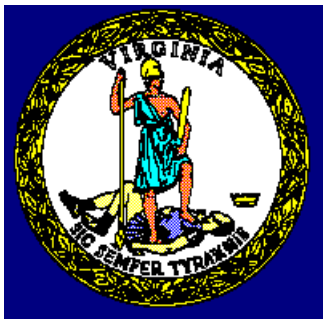


Commonwealth of Virginia
Department of Medical Assistance Services

2019 External Quality Review Technical Report—Medallion 4.0

January 1, 2019–December 31, 2019

April 2020

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Overview of 2019 External Quality Review

Title XIX of the Social Security Act (SSA), Section 1932(c)(2)(A) requires states that operate Medicaid managed care organizations to "provide for an annual external independent review conducted by a qualified independent entity of the quality and timeliness of, and access to, the items and services for which the organization is responsible under the contract." According to the 42nd Code of Federal Regulations (CFR) §438.350, states with capitated Medicaid managed care delivery systems and that contract with managed care entities (MCEs) are required to arrange for the provision of an annual external quality review (EQR) for each Medicaid managed care contractor.

The external quality review organization (EQRO) must annually provide an assessment of each MCE's performance related to the quality and timeliness of, and access to care and services provided by each MCE and produce the results in an annual EQR technical report (42 CFR §438.364). The annual technical report must also describe how data from activities were collected and, in accordance with the CFR, were aggregated and analyzed. To meet this requirement, the Virginia Department of Medical Assistance Services (DMAS) has contracted with Health Services Advisory Group, Inc. (HSAG) to perform an EQR of the Virginia managed care organizations (MCOs) and produce this EQR technical report.

DMAS contracted with HSAG to conduct EQR activities and produce this technical report covering review activities completed during the period of January 1, 2019, through December 31, 2019. HSAG used the U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services' (CMS') December 2018 update of its External Quality Review Toolkit for States when preparing this report.[1-1]

DMAS is responsible for administration of the Medallion 4.0 program. DMAS contracted with six MCOs to deliver services for the Medallion 4.0 program. The Medallion 4.0 program operates statewide, across six regions of the Commonwealth (Table 1-1). Contracted MCOs included Aetna Better Health of Virginia (Aetna); HealthKeepers, Inc. (HealthKeepers); Magellan Complete Care of Virginia (Magellan); Optima Family Care (Optima); UnitedHealthcare of the Mid-Atlantic, Inc. (United); and Virginia Premier Health Plan, Inc. (VA Premier).

The Medallion 4.0 program is intended to ensure the delivery of acute and primary care services; prescription drug coverage; and behavioral health services for most of Virginia's Medicaid Title XIX members and for all members of Family Access to Medical Insurance Security (FAMIS), Virginia's Title XXI Children's Health Insurance Program (CHIP). The Medallion 4.0 population includes children, low income parents and caretaker relatives living with children, pregnant women, FAMIS

[1-1] The Centers for Medicare & Medicaid Services. CMS External Quality Review (EQR) Protocols, December 2018. Available at: https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-R-305.html. Accessed on: June 27, 2019.

members, Medicaid expansion, and current and former foster care and adoption assistance children. The MCOs in the Medallion 4.0 program delivered services to approximately 1,017,698 Medallion 4.0 members across the Commonwealth of Virginia as of July 2019.

Managed Care Organizations

Table 1-1—Managed Care Organization Profiles

MCO	MCO Profile	MCO NCQA Accreditation Status
Aetna	Aetna is the Medicaid/FAMIS Plus program offered by Aetna, a multistate healthcare benefits company headquartered in Hartford, Connecticut.	Accredited
HealthKeepers	HealthKeepers is a Virginia health maintenance organization (HMO) affiliated with Anthem Blue Cross Blue Shield, a publicly owned, for-profit corporation that operates as a multistate healthcare company, headquartered in Indianapolis, Indiana.	Accredited
Magellan	Magellan is a Medicaid/FAMIS Plus program offered by Magellan Health, Inc., conducting business in Virginia since 1972, headquartered in Scottsdale, AZ.	Interim
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
United	United is part of the UnitedHealth Group family of companies, headquartered in Minneapolis, MN. United provides Medicaid managed care and nationally serves more than 6.6 million low-income and medically fragile people, including Dual-Eligible Special Needs Plans (D-SNPs) across 30 states plus Washington, DC.	Interim
VA Premier	VA Premier is a local, not-for-profit MCO owned by the Virginia Commonwealth University (VCU) Medical Center, headquartered in Richmond, Virginia.	Commendable

Mandatory Activities

In accordance with 42 CFR §438.364, and in compliance with CMS' EQR Protocols and the External Quality Review Toolkit for States, this report includes the following information for each activity conducted:

- Describes how data from mandatory and optional EQR activities were aggregated and analyzed by HSAG.
- Describes the scope of the EQR activities.
- Assesses each MCO's strengths and weaknesses and presents conclusions drawn about the quality of, timeliness of, and access to care furnished by the MCOs.
- Includes recommendations for improving the quality of, timeliness of, and access to care and services furnished by the MCOs, including recommendations for each individual MCO and recommendations for DMAS to target in the Quality Strategy to improve the quality of care provided by the DMAS managed care program as a whole.
- Contains methodological and comparative information for all MCOs.
- Assesses the degree to which each MCO has addressed the recommendations for quality improvement made by the EQRO during the 2018 EQR.

How Conclusions Were Drawn From EQRO Activities

To draw conclusions about the quality and timeliness of, and access to care provided by the MCOs, HSAG assigned each of the EQR activities to one or more of three domains. Assignment to these domains is depicted in Table 1-2.

Table 1-2—EQR and DMAS Activities and Domains

Activity	Quality	Access	Timeliness
NCQA HEDIS Compliance Audit™[1-2]	✓	✓	
PMV	✓	✓	✓
Consumer Decision Support Tool	✓		
PIP Validation	✓	✓	✓
Compliance Reviews	✓	✓	✓
CAHPS	✓	✓	✓
Focused Studies	✓	✓	✓

[1-2] NCQA HEDIS Compliance Audit™ is a trademark of NCQA.

Aggregating and Analyzing Statewide Data

For each MCO, HSAG analyzed the results obtained from each EQR mandatory activity as well as those obtained from optional activities. From these analyses, HSAG determined which results were applicable to the domains of quality of, access to, and timeliness of care and services. HSAG then analyzed the data to determine if common themes or patterns existed that would allow conclusions about overall quality of, access to, and timeliness of care and services to be drawn for each MCO independently and the overall statewide Medallion 4.0 program. For a detailed and comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each MCO, please refer to the results of each activity in Sections 4 through 9 of this report.

Definitions

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

Quality

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 or prepaid inpatient health plan (PIHP) increases the likelihood of desired health outcomes of its enrollees through its structural and operations characteristics, through the provision of services consistent with current professional evidence-based knowledge, and through interventions for performance improvement."[1-3]

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 organizations successfully demonstrating and reporting on outcomes information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services)."[1-4]

Timeliness

The National Committee for Quality Assurance (NCQA) defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[1-5] NCQA further states that the intent of this standard is to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other

[1-3] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.
[1-4] Ibid.
[1-5] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs*.

managed care provisions that impact services to enrollees and that require timely response by the MCO—e.g., processing appeals and providing timely care. In the final 2016 Federal Managed Care Regulations, CMS recognized the importance of timeliness of services by incorporating timeliness into the general rule at 42 CFR §438.206(a) and at 42 CFR §438.68(b), requiring states to develop both time and distance standards for network adequacy.

High-Level Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from calendar year (CY) 2019 to assess the performance of Medicaid MCOs in providing quality, timely, and accessible healthcare services to Virginia Medallion 4.0 Medicaid members. For each activity, HSAG provides the following summary of its overall key findings and conclusions based on each MCO's performance. For activity-specific findings, strengths, and recommendations for the activities conducted, refer to Sections 5 through 9.

Compliance Monitoring

DMAS conducts compliance monitoring activities at least once during each three-year EQR cycle. During 2019, HSAG did not conduct MCO compliance review activities for the Medallion 4.0 program. During 2019, DMAS monitored the MCOs' implementation of federal and State requirements and corrective action plans from prior years' compliance reviews.

Performance Measure Validation (PMV)

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

As part of performance measurement, the Virginia MCOs were required to submit Healthcare Effectiveness Data and Information Set (HEDIS®)[1-6] data to NCQA. To ensure that HEDIS rates are accurate and reliable, NCQA required each MCO to undergo an NCQA HEDIS Compliance Audit conducted by a certified independent auditor.

Each MCO contracted with an NCQA-licensed organization (LO) to conduct the HEDIS audit. HSAG reviewed the MCO's final audit reports (FARs), information systems (IS) compliance tools, and the Interactive Data Submission System (IDSS) files approved by each MCO's LO. HSAG found that five of the six MCOs' IS and processes were compliant with the applicable IS standards; one MCO was

[1-6] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

partially complaint with IS 6.0. All MCOs were compliant with the HEDIS reporting requirements for the key Medallion 4.0 Medicaid measures for HEDIS 2019.

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

- *Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combination 3*
- *Children and Adolescents' Access to Primary Care Practitioners*
- *Prenatal and Postpartum Care*
- *Comprehensive Diabetes Care (excluding HbA1c control <7.0%)*

HSAG contracted with Aqurate Health Data Management, Inc. (Aqurate) for assistance with the validation of the performance measures above. Using the validation methodology and protocols described in Appendix A, HSAG determined results for each performance measure. The CMS PMV protocol identifies two possible validation finding designations for performance measures: Report (R)—measure data were compliant with HEDIS and DMAS specifications and the data were valid as reported; or Not Reported (NR)—measure data were materially biased. HSAG's validation results for each MCO are summarized in Table 1-3.

Table 1-3—MCO Validation Results

	Performance Measure	Aetna	HealthKeepers	Magellan*	Optima	United	VA Premier
1.	*Adolescent Well-Care Visits*	R	R	NA	R	R	R
2.	*Childhood Immunization Status—Combination 3*	R	R	NA	R	R	R
3	*Children and Adolescents' Access to Primary Care Practitioners*	R	R	NA	R	R	R
4.	*Prenatal and Postpartum Care*	R	R	NA	R	R	R
5	*Comprehensive Diabetes Care (excluding HbA1c control <7.0%)*	R	R	NA	R	R	R

**Magellan could not report the PMV measures for Medallion 4.0 during the 2019 measurement period. Magellan began providing Medicaid managed care services in 2018; therefore, the MCO did not have performance measure data available for inclusion in this report.*
NA: Not reported, measure data were materially biased.

Statewide HEDIS Results

State fiscal year (SFY) 2018 saw a number of major changes and innovations to the Virginia Medicaid program, particularly with managed care. The magnitude of changes, outlined below, to Virginia's

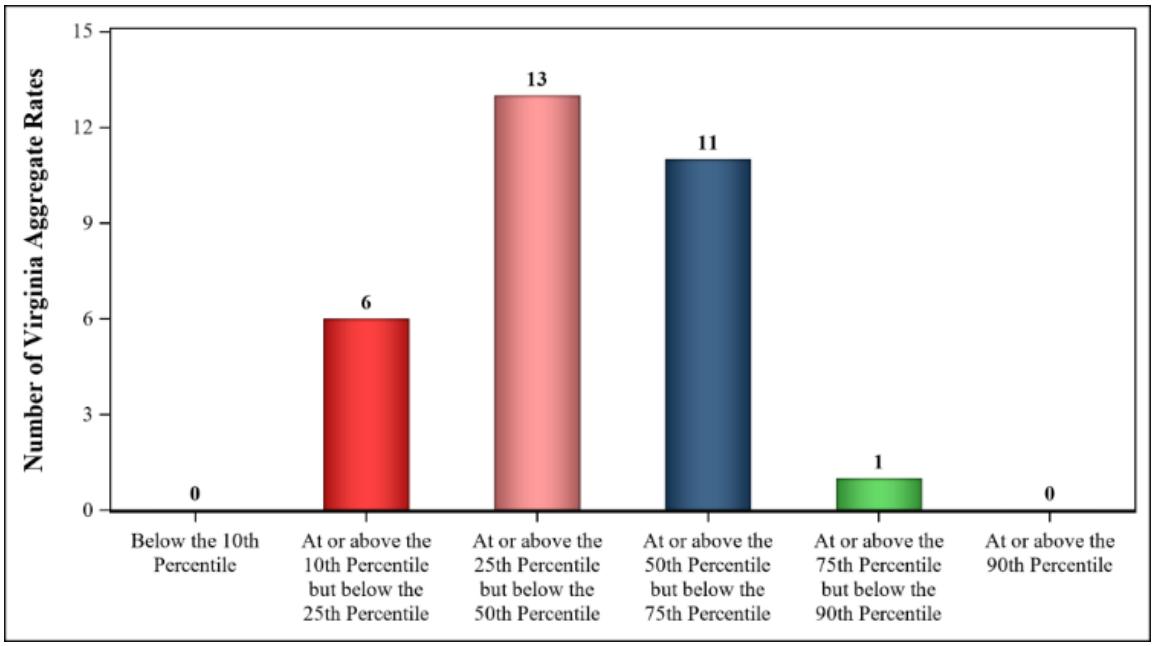
Medicaid managed care programs necessitates a break in trending for all reported measures from previous years.

Data from reporting year 2018 were affected by the regional rollout of Medallion 4.0 from Medallion 3.0, which started August 1, 2018, and ended December 1, 2018. The transition to Medallion 4.0 included newly carved-in services and populations. Medallion 4.0 carved in community mental health services, early intervention services, consumer-directed personal care, and third party liability (TPL) members.

Additionally, the Medallion 4.0 contracts were re-procured, changing the participating MCOs in the program. A brand new MCO entered into the Medallion program. In addition, an existing Medallion 3.0 MCO was acquired by an MCO new to the Medallion program, merging businesses alongside the regional rollout. One Medallion 3.0 MCO exited the Medicaid business in Virginia in 2018. Due to these changes, some members underwent reassignment of their MCO during the transition to Medallion 4.0.

Figure 1-1 shows the Medallion 4.0 aggregated performance on NCQA's HEDIS 2019 (CY 2018 data) performance measure indicators that were comparable to NCQA's Quality Compass®[1-7] national Medicaid HMO percentiles for HEDIS 2018. The aggregate rates represent the average of five MCOs' measure rates weighted by the eligible population. Of note, Magellan began providing Medicaid managed care services in August 2018; therefore, the MCO did not have performance measure data available for inclusion in this report. The bars represent the number of Virginia aggregate rates that fell into each percentile range.

Figure 1-1—HEDIS 2019 Medallion 4.0 Aggregate Results



[1-7] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Overall, the Virginia aggregate rates for HEDIS 2019 indicated opportunities for improvement, as 19 of 31 (61.3 percent) measure rates fell below the 50th percentile, with six of these rates (19.4 percent) falling below the 25th percentile (i.e., *Breast Cancer Screening* and five of six *Comprehensive Diabetes Care* indicators). Of note, the Virginia aggregate rate for the *Asthma Medication Ratio—Total* measure ranked above the 75th percentile.

While there are identified opportunities for improvement from the data, the large-scale changes that occurred in the managed care programs in calendar year 2018 make interpretation of the HEDIS results from this year difficult and analyses should be interpreted with caution.

Consumer Decision Support Tool

The Medallion 4.0 Consumer Decision Support Tool demonstrates how Virginia Medicaid's MCOs compare to one another in key performance areas. The MCOs' Consumer Decision Support Tool results for 2019 are presented in Table 1-4.

Table 1-4—Consumer Decision Support Tool Results—2019

MCO	Doctors' Communication	Getting Care	Keeping Kids Healthy	Living With Illness	Taking Care of Women
Aetna	★★	★★★	★★★	★★	★
HealthKeepers	★★★	★★	★★★★★	★★★★	★★★★★
Optima	★★★	★★★★★	★★★	★★★	★★★★★
United	—	★	★★	★★★	★
VA Premier[1]	★★★	★★★★	—	—	—

Note: The star rating definitions are found in **Table 4-3**.

— Indicates that the MCO did not have sufficient data to receive a rating for this domain.

[1] VA Premier did not submit data specific to the Medallion 4.0 population for all measure rates; therefore, the MCO was not eligible to receive a rating for three domains (Keeping Kids Healthy, Living With Illness, and Taking Care of Women).

For 2019, the MCOs demonstrated similar performance within the Doctors' Communication domain, as three of four MCOs received a three-star rating for this domain. The Getting Care and Taking Care of Women domains showed large variations in performance between the MCOs for 2019, with star ratings ranging from one to five. Of note, Optima demonstrated strength when compared to the other MCOs by performing around the Virginia Medicaid average for three domains and receiving the highest star rating for the other two domains. Additionally, HealthKeepers received high star ratings (i.e., four or five stars) for three of five domains, indicating strength. Conversely, United demonstrated the lowest performance among the MCOs with three of four reportable domains receiving a low star rating (i.e., one or two stars).

Performance Measure Calculation

DMAS contracted with HSAG in 2019 to calculate the Agency for Healthcare Research and Quality's (AHRQ's) Pediatric Quality Indicator (PDI) 14: *Asthma Admission Rate* (PDI 14) to evaluate inpatient

admissions for asthma for children ages 2 to 17 years for the 2018 measurement period. The Virginia total rate of asthma admissions for CY 2018 for children ages 2 to 17 was 7.85 per 100,000 member months (MM). Of note, 74.74 percent of children did not have an active prescription upon admission (controller or reliever) and 46.58 percent of children were not prescribed a medication to manage asthma (controller or reliever) during the admission or within 7 days following discharge, indicating opportunities to increase the number of prescriptions for asthma.

Validation of Performance Improvement Projects

DMAS requires the Medallion 4.0 MCOs to conduct two performance improvement projects (PIPs) annually. DMAS selected the topics to address the CMS requirements related to quality outcomes in the areas of timeliness of and access to care and services. The topics for 2019 were:

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

In 2019, the MCOs used the rapid-cycle PIP approach for the two DMAS-selected PIP topics. During validation, HSAG determined if criteria for each module were *Achieved.* Any validation criteria not applicable (*N/A*) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings from modules 1 through 5 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Table 1-5 details the level of achievement for each module submitted by each MCO for both PIPs. During 2019, the MCOs achieved all the Module 1 and Module 2 validation criteria and were in the process of completing Module 3 to identify potential interventions for the PIP.

Table 1-5—Performance Improvement Project Results

MCO	PIP Topic	PIP Module Results
Aetna	*Ensuring Timeliness of Prenatal Care*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Tobacco Use Cessation in Pregnant Women	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
HealthKeepers	*Timeliness of Prenatal Care*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Tobacco Use Cessation in Pregnant Women	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
Magellan	*Improve Timeliness of Prenatal Care*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Reduce Tobacco Use in Pregnant Women	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
Optima	*Timeliness of Prenatal Care*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved

MCO	PIP Topic	PIP Module Results
	Tobacco Use Cessation in Pregnant Women	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
United	*Timeliness of Prenatal Care*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Tobacco Use Cessation in Pregnant Women	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
VA Premier	*Timeliness of Prenatal Care*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Tobacco Use Cessation in Pregnant Women	Module 1: All Criteria Achieved Module 2: All Criteria Achieved

Overall, the results of the MCOs' submission of PIP Module 1 and Module 2 indicated that the MCOs were able to successfully complete the Module 1 and Module 2 PIP validation requirements. MCOs should continue to follow the PIP rapid cycle process and participate in trainings provided by the EQRO and request technical assistance as often as needed to improve the success of the PIP process. The MCOs' PIP process would benefit from ensuring:

- HSAG PIP Module feedback is addressed prior to resubmission.
- Identification and testing of innovative, actionable changes.
- Continual monitoring of the outcomes and making rapid adjustments, as needed.
- All data and results are provided accurately.

Member Experience of Care Survey

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-8] survey is nationally recognized as an industry standard for both commercial and public payers. Samples and data collection procedures promote standardized administration of survey instruments and comparability of results. The CAHPS survey asks members to report on and evaluate their experiences with healthcare, covering topics important to members, such as accessibility and quality of services.

The CAHPS surveys were conducted for Virginia's Medallion 4.0 managed Medicaid population to obtain information on adult and child Medicaid members' experiences. For the Medallion 4.0 MCOs, data collection occurred through the administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.0H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCOs. MCO top-box scores are shown in Table 1-6.

[1-8] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Table 1-6—CAHPS Top-Box Results

MCO	CAHPS Composite Measure	2018 Rate	2019 Rate
Aetna	*Child: Getting Needed Care*	**88.9%**+	**90.7%**
HealthKeepers	*Child: Rating of Health Plan*	**73.9%**	**80.1%**
	Child: Rating of All Health Care	**67.9%**	**75.9%**
	Child: Rating of Personal Doctor	**74.3%**	81.7% ▲
Optima	*Child: Rating of Health Plan*	**77.9%**	**79.1%**
	Child: Rating of Personal Doctor	**78.3%**	**82.6%**
	Child: Getting Needed Care	**89.2%**	**92.5%**
	Child: Getting Care Quickly	**90.7%**	**93.1%**
	Child: How Well Doctors Communicate	**94.8%**	**96.3%**
United	*Adult: Rating of Specialist Seen Most Often*	–	**82.4%**+
VA Premier	*Adult: Getting Needed Care*	**82.8%**	**88.0%**
	Adult: Getting Care Quickly	**83.9%**	**89.1%**
	Child: Rating of Health Plan	**69.8%**	**77.8%** ▲
	Child: Rating of All Health Care	**69.5%**	77.8% ▲
	Child: Getting Care Quickly	**93.4%**	**93.9%**

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

▲ Statistically significantly higher in 2019 than in 2018.

Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national average.

A dash (–) indicates there were no data available.

Note: Aetna scored statistically significantly lower than the 2018 NCQA adult Medicaid national averages on two measures: Rating of All Health Care and Customer Service.

Note: Aetna scored statistically significantly lower in 2019 than in 2018 on one child measure: Getting Care Quickly.

Note: United scored statistically significantly lower than the 2018 NCQA adult Medicaid national averages on two measures: Rating of Health Plan and Rating of All Health Care.

Note: United scored statistically significantly lower than the 2018 NCQA child Medicaid national average on one measure: Customer Service.

Overall, the 2019 results revealed that all MCOs had at least one measure that scored statistically significantly higher than the 2018 NCQA adult or child Medicaid national average. Three out of the five MCOs scored statistically significantly higher than the 2018 NCQA child Medicaid national averages for at least two of the following three measures: *Rating of Health Plan*, *Rating of All Health Care*, or *Rating of Personal Doctor*. In addition, the top-box score for one measure, *Getting Needed Care*, was statistically significantly higher than the 2018 NCQA adult or child Medicaid national average for three out of the five MCOs. VA Premier had two measures for the adult population and three measures for the child population that were statistically significantly higher than the 2018 NCQA Medicaid national averages. Aetna and United were the only MCOs that had measures (two and three measures, respectively) that were statistically significantly lower than the 2018 NCQA adult or child Medicaid national averages.

Focused Studies

DMAS continued to assess the following clinical topics for the 2019 contract year: improving birth outcomes through adequate prenatal care (Birth Outcomes Focused Study); Perinatal Dental Utilization; and improving the health of children in foster care (Foster Care Focused Study).

Improving Birth Outcomes Through Adequate Prenatal Care

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

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

Results of the Birth Outcomes Focused Study found that births to women in the study population fared better than those in the comparison group for the following indicators: *Births With Early and Adequate Prenatal Care*, *Preterm Births*, and *Newborns With ≥ 1 ED Visit in the 30 Days Following Birth*. Births in the comparison group outperformed the study population for the indicator *Newborns With ≥ 2 PCP Visits in the 30 Days Following Birth*; that is, a greater percentage of children born to mothers in the comparison group had two or more visits with a PCP-type provider in the 30 days following birth compared to children born to mothers in the study population. In measurement year (MY) 2017, result differences between the study population and comparison group were statistically significant for all indicators except *Newborns With Low Birth Weight (<2,500g)* and *Newborns With ≥1 ED Visit in the 30 Days Following Birth*.

Dental Utilization in Pregnant Women Data Brief

As a supplement to the Birth Outcomes Focused Study, HSAG provides annual data briefs on dental utilization 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. During 2019, HSAG completed a Dental Utilization in Pregnant Women Data Brief that reflected all women with deliveries from January 1, 2018, through December 31, 2018 (MY 2018).

The MY 2018 study results indicated that only 19.2 percent of deliveries were to women who received perinatal dental services covered by DMAS. More women received dental services during the prenatal period than during the postpartum period, and 29.3 percent of deliveries occurred among women who received dental services during both the prenatal and postpartum periods. Results of the study also identified regional differences in perinatal dental utilization with the Roanoke/Alleghany region having the lowest percentage of women receiving perinatal dental services. While the VA Smiles For Children program provides pregnant women with a critically important opportunity to receive dental services, relatively few eligible women received prenatal and/or postpartum dental services.

Foster Care Focused Study

HSAG initiated the fourth annual Foster Care Focused Study during 2019, designed to determine the extent to which children in foster care received the expected preventive and therapeutic medical care under managed care service delivery compared to similar children not in foster care.

During 2018–2019, DMAS transitioned from the Medallion 3.0 program to the Medallion 4.0 program. Due to the program change, some members were transitioned to new MCOs, and the MCOs participating in Medallion 4.0 also changed. The MCOs work directly with either the social worker or the foster parent on any decisions regarding care and services. The Medallion 4.0 program also began covering and coordinating services, such as early intervention and non-traditional behavioral health services, that were previously paid through traditional fee-for-service (FFS) Medicaid.

The study determines the extent to which children in foster care utilize healthcare services. HSAG will assess 14 measures, representing 20 study indicators, across the following domains: *Primary Care*, *Oral Health*, *Behavioral Health*, *Reproductive Health*, and *Respiratory Health.* Results of the Foster Care Focused Study will be available in 2020.

Addiction and Recovery Treatment Services

Medicaid members are prescribed opioids at twice the rate of non-Medicaid members and are at three-to-six times the risk of prescription opioid overdose. On April 1, 2017, Virginia's Medicaid program launched an enhanced substance use disorder (SUD) treatment benefit known as Addiction and Recovery Treatment Services (ARTS). The ARTS benefit provides treatment for those with SUDs across the state by providing access to addiction treatment services for all enrolled members in Medicaid, FAMIS, and FAMIS MOMS. The ARTS program is a fully integrated physical and behavioral health continuum of care.

According to a February 2020 joint article published by DMAS and VCU in the research journal *Health Affairs*, there was an increase in the number of Medicaid members, after Medicaid expansion, with a diagnosed SUD.[1-9] More than 69,000 Medicaid members in Virginia had a diagnosed SUD in the second year of the ARTS benefit, including 12,000 adults who enrolled in the three months after the new eligibility rules took effect on January 1, 2019.[1-10] The data showed that 4.4 percent of expansion adults were diagnosed with an SUD compared to 3.6 percent in the traditional Medicaid population. Medicaid eligibility was expanded for adults with family incomes up to 138 percent of the federal poverty level.[1-11]

[1-9] Barnes A, et al., Hospital Use Declines After Implementation of Virginia Medicaid's Addiction and Recovery Treatment Services Program. *Health Affairs*. 2020(2): 238-246.

[1-10] Virginia Department of Medical Assistance Services. Virginia Medicaid Agency Reports Increased Access to Addiction Treatment. Available at: http://www.dmas.virginia.gov/files/links/5220/Virginia%20Medicaid%20Two-Year%20Report%20on%20Addiction%20and%20Recovery%20Treatment%20Services%20Outcomes.pdf. Accessed on: Feb 28, 2020.

[1-11] Virginia Commonwealth University, Department of Health Behavior and Policy. Evaluation Report for the Virginia Department of Medical Assistance Services: Addiction and Recovery Treatment Services—Access and Utilization During

Diagnosed prevalence of SUDs continued to increase among traditional Medicaid members, from almost 51,000 in the first year of ARTS to more than 57,000 in the second year of ARTS, which represents a 12 percent increase in prevalence between year 1 and 2 of the ARTS benefit. The total number of members with an SUD includes almost 30,000 with an opioid use disorder (OUD) and 24,000 with an alcohol use disorder (AUD). In addition, compared to all Medicaid members, those with SUDs are more likely to have other comorbid conditions, including other mental health disorders. Among Medicaid members with SUDs, 40 percent had a physical health comorbidity, while 45.9 percent had a mental health comorbidity.[1-12]

Services included in the ARTS benefit range from outpatient to inpatient services to include medication-assisted treatment (MAT) for opioid use and AUDs. This includes the full continuum of evidence-based addiction treatment to any of the 1.4 million Medicaid and FAMIS members who need treatment.

By adding the services below into managed care, ARTS promoted full integration of physical health, traditional mental health, and addiction treatment services.

- Inpatient detoxification
- Opioid treatment programs
- Residential treatment
- Office-based opioid treatment
- Partial hospitalization
- Case management
- Intensive outpatient programs
- Peer recovery supports

According to the *Health Affairs* article, an independent evaluation of the second year of the ARTS program (April 2018 through March 2019) conducted by VCU's Department of Health Behavior and Policy, treatment rates continued to rise even as more individuals were seeking services.[1-13] Among Medicaid members in the program prior to expansion, the treatment rate more than doubled, to 49 percent, in the two-year history of ARTS.

- Almost 34,000 members—49 percent of those with SUDs—received SUD treatment. Treatment rates have more than doubled since the year before ARTS.
- About 19,000 members—64 percent of those with an OUD—received OUD treatment.

the Second Year (April 2018–March 2019). Available at: http://dmas.virginia.gov/files/links/5218/ARTS%202%20year%20report.Feb2020%20FINAL.pdf. Accessed on: Feb 28, 2020.

[1-12] Ibid.

[1-13] Barnes A, et al., Hospital Use Declines After Implementation of Virginia Medicaid's Addiction and Recovery Treatment Services Program. Health Affairs. 2020(2): 238-246.

- Over 10,000 members received treatment for AUD, for a treatment rate of 44 percent. Treatment rates for AUD increased from 30 percent in the first year of ARTS to 44 percent in the second year of ARTS.

There was a continued decline in emergency department visits and acute inpatient hospital admissions related to SUD among Medicaid members. Emergency department visits for OUDs declined 32 percent since the ARTS benefit began, and total visits for all SUDs decreased 7 percent.[1-14]

One factor identified as driving increased access to treatment is growth in the number of providers serving Medicaid members, including more than 4,000 outpatient practitioners. The number of intensive outpatient providers increased from 49 to 137. The ARTS benefit also initiated a new model of care known as Preferred Office-Based Opioid Treatment programs which pays significantly higher reimbursement rates to qualified providers for MAT and coordination with other medical and social needs.[1-15]

The ARTS program expanded access to MAT by increasing the number of practitioners who were authorized to prescribe buprenorphine. As of 2018, there were a total of 866 waivered prescribers in Virginia, including 165 nurse practitioners and physician assistants. This reflects a 73 percent increase in the number of prescribers since the year before ARTS implementation. The percentage of individuals receiving buprenorphine treatment who were also participating in counseling or psychotherapy also increased from 61 percent to 73 percent between the first and second years of the benefit.[1-16]

During the second year of ARTS, 51 percent of members with an OUD received some type of pharmacotherapy for OUD, which reflects a 133 percent increase since the ARTS benefit began. Buprenorphine continued to be the most prevalent form of pharmacotherapy for members with OUD, accounting for 58 percent of pharmacotherapy treatment in the second year of ARTS. Methadone treatment rates also increased from 6 percent of members in the first year of ARTS to 15 percent in the second year of ARTS.[1-17]

Use of services across all American Society of Addiction Medicine (ASAM) levels of care increased greatly in the second year of ARTS:

[1-14] Virginia Department of Medical Assistance Services. Virginia Medicaid Agency Reports Increased Access to Addiction Treatment. Available at: http://www.dmas.virginia.gov/files/links/5220/Virginia%20Medicaid%20Two-Year%20Report%20on%20Addiction%20and%20Recovery%20Treatment%20Services%20Outcomes.pdf. Accessed on: Feb 28, 2020.

[1-15] Virginia Commonwealth University, Department of Health Behavior and Policy. Evaluation Report for the Virginia Department of Medical Assistance Services: Addiction and Recovery Treatment Services—Access and Utilization During the Second Year (April 2018–March 2019). Available at: http://dmas.virginia.gov/files/links/5218/ARTS%202%20year%20report.Feb2020%20FINAL.pdf. Accessed on: Feb 28, 2020.

[1-16] Ibid.

[1-17] Ibid.

