VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES 1115 DEMONSTRATION EXTENSION APPLICATION

DRAFT

Virginia Building and Transforming Coverage, Services, and Supports for a Healthier Virginia

NUMBER: 11-W-00297/3

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Section I.
Introduction and Historical Narrative Summary

The Department of Medical Assistance Services' (DMAS') mission is to improve the health and well-being of Virginians through access to high quality health care coverage and services. DMAS has been advancing this mission by providing substance use disorder (SUD) benefits and covering out-of-state former foster care youth (FFCY) through an approved section 1115 demonstration for the past several years.

Most recently, on December 30, 2019, the Centers for Medicare and Medicaid Services (CMS) approved a five-year extension of Virginia's Medicaid demonstration, Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation (Project Number 11-W-0029713). Under the approved Special Terms and Conditions (STCs) DMAS provides SUD benefits to Medicaid beneficiaries, including SUD treatment services provided to individuals who are short-term residents in residential treatment facilities that meet the definition of an Institution for Mental Diseases (IMD). Virginia also provides coverage to FFCY up to age 26 who aged out of foster care in another state and now reside in Virginia. (See Attachment 1 for a more through description of the history of Virginia's demonstration.)

On July 9, 2020, CMS approved Virginia's request to provide a High Needs Support benefit that included supportive employment and housing as a new Medicaid feature within Virginia's 1115 demonstration extension application, otherwise approved on December 30, 2019. CMS also approved the section 1115 demonstration name change from Addiction and Recovery Treatment Services Delivery System Transformation to Building and Transforming Coverage, Services, and Supports for a Healthier Virginia to better encompass the current ARTS and former foster youth coverage provisions, the new High Needs Supports program and any potential future programs.

The Building and Transforming Coverage, Services, and Supports for a Healthier Virginia is scheduled to expire on December 31, 2024. Through this amendment, Virginia is requesting a five-year extension of the waiver demonstration to:

- Continue to provide SUD benefits to Medicaid beneficiaries; specifically the authority to provide SUD treatment services to individuals who are short-term residents in residential treatment facilities that meet the definition of an IMD.
- Update the authority to specify that Virginia provides Medicaid coverage for FFCY up to age 26 who aged out of foster care in another state and now reside in Virginia, provided the member turned 18 prior to January 1, 2023.
- Sunset the High Needs Supports benefits because the Virginia General Assembly has not provided funding that has enabled these services to be implemented.

Through this amendment, Virginia will have the opportunity to continue to evaluate the impact of covering residential addiction, recovery, and treatment services on Medicaid members and the impact of providing Medicaid coverage to FFCY who aged out of foster care in another state and now reside in Virginia.

Objectives of Addiction and Recovery Treatment Services (ARTS)

In Virginia, the ARTS benefit provides access to a full continuum of care for SUD treatment based on the American Society of Addition Medicine (ASAM) criteria to ensure Medicaid members with substance use disorders are matched to the right level of care to meet their evolving needs as they enter and pass through treatment. This includes expanded outpatient and community-based addiction and recovery treatment services and coverage of inpatient detoxification and residential substance use disorder treatment.

The ARTS benefit is available to Virginia's Medicaid recipients who meet the medical necessity criteria. Services are delivered to individuals enrolled in managed care through their MCO, and those recipients in fee-for-service (FFS) have services covered through the DMAS FFS contractor. The MCOs are contractually required to employ ARTS Care Coordinators, who are licensed clinical psychologists, licensed clinical social workers, licensed professional counselors, licensed nurse practitioners, or registered nurses with clinical experience in SUD. The ARTS Care Coordinators or licensed physicians make independent medical necessity determinations, using the multidimensional ASAM assessment, for placement at appropriate levels of care and recommendations for lengths of stay in residential treatment settings. Any recipient receiving residential or inpatient SUD services under ARTS, regardless of the length of stay or the bed size of the facility, is a "short-term resident" of the residential or inpatient facility in which they are receiving the services. Short-term residential treatment is defined as a statewide length of stay of thirty days.

The full continuum of care of ARTS services available to all Virginia Medicaid recipients through the state plan benefit as well as through this demonstration is outlined in the table below.

Table 1. ARTS Benefit and Expenditure Authority

ASAM Level of Care	ASAM Description	Authority
N/A	Peer Recovery Support Services	State Plan
N/A	SUD Case Management	State Plan
1	Outpatient	State Plan
2.1	SUD Intensive Outpatient	State Plan
2.5	SUD Partial Hospitalization	State Plan
3.1	Clinically Managed Low Intensity Residential	1115 Demonstration
3.3	Clinically managed Population-Specific High Intensity Residential	1115 Demonstration
3.5	Clinically Managed High Intensity Residential Services (Adults) Clinically Managed Medium Intensity Residential Services (Adolescents)	1115 Demonstration
3.7	Medically Monitored Intensive Inpatient Services (Adults)	1115 Demonstration (for services provided in a residential setting) and State Plan (for services provided in

	Medically Monitored High-Intensity Inpatient Services (Adolescents)	an inpatient setting).
4	Medically Managed Intensive Inpatient	State Plan
N/A	Opioid Treatment Program (OTP)	State Plan
N/A	Office-Based Addiction Treatment (OBAT)	State Plan

To date, Virginia has experienced several positive outcomes from offering the ARTS benefit. Below are some highlights:

- In just the first five months of the ARTS program, the number of emergency department visits related to SUD decreased by 31%, and the number of outpatient providers increased by 173%, including 848 providers who prescribe buprenorphine for beneficiaries with opioid use disorder.
- In the first year of the ARTS program, nearly 25,000 Medicaid beneficiaries used addiction-related treatment services, a 57% increase from the year before. Treatment for beneficiaries with SUD increased by 64%t during the first year compared to the prior year. Treatment rates were higher for beneficiaries with opioid use disorder at 63%, compared to rates for those with alcohol use disorder at 30%.

Based on an independent evaluation by the Virginia Commonwealth University (VCU), since ARTS was implemented on April 1, 2017, there has been a substantial increase in the number of practitioners providing addiction treatment services to Medicaid enrollees.

Prior VCU evaluations have documented the impact of Medicaid expansion on the utilization of ARTS services. Specifically, the number of Medicaid members that utilized ARTS services more than doubled from 2017 to 2019. Further,

- In SFY 2021, 53,614 Medicaid members used some type of ARTS services, a 23.6% increase from SFY 2020.
- Most members who use ARTS services use ASAM Level 1.0 outpatient services (43,299 members, or 81% of all service users).
- Pharmacotherapy, almost all of which was medications for opioid use disorder (MOUD) treatment, was the second most frequently used service (32,724 members).
- Members receiving MOUD treatment increased 21.0% from SFY 2020 to SFY 2021. As in prior years, buprenorphine treatment was the most common form of MOUD treatment (18,941 members, or 57% of all members receiving MOUD), followed by methadone treatment and naltrexone (11,278 and 4,227 members, respectively).
- There was also a 10.8% increase in service use per 100,000 members, from 2,627 members per 100,000 using services in SFY 2020 to 2,912 members per 100,000 using services in SFY 2021.
- Increases in service use per 100,000 members were higher for ASAM 4 services during this reporting period (103%) and peer recovery support services (22%), although the overall use of such services was still relatively low.

- Care coordination services also increased by 17.5%, while pharmacotherapy increased by 14.5%.
- In SFY2021, Medicaid payment of residential treatment services (ASAM 3), allowed under this 1115 demonstration, comprised 9.1% of all members using ARTS services (4,891 members used these services).
    - The average length of stay for residential treatment was 15.5 days, well under the CMS requirements of 30 days or less for a statewide average length of stay.
    - The number of members using residential treatment increased 14.8% between SFY 2020 and SFY 2021, or a 6.9% increase of members using services per 100,000 members.

Members with OUD diagnoses are more likely to receive ARTS services compared to members with other SUD diagnoses. Among members with an OUD diagnosis, more than two-thirds (69.4%) used some type of ARTS service in SFY 2021, compared to 43.3% of those with any SUD using any ARTS services. ARTS utilization is considerably lower among members who had SUD diagnoses other than OUD, including 27.1% for those with Alcohol Use Disorder (AUD), 34.3% among those with a diagnosis of stimulant use disorder, and 16.5% among those with a diagnosis of cannabis use disorder.

One of the goals of the ARTS benefit is to continue to expand provider capacity to meet member's needs. While ARTS greatly increased the availability and quality of treatment services, Medicaid Expansion almost tripled the number of members accessing addiction treatment services, from 17,120 in 2017 to 46,520 in 2019. As of July 15, 2023, 84,835 members have accessed an ARTS service due to being eligible for Medicaid through Expansion. The most recent comprehensive evaluation, which contains the data points above, is attached as Attachment 2 to this extension request.

Objectives of Former Foster Care Youth Coverage

Youth aging out of foster care can face several challenges, including barriers to accessing health care. Ensuring continued Medicaid coverage for these youth as they transition to adulthood is critical to addressing health and is likely to improve outcomes for otherwise uninsured individuals as they transition to adulthood and into managing the responsibilities of living independently.

On November 21, 2016, CMS published a final rule that changed the eligibility requirements for out of state FFCY. As a result, Virginia no longer had the authority to cover out of state FFCY under the State Plan. However, CMS gave states the option to continue to cover these youth under a section 1115 demonstration. On September 22, 2017, Virginia's section 1115 demonstration amendment was approved. This gave Virginia the authority to cover FFCY who were in foster care and receiving Medicaid on their 18th birthday in a different state and who had moved to Virginia. On December 30, 2019, CMS approved a five-year extension of Virginia's demonstration, which continued the Commonwealth's authority to provide coverage to FFCY up to age 26 who aged out of foster care in another state and now reside in Virginia.

To date, Virginia's demonstration has ensured access to Medicaid services for FFCY between the ages of 18 and 26, who previously resided in another state and are now covered through Virginia Medicaid. Based on an independent evaluation conducted by the Virginia Commonwealth University (VCU), since the FFCY demonstration was implemented on September 20, 2017, enrollment has

steadily increased. Specifically, enrollment has increased by 40%--from 65 members in 2019 to 91 members in 2022.

Prior VCU evaluation reports documented the following impacts of the demonstration on service utilization among out-of-state FFCY:

- Among outpatient medical visits, outpatient behavioral health visits, emergency room visits, and inpatient stays,
    - Emergency Room (ER) visits were consistently the highest utilized service. Thirty-eight percent (38%) of members had at least one ER visit in calendar years (CYs) 2019 and 2020, 26% had at least one ER visit in 2021, and 20% had at least one visit in 2022.
    - Inpatient stays were the least utilized service. Nine percent (9%) of out of state FFCY had at least one inpatient stay in (CY) 2019, 11% in 2020, 9% in 2021, and 11% in 2022.

Effective January 1, 2023, changes made by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act expanded eligibility under state plans to individuals who were in foster care from another states. These changes were effective for individuals who reach age 18 on or after January 1, 2023. Virginia effectuated that change via a state plan; however, as outlined in Section VI below, the Commonwealth continues to seek 1115 demonstration authority to enroll individual who received foster care in another state but needs to update the authority to indicate that the demonstration will cover only out-of-state FFCY who turned 18 years of age *prior* to January 1, 2023.

Section II. Summary of Current Demonstration Features to be Continued Under the 1115 Demonstration Extension

This demonstration extension will continue the ARTS program, whereby DMAS will continue to provide SUD benefits to Medicaid beneficiaries, including SUD treatment services provided to individuals who are short-term residents in residential treatment facilities that meet the definition of an IMD.

Demonstration Eligibility - ARTS

The Medicaid eligibility groups affected by this portion of the demonstration are illustrated in the table below. State plan groups derive their eligibility through the Medicaid state plan, and coverage for these groups is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as waived in this demonstration.

Table 2. Medicaid Eligibility Groups Affected by the Demonstration

Demonstration Feature	Eligibility Group	Citations	Income Level
Addiction and Recovery Treatment Services (ARTS)	New adult group	• 1902(a)(10)(A)(i)(VIII) • 42 CFR 435.119	133% FPL

	Aged, blind, and disabled	• 42 CFR 435.121	80% FPL
	Parents and other caretaker relatives	• 1902(a)(10)(A)(i)(I) • 1931 (b) and (d) • 42 CFR 435.110	Group 1: $307/month (~24% FPL) Group 2: $402/month (~32% FPL) Group 3: $603/month (~48% FPL)
	Pregnant women	• 42 CFR 435.116	143% FPL
	Out of state FFCY N/A, no income limit	• Expenditure Authority • 1902(a)(10)(A)(i)(IX)	N/A, no income limit
	Children with Title IV-E adoption assistance, foster care, or guardianship care	• 473(b)(1) • 1902(a)(10)(A)(i)(I) • 42 CFR 435.145	N/A, no income limit N/A
	Children under age 19	• 1902(a)(10)(A)(ii)(XIV) • 1905(u)(2)(B) • 42 CFR 435.229 and 435.4	143% FPL
	Transitional medical assistance	• 1902(a)(52) • 1902(e)(l) • 1925(a)(b)(c) • 42 CFR 435.112	185% FPL
	Extended Medicaid due to spousal support collections	• 408(a)(11)(B) • 1902(a)(10)(A)(i)(I) • 1921(c) • 42 CFR 435.115	No limit so long as the reason the family no longer meets the income limit is due to increased spousal support.
	Former foster care youth up to age 26 who aged out of foster care in Virginia	• 42 CFR 435.150 • 1902(a)(10)(A)(i)(IX)	N/A, no income limit

Demonstration Benefits -ARTS

Virginia is not requesting any changes to the ARTS benefits as part of this extension. Beneficiaries who are eligible for the demonstration will receive the same benefits as set forth in the Medicaid state plan. Additionally, Virginia will provide the SUD benefits established under the ARTS portion of the demonstration. Specifically, Virginia will provide SUD treatment services to individuals who are short-term residents in residential treatment facilities that meet the definition of an IMD.

As illustrated in the Table below, these benefits include ASAM Levels of Care 3.1, 3.3, 3.5, and

3.7. Continuing these benefits will enable all of Virginia's 2.1 million Medicaid enrollees[1] to continue to have access to the full continuum of ARTS services.

Table 3. ASAM Levels of Care

ASAM Level of Care	ASAM Description
3.1	Clinically Managed Low Intensity Residential
3.3	Clinically managed Population-Specific High Intensity Residential
3.5	Clinically Managed High Intensity Residential Services (Adults) Clinically Managed Medium Intensity Residential Services (Adolescents)
3.7	Medically Monitored Intensive Inpatient Services (Adults) – only for services provided in a residential setting. (Does not include services provided in an inpatient setting.) Medically Monitored High-Intensity Inpatient Services (Adolescents) – only for services provided in a residential setting. (Does not include services provided in an inpatient setting.)

Demonstration Cost-Sharing Requirements - ARTS

Cost sharing requirements do not differ from the Medicaid State Plan.

Delivery System and Payment Rates for Services - ARTS

Virginia is not requesting any changes to the delivery system or payment rates as part of this extension. The health care delivery system for demonstration participants is no different than the delivery system in place for the Virginia Medicaid population. The demonstration will utilize the current statewide managed care delivery system and fee-for-service delivery system. Beneficiaries may be enrolled in FFS prior to being enrolled into managed care.

Payment rates for residential treatment services provided under the demonstration are illustrated in the table below.

Table 4. ASAM Rate Structure

ASAM Level of Care	ASAM Description	Current Rate (subject to change for future dates)
3.1	Clinically Managed Low Intensity Residential	1 unit = 1 day Current rate of $196.88 set on 7/1/21

[1] DMAS Monthly Enrollment Report (virginia.gov)

3.3	Clinically managed Population-Specific High Intensity Residential	1 unit = 1 day Rates are based on individual considerations. Maximum daily rate for PRTFs = $460.89 Maximum daily rate for other residential facilities = $518.86
3.5	Clinically Managed High Intensity Residential Services (Adults) Clinically Managed Medium Intensity Residential Services (Adolescents)	1 unit = 1 day Rates are based on individual considerations. Maximum daily rate for PRTFs = $460.89 Maximum daily rate for other residential facilities = $518.86
3.7	Medically Monitored Intensive Inpatient Services (Adults) – only for services provided in a residential setting. (Does not include services provided in an inpatient setting.) Medically Monitored High-Intensity Inpatient Services (Adolescents) – only for services provided in a residential setting. (Does not include services provided in an inpatient setting.)	1 unit = 1 day Rates are based on individual considerations. Maximum daily rate for PRTFs = $460.89 Maximum daily rate for other residential facilities = $518.86

Section III. Summary of Demonstration Features to be Updated Under the 1115 Demonstration Extension

Virginia is not requesting any changes to the ARTS benefits as part of this extension.

Virginia will continue to provide coverage of out-of-state FFCY in this extension but will update the age requirements. Effective January 1, 2023, changes made by the SUPPORT Act expanded eligibility under state plans to individuals who were in foster care from another states. Virginia effectuated that change via a state plan; however, the Commonwealth continues to seek 1115 demonstration authority to enroll individual who received foster care in another state and turned 18 years of age *prior* to January 1, 2023. Consequently, DMAS is requesting that FFCY authority be updated to indicate that the demonstration will cover only out-of-state FFCY who turned 18 years of age before January 1, 2023.

Demonstration Eligibility-FFCY

The population affected by this demonstration is FFCY who are under age 26 who were in foster care under the responsibility of another state and enrolled in Medicaid at age 18 or when they "aged out," and moved to Virginia and are not eligible in any other mandatory Medicaid group. The demonstration extension seeks to update the authority to apply to FFCY who have turned 18 years old prior to January 1, 2023. There is no income or resource test for this group.

Table 5. Eligibility Chart – Mandatory State Plan Groups

Eligibility Group	Social Security Act and CFR Citations	Income level

FFCY up to age 26 who aged out of foster care in another state and now reside in Virginia, provided the member turned 18 prior to January 1, 2023	1115 Demonstration	N/A

Standards and methodologies do not differ from what is already in the Virginia State Plan for Medical Assistance. The projected number of individuals who will be eligible for the demonstration is approximately 86 per month. The projection is based on the current number of enrollees under the Medicaid State Plan. There are no changes to eligibility procedures for this population.

Demonstration Benefits and Cost-Sharing Requirements-FFCY
Benefits provided to the FFCY population are the same benefits provided to Virginia's current Medicaid population under the State Plan. Cost sharing requirements do not differ from the Medicaid State Plan.

Delivery System for Services -FFCY
The health care delivery system for demonstration participants is no different than the delivery system in place today for the Virginia Medicaid population. The demonstration will utilize the current statewide managed care delivery system and fee-for-service (FFS) delivery system. Beneficiaries may be enrolled in FFS prior to being enrolled into managed care.

Demonstration Features to be Removed from the 1115 Demonstration Extension

Virginia requests to sunset the High Needs Supports benefit from the demonstration because the General Assembly has not provided funding that has enabled the following services to be implemented:

- A work and community engagement program for certain adult populations;
- A Health and Wellness program that included premiums and cost-sharing designed to promote healthy behavior for certain adult populations between 100 and 138 percent of the federal poverty level; and
- A housing and employment supports benefit for high-need populations.

Section IV. Requested Waivers and Expenditure Authorities

A list and programmatic description of the waivers and expenditure authorities that are being requested for the extension period, or a statement that the State is requesting the same waiver and expenditure authorities as those approved in the current demonstration.

Table 6: Virginia Waiver and Expenditure Authority Requests

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver Request?
§1902(a)(8) and §1902(a)(10) Provision of	To limit the state plan group coverage to former foster care youth who were in Medicaid and foster care in a different state	Yes

Medical Assistance and Eligibility		
Expenditures related to ARTS	Expenditures not otherwise eligible for federal financial participation may be claimed for otherwise covered services furnished to otherwise eligible individuals (eligible under the State Plan or Former Foster Care Youth components of this demonstration), including services for individuals who are short-term residents in facilities that meet the definition of an Institute of Mental Disease (IMD) for the treatment of SUD and withdrawal management.	Yes

Section V. Summaries of External Quality Review Organization (EQRO) Reports, Managed Care Organization (MCO) and State Quality Assurance Monitoring

Summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration, such as the CMS Form 416 EPSDT/CHIP report.

DMAS' EQRO, Health Services Advisory Group (HSAG), has consistently included an ARTS narrative, results, graphs, and tables (developed by VCU, DMAS' independent ARTS evaluator) in the annual EQR technical report, which is publicly available on the DMAS website here (and, as mentioned above, included as Attachment 2). The 2023 External Quality Review Technical Report – Commonwealth Coordinated Care Plus (MLTSS) and the 2023-2025 Quality Strategy contain additional information concerning the EQRO's work around ARTS, and these documents are also included (as Attachments 3 and 4, respectively) to this application. In addition, HSAG has worked with DMAS for several years on the development of ARTS measures and specifications, the results of which will be published in a future report to support the 1115 SUD Demonstration evaluation.

DMAS also incorporated two quality assurance measures into the Performance Withhold Program that is part of the managed care contracts. The two measures are:

- Follow-Up After ED Visit for AOD Abuse or Dependence
- Initiation and Engagement of SUD Treatment

Under the Performance Withhold Program, the value-based purchasing arrangement currently withholds 1 percent capitation from the MCOs. The MCOs may earned this back if they meet the performance standards set by DMAS.

Section VI. Financial Data

This application presents information on historical and projected data as required by CMS.

The tables below summarize historical ARTS expenditure data for the last five complete years of Virginia's Demonstration and projected data for the requested waiver extension.

Table 7 Historical ARTS Data Without Waiver

	DY5	**DY 6**	**DY 7**	**DY 8**	**DY 9**
Member Months	1,090	711	1,354	1,354	5,980
Per Member Per Month (PMPM)	$3,909.24	$3,315.77	$4,341.16	$4,341.16	$4,429.18
Total Expenditures	$4,261,076	$2,357,512	$5,877,936	$5,877,936	$26,486,471

Table 8: Historical ARTS Data With Waiver

	DY5	**DY 6**	**DY 7**	**DY 8**	**DY 9**
Member Months	1,090	711	1,354	1,354	5,980
Per Member Per Month (PMPM)	$3,909.24	$3,315.77	$4,341.16	$4,341.16	$4,429.18
Total Expenditures	$4,261,076	$2,357,512	$5,877,936	$5,877,936	$26,486,471

Table 9: ARTS Program Projections Without Waiver

	DY 11	**DY 12**	**DY 13**	**DY 14**	**DY 15**
Member Months	7,118	7,262	7,410	7,560	7,713
Per member Per Month (PMPM)	$5,469.69	$5,625.89	$5,786.55	$5,951.80	$6,121.77
Total Expenditures	$38,933,253	$40,855,213	$42,878,336	$44,995,608	$47,217,212

Table 10. ARTS Program Projections With Waiver

	DY 11	**DY 12**	**DY 13**	**DY 14**	**DY 15**
Member Months	7,118	7,262	7,410	7,560	7,713
PMPM	$5,469.69	$5,625.89	$5,786.55	$5,951.80	$6,121.77
Total Expenditures	$38,933,253	$40,855,213	$42,878,336	$44,995,608	$47,217,212

DMAS has six years of experience covering adults with SUD in IMDs under the ARTS benefit. This history was disrupted in calendar years 2020 and 2021 due to the COVID-19 public health emergency, but utilization has since resumed to pre-pandemic levels. Based on that history, disregarding the public health emergency, DMAS assumes a 2% growth in member months per year and a 2.9% growth in per member per month (PMPM) costs. Residential treatment for adults with SUD provided b facilities with over 16 beds is paid through both fee-for-service and managed care. DMAS calculates expenditures using actual fee for service payments and payments by the managed care plans. To calculate total expenditures, DMAS multiples the PMPM by the number of members receiving care.

The Tables below summarize historical out-of-state FFCY enrollment and expenditure data for the last five complete years of Virginia's Demonstration and projected data for the requested waiver extension.

Table 11: Historical Out-of-State FFCY Data Without Waiver

	DY5	**DY 6**	**DY 7**	**DY 8**	**DY 9**
Member Months	925	1,212	1,332	1,437	1,255
Per Member Per Month (PMPM)	$631.86	$586.96	$549.83	$647.45	$960.75
Total Expenditures	$584,474	$711,400	$732,378	$930,391	$1,205,737

Table 12: Historical Out-of-State FFCY Data With Waiver

	DY5	**DY 6**	**DY 7**	**DY 8**	**DY 9**
Member Months	925	1,212	1,332	1,437	1,255
Per Member Per Month (PMPM)	$631.86	$586.96	$549.83	$647.45	$960.75
Total Expenditures	$584,474	$711,400	$732,378	$930,391	$1,205,737

Table 13: Historical Out-of-State FFCY Enrollment Data

	DY 5	**DY 6**	**DY 7**	**DY 8**	**DY 9**
FFCY Members from Out of State	65	82	95	91	91

Table 14: Out-of-State FFCY Projections Without Waiver

	DY 11	**DY 12**	**DY 13**	**DY 14**	**DY 15**
Member Months	1,964	2,164	2,383	2,625	2,892
Per Member Per Month (PMPM)	$768.26	$800.92	$834.97	$870.46	$907.47
Total Expenditures	$1,509,112	$1,732,948	$1,989,985	$2,285,146	$2,624,087

Table 15: Out-of-State FFCY Projections-With Waiver

	DY 11	**DY 12**	**DY 13**	**DY 14**	**DY 15**
Member Months	1,964	2,164	2,383	2,625	2,892
Per Member Per Month (PMPM)	$768.26	$800.92	$834.97	$870.46	$907.47
Total Expenditures	$1,509,112	$1,732,948	$1,989,985	$2,285,146	$2,624,087

CMS requires that all 1115 Demonstration applications demonstrate budget neutrality. DMAS is requesting an extension of the ARTS benefit allowing covering of individuals with SUD in IMDs as well as an extension of the out-of-state FFCY benefit. DMAS will address the federal reporting requirements for the financial data component for FFCY in the quarterly reports submitted to CMS. For budget neutrality for the SUD benefit DMAS assumes hypothetical cost equal to the projected costs of the waiver. That is, in the absence of this demonstration, costs equal to the projected PMPM would have been incurred.

Section VII. Evaluation

A summary of evaluation activities and findings covering the period of approval for the current demonstration waiver to date for the ARTS demonstrations are attached to this application and include the following:

- August 2019: "GAP Quarterly Report Jan-Mar 2019" (Attachment 5)
- September 2019: "State Quarterly Report April-June 2019" (Attachment 6)
- July 2021: "Addiction and Recovery Treatment Services Access, Utilization, and Quality of Care 2016 – 2019" (Attachment 7)
- April 2022: "Member Experiences with Opioid Use Disorder Treatment Services in the Virginia Medicaid Program Results from a survey of Medicaid members receiving treatment services through the Addiction and Recovery Treatment Services program" (Attachment 8)
- May 2022: "Addiction and Recovery Treatment Services Evaluation Report for State Fiscal Years 2019 and 2020" (Attachment 9)
- April 2023: "Addiction and Recovery Treatment Services Evaluation Report for State Fiscal Years 2020, 2021, and the first half of 2022" (Attachment 10)
- May 2023: "Care Coordinator Experiences in the Virginia Medicaid Program Results from a survey of Virginia Medicaid Care Coordinators" (Attachment 11)
- November 2023: "Substance Use Disorders Among Formerly Incarcerated Adults on Medicaid" (Attachment 12)
- January 2024: Submitted draft to CMS: "Addiction and Recovery Treatment Services Interim Evaluation Report for Section 1115 Demonstration" (Attachment 13)*
- February 2024: Submitted draft to CMS: "Virginia Medicaid Section 1115 Demonstration Waiver for the Addiction and Recovery Treatment Services (ARTS) Program Midpoint Assessment" (Attachment 14)*
- March 2024: Submitted draft to CMS: "Virginia GAP Waiver Q4 2019 Quarterly Report" (Attachment 15)*

*Indicates document is not currently published online

In consultation with CMS, the Commonwealth is preparing its FFCY Draft Interim Evaluation Report (IER), which will be submitted at a future date. In lieu of submitting an FFCY IER, Virginia is including excerpts of the FFCY Evaluation Design below, which show the framework that the FFCY IER will be based on, namely:

> A summary of the demonstration's core evaluation questions, hypotheses, data sources, and analytical approaches are provided in the table below. CMS guidance on the evaluation design for the FFCY demonstration suggests including both "process" and "outcome" measures. Process measures include enrollment and basic measures of utilization that will allow Virginia to track and monitor the number of members who benefit from the demonstration. Outcome measures would allow for a more comprehensive assessment of the impact of the demonstration. However, because the number of members expected to be affected by the demonstration is small (less than 100), Virginia does not think it is feasible to assess outcomes or draw any meaningful conclusions about outcomes based on the measures suggested by CMS. Therefore, the evaluation will be limited to an assessment of process measures. The evaluation will use a post-only assessment. The timeframe for the post-only period will begin when the demonstration extension begins and ends when the demonstration extension ends.

Table 16. Evaluation Components

Demonstration Goal 1: Expand access to Medicaid for former foster care youth who were in foster care and Medicaid in another state and are now applying for Medicaid in the Virginia					
Evaluation Component	**Evaluation Question**	**Evaluation Hypotheses**	**Measure [Reported for each Demonstration Year]**	**Recommended Data Source**	**Analytic Approach**
Process	Does the demonstration provide continuous health insurance coverage?	Beneficiaries will be continuously enrolled for 12 months.	Number of beneficiaries continuously enrolled/ total number of enrollees	Administrative data – enrollment data	Descriptive statistics (frequency and percentage)
	How did beneficiaries utilize health services?	Beneficiaries will access health services.	Number of beneficiaries who had an ambulatory care visit/ Total number of beneficiaries	Administrative data – Medicaid claims	Descriptive statistics (frequencies and percentages)
			Number of beneficiaries who had an emergency department visit/ Total number of		

			beneficiaries		
			Number of beneficiaries who had an inpatient visit/ Total number of beneficiaries		
			Number of beneficiaries who had a behavioral health encounter /Total number of beneficiaries		

The ARTS-related evaluation activities for the new demonstration period will include:

- A review of fatal overdose to examine trends related to Medicaid members versus fatal overdoses that had no Medicaid involvement;
- A review of costs for SUD-related and non-SUD-related services, to identify potential trends in cost variations for different types of ARTS services (outpatient, residential, pharmacotherapy), as well as costs for SUD-related emergency department and acute care services; and
- A comparison of Virginia versus other states on key measures such as MOUD treatment rates, continuity of pharmacotherapy, and use of other SUD-related services

Table 17. ARTS Evaluation Approach

ARTS Benefit			
Hypothesis	**Evaluation Approach**	**Data Sources**	**Summary of Findings to Date**
The demonstration will increase the percentage of beneficiaries who are referred and engage in treatment for OUD and other SUDS.	Analyze changes in the supply of treatment providers as well as changes in rates of treatment initiation and engagement.	• Claims/MODRN • DEA list of waivered prescribers N-SSATS	• ARTS and Medicaid expansion have increased supply of waivered prescribers and other treatment providers • ARTS increased IET rates relative to other states
The demonstration will decrease the rate of emergency department and	Analyze changes in SUD-related ED and inpatient use,	• Claims data • MODRN	• ARTS and Medicaid expansion increased utilization of all SUD treatment services.

acute inpatient stays.	use of ARTS services, and MOUD treatment rates		• ARTS decreased ED and acute inpatient use among members with SUD, relative to other members.
The demonstration will increase adherence to and retention in treatment	Analyze changes in continuity of MOUD treatment for members with OUD	• Utilization and cost data	• Continuity of MOUD treatment did not increase initially after ARTS, possibly due to changes in the characteristics of members receiving MOUD treatment
The demonstration will decrease the rate of readmissions to the same or higher level of care.	Analyze changes in readmissions to ASAM 3 and 4 levels of care, as well as number of members who receive follow-up care after ED visit and residential treatment	• Claims data • MODRN	• Analysis in progress
The demonstration will increase the percentage of beneficiaries with SUD who receive treatment for co-morbid conditions.	Analyze changes in use of preventive care, screening for HIV/HCV/HBV, counseling for mental health condition	• Claims data	• Analysis in progress
The demonstration will decrease the rate of overdose deaths due to opioids.	Analyze changes in the rate of fatal overdoses among people enrolled in Medicaid	• Cause of death data linked to Medicaid claims	• To be completed in 2024 when cause of death data become available

The demonstration will increase IMD SUD costs and outpatient SUD treatment costs and decrease SUD-related emergency room visit and inpatient stay costs	Examine changes in spending on residential treatment services, other ARTS services, and SUD-related ED and inpatient services	• Medicaid claims and cost data	• Spending on residential treatment and other ARTS services has greatly increased after both ARTS and Medicaid expansion

Table 18. Independent Evaluator Status of Timeline and Major Milestones for ARTS and FFCY

Milestone	Date	Status as of June 2024
Completion of first interim report under demonstration renewal, posted on DMAS website.	12/2020	Completed
Revised evaluation plan submitted to CMS	2/2021	Completed
Completion of ARTS member survey, second wave of mailings	4/2021	Completed
Ongoing analysis of claims and survey data	1/2021 to 12/2021	Completed
Analysis of cumulative impact of ARTS and Medicaid expansion on provider supply using DEA waivered prescriber data and N-SSATS	5/2021 to 12/2021	Completed (paper in review at Journal of Substance Abuse Treatment – JSAT: Journal of Substance Abuse Treatment | ScienceDirect.com by Elsevier)
Completion of second interim report under demonstration renewal, including separate report on FFCY who aged out of foster care in another state	12/2021	Completed
Ongoing analysis of claims and survey data	1/2022 to 12/2022	Completed
Semi-structured interviews with MCO care coordinators	3/2022 to 9/2022	Completed (changed to survey of care coordinators)
ARTS member survey, wave 3	10/2022 to 3/2023	In progress
Analysis of cumulative impact of ARTS and Medicaid expansion on SUD-related hospital inpatient admissions	5/2022 to 12/2022	Completed
Completion of third interim report under demonstration renewal, including separate report on FFCY who aged out of foster care in another state.	12/2022	Completed
Ongoing analysis of claims and survey data	1/2023 to 12/2023	Completed
Analysis of cumulative impact of ARTS and Medicaid expansion on access to and quality of treatment services for the Virginia population (based on analysis of TEDS)	7/2023 to 6/2024	In Progress
Completion of fourth interim report under	12/2023	In Progress

demonstration renewal, including separate report on FFCY who aged out of foster care in another state		
Ongoing analysis of claims, completion of all analytical tasks	1/2024 to 12/2024	In Progress
Completion of final report	12/2024	Not started

The Commonwealth intends to continue all evaluation activities related to this demonstration consistent with the CMS approved evaluation design, STCs and CMS policy.

Section VIII. Compliance with Public Notice Process

Upon completion of the public comment period, the State will submit documentation of the State's compliance with the public notice process set forth in 42 CFR §431.408, including the post-award public input process described in §431.420(c), with a report of the issues raised by the public during the comment period and how the State considered the comments when developing the demonstration extension application.

Following initial approval of the Virginia Governor's Access Plan (GAP) and Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation waiver, Virginia reported to the public via statewide Town Halls, statewide trainings, and a recorded presentation posted on the website requesting public comments within six months and annually thereafter, consistent with the requirements outlined in 42 CFR §431.420(c)(3)(i). At least 30 days prior to the date of the planned public forum, the Commonwealth published the public forum announcement on its website via the GAP webpage.

Since then, and over the course of the demonstration, Virginia has continued to update the public via regular meetings, trainings, and presentations and has solicited comments and feedback. Moving forward, Virginia attests that it will continue to comply with the post-award public input process in accordance with 42 CFR §431.420(c).

1) Start and end dates of the state's public comment period.

The Commonwealth's comment period was from May 30, 2024 to June 29, 2024.

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

The Commonwealth certifies that it provided public notice of the application on the Commonwealth's Medicaid website (http://www.dmas.virginia.gov/#/1115waiver) beginning on May 30, 2024. The full public notice is included both in Section IX below as well as Attachment 21 of this Demonstration extension request.

The Commonwealth also certifies that it provided notice of the application on the Virginia Regulatory Town Hall website (https://townhall.virginia.gov/L/Forums.cfm) – the State's Administrative Record – on May 30, 2024. A copy of the notice that appeared on Virginia's Regulatory Town Hall website is included as Attachment 16.

3) Certification that the state convened at least 2 public hearings, of which 1 hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

The Commonwealth certifies that it convened two (2) public hearings at least twenty days prior to submitting the Demonstration application to CMS. Specifically, Virginia held the following hearings:

- Richmond, June 18, 2024 from 10:00 am to 12:00 pm – Board of Medical Assistance Services meeting.

  In person attendance:
  Conference Rooms 102 A&B, 600 East Broad Street, Richmond, Virginia 23219

  Virtual attendance:
  https://covaconf.webex.com/weblink/register/rba760d03940653afe731b1cffd21c2e1

  (This meeting satisfies the requirements of 42 CFR 431.408 (a)(3)(ii)). Christine Minnick, Child Welfare Program Specialist, and Jason Lowe, Behavioral Health Integration Advisor, provided an overview of the Demonstration extension application during the Board of Medical Assistance Services public meeting. Individuals could also access this public meeting by teleconference and webinar. This meeting was recorded and transcribed.

- Richmond, June 26, 2024, from 10:00 AM to 11:00 AM. ARTS and Former Foster Care 1115 Renewal - Public Hearing

  In-person attendance:
  Libbie Mill Library, LM Meeting Room, 2100 Libbie Lake East Street, Henrico, Virginia 23230

  Virtual attendance:
  Meeting link. ID: 239 640 294 851, Passcode: fPKSG2
  Dial in by phone: +1 434-230-0065 Phone conference ID: 641 906 294#

  (This meeting satisfies the requirements of 42 CFR 431.408 (a)((3)(iv)). Christine Minnick, Child Welfare Program Specialist, and Jason Lowe, Behavioral Health Integration Advisor, provided an overview of the Demonstration extension application to individuals who were invited to attend in-person, by teleconference, and by webinar. This meeting was recorded.

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public.

The Commonwealth certifies that it used electronic mailing lists to provide notice of the application to the public. Specifically, the Commonwealth provided notice through Granicus. Granicus is a digital communications contractor that assists government agencies to send email and/or SMS messages to members, providers and stakeholders who have opted in to receive information from DMAS. Subscribers can specify the type of information they wish to receive when they sign up, which helps

DMAS determine their role and the type of information to send to them. DMAS currently has more than 215,000 members, providers, and stakeholders subscribed to our Granicus email distribution list. The Commonwealth also utilized the Virginia Regulatory Town Hall automatic notice function, which sends emails about posted notices to providers, advocates, and members of the public. Emails sent to these mailing lists are included as Attachment 17.

5) Comments received by the state during the 30-day public notice period.

The Commonwealth received XXXXXXXXXX comments during the public notice period. XXXXXXXXXX public comments were received by mail and email. In addition, XXXXXXXXXX people provided comments during Virginia's public hearings. All comments are included as Attachment 18 .

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.

A document summarizing and responding to the comments received is attached in Attachment 19. In response to commenters, the Commonwealth added the following points of clarification to its application:

- Clarified that an individual's coverage can also be reinstated "upon the end of the 12-month period of an enrollee's coverage year" as required under legislative language.

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State Plan, or at least 30 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation .

Virginia is home to seven (7) federally recognized tribal governments. In accordance with 42 CFR 431.408(b), on March 27, 2024, the Commonwealth notified tribes by email and postal mail of its intent to pursue a Section 1115 Demonstration and request for tribal consultation. Please see Attachment 20 for a copy of the tribal consultation. No comments were received from any of the tribes or Indian Health programs.

8) Documentation of the State's compliance with the post-award public input process described in 42 CFR §431.420(c).

Following approval of the Virginia Governor's Access Plan (GAP) and Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation waiver, Virginia reported to the public via statewide Town Halls, statewide trainings, and a recorded presentation posted on the website requesting public comments within six months and annually thereafter, consistent with the requirements outlined in 42 CFR §431.420(c)(3)(i). At least 30 days prior to the date of the planned public forum, the Commonwealth published the public forum announcement on its website via the GAP webpage.

Since then and over the course of the demonstration, Virginia has continued to update the public

regularly via meetings, trainings, and presentations and requested public comment. Moving forward, Virginia attests that it will continue to comply with the post-award public input process pursuant to 42 CFR §431.420(c).

Section IX. Public Notice

The full public notice is also included below as Attachment 21.

Building and Transforming Coverage, Services, and Supports for a Healthier Virginia 1115 Demonstration Renewal

Pursuant to 42 CFR §431.408, notice is hereby given that the Virginia Department of Medical Assistance Services (DMAS) is seeking to extend for five years its Medicaid Section 1115 Demonstration entitled "Building and Transforming Coverage, Services, and Supports for a Healthier Virginia." (No. 11-W-0029713).

The demonstration is scheduled to expire on December 31, 2024. Through this amendment, Virginia is requesting a five-year extension in order to:

- Continue to provide to provide short-term residential substance use disorder (SUD) treatment services in facilities that meet the definition of an "Institution for Mental Disease" (IMD).
- Continue to provide Medicaid coverage for former foster care youth and children (FFCY) up to age 26 who aged out of foster care in another state and now reside in Virginia. The demonstration will be updated to reflect that this coverage will apply to individuals who turned 18 prior to January 1, 2023, as individuals who turned 18 after that date are now covered under the State Plan.
- Sunset the High Needs Supports benefits because the Virginia General Assembly has not provided funding to implement these services.

These changes reflect the limits of existing state authority for this demonstration waiver.

DMAS is providing an opportunity for the public to review and provide input on the Demonstration amendment application from May 30, 2024 through June 29, 2024. To view the draft renewal application, please visit the DMAS website at [http://www.dmas.virginia.gov/#/1115waiver].

A. **The program description, goals, and objectives to be implemented or extended under the demonstration project, including a description of the current or new beneficiaries who will be impacted by the demonstration.**

On December 30, 2019, the Centers for Medicare and Medicaid Services (CMS) approved a five-year extension of Virginia's Medicaid demonstration, Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation (Project Number 11-W-0029713). Under the approved Special Terms and Conditions (STCs) DMAS provides SUD benefits to Medicaid beneficiaries, including SUD treatment services provided to individuals who are short-term residents in residential treatment facilities that meet the definition of an IMD. Virginia also provides coverage to FFCY up to age 26 who aged out of foster care in another state and now reside in Virginia.

On July 9, 2020, CMS approved Virginia's request to provide a High Needs Support benefit that included supportive employment and housing as a new Medicaid feature within Virginia's 1115 demonstration extension application, otherwise approved on December 30,

2019. CMS also approved the section 1115 demonstration name change from Addiction and Recovery Treatment Services Delivery System Transformation to Building and Transforming Coverage, Services, and Supports for a Healthier Virginia to better encompass the current ARTS and former foster youth coverage provisions, the new High Needs Supports program and any potential future programs.

This demonstration extension will continue the ARTS program, whereby DMAS will continue to provide SUD benefits to Medicaid beneficiaries, including SUD treatment services provided to individuals who are short-term residents in residential treatment facilities that meet the definition of an IMD. In Virginia, the ARTS benefit provides access to a full continuum of care for SUD treatment based on the American Society of Addition Medicine (ASAM) criteria to ensure Medicaid members with substance use disorders are matched to the right level of care to meet their evolving needs as they enter and pass through treatment. This includes expanded outpatient and community-based addiction and recovery treatment services and coverage of inpatient detoxification and residential substance use disorder treatment.

This demonstration will also update the authority to specify that Virginia provides Medicaid coverage for former foster care youth (FFCY) up to age 26 who aged out of foster care in another state and now reside in Virginia (provided the member turned 18 prior to January 1, 2023).

Finally, DMAS is proposing to sunset the High Needs Supports benefits because the Virginia General Assembly has not provided funding that has enabled these services to be implemented. These services were planned to include:

- A work and community engagement program for certain adult populations;
- A Health and Wellness program that included premiums and cost-sharing designed to promote healthy behavior for certain adult populations between 100 and 138 percent of the federal poverty level; and
- A housing and employment supports benefit for high-need populations.

B. **Proposed health care delivery system and eligibility requirements, benefit coverage and cost sharing (premiums, co-payments and deductibles) required of individuals that will be impacted by the demonstration, and how such provisions vary from the State's current program features**

Demonstration Eligibility - ARTS

The Medicaid eligibility groups affected by this portion of the demonstration are illustrated in the table below. State plan groups derive their eligibility through the Medicaid state plan, and coverage for these groups is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as waived in this demonstration.

Medicaid Eligibility Groups Affected by the Demonstration			
Demonstration Feature	**Eligibility Group**	**Citations**	**Income Level**
Addiction and Recovery	New adult group	• 1902(a)(10)(A)(i)(VIII) • 42 CFR 435.119	133% FPL

Treatment Services (ARTS)			
	Aged, blind, and disabled	• 42 CFR 435.121	80% FPL
	Parents and other caretaker relatives	• 1902(a)(10)(A)(i)(I) • 1931 (b) and (d) • 42 CFR 435.110	Group 1: $307/month (~24% FPL) Group 2: $402/month (~32%) Group 3: $603/month (~48%)
	Pregnant women	• 42 CFR 435.116	143% FPL
	Out of state FFCY	• Expenditure Authority • 1902(a)(10)(A)(i)(IX)	N/A, no income limit
	Children with Title IV-E adoption assistance, foster care, or guardianship care	• 473(b)(1) • 1902(a)(10)(A)(i)(I) • 42 CFR 435.145	N/A, no income limit.
	Children under age 19	• 1902(a)(10)(A)(ii)(XIV) • 1905(u)(2)(B) • 42 CFR 435.229 and 435.4	143% FPL
	Transitional medical assistance	• 1902(a)(52) • 1902(e)(l) • 1925(a)(b)(c) • 42 CFR 435.112	185% FPL
	Extended Medicaid due to spousal support collections	• 408(a)(11)(B) • 1902(a)(10)(A)(i)(I) • 1921(c) • 42 CFR 435.115	No limit so long as the reason the family no longer meets the income limit is due to increased spousal support.
	Former foster care youth up to age 26 who aged out of foster care in Virginia	• 42 CFR 435.150 • 1902(a)(10)(A)(i)(IX)	N/A, no income limit

Demonstration Benefits - ARTS

Virginia is not requesting any changes to the ARTS benefits as part of this extension. Beneficiaries who are eligible for the demonstration will receive the same benefits as set forth in the Medicaid state plan. Additionally, Virginia will provide the SUD benefits established under the ARTS portion of the demonstration. Specifically, Virginia will provide SUD treatment services to individuals who are short-term residents in residential treatment

facilities that meet the definition of an IMD.

As illustrated in the Table below, these benefits include ASAM Levels of Care 3.1, 3.3, 3.5, and 3.7. Continuing these benefits will enable all of Virginia's 2.1 million Medicaid enrollees[2] to continue to have access to the full continuum of ARTS services.

ASAM Level of Care	ASAM Description
3.1	Clinically Managed Low Intensity Residential
3.3	Clinically managed Population-Specific High Intensity Residential
3.5	Clinically Managed High Intensity Residential Services (Adults) Clinically Managed Medium Intensity Residential Services (Adolescents)
3.7	Medically Monitored Intensive Inpatient Services (Adults) – only for services provided in a residential setting. (Does not include services provided in an inpatient setting.) Medically Monitored High-Intensity Inpatient Services (Adolescents) – only for services provided in a residential setting. (Does not include services provided in an inpatient setting.)

Demonstration Cost-Sharing Requirements - ARTS
Cost sharing requirements do not differ from the Medicaid State Plan.

Delivery System and Payment Rates for Services - ARTS
Virginia is not requesting any changes to the delivery system or payment rates as part of this extension. The health care delivery system for demonstration participants is no different than the delivery system in place for the Virginia Medicaid population. The demonstration will utilize the current statewide managed care delivery system and fee-for-service delivery system. Beneficiaries may be enrolled in FFS prior to being enrolled into managed care.

Payment rates for residential treatment services provided under the demonstration are illustrated in the table below.

ASAM Level of Care	ASAM Description	Current Rate (subject to change for future dates)
3.1	Clinically Managed Low Intensity Residential	1 unit = 1 day Current rate of $196.88 set on 7/1/21

[2] DMAS Monthly Enrollment Report (virginia.gov)

3.3	Clinically managed Population-Specific High Intensity Residential	1 unit = 1 day Rates are based on individual considerations. Maximum daily rate for PRTFs = $460.89 Maximum daily rate for other residential facilities = $518.86
3.5	Clinically Managed High Intensity Residential Services (Adults) Clinically Managed Medium Intensity Residential Services (Adolescents)	1 unit = 1 day Rates are based on individual considerations. Maximum daily rate for PRTFs = $460.89 Maximum daily rate for other residential facilities = $518.86
3.7	Medically Monitored Intensive Inpatient Services (Adults) – only for services provided in a residential setting. (Does not include services provided in an inpatient setting.) Medically Monitored High-Intensity Inpatient Services (Adolescents) – only for services provided in a residential setting. (Does not include services provided in an inpatient setting.)	1 unit = 1 day Rates are based on individual considerations. Maximum daily rate for PRTFs = $460.89 Maximum daily rate for other residential facilities = $518.86

Demonstration Eligibility - FFCY

The population affected by this demonstration is FFCY who are under age 26 who were in foster care under the responsibility of another state and enrolled in Medicaid at age 18 or when they "aged out," and moved to Virginia and are not eligible in any other mandatory Medicaid group. The demonstration extension seeks to update the authority to specify that the FFCY has to have turned 18 years old prior to January 1, 2023. There is no income or resource test for this group.

Eligibility Chart Mandatory State Plan Groups

Eligibility Group	Social Security Act and CFR Citations	Income level
FFCY up to age 26 who aged out of foster care in another state and now reside in Virginia, provided the member turned 18 prior to January 1, 2023	1115 Demonstration	N/A

Standards and methodologies do not differ from what is already in the Virginia State Plan for Medical Assistance. The projected number of individuals who will be eligible for the demonstration is approximately 86 per month. The projection is based on the current number

of enrollees under the Medicaid State Plan. There are no changes to eligibility procedures for this population.

Demonstration Benefits and Cost-Sharing Requirements - FFCY

Benefits provided to the FFCY population are the same benefits provided to Virginia's current Medicaid population under the State Plan. Cost sharing requirements do not differ from the Medicaid State Plan.

Delivery System and Payment Rates for Services - FFCY

The health care delivery system for demonstration participants is no different than the delivery system in place today for the Virginia Medicaid population. The demonstration will utilize the current statewide managed care delivery system and fee-for-service (FFS) delivery system. Beneficiaries may be enrolled in FFS prior to being enrolled into managed care.

C. **Estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable. This includes a financial analysis of any changes to the demonstration requested by the State in its extension request**

The Tables below summarize historic and projected enrollment and expenditure data.

Historical ARTS Data Without Waiver

	DY5	**DY 6**	**DY 7**	**DY 8**	**DY 9**
Member Months	1,090	711	1,354	1,354	5,980
Per Member Per Month (PMPM)	$3,909.24	$3,315.77	$4,341.16	$4,341.16	$4,429.18
Total Expenditures	$4,261,076	$2,357,512	$5,877,936	$5,877,936	$26,486,471

Historical ARTS Data With Waiver

	DY5	**DY 6**	**DY 7**	**DY 8**	**DY 9**
Member Months	1,090	711	1,354	1,354	5,980
Per Member Per Month (PMPM)	$3,909.24	$3,315.77	$4,341.16	$4,341.16	$4,429.18
Total Expenditures	$4,261,076	$2,357,512	$5,877,936	$5,877,936	$26,486,471

ARTS Program Projections Without Waiver

	DY 11	**DY 12**	**DY 13**	**DY 14**	**DY 15**
Member Months	7,118	7,262	7,410	7,560	7,713
Per member Per	$5,469.69	$5,625.89	$5,786.55	$5,951.80	$6,121.77

Month (PMPM)					
Total Expenditures	$38,933,253	$40,855,213	$42,878,336	$44,995,608	$47,217,212

ARTS Program Projections With Waiver

	DY 11	DY 12	DY 13	DY 14	DY 15
Member Months	7,118	7,262	7,410	7,560	7,713
PMPM	$5,469.69	$5,625.89	$5,786.55	$5,951.80	$6,121.77
Total Expenditures	$38,933,253	$40,855,213	$42,878,336	$44,995,608	$47,217,212

Historical Out-of-State FFCY Data Without Waiver

	DY5	DY 6	DY 7	DY 8	DY 9
Member Months	925	1,212	1,332	1,437	1,255
Per Member Per Month (PMPM)	$631.86	$586.96	$549.83	$647.45	$960.75
Total Expenditures	$584,474	$711,400	$732,378	$930,391	$1,205,737

Historical Out-of-State FFCY Data With Waiver

	DY5	DY 6	DY 7	DY 8	DY 9
Member Months	925	1,212	1,332	1,437	1,255
Per Member Per Month (PMPM)	$631.86	$586.96	$549.83	$647.45	$960.75
Total Expenditures	$584,474	$711,400	$732,378	$930,391	$1,205,737

Historical Out-of-State FFCY Enrollment Data

	DY 5	DY 6	DY 7	DY 8	DY 9
FFCY Members from Out of State	65	82	95	91	91

Out-of-State FFCY Projections Without Waiver

	DY 11	DY 12	DY 13	DY 14	DY 15

Member Months	1,964	2,164	2,383	2,625	2,892
Per Member Per Month (PMPM)	$768.26	$800.92	$834.97	$870.46	$907.47
Total Expenditures	$1,509,112	$1,732,948	$1,989,985	$2,285,146	$2,624,087

Out-of-State FFCY Projections-With Waiver

	DY 11	**DY 12**	**DY 13**	**DY 14**	**DY 15**
Member Months	1,964	2,164	2,383	2,625	2,892
Per Member Per Month (PMPM)	$768.26	$800.92	$834.97	$870.46	$907.47
Total Expenditures	$1,509,112	$1,732,948	$1,989,985	$2,285,146	$2,624,087

D. **Hypothesis and evaluation parameters of the demonstration**

The hypothesis and evaluation parameters of the demonstration extension are outlined below.

ARTS

ARTS Benefit			
Hypothesis	**Evaluation Approach**	**Data Sources**	**Summary of Findings to Date**
The demonstration will increase the percentage of beneficiaries who are referred and engage in treatment for OUD and other SUDS.	Analyze changes in the supply of treatment providers as well as changes in rates of treatment initiation and engagement.	• Claims/MODRN • DEA list of waivered prescribers N-SSATS	• ARTS and Medicaid expansion have increased supply of waivered prescribers and other treatment providers • ARTS increased IET rates relative to other states
The demonstration will decrease the rate of emergency department and acute inpatient stays.	Analyze changes in SUD-related ED and inpatient use, use of ARTS services,	• Claims data • MODRN	• ARTS and Medicaid expansion increased utilization of all SUD treatment services. • ARTS decreased ED and acute inpatient

	and MOUD treatment rates		use among members with SUD, relative to other members.
The demonstration will increase adherence to and retention in treatment	Analyze changes in continuity of MOUD treatment for members with OUD	• Utilization and cost data	• Continuity of MOUD treatment did not increase initially after ARTS, possibly due to changes in the characteristics of members receiving MOUD treatment
The demonstration will decrease the rate of readmissions to the same or higher level of care.	Analyze changes in readmissions to ASAM 3 and 4 levels of care, as well as number of members who receive follow-up care after ED visit and residential treatment	• Claims data • MODRN	• Analysis in progress
The demonstration will increase the percentage of beneficiaries with SUD who receive treatment for co-morbid conditions.	Analyze changes in use of preventive care, screening for HIV/HCV/HBV, counseling for mental health condition	• Claims data	• Analysis in progress
The demonstration will decrease the rate of overdose deaths due to opioids.	Analyze changes in the rate of fatal overdoses among people enrolled in Medicaid	• Cause of death data linked to Medicaid claims	• To be completed in 2024 when cause of death data become available

The demonstration will increase IMD SUD costs and outpatient SUD treatment costs and decrease SUD-related emergency room visit and inpatient stay costs	Examine changes in spending on residential treatment services, other ARTS services, and SUD-related ED and inpatient services	• Medicaid claims and cost data	• Spending on residential treatment and other ARTS services has greatly increased after both ARTS and Medicaid expansion

The ARTS-related evaluation activities for the new demonstration period will include:

- A review of fatal overdose to examine trends related to Medicaid members versus fata overdoses that had no Medicaid involvement.
- A review of costs for SUD-related and non-SUD-related services, to identify potential trends in cost variations for different types of ARTS services (outpatient, residential, pharmacotherapy), as well as costs for SUD-related emergency department and acute care services.
- A comparison of Virginia versus other states on key measures such as MOUD treatment rates, continuity of pharmacotherapy, and use of other SUD-related services.

FFYC

Demonstration Goal 1: Expand access to Medicaid for former foster care youth who were in foster care and Medicaid in another state and are now applying for Medicaid in the Virginia					
Evaluation Component	Evaluation Question	Evaluation Hypotheses	Measure [Reported for each Demonstration Year]	Recommended Data Source	Analytic Approach
Process	Does the demonstration provide continuous health insurance coverage?	Beneficiaries will be continuously enrolled for 12 months.	Number of beneficiaries continuously enrolled/ total number of enrollees	Administrative data – enrollment data	Descriptive statistics (frequency and percentage)
	How did beneficiaries utilize health services?	Beneficiaries will access health services.	Number of beneficiaries who had an ambulatory care visit/ Total number of beneficiaries	Administrative data – Medicaid claims	Descriptive statistics (frequencies and percentages)
			Number of		

	beneficiaries who had an emergency department visit/ Total number of beneficiaries	
	Number of beneficiaries who had an inpatient visit/ Total number of beneficiaries	
	Number of beneficiaries who had a behavioral health encounter /Total number of beneficiaries	

E. **Specific waiver and expenditure authorities that the State believes to be necessary to authorize the demonstration**

The specific waiver and expenditure authorities Virginia requests include:

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver Request?
§1902(a)(8) and §1902(a)(10) Provision of Medical Assistance and Eligibility	To limit the state plan group coverage to former foster care youth who were in Medicaid and foster care in a different state	Yes
Expenditures related to ARTS	Expenditures not otherwise eligible for federal financial participation may be claimed for otherwise covered services furnished to otherwise eligible individuals (eligible under the State Plan or Former Foster Care Youth components of this demonstration), including services for individuals who are short-term residents in facilities that would otherwise meet the definition of an Institute of Mental Disease (IMD) for the treatment of SUD and withdrawal management.	Yes

ii. Location and Internet address where copies of the demonstration application are available for public review and comment

Copies of the demonstration application are available for public review and comment on the Demonstration page of the DMAS website at:
http://www.dmas.virginia.gov/#/1115waiver

iii. Postal and Internet email addresses where written comments may be sent and reviewed by the public, and the minimum 30-day time period in which comments will be accepted

The public can provide comment on the demonstration application at the Virginia Regulatory Town Hall, available here:
Comments can also be submitted via postal mail, telephone, and email to:
Virginia Department of Medical Assistance Services
Building and Transforming Coverage, Services, and Supports for a Healthier Virginia Demonstration Renewal
Attn: Jason Lowe
600 East Broad Street
Richmond, VA 23219
804-659-8732
jason.lowe@dmas.virginia.gov

The 30-day time period in which comments will be accepted is May 30, 2024 through 11:59 pm on June 29, 2024.

iv. The location, date and time of at least two public hearings convened by the State to seek public input on the demonstration application

Two public hearings will be held to seek public input on the demonstration application. These meetings satisfy the requirements of 42 CFR 431.408 (a)((3)(iv).

The details of the hearings are as follows:

Public Hearing #1:
Board of Medical Assistance Services Meeting
Tuesday, June 18, 2024
10:00 am – 12:00 pm
In person attendance: Conference Rooms 102 A&B, 600 East Broad Street, Richmond, Virginia 23219
Virtual attendance:
https://covaconf.webex.com/weblink/register/rba760d03940653afe731b1cffd21c2e1
Christine Minnick, Child Welfare Program Specialist, and Jason Lowe, Behavioral Health Integration Advisor, will provide an overview of the Demonstration extension application during the Board of Medical Assistance Services public meeting. Individuals can also access this public meeting by teleconference and webinar. This meeting will be recorded and transcribed.

Public Hearing #2:
ARTS and Former Foster Care 1115 Renewal - Public Hearing
Wednesday, June 26, 2024
10:00-11:00 am
In-person attendance: Libbie Mill Library, LM Meeting Room, 2100 Libbie Lake East

Street, Henrico, Virginia 23230
Virtual attendance: Meeting link. ID: 239 640 294 851, Passcode: fPKSG2
Dial in by phone: +1 434-230-0065 Phone conference ID: 641 906 294#
Christine Minnick, Child Welfare Program Specialist, and Jason Lowe, Behavioral Health Integration Advisor, will provide an overview of the Demonstration extension application to individuals who are invited to attend in-person, by teleconference, and by webinar. This meeting will be recorded.

Public Comment

The 30-day public comment period for the demonstration is from May 30, 2024 to June 29, 2024. All comments must be received by 11:59 p.m. (Eastern Time) on June 29, 2024. Public comments may be submitted via the Virginia Regulatory Town Hall public comment page at this link: https://townhall.virginia.gov/L/Forums.cfm (Scroll down to the Department of Medical Assistance Services and click on "View and Enter Comments.") Comments may also be submitted by e-mail to jason.lowe@virginia.gov or by regular mail or in person at the address below.

Virginia Department of Medical Assistance Services
Building and Transforming Coverage, Services, and Supports for a Healthier Virginia Demonstration Renewal
Attn: Jason Lowe
600 East Broad Street
Richmond, VA 23219

After considering public comments about the proposed demonstration renewal application, DMAS will make final decisions about the demonstration and submit a revised application to CMS. The summary of comments, as well as copies of written comments received, will be posted for public viewing on the DMAS website along with the demonstration extension application when it is submitted to CMS.

Information regarding the "Building and Transforming Coverage, Services, and Supports for a Healthier Virginia" Renewal Application can be found on the DMAS website at http://www.dmas.virginia.gov/#/1115waiver. DMAS will update this website throughout the public comment and application process.

For more information about the "Building and Transforming Coverage, Services, and Supports for a Healthier Virginia" Demonstration, which the Commonwealth is seeking to extend, please visit the CMS website at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83451.

Section 1115 of the Social Security Act gives the U.S. Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of Medicaid and the Children's Health Insurance Program (CHIP). Under this authority, the Secretary may waive certain provisions of Medicaid or CHIP to give states additional flexibility to design and improve their programs. To learn more about Section 1115 demonstrations, please visit the CMS website at https://www.medicaid.gov/medicaid/section-1115-demo/index.html.

Contact Information

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Appendix A. Attachments
Please see below.

Attachment 1

Virginia 1115 Demonstration
Waiver History

Virginia Department of Medical Assistance Services
1115 Demonstration Waiver – Substance Use Disorders
Historical Narrative Summary of the Demonstration
May 2024

Approved January 9, 2015, the Virginia Governors Access Plan (GAP) demonstration provided a specified benefits package to childless adults and non-custodial parents ages 21 through 64 with household incomes at or below 100 percent of the FPL using the Modified Adjusted Gross Income (MAGI) methodology, and who had been diagnosed with a serious mental illness (SMI). The demonstration extended access to a limited package of behavioral and physical health services to adults who were not otherwise eligible for Medicaid, Children's Health Insurance Program (CHIP), or Medicare, and were uninsured.

On December 15, 2016, CMS approved Virginia's first GAP Demonstration amendment through December 31, 2019. The amendment included DMAS' new SUD benefit, referred to as the Addiction and Recovery Treatment Services (ARTS) benefit. The ARTS amendment expanded SUD benefits for all Virginia Medicaid recipients eligible under the state plan to cover the full continuum of SUD treatment; introduced quality of care and programmatic features for the successful integration of SUD services into comprehensive managed care for all managed care enrollees; incorporated industry standard SUD treatment criteria into program standards; improved the quality and availability of medication-assisted treatment services; and introduced policy, practice and system reforms consistent with CMS State Medicaid Director Letter (SMDL) #15-003. The amendment also changed the name of Virginia's Demonstration to "The Virginia Governor's Access Plan (GAP) and Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation (Project No. 11-W-00297/3)."

Virginia amended the Medicaid and CHIP state plans to cover the full continuum of community-based SUD care to align with the American Society of Addiction Medicine (ASAM) Criteria. In addition, the 1115 SUD Demonstration allowed Virginia to cover SUD treatment in an Institution of Mental Disease (IMD).

On September 22, 2017, CMS approved another amendment to Virginia's demonstration to:

1. Increase the eligibility level for GAP to 100 percent of the federal poverty level (FPL);
2. Include additional SUD services in the GAP benefit package; and
3. Provide Medicaid coverage to former foster care youth (FFCY) who received Medicaid services in a different state.

As part of the approved amendment, the Commonwealth continued the ARTS demonstration, providing the expanded SUD benefit package to all eligible Medicaid recipients.

On June 7, 2018, Governor Northam signed Item 303.SS(4) of the 2018 Appropriations Act that authorized the Department of Medical Assistance Services (DMAS) to expand coverage to newly eligible non-disabled, non-pregnant adults ages 19 to 64 with income up to 138 percent of the FPL, effective January 1, 2019. CMS approved Virginia's Medicaid Expansion state plan effective January 1, 2019. This allowed Virginia to provide Medicaid coverage to the new adult

group, individuals that are not pregnant, not eligible for Medicare, not eligible for Medicaid, under age 65, and with income under 133 percent of the FPL.

The 2018 Appropriations Act also directed DMAS to submit a request to add new Medicaid program features to its existing 1115 demonstration. DMAS submitted its extension application on November 20, 2018, and it was approved on December 30, 2019. The extension included significant modifications, including a community engagement requirement, premium obligation, and housing and employment supports allowable under the Home and Community Based Services (HCBS) benefit to Medicaid beneficiaries age 18 or older who are eligible under the Medicaid state plan, and who meet certain needs-based criteria and risk factors.[i] The extension also removed GAP from the demonstration because the state decided the program was no longer needed after expanding Medicaid.

On December 30, 2019, CMS approved a five-year extension of the demonstration to allow Virginia to maintain the ARTS benefit and associated authorities, as well as authority to provide eligibility to FFCY who aged out of foster care under the responsibility of another state and applies for Medicaid in Virginia.

Lastly, On July 9, 2020, CMS approved Virginia's demonstration amendment to provide a "High Needs Supports" benefit that allowed coverage of certain otherwise allowable 1915(i) state plan amendment (SPA) services. The services included: housing and employment supports for HCBS Medicaid beneficiaries age 18 or older who are eligible under the Medicaid state plan and enrolled in the managed care delivery system, and individuals age 18 up to age 26 who are eligible under the out-of-state FFCY component of the demonstration and are enrolled in the managed care delivery system, and who meet specific needs based criteria and risk factors.

With this approval, DMAS changed the demonstration title to "Building and Transforming Coverage, Services, and Supports for a Healthier Virginia". CMS approved DMAS' amendment for a five-year period, from January 1, 2020 to December 31, 2024.

Due to competing priorities during the COVID-19 public health emergency, the "High Needs Supports" benefit that consisted of housing and employment services was not implemented because funding was not allotted.

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[i] Passage of the Commonwealth's 2020 - 2022 biennium budget on May 21, 2020 included the formal elimination of the community engagement requirement and premium obligation provisions. DMAS submitted a waiver amendment request on July 1, 2020 that formally requested removal of these components from its 1115 demonstration waiver application.

Attachment 2

Virginia 1115 Demonstration
Current Comprehensive Evaluation

VCU School of Medicine
Health Behavior and Policy

Addiction and Recovery Treatment Services

Evaluation Report for State Fiscal Years 2020, 2021, and the first half of 2022

April 2023

Authors

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Acknowledgements

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Disclaimer

The conclusions in this report are those of the authors, and no official endorsement by Virginia Commonwealth University or the Virginia Department of Medical Assistance Services is intended or should be inferred.

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Executive Summary

Fatal drug-related overdoses increased precipitously between late 2019 and early 2022, peaking at around 108,000 deaths nationally and about 2,600 in Virginia.[1] This represents a 51% increase nationally and 69% increase in Virginia between December 2019 and December 2021. Although the increase began before the COVID-19 pandemic, economic and social stress related to the pandemic, disruptions in access to health services, and greater availability of more lethal forms of opioids, such as fentanyl, are considered the primary reasons for the surge in overdoses. Since late 2021, the increase in overdose deaths has leveled off, and even decreased in Virginia and other states that are part of the Appalachian region. Between June 2021 and June 2022, overdose deaths are estimated to have decreased by 1.5% in Virginia, while increasing nationally by 5.5%.[1]

As a result of the expansion of treatment services through the Addiction and Recovery Treatment Services (ARTS) benefit in April 2017, and increases in eligibility for these services through Medicaid expansion beginning in 2019, Virginia Medicaid was better prepared for the increased prevalence in substance use disorders (SUD) than in previous years. The supply of treatment providers, the prevalence of members receiving SUD treatment, and the rate of treatment for diagnosed SUD increased dramatically after implementation of the ARTS benefit and has continued through Medicaid expansion and the COVID-19 pandemic.[2]

The federal government and the Department of Medical Assistance Services (DMAS) also implemented several initiatives and procedural flexibilities to offset COVID-related access barriers to treatment, including increased use of telemedicine, allowing take-home dosages of methadone and buprenorphine for up to 28 days, allowing for 90-day prescriptions for buprenorphine products, and allowing a member's home to serve as the originating site for prescription of buprenorphine. In addition, the federal Families First Coronavirus Response Act (FFCRA) of 2020 increased the federal share of most Medicaid spending on the condition that states meet certain maintenance of eligibility (MOE) requirements, including pausing eligibility redeterminations and Medicaid disenrollment. This has allowed Medicaid members to stay enrolled in Medicaid continuously since the beginning of the COVID-19 pandemic, increasing overall enrollment.

The Department of Health Behavior and Policy at Virginia Commonwealth University School of Medicine is conducting an independent evaluation of the ARTS benefit. The evaluation of the ARTS demonstration renewal has three main goals:

1) Extend the post-implementation period of the evaluation beyond the first two years of ARTS to include the years 2019-2024. In particular, the evaluation will examine and account for the impact of Virginia's Medicaid expansion in 2019 on SUD prevalence, access to and quality of treatment services, and outcomes among the Medicaid population.

2) To strengthen conclusions about the causal impact of ARTS on key measures of access and quality of care by comparing adjusted summary statistics in Virginia to other states using the Medicaid Outcomes Distributed Research Network (MODRN).

3) To examine the cumulative impact of ARTS and Medicaid expansion on addiction treatment services for the Virginia population, using national data sources that permit comparisons of treatment before and after expansion in Virginia, and between Virginia, other states, and the

overall U.S. on selected measures of SUD treatment access, utilization, quality of treatment, and rates of fatal overdoses.

The primary objective of this report is to examine SUD prevalence, treatment utilization, and outcomes among Virginia Medicaid members during State Fiscal Years (SFY) 2020, 2021, as well as the first two quarters of SFY 2022 (covering the period July 2019 through December 2022). Among the highlights of the report:

Increased prevalence of SUD

- 116,000 Medicaid members had a diagnosed SUD in SFY 2021, an increase of 14% from SFY 2020. On a per member basis, SUD prevalence increased by 6.5% to 6,567 members per 100,000 with a SUD diagnosis in SFY 2021. This represents a much lower rate of increase than observed between SFY 2019 and 2020 (30% overall and 16% per member increase, respectively), which was driven by Medicaid expansion and possibly the beginning of the COVID-19 pandemic.

- While opioid use disorder (OUD) continues to be the most frequently diagnosed SUD among Medicaid members (about 41% of all diagnosed SUD), the prevalence rate increased faster for other substances between SFY 2019 and 2020, especially for hallucinogens (a 45% increase).

Increase in treatment providers

- The number of buprenorphine waivered prescribers increased to over 1,500 prescribers in 2022, a 33% percent increase from 2021. Increases in waivered prescribers were especially large for nurse practitioners and physician assistants, who now comprise a greater number of waivered prescribers than physicians.

- The number of pharmacies dispensing buprenorphine to Medicaid members has increased 44% since the beginning of the ARTS benefit, although one-fourth of all pharmacies did not dispense any buprenorphine for treatment of OUD in 2021.[1] Access to buprenorphine-dispensing pharmacies may be more restricted in some areas of the state, such as the Southwest region.

Increased use of ARTS services

- Use of ARTS services continued to increase between SFY 2020 and SFY 2021, with a total of 53,614 members receiving any type of ARTS treatment service in SFY 2021 (a 24% increase from SFY 2020).

- Treatment rates (the percent of members with a diagnosed SUD who received any ARTS treatment service) are highest among members with an OUD diagnosis (69.4%) but lower among members with other SUD diagnoses, such as alcohol use disorder (27.1%), stimulant use disorder (34.3%) and cannabis use disorder (16.5%).

[1] Buprenorphine for treatment of pain was not included in this analysis.

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

Residential treatment and pharmacotherapy account for half of ARTS expenditures

- Among members who use ARTS services in SFY21, only 9% utilized residential treatment services (ASAM 3), with an average length of stay of 15.5 days. However, residential treatment services account for 26.3% of all expenditures for ARTS services.

- Medically managed intensive inpatient services (ASAM 4) are acute hospital or inpatient psychiatric admissions related to SUD, offering 24 hour nursing care and daily physician care for severe, unstable problems. While these services account for a small fraction of ARTS expenditures (2.5%), they are the most expensive on a per member basis ($50,562 per member who used ASAM 4 services in SFY 2021).

- While pharmacotherapy for MOUD is one of the most heavily utilized ARTS services and accounts for about one-fourth of ARTS expenditures, it has relatively low expenditures on a per member basis ($2,220 per member who utilized pharmacotherapy in SFY 2021).

Treatment gaps in transitions from emergency departments and residential treatment

- Many members who had OUD-related emergency department (ED) visits do not receive follow up care or MOUD treatment. Only 27% of members with an OUD-related ED visit received MOUD treatment within 7 days of the visit, and 37% received MOUD within 30 days of the ED visit. Receipt of MOUD following the ED visit was especially low among those who were not receiving treatment prior to the ED visit.

- More members receive follow up care after discharge from residential treatment, with 54% receiving MOUD within 30 days of discharge. However, follow up MOUD use was lower among those who had not been receiving MOUD treatment prior to the residential stay.

Recently incarcerated at greater risk for OUD and overdoses

- New Medicaid enrollees recently released from state prisons were four times as likely as other new Medicaid enrollees to receive an OUD diagnosis within 6 months of enrollment, and they were five times as likely to have had a fatal or nonfatal overdose.

- Once diagnosed with OUD, formerly incarcerated members tend to have higher rates of outpatient and MOUD treatment compared to other new Medicaid enrollees with OUD, and they are only slightly more likely to experience an overdose.

OUD-related overdose rates may have peaked.

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

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

The Commonwealth of Virginia has made substantial progress since the implementation of the ARTS benefit in 2017 in building a robust treatment infrastructure for Medicaid members, with the number of treatment providers, members using services, and treatment rates for those with SUD diagnoses increasing every year since 2017. Continued progress will depend in part on addressing ongoing gaps in treatment, especially care transitions following discharges from hospitals, residential treatment centers, and carceral settings, as well as addressing uneven access to providers and pharmacies in some areas of the state. System capacity to treat patients may also benefit in the future to the extent that COVID-19 related increases in SUD prevalence and overdoses have leveled off and continue to decrease.

Introduction

Fatal drug-related overdoses surged in Virginia and the nation during 2020 and 2021. Nationally, fatal drug overdoses peaked at around 108,000 deaths in the 12 months ending February, 2022, a 12% increase from the previous year, and a 43% increase from the year ending February 2020.[1] During the same two year period, fatal overdoses in Virginia increased 65%, to almost 2,600 deaths in February 2022.[1] Early reports indicate that fatal drug overdoses may have declined in 2022 in both Virginia and 7 and other states, although it is too early to know if this is temporary or the beginning of a longer-term trend.

Opioids continue to account for the majority of overdose deaths in the U.S. (75%) and Virginia (84%). However, there has been a marked shift in the type of opioids responsible for overdoses. In Virginia, deaths from fentanyl overdoses more than doubled between 2019 and 2022 (from 964 to 1,952), while there was little change in deaths due to prescription opioids, and even a small decrease in deaths from heroin.[3] Fentanyl accounted for 93% of opioid-related fatal overdoses in Virginia in 2022, compared to 74% in 2019 and 55% in 2016. At the same time, overdose deaths in Virginia due to methamphetamines and cocaine increased by 183% and 85%, respectively, between 2019 and 2022.[3] An increase in alcohol use disorder is also contributing to increased mortality from substance use, accounting for 95,000 deaths nationally and 22.1% of prescription opioid overdose deaths.[4,5]

There are a number of possible reasons for the surge in fatal overdoses and greater use of drugs and alcohol during the COVID-19 pandemic, including increases in the supply and availability of illicit drugs – especially fentanyl and methamphetamines – economic dislocation, unemployment, greater social isolation, and an increase in co-occurring mental health problems.[6] Also, access to addiction treatment services may have become more difficult due to COVID-related shutdowns and more restrictions on face-to-face meetings with clinicians and peer recovery specialists, a health system that has been severely strained by the pandemic, and growing shortages of behavioral health providers in Virginia and the nation.[7]

Although it is too early to know conclusively, the leveling off and slight decrease in fatal overdoses during 2022 in some states (including Virginia) may reflect in part an easing of the most severe social, economic, and health system pressures experienced during the height of the pandemic, along with greater public health awareness and efforts to educate the public about the dangers of fentanyl. Notably, the overall decrease in fatal drug overdoses in Virginia in 2022 is driven by a decrease in fentanyl-related overdose deaths, from 2,039 deaths in 2021 to a projected 1,952 in 2022.[3]

Virginia has benefitted from a major expansion of treatment services for SUD in the Virginia Medicaid program. In April 2017, the Addiction and Recovery Treatment Services (ARTS) benefit was implemented. ARTS expanded coverage of many addiction treatment services for Medicaid members, aligning with the American Society of Addiction Medicine (ASAM) levels of care, including community-based services, short-term residential treatment and inpatient withdrawal management services. To allow federal Medicaid payment for addiction treatment services provided in inpatient and short-term residential facilities with 16 or more beds, a Section 1115 Demonstration Waiver for SUD was approved in December 2016 by the Centers for Medicare and

Medicaid Services (CMS), and an extension of this demonstration through 2024 was approved by CMS in December 2019. ARTS also increased provider reimbursement rates for many existing services and introduced a new care delivery model for treatment of Opioid Use Disorders (OUD), the Preferred Office-Based Addiction Treatment (OBAT) provider. OBATs integrate medications for OUD (MOUD) with co-located behavioral and physical health by incentivizing increased use of care coordination activities. Per requirements of Item 313, section ZZZ of the 2020 Appropriations Act, DMAS expanded the OBAT model effective March 1, 2022, to allow for other primary SUDs in addition to OUD.[8]

To further increase integration of addiction treatment services with other health services covered by Medicaid, SUD services are administered by the contracted managed care organizations (MCOs) that manage medical and behavioral health benefits for all Medicaid members, offering a comprehensive care delivery system. During this reporting period, Virginia contracted with six managed care organizations through the two managed care programs: Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus). Medallion 4.0 serves children, pregnant women and adults. CCC Plus serves older adults, children, and adults with disabilities, and individuals receiving long-term services and supports (LTSS).

While ARTS greatly increased the availability and quality of treatment services to Medicaid members, eligibility for these services increased on January 1, 2019, when Virginia expanded Medicaid eligibility for adults ages 19-64 with family incomes of up to 138 percent of the federal poverty level, as allowed for under the Patient Protection and Affordable Care Act. By July 1, 2022, 671,000 members were enrolled through the ACA Medicaid expansion benefit.[9] During the COVID-19 pandemic, Medicaid expansion provided an important safety net for many people who lost their job and their employer-based private health insurance coverage.

Prior evaluation reports on the ARTS benefit have documented the impact of ARTS and Medicaid expansion on utilization of ARTS services. The number of Medicaid members using ARTS treatment services more than doubled, from 17,120 in 2017 to 46,520 in 2019.[10] Among those with OUD, the percent using MOUD treatment increased from 35% in 2016 to 53% in 2019, an increase that was far greater than for Medicaid members in twelve other states.[9] At the same time, ED visits among those with OUD decreased (relative to Medicaid members who did not have OUD), although this analysis preceded the more recent surge in overdose deaths.[11]

Increased prevalence of SUD during the COVID-19 pandemic increased the demand for ARTS services. To offset potential barriers to treatment access due to pandemic-related restrictions, DMAS implemented a number of new initiatives and procedural flexibilities that the federal government permitted as part of the emergency response to COVID-19. These include allowing take-home dosages of methadone and buprenorphine for up to 28 days (which otherwise must be administered at Opioid Treatment Programs (OTPs)), allowing a member's home to serve as the originating site for prescription of buprenorphine, allowing a 90-day supply of buprenorphine, increased use of telehealth, waiver of drug copayments, and fewer restrictions on the use of certain unlicensed providers. In compliance with federal legislation, eligibility redeterminations and coverage cancellations have been suspended in order to increase continuity of coverage and prevent coverage lapses during the pandemic. With the end of the federal Public

Health Emergency in May, 2023, eligibility redeterminations will resume, potentially resulting in more Medicaid members losing eligibility. Despite this, many of the access initiatives and procedural flexibilities implemented at the beginning of the pandemic will be maintained.

The objective of this report is to examine SUD prevalence, treatment utilization, and outcomes among Virginia Medicaid members during State Fiscal Year (SFY) 2020 and 2021, as well as the first two quarters of SFY 2022 (covering July 2019 through December 2021). This time period overlaps with the COVID-19 pandemic that began in March 2020, which has led to substantial increases in the diagnosed prevalence and treatment of SUD among Medicaid members. Some measures in the report related to the supply of treatment providers correspond to calendar year or other time periods.

Methodology

Most of the analysis in this report is based on paid claims for services received by Virginia Medicaid members. As a consequence, the analysis excludes services received during periods in which individuals were not enrolled in Medicaid, services not covered by Medicaid, and claims that were submitted and denied or otherwise processed and not reimbursed at the time of data extraction and analysis for this report (September through November 2022). In general, a "claims runout" period of 10-12 months is a sufficient period for the vast majority of claims to be processed for services received through December 2021.

Diagnosed prevalence of SUD is defined as a member having any claim during the study period with a primary or secondary diagnosis of SUD, based on ICD-10 codes. Measures of the utilization of ARTS services are based on the procedure codes and ICD-10 diagnostic codes used by DMAS, MCOs, and treatment providers to bill for the various ARTS services. These services correspond to the ASAM continuum of care, ranging from medically managed intensive inpatient services (ASAM level 4), residential care (ASAM 3), intensive outpatient and partial hospitalization (ASAM 2) and outpatient treatment services (ASAM levels 1 and 2).[12] Services received in Preferred OBAT and OTP providers are identified separately, as are services for peer recovery support, case management, and care coordination. Pharmacotherapy services are identified through pharmacy claims based on National Drug Codes and Generic Sequence Numbers for prescriptions used to treat OUD (buprenorphine, naltrexone) and Alcohol Use Disorder (AUD), as well as procedure codes for methadone treatment in OTPs.

SUD-related ED visits are defined as ED visits with a primary or secondary diagnosis of SUD, as described above. OUD-related overdoses include fatal as well as nonfatal overdoses based on ICD-10 diagnosis codes for overdoses and poisonings that have been previously validated.[13] Only overdoses that are treated in health care settings and for which the submitted claim was reimbursed by Medicaid are included in this definition. An overdose is excluded if it occurred in the community, did not involve contact with health care providers and was not reimbursed through a Medicaid claim.

Supply of Addiction Treatment Providers

A broad range of addiction treatment facilities and practitioners are available to Medicaid members along the continuum of care, as defined by the ASAM placement criteria.[12] These include hospital-based intensive inpatient facilities, residential treatment centers, and outpatient providers of varying types and treatment intensity. The ARTS benefit also introduced a new model of care delivery, the Preferred OBAT, that pays significantly higher reimbursement rates to qualified providers for medication-assisted treatment (including pharmacotherapy and behavioral health therapy) and coordination with other medical and social needs. The Preferred OBAT model initially was limited to individuals with primary OUD. However, DMAS expanded this benefit in 2022 to allow for reimbursement of other primary SUD. Although there was some decrease in residential treatment providers and intensive outpatient programs between 2020 and 2022, Virginia has seen substantial increases across all types of addiction treatment providers and facilities since ARTS was implemented in 2017. These providers serve not only Medicaid members, but also individuals with other insurance or who are uninsured. The expansion of the provider network supported through ARTS has benefited all individuals in the Commonwealth through increased access to treatment and recovery services based on the ASAM Criteria.

Providers for ARTS Services

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

Buprenorphine Waivered Prescribers

There are three Food and Drug Administration (FDA) approved medications for treatment of OUD: methadone, naltrexone and buprenorphine. Methadone for the treatment of OUD is federally limited to being dispensed in specially licensed clinics, although these restrictions were loosened during the COVID-19 pandemic to allow take-home dosages of up to a 28 day supply. Because buprenorphine treatment for OUD does not require that medication be administered at OTPs, it allows for greater access to MOUD treatment in a wider variety of treatment settings, provider types, and specialties. Virginia Medicaid has promoted the prioritization of patient choice in the selection of evidence-based medication for treatment of OUD. This includes a targeted effort to increase access to buprenorphine treatment through the Preferred OBATs in 2017 – an

integrated care model that receives enhanced reimbursement for OUD treatment – and eliminating the need for prior authorization for buprenorphine prescribing for practitioners regardless if they are enrolled with DMAS, its contractors, or MCO networks. During the COVID-19 pandemic, DMAS permits a member's home to serve as the originating site via telemedicine for a prescription of buprenorphine, both for induction and maintenance dosing. Prior to the pandemic, buprenorphine prescriptions for inductions could only be obtained through a face-to-face meeting with authorized prescribers as required by Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Agency.

Prior to 2023, prescriptions for buprenorphine could only be received from practitioners who apply for and receive waivers through SAMHSA. Research has shown that increases in the number of practitioners who receive waivers are associated with increases in the quantity of prescribing and the number of patients served, and fewer overdoses.[14,15] Therefore, having an adequate supply of buprenorphine-waivered prescribers in the Commonwealth is crucial for patient access to OUD treatment and outcomes.

The expansion of benefits with ARTS, collaborative efforts with the Virginia Department of Health to train and encourage more providers to seek buprenorphine waivers, and the increase in Medicaid members eligible for ARTS services through Medicaid expansion has likely contributed to an increase in waivered prescribers. Prior research has shown that Medicaid expansion in other states led to an increase in buprenorphine prescribing capacity.[16]

The number of waivered prescribers in Virginia has increased steadily each year since the ARTS benefit began. Between 2019 and 2022, the number of waivered prescribers in the state increased by 80.8%, from 852 prescribers in 2019 to 1,540 in 2022. However, most of the increase occurred among those with a limit of 30 patients (from 573 in 2019 to 1,132 in 2022), whereas the number with higher patient limits (100 or 275) increased more modestly. Research has shown that prescribers with 30 patient limits are less likely to treat Medicaid patients relative to those with higher limits.[17]

Number of X-waivered Prescribers in Virginia (As of June For Each Year)

	2019	2020	2021	2022	% change 2019-22
All prescribers	852	1017	1160	1540	80.8%
Patient limit					
30	573	730	794	1,132	97.6%
100 or 275	279	314	366	408	46.2%
License type					
MD or DO	617	628	614	750	21.6%
Nurse practitioner	200	330	458	642	221%
Physician assistants	35	59	88	148	322.9%

Increasingly important to the supply of waivered prescribers are nurse practitioners and physician assistants. Since the federal Comprehensive Addiction and Recovery Act (CARA) of 2016, nurse practitioners and physician assistants are also permitted to obtain waivers to prescribe buprenorphine. Nurse practitioners in Virginia can get approval to practice autonomously from physicians if they have 5 or more years of experience (it had been reduced to 2 or more years of experience starting July 2021, before reverting back to a minimum of 5 years starting July 2022). Since 2019, the number of waivered nurse practitioners has increased 221%, while the number of waivered physician assistants has increased 323% (compared to a 21.6% increase for MDs or DOs). While nonexistent prior to 2017, the combined number of waivered nurse practitioners and physician assistants now outnumber waivered physicians.

The growth in waivered prescribers among nurse practitioners is especially important, as research has shown they are twice as likely to treat Virginia Medicaid patients compared to MDs, and almost three times as likely to treat large numbers of Medicaid patients.[17] As only about 40% of buprenorphine-waivered prescribers treated any Medicaid patients in 2019, continued growth in nurse practitioners and physician assistants with waivers will likely help to address gaps in supply of and access to buprenorphine treatment among Medicaid members.

Pharmacies that dispense buprenorphine

Most buprenorphine prescriptions for treatment of OUD are obtained at retail pharmacies. However, some pharmacies do not dispense buprenorphine, while others often restrict the quantity of buprenorphine dispensing. A recent nationwide audit study of pharmacies in counties with a high opioid overdose rate found that one in five pharmacies did not dispense buprenorphine, with independent pharmacies and those in Southern states being more likely to restrict buprenorphine.[18] Pharmacies may decline to stock buprenorphine or limit dispensing for a number of reasons. Because of concerns that buprenorphine can be diverted for illicit purposes, federal law requires wholesalers to monitor controlled substance orders from pharmacies and report suspicious activity to the Drug Enforcement Agency (DEA). As this could trigger a DEA investigation, some pharmacies may decline to dispense buprenorphine, or place strict limits on the amount they dispense. Stigma towards patients with OUD and distrust of clinician prescribing patterns also may limit buprenorphine dispensing at pharmacies.[19,20] Members with OUD who do not have access to pharmacies that dispense buprenorphine, or who need to travel long distances to obtain new prescriptions or refills, may be less likely to initiate or continue with buprenorphine treatment.

We used Medicaid pharmacy claims to identify individual pharmacies that prescribed medications to Medicaid members, as well as pharmacies that specifically prescribed buprenorphine. In 2021, there were 1,604 pharmacies statewide that dispensed any type of medication to Medicaid members, out of which 1,180 (73.6%), dispensed buprenorphine to Medicaid members. Overall, there were 424 Virginia pharmacies in 2021 that did not dispense buprenorphine to Medicaid members, although it is possible that some of these pharmacies stock buprenorphine but did not receive any prescriptions for Medicaid members in that year.

Pharmacies Dispensing Buprenorphine for Medicaid Members

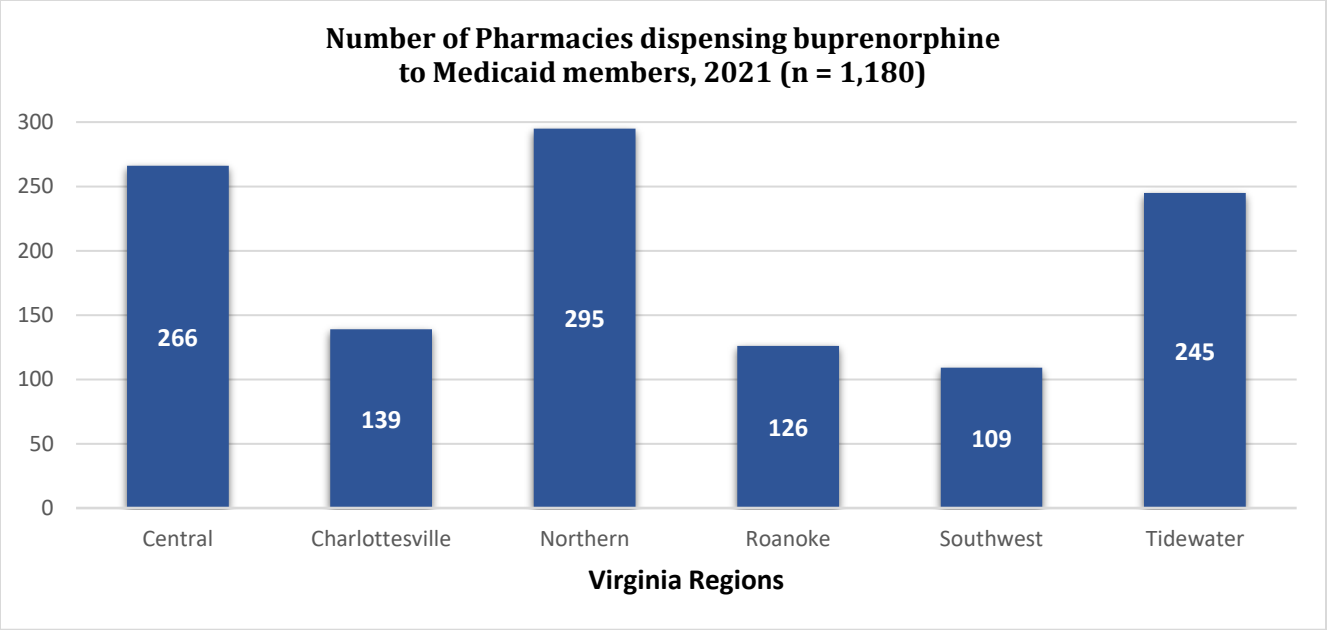
	2017	2019	2021	% change 2017-2021
Number of pharmacies with any Medicaid prescriptions	1,519	1,606	1,604	5.6%
Number of pharmacies with any prescription for buprenorphine	820	1,077	1,180	43.9%
Number of pharmacies with buprenorphine Rx, as a proportion of all pharmacies	54.0%	67.1%	73.6%	36.3%
Total number of buprenorphine prescriptions dispensed	67,980	162,636	278,516	309.7%
Average number of buprenorphine prescriptions per pharmacy	82.9	151.0	236.0	184.7%

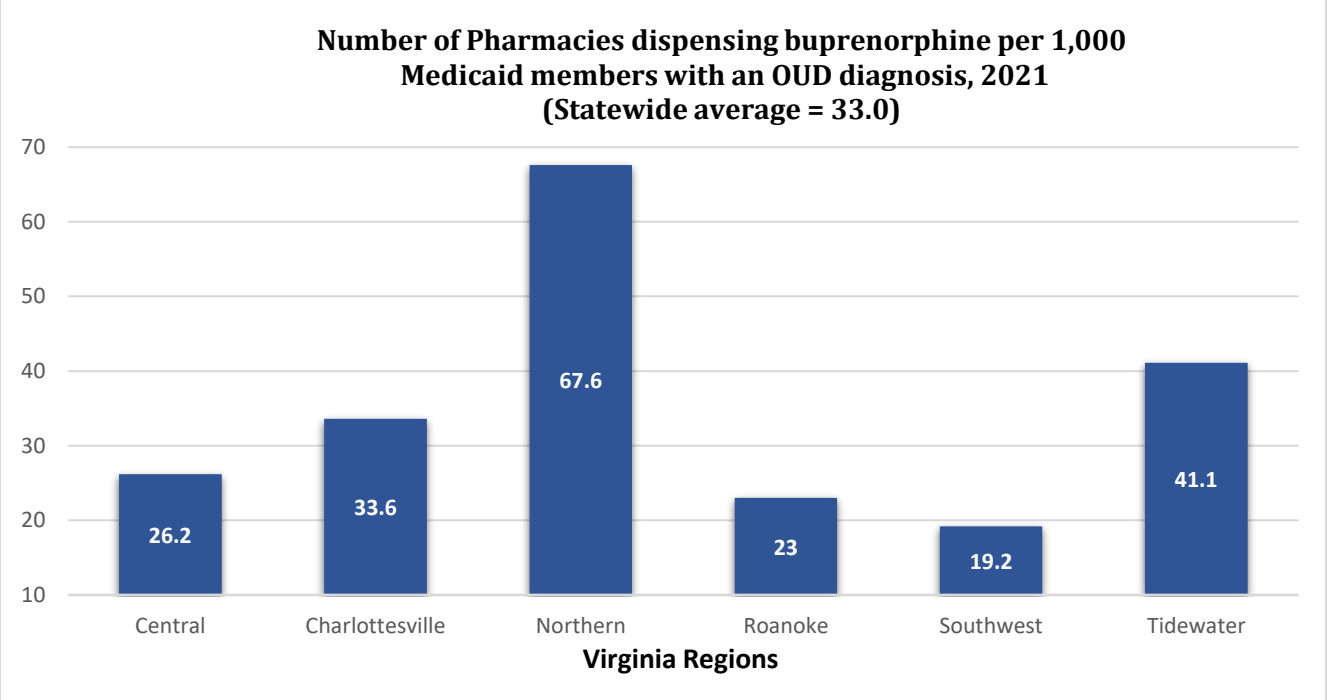
While the overall number of pharmacies prescribing to Medicaid members has remained relatively constant, the number of pharmacies dispensing buprenorphine has increased greatly, from 820 pharmacies in 2017 to 1,180 in 2021, a 44% increase. As a result, the share of pharmacies dispensing buprenorphine prescriptions increased from 54% in 2017 to 73.6% in 2021. The average number of buprenorphine prescriptions per pharmacy has also increased, from an average of 82.9 prescriptions per pharmacy in 2017, to 236 prescriptions per pharmacy in 2021, a 184.7% increase.

Regional Variation in Pharmacy Dispensing of Buprenorphine

The most heavily populated regions of the state – Northern, Central and Tidewater – have correspondingly the largest number of pharmacies that dispense buprenorphine (295, 266, and 245, respectively).

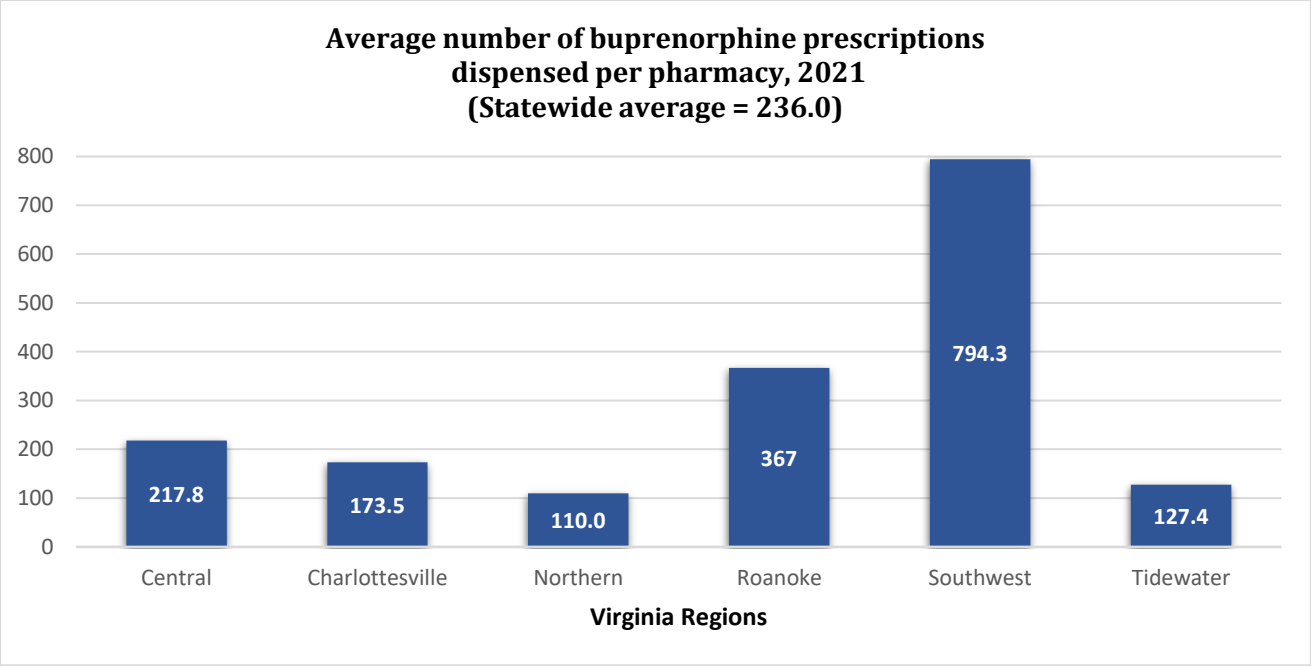
A more accurate assessment of regional variation in the number of buprenorphine-dispensing pharmacies accounts for differences in potential demand, as indicated by the number of members with a diagnosed OUD. By this measure, the Northern region has by far the largest number of buprenorphine-dispensing pharmacies, with 67.6 pharmacies per 1,000 Medicaid members with OUD. By contrast, the Roanoke and Southwest regions – which have some of the highest OUD prevalence rates among all regions – have relatively fewer pharmacies (23 and 19.2 pharmacies per 1,000 members with OUD, respectively).





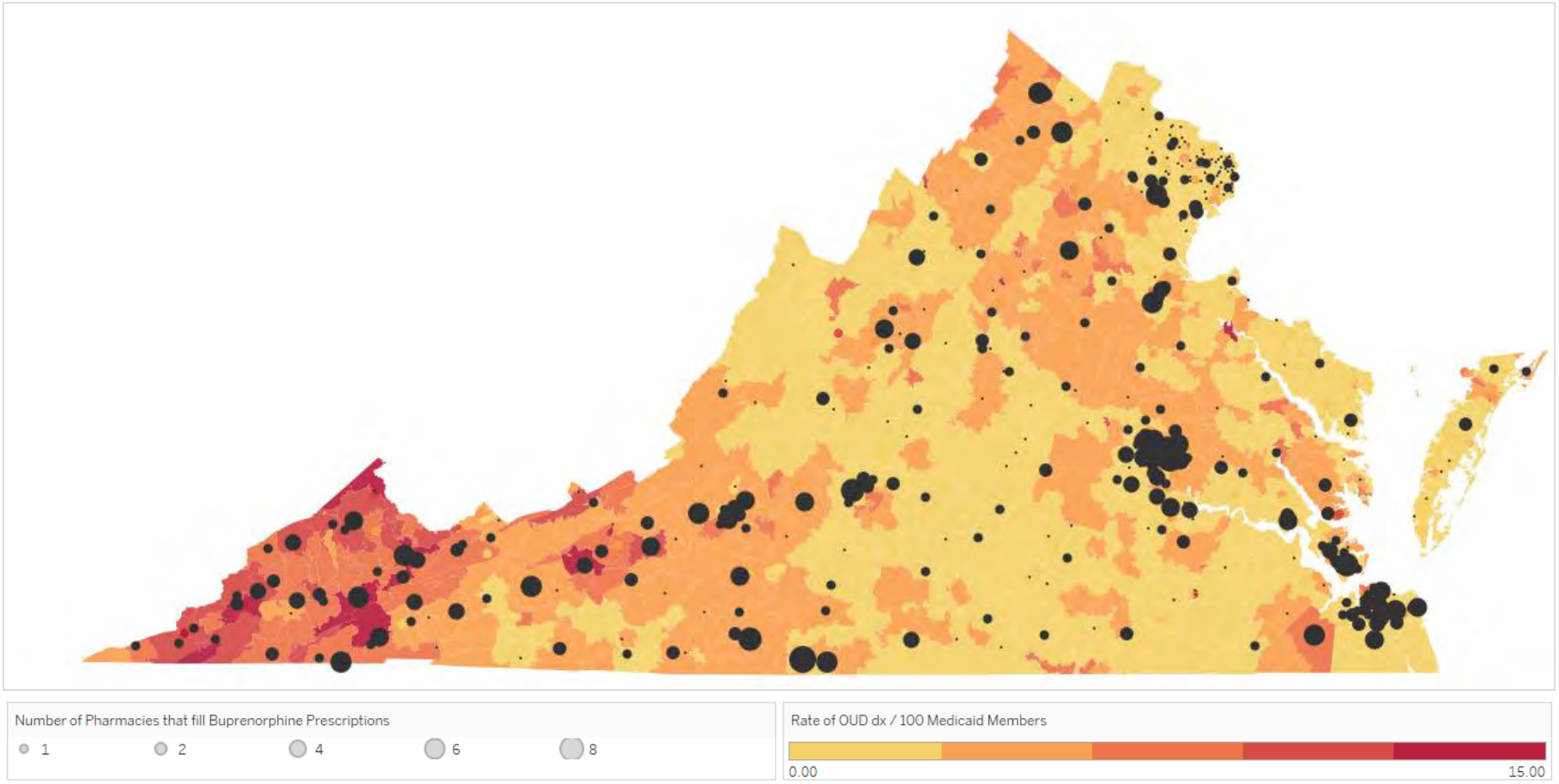
With fewer pharmacies that dispense buprenorphine, pharmacies in Southwest dispense much higher quantities of buprenorphine (794 buprenorphine prescriptions per pharmacy) compared to pharmacies in Northern (110 prescriptions per pharmacy) and other regions of the state. The limitations these pharmacies have on how much buprenorphine they are able and willing to dispense are unknown. Regardless, access to buprenorphine in Southwest could be more difficult not only because there are fewer pharmacies overall that dispense buprenorphine, but it is

likely that at least some of the pharmacies "max out" on how much buprenorphine they are able and willing to dispense over the course of the year.



The map below provides a more detailed depiction of the location of pharmacies that dispense buprenorphine to Medicaid members in Virginia. These locations are overlaid on top of OUD prevalence rates at the zip code level, with darker shaded areas indicating higher prevalence of OUD.

OUD Prevalence Rate with Count of Pharmacies per zip code



Diagnosed Prevalence of Substance Use Disorders

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

SUD diagnoses related to stimulant use and cannabis is concerning given the 19.4% and 26.9% increase, respectively, in Medicaid members with these diagnosis between SFY 2020 and 2021. During the same period, diagnosed OUD prevalence increased by 13.1% and AUD by 14.8%. There was also a 55.4% increase in diagnoses related to hallucinogens, although overall prevalence of hallucinogens is still very low (only 1,290 members with diagnoses in SFY 2021).

The increase in SUD prevalence is partially related to increases in Medicaid enrollment, from 1.48 million average monthly enrollment in SFY 2020 to 1.74 million average monthly enrollment in SFY 2021, a 17 percent increase.[9] However, the prevalence rate for SUD (calculated as the number of members with a SUD diagnosis per 100,000 members) increased by 6.5%, from 6,168 with a SUD diagnosis per 100,000 members in SFY 2020 to 6,567 per 100,000 members in SFY 2021.[ii] The increase in the prevalence rate was higher for SUD diagnoses related to hallucinogens use (44.8%), Cannabis (18.2%), Sedatives (12.6%), and stimulants use (11.2%).

Diagnosed prevalence of SUD, SFY 2020 and 2021

	Number of Medicaid members with diagnosis			Members with diagnosis per 100,000 members		
SUD diagnoses	**SFY 2020**	**SFY 2021**	**Percent change**	**SFY 2020**	**SFY 2021**	**Percent change**
Any SUD	101,875	116,451	14.3%	6,168	6,567	6.5%
Opioid use disorder (OUD)	42,435	48,008	13.1%	2,569	2,707	5.4%
Alcohol use disorder (AUD)	38,374	44,038	14.8%	2,323	2,483	6.9%
Cannabis	28,309	35,911	26.9%	1,714	2,025	18.2%
Hallucinogens	830	1,290	55.4%	50	73	44.8%
Inhalants	172	191	11.0%	10	11	3.4%
Sedatives, hypnotics, etc.	4,816	5,821	20.9%	292	328	12.6%
Stimulants	22,806	27,226	19.4%	1,381	1,535	11.2%
"Other or unknown"	23,583	26,071	10.5%	1,428	1,470	3.0%

SUD prevalence rates are much higher among nonelderly adults compared to youth and elderly members. The percent of members with a diagnosed SUD ranges from 10.5% to 12.9% for members ages 22-64, compared to 2.3% for members ages 12-21, and 5.3% for members aged 65 and older. SUD prevalence rates are also higher for males compared to females, although OUD prevalence is similar for both gender groups. Diagnosed prevalence is also higher for White, non-Hispanic members (7.9%) compared to Black, non-Hispanic members (6.0%) and Hispanic

[ii] For the purposes of computing prevalence rates and to be consistent with the way that annual prevalence was computed, Medicaid enrollment was computed as the number with full-benefit Medicaid coverage at any point in the State Fiscal Year. This differs from the average monthly enrollment numbers mentioned above.

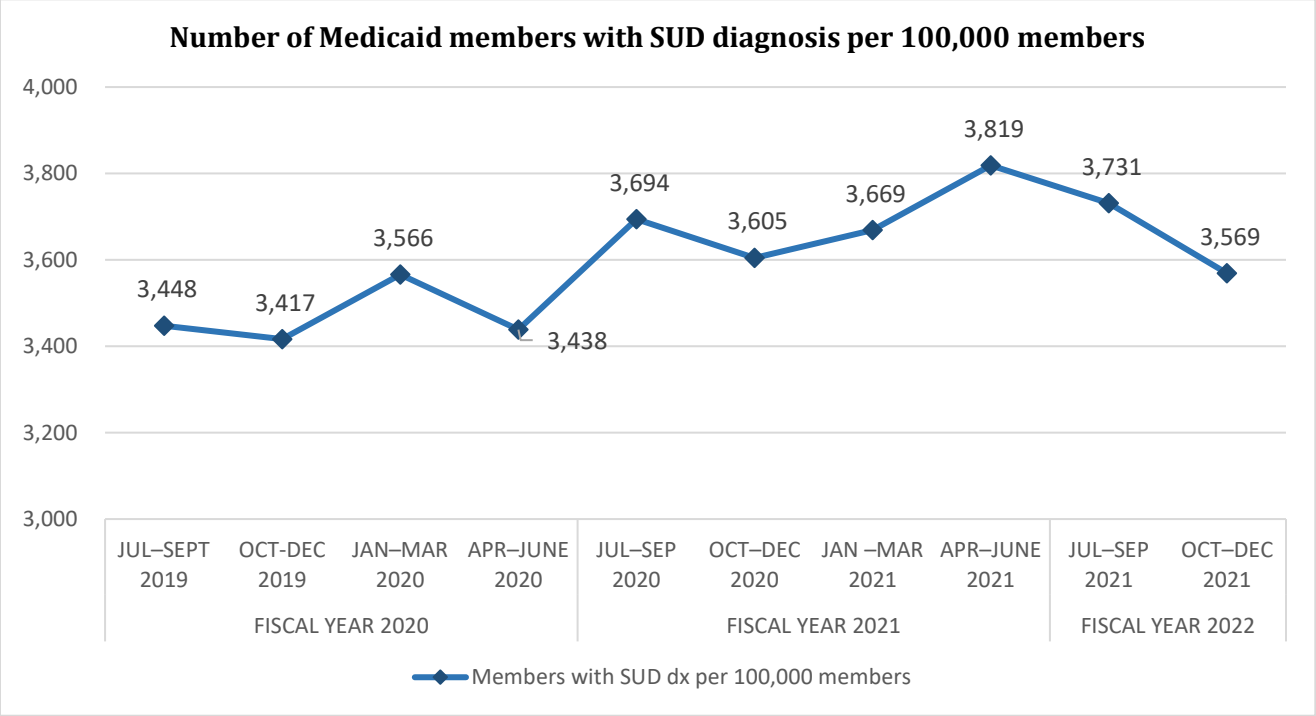
members (2.9%), although the prevalence rate for cannabis diagnosis is higher for Black and Hispanic members compared to White members. Consistent with age-related differences in prevalence, prevalence rates are higher among Medicaid expansion and other non-disabled adults compared to members in other Aid categories.

Prevalence of diagnosed SUD, by member characteristics, SFY 2021

	% with any SUD	% with OUD	% with AUD	% with cannabis diagnosis	% with stimulants diagnosis
All Medicaid members	6.6%	2.7%	2.5%	2.0%	1.5%
Age					
12-21	2.3%	0.3%	0.5%	1.6%	0.3%
22-34	10.5%	4.9%	3.1%	4.2%	2.8%
35-44	14.0%	7.5%	4.6%	3.9%	3.8%
45-54	14.0%	6.2%	6.2%	3.0%	3.6%
55-64	12.8%	4.1%	7.4%	2.1%	2.5%
65+	5.3%	1.8%	3.0%	0.5%	0.6%
Sex					
Male	7.7%	3.2%	3.5%	2.4%	1.9%
Female	5.6%	2.4%	1.7%	1.8%	1.3%
Race/ethnicity					
White, non-Hispanic	7.9%	3.9%	2.8%	2.1%	1.9%
Black, non-Hispanic	6.0%	1.7%	2.5%	2.3%	1.5%
Hispanic	2.9%	0.9%	1.1%	1.2%	0.6%
Other	2.9%	0.9%	1.4%	1.0%	0.5%
Aid category					
Medicaid expansion	11.6%	5.1%	4.6%	3.4%	3.0%
Other non-disabled adults	10.0%	5.4%	2.5%	3.0%	2.2%
Pregnant members	5.8%	2.1%	0.7%	2.6%	1.1%
Low-income children	0.8%	0.1%	0.1%	0.4%	0.1%
Aged	5.2%	1.7%	2.9%	0.5%	0.5%
Blind/disabled	13.2%	5.0%	5.7%	3.8%	3.3%
Region					
Central	6.8%	2.9%	2.5%	2.1%	1.5%
Charlottesville	7.0%	2.4%	2.6%	2.1%	1.7%
Northern	4.1%	1.6%	1.9%	1.4%	0.8%
Roanoke	8.7%	3.8%	2.9%	2.4%	2.3%
Southwest	10.9%	6.7%	2.6%	2.6%	3.1%
Tidewater	6.3%	2.3%	2.7%	2.1%	1.4%

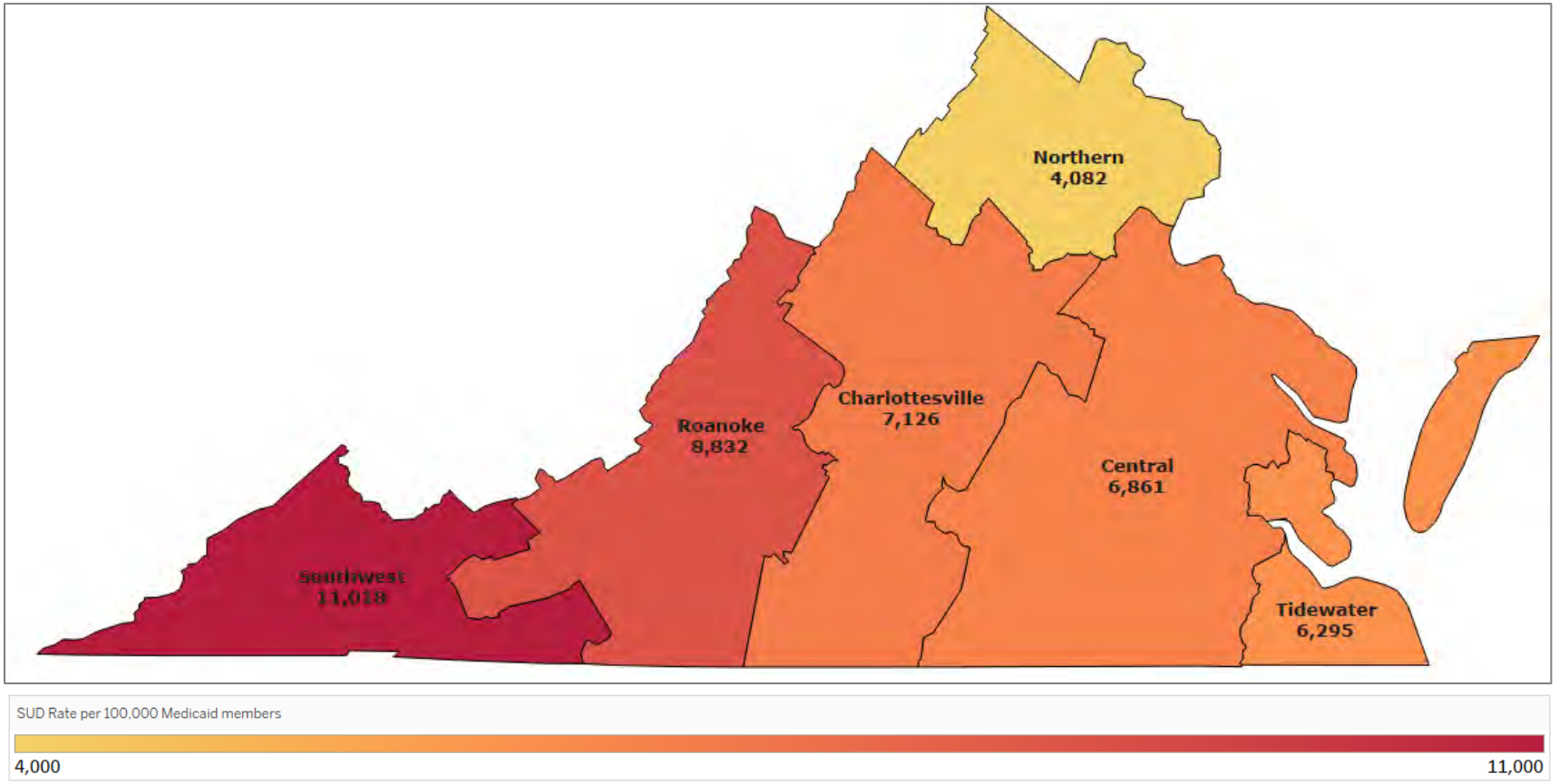
Differences by race/ethnicity, age, gender, and aid category are based on diagnosed prevalence of SUD and do not account for the potential for under-diagnosis in some sub-populations. For example, racial/ethnic differences in access to treatment services, trust in providers due to historical discrimination and racism, stigma, and other factors may result in greater under-diagnosis of SUD among Black Medicaid members and other racial/ethnic minorities. By contrast, SUD prevalence based on patient self-reports (which does not depend on a clinician's diagnosis) shows little or no disparities by race/ethnicity.[21]

On a quarterly basis, the increase in the SUD prevalence rate occurred primarily during calendar year 2020, peaking at 3,819 per 100,000 members with a SUD diagnosis in April-June 2021. The SUD prevalence rate decreased during the first two quarters of SFY2022, to 3,569 members with a SUD diagnosis by Oct-Dec 2021. This includes a decrease in the overall number of members with a SUD diagnosis between the first two quarters of SFY 2022, from 65,898 members in July-Sept 2021 to 64,795 members in Oct-Dec 2021. The reasons for the more recent decreased in SUD prevalence are unknown, nor whether these decreases are temporary or part of a longer-term trend.

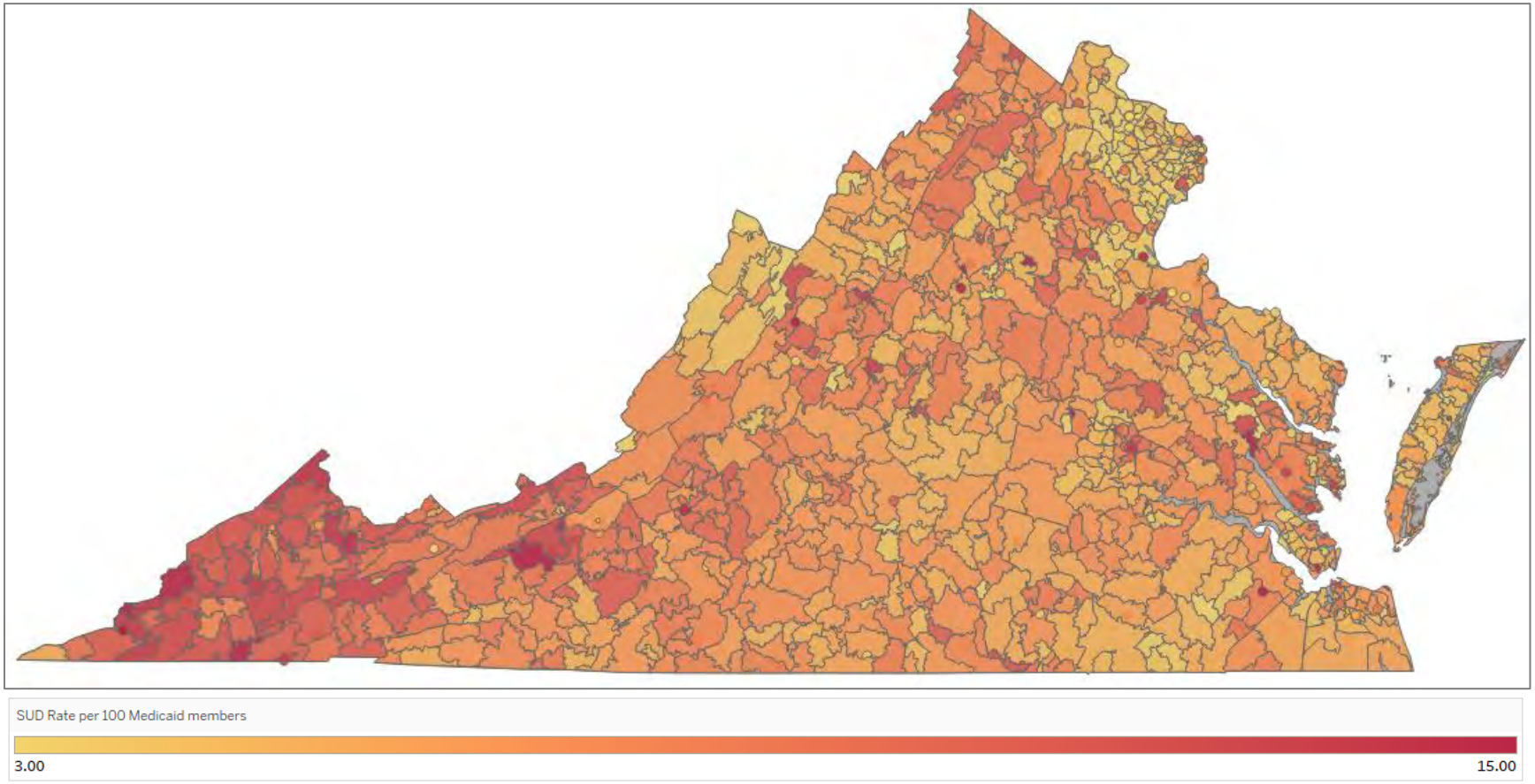


The following maps show regional variation in SUD and OUD prevalence rates. Southwest has the highest SUD and OUD diagnosed prevalence rates, while the Northern region has the lowest. However, prevalence rates computed at the zip code level show pockets of high prevalence in many areas, including some of the urban areas around Northern Virginia, Richmond, and Hampton Roads.

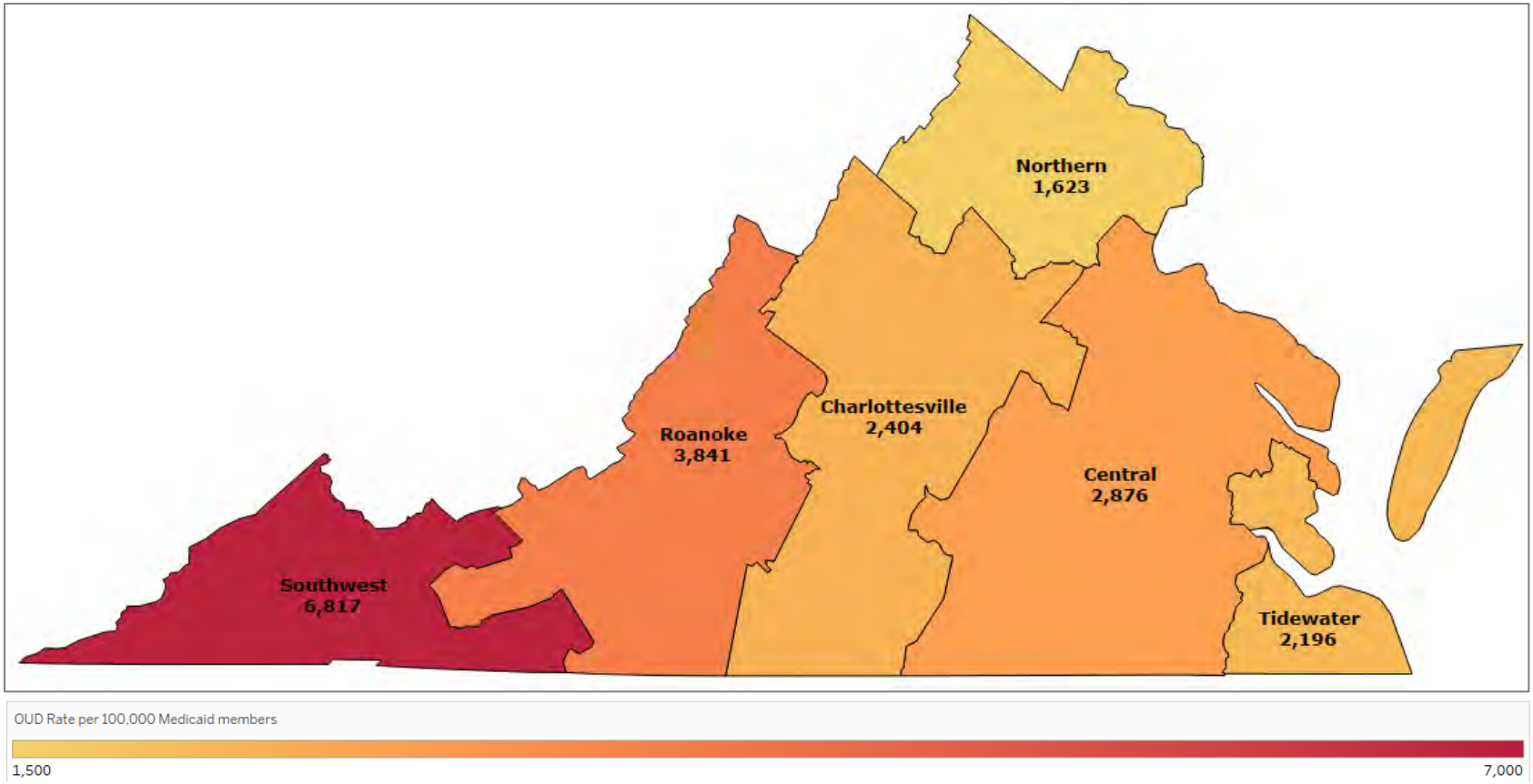
SUD Rate per 100,000 Medicaid members by Region



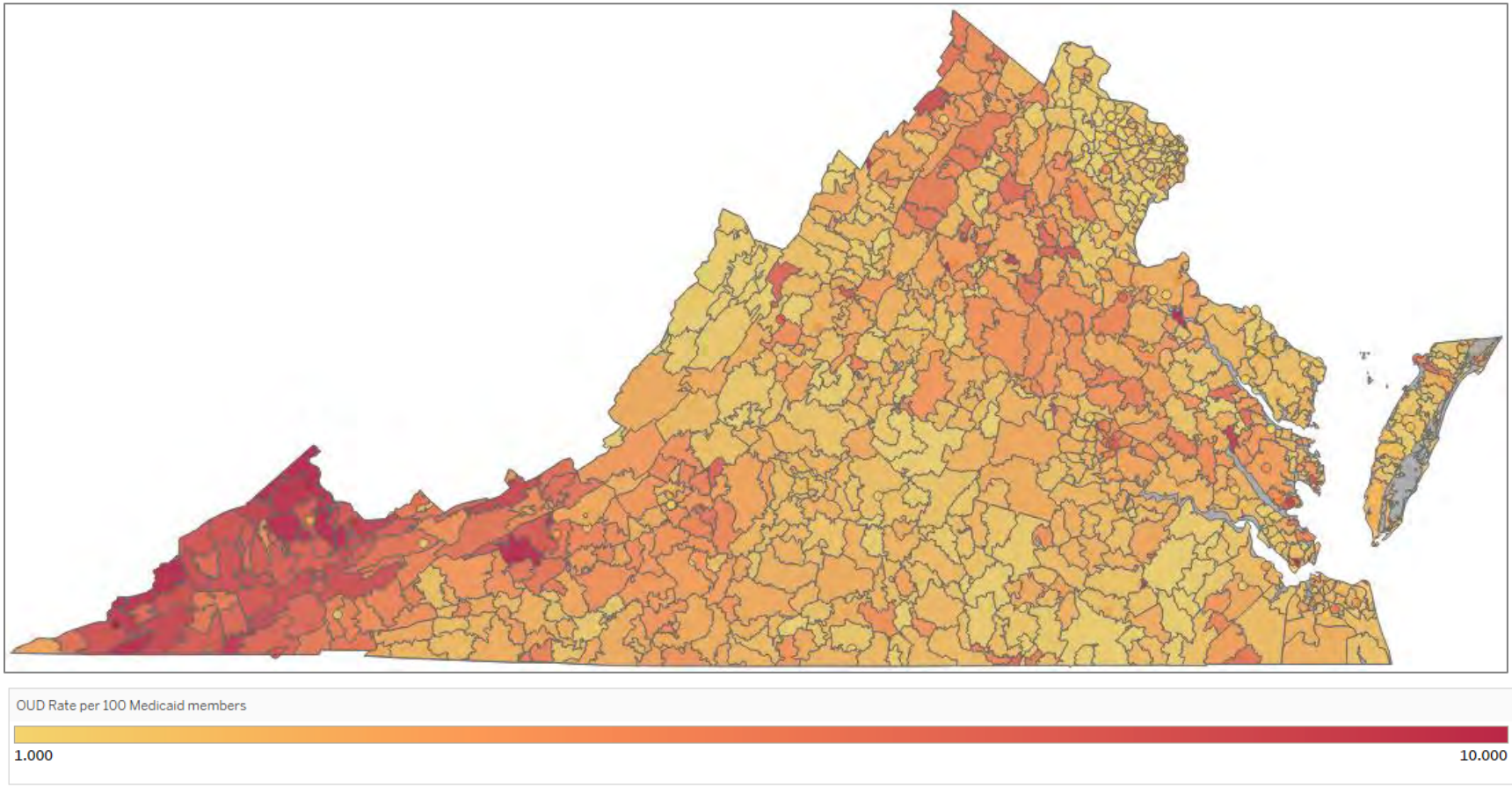
SUD Rate per 100 Medicaid members by Zip Code



OUD Rate per 100,000 Medicaid members by Region



OUD Rate per 100 Medicaid members by Zip Code



ARTS Service Utilization and Expenditures

Trends in use of ARTS services

Coverage of SUD services provided by the ARTS benefit is based on the ASAM National Practice Guidelines, which comprise a continuum of care from Early Intervention/Screening, Brief Intervention, and Referral to Treatment (SBIRT / Level 0.5), outpatient treatment (ASAM 1), intensive outpatient treatment and partial hospitalization (ASAM 2), residential treatment services (ASAM 3) and medically managed intensive inpatient services (ASAM 4).[22] ARTS also emphasizes evidence-based treatment for OUD, which combines pharmacotherapy and counseling. In July 2017, DMAS added peer recovery support services as a covered service under the ARTS benefit, which serves to facilitate recovery from SUD. Care coordination services provided by Preferred OBAT and OTPs facilitate integration of addiction treatment services with physical health and social service needs.

Number of members using ARTS services, SFY 2020 and 2021

	Number of members using services			Members using services per 100,000 members		
	SFY 2020	**SFY 2021**	**Percent change**	**SFY 2020**	**SFY 2021**	**Percent change**
Used any ARTS service	43,389	53,614	23.6%	2,627	2,912	10.8%
Type of service						
ASAM 1	35,709	43,299	21.3%	2,162	2,442	12.9%
OBAT/OTP	13,317	15,976	20.0%	806	901	11.8%
Care Coordination[1]	9,457	11,943	26.3%	573	674	17.5%
ASAM 2	4,611	5,301	15.0%	279	299	7.1%
ASAM 3	4,260	4,891	14.8%	258	276	6.9%
ASAM 4	71	144	102.8%	4	8	103.0%
Pharmacotherapy	27,050	32,724	21.0%	1,120	1,283	14.5%
Case management	3,726	4,136	11.0%	226	233	3.2%
Peer recovery support services	1,119	1,471	31.5%	68	83	22.0%

[1]Care coordination services are a subset of services also counted as part of OBAT/OTP services.

In SFY 2021, 53,614 Medicaid members used some type of ARTS services, a 23.6% increase from SFY 2020. Most members who use ARTS services use ASAM 1 outpatient services (43,299 members, or 81% of all service users). Pharmacotherapy, almost all of which is MOUD treatment, is the second most frequently used service (32,724 members).

There was also a 10.8% increase in service use per 100,000 members, from 2,627 members per 100,000 using services in SFY 2020 to 2,912 members per 100,000 using services in SFY 2021. Increases in service use per 100,000 members was especially high for ASAM 4 services (103%) and peer recovery support services (22%), although the overall use of such services is still relatively low. Care coordination services also increased by 17.5%, while pharmacotherapy increased by 14.5%.

Medicaid payment of residential treatment services (ASAM 3) is allowed under the Section 1115 Demonstration Waiver for SUD, approved in December 2016 by the Centers for Medicare and Medicaid Services (CMS) and extended in 2019. In SFY2021, 4,891 members used these services, comprising 9.1% of all members using ARTS services. The average length of stay for residential treatment was 15.5 days, which is within CMS requirements of 30 days or less for an average length of stay. The number of members using residential treatment increased 14.8% between SFY2020 and SFY2021, or a 6.9% increase of members using services per 100,000 members.

Members receiving any ARTS service, by type of diagnosis

Members with OUD diagnoses are more likely to receive ARTS services compared to members with other SUD diagnoses. Among members with any OUD diagnosis, more than two-thirds (69.4%) used some type of ARTS service in SFY 2021, compared to 43.3% of those with any SUD using any ARTS services. ARTS utilization is considerably lower among members who had SUD diagnoses other than OUD, including 27.1% for those with AUD, 34.3% among those with a diagnosis of stimulant use disorder, and 16.5% among those with a diagnosis of cannabis use disorder. In contrast to OUD, in which the clinical effectiveness of MOUD treatment has been well established, lower use of ARTS services among those with other SUD diagnoses may reflect less evidence about the effectiveness of treatment for other SUD, and greater reliance on non-medical treatment options, such as Alcoholics Anonymous and Narcotics Anonymous.

Number of members using ARTS services, by diagnosis, SFY 2021

	Members with any use of ARTS services[1]	Percent of members using ARTS services
All members	53,614	3.0%
Any SUD diagnosis	50,426	43.3%
Any OUD diagnosis	33,305	69.4%
No OUD diagnosis		
Had AUD diagnosis	11,922	27.1%
Had cannabis diagnosis	5,938	16.5%
Had stimulant diagnosis	9,341	34.3%
Had any other SUD diagnosis	4,670	17.9%

Expenditures for ARTS services

ARTS services accounted for over $294 million in SFY 2021 expenditures.[3] This is a 41% increase from SFY 2020 (not adjusted for inflation). Expenditures increased the most for ASAM 4 level services (216%) and peer recovery support services (66.7%), followed by ASAM 2, Care Coordination, and OBAT/OTP services.

Expenditures associated with ARTS utilization, SFY 2020 and 2021.

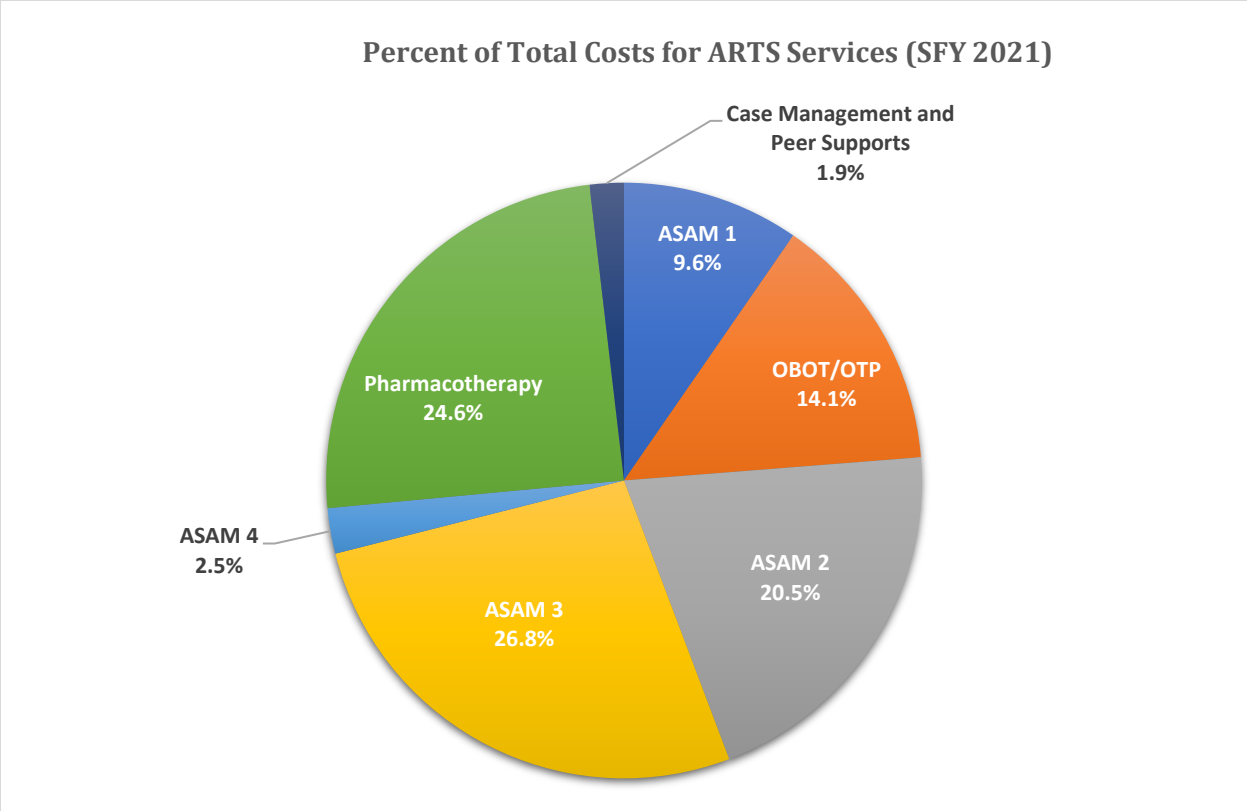
	Total expenditures for ARTS services		
	SFY 2020	**SFY 2021**	**Percent change**
Total costs for any ARTS service	$209,120,709	$294,494,664	41.0%
Type of service			
ASAM 1	$21,839,164	$28,377,952	29.9%
OBAT/OTP	$27,520,375	$41,684,324	51.5%
Care Coordination[1]	$13,728,883	$21,276,827	55.0%
ASAM 2	$38,689,539	$60,464,892	56.3%
ASAM 3	$61,398,876	$79,027,576	28.7%
ASAM 4	$2,304,281	$7,280,940	216.0%
Pharmacotherapy	$53,251,678	$72,652,777	36.4%
Case management	$3,713,463	$4,788,758	29.0%
Peer recovery support services	$403,335	$672,446	66.7%

[1]*Care coordination expenditures are a subset of expenditures for OBAT/OTP services.*

Although relatively few members utilize ASAM 3 services (residential treatment), they account for more than one-fourth of SFY 2021 ARTS expenditures (26.8%), while pharmacotherapy accounts for about another one-fourth of expenditures (24.6%) (see chart below). OBAT/OTP (which includes care coordinator services) and ASAM 1 services together account for about one-fourth of expenditures, while ASAM 4 and Case Management/Peer Support services account for small fractions.

ASAM 4 services – while infrequently utilized – are the most costly services on a per claim and per member basis, averaging $55,562 per member who used such services in SFY 2021. ASAM 3 services averaged $16,157 per user in SFY 2021, while ASAM 2 services averaged $11,406 per member. Pharmacotherapy – among the most frequently utilized ARTS services and which has demonstrated clinical effectiveness in the case of MOUD – averaged just $2,220 per member in SFY 2021.

[3] These estimates differ slightly from internal estimates from DMAS due to some differences in definition of services and the timing of when the computations were made.



Expenditures associated with ARTS utilization, SFY 2020 and 2021

	Average cost per ARTS service claim			Average cost per member using services		
	SFY 2020	**SFY 2021**	**Percent change**	**SFY 2020**	**SFY 2021**	**Percent change**
Type of service						
ASAM 1	$60	$54	**-9.4**	$612	$655	7.2%
OBAT/OTP	$21	$25	14.3	$2,067	$2,609	26.3%
Care Coordination	$237	$240	1.3	$1,452	$1,781	22.7%
ASAM 2	$362	$374	3.5	$8,391	$11,406	35.9%
ASAM 3	$611	$497	-18.7	$14,413	$16,157	12.1%
ASAM 4	$4,492	$3,810	-15.2	$32,455	$50,562	55.8%
Pharmacotherapy	$24	$26	10.3	$1,969	$2,220	12.8%
Case management	$235	$234	-0.6	$997	$1,158	16.2%
Peer recovery support services	$26	$26	-0.2	$360	$457	26.8%

Use of Medications for Opioid Use Disorder

MOUD includes the use of buprenorphine, methadone and naltrexone as part of evidence-based treatment for OUD. This method is considered the evidence-based standard of care for treating OUD and has been found to be the most effective treatment in preventing OUD-related overdoses. A previous report showed MOUD treatment rates among members with OUD increased by over 20% following implementation of the ARTS benefit (from 33.6% in 2016 to 55.0% in 2018), compared to an 8.6% increase over the same time period for Medicaid members in other states that did not implement changes on the scale of the ARTS benefit.[10] To further increase access to buprenorphine treatment beginning in March 2019, DMAS removed prior authorization requirements for suboxone films for in-network prescribers and revised Medicaid policies to ensure that members at any ASAM level of care are screened and referred for MOUD if they are in need and wish to receive this care.[23]

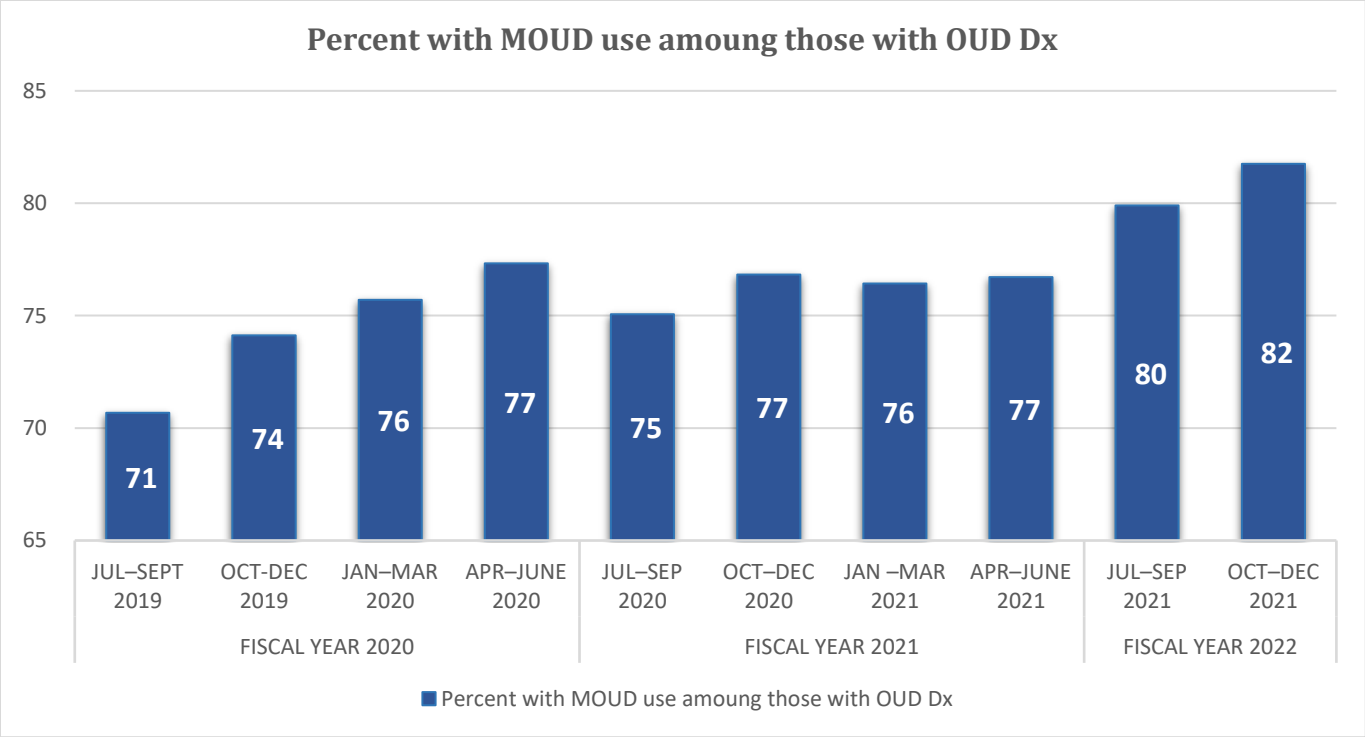
Members receiving MOUD treatment increased 21.0% from SFY 2020 to SFY 2021. As in prior years, buprenorphine treatment was the most common form of MOUD treatment (18,941 members, or 57% of all members receiving MOUD), followed by methadone treatment and naltrexone (11,278 and 4,227 members, respectively).

Medicaid members using MOUD treatment

	SFY 2020	SFY 2021	Percent change
Number of members with any MOUD use	27,254	32,964	21.0%
Buprenorphine	15,379	18,941	23.2%
Methadone	9,503	11,278	18.7%
Naltrexone	3,447	4,227	22.6%
MOUD treatment rate*	64.2%	77.7%	21.0%
Buprenorphine	36.2%	44.6%	23.2%
Methadone	22.4%	26.6%	18.7%
Naltrexone	8.1%	10.0%	22.6%

*Number of members with treatment / number of members with OUD diagnosis

MOUD treatment rates (the percent of members with OUD diagnoses who received MOUD treatment) also increased, from 64.2% in SFY 2020 to 77.7% in SFY 2021. This is a continuation of a longer-term trend since implementation of the ARTS benefit in April, 2017.[10] MOUD treatment rates continued to increase in the first two quarters of SFY 2022, to 82% for the quarter ending December 2021.


Percent with MOUD use amoung those with OUD Dx
85
80
75
70
65
71
74
76
77
75
77
76
77
80
82
JUL–SEPT 2019
OCT-DEC 2019
JAN–MAR 2020
APR–JUNE 2020
JUL–SEP 2020
OCT–DEC 2020
JAN –MAR 2021
APR–JUNE 2021
JUL–SEP 2021
OCT–DEC 2021
FISCAL YEAR 2020
FISCAL YEAR 2021
FISCAL YEAR 2022
Percent with MOUD use amoung those with OUD Dx

Emergency Department Use Related to SUD

Hospital ED visits related to SUD include fatal and nonfatal overdoses as well as other acute events directly or indirectly related to SUD. Previous analyses of the ARTS benefit showed a marked decrease in ED visits among members with OUD following implementation of the ARTS benefit relative to members who did not have a diagnosed OUD.[11] However, SUD-related ED visits increased substantially in recent years, from 70,987 visits in SFY 2020 to 80,426 visits in SFY 2021, a 13.3% increase. In addition, OUD-related ED visits increased 23.6% between SFY 2020 and SFY 2021. By comparison, ED visits for all causes decreased by 8.7%.

Emergency department visits among Medicaid members, SFY 2020 and 2021

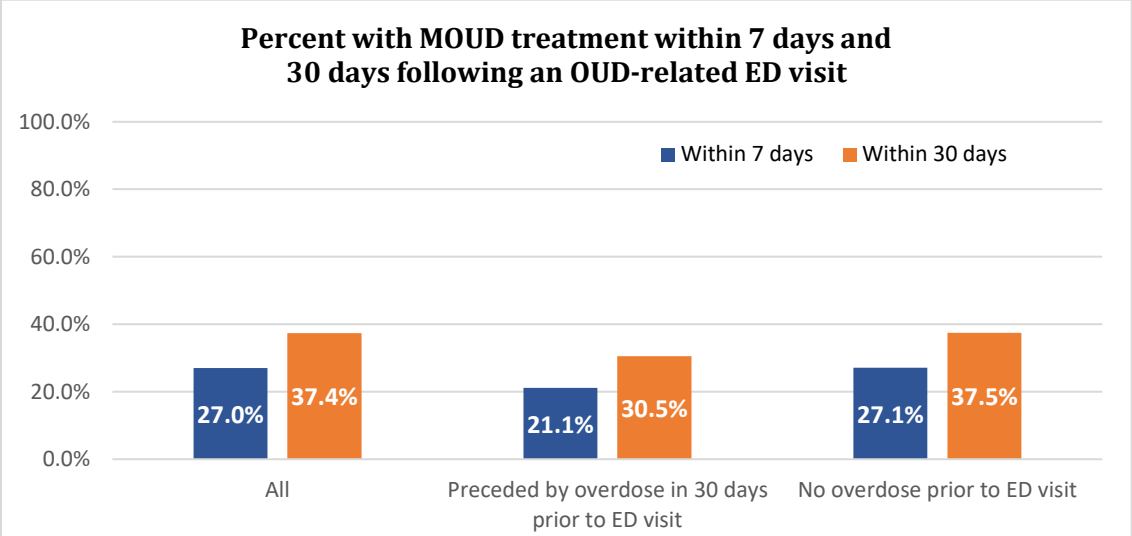
	SFY 2020	SFY 2021	Percent change
ED visits (all cause)			
Number of members with a visit	535,346	495,635	-7.4%
Total number of visits	1,154,685	1,054,744	-8.7%
SUD-related ED visits			
Number of members with a visit	38,829	44,915	15.7%
Total number of visits	70,978	80,426	13.3%
OUD-related ED visits			
Number of members with a visit	9,704	11,703	20.6%
Total number of visits	13,877	17,146	23.6%
ED visits per 1,000 members (all cause)			
Number of members with visit	324.1	279.5	-13.8%
Total visits	699.1	594.8	-14.9%
SUD-related ED visits per 1,000 members			
Number of members with visit	23.5	25.3	7.7%
Total visits	43.0	45.4	5.6%
OUD-related ED visits			
Total members with visit	5.9	6.6	11.9%
Total visits	8.4	9.7	15.5%

SUD-related ED visits have continued to increase, even after adjusting for increases in Medicaid enrollment during the period. There were 45.4 SUD-related ED visits per 1,000 members in SFY 2021, a 5.6% increase from the prior year. Also, there were 9.7 OUD-related ED visits per 1,000 members in SFY 2021, a 15.5% increase from the prior year. By comparison, the overall number of ED visits per 1,000 Medicaid members decreased by almost 15% from SFY 2020 to SFY 2021.

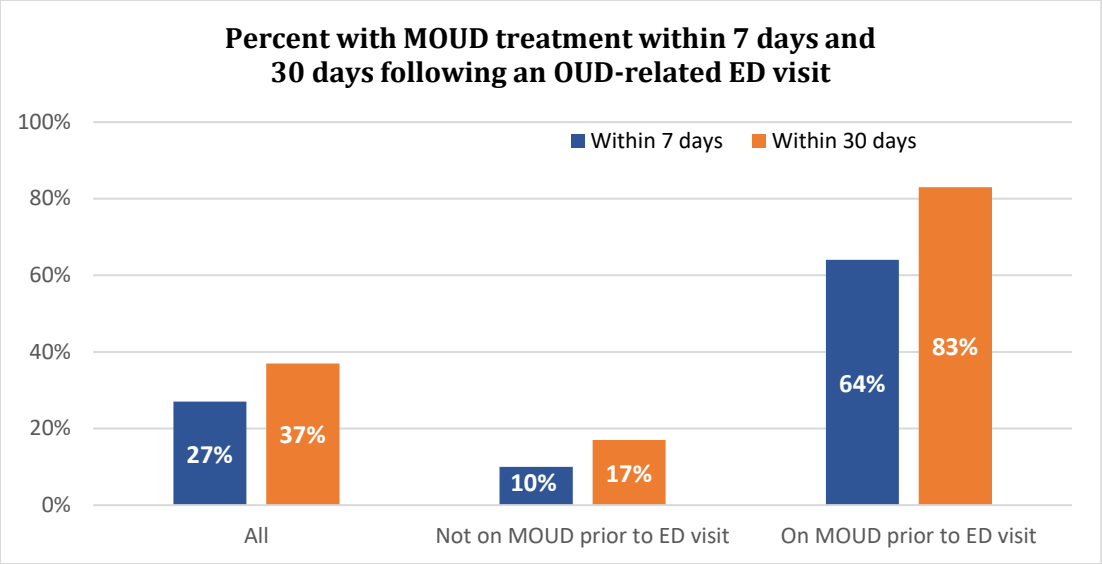
Care Transitions

Follow Up after OUD-Related Emergency Department Visits

Getting patients started on MOUD while at the ED or shortly thereafter is considered crucial for preventing overdoses. Receiving treatment within 7 days of an OUD-related emergency department visit is considered a key measure of treatment quality. From 2016 to 2018, only about 15 percent of Medicaid members in 11 states actually received a follow up visit within 7 days of an OUD-related ED visit.[24] The metric of an ED follow-up visit used by the National Committee for Quality Assurance (NCQA) does not explicitly identify MOUD as part of the follow up care.[25] However, a follow-up visit with a clinician may not be as effective in preventing future overdoses if it does not involve getting patients to initiate or continue with MOUD treatment. To this end, many health systems have started "ED-Bridge" programs that seek to get OUD patients started on buprenorphine treatment in the emergency department and provide them with a warm handoff to treatment providers in the community for follow up treatment and maintenance of MOUD after the ED visit.[26] For Medicaid members who had an ED visit with a primary diagnosis of OUD, 27% received MOUD treatment within 7 days of the visit, while 37% received MOUD treatment within 30 days of the visit.



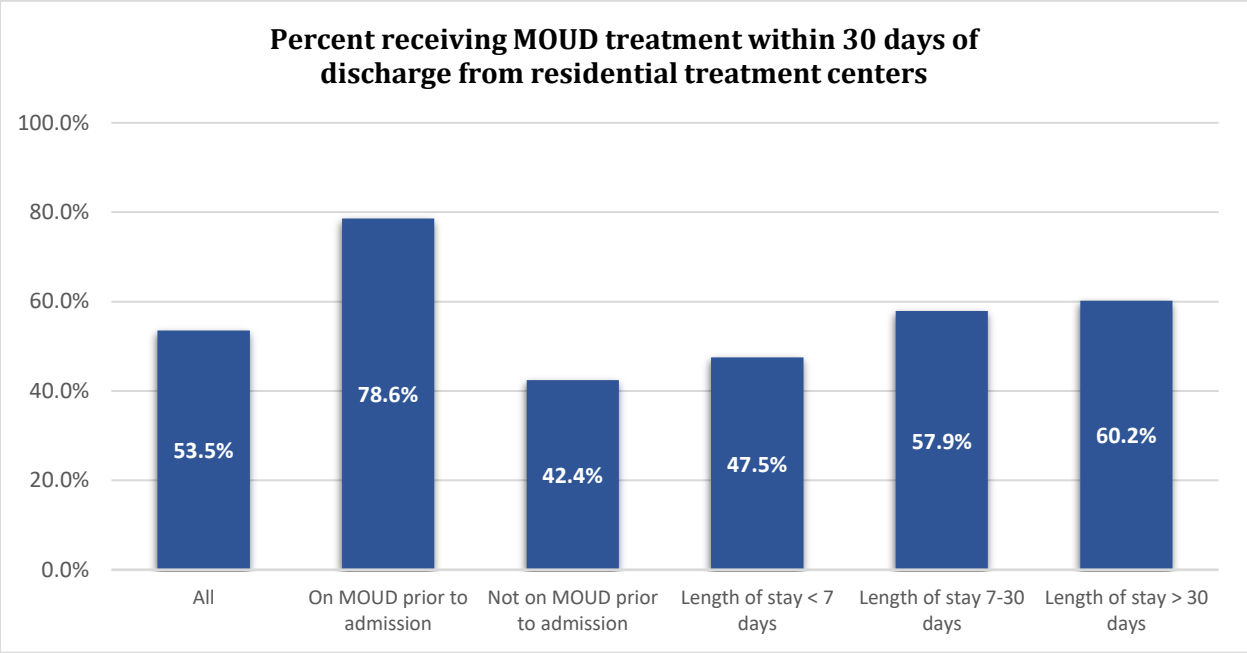
Members who had an overdose in the 30 days prior to the ED visit were somewhat less likely to receive MOUD treatment (21%) within 7 days compared to those who did not have an overdose prior to the ED visit (27%). Members who had not been receiving MOUD treatment prior to the ED visit were less likely to follow up with MOUD treatment compared to those who had been receiving MOUD treatment prior to the ED visit.



Follow Up after Residential Treatment for OUD

Successful transitions after discharge from residential treatment (ASAM level 3 stays) should also include either initiation or continuation of MOUD treatment. Relative to those who do not receive follow-up care after discharge, continuity of care after discharge is a significant predictor of: recovery,[27] remaining abstinent within a year post-discharge,[28] and lower likelihood of mortality within 2 years of discharge.[29] To help ensure continuity, DMAS requires residential treatment providers to document the transition plan on the service authorization for residential treatment.

In contrast to follow up after ED visits, more than half of members (53.5%) discharged from residential treatment centers received MOUD within 30 days of discharge. The rate of MOUD follow up was considerably higher among those who were receiving MOUD prior to admission to the facility (78.6%) compared to those not receiving MOUD prior to admission (42.4%). MOUD receipt was also higher among those with stays of greater than one week or more, compared to those with lengths of stay that lasted less than a week. Multi-state analyses utilizing multivariate methods also showed that prior receipt of MOUD and longer lengths of stay were significant predictors of follow-up treatment after discharge.[30]



OUD diagnosis and treatment following release from prison

Prior research has shown that formerly incarcerated individuals have higher prevalence of SUD and OUD. They are also at higher risk of both fatal and nonfatal overdoses after release from prison or jail, with the highest risk for death occurring immediately after incarceration.[31,32] Therefore, screening for SUD and OUD just before or immediately after release from incarceration is essential for getting formerly incarcerated individuals into treatment and preventing overdoses.

Individuals who are incarcerated can apply for Medicaid at any time. If they apply for Medicaid when their expected release date exceeds 45 days, they will be evaluated for Incarcerated Coverage (limited benefit hospitalization coverage). They can apply up to 45 days before their expected release date if they want coverage following release ("Reentry Application" through the Cover Virginia Incarcerated Unit (CVIU)). Medicaid expansion has increased eligibility for many formerly incarcerated adults through the CVIU mechanism.

By linking Virginia Department of Corrections data to Medicaid enrollment and claims data, the analysis identified Medicaid members recently released from prison, and examined their OUD prevalence, treatment, and rates of overdoses. The analysis is restricted to members released from state prisons and does not include those released from jails.

Of the 10,005 individuals ages 18-64 who were released from prison between July 2019 and June 2021, 8,253 (82.4%) enrolled in full Medicaid benefits within 6 months of release. Most of these individuals (82%) were enrolled in Medicaid within a few days of their release. In comparing formerly incarcerated Medicaid enrollees with other new Medicaid enrollees, those released from prison were more than four times as likely to be diagnosed with an OUD within 6 months of Medicaid enrollment compared to other new enrollees (132 diagnosed with OUD per 1,000 formerly incarcerated members compared to 32 for other new enrollees). Also, formerly

incarcerated were 4.75 times as likely to experience a fatal or nonfatal overdose within 6 months of enrollment compared to other new enrollees (11.4 overdoses per 1,000 formerly incarcerated members compared to 2.4 overdoses per 1,000 other new enrollees). About one-fourth of overdoses occurred within 2 weeks of release from prison among the formerly incarcerated (findings not shown).

OUD prevalence and overdoses among newly enrolled Medicaid members

	Released from prison and enrolled in Medicaid (7/1/19 – 6/30/21)	Other new enrollees not preceded by prison release (1/1/20 – 12/31/21)
Number released from prison	10,005	Not applicable
Number enrolled in Medicaid[1]	8,253	292,320
OUD diagnosis within 6 months, per 1,000 new enrollees	131.5	31.8
OUD-related overdose within 6 months, per 1,000 new enrollees (fatal and nonfatal)	11.4	2.4

[1]Includes Medicaid enrollment within 6 months of release for those released from prison during the study period. For new Medicaid enrollees not preceded by a prison release, excludes those who had any enrollment in full Medicaid benefits within 6 months of enrollment. Sample restricted to those ages 18-64 with 6 months continuous enrollment after Medicaid enrollment date.

Despite the higher OUD prevalence and overdose risk among formerly incarcerated, they tend to have higher treatment rates for OUD compared to other new Medicaid enrollees diagnosed with an OUD. For example, 83.4% of formerly incarcerated with an OUD diagnosis had an outpatient visit with a primary diagnosis of OUD, compared to 70.6% of other new enrollees with an OUD diagnosis. Similarly, 88.4% of formerly incarcerated with OUD received MOUD treatment, compared to 67.7% of other new enrollees with OUD. Residential treatment, emergency department, and inpatient treatment for OUD tended to be lower among the recently incarcerated compared to other new Medicaid enrollees. And despite the overall higher rates of overdoses, recently incarcerated with any OUD diagnosis had only slightly higher overdose rates (8.7%) compared to other new enrollees with an OUD diagnosis (7.7%). Although these findings suggest that many formerly incarcerated individuals are receiving treatment services once they are diagnosed, it is unknown to what extent under-diagnosis of SUD and OUD is greater among this population compared to other Medicaid members.

OUD diagnosis, treatment, and outcomes within 6 months of Medicaid enrollment.

	Released from prison and enrolled in Medicaid (7/1/19 – 6/30/21)	Other new enrollees not preceded by prison release (1/1/20 – 12/31/21)
Members with OUD diagnosis	1,085	9,306
Utilization of OUD-related services		
Outpatient visits with a primary diagnosis of OUD	905 (83.4%)	6,566 (70.6%)
MOUD use (buprenorphine, methadone, or naltrexone)	800 (88.4%)	6,304 (67.7%)
Residential treatment stay	44 (4.1%)	590 (6.3%)
ED visits with a primary diagnosis of OUD	51 (4.7%)	670
Inpatient hospitalization claim with a primary diagnosis of OUD	43 (4.0%)	577 (6.2%)
Opioid-related overdose	94 (8.7%)	713 (7.7%)

[1]Includes Medicaid enrollment within 6 months of release for those released from prison during the study period. For new Medicaid enrollees not preceded by a prison release, excludes those who had any enrollment in full Medicaid benefits within 6 months of enrollment. Sample restricted to those ages 18-64 with 6 months continuous enrollment after Medicaid enrollment date.

