Share with Providers:*<br>The MCO worked with individual provider/ provider groups, conduct monthly meetings, sent gaps in care reports, provided support for member outreach. | **Metric 4.4.2:**<br>Asthma Admission Rate (Ages 2–17)<br>**Metric 4.4.4:**<br>Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *Communicate and Share with Providers:*<br>The MCO worked with individual provider/ provider groups, conduct monthly meetings, sent gaps in care reports, provided support for member outreach. | **Not a QS Metric:**<br>(BCS) Breast Cancer Screening<br>**Not a QS Metric:**<br>(CCS) Cervical Cancer Screening |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | *Communicate and Share with Providers:*<br>The MCO worked with individual provider/ provider groups, conduct monthly meetings, sent gaps in care reports, provided support for member outreach. | **Metric 4.3.4:**<br>Child and Adolescent Well-Care Visits<br>**Metric 4.6.3:**<br>Childhood Immunization Status<br>**Not a QS Metric:**<br>Lead Screening in Children |

| Virginia QS Aim and Goal | Molina's Quality Initiative | Performance Metric |
|---|---|---|
| | *Immunization Campaign Partnerships:*<br>Partnered with community/providers and hosted immunization campaign and provided incentives and school supplies | |
| **Aim 4:** Improved Population Health<br>**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members<br>**Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders | *Communicate and Share with Providers:*<br>The MCO worked with individual provider/ provider groups, conduct monthly meetings, sent gaps in care reports, provided support for member outreach. | **Metric 4.1.2:**<br>Follow-Up After ED Visit for Mental Illness<br>**Metric 4.2.4:**<br>Initiation and Engagement of AOD Abuse or Dependence Treatment |
| **Aim 4:** Improved Population Health<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | *Communicate and Share with Providers:*<br>The MCO worked with individual provider/ provider groups, conduct monthly meetings, sent gaps in care reports, provided support for member outreach.<br>*Member Incentives:*<br>Compliant members received incentives from the MCO's partnered vendor on an agreed upon cadence.<br>*Provider Education:*<br>Claims researched for service date and bundle code issues. Providers were educated on the issues and updated. | **Metric 4.6.1:**<br>Prenatal and Postpartum Care: Postpartum Care<br>**Metric 4.6.2:**<br>Prenatal and Postpartum Care: Timeliness of Prenatal Care |
| **Aim 4:** Improved Population Health<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | *Communicate and Share with Providers:*<br>The MCO worked with individual provider/ provider groups, conduct monthly meetings, sent gaps in care reports, provided support for member outreach. | **Metric 4.6.5:**<br>Well-Child Visits in the First 30 Months of Life |

| Virginia QS Aim and Goal | Molina's Quality Initiative | Performance Metric |
|---|---|---|
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *Clinic Days:*<br>Hosted clinic days in providers' offices to have an open day for appointments for members to get their services done. | **Metric 4.3.2:**<br>Adults' Access to Preventive/Ambulatory Health Services |
| **Aim 4:** Improved Population Health<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | *Clinic Days:*<br>Hosted clinic days in providers' offices to have an open day for appointments for members to get their services done.<br><br>*Member Incentives:*<br>Compliant members received incentives from the MCO's partnered vendor on an agreed upon cadence.<br>Members received a certificate based on their A1c outcomes.<br><br>*Provider Incentives:*<br>Vision centers were incentivized to reach out to members, schedule, and complete the dilated retinal eye exam.<br><br>*Telehealth:*<br>Blood pressure cuffs sent to targeted members and telehealth visits were facilitated to capture required information.<br>Members were sent an HbA1c kit to complete at home. | **Metric 4.4.4:**<br>Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | *Clinic Days:*<br>Hosted clinic days in providers' offices to have an open day for appointments for members to get their services done. | **Metric 4.3.4:**<br>Child and Adolescent Well-Care Visits<br>**Metric 4.6.3:**<br>Childhood Immunization Status<br>**Metric 4.6.5:**<br>Well-Child Visits in the First 30 Months of Life |

| Virginia QS Aim and Goal | Molina's Quality Initiative | Performance Metric |
|---|---|---|
| **Aim 4:** Improved Population Health<br>**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | *Conduct Outreach Calls:*<br>The MCO partnered with MRx vendor partner to do outreach calls and identify barriers preventing members from being adherent to medication. | **Not a QS Metric:**<br>Asthma Medication Ratio<br>**Not a QS Metric:**<br>Adherence to Antipsychotic medications for individuals with Schizophrenia<br>**Not a QS Metric:**<br>Antidepressant Medication Management |
| **Aim 4:** Improved Population Health<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | *Targeted Interventions:*<br>Member outreach targeted kids before they turned two years old and helped them to schedule appointments to close the CIS measure gaps.<br><br>Compliant members received incentives from the MCO's partnered vendor on an agreed upon cadence | **Metric 4.6.3:**<br>Childhood Immunization Status |
| **Aim 4:** Improved Population Health<br>**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | *Conduct Outreach Calls:*<br>The MCO partnered with MRx vendor partner to do outreach calls and identify barriers preventing members from being adherent to medication. | **Not a QS Metric:**<br>Asthma Medication Ratio<br>**QS Metric:**<br>Adherence to Antipsychotic medications for individuals with Schizophrenia<br>**Not a QS Metric:**<br>Antidepressant Medication Management |
| **Aim 4:** Improved Population Health<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | *Communicate and Share with Providers:*<br>The MCO worked with individual provider/ provider groups, conduct monthly meetings, sent gaps in care reports, provided support for member outreach. | **Metric 4.6.3:**<br>Childhood Immunization Status |

# Optima

**Table D-4—Optima's QS Quality Initiatives**

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| **Aim 1:** Enhance Member Care Experience<br>**Goal 1.1:** Improve Member Satisfaction<br>**Goal 1.2:** Improve Home and Community-Based Services | *CAHPS benchmarks and initiatives*<br>• Number and percent of Waiver Individuals who have service plans that are adequate and appropriate to their need and personal goals who receive services in the scope specified by their service plan<br>• Weekly medical and behavioral care coordination and case management rounds with medical directors<br>• Care coordination/case management care gap dashboard (Tableau) to assist in identifying and closing care gaps when engaging with members<br>• Focused vendors for community partners for improving Social Determinants of Health (SDOH)<br>• Quarterly outreach member advisory forums (currently virtual due to COVID-19) | **Metric 1.2.3:**<br>Rating of All Health Care<br>**Metric 1.2.1:**<br>Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and Appropriate to Their Needs and Personal Goals |
| **Aim 2:** Effective Patient Care<br>**Goal 2.1:** Enhance Provider Support<br>**Goal 2.2:** Ensure Access to Care | *CAHPS benchmarks and initiatives*<br>• Dedicated Optima Readmission Prevention Team<br>• Readmission High-Risk Discharge Target and Intervention Committee<br>• Vendors/Partners in care: EMMI, CipherHealth, BioIQ, MDLive, Prealize, Integrated Eye Group (IEG), | **Metric 2.1.1:**<br>Rating of Personal Doctor<br>**Metric 2.1.1:**<br>Getting Needed Care |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| | Ontrak, Lexus Nexus, Focus Care In-Home Assessments, Progeny, Accordant, Inogen, Optum, Alere, Dario, CareNet<br>• Follow-up post- discharge activities | |
| **Aim 3:** Smarter Spending<br>**Goal 3.1:** Focus on Paying for Value<br>**Goal 3.2:** Focus on Efficient Use of Program Funds | *VBP/PWP Performance targets and initiatives. NCQA Quality Compass 50th percentiles*<br>• Focused workgroups to impact DMAS Clinical Efficiency measures: LANE PPA Readmissions<br>• PWP monthly tracking dashboard (Tableau)<br>• Readmission High-Risk Discharge Target and Intervention Committee<br>• Care coordination/case management care gap dashboard (Tableau) to assist in identifying and closing care gaps when engaging with members<br>• Behavioral Health Value-Based Agreements with Medication Assisted Treatment (MAT) clinics and Community Service Boards (CSB) focused on tapering members receiving prescriptive medications within the MAT programs while providing alternative wrap around Behavioral Health outpatient services such as peer recovery support, day treatment, partial hospitalization, Mental Health Intensive outpatient and utilization of long-acting opioid blockers causing long-term savings with the prevention of | **Metric 3.1.3:**<br>Frequency of Potentially Preventable Readmissions<br>**Metric 3.2.1:**<br>Monitor MLR annually by managed care program and aggregate total |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| | overdoses and hospital utilization | |
| **Aim 4:** Improved Population Health<br>**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members<br>**Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions<br>**Goal 4.5:** Improve Outcomes for Nursing Home Eligible Members<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | *VBP/PWP Performance targets and initiatives. NCQA Quality Compass 50th percentiles*<br>• Performance withhold program monthly tracking dashboard (Tableau)<br>• Case management/care coordinator care gap dashboard (Tableau) to assist in identifying and closing care gaps when engaging with members<br>• Quarterly Baby Showers<br>• Partners in Pregnancy (PIP) program<br>• Focused EPSDT care coordination<br>• Targeted behavioral health care coordination focusing on inpatient discharges, emergency room utilization and high-risk readmission member focus from behavioral health facilities<br>• Targeted case management for justice-involved members<br>• Quarterly behavioral health provider education<br>• Dedicated Optima Readmission Prevention team with (CipherHealth) to conduct hospital and ED post-discharge follow-up calls to members to assist with any member-identified concerns (home health, medications, discharge instructions, etc.<br>• Power Hour for all staff to provide weekly educational sessions (examples: | **Metric 4.1.1:**<br>Follow-Up After Hospitalization for Mental Illness<br>**Metric 4.1.2:**<br>Follow-Up After ED Visit for Mental Illness<br>**Metric 4.1.4:**<br>Monitor Mental Health Utilization<br>**Metric 4.2.2:**<br>Follow-Up After ED Visit for AOD Abuse or Dependence<br>**Metric 4.2.3:**<br>Use of Opioids at High Dosage in Persons Without Cancer<br>**Metric 4.2.4:**<br>Initiation and Engagement of AOD Abuse or Dependence Treatment<br>**Metric 4.3.1:**<br>Percentage of Eligibles who Receive Preventive Dental Services<br>**Metric 4.3.2:**<br>Adults' Access to Preventive/Ambulatory Health Services<br>**Metric 4.3.4:**<br>Child and Adolescent Well-Care Visits<br>**Metric 4.4.1:**<br>PQI 08: Heart Failure Admission Rate<br>**Metric 4.4.2:**<br>PDI 14: Asthma Admission Rate (Ages 2–17)<br>**Metric 4.4.3:**<br>PQI 05: COPD and Asthma in Older Adults' Admission Rate<br>**Metric 4.4.4:** |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| | asthma, COPD, diabetes, motivational interviewing, policy, and documentation updates, etc.)<br>• Improve access to follow-up after inpatient and emergency room visits with enhanced care coordination, member education, and scheduling of follow-up care within 7-10 days of discharge utilizing behavioral health care center for members with mental health<br>• Collaboration with CSBs, MAT facilities, and other local agencies to develop peer recovery support specialists to provide additional guidance and education upon release from incarceration for members with substance and alcohol use, ensuring members receive support to initiate and engage in substance abuse treatment | Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)<br>**Metric 4.6.1:**<br>Prenatal and Postpartum Care: Postpartum Care<br>**Metric 4.6.2:**<br>Prenatal and Postpartum Care: Timeliness of Prenatal Care<br>**Metric 4.6.3:**<br>Childhood Immunization Status<br>**Metric 4.6.4:**<br>Live Births Weighing Less than 2,500 Grams<br>**Metric 4.6.5:**<br>Well-Child Visits in the First 30 Months of Life |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members. | *Member Outreach and Engagement*<br>• Postcard reminder to noncompliant women 45 years and older on breast cancer screening<br>• Women 45 and older who have not had a mammogram in the previous 12 months receive a postcard during their birthday month. This card informs them of the recommended mammography schedule, and the importance of screening | **Not a QS Metric** |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| | • Clinical guidelines reviewed and providers are notified of updated<br>• Clinical guidelines via newsletter and provider site<br>• Emmi IVR campaign for mammogram reminders<br>• Provider letters of members with mammogram care gap<br>• Tableau dashboard care gap identification<br>• Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation<br>• Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need | |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *Member Outreach and Engagement*<br>• Increase outreach and education to these members regarding the importance of medication adherence and keeping regular appointments with PCP and behavioral health care providers.<br>• Articles in member and provider newsletters to support improved communication and coordination of care between the provider and the member<br>• Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation | **Not a QS Metric:**<br>Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *Member Outreach and Engagement*<br>• Screening reminders sent to women 21 years and older who have not had a cervical cancer screening in the previous 12 months receive a postcard during their birthday month<br>• Letter is sent to providers of members with cervical care gap<br>• Clinical guidelines reviewed and providers are notified of updated clinical guidelines via newsletter and provider site<br>• Articles in the member newsletter<br>• Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation<br>• Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need | **Not a QS Metric:**<br>Cervical Cancer Screening |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | *Care Coordination and Case Management*<br>• Childhood Immunization Incentive Program<br>• EMMI Well-Child and Immunizations IVR campaign<br>• EMMI Manager utilization for educational videos<br>• Prealize data utilized to identify members to refer to case management (CM)<br>• Case management utilization of Tableau care gap report when engaging members | **Metric 4.3.4:**<br>Child and Adolescent Well-Care Visits<br>**Metric 4.6.3:**<br>Childhood Immunization Status |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| | • Case management documentation of care gap information received from members<br>• Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation<br>• Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need<br>• Immunization program in development to improve member and clinician engagement which includes incentives, targeted outreach, and educational initiatives. Additionally, increased collaboration with the Commonwealth's Department of Health regarding vaccination data. Launch target of first quarter 2023.<br>• Population Health Assessment work group established 7/2022. NCQA standards and tools purchased to perform a comprehensive Population Health Assessment to include but not limited to: SDoH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population Health Assessment to be completed 7/2023. | |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| **Aim 4:** Improved Population Health<br>**Goal 4.4**: Improve Health for Members with Chronic Conditions | *Case Management, Member Outreach, and Incentives*<br>• Diabetic Eye Exam incentive program<br>• EMMMI Manager utilization for educational videos<br>• Prealize data utilized to identify members to refer to case management<br>• Case management utilization of Tableau care gap report when engaging members<br>• Case management documentation of care gap information received from members in Symphony/JIVA<br>• Pop Care Diabetic Eye Exam campaign<br>• BioIQ at-home A1c program.<br>• Focus Care In-Home A1c testing and DEE<br>• HEDIS 4th Quarter Push case management member outreach<br>• Diabetic Eye Exam article for member newsletter.<br>• Conducted a data analysis of care gaps by region to determine if any possible trends in barriers existed, no trends were noted<br>• Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need<br>• Retina Labs: Clinic-based and in-home tele-retinal screening solution for early detection of diabetic retinopathy in diabetic members. This will help | **Metric 4.4.4:**<br>Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| | close critical diabetes care gaps and improve health outcomes for members. Implementation target of fourth quarter 2022.<br>• Dario: The Dario Pilot covers 1,500 Optima Health Plan Medallion 4.0 and CCC Plus members in the Dario Type 2 Diabetes program. The solution provides adaptive, personalized member experiences to drive behavior change through evidence-based interventions, intuitive, clinically proven digital tools, high-quality software, and coaching to encourage individuals to improve their health and sustain meaningful outcomes. If the pilot proves effective at closing Type 2 Diabetes care gaps, it will be scaled to include all eligible members.<br>• Population Health Assessment work group established 7/2022. NCQA standards and tools purchased to perform a comprehensive Population Health Assessment to include but not limited to: SDoH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population Health Assessment to be completed 7/2023 | |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *Provider Education, Clinical Guidelines and Care Coordination*<br>• Clinical guidelines reviewed and updated<br>• Providers are notified of updated clinical guidelines via newsletter and provider website<br>• In-home A1c testing vendor program<br>• Tableau dashboard care gap identification<br>• Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation | **Not a QS Metric:**<br>Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | *Member Incentives, Outreach and Care Coordination*<br>• Well-Child Visit incentive program<br>• Emmi Well Child and Immunization IVR Campaign<br>• Article in the member newsletter<br>• Birthday cards mailing that includes a bookmarker that serves to remind members of the preventative health guidelines they should follow to achieve their personal best health<br>• Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation<br>• Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need | **Metric 4.3.4:**<br>Child and Adolescent Well-Care Visits<br>**Metric 4.6.3:**<br>Childhood Immunization Status<br>**Metric 4.6.5:**<br>Well-Child Visits in the First 30 Months of Life |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| | • Immunization program in development to improve member and clinician engagement which includes incentives, targeted outreach, and educational initiatives. Additionally, increased collaboration with the Commonwealth's Department of Health regarding vaccination data. Launch target of first quarter 2023.<br>• Population Health Assessment work group established 7/2022. NCQA standards and tools purchased to perform a comprehensive population health assessment to include but not limited to: SDoH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population Health Assessment to be completed 7/2023. | |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | *Clinical Guidelines and Care Coordination*<br>• Clinical guidelines reviewed and updated<br>• Providers are notified of updated clinical guidelines via newsletter and provider site<br>• Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation<br>• Collaboration with the Sentara Cares Mobile | **Metric 4.3.4:**<br>Child and Adolescent Well-Care Visits<br>**Metric 4.6.5:**<br>Well-Child Visits in the First 30 Months of Life<br>**Not a QS Metric:**<br>Metabolic Monitoring for Children and Adolescents on Antipsychotics- Blood Glucose Testing-Total, Cholesterol Testing-Total, and Blood Glucose and Cholesterol Testing- Total |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| | Health Services van to provide convenient access to care to areas in need | |
| **Aim 4:** Improved Population Health<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | *Case Management and Clinical Guidelines*<br>• Clinical guidelines reviewed and updated<br>• Providers are notified of updated clinical guidelines via newsletter and provider site<br>• Ongoing telephonic case management services were provided to members with respiratory conditions.<br>• Continue to educate providers on the importance of Spirometry Testing via the Optima Health web site provider portal.<br>• Added COPD link for members on OptimaHealth.com member's page. This link contains facts, educational resources, information, and COPD support groups available for members.<br>• Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation<br>• Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need | **Not a QS Metric:**<br>Pharmacotherapy Management of COPD Exacerbation-Bronchodilator and Systemic Corticosteroid |
| **Aim 3:** Smarter Spending<br>**Aim 4:** Improved Population Health<br>**Goal 3.1:** Focus on Paying for Value | *Transition of Care and Care Coordination*<br>• Enhanced care coordination model that targets members with SMI and chronic medical conditions | **Not a QS Metric:**<br>Plan All-Cause Readmissions-Observed Readmissions—Total |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | • Transition of care and HEDIS performance withhold program/emergency room diversion program that places emphasis on patients discharged from inpatient or ED to a lower level of care within 3-7 days, but no longer than 30 days<br>• Specialized case management program that focuses on high-risk pregnancies, deliveries, and post deliveries with infants<br>• Behavioral health chronic care coordination program<br>• Targeted member education that focuses on top five diagnosis for admissions to medical and behavioral facilities<br>• Immediate follow-up IVR and live calls to members post discharge to assist in transition of care<br>• Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation<br>• Predictive analysis conducted to identify members with a potential cost bloom<br>• Behavioral health care center clinic to assist with behavioral health follow up visits following admission or ED visit<br>• Analysis conducted to identify the top five diagnosis for readmission | |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| | • Educational tool created for members meeting the criteria<br>• In-home IHA and preventative screening program<br>• Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need | |
| **Aim 4:** Improved Population Health<br>**Goal: 4.1:** Improve Behavioral Health and Developmental Services of Members | *Clinical Guidelines and Care Coordination*<br>• Clinical guidelines reviewed and updated<br>• Providers are notified of updated clinical guidelines via newsletter and provider site<br>• Sentara is implementing new protocols and enhancing its outpatient services to improve access to community-based care and reduce the demand for ED services.<br>• Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation | **Metric 4.1.5:**<br>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *Clinical Guidelines, Provider Education, Member Education*<br>• Clinical guidelines reviewed and updated<br>• Providers are notified of updated clinical guidelines via newsletter and provider site<br>• Provider newsletter article<br>• Data analysis based on ordering providers to assist in driving interventions | **Not a QS Metric:**<br>Use of Imaging Studies for Low Back Pain |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| | • Partner with clinically integrated networks to develop action items for addressing the use of advanced imaging for initial diagnosis and treatment of low back pain<br>• Increase member benefit awareness: access to various back health programs available through the MCO's wellness platform - My Life My Plan Rewards, WebMD, IVR and education videos<br>• Add physical therapy recommendations to the member's newsletter to increase the understanding of low back health and how to prevent injuries | |
| **Aim 4:** Improved Population Health<br>**Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders | *Committees, Lock-in Programs*<br>• PUMS placement criteria<br>• Criteria addresses doctor and/or pharmacy shopping<br>• Interventions are made on behalf of the pharmacy, behavioral health/ARTS department, and medical directors<br>• Members are identified for the PUMS program through a monthly pharmacy report that provide pharmacy paid claims for controlled substances meeting the criteria<br>• Behavioral health sends a letter to the member providing a brief explanation of the PUMS program and a statement explaining the reason for placement in the PUMS program | **Metric 4.2.3:**<br>Use of Opioids at High Dosage in Persons Without Cancer<br>**Not a QS Metric:**<br>Use of Opioids from Multiple Providers-Multiple Prescribers |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| | • The PUMS lock-in program is for 12 months<br>• The Chronic Pain Committee consisting of clinical pharmacists, behavioral health/ARTS department, and medical directors evaluate if the member should continue in the program at the end of the 12-month period<br>• Educate providers about, and encourage use of, the Virginia prescription monitoring program to improve member safety by decreasing access to multiple prescribers of narcotics.<br>• Continue to advocate with both members and providers for the recognition and addressing of substance use issues. | |
| **Aim 4:** Improved Population Health<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | *Member Incentives and Member Outreach*<br>• Well-Child Visit incentive program<br>• EMMI Well Child IVR Campaign<br>• Articles in the member newsletter<br>• Birthday cards mailing that includes a bookmarker that serves to remind members of the preventative health guidelines they should follow to achieve their personal best health<br>• Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need | **Not a QS Metric:**<br>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, Counseling for Nutrition—Total, and Counseling for Physical Activity—Total |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| **Aim 1:** Enhance Member Care Experience<br>**Aim 2:** Effective Patient Care<br>**Goal: 1.1:** Increase Member Satisfaction<br>**Goal 2.2**: Ensure access to care | *Member Experience of Care Survey, Member Outreach, and Care Coordination*<br>• CAHPS 101 education annual CBT for all member-facing teams to increase awareness and importance<br>• CAHPS mid-year reminder to review customer service and the importance of the member experience<br>• Customer service post-survey member calls to drive continuous improvement opportunities<br>• Member outreach calls to assist members in navigating their healthcare needs<br>• Care coordination assistance with patient/provider appointment scheduling and transportation<br>• Provider newsletter articles<br>• Collaboration with network education to improve provider-driven measures | **Metric 1.2.1:**<br>Getting Care Quickly Q6<br>**Metric 1.2.3:**<br>Rating of All Health Care<br>**Metric 2.2.3:** Getting Needed Care |
| **Aim 1:** Enhance Member Care Experience<br>**Goal 1.1:** Improve Member Satisfaction | *Member Experience of Care Survey*<br>• CAHPS 101 education annual CBT for all member-facing teams to increase awareness and importance<br>• CAHPS mid-year reminder to review customer service and the importance of the member experience<br>• Customer service post-survey member calls to drive continuous improvement opportunities<br>• Member outreach calls to assist members in | **Metric 1.2.3:**<br>Rating of All Health Care |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| | navigating their healthcare needs<br>• Care coordination assistance with patient/provider appointment scheduling and transportation | |
| **Aim 1:** Enhanced Member Care Experience<br>**Goal 1.1:** Improve Member Satisfaction | *Member Experience of Care Survey*<br>CAHPS Performance Improvement workgroup consisting of key stakeholders across the organization established to collaborate and discuss interventions to improve the bottom three CAHPS measures for both Medallion 4.0 and CCC Plus. Interventions include:<br>• Development of annual CAHPS 101 training for all member-facing team members<br>• Development of CAHPS reminder one-pager for member-facing teams' mid-year<br>• Provider newsletter articles | **Metric 1.2.3:**<br>Rating of All Health Care |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *Review Data Trends*<br>Performance improvement of HEDIS measures to increase the screening and preventive services for members. Collaborate with teams across the organization to review data trends, identify opportunities, implement interventions, and track impact of initiatives. | **Metric 4.3.2:**<br>Adults' Access to Preventive/Ambulatory Health Services |
| **Aim 1:** Enhanced Member Care Experience<br>**Aim 4:** Improved Population Health<br>**Goal 1.1:** Improve Member Satisfaction | *Educational IVR and Member Outreach*<br>Educational IVR and video campaigns via email to improve understanding of preventive screenings and gaps in care. | **Metric 1.2.3:**<br>Rating of All Health Care<br>**Metric 4.3.2:**<br>Adults' Access to Preventive/Ambulatory Health Services |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | Reminds members of preventive screenings due and answers questions they may have about their care. Follow-up live calls from a nurse are made as needed. Improves members satisfaction, experience, and overall health outcomes. | **Metric 4.4.4:**<br>Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) |
| **Aim 1:** Enhanced Member Care Experience<br>**Aim 4:** Improved Population Health<br>**Goal 1.2:** Improve Member Satisfaction<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | *In-Home Care and Assessments*<br>Provide screening kits to members via mail and through in-home health assessments makes it convenient for members to complete screenings and gaps in care by providing it to the member without the need for the member to take an action. This improves member satisfaction, experience, and health outcomes. | **Metric 1.2.3:**<br>Rating of All Health Care<br>**Metric 4.3.2:**<br>Adults' Access to Preventive/Ambulatory Health Services<br>**Metric 4.4.4:**<br>Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | *Dedicated Population Health Team:*<br>By having a dedicated Population Health department, efforts and interventions across the health plan can be centralized in one location for a more targeted approach at improving health outcomes for members.<br>The Population Health Performance Improvement Team facilitates, organizes, and coordinates plan-level quality measures improvement projects and evaluates improvement initiatives. | **Metric 4.3.2:**<br>Adults' Access to Preventive/Ambulatory Health Services |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| **Aim 1:** Enhanced Member Care Experience<br>**Aim 4:** Improved Population Health<br>**Goal 1.2:** Improve Member Satisfaction<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | *Digital/Electronic Health Monitoring*<br>Ovia is a digital app accessible to members on their phone and supports them through coaching and education on their pregnancy and birth journey. The engagement starts with an intake questionnaire and material pushed to the member is tailored to address any concerns that are identified. The member also answers a few questions daily to assess their pregnancy and mental health. Any red flags are immediately escalated to a health coach. The app is available to members' support system as well so they can be engaged in ensuring a positive birth outcome for their loved ones. | **Metric 1.2.3:**<br>Rating of All Health Care<br>**Metric 4.3.2:**<br>Adults' Access to Preventive/Ambulatory Health Services<br>**Metric 4.4.4:**<br>Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)<br>**Metric 4.6.4:**<br>Live Births Weighing Less than 2,500 Grams |
| **Aim 1:** Enhanced Member Care Experience<br>**Aim 4:** Improved Population Health<br>**Goal 1.2:** Improve Member Satisfaction<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | *Diabetes Management Program*<br>Dario: The Dario Pilot is taking 1,500 Optima Health Medicaid and DSNP members and enrolls them into Dario's Type 2 Diabetes program. The solution provides adaptive, personalized member experiences that drive behavior change through evidence-based interventions, intuitive, clinically proven digital tools, high-quality software, and coaching that inspire individuals to improve health and sustain meaningful outcomes. If the pilot proves effective at closing Type 2 Diabetes care gaps, we will scale it to the larger organization.<br>• Onduo | **Metric 1.2.3:**<br>Rating of All Health Care<br>**Metric 4.3.2:**<br>Adults' Access to Preventive/Ambulatory Health Services<br>**Metric 4.4.4:**<br>Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) |

| Virginia QS Aim and Goal | Optima's Quality Initiative | Performance Metric |
|---|---|---|
| | – This is also a T2D initiative that targets all lines of business not touched by Dario. Onduo does not have the capability to take on Medicaid membership at this time<br>• Retina Labs<br>– Clinic-based and in-home diabetic retinal screening solution for early detection of diabetic retinopathy. This will help close critical diabetes care gaps and improve health outcomes for members. Aiming for fourth quarter (CY2022) go-live | |