- **ASAM Level 0.5, Screening, Brief Intervention, and Referral to Treatment:** During the second year of ARTS, 1,274 members had screenings for SUDs, a 21 percent increase from the first year of ARTS.
- **ASAM Level 1, Outpatient Services:** In the second year of ARTS, 5,190 members received services through Preferred Office-Based Opioid Treatment or Opioid Treatment Programs, more than 2.7 times the number of members receiving these services in the first year of ARTS.
- **ASAM Level 2, Partial Hospitalization and Intensive Outpatient Services:** During the second year of ARTS, 2,245 members used these services, almost twice the number seen during the first year of ARTS.
- **ASAM Level 3, Short-Term Residential Treatment Services:** About 1,500 members used short-term residential treatment services in the second year of ARTS, four times the number using such services in the first year of ARTS.
- **ASAM Level 4, Medically Managed Inpatient Services:** During the second year of ARTS, 5,756 members used medically managed inpatient services for SUDs, a 34 percent increase from the first year of ARTS.[1-18]

ARTS Performance Measure Development

DMAS contracted with HSAG to identify additional existing measures for the ARTS program. DMAS and HSAG will review the list of potential existing measures, identify measurement domain gaps, then select and develop measure specifications appropriate for the ARTS program to fill the gaps. Implemented PMV with the selected measures will provide process and outcomes measure results that will allow DMAS to evaluate the effectiveness of the ARTS program and identify opportunities to enhance or improve the program.

Quality Initiatives

Office of Quality and Population Health

Quality Improvement

DMAS' mission is to improve the health and well-being of Virginians through access to high-quality healthcare coverage. In 2019, Virginia Medicaid celebrated its 50th anniversary and successfully oversaw the largest expansion in its history. New eligibility rules elevated membership to 1.4 million individuals. Agency leaders responded to these historic changes by adopting member-focused innovations, including a Medicaid Member Advisory Committee, to provide feedback and ideas for current and futures initiatives. The Office of Quality and Population Health (QPH) continued to build upon the infrastructure of the Office throughout 2019 to include hiring a population health manager and a quality improvement manager. The Office of Value-Based Purchasing focused on a broader set of performance-based payment strategies that linked financial incentives to providers' performance.

[1-18] Ibid.

The following are examples of the agency-wide quality improvement activities conducted during 2019:

- Building the QPH program infrastructure
- Tracking and analyzing trends for improvement
- Improving member health outcomes/metrics
- Providing guidance in developing, implementing, and monitoring DMAS' comprehensive Quality Strategy as well as measuring quality performance
- Supporting programs to monitor quality metrics at the agency level
- Working across divisions to identify and analyze trends and to recommend quality and population health opportunities for improvement
- Focusing on utilizing meaningful and reliable data to enhance member experiences
- Providing smoking cessation assistance to over 300,000 Virginians through expanded Medicaid
- Transforming the Quality Collaborative through more meaningful topics and participation, resulting in better member impacted initiatives
- Expanding coverage and access to prenatal and postpartum care for pregnant women

6|18 Partnership

Virginia was selected to participate in the Centers for Disease Control and Prevention's (CDC's) 6|18 Initiative. DMAS partnered with the Virginia Department of Health (VDH) to receive comprehensive technical assistance to reduce tobacco use and to improve asthma outcomes in Virginia. The program offered one-on-one technical assistance and other opportunities to help advance quality improvement efforts in the aforementioned areas. The 6|18 initiative had a rich network of resources and prior state participants' experiences and accomplishments, which was helpful and insightful.

Tobacco Goals

- Add preventive services, including smoking cessation, to the Virginia Medicaid state plan.
- Actively engage MCOs in conducting a PIP on smoking cessation.
- Increase outreach to MCOs to explore opportunities for Quitline cost-sharing.
- Propose amending Tobacco 21 legislation.

Activities

- DMAS and VDH worked together to engage MCOs regarding Quitline and opportunities to share data to determine a best approach to cost-sharing.
- DMAS worked with its actuary to conduct an analysis of its rate-setting data to identify potentially preventable and/or medically unnecessary emergency room (ER) visits, hospital admissions, and hospital readmissions (i.e., clinical efficiency [CE]) analysis). DMAS reviewed the data to determine if any of the respiratory conditions stemmed from a history of smoking.

- DMAS initiated PIPs focused on tobacco use cessation in pregnant women and piloted small changes to allow flexibility to plan adjustments throughout the improvement process.

Results and Accomplishments

- DMAS conducted a survey with MCOs to characterize available cessation benefits.
- DMAS collaborated with HSAG to develop a series of five modules to guide the MCOs through rapid-cycle PIPs focused on tobacco cessation in pregnant women.
- DMAS submitted a budget proposal to add preventive services, including smoking cessation, to the Virginia Medicaid state plan.
- Medicaid expansion was implemented and provides smoking cessation coverage to 300,000 Virginians.

Next Steps

- VDH-led discussions with MCOs regarding Quitline cost-sharing are ongoing in partnership with DMAS.
- DMAS intends to develop performance dashboards that allow for assessment of individual MCO and hospital performance in the areas of preventable and/or medically unnecessary ER visits, hospitalizations, and readmissions related to smoking. DMAS is currently in the early stages of developing technical specifications for these metrics.
- HSAG continues to provide technical assistance to MCOs on their tobacco cessation PIPs with frequent contact and feedback to ensure that projects are well-designed at the outset and provide opportunities for mid-course adjustments.

MCO Quality Collaborative and Stakeholder Meetings

The MCO Quality Collaborative served as the main platform for the MCOs, the EQRO, and DMAS to share lessons learned, best practices, and potential solutions to common opportunities for improvement. The collaborative was facilitated by DMAS Quality Improvement staff and met monthly, including four on-site meetings in Richmond.

The July 2019 Quality Collaborative was strategically planned and held off-site at a low-income community center in an area where DMAS members resided. The title of the July Medicaid Quality Collaborative was "Moving From Healthcare to Health With a Focus on Health Equity and Social Determinants of Health." The collaborative has been active for more than a decade and continues to be recognized as the pillar for managed care quality in the Commonwealth.

The July Quality Collaborative was symbolic of change, but more importantly, it was symbolic of transformation. The fact that DMAS held a meeting off-site, in a low income neighborhood, and not at the Virginia Medicaid office building on Broad Street, is a reflection of the agency's commitment to fully engage with the community, DMAS' many partners, and its members.

DMAS acknowledges, through deeper engagement, that it will continue to learn and grow in its understanding of the people DMAS serves. Virginians are living longer than before, and medical care is only part of the reason. DMAS understands that people are dealing with complicated life issues while at the same time dealing with healthcare concerns. DMAS members have a holistic view of health, and they are challenging the agency to adapt and adopt a more comprehensive approach to addressing their needs.

As part of this process, DMAS understand that it was imperative that it moved from paying for medical claims based on utilization to paying for health. To be successful, DMAS embraced bold goals. The real work starts with making and securing internal and external commitments to better engage with the community and gain an understanding of the needs of DMAS members.

DMAS had a diverse group of speakers at the Quality Collaborative who addressed the complex needs of members. The first speaker addressed behavioral health transformation for Medicaid. Quality Collaborative participants also heard from a community health worker about her approach to achieving health equity. Next, the keynote speaker, Dr. Jeffrey Brenner, shared strategies on how to deliver better care for complex populations. Finally, participants digested what was learned with a panel discussion including Dr. Brenner and executive leaders from Virginia State agencies.

During 2019, DMAS hosted additional external presentations, such as from the Virginia Hospital & Healthcare Association (VHHA). DMAS also conducted Coffee Talks Care Coordination calls with the MCOs on a weekly basis. The purpose of the calls was to provide training and support to MCO care coordinators and to reinforce DMAS' expectations of the care coordination role and program requirements. DMAS leadership met weekly with the MCOs' executive leadership teams to discuss program-related updates, program development efforts, information related to potential or upcoming changes, and clarification on contract requirements for partnership and collaboration. The DMAS Office of the Chief Medical Officer held monthly meetings with the MCOs' chief medical officers and pharmacy leads for review and discussion of clinical operations. DMAS also conducted contract monitoring calls every other week with the MCOs. A primary topic for the contract monitoring calls was a review and discussion of the issues log and any outstanding issues that were in the resolution process.

Healthy Birthday Virginia

DMAS, upon the direction of Governor Ralph Northam, developed a series of strategies to end maternal and infant mortality among its members by 2025. As part of this directive, the office of the Secretary of Health and Human Resources convened a diverse group of stakeholders and embarked on a 10-stop listening tour across all regions of the Commonwealth. The events were planned to bring together community organizations, local healthcare providers and hospital systems, elected officials, leaders at state agencies, and other stakeholders to hear from individuals with lived experience and discuss strategies to improve maternal health outcomes.

DMAS is working to implement policy and program improvements to streamline enrollment of pregnant women, increase access to treatment for expecting mothers with an SUD, and strengthen accountability for prenatal and postpartum managed care services. Under previous eligibility rules, most women had access to Medicaid coverage for only a narrow window of time during their pregnancy and for 60 days

postpartum. Medicaid expansion enabled more low-income women to receive quality healthcare before, during, and after their pregnancy. Additional strategies adopted by DMAS to improve maternal and infant health outcomes included continuity of coverage, education and outreach, a focus on special populations, and increased accountability and transparency while strengthening partnerships with other stakeholders. DMAS' strategy also strengthened early childhood interventions and curbed tobacco use among pregnant women. DMAS partnered with VDH and the Virginia Department of Behavioral Health & Developmental Services on initiatives to improve birth outcomes.

DMAS Quality Strategy

In 2019, DMAS began the development of its fourth edition of the Quality Strategy, which was submitted to CMS in March 2020. The DMAS Office of Quality and Population Health has developed a robust Quality Strategy that reflects Virginia's focus on quality and addresses the following priorities:

- ARTS program
- Member and provider experience assessments
- Clinical efficiencies
- Connecting to care
- Financial transparency and accountability
- Improved agency member outreach strategies
- Improved agency provider outreach strategies
- Management of at-risk children
- Medicaid Advisory Committee
- Smiles for Children program
- Utilization reviews of critical services

Summary of the Quality and Timeliness of, and Access to Care Furnished by MCOs

The following section provides a high-level overview of examples of the MCOs' performance related to the quality and timeliness of, and access to care furnished to members. The information is intended to be representative and should not be considered an all-inclusive list.

Quality

The MCOs in Virginia submitted two PIPs for the calendar year 2019 validation cycle. The project topics addressed CMS requirements related to quality outcomes, specifically the quality and timeliness of, and access to care and services.

In 2019, three out of the five MCOs demonstrated providing quality care and services to members as they scored statistically significantly higher than the 2018 NCQA child Medicaid national averages for at least two of the following three measures: *Rating of Health Plan*, *Rating of All Health Care*, or *Rating of Personal Doctor*. In addition, one MCO scored statistically significantly higher than the 2018 NCQA child Medicaid national average for the *How Well Doctors Communicate* measure.

The results of the *Cervical Cancer Screening* measure demonstrated quality of care and services for the MCOs, with three MCOs exceeding the 50th percentile and the Virginia aggregate rate.

Timeliness

Timeliness of care and service delivery was demonstrated in the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* performance measure rates, with four of five MCOs exceeding the 50th percentile.

The MCOs demonstrated providing timely care to members, as two MCOs scored statistically significantly higher than the 2018 NCQA adult or child Medicaid national average for the *Getting Care Quickly* measure.

The MCOs generally met the requirements specified in 42 CFR §438 and established standards for timely access to care and services, taking into account the urgency of the member's need for services. Overall, the MCOs' quality evaluation demonstrated that the MCOs had policies, procedures, and programs that described their coverage and authorization of service activities and supported timely access to care and services.

Access

In 2019, three out of the five Medallion 4.0 MCOs demonstrated providing access to care and services to members as they scored statistically significantly higher than the 2018 NCQA adult or child Medicaid national average for the *Getting Needed Care* measure.

PMV results indicate that the MCOs demonstrated access to care in several areas, including adolescent and child access to primary care services.

Children and Adolescents' Access to Primary Care Practitioners was an area of strength for the MCOs, as four of the five MCOs exceeded the 50th percentile for three of the four *Children and Adolescents' Access to Primary Care Practitioners* measure rates, with three of the MCOs (Aetna, HealthKeepers, and VA Premier) exceeding the 50th percentile for all four measure rates.

Quality Strategy Recommendations for DMAS

In 2017, DMAS developed the third edition of its comprehensive Medicaid Quality Strategy in accordance with 42 CFR §438.340. DMAS 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. DMAS' Quality Strategy 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 Quality Strategy 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.

Quality Strategy Focus and Priorities

DMAS' Quality Strategy is based on four aims, which are based on three foundational guiding principles for meeting the mission and vision. The three guiding principles are superior care, cost effectiveness, and continuous improvement.

The four publicly promoted aims are:

- Build a wellness-focused, integrated system of care.
- Focus on screening and prevention.
- Achieve healthier pregnancies and healthier births.
- Maximize well-being across the lifespan.

DMAS' Quality Strategy for 2017 through 2019 states that the measures in the DMAS Quality Dashboard are prioritized for continuous improvement and selected based on the needs of the populations served and the favorable health outcomes that result when there is adherence to relevant clinical guidelines. DMAS also takes into consideration the availability and reliability of the data used in evaluating performance.

The Medallion 4.0 program structure was enhanced to continue to improve care delivery and efficiency. On June 7, 2018, Virginia's Governor signed the State budget that expanded eligibility under Medicaid for approximately 400,000 Virginia adults beginning on January 1, 2019. The Medallion 4.0 program for members enrolled through Medicaid expansion is intended to ensure the delivery of acute and primary care services, prescription drug coverage, and behavioral health services, through a patient-centered program design.

Strengths

Performance Measures

The Virginia MCOs demonstrated strength in the Children's Preventive Care domain with all four measures within the domain exceeding the NCQA 50th percentile.

Cervical Cancer Screening represented an area of strength for the MCOs, with three MCOs exceeding the 50th percentile and the Virginia aggregate in the Women's Health domain.

Children and Adolescents' Access to Primary Care Practitioners was an area of strength for the MCOs, at least four of the five MCOs exceeded the 50th percentile for three of the four *Children and Adolescents' Access to Primary Care Practitioners* measure rates, with three of the MCOs exceeding the 50th percentile for all four measure rates in the Access to Care domain.

Three MCOs demonstrated strength in the Behavioral Health domain by exceeding the 50th percentile for four of the eight (50.0 percent) measure rates. Additionally, the MCOs demonstrated strength for *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*, with four of five MCOs exceeding the 50th percentile.

Member Experience of Care Survey

Three out of the five Medallion 4.0 MCOs demonstrated strength with the *Getting Needed Care* measure, as three MCOs scored statistically significantly higher than the 2018 NCQA adult and child Medicaid national average. Three MCOs scored statistically significantly higher than the 2018 NCQA child Medicaid national averages for at least two of the following three measures: *Rating of Health Plan*, *Rating of All Health Care*, or *Rating of Personal Doctor*. In addition, two MCOs scored statistically significantly higher in 2018 than in 2019 on at least one of the following measures: *Rating of Health Plan*, *Rating of All Health Care*, or *Rating of Personal Doctor*.

Recommendations for Opportunities for Improvement

DMAS should prioritize continuous improvement activities for the Medallion 4.0 populations by focusing on the following areas:

Performance Measures

Four of the five MCOs were below the 50th percentile for the measures within the Children's Preventive Care domain, indicating opportunities for improvement related to well-child/well-care visits and immunizations. HSAG recommends that the MCOs implement quality improvement initiatives aimed at identifying the barriers for children receiving well-care visits and immunizations. HSAG recommends

that the MCOs identify best practices that have been successful in in achieving sustained improvement in preventive health rates.

The *Breast Cancer Screening* measure, in the Women's Health domain, demonstrated opportunities for improvement for all MCOs, as none of the MCOs exceeded the 50th percentile. Additionally, only one MCO exceeded the 50th percentile for the *Prenatal and Postpartum Care* measure rates, demonstrating opportunities for the MCOs to ensure women receive care during and after their pregnancies. HSAG recommends that DMAS work with the MCOs to focus interventions—such as assistance with scheduling, transportation to appointments, and the completion of reminder calls—on removing barriers to completing the breast cancer screening appointment the day prior to the scheduled appointment.

The Care for Chronic Conditions domain represented an area of opportunity for improvement for all of the MCOs, as none of the MCOs exceeded the 50th percentile for more than four of the 10 measure rates that could be compared to benchmarks. MCO performance was particularly low for the *Comprehensive Diabetes Care* measure, with only one MCO exceeding the 50th percentile for the *HbA1c Testing* rate, while no other rates for any of the MCOs within the *Comprehensive Diabetes Care* measure exceeded the 50th percentile. HSAG recommends that the MCOs identify the barriers members are experiencing in receiving care for chronic conditions, such as comprehensive diabetes care. MCOs should identify best practices that have demonstrated success in improving the management of chronic conditions. HSAG recommends that the MCOs consider assigning members to a medical home with a provider who has expertise in a chronic condition and has demonstrated successful outcomes for members with the chronic condition. Other interventions for consideration may include increased use of telehealth options for monitoring and managing chronic disease and monitoring appointment standards.

The MCOs demonstrated opportunities for improvement for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*, with only one MCO exceeding the 50th percentile in the Behavioral Health domain. HSAG recommends that the MCOs consider administrative or other processes to ensure children receive follow-up care when prescribed medications such as those for ADHD. MCOs may want to consider implementing a reminder for pharmacists and primary care providers (PCPs) to connect to encourage families to schedule and complete a follow-up visit prior to the next refill of the prescription.

Performance Improvement Projects

Overall, the results of the MCOs' submission of PIP Module 1 and Module 2 indicated opportunities for improvement. HSAG recommends that the MCOs ensure understanding of the PIP rapid-cycle process, participate in trainings provided by the EQRO, and request technical assistance as often as needed to improve the success of the PIP process. HSAG also recommends the MCOs thoroughly review and address the initial validation findings prior to resubmitting the PIP modules.

Member Experience of Care Survey

HSAG recommends that the Medallion 4.0 MCOs focus quality improvement efforts on measure scores that exhibited a decrease from 2018 to 2019 and were statistically significantly lower than the NCQA national averages. In addition, the MCOs should monitor the measures to ensure there are no significant decreases in rates over time. HSAG recommends that the MCO efforts should also focus on improving survey response rates. One MCO scored statistically significantly lower in 2019 than in 2018 on one measure, *Getting Care Quickly*. Two MCOs scored statistically significantly lower than the 2018 NCQA adult and child Medicaid national average on one measure, *Customer Service*. Also, one MCO scored statistically significantly lower than the 2018 NCQA adult Medicaid national averages on the *Rating of Health Plan* and *Rating of All Health Care* measures. MCOs may want to review their grievances, complaints, and other indicators to better understand the drivers of the lower score for the *Rating of Health Plan* measure.

Focused Studies

While the VA Smiles For Children program provides pregnant women with a critically important opportunity to receive dental services provided by the DMAS dental vendor, DentaQuest, relatively few eligible women received prenatal and/or postpartum dental services. HSAG recommends that the MCOs coordinate with the dental vendor to focus interventions on assisting women in successfully completing prenatal and postpartum dental visits. HSAG recommends that the MCOs consider interventions—such as assisting members with scheduling and transportation to appointments and reminder calls the day before a scheduled appointment—designed to remove barriers that may prevent members from keeping their appointments.

Overall

HSAG recommends that MCO leadership continue to be actively involved and demonstrate a commitment to quality improvement throughout the organization. MCOs should regularly review their data to identify opportunities for improvement early and implement interventions, using the small tests of change process that is used for PIPs. HSAG also recommends that MCOs include the members' perspectives whenever possible to gain a clear understanding of members' perceptions of care and service delivery and the challenges members encounter in receiving the MCOs' healthcare services.

2. Introduction to the Annual Technical Report

Purpose of Report

As required by CFR 42 §438.364,[2-1] the DMAS contracts with HSAG, an EQRO, to prepare an annual, independent, technical report. As described in the CFR, the independent report must summarize findings on access, timeliness, and quality of care, including:

A description of the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the MCO, PIHP, prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity (described in §438.310[c][2]).

Each EQR-related activity conducted in accordance with §438.358 must include:

- Objectives.
- Technical methods of data collection and analysis.
- Description of data obtained, including validated performance measurement data for each activity conducted in accordance with §438.358(b)(1)(i) and (ii).
- Conclusions drawn from the data.
- An assessment of each MCO, PIHP, PAHP, or PCCM entity's strengths and weaknesses for the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.
- Recommendations for improving the quality of healthcare services furnished by each MCO, PIHP, PAHP, and PCCM entity, including how the State can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR Protocols issued in accordance with §438.352(e).
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

[2-1] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. 42 CFR Parts 431,433, 438, et al. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf. Accessed on: Apr 11, 2019.

Methodology for Aggregating and Analyzing EQR Activity Results

For the 2019 EQR Technical Report, HSAG used findings from the EQR activities conducted from January 1, 2019, through December 31, 2019, to derive conclusions and make recommendations about the quality of, access to, and timeliness of care and services provided to the Medallion 4.0 MCO managed Medicaid members. From these analyses, HSAG determined which results were applicable to the domains of quality of, access to, and timeliness of care and services. To identify strengths and weaknesses and draw conclusions for each MCO, HSAG analyzed and evaluated all components of each EQR activity and resulting findings across the continuum of program areas and activities that comprise the Medallion 4.0 program. The composite findings for each MCO were analyzed to identify overarching trends and focus areas for the MCOs.

Scope of External Quality Review (EQR) Activities

At the request of DMAS, HSAG performed a set of mandatory and optional EQR activities, as described in 42 CFR §438.358. These activities are briefly described below. Refer to Appendix A—Technical Methods of Data Collection and Analysis—MCOs for a detailed description of each activity's methodology.

Mandatory Activities

Compliance Monitoring—HSAG conducts compliance monitoring activities at least once during each three-year EQR cycle. During 2019, HSAG did not conduct MCO compliance review activities for the Medallion 4.0 program.

Validation of Performance Measures—The purpose of PMV is to assess the accuracy of performance measures reported by the MCOs and to determine the extent to which performance measures reported by the MCOs follow State specifications and reporting requirements.

DMAS contracted with HSAG to conduct the PMV for each MCO, validating the data collection and reporting processes used to calculate the performance measure rates. DMAS identified a set of performance measures that the MCOs are required to calculate and report. Measures are required to be reported following the specifications provided by DMAS. DMAS identified the measurement period as January 1, 2018, through December 31, 2018.

Validation of Performance Improvement Projects—The MCOs are required to conduct PIPs that have the potential to affect member health, functional status, or satisfaction. To validate each PIP, HSAG obtained the data needed from each MCO's PIP Summary Forms. These forms provide detailed information about the PIPs related to the steps completed and validated by HSAG for the 2019 validation cycle. The results from the CY 2019 PIP validation are presented in this report.

Network Adequacy—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 managed long-term services and supports (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: primary care (adult and pediatric), obstetricians/gynecologists, behavioral health, specialist (adult and pediatric), hospital, pharmacy, pediatric dental, and additional provider types when they promote the objectives of the Medicaid program for the provider type to be subject to such time and distance standards. DMAS has implemented network standards in its contracts with the MCOs.

Optional Activities

Quality Measure Set Validation—HSAG validates rates for performance measures selected by DMAS for validation for the Medallion 4.0 MCOs.

- *Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combination 3*
- *Children and Adolescents' Access to Primary Care Practitioners*
- *Prenatal and Postpartum Care*
- *Comprehensive Diabetes Care*

Performance Measure Incentive Validation—HSAG validates rates for performance measures selected by DMAS for validation.

- *Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combination 3*
- *Children and Adolescents' Access to Primary Care Practitioners*
- *Prenatal and Postpartum Care*
- *Comprehensive Diabetes Care*

Calculate Measures—HSAG calculates one performance measure (selected by DMAS) for the Medicaid population stratified by geographic region and key demographic variables (race, gender, age, etc.).

Calculate Measure Performance Incentive Awards—HSAG develops a methodology to calculate the MCOs' performance incentive awards (PIAs) for DMAS. DMAS is transitioning from the PIA to the performance withhold program (PWP).

Performance Withhold Program—HSAG develops a methodology to calculate the MCO results for the PWP for DMAS. The 2019 PWP will use HEDIS and non-HEDIS measures.

FAMIS CAHPS Survey—HSAG administers the CAHPS 5.0 Child Medicaid Health Plan Survey to FAMIS members receiving healthcare services through FFS or managed care. HSAG analyzes the CAHPS survey data and generates a FAMIS Program Member Satisfaction Report for DMAS.

Medallion 4.0 Consumer Decision Support Tool—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. HSAG uses HEDIS and CAHPS data to compare MCOs to one another in key performance areas.

Prenatal Care and Birth Outcomes Focused Study—HSAG will conduct a focused study that provides quantitative information about prenatal care and associated birth outcomes among Medicaid recipients.

Foster Care Focused Study—HSAG will conduct a Foster Care Focused Study to evaluate healthcare utilization among children in foster care under the Medallion 4.0 program.

Dental Utilization in Pregnant Women Data Brief—HSAG produces a data brief describing dental utilization among pregnant women enrolled in the Medicaid or FAMIS MOMS programs.

Quality Strategy Update—During 2019, DMAS contracted with its EQRO to update the Virginia Quality Strategy. The purpose of the update is to include changes to the Medicaid program including the evolution of CCC to CCC Plus and Medallion 3.0 to Medallion 4.0. The Quality Strategy updates incorporate 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.

ARTS Performance Measure Validation—HSAG validates rates for performance measures for the ARTS program selected by DMAS for validation.

- *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*
- *Follow-up after Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence*
- *Use of Opioids at High Dosage in Persons Without Cancer*
- *Use of Opioids at High Dosage and From Multiple Providers in Persons Without Cancer*
- *Concurrent Use of Opioids and Benzodiazepines*
- *Continuity of Pharmacotherapy for Opioid Use Disorder*

ARTS Measure Specification Development—HSAG identifies, when available, performance measures from existing measure sets or develops performance measures for the ARTS program.

Organizational Structure of Report

Section 1—Executive Summary

This section of the report presents a summary of the EQR activities. The section also includes high-level findings and conclusions regarding the performance of each MCO.

Section 2—Introduction to the Annual Technical Report

This section of the report presents the scope of the EQR activities and provides a brief description of each section's content.

Section 3—Overview of Virginia's Managed Care Program

This section of the report presents a brief description of the Commonwealth of Virginia's managed care program, services, regions, and populations. This section also presents a brief description of Virginia's quality initiatives.

Section 4—MCO Comparative Information

This section presents methodologically appropriate, comparative information about all MCOs by activity and consistent with the guidance provided in the CMS EQR Protocols. Commonwealth-specific recommendations are also included if applicable. This section includes recommendations for improvements to the quality of healthcare services furnished by the MCOs, including how the Commonwealth can target goals and objectives in the Quality Strategy to better support improvement in the quality of, timeliness of, and access to healthcare services furnished to members.

Section 5—Compliance With Standards

This section presents MCO-specific results and conclusions of the compliance with standards review activity. DMAS conducts Compliance with Standards Monitoring reviews using a three-year cycle. During 2019 the Commonwealth of Virginia monitored the MCOs implementation of contract requirements and the MCOs' corrective action plans from prior years' compliance reviews.

Section 6—Validation of Performance Measures

This section presents MCO-specific results and conclusions of the validation of performance measures activity. It includes the following:

- Overview
- Objectives
- MCO-specific results including strengths and recommendations for improvement in the quality of, timeliness of, and access to healthcare services furnished to members
- Assessment of how effectively the MCO addressed the recommendations for quality improvement made by the EQR the prior year
- Conclusions and recommendations

Section 7—Validation of Performance Improvement Projects

This section presents MCO-specific results and conclusions of the validation of performance improvement project activity. It includes the following:

- Overview
- Objectives
- MCO-specific results including strengths and recommendations for improvement in the quality of, timeliness of, and access to healthcare services furnished to members
- Assessment of how effectively the MCO addressed the recommendations for quality improvement made by the EQR the prior year
- Conclusions and recommendations

Section 8—Member Experience of Care Survey

This section presents MCO-specific results and conclusions of the member experience of care surveys activity. It includes the following:

- Overview
- Objectives
- MCO-specific results including strengths and recommendations for improvement in the quality of, timeliness of, and access to healthcare services furnished to members
- Assessment of how effectively the MCO addressed the recommendations for quality improvement made by the EQR the prior year
- Conclusions and recommendations

Section 9—Focused Studies

This section presents aggregate results and conclusions of the focused study activities. It includes the following:

- Overview
- Objectives
- Aggregate results including strengths and recommendations for improvement in the quality of, timeliness of, and access to healthcare services furnished to members
- Assessment of how effectively the MCOs addressed the recommendations for quality improvement made by the EQR the prior year
- Conclusions and recommendations

Appendix A—Technical Methods of Data Collection and Analysis—MCOs

This section of the report presents the objective(s), 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:

- Performance Measure Validation
- Performance Improvement Project Methodology
- PWP Methodology
- CAHPS Survey Methodology
- Focused Studies Methodologies

3. Overview of Virginia's Managed Care Program

Medicaid Managed Care in the Commonwealth of Virginia

Introduction

Medicaid and CHIP provide comprehensive health coverage to approximately 72 million Americans including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities.[3-1] Medicaid is administered by states according to federal requirements. The program is funded jointly by states and the federal government.

In Virginia, Medicaid plays a critical role in the lives of over nearly 1.4 million Virginians, providing access to healthcare for the most vulnerable populations.[3-2] The impact of Medicaid extends far beyond traditional health coverage, to include comprehensive services such as behavioral health and long-term services and supports (LTSS). Medicaid is also the primary funder for LTSS, making it possible for thousands of Virginians to remain in their homes or to access residential care when needed.[3-3]

The Medallion 4.0 program serves as a platform for healthcare with a focus on member-centric care for pregnant women, infants, children, parents, caregivers, and expansion adults. The Medallion 4.0 program takes a holistic and integrated approach to delivering care. The first and foremost goal and expectation for the Medallion 4.0 program is to improve the quality of life and health outcomes of members. DMAS states that integration in the Medallion 4.0 program is more than an operational change, it is an investment in the whole spectrum of care and services. Medallion 4.0 is an integrated delivery model that includes physical, behavioral health, and substance use disorder (SUD) services. Medallion 4.0 incentivizes and promotes innovation and value-based payment strategies.

Medicaid is the largest payer of behavioral health services in the Commonwealth, providing inpatient and outpatient services that support quality of life in the community for those in need of behavioral health support. Virginia has a comprehensive addiction and recovery treatment services benefit that provides SUD, OUD, and AUD treatment and services. This benefit operates under an 1115 waiver, Creating Opportunities for Medicaid Participants to Achieve Self-Sufficiency (COMPASS), which provides SUD services through the ARTS delivery system. The first full year of the demonstration was 2018. The demonstration extends access to certain behavioral and physical health services to uninsured low-income adults with a diagnosis of serious mental illness (SMI) with a goal of the demonstration to use a targeted benefit package to prevent people with SMI diagnoses from becoming fully and permanently disabled.

[3-1] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. October 2019 Medicaid & CHIP Enrollment Data Highlights. Available at: https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html. Accessed on: Jan 15, 2020.

[3-2] Virginia Department of Medical Assistance Services. CCC Plus and M4 Demographic Population Report, July 2019.

[3-3] Virginia Department of Medical Assistance Services. 2019 Medicaid at a Glance. Available at: https://www.dmas.virginia.gov/files/links/221/2019%20MAG%20Draft%20(01.07.2019).pdf. Accessed on: Nov 14, 2019.

The ARTS component of the demonstration, which contributes to a comprehensive statewide strategy to combat prescription drug abuse and OUDs, seeks to expand the SUD benefits package to cover the full continuum of SUD treatment, including short-term residential and inpatient services to all Medicaid-eligible members. The ARTS demonstration was amended to address the substance use crisis by expanding coverage and adding services. The demonstration amendment also expanded Medicaid coverage to former foster care youth who aged out of foster care under the responsibility of another state and were applying for Medicaid in the Commonwealth of Virginia.

The FAMIS MOMS 1115(a) waiver provides health coverage for pregnant women and the FAMIS Select population, which helps families pay for employer-sponsored health insurance. The FAMIS Select program allows families to choose between covering their children through FAMIS or through an employer-sponsored health plan. FAMIS MOMS provides comprehensive healthcare and dental benefits during pregnancy and for two months following the baby's birth. Good healthcare during pregnancy is important for the mom and the baby. FAMIS MOMS encourages pregnant women to get early and regular prenatal care to increase the likelihood for a healthy birth outcome.

Virginia's 1915(b1), (b4), and (c) waivers emphasize DMAS' focus on providing home and community-based services and transition services for individuals 65 years of age and over, physically disabled individuals 0 to 64 years of age, individuals with other disabilities 0 to 64 years of age, and technology dependent individuals of all ages. The 1915(c) waiver provides DMAS the authority to focus on maximizing each individual with developmental disabilities or intellectual disabilities life in his or her community with increased flexibility; new options; and improved access to care, services, and community living. Individuals enrolled in one of the three developmental disability waivers receive their non-waiver services through the CCC Plus program.

For individuals with autism, developmental or intellectual disabilities of any age, and their families, DMAS has implemented a 1915(c) waiver that provides person-centered and family-centered resources, supports, services, and other assistance that encourages community-based living options. The 1915(c) waiver for Virginia Building Independence focuses on providing supports to these individuals to increase independence and integration in community-based settings.