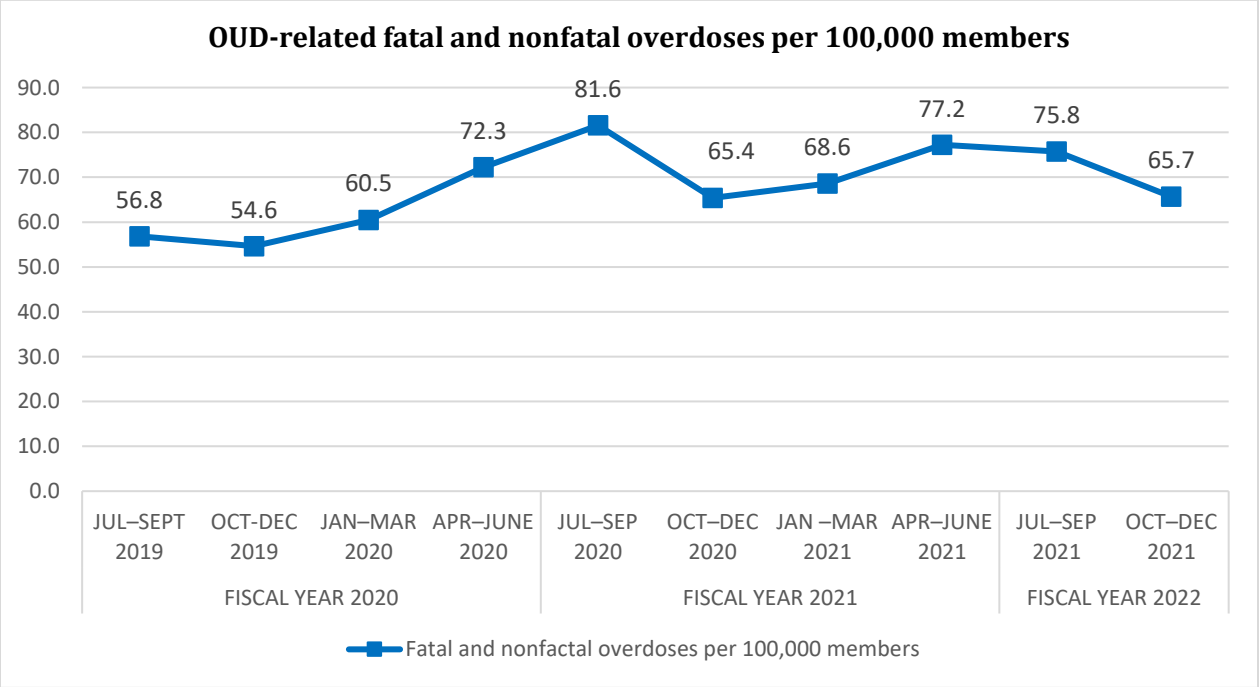
OUD-Related Overdoses

In SFY 2021, there were 4,362 opioid-related overdoses (fatal and nonfatal) among Medicaid members, as reported in the claims data. Consistent with state and national increases in overdose deaths, this represents a 34.1% increase from SFY 2020. Similarly, the rate of opioid-related overdoses per 100,000 members increased 24.9%, from 197 overdoses in SFY 2020 to 246 overdoses per 100,000 members in SFY 2021. Among those with an OUD diagnosis, the proportion with an overdose increased from 7.7% in SFY 2020 to 9.1% in SFY 2021.

OUD-related overdoses among Medicaid members, SFY 2020 and 2021

	SFY 2020	SFY 2021	Percent change
Number of OUD-related overdoses	3,252	4,362	34.1%
OUD-related overdoses per 100,000 members	196.9	246.0	24.9%
Percent with OUD-related overdose among those with OUD diagnosis	7.7%	9.1%	18.6%

A closer look at overdose rates by quarter shows a sharp increase in overdoses near the start of the COVID-19 pandemic in April through September 2020. After peaking at 81.6 overdoses per 100,000 members in July-September 2020, the overdose rate decreased to 65.4 per 100,000 during October-December 2020. Since December 2020, the number of overdoses has mostly held relatively steady between 65.7 and 77.2 per 100,000 members.



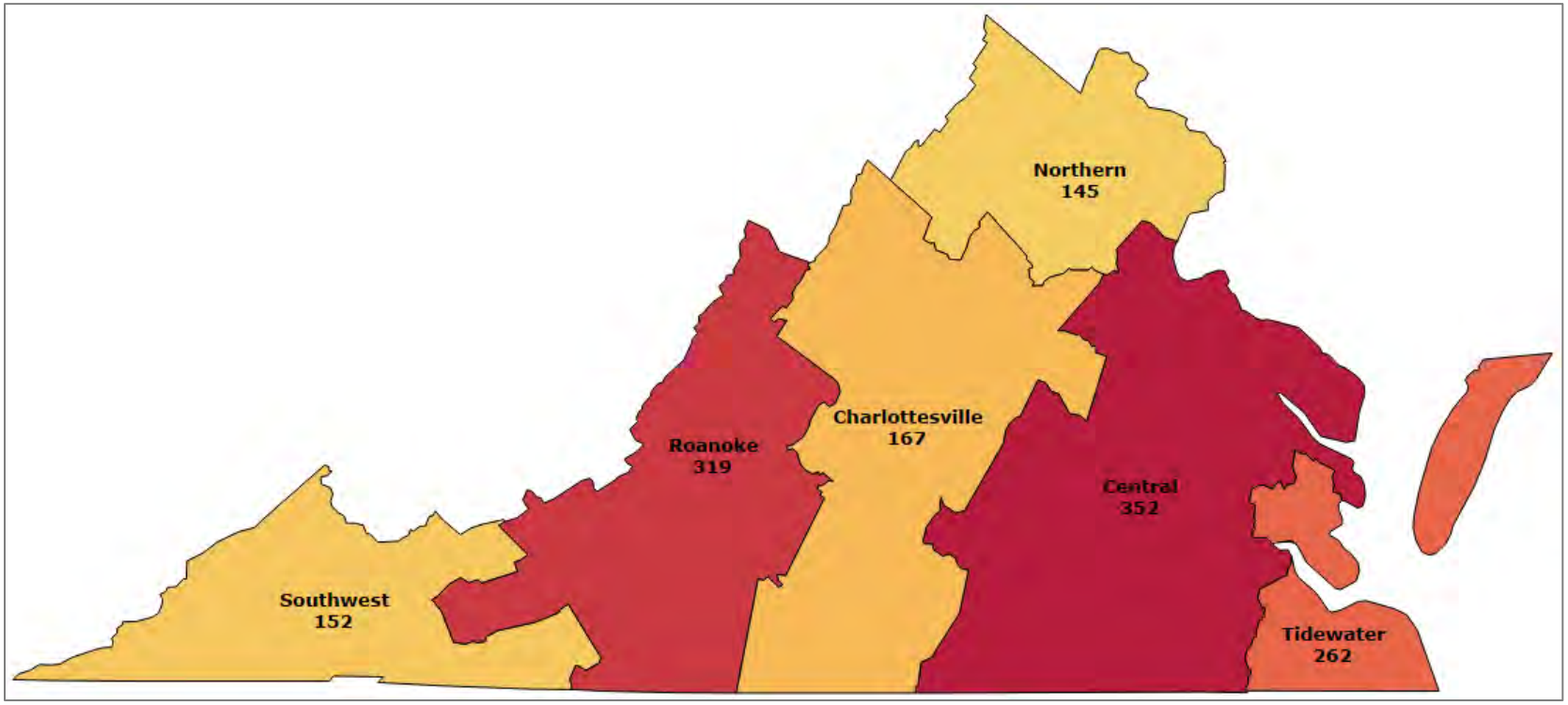
Consistent with trends in OUD prevalence, overdose rates tend to be higher among nonelderly adults, males, and Non-Hispanic Whites. Among Medicaid eligibility categories, overdose rates are highest among Medicaid expansion members and other nondisabled adults (consistent with the higher rates among nonelderly adults) as well as members in the blind and disabled eligibility group.

OUD-related overdoses, by member characteristics

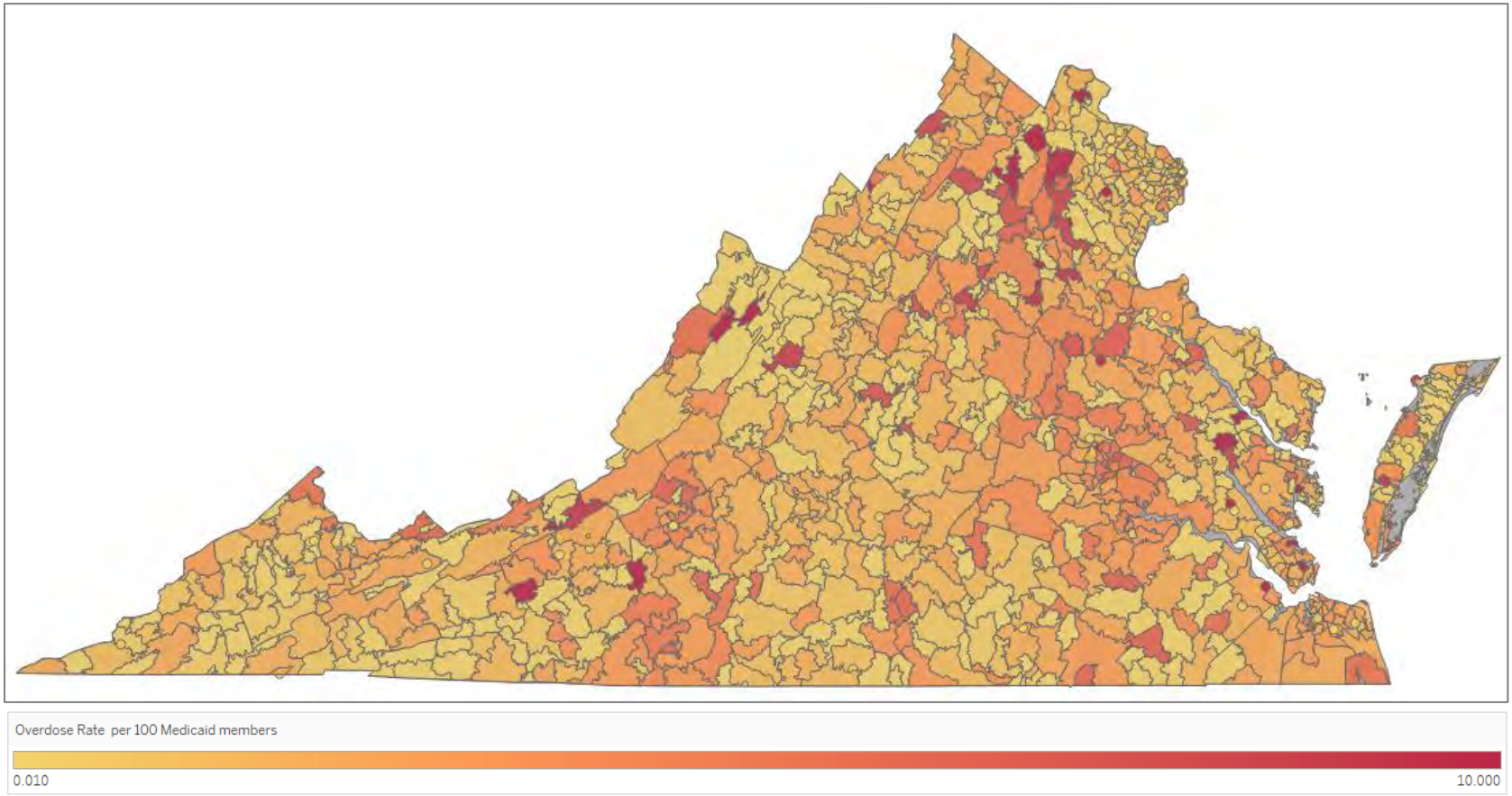
	Medicaid members with overdoses	Overdose rate per 100,000 members
All members[1]	4,362	246.0
Age		
12-21	242	63.2
22-34	1,493	446.6
35-44	1,072	537.1
45-54	784	525.9
55-64	603	396.7
65+	128	127.5
Sex		
Male	2,705	344.6
Female	1,659	167.4
Race/ethnicity		
White, NH	2,628	289.2
Black, NH	1,495	242.3
Hispanic	70	105.4
Other	169	93.3
Aid category		
Medicaid expansion	2,879	491.1
Other non-disabled adults	509	302.9
Pregnant women	40	89.9
Low income children	118	18.1
Aged Adults	116	125.1
Blind/Disabled	683	422.8

The maps below show OUD-related overdose rates by region, as well as by zip code area. While the Southwest region has the highest OUD prevalence rate, it has a lower overdose rate relative to Roanoke, Central, and Tidewater regions. It should be noted that counts of overdoses based on health care claims may be undercounted in rural areas (and heavily rural regions), where there are fewer providers and possibly more overdoses not observed by health care providers.

Overdose Rate per 100,000 Medicaid members by Region



Overdose Rate per 100 Medicaid members by Zip Code



Most Members with overdoses were not receiving MOUD treatment

Most members who had OUD-related overdoses were not receiving MOUD treatment prior to the overdose. Of the 4,362 overdoses in SFY 2021, 60.3% had not received any MOUD treatment in the 12 months prior to the overdose, while 83.8% did not receive MOUD treatment in the month prior to the overdose.

There was a small increase in the percent of members with overdoses who had received MOUD treatment in the 12 months prior to the overdose, from 35.9% among overdoses that occurred in SFY 2020 to 39.7% in SFY 2021. There was no change in the proportion of members with overdoses who received MOUD in the month prior to the overdose (16.2%). Of the total increase in 1,110 members with an OUD-related overdose between SFY 2020 and 2021, 50.9% of the increase is accounted for by members who received MOUD treatment in the 12 months prior to the overdose, while 16.3% is accounted for by members who received MOUD treatment in the month prior to the overdose.

OUD-related overdoses that involved MOUD treatment

	SFY 2020		SFY 2021	
	Number	As Percent of Total Overdoses	Number	As Percent of Total Overdoses
Total number of overdoses	**3,252**		**4,362**	
Any MOUD use in 12 months prior to date of overdose				
Yes	1,167	35.9%	1,732	39.7%
No	2,085	64.1%	2,630	60.3%
Any MOUD use in 30 days prior to date of overdose				
Yes	527	16.2%	708	16.2%
No	2,725	83.8%	3,654	83.8%

Conclusion

SUD prevalence among Medicaid members continued to increase between SFY 2020 and 2021, both in the overall number of Medicaid members with a diagnosed SUD as well as on a per member basis. However, the rate of increase in SUD prevalence (6.5% on a per member basis) was much lower than in prior years (16% between SFY 2019 and 2020) which was influenced by new Medicaid members with SUD enrolling through Medicaid expansion,[2] and possibly the early effects of the COVID-19 pandemic. Although OUD-related overdoses (fatal and nonfatal) increased between SFY 2020 and 2021, overdoses leveled off and declined somewhat during the first two quarters of SFY 2022 (July through December 2021). This is consistent with an apparent statewide decline in fatal overdoses projected for 2022 in Virginia, driven primarily by a leveling off of fentanyl-related overdoses.[1,3] While it is unclear whether the recent decrease in overdoses is temporary or part of a longer-term trend, it may signal an easing of the social, economic, and psychological stresses that contributed to a spike in overdoses during the early years of COVID-19.

Access to and use of ARTS services also continues to increase, as it has since the implementation of the ARTS benefit in 2017. Treatment providers of all types continued to increase in the past year, as well as utilization of ARTS services. Especially notable was the increase in MOUD treatment rates among those with an OUD diagnosis, from 64% in SFY 2020 to 78% in SFY 2021, with the increase continuing in the first two quarters of SFY 2022. Among Medicaid members who had an overdose in SFY 2021, only 16% were receiving MOUD treatment in the 30 days prior to the overdose. The increase in MOUD treatment likely reflects the increase in treatment providers, the removal of prior authorization requirements for suboxone films for in-network prescribers beginning in March 2019 and new initiatives and procedural flexibilities implemented at the beginning of the COVID-19 pandemic that made it easier to access buprenorphine and methadone from home. Greater acceptance and reduced stigma of MOUD treatment by patients, providers, and others in the community may also contribute to higher treatment rates.

Despite these gains, some gaps in treatment remain. While access to providers who prescribe buprenorphine may have increased, there is uneven access to pharmacies that dispense buprenorphine across the state. Retail pharmacies that dispense buprenorphine tend to be more available in urban areas of the state, while some rural areas with high OUD prevalence (Southwest region, for example) may have limited accessibility. There are fewer pharmacies dispensing buprenorphine in Southwest relative to OUD prevalence in this area. This could lead to some members having to travel excessively long distances to obtain buprenorphine medications, which may affect their willingness to initiate and continue with buprenorphine treatment.

Gaps in care transitions after discharge from hospital emergency departments and residential treatment centers for OUD remain, with only 37% and 54%, respectively, receiving MOUD treatment within 30 days of discharge. Treatment rates are relatively high following release from prison for former inmates who are diagnosed with OUD, although the analysis did not assess members who had shorter term stays in local jails. Relatively high Medicaid enrollment and treatment rates among those released from prison may reflect efforts by Department of Corrections officials to screen inmates who are about to be released for SUD and Medicaid eligibility. Finally, while OUD still is the most prevalent SUD diagnosis, prevalence has increased the most for SUD

diagnoses related to other substances, such as cannabis, hallucinogens, and simulants. Use of ARTS services for these other substances remains much lower than that related to OUD diagnoses, which may reflect the lack of pharmacological and other medical treatment options for these diagnoses.

The Commonwealth of Virginia has made substantial progress since the implementation of the ARTS benefit in 2017 in building a robust treatment infrastructure for Medicaid members, with the number of treatment providers, members using services, and treatment rates for those with SUD diagnoses increasing every year since 2017. Continued progress will depend in part on addressing ongoing gaps in treatment, especially care transitions following discharges from hospitals and residential treatment centers, as well as uneven access to providers and pharmacies in some areas of the state. System capacity to treat patients may also benefit in the future to the extent that COVID-19 related increases in SUD prevalence and overdoses have leveled off and continue to decrease.

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Attachment 3

Virginia 1115 Demonstration Current External Quality Technical Report

Commonwealth of Virginia
Department of
Medical Assistance Services

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

April 2024

HSAG HEALTH SERVICES ADVISORY GROUP

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION • QUALITY • VALUE

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Glossary of Acronyms

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

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

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

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

HPV ..... Human Papillomavirus
HRA ..... Health Risk Assessment
HSAG ..... Health Services Advisory Group, Inc.
I/DD ..... Intellectual and Developmental Disability
IACCT ..... Independent Assessment Certification and Coordination Team
ICT ..... Intensive Community Treatment
ID ..... Identification
IDSS ..... Interactive Data Submission System
IES ..... Individual Experience Survey
IIH ..... Intensive In-Home Services
IS ..... Information Systems
ISCA ..... Information Systems Capability Assessment
ISCAT ..... Information Systems Capabilities Assessment Tool
ISP ..... Individual Service Plan
LABA ..... Licensed Applied Behavior Analyst
LANE ..... Lowest Acuity Non-emergent Emergency
LBA ..... Licensed Behavior Analyst
LCPA ..... Licensed Child Placement Agency
LIFC ..... Low Income Families With Children
LMHP ..... Licensed Mental Health Professional
LMHP-R ..... Licensed Mental Health Professional—Resident
LMHP-RP ..... Licensed Mental Health Professional Resident in Psychology
LMHP-S ..... Licensed Mental Health Professional—Supervisee
LMP ..... Last Menstrual Period
LO ..... Licensed Organization
LOB ..... Line of Business
LOCERI ..... Level of Care Review Instrument
LTSS ..... Long-Term Services and Supports
MBHO ..... Managed Behavioral Health Organization
MCE ..... Managed Care Entity
MCO ..... Managed Care Organization
MCP ..... Managed Care Plan
MES ..... Medicaid Enterprise System
MFT ..... Managed File Transfer
MHP ..... Mental Health Provider
MHSS ..... Mental Health Skill-Building Services
MITA ..... Medicaid Information Technology Architecture
MLTSS ..... Managed Long-Term Services and Supports
MMIS ..... Medicaid Management Information System
MODRN ..... Medicaid Outcomes Distributed Research Network

MOUD ..... Medications for Opioid Use Disorder
MRI ..... Magnetic Resonance Imaging
MRRV ..... Medical Record Review Validation
MY ..... Measurement Year
NA ..... Not Applicable
NASHP ..... National Academy for State Health Policy
NCHS ..... National Center for Health Statistics
NCQA ..... National Committee for Quality Assurance
NDC ..... National Drug Code
NF ..... Nursing Facility
NIH ..... National Institutes of Health
NPI ..... National Provider Identifier
NR ..... Not Reported
NVS ..... Network Validation Survey
NVSS ..... National Vital Statistics System
OBAT ..... Office-Based Addiction Treatment
O/E ..... Observed/Expected
OB/GYN ..... Obstetrics and Gynecology
OBOT ..... Office-Based Opioid Treatment
OSR ..... Operational Systems Review
OTP ..... Opioid Treatment Program
OUD ..... Opioid Use Disorder
PAHP ..... Prepaid Ambulatory Health Plan
PCCM ..... Primary Care Case Management
PCP ..... Primary Care Provider
PDI ..... Pediatric Quality Indicator
PDL ..... Preferred Drug List
PDSA ..... Plan-Do-Study-Act
PHA ..... Post-Hospital Assessment
PHE ..... Public Health Emergency
PIHP ..... Prepaid Inpatient Health Plan
PIP ..... Performance Improvement Project
PM ..... Performance Measure
PMV ..... Performance Measure Validation
PNC ..... Prenatal Care
PRTF ..... Psychiatric Residential Treatment Facility
PSR ..... Psychosocial Rehabilitation
PSV ..... Primary Source Verification
PWP ..... Performance Withhold Program
QAPI ..... Quality Assessment and Performance Improvement

QI	Quality Improvement
QS	Quality Strategy
R	Reportable
RAP	Risk Assessment Profile
RPR	Rapid Plasma Reagin
RTC	Residential Treatment Center
SA	Service Authorization
SAFE	Secure Access File Exchange
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDOH	Social Determinants of Health
SFC	Smiles for Children
SFTP	Secure File Transfer Protocol
SFY	State Fiscal Year
SHCN	Special Health Care Needs
SIS	Supports Intensity Scale
SMART	Specific, Measurable, Attainable, Relevant, Time-Bound
SME	Subject Matter Expert
SNF	Skilled Nursing Facility
SSA	Social Security Act
SUD	Substance Use Disorder
SUPPORT Act	Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act
SVR	Sustained Virologic Response
TANF	Transitional Aid to Needy Families
TB	Tuberculosis
TCC	Transition of Care Coordinators
Tdap	Tetanus, Diphtheria Toxoids, and Acellular Pertussis
TDT	Therapeutic Day Treatment
TGH	Therapeutic Group Home
TPL	Third Party Liability
USPSTF	United States Preventive Services Task Force
VA	Virginia
VBP	Value-Based Purchasing
VCU	Virginia Commonwealth University
VDH	Virginia Department of Health
VDSS	Virginia Department of Social Services
WIC	Women, Infants and Children

1. Executive Summary

Overview of 2023 External Quality Review

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

To meet this requirement, the Commonwealth of Virginia, DMAS, contracted with HSAG, as its EQRO, to perform the assessment and produce this report for EQR activities conducted during the period of January 1, 2023, through December 31, 2023 (CY 2023). In addition, this report draws conclusions about the quality of, timeliness of, and access to healthcare services that the contracted MCOs provide. Effective implementation of the EQR-related activities will facilitate Commonwealth efforts to purchase high-value care and to achieve higher performing healthcare delivery systems for their Medicaid and CHIP members.

DMAS administers the CCC Plus (MLTSS) program. DMAS contracted with six privately owned MCOs to deliver physical health and BH services to Medicaid and CHIP members. The MCOs contracted with DMAS during CY 2023 are displayed in Table 1-1.

Table 1-1—Medicaid CCC Plus (MLTSS) MCOs in Virginia

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

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

In June 2021, the Virginia General Assembly mandated that DMAS rebrand the Department's FFS and managed care programs and effectively combine the CCC Plus (MLTSS) and Medallion 4.0 (Acute) programs under a single name, the Cardinal Care program. The combined program achieves a single streamlined system of care that links seamlessly with the FFS program. DMAS received CMS approval for an effective date of October 1, 2023, for the Cardinal Care program. The Cardinal Care program will ensure an efficient, well-coordinated Virginia Medicaid delivery system that provides high-quality care to members and adds value for providers and the Commonwealth. The consolidated program will enable DMAS to ensure better continuity of care for members, operate with improved administrative efficiency,

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

and strengthen the focus on the diverse and evolving needs of the populations served. The Cardinal Care program will continue to offer members the same programs and services and will not reduce or change any existing coverage. The overarching program will ensure a smoother transition for individuals whose healthcare needs evolve over time.

Scope of External Quality Review Activities

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

Methodology for Aggregating and Analyzing EQR Activity Results

For the 2023 EQR technical report, HSAG used findings from the EQR activities conducted from January 1, 2023, through December 31, 2023. From these analyses, HSAG derived conclusions and made recommendations about the quality of, access to, and timeliness of care and services provided by each DMAS MCO and the overall statewide CCC Plus (MLTSS) program. A comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each MCO are found in the results of each activity in sections 4 through 12 of this report and Section 13—Summary of MCO-Specific Strengths and Weaknesses. Detailed information about each activity's methodology is provided in Appendix B of this report. Table 1-2 identifies the EQR mandatory and optional activities included in this report.

Table 1-2—EQR Activities

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

Activity	Description	CMS EQR Protocol
	reporting processes used to calculate the PM rates. DMAS identified and selected the specifications for a set of PMs that the MCOs were required to calculate and report for the measurement period of January 1, 2022, through December 31, 2022.	
Compliance With Medicaid and CHIP Managed Care Regulations	This activity determines the extent to which a Medicaid and CHIP MCO is in compliance with federal standards and associated state-specific requirements, when applicable. HSAG conducted full compliance reviews (called OSRs) that included all federal and state-specific requirements for the review period of July 1, 2021, through June 30, 2022.	*Protocol 3*. Review of Compliance with Medicaid and CHIP Managed Care Regulations
	This activity assesses the readiness of each MCO with which DMAS contracts when the MCO will provide or arrange for the provision of covered benefits prior to DMAS implementing a managed care program, when the MCO has not previously contracted with the State; or when the MCO will provide or arrange for the provision of covered benefits to new eligibility groups.	
Validation of Network Adequacy	The network adequacy validation activity validates MCO network adequacy using DMAS' network standards in its contracts with the MCOs. DMAS established time and distance standards for the following network provider types: primary care (adult and pediatric), OB/GYN, BH, specialist (adult and pediatric), hospital, pharmacy, pediatric dental, and additional provider types that promote the objectives of the Medicaid program.	*Protocol 4*. Validation of Network Adequacy
Optional Activities		
EDV	HSAG conducts EDV, which includes an IS review/assessment of DMAS' and the MCOs' IS and processes to examine the extent to which DMAS' and the MCOs' IS infrastructures are likely to collect and process complete and accurate encounter data. HSAG also completes an administrative profile, which is an analysis of DMAS' electronic encounter data completeness, accuracy, and timeliness. This activity evaluates the extent to which the encounter data in DMAS' EPS database are complete, accurate, and submitted by the MCOs in a timely manner for encounters.	*Protocol 5.* Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan

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

Activity	Description	CMS EQR Protocol
	healthcare quality and transparency and provide information to consumers to make informed decisions about their care within the CCC Plus (MLTSS) program. HSAG uses HEDIS and CAHPS data to compare MCOs to one another in key performance areas.	and Prepaid Ambulatory Health Plans
PWP	HSAG develops a methodology to calculate the MCO results for the PWP for DMAS. The 2023 PWP used HEDIS and non-HEDIS measures.	
QS Update	HSAG works with DMAS to update and maintain the Virginia 2023–2025 QS. QS maintenance incorporates programmatic changes such as DMAS' focus on care and service integration, a patient-centered approach to care, paying for quality and positive member outcomes, and improved health and wellness. HSAG reviews the QS to ensure the most current Managed Care Rule and CMS Medicaid and CHIP Managed Care QS Toolkit requirements are met.	Medicaid and CHIP Managed Care QS Toolkit

Virginia Managed Care Program Findings and Conclusions

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

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

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

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

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

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

Program Strengths		
Domain		**Conclusion**
+	**Quality**	**Strength:** Overall, BH care and ARTS demonstrate a strength for the CCC Plus (MLTSS) program. The ARTS study findings show that identification of members with SUD may be improving, in alignment with ARTS benefit goals. The *Cascade of Care for Members With OUD—High-Risk Members With OUD Diagnosis* indicator assessed identification of members with an OUD. Findings show that this rate increased from 3.8 percent to 5.1 percent from CY 2020 to CY 2021. In addition, several study indicators found that initiation of SUD treatment is increasing overall, though findings differ by type and timeliness of treatment. For example, 44.2 percent of members diagnosed with OUD initiated any OUD treatment (i.e., pharmacotherapy or other treatment) within 14 days of OUD diagnosis in CY 2021, and this rate increased by 4.7 percentage points from CY 2020. The rate change was driven by an increase in members initiating pharmacotherapy, for which the rate increased by 6.2 percentage points from CY 2020 to CY 2021. The emphasis and focus on the ARTS program may be driving improvement in BH measures. The MCOs demonstrated strength within the Behavioral Health PM domain related to the use of medication to treat mental health conditions, as all six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment, Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total, Diagnosed Mental Health Disorders—Total, Diagnosed Substance Use Disorders—Alcohol disorder—Total, Diagnosed Substance Use Disorders—Opioid disorder—Total, Diagnosed Substance Use Disorders—Other or unspecified drugs—Total,* and *Diagnosed Substance Use Disorders—Any disorder—Total* PM indicators. In addition, five of the six MCOs' rates for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Total* measure also met or exceeded the 50th percentile. **Strength:** Overall, the Maternal and Child Health focus study, FAMIS MOMS program results demonstrated strength, with rates for the *Births with Early and Adequate Prenatal Care*, *Preterm Births (<37 Weeks Gestation),* and *Newborns with Low Birth Weight (<2,500 grams)* study indicators outperforming the applicable national benchmarks for all three measurement periods. The Medicaid for Pregnant Women program also had *Preterm Births (<37 Weeks Gestation)* and *Newborns with Low Birth Weight (<2,500 grams)* rates that outperformed the national benchmarks in CY 2021. Additionally, the Medicaid Expansion

Program Strengths		
Domain		**Conclusion**
		program's rate for the *Births with Early and Adequate Prenatal Care* study indicator improved from CY 2020 to exceed the national benchmark in CY 2021. **Strength:** The CCC Plus (MLTSS) program demonstrated strength in the Living With Illness domain. MCO performance showed strength with five of six MCOs' rates having met or exceeded the 50th percentile for the *Asthma Medication Ratio—Total, Eye Exam for Patients With Diabetes—Total, Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Total,* and *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications* PM indicators. **Strength:** The CCC Plus (MLTSS) program also showed strengths within the Taking Care of Children domain. The MCOs demonstrated strength related to metabolic monitoring for children and adolescents on antipsychotics, as five of six MCOs' rates met or exceeded the 50th percentile for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total* and *Blood Glucose and Cholesterol Testing—Total* PM indicators.
	**Access**	**Strength:** For the CCC Plus (MLTSS) program, the Child Welfare focus study demonstrated that children in foster care have higher rates of appropriate healthcare utilization than comparable controls (children not enrolled in child welfare systems) for most study indicators in MY 2019, MY 2020, and MY 2021. Study findings show that MY 2021 rate differences between children in foster care and controls were greatest among the dental study indicators (*Annual Dental Visit; Preventive Dental Services; Oral Evaluation, Dental Services;* and *Topical Fluoride for Children—Dental or Oral Health Services* by 18.2, 19.0, 19.0, and 14.2 percentage points, respectively); the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure (by 20.8 percentage points); and the *Behavioral Health Encounters—CMH Services* indicator (by 17.1 percentage points). Rate differences between children in foster care and controls across study indicators persisted even after matching on many demographic and health characteristics. **Strength:** The Child Welfare focus study findings show that children receiving adoption assistance had higher rates than controls for all six Oral Health domain study indicators, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up, Follow-Up After ED Visit for Mental Illness—30-Day Follow*-Up, *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment*, *Asthma Medication Ratio, Inpatient Visits*, and four out of six *Behavioral Health*

Program Strengths		
Domain		**Conclusion**
		Encounters study indicators. Rate differences between children receiving adoption assistance and controls across study indicators persisted even after matching on many demographic and health characteristics. The Child Welfare focus study results have some alignment with the CCC Plus (MLTSS) MCO PM results. The MCOs demonstrated strength within the Use of Opioids domain, as four of six MCOs' rates met or exceeded the 50th percentile for two of the three *Use of Opioids from Multiple Providers* PM indicators. Molina and VA Premier met or exceeded the 50th percentile for three of four (75.0 percent) measure rates that were compared to national benchmarks. Moreover, VA Premier had four of four (100.0 percent) of the measure rates exceeding the Virginia aggregate. **Strength:** An overall strength for the CCC Plus (MLTSS) program was found within the Access and Preventive Care domain. The MCOs demonstrated strength related to access to care, as all six MCOs' rates met or exceeded the 50th percentile related to the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator.
+	**Timeliness**	**Strength:** CCC Plus (MLTSS) members' experience with receiving timely access to care and services was positive. The CCC Plus (MLTSS) program's 2023 top-box scores were statistically significantly higher than the 2022 NCQA adult Medicaid national averages for four measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Care Quickly*, and *Customer Service*. The CAHPS survey results demonstrate members' overall satisfaction with aspects of the CCC Plus (MLTSS) program.

Program Weaknesses		
Domain		**Conclusion**
−	**Quality**	Disparities were identified in the quality, accessibility, and timeliness of care and services for the CCC Plus (MLTSS) program members. In addition to the total Virginia Medicaid rates, the 2022 ARTS Measure Report evaluated PM rates stratified by demographics, region, delivery system, eligibility group, managed care program, and MCO. Among rates stratified by age category, members 12 to 21 years of age were consistently less likely to receive naloxone and OUD treatment compared to members in other age categories. Additionally, members 65 years of age and older were consistently less likely to initiate or be retained in hepatitis C and HIV care. However, these findings may reflect services billed to Medicare or medications received in institutionalized settings, such as skilled nursing facilities, not being captured in Medicaid administrative data. Rates for male and female members were generally similar. Rate differences among racial/ethnic

Program Weaknesses	
Domain	**Conclusion**
	groups varied across study indicators. However, Asian members prescribed high-dose opioids or with diagnosed OUD were less likely to receive naloxone than other racial/ethnic groups. Asian members at high risk of OUD were also almost half as likely to be diagnosed with OUD than members in other racial/ethnic groups. Additionally, White members were more likely to receive treatment for hepatitis C than Black/African-American members. The Central region had the highest rate of OUD diagnoses yet some of the lowest rates for initiation of pharmacotherapy and other treatment. The Southwest region had the highest rate of hepatitis C diagnoses but the lowest rates for initiation and completion of DAA treatment. The Roanoke/Alleghany region had the lowest rates for receipt of antiretroviral therapy among members with HIV. The ARTS study and related PM results identify opportunities for the MCOs to focus interventions on reducing disparities in care and service delivery. **Weakness:** The ARTS study findings are supported by CCC Plus (MLTSS) PM results. Five of six MCOs' rates fell below the 50th percentile for the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia—Total, Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total,* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measures. **Weakness:** All six CCC Plus (MLTSS) MCOs' rates for the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total* PM indicators fell below the 50th percentile. **Weakness:** Members identified with chronic diseases within the CCC Plus (MLTSS) program also demonstrated opportunities for MCOs to improve receipt of recommended care and services. PM results indicate that five of the six MCOs' rates fell below the 50th percentile for the *Blood Pressure Control for Patients With Diabetes—Total* and *Controlling High Blood Pressure—Total* measures. MCO performance below the 50th percentile indicates that some members with diabetes and hypertension are not receiving appropriate care to support optimal health.

Program Weaknesses		
Domain		**Conclusion**
–	**Access**	**Weakness:** The ARTS study findings show that engagement in OUD treatment may be declining. The *Cascade of Care for Members With OUD—Members who Initiated OUD Treatment who Also Engaged in OUD Treatment* indicator found that 40.7 percent of members who had initiated OUD treatment engaged in OUD treatment for six months following OUD diagnosis, and this rate declined by 8.7 percentage points from CY 2020 to CY 2021. However, the rate for CY 2021 may have been especially impacted by the COVID-19 PHE since this study indicator utilizes visits from the year prior to the measurement year. Therefore, many of these missed engagement visits were supposed to happen during 2020 after the onset of the PHE. The ARTS study findings are consistent with CCC Plus (MLTSS) PM results within the Behavioral Health domain. For *Follow-Up After Hospitalization for Mental Illness* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* PM indicators, none of the MCOs' rates met or exceeded the 50th percentile, reflecting an area of opportunity for improvement. This performance suggests that members have not received timely follow-up after hospitalizations for mental illness. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes and decrease the likelihood of re-hospitalization and the overall cost of outpatient care. **Weakness:** The CCC Plus (MLTSS) program's 2023 top-box scores were statistically significantly lower than the 2022 NCQA child Medicaid national average for *Rating of Health Plan*. The member experience survey results may indicate challenges in scheduling care and services with providers listed in MCO provider directories. The CCC Plus (MLTSS) PCP secret shopper survey revealed that overall, approximately 83 percent of providers were unable to be reached, did not offer primary care services, were not at the sampled location, did not accept the requested MCO, did not accept VA Medicaid, were not accepting new patients, or were unable to offer an appointment date. The overall secret shopper survey response rate was 63.2 percent, with 46.7 percent of the offices accepting the MCO, 43.3 percent accepting VA Medicaid, and 36.1 percent accepting new patients. Among cases offering an appointment, 73.1 percent provided a routine or urgent care appointment date. For cases that were offered a routine appointment, 74.5 percent were compliant with the 30-day standard for routine primary care services. For cases that were offered an urgent appointment, 16.0 percent were compliant with the one-day (i.e., 24 hours) standard for urgent primary care services. **Weakness:** The results of the CCC Plus (MLTSS) PCP secret shopper survey could indicate that members may not consistently have access

Program Weaknesses		
Domain		**Conclusion**
		to well-care and preventive services, resulting in lower rates in some MCO PM rates. For example, within the Access and Preventive Care domain, cancer screenings for women, pregnancy care, and appropriate use of imaging studies for low back pain represent an area for opportunity Virginia-wide, as all reportable MCO rates fell below the 50th percentile for the *Cervical Cancer Screening, Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care,* and *Use of Imaging Studies for Low Back Pain* measures. Additionally, five of six MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* measure. This performance indicates members did not receive screenings according to recommended schedules.
–	**Timeliness**	**Weakness:** The CCC Plus (MLTSS) program's CAHPS 2023 top-box scores were statistically significantly lower than the 2022 top-box scores for *Getting Care Quickly.* CCC Plus (MLTSS) PM results may align with the member experience survey results. Within the Taking Care of Children PM domain, all six MCOs have opportunities for improvement related to the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total* PM indicator rates, as none of the MCOs' rates for these PM indicators met or exceeded the 50th percentile. While the COVID-19 PHE contributed to a decline in routine pediatric vaccine ordering and doses administered, the MCOs' continued performance below the 50th percentile suggests children are not receiving vaccines at a rate in line with national benchmarks. MCO performance is indicative of opportunities to increase PCP and OB/GYN assessment of children and adolescent BMI, counseling for nutrition, and counseling for physical activity.

Quality Strategy Recommendations for the Virginia Managed Care Program

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

Table 1-4—QS Recommendations for the Virginia Medicaid Managed Care Program[1-2]

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

[1-2] Department of Medical Assistance Services. 2023–2025 Quality Strategy. Available at: https://www.dmas.virginia.gov/media/5569/va2023-dmas-quality-strategy-f1.pdf. Accessed on: Dec 20, 2023.

Program Recommendations	
improve accessibility and timeliness of preventive services and well-child visits for members under the age of 21 years, HSAG recommends that DMAS: • Work with the enrollment broker to address the data deficiencies identified during the survey (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify the location's address and appropriate provider type and specialty. Additionally, DMAS may also consider requesting the MCOs to provide evidence of training offered by the MCO to providers' offices regarding the MCO plan names and benefit coverage. Evidence should demonstrate that the office staff responsible for scheduling appointments have been educated on the MCO names and benefit coverage, and that the offices have a plan in place for educating new staff in the event of staff turnover.	**Measure 4.1.1.2:** Child and Adolescent Well-Care Visits **Measure 4.1.1.3:** Childhood Immunization Status **Measure 4.1.1.4:** Immunizations for Adolescents **Measure 4.1.1.9:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents **Objective 4.2:** Improve Outcomes for Maternal and Infant Members **Measure: 4.2.1.4:** Well-Child Visits in the First 30 Months of Life

2. Overview of Virginia's Managed Care Program

Medicaid Managed Care in the Commonwealth of Virginia

The Department of Medical Assistance Services

DMAS is the Commonwealth of Virginia's single State agency that administers all Medicaid and FAMIS health insurance benefit programs in the Commonwealth. Medicaid is delivered to individuals through two models, managed care and FFS. Table 2-1 displays the average annual program enrollment during CY 2023.

Table 2-1—CY 2023 Average Annual Program Enrollment[2-1]

Program	SFY 2023 Enrollment as of 07/01/2023*
Medallion 4.0 (Acute)	1,670,831
CCC Plus (MLTSS)	307,904
Fee-for-Service	214,256
Total Served	2,194,813

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

DMAS contracted with six privately owned MCOs to deliver physical health and BH services to Medicaid and CHIP members. The Optima and VA Premier MCOs merged under the Optima name during CY 2023. The six MCOs contracted with DMAS on December 31, 2023, are displayed in Table 2-2.

Table 2-2—CCC Plus (MLTSS) MCOs in Virginia

MCO	Profile Description	MCO NCQA Accreditation Status
Aetna	Aetna Better Health of Virginia is the Medicaid/FAMIS Plus program offered by Aetna, a multistate healthcare benefits company headquartered in Hartford, Connecticut.	Accredited* through 04/01/2024 LTSS through 04/01/2024

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

MCO	Profile Description	MCO NCQA Accreditation Status
HealthKeepers	HealthKeepers is a Virginia HMO affiliated with Anthem Blue Cross Blue Shield, a publicly owned, for-profit corporation that operates as a multistate healthcare company, headquartered in Indianapolis, Indiana.	Accredited* through 03/09/2024 Health Equity through 11/15/2025 Health Equity Plus through 08/25/2026 LTSS through 03/09/2024
Molina	Molina is a Medicaid/FAMIS Plus program offered by Molina Health, Inc., conducting business in Virginia since 1972. Molina is headquartered in Scottsdale, Arizona.	Accredited* through 11/01/2026 Electronic Clinical Data Health Equity through 02/20/2027 LTSS through 11/01/2026
Optima	Optima is the Medicaid managed care product offered by Optima Health. A subsidiary of Sentara, Optima is a not-for-profit healthcare organization serving Virginia and northeastern North Carolina, headquartered in Norfolk, Virginia.	Accredited* through 04/01/2024 LTSS Distinction through 04/01/2024
United	United is part of the UnitedHealth Group family of companies, headquartered in Minneapolis, Minnesota. United provides Medicaid managed care and nationally serves more than 6.6 million low-income and medically fragile people, including D-SNPs across 30 states plus Washington, DC	Accredited* through 03/10/2026 Electronic Clinical Data Health Equity through 07/08/2025 LTSS through 03/10/2026
VA Premier	VA Premier, founded in 1995, is jointly owned by the integrated, not-for-profit health system Sentara Healthcare, based in Norfolk, Virginia, and VCU Health Systems, based in Richmond, Virginia.	Accredited through 07/26/2025 LTSS Distinction through 07/26/2025

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

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

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

MCO CCC Plus (MLTSS) Enrollment Characteristics

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

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

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

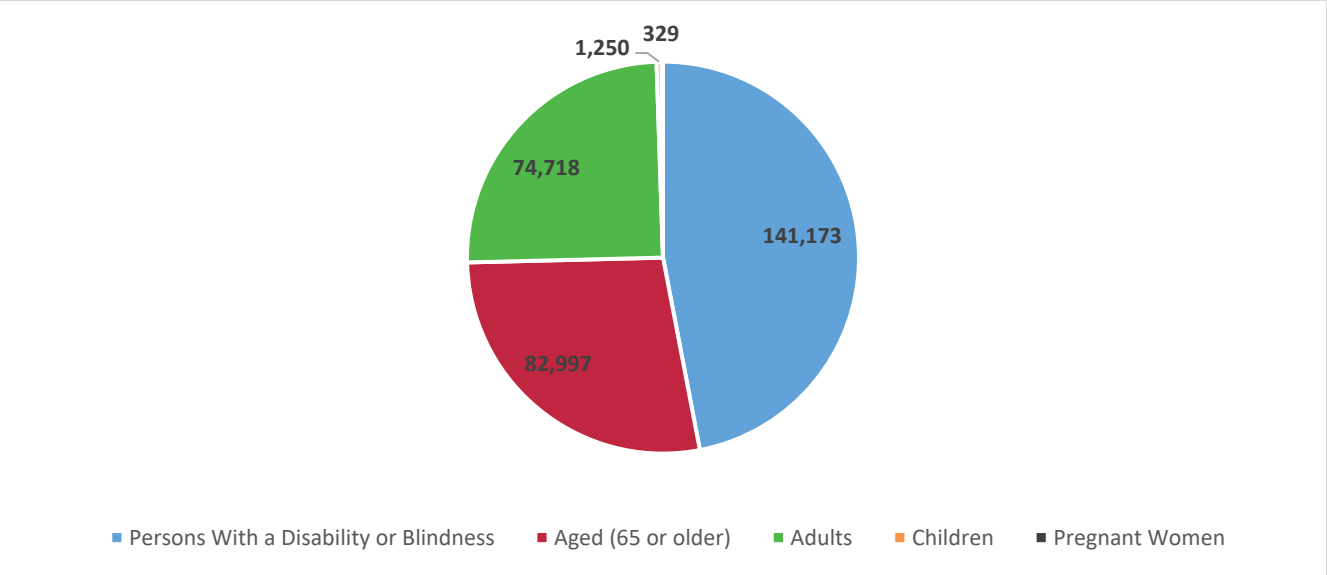


Table 2-3—CCC Plus (MLTSS) Program CY 2023 MCO Eligibility Categories[2-4]

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

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

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

2-4 Ibid.

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

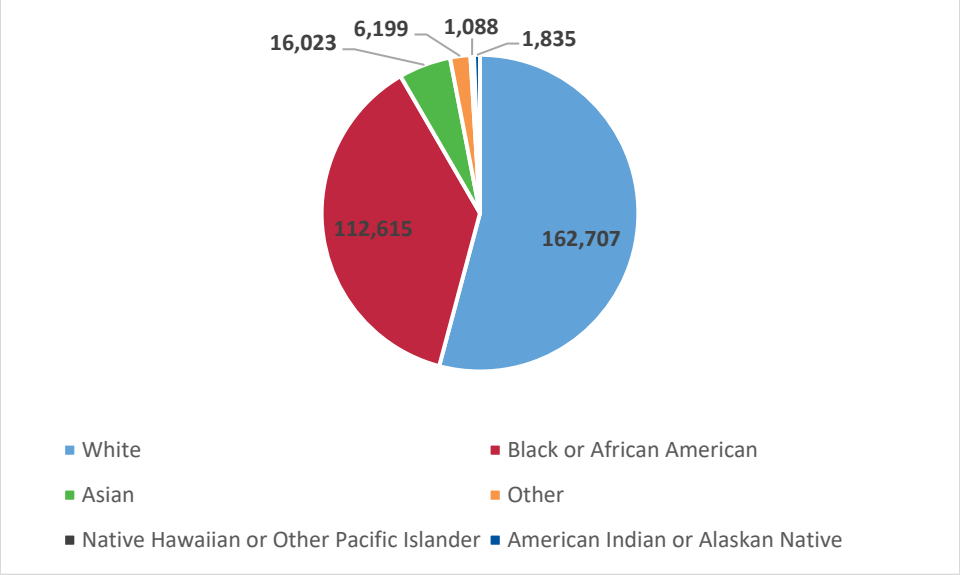


Table 2-4—CCC Plus (MLTSS) Program CY 2023 MCO Categories by Race[2-6]

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

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

2-5 Ibid.
2-6 Ibid.

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

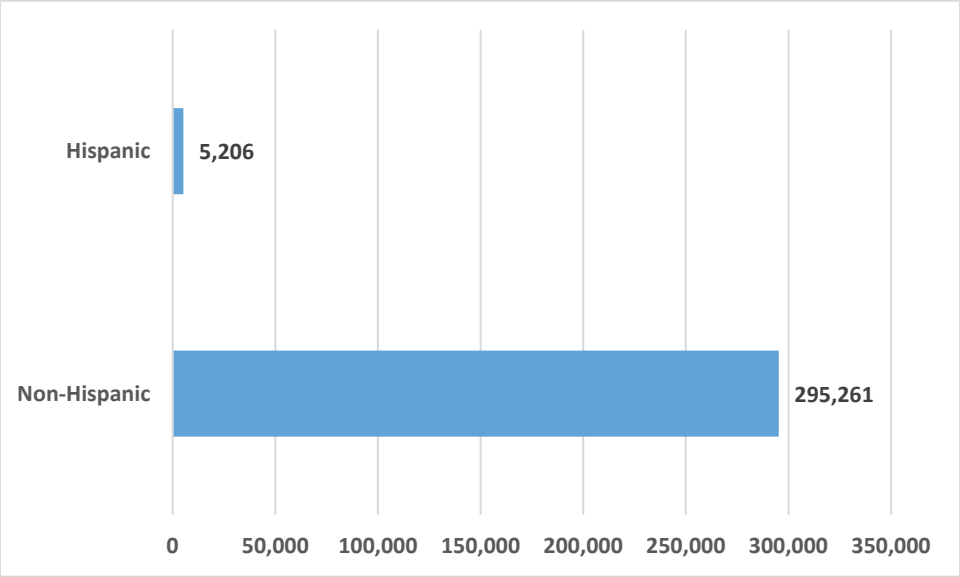


Table 2-5—CCC Plus (MLTSS) Program CY 2023 MCO Categories by Ethnicity[2-8]

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

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

2-7 Ibid.
2-8 Ibid.

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

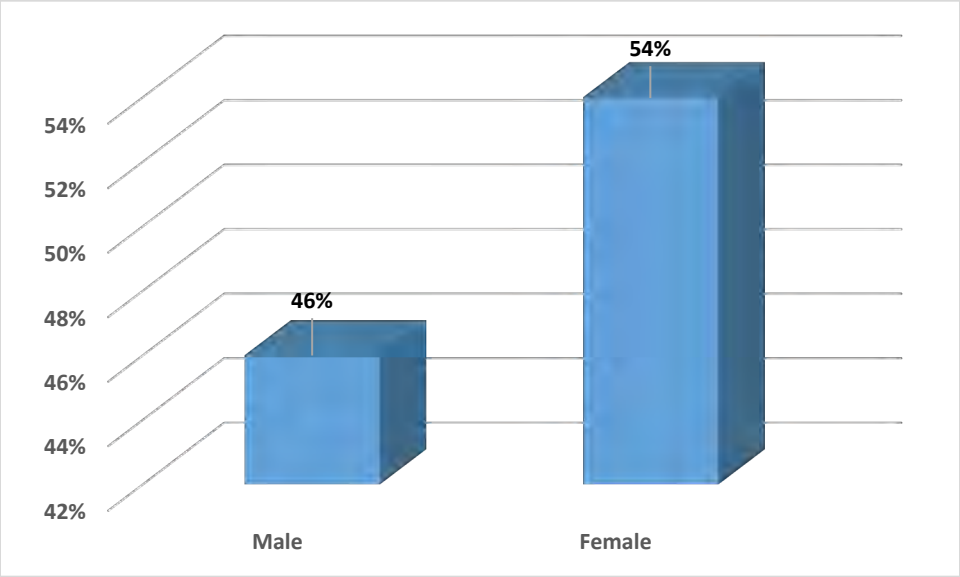


Table 2-6—CCC Plus (MLTSS) Program CY 2023 MCO Percentage by Gender[2-10]

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

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

2-9 Ibid.
2-10 Ibid.

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

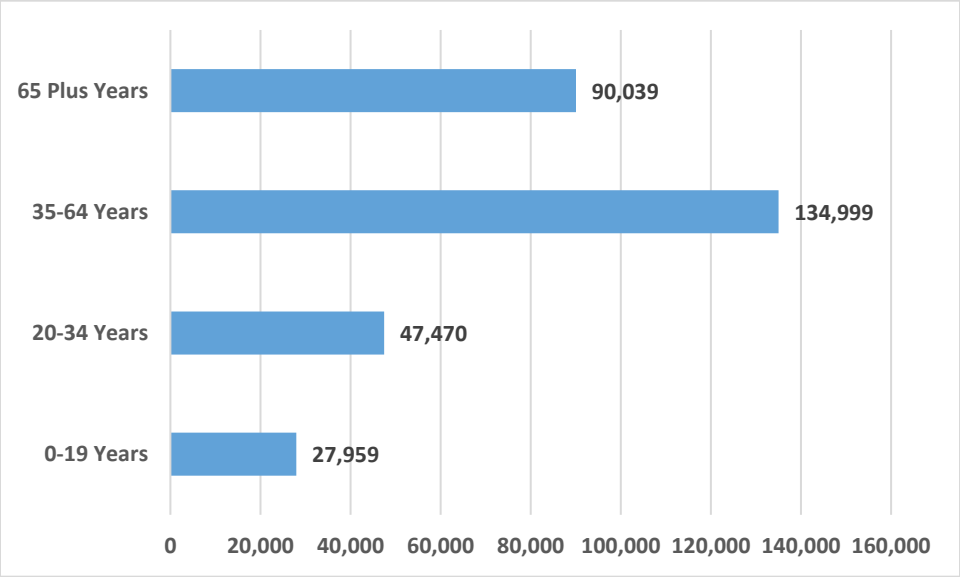


Table 2-7—CCC Plus (MLTSS) Program CY 2023 MCO Enrollment by Age Group[2-12]

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

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

CCC Plus (MLTSS) Program

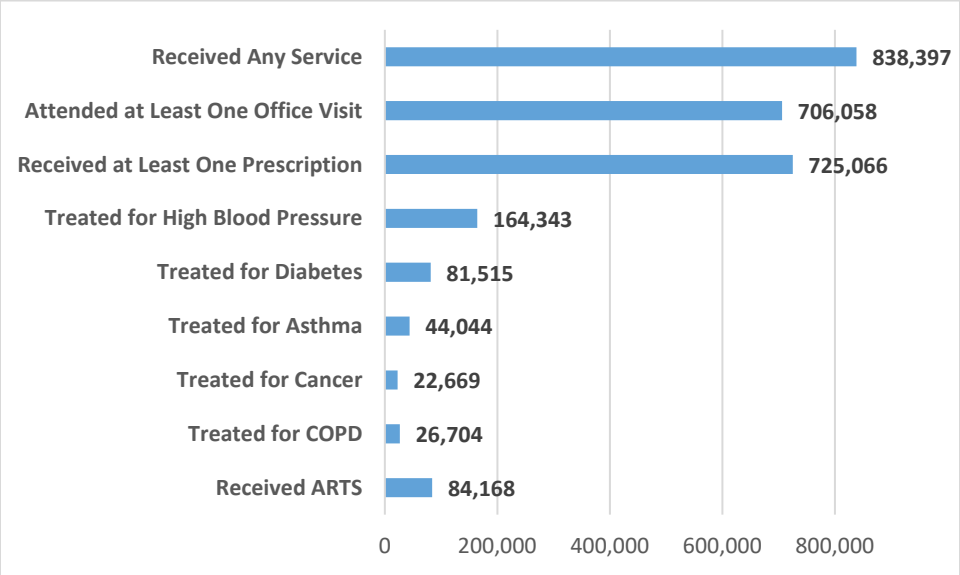
The CCC Plus (MLTSS) program's focus is to improve the quality of, access to, and efficiency of healthcare and services and supports for individuals residing in facilities and in-home and community-based settings. The CCC Plus (MLTSS) program approaches care delivery through a person-centered program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

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

2-11 Ibid.
2-12 Ibid.

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

Figure 2-6—CY 2023 Medicaid Expansion Service Provision



[2-13] Ibid.

[2-14] Cardinal Care, Virginia's Medicaid Program, Department of Medical Assistance Services. Medicaid Expansion Access. Available at: https://www.dmas.virginia.gov/data/medicaid-expansion-access. Accessed on: Feb 20, 2024.

Table 2-8—CY 2023 Medicaid Expansion Service Provision

Age Category	Number of Services Provided
Received ARTS	84,168
Treated for COPD	26,704
Treated for Cancer	22,669
Treated for Asthma	44,044
Treated for Diabetes	81,515
Treated for High Blood Pressure	164,343
Received at Least One Prescription	725,066
Attended at Least One Office Visit	706,058
Received Any Service	838,397

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

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

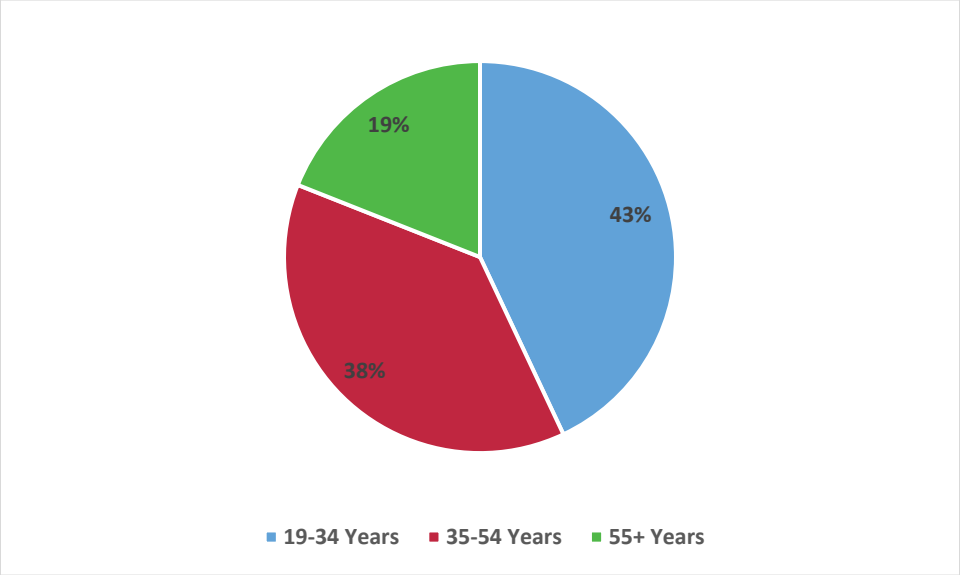


Table 2-9—CY 2023 Medicaid Expansion Percentage by Age Category

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

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

Figure 2-8—Medicaid Expansion Members by FPL Category

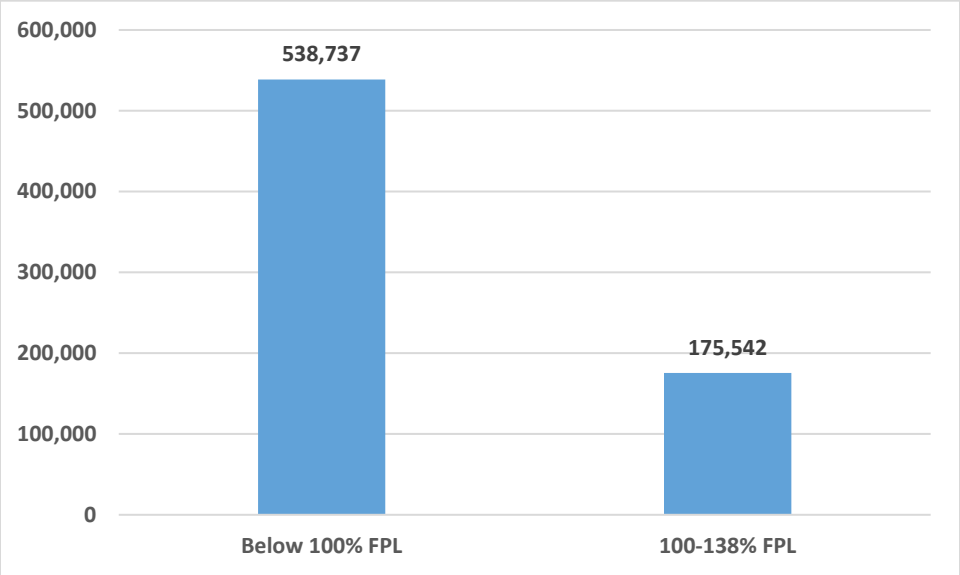


Table 2-10—Medicaid Expansion Members by FPL Category

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

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

Figure 2-9—Medicaid Expansion Members by Medicaid Region

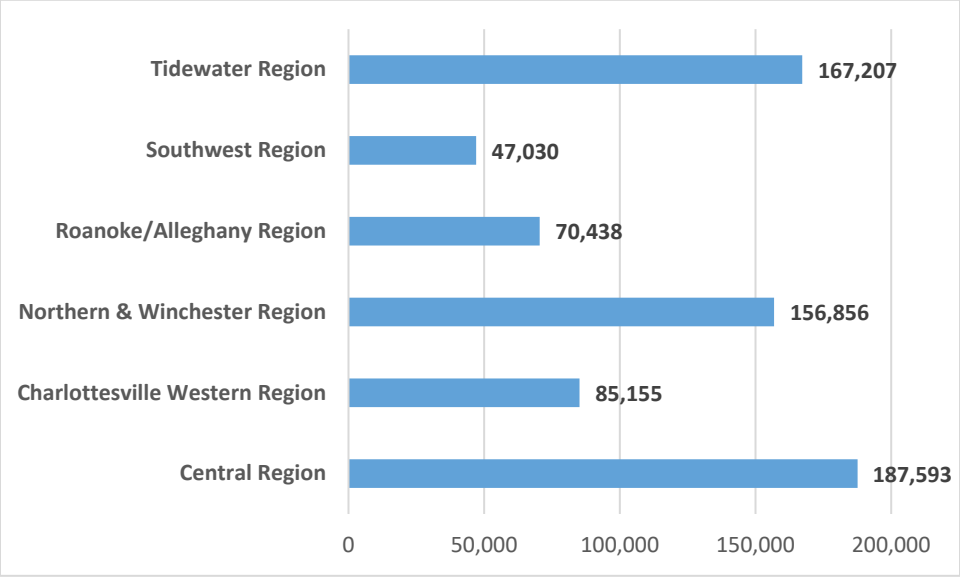


Table 2-11—Medicaid Expansion Members by Medicaid Region

Region	Number
Central Region	187,593
Charlottesville Western Region	85,155
Northern & Winchester Region	156,856
Roanoke/Alleghany Region	70,438
Southwest Region	47,030
Tidewater Region	167,207

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

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

Table 2-12—CCC Plus (MLTSS) Priorities

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

COVID-19 Response

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

DMAS implemented flexibilities for care and services for members receiving LTSS in addition to the flexibilities allowed for all members. DMAS also allowed flexibilities for specific face-to-face visit requirements and other HCBS requirements. The flexibilities were designed to maintain provider staffing, maximize access to care, and minimize viral spread through community contact to protect the most vulnerable populations. Table 2-13 describes the LTSS and other flexibilities allowed by DMAS during 2023.[2-15]

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

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

Waivers
Members who received less than one service per month were not discharged from an HCBS waiver. Any member with a significant change that requested an increase in support due to changes in medical condition and/or changes in natural supports was required to have an in-person visit.
Legally responsible individuals (parents of children under age 18 and spouses) were allowed to provide personal care/personal assistance services for reimbursement. This flexibility was active until November 11, 2023.
Personal care, respite, and companion aides hired by an agency were permitted to provide services prior to receiving the standard 40-hour training. CE/CC was provided through video conferencing for individuals who had the technological resources and ability to participate with remote CE/CC staff via virtual platforms.
In-home support services were delivered via an electronic method or telehealth. Group day services were provided through video conferencing for individuals who had the technological resources and ability to participate with remote group day staff members via virtual platforms.
Reinstatement of requirements for waiver service providers and MCOs to perform visits face-to-face as required by regulations.
Residential providers were permitted to not comply with the HCBS settings requirement at 42 CFR §441.301(c)(4)(vi)(D) that individuals were able to have visitors of their choosing at any time.
Waived the requirements at 42 CFR §483.35(d) (with the exception of 42 CFR §483.35[d][1][i]), which required that an SNF and NF may not employ anyone for longer than four months unless they met the training and certification requirements under 42 CFR §483.35(d).
Allowed beneficiaries to receive monthly monitoring when services were furnished on a less than monthly basis. This flexibility was active until November 11, 2023.
Appeals
For all appeals filed during the state of emergency, Medicaid members will automatically keep their coverage. This flexibility is continuing under a 1902(e)(14) waiver approved by CMS.
There will be no financial recovery for continued coverage for appeals filed during the period of the emergency. This flexibility is continuing under a 1902(e)(14) waiver approved by CMS.
Delay scheduling of fair hearings and issuing fair hearing decisions due to an emergency beyond the state's control. This flexibility is continuing under a 1902(e)(14) waiver approved by CMS for cases that involve existing coverage.
The state may offer to continue benefits to individuals who are requesting a fair hearing if the request comes later than the date of the action under 42 CFR §431.230. This flexibility is continuing under a 1902(e)(14) waiver approved by CMS.
Care and Services
Pre-approvals were not required for many critical medical services and devices, and some existing approvals were automatically extended.
Some rehabilitative services were permitted to be provided via telehealth.

[2-16] Ibid.

Care and Services
90-day supply for many drugs.
Drugs dispensed for 90 days were subject to a 75 percent refill "too-soon" edit. Patients only received a subsequent 90-day supply of drugs after 75 percent of the prescription had been used (approximately day 68). In addition, the agency made exceptions to the published PDL if drug shortages occurred.
ARTS—Opioid treatment programs were able to administer medication as take-home dosages, up to a 28-day supply. Take-home medications were made permanent for opioid treatment programs for up to 28 days. Allowance for home inductions via telemedicine for MOUD was permitted by the federal government.
A member's home was able to serve as the originating site for buprenorphine prescription.
A copay was not required for Medicaid and FAMIS members.
Conducted outreach to higher risk and older members to review critical needs.
Providers
Provider enrollment requirements were streamlined. Site visits, application fees, and certain background checks were waived to temporarily enroll providers in the Medicaid program. Deadlines for revalidations of providers were postponed.
Out-of-state providers were permitted to be reimbursed for services to Medicaid members.
Telehealth was permitted for many practice areas.
Telehealth policies—waiver of penalties for HIPAA noncompliance and other privacy requirements.
Facilities were fully reimbursed for services rendered to an unlicensed facility (during PHE). This rule applied to facility-based providers only.
Electronic signatures were accepted for visits that were conducted through telehealth.
Enrollment and Eligibility
Ended continuous coverage requirement, reinstatement of eligibility determinations and renewals.
Implemented processes to ensure members did not lose coverage due to lapses in paperwork.

Medicaid Enterprise System

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

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

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

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

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

Care Coordination

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

Training, Support, and Oversight of Care Coordination

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

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

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

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

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

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

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

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

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

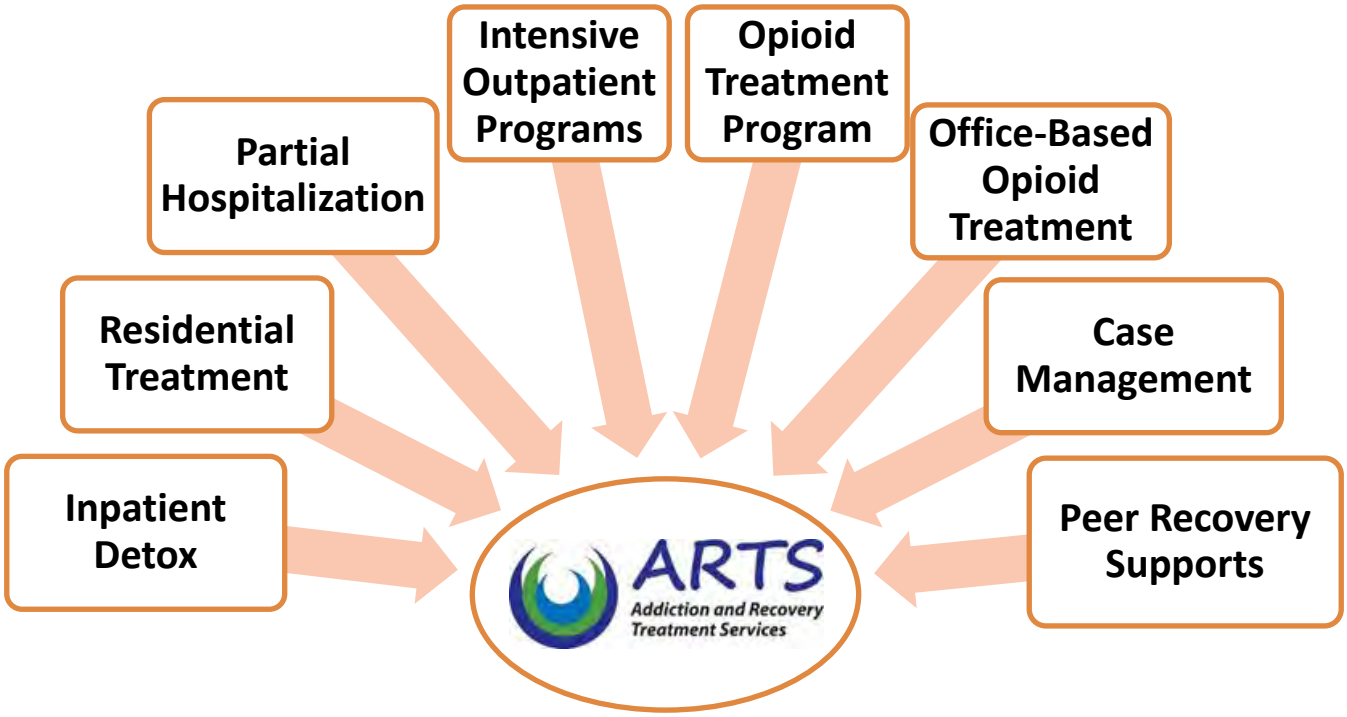
ARTS[2-17]

In 2017, DMAS implemented the ARTS benefit and carved in all services into the CCC Plus (MLTSS) and Medallion 4.0 (Acute) managed care contracts. The ARTS benefit focuses on treatment and recovery services for SUD, including OUD, AUD, and related conditions from SUD. The ARTS benefit expanded coverage of many ARTS services for Medicaid and CHIP members, including medications for OUD treatment, outpatient treatment, short-term residential treatment, and inpatient withdrawal management services. ARTS also increased provider reimbursement rates for many existing services and introduced a new care delivery model for treatment of OUD, the preferred OBAT provider. OBATs integrate MOUD with co-located behavioral and physical health by incentivizing increased use of care coordination activities. In addition, in accordance with requirements of Item 313, section ZZZ of the 2020 Appropriations Act, DMAS expanded the OBAT model effective March 1, 2022, to allow for other primary SUDs in addition to OUD.

ARTS outcomes are measured through reductions in SUD, OUD, and AUD ED utilization; reductions in inpatient admissions; increases in the number and type of healthcare practitioners providing SUD

[2-17] All data in this section were derived from a July 2021 report provided by DMAS titled, *Addiction and Recovery Treatment Services: Access, Utilization, and Quality of Care, 2016–2019*. Available at: FinalARTS3yearcomprehensivereportforPublishing_07142021(1).pdf (vcu.edu). Accessed on: Dec 14, 2023.

treatment and recovery services; and a decrease in opioid prescriptions. The goal is to ensure that members are matched to the right level of care to meet their evolving needs as they enter and progress through treatment. The ARTS benefit is a fully integrated physical health and BH continuum of care.



DMAS provided an April 2023 report titled, *Addiction and Recovery Treatment Services: Evaluation Report for State Fiscal Years 2020, 2021, and the first half of 2022* (report).[2-18] The report was prepared by the VCU School of Medicine, Health Behavior and Policy. The primary objective of this report is to examine SUD prevalence, treatment utilization, and outcomes among Virginia Medicaid members during SFYs 2020, 2021, and the first two quarters of SFY 2022 (covering the period July 2019 through December 2022). The report states that the Commonwealth of Virginia has made substantial progress since the implementation of the ARTS benefit in 2017 in building a robust treatment infrastructure for Medicaid members, with the number of treatment providers, members using services, and treatment rates for those with SUD diagnoses increasing every year since 2017. The highlights of the results of the implementation of the ARTS benefit discussed in the report include:

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

[2-18] VCU School of Medicine Health Behavior and Policy. *Addiction and Recovery Treatment Services: Evaluation Report for State Fiscal Years 2020, 2021, and the first half of 2022.* April 2023. Available at: https://hbp.vcu.edu/media/hbp-2023/FinalARTSComprehensiveReport.4.27.23.docx.pdf. Accessed on: Dec 15, 2023.

Increased prevalence of SUD

- Over 116,000 Medicaid members had a diagnosed SUD in SFY 2021, an increase of 14.3 percent from SFY 2020.
- OUD was the most frequently diagnosed SUD in SFY 2021 (48,008 members) followed by AUD (44,038 members); cannabis (35,911 members, a 26.9 percent increase); and stimulants, which includes the use of methamphetamines (27,226 members, a 19.4 percent increase).
- Use of ARTS services continued to increase between SFY 2020 and SFY 2021, with a total of 53,614 members receiving any type of ARTS treatment service in SFY 2021 (a 24 percent increase from SFY 2020).
- Treatment rates (the percentage of members with a diagnosed SUD who received any ARTS treatment service) are highest among members with an OUD diagnosis (69.4 percent) but lower among members with other SUD diagnoses, such as AUD (27.1 percent), stimulant use disorder (34.3 percent), and cannabis use disorder (16.5 percent).
- MOUD treatment rates (the percentage of those with OUD diagnoses who were treated with one of three MOUD medications) increased from 64 percent in SFY 2020 to 78 percent in SFY 2021. While buprenorphine remains the most frequently prescribed MOUD treatment, use of methadone and naltrexone also increased.

Residential treatment and pharmacotherapy account for half of ARTS expenditures

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

Treatment gaps in transitions from emergency departments and residential treatment

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

Recently incarcerated at great risk for OUD and overdoses

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

OUD-related overdose rates may have peaked

- OUD-related overdoses per 100,000 Medicaid members (fatal and nonfatal) increased 25 percent between SFY 2020 and SFY 2021.
- A more detailed quarterly analysis of overdose rates shows that while they rose precipitously through most of 2020, overdose rates have fluctuated since then. Also, overdose rates decreased during the first two quarters of SFY 2022.

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

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

The report indicated that the number of addiction treatment providers continued to increase in 2022. There were 1,540 practitioners in Virginia in 2022 who had federal authorization to prescribe buprenorphine, including 642 nurse practitioners and 148 physician assistants. Table 2-14 demonstrates the increase in ARTS providers by provider type.

Table 2-14—Providers of ARTS Services

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

Addiction Provider Type	# of Providers Before ARTS (2017)	# of Providers in 2020	# of Providers in 2022
Outpatient practitioners billing for ARTS services (ASAM 1)	1,087	5,089	6,184

Member Utilization of the ARTS Benefit

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

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

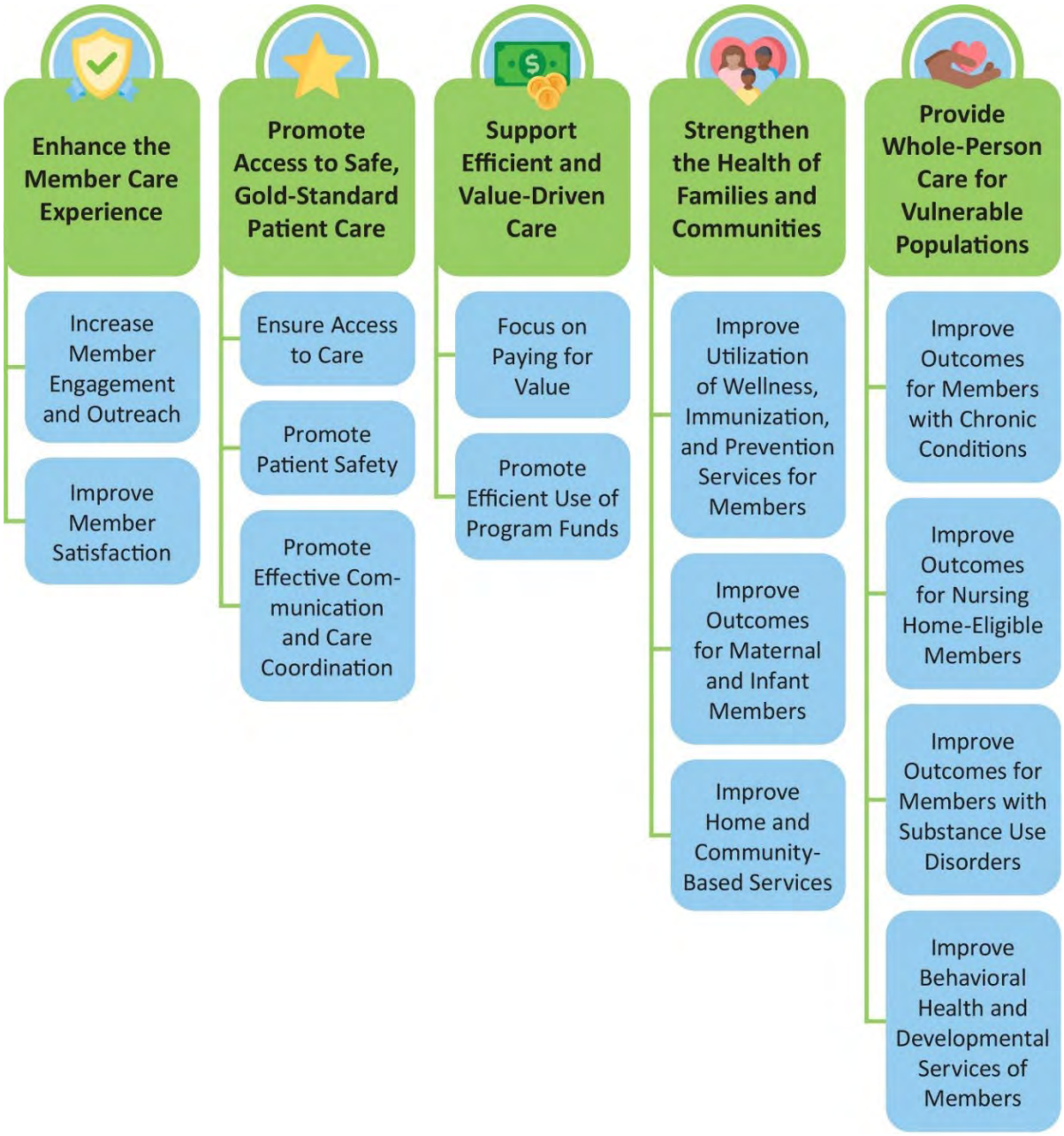
Between SFY 2020 and SFY 2021, the number of members with an ED visit increased. There were 45.4 SUD-related ED visits per 1,000 members in SFY 2021, a 5.6 percent increase from the prior year. Also, there were 9.7 OUD-related ED visits per 1,000 members in SFY 2021, a 15.5 percent increase from the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

Virginia's 2023–2025 Quality Strategy

During 2022, DMAS worked with HSAG to develop the fifth edition of its comprehensive Virginia 2023–2025 QS. DMAS implemented the 2023–2025 QS in 2023. DMAS' QS objectives are to continually improve the delivery of quality healthcare to all Medicaid and CHIP recipients served by the Virginia Medicaid managed care and FFS programs. Virginia's 2023–2025 QS provides the framework to accomplish its overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP system. The QS promotes the identification of creative initiatives to continually monitor, assess, and improve access to care along with supporting the provision of quality, satisfaction, and timeliness of services for Virginia Medicaid and CHIP recipients.

Virginia's 2023–2025 QS is DMAS' guide to achieving Virginia's mission, vision, values, goals, and objectives. DMAS is committed to upholding its core mission and values, which have been consistent across all versions of the Virginia QS. Figure 2-10 displays Virginia's 2023–2025 QS goals and objectives. Appendix F contains Virginia's 2023–2025 QS goals, objectives, and metrics.

Figure 2-10—Virginia's 2023–2025 QS Goals and Objectives



Quality Initiatives

DMAS considers its QS to be its roadmap for the future. The QS promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, the quality of care and services, member satisfaction, and the timeliness of service delivery for Virginia Medicaid and CHIP members. The Virginia QS strives to ensure members receive high-quality care that is safe, efficient, patient-

centered, timely, value and quality-based, data-driven, and equitable. DMAS conducts oversight of the MCOs to promote accountability and transparency for improving health outcomes.

Table 2-15 displays a sample of the initiatives DMAS implemented or continued during CY 2023 that support DMAS' efforts toward achieving the Virginia 2023–2025 QS goals and objectives.

Table 2-15—DMAS Quality Initiatives Driving Improvement

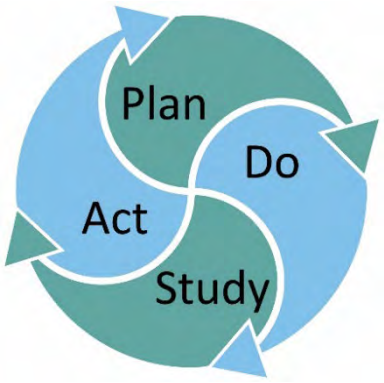
Virginia 2023–2025 QS Goal/Objective/Metric	DMAS Quality Initiative
Goal 5.: Providing Whole-Person Care for Vulnerable Populations **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders **Metric 5.3.1.2:** Follow-Up After Emergency Department Visit for Substance Use	DMAS was awarded funding from the Opioid Abatement Authority to support expansion of the Emergency Department Bridge Clinic model throughout the Commonwealth and provide training and technical assistance to hospitals and health groups who implement this model. This work will begin in October 2023.
Goal 5.: Providing Whole-Person Care for Vulnerable Populations **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders **Metric 5.3.1.2:** Follow-Up After Emergency Department Visit for Substance Use	Through numerous efforts, including the SUPPORT Act Grant, DMAS has been working with stakeholders to identify ways to increase engagement and retention in SUD treatment. This includes supporting the Emergency Department Bridge Clinic model, supporting providers looking to provide Peer Recovery Support Services, providing technical assistance on the ASAM multidimensional assessment to providers, and other initiatives. DMAS is also exploring ways to support members with SUD who are being released from legal/carceral settings by exploring options to strengthen supports provided during that transition.

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

Appendix D provides examples of the quality initiatives the MCOs highlighted as their efforts toward achieving the Virginia 2023–2025 QS goals and objectives.

Best and Emerging Practices

The Virginia 2023–2025 QS promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, the quality of care and services, member satisfaction, and the timeliness of service delivery for Virginia Medicaid and CHIP members. The DMAS QS strives to ensure members receive high-quality care that is safe, efficient, patient-centered, timely, value- and quality-based, data-driven, and equitable. DMAS conducts oversight of the MCOs to promote accountability and transparency for improving health outcomes.



Emerging practices can be achieved by incorporating evidence-based guidelines into operational structures, policies, and procedures. Emerging practices are born out of continuous QI efforts to improve a service, health outcome, systems process, or operational procedure. The goal of these efforts is to improve the quality of and access to services and to improve health outcomes. Only through continual measurement and analyses to determine the efficacy of an intervention can an emerging practice be identified. Therefore, DMAS encourages the MCOs to continually track and monitor the effectiveness of QI initiatives and interventions, using a PDSA cycle, to determine if the benefit of the intervention outweighs the effort and cost. DMAS also actively promotes the use of nationally recognized protocols, standards of care, and benchmarks by which MCO performance is measured. DMAS' best and emerging practices are found in Appendix C.

3. MCO Comparative Information

Comparative Analysis of the MCOs by Activity

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

Definitions

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

Quality

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

Access

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

Timeliness

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

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

MCO Comparative and Statewide Aggregate PIP Results

PIP Highlights

In 2023, the MCOs continued the HEDIS-based DMAS-selected topics of *Ambulatory Care (AMB)—Emergency Department (ED) Visits* and *Follow-Up After Discharge* (following the *Transitions of Care—TRC*) specifications. The MCOs progressed to reporting baseline data and interventions, updating their PIP Submission Forms through Step 8 (Quality Improvement Strategies and Interventions). HSAG validated the baseline data and QI processes and interventions implemented and provided feedback and recommendations to the MCOs in the initial validation tools. The MCOs had an opportunity to seek technical assistance and resubmit the PIPs with corrections or additional documentation to potentially improve the 2023 final PIP validation score and overall confidence rating.

Strengths, Weaknesses, and Recommendations

Strengths	
+	Four of the six MCOs received 100 percent validation scores across all evaluation elements for Steps 1 through 8 and were assigned a *High Confidence* level for both PIPs. These MCOs calculated and reported baseline data accurately and implemented targeted interventions that addressed the identified barriers and developed sound methodologies for evaluating the effectiveness for each intervention.
Weaknesses and Recommendations	
−	**Weakness:** Two of the six MCOs have opportunities for improvement related to accurately defining performance indicators, calculating and reporting baseline data correctly, and effectively evaluating the effectiveness of each individual intervention.
	Recommendations: The MCOs should ensure that all validation feedback is addressed. The MCOs should define the performance indicators correctly and ensure that the measurement data for the performance indicators are calculated and reported accurately. The MCOs should develop methodologically sound processes for evaluating the effectiveness of each intervention and ensure that the evaluation data are calculated and reported correctly in the PIP Submission Form. The MCOs should ensure that the status or next steps for each intervention are data-driven decisions.

Table 3-1—PIP Baseline Performance Results

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

MCO Comparative and Statewide Aggregate PMV Results

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

PMV Highlights

The PMV highlights are included in Table 3-2.

Table 3-2—PM Strengths and Weaknesses

Domain	Strengths	Weaknesses
Access and Preventive Care	All six MCOs' rates met or exceeded the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure.	All reportable MCO rates fell below the 50th percentile for the *Cervical Cancer Screening, Prenatal and Postpartum Care,* and *Use of Imaging Studies for Low Back Pain* measures.
		Four of the six MCOs' rates fell below the 50th percentile for the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* and five of six MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* measures.

Domain	Strengths	Weaknesses
Behavioral Health	All six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment, Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total, Diagnosed Mental Health Disorders—Total, Diagnosed Substance Use Disorders—Alcohol disorder—Total, Diagnosed Substance Use Disorders—Opioid disorder—Total, Diagnosed Substance Use Disorders—Other or unspecified drugs—Total,* and *Diagnosed Substance Use Disorders—Any disorder—Total* PM indicators.	Five of the six MCOs' rates fell below the 50th percentile for the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia—Total* measure. All six MCOs' rates fell below the 50th percentile for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total,* and all three MCOs' rates without a small denominator fell below the 50th percentile for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measures.
	Five of the six MCOs' rates for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Total* measures met or exceeded the 50th percentile.	
Taking Care of Children	Five of six MCOs' rates met or exceeded the 50th percentile for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total F*and *Blood Glucose and Cholesterol Testing—Total* PM indicators.	All six MCOs' rates for the *Immunizations for Adolescents—Combination 2 Meningococcal, Tdap, Human Papillomavirus [HPV])* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total, Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total* PM indicators fell below the 50th percentile.
Living With Illness	MCO performance within the Living With Illness domain was the highest for the *Medical Assistance With Smoking and Tobacco Use Cessation* measure, with five of six MCOs' rates meeting or exceeding the 50th percentile for the *Discussing*	Five of the six MCOs' rates fell below the 50th percentile for the *Blood Pressure Control for Patients With Diabetes—Total* and *Controlling High Blood Pressure—Total* measures.

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

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

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

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

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

- *Initiation and Engagement of Substance Use Disorder Treatment*

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

Table 3-3—HSAG MCO PMV Results

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

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

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

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

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

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

MCO Comparative and Statewide Aggregate HEDIS Results

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Strengths, Weaknesses, and Recommendations

Strengths	
+	Within the Access and Preventive Care domain, the MCOs demonstrated strength related to access to care, as all six MCOs' rates met or exceeded the 50th percentile related to the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator.
+	The MCOs demonstrated strength within the Behavioral Health domain related to the use of medication to treat mental health conditions, as all six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* PM indicators. In addition, follow-up care for BH conditions represented a strength, as five of six MCOs' rates met or exceeded the 50th percentile for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Total* PM indicators.
+	Within the Taking Care of Children domain, the MCOs demonstrated strength related to metabolic monitoring for children and adolescents on antipsychotics, as five of six MCOs' rates met or exceeded the 50th percentile for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total* and *Blood Glucose and Cholesterol Testing—Total* PM indicators.
+	MCO performance within the Living With Illness domain showed strength with five of six MCOs' rates having met or exceeded the 50th percentile for the *Asthma Medication Ratio—Total, Eye Exam for Patients With Diabetes—Total, Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Total,* and *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications* PM indicators. Aetna and United demonstrated the highest performance with nine of the 12 (75.0 percent) measure rates meeting or exceeding the 50th percentile.
+	The MCOs demonstrated strength within the Use of Opioids domain, as four of six MCOs' rates met or exceeded the 50th percentile for two of the three *Use of Opioids from Multiple Providers* PM indicators. Molina and VA Premier met or exceeded the 50th percentile for three of four (75.0 percent) measure rates that were compared to national benchmarks. Moreover, VA Premier had four of four (100.0 percent) of the measure rates exceeding the Virginia aggregate.
Weaknesses and Recommendations	
−	**Weakness:** Within the Access and Preventive Care domain, cancer screenings for women, pregnancy care, and appropriate use of imaging studies for low back pain represent an area for opportunity Virginia-wide, as all reportable MCO rates fell below the 50th percentile for the *Cervical Cancer Screening, Prenatal and Postpartum—Timeliness of Prenatal Care* and *Postpartum Care,* and *Use of Imaging Studies for Low Back Pain* measures. Additionally, five of six MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* measure. Aetna, HealthKeepers, and VA Premier demonstrated the lowest performance in the Access and Preventive Care domain, falling below the 50th percentile for six of seven (85.7 percent) measure rates within the domain. This performance

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

[3-3] National Committee for Quality Assurance. Breast Cancer Screening. Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Dec 27, 2023.
[3-4] Centers for Disease Control and Prevention. Preventing Breast, Cervical, and Colorectal Cancer Deaths: Assessing the Impact of Increased Screening. Available at: https://www.cdc.gov/pcd/issues/2020/20_0039.htm. Accessed on: Nov 8, 2023.
[3-5] National Committee for Quality Assurance. Prenatal and Postpartum Care. Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Oct 27, 2023.
[3-6] National Committee for Quality Assurance. Use of Imaging Studies for Low Back Pain. Available at: https://www.ncqa.org/hedis/measures/use-of-imaging-studies-for-low-back-pain/. Accessed on: Oct 27, 2023.

Weaknesses and Recommendations	
	This performance suggests members have not received timely follow-up after hospitalizations for mental illness. Individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes and decrease the likelihood of re-hospitalization and the overall cost of outpatient care.[3-7] Additionally, MCO performance related to the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure indicator demonstrates that first-line psychosocial interventions were underutilized which may result in children and adolescents incurring unnecessary risks associated with antipsychotic medications.[3-8]
	Recommendations: HSAG recommends that the MCOs develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization. HSAG recommends that the MCOs consider if there are disparities within the MCOs' populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Additionally, HSAG recommends that the MCOs leverage the CMS Improving Behavioral Health Follow-up Care Learning Collaborative[3-9] materials to identify potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care. Furthermore, HSAG recommends that the MCOs identify factors contributing to underutilization of first-line psychosocial interventions for children and adolescents. Based on these factors, MCOs should leverage their annual QAPIs to determine appropriate areas of focus to improve the utilization of such interventions, and to track the effectiveness of programs the MCOs implement to improve in this area.
−	**Weakness:** Within the Taking Care of Children domain, all six MCOs have opportunities for improvement related to the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total* PM indicator rates, as none of the MCOs' rates for these PM indicators met or exceeded the 50th percentile. Vaccines are a safe and effective way to protect adolescents against potential deadly diseases.[3-10] While the COVID-19 PHE contributed to a decline in routine pediatric vaccine ordering and doses administered, the MCOs' continued performance below the 50th percentile suggests children are not receiving

3-7 National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness. Available at: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Oct 27, 2023.

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

3-9 Medicaid.gov. Improving Behavioral Health Follow-up Care Learning Collaborative. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/behavioral-health-learning-collaborative/index.html. Accessed on: Dec 13, 2023.

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

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

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

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

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

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

[3-15] American Diabetes Association. Focus on Diabetes Impact Report. Available at: https://diabetes.org/sites/default/files/2023-09/ADA_2022_FOD_Impact_Report_FINAL.pdf. Accessed on: Dec 12, 2023.

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

Compliance With Standards Monitoring

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

Operational Systems Reviews

Table 3-5 displays the scores for the current three-year period of OSRs conducted in 2021.

Table 3-5—Standards and Scores in the OSR for the Three-Year Period: SFY 2019–SFY 2021

Standard	CFR	Standard Name	Aetna	HealthKeepers	Molina	Optima	United	VA Premier	Overall Score
I.	438.56	Enrollment and Disenrollment: Requirements and Limitations*	100%	100%	100%	100%	100%	85.7%	97.6%
II.	438.100 438.224	Member Rights* and Confidentiality	85.7%	100%	100%	100%	100%	100%	97.6%
III.	438.10	Member Information	100%	100%	95.2%	95.2%	100%	90.5%	96.8%
IV.	438.114	Emergency and Poststabilization Services*	100%	100%	100%	100%	100%	100%	100%

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

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

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

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

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

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

Strengths, Weaknesses, and Recommendations

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

Cardinal Care Program Readiness Reviews

DMAS contracted with HSAG to conduct readiness reviews for the Cardinal Care program that focused on the MCOs' ability and capacity to comply with the Cardinal Care contract requirements and the 2020 Medicaid and CHIP Managed Care Final Rules.[3-17] The readiness review included an assessment of all key program areas noted in 42 CFR §438.66(d)(4). A readiness review primary objective was to assess the ability and capacity of the MCOs to satisfactorily perform the new Model of Care contract requirements. In addition, HSAG assessed the ability and capacity of the MCOs to perform satisfactorily in key operational and administrative functions outlined in the Medicaid and CHIP Managed Care Final Rules and the Cardinal Care MCO contract. Table 3-6 displays the summary of results for the comprehensive 2023 Cardinal Care program readiness review.

Table 3-6—Summary of Results for the Comprehensive 2023 Cardinal Care Program Readiness Review

Standard	CFR	Standard Name	Aetna	HealthKeepers	Molina	Optima	United	VA Premier	Overall Score
OSR Results*									
I.	438.56	Enrollment and Disenrollment: Requirements and Limitations*	100%	100%	100%	100%	100%	100%	100%
II.	438.100 438.224	Member Rights* and Confidentiality	100%	100%	100%	100%	100%	100%	100%
III.	438.10	Member Information	100%	100%	100%	100%	100%	100%	100%
IV.	438.114	Emergency and Poststabilization Services*	100%	100%	100%	100%	100%	100%	100%
V.	438.206 438.207	Assurance of Adequate Capacity and Availability of Services	100%	100%	100%	100%	100%	100%	100%

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

Standard	CFR	Standard Name	Aetna	HealthKeepers	Molina	Optima	United	VA Premier	Overall Score
OSR Results*									
VI.	438.208	Coordination and Continuity of Care	100%	100%	100%	100%	100%	100%	100%
VII.	438.210	Coverage and Authorization of Services	100%	100%	100%	100%	100%	100%	100%
VIII.	438.214	Provider Selection	100%	100%	100%	100%	100%	100%	100%
IX.	438.230	Subcontractual Relationships and Delegation	100%	100%	100%	100%	100%	100%	100%
X.	438.236	Practice Guidelines	100%	100%	100%	100%	100%	100%	100%
XI.	438.242	Health Information Systems**	100%	100%	100%	100%	100%	100%	100%
XII.	438.330	Quality Assessment and Performance Improvement	100%	100%	100%	100%	100%	100%	100%
XIII	438.228	Grievance and Appeal Systems	100%	100%	100%	100%	100%	100%	100%
XIV.	438.608	Program Integrity	100%	100%	100%	100%	100%	100%	100%
XV.	441.58 Section 1905 of the SSA	EPSDT Services	100%	100%	100%	100%	100%	100%	100%
		OSR Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Readiness Review Results**									
Network Adequacy			95.0%	95.0%	100%	95.0	90.0%	90.0%	94.2%
Model of Care			100%	100%	100%	100%	98.1%	100%	99.7%
Organizational Structure, Operations, and Systems			100%	100%	100%	100%	100%	100%	100%
		Readiness Review Total	**99.2%**	**99.2%**	**100%**	**99.2%**	**97.0%**	**98.5%**	
Readiness Review CAP Review Results									
Phase I CAP Review Results			100%	100%	100%	100%	100%	100%	100%
Phase II CAP Review Results			100%	100%	100%	100%	100%	100%	100%
Phase III CAP Review Results			100%	100%	100%	100%	100%	100%	100%
		Comprehensive Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.
Number *Met* = The total number of elements within each standard that supported readiness.
Number *Not Met* = The total number of elements within each standard that did not support readiness.
Comprehensive Total = 2021 OSR and 2023 Readiness Review Results. The Comprehensive Total Number *Met* was calculated by adding the OSR *Deeming* elements, the *Met* elements, and the *DMAS-approved CAPs*.
*OSR scores include DMAS review of the MCOs' implementation of CAPs.
**Score includes Phase II and Phase II Corrective Action Plan element review scores.

Network Adequacy Validation

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

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

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

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

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

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

In February 2023, CMS released the final *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (EQR NAV Protocol).[3-18] The protocol requires that states must ensure that Medicaid and CHIP managed care plans maintain provider networks that are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services. As set forth in 42 CFR §438.68, states are required to set quantitative network adequacy standards for MCOs that account for regional factors and the needs of the state's Medicaid and CHIP populations. HSAG conducts the validation of MCO network adequacy during the preceding 12 months to comply with 42 CFR §438.68, including validating data to determine whether the network standards, as defined by DMAS, were met.

DMAS defines network adequacy standards in the State's QS as required under 42 CFR §340(b)(1). DMAS works with the MCOs to drive improvement in network adequacy and beneficiary access to care, according to the Virginia QS goals and objectives and QAPI program.

DMAS requires the MCOs to conduct various activities to assess the adequacy of their networks as well as maintain provider and beneficiary data sets that allow monitoring of their networks' adequacy. DMAS requires MCOs to conduct:

- Geo-mapping to determine if provider networks meet quantitative time and distance standards.
- Calculation of provider-to-enrollee ratios, by type of provider and geographic region.
- Analysis of in- and out-of-network utilization data to determine gaps in realized access.
- Appointment availability and accessibility studies, including the proportion of in-network providers accepting new patients and the average wait time for an appointment.
- Validation of provider directory information.

DMAS and the MCOs share data, analyses, and results from their network adequacy assessment activities with HSAG. HSAG's NAV activity includes (1) validating the data and methods used by MCOs to assess network adequacy, and (2) validating the results and generating a validation rating. HSAG will report the validation findings in the annual EQR technical report, beginning in 2025. The DMAS NAV activity will review and validate the MCO NAV data submitted to ensure accuracy, completeness, and consistency. Through this process, HSAG will evaluate each MCO's ability to:

- Collect, capture, and monitor valid network adequacy data.
- Evaluate the adequacy of the provider network using sound analytic methods.
- Produce accurate results to support MCO network adequacy monitoring.
- Provide DMAS with accurate network adequacy indicator rates for each required standard.

HSAG will calculate a validation rating for each network adequacy indicator for each MCO.

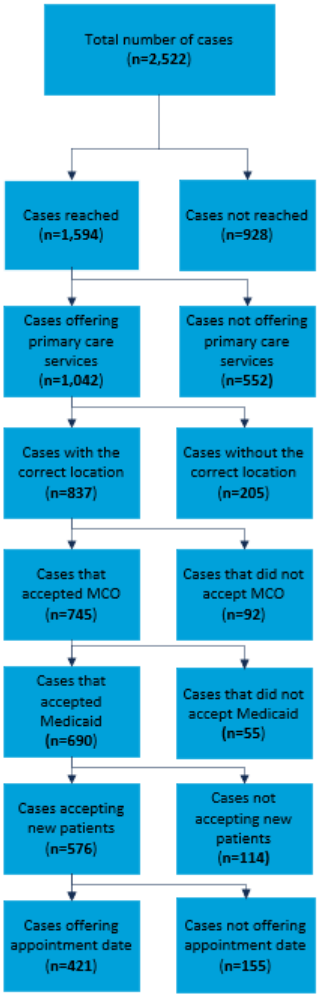
[3-18] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 15,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

Primary Care Provider Secret Shopper Surveys

Secret Shopper Project Highlights

HSAG attempted to contact 2,522 sampled provider locations (i.e., "cases"), with an overall response rate of 63.2 percent across provider locations. Nonresponsive cases included both provider locations that could not be reached (n=928) and locations that did not provide primary care services (n=552) as shown in Figure 3-1.

Figure 3-1—Secret Shopper Survey Data Collection Hierarchy and Count of Cases With Each Outcome



As shown in Table 3-7, among the cases where the survey callers indicated successful contact with the provider location, 46.7 percent stated that the office accepted the MCO, 43.3 percent stated that the office accepted the VA Medicaid program, and 36.1 percent stated that the office accepted new patients.

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

MCO	Denominator[1]	Accepting MCO	Accepting VA Medicaid	Accepting New Patients
Aetna	184	20.1%	19.0%	15.8%
HealthKeepers	273	45.4%	41.8%	34.1%
Molina	254	56.3%	54.3%	41.7%
Optima	283	55.5%	47.7%	41.3%
United	301	44.5%	40.5%	34.2%
VA Premier	299	50.2%	48.8%	42.8%
MCO Total	**1,594**	**46.7%**	**43.3%**	**36.1%**

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

As shown in Figure 3-2 and Figure 3-3, 74.0 percent of calls were offered an appointment date for a routine appointment and 72.3 percent were offered an appointment date for an urgent appointment. Of the appointments that were offered, 74.5 percent met the DMAS standard of offering an appointment within 30 days for routine appointments, with values ranging from 50.0 percent for Aetna to 88.6 percent for Molina. For urgent visit appointments offered, 16.0 percent met the DMAS standard of offering an appointment within one day for urgent appointments, with rates ranging from 0 percent for Aetna to 25.9 percent for VA Premier.

Figure 3-2—New Patient Appointment Availability

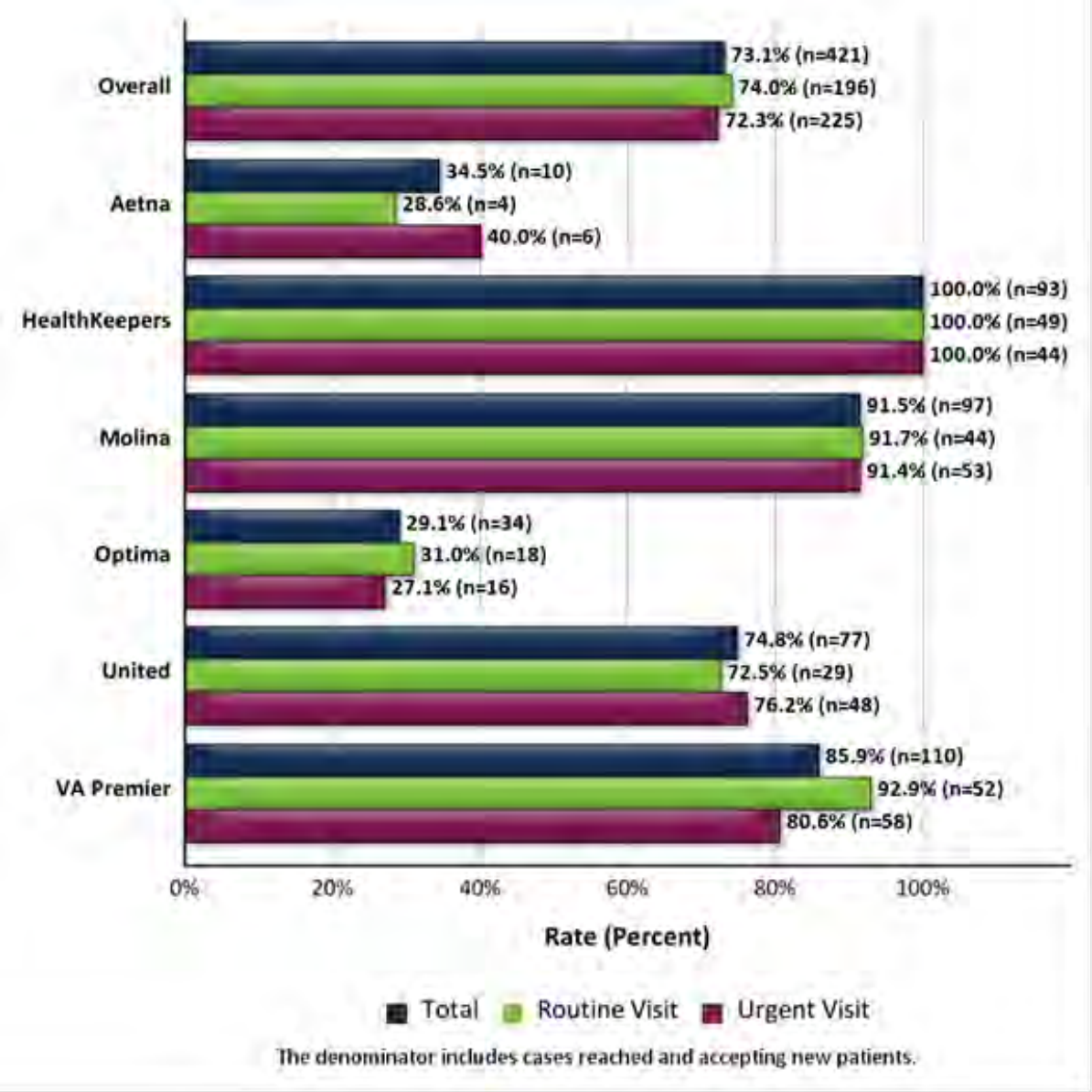
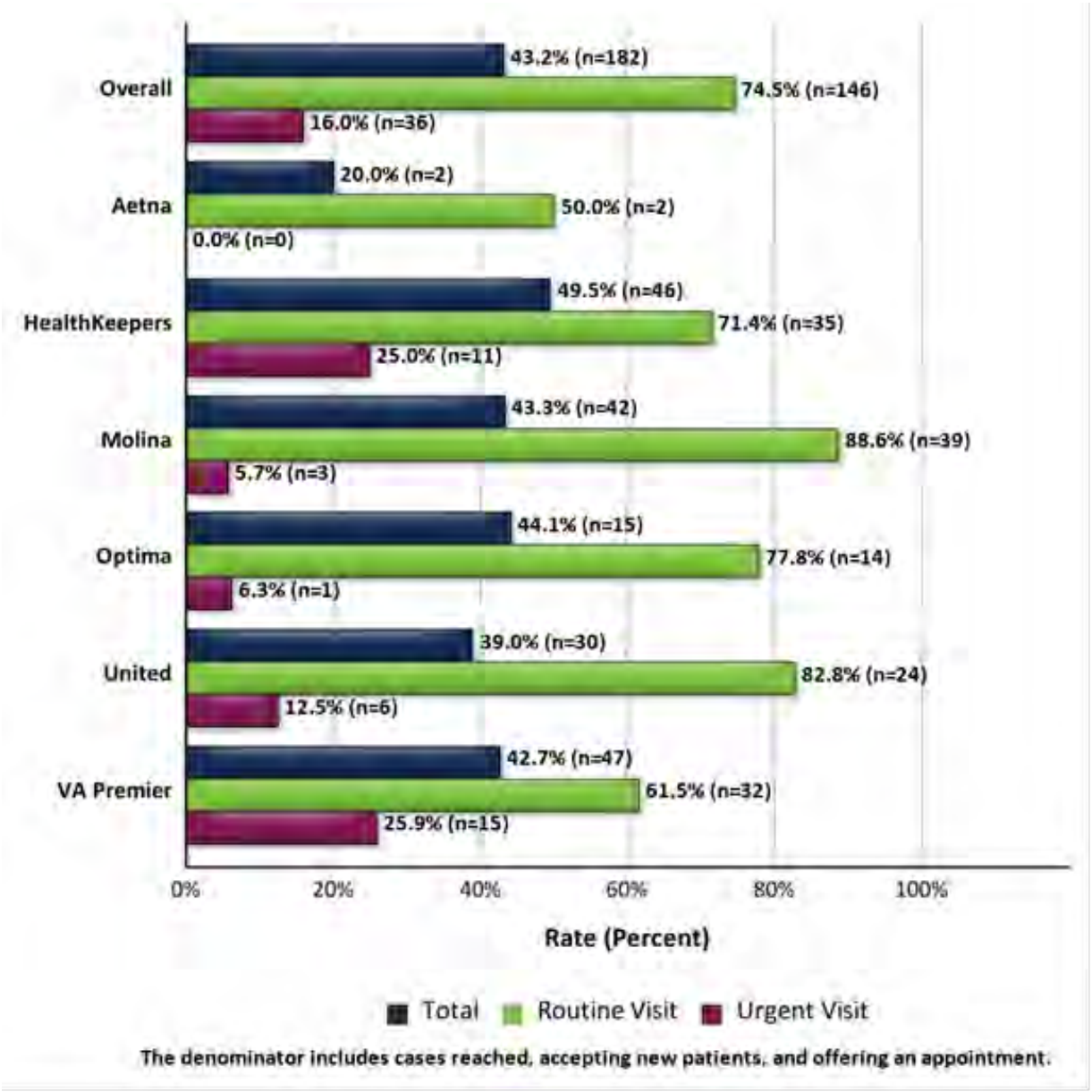


Figure 3-3—Appointments Meeting Compliance Standards



Strengths, Weaknesses, and Recommendations

Weaknesses and Recommendations	
–	**Weakness:** Overall, approximately 83 percent (n=2,101) of cases were unable to be reached, did not offer primary care services, were not at the sampled location, did not accept the requested MCO, did not accept VA Medicaid, were not accepting new patients, or were unable to offer an appointment date. The overall response rate was 63.2 percent, with 46.7 percent of the offices accepting the MCO, 43.3 percent accepting VA Medicaid, and 36.1 percent accepting new patients.
	Recommendations: Since DMAS' enrollment broker supplied HSAG with the PCP data used for this survey, HSAG recommends that DMAS work with the enrollment broker to address the data deficiencies identified during the survey (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify the location's address and appropriate provider type and specialty. DMAS could also consider requesting that the MCOs provide evidence of training offered by the MCOs to providers' offices regarding the MCO plan names and benefit coverage. Evidence should demonstrate that the office staff members responsible for scheduling appointments have been educated on the MCO names and benefit coverage, and that the offices have a plan in place for educating new staff members in the event of staff turnover.
Weaknesses and Recommendations	
–	**Weakness:** Among cases offering an appointment, 73.1 percent provided a routine or urgent care appointment date. For cases that were offered a routine appointment, 74.5 percent were compliant with the 30-day standard for routine primary care services. For cases that were offered an urgent appointment, 16.0 percent were compliant with the one-day (i.e., 24 hours) standard for urgent primary care services.
	Recommendations: HSAG recommends that DMAS and the MCOs consider conducting a review of the provider offices' requirements to ensure that these considerations for scheduling appointments do not unduly burden members' ability to access primary care and to streamline the process of scheduling new patient appointments within the routine (30-day) and urgent (one-day) appointment standards.

Conclusions

Survey findings support specific opportunities for improving the quality of PCP data and streamlining the new patient appointment scheduling process for VA Medicaid members. Approximately 83 percent (n=2,101) of overall cases were unable to be reached, did not offer primary care services, were not at the sampled location, did not accept the requested MCO, did not accept VA Medicaid, were not accepting new patients, or were unable to offer an appointment date. Key findings are listed below:

- The CY 2022–2023 PCP secret shopper survey overall response rate was 63.2 percent, primarily because the provider location was not able to be reached (36.8 percent) or the location did not provide primary care services (21.9 percent).

  - Response rates by MCO ranged from 44.0 percent (Aetna) to 75.9 percent (VA Premier).
  - Aetna had the highest percentage of cases where the provider location was not able to be reached (56.0 percent).
  - United had the highest percentage of cases where the provider location did not offer primary care services (31.4 percent).
- Of the responsive cases:
  - 8.1 percent reported that the sampled address was incorrect, and a forwarding number was not available for the requested address. Aetna had the highest rate (23.9 percent) and Molina had the lowest rate (2.0 percent) of cases with incorrect addresses.
  - 46.7 percent accepted the MCO. Aetna had the lowest rate (20.1 percent) and Molina had the highest rate (56.3 percent) of responsive cases accepting the MCO's members.
  - 43.3 percent accepted VA Medicaid. Aetna had the lowest rate (19.0 percent) and Molina had the highest rate (54.3 percent) of responsive cases accepting VA Medicaid.
  - 36.1 percent of provider locations reported accepting new patients. New patient acceptance rates ranged from 15.8 percent (Aetna) to 42.8 percent (VA Premier). Comments provided by locations not taking new patients included only taking the MCO and/or VA Medicaid for established patients, not taking new patients due to provider retirement, and not taking new patients at the location at all.
- Among cases offering an appointment, 73.1 percent provided a routine or urgent care appointment date. There was not a substantial difference in the percentage of appointments offered by appointment type (i.e., routine or urgent). Common reasons for not scheduling routine or urgent appointments included requiring preregistration, personal information, or medical records prior to scheduling the appointment.
- The overall median wait time was 12 and 14 calendar days for an urgent and routine appointment, respectively.
- For cases that were offered a routine appointment, 74.5 percent were compliant with the 30-day standard for routine primary care services. For cases that were offered an urgent appointment, 16.0 percent were compliant with the one-day (i.e., 24 hours) standard for urgent primary care services.

Other Surveys Conducted

DMAS also conducted the following member experience surveys:

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

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

Statewide Aggregate CAHPS Results

Adult Medicaid

Table 3-8 and Table 3-9 present the 2023 top-box scores for each MCO and the CCC Plus (MLTSS) program (i.e., all MCOs combined) compared to the 2022 adult Medicaid CAHPS scores for the global ratings and composite measures. The 2023 CAHPS scores for each MCO and the CCC Plus (MLTSS) program were also compared to the 2022 NCQA adult Medicaid national averages.

Table 3-8—Comparison of 2022 and 2023 Adult Global Top-Box Scores

	Rating of Health Plan		*Rating of All Health Care*		*Rating of Personal Doctor*		*Rating of Specialist Seen Most Often*	
	2022	*2023*	*2022*	*2023*	*2022*	*2023*	*2022*	*2023*
CCC Plus (MLTSS) Program	66.6%	65.4%	58.8%	58.0%	70.5%	71.8%	72.6%	68.9%
Aetna	63.2%	67.8%	53.6%	51.5%	68.1%	68.1%	73.4%	71.1%
HealthKeepers	67.8%	67.0%	61.5%	59.5%	69.2%	73.2%	74.5%	66.7%
Molina	56.9%	61.5%	56.5%	56.2%	70.4%	67.9%	69.5%	68.1%
Optima	69.1%	68.1%	63.1%	61.8%	72.3%	75.7%	77.7%	74.4%
United	68.0%	63.8%	56.5%	62.8%	69.7%	69.8%	66.9%	68.3%
VA Premier	67.4%	60.7%	56.3%	55.9%	72.0%	70.9%	67.6%	64.8%

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

▲ *Statistically significantly higher in 2023 than in 2022.*

▼ *Statistically significantly lower in 2023 than in 2022.*

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Table 3-9—Comparison of 2022 and 2023 Adult Composite Top-Box Scores

	Getting Needed Care		*Getting Care Quickly*		*How Well Doctors Communicate*		*Customer Service*	
	2022	*2023*	*2022*	*2023*	*2022*	*2023*	*2022*	*2023*
CCC Plus (MLTSS) Program	85.7%	83.3%	85.8%	82.6%▼	93.1%	93.4%	90.4%	91.2%
Aetna	82.6%	80.5%	82.4%	83.1%	92.7%	93.8%	89.1%	87.4%
HealthKeepers	86.0%	82.5%	85.1%	84.9%	92.8%	94.9%	90.6%	93.3%
Molina	84.4%	81.1%	80.8%	77.2%	91.6%	91.0%	87.9%	86.2%
Optima	84.5%	86.2%	86.5%	84.8%	94.7%	92.7%	92.8%	92.6%
United	81.9%	84.5%	81.7%	81.7%	93.2%	93.5%	90.8%	87.8%
VA Premier	90.1%	83.6%▼	90.6%	79.2%▼	92.5%	92.7%	89.5%	93.0%

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

▲ *Statistically significantly higher in 2023 than in 2022.*

▼ *Statistically significantly lower in 2023 than in 2022.*

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Strengths, Weaknesses, and Recommendations

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

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

Child Medicaid

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

Table 3-10—Comparison of 2022 and 2023 Child Global Top-Box Scores

	Rating of Health Plan		Rating of All Health Care		Rating of Personal Doctor		Rating of Specialist Seen Most Often	
	2022	2023	2022	2023	2022	2023	2022	2023
CCC Plus (MLTSS) Program	65.6%	65.5%	66.1%	63.9%	75.6%	75.8%	72.3%	72.4%
Aetna	66.1%	63.9%	62.5%	62.3%	73.1%	72.6%	64.5%	69.2%
HealthKeepers	65.9%	65.3%	63.9%	60.4%	72.3%	70.4%	71.1%	71.4%
Molina	45.2%+	59.0%+	66.7%+	56.5%+	76.2%+	60.6%+	75.0%+	60.0%+
Optima	70.2%	68.8%	70.8%	66.2%	81.6%	81.4%	75.0%	75.5%
United	65.0%	62.5%	65.2%+	70.3%+	78.6%+	78.8%+	83.7%+	76.1%+
VA Premier	67.0%	65.9%	66.0%	68.0%	74.2%	82.8%▲	70.7%	74.3%

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

▲ Statistically significantly higher in 2023 than in 2022.

▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

Table 3-11—Comparison of 2022 and 2023 Child Composite Top-Box Scores

	Getting Needed Care		Getting Care Quickly		How Well Doctors Communicate		Customer Service	
	2022	2023	2022	2023	2022	2023	2022	2023
CCC Plus (MLTSS) Program	84.3%	83.3%	87.6%	85.6%	93.8%	94.7%	87.2%	88.5%
Aetna	81.8%	81.7%	82.9%	85.5%	92.7%	95.8%	84.6%+	89.6%+
HealthKeepers	83.1%	82.0%	86.4%	83.6%	92.2%	92.4%	87.2%+	87.2%
Molina	72.6%+	82.0%+	86.5%+	81.3%+	94.1%+	97.6%+	80.3%+	85.7%+
Optima	85.3%	85.9%	89.0%	85.9%	95.9%	95.8%	93.1%+	89.7%+
United	90.7%+	81.7%+	85.4%+	87.1%+	91.6%+	92.0%+	85.9%+	89.3%+
VA Premier	87.8%	84.4%	90.5%	89.0%+	94.7%	96.9%	84.8%+	89.5%+

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

▲ Statistically significantly higher in 2023 than in 2022.

▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Strengths, Weaknesses, and Recommendations

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

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

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

MCO Comparative and Statewide Calculation of Additional PM Results

Project Highlights

DMAS contracted with HSAG in 2023 to calculate the *Medicaid Managed Long-Term Services and Supports (MLTSS) Successful Transition after Long-Term Facility Stay (MLTSS-8)* PM following the 2022 CMS *Medicaid Managed Long-Term Services and Supports (MLTSS) Measures Technical Specifications and Resource Manual.*[3-19] Table 3-12 displays the CY 2022 *MLTSS-8* PM results stratified by Medicaid managed care program, Medicaid delivery system, MCO, geographic region, and select demographics (i.e., age, gender, and race).

Table 3-12—*MLTSS-8* PM Results

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

[3-19] 2022 Medicaid Managed Long-Term Services and Supports (MLTSS) Measures Technical Specifications and Resource Manual. Available at: https://www.medicaid.gov/medicaid/managed-care/downloads/mltss-tech-specs-res-manual-2022-updated.pdf. Accessed on: Oct 19, 2023.

Stratifications	Facility Admissions	Observed Rate	Expected Rate	O/E Ratio*
Medallion 4.0 (Acute)	86	79.07%	57.92%	1.37
More than One Medicaid Program	147	64.63%	53.74%	1.20
Medicaid Delivery System				
Fee-for-Service	166	18.07%	74.93%	0.24
Managed Care	3,975	33.38%	67.16%	0.50
More than One Delivery System	437	42.56%	68.86%	0.62
MCO				
Aetna	779	38.25%	66.14%	0.58
HealthKeepers	1,013	42.74%	65.02%	0.66
Molina	532	28.57%	68.55%	0.42
Optima	572	20.63%	69.86%	0.30
United	431	26.45%	68.50%	0.39
VA Premier	568	30.11%	68.40%	0.44
More than One MCO	80	51.25%	59.79%	0.86
Geographic Region				
Central	1,192	35.82%	66.51%	0.54
Charlottesville/Western	663	29.71%	69.18%	0.43
Northern & Winchester	727	36.73%	68.28%	0.54
Roanoke/Alleghany	566	31.63%	68.49%	0.46
Southwest	*S*	*S*	*S*	*S*
Tidewater	966	33.75%	66.71%	0.51
Unknown	*S*	*S*	*S*	*S*
Age				
18–44 Years	331	55.29%	53.24%	1.04
45–64 Years	1,674	43.49%	60.67%	0.72
65–74 Years	1,180	26.69%	74.59%	0.36
75–84 Years	878	21.53%	74.56%	0.29
85+ Years	515	24.85%	71.55%	0.35

Stratifications	Facility Admissions	Observed Rate	Expected Rate	O/E Ratio*
Gender				
Male	2,000	35.10%	66.82%	0.53
Female	2,578	32.62%	68.22%	0.48
Race				
White	2,828	32.21%	68.64%	0.47
Black/African American	1,572	34.67%	66.09%	0.52
Asian	90	52.22%	66.40%	0.79
Southeast Asian/Pacific Islander	*S*	*S*	*S*	*S*
Hispanic	*S*	*S*	*S*	*S*
More than One Race/Other/Unknown	54	51.85%	59.88%	0.87

** Please note that for the O/E ratio, a higher rate indicates more favorable performance; therefore, an O/E ratio greater than 1 indicates that more residents were successfully transitioned to the community from their facility than were expected based on the resident case mix (i.e., the residents' age, gender, chronic conditions, and Medicaid status).*

S Indicates that the data were suppressed due to a small numerator or denominator (i.e., fewer than 11). In instances where only one stratification was suppressed, the value for the second smallest population was also suppressed, even if the value was 11 or more.

Successfully transitioning a long-term facility resident back into community settings has shown a significant boost in residents' overall quality of life and satisfaction given the independence associated with being back in the community.[3-20] For Virginia Medicaid, the O/E ratio was 0.5 for CY 2022, indicating that fewer Virginia Medicaid members were successfully discharged to the community after 100 days than expected. Members enrolled in Medallion 4.0 (Acute) and More than One Medicaid Program were more likely to be successfully discharged to the community after 100 days, with an O/E ratio of 1.37 and 1.20, respectively. It is important to note that the risk-adjusted model for this measure expects older people to be successfully discharged to the community at a higher rate than younger people; however, in Virginia, younger residents (i.e., members between the ages of 18 and 64) were more likely to be successfully discharged to the community after 100 days of admission than older residents.

ARTS PM Specification Development and Maintenance Results

DMAS contracted with HSAG as its EQRO to develop and maintain custom PM specifications to evaluate the ARTS program. During 2021, HSAG calculated CY 2019 and CY 2020 information-only

[3-20] Gassoumis ZD, Fike KT, Rahman AN, et al. Who transitions to the community from nursing homes? Comparing patterns and predictors for short-stay and long-stay residents. *Home Health Care Serv Q*. 2013;32(2):75-91. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3711511/. Accessed on: Nov. 6, 2023.

PM rates for DMAS using administrative claims/encounter data. During 2023, HSAG calculated CY 2020 and CY 2021 rates. The results are found in Section 11 of this report for the following PMs:

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

Focus Studies

DMAS elected to continue the following clinical topics during the 2023 contract year: improving birth outcomes through adequate PNC (Medicaid and CHIP Maternal and Child Health Focus Study), improving the health of children in foster care (Child Welfare Focus Study), and Dental Utilization in Pregnant Women Data Brief. Based on methodological considerations, MCO-specific results produced for each focus study are available in the final activity reports.

MCO Comparative and Statewide Aggregate Consumer Decision Support Tool Results

DMAS contracted with HSAG in 2023 to produce a Consumer Decision Support Tool using Virginia Medicaid MCOs' HEDIS data and CAHPS survey results for the CCC Plus (MLTSS) MCOs. The CCC Plus (MLTSS) Consumer Decision Support Tool demonstrates how the Virginia Medicaid CCC Plus (MLTSS) MCOs compared to one another in key performance areas. The tool uses stars to display results for the MCOs, as shown in Table 3-13. Please refer to Appendix B for the detailed methodology used for this tool.

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

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

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

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

Table 3-14—2023 Consumer Decision Support Tool Results

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

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

Strengths, Weaknesses, and Recommendations

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

Performance Withhold Program

In 2023, DMAS contracted with HSAG to establish, implement, and maintain a scoring mechanism for the CCC Plus (MLTSS) PWP. The SFY 2023 PWP assessed CY 2022 PM data to determine what portion, if any, of the MCOs' quality withhold would be earned back. For the SFY 2023 PWP, the CCC Plus (MLTSS) MCOs could earn all or a portion of their 1 percent quality withhold based on performance for seven NCQA HEDIS measures (14 measure indicators), one AHRQ PDI measure (one measure indicator), and two CMS Adult Core Set measures (two measure indicators). The SFY 2023 PWP was based on comparisons to the NCQA Quality Compass national Medicaid HMO percentiles for all HEDIS measures, and receiving a reportable audit status on the AHRQ PDI and CMS Adult Core Set PMs. For detailed information related to the PWP, please see the SFY 2023 PWP Methodology on DMAS' website.[3-21]

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

4. Validation of Performance Improvement Projects

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

Objective

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

Each PIP must involve:

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

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

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

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

Approach to PIP Validation

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

HSAG, with DMAS' input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS EQR protocols. The HSAG PIP validation staff consisted of, at a minimum, an analyst with expertise in statistics and PIP design and a clinician with expertise in performance improvement processes. The CMS EQR protocols identify nine steps that should be validated for each PIP. For the 2023 submissions, the MCOs updated and completed Steps 1 through 8 in the PIP Validation Tool. The nine steps included in the PIP Validation Tool are:

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

PIP Validation Scoring

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

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

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

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

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

- ***Met:*** High Confidence/Confidence in reported PIP results. All critical elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- ***Partially Met:*** Low Confidence in reported PIP results. All critical elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical elements were *Partially Met*.
- ***Not Met:*** No confidence in reported results. All critical elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical elements were *Not Met*.

Training and Implementation

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

PIP Validation Status

For the 2023 validation, the MCOs progressed to reporting baseline data, QI strategies, and interventions. The validation findings for each MCO are provided below.

Validation Findings

Aetna

In 2023, Aetna submitted its baseline data and interventions for the following PIPs for validation: *Ambulatory Care—Emergency Department Visits* and *Follow-Up After Discharge*. The topics selected by DMAS addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-1 displays the PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

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

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

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

Aetna met 100 percent of the requirements in the Implementation stage, Steps 7 and 8. Aetna reported its baseline rate and the QI activities conducted. Aetna completed a causal/barrier analysis, prioritized the identified barriers, and initiated interventions that have the potential to impact the performance indicators. Table 4-2 and Table 4-3 display the PIP intervention summaries.

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

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

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

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

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

Strengths, Weaknesses, and Recommendations

Strengths	
+	Aetna progressed to subsequent PIP stages, successfully collecting data and initiating interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Weaknesses and Recommendations	
–	**Weakness:** None identified.
	Recommendations: NA

HealthKeepers

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

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

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

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

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

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

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

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

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

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

Strengths, Weaknesses, and Recommendations

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

Molina

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

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

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

Ambulatory Care—Emergency Department Visits		
PIP Aim Statement	Do targeted member education and engagement interventions reduce the rate of ED visits that do not result in an inpatient stay?	
Performance Indicator Measure	The percentage of ED visits that did not result in an inpatient stay during the measurement period.	
Description of Data Obtained	Administrative data using claims and encounters	
Validation Scores	*Overall Score:* 88%	*Critical Elements Score:* 89%
Validation Status/Confidence Level	*Partially Met/Low Confidence in reported PIP results*: One or more critical evaluation elements were *Partially Met*.	
Follow-Up After Discharge		
PIP Topic	Follow-Up After Discharge	
PIP Aim Statement	Do targeted interventions increase the percentage of inpatient discharges for members 18 years of age and older that had an ambulatory follow up visit within 30-days of discharge?	
Performance Indicator Measure	The percentage of members provided patient engagement and follow-up service within 30-days after inpatient discharge during the measurement period	
Description of Data Obtained	Administrative data using claims and encounters	
Validation Scores	*Overall Score:* 94%	*Critical Elements Score:* 100%
Validation Status/Confidence Level	*Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all steps.	

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

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

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

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

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

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

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

Strengths, Weaknesses, and Recommendations

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

Optima

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

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

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

Ambulatory Care—Emergency Department Visits		
Validation Status/Confidence Level	*Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all steps.	
Follow-Up After Discharge		
PIP Topic	Follow-Up After Discharge	
PIP Aim Statement	Do targeted interventions increase the percentage of discharges for which the member had a 30-day follow-up visit (can include outpatient visits, telephone visits, transitional care services, and e-visits/virtual check-ins) during the measurement period?	
Performance Indicator Measure	The percentage of follow-up after hospital discharge amongst Optima Health Community Care (OHCC)-enrolled members.	
Description of Data Obtained	Administrative data using claims and encounters	
Validation Scores	*Overall Score:* 100%	*Critical Elements Score:* 100%
Validation Status/Confidence Level	*Met/High Confidence/Confidence in reported PIP results:* All critical evaluation elements were *Met,* and 80 to 100 percent of all evaluation elements were *Met* across all steps.	

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

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

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

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

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

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

Strengths, Weaknesses, and Recommendations

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

United

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

by DMAS addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-13 displays the PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

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

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

United met 100 percent of the requirements in the Implementation stage, Steps 7 and 8. United reported its baseline rate and the QI activities conducted. United completed a causal/barrier analysis, prioritized the identified barriers, and initiated interventions that have the potential to impact the performance indicators. Table 4-14 and Table 4-15 display the PIP intervention summaries.

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

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

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

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

Strengths, Weaknesses, and Recommendations

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

VA Premier

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

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

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

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

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

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

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

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

Strengths, Weaknesses, and Recommendations

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

Recommendations

As the MCOs continue with their PIPs, progress to reporting remeasurement data, and work toward improving outcomes, HSAG has the following recommendations:

- The MCOs should revisit their causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement.
- The MCOs should keep interventions focused on the prioritized barriers and consider making fundamental changes.
- When developing interventions, the MCOs should consider collaborating with external organizations and SMEs.
- The MCOs should use PDSA cycles to test interventions on a small scale before expanding to larger populations. The MCOs should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results quickly. The intervention evaluation results should drive next steps for interventions and determine whether they should be adopted, adapted, or abandoned, or whether continued testing is needed.
- The MCOs should discuss and address barriers to PIP progress with their internal teams and/or HSAG to determine methods on how to overcome any identified barriers.
- The MCOs should continue to reference the PIP Completion Instructions as additional steps of the PIP process are completed. This will help ensure that all documentation requirements have been addressed.
- The MCOs should apply lessons learned and HSAG's validation feedback to their PIPs and other QI projects.

5. Validation of Performance Measures

Overview

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

Objectives

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

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

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

Section 3, Table 3-3, displays, by MCO, the HEDIS MY 2022 PM rates that were used as the basis for the strengths and weaknesses described in the following MCO-specific evaluations.

MCO-Specific HEDIS Measure Results

Aetna

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

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

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

Strengths, Weaknesses, and Recommendations

Strengths	
+	Within the Access and Preventive Care domain, Aetna displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM, meeting or exceeding NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile
+	Aetna's performance within the Behavioral Health domain identified seven PM indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile. The *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up* and *30-Day Follow-Up—Total, Diagnosed Mental Health Disorders—Total, Diagnosed Substance Use Disorders—Alcohol disorder—Total, Opioid disorder—Total, Other or unspecified drugs—Total,* and *Any disorder—Total* PM indicators met or exceeded the 90th percentile.
+	Aetna's performance within the Living With Illness domain identified three PM indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile or 90th percentile. The *Asthma Medication Ratio—Total* and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* PM indicators met or exceeded the 75th percentile, and the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PM indicator met or exceeded the 90th percentile.
+	Aetna displayed strong performance within the Use of Opioids domain, ranking at or above NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 50th percentile for the *Use of Opioids at High Dosage—Total* PM indicator.
Weaknesses and Recommendations	
−	**Weakness:** The following HEDIS MY 2022 PM rates fell below NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Aetna: • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening*

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

HealthKeepers

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

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

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

Strengths, Weaknesses, and Recommendations

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

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

Weaknesses and Recommendations	
−	**Weakness:** The following HEDIS MY 2022 PM rates fell below NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for HealthKeepers: • *Ambulatory Care—ED Visits—Total* • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* • *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* • *Cervical Cancer Screening* • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* • *Use of Imaging Studies for Low Back Pain* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* • *Plan All-Cause Readmissions—Observed Readmissions—Total*
	Recommendations: HSAG recommends that HealthKeepers conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that HealthKeepers analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.

Molina

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

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

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

Strengths, Weaknesses, and Recommendations

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

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

Optima

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

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

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

Strengths, Weaknesses, and Recommendations

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

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

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

United

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

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

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

Strengths, Weaknesses, and Recommendations

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

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

Weaknesses and Recommendations	
−	**Weakness:** The following HEDIS MY 2022 PM rates fell below NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for United: • *Ambulatory Care—ED Visits—Total* • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* • *Cervical Cancer Screening* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* • *Use of Imaging Studies for Low Back Pain* • *Child and Adolescent Well-Care Visits—Total* • *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* • *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies*
	Recommendations: HSAG recommends that United conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that United analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.

VA Premier

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

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

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

Strengths, Weaknesses, and Recommendations

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

Weaknesses and Recommendations	
–	**Weakness:** The following HEDIS MY 2022 PM rates fell below NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier: • *Ambulatory Care—ED Visits—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* • *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* • *Childhood Immunization Status—Combination 3* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* • *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* • *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid* • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* • *Use of Imaging Studies for Low Back Pain* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total* • *Well-Child Visits in the First 30 Months of Life— Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*
	Recommendations: With VA Premier no longer serving members as of July 1, 2023, HSAG has no recommendations. With the VA Premier MCO merging with the Optima MCO, HSAG recommends that Optima consider conducting a root cause analysis or focus study for these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima also consider analyzing the data and consider whether there are disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.

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

Overview

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

The OSR standards were derived from the requirements as set forth in the *Department of Human Services, Division of Health Care Financing and Policy Request for Proposal No. 3260 for Managed Care*, and all attachments and amendments in effect during the review period of July 1, 2020, through June 30, 2021. To conduct the OSR, HSAG followed the guidelines set forth in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (EQR Protocol 3).[6-1]

Objectives

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

[6-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 18, 2023.

Deeming

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

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

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

Table 6-1—OSR Standard Assigned CMS Categories

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

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

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

Aetna

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

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

	CFR	Compliance Reviews	Aetna		
		Standard Name	2019	2020	2021
I.	438.56	Enrollment and Disenrollment			100%
II.	438.100 438.224	Member Rights and Confidentiality			85.7%
III.	438.10	Member Information			100%
IV.	438.114	Emergency and Poststabilization Services			100%
V.	438.206 438.207	Adequate Capacity and Availability of Services			77.8%
VI.	438.208	Coordination and Continuity of Care			100%
VII.	438.210	Coverage and Authorization of Services			100%
VIII.	438.214	Provider Selection			100%
IX.	438.230	Subcontractual Relationships and Delegation			75.0%
X.	438.236	Practice Guidelines			100%
XI.	438.242	Health Information Systems			100%

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

Strengths, Weaknesses, and Recommendations

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

HealthKeepers

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

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

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

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

Strengths, Weaknesses, and Recommendations

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

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

Molina

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

Table 6-4—Molina's CCC Plus (MLTSS) OSR Standards and Scores

	CFR	Compliance Reviews	Molina		
		Standard Name	2019	2020	2021
I.	438.56	Enrollment and Disenrollment			100%
II.	438.100 438.224	Member Rights and Confidentiality			100%

	CFR	Compliance Reviews	Molina		
		Standard Name	2019	2020	2021
III.	438.10	Member Information			95.2%
IV.	438.114	Emergency and Poststabilization Services			100%
V.	438.206 438.207	Adequate Capacity and Availability of Services			77.8%
VI.	438.208	Coordination and Continuity of Care			100%
VII.	438.210	Coverage and Authorization of Services			95.9%
VIII.	438.214	Provider Selection			100%
IX.	438.230	Subcontractual Relationships and Delegation			100%
X.	438.236	Practice Guidelines			100%
XI.	438.242	Health Information Systems			100%
XII.	438.330	Quality Assessment and Performance Improvement			100%
XIII.	438.228	Grievance and Appeal Systems			86.2%
XIV.	438.608	Program Integrity			100%
XV.	441.58 Section 1905 of the SSA	EPSDT Services			62.5%
TOTAL SCORE					**92.2%**

Strengths, Weaknesses, and Recommendations

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

Optima

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

Table 6-5—Optima's CCC Plus (MLTSS) OSR Standards and Scores

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

Strengths, Weaknesses, and Recommendations

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

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

United

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

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

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

Strengths, Weaknesses, and Recommendations

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

VA Premier

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

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

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

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

Strengths, Weaknesses, and Recommendations

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

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

DMAS Intermediate Sanctions Applied

During 2023, DMAS monitored the MCOs' implementation of federal and State requirements and CAPs from prior years' compliance reviews. Table 6-8 contains the compliance actions taken.

Table 6-8—DMAS Compliance Actions

MCO/Vendor	Compliance Action
Aetna CAP - 19927	Aetna encountered internal system issues which impacted CRMS SA data submission. As a result, Aetna developed a crosswalk of expected values to overcome the QNXT system limitations.
Aetna CAP - 19947	On May 27, 2021, Aetna submitted four SA Medical files with authorized decision dates ranging from July 23, 2017, through November 1, 2021, to CRMS Production without approval from DMAS. The files loaded or updated 84,819 records in production. On August 27, 2021, Aetna failed to prevent such an incident from reoccurring and submitted four SA Medical files to CRMS Production without approval from DMAS. Aetna updated internal controls to prevent test files from being loaded into the production environment. Specific action items were added to incorporate the MFT process into the internal control process.

MCO/Vendor	Compliance Action
Optima CAP -19987	Optima entered a member into the DMAS Web Portal for LTSS Services prior to a valid level of care screening being conducted. Optima updated the processing of DMAS 80 forms, the Enrollment Change Request Form, and implemented a second-level review with a supervisor signature requirement.
UHC CAP - 20067	UHC's fiscal/employer agent (F/EA) improperly withheld FICA tax from attendants' paychecks. As a result, the MCO conducted a thorough review of internal controls and developed a remedial process to resolve the payroll software issue and impact to members and their attendants.
UHC CAP - 20068	UHC approved an implementation that migrated its BetterOnline Web portal and website platform to the MyAccount platform without DMAS' approval. The MCO collaborated with DMAS to establish acceptable approval processes for the implementation of system changes that have the potential to significantly impact members.
UHC CAP - 20070	A process was implemented by the F/EA without DMAS' approval. The new process encouraged new attendants to submit DSS forms directly to DSS for processing. This change is in violation of contract requirements. The MCO sent notification with instructions to resume the correct procedure and reimbursed all impacted individuals.
Optima CAP - 20071	Optima's F/EA improperly withheld FICA tax from attendants' paychecks. As a result, the MCO conducted a thorough review of internal controls and developed a remedial process to resolve the payroll software issue and impact to members and their attendants.
Optima CAP - 20072	Optima approved an implementation that migrated its BetterOnline web portal and website platform to the MyAccount platform without DMAS' approval. The MCO collaborated with DMAS to establish acceptable approval processes for the implementation of system changes that have the potential to significantly impact members.
Optima CAP - 20074	A process was implemented by the F/EA without DMAS' approval. The new process encouraged new attendants to submit DSS forms directly to DSS for processing. This change is in violation of contract requirements. The MCO sent notification with instructions to resume the correct procedure and reimbursed all impacted individuals.
Aetna CAP - 20076	A process was implemented by the F/EA without DMAS' approval. The new process encouraged new attendants to submit DSS forms directly to DSS for processing. This change is in violation of contract requirements. The MCO sent notification with instructions to resume the correct procedure and reimbursed all impacted individuals.

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

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

7. Cardinal Care Program Readiness Reviews

Cardinal Care Readiness Review

In June 2021, the Virginia General Assembly mandated that DMAS rebrand the Department's FFS and managed care programs and effectively combine the CCC Plus and Medallion 4.0 programs under a single name, the Cardinal Care program. The combined program achieves a single streamlined system of care that links seamlessly with the FFS program. 42 CFR §438.66(d)(1) describes the circumstances wherein a state must conduct readiness reviews of MCOs using desk reviews and, at the state's option, on-site reviews. In accordance with the regulation, a state must assess the readiness of each MCO with which it contracts when the MCO will provide or arrange for the provision of covered benefits to new eligibility groups.

DMAS contracted with HSAG to conduct readiness reviews for the Cardinal Care program that focused on the MCOs' ability and capacity to comply with the Cardinal Care contract requirements and the 2020 Medicaid and CHIP Managed Care Final Rule regulations.[7-1] The primary objective was to assess the ability and capacity of the MCOs to satisfactorily perform the new Model of Care contract requirements. In addition, HSAG assessed the ability and capacity of the MCOs to perform satisfactorily in key operational and administrative functions outlined in the Cardinal Care MCO contract.

The readiness review included an assessment of all key program areas noted in 42 CFR §438.66(d)(4), which are presented in Table 7-1. The key program areas were divided into three readiness review components—Operations/Administration, Service Delivery, and Information Systems Management—and each component was assessed using a variety of tools, staff interviews, and/or requested data and document submissions.

Table 7-1—Readiness Review Focus Areas

Readiness Review Areas
Operations/Administration
Administrative Staffing and Resources
Delegation and Oversight
Member and Provider Communications
Grievance and Appeals
Member Services and Outreach
Provider Network Management
Program Integrity/Compliance
Service Delivery
Case Management/Care Coordination/Service Planning

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

Readiness Review Areas
Quality Improvement
Utilization Review
Financial Management*
Financial Reporting and Monitoring
Financial Solvency
Information Systems Management
Claims Management
Encounter Data Management
Enrollment Information Management

**Financial reporting and monitoring and financial solvency readiness standards were out of the scope of HSAG's readiness review process and were conducted by DMAS.*

The MCO Cardinal Care program readiness review results are displayed in the following tables.

Aetna

Table 7-2 presents a summary of Aetna's Cardinal Care program readiness review results.

Table 7-2—Aetna's Cardinal Care Program Readiness Review Standards and Scores

Standard		Requirements/Elements Assessed			
		Number of Elements	Number *Met*	Number *In Progress*	Score
OSR Results					
I	Enrollment and Disenrollment	7	7	0	100%
II	Member Rights and Confidentiality	7	7	0	100%
III	Member Information	21	21	0	100%
IV	Emergency and Poststabilization Services	12	12	0	100%
V	Adequate Capacity and Availability of Services	18	18	0	100%
VI	Coordination and Continuity of Care	9	9	0	100%
VII	Coverage and Authorization of Services	20	20	0	100%
VII	Provider Selection	5	5	0	100%
IX	Subcontractual Relationships and Delegation	4	4	0	100%
X	Practice Guidelines	3	3	0	100%
XI	Health Information Systems	6	6	0	100%
XII	Quality Assessment and Performance Improvement	6	6	0	100%
XIII	Grievance and Appeal Systems	29	29	0	100%
XIV	Program Integrity	12	12	0	100%
XV - A	EPSDT Services	8	8	0	100%
	OSR Total	**167**	**167**	**0**	**100%**

Standard		Requirements/Elements Assessed			
		Number of Elements	Number *Met*	Number *In Progress*	Score
Phase III Readiness Review Results*					
XV	Network Adequacy	20	19	1	95.0%
XVI	Model of Care	107	107	0	100%
XVII	Organizational Structure, Operations, and Systems	5	5	0	100%
Readiness Review Total		**132**	131	**1**	99.2%
Readiness Review CAP Review Results					
Phase I CAP Review Results		8	8	0	100%
Phase II CAP Review Results		0	0	0	100%
Phase III CAP Review Results		1	1	0	100%
Comprehensive Total		**299**	**299**	**0**	**100%**

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.
Number *Met* = The total number of elements within each standard that supported readiness.
Number *Not Met* = The total number of elements within each standard that did not support readiness.
Comprehensive Total = 2021 OSR and 2023 Readiness Review Results. The Comprehensive Total Number *Met* was calculated by adding the OSR *Deeming* elements, the *Met* elements, and the *DMAS-approved CAPs*.
*Score includes Phase II and Phase II CAP element review scores.

HealthKeepers

Table 7-3 presents a summary of HealthKeepers Cardinal Care program readiness review results.

Table 7-3—HealthKeepers' Cardinal Care Program Readiness Review Standards and Scores

Standard		Requirements/Elements Assessed			
		Number of Elements	Number *Met*	Number *In Progress*	Score
OSR Results					
I	Enrollment and Disenrollment	7	7	0	100%
II	Member Rights and Confidentiality	7	7	0	100%
III	Member Information	21	21	0	100%
IV	Emergency and Poststabilization Services	12	12	0	100%
V	Adequate Capacity and Availability of Services	18	18	0	100%
VI	Coordination and Continuity of Care	9	9	0	100%
VII	Coverage and Authorization of Services	20	20	0	100%
VII	Provider Selection	5	5	0	100%
IX	Subcontractual Relationships and Delegation	4	4	0	100%
X	Practice Guidelines	3	3	0	100%
XI	Health Information Systems	6	6	0	100%

Standard		Requirements/Elements Assessed			
		Number of Elements	Number *Met*	Number *In Progress*	Score
XII	Quality Assessment and Performance Improvement	6	6	0	100%
XIII	Grievance and Appeal Systems	29	29	0	100%
XIV	Program Integrity	12	12	0	100%
XV - A	EPSDT Services	8	8	0	100%
	OSR Total	**167**	**167**	**0**	**100%**
Phase III Readiness Review Results*					
XV	Network Adequacy	20	19	0	95.0%
XVI	Model of Care	107	107	0	100%
XVII	Organizational Structure, Operations, and Systems	5	5	0	100%
	Readiness Review Total	**132**	**131**	**0**	**99.2%**
Readiness Review CAP Review Results					
Phase I CAP Review Results		13	13	0	100%
Phase II CAP Review Results		0	0	0	100%
Phase III Cap Review Results		1	1	0	100%
	CAP Review Results Total	14	14	0	100%
	Comprehensive Total	**299**	**299**	**0**	**100%**

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.
Number *Met* = The total number of elements within each standard that supported readiness.
Number *Not Met* = The total number of elements within each standard that did not support readiness.
Comprehensive Total = 2021 OSR and 2023 Readiness Review Results. The Comprehensive Total Number *Met* was calculated by adding the OSR *Deeming* elements, the *Met* elements, and the *DMAS-approved CAPs*.
*Score includes Phase II and Phase II CAP element review scores.

Molina

Table 7-4 presents a summary of Molina's Cardinal Care program readiness review results.

Table 7-4—Molina's Cardinal Care Program Readiness Review Standards and Scores

Standard		Requirements/Elements Assessed			
		Number of Elements	Number *Met*	Number *In Progress*	Score
OSR Results					
I	Enrollment and Disenrollment	7	7	0	100%
II	Member Rights and Confidentiality	7	7	0	100%
III	Member Information	21	21	0	100%
IV	Emergency and Poststabilization Services	12	12	0	100%
V	Adequate Capacity and Availability of Services	18	18	0	100%

Standard		Requirements/Elements Assessed			
		Number of Elements	Number *Met*	Number *In Progress*	Score
VI	Coordination and Continuity of Care	9	9	0	100%
VII	Coverage and Authorization of Services	20	20	0	100%
VII	Provider Selection	5	5	0	100%
IX	Subcontractual Relationships and Delegation	4	4	0	100%
X	Practice Guidelines	3	3	0	100%
XI	Health Information Systems	6	6	0	100%
XII	Quality Assessment and Performance Improvement	6	6	0	100%
XIII	Grievance and Appeal Systems	29	29	0	100%
XIV	Program Integrity	12	12	0	100%
XV - A	EPSDT Services	8	8	0	100%
	OSR Total	**167**	**167**	**0**	**100%**
Phase III Readiness Review Results*					
XV	Network Adequacy	20	20	0	100%
XVI	Model of Care	107	107	0*	100%
XVII	Organizational Structure, Operations, and Systems	5	5	0	100%
	Readiness Review Total	**132**	**132**	**8**	**100%**
Readiness Review CAP Review Results					
Phase I CAP Review Results		87	87	0	100%
Phase II CAP Review Results		7	7	0	100%
Phase III CAP Review Results		0	0	0	100%
	Comprehensive Total	**299**	**299**	**0**	**100%**

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.
Number *Met* = The total number of elements within each standard that supported readiness.
Number *Not Met* = The total number of elements within each standard that did not support readiness.
Comprehensive Total = 2021 OSR and 2023 Readiness Review Results. The Comprehensive Total Number *Met* was calculated by adding the OSR *Deeming* elements, the *Met* elements, and the *DMAS-approved CAPs*.
*Score includes Phase II and Phase II CAP element review scores.

Optima

Table 7-5 presents a summary of Optima's Cardinal Care program readiness review results.

Table 7-5—Optima's Cardinal Care Program Readiness Review Standards and Scores

Standard		Requirements/Elements Assessed			
		Number of Elements	Number *Met*	Number *In Progress*	Score
OSR Results					
I	Enrollment and Disenrollment	7	7	0	100%
II	Member Rights and Confidentiality	7	7	0	100%

Standard		Requirements/Elements Assessed			
		Number of Elements	Number *Met*	Number *In Progress*	Score
III	Member Information	21	21	0	100%
IV	Emergency and Poststabilization Services	12	12	0	100%
V	Adequate Capacity and Availability of Services	18	18	0	100%
VI	Coordination and Continuity of Care	9	9	0	100%
VII	Coverage and Authorization of Services	20	20	0	100%
VII	Provider Selection	5	5	0	100%
IX	Subcontractual Relationships and Delegation	4	4	0	100%
X	Practice Guidelines	3	3	0	100%
XI	Health Information Systems	6	6	0	100%
XII	Quality Assessment and Performance Improvement	6	6	0	100%
XIII	Grievance and Appeal Systems	29	29	0	100%
XIV	Program Integrity	12	12	0	100%
XV - A	EPSDT Services	8	8	0	100%
	OSR Total	**167**	**167**	**0**	**100%**
Phase III Readiness Review Results*					
XV	Network Adequacy	20	19	1	95.0%
XVI	Model of Care	107	107	0	100%
XVII	Organizational Structure, Operations, and Systems	5	4	0	100%
	Readiness Review Total	**132**	**131**	**1**	**99.2%**
Readiness Review CAP Review Results					
Phase I CAP Review Results		4	4	0	100%
Phase II CAP Review Results		0	0	0	100%
Phase III CAP Review Results		2	2	0	100%
	Comprehensive Total	**299**	**299**	**0**	**100%**

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.
Number *Met* = The total number of elements within each standard that supported readiness.
Number *Not Met* = The total number of elements within each standard that did not support readiness.
Comprehensive Total = 2021 OSR and 2023 Readiness Review Results. The Comprehensive Total Number *Met* was calculated by adding the OSR *Deeming* elements, the *Met* elements, and the *DMAS-approved CAPs*.
*Score includes Phase II and Phase II Corrective Action Plan element review scores.

United

Table 7-6 presents a summary of United's Cardinal Care program readiness review results.

Table 7-6—United's Cardinal Care Program Readiness Review Standards and Scores

Standard		Requirements/Elements Assessed			
		Number of Elements	Number *Met*	Number *In Progress*	Score
OSR Results					
I	Enrollment and Disenrollment	7	7	0	100%
II	Member Rights and Confidentiality	7	7	0	100%
III	Member Information	21	21	0	100%
IV	Emergency and Poststabilization Services	12	12	0	100%
V	Adequate Capacity and Availability of Services	18	18	0	100%
VI	Coordination and Continuity of Care	9	9	0	100%
VII	Coverage and Authorization of Services	20	20	0	100%
VII	Provider Selection	5	5	0	100%
IX	Subcontractual Relationships and Delegation	4	4	0	100%
X	Practice Guidelines	3	3	0	100%
XI	Health Information Systems	6	6	0	100%
XII	Quality Assessment and Performance Improvement	6	6	0	100%
XIII	Grievance and Appeal Systems	29	29	0	100%
XIV	Program Integrity	12	12	0	100%
XV - A	EPSDT Services	8	8	0	100%
	OSR Total	**167**	**167**	**0**	**100%**
Phase III Readiness Review Results*					
XV	Network Adequacy	20	18	2	90.0%
XVI	Model of Care	107	105	2	98.1%
XVII	Organizational Structure, Operations, and Systems	5	5	0	100%
	Readiness Review Total	**132**	**128**	**4**	**97.0%**
Readiness Review CAP Review Results					
Phase I CAP Review Results		56	56	0	100%
Phase II CAP Review Results		1	1	0	100%
Phase III CAP Review Results		4	3	0	100%
	Comprehensive Total	**299**	**299**	**0**	**100%**

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.
Number *Met* = The total number of elements within each standard that supported readiness.
Number *Not Met* = The total number of elements within each standard that did not support readiness.
Comprehensive Total = 2021 OSR and 2023 Readiness Review Results. The Comprehensive Total Number *Met* was calculated by adding the OSR *Deeming* elements, the *Met* elements, and the *DMAS-approved CAPs*.
*Score includes Phase II and Phase II Corrective Action Plan element review

VA Premier

Table 7-7 presents a summary of VA Premier's Cardinal Care program readiness review results.

Table 7-7—VA Premier's Cardinal Care Program Readiness Review Standards and Scores

Standard		Requirements/Elements Assessed			
		Number of Elements	Number *Met*	Number *In Progress*	Score
OSR Results					
I	Enrollment and Disenrollment	7	7	0	100%
II	Member Rights and Confidentiality	7	7	0	100%
III	Member Information	21	21	0	100%
IV	Emergency and Poststabilization Services	12	12	0	100%
V	Adequate Capacity and Availability of Services	18	18	0	100%
VI	Coordination and Continuity of Care	9	9	0	100%
VII	Coverage and Authorization of Services	20	20	0	100%
VII	Provider Selection	5	5	0	100%
IX	Subcontractual Relationships and Delegation	4	4	0	100%
X	Practice Guidelines	3	3	0	100%
XI	Health Information Systems	6	6	0	100%
XII	Quality Assessment and Performance Improvement	6	6	0	100%
XIII	Grievance and Appeal Systems	29	29	0	100%
XIV	Program Integrity	12	12	0	100%
XV - A	EPSDT Services	8	8	0	100%
	OSR Total	**167**	**167**	**0**	**100%**
Phase III Readiness Review Results*					
XV	Network Adequacy	20	18	2	90.0%
XVI	Model of Care	107	107	0	100%
XVII	Organizational Structure, Operations, and Systems	5	5	0	100%
	Readiness Review Total	**132**	**130**	**2**	**98.5%**
Readiness Review CAP Review Results					
Phase I CAP Review Results		6	6	0	100%
Phase II CAP Review Results		7	7	0	100%
Phase III CAP Review Results		2	2	0	100%
	Comprehensive	**299**	**299**	**0**	**100%**

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.
Number *Met* = The total number of elements within each standard that supported readiness.

Number *Not Met* = The total number of elements within each standard that did not support readiness.
Comprehensive Total = 2021 OSR and 2023 Readiness Review Results. The Comprehensive Total Number *Met* was calculated by adding the OSR *Deeming* elements, the *Met* elements, and the *DMAS-approved CAPs*.
*Score includes Phase II and Phase II Corrective Action Plan element review scores.

8. Secret Shopper Survey

Overview

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

Objectives

DMAS contracted HSAG to conduct a secret shopper telephone survey of appointment availability to collect information on members' access to primary care services under the VA Medicaid managed care program. A secret shopper is a person employed to pose as a patient to evaluate the quality of customer service or the validity of information (e.g., location information). The secret shopper telephone survey allows for objective data collection from healthcare providers without potential bias introduced by knowing the identity of the surveyor.

The primary purpose of the secret shopper survey was to collect appointment availability information among PCPs enrolled with the VA Medicaid MCOs to address the following survey objectives:

- Determine whether primary care service locations accept patients enrolled with the MCOs and the degree to which this information aligns with the enrollment broker's data.
- Determine whether primary care service locations accept new VA Medicaid patients for the requested MCO.
- Determine appointment availability at the sampled primary care service location for urgent and routine primary care services.

Statewide Results

Survey findings support specific opportunities for improving the quality of PCP data and streamlining the new patient appointment scheduling process for VA Medicaid members. Approximately 83 percent (n=2,101) of overall cases were unable to be reached, did not offer primary care services, were not at the sampled location, did not accept the requested MCO, did not accept VA Medicaid, were not accepting new patients, or were unable to offer an appointment date to the caller.

General Recommendations

- Overall, HSAG was unable to reach approximately 37 percent of the sampled cases. Callers noted that key nonresponse reasons involved reaching a voicemail or an extended hold time.[8-1] Approximately 11.5 percent (n=290) of the cases had disconnected phone numbers. Additionally, 6.6 percent (n=167) of the cases reached a nonmedical facility. While conducting the survey calls, callers noted that a high percentage of sampled numbers connected to nonapproved, out-of-state locations not included in the study (i.e., providers practicing outside of Virginia in Kentucky, Maryland, North Carolina, Tennessee, West Virginia, and Washington, DC). Since DMAS' enrollment broker supplied HSAG with the PCP data used for this survey, HSAG recommends that DMAS work with the enrollment broker to address the data deficiencies identified during the survey (e.g., incorrect or disconnected telephone numbers). While the data provided by the enrollment broker were slightly more accurate than the historical data provided by the MCOs, HSAG identified areas in which the data can still be improved.
- Approximately 22 percent of the respondents indicated that the provider location did not provide such services. Additionally, approximately 8 percent of respondents indicated that the address for the sampled location was incorrect. HSAG recommends that the enrollment broker verify that its provider data correctly identify the location's address and appropriate provider type and specialty.
- Survey results indicated that less than 17 percent of respondents accepting new patients offered routine or urgent care appointments. Reasons that appointments were not offered by the providers' offices included offices requiring preregistration, personal information, review of medical records, or that a scheduling calendar was not available to schedule an appointment. HSAG identified considerations due to the nature of a secret shopper survey (i.e., requiring preregistration or personal information to schedule, VA Medicaid ID eligibility verification, and requiring completion of a questionnaire or interview) and separated those considerations from those not related to the nature of a secret shopper survey (e.g., requiring a medical record review or schedule/calendar not available). Those considerations not related to the nature of a secret shopper survey present opportunities to remove barriers applicable to any VA Medicaid member attempting to schedule a primary care appointment. HSAG recommends that DMAS and the MCOs consider conducting a review of the provider offices' requirements to ensure that these considerations to scheduling appointments do not unduly burden members' ability to access primary care and to streamline the process of scheduling new patient appointments within the routine (30-day) and urgent (one-day) appointment standards.
- To further evaluate data inconsistencies, HSAG recommends that DMAS consider conducting an NVS to evaluate the MCOs' provider directory information in addition to appointment wait times. An NVS would evaluate the accuracy of the MCOs' provider directory, and if key indicators (i.e., provider name, address, telephone number, specialty, and new patient acceptance) match between the MCO-submitted data and the online provider directory, a secret or revealed call would be placed to the provider location to verbally confirm the directory information and request appointment availability. Additionally, DMAS could consider providing the enrollment broker data to the MCOs to investigate differences in provider information.

[8-1] Some barriers to reaching the office (e.g., reaching voicemail) are unique to the secret shopper process. To maintain the secret nature of the survey, callers posed as new members but were instructed not to leave voicemails. As such, survey results may not represent response rates for members who are willing to provide personal information or leave voicemail messages.

- In coordination with ongoing outreach and network management activities, DMAS and/or the MCOs should review provider office procedures for ensuring that appointment availability standards are being met, address questions or educate providers and office staff members on DMAS' standards, and incorporate appointment availability standards into educational materials.

MCO-Specific Results

Aetna

Table 8-1 shows the outcome of Aetna's secret shopper survey calls compared to all MCOs combined.

Table 8-1—Secret Shopper Survey Call Outcomes by MCO and VA Medicaid

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

[1]The denominator includes the total number of survey cases.
[2]The denominator includes cases reached.
[3]The denominator includes cases reached and accepting new patients.