# United

**Table D-5—United's QS Quality Initiatives**

| Virginia QS Aim and Goal | United's Quality Initiative | Performance Metric |
|---|---|---|
| **Aim 1:** Enhance Member Care Experience<br>**Goal 1.1:** Improve Member Satisfaction | *Care Coordination, Member Engagement and Member Experience of Care Survey*<br>• UHC's care coordination model and individualized care management plans for members ensure the integration of physical and behavioral health, incorporating medical management, resources, and other supports. Member care plans are member-centered and focus on the member's goals for positive health outcomes. | **Metric 1.2.1:** Getting Care Quickly<br>**Metric 1.2.2:** Enrollees Rating of Health Plan<br>Metric 1.2.3: Rating of All Health Care |

| Virginia QS Aim and Goal | United's Quality Initiative | Performance Metric |
|---|---|---|
| | • UHC's core focus is on social determinants of health; identifying and trending SDoH needs to determine each members' needs for preventative care while ensuring a strong engagement and connection with community resources.<br>• UHC assesses and monitors disparities in relation to race, ethnicity, and language across the Commonwealth to develop appropriate interventions within the communities. | |
| **Aim 2:** Effective Patient Care<br>**Goal 2.1:** Enhance Provider Support<br>**Goal 2.2:** Ensure Access to Care | *Network Monitoring, Provider Incentives, Expanding Telehealth*<br>• UHC diligently monitors network adequacy to ensure members have appropriate access to quality care. UHC conducts routine evaluations of the quality of care provided by our valued provider partners.<br>• UHC partners with providers and enables member support through activities such as:<br>• Ensuring providers have the most current information on Medicaid and Medicare benefits as well as UHC's enhanced benefits and initiatives to facilitate meaningful care with members.<br>• Community Plan Primary Care Provider Incentive (CP-PCPi) Program: With the goal of achieving quality member outcomes, UHC educates providers in HEDIS specifications, provides up- | **Metric 2.1.2:**<br>How Well Doctors Communicate<br>**Metric 2.2.3:**<br>Getting Needed Care |

| Virginia QS Aim and Goal | United's Quality Initiative | Performance Metric |
|---|---|---|
| | to-date detailed data of members experiencing gaps in care, and assists providers with identification and outreach of members to close gaps in care.<br>• Expanding telehealth to increase availability of access to care for members.<br>• Identifying ED visits through the ED care coordination (EDCC) interface and working with ED on adequate discharge plans and follow-up appointments.<br>• Weekly medical, maternal, and behavioral care coordination/ member case rounds with medical directors.<br>• Targeted behavioral health care coordination for emergency room utilization, inpatient discharges, and high-risk readmissions.<br>• Facilitating transportation to/from provider appointments and other key non-medical appointments.<br>• Partnership with Federally Qualified Health Centers (FQHCs), health systems and other community partners for member care and support of community events.<br>• Partnership with community entities to facilitate and promote member self-care and resources. | |
| **Aim 3:** Smarter Spending<br>**Goal 3.1:** Focus on Paying for Value | *Monitoring and Provider Incentives*<br>• UHC continually monitors to ensure it is operating as efficiently and effectively as possible in supporting its | **Metric 3.1.1:**<br>Frequency of Potentially Preventable Admissions<br>**Metric 3.1.2:**<br>Frequency of ED Visits<br>**Metric 3.1.3:** |

| Virginia QS Aim and Goal | United's Quality Initiative | Performance Metric |
|---|---|---|
| | members. There is also focus on medically unnecessary or potentially preventable spending for hospital admissions, hospital readmissions, and ED visits.<br>• Community Plan Primary Care Provider Incentive (CP-PCPi) Program: With the goal of achieving quality member outcomes, UHC educates providers in HEDIS specifications, provides up-to-date detailed data of members experiencing gaps in care, and assists providers with identification and outreach of members to close gaps in care.<br>• UHC continues to monitor clinical efficiencies to track and evaluate success in reducing preventable, avoidable, and medically unnecessary utilization.<br>• Utilization and monitoring Collective Medical data to identify high-utilization members; cross-functional collaboration with SDoH focus to determine gaps in care and provide high-intensity care coordination, strategies, and intervention. | Frequency of Potentially Preventable Readmissions<br>**Metric 3.1.4:**<br>Ambulatory Care: Emergency (ED) Visits |
| **Aim 4:** Improved Population Health<br>**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members<br>**Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders | *Member Outreach and Education*<br>Through a variety of methodologies, UHC provides member and provider education and member outreach, with appropriate focus on sub-populations with special ongoing or episodic needs. Many of these outreach programs are outlined in the | **Metric 4.1.5:**<br>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics<br>**Metric 4.2.1:**<br>Monitor Identification of AO Drug Services<br>**Metric 4.2.2:**<br>Follow-Up After ED Visit for AOD Abuse or Dependence<br>**Metric 4.2.4:** |

| Virginia QS Aim and Goal | United's Quality Initiative | Performance Metric |
|---|---|---|
| | PM validation section on HEDIS measure activities.<br>• Community Plan Primary Care Provider Incentive (CP-PCPi) Program: With the goal of achieving quality member outcomes, UHC educates providers in HEDIS specifications, provides up-to-date detailed data of members experiencing gaps in care, and assists providers with identification and outreach of members to close gaps in care.<br>• Utilization and monitoring Collective Medical data to identify high-utilization members; cross-functional collaboration with SDoH focus to determine gaps in care and provide high-intensity care coordination, strategies, and intervention.<br>• High-utilization member outreach and follow-up following ED or inpatient admission for mental health, alcohol, or other substance abuse.<br>• Member incentives for members who complete follow-up appointment after ED or mental health inpatient admission.<br>• Partnership with community service boards and other community resources.<br>• Supports and encourages the use of telemedicine to assist members with continued access to care: UHC has worked to deploy enhanced virtual models to further assist members with various care needs and | Initiation and Engagement of AOD Abuse or Dependence Treatment—Total |

| Virginia QS Aim and Goal | United's Quality Initiative | Performance Metric |
|---|---|---|
| | social needs and to maintain/improve member engagement and outcomes.<br>• Regional, complex, maternity, and behavioral health rounds: United's regional, complex, maternity, and behavioral health rounds program consist of care coordinators and representatives from pharmacy, behavioral health, utilization management, and external colleagues as needed. The weekly programs address both immediate and long-term member needs, provides support and resources to ensure member's needs were met and promotes quality outcomes.<br>• In addition to using member-level HEDIS and other quality measures, UHC continues to monitor under-utilization of key services that are critical to supporting member needs (e.g., home and community-based services, behavioral health). | |
| **Aim 4:** Improved Population Health<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | *Member and Provider Outreach and Engagement*<br>Through a variety of methodologies, UHC provides member and provider education and member outreach, with appropriate focus on sub-populations with special ongoing or episodic needs. Many of these outreach programs are outlined in the PM validation section on HEDIS measure activities. | **Metric 4.4.2:**<br>PDI 14: Asthma Admission Rate<br>**Metric 4.4.3:**<br>PQI 05: COPD and Asthma in Older Adults' Admission Rate<br>**Metric 4.4.4:**<br>Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)<br>**Metric 4.4.5:**<br>Controlling High Blood Pressure<br>**Metric 4.6.1:**<br>Prenatal and Postpartum Care: Postpartum Care<br>**Metric 4.6.2:** |

| Virginia QS Aim and Goal | United's Quality Initiative | Performance Metric |
|---|---|---|
| | • UHC continually reviews metrics globally to identify where outreach is most needed and to identify emerging trends statewide or regionally. Each care coordinator has immediate access to known gaps at the individual member level when accessing their record for either proactive/planned care management activities or in responding to and supporting unplanned/reactive care events for the member and assists the member with scheduling and completed care events.<br>• CVS Health Tag – Partnered with CVS pharmacies to include messages encouraging members to receive a vaccine shot when picking up their prescriptions.<br>• Community Plan Primary Care Provider Incentive (CP-PCPi) Program: With the goal of achieving quality member outcomes, UHC educates providers in HEDIS specifications, provides up-to-date detailed data of members experiencing gaps in care, and assists providers with identification and outreach of members to close gaps in care.<br>• Utilization and monitoring Collective Medical data to identify high-utilization members; cross-functional collaboration with SDoH focus to determine gaps in care and provide high-intensity care coordination, strategies, and intervention. | Prenatal and Postpartum Care: Timeliness of Prenatal Care<br>**Metric 4.6.3:**<br>Childhood Immunization Status<br>**Metric 4.6.5:**<br>Well-Child Visits in the First 30 Months of Life |

| Virginia QS Aim and Goal | United's Quality Initiative | Performance Metric |
|---|---|---|
| | • Complex Care Management Team: Provides increased outreach, education, and care coordination for members with chronic conditions.<br>• Regional, complex, maternity, and behavioral health rounds: United's regional, complex, maternity, and behavioral health rounds program consist of care coordinators and representatives from pharmacy, behavioral health, utilization management, and external colleagues as needed. The weekly programs address both immediate and long-term member needs, provides support and resources to ensure member's needs were met and promotes quality outcomes.<br>• In addition to using member-level HEDIS and other quality measures, UHC continues to monitor under-utilization of key services that are critical to supporting member needs (e.g., home and community-based services, behavioral health).<br>• Supports and encourages the use of telemedicine to assist members with continued access to care: UHC has worked to deploy enhanced virtual models to further assist members with various care needs and social needs and to maintain/improve member engagement and outcomes. | |

# VA Premier

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

| Virginia QS Aim and Goal | VA Premier's Quality Initiative | Performance Metric |
|---|---|---|
| **Aim 1:** Enhance Member Care Experience<br>**Goal 1.3:** Improve Home and Community Based Services | *Quality Management Reviews*<br><br>Quality management reviews are performed to ensure high quality of service delivery consistent with the attending physician's orders, approved plan of care (POC), and authorized services for Waiver members.<br><br>Onsite/desktop reviews conducted to assure the health and safety of Waiver beneficiaries and maintain compliance with state and federal regulations.<br><br>Quality management reviews (QMR) completed as assigned per Department of Medical Assistance Services (DMAS) with follow-up corrective action plan (CAP) reviews completed appropriately. | **Metric 1.3.1:**<br>Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and Appropriate to Their Needs and Personal Goals |
| **Aim 2:** Effective Patient Care<br>**Goal 2.1:** Enhance Provider Support | *Contracting and Provider Services*<br>Conduct provider implementation meetings to review new initiatives with providers, ensure they understand the processes involved, introduce them to their key points of contact, and address any questions or concerns they may have.<br><br>Facilitate meetings with providers to address any contract related issues and concerns they may have as well as to review any obligations they have under the | **Metric 2.2.3:**<br>Getting Needed Care |

| Virginia QS Aim and Goal | VA Premier's Quality Initiative | Performance Metric |
|---|---|---|
| | terms of their contractual agreement.<br><br>Outreach is made by the provider services team ensure they remain compliant with access standards. Those providers who are non-compliant would receive additional outreach, follow-up and training and practice to become compliant. Provider Services would partner with the contracting team to obtain any missing information and a tracking system to document the issue, when it occurred, and how it will be resolved. | |
| **Aim 2:** Effective Patient Care<br>**Goal 2.1:** Enhance Provider Support | *Contracting and Provider Services*<br><br>Educate providers and practitioners on value-based care incentives and other provider-related topics to give providers/practitioners an opportunity to listen to updates and ask questions from each operational department<br><br>Provider education meetings (PEM) occur quarterly in every region to discuss new initiatives and processes. The purpose of the PEMs is to engage with our provider community and share updates while allowing them an opportunity to ask questions. We cover the newest provider information for all lines of business: Claims submission and issue resolution, utilization management, and quality improvement. The MCO also covers VPHP's many providers self-service tools available | **Metric 2.1.1:**<br>Maintain Provider Engagement |

| Virginia QS Aim and Goal | VA Premier's Quality Initiative | Performance Metric |
|---|---|---|
| | through our website. The MCO also touches on the latest guidance from DMAS and how that applies to Virginia Premier. | |
| **Aim 4:** Improved Population Health<br>**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members | *Implementation of the DMAS Enhanced Behavioral Health (EBH) Services*<br><br>The behavioral health department successfully led the implementation of nine new mandated services, which required inter- and cross departmental work to ensure all impacted systems were configured, providers were educated and contracted or credentialed to provide the services, and utilization/care coordination staff were fully trained on the new services.<br><br>Behavioral health will continue to monitor the utilization trends for these new services and work with cost of care and programs to build reports to assess the impact of these services on member outcomes, ED utilization, and readmissions. | **Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness |

# Appendix E. Assessment of Follow-Up on Prior Recommendations

## DMAS Follow-Up on Prior Year Recommendations for the CCC Plus Program

### *Introduction*

Regulations at §438.364 require an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity (described in §438.310[c][2]) has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. This appendix provides a summary of the follow-up actions per activity that DMAS and the MCOs reported completing in response to HSAG's SFY 2020–2021 recommendations. Please note, content included in this section is presented verbatim as received from the MCOs and has not been edited or validated by HSAG.

### *Scoring*

In accordance with CMS guidance, HSAG used a three-point rating system. The response to each EQRO recommendation was rated as *High*, *Medium,* or *Low* according to the criteria below.

*High* indicates *all* of the following:

1. DMAS or the MCO implemented new initiatives or revised current initiatives that were applicable to the recommendation.
2. Performance improvement directly attributable to the initiative was noted *or* if performance did not improve, DMAS or the MCO identified barriers that were specific to the initiative.
3. DMAS or the MCO included a viable strategy for continued improvement or overcoming identified barriers.

A rating of *high* is indicated by the following graphic:


*Medium* indicates one or more of the following:

1. DMAS or the MCO continued previous initiatives that were applicable to the recommendation.
2. Performance improvement was noted that may or may not be directly attributable to the initiative.
3. If performance did not improve, DMAS or the MCO identified barriers that may or may not be specific to the initiative.
4. DMAS or the MCO included a viable strategy for continued improvement or overcoming barriers.

A rating of *medium* is indicated by the following graphic:


*Low* indicates one or more the following:

1. DMAS or the MCO did not implement an initiative or the initiative was not applicable to the recommendation.
2. No performance improvement was noted *and* DMAS or the MCO did not identify barriers that were specific to the initiative.
3. DMAS or the MCO's strategy for continued improvement or overcoming identified barriers was not specific or viable.

A rating of *low* is indicated by the following graphic:


**Table E-1—Prior Year Recommendations and Responses—CCC Plus Program Overall**

| **Recommendation** | | |
|---|---|---|
| **Aim 4:** Improved Population Health | **Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders<br>**Objective:** Increase Follow-Up After ED Visit for AOD Abuse or Dependence | **Metric 4.2.2:** Follow-Up After ED Visit for AOD Abuse or Dependence |
| **HSAG Recommendation:** To improve program-wide performance in support of Goal 4.2 and improve members' receipt of follow-up services, HSAG recommends the following:<br>• Require the MCOs to identify healthcare disparities within the behavioral health follow-up PM data to focus QI efforts on a disparate population.<br>• Require the MCOs to identify best practices to conduct follow-up with members discharged from the ED and ensure follow-up visits within seven days and 30 days are completed. | | |
| **DMAS' Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• DMAS included the measure *Follow-Up After ED Visit for AOD Abuse or Dependence* in its PWP which provides an incentive to MCOs to increase performance and close gaps. | | |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Follow-up After ED Visit for AOD Abuse or Dependence<br>MY 2020: 7-Day: 11.44% 30-Day: 19.98%<br>MY 2021: 7-Day: 14.55% 30-Day: 22.57% | | |

| Recommendation |
|---|
| Identify any barriers to implementing initiatives:<br>The COVID-19 PHE continued to be a barrier to improving performance to address the HSAG recommendation. |
| **HSAG Assessment:**<br>  |

| Recommendation | | |
|---|---|---|
| **Aim 4:** Improved Population Health | **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members<br>**Objective:** Increase Child and Adolescent Well-Care Visits<br><br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members<br>**Objective:** Increase Well-Child Visits | **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life |
| **HSAG Recommendation:** To improve program-wide performance in support of Goal 4.3 and mitigate the barriers members experience related to access to care, HSAG recommends the following:<br>• 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.<br>• Require the MCOs to identify healthcare disparities within the access-related PM data to focus QI efforts on a disparate population. | | |

| DMAS' Response |
|---|
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• DMAS included the measure *Well-Child Visits in the First 30 Months of Life* measure in its PWP which provides an incentive to MCOs to increase performance and close gaps. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Well-Child Visits in the First 30 Months of Life<br>MY 2020: First 15 Months: 30.67% 15 -30 Months: 71.81%<br>MY 2021: First 15 Months: 26.28% 15 -30 Months: 65.74% |

| Recommendation |
|---|
| Identify any barriers to implementing initiatives:<br>The COVID-19 PHE continued to be a barrier to improving performance to address the HSAG recommendations around improvement in preventive care use. |
| **HSAG Assessment:**<br>  <br> |

| Recommendation | | |
|---|---|---|
| **Aim 4:** Improved Population Health | **Goal 4.4:** Improve Health for Members with Chronic Conditions<br>**Objective:** Decrease Diabetes Poor Control<br>**Objective:** Increase Control of High Blood Pressure | **Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)<br><br>**Metric 4.4.5:** Controlling High Blood Pressure |
| **HSAG Recommendation:** To improve program-wide performance in support of Goal 4.4 and improve members' receipt of recommended care and services for better management of chronic conditions, HSAG recommends the following:<br>• 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.<br>• Require the MCOs to identify healthcare disparities within the chronic health PM data to focus QI efforts on a disparate population. | | |
| **DMAS' Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• DMAS included the *measure Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)* and the *Controlling High Blood Pressure* measures in its PWP which provides an incentive to MCOs to increase performance and close gaps. | | |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)<br>MY 2020: 51.42%<br>MY 2021: 47.39%<br>**Metric:** Controlling High Blood Pressure<br>MY 2020: 48.07%<br>MY 2021: 53.24% | | |
| Identify any barriers to implementing initiatives: | | |

| Recommendation |
| --- |
| The COVID-19 PHE continued to be a barrier to improving performance to address the HSAG recommendations around improvement in preventive care use. |
| **HSAG Assessment:**   |

# MCOs' Follow-Up on Prior Year Recommendations

## *Aetna*

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

| **Recommendation—Performance Improvement Projects** | | |
|---|---|---|
| **Aim 3:** Smarter Spending | **Goal 3.1:** Focus on Paying for Value | **Metric 3.1.4:** Ambulatory Care: Decrease Emergency (ED) Visits |
| **Weakness:** Aetna received *Low Confidence* for both PIPs.<br>**Why the weakness exists:** For the *Ambulatory Care—ED Visits* PIP, the MCO could not link improvement to an intervention tested for the PIP. For the *Follow-Up After Discharge* PIP, the SMART Aim result did not meet the goal.<br>**Recommendation:** HSAG recommends that Aetna:<br>• Test more than one intervention per PIP.<br>• Focus on testing active and engaging interventions. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• Aetna Better Health of Virginia originally initiated three interventions for its AMB PIP. The first planned intervention involved collaborating with the Plan's transportation vendor to improve staffing during high volume hours to reduce driver no-shows. However, due to having no evidence to support the assumption that our transportation vendor does not have an adequate number of drivers in their network, the intervention was abandoned. The third planned intervention involved educating members through a newsletter article about the importance of utilizing a PCP for chronic condition management. Ultimately, at HSAG's further recommendation, the Plan published the article, but refrained from including the intervention in the PIP due to the inability to determine which members did nor did not receive the newsletter article, and if it was in fact read by the member. The MCO continued with the second planned intervention throughout the duration of the intervention testing period.<br>• Aetna Better Health of Virginia originally initiated three interventions for is FUD PIP. The first planned intervention also involved collaborating with the Plan's transportation vendor to improve staffing during high volume hours to reduce driver no-shows. However, as indicated in the AMB PIP, the Plan had no evidence to support the assumption that our transportation vendor does not have an adequate number of drivers in their network at any given time. Therefore, the MCO chose to abandon the intervention. The third planned intervention included updating the outbound call logic. The MCO was unable to complete the planned updates within the limited time frame before intervention testing and therefore, had to abandon the intervention. The MCO continued with the second planned intervention throughout the duration of the intervention testing period.<br>• Per HSAG's recommendation to focus on testing active and engaging interventions, Aetna Better Health of Virginia continued to focus on testing active and engaging AMB and FUD interventions until intervention testing ceased on 5/31/2021. While the Plan could not attribute the overall success of the AMB and FUD interventions tested, overall results demonstrated decreased ED | | |

| Recommendation—Performance Improvement Projects |
|---|
| utilization and improvements with members completing a follow-up visit within 30 days post-discharge. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Ambulatory Care: Decrease Emergency (ED) Visits<br>MY 2020: 84.31<br>MY 2021: 85.92 |
| Identify any barriers to implementing initiatives:<br>Barriers identified with implementing AMB PIP initiatives included:<br>• Delay in obtaining DMAS approval for telephonic script for member outreach in early phases of intervention testing.<br>• Overall low denominators identified for conducting activities throughout intervention testing.<br><br>Barriers identified with implementing FUD PIP initiatives included:<br>• COVID significantly impacted the Plan's ability to perform a concurrent provider intervention, which the MCO believes would have enhanced participant identification and metric rate success.<br>• The MCO intended to add letter templates to the current case management business application system. However, company policy requires corporate approvals for all letter templates and system updates, which impacted the MCO's ability to test the intervention earlier. |
| **HSAG Assessment:**<br>  |

| Recommendation—Performance Measure Validation | | |
|---|---|---|
| **Aim 4:** Improved Population Health | **Goal 4.4:** Improve Health for Members with Chronic Conditions | **Metric: N/A** |
| **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 Aetna:<br>• *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*<br>• *Breast Cancer Screening*<br>• *Cervical Cancer Screening*<br>• *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*<br>• *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*<br>• *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*<br>• *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* and *Cholesterol Testing—Total* | | |