Virginia also participates in the Delivery System Reform Incentive Payment (DSRIP) program through an 1115 Delivery System Transformation Demonstration waiver. The DSRIP has two strategic initiatives that align the MLTSS and DSRIP payments to strengthen and integrate Virginia Medicaid's community delivery structure and accelerate payment reforms toward value-based payments.

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. As of December 2019, more than 90 percent of Medicaid enrollees received their benefits through the managed care model, and less than 10 percent of enrollees participated in Medicaid through the FFS model. The managed Medicaid populations in Virginia included two programs: Medallion 4.0 and CCC Plus.

Medallion 4.0 MCO Model

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

Medallion 4.0 focuses on the following objectives:

- Engaging health systems and stakeholders
- Providing holistic and integrated care
- Adding new services and populations
- Providing flexible delivery systems and payment models
- Growing stronger through improved quality, data, and reporting

Medicaid Expansion

On June 7, 2018, Virginia's Governor, Ralph Northam, signed the State budget, which included expanded eligibility under Medicaid for qualified Virginia adults. Approximately 255,650 Medicaid expansion members were added to the Medallion 4.0 program as of July 2019.[3-4] Medicaid expansion coverage began 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 to 138 percent of the federal poverty level, 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).

Coverage for the Medicaid expansion population is provided through the DMAS managed care and FFS delivery systems. Most individuals are enrolled in one of the DMAS managed care programs—Medallion 4.0 or CCC Plus.

The Medallion 4.0 and CCC Plus programs contract with the same six MCOs, and all offer coverage statewide. In addition, both CCC Plus and Medallion 4.0 provide services that help keep people healthy as well as services that focus on improving health outcomes. CCC Plus provides care coordination services for individuals with more pronounced medical needs and serves as the delivery system that provides coverage for expansion members who are deemed to be "medically complex." Medallion 4.0 serves as the delivery system for expansion individuals who are determined not medically complex. Medically complex individuals include individuals with a complex medical or behavioral health condition and a functional impairment, or an intellectual or developmental disability.

[3-4] Virginia Department of Medical Assistance Services. CCC Plus and M4 Demographic Population Report, July 2019.

Addiction and Recovery Treatment Services (ARTS)

In 2017, DMAS implemented the ARTS program in the CCC Plus and the Medallion 4.0 benefit. ARTS focuses on treatment of SUD, OUD, and AUD. Outcomes are measured through reductions in SUD, OUD, and AUD ED utilization; reductions in inpatient admissions; and a decrease in opioid prescriptions. The ARTS program is a fully integrated physical and behavioral health continuum of care that includes:

- Early intervention
- Outpatient services
- Intensive outpatient and partial hospitalization services
- Intensive outpatient services
- Partial hospitalization services
- Residential and inpatient services
- Clinically managed, population-specific, high-intensity residential services
- Clinically managed, high-intensity residential services
- Medically monitored intensive inpatient services
- Medically managed intensive inpatient services

Virginia Quality Strategy

The HHS CMS Medicaid managed care regulations at 42 CFR §438.340 require Medicaid state agencies that operate Medicaid managed care programs to develop and implement a written quality strategy to assess and improve the quality of healthcare services offered to Medicaid members. The written strategy must describe the standards that a state and its contracted MCOs and PIHPs must meet.

This section outlines the goals and objectives of DMAS' 2017 Quality Strategy as well as the annual evaluation of the strategy for contract year 2019. In addition, the State conducts periodic reviews to examine the scope and content of its Quality Strategy, evaluates the strategy's effectiveness, and updates it as needed. The DMAS Quality Strategy is consistent with CMS' guidance in the 2013 Quality Strategy Toolkit for States[3-5] and aligns with the HHS National Quality Strategy Aims for better care, affordable care, and healthy people/healthy communities.

DMAS considers its Quality Strategy to be its roadmap for the future. DMAS developed its Medicaid comprehensive Quality Strategy to continually improve the delivery of quality healthcare to all Medicaid and CHIP recipients served by the Virginia Medicaid managed care and FFS programs.

[3-5] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Quality Strategy Toolkit for States. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/quality-strategy-toolkit-for-states.pdf. Accessed on: Jan 24, 2019.

DMAS' vision for quality extends beyond the Quality Strategy. Virginia's Quality Strategy serves as the roadmap for developing a dynamic approach to assessing and improving the quality of healthcare and services furnished by the managed care and FFS entities and providers. The mechanisms for assessing quality, timeliness, and access to care vary across the Medicaid programs in Virginia; therefore, the Quality Strategy is tailored to incorporate these variances while ensuring an integrated strategy overall. The strategy requires a succession of incremental steps that DMAS pursues to achieve these quality objectives. The Quality Strategy establishes a strong foundation for quality governance and a comprehensive data analytics strategy.

DMAS' Quality Strategy is based on four aims, which are based on three foundational guiding principles for meeting the mission and vision. The three guiding principles are superior care, cost effectiveness, and continuous improvement.

The four publicly promoted aims are:

- Build a wellness-focused, integrated system of care.
- Focus on screening and prevention.
- Achieve healthier pregnancies and healthier births.
- Maximize well-being across the lifespan.

History

DMAS published its first Quality Strategy in June 2005. The strategy was first updated in May 2011 to include the CHIP managed care delivery system and to provide a framework for the five-year period through 2015. In December 2015, DMAS issued Addendum 1 (Addendum) to the 2011–2015 managed care Quality Strategy as a companion to the previously published second edition. This Addendum was the result of the May 2015 release of the proposed rule to modernize and update the federal Medicaid managed care regulations. It addresses the progression of, and impending changes to, managed care quality in Virginia. The Addendum served to extend the 2011–2015 DMAS Quality Strategy to cover the gap period until the third edition of the Quality Strategy was developed and approved. The third edition was finalized by DMAS on January 31, 2018, for calendar years 2017 through 2019. This third edition aligns with the requirements detailed in the revised federal regulations, specifically 42 CFR §438.340. The new federal regulations advance DMAS' mission of better care, healthier people, and smarter spending.

In 2017, DMAS developed the third edition of its comprehensive Medicaid Quality Strategy in accordance with 42 CFR §438.340. DMAS objective is to continually improve the delivery of quality healthcare to all Medicaid and CHIP recipients served by the Virginia Medicaid managed care and FFS programs.

During 2019, DMAS contracted with its EQRO to update the Virginia Quality Strategy. The purpose of the update is to include changes to the Medicaid program including the evolution of CCC to CCC Plus and Medallion 3.0 to Medallion 4.0. The Quality Strategy updates incorporate 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.

Mission, Vision, Values

The purpose of DMAS' Quality Strategy is to:

- Establish a comprehensive quality improvement system consistent with the National Quality Strategy and CMS Triple Aim to achieve better care for patients, better health for communities, and lower costs through improvement of the healthcare system.
- Provide a framework for DMAS to implement a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP systems. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, clinical quality of care, timeliness, member satisfaction, and health outcomes of the population served.
- Identify opportunities for improvement in the health outcomes of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.

- Identify opportunities to improve quality of care and quality of service and implement improvement strategies to ensure that Virginia Medicaid and CHIP recipients have access to high quality and culturally appropriate care.
- Identify creative and efficient models of care delivery steeped in best practices; and make healthcare more affordable for individuals, families, and the State government.
- Improve recipient satisfaction with care and services.

Quality Strategy Goals and Objectives

Figure 3-1—DMAS' Quality Strategy Quality Dashboard

Quality Strategy Aims	Goals	Measure Examples
 **Aim 1:** Build a Wellness Focused, Integrated System of Care	**Goal 1:** Strengthen access to primary care network	**Measure 1.1:** HEDIS *Adults' Access to Primary Care Preventive and Ambulatory Health Services*
		Measure 1.2: HEDIS *Children and Adolescents' Access to Primary Care*
	Goal 2: Decrease inappropriate utilization and total cost of care	**Objective 2.1:** *All-Cause PQI Admission Rate*
		Objective 2.2: CMS/NQF #1768 *All-Cause Readmissions*
		Objective 2.3: HEDIS *Ambulatory Care—Emergency Department Visits*
		Objective 2.4: *Per Capita Healthcare Expenditures* (future Measure)
	Goal 3: Emphasize member experience of care	**Objective 3.1:** CAHPS/HEDIS/NQF #0006: *Member Rating of Health Plan*
	Goal 4: Integration of behavioral, oral and physical health	**Objective 4.1:** CMS/HEDIS/NQF/#0004: *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* (two rates)
		Objective 4.2: CMS/NQF #1664 SUB-3 *Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB 3a Alcohol and Other Drug Use Disorder Treatment at Discharge*
		Objective 4.3: HEDIS/NQF #0576 *Follow-Up After Hospitalization for Mental Illness, 7-day Follow-Up*
		Objective 4.4: CMS/NQF #2605 *Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence*
		Objective 4.5: CMS *Transition of Members Between SUD LOCs, Hospitals, NF, and the Community*

Quality Strategy Aims	Goals	Measure Examples
	Goal 5: Encourage appropriate management of prescription medications	**Objective 5.1:** *Use of High-Risk Medications in the Elderly*
		Objective 5.2: NCQA *Use of Multiple Concurrent Antipsychotics in Children and Adolescents*
		Objective 5.3: HEDIS *Follow-Up Care for Children Prescribed ADHD Medication—Initiation and Continuation/Maintenance Phases*
		Objective 5.4: HEDIS *Antidepressant Medication Management—Effective Acute Phase Treatment, Effective Continuation Phase Treatment*
		Objective 5.5: PQA *Use of Opioids at High Dosage in Persons Without Cancer*
		Objective 5.6: PQA *Use of Opioids from Multiple Providers in Persons Without Cancer*
		Objective 5.7: PQA *Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer*
 **Aim 2:** Focus on Screening and Prevention	**Goal 6:** Cancers are prevented or diagnosed at the earliest state possible	**Objective 6.1:** HEDIS/NQF #2372 *Breast Cancer Screening Rate*
		Objective 6.2: NQF #0034 *Colorectal Cancer Screening*
		Objective 6.3: HEDIS/NQF #0032 *Cervical Cancer Screening*
	Goal 7: Prevention of nicotine dependency	**Objective 7.1:** AMA PCPI/NQF #0027 *Tobacco Use—Screening and Cessation*
	Goal 8: Virginians protected against vaccine-preventable diseases	**Objective 8.1:** HEDIS *Childhood Immunization Status (Combination 10)*
		Objective 8.2: *HEDIS Immunizations for Adolescents*
		Objective 8.3: HEDIS *Pneumococcal Vaccination Status for Older Adults*
		Objective 8.4: HEDIS *Flu Vaccination*
	Goal 9: Support consistency of recommended pediatric screenings	**Objective 9.1:** CMS/HEDIS *Annual Preventive Dental Visits*
		Objective 9.2: HEDIS *Well-Child Visits, First 15 Months of Life*
		Objective 9.3: HEDIS *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
		Objective 9.4: HEDIS *Adolescent Well-Care Visits (12–21 Years)*

Quality Strategy Aims	Goals	Measure Examples
		Objective 9.5: OHSU *Developmental Screening in the First Three Years of Life*
 **Aim 3:** Achieve Healthier Pregnancies and Healthier Babies	**Goal 10:** Virginians plan their pregnancies	**Objective 10.1:** NQF 2902/OPA *Contraceptive Care—Postpartum Women Ages 15–44*
		Objective 10.2: HEDIS *Postpartum Care Visit*
	Goal 11: Improved pre-term birth rate	**Objective 11.1:** *Early Elective Deliveries Rate*
		Objective 11.2: HEDIS *Timeliness of Prenatal Care*
		Objective 11.3: *Frequency of Ongoing Prenatal Care*
		Objective 11.4: CMS/CDC/PQI *Percent of Live Births <2500 Grams*
 **Aim 4:** Maximize Well-being Across the Lifespan	**Goal 12:** Effective management of chronic respiratory disease	**Objective 12.1:** PQI 14 *Asthma Admission Rate (Ages 2–17)*
		Objective 12.2: PQI 15 *Asthma in Younger Adults Admission Rate*
		Objective 12.3: CMS/PQI 05/NQF #0272 PQI *Diabetes Short-term Complication Admission Rate*
	Goal 13: Comprehensive management of diabetes	**Objective 13.1:** HEDIS *Comprehensive Diabetes Care*
		Objective 13.1: PWI 01/NQF #0272 PQI *Diabetes Short-term Complication Admission Rate*
	Goal 14: Effective management of cardiovascular disease	**Objective 14.1:** HEDIS/NQF #0018 *Controlling High Blood Pressure*
	Goal 15: Ensure quality of life for members with intensive health care needs	**Objective 15.1:** JLARC *Nursing Facility Diversion Number and Percent of New Members Meeting Nursing Facility Level of Care Criteria Who Opt for Home and Community-Based Services (HCBS) Over Institutional Placement*
		Objective 15.2: *Quality of Life and Member Satisfaction Survey* CMS-Specific
		Objective 15.3: *Assessments and Reassessments*
		Objective 15.4: *Plan of Care and POC Revisions*
		Objective 15.5: *Documentation of Care Goals*
		Objective 15.6: JLARC *Transition of Members Between Community Well, LTSS and Nursing Facility—Services and Successful Retention in Lower Care Settings*

Quality Strategy Aims	Goals	Measure Examples
		Objective 15.7: JLARC *Nursing Facility Residents Hospitalization and Readmission Rate*
		Objective 15.8: *Fall Risk Management Intervention/Managing Fall Risk*
	Goal 16: Provide support for end of life	**Objective 16.1:** *Percent Enrollees with Advance Directives*

Note: each objective has targeted metrics to measure progress, as well as outlined interventions to advance the objectives.

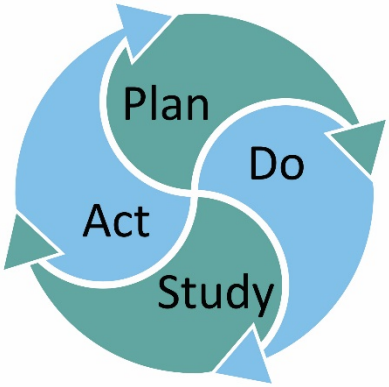
Quality Governance

In 2017, DMAS established an integrated agency-wide quality governance structure with the creation of a Quality Steering Committee with representatives from Integrated Care, Health Care Services, Provider Reimbursement, and the Office of the Chief Medical Officer. The Quality Steering Committee operates under the direction of DMAS Senior Leadership.

The mission of the Quality Steering Committee is to provide cross-agency governance to support the quality delivery of healthcare to all Commonwealth Medicaid programs. The scope of authority includes issue resolution, idea development, setting policy direction, making strategic recommendations (e.g., priority projects and measurement development), and aligning quality priorities with other agency priorities. The scope excludes issues related to compliance, program, and systemic inefficiencies.

Quality Initiatives and Emerging Practices

Emerging practices can be achieved by incorporating evidence-based guidelines into operational structures, policies, and procedures. Emerging practices are born out of continuous quality improvement 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 quality improvement initiatives and interventions, using a Plan-Do-Study-Act (PDSA) cycle, to determine if the benefit of the intervention outweighs the effort and cost.



Another method used by DMAS to promote best and emerging practices among the MCOs was to ensure that the State's contractual requirements for the MCOs were at least as stringent as those described in the federal rules and regulations for managed care (42 CFR Part 438—Managed Care). DMAS actively promotes the use of nationally recognized protocols, standards of care, and benchmarks by which MCO performance is measured.

DMAS Quality Initiatives Driving Improvement

The following are some of the initiatives DMAS implemented during the review period that support the improvement of quality of care and services for Medallion 4.0 members, as well as activities that supported the MCOs' quality improvement efforts.

Secret Shopper Preliminary Work

DMAS has approved a methodology to conduct a secret shopper telephone survey among Medallion MCOs. The secret shopper survey will supplement DMAS' comprehensive oversight of each MCO's ability to ensure timely access to care for its members. A secret shopper survey will be conducted to determine member access to primary care providers contracted by the MCOs to serve Medallion 4.0 and/or CCC Plus members. Additionally, DMAS has approved a methodology to conduct a secret shopper telephone survey among prenatal care providers contracted to serve Medallion 4.0 members.

MCO-Specific Quality Initiatives

DMAS requires each MCO to have a quality improvement program that meets contractual standards at least as stringent as those requirements specified in 42 CFR §438.236–438.242. The MCOs' ongoing program objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and improved health outcomes for their members.

DMAS also requires that the MCOs' quality improvement programs be based on the latest available research around quality assurance and include a method of monitoring, analysis, evaluation, and improvement of the delivery, quality, and appropriateness of healthcare furnished to all members (including under- and overutilization of services). DMAS requires the MCOs to submit annual evaluations of and seek approval from DMAS for any updates to the MCOs' quality improvement programs.

DMAS Quality Improvement Accomplishments

Foster Care Study's Success

DMAS is committed to improving the quality and timeliness of care for children in foster care. DMAS conducts a study of the healthcare utilization among children in foster care compared to children not in foster care who were enrolled in Virginia Medicaid MCOs. The results of the study demonstrate that foster children have higher rates of healthcare utilization than comparable non-foster children for most study indicators, particularly for dental measures, where the rates of foster children having annual dental visits and preventive dental services were over 20 percentage points higher than the rates for non-foster

children. Among the study's 20 study indicators, foster children demonstrated higher rates of healthcare utilization than non-foster children in 16 study indicators. The rate differences between foster children and non-foster children across study indicators persisted even after controlling for many demographic and health characteristics. The Commonwealth of Virginia Department of Social Services informs and requires foster parents to ensure that their foster children receive regular primary care and dental visits, which may explain some findings.

Birth Outcomes Study's Success

DMAS conducts an annual study of Medicaid and CHIP prenatal care and associated birth outcomes. The purpose of the study is to determine the extent that women receive early and adequate prenatal care, and the clinical outcomes that are associated with the Medicaid-paid births. Overall, a higher percentage of women in the study population received early and adequate prenatal care compared to women who were not continuously enrolled in Medicaid prior to delivery. Additionally, there was a lower percentage of births to women in the study population prior to 37 completed weeks of gestation (i.e., preterm) or weighing less than 2,500g (i.e., low birth weight [LBW]) when compared to births to women who were not continuously enrolled in Medicaid prior to delivery. The most promising study indicator results were identified among births to women in the FAMIS MOMs. Though limited in number, births to these women had the highest rate of early and adequate prenatal care, the lowest rates of preterm birth or LBW, and the highest rate of non- neonatal intensive care unit (NICU) singleton births with two or more office visits with a PCP-type provider in the 30 days following birth.

Medicaid Member Advisory Committee

The DMAS director established the Medicaid Member Advisory Committee (MAC). This committee provides a formal method for members' voices to be included in the DMAS decision-making process and to inform DMAS change management strategies.

The committee is made up entirely of Medicaid-enrolled individuals or an authorized representative of a member. The director of DMAS also designates a DMAS staff member to serve on the committee. The committee members examine and provide input on the impact of DMAS services and programs. The purpose of the committee is to obtain the insight and recommendations of Virginia's Medicaid members in order to help the DMAS director improve the overall experience for all Virginia Medicaid applicants and members. Committee members serve for at least one year. The MAC meetings are scheduled quarterly and are open to the public and include a public comment period during each meeting.

4. MCO Comparative Information

Comparative Analysis of the MCOs by Activity

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

Compliance With Standards Monitoring

DMAS conducts Compliance with Standards Monitoring reviews using a three-year cycle. During 2019, DMAS monitored the MCOs' implementation of requirements and corrective action plans from prior years' compliance reviews.

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

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

Performance Measure Validation (PMV)

Monitoring of performance measures allows for the assessment of quality of, access to, and timeliness of the care and services provided to Medicaid members. Validation of the MCOs' performance measure rates reported to the State during the preceding 12 months is a mandatory EQR activity set forth in 42 CFR §438.358(b)(ii).

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

Each MCO contracted with an NCQA LO to conduct the HEDIS audit. HSAG reviewed the MCO's FARs, IS compliance tools, and the IDSS files approved by each MCO's LO. HSAG found that five of the six MCOs' IS and processes were compliant with the applicable IS standards; one MCO was partially complaint with IS 6.0. All MCOs were compliant with the HEDIS reporting requirements for the key Medallion 4.0 Medicaid measures for HEDIS 2019.

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

- *Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combination 3*
- *Children and Adolescents' Access to Primary Care Practitioners*
- *Prenatal and Postpartum Care*
- *Comprehensive Diabetes Care (excluding HbA1c control <7.0%)*

HSAG contracted with Aqurate for assistance with the validation of the performance measures above. Using the validation methodology and protocols described in Appendix A, HSAG determined results for each performance measure. The CMS PMV protocol identifies two possible validation finding designations for performance measures: Report (R)—measure data were compliant with HEDIS and DMAS specifications and the data were valid as reported; or Not Reported (NR)—measure data were materially biased. HSAG's validation results for each MCO are summarized in Table 4-1.

Table 4-1—MCO Validation Results

	Performance Measure	Aetna	Health-Keepers	Magellan *	Optima	United	VA Premier
1.	*Adolescent Well-Care Visits*	R	R	NA	R	R	R
2.	*Childhood Immunization Status—Combination 3*	R	R	NA	R	R	R
3	*Children and Adolescents' Access to Primary Care Practitioners*	R	R	NA	R	R	R
4.	*Prenatal and Postpartum Care*	R	R	NA	R	R	R

	Performance Measure	Aetna	Health-Keepers	Magellan *	Optima	United	VA Premier
5	*Comprehensive Diabetes Care (excluding HbA1c control <7.0%)*	R	R	NA	R	R	R

**Magellan could not report the PMV measures for Medallion 4.0 during the 2019 measurement period. Magellan began providing Medicaid managed care services in 2018; therefore, the MCO did not have performance measure data available for inclusion in this report.*
NA: Not reported, measure data were materially biased.

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

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

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

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

MCO Comparative and Statewide Aggregate HEDIS Results

Table 4-2 displays, by MCO, the HEDIS 2019 measure rate results compared to the 50th percentiles and the Virginia aggregate, which represents the average of five MCOs' measure rates weighted by the eligible population. Of note, yellow-shaded boxes indicate MCO measure rates that were at or above the 50th percentile. Rates performing better than the Virginia aggregates are represented in green font.

Table 4-2—MCO Comparative and Virginia Aggregate HEDIS 2019 Measure Results

Performance Measures	Aetna	HealthKeepers	Optima	United	VA Premier[1]	Virginia Aggregate
Children's Preventive Care						
Adolescent Well-Care Visits						

Performance Measures	Aetna	HealthKeepers	Optima	United	VA Premier[1]	Virginia Aggregate
Adolescent Well-Care Visits	43.31%	**59.85%**	44.53%	50.85%	47.69%	**51.55%**
Childhood Immunization Status[2]						
Combination 3	63.99%	**71.29%**	67.40%	60.34%	**70.32%**	**68.75%**
Well-Child Visits in the First 15 Months of Life						
Six or More Well-Child Visits	61.31%	**72.99%**	63.50%	48.42%	54.74%	**63.56%**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life						
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.05%	**78.59%**	71.29%	69.59%	**75.18%**	**74.88%**
Women's Health						
Breast Cancer Screening[2]						
Breast Cancer Screening	38.30%	48.69%	**51.67%**	**54.39%**	**51.89%**	**51.43%**
Cervical Cancer Screening						
Cervical Cancer Screening	**61.80%**	**64.89%**	**63.50%**	50.66%	44.53%	**56.36%**
Prenatal and Postpartum Care						
Timeliness of Prenatal Care	61.07%	**89.05%**	77.62%	51.09%	79.81%	**80.09%**
Postpartum Care	52.31%	**68.61%**	60.58%	50.36%	56.93%	**61.84%**
Access to Care						
Adults' Access to Preventive/Ambulatory Health Services[2]						
Total	77.80%	80.93%	79.95%	75.24%	**87.81%**	**83.70%**
Children and Adolescents' Access to Primary Care Practitioners						
12–24 Months	**96.59%**	**95.97%**	**95.88%**	91.46%	**96.09%**	**95.51%**
25 Months–6 Years	89.73%	**90.98%**	88.83%	87.22%	**90.43%**	**89.94%**
7–11 Years	**92.73%**	**93.54%**	91.32%	89.22%	**93.52%**	**92.59%**
12–19 Years	89.59%	**91.47%**	89.49%	85.82%	**92.58%**	**90.78%**
Care for Chronic Conditions						
Comprehensive Diabetes Care[2]						
Hemoglobin A1c (HbA1c) Testing	81.20%	82.48%	85.89%	85.14%	**88.32%**	**86.33%**
*HbA1c Poor Control (>9.0%)**	56.40%	**49.39%**	51.34%	56.63%	**50.85%**	**50.94%**
HbA1c Control (<8.0%)	35.60%	**45.74%**	39.42%	36.95%	40.88%	**41.47%**
Eye Exam (Retinal) Performed	44.40%	43.80%	41.85%	BR	**47.20%**	**45.48%**
Medical Attention for Nephropathy	88.00%	86.86%	84.67%	85.14%	**89.78%**	**88.15%**
Blood Pressure Control (<140/90 mm Hg)	48.80%	**62.53%**	**61.31%**	49.00%	42.82%	**50.44%**
Controlling High Blood Pressure[3]						
Controlling High Blood Pressure	46.96%	54.50%	**55.96%**	45.55%	**57.18%**	**55.61%**
Asthma Medication Ratio[2]						
Total	68.02%	**71.97%**	67.01%	**70.39%**	66.29%	**68.58%**
Medical Assistance With Smoking and Tobacco Use Cessation						
Advising Smokers and Tobacco Users to Quit	76.41%	**84.21%**	71.70%	NA	**78.24%**	**77.64%**
Discussing Cessation Medications	43.52%	**55.86%**	40.57%	NA	**54.65%**	**48.65%**
Discussing Cessation Strategies	37.63%	**46.43%**	**44.23%**	NA	**43.27%**	**42.89%**

Performance Measures	Aetna	HealthKeepers	Optima	United	VA Premier[1]	Virginia Aggregate
Behavioral Health‡						
Antidepressant Medication Management						
Effective Acute Phase Treatment	49.02%	48.99%	49.85%	**55.80%**	**59.50%**	**53.40%**
Effective Continuation Phase Treatment	32.68%	33.82%	34.49%	**37.95%**	**42.96%**	**37.51%**
Follow-Up Care for Children Prescribed ADHD Medication						
Initiation Phase	44.83%	42.99%	39.52%	42.82%	**57.28%**	**46.25%**
Continuation and Maintenance Phase	**62.35%**	57.33%	53.00%	59.70%	**71.23%**	**61.44%**
Follow-Up After Hospitalization for Mental Illness[2]						
7-Day Follow-Up—Total	**36.73%**	**37.60%**	**41.96%**	33.33%	31.80%	**35.56%**
Follow-Up After Emergency Department Visit for Alcohol and Other Drug (AOD) Abuse or Dependence						
30-Day Follow-Up—Total	14.58%	15.84%	**21.12%**	**24.74%**	12.05%	**15.85%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics						
Total	**62.90%**	60.74%	**62.50%**	59.57%	**63.25%**	**62.10%**
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*[,2]						
Total	**1.41%**	**2.30%**	**0.80%**	3.62%	3.26%	**2.53%**

** For this indicator, a lower rate indicates better performance.*
[1] VA Premier did not submit data specific to the Medallion 4.0 population for all measure rates. The HEDIS 2019 results for VA Premier include all Medicaid managed care members (i.e., Medallion 4.0 and CCC Plus). Therefore, exercise caution when comparing the results for VA Premier to other MCOs.
[2] Due to changes in the technical specifications for this measure, NCQA recommends trending between HEDIS 2019 and prior years be considered with caution.
[3] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, comparisons to benchmarks are not performed for this measure.
‡ Certain behavioral health services were provided by a third party, Magellan, during all or a portion of HEDIS 2019. As a result, caution should be exercised when making conclusions about MCO performance for measures reported in the Behavioral Health domain.
NA indicates that the MCO followed the specifications, but the denominator was too small to report a valid rate.
BR indicates that the rate was materially biased.
***Note:** MCO measure rates performing better than the Virginia aggregate are represented in green.*

Indicates that the HEDIS 2019 rate was at or above the 50th percentile.

Within the Children's Preventive Care domain, HealthKeepers displayed strong performance, exceeding the 50th percentile and Virginia aggregate for all four measures within the domain. VA Premier exceeded the 50th percentile for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and was the only other MCO to exceed the 50th percentile for any of the measures within the Children's Preventive Care domain, indicating opportunities for improvement related to well-child/well-care visits and immunizations for most MCOs.

HealthKeepers again demonstrated strength within the Women's Health domain, exceeding the 50th percentile and Virginia aggregate for three of the four (75.0 percent) measure rates. *Cervical Cancer Screening* represented an area of strength for the MCOs, with Aetna, HealthKeepers, and Optima all exceeding the 50th percentile and Virginia aggregate. Conversely, *Breast Cancer Screening* demonstrated opportunities for improvement for all MCOs, as none of the MCOs exceeded the 50th percentile. Additionally, only HealthKeepers exceeded the 50th percentile for the *Prenatal and*

Postpartum Care measure rates, demonstrating opportunities for the other MCOs to ensure women receive care during and after their pregnancies.

Within the Access to Care domain, VA Premier demonstrated the highest performance as the only MCO to exceed the 50th percentile for all five measure rates. Of note, *Children and Adolescents' Access to Primary Care Practitioners* was an area of strength for the MCOs, as four of the five MCOs exceeded the 50th percentile for three of the four *Children and Adolescents' Access to Primary Care Practitioners* measure rates, with three of the MCOs (Aetna, HealthKeepers, and VA Premier) exceeding the 50th percentile for all four measure rates. The Access to Care domain represented an area of opportunity for improvement for United, as it was the only MCO to fall below the 50th percentile for all five measure rates within this domain.

The Care for Chronic Conditions domain represented an area of opportunity for improvement for all five MCOs, as none of the MCOs exceeded the 50th percentile for more than four of the 10 measure rates that could be compared to benchmarks. MCO performance was particularly low for the *Comprehensive Diabetes Care* measure, with VA Premier only exceeding the 50th percentile for the *HbA1c Testing* rate, while no other rates for any of the MCOs within the *Comprehensive Diabetes Care* measure exceeded the 50th percentile. Conversely, *Asthma Medication Ratio* was an area of strength, as all five MCOs exceeded the 50th percentile.

MCO performance within the Behavioral Health domain was inconsistent. VA Premier demonstrated the highest performance exceeding the 50th percentile for five of the eight (62.5 percent) measure rates, including five of the six (83.3 percent) rates related to medication management for behavioral health conditions. HealthKeepers demonstrated opportunities for improvement within the Behavioral Health domain with only exceeding the 50th percentile for two of the eight (25.0 percent) measure rates. The remaining three MCOs all exceeded the 50th percentile for four of the eight (50.0 percent) measure rates. Additionally, the MCOs demonstrated strength for *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*, with four of five MCOs exceeding the 50th percentile. However, the MCOs demonstrated opportunities for improvement for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*, with only one MCO exceeding the 50th percentile.

Consumer Decision Support Tool

DMAS was one of the first states to develop a Consumer Decision Support Tool. The Consumer Decision Support Tool allows members to compare MCOs using quality and compliance information. The tool uses HEDIS and CAHPS results to inform members regarding MCO performance.

DMAS contracted with HSAG in 2019 to produce a Consumer Decision Support Tool using Virginia Medicaid MCOs' performance measure data and survey results for the Medallion 4.0 MCOs. The Medallion 4.0 Consumer Decision Support Tool demonstrates how the Virginia Medicaid MCOs compare to one another in key performance areas. The Medallion 4.0 Consumer Decision Support Tool uses stars to display results for the MCOs, as shown in Table 4-3.

Table 4-3—Consumer Decision Support Tool Results—Performance Ratings

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

Table 4-4 displays the 2019 Consumer Decision Support Tool results for each MCO. Due to Magellan being a new plan in 2018, the MCO did not have sufficient data for comparisons to other MCOs.

Table 4-4—Consumer Decision Support Tool Results—2019

MCO	Doctors' Communication	Getting Care	Keeping Kids Healthy	Living With Illness	Taking Care of Women
Aetna	★★	★★★	★★★	★★	★
HealthKeepers	★★★	★★	★★★★★	★★★★	★★★★★
Optima	★★★	★★★★★	★★★	★★★	★★★★★
United	—	★	★★	★★★	★
VA Premier[1]	★★★	★★★★	—	—	—

— Indicates that the MCO did not have sufficient data to receive a rating for this domain.

[1] VA Premier did not submit data specific to the Medallion 4.0 population for all measure rates; therefore, the MCO was not eligible to receive a rating for three domains (Keeping Kids Healthy, Living With Illness, and Taking Care of Women).

For 2019, the MCOs demonstrated similar performance within the Doctors' Communication domain, as three of four MCOs received a three-star rating for this domain. The Getting Care and Taking Care of Women domains showed large variations in performance between the MCOs for 2019, with star ratings ranging from one to five. Of note, Optima demonstrated strength when compared to the other MCOs by performing around the Virginia Medicaid average for three domains and receiving the highest star rating for the other two domains. Additionally, HealthKeepers received high star ratings (i.e., four or five stars) for three of five domains, indicating strength. Conversely, United demonstrated the lowest performance among the MCOs with three of four reportable domains receiving a low star rating (i.e., one or two stars).