Table 8-2 shows the percentage of survey respondents that accepted the MCO, VA Medicaid, and were accepting new patients. Table 8-3 shows the percentage of calls that were offered an appointment and the percentage of those appointments within the compliance standards.

Table 8-2—MCO, VA Medicaid, and New Patient Acceptance Rates

MCO	Accepting MCO*	Accepting VA Medicaid*	Accepting New Patients*
Aetna	20.1%	19.0%	15.8%
MCO Total	**46.7%**	**43.3%**	**36.1%**

* The denominator includes cases reached.

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

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

[1]The denominator includes cases reached and accepting new patients.
[2]The denominator includes cases reached, accepting new patients, and offering an appointment.

Strengths, Weaknesses, and Recommendations

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

Strengths	
+	Of the cases reached, 9.6 percent of the provider locations did not offer primary care services.

Weaknesses and Recommendations	
−	**Weakness:** Of the 418 provider locations surveyed, 56.0 percent could not be reached. Of the cases reached, 20.1 percent accepted Aetna, 19.0 percent accepted VA Medicaid, and 15.8 percent accepted new patients. Of the provider locations accepting new patients, 28.6 percent and 40.0 percent offered a routine and urgent visit appointment, respectively. For routine appointments, 50.0 percent of the routine visit appointments offered were compliant with DMAS' 30-day appointment availability compliance standard. None of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standard. **Why the weakness exists:** These findings suggest that Aetna's provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold time of five minutes for the secret shopper survey; however, this may indicate that the providers' offices were facing delays due to staffing shortages and workforce issues.
	Recommendations: HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that DMAS share those files with Aetna and request that Aetna provide updates or confirmation that the data have been updated as appropriate. Additionally, DMAS can confirm appointment availability and scheduling procedures with Aetna, including panel capacity to accept new patients.

HealthKeepers

Table 8-4 shows the outcome of HealthKeepers' secret shopper survey calls compared to all MCOs combined.

Table 8-4—Secret Shopper Survey Call Outcomes by MCO and VA Medicaid

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

[1]The denominator includes the total number of survey cases.
[2]The denominator includes cases reached.
[3]The denominator includes cases reached and accepting new patients.

Table 8-5 shows the percentage of survey respondents that accepted the MCO, VA Medicaid, and were accepting new patients. Table 8-6 shows the percentage of calls that were offered an appointment and the percentage of those appointments within the compliance standards.

Table 8-5—MCO, VA Medicaid, and New Patient Acceptance Rates

MCO	Accepting MCO*	Accepting VA Medicaid*	Accepting New Patients*
HealthKeepers	45.4%	41.8%	34.1%
MCO Total	**46.7%**	**43.3%**	**36.1%**

* The denominator includes cases reached.

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

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

[1]The denominator includes cases reached and accepting new patients.
[2]The denominator includes cases reached, accepting new patients, and offering an appointment.

Strengths, Weaknesses, and Recommendations

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

Strengths	
+	Of the provider locations accepting new patients, 100.0 percent offered a routine and urgent visit appointment. Additionally, 71.4 percent of the routine visit appointments offered were compliant with DMAS' 30-day appointment availability compliance standard.
Weaknesses and Recommendations	
−	**Weakness:** Of the 433 provider locations surveyed, 37.0 percent could not be reached. Of the cases reached, 22.9 percent did not offer primary care services, 45.4 percent accepted HealthKeepers, 41.8 percent accepted VA Medicaid, and 34.1 percent accepted new patients. For urgent visits, 25.0 percent of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standard. **Why the weakness exists:** These findings suggest that HealthKeepers' provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold time of five minutes for the secret shopper survey; however, this may indicate that the providers' offices were facing delays due to staffing shortages and workforce issues.
	Recommendations: HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that DMAS share those files with HealthKeepers and request that HealthKeepers provide updates or confirmation that the data have been updated as appropriate. Additionally, DMAS can confirm appointment availability and scheduling procedures with HealthKeepers, including panel capacity to accept new patients.

Molina

Table 8-7 shows the outcome of Molina's secret shopper survey calls compared to all MCOs combined.

Table 8-7—Secret Shopper Survey Call Outcomes by MCO and VA Medicaid

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

[1]The denominator includes the total number of survey cases.
[2]The denominator includes cases reached.
[3]The denominator includes cases reached and accepting new patients.

Table 8-8 shows the percentage of survey respondents that accepted the MCO, VA Medicaid, and were accepting new patients. Table 8-9 shows the percentage of calls that were offered an appointment and the percentage of those appointments within the compliance standards.

Table 8-8—MCO, VA Medicaid, and New Patient Acceptance Rates

MCO	Accepting MCO*	Accepting VA Medicaid*	Accepting New Patients*
Molina	56.3%	54.3%	41.7%
MCO Total	**46.7%**	**43.3%**	**36.1%**

*The denominator includes cases reached.

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

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

[1]The denominator includes cases reached and accepting new patients.
[2]The denominator includes cases reached, accepting new patients, and offering an appointment.

Strengths, Weaknesses, and Recommendations

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

Strengths	
+	Of the provider locations accepting new patients, 91.7 percent and 91.4 percent offered a routine and urgent visit appointment, respectively. Additionally, 88.6 percent of the routine visit appointments offered were compliant with DMAS' 30-day appointment availability compliance standard.
Weaknesses and Recommendations	
−	**Weakness:** Of the 410 provider locations surveyed, 38.0 percent could not be reached. Of the cases reached, 23.9 percent did not offer primary care services, 56.3 percent accepted Molina, 54.3 percent accepted VA Medicaid, and 41.7 percent accepted new patients. For urgent appointments, 5.7 percent of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standard. **Why the weakness exists:** These findings suggest that Molina's provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold time of five minutes for the secret shopper survey; however, this may indicate that the providers' offices were facing delays due to staffing shortages and workforce issues.
	Recommendations: HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that DMAS share those files with Molina and request that Molina provide updates or confirmation that the data have been updated as appropriate. Additionally, DMAS can confirm appointment availability and scheduling procedures with Molina, including panel capacity to accept new patients.

Optima

Table 8-10 shows the outcome of Optima's secret shopper survey calls compared to all MCOs combined.

Table 8-10—Secret Shopper Survey Call Outcomes by MCO and VA Medicaid

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

[1]The denominator includes the total number of survey cases.
[2]The denominator includes cases reached.
[3]The denominator includes cases reached and accepting new patients.

Table 8-11 shows the percentage of survey respondents that accepted the MCO, VA Medicaid, and were accepting new patients. Table 8-12 shows the percentage of calls that were offered an appointment and the percentage of those appointments within the compliance standards.

Table 8-11—MCO, VA Medicaid, and New Patient Acceptance Rates

MCO	Accepting MCO*	Accepting VA Medicaid*	Accepting New Patients*
Optima	55.5%	47.7%	41.3%
MCO Total	**46.7%**	**43.3%**	**36.1%**

*The denominator includes cases reached.

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

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

[1]The denominator includes cases reached and accepting new patients.
[2]The denominator includes cases reached, accepting new patients, and offering an appointment.

Strengths, Weaknesses, and Recommendations

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

Strengths	
+	Of the cases reached, 18.7 percent of the provider locations did not offer primary care services. Additionally, 77.8 percent of the routine visit appointments offered were compliant with DMAS' 30-day appointment availability compliance standard.
Weaknesses and Recommendations	
−	**Weakness:** Of the 412 provider locations surveyed, 31.3 percent could not be reached. Of the cases reached, 55.5 percent accepted Optima, 47.7 percent accepted VA Medicaid, and 41.3 percent accepted new patients. Of the provider locations accepting new patients, 31.0 percent and 27.1 percent offered a routine and urgent visit appointment, respectively. For urgent visits, 6.3 percent of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standard. **Why the weakness exists:** These findings suggest that Optima's provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold time of five minutes for the secret shopper survey; however, this may indicate that the providers' offices were facing delays due to staffing shortages and workforce issues.
	Recommendations: HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that DMAS share those files with Optima and request that Optima provide updates or confirmation that the data have been updated as appropriate. Additionally, DMAS can confirm appointment availability and scheduling procedures with Optima, including panel capacity to accept new patients.

United

Table 8-13 shows the outcome of United's secret shopper survey calls compared to all MCOs combined.

Table 8-13—Secret Shopper Survey Call Outcomes by MCO and VA Medicaid

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

[1]The denominator includes the total number of survey cases.
[2]The denominator includes cases reached.
[3]The denominator includes cases reached and accepting new patients.

Table 8-14 shows the percentage of survey respondents that accepted the MCO, VA Medicaid, and were accepting new patients. Table 8-15 shows the percentage of calls that were offered an appointment and the percentage of those appointments within the compliance standards.

Table 8-14—MCO, VA Medicaid, and New Patient Acceptance Rates

MCO	Accepting MCO*	Accepting VA Medicaid*	Accepting New Patients*
United	44.5%	40.5%	34.2%
MCO Total	**46.7%**	**43.3%**	**36.1%**

*The denominator includes cases reached.

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

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

[1]The denominator includes cases reached and accepting new patients.
[2]The denominator includes cases reached, accepting new patients, and offering an appointment.

Strengths, Weaknesses, and Recommendations

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

Strengths	
+	Of the provider locations accepting new patients, 72.5 percent and 76.2 percent offered a routine and urgent visit appointment, respectively. For routine visits, 82.8 percent of the routine visit appointments offered were compliant with DMAS' 30-day appointment availability compliance standard.

Weaknesses and Recommendations	
−	**Weakness:** Of the 455 provider locations surveyed, 33.8 percent could not be reached. Of the cases reached, 31.4 percent did not offer primary care services, 44.5 percent accepted United, 40.5 percent accepted VA Medicaid, and 34.2 percent accepted new patients. For urgent visits, 12.5 percent of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standard. **Why the weakness exists:** These findings suggest that United's provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold time of five minutes for the secret shopper survey; however, this may indicate that the providers' offices were facing delays due to staffing shortages and workforce issues.
	Recommendations: HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that DMAS share those files with United and request that United provide updates or confirmation that the data have been updated as appropriate. Additionally, DMAS can confirm appointment availability and scheduling procedures with United, including panel capacity to accept new patients.

VA Premier

Table 8-16 shows the outcome of VA Premier's secret shopper survey calls compared to all MCOs combined.

Table 8-16—Secret Shopper Survey Call Outcomes by MCO and VA Medicaid

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

[1]The denominator includes the total number of survey cases.
[2]The denominator includes cases reached.
[3]The denominator includes cases reached and accepting new patients.

Table 8-17 shows the percentage of survey respondents that accepted the MCO, VA Medicaid, and were accepting new patients. Table 8-18 shows the percentage of calls that were offered an appointment and the percentage of those appointments within the compliance standards.

Table 8-17—MCO, VA Medicaid, and New Patient Acceptance Rates

MCO	Accepting MCO*	Accepting VA Medicaid*	Accepting New Patients*
VA Premier	50.2%	48.8%	42.8%
MCO Total	**46.7%**	**43.3%**	**36.1%**

*The denominator includes cases reached.

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

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

[1]The denominator includes cases reached and accepting new patients.
[2]The denominator includes cases reached, accepting new patients, and offering an appointment.

Strengths, Weaknesses, and Recommendations

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

Strengths	
+	Of the provider locations accepting new patients, 92.9 percent and 80.6 percent offered a routine and urgent visit appointment, respectively.

Weaknesses and Recommendations	
−	**Weakness:** Of the 394 provider locations surveyed, 24.1 percent could not be reached. Of the cases reached, 24.1 percent did not offer primary care services, 50.2 percent accepted VA Premier, 48.8 percent accepted VA Medicaid, and 42.8 percent accepted new patients. For routine visits, 61.5 percent of the routine visit appointments offered were compliant with DMAS' 30-day appointment availability compliance standard. For urgent visits, 25.9 percent of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standard. **Why the weakness exists:** These findings suggest that VA Premier's provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold time of five minutes for the secret shopper survey; however, this may indicate that the providers' offices were facing delays due to staffing shortages and workforce issues.
	Recommendations: VA Premier is no longer serving members as of July 1, 2023; therefore, HSAG has no recommendations for VA Premier. HSAG provides DMAS with the analytic flat files from the telephone survey. Since VA Premier has merged with Optima, HSAG recommends that Optima consider conducting a root cause analysis and providing updates or confirmation that the MCO's merged network data have been updated as appropriate. Additionally, Optima should confirm the merged MCO's appointment availability and scheduling procedures with DMAS, including panel capacity to accept new patients.

9. Encounter Data Validation

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted MCOs to accurately and effectively monitor and improve the quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to DMAS' overall management and oversight of its Medicaid managed care program. Results of the EDV study will be included in the 2024 External Quality Review Technical Report.

10. Member Experience of Care Survey

Overview

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

Objectives

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

MCO-Specific Results

Aetna

Table 10-1 and Table 10-2 present the 2022 and 2023 MCO-specific adult and child Medicaid CAHPS top-box scores, respectively, for the global ratings and composite measures. A trend analysis was performed that compared Aetna's 2023 CAHPS scores to its corresponding 2022 CAHPS scores. In addition, the 2023 CAHPS scores for Aetna were compared to the 2022 NCQA adult and child Medicaid national averages.

Table 10-1—Comparison of 2022 and 2023 Adult Medicaid CAHPS Results: Aetna

	2022	2023
Global Ratings		
Rating of Health Plan	63.2%	67.8%
Rating of All Health Care	53.6%	51.5%
Rating of Personal Doctor	68.1%	68.1%
Rating of Specialist Seen Most Often	73.4%	71.1%

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

▲ *Statistically significantly higher in 2023 than in 2022.*

▼ *Statistically significantly lower in 2023 than in 2022.*

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Strengths, Weaknesses, and Recommendations

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

Strengths	
+	Aetna's 2023 top-box score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for one measure, *Rating of Health Plan*.
Weaknesses and Recommendations	
−	**Weakness:** Aetna's 2023 top-box scores were not statistically significantly lower than the 2022 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.
	Recommendations: HSAG recommends that Aetna monitor the measures to ensure significant decreases in scores over time do not occur.

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

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

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

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ Statistically significantly higher in 2023 than in 2022.
▼ Statistically significantly lower in 2023 than in 2022.
Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

Strengths, Weaknesses, and Recommendations

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

Strengths	
⊕	Aetna's 2023 top-box scores were not statistically significantly higher than the 2022 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no strengths were identified.
Weaknesses and Recommendations	
⊖	**Weakness:** Aetna's 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for *Rating of Health Plan.*
	Weakness: Aetna's 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for *Rating of All Health Care*.
	Recommendations: HSAG recommends that Aetna conduct a root cause analysis of the measures that have been identified as areas of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that Aetna focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time.

HealthKeepers

Table 10-3 and Table 10-4 present the 2022 and 2023 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures. A trend analysis was performed that compared HealthKeepers' 2023 CAHPS scores to its corresponding 2022 CAHPS scores. In addition, the 2023 CAHPS scores for HealthKeepers were compared to the 2022 NCQA adult and child Medicaid national averages.

Table 10-3—Comparison of 2022 and 2023 Adult Medicaid CAHPS Results: HealthKeepers

	2022	2023
Global Ratings		
Rating of Health Plan	67.8%	67.0%
Rating of All Health Care	61.5%	59.5%
Rating of Personal Doctor	69.2%	73.2%
Rating of Specialist Seen Most Often	74.5%	66.7%
Composite Measures		
Getting Needed Care	86.0%	82.5%
Getting Care Quickly	85.1%	84.9%
How Well Doctors Communicate	92.8%	94.9%
Customer Service	90.6%	93.3%

▲ *Statistically significantly higher in 2023 than in 2022.*

▼ *Statistically significantly lower in 2023 than in 2022.*

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Strengths, Weaknesses, and Recommendations

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

Strengths	
+	HealthKeepers' 2023 top-box score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for *Getting Care Quickly*.
+	HealthKeepers' 2023 top-box score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for *Customer Service*.
Weaknesses and Recommendations	
−	**Weakness:** HealthKeepers' 2023 top-box scores were not statistically significantly lower than the 2022 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.
	Recommendations: HSAG recommends that HealthKeepers monitor the measures to ensure significant decreases in scores over time do not occur.

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

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

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

▲ *Statistically significantly higher in 2023 than in 2022.*

▼ *Statistically significantly lower in 2023 than in 2022.*

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

Strengths, Weaknesses, and Recommendations

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

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

Molina

Table 10-5 and Table 10-6 present the 2022 and 2023 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures. A trend analysis was performed that compared Molina's 2023 CAHPS scores to its corresponding 2022 CAHPS scores. In addition, the 2023 CAHPS scores for Molina were compared to the 2022 NCQA adult and child Medicaid national averages.

Table 10-5—Comparison of 2022 and 2023 Adult Medicaid CAHPS Results: Molina

	2022	2023
Global Ratings		
Rating of Health Plan	56.9%	61.5%
Rating of All Health Care	56.5%	56.2%
Rating of Personal Doctor	70.4%	67.9%
Rating of Specialist Seen Most Often	69.5%	68.1%
Composite Measures		
Getting Needed Care	84.4%	81.1%
Getting Care Quickly	80.8%	77.2%
How Well Doctors Communicate	91.6%	91.0%
Customer Service	87.9%	86.2%

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ Statistically significantly higher in 2023 than in 2022.
▼ Statistically significantly lower in 2023 than in 2022.
Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Strengths, Weaknesses, and Recommendations

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

Strengths	
⊕	Molina's 2023 top-box scores were not statistically significantly higher than the 2022 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no strengths were identified.

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

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

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

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ Statistically significantly higher in 2023 than in 2022.
▼ Statistically significantly lower in 2023 than in 2022.
Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Strengths, Weaknesses, and Recommendations

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

Strengths	
+	Molina's 2023 top-box score was statistically significantly higher than the 2022 NCQA child Medicaid national average for *How Well Doctors Communicate*.

Weaknesses and Recommendations	
−	**Weakness:** Molina's 2023 top-box scores were not statistically significantly lower than the 2022 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no weaknesses were identified

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

Optima

Table 10-7 and Table 10-8 present the 2022 and 2023 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures. A trend analysis was performed that compared Optima's 2023 CAHPS scores to its corresponding 2022 CAHPS scores. In addition, the 2023 CAHPS scores for Optima were compared to the 2022 NCQA adult and child Medicaid national averages.

Table 10-7—Comparison of 2022 and 2023 Adult Medicaid CAHPS Results: Optima

	2022	2023
Global Ratings		
Rating of Health Plan	69.1%	68.1%
Rating of All Health Care	63.1%	61.8%
Rating of Personal Doctor	72.3%	75.7%
Rating of Specialist Seen Most Often	77.7%	74.4%
Composite Measures		
Getting Needed Care	84.5%	86.2%
Getting Care Quickly	86.5%	84.8%
How Well Doctors Communicate	94.7%	92.7%
Customer Service	92.8%	92.6%

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

▲ *Statistically significantly higher in 2023 than in 2022.*

▼ *Statistically significantly lower in 2023 than in 2022.*

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Strengths, Weaknesses, and Recommendations

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

Strengths	
+	Optima's 2023 top-box scores were statistically significantly higher than the 2022 NCQA adult Medicaid national averages for five measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.
Weaknesses and Recommendations	
−	**Weakness:** Optima's 2023 top-box scores were not statistically significantly lower than the 2022 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.
	Recommendations: HSAG recommends that Optima monitor the measures to ensure significant decreases in scores over time do not occur.

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

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

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

▲ *Statistically significantly higher in 2023 than in 2022.*

▼ *Statistically significantly lower in 2023 than in 2022.*

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Strengths, Weaknesses, and Recommendations

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

Strengths	
⊕	Optima's 2023 top-box scores were not statistically significantly higher than the 2022 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no strengths were identified.
Weaknesses and Recommendations	
⊖	**Weakness:** Optima's 2023 top-box scores were not statistically significantly lower than the 2022 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no weaknesses were identified.
	Recommendations: HSAG recommends that Optima monitor the measures to ensure significant decreases in scores over time do not occur.

United

Table 10-9 and Table 10-10 present the 2022 and 2023 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures. A trend analysis was performed that compared United's 2023 CAHPS scores to its corresponding 2022 CAHPS scores. In addition, the 2023 CAHPS scores for United were compared to the 2022 NCQA adult and child Medicaid national averages.

Table 10-9—Comparison of 2022 and 2023 Adult Medicaid CAHPS Results: United

	2022	2023
Global Ratings		
Rating of Health Plan	68.0%	63.8%
Rating of All Health Care	56.5%	62.8%
Rating of Personal Doctor	69.7%	69.8%
Rating of Specialist Seen Most Often	66.9%	68.3%
Composite Measures		
Getting Needed Care	81.9%	84.5%
Getting Care Quickly	81.7%	81.7%
How Well Doctors Communicate	93.2%	93.5%

	2022	2023
Customer Service	90.8%	87.8%

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *Statistically significantly higher in 2023 than in 2022.*
▼ *Statistically significantly lower in 2023 than in 2022.*
Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Strengths, Weaknesses, and Recommendations

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

Strengths	
+	United's 2023 top-box score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for one measure, *Rating of All Health Care*.
Weaknesses and Recommendations	
−	**Weakness:** United's 2023 top-box scores were not statistically significantly lower than the 2022 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.
	Recommendations: HSAG recommends that United monitor the measures to ensure significant decreases in scores over time do not occur.

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

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

	2022	2023
Customer Service	85.9%+	89.3%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ Statistically significantly higher in 2023 than in 2022.
▼ Statistically significantly lower in 2023 than in 2022.
Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

Strengths, Weaknesses, and Recommendations

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

Strengths	
+	United's 2023 top-box scores were not statistically significantly higher than the 2022 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no strengths were identified.
Weaknesses and Recommendations	
−	**Weakness:** United's 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for one measure, *Rating of Health Plan*.
	Recommendations: HSAG recommends that United conduct a root cause analysis of the measure that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that United focus initiatives on raising the statistically significantly lower score and continue to monitor the measure to ensure there is not a significant decrease in the score over time.

VA Premier

Table 10-11 and Table 10-12 present the 2022 and 2023 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures. A trend analysis was performed that compared VA Premier's 2023 CAHPS scores to its corresponding 2022 CAHPS scores. In addition, the 2023 CAHPS scores for VA Premier were compared to the 2022 NCQA adult and child Medicaid national averages.

Table 10-11—Comparison of 2022 and 2023 Adult Medicaid CAHPS Results: VA Premier

	2022	2023
Global Ratings		
Rating of Health Plan	67.4%	60.7%

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

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ Statistically significantly higher in 2023 than in 2022.
▼ Statistically significantly lower in 2023 than in 2022.
Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Strengths, Weaknesses, and Recommendations

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

Strengths	
+	VA Premier's 2023 top-box score was statistically significantly higher than the 2022 NCQA child Medicaid national average for one measure, *Customer Service*.
Weaknesses and Recommendations	
−	**Weakness:** VA Premier's 2023 top-box scores were statistically significantly lower than the 2022 top-box scores for two measures, *Getting Needed Care* and *Getting Care Quickly*.
	Recommendations: As a result of VA Premier merging with Optima during CY 2023, HSAG has no recommendations. HSAG encourages the merged Optima MCO to review the VA Premier results and implement actions to address member experience issues, as appropriate.

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

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

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

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

▲ Statistically significantly higher in 2023 than in 2022.

▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Strengths, Weaknesses, and Recommendations

VA Premier's 2023 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
+	VA Premier's 2023 top-box score was statistically significantly higher than the 2022 top-box score for one measure, *Rating of Personal Doctor*. In addition, VA Premier's 2023 top-box score was statistically significantly higher than the 2022 NCQA child Medicaid national average for one measure, *How Well Doctors Communicate*.
Weaknesses and Recommendations	
−	**Weakness:** VA Premier's 2023 top-box scores were not statistically significantly lower than the 2022 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.
	Recommendations: As a result of VA Premier merging with Optima during CY 2023, HSAG has no recommendations. HSAG encourages the merged Optima MCO to review the VA Premier results and implement actions to address member experience issues, as appropriate.

11. ARTS Measure Specification Development and Maintenance

Overview

Beginning in contract year 2019–2020, DMAS contracted with HSAG, as its EQRO, to identify appropriate existing PMs and to develop new measure specifications, where necessary, for the ARTS benefit as mandated in the CMS Section 1115 Demonstration, "Building and Transforming Coverage, Services, and Supports for a Healthier Virginia." The Special Terms and Conditions of the 1115 Demonstration Waiver require DMAS to monitor the MCOs at least once per year through the EQRO. The ARTS benefit, which was launched in 2017, provides treatment for members with SUDs in Virginia.[11-1] The goals of the ARTS benefit include increasing initiation and engagement in SUD treatment, reducing overdose deaths, and improving access to care for all Medicaid-eligible members with SUD.[11-2] HSAG, in conjunction with DMAS, developed PMs using administrative data for the evaluation of DMAS' ARTS benefit. The 2022 ARTS Measure Report presented the CY 2020 and CY 2021 ARTS measure rates for the eight measures described in Table 11-1.

Table 11-1—ARTS Measures

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

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

[11-2] Centers for Medicare & Medicaid Services Department of Health & Human Services. Building and Transforming Coverage, Services, and Supports for a Healthier Virginia. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/va-gov-access-plan-gap-ca.pdf. Accessed on: Oct 31, 2023.

Findings

Table 11-2 presents the Virginia Medicaid total denominators (displayed as Denom) and rates for all study indicators for CY 2020 and CY 2021. Please note, the table also includes rates for all measure stratifications (i.e., Pharmacotherapy, Other Treatment, and Both Pharmacotherapy and Other Treatment) for the *Cascade of Care for Members With OUD—Members Identified as Having OUD who Initiated OUD Treatment* study indicator.

Table 11-2—Study Indicator Rates for the Virginia Medicaid Total Population, CY 2020 and CY 2021

Measure	CY 2020		CY 2021	
	Denom	Rate	Denom	Rate
Concurrent Prescribing of Naloxone and High-Dose Opioids				
Concurrent Prescribing of Naloxone and High-Dose Opioids	3,404	49.9%	3,306	51.4%
Naloxone Use for High Risk of Overdose				
Naloxone Use for Diagnosed Opioid Use Disorder	26,263	35.1%	38,510	39.2%
Naloxone Use for History of Chronic Opioid Use	2,663	66.6%	2,293	68.0%
Naloxone Use for Concurrent Benzodiazepine and Opioid Use	3,140	57.5%	2,851	58.3%
Naloxone Use for History of Overdose	1,956	37.6%	2,397	43.7%
Treatment of Hepatitis C for Those With Hepatitis C and SUD				
Treatment of Hepatitis C for Those With Hepatitis C and SUD	3,809	29.1%	4,420	31.9%
Treatment of HIV for Those With HIV and SUD				
Treatment of HIV for Those With HIV and SUD	1,104	64.9%	1,303	62.5%
Preferred OBAT Compliance				
Alcohol or Drug Screening: 8+ Screenings	9,492	55.0%	12,788	69.6%
Counseling from an OBAT Provider	9,492	94.2%	12,788	91.0%
Family Planning	4,004	42.6%	5,220	44.1%
Prescription for Naloxone from OBAT Provider	9,492	36.7%	12,788	37.6%
Prescription for Naloxone	9,492	51.1%	12,788	54.4%
Testing for HIV/Hepatitis C	9,492	20.8%	12,788	23.2%
Initiation of Medication for OUD	9,492	20.6%	12,788	19.3%
Concurrent Pharmacotherapy and Care Coordination	9,492	16.9%	12,788	15.4%
RPR Testing	9,492	1.3%	12,788	1.5%
Annual TB Testing	9,492	3.3%	12,788	4.9%
Cascade of Care for Members With OUD				
High-Risk Members With OUD Diagnosis	67,799	3.8%	87,229	5.1%
Members Identified as Having OUD who Initiated OUD Treatment: Pharmacotherapy	2,565	25.0%	4,485	31.2%
Members Identified as Having OUD who Initiated OUD Treatment: Other OUD Treatment	2,565	25.9%	4,485	25.8%

Measure	CY 2020		CY 2021	
	Denom	Rate	Denom	Rate
Members Identified as Having OUD who Initiated OUD Treatment: Both Pharmacotherapy and Other Treatment	2,565	11.4%	4,485	12.8%
Members who Initiated OUD Treatment who Also Engaged in OUD Treatment	1,013	49.4%	1,983	40.7%
Cascade of Care for Members With Hepatitis C				
Prevalence of Hepatitis C	873,579	0.2%	1,073,812	0.2%
Received DAA Treatment for Hepatitis C	1,842	38.3%	1,871	46.1%
Completed DAA Treatment for Hepatitis C	705	90.8%	862	91.3%
Achieved SVR	705	24.5%	862	30.7%
Cascade of Care for Members With HIV				
Received HIV Care	4,938	41.3%	6,213	37.3%
Retained in HIV Care	4,938	68.2%	6,213	66.1%
Received Antiretroviral Therapy	4,938	63.9%	6,213	68.9%

Conclusions

Study findings show that identification of members with SUD may be improving, in alignment with ARTS benefit goals. The *Cascade of Care for Members With OUD—High-Risk Members With OUD Diagnosis* indicator assessed identification of members with an OUD. Findings show that this rate increased from 3.8 percent to 5.1 percent from CY 2020 to CY 2021. However, NIH also reports that substance use has increased since the onset of the COVID-19 PHE,[11-3] so these findings may also reflect an increased incidence of SUD.

Several study indicators found that initiation of SUD treatment is increasing overall, though findings differ by type and timeliness of treatment. 44.2 percent of members diagnosed with OUD initiated any OUD treatment (i.e., pharmacotherapy or other treatment) within 14 days of OUD diagnosis in CY 2021, and this rate increased by 4.7 percentage points from CY 2020. The rate change was driven by an increase in members initiating pharmacotherapy, for which the rate increased by 6.2 percentage points from CY 2020 to CY 2021. Additionally, among members who had an initiation visit with an OBAT provider, 91.0 percent of members received counseling from an OBAT provider during the measurement year, and nearly 70 percent of members received eight or more alcohol or drug screenings during the measurement year. However, the percentage of members receiving counseling from an OBAT provider declined by 3.2 percentage points from CY 2020 to CY 2021. Please note that during the COVID-19 PHE, DMAS allowed for flexibilities to not discontinue a member's medication for OUD if they were not able to engage in counseling.

Study findings show that engagement in OUD treatment may be declining. The *Cascade of Care for Members With OUD—Members who Initiated OUD Treatment who Also Engaged in OUD Treatment* indicator found that 40.7 percent of members who had initiated OUD treatment engaged in OUD

[11-3] National Institutes of Health: National Institute on Drug Abuse. COVID-19 and Substance Use. Available at: https://nida.nih.gov/research-topics/comorbidity/covid-19-substance-use. Accessed on: Oct. 31, 2023.

treatment for six months following OUD diagnosis, and this rate declined by 8.7 percentage points from CY 2020 to CY 2021. However, the rate for CY 2021 may be especially impacted by the COVID-19 PHE, since this study indicator utilizes visits from the year prior to the measurement year. Therefore, many of these missed engagement visits were supposed to happen during 2020 after the onset of the PHE.

Seven study indicators assessed the receipt of naloxone, a medication to reverse opioid overdose, which can help reduce overdose deaths. These indicators demonstrated that the prescribing of naloxone to reduce overdose deaths has been consistent or has improved across CY 2020 and CY 2021, in alignment with ARTS benefit goals. However, there are opportunities for improvement among specific populations. Most members who receive opioids through the healthcare system are receiving naloxone. In CY 2021, 51.4 percent of members prescribed high-dose opioids received naloxone, and this rate improved by 1.5 percentage points from CY 2020 to CY 2021. Additionally, 68.0 and 58.3 percent of members with a history of chronic opioid use and concurrent benzodiazepine and opioid use, respectively, received naloxone. However, naloxone receipt is notably lower among other members at high risk of overdose. Only 39.2 percent of members diagnosed with OUD received naloxone. The rate of naloxone receipt among members receiving OBAT services was substantially higher at 54.4 percent, but still low compared to other high-risk populations. Additionally, only 43.7 percent of members with a history of overdose received naloxone, though this rate improved by 6.1 percentage points from CY 2020 to CY 2021.

Several study indicators assessed utilization of care for physical health conditions among members, with a focus on care for hepatitis C and HIV. These indicators found low rates for initiation of care but high rates for retention in care. Additionally, most rates related to care for physical health conditions improved from CY 2020 to CY 2021. Among members with SUD, 31.9 percent of members diagnosed with hepatitis C initiated antiviral therapy for hepatitis C, and 62.5 percent of members diagnosed with HIV were dispensed an antiretroviral therapy medication within 30 days of their first HIV diagnosis. Treatment for members with hepatitis C and SUD improved by 2.8 percentage points from CY 2020 to CY 2021, while treatment for members with HIV and SUD declined by 2.4 percentage points. In CY 2021, 91.3 percent of members who received DAA treatment completed it; however, only 46.1 percent of members diagnosed with hepatitis C received DAA treatment at all. While the rates of hepatitis C diagnosis and DAA treatment completion were consistent across CY 2020 and CY 2021, the rate of initiating DAA treatment and achieving SVR increased by 7.8 and 6.2 percentage points, respectively, from CY 2020 to CY 2021. Among members diagnosed with HIV, only 37.3 percent received HIV care within 30 days of diagnosis, while 66.1 percent were retained in HIV care for at least three months, and 68.9 percent received antiretroviral therapy within three months of initial HIV diagnosis.

In addition to the total Virginia Medicaid rates, the 2022 ARTS Measure Report evaluated PM rates stratified by demographics, region, delivery system, eligibility group, managed care program, and MCO. Among rates stratified by age category, members 12 to 21 years of age were consistently less likely to receive naloxone and OUD treatment compared to members in other age categories. Additionally, members 65 years of age and older were consistently less likely to initiate or be retained in hepatitis C and HIV care. However, these findings may reflect services billed to Medicare or medications received in institutionalized settings, such as skilled nursing facilities, not being captured in Medicaid administrative data. Rates for male and female members were generally similar. Rate differences among racial/ethnic groups varied across study indicators. However, Asian members prescribed high-dose opioids or with diagnosed OUD were less likely to receive naloxone than other racial/ethnic groups. Asian members at high risk of OUD were also almost half as likely to be diagnosed with OUD

than members in other racial/ethnic groups. Additionally, White members were more likely to receive treatment for hepatitis C than Black/African American members. The Central region had the highest rate of OUD diagnoses yet some of the lowest rates for initiation of pharmacotherapy and other treatment. The Southwest region had the highest rate of hepatitis C diagnoses but the lowest rates for initiation and completion of DAA treatment. The Roanoke/Alleghany region had the lowest rates for receipt of antiretroviral therapy among members with HIV.

Study indicator rates by delivery system varied, since the denominator for FFS members was typically small. Many study indicators had large increases in their denominators driven by an increase in Medicaid Expansion members from CY 2020 to CY 2021, and this increase in Medicaid Expansion sometimes drove overall changes in rates. Also of note, Dual Eligible members were consistently less likely to receive treatment for hepatitis C and HIV; however, this finding may reflect services billed to Medicare or medications received in institutionalized settings, such as skilled nursing facilities, not being captured in Medicaid administrative data. For MCO, Aetna and Molina tended to have lower rates of naloxone prescription compared to other MCOs. Molina also had the highest rate of OUD diagnoses, yet had relatively low rates for initiation of pharmacotherapy, initiation of other OUD treatment, and engagement in OUD treatment.

12. Focus Studies

Overview

Medicaid and CHIP Maternal and Child Health Outcomes Focus Study

The contract year 2021–2022 Medicaid and CHIP Maternal and Child Health Focus Study addressed the following questions:

- To what extent do women with births paid by Medicaid receive early and adequate prenatal care?
- What clinical outcomes (e.g., preterm births, low birth weight) are associated with births paid by Virginia Medicaid?
- What maternal health outcomes (e.g., depression) are associated with births paid by Virginia Medicaid?
- What health disparities exist in birth outcomes for births paid by Virginia Medicaid?

The Medicaid and CHIP Maternal and Child Health Focus Study included four study indicators calculated among singleton births occurring during CY 2020 and paid by Virginia Medicaid: percentage of births with early and adequate prenatal care, percentage of births with inadequate prenatal care, percentage of preterm births (<37 weeks gestation), and percentage of newborns with low birth weight (<2,500g). Study results included all live births paid by Virginia Medicaid, and were assigned to one of five Medicaid programs (i.e., FAMIS MOMS, Medicaid for Pregnant Women, Medicaid expansion, LIFC, or Other Medicaid). Please note, study results are not limited to the women in the CCC Plus (MLTSS) program. Additionally, women may have changed service delivery systems or MCOs while pregnant; as such, analytic stratifications in this study reflect the service delivery system (i.e., managed care or FFS) and Medicaid program in which the woman was enrolled at the time of delivery. Table 12-1 presents the birth outcomes study indicator results by Medicaid delivery system within each measurement period (i.e., CY 2019, CY 2020, and CY 2021).

Table 12-1—Overall Birth Outcomes Study Indicator Findings Among Singleton Births by Medicaid Delivery System, CY 2019–CY2021

Study Indicator	National Benchmark	CY 2019		CY 2020		CY 2021	
		Number	Percent	Number	Percent	Number	Percent
FFS							
Births with Early and Adequate Prenatal Care	76.4%	2,357	65.0%	1,881	64.8%	2,320	60.2%
*Births with Inadequate Prenatal Care**	*NA*	693	19.1%	562	19.4%	962	24.9%
*Births with No Prenatal Care**	*NA*	193	5.3%	117	4.0%	176	4.6%
Preterm Births (<37 Weeks Gestation)*	9.4%	488	12.8%	334	11.0%	413	10.5%

Study Indicator	National Benchmark	CY 2019		CY 2020		CY 2021	
		Number	Percent	Number	Percent	Number	Percent
Newborns with Low Birth Weight (<2,500 grams)*	9.7%	457	12.0%	280	9.3%	338	8.6%
Managed Care							
Births with Early and Adequate Prenatal Care	76.4%	20,035	73.2%	20,364	72.7%	21,460	74.3%
*Births with Inadequate Prenatal Care**	*NA*	4,350	15.9%	4,089	14.6%	4,144	14.4%
*Births with No Prenatal Care**	*NA*	495	1.8%	417	1.5%	509	1.8%
Preterm Births (<37 Weeks Gestation)*	9.4%	2,775	9.7%	2,834	9.7%	2,914	10.0%
Newborns with Low Birth Weight (<2,500 grams)*	9.7%	2,613	9.1%	2,699	9.2%	2,736	9.4%

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

Overall, women enrolled in managed care had better outcomes than women in the FFS population in CY 2021, with the exception of the *Newborns with Low Birth Weight (<2,500 grams)* study indicator rate. The CY 2021 managed care rate for the *Newborns with Low Birth Weight (<2,500 grams)* indicator outperformed the national benchmark but continued to underperform in comparison to the national benchmark for the *Births with Early and Adequate Prenatal Care* and *Preterm Births (<37 Weeks Gestation)* indicators. Of note, the CY 2021 rate for women in FFS continued to improve from prior measurement periods and outperformed the national benchmark for *Newborns with Low Birth Weight (<2,500 grams)*.

Table 12-2 presents the birth outcomes study indicator results by Medicaid program for each measurement period.

Table 12-2—Overall Birth Outcomes Study Indicator Findings Among Singleton Births by Medicaid Program, CY 2019–CY 2021

Study Indicator	National Benchmark	CY 2019		CY 2020		CY 2021	
		Number	Percent	Number	Percent	Number	Percent
Medicaid for Pregnant Women							
Births with Early and Adequate Prenatal Care	76.4%	16,028	73.1%	13,737	72.4%	11,493	73.9%
*Births with Inadequate Prenatal Care**	*NA*	3,451	15.7%	2,839	15.0%	2,337	15.0%
*Births with No Prenatal Care**	*NA*	393	1.8%	241	1.3%	239	1.5%

Study Indicator	National Benchmark	CY 2019		CY 2020		CY 2021	
		Number	Percent	Number	Percent	Number	Percent
Preterm Births (<37 Weeks Gestation)*	9.4%	2,173	9.5%	1,750	8.9%	1,460	9.3%
Newborns with Low Birth Weight (<2,500 grams)*	9.7%	2,062	9.0%	1,699	8.6%	1,333	8.5%
Medicaid Expansion							
Births with Early and Adequate Prenatal Care	76.4%	1,462	70.9%	3,249	73.8%	5,031	77.5%
*Births with Inadequate Prenatal Care**	*NA*	330	16.0%	578	13.1%	722	11.1%
*Births with No Prenatal Care**	*NA*	74	3.6%	90	2.0%	154	2.4%
Preterm Births (<37 Weeks Gestation)*	9.4%	261	12.1%	544	11.9%	733	11.2%
Newborns with Low Birth Weight (<2,500 grams)*	9.7%	235	10.9%	463	10.1%	707	10.8%
FAMIS MOMS							
Births with Early and Adequate Prenatal Care	76.4%	1,626	77.2%	1,564	76.8%	1,382	78.1%
*Births with Inadequate Prenatal Care**	*NA*	292	13.9%	261	12.8%	219	12.4%
*Births with No Prenatal Care**	*NA*	28	1.3%	11	0.5%	12	0.7%
Preterm Births (<37 Weeks Gestation)*	9.4%	168	7.7%	163	7.8%	161	9.0%
Newborns with Low Birth Weight (<2,500 grams)*	9.7%	158	7.2%	150	7.2%	145	8.1%
Other Aid Categories†							
Births with Early and Adequate Prenatal Care	76.4%	3,276	66.9%	3,695	66.9%	5,874	65.9%
*Births with Inadequate Prenatal Care**	*NA*	970	19.8%	973	17.6%	1,828	20.5%
*Births with No Prenatal Care**	*NA*	193	3.9%	192	3.5%	280	3.1%
Preterm Births (<37 Weeks Gestation)*	9.4%	661	12.9%	711	12.3%	973	10.8%
Newborns with Low Birth Weight (<2,500 grams)*	9.7%	615	12.0%	667	11.5%	889	9.9%

**a lower rate indicates better performance for this indicator.*

NA indicates there is not an applicable national benchmark for this indicator.
† Other Aid Categories includes all other births not covered by Medicaid for Pregnant Women, Medicaid Expansion, and FAMIS MOMS programs.

Overall, the FAMIS MOMS program demonstrated strength, with rates for the *Births with Early and Adequate Prenatal Care*, *Preterm Births (<37 Weeks Gestation),* and *Newborns with Low Birth Weight (<2,500 grams)* study indicators outperforming the applicable national benchmarks for all three measurement periods. The Medicaid for Pregnant Women program also had *Preterm Births (<37 Weeks Gestation)* and *Newborns with Low Birth Weight (<2,500 grams)* rates that outperformed the national benchmarks in CY 2021. Additionally, the Medicaid Expansion program's rate for the *Births with Early and Adequate Prenatal Care* study indicator improved from CY 2020 to exceed the national benchmark in CY 2021. Conversely, the Other Aid Categories rates for all three study indicators underperformed in comparison to the national benchmarks for all three measurement periods.

Table 12-3 presents the maternal health outcomes study indicator results by Medicaid delivery system within each measurement period (i.e., CY 2019, CY 2020, and CY 2021).

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

Study Indicator	CY 2021		
	Numerator	Denominator	Percent
FFS			
*Postpartum ED Utilization**	316	3,916	8.1%
Postpartum Ambulatory Care Utilization	1,576	3,916	40.2%
Prenatal Maternal Depression Screening	15	3,916	0.4%
Postpartum Maternal Depression Screening	113	3,916	2.9%
Managed Care			
*Postpartum ED Utilization**	4,311	29,116	14.8%
Postpartum Ambulatory Care Utilization	15,448	29,116	53.1%
Prenatal Maternal Depression Screening	1,623	29,116	5.6%
Postpartum Maternal Depression Screening	2,138	29,116	7.3%

**a lower rate indicates better performance for this indicator.*

Table 12-4 presents the maternal health outcomes study indicator results by Medicaid program for each measurement period.

Table 12-4—Overall Maternal Health Outcomes Study Indicator Findings Among Singleton Births by Medicaid Program, CY 2021

Study Indicator	CY 2021		
	Numerator	Denominator	Percent
Medicaid for Pregnant Women			
*Postpartum ED Utilization**	2,175	15,682	13.9%

Study Indicator	CY 2021		
	Numerator	Denominator	Percent
Postpartum Ambulatory Care Utilization	8,301	15,682	52.9%
Prenatal Maternal Depression Screening	709	15,682	4.5%
Postpartum Maternal Depression Screening	1,147	15,682	7.3%
Medicaid Expansion			
*Postpartum ED Utilization**	905	6,548	13.8%
Postpartum Ambulatory Care Utilization	3,265	6,548	49.9%
Prenatal Maternal Depression Screening	387	6,548	5.9%
Postpartum Maternal Depression Screening	485	6,548	7.4%
FAMIS MOMS			
*Postpartum ED Utilization**	191	1,785	10.7%
Postpartum Ambulatory Care Utilization	855	1,785	47.9%
Prenatal Maternal Depression Screening	48	1,785	2.7%
Postpartum Maternal Depression Screening	109	1,785	6.1%
Other Aid Categories†			
*Postpartum ED Utilization**	1,198	9,017	17.1%
Postpartum Ambulatory Care Utilization	4,603	9,017	51.0%
Prenatal Maternal Depression Screening	494	9,017	5.5%
Postpartum Maternal Depression Screening	510	9,017	5.7%

**a lower rate indicates better performance for this indicator.*
† Other Aid Categories includes all other births not covered by Medicaid for Pregnant Women, Medicaid Expansion, and FAMIS MOMS programs

Births to women in the FAMIS MOMS program had the lowest rates of *Postpartum Ambulatory Care Utilization*, *Prenatal Maternal Health Screening*, and *Postpartum Maternal Depression Screening* for CY 2021. Additionally, the Medicaid for Pregnant Women program had the highest rate of *Postpartum Ambulatory Care* and had some of the highest rates for *Prenatal Maternal Depression Screening* and *Postpartum Maternal Depression Screening* for CY 2021.

Foster Care Focus Study[12-1]

In contract year 2021–2022, HSAG conducted the seventh annual Child Welfare Focus Study to determine the extent to which members in child welfare programs (i.e., children in foster care, children receiving adoption assistance, and former foster care members) received the expected preventive and therapeutic medical care under a managed care service delivery program compared to members not in a child welfare program and receiving Medicaid managed care benefits during MY 2021 (i.e., January

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

1, 2021–December 31, 2021). While historically the Foster Care Focus Study evaluated healthcare utilization among members in the study populations, for this year's focus study, DMAS requested that HSAG also evaluate timely access to care for members who transitioned into or out of the foster care program. For the timely access to care analysis, HSAG developed custom measures to determine the extent to which children newly enrolled in the foster care program and children who aged out of the foster care program were able to access healthcare services in a timely manner.

Additionally, DMAS requested that HSAG evaluate disparities in healthcare utilization and timely access to care based on demographic factors (i.e., age, sex, race, region, and MCO). Federal regulations require state Medicaid agencies to incorporate a plan to identify, evaluate, and reduce health disparities as part of their managed care state quality strategy.[12-2] DMAS' QS is committed to monitoring health disparities to inform QI efforts and ensure that Virginia Medicaid members have access to high-quality care. DMAS' QS defines health disparities as differences in health outcomes between groups within a population.[12-3] The 2021–22 Child Welfare Focus Study presents study indicator results stratified by member demographics and assesses whether health disparities were statistically significant.

A policy statement published in 2015 by AAP outlined a significant number of barriers in providing adequate and timely health services to children in foster care.[12-4] These issues, compounded with the complexities of care for children with histories of trauma and potentially limited healthcare access, make the assessment of preventive and baseline healthcare services critical for a population in the developmental stages of life. Additionally, children in foster care are likely to require services from both physical health and BH providers,[12-5] necessitating levels of care coordination and follow-up beyond those expected for most children and adolescents. These physical health and BH conditions create additional challenges for youth aging out of the foster care system who are unable to find a permanent home and must navigate the transition into adulthood and adult healthcare.[12-6] Given the changes to Medicaid managed care benefits and the barriers to healthcare that children in foster care face, this study examined how healthcare utilization among children in foster care, adoption assistance children, and former foster children compared to utilization among comparable members not in a child welfare program.

Healthcare Utilization Findings

For alignment with other quality initiatives, healthcare utilization measures were based on CMS' Adult and Child Core Set Technical Specifications and Resource Manual for FFY 2021 Reporting or custom measure specifications. The healthcare utilization analysis assessed 20 measures, representing 34 study indicators, across six domains:

12-2 CMS. CMS External Quality Review (EQR) Protocols. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Nov 8, 2023.
12-3 Commonwealth of Virginia DMAS. 2022–2022 Quality Strategy. Available at: https://www.dmas.virginia.gov/media/2649/2020-2022-dmas-quality-strategy.pdf. Accessed on: Nov 8, 2023.
12-4 American Academy of Pediatrics. Health care issues for children and adolescents in foster care and kinship care. *Pediatrics*. Oct 2015:136:4. Available at: https://publications.aap.org/pediatrics/article/136/4/e1131/73819/Health-Care-Issues-for-Children-and-Adolescents-in. Accessed on: Nov 8, 2023.
12-5 Deutsch SA, Lynch A, Zlotnik S, et.al. Mental health, behavioral and developmental issues for youth in foster care. *Current Problems in Pediatric and Adolescent Health Care*. 2015; 45:292–297.
12-6 Dworsky A, Courtney M. Addressing the Mental Health Service Needs of Foster Youth During the Transition to Adulthood: How Big is the Problem and What Can States Do? *Journal of Adolescent Health*.2009; 44:1–2.

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

Table 12-5 through Table 12-7 present study indicator results for the children in foster care, children receiving adoption assistance, and former foster care members study populations and their associated controls. P-values indicate whether the rate differences between the study population and their controls are statistically significant.

Table 12-5—Healthcare Utilization Study Indicator Results for Children in Foster Care and Controls

Measure	Children in Foster Care Rate	Controls Rate	*p*
Primary Care			
Child and Adolescent Well-Care Visits	64.8%	54.7%	<0.001*
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	63.8%	60.0%	0.46
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	79.7%	75.8%	0.31
Oral Health			
Annual Dental Visit	70.6%	52.4%	<0.001*
Preventive Dental Services	64.6%	45.6%	<0.001*
Oral Evaluation, Dental Services	63.5%	44.5%	<0.001*
Topical Fluoride for Children—Dental or Oral Health Services	35.0%	20.8%	<0.001*
Topical Fluoride for Children—Dental Services	28.3%	16.0%	<0.001*
Topical Fluoride for Children—Oral Health Services	2.4%	2.1%	0.43
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	64.2%	59.7%	0.56
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up	92.9%	81.5%	0.25
Metabolic Monitoring for Children and Adolescents on Antipsychotics	38.0%	35.7%	0.67
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	89.2%	68.4%	0.01*
Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up	78.1%	66.4%	0.04*
Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up	88.6%	81.8%	0.13
Follow-Up Care for Children Prescribed ADHD Medication—Three-Month Follow-Up	93.0%	90.2%	0.43

Measure	Children in Foster Care Rate	Controls Rate	*p*
Follow-Up Care for Children Prescribed ADHD Medication—Six-Month Follow-Up	96.5%	96.5%	1.00
Follow-Up Care for Children Prescribed ADHD Medication—Nine-Month Follow-Up	98.2%	97.2%	0.70
Substance Use			
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up	0.0%	0.0%	NC
*Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment^*	39.7%	50.0%	0.39
*Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment^*	20.7%	16.7%	0.77
Respiratory Health			
Asthma Medication Ratio	85.7%	80.2%	0.48
Service Utilization			
Ambulatory Care Visits	88.9%	89.7%	0.33
ED Visits	24.8%	31.5%	<0.001*
Inpatient Visits	4.5%	4.4%	0.82
Behavioral Health Encounters—ARTS	1.9%	0.7%	<0.001*
Behavioral Health Encounters—CMH Services	38.8%	21.7%	<0.001*
Behavioral Health Encounters—RTC Services	4.4%	2.6%	<0.001*
Behavioral Health Encounters—Therapeutic Services	10.4%	5.9%	<0.001*
Behavioral Health Encounters—Traditional Services	67.8%	53.8%	<0.001*
Behavioral Health Encounters—Total	71.0%	57.5%	<0.001*
Overall Service Utilization	92.1%	93.0%	0.18

** Indicates that the rates are statistically different between the children in foster care and controls.*
NC indicates that the p-value could not be calculated since both numerators were zero.
P-values were calculated using Chi-square tests and Fisher's exact tests to quantify the relationship between foster care status and numerator compliance. Measure rates and p-values presented in this table are not adjusted for demographic and health characteristics.
Denominators vary by study indicator; please refer to the technical specifications for denominator criteria.
^ MY 2021 rates were recalculated for the 2022–23 Child Welfare Focus Study; therefore, these rates will not match the MY 2021 rates presented in the 2021–22 Child Welfare Focus Study.

Table 12-6—Healthcare Utilization Study Indicator Results for Children Receiving Adoption Assistance and Controls

Measure	Children in Foster Care Rate	Controls Rate	*p*
Primary Care			
Child and Adolescent Well-Care Visits	47.1%	48.2%	0.17
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	50.0%	65.3%	0.61

Measure	Children in Foster Care Rate	Controls Rate	*p*
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	71.0%	72.9%	0.82
Oral Health			
Annual Dental Visit	53.2%	50.8%	0.003*
Preventive Dental Services	48.3%	45.0%	<0.001*
Oral Evaluation, Dental Services	47.2%	44.0%	<0.001*
Topical Fluoride for Children—Dental or Oral Health Services	23.7%	19.6%	<0.001*
Topical Fluoride for Children—Dental Services	19.4%	16.2%	<0.001*
Topical Fluoride for Children—Oral Health Services	1.4%	1.2%	0.46
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	59.7%	52.0%	0.25
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up	80.0%	67.4%	0.13
Metabolic Monitoring for Children and Adolescents on Antipsychotics	34.1%	34.6%	0.90
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	59.3%	65.3%	0.41
Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up	51.4%	58.1%	0.12
Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up	62.9%	74.3%	0.005*
Follow-Up Care for Children Prescribed ADHD Medication—Three-Month Follow-Up	73.1%	81.0%	0.03*
Follow-Up Care for Children Prescribed ADHD Medication—Six-Month Follow-Up	86.1%	91.5%	0.05*
Follow-Up Care for Children Prescribed ADHD Medication—Nine-Month Follow-Up	91.0%	94.0%	0.19
Substance Use			
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up	0.0%	25.0%	0.40
*Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment^*	54.1%	30.0%	0.03*
*Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment^*	8.1%	10.0%	1.00
Respiratory Health			
Asthma Medication Ratio	86.1%	71.4%	0.001*
Service Utilization			
Ambulatory Care Visits	81.4%	83.6%	<0.001*
ED Visits	16.1%	24.1%	<0.001*
Inpatient Visits	2.8%	2.4%	0.12
Behavioral Health Encounters—ARTS	0.4%	0.5%	0.08
Behavioral Health Encounters—CMH Services	14.0%	14.2%	0.76

Measure	Children in Foster Care Rate	Controls Rate	*p*
Behavioral Health Encounters—RTC Services	2.7%	1.9%	<0.001*
Behavioral Health Encounters—Therapeutic Services	5.0%	4.3%	0.03*
Behavioral Health Encounters—Traditional Services	50.3%	42.4%	<0.001*
Behavioral Health Encounters—Total	51.6%	44.9%	<0.001*
Overall Service Utilization	84.1%	86.7%	<0.001*

** Indicates that the rates are statistically different between the adoption assistance children and controls.*
P-values were calculated using Chi-square tests and Fisher's exact tests to quantify the relationship between adoption assistance status and numerator compliance. Measure rates and p-values presented in this table are not adjusted for demographic and health characteristics.
Denominators vary by study indicator; please refer to the technical specifications for denominator criteria
^ MY 2021 rates were recalculated for the 2022–23 Child Welfare Focus Study; therefore, these rates will not match the MY 2021 rates presented in the 2021–22 Child Welfare Focus Study.

Table 12-7—Healthcare Utilization Study Indicator Results for Former Foster Care Members and Controls

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

Measure	Children in Foster Care Rate	Controls Rate	*p*
Asthma Medication Ratio	69.2%	66.7%	1.00
Service Utilization			
Ambulatory Care Visits	62.3%	66.9%	0.01*
ED Visits	44.3%	38.5%	<0.001*
Inpatient Visits	10.4%	9.6%	0.48
Behavioral Health Encounters—ARTS	5.8%	4.5%	0.08
Behavioral Health Encounters—CMH Services	10.1%	6.3%	<0.001*
Behavioral Health Encounters—RTC Services	5.0%	2.5%	<0.001*
Behavioral Health Encounters—Therapeutic Services	4.1%	2.9%	0.06
Behavioral Health Encounters—Traditional Services	34.2%	30.9%	0.04*
Behavioral Health Encounters—Total	35.6%	31.9%	0.02*
Overall Service Utilization	74.7%	75.4%	0.66

** Indicates that the rates are statistically different between the former foster children and controls.*
NC indicates that the p-value could not be calculated since both numerators were zero.
P-values were calculated using Chi-square tests and Fisher's exact tests to quantify the relationship between former foster care status and numerator compliance. Measure rates and p-values presented in this table are not adjusted for demographic and health characteristics.
Denominators vary by study indicator; please refer to the technical specifications for denominator criteria.
^ MY 2021 rates were recalculated for the 2022–23 Child Welfare Focus Study; therefore, these rates will not match the MY 2021 rates presented in the 2021–22 Child Welfare Focus Study.

This study demonstrated that children in foster care have higher rates of appropriate healthcare utilization than comparable controls for most study indicators in MY 2019, MY 2020, and MY 2021. Study findings show that MY 2021 rate differences between children in foster care and controls were greatest among the dental study indicators (*Annual Dental Visit; Preventive Dental Services; Oral Evaluation, Dental Services;* and *Topical Fluoride for Children—Dental or Oral Health Services* by 18.2, 19.0, 19.0, and 14.2 percentage points, respectively), the *Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics* measure (by 20.4 percentage points), and the *Behavioral Health Encounters—CMH Services* indicator (by 17.1 percentage points). Rate differences between children in foster care and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2021, children in foster care had lower rates compared to controls for only four study indicators: *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment, Ambulatory Care Visits, ED Visits*, and *Overall Service Utilization.* For *Initiation of AOD Treatment*, children in foster care had a higher rate than controls during MY 2019 but a lower rate than controls in MY 2020. However, the rate for children in foster care increased from 29.1 percent to 39.7 percent from MY 2020 to MY 2021, and the gap between children in foster care and controls reduced from 16.7 to 10.3 percentage points. Additionally, the rate for children in foster care for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment* study indicator was lower than controls during MY 2020 but higher than controls during MY 2021, indicating improvement in AOD treatment engagement as well. For the *ED Visits* study indicator, the rate for children in foster care was 6.7 percentage points lower than the rate for controls, which could reflect better management of health conditions for children in foster care. For the *Ambulatory Care Visits* and *Overall Service Utilization* indicators, the rate difference between children in foster care and controls

was less than 1 percentage point, and the rates for children in foster care were very high for both indicators.

Among children in foster care, four study indicator rates increased, while 13 study indicator rates decreased from MY 2020 to MY 2021, and seven study indicator rates increased, while eight study indicator rates decreased from MY 2019 to MY 2021. The largest declines from MY 2020 to MY 2021 were for the *Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up* indicator (by 8.7 percentage points), the *Annual Dental Visit* indicator (by 8.5 percentage points), and the *Preventive Dental Services* indicator (by 7.4 percentage points). Among controls for children in foster care, 13 study indicator rates increased, while four study indicator rates decreased from MY 2020 to MY 2021, and eight study indicator rates increased, while nine study indicator rates decreased from MY 2019 to MY 2022. Some declines in rates may be attributable to the COVID-19 pandemic during MY 2020 and MY 2021. For instance, from March 2020 to May 2020, most elective procedures and outpatient visits were cancelled or postponed nationwide.[12-7] Additionally, utilization of ambulatory care services remained below expected rates into early 2021, and rates for Medicaid enrollees were slower to rebound after COVID-19 outbreaks than commercial, Medicare Advantage, and Medicare fee-for-service (FFS) enrollees.[12-8] Despite the nationwide decline in healthcare utilization, six of the MY 2020 to MY 2021 rate declines were by less than 3 percent.

This study demonstrated that children receiving adoption assistance have higher rates of appropriate healthcare utilization than comparable controls for 47 percent of study indicators in MY 2021 compared to 60 percent of study indicators in MY 2020. Study findings show that children receiving adoption assistance had higher rates than controls for all six Oral Health domain study indicators, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up, Follow-Up After ED Visit for Mental Illness—30-Day Follow*-Up, *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment*, *Asthma Medication Ratio, Inpatient Visits*, and four out of six *Behavioral Health Encounters* study indicators. Rate differences between children receiving adoption assistance and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2021, children receiving adoption assistance had lower rates compared to controls for the three Primary Care domain study indicators, most Behavioral Health domain study indicators, *Ambulatory Care Visits*, *ED Visits*, and *Overall Service Utilization*. The largest differences were for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* study indicator (by 15.3 percentage points) and the *Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up* study indicator (by 11.4 percentage points). However, for eight study indicators, the rates for children receiving adoption assistance were less than 3 percentage points lower than the controls. Additionally, the *ED Visits* rate for children receiving adoption assistance was 8.0 percentage points lower than controls, which may indicate that health conditions for children receiving adoption assistance are being better managed.

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

12-8 Mafi JN, Craff M, Vangala S. *Trends in US Ambulatory Care Patterns During the COVID-19 Pandemic, 2019-2021.* Journal of the American Medical Association. 2022. Available at: https://jamanetwork.com/journals/jama/fullarticle/2788140. Accessed on: Nov 8, 2023.

Among children receiving adoption assistance, four study indicator rates increased, while 12 study indicator rates decreased from MY 2020 to MY 2021. The largest declines from MY 2020 to MY 2021 were for the *Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment* study indicator (by 16.9 percentage points) and the *Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up* study indicator (by 8.9 percentage points). The *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* study indicator also declined by 33.0 percentage points; however, the denominator is very small, so rate changes across time are expected to be larger. Among controls for children receiving adoption assistance, nine study indicator rates increased, while nine study indicator rates decreased from MY 2020 to MY 2021. Some declines in rates may be attributable to the COVID-19 pandemic during MY 2020 and MY 2021. Despite the nationwide decline in healthcare utilization, four of the rate declines among children in adoption assistance were by less than 3 percent.

This study demonstrated that former foster care members have higher rates of appropriate healthcare utilization than comparable controls for 64 percent of study indicators in MY 2021 compared to 45 percent of study indicators in MY 2020. Study findings show that former foster care members had higher rates than controls for *Child and Adolescent Well-Care Visits*, all Oral Health domain study indicators, *Follow-Up After ED Visit for Mental Illness—30-Day Follow*-Up, *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment*, *Asthma Medication Ratio, ED Visits, Inpatient Visits*, and all *Behavioral Health Encounters* study indicators. Rate differences between former foster care members and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2021, former foster care members had lower rates compared to controls for the *Antidepressant Medication Management* study indicators, *Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment*, *Ambulatory Care Visits*, and *Overall Service Utilization*. The largest differences were for the *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* study indicator (by 9.3 percentage points) and the *Antidepressant Medication Management—Effective Acute Phase Treatment* study indicator (by 8.8 percentage points).

Among former foster care members, all study indicator rates except *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* increased from MY 2020 to MY 2021. However, the *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* study indicator only declined by 0.9 percentage points. Among controls for former foster care members, all study indicator rates except two (i.e., *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up)* also increased from MY 2020 to MY 2021.

Timely Access to Care Findings

For the timely access to care analysis, HSAG developed custom measures to determine the extent to which children newly enrolled in the foster care program and children who aged out of the foster care program were able to access healthcare services in a timely manner. HSAG assessed 3 measures, representing 10 study indicators. Table 12-8 contains the timely access to care study indicator results for children newly enrolled in foster care and members who aged out of foster care.

Table 12-8—Timely Access to Care Study Indicator Results for Children Newly Enrolled in Foster Care and Members Who Aged Out of Foster Care

Measure	Denominator	Numerator	Rate
Timely Access to Care for New Foster Care Members—Timely Access to Primary Care for New Foster Care Members	1,699	1,464	86.2%
Timely Access to Care for New Foster Care Members—Timely Access to Dental Care for New Foster Care Members	1,699	747	44.0%
Timely Access to Care for New Foster Care Members—Timely Access to Primary Care or Dental Care for New Foster Care Members	1,699	1,534	90.3%
Timely Access to Care for New Foster Care Members—Timely Access to Primary Care and Dental Care for New Foster Care Members	1,699	677	39.9%
Timely Access to Care for Members Who Aged Out of Foster Care—Timely Access to Primary Care for Members Who Aged Out of Foster Care	179	125	69.8%
Timely Access to Care for Members Who Aged Out of Foster Care—Timely Access to Dental Care for Members Who Aged Out of Foster Care	179	62	34.6%
Timely Access to Care for Members Who Aged Out of Foster Care—Timely Access to Primary Care or Dental Care for Members Who Aged Out of Foster Care	179	133	74.3%
Timely Access to Care for Members Who Aged Out of Foster Care—Timely Access to Primary Care and Dental Care for Members Who Aged Out of Foster Care	179	54	30.2%
Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care—Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care	179	58	32.4%
Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care—Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care with a Behavioral Health Diagnosis	142	56	39.4%

The SFY 2021–2022 study found that 86.2 percent of new foster care members had a visit with a PCP within 30 days after or 90 days prior to entering foster care. Therefore, most children in foster care are receiving timely access to primary care; however, there may be some room for improvement in meeting State guidelines. Additionally, 44.0 percent of new foster care members had a visit with a dental provider within 30 days after or 90 days prior to entering foster care, and most of these children also had a visit with a PCP. Study indicators also assessed timely access to care for members who aged out of foster care. Findings demonstrate that 69.8 percent of members who aged out of foster care in the year prior to the measurement year had a visit with a PCP during the measurement year. Similar to new foster care members, 34.6 percent of members who aged out of foster care had a visit with a dental practitioner during the measurement year, and most of these members also had a visit with a PCP. Additionally, most members who aged out of foster care had a BH diagnosis, and 39.4 percent of these members with a BH diagnosis had a visit with an MHP during the measurement year.

Health Disparities Findings

HSAG assessed health disparities among members in child welfare programs based on key demographic factors (i.e., race, age, gender, MCO, and region) for both the healthcare utilization measures and the timely access to care measures. For the healthcare utilization measures, HSAG also assessed health disparities among each group of controls and compared results to the study

populations. Table 12-9 contains the count and percentage of healthcare utilization study indicators for which a health disparity was identified by member characteristic (e.g., age category) for each analysis.

Table 12-9—Count and Percentage of Study Indicators With a Health Disparity

Disparity Type and Analysis	Count of Study Indicators	Percent of Study Indicators
Age Category*		
Healthcare Utilization: Children in Foster Care	17	64.4%
Healthcare Utilization: Children Receiving Adoption Assistance	14	53.8%
Healthcare Utilization: Former Foster Care Members	1	6.3%
Timely Access to Care	4	100.0%
Sex		
Healthcare Utilization: Children in Foster Care	6	21.4%
Healthcare Utilization: Children Receiving Adoption Assistance	7	25.0%
Healthcare Utilization: Former Foster Care Members	7	29.2%
Timely Access to Care	6	60.0%
Race		
Healthcare Utilization: Children in Foster Care	2	7.1%
Healthcare Utilization: Children Receiving Adoption Assistance	9	32.1%
Healthcare Utilization: Former Foster Care Members	7	29.2%
Timely Access to Care	0	0.0%
Region		
Healthcare Utilization: Children in Foster Care	19	67.9%
Healthcare Utilization: Children Receiving Adoption Assistance	22	78.6%
Healthcare Utilization: Former Foster Care Members	7	29.2%
Timely Access to Care	7	70.0%
MCO		
Healthcare Utilization: Children in Foster Care	13	46.4%
Healthcare Utilization: Children Receiving Adoption Assistance	15	53.6%
Healthcare Utilization: Former Foster Care Members	5	20.8%
Timely Access to Care	7	70.0%

** Only includes study indicators for which there is more than one age category.*

Children in Foster Care

Among children in foster care, 17 study indicators demonstrated disparities across age categories. These disparities were typically seen among the controls as well, and sometimes reflect the relevance of certain services to specific age categories. For example, BH conditions are more likely to be diagnosed later in life, so rates for the *Behavioral Health Encounters* indicators are expected to be higher among older children. However, for other measures, such as *Child and Adolescent Well-Care Visits*, older children were less likely to have a well-care visit despite Virginia state guidelines that

children in foster care should have an annual well-child visit up to age 18.[12-9] Additionally, for the *Follow-Up for Hospitalization After Mental Illness—7-Day Follow-Up* indicator, the rate for children in foster care 14 years of age or older was lower than the rate for controls as well as all other age categories. Six study indicators demonstrated disparities between males and females. Female members were more likely to have an annual dental visit, ED visit, inpatient visit, and BH encounter with RTC services, while male members were more likely to have a BH encounter with ARTS or therapeutic services. Only two study indicators demonstrated disparities between racial groups. Black or African American members were more likely to have a BH encounter with ARTS compared to other racial groups, while White members were less likely, and members in the Other racial group were less likely to have a BH encounter with therapeutic services. These disparities were not seen among controls. There were also some disparities identified across regions and MCOs; however, no region or MCO performed consistently better or worse across study indicators.

Children Receiving Adoption Assistance

Since children receiving adoption assistance is the largest group among the child welfare populations, and *p*-value calculations are influenced by sample size, statistical tests to identify health disparities were most sensitive for this population. Among children receiving adoption assistance, 14 study indicators demonstrated disparities across age categories. Like the findings for children in foster care, these disparities were typically seen among the controls as well, and sometimes reflect the relevance of certain services to specific age categories. However, for other measures, such as Child and Adolescent Well-Care Visits and Annual Dental Visit, older children receiving adoption assistance were less likely to have a well-care visit and annual dental visit compared to younger children. Seven study indicators demonstrated disparities between males and females. Female members were more likely to have an annual dental visit and follow-up visits after hospitalizations or ED visits for mental illness, while male members were more likely to have any BH encounter and BH encounters with CMH, therapeutic, or traditional services.

Nine study indicators demonstrated disparities between racial groups. Black or African American members were more likely to have a well-care visit, oral evaluation, topical fluoride treatment, inpatient visit, and any BH encounter except ARTS compared to other racial groups, while White members were less likely to have a well-care visit, oral evaluation, and any BH encounter except ARTS and CMH services. However, White members on antipsychotics were more likely to have metabolic monitoring. Additionally, children receiving adoption assistance in the Other racial group were less likely to have a BH encounter with CMH or traditional services. Some of these disparities were seen among controls. There were also some disparities identified across regions and MCOs. For example, members in the Northern & Winchester region were less likely to have a well-care visit, any of the services in the Oral Health domain (e.g., annual dental visit, preventive dental services), ambulatory care visit, and BH encounter compared to members in other regions, and members enrolled with Aetna and Molina were less likely to have a well-care visit, any of the services in the Oral Health domain, and an ambulatory care visit compared to members enrolled with other MCOs. Additionally, members enrolled with Aetna were less likely to have a BH encounter.

[12-9] Virginia Department of Social Services. Child and Family Services Manual: Identifying Services To Be Provided. 2021. Available at: https://www.dss.virginia.gov/files/division/dfs/fc/intro_page/guidance_manuals/fc/07_2021/section_12_identifying_services_to_be_provided.pdf. Accessed on: Nov 8, 2023.

Former Foster Care Members

Among former foster care members, only the Overall Service Utilization study indicator demonstrated disparities across age categories, whereby members 23 to 26 years of age were less likely to have an ambulatory care visit, ED visit, inpatient visit, or BH encounter compared to members 19 to 22 years of age. This disparity was not seen among controls. Seven study indicators demonstrated disparities between males and females. Female members were more likely to have a well-care visit, annual dental visit, ambulatory care visit, ED visit, inpatient visit, any BH encounter, and BH encounters with traditional services.

Seven study indicators demonstrated disparities between racial groups. Black or African American former foster care members were more likely to have an oral evaluation or BH encounter with therapeutic services and less likely to initiate AOD treatment or have an ambulatory care visit compared to members in other racial groups, while White former foster care members were less likely to receive an oral evaluation, topical fluoride treatment, or BH encounter with therapeutic services. Additionally, among members with a diagnosis of major depression who were treated with antidepressant medication, Black or African American members were less likely to remain on an antidepressant medication treatment for at least 12 weeks, while White members were more likely. This finding was not seen among controls. For region and MCO, the only notable finding was that former foster care members in the Tidewater region were less likely to have an annual dental visit, preventive dental services, and oral evaluation compared to members in other regions.

Dental Utilization in Pregnant Women Focus Study[12-10]

As a supplement to the Medicaid and CHIP Maternal and Child Health Focus Study, DMAS contracted with HSAG to assess dental utilization and birth outcomes among pregnant women covered by Virginia Medicaid or the FAMIS MOMS program following the expansion of dental services to this population on March 1, 2015, through the SFC program that is administered by DentaQuest.[12-11] During 2023, HSAG completed a Dental Utilization in Pregnant Women Focus Study, referred to as the Dental Utilization in Pregnant Women Data Brief, that included all women with deliveries from January 1 through December 31, 2022 (i.e., CY 2022). HSAG used dental encounter data to identify which dental services, if any, were utilized during the woman's perinatal period (i.e., time of conception to the end of the month following the 60th day after delivery).[12-12] Dental services were identified and grouped according to DentaQuest's covered services and categories. In addition to calculating dental utilization rates, HSAG also performed a statistical analysis related to the association of the receipt of dental health services and the following birth outcomes:

- Relationship between dental utilization and preterm birth (<37 weeks gestation)
- Relationship between dental utilization and newborns with low birth weight (<2,500 grams)
- Relationship between dental utilization and timely prenatal care

[12-10] The Dental Utilization in Pregnant Women Focus Study is not limited to the CCC Plus (MLTSS) population.
[12-11] The SFC program is administered by DentaQuest and covers most perinatal dental services for women ages 21 years and older. The latest DMAS program information is available at: https://www.dmas.virginia.gov/for-members/benefits-andservices/dental/pregnant-women/.
[12-12] The analysis only includes paid claims. All zero-paid claims were excluded.

- Relationship between dental utilization and postpartum ED utilization for non-traumatic dental-related services
  - For this analysis, HSAG also evaluated the top primary diagnoses for the ED visit and timing of the ED visit in relation to the delivery.
- Relationship between dental utilization and postpartum ambulatory care utilization

Overall, HSAG identified 37,260 deliveries from January 1 through December 31, 2022. Of the 37,260 deliveries, 3,922 were to women less than 21 years of age and 33,338 were to women 21 years of age and older.

Table 12-10 displays the count of deliveries from the study population that received preconception dental services (Num), the percentage of deliveries from the study population that received preconception dental services (Rate), and percentage of deliveries wherein preconception dental services were received (Percent of Num) for each age group, stratified by dental service category. Please note that a delivery is counted once for each applicable dental service category; thus, the same delivery may be included in more than one dental service category. Women who were continuously enrolled for six months prior to conception and had a conception date later than January 1, 2022, are included in the results.

Table 12-10—Distribution of Women With Preconception Dental Utilization, by Dental Service Category

Dental Service Category	Less Than 21 Years of Age			21 Years of Age and Older		
	Num*	Rate	Percent of Num	Num*	Rate	Percent of Num
Any Dental Service	142	21.42%	100.00%	637	12.43%	100.00%
Adjunctive General Services	61	9.20%	42.96%	114	2.23%	17.90%
Diagnostic Services	127	19.16%	89.44%	553	10.79%	86.81%
Endodontics	15	2.26%	10.56%	73	1.42%	11.46%
Oral and Maxillofacial Surgery	26	3.92%	18.31%	161	3.14%	25.27%
Periodontics	*S*	*S*	*S*	61	1.19%	9.58%
Preventive Services	106	15.99%	74.65%	270	5.27%	42.39%
Prosthodontics	0	0.00%	0.00%	*S*	*S*	*S*
Restorative	46	6.94%	32.39%	265	5.17%	41.60%

**Because a woman may have had more than one dental service during the preconception period, the count of deliveries for each dental service category may not sum to the overall number of deliveries among women with any dental service.*
S indicates that the data were suppressed due to a small numerator or denominator (i.e., fewer than 11). In instances where only one stratification was suppressed, the value for the second smallest population was also suppressed, even if the value was 11 or more.

As shown in Table 12-10, women less than 21 years of age received preconception dental services in 21.42 percent (n=142) of deliveries, while women 21 years of age and older received preconception dental services in 12.43 percent (n=637) of deliveries. Of the deliveries among women less than

21 years of age who received preconception dental services, 54.93 percent also received dental services during the perinatal period. Of the deliveries among women 21 years of age and older who received preconception dental services, 57.14 percent also received dental services during the perinatal period.

The distribution of deliveries among women receiving perinatal dental services varied widely by Medicaid program (i.e., Medicaid for Pregnant Women, Medicaid Expansion, FAMIS MOMS,[12-13] LIFC, or Other Medicaid[12-14]), managed care program (i.e., Medallion 4.0 [Acute], CCC Plus [MLTSS], or FAMIS), and delivery system (i.e., managed care or FFS). Table 12-11 presents the count of deliveries from the study population (Denom), the percentage of deliveries from the study population (Percent of Denom), the count of deliveries from the study population wherein perinatal dental services were received (Num), and percentage of deliveries that received any perinatal dental services (Rate) for each group, stratified by Medicaid program, managed care program, and delivery system as of the woman's date of delivery.

Table 12-11—Distribution of Women With Perinatal Dental Utilization, by Medicaid Program at Time of Delivery

Stratification	Less Than 21 Years of Age				21 Years of Age and Older			
	Denom	Percent of Denom	Num	Rate	Denom	Percent of Denom	Num	Rate
Any Program	3,922	100.00%	1,010	25.75%	33,338	100.00%	6,938	20.81%
Medicaid Program								
Medicaid for Pregnant Women	952	24.27%	177	18.59%	12,192	36.57%	2,616	21.46%
Medicaid Expansion	533	13.59%	142	26.64%	7,417	22.25%	1,566	21.11%
FAMIS MOMS	448	11.42%	103	22.99%	5,300	15.90%	1,337	25.23%
LIFC	116	2.96%	*S*	*S*	4,054	12.16%	813	20.05%
Other Medicaid	1,823	46.48%	562	30.83%	3,064	9.19%	574	18.73%
Not Enrolled	50	1.27%	*S*	*S*	1,311	3.93%	32	2.44%

[12-13] Starting on July 1, 2021, DMAS began enrolling pregnant women who do not meet immigration status rules for other coverage into the FAMIS Prenatal Coverage program. Within this year's report, these members are included in the FAMIS MOMS Medicaid program.

[12-14] Other Medicaid includes all other births not covered by Medicaid for Pregnant Women, Medicaid Expansion, FAMIS MOMS, and LIFC. Please note that Other Medicaid excludes births to women in Plan First and the Department of Corrections, which are included in the Not Enrolled category.

Stratification	Less Than 21 Years of Age				21 Years of Age and Older			
	Denom	Percent of Denom	Num	Rate	Denom	Percent of Denom	Num	Rate
Medicaid Managed Care Program								
Medallion 4.0 (Acute)	2,948	75.17%	824	27.95%	23,195	69.58%	5,141	22.16%
CCC Plus (MLTSS)	73	1.86%	*S*	*S*	927	2.78%	252	27.18%
FAMIS	492	12.54%	125	25.41%	4,959	14.87%	1,287	25.95%
Not Enrolled	50	1.27%	*S*	*S*	1,311	3.93%	32	2.44%
Medicaid Delivery System								
Managed Care	3,513	89.57%	978	27.84%	29,081	87.23%	6,680	22.97%
FFS	359	9.15%	*S*	*S*	2,946	8.84%	226	7.67%
Not Enrolled	50	1.27%	*S*	*S*	1,311	3.93%	32	2.44%

S indicates that the data were suppressed due to a small numerator or denominator (i.e., fewer than 11). In instances where only one stratification was suppressed, the value for the second smallest population was also suppressed, even if the value was 11 or more.

As shown in Table 12-12, most of the study population was covered by managed care regardless of age, with 89.57 percent (n=3,513) of deliveries to women less than 21 years and 87.23 percent (n=29,081) of deliveries to women 21 years of age and older covered by managed care. Deliveries covered by managed care for women less than 21 years of age had higher rates of receiving any perinatal dental service (27.84 percent) compared to women 21 years of age and older age (22.97 percent). Of note, deliveries covered by FFS had low rates of receiving perinatal dental services for women 21 years of age and older (7.67 percent). Within the managed care program, similar distributions were seen between women less than 21 years of age and women 21 years of age and older, with 75.17 percent (n=2,948) of deliveries covered by Medallion 4.0 (Acute) for women less than 21 years of age and 69.58 percent (n=23,195) for women 21 years of age and older. Women less than 21 years of age had higher rates of receiving any perinatal dental services compared to women 21 years of age and older for Medallion (Acute) 4.0 (27.95 percent compared to 22.16 percent). For deliveries covered by FAMIS, women less than 21 years of age had similar rates of receiving any perinatal dental services compared to women 21 years of age and older (25.41 percent and 25.95 percent, respectively). Additionally, approximately 46 percent (n=1,823) of deliveries to women less than 21 years of age were enrolled in the Other Medicaid program, with 30.83 percent (n=562) receiving any perinatal dental services. For women 21 years of age and older, most deliveries were to women enrolled in Medicaid for Pregnant Women (36.57 percent; n=12,192), with 21.46 percent (n=2,616) receiving any perinatal dental services. Of note, the highest rate (25.23 percent) of receiving any perinatal dental service for the 21 years of age and older group was for women enrolled with FAMIS MOMS.

The length of time a woman was continuously enrolled in Medicaid during pregnancy may have also contributed to the ability to obtain perinatal dental services through the SFC program. Of the overall study population, 72.26 percent (n=2,834) of women less than 21 years of age and 71.61 percent (n=23,872) of women 21 years of age and older were continuously enrolled in Medicaid for at least 90 days prior to and including the day of the delivery. Among the deliveries for continuously enrolled women, 29.25 percent (n=829) of women less than 21 years of age and 23.17 percent (n=5,531) of women 21 years of age and older received one or more dental services during the perinatal period. In contrast, 16.64 percent (n=181) of women less than 21 years of age and 14.86 percent (n=1,407) of women 21 years of age and older who were not continuously enrolled for at least 90 days prior to and including the day of delivery received perinatal dental services.

HSAG performed a statistical analysis related to the association of the receipt of prenatal dental health services and birth outcomes. Table 12-12 presents the total number of deliveries among continuously enrolled women (Denom) and the number (Num) and percentage (Rate) of deliveries with any dental service during the prenatal period, by birth outcome. Additionally, Table 12-12 presents the results of the Pearson's chi-square test with significance between the two rates for each birth outcome indicated by an up arrow (i.e., the Any Dental Services group's rate is significantly higher than the No Dental Services group's rate) or a down arrow (i.e., the Any Dental Services group's rate is significantly lower than the No Dental Services group's rate) on the Any Dental Services group's rate.

Table 12-12—Prenatal Dental Utilization and Birth Outcomes Chi-Square Analysis—Any Dental Services

	Less Than 21 Years of Age			21 Years of Age and Older		
	Denom	Num	Rate	Denom	Num	Rate
Preterm Births (<37 Weeks Gestation)*						
Any Dental Services	682	50	7.33%	4,534	385	8.49% ↓
No Dental Services	3,240	279	8.61%	28,798	2,865	9.95%
Newborns With Low Birth Weight (<2,500 grams)*						
Any Dental Services	682	51	7.48% ↓	4,532	323	7.13% ↓
No Dental Services	3,240	326	10.06%	28,794	2,701	9.38%
Births With Adequate Prenatal Care						
Any Dental Services	648	482	74.38% ↑	4,357	3,380	77.58% ↑
No Dental Services	3,102	2,143	69.08%	27,543	20,572	74.69%

	Less Than 21 Years of Age			21 Years of Age and Older		
	Denom	Num	Rate	Denom	Num	Rate
Postpartum ED Utilization for Non-Traumatic Dental Services*						
Any Dental Services	681	*S*	*S*	4,532	13	0.29%
No Dental Services	3,191	*S*	*S*	27,495	89	0.32%
Postpartum Ambulatory Care Utilization						
Any Dental Services	681	449	65.93% ↑	4,532	3,098	68.36% ↑
No Dental Services	3,191	1,825	57.19%	27,495	15,283	55.58%

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

Table 12-13 shows that women less than 21 years of age had statistically significant differences in rates for deliveries that received any dental services versus those that received no dental services for four of the birth outcomes: *Newborns With Low Birth Weight (<2,500 grams)*, *Births With Adequate Prenatal Care*, *Postpartum ED Utilization for Non-Traumatic Dental Services*, and *Postpartum Ambulatory Care Utilization*. The percentage of deliveries for *Newborns With Low Birth Weight (<2,500 grams)* was significantly lower for those who received at least one prenatal dental service (7.48 percent) compared to those who received no prenatal dental services (10.06 percent). For measures with non-suppressed rates, *Births With Adequate Prenatal Care* and *Postpartum Ambulatory Care Utilization*, women who received at least one prenatal dental service had significantly higher rates (74.38 percent and 65.93 percent, respectively) compared to women who received no dental services (69.08 percent and 57.19 percent, respectively).

For women 21 years of age and older, there were statistically significant differences in rates for deliveries that received any dental services versus those that received no dental services for four of the birth outcomes: *Preterm Births (<37 Weeks Gestation)*, *Newborns With Low Birth Weight (<2,500 grams)*, *Births With Adequate Prenatal Care*, and *Postpartum Ambulatory Care Utilization*. The percentages of deliveries for *Preterm Births (<37 Weeks Gestation)* and *Newborns With Low Birth Weight (<2,500 grams)* were significantly lower for those who received at least one prenatal dental service (8.49 percent and 7.13 percent, respectively) compared to those who received no prenatal dental services (9.95 percent and 9.38 percent, respectively). For *Births With Adequate Prenatal Care* and *Postpartum Ambulatory Care Utilization*, women who received at least one prenatal dental service had significantly higher rates (77.58 percent and 68.36 percent, respectively) compared to women who received no dental services (74.69 percent and 55.58 percent, respectively).

Table 12-13 presents the total number of deliveries among continuously enrolled women and the number and percentage of deliveries with preventive dental services during the prenatal period, by birth. Additionally, Table 12-13 presents the results of the Pearson's chi-square test with significance between the two rates for each birth outcome indicated by an up arrow (i.e., the Preventive Services group's rate is significantly higher than the No Preventive Services group's rate) or a down arrow (i.e., the Preventive Services group's rate is significantly lower than the No Preventive Services group's rate) on the Preventive Services group's rate.

Table 12-13—Prenatal Dental Utilization and Birth Outcomes Correlation Analysis—Preventive Dental Services

	Less Than 21 Years of Age			21 Years of Age and Older		
	Denom	Num	Rate	Denom	Num	Rate
Preterm Births (<37 Weeks Gestation)*						
Preventive Services	500	34	6.80%	2,203	152	6.90% ↓
No Preventive Services	3,422	295	8.62%	31,129	3,098	9.95%
Newborns With Low Birth Weight (<2,500 grams)*						
Preventive Services	500	39	7.80%	2,202	123	5.59% ↓
No Preventive Services	3,422	338	9.88%	31,124	2,901	9.32%
Births With Adequate Prenatal Care						
Preventive Services	476	354	74.37% ↑	2,128	1,686	79.23% ↑
No Preventive Services	3,274	2,271	69.36%	29,772	22,266	74.79%
Postpartum ED Utilization for Non-Traumatic Dental Services*						
Preventive Services	499	*S*	*S*	2,202	*S*	*S*
No Preventive Services	3,373	*S*	*S*	29,825	99	0.33%
Postpartum Ambulatory Care Utilization						
Preventive Services	499	334	66.93% ↑	2,202	1,508	68.48% ↑
No Preventive Services	3,373	1,940	57.52%	29,825	16,873	56.57%

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

S indicates that the data were suppressed due to a small numerator or denominator (i.e., fewer than 11). In instances where only one stratification was suppressed, the value for the second smallest population was also suppressed, even if the value was 11 or more.

Table 12-13 shows that women less than 21 years of age had statistically significant differences in rates for deliveries that received preventive dental services versus those that did not receive any preventive services for two of the birth outcomes: *Births With Adequate Prenatal Care* and *Postpartum Ambulatory Care Utilization*. The percentage of deliveries for *Births With Adequate Prenatal Care* and *Postpartum Ambulatory Care Utilization* was significantly higher for those who received at least one preventive service (74.37 percent and 66.93 percent, respectively) compared to those who did not receive any preventive services (69.36 percent and 57.52 percent, respectively).

For women 21 years of age and older, there were statistically significant differences in rates for deliveries that received any preventive services versus those that did not receive any preventive services for four of the birth outcomes: *Preterm Births (<37 Weeks Gestation)*, *Newborns With Low Birth Weight (<2,500 grams)*, *Births With Adequate Prenatal Care*, and *Postpartum Ambulatory Care Utilization*. The rates for *Preterm Births (<37 Weeks Gestation)* and *Newborns With Low Birth Weight (<2,500 grams)* were significantly lower for those who received at least one preventive dental service (6.90 percent and 5.59 percent, respectively) compared to those who did not receive any preventive dental services (9.95 percent and 9.32 percent, respectively). For *Births With Adequate Prenatal Care* and *Postpartum Ambulatory Care Utilization,* women who received at least one preventive dental service had significantly higher rates (79.23 percent and 68.48 percent, respectively) compared to women who did not receive any preventive dental services (74.79 percent and 56.57 percent, respectively).

13. Summary of MCO-Specific Strengths and Weaknesses

Aetna

Table 13-1—Overall Conclusions for Aetna: Quality, Access, and Timeliness

Strengths Related to Quality	
+	Aetna demonstrated strength in providing care and follow-up for members diagnosed with BH and substance use disorders indicating the MCO had processes in place to monitor care and services and to ensure appropriate follow-up was conducted so that members were connected with care. Aetna's performance within the Behavioral Health domain identified seven PM indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile. The *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up* and *30-Day Follow-Up—Total, Diagnosed Mental Health Disorders—Total, Diagnosed Substance Use Disorders—Alcohol disorder—Total, Opioid disorder—Total, Other or unspecified drugs—Total,* and *Any disorder—Total* PM indicators met or exceeded the 90th percentile.
+	Aetna also showed strength in ensuring members accessed care and services to screen for conditions and to receive timely monitoring of prescribed medications. Aetna's performance within the Living With Illness domain identified three PM indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile or 90th percentile. The *Asthma Medication Ratio—Total* and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* PM indicators met or exceeded the 75th percentile, and the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PM indicator met or exceeded the 90th percentile.
+	Aetna further displayed strength in providing care when prescribing opioids, ensuring that members who may be at high risk for opioid overuse or misuse are identified and monitored to ensure use is conducted with care. Aetna demonstrated strong performance within the Use of Opioids domain, ranking at or above NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 50th percentile for the *Use of Opioids at High Dosage—Total* PM indicator.
+	Overall, adult members rated their experience with Aetna as high; however, for child member representatives, the opposite was true. Aetna's 2023 top-box score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for one measure, *Rating of Health Plan*. However, Aetna's 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for *Rating of Health Plan*. Aetna has an opportunity to apply these processes used in working with adult members to how it manages MCO contacts with parents and guardians of child members.

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

Weaknesses and Recommendations	
−	**Weakness:** The following HEDIS MY 2022 PM rates fell below NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Aetna: • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* • *Use of Imaging Studies for Low Back Pain* • *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* • *Use of Opioids from Multiple Providers—Multiple Pharmacies* and *Multiple Prescribers and Multiple Pharmacies*
	Recommendations: HSAG recommends that Aetna conduct a root cause analysis or focus study for these PMs within the Access and Preventive Care, Taking Care of Children, Use of Opioids, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Aetna analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
−	**Weakness:** Of the 418 provider locations surveyed as part of the secret shopper initiative, 56.0 percent could not be reached. Of the cases reached, 20.1 percent accepted Aetna, 19.0 percent accepted VA Medicaid, and 15.8 percent accepted new patients. Of the provider locations accepting new patients, 28.6 percent and 40.0 percent offered a routine and urgent visit appointment, respectively. Fifty percent of the routine visit appointments offered were compliant with DMAS' 30-day

Weaknesses and Recommendations	
	appointment availability compliance standards. None of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standards. **Why the weakness exists:** These findings suggest that Aetna's provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold times of five minutes for the secret shopper survey; however, this may indicate that the providers' offices are facing delays due to staffing shortages and workforce issues.
	Recommendations: HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that Aetna request the file from DMAS use the file data to correct inaccuracy, validate provider information and data, and provide DMAS updates or confirmation that the data have been updated as appropriate. Additionally, HSAG recommends that Aetna review and update provider appointment availability and the ability of members to schedule appointments within contractual time frames and providers accepting new patients. HSAG recommends that the MCO provide confirmation to DMAS that it has corrected and is in compliance with contractual appointment availability and scheduling procedures, including panel capacity to accept new patients.

HealthKeepers

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

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

Strengths Related to Access and Timeliness	
+	HealthKeepers PM results indicate that members are connected with their PCPs and able to access care for preventive, well-care, and coordination of care. HealthKeepers' processes are reflected within the Access and Preventive Care domain, wherein HealthKeepers displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM, meeting or exceeding NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile. This result also aligns with the high rates in smoking and tobacco use cessation measures and screening for diabetes measures for members receiving BH medications.
+	HealthKeepers scored well in the PCP secret shopper survey conducted by HSAG related to members' ability to schedule appointments. Of the provider locations accepting new patients, 100.0 percent offered a routine and urgent visit appointment. Additionally, 71.4 percent of the routine visit appointments offered were compliant with DMAS' 30-day appointment availability compliance standards.
+	Results in the access to care, BH, and chronic illness PMs support that, overall, members are able to access care when needed. The ability to access care was also reflected in the HealthKeepers' 2023 top-box score that was statistically significantly higher than the 2022 NCQA adult Medicaid national average for *Getting Care Quickly*. In addition, HealthKeepers' 2023 top-box score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for *Customer Service*.

Weaknesses and Recommendations	
−	**Weakness:** Opportunities for improvement exist for the MCO to calculate and report performance indicator data accurately in the data table and in the narrative summary of results when conducting PIPs.
	Recommendations: HSAG recommends that the MCO ensure that the data reported in the submission form are calculated and reported correctly. HSAG recommends that the MCO implement internal quality checks prior to submitting the PIP for the annual HSAG validation process.
−	**Weakness:** Although there was positive performance in many access to care and screening PMs, the following HEDIS MY 2022 PM rates fell below NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for HealthKeepers: • *Ambulatory Care—ED Visits—Total* • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* • *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* • *Cervical Cancer Screening* • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*

Weaknesses and Recommendations	
	• *Use of Imaging Studies for Low Back Pain* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* • *Plan All-Cause Readmissions—Observed Readmissions—Total*
	Recommendations: HSAG recommends that HealthKeepers conduct a root cause analysis or focus study for these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that HealthKeepers analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
−	**Weakness:** HSAG found during the secret shopper survey of PCPs that of the 433 provider locations surveyed, 37.0 percent could not be reached. Of the cases reached, 22.9 percent did not offer primary care services, 45.4 percent accepted HealthKeepers, 41.8 percent accepted VA Medicaid, and 34.1 percent accepted new patients. Of the urgent visit appointments offered, 25.0 percent were compliant with DMAS' 24-hour appointment availability compliance standards. **Why the weakness exists:** These findings suggest that HealthKeepers' provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold times of five minutes for the secret shopper survey; however, this may indicate that the providers' offices are facing delays due to staffing shortages and workforce issues.
	Recommendations: HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that HealthKeepers request a copy of the file from DMAS and review it for accuracy and completeness. HSAG recommends that HealthKeepers provide DMAS with updates or confirmation that the data have been updated as appropriate. Additionally, HSAG recommends that HealthKeepers implement processes to confirm appointment availability and appointment scheduling procedures with providers to ensure contract requirements are met, including requirements for panel capacity and providers who are accepting new patients.
−	**Weakness:** HealthKeepers' 2023 top-box scores were statistically significantly lower than the 2022 NCQA child Medicaid national averages for three measures, *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. These results may reflect and align with the results of the PCP secret shopper survey that found inaccuracies in provider information and ability to schedule appointments.
	Recommendations: HSAG recommends that HealthKeepers conduct a root cause analysis of the study indicator in conjunction with actions taken related to primary care secret shopper survey results that have been identified as an area of low performance. This type of analysis is used to

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

Molina

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

Strengths Related to Quality	
+	Molina's PM results indicate that in most cases members are connected with their PCPs and able to access care for preventive, well-care, and coordination of care. Within the Taking Care of Children domain, Molina displayed strong performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total* and *Blood Glucose and Cholesterol Testing—Total* PM indicators, which met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile.
+	Results in the access to care, BH, and chronic illness PMs support that, overall, members are able to access care when needed. Within the Living With Illness domain, Molina ranked at or above NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Asthma Medication Ratio—Total, Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications,* and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* PM indicators.
Strengths Related to Access and Timeliness	
+	Molina displayed strong performance within the Use of Opioids domain, ranking at or above NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Use of Opioids from Multiple Providers—Multiple Pharmacies* PM indicator.
+	The PCP secret shopper survey found that of the provider locations accepting new patients, 91.7 percent and 91.4 percent offered a routine and urgent visit appointment, respectively. Additionally, 88.6 percent of the routine visit appointments offered were compliant with DMAS' 30-day appointment availability compliance standards. The primary care secret shopper survey results support the PMV findings that members are able to access providers for well-care, screening, and managing conditions such as smoking and tobacco cessation.
Weaknesses and Recommendations	
−	**Weakness:** PIP validation results identified that for the *AMB-ED* PIP, Molina has an opportunity for improvement related to reporting correct data in the narrative summary of results. In addition, for the *Follow-Up After*

Weaknesses and Recommendations	
	Discharge PIP, Molina did not address all documentation requirements for data analysis and interpretation of results.
	Recommendations: HSAG recommends that the MCO ensure that the data reported in the submission form are calculated and reported correctly. HSAG recommends that Molina implement internal quality checks prior to submitting the PIP for the annual validation. HSAG also recommends that Molina ensure it addresses whether there are factors that threaten the validity and comparability of the data annually.
−	**Weakness:** The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Molina: • *Ambulatory Care—ED Visits—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* • *Child and Adolescent Well-Care Visits—Total* • *Controlling High Blood Pressure* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* • *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* • *Use of Imaging Studies for Low Back Pain* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
	Recommendations: Although Molina members are able to access some well-care, preventive, and screening appointments with PCPs, HSAG recommends that Molina conduct a root cause analysis or focus study for these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Molina analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
−	**Weakness:** The PCP secret shopper survey results found that of the 410 provider locations surveyed, 38.0 percent could not be reached. Of the cases reached, 23.9 percent did not offer primary care services, 56.3 percent accepted Molina, 54.3 percent accepted VA Medicaid, and 41.7 percent accepted new patients. Of the urgent visit appointments offered,

Weaknesses and Recommendations	
	5.7 percent were compliant with DMAS' 24-hour appointment availability compliance standards. **Why the weakness exists:** These findings suggest that Molina's provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold times of five minutes for the secret shopper survey; however, this may indicate that the providers' offices are facing delays due to staffing shortages and workforce issues.
	Recommendations: HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that Molina request a copy of the file from DMAS and review it for accuracy and completeness. HSAG recommends that Molina provide DMAS with updates or confirmation that the data have been updated as appropriate. Additionally, HSAG recommends that Molina implement processes to confirm appointment availability and appointment scheduling procedures with providers to ensure contract requirements are met, including requirements for panel capacity and providers who are accepting new patients.

Optima

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

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

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

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

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

Weaknesses and Recommendations	
	Recommendations: A significant number of PMs were below the NCQA Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile. In consideration of the results of the PCP secret shopper survey, access to network providers may also be impacting these PM results. HSAG recommends that Optima conduct a root cause analysis or focus study for these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, Use of Opioids, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. HSAG also recommends that Optima conduct a review to identify best practices for providing care and services that fall in these care domains and identify best practices that will increase these PM rates.
−	**Weakness:** Of the 412 provider locations surveyed, 31.3 percent could not be reached. Of the cases reached, 55.5 percent accepted Optima, 47.7 percent accepted VA Medicaid, and 41.3 percent accepted new patients. Of the provider locations accepting new patients, 31.0 percent and 27.1 percent offered a routine and urgent visit appointment, respectively. Of the urgent visit appointments offered, 6.3 percent were compliant with DMAS' 24-hour appointment availability compliance standards. **Why the weakness exists:** These findings suggest that Optima's provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold times of five minutes for the secret shopper survey; however, this may indicate that the providers' offices are facing delays due to staffing shortages and workforce issues.
	Recommendations: HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that Optima request a copy of the file from DMAS and review it for accuracy and completeness. HSAG recommends that Optima provide DMAS with updates or confirmation that the data have been updated as appropriate. Additionally, HSAG recommends that Optima implement processes to confirm appointment availability and appointment scheduling procedures with providers to ensure contract requirements are met, including requirements for panel capacity and providers who are accepting new patients. HSAG recommends that Optima review best practices for ensuring members are able to schedule appointments and to access recommended or needed care and services within the timelines outlined in Optima's contract with DMAS.

United

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

Strengths Related to Quality	
+	United has implemented effective procedures for ensuring that members receiving medications to manage BH diagnosis receive necessary screenings to identify and treat associated chronic illnesses. These findings are supported by United's results within the Behavioral Health domain. United met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia Strategies* and *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* PM indicators.
+	United's performance within the Living With Illness domain identified six PM indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile or 90th percentile. The *Blood Pressure Control for Patients With Diabetes—Total, Eye Exam for Patients With Diabetes—Total, Controlling High Blood Pressure—Total,* and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* PM indicators met or exceeded the 75th percentile, and the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%),* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PM indicators met or exceeded the 90th percentile. These findings related to managing chronic conditions indicate that United has developed procedures to ensure that members are assisted in receiving recommended care and services for their chronic condition.
+	United's processes for ensuring members with chronic conditions are managed and are receiving recommended services may also have an impact on ensuring members do not experience readmissions. United displayed strong performance within the Utilization domain, ranking at or above NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Plan All-Cause Readmissions—O/E Ratio—Total* PM indicator.
+	United's 2023 top-box score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for one measure, *Rating of All Health Care*. This rating may reflect members' satisfaction with their ability to receive care that allows them to manage their chronic conditions.
Strengths Related to Access and Timeliness	
+	Within the Access and Preventive Care domain, United displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator, which met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile.

Weaknesses and Recommendations	
−	**Weakness:** The following HEDIS MY 2022 PM rates fell below NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for United: • *Ambulatory Care—ED Visits—Total* • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* • *Cervical Cancer Screening* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* • *Use of Imaging Studies for Low Back Pain* • *Child and Adolescent Well-Care Visits—Total* • *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* • *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies*
	Recommendations: HSAG recommends that United conduct a root cause analysis or focus study for these PMs within the Access and Preventive Care and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that United analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. HSAG recommends that United consider its effective practices that have resulted in high PM rates for some chronic illness measures and determine whether a similar impact could be derived for care associated with these measures.
−	**Weakness:** PCP secret shopper survey results identified that of the 455 provider locations surveyed, 33.8 percent could not be reached. Of the cases reached, 31.4 percent did not offer primary care services, 44.5 percent accepted United, 40.5 percent accepted VA Medicaid, and 34.2 percent accepted new patients. Of the urgent visit appointments offered, 12.5 percent were compliant with DMAS' 24-hour appointment availability compliance standards. **Why the weakness exists:** These findings suggest that United's provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach providers could be affected by the limited hold times of five minutes for the secret shopper survey; however, this may indicate that the providers' offices are facing delays due to staffing shortages and workforce issues.
	Recommendations: HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that United request a copy of

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

VA Premier

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

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

Strengths Related to Quality	
	Cessation—Discussing Cessation Strategies and *Advising Smokers and Tobacco Users to Quit* PM indicators. The MCO should review its processes for ensuring members receive these screenings and determine if any best practices could be used to improve other PM indicator rates.
+	VA Premier's 2023 top-box score was statistically significantly higher than the 2022 NCQA child Medicaid national average for *Customer Service*. VA Premier's 2023 top-box score was statistically significantly higher than the 2022 top-box score for one measure, *Rating of Personal Doctor*. In addition, VA Premier's 2023 top-box score was statistically significantly higher than the 2022 NCQA child Medicaid national average for *How Well Doctors Communicate*.
Strengths Related to Access and Timeliness	
+	Within the Access and Preventive Care domain, VA Premier displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM, which met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile.
Weaknesses and Recommendations	
−	**Weakness:** The following HEDIS MY 2022 PM rates fell below NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier: • *Ambulatory Care—ED Visits—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care* • *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* • *Childhood Immunization Status—Combination 3* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* • *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* • *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid* • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* • *Use of Imaging Studies for Low Back Pain* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*

Weaknesses and Recommendations	
	• *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*
	Recommendations: With VA Premier merging with Optima, HSAG has no recommendations for VA Premier. HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that Optima request a copy of the analytic flat files from the PCP secret shopper survey and use the files to provide updates or confirmation to DMAS that the data have been updated as appropriate. Additionally, HSAG recommends that Optima review appointment availability and scheduling procedures, including panel capacity to accept new patients and provide an update to DMAS of its findings. Initiatives focused on improving the accuracy of the provider data may result in improved members' access to care. HSAG recommends that Optima conduct a root cause analysis or focus study for these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. HSAG recommends that Optima consider its effective practices that have resulted in high PM rates for some BH measures and determine whether a similar impact could be derived for care associated with these measures.
−	**Weakness:** PCP secret shopper survey results identified that of the 394 provider locations surveyed, 24.1 percent could not be reached. Of the cases reached, 24.1 percent did not offer primary care services, 50.2 percent accepted VA Premier, 48.8 percent accepted VA Medicaid, and 42.8 percent accepted new patients. Of the routine visit appointments offered, 61.5 percent were compliant with DMAS' 30-day appointment availability compliance standards, and 25.9 percent of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standards. **Why the weakness exists:** These findings suggest that VA Premier's provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach providers could be affected by the limited hold times of five minutes for the secret shopper survey; however, this may indicate that the providers offices are facing delays due to staffing shortages and workforce issues.
	Recommendations: With VA Premier merging with Optima, HSAG has no recommendations for VA Premier. HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that Optima request a copy of the analytic flat files from the PCP secret shopper survey and use the files to provide updates or confirmation to DMAS that the data

Weaknesses and Recommendations	
	have been updated as appropriate. Additionally, HSAG recommends that Optima review appointment availability and scheduling procedures, including panel capacity to accept new patients and provide an update to DMAS of its findings. Initiatives focused on improving the accuracy of the provider data may result in improved members' access to care.
–	**Weakness:** VA Premier's 2023 top-box scores were statistically significantly lower than the 2022 top-box scores for two measures, *Getting Needed Care* and *Getting Care Quickly*.
	Recommendations: These results may align with the low PM results in some of the women's health and children's health measures. With VA Premier merging with Optima and no longer serving members as of July 1, 2023, HSAG has no additional recommendations.

Appendix A. Technical Report and Regulatory Crosswalk

Table A-1 lists the required and recommended elements for EQR Annual Technical Reports, per 42 CFR §438.364 and recent CMS technical report feedback received by states. The Table identifies the page number where the corresponding information that addresses each element is located in the Virginia EQR Annual Technical Report.

Table A-1—Technical Report Elements

	Required Elements	Page Number
1a	The state submitted its EQR technical report by April 30th.	Cover Page
1b	Include a clickable or hyperlinked table of contents for easy navigation throughout the report.	Table of Contents
1c	Produce a searchable PDF to enable stakeholders to review topics of interest and facilitate use of the reports for topic-specific analyses.	Entire Document
1d	Use the names of the MCEs when referring to plan performance. Findings and comparisons should refer to MCEs by name in order to facilitate transparency and stakeholder understanding of specific plan performance.	Entire Document
2	All eligible Medicaid and Children's Health Insurance Program (CHIP) plans are included in the report. *TIPS: Identify the MCPs subject to EQR by plan name, MCP type, managed care authority, and population(s) served in an introduction, executive summary, or appendix. Explain MCE exclusions (overall or by mandatory or optional EQR activity) by providing context on MCE mergers, acquisitions, or terminations. §438.364(a)*	Page 2 Each Section
3a	Required elements are included in the report: The technical report must summarize findings on quality, access, and timeliness of care for each MCO, PIHP, PAHP, and PCCM entity that provides benefits to Medicaid and CHIP enrollees. *TIPS: Describe the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 and 2 CFR 438.364(a)(1) were 1. Aggregated, 2. analyzed, and 3. conclusions were drawn about the MCP's ability to furnish services. These findings should reflect a comparison to the domains of quality, timeliness, and access to the healthcare services furnished by the MCO, PIHP, PAHP, or PCCM entity.*	Sections 3 – 13
3b	Required elements are included in the report: An assessment of the strengths and weaknesses of each MCO, PIHP, PAHP and PCCM entity with respect to (a) quality, (b) timeliness, and (c) access to the health care services furnished by each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) 42 CFR 438.364(a)(1), and §438.364(a)(3)), furnished to Medicaid and/or CHIP beneficiaries. Contain specific recommendations for improvement of identified weaknesses. *TIPS:* • *Include a chart outlining each MCP's strengths and weaknesses for each EQR activity and designate a quality, timeliness, and access domain.*	Sections 3 – 13

	Required Elements	Page Number
	• *Highlight substantive findings concerning the extent to which each MCP is furnishing high quality, timely, and appropriate access to health care services. Findings should focus on the specific strengths and weaknesses the EQRO identified, rather than on numerical ratings or validation scores obtained under the EQRO's review methodology.*	
3c	Required elements are included in the report: Describe how the state can target goals and objectives in the quality strategy, under 42 CFR §438.340 and 42 CFR 438.364(a)(4), to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid or CHIP enrollees. *TIPS:* • *Consider connecting EQR findings to the quality strategy goals and objectives, particularly in sections of the report that assess the state's overall performance of the quality, timeliness, and access to health care services; when discussing strengths and weaknesses of a MCP or activity; or when discussing the basis of performance measures or PIPs. Note when goals in the quality strategy are considered in EQR activities and which goals they are. Describe the relationship between goals in the state's quality strategy and the four mandatory EQR activities.*	Pages 1-11 – 1-12
3d	Recommend improvements for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM Entity. §438.310(c)(2) and 2 CFR 438.364(a)(4) *TIPS:* • *Include recommendations for each MCP. Recommendations should share the EQRO's understanding of why the weakness exists and suggest steps for how the MCP—potentially in concert with the state—can best address the issue. If the cause for the weakness is unclear or unknown, the EQRO should suggest how the MCP and/or state can identify the cause.* • *When determining recommendations, EQROs should consider whether the suggested actions are within the authority of the MCP (or state).*	Section 13
3e	Summarize results across all MCEs and provide state-level recommendations for performance improvement.	Section 3
3f	Ensure methodologically appropriate, comparative information about all MCPs in accordance with 42 CFR 438.364(a)(5). *TIPS:* • *Aggregate findings across MCPs for each EQR activity and show comparisons.* • *Provide context for the individual MCP to make it easier for stakeholders to understand the results of the review and more readily determine whether issues are localized or systemic.*	Section 3 Appendix B
3f	Assess the degree to which each MCP has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. §438.364(a)(6) *TIPS:*	Appendix E

	Required Elements	Page Number
	• *State the prior year finding and describe the assessment of each MCP's approach to addressing the recommendation or findings issued by the state or EQRO in the previous year's EQR technical report. This is not a restatement of a response or rebuttal to the recommendation by the MCP or state.* • *Document assessments with the same specificity used when reporting on initial findings.*	
3g	The information included in the technical report must not disclose the identity or other protected health information of any patient. 2 CFR 438.364(d) *TIPS:* • *Ensure the technical report is consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 C.F.R. §431 Subpart F and § 457.1110).* • *Ensure that MCPs comply with HIPAA and all other federal and state laws concerning confidentiality and disclosure.* • *Ensure that EQR-related data collection and reporting activities are consistent with HIPAA requirements.*	Entire Report
3h	An assessment of the MCO, PIHP, PAHP, or PCCM entity information system as part of the validation process. §438.242	Section 8 Pages 5-1 – 5-2
	The EQRO can address these plan level reporting requirements via tables or appendices to the aggregate report or prepare separate aggregate reports by type of MCP if appropriate.	
4	**Validation of performance improvement projects (PIPs):** A description of **PIP interventions** associated with each state-required PIP topic that were underway during the preceding 12 months, and the following for the validation of PIPs: **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.** §438.358(b)(1)(i) and 2 CFR 438.364(a)(2)(iiv) *CONSIDERATIONS:* • *Provide a validation of all PIPs underway during the 12-month period preceding the EQR review, regardless of the phase of the PIP's implementation. States often link the timeframe under review to a corresponding measurement or performance period such as state or federal fiscal year, or calendar year.*	
4a	Validation of performance improvement projects (PIPs): • **Interventions** The technical report must include a description of PIP interventions associated with each state-required PIP topic for the current EQR review cycle. §438.330(d) *CONSIDERATIONS:* • *For states with many MCPs and PIPs, provide an appendix or link to each plan-level report, an appendix in an aggregate report, or a separate PIP-report that compiles the PIPs applicable to all or a group of plans. Present this information in a cohesive way that allows for brevity in the sections that describe data analysis and conclusions.* • *Note that a table listing all PIP interventions will not alone be considered as methodologically appropriate comparative information, as the table simply organizes information, but does not compare or draw conclusions from the information presented.*	Section 4 Pages 4-4 – 4-16

	Required Elements	Page Number
4b	Validation of performance improvement projects (PIPs): • **Objectives** *CONSIDERATIONS:* • *Provide the state or EQRO's objective for conducting the mandatory activity itself, including the general approach or methods of validation used by the EQRO. The state may also include the objective or aim statement for each PIP to satisfy this criterion for the PIP validation activity.*	Section 4 Page 4-1
4c	Validation of performance improvement projects (PIPs): • **Technical methods of data collection and analysis** *CONSIDERATIONS:* • *Provide a description of how data was obtained by the EQRO to conduct the validation activity. If a collection tool is used, providing an example of the format of the tool, or questions asked, in an appendix is a best practice. Further, describe how data is analyzed to connect the data requested to the analytical methods that eventually support the conclusions drawn with those data and analyses.*	Appendix B
4d	Validation of performance improvement projects (PIPs): • **Description of data obtained;** *CONSIDERATIONS:* • *Based upon the collection efforts above, describe the types of data obtained – information system extracts, documents, answers to questions in data collection tools, and others – to explain the nature of the data collected and analyzed.*	Appendix B
4e	Validation of performance improvement projects (PIPs): • **Conclusions drawn from the data** *CONSIDERATIONS:* • *Having employed the process of data collection and validation using the types and nature of the data received, provide conclusions relevant to the mandatory activity.*	Section 4 Pages 4-3 – 4-17
5	Validation of performance measures (2 CFR 438.358(b)(1)(ii)): The technical report must include information on the validation of each MCO's, PIHP's, PAHP's, or PCCM entity's performance measures for each MCO, PIHP, PAHP, and PCCM entity performance measure calculated by the state during the preceding 12 months. Include a description of objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data. *CONSIDERATIONS:* • *Provide a validation of all performance measures in use during the 12-month period preceding the EQR review, regardless of the phase of the performance measure's implementation.* • *States often link the timeframe under review to a corresponding measurement or performance period such as state or federal fiscal year, or calendar year.*	

	Required Elements	Page Number
5a	Validation of performance measure validation (PMV): • **Objectives** *CONSIDERATIONS:* • *Provide the state or EQRO's objective for conducting the mandatory activity itself, including the general approach or methods of validation used by the EQRO.*	Page 5-1 Appendix B
5b	Validation of performance measure validation (PMV): • **Technical methods of data collection and analysis** *CONSIDERATIONS:* • *Provide a description of how data was obtained by the EQRO to conduct the validation activity. If a collection tool is used, providing an example of the format of the tool, or questions asked, in an appendix is a best practice. Further, describe how data is analyzed to connect the data requested to the analytical methods that eventually support the conclusions drawn with those data and analyses.*	Appendix B
5c	Validation of performance measure validation (PMV): • **Description of data obtained** *CONSIDERATIONS:* • *Based upon the collection efforts above, describe the types of data obtained – information system extracts, documents, answers to questions in data collection tools, and others – to explain the nature of the data collected and analyzed.*	Appendix B
5d	Validation of performance measure validation (PMV): • **Conclusions drawn from the data.** *CONSIDERATIONS:* • *Having employed the process of data collection and validation using the types and nature of the data received, provide conclusions relevant to the mandatory activity.*	Pages 5-2 – 5-11
6	Review for compliance: 42 CFR §438.358(b)(1)(iii) (cross-referenced in CHIP regulations at 42 CFR §457.1250[a]) requires the technical report including information **on a review, conducted within the previous three-year period**, to determine each MCO's, PIHP's, PAHP's or PCCM's compliance with the standards set forth in Subpart D and the QAPI requirements described in 42 CFR §438.330. The technical report must provide MCP results for the following 11 Subpart D and QAPI standards: 42 CFR 438.206, 457.1230(a), Availability of services 42 CFR 438.207, 457.1230(b), Assurances of adequate capacity and services 42 CFR 438.208, 457.1230(c) Coordination and continuity of care 42 CFR 438.210, 457.1230(d), Coverage and authorization of services 42 CFR 438.214, 457.1233(a), Provider selection 42 CFR 438.224, 457.1230(c), Confidentiality 42 CFR 438.228, 457.1260, Grievance and appeals system 42 CFR 230, 457.1233(b), Subcontractual relationships and delegation 42 CFR 438.236, 457.1233(c), Practice guidelines 42 CFR 438.242, 457.1233(d), Health information system 42 CFR 438.330, 457.1240(b), QAPI. *CONSIDERATIONS:*	

	Required Elements	Page Number
	• *For each of the 10 Subpart D standards and individual QAPI standard, ensure that the method of compliance review clearly links the EQRO's activities to the standard under review. Further, ensure that a clear compliance determination is made and recorded for each standard for each plan. A best practice is to list a compliance score of a numerical or semi-quantitative nature.* • *EQROs that assess domains, standards, and requirements that do not neatly overlap with the regulatory standards should provide a clear crosswalk of their activities to the standards under review. As a best practice, the technical report may include a table outlining the timeline for reviewing all standards for MCPs across the three-year review period.* Additional information that needs to be included for compliance is listed in the rows below:	
6a	Review for compliance: • **Objectives** *CONSIDERATIONS:* • *Provide the state or EQRO's objective for conducting the mandatory activity itself, including the general approach or methods of validation used by the EQRO.*	Page 6-1 Appendix B
6b	Review for compliance: • **Technical methods of data collection and analysis** *CONSIDERATIONS:* • *Provide a description of how data was obtained by the EQRO to conduct the validation activity. If a collection tool is used, providing an example of the format of the tool, or questions asked, in an appendix is a best practice. Further, describe how data is analyzed to connect the data requested to the analytical methods that eventually support the conclusions drawn with those data and analyses.*	Appendix B
6c	Review for compliance: • **Description of data obtained** CONSIDERATIONS: • *This requirement does not apply to the compliance review activity (Protocol 3).*	Section 6 Appendix B
6d	Review for compliance: • **Conclusions drawn from the data** *CONSIDERATIONS:* • *Having employed the process of data collection and validation using the types and nature of the data received, provide conclusions relevant to the mandatory activity.*	Pages 6-2 – 6-10
7	**Each remaining activity** included in the technical report must include a **description of the activity** and the following information:	
7a.1	Optional activities: Secret Shopper Survey **Objectives;**	Page 8-1 Appendix B

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

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

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

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

- PIP Validation Approach and Methodology
- Validation of Performance Measure Methodology
- Assessment of Compliance With Medicaid Managed Care Regulations—Operational Systems Review Methodology
- Readiness Review
- PCP Secret Shopper Methodology
- Encounter Data Validation Methodology
- Member Experience of Care Survey Methodology
- MCO Comparative and Statewide Calculation of Additional Performance Measure Results
- Prenatal Care and Birth Outcomes Focus Study Methodology
- Foster Care Focus Study Methodology
- Dental Utilization in Pregnant Women Focus Study Methodology
- Consumer Decision Support Tool Methodology
- Performance Withhold Program Methodology

PIP Validation Approach and Methodology

The purpose of PIP validation is to ensure that PIPs are conducted in a manner that is consistent with the Department of Health and Human Services, CMS publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[B-1] For future validations, HSAG will use *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[B-2] HSAG's PIP validation process includes two key components:

1. HSAG evaluates the technical structure of the PIP to ensure that the MCOs design, conduct, and report the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., topic supported by data, Aim statement, population, sampling techniques, performance indicator measure, and data collection methodology) is based on sound methodological principles and can reliably measure outcomes. Successful

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

[B-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Aug 22, 2023.

execution of this component ensures that reported PIP results are accurate and indicators used have the capability to achieve statistically significant and sustained improvement.

2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process; analysis of data; and identification and prioritization of barriers and subsequent development of relevant, actionable interventions. Through this component, HSAG evaluates how well the MCO improves its rates by implementing effective processes (i.e., barrier analyses, intervention, and evaluation of results).

PIP Submission Form

HSAG developed a PIP Submission Form that MCOs use to document each required step, as well as accompanying instructions to aid them in addressing all documentation requirements. The accompanying instructions describe the requirements for each step in the process and explain step by step how to document and complete the PIP Submission Form.

PIP Validation Tool

HSAG designed its PIP Validation Tool, which it uses to validate the submitted PIPs. The PIP Validation Tool corresponds to the PIP Submission Form. For each submitted PIP, HSAG completed the validation tool and submitted it to the MCO and DMAS as formal feedback and the validation tool will be part of the MCO-specific PIP report.

PIP Validation Methodology

HSAG's approach to assessing the PIP methodology and documentation of the validation findings provides a consistent, structured process and a mechanism that gives the MCOs specific detailed feedback and recommendations for the PIP. HSAG performs the following nine PIP validation steps:

- Step I: Review the Selected PIP Topic
- Step II: Review the PIP Aim Statement
- Step III: Review the Identified PIP Population
- Step IV: Review the Sampling Method
- Step V: Review the Selected PIP Variables and Performance Measures
- Step VI: Review the Data Collection Procedures
- Step VII: Review the Data Analysis and Interpretation of PIP Results
- Step VIII: Assess the Improvement Strategies
- Step IX: Assess the Likelihood That Significant and Sustained Improvement Occurred

HSAG used its standardized scoring methodology within the PIP Validation Tool to rate each MCO's compliance with each of the nine steps. The PIP Validation Tool includes, for each required validation step, a set of evaluation elements. Each element receives a score of *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed* based on the MCO's documentation and performance indicator outcomes. Once all elements have been scored, HSAG rates and reported the overall validity and reliability of the PIP findings as one of the following:

- *Met*: High confidence/confidence in the reported PIP results. All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all steps.
- *Partially Me*t: Low confidence in the reported PIP results. All critical evaluation elements were *Met,* and 60 to 79 percent of all evaluation elements were *Met* across all steps, or one or more critical evaluation elements were *Partially Met*.
- *Not Met:* No confidence in the reported PIP results. All critical evaluation elements were *Met,* and less than 60 percent of all evaluation elements were *Met* across all steps, or one or more critical evaluation elements were *Not Met*.

HSAG has designated some of the evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must receive a *Met* score. Given the importance of critical elements to the scoring methodology, any critical element that receives a score of *Not Met* will result in an overall PIP validation rating of *Not Me*t.

HSAG assigns each PIP an overall percentage score for all evaluation elements (including critical elements), calculating the overall score by dividing the total number of elements scored as *Met* by the sum of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met, Partially Met*, and *Not Met*. HSAG then assigns a level of confidence to the validated PIP.

PIP Technical Assistance

HSAG provides ongoing PIP technical assistance to the MCOs and DMAS that includes training on how to complete the PIP Submission Form, quality improvement science tools, logically linking interventions that have the potential to impact the performance indicator outcomes with priority barriers, and evaluation of interventions to aid MCOs in making data driven decisions.

Validation of Performance Measure Methodology

DMAS contracted with HSAG, as its EQRO, to conduct PMV for the MCOs. Title 42 of the CFR §438.350(a) requires states that contract with MCOs, PIHPs, PAHPs, or PCCM entities to have a qualified EQRO perform an annual EQR that includes validation of contracted entity performance measures (42 CFR §438.358[b][1][ii]). HSAG, in conjunction with ALI Consulting Services, LLC, conducted PMV for DMAS, validating the data collection and reporting processes used to calculate the performance measure rates by the MCOs in accordance with the CMS publication, *Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity, February 2023*.[B-3]

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

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

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

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

Table B-2—CY 2022 CCC Plus (MLTSS) MCOs

MCO Name
Aetna
HealthKeepers
Molina
Optima
United
VA Premier

Objectives

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

Technical Methods of Data Collection

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

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

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

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

Description of Data Obtained

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

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

How Data Were Aggregated and Analyzed

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

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

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

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

How Conclusions Were Drawn

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

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

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

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

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

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

Table B-4 lists the performance measures selected by DMAS, the method* (i.e., hybrid or admin) required for data collection, and the specifications that the MCOs were required to use.

Table B-4—Performance Measure List for SFY 2023

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

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

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

Assessment of Compliance With Medicaid Managed Care Regulations

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

HSAG divided the federal regulations into 14 standards consisting of related regulations and contract requirements. Table B-5 describes the standards and associated regulations and requirements reviewed for each standard during the OSRs.

Table B-5—Summary of Compliance Standards and Associated Regulations

Standard	Federal Requirements Included	Standard	Federal Requirements Included
Standard I—Enrollment and Disenrollment	42 CFR §438.3(d) 42 CFR §438.56	Standard VIII—Provider Selection	42 CFR §438.12 42 CFR §438.102 42 CFR §438.106 42 CFR §438.214
Standard II—Member Rights and Confidentiality	42 CFR §438.100 42 CFR §438.224 42 CFR §422.128	Standard IX—Subcontractual Relationships and Delegation	42 CFR §438.230
Standard III—Member Information	42 CFR §438.10	Standard X—Practice Guidelines	42 CFR §438.236
Standard IV—Emergency and Poststabilization Services	42 CFR §438.114	Standard XI—Health Information Systems*	42 CFR §438.242
Standard V—Adequate Capacity and Availability of Services	42 CFR §438.206 42 CFR §438.207	Standard XII—Quality Assessment and Performance Improvement	42 CFR §438.330

Standard	Federal Requirements Included	Standard	Federal Requirements Included
Standard VI—Coordination and Continuity of Care	42 CFR §438.208	Standard XIII—Grievance and Appeal Systems	42 CFR §438.228 42 CFR §438.400– 42 CFR §438.424
Standard VII—Coverage and Authorization of Services	42 CFR §438.210 42 CFR §438.404	Standard XIV—Program Integrity	42 CFR §438.602(b) 42 CFR §438.608 42 CFR §438.610

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

Objectives

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

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

Technical Methods of Data Collection

To assess for MCOs' compliance with regulations, HSAG conducted the five activities described in CMS EQR Protocol 3. Table B-6 describes the five protocol activities and the specific tasks that HSAG performed to complete each activity.

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

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

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

Description of Data Obtained

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

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

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

How Data Were Aggregated and Analyzed

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

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

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

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

How Conclusions Were Drawn

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

Table B-7—Assignment of Compliance Standards to the Quality, Timeliness, and Access Domains

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

Cardinal Care Program Readiness Review Methodology

Introduction

DMAS is the single state agency that administers the Medicaid managed care program in the Commonwealth of Virginia. In June 2021, the Virginia General Assembly mandated that DMAS rebrand the Department's FFS and managed care programs and effectively combine the CCC Plus (MLTSS) and Medallion 4.0 (Acute) programs under a single name, the Cardinal Care program. The combined program will achieve a single streamlined system of care that links seamlessly with the FFS program. The Cardinal Care program will ensure an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality, equitable care to its members, and adds value for its providers and the Commonwealth.

The transition to Cardinal Care is planned for January 1, 2023. Cardinal Care will merge the CCC Plus (MLTSS) program and the Medallion 4.0 (Acute) program and rebrand the Medicaid program as the Cardinal Care program. Table B-8 contains a list of the MCOs that will serve the members enrolled in the Cardinal Care program. The transition to the Cardinal Care program will retain the MCOs that served the members prior to the program transition.

Table B-8—Cardinal Care Program MCOs

MCOs
Aetna
HealthKeepers
Molina
Optima
United
VA Premier

Federal Readiness Review Requirements

42 CFR §438.66 describes the state monitoring requirements, including MCO readiness reviews, when states implement a managed care program or when an MCO entity currently contracting with the state will provide or arrange for the provision of covered benefits to new eligibility groups. The regulation further states that the readiness review must be started at least three months prior to the contract effective date and that the results must be submitted to the CMS for approval.

HSAG conducts readiness reviews for each of the MCOs to evaluate the MCOs' ability and capacity to comply with the federal and State Medicaid Cardinal Care program requirements. The readiness reviews rely heavily on reviewing real-time data and processes and assessing the MCOs' preparedness to fulfill future functions required for the success of the Cardinal Care program. The readiness reviews conducted by HSAG assess the ability and the capacity of the MCOs to perform satisfactorily in key operational and administrative functions outlined in CMS requirements and provisions in the Commonwealth's contract with the MCOs.

The readiness reviews standards completed by HSAG are based on CMS requirements and are conducted in compliance with the CMS EQR *Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations*, February 2023.[B-4] HSAG utilizes the protocol to guide the review of each MCO and assess each MCO's ability to meet the readiness review requirements and report on the findings.

Objectives

The primary objective of the Cardinal Care program readiness reviews conducted by HSAG is to assess the ability and the capacity of the MCOs to perform satisfactorily in key operational and administrative functions, service delivery, and systems management. The readiness review includes a robust review of the MCOs' administrative, operational, and function capacities to fully implement the Cardinal Care program requirements by January 2023. The MCOs are expected to remediate deficiencies that HSAG and DMAS deem critical prior to the January 2023, program implementation.

[B-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 18, 2023.

To accomplish these objectives, HSAG, in collaboration with DMAS, defines the scope of the review by conducting an evaluation and prioritization of the following:

- Commonwealth of Virginia Cardinal Care program MCO contractual requirements
- 2020 Federal Managed Care Final Rule readiness review requirements

Readiness Review Process

As required in 42 CFR §438.66(d), HSAG's readiness review process includes an assessment of the ability and capacity of the MCOs to perform satisfactorily, specifically in relation to the Cardinal Care program requirements, in the following required functional and organizational areas:

- Operations/administration
  - Administrative staffing and resources
  - Delegation and oversight of MCO entity responsibilities
  - Enrollee and provider communications
  - Grievances and appeals
  - Member services and outreach
  - Provider network management
  - Program integrity/compliance
- Service delivery, including
  - Case management/care coordination/service planning
  - Quality improvement
  - Utilization review
- Systems management, including
  - Claims management
  - Encounter data
  - Enrollment information management

HSAG uses the results of the MCOs' 2021 CCC Plus (MLTSS) and Medallion 4.0 (Acute) OSRs to reduce MCOs' and DMAS' burden and duplication of review activities. The readiness review include a focus on:

- 2021 MCO OSR identified deficiencies (Not Met) and implementation of corrective action plans
- MCO operational and administrative changes implemented for the Cardinal Care program requirements
- Updated policies and procedures that reflect the MCO Cardinal Care contract requirements
- Anticipated staffing changes
- System changes

Model of Care Readiness Review

HSAG's readiness review process includes a readiness review of the MCOs' readiness to implement the DMAS Model of Care for the following populations:

- CCC Plus Waiver members receiving PDN
- Children receiving PDN through EPSDT
- Ventilator-dependent members (by setting)

The review includes the DMAS requirement that the MCOs' implementation plans for the Model of Care includes:

- Strategy for how members will be identified—new and current
- Staffing plan and care manager assignment process or procedure
- Process for how the care manager will follow the member through transitions
- Summary of updated MCO contract Model of Care policies and procedures
- Clinical documentation and alerts procedure
- Care management policies and procedures to ensure Model of Care requirements have been updated to reflect the Cardinal Care program Model of Care requirements

HSAG conducts follow-up with the MCOs to ensure all gaps or deficiencies that have the potential to impact the ability of the MCO to be ready to serve the Cardinal Care population on the go-live date are satisfactorily addressed.

Technical Methods of Data Collection

The HSAG readiness review methodology aligns with the guidelines and processes set forth in CMS' *EQR Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations*, October 2019. Utilizing the CMS EQR protocol, HSAG will assess each MCO's readiness to serve the Cardinal Care program members, compliance with the Medicaid Managed Care Rule requirements, and the MCO's contract requirements. HSAG reports on the findings.

Planning Review Activities

This methodology document represents the initial planning activities for the readiness review. Upon DMAS' approval of the methodology and high-level timeline, HSAG will proceed with creating the readiness review tools with the Cardinal Care program requirements. HSAG will utilize results and findings from the 2021 CCC Plus (MLTSS) and Medallion 4.0 (Acute) OSRs. HSAG will collaborate with DMAS regarding the standards and elements included in the desk review tools for the Cardinal Care program readiness review. HSAG will develop an MCO kick-off readiness review webinar. The webinar will contain an overview of the HSAG readiness review processes, timeline, documentation submission requirements, and the readiness review tools.

Description of Data Obtained

To assess the MCOs' compliance with the CMS Final Rule requirements and the MCOs' readiness to implement the Cardinal Care program requirements as defined in the MCO contracts, HSAG will review information from a wide range of written documents including, but not limited to, the following:

- Results of the CCC Plus (MLTSS) 2021 OSRs
- Results of the Medallion 4.0 (Acute) 2021 OSRs
- MCO CAPs and follow-up activities

- MCO updates specific to the Cardinal Care program requirements including:
  - Updated policies, procedures, and processes specific to the Cardinal Care program
  - Organizational staffing plans and organization structure
  - Call Center and claims processing staffing plans
  - Training and coordination schedule and curriculum
  - Cardinal Care program Model of Care requirements
  - Member information updated with Cardinal Care program information and requirements
  - Provider information updated with Cardinal Care program benefits and requirements
  - Provider, subcontractor, and vendor contracts as applicable to Cardinal Care program requirements
  - MCO websites
  - Network data and information
  - Narrative and/or data reports across performance and content areas focused on the Cardinal Care program requirements

HSAG will obtain additional information for the readiness review through virtual discussions and interviews with the MCOs' key staff members and subject matter experts, as necessary.

Communication With the MCOs

HSAG will establish early communication with the MCOs through written notice of the readiness reviews and dates for the kick-off webinars. HSAG will manage ongoing communications with the MCOs and provide technical assistance throughout the readiness review process. HSAG will schedule interviews of MCO staff, if determined necessary, to ensure implementation of the MCOs' Cardinal Care program implementation plans. DMAS will be provided for review and approval all MCO-wide communications.

Document Submission

HSAG will require the MCOs to populate the focused readiness review tools with supporting documentation (evidence of readiness) and upload the source documents to the secure HSAG Virginia SharePoint site or the HSAG SAFE site on or before the desk review tool submission deadline. MCOs will be required to highlight or annotate compliant information within submissions to streamline the review purposes.

How Data Were Aggregated and Analyzed

The evaluation phase will consist of a desk review of documentation submitted by the MCOs, virtual staff interviews, as necessary, and the assignment of readiness review scores.

Desk Review Process

Upon receipt of the desk review tools, the MCOs will have three weeks to submit the completed desk readiness review tool and supporting documentation. Upon receipt of the desk review materials, the HSAG review team will conduct the desk reviews.

The HSAG project leader will conduct training of the readiness review team. The training for the reviewers is intended to ensure quality and consistency with the ratings, maintain review process efficiencies, and provide DMAS and the MCOs with actionable feedback. The HSAG review team will conduct in-depth desk reviews that include MCO submitted documentation and results of the previous CCC Plus (MLTSS) and Medallion 4.0 (Acute) OSRs. The reviewers are required to have the preliminary desk review findings and lists of follow-up items and interview questions prepared for any MCO follow-up conference calls or virtual meeting reviews that are needed.

How Conclusions Were Drawn

From a review of documents, observations, and interviews with key staff members during the readiness review, the HSAG reviewers assign a score for each element and an aggregate score for each standard in the Readiness Review Evaluation Tool. Each element will be given a score of *Met* or *Not Met*.

HSAG's scoring is based upon the following:

- ***MET*** indicates full compliance or readiness defined as ***all of*** the following:
  - All documentation was present and updated to include Cardinal Care program requirements.
  - The documentation (whether it was a policy, procedure, diagram, or some other form of communication) contained sufficient information to ascertain how the MCO met this requirement.
  - The documentation included appropriate identification that signified the functional area(s) or organization(s) responsible for carrying out the specifics outlined in the document.
  - Staff members provided responses consistent with the policies and/or processes described in documentation.

- ***NOT MET*** indicates noncompliance defined as ***any of*** the following:
  - A substantive portion of the documentation was not updated with Cardinal Care program requirements, was unclear, or contained conflicting information that did not address the regulatory and/or contractual requirements.
  - The documentation (whether it was a policy, procedure, diagram, or some other form of communication) did not contain the information needed to ascertain how the MCO met this requirement.
  - The documentation did not have the appropriate identification that signified the functional area(s) or organization(s) responsible for carrying out the specifics outlined in the document.
  - Staff members had little or no knowledge of processes or issues addressed by the regulatory and/or contractual provisions.
  - For those elements with multiple components, key components of the element could be identified; and, if the reviewer was unable to assess the MCO's ability and capacity to meet the requirement based upon the information submitted, any deficiencies identified could result in an overall finding of *Incomplete* regardless of the findings noted for the remaining components.

If the MCO receives a ***NOT MET*** score for an element and is required to submit a CAP prior to Cardinal Care program implementation, HSAG's criteria for evaluating the sufficiency of the CAPs include:

- The completeness of the CAP in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific actions/interventions that the organization will take.
- The degree to which the planned activities/interventions meet the intent of the requirement.
- The appropriateness of the timeline for correcting the deficiency.

CAPs that do not meet the above criteria will require resubmission to HSAG and technical assistance calls with the MCO, as needed, until the CAPs are approved.

From the scores HSAG reviewers assign for each of the requirements, HSAG calculates a total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across the standards.

Deliverables

The readiness reviews deliverables will include:

- Approved timeline
- Review tools and scoring methodology
- Kick-off readiness review webinar with the MCOs
- MCO-specific readiness review reports
- Corrective action plan templates

Throughout the readiness review process, HSAG will provide technical assistance as requested or when a need is identified.

HSAG will produce MCO-specific reports and forward the reports to DMAS for initial review. Upon DMAS' approval of the reports, HSAG will finalize the reports and distribute to the MCOs along with CAP templates for the MCOs to complete and submit back to HSAG for review. HSAG will review and evaluate the MCO CAP submissions, make recommendations for acceptance of CAPs, and review follow-up documentation submitted by the MCOs to show evidence of implementation of the CAPs.

HSAG will conduct regular monitoring and follow-up to ensure MCO readiness review requirements have been met prior to the Cardinal Care program implementation date (January 2023). HSAG will work closely with DMAS regarding any identified concerns that indicate an MCO may not meet the federal and DMAS requirements to go live with the Cardinal Care program on January 1, 2023.

PCP Secret Shopper Methodology

Overview

DMAS contracted with HSAG to conduct a secret shopper telephone survey of appointment availability to collect information on members' access to primary care services under the VA Medicaid managed

care program. A secret shopper is a person employed to pose as a patient to evaluate the quality of customer service or the validity of information (e.g., location information). The secret shopper telephone survey allows for objective data collection from healthcare providers without potential bias introduced by knowing the identity of the surveyor.

HSAG evaluated appointment availability information among PCPs enrolled with the Virginia Medicaid MCOs to address the following survey objectives:

- Determine whether primary care service locations accept patients enrolled with the MCOs and the degree to which this information aligns with the enrollment broker's data.
- Determine whether primary care service locations accept new VA Medicaid patients for the requested MCO.
- Determine appointment availability at the sampled primary care service location for urgent and routine primary care services.

HSAG used a DMAS-approved survey script to complete calls to all sampled provider locations during January and February 2023, recording survey responses in an electronic data collection tool.

Eligible Population

The eligible population included PCPs actively enrolled with one or more Virginia Medicaid MCO as of November 1, 2022. Using DMAS-approved data request materials, the DMAS enrollment broker identified providers potentially eligible for survey inclusion and submitted the PCP data files to HSAG. The enrollment broker was asked to ensure that the PCP data included out-of-state providers contracted to serve Virginia Medicaid managed care members (i.e., providers practicing in Kentucky, Maryland, North Carolina, Tennessee, West Virginia, and Washington, DC). Eligible PCPs were identified based on the PCP flag, provider specialty, and whether they accepted new patients. Provider types and specialties considered for the study included, but were not limited to the following:

- Provider type: MD, DO, Nurse Practitioner, Physician Assistant
- Provider specialties: Primary Care, Family Medicine, General Practice, Internal Medicine, Geriatric Medicine, Adolescent Medicine, Pediatrics, Preventive Medicine

HSAG reviewed key data fields to assess potential duplication and completeness. Key data fields included, but were not limited to, telephone number, provider name, and service street address. HSAG standardized provider address data to align with the United States Postal Service Coding Accuracy Support System to identify potential data concerns with street addresses and to facilitate deduplication.

Sampling Approach

The following random sampling approach was used to generate a list of primary care service locations (i.e., "cases") from each MCO for inclusion in the survey:

- **Step 1**: HSAG assembled the sample frame using records from all primary care service locations identified for each MCO.[B-5]
  - Out-of-state service locations with service addresses in Kentucky, Maryland, North Carolina, Tennessee, West Virginia, or Washington, DC were included in the sample frame.
  - In order to minimize the number of repeat phone calls to providers, HSAG identified service locations using unique telephone numbers.
- **Step 2**: HSAG used the sample frame to determine a statistically valid number of unique service locations based on a 95 percent confidence level and ±5 percent margin of error.
- **Step 3**: The calculated sample size for each MCO was proportionately split across the six regional geographic area assignments based on the number of providers in the sample frame for each region. The sample size calculated at the region level was used for sampling the providers equally among urgent and non-urgent appointment scenarios. The six regional geographic are assignments are listed below:
  - Region 1: Tidewater
  - Region 2: Central
  - Region 3: Western/ Charlottesville
  - Region 4: Roanoke/ Alleghany
  - Region 5: Southwest
  - Region 6: Northern/ Winchester

Telephone Survey Process

HSAG's secret shopper callers collected survey responses using a standardized script approved by DMAS. Callers were instructed to conduct the survey as though they had moved to the area and were trying to arrange an appointment for themselves or a family member. Due to the secret shopper nature of the calls, callers may have improvised during actual calls as needed. Callers were instructed not to leave voicemail messages or schedule appointments.

Callers made two attempts to contact each survey case during standard business hours (i.e., 9:00 a.m. to 5:00 p.m. Eastern Time).[B-6] If the caller was put on hold at any point during the call, they waited on hold for five minutes before ending the call. If a call attempt was answered by an answering service or voicemail during normal business hours, the caller made a second call attempt on a different day and at a different time of day. A survey case was considered nonresponsive if any of the following criteria were met:

- Disconnected/invalid telephone number (e.g., the telephone number connected to a fax line or a message that the number was no longer in service).

[B-5] Provider locations may be included in the eligible population for the prenatal care and PCP survey if the provider location is identified as having providers meeting the criteria for prenatal care providers and PCPs.

[B-6] HSAG did not consider a call attempted when the caller reached an office outside of the office's usual business hours. For example, if the caller reached a recording that stated that office was closed for lunch, the call attempt did not count toward the two attempts to reach the office. The caller attempted to contact the office up to two times outside of the known lunch hour.

- Telephone number connected to an individual or business unrelated to a medical provider, practice, or facility.
- The caller was unable to speak with office personnel during either call attempt (e.g., the caller was put on hold for more than five minutes or the call was answered by an automated voicemail or answering service that prevented the caller from speaking with office staff).

Survey Indicators

HSAG classified survey indicators into domains that consider provider data accuracy and appointment availability by MCO. Provider data accuracy was evaluated based on survey responses. In general, matched information received a "Yes" response and nonmatched information received a "No" response. For data collected on the first available appointment, the average wait time was calculated based on call date and earliest appointment date. HSAG also assessed appointment availability in relation to DMAS' primary care appointment standards for urgent and routine care:

- Appointments for urgent symptomatic visits (e.g., sore throat without a fever) shall be scheduled within 24 hours[B-7] of request.
- Appointments for routine visits (e.g., annual well-check appointment) shall be scheduled within 30 calendar days of request.

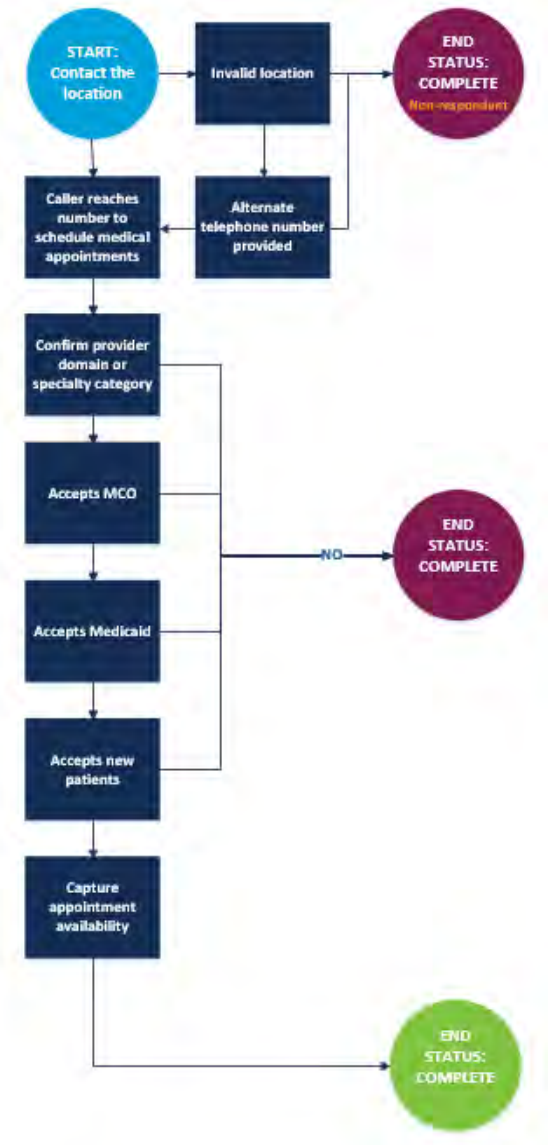
HSAG collected the following information pertaining to provider data accuracy:

- Telephone number
- Address
- Provider location's identification as offering services for the designated provider domain or specialty category
- Affiliation with the requested MCO
- Accuracy of accepting VA Medicaid managed care

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

[B-7] For the purposes of the secret shopper survey, HSAG assumed appointments were within the standards if they were scheduled within one business day since follow-up with urgent care or emergency clinics cannot be assessed.

Figure B-1—Survey Decision Stop Points



HSAG collected the following access-related information when calling sampled locations:

- Information on whether the location accepted new patients
- Date until the next available new patient appointment for an urgent or routine visit at the sampled service location with any individual practitioner at the sampled service location
- Any considerations to scheduling an appointment; this included the service location requiring:
  - Personal information or preregistration with the practice
  - Patients to complete a questionnaire
  - A review of the member's medical records
  - Verification of the member's insurance eligibility

Encounter Data Validation Methodology

Overview

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

Methodology

During SFY 2022–2023, DMAS contracted with HSAG to conduct an EDV study. In alignment with CMS EQR Protocol 5. *Validation of Encounter Data Reported by the Medicaid and CHIP [Children's Health Insurance Program] Managed Care Plan: An Optional EQR-Related Activity*, February 2023,[B-8] HSAG conducted the following two core evaluation activities:

- IS review—assessment of DMAS' and the MCOs' information systems and processes.
- Comparative analysis—analysis of DMAS' electronic encounter data completeness and accuracy through a comparison between DMAS' electronic encounter data and the data extracted from the MCOs' claims payment data systems.

HSAG conducted the EDV study for the six CCC Plus (MLTSS) MCOs displayed in Table B-9.

Table B-9—CCC Plus (MLTSS) MCOs

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

Information Systems Review

The IS review seeks to define how each participant in the encounter data process collects and processes encounter data such that the data flow from the MCOs to DMAS is understood. The IS review is key to understanding whether the IS infrastructures are likely to produce complete and

[B-8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 18, 2023.

accurate encounter data. To ensure the collection of critical information, HSAG employed a three-stage review process that included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members.

Stage 1—Document Review

HSAG initiated the EDV activity with a thorough desk review of documents related to encounter data initiatives/validation activities currently put forth by DMAS. Documents requested for review included data dictionaries, process flow charts, data system diagrams, encounter system edits, sample rejection reports, work group meeting minutes, and DMAS' current encounter data submission requirements, among others. The information obtained from this review is important for developing a targeted questionnaire to address important topics of interest to DMAS.

Stage 2—Development and Fielding of a Customized Encounter Data Assessment

To conduct a customized encounter data assessment, HSAG first evaluated the MCOs' most recent ISCA collected through CMS *Protocol 2. Validation of Performance Measures*: *A Mandatory EQR-Related Activity*, February 2023.[B-9] This process allows the IS review activity to be coordinated across projects, preventing duplication and minimizing the impact on the MCOs. HSAG then developed a questionnaire customized in collaboration with DMAS to gather information and specific procedures for data processing, personnel, and data acquisition capabilities. Lastly, since HSAG conducted an IS review two years ago, this review included specific topics of interest to DMAS. For example, HSAG included DMAS staffing and encounter quality monitoring reports for MCOs' subcontractors as focus areas in the questionnaire.

Stage 3—Key Informant Interviews

After reviewing the completed assessments, HSAG followed up with key DMAS and MCO information technology personnel to clarify any questions from the questionnaire responses. Overall, the IS review allowed HSAG to document current processes and develop a thematic process map identifying critical points that impact the submission of quality encounter data.

Comparative Analysis

The goal of the comparative analysis is to evaluate the extent to which encounters submitted to DMAS by the MCOs are complete and accurate, based on corresponding information stored in the MCOs' claims payment data systems. This step corresponds to another important validation activity described in the CMS protocol—i.e., analyses of MCO electronic encounter data. In this activity, HSAG developed a data requirements document requesting encounter data from both DMAS and the MCOs. To help the MCOs prepare data for the EDV study, HSAG added a section regarding data extraction tips to the data requirements document. A follow-up technical assistance session occurred approximately one week after distributing the data requirements document to the MCOs, thereby allowing the MCOs time to review and prepare their questions for the session.

[B-9] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 18, 2023.

HSAG used data from both DMAS and the MCOs with dates of service between January 1, 2022, and December 31, 2022, to evaluate the accuracy and completeness of the encounter data. To ensure that the extracted data from both sources represent the same universe of encounters, the data targeted professional, institutional, and pharmacy encounters with MCO adjustment/paid dates on or before April 30, 2023, and submitted to DMAS on or before May 31, 2023. This anchor date allowed enough time for the encounters in the study period to be submitted, processed, and available for evaluation in the DMAS data warehouse.

Once HSAG received data files from both data sources, the analytic team conducted a preliminary file review to ensure that the submitted data were adequate to conduct the evaluation. The preliminary file review included the following basic checks:

- Data extraction—Data were extracted based on the data requirements document.
- Percentage present—Required data fields were present on the file and had values in those fields.
- Percentage of valid values—The values included were the expected values (e.g., valid ICD-10 codes in the diagnosis field).
- Evaluation of matching claim numbers—The percentage of claim numbers that matched between the data extracted from DMAS' data warehouse and the MCOs' data submitted to HSAG.

Based on the preliminary file review results, HSAG generated a report that highlighted major findings requiring the MCOs to resubmit data, as needed.

Once HSAG received and processed the final set of data from DMAS and each MCO, HSAG conducted a series of comparative analyses, which were divided into two analytic sections. First, HSAG assessed record-level data completeness using the following metrics for each encounter data type:

- The number and percentage of records present in the MCOs' submitted files but not in DMAS' data warehouse (record omission).
- The number and percentage of records present in DMAS' data warehouse but not in the MCOs' submitted files (record surplus).

Second, based on the number of records present in both data sources, HSAG further examined completeness and accuracy for key data elements listed in Table B-10. The analyses focused on an element-level comparison for each data element.

Table B-10—Key Data Elements for Comparative Analysis

Key Data Elements	Professional	Institutional	Pharmacy
Member ID	✓	✓	✓
Detail Service From Date	✓	✓	✓
Detail Service To Date	✓		✓
Header Service From Date		✓	
Header Service To Date		✓	
Billing Provider NPI	✓	✓	✓
Rendering Provider NPI	✓		

Key Data Elements	Professional	Institutional	Pharmacy
Attending Provider NPI		✓	
Servicing Provider Taxonomy Code	✓	✓	
Prescribing Provider NPI			✓
Referring Provider Number/NPI	✓	✓	
Primary Diagnosis Code	✓	✓	
Secondary Diagnosis Codes	✓	✓	
Procedure Code	✓	✓	
Procedure Code Modifiers	✓	✓	
Surgical Procedure Codes		✓	
NDC	✓	✓	✓
Drug Quantity	✓	✓	✓
Revenue Code		✓	
DRG		✓	
Type of Bill Codes		✓	
Header Paid Amount	✓	✓	
Header TPL Paid Amount	✓	✓	
Detail Paid Amount	✓	✓	✓
Detail TPL Paid Amount	✓	✓	✓
MCO Received Date (i.e., the date when the MCOs received claims from providers)	✓	✓	✓
MCO Paid Date	✓	✓	✓

For the matching records between DMAS' data and the MCOs' data from the first step, HSAG then evaluated the element-level completeness based on the following metrics:

- The number and percentage of records with values present in the MCOs' submitted files but not in DMAS' data warehouse (element omission).
- The number and percentage of records with values present in DMAS' data warehouse but not in the MCOs' submitted files (element surplus).
- The number and percentage of records with values missing from both DMAS' data warehouse and the MCOs' submitted files (element missing values).

Element-level accuracy was limited to those records with values present in both the MCOs' submitted files and DMAS' data warehouse. For each key data element, HSAG determined the number and percentage of records with the same values in both the MCOs' submitted files and DMAS' data warehouse (element accuracy).

For the records present in both DMAS' data and the MCOs' data, HSAG evaluated the number and percentage of records with the same values for all key data elements relevant to each encounter data type (all-element accuracy).

Additionally, results were stratified by subcontractor as needed to provide a better understanding of the aggregate results by distinguishing data anomalies that may only pertain to a specific subcontractor.

Member Experience of Care Survey Methodology

Objectives

The primary objective of the adult and child CAHPS surveys was to effectively and efficiently obtain information on the levels of experience of adult and child Medicaid members enrolled in the CCC Plus (MLTSS) MCOs (Aetna, HealthKeepers, Molina, Optima, United, and VA Premier) with their MCO and healthcare.

Technical Methods of Data Collection

For the CCC Plus (MLTSS) MCOs, the technical method of data collection was through administration of the CAHPS 5.1H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.1H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCO.[B-10] The mode of CAHPS survey data collection varied slightly among the MCOs. Aetna, HealthKeepers, Molina, Optima, United, and VA Premier used an enhanced mixed-mode survey methodology that was pre-approved by NCQA for both their adult and child populations. In addition, Aetna, Molina and United included the option for adult and child members to complete the survey via the Internet, and Optima included the option for adult members only to complete the survey via the Internet. Following NCQA's standard HEDIS timeline, adult members and parents/caretakers of child members enrolled in each of the MCOs completed the surveys between the time period of January to May 2023.

Each MCO was responsible for contracting with an NCQA-certified survey vendor to conduct CAHPS surveys of the MCO's adult and child Medicaid populations on the MCO's behalf. To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed to select members and distribute surveys.[B-11] These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis. Each MCO provided HSAG with its NCQA Summary Reports of adult and child Medicaid CAHPS survey results (i.e., summary report produced by NCQA of calculated CAHPS results) and raw data files for purposes of reporting.

The CAHPS 5.1H Surveys include a set of standardized items (40 items for the CAHPS 5.1H Adult Medicaid Health Plan Survey and 76 items for the CAHPS 5.1H Child Medicaid Health Plan Survey with

[B-10] Aetna, HealthKeepers, Molina, Optima, United, and VA Premier administered the CAHPS 5.1H Child Medicaid Health Plan Survey with the CCC measurement set to their child Medicaid populations. For purposes of this report, the child Medicaid CAHPS results presented for the MCOs represent the CAHPS results for their general child populations (i.e., general child CAHPS results).

[B-11] Aetna and HealthKeepers contracted with CSS; and Molina, Optima, United, and VA Premier contracted with SPH Analytics to conduct the CAHPS survey administration, analysis, and reporting of survey results for their respective adult and child Medicaid populations.

the Children with Chronic Conditions measurement set) that assess adult members' and parents'/caretakers' of child members perspectives on care. For the MCOs, the CAHPS survey questions were categorized into eight measures of experience. These measures included four global ratings and four composite scores. The global ratings reflected members' overall experience with their health plan, all health care, personal doctor, and specialist. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*).

For each of the four global ratings, the percentage of respondents who chose the top-box experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. For each of the four composite measures, the percentage of respondents who chose a positive, or top-box, response was calculated. CAHPS composite question response choices were "Never," "Sometimes," "Usually," or "Always. A top-box response for the composite measures was defined as a response of "Usually" or "Always." These percentages are referred to as top-box scores.

Description of Data Obtained

The CAHPS survey asks members to report on and to evaluate their experiences with health care. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services.

The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. For the CAHPS 5.1H Adult Medicaid Health Plan Survey, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 10, 19, 23, and 28. For the CAHPS 5.1H Child Medicaid Health Plan Survey with the CCC measurement set, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 25, 40, 44, and 49. Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), they had a language barrier, or they were mentally or physically incapacitated (adult population only). Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

How Data Were Aggregated and Analyzed

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

Also, the 2023 top-box scores for each MCO and the statewide aggregate were compared to the 2022 NCQA Medicaid national averages.[B-12,B-13,B-14] Statistically significant differences are noted with colors. A cell is highlighted in orange if the MCO score was statistically significantly higher than the national average. However, if the MCO score was statistically significantly lower than the national average, then a cell is highlighted in gray. An MCO's score that was not statistically significantly different than the national average is not highlighted.

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

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to services provided by the MCOs, HSAG assigned each of the measures to one or more of these three domains. This assignment to domains is depicted in Table B-11.

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

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

B-12 For the NCQA Medicaid national averages, the source for the data contained in this publication is Quality Compass® 2022 data and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2022 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA.

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

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

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

Performance Overview

Virginia DMAS contracts with HSAG to calculate one performance measure as part of the Task J—Performance Measure Calculation activity. For the CY 2022 performance measure calculation activity, DMAS requested that HSAG calculate the *MLTSS-8* performance measure. This document provides an overview of the methodology for the CY 2022 *MLTSS-8* performance measure rate calculation.

Performance Measure

For the CY 2022 performance measure calculation, HSAG calculated the *MLTSS-8* performance measure, which measures the proportion of long-term facility stays (i.e., stays at least 101 days long) among members 18 years of age and older that resulted in a successful transition to the community (i.e., the member was in the community for 60 or more days). HSAG followed the 2022 CMS *Medicaid MLTSS Measures Technical Specifications and Resource Manual.* [B-16]

Performance Period

In 2023, HSAG calculated the *MLTSS-8* measure rates for CY 2022 using data collected by DMAS and submitted to HSAG.

Data Collection

The *MLTSS-8* performance measure was calculated using administrative data sources, including demographic, enrollment, professional claims/encounters, and institutional claims/encounters, for Medicaid eligible individuals. DMAS supplied SAS® data sets extracted by claims' paid dates. [B-17] HSAG retrieved the data files from DMAS' SFTP site.

HSAG used SAS software to perform all analytics. Upon receiving the data, HSAG confirmed the reasonability and completeness of the data.

[B-15] Note: This methodology is presented as it appeared in the final report for this activity.
[B-16] 2022 Medicaid Managed Long-Term Services and Supports (MLTSS) Measures Technical Specifications and Resource Manual. Available at: https://www.medicaid.gov/medicaid/managed-care/downloads/mltss-tech-specs-res-manual-2022-updated.pdf. Accessed on: Oct 19, 2023.
[B-17] SAS is a registered trademark of the SAS Institute, Inc.

Performance Measure Calculation

HSAG developed SAS program code to calculate the measure rates following the performance measure specifications. A lead analyst and validation analyst independently calculated the *MLTSS-8* measure rates. The lead analyst produced the production programming code to generate the results and output for DMAS. In parallel with the work that was performed by the lead analyst, the validation analyst created a separate code and confirmed the rates generated by the lead analyst. The Director overseeing performance measure calculations performed a final review of the rates, which included a rate review by the Chief Data Officer, as necessary. Prior to the rate deliverable submission, HSAG reviewed the final output for appropriate formatting and numerical reasonability.

HSAG calculated a Virginia total measure rate and stratified results by Medicaid Program, Medicaid Delivery System, MCO, and managed care geographic region using FIPS codes. In addition, rates were stratified by age, race, and gender. Table B-12 presents the *MLTSS-8* performance measure rate stratifications and values for Medicaid Program, Medicaid Delivery System, MCO, geographic region, age group, and gender.

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

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

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

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

Table B-13—Race Category Stratification Values

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

Once rates were generated, HSAG produced a single Microsoft Excel workbook containing numerator, denominator, and rate results. HSAG denoted measure rates based on relatively small numerators or denominators (i.e., fewer than 11) within the report. Please note, rates based on small numerators or denominators should not be made publicly available. HSAG also provided DMAS with a member-level file that included the member's demographic information, risk adjustment information, and a numerator flag.