| Recommendation—Performance Measure Validation |
|---|
| • *Plan All-Cause Readmissions—Observed Readmissions—Total*<br>• *Use of Opioids from Multiple Providers—Multiple Pharmacies* and *Multiple Prescribers and Multiple Pharmacies*<br>• *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*<br>**Why the weakness exists:** Across all domains, Aetna members are not accessing and completing timely screenings, or receiving 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.<br>**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, behavioral health services, and care and services for chronic conditions. HSAG recommends that Aetna analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. 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 ambulatory services, which can significantly reduce non-urgent ED visits. |
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• Per HSAG's recommendation Aetna Better Health of Virginia continues to develop new and monitor current initiatives and interventions. Specifically, the MCO conducted a health equities analysis to evaluate our membership population. The MCO also designated measure subject matter experts (SMEs) to complete deep dives into race, ethnicity, language, age group, and ZIP code for various measures to drive initiatives. One initiative implemented as a result of the analysis, includes targeted outreach to members aged 18-21 years who were identified as non-compliant with preventative healthcare. The MCO also initiated the use of a social determinants of health (SDoH) software application to assist in identifying specific needs in each region and using *FindHelp* to assist members in finding resources for health care inequities. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications<br>MY 2020: 77.51%<br>MY 2021: 82.66%<br>**Metric:** Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)<br>MY 2020: 45.0% |

| Recommendation—Performance Measure Validation |
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| MY 2021: 53.03%<br>**Metric:** Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)<br>MY 2020: 30.71%<br>MY 2021: 37.12%<br>**Metric:** Plan All Cause Readmissions - Observed Rate<br>MY 2020: 12.15%<br>MY 2021: 10.59%<br>**Metric:** Use of Opioids from Multiple Providers - Multiple Prescribers and Multiple Pharmacies (lower percentage desired)<br>MY 2020: 4.48%<br>MY 2021: 3.34%<br>**Metric:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)<br>MY 2020: 62.77%<br>MY 2021: 70.32%<br>**Metric:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)<br>MY 2020: 56.45%<br>MY 2021: 60.07%<br>**Metric:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)<br>MY 2020: 46.72%<br>MY 2021: 54.74% |
| Identify any barriers to implementing initiatives:<br>Aetna Better Health of Virginia did not identify any barriers with implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim: N/A** | **Goal: N/A** | **Metric: N/A** |
| **Weakness:** The MCO's network adequacy policies and analysis did not align with federal and Commonwealth requirements for all provider types. The MCO did not include all federal and Commonwealth member rights in its Member Rights and Responsibilities policy.<br>**Why the weakness exists:** The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements.<br>**Recommendation:** The MCO must update its policies, procedures, and process to ensure all 2020 Medicaid Managed Care Rule and DMAS contract requirements are met. | | |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• Per HSAG's recommendation to update MCO policies and analysis procedures to include all current federal and Commonwealth requirements for all provider types, Aetna Better Health of Virginia updated its *Access to Care Plan* policy to ensure the appointment time frames for all provider types align with federal and Commonwealth requirements. The MCO will continue to review the policy annually to ensure the access requirements continue to reflect federal and state requirements.<br>• Per HSAG's recommendation to update MCO subcontractor and delegated entity agreements to include the Virginia-specific requirements, Aetna Better Health of Virginia developed a desktop to define the process for ensuring our Regulatory Compliance Addendum be included in all delegated entity agreements and available to all delegated providers. Additionally, the MCO updated the health plan provider manual and website to include the most recent DMAS approved Regulatory Compliance Addendums. Additionally, quality management and compliance conduct routine audits to assess compliance with delegated entity agreements containing current Regulatory Compliance Addendums. Audit results demonstrate 100 percent compliance with the recommendation. | | |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric** NA | | |
| Identify any barriers to implementing initiatives:<br>Aetna Better Health of Virginia did not identify any barriers with implementing initiatives. | | |
| **HSAG Assessment:**<br>  | | |
| **Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations** | | |
| **Aim: N/A** | **Goal: N/A** | **Metric: N/A** |
| **Weakness:** The MCO's appeal policy did not specifically address adverse benefit determinations based on the type or level of service, appropriateness, setting, or effectiveness of a covered benefit. The MCO also did not consistently send grievance resolution letters to members.<br>**Why the weakness exists:** The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements.<br>**Recommendation:** The MCO must update its policies, procedures, and process to ensure all 2020 Medicaid Managed Care Rule and DMAS contract requirements are met. The MCO must ensure that grievance resolution letters are consistently sent to members. | | |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations |
|---|
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• Per HSAG's recommendation, Aetna Better Health of Virginia updated its Enrollee Appeals and Enrollee Complaint_Grievance policies in August 2021 to reflect the 2020 Medicaid Managed Rule and DMAS contract requirements. Specifically, the MCO clarified *adverse benefit determinations are based on the type or level of service, appropriateness, setting, or effectiveness of a covered benefit* in the Plan's adverse benefit determination definition. Additionally, to ensure grievance resolution letters are consistently sent to members, Aetna Better Health of Virginia developed an internal job aid for the grievance team that establishes a step-by-step instructions for documenting and processing a standard grievance. The MCO also conducted training on 12/31/2021 to educate staff about the importance of providing written grievance resolution notices timely and in an easy-to-understand format. The grievance department conducts ongoing random audits to ensure staff compliance with training. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** NA |
| Identify any barriers to implementing initiatives:<br>Aetna Better Health of Virginia did not identify any barriers with implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim: N/A** | **Goal: N/A** | **Metric: N/A** |
| **Weakness:** The MCO did not consistently inform members that although an EPSDT service was carved out and therefore not covered under the member's managed care health plan, it may be available through DMAS under the Medicaid state plan and provide the appropriate contact information for the member to inquire with DMAS.<br>**Why the weakness exists:** The MCO's adverse benefit determination letters to members focused on coverage decisions of benefits provided by the MCO and not all benefits available to the member.<br>**Recommendation:** The MCO should consistently inform members that EPSDT benefits not covered by the MCO may be available through DMAS, and how to contact DMAS to receive a benefit determination. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• Per HSAG's recommendation, Aetna Better Health of Virginia revised is CCC Plus Appeal Backer to include verbiage notifying members that EPSDT criteria was applied to include a secondary | | |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations |
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| review, that the criteria applies to any adverse determination rendered, that although a particular service may be carved out and not covered by the MCO, it may be available through DMAS under the Medicaid State Plan, and an email to send all inquiries. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** NA |
| Identify any barriers to implementing initiatives:<br>Aetna Better Health of Virginia did not identify any barriers with implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Encounter Data Validation | | |
|---|---|---|
| **Aim: N/A** | **Goal: N/A** | **Metric N/A** |
| **Weakness:** Aetna did not meet the timeliness standards for both institutional and professional encounters.<br>**Why the weakness exists:** The IS review and administrative profile analysis did not identify the specific root cause of the weakness.<br>**Recommendation:** HSAG recommends Aetna identify the root cause of any delays in submitting institutional and professional encounters to rectify any issues. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• Aetna Better Health of Virginia experienced a drop in timeliness due to an encounter system migration, which was fully resolved in February 2021. The MCO was performing required state testing against all file types. Timeliness misses were directly related to receiving approval of our test plans to move into production. DMAS was aware of these misses/holding of production files until the testing phase was complete. Since the migration, submission timeliness has been 99 plus percent respectively for Institutional and pharmacy form types. | | |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Not Applicable | | |
| Identify any barriers to implementing initiatives:<br>Aetna Better Health of Virginia did not identify any barriers with implementing initiatives. | | |
| **HSAG Assessment:**<br>  | | |

| Recommendation—Member Experience of Care Survey | | |
|---|---|---|
| **Aim 1:**<br>Enhance Member Care Experience | **Goal 1.2:**<br>Improve Member Satisfaction | **Metric 1.2.1:**<br>Getting Care Quickly (CAHPS)<br>**Metric 1.2.3:**<br>Rating of All Health Care (CAHPS) |

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

**Why the weakness exists:** NA.

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

**MCO's Response**

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Per HSAG's recommendation to monitor the measures to ensure significant decreases in scores over time do not occur, the MCO implemented a workplan to be proactive to focus on activities to address measures. Specifically, the MCO merged its HEDIS and CAHPS workgroups to avoid duplicative efforts among departments. The MCO performed a barrier analysis to identify the issues or problems believed to cause the decrease in scores. Quality management then developed a workplan to address the identified issues or problems, explore the actions necessary to address the identified root issues, and included a series of two-week sprints for completing planned activities. Quality management also identified specific staff for attendance and participation in biweekly meetings to update the group on the progress of planned/completed activities.

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

PMV results showed:

**Metric** CAHPS Getting Care Quickly

MY 2020: 84.1%

MY 2021: 82.4%

**Metric** CAHPS Rating of All Health Care

MY 2020: 56.1%

MY 2021: 57.9%

Identify any barriers to implementing initiatives:

Aetna Better Health of Virginia did not identify any barriers with implementing initiatives.

**HSAG Assessment:**

| Recommendation—Member Experience of Care Survey | | |
|---|---|---|
| **Aim 1:**<br>Enhance Member Care Experience<br>**Aim 2:**<br>Effective Patient Care | **Goal 1.2:**<br>Improve Member Satisfaction<br>**Goal 2.1:**<br>Enhance Provider Support | **Metric 1.2.3:**<br>Rating of All Health Care (CAHPS)<br>**Metric 2.1.2:**<br>How Well Doctors Communicate (CAHPS) |

**Weakness:** Aetna's 2021 top-box scores were statistically significantly lower than the NCQA child Medicaid national averages for two measures: *Rating of Health Plan* 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 Aetna overall, 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 Aetna conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that Aetna focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time.

**MCO's Response**

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Per HSAG's recommendation, Aetna Better Health of Virginia conducted a root cause analysis of study indicators identified as areas of low performance. Based on the identified root causes, the MCO implemented a workplan to actively focus on activities to address the issues. Quality management then developed a workplan to explore the actions necessary to address the identified root issues and included a series of two-week sprints for completing planned activities. Quality management also identified specific staff for attendance and participation in biweekly meetings to update the group on the progress of planned/completed activities.

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

PMV results showed:

**Metric** CAHPS Rating of All Health Care

MY 2020: 57.9%

MY 2021: 53.6%

**Metric** CAHPS How Well Doctors Communicate

MY 2020: 91.8%

MY 2021: 92.7%

Identify any barriers to implementing initiatives:

Aetna Better Health of Virginia did not identify any barriers with implementing initiatives.

**HSAG Assessment:**

| Recommendation—Member Experience of Care Survey |
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## *HealthKeepers*

**Table E-3—Prior Year Recommendations and Responses—HealthKeepers**

| Recommendation—Performance Improvement Projects | | |
|---|---|---|
| **Aim 1:** Enhance Member Care Experience | **Goal 1.1:** Improve Member Satisfaction | **Metric 1.2.1:** Getting Care Quickly |
| **Weakness:** HealthKeepers received *Reported PIP results were not credible* for both PIPs.<br>Why the weakness exists: The MCO did not address all HSAG's PIP validation feedback in the resubmission and did not include all the requested SMART Aim and intervention evaluation data.<br>**Recommendation:** HSAG recommends that HealthKeepers:<br>• Address all feedback and recommendations in a PIP resubmission.<br>• Design a complete and accurate intervention evaluation plan.<br>• Provide the required data for the PIP's SMART Aim measure.<br>• Explain possible reasons for changes in the total population size.<br>• Provide additional SMART Aim measure data in the resubmission.<br>• Test more than one intervention per PIP.<br>• Reach out to HSAG for PIP technical assistance. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• HealthKeepers Inc. will incorporate the recommendations from HSAG for the next PIP submission. | | |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** CAHPS Getting Care Quickly<br>MY 2022: 84.1%<br>MY 2021: 85.1% | | |
| Identify any barriers to implementing initiatives:<br>The MCO did not provide a description of barriers identified related to implementing initiatives. | | |
| **HSAG Assessment:** | | |

| Recommendation—Performance Improvement Projects |
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|   |

| Recommendation—Performance Measure Validation | | |
|---|---|---|
| **Aim 4:** Improved Population Health | **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | **Metric 4.1.5:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics<br>**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services<br>**Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)<br>**Metric 4.6.3:** Childhood Immunization Status |

**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:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total*
- *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*

**Why the weakness exists:** HealthKeepers' rates for several measure indicators in the Access and Preventive Care, Behavioral Health, Taking Care of Children, and Living With Illness domains falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile suggests a lack of access to care or an understanding of recommended or needed care, or that a disparity may exist in access and availability of care. HealthKeepers members are not consistently seeking well and preventive care or managing their behavioral or chronic conditions according to evidence-based guidelines through the appropriate use of medications, diet and nutrition, screening and monitoring visits, or physical activity. Screening declines may have coincided with the rapid increase of COVID-

| Recommendation—Performance Measure Validation |
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| 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.<br>**Recommendation:** HSAG recommends that HealthKeepers conduct a root cause analysis or focus study to determine why members are not consistently following evidence-based care guidelines or receiving recommended screenings, care, or services. HSAG recommends that HealthKeepers analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause or causes, HSAG recommends that HealthKeepers implement appropriate evidence-based interventions to improve the receipt of diagnosis-specific monitoring visits, well and preventive care, and evidence-based care and services that impact the health of its members and to improve the performance related to these measures. |
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• HealthKeepers Inc. conducted a root cause analysis and identified the following barriers and implemented interventions for measures that did not meet goal:<br>• **Barriers**<br>– Providers only seeing patients if sick<br>– Elective procedures temporarily postponed<br>– Members were apprehensive to go to the doctor/emergency room for any kind of issue<br>– Successfully contacting members is difficult<br>– Many members tend to seek care only when they're sick<br>– Behavioral health issues affecting care<br>– Lack of staffing to reach out to members (case managers and care coordinators have large caseloads)<br>– Members seek emergency room treatment instead of preventive visits<br>– Low dollar member incentives<br>– Inappropriate provider coding or provider documentation for preventive visits<br>– Members lack of knowledge about their benefits<br>– Member education about healthy living<br>– Social determinants of health<br>• **Interventions**<br>– Partnering with care delivery transformation team, provider relations, and marketing to identify and educate providers with low quality scores<br>– HEDIS RNs attend Clinic Days to educate providers on HEDIS or educate remotely by WebEx or Microsoft Teams meetings<br>– Continuous HEDIS training for case managers/care coordinators<br>– CPT II code provider incentives<br>– Care coordinators continue addressing gaps in care with members by using the Gap in Care Report |

| Recommendation—Performance Measure Validation |
|---|
| – Expanding HealthCrowd messaging campaigns<br>– Social media ads Facebook/Instagram – monthly revolving topics<br>– Updated Coding Book for providers/CPT II Code cheat sheets<br>– American Cancer Society (ACS) collaboration<br>– American Health Catalyst collaboration (advocacy group for oral health)<br>– Anthem Foundation/American Heart and Lung Association collaboration<br>– ImmunizeVA collaboration (ImmunizeVA is a project of the Institute for Public Health Innovation in partnership with Virginia Department of Health)<br>– Implementing the standing order initiative for breast cancer screenings<br>– Continue to investigate mammogram bus opportunities<br>– Working behavioral health fail lists<br>– Behavioral health homes<br>– Developing provider fax blasts that focus on accreditation measures<br>– Continue leveraging Collective Medical to notify care coordinators via email or text when member has an ED visit<br>– 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):<br>PMV results showed:<br>**Metric:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics<br>MY 2020: 35.64%<br>MY 2021: 36.84%<br>**Metric:** Adults' Access to Preventive/Ambulatory Health Services<br>MY 2020: 88.70%<br>MY 2021: 90.86%<br>**Metric:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)<br>MY 2020: 46.47%<br>MY 2021: 37.47%<br>**Metric:** Childhood Immunization Status<br>MY 2020: 75.00%<br>MY 2021: 55.08% |
| Identify any barriers to implementing initiatives:<br>The MCO did not provide a description of barriers identified related to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim 4:** Improved Population Health | **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services<br>**Metric 4.3.4:** Child and Adolescent Well-Care Visits<br>**Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)<br>**Metric 4.4.5:** Controlling High Blood Pressure |

**Weakness:** The MCO's policies and procedures did not consistently contain all federal requirements regarding capacity and availability of services. The MCO did not ensure that travel time and distance standards were monitored according to the appropriate DMAS travel time and distance standards for each region. The MCO did not consistently monitor access to care according to DMAS' requirement to determine provider compliance or take corrective action when there was a failure to comply with requirements. Provider access standards were not consistent in the MCO's provider manual and network policies. The MCO 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 did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements regarding network requirements and network monitoring.

**Recommendation:** The MCO must update its policies, procedures, and process to ensure all 2020 Medicaid Managed Care Rule and DMAS contract requirements are met. The MCO must implement monitoring processes to ensure all federal and Commonwealth network requirements and monitoring requirements are met.

**MCO's Response**

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- HealthKeepers, Inc. has updated the Practitioner Availability Monitoring and Analysis - VA policy. In addition to the policy, HealthKeepers, Inc. has reviewed our geo access report and added a cover page to the report that includes the date of the report.
- HealthKeepers, Inc. has added a coversheet to our geo access report to define family planning providers as obstetricians/gynecologists, pediatricians, internal medicine providers, and family medicine providers. HealthKeepers, Inc. monitors access to these providers through its geo access report.
- HealthKeepers, Inc. submits to DMAS a weekly enrollment broker file, and quarterly provider network file. These allow HealthKeepers, Inc. and DMAS to monitor that time and distance standards are being met and significant changes can be identified. On-going reporting continues to be submitted according to current DMAS requirements. Request for DMAS to add dates the reporting specifications for these reports was sent to DMAS 12/16/2021. Changes to the report specifications will depend on approval by DMAS to add a date as an element.

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

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations |
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| PMV results showed:<br>**Metric:** Adults' Access to Preventive/Ambulatory Health Services<br>MY 2020: 88.70%<br>MY 2021: 90.86%<br>**Metric:** Child and Adolescent Well-Care Visits<br>MY 2020: NR<br>MY 2021: 51.00%<br>**Metric:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)<br>MY 2020: 46.47%<br>MY 2021: 37.47%<br>**Metric:** Controlling High Blood Pressure<br>MY 2020: 49.64%<br>MY 2021: 58.15% |
| Identify any barriers to implementing initiatives:<br>The MCO did not provide a description of barriers identified related to implementing initiatives. |
| **HSAG Assessment:**<br>  <br> |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim 3:** Enhance Member Care Experience | **Goal 1.1:** Improve Member Satisfaction | **Metric 1.2.3:** Rating of All Health Care |
| **Weakness:** The MCO did not have a defined process to identify members with SHCN, monitor the quality and appropriateness of care furnished to members with SHCN, or conduct assessments of the quality and appropriateness of care provided to members with SHCN.<br>**Why the weakness exists:** The MCO applied general policies to all populations served, including members with SHCN. Therefore, the MCO was unable to assess the quality and appropriateness of care provided to SHCN members.<br>**Recommendation:** The MCO must define and identify members with SHCN. The MCO must develop and implement processes to conduct assessments of the quality and appropriateness of care and services delivered to members with SHCN. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• HealthKeepers, Inc also ensures the delivery of quality, family centered care for children and youth with special health care needs (CYSHCN), who have been identified as having needs that are not typical of the general pediatric population. Examples of CYSHCN:<br>– Children on Supplemental Security Income (SSI) (as identified from our reporting mechanism)<br>– Children identified as early intervention (EI) per the state | | |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations |
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| – Children with childhood obesity<br>– Children with chronic or complex conditions (diabetes, asthma, cystic fibrosis [CF], sickle cell, cancers)<br>– Children with disabilities (autism, cerebral palsy [CP], etc.)<br>– Those with increased utilization of services above what would be expected for a child that age<br>– Foster children<br>– Those covered under adoption assistance<br>– Children participating under the Health and Acute Care Program (HAP)<br>– Members with special health care needs, including people with disabilities or chronic or complex medical and behavioral health conditions and individuals participating under HAP and children and youth with special health care needs, who may need enhanced services to promote a better quality of life, are proactively identified.<br>• HealthKeepers, Inc has policies and procedures for identifying members, children and youth with special health care needs. The policy defines Anthem's Predictive Model of Case Management that uses lists of acuity rankings, claims, pharmacy, pre-authorization and other data to identify new and existing children and youth with special needs. Based upon screening of this collective data, referrals are made to health plan case management units for further assessment by case management staff (RN, social worker, licensed mental health providers, and variable support staff) and/or social worker, HealthKeepers, Inc Predictive Model of Case Management uses lists of acuity rankings, claims, pharmacy, pre-authorization and other data to identify new and existing children and youth with special needs. Monthly data sweeps of the transition file, EI file, SSI report, behavioral health services authorizations report, operational CYSHCN report are also done.<br>• HealthKeepers, Inc makes every effort to conduct a comprehensive health assessment of all MSHCN, including CYSHCN, as identified and reported by the Virginia Department of Medical Assistance Services (DMAS) or identified through other means, within 60 calendar days of enrollment and yearly thereafter. After the initial assessment, HealthKeepers, Inc will assess members with special health care needs (MSHCN) every year thereafter and aged and disabled members at least once every year. All CYSHCN shall be assessed pursuant to Section 8.6, except that foster care and adoption assistance children shall be assessed pursuant to the standards in the Virginia Medicaid and FAMIS PM Validation Technical Specifications and will be evaluated on a sixty (60) day timeframe. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Rating of All Health Care<br>MY 2020: 57.3%<br>MY 2021: 61.5% |
| Identify any barriers to implementing initiatives:<br>The MCO did not provide a description of barriers identified related to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim 1:** Enhance Member Care Experience | **Goal 1.1:** Improve Member Satisfaction. | **Metric 1.2.3:** Rating of All Health Care |
| **Weakness:** The MCO's grievance and appeal policies did not include requiring easily understood format and language requirements. Member notices were not consistently in a format and language that was easily understood by the member. An opportunity exists for the MCO to strengthen grievance resolution notifications to clearly state the resolution so that it is easily understood by the member. The MCO's appeal policy was not updated to include all requirements in the most current 2020 Medicaid Managed Care Rule, including that an oral appeal does not need to be followed with a written and signed request for an appeal; the member's right to dispute an extension of time proposed by the MCO to make an authorization decision; and the member's right to request a State fair hearing.<br>**Why the weakness exists:** The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements that assure member rights are respected.<br>**Recommendation:** The MCO must update its policies, procedures, and process to ensure all 2020 Medicaid Managed Care Rule and DMAS contract requirements are met. Grievance and appeal notices to members must be easily understood and include all member rights. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• HealthKeepers, Inc. updated the policies, procedures, and process to ensure all 2020 Medicaid Managed Care Rule and DMAS contract requirements were met. Member notices have been formatted with language easily understood by the members. The grievance and appeals team also perform quality assurance review of all resolution letters | | |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Rating of All Health Care<br>MY 2020: 57.3%<br>MY 2021: 61.5% | | |
| Identify any barriers to implementing initiatives:<br>The MCO did not provide a description of barriers identified related to implementing initiatives. | | |
| **HSAG Assessment:**<br>  | | |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim 4:** Improved Population Health | **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | **Metric 4.3.4:** Child and Adolescent Well-Care Visits<br>**Metric 4.6.3:** Childhood Immunization Status |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| | **Goal 4.6:** Improve Outcomes for Maternal and Infant Members | **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life |

**Weakness:** The MCO did not ensure monitoring of CCC Plus members for the use of EPSDT services, including tuberculosis screening/skin testing. The MCO did not have a documented process to educate its members about the risks of childhood obesity and services available to treat members. The MCO had not implemented a process to monitor, track, and evaluate PCP fluoride varnish applications in accordance with the American Academy of Pediatrics guidelines.

**Why the weakness exists:** The MCO did not have documented and implemented processes that ensured EPSDT age members and providers that service EPSDT age members were aware of EPSDT benefits. The MCO did not have implemented processes to monitor and track members' receipt of EPSDT services.

**Recommendation:** The MCO should consider developing EPSDT-specific policies and procedures to ensure that members and providers are aware of EPSDT benefits, and to ensure that EPSDT service utilization is tracked, monitored, and action is taken to increase utilization of covered EPSDT services.

**MCO's Response**

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- HealthKeepers, Inc. measures, monitors and implements activities to improve member participation rates for age-appropriate screenings, according to the most current EPSDT Periodicity Schedule. This includes, but is not limited to, targeted blood lead screenings/testing, tuberculosis screening/skin testing, developmental/behavioral health assessments, immunizations, BMI/growth percentile. The MCO requires pediatric primary care providers to incorporate the use of a standardized developmental screening tool for children consistent with the American Academy of Pediatrics (AAP) policy statements and clinical guidelines. AAP policy recommends surveillance (assessing for risk) at all well-child visits, and screening using a standardized tool routinely. Developmental screenings must be documented in the medical record using a standardized screening tool. Anthem shall not require any service authorization associated with the appropriate billing of these developmental screening services (e.g., CPT 96110) in accordance with AAP recommendations.
- HealthKeepers, Inc. informs all EPSDT eligible individuals and/or their families about the EPSDT program within specified State/Federal mandated timeframes. Outreach materials are distributed to educate members on the importance of EPSDT services, including childhood obesity and dangers of lead exposure. Using clear non-technical language, HealthKeepers Inc. provides each member a handbook/guide with information about services available under the EPSDT program and where and how to obtain those services, services provided under the EPSDT program are without cost to eligible individuals under twenty-one (21) years of age, per federal law and Virginia Department of Medical Assistance Services (DMAS) provisions; and That necessary transportation and scheduling assistance described in 42 CFR §441.62 is available to the EPSDT eligible individual upon request. HealthKeepers Inc. coordinates targeted outreach attempts to members for EPSDT services while Corporate oversees a general mailings program for member birthday card EPSDT service reminders and overdue services postcards. PCPs also receive notification of paneled members who are past due for EPSDT services. HealthKeepers Inc.