Performance Measure Calculation

DMAS contracted with HSAG in 2019 to calculate the Agency for Healthcare Research and Quality's (AHRQ's) Pediatric Quality Indicator (PDI) 14: *Asthma Admission Rate* (PDI 14) to evaluate inpatient admissions for asthma for children ages 2 to 17 years for the 2018 measurement period. HSAG deviated slightly from the technical specifications to report the rate as per 100,000 MM, in alignment with the approach for reporting AHRQ's PQI measures in CMS' Core Set of Adult Health Care Quality

Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2019 Reporting. This measure is important because asthma is the leading chronic disease in children, affecting one in 13 U.S. children.[4-1] From 2008–2013, children with asthma missed an average of 2.3 days of school and incurred $1,737 in medical costs per year due to asthma. Asthma can be controlled with proper treatment, leading to a reduction in associated costs.[4-2] Table 4-5 displays the PDI 14 performance measure results calculated for the Virginia FAMIS and Medallion populations, stratified by managed care geographic region, age, gender, race, gender/race, gender/age, physician management (i.e., outpatient visit with a PCP), active asthma medications on admission by therapeutic classification, and asthma medications prescribed during admission or within 7 days of discharge by therapeutic classification. Of note, the results stratified by population (i.e., members receiving foster care services and adoption assistance) and number of readmissions are not reported due to low numerators (i.e., fewer than 11) for all rates. A lower rate indicates better performance for this measure.

Table 4-5—PDI 14: Asthma Admission Rate Measure Results*

Rate Stratifications	Results (CY 2018)
Virginia Total Rate (Admissions Per 100,000 MM)	
Virginia Total Rate	7.85
Rates by Region (Admissions Per 100,000 MM)	
Central Virginia	14.27
Far Southwest Virginia	—
Halifax	9.00
Lower Southwest Virginia	5.94
Northern Virginia	4.96
Tidewater	5.84
Upper Southwest Virginia	6.97
Rates by Age Group (Admissions Per 100,000 MM)	
2–4 Years	12.63
5–11 Years	8.19
12–17 Years	4.23
Rates by Gender (Admissions Per 100,000 MM)	
Male	9.34
Female	6.33
Rates by Race Category (Admissions Per 100,000 MM)	
White	5.06
Black/African American	12.35
Asian	—
Southeast Asian/Pacific Islander	—
Hispanic	—

[4-1] Asthma and Allergy Foundation of America. *Asthma Facts and Figures*. Available at: https://www.aafa.org/asthma-facts/. Accessed on: Oct 27, 2019.

[4-2] Annals of the American Thoracic Society. *The Economic Burden of Asthma in the United States, 2008 – 2013.* (2018). Available at: https://www.atsjournals.org/doi/abs/10.1513/AnnalsATS.201703-259OC. Accessed on: Oct 27, 2019.

Rate Stratifications	Results (CY 2018)
More than One Race/Other/Unknown	13.23
Rates by Gender and Race Category (Admissions Per 100,000 MM)	
Male	
White	5.85
Black/African American	14.86
Asian	—
Southeast Asian/Pacific Islander	—
Hispanic	—
More than One Race/Other/Unknown	—
Female	
White	4.26
Black/African American	9.85
Asian	—
Southeast Asian/Pacific Islander	—
Hispanic	0.00
More than One Race/Other/Unknown	—
Rates by Gender and Age Group (Admissions Per 100,000 MM)	
Male	
2–4 Years	15.94
5–11 Years	9.29
12–17 Years	5.04
Female	
2–4 Years	9.17
5–11 Years	7.08
12–17 Years	3.43
Rates by Physician Management	
No Visit	17.81%
Visit Within 1 Month	30.43%
Visit Within 1–3 Months	21.74%
Visit Within 3–6 Months	15.32%
Visit Within 6–12 Months	14.70%
Rates by Active Asthma Medications on Admission	
Controller	
Antiasthmatic Combinations	0.00%
Antibody Inhibitors	—
Antiinterleukin-5	0.00%
Inhaled Steroid Combinations	5.18%
Inhaled Corticosteroids	7.87%
Leukotriene Modifiers	11.59%
Methylxanthines	0.00%
Mast Cell Stabilizers	0.00%
No Medication	80.75%

Rate Stratifications	Results (CY 2018)
Any Controller	19.25%
Reliever	
Short-Acting Inhaled Beta-2 Agonists	13.04%
No Medication	86.96%
All Medications	
Any Medication	25.26%
No Medication	74.74%
Rates by Asthma Medications Prescribed During Admission and Within 7 Days of Discharge	
Controller	
Antiasthmatic Combinations	0.00%
Antibody Inhibitors	0.00%
Antiinterleukin-5	0.00%
Inhaled Steroid Combinations	10.77%
Inhaled Corticosteroids	23.81%
Leukotriene Modifiers	24.02%
Methylxanthines	0.00%
Mast Cell Stabilizers	0.00%
No Medication	55.90%
Any Controller	44.10%
Reliever	
Short-Acting Inhaled Beta-2 Agonists	37.68%
No Medication	62.32%
All Medications	
Any Medication	53.42%
No Medication	46.58%

** For this measure, a lower rate indicates better performance.*
— Indicates that the rate is not presented given the numerator included fewer than 11 cases.

The Virginia total rate of asthma admissions for CY 2018 for children ages 2 to 17 was 7.85 per 100,000 MM. Regional variation exists in the reportable rates of asthma admissions, with Central Virginia having the highest admission rate at 14.27 per 100,000 MM and Northern Virginia having the lowest admission rate at 4.96 per 100,000 MM. Rates indicated that children ages 2 to 4 years were more likely to be admitted for asthma, with admissions more prevalent among male children and children of Black/African American race when compared to other races. Of note, 74.74 percent of children did not have an active prescription upon admission (controller or reliever) and 46.58 percent of children were not prescribed a medication to manage asthma (controller or reliever) during the admission or within 7 days following discharge, indicating opportunities to increase the number of prescriptions for asthma. Additionally, 52.17 percent of children admitted for asthma had a visit with a PCP within 3 months prior to the admission; however, less than 20 percent of children were on a medication to control their asthma, demonstrating opportunities to increase preventive care for children with asthma.

MCO Comparative and Statewide Aggregate PIP Results

In 2019, DMAS required the Medallion 4.0 MCOs to conduct two PIPs. The MCOs used the rapid-cycle PIP approach to conduct the PIPs. DMAS selected the topics to address the CMS requirements related to quality outcomes in the areas of timeliness of and access to care and services. The topics for 2019 were:

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

During validation, HSAG determined if criteria for each module were *Achieved.* Any validation criteria not applicable (*N/A*) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings from modules 1 through 5 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Table 4-6 details the level of achievement for each module submitted by each MCO for both PIPs. During 2019, the MCOs achieved all the Module 1 and Module 2 validation criteria and were in the process of completing Module 3 to identify potential interventions for the PIPs.

Table 4-6—Performance Improvement Project Results

MCO	PIP Topic	PIP Module Results
Aetna	*Ensuring Timeliness of Prenatal Care*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Tobacco Use Cessation in Pregnant Women	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
HealthKeepers	*Timeliness of Prenatal Care*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Tobacco Use Cessation in Pregnant Women	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
Magellan	*Improve Timeliness of Prenatal Care*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Reduce Tobacco Use in Pregnant Women	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
Optima	*Timeliness of Prenatal Care*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Tobacco Use Cessation in Pregnant Women	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
United	*Timeliness of Prenatal Care*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Tobacco Use Cessation in Pregnant Women	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
VA Premier	*Timeliness of Prenatal Care*	Module 1: All Criteria Achieved

MCO	PIP Topic	PIP Module Results
		Module 2: All Criteria Achieved
	Tobacco Use Cessation in Pregnant Women	Module 1: All Criteria Achieved Module 2: All Criteria Achieved

Overall, the results of the MCOs' submission of PIP Module 1 and Module 2 indicated that the MCOs were able to successfully complete the Module 1 and Module 2 PIP validation requirements. MCOs should continue to follow the PIP rapid-cycle process and participate in trainings provided by the EQRO and request technical assistance as often as needed to improve the success of the PIP process. The MCOs' PIP process would benefit from ensuring:

- HSAG PIP module feedback is addressed prior to resubmission.
- Identification and testing of innovative, actionable changes.
- Continual monitoring of the outcomes and making rapid adjustments, as needed.
- All data and results are provided accurately.

Statewide Aggregate CAHPS Results

Adult Medicaid

Table 4-7 presents the 2018 and 2019 top-box scores for each MCO and the statewide aggregate adult Medicaid CAHPS scores for the global ratings and composite measures. The 2019 CAHPS scores for each MCO and the statewide aggregate were compared to the 2018 NCQA national adult Medicaid averages.

Table 4-7—Comparison of 2018 and 2019 Adult Medicaid CAHPS Results

	Aetna		HealthKeepers		Optima		United		VA Premier		Statewide Aggregate	
	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019
Global Ratings												
Rating of Health Plan	60.2%	60.1%	63.8%	64.9%	62.0%	65.0%	–	47.2%+	59.6%	63.1%	62.3%	63.0%
Rating of All Health Care	54.9%	47.2%	62.4%	54.5%	52.6%	63.1%+	–	42.3%+	44.5%	54.2%	56.0%	54.9%
Rating of Personal Doctor	68.7%	63.7%	73.3%	63.2%	65.1%	68.2%+	–	59.6%+	65.5%	66.9%	69.6%	65.6%
Rating of Specialist Seen Most Often	58.2%+	63.6%	69.7%	62.3%+	63.2%+	57.8%+	–	82.4%+	59.4%+	72.4%	65.3%	67.0%

	Aetna		HealthKeepers		Optima		United		VA Premier		Statewide Aggregate	
Composite Measures												
Getting Needed Care	86.4%	80.8%	86.5%	84.0%+	81.4%	86.8%+	–	81.7%+	82.8%	88.0%	84.7%	85.9%
Getting Care Quickly	86.4%+	79.9%	84.5%	80.5%+	81.2%	85.7%+	–	75.9%+	83.9%	89.1%	83.8%	84.9%
How Well Doctors Communicate	90.7%	92.3%	94.2%	92.2%+	90.7	93.6%+	–	86.9%+	89.3%	93.0%	92.2%	92.5%
Customer Service	89.0%+	81.9%	83.2%	88.1%+	91.4%+	91.2%+	–	86.6%+	87.8%+	90.3%	86.3%	89.2%
Shared Decision Making	81.3%+	80.7%	80.0%	84.2%+	72.0%+	78.9%+	–	77.8%+	79.3%+	77.3%	78.3%	79.8%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
A dash (–) indicates there were no data available.
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2018 NCQA Medicaid national averages.

Overall, the top-box score for one measure, *Getting Needed Care*, for all MCOs (i.e., the statewide aggregate) was statistically significantly higher than the 2018 NCQA Medicaid national average. Aetna and United were the only MCOs that had measures that were statistically significantly lower than the 2018 NCQA Medicaid national averages. VA Premier had two measures that were statistically significantly higher than the 2018 NCQA Medicaid national averages.

Child Medicaid

Table 4-8 presents the 2018 and 2019 top-box scores for each MCO and the statewide aggregate child Medicaid CAHPS scores for the global ratings and composite measures. The 2019 CAHPS scores for each MCO and the statewide aggregate were compared to the 2018 NCQA national child Medicaid averages.

Table 4-8—Comparison of 2018 and 2019 Child Medicaid CAHPS Results

	Aetna		HealthKeepers		Optima		United		VA Premier		Statewide Aggregate	
	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019
Global Ratings												
Rating of Health Plan	70.1%	72.3%	73.9%	80.1%	77.9%	79.1%	–	66.9%	69.8%	77.8%	73.5%	77.6%
Rating of All Health Care	69.6%	66.8%	67.9%	75.9%	74.7%	70.6%	–	67.6%	69.5%	77.8%	70.1%	73.8%
Rating of Personal Doctor	76.5%	76.2%	74.3%	81.7%	78.3%	82.6%	–	75.0%	81.3%	79.8%	77.2%	80.5%
Rating of Specialist Seen Most Often	67.6%+	75.8%	67.1%+	78.3%+	79.7%+	73.5%+	–	60.9%+	78.1%	79.5%+	73.0%	75.7%
Composite Measures												
Getting Needed Care	88.9%+	90.7%	83.5%	83.5%	89.2%	92.5%	–	77.0%+	88.2%	88.2%	86.4%	86.5%
Getting Care Quickly	94.3%	89.8%	85.2	87.0%	90.7%	93.1%	–	82.6%+	93.4%	93.9%	89.2%	89.8%
How Well Doctors Communicate	96.9%	94.8%	92.3%	91.7%	94.8%	96.3%	–	91.2%+	97.3%	95.8%	94.5%	93.9%
Customer Service	85.0%+	90.4%	83.8%	85.9%+	82.7%+	91.7%+	–	77.3%+	88.4%	93.5%+	84.8%	88.5%
Shared Decision Making	76.1%+	79.1%	81.5%+	81.3%+	79.1%+	79.4%+		71.9%+	81.3%	77.2%+	80.6%	78.8%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
A dash (–) indicates there were no data available.
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2018 NCQA Medicaid national averages.

Overall, the top-box scores for three measures, *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*, for all MCOs (i.e., the statewide aggregate) was statistically significantly higher than the 2018 NCQA Medicaid national averages. Aetna, HealthKeepers, Optima, and VA Premier had at least one measure that was statistically significantly higher than the 2018 NCQA Medicaid national average, while United had one measure that was statistically significantly lower than the 2018 NCQA Medicaid national average.

Performance Incentive Award

From SFY 2016 through SFY 2018, DMAS implemented a PIA program for the Medallion MCOs to assess managed care quality. MCO performance was evaluated using benchmarks and thresholds for various HEDIS measures and measures developed by Virginia and compared the relative level of performance against the performance of the other MCOs. The PIA program was designed to be budget neutral (i.e., the total MCO awards were equal to the total MCO penalties). Beginning SFY 2020, DMAS transitioned to a PWP to evaluate the quality of care received by Medicaid managed care members. For the PWP, MCO performance is evaluated on various process and outcome measures that are compared to performance standards set by DMAS. DMAS retains a 1 percent quality withhold from each MCO, and MCOs are eligible to earn back all or a portion of their respective quality withhold based on their performance.

Performance Withhold Program

During 2019, DMAS established the PWP for the Medallion 4.0 MCOs to reinforce value-based payment (VBP) principles by connecting financial incentives to the quality of care received by Virginia Medicaid managed care members. The PWP was developed to allow a pay-for-reporting and baseline period in order for the MCOs to assess current performance levels. For the Medallion 4.0 MCOs, the PWP pay-for-reporting and baseline period is SFY 2020 and will transition to pay-for-performance in SFY 2021. Annually, DMAS retains a quality withhold from each MCO that is equal to 1 percent of each MCO's total capitation amount (i.e., the per member per month capitation rate multiplied by the total monthly membership). By successfully meeting or exceeding the performance standards and expectations developed by DMAS, MCOs are eligible to earn back all or a portion of their quality withhold. DMAS established the performance thresholds to foster high performance and continuous improvement from the MCOs.

DMAS chose process and outcome performance measures that align with the goals of the Medallion 4.0 program and the characteristics of the population. PWP performance is evaluated on measures from the following organizations:

- National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS)
- Centers for Medicare & Medicaid Services' (CMS') Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)
- Agency for Healthcare Research and Quality's (AHRQ's) Pediatric Quality Indicators (PDIs)

The percentage of the quality withhold that MCOs are eligible to earn back is based on MCO performance for the applicable performance period and/or improvement on each of the measures, and the amount of quality withhold is contingent upon the annual total capitation payments for the MCO.

Focused Studies

DMAS selected the following clinical topics for the 2019 contract year: improving birth outcomes through adequate prenatal care (Birth Outcomes Focused Study), Perinatal Dental Utilization, and improving the health of children in foster care (Foster Care Focused Study).

Improving Birth Outcomes Through Adequate Prenatal Care

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

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

The Birth Outcomes Focused Study included five study indicators for births occurring during the 2016 and 2017 calendars years (i.e., MYs: percentage of births with early and adequate prenatal care, percentage of births by gestational estimate, percentage of newborns with low birth weight, percentage of newborns receiving at least two visits with a PCP in the 30 days following birth, and percentage of newborns who had at least one ED visit in the 30 days following birth). As in prior years, the study used deterministic and probabilistic data linking to match eligible Virginia Medicaid or FAMIS MOMS recipients with birth registry records to identify births paid by Virginia Medicaid during MYs 2016 or 2017. The study population included women continuously enrolled in the Medicaid for Pregnant Women (MPW), FAMIS MOMS (FM), or an "Other Medicaid" [4-3] (OM) program for a minimum of 43 days prior to and including the date of delivery. The comparison group included women covered by one of the three Medicaid program groups on the date of delivery but without prior continuous enrollment.

Table 4-9 presents study indicator results by population group within each measurement period, as well as whether each indicator's results were statistically significantly different between the study population and comparison group within each measurement period.

Table 4-9—Overall Study Findings by Indicator and Population Group Among Singleton Births, MYs 2016 and 2017

Study Indicator	2017 National Benchmark[1]	Study Population		Comparison Group		Statistically Significant Difference (Yes/No)
		n	%	n	%	
MY 2016						
Births With Early and Adequate Prenatal Care	77.6%	19,685	74.4	3,075	66.6	Yes
Preterm Births (< 37 Weeks Gestation)*	8.1%	2,491	9.2	514	10.9	Yes

[4-3] The "Other Medicaid" category includes births paid by Medicaid that do not fall within the FAMIS MOMS or the Medicaid for Pregnant Women programs (i.e., the pregnancy aid categories). Births among the OM programs may also include women with Medicaid coverage for emergency services only.

Study Indicator	2017 National Benchmark[1]	Study Population		Comparison Group		Statistically Significant Difference (Yes/No)
		n	%	n	%	
Newborns With Low Birth Weight (< 2,500g)*	6.6%	2,366	8.7	442	9.4	No
Newborns With ≥ 2 PCP Visits in the 30 Days Following Birth	N/A	11,784	44.1	2,223	47.2	Yes
Newborns With ≥ 1 ED Visit in the 30 Days Following Birth*	N/A	2,257	8.4	358	7.6	No
MY 2017						
Births With Early and Adequate Prenatal Care	77.6%	18,958	73.7	2,895	65.1	Yes
Preterm Births (< 37 Weeks Gestation)*	8.1%	2,364	8.9	528	11.5	Yes
Newborns With Low Birth Weight (< 2,500g)*	6.6%	2,334	8.8	439	9.5	No
Newborns With ≥ 2 PCP Visits in the 30 Days Following Birth	N/A	11,977	45.8	2,216	48.4	Yes
Newborns With ≥ 1 ED Visit in the 30 Days Following Birth*	N/A	2,263	8.6	361	7.9	No

[1] The national benchmark for *Births With Early and Adequate Prenatal Care* is the Healthy People 2020 goal. The national benchmarks for *Preterm Births* and *Newborns With Low Birth Weight (< 2,500g)* were identified from CY 2017 national data available from the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS)[4-4] final data for 2017. Due to the study-specific nature of the remaining indicators, national benchmarks are not available for comparison.
* For this indicator, a lower rate indicates better performance.

Results of the Birth Outcomes Focused Study found that births to women in the study population fared better than those in the comparison group for the following indicators: *Births With Early and Adequate Prenatal Care*, *Preterm Births*, *Newborns With Low Birth Weight (< 2,500g)*, and *Newborns With ≥ 1 ED Visit in the 30 Days Following Birth*. Births in the comparison group outperformed the study population for the indicator *Newborns With ≥ 2 PCP Visits in the 30 Days Following Birth*; that is, a greater percentage of children born to mothers in the comparison group had two or more visits with a PCP-type provider in the 30 days following birth compared to children born to mothers in the study population. In MY 2017, results differences between the study population and comparison group were statistically significant for all indicators except *Newborns With Low Birth Weight (< 2,500g)* and *Newborns With ≥ 1 ED Visit in the 30 Days Following Birth*.

During 2019, HSAG also initiated the fourth annual Birth Outcomes Focused Study, covering births occurring during MY 2018 and using a methodology similar to prior studies. Results from this study are scheduled to be released in 2020.

[4-4] Martin JA, Hamilton BE, Osterman MJK, et al. Births: Final data for 2017. *National Vital Statistics Reports*. 2018; 67(8). Hyattsville, MD: National Center for Health Statistics. 2018. Available at: https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_08-508.pdf.

Dental Utilization in Pregnant Women Data Brief

As a supplement to the Birth Outcomes Focused Study, DMAS contracted HSAG to provide annual data briefs on dental utilization 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. This focused study is designed to provide quantitative information supporting DMAS' implementation of effective strategies to improve prenatal care and birth outcomes among Medicaid and FAMIS members receiving dental services.

During 2019, HSAG completed a Dental Utilization in Pregnant Women Data Brief that reflected all women with deliveries from January 1, 2018, through December 31, 2018 (i.e., MY 2018). Since women younger than 21 years of age are eligible for dental services under a separate benefit, this assessment was limited to deliveries among women 21 years of age and older at the time of the dental service during the perinatal period (i.e., 280 days prior to the date of delivery through the end of the month following the 60th day after delivery).

Table 4-10 presents the number and percentage of MY 2018 deliveries among women who received perinatal dental services.

Table 4-10—MY 2018 Perinatal Dental Utilization by Dental Service Category

Measure	MY 2018 Count of Deliveries	MY 2018 Percent of Deliveries Among Study Population (n=31,952)	MY 2018 Percent of Deliveries Among Women With Any Perinatal Dental Service (n=6,125)
Any Dental Service*	**6,125**	**19.2**	**100.0**
Adjunctive General Services	1,052	3.3	17.2
Crowns	1,151	3.6	18.8
Diagnostic Services	5,898	18.5	96.3
Endodontics	2,218	6.9	36.2
Periodontics	1,298	4.1	21.2
Preventive Services	3,029	9.5	49.5
Prosthodontics	194	0.6	3.2
Restorative Services, Including Crowns	3,392	10.6	55.4
Surgery or Extractions	1,994	6.2	32.6

* A woman may have had more than one dental service during the perinatal period; therefore, the count of deliveries for each dental service category does not sum to the overall number of deliveries among women with any dental service.

The MY 2018 study results indicated that only 19.2 percent of deliveries were to women who received perinatal dental services covered by DMAS. More women received dental services during the prenatal period than during the postpartum period, and 29.3 percent of deliveries occurred among women who received dental services during both the prenatal and postpartum periods.

Results of the study also identified regional differences in perinatal dental utilization. Table 4-11 presents the number and percentage of deliveries among all women in the study population who received perinatal dental services by the women's Medallion 4.0 region of residence.

Table 4-11—MY 2018 Dental Utilization by Region of Residence

Region of Residence	MY 2018 Count of Deliveries	MY 2018 Deliveries Among Women Receiving Perinatal Dental Services		MY 2018 Deliveries Among Women Receiving Preventive Perinatal Dental Services	
		#	%	#	%*
Central	7,752	1,676	21.6	851	50.8
Charlottesville/Western	3,745	640	17.1	266	41.6
Northern/Winchester	9,110	1,643	18.0	951	57.9
Roanoke/Alleghany	2,793	469	16.8	201	42.9
Southwest	1,546	347	22.4	194	55.9
Tidewater	7,004	1,349	19.3	565	41.9
No Region Listed	2	1	50.0	1	100.0
Total	**31,952**	**6,125**	**19.2**	**3,029**	**49.5**

*As a percentage of deliveries among women who received any perinatal dental service(s).

While the VA Smiles For Children program provides pregnant women with a critically important opportunity to receive dental services, relatively few eligible women received prenatal and/or postpartum dental services.

During MY 2018, overall dental utilization among pregnant women and receipt of preventive dental services varied by age, and study findings identified that more women received dental services during the prenatal period than during the postpartum period. Utilization of dental services also varied by region, with the Roanoke/Alleghany region having the lowest percentage of women receiving perinatal dental services. Women may have received services from providers located outside their region of residence or not covered by DMAS (e.g., maternal and child health home visiting initiatives[4-5]); however, the regional distribution of perinatal dental utilization may be indicative of women's access to dental providers.

Foster Care Focused Study

During 2019, HSAG also initiated the fourth Foster Care Focused Study, designed to determine the extent to which children in foster care received the expected preventive and therapeutic medical care under managed care service delivery compared to similar children not in foster care. Results from this study are scheduled to be released in 2020 and will include measures in the *Primary Care*, *Oral Health*, *Behavioral Health*, *Reproductive Health*, and *Respiratory Health* domains.

[4-5] Virginia's Experience: Improving Oral Health Outcomes for Pregnant Women and Infants. Association of State & Territorial Dental Directors. Available at: https://www.astdd.org/bestpractices/DES53007VAhomevisiting-2019.pdf. Accessed on Sept 10, 2019.

5. Compliance With Standards

Activity-Specific Findings—Compliance With Standards Monitoring

During 2019, HSAG did not conduct MCO compliance review activities for the Medallion 4.0 program. During 2019, DMAS monitored the MCOs' implementation of federal and State requirements and corrective action plans from prior years' compliance reviews.

Activity-Specific Findings—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 quality improvement made by HSAG during the previous year. The methodology for each activity can be found in Appendix A—Technical Methods of Data Collection and Analysis—MCOs.

Objectives

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

DMAS assigns the performance measures to the following domains of quality, access, and timeliness (Table 6-1):

Table 6-1—Medallion 4.0 Assignment of Performance Measures to the Quality of, Access to, and Timeliness of Care Domains

Performance Measure	Quality	Access	Timeliness
Children's Preventive Care			
Adolescent Well-Care Visits	✓		
Childhood Immunization Status—Combination 3	✓		
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	✓		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		

Performance Measure	Quality	Access	Timeliness
Women's Health			
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services—Total		✓	
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, *25 Months–6 Years*, *7–11 Years*, and *12–19 Years*		✓	
Care for Chronic Conditions			
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, *Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*	✓		
Controlling High Blood Pressure	✓		
Medication Management for People With Asthma—Medication Compliance 75%—Total	✓		
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*	✓		
Behavioral Health			
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	✓	✓	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	✓		

Validation of Performance Measures

Aetna

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

Additionally, based on HSAG's validation of performance measures, HSAG had no concerns with Aetna's data processing, integration, and measure production. HSAG determined that Aetna followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

As HEDIS 2019 was the first year of reporting performance measures for the Medallion 4.0 MCOs, trending of performance to historical rates was not conducted. Please refer to Section 4 for more information on current year performance measure results for Aetna.

Strengths

The following HEDIS 2019 measure rate was determined to be a strength for Aetna (i.e., ranked at or above the 75th percentile):

- *Asthma Medication Ratio—Total*

Recommendations for Improvement

HSAG recommends that Aetna work closely with Athena and Aetna's HEDIS auditor to ensure the source of each record in the supplemental data is clearly identified so Aetna can ensure this data source is compliant with audit guidelines.

The following HEDIS 2019 measure rates were determined to be opportunities for improvement for Aetna (i.e., fell below the 25th percentile):

- *Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combination 3*
- *Breast Cancer Screening*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, *Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications* and *Discussing Cessation Strategies*
- *Antidepressant Medication Management—Effective Continuation Phase Treatment*

Assessment of Follow-Up on Prior Recommendations

As CY 2019 was the first year the performance measure review activity was completed for the MCO, there were no prior recommendations.

HealthKeepers

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

Additionally, based on HSAG's validation of performance measures, HSAG had no concerns with HealthKeepers' data processing, integration, and measure production. HSAG determined that HealthKeepers followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

As HEDIS 2019 was the first year of reporting performance measures for the Medallion 4.0 MCOs, trending of performance to historical rates was not conducted. Please refer to Section 4 for more information on current year performance measure results for HealthKeepers.

Strengths

The following HEDIS 2019 measure rates were determined to be strengths for HealthKeepers (i.e., ranked at or above the 75th percentile):

- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* and *7–11 Years*
- *Asthma Medication Ratio—Total*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*

Recommendations for Improvement

HSAG recommends that HealthKeepers work closely with Care Evolution and HealthKeepers' HEDIS auditor to ensure the source of each record in the supplemental data set is clearly identified so HealthKeepers can ensure this data source is compliant with audit guidelines.

The following HEDIS 2019 measure rates were determined to be opportunities for improvement for HealthKeepers (i.e., fell below the 25th percentile):

- *Breast Cancer Screening*
- *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *Eye Exam (Retinal) Performed*, and *Medical Attention for Nephropathy*

Assessment of Follow-Up on Prior Recommendations

As CY 2019 was the first year the performance measure review activity was completed for the MCO, there were no prior recommendations.

Magellan

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

Additionally, based on HSAG's validation of performance measures, HSAG had no concerns with Magellan's data processing, integration, and measure production. Since Medallion 4.0 was implemented in August 2018, Medallion 4.0 members did not meet continuous enrollment criteria for the measures that were included in PMV reporting; therefore, Magellan could not report the 2018 PMV measures for Medallion 4.0.

Magellan began as a Virginia Medicaid MCO for the Medallion 4.0 program on July 1, 2018. Therefore, Magellan's first year of reporting performance measures, including the HEDIS measures, will be reporting year 2020.

Recommendations for Improvement

HSAG recommends that, for future reporting, Magellan review and revise the provider specialty mapping to ensure the mappings are compliant with NCQA guidelines.

Assessment of Follow-Up on Prior Recommendations

As CY 2019 was the first year the performance measure review activity was completed for the MCO, there were no prior recommendations.

Optima

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

Additionally, based on HSAG's validation of performance measures, HSAG had no concerns with Optima's data processing, integration, and measure production. HSAG determined that Optima followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

As HEDIS 2019 was the first year of reporting performance measures for the Medallion 4.0 MCOs, trending of performance to historical rates was not conducted. Please refer to Section 4 for more information on current year performance measure results for Optima.

Strengths

The following HEDIS 2019 measure rate was determined to be a strength for Optima (i.e., ranked at or above the 75th percentile):

- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*

Recommendations for Improvement

Optima should continue to ensure that provider data mapping meets HEDIS technical specifications.

The following HEDIS 2019 measure rates were determined to be opportunities for improvement for Optima (i.e., fell below the 25th percentile):

- *Adolescent Well-Care Visits*
- *Breast Cancer Screening*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Medical Attention for Nephropathy*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications*

Assessment of Follow-Up on Prior Recommendations

As CY 2019 was the first year the performance measure review activity was completed for the MCO, there were no prior recommendations.

United

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

Additionally, based on HSAG's validation of performance measures, HSAG had no concerns with United's data processing, integration, and measure production. HSAG determined that United followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

As HEDIS 2019 was the first year of reporting performance measures for the Medallion 4.0 MCOs, trending of performance to historical rates was not conducted. Please refer to Section 4 for more information on current year performance measure results for United.

Strengths

The following HEDIS 2019 measure rates were determined to be strengths for United (i.e., ranked at or above the 75th percentile):

- *Asthma Medication Ratio—Total*
- *Follow-Up After Emergency Department Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total*

Recommendations for Improvement

HSAG recommends that United work closely with vendors and their HEDIS auditor to ensure the data sources are compliant with audit guidelines to be considered as standard supplemental data sources.

The following HEDIS 2019 measure rates were determined to be opportunities for improvement for United (i.e., fell below the 25th percentile):

- *Childhood Immunization Status—Combination 3*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Cervical Cancer Screening*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*
- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*

Assessment of Follow-Up on Prior Recommendations

As CY 2019 was the first year the performance measure review activity was completed for the MCO, there were no prior recommendations.

VA Premier

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

Additionally, based on HSAG's validation of performance measures, HSAG had no concerns with VA Premier's data processing, integration, and measure production. HSAG determined that VA Premier followed the measure specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

As HEDIS 2019 was the first year of reporting performance measures for the Medallion 4.0 MCOs, trending of performance to historical rates was not conducted. Please refer to Section 4 for more information on current year performance measure results for VA Premier.

Strengths

HSAG PMV auditors indicated that VA Premier's measure data were compliant with HEDIS and DMAS specifications and that the data, as reported, were valid. VA Premier systems appear to support accurate performance measure production.

The following HEDIS 2019 measure rates were determined to be strengths for VA Premier (i.e., ranked at or above the 75th percentile):

- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years*
- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*

Recommendations for Improvement

The following HEDIS 2019 measure rates were determined to be opportunities for improvement for VA Premier (i.e., fell below the 25th percentile):

- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Cervical Cancer Screening*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*

Assessment of Follow-Up on Prior Recommendations

As CY 2019 was the first year the performance measure review activity was completed for the MCO, there were no prior recommendations.