ARTS Measurement Specification Development and Maintenance

Objectives

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

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

Technical Methods of Data Collection

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

Description of Data Obtained

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

How Data Were Aggregated and Analyzed

Measures

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

Table B-14—ARTS Measures

Measure and Indicators
Concurrent Prescribing of Naloxone and *High-Dose Opioids*
Naloxone Use for High Risk of Overdose—Naloxone Use for Diagnosed Opioid Use Disorder, Naloxone Use for History of Chronic Opioid Use, Naloxone Use for Concurrent Benzodiazepine and Opioid Use, and *Naloxone Use for History of Overdose*
Treatment of Hepatitis C for Those With Hepatitis C and SUD
Treatment of HIV for Those With HIV and SUD
Preferred OBAT Compliance—Alcohol or Drug Screening, Counseling from an OBAT Provider, Family Planning, Prescription for Naloxone from OBAT Provider, Prescription for Naloxone, Testing for HIV/Hepatitis C, Initiation of Medication for OUD, Concurrent Pharmacotherapy and Care Coordination, RPR Testing, and *Annual TB Testing*
Cascade of Care for Members With OUD—High-Risk Members With OUD Diagnosis, Members Identified as having OUD who Initiated OUD Treatment, and *Members who Initiated OUD Treatment who Also Engaged in OUD Treatment*
Cascade of Care for Members With Hepatitis C—Prevalence of Hepatitis C, Received DAA Treatment for Hepatitis C, Completed DAA Treatment for Hepatitis C, and *Achieved SVR*
Cascade of Care for Members With HIV—Received HIV Care, Retained in HIV Care, and *Received Antiretroviral Therapy*

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

Stratified Rates

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

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

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

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

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

Table B-15—Eligibility Group Definitions

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

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

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

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

How Conclusions Were Drawn

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

Medicaid and CHIP Maternal and Child Health Focus Study Methodology

Project Overview

DMAS has contracted with HSAG since SFY 2015–2016, as their EQRO, to conduct an annual focus study that will provide quantitative information about prenatal care and associated birth outcomes among women with births paid by Title XIX or Title XXI, which includes the Medicaid, FAMIS MOMS, and Medicaid Expansion programs. The SFY 2021–2022 (Contract Year 1) Task I.1 Medicaid Maternal and Child Health Focus Study will address the following study questions:

- To what extent do women with births paid by Virginia Medicaid receive early and adequate prenatal care during pregnancy?
- What clinical outcomes (e.g., preterm births, low birth weight) are associated with births paid by Virginia Medicaid?
- What maternal health outcomes (e.g., depression) are associated with births paid by Virginia Medicaid?
- What health disparities exist in maternal and birth outcomes for births paid by Virginia Medicaid?

Study Design

Eligible Population

The eligible population will consist of all live births to women enrolled in Virginia Medicaid on the date of delivery during CY 2021, regardless of whether the births occurred in Virginia. Births paid by Virginia Medicaid were assigned to one of four full-scope Medicaid program categories based on the mother's enrollment in the program at the time of delivery:

- The Medicaid for Pregnant Women program uses Title XIX (Medicaid State Plan) funding to serve pregnant women with incomes up to 143 percent of the FPL.
- The Medicaid Expansion program uses Title XIX funding to serve adults 19 years of age and older with incomes up to 138 percent of the FPL.
- The FAMIS MOMS program uses Title XXI (CHIP) funding to serve pregnant women with incomes up to 200 percent[B-19] of the FPL and provides benefits similar to Medicaid through the duration of pregnancy and for 60 days postpartum.
- The "Other Aid Categories" include births paid by Medicaid or CHIP that do not fall into the three main categories of Medicaid for Pregnant Women, Medicaid Expansion, or FAMIS MOMS. Other Aid Categories include LIFC (parents and caretaker adults), disabled individuals, Medicaid Children, Foster Children and Former Foster Youth, Adoption Assistance Children, FAMIS Children, FAMIS Prenatal Coverage, presumptively eligible individuals, and others. Other Aid Categories excludes births to women in Plan First, incarcerated individuals, and emergency only benefits.

Births covered by emergency only benefits will also be included in the eligible population for this study. However, because women covered by emergency only benefits were enrolled in Medicaid immediately before or on the day of the delivery, and these individuals typically did not have access to Medicaid coverage and benefits earlier in their pregnancy, these births will be evaluated separately. Additionally, births to women enrolled in the FAMIS Prenatal Coverage program, which launched on July 1, 2021, will be included in the "Other Aid Categories" eligible population for this study. HSAG will also evaluate these births separately and provide DMAS with informational only results regarding this program for DMAS' internal use.

Data Collection

From the Medicaid member demographic and eligibility data provided by DMAS, HSAG will assemble a list (i.e., a Finder's File) of female members between the ages of 10 and 55 years with any Medicaid eligibility during CY 2021. HSAG will submit the Finder's File to DMAS with instructions for conducting two types of data linkages. DMAS will work with the VDH to obtain the birth registry data and conduct the following data linkages:

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

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

DMAS will return data files to HSAG containing the information from the Finder's File and select birth registry data fields for matching members for each of the data linkage processes, as well as documentation regarding the linked data files. The data files DMAS submits to HSAG will only include information for live births (i.e., non-live births are excluded from the linked registry records). HSAG will include all probabilistically or deterministically linked birth registry records from births occurring during CY 2021 in the overall eligible population for this focus study.

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

Study Indicators

Table B-16 presents the study indicators that HSAG will calculate for this study limited to singleton births, defined using the Plurality field in the birth registry data. Please note that the Maternal Health Outcome measures listed below will not be calculated for the emergency only population.

Table B-16—Study Indicators†

Indicator	Denominator	Numerator
Birth Outcomes		
Births with Early and Adequate Prenatal Care	Number of singleton, live births paid by Virginia Medicaid during the measurement period	Number of singleton, live births with an Adequacy of Prenatal Care Utilization Index (i.e., the Kotelchuck Index) score greater than or equal to 80 percent, which includes the Adequate Plus category (greater than or equal to 110 percent).
Births with Inadequate Prenatal Care	Number of singleton, live births paid by Virginia Medicaid during the measurement period	Number of singleton, live births with a Kotelchuck Index score less than 50 percent.
Births with No Prenatal Care	Number of singleton, live births paid by Virginia Medicaid during the measurement period	Number of singleton, live births with no prenatal care.
Preterm Births (<37 Weeks Gestation)*	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births by gestational estimate category: • Preterm: Less than 37 weeks - Late preterm: 34–36 weeks - Moderate preterm: 32–33 weeks - Very preterm: 28–31 weeks - Extremely preterm: <28 weeks

Indicator	Denominator	Numerator
Newborns with Low Birth Weight (<2,500 grams)	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births by low birth weight category: • Overall low birth weight: <2,500 grams - Moderately low birth weight: 1,500 grams–2,499 grams - Very low birth weight: <1,500 grams
Maternal Health Outcomes		
Postpartum Emergency Department (ED) Utilization	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of postpartum women who utilized ED services within 90 days of delivery.
Postpartum Ambulatory Care Utilization	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of postpartum women who utilized ambulatory care services within 90 days of delivery.
Prenatal Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of women who received an SBIRT evaluation during pregnancy. The following codes are used to define an SBIRT evaluation: • HCPCS Codes: - H0049 - H0050 - G0396 - G0397 • CPT Codes: - 99408 - 99409
Postpartum SBIRT	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of women who received an SBIRT evaluation on or between 7 and 84 days after delivery. The same SBIRT codes used for the Prenatal SBIRT measure will be used for the Postpartum SBIRT measure.

Indicator	Denominator	Numerator
Prenatal Maternal Depression Screening	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of women who received a screening for depression during pregnancy. The following codes are used to define maternal depression screening: • Managed Care Codes: - 96127 - 96160 - 96161 - 99401 - 99402 - 99403 - 99404 - G0444 - G9000 - G9001 • FFS Codes: - 96127 - 96169 - 96161
Postpartum Maternal Depression Screening	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of women who received a screening for depression on or between 7 and 84 days after delivery. The same maternal depression screening codes used for the Prenatal Maternal Depression Screening measure will be used for the Postpartum Maternal Depression Screening measure.

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

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

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

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

use the FFY 2021 CMS Core Set benchmarks, if available, for the *Newborns with Low Birth Weight (<2,500 grams)* study indicator.

HSAG will also present CY 2021 birth outcome study indicator results compared to historical results (i.e., CY 2019 and CY 2020), when available. Please note, HSAG will re-calculate historical study indicator results for the Other Aid Categories to include births to women in the LIFC program given that LIFC was previously reported separately for CY 2019 and CY 2020. For CY 2021, the births covered by emergency-only benefits will be calculated and reported separately.

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

Study Indicator Stratifications

HSAG will stratify the CY 2021 study indicator rates by the categories listed in Table B-17, on the page below. Please note, HSAG will re-calculate historical rates for the Medallion 4.0 (Acute) managed care program to include the FAMIS managed care program, given that FAMIS was previously reported separately for CY 2019 and CY 2020.

Table B-17—Study Indicator Stratifications

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

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

**Where appropriate, HSAG will compare the CY 2021 results for Molina Complete Care to the CY 2019 and CY 2020 results for Magellan Complete Care of Virginia.*

^ *Please note that the Emergency-Only program will be displayed separately within the report.*

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

Comparative Analysis

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

- The study population will include women continuously enrolled in the following programs or combination of programs for a minimum of 120 days prior to, and including, the date of delivery: Medicaid for Pregnant Women, Medicaid Expansion, FAMIS MOMS, or Other Aid Categories.

- The comparison group will include women enrolled in any of the four Medicaid programs (i.e., Medicaid for Pregnant Women, Medicaid Expansion, FAMIS MOMS, or Other Aid Categories) defined above on the date of delivery, but less than 120 days of continuous enrollment prior to the date of delivery.

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

Additional Population-Specific Stratifications

FAMIS MOMS

For the FAMIS MOMS study indicator results, HSAG will also stratify the CY 2021 results by Medicaid delivery system, maternal race/ethnicity, maternal age at delivery, managed care region of maternal residence, length of continuous enrollment prior to delivery, and trimester of prenatal care initiation. Please refer to the category values defined in Table B-17 for more information regarding these stratifications.

Emergency Only Benefits

For the emergency only benefits study indicator results, HSAG will stratify the CY 2021 results by maternal race/ethnicity, maternal age at delivery, and managed care region of maternal residence. Additionally, HSAG will compare the CY 2021 study indicators to the CY 2019 and 2020 study indicator results for the women covered by emergency only benefits. Please refer to the category values defined in Table B-17 for more information regarding these stratifications.

FAMIS Prenatal Coverage

For the FAMIS Prenatal Coverage study indicator results for DMAS' internal use, HSAG will stratify the CY 2021 results by Medicaid delivery system, MCO, maternal race/ethnicity, maternal age at delivery, managed care region of maternal residence, length of continuous enrollment prior to delivery, and trimester of prenatal care initiation. Please refer to the category values defined in Table B-17 for more information regarding these stratifications. HSAG will provide DMAS with these results in an Excel spreadsheet.

Health Disparities Analysis

For the Maternal Race/Ethnicity stratification group, HSAG will perform an analysis to identify positive and negative health disparities for the *Births with Early and Adequate Prenatal Care*, *Preterm Births (<37 Weeks Gestation)*, and *Newborns with Low Birth Weight (<2,500 grams)* measures. For each stratified rate, the reference group will be the aggregated rate for all other stratifications within the stratification group (i.e., the rate for the White, Non-Hispanic group will be compared to the aggregate of all other race/ethnicity stratifications). The *p*-value of the coefficient from the logistic regression will be used to identify statistically significant differences when comparing the stratified rates to the reference groups.

For this report, a health disparity will be defined as a stratified rate with a *p*-value of the coefficient of the logistic regression that is less than 0.005.[B-21] When analyzing a given stratification, HSAG will classify the rate in one of the following three categories based on the preceding analyses:

- Better Rate
  - The *p*-value of the coefficient of the logistic regression is less than 0.005 and the stratified rate is higher or more favorable than the rate for the reference group. In other words, the reference group shows a health disparity compared to the stratification being evaluated.
- Worse Rate
  - The *p*-value of the coefficient of the logistic regression is less than 0.005 and the stratified rate is lower or less favorable than the rate for the reference group. In other words, the stratification being evaluated showed a health disparity compared to the reference group.
- Similar Rate
  - The *p*-value of the coefficient of the logistic regression is greater than or equal to 0.005. This means no health disparities are identified when the stratification was compared to the reference group.

Member-Level Data File

HSAG will produce a member-level data file and Excel spreadsheet that DMAS can use for internal purposes. The member-level data file will include all data elements listed in Table B-18.

Table B-18—Member-Level Data File

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

[B-21] A *p*-value of the coefficient of the logistic regression less than 0.005 was chosen due to the anticipated large eligible populations for the measures.

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

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

B-22 Identification of asthma will use administrative data sources; therefore, this stratification will not be applied to women without Medicaid enrollment prior to delivery.

B-23 Identification of diabetes will use administrative data sources; therefore, this stratification will not be applied to women without Medicaid enrollment prior to delivery.

Demographic Category	Category Values
Maternal Gestational Diabetes[B-24]	• Gestational Diabetes • No gestational diabetes • NA
Prenatal Care (PNC) Index	• Adequate Plus PNC • Adequate PNC • Intermediate PNC • Inadequate PNC • Missing Info
Gestational Age	• Preterm: Less than 37 weeks • Late preterm: 34–36 weeks • Moderate preterm: 32–33 weeks • Very preterm: 28–31 weeks • Extremely preterm: <28 weeks • Term: 37–41 weeks • Late Term: 41 weeks • Full Term: 39–40 weeks • Early Term: 37–38 weeks • Post Term: > 42 weeks
Birth Weight	• Moderately Low • Very Low • Not Low • Missing
Method of Delivery *Note: Defined from the birth registry data.*	• C-Section Delivery • Vaginal Delivery • Missing
Postpartum ED Utilization *Note: Only ED services up to 90 days after delivery will be considered.*	• Yes • No
Postpartum Ambulatory Care Utilization *Note: Only ambulatory care services up to 90 days after delivery will be considered.*	• Yes • No

B-24 Identification of gestational diabetes will use administrative data sources; therefore, this stratification will not be applied to women without Medicaid enrollment prior to delivery.

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

Deliverables

For the 2021–2022 Medicaid Maternal and Child Health Focus Study, HSAG will provide DMAS with the following deliverables:

- HSAG will present the findings of this focus study in a formal report for DMAS to share with stakeholders. HSAG will apply suppression (i.e., suppress numerators and denominators fewer than 11) to the version of the report that is made 508-compliant. A non-suppressed version of the report will be provided to DMAS for internal purposes.
- HSAG will provide a member-level analytic dataset as an Excel spreadsheet with an accompanying data dictionary.
- HSAG will supply a supplemental Excel spreadsheet that provides additional stratifications not included in the report, including FAMIS Prenatal Coverage study indicators.
- A corresponding PowerPoint slide deck will be produced based upon the report and delivered to DMAS. At DMAS' request, HSAG will present the slides at the quarterly MCO Quality Collaborative meeting that occurs in the calendar quarter after delivery of the final report.

Child Welfare Focus Study Methodology[B-25]

Objectives

DMAS has contracted with HSAG since SFY 2015–2016 to conduct a focus study that assesses healthcare utilization among members in child welfare programs receiving medical services through MCOs. The SFY 2022–2023 (Contract Year 2) Task I.2 Child Welfare Focus Study assessed how healthcare utilization among members in child welfare programs (i.e., children in foster care, children receiving adoption assistance, and former foster care members) compared to utilization among members not in child welfare programs and receiving Medicaid managed care benefits and to national benchmarks, where applicable. Additionally, the 2022–2023 study assessed timely access to care for members who transitioned into or out of the foster care program and identified disparities in healthcare utilization and timely access to care based on demographic factors.

Technical Methods of Data Collection

HSAG extracted information needed for the study from administrative claims and encounter data, as well as member, provider, eligibility, and enrollment data received from DMAS. In addition, DMAS supplied HSAG with dental encounter data during the measurement period from the Medicaid DBM, DentaQuest. A six-month data run-out period was allowed between the end of the measurement period and data extraction; data extraction began July 1, 2023.

Description of Data Obtained

Study data included administrative claims and encounters, as well as demographic, eligibility, and enrollment data to examine services received by members for MY 2022.

How Data Were Aggregated and Analyzed

Healthcare Utilization Analysis

For the healthcare utilization analysis, HSAG identified the eligible populations for each child welfare program using the specific program's aid category to determine member enrollment at any point during the measurement period:

- Children in Foster Care—All children enrolled in Medicaid under 18 years of age as of January 1, 2022, and identified by DMAS as enrolled in Medicaid under the aid category "076" for children in foster care.

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

- Children Receiving Adoption Assistance—All children enrolled in Medicaid under 18 years of age as of January 1, 2022, and identified by DMAS as enrolled in Medicaid under the aid category "072" for children in the adoption assistance program.
- Former Foster Care Members—All members enrolled in Medicaid 19 to 26 years of age as of January 1, 2022, and identified by DMAS as enrolled in Medicaid under the aid category "070" for young adults formerly in foster care.

Selected study indicators assess demographic characteristics among the eligible populations for any length of Medicaid enrollment during the measurement period. For study indicators assessing healthcare utilization, the eligible populations were limited to members enrolled in the Medallion 4.0 (Acute) or CCC Plus (MLTSS) managed care programs with any MCO or a combination of MCOs during the measurement year, with enrollment gaps totaling no more than 45 days. This approach ensured that these members were continuously enrolled and covered by Medicaid for study indicators assessing healthcare utilization. Additionally, HSAG matched this group of continuously enrolled members to controls meeting the same age and enrollment criteria and sharing similar demographic and health characteristics to determine the final study populations and controls.

To determine the extent to which children in foster care, children receiving adoption assistance, and former foster care members who were continuously enrolled with one or more MCOs throughout the study period utilized healthcare services, HSAG assessed 20 measures, representing 32 study indicators, across six domains, as displayed Table B-19.

Table B-19—Healthcare Utilization Measure Indicators

Measure and Indicators
Primary Care
Child and Adolescent Well-Care Visits (WCV)
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)^ and Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+)^
Oral Health
Annual Dental Visit (ADV)
Preventive Dental Services (PDENT-CH)
Oral Evaluation, Dental Services (OEV-CH)
Topical Fluoride for Children—Dental or Oral Health Services (TFL-CH)
Behavioral Health
Antidepressant Medication Management—Effective Acute Phase Treatment (AMM–A) and Effective Continuation Phase Treatment (AMM–C)*
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up (FUH)
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up (FUM)
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing (APM)^

Measure and Indicators
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)^
Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up, Two-Month Follow-Up, Three-Month Follow-Up, Six-Month Follow-Up, and Nine-Month Follow-Up (ADD)^
Substance Use
Follow-Up After ED Visit for Substance Use—30-Day Follow-Up (FUA)†
Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment (IET–I) and Engagement of SUD Treatment (IET–E)
Respiratory Health
Asthma Medication Ratio (AMR)
Service Utilization
Ambulatory Care Visits
ED Visits
Inpatient Visits
Behavioral Health Encounters—Total, ARTS, CMH Services, RTC Services, Therapeutic Services, and Traditional Services
Overall Service Utilization

^Indicates these study indicators were not calculated for former foster care members as the measure indicators are not applicable to members 19 to 26 years of age.
**Indicates these study indicators were only calculated for former foster care members as the measure indicators are only applicable to members 18 years of age and older.*
†Indicates these study indicators were only calculated for the former foster care members, as the denominators for the children in foster care and the children receiving adoption assistance members are historically very small.

Timely Access to Care Analysis

For the timely access to care analysis, HSAG worked with DMAS to develop custom measure specifications to assess timely access to care for members who transitioned into or out of the foster care or adoption assistance programs during the measurement year. These members were continuously enrolled in Medallion 4.0 (Acute) or CCC Plus (MLTSS) managed care programs with any MCO or a combination of MCOs during the follow-up period for assessing timely care. These populations were not matched to controls.

HSAG assessed five measures, representing 16 study indicators, as displayed in Table B-20.

Table B-20—Timely Access to Care Measure Indicators

Measure and Indicators
Timely Access to Care for New Foster Care Members—Timely Access to Primary Care for New Foster Care Members, Timely Access to Dental Care for New Foster Care Members, Timely Access to Primary Care or

Measure and Indicators
Dental Care for New Foster Care Members, and Timely Access to Primary Care and Dental Care for New Foster Care Members
Timely Access to Care for Members Who Aged Out of Foster Care—Timely Access to Primary Care for Members Who Aged Out of Foster Care, Timely Access to Dental Care for Members Who Aged Out of Foster Care, Timely Access to Primary Care or Dental Care for Members Who Aged Out of Foster Care, and Timely Access to Primary Care and Dental Care for Members Who Aged Out of Foster Care
Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care—Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care and Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care With a Behavioral Health Diagnosis
Timely Access to Behavioral Health Care for New Foster Care Members—Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members, Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members With a Behavioral Health Diagnosis, Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members, and Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members With a Behavioral Health Diagnosis
Timely Access to Behavioral Health Care for Members Receiving Adoption Assistance—Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members and Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members With a Behavioral Health Diagnosis

Health Disparities Analysis

HSAG assessed health disparities among members in child welfare programs based on key demographic factors (i.e., race, age, gender, MCO, and region) for both the healthcare utilization measures and the timely access to care measures. For the healthcare utilization measures, HSAG also assessed health disparities among each group of controls and compared results to the study populations. HSAG identified health disparities using logistic regression models that predict numerator compliance and compare the results of each demographic stratification to a reference group. HSAG excluded comparisons for which disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model). The reference groups consisted of members in any other stratification (e.g., the reference group for members in Tidewater was all other members not in the Tidewater region).

How Conclusions Were Drawn

For the Healthcare Utilization and Timely Access to Care analyses, HSAG compared MY 2022 study indicator rates to NCQA's Quality Compass®,[B-26] national Medicaid HMO percentiles, when available, to provide additional context for indicator results.

Additionally, to assess whether indicator rates were statistically different between the study populations and their matched controls, HSAG calculated *p*-values to determine the association between program

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

status (e.g., membership in the foster care program) and numerator compliance. For indicators for which all contingency table cell sizes (i.e., the number of numerator-positive and numerator-negative members for each group) were greater than or equal to 5, HSAG calculated *p*-values using Chi-square tests. For indicators with small contingency table cell sizes, HSAG used Fisher's exact test because Fisher's exact test is more accurate than the Chi-square test when cell sizes are small. A *p*-value less than 0.05 was considered statistically significant.

For the Health Disparities analysis, the *p*-value for the demographic group's coefficient in the logistic regression model was used to identify statistically significant health disparities between the demographic groups and their reference groups. HSAG excluded comparisons for which disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).

For this report, a *p*-value less than 0.05 indicated a health disparity. When analyzing a given demographic group, HSAG classified the stratified rate in one of the following three categories based on the preceding analyses:

- Higher Rate
  - The *p*-value for the coefficient in the logistic regression model was less than 0.05, indicating a health disparity, and the stratified rate for the demographic group was higher than the rate for the reference group.
- Lower Rate
  - The *p*-value for the coefficient in the logistic regression model was less than 0.05, indicating a health disparity, and the stratified rate for the demographic group was lower than the rate for the reference group.
- Similar Rate

The *p*-value for the coefficient in the logistic regression model was greater than or equal to 0.05. This means no health disparity was identified when the stratification was compared to the reference group.

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

Overview

DMAS contracted with HSAG to conduct the 2022–2023 EQR Task N: Dental Utilization in Pregnant Women Data Brief activity, which assesses dental utilization and birth outcomes among pregnant women covered by Virginia Medicaid or FAMIS MOMS through the Virginia Medicaid Smiles for Children program that is administered by DentaQuest. This document outlines HSAG's methodology for performing this analysis.

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

Data Sources

HSAG will use vital statistics data provided by DMAS and the VDH. If vital statistics data are not received by August 4, 2023, HSAG will use the member enrollment and eligibility, and claims/encounter data files provided by DMAS in July 2023 for the analysis.

Measurement Period

HSAG will assess the utilization of dental services during the preconception, prenatal, and postpartum periods for women with deliveries during CY 2022 (i.e., January 1, 2022, through December 31, 2022).[B-28]

Eligible Population

If vital statistics data are received by August 4, 2023, HSAG will use vital statistics data to identify deliveries to women during CY 2022. If vital statistics data are not available, HSAG will identify women with a delivery during the measurement period using the member enrollment/eligibility and claims/encounter data provided by DMAS. HSAG will identify deliveries using the *Deliveries Value Set* from the *Prenatal and Postpartum Care* measure in the FFY 2023 CMS Adult and Child Core Set of Health Care Quality Measures.[B-29] HSAG will exclude non-live births from the deliveries using the *Non-Live Birth Value Set* for the *Prenatal and Postpartum Care* measure.[B-30] Additionally, if vital statistics data are not available, HSAG will not be able to complete analyses that depend on information that is only available in the vital statistics data (e.g., study indicators and stratifications utilizing Kotelchuck Index score).

HSAG will include women of any age at the time of conception in the analysis but will calculate rates separately for women 21 years of age and older and women under 21 years of age. HSAG will use the vital statistics data to determine gestational age. In the absence of vital statistics data, HSAG will estimate the time of conception as 280 days prior to the date of delivery.[B-31]

[B-28] A women's pregnancy would begin during March 2021 for a live birth delivered on January 1, 2022. Therefore, all women with deliveries beginning in CY 2022 would have been eligible for the VA Smiles for Children program, contingent upon their enrollment in Medicaid or FAMIS MOMS.

[B-29] Centers for Medicare & Medicaid Services. Core Set of Adult and Child Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for Federal Fiscal Year 2023 Reporting, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf?t=1681155105. Accessed on: Apr 10, 2023.

[B-30] Ibid.

[B-31] Historically, the VA Smiles for Children program covered most dental services for children under 21 years of age and pregnant women aged 21 years and older through their pregnancy and postpartum period. Starting July 1, 2021, the VA Smiles for Children program also began covering comprehensive dental services for adults, aged 21 years and older, who are receiving full Medicaid benefits. Further information about the program is available at: https://www.dentaquest.com/getattachment/State-Plans/Regions/Virginia/Dentist-Page/VA-Smiles-For-Children-ORM.pdf/?lang=en-US.

Study Indicators

Dental Utilization

HSAG will use the dental encounter data to determine which dental services, if any, were utilized during the member's preconception, pregnancy, or postpartum period, using the following code sets:[B-32]

- Any Dental Service Code Set
- Adjunctive Services Code Set
- Diagnostic Services Code Set
- Endodontics Code Set
- Oral & Maxillofacial Surgery Code Set
- Periodontics Code Set
- Preventive Services Code Set
- Prosthodontics Code Set
- Restorative Code Set

Dental Utilization Stratifications

HSAG will stratify the CY 2022 dental utilization study indicator rates by the categories listed in Table B-21.

Table B-21—Dental Utilization Study Indicator Stratifications

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

[B-32] For detailed information related to the code sets used for this report, please refer to the *VA Task N_Dental Utilization in Pregnant Women Data Brief Code Set* Excel File.

Stratification	Description/Values
Managed Care Program	• Medallion 4.0 (Acute) • CCC Plus (MLTSS) • FAMIS • Not Enrolled
Medicaid Delivery System	• Fee-for-Service (FFS) • Managed Care • Not Enrolled
Perinatal Timing of Dental Service	The perinatal timing of the utilization of dental services. The following categories will be presented: • Preconception period: the defined lookback period prior to conception (e.g., 3 months, 6 months)* • Prenatal period: the start of the first trimester based on gestational age at time of delivery (or the 280 days prior to the date of delivery if only administrative data are available) • Postpartum period: through six months postpartum** • Perinatal period: anytime during the prenatal and postpartum periods defined above
Continuous Enrollment During Dental Service	Dental service utilization occurred for members continuously enrolled in any Medicaid program for a minimum of 90 days prior to, and including, the date of delivery.
Age	The age of the woman on the date of delivery. The following age groups will be presented: • 20 and Under • 21 and Older (21–24, 25–29, 30–34, 35–39, 40 and Older)
Race/Ethnicity	The race/ethnicity of the woman. The following race/ethnicity categories will be presented: • White, Non-Hispanic • Black, Non-Hispanic • Asian, Non-Hispanic • Hispanic, Any Race • Other/Unknown

Stratification	Description/Values
Managed Care Region of Residence	The region of the woman's residence at the time of delivery. The following regions will be presented: • Central • Charlottesville/Western • Northern & Winchester • Roanoke/Alleghany • Southwest • Tidewater
Prenatal Care***	• Received Prenatal Care • Did Not Receive Prenatal Care
Trimester of Prenatal Care Initiation***	• First Trimester • Second Trimester • Third Trimester • No Prenatal Care • Unknown
Adequacy of Prenatal Care***	• Adequate Prenatal Care (i.e., Kotelchuck Index score greater than or equal to 80 percent, which includes the Adequate Plus category [greater than or equal to 110 percent]) • Intermediate Prenatal Care (i.e., Kotelchuck Index score less than 80 percent and greater than or equal to 50 percent) • Inadequate Prenatal Care (i.e., Kotelchuck Index score less than 50 percent)

** Since dental coverage for non-pregnant adult members began July 1, 2021, HSAG will assess appropriate time frames for the preconception period after receiving the administrative data for this measurement year.*

*** Starting July 1, 2022, coverage of postpartum benefits was expanded from 60 days to one year postpartum. However, HSAG will only receive complete claims/encounter data through May 2023 for this report. Therefore, HSAG will only be able to assess services for up to six months postpartum for deliveries during CY 2022. Additionally, HSAG will caveat in the report that that postpartum data for deliveries at the end of CY 2022 may be less complete, and women with deliveries prior to April 2022 may have had a gap in coverage between the end of their 60 days postpartum coverage and the expansion of postpartum benefits in July 2022.*

**** For stratifications that are new to this year's analysis, HSAG will evaluate the appropriateness of these approaches based on the data received and modify the stratifications as needed with DMAS' approval.*

Birth Outcomes

In addition to dental utilization rates, HSAG will perform a statistical analysis related to the association of the receipt of dental health services and birth outcomes. To determine whether there is a significant difference between members with any dental services and members with no dental services for each of

the birth outcomes listed below, HSAG will use Pearson's chi-square test of significance. HSAG will use a *p*-value <0.05 to identify significant associations.

HSAG will include the following comparisons in the report:

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

In the absence of vital statistics data, HSAG will not be able to calculate the relationship between dental utilization and preterm birth (<37 weeks gestation), newborns with low birth weight (<2,500 grams), and timely prenatal care.

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

Table B-22—Birth Outcomes Analysis

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

Indicator	Denominator	Numerator
		• A primary diagnosis for other non-traumatic dental conditions (Other Non-Traumatic Dental Cond Code Set) with a secondary diagnosis of non-traumatic dental conditions (Non-Traumatic Dental Cond Code Set) For this indicator, HSAG will stratify rates by race/ethnicity, region, and MCO. Additionally, HSAG will provide additional information on the most common diagnoses for these visits and when the visits occur during the postpartum period.
Postpartum Ambulatory Care Utilization	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of postpartum women who utilized ambulatory care services within 60 days of delivery. Ambulatory visits are identified as: • An ambulatory outpatient visit (Ambulatory Outpatient Visits Code Set) • A telephone visit (Telephone Visits Code Set) or online assessment (Online Assessments Code Set) • Any one of the following: – An ED visit (ED Code Set) – An ED procedure code (ED Procedure Code Set) with an ED POS code (ED POS Code Set)
Births with Early and Adequate Prenatal Care	Number of singleton, live births paid by Virginia Medicaid during the measurement period	Number of singleton, live births with an Adequacy of Prenatal Care Utilization Index (i.e., the Kotelchuck Index) score greater than or equal to 80 percent, which includes the Adequate Plus category (greater than or equal to 110 percent).

Deliverables

HSAG will present the findings of the dental utilization analysis in a data brief by October 1, 2023. Additionally, HSAG will apply suppression (i.e., suppress numerators and denominators fewer than 11) to the version of the report that is made 508-compliant. A non-suppressed version of the report will be provided to DMAS for internal purposes.

Consumer Decision Support Tool Methodology

Objectives

DMAS contracted with HSAG to analyze MY 2022 HEDIS results, including MY 2022 CAHPS data from six Virginia MCOs serving the CCC Plus (MLTSS) population for presentation in the 2023 CCC Plus (MLTSS) Consumer Decision Support Tool. The CCC Plus (MLTSS) Consumer Decision Support Tool analysis helps support DMAS' public reporting of MCO performance information. Please note that due to the merger of Optima and VA Premier during CY 2023, HSAG combined the results for Optima and VA Premier for the 2023 Consumer Decision Support Tool.

Data Collection

For this activity, HSAG received the MCO's CAHPS member-level data files and HEDIS data from the MCOs. The CAHPS survey was most recently administered in 2022. The *HEDIS MY 2022 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS MY 2022 Technical Specifications for Health Plans, Volume 2* was used to collect and report on the HEDIS measures.

Reporting Categories

The CCC Plus (MLTSS) Consumer Decision Support Tool reporting categories and descriptions of the measures they contain are:

- **Overall Rating**: Includes all HEDIS and CAHPS measures included in the 2023 Consumer Decision Support Tool analysis. This category also includes adult, general child, and children with chronic conditions CAHPS measures on consumer perceptions of the overall rating of the MCO, MCO customer service, and their overall health care.
- **Doctors' Communication**: Includes adult, general child, and children with chronic conditions CAHPS composites on consumer perceptions regarding how well their doctors communicate and the overall ratings of personal doctors and specialists seen most often. This category also includes children with chronic conditions CAHPS composites and question summary rates related to family centered care for children with chronic conditions. Additionally, this category includes a CAHPS measure related to medical assistance with smoking and tobacco use cessation.
- **Access and Preventive Care**: Includes adult, general child, and children with chronic conditions CAHPS composites on consumer perceptions regarding the ease of obtaining needed care and

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

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

Measures Used in Analysis

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

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

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

[B-34] The following measures were removed from the 2023 Consumer Decision Support Tool analysis due to half or more of the MCOs having *Not Applicable (NA)* statuses: *General Child Medicaid—Customer Service (CAHPS Composite)*, *Children with Chronic Conditions Medicaid—Customer Service (CAHPS Composite)*, *Children with Chronic Conditions Medicaid—Coordination of Care for Children with Chronic Conditions (CAHPS Question Summary Rates)*, *Children with Chronic Conditions Medicaid—Access to Specialized Services (CAHPS Composite)*, *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—3 Months–17 Years*, *Childhood Immunization Status—Combination 3, Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*.

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

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

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

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

Measures	Measure Weight
Antidepressant Medication Management	
Effective Acute Phase Treatment	1/2
Effective Continuation Phase Treatment	1/2
Taking Care of Children	
Immunizations for Adolescents—Combination 2	1
Well-Child Visits in the First 30 Months of Life	
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	1
Child and Adolescent Well-Care Visits	
3–11 Years	1
12–17 Years	1
18–21 Years	1
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile Documentation—Total	1/3
Counseling for Nutrition—Total	1/3
Counseling for Physical Activity—Total	1/3
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	1
Living With Illness	
HbA1c Control for Patients with Diabetes	
HbA1c Control (<8.0%)	1/4
HbA1c Poor Control (>9.0%)	1/4
Blood Pressure Control for Patients with Diabetes	1/4
Eye Exam for Patients with Diabetes	1/4
Controlling High Blood Pressure	1
Asthma Medication Ratio—Total	1
Pharmacotherapy Management of COPD Exacerbation	
Systemic Corticosteroid	1/2
Bronchodilator	1/2
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	1

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

Missing Values

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

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

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

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

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

For MCOs with an *NA* status, or *NR* or *BR* audit results, HSAG used the average variance of the non-missing observations across all MCOs. This ensured that all rates reflected some level of variability, rather than simply omitting the missing variances in subsequent calculations.

Additionally, HSAG replaced missing values where an MCO reported data for at least 50 percent of the indicators in a reporting category. If an MCO was missing more than 50 percent of the measures that comprised a reporting category, HSAG gave the MCO a designation of "Insufficient Data" for that category.

Comparing MCO Performance

HSAG computed six summary scores for each MCO, as well as the summary mean values for the MCOs as a group. Each score was a standardized score where higher values represented more favorable performance. Summary scores for the six reporting categories (Overall Rating, Doctors' Communication, Access and Preventive Care, Behavioral Health, Taking Care of Children, and Living With Illness) were calculated from MCO scores on selected HEDIS measures and CAHPS questions and composites.

1. HEDIS rates were extracted from the auditor-locked IDSS data sets and HSAG calculated the CAHPS rates using the NCQA CAHPS member-level data files. To calculate a rate for a CAHPS measure, HSAG converted each individual question by assigning the top-box responses (i.e., "Usually/Always," "9/10," and "Yes," where applicable) to a 1 for each individual question, as described in *HEDIS MY 2022 Volume 3: Specifications for Survey Measures*. All other non-missing responses were assigned a value of 0. HSAG then calculated the percentage of respondents with a top-box response (i.e., a 1). For composite measures, HSAG calculated the composite rate by taking the average percentage for each question within the composite.
2. For each HEDIS and CAHPS measure, HSAG calculated the measure variance. The measure variance for HEDIS measures was calculated as follows:

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

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

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

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

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

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

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

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

3. For MCOs with an *NA* status, or *NR* or *BR* audit results, HSAG used the average variance of the non-missing rates across all MCOs. This ensured that all rates reflected some level of variability, rather than simply omitting the missing variances in subsequent calculations.
4. HSAG computed the MCO composite mean for each CAHPS and HEDIS measure.
5. Each MCO mean (CAHPS or HEDIS) was standardized by subtracting the mean of the MCO means and dividing by the standard deviation of the MCO means to give each measure equal

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

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

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

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

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

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

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

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

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

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

Additionally, due to the merger of Optima and VA Premier, HSAG combined results for Optima and VA Premier for MY 2022. HSAG employed the following methodology to combine the results:

The formula for computing the combined mean ($\overline{X}_c$) for each measure is:

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

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

The formula for computing the combined variance is as follows:

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

where: S_1^2 = Variance of Optima population
S_2^2 = Variance of VA Premier population

m_1 = Number of members in Optima's denominator

m_2 = Number of members in VA Premier's denominator

If the measure was reported using the hybrid methodology, then the hybrid sample was used as m_i for the calculation of S_c^2. If the measure was reported using the administrative methodology, then the eligible population was used as m_i for the calculations of S_c^2.[B-36]

How Conclusions Were Drawn

A five-level rating scale provides consumers with an easy-to-read "picture" of quality performance across MCOs and presents data in a manner that emphasizes meaningful differences between MCOs.

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

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

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

[B-36] When combining the data for Optima and VA Premier, if both MCOs had a rate with an NA status, HSAG used the NA status for the combined rate.

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

Performance Withhold Program Methodology

Objectives

DMAS contracted with HSAG as their EQRO to establish, implement, and maintain a scoring mechanism for the managed care PWP, also referred to as the "quality withhold." For the SFY 2023 PWP, MCOs' performance is evaluated on seven NCQA HEDIS measures (14 measure indicators), one AHRQ PDI measure (one measure indicator), and two CMS Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) measures (two measure indicators). The EQRO is responsible for collecting MCOs' audited HEDIS measure rates, the AHRQ PDI measure rates, and CMS Adult Core Set measure rates from DMAS. The EQRO will derive PWP scores for each measure and calculate the portion of the 1 percent quality withhold earned back for each MCO.

The following sections provide the PWP calculation methodology for the SFY 2023. MCOs will be eligible to earn back all, or a portion of, their 1 percent quality withhold based on the scoring methods and quality withhold funds model described in this document.

Performance Measures

DMAS selected the following seven HEDIS measures (14 measure indicators), one AHRQ PDI measure (one measure indicator), and two CMS Adult Core Set measures (two measure indicators) for the PWP indicated in Table B-25 on the next page.

Table B-25—PWP Measures

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

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

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

Performance Period

The SFY 2023 PWP assesses CY 2022 performance measure data (i.e., the performance measures will be calculated following HEDIS MY 2022, AHRQ's PDI Technical Specifications [July 2021], and CMS FFY 2023 Adult Core Set Specifications that use a CY 2022 measurement period) to determine what portion, if any, the MCOs will earn back from the funds withheld in SFY 2023 (i.e., the 1 percent of capitation payments withheld from July 1, 2022, through June 30, 2023).[B-38]

Technical Methods of Data Collection and Description of Data Obtained

The HEDIS IDSS files for the PWP calculation will be audited as required by NCQA. The auditor-locked IDSS files containing the HEDIS measure rates will be provided to the EQRO by the MCOs. DMAS will contract with their EQRO to validate the AHRQ PDI measure and the two CMS Adult Core Set measures in accordance with *CMS EQR Protocols: Protocol 2. Validation of Performance Measures: A*

[B-37] Starting with HEDIS MY 2022, the Comprehensive Diabetes Care measure has been removed and three new measures have been established. For the purposes of the PWP, the measures will be combined as a composite measure and weighted similar to the other measures.

[B-38] Per the technical measure specifications, the Asthma Admission Rate is reported per 100,000 population. However, this measure should be reported per 100,000 MM instead. This slight deviation is in alignment with the approach for reporting AHRQ's Prevention Quality Indicator (PQI) measures in the Centers for Medicare & Medicaid Services' (CMS') Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set).

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

How Data Were Aggregated and Analyzed

PWP Calculation

The following sections provide a detailed description and examples of the PWP scoring and quality withhold funds model for the SFY 2023 PWP (i.e., the initial performance year). With receipt of audited HEDIS measure rates and validated CMS Adult Core Set measure rates (i.e., non-HEDIS measure rates), each measure will be scored prior to calculating the amount of the quality withhold, if any, each MCO will earn back.

Only measure rates with a "*Reportable (R)*" (HEDIS and non-HEDIS rates) audit result (i.e., the plan produced a reportable rate for the measure in alignment with the technical specifications) will be included in the PWP calculation. Measure rates with a "*Small Denominator (NA)*" (HEDIS rates only) audit result (i.e., the plan followed the specifications, but the denominator was too small to report a valid rate) will be excluded from the PWP calculation. Measure rates with any audit result other than "*Reportable (R)*" or "*Small Denominator (NA)*" will receive a score of zero (i.e., the MCO will not be eligible to earn a portion of the quality withhold back for that measure).

SFY 2023 PWP

As indicated above, SFY 2023 PWP will use the MCOs' audited HEDIS MY 2022 and validated CY 2022 AHRQ PDI and CMS FFY 2023 CMS Adult Core Set performance measure data. Table B-26 shows the percentage of withhold associated with each performance measure indicator.

Table B-26—SFY 2023 PWP Measure Weights

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

[B-39] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Nov 3, 2023.

Indicator	Measure Weight
Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total and 30-Day Follow-Up—Total	10%
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total	10%
*Heart Failure Admission Rate (per 100,000 MM)—Total**	10%
Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment and *Engagement of SUD Treatment*	10%
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	10%

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

Scoring Methods

The next several sections describe the PWP calculation method for the SFY 2023 PWP.

Indicator Partial Score

For SFY 2023, the AHRQ PDI and CMS Adult Core Set measure scoring will be based on whether the MCO reported valid HEDIS MY 2022 (i.e., CY 2022) measure rates to NCQA in the required reporting method as indicated in Table B-27 on the next page. Due to the planned transition to Cardinal Care, beginning with the SFY 2024 PWP and forwards, DMAS will attempt to set benchmarks for determining the Cardinal Care MCO performance scores for the AHRQ PDI and CMS Adult Core Set measures, based on available data from SFY 2023.

Table B-27—Audit Designations (AHRQ PDI and CMS Adult Core Set)

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

As indicated in Table B-27, only measures with a "*Reportable (R)*" audit result (i.e., the plan produced a reportable rate for the measure in alignment with the technical specifications) will be included in the PWP calculation for the AHRQ PDI and CMS Adult Core Set measures. Measure rates with the following audit results will receive a score of zero (i.e., the MCO will not be eligible to earn a portion of the quality withhold back for that measure):

- "*Do Not Report (DNR)*" audit result (i.e., the calculated rate was materially biased)
- "*Not Applicable (NA)*" audit result (i.e., the plan was not required to report the measure)

- "*No Benefit (NR)*" audit result (i.e., the measure was not reported because the plan did not offer the required benefit)

The performance scores for the HEDIS measures will be determined by comparing each rate to NCQA's Quality Compass national Medicaid HMO percentiles (referred to in this document as percentiles). Table B-28 presents the possible scores for each HEDIS indicator based on the MCO performance for the current year. Rates will be rounded to two decimals prior to comparing to the percentiles and determining the measure score, and no scores will be dropped.

Table B-28—PWP HEDIS Indicator Scoring

Criteria for Each Indicator	Score
MCO's rate is below the 25th percentile	0.00
MCO's rate is at or above the 25th percentile but below the 50th percentile	Between 0.00 and 1.00
MCO's rate is at or above the 50th percentile	1.00

HEDIS indicator rates that are below the 25th percentile will receive a score of zero (i.e., no portion of the quality withhold will be earned for this indicator). Indicator rates that are at or above the 50th percentile will receive the maximum score for that indicator (i.e., 1 point). If an indicator rate is at or above the 25th percentile but below the 50th percentile, the MCO will be eligible to receive a partial score (i.e., a partial point value that falls between 0 and 1). To calculate the partial points at the indicator level, each MCO's rate will be compared to the percentiles to determine how close the MCO's rate is to the 50th percentile. In future iterations of the PWP, the minimum performance level (i.e., 25th percentile) may increase to encourage continued positive performance and quality improvement. The partial score for each measure will be derived using the following formula:

$$Partial\ Point\ Value = \left[\frac{(MCO\ Rate - 25th\ Percentile)}{(50th\ Percentile - 25th\ Percentile)}\right]$$

For example, if the 25th percentile is 40 percent and the 50th percentile is 60 percent, and an MCO has a rate of 55 percent for an indicator, then the partial point value is calculated as follows:

$$Partial\ Point\ Value = \left[\frac{(55 - 40)}{(60 - 40)}\right] = 0.75$$

Improvement Bonus

For the AHRQ PDI and CMS Adult Core Set measure indicators, DMAS will determine an appropriate method of assigning improvement bonus points for future iterations of the PWP, if applicable.

For the SFY 2023 PWP, MCOs that failed to meet the 50th percentile in CY 2021 (i.e., HEDIS MY 2021 data) for a HEDIS indicator may be eligible to earn an improvement bonus if an indicator rate

demonstrates substantial improvement from CY 2021.[B-40] Substantial improvement will be defined as 20 percent of the difference between the 25th and 50th percentile. An improvement bonus of 0.25 points will be awarded for each indicator, if the MCO was below the 50th percentile in CY 2021 and the following is true:

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

For each MCO, HSAG will assess which indicator rates are eligible for an improvement determination. HSAG will only determine improvement bonus eligibility if an indicator meets the following criteria:

- The MCO current year rate demonstrated an improvement from the CY 2021 rate;
- The MCO reported the indicator rate in both the current year and CY 2021;
- The MCO's reported indicator rate was below the 50th percentile in CY 2021;
- The MCO reported the indicator rate using the same reporting methodology in both years (e.g., the reporting methodology did not change from administrative in CY 2021 to hybrid in the current year); and
- NCQA did not recommend a break in trending for the indicator due to a change in the technical specifications for the Medicaid product line.

If an MCO demonstrates substantial improvement for an indicator rate and meets all of the criteria for improvement bonus determinations, then the MCO will receive an improvement bonus for that indicator.

High Performance Bonus

For the AHRQ PDI and CMS Adult Core Set measure indicators, DMAS will determine an appropriate method of assigning high performance bonus points for future iterations of the PWP, if applicable.

For the SFY 2023 PWP, if an MCO demonstrates a strong performance trend over time for a HEDIS indicator, the MCO will be eligible for a high performance bonus. The high performance bonus will be awarded for indicator rates that exceed the 66.67th percentile for both the current year and CY 2021. Each indicator rate that ranks above the 66.67th percentile for the current year and CY 2021 will be eligible for a maximum high performance bonus of 0.25 points that will be added to the indicator partial score described above (i.e., 1 point).

How Conclusions Were Drawn

Scoring Model Example

Table B-29 and Table B-30, on the two next pages, provide examples of how indicator partial scores will be determined, by MCO. All data presented in the tables below (both measure rates and percentile values) are mock data and do not represent actual data or results.

[B-40] HSAG will use the HEDIS MY 2021 Combined Aggregate files (i.e., the MCO's standard NCQA HEDIS submission) as a comparison to the HEDIS MY 2022 data submissions.

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

Indicator	Current Year Rate	25th Percentile	50th Percentile	Indicator Partial Score
Child and Adolescent Well-Care Visits				
Total	55.55%	44.28%	54.26%	1.00
Childhood Immunization Status				
Combination 3	73.82%	65.45%	70.68%	1.00
Comprehensive Diabetes Care Composite				
Blood Pressure Control for Patients With Diabetes—Total	53.00%	50.23%	54.55%	0.64
Eye Exam for Patients With Diabetes—Total	42.68%	41.77%	52.00%	0.09
HbA1c Control (<8.0%)—Total	54.74%	44.11%	51.22%	1.00
*HbA1c Poor Control (<9.0%)—Total**	50.70%	45.55%	38.66%	0.00
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—Total	6.94%	6.25%	9.73%	0.20
30-Day Follow-Up—Total	11.04%	9.89%	15.25%	0.21
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total	46.22%	29.21%	35.49%	1.00
30-Day Follow-Up—Total	58.92%	43.17%	51.45%	1.00
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment	42.26%	39.25%	41.99%	1.00
Engagement of SUD Treatment	11.16%	9.53%	11.01%	1.00
Prenatal and Postpartum Care				
Timeliness of Prenatal Care—Total	78.01%	78.10%	83.76%	0.00
Postpartum Care—Total	64.70%	59.38%	65.69%	0.84

**For this measure indicator, a lower rate indicates better performance.*
Please note that the numbers in the table have been rounded for display purposes. Calculations will be based off unrounded data.

Table B-30—Indicator Partial Score Calculations—AHRQ PDI and CMS Adult Core Set Measures
(Example Using Mock Data)

Indicator	Audit Designation*	Met Reporting Requirements	Indicator Partial Score
Asthma Admission Rate (per 100,000 MM)			
Total	R	Yes	1.00
COPD or Asthma in Older Adults Admission Rate (per 100,000 MM)			
Total	R	Yes	1.00
Heart Failure Admission Rate (per 100,000 MM)			
Total	NA	No	0.00

**Audit designations include: Reportable (R); Do Not Report (DNR); Not Applicable (NA); No Benefit (NR).*

The indicator partial scores for the HEDIS measures are calculated by first determining the applicable percentile level for the indicator rate. For example, the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* indicator received an indicator partial score of one point because the rate (46.22 percent) is above the 50th percentile (35.49 percent). For the AHRQ PDI and CMS Adult Core Set measures, the *Asthma Admission Rate—Total* indicator receives an indicator partial score of 1.00 because the audit designation was "*Reportable (R)*."

Table B-31 provides an example of how the improvement bonus scores will be determined by MCO based on performance for the current year and CY 2021 for the HEDIS measures. Improvement bonus determinations for the AHRQ PDI and CMS Adult Core Set measures will be evaluated for future iterations of the PWP.

Table B-31—Indicator Improvement Bonus Score Calculations—HEDIS Measures
(Example Using Mock Data)

Indicator	CY 2021 Rate	Current Year Rate	Rate Difference	Substantial Improvement Value	Below 50th Percentile in Prior Year	Met Substantial Improvement	Improvement Bonus†
Child and Adolescent Well-Care Visits							
Total	50.85%	55.55%	4.70%	2.00%	Y	Y	0.25
Childhood Immunization Status							
Combination 3	71.29%	73.82%	2.53%	1.05%	N	Y	0.00
Comprehensive Diabetes Care Composite							
Blood Pressure Control for Patients With Diabetes—Total	53.25%	53.00%	-0.25%	0.86%	Y	N	0.00
Eye Exam for Patients With Diabetes—Total	44.27%	42.68%	-1.59%	2.05%	Y	N	0.00
HbA1c Control (<8.0%)—Total	57.41%	54.74%	-2.67%	1.42%	N	N	0.00

Indicator	CY 2021 Rate	Current Year Rate	Rate Difference	Substantial Improvement Value	Below 50th Percentile in Prior Year	Met Substantial Improvement	Improvement Bonus†
*HbA1c Poor Control (>9.0%)—Total**	52.26%	50.70%	-1.56%	-1.38%	Y	Y	0.25
Follow-Up After ED Visit for Substance Use							
7-Day Follow-Up—Total	5.66%	6.94%	1.28%	0.70%	Y	Y	0.25
30-Day Follow-Up—Total	11.42%	11.04%	-0.38%	1.07%	Y	N	0.00
Follow-Up After ED Visit for Mental Illness							
7-Day Follow-Up—Total	45.12%	46.22%	1.10%	1.26%	N	N	0.00
30-Day Follow-Up—Total	59.67%	58.92%	-0.75%	1.66%	N	N	0.00
Initiation and Engagement of SUD Treatment							
Initiation of SUD Treatment	41.68%	42.26%	0.58%	0.55%	N	Y	0.00
Engagement of SUD Treatment	11.11%	11.16%	0.05%	0.30%	Y	N	0.00
Prenatal and Postpartum Care							
Timeliness of Prenatal Care—Total	77.62%	78.01%	0.39%	1.13%	Y	N	0.00
Postpartum Care—Total	60.58%	64.70%	4.12%	1.26%	Y	Y	0.25

†A measure indicator is eligible for an improvement bonus if the indicator rate was below the 50th percentile in CY 2021 and the indicator rate demonstrated substantial improvement from CY 2021.
**For this indicator, a lower rate indicates better performance.*

Table B-32 provides an example of how the high performance bonus scores will be determined, by MCO, based on performance for the current year and CY 2021 for the HEDIS measures. Once the high performance bonus scores are determined, the indicator partial score, the improvement bonus score, and high performance bonus score (i.e., 0.00 or 0.25) will be summed to obtain the final indicator score. High performance bonus determinations for the AHRQ PDI and CMS Adult Core Set measures will be evaluated for future iterations of the PWP.

Table B-32—High Performance Bonus Score Calculations—HEDIS Measures
(Example Using Mock Data)

Indicator	CY 2021 Rate	CY 2021 66.67th Percentile	Current Year Rate	Current Year 66.67th Percentile	High Performance Bonus		
					Prior Year	Current Year	Points Earned
Child and Adolescent Well-Care Visits							
Total	50.85%	59.49%	55.55%	60.34%	N	N	0.00

Indicator	CY 2021 Rate	CY 2021 66.67th Percentile	Current Year Rate	Current Year 66.67th Percentile	High Performance Bonus		
					Prior Year	Current Year	Points Earned
Childhood Immunization Status							
Combination 3	71.29%	73.72%	73.82%	72.75%	N	Y	0.00
Comprehensive Diabetes Care Composite							
Blood Pressure Control for Patients With Diabetes—Total	53.25%	56.12%	53.00%	57.89%	N	N	0.00
Eye Exam for Patients With Diabetes—Total	44.27%	57.16%	42.68%	58.02%	N	N	0.00
HbA1c Control (<8.%)—Total	57.41%	53.48%	54.74%	54.51%	Y	Y	0.25
*HbA1c Poor Control (>9.0%)—Total**	52.26%	33.23%	50.70%	34.15%	N	N	0.00
Follow-Up After ED Visit for Substance Use							
7-Day Follow-Up—Total	5.66%	10.85%	6.94%	11.01%	N	N	0.00
30-Day Follow-Up—Total	11.42%	15.30%	11.04%	15.75%	N	N	0.00
Follow-Up After ED Visit for Mental Illness							
7-Day Follow-Up—Total	45.12%	44.56%	46.22%	45.77%	Y	Y	0.25
30-Day Follow-Up—Total	59.67%	54.66%	58.92%	55.79%	Y	Y	0.25
Initiation and Engagement of SUD Treatment							
Initiation of SUD Treatment	41.68%	47.00%	42.26%	48.04%	N	N	0.00
Engagement of SUD Treatment	11.11%	12.16%	11.16%	12.13%	N	N	0.00
Prenatal and Postpartum Care							
Timeliness of Prenatal Care—Total	77.62%	85.59%	78.01%	86.37%	N	N	0.00
Postpartum Care—Total	60.58%	67.82%	64.70%	68.36%	N	N	0.00

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

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

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

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

Indicator	Indicator Level Score	Improvement Bonus	High Performance Bonus	Final Indicator Score	Measure Level Score
Child and Adolescent Well-Care Visits					
Total	1.00	0.25	0.00	1.25	**1.25**
Childhood Immunization Status					
Combination 3	1.00	0.00	0.00	1.00	**1.00**
COPD or Asthma in Older Adults Admission Rate (per 100,000 MM)*					
Total	1.00	NE	NE	1.00	**1.00**
Comprehensive Diabetes Care Composite					
Blood Pressure Control for Patients with Diabetes—Total	0.64	0.00	0.00	0.64	**0.56**
Eye Exam for Patients with Diabetes—Total	0.09	0.00	0.00	0.09	
HbA1c Control (<8.0 Percent)—Total	1.00	0.00	0.25	1.25	
*HbA1c Poor Control (>9.0 Percent)—Total**	0.00	0.25	0.00	0.25	
Follow-Up After ED Visit for Substance Use					
7-Day Follow-Up—Total	0.20	0.25	0.00	0.45	**0.33**
30-Day Follow-Up—Total	0.21	0.00	0.00	0.21	
Follow-Up After ED Visit for Mental Illness					
7-Day Follow-Up—Total	1.00	0.00	0.25	1.25	**1.25**
30-Day Follow-Up—Total	1.00	0.00	0.25	1.25	
Heart Failure Admission Rate (per 100,000 MM)*					
Total	0.00	NE	NE	0.00	**0.00**
Initiation and Engagement of SUD Treatment					
Initiation of SUD Treatment	1.00	0.00	0.00	1.00	**1.00**
Engagement of SUD Treatment	1.00	0.00	0.00	1.00	
Prenatal and Postpartum Care					
Timeliness of Prenatal Care—Total	0.00	0.00	0.00	0.00	**0.55**
Postpartum Care—Total	0.84	0.25	0.00	1.09	

Please note that the numbers in the table have been rounded for display purposes. Calculations will be based off unrounded data.
NE indicates the measure is not eligible for an Improvement Bonus or High Performance Bonus.
**For this measure indicator, a lower rate indicates better performance.*

As shown above, the *Follow-Up After ED Visit for Substance Use* measure level score (0.33) was obtained by averaging the indicator level scores for *7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* (0.45 and 0.21 respectively).

Table B-34 provides an example of how the percentage of the quality withhold is derived (i.e., overall withhold earned) based on the ten measure level scores calculated above. The percentage of the quality withhold that the MCO is eligible to earn back is calculated by multiplying the measure level score with the applicable measure weight and then summing the measure withhold earned values together. An MCO is not able to earn back more than 100 percent of its total withhold amount. If an overall withhold amount is greater than 100 percent (due to bonus points), the overall withhold earned will be reduced to 100 percent.

Table B-34—Percentage Withhold Earned
(Example Using Mock Data)

Indicator	Measure Level Score	Weight	Measure Withhold Earned	Overall Withhold Earned
Asthma Admission Rate (per 100,000 MM)	1.00	10.00%	10.00%	**79.33%**
Child and Adolescent Well-Care Visits	1.25	10.00%	12.50%	
Childhood Immunization Status	1.00	10.00%	10.00%	
COPD or Asthma in Older Adults Admission Rate (per 100,000 MM)	1.00	10.00%	10.00%	
Comprehensive Diabetes Care Composite	0.56	10.00%	5.58%	
Follow-Up After ED Visit for Substance Use	0.33	10.00%	3.30%	
Follow-Up After ED Visit for Mental Illness	1.25	10.00%	12.50%	
Heart Failure Admission Rate (per 100,000 MM)	0.00	10.00%	0.00%	
Initiation and Engagement of SUD	1.00	10.00%	10.00%	
Prenatal and Postpartum Care	0.55	10.00%	5.45%	

Please note that the numbers in the table have been rounded for display purposes. Calculations will be based off unrounded data.

Quality Withhold Funds Model

The quality withhold percentage is 1 percent of the total MCO capitation payments for the year. An MCO is eligible to earn the entire quality withhold by having 100 percent for the overall withhold as shown (i.e., the MCO would not lose any quality withhold funds).

Table B-35—PWP Funds Allocation
(Example Using Mock Data)

MCO Name	Total Capitation Payment	Maximum At-Risk Amount (1% Withhold)	Percentage Withhold Earned	Final Withhold Earned Back Amount
MCO	$735,790,000.00	$7,357,900.00	79.33%	$5,836,654.18

Please note that the numbers in the table have been rounded for display purposes. Calculations will be based off unrounded data.

As shown in Table B-35, the one percent at risk amount for the example MCO is $7,357,900.00. The MCO earned 79.33 percent of the quality withhold through the review of the HEDIS, AHRQ PDI, and CMS Adult Core Set measure indicator rates, thus the MCO is eligible to receive $5,836,654.18 of the quality withhold according to the following equation:

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

Appendix C. MCO Best and Emerging Practices

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

Table C-1—DMAS' Best and Emerging Practices

Best and Emerging Practices
Topic/Title: ARTS Internal Metrics Dashboard Improvements **Description:** The ARTS team has worked with DMAS' Healthcare Analytics Division to make improvements to the ARTS dashboard so that it can provide information similar to the internal dashboard used by DMAS staff for mental health disorder services. This allows ARTS team more capability to do real time data analysis and quality assurance/improvement work.
Topic/Title: OBAT Managed Care Committee **Description:** The ARTS team has worked with internal and external stakeholders to begin holding regularly scheduled meetings with the Managed Care Organizations (MCOs) to discuss any issues with Medicaid members accessing OBAT services and medications. These meetings have provided opportunities for DMAS and the MCOs to discuss successes and challenges, including improving access and capacity issues. MCOs have reported that these meetings are valuable and insightful and are helping to improve members' experiences accessing OBAT services.
Topic/Title: CMS Infant Well-Child Visit Learning Collaborative **Description:** The learning collaborative offers technical assistance to state Medicaid and Children's Health Insurance Program (CHIP) agencies and their partners (MCOs and other partners, DMAS and its partners are receiving technical assistance in designing and implementing a quality improvement project aimed at identifying ways to increase participation in well-child visits. The collaborative initiated interventions with providers in Roanoke, Winchester, Tidewater Area, Petersburg, and Southwest Virginia. The initiative started in March 2021 and will conclude in December 2023. Initiatives have focused on enrollment processes (newborn), member education, consistent messaging across MCOs regarding enrollment.
Topic/Title: Baby Steps Virginia **Description:** Baby Steps Virginia is the vehicle with which Virginia Medicaid brings together sister agencies, other key partners and stakeholders and the voice of the member with the focus of improving maternal health outcomes, eliminate racial disparity in outcomes and maternal mortality. Baby Steps Virginia incorporates awareness of issues like social determinants of health (SDOH), barriers to care, and member/provider engagement. **Baby Step VA successes-** • Three CMS affinity groups (quality improvement) targeting child, foster care youth and maternal health improvement plans • LRCD Affinity Group – Reducing Low Risk Cesarean Delivery • Outreach events to support pregnant, postpartum and parenting families
Topic/Title: Community Doula Program **Description:** To date, 125 doulas have received state certification. Of the 125 state-certified doulas, 90 are approved and enrolled as Medicaid Doula Providers. There have been 107 doula-

Best and Emerging Practices
supported births to Medicaid members and over 304 birthing families have received doula services through Virginia Medicaid. Feedback continues to be positive from families who have received care and support from a doula. DMAS continues to focus on increasing the network of doula providers, community and provider engagement, and data. The availability of state-certified Medicaid-approved doula providers within the Commonwealth means greater access to care and support for pregnant people with the goal of improving maternal and infant health outcomes, reducing infant and maternal mortality, and helping to address racial and health disparities. More information is available about doulas, the state certification process, and the Medicaid doula benefit, on the DMAS website.
Topic/Title: Nursing Facility Value Based Purchasing Program **Description:** A value-based performance payment program incentivizing improved quality of care in VA nursing facilities for Medicaid members. The NF VBP program began in July 2022 and is currently focused on both providing resources for and rewarding improvements in staffing and avoidance of negative care events.

Table C-2 identifies the MCOs' self-reported best and emerging practices. The narrative within the table was provided by the MCOs and has not been altered by HSAG except for minor formatting.

Table C-2—MCOs' Best and Emerging Practices

MCO	Best and Emerging Practices
Aetna	**Topic/Title:** Vital Decisions **Description:** A national clinician-guided telehealth services vendor that collaborates with and supports members with making decisions about advance care planning. The service helps individuals, and their families think through, communicate, and document their preferences to ensure their care is aligned with their wishes – now and in the future as their medical situation changes. **Topic/Title:** New Moms Box **Description:** A care package that contains a variety of products and educational material to help new mothers adjust to life and care for their new baby while also reinforcing the importance of care management to drive healthier outcomes. **Topic/Title:** Social Care Team **Description:** The Social Care Team is a field team that proactively outreaches members who score as high-risk via our partner's predictive analytics tool. After completing a SDOH screening, the team identifies appropriate and timely resources based on the member's needs and follows up with members and service providers to support loop closure for all members. Data and reporting from the Social Care Team influences relationships, investments in programs, and health equity strategies that they pursue. The program is designed to increase engagement and satisfaction, decrease ED visits and readmissions, and improve HEDIS scores and overall health outcomes.

MCO	Best and Emerging Practices
	Topic/Title: Readmission Avoidance Program (RAP) **Description:** Identifies high-risk members for inpatient readmission utilizing inpatient RAP score and identifies members for referral to Care Management to engage at the intensive level of care for 30-days post discharge. **Topic/Title:** Pyx **Description:** An app that increases member engagement with the Health Plan and steerage to the right resources/assistance. Members receive personalized assistance to find resources, activities to reduce feeling of loneliness and social isolation, and companionship of having someone to talk to when they need it. Additional features include a 24/7 chatbot, screenings for loneliness, depression, SDOH, self-management tips, and Health Plan resources, such as 24/7 member services and nurse line.
HealthKeepers	**Topic/Title:** Obstetric Quality Incentive Program (OBQIP) and Program Consultants **Description:** OBQIP offers incentives to OB Providers to provide quality and efficient care while keeping Members' healthcare needs primary. OB Providers are prohibited from encouraging Member selection or deselection and from discriminating against Members based on location, ethnicity, culture, race, religion, disability, political belief, sex, age, socioeconomic status, health status, or medical history. OB Providers are also prohibited from withholding or preventing medically necessary services from being delivered to Anthem HealthKeepers Plus Members. The Program is not intended to limit the OB Providers' judgment in treating Members or to limit their ability to discuss available treatment options with Members. OBQIP does not discriminate against OB Providers who provide service to any Member; any ethnic, cultural, or socioeconomic groups in particular geographic locations; or groups with specific medical conditions. The program is supported by OB Practice Consultants who provide in person and virtual support for Medicaid OB maternity providers. **Topic/Title:** Embedded Care Coordination Department Social Services Program **Description:** The DSS/Anthem Embedded Care Coordination program aims to strengthen the relationship between DSS, CSA and MCO and to better serve Anthem foster and former foster care members with a focus on whole person care. Anthem HealthKeepers Plus care coordinators from the foster care team are embedded in DSS offices two to three days a week, providing face to face support to DSS and CSA workers. Key areas of support include assisting with transportation, addressing SDOH needs, connecting members to PCPs, dentists, and other specialty BH and PH treatment providers, and attending FPM/FAPT meetings. They also serve as a resource in walking members through the IACCT process and assist with securing RTC placements. Expected outcomes include a decrease in ER utilization, increased use of PCP services, and to increase DSS knowledge of care coordination and the benefits offered by Anthem HealthKeepers Plus.

MCO	Best and Emerging Practices
	Topic/Title: Gold Card Program **Description:** Authorizations/registrations for specific CMHRS are waived for select proven quality providers. This serves as an incentive to our top-tier providers while motivating others to ensure they are providing quality services in an efficient manner. In addition, internal staffing opportunities are created for the effective management of those providers requiring extra attention. Gold card providers are forward thinking, creative and many are currently partnered with us on additional programs. They work closely with our care coordinators and are highly responsive to assisting with emergent member needs. Data is reviewed quarterly to determine a provider's continued participation and support the ongoing development of an optimized network. **Topic/Title:** Life Skill Building Program **Description:** A partnership with select quality CMHRS providers in which an integrated care approach is utilized with identified complex populations (sickle cell/foster care/former foster care) and general population high needs/high-cost PH members where specialized high touch services are offered for a period to assist with coordination of whole person needs and navigation of barriers. Key components include enhanced engagement, coaching, creativity in addressing member needs with a focus on integrated care and SDOH, provider collaboration, assistance with healthcare system navigation, community resource engagement and crisis intervention. **Topic/Title:** Valued Relationship Inc. (VRI) **Description:** Engage Educate Empower (E3 Pilot) focuses targeted live messaging to members identified as having a gap in care via a report that we share monthly. Member that are part of this pilot receive personalized gap in care education and support via a live person that communicates with them through their PERS Device. HEDIS Measures address: HbA1C, Diabetic retinal exam, controlling BP, Statin Therapy, and colorectal cancer screening. In addition to monthly messaging on various topics such as medication adherence, fall prevention, and education on levels of care (ER, Urgent Care, and Telehealth) **Topic/Title:** HEDIS Pay for Quality Program (P4Q) **Description:** This is a program that offers annual incentives to PCPs to close HEDIS care gaps. This program includes admin-only, PCP-based HEDIS measures. It is intended to complement our PCP VBP program and transition providers into a VB contract. The program incentive program was extended from 3 months to the last 6 months of the year as a strategy to close more gaps in care
Molina	**Topic/Title:** Pay for Quality (P4Q) Program **Description:** Description: For 2023, Molina selected a set of quality measures aligning with the state quality strategy and performance withhold program to include in an incentive program, P4Q. Molina will pay in-network primary care group practices a dollar amount to incentivize competition of preventative care and follow up appointments. This will be paid out per member after the primary care

MCO	Best and Emerging Practices
	group achieves enough appointments within the designated measure to meet the 50th percentile benchmark for their assigned panel. **Topic/Title:** Clinic Day **Description:** Molina partnered with network providers by holding clinic day events for its members to schedule new and/or existing member appointments, arrange transportation service and performing reminder calls. Molina's approach included identification of members with active care gaps, increasing access to healthcare with in-network PCPs, providing health education and rewarding members for their participation in connection to completion of health actions. This contributed to improved overall health outcomes and experiences, reduced administrative burden on provider office staff, decreased no-show rates, and improved member/provider experience. The Clinic Day offered a fun way to encourage members to: • Obtain needed health services • Improve health outcomes • Improve HEDIS score/close care gaps • Improve member/provider experience • Meet and interact with Molina team members **Topic/Title:** Provider Network and Quality Partnership **Description:** Molina's Quality and Provider Networking teams work collaboratively with target provider groups within each state region to build relationships, eliminate barriers to care, educate providers within the health plan to improve member health outcomes and overall patient satisfaction. **Topic/Title:** Direct Scheduling **Description:** Molina Healthcare has partnered to offer a direct appointment scheduling solution to our provider groups to assist with outreaching members with gaps in care. Provider groups can select specific days, times and specific care gaps/preventative screenings that Molina Representatives can schedule Molina Healthcare members. This reduces member call duration and hold times for appointment scheduling versus contacting the practice directly and serves as a reminder for preventative care that may have been forgotten. It decreases member frustration and abrasion, increases member confidence in the provider group and health plan, and increases positive health outcomes while alleviating the administrative burden and staffing challenges faced by many practices. This partnership is leveraged for clinic day participation to help with timely scheduling of events, improving provider practice participation by eliminating outreach staff barriers and unused appointment blocks.

MCO	Best and Emerging Practices
Optima	**Topic/Title:** Justice Care Coordination Program **Description:** Justice Care Coordination program aims to ensure that justice-involved individuals are informed about the services and resources available to treat mental illness and substance use disorders. The members receive aid in navigating and coordinating their benefits while under state supervision before entry into or upon discharge from jail or prison to prevent recidivism and relapse. The Justice Care Coordinators collaborate with community partners and stakeholders to increase awareness and remove the stigma around mental illness and substance use disorders for justice-involved individuals while encouraging them to invest in their overall health. **Topic/Title:** Tribal Care Coordination **Description:** Tribal Care Coordination program aims to decrease barriers to treatment for individuals of Indian/Native American/Tribal descent. Our goal is to reduce the reluctance of the Native American/Tribal members to use providers available to them under their Medicaid benefits despite their use of the Indian healthcare system. We aim to connect this population to providers sensitive to their cultural needs. **Topic/Title:** UHS Telehealth Program **Description:** This program expands telehealth access of BH follow up treatment to members who are discharged from the Emergency Department (ED) and inpatient stays. For members at Sentara Hospitals, the hospital staff in the ED are able to use this telehealth program to schedule appointments for members in the ED. **Topic/Title:** BH Coaching Program **Description:** BH Coaching seeks to intervene when members are feeling “stuck” or distressed. The BH coaches provide interventions that will assist members in gaining longer-term benefits from changing their health behavior, stave off functional decline, and minimize the onset or exacerbation of chronic conditions. BH Coaching supports clinical management and helps members maximize health and overall functioning by building self-care capacity, long-term health behavior changes, and the functional resilience necessary to sustain or regain independent living. **Topic/Title:** Peer Support Program **Description:** This program utilizes the real-life experiences of our peer support specialists to promote recovery and foster well-being among members with mental health and substance use disorders. The peer support specialists use recovery-oriented goals with members to help promote improvements in confidence, empowerment, and functioning. This approach to treatment supports the engagement of members through person-centered assessment and self-directed treatment planning that aims to increase members’ social support systems,

MCO	Best and Emerging Practices
	hopefulness for recovery, awareness of early warning signs of problems, and improvement in taking responsibility for wellness and their recovery. **Topic/Title:** Mental Health Group **Description:** This group includes BH team members and the focus are developing trainings to share with the BH team and internal partners. Topics have included: trauma-informed care practices, sex trafficking and the impact on members, gambling addiction, and the importance of peer support training. This group also participates in community events, sharing mental health issues impacting the community. **Topic/Title:** Quality Accreditation Team • CCC Plus: ☒ • Medallion 4.0: ☒ **Description:** Quality Committee Governance and Oversight Optima Health has updated and enhanced its governance structure. The quality committees facilitate and evaluate quality improvement activities carried out across various departments within the organization. There was a coordinated effort for subcommittee reporting. As of 07/01/2023, the committees have been integrated for efficiencies. There are three subcommittees reporting to the Corporate Quality Improvement Committee (QIC). These three subcommittees include: • Physician Leadership Committee (PLC) –responsible for the development, implementation, and management of quality and utilization improvement processes, and for providing overall direction to health plan staff and providers on the appropriate use of covered services. • Quality Performance Improvement Committee (QPIC) (newly formed) – responsible for the strategic oversight of improving quality measures and member experience and advancing clinical excellence through the provision of compassionate member-centered care. • Policies and Procedure (P&P) Committee - responsible to ensure policies and their outcomes support the mission, values, and strategic goals of the organization. These three subcommittees have 10 reporting committees which include internal and external physicians. To improve awareness of organizational activities, the frequency of meetings increased from quarterly to every other month. As the overarching committee, the Quality Improvement Committee (QIC) is the foundation of the Quality Improvement Program (QIP). The QIC assists the Health Plan leadership in overseeing, maintaining, and supporting the QIP and Work Plan activities. The committee is to ensure that the plan remains accountable and

MCO	Best and Emerging Practices
	compliant with state regulators, NCQA, CMS, and other regulatory bodies for the covered services. • Formal Committee charters for all subcommittees • Process Maps **Topic/Title:** Quality Member Safety/Contractual and Regulatory Team **Description:** As of 7/1/2023, newly implemented, dedicated team for Quality Management Reviews (QMRs). **Topic/Title:** Quality Member Safety/Contractual and Regulatory Team **Description:** Alignment of critical incident criteria across all lines of business. Developed a single assessment/referral tool for critical incident reporting which is easily accessible in the electronic case management system for internal use. **Topic/Title:** Member Recertification Specialty Team **Description:** Use of a specialty team to support the member recertification process. An unwinding application assistance program to include telephonic and in-person assistance, collaboration with DSS, and connection to CoverVA and CommonHelp. Programming and training specialized to: • Provide customized/individual application assistance · • Use of SDOH data to drive member engagement **Topic/Title:** Use of Community Health Workers **Description:** Use of Certified Community Health Workers (CHW) to support member onboarding, outreach, and education. Outreach and education programming to include telephonic and in-person assistance, connection to community and faith-based resources, wrap-around services, and community events. Programming and training specialized to: • Address social needs • Promote health equity· • Foster Cultural Competence • Enhance health literacy • Improve health screenings • Reduce care gaps **Topic/Title:** Chronic Care Management Program

MCO	Best and Emerging Practices
	Description: Chronic Care Management is a program administered by Optima health that provides the following: A. Telephonic engagement from a Registered Nurse to help the member in managing Diabetes, Asthma Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Heart Disease, Heart Failure, and Cancer. B. Assistance with helping members find and establish a relationship with a Primary Care Provider, Transportation, and connection to other inter-services offered through Optima Health. C. Develop a care plan and follow up with members to address barriers to them receiving care. D. Print member education materials. E. Assist members with obtaining a scale, blood pressure cuff, or glucometer to help manage care. **Topic/Title:** Population Health - IVR and Educational Video Campaigns **Description:** EMMI IVR call campaigns are conducted monthly and EMMI educational videos are sent to members regarding gaps in care, primarily around diabetes management, immunizations, and blood pressure. The calls and videos provide education around focus measures and help to answer questions members may have otherwise asked their provider and aid in providing a response to any clarifying questions members may have. There is live call follow-up to members who were not engaged with the IVR call or may need further assistance. This is an effort to improve PWP measures for both M4 and CCCP. **Topic/Title:** Population Health – Coaching and educational tools for members with Type II Diabetes **Description:** Eligible members are provided the Dario App which provides multichannel engagement, coaching and free blood glucose monitors and test strips. Members engage with coaches and are encouraged to test their blood sugar levels more frequently. Members have the ability to set reminders, use the in-app logbook, capture their weight and much more in the app. **Topic/Title: Population Health** – Digital Health Apps that help members track ovulation, cycle, pregnancy and navigate the early years of parenthood. **Description:** The Ovia App connects members to Registered Nurses for health coaching. The Ovia Fertility app allows members to view a personalized health summary and track their periods from fertility signs to menopause symptoms. Members can track their pregnancy journey, appointment reminders, nutrition,

MCO	Best and Emerging Practices
	medications, vitamins, symptoms, sleep and more. Parenting allows members to track baby's milestones and learn about parenting styles, breastfeeding and more. **Topic/Title:** Population Health - Preventive Screening Kits **Description:** The health plan collaborates with vendor partners to provide screening kits to members of both the CCC Plus and M4 product lines. Retina Labs performs in-home DREs. The vendor mail screening kits for A1c for diabetic members and FIT kits for colorectal cancer screening for members that have gaps in these measures. This is an effort to improve PWP measures as well as improve overall population health and member satisfaction by making the preventative screenings easily accessible.
United	**Topic/Title:** Creating Communities of Health – **Description:** Addressing health disparities at the community level is vital to our mission of making the health system work better for everyone. Through a commitment to support the Governor's Partnership for Petersburg initiative, we have strengthened and expanded our Creating Communities of Health strategy. Through this process, we have gained valuable insight into the importance of redefining the concept of a community to achieve improved health outcomes. Supporting Petersburg taught us that to effectively improve community health outcomes we must: 1) Think differently about what a "community" is. It's not just the people who live in a certain ZIP code. Or a handful of businesses. It's the whole environment — the people, businesses, organizations, faith-based organizations, and health care systems that serve the community. 2) Work with community leaders to identify community health needs to best collaborate on solutions, from improving systems and providing necessary resources to building physical spaces and empowering workforces, that increase access to health and social services. 3) Acknowledge that the economic well-being of a community directly depends on the health of its people. A healthier community alleviates pressure on overextended health systems. In turn, this can lower the cost of health care for everyone. 4) Listen to, engage, and work with people throughout a community to build and support community specific solutions that remove social barriers to enable health and well-being. *How we support our communities.* Taking on big challenges is a shared effort. We develop relationships with individuals and consult and collaborate with trusted organizations within a community to impact culturally responsive health and well-being.

MCO	Best and Emerging Practices
	Data and analytics. Every aspect of Creating Communities of Health — from identifying communities in need to how we invest money and resources — is informed by data analysis and community participation. *Strengthening access for everyone.* Our efforts support better health access for everyone. This includes people with all types of medical coverage — from Medicare and Medicaid to employer-sponsored plans — and those who don't have insurance. *Broad collaboration.* We partner with and listen to community organizations, local governments and private companies that reside in and serve the community. By combining our data analysis with their local insight, we can better support a community's biggest needs. *Taking action to deliver results.* From building physical spaces to strengthening the community workforce and health systems, our focus is on investing in areas that will help communities grow and prosper. **Topic/Title:** Housing + Health 2.0 – Continuums of Care **Description:** Our Housing + Health strategy makes a difference in the lives of our members by working within existing systems to bring the functional components of the housing and health care systems closer together with integrated care management, behavioral health, and housing navigation support. Our dedicated housing navigators collaborate with local CBOs, housing partners and our care management team to 1) help **assess members' housing needs,** 2) **identify barriers** impacting housing stability, 3) help members **develop a housing stability plan**, and 4) **navigate members to community resources** that can address both long-term housing sustainability and short-term urgent housing barriers. To facilitate a case conference, we created a two-way member consent form to improve collaboration. Participating CoCs are now able to make immediate outreach to us upon discovering that our members need support. By matching our membership to the Homeless Management Information System (HMIS) database, we can identify our members who are actively receiving homelessness or housing services. By leveraging the two-way release form, UnitedHealthcare can participate in a multidisciplinary approach to addressing needs (housing, behavioral health, justice-involved, medical, and vocational staff). Our case conferencing with the CoCs enables us to work with the agency providing services to locate, engage and provide a warm introduction to CHWs or behavioral health peers so we can ensure Medicaid benefits are accessible and understood. Current case conferencing data shows that we have conferenced on 75 families with 29 of them being sheltered since December 2022**.** **Topic/Title:** One Pass **Description:** To improve physical and mental well-being for our members and potentially reduce the risk of diseases, UHC offers an enhanced benefit to

MCO	Best and Emerging Practices
	members ages 18 and older. Through this program, members gain access to more than 300 fitness locations in Virginia, including a digital library of more than 20,000 on-demand and livestream classes. UHC expanded this program to our CCC Plus population in support of the transition to Cardinal Care effective January 1, 2023. UHC also partners with in-network gyms/YMCAs for community events such as live cooking demonstrations complete with complimentary cookware and ingredients for featured recipes. Our pilot event was featured at the Petersburg Family YMCA. Over the last twelve months, we have accomplished a 500% increase in the number of Members using this benefit. **Topic/Title:** Integrated Behavioral Health Home **Description:** Our Integrated Behavioral Health Homes (IBHH) program is an innovative, integrated value-based program aimed at large outpatient community mental health centers (CMHCs). This program improves total cost of care by delivering key core services to attributed members, leveraging numerous BH and physical health quality and efficiency metrics and using comprehensive data sharing and technical support. By shifting the focus from the volume of services provided to the value of care delivered, the IBHH program enhances access to high-quality BH services. When compared to baseline data, the IBHH program drove between 25% and 40% improvement in Medication Adherence for Antidepressants, Antipsychotics, and Mood Stabilizers and a 30% reduction in inpatient admissions for members most vulnerable to crisis in the Commonwealth. **Topic/Title:** Careforth **Description:** UnitedHealthcare is partnering with Careforth to deliver caregiver support services to our family caregivers. Careforth focuses on engaging, empowering, educating and supporting caregivers. UHC understands that informal family caregivers are the safety net for our UHC members with complex needs who choose to remain living in the community rather than a nursing facility. Demands on caregivers are on the rise, and their own support needs are becoming more complicated. UnitedHealthcare recognizes the vital role caregivers play in supporting our members, often neglecting their own well-being. These vital caregivers are often the “last mile” between an individual aging in a place of their choice and more costly options.
VA Premier	**Topic/Title:** Health-Related Social Needs Team **Description:** Developed a Health-Related Social Needs (HRSN) Team to support members with social needs that impact their health, such as housing, employment, and food scarcity. We combined the team of telephonic and field-based Housing Specialists and Social Workers to directly address members’ needs across the state. **Topic/Title:** Case Conferencing with Homeless Shelters

MCO	Best and Emerging Practices
	Description: Established a process and a regular schedule with the Greater Richmond Continuum of Care (CoC) for homelessness, to conduct case conferencing on members who enter the shelter system. **Topic/Title:** Personal ID Procurement **Description:** Support members to obtain their identification documents, including state-issued photo ID, Social Security Card, and Birth Certificate. These present a barrier to applying for benefits, housing, and employment if they are missing. We assist members in getting their documents and cover the fees if needed. **Topic/Title:** Financial Stability Planning Program **Description:** Provide members with personal guidance to access benefits, education and training, and job search resources to improve their income and increase their independence. **Topic/Title:** Chronic Care Management Program **Description:** Chronic Care Management is a program that provides the following: A. Assist member in managing Diabetes, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Heart Disease, Heart Failure, and Cancer via telephonic engagement from a Registered Nurse. B. Assist members to find and establish a relationship with a Primary Care Provider, transportation, and connection to other inter-services offered by the Health Plan. C. Develop a care plan and follow up with members to address barriers to receiving care. D. Print member education materials. E. Assist members with obtaining a scale, blood pressure cuff, or glucometer to help manage care. **Topic/Title:** Peer Support Specialist Program **Description:** This program utilizes the real-life experiences of our peer support specialists to promote recovery and foster well-being among members with mental health and substance use disorders. The peer support specialists use recovery-oriented goals with members to help promote improvements in confidence, empowerment, and functioning. This approach to treatment supports the engagement of members through person-centered assessment and self-directed treatment planning that aims to increase members' social support systems, hopefulness for recovery, awareness of early warning signs of problems, and improvement in taking responsibility for wellness and their recovery.

MCO	Best and Emerging Practices
	Topic/Title: ARTS Transition of Care for all ASAM levels of care **Description:** The ARTS Transition of Care team is primary for discharge planning for any member in ASAM levels of care. ARTS Care Coordinators (CC) manage all ASAM discharges to provide transition services for 14 days post discharge. In addition, the ARTS CC supports transitioning members throughout the ASAM outpatient continuum. **Topic/Title:** UHS Telehealth Program **Description:** This program expands telehealth access to Behavioral Health (BH) follow-up treatment to members who are discharged from the Emergency Department (ED) and inpatient stays. For members at Sentara Hospitals, the hospital staff in the ED rooms can use this telehealth program to schedule appointments for members in the ED. **Topic/Title:** Edinburgh and 5'Ps Screening assessments for maternal population **Description:** BH Chronic Care Coordinators (CCC) administer the Edinburgh Postnatal Depression Scale for at-risk women receiving prenatal and postpartum care. Members with a positive screening are connected to appropriate maternal health providers for follow-up screening, monitoring, and treatment and ensure engagement. The BH CCC also utilize the 5 P's (Parents, Peers, Partners, Past, and Present) Screening Tool for prenatal and postpartum women. This is a substance-use screening for at-risk women challenged with substance-use during pregnancy. **Topic/Title:** Community Stabilization Team **Description:** The goal of Community Stabilization Services is to stabilize the individual within the community and assist the individual and natural support system during the following: 1) initial Mobile Crisis Response and entry into an established follow-up service at the appropriate level of care, if the appropriate level of care is identified but not immediately available for access 2) transitional step-down from a higher level of care, if the next level of care is identified but not immediately available or 3) diversion from a higher level of care. Community Stabilization Care Coordinators link/transition the individual to follow-up services and other needed resources to stabilize the individual within their community. **Topic/Title:** Continuity of Care **Description:** Behavioral Health and ARTS Inpatient Reviewers sends a notification at admission and discharge to the members' Care Coordinator and/or BH/ARTS Transition of Care Coordinator to initiate discharge planning with the inpatient facility to identify and resolve barriers for safe and effective discharge, while initiating community-based services, as needed, to reduce the chance for member readmission.

Appendix D. MCO Quality Strategy Quality Initiatives

Table D-1 through Table D-6 provide examples of the quality initiatives the MCOs highlighted as their efforts toward achieving the Virginia 2023–2025 QS's goals and objectives. Note: The narrative within the Quality Initiatives section was provided by the MCO and has not been altered by HSAG except for minor formatting.

Aetna

Table D-1—Aetna's QS Quality Initiatives

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
Goal 1: Enhance the Member Care Experience **Objective 1.1:** Increase Member Engagement and Outreach	**Description of Quality Initiative:** *Language Monitoring:* The Plan continues to conduct ongoing monitoring of membership population to assess and evaluate members' language spoken to ensure member materials and services are available to meet members' language needs, and remain in alignment with Aetna's health equity mission to assist members in obtaining personalized culturally and linguistically appropriate healthcare services.	**Metric:** 1.1.1.2 Monitor Language and Disability Access Reports
Goal 1: Enhance the Member Care Experience **Objective 1.1:** Increase Member Engagement and Outreach	**Description of Quality Initiative:** *Language Monitoring:* The Plan continues to conduct ongoing monitoring of membership population to assess and evaluate members' language spoken to ensure member materials and services are available to meet members' language needs, and remain in alignment with Aetna's health equity mission to assist members in obtaining personalized culturally and	**Metric:**1.1.1.3 Monitor Member Language Counts

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	linguistically appropriate healthcare services.	
Goal 1: Enhance the Member Care Experience **Objective 1.2:** Improve Member Satisfaction	**Description of Quality Initiative:** *HEDIS and CAHPS Workgroup:* Multi-departmental workgroup that continuously looks for opportunities to improve member and provider satisfaction. The workgroup conducts deep dives into barriers related to members not having a PCP, members' ability to get urgent and routine appointments as needed, obtaining needed information from Member Services, and having access to highly rated or specialty providers. The workgroup focuses on initiatives that encourage same-day scheduling, increasing utilization of telehealth services, improving communications between providers and members, and increasing member use of patient-centered medical homes.	**Metric:**1.2.1.1 Rating of all Health Care
Goal 1: Enhance the Member Care Experience **Objective 1.1:** Improve Member Satisfaction	**Description of Quality Initiative:** *HEDIS and CAHPS Workgroup:* Multi-departmental workgroup that continuously looks for opportunities to improve member and provider satisfaction. The workgroup conducts deep dives into barriers related to members not having a PCP, members' ability to get urgent and routine appointments as needed, obtaining needed information from Member Services, and having access to highly rated or specialty providers. The	**Metric:**1.2.1.2 Rating of Personal Doctor

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	workgroup focuses on initiatives that encourage same-day scheduling, increasing utilization of telehealth services, improving communications between providers and members, and increasing member use of patient-centered medical homes.	
Goal 2: Promote Access to Safe, Gold-Standard Patient Care **Objective 2.1:** Ensure Access to Care	**Description of Quality Initiative:** *HEDIS and CAHPS Workgroup*: Multi-departmental workgroup that continuously looks for opportunities to improve member and provider satisfaction. The workgroup conducts deep dives into barriers related to members not having a PCP, members' ability to get urgent and routine appointments as needed, obtaining needed information from Member Services, and having access to highly rated or specialty providers. The workgroup focuses on initiatives that encourage same-day scheduling, increasing utilization of telehealth services, improving communications between providers and members, and increasing member use of patient-centered medical homes.	**Metric:** 2.1.1.1 Getting Care Quickly
Goal 2: Promote Access to Safe, Gold-Standard Patient Care **Objective 2.1:** Ensure Access to Care	**Description of Quality Initiative:** *HEDIS and CAHPS Workgroup*: Multi-departmental workgroup that continuously looks for opportunities to improve member and provider satisfaction. The workgroup conducts deep dives into barriers related to members not	**Metric:** 2.1.1.2 Respondent Got Non-Urgent Appointment as Soon as Needed

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	having a PCP, members' ability to get urgent and routine appointments as needed, obtaining needed information from Member Services, and having access to highly rated or specialty providers. The workgroup focuses on initiatives that encourage same-day scheduling, increasing utilization of telehealth services, improving communications between providers and members, and increasing member use of patient-centered medical homes.	
Goal 2: Promote Access to Safe, Gold-Standard Patient Care **Objective 2.1:** Ensure Access to Care	**Description of Quality Initiative:** *HEDIS and CAHPS Workgroup:* Multi-departmental workgroup that continuously looks for opportunities to improve member and provider satisfaction. The workgroup conducts deep dives into barriers related to members not having a PCP, members' ability to get urgent and routine appointments as needed, obtaining needed information from Member Services, and having access to highly rated or specialty providers. The workgroup focuses on initiatives that encourage same-day scheduling, increasing utilization of telehealth services, improving communications between providers and members, and increasing member use of patient-centered medical homes.	**Metric:** 2.1.1.3 Getting Needed Care
Goal 2: Promote Access to Safe, Gold-Standard Patient Care	**Description of Quality Initiative:**	**Metric:** 2.2.1.2 Monitor the Frequency of Reported Critical Incidents by Member Classification

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
Objective 2.3: Promote Patient Safety	*Improved Critical Incident Report Process and Data Management:* Ongoing curriculum focused education and training for providers and care management staff, software application edits and additions for submission and management of reports, critical incident identification, and reporting process. Additionally, the Plan added a dedicated trainer to address CM urgent and ongoing training needs, which includes a curriculum	
Goal 2: Promote Access to Safe, Gold-Standard Patient Care **Objective 2.3:** Promote Effective Communication and Care Coordination	**Description of Quality Initiative:** *HEDIS and CAHPS Workgroup*: Multi-departmental workgroup that continuously looks for opportunities to improve member and provider satisfaction. The workgroup conducts deep dives into barriers related to members not having a PCP, members' ability to get urgent and routine appointments as needed, obtaining needed information from Member Services, and having access to highly rated or specialty providers. The workgroup focuses on initiatives that encourage same-day scheduling, increasing utilization of telehealth services, improving communications between providers and members, and increasing member use of patient-centered medical homes.	**Metric:** 2.3.1.1 How Well Doctors Communicate
Goal 2: Promote Access to Safe, Gold-Standard Patient Care	**Description of Quality Initiative:** *BH/ARTS Preferred Provider Program:* Aetna-designed BH/ARTS Preferred Provider	**Metric:** 2.3.1.2 Service Authorizations

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
Objective 2.3: Promote Effective Communication and Care Coordination	program for private and public providers that reduces administrative burdens for providers, allowing members to get access to care more quickly. *Behavioral Health Clinical Liaison Team:* A best-in-class model that provides integrated Utilization Management and Care Management supports to members with BH/substance use disorder combined with high touch provider collaboration, connection, and training.	
Goal 3: Support Efficient and Value-Driven Care **Objective 3.1:** Focus on Paying for Value	**Description of Quality Initiative:** *Readmission Avoidance Program (RAP):* Identifies high-risk members for inpatient readmission utilizing inpatient RAP score and identifies members for referral to Care Management to engage at the intensive level of care for 30-days post discharge.	**Metric:** 3.1.1.1 Frequency of Potentially Preventable Admissions
Goal 3: Support Efficient and Value-Driven Care **Objective 3.1:** Focus on Paying for Value	**Description of Quality Initiative:** *Ambulatory Care – Emergency Department Visits Initiative:* Care Managers educating and reminding members about the availability of 24 hr. nurse line services and ED utilization during every contact.	**Metric:** 3.1.1.3 Frequency of Potentially Preventable Emergency Department Visits
Goal 3: Support Efficient and Value-Driven Care **Objective 3.1:** Focus on Paying for Value	**Description of Quality Initiative:** *Readmission Avoidance Program (RAP):* Identifies high-risk members for inpatient readmission utilizing inpatient RAP score and identifies members for referral to Care	**Metric:**3.1.1.3 Frequency of Potentially Preventable Readmissions

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	Management to engage at the intensive level of care for 30-days post discharge.	
Goal 3: Support Efficient and Value-Driven Care **Objective 3.1:** Focus on Paying for Value	**Description of Quality Initiative:** *Value Based Agreements:* Plan contracts with high-volume providers that include performance metrics to increase members engaged with a primary care provider/patient centered medical home. *Provider Collaborated Outreach and Onsite Clinic Days:* QM collaborates with high-density provider offices to outreach members identified as not having completed a well-child visit or vaccines. Staff assists with scheduling appointment during planned clinic days for which Plan QM staff will be onsite.	**Metric:** 3.1.1.4 Ambulatory Care
Goal 3: Support Efficient and Value-Driven Care **Objective 3.1:** Focus on Paying for Value	**Description of Quality Initiative:** *AMB PIP Intervention:* Care manager educate members on availability of 24-hour Nurse Line services and ED/ER utilization during every contact.	**Metric:** 3.1.1.5 Ambulatory Care: Emergency Department (ED) Visits
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *Value Based Agreements:* Plan contracts with high-volume providers that include performance metrics to increase members engaged with a primary care provider/patient centered medical home.	**Metric:** 4.1.1.1 Adults' Access to Preventive/Ambulatory Health Services
Goal 4: Strengthen the Health of Families and Communities	**Description of Quality Initiative:**	**Metric:** 4.1.1.2 Child and Adolescent Well-Care Visits

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
Objective 4.1: Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	*EPSDT Preventive Screening Brochure:* A comprehensive but easy to read brochure that educates members about important and recommended child preventive screenings and services with icons and timetable. *EPSDT Birthday Mailers:* Health education postcards mailed to members (parents) birth-20 years notifying them that they are due for a well child visit. Each postcard is age appropriate and lets parents know what they can expect at their child's check-up and what they can do to prepare for the appointment. The mailers also include important education and other information related to age-appropriate health issues and tips on how to keep the child safe and healthy. *Targeted Member Outreach:* Dedicated team outreaches parents/guardians of members in Petersburg area aged 0-20 years identified as being past due for a well-child visit and assists with scheduling appointments. *Provider Collaborated Outreach and Onsite Clinic Days:* QM collaborates with high-density provider offices to outreach members identified as not having completed a well-child visit or vaccines. Staff assists with scheduling appointment during planned clinic days for which Plan QM staff will be onsite.	

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *EPSDT Preventive Screening Brochure:* A comprehensive but easy to read brochure that educates members about important and recommended child preventive screenings and services with icons and timetable. *EPSDT Birthday Mailers:* Health education postcards mailed to members (parents) birth-20 years notifying them that they are due for a well child visit. Each postcard is age appropriate and lets parents know what they can expect at their child's check-up and what they can do to prepare for the appointment. The mailers also include important education and other information related to age-appropriate health issues and tips on how to keep the child safe and healthy. *CIS SMS Text Campaign:* Vendor initiated SMS text messaging to members identified as not having completed all age-appropriate recommended immunizations reminding them of importance of completing them.	**Metric:** 4.1.1.3 Child Immunization Status
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *EPSDT Preventive Screening Brochure:* A comprehensive but easy to read brochure that educates members about important and recommended child preventive screenings and services with icons and timetable.	**Metric:** 4.1.1.4 Immunizations for Adolescents

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	EPSDT Birthday Mailers: Health education postcards mailed to members (parents) birth-20 years notifying them that they are due for a well child visit. Each postcard is age appropriate and lets parents know what they can expect at their child's check-up and what they can do to prepare for the appointment. The mailers also include important education and other information related to age-appropriate health issues and tips on how to keep the child safe and healthy. *Ted E. Bear M.D. Wellness Club:* Kids program encompassing children ages newborn to 17 years that incentivizes parents to ensure their child completes an annual well-child check-up. Every child receives an enrollment age-appropriate gift and a gift card upon completion of well-child visits (gift cards vary based on age group). *HPV Vaccine Adherence Program:* Conducted live outreach calls to members aged 9-13 years in Petersburg, identified as not having completed the HPV vaccine series with follow up educational flyers mailed to unable to reach members.	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *CVS Health Tags:* CVS Pharmacies attach messages to prescription bags that educates members about the importance of flu vaccination	**Metric:** 4.1.1.5 Flu Vaccinations for Adults 18-64

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	MS Hold Line Flu Shot Message: When members call into plan, they will hear a recorded message reminding them to get their free flu shot.	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *EPSDT Preventive Screening Brochure:* A comprehensive but easy to read brochure that educates members about important and recommended child preventive screenings and services with icons and timetable.	**Metric:** 4.1.1.6 Topical Fluoride for Children
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *EPSDT Preventive Screening Brochure:* A comprehensive but easy to read brochure that educates members about important and recommended child preventive screenings and services with icons and timetable. *EPSDT Birthday Mailers:* Health education postcards mailed to members (parents) birth-20 years notifying them that they are due for a well child visit. Each postcard is age appropriate and lets parents know what they can expect at their child's check-up and what they can do to prepare for the appointment. The mailers also include important education and other information related to age-appropriate health issues and tips on how to keep the child safe and healthy.	**Metric:** 4.1.1.7 Oral Evaluation, Dental Services
Goal 4: Strengthen the Health of Families and Communities	**Description of Quality Initiative:**	**Metric:** 4.1.1.8 Sealant Receipt of Permanent First Molars

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
Objective 4.1: Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	*EPSDT Preventive Screening Brochure:* A comprehensive but easy to read brochure that educates members about important and recommended child preventive screenings and services with icons and timetable. *EPSDT Birthday Mailers:* Health education postcards mailed to members (parents) birth-20 years notifying them that they are due for a well child visit. Each postcard is age appropriate and lets parents know what they can expect at their child's check-up and what they can do to prepare for the appointment. The mailers also include important education and other information related to age-appropriate health issues and tips on how to keep the child safe and healthy.	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *EPSDT Birthday Mailers:* Health education postcards mailed to members (parents) birth-20 years notifying them that they are due for a well child visit. Each postcard is age appropriate and lets parents know what they can expect at their child's check-up and what they can do to prepare for the appointment. The mailers also include important education and other information related to age-appropriate health issues and tips on how to keep the child safe and healthy. *Ted E. Bear M.D. Wellness Club:* Kids program encompassing children ages	**Metric:** 4.1.1.9 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	newborn to 17 years that incentivizes parents to ensure their child completes an annual well-child check-up. Every child receives an enrollment age-appropriate gift and a gift card upon completion of well-child visits (gift cards vary based on age group).	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *Well Woman Exam Incentive:* Eligible members can earn gift card for completing Pap Smear, Mammogram, Chlamydia Screening, Colorectal Cancer Screening, and Flu Vaccine. *Moving On: Transitioning from Pediatrics to Primary Care:* Members between the ages of 18-20 years can earn a reward for completing preventive care services, adult medical screenings, weight management, and recommended vaccines.	**Metric:** 4.1.1.10 Chlamydia Screening in Women Ages 16 to 20
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *EPSDT Birthday Mailers:* Health education postcards mailed to members (parents) birth-20 years notifying them that they are due for a well child visit. Each postcard is age appropriate and lets parents know what they can expect at their child's check-up and what they can do to prepare for the appointment. The mailers also include important education and other information related to age-appropriate health issues and tips on how to keep the child safe and healthy.	**Metric:**4.1.1.11 Lead Screening in Children

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	Ted E. Bear M.D. Wellness Club: Kids program encompassing children ages newborn to 17 years that incentivizes parents to ensure their child completes an annual well-child check-up. Every child receives an enrollment age-appropriate gift and a gift card upon completion of well-child visits (gift cards vary based on age group).	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** *Maternity Incentive:* Pregnant members can earn rewards for attending all recommended prenatal and postpartum appointments. *New Moms Box*: Value-added service offers eligible members who are pregnant through one year postpartum $25 monthly to spend on over-the-counter items for themselves and their baby through CVS Pharmacy. New moms can also attend baby showers and earn prizes. Plus, new moms can get a fee breast pump and 300 count free size one baby diapers delivered to their home after their baby is born. *Postpartum Depression (PPD) Initiative:* BH and CM collaborate to conduct targeted outreach members identified as receiving prenatal or postnatal care in the last 18 months to educate them about PPD and how to identify symptoms and seek treatment. BH clinical liaisons also educate members and encourage postpartum	**Metric:** 4.2.1.1 Prenatal and Postpartum Care: Postpartum Care

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	appointment adherence during virtual baby showers. *Postpartum Text Campaign:* Women identified as having received prenatal or postnatal care in the last 18 months receive text alerts to reminding them of the importance of follow up care with their provider.	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** *Maternity Incentive:* Pregnant members can earn rewards for attending all recommended prenatal and postpartum appointments. *New Moms Box*: Value-added service offers eligible members who are pregnant through one year postpartum $25 monthly to spend on over-the-counter items for themselves and their baby through CVS Pharmacy. New moms can also attend baby showers and earn prizes. Plus, new moms can get a fee breast pump and 300 count free size one baby diapers delivered to their home after their baby is born. *Virtual Baby Showers*: Quarterly virtual baby shower for Medicaid members statewide that provide pregnant women an opportunity to celebrate their soon-to-be-arrival within the comfort and safety of their own homes. The Plan educates attendees with dietary, physical, and dental health recommendations. *Timeliness of Prenatal Care PIP Intervention:* Care	**Metric:** 4.2.1.2 Prenatal and Postpartum Care: Timeliness of Prenatal Care

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	managers outreach members within 15 days of receiving monthly Maternal Care Report to educate members about the importance of completing and assist with scheduling first trimester prenatal appointments.	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** *Maternity Incentive:* Pregnant members can earn rewards for attending all recommended prenatal and postpartum appointments. *Benefits of Quitting: Tobacco Use Cessation in Pregnant Women:* Health Plan and American Cancer Society cobranded flyer that educates members about the benefits of quitting smoking/ tobacco cessation and the health risks of smoking during pregnancy. *Timeliness of Prenatal Care PIP Intervention:* Care managers outreach members within 15 days of receiving monthly Maternal Care Report to educate members about the importance of completing and assist with scheduling first trimester prenatal appointments. *Progeny:* A program that aims to improve NICU infant outcomes, decrease the cost of NICU care, and increase member and provider satisfaction. The program includes utilization and care management teams that monitor the baby telephonically from NICU admission and	**Metric:** 4.2.1.3 Live Births Weighing Less than 2,500 Grams

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	maintain consistent interaction with the hospital team through a care plan driven approach. The care management team connects with the family early in the hospital stay and continues to support them for the entire first year. *Preeclampsia Prevention*: Provides high-risk pregnant members with a personalized prenatal care kit containing education about preeclampsia risk factors and low-dose aspirin and supports women to have conversations with their providers about their risk and steps they can take to reduce it.	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** *EPSDT Birthday Mailers:* Health education postcards mailed to members (parents) birth-20 years notifying them that they are due for a well child visit. Each postcard is age appropriate and lets parents know what they can expect at their child's check-up and what they can do to prepare for the appointment. The mailers also include important education and other information related to age-appropriate health issues and tips on how to keep the child safe and healthy. *Ted E. Bear M.D. Wellness Club:* Kids program encompassing children ages newborn to 17 years that incentivizes parents to ensure their child completes an annual well-child check-up. Every child receives an enrollment age-appropriate gift and a gift card	**Metric:** 4.2.1.4 Well-Child Visits in the Frist 30 Months of Life

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	upon completion of well-child visits (gift cards vary based on age group). *IWC Outreach:* Dedicated team outreaches parents/guardians of members aged 15 months identified as being past due for well-child visit and assists with scheduling appointments. *National NBA:* Direct mail, SMS, emails, and live calls to members (0-30 months) identified as not having completed well-child visit.	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** *Maternity Incentive:* Pregnant members can earn rewards for attending all recommended prenatal and postpartum appointments. *Timeliness of Prenatal Care PIP Intervention:* Care managers outreach members within 15 days of receiving monthly Maternal Care Report to educate members about the importance of completing and assist with scheduling first trimester prenatal appointments. Additional CM follow up occurs within 15 days of making appointment referral. *High Risk Pregnancy NBA:* Initiative that sends educational material to high-risk pregnant women informing them about gestational diabetes, hypertension, and preterm labor and how to stay healthy during pregnancy.	**Metric:** 4.2.1.5 Low-Risk Cesarean Delivery

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
Goal 4: Strengthen the Health of Families and Communities **Objective 4.3:** Improve Home and Community-Based Services	**Description of Quality Initiative:** *Non-Traditional Provider Education:* Quality Management staff educate providers about how to write corrective action plans and publish Provider Newsletter articles educating community-based providers about trended review findings and helpful best practices and resources to aid in improving health outcomes for waiver members.	**Metric:** 4.3.1.1 Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and Appropriate to Their Needs and Personal Goals
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** *Readmission Avoidance Program (RAP):* Identifies high-risk members for inpatient readmission utilizing inpatient RAP score and identifies members for referral to Care Management to engage at the intensive level of care for 30-days post discharge. *Chronic Conditions Education Series:* Quarterly virtual education sessions for members with chronic conditions. Each session is hosted by Health Plan staff or non-profit organization guest speaker relevant to the session topic and provides information and help tips about how to better manage chronic conditions.	**Metric:** 5.1.1.1 Heart Failure Admission Rate
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** *Readmission Avoidance Program (RAP):* Identifies high-risk members for inpatient readmission utilizing inpatient RAP score and identifies	**Metric:** 5.1.1.2 Asthma Admission Rate

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	members for referral to Care Management to engage at the intensive level of care for 30-days post discharge. *Chronic Conditions Education Series:* Quarterly virtual education sessions for members with chronic conditions. Each session is hosted by Health Plan staff or non-profit organization guest speaker relevant to the session topic and provides information and help tips about how to better manage chronic conditions. *Asthma/COPD Inhaler NBA:* Multiple channels educating members identified as having a diagnosis of asthma about how to use prescribed inhalers and spacers and common asthma triggers.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** *Readmission Avoidance Program (RAP):* Identifies high-risk members for inpatient readmission utilizing inpatient RAP score and identifies members for referral to Care Management to engage at the intensive level of care for 30-days post discharge. *Chronic Conditions Education Series:* Quarterly virtual education sessions for members with chronic conditions. Each session is hosted by Health Plan staff or non-profit organization guest speaker relevant to the session topic and provides information and help tips about how to	**Metric:** 5.1.1.3 COPD and Asthma in Older Adults' Admission Rate

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

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	18-20 years can earn a reward for completing preventive care services, adult medical screenings, weight management, and recommended vaccines. *Chronic Conditions Education Series:* Quarterly virtual education sessions for members with chronic conditions. Each session is hosted by Health Plan staff or non-profit organization guest speaker relevant to the session topic and provides information and help tips about how to better manage chronic conditions. *CPT II Code Incentive:* Provider incentive of $25 for submitting claims with CPT II codes for Diabetes A1c testing, blood pressure, and eye exams, prenatal and postpartum visits, and immunizations.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** *My ActiveHealth:* Free app that features diabetes management, appointment and medication reminders, and exercise/weight goals setting and tracking. *Chronic Conditions Education Series:* Quarterly virtual education sessions for members with chronic conditions. Each session is hosted by Health Plan staff or non-profit organization guest speaker relevant to the session topic and provides information and help tips about how to better manage chronic conditions.	**Metric:** 5.1.1.5 Controlling High Blood Pressure

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	Wellness Incentive: Members can earn rewards for completing recommended screenings and annual wellness exams. *CPT II Code Incentive:* Provider incentive of $25 for submitting claims with CPT II codes for Diabetes A1c testing, blood pressure, and eye exams, prenatal and postpartum visits, and immunizations. *Outreach Call Campaign:* Plan conducted live outreach call to members identified as not having completed a blood pressure screening and to discuss dietary recommendations and access to PCP.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** *My ActiveHealth:* Free app that features diabetes management, appointment and medication reminders, and exercise/weight goals setting and tracking.	**Metric:** 5.1.1.6 Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** *My ActiveHealth:* Free app that features diabetes management, appointment and medication reminders, and exercise/weight goals setting and tracking. *Chronic Conditions Education Series:* Quarterly virtual education sessions for members with chronic conditions. Each session is hosted by Health Plan staff or non-profit organization guest speaker relevant to the session topic and provides information and help tips about how to	**Metric:** 5.1.1.7 Asthma Medication Ratio: Ages 5 to 18 Years

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	better manage chronic conditions. *Asthma/COPD Inhaler NBA:* Multiple channels educating members identified as having a diagnosis of asthma about how to use prescribed inhalers and spacers and common asthma triggers.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders	**Description of Quality Initiative:** *Residential Substance Use Disorder (SUD) Discharge Program:* Plan partners with residential treatment facilities to offer support with recovery planning, housing, transportation, food, workforce engagement, engagement with needed medical/psychiatric services for members returning to home community after discharge. *National Opioid Use Disorder (OUD) Program:* Collaboration with providers to reduce opioid prescriptions/increase medication assisted treatment (MAT) by educating them about prescribing behavior and opportunities for member intervention, sharing member data so they can focus their outreach and engagement members with OUD in care management. *Harm Reduction Coalitions:* Aetna donation to purchase supplies and educate communities around opioid use disorder and prevention.	**Metric:** 5.3.1.1 Monitor Identification of Alcohol and Other Drug Services
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Description of Quality Initiative:**	**Metric:** 5.3.1.2 Follow-Up After Emergency Department Visit for Substance Use

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
Objective 5.3: Improve Outcomes for Members with Substance Use Disorders	*Community Health Workers Initiative:* Community Health Workers located throughout each region to link members to safe housing, local food markets, job opportunities and training, access to health care services, community-based resources, transportation, recreational activities, and other services *Find Help Initiative*: Site used to provide resources and services for social determinants of health	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders	**Description of Quality Initiative:** *Annual DUR Program Initiative:* Program that targets outreach to providers prescribing over 90 milligram morphine equivalent (mme)/day. A list of members is shared along with a peer matched prescriber report card. This reporting shares information with the provider and highlights the importance of ensuring members have access to naloxone.	**Metric:** 5.3.1.3 Use of Opioids at High Dosage in Persons Without Cancer
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders	**Description of Quality Initiative:** *Residential Substance Use Disorder (SUD) Discharge Program:* Plan partners with residential treatment facilities to offer support with recovery planning, housing, transportation, food, workforce engagement, engagement with needed medical/psychiatric services for members returning to home community after discharge.	**Metric:** 5.3.1.4 Initiation and Engagement of Substance Use Disorder Treatment

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	Justice Integrated Care Pilot Program: Program targeting members returning to the community, that includes an integrated care team to coordinate case management services, conduct health screenings, identify health-related social needs (HRSNs) and make closed loop referrals to community organizations that can address them and discuss participant needs through integrated weekly rounds. The team includes an Adult and Juvenile System of Care Administrators, Peer Support Specialists, Community Health Worker, and Sr. Clinical Strategist. The program will be expanded into other areas of the state.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders	**Description of Quality Initiative:** *The High Utilizers of Virginia (HUV) Program*: Program emphasizing in-person engagement with individuals at time of program enrollment, engagement, and coordination with local resources, 24/7/365 program access for enrollees, including crisis availability, close follow-up with participants after every provider encounter, close coordination with the Collective Medical tools, and customized care plans. The program is intended to improve enrollee care, decrease duplicative care efforts among providers, reduce mental health admissions, general hospital admissions, ED visits, and	**Metric:** 5.4.1.1 Follow-Up After Hospitalization for Mental Illness

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	overall cost of care for and among participants. *Development of Behavioral Health Toolkits:* Educational publications specific to coping strategies, managing stress and decompensation, how to access services, helping members recognize symptoms, and how to access services – Distributed to inpatient facilities and schools.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *The High Utilizers of Virginia (HUV) Program*: Program emphasizing in-person engagement with individuals at time of program enrollment, engagement, and coordination with local resources, 24/7/365 program access for enrollees, including crisis availability, close follow-up with participants after every provider encounter, close coordination with the Collective Medical tools, and customized care plans. The program is intended to improve enrollee care, decrease duplicative care efforts among providers, reduce mental health admissions, general hospital admissions, ED visits, and overall cost of care for and among participants.	**Metric:** 5.4.1.2 Follow-Up After Emergency Department for Mental Illness
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *2023 Interactive Voice Response (IVR) Message Outreach Initiative*: IVR campaign educating members about the importance of follow up care for children prescribed	**Metric:** 5.4.1.3 Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	ADHD/ADD Medications, within 30 days and throughout treatment is ongoing. *ADHD Initiative*: Campaign that outreaches and educate providers, and parents/guardians based on new fill pharmacy reports to remind parents to set up follow up appointments and use of non-medication management education resources. The program also includes CM outreach to members how have started the initiation phase of the medication and are non-adherent to their medication with a 6-month rolling period. *Member Educational Brochure:* Educational publication that includes behavioral therapies and how to access MyActive Health via the member portal.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *Transition Age Youth (TAY):* Targets members ages 16-29 years to reduce utilization of emergency services and inpatient admissions. The program is based on the Transition to Independence Process (TIP) Model, an evidence-supported practice that focuses on youth engagement, futures planning, and skill-building through a person-centered, strength-based approach. Members who meet admissions thresholds benefit from focused care coordination, advanced engagement, connection with appropriate formal and informal	**Metric:** 5.4.1.4 Monitor Mental Health Utilization

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	services and natural and community support, as well as flexible individualized plans for treatment. *Postpartum Depression (PPD) Initiative:* BH and CM collaborate to conduct targeted outreach members identified as receiving prenatal or postnatal care in the last 18 months to educate them about PPD and how to identify symptoms and seek treatment. BH clinical liaisons also educate members and encourage postpartum appointment adherence during virtual baby showers. *Richmond Behavioral Health Authority (RBHA) Enhanced Care Coordination (ECC) Initiative:* Value-based program with a community partner to provide enhanced care coordination to manage needs of adult members with co-morbid behavioral health and physical health needs. Includes review of claims history and authorizations to identify members with gaps in care. Aetna staff educate partner staff about covered benefits and formulary, as well as referrals to in-network providers as needed. Monthly rounds are held to coordinate care.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *The High Utilizers of Virginia (HUV) Program*: Program emphasizing in-person engagement with individuals at time of program enrollment, engagement, and coordination	**Metric:** 5.4.1.1 Follow-Up After Hospitalization for Mental Illness

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	with local resources, 24/7/365 program access for enrollees, including crisis availability, close follow-up with participants after every provider encounter, close coordination with the Collective Medical tools, and customized care plans. The program is intended to improve enrollee care, decrease duplicative care efforts among providers, reduce mental health admissions, general hospital admissions, ED visits, and overall cost of care for and among participants.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *Flourish Health Partnership Initiative*: Program focuses on first episode psychosis and serious mental illness for members/enrollees ages 13-26 years to offer family systems therapy, in-person, and telehealth support, medication monitoring, and skills development. *Prior Authorization Criteria Utilized:* Clinical Criteria for Antipsychotics in children less than 18 years of age	**Metric:** 5.4.1.5 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *Behavioral Health Case Management Member Engagement Initiative*: Program focused on engaging member, educating them about regular screening, encouraging participation in Case Management. Includes support from CM to help schedule follow-up appointments and	**Metric:** 5.4.1.6 Metabolic Monitoring for Children and Adolescents on Antipsychotics

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	address transportation, childcare, and other social determinants of health (SDOH) challenges/issues. *DUR program Initiative*: Reviews and monitors children on concomitant antipsychotics and antidepressants *Gaps in Care Reporting:* Plan generated gap in care reports with information on eligible members that are due or overdue for care and screening. *High ED Utilizer Monitoring Initiative*: Identification of and outreach to educate high ED utilizers and members who utilize ED for conditions that could be treated at a lower level of care. *Pharmacy DUR Program: 1st Fill Antipsychotic Initiative:* Geared to increase provider awareness of metabolic monitoring, engagement of members in supportive/non-pharm services. Includes sending letters to providers of members filling 1st atypical script with follow-up monitoring and information on how to help members engage in other covered services that can mitigate metabolic impact of this therapy and improve adherence. *CVS Pharmacy Advisor Program Initiative*: Geared to increase awareness of risks associated with co-prescribing of antipsychotics and SSRI/SNRI/TCA	

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	antidepressants for members under 17 years old.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *Chronic Conditions Education Series:* Quarterly virtual education sessions for members with chronic conditions. Each session is hosted by Health Plan staff or non-profit organization guest speaker relevant to the session topic and provides information and help tips about how to better manage chronic conditions.	**Metric:** 5.4.1.7 Medial Assistance with Smoking and Tobacco Use Cessation
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *Member Outreach Letters:* Outreach letters sent to members identified as having been prescribed antidepressant medications to inform them of 90-day medication supply.	**Metric:** 5.4.1.8 Antidepressant Medication Management
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *EPSDT Periodicity Schedule:* Provider education about the EPSDT requirement to screen all children ages 12-20 years for depression, utilizing a validated, standardized screening tool. *Postpartum Depression (PPD) Initiative:* BH and CM collaborate to conduct targeted outreach members identified as receiving prenatal or postnatal care in the last 18 months to educate them about PPD and how to identify symptoms and seek treatment. BH clinical liaisons also educate members	**Metric:** 5.4.1.9 Screening for Depression and Follow-Up Plan: Ages 18 and Older

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	and encourage postpartum appointment adherence during virtual baby showers. *Postpartum Text Campaign:* Women identified as having received prenatal or postnatal care in the last 18 months receive text alerts to reminding them of the importance of follow up care with their provider. *Provider Manual and Education/Training:* Includes guidance for screening depression, anxiety, post-traumatic stress disorder, through pediatric and adult tools. Providers are informed they can access these screenings utilizing our provider portal. Additionally, CM staff is trained on the use of screening tools and offers offer providers monthly virtual and recorded training on these tools.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *Behavioral Health Case Management Member Engagement Initiative*: Program focused on engaging member, educating them about regular screening, encouraging participation in Case Management. Includes support from CM to help schedule follow-up appointments and address transportation, childcare, and other social determinants of health (SDOH) challenges/issues. *Gaps in Care Reporting:* Plan generated gap in care reports with information on eligible	**Metric:** 5.4.1.10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	members that are due or overdue for care and screening. *HEDIS Toolkit:* Comprehensive Plan-developed provider educational resource educating providers about HEDIS measure specifications, applicable coding, and tips. Our Toolkit is available on our website on the provider portal. The onsite and webinar practitioner HEDIS trainings also include instructions for how to use the HEDIS toolkit. *High ED Utilizers Initiative:* Case managers continue to identify high ED utilizers and those members that use ED for conditions that could be treated at a lower level of care; outreach those members and their PCP/BH practitioner. *Pharmacy DUR Program: 1st Fill Antipsychotic Initiative:* Geared to increase provider awareness of metabolic monitoring, engagement of members in supportive/non-pharm services. Includes sending letters to providers of members filling 1st atypical script with follow-up monitoring and information on how to help members engage in other covered services that can mitigate metabolic impact of this therapy and improve adherence. *CVS Pharmacy Advisor Program Initiative*: Geared to increase awareness of risks associated with co-prescribing of antipsychotics and SSRI/SNRI/TCA	

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	antidepressants for members under 17 years old *Medication Therapy Management Initiative*: Pharmacists conduct telephonic outreach targeting members who would most benefit from interaction based on chronic conditions, maintenance medications and drug spend	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *Behavioral Health Case Management Member Engagement Initiative*: Program focused on engaging member, educating them about regular screening, encouraging participation in Case Management. Includes support from CM to help schedule follow-up appointments and address transportation, childcare, and other social determinants of health (SDOH) challenges/issues. *Gaps in Care Reporting:* Plan generated gap in care reports with information on eligible members that are due or overdue for care and screening. *HEDIS Toolkit:* Comprehensive Plan-developed provider educational resource educating providers about HEDIS measure specifications, applicable coding, and tips. Our Toolkit is available on our website on the provider portal. The onsite and webinar practitioner HEDIS trainings also include instructions for how to use the HEDIS toolkit.	**Metric:** 5.4.1.11 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	High ED Utilizers Initiative: Case managers continue to identify high ED utilizers and those members that use ED for conditions that could be treated at a lower level of care; outreach those members and their PCP/BH practitioner. *Pharmacy DUR Program: 1st Fill Antipsychotic Initiative:* Geared to increase provider awareness of metabolic monitoring, engagement of members in supportive/non-pharm services. Includes sending letters to providers of members filling 1st atypical script with follow-up monitoring and information on how to help members engage in other covered services that can mitigate metabolic impact of this therapy and improve adherence. *CVS Pharmacy Advisor Program Initiative*: Geared to increase awareness of risks associated with co-prescribing of antipsychotics and SSRI/SNRI/TCA antidepressants for members under 17 years old *Medication Therapy Management Initiative*: Pharmacists conduct telephonic outreach targeting members who would most benefit from interaction based on chronic conditions, maintenance medications and drug spend	
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Description of Quality Initiative:** *NBA Adherence Program Initiative:* Provides members	**Metric:** 5.4.1.12 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
Objective 5.4: Improve Behavioral Health and Developmental Services for Members	with refill reminder leveraging channels such as IVR, SMS, and direct mail. Initiative utilizes predictive analytics to identify members who will be nonadherent to therapy. By sharing reminders, we equip members with the information to contact their pharmacy and fill the respective drug. Additionally, the PBM provides a drop in therapy notification to providers when nonadherence has been observed.	

HealthKeepers

Table D-2—HealthKeepers' QS Quality Initiatives

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

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	provider education and is distributed by the health plan	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	Description of Quality Initiative: EPSDT Birthday Reminders: Reminders are sent out approximately 45-60 days before the members birthday to remind them to go in for services that are due. If after 90days from the member's birthday they have not had their Well Visit, we will send out another reminder to get services completed.	**Metric:** 4.1.1.2 Child and Adolescent Well-Care Visits
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** EPSDT Co-Branding Initiative: Partnering with high volume providers to distribute reminders for overdue services. Co-Branded Birthday Reminders are sent out approximately 45-60 days before the members birthday to remind them to go in for services that are due. If after 90days from the member's birthday they have not had their Well Visit, we will send out another reminder to get services completed.	**Metric:** 4.1.1.2 Child and Adolescent Well-Care Visits
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	Description of Quality Initiative: EPSDT Birthday Reminders: Reminders are sent out approximately 45-60 days before the members birthday to remind them to go in for services that are due. If after 90days from the member's birthday they have not had their Well Visit, we will send out another reminder to get services completed. Age Out Immunization Outreach: Targets members who need immunizations who have aged out AND members who are about	**Metric:** 4.1.1.3 Childhood Immunization Status

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

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
Objective 4.1: Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	provider education and is distributed by the health plan	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** New Baby New Life Program: This program provides quality, culturally competent case management to pregnant Medicaid members during the prenatal and postpartum periods. At-risk pregnant members are supported by a dedicated OB Nurse Case Manager who encourages the member to take action to optimize the outcome of her pregnancy, prepare for the delivery and homecoming of her infant, and participate in her infant's care should a NICU stay be required. All members identified as pregnant and recently delivered, receive an educational packet with self-care booklets and additional resources. In addition, providers receive an educational packet as well. Program: The Availity Maternity HEDIS Attestation Tool: Requires OB clinics to notify Anthem if an Anthem patient is pregnant during the check-in process. The notification occurs through a secure data file which links to the care management system and triggers for outbound calls to members for risk screening and enrollment in appropriate case management or care coordination services. The tool also includes HEDIS® alerts to remind providers to schedule timely postpartum appointments.	**Metric:** 4.2.1.2 Prenatal and Postpartum Care: Postpartum Care

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	When an OB provider checks eligibility and the member is an Anthem Medicaid member, they will automatically be enrolled in MyAdvocate via the eligibility questions answered. Program: Doula Program available to all Medicaid members reimbursing for prenatal, delivery and postpartum doula services. Referral from licensed provider required and incentive to doula for member to pursue services. Program: My Advocate: is maternal health education by telephone, text message and by Smartphone app to pregnant women and postpartum women. Pregnant/postpartum women are provided answers to their questions and directed to community and medical support if needed. The application provides for live chats over the My Advocate™ Dashboard. This program uses the OB screener which allows for stratification of the member into low, mid, high. If they are ranked high-risk, they are assigned a CM. HEDIS Cat II Coding Tips Bulletin: This is a bulletin intended to provide Cat II coding guidance. This is faxed/distributed to health care providers.	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** New Baby New Life Program: This program provides quality, culturally competent case management to pregnant Medicaid members during the prenatal and postpartum periods. At-risk pregnant members are	**Metric:** 4.2.1.2 Prenatal and Postpartum Care: Timeliness of Prenatal Care

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	supported by a dedicated OB Nurse Case Manager who encourages the member to take action to optimize the outcome of her pregnancy, prepare for the delivery and homecoming of her infant, and participate in her infant's care should a NICU stay be required. All members identified as pregnant and recently delivered, receive an educational packet with self-care booklets and additional resources. In addition, providers receive an educational packet as well. The Availity Maternity HEDIS® Attestation Tool: Requires OB clinics to notify Anthem if an Anthem patient is pregnant during the check-in process. The notification occurs through a secure data file which links to the care management system and triggers for outbound calls to members for risk screening and enrollment in appropriate case management or care coordination services. The tool also includes HEDIS alerts to remind providers to schedule timely postpartum appointments. When an OB provider checks eligibility and the member is an Anthem Medicaid member, they will automatically be enrolled in MyAdvocate via the eligibility questions answered. Doula Program available to all Medicaid members reimbursing for prenatal, delivery and postpartum doula services. Referral from licensed provider required and incentive to doula for member to pursue services.	

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	My Advocate: is maternal health education by telephone, text message and by Smartphone app to pregnant women and postpartum women. Pregnant/postpartum women are provided answers to their questions and directed to community and medical support if needed. The application provides for live chats over the My Advocate™ Dashboard. This program uses the OB screener which allows for stratification of the member into low, mid, high. If they are ranked high-risk, they are assigned a CM. HEDIS Cat II Coding Tips Bulletin: This is a bulletin intended to provide Cat II coding guidance. This is faxed/distributed to health care providers.	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** Visit Compliance Report: Monthly report that identifies the number of visits needed for compliancy. HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes. HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed to healthcare providers. HEDIS Well Child and Immunizations Coding Tips Bulletin: This is a bulletin intended to provide coding guidance to health care providers for Well Child and Immunizations.	**Metric:** 4.2.1.4 Well-Child Visits in the First 30 Months of Life

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	This is faxed/distributed to health care providers.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** Care Coordination Outreach Healthwise Job Aides: Assisting Care Coordinators/Case Managers in educating members on Controlling Hypertension. Job aide includes education on Hypertension risk factors, how to manage high blood pressure. Smoking cessation information is provided	**Metric:** 5.1.1.1 PQI 08: Heart Failure Admission Rate
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** Care Coordination Outreach Healthwise Job Aides: Assisting Care Coordinators/Case Managers in educating members on the disease process of COPD (Chronic Obstructive Pulmonary Disease). Job aide includes education on Asthma disease process, medications such as the importance of maintenance/controller medications and rescue inhalers (bronchodilators), asthma action plan and information when to call 911, knowing triggers	**Metric:** 5.1.1.2 PQI 14: Asthma Admission Rate (Ages 2–17)
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** Care Coordination Outreach Healthwise Job Aides: Assisting Care Coordinators/Case Managers in educating members on the disease process of COPD (Chronic Obstructive Pulmonary Disease). Job aide includes education on COPD disease process, medications such as bronchodilators short and long acting, COPD action plan information and when to call 911, how to avoid triggers	**Metric:** 5.1.1.3 PQI 05: COPD and Asthma in Older Adults' Admission Rate

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** Care Coordination Outreach Healthwise Job Aides: Assisting Care Coordinators/Case Managers in educating members on the disease process of Diabetes. Job aide includes education on Diabetes disease process, most commonly prescribed medications, risk factors and prevention, A1c testing, diet and exercise, how to obtain a glucose meter CVS Health Tags Program: CVS provides written health messages and assistance from a Tech. HEDIS Cat II Coding Tips Bulletin: This is a bulletin intended to provide Cat II coding guidance. This is faxed/distributed to health care providers, by the health plan. Zip Drug Program: Connects members to high-quality participating pharmacies to administer clinical services (such as BP screenings, A1c monitoring). Monitors members for adherence improvement, HEDIS gap closure, and cost-of-care reduction.	**Metric:** 5.1.1.4 Diabetes Care for Patients with Diabetes: Hemoglobin A1c (HbA1c) Control (<8.0%)
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	Description of Quality Initiative: HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes. HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan.	**Metric:** 5.1.1.5 Controlling High Blood Pressure

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	CVS Health Tags Program: CVS provides written health messages and assistance from a Tech. Zip Drug Program: Connects members to high-quality participating pharmacies to administer clinical services (such as BP screenings, A1c monitoring). Monitors members for adherence improvement, HEDIS gap closure, and cost-of-care reduction.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** Data Deep Dives: Data deep dives, are intensive and targeted analyses of specific HEDIS measures, that have enabled the Quality team to develop tailored, strategic interventions to improve member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region. HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes.	**Metric:** 5.1.1.6 Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders	**Description of Quality Initiative:** Emergency Department Care Coordination Program: Anthem Inc, in partnership with DMAS and PointClickCare, is utilizing PreManage, a platform that connects all MCO's with hospital emergency room departments across the state via a two-portal interface allowing for the real-time sharing of member level information that our care coordinators use daily to drive member care. Via this portal Care Coordinators, ER staff and	**Metric:** 5.3.1.2 Follow-Up After Emergency Department Visit for Substance Use Disorders

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	downstream providers share information, collaborate on care planning, and utilize actionable insights to improve outcomes for our members. Anthem Inc was identified as a forerunner in the initial full implementation and utilization of the product as well as playing a key role in the on boarding of downstream providers. Data Deep Dives: Data deep dives, are intensive and targeted analyses of specific HEDIS measures, that have enabled the Quality team to develop tailored, strategic interventions to improve member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region. HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes. HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan. HEDIS Telehealth Coding Bulletin: This is a bulletin intended to provide coding guidelines to health care providers for Telehealth visits. This is faxed/distributed to health care providers, by the health plan.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Description of Quality Initiative:** HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource	**Metric:** 5.3.1.4 Initiation and Engagement of Substance Use Disorder Treatment

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
Objective 5.3: Improve Outcomes for Members with Substance Use Disorders	for specific HEDIS Measures and Codes. HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan. HEDIS Telehealth Coding Bulletin: This is a bulletin intended to provide coding guidelines to health care providers for Telehealth visits. This is faxed/distributed to health care providers, by the health plan.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders	**Description of Quality Initiative:** Substance Use Disorder Medication Management with Medication Assisted Therapy: Provider Fax to promote continuity of Medication Assisted Therapy (MAT) through medication adherence and BH follow up care.	**Metric:** 5.3.1.5 Use of Pharmacotherapy for Opioid Use Disorder
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** Gold Card Program: Authorizations/registrations for specific CMHRS are waived for select proven quality providers. This serves as an incentive to our top-tier providers while motivating others to ensure they are providing quality services in an efficient manner. In addition, internal staffing opportunities are created for the effective management of those providers requiring extra attention. Gold card providers are forward thinking, creative and many are currently partnered with us on additional programs. They work closely with our care coordinators and are highly responsive to	**Metric:** 5.4.1.1 Follow-Up After Hospitalization for Mental Illness

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	assisting with emergent member needs. Data is reviewed quarterly to determine a provider's continued participation and support the ongoing development of an optimized network. HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes. HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan. HEDIS Telehealth Coding Bulletin: This is a bulletin intended to provide coding guidelines to health care providers for Telehealth visits. This is faxed/distributed to health care providers, by the health plan.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** Gold Card Program: Authorizations/registrations for specific CMHRS are waived for select proven quality providers. This serves as an incentive to our top-tier providers while motivating others to ensure they are providing quality services in an efficient manner. In addition, internal staffing opportunities are created for the effective management of those providers requiring extra attention. Gold card providers are forward thinking, creative and many are currently partnered with us on additional programs. They work closely with our care coordinators and are highly responsive to assisting with emergent member	**Metric:** 5.4.1.2 Follow-Up After Emergency Department Visit for Mental Illness

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	needs. Data is reviewed quarterly to determine a provider's continued participation and support the ongoing development of an optimized network. Emergency Department Care Coordination Program: Anthem Inc, in partnership with DMAS and PointClickCare, is utilizing PreManage, a platform that connects all MCO's with hospital emergency room departments across the state via a two-portal interface allowing for the real-time sharing of member level information that our care coordinators use daily to drive member care. Via this portal Care Coordinators, ER staff and downstream providers share information, collaborate on care planning, and utilize actionable insights to improve outcomes for our members. In partnership with Flourish Health members with SMI (serious mental illness) and SED (serious emotional disturbance) between the ages of 13 and 26 receive high touch in person support in combination with virtual therapeutic and psychiatric care empowering our members to achieve effective and lasting outcomes. Services offered include individual group and family therapy, medication management, mentorship and guidance, community resource navigation and 24/7 crisis support. In addition, a Fitbit wearable device with a mobile app to encourage a healthy lifestyle is provided. With the above programming in place	

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	engaged members will be supported and therefore better equipped to lead a quality life in the community with a decrease in IP BH admission and ED utilization. Data Deep Dives: Data deep dives, are intensive and targeted analyses of specific HEDIS measures, that have enabled the Quality team to develop tailored, strategic interventions to improve member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region. HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes. HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan. HEDIS Telehealth Coding Bulletin: This is a bulletin intended to provide coding guidelines to health care providers for Telehealth visits. This is faxed/distributed to health care providers, by the health plan.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes. HEDIS Telehealth Coding Bulletin: This is a bulletin intended to provide coding	**Metric:** 5.4.1.3 Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	guidelines to health care providers for Telehealth visits. This is faxed/distributed to health care providers, by the health plan.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** Data Deep Dives: Data deep dives, are intensive and targeted analyses of specific HEDIS measures, that have enabled the Quality team to develop tailored, strategic interventions to improve member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region.	**Metric:** 5.4.1.5 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** Data Deep Dives: Data deep dives, are intensive and targeted analyses of specific HEDIS measures, that have enabled the Quality team to develop tailored, strategic interventions to improve member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region.	**Metric:** 5.4.1.6 Metabolic Monitoring for Children and Adolescents on Antipsychotics
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** OB Practice Consultants meet with OBQIP providers in the OBQIP provider incentive program to close prenatal and postpartum gaps. Consultants encourage providers to refer members to 1-800-QuitNow or to the CM team for other resources. Care Coordinators and Case Managers educate members regarding the dangers of smoking and tobacco use, the different forms of tobacco use such as vaping, and the different	**Metric:** 5.4.1.7 Medical Assistance with Smoking and Tobacco Use Cessation

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	modalities for cessation, including support groups. mPulse Text Messages: Informative and/or educational text messages via mPulse to members regarding timely prenatal visits, as a reminder to make an appointment with their OB and educate members on tobacco cessation.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** Anti-Depressant New Start Behavioral Health Medication Management: Member: New Start Education: Analysis of pharmacy claims identify a new (first time) prescription for Depression medications: Member Live calls New Start education and Pharmacist outreach to members recently started on an anti-depressant medication to provide medication education, expectations, and address barriers to adherence. Data Deep Dives: Data deep dives, are intensive and targeted analyses of specific HEDIS measures, that have enabled the Quality team to develop tailored, strategic interventions to improve member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region.	**Metric:** 5.4.1.8 Antidepressant Medication Management
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** Data Deep Dives: Data deep dives, are intensive and targeted analyses of specific HEDIS measures, that have enabled the Quality team to develop tailored, strategic interventions to improve	**Metric:** 5.4.1.10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

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

Molina

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

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

Virginia QS Goals and Objectives	Molina's Quality Initiative	Performance Metric
Immunization, and Prevention Services for Members	support for member outreach and scheduling to new or existing patient to link members with providers as part of their care team, and coordination of care with our CM team with need is identified.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** MHI is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach. Molina partners with CVS to promote sharing of education materials to help members clearing understand the importance of timely medication refills and usage.	**Metric:** 5.1.1.7 Asthma Medication Ratio
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** MHI is working with individual provider/ provider groups to conduct monthly meetings, create a tactical workplan, share comprehensive gaps in care report, provide staffing support for member outreach when need is identified	**Metric:** 4.1.1.3 Childhood Immunization Status
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** MHI is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach. Target member list of members who have a gap for preventative screenings to help drive outreach efforts, promote timely referrals and to create better outcomes. Molina has revised and revamp preventative screening	**Metric:** Breast Cancer Screening **Metric:** Cervical Cancer Screening **Metric:** Colorectal Cancer Screening *Note: Not DMAS QS metrics.*

Virginia QS Goals and Objectives	Molina's Quality Initiative	Performance Metric
	materials to ensure accuracy and up to date information is shared	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** MHI is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, educate them on CPT II codes, provide them support for member outreach. Molina uses home lab kit to ensure members have adequate access to screenings, once the kit is received it is complemented by an outreach call from the diabetic educate offer support, resources and education with health management skills. Members are provided assistance with scheduling diabetic exam and receive a blood pressure cuff to check and monitor their blood pressure as part of the program. Members will also receive a curated meal box	**Metric:** 5.1.1.4 Comprehensive Diabetes Care Hemoglobin A1c (HbA1c) Control (<8.0%)
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** MHI is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach. Partner with network providers, VDH and schools to participate in immunization campaign, provide education and materials, incentives and school supplies.	**Metric:** 4.1.1.3 Childhood Immunization Status **Metric:** 4.1.1.4 Immunization for Adolescents **Metric:** 4.1.1.11 Lead Screening in Children
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Description of Quality Initiative:** MHI is working with BH provider groups to share data and identify opportunities for improvement such as	**Metric:** 5.3.1.2 – Follow up after Emergency Department visit for Alcohol and other drug

Virginia QS Goals and Objectives	Molina's Quality Initiative	Performance Metric
★ **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders ★ **Objective: 5.4:** Improve Behavioral Health and Developmental Services for Members	coding to ensure services are captured appropriately and timely to improve outcomes and reduce readmission. Molina host internal clinical rounds with the CMO and BH Medical Director, peer support, BH case management and TOC program to coordinate services for identified members, timely outreach, partner with BH providers to ensure timely referrals, monitor PointClickCare for diagnose and discharge data Target Pay for performance in progress to target BH providers for timely addressing BH quality measures in progress	Dependence Treatment – 7 and 30 days total **Metric:** 5.4.1.2 - Follow up after Emergency Department visit for Mental Illness – 7- and 30-days total **Metric:** 5.3.1.4 Initiation and Engagement for Alcohol and other drug Dependence Treatment
Goal 4: Strengthen the Health of Families and Communities ★ **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** MHI is working with both OB/GYN and network provider groups to conduct monthly meetings, send them gaps in care report for members in the prenatal measure, educate them on CPT II codes, provide them support for member outreach. Compliant members receive incentives for timely completion of their prenatal and postpartum visits. High Risk members are referred to the High Risk OB team to provide timely support, education and resources to ensure a healthy pregnancy. Molina uses Lucina Analytics a data tool in conjunction with the pregnancy dashboard, which identifies of pregnancy early,	**Metric:** 4.2.1.1 Prenatal and Postpartum Care

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

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

Optima

Table D-4—Optima's QS Quality Initiatives

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

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

United

Table D-5—United's QS Quality Initiatives

Virginia QS Goals and Objectives	United's Quality Initiative	Performance Metric
Goal 1: Enhance the Member Care Experience **Goal 2:** Promote Access to Safe, Gold-Standard Patient Care **Objective 1.2:** Improve Member Satisfaction **Objective 2.1:** Ensure Access to Care	**Description of Quality Initiative:** • *Dr. Chat*: The UHC Doctor Chat App provides 24/7/365 virtual care for UnitedHealthcare Community Plan members. UHC Doctor Chat provides a real time option for members in lieu of the ER and helps reduce avoidable readmissions by offering an after-hours option for patients to ask questions about their post-discharge plan. UHC Doctor Chat can address acute care, chronic care, mental health, women's health and more. • *Addition of major health system*: UHC added the Riverside Health System in the Tidewater region, expanding member care access to six hospitals and nearly 1k primary and specialty care physicians. Additionally, tying this system to value fosters highly engaged providers to service members. • *Member/Provider Satisfaction*: UHC monitors provider and member	**Metric 1.2.1.1:** Enrollees' Rating Q8-Rating of All Health Care **Metric 2.1.1.1:** Getting Care Quickly Q6 **Metric 2.1.1.3:** Getting Needed Care

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

VA Premier

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

Virginia QS Goal and Objective	VA Premier's Quality Initiative	Performance Metric
Goal 1: Enhance the Member Care Experience **Objective 1.2**: Improve Member Satisfaction	**Description of Quality Initiative:** UHS Telehealth Program This program expands telehealth access to BH follow-up treatment to members who are discharged from ED and inpatient stays; and, for members at Sentara Hospitals, the hospital staff in the ED rooms can use this telehealth program to schedule appointments for Optima and legacy Virginia Premier members in ED.	**Metric:** 1.2.1.1 Enrollees' Ratings Q8-Rating of all Health Care
Goal: 2: Promote Access to Safe, Gold-Standard Patient Care **Objective 2.1**: Ensures Access to Care **Objective 2.2:** Promote Patient Safety **Objective 2.3:** Promote Effective Communication and Care Coordination	**Description of Quality Initiative:** Peer Support Specialist Program This program utilizes the real-life experiences of our peer support specialists to promote recovery and foster well-being among members with mental health and substance use disorders. The peer support specialists use recovery-oriented goals with members to help promote improvements in confidence, empowerment, and functioning. This approach to treatment supports the engagement of members through person-centered assessment and self-directed treatment planning that aims to increase members' social support systems, hopefulness for recovery, awareness of early warning signs of problems, and improvement in	**Metric:** 2.1.1.3 Getting Needed Care

Virginia QS Goal and Objective	VA Premier's Quality Initiative	Performance Metric
	taking responsibility for wellness and their recovery.	
Goal 3: Support Efficient and Value-Driven Care **Objective 3.1**: Focus on Paying for Value **Objective 3.2:** Promote Efficient Use of Program Funds	**Description of Quality Initiative:** Community Stabilization Team The goal of Community Stabilization Services is to stabilize the individual within their community and assist the individual and natural support system during the following: 1) initial Mobile Crisis Response and entry into an established follow-up service at the appropriate level of care if the appropriate level of care is identified but not immediately available for access 2) transitional step-down from a higher level of care if the next level of care is identified but not immediately available or 3) diversion from a higher level of care. Community Stabilization care coordinators link/transition the individual to follow-up services and other needed resources to stabilize the individual within the community.	**Metric:** 3.2.1.1 Monitor Medical Loss Ratio
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1**: Improve Outcomes for Members with Chronic Conditions **Objective 5.2:** Improve Outcomes for Nursing Home Eligible Members **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders	**Description of Quality Initiative:** Case Conferencing with Homeless Shelters Established a process and a regular schedule with the Greater Richmond Continuum of Care (CoC) for homelessness, to conduct case conferencing on members who enter the shelter system	**Metric:** 5.1.1.4 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) Metric: 5.2.1.1 Use of High-Risk Medications in Older Adults (Elderly **Metric:** 5.3.1.4 Initiation and Engagement of Substance Use Disorder Treatment **Metric:** 5.4.1.3 Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

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

Appendix E. Assessment of Follow-Up on Prior Recommendations

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

Introduction

Regulations at §438.364 require an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity (described in §438.310[c][2]) has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. This appendix provides a summary of the follow-up actions per activity that DMAS and the MCOs reported completing in response to HSAG's SFY 2022–2023 recommendations. Please note, content included in this section is presented verbatim as received from the MCOs and has not been edited or validated by HSAG.

Scoring

In accordance with CMS guidance, HSAG used a three-point rating system. The response to each EQRO recommendation was rated as *High*, *Medium,* or *Low* according to the criteria below.

High indicates *all* of the following:

1. DMAS or the MCO implemented new initiatives or revised current initiatives that were applicable to the recommendation.
2. Performance improvement directly attributable to the initiative was noted *or* if performance did not improve, DMAS or the MCO identified barriers that were specific to the initiative.
3. DMAS or the MCO included a viable strategy for continued improvement or overcoming identified barriers.

A rating of *high* is indicated by the following graphic:

Medium indicates one or more of the following:

1. DMAS or the MCO continued previous initiatives that were applicable to the recommendation.
2. Performance improvement was noted that may or may not be directly attributable to the initiative.
3. If performance did not improve, DMAS or the MCO identified barriers that may or may not be specific to the initiative.
4. DMAS or the MCO included a viable strategy for continued improvement or overcoming barriers.

A rating of *medium* is indicated by the following graphic:

Low indicates one or more the following:

1. DMAS or the MCO did not implement an initiative or the initiative was not applicable to the recommendation.
2. No performance improvement was noted *and* DMAS or the MCO did not identify barriers that were specific to the initiative.
3. DMAS or the MCO's strategy for continued improvement or overcoming identified barriers was not specific or viable.

A rating of *low* is indicated by the following graphic:

Table E-1—Prior Year Recommendations and Responses—CCC Plus (MLTSS) Program Overall

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

Recommendation
• DMAS included the measure Follow-Up After Emergency Department Visit for Substance Use in its PWP which provides an incentive to MCOs to increase performance and close gaps.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure:** Follow-Up After Emergency Department Visit for Substance Use **MY 2021:** 7-Day: 11.44% 30-Day: 19.98% **MY 2022:** 7-Day: 14.55% 30-Day: 22.57%
Identify any barriers to implementing initiatives: The ramifications of the COVID-19 PHE continued to be a barrier to improving performance to address the HSAG recommendation.
HSAG Assessment: 

Recommendation		
Goal 4: Strengthen the Health of Families and Communities	**Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Metric 4.1.1.4:** Immunizations for Adolescents **Metric 4.2.1.4:** Well-Child Visits in the First 30 Months of Life
HSAG Recommendation: To improve program-wide performance in support of Objective 4.1 and 4.2 and improve preventive services and well-child visits for members under the age of 21 years, HSAG recommends DMAS: • Require the MCOs to identify best practices for ensuring children receive all preventive vaccinations and well-child services according to recommended schedules. • Require the MCOs to conduct a root cause analysis to identify barriers that their members are experiencing in accessing well-child and preventive care and services. • Require the MCOs to identify best practices to improve care and services according to the Bright Futures guidelines.		
DMAS' Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure:** Immunizations for Adolescents **MY 2021:** 70.70%; 30.52% **MY 2022:** 79.96%; 30.96%		

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

Recommendation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.1:** Improve Outcomes for Members With Chronic Conditions	**Metric 5.1.1.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
HSAG Recommendation: To improve program-wide performance in support of Objective 5.1 and improve outcomes for members with chronic conditions, HSAG recommends DMAS: • Require that the MCOs conduct a root cause analysis to determine why members are not maintaining their diabetes care. • Upon identification of a root cause, require the MCOs to implement appropriate interventions to improve the performance related to proper diabetes management. • Require the MCOs to identify best practices to improve care and services according to chronic care recommended guidelines.		
DMAS' Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • DMAS included a Comprehensive Diabetes Care measure that includes HbA1c Poor Control (>9.0) in its PWP which provides an incentive to MCOs to increase performance and close gaps.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) MY 2021: 51.42% MY 2022: 47.39%		
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.		
HSAG Assessment: 		

MCOs' Follow-Up on Prior Year Recommendations

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

Aetna

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

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

Recommendation—Performance Improvement Projects		
HSAG Assessment: 		
Recommendation—Performance Measure Validation		
Goal 3: Support Efficient and Value-Driven Care **Goal 5**: Providing Whole-Person Care for Vulnerable Populations **Goal 2:** Promote Access to Safe, Gold-Standard Patient Care **Goal 4:** Strengthen the Health of Families and Communities	**Objective 3.1** Focus on Paying for Value **Objective 5.1** Improve Outcomes for Members with Chronic Conditions **Objective 2.1** Ensure Access to Care **Objective 4.1** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Metric 3.1.1.5:** Ambulatory Care: Emergency Department (ED) Visits **Metric 5.1.1.6:** Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years **Metric 5.1.1.5:** Controlling High Blood Pressure **Metric 2.1.1.12:** Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 18 and Older **Metric 2.1.1.9:** Breast Cancer Screening **Metric 2.1.1.6:** Cervical Cancer Screening **Metric 4.1.1.3:** Childhood Immunization Status **Metric 4.1.1.4:** Immunizations for Adolescents **Metric 4.1.1.9:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Aetna: • *Ambulatory Care—ED Visits—Total* • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening* • *Use of Imaging Studies for Low Back Pain* • *Childhood Immunization Status—Combination 3* • *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* • *Controlling High Blood Pressure*		

Recommendation—Performance Measure Validation
• *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* • *Use of Opioids From Multiple Providers—Multiple Pharmacies* and *Multiple Prescribers and Multiple Pharmacies* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* **Recommendation:** HSAG recommends that Aetna: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Taking Care of Children, Use of Opioids, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Aetna analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
MCO's Response
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Per HSAG's recommendation Aetna Better Health of Virginia continues to develop new and monitor current initiatives and interventions. Specifically, the Health Plan conducted a health equities analysis to evaluate our membership population. The Plan also designated measure subject matter experts (SMEs) to complete deep dives into race, ethnicity, language, age group, and ZIP code for various measures to drive initiatives. The Health Plan also initiated the use of a Social Determinants of Health (SDOH) software application to assist in identifying specific needs in each region. The health plan engaged providers to increase coding and electronic data to capture services rendered One member initiative implemented as a result of the analysis, includes targeted outreach to members aged 18-21 who were identified as non-compliant with preventative healthcare. One provider intervention included incentivizing for use of CPT2 codes.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure** *Ambulatory Care ED Visits—Total* 2021: 89.52 2022: 1083.05 **Measure:** *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* 2021: 39.24% 2022: 39.18% **Measure:** *Breast Cancer Screening* 2021: 46.10% 2022: 48.43% **Measure:** *Cervical Cancer Screening* 2021: 41.12% 2022: 47.93% **Measure:** *Use of Imaging Studies for Low Back Pain* 2021: 66.95%

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

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

Recommendation—Member Experience of Care Survey—Child Medicaid
Conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that Aetna focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time.
MCO's Response
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Per HSAG's recommendation, Aetna Better Health of Virginia conducted a root causes analysis that focused on low performance related to Rating of Health Plan, All Health Care, and Specialist Seen Most Often. Based on the identified root causes, the Health Plan expanded its existing HEDIS and CAHPS workgroup to include additional member and provider facing staff. To identify potential opportunities, the Workgroup conducted deep dives into the barriers related to members not having a PCP, members ability to get urgent and routine appointments as needed, getting needed information from member services, and access to highly rated providers or specialists. Initiatives to improve, include working with providers to encourage same-day scheduling, increasing utilization of telehealth services, improving communication between providers, and working with members to increase use of patient-centered medical homes and member/patient communication with providers. • Additional activities implemented included developing talking prompts during committees to solicit feedback and recommendations for improving access to care and communication between providers and settings, conducting an ad hoc appointment survey and implementing corrective action plans (CAPs) for those providers not meeting contractual requirements. The Plan also deployed a dedicated team to meet with providers to discuss performance related to access and communication and learned many provider offices are experiencing significant staff reduction. The Plan also conducted a CAHPS presentation at member advisory committee (MAC) meetings to educate members about CAHPS and discuss additional resources, including the 24-hour Nurse Line and telehealth.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure:** *Rating of All Health Plan—CCC Plus* Adult MY2021: 63.2% Adult MY2022: 67.8% Child MY2021: 66.1% Child MY2022: 63.9% **Measure:** *Rating of All Health Care—CCC Plus* Adult MY2021: 53.6% Adult MY2022: 51.5% Child MY2021: 62.5% Child MY2022: 62.3% **Measure:** *Rating of Specialist—CCC Plus* Adult MY2021: 73.4%

Recommendation—Member Experience of Care Survey—Child Medicaid
Adult MY2022: 71.1% Child MY2021: 64.5% Child MY2022: 60.0%
Identify any barriers to implementing initiatives: Aetna Better Health of Virginia experienced challenges related to meeting or talking with some provider office staff due to many provider offices experiencing a significant decrease in office staff and/or hours.
HSAG Assessment: 

Recommendation—Member Experience of Care Survey—Child Medicaid		
Goal 1: Enhance the Member Care Experience	**Objective 1.2:** Ensure Access to Care	**Metrics 2.1.1.1:** Getting Care Quickly Q6 **Metric 2.1.1.3** Getting Needed Care
Weakness: Aetna's 2022 top-box scores were statistically significantly lower than the 2021 top-box scores for three measures: *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Getting Care Quickly*. **Recommendation:** HSAG recommends that Aetna: Conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that Aetna focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Per HSAG's recommendation, Aetna Better Health of Virginia conducted a root causes analysis that focused on low performance related to Rating of Health Plan, All Health Care, and Specialist Seen Most Often. Based on the identified root causes, the Health Plan expanded its existing HEDIS and CAHPS workgroup to include additional member and provider facing staff. To identify potential opportunities, the workgroup conducted deep dives into the barriers related to members not having a PCP, members ability to get urgent and routine appointments as needed, getting needed information from member services, and access to highly rated providers or specialists. Initiatives to improve, include working with providers to encourage same-day scheduling, increasing utilization of telehealth services, improving communication between providers, and working with members to increase use of patient-centered medical homes and member/patient communication with providers. • Additional activities implemented included developing talking prompts during committees to solicit feedback and recommendations for improving access to care and communication between		

Recommendation—Member Experience of Care Survey—Child Medicaid
providers and settings, conducting an ad hoc appointment survey and implementing CAPs for those providers not meeting contractual requirements. The Plan also deployed a dedicated team to meet with providers to discuss performance related to access and communication and learned many provider offices are experiencing significant staff reduction. The Plan also conducted a CAHPS presentation at MAC meetings to educate members about CAHPS and discuss additional resources, including the 24-hour Nurse Line and telehealth.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure:** *Rating of All Specialist Seen Most Often—CCC Plus* Adult MY2021: 73.4% Adult MY2022: 71.1% Child MY2021: 64.5% Child MY2022: 60.0% **Measure:** *Getting Needed Care—CCC Plus* Adult MY2021: 82.6% Adult MY2022: 80.5% Child MY2021: 81.8% Child MY2022: 81.7% **Measure:** *Getting Care Quickly—CCC Plus* Adult MY2021: 82.4% Adult MY2022: 83.0% Child MY2021: 82.9% Child MY2022: 85.6%
Identify any barriers to implementing initiatives: Aetna Better Health of Virginia experienced challenges related to meeting or talking with some provider office staff due to many provider offices experiencing a significant decrease in office staff and/or hours.
HSAG Assessment: 

HealthKeepers

Table E-3—Prior Year Recommendations and Responses—HealthKeepers

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

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

Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for HealthKeepers:

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

Recommendation: HSAG recommends that HealthKeepers:

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

MCO's Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

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

Recommendation—Performance Measure Validation
Anthem Virginia departments: QM, CM, Maternal Child Health Services, Managed Long Term Supports and Services, Provider Experience, BH, and included the plan Medical Director and BH Medical Director. This RCA work group analyzed rates and performed a root cause analysis of HEDIS measures. The QM department includes the Director of QM, Clinical Quality Program Managers/Administrators and Quality Specialists. The following initiatives were implemented because of the root cause analysis for Ambulatory Care—ED Visits—Total: • The Utilization Management Team implemented a Case Management Trigger list to identify members to refer for Case Management/CCC Plus Care Coordination • Implemented adding members who identified as outliers on the Inpatient daily census to weekly complex rounds capturing the members "clinical picture". • Established a Clinical Efficiency process that targets members that have been admitted to the hospital. The following initiatives were implemented because of the root cause analysis for Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total: • Provider Outreach-targets PCP's with members who have filled an antibiotic prescription > 50% within 3 days of diagnosis of bronchitis/bronchiolitis. The communication addresses coding tips, member antibiotic awareness educational video QR code and continuing education opportunities. The following initiatives were implemented because of the root cause analysis for Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia: • Data Deep Dives: Data deep dives, are intensive and targeted analyses of specific HEDIS measures, that have enabled the Quality team to develop tailored, strategic interventions to improve member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region. The following initiatives were implemented because of the root cause analysis for Cervical Cancer Screening: • Take Action Initiatives-these are initiatives between Anthem and national organizations to help reduce health disparities in African American and Latino communities. These websites include interactive content, cultural and trusted resources, and specific actions that can be taken to improve a member's health. Take Action for Health | Home • A SMS text message to increase awareness of services available to support their health care needs. Members are encouraged to complete the appropriate screening in a timely manner. The following initiatives were implemented because of the root cause analysis for Childhood Immunization Combo 3: • A SMS text message to increase awareness of services available to support their health care needs. Members are encouraged to complete the appropriate immunizations in a timely manner. • Data Deep Dives: Data deep dives, are intensive and targeted analyses of specific HEDIS measures, that have enabled the Quality team to develop tailored, strategic interventions to

Recommendation—Performance Measure Validation

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

- EPSDT Co-Branding Initiative with High Volume Providers: Partnering with high volume providers to distribute reminders for overdue services. Co-Branded Birthday Reminders are sent out approximately 45-60 days before the members birthday to remind them to go in for services that are due. If after 90days from the member's birthday they have not had their Well Visit, we will send out another reminder to get services completed.
- Age Out Immunization Outreach: Targets members who need immunizations who have aged out AND members who are about to age out to get immunized in a timely manner.
- Partnering with Department of Social Services (DSS) offices across the state to ensure new Foster Care members complete a doctor's visit within 60 days of enrollment.

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

- Age Out Immunization Outreach: Targets members who need immunizations who have aged out AND members who are about to age out to get immunized in a timely manner.
- Partnering with DSS offices across the state to ensure new Foster Care members complete a doctor's visit within 60 days of enrollment.