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations |
|---|
| provides copies of any EPSDT member related notices to DMAS as well as any additional information requested regarding the frequency and timing of these notices, upon request. Corporate Clinical Quality Management gathers, tracks, trends, and monitors member and provide reports and information. Data collected is used in monitoring EPSDT rates and identify potential outreach opportunities for educating members and providers. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Child and Adolescent Well-Care Visits<br>MY 2020: 44.78%<br>MY 2021: 51.0%<br>**Metric:** Childhood Immunization Status<br>MY 2020: 75.00%<br>MY 2021: 55.08%<br>**Metric:** Well-Child Visits in the First 30 Months of Life<br>MY 2020: First 15 Months: 31.37% 15-30 Months: 69.48%<br>MY 2021: First 15 Months: 25.93% 15-30 Months: 68.84% |
| Identify any barriers to implementing initiatives:<br>The MCO did not provide a description of barriers identified related to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Encounter Data Validation | | |
|---|---|---|
| **Aim 3:**<br>Smarter Spending | **Goal 3.2:**<br>Focus on Efficient Use of Program Funds | **Metric 3.2.3:** Monitor MLR annually by managed care program and aggregate total |
| **Weakness:** HealthKeepers did not meet the validity criteria for both institutional and professional encounters.<br>**Why the weakness exists:** The IS review and administrative profile analysis did not identify the specific root cause of the weakness.<br>**Recommendation:** HSAG recommends HealthKeepers:<br>Incorporate additional logic and referential checks to assess the validity of data elements. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• HealthKeepers, Inc. will heed to the recommendations of HSAG and will incorporate additional logic and referential checks to assess the validity of data elements. | | |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed: | | |

| Recommendation—Encounter Data Validation |
|---|
| **Metric:** Monitor MLR annually by managed care program and aggregate total<br>MY 2020: NR<br>MY 2021: NR |
| Identify any barriers to implementing initiatives:<br>The MCO did not provide a description of barriers identified related to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Member Experience of Care Survey | | |
|---|---|---|
| **Aim 1:** Enhance Member Care Experience | **Goal 1.1:** Improve Member Satisfaction | **Metric 1.2.1:** Getting Care Quickly |
| **Weakness:** HealthKeepers' 2021 top-box scores were not statistically significantly lower than the 2020 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.<br>**Why the weakness exists:** NA.<br>**Recommendation:** HSAG recommends that HealthKeepers monitor the measures to ensure significant decreases in scores over time do not occur. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• HealthKeepers, Inc will continue to monitor measures to ensure significant decreases in scores over time do not occur. | | |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** CAHPS Getting Care Quickly<br>MY 2020: 84.1%<br>MY 2021: 85.1% | | |
| Identify any barriers to implementing initiatives:<br>The MCO did not provide a description of barriers identified related to implementing initiatives. | | |
| **HSAG Assessment:**<br>  | | |

| Recommendation—Member Experience of Care Survey | | |
|---|---|---|
| **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 |
|---|
| **Weakness:** HealthKeepers' top-box score was statistically significantly lower than the 2020 NCQA child Medicaid national average for one measure, *Rating of Health Plan*. In addition, HealthKeepers' 2021 top-box score was statistically significantly lower than the 2020 top-box score for one measure, *Getting Care Quickly*.<br>**Why the weakness exists:** Based on the survey results, parents/caretakers of child members have a lower level of satisfaction with HealthKeepers overall, which may be associated with their perception of their child's ability to receive access to care or services in a timely manner.<br>**Recommendation:** HSAG recommends that HealthKeepers conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that HealthKeepers continue to monitor the measures to ensure significant decreases in scores over time do not occur. |
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• HealthKeepers, Inc conducted a root cause analysis, completed an analyses of complaint data and identified the following barriers:<br>– Access to PCP's who provide primary care is an issue.<br>– Members not able to reach providers due to COVID-19.<br>– MCO increased in membership related to COVID-19.<br>• As a result of the analysis, the following interventions were implemented<br>– Added availability of provider telehealth to online physician directories.<br>– Member website has information on getting care that is easy to find, including Quick Start Guide.<br>– Meetings held on a regular basis with transportation vendor.<br>– Corrective action plan put into place with transportation vendor.<br>– Provider offices can chat directly electronically with the prior authorization department to have questions answered.<br>• Updates and additional clinical information can be submitted electronically to pre-authorization department. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** CAHPS Getting Care Quickly<br>MY 2020: 84.1%<br>MY 2021: 85.1% |
| Identify any barriers to implementing initiatives:<br>The MCO did not provide a description of barriers identified related to implementing initiatives. |
| **HSAG Assessment:**<br>  |

## *Molina*

**Table E-4—Prior Year Recommendations and Responses—Molina**

| **Recommendation—Performance Improvement Projects** | | |
|---|---|---|
| **Aim 3:** Smarter Spending<br><br>**Aim 4:** Improved Population Health | **Goal 3.1:** Focus on Paying for Value<br><br>**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members | **Metric 3.1.2:** Frequency of ED Visits<br><br>**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness |
| **Weakness:** Molina received *Low Confidence* for both PIPs.<br>**Why the weakness exists:** For the *Reduce ED Visits* PIP, the SMART Aim goal was not achieved. For the *Increasing Follow-Up Visits After Discharge* PIP, the intervention was not effective at impacting the SMART Aim and could not be linked to the improvement.<br>**Recommendation:** HSAG recommends that Molina:<br>• Test more than one intervention per PIP.<br>• Ensure that all data are reported accurately in the PIP submission. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• Expand the intervention type to be coupled with additional action items.<br>• Weekly monitoring of claims/encounters and data collected by care coordinators to assess the effectiveness of programs. | | |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Frequency of ED Visits<br>MY 2020: 85.22<br>MY 2021: 92.26<br>**Metric:** Follow-Up After Hospitalization for Mental Illness<br>MY 2020: 7-Day: 23.60 30-Day: 45.47%<br>MY 2021: 7-Day: 20.80 30-Day: 37.78% | | |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. | | |
| **HSAG Assessment:**<br>  | | |

| Recommendation—Performance Measure Validation | | |
|---|---|---|
| **Aim 4:** Improved Population Health | **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members<br><br>**Goal 4.4:** Improve Health for Members with Chronic Conditions | **Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness<br><br>**Metric 4.1.5:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics<br><br>**Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) |

**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 Molina:

- *Asthma Medication Ratio—Total*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total, Cholesterol Testing—Total,* and *Blood Glucose and Cholesterol Testing—Total*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*
- *Use of Imaging Studies for Low Back Pain*
- *Use of Opioids From Multiple Providers—Multiple Prescribers*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total*

**Why the weakness exists:** Molina's rates for several measures across several domains falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile suggests a lack of access and use of well and preventive care, behavioral health services, and chronic disease management. Molina's members are not consistently scheduling or completing follow-up on recommended care or services or scheduling evidence-based care and services. With low performance across several domains, healthcare disparities may exist and members may not have a comprehensive understanding of their healthcare needs or benefits. Factors that may have

| Recommendation—Performance Measure Validation |
|---|
| 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.<br>**Recommendation:** HSAG recommends that Molina conduct a root cause analysis or focus study to identify the reasons why members are not accessing preventive care, behavioral healthcare, and care for chronic conditions. HSAG recommends that Molina analyze its data and results of any root cause analysis or focus study to identify opportunities to reduce any disparities within the MCOs' populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of root causes, HSAG recommends that Molina implement appropriate evidence-based interventions to improve the performance related to these low-scoring healthcare domains. |
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• Molina will couple interventions to ensure the quality of care if met.<br>• Molina has expanded it's dashboard to reflect actionable data and plan target intervention<br>• Provider partnership and meetings to identify and target member with open gaps.<br>• Identification of member attribution barriers, to help members get properly aligned with PCP care<br>• Timely distribution and meetings with of provider scorecards to include monthly strategy<br>• Increase member awareness of importance of wellness and preventative care through member outreach activities, community events, mobile and pop up clinics throughout each region of Virginia. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Follow-Up After Hospitalization for Mental Illness<br>MY 2020: 7-Day: 23.60% 30-Day: 45.47%<br>MY 2021: 7-Day: 20.80% 30-Day: 37.78%<br>**Metric:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics<br>MY 2020: 46.15%<br>MY 2021: NR<br>**Metric:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)<br>MY 2020: 59.85%<br>MY 2021: 57.42% |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim 1:** Enhance Member Care Experience | **Goal 1.1:** Improve Member Satisfaction | **Metric 1.2.2:** Enrollees' Ratings Rating of Health Plan |

**Weakness:** The MCO has an opportunity to improve consistency across member information policies and member materials. 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 have processes to ensure that federal and DMAS requirements were consistently included and applied in its policies and procedures. 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.

**Recommendation:** The MCO should consider establishing a review process to ensure that member information policies, procedures, and member materials are consistent and contain all requirements. The MCO should also review member materials to ensure that federal requirements, including easily understood and machine-readable formats, are available to members.

**MCO's Response**

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Molina has collaborated with the internal marketing and communication teams to identify barriers to ensuring information on the website is in the proper format and is readable
- Testing prior to go live to identify areas of concerns and opportunities when updating the website to ensure guidelines are met and validate all information is in a machine-readable format.

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

PMV results showed:

**Metric:** Enrollees' Ratings Rating of Health Plan
MY 2020: 62.4%
MY 2021: 56.9%

Identify any barriers to implementing initiatives:

The MCO did not identify any barriers to implementing initiatives.

**HSAG Assessment:**


| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim 1:** Enhance Member Care Experience | **Goal 1.1:** Improve Member Satisfaction | **Metric 1.2.2:** Enrollees' Ratings Rating of Health Plan |

**Weakness:** The MCO's grievance and appeals policies and procedures did not consistently contain all federal and DMAS requirements. The MCO did not consistently resolve the appeal and provide written notice to the member within the required time frames. In addition, a review of case files

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations |
|---|
| identified that the MCO did not consistently meet the time frame to mail the notice of adverse benefit determination to the member.<br>**Why the weakness exists:** The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements that assure member rights are respected.<br>**Recommendation:** The MCO must update its policies, procedures, and process to ensure all 2020 Medicaid Managed Care Rule and DMAS contract requirements are met. Grievance and appeal notices to members must be easily understood and include all member rights. |
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• Workgroups to identify all policies and procedures, to review and update according to state and federal requirements<br>• Create a catalogue of all the policies and procedures, each functional areas to include appeals and grievances are to review and update policies in accordance with DMAS and the Medicaid Managed Care Rule.<br>• Review all member materials to ensure all pertinent information is included, member rights |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Enrollees' Ratings Rating of Health Plan<br>MY 2020: 62.4%<br>MY 2021: 56.9% |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim 1:** Enhance Member Care Experience | **Goal 1.1:** Improve Member Satisfaction | **Metric 1.2.2:** Enrollees' Ratings Rating of Health Plan |
| **Weakness:** The MCO did not consistently provide the member with a written appeal resolution notice that included all member rights or inform the member how to request continued services, notice that the member may be liable for the cost of the continued benefits if the hearing decision upholds the MCO's adverse benefit determination, and the time frame to request a State fair hearing. | | |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations |
|---|
| **Why the weakness exists:** The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements that assure member rights are respected.<br>**Recommendation:** The MCO must update its policies, procedures, and process to ensure all 2020 Medicaid Managed Care Rule and DMAS contract requirements are met. Grievance and appeal notices to members must be easily understood and include all member rights. |
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• Review all member materials and communication to ensure all language meets contract requirements.<br>• Create a catalogue of all the policies and procedures, each functional areas to include appeals and grievances are to review and update policies in accordance with DMAS and the Medicaid Managed Care Rule.<br>• Track and monitor policy updates and changes to ensure all policies and procedures are up to date. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Enrollees' Ratings Rating of Health Plan<br>MY 2020: 62.4%<br>MY 2021: 56.9% |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim 4:**<br>Improved Population Health | **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 |
| **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. The MCO did not monitor, track, and evaluate PCP fluoride varnish applications in accordance with American Academy of Pediatrics guidelines. The MCO did not educate members about the dangers of lead exposure.<br>**Why the weakness exists:** The MCO did not have documented and implemented processes that ensured EPSDT age members and providers that service EPSDT age members were aware of | | |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations |
|---|
| EPSDT benefits. The MCO did not have implemented processes to monitor and track members' receipt of EPSDT services.<br>**Recommendation:** The MCO should consider developing EPSDT-specific policies and procedures to ensure that members and providers are aware of EPSDT benefits, and to ensure that EPSDT service utilization is tracked, monitored, and action is taken to increase utilization of covered EPSDT services. |
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• Work with the data team to build a claim driven dashboard report that will be refreshed on a monthly cadence, using the identified CPT Codes<br>• Monitor monthly reports to track and monitor volumes of members who have received at least one topical fluoride application by a PCP<br>• Provider tip sheet distribution for dental fluoride varnish application |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Percentage of Eligibles who Receive Preventive Dental Services<br>MY 2020: NR<br>MY 2021: NR |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Encounter Data Validation | | |
|---|---|---|
| **Aim 3:**<br>Smarter Spending | **Goal 3.2:**<br>Focus on Efficient Use of Program Funds | **Metric 3.2.1:** Monitor MLR annually by managed care program and aggregate total |
| **Weakness:** The IS review revealed Molina could improve its internal monitoring tools for assessing quality and timeliness of encounter data. In addition, Molina did not meet the validity criteria for both institutional and professional encounters. Lastly, Molina had virtually no header TPL paid amounts for the first half of 2020 in its institutional encounters.<br>**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 field validity and header TPL paid amounts, the IS review and administrative profile analysis did not identify the specific root cause of the weakness.<br>**Recommendation:** HSAG recommends Molina: | | |

| Recommendation—Encounter Data Validation |
|---|
| • 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.<br>• Incorporate additional logic and referential checks to assess the validity of data elements.<br>• Identify the root cause of missing header TPL paid amounts for the first half of 2020 in its institutional encounters to rectify any issues. |
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• Work with the Molina data team to enhance the applications for quality and encounter data to be more effective.<br>• Identify areas of concern with quality data and claims, to mitigate risk and ensure timely claims processing of claims, which will provide timely action for quality engagement and activities<br>• Create meaning logic to validate data<br>• Data mining to assess it accuracy |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Monitor MLR annually by managed care program and aggregate total<br>MY 2020: NR<br>MY 2021: NR |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing interventions. |
| **HSAG Assessment:**<br>  |

| Recommendation—Member Experience of Care Survey | | |
|---|---|---|
| **Aim 1:** Enhance Member Care Experience | **Goal 1.1:** Improve Member Satisfaction | **Metric 1.2.2:** Enrollees' Ratings Rating of Health Plan |
| **Weakness:** Molina's 2021 top-box 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.<br>**Why the weakness exists:** NA.<br>**Recommendation:** HSAG recommends that Molina monitor the measures to ensure significant decreases in scores over time do not occur. | | |

| Recommendation—Member Experience of Care Survey |
|---|
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• Develop and implement innovative interventions and activities to support member overall health outcomes. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Enrollees' Ratings Rating of Health Plan<br>MY 2020: 62.4%<br>MY 2021: 56.9% |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing interventions. |
| **HSAG Assessment:**<br>  |

| Recommendation—Member Experience of Care Survey | | |
|---|---|---|
| **Aim 1:**<br>Enhance Member Care Experience | **Goal 1.1:** Improve Member Satisfaction | **Metric 1.2.2:** Enrollees' Rating of Health Plan<br>**Metric 1.2.3:** Rating of All Health Care |
| **Weakness:** Molina's 2021 top-box scores were statistically significantly lower than the 2020 NCQA child Medicaid national average on three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*.<br>**Why the weakness exists:** Based on the survey results, parents/caretakers of child members have a lower level of satisfaction with Molina or their provision in healthcare overall, which may be associated with their perception of their child's ability to receive care or services from the MCO and from their child's specialist.<br>**Recommendation:** HSAG recommends that Molina conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that Molina focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• Identify key drivers and appropriate intervention that would help improve the overall satisfaction | | |

| Recommendation—Member Experience of Care Survey |
|---|
| • Build awareness of the CAHPS survey and provide key interventions to leverage with internal teams and providers<br>• Provider tips on improving patient experience<br>• Improve the Molina website to ensure it is user friendly and accessible<br>• Care coordinators to provide assistance with the coordination of care, referrals to specialist, appointment scheduling, identification of resources. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Enrollees' Ratings Rating of Health Plan<br>MY 2020: 62.4%<br>MY 2021: 56.9%<br>**Metric:** Enrollees' Ratings Rating of All Health Care<br>MY 2020: 58.4%<br>MY 2021: 56.5% |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

## *Optima*

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

| Recommendation—Performance Improvement Projects | | |
|---|---|---|
| **Aim 3:** Smarter Spending | **Goal 3.1:** Focus on Paying for Value | **Metric 3.1.1:** Frequency of Potentially Preventable Admissions<br>**Metric 3.1.2:** Frequency of ED Visits<br>**Metric 3.1.3:** Frequency of Potentially Preventable Readmissions |
| **Weakness:** Optima received *Low Confidence* for the *Improving Compliance in 30-Day Ambulatory Follow-Up Appointments for Tidewater Regional Members* PIP.<br>**Why the weakness exists:** The SMART Aim results did not achieve the goal.<br>**Recommendation:** HSAG recommends that Optima:<br>• Ensure that interventions reach the maximum number of eligible members.<br>• Provide SMART Aim data beyond May 31, 2021, in the resubmissions. | | |

| Recommendation—Performance Improvement Projects |
|---|
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• Optima continues to utilize CipherHealth to perform automated follow-up with members after discharge as well as utilization of the Optima Health Readmission Prevention Team. A behavior health program launched for improved collaboration with hospital transition care coordinators, case managers, facility case managers and discharge planners. LANE Initiatives continue.<br>• Implementing extensive outreach and education tools to assist members and providers with accessing appropriate level of care as an alternative to going to the emergency room. Evaluating locations were access to primary or urgent care drive higher rates of LANE utilization. Adjusting resources (case management rounds, TOC meetings, member/provider communications, collaboration with other groups) to impact LANE/PPA rate.<br>• SMART AIM data is provided beyond May 31, 2021, through to December 31, 2021. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Improve Compliance in 30 Day Ambulatory Follow-up Appointments within the Tidewater area<br>MY 2020: 63.91%<br>MY 2021: 65.08%<br>**Metric:** Frequency of Potentially Preventable Admissions<br>MY 2020: NR<br>MY 2021: NR<br>**Metric:** Frequency of ED Visits<br>MY 2020: 78.65<br>MY 2021: 83.13<br>**Metric:** Frequency of Potentially Preventable Readmissions<br>MY 2020: 11.81%<br>MY 2021: 11.04% |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Performance Measure Validation | | |
|---|---|---|
| **Aim 3:** Smarter Spending<br>**Aim 4:** Improved Population Health | **Goal 3.1:** Focus on Paying for Value | **Metric 3.1.1:** Frequency of Potentially Preventable Admissions |

| Recommendation—Performance Measure Validation | | |
|---|---|---|
| | **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members<br>**Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | **Metric 3.1.3:** Frequency of Potentially Preventable Readmissions<br>**Metric 4.1.5:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics<br>**Metric 4.2.3:** Use of Opioids at High Dosage in Persons Without Cancer<br>**Metric 4.3.4:** Child and Adolescent Well-Care Visits<br>**Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)<br>**Metric 4.6.3:** Childhood Immunization Status |

**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:

- *Breast Cancer Screening*
- *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total*
- *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*
- *Use of Imaging Studies for Low Back Pain*
- *Use of Opioids From Multiple Providers—Multiple Prescribers*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*

| Recommendation—Performance Measure Validation |
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| **Why the weakness exists:** Optima's rates across multiple domains falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile suggests a lack of access to preventive care, screenings, behavioral healthcare, and care for chronic conditions. Optima's members are not consistently scheduling well visits or receiving immunizations according to the recommended schedules. Chronic care results indicate that members may not understand care recommendations or follow up on evidence-based care and services. With low performance across several domains, healthcare disparities may exist or 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.<br>**Recommendation:** HSAG recommends that Optima conduct a root cause analysis or focus study to determine why members are not receiving well visits, immunizations, and screenings according to recommended schedules. HSAG also recommends that Optima conduct similar processes and analyses of data to better understand barriers members experience across all domains of care. HSAG recommends that Optima consider whether 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 or causes, HSAG recommends that Optima implement appropriate interventions to improve access to and timeliness of well visits, screenings, behavioral healthcare, and recommended services for members diagnosed with a chronic condition. |
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>***Breast Cancer Screening***<br>Initiatives:<br>• Postcard reminder to noncompliant women 45 plus years of age on breast cancer screening<br>• Women 45 and older who have not had a mammogram in the previous 12 months receive a postcard during their birthday month. This card informs them of the recommended mammography schedule, and the importance of screening<br>• Clinical guidelines reviewed and providers are notified of updated<br>• Clinical guidelines via newsletter and provider site<br>• Emmi IVR Campaign for mammogram reminders<br>• Letter is sent to providers of members with mammogram care gap<br>• Tableau dashboard care gap identification<br>• Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation<br>• Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need<br><br>***Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia***<br>Initiatives:<br>• Increase outreach and education to these members regarding the importance of medication adherence and keeping regular appointments with PCP and BH care providers. |

| Recommendation—Performance Measure Validation |
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- Articles in member and provider newsletters to support improved communication and coordination of care between the provider and the member
- Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation

***Cervical Cancer Screening***

Initiatives:

- Screening reminders sent to women 21 years and older who have not had a cervical cancer screening in the previous 12 months receive a postcard during their birthday month
- Letter is sent to providers of members with cervical care gap
- Clinical guidelines reviewed and providers are notified of updated clinical guidelines via newsletter and provider site
- Articles in the member newsletter
- Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation
- Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need

***Childhood Immunization Status—Combination 3***

Initiatives:

- Childhood Immunization Incentive Program
- EMMI Well-Child and Immunizations IVR campaign
- EMMI Manager utilization for educational videos
- Prealize data utilized to identify members to refer to case management (CM)
- CM utilization of Tableau care gap report when engaging members
- CM documentation of care gap information received from members
- Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation
- Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need
- Childhood Immunization Incentive Program, Back to School Fairs across the State. Well Child and Immunization Campaigns. Educational Outreach. Data utilized from VIS and Health Fair Capture to close gaps and refer to case management. FTE for EPDST
- Immunization program in development to improve member and clinician engagement which includes incentives, targeted outreach, and educational initiatives. Additionally, increased collaboration with the commonwealth's department of health regarding vaccination data. Launch target of first quarter 2023.
- Population Health Assessment work group established 7/2022. NCQA standards and tools purchased to perform a comprehensive population health assessment to include but not limited to: SDoH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code, etc. Population Health Assessment to be completed 7/2023.

***Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%),* and *Eye Exam (Retinal) Performed***

| Recommendation—Performance Measure Validation |
|---|

Initiatives:

- Diabetic eye exam incentive program
- EMMI Manager utilization for educational videos
- Prealize data utilized to identify members to refer to case management
- Case management utilization of Tableau care gap report when engaging members
- Case management documentation of care gap information received from members in Symphony/JIVA
- Pop Care Diabetic Eye Exam campaign
- BioIQ at-home A1c program
- Focus Care In-Home A1c testing and DEE
- HEDIS fourth quarter push case management member outreach
- Diabetic eye exam article for member newsletter
- Conducted a data analysis of care gaps by region to determine if any possible trends in barriers existed, no trends were noted
- Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need
- Retina Labs: Clinic-based and in-home tele-retinal screening solution for early detection of diabetic retinopathy in diabetic members. This will help close critical diabetes care gaps and improve health outcomes for members. Implementation target of fourth quarter 2022.
- Dario: The Dario Pilot covers 1,500 Optima Health Plan Medallion 4.0 and CCC Plus members in the Dario Type 2 Diabetes program. The solution provides adaptive, personalized member experiences to drive behavior change through evidence-based interventions, intuitive, clinically proven digital tools, high-quality software, and coaching to encourage individuals to improve their health and sustain meaningful outcomes. If the pilot proves effective at closing Type 2 Diabetes care gaps, it will be scaled to include all eligible members.
- Population Health Assessment work group established 7/2022. NCQA standards and tools purchased to perform a comprehensive population health assessment to include but not limited to: SDoH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population Health Assessment to be completed 7/2023

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

Initiatives:

- Clinical guidelines reviewed and updated
- Providers are notified of updated clinical guidelines via newsletter and provider site
- In-home A1c testing vendor program
- Tableau dashboard care gap identification
- Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation

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

**Recommendation—Performance Measure Validation**

Initiatives:

- Well-Child Visit incentive program
- Emmi Well Child and Immunization IVR Campaign
- Article in the member newsletter
- Birthday cards mailing that includes a bookmarker that serves to remind members of the preventative health guidelines they should follow to achieve their personal best health
- Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation
- Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need
- Immunization program in development to improve member and clinician engagement which includes incentives, targeted outreach, and educational initiatives. Additionally, increased collaboration with the commonwealth's department of health regarding vaccination data. Launch target of first quarter 2023
- Childhood Immunization Incentive Program, Back to School Fairs across the State. Well Child & Immunization Campaigns. Educational Outreach. Data utilized from VIS and Health Fair Capture to close gaps and refer to case management. FTE for EPDST
- Population Health Assessment work group established 7/2022. NCQA standards and tools purchased to perform a comprehensive population health assessment to include but not limited to: SDoH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population Health Assessment to be completed 7/2023

***Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total***

Initiatives:

- Clinical guidelines reviewed and updated
- Providers are notified of updated clinical guidelines via newsletter and provider site
- Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation
- Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need

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

Initiatives:

- Clinical guidelines reviewed and updated
- Providers are notified of updated clinical guidelines via newsletter and provider site
- Ongoing telephonic case management services were provided to members with respiratory conditions
- Continue to educate providers on the importance of Spirometry Testing via the Optima Health web site provider portal

**Recommendation—Performance Measure Validation**

- Added COPD link for members on OptimaHealth.com member's page. This link contains facts, educational resources, information, and COPD support groups available for members
- Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation
- Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need

***Plan All-Cause Readmissions—Observed Readmissions—Total***

Initiatives:

- Enhanced care coordination model that targets members with SMI and chronic medical conditions
- Transition of care and HEDIS performance withhold program /emergency room diversion program that places emphasis on patients discharged from inpatient or ED to a lower level of care within three to seven days, but no longer than 30 days
- Specialized case management program that focuses on high-risk pregnancies, deliveries, and post deliveries with infants
- Behavioral health chronic care coordination program
- Targeted member education that focuses on top five diagnosis for admissions to medical and behavioral facilities
- Immediate follow-up IVR and live calls to members post discharge to assist in transition of care
- Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation
- Predictive analysis conducted to identify members with a potential cost bloom
- Behavioral health care center clinic to assist with behavioral health follow up visits following admission or ED visit
- Analysis conducted to identify the top five diagnosis for readmission
- Educational tool created for members meeting the criteria
- In-home IHA and preventative screening program
- Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need

***Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total***

Initiatives:

- Clinical guidelines reviewed and updated
- Providers are notified of updated clinical guidelines via newsletter and provider site
- Sentara is implementing new protocols and enhancing its outpatient services to improve access to community-based care and reduce the demand for ED services
- Care coordination engagement with members to assist in managing care, making appointments, and scheduling transportation

***Use of Imaging Studies for Low Back Pain***

Initiatives:

| Recommendation—Performance Measure Validation |
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| • Clinical guidelines reviewed and updated<br>• Providers are notified of updated clinical guidelines via newsletter and provider site<br>• Provider newsletter article<br>• Data analysis based on ordering providers to assist in driving interventions<br>• Partner with our clinically integrated networks to develop action items for addressing the use of advanced imaging for initial diagnosis and treatment of low back pain<br>• Increase member benefit awareness: access to various back health programs available through our wellness platform - My Life My Plan Rewards, WebMD, IVR and education videos.<br>• Add physical therapy recommendations to the member's newsletter to increase the understanding of low back health and how to prevent injuries<br><br>***Use of Opioids from Multiple Providers—Multiple Prescribers***<br>Initiatives:<br>• PUMS placement criteria<br>• Criteria addresses doctor and/or pharmacy shopping<br>• Interventions are made on behalf of the pharmacy, behavioral health/ARTS department, and medical directors<br>• Members are identified for the PUMS program through a monthly pharmacy report that provide pharmacy paid claims for controlled substances meeting the criteria<br>• Behavioral health sends a letter to the member providing a brief explanation of the PUMS program and a statement explaining the reason for placement in the PUMS program<br>• The PUMS lock-in program is for 12 months<br>• The Chronic Pain Committee consisting of clinical pharmacists, behavioral health/ARTS department, and medical directors evaluate if the member should continue in the program at the end of the 12-month period<br>• Educate providers about, and encourage use of, the Virginia prescription monitoring program to improve member safety by decreasing access to multiple prescribers of narcotics.<br>• Continue to advocate with both members and providers for the recognition and addressing of substance use issues.<br><br>***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total***<br>Initiatives:<br>• Well-Child Visit incentive program<br>• Emmi Well Child IVR campaign<br>• Articles in the Member Newsletter<br>• Birthday cards mailing that includes a bookmarker that serves to remind members of the preventative health guidelines they should follow to achieve their personal best health<br>• Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed: |

| Recommendation—Performance Measure Validation |
| --- |
| **Metric:** Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia<br>MY 2020: 68.75%<br>MY 2021: 72.31%<br>**Metric:** Cervical Cancer Screening<br>MY 2020: 43.31%<br>MY 2021: 47.93%<br>**Metric:** Comprehensive Diabetes Care - HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), and Eye Exam (Retinal) Performed<br>*HbA1cTesting:*<br>MY 2020: 84.67%<br>MY 2021: 85.89%<br>*HbA1c Poor Control:*<br>MY 2020: 60.10%<br>MY 2021: 61.80%<br>*HbA1c Control:*<br>MY 2020: 35.52%<br>MY 2021: 32.60%<br>*Eye Exam (Retinal) Performed:*<br>MY 2020: 46.72%<br>MY 2021: 48.18%<br>**Metric:** Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications<br>MY 2020: 70.87%<br>MY 2021: 73.27%<br>**Metric:** Immunizations for Adolescents - Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)<br>*Combination 1:*<br>MY 2020: 64.60%<br>MY 2021: 69.19%<br>*Combination 2:*<br>MY 2020: 25.06%<br>MY 2021: 30.07%<br>**Metric:** Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing - Total, Cholesterol Testing -Total, and Blood Glucose and Cholesterol Testing -Total<br>*Blood Glucose Testing - Total:*<br>MY 2020: 35.80%<br>MY 2021: 39.09%<br>*Cholesterol Testing - Total:*<br>MY 2020: 26.40%<br>MY 2021: 30.24%<br>*Blood Glucose and Cholesterol Testing - Total:* |

| Recommendation—Performance Measure Validation |
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| MY 2020: 24.60%<br>MY 2021: 28.08%<br>**Metric:** Use of Opioids from Multiple Providers—Multiple Prescribers<br>MY 2020: 24.80%<br>MY 2021: 25.92%<br>***Metric:*** *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile - Total, Counseling for Nutrition - Total, and Counseling for Physical Activity - Total*<br>*BMI Percentile-Total:*<br>MY 2020: 61.80%<br>MY 2021: 63.02%<br>*Counseling for Nutrition-Total:*<br>MY 2020: 46.96%<br>2MY 021: 56.93%<br>*Counseling for Physical Activity-Total:*<br>MY 2020: 37.23%<br>MY 2021: 47.45% |
| Identify any barriers to implementing initiatives:<br><br>***Breast Cancer Screening***<br>• To decrease the risk of transmitting the virus to either patients or health care workers within healthcare practices, providers deferred elective and preventive visits, such as annual physicals.<br>• Continued controversy in the new screening guideline recommendation differences from The American Cancer Society, The American Congress of Obstetricians and Gynecologist and the U.S. Preventive Services Task Force over the age when women should start yearly screenings for breast cancer.<br>• Logistical barriers like childcare, transportation problems, and taking time off from work are still having implications in women accessing preventive health care services.<br>• Language, cultural and immigration barriers continue to prevent non-English speaking populations from enrolling in a health plan and for available financial support for preventive care.<br>• Avoidance due to fear of diagnosis of breast cancer.<br>• Possible harms of breast cancer screening include unnecessary treatment for potentially harmless forms of breast cancer, incorrect results, and additional unnecessary testing.<br>• HEDIS specifications for MY 2020 added palliative care as a required exclusion for breast cancer screening.<br><br>***Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia***<br>• Persons with schizophrenia have high rates of medication non-adherence for a variety of reasons, including symptoms of the illness itself and undesired side effects of medications.<br>• Persons with serious mental illnesses are at increased risk of metabolic syndrome even before being prescribed antipsychotic medication |

**Recommendation—Performance Measure Validation**

- Persons with serious mental illness often see their psychiatrist (behavioral health provider) as their main health care provider and may not see their PCP (medical care provider) on a regular basis for preventive care.
- Behavioral health providers often do not have the equipment/staff resources to perform lab testing in their offices. Patients may not go to an unfamiliar setting (lab) to get ordered testing
- Lab testing done during an inpatient hospitalization may not be captured on claims data
- Lack of coordination of care between medical and behavioral health providers to ensure appropriate lab monitoring is completed and results shared.

***Cervical Cancer Screening***

- The coronavirus PHE impact on health plan business operations, including its potential effect on medical record data collection due to imposed travel bans, limited access to provider offices, quarantines, and risk to staff.
- To decrease the risk of transmitting the virus to either patients or health care workers within healthcare practices, providers deferred elective and preventive visits, such as annual physicals.
- Lack of awareness that the Affordable Care Act (ACA) has eliminated out of pocket expenses for women's preventive services such as mammograms, screenings for cervical cancer, and other services.
- Logistical barriers like childcare, transportation problems, and taking time off from work are still having implications in women accessing preventive health care services.
- Emotional barriers (fear, embarrassment, and anticipated shame) and low perceived risk might contribute to explaining lower cervical screening coverage for some ethnic groups.
- Lack of awareness regarding recommended screening intervals for HPV vaccine recipients and non-recipients.
- Cultural and psychosocial barriers regarding the screening procedure.

***Childhood Immunization Status—Combination 3***

- Decrease visits to pediatricians due to COVID-19 PHE
- Lack of childcare for parents, children not allowed in waiting areas due to Covid
- Knowledge/awareness deficit:
  - Language /communication barriers
  - Unaware of vaccination recommendations
  - Concerns over overloading immune system and side effects or adverse reactions of vaccines
- Access Issues
  - Cost
  - Inappropriate/limited-service hours (limited days/hours; sessions begin late/end early)
  - Fragmented care (no shows, cancellations)
- Transportation Issues

***Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%),* and *Eye Exam (Retinal) Performed***

- Decrease visits to PCP or specialist due to COVID-19 PHE
- Member unaware of symptoms related to diabetic disease
- Member has a language/communication barrier

| Recommendation—Performance Measure Validation |
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- Member unaware of benefits offered by MCO
- Lack of awareness of importance of dilated eye exams
- Member unable to attend provider appointments due to transportation challenges
- Member experiencing socioeconomic hardships/cultural issues
- Member dissatisfied with level of care received
- Lack of communication between member and provider
- Providers unaware of noncompliant members with healthcare gaps/dismissive of gap in care letter sent from the health plan
- Member having trouble obtaining needed provider appointments

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

- Persons with schizophrenia have high rates of medication non-adherence for a variety of reasons, including symptoms of the illness itself and undesired side effects of medications.
- Persons with serious mental illnesses are at increased risk of metabolic syndrome even before being prescribed antipsychotic medication
- Persons with serious mental illness often see their psychiatrist (behavioral health provider) as their main health care provider and may not see their PCP (medical care provider) on a regular basis for preventive care.
- Behavioral health providers often do not have the equipment/staff resources to perform lab testing in their offices. Patients may not go to an unfamiliar setting (lab) to get ordered testing
- Lab testing done during an inpatient hospitalization may not be captured on claims data
- Lack of coordination of care between medical and behavioral health providers to ensure appropriate lab monitoring is completed and results shared.

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

- Knowledge/awareness deficit
- Language /communication barriers
- Unaware of vaccination recommendations
- Concerns over overloading immune system and side effects or adverse reactions of vaccines
- Access Issues due to the availability of appointments with pediatricians due to COVID PHE
- Cost
- Inappropriate/limited- service hours (limited days/hours; sessions begin late/end early)
- Fragmented care (no-shows, cancellations)
- Transportation issues
- Health screening events suspended due to COVID PHE
- Communication barriers related to language and culture
- Availability of vaccines at provider offices
- Missed opportunities to immunize/false contraindications
- Data collection issues for capturing Hepatitis B vaccination given at birth
- Unable to capture/collect data on children immunized at military clinics

**Recommendation—Performance Measure Validation**

- Unable to capture/collect data using state health department records with Optima Health plan records if children's name, date of birth is not entered identically in both systems

***Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total***

- Many of these young people are being prescribed antipsychotics for behavioral issues related to diagnoses of autism spectrum disorders and may be particularly difficult to get to cooperate with blood testing.
- Many prescribers are not aware that the metabolic effect of this medication class is not dose dependent; there is a false belief that monitoring is not necessary if the child is on a low dose.
- Fewer providers who treat children/adolescents versus. adults, possibly leading to longer wait times for initial appointments. Also, psychosocial care generally requires greater parental/family involvement in treatment, which involves a time commitment (possibly missing work, etc.).

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

- Due to COVID-19 PHE members reluctant to go to PCP or specialist provider office for appointments.
- Members over 40 years old with asthma potentially have COPD but have not yet been diagnosed/ treated for COPD.
- Tobacco dependent members may be less compliant overall with health/wellness measures and less likely to monitor respiratory issues.
- Some skepticism expressed by some PCPs about the relevance of spirometry to the diagnosis of COPD and a reluctance to make the diagnosis before acute exacerbations occur are barriers that will need to be overcome.
- Member COPD self-management may not follow recommendations, contribute to exacerbations and avoidance in seeking medical interventions until in severe clinical distress
- Members may not be compliance with ongoing prescribed medication regimen, or it may appear that non-compliance exists due to
- Prescription fills/refills may not be captured if filled by local military clinics or a special low-cost med on retail pharmacy program and claim is not filed
- Economic stress may be affecting member's ability to obtain or refill medications due to financial hardship.

***Plan All-Cause Readmissions—Observed Readmissions—Total***

- Inadequate quality of care in the hospital
- Inadequate discharge planning and care coordination following hospitalization
- Communication barriers- members not sure what the expectations are for them once discharged
- Poor transition of care from hospital to home
- Delay in home health services in the community
- Socioeconomic strains on finances/strains on family life with illness
- Lack of care giver in the home
- Lack of knowledge of support services available upon discharge from the health plan

**Recommendation—Performance Measure Validation**

***Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total***

- Fewer providers who treat children/adolescents vs. adults, increased the wait times for initial appointments for behavioral health.
- Psychosocial care generally requires greater parental/family involvement in treatment, which involves a time commitment (possibly missing work, etc.).
- Influx of behavioral health patients seeking care through its ED. The spike follows Virginia's reduction in bed capacity at state psychiatric hospitals last July due to staffing and safety issues.

***Use of Imaging Studies for Low Back Pain***

- Early identification of members with low back pain prior to advanced imaging
- Patient expectations and provider defensive medicine
- Defensive medicine meaning physicians/providers ordering advanced imaging studies due to a perceived potential malpractice liability
- Members requesting advance imaging no matter the cost, to alleviate the back pain

***Use of Opioids from Multiple Providers—Multiple Prescribers***

- Reluctance by some medical and behavioral health providers to formally screen clients for substance use (or to code this diagnosis) for a variety of reasons: lack of time, lack of reimbursement, lack of recognition of prevalence of substance uses disorders co-occurring with other medical and behavioral health conditions, concern re: implications of this diagnosis for members in the military or other occupations requiring security clearance, discomfort with topic.
- Lack of knowledge or use of Virginia prescription monitoring program by providers.
- Hesitance of members to accept the diagnosis due to denial, and/or to seek treatment for substance use issues due to perceived stigma, privacy concerns.
- Financial concerns (related to copays) and time commitment for intensive outpatient substance abuse programs, which may meet three times/week.

***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total***

- Parental work schedules may not permit time for both sick and well-child visits.
- Parents may not understand the need for well-child visits, especially for adolescents.
- Adolescents may receive well-child checks at their schools for sports physicals and parents may not notify providers of these exams.
- Adolescents may be resistant about going to medical appointments when they are feeling well.
- Race, language, gender, and/or social determinants may be barriers that prohibit communication between adolescents, providers, and parents.
- Provider documentation may not accurately capture anticipatory guidance provided verbally.
- Systems issues may prevent capture of appropriate coding. (i.e., claims system may only allow for a specific number of codes to be entered).

**HSAG Assessment:**

| Recommendation—Performance Measure Validation |
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|  |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim 2:** Effective Patient Care | **Goal 2.2:** Ensure Access to Care | **Metric 2.2.3:** Getting Needed Care |
| **Weakness:** The MCO did not have a provider directory in a machine-readable file format available to members on its website.<br>**Why the weakness exists:** 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.<br>**Recommendation:** The MCO should establish a process to review member materials to ensure that federal requirements, including easily understood language and machine-readable formats, are available to members. | | |

| MCO's Response |
|---|
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• The machine-readable link functionality has been resolved. It is located at the footer of the online directory page and takes the user to the landing page, which is a text file.<br>• The formulary link remains visible and functional on the Optima Health website.<br>• The Provider Directory Policy NM024 was updated for the current accuracy and accessibility oversight process of the provider file.<br>• Optima Health monitors the machine-readable link monthly to ensure the link is working as expected. Any disruption to link access would be escalated to the vendor for resolution. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** CAHPS Getting Needed Care<br>MY 2020: 85.5%<br>MY 2021: 88.6% |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim 2:** Effective Patient Care | **Goal 2.2:** Ensure Access to Care | **Metric 2.2.3:** Getting Needed Care |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations |
|---|
| **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. The MCO did not consider all required factors when establishing and maintaining its network. The MCO's subcontractor and delegated entity agreements did not consistently include the Virginia-specific requirements. The MCO developed a Medicaid Addendum but did not consistently include it in the subcontractor and delegated entity agreements.<br>**Why the weakness exists:** The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements regarding network requirements and the content of subcontractor and delegated entity agreements.<br>**Recommendation:** The MCO must update its policies and procedures to ensure that network requirements outlined in the 2020 Medicaid Managed Care Rule and in the DMAS contract are met. The MCO must also ensure that its subcontractor and delegated entity agreements include all DMAS requirements. |
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• Policy NM006 Network Adequacy was updated to reflect the provider types available to members. Optima Health follows the quantitative network adequacy standards as required by the DMAS contract.<br>• Network adequacy is assessed and submitted to DMAS on a daily, monthly, and quarterly basis as required by DMAS. Any time a significant change impacts Optima Health's service area or other operations, DMAS is notified.<br>• The Medicaid Compliance stakeholders review contracts to ensure that the Medicaid Addendum is included in the contract, when necessary, that DMAS requirements are included in the contract when applicable, and that contracts requiring DMAS review are identified and sent to DMAS for review and approval. The VMO is currently partnering with the Optima Health Medicaid Compliance lead to add the updated Medicaid Addendum to identified vendor contracts by EOY 2022. This effort ensures that applicable contracts include the Medicaid Addendum, and that the Medicaid Addendum includes all approved DMAS language, including Cardinal Care updates. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** CAHPS Getting Needed Care<br>MY 2020: 88.6%<br>MY 2021: 84.5% |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim 1:** Enhance Member Satisfaction<br>**Aim 2:** Effective Patient Care | **Goal 1.1:** Improve Member Satisfaction<br>**Goal 2.2:** Ensure Access to Care | **Metric 1.2.3:** Rating of All Health Care<br>**Metric 2.2.3:** Getting Needed Care |
| **Weakness:** The MCO did not consistently resolve each appeal and provide written notice of the disposition to the member within the required time frames. A review of a sample of the MCO's denial case files identified that the MCO did not consistently meet timeliness or content requirements in the notice of action to the members.<br>**Why the weakness exists:** The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements that assure member rights are respected.<br>**Recommendation:** The MCO must develop and implement processes to monitor and ensure that all denial, grievance, and appeal time frames are met. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br><br>As a result of not consistently resolving each appeal and providing written notification of the dispositions to the members within the required time frames as well as not meeting content requirements in the notice of action to members, grievance and appeals have taken several actions to address staffing issues, process improvement, quality, and compliance. | | |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** CAHPS Rating of All Health Care<br>MY 2020: 61.2%<br>MY 2021: 63.1%<br>**Metric:** CAHPS Getting Needed Care<br>MY 2020: 88.6%<br>MY 2021: 84.5% | | |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. | | |
| **HSAG Assessment:**<br>  | | |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim 2:** Effective Patient Care | **Goal 2.2:** Ensure Access to Care | **Metric 2.2.3:** Getting Needed Care |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations |
|---|
| **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 is denied by the MCO, the service may be available through DMAS or provide DMAS contact information to the member.<br>**Why the weakness exists:** The MCO's adverse benefit determination letters to members focused on coverage decisions of MCO covered benefits and not all benefits available to the member.<br>**Recommendation:** The MCO should consistently inform members that EPSDT benefits not covered by the MCO may be available through DMAS, and how to contact DMAS to receive a benefit determination. |
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• Language was created and EPSDT letter was sent to DMAS for approval.<br>• Updated letter was sent to AIM Specialty Health. AIM team was educated on how and when to use this letter.<br>• Alternative services are listed in the letter. The language used may include, but is not limited to, refer to your MD for other treatment options, discuss plan of care with your care coordinator. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** CAHPS Getting Needed Care<br>MY 2020: 88.6%<br>MY 2021: 84.5% |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Encounter Data Validation | | |
|---|---|---|
| **Aim 4:** Improved Population Health | **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members<br>**Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders | **Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness<br>**Metric 4.2.2:** Follow-Up After ED Visit for AOD Abuse or Dependence |
| **Weakness:** The IS review revealed Optima could improve its internal monitoring tools for assessing quality and timeliness of encounter data. Additionally, Optima did not meet the validity criteria for institutional encounters.<br>**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 | | |

| Recommendation—Encounter Data Validation |
|---|
| part of the IS review. The IS review and administrative profile analysis did not identify the specific root cause of the weakness in validity.<br>**Recommendation:** HSAG recommends Optima:<br>• 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.<br>• Incorporate additional logic and referential checks to assess validity of data elements for institutional encounters. |
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br><br>Optima leverages a suite of tools and processes to ensure continued monitoring of both quality and timeliness of encounter data resulting from claims processing, of which general monitoring of acceptance rates is a single component. These include, but are not limited to:<br><br>• Automated schedules for encounter file generation, review, and submission to DMAS (weekly cadence), with system notifications communicating to key encounters and information technology stakeholders the completion/failure during key steps of the process.<br>• System-managed automated review of generated files out of Optima's primary claims adjudication system (CSC), which applies a variety of conditional logic and data completeness steps to identify and quarantine for correction those records that could potentially create an error when submitted to DMAS.<br>  – Ongoing active review of current automated review (above) conditions to keep updated as DMAS updates requirements for encounters submissions.<br>• Assigned encounters analysts for Medicaid encounter submissions, who maintain active and current knowledge of DMAS encounters submissions standards. In additional to the ongoing responsibility for encounters submissions and overall accuracy and acceptance of records submitted, these individuals also act as subject matter experts (SMEs) for DMAS encounters requirements, engaging with DMAS encounters, internal departmental stakeholders, and external vendor partners to further ongoing improvements and system enhancements towards general quality and timeliness goals.<br>• The table is representative of an example of internal tracking of encounters submissions / acceptance, providing comparison across not just different submission types, but also YTD comparison and trend analysis. Any monthly / quarterly / YTD indications (color codes) that imply an issue are investigated, remediated, and reported to claims and operational leadership on a monthly basis. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Follow-Up After Hospitalization for Mental Illness<br>MY 2020: 7-Day: 35.21% 30-Day: 61.18%<br>MY 2021: 7-Day: 35.70% 30-Day: 60.18%<br>**Metric:** Follow-Up After ED Visit for AOD Abuse or Dependence |

| Recommendation—Encounter Data Validation |
|---|
| MY 2020: 7-Day: 11.87% 30-Day: 60.54%<br>MY 2021: 7-Day: 15.35% 30-Day: 22.20% |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Member Experience of Care Survey | | |
|---|---|---|
| **Aim 1:** Enhance Member Care Experience<br>**Aim 2**: Effective Patient Care | **Goal 1.1:** Improve Member Satisfaction<br>**Goal 2.2:** Ensure Access to Care | **Metric 1.2.1:** Getting Care Quickly Q6<br>**Metric 1.2.3:** Rating of All Health Care<br>**Metric 2.2.3:** Getting Needed Care |
| **Weakness:** Optima'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.<br>**Why the weakness exists:** NA.<br>**Recommendation:** HSAG recommends that Optima monitor the measures to ensure significant decreases in scores over time do not occur. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• CAHPS 101 education annual CBT for all member-facing teams to increase awareness and importance<br>• CAHPS mid-year reminder to review customer service and the importance of the member experience<br>• Customer service post-survey member calls to drive continuous improvement opportunities<br>• Member outreach calls to assist members in navigating their healthcare needs<br>• Care coordination assistance with patient/provider appointment scheduling and transportation<br>• Provider newsletter articles<br>• Collaboration with network education to improve provider-driven measures | | |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Rating of Specialist<br>MY 2020: 74.1%<br>MY 2021: 77.7%<br>**Metric:** Rating of Health Care<br>MY 2020: 61.2% | | |

| Recommendation—Member Experience of Care Survey |
|---|
| MY 2021: 63.1%<br>**Metric:** Getting Care Quickly<br>MY 2020: 84.4%<br>MY 2021: 86.5% |
| Identify any barriers to implementing initiatives:<br>The COVID-19 PHE caused significant disruption throughout most of 2020 and continuing through today. The disruption is reflected in the variation we've seen in health system experience scores over the last few years. |
| **HSAG Assessment:**<br>  |

| Recommendation—Member Experience of Care Survey | | |
|---|---|---|
| **Aim 1:** Enhance Member Care Experience<br>**Aim 2**: Effective Patient Care | **Goal 1.1:** Improve Member Satisfaction<br>**Goal 2.2:** Ensure Access to Care | **Metric 1.2.1:** Getting Care Quickly Q6<br>**Metric 1.2.3:** Rating of All Health Care<br>**Metric 2.2.3:** Getting Needed Care |
| **Weakness:** Optima's top-box score was statistically significantly lower than the 2020 NCQA adult Medicaid national average for one measure, *Rating of Health Plan*.<br>**Why the weakness exists:** Based on the survey results, parents/caretakers of child 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.<br>**Recommendation:** HSAG recommends that Optima conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that Optima continue to monitor the measures to ensure significant decreases in scores over time do not occur. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• CAHPS 101 education annual CBT for all member-facing teams to increase awareness and importance<br>• CAHPS mid-year reminder to review customer service and the importance of the member experience<br>• Customer service post-survey member calls to drive continuous improvement opportunities<br>• Member outreach calls to assist members in navigating their healthcare needs<br>• Care coordination assistance with patient/provider appointment scheduling and transportation | | |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed: | | |

| Recommendation—Member Experience of Care Survey |
|---|
| **Metric:** CAHPS Rating of Health Plan<br>MY 2020: 62.7%<br>MY 2021: 69.1%<br>**Metric:** CAHPS Rating of All Health Care<br>MY 2020: 59.5%<br>MY 2021: 61.2%<br>**Metric:** CAHPS Getting Care Quickly<br>MY 2020: 83.5%<br>MY 2021: 84.4% |
| Identify any barriers to implementing initiatives:<br>The COVID-19 PHE caused significant disruption throughout most of 2020 and continuing through today. The disruption is reflected in the variation we've seen in health system experience scores over the last few years. |
| **HSAG Assessment:**<br>  |