Conclusions and Recommendations

Follow-Up to Prior EQR Recommendations

Aetna

Table 6-2—PMV—Prior Recommendations and Aetna's Response

	Prior Recommendations (CY 2019)	Aetna's Response to Recommendations
HSAG recommended that Aetna focus QI efforts on the following HEDIS recommendations.		
1	Given that Aetna is performing above the national Medicaid 50th percentile for *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*, this may provide an opportunity to ensure that no opportunities are missed to work with PCPs to ensure provision and documentation of comprehensive services during these visits. HSAG recommends that Aetna work with PCPs to ensure that children's health visits provide opportunities for children to receive recommended immunizations timely and for developmental screenings to be completed.	Aetna completed various QI efforts, including: • Sending monthly EPSDT mailers to members. • Revising its Back to School campaign, encouraging well-child visits before the start of each new school year. • Ensuring the correct and most recent version of the recommended child and adolescent immunization schedule is readily available on Aetna's website.
2	Aetna's rate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* has continued to decline since 2016. Aetna should develop and implement quality initiatives focused on ensuring that members are informed about and using prenatal care as well as participating in their postpartum care visits. Prenatal and postpartum care work in some state Medicaid programs provides opportunities to partner with obstetrical practices to conduct reminder calls the day before scheduled appointments, to assist with ensuring that transportation is arranged for appointments by completing warm transfers to transportation vendors, and to provide additional educational opportunities such as parenting classes.	Aetna completed various QI efforts, including: • Incentivizing Maternity Incentive program pregnant members to complete all prenatal appointments. Specifically, eligible members can receive one gift card for every six prenatal visits completed and up to four gift cards in total. • Implementing in 2019 the Maternity Notification and Risk Screening program. • Mailing the plan-published *Let's Go Baby Book* with the Maternity Incentive pamphlet and educating pregnant members and new moms on health plan benefits. • Conducting the Text4Baby program to send new mothers and pregnant members free text messages weekly to help them through their pregnancy and their baby's first year.
3	Aetna should review the declines in medication management performance to ensure that providers are appropriately	Aetna completed various QI efforts, including:

	Prior Recommendations (CY 2019)	Aetna's Response to Recommendations
	monitoring members on long-term medications. Aetna should focus efforts on medications used for chronic diseases such as asthma, depression, and ADHD. Lessons learned should be applied toward overall medication management for members. HSAG's work with other states has identified best practices in medication management such as working with PCPs or health home providers to ensure that medication refills are completed. Medicaid MCOs in some states utilize their internal pharmacy departments to conduct follow-up on medication refills, outreach to review medications upon member discharge from an inpatient stay or an emergency department visit and reconcile medications for the elderly or members with comorbid conditions requiring multiple prescriptions.	• Working with its pharmacy benefit manager, CVS, to target 11 prevalent and costly conditions and promote optimal adherence by alerting prescribing providers when members are non-adherent in therapy. • Targeting six chronic conditions that are best managed with combination therapy. CVS provides physicians with timely alerts to ensure members are on all necessary medications per evidence-based recommendations. • Through CVS, offering a free adherence outreach program to notify providers when members do not fill medications for depression as prescribed. • Implementing an Asthma Medication Ratio (AMR) initiative with a three-pronged approach to improve asthma health outcomes. Specific activities include CVS outreaching to members.
HSAG recommended that Aetna focus QI efforts on the following PMV recommendations.		
4	Aetna should continue to build quality checks into existing processes to ensure that the foster care assessment (FCA) data reported to DMAS are accurate and complete and include the Analytics and Informatics Team in this process. Aetna should develop an interrater reliability process to ensure that foster care assessment data reported to DMAS are accurate and complete. Training programs should be developed and implemented when issues are identified related to accuracy or completeness of data.	Aetna completed various QI efforts, including: • Reviewing the logic behind the reporting when completed assessments were not all captured appropriately. • Implementing extra quality checks to ensure accurate reporting to DMAS.
5	Aetna should ensure following measure specifications related to completing assessments within 60 days. Aetna should develop a quality review process or interrater reliability process to ensure accuracy and completeness of assessments and resulting data.	Aetna completed various QI efforts, including: • Reviewing and revising the logic behind the reporting to implement extra quality checks to ensure accurate reporting to DMAS.
6	Aetna should continue efforts and allocate resources to complete the assessments as early as possible because of the challenges associated with completing assessments within the required time frame. Aetna should review its staffing structure to ensure that	Aetna completed various QI efforts, including: • Conducting an in-depth review of allocated resources across the entire health plan in 2019 to identify additional needs and adjusting staffing based on that review.

	Prior Recommendations (CY 2019)	Aetna's Response to Recommendations
	adequate staffing levels are maintained to meet the required time frames for completing assessments.	
7	For 2019, Federally Qualified Health Center (FQHC) mapping to PCP type criteria will change; so, Aetna is encouraged to review the updated criteria and work with its auditor to be prepared to comply with the more stringent requirements for such mapping. Aetna should maintain documentation that demonstrates the changes made to ensure that the FQHC PCP mapping process was tested and accurately completed.	Aetna completed various QI efforts, including: • Working with DMAS and Cenevia Health Business Services (formerly Community Care Network of Virginia) to identify all FQHC providers and load them into QNXT.

Anthem

Table 6-3—PMV—Prior Recommendations and Anthem's Response

	Prior Recommendations (CY 2019)	Anthem's Response to Recommendations
HSAG recommended that Anthem focus QI efforts on the following HEDIS recommendations.		
1	Anthem's Childhood Immunization Status—Combination 3 three-year trend performance inconsistencies and the 18 percentage-point decline suggest that Anthem should identify ways to examine childhood immunization rates and consider the alignment with the Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits rate closely to determine the causal relationships. Potential circumstances that can affect immunization rates are timing and frequency of visits to providers and the providers' ability to identify gaps in care, also referred to as "missed opportunities." If care gaps can be reported at a provider level, HSAG recommends that Anthem use the opportunity to target education and outreach to PCPs who need additional support. The Virginia Department of Health supports the Assessment Feedback Incentive Exchange (AFIX) program[6-1] to increase vaccination of	Anthem completed various QI efforts, including: • Analyzing HEDIS measure rates against national benchmarks and State performance goals to identify opportunities to improve clinical care and service. • Focusing on an outreach program to include preventive health reminder mailings, overdue service reminder postcards, welcome calls, and more. • Engaging members and providers in Anthem's Clinic Day program in improving access to care and patient compliance. A Clinic Day event is when a provider agrees to hold open appointments for particular health services for Anthem members over the course of one or more days. • Distributing Gap in Care reports to providers to educate them on missed opportunities to complete services. • Incorporating the AFIX program to increase vaccination of children and adolescents by reducing missed opportunities to vaccinate and by improving delivery practices at the provider level.

[6-1] The Virginia Department of Health—Division of Immunization. Assessment Feedback Incentive Exchange. Available at: http://www.vdh.virginia.gov/immunization/afix/. Accessed on: Feb 15, 2018.

	Prior Recommendations (CY 2019)	Anthem's Response to Recommendations
	children and adolescents by reducing missed opportunities to vaccinate and by improving delivery practices at the provider level. HSAG recommends that Anthem consider leveraging these resources for educating providers to look for missed opportunities to complete EPSDT services and immunizations.	
2	Anthem's performance for *Prenatal and Postpartum Care—Postpartum Care* indicates an opportunity for improvement. The measure rate for *Prenatal and Postpartum Care—Postpartum Care* declined by more than 7 percentage points from HEDIS 2017 to HEDIS 2018, falling below the national Medicaid 50th percentile. HSAG recommends that Anthem use performance improvement processes to develop interventions to reverse the trend in rates and to improve prenatal and postpartum care and service delivery. HSAG recommends that Aetna develop and implement quality initiatives focused on ensuring that members are informed and using prenatal care as well as participating in postpartum care visits. Prenatal and postpartum care work in some state Medicaid programs provide opportunities to partner with obstetrical practices to: conduct reminder calls the day before scheduled appointments, assist with ensuring that transportation is arranged for appointments by completing warm transfers to the transportation vendors, and provide additional educational opportunities such as parenting classes.	Anthem completed various QI efforts, including: • Implementing a maternal and child health program known as New Baby New Life. The program supports pregnant members during the prenatal and postpartum period and newborn members up to 90 days after discharge, including those hospitalized and discharged from the NICU. Mothers of newborns are supported and encouraged to complete well-child checks through the first year of life. • Developing associates called OB provider practice consultants to serve as a positive clinical liaison between the VA OB providers and Anthem. The consultant works closely with the providers to: – Improve clinical quality indicators. – Improve member maternity outcomes. – Improve access to prenatal and postpartum care and education. – Improve efficient and appropriate utilization of benefits. – Offer education.
3	Anthem's performance in *Comprehensive Diabetes Care* indicates an opportunity for improvement. Anthem's performance for four of the five *Comprehensive Diabetes Care* indicators declined slightly, and rates for three indicators (*HbA1c Testing*, *Eye Exam [Retinal] Performed*, and *Medical Attention for Nephropathy*) fell below the national Medicaid 50th percentile. HSAG recommends that, for persons diagnosed with	Anthem completed various QI efforts, including: • Offering Anthem's Clinic Day program to engage members and providers in improving access to care and patient compliance. • Conducting reminder calls prior to scheduled appointments and assisting with transportation. • Encouraging sharing of best practices from high-performing providers to other providers in the network.

	Prior Recommendations (CY 2019)	Anthem's Response to Recommendations
	diabetes, Anthem focus interventions on improving the rate at which members receive recommended care and services. HSAG recommends that Anthem consider identifying PCPs with strong diabetes outcomes and encourage members to utilize these providers as their medical homes. Anthem has opportunity to learn from high-performing providers best practices which may be shared with other providers treating individuals diagnosed with diabetes.	
4	Five of the six (approximately 83 percent) measure rates related to prescription medications (Medication Management for People With Asthma; Antidepressant Medication Management; Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase; and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics) remained at or fell below the national Medicaid 50th percentiles. HSAG recommends that quality improvement efforts be focused on ensuring that members are monitored appropriately and remain on long-term medications as prescribed. HSAG recommends that Anthem review the declines in medication management performance to ensure that providers are appropriately monitoring members on long-term medications. HSAG recommends that Anthem focus efforts on medications for chronic diseases such as asthma, depression, and ADHD. Lessons learned should be applied toward the overall medication management of members. HSAG's work with other states has identified best practices in medication management such as working with PCPs or health home providers to ensure that medication refills are completed. Medicaid MCOs in some states utilize their internal pharmacy department successfully to conduct follow-up on medication refills, outreach to review medications upon member discharge from an inpatient stay or an emergency department visit, and reconcile	Anthem completed various QI efforts, including: • Administering numerous retrospective pharmacy programs to address medication management, including asthma, depression, and attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD). • Providing telephonic outreach to members to address adherence and new start education. • Using pharmacy technicians to place outbound calls to members to address the importance of being adherent, the difference between a rescue inhaler and a long-term control medication, and adherence barriers. • Having pharmacists place outbound calls to members (caregivers) under 18 years of age who have recently started on an asthma control medication and have been newly diagnosed with persistent asthma.

	Prior Recommendations (CY 2019)	Anthem's Response to Recommendations
	medications for the elderly or members with comorbid conditions requiring multiple prescriptions.	
4	HSAG recommends that Anthem implement processes to limit quantity prescribed for new ADHD prescriptions and conduct outreach to the member's family or caregivers to educate them on the need for continued use and benefits of the prescribed medication. Members should be encouraged to seek and receive assistance in scheduling follow-up care to renew the prescriptions.	Anthem completed various QI efforts, including: • Addressing adherence and new start education (adults and children within Anthem's behavioral health medication management programs). • Conducting prescriber outreach initially by fax with follow-up outbound calls to providers. • Targeting members using medications for these disease states, as well as members with multiple prescribers and multiple medications in the same class. • Encouraging member follow-up with the prescribing physician 30 days after being prescribed a new ADD/ADHD medication.
5	HSAG continues to recommend that Anthem leverage its pharmacy benefit manager (PBM)'s educational tools and resources to support member adherence with antidepressant medications.	Anthem agrees with HSAG's recommendations and has shared with the pharmacy team.
HSAG recommended that Anthem focus QI efforts on the following PMV recommendations.		
6	Anthem should continue to monitor claims inventory reports closely to ensure that reporting requirements are met.	Anthem completed various QI efforts, including: • Sharing the reports with the department responsible for claims monitoring.
7	Anthem should continue to monitor eligibility requirements for its foster care population closely and perform some double checks as needed before reporting, to ensure accuracy. Further, Anthem should establish interrater reliability processes to ensure accuracy in reporting.	Anthem completed various QI efforts, including: • Reviewing the eligibility history in the care management system to ensure that current members, including members that change aid category, are included in outreach attempts. • Assigning new members to a care coordinator for outreach. • Conducting monthly SWAT meetings to review the outreach report findings compared to the assessment detail report. • Manually reviewing the care management system to ensure the eligibility and assessment completion dates are reporting accurately.
8	Anthem should more closely monitor hard-copy assessments received and ensure that staff members are trained to scan and enter the foster care assessment (FCA) data	Anthem completed various QI efforts, including:

	Prior Recommendations (CY 2019)	Anthem's Response to Recommendations
	promptly upon receipt and according to existing policies and procedures. HSAG also recommends that Anthem implement interrater reliability processes to ensure consistency in completing, scanning, and entering data. Interrater reliability processes provide opportunity to conduct staff training when discrepancies or errors are identified.	• Conducting bi-weekly team huddles to review current processes, provide coaching and training, and communicate any new issues that arise. • Performing internal audits monthly to ensure proper handling of data.
9	In 2019, FQHC mapping to PCP provider type criteria will change; and HSAG recommends that Anthem review the updated criteria and work with its auditor to be prepared to comply with the more stringent mapping requirements.	Anthem completed various QI efforts, including: • Working with the NCQA-certified auditor to map all PCP providers.

Optima

Table 6-4—PMV—Prior Recommendations and Optima's Response

	Prior Recommendations (CY 2019)	Optima's Response to Recommendations
HSAG recommended that Optima focus QI efforts on the following HEDIS Recommendations.		
1	Optima performed above the national Medicaid 50th percentiles for the *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* measures. HSAG recommends that Optima identify opportunities during these visits to ensure that PCPs are providing and documenting comprehensive well-child and preventive health services such as immunizations. Best practices identified in other states include ensuring that opportunities such as providing childhood and adolescent immunizations and completing developmental screenings are not missed during these visits.	Optima completed various QI efforts, including: • Conducting an interactive voice response (IVR) call campaign once a year in the fall to remind and/or provide information to guardians of members age 0 to 20 who (1) are due for a wellness visit, (2) are due for vaccinations, (3) may require encouragement to schedule wellness exams, and (4) need information on how to find a doctor through the optimahealth.com website. • Posting HEDIS tips on the Optima website encouraging providers to include elements of well-child visits in all contacts with their patients. • Having care managers work with members' guardians to review needed immunizations, well child visits and to provide needed education and answer questions. • Launching its preventive incentive program July 1, 2019, which is a quality improvement initiative for Optima's Medicaid population (both Medallion and CCC+).
2	With the *Postpartum Care* rate falling more than 6 percentage points below the national Medicaid 50th percentile, HSAG	Optima completed various QI efforts, including: • Distributing gap-in-care letters to providers regarding postpartum visits.

	Prior Recommendations (CY 2019)	Optima's Response to Recommendations
	recommends that Optima identify opportunities to outreach to pregnant members and to providers to increase care for female members while they are pregnant. HSAG recommends that Optima develop and implement quality initiatives focused on ensuring that members are informed about and practicing prenatal care and that members participate in their postpartum care visits. Prenatal and postpartum care work in some state Medicaid programs provide opportunities to partner with obstetrical practices to conduct reminder calls the day before the scheduled appointment, assist with ensuring that transportation is arranged for the appointment by completing warm transfers to the transportation vendors, and provide additional educational opportunities such as parenting classes.	• Sending monthly mailings to pregnant members in various stages of pregnancy (12, 20, 30, and 38 weeks) that include information, resources, and incentives. • Preparing customized mailings with education about the importance of prenatal and postpartum care, arranging referrals to community partners for in-home visits, quarterly education sessions, and prenatal and postpartum incentives. • The clinical case management team connecting members to the Partners in Pregnancy team as soon as a member is identified as being pregnant. • Launching its postpartum incentive program February 1, 2019, which is a quality improvement initiative for the Medicaid population (Medallion).
3	Performance for four of five *Comprehensive Diabetes Care* indicators declined, and all indicators fell below the national Medicaid 50th percentile for HEDIS 2018. Despite increasing by more than 5 percentage points since HEDIS 2016, the *Controlling High Blood Pressure* measure continued to be below the national Medicaid 50th percentile. HSAG recommends that Optima identify quality improvement opportunities to improve care related to management of chronic conditions. Optima should focus efforts on medications for chronic diseases such as asthma, depression, and ADHD. Lessons learned should be applied toward the overall medication management of members. HSAG's work with other states has identified best practices in medication management such as working with PCPs or health home providers to ensure that medication refills are completed. Medicaid MCOs in some states utilize their internal pharmacy department to conduct follow-up on medication refills, to outreach to review medications upon member discharge from an inpatient stay or an emergency department visit, and to reconcile medications for the elderly or	Optima completed various QI efforts, including: • Conducting an IVR diabetic eye exam campaign once a year encouraging members to get their eye exam or connecting them with an eye provider to schedule. • Conducting weekly campaigns to call members who have a new ADHD medication prescribed to encourage follow-up with their provider within 30 days. • Screening members for cardiovascular health risks, including elevated cholesterol, blood pressure, body mass index, HbA1c, tobacco use, and lack of regular exercise, and offering interactions with RNs to discuss a behavior modification plan to reduce risks.

	Prior Recommendations (CY 2019)	Optima's Response to Recommendations
	members with comorbid conditions requiring multiple prescriptions.	
4	HSAG recommends that Optima, in the Behavioral Health domain, review performance measure rates that fell below the national Medicaid 50th percentile and identify quality improvement opportunities to improve performance.	Optima completed various QI efforts, including: • Ensuring that members have a scheduled follow-up appointment after an ED visit for mental health conditions with their behavioral health provider. • Including the follow-up after ED visit for mental health conditions. • Offering follow-up with a telehealth behavioral health provider within the recommended time frame. • Generating daily reports through the Collective Medical software for *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* so care coordination can assist the member in arranging follow-up at 14 and 30 days.
5	Optima's measure rate for *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* continued to be higher than the national Medicaid 50th percentile, and the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure rate continued to be lower than the 50th percentile. Documentation reviewed during readiness reviews did not suggest that Optima had implemented recommendations made in the 2017 annual technical report, including opportunities for the MCO to limit in its formulary the quantity prescribed for new ADHD prescriptions. HSAG has found that when state and/or health plan formularies limit the quantity prescribed for new ADHD prescriptions this may result in improvement in the *Initiation Phase* measure indicator rates. This intervention requires the member's family or caregivers to seek follow-up care to renew prescriptions, which also provides an opportunity for the member to receive well-child visits, immunizations, and other needed EPSDT services. HSAG recommends that Optima follow up on the 2017 recommendation that the MCO's Pharmaceutical and Therapeutics Committee evaluate the benefits and risks associated with implementation of this pharmacy	Optima completed various QI efforts, including: • Producing daily pull lists of members who recently started taking ADHD medication and scheduling IVR reminder calls for 30-day follow-up. • Calling members in 2019 on a weekly basis who were prescribed a new ADHD medication to encourage follow-up with the provider within 30 days as well as follow-up with members who stated that they were going to make an appointment. • Setting quantity limits by the Optima Health Pharmacy that are FDA guided to avoid overutilization and adverse effects.

	Prior Recommendations (CY 2019)	Optima's Response to Recommendations
	benefit system control as a mechanism to drive improved follow-up rates for children newly prescribed ADHD medication.	
HSAG recommended that Optima focus QI efforts on the following PMV recommendations.		
6	Ensure that the FCA measure documentation in Performance Clinical Systems (PCS) Symphony provides sufficient detail to identify the source of the information used to complete the assessment. HSAG recommends that Optima implement interrater reliability processes to ensure consistency and accuracy in data entry.	Optima completed various QI efforts, including: • Implementing the IVR with the Optima clinical care management team and testing staff members annually. • Storing information obtained outside of the standard MCO Member Health Screening questions in the notes field of the member's account within PCS. • Using a foster care barrier report within PCS that allows Outreach to notate any difficulties in reaching the member.
7	Optima mapped FQHCs to the PCP provider types for HEDIS 2018; therefore, the MCO should ensure that the updated criteria for this mapping are met for HEDIS 2019.	Optima completed various QI efforts, including: • Verifying provider designation of FQHC or Rural Health Clinic with the CMS listing of approved Essential Community Providers on the CMS website. • Ensuring these providers have an additional facility record type to accommodate the use of the UB-04 form in crossover claims.
8	Optima should explore creating a data feed from Echo to Consumer Science Corporation (CSC). This would mitigate manual data entry and instill greater confidence in data accuracy.	Optima completed various QI efforts, including: • Implementing a new provider data management database to have information uploaded to update new practitioner data with contracted information into Optima's claims software system. • Creating an upload that loads provider data into the Echo credentialing database, with the goal to update from Echo to the new provider management database for specific data (i.e., approval dates and licensure info) and incorporating the upload into the claims system on particular fields for phase 1 in 2020.

VA Premier

Table 6-5—PMV—Prior Recommendations and VA Premier's Response

	Prior Recommendations (CY 2019)	VA Premier's Response to Recommendations
HSAG recommended that VA Premier focus QI efforts on the following HEDIS recommendations.		
1	Review claims processing data more rigorously prior to reporting, looking at volume trending over time.	VA Premier completed various QI efforts, including: • Engaging the VA Premier Claims Department new leadership team in the PMV validation process,

	Prior Recommendations (CY 2019)	VA Premier's Response to Recommendations
		paving the way for both experience and knowledge acquisition. • Continuing pre-audit preparedness activities as the claims team works to ensure claims processing data are reviewed with greater scrutiny.
HSAG recommended that VA Premier focus QI efforts on the following PMV recommendations.		
2	Continue to explore mechanisms to enable production of claims processing measure data that do not require manual verification (e.g., confirming "clean" claim counts).	VA Premier completed various QI efforts, including: • Modifying the claims batch process to ensure more efficient and faster processing time. • Moving from two-day payment runs to payment runs four days per week to improve timeliness of provider payments. • Making 834 enhancements for member matching and inbound processing. • Developing a bot (automation technology) to sweep claims with no human intervention. • Modifying the process for managing COB paper claims that currently flags edit 913.
3	Continue to monitor electronic data interchange (EDI) claims loads closely and conduct reconciliations to ensure that all claims are flowing through the process as expected.	VA Premier completed various QI efforts, including: • VA Premier's claims team will follow the recommendations provided by HSAG and develop additional interventions and oversight moving forward.
4	For HEDIS 2019, work with its HEDIS auditor and FQHCs to ensure that the MCO is able to meet NCQA's updated criteria for mapping FQHCs to the PCP provider type.	VA Premier completed various QI efforts, including: • VA Premier's HEDIS director and quality data team will use this recommendation moving forward to ensure mapping criteria are updated.

Summary of Strengths, Weaknesses, and Overall Conclusions

Strengths

The MCOs demonstrated strength within the Children's Preventive Care domain. HealthKeepers displayed strong performance, exceeding the 50th percentile and the Virginia aggregate for all four measures within the domain. VA Premier exceeded the 50th percentile for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.*

Cervical Cancer Screening represented an area of strength for the MCOs, with Aetna, HealthKeepers, and Optima all exceeding the 50th percentile and Virginia aggregate.

Within the Access to Care domain, *Children and Adolescents' Access to Primary Care Practitioners* was an area of strength for the MCOs, as four of the five MCOs exceeded the 50th percentile for three of the four *Children and Adolescents' Access to Primary Care Practitioners* measure rates, with three of the MCOs (Aetna, HealthKeepers, and VA Premier) exceeding the 50th percentile for all four measure rates.

Three of the MCOs exceeded the 50th percentile for four of the eight (50.0 percent) measure rates demonstrating strength in the Behavioral Health domain. Additionally, the MCOs demonstrated strength in the Behavioral Health domain for *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*, with four of five MCOs exceeding the 50th percentile.

Recommendations for Improvement

Four of the six MCOs were below the NCQA 50th percentile for the measures within the Children's Preventive Care domain, indicating opportunities for improvement related to well-child/well-care visits and immunizations. HSAG recommends that the MCOs implement quality improvement initiatives aimed at identifying the barriers for children receiving well-care visits and immunizations. HSAG recommends the MCOs identify best practices that have been successful in achieving sustained improvement in preventive health rates.

The *Breast Cancer Screening* measure in the Women's Health domain demonstrated opportunities for improvement for all MCOs, as none of the MCOs exceeded the 50th percentile. Additionally, only one MCO exceeded the 50th percentile for the *Prenatal and Postpartum Care* measure rates, demonstrating opportunities for the MCOs to ensure women receive care during and after their pregnancies. HSAG recommends that DMAS work with the MCOs to focus interventions—such as assistance with scheduling, transportation to the appointment, and the completion of reminder calls—on removing barriers to completing the breast cancer screening appointment the day prior to the scheduled appointment.

The Care for Chronic Conditions domain represented an area of opportunity for improvement for all of the MCOs, as none of the MCOs exceeded the 50th percentile for more than four of the 10 measure rates that could be compared to benchmarks. MCO performance was particularly low for the *Comprehensive Diabetes Care* measure, with only one MCO exceeding the 50th percentile for the *HbA1c Testing* rate, while no other rates for any of the MCOs within the *Comprehensive Diabetes Care* measure exceeded the 50th percentile. HSAG recommends that the MCOs identify the barriers members are experiencing in receiving care for chronic conditions, such as comprehensive diabetes care. MCOs should identify best practices that have demonstrated success in improving the management of chronic conditions. HSAG recommends that the MCOs consider assigning members to a medical home with a provider who has expertise in a chronic condition and has demonstrated successful outcomes for members with the chronic condition.

The MCOs demonstrated opportunities for improvement for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*, with only one MCO exceeding the 50th percentile in the Behavioral Health domain. HSAG recommends that the MCOs consider administrative or other processes to ensure children receive follow-up care when prescribed medications, such as those for ADHD. MCOs may want to consider implementing a reminder for pharmacists and PCPs to connect to encourage families to schedule and complete a follow-up visit prior to the next refill of the prescription.

7. Validation of Performance Improvement Projects

Activity-Specific Findings—Validation of Performance Improvement Projects

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

Objective

As part of the State's quality strategy, 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 Balanced Budget Act of 1997 (BBA), HSAG, as the State's EQRO, validated the PIPs through an independent review process. To ensure methodological soundness while meeting all State and federal requirements, HSAG follows validation guidelines established in the CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[7-1] Additionally, HSAG's PIP process facilitates frequent communication with the MCOs. HSAG provides written feedback after each module is validated and provides technical assistance for further guidance. HSAG conducts webinar trainings prior to each module submission and progress check-ins while MCOs test interventions.

DMAS requires the MCOs to conduct two PIPs annually. The topics initiated in 2019 were:

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

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

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

[7-1] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Jan 22, 2019.

- **S**pecific: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **M**easurable: The indicator to measure the goal: What is the measure that will be used? What is the current data figure (i.e., count, percent, or rate) for that measure? What do you want to increase/decrease that number to?
- **A**ttainable: Rationale for setting the goal: Is the achievement you want to attain based on a particular best practice/average score/benchmark? Is the goal attainable (not too low or too high)?
- **R**elevant: The goal addresses the problem to be improved.
- **T**ime-bound: The timeline for achieving the goal.

Approach to PIP Validation

In 2019, HSAG obtained the data needed to conduct the PIP validation from the MCOs' module submission forms. These forms provided detailed information about each of the PIPs and the activities completed in Module 1 and Module 2.

The MCOs submitted each module according to the approved timeline. After the initial validation of each module, the MCOs received HSAG's feedback and technical assistance and resubmitted the modules until all validation criteria were met. This process ensured that the methodology was sound before the MCO progressed to the next phase of the PIP process.

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

PIP Validation Scoring

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

- ***High confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the MCO accurately summarized the key findings.

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

Training and Implementation

HSAG trained the MCOs on the PIP submission and validation requirements prior to the Module 1 and Module 2 submission due date in August 2019. HSAG also trained the MCOs on the Module 3 requirements in September 2019 in advance of the Module 3 submissions for validation.

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

PIP Validation Status

At the time of this report, all MCOs achieved the Module 1 and Module 2 validation criteria and progressed to Module 3 to identify potential interventions to test for the PIP. HSAG will report the final validation findings for Module 3 and Module 4 in the next annual report.

Recommendations

The MCOs should address all module validation recommendations in the resubmissions in order to advance to intervention testing for the PIPs as rapidly as possible. Once in the intervention testing phase of the PIP, MCOs should evaluate interventions and determine quickly whether changes need to be made. If an intervention is not working, MCOs should start new interventions and monitor for effectiveness. Interventions should be tested for the PIP through the SMART Aim end date of December 31, 2020. If MCOs have any questions or need technical assistance with their PIPs, they should reach out to HSAG.

Validation Findings

Aetna

In 2019, Aetna started the following DMAS-selected topics: *Ensuring Timeliness of Prenatal Care* and *Tobacco Use Cessation in Pregnant Women*. The topics selected addressed CMS requirements related to quality outcomes—specifically, timeliness and quality of care and services. Table 7-1 displays the SMART Aim for each PIP at the time of the initial validation.

Table 7-1—SMART Aim Statements: Aetna

PIP Title	SMART Aim Statement*
Ensuring Timeliness of Prenatal Care	By December 31, 2020, increase the percentage of HEDIS PPC prenatal care visit rates among members aged 18–29 years in the Central Virginia region, from 14.2 percent to 21.28 percent.
Tobacco Use Cessation in Pregnant Women	By December 31, 2020, decrease the rate of identified smokers among pregnant members in the Central Virginia region, from 3.1 percent to 0.4 percent.

Conclusions and Recommendations

At the time of this report, there were no results to report. HSAG recommended that Aetna should:

- Attend all module-specific trainings.
- Identify and test innovative, actionable changes for the PIP.
- Continually monitor the outcomes and make rapid adjustments, as needed.
- Request PIP technical assistance from HSAG as often as needed.

HealthKeepers

In 2019, HealthKeepers started the following DMAS-selected topics: *Timeliness of Prenatal Care* and *Tobacco Use Cessation in Pregnant Women*. The topics selected addressed CMS requirements related to quality outcomes—specifically, timeliness and quality of care and services. Table 7-2 displays the SMART Aim for each PIP at the time of the initial validation.

Table 7-2—SMART Aim Statements: HealthKeepers

PIP Title	SMART Aim Statement*
Timeliness of Prenatal Care	By December 31, 2020, increase the percentage of members who have received timely prenatal care during the first trimester, on or before the enrollment start date or within 42 days of enrollment assigned to Dominion Women's Health,

PIP Title	SMART Aim Statement*
	who were identified as pregnant and receiving a prenatal care visit, 68.94 percent to 75 percent.
Tobacco Use Cessation in Pregnant Women	By December 31, 2020, increase the percentage of members who have received tobacco cessation plan-wide, who were identified as pregnant and were tobacco users screened for tobacco use, from 10.5 percent to 30 percent.

Conclusions and Recommendations

At the time of this report, there were no results to report. HSAG recommended that HealthKeepers should:

- Ensure all data and results are provided accurately.
- Attend all module-specific trainings.
- Identify and test innovative, actionable changes for the PIP.
- Continually monitor the outcomes and make rapid adjustments, as needed.
- Request PIP technical assistance from HSAG as often as needed.

Magellan

In 2019, Magellan started the following DMAS-selected topics: *Improve Timeliness of Prenatal Care* and *Reduce Tobacco Use in Pregnant Women*. The topics selected addressed CMS requirements related to quality outcomes—specifically, timeliness and quality of care and services. Table 7-3 displays the SMART Aim for each PIP at the time of the initial validation.

Table 7-3—SMART Aim Statements: Magellan

PIP Title	SMART Aim Statement*
Improve Timeliness of Prenatal Care	By December 31, 2020, increase the rate of members receiving a prenatal visit within their first trimester, on MCO enrollment date or within 42 days of MCO enrollment by X percentage points from a to be determined percent to a to be determined percent seen by top five providers meeting the PPC criteria.
Reduce Tobacco Use in Pregnant Women	By December 31, 2020, increase the rate of pregnant women identified as smokers or tobacco user who receive smoking cessation treatments including medication and/or counseling by a to be determined percentage points from a to be determined percent to a to be determined percent.

*Magellan's SMART Aims were not yet finalized because the MCO did not have 12-months of data. The MCO will provide the data and completed SMART Aims for review in 2020.

Conclusions and Recommendations

At the time of this report, there were no results to report. HSAG recommended that Magellan should:

- Attend all module-specific trainings.
- Identify and test innovative, actionable changes for the PIP.
- Continually monitor the outcomes and make rapid adjustments, as needed.
- Request PIP technical assistance from HSAG as often as needed.

Optima

In 2019, Optima started the following DMAS-selected topics: *Timeliness of Prenatal Care* and *Tobacco Use Cessation in Pregnant Women*. The topics selected addressed CMS requirements related to quality outcomes—specifically, timeliness and quality of care and services. Table 7-4 displays the SMART Aim for each PIP at the time of the initial validation.