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

- In partnership with Flourish Health members with SMI (serious mental illness) and SED (serious emotional disturbance) between the ages of 13 and 26 receive high touch in person support in combination with virtual therapeutic and psychiatric care empowering our members to achieve effective and lasting outcomes. Services offered include individual group and family therapy, medication management, mentorship and guidance, community resource navigation and 24/7 crisis support. In addition, a Fitbit wearable device with a mobile app to encourage a healthy lifestyle is provided. With the above programming in place engaged members will be supported and therefore better equipped to lead a quality life in the community with a decrease in IP BH admission and ED utilization.
- Data Deep Dives: Data deep dives, are intensive and targeted analyses of specific HEDIS measures, that have enabled the Quality team to develop tailored, strategic interventions to improve member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region.

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

- Data Deep Dives: Data deep dives, are intensive and targeted analyses of specific HEDIS measures, that have enabled the Quality team to develop tailored, strategic interventions to improve member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region.
- Provider education via fax blast based on providers driving non-compliance.

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

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

Recommendation—Performance Measure Validation

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

The barriers identified for Childhood Immunization Combo 3 included:

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

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

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

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

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

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

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

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

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

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

Recommendation—Member Experience of Care Survey—Child Medicaid		
Goal 1: Enhance the Member Care Experience	**Objective 1.2**: Improve Member Satisfaction	**Metric** 1.2.1.1: Enrollees' Ratings Q8-Rating of all Health Care **Metric** 1.2.1.2: Rating of Personal Doctor
Weakness: HealthKeepers' 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for three measures, *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. **Recommendation:** HSAG recommends that HealthKeepers: conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that HealthKeepers continue to monitor the measures to ensure significant decreases in scores over time do not occur.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): The Anthem Virginia CAHPS Work Group, chaired by the Director of QM, consists of representatives from the following areas: Quality Management, Medicaid National Quality & Accreditation, Customer Care (Call Center), Government and Business Division (GBD) Quality Analytics, Provider Experience, and Medical Management meet monthly to review, analyze, and determine barriers and opportunities for improvement. The Anthem Virginia CAHPS Work Group held monthly meetings and performed a root cause analysis utilizing brainstorming techniques to identify the key drivers for member experience regarding the CAHPS questions. The survey vendor identified the rating of personal doctor to be the highest key driver for member satisfaction in the child survey followed by ease of getting needed care, tests, or treatment, got an appointment for urgent care as soon as needed, customer service provided information or help, and rating of specialist seen most often. The following initiatives were implemented because of the root cause analysis:		

Recommendation—Member Experience of Care Survey—Child Medicaid
• CAHPS Proxy Survey- after a review of the weekly claims data, a member outreach initiative is conducted to obtain their feedback regarding recent visits. Metrics are in place to avoid multiple outreaches within 90 days. The member feedback is shared with the providers. • Revamp of Provider Education material - Elevance online learning course for Providers: Provider and community organization facing staff promote the "What Matters Most" education material. • CAHPS playbook launched for education and resource for internal associates.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure** Enrollees' Ratings Q8-Rating of all Health Care 2021: 57.3% 2022: 61.5% **Measure** Rating of Personal Doctor 2021: 69.8% 2022: 69.2%
Identify any barriers to implementing initiatives: The barriers identified during the root cause analysis were: • Physicians and office staff shortages • Limited appointment availability • Lack of transportation • Physician offices no longer accepting new patients. • Members may not be informed of the alternatives to urgent care. • Physicians are not adhering to after-hours availability requirements. • Physicians do not communicate clearly. • Language barriers • Assigned doctor not available. • Generation gap between patient and physician. • Providers rush visits and take too long to see the patient. • Lack of provider awareness of tools available and how to use.
HSAG Assessment: 

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

Recommendation—Member Experience of Care Survey—Child Medicaid
Conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that HealthKeepers continue to monitor the measures to ensure significant decreases in scores over time do not occur.
MCO's Response
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): The Anthem Virginia CAHPS Work Group, chaired by the Director of QM, consists of representatives from the following areas: Quality Management, Medicaid National Quality & Accreditation, Customer Care (Call Center), GBD Quality Analytics, Provider Experience, and Medical Management meet monthly to review, analyze, and determine barriers and opportunities for improvement. The Anthem Virginia CAHPS Work Group held monthly meetings and performed a root cause analysis utilizing brainstorming techniques to identify the key drivers for member experience regarding the CAHPS questions. The survey vendor identified the rating of personal doctor to be the highest key driver for member satisfaction in the child survey followed by ease of getting needed care, tests, or treatment, got an appointment for urgent care as soon as needed, customer service provided information or help, and rating of specialist seen most often. The following initiatives were implemented because of the root cause analysis: • CAHPS Proxy Survey- after a review of the weekly claims data, a member outreach initiative is conducted to obtain their feedback regarding recent visits. Metrics are in place to avoid multiple outreaches within 90 days. The member feedback is shared with the providers. • Revamp of Provider Education material - Elevance online learning course for Providers: Provider and community organization facing staff promote the "What Matters Most" education material. • CAHPS playbook launched for education and resource for internal associates.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure** Rating of Personal Doctor 2021: N/A_____% 2022: N/A_____%
Identify any barriers to implementing initiatives: The barriers identified during the root cause analysis were: • Physicians and office staff shortages • Limited appointment availability • Lack of transportation • Physician offices no longer accepting new patients. • Members may not be informed of the alternatives to urgent care. • Physicians are not adhering to after-hours availability requirements. • Physicians do not communicate clearly. • Language barriers

Recommendation—Member Experience of Care Survey—Child Medicaid
• Assigned doctor not available. • Generation gap between patient and physician. • Providers rush visits and take too long to see the patient. • Lack of provider awareness of tools available and how to use.
HSAG Assessment: 

Molina

Table E-4—Prior Year Recommendations and Responses—Molina

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

Recommendation—Performance Improvement Projects		
		
Recommendation—Performance Improvement Projects		
Goal 3: Support Efficient and Value-Driven Care	**Objective 3.1:** Focus on Paying for Value	**Metric** 3.1.1.5: Ambulatory Care: Emergency Department (ED) Visits
Weakness: For the *Follow-Up After Discharge* PIP, the MCO received a *Low Confidence* rating related to *Partially Met* validation scores for a critical element for not defining the numerator and denominator correctly for the performance indicator and not referencing the measure specifications represented when defining the eligible population and performance indicator. **Recommendation:** HSAG recommends that Molina: Ensure it accurately documents any specifications followed for the PIP. The MCO should ensure it addresses all initial validation feedback and makes all revisions.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Re-evaluation of PIP designs to create a more integrated approach. • Weekly data review to ensure accuracy and to track and monitor activities to identify effectiveness early		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure:** HEDIS AMB-ED 2021: 92.26 2022: 1,132.40		
Identify any barriers to implementing initiatives: N/A		
HSAG Assessment: 		
Recommendation—Performance Measure Validation		
Goal 3: Support Efficient and Value-Driven Care **Goal 2:** Promote Access to Safe, Gold-Standard Patient Care	**Objective 3.1:** Focus on Paying for Value **Objective 2.**1 Ensure Access to Care **Objective 4.**1 Improve the Utilization of Wellness,	**Metric** 3.1.1.5**:** Ambulatory Care: Emergency Department (ED) Visits-Total **Metric 2.1.1.12:** Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis **Metric 2.1.1.9** Breast Cancer Screening

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

Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Molina:

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

Recommendation: HSAG recommends that Molina:

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

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

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

Recommendation—Member Experience of Care Survey—Child Medicaid		
Goal 1: Enhance the Member Care Experience **Goal 2:** Promote Access to Safe, Gold-Standard Patient Care	**Objective 1.2:** Improve Member Satisfaction **Objective 2.1:** Ensure Access to Care	**Metric**1.2.1.1: Enrollees' Ratings Q8-Rating of all Health Care **Metric** 2.1.1.1: Getting Care Quickly Q6 **Metric** 2.1.1.3: Getting Needed Care
Weakness: Molina's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national average for two measures: *Rating of Health Plan* and *Getting Needed Care*. **Recommendation:** HSAG recommends that Molina: Conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that Molina focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Identification of key drivers • Member education on tips to prepare for doctor's visit. • Support providers and their members by informing of all up-to-date tools, resources and guides that address clinical needs and self-management topics. Leverage provider and member newsletters. • Build provider partnerships through monthly meetings to facilitate a targeted approach in new visit and f/u appointment scheduling		

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

Optima

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

Recommendation—Performance Measure Validation		
Goal 3: Support Efficient and Value-Driven Care	**Objective 3.1:** Focus on Paying for Value	**Measure 3.1.1.5:** Ambulatory Care: Emergency Department (ED) Visits
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima: • ***Ambulatory Care - ED Visits -Total*** **Recommendation:** HSAG recommends that Optima: • Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, Use of Opioids, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		

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

Recommendation—Performance Measure Validation
2021: 83.13 2022: 1063.44
Identify any barriers to implementing initiatives: • Need a more targeted way of highlighting LANE visits with providers • Members continue to need education on when to use the Emergency Department versus going to their Primary Care Provider (PCP)
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 4: Strengthen the Health of Families and Communities	**Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Metric 4.1.1.3:** Childhood Immunization Status
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima: • ***Childhood Immunization Status - Combination 3*** **Recommendation:** HSAG recommends that Optima: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Childhood Immunization Incentive Program • Immunization Health Fairs across the State • HEDIS Blitz • Provider educational Outreach • Data from VIIS and Health Fair Capture is being used to close Gaps. Members are referred to Case Management when appropriate • A dedicated full-time employee to support EPSDT • Partnership with the Virginia Department of Health to increase access to immunizations and provide education • Quality Measure Improvement Committee (QMIC) re-established – this committee identifies business owners of measures and documents all interventions.		

Recommendation—Performance Measure Validation
• NCQA PHM Standards and Audit tools purchased to perform a comprehensive population health assessment to include but not limited to SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code, etc. A PWP Team was established to monitor and track data trends with this measure and alert the organization when rates are dropping.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: Childhood Immunization Status - Combination 3** 2021: 54.65% 2022: 73.97%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 2: Promote Access to Safe, Gold-Standard Patient Care	**Objective:** Ensure Access to Care	**Metric 2.1.1.9:** Breast Cancer Screening
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima: • ***Breast Cancer Screening*** **Recommendation:** HSAG recommends that Optima: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Perform live outreach calls to discuss the importance of breast cancer screening and remind members they are due for a mammogram • Live call outreach to members advising the importance of obtaining mammogram • Pop Care Team sends letters to members with multiple gaps		

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

Recommendation—Performance Measure Validation		
Goal 2: Promote Access to Safe, Gold-Standard Patient Care	**Objective 2.1:** Ensure Access to Care	**Metric 2.1.1.6:** Cervical Cancer Screening
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima: • ***Cervical Cancer Screening*** **Recommendation:** HSAG recommends that Optima: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Collaborate with Health Prevention to send out annual reminders regarding screenings • Incentive provided to member for completing gap in care and obtaining preventative care • Implemented targeted campaigns around cancer screenings • Quality Measure Improvement Committee (QMIC) re-established – this committee identifies business owners of measures and documents all interventions.		

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

Recommendation—Performance Measure Validation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.1:** Improve Outcomes for member with Chronic Conditions	**Metric 5.1.1.4:** Comprehensive Diabetes Care Hemoglobin Control (<8%)
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima: • ***Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*** **Recommendation:** HSAG recommends that Optima: Conduct a root cause analysis or focus study as it relates to these PMs within the Access to Care, Children's Preventive Care, BH, Women's Health, and Care for Chronic Conditions domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and results of any root cause analysis or focus groups to identify opportunities to reduce any disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		

MCO's Response
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented and any activities still underway to address the finding that resulted in the recommendation): • Diabetic Eye Exam incentive program • EMMI Manager utilization for educational videos • Prealize data utilized to identify members to refer to CM • CM utilization of Tableau care gap report when engaging members • CM documentation of care gap information received from members in Symphony/JIVA • Pop Care Diabetic Eye Exam campaign • BioIQ at-home A1c program • Focus Care In-Home A1c testing

Recommendation—Performance Measure Validation
• HEDIS 4th QTR Push CM member outreach • Diabetic Eye Exam article for member newsletter • Conducted a data analysis of care gaps by region to determine if any possible trends in barriers existed, no trends were noted • Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need • Retina Labs: Clinic-based and in-home tele-retinal screening solution for early detection of diabetic retinopathy in diabetic members. This will help close critical diabetes care gaps and improve health outcomes for members. Implementation target of Q4 2022 • Dario: The Dario Pilot covers 1,500 Optima Health Plan Medallion 4.0 and CCC+ members in the Dario Type 2 Diabetes program. The solution provides adaptive, personalized member experiences to drive behavior change through evidence-based interventions, intuitive, clinically proven digital tools, high-quality software, and coaching to encourage individuals to improve their health and sustain meaningful outcomes. If the pilot proves effective at closing Type 2 Diabetes care gaps, it will be scaled to include all eligible members • Population Health Assessment work group was established 7/2022. • NCQA standards and tools purchased to perform a comprehensive population health assessment to include but not limited to: SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code, etc. Population Health Assessment to be completed 7/2023
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: *Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)*** 2021: 61.80% 2022: 52.31%
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: *Eye Exam (Retinal) Performed*** 2021: 48.18% 2022: 51.58%
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: *Blood Pressure Control (<140/90 mm Hg)*** 2021: 44.28% 2022: 54.74%
Identify any barriers to implementing initiatives: • No barriers Identified
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Metric 5.1.1.5:** Controlling High Blood Pressure

Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima:

- ***Controlling High Blood Pressure***

Recommendation: HSAG recommends that Optima:

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

MCO's Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Chronic Care Management completes assessments for members who have diabetes. This assessment is conducted telephonically. Equipment and/or supplies to help manage members' care are provided such as a glucometer, blood pressure cuff, or scale, if needed
- Members are sent written education materials to reinforce how to best manage diabetes
- Incentive provided to member for completing gap in care and obtaining preventative care
- Quality Measure Improvement Committee (QMIC) re-established – this committee identifies business owners of measures and documents all interventions.

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

PMV results showed:

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

2021: 48.42%

2022: 51.58%

Identify any barriers to implementing initiatives:

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

HSAG Assessment:

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

Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima:

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

Recommendation: HSAG recommends that Optima:

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

MCO's Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

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

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

PMV results showed:

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

2021: 61.90%

2022: 80.20%

Identify any barriers to implementing initiatives:

No barrier identified

HSAG Assessment:

Recommendation—Performance Measure Validation


Recommendation—Performance Measure Validation		
Goal 4: Strengthen the Health of Families and Communities	**Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Metric 4.1.1.4:** Immunizations for Adolescents

Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima:

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

Recommendation: HSAG recommends that Optima:

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

MCO's Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

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

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

PMV results showed:

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

2021: 69.19%

2022: 72.04%

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

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

Recommendation—Performance Measure Validation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.4:** Improve Behavioral Health and Development of Services for Members	**Metric 5.4.1.6:** Metabolic Monitoring for Children and Adolescents on Antipsychotics
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima: • ***Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing - Total*** **Recommendation:** HSAG recommends that Optima: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Clinical coordination program for those members aged 6-12 who are taking an atypical antipsychotic • Care Coordination letters are sent to the member's PCP and prescriber of atypical antipsychotic • The goal is to ensure appropriate clinical monitoring of the member is being completed and reported • Team meetings are held monthly to discuss the program, suggest any improvements, and review data results		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: *Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing - Total***		

Recommendation—Performance Measure Validation		
2021: 39.09% 2022: 46.56%		
Identify any barriers to implementing initiatives: An influx of BH patients seeking care through emergency departments (EDs).		
HSAG Assessment: 		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.1**: Improve Outcomes for Members with Chronic Conditions	**Metric:** Pharmacotherapy Management of COPD Exacerbation (PCE) *Note: Not a Quality Strategy metric.*
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima: • ***Pharmacotherapy Management of COPD Exacerbation - Bronchodilator* and *Systemic Corticosteroid*** **Recommendation:** HSAG recommends that Optima: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Ensure appropriate clinical monitoring of the member is being completed and reported • Team meetings are held monthly to discuss the program, suggest any improvements, and review data results • Clinical program to help adherence and therapy completeness • Care Coordinators reach members to educate them on side effects and provide any additional support needed		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: *Pharmacotherapy Management of COPD Exacerbation - Bronchodilator*** 2021: 58.05% 2022: 67.60%		
• **Measure: *Pharmacotherapy Management of COPD Exacerbation - Bronchodilator-Systemic Corticosteroid***		

Recommendation—Performance Measure Validation
2021: 46.87% 2022: 56.84%
Identify any barriers to implementing initiatives: Member education on importance of taking prescribed medication
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Metric 5.4.1.5:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima:

- ***Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics - Total***

Why the weakness exists:

Recommendation: HSAG recommends that Optima:

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

MCO's Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Ensure appropriate clinical monitoring of the member is being completed and reported
- Team meetings are held monthly to discuss the program, suggest any improvements, and review data results
- Clinical program to help adherence and therapy completeness
- Care coordinators reach members to educate them on side effects and provide any additional support needed

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

PMV results showed:

- **Measure*: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics - Total***

Recommendation—Performance Measure Validation
2021: 36.62% 2022: 36.25%
Identify any barriers to implementing initiatives: • Member COPD self-management may not follow recommendations, contribute to exacerbations, and avoid seeking medical interventions until in severe clinical distress • Members may not comply with the ongoing prescribed medication regimen, or non-compliance may exist due to economic stress may be affecting members' ability to obtain or refill medications due to financial hardship
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders	**Metric:** Use of Opioids from Multiple Providers (UOP) *Note: Not a Quality Strategy metric.*
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima: • ***Use of Opioids From Multiple Providers - Multiple Prescribers*** **Recommendation:** HSAG recommends that Optima: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		

MCO's Response
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Ensure appropriate clinical monitoring of the member is completed and reported • Team meetings are held monthly to discuss the program, suggest any improvements, and review data results • Clinical program to help adherence and therapy completeness • Care Coordinators reach members to educate them on side effects and provide any additional support needed
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed:

Recommendation—Performance Measure Validation
• **Measure:** ***Use of Opioids From Multiple Providers - Multiple Prescribers*** 2021: 2.46% 2022: 1.95%
Identify any barriers to implementing initiatives: • Member COPD self-management may not follow recommendations, contribute to exacerbations, and avoid seeking medical interventions until in severe clinical distress • Members may not comply with the ongoing prescribed medication regimen, or non-compliance may exist due to economic stress may be affecting members' ability to obtain or refill medications due to financial hardship
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 4: Strengthen the Health of Families and Communities	**Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Metric 4.1.1.9:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima: • ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile - Total*, *Counseling for Nutrition - Total*, and *Counseling for Physical Activity - Total*** **Recommendation:** HSAG recommends that Optima: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Incentive Program, Back to School Fairs across the State • Well Child Campaigns • Educational Outreach. Data utilized from VIS and Health Fair Capture to close Gaps and refer to Case Management. FTE for EPSDT • NCQA PHM Standards and Audit tools purchased to perform a comprehensive population health assessment include but are not limited to SDOH, barriers to care, preferences regarding		

Recommendation—Performance Measure Validation
healthcare, clinical communications, and health disparities including race/ethnicity, age, zip code, etc. • Well Child & Immunization Campaigns
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure:** ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile - Total*** 2021: 63.02% 2022: 63.75%
• **Measure:** ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition - Total*** 2021: 56.93% 2022: 52.55%
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 3: Support Efficient and Value-Driven Care	**Objective 3.2:** Promote Efficient Use of Program Funds	**Metric 3.2.1.6:** Plan All-Cause Readmission Rate
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima: • ***Plan All-Cause Readmission - Observed Readmissions - Total*** **Recommendation:** HSAG recommends that Optima: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented and any activities still underway to address the finding that resulted in the recommendation): The Case Management Team sends a Where to Go Flyer addressing when to visit the Doctor's Office, Urgent Care, and the Emergency Room. This flyer also includes the Free 24-hour Nurse Advice Line education. Case Management outreaches to members to provide education, engage in		

Recommendation—Performance Measure Validation
case management services to include a plan of care, and mail a list of providers in their region for member utilization to address their healthcare needs.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: *Plan All-Cause Readmissions - Observed Readmissions - Total*** 2021: NDR% 2022: 11.11% 0.9344
Identify any barriers to implementing initiatives: No barrier Identified.
HSAG Assessment: 

United

Table E-6—Prior Year Recommendations and Responses—United

Recommendation—Performance Measure Validation		
Goal 2: Promote Access to Safe, Gold Standard Patient Care **Goal 3:** Support Efficient and Value-Driven Care	**Objective 2.1:** Ensure Access to Care **Objective 3.1:** Focus on Paying for Value	**Metric 2.1.1.6:** Cervical Cancer Screening **Metric 2.1.1.12:** Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis **Metric 3.1.1.5:** Ambulatory Care: Emergency Department (ED) Visits-Total
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for United: • *Ambulatory Care—ED Visits—Total* • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* • *Cervical Cancer Screening* **Recommendation:** HSAG recommends that United: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that United analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		

Recommendation—Performance Measure Validation
MCO's Response
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): UHC conducted root cause analysis and focus studies for these measures, including performance by race, ethnicity, gender, and region. The following initiatives were continued and further developed in areas noted with lower performance. • Member outreach to educate, remind and assist members with scheduling an appointment for cervical cancer screenings. Transportation for members was also arranged as needed. • Comprehensive Case management services addressing SDOH, medical, and behavioral needs for member with chronic conditions and high ED utilizers. • Assisted members with obtaining in-home & telehealth visits as needed. • Increased provider incentives participating in Community Plan Primary Care Professional (CP-PCPi) program to close opportunities. • Increased provider education, engagement and incentives through CP PCPi Program. • Provider education through uhcprovider.com.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure 2.1.1.6: Cervical Cancer Screening** 2021: 45.74% 2022: 45.50% **Measure 2.1.1.12: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis** 2021: 31.37% 2022: 30.42% **Measure 3.1.1.5: Ambulatory Care: Emergency Department (ED) Visits-Total** 2021: 89.84% 2022: 96.04%
Identify any barriers to implementing initiatives: During the COVID-19 national public health emergency, UHC determined members continued to have some hesitancy in returning to provider offices for preventative and follow-up care.
HSAG Assessment: 

VA Premier

Table E-7—Prior Year Recommendations and Responses—VA Premier

Recommendation—Performance Measure Validation		
Goal 3: Support Efficient and Value-Driven Care	**Objective 3.1:** Focus on Paying for Value	**Metric 3.1.1.5**: Ambulatory Care: Emergency Department (ED) Visits
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier: • ***Ambulatory Care—ED Visits—Total*** **Recommendation:** HSAG recommends that VA Premier: • Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • The Clinical Care Coordinator (CCT) will contact members to help educate them on when to use Urgent Care (UC), Primary Care Provider (PCP), or Emergency Department (ED) and will send a "Where to Go flyer" The Clinical Care Coordinator (CCT) will determine if the member has an assigned PCP and connect them to Member Services if they need to change or select a provider.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: Ambulatory Care—ED Visits—Total** 2021: 81.83% 2022: 62.41		
Identify any barriers to implementing initiatives: Members will need to be educated on when to use the Emergency Department versus going to their PCP.		
HSAG Assessment: 		

Recommendation—Performance Measure Validation		
Goal 2: Promote Access to Safe, Gold Standard Patient Care	**Objective 2.1:** Ensure Access to Care	**Metric 2.1.1.12:** Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis *Note: Not a Quality Strategy metric.*

Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier:

- ***Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total***

Recommendation: HSAG recommends that VA Premier:

Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.

MCO's Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Team meetings are held monthly to discuss the program, suggest any improvements, and review data results
- Clinical program has been established to help adherence and therapy completeness

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

PMV results showed:

- **Measure: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total**

2021: 19.92%

2022: 48.75%

Identify any barriers to implementing initiatives:

- No identified barriers

HSAG Assessment:

Recommendation—Performance Measure Validation		
Goal 2: Promote Access to Safe, Gold-Standard Patient Care	**Objective** 2.1: Ensure Access to Care	**Metric** 2.1.1.9: Breast Cancer Screening *Note: Aspirational metric.*

Recommendation—Performance Measure Validation
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier: • ***Breast Cancer Screening*** **Recommendation:** HSAG recommends that VA Premier: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
MCO's Response
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Live outreach calls are made to discuss the importance of breast cancer screening and remind members they are due for a mammogram • HEDIS Blitz conducted annually to close care gaps • Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement • Multiple gaps letters mailed to members advising of the need to obtain mammogram • Ongoing partnership with provider practices to review patient gap reports
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: Breast Cancer Screening** 2021: 36.71% 2022: 36.91%
Identify any barriers to implementing initiatives: • Timely access to Primary Care Provider (PCP)
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 4: Improved Population Health	**Objective 4.1:** Improve Behavioral Health and Developmental Services of Members	**Metric:** Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia *Note: Not a Quality Strategy metric.*

Recommendation—Performance Measure Validation
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier: • ***Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia*** **Recommendation:** HSAG recommends that VA Premier: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
MCO's Response
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Chronic Care Management conducts assessments for members who have been identified to have a cardiovascular condition such as Hypertension, Coronary Artery Disease, and Heart Failure. For respective members, a scale and blood pressure cuff are provided, as needed, to enable the member to monitor their progress and notify the PCP if they have abnormal readings. • Chronic Care Management Team mails hard copy member educational materials that guide healthy eating, exercise, and symptom awareness to enable members to contact their PCP in a timely manner. • Chronic Care Management conducts the PHQ-2 screening for all members we engage. Based on a risk stratification scale, members are referred to the Behavioral Health team for further evaluation by a Mental Health provider.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia** 2021: 61.90% 2022: 63.64%
Identify any barriers to implementing initiatives: • No Barriers Identified
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 4: Improved Population Health	**Objective 4.1:** Improve Outcomes for Maternal and Infant Members	**Metric 4.6.3:** Childhood Immunization Status—Combination 3

Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier:

- ***Childhood Immunization Status—Combination 3***

Recommendation: HSAG recommends that VA Premier:

Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.

MCO's Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Childhood Immunization Incentive Program
- Immunization Health Fairs across the State
- HEDIS Blitz conducted annually to close care gaps
- Provider Educational Outreach
- Hired a dedicated full-time employee to support EPSDT (Early and Periodic Screening, Diagnosis and Treatment)
- Data from VIIS is used to close gaps and referred to Case Management when appropriate
- Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement
- NCQA PHM Standards and Audit tools were purchased to perform a comprehensive population health assessment to include but are not limited to SDOH (Social Determinants of Health), barriers to care, preferences regarding healthcare, clinical communications, and health disparities including race/ethnicity, age, zip code, etc.

A Performance Withhold Performance (PWP) team was established to monitor and track data trends with this measure and alert the organization when rates are dropping.

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

PMV results showed:

- **Measure: Childhood Immunization Status—Combination 3**

2021: 61.97%

2022: 62.22%

Identify any barriers to implementing initiatives:

- No Barriers identified

Recommendation—Performance Measure Validation
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.1:** Improve Outcomes for Members With Chronic Conditions	**Metric:** Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg) *Note: Not a Quality Strategy metric.*

Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier:

- ***Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)***

Recommendation: HSAG recommends that VA Premier:

- Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.

MCO's Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Chronic Care Management completes assessments for members who have diabetes. This assessment is conducted telephonically. Equipment and/or supplies to help manage members' care are provided such as glucometer, blood pressure cuff, or scale, as needed
- HEDIS Blitz conducted annually to close care gaps
- Provider Education conducted statewide
- Vendor Dario is used to outreach to members gap-closing efforts
- Members are sent written education materials to reinforce how to best manage diabetes

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

- **Measure: Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)**

2021: 46.47%
2022: 58.39%

Identify any barriers to implementing initiatives:
No Barriers identified

Recommendation—Performance Measure Validation		
HSAG Assessment: 		
Recommendation—Performance Measure Validation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective** 5.1 Improve Outcomes for Members with Chronic Conditions	**Metric** 5.1.1.5: Controlling High Blood Pressure
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier: • ***Controlling High Blood Pressure*** **Recommendation:** HSAG recommends that VA Premier: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Chronic Care Management completes assessments for members who have diabetes. This assessment is conducted telephonically. Equipment and/or supplies to help manage members' care are provided such as glucometer, blood pressure cuff, or scale, as needed • Members are sent written education materials to give them reinforcement on how to best manage their blood pressure • HEDIS Blitz conducted annually to close care gaps • Provider Education conducted statewide		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: Controlling High Blood Pressure** 2021: 47.69% 2022: 58.15%		
Identify any barriers to implementing initiatives: No Barriers identified		

Recommendation—Performance Measure Validation
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective** 5.4, Improve Behavioral Health and Developmental Services of Members	**Metric** 5.4.1.1: Follow-Up After Hospitalization for Mental Illness
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier: • ***Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*** **Recommendation:** HSAG recommends that VA Premier: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total** 2021: 19.16% 2022: 21.38%		
• **Measure: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total** 2021: 37.28% 2022: 41.02%		
Identify any barriers to implementing initiatives: • Numerous unsuccessful outreach attempts to assist member with scheduling follow-up appointment post discharge		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total** 2021: 19.16% 2022: 21.38%		

Recommendation—Performance Measure Validation
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 4: Strengthen the Health of Families and Communities	**Objective 4.1:** Improve Utilization of Wellness, Immunization, and Prevention Services for Members	**Metric 4.1.1.4:** Immunizations for Adolescents

Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier:

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

Recommendation: HSAG recommends that VA Premier:

- Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.

MCO's Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Childhood Immunization Incentive Program, Back to School Fairs across the State. Well, Child & Immunization Campaigns. Educational Outreach. Data utilized from VIIS to close gaps and referred to case management, when needed.
- Immunization program in development to improve member and clinician engagement which includes incentives, targeted outreach, and educational initiatives. Additionally, increased collaboration with the commonwealth's Department of Health regarding vaccination data.
- HEDIS Blitz conducted annually to close care gaps
- Provider Education conducted statewide

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

PMV results showed:

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

2021: 72.99%

2022: 78.47%

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

2021: 30.66%

Recommendation—Performance Measure Validation
2022: 28.47%
Identify any barriers to implementing initiatives: • No Barrier Identified
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.1**: Improve Outcomes for Members with Chronic Conditions	**Metric** Pharmacotherapy Management of COPD Exacerbation (PCE) *Note: Not a Quality Strategy metric.*
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier: • ***Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*** **Recommendation:** HSAG recommends that VA Premier: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Ensure appropriate clinical monitoring of the member is being completed and reported • Team meetings are held monthly to discuss the program, suggest any improvements, and review data results • Clinical program to help adherence and therapy completeness • Care Coordinators reach members to educate them on side effects and provide any additional support, as needed		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator** 2021: 59.54% 2022: 61.31%		

Recommendation—Performance Measure Validation
• **Measure: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator-Systemic Corticosteroid** 2021: 50.13% 2022: 51.45%
Identify any barriers to implementing initiatives: Member education on importance of taking prescribed medication
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.4:** Improve Behavioral Health and Developmental Services of Members	**Metric** 5.4.1.5: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier: • ***Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*** **Recommendation:** HSAG recommends that VA Premier: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Clinical coordination program for those members aged 6-12 who are taking an atypical antipsychotic • Care coordination letters are sent to the member's PCP and prescriber of atypical antipsychotic • Ensure appropriate clinical monitoring of the member is being completed and reported • Team meetings are held monthly to discuss the program, suggest any improvements, and review data results		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed:		

Recommendation—Performance Measure Validation
• **Measure: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total** 2021: 50.00% 2022: 41.27%
Identify any barriers to implementing initiatives: No Barriers Identified
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 3: Support Efficient and Value-Driven Care	**Objective 3.1** Focus on Paying for Value	**Metric:** Use of Imaging Studies for Low Back Pain *Note: Not a Quality Strategy metric.*
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier: • ***Use of Imaging Studies for Low Back Pain*** **Recommendation:** HSAG recommends that VA Premier: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Clinical Guidelines reviewed and updated • Providers are notified of updated clinical guidelines via newsletter & provider website • Provider newsletter article • Data analysis based on ordering providers to assist in driving interventions • Partner with our Clinically Integrated Networks to develop action items for addressing the use of advanced imaging for initial diagnosis and treatment of low back pain • Adding physical therapy recommendations to the member's newsletter to increase the understanding of low back health and how to prevent injuries		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: Use of Imaging Studies for Low Back Pain**		

Recommendation—Performance Measure Validation
2021: 68.34% 2022: 67.55%
Identify any barriers to implementing initiatives: • No Barriers Identified
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 4: Strengthen the Health of Families and Communities	**Objective 4.1:** Improve Utilization of Wellness, Immunization, and Prevention Services for Members	**Metric** 4.1.1.9: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier:

- ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total***

Recommendation: HSAG recommends that VA Premier:

Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.

MCO's Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Well Child and Immunization Campaigns created to address gaps in care
- HEDIS Blitz conducted annually to close care gaps
- Provider Education conducted statewide
- Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement
- NCQA PHM Standards and Audit tools purchased to perform a comprehensive population health assessment include but are not limited to SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities including race/ethnicity, age, zip code, etc.

Recommendation—Performance Measure Validation
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total** 2021: 58.64% 2022: 66.67% • **Measure: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total** 2021: 48.18% 2022: 60.10% • **Measure: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total** 2021: 40.88% 2022: 52.80%
Identify any barriers to implementing initiatives: • No Barrier Identified
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 4: Strengthen the Health of Families and Communities	**Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Metric: 4.2.1.4:** Well-Child Visits in the First 30 Months of Life
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier: • ***Well-Child Visits in the First 30 Months of Life—Age 15 to 30 Months*** **Recommendation:** HSAG recommends that VA Premier: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):		

Recommendation—Performance Measure Validation
• Childhood Incentive Program • Health fairs throughout the state of Virginia • HEDIS Blitz • Provider educational outreach • A dedicated full-time employee to support EPSDT • Partnership with the Virginia Department of Health to increase access to appointments and provide education • Quality Measure Improvement Committee (QMIC) re-established – this committee identifies business owners of measures and documents all interventions. • The Population Health Assessment work group was established on 7/2022 • NCQA PHM Standards and Audit tools were purchased to perform a comprehensive population health assessment to include but are not limited to SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities including race/ethnicity, age, zip code, etc.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: Well-Child Visits in the First 30 Months of Life** 2021: 27.27% 2022: NDR%
• **Measure: Well-Child Visits in the First 30 Months -Age 15 to 30 Months** 2021: 64.00% 2022: 53.57%
Identify any barriers to implementing initiatives: • Timely access to Primary Care Provider (PCP)
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 3: Support Efficient and Value-Driven Care	**Objective 3.2:** Promote Efficient Use of Program Funds	**Metric 3.2.1.6:** Plan All-Cause Readmission Rate *Note: Not a Quality Strategy metric.*
Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier: • ***Plan All-Cause Readmissions—Observed Readmissions—Total*** **Recommendation:** HSAG recommends that VA Premier: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement.		

Recommendation—Performance Measure Validation
In addition, HSAG recommends that VA Premier analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
MCO's Response
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Case Management Team sends a Where to Go Flyer addressing when to visit the Doctor's Office, Urgent Care, and the Emergency Room. This flyer also includes the Free 24-hour Nurse Advice Line education. • Case Management outreaches to members to provide health education, engage in case management services to include a plan of care, and mail a list of providers in their region for member utilization to address their healthcare needs.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: Plan All-Cause Readmissions—Observed Readmissions—Total** 2021: NDR% 2022: 11.59% 0.9655
Identify any barriers to implementing initiatives: No Barriers Identified
HSAG Assessment: 

Recommendation—Member Experience of Care Survey—Child Medicaid		
Goal 1: Enhance the Member Care Experience	**Objective 1.2:** Improve Member Satisfaction	**Metric 1.2.1.1:** Enrollees' Ratings Q8 – Rating of all Health Care
Weakness: VA Premier's 2022 top-box score was statistically significantly lower than the 2021 NCQA child Medicaid national average for one measure, *Rating of All Health Care*. **Recommendation:** HSAG recommends that VA Premier: Conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that VA Premier focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):		

Recommendation—Member Experience of Care Survey—Child Medicaid
• The Quality Satisfaction Committee (QSC) was established to ensure timely fielding of surveys and interventions are implemented • Members receive reminders via social media, mail, & voice recordings to complete survey
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure: Rating of All Health Care** 2021: 83.48% 2022: 88.74%
Identify any barriers to implementing initiatives: No barriers identified
HSAG Assessment: 

Appendix F. 2023–2025 Quality Strategy Status Assessment

Evaluation Methodology Description

Quality Strategy

In accordance with 42 Code of Federal Regulations (CFR) §438.340, the Virginia Department of Medical Assistance Services (DMAS) implemented a written quality strategy for assessing and improving the quality of healthcare and services furnished by the managed care organizations (MCOs) to Virginia Medicaid members under the Commonwealth Coordinated Care (CCC) Plus (Managed Long-Term Services and Supports [MLTSS]), Medallion 4.0 (Acute), and the Cardinal Care Medicaid managed care program. DMAS is the Commonwealth of Virginia's single State agency that administers all Medicaid and Family Access to Medical Insurance Security (FAMIS) health insurance benefit programs in the Commonwealth. Medicaid is delivered to individuals through two models, managed care and fee-for-service (FFS). Table F-1 displays the average annual program enrollment during CY 2023.

Table F-1—CY 2023 Average Annual Program Enrollment[F-1]

Program	SFY 2023 Enrollment as of 08/01/2023*
Title XIX Medicaid	1,933,150
Title XXI CHIP	190,660
Medallion 4.0 (Acute)	1,605,199
CCC Plus (MLTSS)	300,467
Fee-for-Service	228,429
Total Served	2,135,985

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

In June 2021, the Virginia General Assembly mandated that DMAS rebrand the Department's FFS and managed care programs and effectively combine the CCC Plus (MLTSS) and Medallion 4.0 (Acute) programs under a single name, the Cardinal Care program. The combined program achieves a single streamlined system of care that links seamlessly with the FFS program. DMAS received Centers for Medicare & Medicaid Services (CMS) approval for an effective date of October 1, 2023, for the Cardinal Care program.

The Cardinal Care program will ensure an efficient, well-coordinated Virginia Medicaid delivery system that provides high-quality care to members and adds value for providers and the Commonwealth. The consolidated program will enable DMAS to ensure better continuity of care for members, operate with improved administrative efficiency, and strengthen the focus on the diverse and evolving needs of the

[F-1] Cardinal Care, Virginia's Medicaid Program, Department of Medical Assistance Services. Medicaid/FAMIS Enrollment. Available at: https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/. Accessed on: Dec 6, 2023.

populations served. The Cardinal Care program will continue to offer members the same programs and services and will not reduce or change any existing coverage. The overarching program will ensure a smoother transition for individuals whose healthcare needs evolve over time.

Virginia's 2023–2025 Quality Strategy provides the framework to accomplish DMAS' overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP system. The Quality Strategy is intended to guide Virginia's Medicaid managed care program by establishing clear goals to drive improvements in care delivery and outcomes, and the metrics by which progress will be measured.

The Quality Strategy sets a clear direction for priority interventions and details the standards and mechanisms for holding MCOs accountable for desired outcomes. The Quality Strategy is a roadmap through which DMAS will use the managed care infrastructure to facilitate improvements in health and healthcare through programmatic innovations, whole-person care, inclusive healthcare, provider supports, and steps to address health-related unmet resource needs. This vision is distilled into five central goals:

1. Enhance the member care experience
2. Promote access to safe, gold-standard patient care
3. Support efficient and value-driven care
4. Strengthen the health of families and communities
5. Provide whole-person care for vulnerable populations

DMAS' mission is to improve the health and well-being of Virginians through access to high-quality healthcare coverage. The Medicaid managed care program in Virginia is responsible for providing high-quality, innovative, and cost-effective healthcare to Medicaid enrollees.

DMAS contracted with six MCOs through September 30, 2023. During CY 2023, the Optima and VA Premier MCOs merged under the Optima name. The five MCOs contracted with DMAS on December 31, 2023, are displayed in Table F-2. These MCOs pay for Medicaid benefits and services included in the Virginia Medicaid State plan, State statutes and administrative rules, and Medicaid policy and procedure manuals.

Table F-2—CCC Plus (MLTSS) MCOs in Virginia

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

**VA Premier and Optima merged during CY 2023. As of January 1, 2024, the MCOs name is Sentara Health Plan.*

Goals and Objectives

The Virginia 2021–2023 Quality Strategy identified goals and objectives that focus on process as well as achieving outcomes. The goals and supporting objectives are measurable and take into consideration the health status of all populations served by the Virginia Medicaid managed care program. Refer to Appendix B for a detailed description of the objectives and performance measures (PMs) used to support each goal.

Virginia's Quality Strategy identifies the following five goals and associated objectives:

Table F-3—Quality Strategy Goals and Objectives

Goals	Objectives
 **Goal 1**: Enhance the Member Care Experience	**Objective 1.1:** Increase Member Engagement and Outreach
	Objective 1.2: Improve Member Satisfaction
 **Goal 2:** ★ Promote Access to Safe, Gold-Standard Patient Care ★	**Objective 2.1:** Ensure Access to Care
	Objective 2.2: Promote Patient Safety
	Objective 2.3: Promote Effective Communication and Care Coordination
 **Goal 3:** ★ Support Efficient and Value-Driven Care ★	**Objective 3.1**: Focus on Paying for Value
	Objective 3.2: Promote Efficient Use of Program Funds
	**Objective 4.1:** Improve Utilization of Wellness, Immunization, and Prevention Services for Members
	★ **Objective 4.2:** Improve Outcomes for Maternal and Infant Members ★

Goals	Objectives
Goal 4: Strengthen the Health of Families and Communities	**Objective 4.3**Improve Home and Community-Based Services
 **Goal 5:** Providing Whole-Person Care for Vulnerable Populations	**Objective 5.1:** Improve Outcomes for Members with Chronic Conditions
	Objective 5.2: Improve Outcomes for Nursing Home Eligible Members
	★ **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders ★
	★ **Objective 5.4:** Improve Behavioral Health and Developmental Services of Members ★

Note: Each goal has targeted metrics to measure progress, as well as outlined interventions to advance the goals. See Appendix B.
★ In alignment with Governor Glenn Youngkin's identified priorities for the Medicaid program.

Each of the 14 objectives is tied to focused interventions used to drive improvements within, and, in many cases, across the goals and objectives set forth in the 2023–2025 Quality Strategy. To assess the impact of these interventions and continue to identify opportunities for improving the quality of care delivered under Medicaid managed care, and in compliance with the requirements set forth in 42 CFR §438.340(b)(3), these interventions are tied to a set of metrics by which progress is assessed. This approach provides for data-driven decision making to drive interventions, inform priority setting, and facilitate efficient and effective deployment of resources.

Evaluation

DMAS uses several mechanisms to monitor and enforce MCO compliance with the standards set forth throughout the Quality Strategy, and to assess the quality and appropriateness of care provided to Medicaid managed care enrollees. The following sections provide an overview of the key mechanisms DMAS uses to enforce these standards and to identify ongoing opportunities for improvement.

Performance Measures

DMAS requires MCOs to report annually on patient quality, access, timeliness, and outcomes performance measures, including the Healthcare Effectiveness Data and Information Set (HEDIS®)[F-2] quality metrics, CMS Adult and Child Core Set of Health Care Quality Measures for Medicaid, Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs), Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[F-3] measures, and State-specified quality measures. The MCO performance measures align with the Quality Strategy's goals of enhancing the members' care experience, promoting access to safe, gold-standard patient care, supporting efficient and value-driven care, strengthening the health of families and communities, and providing whole-person care for vulnerable populations. DMAS assesses if MCO performance measures meet target objectives or improvement objectives.

Medallion 4.0 (Acute)

Progress

In alignment with the DMAS Quality Strategy goal of strengthening the health of families and communities, in the Children's Preventive Health domain, four of six MCOs' rates met or exceeded the 50th percentile for the *Child and Adolescent Well-Care Visits—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* PM indicators. The Child Welfare Focus Study also demonstrated improvements towards Quality Strategy goals. The study found that children in foster care have higher rates of appropriate healthcare utilization than comparable controls for most study indicators in MY 2019, MY 2020, and MY 2021. Study findings show that MY 2021 rate differences between children in foster care and controls were greatest among the dental study indicators (*Annual Dental Visit; Preventive Dental Services; Oral Evaluation, Dental Services;* and *Topical Fluoride for Children—Dental or Oral Health Services* by 18.2, 19.0, 19.0, and 14.2 percentage points, respectively); the *Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics* measure (by 20.4 percentage points); and the *Behavioral Health Encounters—CMH Services* indicator (by 17.1 percentage points).

Progress was made toward achieving DMAS' Quality Strategy goal of providing whole-person care for vulnerable populations in the Care for Chronic Conditions domain. Five of six MCOs' rates met or exceeded the 50th percentile for the *Asthma Medication Ratio—Total* and *Hemoglobin A1c Control for Patients With Diabetes—HbA1c control (<8.0%)* measure indicators.

[F-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[F-3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

The DMAS Quality Strategy goal of improving outcomes for maternal and infant health also demonstrated improvement in the Maternal and Child Health Focus Study results, where the FAMIS MOMS program results demonstrated improvement, with rates for the *Births with Early and Adequate Prenatal Care*, *Preterm Births (<37 Weeks Gestation),* and *Newborns with Low Birth Weight (<2,500 grams)* study indicators outperforming the applicable national benchmarks for all three measurement periods. The Medicaid for Pregnant Women program had rates for the *Preterm Births (<37 Weeks Gestation)* study indicator that outperformed national benchmarks in CYs 2020 and 2021. and had rates for the *Newborns with Low Birth Weight (<2,500 grams)* study indicator that outperformed national benchmarks in CYs 2019, 2020, 2021, Additionally, the Medicaid Expansion program's rate for the *Births with Early and Adequate Prenatal Care* study indicator improved from CY 2020 and outperformed the national benchmark in CY 2021.

Progress toward achieving the DMAS Quality Strategy objective of improving outcomes for members with substance use disorders (SUDs) and improving behavioral health and developmental services for members was demonstrated with all six MCOs' rates meeting or exceeding the 50th percentile for the *Follow-Up After Emergency Department (ED) Visit for Substance Use—7-Day Follow-Up—Total, 30-Day Follow-Up—Total* and *Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment* PM indicators. Additionally, five of six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment* PM indicators.

Additional evidence of progress toward achieving the Quality Strategy goals was found in the *Cascade of Care for Members With Opioid Use Disorder* (*OUD)—High-Risk Members With OUD Diagnosis* indicator, which assessed identification of members with an OUD. Findings show that this rate increased from 3.8 percent to 5.1 percent from CY 2020 to CY 2021. In addition, several study indicators showed that initiation of SUD treatment is increasing overall, though findings differ by type and timeliness of treatment. Of members diagnosed with OUD, 44.2 percent initiated any OUD treatment (i.e., pharmacotherapy or other treatment) within 14 days of OUD diagnosis in CY 2021, and this rate increased by 4.7 percentage points from CY 2020. The rate change was driven by an increase in members initiating pharmacotherapy, for which the rate increased by 6.2 percentage points from CY 2020 to CY 2021.

Opportunities

Opportunities for improvement in achieving the Quality Strategy goal of strengthening the health of families and communities in the Children's Preventive Health domain. Four of the six MCOs' rates fell below the 50th percentile for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits and Childhood Immunization Status—Combination 3* PM indicators.

The DMAS Quality Strategy goal of improving outcomes for maternal and infant health also demonstrated opportunities for improvement. All six MCOs' rates fell below the 50th percentile for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* PM indicators. In addition, the DMAS Quality Strategy goal of strengthening the health of families and communities also had opportunities for improvement in the Access to Care domain as all six MCOs' rates fell below the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator.

The Quality Strategy goal of promoting access to safe, gold-standard patient care also demonstrated opportunities for improvement in preventive screenings. While one MCO improved performance over the prior year, the overall MCO performance was below the 50th percentile for the *Cervical Cancer Screening* PM indicator. In addition, all six MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* indicator.

Opportunities were also identified in achieving DMAS' Quality Strategy goal of providing whole-person care for vulnerable populations. Within the Care for Chronic Conditions domain, five of the six Medallion 4.0 (Acute) MCOs' rates fell below the 50th percentile for the *Eye Exam for Patients With Diabetes—Total* PM indicator. MCO performance below the 50th percentile indicates some members with diabetes are not receiving eye examinations as recommended to appropriately manage risks associated with diabetes.

Although progress was made overall in behavioral health and substance use quality goals, opportunities persist in achieving the DMAS Quality Strategy objective of improving outcomes for members with SUDs. The Addiction and Recovery Treatment Services (ARTS) study findings show that engagement in OUD treatment may be declining. The *Cascade of Care for Members With OUD—Members who Initiated OUD Treatment who Also Engaged in OUD Treatment* indicator found that 40.7 percent of members who had initiated OUD treatment engaged in OUD treatment for six months following OUD diagnosis, and this rate declined by 8.7 percentage points from CY 2020 to CY 2021. However, the rate for CY 2021 may be especially impacted by the coronavirus disease 2019 (COVID-19) public health emergency (PHE), since this study indicator utilizes visits from the year prior to the measurement year. Therefore, many of these missed engagement visits were supposed to happen during 2020 after the onset of the PHE. The ARTS study findings are consistent with the overall Medallion 4.0 (Acute) PM results, with five of the six MCOs' rates falling below the 50th percentile for the *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* and *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators. Additionally, four of the six MCOs' rates fell below the 50th percentile for the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* PM indicator. This performance suggests that members have not received timely follow-up after ED visits and hospitalizations for mental illness. Individuals hospitalized for mental health disorders often do not receive adequate follow-up care.

CCC Plus (MLTSS)

Progress

Progress in achieving the DMAS Quality Strategy objective of improving outcomes for members with substance use disorders and improving behavioral health and substance use disorders. Overall, behavioral health (BH) care and ARTS demonstrated improvement for the CCC Plus (MLTSS) program. The ARTS study findings show that identification of members with SUD may be improving, in alignment with ARTS benefit goals. The *Cascade of Care for Members With OUD—High-Risk Members With OUD Diagnosis* indicator assessed identification of members with an OUD. Findings show that this rate increased from 3.8 percent to 5.1 percent from CY 2020 to CY 2021. In addition, several study indicators found that initiation of SUD treatment is increasing overall, though findings differ by type and timeliness of treatment. For example, 44.2 percent of members diagnosed with OUD initiated any OUD treatment (i.e., pharmacotherapy or other treatment) within 14 days of OUD diagnosis in CY 2021, and this rate increased by 4.7 percentage points from CY 2020. The rate change was driven by an increase in members initiating pharmacotherapy, for which the rate increased by 6.2 percentage points from CY

2020 to CY 2021. The emphasis and focus on the ARTS program may be driving improvement in BH measures.

The MCOs also demonstrated progress in achieving Quality Strategy goals and objectives within the Behavioral Health PM domain related to the use of medication to treat mental health conditions, as all six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment, Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total, Diagnosed Mental Health Disorders—Total, Diagnosed Substance Use Disorders—Alcohol disorder—Total, Diagnosed Substance Use Disorders—Opioid disorder—Total, Diagnosed Substance Use Disorders—Other or unspecified drugs—Total,* and *Diagnosed Substance Use Disorders—Any disorder—Total* PM indicators. In addition, five of the six MCOs' rates for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Total* measure also met or exceeded the 50th percentile.

There was demonstrated progress toward achieving the DMAS Quality Strategy goal of strengthening the health of families and communities in the Access to Care domain Access and Preventive Care: All six MCOs' rates met or exceeded the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure.

In alignment with the DMAS Quality Strategy goal of strengthening the health of families and communities and the Taking Care of Children domain, five of six MCOs' rates met or exceeded the 50th percentile for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total* and *Blood Glucose and Cholesterol Testing—Total* PM indicators.

Progress was made toward achieving DMAS' Quality Strategy goal of providing whole-person care for vulnerable populations in the Living With Illness domain—MCO performance showed improvement with five of six MCOs' rates having met or exceeded the 50th percentile for the *Asthma Medication Ratio—Total, Eye Exam for Patients With Diabetes—Total, Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Total,* and *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications* PM indicators.

Opportunities

The DMAS Quality Strategy goal of strengthening the health of families and communities also demonstrated opportunities for improvement in the Access to Care and Preventive Care domain. within the Access and Preventive Care domain, cancer screenings for women, pregnancy care, and appropriate use of imaging studies for low back pain represent an area for opportunity Virginia-wide, as all reportable MCO rates fell below the 50th percentile for the *Cervical Cancer Screening, Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care,* and *Use of Imaging Studies for Low Back Pain* measures. Additionally, five of six MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* measure.

Opportunities exist in achieving the DMAS Quality Strategy objective of improving outcomes for members with SUDs and improving behavioral health and developmental services. Five of six MCOs' rates fell below the 50th percentile for *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia—Total, Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total,* and all three MCOs' rates without a small denominator fell

below the 50th percentile for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measures.

Opportunities also exist in the Taking Care of Children domain. All six CCC Plus (MLTSS) MCOs' rates for the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total* PM indicators fell below the 50th percentile. While the COVID-19 PHE contributed to a decline in routine pediatric vaccine ordering and doses administered, the MCOs' continued performance below the 50th percentile suggests children are not receiving vaccines at a rate in line with national benchmarks.

The MCOs did not meet improvement objectives for measures related to DMAS' goal to strengthen providing whole-person care for vulnerable populations in the Care for Chronic Conditions domain. Five of the six MCOs' rates fell below the 50th percentile for the *Blood Pressure Control for Patients With Diabetes—Total* and *Controlling High Blood Pressure—Total* measures. MCO performance below the 50th percentile indicates that some members with diabetes and hypertension are not receiving appropriate care to support optimal health.

CAHPS

DMAS requires the external quality review organization (EQRO) to administer a CAHPS survey according to the NCQA HEDIS Specifications for Survey measures. This activity assesses member experience with an MCO and its providers and the quality of care members receive. The standard survey instruments are the CAHPS 5.1H Child Medicaid Health Plan Survey and the 5.1H Adult Medicaid Health Plan Survey. CAHPS global ratings are for *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Personal Doctor*. Additionally, CAHPS composite measures are *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*.

However, the CCC Plus (MLTSS) *Getting Care Quickly* indicator rate was statistically significantly lower in 2023 than in 2022.

Medallion 4.0 (Acute) Adult Survey

In alignment with the DMAS Quality Strategy goal of promoting access to safe, gold-standard patient care, and the objective of ensuring access to care, the Medallion 4.0 (Acute) adult member CAHPS 5.1 Adult Medicaid Health Plan Survey scores met or exceeded the national Medicaid benchmarks in the NCQA Quality Compass®, [F-4] for the *Rating of Health Plan* Global indicator.

Medallion 4.0 (Acute) Child Survey

The Medallion 4.0 (Acute) program's 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for *Getting Care Quickly*. This represents an opportunity for improvement in relation to the Quality Strategy goal of Enhancing the Member Care Experience.

[F-4] Quality Compass® is a registered trademark of NCQA.

CCC Plus (MLTSS) Child Survey

Also, in alignment with the DMAS Quality Strategy goal of promoting access to safe, gold-standard patient care, and the objective of ensuring access to care, the Medallion 4.0 (Acute) program Global child member CAHPS 5.1H Child Medicaid Health Plan Survey scores did not meet or exceed the national Medicaid benchmarks in the NCQA Quality Compass for any indicators. In addition, the Composite Top-Box Scores showed a Medallion 4.0 (Acute) statistically significantly lower rate in the *Getting Care Quickly* indicator than the 2022 NCQA Medicaid national average.

The CCC Plus (MLTSS) Global child member CAHPS 5.1H Child Medicaid Health Plan Survey rates were statistically significantly lower in the *Rating of Health Plan* and *Rating of All Health Care* indicators. The CCC Plus (MLTSS) Top-Box scores for the *How Well Doctors Communicate* indicator was statistically significantly higher than the 2022 NCQA Medicaid national average. The results identify an opportunity for improvement for achieving Quality Strategy Goal 1: Enhance the Member Care Experience.

CCC Plus (MLTSS) Adult Survey

Progress toward achieving the Quality Strategy goal of improving member satisfaction was demonstrated in the 2023 CAHPS results. The CCC Plus (MLTSS) program's 2023 top-box scores were statistically significantly higher than the 2022 NCQA adult Medicaid national averages for four measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Care Quickly*, and *Customer Service*. The CAHPS survey results demonstrate members' overall satisfaction with aspects of the CCC Plus (MLTSS) program.

The CCC Plus (MLTSS) adult member CAHPS 5.1 Adult Medicaid Health Plan Survey scores met or exceeded the national Medicaid benchmarks in the NCQA Quality Compass® for the *Rating of Health Plan* and *Rating of Specialist Seen Most Often* Global indicators. The Composite Top-Box Scores showed CCC Plus (MLTSS) statistically significantly higher rate than the 2022 NCQA Medicaid national averages in the *Getting Care Quickly* and *Customer Service* indicators.

FAMIS Program Child Survey

Although not a metric in the Quality Strategy, the FAMIS general child and CCC 2023 CAHPS scores in the Composite measure, *Customer Service*, identified a top-box score that was statistically significantly higher than the 2022 top-box score. However, the CCCs 2023 top-box scores were statistically significantly lower than the 2022 NCQA Child Medicaid national averages for two measures: *Rating of All Health Care* and *Getting Needed Care.* These results represent an opportunity for improvement for achieving Goal 1—Enhance the Member Care Experience.

External Quality Review (EQR) Activities

As noted in the Quality Strategy, the EQRO plays a critical role in reporting MCOs' performance in several required areas (meaning federal regulations require that these activities be completed by the EQRO) and some optional areas (meaning that the State has elected to use the EQRO for these activities) under 42 CFR §§438.352 and 438.364.

Performance Evaluation and Improvement

The final audit reports (FARs) issued by each MCO's independent auditor, were reviewed and it was identified that all MCOs were determined to be fully compliant with all applicable NCQA HEDIS information systems standards. Additionally, the MCO's independent audit determined that all reported rates were calculated in accordance with NCQA's specifications and no data collection or reporting concerns were identified.

Health Services Advisory Group, Inc. (HSAG) also conducted the PMV for each MCO to assess the accuracy of PMs reported by the MCOs, determine the extent to which these PMs follow Commonwealth specifications and reporting requirements, and validate the data collection and reporting processes used to calculate the PM rates. DMAS identified and selected the specifications for a set of PMs that the MCOs were required to calculate and report.

An ISCA was also conducted for each MCO, and the assessment indicated that the MCOs met the federal requirement of maintaining a health information system that collects, analyzes, integrates, and reports data.

Performance Improvement Project (PIP) Validation

MCOs had an ongoing program of PIPs that intended to improve the care, services, and enrollee outcomes in each topic area. DMAS-approved MCO PIPs are listed below in Table F-4. DMAS and the EQRO facilitated regular PIP meetings with the MCOs to provide guidance and collaboration. The EQRO validated each MCO's PIPs and provided results and findings for each MCO, along with recommendations for improvement.

Table F-4—DMAS-Approved MCO PIPs

Program	PIP Topic Area
Medallion 4.0 (Acute)	*Timeliness of Prenatal Care* rates for the percentage of deliveries that received a prenatal care visit in the first trimester, on or before enrollment start date, or within 42 days of enrollment with the MCO as defined by the HEDIS MY 2022 *Prenatal and Postpartum Care* (PPC) Technical Specifications. (Quality Strategy goal: Strengthen the Health of Families and Communities; objective: ★ Improve Outcomes for Maternal and Infant Members. ★)
Medallion 4.0 (Acute)	*Tobacco Use Cessation in Pregnant Women* rates for all pregnant women, as defined by the HEDIS MY 2022 PPC Technical Specifications, identified as smokers or tobacco users. (Quality Strategy goal: Strengthen the Health of Families and Communities; objective: ★ Improve Outcomes for Maternal and Infant Members ★; and goal: Providing Whole Person Care for Vulnerable Populations; objective: Improve Behavioral Health and Developmental Services for Members.)
CCC Plus (MLTSS)	*Ambulatory Care—Emergency Department Visits* rates for the percentage of members in the entire eligible population aligned with the HEDIS MY 2022 Technical Specifications *Ambulatory Care* (AMB) measure specifications and who had more than one emergency department visit. (Quality Strategy goal: ★

Program	PIP Topic Area
	Support Efficient and Value-Driven Care ★; objective: Focus on Paying for Value.)
CCC Plus (MLTSS)	*Follow-Up After Discharge* rates for the percentage of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge. (Quality Strategy goal: ★ Support Efficient and Value-Driven Care ★; objective: Focus on Paying for Value.)

Validation of Network Adequacy

HSAG will conduct the *EQR Protocol 4. Validation of Network Adequacy* activity beginning in calendar year 2024. In preparation for the task, HSAG identified that to assess appointment availability, DMAS established minimum standards to ensure members' needs were sufficiently met. DMAS monitors the MCO's compliance with these standards through regular reporting requirements outlined in the DMAS Managed Care Technical Manual. In addition, DMAS requires the MCOs to conduct various activities to assess the adequacy of their networks as well as maintain provider and beneficiary data sets that allow monitoring of their networks' adequacy. DMAS requires MCOs to conduct:

- Geomapping to determine if provider networks meet quantitative time and distance standard
- Calculation of provider-to-enrollee ratios, by type of provider and geographic region
- Analysis of in-network and out-of-network utilization data to determine gaps in realized access
- Appointment availability and accessibility studies, including the proportion of in-network providers accepting new patients and the average wait time for an appointment
- Validation of provider directory information

In preparation for the 2024 Network Adequacy Validation task, HSAG obtained from DMAS a list of the State's quantitative network adequacy standards, by provider and plan type, as specified in the State's contract with the MCOs. DMAS has also provided a description of the network adequacy data and documentation that MCOs submit to the State to demonstrate compliance with network adequacy standards, including a list of the data and documentation submitted by the MCOs; the frequency with which the MCOs submit each type of data; formatting requirements for MCO data and documentation; DMAS standards for data completeness and accuracy, and DMAS data dictionaries and applicable companion guides.

Prenatal Care Secret Shopper Survey

The prenatal care secret shopper survey provides indicators for MCO performance in relation to Goal 2: ★ Promote Access to Safe, Gold-Standard Patient Care ★, Objective 2.1: Ensure Access to care, and Goal 4: Strengthen the Health of Families and Communities, Objective 4.2: ★ Improve Outcomes for Maternal and Infant Members ★. HSAG conducts a prenatal care secret shopper survey of appointment availability to collect information on members' access to initial prenatal care services. For the Medallion 4.0 (Acute) program, 29.6 percent of offices contacted stated that the office accepted the VA Medicaid program, and 26.0 percent stated that the office accepted new patients. A first, second, and third trimester appointment date was provided 28.0 percent of the time. Of the appointments which were offered, 15.1 percent were compliant with DMAS wait time standards. There was a substantial difference in the percentage of appointments offered by trimester (i.e., first, second, or third). For cases

that were offered a first trimester appointment, 15.1 percent (n=8) were compliant with the seven-calendar-day standard for prenatal care services. For cases that were offered a second trimester appointment, 21.4 percent (n=3) were compliant with the seven-calendar-day standard for prenatal care services. For cases that were offered a third trimester appointment, 10.5 percent (n=2) were compliant with the three-business-day standard for prenatal care services.

Primary Care Provider (PCP) Secret Shopper Survey

HSAG also conducts a PCP secret shopper survey of appointment availability to collect information on members' access to primary care services. The primary care provider secret shopper survey provides indicators for MCO performance in relation to Goal 2: ★ Promote Access to Safe, Gold-Standard Patient Care ★, Objective 2.1: Ensure Access to care, and Goal 4: Strengthen the Health of Families and Communities, Objective 4.1: Improve the Utilization of Wellness, Immunization, and Prevention Services for Members. For the Medallion 4.0 (Acute) program, 46.7 percent of offices contacted stated that the office accepted the MCO, 43.3 percent stated that the office accepted the VA Medicaid program, and 36.1 percent stated that the office accepted new patients. Survey results showed that 4.0 percent of calls were offered an appointment date for a routine appointment and 73.1 percent were offered an appointment date for an urgent or routine appointment. Of the appointments which were offered, 74.5 percent met the DMAS standard of offering an appointment within 30 days for routine appointments. For urgent visit appointments offered, 16.0 percent met the DMAS standard of offering an appointment within one day for urgent appointments.

For the CCC Plus (MLTSS) program, 46.7 percent stated the office accepted the MCO, 43.3 percent stated that the office accepted the VA Medicaid program, and 36.1 percent stated that the office accepted new patients. Survey results showed that 74.0 percent of calls were offered an appointment date for a routine appointment and 72.3 percent were offered an appointment date for an urgent appointment. Of the appointments which were offered, 74.5 percent met the DMAS standard of offering an appointment within 30 days for routine appointments. For urgent visit appointments offered, 16.0 percent met the DMAS standard of offering an appointment within one day for urgent appointments with rates.

Cardinal Care Program Readiness Reviews

During 2022 and 2023, Cardinal Care program readiness reviews were conducted for all six MCOs. The readiness review included an assessment of all key program areas noted in 42 CFR §438.66(d)(4). The key program areas and related requirements were delineated between four separate readiness review components—Operations/Administration, Service Delivery, Information Systems Management, and Financial Management.

The readiness review process included federal and State-specific standards for 438.12—Prohibition on Provider Discrimination, 438.206—Availability of Services, 438.207—Assurances of Adequate Capacity and Services, and 438.214—Provider Selection. The review also contained federal standards and state-specific requirements for 438.230—Subcontractual Relationships and Delegation. Network adequacy was determined from a review of policies and procedures and a review of the MCOs' monthly and quarterly GeoAccess and other network reports, network contracting status, credentialing status, and network exception reports when network requirements were not met as a result of a lack of providers in the region, or the geographic area being determined a dearth county by DMAS. All network exception reports were approved by DMAS. MCO Cardinal Care program readiness review results

indicated that the MCOs had adequate access and availability to serve members enrolled in the Cardinal Care program.

Compliance Monitoring

During 2021 a compliance audit was conducted for each MCO to review compliance with federal regulations and state contract requirements. The comprehensive MCO compliance audit included all federal requirements and related state-specific requirements including:

- Enrollment and Disenrollment: 438.56
- Member Rights and Confidentiality: 438.100; 438l.224
- Member Information: 438.10
- Emergency and Poststabilization Services: 438.114
- Assurance of Adequate Capacity and Availability of Services: 438.206; 438.207
- Coordination and Continuity of Care: 438.208
- Coverage and Authorization of Services: 438.210
- Provider Selection: 438.214
- Subcontractual Relationships and Delegation: 438.230
- Practice Guidelines: 438.236
- Health Information Systems (including ISCA): 438.242
- Quality Assessment and Performance Improvement: 438.330
- Grievance and Appeal Systems: 438.228
- Program Integrity: 438.608
- EPSDT Services: 441.58 Section 1905 of the SSA
- Assurances of Adequate Capacity and Services
- Coverage and Authorization of Services
- Provider Selection
- Enrollee Rights and Protection
- Grievance and Appeal Systems
- Quality Assessment and Performance Improvement
- Provider Selection
- Enrollee Rights and Protection

For the elements in standards that were not fully compliant, the MCOs were required to develop a corrective action plan which was reviewed by the EQRO and DMAS. Corrective action plans were approved when it was determined that the corrective action plan would bring the MCO into compliance with the requirements. DMAS provided ongoing monitoring of the implementation of the MCOs' corrective action plans.

Annual EQR Technical Reports

To ensure DMAS' compliance with 42 CFR §438.364, aggregate technical reports were prepared and included all required components as outlined in the EQR protocols. Aggregated and analyzed data from the EQR activities was included, and conclusions were drawn with regard to the quality of, timeliness of, and access to health services furnished to MCO members. Conclusions were described in detail and actionable recommendations, as applicable, were provided. Additionally, based on the assessment, notable strengths were included so that the MCOs were able to build upon identified performance improvement and recommendations for identified Quality Strategy opportunities for improvement. The MCOs provided a summary of the quality improvement initiatives implemented as a result of the previous year's EQR recommendations. Quality Strategy performance metric rates were included as evidence of the extent to which those actions resulted in improvement in the Quality Strategy goals and objectives tied to quality, access, or timeliness of care and services.

Addressing Health Disparities

During the VA 2021–2023 review period, DMAS continued to work diligently, in collaboration with the MCOs, to operationalize community engagement and health equity best practices and standards. To meet Virginia's Quality Strategy goal of providing whole-person care for vulnerable populations, DMAS and/or the MCOs implemented the following strategies to address health disparities:

- Partnership for Petersburg: In August of 2022, Governor Glenn Youngkin announced a transformative program called "Partnership for Petersburg." This program has been focused on bringing together public and private resources to help the City of Petersburg and its residents, who have experienced negative health, public safety, education, and economic outcomes. One component of this plan is to improve the health of Petersburg's residents by increasing access to preventative screenings, promoting awareness of primary care and addressing prenatal health disparities by connecting Petersburg residents with medical and social services. DMAS Focus Areas: 1. Improve Petersburg maternal and infant health outcomes. 2. Provide Primary Care Services, Mobile Health Clinics, and Community Events 3. Expand School-Based Clinic Services through the Crimson Clinic Information Request Submitted Response 4. Establish Community-Based Health Literacy Hubs. DMAS's Key Collaborators and Partners: Medicaid MCOs (Aetna, Anthem, Molina, Optima and United), Central Virginia Health Services, Crimson Clinic, Crater Health District, Bon Secours Southside Regional Hospital, Petersburg City Public Schools, DentaQuest, Conexus, Petersburg Sheriff's Office, VDH, and the Department of Social Services.
- CMS Infant Well-Child Visit Learning Collaborative: The learning collaborative offers technical assistance to state Medicaid and Children's Health Insurance Program (CHIP) agencies and their partners (MCOs and other partners, DMAS and its partners are receiving technical assistance in designing and implementing a quality improvement project aimed at identifying ways increase participation in well-child visits. The collaborative initiated interventions with providers in Roanoke, Winchester, Tidewater Area, Petersburg, and Southwest Virginia. The initiative started in March 2021 and will conclude in December 2023. Initiatives have focused on enrollment processes (newborn), member education, consistent messaging across MCOs regarding enrollment.
  - Baby Steps Virginia: Baby Steps Virginia is the vehicle with which Virginia Medicaid brings together sister agencies, other key partners and stakeholders and the voice of the member with the focus of improving maternal health outcomes, eliminate racial disparity in outcomes and

maternal mortality. Baby Steps Virginia incorporates awareness of issues like social determinants of health (SDOH), barriers to care, and member/provider engagement.

- Community Doula Program: To date, 125 doulas have received state certification. Of the 125 state-certified doulas, 90 are approved and enrolled as Medicaid Doula Providers. There have been 107 doula-supported births to Medicaid members and over 304 birthing families have received doula services through Virginia Medicaid. Feedback continues to be positive from families who have received care and support from a doula. DMAS continues to focus on increasing the network of doula providers, community and provider engagement, and data. The availability of state-certified Medicaid-approved doula providers within the Commonwealth means greater access to care and support for pregnant people with the goal of improving maternal and infant health outcomes, reducing infant and maternal mortality, and helping to address racial and health disparities.
- Improving Timely Health Care for Children and Youth in Foster Care—Affinity Group: developed, tested, and collected data around a variety of pilot interventions in order to identify changes that would lead to improvement in the rate of the specific health care service being measured (*initial comprehensive medical examination within 30 days of a child entering foster care*). By the end of the 2-year Affinity Group, the team was able to identify barriers to accessing timely health care services for the foster care member population, as well as utilize data to demonstrate the success of several pilot tests that improved the identified process measures and outcome measures of the project.

  The most successful interventions identified were several iterations of warm handoffs of new foster care member information between VDSS or LDSS agencies and DMAS or the assigned MCO care coordinators, in order for MCOs to support the scheduling and completion of comprehensive health care visits within the first 30 days of placement. One 9-month pilot test with Bedford County Department of Social Services resulted in an improvement in MCO successful outreach to members in Bedford from an average of 52 days down to 2 days after entering foster care. The team then scaled the pilot up statewide and tested a less labor-intense process while continuing to see improvement, though not as significant (down to an average of 28 days). Outcome measures for both warm handoff pilots discussed also improved, with 100% of members in Bedford County receiving initial medical examinations within 30 days of entering custody for the final 7 months of the test.

MCO Cardinal Care Program Contract Language

DMAS included healthy equity requirements in the Cardinal Care program MCO contract. The MCO contract requires that the MCO consider the importance of health equity and disparities among populations in developing its various programs to provide services to members. The MCO must develop and maintain an annual report outlining its efforts to address health disparities for the managed care population. The contract also states that the MCO may refer to the Virginia Department of Health's Office of Health Equity for more information regarding health disparities in the Commonwealth of Virginia.

The MCO contract also includes MCO requirements for the CMS 1115 demonstration for the 12-month postpartum coverage extension. Among the measures the demonstration evaluation includes is the advancement of health equity by reducing racial/ethnic and other disparities in maternal health coverage, access, and outcomes as well as infant health outcomes among postpartum Medicaid and CHIP enrolled women and infants.

Quality improvement requirements in the MCO contract state that the MCO's QI initiatives must be designed to help achieve the goals outlined in the Virginia Quality Strategy. Quality improvement requirements also state that DMAS is responsible for evaluating the quality of care provided to eligible enrollees in the contracted MCOs. DMAS partners with the MCOs and follows state, federal and DMAS policies to ensure that Medicaid members, both those receiving physical and mental health services, receive high quality cost-effective care, driven by innovation. The contract states that the care provided must meet standards for improving quality of care and services, access, transition of care, health disparities and timeliness.

MCOs are required to include in their quality assessment and performance improvement plan a description of the processes for collection and submission of performance measurement data, including any required by DMAS for identifying and analyzing objectives for servicing diverse memberships that includes but is not limited to analyzing significant health care disparities gaps.

The MCO contract includes additional requirements aimed at addressing and reducing healthcare disparities such as:

- **Doulas:** MCOs implementation of a community-based doula service. Doulas are community-based and trained to provide extended, culturally congruent support to families through pregnancy to include antepartum, intrapartum, during labor and birth, and up to one year postpartum. The community-based doulas provide an expanded set of services and play a crucial role in improving outcomes and experiences for communities most affected by discrimination and disparities in health outcomes.
- **Enhanced Benefits:** Enhanced benefits are services offered by the Contractor to Members in excess of the Managed Care program's covered services. The contract provides an example of an enhanced benefit as coverage by the MCO of services that address social determinants of health. For members with long-term care needs, enhanced benefits may include strategies to address social needs.
- **Community-Based Resources:** Strategies may include providing linkages to community-based resources and information on service providers and referrals (social needs are related to the conditions that make up the social determinants of health, including but not limited to housing, food, economic security, community and information supports, and personal goals.
- **Addressing Social Determinants of Health:** The MCO contract states that the MCO must develop programs, establish partnerships, and provide care coordination efforts that identify, address and track member needs across each of the five (5) key SDOH areas identified by the federal Office of Disease Prevention and Health Promotion's, Healthy People 2020, including each of the Economic Stability subsections listed below:
    1. Economic Stability (access to employment, food security, housing);
    2. Education;
    3. Social and Community Context;
    4. Health and Health Care; and
    5. Neighborhood and Built Environment.

The MCO contract requires the submission of an annual report detailing how the MCO is identifying, addressing via programs and partnerships, and tracking each of the five key areas of SDOH.

Other Medicaid Health Equity Initiatives

- Convening a quality collaborative to address best practices, review results of performance measures, and performance improvement projects that focused on health disparities.
- Working closely with the Virginia Commonwealth University Office of Health Equity (OHE) to identify health disparities and their root causes and to promote opportunities to be healthy. The work includes the development of programs and partnerships to empower racial and ethnic minority communities to promote awareness of health disparities.
- Working with the OHE Division of Multicultural Health and Community engagement in initiatives to identify approaches to eliminate health disparities through a focus on SDOH as a key strategy to eliminate health disparities that exist by socioeconomic status, race/ethnicity, geography, gender, immigrant status, and other social classifications.
- Producing an annual study of Medicaid and CHIP prenatal care and associated birth outcomes to identify, evaluate, and reduce—to the extent practicable—health disparities based on age, race, ethnicity, sex, primary language, geographic location, and disability status in birth outcomes.
- Working with MCOs in addressing the SDOH that are impacting members including:
  - Screening members for food insecurity, housing instability, transportation needs, and interpersonal violence.
  - Providing resources and assistance in securing health-related services and resource navigation to members identified with unmet health-related needs.
  - Supporting public-private evidence-based interventions designed to reduce costs and improve health by addressing eligible Medicaid beneficiaries' housing instability, transportation insecurity, food insecurity, and interpersonal violence.
  - Identifying areas of high disparity to guide resources and to work with communities to address SDOH.
  - Maintaining a resource platform accessible to members both online and through the MCO's call center.
- Stratifying performance measure data to identify, evaluate, and reduce—to the extent practicable—health disparities based on age, race, ethnicity, sex, primary language, and disability status.
- Engaging and collaborating with internal and external stakeholders (providers, MCOs, other state agencies, members, etc.) to reduce health disparities and address health equity concerns.

Use of Sanctions

DMAS may impose sanctions due to noncompliance with contract requirements or applicable federal or state laws. The types of intermediate sanctions that DMAS may impose on the MCO shall be in accordance with §1932 of the Social Security Act (42 U.S.C. §1396u-2) and 42 CFR §438.702-708 and may include any of the following:

- Civil monetary penalties in the amounts specified in 42 CFR §438.704
- Appointment of temporary management for an MCO as provided in 42 CFR §438.706;
- Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll;
- Suspension of all new enrollments, including automatic assignment, after the effective date of the sanction;

- Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or DMAS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur in accordance with 42 CFR §438.730; and
- Additional sanctions allowed under state statutes or regulations that address areas of noncompliance described above.

The following areas of noncompliance resulted in an MCO receiving a notice of corrective action:

- Internal system issues which impacted CRMS SA data submission. As a result, the MCO developed a crosswalk of expected values to overcome the QNXT system limitations.
- An MCO submitted four (4) SA Medical files with authorized decision dates ranging from July 23, 2017 through November 1, 2021 to CRMS Production without approval from DMAS. The files loaded or updated 84,819 files in production. On August 27, 2021, the MCO failed to prevent such an incident from reoccurring and submitted four (4) SA Medical files to CRMS Production without approval from DMAS. The MCO updated internal controls to prevent test files from being loaded into the production environment. Specific action items were added to incorporate the MFT process into the internal control process.
- An MCO entered a member into the DMAS Web Portal for LTSS Services prior to a valid level of care screening being conducted. The MCO updated DMAS 80 forms processing, the Enrollment Change Request Form, and implemented a second-level review with a supervisor signature requirement.
- An MCO's Fiscal/Employer Agent improperly withheld FICA tax from attendants' paychecks. As a result, the MCO conducted a thorough review of internal controls and developed a remedial process to resolve the payroll software issue and impact to members and their attendants.
- An MCO approved an implementation that migrated their web portal and website platform to their MyAccount platform without DMAS' approval. The MCO collaborated with DMAS to establish acceptable approval processes for the implementation of system changes that have the potential to significantly impact members.

Performance Withhold Program

In 2023, DMAS contracted with HSAG to establish, implement, and maintain a scoring mechanism for the Medallion 4.0 (Acute) and the CCC Plus (MLTSS) PWPs. The SFY 2023 PWP assessed CY 2022 PM data to determine what portion, if any, of the MCOs' quality withhold would be earned back. For the SFY 2023 PWP, the Medallion 4.0 (Acute) MCOs could earn all or a portion of their one percent quality withhold based on performance for seven NCQA HEDIS measures (14 measure indicators), one Agency for Healthcare Quality (AHRQ) Pediatric Quality Indicator (PDI) measure (one measure indicator), and two CMS Adult Core Set measures (two measure indicators). The SFY 2023 PWP was based on comparisons to the NCQA Quality Compass national Medicaid HMO percentiles for all HEDIS measures and, receiving a reportable audit status on the AHRQ PDI and CMS Adult Core Set PMs.

Health Information Technology

Virginia's HIS and other technology initiatives support the overall operation and review of the Quality Strategy. DMAS' modernized technology system allowed for increased data collection, analytics, oversight, and reporting functions for DMAS. The MES includes the Enterprise Data Warehouse

System (EDWS), a component that significantly enhanced DMAS' ability to analyze MCO data. Within the EDWS, there are powerful management, analytic, and visualization tools that allow DMAS to review and monitor MCOs with increased oversight and detail.

Quality Initiatives

Virginia has developed a series of initiatives aligned closely to the Quality Strategy and designed to build an innovative, person-centered, coordinated system of care that addresses both medical and nonmedical drivers of health. These initiatives drive progress towards the Quality Strategy goals and objectives. These initiatives are discussed below.

Right Help, Right Now

Governor Glenn Youngkin created *Right Help, Right Now* to reform Virginia's behavioral health system and to support individuals in crisis. The goal of *Right Help, Right Now* is to support Virginians before, during, and after a behavioral health crisis occurs. The *Right Help, Right Now* plan aims to ensure that there will be same-day care delivered through mobile crisis units and crisis centers in order to reduce overcrowding at emergency departments. By doing so, there will be less strain on law enforcement who can instead better serve the communities where they are needed. This will also serve to reduce the criminalization of mental health in Virginia. The *Right Help, Right Now* plan includes specialized resources for individuals with substance use disorders or who have high risks of overdosing. Virginians should have immediate access to all the resources they need anytime and anywhere.

The *"Right Help, Right Now"* Six Pillars:

First: Ensure same-day care for individuals experiencing behavioral health crises.	**Second: R**elieve the law enforcement community's burden and reduce the criminalization of mental health.	**Third: D**evelop more capacity throughout the system, going beyond hospitals, especially community-based services.
Fourth: Provide targeted support for substance use disorder and efforts to prevent overdose.	**Fifth: M**ake the behavioral health workforce a priority, particularly in underserved communities.	**Sixth: I**dentify service innovations and best practices in pre-crisis prevention services, crisis care, post-crisis recovery and support and develop tangible and achievable means to close capacity gaps.

Youth Mental Health Strategy

Governor Glenn Youngkin unveiled the Youth Mental Health Strategy on the one-year anniversary of the *Right Help, Right Now* initiative. In 2023, according to Mental Health America, Virginia ranked 48th in the nation for youth mental health, which demands a collective and comprehensive approach to prioritize the health of the Commonwealth's youngest and most vulnerable citizens. Children spend on average nearly five hours daily on social media; recent studies have suggested that children who spend more than a few hours per day on social media have double the risk of poor mental health.

Governor Glenn Youngkin is taking immediate action in year two of *Right Help, Right Now*. To better equip parents and support Virginia's young people, Governor Glenn Youngkin, through budget proposals, legislation, and executive action, and the Youth Mental Health Strategy, will address critical components and harmful aspects of social media on Virginia's youth. The strategy includes interventions in the following areas:

- Addictive and harmful aspects of social media on youth
- Inside Virginia schools—school-based mental health services for students
- In behavioral health care settings—family empowerment and rights

Additional Developmental Disabilities Waiver Slots

Governor Glenn Youngkin committed to enhance support for Virginians with developmental disabilities and their families. Included in the *Right Help, Right Now* initiative, Virginia is one step closer to the goal of providing enough priority one slots for everyone in urgent need of services by the end of the Governor's term. Governor Glenn Youngkin announced an additional $300 million over the biennium to fund enough priority one slogs for every Virginian with a developmental disability on the waitlist for Medicaid Home and Community-Based Developmental Disability (DD) waiver slots.

These improvements give Virginians with disabilities the supports and services they need to live their best lives in their communities. Through these improvements, Virginians with disabilities are provided supports and services they need to live their best lives in their communities. Secretary of Health and Human Resources John Littel stated that they've heard from Virginians and their families about the important difference a DD waiver can have in their life of the life of a loved one. Whether it be paying for in-home care or the kind of assistive technology that can help an individual avoid living in a hospital, nursing home, or other institution, these waivers can change lives. The waivers also cover services such as medical care, employment supports, assistance for community living, behavioral interventions, and other items like medical goods and assistive technology.

Baby Steps

DMAS and its contracted MCOs have undertaken a variety of initiatives aimed at improving quality outcomes in maternal health, a primary goal of the Virginia QS. The DMAS maternity program, Baby Steps Virginia, actively partners with a variety of stakeholders including DMAS MCOs to improve quality maternity outcomes. All of these efforts have focused on eliminating racial disparities in maternal mortality by 2025.

The program has five key subgroups including eligibility and enrollment, outreach and information, community connections, services and policies, and oversight, all with the aim to promote health equity and quality maternity outcomes. During 2023 teams addressed a variety of topics such as Medicaid member outreach including a social media campaign, newborn screening education, WIC enrollment and services, MCO maternity care coordination, breastfeeding awareness, and flu vaccine access, all with the goal of advancing the holistic well-being of Medicaid and CHIP members.

Behavioral Health Enhancement and Project BRAVO

The Commonwealth is focused on improving behavioral health services. The vision for the Enhancement of Behavioral Health is to keep Virginians well and thriving in their communities, shift the

system's current need to focus on crisis by investing in prevention and early intervention for mental health and substance use disorder (SUD) comorbidities, and support comprehensive alignment of services across the systems that serve Medicaid members. This includes efforts to reduce the burden on state psychiatric hospitals and EDs, with efforts including increasing use of mobile crisis response and reduction of emergency department utilization, as well as working to ensuring appropriate access to acute behavioral health services for foster care youths by working to carve in residential services into the managed care programs.

DMAS is also committed to the continued expansion of access to BRAVO services by implementing new services and engaging the communities to support these services. Project BRAVO is a comprehensive vision that details a "north star" continuum of services and a preliminary set of prioritized services to build out critical levels of care, including comprehensive crisis services.

Beginning in 2017, the Addiction and Recovery Treatment Services (ARTS) benefit provides treatment for members with SUDs across the state and provides access to addiction treatment services for all enrolled members in Medicaid, FAMIS, and FAMIS MOMS. A DMAS goal for the ARTS delivery system transformation includes ensuring that a full continuum of care is available, based on evidence-based practice, to effectively treat individuals with SUD.

This approach is expected to provide Medicaid members with access to the evidence-based care needed to achieve sustainable recovery. The MCOs work with DMAS, as required by contract, to ensure that their members' care needs for SUD treatment and recovery are met and include care coordination, utilization review, and a robust array of services and treatment methods to address immediate and long-term physical, mental, and SUD service needs.

Foster Member and Provider Engagement

DMAS has established the Medicaid Member Advisory Committee (MAC) in order to provide a formal method for members' voices to be included in the DMAS decision-making process and to inform DMAS change management strategies. The diverse committee is comprised of representatives from across the state and is entirely made up of Medicaid-enrolled individuals and individuals' authorized representatives. The MAC's purpose is to obtain the insight and recommendations of Virginia's Medicaid members in order to help the DMAS Medicaid Director improve the overall experience for all Virginia Medicaid applicants and members.

DMAS' provider committee is called the Medicaid Provider Managed Care Liaison Committee (MPMCLC). The MPMCLC meets quarterly to provide a forum for Medicaid providers, DMAS, and the MCOs to come together to discuss opportunities, provide feedback, and create alignment across Virginia's Medicaid managed care programs.

DMAS created the Civil Rights Coordinator position in November 2019 to ensure that individuals with limited English proficiency (LEP) and individuals with disabilities have meaningful access to programs and services. This position serves the critical function of ensuring continued compliance with federal and Commonwealth of Virginia civil rights requirements and ensures that internal and external stakeholders have language and disability access resources available to improve communications with LEP individuals and those with disabilities.

Value-Based Purchasing

DMAS is focused on increasing the use of value-based purchasing arrangements with MCOs and providers. VBP includes a broad set of policies and strategies intended to improve healthcare quality, outcomes, and efficiency by linking financial and nonfinancial incentives to the performance of various stakeholders serving Virginia Medicaid members. Movement toward and achievement of these goals is measured through a set of defined metrics evaluating quality, cost, and patient-centered care. There is no "one-size-fits-all" approach to VBP, and DMAS' efforts focus on a range of healthcare stakeholders, populations, and care events that are important to members, specifically highlighting chronic conditions, maternity care, behavioral health, and prevention.

Safe and Sound Task Force

Virginia launched an initiative aimed at creating safe housing placements for children in foster care. The Safe and Sound Task Force brings together government agencies, the Virginia League of Social Services Executives, and other community partners to end the practice of children sleeping in local departments of social services, hotels, and emergency rooms. The initiative ensures that every child has a safe place to belong.

Adult Dental Coverage

The comprehensive adult dental benefit became effective July 1, 2021. More than 960,000 members now have access to comprehensive dental benefits that make available each of the dental specialties. It was established on the premise that the dental treatment procedures would be prevention and control to keep the mouth disease free, and then restore it to healthy function. Beginning with preventive services will aid in improving systemic health concerns that may be in existence and prepare the patient for success with additional treatment that may be needed. The goal of additional treatment would focus on removing what cannot be saved and restoring what can be built around, therefore increasing longevity for any prosthetic appliances that may be in order.

12-Month Postpartum Coverage

DMAS' 1115 waiver amendment to extend 12 months postpartum coverage was approved by the federal government in November 2021, making Virginia one of the first states to provide guaranteed continuous full-benefit coverage across eligibility categories for a full 12 months postpartum. The expanded coverage enables Medicaid and FAMIS MOMS members to receive critical postpartum care for a full year postpartum, an important step in improving health outcomes for both women and their newborns.

Perinatal Quality Collaborative

Funding for the Perinatal Quality Collaborative was provided for the Virginia Department of Health (VDH) to establish and administer a learning collaborative to improve pregnancy outcomes for women and newborns by advancing evidence-based clinical practices and processes through CQI, with an initial focus on pregnant women with a SUD and infants impacted by neonatal abstinence syndrome (NAS).

12-Month Contraceptive Coverage

In 2021, DMAS began covering a 12-month supply of contraception for Medicaid and FAMIS members. Medicaid members may pick up a full year's supply of contraception at a single visit to their pharmacy.

Doula Project

To combat maternal morbidity and unintended consequences of pregnancy that result in life-altering health challenges, DMAS placed emphasis on the need for community doula care for women during the perinatal period, at labor and delivery, and during the postpartum period. According to the American Pregnancy Foundation, doulas serve to reduce the number of Cesarean sections, which increase the risk of maternal death by infection and hemorrhage and reduce the duration of labor by a quarter. Virginia Medicaid introduced a model of care to include doula services as a cost-saving measure and an effective way to improve health outcomes.

Preventive Services for Adults

Starting in September 2022, all adult Medicaid members have access to preventive services, including screenings, check-ups, and counseling to support positive health outcomes. Under a policy, similar to commercial insurance policies, preventive services are available to Medicaid members at no cost and without prior authorization from their doctor.

Emergency Department Care Coordination

The Emergency Department Care Coordination (EDCC) program provides a single, statewide technology solution that connects all hospital EDs in the Commonwealth to facilitate real-time communication and collaboration between physicians, other healthcare providers, and other clinical and care management personnel for patients receiving services in hospital EDs, for the purpose of improving the quality of patient care services. Real-time patient visit information from electronic health records is integrated with the Prescription Monitoring Program and the Advanced Health Directory. This sharing of information allows facilities, providers, and MCOs to identify patient-specific risks, create and share care coordination plans and other care recommendations, and access other clinically beneficial information related to patients receiving services in hospital EDs in the Commonwealth.

Actions on EQR Recommendations

In accordance with 42 CFR §438.364(a)(4), the EQR technical report included recommendations for improving the quality of healthcare services furnished by each MCO contracted with DMAS to provide services to Virginia Medicaid members under Medallion 4.0 (Acute) and the CCC Plus (MLTSS) Medicaid managed care programs. These recommendations include how DMAS can target goals and objectives in the Quality Strategy to better support improvement in the quality and timeliness of, and access to health services furnished to Medicaid managed care members. Table F-5 and Table F-6 include the prior year Quality Strategy recommendations and actions taken by DMAS to support program improvement and progress in meeting the goals of the Quality Strategy.

Table F-5—CCC Plus (MLTSS) Prior Year Recommendations and DMAS Responses

2021–2022 EQRO Recommendations	DMAS Actions
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorder **Measure: 5.3.1.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment **Objective: 5.4:** Improve Behavioral Health and Developmental Services for Members **Measure 5.4.1.1:** Follow-Up After Hospitalization for Mental Illness To improve program-wide performance in support of Objective 5.3 and improve outcomes for members with SUD, HSAG recommends DMAS: • Require the MCOs to develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization. • Require the MCOs to identify healthcare disparities (race, ethnicity, age group, geographic location, etc.) with the behavioral health follow-up PM data. • Upon identification of a root cause issue, require the MCOs to implement appropriate QI interventions to improve use of evidence-based practices related to behavioral healthcare and services. • Require the MCOs to identify best practices to conduct follow-up with members discharged from the ED and ensure follow-up visits within seven days and 30 days are completed.	DMAS included the measure *Follow-Up After Emergency Department Visit for Substance Use* in its PWP which provides an incentive to MCOs to increase performance and close gaps. **Measure:** *Follow-Up After Emergency Department Visit for Substance Use* **MY 2021:** 7-Day: 11.44% 30-Day: 19.98% **MY 2022:** 7-Day: 14.55% 30-Day: 22.57%
Goal: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members With Chronic Conditions	DMAS included a *Comprehensive Diabetes Care measure that includes HbA1c Poor Control (>9.0)* in its PWP which provides an incentive to MCOs to increase performance and close gaps.

2021–2022 EQRO Recommendations	DMAS Actions
Measure: 5.1.1.4: Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) To improve program-wide performance in support of Objective 5.1 and improve outcomes for members with chronic conditions, HSAG recommends DMAS: • Require that the MCOs conduct a root cause analysis to determine why members are not maintaining their diabetes care. • Upon identification of a root cause, require the MCOs to implement appropriate interventions to improve the performance related to proper diabetes management. • Require the MCOs to identify best practices to improve care and services according to chronic care recommended guidelines.	**Measure:** *Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)* **MY 2021:** 51.42% **MY 2022:** 47.39%

Table F-6—Medallion 4.0 (Acute) Prior Year Recommendations and DMAS Responses

2021–2022 EQRO Recommendations	DMAS Actions
Goal: Providing Whole-Person Care for Vulnerable Populations **Objective: 5.4:** Improve Behavioral Health and Developmental Services for Members **Measure 5.4.1.1:** Follow-Up After Hospitalization for Mental Illness To improve program-wide performance in support of Objective 5.4 and improve outcomes for members in need of BH and developmental services, HSAG recommends DMAS: • Require the MCOs to develop processes to ensure providers follow recommended guidelines for	• The DMAS BH team continues to work on the following initiative to improve Medicaid funded behavioral health care across Virginia including the following efforts: - Implementation of evidence-based behavioral health care and building out of, Multisystemic Therapy, Functional Family Therapy, Assertive Community Treatment and implementation of 4 crisis services based on the Crisis Now model, SAMHSA has identified as best practice. The implementation of these services is key to assisting individuals that are discharged from residential and hospital settings. - DMAS has been instrumental in the planning and implementation of the Governor's *Right Help Right Now* plan, which aims to achieve the goal that all Virginians will, i) be able to

2021–2022 EQRO Recommendations	DMAS Actions
follow-up and monitoring after hospitalization. • Require the MCOs to identify healthcare disparities (race, ethnicity, age group, geographic location, etc.) with the BH follow-up PM data. • Upon identification of a root cause issue, require the MCOs to implement appropriate QI interventions to improve use of evidence-based practices related to behavioral healthcare and services. • Require the MCOs to identify best practices to conduct follow-up with members discharged from the ED and ensure follow-up visits within seven days and 30 days are completed.	access behavioral health care when they need it; ii) have prevention and management services personalized to their needs, particularly for children, youth and families; iii) know who to call, who will help and where to go when in crisis; and iv) have paths to reentry and stabilization when transitioning from a crisis. DMAS is an integral partner and stakeholder within this plan. This year, in support of the Governor's Right Help, Right Now Behavioral Health Transformation Plan, DMAS in collaboration with other state agencies and stakeholders has been working on the following initiatives: i) identifying service innovations and best practices in behavioral health services, this includes a specific focus on developing a new school-based behavioral health service for youth and researching best practice models for youth mental health residential treatment services; ii) identify and research evidence-based programs specific to youth and iii) assessment of health plan behavioral health network adequacy. The goal of DMAS in partnership with this plan is to increase efficacy, access, and utilization of effective and appropriate behavioral health services for Medicaid members in Virginia. - A collaboration and partnership among health and human services state agencies in Virginia, came together to () the Center for Evidence-Based Partnerships (CEP-VA) to assist in centralizing data, implementation work and collaboration around supporting and implementing evidence-based behavioral health services across Virginia agnostic of payer. The Center continues to support and analyze Virginia implementation of these services and provide technical assistance and training to providers. • DMAS' ICER team included the measure Follow-Up After Emergency Department (ED) Visit for Mental Illness in its PWP which provides an incentive to MCOs to increase performance and close gaps.

2021–2022 EQRO Recommendations	DMAS Actions
	Measure: *Follow-Up After Emergency Department (ED) Visit for Mental Illness* **MY 2021:** 7-Day: 45.34% 30-Day: 57.38% **MY 2022:** 7-Day: 43.04% 30-Day: 55.53%
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members **Measure 4.1.1.4:** Immunizations for Adolescents **Objective 4.2: ★ Improve Outcomes for Maternal and Infant Members. ★** **Measure: 4.2.1.4:** Well-Child Visits in the First 20 Months of Life To improve program-wide performance in support of Objective 4.1 and 4.2 and improve preventive services and well-child visits for members under the age of 21 years, HSAG recommends DMAS: • Require the MCOs to identify best practices for ensuring children receive all preventive vaccinations and well-child services according to recommended schedules. • Require the MCOs to conduct a root cause analysis to identify barriers that their members are experiencing in accessing well-child and preventive care and services. • Require the MCOs to identify best practices to improve care and services according to the Bright Futures guidelines.	DMAS has improved its ability to track MCO required monthly data submissions. **MCH:** • The new Cardinal M4 draft contract (now in RFP) includes a requirement to incorporate AAP and Bright Futures in its quality assurance activities. If implemented as written, the Contractor will be required to follow a long-term improvement plan relating to improving EPSDT indicators that will not exceed five (5) years. The contractor must implement interventions or strategies to address following criteria: 1. Childhood Immunization rates 2. Well-child rates in all age groups 3. Lead testing rates 4. Increase percentage of lead testing of children aged one (1) to five (5) each contract year 5. Improve the current tracking system for monitoring EPSDT corrective action referrals (referrals based on the correction or amelioration of the diagnosis). • MCOs are involved in the DMAS CMS Affinity Groups that targets increasing in well-child visit rates, immunizations, timeliness of care and increased access to quality care for children. **ICER:** DMAS included the measures *Child and Adolescent Well-Care Visits and Childhood Immunization Status* in its PWP which provides an incentive to MCOs to increase performance and close gaps. **Measure**: *Child and Adolescent Well-Care Visits* **MY 2021:** 46.57% **MY 2022:** 50.27% **Measure:** *Childhood Immunization Status* **MY 2021:** 65.82% **MY 2022:** 63.22%

2021–2022 EQRO Recommendations	DMAS Actions
Goal 4: Strengthen the Health of Families and Communities **Objective 4.2: ★ Improve Outcomes for Maternal and Infant Members ★** **Measure: 4.2.1.1:** Prenatal and Postpartum Care: Postpartum Care **Measure: 4.2.1.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care To improve program-wide performance in support of Objective 4.2 and improve use of prenatal and postpartum care, HSAG recommends DMAS: • Require the MCOs to identify access- and timeliness-related PM indicators such as the *Prenatal and Postpartum Care—Postpartum Care* and *Timeliness of Prenatal Care* PM indicators that fell below the NCQA Quality Compass national Medicaid HMO 50th percentile, and focus QI efforts on identifying the root cause and implementing interventions to improve access to care. • Require the MCOs to identify healthcare disparities within the access-related PM data to focus QI efforts on a disparate population. DMAS should also require the MCOs to identify best practices for ensuring prenatal and postpartum care and ensure members receive all prenatal and maternity care according to recommended schedules. • Require the MCOs to identify best practices to improve care and services according to evidence-based guidelines.	**MCH:** • Within the new DRAFT Cardinal M4 contract (now in RFP), MCOs will be required to conduct annual Performance Improvement Projects (PIPs) for validation by the EQRO. Each PIP must include implementation of interventions to achieve improvement in the access to care, timeliness and quality of care, consistent with 42 CFR §430.330. The Contractor must identify benchmarks and set measurable achievable performance goals for each of its PIPs, which will be submitted to the Department for review and approval. In the first year of this Contract, one PIP shall be focused on maternal health. The due date for PIPs and validation must be in accordance with the process and methodology agreed upon by the Department and its EQRO agent. All PIP requirements will be located within the Cardinal Care Technical Manual. • The new contract specifies measures to be used in DMAS' Performance Withhold Program (PWP) that include timeliness of prenatal care and timeliness of postpartum care. MCOs will have to report these measures, which will be validated by DMAS' EQRO. **ICER:** DMAS included the measures *Prenatal and Postpartum Care* in its PWP which provides an incentive to MCOs to increase performance and close gaps. **Measure:** *Prenatal and Postpartum Care* **MY 2021:** *Timeliness of Prenatal Care:* 73.00% *Postpartum Care:* 66.52% **MY 2022:** *Timeliness of Prenatal Care:* 76.44% *Postpartum Care:* 66.76%

Strengths and Recommendations

Strengths

DMAS considers the Virginia 2023–2025 Quality Strategy to be its roadmap for the future. DMAS' Quality Strategy provides the roadmap to accomplish its dynamic approach to achieving its overarching goal of designing, implementing, improving, and assessing the quality of healthcare and services furnished through Virginia's coordinated and comprehensive system. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, and quality, satisfaction, and timeliness of services for Virginia Medicaid and CHIP members. Overall, the Quality Strategy represents an effective tool for measuring and improving the quality of Virginia's Medicaid managed care services. The Quality Strategy promotes identification of creative initiatives to continually monitor, assess, and improve access to care, the quality of care and services, member satisfaction, and the timeliness of service delivery for the Virginia Medicaid members. Additionally, DMAS's initiatives tie to the Quality Strategy goals, and objectives. The Virginia Medicaid Quality Strategy strives to ensure members receive high-quality care that is safe, efficient, patient-centered, timely, value and quality-based, data-driven, and equitable.

DMAS conducts oversight of the MCOs in coordination with the Quality Strategy to promote accountability and transparency for improving health outcomes. DMAS has an MCO contract requirement that the MCO should be committed to quality improvement and its overall approach and specific strategies will be used to advance Virginia Medicaid's Quality Strategy and incentive-based quality measures. In addition, each MCO is required to be NCQA accredited and to conduct HEDIS performance measure reporting.

Recommendations

The EQRO has identified the following recommendations for the Quality Strategy:

To improve program-wide performance in support **of Goal 4: Strengthen the Health of Families and Communities, Objectives 4.1 and 4.2** and improve preventive services and well-child visits for members under the age of 21 years, HSAG recommends DMAS:

- Work with MCOs to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended cancer screenings and to make appropriate health decisions. HSAG continues to recommend that DMAS monitor MCOs to ensure that the MCOs analyze their data and consider if there are disparities within the MCOs' populations that contributed to lower screening rates. Additionally, HSAG recommends that DMAS require the MCOs to analyze the factors that contributed to the higher usage of imaging studies when not clinically appropriate for a particular age group, ZIP Code, etc. MCOs should focus resources and implement appropriate interventions to increase the screening rates, pregnancy care and to reduce unnecessary low back pain-related imaging studies due to the low rates for the four measures.

To improve program-wide performance in support of **Goal 4: Strengthen the Health of Families and Communities, Objective 4.1** and improve adolescent well visits and adolescent immunizations for

members under the age of 21 years, HSAG recommends DMAS, considering the recurring MCO opportunities related to measures within the Taking Care of Children domain:

- Work with the MCOs to identify best practices for ensuring adolescents receive all preventive vaccinations according to recommended schedules. HSAG recommends that the MCOs identify and implement new interventions based on their completed root cause analyses which identified barriers their members' parents and guardians have experienced in accessing care and services. Additionally, HSAG recommends that MCOs evaluate providers' barriers to completing BMI assessments, counseling for nutrition, and counseling for physical activity, then implement targeted interventions to address these barriers.

To improve the accuracy of provider information available to members in support of **Goal 4: Strengthen the Health of Families and Communities**, **Objective 4.1** and improve access and timeliness of preventive services and well-child visits for members under the age of 21 years, HSAG recommends that DMAS:

- Work with the enrollment broker to address the data deficiencies identified during the survey (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify the location's address and appropriate provider type and specialty. Additionally, DMAS may also consider requesting the MCOs to provide evidence of training offered, by the MCO, to provider's offices regarding the MCO plan names and benefit coverage. Evidence should demonstrate that the office staff responsible for scheduling appointments have been educated on the MCO names and benefit coverage and the offices have a plan in place for educating new staff in the event of staff turnover.

To improve program-wide performance in support **of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4** and improve behavioral health and developmental services for members, HSAG recommends that DMAS:

- Work with the MCOs to develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization for mental illness and after emergency department visit for mental illness. HSAG also recommends that DMAS work with the MCOs to consider if there are disparities within the MCOs' populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Additionally, HSAG recommends that DMAS continue leveraging the CMS Improving Behavioral Health Follow-up Care Learning Collaborative [F-5] materials to identify potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care.

To improve the accuracy of provider information available to members in support of **Goal 4: Strengthen the Health of Families and Communities**, **Objective 4.1** and improve access and timeliness of well-child visits and preventive health care for members under the age of 21 years, and the timeliness of pregnancy related care, HSAG recommends that DMAS:

- Work with the enrollment broker to address the data deficiencies identified during the primary care provider and the prenatal care secret shopper surveys (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data

[F-5] Centers for Medicare & Medicaid Services. Improving Behavioral Health Follow-up Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/behavioral-health-learning-collaborative/index.html. Accessed on: Feb 26, 2024.

correctly identifies the location address and appropriate provider type and provider specialty. DMAS may also consider requesting that the MCOs provide evidence of training offered, by the MCO, to provider's offices regarding the MCO plan names and benefit coverage. MCO evidence should demonstrate that the office staff responsible for scheduling appointments have been educated on the MCO names and benefit coverage and the offices have a plan in place for educating new staff in the event of staff turnover. Accurate provider information, including provider specialties and contact information may result in improved access to care for members seeking well-care, preventive health, childhood immunizations, and pregnancy related care.

- Work with MCOs to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended well-visits according to the EPSDT and Bright Futures schedule and to make appropriate health decisions. HSAG continues to recommend that DMAS monitor MCOs to ensure that the MCOs analyze their data and consider if there are disparities within the MCOs' populations.

Quality Strategy Evaluation Methodology

Evaluation Methodology Description

Review Period

The evaluation period focuses on the 12-month performance period of January 1, 2023–December 31, 2023.

Goals and Objectives

The Virginia 2023–2025 Quality Strategy identified goals and objectives that focus on process as well as achieving outcomes. Virginia's Quality Strategy identifies the following five goals and fourteen associated objectives:

- Goal 1: Enhance the Member Care Experience:
  - Objective 1.1: Increase Member Engagement and Outreach
  - Objective 1.2: Improve Member Satisfaction
- Goal 2: ★ Promote Access to Safe, Gold-Standard Patient Care ★
  - Objective 2.1: Ensure Access to Care
  - Objective 2.2: Promote Patient Safety
  - Objective 2.3: Promote Effective Communication and Care Coordination
- Goal 3: ★ Support Efficient and Value-Driven Care ★
  - Objective 3.1: Focus on Paying for Value
  - Objective 3.2: Promote Efficient Use of Program Funds
- Goal 4: Strengthen the Health of Families and Communities
  - Objective 4.1: Improve Utilization of Wellness, Immunization, and Prevention Services for Members

  - Objective 4.2: ★ Improve Outcomes for Maternal and Infant Members ★
  - Objective 4.3: Improve Home and Community-Based Services
- Goal 5: Providing Whole-Person Care for Vulnerable Populations
  - Objective 5.1: Improve Outcomes for Members with Chronic Conditions
  - Objective 5.2: Improve Outcomes for Nursing Home Eligible Members
  - Objective 5.3: ★ **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders ★
  - Objective 5.4: ★ **Objective 5.4:** Improve Behavioral Health and Developmental Services of Members ★

Evaluation

HSAG conducts a formal evaluation of the Quality Strategy to assess its overall effectiveness to improve healthcare delivery, accessibility, and quality in the populations served by the managed care program. For DMAS, HSAG's evaluation includes an assessment of managed care performance compared to national benchmarks; MCO target and improvement objectives; performance improvement initiatives; and an examination of strengths, opportunities for improvement, and recommendations to add, enhance, or modify quality initiatives aimed at improving service delivery, accessibility, and quality.

To evaluate the Quality Strategy, HSAG analyzes the following to determine performance and progress in achieving the goals of the DMAS Quality Strategy.

- HEDIS measures
- CAHPS surveys
- Core Set of Adult Health Care Quality Measures for Medicaid
- Core Set of Children's Health Care Quality Measures for Medicaid and CHIP
- State-specific measures
- Addressing health disparities
- Use of sanctions
- EQR activities, such as the following:
  - PIP validation
  - Network adequacy and availability validation
  - Compliance monitoring
  - Annual EQR technical reports
- MCO performance withholds of capitation payments
- Quality initiatives

The Quality Strategy evaluation provides critical information about the structure of the quality program and the process for improving health service quality, access, and timeliness, and whether the program is achieving its goals. When opportunities for improvement are identified, HSAG will work with DMAS and its contracted MCOs to identify the leading causes for stagnant or declining performance. HSAG also will work with DMAS to examine health policies that may impact, either positively or negatively, service delivery, accessibility, and quality of care and to refine its methodology and tools as needed based on lessons learned from the previous year's evaluation.

Evaluation Tool

To track the progress of achieving goals and objectives outlined in the 2023–2025 Quality Strategy, HSAG tracks annual results of contractual performance metrics that aligned with the performance measures included in the Quality Strategy to measure improvement. HSAG developed a Virginia Medicaid Goals Tracking Table. The table includes the metrics included in the 2023–2025 Virginia Quality Strategy and categorized by the State's associated goals and objectives, along with baseline rates from measurement year (MY) 2020. The most recent MY rates are compared to baseline rates, targets, and improvement objectives.

Quality Strategy Evaluation Virginia Medicaid Goals Tracking Table

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
Goal 1: Enhance the Member Care Experience	**Objective 1.1** Increase Member Engagement and Outreach	1.1.1.1. Number of Outreach and Engagement (O&E) Activities Per year	DMAS Cover Virginia	**Cover Virginia 2021:** Spanish Calls Taken by Spanish-Speaking Bilingual Staff: 73,088 **Cover Virginia 2021:** Calls Taken with Language Assistance Services: 50,902 **Medallion 4.0** Call Center Language Calls 2021: 7,551 **CCC Plus** Call Center Language Calls 2021: 545 **2021 DMAS Website** Translation Requests 2021: 3,489	Increase by X percent the Cover Virginia Spanish language calls taken by Spanish-speaking bilingual staff Increase by X percent the Cover Virginia calls taken with language assistance by 2025 Increase by X percent the Medallion 4.0 call center language calls taken by 2025 Increase by X percent the CCC Plus call center language calls taken by 2025. Increase by X percent the translation requests taken by 2025	
		1.1.1.2 Monitor Language and Disability Access Reports	DMAS	• CCC Plus: • Medallion 4.0:	Increase by X percent the Language and Disability Access report monitoring: • Cardinal Care Program:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		1.1.1.3 Monitor Member Language Counts	DMAS	• CCC Plus: • Medallion 4.0:	Increase by X percent the Member Language Counts reported • Cardinal Care Program:	
	Objective 1.2 Improve Member Satisfaction	1.2.1.1 Enrollees' Ratings Q8-Rating of all Health Care	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus: 68.5% • Medallion 4.0: 75.7% Adult: • CCC Plus: 58.7% • Medallion 4.0: 55.8%	Increase the Cardinal Care annual CAHPS overall Rating of *all Health Care* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	
		1.2.1.2 Rating of Personal Doctor	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus: 79.5% • Medallion 4.0: 77.7% Adult: • CCC Plus: 72.8% • Medallion 4.0: 68.0%	Increase the Cardinal Care annual CAHPS overall Rating of *Personal Doctor* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	
★ Goal 2: Promote Access to Safe, Gold-Standard Patient Care	**Objective 2.1** Ensure Access to Care	2.1.1.1 Getting Care Quickly Q6	CAHPS – AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus: 89.7% • Medallion 4.0: 86.0% Adult: • CCC Plus: 85.0%	Increase the Cardinal Care annual CAHPS overall Rating of *Getting Care Quickly* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0: 81.1%		
		2.1.1.2 Respondent Got Non-Urgent Appointment as Soon as Needed	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus: % • Medallion 4.0: % Adult: • CCC Plus: % • Medallion 4.0: %	Increase the Cardinal Care annual CAHPS overall Rating of *Got Non-Urgent Appointment as Soon as Needed* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	
		2.1.1.3 Getting Needed Care	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	AHRQ CAHPS 2021 Child: • CCC Plus: 87.3% • Medallion 4.0: 84.6% Adult: • CCC Plus: 86.1% • Medallion 4.0: 82.9%	Increase the Cardinal Care annual CAHPS overall Rating of *Getting Needed Care* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	
	Objective 2.2 Promote Patient Safety	2.2.1.1 Prevalence of Pressure Ulcers Among LTSS Members	DMAS	Long-Term Nursing Facility: 3.3%[1] Short-Term Nursing Facility: 7.1%[1] CCC Plus Waiver Members: 1.9%[1]	Decrease the prevalence percentage of LTSS members with pressure ulcers by 2025: • Long-Term Nursing Facility: • Short-Term Nursing Facility:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• CCC Plus Waiver Members:	
		2.2.1.2 Monitor the Frequency of Reported Critical Incidents by Member Classification	DMAS	• CCC Plus Waiver w/o PDN: 694 • CCC Plus Waiver: 26 • CCC Plus Waiver W PDN: 30 • DD Waiver: 9 • Emerging Vulnerable: 349 • Minimal Need: 107 • Nursing Facility: 446 • Other: 732 • Total: 2,393[2]	Increase the number and percentage of Cardinal Care program members without PDN critical incidents reported by 2025: • CCC Plus Waiver w/o PDN: • CC Plus Waiver: • DD Waiver: • Emerging Vulnerable: • Minimal Need: • Nursing Facility: • Other: • Total:	
	Goal 2.3 Promote Effective Communication and Care Coordination	2.3.1.1 How Well Doctors Communicate	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus: 93.9% • Medallion 4.0: 93.7% Adult: • CCC Plus: 94.2% • Medallion 4.0: 93.3%	Increase the Cardinal Care annual CAHPS overall Rating of *How Well Doctors Communicate* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		2.3.1.2 Service Authorizations	DMAS https://www.dmas.virginia.gov/data/mco-service-authorization-performance/	2022 Fourth Quarter MCO Reporting	Maintain or Increase by X% service authorizations adjudicated timely by 2025: • Cardinal Care Program:	
★ **Goal 3:** Support Efficient and Value-Driven Care	**Objective 3.1** Focus on Paying for Value	3.1.1.1 Frequency of Potentially Preventable Admissions	DMAS Clinical Efficiency Measures	Clinical Efficiency Measures 2021 CCC Plus: 2.942	Decrease by 10% Potentially Preventable Admissions: • Cardinal Care Program:	
		3.1.1.2 Frequency of Emergency Department Visits	DMAS Clinical Efficiency Measure	Clinical Efficiency Measures 2021 CCC Plus: 43.08	Decrease by 1% the Potentially Preventable, Avoidable, and/or Medically Unnecessary Emergency Department Visits: • Cardinal Care Program:	
		3.1.1.3 Frequency of Potentially Preventable Readmissions	DMAS Clinical Efficiency Measure	2021 CCC Plus: 18.77%	Decrease by 8% Potentially Preventable Readmissions Within 30 Days: • Cardinal Care Program:	
		3.1.1.4 Ambulatory Care	NCQA HEDIS	HEDIS MY 2020 • CCC Plus: 77.45 • Medallion 4.0:	Decrease the HEDIS Ambulatory Care: Emergency Department (ED) Visit measure rate to perform at or above	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					the HEDIS 50th percentile by 2025: • Cardinal Care Program:	
		3.1.1.5 Ambulatory Care: Emergency (ED) Visits	DMAS Clinical Efficiency Measures NCQA HEDIS (AMB) CMS Child Core Set: AMB-CH	Clinical Efficiency Measures • 2021 CCC Plus: 43.08 HEDIS MY 2020 • CCC Plus: 77.45% • Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0	Decrease the HEDIS Ambulatory Care: Emergency Department (ED) Visit measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program HEDIS: • Cardinal Care Program Child Core Set: • Less than 1 Year: • 1-9 Years: • 10-19 Years: • Total: Decrease the CMS Child Core Set Ambulatory Care: Emergency Department (ED) Visit measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program HEDIS: • Cardinal Care Program Child Core Set: • Less than 1 Year:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• 1-9 Years: • 10-19 Years: • Total:	
		3.1.1.6 Days Without Minimum RN Hours	DMAS VBP Reporting Team CMS Payroll Based Journal	NF VBP Program 2019 • CCC Plus:	NF VBP Decrease by X% the number of nursing facility y days without minimum RN hours. • Cardinal Care Program:	
		3.1.1.7 Total Nurse Staffing Hours Per Resident Day (RN, LPN, CAN) – Case-Mix Adjusted	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus:	NF VBP Increase by X% the number of days with total nurse staffing hours per resident day meeting minimum requirements. • Cardinal Care Program:	
		3.1.1.8 Percentage of Long-Stay Resident with a Urinary Tract Infection (UTI)	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus:	NF VBP Decrease by X% Long-Stay Residents with a Urinary Tract Infection. • Cardinal Care Program	
		3.1.1.9 Number of Hospitalizations per 1,000 Long-Stay Resident Days	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus:	NF VBP Decrease by X% the number of unplanned inpatient admissions or outpatient observations stays that occurred among long-stay residents of a nursing home.	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• Cardinal Care Program:	
		3.1.1.10 Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus:	NF VBP Decrease by X% the number of outpatient ED visits that occurred among long-stay residents of a nursing home.	
		3.1.1.11 Percentage of Long-Stay High-Risk Residents with Pressure Ulcers	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus:	NF VBP Decrease by X% Long-Stay High-Risk Residents with Pressure Ulcers	
	Objective 3.2 Promote Efficient Use of Program Funds	3.2.1.1 Monitor Medical Loss Ratio	DMAS—MCO Financials https://www.dmas.virginia.gov/data/mco-financials/	• CCC Plus: • Medallion 4.0:	Maintain MLR XXXX	
Goal 4: Strengthen the Health of Families and Communities	**Objective 4.1** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	4.1.1.1 Adults' Access to Preventive/Ambulatory Health Services	NCQA HEDIS (AAP)	HEDIS MY 2020 • CCC Plus: 87.12% • Medallion 4.0: 72.75%	Increase the HEDIS Adults' Access to Preventive/Ambulatory Health Services measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program:	
		4.1.1.2 Child and Adolescent Well-Care Visits	NCQA HEDIS (WCV) Child Core Set: WCV-CH	HEDIS MY 2020 • CCC Plus: 39.86% • Medallion 4.0: 46.57% Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Child and Adolescent Well-Care Visits measure rate to perform at or above the HEDIS 50th percentile by 2025:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• Cardinal Care Program: Increase the CMS Child Core Set Child and Adolescent Well-Care Visits measure rate to perform at or above the CMCS 50th percentile by 2025: • 3-11 Years: • 12-17 Years: • 18-21 Years: • Total:	
		4.1.1.3 Childhood Immunization Status	NCQA HEDIS (CIS) • Combo 3 Child Core Set: CIS-CH	HEDIS MY 2020 • CCC Plus: 65.58% • Medallion 4.0: 65.82% Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Childhood Immunization Status measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program: Increase the CMS Child Core Set Child and Adolescent Well-Care Visits measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program:	
		4.1.1.4 Immunizations for Adolescents	NCQA HEDIS (IMA) • Combo 1 • Combo 2 Child Core Set: IMA-CH	HEDIS MY 2020 Combo 1 • CCC Plus: 64.10%	Increase the HEDIS Immunization for Adolescents measure rate to perform at or	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0: % Combo 2 • CCC Plus: 26.02% • Medallion 4.0: % Child Core Set • CCC Plus: • Medallion 4.0:	above the HEDIS 50th percentile by 2025: • Combo 1: • Combo 2: Increase the CMS Child Core Set Child and Adolescent Well-Care Visits measure rate to perform at or above the CMCS 50th percentile by 2025: Cardinal Care Program: • Combo 1: • Combo 2:	
		4.1.1.5 Flu Vaccinations for Adults 18-64	AHRA CAHPS Adult Core Set: CPA-AD	CAHPS 2021: ND Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the CAHPS Flu Vaccinations for Adults 18-64 Years measure rate to perform at or above the CAHPS 50th percentile by 2025: • Cardinal Care Program: Increase the CMS Adult Core Set Flu Vaccinations for Adults 18-64 Years measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		4.1.1.6 Topical Fluoride for Children	NCQA HEDIS (TFC) Child Core Set: TFL-CH CMS 416	HEDIS MY 2020 • CCC Plus: • Medallion 4.0: Child Core Set • CCC Plus: • Medallion 4.0: CMS 416 2021	Increase the HEDIS Topical Fluoride for Children measure rate to perform at or above the HEDIS 50th percentile by 2025: *Note: MY 2023 Year 1 measure – percentile rankings may not be available.* • Cardinal Care Program – Total: Increase the CMS Child Core Set Topical Fluoride for Children measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program: *Note: Need to determine target for a CMS 416 measure.*	
		4.1.1.7 Oral Evaluation, Dental Services	NCQA HEDIS (OED) Child Core Set: OEV-CH CMS 416	HEDIS MY 2020 • CCC Plus: • Medallion 4.0: Child Core Set • CCC Plus: • Medallion 4.0: • CMS 416 2021	Increase the HEDIS Oral Evaluation, Dental Services measure rate to perform at or above the HEDIS 50th percentile by 2025: *Note: MY 2023 Year 1 measure – percentile rankings may not be available.*	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• Cardinal Care Program Increase the CMS Child Core Set Evaluation, Dental Services measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Need to determine target for a CMS 416 measure.*	
		4.1.1.8 Sealant Receipt on Permanent First Molars	Child Core Set: SFM-CH CMS 416	Child Core Set • CCC Plus: • Medallion 4.0: CMS 416 2021	Increase the HEDIS Sealant Receipt on Permanent First Molars measure rate to perform at or above the HEDIS 50th percentile by 2025: *Note: MY 2023 Year 1 measure – percentile rankings may not be available.* • Cardinal Care Program Increase the CMS Child Core Set Sealant Receipt of Permanent First Molars measure rate to perform at or above the CMCS 50th percentile by 2025:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• Cardinal Care Program – Total: *Note: Need to determine target for a CMS 416 measure.*	
		4.1.1.9 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA HEDIS (WCC) CMS Child Core Set (WCC-CH)	HEDIS MY 2020 CCC Plus: •	Increase the HEDIS Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • BMI Percentile Documentation • Counseling for Nutrition • Counseling for Physical Activity Increase the CMS Child Core Set Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• BMI Percentile Documentation • Counseling for Nutrition • Counseling for Physical Activity	
		4.1.1.10 Chlamydia Screening in Women Ages 16 to 20	NCQA HEDIS (CHL) CMS Child Core Set (CHL-CH)	HEDIS MY 2020 • CCC Plus: NR • Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Chlamydia Screening in Women Ages 16-20 measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program *Note: HEDIS measure age is 16-24 Years.* Increase the CMS Child Core Set Chlamydia Screening in Women Ages 16-20 Years measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		4.1.1.11 Lead Screening in Children	NCQA HEDIS (LSC) CMS Child Core Set (LSC-CH)	HEDIS MY 2020 • CCC Plus: NR • Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Lead Screening in Children measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Increase the CMS Child Core Set Lead Screening in Children measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
	★ **Objective 4.2** Improve Outcomes for Maternal and Infant Members	4.2.1.1 Prenatal and Postpartum Care: Postpartum Care	NCQA HEDIS (PPC) Adult Core Set: PPC-AD	HEDIS MY 2020 Postpartum Care • CCC Plus: NR • Medallion 4.0: 66.52% Adult Core Set Postpartum Care • CCC Plus: • Medallion 4.0:	Increase the HEDIS Prenatal and Postpartum Care: Timeliness of Prenatal Care measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Adult Core Set Prenatal and Postpartum Care: Timeliness of Prenatal Care measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		4.2.1.2 Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA HEDIS (PPC) Child Core Set: PPC-CH	HEDIS MY 2020 Timeliness of Prenatal Care • CCC Plus: NR	Increase the HEDIS Prenatal and Postpartum Care: Postpartum Care measure rate to	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0: 73.00% Adult Core Set Timeliness of Prenatal Care • CCC Plus: • Medallion 4.0:	perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Child Core Set Prenatal and Postpartum Care: Postpartum Care measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		4.2.1.3 Live Births Weighing Less than 2,500 Grams	Child Core Set: LBW-CH CDC Wonder State Vital Records	CMS 2021 Child Core Set Reported Rate—CDC Wonder Data:	Decrease the CMS Child Core Set Live Births Weighing Less than 2,500 Grams measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		4.2.1.4 Well-Child Visits in the First 30 Months of Life	NCQA HEDIS (W30) Child Core Set: W30-CH	HEDIS MY 2020 • CCC Plus: 71.81% • Medallion 4.0: 72.10% Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Well-Child Visits in the First 30 Months of Life measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • First 15 Months:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• 15-30 Months Increase the CMS Child Core Set Well-Child Visits in the First 30 Months of Life measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program • First 15 Months: • 15-30 Months	
		4.2.1.5 Low-Risk Cesarean Delivery	Child Core Set: LRCD-CH CDC Wonder State Vital Records	Child Core Set CMS 2021 Reported Rate—CDC Wonder Data:	Decrease the CMS Child Core Set Low-Risk Cesarean Delivery measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Lower rate is better.*	
	Objective 4.3 Improve Home and Community-Based Services	4.3.1.1 Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and Appropriate to Their Needs and Personal Goals	QMR	**FY22** Q1: 86.0% Q2: 50% Q3: 53%	Increase the number and percent of waiver individuals who have service plans that are adequate and appropriate to their needs and personal goals by 5% by 2025: • Cardinal Care Program – Total:	
		4.3.1.2 Number and Percent of Individuals Who Received	QMR	**FY22** Q1: 97.0%	Increase the number and percent of individuals who	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		Services in the Scope Specified in the Service Plan		Q2: 100% Q3: 100%	received services in the scopes specified in their service plan by 5% by 2025: • Cardinal Care Program – Total:	
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.1** Improve Outcomes for Members with Chronic Conditions	5.1.1.1 PQI 08: Heart Failure Admission Rate	Adult Core Set: PQI08-AD	Adult Core Set • CCC Plus: • Medallion 4.0:	Decrease the CMS Adult Core Set Heart Failure Admission measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Lower rate is better.*	
		5.1.1.2 PQI 14: Asthma Admission Rate (Ages 2–17)	Adult Core Set: PQI15-AD	Adult Core Set • CCC Plus: • Medallion 4.0:	Decrease the CMS Adult Core Set Asthma Admission measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Lower rate is better.*	
		5.1.1.3 PQI 05: COPD and Asthma in Older Adults' Admission Rate	Adult Core Set: PQI105-AD	Adult Core Set • CCC Plus: 41.04% • Medallion 4.0:	Decrease the CMS Adult Core Set Asthma in Older Adults' Admission measure rate to perform at or above the CMCS 50th percentile by 2025:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• Cardinal Care Program – Total: *Note: Lower rate is better.*	
		5.1.1.4 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	NCQA HEDIS (HPC) Adult Core Set: HPC-AD	HEDIS MY 2020 • CCC Plus: 51.42% • Medallion 4.0: 41.04% Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Adult Core Set Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		5.1.1.5 Controlling High Blood Pressure	NCQA HEDIS (CBP) Adult Core Set: CBP-AD	HEDIS MY 2020 • CCC Plus: 48.07% • Medallion 4.0: 46.91% Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Controlling High Blood Pressure measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Increase the CMS Adult Core Set Controlling High Blood Pressure measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		5.1.1.6 Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years	NCQA HEDIS (AAB) CMS Child Core Set: AAB-CH	HEDIS MY 2020 • CCC Plus: 47.93% • Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • *3 Months to 17 Years:* • *18- 64 Years:* • *65 Years and older:* • *Total:* *Note: Recommend dropping the 18-64, 65 years and older, and total.* Increase the CMS Child Core Set Avoidance of Antibiotic Treatment for Acute Bronchitis:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Ages 3 Months to 17 Years measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: • *3 Months to 17 Years:*	
		5.1.1.7 Asthma Medication Ratio: Age 5 to 18 Years	NCQA HEDIS (AMR) CMS Child Core Set: AMR-CH	HEDIS MY 2020 • CCC Plus: 63.62% • Medallion 4.0: 71.00% Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Asthma Medication Ratio: Age 5 to 18 Years measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Child Core Set Asthma Medication Ratio: Age 5 to 18 Years measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
	Objective 5.2 Improve Outcomes for Nursing Home Eligible Members	5.2.1.1 Use of High-Risk Medications in Older Adults (Elderly)	NCQA HEDIS (DAE)	HEDIS MY 2020: CCC Plus: 14.88%	Decrease the HEDIS Use of High-Risk Medications in Older Adults (Elderly) measure rate to perform at or above the HEDIS 50th percentile by 2025:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• Cardinal Care Program – Total: *Note: Lower rate is better.*	
	★ **Objective 5.3** Improve Outcomes for Members with Substance Use Disorders	5.3.1.1 Monitor Identification of Alcohol and Other Drug Services	DMAS	• CCC Plus: • Medallion 4.0:	Increase the percentage of members with Identification of Alcohol and Other Drug Services by 5% by 2025.	
		5.3.1.2 Follow-Up After Emergency Department Visit for Substance Use	NCQA HEDIS (FUA) Child Core Set: FUA-CH	HEDIS MY 2020 CCC Plus • 7-Day: 11.44% • 30-Day: 19.98% Medallion 4.0: • 7-Day: 13.92% • 30-Day: 21.88% Child Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0: • 7-Day: • 30-Day:	Increase the HEDIS Follow-Up After Emergency Department Visit for Substance Use measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Child Core Set Follow-Up After Emergency Department Visit for Substance Use measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		5.3.1.3 Use of Opioids at High Dosage in Persons Without Cancer	NCQA HEDIS (OHD) Adult Core Set: OHD-AD	HEDIS MY 2020 • CCC Plus: • Medallion 4.0: Adult Core Set • CCC Plus: • Medallion 4.0:	Decrease the HEDIS Use of Opioids at High Dosage in Persons Without Cancer measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Decrease the CMS Adult Core Set Use of Opioids at High Dosage in Persons Without Cancer measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		5.3.1.4 Initiation and Engagement of Substance Use Disorder Treatment	NCQA HEDIS (IET) Adult Core Set: IET-AD	HEDIS MY 2020 CCC Plus: • Initiation: 46.41% • Engagement: 12.51% Medallion 4.0: • Initiation: • Engagement: Adult Core Set CCC Plus: • Initiation: • Engagement: • Medallion 4.0: • Initiation:	Increase the HEDIS Initiation and Engagement of Substance Use Disorder Treatment measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Adult Core Set Initiation and	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Engagement:	Engagement of Substance Use Disorder Treatment measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		5.3.1.5 Use of Pharmacotherapy for Opioid Use Disorder	CMS Adult Core Set: OUD-AD	Adult Core Set • CCC Plus • Medallion 4.0:	Increase the CMS Adult Core Measure rate Use of Pharmacotherapy for Opioid Use Disorder measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
	Goal: 5.4 Improve Behavioral Health and Developmental Services for Members	5.4.1.1 Follow-Up After Hospitalization for Mental Illness	NCQA HEDIS (FUH) Adult Core Set: FUH-AD Child Core Set: FUH-CH	HEDIS MY 2020 CCC Plus • 7-Day: 30.77% • 30-Day: 54.12% Medallion 4.0: • 7-Day: 35.63% • 30-Day: 56.84% Adult Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0:	Increase the HEDIS Follow-Up After Hospitalization for Mental Illness measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program 6 Years and Older • Within 7 Days • Within 30 Days Increase the CMS Adult Core Set Follow-	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• 7-Day: • 30-Day: Child Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0: • 7-Day: • 30-Day:	Up After Hospitalization for Mental Illness measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – 18 and Older: • Within 7 Days • Within 30 Days Increase the CMS Child Core Set Follow-Up After Hospitalization for Mental Illness measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program ages 6-17 Years: • Within 7 Days • Within 30 Days	
		5.4.1.2 Follow-Up After Emergency Department Visit for Mental Illness	NCQA HEDIS (FUM) Adult Core Set: FUM-AD Child Core Set: FUM-CH	HEDIS MY 2020 CCC Plus • 7-Day: 47.03% • 30-Day: 62.83% Medallion 4.0: • 7-Day: 45.34% • 30-Day: 57.38%	Increase the HEDIS Follow-Up After Emergency Department Visit for Mental Illness measure rate to perform at or above the HEDIS 50th percentile by 2025:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Adult Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0: • 7-Day: • 30-Day: Child Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0: • 7-Day: • 30-Day:	• Cardinal Care Program 6 Years and Older • Within 7 Days • Within 30 Days Increase the CMS Adult Core Set Follow-Up After Emergency Department for Mental Illness measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – 18 and Older: • Within 7 Days • Within 30 Days Increase the CMS Child Core Set Follow-Up After Emergency Department for Mental Illness measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program ages 6-17 Years: • Within 7 Days • Within 30 Days	
		5.4.1.3 Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity	NCQA HEDIS (ADD) Child Core Set: ADD-CH	HEDIS MY 2020 CCC Plus • Initiation:	Increase the HEDIS Follow-Up for Children Prescribed Attention-Deficit/Hyperactivity	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		Disorder (ADHD) Medication		• Continuation: Medallion 4.0 • Initiation: 45.20% • Continuation: 58.61% Child Core Set CCC Plus: • Initiation: • Continuation: CCC Plus: • Initiation: • Continuation:	Disorder (ADHD) Medication measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program – Ages 6-12 Years • Initiation Phase: • Continuation and Maintenance Phase: Increase the CMS Child Core Set Follow-Up for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Ages 6-12 Years • Initiation Phase: • Continuation and Maintenance Phase:	
		5.4.1.4 Monitor Mental Health Utilization	DMAS	DMAS • CCC Plus: • Medallion 4.0:	Increase the percentage of members receiving mental health services by X% by 2025.	
		5.4.1.5 Use of First-Line Psychosocial	NCQA HEDIS (APP)	HEDIS MY 2020	Increase the HEDIS Use of First-Line	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		Care for Children and Adolescents on Antipsychotics	Child Core Set: APP-CH	• CCC Plus: 43.71% • Medallion 4.0: 69.58% Child Core Set • CCC Plus: • Medallion 4.0:	Psychosocial Care for Children and Adolescents on Antipsychotics measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program – Ages 1-17 Years Increase the CMS Child Core Set Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Ages 1-17 Years	
		5.4.1.6 Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA HEDIS (APM) CMS Child Core Set: APM-CH	HEDIS MY 2020 CCC Plus: • Blood Glucose Testing—Total: 41.33 • Cholesterol Testing—Total: 28.59% • Blood Glucose and Cholesterol	Increase the HEDIS Metabolic Monitoring for Children and Adolescents on Antipsychotics measure rate to perform at or above the HEDIS 50th percentile by 2025:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Testing—Total: 27.05% Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0:	• Cardinal Care Program – Ages 1-17 Years Increase the CMS Child Core Set Metabolic Monitoring for Children and Adolescents on Antipsychotics measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Ages 1-17 Years	
		5.4.1.7 Medical Assistance with Smoking and Tobacco Use Cessation	CMS Adult Core Set: MSC-AD	Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Medical Assistance with Smoking and Tobacco Use Cessation measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • 3 Months – 17 Years • 18 – 64 Years • 65 and Older • Total Increase the CMS Adult Core Set Medical Assistance	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					with Smoking and Tobacco Use Cessation measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program • 18-64 Years • 65 and Older	
		5.4.1.8 Antidepressant Medication Management	NCQA HEDIS (AMM) CMS Adult Core Set: AMM-AD	HEDIS MY 2020: CCC Plus: • Effective Acute Phase Treatment: 61.11% • Effective Continuation Phase: 48.29% Medallion 4.0: • Effective Acute Phase Treatment: 57.12% • Effective Continuation Phase: 42.02% Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Antidepressant Medication Management measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • 18 and Older • Effective Acute Phase Treatment • Effective Continuation Phase Treatment Increase the CMS Adult Core Set Antidepressant Medication Management measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program • 18 – 64 Years	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• 65 and Older • Total • Effective Acute Phase Treatment • Effective Continuation Phase Treatment	
		5.4.1.9 Screening for Depression and Follow-Up Plan: Ages 18 and Older	CMS Adult Core Set: CDF-AD	Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the CMS Adult Core Set Screening for Depression and Follow-Up Plan: Ages 18 and Older measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program	
		5.4.1.10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA HEDIS (SSD) CMS Adult Core Set: SSD-AD	HEDIS MY 2020: • CCC Plus: 77.18% • Medallion 4.0: NR Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • 18 to 64 Years Increase the CMS Adult Core Set Diabetes Screening for People with	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program • 18 – 64 Years	
		5.4.1.11 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA HEDIS (HPCMI) CMS Adult Core Set: HPCMI-AD	HEDIS MY 2020 • CCC Plus: • Medallion 4.0 Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • 18 to 75 Years Increase the CMS Adult Core Set Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure rate to perform at or above the CMCS 50th percentile by 2025:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• Cardinal Care Program • 18 – 64 Years • 65 – 75 Years	
		5.4.1.12 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA HEDIS (SAA) CMS Adult Core Set: SAA-AD	HEDIS MY 2020: • CCC Plus: 69.50% • Medallion 4.0: NR Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • 18 to 39 Years Increase the CMS Adult Core Set Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program • 18 – 39 Years	

[1] *DMAS Cumulative data from MCO quarterly reports 1/1/2020–3/31/2022.*

[2] *MCO critical incident data reported to DMAS for calendar year 2021.*

**The baseline measure rate is the final validated 2021 HEDIS, performance measure rate or CAHPS reported in the 2021 Annual Technical Report and posted to the DMAS website.*

***Target established in the CY2021 PWP Methodology.*

****The baseline measure rate is the final validated 2020 HEDIS rate reported in the 2021 Annual Technical Report and posted to the DMAS website.*

^The baseline measure rate is the final 2021 rate calculated by HSAG for the PWP.

^^The baseline measure rate is the final 2021 rate reported by DMAS for the Quality Management Review.

^^^The baseline measure rate is the final 2021 rate reported by the DMAS Finance Team

▲ *Statistically significantly higher in 2020 than in 2019.*
▼ *Statistically significantly lower in 2020 than in 2019.*

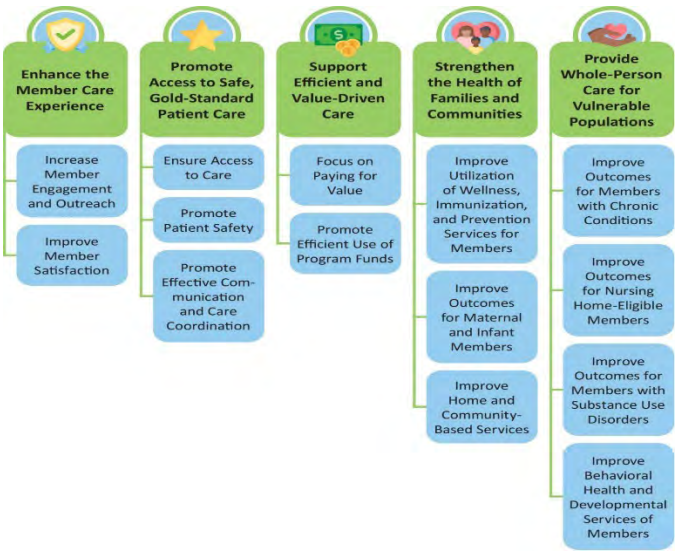
★ *These goals are inclusive of Governor Glenn Youngkin's identified priorities for the Medicaid program that focus on behavioral health enhancement, maternal health outcomes, and access to high quality healthcare services.*

Appendix G. CCC Plus (MLTSS) Program 2023 Snapshot

Virginia Medicaid Background

DMAS administers the CCC Plus (MLTSS) program, which includes the Virginia Medicaid program and FAMIS, the Commonwealth's CHIP program.

Virginia's 2023–2025 Quality Strategy Goals and Objectives



CCC Plus (MLTSS) Participating NCQA Accredited MCOs

DMAS contracted with six privately owned MCOs to deliver physical and behavioral health services to Medicaid and CHIP members.

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

*NCQA Health Plan and LTSS accredited
**NCQA Health Plan, Health Equity, LTSS, and Electronic Clinical Data Accredited
Note: Optima and VA Premier merged during CY 2023

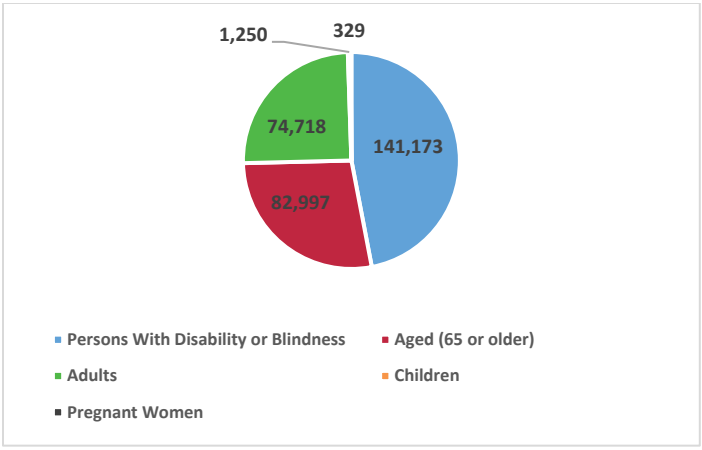
CCC Plus (MLTSS) Program Enrollment

Calendar Year 2023 Average Annual Program Enrollment

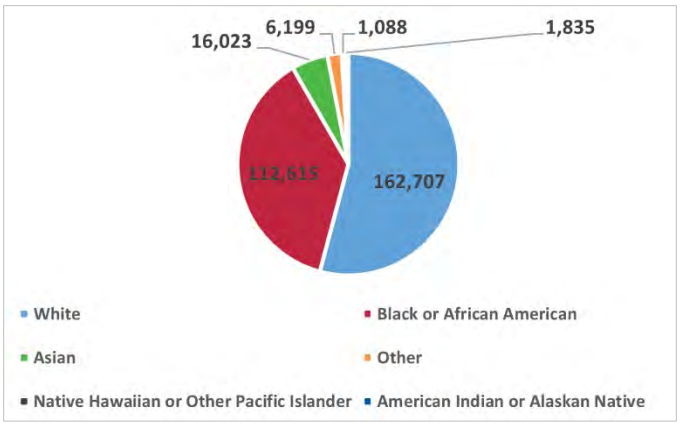
Program	SFY 2023 Enrollment as of 7/1/2023
CCC Plus	307,904

CCC Plus (MLTSS) Program Demographics

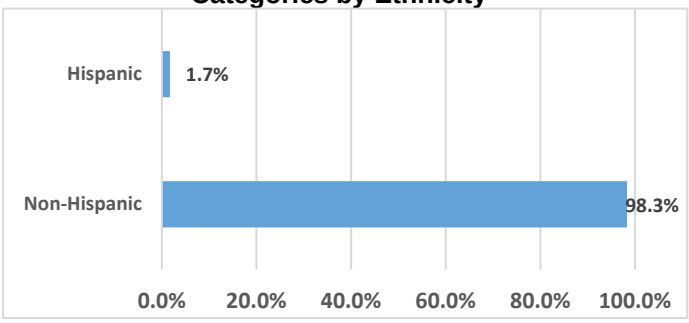
Eligibility Categories



Categories by Race

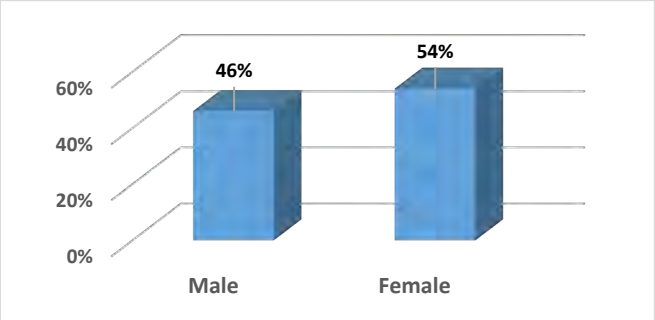


Categories by Ethnicity

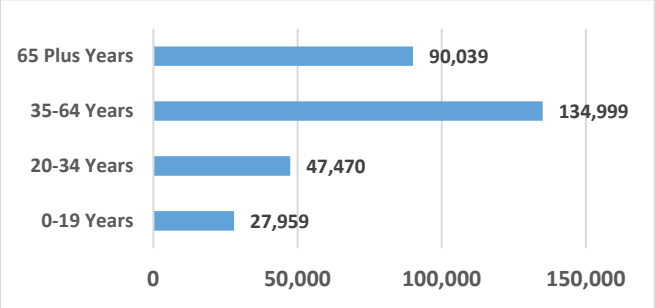


CCC Plus (MLTSS) Program Demographics

Percentage by Gender

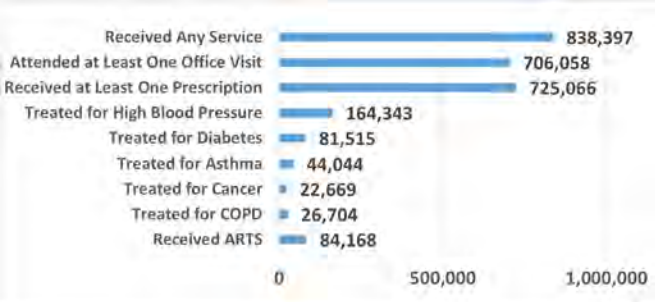


Enrollment by Age Group

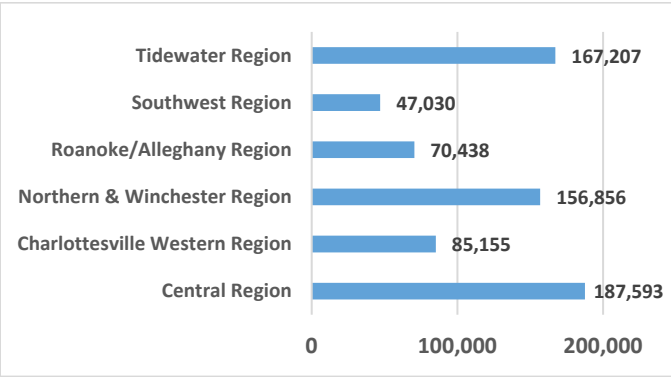


Medicaid Expansion

Medicaid Expansion Service Provision



Medicaid Expansion Members by Medicaid Region



ARTS Benefit Outcomes SFY 2020, 2021, and First Half of 2022

- Over 116,000 Medicaid members had a diagnosed SUD in SFY 2021, an increase of 14.3% from SFY 2020.
- Use of ARTS services continued to increase with a 24% increase between SFY 2020 and 2021.
- MOUD treatment rates increased from 64% in SFY 2020 to 78% in SFY 2021.
- Among members who used ARTS services in SFY 2021, only 9% utilized residential treatment, with an average length of stay of 15.5 days.
- Only 27% of members with an OUD-related ED visit received MOUD treatment within 7 days of the visit, and 37% within 30 days of the visit.
- Of members discharged from residential treatment, 54% received MOUD within 30 days of discharge.
- OUD-related overdoses per 100,000 Medicaid members increased 25% between SFY 2020 and SFY 2021. However, overdose rates decreased during the first two quarters of SFY 2022.

Provider Network Expansion Supported Through ARTS

- The percentage change from 2019 through 2022 of buprenorphine waivered prescribers was 80.8%.
- The percentage change of pharmacies with any prescription for buprenorphine increased 43.9%

Increase in Providers of ARTS Services

Addiction Provider Type	Number of Providers before ARTS (2017)	# of Providers in 2020	# of Providers in 2022
Inpatient Detox	N/A	51	70
Residential Treatment	4	123	95
Partial Hospitalization Programs	N/A	41	40
Intensive Outpatient Programs	49	252	209
Opioid Treatment Programs	6	40	43
Preferred Office-Based Addiction Treatment Providers	N/A	154	200
Outpatient Practitioners Billing for ARTS Services	1,087	5,089	6,184

2023 Statewide Aggregate PIP Results

PIP Topics:

- Ambulatory Care—Emergency Department Visits
- Follow-Up After Discharge

Strengths	Four of the six MCOs received 100 percent validation scores across all evaluation elements for Steps 1 through 8 and were assigned a *High Confidence* level for both PIPs. These MCOs calculated and reported baseline data accurately and implemented targeted interventions that addressed the identified barriers and developed sound methodologies for evaluating the effectiveness for each intervention.
Weaknesses	Two of the six MCOs have opportunities for improvement related to accurately defining performance indicators, calculating and reporting baseline data correctly, and effectively evaluating the effectiveness of each individual intervention.

Performance Measure Validation Results

Domain	Strengths
Access and Preventive Care	All six MCOs' rates met or exceeded the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure.
Behavioral Health	All six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment, Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total, Diagnosed Mental Health Disorders—Total, Diagnosed Substance Use Disorders—Alcohol disorder—Total, Diagnosed Substance Use Disorders—Opioid disorder—Total, Diagnosed Substance Use Disorders—Other or unspecified drugs—Total,* and *Diagnosed Substance Use Disorders—Any disorder—Total* PM indicators.
	Five of the six MCOs' rates for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Total* measures met or exceeded the 50th percentile.
Taking Care of Children	Five of six MCOs' rates met or exceeded the 50th percentile for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total* Fand *Blood Glucose and Cholesterol Testing—Total* PM indicators.
Living With Illness	MCO performance within the Living With Illness domain was the highest for the *Medical Assistance With Smoking and Tobacco Use Cessation* measure, with five of six MCOs' rates meeting or exceeding the 50th percentile for the *Discussing Cessation* PM indicator, and five of six MCOs' rates meeting or exceeding the 50th percentile for the *Advising Smokers and Tobacco Users to Quit* PM indicators.
	Five of six MCOs' rates met or exceeded the 50th percentile for the *Asthma Medication Ratio—Total, Eye Exam for Patients With Diabetes—Total,* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure indicators.
Use of Opioids	Four of six MCOs' rates met or exceeded the 50th percentile for *Use of Opioids from Multiple Providers—Multiple Pharmacies* and *Multiple Prescribers and Multiple Pharmacies* PM indicators.

Domain	Opportunities for Improvement
Access and Preventive Care	All reportable MCO rates fell below the 50th percentile for the *Cervical Cancer Screening, Prenatal and Postpartum Care,* and *Use of Imaging Studies for Low Back Pain* measures.
	Four of the six MCOs' rates fell below the 50th percentile for the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* and five of six MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* measures.
Behavioral Health	Five of the six MCOs' rates fell below the 50th percentile for the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia—Total* measure. All six MCOs' rates fell below the 50th percentile for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total,* and all three MCOs' rates without a small denominator fell below the 50th percentile for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measures.
Taking Care of Children	All six MCOs' rates for the *Immunizations for Adolescents—Combination 2 Meningococcal, Tdap, Human Papillomavirus [HPV])* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total, Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total* PM indicators fell below the 50th percentile.
Living With Illness	Five of the six MCOs' rates fell below the 50th percentile for the *Blood Pressure Control for Patients With Diabetes—Total* and *Controlling High Blood Pressure—Total* measures.

Compliance With Standards Monitoring Results

The MCOs' 2021 compliance scores, for the three-year cycle, ranged from 86.2 percent to 95.2 percent. All six MCOs received a 100 percent compliance score for the following standards:

Standards
Emergency and Poststabilization Services
Coordination and Continuity of Care
Provider Selection
Practice Guidelines
Health Information Systems
Program Integrity

Cardinal Care Program Readiness Review Results

MCO Cardinal Care program readiness review results ranged from 90.0% to 100%. MCOs remediated readiness review identified deficiencies resulting in all six MCOs' final readiness reviews scores achieving 100%.

Primary Care Provider Secret Shopper Survey Results

New Patient Acceptance Rates

	Accepting MCO	Accepting VA Medicaid	Accepting New Patients
MCO Total	46.7%	43.3%	36.1%

New Patient Appointment Availability

	Routine Visit	Urgent Visit	Total
MCO Total	74.0%	72.3%	73.1%

New Patient Appointments Meeting Compliance Standards

	Routine Visit	Urgent Visit	Total
MCO Total	74.5%	16.0%	43.2%

Performance Measure Calculation Results

HSAG calculated the *Medicaid Managed Long-Term Services and Supports (MLTSS) Successful Transition after Long-Term Facility Stay* performance measure following the2022 CMS *Medicaid MLTSS Measures Technical Specifications and Resource Manual*. The 2022 Virginia Medicaid total and the CCC Plus program results were:

Stratification	Facility Admissions	Observed Rate	Expected Rate	Observed-to-Expected (O/E) Ratio
Virginia Total	4,578	33.70%	67.61%	0.50
CCC Plus (MLTSS)	3,742	31.11%	67.90%	0.46
Medallion 4.0 (Acute)	86	79.07%	57.92%	1.37
Fee-for-Service	166	18.07%	74.93%	0.24
Managed care	3,975	33.38%	67.16%	0.50

Member Experience of Care Survey Results

	Adult 2022	Adult 2023	Child 2022	Child 2023
Global Top-Box Scores				
Rating of Health Plan	66.6%	65.4%	65.6%	65.5%
Rating of All Health Care	58.8%	58.0%	66.1%	63.9%
Rating of Personal Doctor	70.5%	71.8%	75.6%	75.8%
Rating of Specialist Seen Most Often	72.6%	68.9%	72.3%	72.4%
Composite Tob-Box Scores				
Getting Needed Care	85.7%	83.3%	84.3%	83.3%
Getting Care Quickly	85.8%	82.6%▼	87.6%	85.6%
How Well Doctors Communicate	93.1%	93.4%	93.8%	94.7%
Customer Service	90.4%	91.2%	87.2%	88.5%

▼ *Statistically significantly lower in 2023 than in 2022.*

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

Member Experience of Care Survey Results

Strengths

2023 Medicaid top-box score results:

- Adult—The CCC Plus program's 2023 top-box scores were statistically significantly higher than the 2022 NCQA adult Medicaid national averages for four measures: *Rating of Health Plan, Rating of Personal Doctor, Getting Care Quickly*, and *Customer Service*.

Opportunities for Improvement

2023 Medicaid top-box score result for the CCC Plus (MLTSS) Program:

- Adult—2023 top-box scores were statistically significantly lower than the 2022 top-box scores for *Getting Care Quickly*.
- Child—2023 top-box scores were statistically significantly lower than the 2022 NCQA child Medicaid national average for *Rating of Health Plan*.
- Child—2023 top-box scores were statistically significantly lower than the 2022 NCQA child Medicaid national average for *Rating of All Health Care*.

Consumer Decision Support Tool

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

MCO	Overall Rating*	Doctors' Communication	Access and Preventive Care
Aetna	★★★	★★★	★★★
HealthKeepers	★★★★	★★★	★★★
Molina	★	—	★★
Optima**	★★★★	★★★	★★★★
United	★★★	—	★★★

MCO	Behavioral Health	Taking Care of Children	Living With Illness
Aetna	★★★★	★★★★	★★★
HealthKeepers	★★★★★	★★★★★	★★★
Molina	★	★★	★★
Optima**	★★★	★	★
United	★★★	★★★	★★★★★

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

***Data for Optima also include data for members enrolled in VA Premier in 2022.*

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

Attachment 4

Virginia 1115 Demonstration
Current Quality Strategy

2023–2025 Quality Strategy

Commonwealth of Virginia
Department of Medical Assistance Services

The Virginia Quality Strategy was submitted to the Centers for Medicare & Medicaid Services in February 2023.

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Glossary of Acronyms

42 CFR ..... Title 42 of the Code of Federal Regulations
AAP ..... American Academy of Pediatrics
ABD ..... Aged, Blind, and Disabled
ACOG ..... American Congress of Obstetricians and Gynecologists
ADHD ..... Attention-Deficit/Hyperactivity Disorder
Adult Core Set ..... CMS Core Set of Adult Health Care Quality Measures for Medicaid
AHRQ ..... Agency for Healthcare Research and Quality
ARTS ..... Addiction and Recovery Treatment Services
ASAM ..... American Society of Addiction Medicine
AUD ..... Alcohol Use Disorder
BAG ..... Beneficiary Advisory Group
BMI ..... Body Mass Index
BRAVO ..... Behavioral Health Redesign for Access, Value, and Outcomes
CAHPS®,[1] ..... Consumer Assessment of Healthcare Providers and Systems
CAP ..... Corrective Action Plan
CC ..... Community Coaching
CCC Plus (MLTSS) ..... Commonwealth Coordinated Care Plus
CDC ..... Centers for Disease Control and Prevention
CE ..... Community Engagement
CHCA ..... Certified HEDIS Compliance Auditor
Child Core Set ..... CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP
CHIP ..... Children's Health Insurance Program
CHIPRA ..... Children's Health Insurance Program Reauthorization Act of 2009
CMP ..... Civil Money Penalty
CMPRP ..... Civil Money Penalty Reinvestment Program
CMS ..... Centers for Medicare & Medicaid Services
COPD ..... Chronic Obstructive Pulmonary Disease
COVID-19 ..... Coronavirus Disease 2019
CPT ..... Current Procedural Terminology
CQI ..... Continuous Quality Improvement
CY ..... Calendar Year
DBHDS ..... Department of Behavioral Health and Developmental Services
DD ..... Developmental Disability
DMAS ..... Department of Medical Assistance Services
DUR ..... Drug Utilization Review
ED ..... Emergency Department
EDCC ..... Emergency Department Care Coordination
EDCD ..... Elderly or Disabled With Consumer Direction

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

EDWS ..... Enterprise Data Warehouse System
EOR ..... Employer of Record
EPAP ..... External Provider Audit & Policy Unit
EPS ..... Encounter Processing System
EPSDT ..... Early and Periodic Screening, Diagnostic and Treatment
EQR ..... External Quality Review
EQRO ..... External Quality Review Organization
FAMIS ..... Family Access to Medical Insurance Security
FC/AA ..... Foster Care and Adoption Assistance
FFCRA ..... Families First Coronavirus Relief Act
FFS ..... Fee-for-Service
FFY ..... Federal Fiscal Year
FMAP ..... Federal Medical Assistance Percentage
FMEA ..... Failure Mode and Effects Analysis
FPL ..... Federal Poverty Level
HbA1c ..... Hemoglobin A1c
HCBS ..... Home- and Community-Based Services
HCCI ..... Health Care Cost Institute
HEDIS®,[2] ..... Healthcare Effectiveness Data and Information Set
HHS ..... United States Department of Health and Human Services
HIPAA ..... Health Insurance Portability and Accountability Act of 1996
HIT ..... Health Information Technology
HMO ..... Health Maintenance Organization
HRSN ..... Health-Related Social Need
HSAG ..... Health Services Advisory Group, Inc.
ICF ..... Intermediate Care Facility
IDEA ..... Individuals with Disabilities Education Improvement Act of 2004
IEP ..... Individualized Education Plan
IT ..... Information Technology
JLARC ..... Joint Legislative Audit and Review Commission
LEP ..... Limited English Proficiency
LPN ..... Licensed Practical Nurse
LTSS ..... Long-Term Services and Supports
MAC ..... Member Advisory Committee
MCO ..... Managed Care Organization
MDS ..... Minimum Data Set
MEI ..... Member Efficiencies and Innovation
MES ..... Medicaid Enterprise System
MIP ..... MCO Improvement Plan
MLR ..... Medical Loss Ratio

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

MLTSS ..... Managed Long-Term Services and Supports
MM ..... Member Months
MMIS ..... Medicaid Management Information System
MODRN ..... Medicaid Outcomes Distributed Research Network
MOUD ..... Medications for Opioid Use Disorder
MPMCLC ..... Medicaid Physician and Managed Care Liaison Committee
MY ..... Measurement Year
NAS ..... Neonatal Abstinence Syndrome
NCHS ..... National Center for Health Statistics
NCQA ..... National Committee for Quality Assurance
NF ..... Nursing Facility
NICU ..... Neonatal Intensive Care Unit
NQS ..... National Quality Strategy
NR ..... Not Reported
O/E ..... Observed/Expected
OB/GYN ..... Obstetrics and Gynecology
OBOT ..... Office-Based Opioid Treatment
OCMO ..... Office of the Chief Medical Officer
OHE ..... Office of Health Equity
OTP ..... Opioid Treatment Program
OUD ..... Opioid Use Disorder
PACE ..... Program of All-Inclusive Care for the Elderly
PAHP ..... Prepaid Ambulatory Health Plan
PAS ..... PreAdmission Screening
PCCM ..... Primary Care Case Management
PCP ..... Primary Care Provider
PDI ..... Pediatric Quality Indicator
PDSA ..... Plan-Do-Study-Act
PH ..... Population Health
PHE ..... Public Health Emergency
PHM ..... Population Health Management
PI ..... Program Integrity
PID ..... Program Integrity Division
PIHP ..... Prepaid Inpatient Health Plan
PIP ..... Performance Improvement Project
PM ..... Performance Measure
PMPM ..... Per Member Per Month
PMV ..... Performance Measure Validation
PQI ..... Prevention Quality Indicator
Project BRAVO ..... Behavioral Health Redesign for Access, Value and Outcomes Project
PWP ..... Performance Withhold Program

QAPI ..... Quality Assessment and Performance Improvement
QI ..... Quality Improvement
QPH ..... Quality and Population Health
QRS ..... Quality Rating System
QS ..... Quality Strategy
RACI ..... Responsible, Accountable, Consulted, Informed
RN ..... Registered Nurse
RPM ..... Remote Patient Monitoring
SARS-CoV-2 ..... Severe Acute Respiratory Syndrome Coronavirus 2
SBE ..... State-Based Exchange
SBIRT ..... Screening, Brief Intervention, and Referral to Treatment
SDOH ..... Social Determinant of Health
SFC ..... Smiles For Children
SFY ..... State Fiscal Year
SHCN ..... Special Health Care Needs
SMART ..... Specific, Measurable, Attainable, Relevant, and Time-bound
SUD ..... Substance Use Disorder
TPL ..... Third-Party Liability
UAI ..... Uniform Assessment Instrument
U.S. ..... United States
UTI ..... Urinary Tract Infection
VA ..... Virginia
VAC ..... Virginia Administrative Code
VBP ..... Value-Based Purchasing
VCU ..... Virginia Commonwealth University
VDH ..... Virginia Department of Health

Introduction and Overview

Executive Summary

The Commonwealth of Virginia Department of Medical Assistance Services (DMAS) is the single State agency that administers all Medicaid and Family Access to Medical Insurance Security (FAMIS) health insurance benefit programs and is the gold standard of health and human services. As of June 2022, 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 fee-for-service (FFS) model. As of October 1, 2023, the Virginia Medicaid managed care program is called the Cardinal Care program.