## *United*

**Table E-6—Prior Year Recommendations and Responses—United**

| Recommendation—Performance Improvement Projects | | |
|---|---|---|
| **Aim 4:** Improving Population Health | **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | **Metric:** Not a QS Metric |
| **Weakness:** United received *Low Confidence* for the *Follow-Up After Discharge* PIP.<br>**Why the weakness exists:** Improvement could not be linked to the interventions.<br>**Recommendation:** HSAG recommends that United:<br>• Continue efforts to achieve further improvement and spread interventions to other populations as appropriate. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• The Follow-Up After Discharge PIP methodology was executed as approved; however, the SMART Aim goal was not achieved.<br>• UHC provided additional SMART Aim data points in October 2021 showing improvement, but the result still did not meet the goal after intervention testing began. | | |

| Recommendation—Performance Improvement Projects |
|---|
| • The original interventions focused on the Tidewater and Roanoke regions. UHC's current initiatives will continue to achieve further improvement by expanding the interventions to other populations and enhancing data analysis and processes to identify trends and barriers. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** 2.13 (DMAS CCC Plus Technical Manual) - Follow Up After Discharge<br>MY 2020: 54.53%<br>MY 2021: 58.32% |
| Identify any barriers to implementing initiatives:<br>COVID-19 played a large role completion of post-hospital assessments. Health coaches were unable to outreach members directly in the hospital and conduct follow-up home visits. |
| **HSAG Assessment:**<br>  |

| Recommendation—Performance Measure Validation | | |
|---|---|---|
| **Aim 3:** Smarter Spending<br><br>**Aim 4:** Improved Population Health | **Goal 3.2:** Focus on Efficient Use of Program Funds<br>**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members | **Metric 3.2.3:** Monitor MLR annually by managed care program and aggregate total **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services<br>**Not a QS Metric:**<br>**Metric:** (AAB)<br>**Metric:** (CCS)<br>**Metric:** (SSD)<br>**Metric:** (IMA) |
| **Weakness:** The following HEDIS 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:<br>• *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*<br>• *Cervical Cancer Screening*<br>• *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*<br>• *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*<br>• *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total*<br>• *Plan All-Cause Readmissions—Observed Readmissions—Total* | | |

| Recommendation—Performance Measure Validation |
|---|
| • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*<br>**Why the weakness exists:** Several of United's rates in the Access and Preventive Care, Taking Care of Children, and Living With Illness domains falling below the HEDIS MY 2019 25th percentile suggests a lack of access or understanding of the need for preventive care and screenings. United's members are not consistently scheduling cancer screenings; adults and children are not accessing care or services according to evidence-based recommendations; and members with chronic conditions are not consistently following evidence-based, diagnosis-specific care and recommendations. With low performance across several domains, healthcare disparities may exist, and members may not have a comprehensive understanding of their healthcare needs or benefits. United members may need the tools and support 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.<br>**Recommendation:** HSAG recommends that United conduct a root cause analysis or focus group(s) to determine why members are not consistently receiving well care, screenings, behavioral healthcare, or care for chronic conditions according to recommended schedules or evidence-based guidelines. HSAG also recommends that United conduct data analyses to better understand barriers members may 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 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** |
| 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):<br>• UHC conducts risk scoring and uses other algorithms to identify and stratify members with chronic conditions, short-term care needs, long-term care needs or social supports. These members are subsequently connected with enhanced care coordination and outreach activities.<br>• UHC conducted root cause analysis based on race, ethnicity, and language state-wide and implemented multiple interventions, including member events and increased member outreach activities to improve access to and timeliness of preventative screenings and members diagnosed with a chronic condition.<br>• Identified trending SDoH needs to determine members' needs for preventative care while ensuring a strong engagement and connection with community resources.<br>• CP-PCPi Program – Provide PCPs with up-to-date data of members experiencing gaps in care and partnering with providers and facilities to promote member events to close gaps in care.<br>• Expanded telehealth to increase availability of access to care for members.<br>• Partnership with Federally Qualified Health Centers (FQHCs), health systems and other community partners for member care and support of community events.<br>• Partnership with community entities to facilitate and promote member self-care and resources. |

| Recommendation—Performance Measure Validation |
|---|
| • UHC continues to evaluate data and identify areas of opportunity and strategies to address health disparities. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis<br>MY 2020: 34.66%<br>MY 2021: 31.37%<br>**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services: Breast Cancer Screening<br>MY 2020: 40.15%<br>MY 2021: 45.74%<br>**Metric:** Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications<br>MY 2020: 78.62%<br>MY 2021: 83.72%<br>**Metric 4.3.4:** Child and Adolescent Well-Care Visits: Immunizations for Adolescents: Combination 1:<br>MY 2020: 65.65%<br>MY 2021: 76.99%<br>**Metric 4.3.4:** Child and Adolescent Well-Care Visits: Immunizations for Adolescents: Combination 2:<br>MY 2020: 25.19%<br>MY 2021: 37.17%<br>**Metric:** Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing:<br>MY 2020: 45.10%<br>MY 2021: 47.78%<br>**Metric:** Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing:<br>MY 2020: 26.47%<br>MY 2021: 31.11%<br>**Metric:** Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing:<br>MY 2020: 26.47%<br>MY 2021: 30.00%<br>**Metric:** Plan All-Cause Readmissions:<br>MY 2020: 12.01%<br>MY 2021: 10.64%<br>**Metric 4.3.4:** Child and Adolescent Well-Care Visits: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile:<br>MY 2020: 65.69%<br>MY 2021: 77.37%<br>**Metric 4.3.4:** Child and Adolescent Well-Care Visits: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Nutrition:<br>MY 2020: 57.42% |

| Recommendation—Performance Measure Validation |
|---|
| MY 2021: 62.53%<br>**Metric 4.3.4:** Child and Adolescent Well-Care Visits: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Physical Activity:<br>MY 2020: 52.55%<br>MY 2021: 58.15% |
| Identify any barriers to implementing initiatives:<br>UHC did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim:** NA | **Goal:** NA | **Not a QS Metric** |
| **Weakness:** The MCO's subcontractor and delegated entity agreements did not consistently include the Virginia-specific requirements. The MCO developed a subcontractor agreement, the Virginia Medicaid Regulatory Appendix, but it was not consistently included in the subcontractor and delegated entity agreements.<br>**Why the weakness exists:** The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements regarding network requirements and the subcontractor and delegated entity agreements.<br>**Recommendation:** The MCO must also ensure that its subcontractor and delegated entity agreements include all DMAS requirements. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• In March 2022, in follow-up to the HSAG OSR audit, UHC received approval from DMAS of its updated Medicaid Regulatory Appendices containing all applicable DMAS requirements. Subsequently following approval, UHC coordinated contract amendments with delegated entities to append the updated appendix to those contracts. UHC submitted evidence of amended contracts to DMAS in May 2022, and the corrective action was approved for closure. | | |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** NA | | |
| Identify any barriers to implementing initiatives:<br>UHC did not identify any barriers to implementing initiatives. | | |
| **HSAG Assessment:** | | |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations |
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|  |



| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim:** NA | **Goal:** NA | **Not a QS Metric** |
| **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.<br>**Why the weakness exists:** The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements regarding network requirements and the content of subcontractor and delegated entity agreements.<br>**Recommendation:** The MCO must update its policies and procedures to ensure that grievance and appeal requirements outlined in the 2020 Medicaid Managed Care Rule and in the DMAS contract are met. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• The correction had been made in response to the HSAG OSR 2021 audit. The updated Appeals and Grievance Policy and Procedure was provided at that required time. UHC continues to operate according to the updated policy and procedure. | | |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** NA | | |
| Identify any barriers to implementing initiatives:<br>UHC did not identify any barriers to implementing initiatives. | | |
| **HSAG Assessment:** | | |



| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim:** NA | **Goal:** NA | **Not a QS Metric** |
| **Weakness:** The MCO did not have an implemented process to provide information about the grievance process, appeal process, and State fair hearing system to all providers, subcontractors, and delegated entities at the time they entered into a contract.<br>**Why the weakness exists:** The MCO informed providers of grievance, appeal, and State fair hearing system rights in notice of adverse benefit determination, grievance, and appeal notifications. | | |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations |
|---|
| The MCO did not ensure information on the processes were consistently available to providers upon entering a contractual relationship with the MCO.<br>**Recommendation:** The MCO should consider providing information to providers upon signing of a contract with the MCO on the grievance, appeal, and State fair hearing processes in a consistent and standardized method. |
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• UHC updated the provider manual in response to the HSAG OSR 2021 audit regarding appeals and grievance provider processes. UHC also provides education to providers as part of onboarding practices to incorporate education on appeals and grievance in our provider education materials which includes a directive for the providers pointing them to the provider manual resource. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** NA |
| Identify any barriers to implementing initiatives:<br>UHC did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Encounter Data Validation | | |
|---|---|---|
| **Aim:** NA | **Goal:** NA | **Not a QS Metric** |
| **Weakness:** United did not meet the validity criteria for institutional encounters.<br>**Why the weakness exists:** The IS review and administrative profile analysis did not identify the specific root cause of the weakness in meeting the validity criteria.<br>**Recommendation:** HSAG recommends United:<br>• Assess how submission and payment dates are populated on pharmacy encounters to determine the root cause for having submission dates prior to payment.<br>• Incorporate additional logic and referential checks to assess the validity of data elements for institutional encounters. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• State guidelines require encounters to be submitted with the actual check date. UHC's pharmacy vendor batches claims every three days which allows them to set check dates and check | | |

| Recommendation—Encounter Data Validation | | |
|---|---|---|
| numbers to claims. Those dates are posted to claims and subsequently reported on the encounter. The posted check dates have potential to be future dates. | | |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** NA | | |
| Identify any barriers to implementing initiatives:<br>UHC did not identify any barriers to implementing initiatives. | | |
| **HSAG Assessment:**<br>  | | |
| **Recommendation—Member Experience of Care Survey** | | |
| **Aim 1:** Enhance Member Care Experience<br>**Aim 2:** Effective Patient Care | **Goal 1.1:** Improve Member Satisfaction<br>**Goal 2.1:** Enhance Provider Support<br>**Goal 2.2:** Ensure Access to Care | **Metric 1.2.1:** Getting Care Quickly<br>**Metric 1.2.2:** Rating of Health Plan<br>**Metric 1.2.3:** Rating of All Health Care<br>**Metric 2.1.1:** Rating of Personal Doctor<br>**Metric 2.1.2:** How Well Doctors Communicate<br>**Metric 2.2.3:** Getting Needed Care |
| **Weakness:** United's 2021 top-box scores were not statistically significantly lower than the 2020 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.<br>**Why the weakness exists:** NA.<br>**Recommendation:** HSAG recommends that United monitor the measures to ensure significant decreases in scores over time do not occur. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>• UHC continues to survey providers on appointment availability. Outreach and education were provided to providers on scheduling best practices and how to improve access to routine/urgent care.<br>• UHC regularly assesses the accuracy of marketing materials and how well new members understand their benefits, services, and materials upon enrollment, and uses commonly used medical and insurance terms in easy-to-understand language available in multiple languages. These materials enhance communication between health care professionals and members, while also facilitating member's ability to make informed healthcare decisions. | | |

| Recommendation—Member Experience of Care Survey |
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| • UHC continues to monitor measures to evaluate areas of opportunity and strategies to provide continuous improvement. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>PMV results showed:<br>**Metric 1.2.2:** CAHPS Enrollees' Rating of Health Plan: Customer Service<br>MY 2020: 88.3%<br>MY 2021: 91.5%<br>**Metric 1.2.3:** CAHPS Rating of All Health Care<br>MY 2020: 59.3%<br>MY 2021: 59.9%<br>**Metric 2.1.2:** CAHPS How Well Doctors Communicate<br>MY 2020: 92.6%<br>MY 2021: 93.0%<br>**Metric 2.2.3:** CAHPS Getting Needed Care<br>MY 2020: 80.9%<br>MY 2021: 83.8% |
| Identify any barriers to implementing initiatives:<br>UHC did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Member Experience of Care Survey | | |
|---|---|---|
| **Aim 1:** Enhance Member Care Experience | **Goal 1.1:** Improve Member Satisfaction | **Metric 1.2.2:** Rating of Health Plan |
| **Weakness:** United's 2021 top-box score was statistically significantly lower than the 2020 NCQA child Medicaid national average for one measure, *Rating of Health Plan*.<br>**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 the ability to receive care or services for their child.<br>**Recommendation:** HSAG recommends that United conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that United continue to monitor the measures to ensure significant decreases in scores over time do not occur. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): | | |

| Recommendation—Member Experience of Care Survey |
|---|
| • UHC continued to evaluate data and identify strategies for barrier removal as part of United's ongoing processes.<br>• UHC conducted focus group studies with parents to better understand barriers to their child receiving access to care or services in a timely manner. UHC additionally obtained feedback from care coordinators and member advisory committees.<br>• On an ongoing basis, UHC continues to evaluate areas of opportunity and strategies to promote continuous improvement in this area.<br>• UHC scored statistically significantly higher than the NCQA 2020 national Medicaid average on measure, *Rating of Specialist Seen Most Often*.<br>• UHC continues to monitor all measures to ensure there are no significant decrease in rates over time. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric 1.2.2:** CAHPS Rating of Health Plan<br>MY 2020: 60.0%<br>MY 2021: 62.3%<br>**Metric 1.2.3:** CAHPS Rating of Health All Health Care<br>MY 2020: 67.6%<br>MY 2021: 70.2%<br>**Metric 2.1.1:** CAHPS Rating of Personal Doctor<br>MY 2020: 74.8%<br>MY 2021: 76.8%<br>**Metric 2.2.3:** CAHPS Getting Needed Care<br>MY 2020: 86.4%<br>MY 2021: 87.7% |
| Identify any barriers to implementing initiatives:<br>UHC did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

## *VA Premier*

**Table E-7—Prior Year Recommendations and Responses—VA Premier**

| Recommendation—Performance Improvement Projects | | |
|---|---|---|
| **Aim 1:**<br>Enhance Member Care Experience | **Goal 1.1:** Improve Member Satisfaction | **Metric 1.2.3:** Rating of All Health Care |

| Recommendation—Performance Improvement Projects |
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| **Weakness:** VA Premier received *Reported PIP results were not credible* for both PIPs.<br>**Why the weakness exists:** The MCO did not address all HSAG's feedback in the resubmissions and documented SMART Aim remeasurement data that appeared to be not comparable to the baseline.<br>**Recommendation:** HSAG recommends that VA Premier:<br>• Ensure understanding of the PIP methodology and data reporting requirements.<br>• Address all feedback and recommendations in PIP resubmissions. |
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br>The MCO did not submit any initiatives implemented.<br><br>The greatest barrier encountered was the COVID-19 PHE. Understanding the effects of COVID-19 on our efforts and making the necessary adjustments to transition to a remote work environment while implementing actions to sustain improvement over time was paramount. Additionally, alert fatigue was a concern when implementing real-time notifications for ED visit encounters to be transmitted to the care coordination staff. Collaboration efforts with the vendor supplying the alerts to identify focused alerts and modifying the method which the notifications were received was proven beneficial and resolved the barrier for alert fatigue prevention. The PIPs team addressed all feedback, as we understood it, and made adjustments accordingly with resubmissions. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Ambulatory Care - ED Visits<br>MY 2020: 2.93%<br>MY 2021: 98.10%<br>**Metric:** CAHPS Rating of All Health Care<br>MY 2020: 58.0%<br>MY 2021: 56.3% |
| Identify any barriers to implementing initiatives:<br>The greatest barrier encountered was the COVID-19 PHE. |
| **HSAG Assessment:**<br>  |

| 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 |

| Recommendation—Performance Measure Validation | | |
|---|---|---|
| | **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members<br>**Goal 4.4:** Improve Health for Members with Chronic Conditions<br>**Goal 4.6:** Improve Outcomes for Maternal and Infant Members | **Metric 4.1.5:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics<br>**Metric 4.3.2:** Adults' Access to preventive/Ambulatory Health Services<br>**Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) |

**Weakness:** The following HEDIS 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 VA Premier:

- *Breast Cancer Screening*
- *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*
- *Use of Imaging Studies for Low Back Pain*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*

**Why the weakness exists:** Several of VA Premier's rates in the Access and Preventive Care, Behavioral Health, Taking Care of Children, and Living With Illness domains falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile suggests members may not have adequate access to well and preventive care, screenings, behavioral healthcare, and care for chronic conditions. VA Premier's members are not consistently scheduling well visits or cancer screenings, adults are not accessing care or services according to evidence-based chronic care recommendations, and members with a behavioral health diagnosis are not receiving appropriate follow-up after prescribing. With low performance across several domains, healthcare disparities may exist, and members may not have a comprehensive understanding of their healthcare needs or benefits. Screening declines may have coincided with the rapid increase of COVID-19 cases in 2020.

| Recommendation—Performance Measure Validation |
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| 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.<br>**Recommendation:** HSAG recommends that VA Premier conduct root cause or data analysis or conduct focus group(s) to determine why members are not consistently receiving well visits, preventive screenings, behavioral healthcare, or care for chronic conditions according to recommended schedules. HSAG recommends that VA Premier consider whether 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 or causes, HSAG recommends that VA Premier implement appropriate interventions to improve access to and timeliness of well and preventive visits and screenings and recommended services for members diagnosed with a behavioral health or chronic condition, and implement appropriate interventions to improve the performance related to these measures. |
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br><br>**Breast Cancer Screening**<br>Initiatives:<br>• Formalized Population Health Committee and formalized HEDIS workgroups established as part of quality governance structure<br>• Performs live outreach calls to discuss the importance of breast cancer screening and remind members they are due for mammogram<br>• Makes direct calls monthly to members with breast cancer screening gaps<br>• Newly formed Pop Care Team sends letters to members with multiple gaps. Members are identified by using predictive analytics and targeted when they are most likely to close the gap<br>• Rewards/incentive language is included in these care gap letters<br>• Partners with network education to distribute patient gap reports<br>• Population Health Assessment work group was established 7/2022<br>• NCQA PHM standards and audit tools purchased to perform a comprehensive population health assessment to include but not limited to: SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population Health Assessment to be completed 7/2023<br><br>**Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia**<br>Initiatives:<br>• Chronic care management conducts assessments for members who have been identified to have a cardiovascular condition such as hypertension, coronary artery disease, and heart failure. For all these members, we send them a scale and a blood pressure cuff as need so that the member can monitor their progress and notify the PCP if they have abnormal readings.<br>• Chronic care management sends hard copy educational materials that provide guidance on healthy eating, exercise, and knowing what symptoms to be aware of so that they can contact their PCP in a timely manner. |

**Recommendation—Performance Measure Validation**

- Currently, chronic care management conducts the PHQ-2 screening for all members we engage. If the member's scores high, then the member is referred to behavioral health team for further evaluation by a mental health provider.

**Comprehensive Diabetes Care—HbA1c Testing**

Initiatives:

- Implemented a pilot with Dario which covers 1,500 Virginia Premier Health Plan Medallion 4.0 and CCC Plus members in the Dario Type 2 Diabetes program. The solution provides adaptive, personalized member experiences to drive behavior change through evidence-based interventions, intuitive, clinically proven digital tools, high-quality software, and coaching to encourage individuals to improve their health and sustain meaningful outcomes. If the pilot proves effective at closing Type 2 Diabetes care gaps, it will be scaled to include all eligible members
- Like Dario, Virginia Premier is implementing a program with Onduo is a T2D initiative to target the VPHP Medallion 4.0 and CCC Plus population
- Performs live outreach calls to discuss the importance of A1c testing and blood sugar control as well as retinal eye exams
- Pop Care sends letters to members with multiple gaps. Members are identified by using respective analytics and targeted when they are most likely to close the gap
- Rewards/Incentive language is included in these care gap letters
- Population Care works in partnership with Bio IQ to send at-home diabetes testing kits to members who have not completed and A1c during the measurement period. The health plan is currently developing a process to refer members with elevated results to case management
- Population Care works in partnership with Focus Care to complete in-home assessments for eligible members. Part of the assessment includes assistance in completing at home A1c testing and diabetic eye exams
- The health plan recently started offering retinal eye exams to members who are not eligible for home assessments through focus care to improve access to care
- Chronic care management completes assessments for members who have diabetes. This assessment is conducted telephonically. We send the member a glucometer, blood pressure cuff, or scale if equipment is needed. Furthermore, we send members written education materials to give them reinforcement on how to best manage their diabetes. Also, we follow up with each member we engage at least every 90 days to review their individualized care plan goals and provide further guidance as it relates to managing diabetes. Chronic care management encourages and helps facilitate the member getting their HbA1c checked. If the member does not have a primary care provider (PCP) chronic care management will connect the member with our member services team to help them find an in-network provider, facilitate transportation, and offer additional help as needed

**Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)**

Initiatives:

- Chronic care management completes assessments for members who have diabetes. This assessment is conducted telephonically. The MCO sends the member a glucometer, blood pressure cuff, or scale if equipment is needed. Furthermore, we send members written education

| Recommendation—Performance Measure Validation |
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materials to give them reinforcement on how to best manage their diabetes. Also, we follow up with each member we engage at least every 90 days to review their individualized care plan goals and provide further guidance as it relates to managing diabetes. Chronic care management encourages and helps facilitate the member getting their HbA1c checked. If the member does not have a primary care provider (PCP), chronic care management will connect the member with our member services team to help them find an in-network provider, facilitate transportation, and offer additional help, as needed

**Comprehensive Diabetes Care—HbA1c Control (< 8.0%)**

Initiatives:

- Chronic care management completes assessments for members who have diabetes. This assessment is conducted telephonically. We send the member a glucometer, blood pressure cuff, or scale if equipment is needed. Furthermore, we send members written education materials to give them reinforcement on how to best manage their diabetes. Also, we follow up with each member we engage at least every 90 days to review their individualized care plan goals and provide further guidance as it relates to managing diabetes. Chronic care management encourages and helps facilitate the member getting their HbA1c checked. If the member does not have a primary care provider (PCP), chronic care management will connect the member with our Member Services team to help them find an in-network provider, facilitate transportation, and offer additional help, as needed

**Comprehensive Diabetes Care—Eye Exam (Retinal) Performed**

Initiatives:

- An initiative with Retina Labs implemented in the fourth quarter 2022 to support the completion of diabetic eye exams for members in Virginia Premier Health Plan Medallion 4.0 and CCC Plus with a diagnosis of diabetics:
  - Members with diabetes will be offered either clinic-based or in-home tele-retinal screening for early detection of diabetic retinopathy
  - Providing a choice of screening options will help improve member satisfaction, close this critical diabetes care gap, and improve health outcomes for Virginia Premier Health Plan members
- Rewards/Incentive language is included in these care gap letters
  - Population Care works in partnership with Focus Care to complete in-home assessments for eligible members. Part of the assessment includes assistance in completing at home A1c testing and diabetic eye exams
- The health plan recently started offering retinal eye exams to members who are not eligible for home assessments through focus care to improve access to care
- Chronic care management completes assessments for members who have diabetes. This assessment is conducted telephonically. We send the member a glucometer, blood pressure cuff, or scale if equipment is needed. Furthermore, we send members written education materials to give them reinforcement on how to best manage their diabetes. Also, we follow up with each member we engage at least every 90 days to review their individualized care plan goals and provide further guidance as it relates to managing diabetes. Chronic care management encourages and helps facilitate the member getting their HbA1c checked. If the member does not have a primary care provider (PCP) chronic care management will connect the member with our

| Recommendation—Performance Measure Validation |
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member services team to help them find an in-network provider, facilitate transportation, and offer additional help as needed

**Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total**
**Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total**

Initiatives:

- Behavioral Health Care Coordination Team supports all members who have 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 inpatient reviewers send notification at admission and discharge to members care coordination 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
- Behavioral Health Inpatient Reviewers send notification at admission and discharge to members care coordinator and/or transition coordinator to initiate discharge planning with inpatient facility to identify and resolve barriers for safe and effective discharge, while initiating community-based services, as needed, to reduce chance for member readmission

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

Initiatives:

- Childhood Immunization Incentive Program, Back to School Fairs across the State. Well Child and Immunization Campaigns. Educational Outreach. Data utilized from VIS and Health Fair Capture to close gaps and refer to case management. FTE for EPSDT
- Immunization program in development to improve member and clinician engagement which includes incentives, targeted outreach, and educational initiatives. Additionally, increased collaboration with the commonwealth's department of health regarding vaccination data. Launch target of first quarter 2023
- Population Health Assessment work group was established 7/2022
- NCQA PHM standards and audit tools purchased to perform a comprehensive population health assessment to include but not limited to: SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc.
- Population Health Assessment to be completed 7/2023
- Well Child and Immunization Campaigns

**Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total**

Initiatives:

- Clinical coordination program for those members aged 6-12 years who are taking an atypical antipsychotic
- Care coordination letters are sent to member's PCP and prescriber of atypical antipsychotic
- Goal is to ensure appropriate clinical monitoring of the member is being completed and reported

| Recommendation—Performance Measure Validation |
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- Team meetings are held monthly to discuss program, suggest any improvements, and review data results

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

Initiatives:

- Goal is to ensure appropriate clinical monitoring of the member is being completed and reported
- Team meetings are held monthly to discuss program, suggest any improvements, and review data results
- Clinical program to help adherence and therapy completeness
- Care coordinators outreach members to educate on side effects and provide any additional support needed

**Plan All-Cause Readmissions—Observed Readmissions—Total**

Initiatives:

The case management team sends a Where to Go Flyer addressing when to visit the doctor's office, urgent care, and the emergency room. This flyer also includes the free 24-hour nurse advice line education. Case management outreaches members to provide education, engage in case management services to include a plan of care, and mail a list of providers in their region for member utilization to address their healthcare needs

**Use of Imaging Studies for Low Back Pain**

Initiatives:

- Clinical guidelines reviewed and updated
- Providers are notified of updated clinical guidelines via newsletter and provider site
- Provider newsletter article
- Data analysis based on ordering providers to assist in driving interventions
- Partner with our clinically integrated networks to develop action items for addressing the use of advanced imaging for initial diagnosis and treatment of low back pain
- Add physical therapy recommendations to the member's newsletter to increase the understanding of low back health and how to prevent injuries

**Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total**

Initiatives:

- Clinical coordination program for those members aged 6-12 years who are taking an atypical antipsychotic
- Care coordination letters are sent to the member's PCP and prescriber of atypical antipsychotic
- The goal is to ensure appropriate clinical monitoring of the member is being completed and reported
- Team meetings are held monthly to discuss the program, suggest any improvements, and review data results

| Recommendation—Performance Measure Validation |
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| • Fewer providers who treat children/adolescents versus adults, possibly leading to longer wait times for initial appointments<br>• Also, psychosocial care generally requires greater parental/family involvement in treatment, which involves a time commitment (possibly missing work, etc.)<br>• An influx of behavioral health patients seeking care through its ED. The spike follows Virginia's reduction in bed capacity at state psychiatric hospitals last July due to staffing and safety issues<br><br>**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, Counseling for Nutrition—Total, and Counseling for Physical Activity—Total**<br>Initiatives:<br>• Incentive Program, Back to School Fairs across the State<br>• Well Child campaigns<br>• Educational Outreach. Data utilized from VIS and Health Fair Capture to close gaps and refer to case management. FTE for EPSDT<br>• The Population Health Assessment work group was established on 7/2022<br>• NCQA PHM standards and audit tools purchased to perform a comprehensive population health assessment include but are not limited to SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities including race/ethnicity, age, zip code, etc. Population Health Assessment to be completed 7/2023<br>• Well Child and Immunization Campaigns |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia<br>MY 2020: 60.32%<br>MY 2021: 61.90%<br>**Metric:** Comprehensive Diabetes Care—HbA1c Testing<br>MY 2020: 74.21%<br>MY 2021: 81.75%<br>**Metric:** Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)<br>MY 2020: 55.47%<br>MY 2021: 49.64%<br>**Metric:** Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)<br>MY 2020: 60.34%<br>MY 2021: 72.99%<br>**Metric:** Combination 2 (Meningococcal, Tdap, HPV)<br>MY 2020: 23.84%<br>MY 2021: 31.87%<br>**Metric:** Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total<br>MY 2020: 32.48%<br>MY 2021: 37.39% |

| Recommendation—Performance Measure Validation |
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| **Metric:** Plan All-Cause Readmissions—Observed Readmissions—Total<br>MY 2020: 0.83%<br>MY 2021: 0.94%<br>**Metric:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile<br>MY 2020: 55.23%<br>MY 2021: 58.64% |
| Identify any barriers to implementing initiatives:<br>• Member's experiencing SDOH<br>• Member may lack of social support<br>• Member's lack of understanding of care recommendations for optimal health<br>• Members may need additional education<br>• Members not interested in the in-home services being offered<br>• Not returning kits in a timely manner<br>• Lack of understanding on how to use kits<br>• Homelessness<br>• Although parents are getting their children vaccinated, vaccines were not received in an adequate timeframe<br>• Lack of appointment availability in outpatient settings due staffing issues<br>• Poor communication between member and provider regarding the need for vaccines during well-check visits for members<br>• Many of these young people are being prescribed antipsychotics for behavioral issues related to diagnoses of autism spectrum disorders and may be particularly difficult to get to cooperate with blood testing<br>• Many prescribers are not aware that the Metabolic effect of this medication class is not dose dependent; there is a false belief that monitoring is not necessary if the child is on a low dose.<br>• Fewer providers who treat children/adolescents vs. adults, possibly leading to longer wait times for initial appointments. Also, psychosocial care generally requires greater parental/family involvement in treatment, which involves a time commitment (possibly missing work, etc.)<br>• Due to the COVID PHE members are reluctant to go to PCP or specialist provider offices for appointments<br>• Members over 40 years old with asthma potentially have COPD but have not yet been diagnosed/ treated for COPD<br>• Tobacco-dependent members may be less compliant overall with health/wellness measures and less likely to monitor respiratory issues<br>• Some skepticism expressed by some PCPs about the relevance of spirometry to the diagnosis of COPD and a reluctance to make the diagnosis before acute exacerbations occur are barriers that will need to be overcome<br>• Member COPD self-management may not follow recommendations, contribute to exacerbations, and avoidance in seeking medical interventions until in severe clinical distress |

| Recommendation—Performance Measure Validation |
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| • Members may not comply with the ongoing prescribed medication regimen, or non-compliance may exist due to economic stress may be affecting members' ability to obtain or refill medications due to financial hardship<br>• Inadequate discharge planning and care coordination following hospitalization<br>• Communication barriers- members not sure what the expectations are for them once discharged<br>• Poor transition of care from hospital to home<br>• Delay in-home health services in the community<br>• Socioeconomic strains on finances strain on family life with illness<br>• Lack of caregivers in the home<br>• Lack of knowledge of support services available upon discharge from the health plan<br>• Early identification of members with low back pain before advanced imaging<br>• Patient expectations and provider defensive medicine; defensive medicine meaning physicians/providers ordering advanced imaging studies due to a perceived potential malpractice liability<br>• Parental work schedules may not permit time for both sick and well-child visits<br>• Parents may not understand the need for well-child visits, especially for adolescents<br>• Adolescents may receive well-child checks at their schools for sports physicals and parents may not notify providers of these exams<br>• Adolescents may be resistant to going to medical appointments when they are feeling well<br>• Race, language, gender, and/or social determinants may be barriers that prohibit communication between adolescents, providers, and parents<br>• Provider documentation may not accurately capture anticipatory guidance provided verbally<br>• Systems issues may prevent the capture of appropriate coding. (i.e., claims system may only allow for a specific number of codes to be entered) |
| **HSAG Assessment:**<br>  |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim 2:** Effective Patient Care | **Goal 2.1:** Enhance Provider Support | **Metric 2.2.3:** Getting Needed Care |
| **Weakness:** The MCO did not provide machine-readable file formats of the formulary and provider directories on its website.<br>**Why the weakness exists:** 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.<br>**Recommendation:** The MCO should establish a process to review member materials to ensure that federal requirements, including easily understood language and machine-readable formats, are available to members. | | |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations |
|---|
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br><br>Virginia Premier updated the provider directory available on the website to include a machine-readable format. This was deployed on 9/22/2021. Virginia Premier updated the Provider Directory Requirements Policy to include a verification process of confirming accessibility to the machine-readable file on a monthly basis. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** CAHPS Getting Needed Care<br>MY 2020: 86.2%<br>MY 2021: 90.1% |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim 2:** Effective Patient Care | **Goal 2.1:** Enhance Provider Support | **Metric 2.2.3:** Getting Needed Care |
| **Weakness:** The MCO did not delineate the requirements for the number of providers in each CCC Plus locality or measure the adequacy accordingly in its policies and procedures. The MCO did not have a process to measure the accessibility of the provider network quarterly or follow up with providers on the failure to comply with accessibility standards. The MCO did not have a process to evaluate its network to ensure timely access to family planning services.<br>**Why the weakness exists:** The MCO's policies and procedures regarding network adequacy were not updated to reflect the federal and DMAS contract requirements. The MCO also did not have a process to monitor and measure provider network accessibility according to DMAS requirements.<br>**Recommendation:** The MCO must update its policies and procedures to reflect federal and DMAS network requirements. The MCO must implement processes to monitor its network to ensure member network accessibility. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): | | |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations |
|---|
| The policy title was changed to be consistent with the file name. The old policy's name was CON 001 Requirements for Maintaining Network Adequacy Access to Care Standards and has been changed to Policy 3413–CON–Requirements for Provider Network Management & Mandated Reporting Procedures.<br><br>Virginia Premier will continue to monitor provider availability by running bi-weekly adequacy reports to ensure that any deficiencies and access gaps are addressed in a timely manner when reported to confirm compliance by our network to ensure access to services, monitor network providers regularly, and institute corrective action for any notable deficiencies if applicable. Virginia Premier will continue to report to DMAS, (by provider type) that the access standards are being monitored and that requirements are being met. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** CAHPS Getting Needed Care<br>MY 2020: 86.2%<br>MY 2021: 90.1% |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim 2:** Effective Patient Care | **Goal 2.1:** Enhance Provider Support | **Metric 2.2.3:** Getting Needed Care |
| **Weakness:** The MCO did not appropriately apply its appointment access standards to the entire network. The MCO did not have processes to ensure that providers ensured the same hours of operation for its Medicaid members as commercial or FFS members or ensure that the provider network offered care and services 24 hours a day, seven days a week. 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.<br>**Why the weakness exists:** Although the MCO's policies and procedures contained most federal and DMAS requirements regarding access to care and services, the MCO did not have implemented processes to monitor and ensure that requirements are met.<br>**Recommendation:** The MCO must develop and implement processes to monitor and track that its appointment standards and access requirements are consistently met. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): | | |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations |
|---|
| Virginia Premier updated Policy CON 3413 to reflect the requirement that providers must offer the same hours of operation for Medicaid members as offered to Medicaid fee-for-service. The Virginia Premier Medicaid provider manual was also updated to include this requirement. Policy CON 3413 was updated to indicate providers must offer medically necessary services 24 hours a day, seven days per week or ensure a covering physician is available to provide services.<br><br>The appointment access standards were updated in the Virginia Premier provider manual and providers receive education on these standards during provider education meetings. In addition, Virginia Premier utilizes SPH Analytics to evaluate adherence to these standards and any noncompliant providers receive outreach. Continued noncompliance would result in collaboration with the contracting department to document the issue and track the resolution. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** CAHPS Getting Needed Care<br>MY 2020: 86.2%<br>MY 2021: 90.1% |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim 2:** Effective Patient Care | **Goal 2.2:** Ensure Access to Care | **Metric 2.2.3:** Getting Needed Care |
| **Weakness:** The MCO's subcontractor and delegated entity agreements did not consistently include the DMAS-specific requirements. The MCO's subcontractor and delegated entity agreements did not consistently include the Virginia Medicaid Addendum.<br>**Why the weakness exists:** The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements regarding network requirements and the subcontractor and delegated entity agreements.<br>**Recommendation:** The MCO must also ensure that its subcontractor and delegated entity agreements include all DMAS requirements. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br><br>The Non-Provider Contract Management (NPCM) process was implemented as the standard process to review and approve Virginia Premier's non-provider contracts. This process requires that internal business owners submit their contract requests to the Vendor Management Organization (VMO) for | | |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations |
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| review and approval. Contract approval includes the review of the contract by an established, cross-functional set of subject matter experts. These subject matter experts are referred to as NPCM stakeholders and include representation from the following business areas: vendor oversight, finance, data analytics, information technology, information technology security, quality, Medicaid compliance, Medicare compliance, commercial compliance, as applicable, and legal. The Medicaid compliance stakeholders review contracts to ensure the Medicaid Addendum and DMAS requirements are included, as deemed appropriately. Contracts requiring DMAS review are identified and sent to DMAS for review and approval.<br><br>The VMO is currently partnering with the Virginia Premier Medicaid compliance lead to add the updated Medicaid Addendum to identified vendor contracts by end of year 2022. This effort ensures that applicable contracts include the Medicaid Addendum, and that the Medicaid Addendum includes all approved DMAS language, including Cardinal Care updates. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** CAHPS Getting Needed Care<br>MY 2020: 86.2%<br>MY 2021: 90.1% |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim 2:** Effective Patient Care | **Goal 2.1:** Enhance Provider Support | **Metric 2.1.1:** Rating of Personal Doctor |
| **Weakness:** The MCO's grievance and appeals policies and procedures did not consistently contain all federal and DMAS contract requirements. The MCO's grievance and appeals policies and procedures did not require the member's approval for an authorized representative or provider to act on his or her behalf when filing a grievance or appeal. A review of the MCO's sample appeal case files identified that the MCO did not consistently acknowledge receipt of appeals. The MCO's appeal resolution notices to the member were not consistently sent, and when sent, did not consistently include all member rights.<br>**Why the weakness exists:** The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements that assure member rights are respected.<br>**Recommendation:** The MCO must update its policies, procedures, and process to ensure all 2020 Medicaid Managed Care Rule and DMAS contract requirements are met. Grievance and appeal notices to members must be easily understood and include all member rights. The MCO must also ensure that it consistently provides grievance and appeal notices to the member. | | |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations |
|---|
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br><br>• Appeals coordinators were retrained on sending out resolution letters and attaching the appropriate documents (appeals rights and multi-language inserts).<br>• The templates were updated to include the two documents to eliminate errors for the future.<br>• Daily huddles to review cases and update employees on any issues to ensure requirements are met and/or exceeded.<br>• Medicaid grievance policy updated, reviewed, and approved at Policy and Procedure Committee (May 2022)<br>• Employee training on contract and medical management/grievance and appeals policies which aligns with DMAS contractual agreements.<br>• Monitoring of files is ongoing. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** CAHPS Rating of Personal Doctor<br>MY 2020: 72.2%<br>MY 2021: 72.0% |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations | | |
|---|---|---|
| **Aim 2:** Effective Patient Care | **Goal 2.2:** Ensure Access to Care | **Metric 2.2.3:** Getting Needed Care |
| **Weakness:** The MCO did not sufficiently inform providers about EPSDT services they are required to provide, adequately monitor service provision, and implement interventions to improve member participation in EPSDT services. The MCO did not inform providers about the provision of oral health screenings as part of the EPSDT visit, or track, monitor, and evaluate PCP fluoride varnish applications. The MCO did not conduct member outreach regarding childhood obesity.<br>**Why the weakness exists:** The MCO did not have documented and implemented processes that ensured EPSDT age members and providers that service EPSDT age members were aware of EPSDT benefits. The MCO did not have implemented processes to monitor and track members' receipt of EPSDT services.<br>**Recommendation:** The MCO should consider developing EPSDT-specific policies and procedures to ensure that members and providers are aware of EPSDT benefits, and to ensure that EPSDT | | |

| Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations |
|---|
| service utilization is tracked, monitored, and action is taken to increase utilization of covered EPSDT services. |
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br><br>The care management team collaborated with provider services to update the website, established an EPSDT flyer and provider resource links placed on the provider website. Updated current policies to reflect EPSDT screenings based on the American Academy of Pediatrics guidelines.<br><br>Virginia Premier has established an EPSDT provider resource website link to aid providers with understanding the requirements of the screenings and includes resources for parents or caregivers regarding dental care and fluoride varnish applications. Providers receive training on the EPSDT program, goals, and requirements during regional meetings. Virginia Premier has updated the provider education meeting policy to document the training that providers receive for EPSDT. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** CAHPS Getting Needed Care<br>MY 2020: 86.2%<br>MY 2021: 90.1% |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Encounter Data Validation | | |
|---|---|---|
| **Aim 3:** Smarter Spending | **Goal 3.2:** Efficient Use of Funds | **Metric 3.2:** Ensure High-Value Appropriate Care |
| **Weakness:** The IS review revealed VA Premier could improve its internal monitoring tools for assessing quality and timeliness of encounter data. In addition, VA Premier did not meet the timeliness standards for both institutional and pharmacy encounters.<br>**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.<br>**Recommendation:** HSAG recommends VA Premier:<br>• 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. | | |

| Recommendation—Encounter Data Validation |
|---|
| • Identify the root cause of any delays in submitting institutional and pharmacy encounters to rectify any issues. |
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br><br>The reference to "validity of data elements for Institutional encounters" is inconsistent with our generally high acceptance rates for Institutional encounters, as a subset of our total submissions. If these comments are in reference to earlier comments shared with the MCO via the comprehensive MCO EDV Aggregate Report summary report in late 2021, our observations in this area point the optional data element for DMAS submission (i.e., not a specific data element that would create a failure / rejection if missing.) These would include:<br><br>• Referring Provider NPI / Rendering Provider NPI – Institutional Claims: Not a data requirement on front end and is a situational field in DMAS Companion Guides. This is a requirement for Medicare, but not Medicaid, from our research into Tech Manuals and Companion Guides. The MCO does the ability to influence configurations within both the Claims Adjudication and Encounters creation areas, should DMAS makes a change in policy to require these, future state. |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** Ensure High-Value Appropriate Care<br>MY 2020: NR<br>MY 2021: NR |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Member Experience of Care Survey | | |
|---|---|---|
| **Aim 1:** Enhance Member Care Experience | **Goal 1.3:** Increase Member Satisfaction | **Metric 1.2.2:** Enrollees' Ratings of all Health Care |
| **Weakness:** VA Premier's 2021 top-box scores were not statistically significantly lower than the 2020 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.<br>**Why the weakness exists:** NA.<br>**Recommendation:** HSAG recommends that VA Premier monitor the measures to ensure significant decreases in scores over time do not occur. | | |

| Recommendation—Member Experience of Care Survey |
|---|
| **MCO's Response** |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):<br><br>• Customer Service Improvement Committee (CPSIC) has been formalized into Quality Improvement Governance in 2022. Chartered Initiatives/projects are all aimed at development to improve member and clinician engagement which includes<br>• Targeted outreach and educational initiatives. Additionally, increased collaboration with the commonwealth's department of health regarding vaccination data. Launch target of first quarter 2023<br>• Population Health Assessment work group was established 7/2022<br>• NCQA PHM standards and audit tools purchased to perform a comprehensive population health assessment to include but not limited to: SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population Health Assessment to be completed 7/2023 |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** CAHPS Enrollees' Rating of All Health Care<br>MY 2020: 58.0%<br>MY 2021: 56.3% |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

| Recommendation—Member Experience of Care Survey | | |
|---|---|---|
| **Aim 1:** Enhance Member Care Experience | **Goal 1.3:** Increase Member Satisfaction | **Metric 1.2.2:** Enrollees' Ratings of All Health Care |
| **Weakness:** VA Premier's 2021 top-box scores were not statistically significantly lower than the 2020 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no weaknesses were identified.<br>**Why the weakness exists:** NA.<br>**Recommendation:** HSAG recommends that VA Premier monitor the measures to ensure significant decreases in scores over time do not occur. | | |
| **MCO's Response** | | |
| Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): | | |

| Recommendation—Member Experience of Care Survey |
|---|
| • Customer Service Improvement Committee (CPSIC) has been formalized into Quality Improvement Governance in 2022. Chartered Initiatives/projects are all aimed at development to improve member and clinician engagement which includes<br>• Targeted outreach and educational initiatives. Additionally, increased collaboration with the commonwealth's department of health regarding vaccination data. Launch target of first quarter 2023<br>• Population Health Assessment work group was established 7/2022<br>• NCQA PHM standards and audit tools purchased to perform a comprehensive population health assessment to include but not limited to: SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population Health Assessment to be completed 7/2023 |
| Identify any noted performance improvement as a result of initiatives implemented (if applicable):<br>PMV results showed:<br>**Metric:** CAHPS Enrollees' Rating of All Health Care<br>MY 2020: 58.0%<br>MY 2021: 56.3% |
| Identify any barriers to implementing initiatives:<br>The MCO did not identify any barriers to implementing initiatives. |
| **HSAG Assessment:**<br>  |

# Appendix F. 2020–2022 Quality Strategy Status Assessment

## Evaluation Methodology Description

The methodology used by DMAS to evaluate the effectiveness of the State's QS included tracking and monitoring the MCOs' performance for the priority areas outlined in the DMAS QS. To track the progress of achieving the goals and objectives outlined in the 2020–2022 QS, DMAS tracked the aggregate annual results of contractual performance metrics that aligned with the PM included in the QS to measure improvement.

DMAS' initial QS reflected the time period of 2017 through 2019. During this time frame, Virginia experienced significant programmatic changes that changed and expanded populations served, integrated care and services, and expanded ARTS. DMAS also transitioned to a VBP model that initially included performance incentive awards that further transitioned into a PWP that focused on driving QI. The programmatic changes resulted in DMAS' reconsideration of its QI priorities and a need to reassess the goals, objectives, and performance metrics to better reflect the populations served and the programmatic changes. DMAS continued to evolve its QS priorities and associated goals, objectives, and metrics based on achievement success, lack of progress, and relevancy based on programmatic and population changes.

DMAS updated its QS for the time period of 2020 through 2022. During the 2020–2022 QS time frame, Virginia experienced significant programmatic changes that changed and expanded populations served. DMAS continued to integrate care and services and enhanced the ARTS. DMAS also implemented Medicaid expansion on January 1, 2019, allowing more adults living in Virginia to gain access to quality, low-cost health insurance. The Medicaid expansion benefit plan included all services currently covered by Medicaid for the existing populations as well as additional federally required adult preventive care and disease management programs. Medicaid expansion provided coverage for adults ages 19–64 who were not Medicare eligible, who had income from 0 percent to 138 percent of the FPL, and who were not already eligible for a mandatory coverage group (e.g., children, caretaker adults, pregnant women, individuals over the age of 65, and individuals who were blind or had a disability). In addition, women that were 60 days postpartum were eligible for coverage as an expansion member.

## Measure Alignment

DMAS continued to work toward aligning most goals, objectives, and quality metrics detailed in its QS with MCO PM requirements outlined in the MCOs' contract with the Commonwealth. DMAS required the MCOs to be NCQA accredited and to conduct HEDIS PM reporting. In addition, DMAS required the MCOs to undergo PMV with the EQRO for CMS Core Set measures not included in HEDIS reporting. The MCO contracts also state that the MCO's quality initiatives must be designed to help achieve the goals outlined in the Virginia QS.

Table F-1 provides DMAS' baseline rates and progress in achieving the 2020–2022 QS goals. The table identifies the goals, measures, and available baseline HEDIS 2020 measurement rates and aggregate MY 2020 (CY 2021) remeasurement rates.