Table 7-4—SMART Aim Statements: Optima

PIP Title	SMART Aim Statement*
Timeliness of Prenatal Care	By December 31, 2020, increase the percentage of timely prenatal visits among pregnant Optima health Medicaid insured women in the city of Norfolk, Virginia, by 10 percent (43.49 percent to 53.49 percent.)
Tobacco Use Cessation in Pregnant Women	By December 31, 2020, decrease tobacco use among Optima Health Medicaid-insured pregnant women in the City of Norfolk, VA, by 2 percent (from 28 percent to 26 percent).

Conclusions and Recommendations

At the time of this report, there were no results to report. HSAG recommended that Optima should:

- Provide all data and results accurately.
- Attend all module-specific trainings.
- Identify and test innovative, actionable changes for the PIP.
- Continually monitor the outcomes and make rapid adjustments, as needed.
- Request PIP technical assistance from HSAG as often as needed.

United

In 2019, United started the following DMAS-selected topics: *Timeliness of Prenatal Care* and *Tobacco Use Cessation in Pregnant Women.* The topics selected addressed CMS requirements related to quality outcomes—specifically, timeliness and quality of care and services. Table 7-5 displays the SMART Aim for each PIP at the time of the initial validation.

Table 7-5—SMART Aim Statements: United

PIP Title	SMART Aim Statement*
Timeliness of Prenatal Care	The Virginia UnitedHealthcare Medallion MCO will increase the percentage of deliveries to members in the Northern and Winchester Regions that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization from a to be determined percent to a to be determined percent, by December 31, 2020.
Tobacco Use Cessation in Pregnant Women	The Virginia UnitedHealthcare Medallion MCO will increase the percentage of pregnant women (identified as tobacco users) who receive advice to quit smoking and/or who discussed or were provided cessation methods or strategies among pregnant women, from a to be determined percent to a to be determined percent by December 31, 2020.

*At the time of this report, United's SMART Aims were not yet finalized because the MCO did not have 12-months of data. The MCO will provide the data and completed SMART Aims for review in 2020.

Conclusions and Recommendations

At the time of this report, there were no results to report. HSAG recommended that United should:

- Attend all module-specific trainings.
- Identify and test innovative, actionable changes for the PIP.
- Continually monitor the outcomes and make rapid adjustments, as needed.
- Request PIP technical assistance from HSAG as often as needed.

VA Premier

In 2019, VA Premier started the following DMAS-selected topics: *Timeliness of Prenatal Care* and *Tobacco Use Cessation in Pregnant Women*. The topics selected addressed CMS requirements related to quality outcomes—specifically, timeliness and quality of care and services. Table 7-6 displays the SMART Aim for each PIP at the time of the initial validation.

Table 7-6—SMART Aim Statements: VA Premier

PIP Title	SMART Aim Statement*
Timeliness of Prenatal Care	By December 31, 2020, there will be an increase in the timeliness of prenatal care in the Roanoke Region for Virginia Premier members from 55 percent to 65 percent compliance.
Tobacco Use Cessation in Pregnant Women	By December 31, 2020, there will be a decrease in the percentage of pregnant members in the Roanoke region that did not receive counselling, medications, and advice on smoking cessation from 93 percent to 88 percent.

Conclusions and Recommendations

At the time of this report, there were no results to report. HSAG recommended that VA Premier should:

- Attend all module-specific trainings.
- Identify and test innovative, actionable changes for the PIP.
- Continually monitor the outcomes and make rapid adjustments, as needed.
- Request PIP technical assistance from HSAG as often as needed.

Follow-Up to Prior EQR Recommendations

The MCOs finished the prior PIP topic in 2018 and started new PIP topics in 2019. The recommendations in the 2018 EQR report pertained to the final stages of the rapid-cycle PIP process. The MCOs should ensure that those recommendations are applied during intervention testing and reporting of the final PIP results for the current topics that were initiated in 2019.

Aetna

Table 7-7—PIP Recommendations and Aetna's Response

Prior PIP Recommendations (CY 2019)	Aetna's Response to Recommendations
HSAG recommended that Aetna focus QI efforts on the following PIP Recommendations.	
Work to address the key driver related to ability to locate members for outreach. Aetna received a *Low Confidence* score for its State-mandated PIP, *Increasing Diabetic Retinal Exam Screenings Among Members Diagnosed with Diabetes*.	Aetna completed various QI efforts, including: • Utilizing member demographic information from pharmacy providers. • Capturing additional telephone numbers through the care management reporting database that does not get overwritten by the 834 files sent by DMAS.
Proactively estimate the approximate total number of members eligible for interventions prior to testing to help ensure meaningful evaluation results and ability to impact the SMART Aim.	Aetna completed various QI efforts, including: • Using NCQA-approved HEDIS software that captures eligible populations based on HEDIS Technical Specifications.
Ensure that the narrative summary of overall key findings and interpretation of results are reported accurately.	Aetna completed various QI efforts, including: • Ensuring overall key findings and interpretation results are clearly described.
Consider tailoring future interventions to address specific needs of the special needs populations, which may require additional assistance and/or more intense monitoring.	Aetna completed various QI efforts, including: • Using the Population Health Management report to assess the population size and demographic characteristics of members that are critical to defining

Prior PIP Recommendations (CY 2019)	Aetna's Response to Recommendations
	health service needs, ensuring accessible healthcare and developing appropriate quality improvement interventions.
Report a more thorough analysis of results for the PIP—numerators and denominators for SMART Aim monthly measurements, total number of members outreached, number of members outreached successfully, number of members scheduled for eye exams who subsequently attended those eye exams.	• Aetna's future PIP analyses will capture more in-depth detail as noted.
Report a more thorough analysis of results for the PIP—numerators and denominators for SMART Aim monthly measurement; number of members who received an intervention; and, subsequently, number of members compliant (at least monthly).	• Aetna will ensure future PIPs contain a more thorough analysis and other specific detail as noted.

Anthem

Table 7-8—PIP Recommendations and Anthem's Response

Prior PIP Recommendations (CY 2019)	Anthem's Response to Recommendations
HSAG recommended that Anthem focus QI efforts on the following PIP Recommendations.	
Ensure understanding of the rapid-cycle PIP process and requirements. Anthem received a Low Confidence score for its State-mandated PIP, Comprehensive Diabetes Care—Eye Exam (Retinal) Performed.	Anthem completed various QI efforts, including: • Attending the trainings held by HSAG for its current PIPs assigned and soliciting assistance when needed.
Address all Module 4 pre-validation review feedback in the final submission of Module 4.	Anthem completed various QI efforts, including: • Attending the trainings held by HSAG for its current PIPs assigned.
Submit a Module 4 for each intervention it tests.	Anthem completed various QI efforts, including: • Continuing to attend the trainings held by HSAG.
Report a more thorough analysis of results for the PIP—numerators and denominators for SMART Aim monthly measurement; number of members who received an intervention; and, subsequently, number of members compliant (at least monthly).	Anthem completed various QI efforts, including: • Taking steps to ensure the understanding of the rapid-cycle PIP process and its requirements.

Optima

Table 7-9—PIP Recommendations and Optima's Response

Prior PIP Recommendations (CY 2019)	Optima's Response to Recommendations
HSAG recommended that Optima focus QI efforts on the following PIP Recommendations.	
Optima received a *Low Confidence* score for its State-mandated PIP, *Diabetic Retinal Exam Compliance Rate*. HSAG recommends that Optima: • Provide a clear data collection plan for each component of the intervention.	Optima completed various QI efforts, including: • Developing a data collection plan for diabetic retinal exam compliance. • Measuring the number of eye exams performed in one month according to the ZIP codes provided. • Measuring the number of Optima diabetic members 18–75 years of age residing in the identified ZIP codes. • Measuring the number of members who were provided transportation. • Providing a percentage of members who were provided transportation based on ZIP codes. • Providing a percentage of members who completed their diabetic eye exams based on ZIP codes identified.
Provide intervention evaluation data that include monthly numerator and denominator numbers related to how many members were contacted by outreach; how many of those members needed transportation; and, subsequently, how many of those members each received a diabetic eye exam.	Optima completed various QI efforts, including: • Creating a new "Follow-up Care Gaps" encounter to give better reporting on this measure.
Test an intervention until the SMART Aim end date.	Optima completed various QI efforts, including: • Testing telephonic outreach using a 12-month rolling methodology from January 31, 2017, through December 31, 2017.
Report results using the approved rolling 12-month methodology, including the numerators and denominators for each SMART Aim monthly measurement.	Optima completed various QI efforts, including: • Reporting results from the 2017 diabetic retinal eye compliance PIP detailing methodology used for each intervention and showing how this affects the SMART Aim goal. • Appropriately using the rolling 12-month methodology. • Separating Module 4 submissions for each intervention tested.

VA Premier

Table 7-10—PIP Recommendations and VA Premier's Response

Prior PIP Recommendations (CY 2019)	VA Premier's Response to Recommendations
HSAG recommended that VA Premier focus QI efforts on the following PIP Recommendations.	
VA Premier received a *Low Confidence* score for its State-mandated PIP, *Comprehensive Diabetes Care: Eye Exams*. VA Premier should: • Provide a comprehensive intervention methodology and submit a Module 4 for each intervention tested.	VA Premier completed various QI efforts, including: • Using monthly monitoring for regular examination of eye exam adherence. • Incorporating a biostatistician to assist with this effort moving forward.
Provide clear intervention evaluation data that include results for each component of the evaluation plan.	VA Premier completed various QI efforts, including: • Attending HSAG's training for PIP modules to enhance future evaluation plans.
Report accurate results following the approved rolling 12-month methodology, including the numerators and denominators for each SMART Aim monthly measurement.	VA Premier completed various QI efforts, including: • Attending HSAG's training for PIP modules to enhance 12-month reporting methodology utilization.

Summary of Strengths, Weaknesses, and Overall Conclusions

In 2019, all MCOs submitted Module 1 and Module 2 for the new DMAS-specified PIP topics, achieved all Module 1 and Module 2 validation criteria, and progressed to Module 3 for identifying potential interventions to test for the PIP.

Recommendations for Improvement

HSAG recommends that the MCOs follow the PIP rapid-cycle process, participate in trainings provided by the EQRO, and request technical assistance as often as needed to improve the success of the PIP process.

Activity-Specific Findings—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 quality improvement made by HSAG during the previous year. The methodology for each activity can be found in Appendix A—Technical Methods of Data Collection and Analysis—MCOs.

Objectives

The CAHPS surveys were conducted for Virginia's Medallion 4.0 managed Medicaid population to obtain information on the levels of satisfaction of adult and child Medicaid members. For the Medallion 4.0 MCOs (Aetna, HealthKeepers, Magellan, Optima, United, and VA Premier), the technical method of data collection was conducted through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.0H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCOs.

These CAHPS surveys were conducted in accordance with the Children's Health Insurance Program Reauthorization Act (CHIPRA) reporting requirements.

MCO-Specific Results

Aetna

Table 8-1 and Table 8-2 present the 2018 and 2019 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. A trend analysis was performed that compared Aetna's 2019 CAHPS scores to its corresponding 2018 CAHPS scores. In addition, the 2019 CAHPS scores for Aetna were compared to the 2018 NCQA national adult and child Medicaid averages.

Table 8-1—Comparison of 2018 and 2019 Adult Medicaid CAHPS Results: Aetna

	2018	2019
Global Ratings		
Rating of Health Plan	60.2%	60.1%
Rating of All Health Care	54.9%	47.2%
Rating of Personal Doctor	68.7%	63.7%
Rating of Specialist Seen Most Often	58.2%+	63.6%
Composite Measures		
Getting Needed Care	86.4%	80.8%
Getting Care Quickly	86.4%+	79.9%
How Well Doctors Communicate	90.7%	92.3%
Customer Service	89.0%+	81.9%
Shared Decision Making	81.3%+	80.7%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in red represent rates that are statistically significantly lower than the 2018 NCQA Medicaid national averages.

Aetna's 2018 and 2019 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- Aetna's 2019 score was statistically significantly lower than the 2018 NCQA adult Medicaid national average on two measures: *Rating of All Health Care* and *Customer Service*.
- Aetna did not score statistically significantly higher in 2019 than in 2018 on any measure.

Table 8-2—Comparison of 2018 and 2019 Child Medicaid CAHPS Results: Aetna

	2018	2019
Global Ratings		
Rating of Health Plan	70.1%	72.3%
Rating of All Health Care	69.6%	66.8%
Rating of Personal Doctor	76.5%	76.2%
Rating of Specialist Seen Most Often	67.6%+	75.8%
Composite Measures		
Getting Needed Care	88.9%+	90.7%
Getting Care Quickly	94.3%	89.8% ▼
How Well Doctors Communicate	96.9%	94.8%
Customer Service	85.0%+	90.4%

	2018	2019
Shared Decision Making	76.1%+	79.1%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▼ statistically significantly lower in 2019 than in 2018.
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.

Aetna's 2018 and 2019 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- Aetna's 2019 score was statistically significantly higher than the 2018 NCQA child Medicaid national average on one measure, *Getting Needed Care*.
- Aetna scored statistically significantly lower in 2019 than in 2018 on one measure, *Getting Care Quickly*.

CAHPS Recommendations

- HSAG recommends that Aetna focus quality improvement efforts on measure scores that exhibited a decrease from 2018 to 2019 (e.g., *Getting Care Quickly*) and were statistically significantly lower than the NCQA Medicaid national averages. Aetna could conduct a root cause analysis of study indicators that have been identified as areas of low performance.
- HSAG recommends that Aetna continue to monitor the measures to ensure there are no significant decreases in rates over time.

HealthKeepers

Table 8-3 and Table 8-4 present the 2018 and 2019 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. A trend analysis was performed that compared HealthKeepers' 2019 CAHPS scores to its corresponding 2018 CAHPS scores. In addition, the 2019 CAHPS scores for HealthKeepers were compared to the 2018 NCQA national adult and child Medicaid averages.

Table 8-3—Comparison of 2018 and 2019 Adult Medicaid CAHPS Results: HealthKeepers

	2018	2019
Global Ratings		
Rating of Health Plan	63.8%	64.9%
Rating of All Health Care	62.4%	54.5%
Rating of Personal Doctor	73.3%	63.2%
Rating of Specialist Seen Most Often	69.7%	62.3%+
Composite Measures		

	2018	2019
Getting Needed Care	86.5%	84.0%+
Getting Care Quickly	84.5%	80.5%+
How Well Doctors Communicate	94.2%	92.2%+
Customer Service	83.2%	88.1%+
Shared Decision Making	80.0%	84.2%+
+ *indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.*		

HealthKeepers' 2018 and 2019 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed there were no differences observed.

Table 8-4—Comparison of 2018 and 2019 Child Medicaid CAHPS Results: HealthKeepers

	2018	2019
Global Ratings		
Rating of Health Plan	73.9%	80.1%
Rating of All Health Care	67.9%	75.9%
Rating of Personal Doctor	74.3%	81.7% ▲
Rating of Specialist Seen Most Often	67.1%+	78.3%+
Composite Measures		
Getting Needed Care	83.5%	83.5%
Getting Care Quickly	85.2%	87.0%
How Well Doctors Communicate	92.3%	91.7%
Customer Service	83.8%+	85.9%+
Shared Decision Making	81.5%+	81.3%+
+ *indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.* ▲ *statistically significantly higher in 2019 than in 2018.* *Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.*		

HealthKeepers' 2018 and 2019 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- HealthKeepers' 2019 score was statistically significantly higher than the 2018 NCQA child Medicaid national average on three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*.
- HealthKeepers scored statistically significantly higher in 2019 than in 2018 on one measure, *Rating of Personal Doctor*.

CAHPS Recommendations

- HSAG recommends that HealthKeepers focus quality improvement efforts on measure scores that exhibited a decrease from 2018 to 2019 (e.g., *Getting Needed Care* for the adult Medicaid population, *How Well Doctors Communicate* for the child Medicaid population). HealthKeepers could conduct a root cause analysis of study indicators that have been identified as areas of low performance.
- HSAG recommends that HealthKeepers continue to monitor the measures to ensure there are no significant decreases in rates over time.

Optima

Table 8-5 and Table 8-6 present the 2018 and 2019 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. A trend analysis was performed that compared Optima's 2019 CAHPS scores to its corresponding 2018 CAHPS scores. In addition, the 2019 CAHPS scores for Optima were compared to the 2018 NCQA national adult and child Medicaid averages.

Table 8-5—Comparison of 2018 and 2019 Adult Medicaid CAHPS Results: Optima

	2018	2019
Global Ratings		
Rating of Health Plan	62.0%	65.0%
Rating of All Health Care	52.6%	63.1%+
Rating of Personal Doctor	65.1%	68.2%+
Rating of Specialist Seen Most Often	63.2%+	57.8%+
Composite Measures		
Getting Needed Care	81.4%	86.8%+
Getting Care Quickly	81.2%	85.7%+
How Well Doctors Communicate	90.7%	93.6%+
Customer Service	91.4%+	91.2%+
Shared Decision Making	72.0%+	78.9%+
+ *indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.*		

Optima's 2018 and 2019 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed there were no differences observed.

Table 8-6—Comparison of 2018 and 2019 Child Medicaid CAHPS Results: Optima

	2018	2019
Global Ratings		
Rating of Health Plan	77.9%	79.1%
Rating of All Health Care	74.7%	70.6%
Rating of Personal Doctor	78.3%	82.6%
Rating of Specialist Seen Most Often	79.7%+	73.5%+
Composite Measures		
Getting Needed Care	89.2%	92.5%
Getting Care Quickly	90.7%	93.1%
How Well Doctors Communicate	94.8%	96.3%
Customer Service	82.7%+	91.7%+
Shared Decision Making	79.1%+	79.4%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.

Optima's 2018 and 2019 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- Optima's 2019 score was statistically significantly higher than the 2018 NCQA child Medicaid national average on five measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*.
- Optima did not score statistically significantly higher or lower in 2019 than in 2018 on any measure.

CAHPS Recommendations

- HSAG recommends that Optima focus quality improvement efforts on measure scores that exhibited a decrease from 2018 to 2019 (e.g., *Rating of Specialist Seen Most Often* for the adult and child Medicaid populations). Optima could conduct a root cause analysis of study indicators that have been identified as areas of low performance.
- HSAG recommends that Optima continue to monitor the measures to ensure there are no significant decreases in rates over time.

United

Table 8-7 and Table 8-8 present the 2019 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. The 2019 CAHPS scores for United

were compared to the 2018 NCQA national adult and child Medicaid averages. Since this is the first year that United has submitted CAHPS data, HSAG could not perform a trend analysis.

Table 8-7—Comparison of 2018 and 2019 Adult Medicaid CAHPS Results: United

	2018	2019
Global Ratings		
Rating of Health Plan	–	47.2%+
Rating of All Health Care	–	42.3%+
Rating of Personal Doctor	–	59.6%+
Rating of Specialist Seen Most Often	–	82.4%+
Composite Measures		
Getting Needed Care	–	81.7%+
Getting Care Quickly	–	75.9%+
How Well Doctors Communicate	–	86.9%+
Customer Service	–	86.6%+
Shared Decision Making	–	77.8%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
A dash (–) indicates there were no data available
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2018 NCQA Medicaid national averages.

United's 2019 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- United scored statistically significantly higher than the 2018 NCQA adult Medicaid national average on one measure, *Rating of Specialist Seen Most Often*.
- United scored statistically significantly lower than the 2018 NCQA adult Medicaid national average on two measures: *Rating of Health Plan* and *Rating of All Health Care*.

Table 8-8—Comparison of 2018 and 2019 Child Medicaid CAHPS Results: United

	2018	2019
Global Ratings		
Rating of Health Plan	–	66.9%
Rating of All Health Care	–	67.6%
Rating of Personal Doctor	–	75.0%
Rating of Specialist Seen Most Often	–	60.9%+
Composite Measures		
Getting Needed Care	–	77.0%+
Getting Care Quickly	–	82.6%+

	2018	2019
How Well Doctors Communicate	–	91.2%+
Customer Service	–	77.3%+
Shared Decision Making	–	71.9%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
A dash (–) indicates there were no data available.
Cells highlighted in red represent rates that are statistically significantly lower than the 2018 NCQA Medicaid national averages.

United's 2019 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- United scored statistically significantly lower than the 2018 NCQA child Medicaid national average on one measure, *Customer Service*.

CAHPS Recommendations

- HSAG recommends that United focus quality improvement efforts on measure scores that were statistically significantly lower than the NCQA Medicaid national averages. United could conduct a root cause analysis of study indicators that have been identified as areas of low performance.
- HSAG recommends that United continue to monitor the measures to ensure there are no significant decreases in rates over time.

VA Premier

Table 8-9 and Table 8-10 present the 2018 and 2019 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. A trend analysis was performed that compared VA Premier's 2019 CAHPS scores to its corresponding 2018 CAHPS scores. In addition, the 2019 CAHPS scores for VA Premier were compared to the 2018 NCQA national adult and child Medicaid averages.

Table 8-9—Comparison of 2018 and 2019 Adult Medicaid CAHPS Results: VA Premier

	2018	2019
Global Ratings		
Rating of Health Plan	59.6%	63.1%
Rating of All Health Care	44.5%	54.2%
Rating of Personal Doctor	65.5%	66.9%
Rating of Specialist Seen Most Often	59.4%+	72.4%
Composite Measures		
Getting Needed Care	82.8%	88.0%
Getting Care Quickly	83.9%	89.1%

	2018	2019
How Well Doctors Communicate	89.3%	93.0%
Customer Service	87.8%+	90.3%
Shared Decision Making	79.3%+	77.3%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results. Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.

VA Premier's 2018 and 2019 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- VA Premier's 2019 score was statistically significantly higher than the 2018 NCQA adult Medicaid national average on two measures: *Getting Needed Care* and *Getting Care Quickly*.
- VA Premier did not score statistically significantly higher or lower in 2019 than in 2018 on any measure.

Table 8-10—Comparison of 2018 and 2019 Child Medicaid CAHPS Results: VA Premier

	2018	2019
Global Ratings		
Rating of Health Plan	69.8%	77.8% ▲
Rating of All Health Care	69.5%	77.8% ▲
Rating of Personal Doctor	81.3%	79.8%
Rating of Specialist Seen Most Often	78.1%	79.5%+
Composite Measures		
Getting Needed Care	88.2%	88.2%
Getting Care Quickly	93.4%	93.9%
How Well Doctors Communicate	97.3%	95.8%
Customer Service	88.4%	93.5%+
Shared Decision Making	81.3%	77.2%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ statistically significantly higher in 2019 than in 2018.
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.

VA Premier's 2018 and 2019 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- VA Premier's 2019 score was statistically significantly higher than the 2018 NCQA child Medicaid national average on three measures: *Rating of Health Plan*, *Rating of All Health Care*, *Getting Care Quickly*.

- VA Premier scored statistically significantly higher in 2019 than in 2018 on two measures: *Rating of Health Plan* and *Rating of All Health Care*.

CAHPS Recommendations

- HSAG recommends that VA Premier focus quality improvement efforts on measure scores that exhibited a decrease from 2018 to 2019 (e.g., *How Well Doctors Communicate* for the child Medicaid population). VA Premier could conduct a root cause analysis of study indicators that have been identified as areas of low performance.
- HSAG recommends that VA Premier continue to monitor the measures to ensure there are no significant decreases in rates over time.

FAMIS Program Statewide Aggregate Results

The FAMIS 2019 CAHPS results were compared to the 2018 results and rates that were statistically significantly higher or lower than the NCQA Medicaid national averages where highlighted. Table 8-11 presents the 2018 and 2019 FAMIS CAHPS top-box scores for the global ratings and composite measures. The FAMIS general child and CCC 2019 CAHPS scores were compared to the 2018 NCQA national child Medicaid and CCC Medicaid averages.[8-1]

Table 8-11—Comparison of 2018 and 2019 FAMIS Program General Child and CCC Results

	General Child		CCC	
Global Ratings	**2018**	**2019**	**2018**	**2019**
Rating of Health Plan	70.9%	72.4%	69.6%	63.6%
Rating of All Health Care	70.8%	70.6%	67.2%	64.3%
Rating of Personal Doctor	78.1%	72.1%	74.4%	71.0%
Rating of Specialist Seen Most Often	83.3%+	78.4%+	74.8%	68.8%+
Composite Measures	**2018**	**2019**	**2018**	**2019**
Getting Needed Care	87.2%	86.9%	87.2%	87.7%
Getting Care Quickly	89.6%	86.0%	91.7%	94.3%
How Well Doctors Communicate	94.3%	95.1%	94.6%	94.5%
Customer Service	83.9%+	81.2%+	89.1%+	85.6%+
Shared Decision Making	80.0%+	70.7%+	82.3%	80.6%+

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

[8-1] For the NCQA national child and CCC Medicaid averages, the source for data contained in this publication is Quality Compass® 2018 data and is used with permission of NCQA. Quality Compass 2018 include 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.

Conclusions and Recommendations

Follow-Up to Prior EQR Recommendations

Aetna

Table 8-12—CAHPS Recommendations and Aetna's Response

Prior CAHPS Recommendations (CY 2019)	Aetna's Response to Recommendations
HSAG recommended that Aetna focus QI efforts on the following CAHPS Recommendations.	
HSAG recommends reviewing the measures included in the CAHPS adult global rating "All Health Care" as an area of focus and quality improvement.	Aetna completed various QI efforts, including: • Completing a barrier analysis of the 2018 CAHPS Survey results and identifying the areas of health plan performance as aspects of member experience that shape members' overall assessment of the plan. • Educating providers on the need to adhere to contractually required appointment standards as well as the importance of leaving part of the provider's day open for same-day appointments. • Revising and revamping its health literacy programs to educate and provide members with recommended resources, communication, and health literacy measures. • Restructuring its Member Services department to include ongoing soft skills training and quality monitoring of calls.
For the CAHPS child global rating of "Specialist Seen Most Often" and the CAHPS child composite rating of "Shared Decision Making," opportunities exist to provide outreach and education to providers—particularly specialty providers—related to effective communication with members and to developing patient-centered focus related to member care and treatment.	Aetna completed various QI efforts, including: • Continuing to trend data to determine if there is an overall decline in child members seen by specialists. • Providing outreach to providers and educating them on the importance of including members in their treatment and care plan.

Anthem

Table 8-13—CAHPS Recommendations and Anthem's Response

Prior CAHPS Recommendations (CY 2019)	Anthem's Response to Recommendations
HSAG recommended that Anthem focus QI efforts on the following CAHPS Recommendations.	
Anthem had overall declines in the Children's CAHPS scores. HSAG recommends reviewing data points and trends in customer calls, grievances	Anthem completed various QI efforts, including:

Prior CAHPS Recommendations (CY 2019)	Anthem's Response to Recommendations
and appeals, prior authorization denials, and quality of care concerns to identify opportunities to address member concerns and improve member satisfaction rates related to care provided to children.	• Reviewing the decline in the children's CAHPS scores to identify key drivers and barriers to improvement and determining priorities.

Optima

Table 8-14—CAHPS Recommendations and Optima's Response

Prior CAHPS Recommendations (CY 2019)	Optima's Response to Recommendations
HSAG recommended that Optima focus QI efforts on the following CAHPS Recommendations.	
Optima experienced declines in both the Adult CAHPS and the Children's CAHPS global and composite scores. HSAG recommends reviewing data points and trends in customer calls, grievances and appeals, prior authorization denials, and quality of care concerns to identify opportunities to address member concerns and improve member satisfaction rates related to care provided to adults and children.	Optima completed various QI efforts, including: • Presenting CAHPS results in the Quality Improvement Committee (QIC) meeting. • Posting survey results on Optima's website and distributing in newsletters for both members and providers. • Using success stories from member concerns and sharing with the care management team for training/learning opportunities to help overall member satisfaction. • Working closely with all internal teams that may have an impact on the grievance or appeal to understand trending issues and work together toward solutions. • Reporting to the quality improvement team the trending issues, how Optima focuses on the issues, and how Optima made changes to improve member or provider satisfaction.

Virginia Premier

Table 8-15—CAHPS Recommendations and VA Premier's Response

Prior CAHPS Recommendations (CY 2019)	VA Premier's Response to Recommendations
HSAG recommended that VA Premier focus QI efforts on the following CAHPS Recommendations.	
VA Premier experienced declines in both the adult CAHPS and child CAHPS global and composite scores. VA Premier demonstrated positive results in *Rating of Personal Doctor* in the child global score. HSAG recommends reviewing data points and trends in customer calls, grievances and appeals, prior authorization denials, and quality of care	VA Premier completed various QI efforts, including: • Developing a Quality Measures Improvement Committee and a Corporate Quality Satisfaction Committee. • Reviewing survey scoring and discussing improvement strategies that are documented and tracked.

Prior CAHPS Recommendations (CY 2019)	VA Premier's Response to Recommendations
concerns to identify opportunities to address member concerns and improve member satisfaction rates related to care provided to adults and children.	• Maintaining the improved *Rating of Personal Doctor* in the child global score.

Summary of Strengths, Weaknesses, and Overall Conclusions

Strengths

Overall, in 2019, all Medallion 4.0 MCOs demonstrated strength in the adult survey in *Getting Needed Care* (two MCOs scored above the 2018 NCQA adult Medicaid national average) and in the child survey in *Shared Decision Making* and *Getting Care Quickly* (two MCOs scored above the 2018 NCQA child Medicaid national average in each category).

Recommendations for Improvement

Overall, HSAG recommends that the Medallion 4.0 MCOs focus on maintaining and improving the members' experience of care as the MCO CAHPS survey results indicated opportunities for improvement in most domains when compared to the 2018 NCQA child and adult Medicaid national averages. HSAG recommends that the MCO efforts also focus on improving survey response rates.

HSAG recommends that MCOs focus quality improvement activities on the members' experience with their health plan as two MCOs scored below the 2018 NCQA child Medicaid national average for *Rating of Health Plan*. MCOs may want to review their grievances, complaints, and other indicators to better understand the drivers of the lower rate for the *Rating of Health Plan* measure.

Activity-Specific Findings—Birth Outcomes Focused Study

This section presents HSAG's findings and conclusions from the focused studies 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 quality improvement made by HSAG during the previous year. The methodology for each study can be found in Appendix A—Technical Methods of Data Collection and Analysis—MCOs.

Overview

DMAS continued to assess the following clinical topics for the 2019 contract year: improving birth outcomes through adequate prenatal care (Birth Outcomes Focused Study); Perinatal Dental Utilization; and improving the health of children in foster care (Foster Care Focused Study).

Improving Birth Outcomes Through Adequate Prenatal Care

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

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

The Birth Outcomes Focused Study included five study indicators: percentage of births with early and adequate prenatal care, percentage of births by gestational estimate, percentage of newborns with low birth weight, percentage of newborns receiving at least two visits with a PCP in the 30 days following birth, and percentage of newborns who had at least one ED visit in the 30 days following birth. Table 9-1 presents study indicator results by population group within each measurement period, as well as whether each indicator's results were statistically significantly different between the study population and comparison group within each measurement period.

Table 9-1—Overall Study Findings by Indicator and Population Group Among Singleton Births, MYs 2016 and 2017

Study Indicator	2017 National Benchmark[1]	Study Population		Comparison Group		Statistically Significant Difference (Yes/No)
		n	%	n	%	
MY 2016						
Births With Early and Adequate Prenatal Care	77.6%	19,685	74.4	3,075	66.6	Yes
Preterm Births (< 37 Weeks Gestation)*	8.1%	2,491	9.2	514	10.9	Yes
Newborns With Low Birth Weight (< 2,500g)*	6.6%	2,366	8.7	442	9.4	No
Newborns With ≥ 2 PCP Visits in the 30 Days Following Birth	N/A	11,784	44.1	2,223	47.2	Yes
Newborns With ≥ 1 ED Visit in the 30 Days Following Birth*	N/A	2,257	8.4	358	7.6	No
MY 2017						
Births With Early and Adequate Prenatal Care	77.6%	18,958	73.7	2,895	65.1	Yes
Preterm Births (< 37 Weeks Gestation)*	8.1%	2,364	8.9	528	11.5	Yes
Newborns With Low Birth Weight (< 2,500g)*	6.6%	2,334	8.8	439	9.5	No
Newborns With ≥ 2 PCP Visits in the 30 Days Following Birth	N/A	11,977	45.8	2,216	48.4	Yes
Newborns With ≥ 1 ED Visit in the 30 Days Following Birth*	N/A	2,263	8.6	361	7.9	No

[1] The national benchmark for *Births With Early and Adequate Prenatal Care* is the Healthy People 2020 goal. The national benchmarks for *Preterm Births* and *Newborns With Low Birth Weight* were identified from calendar year 2017 national data available from the CDC, NCHS, and NVSS[9-1] final data for 2017. Due to the study-specific nature of the remaining indicators, national benchmarks are not available for comparison.