DMAS plays an essential role in the Commonwealth's healthcare system by offering lifesaving coverage to one in five Virginians, ensuring vulnerable citizens are safeguarded and families are strengthened. Children are the largest eligibility group served by Virginia Medicaid, with approximately 672,106 enrolled in Medicaid and approximately 187,530 enrolled in the Children's Health Insurance Program (CHIP). Other eligible populations include people with disabilities, older and low-income adults, and pregnant individuals.[3] In Virginia, Medicaid also covered approximately 37,000 births in 2021 with enrollees being predominately White and African American.

Virginia's Medicaid managed care organization (MCO) budgets expend approximately 84.0 percent of their funds on medical services and 8.25 percent on administrative expenses.[4] Virginia has a strong record of investing in innovative programs, managing cost growth, boasting high rates of beneficiary participation in primary care medical homes, and enjoying strong provider participation with over 139,000 enrolled providers. Virginia continues to build upon its investment successes to achieve even more—innovation to improve the health of Virginians and to support individuals becoming and remaining self-sufficient.

In June 2021, the Virginia General Assembly mandated that DMAS rebrand the Department's FFS and managed care programs and effectively combine the Commonwealth Coordinated Care Plus (CCC Plus) (Managed Long-Term Services and Supports [MLTSS]) and Medallion 4.0 (Acute) programs under a single name, the Cardinal Care program. The combined program achieves a single streamlined system of care that links seamlessly with the FFS program. Cardinal Care will continue to offer members the same programs and services and will not reduce or change any existing coverage. The overarching program ensures a smoother transition for individuals whose healthcare needs evolve over time. The Cardinal Care program ensures an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality care to its members, and adds value for its providers and the Commonwealth.

New Strategic Vision for DMAS

Under the leadership of Governor Glenn Youngkin and Health and Human Resources Secretary John Littel, Virginia has embarked on a reinvigorated new strategic vision to serve and improve

[3] Virginia Department of Medical Assistance Services. Medicaid at a Glance 2022. Available at: https://www.dmas.virginia.gov/about-us/medicaid-at-a-glance/. Accessed on: Aug 3, 2022.
[4] Virginia Department of Medical Assistance Services. MCO Financials. Available at: https://www.dmas.virginia.gov/data/mco-financials/. Accessed on: Nov 27, 2023.

the lives of Virginians. DMAS, as the agency that oversees the Medicaid program in the Commonwealth, is focused on three core goals to assist with:

- Behavioral health enhancement
- Increasing access to healthcare
- Enhanced managed care delivery system

These strategic initiatives are woven into the foundation of the new 2023–2025 DMAS Quality Strategy to promote alignment and further support these vital efforts. Each agency is working with the administration to develop metrics and performance targets to achieve by 2025.

Behavioral Health Enhancement

Medicaid is the largest payer of behavioral health services in the Commonwealth. Medicaid provides inpatient and outpatient services that support quality of life in the community for those in need of behavioral health support. In the new strategy, increased focus is placed on behavioral health services and outcomes for Medicaid members. This includes efforts to reduce the burden on state psychiatric hospitals and emergency departments (EDs), with efforts including increasing use of mobile crisis response and reduction of ED utilization. DMAS is also committed to the continued expansion of access to BRAVO (Behavioral Health Redesign for Access, Value, and Outcomes) services by implementing new services and engaging the communities to support these services. Supporting Virginia's foster care youth is a main focus of the agency, and DMAS has committed to ensuring appropriate access to acute behavioral health services by working to carve in residential services into the managed care programs. Additional information about the behavioral health enhancement and BRAVO services can be found in the Quality Strategy Interventions section, starting on page 38.

Increasing Access to Healthcare

As highlighted by events such as the coronavirus disease 2019 (COVID-19) pandemic, ensuring Virginians have access to high quality healthcare coverage is a core mission of DMAS. To support the needs for increasing access, DMAS is committed to modernization processes for eligibility and enrollment. This includes the automation of eligibility enrollment and determination, improving enrollment in the State-Based Exchange (SBE) Marketplace, and modernization of self-service applications to make online changes and renewals more accessible to individuals looking to access or continue services. DMAS is also preparing for the redetermination of the over two million lives in Virginia Medicaid as part of the unwinding of COVID-19 rules that allowed members to retain necessary healthcare coverage during the public health emergency (PHE) and that will now be walked back as the emergency ends. Additional access-related initiatives for the Commonwealth include:

- Improving maternal outcomes by increasing the number of women receiving postpartum care.
- Automation of the collection of eligibility information.
- Reducing opioid-related deaths.

Enhanced Managed Care Delivery System

On October 4th, 2022, Virginia Secretary of Health and Human Resources John Littel announced that the Commonwealth's Medicaid agency plans to launch a transformational new

procurement next year to drive innovation and strengthen quality and accountability in its managed care program. The target implementation timeline for this $14 billion procurement is 2024. State leaders will evaluate commercial health plans that participate in the competitive procurement based on their use of data-driven strategies to address challenges in the rapidly evolving healthcare environment, including value-based care models that tie funding to measurable improvements in health outcomes. The Virginia Medicaid agency will hire nationally recognized consultants with expertise in the managed care field to assist in drafting the request for proposals. The agency also plans to seek approval from the General Assembly, as well as input from Medicaid members, healthcare providers, other State agency representatives and community stakeholders on the design and goals of the new managed care program. This re-procurement of the managed care programs will occur under the new, united Cardinal Care Program. Other key initiatives covered under this goal include:

- Expansion of the use of value-based purchasing (VBP) programs.
- Reduction in payment error rate.

To these ends and more, this Quality Strategy aims to guide Virginia's Medicaid program by establishing clear goals and objectives to drive improvement in care delivery and outcomes and establishes the metrics by which progress will be measured. The Quality Strategy sets a clear direction for priority interventions and details the standards and mechanisms for holding managed care entities accountable for desired outcomes. The Quality Strategy serves as the roadmap for developing a dynamic approach to assessing, monitoring outcomes, and improving the quality of healthcare and services furnished by the managed care and FFS entities and providers.

DMAS developed this Quality Strategy in accordance with Title 42 of the Code of Federal Regulations (42 CFR), at 42 CFR §438.340 et. seq. DMAS developed the Quality Strategy to continually monitor, assess, and improve the timeliness and delivery of quality healthcare to all Medicaid and CHIP members served by the Virginia Medicaid managed care and FFS programs. DMAS' Quality Strategy provides the framework to accomplish DMAS' overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP system.

The Quality Strategy's purpose, goals, scope, assessment of performance, interventions, and annual high-level evaluation are detailed in this Quality Strategy. Documents referenced in the Quality Strategy include:

The Annual External Quality Review (EQR) Technical Report

Medallion 4.0 (Acute):
https://www.dmas.virginia.gov/about-us/office-of-quality-and-population-health/studies-and-reporting/#Annual%20Technical%20Reports%20(ATR)

CCC Plus (MLTSS):
https://www.dmas.virginia.gov/about-us/office-of-quality-and-population-health/studies-and-reporting/#Annual%20Technical%20Reports%20(ATR)

The Medicaid State Plan

https://www.dmas.virginia.gov/about-us/state-plan/

Medicaid Managed Care Organization Contracts and Amendments

Medallion 4.0 (Acute):
http://www.dmas.virginia.gov/#/med4information

CCC Plus (MLTSS):
http://www.dmas.virginia.gov/#/cccplusinformation

DMAS remains committed to a culture of quality. Across departments, attention to outcomes, process improvement, and sustainability are important to achieving the goals of the DMAS Quality Strategy. DMAS maintains ultimate authority and responsibility for the maintenance and annual evaluation of the Quality Strategy. DMAS updates the Quality Strategy as needed based on MCO performance; stakeholder input and feedback; achievement of goals; changes resulting from the General Assembly, Commonwealth, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Virginia Medicaid program.

To demonstrate compliance with the Centers for Medicare & Medicaid Services (CMS) Quality Strategy Toolkit for States, DMAS created a crosswalk (Appendix A) that lists each of the required and recommended elements of state quality strategies, and the corresponding section of the DMAS Quality Strategy and/or DMAS/MCO contract that addresses the required or recommended elements.

Purpose, Scope, and Goals of the Quality Strategy

Purpose of the Quality Strategy

Consistent with its mission, the purpose of DMAS' Quality Strategy is to:

- Establish a comprehensive quality improvement (QI) system that is consistent with the National Quality Strategy (NQS) and CMS Triple Aim, to enhance member care experiences, promote effective patient care, achieve smarter spending, and improve population health.
- Provide a proactive framework for DMAS to implement a coordinated and comprehensive approach to drive quality throughout the Virginia Medicaid and CHIP systems.
- Improve member satisfaction with care and services.
- 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 Virginia Medicaid and CHIP members have access to high quality and culturally appropriate care.
- Identify innovative and efficient models of care delivery that are best practices and make healthcare more affordable for individuals, families, and the State government.

Scope of the Quality Strategy

The following are included in the scope of the Quality Strategy:

- All Medicaid and CHIP managed care members in all demographic groups and in all service areas for which the MCOs are approved to provide Medicaid and CHIP managed care services.
- All aspects of care—including accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services covered by DMAS' Medicaid and CHIP managed care programs.
- All aspects of the MCOs' performance related to access to care, quality of care, and quality of service, including networking, contracting, and credentialing; and medical record-keeping practices.
- All services covered—including preventive care services, primary care, specialty care, ancillary care, emergency services, chronic disease, special needs care, dental services, mental health services, diagnostic services, pharmaceutical services, skilled nursing care, home healthcare, prescription drugs, and long-term services and supports (LTSS).
- All professional and institutional care in all settings, including inpatient, outpatient, and home settings.
- All providers and any other delegated or subcontracted provider type.

- All aspects of the MCOs' internal administrative processes related to service and quality of care—including customer services, enrollment services, provider relations, confidential handling of medical records and information, case management services, utilization review activities, preventive health services, health education, information services, and QI.

Strategic Overview

Quality Strategy Goals and Objectives

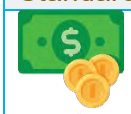
The Quality Strategy is intended to guide Virginia's Medicaid managed care program by establishing clear goals to drive improvements in care delivery and outcomes, and the metrics by which progress will be measured. The Quality Strategy sets a clear direction for priority interventions and details the standards and mechanisms for holding MCOs accountable for desired outcomes. The Quality Strategy is a roadmap through which DMAS will use the managed care infrastructure to facilitate improvements in health and healthcare through programmatic innovations, whole-person care, inclusive healthcare, provider supports, and steps to address health-related unmet resource needs. This vision is distilled into five central goals:

1. Enhance the member care experience
2. Promote access to safe, gold-standard patient care
3. Support efficient and value-driven care
4. Strengthen the health of families and communities
5. Provide whole-person care for vulnerable populations

Included within each of these five goals is a series of goals, intended to highlight key areas of expected progress and quality focus. These goals are inclusive of Governor Glenn Youngkin's identified priorities for the Medicaid program that focus on behavioral health enhancement, maternal health outcomes, and access to high quality healthcare services. Governor Glenn Youngkin's priorities are highlighted with gold font and a gold star (★).

Together, as is shown in Table 1, these create a framework through which Virginia defines and drives the overall vision for advancing the quality of care provided to Medicaid members in the Commonwealth. These goals and objectives were designed to align closely with CMS' Quality Strategy, adapted to address Virginia's local priorities, challenges, and opportunities for Virginia's Medicaid program. DMAS capitalizes on strategic community partnerships and leverage of MCOs to achieve the goals of the Quality Strategy. DMAS' quality measures and metrics can be found in Appendix B.

Table 1—Quality Strategy Goals and Objectives

Goals	Objectives
 **Goal 1**: Enhance the Member Care Experience	**Objective 1.1:** Increase Member Engagement and Outreach
	Objective 1.2: Improve Member Satisfaction
 **Goal 2:** ★ Promote Access to Safe, Gold-Standard Patient Care ★	**Objective 2.1:** Ensure Access to Care
	Objective 2.2: Promote Patient Safety
	Objective 2.3: Promote Effective Communication and Care Coordination
 **Goal 3:** ★ Support Efficient and Value-Driven Care ★	**Objective 3.1**: Focus on Paying for Value
	Objective 3.2: Promote Efficient Use of Program Funds
 **Goal 4:** Strengthen the Health of Families and Communities	**Objective 4.1:** Improve Utilization of Wellness, Immunization, and Prevention Services for Members
	★ **Objective 4.2:** Improve Outcomes for Maternal and Infant Members ★
	Objective 4.3 Improve Home and Community-Based Services
 **Goal 5:** Providing Whole-Person Care for Vulnerable Populations	**Objective 5.1:** Improve Outcomes for Members with Chronic Conditions
	Objective 5.2: Improve Outcomes for Nursing Home Eligible Members
	★ **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders ★
	★ **Objective 5.4:** Improve Behavioral Health and Developmental Services of Members ★

Note: Each goal has targeted metrics to measure progress, as well as outlined interventions to advance the goals. See Appendix B.
★ In alignment with Governor Glenn Youngkin's identified priorities for the Medicaid program.

Each of the 14 objectives is tied to focused interventions used to drive improvements within, and, in many cases, across the goals and objectives set forth in this Quality Strategy. To assess the impact of these interventions and continue to identify opportunities for improving the quality of care delivered under Medicaid managed care, and in compliance with the requirements set forth in 42 CFR 438.340(b)(3), these interventions are tied to a set of metrics by which progress is assessed. This approach provides for data-driven decision making to drive interventions, inform priority setting, and facilitate efficient and effective deployment of resources.

Development of the Quality Strategy Goals and Objectives

These goals reflect significant community and stakeholder input as well as thoughtful consideration of the quality issues that are most important in Virginia. DMAS additionally considered the quality areas of greatest importance to Virginia's Medicaid population, and where current data indicated an opportunity for targeted improvement. The goals are similarly aligned to ensuring beneficiary access to services.

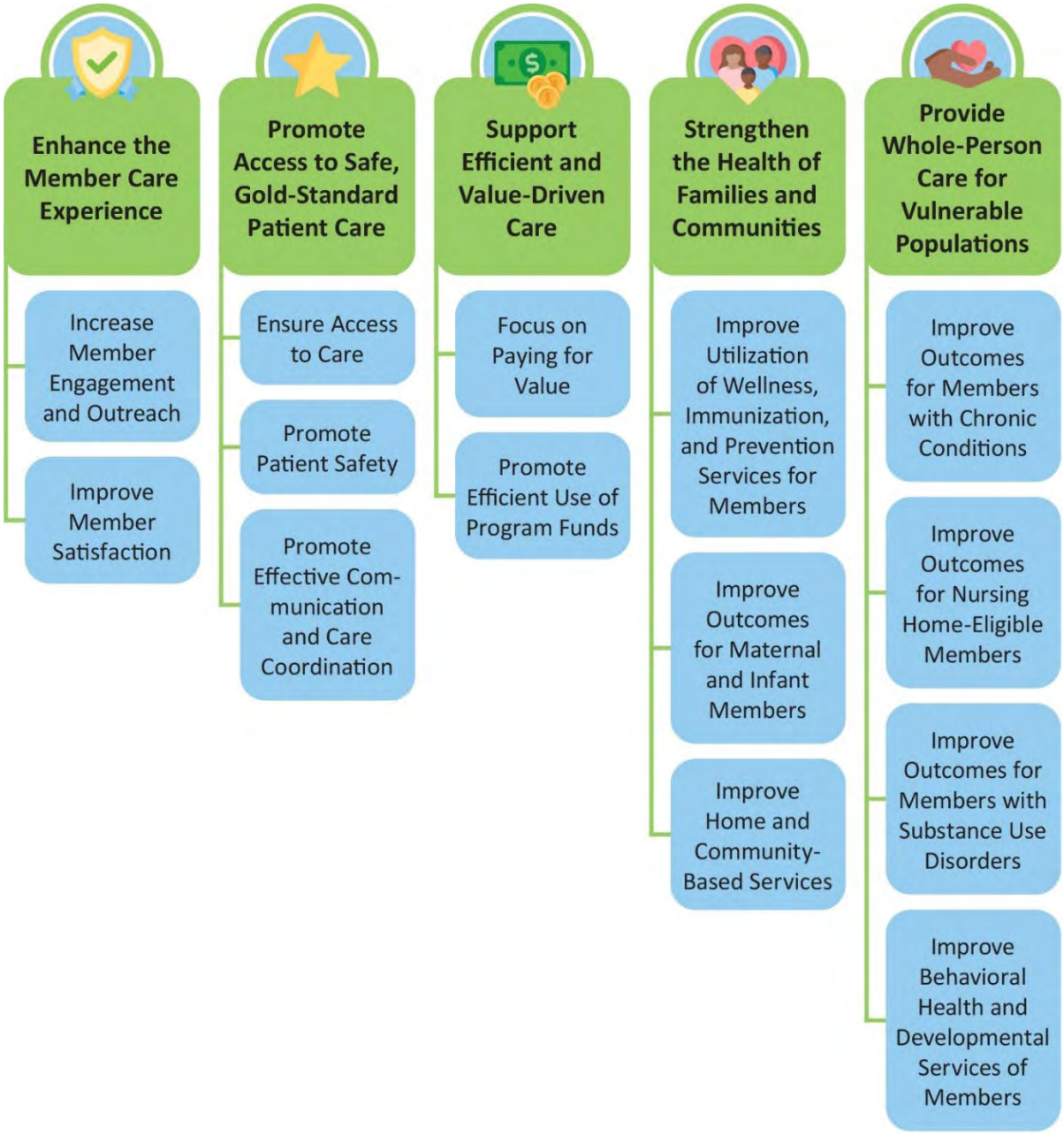
The DMAS Quality Strategy aligns with the NQS, which was launched on April 12, 2022.[5] The NQS includes three aims: Better Care, Healthy People/Healthy Communities, and Affordable Care. To advance these aims, the NQS focuses on seven priorities: safer care, patient engagement, communication, care coordination, promoting best practices, healthy living, and making quality care affordable. In addition, the NQS also includes nine levers that represent core business functions, resources, and/or actions used to align to the NCQA.

As updated data related to the Medicaid program performance becomes available, DMAS intends to further refine these objectives to target specific improvement goals, including additional metrics that address disparities in health. MCOs are required to maintain systems that collect, analyze, integrate, and report encounter data that are timely, accurate, and complete. These data are used for several purposes and will be key to assessing the quality, access, and timeliness of Virginia's Medicaid managed care program. The external quality review organization (EQRO) will play a critical role in ensuring the validity of MCOs' reported encounter data, as well as in the validation and calculation of quality measures. DMAS is committed to using these reports to assess opportunities for continued improvement, and how priorities may evolve over time.

Together, this framework represents a comprehensive plan for delivering high quality, accessible, timely care to Medicaid managed care beneficiaries (Figure 1).

[5] Centers for Medicare & Medicaid Services. National Quality Strategy (NQS). Available at: https://www.cms.gov/files/document/cms-national-quality-strategy-handout.pdf. Accessed on: Mar 5, 2024.

Figure 1—Virginia's 2023–2025 Quality Strategy Framework



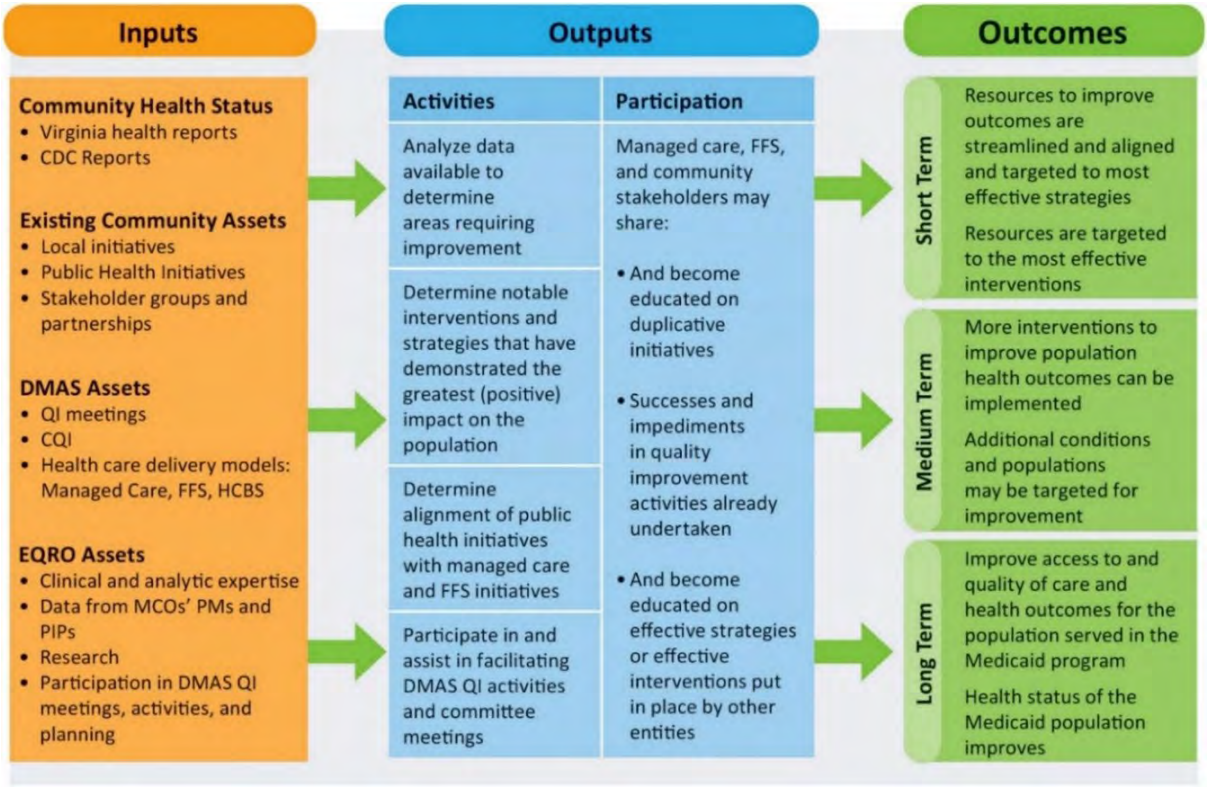
Strategy for Meeting Goals

The methods employed by DMAS to achieve these goals include:

- Developing and maintaining collaborative strategies among Commonwealth agencies, community resources, and external partners to improve health education and health outcomes, protect public health, safeguard vulnerable and at-risk citizens, and improve quality of care and access to services for all Virginia Medicaid members.
- Using additional performance measures, performance improvement projects (PIPs), contract compliance monitoring, and emerging practice activities to drive improvement in member healthcare outcomes.
- Strengthening evidence-based prevention, wellness, and health management initiatives to improve members' health status and achievement of personal health goals.
- Enhancing member services and member satisfaction with services.
- Identifying opportunities for improvement from grievances and other feedback to create efficiencies in how programs and services are structured and delivered.
- Improving health information technology (HIT) to ensure that information retrieval and reporting are timely, accurate, and complete.

The logic model contained in Figure 2 depicts the DMAS strategy for improving health outcomes.

Figure 2—Quality Strategy Logic Model



Abbreviations used in the logic model: CDC—Centers for Disease Control and Prevention; CQI—continuous quality improvement; HCBS—home- and community-based services; PM—performance measure

Background and Structure of Virginia's Medicaid Program

History of Medicaid in Virginia

Managed healthcare delivery system design is essential to improving outcomes for members while assuring that the care provided is of high quality and cost-effective and easy for members and families to access. Integrated MCOs that are able to address the whole health needs of Virginia's Medicaid population are essential to reducing system fragmentation and improving service delivery to members. DMAS continues to weave the service delivery system components together to create a more effective and efficient healthcare system. DMAS' efforts to integrate care delivery systems and properly align incentives are designed to transition the structure of the Medicaid program to improve health outcomes and better manage limited resources and result in a positive impact to the quality of healthcare delivered to Virginia's Medicaid and CHIP members.

Integration at the administrative and managed care levels is key in promoting and supporting efforts of providers to deliver integrated services through primary care, integrated clinics, health homes, and other models and the utilization of innovative reimbursement models are critical to a delivery system that can address the whole health needs of Medicaid members. DMAS looks to numerous initiatives to support providers in this effort, which will ultimately address the cost of care and service delivery, access to care and services, and the quality of care delivered.

DMAS Mission and Values

DMAS is committed to upholding its core mission and values. The mission of DMAS is:

To improve the health and well-being of Virginians through access to high-quality healthcare coverage.

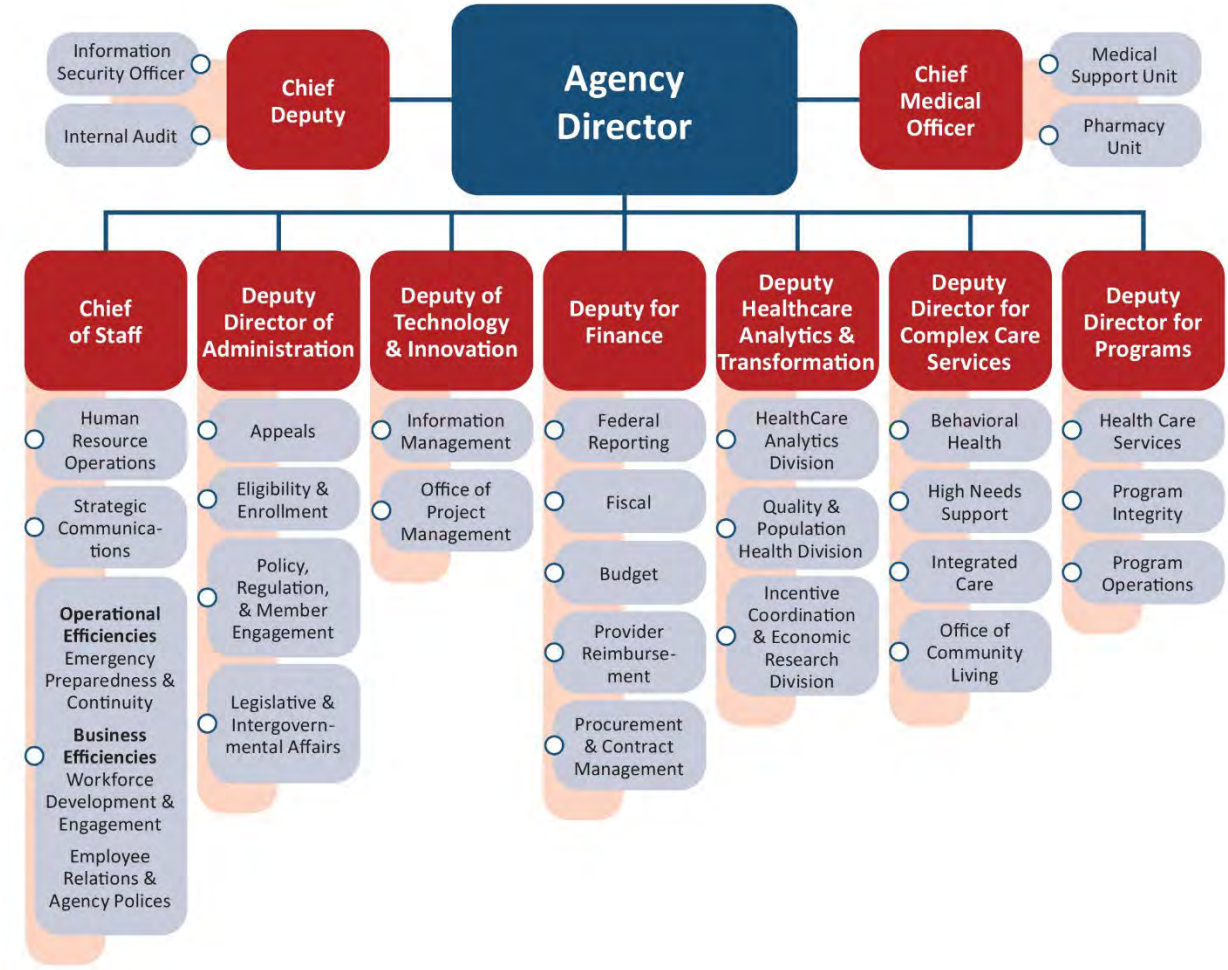
DMAS maintains the following values while operating its mission to the Commonwealth:

- ***Service****: We are committed to serving all who are touched by our system with caring, integrity, and respect.*
- ***Collaboration****: We value professional, respectful cooperation to achieve common goals. Everyone's input is welcome.*
- ***Trust****: We are continuously building a culture that is honest, supportive, and fosters integrity.*
- ***Adaptability****: We work together to anticipate and embrace change to meet Virginia's health care needs.*
- ***Problem solving****: We promote problem solving processes and respond to challenges with a forward-thinking approach.*

DMAS Organizational Structure

DMAS maintains a strong organizational structure that is committed to the implementation and oversight of programs that service DMAS members. The Quality Strategy's implementation is overseen by the DMAS Executive Leadership Team with specific responsibility assigned to the Chief Medical Officer and the Office of Quality and Population Health. DMAS' Administration and Management Organizational Chart is found in Figure 3.

Figure 3—Administration and Management Organizational Chart



Board of Medical Assistance Services

The State Board of Medical Assistance Services, as required by Virginia code, consists of 11 residents of the Commonwealth appointed by the Governor. Five Board members are healthcare providers; six Board members are nonhealthcare providers of which at least two are individuals with significant professional experience in the detection, investigation, or prosecution of healthcare fraud. The Board oversees DMAS.

The Medicaid Director and Executive Leadership Team

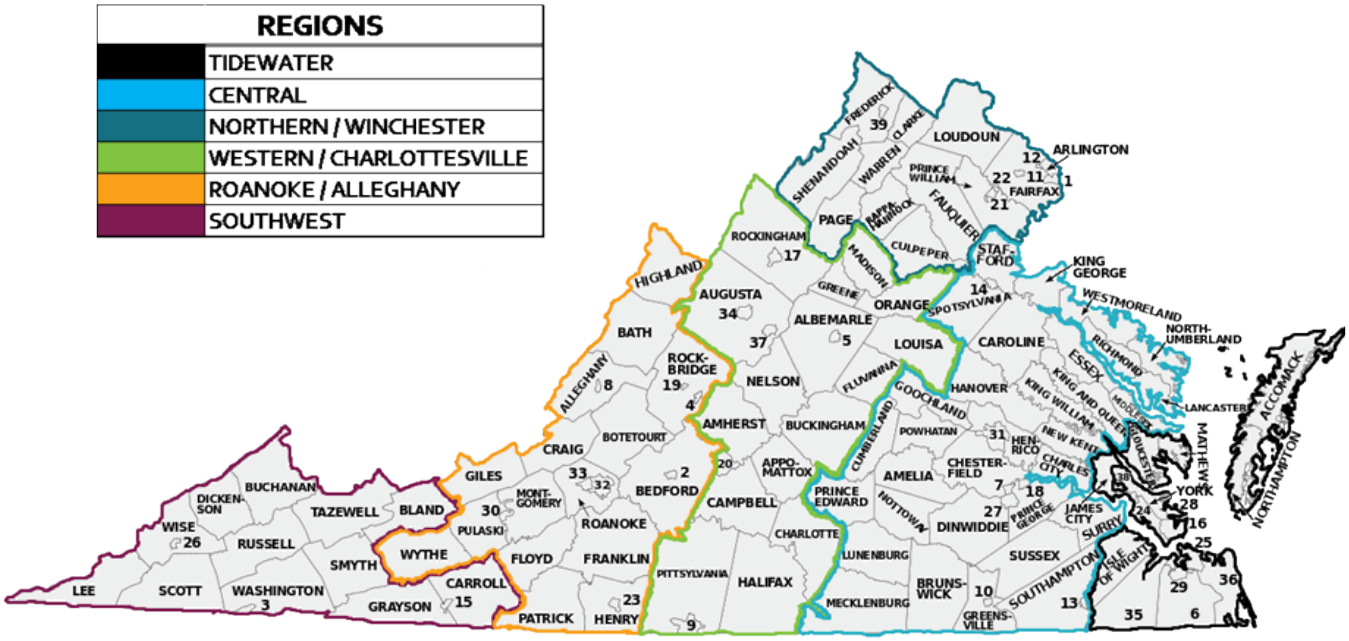
The DMAS Medicaid Director has overall responsibility for ensuring that DMAS meets the established goals of the Quality Strategy and ensures the organization maintains the administrative infrastructure to meet the needs of DMAS. The Medicaid Director works in collaboration with DMAS' Executive Leadership Team to manage the business and develop and implement administrative policies and procedures to support the delivery of quality care and services to over 2 million Virginia Medicaid members.

The DMAS annual report provides a detailed accounting of the agency's organization and operations through fiscal year-end 2022. The report provides summary information by each Division/Office along with unit responsibilities and/or core functions. An organizational chart for each Division/Office follows each summary. The annual report is located at: https://www.dmas.virginia.gov/media/4853/308c__annual_dmas_organizational_report_fye_2022_final-7-22-2022.pdf.

Virginia Medicaid Regions

The map of Virginia in Figure 4 is color coded to delineate the counties included in each of the six distinct regions established for the delivery of Medicaid MCO services provided by the Cardinal Care program.

Figure 4—Virginia Healthcare Service Regions



Populations Served in Managed Care

Waivers

CMS approves Section 1115 demonstrations and waiver authorities in section 1915 of the Social Security Act as vehicles that states may use to test new or existing ways to deliver and pay for healthcare services in the Medicaid and CHIP programs. 1915b waivers allow states to require Medicaid members to enroll in managed care and allow states to offer home- and community-based services (HCBS) to limited groups of enrollees as an alternative to institutional care. 1115 demonstration waivers give states additional flexibility to test program innovations that further the goals of Medicaid. Virginia has the following CMS-approved waivers:

- **1915(b): Cardinal Care Managed Care Waiver:** The waiver to administer a unified managed care delivery system for Medicaid (Title XIX) and FAMIS (Title XXI). The Cardinal Care Managed Care waiver combines the existing managed care programs (Medallion 4.0 [Acute] and CCC Plus [MLTSS]) to achieve a single streamlined system of care that links seamlessly with the Department's FFS program, ensuring an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality care to its members, and adds value for its providers and the Commonwealth. The consolidated program will enable DMAS to ensure better continuity of care for members, operate with improved administrative efficiency, and strengthen the focus on the diverse and evolving needs of the populations served.[6]
- **1915 (c): Virginia Community Living:** The Community Living waiver is focused on maximizing each individual with developmental disabilities or intellectual disabilities' life in his or her community with increased flexibility, new options, and improved access. It provides individuals and families with more targeted, needs-based services; increased flexibility in service options; easier navigation through the waiver process; and the ability to more easily change options as needs change. The Community Living waiver also gives providers enhanced service delivery options; increased flexibility in service design; rates that better ensure qualified, well-trained staff members to support individuals' changing needs; and rates that incentivize and support smaller, more community-integrated residential settings.
- **1915 (c): Virginia Family and Individual Support:** The Family and Individual Support waiver assists individuals with autism, developmental, or intellectual disabilities of any age and their families with accessing person-centered and family-centered resources, supports, services and other assistance.
- **1915 (c): Virginia Building Independence:** The Building Independence waiver provides support in the community rather than in an intermediate care facility (ICF) for individuals with autism and intellectual disability or developmental disabilities for individuals of all ages.
- **1115(a): FAMIS MOMS**, **FAMIS Select**, **and 12 Months Postpartum Coverage:** The FAMIS MOMS and FAMIS Select programs were established under 1115 authority in 2005.

[6] Upon CMS approval of the Cardinal Care Program waiver, the Cardinal Care Program will replace the Medallion 4.0 (Acute) and CCC Plus (MLTSS) Programs during the timeframe of the 2023-2025 Quality Strategy.

FAMIS MOMS provides healthcare coverage for uninsured pregnant women in the CHIP income eligibility range, offering comprehensive healthcare and dental benefits during pregnancy and following the baby's birth. FAMIS Select is a premium assistance program that helps families with FAMIS-enrolled children pay for employer-sponsored health insurance. In November 2021, CMS approved Virginia's application to amend the FAMIS MOMS and FAMIS Select waiver to add a new component to the demonstration extending 12 months postpartum continuous coverage for all Medicaid and FAMIS MOMS pregnant individuals. Full implementation of the 12 months postpartum continuous coverage took effect July 1, 2022.

DMAS Programs

Cardinal Care Program

The Cardinal Care program combines the Department's FFS and managed care programs, the CCC Plus (MLTSS) and Medallion 4.0 (Acute) programs, under a single name, the Cardinal Care program. The combined program achieves a single streamlined system of care that links seamlessly with the FFS program. The Cardinal Care program ensures an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality care to its members, strengthens families, safeguards vulnerable citizens, ensures individuals become and remain self-sufficient, adds value for its providers and the Commonwealth, and serves as the gold standard health and human services agency in Virginia.

Medallion 4.0 (Acute)

The Medallion 4.0 (Acute) program ensures 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 and FAMIS MOMS, Virginia's Title XXI CHIP programs. Medallion 4.0 (Acute) includes services that were previously carved out of mandatory managed care, including community mental health services, early intervention services, and third-party liability (TPL) members. The Medallion 4.0 (Acute) population includes children, low-income parents and caretaker relatives living with children, pregnant women, and current and former foster care and adoption assistance children.

Medallion 4.0 (Acute) focuses on the following priorities:

- 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

Commonwealth Coordinated Care Plus (CCC Plus)—Managed Long-Term Services and Supports

The CCC Plus (MLTSS) program is DMAS' mandatory integrated care initiative for certain qualifying individuals, including dual-eligible individuals and individuals receiving LTSS. The CCC Plus (MLTSS) program includes individuals who receive services through nursing facility care, or from four of DMAS' five HCBS 1915(c) waivers. CCC Plus (MLTSS) rolled in services that were previously carved out of mandatory managed care, including community mental health services, early intervention services, consumer directed personal care, and TPL members. The program also included members that transitioned from Medallion 3.0 and CCC into CCC Plus (MLTSS), such as the ABD adult and child populations.

All CCC Plus (MLTSS) members receive care coordination through a person-centered program design, which is an integrated delivery model that includes medical and behavioral health services with LTSS.

Participation is mandatory for eligible populations, which include:

- Individuals ages 65 and older
- Adults and children with disabilities
- Individuals eligible for Medicare and Medicaid (dual eligible)
- Nondual eligible members receiving LTSS (facility and community-based)
- Members in the Developmental Disabilities waiver (for nonwaiver services only)

Consumer-Directed Services Program

Members in the Community Living Waiver, Family and Individual Support Waiver, or the Elderly or Disabled with Consumer Direction Waiver have the option of consumer-directed services if criteria are met. Members eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program services also have the option for consumer-directed (CD) services. Consumer-directed services represent a delivery model of care. The CD model empowers members by expanding the degree of choice and control over the services and supports needed to live at home and in the community. To receive CD services, the individual or designated individual must act as the employer of record (EOR). The EOR hires, trains, and supervises the attendee(s). Services may include personal care, respite care, and/or companion services necessary for individuals to remain in the community. Services facilitators provide assistance to the EOR in arranging for directing and managing services provided through the CD model. The service facilitator is responsible for assessing the member's particular needs for a requested CD service, assisting in the development of the plan of care, and training to the EOR on responsibilities as an employer. A fiscal/employer agent also supports EORs in their employer role by:

- Providing pre-employment background checks.
- Processing employee timesheets and payroll.
- Filing, depositing, and paying state and federal employer taxes on behalf of the EOR.

Medicaid Expansion

Beginning January 1, 2019, more adults living in Virginia gained access to quality, low-cost, health insurance through Virginia Medicaid expansion. The Medicaid expansion benefit plan includes all services currently covered by Medicaid for the existing populations as well as additional federally required adult preventive care and disease management programs. Medicaid expansion provides coverage for adults ages 19–64 who are not Medicare eligible, who have income from 0 percent to 138 percent of the Federal Poverty Level (FPL), and who are not already eligible for a mandatory coverage group (e.g., children, caretaker adults, pregnant women, individuals over the age of 65, and individuals who are blind or have a disability).

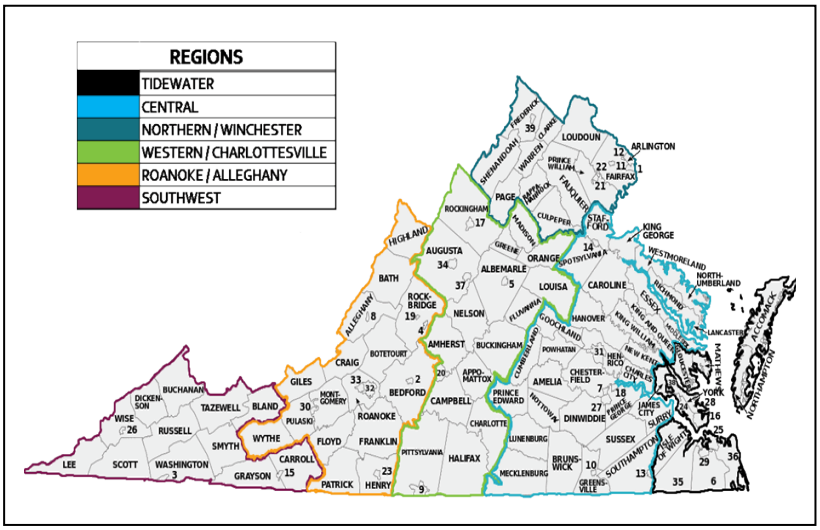
As of July 1, 2023, Medicaid expansion statistics showed:[7]

- 739,643 adults newly enrolled in Medicaid.
- 167,795 newly enrolled adults that were parents.
- 47 percent were men.
- 53 percent were women.
- 44 percent were 19 to 34 years of age.
- 37 percent were 35 to 54 years of age.
- 19 percent were 55 plus years of age.
- 550,781 were below 100 percent FPL.
- 188,862 were between 100 and 138 percent of the FPL.

Figure 5 shows the number of Medicaid expansion members enrolled in each Medicaid Region.

[7] Virginia Department of Medical Assistance Services. Medicaid Expansion Enrollment. Available at: https://www.dmas.virginia.gov/data/medicaid-expansion-enrollment/. Accessed on: Dec 1, 2023.

Figure 5—Medicaid Regions[8]



Medicaid Region	
Central Region	192,152
Charlottesville/Western Region	89,120
Northern/Winchester Region	164,110
Roanoke/Alleghany Region	73,826
Southwest Region	49,824
Tidewater Region	170,611
Grand Total	**739,643**

Income eligibility levels for each population are detailed in Figure 6.

Figure 6—Virginia Medicaid and CHIP Income Limits

Note: The FPL is an economic measure used to decide whether the income level of an individual or family qualifies them for certain federal or Commonwealth benefits and programs.

[8] Ibid.

Program of All-Inclusive Care for the Elderly (PACE)

Program of All-Inclusive Care for the Elderly (PACE) was established to help adults ages 55 and over who are living with chronic healthcare needs and/or disabilities receive community-based healthcare services and supports. By providing flexibility in how participants' healthcare needs are met, PACE is often able to assist persons meeting functional nursing facility level of care to reside within their own homes and communities longer than would have been possible otherwise.

PACE has been in operation in Virginia since 2007 with 13 individual PACE locations currently serving over 1,900 participants. PACE program oversight is provided by both CMS and DMAS. The 12 sites include Alexandria, Richmond, Salem, Lynchburg, Gretna, Farmville, Norfolk, Portsmouth, Charlottesville, Big Stone Gap, Newport News, Marion, and Cedar Bluff.

PACE is an integrated system of care for individuals ages 55 and over who also meet the following criteria: (1) Reside within a PACE service area, (2) are certified as meeting the functional need for nursing facility level of care, and (3) are able to reside safely in the community with the help of PACE services.

In order to be certified as meeting the functional need for nursing facility level of care, a member must be evaluated using the LTSS screening administered by a certified screening team. PACE services include the following, as well as other services determined necessary by the PACE healthcare professional teams to improve and maintain overall health for members:

- Primary care
- Respite care
- Hospital care
- Medical specialty services
- Prescription medications
- Emergency services
- Home care
- Physical therapy
- Occupational therapy
- Adult day care
- Dentistry
- Social services
- Transportation
- Lab and radiology services
- Nursing facility care
- End-of-life care
- Other services to improve and maintain overall health for members may be provided as determined necessary by the PACE healthcare professional team

Fee-for-Service (FFS)

While the vast majority of Virginia's Medicaid populations are managed by an MCO, as of November 2023, approximately 9.7 percent are served under FFS management. FFS is the traditional healthcare payment system in which physicians and other providers receive a payment for each unit of service they provide. DMAS is responsible for the clinical, administrative, and claims functions of the FFS population. The members of the FFS population include those Medicaid covered groups that are not in managed care, as well as those members who are awaiting managed care assignment and are temporarily placed in FFS until they are assigned to a participating MCO.

Populations Not Included in Managed Care

- Anyone enrolled in a PACE.
- Anyone who is enrolled in a Medicare Savings Plan or Plan First and anyone with temporary coverage.
- Anyone enrolled in premium assistance programs such as the Health Insurance Premium Program or FAMIS Select.
- Anyone who lives on Tangier Island.
- Anyone enrolled in the Medicaid hospice covered group (if the member is already enrolled in the Cardinal Care program when hospice enrollment occurs, the member remains in the Cardinal Care program).
- Anyone receiving services in facilities outside of Virginia and individuals (other than students) who live outside of the area of residence for more than 60 days (unless away for medically necessary services).
- Anyone who is placed on a spend-down.
- Anyone who lives in a nursing facility operated by the Veterans Administration or anyone who elects to receive services at one of the following nursing facilities:
  - The Virginia Home Nursing Facility
  - Bedford County Nursing Home
  - Birmingham Green
  - Dogwood Village of Orange County Health
  - Lake Taylor Transitional Care Hospital
  - Lucy Corr Nursing Home
  - Virginia Veterans Care Center
  - Sitter and Barfoot Veterans Care Center
- Anyone who is incarcerated.
- Anyone who has eligibility that is only retroactive (in the past).
- Anyone under age 21 who is approved for a DMAS psychiatric residential treatment facility.
- Anyone who resides in a State or private ICF for Individuals with an Intellectual Disability or a State ICF for Mental Health.
- Anyone who resides at Piedmont, Catawba, Central State Hospital, and Hancock Geriatric Treatment Center facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS).

COVID-19: Impact on Virginia's Medicaid Program

The COVID-19 pandemic created an unprecedented challenge for DMAS' work on achieving the Medicaid and CHIP Quality Strategy goals and objectives. COVID-19 became a PHE in January 2020 and was declared a pandemic in March 2020. The COVID-19 pandemic is a coronavirus disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The first confirmed case in Virginia was declared on March 7, 2020. A State of Emergency in the Commonwealth of Virginia was declared on March 12, 2020.

The pandemic had a significant impact on healthcare services. Many provider offices were closed and offered limited telehealth services. The worldwide COVID-19 pandemic impacted demand on accessing healthcare services, with some families electing to defer routine, nonemergency care to adhere to widespread guidance on physical distancing.

According to the Health Care Cost Institute (HCCI)—an independent, nonprofit organization with leading healthcare claims datasets that enable research, policy, and journalism—COVID-19 has had an extraordinary impact on the United States healthcare system since its emergence in early 2020.[9] According to HCCI, several studies have identified a substantial drop in healthcare utilization. Claims for services between 2019 and 2020 showed the following decreases in preventive and diagnostic healthcare services in the United States:

- Childhood immunizations: −18 percent
- Colonoscopies: −24 percent
- Mammograms: −16 percent
- Pap smears: −8 percent

In the United States, maternal deaths increased substantially (33.3 percent) after March 2020, corresponding to the COVID-19 onset. According to a JAMA Network Open article published June 28, 2022, the National Center for Health Statistics (NCHS) reported an 18.4 percent increase in United States maternal mortality (i.e., death during pregnancy or within 42 days of pregnancy) between 2019 and 2020. The relative increase was 44.4 percent among Hispanic, 25.7 percent among non-Hispanic Black, and 6.1 percent among non-Hispanic White women.[10]

On July 2, 2020, DMAS directed each MCO to increase payments to network physicians and nonphysician practitioners by 29 percent for certain services provided between March 1 and June 30, 2020. The services included primary care; preventive care; telehealth visits; and EPSDT screenings and treatments.[11] DMAS also implemented flexibilities for care and services for members receiving LTSS. DMAS allowed flexibilities for specific face-to-face visit requirements and other home- and community-based services (HCBS). The flexibilities were designed to maintain provider staffing, maximize access to care, and minimize viral spread

[9] Martin K, Kurowski D, Given P, et al. The Impact of COVID-19 on the Use of Preventive Health Care, Updated April 16, 2021. Available at: https://healthcostinstitute.org/hcci-research/the-impact-of-covid-19-on-the-use-of-preventive-health-care. Accessed on: Aug 3, 2022.

[10] Hoyert DL. Maternal Mortality Rates in the United States, 2020. NCHS Health E-Stats, February 23, 2022. Available at: https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/E-stat-Maternal-Mortality-Rates-2022.pdf. Accessed on: Aug 3, 2022.

[11] Georgetown University Health Policy Institute, Center for Children and Families. Redirecting Medicaid MCO Gains to Offset Network Provider Losses in the Time of COVID-19. Available at: https://ccf.georgetown.edu/2020/07/27/redirecting-medicaid-mco-gains-to-offset-network-provider-losses-in-the-time-of-covid-19/. Accessed on: July 14, 2022.

through community contact to protect the most vulnerable populations. Table 2 describes some of the flexibilities allowed during the pandemic.[12]

Table 2—Virginia Medicaid is Taking Action to Fight COVID-19

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

DMAS also provided consumer-directed attendants who worked anytime between July 1, 2021, and September 30, 2021, with a COVID-19 supplemental support payment of $1,000.

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

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

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

With the passage of the 2023 Consolidated Appropriations Act and associated omnibus bill that decoupled the continuous coverage requirement from the COVID-19 PHE, Virginia Medicaid enrollment processes returned to normal on April 1, 2023. DMAS began conducting eligibility determinations and renewals for all Medicaid and FAMIS members. DMAS is working with healthcare advocates and other partners to make sure eligible Virginians keep getting high quality healthcare coverage.

[12] Virginia Department of Medical Assistance Services. COVID-19 Response. Available at: https://www.dmas.virginia.gov/covid-19-response/. Accessed on: Aug 3, 2022.

Process for Quality Strategy Development, Review, and Revision

A Roadmap for the Future

DMAS developed this comprehensive Quality Strategy to continually improve the delivery of quality healthcare to all Medicaid and CHIP members served by the Virginia Medicaid managed care and FFS programs. DMAS' Quality Strategy provides the roadmap to accomplish its dynamic approach to achieving its overarching goal of designing, implementing, improving, and assessing the quality of healthcare and services furnished through Virginia's coordinated and comprehensive system. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, and quality, satisfaction, and timeliness of services for Virginia Medicaid and CHIP members.

DMAS' vision for quality extends beyond the 2023–2025 Quality Strategy. The mechanisms for assessing quality, timeliness, and access to care will vary across the Medicaid programs in Virginia; therefore, the Quality Strategy is tailored to incorporate these variances while ensuring an integrated strategy overall. The Quality Strategy requires a succession of incremental steps that DMAS will pursue to achieve these quality objectives. The actions and plans outlined herein lay the necessary groundwork for an evolving approach by establishing a strong foundation for quality governance.

With input provided by Virginia Medicaid MCOs, external stakeholders, and the Medical Care Advisory Committee, and in alignment with Governor Glenn Youngkin's strategic vision for the Commonwealth, DMAS identified goals and objectives for the Virginia Medicaid program across all populations and product lines. Those goals are supported by performance measures (each performance measure serves as a metric) used to measure performance in achieving the goals identified in the Quality Strategy. DMAS uses the NCQA HEDIS and the CMS Core Measure Sets to develop, collect, and report performance measures, in addition to DMAS-developed metrics.

Initial Quality Strategy and History

42 CFR §438.340

DMAS fosters a multidisciplinary approach to developing, reviewing, and revising the Quality Strategy. The approach involves input from the public, medical providers, stakeholders, member advocates, and outside partners who have a direct concern for—and impact on—access, quality of care, and quality of service. All stakeholders may comment on the development of quality goals and objectives highlighted in the Quality Strategy.

DMAS published its initial 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 addressed 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 (CYs) 2017 through 2019. DMAS completed a comprehensive update to the Quality Strategy, fourth edition, for CY 2020 through 2022. This edition of the Quality Strategy aligned with the requirements detailed in the revised federal regulations, specifically 42 CFR §438.340.

This document is the sixth edition of DMAS' Quality Strategy for CYs 2023–2025. It builds upon the Quality Strategy currently in place. This sixth edition aligns with the requirements detailed in the revised federal regulations, 42 CFR §438.340. The CMS Final Managed Care Rule issued by CMS, United States Department of Health and Human Services (HHS) was published in the Federal Register on May 6, 2016, and subsequently updated, and is hereinafter referred to as the "federal regulations." This CMS Final Managed Care Rule was updated in 2020 with changes to continue the commitment to promote flexibility, strengthen accountability, and maintain and enhance PI in Medicaid and CHIP. The changes reflect a broader strategy to relieve regulatory burdens; support state flexibility and local leadership; and promote transparency, flexibility, and innovation in care delivery. The federal regulations advance DMAS' mission of better care, smarter spending, and healthier people. According to 42 CFR, the federal regulation (Final Rule):

> *… advances CMS' efforts to streamline the Medicaid and Children's Health Insurance Program (CHIP) managed care regulatory framework and reflects a broader strategy to relieve regulatory burdens; support state flexibility and local leadership; and promote transparency, flexibility, and innovation in the delivery of care. These revisions of the Medicaid and CHIP managed care regulations are intended to ensure that the regulatory framework is efficient and feasible for states to implement in a cost-effective manner and ensure that states can implement and operate Medicaid and CHIP managed care programs without undue administrative burdens.*[13]

The federal regulations expand the scope of the Quality Strategy to address additional requirements in the following five areas:[14]

- Plan for improving quality of care and services
- Standards for network adequacy and availability of services
- Transition of care policy
- Identifying, evaluating, and reducing health disparities
- Identifying persons needing LTSS and persons with special needs

DMAS submits both updates and revisions of its Quality Strategy to CMS for review and approval.

For purposes of updating and revising the Quality Strategy, "significant change" is defined as:

[13] The Centers for Medicare & Medicaid Services. Medicaid and CHIP Managed Care Final Rule. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: July 14, 2022.
[14] Ibid.

- A pervasive pattern of quality deficiencies identified through analysis of the quality performance data submitted by the MCOs that results in a change to the goals or objectives of the Quality Strategy;
- Overarching changes to quality standards resulting from regulatory authorities or legislation at the Commonwealth or federal level; or
- A change in membership demographics or the provider network of 50 percent or greater within one year.

Changes to formatting, dates, or other similar edits are defined as "insignificant," as well as regulatory/legislative changes that do not change the intent or content of the requirements contained within the Quality Strategy. Changes to the details included in the Appendices of the Quality Strategy will also be considered insignificant. Appendices will be regularly updated as needed in the version of the Quality Strategy posted on the DMAS website.

Updates and Revision of the Quality Strategy

42 CFR §438.340(c)(2)

Updates to the Quality Strategy will be a part of Virginia's continuous quality improvement (CQI) process and, as required by 42 CFR 438.340(c)(2)(iii), will consider the recommendations provided by the EQRO for: (1) improving the quality of healthcare services provided by each MCO; and (2) how DMAS can target goals and objectives in the Quality Strategy to better support improvement in the quality, timeliness, and access to healthcare services provided to Medicaid beneficiaries. Annually, DMAS conducts a comprehensive review of its Quality Strategy to ensure its continued alignment with the direction and operations of the Medicaid program. DMAS applies its definition of significant change during each review of the Quality Strategy.

DMAS and its EQRO review and evaluate the effectiveness of the Quality Strategy and report on the evaluations in the annual EQR technical report. DMAS updates the Quality Strategy, at least triennially, based on each MCO's performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, Commonwealth, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Virginia Medicaid program. Each revised Quality Strategy is submitted to CMS. DMAS solicits feedback from Virginia Medicaid stakeholders, including the advisory committees, and the public during the revision phase of the Quality Strategy.

Obtaining Public Comment

42 CFR §438.340(c)

DMAS has several processes to obtain and consider public comment on the Quality Strategy. The Medical Care Advisory Committee receives feedback from the statewide provider community. DMAS posts the draft Quality Strategy to its website and ensures stakeholder groups are made aware of the public comment period. DMAS also consults with Tribes regarding updates made to the Quality Strategy.

DMAS posted the draft Quality Strategy for public comment on its website from March 7, 2024, through April 7, 2024. DMAS reviewed and considered the public comments received, and incorporated public feedback into the draft Quality Strategy prior to submission to CMS.

Medicaid Advisory Committee

The DMAS Medicaid Advisory Committee is titled the Medicaid Physician and Managed Care Liaison Committee (MPMCLC). Committee membership includes, but is not limited to, representatives from the following organizations: Virginia Academy of Family Physicians, American Academy of Pediatrics—Virginia Chapter, Virginia College of Emergency Physicians, American College of Obstetrics and Gynecology—Virginia Section, American College of Radiology, Psychiatric Society of Virginia, Virginia Medical Group Management Association, and the Medical Society of Virginia. The committee includes representatives from each of DMAS' contracted MCOs and a representative from the Virginia Association of Health Plans.

The Medical Care Advisory Committee reviews and advises on the operations, programs, and planning for Virginia's Medicaid program. The committee provides feedback and input on policy, operations, and administrative issues of the Medicaid program, including issues of concern to the community. The committee operates in accordance with 42 CFR 431.12 and the State Medicaid Plan.

Beneficiary Advisory Group

DMAS obtains input from the Beneficiary Advisory Group (BAG). The BAG includes Medicaid beneficiaries, their family members, and/or their caregivers. The BAG has crossover membership with the MAC, with 25 percent of MAC members also being BAG members. MAC and BAG information is publicly available to promote transparency and accountability between the State and its stakeholders.

Beneficiary and Stakeholder Input

DMAS also obtains input from members and other stakeholders on the Quality Strategy. Internal and external key stakeholders are invited to review the strategy during the public comment period, before it is considered final. Internal stakeholders include representatives from Health Care Services, Integrated Care, and other DMAS divisions, including Developmental Disabilities and Behavioral Health, and the Office of the Chief Medical Officer (OCMO). DMAS posts the final draft of the Quality Strategy on the DMAS website for public comment, allowing a minimum of 30 days for stakeholder input and written feedback. Internal and external public input and feedback is considered after the public comment period is closed.

Consulting With Tribes

42 CFR §438.340(c)(1)(ii)

DMAS understands that access to the decision-making process regarding the Medicaid and CHIP programs is especially critical for tribes for cultural, treaty, and statutory reasons. Therefore, DMAS' tribal consultation policy follows the federal requirements for tribal consultation. DMAS notifies the tribes in writing 30 days prior to the Commonwealth's

submission of any Medicaid or CHIP State Plan Amendment, and at least 60 days prior to any waiver request, proposal for a demonstration project, policy or procedure, or Quality Strategy update that is likely to have a direct effect on Indians, Indian health programs, or urban Indian organizations. The Quality Strategy is shared with, and input solicited from, the following Virginia tribes:

- Pamunkey Indian Tribe
- Chickahominy Indian Tribe
- Chickahominy Indian Tribe, Eastern Division
- Monacan Indian Nation
- Nansemond Indian Tribe
- Rappahannock Tribe
- Mattaponi Tribe
- Indian Health Services
- Pamunkey Health Clinic

The notification describes the purpose and the anticipated impact on tribal members. It also describes a method for appropriate tribal representatives to provide official written comments and questions within an adequate time frame (at least 30 days) that allows time for DMAS' analysis, consideration of any issues that are raised, and discussion between DMAS and tribes responding to the notification.

DMAS consulted with tribes regarding the updates to the Quality Strategy by providing the draft Quality Strategy and a summary table of changes made to the Quality Strategy, for their review and to encourage tribal input. DMAS did not receive any tribal input to consider prior to finalizing the Quality Strategy.

DMAS provides written acknowledgement on its website to stakeholders that provide written feedback on the Quality Strategy during the public comment period. Recommendations are shared with appropriate departments within DMAS for consideration and are incorporated into the final version of the Quality Strategy as determined appropriate by DMAS. The recommendations and responses from DMAS are posted on the DMAS website.

Submitting the Quality Strategy to CMS

42 CFR §438.340(c)(3)

CMS Review and Approval

If significant changes are made to the 2023–2025 edition of the Quality Strategy, the revision(s) will include a public comment period, CMS review and approval, and a resultant new edition. Insignificant changes would not warrant the need for a new edition.

Posting the Final CMS-Approved Edition on the Website

42 CFR §438.340(d)

After review by CMS, DMAS provides members, providers, and other internal and external stakeholders access to the organization's Quality Strategy by posting the final version on DMAS' Virginia Medicaid portal, website, and other communication portals. The final version of the Quality Strategy can be found on the DMAS website.[15]

[15] Virginia Department of Medical Assistance Services. 2020–2022 Quality Strategy. Available at: https://www.dmas.virginia.gov/media/2649/2020-2022-dmas-quality-strategy.pdf. Accessed on: Aug 4, 2022.

Virginia's Quality Assessment and Performance Improvement

DMAS requires that MCOs, in compliance with 42 CFR 438.330 and additional DMAS requirements, establish and implement an ongoing comprehensive quality assessment and performance improvement (QAPI) program that is reviewed annually and approved by DMAS. DMAS requires that each MCO has in effect a process for a self-evaluation of the impact and effectiveness of its QAPI program. Each MCO's QAPI program includes:

- Completion of DMAS-specified PIPs (DMAS and MCO PIP topics are included in Appendix C).
- Collection and submission of all designated quality performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care for beneficiaries with special health care needs (SHCN).
- Mechanisms to assess and address health disparities.
- Mechanisms to assess the quality and appropriateness of care provided to beneficiaries needing LTSS, including assessment of care between settings and a comparison of services and supports received with those set forth in the member's treatment/service plan.
- Participation in efforts by the Commonwealth to prevent, detect, and remediate critical incidents.

The DMAS QI program embodies a CQI process and problem-solving approach applied to specific and measurable performance indicators and operational activities. The CQI process is used to (1) monitor access to care, timeliness and quality of care, and operational performance; (2) identify opportunities for improvement that exist throughout the Virginia Medicaid program; (3) implement intervention strategies to improve outcomes and performance; (4) evaluate interventions to determine successfulness; and (5) reassess performance through measurement to identify new opportunities for improvement. To ensure that a consistent process for CQI is applied, DMAS has adopted the W. Edwards Deming cycle of performance improvement—Plan-Do-Study-Act (PDSA). The PDSA cycle follows a systematic series of steps for gaining knowledge about how to improve a process or outcome." The PDSA cycle is discussed below and depicted in Figure 7.

Figure 7—PDSA Cycle

1. **Plan:** Define the objective, interventions, questions, and hypotheses that will answer the following questions: *Who? What? Where? When?* Data collection should be targeted toward answering the questions.
2. **Do:** Carry out the plan (and interventions) by collecting data and beginning data analyses.
3. **Study:** Complete the data analysis and compare results to predictions to determine if interventions were successful or if opportunities for improvement still exist. Summarize what was learned.
4. **Act:** Plan the next cycle. If interventions were successful, plan to extend or standardize them. If interventions were not successful, replace them with new interventions intended to bring about truly improved processes or outcomes.

DMAS uses several key interventions to drive QI in the Virginia Medicaid program, which include:

- Maintaining a robust QI framework that encompasses a CQI approach, as described above.
- Using HEDIS and the CMS Core Measure Sets and other performance measures to continually assess each MCO's achievement of the DMAS goals.
- Implementing PIPs, which measure and assess targeted performance improvement interventions on specific topics.
- Monitoring Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[16] survey results and other satisfaction survey data to determine how satisfied Virginia Medicaid members are with the care and services they receive.
- Monitoring FFS Non-Emergency Medical Transportation survey results to determine how satisfied Virginia FFS Medicaid members are with transportation services.
- Monitoring the MCOs' QI activities and compliance with contractual requirements to verify if the MCOs are appropriately implementing federal and Commonwealth contractual standards.
- Facilitating cross-agency collaborative meetings to identify opportunities to improve service delivery and to leverage resources to achieve common goals.
- Trending performance measure results to ensure that the MCOs' performance is improving over time.
- Implementing other initiatives, as needed, to adhere to changes in federal policy.
- Studying the healthcare disparities among racial and ethnic groups to implement targeted and culturally competent interventions to ensure that Medicaid members have access to high-quality care.
- Studying the healthcare disparities among members with SHCN as well as by age, sex, or disability status to implement targeted interventions to ensure that all Medicaid members have access to high-quality care.

So that DMAS may monitor and ensure the accuracy of MCO reporting and assess performance against those measures on an MCO-specific and program-wide basis, the MCOs:

- Provide all quality data, at minimum, annually to DMAS.
- Provide to DMAS all accreditation reports.

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

- Provide all information required by the EQRO, in compliance with the protocols set forth by CMS.[17]

MCOs develop a process to evaluate the impact and effectiveness of their own QAPI programs. A description of this MCO process is submitted to and approved by DMAS with submission of the QAPI program itself and is closely aligned to this Quality Strategy.

MCOs participate in ongoing cross-MCO meetings with DMAS and MCO quality directors, which are designed to exchange and build upon MCO-identified best practices, discuss arising issues, and plan for upcoming projects. MCOs are also required to participate in DMAS Quality Improvement Collaborative meetings. The Quality Improvement Collaborative serves as a key DMAS interface with MCOs and is driven by the data collected throughout the assessment process.

★ Quality Strategy Interventions ★

Virginia has developed a series of interventions aligned closely to this Quality Strategy and designed to build an innovative, person-centered, coordinated system of care that addresses both medical and nonmedical drivers of health. These interventions drive progress towards the Quality Strategy goals and objectives, described in Table 1. DMAS developed a Responsible, Accountable, Consulted, Informed (RACI) chart, depicted in Table 3, to clarify and define the roles and responsibilities of its cross-functional efforts focused on achieving goals and objectives contained in the Quality Strategy.

Table 3—Quality Strategy RACI Chart

Intervention Categories	**1.1** Increase member engagement and outreach	**1.2** Improve member satisfaction	**2.1** Ensure access to care	**2.2** Promote patient safety	**2.3** Promote effective communication and care coordination	**3.1** Focus on paying for value	**3.2** Focus on efficient use of program funds	**4.1** Improve utilization of wellness, immunization, and prevention services for members	**4.2** Improve outcomes for maternal and infant members	**4.3** Improve home and community-based services	**5.1** Improve Outcomes for Members with Chronic Conditions	**5.2** Improve Outcomes for Nursing Home Eligible Members	**5.3** Improve Outcomes for Members with Substance Use Disorders	**5.4** Improve Behavioral Health and Developmental Services of Members
Project BRAVO	X	X	X	X	X				X				X	X
Foster Member and Provider Engagement	X	X	X		X									
Value-Based Purchasing			X	X	X	X	X	X	X	X	X	X	X	X

[17] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols,* October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: July 20, 2022.

Intervention Categories	**1.1** Increase member engagement and outreach	**1.2** Improve member satisfaction	**2.1** Ensure access to care	**2.2** Promote patient safety	**2.3** Promote effective communication and care coordination	**3.1** Focus on paying for value	**3.2** Focus on efficient use of program funds	**4.1** Improve utilization of wellness, immunization, and prevention services for members	**4.2** Improve outcomes for maternal and infant members	**4.3** Improve home and community-based services	**5.1** Improve Outcomes for Members with Chronic Conditions	**5.2** Improve Outcomes for Nursing Home Eligible Members	**5.3** Improve Outcomes for Members with Substance Use Disorders	**5.4** Improve Behavioral Health and Developmental Services of Members
Telehealth	X	X	X		X			X	X		X		X	X
Management of At-Risk Children				X				X	X		X		X	X
Financial Transparency and Accountability						X	X							
Smiles for Children Dental Program		X	X			X		X	X		X	X	X	
Maternal and Family Health Initiatives	X	X	X	X	X	X	X	X	X		X		X	X
Right Help, Right Now	X	X	X	X										X

The following paragraphs describe in more detail each of the interventions listed in the Quality Strategy RACI chart.

★ *Right Help, Right Now* ★

Governor Glenn Youngkin created *Right Help, Right Now* to reform Virginia's behavioral health system and to support individuals in crisis. The goal of *Right Help, Right Now* is to support

Virginians before, during, and after a behavioral health crisis occurs. The *Right Help, Right Now* plan aims to ensure that there will be same-day care delivered through mobile crisis units and crisis centers in order to reduce overcrowding at emergency departments. By doing so, there will be less strain on law enforcement, who can instead better serve the communities where they are needed. This will also serve to reduce the criminalization of mental health in Virginia. The *Right Help, Right Now* plan includes specialized resources for individuals with substance use disorders or who have a high risk of overdosing. Virginians should have immediate access to all the resources they need anytime and anywhere.

Governor Glenn Youngkin's three-year plan to transform Virginia's behavioral health is a six-pillared approach to address Virginia's behavioral health challenges, encompassing crisis care, law enforcement burden, substance use disorder support, behavioral health workforce, and service delivery innovation.

"We are facing a behavioral health crisis across Virginia and the United States. This crisis is present throughout our society, at home, in schools and in the workplace. The three-year *Right Help, Right Now* vision is to revolutionize Virginia's behavioral health delivery system," said Governor Glenn Youngkin. "*Right Help, Right Now*. incorporates best-in-class models of behavioral health from across the country for a system that delivers the *Right Help, Right Now* to the people who need it most. *Right Help, Right Now* is a transformational advancement in behavioral health that prioritizes care for the most vulnerable, particularly Virginia's youth."

"This is a massive undertaking of the entire behavioral health system and continuum of care. Every Virginian needs to know who to call, who will help and where to go in a crisis, and we are working to rebuild a holistic system that does so," said Secretary of Health and Human Resources John Littel.

Governor Glenn Youngkin's three-year plan includes over $230 million in new funding for behavioral health. The centerpiece of these proposals includes a $20 million proposal to fully fund more than 30 new mobile crisis teams to respond to calls to Virginia's 9-8-8 hotline.

Included in the Governor's budget is:

- $20 million to fund 30+ new mobile crisis teams, meeting our statewide goal in the first year, to respond to 9-8-8 hotline calls
- $58 million to increase the number of Crisis Receiving Centers and Crisis Stabilization Units, fully-funding the number of necessary centers in Southwest Virginia and Hampton Roads
- $15 million to expand the elementary, middle, and high school-based mental health program to dozens of new communities
- $9 million to expand tele-behavioral health services in public schools and on college campuses
- $20 million for partnerships with hospitals for alternatives to emergency departments for crisis
- $9 million for transportation and in-hospital monitoring by law enforcement and other personnel
- $8 million for Serious Mental Illness housing, creating 100 new placements for SMI patients with extraordinary barriers to discharge

- $57 million for 500 additional Medicaid Waiver Priority 1 Waitlist Slots and increased provider rates including respite and companion services
- $15 million in opioid abatement initiatives including a campaign to reduce fentanyl poisoning among our youth.

Properly funded, staffed, and located regional crisis centers can play an important role in meeting a crisis, and removing stress from the rest of the system. Because every Virginian should have access to the quality services they need, regardless of their ZIP code.

Figure 8—The *"Right Help, Right Now"* Six Pillars:

★ *Youth Mental Health Strategy* ★

Governor Glenn Youngkin unveiled the Youth Mental Health Strategy on the one-year anniversary of the *Right Help, Right Now* initiative. In 2023, according to Mental Health America, Virginia ranked 48th in the nation for youth mental health, which demands a collective and comprehensive approach to prioritize the health of the Commonwealth's youngest and most vulnerable citizens. Children spend on average nearly five hours daily on social media; recent studies have suggested that children who spend more than a few hours per day on social media have double the risk of poor mental health.

Governor Glenn Youngkin is taking immediate action in year two of *Right Help, Right Now*. To better equip parents and support Virginia's young people, Governor Glenn Youngkin, through budget proposals, legislation, and executive action, and the Youth Mental Health Strategy, will address critical components and harmful aspects of social media on Virginia's youth.

To address addictive and harmful aspects of social media on youth:

- Virginia will protect minors from TikTok's predatory influence in the Commonwealth of Virginia.
- Virginia will protect the privacy of all children under 18 years of age from social media companies by banning targeted advertising to children, selling children's data, or creating a marketing profile of a child without parental consent.
- Virginia will prohibit social media companies from using addictive practices, designs, or features, such as auto-playing videos, gamification, and virtual gifts, on children.

- Virginia will give parents the ability to implement guardrails on minors' social media use and limit social media companies from disrupting teens' sleep by knowingly or intentionally keeping children on their phones.

Inside our schools:

- Virginia will expand eligibility for school-based mental health services to students across Virginia using a waiver and provide technical assistance and support to localities that provide matching funds and wish to utilize these services.
- Virginia will require school divisions that monitor student Internet use to disclose what activity is tracked and monitored, obtain parental consent, and notify parents when a safety alert is issued.
- Virginia will expand the behavioral health workforce in schools and other community settings.
- Virginia will increase access to care by providing funds for tele-behavioral health for children in grades 6–12, with their parents' permission, as well as in our public colleges.

In behavioral health care settings:

- Virginia will ensure that Virginia families have the right to be in close physical proximity to a relative during a medical, mental health, or substance use emergency and provide the relative with previously prescribed medications.
- Virginia will empower parents with the right to consent for their child to receive inpatient psychiatric care and choose where their child receives inpatient psychiatric care, and include minors from code-mandated State psychiatric treatment.

Year 2 *Right Help, Right Now* budget priorities:

Governor Glenn Youngkin proposed $500 million in new funding for his biennium budget. This is a giant step forward when combined with the funding appropriated in the last budget—bringing the commitment to nearly $1.4 billion, including:

- $307 million to provide 3,440 waiver slots, a slot per person on the priority one waitlist.
- $23 million to expand access to school-based mental health services for children, including telehealth.
- $46 million to meet the three-year target of emergency room alternatives, such as crisis receiving centers and crisis stabilization units, and publicly funded mobile crisis response teams to ensure that people have someone to respond and somewhere to go in a crisis.
- $10 million for partnerships with hospitals to build specialized emergency rooms for psychiatric patients called comprehensive psychiatric emergency programs.
- $23 million to ease law enforcement burden, including expanding alternative transportation.
- $58 million for building a best-in-class behavioral health workforce through salary increases in state hospitals, behavioral health loan repayment, and more clinical training sites and residency slots.
- $28 million in opioid abatement and response initiatives, including a campaign to reduce youth fentanyl poisoning, wastewater monitoring, naloxone availability, and services for those with substance use disorder.

Virginia will continue to transform its behavioral health system in a way that will positively affect generations to come. The Youngkin administration is committed to doing its part to make Virginia an even better place to live, work, and raise a healthy family.

Additional Funding and Waiver Slots for Virginians with Developmental Disabilities, Enhancing Support

Governor Glenn Youngkin committed to enhance support for Virginians with developmental disabilities and their families. Included in the *Right Help, Right Now* initiative, Virginia is one step closer to the goal of providing enough priority one slots for everyone in urgent need of services by the end of the Governor's term. Governor Glenn Youngkin announced an additional $300 million over the biennium to fund enough priority one slots for every Virginian with a developmental disability on the waitlist for Medicaid Home and Community-Based Developmental Disability (DD) waiver slots.

These improvements give Virginians with disabilities the supports and services they need to live their best lives in their communities. Secretary of Health and Human Resources John Littel stated that the Commonwealth has heard from Virginians and their families about the important difference a DD waiver can have in their life of the life of a loved one. Whether it be paying for in-home care or the kind of assistive technology that can help an individual avoid living in a hospital, nursing home, or other institution, these waivers can change lives. The waivers also cover services such as medical care, employment supports, assistance for community living, behavioral interventions, and other items like medical goods and assistive technology.

★ *Behavioral Health Enhancement and Project BRAVO* ★ [18,19]

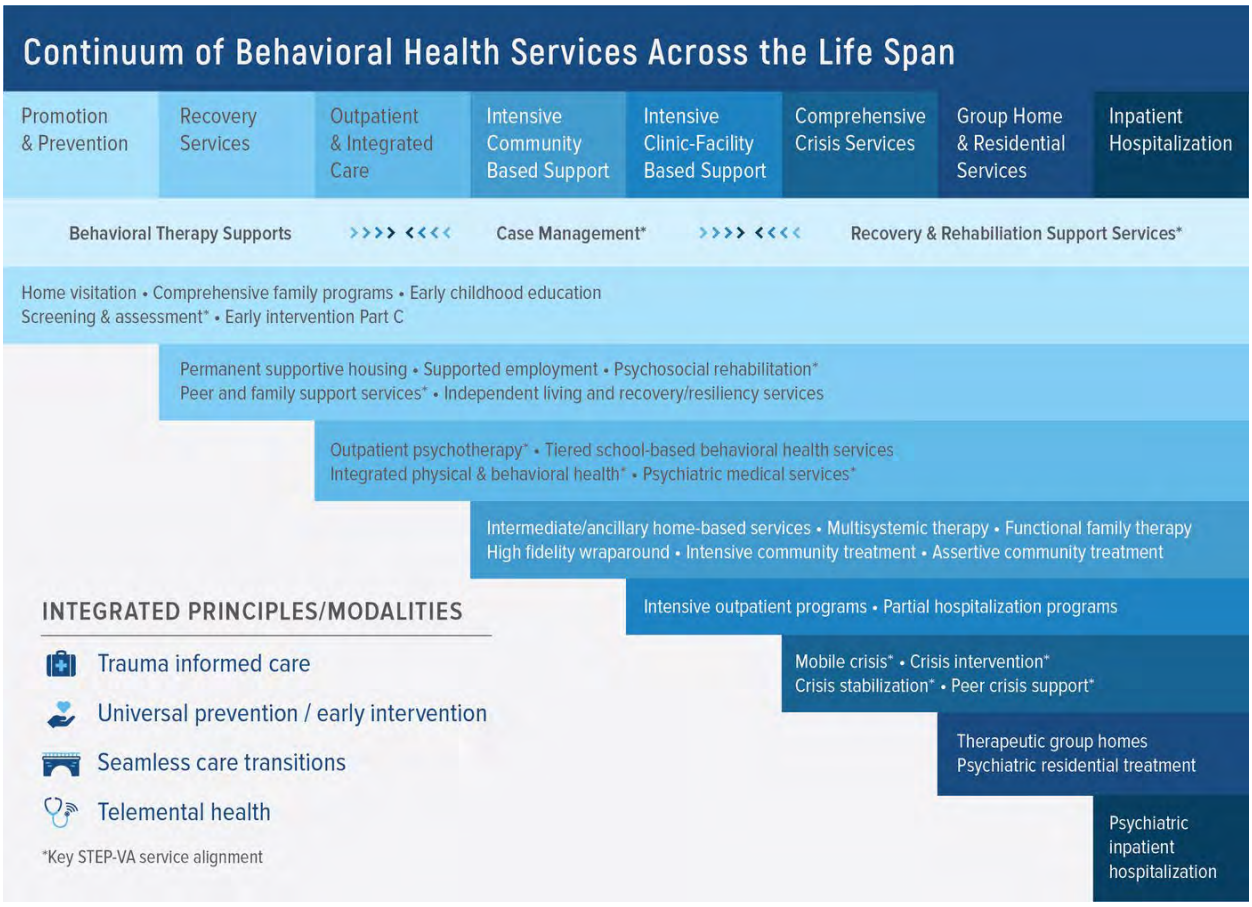
Under Governor Glenn Youngkin, the Commonwealth is focused on improving behavioral health services. The vision for the Enhancement of Behavioral Health is to keep Virginians well and thriving in their communities, shift our system's current need to focus on crisis by investing in prevention and early intervention for mental health and substance use disorder (SUD) comorbidities, and support comprehensive alignment of services across the systems that serve Medicaid members. This includes efforts to reduce the burden on state psychiatric hospitals and EDs, with efforts including increasing use of mobile crisis response and reduction of emergency department utilization, as well as working to ensuring appropriate access to acute behavioral health services for foster care youths by working to carve in residential services into the managed care programs.

DMAS is also committed to the continued expansion of access to BRAVO services by implementing new services and engaging the communities to support these services. Project BRAVO is a comprehensive, General Assembly supported vision that details a "north star" continuum of services and a preliminary set of prioritized services to build out critical levels of care, including comprehensive crisis services. Figure 9 displays the Project BRAVO continuum of services. As part of this work, DMAS DBHDS collaboratively selected new services that have

[18] ★ Governor Glenn Youngkin's identified priority for the Medicaid program that focuses on and access to high quality healthcare services. Objective 5.3: Improve Outcomes for Members with Substance Use Disorders.
[19] ★ Governor Glenn Youngkin's identified priority for the Medicaid program that focuses on and access to high quality healthcare services. Objective 5.4: Improve Behavioral Health and Developmental Services of Members.

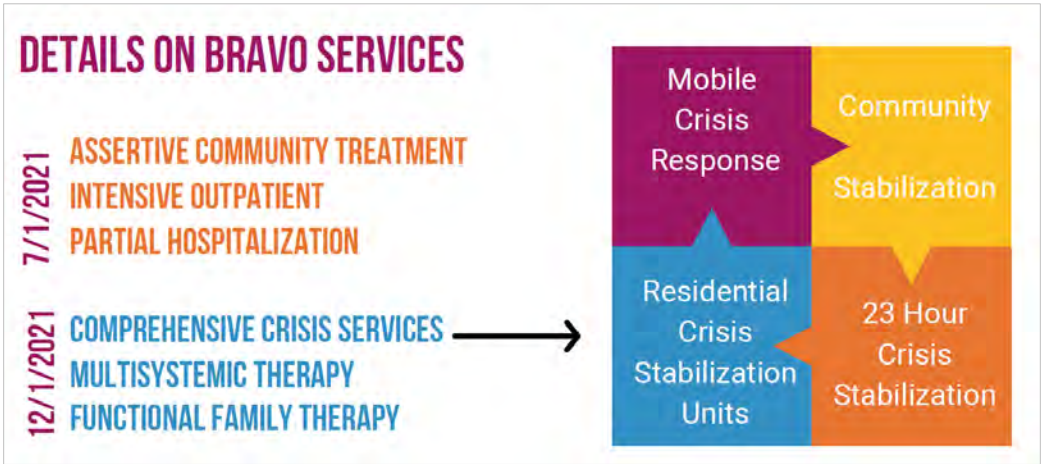
demonstrated success and value to individuals across the nation that will provide care in the community to ultimately avoid inpatient hospital stays.

Figure 9—Project BRAVO Continuum of Services



DMAS began providing coverage of these community-based services for adult and youth Medicaid members with the first phase implemented in July 2021 and the second phase implemented in December 2021. These new services include crisis services for youth and adults to support and stabilize the individual prior to, during, and following a crisis. Figure 10 shows the services included in each Project Bravo implementation phase.

Figure 10—Project BRAVO Service Implementation Phases



Fatal drug-related overdoses surged during the COVID-19 pandemic, exceeding 100,000 overdoses in the U.S. and over 2,400 in Virginia in state fiscal year (SFY) 2021. This represents a 20 percent increase nationally and a 35 percent increase in Virginia, respectively, since the previous year. Pandemic-related economic and social stress, disruptions in access to health services, and greater availability of more lethal forms of opioids, such as fentanyl, are considered the primary reasons for the surge in overdoses, although no definitive causes have been identified. The demand for both mental health and SUD services have increased with the COVID-19 pandemic, and Virginia's drug overdose rates remain higher than ever before. In order to make the most of its Medicaid investments, Virginia needs to implement services that are evidence-based, trauma-informed, and support efforts to build and sustain a strong healthcare workforce.

Beginning in 2017, the Addiction and Recovery Treatment Services (ARTS) benefit provides treatment for members with SUDs across the state and provides access to addiction treatment services for all enrolled members in Medicaid, FAMIS, and FAMIS MOMS. A DMAS goal for the ARTS delivery system transformation includes ensuring that a full continuum of care is available, based on evidence-based practice, to effectively treat individuals with SUD. Primary drivers of the ARTS benefit to reduce the opioid-related overdose deaths include:

1. Increase the rates of initiation and engagement in treatment for opioid use disorder (OUD) and other SUDs.
2. Reduce utilization of ED and inpatient hospital settings for SUD treatment.
3. Improve adherence to treatment for OUD and other SUDs.
4. Reduce readmissions to the same or higher level of care for SUD treatment.
5. Improve access to care for co-morbid physical health conditions among beneficiaries with SUD.

This approach is expected to provide Medicaid members with access to the evidence-based care needed to achieve sustainable recovery. The MCOs work with DMAS, as required by contract, to ensure that their members' care needs for SUD treatment and recovery are met and include care coordination, utilization review, and a robust array of services and treatment methods to address immediate and long-term physical, mental, and SUD service needs. The ARTS provider network ensures member access to timely care through a sufficient network of high quality, credentialed, and knowledgeable providers in each level of care as well as

ensuring medications for treating OUD and alcohol use disorder (AUD) are available in all levels of care.

As a result of the expansion of treatment services through ARTS and increases in eligibility for these services through Medicaid expansion beginning in 2019, Virginia Medicaid was far better prepared for the increased prevalence in SUD than in previous years. The supply of treatment providers, the prevalence of members receiving SUD treatment, and the rate of treatment for diagnosed SUD increased dramatically after implementation of the ARTS benefit and has continued through Medicaid expansion and the COVID-19 pandemic. While there was concern that COVID-19 related shutdowns and stay-at-home orders may negatively affect access to and use of SUD treatment services, the federal government and DMAS implemented a number of initiatives and procedural flexibilities to offset these barriers, including increased use of telemedicine, allowing take-home dosages of methadone and buprenorphine for up to 28 days, allowing for 90-day prescriptions for buprenorphine products, and allowing a member's home to serve as the originating site for prescription of buprenorphine.

The ARTS four-year evaluation examined SUD prevalence, treatment utilization, and outcomes among Virginia Medicaid members during SFYs 2019 and 2020, as well as the first two quarters of SFY 2021 (covering the period July 2018 through December 2020).

Foster Member and Provider Engagement

DMAS has established the Medicaid Member Advisory Committee (MAC) in order to provide a formal method for members' voices to be included in the DMAS decision-making process and to inform DMAS change management strategies. The diverse committee is comprised of representatives from across the state and is entirely made up of Medicaid-enrolled individuals and individuals' authorized representatives. The MAC's purpose is to obtain the insight and recommendations of Virginia's Medicaid members in order to help the DMAS Medicaid Director improve the overall experience for all Virginia Medicaid applicants and members. The committee members examine and provide input on the impact of DMAS policy, services, and programs. Committee members serve for at least one year. Scheduled quarterly meetings are open to the public, with a comment period reserved in each meeting. Each MCO is also required to have a MAC to provide a platform for member input.

DMAS' provider committee is called the MPMCLC. The MPMCLC meets quarterly to provide a forum for Medicaid providers, DMAS, and the MCOs to come together to discuss opportunities, provide feedback, and create alignment across Virginia's Medicaid managed care programs. DMAS also solicits feedback from providers and members through a variety of surveys, including secret shopper calls, to assess their experience in accessing and utilizing care, as well as to monitor the quality of care available to Virginia's Medicaid members.

DMAS created the Civil Rights Coordinator position in November 2019 to ensure that individuals with limited English proficiency (LEP) and individuals with disabilities have meaningful access to programs and services. This position serves the critical function of ensuring continued compliance with federal and Commonwealth of Virginia civil rights requirements and ensures that internal and external stakeholders have language and disability access resources available to improve communications with LEP individuals and those with disabilities.

In 2021, the Civil Rights Coordinator completed the DMAS Language and Disability Access Plan, which is available to internal and external staff members, as well as to the public at:

https://www.dmas.virginia.gov/about-us/2021-language-and-disability-access-plan/. The Plan includes the Four Factor Analysis that evaluates the following for the Virginia Medicaid program: (1) the number or proportion of LEP persons and individuals with disabilities eligible to be served or likely to be encountered, (2) the frequency of contact, (3) the nature of the program and services, and (4) the availability of resources and costs. The Plan will be evaluated each year to determine what strategic initiatives can further DMAS' commitment to serving the LEP and disabled populations. One of the most crucial initiatives identified in 2021 was to develop language and disability access related training, as well as linguistic and cultural competency training, for agency staff to ensure effective communication with LEP individuals and individuals with disabilities. This training initiative launched in early 2022 and is required for all DMAS staff.

Provider Outreach and Engagement

All provider outreach, marketing, and promotional activities (including provider promotional activities) comply with relevant federal and Commonwealth laws. This includes both the Anti-Kickback Statute and the Civil Monetary Penalty law, which prohibits inducements to beneficiaries. DMAS is in the process of reviewing all provider O&E materials in order to ensure compliance with regulations, readability, and availability of technical documentation and support for Medicaid providers, especially with the transition to Cardinal Care. Cardinal Care will simplify provider contracting and credentialing processes during provider enrollment and renewal. With the retirement of Medallion 4.0 (Acute) and CCC Plus (MLTSS), providers will maintain and adhere to only one contract and credentialing process for each of the health plans in which they participate as network providers. Cardinal Care Managed Care will cover the full scope of Medicaid managed care covered services, including LTSS within the established screening and coverage criteria. Cardinal Care Managed Care will continue to provide comprehensive care management for members with significant health needs. DMAS is updating the agency website across the different programs and divisions to provide detailed information to providers. The purpose of these updates is to support the understanding of provider processes, appeals, credentialing, education and trainings, and payment systems.

★ *Value-Based Purchasing* ★ [20]

Under the administration of Governor Glenn Youngkin, there is a push for DMAS to increase the utilization of VBP arrangements with MCOs and providers. VBP includes a broad set of policies and strategies intended to improve healthcare quality, outcomes, and efficiency by linking financial and nonfinancial incentives to the performance of various stakeholders serving Virginia Medicaid members. Movement toward and achievement of these goals is measured through a set of defined metrics evaluating quality, cost, and patient-centered care. There is no "one-size-fits-all" approach to VBP, and DMAS' efforts focus on a range of healthcare stakeholders, populations, and care events that are important to members, specifically highlighting chronic conditions, maternity care, behavioral health, and prevention.

As part of these efforts, Virginia's Medicaid MCOs are held accountable for performance in key areas through PWPs under the Cardinal Care program, whereby each MCO must earn back a portion of its capitation payments through demonstrated performance against key metrics. MCOs are held accountable for potentially preventable, avoidable, and/or medically

[20] ★ Governor Glenn Youngkin's identified priority for the Medicaid program that focuses on maternal health outcomes. Goal 3: Support Efficient and Value-Driven Care.

unnecessary utilization in high-acuity settings of care through measures developed by DMAS. As part of this effort, DMAS contracted with its actuary to identify clinical efficiencies under its managed care programs. The first set of clinical efficiency analyses focused on medically unnecessary or potentially preventable spending for hospital admissions, hospital readmissions, and ED visits.

In 2021, the VA General Assembly directed DMAS to establish a nursing facility value-based purchasing (NF VBP) program. DMAS developed a provider-facing NF VBP targeting staffing measures, such as reducing the number of days facilities do not meet the CMS-mandated minimum number of staffed registered nurse (RN) hours and the weighted average of case-mix adjusted total nurse staffing hours, and avoidance of negative care events measures, such as reducing pressure ulcers, urinary tract infections (UTIs), hospitalizations, and ED visits. The program targets will continue to evolve over time.

Assessments of Essential Services and Vulnerable Populations

DMAS requires the MCOs to have mechanisms to detect under- and overutilization of care and services. The DMAS assessments of essential services provided by the MCOs include procedures to evaluate medical necessity, criteria used, information source, and the process used to review and approve or deny the provision of services. In accordance with 42 CFR §438.3(s)(4), each MCO develops and maintains a drug utilization review (DUR) program that complies with the DUR program standards as described in Section 1927(g) of the Social Security Act and 42 CFR §456 Subpart K, including prospective DUR, retrospective DUR, and the DUR Board. DMAS requires each MCO to demonstrate that all members have access to all services covered under its benefit in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services as provided under the FFS program. DMAS also requires MCOs to monitor and report critical incidents, as well as to implement plans to address potential and actual quality of care and/or health and safety issues in healthcare settings, including but not limited to nursing facilities and home- and community-based settings. DMAS includes but does not limit its definition of vulnerable populations to include individuals in a PACE; DD waiver members; and individuals with chronic illnesses, including both physical and/or behavioral health.

Improving Access to Care in Underserved Areas—Petersburg

Governor Glenn Youngkin unveiled a "pilot program" for helping underserved localities get on, and remain on, their feet, with Petersburg leading the way. Governor Glenn Youngkin and several of his cabinet secretaries joined Petersburg leaders to present "Partnership for Petersburg," a 42-initiative plan involving 61 local and state agencies. The goal is to strengthen Petersburg's infrastructure in six key areas—public safety, public education, transportation, healthcare, economic development and a bond between community and faith leaders.

Secretary of Health and Human Resources John Littel said hours and services at the Petersburg Health Department will be expanded, and more mobile clinics will be offered to increase access to important screenings and overall health maintenance. Over the past decade, Petersburg has been consistently ranked as the unhealthiest locality in Virginia by the University of Wisconsin's Population Health Institute.

Littel cited statistics noting that Petersburg's average life expectancy is almost 13 years lower than the state average, and rates for cancer, heart disease, diabetes, and other significant illnesses are higher. Infant mortality and low-birth weight rates are also higher. Other health-related initiatives include the establishment of health literacy "hubs" through Bon Secours Southside Medical Center in Petersburg, Central Virginia Health Services, DMAS' MCOs and other healthcare partners, as well as improvements to water and wastewater quality for the Poor Creek water station in south Petersburg.

Nursing Facility Quality Improvement Program

Since 2018, DMAS has maintained a plan for administering the Civil Money Penalty Reinvestment Program (CMPRP) in Virginia, which reinvests penalties assessed on noncompliant nursing facilities back into facilities through projects that directly improve the quality of life of residents. The Civil Money Penalty (CMP) Fund in Virginia is the collection of these monetary penalties assessed against nursing facilities that are found to be out of compliance with one or more Medicare and Medicaid participation requirements. A portion of these funds can be reinvested into projects that directly benefit residents of nursing facilities. DMAS oversees the program, the Virginia General Assembly appropriates the amount of CMP special funds to be used for the program, and CMS makes the final funding determination and approval.

In 2022, the Virginia General Assembly directed DMAS to design and implement a quality improvement program addressing nursing facility capacity building using CMP reinvestment funds. Following extensive research and feedback from key stakeholders, DMAS developed a proposed program that will improve workforce measures of competency, retention, and staffing in nursing facilities. This will be done through a series of trainings and opportunities for targeted technical assistance that reach all levels of nursing facility staff and focus on the areas of dementia care; behavioral health; and person-directed care, leadership, and improved workplace culture.

DMAS will need to seek CMS approval for use of the funds for this proposed program, and the application to CMS is currently under development and will be submitted upon notification by CMS that it will resume accepting new applications.

Connecting to Care

DMAS works with the MCOs to ensure that their delivery systems provide adequate numbers of facilities, accessible locations, and qualified personnel for the provision of covered services, including emergency services provided 24 hours a day, 7 days a week. The MCOs' provider networks are required to meet or exceed federal network adequacy standards as detailed at 42 CFR §438.68. The MCOs are also required to have sufficient types and numbers of traditional and specialty providers in their networks to meet the historical need and also add providers to meet increased member needs in specific geographic areas. DMAS assesses network adequacy by evaluating a number of factors, including number of providers, mix of provider types, hours of operation, ratio of providers not accepting new patients, accommodations for individuals with physical disabilities (wheelchair access), barriers to communication (translation services), and geographic proximity to beneficiaries (providers to members or members to providers).

The MCOs also provide emergency, urgent, and nonemergency transportation services to ensure that members have necessary access to and from providers of covered medical, behavioral health, dental, LTSS, and rehabilitative medical services and supports needed in a manner that ensures the member's health, safety, and welfare as required by 42 CFR §440.170(a) and 12 Virginia Administrative Code (VAC) 30-50-530.

Management of At-Risk Children

Children and youth with SHCN are those members up to age 21 who have or are at increased risk for chronic physical, developmental, behavioral, or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age. These include, but are not limited to, the children in the Medicaid eligibility categories of expansion, foster care and adoption assistance, youth who have aged out of the foster care system, children identified as EIS participants, children and youth with significant behavioral health conditions, and others as identified through the MCO's assessment or by DMAS. DMAS assesses the quality of care provided to these at-risk children in the following areas: program development, enrollment procedures, assessments and referrals, provider network, care coordination, and access to specialists.

In addition, the Virginia Department of Social Services (VDSS) Fostering Futures program provides Medicaid covered services to former foster care children when they turn 21 years of age. The voluntary program continues to provide financial and social support and services until 21 years of age; foster children are then automatically enrolled in the Former Foster Care adult Medicaid eligibility category. The Fostering Futures and Former Foster Care adult members have access to basic medical care, including preventive care, mental and behavioral health services, substance abuse treatment, prenatal care for pregnant women, and limited vision and dental care.

★ *Safe and Sound Task Force* ★ [21]

Governor Glenn Youngkin launched an initiative aimed at creating safe housing placements for children in foster care. The Safe and Sound Task Force will bring together government agencies, the Virginia League of Social Services Executives, and other community partners to end the practice of children sleeping in local departments of social services, hotels, and emergency rooms. Governor Glenn Youngkin formed the task force to ensure that every child has a safe place to belong.

Virginia has a dire shortage of foster homes, kinship family placements, and beds in group homes and residential treatment centers. The Special Advisor for Children's Issues convenes State and local government agencies, residential facilities and hospitals, and community partners to collaboratively seek immediate solutions to this crisis. The Task Force objectives include finding safe placements for kids who are currently displaced, ensuring a reservoir of safe placements for kids who may need them in the future, and eventually making recommendations that go upstream to address policy and systemic changes.

The Virginia Secretary of Health and Human Resources, John Littel, appreciates how swiftly Governor Glenn Youngkin reacted to the concern and provided the leadership necessary to end

[21] ★ Governor Glenn Youngkin's identified priority for the Medicaid program that focuses on behavioral health enhancement. Goal 2: Promote Access to Safe, Gold-Standard Patient Care.

the practice. Secretary Littel indicates that while there are a number of issues that created this untenable situation, it will require collaboration and creativity at both the local and State levels to solve it.

Financial Transparency and Accountability

DMAS continually evaluates its Medicaid programs to ensure that they are operating as efficiently and effectively as possible. To achieve this, DMAS: 1) deploys an internal financial scorecard to measure expenditures to budget, 2) deploys an external dashboard on utilization of finances to support Medicaid, and 3) updates its Medicaid forecast and rate-setting processes by implementing the recommendations of an external reviewer. DMAS includes transparency in its forecast and rate-setting processes by holding quarterly meetings with staff members from various legislative committees as well as the Joint Legislative Audit and Review Commission (JLARC), the Department of Planning and Budget, and the Secretary of Health and Human Resources to review key policy changes.

DMAS launched a transformational new procurement to drive innovation and strengthen quality and accountability in its managed care program in 2024. State leaders will evaluate commercial health plans that participate in the competitive procurement based on their use of data-driven strategies to address challenges in the rapidly evolving healthcare environment, including value-based care models that tie funding to measurable improvements in health outcomes.

Smiles for Children

Smiles For Children (SFC) is Virginia's Medicaid and FAMIS dental program. SFC provides comprehensive dental benefits to three target populations. Members under 21 years of age receive comprehensive dental benefits. Pregnant members have access to a comprehensive list of medically appropriate dental procedures excluding orthodontics. Finally, effective July 1, 2021, non-pregnant members over 21 have access to a comprehensive list of dental benefits with the exception of orthodontics.

On July 1, 2021, DMAS launched the comprehensive dental benefit plan for adults. This dental benefit provides comprehensive coverage for approximately 960,000 adults in the Commonwealth of Virginia. Modeled after the DMAS pregnant women benefit, the adult dental benefit provides no annual maximums, no copayments, and no deductibles for covered adult procedures. The dental benefit was designed with the realization that oral health has a substantial impact on overall health. The focus of the comprehensive adult dental benefit is to support a healthy mouth and gums with routine preventive services. Beginning with preventive services will aid in improving systemic health concerns that may be in existence and prepare the member for success with additional treatment that may be needed. The goal of additional treatment allows extractions when necessary for a healthier mouth and restorations to preserve fixable teeth. The adult dental plan also allows for up to three cleanings in a 12-month period by medical necessity and dentures for adults that lack teeth.

The MCOs are responsible for transportation and medication related to all covered dental services and are responsible for working closely with their respective Dental Benefits Administrator to coordinate medically necessary procedures for adults and children.

Adult Dental Coverage

Oral diseases, ranging from dental caries (cavities) to oral cancers, continue to cause pain and discomfort for millions of Americans. A growing body of evidence has linked oral health to several chronic diseases, including heart disease, endocarditis, and diabetes. DMAS understands the need for comprehensive dental benefits for all members program in the Commonwealth.

Prior to July 1, 2021, Virginians, age 21 years and older who were enrolled in Medicaid had limited dental benefits, covering medically necessary services only. With limited dental coverage, adult members lacked access to much needed preventive and diagnostic care. There have been various studies done linking a decrease in access to care to an increase in ED utilization. According to the Virginia Health Catalyst, in 2018, Virginia spent $3.31 million on 12,617 visits to the ED for dental-related pain and infection; however, no treatment was provided in the ED.

The comprehensive adult dental benefit became effective July 1, 2021. More than 1,000,000 members now have access to comprehensive dental benefits that make available each of the dental specialties. It was established on the premise that the dental treatment procedures would be prevention and control to keep the mouth disease free, and then restore it to healthy function. Beginning with preventive services will aid in improving systemic health concerns that may be in existence and prepare the patient for success with additional treatment that may be needed. The goal of additional treatment would focus on removing what cannot be saved and restoring what can be built around, therefore increasing longevity for any prosthetic appliances that may be in order. The adult dental plan also allows for up to three cleanings in a 12-month period by medical necessity and dentures for adults that are edentulous. Benefits also include cleanings, exams, fillings, crowns, root canals, x-rays, and anesthesia. There is no waiting period, no annual maximums, and no deductibles for covered adult procedures as a part of the comprehensive adult dental benefit.

★ *Maternal and Family Health Initiatives* ★ [22]

DMAS developed a series of strategies to improve maternal and infant outcomes among its members, with a particular administrative focus under Governor Glenn Youngkin on ensuring women receiving timely postpartum care after giving birth. DMAS recently implemented coverage expansions that will improve access to health care for pregnant and postpartum individuals and their infants. In July 2022, DMAS implemented 12 months postpartum continuous coverage under its approved Section 1115 demonstration amendment. Another coverage expansion broadening health care access for pregnant individuals was the July 2021 launch of the new FAMIS Prenatal Coverage option for women previously ineligible due to immigration status. DMAS is working to implement policy and program improvements to

[22] ★ Governor Glenn Youngkin's identified priority for the Medicaid program that focuses on and access to high quality healthcare services. Objective 4.2: Improve Outcomes for Maternal and Infant Members.

streamline enrollment of pregnant women, increase access to treatment for expecting mothers with SUD, and strengthen accountability for prenatal and postpartum managed care services.

Increasing Access, Quality, and Equity in Postpartum Care in Medicaid and CHIP

In August 2023, CMS released the Increasing Access, Quality, and Equity in Postpartum Care in Medicaid and CHIP toolkit. In alignment with the toolkit strategies, as allowed by the American Rescue Plan and in the Consolidated Appropriations Act of 2023, DMAS expanded postpartum coverage from 60 days to 12 months. DMAS extended postpartum coverage to ensure continuity of coverage. During the prenatal period, the MCOs work with individuals to increase awareness of the postpartum visit's importance and facilitate access to postpartum appointments. MCOs also facilitate transportation to and from scheduled postpartum visits.

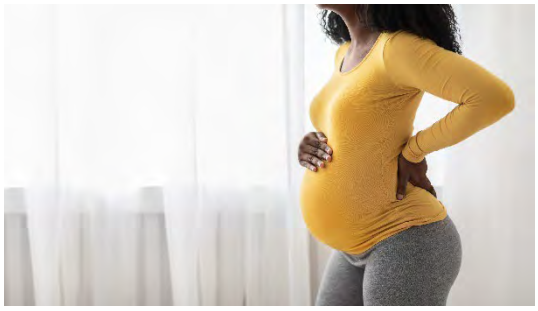
12 Months Postpartum Coverage

Medicaid expansion enabled more women to benefit from continuous Medicaid coverage before and after pregnancy; however, a coverage gap continued to exist for women who were not eligible to transition into the new adult coverage at the end of their 60 days postpartum, including FAMIS MOMS and women above income for Medicaid expansion. In 2020, Virginia policymakers took action to address this coverage gap with a provision in the State budget directing DMAS to seek federal authority to extend postpartum coverage from 60 days to 12 months for Medicaid and FAMIS MOMS members. DMAS' 1115 waiver amendment to extend 12 months postpartum coverage was approved by the federal government in November 2021, making Virginia one of the first states to provide guaranteed continuous full-benefit coverage across eligibility categories for a full 12 months postpartum. The expanded coverage enables Medicaid and FAMIS MOMS members to receive critical postpartum care for a full year postpartum, an important step in improving health outcomes for both women and their newborns.

Improving Birth Outcomes

Virginia, on its 50th anniversary of the Medicaid program, outlined plans for improving maternal and infant health and eliminating racial disparities in maternal mortality. While women of color are at increased risk for poor outcomes, particularly in Native American and some Latina communities, the racial disparities for Black women are the most significant. The maternal mortality rate of Black women (36.0) is over two times higher than that for White women (11.0). DMAS listens to the voice of the member and talks with community-based organizations, advocates, and stakeholders to learn more about what is impacting birth outcomes and what can be done, by working together, to solve the problems.

Perinatal Quality Collaborative



Funding for the Perinatal Quality Collaborative was provided for the Virginia Department of Health (VDH) to establish and administer a learning collaborative to improve pregnancy outcomes for women and newborns by advancing evidence-based clinical practices and processes through CQI, with an initial focus on pregnant women with a SUD and infants impacted by neonatal abstinence syndrome (NAS). DMAS' participation is vital, both because of the ability to provide data to inform improvement efforts, and because of its ability to draw down matching federal Medicaid administrative funds to support the work.

The funding includes support for several administrative positions to run operations, and also memberships/connections for a limited number of pilot sites to the Vermont Oxford Network. Vermont Oxford Network data are collected from neonatal intensive care units (NICUs) across the country and are reported in accordance with national standards. The network provides resources for states and members on many topics relevant to perinatal care, including NAS.

FAMIS Prenatal Coverage

Effective July 1, 2021, uninsured pregnant individuals with income below 200 percent of the FPL now qualify for prenatal coverage regardless of immigration status. FAMIS Prenatal Coverage participants are enrolled in the managed care program and receive the same benefits as other pregnant individuals; comprehensive coverage, including doctor visits, prescription medication, prenatal screening and testing, dental care, behavioral health services, and more. Coverage spans prenatal, labor and delivery, and postpartum services, and is effective through the end of the month in which the 60th postpartum day occurs. FAMIS Prenatal Coverage members are not eligible for extended postpartum coverage under the 12 months postpartum demonstration.

12 Months Contraceptive Coverage

In 2021, DMAS began covering a 12-month supply of contraception for Medicaid and FAMIS members. Medicaid members may pick up a full year's supply of contraception at a single visit to their pharmacy. Contraception is most effective when used consistently and correctly. For patients using contraceptive pills, patches, rings, and self-administered injections, delays in prescription refills may result in missing doses, thus increasing the chance of pregnancy. A variety of barriers can prevent patients from routinely visiting their pharmacy, including having limited access to transportation, inflexible work schedules, and disruptions in childcare. When Medicaid members have the option to receive a 12-month supply of contraception, they are more likely to have access to the supplies they need to carry out their reproductive life plans.

Doula Project

At 17.4 deaths per 100,000 live births, the nation suffers from a higher rate of maternal mortality than any other developed country. Regardless of their income or education levels, America's maternal mortality rates are among the highest among Black women and Native American women. According to the Centers for Disease Control and Prevention (CDC), approximately 60 percent of these deaths are preventable. To combat maternal morbidity and unintended

consequences of pregnancy that result in life-altering health challenges, DMAS placed emphasis on the need for community doula care for women during the perinatal period, at labor and delivery, and during the postpartum period. According to the American Pregnancy Foundation, doulas serve to reduce the number of Cesarean sections, which increase the risk of maternal death by infection and hemorrhage and reduce the duration of labor by a quarter. Virginia Medicaid introduced a model of care to include doula services as a cost-saving measure and an effective way to improve health outcomes. With the approval of its State Plan Amendment in October 2021, Virginia became the fourth state in the country to implement a doula Medicaid benefit.

Virginia is the fourth state in the nation to offer community doula services as a benefit for Medicaid members. Doulas in Virginia are State-certified and register with the Virginia Medicaid program. Doulas are trained, community-based, non-medical professionals who offer a broad set of nonclinical, continuous support services to pregnant individuals throughout pregnancy, at labor and delivery, and during the postpartum period. Community doulas provide support to pregnant and postpartum women through their grounding within the community, languages spoken, and shared value systems of the populations they serve. The emotional, physical, and informational support provided by doulas include childbirth education, lactation support, and referrals for health or social services. A State-certified community doula is certified by the Virginia Certification Board.[23]

VDH, through collaboration with DMAS and the Virginia Doula Task Force, established the minimum requirements to be a State-certified community doula in Virginia based on the core competencies for doula certification used by national organizations and community-based organizations in Virginia. These regulations were effective as of January 6, 2022. As defined by VDH, a “community-based doula" means a doula who often has shared lived experiences and is trained to provide extended, culturally congruent support to families throughout pregnancy to include antepartum, intrapartum, during labor and birth, and up to one year postpartum.

A State-certified community doula is a trained, community-based nonmedical professional who provides continuous physical, emotional, and informational support to a pregnant person during the antepartum or intrapartum period or during the period up to one year postpartum who has been certified by an approved entity recognized by the Board of Health and Virginia Certification Board. Community doulas provide the member with continuous physical, emotional, and support services. These support services are nonclinical, peer-to-peer activities that engage, educate, and support an individual's prenatal, antenatal, and postpartum self-care to improve the individual’s health and wellness.

Additional strategies adopted by DMAS to improve maternal and infant health outcomes include education and outreach, focus on special populations, increasing accountability and transparency, while strengthening partnerships with other stakeholders. DMAS’ strategy also strengthens early childhood interventions and curbs tobacco use among pregnant women. DMAS partners with VDH and DBHDS on initiatives to improve birth outcomes.

CMS Affinity Groups: State and Federal Partnership

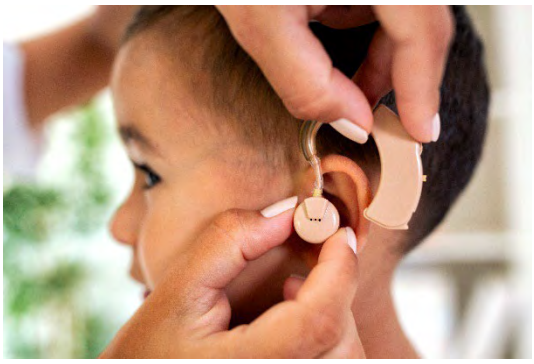
DMAS is currently participating in several affinity groups led by CMS and its vendor, Mathematica, to create state and federal workgroups designed to target specific issues of

[23] Virginia Department of Medical Assistance Services. Community Doula Program. Available at: https://www.dmas.virginia.gov/for-providers/maternal-and-child-health/community-doula-program/. Accessed on: July 20, 2022.

interest for Medicaid agencies. In Virginia, DMAS leads these efforts in collaboration with other state agencies, such as VDH, as well as MCOs and other stakeholders across the state. Each group works together to design a quality improvement project to address the topic.

- *Low Risk Cesarean Delivery*: A workgroup designed to look into reducing rates of cesarean deliveries that would be low risk if delivered vaginally. Cesarean deliveries that are not medically necessary can cause adverse outcomes in mothers and infants. This DMAS team is led by the Maternal and Child Health unit, and includes VDH, MCOs, as well as state partners, such as the Virginia Neonatal and Perinatal Collaborative.
- *Infant Well Child Visits:* A workgroup designed to look into increasing the rate of infant well-child visits to improve overall child health, as they are more likely to receive appropriate screenings, vaccinations, and other needed services. This DMAS team is led by the Maternal and Child Health Unit, and includes MCOs and state provider partners.

EPSDT and Utilization



EPSDT services, Medicaid's comprehensive and preventive child health program for individuals under the age of 21, includes periodic screening, pediatric and adolescent preventive care and screenings, vision, dental and hearing services. The EPSDT benefit is geared to the early assessment of children's healthcare needs through periodic screenings. The goal of EPSDT is to ensure that health problems are diagnosed and treated as early as possible. In addition, Medicaid is required to provide any medically necessary healthcare to correct and ameliorate physical and mental conditions.

EPSDT Specialized Services are medically necessary treatment services for children that are not routinely covered through Virginia Medicaid. The six most commonly requested EPSDT Specialized Services are listed below. Determination of whether a service is medically necessary is made on a case-by-case basis, taking into account a particular child's needs.

- Assistive technology
- Hearing aids
- Private duty nursing
- Behavioral therapy
- Personal care
- Medical formula and nutritional supplements

DMAS is committed to monitoring the utilization of EPSDT services for Virginia Medicaid members, with a goal of increasing utilization of these services to ensure health and developmental concerns are diagnosed as early as possible, that the treatment is provided before problems become complex, and that medically justified services are provided to treat or correct identified problems.

Additional Core Quality Improvement Activities

Population Health

Population health is defined as the health of a population as measured by health status indicators and as influenced by social, economic, and physical environments; personal health practices; individual capacity and coping skills; human biology; early childhood development; and health services, as well as the distribution of such outcomes within the population.[24]

At DMAS, within the Office of Quality and Population Health, the Population Health (PH) Unit is responsible for identifying, collecting, analyzing, and maintaining quality and population health data from the MCOs to evaluate issues that support prospective business decisions. The PH Unit assists with coordinating projects for the agency focusing on population disparities, including maternal health, behavioral health, foster care, health disparities, and social determinants of health. DMAS collaborates with the MCOs to improve the health and well-being of Virginians through access to high-quality healthcare coverage while providing members with the correct services at the appropriate time. This is achieved by improving population health, enhancing member care experience, providing effective patient care, and reducing the cost of healthcare by spending smarter.

The MCOs also review population health management (PHM) for their members and monitor and share the outcomes with DMAS. PHM is the process of improving clinical health outcomes of a defined population that is a representation of the entire population by providing improved care coordination and member engagement by utilizing effective care and financial models.[25] According to NCQA, at a minimum, PHM addresses the needs of the member by focusing on the following key areas:[26]

- Keeping members safe
- Managing members with emerging high risk
- Patient safety or outcomes across settings
- Managing multiple chronic illnesses

Overall, the PH Unit, using this data-driven approach to population health, works to advance DMAS' mission to continue to improve the health of Virginians and ensure members receive access to high quality care.

Preventative Services for Adults

Starting in September 2022, all adult Medicaid members will have access to preventive services, including screenings, check-ups, and counseling to support positive health outcomes. Under a policy, similar to commercial insurance policies, preventive services are available to Medicaid members at no cost and without a prior authorization from their doctor. DMAS

[24] Center for Urban Population Health. Population Health Framework. Available at: https://www.cuph.org/population-health-framework.html. Accessed on: July 14, 2022.
[25] The American Hospital Association Center for Health Innovation. Population Health Management. Available at: https://www.aha.org/center/population-health-management. Accessed on: July 14, 2022.
[26] The National Committee for Quality Assurance. Population Health Management Resource Guide.

designed the preventive services benefits package to align with recommendations from the U.S. Preventive Services Task Force, an independent, volunteer panel of experts in primary care and prevention who evaluate the effectiveness of services and advise on evidence-based practices for disease prevention. Preventive services covered by Medicaid without a prior authorization include the following:

- Adult wellness exams
- Individual and group smoking cessation and alcohol counseling
- Vaccines, including tetanus and diphtheria, shingles, hepatitis A and B, influenza, COVID-19, and human papillomavirus
- Mammography, prostate, and other cancer screenings
- Sexually transmitted disease screenings
- Depression screenings
- Type 2 diabetes screenings
- Blood pressure and cholesterol screenings

The state budget that took effect July 1, 2022, establishes preventive services as a standard Medicaid benefit, ensuring that all adult Medicaid members have access to the same services. Preventive services are already available to all children receiving Medicaid coverage. DMAS Director Cheryl Roberts stated that "Virginia Medicaid supports a whole-health approach to coverage that includes preventive care, dental benefits, and a full array of behavioral health services. DMAS has made great strides to provide a comprehensive set of services that will generate meaningful improvements in health outcomes for Virginia."

Federal law established the benefit package that includes preventive services, available to newly eligible adults receiving Medicaid coverage starting in 2019. The traditional Medicaid benefits package for adults in other eligibility categories previously did not include all of these preventive services. However, managed care health plans offered additional preventive services to adults in all eligibility categories as an enhanced benefit to ensure consistency and to support overall wellness goals.

Emergency Department Care Coordination

The 2017 General Assembly established the Emergency Department Care Coordination (EDCC) program in the Department of Health to provide a single, statewide technology solution that connects all hospital EDs in the Commonwealth to facilitate real-time communication and collaboration between physicians, other healthcare providers, and other clinical and care management personnel for patients receiving services in hospital EDs, for the purpose of improving the quality of patient care services (Code of Virginia §32.1-372). Real-time patient visit information from electronic health records is integrated with the Prescription Monitoring Program and the Advanced Health Directory. This sharing of information allows facilities, providers, and MCOs to identify patient-specific risks, create and share care coordination plans and other care recommendations, and access other clinically beneficial information related to patients receiving services in hospital EDs in the Commonwealth.

The EDCC program aims to improve individuals' health by providing information, which assists providers in proactively redirecting their care and connecting them to more appropriate primary care settings. According to the National Library of Medicine, 7.9 percent of patients using the

ED accounted for 31.3 percent of ED visit utilization.[27] These high utilizers of ED services typically do not receive the right care, with the right provider, at the right time—or at the right price. High utilizers often present to the ED with low-acuity, chronic health concerns that are less appropriately addressed in the ED, which is designed to care for acute, episodic, and emergent health conditions.

Establishing comprehensive primary care relationships with these individuals may reduce ED visits and decrease hospital charges, while providing the right care in the best setting for the patient. Ultimately, a patient's relationship with his or her community-based, primary care provider (PCP) is supported and strengthened, leading to improved adherence to treatment recommendations and continuity of care. Reinforcement of the proper use of the healthcare delivery system teaches and enables participants to have their needs met by making informed decisions and directly accessing appropriate care.

★ *Families First Coronavirus Relief Act (FFCRA)* ★ [28]

To support states and promote stability of coverage during the COVID-19 pandemic, the Families First Coronavirus Relief Act (FFCRA) provided DMAS access to enhanced funding to support Medicaid members during the PHE. As one of several conditions of receiving the temporary Federal Medical Assistance Percentage (FMAP) increase under FFCRA, states are required to maintain enrollment of individuals in Medicaid until the end of the month in which the PHE ends (the continuous coverage requirement). The continuous coverage requirement applies to individuals enrolled in Medicaid as of March 18, 2020, or who were determined eligible on or after that date, and has allowed people to retain Medicaid coverage and get needed care during the pandemic. Since that time, the Medicaid population has grown from 1.5 million members to approximately 2.1 million members. When the federally declared PHE ends, DMAS and VDSS will be charged with evaluating the entire population for continued eligibility in the Medicaid program.

While most people will continue to be eligible for Medicaid or Marketplace coverage when the Commonwealth begins to redetermine eligibility again, the potential for loss of coverage for thousands of residents due to administrative reasons (e.g., failure to return the renewal form) is significant. Black, Latino(a), and other people of color will be most at risk, since they are significantly overrepresented in state Medicaid/ CHIP programs.

DMAS has begun work to transition Medicaid members back to normal operations once the continuous coverage requirements have ended. DMAS is collaborating with stakeholders across the Commonwealth to include sister agencies, health plans, advocates, application assisters, and providers to ensure a smooth transition for members and partners. Virginians who are no longer eligible for Medicaid will receive information they need to choose other health insurance options, and DMAS will provide these individuals with referrals to Virginia's Insurance Marketplace. This includes collaboration with the health plans to reach out to members who do not complete the redetermination process to assist with enrollment in other health coverage. DMAS has developed toolkits for advocates, providers, legislators, health plans, and other key

[27] Matsumoto CL, O'Driscoll T, Madden S, Blakelock B, Lawrance J, Kelly L. Defining "high-frequency" emergency department use: Does one size fit all for urban and rural areas? Can Fam Physician. 2017;63(9):e395-e399. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5597030/. Accessed on: Aug 4, 2022.

[28] ★ Governor Glenn Youngkin's identified priority for the Medicaid program that focuses on behavioral health enhancement. Goal 2: Promote Access to Safe, Gold-Standard Patient Care.

stakeholder partners to ensure a coordinated effort to educate Medicaid members about the upcoming redetermination process.

DMAS Language and Disability Access Plan

DMAS is committed to providing language access services and reasonable accommodations to Medicaid applicants and members with disabilities and those with LEP. This includes the availability of language assistance services and auxiliary aids throughout the entire Medicaid process, including accessing information about the Medicaid program, completion of an application, obtaining medical services, and the appeals process. The DMAS Language and Disability Access Plan reflects DMAS' commitment to communicating effectively and meaningfully with the Virginia Medicaid population. The Language and Disability Access Plan is a roadmap that ensures compliance with Federal and State laws. It guarantees that people with LEP and individuals with disabilities can fully access and benefit from DMAS services. The plan is an essential guide for DMAS staff and stakeholders that outlines the steps required to deliver language services, collect relevant data, and provide services while ensuring cultural sensitivity. DMAS will make every effort to ensure individuals who need services will receive them from qualified interpreters, translators, and auxiliary aids suppliers in order to access in a meaningful way programs and services that they qualify for, in accordance with federal and State laws, as well as Executive Order 13166, Improving Access to Services for Persons with LEP, issued August 11, 2000.

The plan includes the following DMAS-guaranteed language and disability access services:

- An agency-wide written language and disability access plan with written standard policies and procedures.
- Timely and qualified language access services for LEP individuals and auxiliary aids for individuals with disabilities, all provided at no cost.
- An in-house coordinator to manage language services.
- A record of the LEP member's preferred written and spoken language during Medicaid enrollment and ongoing case management captured in the Virginia Case Management System (VaCMS).
- Brochures, flyers, and vital documents available for translation upon request
- LEP individuals are informed about their right to free language services at any point of contact with DMAS:
  - Language taglines included with vital member communications, web pages, and the DMAS reception area.
  - Language Access Posters and "Point to Your Language" cards available at the DMAS reception area.
- DMAS and DMAS subcontractors' websites and digital applications largely available in Spanish and in other languages.
- DMAS and DMAS subcontractor's call centers equipped to:
  - Assist callers who are deaf or hard of hearing.
  - Assist LEP individuals with language access services.
- Verbal interpreting services available to members and providers through all six MCOs.

Plan to Address Health Disparities

DMAS defines health disparities and social determinants of health (SDOH) as:

- Health disparity is defined as a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.[29]
- SDOH are defined as conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life risks and outcomes.

DMAS is committed to improving the health and well-being of all Virginians through access to high-quality healthcare coverage and services. In order to address health disparities, DMAS established an internal workgroup focused on diversity, opportunity, and inclusion. The workgroup's purpose is to develop an agency-wide strategy to ensure that DMAS provides access to quality services for all Medicaid members and providers.

DMAS' framework to achieve a reduction in health disparities is adapted from an Institute for Healthcare Improvement's white paper.[30]

Plan to Reduce Health Disparities

DMAS identifies member characteristics in pediatric and adult populations including age, race, ethnicity, sex, primary language, geographic location, and disability status and provides the information to the MCOs at the time of enrollment and in enrollment change files. DMAS applies QI principles in designing initiatives to reduce health disparities. DMAS updates initiatives and

[29] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Health Equity in Healthy People 2030. Available at: https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030. Accessed on: Mar 5, 2024.

[30] Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. *Achieving Health Equity: A Guide for Health Care Organizations*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org). Accessed on: July 14, 2022.

measures in consideration of best or evidence-based practices, as needed, to reduce health disparities.

Virginia Medicaid offers two types of waivers for individuals identified with disabilities, the Developmental Disability (DD) waiver and the Cardinal Care waiver. Inclusive in the waivers is DMAS's definition of disability status by which eligibility is determined. The data sources used to determine disability status may include, but are not limited to, medical and behavioral health records, interviews, screening tools, and financial information.

Developmental Disability Waiver Eligibility Requirements

- The individual must meet the definition of developmental disability diagnostic eligibility: Developmental disability means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated (Virginia Title 37.2, Chapter 1, Section 37.2-100).
- The individual must meet the functional criteria as assessed on the VIDES screening tool.

Cardinal Care Program Waiver Eligibility Requirements

- The individual must be less than 65 years of age with a disability and a medical or nursing need such as:
  - Meet the nursing facility level of care criteria (i.e., they are functionally dependent and have a medical nursing need); or
  - Individuals who are dependent upon technological support and require substantial, ongoing skilled nursing care; and
  - The health, safety, welfare of the individual must be safely maintained in the home when the nurse personal care aide is not present; and
  - Are determined to be at imminent risk of nursing facility placement; and
  - Are determined that community-based care services under the waiver are the critical services that enable the individual to remain at home rather than being place in a nursing facility.
- Complete a screening to determine eligibility for the waiver services.

Beginning in NCQA HEDIS measurement year (MY) 2022, DMAS required the MCOs to report the HEDIS Medicaid measures and the CMS Core Set of Adult Health Care Quality Measures for Medicaid and the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP to which stratification applies. DMAS will add additional stratified measures as NCQA expands the HEDIS measures that include race and ethnicity stratification over the next several years to help identify disparities in care among patient populations. During MY 2022, HEDIS measures that included race and ethnicity stratification included:

- *Colorectal Cancer Screening*

- *Controlling High Blood Pressure*
- *Hemoglobin A1c Control for Patients With Diabetes*
- *Prenatal and Postpartum Care*
- *Child and Adolescent Well-Care Visits*

During MY 2023, NCQA added eight additional measures that included race and ethnicity stratification:

- *Immunizations for Adolescents*
- *Asthma Medication Ratio*
- *Follow-Up After Emergency Department Visit for Substance Use*
- *Pharmacotherapy for Opioid Use Disorder*
- *Initiation and Engagement of Substance Use Disorder Treatment*
- *Well-Child Visits in the First 30 Months of Life*
- *Breast Cancer Screening*
- *Adult Immunization Status*

DMAS identifies, evaluates, and plans to reduce—to the extent practicable—health disparities as follows:

Age

- *Identify Disparity:* DMAS use results from disparity sensitive performance measures to identify age health disparities. DMAS stratifies data from the following performance measures to identify age health disparities:
  - NCQA HEDIS: *AAP—Adults' Access to Preventive/Ambulatory Health Services*
  - CMS Child Core Set: *Child and Adolescent Well-Care Visit*
  - CMS Adult Core Set: *HPC-AD—Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*
- *Evaluate Disparity:* DMAS completes a formative evaluation to determine the best approach and to assess progress that are inclusive and reflective of the unique aspects of age disparities.
- *Reduce Disparity:* DMAS uses an interventional approach to reducing age disparities that includes qualitative and quantitative data to understand individual experiences and health outcomes. Interventions to reduce age disparities include:
  - Strengthen safety nets and supports for caregivers to ensure long-term change.
  - Utilize existing data sources that measure health disparities to raise awareness and drive action.

Race

- *Identify Disparity:* DMAS uses results from the following disparity sensitive performance measures to identify racial health disparities:
  - CMS Child Core Set: *Child and Adolescent Well-Care Visit*
  - CMS Adult Core Set: *CBP-AD—Controlling High Blood Pressure*

  - CMS Adult Core Set: *PPC-AD—Prenatal and Postpartum Care: Postpartum Care*
- *Evaluate Disparity:* DMAS completes a formative evaluation to determine the best approach and to assess progress that are inclusive and reflective of the unique aspects of racial disparities.
- *Reduce Disparity:* DMAS uses an interventional approach to reduce race disparities that includes qualitative and quantitative data to understand individual experiences and health outcomes. Interventions to reduce racial disparities include:
  - Improve the level of member health literacy through member outreach and review and update of member communications.
  - Coordinate and engage organizations that highlight racial issues facing members.

Ethnicity

- *Identify Disparity:* DMAS uses results from the following disparity sensitive performance measure to identify ethnicity health disparities:
  - CMS Child Core Set: *Child and Adolescent Well-Care Visit*
  - CMS Adult Core Set: *CBP-AD—Controlling High Blood Pressure*
  - CMS Adult Core Set: *IET-AD—Initiation and Engagement of Substance Use Disorder Treatment*
- *Evaluate Disparity:* DMAS completes a formative evaluation to determine the best approach and to assess progress that are inclusive and reflective of the unique aspects of ethnicity disparities.
- *Reduce Disparity:* DMAS uses an interventional approach to reduce ethnicity disparities that includes qualitative and quantitative data to understand individual experiences and health outcomes. Interventions to reduce ethnicity disparities include:
  - Re-evaluate and tailor existing policies and programs according to what barriers related to an individual's ethnicity may exist for reaching members.

Sex

- *Identify Disparity:* DMAS uses results from the following disparity sensitive performance measures to identify sex health disparities:
  - CMS Child Core Set: *Child and Adolescent Well-Care Visit*
  - CMS Adult Core Set: *FUH-AD—Follow-Up After Hospitalization for Mental Illness*
  - CMS Adult Core Set: *PQ108-AD—Heart Failure Admission Rate*
- *Evaluate Disparity:* DMAS completes a formative evaluation to determine the best approach and to assess progress that are inclusive and reflective of the unique aspects of sex disparities.
- *Reduce Disparity:* DMAS uses an interventional approach to reduce sex disparities that includes qualitative and quantitative data to understand individual experiences and health outcomes. Interventions to reduce sex disparities include:
  - Coordinate and engage organizations that highlight issues facing men and women including public health, American College of Obstetricians, Title X programs, and the American Cancer Society.

Primary Language

- *Identify Disparity:* DMAS uses results from the following disparity sensitive performance measures to identify primary language disparities:
  - Quarterly and/or annual MCO reports to DMAS: Monitor language and disability access reports
- *Evaluate Disparity:* DMAS completes a formative evaluation to determine the best approach and to assess progress that are inclusive and reflective of the unique aspects of primary language disparities.
- *Reduce Disparity:* DMAS uses an interventional approach to reduce primary language disparities that includes qualitative and quantitative data to understand individual experiences and health outcomes. Interventions to reduce primary language disparities include:
  - Review and update of member communications.

Geographic Location

- *Identify Disparity:* DMAS uses results from the following disparity sensitive performance measures, stratified by geographic location, to identify geographic location disparities:
  - NCQA HEDIS: *AAP—Adults' Access to Preventive/Ambulatory Health Services*
  - CMS Child Core Set: *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
  - CMS Child Core Set: *Child and Adolescent Well-Care Visits*
- *Evaluate Disparity:* DMAS completes a formative evaluation to determine the best approach and to assess progress that is inclusive and reflective of the unique aspects of geographic location disparities.
- *Reduce Disparity:* DMAS uses an interventional approach to reduce geographic location disparities that includes qualitative and quantitative data to understand individual experiences and health outcomes. Interventions to reduce geographic disparities include:
  - Reevaluate and tailor existing policies and programs according to what barriers related to an individual's geographic location may exist for ensuring access to care.
  - Optimizing use of technology, such as telehealth, to reduce geographic location barriers to accessing care.
  - Review MCO provider networks to determine whether available region-specific providers are contracted with the MCOs.
  - Reviewing MCO policies for non-emergency transportation to ensure members can access care at closest providers whether in or outside their region of residence.

Disability Status

- *Identify Disparity:* DMAS uses results from the following disparity sensitive performance measures to identify disability status disparities:
  - CMS Child Core Set: *Child and Adolescent Well-Care Visit*
  - CMS Adult Core Set: *HPC-AD—Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*
  - CMS Adult Core Set: *CBP-AD—Controlling High Blood Pressure*

    - *Evaluate Disparity:* DMAS completes a formative evaluation to determine the best approach and to assess progress that is inclusive and reflective of the unique aspects of disability status disparities.
- *Reduce Disparity:* DMAS uses an interventional approach to reduce disability status disparities that includes qualitative and quantitative data to understand individual experiences and health outcomes. Interventions to reduce disability status disparities include:
    - Increase data collection regarding use and access to healthcare services by the disability population.

DMAS publishes an agency-wide Health Equity Report. The goal of the report is to catalog health equity initiatives underway at the agency in a centralized manner. Further, it helps to bring visibility to the various initiatives and embed the concept of health equity throughout the agency in a systemic fashion. In the creation of the report, over 50 initiatives were documented across seven functional areas.

In addition to publishing the annual Health Equity Report, the Member Efficiencies and Innovation (MEI) Team hosts the monthly Health Equity Roundtable. The Roundtable serves as a forum for representatives of the agency's various divisions to share and learn about health equity projects underway at the agency. As an example, the forum allowed for respective subject matter experts and project owners to discuss efforts such as a Diabetes Prevention Program pilot (by OCMO) and the doula benefit (by the Maternal Health Unit) providing real-time insight and collaboration.

Partnerships Focused on Health Disparities

DMAS aspires to increase synergy between DMAS and local, state, and national healthcare QI stakeholders by aligning initiatives and leveraging their work. One approach to increase synergy involves convening collaboratives amongst health plans and the Commonwealth. Collaborative topics include discussions of best practices, review of results of performance measures, and training for PIPs.

DMAS works closely with the VDH Office of Health Equity (OHE). OHE's mission is to identify health disparities and their root causes and promote opportunities to be healthy. The office develops programs and partnerships to empower racial and ethnic minority communities to promote awareness of health disparities. The goal of OHE is to permanently change the conditions that produce differential health outcomes that will, over time, have a greater effect than traditional interventions.

Within OHE, the Division of Multicultural Health and Community Engagement works with stakeholders to identify approaches to eliminate health disparities through a focus on SDOH as a key strategy to eliminate health disparities that exist by socioeconomic status, race/ethnicity, geography, gender, immigrant status, and other social classifications. There are five U.S. Census-recognized racial and ethnic minority populations in Virginia:

1. African American/Black
2. Hispanic/Latino
3. Asian American

4. Native Hawaiian or Other Pacific Islander
5. American Indian and Alaskan Native

Identifying, Evaluating, and Reducing Health Disparities

Virginia has implemented strategies aimed at eliminating racial disparities in maternal mortality by 2025. African-American mothers in Virginia have consistently died at more than twice the rate of White mothers during and after pregnancy. Virginia uses technology to ensure qualifying low-income women do not experience a gap in healthcare coverage, experience streamlined enrollment processes, and pregnant women are connected with SUD treatment. DMAS' strategy also strengthens early childhood interventions, and curbs tobacco use among pregnant women. DMAS listens to the voice of the member and talks with community-based organizations, advocates, and stakeholders to learn more about what is impacting birth outcomes and what can be done, by working together, to solve the problems.

Virginia's infant mortality rate improved from 5.9 in 2017 to a rate of 5.6 deaths in 2020 per 1,000 live births, according to the CDC's NCHS, 2020.[31] DMAS delivers one-third of all babies born in the Commonwealth or approximately 33,000 deliveries per year. DMAS covers a full spectrum of services for pregnant women from prenatal care to opioid treatment. DMAS partners with the VDH and DBHDS on initiatives to improve birth outcomes. However, Virginia still has racial and health disparities.

To identify, evaluate, and reduce—to the extent practicable—health disparities based on age, race, ethnicity, sex, primary language, geographic location, and disability status in birth outcomes, 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 2,500 grams (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 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-NICU singleton births with two or more office visits with a PCP in the 30 days following birth. Demographic categories included the following:

Table 4—Demographic Categories

Demographic Category	Category Values
Medicaid Program	FAMIS MOMS (Eligibility category 005) Medicaid for Pregnant Women (Eligibility categories 091, 097)

[31] Centers for Disease Control and Prevention. Infant Mortality Rates by State, reviewed March 3, 2022. Available at: https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm. Accessed on: Aug 4, 2022.

Demographic Category	Category Values
	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	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 codes defined in Appendix A of the EQRO Request for Proposal.	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	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”)
Maternal Emergency Only Coverage	Emergency Only Benefits Not Emergency Only Benefits

Social Determinants of Health

Central to the State’s effort to improve access, quality, and timeliness of care is a commitment to address the social and environmental factors that directly impact health outcomes and cost,

or, the SDOH. Social determinants disproportionately impact Medicaid members, increase the risk of developing chronic conditions, drive healthcare costs, and are closely tied to health outcomes.

SDOH include the environment and conditions in which people are born, grow, live, work, and age. Food insecurity, housing instability, safety, violence, trauma, and transportation challenges are considered critical barriers to an individual's health status.

DMAS, working with the MCOs, is addressing the SDOH that are impacting members in several ways, including but not limited to:

- Screening members for food insecurity, housing instability, transportation needs, and interpersonal violence.
- Providing resources and assistance in securing health-related services and resource navigation to members identified with unmet health-related needs.
- Supporting public-private evidence-based interventions designed to reduce costs and improve health by addressing eligible Medicaid beneficiaries' housing instability, transportation insecurity, food insecurity, and interpersonal violence.
- Identifying areas of high disparity to guide resources and to work with communities to address SDOH.
- Maintaining a resource platform accessible to members both online and through the MCO's call center.

Progress in Reducing Disparities

Performance Measurement Disparity Stratifications

An example of how DMAS stratifies performance measure data to identify, evaluate, and reduce—to the extent practicable—health disparities based on age, race, ethnicity, sex, primary language, and disability status is the *Medicaid Managed Long-Term Services and Supports (MLTSS) Successful Transition after Long-Term Facility Stay (MLTSS-8)* performance measure. The *MLTSS-8* performance measure, measures the proportion of long-term facility stays (i.e., stays at least 101 days long) among members 18 years of age and older that resulted in a successful transition to the community (i.e., the member was in the community for 60 or more days). Table 5–Table 7 display the CY 2022 *MLTSS-8* performance measure results stratified by Medicaid delivery system, MCO, geographic region, age, gender and race.

Table 5—*Medicaid Managed Long-Term Services and Supports (MLTSS) Successful Transition after Long-Term Facility Stay (MLTSS-8)* Performance Measure
Calendar Year 2022 (January 1, 2022–December 31, 2022

Stratification	Facility Admissions	Observed Numerator	Observed Rate	Expected Numerator	Expected Rate	O/E Ratio*
Medicaid Program						
CCC Plus (MLTSS)	3,742	1,164	31.11%	2,540.9823	67.90%	0.46

Stratification	Facility Admissions	Observed Numerator	Observed Rate	Expected Numerator	Expected Rate	O/E Ratio*
Medallion 4.0 (Acute)	86	68	79.07%	49.8154	59.92%	1.37
More than one Medicaid Program	147	95	64.63%	78.9910	53.74%	1.20
Virginia Total[1]	4,578	1,543	33.70%	3,095.1150	67.61%	0.50
Medicaid Delivery System						
Fee-For-Service	166	30	18.07%	124.3873	74.93%	0.24
Managed Care	3,975	1,327	33.38%	2,669.7887	67.16%	0.50
More than one Delivery System	437	186	42.56%	300.9390	68.86	0.62
Virginia Total	4,578	1,543	33.70%	3,095.1150	67.61%	0.50
MCO						
Aetna	779	298	38.25%	515.2395	66.14%	0.58
HealthKeepers	1,013	433	42.74%	658.6862	65.02%	0.66
Molina	532	152	28.57%	364.6979	68.55%	0.42
Optima	572	118	20.63%	399.5988	169.86%	0.30
United	431	114	26.45%	295.2245	68.50%	0.39
VA Premier	568	171	30.11%	388.5100	68.40%	0.44
More than One MCO	80	41	51.25%	47.8318	59.79%	0.86
Virginia Total[1]	4.578	1,543	33.70%	3,095.1150	67.61%	0.50
Geographic Region						
Central	1,193	427	35.82%	792.8184	66.51%	0.54
Charlottesville/ Western	663	197	29.71%	458.6504	69.18%	0.43
Northern & Winchester	727	267	36.73%	496.4302	68.28%	0.54
Roanoke/ Alleghany	566	179	31.63%	3897.6750	68.49%	0.46
Southwest	462	146	31.60%	313.9027	67.94%	0.47
Tidewater	966	326	33.75%	644.3805	66.71%	0.51
Unknown	2	1	50.00%	1.2578	62.89%	0.80
Virginia Total[1]	4,578	1,543	33.70%	3,095.1150	67.61%	0.50
Age						
18–44 Years	331	183	55.29%	176.2221	53.24%	1.04

Stratification	Facility Admissions	Observed Numerator	Observed Rate	Expected Numerator	Expected Rate	O/E Ratio*
45–64 Years	1,674	728	43.49%	1,015.5869	60.67%	0.72
65–74 Years	1,180	315	26.69%	880.1377	74.59%	0.36
75–84 Years	878	189	21.53%	654.6743	74.56%	0.29
85+ Years	515	128	24.85%	368.4940	71.55%	0.35
Virginia Total[1]	4,578	1,543	33.70%	3,036.1150	67.61%	0.50
Gender						
Male	2,000	702	35.10%	1,336.4265	66.82%	0.53
Female	2,578	841	32.62%	1,758.6886	68.22%	0.48
Virginia Total	4,578	1,543	33.70%	3,095.1150	67.61%	0.50
Race						
White	2,828	911	32.21%	1,941.1562	68.64%	0.47
Black/ African American	1,572	545	34.67%	1,038.8659	66.095	0.52
Asian	90	47	152.22%	59.7583	66.40%	0.79
Southeast Asian/ Pacific Islander	4	3	75.00%	2.8331	70.83%	1.06
Hispanic	30	9	30.00%	20.1648	67.22%	0.45
More than One Race/Other/ Unknown	54	28	51.85%	32.3368	59.88%	0.87
Virginia Total	4,578	1,543	33.70%	3,095.1150	67.61%	0.50

** Please note that for the O/E Ratio, a higher rate indicates more favorable performance; therefore, an O/E Ratio greater than 1 indicates that more residents were successfully transitioned to the community from their facility than were expected based on the resident case mix (i.e., the residents' age, gender, chronic conditions, and Medicaid status).*

[1] *Please note that the Virginia Total includes Fee-for-Service members and members with more than one Medicaid delivery system; therefore, the sum of the MCO numerators and denominators do not equal the Virginia Total numerator or denominator.*

Another example of how DMAS stratifies performance measure data to identify, evaluate, and reduce—to the extent practicable—health disparities based on age, race, ethnicity, sex, primary language, and disability status is the *Prediabetes* performance measure. DMAS contracted with HSAG in 2021 to develop a custom PM related to identifying members with prediabetes who were prescribed metformin and adhered to metformin during the measurement year. Table 6 displays the CY 2019 and CY 2020 prediabetes PM results stratified by Medicaid program, MCO, geographic region, and select demographics (i.e., age, gender, and race).

Table 6—Prediabetes PM Results

Rate Stratification	CY 2019 Results	CY 2020 Results
Rate 1—Prevalence of Prediabetes		
Virginia Total	4.68%	4.04%

Rate Stratification	CY 2019 Results	CY 2020 Results
Medicaid Program		
CCC Plus (MLTSS)	6.66%	6.11%
Medallion 4.0 (Acute)	3.58%	3.35%
More Than One Medicaid Program	6.98%	6.52%
MCO		
Aetna	4.88%	4.06%
HealthKeepers	4.89%	4.29%
Molina	4.51%	3.52%
Optima	4.50%	4.18%
United	4.58%	3.88%
VA Premier	4.30%	3.78%
More Than One MCO	6.37%	5.25%
Geographic Region		
Central	4.73%	4.03%
Charlottesville/Western	3.92%	3.67%
Northern & Winchester	4.88%	3.93%
Roanoke/Alleghany	4.24%	3.70%
Southwest	4.84%	4.20%
Tidewater	5.02%	4.43%
Age		
18–44 Years	3.01%	2.48%
45–60 Years	8.32%	7.63%
Gender		
Male	4.39%	3.56%
Female	4.83%	4.35%
Race		
White	4.46%	3.81%
Black/African American	4.97%	4.47%
Asian	5.82%	4.75%
Southeast Asian/Pacific Islander	4.02%	3.69%
Hispanic	2.74%	2.54%
More Than One Race/Other/Unknown	4.15%	3.19%
Rate 2—Metformin Use for Prediabetics		
Virginia Total	6.97%	7.37%
Medicaid Program		
CCC Plus (MLTSS)	4.58%	4.53%
Medallion 4.0 (Acute)	8.77%	8.80%
More Than One Medicaid Program	8.89%	7.93%
MCO		
Aetna	7.61%	7.86%
HealthKeepers	6.80%	7.55%
Molina	6.70%	6.80%
Optima	6.09%	6.52%

Rate Stratification	CY 2019 Results	CY 2020 Results
United	6.13%	5.88%
VA Premier	8.05%	8.40%
More Than One MCO	7.48%	8.90%
Geographic Region		
Central	6.93%	7.44%
Charlottesville/Western	9.04%	8.60%
Northern & Winchester	6.66%	6.78%
Roanoke/Alleghany	8.18%	9.08%
Southwest	8.48%	9.85%
Tidewater	5.34%	5.75%
Age		
18–44 Years	10.02%	10.86%
45–60 Years	4.40%	4.65%
Gender		
Male	4.77%	4.51%
Female	8.00%	8.76%
Race		
White	7.20%	8.18%
Black/African American	6.55%	6.43%
Asian	5.00%	6.86%
Southeast Asian/Pacific Islander	*	*
Hispanic	*	*
More Than One Race/Other/Unknown	10.55%	7.39%
Rate 3—Adherence to Metformin		
Virginia Total	42.17%	45.22%
Medicaid Program		
CCC Plus (MLTSS)	55.32%	49.66%
Medallion 4.0 (Acute)	35.23%	44.03%
More Than One Medicaid Program	54.69%	45.83%
MCO		
Aetna	46.90%	50.40%
HealthKeepers	40.86%	42.49%
Molina	35.29%	39.36%
Optima	39.16%	46.85%
United	38.96%	46.23%
VA Premier	45.45%	43.51%
More Than One MCO	46.34%	60.00%
Geographic Region		
Central	39.23%	44.44%
Charlottesville/Western	42.86%	42.86%
Northern & Winchester	41.51%	46.69%
Roanoke/Alleghany	48.31%	42.94%
Southwest	52.54%	47.34%

Rate Stratification	CY 2019 Results	CY 2020 Results
Tidewater	36.32%	46.71%
Age		
18–44 Years	38.02%	41.07%
45–60 Years	50.15%	52.77%
Gender		
Male	50.23%	50.34%
Female	39.92%	43.95%
Race		
White	47.21%	48.88%
Black/African American	35.14%	39.73%
Asian	46.15%	44.64%
Southeast Asian/Pacific Islander	*	*
Hispanic	*	*
More Than One Race/Other/Unknown	43.10%	48.68%

** Indicates that the data were suppressed due to a small numerator or denominator (i.e., fewer than 11). In instances where only one stratification was suppressed, the value for the second smallest population was also suppressed, even if the value was 11 or more.*

The Virginia total Prevalence of Prediabetes rates for CY 2019 and CY 2020 remained stable, with a rate ranging between 4 and 5 percent. According to a 2016 CDC estimate, 9 percent of adults in Virginia (among all payers) have been diagnosed with prediabetes, indicating that the prevalence of prediabetes may be underrepresented in the data used for measure calculation, as the CY 2020 rate was nearly half that of the CDC estimates.[32]

The Virginia total rate of Metformin Use for Prediabetics was stable between CY 2019 and CY 2020, with rates higher among those 18–44 years of age, females, and the White race. The lowest rates of Metformin Use for Prediabetics were for members 45–60 years of age, males, and the Black/African American population. According to research, approximately 14 individuals would need to receive metformin over a three-year period to prevent one individual from being diagnosed with diabetes.[33] Thus, if the Black/African American population in Virginia were to receive metformin at the same rate as the statewide average, given their current adherence rate of 39.73 percent, then approximately 17 cases of diabetes could potentially be prevented for the Black/African American population.

The Virginia total Adherence to Metformin rate increased between CY 2019 and CY 2020 to 45.22 percent. Similar to the rate of metformin use for prediabetes, adherence rates for the Black/African American population were between 5 and 9 percentage points below the other race categories.

Another example of how DMAS stratifies performance measure data to identify, evaluate, and reduce—to the extent practicable—health disparities based on age, race, ethnicity, sex, primary language, and disability status is the *Colorectal Cancer Screening (COL)* performance measure. DMAS contracted with HSAG in 2022 to calculate the CMS Core Set of Adult Care Quality Measures for Medicaid colorectal cancer screening performance measure, which measures the percentage of members 51 to 75 years of age who had appropriate screening for colorectal cancer during the measurement year. Table 7 displays the CY 2021 colorectal cancer screening

[32] Ibid.
[33] Ibid.

performance measure results stratified by Medicaid program, MCO, geographic region, and select demographics (i.e., age, gender, and race).

Table 7—Colorectal Cancer Screening PM Results

Rate Stratification	CY 2021 Results
Virginia Total	32.73%
Medicaid Managed Care Program	
CCC Plus (MLTSS)	40.35%
Medallion 4.0 (Acute)	28.24%
More Than One Medicaid Program	35.80%
Medicaid Delivery System	
Managed Care	35.08%
Fee-for-Service	4.84%
More than One Delivery System	22.72%
Virginia Total	32.73%
MCO	
Aetna	31.10%
HealthKeepers	36.54%
Molina	25.72%
Optima	40.52%
United	31.36%
VA Premier	37.96%
More Than One MCO	39.01%
Virginia Total	32.73%
Geographic Region	
Central	31.90%
Charlottesville/Western	31.07%
Northern & Winchester	32.15%
Roanoke/Alleghany	32.62%
Southwest	31.61%
Tidewater	35.67%
Virginia Total	32.73%
Age	
51–64 Years	31.89%
65–75 Years	35.73%
Virginia Total	32.73%
Gender	
Male	28.40%
Female	36.07%
Virginia Total	32.73%
Race	
White	31.40%
Black/African American	35.79%
Asian	34.32%

Rate Stratification	CY 2021 Results
Southeast Asian/Pacific Islander	31.55%
Hispanic	49.04%
More Than One Race/Other/Unknown	25.06%
Virginia Total	32.73%
Screening Type	
Fecal Occult Blood Test (FOBT)	5.49%
Flexible Sigmoidoscopy	0.91%
Colonoscopy	25.56%
Computerized Tomography (CT) Colonography	0.08%
Fecal Immunochemical Test (FIT)-Deoxyribonucleic Acid (DNA) Test	1.88%
Virginia Total	32.73%

Note: The Virginia Total includes Fee-for-Service members and members with more than one Medicaid delivery system.

Population Level

DMAS is partnering with VDH, via OHE, to identify at-risk populations. DMAS collaborates with the OHE on its many initiatives to reduce health disparities including:

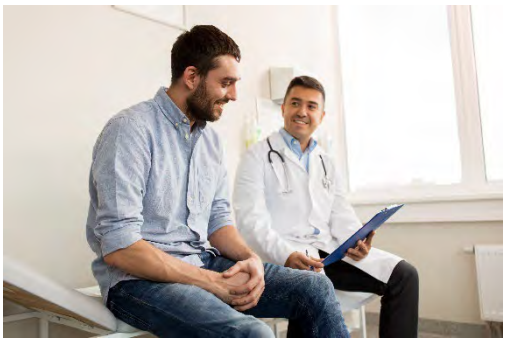
1. Analyze data to characterize inequities in health and healthcare, their geographic distribution (e.g., neighborhood, rural, inner city), and their association with SDOH; and identify high-priority target areas.
2. Promote access to quality healthcare and providers.
3. Empower communities to promote health equity.
4. Influence health, healthcare, and public policy in order to reduce health disparities.
5. Enhance the capacity of public health and its partners to reduce health disparities.

MCO Level

Each MCO participates in DMAS' efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

DMAS requires its MCOs to submit an annual report outlining their efforts to address health disparities in the managed care populations. The MCOs are encouraged to refer to the VDH's OHE for information regarding health disparities in the Commonwealth of Virginia. At the level of the individual Medicaid or CHIP member, the MCOs are developing methods to stratify the data by high-risk disparate populations to identify whether any subset of the population is negatively or positively impacted. DMAS collaborates with the MCOs and OHE using DMAS' internal analysis of performance measure data at the population level, on OHE's many initiatives to reduce health disparities.

Healthy Opportunities—Health-Related Social Needs (HRSNs)



Central to the Commonwealth's effort to improve access, quality, and timeliness of care is a commitment to address the social and environmental factors that directly impact health outcomes and cost, or, the HRSNs. HRSNs disproportionately impact Medicaid members, increase the risk of developing chronic conditions, drive healthcare costs, and are closely tied to health outcomes.

The HRSNs include the environment and conditions in which people are born, grow, live, work, and age. Food insecurity, housing instability, safety, violence, trauma, and transportation challenges are considered critical barriers to an individual's health status.

DMAS, working with the MCOs, is addressing the HRSNs that are impacting members in several ways, including:

- Screening members for food insecurity, housing instability, transportation needs, and interpersonal violence.
- Providing resources and assistance in securing health-related services and resource navigation to members identified with unmet health-related needs.
- Supporting public-private evidence-based interventions designed to reduce costs and improve health by addressing eligible Medicaid members' housing instability, transportation insecurity, food insecurity, and interpersonal violence.
- Identifying areas of high disparity to guide resources and to work with communities to address HRSNs.
- Maintaining a resource platform accessible to members both online and through the MCO's call center.

Oversight and Governance of the Quality Strategy

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 OCMO. 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 of the Commonwealth's Medicaid programs (e.g., managed care and FFS). 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.

Medicaid Managed Care Quality Collaborative

The Medicaid Managed Care Quality Collaborative has been active for more than a decade and continues to be the main platform for the MCOs, EQRO, and DMAS to share lessons learned, best practices, and potential solutions to common opportunities for improvement. The collaborative is facilitated by the DMAS Quality and Population Health staff members and meets approximately four times per year in Richmond. The Collaborative continues to be recognized as the pillar for managed care quality.

Reviewing and Evaluating the Effectiveness of the Quality Strategy

42 CFR §438.10 and 42 CFR §438.340

Data collection and analysis and other evaluation activities are used in the evaluation of the effectiveness of the interventions described in the Quality Strategy. Included within the analysis are trends and comparisons with established goals and benchmarks. Examples of these data include results of performance measures and PIPs, as well as other data from the FFS program and data reported by MCOs.

The Quality Strategy is considered a companion document to the EQR technical reports. The annual EQR technical reports encompass specific details of the assessment, results, and

recommendations related to the goals and strategies found in the Quality Strategy. This information is used to assess the ongoing effectiveness of the currently stated goals and strategies and provides a roadmap for potential changes and the development of new goals and strategies. Quality Strategy effectiveness, progress, and updates are also reported in Virginia's CMS mandatory waiver reports. Results of the review are made available on the DMAS website.

Annual EQR technical reports are required by CMS and include the EQRO's assessment of the effectiveness of the Quality Strategy. As such, the Quality Strategy is reviewed for its effectiveness annually by the EQRO. The EQRO findings on the quality, access, and timeliness of DMAS' managed care delivery system are included in the EQRO's annual technical report(s) for the Cardinal Care program. An assessment of the effectiveness of the State's Quality Strategy and DMAS' progress on its Quality Strategy goals and objectives are found in Appendix F.

Community Involvement for Quality Development

Ensuring that the voice of the community is heard is important to DMAS. Quality is a community process that is continuously informed and shaped by the voices and choices made by internal and external stakeholders. DMAS ensures transparency and the inclusion of community feedback into its Quality Strategy development.

DMAS also employs a social media strategy to increase public access to information, generate positive public relations, interface with the media, support MCO community efforts, and gather information to increase business intelligence. DMAS distributes public-facing information about the DMAS programs using press releases, website content, public and media relations, email newsletters, and social media.

Medicaid Contract Provisions

42 CFR §438.66 and 438.340

Contract Compliance

DMAS monitors each MCO's compliance with its contract, and with the goals identified in the Quality Strategy, via an internal quality assurance program and through on-site operational systems reviews of compliance with various quality assessment and improvement standards. DMAS' EQRO conducts the operational systems reviews at least once every three years. The purpose of the reviews is to determine an MCO's understanding and application of the Final Rule and contractually required standards from a review of documents, observation, and interviews with key MCO staff members, as well as file reviews conducted during evaluation. The operational systems review also includes an assessment of each MCO's QI structure. This structure is necessary to facilitate QI and ongoing assessment of performance measures and PIPs. This process enables DMAS and the MCOs to assess each MCO's performance in achieving quality goals specified in the Quality Strategy. The operational systems review report enables each MCO to implement remediation plans to correct any areas of deficiency found during the operational systems review. The report also helps DMAS determine each MCO's compliance with the Final Rule and DMAS' contract and to identify areas of the contract that need to be modified or strengthened to ensure that an MCO complies with the requirements.

To assess the quality and appropriateness of care/services for members with routine and SHCN, DMAS also regularly reviews the MCOs' contractually required reports and deliverables.

DMAS monitors all aspects of the managed care program, including the performance of each MCO in at least the following areas:

- Administration and management
- Appeal and grievance systems
- Claims management
- Enrollee materials and customer services, including activities of the beneficiary support system
- Finance, including medical loss ratio (MLR) reporting
- Information systems, including encounter data reporting
- Marketing
- Medical management, including utilization management and case management
- Program integrity
- Provider network management, including provider directory standards
- Availability and accessibility of services, including network adequacy standards
- QI
- Other contract provisions, as needed

DMAS reviews all deliverables submitted by the MCOs and, as applicable, requires revisions. DMAS approves the deliverables as complete when fully compliant with the contract.

Use of National Performance Measures and Performance Measure Reporting

42 CFR 438.330

Performance Measure Reporting

DMAS uses HEDIS and the CMS Child and Adult Core Set whenever possible to measure the MCOs' performance with specific indices of quality, timeliness, and access to care. DMAS' EQRO conducts CMS Core Measure Sets and NCQA HEDIS Compliance Audits™ of the MCOs annually and reports the results to DMAS. DMAS is implementing processes and MCO requirements in order to report all CMS Child Core Set measures and all Adult Behavioral Health measures in the CMS Core Measure Set by 2024. As part of the annual EQR technical report, the EQRO trends each MCO's rates over time and also performs a comparison of the MCOs' rates and a comparison of each MCO's rates to selected national benchmarks. The EQRO uses trending to compare rates year-over-year when national benchmarks are not available to determine if improvement in the related measures is occurring.