## Table F-1—Virginia Medicaid 2020–2022 QS Status Assessment

| AIM | Goal | Objective | Measure Name | Metric Specifications | HEDIS 2020 Baseline Performance | Performance Measure Target | MY 2020 Aggregate Rate |
|---|---|---|---|---|---|---|---|
| **Aim 1: Enhance Member Care Experience** | **Goal 1.1:** Improve Member Satisfaction | Increase Timely Access to Care | **Metric 1.2.1:** Getting Care Quickly Q6 | CMS Adult Core Set: CPA-AD | 82.1%* | CAHPS benchmarks | ND |
| | | Increase Member Satisfaction | **Metric 1.2.2:** Enrollees' Ratings Rating of Health Plan | CMS Adult Core Set: CPA-AD | 62.5%* | CAHPS benchmarks | 62.5% |
| | | Increase Member Satisfaction with Care | **Metric 1.2.3:** Rating of All Health Care | CMS Adult Core Set: CPA-AD | 59.0%* | CAHPS benchmarks | 77.71%% |
| | **Goal 1.2:** Improve Home and Community-Based Services | Ensure Patient-Centered Care and Services | **Metric 1.3.1:** Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and Appropriate to Their Needs and Personal Goals | Quality Management Review (QMR) | ^^ | 86% | Not Reported |
| | | Ensure Access to Care | **Metric 1.3.2:** Number and Percent of Individuals Who Received Services in the Scope Specified in the Service Plan | Quality Management Review (QMR) | ^^ | 86% | Not Reported |
| **Aim 2: Effective Patient Care** | **Goal 2.1:** Enhance Provider Support | Maintain Provider Engagement | **Metric 2.1.1:** Rating of Personal Doctor | CMS Adult Core Set: CPA-AD | 71.3%*▲ | CAHPS benchmarks | 83.15% |
| | **Goal 2.2:** Ensure Access to Care | Improve Health Communication | **Metric 2.1.2:** How Well Doctors Communicate | CMS Adult Core Set: CPA-AD | 94.6%* | CAHPS benchmarks | 92.42% |

| AIM | Goal | Objective | Measure Name | Metric Specifications | HEDIS 2020 Baseline Performance | Performance Measure Target | MY 2020 Aggregate Rate |
|---|---|---|---|---|---|---|---|
| | | Increase Access to Care | **Metric 2.2.3:** Getting Needed Care | CMS Adult Core Set: CPA-AD | 83.3%* | CAHPS benchmarks | 80.58% |
| **Aim 3: Smarter Spending** | **Goal 3.1:** Focus on Paying for Value | Decrease Potentially Preventable Admissions | **Metric 3.1.1:** Frequency of Potentially Preventable Admissions | VBP Reporting Team | ^ | VBP/CE Performance Target | SFY 2021 Medallion 4.0: 0.249<br>SFY 2021 CCC Plus: 2.484 |
| | | Decrease Emergency Department Visits | **Metric 3.1.2:** Frequency of Emergency Department Visits | VBP Reporting Team | ^ | VBP/CE Performance Target | SFY 2021 Medallion 4.0: 14.30%<br>SFY 2021 CCC Plus: 29.95% |
| | | Decrease Potentially Preventable Readmissions | **Metric 3.1.3:** Frequency of Potentially Preventable Readmissions | VBP Reporting Team | ^ | VBP/CE Performance Target | SFY 2021 Medallion 4.0: 6.62%<br>SFY 2021 CCC Plus: 18.40% |
| | | Decrease Emergency Department Visits | **Metric 3.1.4:** Ambulatory Care: Emergency (ED) Visits | NCQA HEDIS | * | NCQA Quality Compass 50th and 75th percentile | Not Reported |
| | **Goal 3.2:** Focus on Efficient Use of Program Funds | Ensure High-Value Appropriate Care | **Metric 3.2.3:** Monitor MLR annually by managed care program and aggregate total | Finance Team Reporting | ^^^ | Minimum Loss Ration in Final Rule | Not Reported |
| **Aim 4: Improved Population Health** | **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members | Increase Follow-Up Visits After Hospitalization for Mental Illness | **Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness | CMS Adult Core Set: FUH-AD | 7-Day—Total: 38.74%*<br>30-Day—Total: 60.89%* | NCQA Quality Compass 50th and 75th percentile | 7-Day—Total: 35.63%<br>30-Day—Total: 56.84% |
| | | Increase Follow-Up Visits After Emergency Department Visit for Mental Illness | **Metric 4.1.2:** Follow-Up After ED Visit for Mental Illness | CMS Adult Core Set: FUM-AD | 7-Day—Total: 48.75%*<br>30-Day—Total: 61.31%* | VBP/PWP Performance Target | 7-Day—Total: 45.34%<br>30-Day—Total: 57.38% |
| | | Increase Follow-Up Care for Children | **Metric 4.1.3:** Follow-Up Care for Children | CMS Child Core Set: ADD-CH | Initiation Phase: 39.00%* | NCQA Quality Compass 50th | Initiation Phase: 45.20% |

| AIM | Goal | Objective | Measure Name | Metric Specifications | HEDIS 2020 Baseline Performance | Performance Measure Target | MY 2020 Aggregate Rate |
|---|---|---|---|---|---|---|---|
| | | Prescribed Attention-Deficit/Hyperactivity Disorder Medication | Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication | | Continuation and Maintenance Phase: 55.33%* | and 75th percentile | Continuation and Maintenance Phase: 58.61% |
| | | Increase Mental Health Utilization | **Metric 4.1.4:** Monitor Mental Health Utilization | NCQA HEDIS MPT | * | NCQA Quality Compass 50th and 75th percentile | 13.04% |
| | | Increase Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics. | **Metric 4.1.5:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics | CMS Child Core Set: APP-CH | Total: 72.83%* | NCQA Quality Compass 50th and 75th percentile | Total: 65.43% |
| | **Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders | Increase Identification of OD Services | **Metric 4.2.1:** Monitor Identification of AOD Services | NCQA HEDIS IAD | * | NCQA Quality Compass 50th and 75th percentile | Not Reported |
| | | Increase Follow-Up After ED Visit for AOD Abuse or Dependence | **Metric 4.2.2:** Follow-Up After ED Visit for AOD Abuse or Dependence | CMS Adult Core Set: FUA-AD | 7-Day–Total: 13.11%* 30-Day–Total: 20.04%* | VBP/PWP Performance Target | Medallion 4.0: 7-Day—Total: 11.44% 30-Day—Total: 21.31% |
| | | Decrease Use of Opioids at High Dosage in Persons Without Cancer | **Metric 4.2.3:** Use of Opioids at High Dosage in Persons Without Cancer | CMS Adult Core Set: OHD-AD | * | NCQA Quality Compass 50th and 75th percentile | 4.83% |
| | | Increase Initiation and Engagement of AOD Abuse or Dependence Treatment | **Metric 4.2.4:** Initiation and Engagement of AOD Abuse or Dependence Treatment | CMS Adult Core Set: IET-AD | * | VBP/PWP Performance Target | CCC Plus: Initiation: 46.41% Engagement: 12.51% |
| | **Goal 4.3:** Improve Utilization of Wellness, | Increase Percentage of Eligibles who Receive Preventive Dental Services | **Metric 4.3.1:** Percentage of Eligibles who Receive Preventive Dental Services | CMS Child Core Set: PDENT-CH | * | CMS Child Core Set Benchmark | Not Reported |

| AIM | Goal | Objective | Measure Name | Metric Specifications | HEDIS 2020 Baseline Performance | Performance Measure Target | MY 2020 Aggregate Rate |
|---|---|---|---|---|---|---|---|
| | Screening, and Prevention Services for Members | Increase Adults' Access to Preventive/Ambulatory Health Services | **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services | NCQA HEDIS AAP | Total: 76.40%* | NCQA Quality Compass 50th and 75th percentile | Total: 72.75% |
| | | Increase Child and Adolescent Well-Care Visits | **Metric 4.3.4:** Child and Adolescent Well-Care Visits | CMS Child Core Set AWC-CH | Total: 46.57%*** | VBP/PWP Performance Target** | 46.57% |
| | **Goal 4.4:** Improve Health for Members with Chronic Conditions | Decrease Heart Failure Admission Rate | **Metric 4.4.1:** PQI 08: Heart Failure Admission Rate | CMS Adult Core Set PQI08-AD | * | VBP/PWP Performance Target** | Medallion 4.0: Not Reported<br><br>CCC Plus: 126.76 |
| | | Decrease Asthma Admission Rate | **Metric 4.4.2:** PDI 14: Asthma Admission Rate (Ages 2–17) | AHRQ Quality Indicators PDI 14 | ^ | VBP/PWP Performance Target** | Not Reported |
| | | Decrease COPD and Asthma in Older Adults' Admission Rate | **Metric 4.4.3:** PQI 05: COPD and Asthma in Older Adults' Admission Rate | CMS Adult Core Set PQI05-AD | * | VBP/PWP Performance Target** | ND FFY 2020 |
| | | Decrease Diabetes Poor Control | **Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) | CMS Adult Core Set HPC-AD | 48.43%* | VBP/PWP Performance Target** | Medallion 4.0: 50.30%<br><br>CCC Plus: 51.42% |
| | | Increase Control of High Blood Pressure | **Metric 4.4.5:** Controlling High Blood Pressure | CMS Adult Core Set CBP-AD | 44.09%* | NCQA Quality Compass 50th and 75th percentile | 46.91% |

| AIM | Goal | Objective | Measure Name | Metric Specifications | HEDIS 2020 Baseline Performance | Performance Measure Target | MY 2020 Aggregate Rate |
|---|---|---|---|---|---|---|---|
| | **Goal 4.5:** Improve Outcomes for Nursing Home Eligible Members | Decrease Use of High-Risk Medications in Older Adults (Elderly) | **Metric 4.5.1:** Use of High-Risk Medications in Older Adults (Elderly) | NCQA HEDIS DAE | * | NCQA Quality Compass 50th and 75th percentile | Not Reported |
| | **Goal 4.6:** Improve Outcomes for Maternal and Infant Members | Increase Postpartum Care | **Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care | CMS Adult Core Set PPC-AD | 64.23%* | VBP/PWP Performance Target** | 66.52% |
| | | Increase Timeliness of Prenatal Care | **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care | CMS Child Core Set PPC-CH | 73.27%* | VBP/PWP Performance Target** | 73.00% |
| | | Increase Childhood Immunization Status | **Metric 4.6.3:** Childhood Immunization Status | CMS Child Core Set CIS-CH | Combination 3: 66.26%* | VBP/PWP Performance Target** | Combination 3: 65.82%* |
| | | Decrease Low Birth Weight Babies | **Metric 4.6.4:** Live Births Weighing Less than 2,500 Grams | CMS Child Core Set LBW-CH | State Mean: 9.9 | CDC Wonder Data from CMS benchmarks | Not Reported |
| | | Increase Well-Child Visits | **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life | CMS Child Core Set W30-CH | Six or More Visits: 54.35% Two or More Visits: 72.10%*** | NCQA Quality Compass 50th and 75th percentile | Not Reported |

**The baseline measure rate is the final validated 2020 HEDIS, PM rate or CAHPS reported in the 2021 Annual Technical Report and posted to the DMAS website.*
***Target established in the CCC Plus SFY 2022 PWP Methodology.*
****The baseline 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.*
▲ *Statistically significantly higher in 2020 than in 2019.*
▼ *Statistically significantly lower in 2020 than in 2019.*

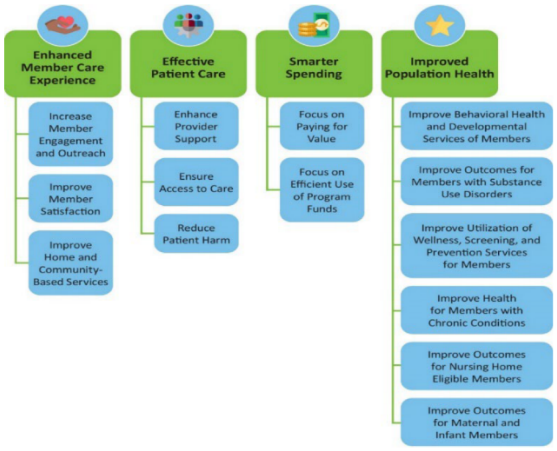
# Appendix G. CCC Plus Program 2022 Snapshot

**Commonwealth of Virginia**
**Department of Medical Assistance Services**
**2022 External Quality Review CCC Plus Technical Report Snapshot**

## Virginia Medicaid Background

DMAS administers the CCC Plus program, which includes the Virginia Medicaid program and the FAMIS program, the Commonwealth's CHIP.

## Virginia's 2020–2022 Quality Strategy Aims and Goals




## CCC Plus Participating NCQA Accredited MCOs

DMAS contracted with six privately owned MCOs to deliver physical and behavioral health services to Medicaid and CHIP members.

| MCO Name |
|---|
| Aetna Better Health of Virginia (Aetna)* |
| HealthKeepers, Inc. (HealthKeepers)* |
| Molina Complete Care of Virginia (Molina)* |
| Optima Health (Optima)* |
| United Healthcare of the Mid-Atlantic, Inc. (United)* |
| Virginia Premier Health Plan, Inc. (VA Premier)* |

*NCQA health plan and LTSS distinction accredited

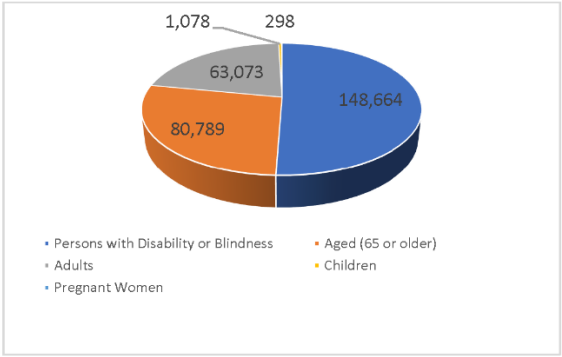
## CCC Plus Program Enrollment

**CY 2022 Average Annual Program Enrollment**

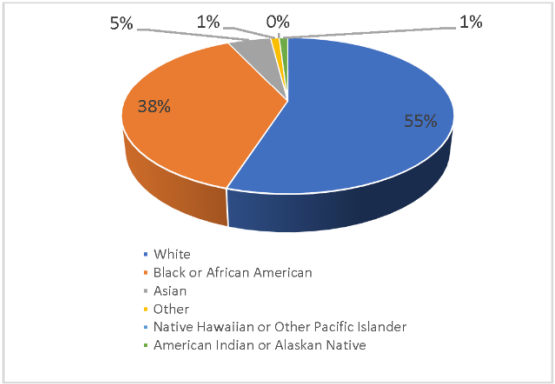
| Program | SFY 2022 Enrollment as of 06/30/2022 |
|---|---|
| CCC Plus | 305,846 |

## CCC Plus Program Demographics

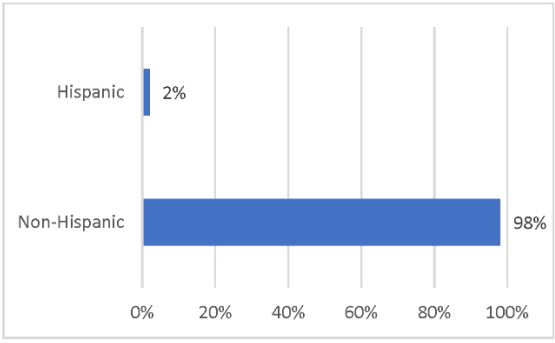
**Eligibility Categories**




**Categories by Race**



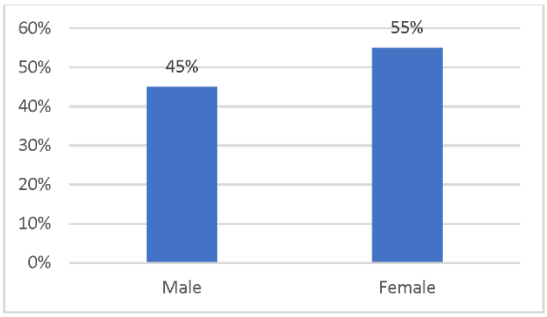

**Categories by Ethnicity**



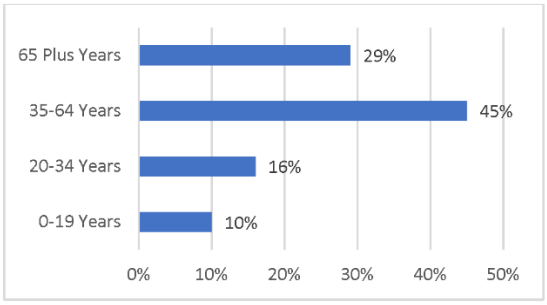
## Commonwealth of Virginia
## Department of Medical Assistance Services
## 2022 External Quality Review CCC Plus Technical Report Snapshot

### CCC Plus Program Demographics

**Percentage by Gender**

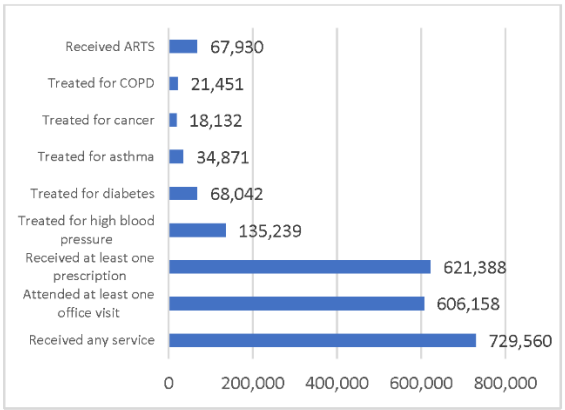



**Enrollment by Age Group**




### Medicaid Expansion

**Medicaid Expansion Service Provision**

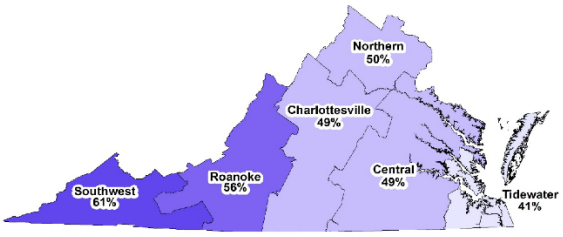



### DMAS COVID-19 LTSS Access Flexibilities

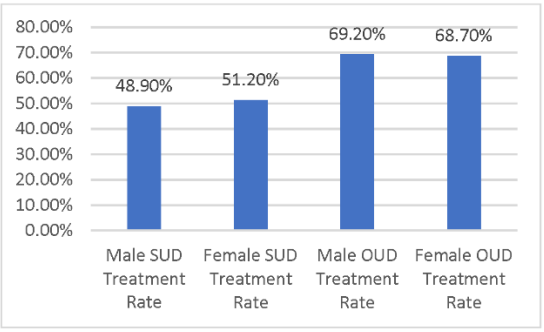
| COVID-19 Medicaid Flexibilities |
|---|
| No co-pays for any Medicaid or FAMIS covered services. |
| Outreach to higher risk and older members to review critical needs. |
| Encouraging use of telehealth. |
| 90-day supply of many routine medications. |
| Ensuring members do not lose coverage due to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

### ARTS Benefit

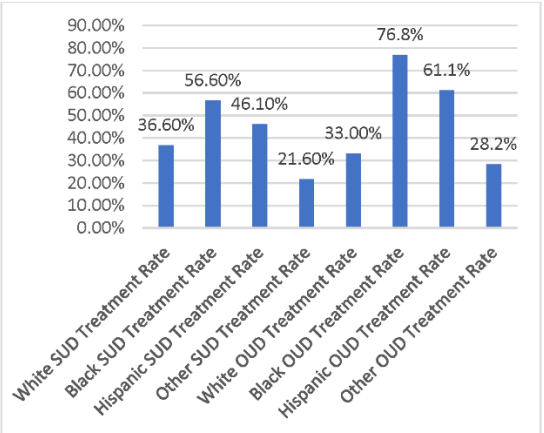
**SUD Treatment Rates in 2019, All Members**




**2019 Treatment Rates for SUD and OUD by Gender**

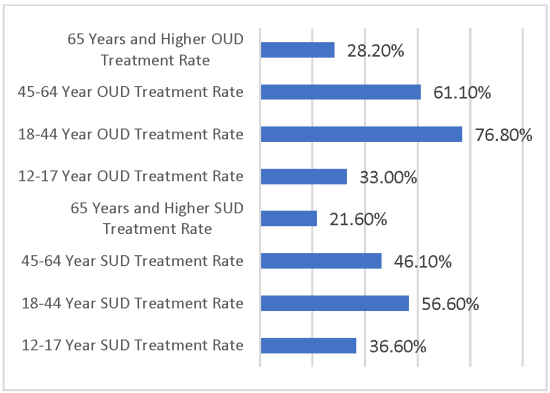



**2019 Treatment Rates for SUD and OUD by Race/Ethnicity**



# Commonwealth of Virginia
# Department of Medical Assistance Services
# 2022 External Quality Review CCC Plus Technical Report Snapshot

**2019 Treatment Rates for SUD and OUD by Age**




## 2022 Statewide Aggregate PIP Results

*PIP Topics:*

- Ambulatory Care—Emergency Department Visits
- Follow-Up After Discharge

| | |
|---|---|
| **Strengths** | All six MCOs developed methodologically sound projects that met both State and federal requirements. A sound design created the foundation for each MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project.<br><br>Four of the six MCOs received 100 percent validation scores and were assigned a *High Confidence* level for both PIPs. |

## Performance Measure Validation Results

| Domain | Strengths |
|---|---|
| **Access and Preventive Care** | Five of six MCOs' rates met or exceeded the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator. |
| **Behavioral Health** | All six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators. |
| | All six MCOs' rates met or exceeded the 50th percentile for both *Follow-Up After Emergency Department Visit for Mental Illness* measure indicators. |
| **Taking Care of Children** | Three of six MCOs' rates met or exceeded the 50th percentile for all *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure indicators. |
| **Living With Illness** | MCO performance within the Living With Illness domain was the highest for the *Medical Assistance With Smoking and Tobacco Use Cessation* measure, with five of six MCOs' rates meeting or exceeding the 50th percentile for the *Discussing Cessation Medications* and *Discussing Cessation Strategies* measure indicators, and all six MCOs' rates meeting or exceeding the 50th percentile for the *Advising Smokers and Tobacco Users to Quit* measure indicator. |
| | Five of six MCOs' rates met or exceeded the 50th percentile for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure indicators. |
| **Use of Opioids** | Three of six MCOs' rates met or exceeded the 50th percentile for at least two of the three *Use of Opioids From Multiple Providers* measure indicators. |
| | All six MCOs' rates fell below the 50th percentile for the *Use of Opioids From Multiple Providers—Multiple Prescribers* measure indicator. |

| Domain | Opportunities for Improvement |
|---|---|
| **Access and Preventive Care** | All reportable MCO rates fell below the 50th percentile for the *Cervical Cancer Screening* and *Use of Imaging Studies for Low Back Pain* measures. |
| | Five of six MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* measure. |
| **Behavioral Health** | All MCO rates fell below the 50th percentile for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* measure indicator. |
| **Taking Care of Children** | All six MCOs' rates for the *Immunizations for Adolescents—Combination 1* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total* measure indicators fell below the 50th percentile. |
| **Living With Illness** | Five of the six MCOs' rates fell below the 50th percentile for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator. |
| | Four of the six MCOs' rates fell below the 50th percentile for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed* measure indicators. |

## Compliance With Standards Monitoring Results

The MCOs' 2021 compliance scores, for the three-year cycle, ranged from 86.2 percent to 95.2 percent. All six MCOs

## Commonwealth of Virginia
## Department of Medical Assistance Services
## 2022 External Quality Review CCC Plus Technical Report Snapshot

received a 100 percent compliance score for the following standards:

| Standard Number | Description |
|---|---|
| IV | Emergency and Poststabilization Services |
| VI | Coordination and Continuity of Care |
| VIII | Provider Selection |
| X | Practice Guidelines |
| XI | Health Information Systems |
| XIV | Program Integrity |

### Member Experience of Care Survey Results

**Strengths**

2022 Medicaid top-box score results:

- Adult—The CCC Plus program's scores were statistically significantly higher than the 2021 NCQA adult Medicaid national averages for four measures: *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Getting Care Quickly*.

**Opportunities for Improvement**

2022 Medicaid top-box score results:

- Child—The CCC Plus program's scores were statistically significantly lower than the 2021 top-box scores for two measures: *Rating of Personal Doctor* and *Getting Needed Care*.
- Child—Three CCC Plus MCOs' scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for two measures: *Rating of Health Plan* and *Rating of All Health Care*.
- Child—One MCO's score was statistically significantly lower than the 2021 NCQA child Medicaid national average for *Rating of Specialist Seen Most Often*.
- Child—One MCO's score was statistically significantly lower than the 2021 NCQA child Medicaid national average for *Rating of Personal Doctor*.
- Child—One MCO's score was statistically significantly lower than the 2021 NCQA child Medicaid national average for *Getting Needed Care*.
- Child—One MCO's score was statistically significantly lower than the 2021 top-box scores for three measures: *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Getting Care Quickly*.

### Performance Measure Calculation Results

HSAG calculated the *Colorectal Cancer Screening (COL)* performance measure following the CMS *Core Set of Adult Health Care Quality Measures for Medicaid*. The Virginia Medicaid total and the CCC Plus program results were:

| Medicaid Program | CY 2021 Results |
|---|---|
| Virginia Total | 32.73% |
| CCC Plus | 40.35% |

### Consumer Decision Support Tool

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

| MCO | Overall Rating | Doctors' Communication | Access and Preventive Care |
|---|---|---|---|
| Aetna | ★ | ★ | ★ |
| HealthKeepers | ★★★★★ | ★★★ | ★★★★ |
| Molina | ★ | — | ★★ |
| Optima | ★★★★★ | ★★★★★ | ★★★★★ |
| United | ★★★ | — | ★★★ |
| VA Premier | ★★★★ | ★★★ | ★★★★★ |

| MCO | Behavioral Health | Taking Care of Children | Living With Illness |
|---|---|---|---|
| Aetna | ★★★ | ★★★ | ★★★★★ |
| HealthKeepers | ★★★★★ | ★★★★★ | ★★★★★ |
| Molina | ★ | ★ | ★ |
| Optima | ★★ | ★★★ | ★ |
| United | ★★★ | ★★★ | ★★★★★ |
| VA Premier | ★★★ | ★★★ | ★★ |