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

Results of the Birth Outcomes Focused Study found that births to women in the study population fared better than those in the comparison group for the following indicators: *Births With Early and Adequate Prenatal Care*, *Preterm Births*, *Newborns With Low Birth Weight (< 2,500g)*, and *Newborns With ≥ 1 ED Visit in the 30 Days Following Birth*. Births in the comparison group outperformed the study population for the indicator *Newborns With ≥ 2 PCP Visits in the 30 Days Following Birth*; that is, a greater percentage of children born to mothers in the comparison group had two or more visits with a PCP-type provider in the 30 days following birth compared to children born to mothers in the study population. In MY 2017, result differences between the study population and comparison group were statistically significant for all indicators except *Newborns With Low Birth Weight (< 2,500g)* and *Newborns With ≥ 1 ED Visit in the 30 Days Following Birth*.

[9-1] Martin JA, Hamilton BE, Osterman MJK, et al. Births: Final data for 2017. *National Vital Statistics Reports*. 2018; 67(8). Hyattsville, MD: National Center for Health Statistics. 2018. Available at: https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_08-508.pdf.

During 2019, HSAG also initiated the fourth annual Birth Outcomes Focused Study, covering births occurring during MY 2018 and using a methodology similar to prior studies. Results from this study are scheduled to be released in 2020.

Dental Utilization in Pregnant Women Data Brief

As a supplement to the Birth Outcomes Focused Study, DMAS contracted HSAG to provide annual data briefs on dental utilization 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. During 2019, HSAG completed a Dental Utilization in Pregnant Women Data Brief that reflected all women with deliveries from January 1, 2018, through December 31, 2018 (MY 2018). Table 9-2 presents the number and percentage of deliveries among women who received perinatal dental services and were 21 years or older at the time of the dental service(s).

Table 9-2—MY 2018 Perinatal Dental Utilization by Study Indicator

Measure	MY 2018 Count of Deliveries	MY 2018 Percent of Deliveries Among Study Population (n=31,952)	MY 2018 Percent of Deliveries Among Women With Any Perinatal Dental Service (n=6,125)
Any Dental Service*	**6,125**	**19.2**	**100.0**
Adjunctive General Services	1,052	3.3	17.2
Crowns	1,151	3.6	18.8
Diagnostic Services	5,898	18.5	96.3
Endodontics	2,218	6.9	36.2
Periodontics	1,298	4.1	21.2
Preventive Services	3,029	9.5	49.5
Prosthodontics	194	0.6	3.2
Restorative Services, including Crowns	3,392	10.6	55.4
Surgery or Extractions	1,994	6.2	32.6

* A woman may have had more than one dental service during the perinatal period; therefore, the count of deliveries for each dental service category do not sum to the overall number of deliveries among women with any dental service.

The MY 2018 study results indicated that only 19.2 percent of deliveries were to women who received perinatal dental services covered by DMAS. More women received dental services during the prenatal period than during the postpartum period, and 29.3 percent of deliveries occurred among women who received dental services during both the prenatal and postpartum periods.

Results of the study also identified regional differences in perinatal dental utilization. Table 9-3 presents the number and percentage of deliveries among women in the study population who received dental services during pregnancy by the women's Medallion 4.0 region of residence.

Table 9-3—Perinatal Dental Utilization by Region of Residence

Region of Residence	MY 2018 Count of Deliveries	MY 2018 Deliveries Among Women Receiving Perinatal Dental Services		MY 2018 Deliveries Among Women Receiving Preventive Perinatal Dental Services	
		#	%	#	%*
Central	7,752	1,676	21.6	851	50.8
Charlottesville/Western	3,745	640	17.1	266	41.6
Northern/Winchester	9,110	1,643	18.0	951	57.9
Roanoke/Alleghany	2,793	469	16.8	201	42.9
Southwest	1,546	347	22.4	194	55.9
Tidewater	7,004	1,349	19.3	565	41.9
No Region Listed	2	1	50.0	1	100.0
Total	**31,952**	**6,125**	**19.2**	**3,029**	**49.5**

*As a percentage of deliveries among women who received any perinatal dental service(s).

While the VA Smiles For Children program provides pregnant women with a critically important opportunity to receive dental services, relatively few eligible women received prenatal and/or postpartum dental services.

During MY 2018, overall dental utilization among pregnant women and receipt of preventive dental services varied by age, and study findings identified that more women received dental services during the prenatal period than during the postpartum period. Utilization of dental services also varied by region, with the Roanoke/Alleghany region having the lowest percentage of women receiving perinatal dental services. Women may have received services from providers located outside their region of residence or not covered by DMAS (e.g., maternal and child health home visiting initiatives[9-2]); however, the regional distribution of perinatal dental utilization may be indicative of women's access to dental providers.

Foster Care Focused Study

HSAG initiated the fourth annual Foster Care Focused Study during 2019, designed to determine the extent to which children in foster care received the expected preventive and therapeutic medical care under managed care service delivery compared to similar children not in foster care.

During 2018–2019, DMAS transitioned from the Medallion 3.0 program to the Medallion 4.0 program. Due to the program change, some members were transitioned to new MCOs, and the MCOs participating in Medallion 4.0 also changed. The MCOs work directly with either the social worker or the foster parent on any decisions regarding care and services. The Medallion 4.0 program also began

[9-2] Virginia's Experience: Improving Oral Health Outcomes for Pregnant Women and Infants. Association of State & Territorial Dental Directors. Available at: https://www.astdd.org/bestpractices/DES53007VAhomevisiting-2019.pdf. Accessed on September 10, 2019.

covering and coordinating services, such as early intervention and non-traditional behavioral health services, that were previously paid through traditional FFS Medicaid.

The study will determine the extent to which children in foster care utilized healthcare services. HSAG will assess 14 measures, representing 20 study indicators, across the following domains:

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

Results of the Foster Care Focused Study will be available in 2020.

Appendix A. 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:

- Performance Measure Validation Methodology
- Consumer Decision Support Tool Methodology
- Rapid-Cycle Performance Improvement Project Validation Approach
- CAHPS Survey Methodology
- Focused Study Methodology
  - Birth Outcomes Focused Study
  - Dental Utilization in Pregnant Women Data Brief
  - Foster Care Focused Study

These methodologies have been taken from the final, DMAS-approved versions of their respective reports.

Performance Measure Validation Methodology

Overview

The Virginia Department of Medical Assistance Services (DMAS) is responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP) in the Commonwealth of Virginia. DMAS refers to its CHIP program as Family Access to Medical Insurance Security (FAMIS). The DMAS CCC Plus Program is an integrated delivery model that includes medical services, behavioral health services, and long-term services and supports (LTSS). DMAS contracts with six privately owned managed care organizations (MCOs) to deliver services to members enrolled in Medicaid and CHIP. The six MCOs are Aetna Better Health of Virginia; HealthKeepers, Inc.; Magellan Complete Care of Virginia; UnitedHealthcare of the Mid-Atlantic, Inc.; Optima Health (Sentara); and Virginia Premier Health Plan, Inc. These six MCOs are contracted for both the Medallion 4.0 and CCC Plus programs.

The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with MCOs, measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of performance measures is one of three mandatory external quality review (EQR) activities required by the Balanced Budget Act of 1997 (BBA) described in the Code of Federal Regulations (CFR) at 42 CFR §438.358(b)(2). The purpose of performance measure validation (PMV) is to assess the accuracy of performance measure rates reported by MCOs and to determine the extent to which performance measures reported by the MCOs follow state specifications and reporting

requirements. According to the EQR protocol[A-1] developed by CMS, the mandatory PMV activity may be performed by the State Medicaid agency, an agent that is not an MCO, or an external quality review organization (EQRO).

To meet the PMV requirements, DMAS contracted with Health Services Advisory Group, Inc. (HSAG), under Task D3, G1 and G2 to conduct the PMV for each MCO, validating the data collection and reporting processes used for the calculation of the performance measure rates for the Medallion 4.0 and CCC Plus programs. HSAG has contracted with Aqurate Health Data Management, Inc. (Aqurate), to assist in conducting the validation of performance measures.

Annually, DMAS identifies a set of performance measures that the MCOs are required to calculate and report. Five of the measures selected for the Medallion 4.0 program were selected from HEDIS, developed by NCQA and one measure was developed by DMAS. For the CCC Plus program, four measures were NCQA HEDIS measures and two measures were from the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set). The measurement period identified by DMAS is measurement year (MY) 2018 (January 1, 2018, through December 31, 2018) for HEDIS and Core set measures and State fiscal year (SFY) 2019 (July 1, 2018, through June 30, 2019) for the one state specific measure for Medallion 4.0. Table A-2 lists the selected performance measures, the method required for data collection, and the specifications that the MCOs were required to use for Medallion 4.0 and CCC Plus.

Objectives

The primary objectives of HSAG's PMV process are to:

- Evaluate the accuracy of the performance measure data reported by the MCOs.
- Determine the extent to which the performance measures calculated by the MCOs follow DMAS' reporting requirements.

Description of Validation Activities

HSAG will focus on data used for calculating and reporting the performance measures for MY 2018 for the HEDIS and Core set measures and SFY 2019 for the state specific measure. HSAG will use several validation strategies to achieve the validation objectives.

The validation activities described below will be used in combination as appropriate for the type of measures evaluated (HEDIS or non-HEDIS).

[A-1] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: May 22, 2019.

The validation of the foster care assessment measure will be focused on ensuring that the MCOs have appropriate systems and processes in place to identify new members requiring an assessment, tools to conduct assessments, as well as appropriate methods of tracking and counting completed assessments and reporting data to DMAS based on guidelines in the Medallion 4.0 contract.

Pre-On-Site Activities

HSAG will conduct the validation activities as outlined in the CMS PMV protocol. HSAG will prepare a document request letter for the MCOs outlining the steps in the PMV process. The document request letter will include a request for source code for each performance measure; a completed HEDIS 2019 Record of Administration, Data Management, and Processes (Roadmap); a completed Information Systems Capabilities Assessment Tool (ISCAT); any additional supporting documentation necessary to complete the audit; a timetable for completion; and instructions for submission. A single document request letter will be sent for both Medallion 4.0 and CCC Plus PMV validation.

The document request letter will also provide guidance to the MCOs that when there are questions in the ISCAT that are also covered in the Roadmap submission, MCOs may reference the Roadmap by providing details about the section or document title and page number from the Roadmap in lieu of a response. In addition, HSAG will forward a letter that includes requested documentation needed to complete the medical record review validation (MRRV) process. Approximately two weeks prior to the on-site visit, HSAG will provide the MCOs with an agenda describing all on-site visit activities and indicating the type of staff needed for each session. HSAG will also conduct a pre-on-site conference call with the MCOs to discuss on-site logistics and expectations, important deadlines, and any outstanding questions.

HSAG will help DMAS to calculate a rate for the *Foster Care Assessments* measure. This rate will be calculated based on data HSAG received from DMAS. The data provided by DMAS will be a combination of self-reported completed foster care assessment counts as reported by the MCOs and eligibility data maintained by DMAS.

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

Technical Methods of Data Collection and Analysis

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

- **NCQA's HEDIS 2019 Roadmap:** The MCO will complete and submit the required and relevant portions of its Roadmap for HSAG's review of the required DMAS measures under review that are HEDIS measures. HSAG will use responses from the Roadmap to complete the pre-on-site assessment of information systems.

- **Information Systems Capabilities Assessment Tool (ISCAT):** The MCOs will complete and submit an ISCAT for HSAG's review of the Core Set and DMAS-developed measures. HSAG will use responses from the ISCAT to complete the pre-on-site assessment of information systems.
- **Medical record documentation:** The MCOs will be responsible for completing the medical records review section within the Roadmap. In addition, HSAG will request that the MCOs submit the following documentation for review: medical record abstraction tools and instructions, training materials for medical record review staff members, and policies and procedures outlining the processes for monitoring the accuracy of the abstractions performed by the review staff members. HSAG will conduct over-read of 30 records from the hybrid sample. HSAG will follow NCQA's guidelines to validate the integrity of the MRRV processes used by the MCOs and will then use the MRRV results to determine if the findings impact the audit results for any performance measure rate.
- **Source code (programming language) for performance measures:** MCOs that calculate the performance measures using internally developed source code will be required to submit source code for each performance measure being validated. HSAG will complete a line-by-line review of the supplied source code to ensure compliance with the measure specifications required by DMAS. HSAG will identify 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 will be required to submit documentation describing the steps taken for performance measure calculation. If the MCOs outsourced programming for HEDIS measure production to an outside vendor, the MCOs will be required to submit the vendor's NCQA measure certification reports.
- **Supporting documentation:** HSAG will request 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 will review all supporting documentation, identifying issues or areas needing clarification for further follow-up.

On-Site Activities

During the on-site visit, HSAG will collect additional information to compile PMV findings using several methods including interviews, system demonstration, review of data output files, observation of data processing, and review of data reports. The onsite review will be combined for the Medallion 4.0 and CCC Plus programs. The on-site strategies will include:

- **Opening meetings:** These meetings include introductions of the validation team and key MCO staff involved in the calculation or reporting of the performance measures. The purpose of the PMV, required documentation, basic meeting logistics, and queries to be performed will be discussed.
- **Review of ISCAT and Roadmap documentation:** This session is 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 will conduct interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures are used and followed in daily practice.

- **Evaluation of enrollment, eligibility, foster care risk assessment, and claims systems and processes:** The evaluation includes a review of the information systems, focusing on the processing of claims, processing of enrollment and disenrollment data, and tracking of foster care assessments. This review will include confirming systems and processes in place to identify completed foster care assessments.

  HSAG will conduct interviews with key staff familiar with the processing, monitoring, reporting, and calculating of the performance measures. Key staff may include executive leadership, enrollment specialists, business analysts, customer operations staff, data analytics staff, and other front-line staff familiar with the processing, monitoring, and generating of the performance measure. HSAG will use 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 will include a review of the information systems and evaluation of processes used to collect, calculate, and report the performance measures, including accurate numerator and denominator identification and algorithmic compliance (which will evaluate whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).

  HSAG will perform additional validation using primary source verification (PSV) to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Using this technique, HSAG will assess the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG will select 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 are detected, the outcome is determined based on the type of error. For example, the review of one case may be sufficient in detecting a programming language error, and as a result no additional cases related to that issue may be reviewed. In other scenarios, one case error detected may result in the selection of additional cases to better examine the extent of the issue and its impact on reporting.
- **Closing conference:** At the end of each on-site visit, HSAG will summarize preliminary findings, discuss follow-up items, and revisit the documentation requirements for any post-on-site activities.

Post On-Site Activities

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

HSAG will prepare a separate PMV report for CCC Plus and Medallion 4.0 for each MCO, documenting the validation findings. Based on all validation activities, HSAG will determine the validation result for

each performance measure listed below. The CMS PMV Protocol identifies possible validation results for performance measures, defined in the table below.

Table A-1—Validation Results and Definitions for Performance Measures

Report (R)	Measure was compliant with the specifications, and the rate can be reported.
Not Reported (NR)	This designation is assigned to measures for which the MCO rate was materially biased.

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

Any corrective action that cannot be implemented in time will be 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 "NR."

Performance Measure List for SFY 2019

The following table lists the performance measures selected by DMAS, the method (i.e., hybrid or admin) required for data collection, and the specifications that the MCOs are required to use.

Table A-2—2018 Performance Measures Selected by DMAS for Validation for Medallion 4.0 and CCC Plus

Performance Measures for Medallion 4.0	Specifications	Methodology
Foster Care Assessments	DMAS	Hybrid*
Adolescent Well-Care Visits	HEDIS	Hybrid
Childhood Immunization Status- combo 3	HEDIS	Hybrid
Children and Adolescents' Access to Primary Care Practitioners	HEDIS	Admin
Prenatal and Postpartum Care	HEDIS	Hybrid
Comprehensive Diabetes Care	HEDIS	Hybrid
* Hybrid refers to a review of both the administrative data system as well as foster care assessments contained in the MCOs' care/case management systems.		

Performance Measures for CCC Plus	Specifications	Methodology
Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	HEDIS	Admin
Follow-up after Emergency Department Visit for Mental Illness	HEDIS	Admin

Performance Measures for CCC Plus	Specifications	Methodology
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	HEDIS	Admin
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admissions rate (PQI05-AD)	ADULT CORE SET	Admin
Comprehensive Diabetes Care	HEDIS	Hybrid
Heart Failure Admissions Rate (PQI08-AD)	ADULT CORE SET	Admin

Consumer Decision Support Tool Methodology

Project Overview

Virginia's Department of Medical Assistance Services (DMAS) contracted with Health Services Advisory Group, Inc. (HSAG) to analyze 2019 Healthcare Effectiveness Data and Information Set (HEDIS®)[A-2] results, including 2019 Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[A-3] data from five Virginia Managed Care Organizations (MCOs) for presentation in the 2019 Virginia Medicaid Consumer Decision Support Tool.[A-4] The Consumer Decision Support Tool analysis helps support DMAS' public reporting of MCO performance information.

Data Collection

For this activity, HSAG received the MCOs' CAHPS member-level data files and HEDIS data from the MCOs. The CAHPS survey was most recently administered in 2019. The *HEDIS 2019 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS 2019 Technical Specifications for Health Plans, Volume 2* was used to collect and report on the HEDIS measures.

Reporting Categories

The Consumer Decision Support Tool reporting categories and descriptions of the measures they contain are:

- **Doctors' Communication:** Includes child and adult CAHPS composites and items on consumer perceptions about how well their doctors communicate and overall ratings of personal doctors. In addition, this category includes a CAHPS measure related to medical assistance with smoking and tobacco use cessation.
- **Getting Care:** Includes child CAHPS composites on consumer perceptions regarding the ease of obtaining needed care and how quickly they received that care. This category includes HEDIS measures that assess adults' and children's access to care, as well as appropriate follow-up for mental illness and alcohol or other drug (AOD) abuse or dependence.
- **Keeping Kids Healthy:** Includes HEDIS measures of how often preventive services and appropriate treatment are provided (e.g., child immunizations, well-child visits, well-care visits for adolescents, attention deficit hyperactivity disorder [ADHD] medication follow-up care, first-line psychosocial

[A-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[A-3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[A-4] Due to Magellan Complete Care of Virginia (Magellan) being a new plan in 2018, the MCO did not have sufficient data to be included in the Consumer Decision Support Tool; therefore, Magellan will be included in future Consumer Decision Support Tools.

care for children and adolescents prior to prescribing antipsychotics, and avoidance of prescribing multiple concurrent antipsychotics for children and adolescents).

- **Living With Illness:** Includes HEDIS measures that assess how well MCOs take care of people who have chronic conditions (e.g., diabetes and high blood pressure). In addition, this category includes HEDIS measures that assess medication management for people living with depression and asthma.
- **Taking Care of Women:** Includes HEDIS measures that assess how often women-specific services are provided (e.g., screenings for breast cancer and cervical cancer, and prenatal and postpartum care).

Measures Used In Analysis

DMAS, in collaboration with HSAG, chose measures for this year's Consumer Decision Support Tool based on a number of factors. In an effort to align with the Performance Incentive Awards (PIA) Program, the HEDIS measures evaluated as part of the PIA will be included in this analysis, as well as many measures required by the Medallion 4.0 Managed Care Contract for reporting. Per NCQA specifications, the CAHPS 5.0H Adult Medicaid Health Plan Survey instrument was used for the adult population and the CAHPS 5.0H Child Medicaid Health Plan Survey instrument was used for the child population.

Table A-3 lists the 38 measure indicators, eight CAHPS and 30 HEDIS, and their associated weights.[A-5] Weights will be applied when calculating the category summary scores and the confidence intervals to ensure that all measures contribute equally in the derivation of the final results. Please see section VI for more detail on comparing MCO performance.

Table A-3—MCO Consumer Decision Support Tool Reporting Categories, Measures, and Weights

Measures	Measure Weight
Category: Doctors' Communication	
Child Medicaid—*How Well Doctors Communicate* (CAHPS Composite)	1
Child Medicaid—*Rating of Personal Doctor* (CAHPS Global Rating)	1
Adult Medicaid—*Rating of Personal Doctor* (CAHPS Global Rating)	1
Medical Assistance With Smoking and Tobacco Use Cessation	
Advising Smokers and Tobacco Users to Quit	1/3
Discussing Cessation Medications	1/3
Discussing Cessation Strategies	1/3

[A-5] Two child CAHPS measures (*Shared Decision Making* and *Rating of Specialist Seen Most Often*), four adult CAHPS measures (*How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Specialist Seen Most Often*, and *Getting Needed Care*), and one HEDIS measure indicator (*Adults' Access to Preventive/Ambulatory Health Services—65+ Years*) were excluded from the 2019 Consumer Decision Support Tool based on insufficient data reported by half of the MCOs. These measures will be reevaluated for inclusion in a future Consumer Decision Support Tool.

Measures	Measure Weight
Category: Getting Care	
Child Medicaid—Getting Needed Care (CAHPS Composite)	1
Child Medicaid—Getting Care Quickly (CAHPS Composite)	1
Adults' Access to Preventive/Ambulatory Health Services	
20–44 Years	1/2
45–64 Years	1/2
Children and Adolescents' Access to Primary Care Practitioners	
12–24 Months	1/4
25 Months–6 Years	1/4
7–11 Years	1/4
12–19 Years	1/4
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	1
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total	1
Category: Keeping Kids Healthy	
Childhood Immunization Status—Combination 3	1
Well-Child Visit in the First 15 Months of Life—Six or More Well-Child Visits	1
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	1
Adolescent Well-Care Visits	1
Follow-Up Care for Children Prescribed ADHD Medication	
Initiation Phase	1/2
Continuation and Maintenance Phase	1/2
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	1
Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total	1
Category: Living With Illness	
Comprehensive Diabetes Care	
Hemoglobin A1c (HbA1c) Testing	1/6
HbA1c Poor Control (>9.0%)	1/6
HbA1c Control (<8.0%)	1/6
Eye Exam (Retinal) Performed	1/6
Blood Pressure Control (<140/90 mm Hg)	1/6
Medical Attention for Nephropathy	1/6
Controlling High Blood Pressure	1

Measures	Measure Weight
Antidepressant Medication Management	
Effective Acute Phase Treatment	1/2
Effective Continuation Phase Treatment	1/2
Asthma Medication Ratio—Total [A-6]	1
Category: Taking Care of Women	
Breast Cancer Screening	1
Cervical Cancer Screening	1
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	1
Postpartum Care	1

Missing Values

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

- *Not Reported (NR)*—MCOs chose not to submit data, even though it was possible for them to do so.
- *Biased Rate (BR)*—MCOs' measure rates were determined to be materially biased in a HEDIS Compliance Audit.
- *Not Applicable (NA)*—MCOs were unable to provide a sufficient amount of data (e.g., too few members met the eligibility criteria for a measure).

In developing scores and ratings for the reporting categories, HSAG handled the missing rates for measures as follows:

- Rates with an *NR* designation were assigned the minimum rate.
- Rates with a *BR* designation were assigned the minimum rate.
- Rates with an *NA* designation were assigned the average value.

For measures with an *NA* audit result, HSAG used the mean of non-missing observations across all MCOs. For measures with an *NR* or *BR* audit result, HSAG used the minimum value of the non-missing observations across all MCOs. This minimized the disadvantage for MCOs that were willing but unable to report data and ensured that MCOs did not gain advantage from intentionally failing to report complete and accurate data. If more than half of the plans had an *NR, BR,* or *NA* for any measure, then the measure was excluded from the analysis.

[A-6] As the *Medication Management for People With Asthma* measure is no longer endorsed by National Quality Forum (NQF), HSAG replaced this measure with the *Asthma Medication Ratio* measure.

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 five 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 five reporting categories (Doctors' Communication, Getting Care, Keeping Kids Healthy, Living With Illness, and Taking Care of Women) were calculated from MCO scores on selected HEDIS measures and CAHPS questions and composites.

1. HEDIS rates were extracted from the auditor-locked IDSS data sets and HSAG calculated the CAHPS rates using the NCQA CAHPS member-level data files. To calculate a rate for a CAHPS measure, each individual response was converted to a score of 1, 2, or 3 as described in *HEDIS 2019 Volume 3: Specifications for Survey Measures*. HSAG then calculated the average of the individual three-point means scores to reach a plan average for each CAHPS item. For the CAHPS global rating measures (e.g., Rating of Personal Doctor), this plan average acted as the CAHPS measure score. For the CAHPS composite measures, the CAHPS measure score was the average of the three-point means for each CAHPS item.
2. For each HEDIS and CAHPS measure, HSAG calculated the measure variance. The measure variance for HEDIS measures was calculated as follows:

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

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

For CAHPS global rating measures, the variance was calculated as follows:

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

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

n = number of responses in MCO k

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

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

where: j = 1,…,m questions in the composite measure
i = 1….,n_j members responding to question j
x_{ij} = response of member i to question j (1, 2, or 3)
$\bar{x}_j$ = MCO mean for question j
N = members responding to at least one question in the composite

3. For MCOs with *NA* and *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 rating.
6. HSAG summed the standardized MCO means, weighted by the individual measure weights to derive the MCO category summary measure score.
7. For each MCO k, HSAG calculated the category variance, CV_k, as: $CV_k = \sum_{j=1}^{m}\frac{w_j}{c_j^2}V_j$

   where: j = 1,…,m HEDIS or CAHPS measures in the summary
   V_j = variance for measure j
   c_j = group standard deviation for measure j
   w_j = measure weight for measure j
8. The summary scores were used to compute the group mean and the difference scores. The group mean was the average of the MCO summary measure scores. The difference score, d_k, was calculated as d_k = MCO k score – group mean.
9. For each MCO k, HSAG calculated the variance of the difference scores, $Var(d_k)$, as:

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

   where: P = total number of MCOs
   CV_k = category variance for MCO k
10. The statistical significance of each difference was determined by computing a confidence interval (CI). A 95 percent CI and 68 percent CI were calculated around each difference score to identify plans that were significantly higher than or significantly lower than the mean. Plans with differences significantly above or below zero at the 95 percent confidence level received the top (Highest Performance) and bottom (Lowest Performance) designations, respectively. Plans with

differences significantly above or below zero at the 68 percent confidence level, but not at the 95 percent confidence level, received High Performance and Low Performance designations, respectively. A plan was significantly above zero if the lower limit of the CI was greater than zero; and was significantly below zero if the upper limit of the CI was below zero. Plans that do not fall either above or below zero at the 68 percent confidence level received the middle designation (Average Performance). For a given measure, the formulas for calculating the CIs were:

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

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

A five-level rating scale provides consumers with an easy-to-read "picture" of quality performance across MCOs and presents data in a manner that emphasizes meaningful differences between MCOs. The Consumer Decision Support Tool displays results for each MCO as follows:

Table A-4—2019 Consumer Decision Support Tool–Performance Ratings

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

Deliverables

For the 2019 Consumer Decision Support Tool activity, HSAG provided DMAS with the following deliverables:

- Results report displaying star ratings and NCQA accreditation status levels for each MCO (i.e., Excellent, Commendable, Accredited, Provisional, or Interim) for DMAS to post on its website for public comment.

Individual measure rates and summary results for each MCO in Microsoft Excel file format.

HSAG's Rapid-Cycle Performance Improvement Project (PIP) Validation Approach

HSAG's PIP approach guides MCOs through a process using a rapid-cycle improvement method to pilot small changes rather than implementing one large transformation. Performing small tests of change should require fewer resources and allow more flexibility for adjustments throughout the improvement process. By piloting on a smaller scale, MCOs have an opportunity to determine the effectiveness of changes prior to expanding successful interventions. HSAG developed a series of five modules that MCOs complete as they progress through the PIP.

Module 1—PIP Initiation

The objective of this module is to ask and answer the first fundamental question of the Model for Improvement: "What are we trying to improve?" In Module 1, MCOs outline the project's framework. The framework includes the topic rationale, data supporting the need to improve the selected topic, members who make up the PIP team, and the key driver diagram that defines the aim, factors that influence achievement of the aim, and interventions that can lead to the desired improvement.

Module 2—SMART (Specific, Measurable, Attainable, Relevant, Time-bound) Aim Data Collection

The objective for this module is to ask and answer the second fundamental question of the Model for Improvement: "How will we know that a change is an improvement?" In Module 2, MCOs define how and when it will be known that improvement is happening. MCOs define the SMART Aim measure, data collection methodology, data collection plan, and develop a SMART Aim measure run chart.

Module 3—Intervention Determination

The objective for this module is to ask and answer the third fundamental question of the Model for Improvement: "What changes can we make that will result in improvement?" In Module 3, MCOs identify potential interventions that can impact the SMART Aim using quality improvement activities. The MCO's PIP team employs a step-by-step process that uses process mapping and failure modes effect analysis (FMEA) to determine interventions that may be tested using Plan-Do-Study-Act (PDSA).

Module 4—PDSA

In Module 4, MCOs test interventions that have the potential to impact the SMART Aim using PDSA cycles. MCOs document details about the change and an evaluation plan. Based on testing, MCOs analyze the data and summarize results. MCOs subsequently determine what needs to be done with the

intervention based on what was learned from the test (i.e., adopt, adapt, abandon, continue testing). MCOs complete a Module 4 submission form for each intervention that it tests for the PIP.

Module 5—PIP Conclusions

In Module 5, MCOs summarize key findings, comparison of successful and unsuccessful interventions, and outcomes. MCOs synthesize all data collected, information gathered, and lessons learned to document the impact of the PIP and to consider how any demonstrated improvement can be shared and used as a foundation for further improvement going forward. MCOs submit the PIP's final key driver diagram, SMART Aim run chart with mapped interventions, and FMEA. Additionally, the MCO will update Module 3's intervention determination table if it selected an intervention to test in Module 4 that was not identified in Module 3.

PIP Validation Overview

HSAG's methodology for validating PIPs is a consistent, structured process that uses standardized scoring. HSAG validates PIPs annually to the point of progression using criteria that it developed to align with CMS PIP validation protocols and rapid-cycle improvement principles. The validation process determines if DMAS and other key stakeholders can have confidence in the MCOs' reported PIP results.

HSAG provides DMAS and the MCOs with a PIP Validation Tool for each submitted module that consists of validation criteria necessary for successful completion of a valid PIP. HSAG scores the criteria as *Achieved* or *Not Achieved* and provides detailed written feedback and recommendations. HSAG provides general comments for achieved criteria when enhanced documentation would demonstrate a stronger application of the PIP requirements. HSAG also provides annual MCO-specific PIP Validation Reports that include the validation findings and recommendations for improvement.

CAHPS Survey Methodology

The primary objective of the Adult and Child CAHPS surveys was to effectively and efficiently obtain information on the levels of satisfaction of adult and child Medicaid members enrolled in the FAMIS program, Aetna, HealthKeepers, Optima, United, and VA Premier with their MCO and healthcare experiences.

Technical Methods of Data Collection and Analysis

MCO CAHPS

For the Medallion 4.0 MCOs, the technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.0H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCO.[A-7] The mode of CAHPS survey data collection varied slightly among the MCOs. HealthKeepers and United used an enhanced mixed-mode survey methodology that was pre-approved by NCQA for both their adult and child populations. Aetna and VA Premier used an enhanced Internet mixed-mode methodology for both their adult and child populations. Optima used an enhanced Internet mixed-mode methodology of data collection for its adult Medicaid members and a mixed-mode methodology for its child Medicaid members. Following NCQA's standard HEDIS timeline, adult members and parents/caretakers of child members enrolled in each of the MCOs completed the surveys between the time period of January to May 2019.

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.[A-8] 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 5.0H Surveys include a set of standardized items (53 items for the CAHPS 5.0H Adult Medicaid Health Plan Survey and 48 items for the CAHPS 5.0H Child Medicaid Health Plan Survey

[A-7] HealthKeepers and United administered the CAHPS 5.0H Child Medicaid Health Plan Survey with the CCC measurement set to their child Medicaid populations, while the other MCOs administered the CAHPS 5.0 Child Survey without the chronic conditions measurement set. For purposes of this report, the child Medicaid CAHPS results presented for HealthKeepers and Kaiser Permanente represent the CAHPS results for their general child populations (i.e., general child CAHPS results).

[A-8] Aetna contracted with the Center for the Study of Services (CSS), HealthKeepers and United both contracted with DSS Research, and Optima and VA Premier both contracted with SPH Analytics to conduct the CAHPS survey administration and analysis and reporting of survey results for their respective adult and child Medicaid populations.

without the Children with Chronic Conditions measurement set) that assess members' perspectives on care. For the MCOs, the CAHPS survey questions were categorized into nine measures of satisfaction.[A-9] These measures included four global ratings and five composite scores. The global ratings reflected members' overall experience with their health plan, all healthcare, personal doctor, and specialist. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*).

For each of the four global ratings, the percentage of respondents who chose the top experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a top-box response or top-box score. For each of the five composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always"; or (2) "No" or "Yes." A top-box response or top-box score for the composite measures was defined as a response of "Usually/Always" or "Yes."

The 2019 CAHPS scores for each MCO and the statewide aggregate were compared to the 2018 NCQA Medicaid national averages.[A-10] A statistically significant difference was identified by using the confidence interval for each measure rate. Statistically significant differences are noted with colors. A cell was highlighted in yellow if the lower bound of the confidence interval was higher than the national average. However, if the upper bound of the confidence interval was lower than the national average, then a cell was highlighted in red.