DMAS assigns the performance measures to the following domains of quality, timeliness, and access (Table 8):

Table 8—Assignment of Performance Measures to the Quality of, Access to, and Timeliness of Care Domains

Performance Measure	Quality	Access	Timeliness
Taking Care of Children			
Children and Adolescents' Access to Primary Care Practitioners	✓	✓	
Childhood Immunization Status—Combination 3	✓		
Well-Child Visits in the First 30 Months of Life	✓	✓	✓
Child and Adolescent Well-Care Visits	✓	✓	✓
Immunizations for Adolescents	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
Access and Preventive Health			
Breast Cancer Screening	✓		✓
Cervical Cancer Screening	✓		✓
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	✓		
Colorectal Cancer Screening	✓		✓
Adults' Access to Preventive/Ambulatory Health Services—Total		✓	
Living With Illness			
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, *HbA1c Control (<8.0%)*, *HbA1c Poor Control (>9.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*	✓		
Controlling High Blood Pressure	✓		
Asthma Medication Ratio	✓		
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*	✓		
Pharmacotherapy Management of COPD Exacerbation	✓		
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*	✓	✓	✓

Performance Measure	Quality	Access	Timeliness
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	✓	✓	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	✓		
Metabolic Monitoring for Children and Adolescents on Antipsychotics	✓		
Initiation and Engagement of Substance Use Disorder Treatment	✓		✓
Initiation and Engagement of Substance Use Disorder Treatment	✓		
Follow-up After Emergency Department Visit for Substance Use	✓		✓
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	✓		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	✓		
Outpatient Behavioral Health Encounter in the Last 12 Months for Population with Behavioral Health Condition	✓		✓
Follow-up After Emergency Department Visit for Mental Illness	✓		✓
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓		
Utilization Measures			
Use of Imaging Studies for Low Back Pain	✓		
Inpatient Utilization—General Hospital/Acute Care	✓		
Ambulatory Care—ED Visits	✓	✓	✓
Mental Health Utilization	✓		
Diabetes Short-Term Complications Admission Rate	✓		
Congestive Heart Failure Admission Rate	✓		
COPD and Asthma in Older Adults Admission Rate	✓		
Plan All-Cause Readmissions	✓		
Long-Term Care			
Use of High-Risk Medications in the Elderly	✓		
LTSS Enrollees Using Consumer-Directed Care	✓		
Nursing Facility Residents Hospitalization Rate	✓		
Nursing Facility Diversion Rate	✓		
Reassessments	✓		✓
Documentation of Care Goals	✓		
Advance Planning Directives	✓		

Performance Measure	Quality	Access	Timeliness
Members Who Re-Entered the Community After a Short-Term Nursing Facility Stay	✓		
Members Who Transitioned from a Nursing Facility to the Community Who Returned to the Nursing Facility Within 90 Days	✓		
Members Who Transitioned from a Nursing Facility to the Waiver and Remained in the Waiver for at Least One Year	✓		
Waiver Members Who Transitioned to a Nursing Facility and Remained in a Nursing Facility for at Least 180 Days	✓		
Follow-Up After Discharge Within 30 Days	✓	✓	✓
Prevalence of Pressure Ulcers Among LTSS Members	✓		
Injury Prevention	✓		
Use of Opioids			
Use of Opioids at High Dosage	✓		
Use of Opioids from Multiple Providers	✓		
Continuity of Pharmacotherapy for Opioid Use Disorder	✓		

DMAS posts the quality measures and performance outcomes annually online in the following location:

The Annual EQR Technical Report

Medallion 4.0 (Acute):

https://www.dmas.virginia.gov/about-us/office-of-quality-and-population-health/studies-and-reporting/#Annual%20Technical%20Reports%20(ATR)

CCC Plus (MLTSS):

https://www.dmas.virginia.gov/about-us/office-of-quality-and-population-health/studies-and-reporting/#Annual%20Technical%20Reports%20(ATR)

DMAS publishes key quality performance measures for its managed care programs as part of DMAS' commitment to transparency. The data, known as HEDIS, are nationally recognized measures that are audited for accuracy by NCQA Certified HEDIS Compliance Auditors (CHCAs). The MCO contract performance benchmark is the NCQA National 50th percentile, meaning that the MCOs must perform in the top 50 percent for these quality measures.

Virginia Medicaid is committed to working toward continuous quality improvement goals to ensure that Virginia Medicaid members have timely access to quality healthcare. The DMAS dashboards are an important part of DMAS' effort to demonstrate the value of managed care to the Virginia Medicaid program.

DMAS posts the MCO dashboards annually online in the following location:

The MCO Dashboard

Managed Care HEDIS Dashboards | DMAS—Department of Medical Assistance Services (virginia.gov)

Children's Health Insurance Program Reauthorization Act

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) reauthorized CHIP under Title XXI of the Social Security Act. Section 2108(a) of the Social Security Act provides that states must assess the operation of the state CHIP in each federal fiscal year (FFY), and report to the Secretary, by January 1 following the end of the FFY, on the results of the assessment. Accordingly, DMAS submits an annual CHIP report to CMS, as well as Medicaid and CHIP performance measure rates and other data as part of its annual CHIPRA reporting activities. The annual EQR technical report also includes an assessment of the operation of Virginia's CHIP program.

Medicaid and CHIP Program System Reporting

DMAS reports the results for child, adult, and maternal and infant health quality measures it collects in the CMS Quality Measure Reporting (QMR) system annually. DMAS continually works with CMS to report all available data as part of CMS' state quality reporting initiatives.

Quality Rating System

42 CFR §438.334

The DMAS Quality Rating System (QRS) is designed to establish a framework aimed to empower member choice and ensure monitoring of plan performance. DMAS' QRS is a one-stop shop for members to access information about Medicaid and CHIP eligibility and managed care, compare MCOs based on quality and other factors key to member decision making, and select an MCO that meets their needs.

DMAS developed its MCO QRS to serve as DMAS' alternative Medicaid managed care QRS. The QRS reflects the performance of the MCOs contracted to provide services through the use of various quality data elements including: CAHPS survey results, performance measure rates, and business operations metrics. DMAS continues to initiate QRS updates geared toward enhancement of transparency and as a vehicle to assist members in MCO selection.

State Monitoring and Evaluation of MCOs' Contractual Compliance

42 CFR §438.66

Compliance (Operational Systems) Review

42 CFR §438.358 and §438.330

According to 42 CFR §438.358, which describes the activities related to EQRs, a state or its EQRO must conduct a review within a three-year period to determine a Medicaid MCO's compliance with standards established by the state for access to care, structure and operations, and quality measurement and improvement. The review must include those standards detailed in 42 CFR §438 Subpart D as well as those detailed in 42 CFR §438.56, §438.100, §438.114, and §438.330. To meet this requirement, DMAS contracts with its EQRO to perform a comprehensive review of compliance of the MCOs. Operational systems reviews adhere to guidelines detailed in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.

The purpose of the operational systems review is to determine the extent to which Medicaid and CHIP MCOs are in compliance with federal standards. The 14 compliance standards are derived from requirements in the Final Rule. The 14 compliance standards are listed below:

- Enrollment and Disenrollment (42 CFR §438.3; 42 CFR §438.56)
- Member Rights and Confidentiality (42 CFR §438.3; 42 CFR §438.10; 42 CFR §438.100; 42 CFR §438.128; 42 CFR §438.224)
- Member Information (42 CFR §438.10)
- Emergency and Poststabilization Services (42 CFR §438.10; 42 CFR §438.114; 42 CFR §422.113; 42 CFR §438.114)
- Subcontractual Relationships and Delegation (42 CFR §438.230)
- Adequate Capacity and Availability of Services (42 CFR §438.68; 42 CFR §438.206; 42 CFR §438.207)
- Coordination and Continuity of Care (42 CFR §438.208)
- Coverage and Authorization of Services (42 CFR §438.3; 42 CFR §438.210; 42 CFR §438.211; 42 CFR §438.213; 42 CFR §438.214; 42 CFR §438.404)
- Provider Selection (42 CFR §438.12; 42 CFR §438.206; 42 CFR §438.214; 42 CFR §438.230)
- Practice Guidelines (42 CFR §438.236)
- Health Information Systems (42 CFR §438.242)
- Quality Assessment and Performance Improvement Program (42 CFR §438.330)

- Grievance and Appeal Systems (42 CFR §438.42; 42 CFR §438.400; 52 CFR §438.402; 42 CFR §438.406; 42 CFR §438.408; 42 CFR §438.410; 42 CFR §438.414; 42 CFR §438.416; 42 CFR §438.420; 42 CFR §438.424)
- Program Integrity (42 CFR §438.10; 42 CFR §438.102; 42 CFR §438.106; 42 CFR §438.214; 42 CFR §438.602; 42 CFR §438.608; 42 CFR §438.610)

DMAS, with CMS encouragement, utilizes other monitoring processes, review of deliverables, and expands the scope of the reviews to cover compliance with federal and state requirements beyond those specified in 42 CFR §438. These include other state statutory, regulatory, or contractual requirements such as the following areas:

- Access to providers, including accurate provider directory, timeliness of available appointments, physical accessibility of service sites and medical and diagnostic equipment, accessibility of information (compliance with web-based information, literacy levels of written materials, and alternate formats), and other accommodations.
- Availability and use of HCBS as alternatives to institutional care, so individuals can receive the services they need in the most integrated setting appropriate.
- Credentialing or other selection processes for LTSS providers, including those required where the enrollee can choose their caregiver (such as verification of completion of criminal background checks).
- Person-centered assessment; person-centered care planning; service planning and authorization; service coordination and care management for LTSS, including authorization/utilization management for LTSS; and any beneficiary rights or protections related to care planning and service planning such as conflict-free case management, self-direction of services, and appeal rights related to person-centered planning.
- Integration of managed medical, behavioral, and LTSS.

Results from operational systems reviews assist DMAS in determining each MCO's compliance with federal and Commonwealth requirements. The operational systems review results also assist DMAS in identifying any areas of the contract that need modification or strengthening to ensure that the MCOs can achieve the goals identified in the Quality Strategy. DMAS' EQRO also assists DMAS with a review of corrective action plans (CAPs) submitted by the MCOs to correct areas found to be deficient in the operational systems review.

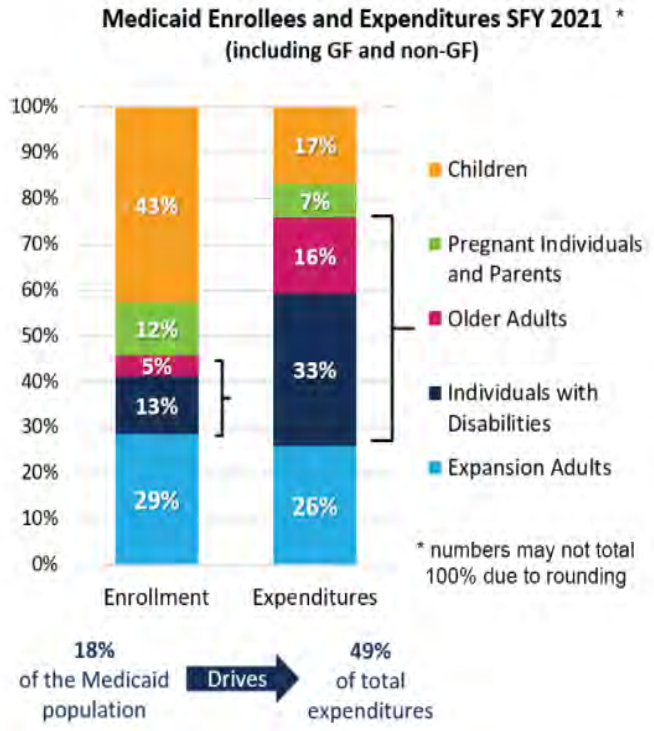
Using Incentives and Intermediate Sanctions to Drive Improvement

42 CFR §438 Subpart I

Financial Transparency and Accountability

DMAS seeks financial transparency and accountability in its Medicaid programs and continually evaluates the programs to ensure that they are operating as efficiently and effectively as possible. Medicaid enrollees and expenditures during SFY 2021 are shown in Figure 11.

Figure 11—Medicaid Enrollees and Expenditures—SFY 2021



To achieve financial transparency and fiscal accountability, DMAS:

- Maintains an internal financial scorecard to measure expenditures to budget
- Deploys an external dashboard on utilization of finances to support Medicaid
- Updates its Medicaid forecast and rate-setting processes by implementing the recommendations of an external reviewer.

To increase transparency in its rate-setting process, forecasting process, and key policy changes, DMAS conducts quarterly meetings with staff members from various legislative committees, JLARC, the Department of Planning and Budget, and the Secretary of Health and Human Resources.

Managing Spending in Virginia's Medicaid Program

DMAS cultivates a culture of collaboration with the MCOs. DMAS recognizes the importance of having a Medicaid and CHIP managed care delivery system that is firmly accountable to provide accessible, timely, and quality focused healthcare. The contract between the Commonwealth and each MCO is designed to delineate the regulatory and State-specific performance expectations of the MCO. DMAS monitors each MCO's compliance with the contract and responds promptly and effectively if an MCO fails to meet certain standards.

DMAS imposes intermediate sanctions if performance or noncompliance with the provision of covered, medically necessary benefits and services becomes an impediment to meeting the healthcare needs of members and/or the ability of providers to adequately attend to those healthcare needs. Such sanctions may disallow further Medicaid and CHIP enrollment and may also include adjusting auto-assignment formulas used for member enrollment.

Managed Care Compliance

DMAS uses an ongoing compliance monitoring process to detect and respond to issues of MCO noncompliance and to remediate contractual violations, when necessary, through progressive sanctions based on the number of points accumulated at the time of the most recent compliance violation/incident. The Department has a seven-level compliance point system. The MCO will incur points due to its own or its subcontractor's noncompliance with federal and/or State law, the MCO's contract, and any DMAS guidance. Points are assessed per incident of noncompliance. Points accumulate over a rolling 12-month schedule. All active points are carried over from the previous contract cycle; however, points more than 12 months old expire and will no longer be counted. Progressive sanctions are assessed monthly based on the tiered point system described in Table 9.

Table 9—MCO Contract Compliance Point System

Points	Penalty
0–10	None
11–25	$15,000
26–50	$30,000
51–70	$60,000
71–100	$90,000
101–150	Suspend Enrollment
>150	Possible Agreement Termination

In addition to imposing points and associated penalties, DMAS may impose liquidated damages.

The MCOs can incur points for a variety of issues, including but not limited to those listed below. Each of the examples listed below increase not only in the severity of the violation, but also in the number of points assessed, from one-point infractions, five-point infractions, up to 10-point infractions.

Specific pre-determined sanctions include:

- Adequate network—minimum provider panel requirements
- Submissions of reporting deliverables
- Noncompliance with claims adjudication requirements

Intermediate sanctions may also be assessed on the MCO per federal regulations. For more details on compliance and sanctions, please refer to the Cardinal Care contract available on DMAS' website.

Intermediate Sanctions

42 CFR §438.340

DMAS Intermediate Sanctions Policy

DMAS has developed an intermediate sanctions policy that is based on Section 1932(e)(1)(A) of the Social Security Act and requirements found in 42 CFR 438 Subpart I. Accordingly, intermediate sanctions may be imposed based on findings from on-site surveys, member or other complaints, financial status, or other sources if it is determined that the MCO:

- Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with the State, to an enrollee covered under the contract.
- Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
- Acts to discriminate among enrollees on the basis of their health status or need for healthcare services. This includes termination of enrollment or refusal to re-enroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.
- Misrepresents or falsifies information that it furnishes to CMS or to the State.
- Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or healthcare provider.
- Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in §§422.208 and 422.210 of this chapter.
- Distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.
- Has violated any of the other requirements of sections 1903(m) or 1932 of the Act, or any implementing regulations; or 1905(t)(3) of the Act, or any implementing regulations.

In addition to intermediate sanctions, there are provisions in the MCO contract that address sanctions if an MCO repeatedly fails to meet certain standards and provisions that give DMAS the authority to terminate the contract. DMAS has also established a compliance monitoring process that includes a compliance review committee and a compliance collaborative.

Clinical Efficiencies

In December 2016, JLARC published a study titled Managing Spending in Virginia's Medicaid Program.[34] Among the study's recommendations, JLARC called for DMAS to work with its actuary to identify potential inefficiencies in the Medallion 4.0 (Acute) and CCC Plus (MLTSS) programs and adjust capitation rates to account for these efficiencies. The Virginia General Assembly subsequently enacted budget language to execute this recommendation. To

[34] Virginia Joint Legislative Audit & Review Commission. Managing Spending in Virginia's Medicaid Program. Available at: http://jlarc.virginia.gov/medicaid-2016.asp. Accessed on: July 14, 2022.

implement this mandate, DMAS contracted with its actuary to identify clinical efficiencies under its managed care program. The clinical efficiency measures focus on medically unnecessary, avoidable, or potentially preventable spending for hospital admissions, hospital readmissions, and ED visits, as well as efficient utilization and management of prescription drugs. DMAS used these analyses to apply a 0.25 percent withhold and to adjust capitation rates under the Medallion 4.0 (Acute)CCC Plus (MLTSS) managed care program.

Value-Based Payments

The VBP program is of strategic importance to DMAS' Quality Strategy, which is why this program is one of the key interventions outlined in that section. Value-based purchasing is a broad set of strategies intended to improve healthcare quality, outcomes, and efficiency by linking financial and nonfinancial incentives to performance. Measurement is based on a set of defined outcome metrics of quality, cost, and patient-centered care. DMAS requires the MCOs to maintain a VBP strategy that follows the alternate payment model framework in the white paper developed by the Health Care Payment Learning & Action Network with a special emphasis on models in categories three and four.[35] The MCO will assure annual improvement in the level of VBP penetration until such time that the MCO has a minimum of 25 percent of its relevant spending for medical services governed under VBP arrangements. DMAS expects the MCO's VBP Plan to consider, but not be limited to, the following DMAS goals:

- Improved birth outcomes.
- Appropriate, efficient utilization of high-cost, high-intensity clinical settings.
- Improved MCO performance on DMAS Clinical Efficiency Performance Measures, including potentially preventable and/or avoidable ED visits, hospital admissions, and hospital readmission.

Nursing Facility Value-Based Purchasing

In 2021, the Virginia General Assembly directed DMAS to establish an NF VBP program designed to improve the quality of care furnished to Medicaid members. This program seeks to improve the quality and outcomes of care furnished to Medicaid members by enhancing performance accountability in the areas of staffing and avoidance of negative care events. DMAS has developed a provider-facing NF focused VBP program targeting specific performance measures for eligible NFs.

To prioritize simplicity and reduce administrative burden, DMAS selected PMs that are already standard reporting for Virginia nursing facilities through CMS' Minimum Data Set (MDS), Nursing Home (NH) Compare claims-based quality measures and Payroll Based Journal NF staffing measures. Utilizing these established measure sources allows Virginia nursing facilities to participate in the NF VBP program without additional reporting requirements. For SFY 2023, DMAS selected six performance measures that aligned with DMAS and the General Assembly's quality initiatives. The performance measures include staffing measures such as reducing the number of days NFs do not meet the CMS-mandated minimum number of staffed RN hours and the weighted average of case-mix adjusted total nurse staffing hours. The performance measures also include avoidance of negative care events measures such as reducing pressure

[35] Health Care Payment Learning & Action Network. Accelerating and Aligning Primary Care Payment Models. Available at: https://hcp-lan.org/workproducts/pcpm-whitepaper-final.pdf. Accessed on: July 14, 2022.

ulcers, UTIs, hospitalizations, and ED visits. The program targets will continue to evolve over time.

The performance measures are listed in Table 10. Performance measure tiers and improvement thresholds are included in Table 11.

Table 10—SFY 2023 NF VBP Performance Measures

Performance Measure	Description	Domain	NF VBP Performance Weight
Days without minimum RN hours	Facility reported RN staffing hours each day within a quarter Required standards addressed 42 CFR §483.35(b)	Staffing	20%
Total Nursing Hours per Resident Day (RN + licensed practical nurse [LPN] + nurse aide hours)—Case-Mix Adjusted[36]	Total nurse staffing hours per resident day within a quarter, adjusted for case mix.	Staffing	20%
Number of Hospitalizations per 1,000 Long-Stay Resident Days[37,38]	Number of unplanned inpatient admissions or outpatient observation stays that occurred during a one-year period among long-stay residents.	Avoidance of Negative Care Events	15%
Number of Outpatient ED Visits per 1,000 Long-Stay Resident Days[39]	Number of all-cause outpatient ED visits occurring in a one-year period while the individual is a long-term NH resident.	Avoidance of Negative Care Events	15%

[36] Data for the Total Nursing Hours per Resident Day—Case-Mix Adjusted measure is found in the NH Provider Info File PQDC, 2021. Available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py. Accessed on: Aug 4, 2022.

[37] Long-stay resident quality measures show the average quality of care for certain care areas in an NH for those who stayed in an NH for 101 days or more.

[38] Data for the Number of Hospitalizations per 1,000 Long-Stay Resident Days performance measure is found in the NH Quality Measure MDS Claims File PQDC—MDS Quality Measures, 2021. Available at: https://data.cms.gov/providerdata/dataset/djen-97ju. Accessed on: Aug 4, 2022.

[39] Data for the Number of Outpatient ED Visits per 1,000 Long-Stay Resident Days performance measure is found in the NH Quality Measure MDS Claims File PQDC—MDS Quality Measures, 2021. Available at: https://data.cms.gov/providerdata/dataset/djen-97ju. Accessed on: Aug 4, 2022.

Performance Measure	Description	Domain	NF VBP Performance Weight
Percentage of Long-Stay High-Risk Residents With Pressure Ulcers[40]	Percentage of long-stay, high-risk residents with Stage II-IV or unstageable pressure ulcers.	Avoidance of Negative Care Events	15%
Percentage of Long-Stay Residents With a UTI[41]	Percentage of long-stay residents who have had a UTI within the past 30 days.	Avoidance of Negative Care Events	15%

Table 11—NF VBP 2023 Performance Measure Attainment and Improvement Thresholds

Performance Measure Tiers	Fair Thresholds	Better Thresholds	Best Thresholds	Improvement Thresholds
Days Without Minimum RN Hours	13.00–16.00	5.00–12.00	0.00–4.00	>5%; Up to the Best Tier*
Total Nurse Staffing Hours per Resident Day (RN, LPN, certified nursing assistant [CNA])—Case-Mix Adjusted	3.08–3.19	3.20–3.30	3.31+	>0.5%; Up to the Best Tier*
Number of Hospitalizations per 1,000 Long-Stay Resident Days	1.36–1.75	1.00–1.35	0–0.99	>5%
Number of Outpatient ED Visits per 1,000 Long-Stay Resident Days	0.64–0.95	0.39–0.63	0–0.38	>5%
Percentage of Long-Stay High-Risk Residents With Pressure Ulcers	8.06–10.92	5.43–8.05	0–5.42	>5%
Percentage of Long-Stay Residents With a UTI	2.39–4.36	1.31–2.38	0–1.30	>5%

[40] Data for the Percentage of Long-Stay High-Risk Residents With Pressure Ulcers performance measure is found in the NH Quality Measure MDS Claims File PQDC—MDS Quality Measures, 2021. Available at: https://data.cms.gov/providerdata/dataset/djen-97ju. Accessed on: Aug 4, 2022.

[41] Data for the Percentage of Long-Stay Residents With a UTI performance measure is found in the NH Quality Measure MDS Claims File PQDC—MDS Quality Measures, 2021. Available at: https://data.cms.gov/providerdata/dataset/djen-97ju. Accessed on: Aug 4, 2022.

Performance Withhold Program

DMAS established the PWP for the MCOs to reinforce VBP principles by connecting financial incentives to the quality of care received by Virginia Medicaid managed care members. The PWP includes measures designed to evaluate managed care quality by setting performance standards and expectations for the MCOs in key areas influencing member health and health outcomes. Annually, DMAS reviews and updates measures, as appropriate. The PWP utilizes a financial incentive structure withholding a set percentage of the MCO's per member per month (PMPM) capitation rate system payments that the MCO can subsequently earn back based on performance attainment or improvement against the designated measures. By tying financial incentives to MCO performance on designated quality measures, the PWP focuses performance attainment and improvement efforts on areas of high importance to members.

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 PMPM capitation rate multiplied by the total MCO 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 MCOs' high performance and continuous improvement.

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

- NCQA's HEDIS
- CMS' Adult Core Set
- CMS Child Core Set
- AHRQ's 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.

Assessment

Procedures for Age, Sex, Race, Ethnicity, Disability Status and Primary Language Data Collection and Communication

42 CFR §438.340(b)(6)

To comply with the regulatory requirement for State procedures for race, ethnicity, primary language, and disability status, DMAS requires the MCOs to participate in Virginia's efforts to promote the delivery of service in a culturally competent manner to all members, including those with LEP and those with diverse cultural and ethnic backgrounds. DMAS continually monitors how age, sex, race, ethnicity, geographic location, disability status, and the primary language of members are collected, coded, and entered into the system to ensure that this information is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and with CMS requirements to improve the delivery of services in a culturally competent manner. DMAS provides demographic information for age, sex, race, ethnicity, geographic location, disability status, and primary language spoken to the MCOs as part of the member eligibility file. MCOs are required to use the data in their efforts to identify and overcome health disparities.

Identification of Members With Special Health Care Needs

42 CFR §438.208 and §438.340

DMAS defines children and youth with SHCN as members from birth through 21 years of age who have or are at increased risk for chronic physical, developmental, behavioral, or emotional condition(s) who may need health and related services of a type or amount over and above those usually expected for the child's age. DMAS also includes FC/AA programs, children zero to three years of age receiving early intervention services, and children and adolescents with significant behavioral health needs in its definition of SHCN.

Virginia's early intervention services (as described in 20 U.S.C. §1471 and 34 CFR §303.12, Part C) provides services to children from birth through two years of age with a disability in any one or more of the following areas: physical, cognitive, communication, social or emotional, or adaptive development, based on federal regulations of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA). Children are eligible in Virginia if they have a 25 percent delay in one or more areas of development, atypical development, or a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

MCOs are required to ensure that members of any age with a SHCN are assessed by an appropriate healthcare professional. For members of all ages that are identified as having SHCN, the MCOs must develop treatment plans in collaboration with the member's PCP, with member participation, and in consultation with any specialists providing care and services to the member. DMAS requires MCOs to ensure that members have direct access to specialists able to treat their needs. The treatment or care plan must be approved in a timely manner by the MCO. DMAS requires the MCOs to share with other MCOs serving the member with SHCN the results of its identification and assessment to prevent duplication of services.

School-Based Health Services

Virginia's public schools provide a range of school-based health services to students with SHCN in order to ensure their safety, attendance, and academic performance in the school setting. Some of those students are covered by Virginia's Medicaid or CHIP program, and some of the school-based health services provided are covered under these programs as medically necessary services. School divisions that are defined under State law as Local Education Agencies may enroll with DMAS as providers and seek reimbursement on a cost basis for providing those covered services when rendered by appropriately qualified providers to students enrolled in Medicaid or FAMIS. Because schools are reimbursed based on actual reported costs of providing the services, these services are carved out of managed care. School divisions submit interim claims through the FFS system, as required by CMS for such programs.

Eligibility

- Students must be eligible for Medicaid or CHIP on the date of service.
- Students must be 3 to 20 years of age.
- Students must be eligible for IDEA special education, and the reimbursed services must be written in the student's Individualized Education Plan (IEP).
- All treatment services must relate to a medical diagnosis and be determined to be medically necessary by an appropriately qualified individual.
- Ongoing treatment services must be based on a written plan of care prepared by an appropriately qualified individual. The plan must contain the diagnosis (disability), desired outcome (goals), nature of treatment (type of therapy), frequency of treatment (minutes/number per week), and duration (length of time).

The MCOs coordinate healthcare services for Medicaid and CHIP members who are identified as children with SHCN and who remain voluntarily enrolled in the MCO.

External Quality Review and Annual Independent Review of Access to and Quality and Timeliness of Care

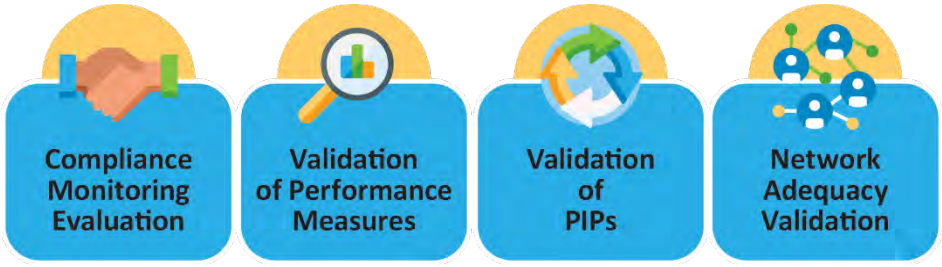
42 CFR §438.350–§438.358

In accordance with 42 CFR §438.356, DMAS contracts with HSAG as its EQRO to conduct the mandatory and optional EQR activities as set forth in 42 CFR §438.358. DMAS contracts with a CMS QI organization, which is also a CMS Network of Quality Improvement and Innovation Contractor, to serve as the EQRO for Virginia. HSAG has been DMAS' EQRO since 2014. HSAG's EQRO contract is for four years with four consecutive one-year renewal options. The conducting of EQR activities is a core feature of Virginia's Medicaid managed care quality initiative. The Medicaid managed care quality assessment activities are conducted for DMAS by its EQRO. Consistent with CMS guidance, the EQRO conducts the mandatory and optional activities using CMS published protocols.

Mandatory EQR Activities

42 CFR §438.358

To evaluate the quality and timeliness of, and access to, the services covered under the MCO contract, DMAS' EQRO conducts mandatory EQR activities for the Virginia Medicaid and CHIP programs. DMAS has determined that the mandatory activities completed by the EQRO do not duplicate activities performed through private accreditation. DMAS has contracted with its EQRO to perform the following mandatory activities:



- **Compliance monitoring evaluation.** DMAS' EQRO conducts comprehensive, on-site reviews of compliance, called operational systems reviews, of the MCOs at least once in a three-year period. DMAS' EQRO reviews MCO compliance with federal standards and those established by the State for access to care, structure and operations, and quality measurement and improvement. The State standards are as stringent as the federal Medicaid managed care standards described in 42 CFR §438.358(b)(iii), which address requirements related to access, structure and operations, and measurement and improvement. Compliance is also determined through a review of individual files to evaluate MCO implementation of standards.
- **Validation of performance measures.** In accordance with 42 CFR §438.340(b)(3)(i), DMAS requires MCOs to submit performance measurement data as part of their QAPI programs. To comply with 42 CFR §438.332, DMAS' requires the MCOs to be NCQA accredited and complete NCQA HEDIS Compliance Audits. DMAS' EQRO validates the non-HEDIS performance measures, including non-HEDIS CMS Child and Adult Core Set measures through MCO performance measure validation audits. The NCQA HEDIS Compliance Audits and the EQRO performance measure validation activities focus on the ability of the MCOs to accurately process claims and encounter data, pharmacy data, laboratory data, enrollment (or membership) data, and provider data. DMAS' EQRO validates the performance measures identified by the State to evaluate their accuracy as reported by, or on behalf of, the MCO. As part of EQRO performance measure validation audits, DMAS' EQRO also explores the issue of completeness of claims and encounter data to improve rates for the performance measures.
- **Validation of PIPs.** As described in 42 CFR §438.340(b)(3)(ii), DMAS requires MCOs to conduct PIPs in accordance with 42 CFR §438.330(d). PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention, and they must be designed to have a favorable effect on health outcomes and enrollee satisfaction. In accordance with 42 CFR §438.358(b)(1)(i), DMAS' EQRO validates PIPs required by the State to ensure that the PIPs were designed, conducted, and reported in a methodologically sound manner, meeting all State and federal requirements.

- **Network adequacy validation.** In accordance with 42 CFR §438.68, DMAS uses its EQRO to perform validation of MCO network adequacy. The analysis will evaluate each MCO's ability to:
  - Collect, capture, and monitor valid network adequacy data.
  - Evaluate the adequacy of the provider network using sound analytic methods.
  - Produce accurate results to support MCO network adequacy monitoring.
  - Provide DMAS with accurate network adequacy indicator rates for each required standard.
  - Provide a calculated validation rating for each network adequacy indicator for each MCO.
- **Annual technical report.** As described in 42 CFR §438.364, DMAS uses its EQRO to produce the annual EQR technical report. HSAG produces the annual technical report, which is an analysis and evaluation of information generated by the EQR-related activities regarding the quality, timeliness, and access to the healthcare services that an MCO, or its contractors furnish to beneficiaries. The report satisfies regulatory requirements and clearly and concisely indicates the methods that were used, the results that were achieved, and recommendations for future actions.

Optional EQR Activities

42 CFR §438.358

DMAS' EQRO conducts the following optional EQR activities for the Virginia Medicaid program:

- Consumer decision support tool
- Performance withhold program
- Population Focused Studies
  - Medicaid Maternal and Child Health Focused Study
  - Child Welfare Focused Study—Foster Care Study
- Calculate performance measures
- FAMIS CAHPS survey
- Quality strategy update
- Dental utilization in pregnant women data brief (focused study)
- ARTS measurement specification and reporting
- Appointment standards monitoring, prenatal care, and PCP secret shopper surveys
- Encounter data validation—information systems assessment and administrative profile

EQR Technical Report

42 CFR §438.364

The Final Rule, last updated in 2020, requires states to use an EQRO to prepare an annual technical report that describes the manner in which data were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care and

services furnished by the states' MCOs. DMAS' EQRO produces the EQR technical report, which presents all mandatory and optional EQR activities performed.

The EQR technical report includes a review of members' access to care and the quality of services received by members of Title XIX, Medicaid, and Title XXI, CHIP. In accordance with 42 CFR §438.364, the report includes the following information for each mandatory activity conducted:

- Assessment of the quality and timeliness of, and access to the care furnished by the MCO
- Activity objectives
- Technical methods of data collection and analysis
- Description of data obtained
- Conclusions drawn from the data
- Assessment of MCO strengths and weaknesses, as well as recommendations for improvements
- Methodologically appropriate comparative information about all MCOs in the program
- An assessment of the degree to which each MCO has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR

DMAS uses the information obtained from each of the EQR activities, as well as the information presented in the EQR technical report, to make programmatic changes and modifications to the Quality Strategy. The EQR technical report also contains a description of the EQRO evaluation of the effectiveness of the Quality Strategy. Follow-up on EQR technical report recommendations can be found in Appendix E. The most recent EQR technical reports may be accessed at:

Medallion 4.0 (Acute):

https://www.dmas.virginia.gov/about-us/office-of-quality-and-population-health/studies-and-reporting/#Annual%20Technical%20Reports%20(ATR)

CCC Plus (MLTSS):

https://www.dmas.virginia.gov/about-us/office-of-quality-and-population-health/studies-and-reporting/#Annual%20Technical%20Reports%20(ATR)

Non-Duplication of Mandatory Activities—Methodology for Determining Comparability

The Final Rule addresses the non-duplication of mandatory activities with Medicare or accreditation reviews. The Final Rule allows states to use information obtained from a Medicare or national accreditation review for the mandatory EQR activities when the state Medicaid contract has been in effect with the MCO for at least two years and subject to the EQR and met the quality, timeliness, and access to health care services standards for Medicaid beneficiaries, the MCO is accredited by a private accrediting organization recognized by CMS, when the accreditation standards are at least as stringent as those required by CMS (§422.158); are comparable to standards established through the EQR protocols (§438.352 and §438.358); and the MCOs provide the state with all reports, findings and results of the private accreditation

review activities including accreditation review activities, an evaluation of compliance with individual accreditation standards, any deficiencies, corrective action plans, and summaries of unmet accreditation requirements.

DMAS requires all the Virginia Medicaid MCOs to be accredited by NCQA. To reduce MCO burden, DMAS leverages the non-duplication option described in 42 CFR 438.360 to use information for the MCO review described in 438.360(a) for the annual EQR. DMAS has exercised this option as follows:

- Operational Systems Review (compliance review): DMAS' EQRO assesses the completeness of information from the MCOs' accreditation review to determine the extent of non-duplication, including confirming that the comparable information fully meets the Medicaid requirements. For OSR elements/requirements that fully meet Medicaid requirements, the element is "deemed" by the EQRO and not included in elements reviewed during the OSR. The EQRO reviews all elements not included in the subset of deemed elements during the compliance review.
- Performance Measure Validation: DMAS' EQRO conducts the mandatory activity of performance measure validation, including measures in the CMS Core Measure Sets. In addition, DMAS requires the NCQA accredited MCOs to annually submit their audited HEDIS performance measure rates. For inclusion of the MCOs' audited HEDIS rates in the annual EQR report, the EQRO reviews the final audit report to determine the extent to which the activity meets Medicaid requirements. The EQRO aggregates the MCOs' audited rates for inclusion in the annual EQR report. The aggregated rates are used to determine progress in achieving the Virginia Quality Strategy goals and objectives.

DMAS deems some of the duplicative CMS-EQR requirements as being met (hereafter referred to as "deeming") as long as the MCO meets the accreditation standards. The criteria for deeming are supported in 42 CFR §438.360 (non-duplication of mandatory activities).

Using NCQA Accreditation Results

42 CFR §438.360

CMS determines the CFR requirements that can be considered for deeming. HSAG uses the most current CFRs and compares the requirements to the most current NCQA Medicaid Managed Care Crosswalk to determine comparability. For de-duplication (deeming) purposes, HSAG assesses whether each accreditation standard met the relevant regulation in the CFR in its entirety.

DMAS requires the Medicaid MCOs in the Commonwealth of Virginia to be accredited by NCQA. HSAG reviews accreditation standards that are fully comparable with the federal standards pertaining to an MCO's operations. If the Commonwealth's MCO contract requirements are more stringent or include additional requirements than the Final Rule, HSAG compares the NCQA accreditation standard to the State-specific requirements.

Rationale for Determining Comparability to EQR Activities

DMAS determined that all standards found to be 100 percent comparable with the Final Rule are eligible for deeming with the following caveats:

- DMAS requires the MCOs to receive full (100 percent) compliance with the applicable accreditation element, standard, and/or CFR requirement.
- An NCQA standard was not eligible for deeming unless the standard was 100 percent compliant with the Medicaid CFR requirement.

State Monitoring and Evaluation of MCO Requirements

42 CFR §438.66

Performance Measures Used to Assess Members' Timely Access to Appropriate Healthcare

42 CFR §438.206(c)(1)

DMAS selected standard performance measures that MCOs are required to measure and report to DMAS. Consistent with DMAS' desire to benchmark its progress against other states' performance and assess key priorities to drive CQI efforts, nearly all of these measures are nationally recognized and include the NCQA HEDIS, CMS Child Core Set, and the CMS Adult Core Set measures. MCOs must attain annual improvement in the Medicaid HEDIS measures until such time that the MCO is performing at least at the 50th percentile for health maintenance organizations (HMOs) as reported in NCQA's Quality Compass®.[42]

Criteria for Selecting Access Measures

42 CFR §438.206

DMAS selects a mix of measures related to access to acute, primary, and specialty services. These include access metrics specific to mental health and SUD services for behavioral health organizations, and metrics related to LTSS for MLTSS programs. The managed care program covers diverse populations—such as nondisabled children, pregnant women, disabled adults, and seniors—and the access metrics address each of these groups.

Performance measure selection is dependent on:

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

Standards for Access to Care

42 CFR §438.206–42 CFR §438.210

DMAS contracts with its EQRO to perform an annual EQR of each MCO to determine MCO compliance with network adequacy and access requirements, confirm the adequacy of each MCO's network, and validate the MCO's network data. Virginia's MCO contracts include robust requirements to ensure that MCOs meet and, in some cases, exceed the standards outlined in 42 CFR Part 438 Subpart D and standards specified by DMAS. These standards are detailed throughout this section of the Quality Strategy and include requirements related to member access to care such as network adequacy, availability of services, access to care during transitions of coverage, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services. These requirements relate to the structure and operations that MCOs must have in place in order to ensure the provision of high-quality care including provider selection requirements, practice guidelines, information made available to beneficiaries, enrollment and disenrollment processes, confidentiality, appeals and grievance systems, sub-contractual relationships and delegation, and the information technology (IT) utilized by the MCOs.

The contracts between DMAS and the MCOs detail Virginia's Medicaid standards for access to care, and as outlined in Subpart D of the Final Rule. DMAS' standards are at least as stringent as those specified in 42 CFR §438.206–§438.210. The MCOs are required to implement the following standards for access to care:

- Availability of services (42 CFR §438.206)
- Assurances of adequate capacity and services (42 CFR §438.207)
- Coordination and continuity of care (42 CFR §438.208)
- Coverage and authorization of services (42 CFR §438.210)

Availability of Services

42 CFR §438.206

DMAS ensures that all services covered under the Medicaid State Plan are available and accessible to MCO members in a timely manner. DMAS also ensures that the MCO provider network for services covered under the contract meet DMAS' network adequacy standards defined in each managed care contract. MCO provider contracts require providers to offer hours of operation for Medicaid members that are no less than the hours of operation offered to commercial members or Medicaid FFS members, and that services are available to members 24 hours a day, seven days a week. DMAS also requires the MCOs to provide care as expeditiously as the member's health condition requires. MCOs are required to adequately and timely cover services that are not available within their managed care network. In cases where a member receives services from an out-of-network provider, DMAS requires the MCOs to coordinate with the provider for payment. The MCOs are required to meet the following appointment standards:

Emergency Services

Appointments for emergency services shall be made available immediately upon the member's request.

Urgent Medical Conditions

Appointments for urgent medical conditions shall be made within 24 hours of the member's request.

Routine Primary Care Services

Appointments for routine, primary care services shall be made within 30 calendar days of the member's request. This standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days, or for routine specialty services like dermatology, allergy care, etc.

Maternity Care Appointments

For maternity care, the MCO shall be able to provide initial prenatal care appointments for pregnant members as follows:

First trimester: Appointments shall be scheduled within seven calendar days of request.

Second Trimester: Appointments shall be scheduled within seven calendar days of request.

Third trimester: Appointments shall be scheduled within three business days of request.

High-Risk Pregnancies: Appointments shall be scheduled for high-risk pregnancies within three business days of identification of high risk to the MCO or maternity provider, or immediately if an emergency exists.

Mental Health Services

Behavioral health appointments must be made available as expeditiously as the member's condition requires and within no more than five business days from the Contractor's determination that coverage criteria are met.

LTSS

LTSS must be made available as expeditiously as the member's condition requires and within no more than five business days from the Contractor's determination that coverage criteria are met.

Assurances of Adequate Capacity and Services

42 CFR §438.207

Essential Services and Vulnerable Populations

42 CFR §438.3 and 42 CFR §456 Subpart K, Section 1927(g) of the Social Security Act

DMAS recognizes that the essential services for vulnerable populations are of strategic importance to the Quality Strategy, which is why these services are outlined as one of the key interventions. DMAS defines vulnerable populations served in the Medicaid programs as, but not limited to, individuals enrolled in a PACE, DD waiver members, and members diagnosed with a chronic physical and/or behavioral health condition.

DMAS reviews MCOs' policies, procedures, and processes used to evaluate medical necessity, the criteria used, the information source, and processes for approval and denial of essential services. DMAS also reviews the MCOs' mechanisms to detect under- and overutilization of care and services. DMAS requires the MCOs to develop and maintain a drug utilization review (DUR) program that consists of prospective and retrospective DUR. DMAS reviews the MCOs' implementation of their policies and procedures by requiring the MCOs to demonstrate that all members have access to all services covered under the Medicaid State Plan in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services as provided under the DMAS FFS Medicaid program.

DMAS considers quality to be the foundation of MCO health plan operations and requires the MCOs to monitor and report critical incidents and for QI plans to address potential and actual quality of care and/or health and safety issues.

Coordination and Continuity of Services

42 CFR §438.206; 42 CFR §438.208; and 42 CFR §438.210

Individuals who may be eligible for Medicaid LTSS are screened to determine their needs and eligibility for services. This screening is known as the Medicaid LTSS Screening and includes use of Virginia's Uniform Assessment Instrument (UAI); assessment of risk for institutionalization; preadmission screening (PAS) for mental illness, intellectual disability, and related conditions for NF admissions; documentation of an individual's choice of services; notification of appeal rights; and the Medicaid Authorization form for LTSS. Screeners may be staff members from the local departments of health and social services, hospitals, or nursing facilities. A physician must always review the screening results and be the final individual to approve authorization for services.

DMAS contracts with vendors to administer the Virginia Uniform Assessment Instrument that is used to determine eligibility for LTSS. Assessment vendors include hospitals, social service agencies, or other entities overseeing care of members. Additional services for members with SHCN or members who need LTSS are provided through the managed care model. The MCOs stratify members to coordinate care and measure quality for different groups of persons with special needs such as the nursing facility population; waiver population; EPSDT; foster care; members receiving early intervention services; and vulnerable subpopulations.

MCOs have overall responsibility for ensuring that all members have an ongoing source of primary care, according to their needs, and that they communicate this responsibility to the member along with an MCO point of contact. MCO contracts require the MCO to cover the same services as are required in Medicaid FFS. DMAS requires the MCOs to maintain and monitor a contracted provider network that is sufficient to provide adequate access to all services covered under the contract for all members, including those with LEP or physical or mental disabilities. Providers must maintain and share, as appropriate, a member health record in accordance with professional standards. MCOs are required to provide female enrollees with direct access to a women's health specialist within the provider network for women's routine and preventive healthcare services. MCOs are required to provide for a second opinion from a network provider or arrange for the member to obtain a second opinion outside the network, at no cost to the member. DMAS also requires the MCOs to coordinate care and service delivery with the services the member receives from any other MCO or prepaid inpatient health plan (PIHP).

The MCOs establish systems to monitor the provider network to ensure that the access standards are met, regularly monitor the network to determine compliance, takes corrective action when there is a failure to comply, and demonstrate that the access standards are met. MCOs expand provider networks to ensure access to care standards are met.

Accessing Continued Services Upon Transition in Care

42 CFR §438.62

DMAS makes its transition of care policy publicly available and provides instructions to members on how to access continued services during a transition when the member could suffer serious detriment to his or her health or be at risk of hospitalization or institutionalization upon transition from the FFS program to an MCO or from one MCO to another MCO. To ensure that there is no interruption of any covered service, DMAS requires the MCOs to allow members to use their current providers for up to 30 calendar days or for the duration of the service authorizations issued prior to the transition, and to receive continued prescription refills for at least 30 calendar days or through the expiration date of the prescription. DMAS also requires MCOs to transfer service authorizations and other pertinent information to an MCO to which the member is transitioning to ensure continuity of care and services. Members who are receiving LTSS services are able to stay in the residential facility regardless of the facility's contractual status with the member's new MCO.

Coverage and Authorization of Services

42 CFR §438.68 and 42 CFR §438.210

DMAS requires the MCOs to identify, define, and specify the amount, duration, and scope of each service. MCOs are required to furnish services in an amount, duration, and scope that is no less than those furnished to beneficiaries under Virginia's Medicaid FFS program. In addition, MCOs are required to ensure that the services are authorized in amount, duration, and scope so that they are reasonably expected to achieve the purpose for which they are furnished. DMAS ensures that the MCOs do not deny or reduce a service because of the member's diagnosis, type of illness, or condition. MCOs are, however, able to place appropriate limits on a service, such as due to a medical necessity determination. DMAS has provided the MCOs with a definition of what constitutes a medically necessary service. Medical necessity

criteria are incorporated into the MCOs' prior authorization policies and procedures. MCOs have implemented interrater reliability processes to ensure consistent application of authorization review criteria. MCO authorization processes also require an appropriate healthcare professional to make any decision to deny or reduce a service authorization request and to provide timely notice of the decision. MCOs are not allowed to compensate individuals or entities that conduct utilization management activities with incentives to deny, limit, or discontinue medically necessary services.

The managed care MCO contract requires MCOs to ensure that the MLTSS delivery system provides available, accessible, and adequate numbers of facilities, locations, and personnel for the provision of covered services. DMAS requires that the MCOs' networks meet or exceed federal network adequacy standards and have sufficient types and numbers of traditional and LTSS providers in their networks to meet historical need and that the MCOs add providers to meet increased member needs in specific provider types or geographic areas.

Standards for Structure and Operations

42 CFR §438.10; 42 CFR 438.54; 42 CFR 438.214; and 42 CFR 438.242

The contracts between DMAS and the MCOs detail Virginia's Medicaid standards for MCO structure and operations. DMAS' standards are at least as stringent as those specified in the Final Rule. DMAS requires the MCOs to implement the following standards for structure and operations:

- Provider selection (42 CFR §438.214)
- Information requirements (42 CFR §438.10)
- Confidentiality (42 CFR §438.224)
- Enrollment and disenrollment (42 CFR §438.54 and §438.56)
- Grievance and appeal systems (42 CFR §438.228 and 42 CFR §438 Subpart F)
- Subcontractual relationships and delegation (42 CFR §438.230)

Provider Selection

42 CFR §438.68, 42 CFR 4§38.214; 42 CFR §440.170(a) and 12 VAC 30-50-530

MCO provider networks include sufficient types and numbers of traditional and specialty providers to meet the historical need of members. MCOs continually assess their contracted provider network and, when needs are identified, MCOs add providers to meet increased member needs in specific geographic areas. MCOs select and credential providers following the NCQA credentialing requirements. DMAS has developed processes to assess MCO network adequacy by evaluating a number of factors, including:

- Number of providers
- Mix of provider types
- Hours of operation
- Ratio of providers not accepting new patients
- Accommodations for individuals with physical disabilities
- Barriers to communication

- Geographic proximity to members

To ensure access to care, MCOs provide emergency, urgent, and nonemergency transportation services to and from providers of covered medical, behavioral health, dental, LTSS, and rehabilitative medical services and supports needed. MCOs are also required to offer telehealth services, when appropriate, to ensure access to care requirements are met.

Development of Network Adequacy Standards

42 CFR §438.68; 42 CFR §438.207; 42 CFR §438.214; 42 CFR §438.340

DMAS works with the MCOs to ensure that their delivery systems provide adequate numbers of facilities, accessible locations, and qualified personnel for the provision of covered services, including emergency services 24 hours a day, 7 days a week.

DMAS ensures that MCOs maintain written policies and procedures for the selection and retention of providers that include documented, uniform credentialing and recredentialing policies. Credentialing and recredentialing policies, procedures, and provider contracts include processes to verify that providers excluded from federal healthcare programs do not contract with or provide services to MCO members. DMAS ensures that the MCOs' policies and procedures do not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.

MCOs develop and enforce network adequacy standards that include time and distance standards for provider types, which include adult and pediatric primary care, obstetrics and gynecology, behavioral health, adult and pediatric specialists, hospitals, enhanced dental benefits, and pharmacies. DMAS delegates the oversight of the time and distance standards for SFC members to the State's Dental Benefits Administrator.

MCOs maintain a network of providers sufficient in number, mix, and geographic distribution to meet the needs of their members. MCOs offer an appropriate range of preventive, primary care, and specialty services.

DMAS determines the demand for specific services on utilization patterns derived from Medicaid and CHIP claims and encounter data available for previous periods in DMAS' Medicaid Management Information System (MMIS). For existing managed care programs, DMAS uses MCO encounter data from the past two or three years to determine the demand for specific services. For new managed care programs, FFS claims are the primary source of data for analyzing previous service use.

Provider-Specific Time and Distance Standards

42 CFR §438.68 and 42 CFR §438.207

In addressing standards for network adequacy and availability requirements, DMAS takes into consideration elements supporting the member's choice of provider and strategies supporting community integration of the member. In addition, other elements in the best interest of members who need LTSS are taken into consideration. Travel time and distance are defined per line of business and as urban versus rural. For urban areas, each member has a choice of

at least two providers of each service type located within no more than 30 minutes travel time from any member unless the MCO has a DMAS-approved alternative time or distance standard.

DMAS developed time and distance standards to ensure that all covered Medicaid services delivered through contracted MCOs are available and accessible to members with an adequate MCO provider network. The standards address providing access to covered services through providers who are within reasonable travel time, provide the full scope of Medicaid and CHIP services, have timely access to services, and provide services in a culturally competent manner.

DMAS establishes time and distance standards based on provider type and the characteristics and special needs of specific Medicaid populations as illustrated in Table 12.

Table 12—Network Adequacy Standards

MCO Network Adequacy Standards	MCO Contract Requirement
Anticipated Medicaid enrollment	
Expected utilization of services	
Characteristics and healthcare needs of specific Medicaid populations covered in the MCO contract	
Numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services	
Numbers of network providers who are not accepting new Medicaid patients	
Geographic location of network providers and Medicaid enrollees, considering distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees	
Ability of network providers to communicate with limited English-proficient enrollees in their preferred language	
Ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities	
Availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions	

Exception Process

42 CFR §438.66, 42 CFR §438.68

If DMAS permits an exception to any of the provider-specific network standards, the standard by which the exception will be evaluated and approved is specified in the MCO contract based on the number of providers in that specialty practicing in the MCO service area. If DMAS grants an

exception, member access to that provider type is monitored on an ongoing basis and the findings are included in the managed care program assessment report submitted to CMS.

Telehealth

Telehealth means the use of telecommunications and information technology to provide access to medical and behavioral health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth encompasses telemedicine—defined as two-way, real-time interactive electronic communication—as well as a broader umbrella of services that includes the use of such technologies as telephones, interactive and secure medical tablets, remote patient monitoring devices, and store-and-forward devices.

DMAS supports the delivery of services by telehealth to cost-effectively improve access to and quality of services. Specifically, telehealth may help to increase and sustain members' equitable access to services, improve member engagement and participation in treatment plans and services, maintain quality of services by appropriately covering selected services delivered via telehealth, and reduce Medicaid costs for covered services by intervening earlier and/or more efficiently acting on identified physical and behavioral health needs. When delivering services via telehealth, providers are required to adhere to the same standards of clinical practice and record keeping that apply to other covered services.

Starting with the beginning of the COVID-19 pandemic, DMAS extended telehealth and telemedicine benefits to members to ensure access to care during the public health emergency. The use of these modalities of care has continued to grow, and DMAS has released long-term guidance to members and providers about the use of telehealth, including standardized definitions and details on covered services. Providers are required to get informed consent from members for telehealth services and use appropriate equipment and technology to ensure confidentiality. Any information shared during telehealth services must be consistent with applicable federal and State laws and regulations and DMAS policy. HIPAA confidentiality requirements are applicable to telemedicine encounters.

DMAS encourages MCOs to implement the use of telehealth, including electronic information and telecommunications to support remote and long-distance healthcare services. Telehealth includes services delivered in the dental health setting (i.e., teledentistry), and telehealth policies for dentistry are also covered. DMAS encourages MCOs to ensure their networks include behavioral health professionals performing addiction and recovery treatment service assessments via telehealth, particularly in rural and other hard to access areas. MCOs are also able to conduct member health risk assessments via telehealth as an accepted means of face-to-face communication.

Telemedicine

Telemedicine is a means of providing services through the use of two-way, real time interactive electronic communication between the member and the Provider located at a site distant from the member. This electronic communication must include, at a minimum, the use of audio and video equipment. Telemedicine does not include an audio-only telephone.

DMAS requires the MCO to provide coverage for telemedicine services as medically necessary, and within at least equal amount, duration, and scope as is available through the Medicaid FFS

program. DMAS defines telemedicine as the real-time or near real-time two-way transfer of medical data and information using an interactive audio/video connection for the purpose of medical diagnosis and treatment services. Telemedicine services are provided in a manner that meets the needs of vulnerable and emerging high-risk populations and are consistent with integrated care delivery. Telemedicine services may be provided in the home or at another location.

Telemedicine remote providers include physicians, nurse practitioners, certified nurse midwives, clinical psychiatric nurse specialists, clinical psychologists, clinical social workers, licensed and professional counselors, licensed marriage and family counselors, licensed substance abuse practitioners, and credentialed addiction treatment providers. DMAS covers the following telemedicine services:

- Teleretinal screening for diabetic retinopathy
- Teledermatology
- Teleradiology
- Remote patient monitoring (vital signs such as weight, blood pressure, blood sugar, and heart rate), especially for members with one or more chronic conditions, such as congestive heart failure, cardiac arrhythmias, diabetes, pulmonary diseases, or the need for anticoagulation
- Telepsychiatry

Remote Patient Monitoring

Remote patient monitoring (RPM) involves the collection and transmission of personal health information from a member in one location to a provider in a different location for the purposes of monitoring and management. This includes monitoring of both patient physiologic and therapeutic data.

Clinicians use their clinical judgment to determine the appropriateness of service delivery via telehealth, considering the needs and presentation of each individual. Covered services can include prenatal and postpartum care visits, radiology, speech language therapy, and a variety of mental health and substance use disorder services.

Information Requirements

42 CFR §438.10

To ensure the capacity for Medicaid managed care education, DMAS procured an enrollment broker to facilitate outreach, education, and consumer assistance to members and potential members. Informational materials developed by the Commonwealth, the enrollment broker, the Ombudsman Program, and MCOs are available in formats and languages that ensure their accessibility, including providing materials at an appropriate reading level.

Confidentiality

42 CFR §438.208(b)(6) and 42 CFR §438.224

MCO contracts require that the MCO ensures that network providers and subcontractors comply with HIPAA and its implementing regulations, the Health Information Technology for Economic and Clinical Health Act of 2009 and its implementing regulations (collectively, "HITECH"), and all applicable federal and state privacy laws that are more restrictive. Individually identifiable health information is disclosed only in accordance with federal privacy requirements. Accordingly, members are notified of any inappropriate disclosures as required by law. MCOs and providers are required to protect member privacy when coordinating care.

Enrollment and Disenrollment

42 CFR §438.54, 42 CFR §438.56

In designing the managed care enrollment and disenrollment policies, Virginia recognizes the importance of ensuring Medicaid applicants and their families experience a simple, streamlined eligibility and enrollment process that ensures a timely and accurate determination of Medicaid eligibility and a user-friendly MCO and PCP selection process. The Commonwealth and the enrollment broker maintain responsibility for effectuating enrollment and disenrollment requirements.

Medicaid Enrollment Application

Virginia managed care members are able to choose an MCO using a no-cost application (app) available for download for iPhone or for android users. Users only need to search for Virginia Managed Care in the App Store or Google Play and download the app. After downloading the app, members log in using a two-step identification process, Medicaid identification number and date of birth or social security number and date of birth. Nonmembers can log in as guests.

The app allows members to view their profile, compare MCOs, choose and enroll in an MCO, search for providers, and more. Members can choose a PCP and then select an MCO based on the networks in which their PCP participates. Members may also choose their preferred MCO and then choose from the list of participating in-network providers.

The Virginia Managed Care mobile app is designed to make it simple to find and enroll in an MCO.

Other features of the app include:

- Compare health insurance plans easily
- Find driving directions to nearby providers, hospitals, and pharmacies quickly
- For use on a phone or tablet
- Available in Spanish

Grievance and Appeal Systems

42 CFR §438.228 42 CFR §438.230 Subpart F 42 CFR §438.400, 42 CFR §438.402

DMAS is committed to ensuring that members are able to address their problems quickly and with minimal burden. The DMAS contracts with MCOs do not allow delegation of member notice of adverse benefit determinations. Virginia is committed to honoring and supporting the right of members to pursue a formal appeal of an adverse benefit determination through their MCO, or upon exhaustion of the MCO appeal process, through timely access to a State fair hearing. Additionally, members and applicants are also able to appeal enrollment and disenrollment determinations made by the enrollment broker under a similar process. Members are provided the opportunity to file a grievance with their MCO to express their dissatisfaction with any issue that does not relate to an adverse benefit determination (e.g., concerns and expressions of dissatisfaction). DMAS requires MCOs to report on their appeal and grievance processes and outcomes and monitors MCO performance to ensure compliance with related requirements and addresses any issues that may arise.

Adverse Benefit Determination

42 CFR §438.210; 42 CFR §438.400; 42 CFR §438.404

MCOs are required to notify members of an adverse benefit determination and explain the reasons for the determination. The notice of adverse benefit determination must be provided by the MCO as expeditiously as the member's condition requires but may not exceed 14 calendar days following the receipt of the request for service, unless an extension is allowed, and is in the best interest of the member.

Member Grievances

42 CFR §438.402; 42 CFR §438.406; §438.408

Members may file a grievance with an MCO at any time, either orally or in writing. MCOs are required to acknowledge receipt of each grievance and must resolve the grievance within 90 calendar days from the date the MCO receives the grievance. In instances in which the grievance relates to the denial of an expedited appeal request, MCOs are required to resolve the grievance and provide notice to all affected parties within five calendar days from the date the MCO received the grievance.

Member Civil Rights Grievances

DMAS and its contractors do not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities. To ensure that allegations or complaints of discrimination receive prompt attention, DMAS has established a procedure to review and resolve discrimination complaints in a timely manner and in accordance with applicable federal and State civil rights laws and regulations, as well as other DMAS policies, procedures, and contract requirements. Members may file a civil rights grievance with DMAS either orally or in writing. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought. DMAS civil rights complaint forms can be accessed by the public by contacting the DMAS Civil Rights Coordinator or a complaint can be filed by directly emailing

the DMAS Civil Rights Coordinator. Members may also directly file a nondiscrimination grievance with HHS, Office for Civil Rights.

Member Appeals

42 CFR §438.402; 42 CFR §438.406; 42 CFR §438.408; 42 CFR §438.420

Federal law establishes the specific standards for member rights for appeals which all MCOs are expected to follow. Specifically, in Virginia, members or authorized representatives may appeal a notice of adverse benefit determination within 60 calendar days from the date on the notice of adverse benefit determination. The MCO resolves and provides notice to the member as expeditiously as the member's health condition requires, and no longer than 30 calendar days from the initial date of receipt of the appeal.

Expedited Appeals

42 CFR §438.402; 42 CFR §438.406; 42 CFR §438.408; 42 CFR §438.420

DMAS requires MCOs to maintain an expedited appeal process in cases when a member requests or the provider indicates that the time expended in a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. DMAS requires the MCOs to issue decisions for expedited appeals as expeditiously as the member's health condition requires but may not exceed 72 hours from the initial receipt of the appeal.

Subcontractual Relationships and Delegation

42 CFR §438.230

MCOs remain accountable for all contract terms which are performed by subcontractors or through delegation agreements. MCOs are required to complete pre-delegation assessments or reviews prior to the delegation effective date to assess the subcontractor's readiness to perform the subcontracted or delegated functions. MCO delegation subcontractor agreements specify the activities and report responsibilities delegated to the subcontractor and provides for revocation of delegation or imposing sanctions if the subcontractor's performance is inadequate. DMAS confirms that MCOs have the necessary policies, procedures, and documents to demonstrate compliance, including processes for periodically performing audits of the subcontractor's and delegate's compliance, implementing corrective actions for identified deficiencies or identified areas of improvement during the term of the contract.

Standards for Measurement and Improvement

42 CFR §438.236; 42 §438.330; 42 CFR §438.242

The contracts between DMAS and the MCOs detail Virginia's Medicaid standards for measurement and improvement. DMAS' standards are at least as stringent as those specified in the Final Rule. The MCOs are required to implement the following standards for measurement and improvement:

- Practice guidelines (42 CFR §438.236)
- Quality assessment and performance improvement program (42 CFR §438.330)
- Health information systems (42 CFR §438.242)

Practice Guidelines

42 CFR §438.236

DMAS includes in its MCOs' contracts required evidence-based clinical practice guidelines. Examples of the evidence-based clinical practice guidelines include:

Well Baby and Well Child Care: All routine well baby and well childcare must be provided according to the recommendations by the American Academy of Pediatrics (AAP) Advisory Committee, including routine office visits with health assessments and physical exams, as well as routine lab work and age-appropriate immunizations, and ensure provision of services meets EPSDT requirements. The following services are rendered for the routine care of a well child:

- Unclothed Physical Exam: Regularly scheduled, comprehensive, full-body exams including weight, length, head measurement; BMI percentile; and blood pressure.
- Anticipatory Guidance: Newborn care, safety, development, nutrition, feeding, exercise, growth, healthy habits, emotional and mental health, substance use, alcohol use, skin cancer risks, tobacco use, school performance, and parent and family health and well-being.
- Laboratory Services: Blood lead testing, hemoglobin, hematocrit, or free erythrocyte protoporphyrin (maximum of two, any combination); Tuberculin test (maximum of three covered); Urinalysis (maximum of two covered); Pure tone audiogram for ages 3–5 (maximum of one).
- Well-child visits rendered at home, office, and other outpatient provider locations are covered at birth and months, according to the AAP recommended periodicity schedule.
- Immunizations: According to the Advisory Committee on Immunization Practices (ACIP). In addition, the Contractor shall also allow for an annual flu vaccine without limitations to age and without the requirement of meeting the CDC at-risk guidelines.
- Vision Screening: Machine vision test.
- Psychosocial/Behavioral Health Assessment: Depression screening, emotional and mental health, substance use, alcohol use, and tobacco use.
- Developmental Testing: Approved tools include Parents' Evaluation of Developmental Status (PEDS), Ages & Stages Questionnaire (ASQ), Bayley Infant Neurodevelopmental Screener (BINS), and focused screening for health conditions such as the Modified Checklist for Autism in Toddlers (M-CHAT), cognitive Adaptive Test/Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CLAMS) for general developmental delays, Language Development Survey for identifying language delays, and CLAMS for identification of language delays.
- Hearing Services: All newborn infants will be given a hearing screening before discharge from the hospital after birth. Those children who did not pass the newborn hearing screening, those who were missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist. In addition, newborns who fail their newborn hearing screening must be tested for congenital cytomegalovirus.

- Periodic auditory assessments appropriate to age, health history, and risk, which include assessments by observation (subjective) and/or standardized tests (objective). At a minimum, these services shall include diagnosis of and treatment for defects in hearing, including hearing aids.
- Dental Home/Assess Oral Risks: Oral examination, fluoride supplementation, fluoride varnish when teeth start coming in (usually around 6 to 24 months old), dietary counseling, and counseling for nonnutritive habits.

Depression Screenings and Referrals: Pregnant women must be screened for maternal mental health concerns, including but not limited to, postpartum depression in accordance with the American Congress of Obstetricians and Gynecologists (ACOG) or AAP standards.

Obstetric and Gynecologic Services: Routine and medically necessary obstetrics and gynecology (OB/GYN) healthcare services must be provided and include the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system in accordance with the most current published recommendations of the ACOG.

Colorectal Cancer Screening: Colorectal cancer screening must be provided in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.

In addition, DMAS ensures that the MCO practice guidelines are based on valid and reliable clinical evidence or a consensus of providers in the particular field; consider the needs of members; are adopted in consultation with contracting healthcare professionals; and are reviewed and updated periodically, as appropriate. MCOs disseminate practice guidelines to all providers, and upon request, to members.

Quality Assessment and Performance Improvement Program

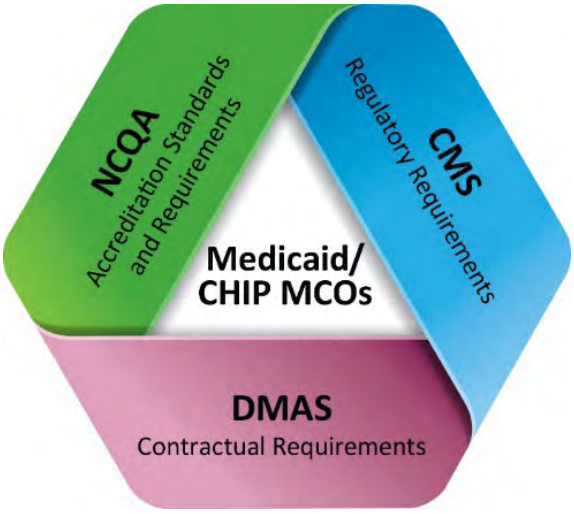
42 CFR §438.330

Each MCO is required to have an ongoing QAPI program. DMAS developed and uses a quality framework that leverages existing sets of standards and requirements for providing and continuously improving the quality of its managed care delivery system.

There are two fundamental sets of requirements from CMS and DMAS and one set of NCQA standards that converge for a bold quality framework for Virginia's Medicaid/CHIP managed care delivery system. Some of the requirements and standards overlap, resulting in resource efficiencies for assessing quality; however, each set provides for a different and important perspective on the quality of managed care.

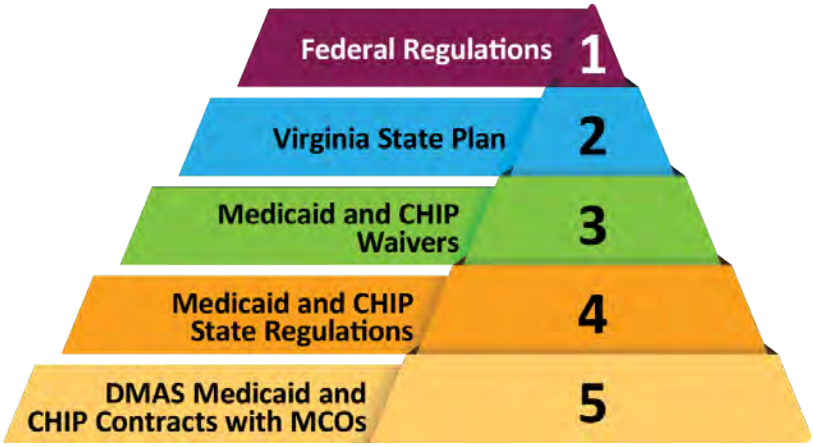
The requirements and standards serve as the basis for the Quality Strategy and are depicted in the framework in Figure 12.

Figure 12—Virginia's Medicaid/CHIP Managed Care Quality Framework



DMAS contracts with each MCO provide for the legal order of precedence, as shown in Figure 13:

Figure 13—Virginia's Legal Order of Precedence



Should there be any conflicting requirements or standards between CMS, DMAS, or NCQA, this legal order of precedence is followed.

Establishing Quality Metrics and Performance Targets Used for Measuring Performance and Improvement

DMAS has identified clinical quality, access, and utilization measures for the managed care program. DMAS includes a subset of HEDIS measures to track and trend MCO performance and to establish benchmarks for improving the health of Medicaid and CHIP populations served through the managed care delivery system. The measures listed 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 relevant clinical

guidelines are adhered to by each MCO's provider network. Additionally, when selecting measures for the specific needs of the managed care program, DMAS takes into consideration the availability and reliability of the data that are used to calculate the measures.

DMAS selects the same measures for a number of years to enable statistically sound trending of data. Trending provides DMAS and the MCOs the opportunity to further realize the impact of ongoing QI initiatives, rather than basing the effectiveness on just one year's worth of data.

DMAS and the MCOs recognize that effective QI includes:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing and sustaining improvement.

DMAS requires the MCOs to achieve annual improvement in HEDIS performance measures until the MCO is performing at least at the 50th percentile for HMOs as reported in NCQA's Quality Compass. Thereafter, DMAS requires the MCOs to sustain performance at the Medicaid 50th percentile and encourages the MCOs to set goals to attain the 75th percentile for each of the HEDIS measures. NCQA's Quality Compass report provides up to three years of performance trending of HEDIS and CAHPS measures for publicly reporting plans and includes comparative and descriptive performance information on hundreds of commercial, Medicaid, and Medicare health plan submissions as well as national, regional, and state benchmarks.

Ongoing Review of Performance Improvement

42 CFR §438.330; 42 CFR §438.358

DMAS uses multiple approaches to review the Quality Strategy on an ongoing basis. The MCOs are required to track their own ongoing performance and to report achievements and opportunities for improvement in an MCO quality evaluation, which is submitted annually to DMAS by each MCO.

DMAS requires the MCOs to conduct PIPs annually. PIPs must be designed to have the potential for achieving significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention, and to have a favorable effect on health outcomes and enrollee satisfaction. DMAS' EQRO validates the PIPs that are required by the Commonwealth annually. DMAS selects PIP topics that address CMS requirements and have the potential to impact the quality and timeliness of, and/or access to care and services.

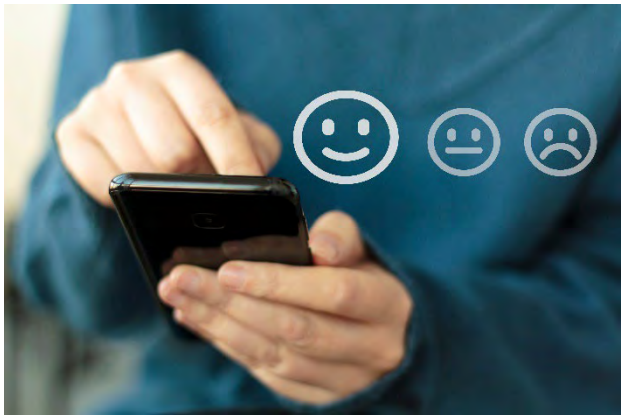
DMAS' EQRO validates PIPs required by the Commonwealth. The objective of PIP validation is to determine compliance with federal requirements and to ensure that DMAS, MCOs, and key stakeholders can have confidence that reported improvement can be reasonably linked to the QI strategies and activities conducted during the PIP. The EQRO's validation of PIPs includes two key components:

- The technical structure of the PIP to ensure that the MCO designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. The implementation of the PIP. Once designed, a MCO's effectiveness in improving

outcomes depends on the systematic data collection process, analysis of data, the identification of barriers, and development of interventions.

The results of the MCO PIP validation are reported to DMAS in an annual report. DMAS uses PIP results to assess each MCO's achievement of goals and to make any necessary modifications to the Quality Strategy based on each MCO's performance. PIP topics, PIP Aim statements, PIP population, PIP measures, and a description of the PIP status and any results that are available are included in Appendix C.

Member Satisfaction with Experience of Care



Annually, the EQRO administers a CAHPS survey. The primary objective of the CAHPS survey is to obtain information on the level of satisfaction members have with their healthcare experiences. CAHPS surveys ask members to report on and evaluate their experiences with healthcare; these surveys cover topics important to members, such as the communication skills of providers and the accessibility of services.

The EQRO conducts a CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the Children with Chronic Conditions measurement set for a statewide sample of FAMIS members, which is representative of the entire population of children covered by Virginia's Title XXI CHIP, members in the FFS, or managed care programs. DMAS uses CAHPS survey information to measure MCO and provider performance, member satisfaction with services provided and program characteristics, member access to care, and member expectations. DMAS' EQRO summarizes the findings of each CAHPS survey and incorporates the summary in the annual EQR technical report.

National Core Indicators—Aging and Disabilities Survey

Annually, DMAS administers the National Core Indicators for Aging and Disabilities© (NCI-AD) survey. The NCI-AD survey includes standard measures used to assess the quality of life and outcomes of seniors and adults with physical disabilities—including traumatic or acquired brain injury—who are accessing publicly-funded services through Virginia's Medicaid program. The NCI-AD surveys are coordinated by ADvancing States (formerly the National Association of States United for Aging and Disabilities [NASUAD]) and Human Services Research Institute (HSRI). NCI-AD data are gathered through the yearly administration of in-person adult consumer surveys of a statistically representative sample of each MCO's membership. NCI-AD data measure the performance at the statewide Medicaid level and of the DMAS contracted MCOs' LTSS systems and member outcomes. DMAS uses the results of the NCI-AD survey to help prioritize QI initiatives, engage in thoughtful decision making, and conduct futures planning with valid and reliable LTSS data.

Health Information Systems and Information Technology

42 CFR §438.242

Virginia's HIS and other technology initiatives support the overall operation and review of the Quality Strategy. The Commonwealth's IT approach is based on a strategy that spans all stakeholders and takes into consideration current and future plans, policies, processes, and technical capabilities.

DMAS is committed to increasing its IT infrastructure and data analytics capabilities. DMAS' modernized technology system, the Medicaid Enterprise System (MES), replaced the MMIS. The new system completely overhauled the existing system's framework and allowed for increased data collection, analytic, oversight, and reporting functions for DMAS. The MES includes the Enterprise Data Warehouse System (EDWS), a component that significantly enhanced DMAS' ability to analyze MCO data. Within the EDWS, there are powerful management, analytic, and visualization tools that allow DMAS to review and monitor MCOs with increased oversight and detail. The new Encounter Processing System (EPS), which is another component of the MES, enhances data quality through implementation of program-specific business rules.

MCO Health Information Technology

42 CFR §438.242

MCOs maintain health information systems that collect data and ensure that data are accurate, valid, reliable, and complete. Virginia requires each MCO to maintain a health information system that collects, analyzes, integrates, and reports to the State encounter data and other types of information to support utilization, rendering service providers, grievances and appeals, and disenrollment for reasons other than the loss of Medicaid eligibility. MCO health information systems collect data on member and provider characteristics and on the services furnished to members. Each MCO and PIHP ensures data received, including capitated data, are accurate and complete, and are screened for data completeness, logic, and consistency; include allowed amount and paid amount; and are collected in standardized formats, including secure information exchanges and technologies. MCO health information systems also support effective and efficient care management and coordination. DMAS requires MCOs to submit encounter data to the State in standardized Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats, and the ASC X12N 835 format as appropriate.

Goals Tracking Table

To continually track the progress of achieving the goals outlined in the Quality Strategy, DMAS developed a goals tracking table (Appendix D). The tracking table lists each of the goals and corresponding performance measures used to measure achievement of the goals. DMAS updates the tracking table quarterly. DMAS monitors the MCOs' progress in meeting the Quality Strategy

goals and is able to proactively identify performance data that may indicate a need for performance review or discussions with the MCO.

Annually, DMAS uses the information in the tracking table, which includes each MCO's performance measure results, to determine what additional QI efforts MCOs should make to improve quality of care and the health outcomes of the Medicaid population. PIP performance is also taken into consideration when determining the focus of the following year's QI activities.

Appendix A. Quality Strategy and Regulatory Reference Crosswalk

Virginia Quality Strategy
Crosswalk to CMS Toolkit

Each state contracting with an MCO, PIHP, PAHP, or PCCM entity must draft and implement a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCO, PIHP, PAHP or PCCM entity, per §438.340(a). The following table lists the required and recommended elements for state quality strategies, per 42 CFR §438.340(b), the CMS June 2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit, and the corresponding sections in the Virginia Quality Strategy that address each required and recommended element.

Introduction

Table 13—Introduction

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.340(a)	II.C. Exhibit 1 42 CFR §438.340(a), applicable also to CHIP managed care programs per 42 CFR §457.1240(e)	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** The state must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by each MCO, PIHP, PAHP, and PCCM entity it contracts with. **Toolkit Requirement:** • Indicate in the footer of the cover page of the initial quality strategy the date when the state submitted the quality strategy to CMS for comment and feedback. If the quality strategy is a revision of a previous version, indicate when the state published the previous version. Also indicate whether the quality strategy is an initial version or a revised version.	Cover page
§§438.340(a), 457.1240(e)	II.C. Exhibit 1	Include a brief history of the state's Medicaid and CHIP managed care programs.	12 18

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
Note: Not all requirements in the CFR are included in the Quality Strategy Toolkit.	42 CFR §438.340(a), applicable also to CHIP managed care programs per 42 CFR §457.1240(e)	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** The state must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by each MCO, PIHP, PAHP, and PCCM entity it contracts with. **Toolkit Requirement:** • Describe the types of MCPs (such as MCOs and PIHPs) that the state contracts with to deliver services to beneficiaries; the managed care authorities, including relevant state plans (for example Medicaid, CHIP) and waiver types (such as Section 1115 demonstrations), that the state uses for each MCP. • The types of benefits (such as LTSS and dental) that each MCP provides to beneficiaries. • Specify which populations are addressed; children with disabilities may be included with children or people with disabilities. • Use this information to ensure that the quality strategy addresses all plans and populations in the state's managed care programs. • Indicate whether the state's CHIP program type is expansion, separate, or combined; whether the state provides CHIP benefits through managed care; and which MCPs provide CHIP benefits. If the state provides CHIP benefits through managed care, indicate whether the quality strategy addresses the state's CHIP program.	21-24
42 CFR §438.340(b)(3)(i); 42 CFR §457.1240(e); §438.330(c)(1)(ii)	II.E.3 LTSS Performance Measures 42 CFR §438.340(b)(3)(i); 42 CFR §457.1240(e); §438.330(c)(1)(ii)	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** If the state contracts with MCOs, PIHPs, PAHPs, and/or PCCM entities to provide LTSS, the state must describe the standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving LTSS. If the state does not provide LTSS through managed care, this requirement does not apply. **Toolkit Requirement:** • Indicate in the quality strategy whether the state delivers LTSS through managed care.	21-24

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		• For concurrent managed care and home and community-based services (HCBS) authorities, review HCBS quality assurance provisions required for HCBS for those programs with and without an institutional level of care found at 42 CFR 441.302(a)-(c), 441.303(a)-(e) 441.715(a) and 441.745(b).	
Optional		Include an overview of the quality management structure that is in place at the state level. For example, how is the leadership team structured, are there any quality task forces, an MCO collaborative, etc.	19-20
Optional		Include general information about the state's decision to contract with MCOs/PIHPs (e.g., to address issues of cost, quality, and/or access). Include the reasons why the state believes the use of a managed care system will positively impact the quality of care delivered in Medicaid and CHIP.	8-10
§438.340(b)(2)	II.D. Goals and Objectives 42 CFR §438.340(b)(2), applicable also to CHIP managed care programs per 42 CFR §457.1240(e).	Include a description of the goals and objectives of the state's managed care program. This description should include priorities, strategic partnerships, and quantifiable performance driven objectives. These objectives should reflect the state's priorities and areas of concern for the population covered by the MCO/PIHP contracts. For example, "the state will demonstrate a 10 percent improvement in childhood immunization rates over the next three years" or "through expansion of the primary care network, as evidenced by geographical reporting, the state will demonstrate a 5 percent improvement in member access to primary care." **CFR Description:** The state must identify its goals and objectives for continuous quality improvement. These goals and objectives must be measurable and take into consideration the health status of all populations served by the state's MCPs. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** Include measurable goals and objectives in the quality strategy. • Goals are defined as high-level managed care performance aims that provide direction.	13-14 Appendix B Appendix D

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		• Objectives are defined as measurable steps toward meeting the state's goals, and typically include quality measures. • Link each goal to one or more objectives. Together, CMS recommends that the goals and objectives be specific, measurable, attainable, relevant, and time-bound (SMART) • Crosswalk the goals and objectives to the populations and plans included in the state's managed care program to ensure that the goals and objectives address each population and plan.	
Optional		Include a description of the formal process used to develop the quality strategy.	30-32
§438.340(c)(1)(i)		Include a description of how the state obtained the input of beneficiaries and other stakeholders in the development of the quality strategy.	32-35
§438.340(c)(1)		Include a description of how the state made (or plans to make) the quality strategy available for public comment before adopting it in final.	32-33
§438.340(c)(2)(i)		Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually).	32
§438.340(b)(10) and (c)(3)(ii)	III.A.1 Updates for State-Defined Significant Changes §438.340(b)(10) and (c) (3)(ii), §457.1240(e)	Include a timeline for modifying or updating the quality strategy. If this is based on an assessment of "significant change," include the state's definition of "significant change." **CFR Description:** The state must include in its quality strategy a definition for a "significant change" for the purpose of revising the quality strategy. If such a significant change occurs, the state must update its quality strategy. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** • Consider factors to define as a significant change, such as, but not limited to: • Adding or removing goals and objectives. • Changes that trigger public comment, tribal consultation, and input from the state's Medical Care Advisory Committee. • Substantive changes to the state's managed care quality laws.	31-32

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.340(b)(10)	III.A.2 Updates for Significant Changes That Occur Within the State's Medicaid Program §438.340(c)(3)(ii), §457.1240(e)	**CFR Description:** In addition to updates made to reflect significant changes as defined by the state, the state must also update its quality strategy whenever significant changes occur within the state's Medicaid program. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** No details provided in the toolkit.	32
§438.340(c)(1)	IV.A. Public and Tribal Comment Process Exhibit 18 42 CFR §§438.340(c)(1)(i), 438.340(c)(1)(ii), cross-referencing 42 CFR §431.12, §457.1240(e).	**CFR Description:** The state must make the strategy available for public comment before submitting the strategy to CMS for review, including by obtaining input from its Medical Care Advisory Committee (Medicaid only), beneficiaries, and other stakeholders. In addition, the state must consult with Tribes in accordance with the state's Tribal consultation policy established pursuant to 1902(a)(73) of the Social Security Act, if the state enrolls American Indians and Alaska Natives (AI/ANs) in any of its MCPs. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** • Indicate whether the state enrolls AI/ANs in managed care and whether the state has officially recognized Tribes; comply with the state's Tribal consultation policy. • Detail the public and Tribal comment process or provide a link in the quality strategy to a document posted on the state's website that details how the state addressed this requirement. • Consider including comments received during the public comment and Tribal consultation period as an appendix to the quality strategy. • Indicate when the state made the quality strategy available for public comment and Tribal consultation. If the state has not made its quality strategy available for public comment and Tribal consultation, indicate when it will do so. • Describe comments and input received, along with whether and how the state refined its quality strategy based on the comments and input.	32-34

Assessment

Table 14—Assessment

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.330(b)(4)		Summarize state procedures that assess the quality and appropriateness of care and services furnished to all Medicaid members under the MCO and PIHP contracts, and to individuals with SHCN.	36-39
§438.330(b)(4) *Note: Not required but supports the above requirement.*		Include the state's definition of SHCN.	94
§438.330 (b)(8) §438.208(c)(1)	II.E.7 Identification of Persons Who Need LTSS or Persons with Special Health Care Needs 42 CFR §438.340(b)(8), 42 CFR §457.1240(e), §§438.208(c)(1), 457.1230(c)	**CFR Description:** The state must describe its mechanisms to identify persons who need LTSS or persons with special health care needs. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** • Indicate in the quality strategy whether the state provides LTSS benefits through managed care. • In the description of the mechanisms the state uses to identify persons who need LTSS or persons with special health care needs, indicate whether the state uses its staff, the state's enrollment broker, or the state's MCPs to identify these persons.	23 31 94
§438.340(b)(6)		Detail the methods or procedures the state uses to identify the race, ethnicity, and primary language spoken of each Medicaid member. States must provide this information to the MCO and PIHP for each Medicaid member at the time of enrollment.	60-66 Appendix D

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.340(b)(6); §457.1240(e) *Note: The CFR does not include the level of detail included in the Quality Strategy Toolkit*	II.E.6 Disparities Plan 42 CFR §§438.340(b)(6); 457.1240(e)	Document any efforts or initiatives that the state or MCO/PIHP has engaged in to reduce disparities in health care. **CFR Description:** The state must include its plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. The state must include in this plan the state's definition of disability status and how the state will make the determination that a Medicaid enrollee meets the standard. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** • Include the following elements for each disparity factor (age, race, ethnicity, sex, primary language, and disability status): • Disparity identification and evaluation method, such as an analysis of health plan information, beneficiary and provider outreach, and stratifying quality metrics by eligibility and enrollment demographic data. • A description of the state's plan to reduce disparities, by target programs and populations, such as CHIP, LTSS, and beneficiaries with behavioral health needs. • A description of the state's progress towards reducing disparities. • A description of the state's progress on any initiatives described in its previous quality strategy. • Coordinate to the extent practicable with public health authorities on plans for disparities reduction implement outside of the state Medicaid and CHIP agencies. • Identify and use measures that pertain to health care conditions and/or Medicaid and CHIP populations marked by a high degree of health disparities – for instance, by linking to other available data sources such as eligibility and enrollment demographic data to stratify by race, ethnicity, sex, language, disability status, or geography. States can also collect information on sociodemographic characteristics and then stratify the measure to detect disparities. • Capture data on social determinants of health and chronic conditions associated with disability when feasible.	

National Performance Measures

Table 15—National Performance Measures

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.330(c)(1)(i)	II.E.1 Quality Metrics and Performance Targets Exhibit 3 42 CFR §438.340(b)(3)(i), applicable also to CHIP managed care programs per 42 CFR §457.1240(e), cross-referencing §438.330(c)	Include a description of any required national performance measures and levels identified and developed by CMS in consultation with states and other stakeholders. **CFR Description:** The state must include a description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, or PCCM entity with which it contracts. This must include, but is not limited to, the state's QAPI metrics. After consulting with states and other stakeholders, and providing public notice and opportunity to comment, CMS may specify national performance measures. The state must include a description of these measures in its quality strategy. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** If CMS specifies performance measures, include them in the EQR performance measure validation activity. Through its EQR report, the state can reference information on these measures. The state may request an exemption from including these measures by submitting a written request to CMS explaining the basis for the request.	80-83 Appendix B Appendix D
§438.340(b)(3) §438.330(c)	II.E.1 Quality Metrics and Performance Targets 42 CFR §438.340(b)(3)(i), applicable also to CHIP managed	**CFR Description:** The state must include a description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, or PCCM entity with which it contracts. This must include, but is not limited to, the state's QAPI metrics. After consulting with states and other stakeholders, and providing public notice and opportunity to comment, CMS may specify national performance measures. The state must include a description of these measures in its quality strategy.	80-83 Appendix B Appendix D

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
	care programs per 42 CFR §457.1240(e), cross-referencing §438.330(c)	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** Indicate whether the state plans to voluntarily collect any of the CMS core performance measures for children and adults in Medicaid/CHIP. If so, identify state targets/goals for any of the core measures selected by the state for voluntary reporting. **CFR Description:** The state must include a description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, or PCCM entity with which it contracts. This must include, but is not limited to, the state's QAPI metrics. After consulting with states and other stakeholders, and providing public notice and opportunity to comment, CMS may specify national performance measures. The state must include a description of these measures in its quality strategy. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** Use measure results to monitor progress toward meeting the state's goals and objectives. CMS recommends that the state also review measure results when revising its quality strategy and address areas of poor performance in its goals and objectives.	
§§438.340(b)(3)(i); 457.1240(e)	II.E.2 Public Posting of Quality Measures and Performance Outcomes §§438.340(b)(3)(i); 457.1240(e)	**CFR Description:** The state must identify which quality measures and performance outcomes it will publish at least annually on its website. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** • Include a link in the quality strategy to where the state publishes measures and performance outcomes online. • Consider which measures are most meaningful and responsive to stakeholders and which would best illustrate progress on the quality strategy. • Consider selecting from measures for public posting that pertain to health conditions and/or Medicaid and CHIP populations marked by a large degree of health disparity, such as sickle cell disease in children or unnecessary cesarean section for pregnant women.	83-84

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		• Ensure that appropriate translation services are available and that websites are accessible in order to provide all information needed by beneficiaries.	
§438.340(b)(3)(i)	II.E.3 LTSS Performance Measures 42 CFR §438.340(b)(3)(i); 42 CFR §§457.1240(e); 438.330(c)(1)(ii)	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** If the state contracts with MCOs, PIHPs, PAHPs, and/or PCCM entities to provide LTSS, the state must describe the standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving LTSS. If the state does not provide LTSS through managed care, this requirement does not apply. **Toolkit Requirement:** Use measure results to monitor progress toward meeting the state's goals and objectives. CMS recommends that the state also review measure results when revising its quality strategy and address areas of poor performance in its goals and objectives.	80-83 Appendix B Appendix D

Monitoring and Compliance

Table 16—Monitoring and Compliance

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.66		Detail procedures that account for the regular monitoring and evaluation of MCO and PIHP compliance with the standards of subpart D (access, structure and operations, and measurement and improvement standards). The State's system must address all aspects of the managed care program, including the performance of each MCO, PIHP, PAHP, and PCCM entity (if applicable) in at least the following areas:	85-86 101-117

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		(1) Administration and management. (2) Appeal and grievance systems. (3) Claims management. (4) Enrollee materials and customer services, including the activities of the beneficiary support system. (5) Finance, including medical loss ratio reporting. (6) Information systems, including encounter data reporting. (7) Marketing. (8) Medical management, including utilization management and case management. (9) Program integrity. (10) Provider network management, including provider directory standards. (11) Availability and accessibility of services, including network adequacy standards. (12) Quality improvement. (13) Areas related to the delivery of LTSS not otherwise included in paragraphs (b)(1) through (12) of this section as applicable to the managed care program. (14) All other provisions of the contract, as appropriate. (c) The State must use data collected from its monitoring activities to improve the performance of its managed care program, including at a minimum: (1) Enrollment and disenrollment trends in each MCO, PIHP, or PAHP. (2) Member grievance and appeal logs. (3) Provider complaint and appeal logs.	

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		(4) Findings from the State's External Quality Review process. (5) Results from any enrollee or provider satisfaction survey conducted by the State or MCO, PIHP, or PAHP. (6) Performance on required quality measures. (7) Medical management committee reports and minutes. (8) The annual quality improvement plan for each MCO, PIHP, PAHP, or PCCM entity. (9) Audited financial and encounter data submitted by each MCO, PIHP, or PAHP. (10) The medical loss ratio summary reports required by § 438.8. (11) Customer service performance data submitted by each MCO, PIHP, or PAHP and performance data submitted by the beneficiary support system. (12) Any other data related to the provision of LTSS not otherwise included in paragraphs (c)(1) through (11) of this section as applicable to the managed care program. Some examples of mechanisms that may be used for monitoring include, but are not limited to: • Member or provider surveys; • HEDIS results; • Report Cards or profiles; • Required MCO/PIHP reporting of performance measures; • Required MCO/PIHP reporting on performance improvement projects; • Grievance/Appeal logs, etc.	

External Quality Review (EQR)

Table 17—External Quality Review (EQR)

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.350(a) and §340(b)(4)		Include a description of the state's arrangements for an annual, external independent quality review of the quality, access, and timeliness of the services covered under each MCO and PIHP contract. Identify what entity will perform the EQR and for what period of time.	96-100
§438.350(a) and §340(b)(4) *Note: The CFR does not include the detailed requirements included in the Quality Strategy Toolkit*	II.G.1 EQR Arrangements 42 CFR §438.340(b)(4), 42 CFR §§457.1240(e), 438.350, 457.1250	Identify what, if any, optional EQR activities the state has contracted with its External Quality Review Organization (EQRO) to perform. The five optional activities include: 1. Validation of encounter data reported by an MCO or PIHP; 2. Administration or validation of consumer or provider surveys of quality of care; 3. Calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO; 4. Conduct of performance improvement projects (PIPs) in addition to those conducted by an MCO or PIHP and validated by an EQRO; and 5. Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** The state must provide a description of its arrangements for annual, external, independent reviews of the quality outcomes, timeliness of, and access to the services covered under each MCO, PIHP, PAHP, and PCCM entity. **Toolkit Requirement:** • Describe what mandatory and optional tasks the EQRO will perform and whether the state contracts with a separate EQRO for certain types of managed care, such as behavioral health.	96-100

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		• Identify the EQRO that will perform the EQR and the length of the EQRO's contract. • Review prior EQR technical reports, paying special attention to areas of low performance. • Ensure that performance measures, PIPs, and standards related to elements in 42 CFR 438 subpart D and 438.330 are validated and then reported by an EQRO per 42 CFR 438.364.	
§438.360; and §438.340(c)(2)(iii)	III.B.2 EQRO Recommendations 42 CFR §§438.340(c)(2)(iii), 457.1240(e), cross-referencing §438.364(a)(4) and 457.1250(a).	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** The state must ensure that updates to the quality strategy take into consideration the recommendations provided by an EQRO and should describe how updates to the quality strategy take those recommendations into consideration. **Toolkit Requirement:** • Review findings and recommendations from the state's EQR reports to develop and monitor progress toward meeting its goals and objectives. • Summarize findings and recommendations from the state's latest EQR reports and describe how the quality strategy has been updated to address them.	Appendix E
§438.350(c) and §438.360		Identify the standards for which the EQR will use information from Medicare or private accreditation reviews. This must include an explanation of the rationale for why the Medicare or private accreditation standards are duplicative to those in 42 CFR §438.204(g).	98-100
§438.360(c)	II.G.2 EQR Non-Duplication Option 42 CFR §438.340(b)(9), 42 CFR §§457.1240(e), 438.360(c), 457.1250(a)	If applicable, for MCOs or PIHPs serving only dual eligibles, identify the mandatory activities for which the state has exercised the non-duplication option under §438.360(c) and include an explanation of the rationale for why the activities are duplicative to those under §§ 438.358(b)(1) and (b)(2). **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** If the state leverages the non-duplication option described 42 CFR 438.360 to use information from an MCP review described in 438.360(a) for	98-100

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		the annual EQR instead of conducting one or more of the mandatory EQR-related activities described in 438.358(b)(1)(i) through (iii), the state's quality strategy must: • Identify the EQR-related activities for which it has exercised this option. • Explain the rationale for its determination that the Medicare review or private accreditation activity is comparable to such EQR-related activities. **Toolkit Requirement:** • It is recommended that all states indicate in their quality strategies whether the state does or does not leverage the non-duplication option. A state that does leverage the non-duplication option must include the information discussed under the regulatory requirements section in its quality strategy. • If a state does leverage the non-duplication option, it should consider including sufficient information to establish that all information relied upon for the purposes of non-duplication meets the conditions identified in 42 CFR 438.360(a)(1) and (a)(3) in addition to the required explanation of the rationale for the determination required by 438.360(a)(2).	

State Standards

Table 18—State Standards

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.206 Subpart D Requirements		**Availability of Services**	
§438.68 §438.206 CHIP §457.1218 §457.1230(a)	II.F.1 Network Adequacy and Availability of Services 42 CFR §438.340(b)(1), 42 CFR §§457.1240(e), 438.68, 438.206, 457.1218, 457.1230(a)	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** The state must include its network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs. **Toolkit Requirement:** • Provide detail for each of the state's network adequacy and availability of services standards under 42. CFR 438.68 and 438.206 for Medicaid managed care programs. These standards apply to CHIP managed care programs under 42 CFR 457.1218 and 457.1230(a). For example, detail the state's standards for each provider type included in 42 CFR 438.68, such as primary care, behavioral health, and LTSS. • Detail the state's network adequacy standards or link to standards contained in a separate document.	49 97 101-104 105-109
§438.206(b)(1)		Maintains and monitors a network of appropriate providers	105-109
§438.206(b)(2)		Female members have direct access to a women's health specialist	105
§438.206(b)(3)		Provides for a second opinion from a qualified health care professional	105
§438.206(b)(4)		Adequately and timely coverage of services not available in network	102
§438.206(b)(5)		Out-of-network providers coordinate with the MCO or PIHP with respect to payment	102
§438.206(b)(6)		Credential all providers as required by §438.214	106-107
§438.206(b)(7)		Demonstrate that network includes sufficient family planning providers to ensure timely access to covered services	105
§438.206(c)(1)(i)		Providers meet state standards for timely access to care and services	107-108

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.206(c)(1)(ii)		Network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service	102
§438.206(c)(1)(iii)		Services included in the contract available 24 hours a day, 7 days a week	49 102 107
§438.206(c)(1)(iv)-(vi)		Mechanisms to ensure compliance by providers	102-103 107-108
§438.206(c)(2)		Culturally competent services to all members	76 94 108
§438.206(c)(3)		Ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities	85-86 106-108
§438.207 Subpart D Requirements		**Assurances of Adequate Capacity and Services**	
§438.207(a)		Assurances and documentation of capacity to serve expected enrollment	107-108
§438.207(b)(1)		Offer an appropriate range of preventive, primary care, and specialty services	107
§438.207(b)(2)		Maintain network sufficient in number, mix, and geographic distribution	107
§438.208 Subpart D Requirements		**Coordination and Continuity of Care**	
§438.208(b)(1)		Each member has an ongoing source of primary care appropriate to his or her needs	105
§438.208(b)(2)		All services that the member receives are coordinated with the services the member receives from any other MCO/PIHP	105

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.208(b)(4)		Share with other MCOs, PIHPs, and PAHPs serving the member with SHCN the results of its identification and assessment to prevent duplication of services	94
§438.208(b)(5)		Provider maintains and shares, as appropriate, an enrollee health record in accordance with professional standards	105
§438.208(b)(6)		Protect member privacy when coordinating care	111
§438.208(c)(1)		State mechanisms to identify persons with SHCN	94
§438.208(c)(2)		Mechanisms to assess members with SHCN by appropriate health care professionals	94
§438.208(c)(3)		If applicable, treatment plans developed by the member's primary care provider with member participation, and in consultation with any specialists caring for the member; approved in a timely manner; and in accord with applicable state standards	94
§438.208(c)(4)		Direct access to specialists for members with SHCN	94
§438.210 Subpart D Requirements		**Coverage and Authorization of Services**	
§438.210(a)(1)		Identify, define, and specify the amount, duration, and scope of each service	104
§438.210(a)(2)		Services are furnished in an amount, duration, and scope that is no less than the those furnished to beneficiaries under fee-for-service Medicaid	104
§438.210(a)(3)(i)		Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished	104
§438.210(a)(3)(ii)		No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition	105
§438.210(a)(4)		Each MCO/PIHP may place appropriate limits on a service, such as medical necessity	105
§438.210(a)(5)		Specify what constitutes “medically necessary services”	105-106
§438.210(b)(1)		Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services	105-106

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.210(b)(2)		Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions	106
§438.210(b)(3)		Any decision to deny or reduce services is made by an appropriate health care professional	106
§438.210(c)		Each MCO/PIHP must notify the requesting provider, and give the member written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested	106
§438.210(d)		Provide for the authorization decisions and notices as set forth in §438.210(d)	112
§438.210(e)		Compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services	106
§340(b)(5)		**Transition of Care Policy**	
42 CFR §438.340(b)(5), 42 CFR §457.1240(e), cross-referencing §438.62(b)	II.E.5 Transition of Care Policy 42 CFR §438.340(b)(5), 42 CFR §457.1240(e), cross-referencing §438.62(b)	**CFR Description:** The state must include a description of its transition of care policy. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** Review the transition of care policy to ensure the following requirements are addressed: • The beneficiary has access to services consistent with the access that the beneficiary previously had and is permitted to retain a current provider for a period of time if that provider is not in the MCO, PIHP, or PAHP network. • The beneficiary is referred to appropriate providers of services that are in the network. • The state (if the beneficiary was enrolled in fee-for-service (FFS) (Medicaid), or an MCO, PIHP, PAHP, PCCM, or PCCM entity will fully and timely comply with requests for historical utilization data from the new MCO, PIHP, PAHP, PCCM or PCCM entity. • Consistent with federal and state law, the enrollee's new providers are able to obtain copies of the enrollee's medical records, as appropriate.	105

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		• The process for the electronic exchange of beneficiary data. • Any other necessary procedures, as specified by the state, to ensure continued access to services to 1) prevent serious detriment to the enrollee's health or 2) reduce the risk of hospitalization or institutionalization.	

Structure and Operations Standards

Table 19—Structure and Operations Standards

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.214 Subpart D Requirements		**Provider Selection**	
§438.214(a)		Written policies and procedures for selection and retention of providers	106-107
§438.214(b)(1)		Uniform credentialing and recredentialing policy that each MCO/PIHP must follow	106-107
§438.214(b)(2)		Documented processes for credentialing and recredentialing that each MCO/PIHP must follow	107
§438.214(c)		Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment	107
§438.214(d)		MCOs/PIHPs may not employ or contract with providers excluded from Federal health care programs	107
§438.214(e)		Comply with any additional requirements established by the state	107
§438.10		**Information Requirements**	
§438.10		Incorporate member information requirements of §438.10	85 110
§438.224		**Confidentiality**	

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
Subpart D Requirements			
§438.224		Individually identifiable health information is disclosed in accordance with Federal privacy requirements	111
§438.56		**Enrollment and Disenrollment**	
§438.56		Each MCO/PIHP contract complies with the enrollment and disenrollment requirements and limitations set forth in §438.56	111
§438.228 Subpart D Requirements		**Grievance and Appeal Systems**	
§438.228(a)		Grievance systems meet the requirements of Part 438, subpart F	112
§438.228(b)		If applicable, random state reviews of notice of action delegation to ensure notification of members in a timely manner	NA
§438.230 Subpart D Requirements		**Subcontractual Relationships and Delegation**	
§438.230(b)(1)		Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities	113
§438.230(b)(1)		Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform	113
§438.230(c)(1)		Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	113
§438.230(c)(1)(iii)		Monitoring of subcontractor performance on an ongoing basis	113
§438.230(c)(1)(iii)		Corrective action for identified deficiencies or areas for improvement	113

Measurement and Improvement Standards

Table 20—Measurement and Improvement Standards

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.236 Subpart D Requirements		**Practice Guidelines**	
§438.236(b)		Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of members; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate.	114-115
§438.236(c)		Dissemination of practice guidelines to all providers, and upon request, to members	114-115
§438.236(b)	II.F.2 Clinical Practice Guidelines 42 CFR §438.340(b)(1), 42 CFR §§457.1240(e), 438.236 and 457.1233(c)	**CFR Description:** The state must include examples of evidence-based clinical practice guidelines that it requires plans to use. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** Detail examples of clinical practice guidelines or link to guidelines contained in a separate document.	114-115
§ 438.330		**Quality Assessment and Performance Improvement Program**	
§438.330(a)(3)		An ongoing quality assessment and performance improvement program	115
§438.330(b)(1) §438.330(b)(2) §438.330(b)(3)	II.E.4 Performance Improvement Projects (PIP) and Interventions 42 CFR §438.340(b)(3)(ii);	Each MCO and PIHP must conduct PIPs List out PIPs in the quality strategy **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** The state must identify the PIPs to be implemented in accordance with the state's QAPI program, including a description of any interventions it proposes to improve access, quality, or timeliness of care for	115-116 Appendix C

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
	42 CFR §§457.1240(e); 438.330(d); 457.1240(b)	beneficiaries enrolled in an MCO, PIHP, PAHP, or PCCM entity. If CMS has specified a PIP, the state must include a description of PIPs required by CMS. **Toolkit Requirement:** • For each PIP that MCPs implement, consider including information on the PIP topic, aim, and intervention. • All PIPs should be included in the EQR PIP validation activity. Therefore, the state can reference its EQR reports for information on them.	
§438.330(d)		Conduct performance improvement projects, including any performance improvement projects required by CMS, that focus on both clinical and nonclinical areas: • Measurement of performance using objective quality indicators • Implementation of interventions to achieve improvement in the access to and quality of care • Evaluation of the effectiveness of the interventions based on the performance measures in the quality strategy • Planning and initiation of activities for increasing or sustaining improvement	117-118 Appendix C
§438.330(d)(3)		Report the status and results of each project conducted, not less than once per year	117-118
§438.330(b)(2)		Measure and report to the state on its performance, using the standard measures or performance data as specified by the state	101 117-118
§438.330(c)(i)		Identify standard performance measures, including those performance measures that may be specified by CMS	117-118 Appendix D
§438.330(c)(ii)		In the case of an MCO, PIHP, or PAHP providing long-term services and supports: Identify standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving long-term services and supports	117-118 Appendix D
§438.330(b)(3)		Mechanisms to detect both underutilization and overutilization of services	36 44

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.330(b)(4)		Mechanisms to assess the quality and appropriateness of care furnished to members with SHCN	80
§438.330(b)(5)(i) §438.330(b)(5)(ii)		For MCOs, PIHPs, or PAHPs providing long-term services and supports: Mechanisms to assess the quality and appropriateness of care furnished to enrollees using long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan, if applicable; and Participate in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare that are based, at a minimum, on the requirements on the State for home and community-based waiver programs per §441.302(h).	104
§438.330(e)		Annual review by the state of each quality assessment and performance improvement program. If the state requires that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program, indicate this in the quality strategy. The review must include: • Performance on the measures on which it is required to report • The outcomes and trended results of performance improvement projects • The results of any efforts to support community integration for enrollees using long-term services and supports • *May* require a developed process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program	38 117-118
§ 438.242 Subpart D Requirements		**Health Information Systems**	
§438.242(a)		Each MCO and PIHP must maintain a health information system that can collect, analyze, integrate, and report data and is not limited to utilization, claims, grievance and appeals, and disenrollments for other than loss of Medicaid eligibility	119

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.242(b)(2)		Each MCO and PIHP must collect data on member and provider characteristics and on services furnished to members	119
§438.242(b)(3)		Each MCO and PIHP must ensure data received, including capitated data, is accurate and complete, screened for data completeness, logic and consistency, and is collected in standardized formats including secure information exchanges and technologies	119
§438.242(c)(1)		Each MCO collects and maintains sufficient enrollee encounter data to identify the providers who deliver any items or services to enrollees	119
§438.242(c)(2)		Each MCO submits enrollee encounter data to the state at a frequency and level of detail specified by CMS or the state based on program administration, oversight, and program integrity needs	119
§438.242(c)(3)		Each MCO submits enrollee encounter data, including allowed amount and paid amount, to the state	119
§438.242(c)(4)		Specifications for submitting encounter data to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate	119
Optional		Include any health information technology (HIT) initiatives that will support the objectives of the state's quality strategy.	119

Improvement and Interventions

Table 21—Improvement and Interventions

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
Optional		Describe, based on the results of assessment activities, how the state will attempt to improve the quality of care delivered by MCOs and PIHPs through interventions such as, but not limited to: 1. Cross-state agency collaborative;	10 24 37 89-92

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		2. Pay-for-performance or value-based purchasing initiatives; 3. Accreditation requirements; 4. Grants; 5. Disease management programs; 6. Changes in benefits for members; 7. Provider network expansion, etc.	
Optional		Describe how the state's planned interventions tie to each specific goal and objective of the quality strategy.	10 13-16

Intermediate Sanctions

Table 22—Intermediate Sanctions

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.340(b)(7) 42 CFR Part 438, subpart I		For MCOs, detail how the state will appropriately use intermediate sanctions that meet the requirements of 42 CFR Part 438, subpart I.	89
Optional		Specify the state's methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems.	89
§438.340(b)(7) 42 CFR Part 438, subpart I *Note: The CFR does not include the level of detail that is included in*	II.F.3 Intermediate Sanctions 42 CFR §438.340(b)(7), 42 CFR §457.1240(e), Part 438 Subpart I	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** For MCOs, the state must include appropriate use of intermediate sanctions that, at a minimum, meet the sanctions requirements in Part 438 subpart I. **Toolkit Requirement:** • Indicate whether the state applied any intermediate sanctions to any MCP in the past three years, the number and types of those sanctions, and for what	89-92

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
the Quality Strategy Toolkit.		reasons. The state can determine whether to describe the sanctions it applied at the MCP level or the aggregate level. • Describe other actions taken in the past three years to enforce MCP compliance with state and federal rules, such as corrective action plans.	

Conclusions and Opportunities

Table 23—Conclusions and Opportunities

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
Optional		Identify any successes that the state considers to be best or promising practices.	39-48
Optional		Include a discussion of the ongoing challenges the state faces in improving the quality of care for beneficiaries.	13 28-29 39-51 61
Optional		Include recommendations that the state has for ongoing Medicaid and CHIP quality improvement activities in the state. Highlight any grants received that support improvement of the quality of care received by managed care members, if applicable.	NA

★ Appendix B. Performance Measure Metrics ★

Table 24—Performance Measure Metrics

Measure Name	Data Source	Measure Steward *(if applicable)*
Goal 1: Enhance the Member Care Experience		
Objective 1.1 Increase Member Engagement and Outreach		
1.1.1.1. Number of Outreach and Engagement (O&E) Activities Per year	MCO Reporting	DMAS
1.1.1.2 Monitor Language and Disability Access Reports	DMAS	DMAS
1.1.1.3 Monitor Member Language Counts	DMAS	DMAS
Objective 1.2 Improve Member Satisfaction		
1.2.1.1 Enrollees' Ratings Q8-Rating of all Health Care	CAHPS CMS Child Core Set CMS Adult Core Set	AHRQ
1.2.1.2 Rating of Personal Doctor	CAHPS CMS Child Core Set CMS Adult Core Set	AHRQ
★ Goal 2: Promote Access to Safe, Gold-Standard Patient Care ★		
Objective 2.1 Ensure Access to Care		
2.1.1.1 Getting Care Quickly Q6	CAHPS CMS Child Core Set CMS Adult Core Set	AHRQ
2.1.1.2 Respondent Got Non-Urgent Appointment as Soon as Needed	CAHPS CMS Child Core Set CMS Adult Core Set	AHRQ
2.1.1.3 Getting Needed Care	CAHPS CMS Child Core Set CMS Adult Core Set	AHRQ
Objective 2.2 Promote Patient Safety		
2.2.1.1 Prevalence of Pressure Ulcers Among LTSS Members	DMAS	DMAS
2.2.1.2 Monitor the Frequency of Reported Critical Incidents by Member Classification	DMAS	DMAS
Objective 2.3 Promote Effective Communication and Care Coordination		
2.3.1.1 How Well Doctors Communicate	CAHPS CMS Child Core Set CMS Adult Core Set	AHRQ
2.3.1.2 Service Authorizations	MCO Reporting https://www.dmas.virginia.gov/data/mco-service-authorization-performance/	DMAS

Measure Name	Data Source	Measure Steward *(if applicable)*
★ Goal 3: Support Efficient and Value-Driven Care ★		
Objective 3.1 Focus on Paying for Value		
3.1.1.1 Frequency of Potentially Preventable Admissions	Clinical Efficiency Measures	DMAS
3.1.1.2 Frequency of Emergency Department Visits	Clinical Efficiency Measure	DMAS
3.1.1.3 Frequency of Potentially Preventable Emergency Department Visits	Clinical Efficiency Measures	DMAS
3.1.1.3 Frequency of Potentially Preventable Readmissions	DMAS	DMAS
3.1.1.4 Ambulatory Care	HEDIS	NCQA
3.1.1.5 Ambulatory Care: Emergency Department (ED) Visits	Clinical Efficiency Measures HEDIS CMS Child Core Set	DMAS NCQA
3.1.1.6 Days Without Minimum RN Hours	DMAS VBP Reporting Team CMS Payroll Based Journal	DMAS
3.1.1.7 Total Nurse Staffing Hours Per Resident Day (RN, LPN, CAN)—Case-Mix Adjusted	DMAS VBP Reporting Team CMS Nursing Home Compare	DMAS
3.1.1.8 Percentage of Long-Stay Resident with a Urinary Tract Infection (UTI)	DMAS VBP Reporting Team CMS Nursing Home Compare	DMAS
3.1.1.9 Number of Hospitalizations per 1,000 Long-Stay Resident Days	DMAS VBP Reporting Team CMS Nursing Home Compare	DMAS
3.1.1.10 Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days	DMAS VBP Reporting Team CMS Nursing Home Compare	DMAS
3.1.1.11 Percentage of Long-Stay High-Risk Residents with Pressure Ulcers	DMAS VBP Reporting Team CMS Nursing Home Compare	DMAS
Objective 3.2 Promote Efficient Use of Program Funds		
3.2.1.1 Monitor Medical Loss Ratio	DMAS—MCO Financials https://www.dmas.virginia.gov/data/mco-financials/	DMAS
Goal 4: Strengthen the Health of Families and Communities		
Objective 4.1 Improve the Utilization of Wellness, Immunization, and Prevention Services for Members		
4.1.1.1 Adults' Access to Preventive/Ambulatory Health Services	HEDIS	NCQA

Measure Name	Data Source	Measure Steward *(if applicable)*
4.1.1.2 Child and Adolescent Well-Care Visits	HEDIS CMS Child Core Set	NCQA
4.1.1.3 Childhood Immunization Status	HEDIS CMS Child Core Set	NCQA
4.1.1.4 Immunizations for Adolescents	HEDIS CMS Child Core Set	NCQA
4.1.1.5 Flu Vaccinations for Adults 18–64	CAHPS CMS Adult Core Set	AHRQ
4.1.1.6 Topical Fluoride for Children	CMS 416 CMS Child Core Set	CMS
4.1.1.7 Oral Evaluation, Dental Services	CMS 416 CMS Child Core Set	CMS
4.1.1.8 Sealant Receipt on Permanent First Molars	CMS Child Core Set CMS Child Core Set	CMS
4.1.1.9 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	HEDIS CMS Child Core Set	NCQA
4.1.1.10 Chlamydia Screening in Women Ages 16 to 20	HEDIS CMS Child Core Set	NCQA
4.1.1.11 Lead Screening in Children	HEDIS CMS Child Core Set	NCQA
★ Objective 4.2 Improve Outcomes for Maternal and Infant Members ★		
4.2.1.1 Prenatal and Postpartum Care: Postpartum Care	HEDIS CMS Adult Core Set	NCQA
4.2.1.2 Prenatal and Postpartum Care: Timeliness of Prenatal Care	HEDIS CMS Child Core Set	NCQA
4.2.1.3 Live Births Weighing Less than 2,500 Grams	CDC Wonder State Vital Statistics CMS Child Core Set	CMS
4.2.1.4 Well-Child Visits in the First 30 Months of Life	HEDIS CMS Child Core Set	NCQA
4.2.1.5 Low-Risk Cesarean Delivery	CMS Child Core Set	CDC
Objective 4.3 Improve Home and Community-Based Services		
4.3.1.1 Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and Appropriate to Their Needs and Personal Goals	QMR	DMAS
4.3.1.2 Number and Percent of Individuals Who Received Services in the Scope Specified in the Service Plan	QMR	DMAS
Goal 5: Providing Whole-Person Care for Vulnerable Populations		
Objective 5.1 Improve Outcomes for Members with Chronic Conditions		

Measure Name	Data Source	Measure Steward *(if applicable)*
5.1.1.1 PQI 08: Heart Failure Admission Rate	Performance Measure CMS Adult Core Set	AHRQ
5.1.1.2; PDI 14: Asthma Admission Rate (Ages 2–17)	Performance Measure	AHRQ
5.1.1.3 PQI 05: COPD and Asthma in Older Adults' Admission Rate	Performance Measure CMS Adult Core Set	AHRQ
5.1.1.4 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	HEDIS CMS Adult Core Set	NCQA
5.1.1.5 Controlling High Blood Pressure	HEDIS	NCQA
5.1.1.6 Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years	HEDIS CMS Child Core Set	NCQA
5.1.1.7 Asthma Medication Ratio: Ages 5 to 18 Years	HEDIS CMS Child Core Set	NCQA
Objective 5.2 Improve Outcomes for Nursing Home Eligible Members		
5.2.1.1 Use of High-Risk Medications in Older Adults (Elderly)	HEDIS	NCQA
★ Objective 5.3 Improve Outcomes for Members with Substance Use Disorders ★		
5.3.1.1 Monitor Identification of Alcohol and Other Drug Services	DMAS	DMAS
5.3.1.2 Follow-Up After Emergency Department Visit for Substance Use	HEDIS CMS Child Core Set CMS Adult Core Set	NCQA
5.3.1.3 Use of Opioids at High Dosage in Persons Without Cancer	HEDIS CMS Adult Core Set	NCQA
5.3.1.4 Initiation and Engagement of Substance Use Disorder Treatment	HEDIS CMS Adult Core Set	NCQA
5.3.1.5 Use of Pharmacotherapy for Opioid Use Disorder	CMS Adult Core Set	CMS
★ Objective: 5.4 Improve Behavioral Health and Developmental Services for Members ★		
5.4.1.1 Follow-Up After Hospitalization for Mental Illness	HEDIS	NCQA
5.4.1.2 Follow-Up After Emergency Department Visit for Mental Illness	HEDIS CMS Adult Core Set	NCQA
5.4.1.3 Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	HEDIS CMS Child Core Set	NCQA
5.4.1.4 Monitor Mental Health Utilization	DMAS	DMAS

Measure Name	Data Source	Measure Steward *(if applicable)*
5.4.1.5 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	HEDIS CMS Child Core Set	NCQA
5.4.1.6 Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS CMS Child Core Set	NCQA
5.4.1.7 Medical Assistance with Smoking and Tobacco Use Cessation	CAHPS CMS Adult Core Set	NCQA
5.4.1.8 Antidepressant Medication Management	HEDIS CMS Adult Core Set	NCQA
5.4.1.9 Screening for Depression and Follow-Up Plan: Ages 18 and Older	CMS Adult Core Set	CMS
5.4.1.10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS CMS Adult Core Set	NCQA
5.4.1.11 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	HEDIS CMS Adult Core Set	NCQA
5.4.1.12 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	HEDIS CMS Adult Core Set	NCQA

★ These goals are inclusive of Governor Glenn Youngkin's identified priorities for the Medicaid program that focus on behavioral health enhancement, maternal health outcomes, and access to high quality healthcare services.

Table 25—Aspirational Performance Measure Metrics

Measure Name	Data Source	Measure Steward *(if applicable)*
Goal 1: Enhance the Member Care Experience		
Objective 1.2 Improve Member Satisfaction		
1.2.1.3 Timely Processing of Member Applications, Renewals, and Appeals	DMAS	DMAS
Goal 2: Promote Access to Safe, Gold-Standard Patient Care		
Objective 2.1 Ensure Access to Care		
2.1.1.4 Monitor Network Adequacy by Region and Provider Types	MCO Reporting	DMAS
2.1.1.5 Monitor Frequency and Reasons for Missed Trips	MCO Reporting	DMAS
2.1.1.6 Cervical Cancer Screening	HEDIS CMS Adult Core Set	NCQA
2.1.1.7 Chlamydia Screening in Women Ages 21 to 24	HEDIS CMS Adult Core Set	NCQA

Measure Name	Data Source	Measure Steward *(if applicable)*
2.1.1.8 Colorectal Cancer Screening	HEDIS CMS Adult Core Set	NCQA
2.1.1.9 Breast Cancer Screening	HEDIS CMS Adult Core Set	NCQA
2.1.1.10 Contraceptive Care—Postpartum Women Ages 21 to 44	CMS Adult Core Set	OPA
2.1.1.11 Contraceptive Care—All Women Ages 21 to 44	CMS Adult Core Set	OPA
2.1.1.12 Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 18 and Older	HEDIS CMS Adult Core Set	NCQA
2.1.1.13 Asthma Medication Ratio: Ages 19 to 64	HEDIS CMS Adult Core Set	NCQA
2.1.1.14 HIV Viral Load Suppression	CMS Adult Core Set	HRSA
2.1.1.15 Concurrent Use of Opioids and Benzodiazepines	CMS Adult Core Set	PQA
Goal 3: Support Efficient and Value-Driven Care		
Objective 3.2 Promote Efficient Use of Program Funds		
3.2.1.1 Number of Administrative and Medical Deferrals and Disallowances;	DMAS—MCO Financials https://www.dmas.virginia.gov/data/mco-financials/	DMAS
3.2.1.3 Diabetes Short-Term Complications Admission Rate	CMS Adult Core Measure Set	AHRQ
3.2.1.4 Heart Failure Admission Rate	CMS Adult Core Measure Set	AHRQ
3.2.1.5 Asthma in Younger Adults Admission Rate	CMS Adult Core Measure Set	AHRQ
3.2.1.6 Plan All-Cause Readmission Rate	HEDIS CMS Adult Core Measure Set	NCQA
Objective 5.2 Improve Outcomes for Nursing Home Eligible Members		
5.2.1.2 Nursing Facility Residents Hospitalization Rate	DMAS	DMAS
5.2.1.3 CCC Plus (MLTSS) Waiver Members Who Re-Enter the Community After a Short-Term Nursing Facility Stay	DMAS	DMAS
5.2.1.4 Members Who Transitioned from a Nursing Facility to the Community Who Returned to the Nursing Facility Within 90 Days	DMAS	DMAS

Measure Name	Data Source	Measure Steward *(if applicable)*
5.2.1.5 Long-Term Services and Supports Comprehensive Care Plan and Update	HEDIS CMS Adult Core Set	NCQA
5.2.1.6 National Core Indicators Survey	Survey	National Association of State Directors of Development Disabilities Services/HSRI

Appendix C. Performance Improvement Topics

Table 26—Performance Improvement Projects 2023

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
Aetna Better Health of Virginia	Ensuring Timeliness of Prenatal Visits	Do targeted interventions increase the percentage of deliveries that had a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Aetna Better Health of Virginia?	Percentage of deliveries that had a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.	Care management (CM) will outreach members within 15-days of receiving a monthly maternal care report. CM will outreach identified pregnant members and assist the member during the prenatal screening process. CM will focus on ensuring that members have an OB/GYN provider and will follow up with members within 15-days of making an appointment referral that accommodates the member's schedule.
	Tobacco Use Cessation in Pregnant Women	Do targeted interventions increase the percentage of pregnant women screened for tobacco use during at least one prenatal visit?	Percentage of pregnant women who are screened for tobacco use.	A fax blast was sent to all three provider types: OB/GYNs, family practitioners, and general practitioners. The fax blast included provider talking points and member resources for tobacco use cessation, correct codes to submit to indicate that the counseling was completed and information on smoking cessation programs and pharmaceutical treatment options for the provider to educate their pregnant members.
	Ambulatory Care—Emergency Department Visits	Do targeted interventions decrease emergency department visits for the eligible population?	The percentage of members in the entire eligible population aligned with HEDIS AMB-ED measure specifications and who had more than one ED visit within the measurement period.	Case manager educates the member on availability of 24-hour nurse line services and ED/ER utilization at each phone contact.
	Follow-Up After Discharge	Do targeted interventions increase the percentage of	The percentage of members who were hospitalized and had an	Implementation of an automated alerts process using Med Compass when a member is admitted to or discharged from an inpatient facility.

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
		members who were hospitalized and had an ambulatory follow-up visit with a primary care provider or licensed provider within 30-days of discharge?"	ambulatory follow-up visit with a primary care provider or licensed provider within 30 days of discharge.	Initiate a Transition of Care Coordinators (TCC) contract for members with ED criteria of three visits in 90-days and/or ER visit post fall. If the member has a risk assessment profile (RAP) score of greater than 50, the TCC will call the member while in the hospital, assist with a discharge plan as appropriate, and follow for discharge date to transition to care management for post discharge follow-up. Care manager conducts a post discharge follow-up call to member who met intervention criteria and have a RAP score of 49.9 or less (low risk) to remind member of follow-up visit and answer any post discharge questions.
HealthKeepers, Inc.	Timeliness of Prenatal Care	Do targeted interventions increase the percentage of deliveries that had a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with the organization?"	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.	Send informative and educational text messages to members regarding timely prenatal visits, as a reminder to make an appointment with their Obstetrics (OB) provider. Generated HEDIS tags in Pointclickcare (Collective Medical) using identified Gap in Care report to alert care coordinators to HEDIS gaps and generate a return report from Pointclickcare overlaying gaps with emergency room visits in real time. Provide education to members on the value of prenatal visits by informing them of the Doula benefit via flyer and text message. Developed a report that identifies members with SDOH needs, including pregnant members, for care coordinators/care managers to outreach the members and assist with addressing the identified SDOH needs. Extended Pay for Quality Provider Incentive Programs for providers. This program allows the providers to earn

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
				incentives for closing gaps in care earlier in the year to allow for additional gap closures. Hired an additional OB Practice Consultant to increase participation in the OBQIP (Obstetric Quality Incentive Program) that incentivizes providers for improving maternal performance indicators, including timely prenatal care. Added Timeliness of Prenatal Care measure to Provider Incentive Category II program to encourage providers to use the correct codes for billing.
	Tobacco Use Cessation in Pregnant Women	Do targeted interventions increase the percentage of deliveries that were screened for tobacco use during at least one prenatal care visit?	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization who had screening for tobacco use within one of the first two prenatal visits. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization who had screening for tobacco use within one of the first two prenatal visits and if screen was	Informative and/or educational text messages via mPulse to members regarding timely prenatal visits, as a reminder to make an appointment with their OB and educate members on tobacco cessation. OB Practice Consultants meet with providers in the OBQIP provider incentive program to close prenatal and postpartum gaps in care. Consultants encourage providers to refer members to 1-800-QuitNow or to the care management team for other resources. Care coordinators and case managers educate members regarding the dangers of smoking and tobacco use, the different forms of tobacco use such as vaping, and the different modalities for cessation, including support groups.

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
			positive for smoking subsequently received counseling/advice for smoking cessation.	
	Ambulatory Care—Emergency Department Visits	Do targeted interventions decrease the percentage of emergency department visits that do not result in an inpatient encounter?	The percentage of ED encounters during the measurement period that did not result in an inpatient encounter.	Collaborative Insights Process provides seamless coordination of transitions of care through the emergency room, inpatient, and discharge planning for members. This intervention will provide community inpatient providers with available member resources that promote health maintenance in the community and encourage primary care utilization to reduce emergency room utilization and in-patient readmissions.
	Follow-Up After Discharge	Do targeted interventions increase the percentage of inpatient discharges that had an ambulatory follow-up visit within 30 days?"	The percentage of discharges where the member had an ambulatory follow-up visit within 30 days of discharge .	Dispatch health is a full-service in-home care continuum that provides medical services and addresses social needs in a member's home in the Central and Nova areas. Dispatch Health will provide Bridge Care visits post-hospitalization within 24-72 hours of discharge. If a member lives in the service area, care coordinators educate the member and hospital discharge planner on Dispatch Health and Bridge Care and will refer the member to Bridge Care prior to the hospital discharge if the member offers consent. Collaborative Insights Process provides seamless coordination of transitions of care through the emergency room, inpatient, and discharge planning for members. This intervention will provide community inpatient providers with available member resources that promote health maintenance in the community and encourage primary care utilization to reduce emergency room utilization and in-patient readmissions.
Molina	Timeliness of Prenatal Care	Do targeted interventions increase the percentage of deliveries that had a prenatal care visit in the	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment	Member outreach: The outreach allows for additional support to be incorporated to ensure multiple attempts are made to reach members and their assigned providers to collect and update information for the purposes of

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
		first trimester, on or before the enrollment start date, or within 42 days of enrollment with Molina Complete Care of Virginia?	start date, or within 42 days of enrollment with Molina Complete Care as defined by the HEDIS PPC measure specifications.	education, provider alignment, and appointment scheduling. Provider quality meetings are conducted with education provided on available resources, coding, required documentation, data sharing, and scheduling members for timely appointments.
	Tobacco Use Cessation in Pregnant Women	Do targeted interventions decrease the use of tobacco products or smoking in pregnant women?	The percentage of pregnant members as defined by the HEDIS PPC measure specifications who have quit smoking or use of tobacco products while pregnant during the measurement period.	Member outreach: The MCO uses various tools to identify alternative methods of communication or contact information and will target all prenatal members after three attempts have been made by the health care service team.
	Ambulatory Care—Emergency Department Visits	Do targeted member education and engagement interventions reduce the rate of ED visits that do not result in an inpatient stay?	The percentage of ED visits that did not result in an inpatient stay during the measurement period.	Provider Quality Meetings: The MCO will share a list of frequent ED utilizers to target for outreach and support and provide education on the measurement requirements. Targeted meeting includes action items, actionable data, and resources to promote engagement and intervention activities. Care coordinators outreach members to provide support, raise awareness, and address any social needs of the members to help members navigate the health system through connecting members with primary care providers and providers with extended hours and/or urgent care facilities to reduce the use of ED visits
	Follow-Up After Discharge	Do targeted interventions increase the percentage of inpatient discharges for members 18 years of age and older that had	The percentage of members provided patient engagement and follow-up service within 30 days after inpatient discharge	Targeted member outreach by Healthcare Services Team: Outreach includes appointment scheduling assistance, educate the member on the importance of timely care, and offer additional support for areas of concern.

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
		an ambulatory follow-up visit within 30 days of discharge?	during the measurement period.	Members who are identified as “Unable to Contact” are sent to the unable to contact designated team to help identify alternate contact information. Research is completed in various settings to identify contact information. Letters are also mailed when no additional information has been collected. In conjunction of research for the unable to contact members, the assigned primary care provider is outreached to help identify additional contact information as well. Provider Quality Meetings. Provider quality meetings are conducted to engage providers and provide actionable data. Quality improvement (QI) department is conducting outreach to support provider groups with scheduling new member appointments. QI and network departments are working with members to update provider as directed by members when members express having a primary care provider, but they are assigned to a different provider. Outreach conducted to raise awareness of the importance of primary care services and completion of preventative screenings to increase the number of members completing wellness and preventative screenings.
Optima Health Community Care	Timeliness of Prenatal Care	Do targeted interventions increase the percentage of deliveries who received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.	Increase case management efforts and utilize the maternity assessment for pregnant Medallion 4.0 (Acute) members. The Partners in Pregnancy (PIP) team receives a monthly member enrollment list from DMAS. Based on this list, the

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
		days of enrollment in the organization?		PIP team outreaches members and completes a maternity assessment. The MCO utilizes Ovia a digital application so members can have real-time access to pregnancy information at their own pace. The Ovia information is posted on our Optima Health website for easy access. Ovia also provides the MCO with a monthly list of Medallion 4.0 (Acute) members who accessed the pregnancy topic in the application.
	Tobacco Use Cessation in Pregnant Women	Do targeted interventions increase the percentage of identified non-smoking pregnant members during the measurement period?	The percentage of identified non-smoking pregnant members during the measurement period.	Increase case management efforts and utilize the maternity assessment to identify pregnant smokers. The Partners in Pregnancy (PIP) team receives a monthly member enrollment list from DMAS. Based on this list, the PIP team outreaches members and completes a maternity assessment. This assessment includes a question about smoking. It asks: Do you smoke? Optima's analytics team provides a monthly report from the JIVA application that includes the number of completed assessments completed and the number of members who answered "Yes" to the question of: Do you smoke? The PIP team offers educational materials to these identified smoking pregnant members. Offer Emmi educational videos that are easily accessible. Optima Health sends the Emmi video links to pregnant Medallion 4.0 (Acute) members on a cadence by trimester. The member registers for the Emmi video and will be able to access Tobacco Cessation videos. The Emmi vendor can identify members who were accessed the educational videos and viewed the videos assigned. The Emmi vendor also provides a monthly report to Optima.

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
	Ambulatory Care—Emergency Department Visits	Do targeted interventions decrease the percentage of ED visits during the measurement period?	The percentage of utilization of emergency department visits among Optima Health Community Care enrolled members.	Identify providers with the lowest acuity non-emergent emergency department (LANE) visits. The business analyst uses claims with LANE top 10 diagnosis and national provider identifier (NPI) number of the primary care providers and practice, to identify opportunities for educating the providers. The Network management team provides education with newsletters and email blasts. Education includes reminders about other options for care for members in the health plan. Provide case management and education to LANE members. Using specific reports, the transition care coordinator (TCC) completes a triggering event encounter (TEE) and sends a reminder to the care coordinator (CC) to complete TEE in specified timeframe. The TCC sets a reminder to follow up on TEE completion within the specified timeframe. TCC completes telephone call and reminder to CC to complete a Face-to-Face (FTF) TEE assessment with member. During the assessment, services are identified, and education is provided to the member to mitigate high ED utilization and referrals are generated as appropriate. Identify transportation issues. The business analyst pulls data from claims and the data is reviewed and discussed by the LANE subcommittee and Clinical Efficiency Committee to identify opportunities for improvement.
	Follow-Up After Discharge	Do targeted interventions increase the percentage of discharges for which the member had a 30-day follow-up visit (can include outpatient visits, telephone visits, transitional care	The percentage of follow-up after hospital discharge amongst Optima Health Community Care (OHCC)-enrolled members.	TCC's work with members, the members' care coordinators and the treatment team to facilitate safe and effective treatment that supports the appropriate next level of care that prevents over or under utilization of services and improves member outcomes. An assessment is initiated for each admission. The assessment is used to document TCC activity. Care plan will be transitioned to the care coordinator after member is discharged from the acute facility.

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
		services, and e-visits/virtual check-ins) during the measurement period?"		The following are completed during the TOC assessment: If after three calls and the TCC is unable to contact member, the TCC documents the attempts in the Discharge Planning Contact Log . TCCs ensure members have a follow-up appointment scheduled and if there are no appointments available within 30 days, the case coordinators assist the member in locating an alternative solution.
UnitedHealthcare Community Care Plan	Timeliness of Prenatal Care	Targeted interventions supported by the Virginia UnitedHealthcare Medallion Plan and focused on member outreach and engagement will increase the percentage of women who receive a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment for the Medallion 4.0 (Acute) population	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.	Redesigning the maternity program to focus on identifying healthy pregnant members with no prenatal care upon enrollment into the health plan and conduct case management outreach to encourage these members to complete prenatal care visits at recommended intervals.
	Tobacco Use Cessation in Pregnant Women	Targeted interventions supported by the Virginia UnitedHealthcare Medallion Plan and focused on member engagement increase the percentage of pregnant women (identified as tobacco	The percentage of pregnant women using tobacco who received smoking cessation services.	Define and implement a process to integrate claims and other data sources to identify and capture more pregnant members who have a history of current tobacco use into the case management process for member outreach and follow-up by case manager.

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
		users) who receive advice to quit smoking and/or who discussed or were provided cessation methods or strategies among pregnant women		
	Ambulatory Care—Emergency Department Visits	Do targeted interventions decrease overall ED visits that do not result in an inpatient stay during the measurement period	The percentage of emergency department visits that did not result in an inpatient stay during the measurement period.	For medically complex members, care managers review the pre-manage report daily to identify members who had an ED visit. Pre-manage is a secure, web-based care management system that provides real-time information about patients receiving emergency department care. Care managers outreach identified members within 24-48 business hours following ED alert or discharge notification. Care managers complete ED follow-up script in communication care documentation platform. While on the phone with the member, the care manager reviews alternatives to ED care, identifies potential resource needs, and ensures appropriate follow-up care is scheduled.
	Follow-Up After Discharge	Do targeted interventions increase the percentage of patient engagements within 30-days after discharge	The percentage of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge.	Care managers/vendor run a discharge report to identify the number of discharges and number of post hospital assessments (PHA) and triggering event health risk assessments (HRAs) completed following an inpatient stay and ensure PHAs are completed within 72 hours of discharge. The vendor manager reviews and analyzes the data to identify trends and barriers, then shares the results in monthly committee meetings.

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
				Pending results, corrective action plan will be implemented to address barriers to completing the PHAs.
Virginia Premier	Timeliness of Prenatal Care	Do targeted interventions increase the percentage of deliveries who had a prenatal care visit during the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the Virginia Premier Health Plan during the measurement period	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.	Pregnancy incentive-based prenatal care program and early identification of pregnancy with outreach. Transportation through Verida OB registration program
	Tobacco Use Cessation in Pregnant Women	Do targeted interventions increase the percentage of pregnant members who report smoking cessation during the measurement year	The percentage of tobacco use cessation in pregnant members.	Referrals to community resources and to the internal SDOH social work team. Trained outreach team as Community Health Workers. Education to prenatal members by member and case management. Doula program.
	Ambulatory Care—Emergency Department Visits	Do targeted inventions decrease the rate of emergency department utilization among members enrolled in the Virginia Premier Health Plan	The percentage of emergency department visits in ambulatory care among members enrolled in the Commonwealth Coordinated Care (CCC) Plus (MLTSS) program.	Collective Medical report developed by Medical Director subject matter expert to identify low acuity non-emergent emergency department visits (LANE) diagnosis. Also, developed an ED cohort for initial ED visits and a Cohort for three or more ED visits within 90 days. Developed a high ED utilizer report for 10 or more and 20 and more ED visits. This report helps the team identify those members utilizing the ED for LANE-specific diagnoses. Implementation of high ED utilizer Rounds. Care manager team brings complex cases for members with five or more

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
				ED visits to determine the next approach or steps with managing these members. Outreach to the member to help educate them on when to use urgent care, primary care provider, and ED and the member is sent a “Where to Go flyer.” Determine if the member has an assigned primary care provider and connect them to Member Services should they need to change their assigned provider.
	Follow-Up After Discharge	Do targeted interventions increase the percentage of discharges that have a follow-up visit within 30 days after an inpatient discharge during the measurement period	The percentage of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge.	Referrals to community resources and referrals to the internal social determinants of health work team. Transition of Care coordinator conducts outreach to members following the current transitions of care model.

Note: Listed PIP interventions were documented by the MCOs with the reporting of baseline data in 2023 and are subject to change over the course of the PIP.

Appendix D. Goals Tracking Table

DMAS continues to monitor the impact of the COVID-19 pandemic on health plan business operations, including its potential effect on medical record data collection, limited access to provider offices, and quarantines and risk to staff. DMAS placed the health and well-being of healthcare workers and members as its top priority.

However, the pandemic had a significant impact on delivery of healthcare services. Many provider offices were closed and offered limited telehealth services. Initially, COVID-19 resulted in a lack of demand for healthcare services. Families deferred going to the doctor's office for routine, nonemergency care. DMAS required MCOs to extend authorizations and expanded the use of telehealth. DMAS also implemented flexibilities for care and services for members receiving LTSS. DMAS allowed flexibilities for specific face-to-face visit requirements and other HCBS. The flexibilities were designed to maintain provider staffing, maximize access to care, and minimize viral spread through community contact to protect the most vulnerable populations.

Decreased access and lack of scheduling of routine and preventive services, may have negatively impacted rates. The impact from COVID-19 was an environmental factor that was beyond DMAS' control and may have an impact on the overall achievement of goals and outcomes anticipated from the implementation of the Quality Strategy.

Table 27—Goals Tracking Table

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
Goal 1: Enhance the Member Care Experience	**Objective 1.1** Increase Member Engagement and Outreach	1.1.1.1. Number of Outreach and Engagement (O&E) Activities Per year	DMAS Cover Virginia	**Cover Virginia 2021:** Spanish Calls Taken by Spanish-Speaking Bilingual Staff: 73,088 **Cover Virginia 2021:** Calls Taken with Language Assistance Services: 50,902	Increase by X percent the Cover Virginia Spanish language calls taken by Spanish-speaking bilingual staff Increase by X percent the Cover Virginia calls taken with language assistance by 2025 Increase by X percent the Medallion 4.0 call center language calls taken by 2025	Maintain or increase these statistics by a minimum of 1%.

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Medallion 4.0 (Acute) Call Center Language Calls 2021: 7,551 **CCC Plus (MLTSS)** Call Center Language Calls 2021: 545 **2021 DMAS Website** Translation Requests 2021: 3,489	Increase by X percent the CCC Plus call center language calls taken by 2025. Increase by X percent the translation requests taken by 2025	
		1.1.1.2 Monitor Language and Disability Access Reports	DMAS	• CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Increase by X percent the Language and Disability Access report monitoring: Cardinal Care Program:	Maintain or increase these stats by a minimum of 1%.
		1.1.1.3 Monitor Member Language Counts	DMAS	• CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Increase by X percent the Member Language Counts reported : Cardinal Care Program:	Maintain or increase these stats by a minimum of 1%.
	Objective 1.2 Improve Member Satisfaction	1.2.1.1 Enrollees' Ratings Q8-Rating of all Health Care	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus (MLTSS): 68.5% • Medallion 4.0 (Acute): 75.7% Adult:	Increase the Cardinal Care annual CAHPS overall Rating of *all Health Care* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	Use CAHPS benchmarks

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• CCC Plus (MLTSS): 58.7% • Medallion 4.0 (Acute): 55.8%		
		1.2.1.2 Rating of Personal Doctor	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus (MLTSS): 79.5% • Medallion 4.0 (Acute): 77.7% Adult: • CCC Plus (MLTSS): 72.8% • Medallion 4.0 (Acute): 68.0%	Increase the Cardinal Care annual CAHPS overall Rating of *Personal Doctor* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	Use CAHPS benchmarks
★ **Goal 2:** Promote Access to Safe, Gold-Standard Patient Care	**Objective 2.1** Ensure Access to Care	2.1.1.1 Getting Care Quickly Q6	CAHPS – AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus (MLTSS): 89.7% • Medallion 4.0 (Acute): 86.0% Adult: • CCC Plus (MLTSS): 85.0%	Increase the Cardinal Care annual CAHPS overall Rating of *Getting Care Quickly* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child	Use CAHPS benchmarks

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0 (Acute): 81.1%		
		2.1.1.2 Respondent Got Non-Urgent Appointment as Soon as Needed	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus (MLTSS): % • Medallion 4.0 (Acute): % Adult: • CCC Plus (MLTSS): % • Medallion 4.0 (Acute): %	Increase the Cardinal Care annual CAHPS overall Rating of *Got Non-Urgent Appointment as Soon as Needed* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	Use CAHPS benchmarks
		2.1.1.3 Getting Needed Care	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	AHRQ CAHPS 2021 Child: • CCC Plus (MLTSS): 87.3% • Medallion 4.0 (Acute): 84.6% Adult: • CCC Plus (MLTSS): 86.1% • Medallion 4.0 (Acute): 82.9%	Increase the Cardinal Care annual CAHPS overall Rating of *Getting Needed Care* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	Use CAHPS benchmarks
	Objective 2.2 Promote Patient Safety	2.2.1.1 Prevalence of Pressure Ulcers Among LTSS Members	DMAS	Long-Term Nursing Facility: 3.3%[1]	Decrease the prevalence percentage of LTSS members with	Clarify difference from 3.1.1.11; increase

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Short-Term Nursing Facility: 7.1%[1] CCC Plus (MLTSS) Waiver Members: 1.9%[1]	pressure ulcers by 2025: • Long-Term Nursing Facility: • Short-Term Nursing Facility: • CCC Plus Waiver Members:	numbers over 2022 benchmark, 1% minimum
		2.2.1.2 Monitor the Frequency of Reported Critical Incidents by Member Classification	DMAS	• CCC Plus (MLTSS) Waiver w/o PDN: 694 • CCC Plus (MLTSS) Waiver: 26 • CCC Plus (MLTSS) Waiver W PDN: 30 • DD Waiver: 9 • Emerging Vulnerable: 349 • Minimal Need: 107 • Nursing Facility: 446 • Other: 732 • Total: 2,393[2]	Increase the number and percentage of Cardinal Care program members without PDN critical incidents reported by 2025: • CCC Plus Waiver w/o PDN: • CC Plus Waiver: • DD Waiver: • Emerging Vulnerable: • Minimal Need: • Nursing Facility: • Other: • Total:	Increase number over 2022 benchmark, 1% minimum
	Goal 2.3 Promote Effective Communication and Care Coordination	2.3.1.1 How Well Doctors Communicate	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus (MLTSS): 93.9%	Increase the Cardinal Care annual CAHPS overall Rating of *How Well Doctors Communicate* to perform at or above	Use CAHPS benchmarks

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0 (Acute): 93.7% Adult: • CCC Plus (MLTSS): 94.2% • Medallion 4.0 (Acute): 93.3%	the CAHPS 50th percentile by 2025: • Adult: • Child:	
		2.3.1.2 Service Authorizations	DMAS https://www.dmas.virginia.gov/data/mco-service-authorization-performance/	MCO Reporting	Maintain or Increase by X% service authorizations adjudicated timely by 2025: • Cardinal Care Program:	Increase number over 2022 benchmark, 1% minimum
★ **Goal 3:** Support Efficient and Value-Driven Care	**Objective 3.1** Focus on Paying for Value	3.1.1.1 Frequency of Potentially Preventable Admissions	DMAS Clinical Efficiency Measures	Clinical Efficiency Measures	Decrease by 10% Potentially Preventable Admissions: • Cardinal Care Program:	Based on CE benchmarks from DMAS website
		3.1.1.2 Frequency of Emergency Department Visits	DMAS Clinical Efficiency Measure	Clinical Efficiency Measures	Decrease by 1% the Potentially Preventable, Avoidable, and/or Medically Unnecessary Emergency Department Visits: • Cardinal Care Program:	Based on CE benchmarks from DMAS website
		3.1.1.3 Frequency of Potentially	DMAS Clinical Efficiency Measure	CCC Plus (MLTSS):	Decrease by 8% Potentially	Based on CE

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		Preventable Readmissions		Medallion 4.0 (Acute)	Preventable Readmissions Within 30 Days: • Cardinal Care Program:	benchmarks from DMAS website
		3.1.1.4 Ambulatory Care	NCQA HEDIS	HEDIS MY 2020 • CCC Plus (MLTSS): 77.45 • Medallion 4.0 (Acute):	Decrease the HEDIS Ambulatory Care: Emergency Department (ED) Visit measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program:	Use HEDIS MY2022 percentile benchmark
		3.1.1.5 Ambulatory Care: Emergency (ED) Visits	DMAS Clinical Efficiency Measures NCQA HEDIS (AMB) CMS Child Core Set: AMB-CH	Clinical Efficiency Measures • CCC Plus (MLTSS): • Medallion 4.0 (Acute): HEDIS MY 2020 • CCC Plus (MLTSS): 77.45% • Medallion 4.0 (Acute): NR Child Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute)	Decrease the HEDIS Ambulatory Care: Emergency Department (ED) Visit measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program HEDIS: • Cardinal Care Program Child Core Set: • Less than 1 Year: • 1-9 Years: • 10-19 Years: • Total: Decrease the CMS Child Core Set Ambulatory Care:	Use HEDIS MY2022 percentile benchmark

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Emergency Department (ED) Visit measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program HEDIS: • Cardinal Care Program Child Core Set: • Less than 1 Year: • 1-9 Years: • 10-19 Years: • Total:	
		3.1.1.6 Days Without Minimum RN Hours	DMAS VBP Reporting Team CMS Payroll Based Journal	NF VBP Program 2019 • CCC Plus (MLTSS): • Cardinal Care Program:	NF VBP Decrease by X% the number of nursing facility y days without minimum RN hours.	Fair: 13.00-16.00 Better: 5.00 – 12.00 Best: 0 – 4.00
		3.1.1.7 Total Nurse Staffing Hours Per Resident Day (RN, LPN, CAN) – Case-Mix Adjusted	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus (MLTSS): • Cardinal Care Program:	NF VBP Increase by X% the number of days with total nurse staffing hours per resident day meeting minimum requirements.	Fair: 3.16 – 3.45 Better: 3.46 – 3.83 Best: 3.84+
		3.1.1.8 Percentage of Long-Stay Resident with a Urinary Tract Infection (UTI)	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus (MLTSS):	NF VBP Decrease by X% Long-Stay Residents	Fair: 2.39–4.36 Better: 1.31 – 2.38

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					with a Urinary Tract Infection. • Cardinal Care Program	Best:0 – 1.30
		3.1.1.9 Number of Hospitalizations per 1,000 Long-Stay Resident Days	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus (MLTSS):	NF VBP Decrease by X% the number of unplanned inpatient admissions or outpatient observations stays that occurred among long-stay residents of a nursing home. • Cardinal Care Program:	Fair: 1.36 – 1.75 Better: 1.00 – 1.35 Best: 0 – 0.99
		3.1.1.10 Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus (MLTSS):	NF VBP Decrease by X% the number of outpatient ED visits that occurred among long-stay residents of a nursing home.	Fair: 0.64 – 0.95 Better: 0.39 – 0.63 Best: 0 – 0.38
		3.1.1.11 Percentage of Long-Stay High-Risk Residents with Pressure Ulcers	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus (MLTSS):	NF VBP Decrease by X% Long-Stay High-Risk Residents with Pressure Ulcers	Fair: 8.06 – 10.92 Better: 5.43 – 8.05 Best: 0 – 5.42
	Objective 3.2 Promote Efficient Use of Program Funds	3.2.1.1 Monitor Medical Loss Ratio	DMAS—MCO Financials https://www.dmas.virginia.gov/data/mco-financials/	• CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Maintain MLR XXXX	Maintain compliance with MLR requirements
Goal 4: Strengthen the Health of	**Objective 4.1** Improve the Utilization of Wellness,	4.1.1.1 Adults' Access to Preventive/Ambulatory Health Services	NCQA HEDIS (AAP)	HEDIS MY 2020	Increase the HEDIS Adults' Access to Preventive/Ambulatory Health Services	Use HEDIS MY2022 percentile benchmark

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
Families and Communities	Immunization, and Prevention Services for Members			• CCC Plus (MLTSS): 87.12% • Medallion 4.0 (Acute): 72.75%	measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program:	
		4.1.1.2 Child and Adolescent Well-Care Visits	NCQA HEDIS (WCV) Child Core Set: WCV-CH	HEDIS MY 2020 • CCC Plus (MLTSS): 39.86% • Medallion 4.0 (Acute): 46.57% Child Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Increase the HEDIS Child and Adolescent Well-Care Visits measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program: Increase the CMS Child Core Set Child and Adolescent Well-Care Visits measure rate to perform at or above the CMCS 50th percentile by 2025: • 3-11 Years: • 12-17 Years: • 18-21 Years: • Total:	Use HEDIS MY2022 percentile benchmark
		4.1.1.3 Childhood Immunization Status	NCQA HEDIS (CIS) • Combo 3 Child Core Set: CIS-CH	HEDIS MY 2020 • CCC Plus (MLTSS): 65.58% • Medallion 4.0 (Acute): 65.82% Child Core Set	Increase the HEDIS Childhood Immunization Status measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program:	Update to PWP target

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Increase the CMS Child Core Set Child and Adolescent Well-Care Visits measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program:	
		4.1.1.4 Immunizations for Adolescents	NCQA HEDIS (IMA) • Combo 1 • Combo 2 Child Core Set: IMA-CH	HEDIS MY 2020 Combo 1 • CCC Plus (MLTSS): 64.10% • Medallion 4.0 (Acute): % Combo 2 • CCC Plus (MLTSS): 26.02% • Medallion 4.0 (Acute): % Child Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Increase the HEDIS Immunization for Adolescents measure rate to perform at or above the HEDIS 50th percentile by 2025: • Combo 1: • Combo 2: Increase the CMS Child Core Set Child and Adolescent Well-Care Visits measure rate to perform at or above the CMCS 50th percentile by 2025: Cardinal Care Program: • Combo 1: • Combo 2:	Update to PWP target
		4.1.1.5 Flu Vaccinations for Adults 18-64	AHRA CAHPS Adult Core Set: CPA-AD	CAHPS 2021: ND Adult Core Set • CCC Plus (MLTSS):	Increase the CAHPS Flu Vaccinations for Adults 18-64 Years measure rate to perform at or above	Use CAHPS benchmarks

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0 (Acute):	the CAHPS 50th percentile by 2025: • Cardinal Care Program: Increase the CMS Adult Core Set Flu Vaccinations for Adults 18-64 Years measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program:	
		4.1.1.6 Topical Fluoride for Children	NCQA HEDIS (TFC) Child Core Set: TFL-CH CMS 416	HEDIS MY 2020 • CCC Plus (MLTSS): • Medallion 4.0 (Acute): Child Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute): CMS 416 2021	Increase the HEDIS Topical Fluoride for Children measure rate to perform at or above the HEDIS 50th percentile by 2025: *Note: MY 2023 Year 1 measure – percentile rankings may not be available.* • Cardinal Care Program – Total: Increase the CMS Child Core Set Topical Fluoride for Children measure rate to perform at or above the CMCS 50th percentile by 2025:	Use HEDIS MY2022 percentile benchmark

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• Cardinal Care Program: *Note: Need to determine target for a CMS 416 measure.*	
		4.1.1.7 Oral Evaluation, Dental Services	NCQA HEDIS (OED) Child Core Set: OEV-CH CMS 416	HEDIS MY 2020 • CCC Plus (MLTSS): • Medallion 4.0 (Acute): Child Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute): • CMS 416 2021	Increase the HEDIS Oral Evaluation, Dental Services measure rate to perform at or above the HEDIS 50th percentile by 2025: *Note: MY 2023 Year 1 measure – percentile rankings may not be available.* • Cardinal Care Program Increase the CMS Child Core Set Evaluation, Dental Services measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Need to determine target for a CMS 416 measure.*	Use HEDIS MY2022 percentile benchmark
		4.1.1.8 Sealant Receipt on Permanent First Molars	Child Core Set: SFM-CH CMS 416	Child Core Set • CCC Plus (MLTSS):	Increase the HEDIS Sealant Receipt on Permanent First Molars measure rate to perform at or above	Use HEDIS MY2022 percentile benchmark

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0 (Acute): CMS 416 2021	the HEDIS 50th percentile by 2025: *Note: MY 2023 Year 1 measure – percentile rankings may not be available.* • Cardinal Care Program Increase the CMS Child Core Set Sealant Receipt of Permanent First Molars measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Need to determine target for a CMS 416 measure.*	
		4.1.1.9 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA HEDIS (WCC) CMS Child Core Set (WCC-CH)	HEDIS MY 2020 CCC Plus (MLTSS): • Blood Glucose Testing-Total: 41.33% • Cholesterol Testing—Total: 28.59%	Increase the HEDIS Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • BMI Percentile Documentation	Use HEDIS MY2022 percentile benchmark

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Blood Glucose and Cholesterol Testing-Total: 27.05% • Medallion 4.0 (Acute): NR Child Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	• Counseling for Nutrition • Counseling for Physical Activity Increase the CMS Child Core Set Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: • BMI Percentile Documentation • Counseling for Nutrition • Counseling for Physical Activity	
		4.1.1.10 Chlamydia Screening in Women Ages 16 to 20	NCQA HEDIS (CHL) CMS Child Core Set (CHL-CH)	HEDIS MY 2020 • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR Child Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Increase the HEDIS Chlamydia Screening in Women Ages 16-20 measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program *Note: HEDIS measure age is 16-24 Years.*	Use HEDIS MY2022 percentile benchmark

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Increase the CMS Child Core Set Chlamydia Screening in Women Ages 16-20 Years measure rate to perform at or above the CMCS 50th percentile by 2025: Cardinal Care Program – Total	
		4.1.1.11 Lead Screening in Children	NCQA HEDIS (LSC) CMS Child Core Set (LSC-CH)	HEDIS MY 2020 • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR Child Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Increase the HEDIS Lead Screening in Children measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Child Core Set Lead Screening in Children measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	Use HEDIS MY2022 percentile benchmark
	★ **Objective 4.2** Improve Outcomes for Maternal and Infant Members	4.2.1.1 Prenatal and Postpartum Care: Postpartum Care	NCQA HEDIS (PPC) Adult Core Set: PPC-AD	HEDIS MY 2020 Postpartum Care • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): 66.52%	Increase the HEDIS Prenatal and Postpartum Care: Timeliness of Prenatal Care measure rate to perform at or above the HEDIS 50th percentile by 2025:	Use PWP target

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Adult Core Set Postpartum Care • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	• Cardinal Care Program Increase the CMS Adult Core Set Prenatal and Postpartum Care: Timeliness of Prenatal Care measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		4.2.1.2 Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA HEDIS (PPC) Child Core Set: PPC-CH	HEDIS MY 2020 Timeliness of Prenatal Care • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): 73.00% Adult Core Set Timeliness of Prenatal Care • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Increase the HEDIS Prenatal and Postpartum Care: Postpartum Care measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Child Core Set Prenatal and Postpartum Care: Postpartum Care measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	Use PWP target

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		4.2.1.3 Live Births Weighing Less than 2,500 Grams	Child Core Set: LBW-CH CDC Wonder State Vital Records	CMS 2021 Child Core Set Reported Rate—CDC Wonder Data:	Decrease the CMS Child Core Set Live Births Weighing Less than 2,500 Grams measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	Use national mean (9.9) from 2019 CDC Wonder data or most recent available
		4.2.1.4 Well-Child Visits in the First 30 Months of Life	NCQA HEDIS (W30) Child Core Set: W30-CH	HEDIS MY 2020 • CCC Plus (MLTSS): 71.81% • Medallion 4.0 (Acute): 72.10% Child Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Increase the HEDIS Well-Child Visits in the First 30 Months of Life measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • First 15 Months: • 15-30 Months Increase the CMS Child Core Set Well-Child Visits in the First 30 Months of Life measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program • First 15 Months: • 15-30 Months	Use HEDIS MY2022 percentile benchmark
		4.2.1.5 Low-Risk Cesarean Delivery	Child Core Set: LRCD-CH CDC Wonder State Vital Records	Child Core Set CMS 2021 Reported Rate—	Decrease the CMS Child Core Set Low-Risk Cesarean	Use national mean (23.2%) from

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				CDC Wonder Data:	Delivery measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Lower rate is better.*	2019 CDC Wonder data or most recent available
	Objective 4.3 Improve Home and Community-Based Services	4.3.1.1 Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and Appropriate to Their Needs and Personal Goals	QMR	**FY22** Q1: 86.0% Q2: 50% Q3: 53%	Increase the number and percent of waiver individuals who have service plans that are adequate and appropriate to their needs and personal goals by 5% by 2025: • Cardinal Care Program – Total:	5%
		4.3.1.2 Number and Percent of Individuals Who Received Services in the Scope Specified in the Service Plan	QMR	**FY22** Q1: 97.0% Q2: 100% Q3: 100%	Increase the number and percent of individuals who received services in the scopes specified in their service plan by 5% by 2025: • Cardinal Care Program – Total:	5%
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.1** Improve Outcomes for Members with Chronic Conditions	5.1.1.1 PQI 08: Heart Failure Admission Rate	Adult Core Set: PQI08-AD	Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Decrease the CMS Adult Core Set Heart Failure Admission measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	Use PWP target

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Note: Lower rate is better.	
		5.1.1.2 PDI 14: Asthma Admission Rate (Ages 2–17)	Adult Core Set: PQI15-AD	Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Decrease the CMS Adult Core Set Asthma Admission measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Lower rate is better.*	Use PWP target
		5.1.1.3 PQI 05: COPD and Asthma in Older Adults' Admission Rate	Adult Core Set: PQI105-AD	Adult Core Set • CCC Plus (MLTSS): 41.04% • Medallion 4.0 (Acute):	Decrease the CMS Adult Core Set Asthma in Older Adults' Admission measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Lower rate is better.*	Use PWP target
		5.1.1.4 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	NCQA HEDIS (HPC) Adult Core Set: HPC-AD	HEDIS MY 2020 • CCC Plus (MLTSS): 51.42% • Medallion 4.0 (Acute): 41.04% Adult Core Set • CCC Plus (MLTSS):	Increase the HEDIS Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program	Use PWP target

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0 (Acute):	Increase the CMS Adult Core Set Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		5.1.1.5 Controlling High Blood Pressure	NCQA HEDIS (CBP) Adult Core Set: CBP-AD	HEDIS MY 2020 • CCC Plus (MLTSS): 48.07% • Medallion 4.0 (Acute): 46.91% Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Increase the HEDIS Controlling High Blood Pressure measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Adult Core Set Controlling High Blood Pressure measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	Use HEDIS MY2022 percentile benchmark
		5.1.1.6 Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years	NCQA HEDIS (AAB) CMS Child Core Set: AAB-CH	HEDIS MY 2020 • CCC Plus (MLTSS): 47.93%	Increase the HEDIS Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17	Use HEDIS MY2022 percentile benchmark

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0 (Acute): NR Child Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Years measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • *3 Months to 17 Years:* • *18-64 Years:* • *65 Years and older:* • *Total:* *Note: Recommend dropping the 18-64, 65 years and older, and total.* Increase the CMS Child Core Set Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: • *3 Months to 17 Years:*	
		5.1.1.7 Asthma Medication Ratio: Age 5 to 18 Years	NCQA HEDIS (AMR) CMS Child Core Set: AMR-CH	HEDIS MY 2020 • CCC Plus (MLTSS): 63.62%	Increase the HEDIS Asthma Medication Ratio: Age 5 to 18 Years measure rate to perform at or above	Use HEDIS MY2022 percentile benchmark

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0 (Acute): 71.00% Child Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Child Core Set Asthma Medication Ratio: Age 5 to 18 Years measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
	Objective 5.2 Improve Outcomes for Nursing Home Eligible Members	5.2.1.1 Use of High-Risk Medications in Older Adults (Elderly)	NCQA HEDIS (DAE)	HEDIS MY 2020: CCC Plus (MLTSS): 14.88%	Decrease the HEDIS Use of High-Risk Medications in Older Adults (Elderly) measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Lower rate is better.*	Use HEDIS MY2022 percentile benchmark
	★ **Objective 5.3** Improve Outcomes for Members with Substance Use Disorders	5.3.1.1 Monitor Identification of Alcohol and Other Drug Services	DMAS	• CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Increase the percentage of members with Identification of Alcohol and Other Drug Services by 5% by 2025.	5%
		5.3.1.2 Follow-Up After Emergency	NCQA HEDIS (FUA) Child Core Set: FUA-CH	HEDIS MY 2020	Increase the HEDIS Follow-Up After	Use PWP target

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		Department Visit for Substance Use		CCC Plus (MLTSS) • 7-Day: 11.44% • 30-Day: 19.98% Medallion 4.0 (Acute): • 7-Day: 13.92% • 30-Day: 21.88% Child Core Set CCC Plus (MLTSS) • 7-Day: • 30-Day: Medallion 4.0 (Acute): • 7-Day: • 30-Day:	Emergency Department Visit for Substance Use measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Child Core Set Follow-Up After Emergency Department Visit for Substance Use measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		5.3.1.3 Use of Opioids at High Dosage in Persons Without Cancer	NCQA HEDIS (OHD) Adult Core Set: OHD-AD	HEDIS MY 2020 • CCC Plus (MLTSS): • Medallion 4.0 (Acute): Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Decrease the HEDIS Use of Opioids at High Dosage in Persons Without Cancer measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Decrease the CMS Adult Core Set Use of Opioids at High	Use HEDIS MY2022 percentile benchmark

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Dosage in Persons Without Cancer measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		5.3.1.4 Initiation and Engagement of Substance Use Disorder Treatment	NCQA HEDIS (IET) Adult Core Set: IET-AD	HEDIS MY 2020 CCC Plus (MLTSS): • Initiation: 46.41% • Engagement: 12.51% Medallion 4.0 (Acute): • Initiation: • Engagement: Adult Core Set CCC Plus (MLTSS): • Initiation: • Engagement: • Medallion 4.0 (Acute): • Initiation: • Engagement:	Increase the HEDIS Initiation and Engagement of Substance Use Disorder Treatment measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Adult Core Set Initiation and Engagement of Substance Use Disorder Treatment measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	Use PWP target
		5.3.1.5 Use of Pharmacotherapy for Opioid Use Disorder	CMS Adult Core Set: OUD-AD	Adult Core Set • CCC Plus (MLTSS)	Increase the CMS Adult Core Measure rate Use of Pharmacotherapy for	If not available, use 1% as a minimum

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0 (Acute):	Opioid Use Disorder measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	performance improvement
	★ **Goal: 5.4** Improve Behavioral Health and Developmental Services for Members	5.4.1.1 Follow-Up After Hospitalization for Mental Illness	NCQA HEDIS (FUH) Adult Core Set: FUH-AD Child Core Set: FUH-CH	HEDIS MY 2020 CCC Plus (MLTSS) • 7-Day: 30.77% • 30-Day: 54.12% Medallion 4.0 (Acute): • 7-Day: 35.63% • 30-Day: 56.84% Adult Core Set CCC Plus (MLTSS) • 7-Day: • 30-Day: Medallion 4.0 (Acute): • 7-Day: • 30-Day: Child Core Set CCC Plus (MLTSS) • 7-Day:	Increase the HEDIS Follow-Up After Hospitalization for Mental Illness measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program 6 Years and Older • Within 7 Days • Within 30 Days Increase the CMS Adult Core Set Follow-Up After Hospitalization for Mental Illness measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – 18 and Older: • Within 7 Days • Within 30 Days	Use HEDIS MY2022 percentile benchmark

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• 30-Day: Medallion 4.0 (Acute): • 7-Day: • 30-Day:	Increase the CMS Child Core Set Follow-Up After Hospitalization for Mental Illness measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program ages 6-17 Years: • Within 7 Days • Within 30 Days	
		5.4.1.2 Follow-Up After Emergency Department Visit for Mental Illness	NCQA HEDIS (FUM) Adult Core Set: FUM-AD Child Core Set: FUM-CH	HEDIS MY 2020 CCC Plus (MLTSS) • 7-Day: 47.03% • 30-Day: 62.83% Medallion 4.0 (Acute): • 7-Day: 45.34% • 30-Day: 57.38% Adult Core Set CCC Plus (MLTSS) • 7-Day: • 30-Day: Medallion 4.0 (Acute):	Increase the HEDIS Follow-Up After Emergency Department Visit for Mental Illness measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program 6 Years and Older • Within 7 Days • Within 30 Days Increase the CMS Adult Core Set Follow-Up After Emergency Department for Mental Illness measure rate to perform at or above	Use PWP target

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• 7-Day: • 30-Day: Child Core Set CCC Plus (MLTSS) • 7-Day: • 30-Day: Medallion 4.0 (Acute): • 7-Day: • 30-Day:	the CMCS 50th percentile by 2025: • Cardinal Care Program – 18 and Older: • Within 7 Days • Within 30 Days Increase the CMS Child Core Set Follow-Up After Emergency Department for Mental Illness measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program ages 6-17 Years: • Within 7 Days • Within 30 Days	
		5.4.1.3 Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	NCQA HEDIS (ADD) Child Core Set: ADD-CH	HEDIS MY 2020 CCC Plus (MLTSS) • Initiation: • Continuation: Medallion 4.0 (Acute) • Initiation: 45.20% • Continuation: 58.61% Child Core Set	Increase the HEDIS Follow-Up for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program – Ages 6-12 Years • Initiation Phase:	Use HEDIS MY2022 percentile benchmark

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				CCC Plus (MLTSS): • Initiation: • Continuation: CCC Plus (MLTSS): • Initiation: • Continuation:	• Continuation and Maintenance Phase: Increase the CMS Child Core Set Follow-Up for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Ages 6-12 Years • Initiation Phase: • Continuation and Maintenance Phase:	
		5.4.1.4 Monitor Mental Health Utilization	DMAS	DMAS • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Increase the percentage of members receiving mental health services by X% by 2025.	Use HEDIS MY2022 percentile benchmark
		5.4.1.5 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA HEDIS (APP) Child Core Set: APP-CH	HEDIS MY 2020 • CCC Plus (MLTSS): 43.71% • Medallion 4.0 (Acute): 69.58% Child Core Set • CCC Plus (MLTSS):	Increase the HEDIS Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics measure rate to perform at or above the HEDIS 50th percentile by 2025:	Use HEDIS MY2022 percentile benchmark

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0 (Acute):	• Cardinal Care Program – Ages 1-17 Years Increase the CMS Child Core Set Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics measure rate to perform at or above the CMCS 50th percentile by 2025: Cardinal Care Program – Ages 1-17 Years	
		5.4.1.6 Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA HEDIS (APM) CMS Child Core Set: APM-CH	HEDIS MY 2020 CCC Plus (MLTSS): • Blood Glucose Testing—Total: 41.33 • Cholesterol Testing—Total: 28.59% • Blood Glucose and Cholesterol Testing—Total: 27.05% Medallion 4.0 (Acute): NR	Increase the HEDIS Metabolic Monitoring for Children and Adolescents on Antipsychotics measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program – Ages 1-17 Years Increase the CMS Child Core Set Metabolic Monitoring for Children and Adolescents on Antipsychotics	Use HEDIS MY2022 percentile benchmark

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Child Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Ages 1-17 Years	
		5.4.1.7 Medical Assistance with Smoking and Tobacco Use Cessation	CMS Adult Core Set: MSC-AD	Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Increase the HEDIS Medical Assistance with Smoking and Tobacco Use Cessation measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • 3 Months – 17 Years • 18 – 64 Years • 65 and Older • Total Increase the CMS Adult Core Set Medical Assistance with Smoking and Tobacco Use Cessation measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program • 18-64 Years	Use CAHPS benchmarks

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• 65 and Older	
		5.4.1.8 Antidepressant Medication Management	NCQA HEDIS (AMM) CMS Adult Core Set: AMM-AD	HEDIS MY 2020: CCC Plus (MLTSS): • Effective Acute Phase Treatment: 61.11% • Effective Continuation Phase: 48.29% Medallion 4.0 (Acute): • Effective Acute Phase Treatment: 57.12% • Effective Continuation Phase: 42.02% Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Increase the HEDIS Antidepressant Medication Management measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • 18 and Older • Effective Acute Phase Treatment • Effective Continuation Phase Treatment Increase the CMS Adult Core Set Antidepressant Medication Management measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program • 18 – 64 Years • 65 and Older • Total • Effective Acute Phase Treatment • Effective Continuation Phase Treatment	Use HEDIS MY2022 percentile benchmark

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		5.4.1.9 Screening for Depression and Follow-Up Plan: Ages 18 and Older	CMS Adult Core Set: CDF-AD	Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Increase the CMS Adult Core Set Screening for Depression and Follow-Up Plan: Ages 18 and Older measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program	If not available, use 1% as a minimum performance improvement
		5.4.1.10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA HEDIS (SSD) CMS Adult Core Set: SSD-AD	HEDIS MY 2020: • CCC Plus (MLTSS): 77.18% • Medallion 4.0 (Acute): NR Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Increase the HEDIS Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • 18 to 64 Years Increase the CMS Adult Core Set Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications measure rate to perform at or	Use HEDIS MY2022 percentile benchmark

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					above the CMCS 50th percentile by 2025: • Cardinal Care Program • 18 – 64 Years	
		5.4.1.11 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA HEDIS (HPCMI) CMS Adult Core Set: HPCMI-AD	HEDIS MY 2020 • CCC Plus (MLTSS): • Medallion 4.0 (Acute) Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Increase the HEDIS Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • 18 to 75 Years Increase the CMS Adult Core Set Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program • 18 – 64 Years • 65 – 75 Years	Use HEDIS MY2022 percentile benchmark

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		5.4.1.12 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA HEDIS (SAA) CMS Adult Core Set: SAA-AD	HEDIS MY 2020: • CCC Plus (MLTSS): 69.50% • Medallion 4.0 (Acute): NR Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):	Increase the HEDIS Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • 18 to 39 Years Increase the CMS Adult Core Set Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program • 18 – 39 Years	Use HEDIS MY2022 percentile benchmark

[1] DMAS Cumulative data from MCO quarterly reports 1/1/2020–3/31/2022.