Additionally, a trend analysis was performed for each MCO, where applicable, that compared its 2019 CAHPS scores to its corresponding 2018 scores to determine whether there were statistically significant differences. Scores that were statistically significantly higher in 2019 than in 2018 are noted with upward (▲) triangles. Scores that were statistically significantly lower in 2019 than in 2018 are noted with downward (▼) triangles. Scores in 2019 that were not statistically significantly different from scores in 2018 are not noted with triangles.

It is important to note that NCQA requires a minimum of 100 respondents in order to report the CAHPS item as a valid survey result. If the NCQA minimum reporting threshold of 100 respondents was not met, the CAHPS score was denoted with a cross (+). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

FAMIS CAHPS

For the FAMIS CAHPS surveys, the technical method of data collection was through administration of the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the CCC measurement set. The CAHPS surveys were conducted per the Centers for Medicare & Medicaid

[A-9] For purposes of this report, CAHPS survey results are not reported for the two individual item measures: *Coordination of Care* and *Health Promotion and Education*. Therefore, reported results are limited to the four global ratings and five composite measures.

[A-10] Quality Compass 2018 data serve as the source for the 2018 NCQA CAHPS adult Medicaid and child Medicaid national averages.

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

Based on NCQA protocol, child members included as eligible for the survey were 17 years of age or younger as of December 31, 2018. A mixed-mode methodology for data collection was utilized (i.e., mailed surveys followed by computer assisted telephone interviewing [CATI] of non-respondents to the mailed surveys). Parents or caretakers of child members completed the surveys between the time period of March to June 2019. The surveys were administered in English and Spanish. Members identified as Spanish speaking through administrative data received a Spanish version of the survey with the option to complete the survey in English. All other members received an English version of the survey with the option to complete the survey in Spanish.

The CAHPS 5.0 Child Medicaid Health Plan Survey with the chronic conditions measurement set includes a standardized set of 83 items that assess patient perspectives on care. To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed to select the general child and children with chronic conditions members and distribute the surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instrument and the comparability of the resulting data. An analysis of the CAHPS 5.0 Child Medicaid Health Plan Survey results was conducted using NCQA HEDIS Specifications for Survey Measures.[A-11]

For the FAMIS program, the survey questions were categorized into nine measures of satisfaction.[A-12] These measures included four global ratings and five composite measures. The global measures (also referred to as global ratings) reflected patients' overall experience with their health plan, all healthcare, personal doctor, and specialist. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* or *Getting Care Quickly*).

For each of the four global ratings, the percentage of respondents who chose the top experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a top-box response or top-box score. For each of the five composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always;" or (2) "No" or "Yes." A top-box response or top-box score for the composite measures was defined as a response of "Usually/Always" or "Yes."

[A-11] National Committee for Quality Assurance. *HEDIS® 2019, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2018.

[A-12] For purposes of this report, CAHPS survey results are not reported for the two individual item measures: *Coordination of Care* and *Health Promotion and Education*, or the five CCC composite measures and items. Therefore, reported results are limited to the four global ratings and five composite measures.

The FAMIS program's general child and CCC populations' survey findings were compared to 2018 NCQA CAHPS child and CCC Medicaid national averages.[A-13] A statistically significant difference was identified by using the confidence interval for each measure rate. Statistically significant differences are noted with colors. A cell was highlighted in yellow if the lower bound of the confidence interval was higher than the national average. However, if the upper bound of the confidence interval was lower than the national average, then a cell was highlighted in red.

NCQA requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result. However, for purposes of reporting the FAMIS CAHPS results, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Caution should be exercised when interpreting results for those measures with fewer than 100 respondents. CAHPS scores with fewer than 100 respondents are denoted with a cross (+).

Description of the Data Obtained/Time Period

The CAHPS survey asks members to report on and to evaluate their experiences with healthcare. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The CAHPS surveys were administered from January to May 2019 for the Medallion 4.0 MCOs, and from March to June 2019 for the FAMIS program.

The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. For the CAHPS 5.0H 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, 15, 24, 28, and 35. For the CAHPS 5.0H Child Medicaid Health Plan Survey without the CCC measurement, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 15, 27, 31, and 36. For the CAHPS 5.0 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, 30, 45, 49, and 54. Eligible members included the entire sample minus ineligible members. For the child population, ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), or they had a language barrier. For the adult population, ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), they had a language barrier, or they were mentally or physically incapacitated. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

Following the administration of the FAMIS CAHPS surveys, HSAG provided DMAS with an aggregate report of the general child and children with chronic condition populations' CAHPS survey results, representing the CAHPS survey results for the statewide FAMIS program in aggregate (i.e., FAMIS program members enrolled in FFS and managed care).

[A-13] The source for the 2018 NCQA national child and CCC Medicaid averages for the general child population and children with chronic conditions population is Quality Compass® 2018 data.

Birth Outcomes Focused Study Methodology

Purpose

The Virginia Department of Medical Assistance Services (DMAS) has contracted with Health Services Advisory Group, Inc. (HSAG) to conduct a focused study that will provide quantitative information about prenatal care and associated birth outcomes among Medicaid recipients. In alignment with the Task F.1 studies conducted during state fiscal years (SFYs) 2015–2016 and 2016–2017, the SFY 2017–2018 Task F.1 Birth Outcomes Focused Study will continue to address the following questions:

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

Study Design

Measurement Period

The study will include all singleton births paid by Virginia Medicaid during calendar year (CY) 2016 or CY 2017. Results for CY 2015 will be taken from the previously published 2016–2017 Task F.1 Birth Outcomes Focused Study report and included in the current study for trending purposes.

Eligible Population

The eligible population will consist of all live births during CY 2016 or CY 2017 that were paid by Virginia Medicaid, regardless of whether the births occurred in Virginia. The birth registry contains records of live births; other pregnancy outcomes will be excluded from this study.

To examine outcomes among all Medicaid-paid births in light of expected services, births will be grouped 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 FAMIS MOMS, the Medicaid for Pregnant Women, or an "Other Medicaid" program for a minimum of 43 days prior to, and including, the date of delivery. The "Other Medicaid" category will include births paid by Medicaid that do not fall within the FAMIS MOMS or the Medicaid for Pregnant Women categories.
- The comparison group will include women enrolled in one of the three Medicaid program groups defined above on the date of delivery, but without prior continuous enrollment.

HSAG will conduct tests for statistical significance between the CY 2017 study group results and across overall CY 2015 through CY 2017 results for the study and comparison populations, as directed by DMAS.

Data Collection

Using Medicaid recipient, claims, and encounter data files supplied by DMAS, HSAG will identify women eligible for the study. HSAG will assemble a list of members eligible for the study (i.e., a Finder File) and submit this list to DMAS with instructions for conducting the data linkages. DMAS will work with the Virginia Department of Health (VDH) to conduct the data linkages. DMAS will use probabilistic data linking to match HSAG's list of members eligible for the study to birth registry records. In addition to the probabilistic data linkage, DMAS will match HSAG's list of study-eligible members to birth registry records using social security numbers (i.e., a deterministic linkage). DMAS will return data files to HSAG containing the information from HSAG's original Finder File and all birth registry data fields for matching members for each of the data linkage processes, as well as documentation regarding the linked data files.

HSAG will identify study-eligible women as all members with birth registry records probabilistically linked or deterministically linked to the Finder File for CY 2016 or CY 2017. A four-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 May 1, 2018.

Indicators

Study indicators are limited to singleton births, defined using the *Plurality* field in the birth registry. Since multiple gestation births are subject to different clinical guidelines, results for multiple births will be limited to demographic summaries (e.g., maternal age, Medicaid program, neonatal characteristics) and used for informational purposes only. Table A-5 illustrates the study indicators included in the study, as well as the numerator and denominator definitions. Please note that calculation of the measures is contingent upon the availability of timely, complete, and accurate data.

Table A-5—Study Indicators

Indicator	Denominator	Numerator
1. Percentage of 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. Note: Secondary analyses will be completed to determine the number of singleton, live births with a Kotelchuck Index score greater than or equal to 110 percent (i.e., "Adequate Plus"). This information will be used for informational purposes only.
2. Percentage of births by gestational estimate.[1]	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births by gestational estimate category: 1. Preterm: Less than 37 weeks a. Extremely preterm: <28 weeks b. Very preterm: 28 through 31 weeks c. Moderate preterm: 32 through 33 weeks d. Late preterm: 34 through 36 weeks 2. Term: 37 weeks through 41 weeks (may be reported weekly) a. Early Term: 37 weeks though 38 weeks b. Full Term: 39 weeks through 40 weeks

Indicator	Denominator	Numerator
		c. Late Term: 41 weeks 3. Post Term: 42 weeks and beyond
3. Percentage of newborns with low birth weight.	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births by low birth weight category: 1. Overall low birth weight: less than 2,500 grams a. Moderately low birth weight: 1,500 grams through 2,499 grams b. Very low birth weight: less than 1,500 grams
4. Percentage of newborns receiving at least two visits with a primary care provider (PCP) in the 30 days following birth.[2] Note: Supplemental analyses will identify the percentage of newborns receiving 1) zero visits in the 30 days following birth, and 2) one visit in the 30 days following birth.	Number of singleton, live births paid by Virginia Medicaid during the measurement period. Note: Newborns with a neonatal intensive care unit (NICU) stay may be excluded from the measure results.	Number of singleton, live births where the newborn received at least two office visits in the 30 days following birth with any PCP-type provider.[3] Visits must occur on separate days and do not have to be with the same provider. **PCPs** = Pediatricians, family practice physicians, general practice physicians, internal medicine physicians, nurse practitioners, and physician assistants. **Office Visits** = Identified from claims/encounter data with any of the following procedure and/or diagnosis codes for office or other outpatient services, home services, preventive medicine, or general medical examination: CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99385, 99391-99395, 99401-99404, 99411-99412, 99420, 99429 HCPCS: G0438, G0439 ICD-9-CM[4]: V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9 ICD-10-CM: Z00.0x, Z00.1x, Z00.8 **Neonatal Visits** = Identified from claims/encounter data with revenue code 0173 or 0174.

Indicator	Denominator	Numerator
5. Percentage of newborns who had at least one emergency department (ED) visit in the 30 days following birth. Note: Supplemental analyses will identify the range in the number of ED visits reported within the 30 days following birth. Pending review of the data, supplemental analysis may be included to report on the reasons for ED visits.	Number of singleton, live births paid by Virginia Medicaid during the measurement period. Note: Newborns with a neonatal intensive care unit (NICU) stay may be excluded from the measure results.	Number of singleton, live births where the newborn had at least one ED visit in the 30 days following birth.[5] ED visits will be considered unique by facility, date of service, and member. **ED Visit** = Identified from claims/encounter data with any of the following procedure or revenue codes for emergency department visits CPT: 99281-99285 CPT: 10040-69979 AND Place of Service = "23" (Emergency Room – Hospital) Revenue: 045x, 0981 **Neonatal Visits** = Identified from claims/encounter data with revenue code 0173 or 0174.

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

[2] HSAG will use the classification of PCP-type providers established for prior Task F.1 Birth Outcomes Focused Studies.

[3] Based on the *Virginia EPSDT Periodicity Chart* published online by Virginia DMAS at http://dmasva.dmas.virginia.gov/Content_atchs/mch/mch-epsdt_poi2.pdf [Accessed on May 15, 2018], infants are expected to have at least two visits with a PCP-type provider in the first 30 days of life.

[4] While ICD-9-CM diagnosis codes are not anticipated for services during the measurement period, this measure definition has been retained for consistency with prior years' Task F.1 Birth Outcomes Focused Studies.

[5] ED visits associated with the infant's birth and resulting hospital stay will be excluded, as will ED visits associated with transfers between acute inpatient facilities.

Additionally, unless otherwise specified, all measure results will be stratified by the key demographic categories listed in Table A-6.

Table A-6—Demographic Categories

Demographic Category	Category Values
Medicaid Program	FAMIS MOMS (Eligibility category 005) Medicaid for Pregnant Women (Eligibility categories 091, 097) The "other Medicaid" category will include births paid by Medicaid that do not fall within the FAMIS MOMS or Medicaid for Pregnant Women program categories.
Medicaid Delivery System	Fee-for-Service (FFS) Managed Care
Maternal Region of Residence Note: Maternal region of residence will be defined based on members' county of residence at time of delivery using the Virginia Managed Care Regions Map and Federal Information Processing Standards (FIPS) codes defined in Appendix A of the External Quality Review Organization (EQRO) Request for Proposal (RFP).	Central Charlottesville Far Southwest Halifax/Lynchburg Northern/Winchester Roanoke/Alleghany Tidewater
Race/Ethnicity Note: Race/ethnicity will be defined based on maternal non-Hispanic race (i.e., White, non-Hispanic) classification with Hispanic members of any race being reported in the HISPANIC category.	White African American Asian Hispanic Other
Maternal Age[1]	15 years and younger 16 years through 17 years 18 years through 20 years 21 years through 24 years 25 years through 29 years 30 years through 34 years 35 years through 39 years 40 years through 44 years 45 years and older
Maternal Immigration Status	U.S. Citizen (Citizenship Status = "C", "N") Documented immigrant (Citizenship Status = "E", "I", "P", "R") Undocumented immigrant (Citizenship Status = "A") Other (Citizenship Status = "V")

Demographic Category	Category Values
Maternal Emergency Only Coverage[2]	Emergency Only Benefits Not Emergency Only Benefits
Managed Care Organization (MCO)[3]	HealthKeepers, Inc. (HealthKeepers) Aetna Better Health of Virginia (Aetna)[4] INTotal Health (INTotal) Kaiser Permanente Optima Family Care (Optima) Virginia Premier Health Plan, Inc. (VA Premier) Fee-for-Service

[1] Maternal age categories may be aggregated into four groups to facilitate graphic presentation: 18 years and younger, 18 years through 21 years, 22 years through 34 years, and 35 years and older.

[2] The Emergency Only Coverage category identifies births to women receiving benefits which cover only emergency services. This indicator will be included in the analytic dataset submitted to DMAS. The degree to which these results are presented in the report and slide deck will be determined in collaboration with DMAS following preliminary analyses.

[3] The MCO to which each study member was assigned at the time of the infant's delivery will be included in the analytic dataset submitted to DMAS, but will not be presented in the report or the slide deck.

[4] As of April 1, 2016, CoventryCares of Virginia changed its name to Aetna Better Health of Virginia. This health plan was known as CoventryCares of Virginia during a portion of the measurement period for the study (i.e., prior to April 1, 2016).

Deliverables

HSAG will present the findings of this focused study in a data report. The data report will primarily consist of tables and graphs with text discussing the results presented in the tables and graphs. Appendices will present data tables with detailed findings by study indicator. HSAG will also provide a copy of the analytic dataset as an Excel workbook with an accompanying data dictionary.

A corresponding PowerPoint slide deck will be produced based upon the report, and HSAG will present the slides at the quarterly MCO Quality Collaborative meeting that occurs in the calendar quarter after delivery of the final report. Per DMAS' direction in May 2018, the contents of the slide deck will contain a level of detail similar to the slides that accompanied the 2015–2016 Task F.1 Birth Outcomes Focused Study Report.

Dental Utilization in Pregnant Women Data Brief Methodology

During state fiscal year 2015–2016 (i.e., CY2), the Commonwealth of Virginia's Department of Medicaid Assistance Services (DMAS) contracted Health Services Advisory Group, Inc. (HSAG) to provide a data brief describing dental utilization among pregnant women enrolled in the Medicaid or FAMIS MOMS programs following the expansion of dental services to this population on March 1, 2015, through the VA Smiles for Children program.

To provide continued monitoring for this dental coverage change, DMAS Contract #10021, Modification #6, Attachment C added the External Quality Review (EQR) Task S: Dental Utilization in Pregnant Women Data Brief. To fulfill Task S, HSAG will provide DMAS with an annual data brief assessing dental utilization among pregnant women covered by Virginia Medicaid or FAMIS MOMS. The contract description for Task S notes that the data brief will be assembled using Medicaid recipient, claims, and encounter data files supplied to HSAG by DMAS.

Beginning in CY4, DMAS directed HSAG to align the Task S methodology with reporting parameters used by DMAS' Dental Benefits Administrator (DBA), DentaQuest. Based on DMAS' February 12, 2019, confirmation to retain the CY4 methodology during CY5, the remainder of this document details the methodology for the CY5 Task S data brief.

Methods

Measurement Period

The CY5 (i.e., 2018–2019) data brief will focus on dental services used during the prenatal and postpartum periods for women with live births delivered from January 1, 2018, through December 31, 2018.[A-14]

Eligible Population

HSAG will identify women with a delivery during the measurement period using the *Deliveries Value Set* referenced in the HEDIS technical specifications.[A-15] The data will be sourced primarily from the Medicaid recipient, claims, and encounter data files previously supplied by DMAS for use in Tasks F.1 and F.2.[A-16] As women younger than 21 years of age are eligible for dental services under a separate benefit, this assessment will be limited to women 21 years of age and older at the time of the dental service during the perinatal period (i.e., 280 days prior to the date of delivery or within the postpartum period, through the end of the month following the 60th day after delivery).[A-17]

HSAG will identify study-eligible members as all women 21 years of age and older at the time of the dental service with a live or non-live birth during the measurement period and subsequently identify

[A-14] A woman's pregnancy would begin during March 2017 for a live birth delivered on January 1, 2018. Therefore, all women with deliveries beginning in calendar year 2018 would have been eligible for the VA Smiles for Children program, contingent upon their enrollment in Medicaid or FAMIS MOMS.

[A-15] HEDIS 2019 technical specifications align with measure results reported to NCQA for the measurement period from January 1, 2018, through December 31, 2018, and will be used for births that occurred during calendar year 2018.

[A-16] To date, DMAS has supplied HSAG with Medicaid recipient, claims, and encounter data files through July 2018. Data requested for the CY5 Task F Focused Studies will meet the data needs for the CY5 Task S data brief, allowing sufficient run-out for the evaluation of dental utilization during the postpartum period.

[A-17] The VA Smiles for Children program covers most dental services for pregnant women aged 21 years and older through their pregnancy and postpartum period. Further information about the program is available at: http://www.dentaquest.com/getattachment/State-Plans/Regions/Virginia/Dentist-Page/VA-Smiles-For-Children_ORM.pdf/?lang=en-US.

dental encounters during the prenatal and postpartum periods for these members. Dental encounters will be limited to services during a study member's pregnancy (i.e., within 280 days prior to the member's date of delivery or within the postpartum period, through the end of the month following the 60th day after delivery).

Study Indicators

HSAG will use the dental encounter data to assign each study member a series of indicators that identify which dental services, if any, were utilized during the member's pregnancy or postpartum period. Indicators will include the following:

- A binary flag for utilization of any dental services during pregnancy
  1. DentaQuest list of covered services
- A categorical indicator noting whether utilization of dental services occurred during the prenatal period, the postpartum period, or both periods
- Number of unique days on which dental services were rendered
- A binary flag for utilization of **Adjunctive Services**, including IV sedation and emergency services provided for relief of dental pain.
  2. CDT codes D9110, D9222, D9223, D9230, D9239, D9243, D9248, D9310, D9420, D9610, D9630, D9930, D9994, or D9999
- A binary flag for dental procedures associated with **Crowns**
  3. CDT codes D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794, D2920, or D2931
- A binary flag for utilization of **Diagnostic Services**
  4. CDT codes D0120, D0140, D0150, D0220, D0230, D0240, D0250, D0251, D0270, D0272, or D0330
- A binary flag for dental procedures associated with **Endodontics**
  5. CDT codes D3110, D3120, D3310, D3320, D3330, D4210, D4211, D4341, D4342, D4346, D4355, or D4910
- A binary flag for dental procedures associated with **Periodontics**
  6. CDT codes D4210, D4211, D4341, D4342, D4346, D4355, or D4910
- A binary flag for utilization of **Preventive Services**
  7. CDT codes D1110 or D1208
- A binary flag for dental procedures associated with **Prosthodontics**
  8. CDT codes D5110, D5120, D5213, D5214, D5410, D5411, D5421, D5422, or D6930
- A binary flag for dental procedures associated with **Restorative Services, including Crowns**
  9. CDT codes D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794, D2920, D2931, D2940, D2950, D2951, D2952, or D2954
- A binary flag for dental procedures associated with **Surgery or Extractions**

10. CDT codes D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7285, D7286, D7288, D7310, D7311, D7320, D7321, D7450, D7451, D7471, D7472, D7473, D7510, D7511, or D7880

- A categorical variable indicating the woman's age as of their date of delivery
- A categorical variable indicating the woman's race/ethnicity
- A categorical variable indicating the women's region of residence

HSAG will aggregate the indicator information across all study members for presentation in a data brief of no more than five pages.

General Work Plan

The CY5 data brief will be delivered no later than October 1, 2019, pending data availability. Specific deadlines associated with Task S will be provided to DMAS in the overall contract work plan and will be updated monthly.

Foster Care Focused Study Methodology

Purpose

The Virginia Department of Medical Assistance Services (DMAS) has contracted with Health Services Advisory Group, Inc. (HSAG) since state fiscal year (SFY) 2015–2016 to conduct a focused study that assesses healthcare utilization among foster care children receiving medical services through Medicaid managed care organizations (MCOs).[A-18] The SFY 2018–2019 (Contract Year 5) Task F.2 Foster Care Focused Study will provide baseline data to determine the extent to which MCOs will demonstrate a 20 percent increase in healthcare utilization among children in foster care under the Medallion 4.0 program. In addition to addressing this goal, the study will also consider how the healthcare utilization among children in foster care compares to utilization among children not in foster care and receiving Medicaid managed care benefits.

[A-18] Most children in foster care who received Medicaid benefits were transitioned from fee-for-service (FFS) programs to managed care no later than June 2014. Under Medallion 3.0, some children in foster care continued to receive Medicaid services on an FFS basis because they met exclusion criteria for managed care participation, such as utilizing Medicaid benefits as secondary insurance or receiving residential care services.

Study Design

Measurement Period

The study will include children in foster care for any length of enrollment between January 1, 2018, and December 31, 2018.

Eligible Population

The eligible population will consist of all children enrolled in Medicaid under 18 years of age as of January 1, 2018, and identified by DMAS as enrolled in Medicaid under the aid category for children in foster care (Aid Category "76").

HSAG will identify all children enrolled in the foster care aid category at any point during the measurement period. As study indicators will apply to different sub-groups of children in foster care, HSAG will then assign each child to the following groups based on Medicaid enrollment; a child may be assigned to multiple groups:

- Group 1: All children enrolled in the foster care aid category for any length of time during the measurement period (i.e., the study population).
- Group 2: All children newly enrolled in managed care between January 1, 2018, and October 31, 2018 (i.e., not enrolled in managed care as a foster child for six months prior to enrollment during the measurement period).
- Group 3: All children continuously enrolled in managed care with any MCO or combination of MCOs from January 1, 2018, through December 31, 2018, with one or more gaps in enrollment totaling no more than 45 days.

Since this study will compare healthcare utilization among children in foster care and their Medicaid peers not in foster care, HSAG will identify a comparison group of children not in foster care and receiving Medicaid managed care benefits ("non-foster children"). HSAG will use propensity score-based matching to identify a group of non-foster children that is statistically similar to the Group 3 children in foster care. Propensity score-based matching allows for the construction of a comparison group similar to the treatment group (i.e., children in foster care) without the use of randomized selection. As such, the propensity score reduces bias and controls for multiple confounders. Children will be matched using demographic characteristics, including age, gender, race/ethnicity, MCO enrollment, and selected health conditions (e.g., asthma, attention-deficit/hyperactivity disorder [ADHD]).[A-19] Once the matches have been made, HSAG will evaluate the similarity between the

[A-19] HSAG will use a Greedy 5 → 1 algorithm to select the "best" matches first, followed by the next "best" matches until no more matches can be made at a reasonable caliber. Specifically, this algorithm will match children in foster care with non-foster children using a propensity score rounded to the fifth decimal place until no more matches can be made. Then, matches will be made on the propensity score rounded to the fourth decimal place, and so on down to one decimal place. HSAG will recommend an alternate matching algorithm if review of the Group 3 study population and potentially comparable non-foster children suggests that an alternate matching algorithm will provide a greater number of comparable matches.

matched children in foster care and the matched non-foster children through a variety of tests and assessments.[A-20]

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 from the Medicaid Dental Benefit Manager (DBM), DentaQuest, and behavioral health encounter data from Magellan. A four-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 May 1, 2019.

[A-20] HSAG will evaluate covariate balance between the two matched groups using bivariate statistical testing (i.e., chi-square and two-sample *t*-tests), an assessment of standardized differences, and an omnibus test to evaluate statistical balance across all covariates simultaneously.

Indicators

The unit of analysis for this study will be Medicaid members, and indicators will vary by population group (i.e., Group 1, Group 2, and Group 3, described in the *Eligible Population* section), as described in Table 1. Calculation of study indicators is contingent upon the availability of timely, complete, and accurate data.

For consistency with other quality initiatives, healthcare utilization indicators are based on either the 2019 Child Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) or the HEDIS 2019 technical specifications.[A-21] However, HSAG will modify the HEDIS continuous enrollment criteria to reflect the ability of children in foster care to move between MCOs during the measurement period. Additionally, study indicators for Group 3 will be calculated only for the Group 3 population of continuously enrolled children in foster care and the matched non-foster children.[A-22]

When identification of provider types is necessary for study indicator calculations, HSAG will work with DMAS to classify primary care providers (PCPs) and mental health providers (MHPs) as defined in the HEDIS 2019 technical specifications. 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 Federally Qualified Health Centers (FQHCs).

[A-21] HEDIS 2019 technical specifications align with indicator results reported to NCQA for the measurement period from January 1, 2018, through December 31, 2018.

[A-22] Due to changes in individuals' MCO assignments resulting from the transition to the Medallion 4.0 program, Group 3 study indicators will be calculated at the study group level (i.e., children in foster care and non-foster children).

Table A-7—Study Indicators

Indicator	Description and/or Category Values
Group 1—Characteristics of Medicaid Members in Foster Care[A-23]	
1-1. Sex	Category Values: Female, Male, Other
1-2. Age	Category Values: Year of Age (e.g., 1 year, 2 years, 3 years, etc.) Age categories will be aggregated into four groups for graphic presentation: 3 years and younger, 4 years through 11 years, 12 years through 17 years, and 18 years of age (i.e., the children aged out of foster care during the measurement period).
1-3. Race/Ethnicity	Category Values: White, African American, Asian, Hispanic, Other Race/ethnicity will be defined based on members' non-Hispanic race (i.e., White, non-Hispanic) classification with Hispanic members of any race being reported in the Hispanic category. Race/ethnicities in the Other category may be reported as a separate category if the denominator is greater than 30.
1-4. Region of Residence	Category Values: Central, Far Southwest, Northern/Winchester, Roanoke/Alleghany, Tidewater, Western Region of residence will be defined based on members' county of residence as of December 31, 2018 using the Virginia Medallion 4.0 managed care regions.
1-5. MCO	Category Values: Aetna Better Health of Virginia (Aetna) HealthKeepers, Inc. (HealthKeepers) INTotal Health (INTotal, phased out with Medallion 4.0) Kaiser Permanent (Kaiser, recipients moved to VA Premier) Magellan Complete Care (Magellan, active August 2018)

[A-23] Indicators in this category will be provided for informational purposes only and will not be subject to continuous enrollment criteria.

Indicator	Description and/or Category Values
	Optima Family Care (Optima) UnitedHealthcare Community Plan (UHCCP) Virginia Premier Health Plan, Inc. (VA Premier) Based on initial data findings, HSAG will propose an MCO attribution approach for children continuously enrolled in foster care during the measurement period and the corresponding non-foster children.
1-6. Psychotropic Medication Utilization	The psychotropic medication utilization rate among Members in the Group 1 study population, limited to National Drug Codes (NDCs) for psychotropic medications commonly prescribed for children and adolescents. Mirroring an SFY 2017 – 2018 ad hoc analysis, this indicator will constitute a sub-analysis and will be reported in an Excel spreadsheet separate from other study deliverables.
Group 2—Preventive Care Initiation Among Medicaid Members Newly Enrolled in Foster Care[A-24]	
2-1. Access to Primary Care Providers Among Newly Enrolled Children in Foster Care	Members in the Group 2 study population who had at least one visit with a PCP (HEDIS 2019 *Ambulatory Visits* Value Set) during the first 30 days of managed care enrollment as a child in foster care.
2-2. Access to Dental Care Among Newly Enrolled Children in Foster Care	Members in the Group 2 study population at least 3 years of age as of managed care enrollment who had at least one dental visit (HEDIS 2019 *Dental Visits* Value Set) with a dental practitioner during the first 60 days of managed care enrollment as a child in foster care.
Group 3—Healthcare Utilization Among Children in Foster Care and Comparable Non-Foster Children[A-25]	
3-1. Children and Adolescents' Annual Access to Primary Care Practitioners (CAP)	Members in the Group 3 study population who had one or more visits with a PCP-type provider during the measurement period. Adapted from HEDIS 2019 technical specifications for the CAP indicator, with study-specific continuous enrollment modifications.

[A-24] Indicators in this category will be subject to continuous enrollment criteria beginning with each child's earliest enrollment as a foster child in managed care during the measurement period.

[A-25] Indicators in this category will be subject to continuous enrollment criteria and calculated for children in foster care and a matched group of non-foster children.

Indicator	Description and/or Category Values
3-2. Annual Dental Visit (ADV)	Defined using HEDIS 2019 technical specifications for the ADV indicator, with study-specific continuous enrollment modifications.
3-3. Preventive Dental Services (PDENT-CH)	Defined using the 2019 Child Core Set technical specifications for the PDENT-CH indicator, with study-specific continuous enrollment modifications.
3-4. Dental Sealants for 6-9 Year-Old Children At Elevated Caries Risk (SEAL-CH)	Defined using the 2019 Child Core Set technical specifications for the SEAL-CH indicator, with study-specific continuous enrollment modifications.
3-5. Chlamydia Screening in Among Women (CHL)	Defined using HEDIS 2019 technical specifications for the CHL indicator, limited to females aged 16 years and older, with study-specific continuous enrollment modifications.
3-6. Contraceptive Care (CCW-CH)	Defined using the 2019 Child Core Set technical specifications for the CCW-CH indicator, limited to females aged 15 years and older, with study-specific continuous enrollment modifications.
3-7. Asthma Medication Ratio (AMR)	Defined using HEDIS 2019 technical specifications for the AMR indicator, with study-specific continuous enrollment modifications and a one-year look-back period for all eligible children.
3-8. Seven-Day Follow-Up After Hospitalization for Mental Illness (FUH)	Defined using HEDIS 2019 technical specifications for the FUH – 7-Day indicator, with study-specific continuous enrollment modifications.
3-9. Thirty-Day Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Defined using HEDIS 2019 technical specifications for the FUM – 30-Day indicator, with study-specific continuous enrollment modifications.
3-10. Thirty-Day Follow-Up After Emergency Department Visit for Alcohol and Other Drug (AOD) Abuse or Dependence (FUA)	Defined using HEDIS 2019 technical specifications for the FUA – 30-Day indicator, with study-specific continuous enrollment modifications.
3-11. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Defined using HEDIS 2019 technical specifications for the APM indicator, with study-specific continuous enrollment modifications.
3-12. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Defined using HEDIS 2019 technical specifications for the APP indicator, with study-specific continuous enrollment modifications and a four-month look-back period from the earliest prescription dispensing date for all eligible children.

Indicator	Description and/or Category Values
3-13. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Defined using HEDIS 2019 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 children.
3-14. Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Members in the Group 3 study population who had a prescription for ADHD medication and received follow-up care within 1, 2, 3, 6, or 9 months during the measurement period. Adapted from HEDIS 2019 technical specifications for the ADD indicator, with study-specific continuous enrollment modifications.

Comparative Analyses

Following calculation of the Table 1 study indicator rates for Group 3 and the matched non-foster children, HSAG will perform appropriate statistical testing to assess whether the indicator rates are statistically different between the children in foster care (i.e., the study population) and their matched non-foster peers (i.e., the comparison group). HSAG anticipates using regression analyses to compare any differences in study indicator rates between the two populations. Matching on the propensity score has been shown to demonstrate "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.

Deliverables

HSAG will present the findings of this focused study in a data report that will include a stand-alone executive summary.[A-26] The data report will primarily consist of tables and graphs with selected text discussing the results presented in the tables and graphs. As applicable, appendices will present data tables with detailed findings by study indicator. HSAG will also provide DMAS with a copy of the analytic dataset as an Excel workbook with an accompanying data dictionary.

A corresponding PowerPoint slide deck will be produced based on the report, and HSAG will present the slides at the quarterly MCO Quality Collaborative meeting that occurs in the calendar quarter after delivery of the final report.

[A-26] The psychotropic medication utilization indicator will be calculated as a sub-analysis and will be reported in an Excel spreadsheet separate from other study deliverables.