[2] MCO critical incident data reported to DMAS for calendar year 2021.

**The baseline measure rate is the final validated 2021 HEDIS, performance measure rate or CAHPS reported in the 2021 Annual Technical Report and posted to the DMAS website.*

***Target established in the CY2021 PWP Methodology.*

****The baseline measure rate is the final validated 2020 HEDIS rate reported in the 2021 Annual Technical Report and posted to the DMAS website.*

^The baseline measure rate is the final 2021 rate calculated by HSAG for the PWP.

^^The baseline measure rate is the final 2021 rate reported by DMAS for the Quality Management Review.

^^^The baseline measure rate is the final 2021 rate reported by the DMAS Finance Team

▲ *Statistically significantly higher in 2020 than in 2019.*

▼ *Statistically significantly lower in 2020 than in 2019.*

★ *These goals are inclusive of Governor Glenn Youngkin's identified priorities for the Medicaid program that focus on behavioral health enhancement, maternal health outcomes, and access to high quality healthcare services.*

Table 28—Aspirational Goals Tracking Table

Goal	Objective	Measure Name	Metric specifications	2021 Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
Goal 1: Enhance the Member Care Experience	**Objective 1.2** Improve Member Satisfaction	1.2.1.3 Timely Processing of Member Applications, Renewals, and Appeals	DMAS	DMAS		
Goal 2: Promote Access to Safe, Gold-Standard Patient Care	**Objective 2.1** Ensure Access to Care	2.1.1.4 Monitor network adequacy by region and provider types	DMAS	MCO Reporting		
		2.1.1.5 Monitor frequency and reasons for missed trips	DMAS	MCO Reporting		
		2.1.1.6 Cervical Cancer Screening	NCQA HEDIS (CCS) CMS Adult Core Set: CCS-AD	HEDIS MY 2020 • CCC Plus (MLTSS): 41.86% • Medallion 4.0 (Acute): 50.09% Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):		MY 2022 CCC Plus (MLTSS): 45.47%

Goal	Objective	Measure Name	Metric specifications	2021 Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		2.1.1.7 Chlamydia Screening in Women Ages 21 to 24	NCQA HEDIS (CHL) CMS Adult Core Set: CHL-AD	HEDIS MY 2020 • CCC Plus (MLTSS): • Medallion 4.0 (Acute): Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):		
		2.1.1.8 Colorectal Cancer Screening	NCQA HEDIS (COL) CMS Adult Core Set: COL-AD	HEDIS MY 2020 • CCC Plus (MLTSS): • Medallion 4.0 (Acute): Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):		
		2.1.1.9 Breast Cancer Screening	NCQA HEDIS (BCS) CMS Adult Core Set: BCS-AD	HEDIS MY 2020 • CCC Plus (MLTSS): 46.58% • Medallion 4.0 (Acute): 48.82% Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):		MY 2022 CCC Plus (MLTSS): 46.76%

Goal	Objective	Measure Name	Metric specifications	2021 Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		2.1.1.10 Contraceptive Care—Postpartum Women Ages 21 to 44	CMS Adult Core Set: CCP-AD	Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):		
		2.1.1.11 Contraceptive Care—All Women Ages 21 to 44	CMS Adult Core Set: CCW-AD	Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):		
		2.1.1.12 Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Age 18 and Older	NCQA HEDIS (AAB) CMS Adult Core Set: AAB-AD	HEDIS MY 2020 • CCC Plus (MLTSS): 47.93% • Medallion 4.0 (Acute): NR Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):		MY 2022 CCC Plus (MLTSS): 45.65%
		2.1.1.13 Asthma Medication Ratio: Ages 19 60 64	NCQA HEDIS (AMR) CMS Adult Core Set: AMR-AD	HEDIS MY 2020 • CCC Plus (MLTSS): 63.62% • Medallion 4.0 (Acute): 71.00% Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):		MY 2022 CCC Plus (MLTSS): 68.30%

Goal	Objective	Measure Name	Metric specifications	2021 Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		2.1.1.14 HIV Viral Load Suppression	CMS Adult Core Set: HVL-AD	Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):		
		2.1.1.15 Concurrent Use of Opioids and Benzodiazepines	CMS Adult Core Set: COB-AD	Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):		
Goal 3: Support Efficient and Value-Driven Care	**Objective 3.2** Promote Efficient Use of Program Funds	3.2.1.2 Number of Administrative and Medical Deferrals and Disallowances	DMAS	DMAS		
		3.2.1.3 Diabetes Short-Term Complications Admission Rate	CMS Adult Core Set: PQI01-AD	Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):		
		3.2.1.4 Heart Failure Admission Rate	CMS Adult Core Set: PQI08-AD	Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):		
		3.2.1.5 Asthma in Younger Adults Admission Rate	CMS Adult Core Set: PQI15-AD	Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):		

Goal	Objective	Measure Name	Metric specifications	2021 Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		3.2.1.6 Plan All-Cause Readmission Rate	NCQA HEDIS (PCR) CMS Adult Core Set: PCR-AD	HEDIS CCC Plus (MLTSS) • Observed Readmissions—Total: 11.42% • O/E Ratio—Total: 0.94 Medallion 4.0 (Acute): NR Adult Core Set • CCC Plus (MLTSS): • Medallion 4.0 (Acute):		MY 2022 CCC Plus (MLTSS) Observed Readmissions: 12.08% O/E Ratio Total: 0.9956
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.2** Improve Outcomes for Nursing Home Eligible Members	5.2.1.2 Nursing Facility Residents Hospitalization Rate	DMAS	DMAS		
		5.2.1.3 CCC Plus (MLTSS) Waiver Members Who Re-Enter the Community After a Short-Term Nursing Facility Stay	DMAS	DMAS		
		5.2.1.4 Members Who Transitioned from a Nursing Facility to the Community Who Returned to the Nursing Facility Within 90 Days	DMAS	DMAS		

Appendix E. EQRO Findings and Recommendations

EQR Annual Technical Report Recommendations

DMAS makes the EQRO Annual Technical Report available to MCOs. Annually, MCOs are required to submit information on actions taken to address the recommendations contained in the EQRO Annual Technical Report. Annually, DMAS' EQRO collects and reviews the actions taken by the Commonwealth and by the MCOs in relation to the EQR recommendations contained in the report. The recommendations provided to DMAS for the EQR activities in the *March 2023 External Quality Review Technical Report* are summarized in Table 29.

Table 29—March 2023 CCC Plus (MLTSS) and Medallion 4.0 (Acute) Quality Strategy Recommendations For the Virginia Medicaid Managed Care Program

Program Recommendations	
Recommendations—CCC Plus (MLTSS)	**Associated 2023–2025 QS Goal and/or Objective**
To improve program-wide performance in support of Objective 5.3 and improve outcomes for members with SUD, HSAG recommends DMAS: • Require the MCOs to develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization. • Require the MCOs to identify healthcare disparities (race, ethnicity, age group, geographic location, etc.) with the behavioral health follow-up PM data. • Upon identification of a root cause issue, require the MCOs to implement appropriate QI interventions to improve use of evidence-based practices related to behavioral healthcare and services. • Require the MCOs to identify best practices to conduct follow-up with members discharged from the ED and ensure follow-up visits within seven days and 30 days are completed.	• **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorder • **Measure: 5.3.1.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment • **Objective: 5.4:** Improve Behavioral Health and Developmental Services for Members **Measure 5.4.1.1:** Follow-Up After Hospitalization for Mental Illness
To improve program-wide performance in support of Objective 4.1 and 4.2 and improve preventive services and well-child visits for members under the age of 21 years, HSAG recommends DMAS: • Require the MCOs to identify best practices for ensuring children receive all preventive vaccinations and well-child services according to recommended schedules.	**Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members **Measure 4.1.1.4:** Immunizations for Adolescents **Objective 4.2:** Improve Outcomes for Maternal and Infant Members **Measure: 4.2.1.4:** Well-Child Visits in the First 20 Months of Life

Program Recommendations	
• Require the MCOs to conduct a root cause analysis to identify barriers that their members are experiencing in accessing well-child and preventive care and services. • Require the MCOs to identify best practices to improve care and services according to the Bright Futures guidelines.	
To improve program-wide performance in support of Objective 5.1 and improve outcomes for members with chronic conditions, HSAG recommends DMAS: • Require that the MCOs conduct a root cause analysis to determine why members are not maintaining their diabetes care. • Upon identification of a root cause, require the MCOs to implement appropriate interventions to improve the performance related to proper diabetes management. • Require the MCOs to identify best practices to improve care and services according to chronic care recommended guidelines.	**Objective 5.1:** Improve Outcomes for Members With Chronic Conditions **Measure: 5.1.1.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
Recommendations—Medallion 4.0 (Acute)	**Associated 2023–2025 QS Goal and/or Objective**
To improve program-wide performance in support of Objective 5.4 and improve outcomes for members in need of BH and developmental services, HSAG recommends DMAS: • Require the MCOs to develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization. • Require the MCOs to identify healthcare disparities (race, ethnicity, age group, geographic location, etc.) with the BH follow-up PM data. • Upon identification of a root cause issue, require the MCOs to implement appropriate QI interventions to improve use of evidence-based practices related to behavioral healthcare and services. • Require the MCOs to identify best practices to conduct follow-up with members discharged from the ED and ensure follow-up visits within seven days and 30 days are completed.	**Objective: 5.4:** Improve Behavioral Health and Developmental Services for Members **Measure 5.4.1.1:** Follow-Up After Hospitalization for Mental Illness
To improve program-wide performance in support of Objective 4.1 and 4.2 and improve preventive services and well-child visits for members under the age of 21 years, HSAG recommends DMAS:	**Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members **Measure 4.1.1.4:** Immunizations for Adolescents

Program Recommendations	
• Require the MCOs to identify best practices for ensuring children receive all preventive vaccinations and well-child services according to recommended schedules. • Require the MCOs to conduct a root cause analysis to identify barriers that their members are experiencing in accessing well-child and preventive care and services. • Require the MCOs to identify best practices to improve care and services according to the Bright Futures guidelines.	**Objective 4.2:** Improve Outcomes for Maternal and Infant Members **Measure: 4.2.1.4:** Well-Child Visits in the First 20 Months of Life
To improve program-wide performance in support of Objective 4.2 and improve use of prenatal and postpartum care, HSAG recommends DMAS: • Require the MCOs to identify access- and timeliness-related PM indicators such as the *Prenatal and Postpartum Care—Postpartum Care* and *Timeliness of Prenatal Care* PM indicators that fell below the NCQA Quality Compass national Medicaid HMO 50th percentile, and focus QI efforts on identifying the root cause and implementing interventions to improve access to care. • Require the MCOs to identify healthcare disparities within the access-related PM data to focus QI efforts on a disparate population. DMAS should also require the MCOs to identify best practices for ensuring prenatal and postpartum care and ensure members receive all prenatal and maternity care according to recommended schedules. • Require the MCOs to identify best practices to improve care and services according to evidence-based guidelines.	**Objective 4.2:** Improve Outcomes for Maternal and Infant Members **Measure: 4.2.1.1:** Prenatal and Postpartum Care: Postpartum Care **Measure: 4.2.1.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care

From the overall findings of the Medallion 4.0 (Acute) CY 2021 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Medallion 4.0 (Acute) program. The recommendations provided to DMAS for the EQR activities in the *March 2022 External Quality Review Medallion 4.0 (Acute) Technical Report* are summarized in Table 30. Table 30 also describes the interventions undertaken by DMAS to address the EQR recommendations, QI achieved as a result of the interventions, and identified barriers to implementing the interventions focused on addressing the recommendations, if applicable.

Table 30—Prior Year Recommendations and Actions Taken—Medallion 4.0 (Acute) Program Overall

Recommendation—Performance Improvement Projects		
Aim 4: Improve population health	**Goal 4.3:** Improve Utilization of Wellness, Screening, and	**Metric 4.3.4:** Child and Adolescent Well-Care Visits

Recommendation—Performance Improvement Projects		
	Prevention Services for Members **Objective:** Increase Child and Adolescent Well-Care Visits	

HSAG Recommendation: To improve program-wide performance in support of Goal 4.3 and mitigate the barriers members experience related to access to care, HSAG recommends the following:

- Require the MCOs to identify access-related PMs, such as *Child and Adolescent Well-Care Visits*, that fell below the NCQA Quality Compass national Medicaid HMO 50th percentile and focus QI efforts on identifying the cause and implementing interventions to improve access to care.
- Require the MCOs to identify healthcare disparities within the access-related PM data to focus QI efforts on a disparate population.

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

DMAS is committed to promoting members. To address the EQRO recommendations, DMAS:

- DMAS included the PM *Well-Child Visits in the First 30 Months of Life* PM in its PWP which provides an incentive to MCOs to increase performance and close gaps.

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

PMV results showed:

Metric 4.6.2: Prenatal and Postpartum Care: Timeliness of Prenatal Care

MY 2020: 46.57%

MY 2021: 50.27%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing initiatives.

HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improve population health	**Goal 4.4:** Improve Health for Members with Chronic Conditions **Objective:** Decrease Diabetes Poor Control **Objective:** Increase Control of High Blood Pressure	**Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure
• HSAG recommended that the MCOs conduct a root cause analysis to determine why some children have not received well-child visits or immunizations according to the well-visit schedule. • HSAG recommended that the MCOs analyze their data and consider if there are disparities within the MCOs' populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. • Upon identification of a root cause, HSAG recommended that the MCOs implement appropriate interventions to increase the number of children who receive a well-child visit or immunizations using interventions that address the root cause of the issue.		
HSAG Recommendation: To improve program-wide performance in support of Goal 4.4 and improve members' receipt of recommended care and services for better management of chronic conditions, HSAG recommends the following: • Require the MCOs to identify chronic health-related PMs that fell below the NCQA Quality Compass national Medicaid HMO 50th percentile and focus QI efforts on identifying the cause and implementing interventions to improve access to care. • Require the MCOs to identify healthcare disparities within the Care for Chronic Conditions domain PMs' data to focus QI efforts on a disparate population. •		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV rates showed: **Metric:** Comprehensive Diabetes Care HbA1c Poor Control (>9.0%) MY 2020: 50.30% MY 2021: 47.45% **Metric:** Controlling High Blood Pressure MY 2020: 46.91% MY 2021: 49.68%		
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.		

Recommendation—Performance Measure Validation
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

The recommendations provided to DMAS for the EQR activities in the *March 2022 External Quality Review CCC Plus (MLTSS) Technical Report* are summarized in Table 31. Table 31 also describes the interventions undertaken by DMAS to address the EQR recommendations, QI achieved as a result of the interventions, and identified barriers to implementing the interventions focused on addressing the recommendations, if applicable.

Table 31—Prior Year Recommendations and Actions Taken—CCC Plus (MLTSS) Program Overall

Recommendation—Performance Improvement Projects		
Aim 4: Improved Population Health	**Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders **Objective:** Increase Follow-Up After ED Visit for AOD Abuse or Dependence	**Metric 4.2.2:** Follow-Up After ED Visit for AOD Abuse or Dependence
HSAG Recommendation: To improve program-wide performance in support of Goal 4.2 and improve members' receipt of follow-up services, HSAG recommends the following: • Require the MCOs to identify healthcare disparities within the behavioral health follow-up PM data to focus QI efforts on a disparate population. • Require the MCOs to identify best practices to conduct follow-up with members discharged from the ED and ensure follow-up visits within seven days and 30 days are completed.		
DMAS' Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:		

Recommendation—Performance Improvement Projects
• DMAS included the measure *Follow-Up After ED Visit for AOD Abuse or Dependence* in its PWP which provides an incentive to MCOs to increase performance and close gaps.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** Follow-up After ED Visit for AOD Abuse or Dependence MY 2020: 7-Day: 11.44% 30-Day: 19.98% MY 2021: 7-Day: 14.55% 30-Day: 22.57%
Identify any barriers to implementing initiatives: The COVID-19 PHE continued to be a barrier to improving performance to address the HSAG recommendation.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report. 

Recommendation—Performance Measure Validation		
Aim 4: Improve population health	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members **Objective:** Increase Child and Adolescent Well-Care Visits **Goal 4.6:** Improve Outcomes for Maternal and Infant Members **Objective:** Increase Well-Child Visits	**Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life
HSAG Recommendation: To improve program-wide performance in support of Goal 4.3 and mitigate the barriers members experience related to access to care, HSAG recommends the following: • Require the MCOs to identify access-related PMs, such as *Child and Adolescent Well-Care Visits*, that fell below the NCQA Quality Compass national Medicaid HMO 50th percentile and focus QI efforts on identifying the cause and implementing interventions to improve access to care.		

Recommendation—Performance Measure Validation
• Require the MCOs to identify healthcare disparities within the access-related PM data to focus QI efforts on a disparate population.
DMAS' Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • DMAS included the measure *Well-Child Visits in the First 30 Months of Life* measure in its PWP which provides an incentive to MCOs to increase performance and close gaps.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** Well-Child Visits in the First 30 Months of Life MY 2020: First 15 Months: 30.67% 15 -30 Months: 71.81% MY 2021: First 15 Months: 26.28% 15 -30 Months: 65.74%
Identify any barriers to implementing initiatives: The COVID-19 PHE continued to be a barrier to improving performance to address the HSAG recommendations around improvement in preventive care use.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report. 

Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.4:** Improve Health for Members with Chronic Conditions **Objective:** Decrease Diabetes Poor Control **Objective:** Increase Control of High Blood Pressure	**Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure
HSAG Recommendation: To improve program-wide performance in support of Goal 4.4 and improve members' receipt of		

Recommendation—Performance Measure Validation
recommended care and services for better management of chronic conditions, HSAG recommends the following: • Require the MCOs to identify chronic health-related PMs that fell below the NCQA Quality Compass national Medicaid HMO 50th percentile and focus QI efforts on identifying the cause and implementing interventions to improve access to care. • Require the MCOs to identify healthcare disparities within the chronic health PM data to focus QI efforts on a disparate population.
DMAS' Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: • DMAS included the *measure Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)* and the *Controlling High Blood Pressure* measures in its PWP which provides an incentive to MCOs to increase performance and close gaps.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) MY 2020: 51.42% MY 2021: 47.39% **Metric:** Controlling High Blood Pressure MY 2020: 48.07% MY 2021: 53.24%
Identify any barriers to implementing initiatives: The COVID-19 PHE continued to be a barrier to improving performance to address the HSAG recommendations around improvement in preventive care use.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report. 

Appendix F. Quality Strategy Evaluation

Quality Strategy

In accordance with 42 Code of Federal Regulations (CFR) §438.340, the Virginia Department of Medical Assistance Services (DMAS) implemented a written quality strategy for assessing and improving the quality of healthcare and services furnished by the managed care organizations (MCOs) to Virginia Medicaid members under the Commonwealth Coordinated Care (CCC) Plus (Managed Long-Term Services and Supports [MLTSS]), Medallion 4.0 (Acute), and the Cardinal Care Medicaid managed care program. DMAS is the Commonwealth of Virginia's single State agency that administers all Medicaid and Family Access to Medical Insurance Security (FAMIS) health insurance benefit programs in the Commonwealth. Medicaid is delivered to individuals through two models, managed care and fee-for-service (FFS). Table 32 displays the average annual program enrollment during CY 2023.

Table 32—CY 2023 Average Annual Program Enrollment[43]

Program	SFY 2023 Enrollment as of 08/01/2023*
Title XIX Medicaid	1,933,150
Title XXI CHIP	190,660
Medallion 4.0 (Acute)	1,605,199
CCC Plus (MLTSS)	300,467
Fee-for-Service	228,429
Total Served	2,135,985

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

In June 2021, the Virginia General Assembly mandated that DMAS rebrand the Department's FFS and managed care programs and effectively combine the CCC Plus (MLTSS) and Medallion 4.0 (Acute) programs under a single name, the Cardinal Care program. The combined program achieves a single streamlined system of care that links seamlessly with the FFS program. DMAS received Centers for Medicare & Medicaid Services (CMS) approval for an effective date of October 1, 2023, for the Cardinal Care program.

The Cardinal Care program will ensure an efficient, well-coordinated Virginia Medicaid delivery system that provides high-quality care to members and adds value for providers and the Commonwealth. The consolidated program will enable DMAS to ensure better continuity of care for members, operate with improved administrative efficiency, and strengthen the focus on the diverse and evolving needs of the populations served. The Cardinal Care program will continue to offer members the same programs and services and will not reduce or change any existing coverage. The overarching program will ensure a smoother transition for individuals whose healthcare needs evolve over time.

[43] Cardinal Care, Virginia's Medicaid Program, Department of Medical Assistance Services. Medicaid/FAMIS Enrollment. Available at: https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/. Accessed on: Dec 6, 2023.

Virginia's 2023–2025 Quality Strategy provides the framework to accomplish DMAS' overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP system. The Quality Strategy is intended to guide Virginia's Medicaid managed care program by establishing clear goals to drive improvements in care delivery and outcomes, and the metrics by which progress will be measured.

The Quality Strategy sets a clear direction for priority interventions and details the standards and mechanisms for holding MCOs accountable for desired outcomes. The Quality Strategy is a roadmap through which DMAS will use the managed care infrastructure to facilitate improvements in health and healthcare through programmatic innovations, whole-person care, inclusive healthcare, provider supports, and steps to address health-related unmet resource needs. This vision is distilled into five central goals:

6. Enhance the member care experience
7. Promote access to safe, gold-standard patient care
8. Support efficient and value-driven care
9. Strengthen the health of families and communities
10. Provide whole-person care for vulnerable populations

DMAS' mission is to improve the health and well-being of Virginians through access to high-quality healthcare coverage. The Medicaid managed care program in Virginia is responsible for providing high-quality, innovative, and cost-effective healthcare to Medicaid enrollees.

DMAS contracted with six MCOs through September 30, 2023. In October 2023, the Optima and VA Premier MCOs merged under the Optima name. The five MCOs contracted with DMAS on December 31, 2023, are displayed in Table 33. These MCOs pay for Medicaid benefits and services included in the Virginia Medicaid State plan, State statutes and administrative rules, and Medicaid policy and procedure manuals.

Table 33—CCC Plus (MLTSS) MCOs in Virginia

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

**VA Premier and Optima merged on October 1, 2023. As of January 1, 2024, the MCOs name is Sentara Health Plan.*

Goals and Objectives

The Virginia 2021–2023 Quality Strategy identified goals and objectives that focus on process as well as achieving outcomes. The goals and supporting objectives are measurable and take into consideration the health status of all populations served by the Virginia Medicaid managed care program. Refer to Appendix B for a detailed description of the objectives and performance measures (PMs) used to support each goal.

Virginia's Quality Strategy identifies the following five goals and associated objectives:

Table 34—Quality Strategy Goals and Objectives

Goals	Objectives
 **Goal 1**: Enhance the Member Care Experience	**Objective 1.1:** Increase Member Engagement and Outreach
	Objective 1.2: Improve Member Satisfaction
 **Goal 2:** ★ Promote Access to Safe, Gold-Standard Patient Care ★	**Objective 2.1:** Ensure Access to Care
	Objective 2.2: Promote Patient Safety
	Objective 2.3: Promote Effective Communication and Care Coordination
 **Goal 3:** ★ Support Efficient and Value-Driven Care ★	**Objective 3.1**: Focus on Paying for Value
	Objective 3.2: Promote Efficient Use of Program Funds
	**Objective 4.1:** Improve Utilization of Wellness, Immunization, and Prevention Services for Members
	★ **Objective 4.2:** Improve Outcomes for Maternal and Infant Members ★

Goals	Objectives
Goal 4: Strengthen the Health of Families and Communities	**Objective 4.3**Improve Home and Community-Based Services
 **Goal 5:** Providing Whole-Person Care for Vulnerable Populations	**Objective 5.1:** Improve Outcomes for Members with Chronic Conditions
	Objective 5.2: Improve Outcomes for Nursing Home Eligible Members
	★ **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders ★
	★ **Objective 5.4:** Improve Behavioral Health and Developmental Services of Members ★

Note: Each goal has targeted metrics to measure progress, as well as outlined interventions to advance the goals. See Appendix B.
★ In alignment with Governor Glenn Youngkin's identified priorities for the Medicaid program.

Each of the 14 objectives is tied to focused interventions used to drive improvements within, and, in many cases, across the goals and objectives set forth in the 2023–2025 Quality Strategy. To assess the impact of these interventions and continue to identify opportunities for improving the quality of care delivered under Medicaid managed care, and in compliance with the requirements set forth in 42 CFR §438.340(b)(3), these interventions are tied to a set of metrics by which progress is assessed. This approach provides for data-driven decision making to drive interventions, inform priority setting, and facilitate efficient and effective deployment of resources.

Evaluation

DMAS uses several mechanisms to monitor and enforce MCO compliance with the standards set forth throughout the Quality Strategy, and to assess the quality and appropriateness of care provided to Medicaid managed care enrollees. The following sections provide an overview of the key mechanisms DMAS uses to enforce these standards and to identify ongoing opportunities for improvement.

Performance Measures

DMAS requires MCOs to report annually on patient quality, access, timeliness, and outcomes performance measures, including the Healthcare Effectiveness Data and Information Set (HEDIS®)[44] quality metrics, CMS Adult and Child Core Set of Health Care Quality Measures for Medicaid, Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs), Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[45] measures, and State-specified quality measures. The MCO performance measures align with the Quality Strategy's goals of enhancing the members' care experience, promoting access to safe, gold-standard patient care, supporting efficient and value-driven care, strengthening the health of families and communities, and providing whole-person care for vulnerable populations. DMAS assesses if MCO performance measures meet target objectives or improvement objectives.

Medallion 4.0 (Acute)

Progress

In alignment with the DMAS Quality Strategy goal of strengthening the health of families and communities, in the Children's Preventive Health domain, four of six MCOs' rates met or exceeded the 50th percentile for the *Child and Adolescent Well-Care Visits—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* PM indicators. The Child Welfare Focus Study also demonstrated improvements towards Quality Strategy goals. The study found that children in foster care have higher rates of appropriate healthcare utilization than comparable controls for most study indicators in MY 2019, MY 2020, and MY 2021. Study findings show that MY 2021 rate differences between children in foster care and controls were greatest among the dental study indicators (*Annual Dental Visit; Preventive Dental Services; Oral Evaluation, Dental Services;* and *Topical Fluoride for Children—Dental or Oral Health Services* by 18.2, 19.0, 19.0, and 14.2 percentage points, respectively); the *Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics* measure (by 20.4 percentage points); and the *Behavioral Health Encounters—CMH Services* indicator (by 17.1 percentage points).

Progress was made toward achieving DMAS' Quality Strategy goal of providing whole-person care for vulnerable populations in the Care for Chronic Conditions domain. Five of six MCOs' rates met or exceeded the 50th percentile for the *Asthma Medication Ratio—Total* and

[44] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[45] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Hemoglobin A1c Control for Patients With Diabetes—HbA1c control (<8.0%) measure indicators.

The DMAS Quality Strategy goal of improving outcomes for maternal and infant health also demonstrated improvement in the Maternal and Child Health Focus Study results, where the FAMIS MOMS program results demonstrated improvement, with rates for the *Births with Early and Adequate Prenatal Care*, *Preterm Births (<37 Weeks Gestation),* and *Newborns with Low Birth Weight (<2,500 grams)* study indicators outperforming the applicable national benchmarks for all three measurement periods. The Medicaid for Pregnant Women program had rates for the *Preterm Births (<37 Weeks Gestation)* study indicator that outperformed national benchmarks in CYs 2020 and 2021. and had rates for the *Newborns with Low Birth Weight (<2,500 grams)* study indicator that outperformed national benchmarks in CYs 2019, 2020, 2021, Additionally, the Medicaid Expansion program's rate for the *Births with Early and Adequate Prenatal Care* study indicator improved from CY 2020 and outperformed the national benchmark in CY 2021.

Progress toward achieving the DMAS Quality Strategy objective of improving outcomes for members with substance use disorders (SUDs) and improving behavioral health and developmental services for members was demonstrated with all six MCOs' rates meeting or exceeding the 50th percentile for the *Follow-Up After Emergency Department (ED) Visit for Substance Use—7-Day Follow-Up—Total, 30-Day Follow-Up—Total* and *Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment* PM indicators. Additionally, five of six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment* PM indicators.

Additional evidence of progress toward achieving the Quality Strategy goals was found in the *Cascade of Care for Members With Opioid Use Disorder* (*OUD)—High-Risk Members With OUD Diagnosis* indicator, which assessed identification of members with an OUD. Findings show that this rate increased from 3.8 percent to 5.1 percent from CY 2020 to CY 2021. In addition, several study indicators showed that initiation of SUD treatment is increasing overall, though findings differ by type and timeliness of treatment. Of members diagnosed with OUD, 44.2 percent initiated any OUD treatment (i.e., pharmacotherapy or other treatment) within 14 days of OUD diagnosis in CY 2021, and this rate increased by 4.7 percentage points from CY 2020. The rate change was driven by an increase in members initiating pharmacotherapy, for which the rate increased by 6.2 percentage points from CY 2020 to CY 2021.

Opportunities

Opportunities for improvement in achieving the Quality Strategy goal of strengthening the health of families and communities in the Children's Preventive Health domain. Four of the six MCOs' rates fell below the 50th percentile for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits and Childhood Immunization Status—Combination 3* PM indicators.

The DMAS Quality Strategy goal of improving outcomes for maternal and infant health also demonstrated opportunities for improvement. All six MCOs' rates fell below the 50th percentile for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* PM indicators. In addition, the DMAS Quality Strategy goal of strengthening the health of families and communities also had opportunities for improvement in the Access to Care domain as all six MCOs' rates fell

below the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator.

The Quality Strategy goal of promoting access to safe, gold-standard patient care also demonstrated opportunities for improvement in preventive screenings. While one MCO improved performance over the prior year, the overall MCO performance was below the 50th percentile for the *Cervical Cancer Screening* PM indicator. In addition, all six MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* indicator.

Opportunities were also identified in achieving DMAS' Quality Strategy goal of providing whole-person care for vulnerable populations. Within the Care for Chronic Conditions domain, five of the six Medallion 4.0 (Acute) MCOs' rates fell below the 50th percentile for the *Eye Exam for Patients With Diabetes—Total* PM indicator. MCO performance below the 50th percentile indicates some members with diabetes are not receiving eye examinations as recommended to appropriately manage risks associated with diabetes.

Although progress was made overall in behavioral health and substance use quality goals, opportunities persist in achieving the DMAS Quality Strategy objective of improving outcomes for members with SUDs. The Addiction and Recovery Treatment Services (ARTS) study findings show that engagement in OUD treatment may be declining. The *Cascade of Care for Members With OUD—Members who Initiated OUD Treatment who Also Engaged in OUD Treatment* indicator found that 40.7 percent of members who had initiated OUD treatment engaged in OUD treatment for six months following OUD diagnosis, and this rate declined by 8.7 percentage points from CY 2020 to CY 2021. However, the rate for CY 2021 may be especially impacted by the coronavirus disease 2019 (COVID-19) public health emergency (PHE), since this study indicator utilizes visits from the year prior to the measurement year. Therefore, many of these missed engagement visits were supposed to happen during 2020 after the onset of the PHE. The ARTS study findings are consistent with the overall Medallion 4.0 (Acute) PM results, with five of the six MCOs' rates falling below the 50th percentile for the *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* and *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators. Additionally, four of the six MCOs' rates fell below the 50th percentile for the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* PM indicator. This performance suggests that members have not received timely follow-up after ED visits and hospitalizations for mental illness. Individuals hospitalized for mental health disorders often do not receive adequate follow-up care.

CCC Plus (MLTSS)

Progress

Progress in achieving the DMAS Quality Strategy objective of improving outcomes for members with substance use disorders and improving behavioral health and substance use disorders. Overall, behavioral health (BH) care and ARTS demonstrated improvement for the CCC Plus (MLTSS) program. The ARTS study findings show that identification of members with SUD may be improving, in alignment with ARTS benefit goals. The *Cascade of Care for Members With OUD—High-Risk Members With OUD Diagnosis* indicator assessed identification of members with an OUD. Findings show that this rate increased from 3.8 percent to 5.1 percent from CY 2020 to CY 2021. In addition, several study indicators found that initiation of SUD treatment is increasing overall, though findings differ by type and timeliness of treatment. For example, 44.2 percent of members diagnosed with OUD initiated any OUD treatment (i.e., pharmacotherapy or

other treatment) within 14 days of OUD diagnosis in CY 2021, and this rate increased by 4.7 percentage points from CY 2020. The rate change was driven by an increase in members initiating pharmacotherapy, for which the rate increased by 6.2 percentage points from CY 2020 to CY 2021. The emphasis and focus on the ARTS program may be driving improvement in BH measures.

The MCOs also demonstrated progress in achieving Quality Strategy goals and objectives within the Behavioral Health PM domain related to the use of medication to treat mental health conditions, as all six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment, Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total, Diagnosed Mental Health Disorders—Total, Diagnosed Substance Use Disorders—Alcohol disorder—Total, Diagnosed Substance Use Disorders—Opioid disorder—Total, Diagnosed Substance Use Disorders—Other or unspecified drugs—Total,* and *Diagnosed Substance Use Disorders—Any disorder—Total* PM indicators. In addition, five of the six MCOs' rates for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Total* measure also met or exceeded the 50th percentile.

There was demonstrated progress toward achieving the DMAS Quality Strategy goal of strengthening the health of families and communities in the Access to Care domain Access and Preventive Care: All six MCOs' rates met or exceeded the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure.

In alignment with the DMAS Quality Strategy goal of strengthening the health of families and communities and the Taking Care of Children domain, five of six MCOs' rates met or exceeded the 50th percentile for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total* and *Blood Glucose and Cholesterol Testing—Total* PM indicators.

Progress was made toward achieving DMAS' Quality Strategy goal of providing whole-person care for vulnerable populations in the Living With Illness domain—MCO performance showed improvement with five of six MCOs' rates having met or exceeded the 50th percentile for the *Asthma Medication Ratio—Total, Eye Exam for Patients With Diabetes—Total, Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Total,* and *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications* PM indicators.

Opportunities

The DMAS Quality Strategy goal of strengthening the health of families and communities also demonstrated opportunities for improvement in the Access to Care and Preventive Care domain. within the Access and Preventive Care domain, cancer screenings for women, pregnancy care, and appropriate use of imaging studies for low back pain represent an area for opportunity Virginia-wide, as all reportable MCO rates fell below the 50th percentile for the *Cervical Cancer Screening, Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care,* and *Use of Imaging Studies for Low Back Pain* measures. Additionally, five of six MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* measure.

Opportunities exist in achieving the DMAS Quality Strategy objective of improving outcomes for members with SUDs and improving behavioral health and developmental services. Five of six MCOs' rates fell below the 50th percentile for *Cardiovascular Monitoring for People With*

Cardiovascular Disease and Schizophrenia—Total, Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total,* and all three MCOs' rates without a small denominator fell below the 50th percentile for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measures.

Opportunities also exist in the Taking Care of Children domain. All six CCC Plus (MLTSS) MCOs' rates for the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total* PM indicators fell below the 50th percentile. While the COVID-19 PHE contributed to a decline in routine pediatric vaccine ordering and doses administered, the MCOs' continued performance below the 50th percentile suggests children are not receiving vaccines at a rate in line with national benchmarks.

The MCOs did not meet improvement objectives for measures related to DMAS' goal to strengthen providing whole-person care for vulnerable populations in the Care for Chronic Conditions domain. Five of the six MCOs' rates fell below the 50th percentile for the *Blood Pressure Control for Patients With Diabetes—Total* and *Controlling High Blood Pressure—Total* measures. MCO performance below the 50th percentile indicates that some members with diabetes and hypertension are not receiving appropriate care to support optimal health.

CAHPS

DMAS requires the external quality review organization (EQRO) to administer a CAHPS survey according to the NCQA HEDIS Specifications for Survey measures. This activity assesses member experience with an MCO and its providers and the quality of care members receive. The standard survey instruments are the CAHPS 5.1H Child Medicaid Health Plan Survey and the 5.1H Adult Medicaid Health Plan Survey. CAHPS global ratings are for *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Personal Doctor*. Additionally, CAHPS composite measures are *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*.

However, the CCC Plus (MLTSS) *Getting Care Quickly* indicator rate was statistically significantly lower in 2023 than in 2022.

Medallion 4.0 (Acute) Adult Survey

In alignment with the DMAS Quality Strategy goal of promoting access to safe, gold-standard patient care, and the objective of ensuring access to care, the Medallion 4.0 (Acute) adult member CAHPS 5.1 Adult Medicaid Health Plan Survey scores met or exceeded the national Medicaid benchmarks in the NCQA Quality Compass®,[46] for the *Rating of Health Plan* Global indicator.

Medallion 4.0 (Acute) Child Survey

The Medallion 4.0 (Acute) program's 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for *Getting Care Quickly*. This represents an

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

opportunity for improvement in relation to the Quality Strategy goal of Enhancing the Member Care Experience.

CCC Plus (MLTSS) Child Survey

Also, in alignment with the DMAS Quality Strategy goal of promoting access to safe, gold-standard patient care, and the objective of ensuring access to care, the Medallion 4.0 (Acute) program Global child member CAHPS 5.1H Child Medicaid Health Plan Survey scores did not meet or exceed the national Medicaid benchmarks in the NCQA Quality Compass for any indicators. In addition, the Composite Top-Box Scores showed a Medallion 4.0 (Acute) statistically significantly lower rate in the *Getting Care Quickly* indicator than the 2022 NCQA Medicaid national average.

The CCC Plus (MLTSS) Global child member CAHPS 5.1H Child Medicaid Health Plan Survey rates were statistically significantly lower in the *Rating of Health Plan* and *Rating of All Health Care* indicators. The CCC Plus (MLTSS) Top-Box scores for the *How Well Doctors Communicate* indicator was statistically significantly higher than the 2022 NCQA Medicaid national average. The results identify an opportunity for improvement for achieving Quality Strategy Goal 1: Enhance the Member Care Experience.

CCC Plus (MLTSS) Adult Survey

Progress toward achieving the Quality Strategy goal of improving member satisfaction was demonstrated in the 2023 CAHPS results. The CCC Plus (MLTSS) program's 2023 top-box scores were statistically significantly higher than the 2022 NCQA adult Medicaid national averages for four measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Care Quickly*, and *Customer Service*. The CAHPS survey results demonstrate members' overall satisfaction with aspects of the CCC Plus (MLTSS) program.

The CCC Plus (MLTSS) adult member CAHPS 5.1 Adult Medicaid Health Plan Survey scores met or exceeded the national Medicaid benchmarks in the NCQA Quality Compass® for the *Rating of Health Plan* and *Rating of Specialist Seen Most Often* Global indicators. The Composite Top-Box Scores showed CCC Plus (MLTSS) statistically significantly higher rate than the 2022 NCQA Medicaid national averages in the *Getting Care Quickly* and *Customer Service* indicators.

FAMIS Program Child Survey

Although not a metric in the Quality Strategy, the FAMIS general child and CCC 2023 CAHPS scores in the Composite measure, *Customer Service*, identified a top-box score that was statistically significantly higher than the 2022 top-box score. However, the CCCs 2023 top-box scores were statistically significantly lower than the 2022 NCQA Child Medicaid national averages for two measures: *Rating of All Health Care* and *Getting Needed Care.* These results represent an opportunity for improvement for achieving Goal 1—Enhance the Member Care Experience.

External Quality Review (EQR) Activities

As noted in the Quality Strategy, the EQRO plays a critical role in reporting MCOs' performance in several required areas (meaning federal regulations require that these activities be completed

by the EQRO) and some optional areas (meaning that the State has elected to use the EQRO for these activities) under 42 CFR §§438.352 and 438.364.

Performance Evaluation and Improvement

The final audit reports (FARs) issued by each MCO's independent auditor, were reviewed and it was identified that all MCOs were determined to be fully compliant with all applicable NCQA HEDIS information systems standards. Additionally, the MCO's independent audit determined that all reported rates were calculated in accordance with NCQA's specifications and no data collection or reporting concerns were identified.

Health Services Advisory Group, Inc. (HSAG) also conducted the PMV for each MCO to assess the accuracy of PMs reported by the MCOs, determine the extent to which these PMs follow Commonwealth specifications and reporting requirements, and validate the data collection and reporting processes used to calculate the PM rates. DMAS identified and selected the specifications for a set of PMs that the MCOs were required to calculate and report.

An ISCA was also conducted for each MCO, and the assessment indicated that the MCOs met the federal requirement of maintaining a health information system that collects, analyzes, integrates, and reports data.

Performance Improvement Project (PIP) Validation

MCOs had an ongoing program of PIPs that intended to improve the care, services, and enrollee outcomes in each topic area. DMAS-approved MCO PIPs are listed below in Table 35. DMAS and the EQRO facilitated regular PIP meetings with the MCOs to provide guidance and collaboration. The EQRO validated each MCO's PIPs and provided results and findings for each MCO, along with recommendations for improvement.

Table 35—DMAS-Approved MCO PIPs

Program	PIP Topic Area
Medallion 4.0 (Acute)	*Timeliness of Prenatal Care* rates for the percentage of deliveries that received a prenatal care visit in the first trimester, on or before enrollment start date, or within 42 days of enrollment with the MCO as defined by the HEDIS MY 2022 *Prenatal and Postpartum Care* (PPC) Technical Specifications. (Quality Strategy goal: Strengthen the Health of Families and Communities; objective: ★ Improve Outcomes for Maternal and Infant Members. ★)
Medallion 4.0 (Acute)	*Tobacco Use Cessation in Pregnant Women* rates for all pregnant women, as defined by the HEDIS MY 2022 PPC Technical Specifications, identified as smokers or tobacco users. (Quality Strategy goal: Strengthen the Health of Families and Communities; objective: ★ Improve Outcomes for Maternal and Infant Members ★; and goal: Providing Whole Person Care for Vulnerable Populations; objective: Improve Behavioral Health and Developmental Services for Members.)
CCC Plus (MLTSS)	*Ambulatory Care—Emergency Department Visits* rates for the percentage of members in the entire eligible population aligned with the HEDIS MY 2022 Technical Specifications *Ambulatory Care* (AMB) measure specifications and who had more than one emergency department visit. (Quality Strategy goal: ★

Program	PIP Topic Area
	Support Efficient and Value-Driven Care ★; objective: Focus on Paying for Value.)
CCC Plus (MLTSS)	*Follow-Up After Discharge* rates for the percentage of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge. (Quality Strategy goal: ★ Support Efficient and Value-Driven Care ★; objective: Focus on Paying for Value.)

Validation of Network Adequacy

HSAG will conduct the *EQR Protocol 4. Validation of Network Adequacy* activity beginning in calendar year 2024. In preparation for the task, HSAG identified that to assess appointment availability, DMAS established minimum standards to ensure members' needs were sufficiently met. DMAS monitors the MCO's compliance with these standards through regular reporting requirements outlined in the DMAS Managed Care Technical Manual. In addition, DMAS requires the MCOs to conduct various activities to assess the adequacy of their networks as well as maintain provider and beneficiary data sets that allow monitoring of their networks' adequacy. DMAS requires MCOs to conduct:

- Geomapping to determine if provider networks meet quantitative time and distance standard
- Calculation of provider-to-enrollee ratios, by type of provider and geographic region
- Analysis of in-network and out-of-network utilization data to determine gaps in realized access
- Appointment availability and accessibility studies, including the proportion of in-network providers accepting new patients and the average wait time for an appointment
- Validation of provider directory information

In preparation for the 2024 Network Adequacy Validation task, HSAG obtained from DMAS a list of the State's quantitative network adequacy standards, by provider and plan type, as specified in the State's contract with the MCOs. DMAS has also provided a description of the network adequacy data and documentation that MCOs submit to the State to demonstrate compliance with network adequacy standards, including a list of the data and documentation submitted by the MCOs; the frequency with which the MCOs submit each type of data; formatting requirements for MCO data and documentation; DMAS standards for data completeness and accuracy, and DMAS data dictionaries and applicable companion guides.

Prenatal Care Secret Shopper Survey

The prenatal care secret shopper survey provides indicators for MCO performance in relation to Goal 2: ★ Promote Access to Safe, Gold-Standard Patient Care ★, Objective 2.1: Ensure Access to care, and Goal 4: Strengthen the Health of Families and Communities, Objective 4.2: ★ Improve Outcomes for Maternal and Infant Members ★. HSAG conducts a prenatal care secret shopper survey of appointment availability to collect information on members' access to initial prenatal care services. For the Medallion 4.0 (Acute) program, 29.6 percent of offices contacted stated that the office accepted the VA Medicaid program, and 26.0 percent stated that the office accepted new patients. A first, second, and third trimester appointment date was provided 28.0 percent of the time. Of the appointments which were offered, 15.1 percent were compliant with DMAS wait time standards. There was a substantial difference in the percentage

of appointments offered by trimester (i.e., first, second, or third). For cases that were offered a first trimester appointment, 15.1 percent (n=8) were compliant with the seven-calendar-day standard for prenatal care services. For cases that were offered a second trimester appointment, 21.4 percent (n=3) were compliant with the seven-calendar-day standard for prenatal care services. For cases that were offered a third trimester appointment, 10.5 percent (n=2) were compliant with the three-business-day standard for prenatal care services.

Primary Care Provider (PCP) Secret Shopper Survey

HSAG also conducts a PCP secret shopper survey of appointment availability to collect information on members' access to primary care services. The primary care provider secret shopper survey provides indicators for MCO performance in relation to Goal 2: ★ Promote Access to Safe, Gold-Standard Patient Care ★, Objective 2.1: Ensure Access to care, and Goal 4: Strengthen the Health of Families and Communities, Objective 4.1: Improve the Utilization of Wellness, Immunization, and Prevention Services for Members. For the Medallion 4.0 (Acute) program, 46.7 percent of offices contacted stated that the office accepted the MCO, 43.3 percent stated that the office accepted the VA Medicaid program, and 36.1 percent stated that the office accepted new patients. Survey results showed that 4.0 percent of calls were offered an appointment date for a routine appointment and 73.1 percent were offered an appointment date for an urgent or routine appointment. Of the appointments which were offered, 74.5 percent met the DMAS standard of offering an appointment within 30 days for routine appointments. For urgent visit appointments offered, 16.0 percent met the DMAS standard of offering an appointment within one day for urgent appointments.

For the CCC Plus (MLTSS) program, 46.7 percent stated the office accepted the MCO, 43.3 percent stated that the office accepted the VA Medicaid program, and 36.1 percent stated that the office accepted new patients. Survey results showed that 74.0 percent of calls were offered an appointment date for a routine appointment and 72.3 percent were offered an appointment date for an urgent appointment. Of the appointments which were offered, 74.5 percent met the DMAS standard of offering an appointment within 30 days for routine appointments. For urgent visit appointments offered, 16.0 percent met the DMAS standard of offering an appointment within one day for urgent appointments with rates.

Cardinal Care Program Readiness Reviews

During 2022 and 2023, Cardinal Care program readiness reviews were conducted for all six MCOs. The readiness review included an assessment of all key program areas noted in 42 CFR §438.66(d)(4). The key program areas and related requirements were delineated between four separate readiness review components—Operations/Administration, Service Delivery, Information Systems Management, and Financial Management.

The readiness review process included federal and State-specific standards for 438.12—Prohibition on Provider Discrimination, 438.206—Availability of Services, 438.207—Assurances of Adequate Capacity and Services, and 438.214—Provider Selection. The review also contained federal standards and state-specific requirements for 438.230—Subcontractual Relationships and Delegation. Network adequacy was determined from a review of policies and procedures and a review of the MCOs' monthly and quarterly GeoAccess and other network reports, network contracting status, credentialing status, and network exception reports when network requirements were not met as a result of a lack of providers in the region, or the geographic area being determined a dearth county by DMAS. All network exception reports were approved by DMAS. MCO Cardinal Care program readiness review results indicated that

the MCOs had adequate access and availability to serve members enrolled in the Cardinal Care program.

Compliance Monitoring

During 2021 a compliance audit was conducted for each MCO to review compliance with federal regulations and state contract requirements. The comprehensive MCO compliance audit included all federal requirements and related state-specific requirements including:

- Enrollment and Disenrollment: 438.56
- Member Rights and Confidentiality: 438.100; 438l.224
- Member Information: 438.10
- Emergency and Poststabilization Services: 438.114
- Assurance of Adequate Capacity and Availability of Services: 438.206; 438.207
- Coordination and Continuity of Care: 438.208
- Coverage and Authorization of Services: 438.210
- Provider Selection: 438.214
- Subcontractual Relationships and Delegation: 438.230
- Practice Guidelines: 438.236
- Health Information Systems (including ISCA): 438.242
- Quality Assessment and Performance Improvement: 438.330
- Grievance and Appeal Systems: 438.228
- Program Integrity: 438.608
- EPSDT Services: 441.58 Section 1905 of the SSA
- Assurances of Adequate Capacity and Services
- Coverage and Authorization of Services
- Provider Selection
- Enrollee Rights and Protection
- Grievance and Appeal Systems
- Quality Assessment and Performance Improvement
- Provider Selection
- Enrollee Rights and Protection

For the elements in standards that were not fully compliant, the MCOs were required to develop a corrective action plan which was reviewed by the EQRO and DMAS. Corrective action plans were approved when it was determined that the corrective action plan would bring the MCO into compliance with the requirements. DMAS provided ongoing monitoring of the implementation of the MCOs' corrective action plans.

Annual EQR Technical Reports

To ensure DMAS' compliance with 42 CFR §438.364, aggregate technical reports were prepared and included all required components as outlined in the EQR protocols. Aggregated and analyzed data from the EQR activities was included, and conclusions were drawn with

regard to the quality of, timeliness of, and access to health services furnished to MCO members. Conclusions were described in detail and actionable recommendations, as applicable, were provided. Additionally, based on the assessment, notable strengths were included so that the MCOs were able to build upon identified performance improvement and recommendations for identified Quality Strategy opportunities for improvement. The MCOs provided a summary of the quality improvement initiatives implemented as a result of the previous year's EQR recommendations. Quality Strategy performance metric rates were included as evidence of the extent to which those actions resulted in improvement in the Quality Strategy goals and objectives tied to quality, access, or timeliness of care and services.

Addressing Health Disparities

During the VA 2021–2023 review period, DMAS continued to work diligently, in collaboration with the MCOs, to operationalize community engagement and health equity best practices and standards. To meet Virginia's Quality Strategy goal of providing whole-person care for vulnerable populations, DMAS and/or the MCOs implemented the following strategies to address health disparities:

- Partnership for Petersburg: In August of 2022, Governor Glenn Youngkin announced a transformative program called "Partnership for Petersburg." This program has been focused on bringing together public and private resources to help the City of Petersburg and its residents, who have experienced negative health, public safety, education, and economic outcomes. One component of this plan is to improve the health of Petersburg's residents by increasing access to preventative screenings, promoting awareness of primary care and addressing prenatal health disparities by connecting Petersburg residents with medical and social services. DMAS Focus Areas: 1. Improve Petersburg maternal and infant health outcomes. 2. Provide Primary Care Services, Mobile Health Clinics, and Community Events 3. Expand School-Based Clinic Services through the Crimson Clinic Information Request Submitted Response 4. Establish Community-Based Health Literacy Hubs. DMAS's Key Collaborators and Partners: Medicaid MCOs (Aetna, Anthem, Molina, Optima and United), Central Virginia Health Services, Crimson Clinic, Crater Health District, Bon Secours Southside Regional Hospital, Petersburg City Public Schools, DentaQuest, Conexus, Petersburg Sheriff's Office, VDH, and the Department of Social Services.
- CMS Infant Well-Child Visit Learning Collaborative: The learning collaborative offers technical assistance to state Medicaid and Children's Health Insurance Program (CHIP) agencies and their partners (MCOs and other partners, DMAS and its partners are receiving technical assistance in designing and implementing a quality improvement project aimed at identifying ways increase participation in well-child visits. The collaborative initiated interventions with providers in Roanoke, Winchester, Tidewater Area, Petersburg, and Southwest Virginia. The initiative started in March 2021 and will conclude in December 2023. Initiatives have focused on enrollment processes (newborn), member education, consistent messaging across MCOs regarding enrollment.
    - Baby Steps Virginia: Baby Steps Virginia is the vehicle with which Virginia Medicaid brings together sister agencies, other key partners and stakeholders and the voice of the member with the focus of improving maternal health outcomes, eliminate racial disparity in outcomes and maternal mortality. Baby Steps Virginia incorporates awareness of issues like social determinants of health (SDOH), barriers to care, and member/provider engagement.

- Community Doula Program: To date, 125 doulas have received state certification. Of the 125 state-certified doulas, 90 are approved and enrolled as Medicaid Doula Providers. There have been 107 doula-supported births to Medicaid members and over 304 birthing families have received doula services through Virginia Medicaid. Feedback continues to be positive from families who have received care and support from a doula. DMAS continues to focus on increasing the network of doula providers, community and provider engagement, and data. The availability of state-certified Medicaid-approved doula providers within the Commonwealth means greater access to care and support for pregnant people with the goal of improving maternal and infant health outcomes, reducing infant and maternal mortality, and helping to address racial and health disparities.
- Improving Timely Health Care for Children and Youth in Foster Care—Affinity Group: developed, tested, and collected data around a variety of pilot interventions in order to identify changes that would lead to improvement in the rate of the specific health care service being measured (*initial comprehensive medical examination within 30 days of a child entering foster care*). By the end of the 2-year Affinity Group, the team was able to identify barriers to accessing timely health care services for the foster care member population, as well as utilize data to demonstrate the success of several pilot tests that improved the identified process measures and outcome measures of the project.

  The most successful interventions identified were several iterations of warm handoffs of new foster care member information between VDSS or LDSS agencies and DMAS or the assigned MCO care coordinators, in order for MCOs to support the scheduling and completion of comprehensive health care visits within the first 30 days of placement. One 9-month pilot test with Bedford County Department of Social Services resulted in an improvement in MCO successful outreach to members in Bedford from an average of 52 days down to 2 days after entering foster care. The team then scaled the pilot up statewide and tested a less labor-intense process while continuing to see improvement, though not as significant (down to an average of 28 days). Outcome measures for both warm handoff pilots discussed also improved, with 100% of members in Bedford County receiving initial medical examinations within 30 days of entering custody for the final 7 months of the test.

MCO Cardinal Care Program Contract Language

DMAS included healthy equity requirements in the Cardinal Care program MCO contract. The MCO contract requires that the MCO consider the importance of health equity and disparities among populations in developing its various programs to provide services to members. The MCO must develop and maintain an annual report outlining its efforts to address health disparities for the managed care population. The contract also states that the MCO may refer to the Virginia Department of Health's Office of Health Equity for more information regarding health disparities in the Commonwealth of Virginia.

The MCO contract also includes MCO requirements for the CMS 1115 demonstration for the 12-month postpartum coverage extension. Among the measures the demonstration evaluation includes is the advancement of health equity by reducing racial/ethnic and other disparities in maternal health coverage, access, and outcomes as well as infant health outcomes among postpartum Medicaid and CHIP enrolled women and infants.

Quality improvement requirements in the MCO contract state that the MCO's QI initiatives must be designed to help achieve the goals outlined in the Virginia Quality Strategy. Quality improvement requirements also state that DMAS is responsible for evaluating the quality of care provided to eligible enrollees in the contracted MCOs. DMAS partners with the MCOs and follows state, federal and DMAS policies to ensure that Medicaid members, both those receiving

physical and mental health services, receive high quality cost-effective care, driven by innovation. The contract states that the care provided must meet standards for improving quality of care and services, access, transition of care, health disparities and timeliness.

MCOs are required to include in their quality assessment and performance improvement plan a description of the processes for collection and submission of performance measurement data, including any required by DMAS for identifying and analyzing objectives for servicing diverse memberships that includes but is not limited to analyzing significant health care disparities gaps.

The MCO contract includes additional requirements aimed at addressing and reducing healthcare disparities such as:

- **Doulas:** MCOs implementation of a community-based doula service. Doulas are community-based and trained to provide extended, culturally congruent support to families through pregnancy to include antepartum, intrapartum, during labor and birth, and up to one year postpartum. The community-based doulas provide an expanded set of services and play a crucial role in improving outcomes and experiences for communities most affected by discrimination and disparities in health outcomes.
- **Enhanced Benefits:** Enhanced benefits are services offered by the Contractor to Members in excess of the Managed Care program's covered services. The contract provides an example of an enhanced benefit as coverage by the MCO of services that address social determinants of health. For members with long-term care needs, enhanced benefits may include strategies to address social needs.
- **Community-Based Resources:** Strategies may include providing linkages to community-based resources and information on service providers and referrals (social needs are related to the conditions that make up the social determinants of health, including but not limited to housing, food, economic security, community and information supports, and personal goals.
- **Addressing Social Determinants of Health:** The MCO contract states that the MCO must develop programs, establish partnerships, and provide care coordination efforts that identify, address and track member needs across each of the five (5) key SDOH areas identified by the federal Office of Disease Prevention and Health Promotion's, Healthy People 2020, including each of the Economic Stability subsections listed below:
  1. Economic Stability (access to employment, food security, housing);
  2. Education;
  3. Social and Community Context;
  4. Health and Health Care; and
  5. Neighborhood and Built Environment.

The MCO contract requires the submission of an annual report detailing how the MCO is identifying, addressing via programs and partnerships, and tracking each of the five key areas of SDOH.

Other Medicaid Health Equity Initiatives

- Convening a quality collaborative to address best practices, review results of performance measures, and performance improvement projects that focused on health disparities.
- Working closely with the Virginia Commonwealth University Office of Health Equity (OHE) to identify health disparities and their root causes and to promote opportunities to be healthy.

The work includes the development of programs and partnerships to empower racial and ethnic minority communities to promote awareness of health disparities.

- Working with the OHE Division of Multicultural Health and Community engagement in initiatives to identify approaches to eliminate health disparities through a focus on SDOH as a key strategy to eliminate health disparities that exist by socioeconomic status, race/ethnicity, geography, gender, immigrant status, and other social classifications.
- Producing an annual study of Medicaid and CHIP prenatal care and associated birth outcomes to identify, evaluate, and reduce—to the extent practicable—health disparities based on age, race, ethnicity, sex, primary language, geographic location, and disability status in birth outcomes.
- Working with MCOs in addressing the SDOH that are impacting members including:
  - Screening members for food insecurity, housing instability, transportation needs, and interpersonal violence.
  - Providing resources and assistance in securing health-related services and resource navigation to members identified with unmet health-related needs.
  - Supporting public-private evidence-based interventions designed to reduce costs and improve health by addressing eligible Medicaid beneficiaries' housing instability, transportation insecurity, food insecurity, and interpersonal violence.
  - Identifying areas of high disparity to guide resources and to work with communities to address SDOH.
  - Maintaining a resource platform accessible to members both online and through the MCO's call center.
- Stratifying performance measure data to identify, evaluate, and reduce—to the extent practicable—health disparities based on age, race, ethnicity, sex, primary language, and disability status.
- Engaging and collaborating with internal and external stakeholders (providers, MCOs, other state agencies, members, etc.) to reduce health disparities and address health equity concerns.

Use of Sanctions

DMAS may impose sanctions due to noncompliance with contract requirements or applicable federal or state laws. The types of intermediate sanctions that DMAS may impose on the MCO shall be in accordance with §1932 of the Social Security Act (42 U.S.C. §1396u-2) and 42 CFR §438.702-708 and may include any of the following:

- Civil monetary penalties in the amounts specified in 42 CFR §438.704
- Appointment of temporary management for an MCO as provided in 42 CFR §438.706;
- Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll;
- Suspension of all new enrollments, including automatic assignment, after the effective date of the sanction;
- Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or DMAS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur in accordance with 42 CFR §438.730; and
- Additional sanctions allowed under state statutes or regulations that address areas of noncompliance described above.

The following areas of noncompliance resulted in an MCO receiving a notice of corrective action:

- Internal system issues which impacted CRMS SA data submission. As a result, the MCO developed a crosswalk of expected values to overcome the QNXT system limitations.
- An MCO submitted four (4) SA Medical files with authorized decision dates ranging from July 23, 2017 through November 1, 2021 to CRMS Production without approval from DMAS. The files loaded or updated 84,819 files in production. On August 27, 2021, the MCO failed to prevent such an incident from reoccurring and submitted four (4) SA Medical files to CRMS Production without approval from DMAS. The MCO updated internal controls to prevent test files from being loaded into the production environment. Specific action items were added to incorporate the MFT process into the internal control process.
- An MCO entered a member into the DMAS Web Portal for LTSS Services prior to a valid level of care screening being conducted. The MCO updated DMAS 80 forms processing, the Enrollment Change Request Form, and implemented a second-level review with a supervisor signature requirement.
- An MCO's Fiscal/Employer Agent improperly withheld FICA tax from attendants' paychecks. As a result, the MCO conducted a thorough review of internal controls and developed a remedial process to resolve the payroll software issue and impact to members and their attendants.
- An MCO approved an implementation that migrated their web portal and website platform to their MyAccount platform without DMAS' approval. The MCO collaborated with DMAS to establish acceptable approval processes for the implementation of system changes that have the potential to significantly impact members.

Performance Withhold Program

In 2023, DMAS contracted with HSAG to establish, implement, and maintain a scoring mechanism for the Medallion 4.0 (Acute) and the CCC Plus (MLTSS) PWPs. The SFY 2023 PWP assessed CY 2022 PM data to determine what portion, if any, of the MCOs' quality withhold would be earned back. For the SFY 2023 PWP, the Medallion 4.0 (Acute) MCOs could earn all or a portion of their one percent quality withhold based on performance for seven NCQA HEDIS measures (14 measure indicators), one Agency for Healthcare Quality (AHRQ) Pediatric Quality Indicator (PDI) measure (one measure indicator), and two CMS Adult Core Set measures (two measure indicators). The SFY 2023 PWP was based on comparisons to the NCQA Quality Compass national Medicaid HMO percentiles for all HEDIS measures and, receiving a reportable audit status on the AHRQ PDI and CMS Adult Core Set PMs.

Health Information Technology

Virginia's HIS and other technology initiatives support the overall operation and review of the Quality Strategy. DMAS' modernized technology system allowed for increased data collection, analytics, oversight, and reporting functions for DMAS. The MES includes the Enterprise Data Warehouse System (EDWS), a component that significantly enhanced DMAS' ability to analyze MCO data. Within the EDWS, there are powerful management, analytic, and visualization tools that allow DMAS to review and monitor MCOs with increased oversight and detail.

Quality Initiatives

Virginia has developed a series of initiatives aligned closely to the Quality Strategy and designed to build an innovative, person-centered, coordinated system of care that addresses both medical and nonmedical drivers of health. These initiatives drive progress towards the Quality Strategy goals and objectives. These initiatives are discussed below.

Right Help, Right Now

Governor Glenn Youngkin created *Right Help, Right Now* to reform Virginia's behavioral health system and to support individuals in crisis. The goal of *Right Help, Right Now* is to support Virginians before, during, and after a behavioral health crisis occurs. The *Right Help, Right Now* plan aims to ensure that there will be same-day care delivered through mobile crisis units and crisis centers in order to reduce overcrowding at emergency departments. By doing so, there will be less strain on law enforcement who can instead better serve the communities where they are needed. This will also serve to reduce the criminalization of mental health in Virginia. The *Right Help, Right Now* plan includes specialized resources for individuals with substance use disorders or who have high risks of overdosing. Virginians should have immediate access to all the resources they need anytime and anywhere.

The *"Right Help, Right Now"* Six Pillars:

Youth Mental Health Strategy

Governor Glenn Youngkin unveiled the Youth Mental Health Strategy on the one-year anniversary of the *Right Help, Right Now* initiative. In 2023, according to Mental Health America, Virginia ranked 48th in the nation for youth mental health, which demands a collective and comprehensive approach to prioritize the health of the Commonwealth's youngest and most vulnerable citizens. Children spend on average nearly five hours daily on social media; recent studies have suggested that children who spend more than a few hours per day on social media have double the risk of poor mental health.

Governor Glenn Youngkin is taking immediate action in year two of *Right Help, Right Now*. To better equip parents and support Virginia's young people, Governor Glenn Youngkin, through budget proposals, legislation, and executive action, and the Youth Mental Health Strategy, will address critical components and harmful aspects of social media on Virginia's youth. The strategy includes interventions in the following areas:

- Addictive and harmful aspects of social media on youth
- Inside Virginia schools—school-based mental health services for students
- In behavioral health care settings—family empowerment and rights

Additional Developmental Disabilities Waiver Slots

Governor Glenn Youngkin committed to enhance support for Virginians with developmental disabilities and their families. Included in the *Right Help, Right Now* initiative, Virginia is one step closer to the goal of providing enough priority one slots for everyone in urgent need of services by the end of the Governor's term. Governor Glenn Youngkin announced an additional $300 million over the biennium to fund enough priority one slogs for every Virginian with a developmental disability on the waitlist for Medicaid Home and Community-Based Developmental Disability (DD) waiver slots.

These improvements give Virginians with disabilities the supports and services they need to live their best lives in their communities. Through these improvements, Virginians with disabilities are provided supports and services they need to live their best lives in their communities. Secretary of Health and Human Resources John Littel stated that they've heard from Virginians and their families about the important difference a DD waiver can have in their life of the life of a loved one. Whether it be paying for in-home care or the kind of assistive technology that can help an individual avoid living in a hospital, nursing home, or other institution, these waivers can change lives. The waivers also cover services such as medical care, employment supports, assistance for community living, behavioral interventions, and other items like medical goods and assistive technology.

Baby Steps

DMAS and its contracted MCOs have undertaken a variety of initiatives aimed at improving quality outcomes in maternal health, a primary goal of the Virginia QS. The DMAS maternity program, Baby Steps Virginia, actively partners with a variety of stakeholders including DMAS MCOs to improve quality maternity outcomes. All of these efforts have focused on eliminating racial disparities in maternal mortality by 2025.

The program has five key subgroups including eligibility and enrollment, outreach and information, community connections, services and policies, and oversight, all with the aim to promote health equity and quality maternity outcomes. During 2023 teams addressed a variety of topics such as Medicaid member outreach including a social media campaign, newborn screening education, WIC enrollment and services, MCO maternity care coordination, breastfeeding awareness, and flu vaccine access, all with the goal of advancing the holistic well-being of Medicaid and CHIP members.

Behavioral Health Enhancement and Project BRAVO

The Commonwealth is focused on improving behavioral health services. The vision for the Enhancement of Behavioral Health is to keep Virginians well and thriving in their communities, shift the system's current need to focus on crisis by investing in prevention and early intervention for mental health and substance use disorder (SUD) comorbidities, and support comprehensive alignment of services across the systems that serve Medicaid members. This includes efforts to reduce the burden on state psychiatric hospitals and EDs, with efforts including increasing use of mobile crisis response and reduction of emergency department

utilization, as well as working to ensuring appropriate access to acute behavioral health services for foster care youths by working to carve in residential services into the managed care programs.

DMAS is also committed to the continued expansion of access to BRAVO services by implementing new services and engaging the communities to support these services. Project BRAVO is a comprehensive vision that details a “north star” continuum of services and a preliminary set of prioritized services to build out critical levels of care, including comprehensive crisis services.

Beginning in 2017, the Addiction and Recovery Treatment Services (ARTS) benefit provides treatment for members with SUDs across the state and provides access to addiction treatment services for all enrolled members in Medicaid, FAMIS, and FAMIS MOMS. A DMAS goal for the ARTS delivery system transformation includes ensuring that a full continuum of care is available, based on evidence-based practice, to effectively treat individuals with SUD.

This approach is expected to provide Medicaid members with access to the evidence-based care needed to achieve sustainable recovery. The MCOs work with DMAS, as required by contract, to ensure that their members’ care needs for SUD treatment and recovery are met and include care coordination, utilization review, and a robust array of services and treatment methods to address immediate and long-term physical, mental, and SUD service needs.

Foster Member and Provider Engagement

DMAS has established the Medicaid Member Advisory Committee (MAC) in order to provide a formal method for members’ voices to be included in the DMAS decision-making process and to inform DMAS change management strategies. The diverse committee is comprised of representatives from across the state and is entirely made up of Medicaid-enrolled individuals and individuals’ authorized representatives. The MAC’s purpose is to obtain the insight and recommendations of Virginia’s Medicaid members in order to help the DMAS Medicaid Director improve the overall experience for all Virginia Medicaid applicants and members.

DMAS’ provider committee is called the Medicaid Provider Managed Care Liaison Committee (MPMCLC). The MPMCLC meets quarterly to provide a forum for Medicaid providers, DMAS, and the MCOs to come together to discuss opportunities, provide feedback, and create alignment across Virginia’s Medicaid managed care programs.

DMAS created the Civil Rights Coordinator position in November 2019 to ensure that individuals with limited English proficiency (LEP) and individuals with disabilities have meaningful access to programs and services. This position serves the critical function of ensuring continued compliance with federal and Commonwealth of Virginia civil rights requirements and ensures that internal and external stakeholders have language and disability access resources available to improve communications with LEP individuals and those with disabilities.

Value-Based Purchasing

DMAS is focused on increasing the use of value-based purchasing arrangements with MCOs and providers. VBP includes a broad set of policies and strategies intended to improve healthcare quality, outcomes, and efficiency by linking financial and nonfinancial incentives to the performance of various stakeholders serving Virginia Medicaid members. Movement toward and achievement of these goals is measured through a set of defined metrics evaluating quality,

cost, and patient-centered care. There is no “one-size-fits-all” approach to VBP, and DMAS’ efforts focus on a range of healthcare stakeholders, populations, and care events that are important to members, specifically highlighting chronic conditions, maternity care, behavioral health, and prevention.

Safe and Sound Task Force

Virginia launched an initiative aimed at creating safe housing placements for children in foster care. The Safe and Sound Task Force brings together government agencies, the Virginia League of Social Services Executives, and other community partners to end the practice of children sleeping in local departments of social services, hotels, and emergency rooms. The initiative ensures that every child has a safe place to belong.

Adult Dental Coverage

The comprehensive adult dental benefit became effective July 1, 2021. More than 960,000 members now have access to comprehensive dental benefits that make available each of the dental specialties. It was established on the premise that the dental treatment procedures would be prevention and control to keep the mouth disease free, and then restore it to healthy function. Beginning with preventive services will aid in improving systemic health concerns that may be in existence and prepare the patient for success with additional treatment that may be needed. The goal of additional treatment would focus on removing what cannot be saved and restoring what can be built around, therefore increasing longevity for any prosthetic appliances that may be in order.

12-Month Postpartum Coverage

DMAS’ 1115 waiver amendment to extend 12 months postpartum coverage was approved by the federal government in November 2021, making Virginia one of the first states to provide guaranteed continuous full-benefit coverage across eligibility categories for a full 12 months postpartum. The expanded coverage enables Medicaid and FAMIS MOMS members to receive critical postpartum care for a full year postpartum, an important step in improving health outcomes for both women and their newborns.

Perinatal Quality Collaborative

Funding for the Perinatal Quality Collaborative was provided for the Virginia Department of Health (VDH) to establish and administer a learning collaborative to improve pregnancy outcomes for women and newborns by advancing evidence-based clinical practices and processes through CQI, with an initial focus on pregnant women with a SUD and infants impacted by neonatal abstinence syndrome (NAS).

12-Month Contraceptive Coverage

In 2021, DMAS began covering a 12-month supply of contraception for Medicaid and FAMIS members. Medicaid members may pick up a full year’s supply of contraception at a single visit to their pharmacy.

Doula Project

To combat maternal morbidity and unintended consequences of pregnancy that result in life-altering health challenges, DMAS placed emphasis on the need for community doula care for women during the perinatal period, at labor and delivery, and during the postpartum period. According to the American Pregnancy Foundation, doulas serve to reduce the number of Cesarean sections, which increase the risk of maternal death by infection and hemorrhage and reduce the duration of labor by a quarter. Virginia Medicaid introduced a model of care to include doula services as a cost-saving measure and an effective way to improve health outcomes.

Preventive Services for Adults

Starting in September 2022, all adult Medicaid members have access to preventive services, including screenings, check-ups, and counseling to support positive health outcomes. Under a policy, similar to commercial insurance policies, preventive services are available to Medicaid members at no cost and without prior authorization from their doctor.

Emergency Department Care Coordination

The Emergency Department Care Coordination (EDCC) program provides a single, statewide technology solution that connects all hospital EDs in the Commonwealth to facilitate real-time communication and collaboration between physicians, other healthcare providers, and other clinical and care management personnel for patients receiving services in hospital EDs, for the purpose of improving the quality of patient care services. Real-time patient visit information from electronic health records is integrated with the Prescription Monitoring Program and the Advanced Health Directory. This sharing of information allows facilities, providers, and MCOs to identify patient-specific risks, create and share care coordination plans and other care recommendations, and access other clinically beneficial information related to patients receiving services in hospital EDs in the Commonwealth.

Actions on EQR Recommendations

In accordance with 42 CFR §438.364(a)(4), the EQR technical report included recommendations for improving the quality of healthcare services furnished by each MCO contracted with DMAS to provide services to Virginia Medicaid members under Medallion 4.0 (Acute) and the CCC Plus (MLTSS) Medicaid managed care programs. These recommendations include how DMAS can target goals and objectives in the Quality Strategy to better support improvement in the quality and timeliness of, and access to health services furnished to Medicaid managed care members. Table 36 and Table 37 include the prior year Quality Strategy recommendations and actions taken by DMAS to support program improvement and progress in meeting the goals of the Quality Strategy.

Table 36—CCC Plus (MLTSS) Prior Year Recommendations and DMAS Responses

2021–2022 EQRO Recommendations	DMAS Actions
Goal 5: Providing Whole-Person Care for Vulnerable Populations	DMAS included the measure *Follow-Up After Emergency Department Visit for Substance Use* in

2021–2022 EQRO Recommendations	DMAS Actions
Objective 5.3: Improve Outcomes for Members with Substance Use Disorder **Measure: 5.3.1.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment **Objective: 5.4:** Improve Behavioral Health and Developmental Services for Members **Measure 5.4.1.1:** Follow-Up After Hospitalization for Mental Illness To improve program-wide performance in support of Objective 5.3 and improve outcomes for members with SUD, HSAG recommends DMAS: • Require the MCOs to develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization. • Require the MCOs to identify healthcare disparities (race, ethnicity, age group, geographic location, etc.) with the behavioral health follow-up PM data. • Upon identification of a root cause issue, require the MCOs to implement appropriate QI interventions to improve use of evidence-based practices related to behavioral healthcare and services. • Require the MCOs to identify best practices to conduct follow-up with members discharged from the ED and ensure follow-up visits within seven days and 30 days are completed.	its PWP which provides an incentive to MCOs to increase performance and close gaps. **Measure:** *Follow-Up After Emergency Department Visit for Substance Use* **MY 2021:** 7-Day: 11.44% 30-Day: 19.98% **MY 2022:** 7-Day: 14.55% 30-Day: 22.57%
Goal: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members With Chronic Conditions **Measure: 5.1.1.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	DMAS included a *Comprehensive Diabetes Care measure that includes HbA1c Poor Control (>9.0)* in its PWP which provides an incentive to MCOs to increase performance and close gaps. **Measure:** *Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)* **MY 2021:** 51.42% **MY 2022:** 47.39%

2021–2022 EQRO Recommendations	DMAS Actions
To improve program-wide performance in support of Objective 5.1 and improve outcomes for members with chronic conditions, HSAG recommends DMAS: • Require that the MCOs conduct a root cause analysis to determine why members are not maintaining their diabetes care. • Upon identification of a root cause, require the MCOs to implement appropriate interventions to improve the performance related to proper diabetes management. • Require the MCOs to identify best practices to improve care and services according to chronic care recommended guidelines.	

Table 37—Medallion 4.0 (Acute) Prior Year Recommendations and DMAS Responses

2021–2022 EQRO Recommendations	DMAS Actions
Goal: Providing Whole-Person Care for Vulnerable Populations **Objective: 5.4:** Improve Behavioral Health and Developmental Services for Members **Measure 5.4.1.1:** Follow-Up After Hospitalization for Mental Illness To improve program-wide performance in support of Objective 5.4 and improve outcomes for members in need of BH and developmental services, HSAG recommends DMAS: • Require the MCOs to develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization. • Require the MCOs to identify healthcare disparities (race, ethnicity, age group, geographic	• The DMAS BH team continues to work on the following initiative to improve Medicaid funded behavioral health care across Virginia including the following efforts: - Implementation of evidence-based behavioral health care and building out of, Multisystemic Therapy, Functional Family Therapy, Assertive Community Treatment and implementation of 4 crisis services based on the Crisis Now model, SAMHSA has identified as best practice. The implementation of these services is key to assisting individuals that are discharged from residential and hospital settings. - DMAS has been instrumental in the planning and implementation of the Governor's *Right Help Right Now* plan, which aims to achieve the goal that all Virginians will, i) be able to access behavioral health care when they need it; ii) have prevention and management services personalized to their needs, particularly for children, youth and families; iii) know who to call, who will help and where

2021–2022 EQRO Recommendations	DMAS Actions
location, etc.) with the BH follow-up PM data. • Upon identification of a root cause issue, require the MCOs to implement appropriate QI interventions to improve use of evidence-based practices related to behavioral healthcare and services. • Require the MCOs to identify best practices to conduct follow-up with members discharged from the ED and ensure follow-up visits within seven days and 30 days are completed.	to go when in crisis; and iv) have paths to reentry and stabilization when transitioning from a crisis. DMAS is an integral partner and stakeholder within this plan. This year, in support of the Governor's Right Help, Right Now Behavioral Health Transformation Plan, DMAS in collaboration with other state agencies and stakeholders has been working on the following initiatives: i) identifying service innovations and best practices in behavioral health services, this includes a specific focus on developing a new school-based behavioral health service for youth and researching best practice models for youth mental health residential treatment services; ii) identify and research evidence-based programs specific to youth and iii) assessment of health plan behavioral health network adequacy. The goal of DMAS in partnership with this plan is to increase efficacy, access, and utilization of effective and appropriate behavioral health services for Medicaid members in Virginia. - A collaboration and partnership among health and human services state agencies in Virginia, came together to () the Center for Evidence-Based Partnerships (CEP-VA) to assist in centralizing data, implementation work and collaboration around supporting and implementing evidence-based behavioral health services across Virginia agnostic of payer. The Center continues to support and analyze Virginia implementation of these services and provide technical assistance and training to providers. • DMAS' ICER team included the measure Follow-Up After Emergency Department (ED) Visit for Mental Illness in its PWP which provides an incentive to MCOs to increase performance and close gaps. **Measure:** *Follow-Up After Emergency Department (ED) Visit for Mental Illness* **MY 2021:** 7-Day: 45.34% 30-Day: 57.38% **MY 2022:** 7-Day: 43.04% 30-Day: 55.53%
Goal 4: Strengthen the Health of Families and Communities	DMAS has improved its ability to track MCO required monthly data submissions.

2021–2022 EQRO Recommendations	DMAS Actions
Objective 4.1: Improve the Utilization of Wellness, Immunization, and Prevention Services for Members **Measure 4.1.1.4:** Immunizations for Adolescents **Objective 4.2: ★ Improve Outcomes for Maternal and Infant Members. ★** **Measure: 4.2.1.4:** Well-Child Visits in the First 20 Months of Life To improve program-wide performance in support of Objective 4.1 and 4.2 and improve preventive services and well-child visits for members under the age of 21 years, HSAG recommends DMAS: • Require the MCOs to identify best practices for ensuring children receive all preventive vaccinations and well-child services according to recommended schedules. • Require the MCOs to conduct a root cause analysis to identify barriers that their members are experiencing in accessing well-child and preventive care and services. • Require the MCOs to identify best practices to improve care and services according to the Bright Futures guidelines.	**MCH:** • The new Cardinal M4 draft contract (now in RFP) includes a requirement to incorporate AAP and Bright Futures in its quality assurance activities. If implemented as written, the Contractor will be required to follow a long-term improvement plan relating to improving EPSDT indicators that will not exceed five (5) years. The contractor must implement interventions or strategies to address following criteria: 1. Childhood Immunization rates 2. Well-child rates in all age groups 3. Lead testing rates 4. Increase percentage of lead testing of children aged one (1) to five (5) each contract year 5. Improve the current tracking system for monitoring EPSDT corrective action referrals (referrals based on the correction or amelioration of the diagnosis). • MCOs are involved in the DMAS CMS Affinity Groups that targets increasing in well-child visit rates, immunizations, timeliness of care and increased access to quality care for children. **ICER:** DMAS included the measures *Child and Adolescent Well-Care Visits and Childhood Immunization Status* in its PWP which provides an incentive to MCOs to increase performance and close gaps. **Measure**: *Child and Adolescent Well-Care Visits* **MY 2021:** 46.57% **MY 2022:** 50.27% **Measure:** *Childhood Immunization Status* **MY 2021:** 65.82% **MY 2022:** 63.22%
Goal 4: Strengthen the Health of Families and Communities **Objective 4.2: ★ Improve Outcomes for Maternal and Infant Members ★** **Measure: 4.2.1.1:** Prenatal and Postpartum Care: Postpartum Care	**MCH:** • Within the new DRAFT Cardinal M4 contract (now in RFP), MCOs will be required to conduct annual Performance Improvement Projects (PIPs) for validation by the EQRO. Each PIP must include implementation of interventions to achieve improvement in the access to care, timeliness and quality of care, consistent with 42 CFR §430.330. The Contractor must identify

2021–2022 EQRO Recommendations	DMAS Actions
Measure: 4.2.1.2: Prenatal and Postpartum Care: Timeliness of Prenatal Care To improve program-wide performance in support of Objective 4.2 and improve use of prenatal and postpartum care, HSAG recommends DMAS: • Require the MCOs to identify access- and timeliness-related PM indicators such as the *Prenatal and Postpartum Care—Postpartum Care* and *Timeliness of Prenatal Care* PM indicators that fell below the NCQA Quality Compass national Medicaid HMO 50th percentile, and focus QI efforts on identifying the root cause and implementing interventions to improve access to care. • Require the MCOs to identify healthcare disparities within the access-related PM data to focus QI efforts on a disparate population. DMAS should also require the MCOs to identify best practices for ensuring prenatal and postpartum care and ensure members receive all prenatal and maternity care according to recommended schedules. • Require the MCOs to identify best practices to improve care and services according to evidence-based guidelines.	benchmarks and set measurable achievable performance goals for each of its PIPs, which will be submitted to the Department for review and approval. In the first year of this Contract, one PIP shall be focused on maternal health. The due date for PIPs and validation must be in accordance with the process and methodology agreed upon by the Department and its EQRO agent. All PIP requirements will be located within the Cardinal Care Technical Manual. • The new contract specifies measures to be used in DMAS' Performance Withhold Program (PWP) that include timeliness of prenatal care and timeliness of postpartum care. MCOs will have to report these measures, which will be validated by DMAS' EQRO. **ICER:** DMAS included the measures *Prenatal and Postpartum Care* in its PWP which provides an incentive to MCOs to increase performance and close gaps. **Measure:** *Prenatal and Postpartum Care* **MY 2021:** *Timeliness of Prenatal Care:* 73.00% *Postpartum Care:* 66.52% **MY 2022:** *Timeliness of Prenatal Care:* 76.44% *Postpartum Care:* 66.76%

Strengths and Recommendations

Strengths

DMAS considers the Virginia 2023–2025 Quality Strategy to be its roadmap for the future. DMAS' Quality Strategy provides the roadmap to accomplish its dynamic approach to achieving its overarching goal of designing, implementing, improving, and assessing the quality of healthcare and services furnished through Virginia's coordinated and comprehensive system. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, and quality, satisfaction, and timeliness of services for Virginia Medicaid and CHIP members. Overall, the Quality Strategy represents an effective tool for measuring and improving the quality of Virginia's Medicaid managed care services. The Quality Strategy promotes identification of creative initiatives to continually monitor, assess, and improve access to care, the quality of care and services, member satisfaction, and the timeliness of service delivery for the Virginia Medicaid members. Additionally, DMAS's initiatives tie to the Quality Strategy goals, and objectives. The Virginia Medicaid Quality Strategy strives to ensure members receive high-quality care that is safe, efficient, patient-centered, timely, value and quality-based, data-driven, and equitable.

DMAS conducts oversight of the MCOs in coordination with the Quality Strategy to promote accountability and transparency for improving health outcomes. DMAS has an MCO contract requirement that the MCO should be committed to quality improvement and its overall approach and specific strategies will be used to advance Virginia Medicaid's Quality Strategy and incentive-based quality measures. In addition, each MCO is required to be NCQA accredited and to conduct HEDIS performance measure reporting.

Recommendations

The EQRO has identified the following recommendations for the Quality Strategy:

To improve program-wide performance in support **of Goal 4: Strengthen the Health of Families and Communities, Objectives 4.1 and 4.2** and improve preventive services and well-child visits for members under the age of 21 years, HSAG recommends DMAS:

- Work with MCOs to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended cancer screenings and to make appropriate health decisions. HSAG continues to recommend that DMAS monitor MCOs to ensure that the MCOs analyze their data and consider if there are disparities within the MCOs' populations that contributed to lower screening rates. Additionally, HSAG recommends that DMAS require the MCOs to analyze the factors that contributed to the higher usage of imaging studies when not clinically appropriate for a particular age group, ZIP Code, etc. MCOs should focus resources and implement appropriate interventions to increase the screening rates, pregnancy care and to reduce unnecessary low back pain-related imaging studies due to the low rates for the four measures.

To improve program-wide performance in support of **Goal 4: Strengthen the Health of Families and Communities, Objective 4.1** and improve adolescent well visits and adolescent immunizations for members under the age of 21 years, HSAG recommends DMAS, considering the recurring MCO opportunities related to measures within the Taking Care of Children domain:

- Work with the MCOs to identify best practices for ensuring adolescents receive all preventive vaccinations according to recommended schedules. HSAG recommends that the MCOs identify and implement new interventions based on their completed root cause analyses which identified barriers their members' parents and guardians have experienced in accessing care and services. Additionally, HSAG recommends that MCOs evaluate providers' barriers to completing BMI assessments, counseling for nutrition, and counseling for physical activity, then implement targeted interventions to address these barriers.

To improve the accuracy of provider information available to members in support of **Goal 4: Strengthen the Health of Families and Communities**, **Objective 4.1** and improve access and timeliness of preventive services and well-child visits for members under the age of 21 years, HSAG recommends that DMAS:

- Work with the enrollment broker to address the data deficiencies identified during the survey (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify the location's address and appropriate provider type and specialty. Additionally, DMAS may also consider requesting the MCOs to provide evidence of training offered, by the MCO, to provider's offices regarding the MCO plan names and benefit coverage. Evidence should demonstrate that the office staff responsible for scheduling appointments have been educated on the MCO names and benefit coverage and the offices have a plan in place for educating new staff in the event of staff turnover.

To improve program-wide performance in support **of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4** and improve behavioral health and developmental services for members, HSAG recommends that DMAS:

- Work with the MCOs to develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization for mental illness and after emergency department visit for mental illness. HSAG also recommends that DMAS work with the MCOs to consider if there are disparities within the MCOs' populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Additionally, HSAG recommends that DMAS continue leveraging the CMS Improving Behavioral Health Follow-up Care Learning Collaborative[47] materials to identify potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care.

To improve the accuracy of provider information available to members in support of **Goal 4: Strengthen the Health of Families and Communities**, **Objective 4.1** and improve access and timeliness of well-child visits and preventive health care for members under the age of 21 years, and the timeliness of pregnancy related care, HSAG recommends that DMAS:

- Work with the enrollment broker to address the data deficiencies identified during the primary care provider and the prenatal care secret shopper surveys (e.g., incorrect or

[47] Centers for Medicare & Medicaid Services. Improving Behavioral Health Follow-up Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/behavioral-health-learning-collaborative/index.html. Accessed on: Feb 26, 2024.

disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identifies the location address and appropriate provider type and provider specialty. DMAS may also consider requesting that the MCOs provide evidence of training offered, by the MCO, to provider's offices regarding the MCO plan names and benefit coverage. MCO evidence should demonstrate that the office staff responsible for scheduling appointments have been educated on the MCO names and benefit coverage and the offices have a plan in place for educating new staff in the event of staff turnover. Accurate provider information, including provider specialties and contact information may result in improved access to care for members seeking well-care, preventive health, childhood immunizations, and pregnancy related care.

- Work with MCOs to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended well-visits according to the EPSDT and Bright Futures schedule and to make appropriate health decisions. HSAG continues to recommend that DMAS monitor MCOs to ensure that the MCOs analyze their data and consider if there are disparities within the MCOs' populations.

Quality Strategy Evaluation Methodology

Evaluation Methodology Description

Review Period

The evaluation period focuses on the 12-month performance period of January 1, 2023–December 31, 2023.

Goals and Objectives

The Virginia 2023–2025 Quality Strategy identified goals and objectives that focus on process as well as achieving outcomes. Virginia's Quality Strategy identifies the following five goals and fourteen associated objectives:

- Goal 1: Enhance the Member Care Experience:
  - Objective 1.1: Increase Member Engagement and Outreach
  - Objective 1.2: Improve Member Satisfaction
- Goal 2: ★ Promote Access to Safe, Gold-Standard Patient Care ★
  - Objective 2.1: Ensure Access to Care
  - Objective 2.2: Promote Patient Safety
  - Objective 2.3: Promote Effective Communication and Care Coordination
- Goal 3: ★ Support Efficient and Value-Driven Care ★
  - Objective 3.1: Focus on Paying for Value
  - Objective 3.2: Promote Efficient Use of Program Funds
- Goal 4: Strengthen the Health of Families and Communities
  - Objective 4.1: Improve Utilization of Wellness, Immunization, and Prevention Services for Members

  - Objective 4.2: ★ Improve Outcomes for Maternal and Infant Members ★
  - Objective 4.3: Improve Home and Community-Based Services
- Goal 5: Providing Whole-Person Care for Vulnerable Populations
  - Objective 5.1: Improve Outcomes for Members with Chronic Conditions
  - Objective 5.2: Improve Outcomes for Nursing Home Eligible Members
  - Objective 5.3: ★ **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders ★
  - Objective 5.4: ★ **Objective 5.4:** Improve Behavioral Health and Developmental Services of Members ★

Evaluation

HSAG conducts a formal evaluation of the Quality Strategy to assess its overall effectiveness to improve healthcare delivery, accessibility, and quality in the populations served by the managed care program. For DMAS, HSAG's evaluation includes an assessment of managed care performance compared to national benchmarks; MCO target and improvement objectives; performance improvement initiatives; and an examination of strengths, opportunities for improvement, and recommendations to add, enhance, or modify quality initiatives aimed at improving service delivery, accessibility, and quality.

To evaluate the Quality Strategy, HSAG analyzes the following to determine performance and progress in achieving the goals of the DMAS Quality Strategy.

- HEDIS measures
- CAHPS surveys
- Core Set of Adult Health Care Quality Measures for Medicaid
- Core Set of Children's Health Care Quality Measures for Medicaid and CHIP
- State-specific measures
- Addressing health disparities
- Use of sanctions
- EQR activities, such as the following:
  - PIP validation
  - Network adequacy and availability validation
  - Compliance monitoring
  - Annual EQR technical reports
- MCO performance withholds of capitation payments
- Quality initiatives

The Quality Strategy evaluation provides critical information about the structure of the quality program and the process for improving health service quality, access, and timeliness, and whether the program is achieving its goals. When opportunities for improvement are identified, HSAG will work with DMAS and its contracted MCOs to identify the leading causes for stagnant or declining performance. HSAG also will work with DMAS to examine health policies that may impact, either positively or negatively, service delivery, accessibility, and quality of care and to refine its methodology and tools as needed based on lessons learned from the previous year's evaluation.

Evaluation Tool

To track the progress of achieving goals and objectives outlined in the 2023–2025 Quality Strategy, HSAG tracks annual results of contractual performance metrics that aligned with the performance measures included in the Quality Strategy to measure improvement. HSAG developed a Virginia Medicaid Goals Tracking Table. The table includes the metrics included in the 2023–2025 Virginia Quality Strategy and categorized by the State's associated goals and objectives, along with baseline rates from measurement year (MY) 2020. The most recent MY rates are compared to baseline rates, targets, and improvement objectives.

Quality Strategy Evaluation Virginia Medicaid Goals Tracking Table

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
Goal 1: Enhance the Member Care Experience	**Objective 1.1** Increase Member Engagement and Outreach	1.1.1.1. Number of Outreach and Engagement (O&E) Activities Per year	DMAS Cover Virginia	**Cover Virginia 2021:** Spanish Calls Taken by Spanish-Speaking Bilingual Staff: 73,088 **Cover Virginia 2021:** Calls Taken with Language Assistance Services: 50,902 **Medallion 4.0** Call Center Language Calls 2021: 7,551 **CCC Plus** Call Center Language Calls 2021: 545 **2021 DMAS Website** Translation Requests 2021: 3,489	Increase by X percent the Cover Virginia Spanish language calls taken by Spanish-speaking bilingual staff Increase by X percent the Cover Virginia calls taken with language assistance by 2025 Increase by X percent the Medallion 4.0 call center language calls taken by 2025 Increase by X percent the CCC Plus call center language calls taken by 2025. Increase by X percent the translation requests taken by 2025	
		1.1.1.2 Monitor Language and Disability Access Reports	DMAS	• CCC Plus: • Medallion 4.0:	Increase by X percent the Language and Disability Access report monitoring: • Cardinal Care Program:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		1.1.1.3 Monitor Member Language Counts	DMAS	• CCC Plus: • Medallion 4.0:	Increase by X percent the Member Language Counts reported • Cardinal Care Program:	
	Objective 1.2 Improve Member Satisfaction	1.2.1.1 Enrollees' Ratings Q8-Rating of all Health Care	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus: 68.5% • Medallion 4.0: 75.7% Adult: • CCC Plus: 58.7% • Medallion 4.0: 55.8%	Increase the Cardinal Care annual CAHPS overall Rating of *all Health Care* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	
		1.2.1.2 Rating of Personal Doctor	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus: 79.5% • Medallion 4.0: 77.7% Adult: • CCC Plus: 72.8% • Medallion 4.0: 68.0%	Increase the Cardinal Care annual CAHPS overall Rating of *Personal Doctor* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	
★ **Goal 2:** Promote Access to Safe, Gold-Standard Patient Care	**Objective 2.1** Ensure Access to Care	2.1.1.1 Getting Care Quickly Q6	CAHPS – AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus: 89.7% • Medallion 4.0: 86.0% Adult: • CCC Plus: 85.0% • Medallion 4.0: 81.1%	Increase the Cardinal Care annual CAHPS overall Rating of *Getting Care Quickly* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	
		2.1.1.2 Respondent Got Non-Urgent Appointment as Soon as Needed	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus: % • Medallion 4.0: % Adult:	Increase the Cardinal Care annual CAHPS overall Rating of *Got Non-Urgent Appointment as Soon as Needed* to perform	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• CCC Plus: % • Medallion 4.0: %	at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	
		2.1.1.3 Getting Needed Care	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	AHRQ CAHPS 2021 Child: • CCC Plus: 87.3% • Medallion 4.0: 84.6% Adult: • CCC Plus: 86.1% • Medallion 4.0: 82.9%	Increase the Cardinal Care annual CAHPS overall Rating of *Getting Needed Care* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	
	Objective 2.2 Promote Patient Safety	2.2.1.1 Prevalence of Pressure Ulcers Among LTSS Members	DMAS	Long-Term Nursing Facility: 3.3%[1] Short-Term Nursing Facility: 7.1%[1] CCC Plus Waiver Members: 1.9%[1]	Decrease the prevalence percentage of LTSS members with pressure ulcers by 2025: • Long-Term Nursing Facility: • Short-Term Nursing Facility: • CCC Plus Waiver Members:	
		2.2.1.2 Monitor the Frequency of Reported Critical Incidents by Member Classification	DMAS	• CCC Plus Waiver w/o PDN: 694 • CCC Plus Waiver: 26 • CCC Plus Waiver W PDN: 30 • DD Waiver: 9	Increase the number and percentage of Cardinal Care program members without PDN critical incidents reported by 2025:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Emerging Vulnerable: 349 • Minimal Need: 107 • Nursing Facility: 446 • Other: 732 • Total: 2,393[2]	• CCC Plus Waiver w/o PDN: • CC Plus Waiver: • DD Waiver: • Emerging Vulnerable: • Minimal Need: • Nursing Facility: • Other: • Total:	
	Goal 2.3 Promote Effective Communication and Care Coordination	2.3.1.1 How Well Doctors Communicate	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus: 93.9% • Medallion 4.0: 93.7% Adult: • CCC Plus: 94.2% • Medallion 4.0: 93.3%	Increase the Cardinal Care annual CAHPS overall Rating of *How Well Doctors Communicate* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	
		2.3.1.2 Service Authorizations	DMAS https://www.dmas.virginia.gov/data/mco-service-authorization-performance/	2022 Fourth Quarter MCO Reporting	Maintain or Increase by X% service authorizations adjudicated timely by 2025: • Cardinal Care Program:	
★ **Goal 3:** Support Efficient and Value-Driven Care	**Objective 3.1** Focus on Paying for Value	3.1.1.1 Frequency of Potentially Preventable Admissions	DMAS Clinical Efficiency Measures	Clinical Efficiency Measures 2021 CCC Plus: 2.942	Decrease by 10% Potentially Preventable Admissions: • Cardinal Care Program:	
		3.1.1.2 Frequency of Emergency Department Visits	DMAS Clinical Efficiency Measure	Clinical Efficiency Measures 2021 CCC Plus: 43.08	Decrease by 1% the Potentially Preventable, Avoidable, and/or	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Medically Unnecessary Emergency Department Visits: • Cardinal Care Program:	
		3.1.1.3 Frequency of Potentially Preventable Readmissions	DMAS Clinical Efficiency Measure	2021 CCC Plus: 18.77%	Decrease by 8% Potentially Preventable Readmissions Within 30 Days: • Cardinal Care Program:	
		3.1.1.4 Ambulatory Care	NCQA HEDIS	HEDIS MY 2020 • CCC Plus: 77.45 • Medallion 4.0:	Decrease the HEDIS Ambulatory Care: Emergency Department (ED) Visit measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program:	
		3.1.1.5 Ambulatory Care: Emergency (ED) Visits	DMAS Clinical Efficiency Measures NCQA HEDIS (AMB) CMS Child Core Set: AMB-CH	Clinical Efficiency Measures • 2021 CCC Plus: 43.08 HEDIS MY 2020 • CCC Plus: 77.45% • Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0	Decrease the HEDIS Ambulatory Care: Emergency Department (ED) Visit measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program HEDIS: • Cardinal Care Program Child Core Set: • Less than 1 Year:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• 1-9 Years: • 10-19 Years: • Total: Decrease the CMS Child Core Set Ambulatory Care: Emergency Department (ED) Visit measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program HEDIS: • Cardinal Care Program Child Core Set: • Less than 1 Year: • 1-9 Years: • 10-19 Years: • Total:	
		3.1.1.6 Days Without Minimum RN Hours	DMAS VBP Reporting Team CMS Payroll Based Journal	NF VBP Program 2019 • CCC Plus:	NF VBP Decrease by X% the number of nursing facility y days without minimum RN hours. • Cardinal Care Program:	
		3.1.1.7 Total Nurse Staffing Hours Per Resident Day (RN, LPN, CAN) – Case-Mix Adjusted	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus:	NF VBP Increase by X% the number of days with total nurse staffing hours per resident day meeting minimum requirements.	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• Cardinal Care Program:	
		3.1.1.8 Percentage of Long-Stay Resident with a Urinary Tract Infection (UTI)	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus:	NF VBP Decrease by X% Long-Stay Residents with a Urinary Tract Infection. • Cardinal Care Program	
		3.1.1.9 Number of Hospitalizations per 1,000 Long-Stay Resident Days	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus:	NF VBP Decrease by X% the number of unplanned inpatient admissions or outpatient observations stays that occurred among long-stay residents of a nursing home. • Cardinal Care Program:	
		3.1.1.10 Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus:	NF VBP Decrease by X% the number of outpatient ED visits that occurred among long-stay residents of a nursing home.	
		3.1.1.11 Percentage of Long-Stay High-Risk Residents with Pressure Ulcers	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus:	NF VBP Decrease by X% Long-Stay High-Risk Residents with Pressure Ulcers	
	Objective 3.2 Promote Efficient Use of Program Funds	3.2.1.1 Monitor Medical Loss Ratio	DMAS—MCO Financials https://www.dmas.virginia.gov/data/mco-financials/	• CCC Plus: • Medallion 4.0:	Maintain MLR XXXX	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
Goal 4: Strengthen the Health of Families and Communities	**Objective 4.1** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	4.1.1.1 Adults' Access to Preventive/Ambulatory Health Services	NCQA HEDIS (AAP)	HEDIS MY 2020 • CCC Plus: 87.12% • Medallion 4.0: 72.75%	Increase the HEDIS Adults' Access to Preventive/Ambulatory Health Services measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program:	
		4.1.1.2 Child and Adolescent Well-Care Visits	NCQA HEDIS (WCV) Child Core Set: WCV-CH	HEDIS MY 2020 • CCC Plus: 39.86% • Medallion 4.0: 46.57% Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Child and Adolescent Well-Care Visits measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program: Increase the CMS Child Core Set Child and Adolescent Well-Care Visits measure rate to perform at or above the CMCS 50th percentile by 2025: • 3-11 Years: • 12-17 Years: • 18-21 Years: • Total:	
		4.1.1.3 Childhood Immunization Status	NCQA HEDIS (CIS) • Combo 3 Child Core Set: CIS-CH	HEDIS MY 2020 • CCC Plus: 65.58% • Medallion 4.0: 65.82% Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Childhood Immunization Status measure rate to perform at or above the HEDIS 50th percentile by 2025:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• Cardinal Care Program: Increase the CMS Child Core Set Child and Adolescent Well-Care Visits measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program:	
		4.1.1.4 Immunizations for Adolescents	NCQA HEDIS (IMA) • Combo 1 • Combo 2 Child Core Set: IMA-CH	HEDIS MY 2020 Combo 1 • CCC Plus: 64.10% • Medallion 4.0: % Combo 2 • CCC Plus: 26.02% • Medallion 4.0: % Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Immunization for Adolescents measure rate to perform at or above the HEDIS 50th percentile by 2025: • Combo 1: • Combo 2: Increase the CMS Child Core Set Child and Adolescent Well-Care Visits measure rate to perform at or above the CMCS 50th percentile by 2025: Cardinal Care Program: • Combo 1: • Combo 2:	
		4.1.1.5 Flu Vaccinations for Adults 18-64	AHRA CAHPS Adult Core Set: CPA-AD	CAHPS 2021: ND Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the CAHPS Flu Vaccinations for Adults 18-64 Years measure rate to perform at or above	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					the CAHPS 50th percentile by 2025: • Cardinal Care Program: Increase the CMS Adult Core Set Flu Vaccinations for Adults 18-64 Years measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program:	
		4.1.1.6 Topical Fluoride for Children	NCQA HEDIS (TFC) Child Core Set: TFL-CH CMS 416	HEDIS MY 2020 • CCC Plus: • Medallion 4.0: Child Core Set • CCC Plus: • Medallion 4.0: CMS 416 2021	Increase the HEDIS Topical Fluoride for Children measure rate to perform at or above the HEDIS 50th percentile by 2025: *Note: MY 2023 Year 1 measure – percentile rankings may not be available.* • Cardinal Care Program – Total: Increase the CMS Child Core Set Topical Fluoride for Children measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Note: Need to determine target for a CMS 416 measure.	
		4.1.1.7 Oral Evaluation, Dental Services	NCQA HEDIS (OED) Child Core Set: OEV-CH CMS 416	HEDIS MY 2020 • CCC Plus: • Medallion 4.0: Child Core Set • CCC Plus: • Medallion 4.0: • CMS 416 2021	Increase the HEDIS Oral Evaluation, Dental Services measure rate to perform at or above the HEDIS 50th percentile by 2025: *Note: MY 2023 Year 1 measure – percentile rankings may not be available.* • Cardinal Care Program Increase the CMS Child Core Set Evaluation, Dental Services measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Need to determine target for a CMS 416 measure.*	
		4.1.1.8 Sealant Receipt on Permanent First Molars	Child Core Set: SFM-CH CMS 416	Child Core Set • CCC Plus: • Medallion 4.0: CMS 416 2021	Increase the HEDIS Sealant Receipt on Permanent First Molars measure rate to perform at or above the HEDIS 50th percentile by 2025:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Note: MY 2023 Year 1 measure – percentile rankings may not be available. • Cardinal Care Program Increase the CMS Child Core Set Sealant Receipt of Permanent First Molars measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Need to determine target for a CMS 416 measure.*	
		4.1.1.9 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA HEDIS (WCC) CMS Child Core Set (WCC-CH)	HEDIS MY 2020 CCC Plus: •	Increase the HEDIS Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • BMI Percentile Documentation • Counseling for Nutrition • Counseling for Physical Activity	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Increase the CMS Child Core Set Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: • BMI Percentile Documentation • Counseling for Nutrition • Counseling for Physical Activity	
		4.1.1.10 Chlamydia Screening in Women Ages 16 to 20	NCQA HEDIS (CHL) CMS Child Core Set (CHL-CH)	HEDIS MY 2020 • CCC Plus: NR • Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Chlamydia Screening in Women Ages 16-20 measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program *Note: HEDIS measure age is 16-24 Years.* Increase the CMS Child Core Set Chlamydia Screening in Women Ages 16-20 Years measure rate to	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		4.1.1.11 Lead Screening in Children	NCQA HEDIS (LSC) CMS Child Core Set (LSC-CH)	HEDIS MY 2020 • CCC Plus: NR • Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Lead Screening in Children measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Child Core Set Lead Screening in Children measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
	★ **Objective 4.2** Improve Outcomes for Maternal and Infant Members	4.2.1.1 Prenatal and Postpartum Care: Postpartum Care	NCQA HEDIS (PPC) Adult Core Set: PPC-AD	HEDIS MY 2020 Postpartum Care • CCC Plus: NR • Medallion 4.0: 66.52% Adult Core Set Postpartum Care • CCC Plus: • Medallion 4.0:	Increase the HEDIS Prenatal and Postpartum Care: Timeliness of Prenatal Care measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Adult Core Set Prenatal and	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Postpartum Care: Timeliness of Prenatal Care measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		4.2.1.2 Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA HEDIS (PPC) Child Core Set: PPC-CH	HEDIS MY 2020 Timeliness of Prenatal Care • CCC Plus: NR • Medallion 4.0: 73.00% Adult Core Set Timeliness of Prenatal Care • CCC Plus: • Medallion 4.0:	Increase the HEDIS Prenatal and Postpartum Care: Postpartum Care measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Child Core Set Prenatal and Postpartum Care: Postpartum Care measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		4.2.1.3 Live Births Weighing Less than 2,500 Grams	Child Core Set: LBW-CH CDC Wonder State Vital Records	CMS 2021 Child Core Set Reported Rate—CDC Wonder Data:	Decrease the CMS Child Core Set Live Births Weighing Less than 2,500 Grams measure rate to perform at or above the CMCS 50th percentile by 2025:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• Cardinal Care Program – Total:	
		4.2.1.4 Well-Child Visits in the First 30 Months of Life	NCQA HEDIS (W30) Child Core Set: W30-CH	HEDIS MY 2020 • CCC Plus: 71.81% • Medallion 4.0: 72.10% Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Well-Child Visits in the First 30 Months of Life measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • First 15 Months: • 15-30 Months Increase the CMS Child Core Set Well-Child Visits in the First 30 Months of Life measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program • First 15 Months: • 15-30 Months	
		4.2.1.5 Low-Risk Cesarean Delivery	Child Core Set: LRCD-CH CDC Wonder State Vital Records	Child Core Set CMS 2021 Reported Rate—CDC Wonder Data:	Decrease the CMS Child Core Set Low-Risk Cesarean Delivery measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Lower rate is better.*	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
	Objective 4.3 Improve Home and Community-Based Services	4.3.1.1 Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and Appropriate to Their Needs and Personal Goals	QMR	**FY22** Q1: 86.0% Q2: 50% Q3: 53%	Increase the number and percent of waiver individuals who have service plans that are adequate and appropriate to their needs and personal goals by 5% by 2025: • Cardinal Care Program – Total:	
		4.3.1.2 Number and Percent of Individuals Who Received Services in the Scope Specified in the Service Plan	QMR	**FY22** Q1: 97.0% Q2: 100% Q3: 100%	Increase the number and percent of individuals who received services in the scopes specified in their service plan by 5% by 2025: • Cardinal Care Program – Total:	
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.1** Improve Outcomes for Members with Chronic Conditions	5.1.1.1 PQI 08: Heart Failure Admission Rate	Adult Core Set: PQI08-AD	Adult Core Set • CCC Plus: • Medallion 4.0:	Decrease the CMS Adult Core Set Heart Failure Admission measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Lower rate is better.*	
		5.1.1.2 PQI 14: Asthma Admission Rate (Ages 2–17)	Adult Core Set: PQI15-AD	Adult Core Set • CCC Plus: • Medallion 4.0:	Decrease the CMS Adult Core Set Asthma Admission measure rate to perform at or above the CMCS 50th percentile by 2025:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• Cardinal Care Program – Total: *Note: Lower rate is better.*	
		5.1.1.3 PQI 05: COPD and Asthma in Older Adults' Admission Rate	Adult Core Set: PQI105-AD	Adult Core Set • CCC Plus: 41.04% • Medallion 4.0:	Decrease the CMS Adult Core Set Asthma in Older Adults' Admission measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Lower rate is better.*	
		5.1.1.4 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	NCQA HEDIS (HPC) Adult Core Set: HPC-AD	HEDIS MY 2020 • CCC Plus: 51.42% • Medallion 4.0: 41.04% Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Adult Core Set Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) measure rate to perform at or above	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		5.1.1.5 Controlling High Blood Pressure	NCQA HEDIS (CBP) Adult Core Set: CBP-AD	HEDIS MY 2020 • CCC Plus: 48.07% • Medallion 4.0: 46.91% Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Controlling High Blood Pressure measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Adult Core Set Controlling High Blood Pressure measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		5.1.1.6 Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years	NCQA HEDIS (AAB) CMS Child Core Set: AAB-CH	HEDIS MY 2020 • CCC Plus: 47.93% • Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • *3 Months to 17 Years:* • *18- 64 Years:*	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• *65 Years and older:* • *Total:* *Note: Recommend dropping the 18-64, 65 years and older, and total.* Increase the CMS Child Core Set Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: • *3 Months to 17 Years:*	
		5.1.1.7 Asthma Medication Ratio: Age 5 to 18 Years	NCQA HEDIS (AMR) CMS Child Core Set: AMR-CH	HEDIS MY 2020 • CCC Plus: 63.62% • Medallion 4.0: 71.00% Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Asthma Medication Ratio: Age 5 to 18 Years measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Child Core Set Asthma Medication Ratio: Age 5 to 18 Years measure rate to	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
	Objective 5.2 Improve Outcomes for Nursing Home Eligible Members	5.2.1.1 Use of High-Risk Medications in Older Adults (Elderly)	NCQA HEDIS (DAE)	HEDIS MY 2020: CCC Plus: 14.88%	Decrease the HEDIS Use of High-Risk Medications in Older Adults (Elderly) measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Lower rate is better.*	
	★ **Objective 5.3** Improve Outcomes for Members with Substance Use Disorders	5.3.1.1 Monitor Identification of Alcohol and Other Drug Services	DMAS	• CCC Plus: • Medallion 4.0:	Increase the percentage of members with Identification of Alcohol and Other Drug Services by 5% by 2025.	
		5.3.1.2 Follow-Up After Emergency Department Visit for Substance Use	NCQA HEDIS (FUA) Child Core Set: FUA-CH	HEDIS MY 2020 CCC Plus • 7-Day: 11.44% • 30-Day: 19.98% Medallion 4.0: • 7-Day: 13.92% • 30-Day: 21.88% Child Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0: • 7-Day:	Increase the HEDIS Follow-Up After Emergency Department Visit for Substance Use measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• 30-Day:	Increase the CMS Child Core Set Follow-Up After Emergency Department Visit for Substance Use measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		5.3.1.3 Use of Opioids at High Dosage in Persons Without Cancer	NCQA HEDIS (OHD) Adult Core Set: OHD-AD	HEDIS MY 2020 • CCC Plus: • Medallion 4.0: Adult Core Set • CCC Plus: • Medallion 4.0:	Decrease the HEDIS Use of Opioids at High Dosage in Persons Without Cancer measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Decrease the CMS Adult Core Set Use of Opioids at High Dosage in Persons Without Cancer measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		5.3.1.4 Initiation and Engagement of Substance Use Disorder Treatment	NCQA HEDIS (IET) Adult Core Set: IET-AD	HEDIS MY 2020 CCC Plus: • Initiation: 46.41% • Engagement: 12.51% Medallion 4.0:	Increase the HEDIS Initiation and Engagement of Substance Use Disorder Treatment	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Initiation: • Engagement: Adult Core Set CCC Plus: • Initiation: • Engagement: • Medallion 4.0: • Initiation: • Engagement:	measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Adult Core Set Initiation and Engagement of Substance Use Disorder Treatment measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		5.3.1.5 Use of Pharmacotherapy for Opioid Use Disorder	CMS Adult Core Set: OUD-AD	Adult Core Set • CCC Plus • Medallion 4.0:	Increase the CMS Adult Core Measure rate Use of Pharmacotherapy for Opioid Use Disorder measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
	Goal: 5.4 Improve Behavioral Health and Developmental Services for Members	5.4.1.1 Follow-Up After Hospitalization for Mental Illness	NCQA HEDIS (FUH) Adult Core Set: FUH-AD Child Core Set: FUH-CH	HEDIS MY 2020 CCC Plus • 7-Day: 30.77% • 30-Day: 54.12% Medallion 4.0: • 7-Day: 35.63%	Increase the HEDIS Follow-Up After Hospitalization for Mental Illness measure rate to perform at or above	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• 30-Day: 56.84% Adult Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0: • 7-Day: • 30-Day: Child Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0: • 7-Day: • 30-Day:	the HEDIS 50th percentile by 2025: • Cardinal Care Program 6 Years and Older • Within 7 Days • Within 30 Days Increase the CMS Adult Core Set Follow-Up After Hospitalization for Mental Illness measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – 18 and Older: • Within 7 Days • Within 30 Days Increase the CMS Child Core Set Follow-Up After Hospitalization for Mental Illness measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program ages 6-17 Years:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• Within 7 Days • Within 30 Days	
		5.4.1.2 Follow-Up After Emergency Department Visit for Mental Illness	NCQA HEDIS (FUM) Adult Core Set: FUM-AD Child Core Set: FUM-CH	HEDIS MY 2020 CCC Plus • 7-Day: 47.03% • 30-Day: 62.83% Medallion 4.0: • 7-Day: 45.34% • 30-Day: 57.38% Adult Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0: • 7-Day: • 30-Day: Child Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0: • 7-Day: • 30-Day:	Increase the HEDIS Follow-Up After Emergency Department Visit for Mental Illness measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program 6 Years and Older • Within 7 Days • Within 30 Days Increase the CMS Adult Core Set Follow-Up After Emergency Department for Mental Illness measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – 18 and Older: • Within 7 Days • Within 30 Days Increase the CMS Child Core Set Follow-Up After Emergency Department for Mental Illness measure rate to perform at or above	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					the CMCS 50th percentile by 2025: • Cardinal Care Program ages 6-17 Years: • Within 7 Days • Within 30 Days	
		5.4.1.3 Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	NCQA HEDIS (ADD) Child Core Set: ADD-CH	HEDIS MY 2020 CCC Plus • Initiation: • Continuation: Medallion 4.0 • Initiation: 45.20% • Continuation: 58.61% Child Core Set CCC Plus: • Initiation: • Continuation: CCC Plus: • Initiation: • Continuation:	Increase the HEDIS Follow-Up for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program – Ages 6-12 Years • Initiation Phase: • Continuation and Maintenance Phase: Increase the CMS Child Core Set Follow-Up for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Ages 6-12 Years	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• Initiation Phase: • Continuation and Maintenance Phase:	
		5.4.1.4 Monitor Mental Health Utilization	DMAS	DMAS • CCC Plus: • Medallion 4.0:	Increase the percentage of members receiving mental health services by X% by 2025.	
		5.4.1.5 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA HEDIS (APP) Child Core Set: APP-CH	HEDIS MY 2020 • CCC Plus: 43.71% • Medallion 4.0: 69.58% Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program – Ages 1-17 Years Increase the CMS Child Core Set Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Ages 1-17 Years	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		5.4.1.6 Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA HEDIS (APM) CMS Child Core Set: APM-CH	HEDIS MY 2020 CCC Plus: • Blood Glucose Testing—Total: 41.33 • Cholesterol Testing—Total: 28.59% • Blood Glucose and Cholesterol Testing—Total: 27.05% Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Metabolic Monitoring for Children and Adolescents on Antipsychotics measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program – Ages 1-17 Years Increase the CMS Child Core Set Metabolic Monitoring for Children and Adolescents on Antipsychotics measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Ages 1-17 Years	
		5.4.1.7 Medical Assistance with Smoking and Tobacco Use Cessation	CMS Adult Core Set: MSC-AD	Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Medical Assistance with Smoking and Tobacco Use Cessation measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• 3 Months – 17 Years • 18 – 64 Years • 65 and Older • Total Increase the CMS Adult Core Set Medical Assistance with Smoking and Tobacco Use Cessation measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program • 18-64 Years • 65 and Older	
		5.4.1.8 Antidepressant Medication Management	NCQA HEDIS (AMM) CMS Adult Core Set: AMM-AD	HEDIS MY 2020: CCC Plus: • Effective Acute Phase Treatment: 61.11% • Effective Continuation Phase: 48.29% Medallion 4.0: • Effective Acute Phase Treatment: 57.12% • Effective Continuation Phase: 42.02% Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Antidepressant Medication Management measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • 18 and Older • Effective Acute Phase Treatment • Effective Continuation Phase Treatment	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Increase the CMS Adult Core Set Antidepressant Medication Management measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program • 18 – 64 Years • 65 and Older • Total • Effective Acute Phase Treatment • Effective Continuation Phase Treatment	
		5.4.1.9 Screening for Depression and Follow-Up Plan: Ages 18 and Older	CMS Adult Core Set: CDF-AD	Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the CMS Adult Core Set Screening for Depression and Follow-Up Plan: Ages 18 and Older measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program	
		5.4.1.10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA HEDIS (SSD) CMS Adult Core Set: SSD-AD	HEDIS MY 2020: • CCC Plus: 77.18% • Medallion 4.0: NR Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications measure rate to perform at or	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					above the HEDIS 50th percentile by 2025: • Cardinal Care Program • 18 to 64 Years Increase the CMS Adult Core Set Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program • 18 – 64 Years	
		5.4.1.11 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA HEDIS (HPCMI) CMS Adult Core Set: HPCMI-AD	HEDIS MY 2020 • CCC Plus: • Medallion 4.0 Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • 18 to 75 Years Increase the CMS Adult Core Set	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program • 18 – 64 Years • 65 – 75 Years	
		5.4.1.12 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA HEDIS (SAA) CMS Adult Core Set: SAA-AD	HEDIS MY 2020: • CCC Plus: 69.50% • Medallion 4.0: NR Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • 18 to 39 Years Increase the CMS Adult Core Set Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure rate to perform at or above	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					the CMCS 50th percentile by 2025: • Cardinal Care Program • 18 – 39 Years	

[1] DMAS Cumulative data from MCO quarterly reports 1/1/2020–3/31/2022.

[2] MCO critical incident data reported to DMAS for calendar year 2021.

**The baseline measure rate is the final validated 2021 HEDIS, performance measure rate or CAHPS reported in the 2021 Annual Technical Report and posted to the DMAS website.*

***Target established in the CY2021 PWP Methodology.*

****The baseline measure rate is the final validated 2020 HEDIS rate reported in the 2021 Annual Technical Report and posted to the DMAS website.*

^The baseline measure rate is the final 2021 rate calculated by HSAG for the PWP.

^^The baseline measure rate is the final 2021 rate reported by DMAS for the Quality Management Review.

^^^The baseline measure rate is the final 2021 rate reported by the DMAS Finance Team

▲ *Statistically significantly higher in 2020 than in 2019.*
▼ *Statistically significantly lower in 2020 than in 2019.*

★ *These goals are inclusive of Governor Glenn Youngkin's identified priorities for the Medicaid program that focus on behavioral health enhancement, maternal health outcomes, and access to high quality healthcare services.*

Attachment 5

Virginia 1115 Demonstration
GAP Quarterly Report Jan-Mar 2019

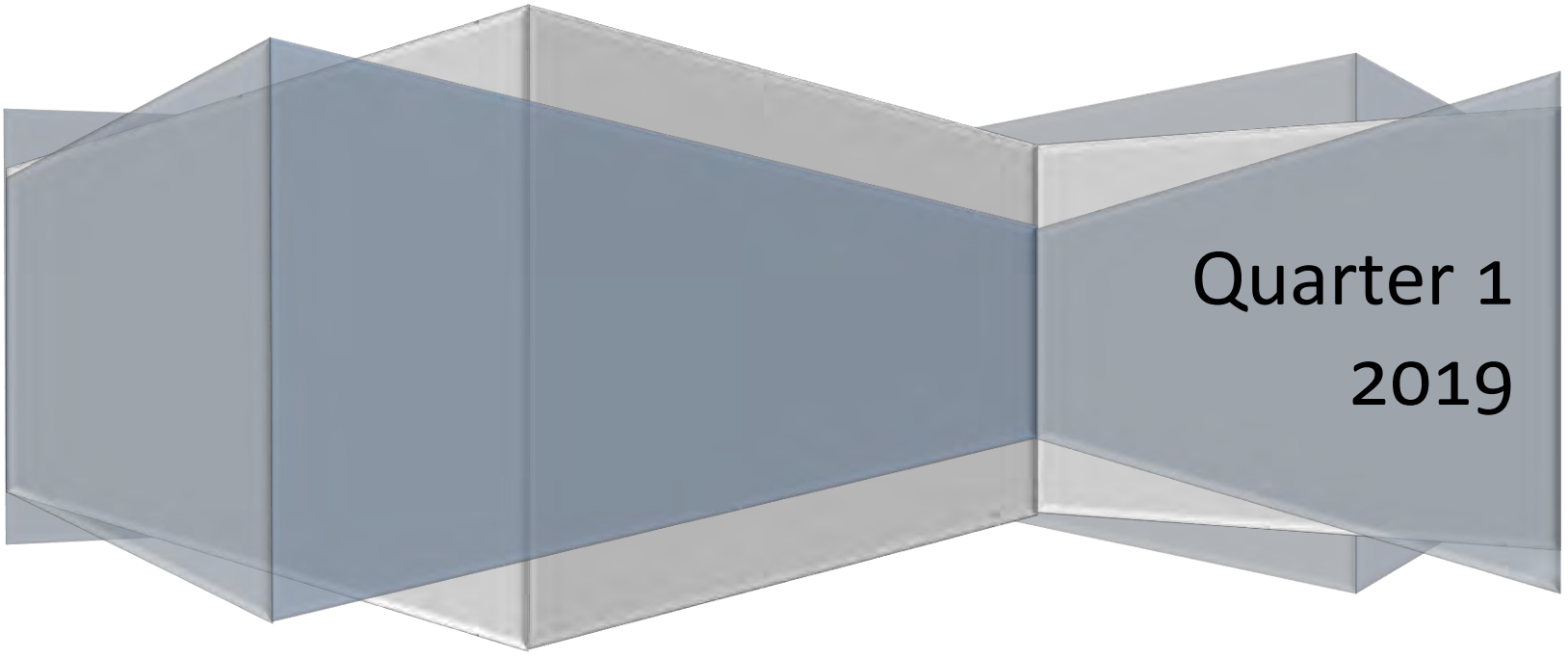
Virginia Department of Medical Assistance Services

The Virginia Addiction & Recovery Treatment Services (ARTS), and Former Foster Care Youth (FFCY) Delivery System Transformation

Section 1115 Quarterly Report

Demonstration Waiver 1115
Project 11 – W- 00297/3

Demonstration Year: 5 (01/01/2019 – 12/31/2019)
Quarter 1 (01/01/2019-03/31/2019)
Approval Period (1/12/2015-12/31/2019)



Addiction and Recovery Treatment Services

INTRODUCTION

In September 2014, to address the prescription drug and heroin overdoses taking the lives of thousands of Virginians, Governor McAuliffe signed Executive Order 29 creating the Governor's Task Force on Prescription Drug and Heroin Abuse. Dovetailing with Virginia's concern, in July 2015, CMS issued the CMS State Medicaid Director letter, #15-003 to Medicaid Directors that highlighted new service delivery and funding opportunities for Medicaid members experiencing a Substance Use Disorder (SUD). The CMS opportunities significantly aligned with the Governor's Task Force conclusions. In 2016, the Virginia General Assembly and Governor McAuliffe authorized the Department of Medical Assistance Services (DMAS) to make changes to its existing substance use disorder treatment services. Under this authority, DMAS and the Department of Behavioral Health and Disability Services (DBHDS) worked with stakeholders (Virginia Department of Health, Department of Health Professions, the managed care organizations and others) to develop an enhanced and comprehensive benefit package to cover addiction and recovery treatment services. DMAS also submitted an application for and received CMS 1115 Demonstration waiver authority to waive the limits for using Medicaid federal dollars to fund individuals seeking treatment in Institutions for Mental Diseases (IMDs) for SUD related residential services. Virginia continued efforts to address the number of opioid fatalities and in November 2016, the State Health Commissioner declared a Public Health Emergency for Virginia as a result of the opioid addiction epidemic.

This report highlights progress made with the State's implementation of the system transformation of the SUD treatment services: Addiction and Recovery Treatment Services (ARTS).

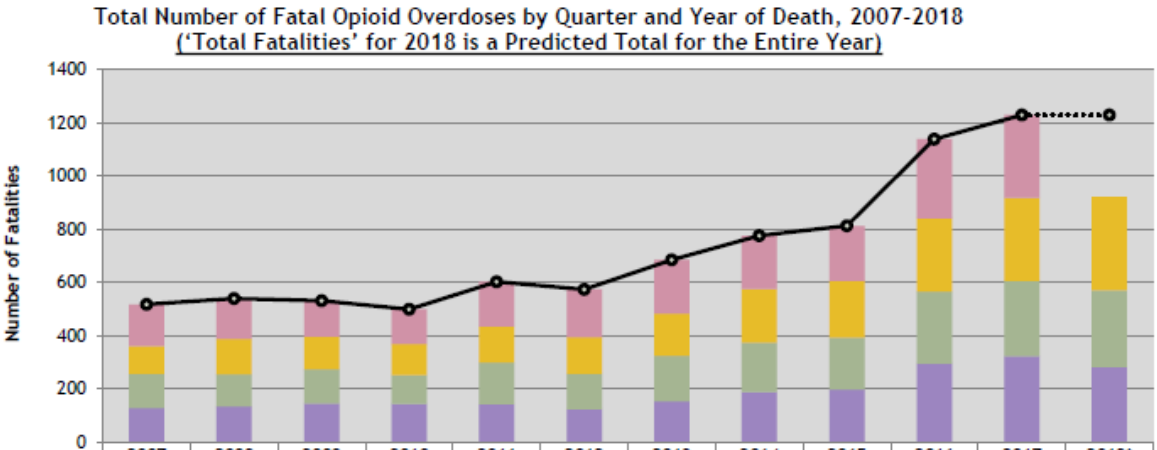
BACKGROUND

Virginia's Medicaid members are disproportionately impacted by the substance use epidemic. Nationally, Medicaid members are four times more likely than people with private insurance to have ever used heroin or had pain reliever dependence[1]. Medicaid members are also prescribed opioids at twice the rate of non-Medicaid members and are at three-to-six times the risk of prescription opioid overdose. In 2014, Virginia spent $44 million on Medicaid members with a primary or secondary diagnosis of SUD who were admitted to hospitals or Emergency Departments. Due to the overwhelming impact of SUD for Medicaid members, the Governor's Task Force on Prescription Drug and Heroin Addiction made a recommendation to increase access to treatment for opioid addiction by increasing Medicaid reimbursement rates for SUD treatment services. As part of the Governor's Task Force recommendations, DMAS initiated a large stakeholder workgroup to develop the comprehensive benefit for SUD treatment services, resulting in the ARTS benefit, which implemented on April 1, 2017. As of March 2019, Virginia Medicaid has over 1.3 million individuals enrolled in its program. The Virginia Department of Health (VDH) reported that nearly 1,300 Virginians died from opioid overdoses in 2017, nearly doubling since 2011 (see Figure 1). Projected estimates for 2018 (entire year) are calculated based upon initial counts by

[1] *MACPAC (June 2017), Report to Congress on Medicaid & CHIP, Chapter 2: Medicaid and the Opioid Epidemic.*

quarter, average toxicology turnaround time at the time of the report, the date of data analysis, and previous quarter fatality trend review.

Figure 1: Total Number of Fatal Opioid Overdoses in Virginia as of April 2019



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018*
Q4	156	151	136	131	168	179	202	201	208	298	312	
Q3	104	134	122	116	136	137	158	202	213	275	312	351
Q2	130	120	128	109	156	134	173	185	195	272	284	290
Q1	126	133	144	142	141	122	151	187	196	293	321	280
Total Fatalities	516	538	530	498	601	572	684	775	812	1138	1229	1229

Even after the initiation of the ARTS benefit, Virginia continues to feel the impact of the opioid epidemic. As Figure 1 shows above, the overarching trend for all drug fatalities statewide is leveling off. However, this trend may not be consistent in all areas of the state and there are geographic variations in terms of the type of substance associated with fatality. Further, there are variances in substance use patterns depending on the community in comparison to overall statewide numbers regarding opioid related fatalities. There have been many efforts directed at opioids both nationally and within the state, however, Virginia is experiencing increases in fatal overdoses of non-opioid substances such as cocaine and methamphetamine. This reinforces the fact that Virginia is experiencing a crisis of addiction and not just one of opioids.

From 2007-2015, opioids (fentanyl, heroin, U-47700, and/or one or more prescription opioids) made up approximately 75% of all fatal drug overdoses annually in Virginia. However, this percentage is increasing each year due to the significant increase in fatal fentanyl and/or heroin overdoses that began in late 2013 and early 2014. Fatal opioid overdoses increased by 8.0% in 2017 when compared to 2016.

In 2013, fatal drug overdose became the leading method of unnatural death in the Commonwealth. This trend has continued to worsen at a greater magnitude due mainly to illicit opioids (heroin, illicit fentanyl, and fentanyl analogs).

In 2018, VDH estimated that almost 1,229 individuals died as a result of drug overdoses involving fentanyl and/or heroin and prescription opioid overdoses; and approximately 11,609 individuals presented at an emergency department with either a heroin or opioid overdose[2].

[2] http://www.vdh.virginia.gov/data/opioid-overdose/

GOALS

Virginia's overall goal for the ARTS benefit is to improve quality of care, to offer a continuum of care across the benefit plan, improved population health, and decreased costs for the Medicaid population with SUD. DMAS' specific objectives for this benefit are outlined below in Figure 2:

Figure 2: DMAS's Objectives of the ARTS Benefit

Improve quality of care and population health outcomes for the Medicaid population.

- Improve quality of addiction treatment (as measured by performance on identified quality measures).
- Reduce prescription opioid drug abuse (measured by Pharmacy Quality Assurance opioid performance measures).
- Decrease fatal and non-fatal drug overdoses among Medicaid members.

Increase Medicaid members' access to and utilization of community-based and outpatient addiction treatment services.

- Increase the percentage of Medicaid members living in communities with an adequate supply of clinicians offering addiction treatment services to Medicaid members.
- Increase the quantity of community-based and outpatient addiction treatment services used by Medicaid members with SUD.

Decrease utilization of high-cost Emergency Department and hospital services by Medicaid members with SUD.

- Decrease ED visits, inpatient admissions, and readmissions to the same level of care or higher for a primary diagnosis of SUD.
- Decrease inappropriate utilization for other physical and behavioral health care services for other conditions such as chronic diseases and serious mental illness.

Improve care coordination and care transitions for Medicaid members with SUD.

- Improve the coordination of addiction treatment with other behavioral and physical health services.
- Improve care transitions to outpatient care, including hand-offs between levels of care within the SUD care continuum and linkages with primary care upon discharge.

Increase the number and type of health care clinicians providing SUD services to Medicaid members with SUD.

- Increase number of addiction treatment providers providing all ASAM Levels of Care in each region of the Commonwealth.
- Increase the number of buprenorphine-waivered physicians and the number of physicians providing Medication Assisted Treatment.
- Increase the number of clinicians with substance abuse training and the number of behavioral health clinicians providing addiction treatment .

ELIGIBILITY AND BENEFIT INFORMATION

The ARTS benefit expands access to a comprehensive continuum of addiction treatment services for all enrolled members in Medicaid, in Virginia's CHIP-Family Access to Medical Insurance Security (FAMIS), FAMIS MOMS and Governor's Access Plan (GAP) (Note: FAMIS and FAMIS MOMS are

programs covered by the Child Health Insurance Program (CHIP) benefit). The ARTS benefit is covered through the fee for service, Medallion 4.0 Managed Care, and Commonwealth Coordinated Care Plus (CCC Plus) Medicare/Medicaid Programs. All MCOs and Magellan of Virginia are covering the full range of ARTS services. The full continuum of the ARTS benefit is listed in Figure 3:

Figure 3: ARTS Continuum of Care

Expansion of the administration of community-based addiction and recovery treatment services

- Transition through the DMAS contracted managed care organizations (MCOs) including Medallion 4.0, Commonwealth Coordinated Care (CCC) and CCC Plus.
- The DMAS contracted Behavioral Health Services Administrator (BHSA), Magellan of Virginia, will cover ARTS for those members who are enrolled in the full coverage Fee-For-Service (FFS) and members enrolled in the GAP benefit, thus providers will continue to bill Magellan for these FFS enrolled members only.

Expansion of Community-based addiction and recovery treatment services for all members

- Residential Treatment,
- Partial Hospitalization,
- Intensive Outpatient Treatment,
- Medication Assisted Treatment/Opioid Treatment Services (includes individual, group counseling and family therapy and medication administration), and
- Substance Use Case Management.

Allowing for coverage of inpatient detoxification and inpatient substance use disorder treatment for all members

- For all full-benefit Medicaid and FAMIS enrolled members.
- DMAS expanded coverage of residential detoxification and residential substance use disorder treatment for all full-benefit Medicaid enrolled members.

ENROLLMENT COUNTS FOR YEAR TO DATE

DMAS provides SUD treatment services and co-occurring substance use and mental health disorder treatment services to all 1.3 million members enrolled in Medicaid, FAMIS, FAMIS MOMS and GAP. Virginia expanded Medicaid effective January 1, 2019. As a result, the GAP benefit ended at the end of this reporting period as the majority of GAP members were eligible for Medicaid expansion. The population that the Medicaid expansion includes are adults with incomes ≤ 138% federal poverty limit (FPL). Virginia has enrolled over 251,000 newly eligible adults as of March 2019 Medicaid expansion could enable as many as 60,000 uninsured Virginians to gain access to SUD treatment services, including 18,000 with opioid use disorder (OUD).

DMAS contracted with Virginia Commonwealth University (VCU) to conduct an independent evaluation of the ARTS program. Highlights of the first fifteen months of evaluation outcomes covering April 1, 2017 to June 1, 2018 are provided below. The next evaluation is scheduled for the first 24 months post implementation.

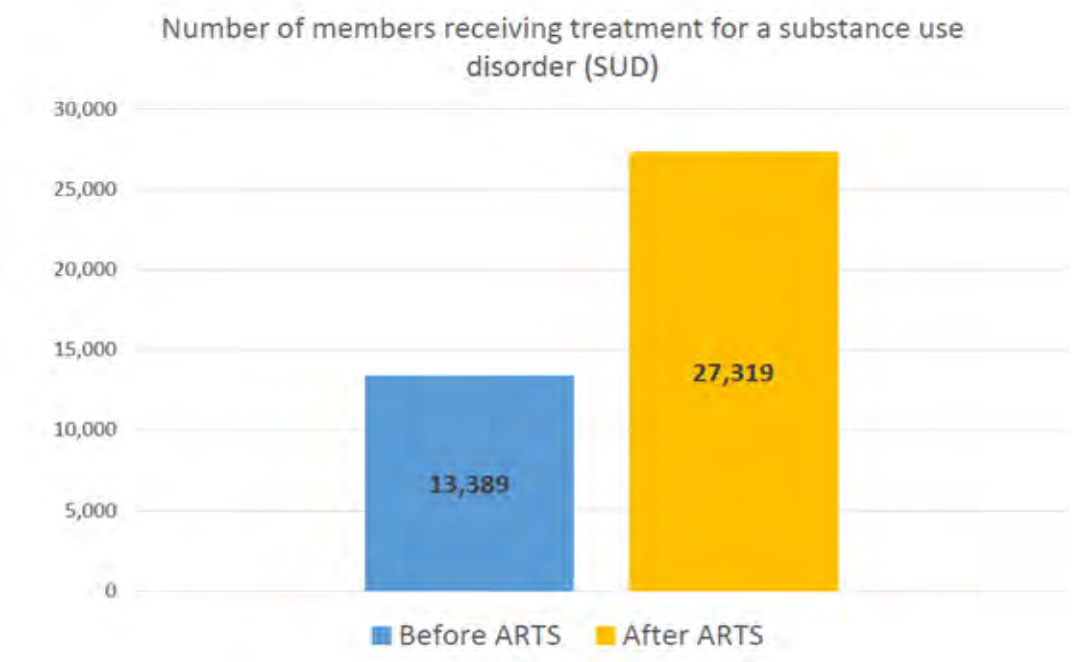
Key Findings

The percent of Medicaid members with a SUD who received any treatment increased from 24 percent before ARTS to 44 percent during the first fifteen months of ARTS (see Figure 4 and 5).

Figure 4: Increase in Number of Members with SUD and Receiving Treatment

	Before ARTS January 2016-March 2017	After ARTS April 2017-June 2018	Percent Change
Total number of members with SUD	56,530	62,356	10%
Members with SUD receiving any SUD treatment	13,389	27,319	104%
Percent receiving SUD treatment	**24%**	**44%**	**85%**

Figure 5: Number of Members Receiving SUD Treatment



The percent of Medicaid members with an OUD who received any treatment increased from 45 percent before ARTS to 65 percent during the first fifteen months of ARTS (See Figure 6). The rate of Medicaid members receiving pharmacotherapy for treatment of an OUD also increased 34% (See Figure 7).

Figure 6: Number of Members with OUD and Receiving Treatment

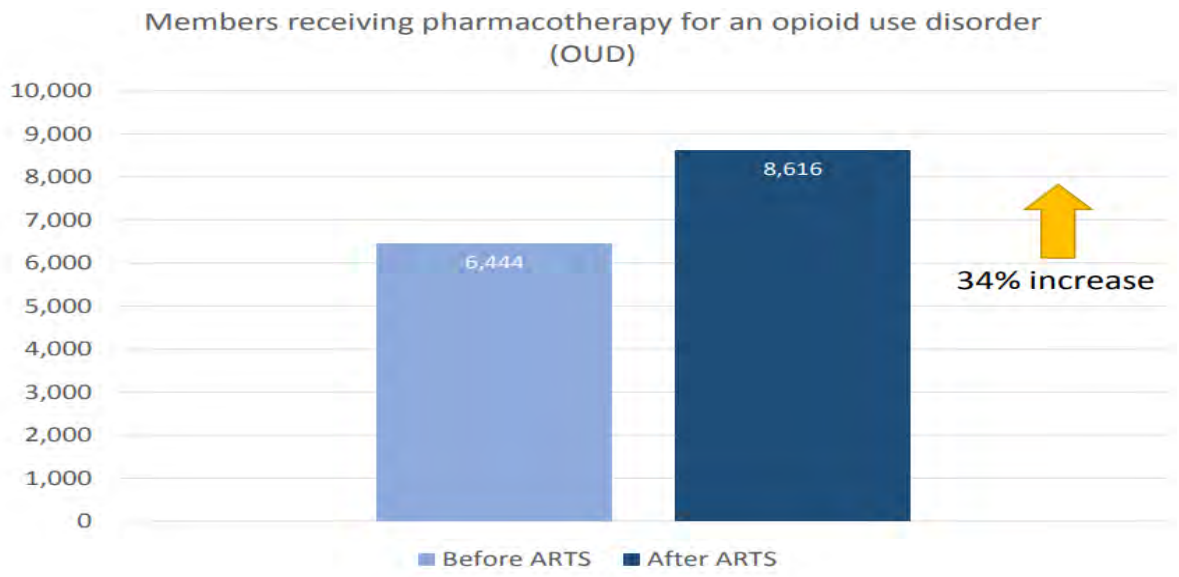


Figure 7: Number of Members with OUD Receiving Pharmacotherapy

	Before ARTS January 2016-March 2017	After ARTS April 2017-June 2018	Percent Change
Total number of members with an (OUD)	20,167	25,292	25%
Members with OUD receiving any OUD treatment	9,095	16,383	80%
Percent receiving OUD treatment	**45%**	**65%**	**44%**

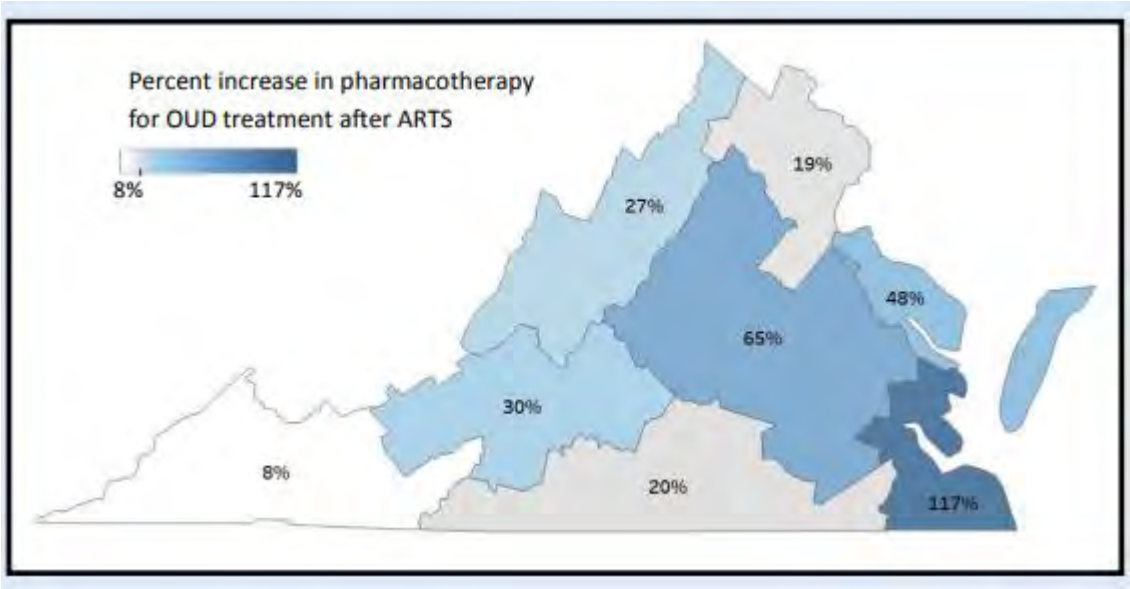
The number of opioid pain medications prescribed for Medicaid members decreased by 28 percent during the first fifteen months of ARTS (See Figure 8).

Figure 8: Number of Members per 1,000 with Opioid Prescription

	Before ARTS January 2016-March 2017	After ARTS April 2017-June 2018	Percent Change
Total number of opioid prescriptions	696,927	501,743	-28%
Number of opioid prescriptions per 10,000 members	**4,650**	**3,335**	**-28%**

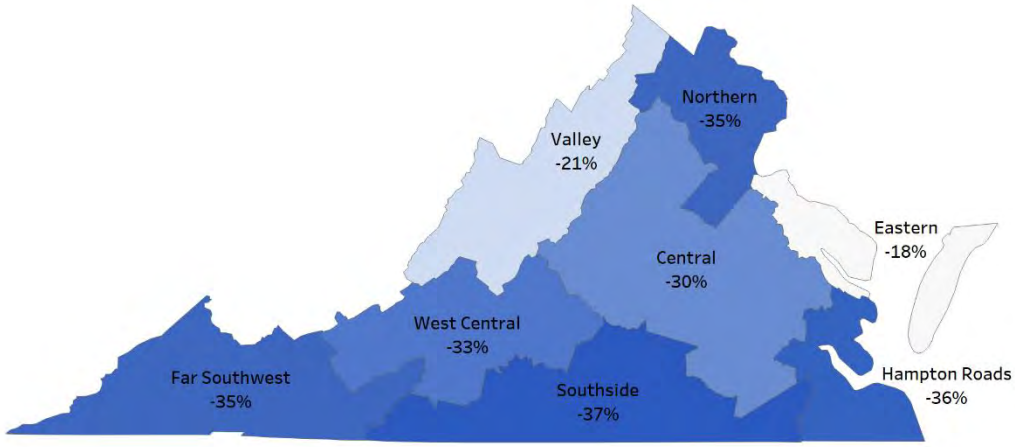
Pharmacotherapy for OUD treatment increased in all regions of Virginia after ARTS implementation. The largest increase in numbers of members receiving pharmacotherapy for OUD was 117% in the Eastern Virginia region. Rates of receiving any treatment among members has increased approximately 3% to 24% prior to ARTS, to 38% in the first 15 months of ARTS implementation (See Figure 9).

Figure 9: Member Receiving Pharmacotherapy for OUD



The number of emergency department visits related to OUD per 1,000 Medicaid members with OUD decreased by one-third during the first fifteen months of ARTS (See Figure 10).

Figure 10: Percent Change in Number of OUD-Related Emergency Department Visits per 1,000 Medicaid Members with OUD



DMAS continues to promote use and access of the Peer Recovery Support Services benefit which includes Peer and Family Support Services (Peer Services for Adults as well as for Parents/Caregivers of minors). There have been concerns noted that the barriers to providers utilizing this service include a rate for these services that is not equivalent to the cost of delivery and burdensome documentation and supervision requirements. DBHDS has contracted with Virginia Commonwealth University to evaluate the workforce issues that Peer Recovery Support Specialists may be experiencing and to help the state develop a plan to address these barriers and increase access to services. DMAS has engaged with the Virginia Recovery Initiative, a team of stakeholders who champion efforts to emphasize the value of people's lived experience of recovery from

substance use and mental health conditions. DMAS continues to work to increase member use and access of the Peer Recovery Support Services benefit.

OPERATIONAL UPDATES

During Quarter 1 of year three post ARTS implementation, DMAS continued to monitor activity with the MCOs and Magellan of Virginia to determine if there were any significant operational, policy, systems, or fiscal developmental issues. There continued to be claim issues identified by providers and reported to DMAS, however the amount of claims issues being reported has reduced with an average claim inquiry of 20 per month, all of which being resolved within 2 weeks of the provider reporting an issue. DMAS tracks all emails and calls related to the ARTS benefit to ensure any concerns or issues are addressed. DMAS works with the MCOs and Magellan of Virginia to work through all claims issues on a case by case basis. DMAS continues to promote the use of the MCOs ARTS Care Coordinators, who are licensed practitioners and Registered Nurses, to help field clinical concerns, assist with member transition and discharge and field questions.

During the first quarter of 2019, DMAS continued to monitor the MCOs and Magellan of Virginia to ensure contractual compliance with operations, system readiness, provider network adequacy and claims processing. MCOs and Magellan of Virginia continue to show compliance with all areas; there are some claims issues that present themselves. Each claim issue is handled on a case by case basis and DMAS works closely with the provider and MCO to track and follow up with all claims issues to resolution.

DMAS continues to work to update ARTS regulations, provider manuals and increase access to ARTS services. DMAS' goal is to minimize treatment barriers for members who have an OUD while ensuring these members obtain access to high quality Medication Assisted Treatment (MAT) and other proven therapies. DMAS posted a bulletin in February 2019 on "Evidence-Based Practices and Medication Assisted Treatment for Opioid Use Disorder." The goal of this bulletin was to highlight evidence-based practices for the treatment of OUD and coverage of these services by the Medicaid ARTS program. DMAS facilitated a webinar on these best practices to promote coverage with the current evidence to provide the best outcomes for Medicaid members with an OUD to emphasize the importance of providing care that is responsive to individual patient preferences, needs and values. The webinar was designed to supports Medicaid providers to effectively address the needs of members with OUD. DMAS had 161 individuals register for this webinar.

DMAS made other significant changes to increase access to evidenced-based practices including:

- Removal of prior authorize for up to 24 mg/day of Suboxone film for in-network buprenorphine waivered practitioners;
- Removal of the automatic lock-in to a prescriber or a pharmacy for members receiving a buprenorphine product;
- Allow and encourage same-day billing of medical and behavioral health services for promotion of fully integrated care;
- Require providers to assess members and facilitate access to MAT along the addiction continuum; and
- Encourage MAT during and after release from institutional settings including hospitals, emergency departments, jails, and inpatient rehabilitation.

The current DMAS regulations are under review and final provider manual updates will take place once the regulations have been finalized. The Peer Recovery Support Services manual has also been updated and is currently posted on the Virginia Legislative TownHall for a 30 day public comment period.

DMAS continues to seek other ways to improve communications with the MCOs and Magellan of Virginia to ensure members are receiving the most appropriate services in a timely manner. DMAS added an ARTS Helpline, which is maintained by DMAS part-time staff within the Division of Behavioral Health. The ARTS Helpline is a designated telephone number to assist providers and members with questions and or concerns related to the ARTS program and all call are return within three business days.

PERFORMANCE METRICS

Each MCO and Magellan of Virginia are to use, and expand as necessary, their existing quality improvement infrastructures, quality improvement processes and performance measurement data systems to ensure continuous quality improvement of ARTS. At a minimum, each MCO and Magellan of Virginia must have an Annual Quality Management Plan that includes their plan to monitor the service delivery capacity as evidenced by a description of the current number, types and geographic distribution of SUD services. Monitoring of performance includes determining and analyzing the root causes for performance issues. DMAS is working to modify the external quality review organization (EQRO) contract to focus on ARTS quality metrics to evaluate the outcomes of the program as well as analyze outcomes of individual MCOs.

DMAS continues to work with CMS as one of the six pilot states working to implement new quality metrics for the ARTS program. DMAS has submitted the final metrics protocol and received feedback from CMS on areas that need to be updated and better defined.

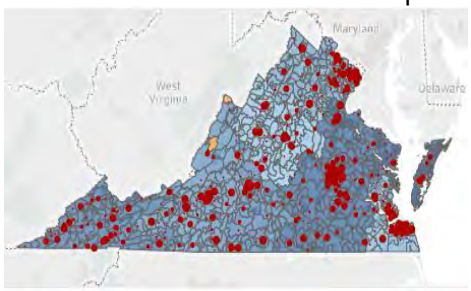
COLLECTION & VERIFICATION OF UTILIZATION & ENROLLMENT DATA

DMAS has collected data submitted from the MCOs and Magellan of Virginia on network and service authorizations for ARTS services. The Special Terms and Conditions (STCs) require the state to report on residential levels of care, at least one sublevel level of care is required to be available to members upon implementation within each MCO and Magellan of Virginia network. The STCs also require access standards and timeliness requirements, including number of days to first ARTS service at appropriate level of care after referral. This is specified in the ARTS Network Development Plans and the ARTS Network Readiness Plans and referenced in the relevant contracts.

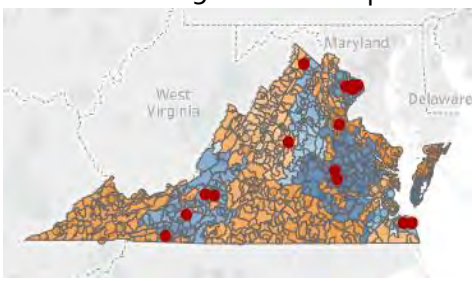
The following maps show network adequacy for this quarter. The orange shaded areas of the map are areas in which provider needs are the greatest. Currently network adequacy is based on a 30 mile radius in urban areas and 60 mile radius in rural areas.

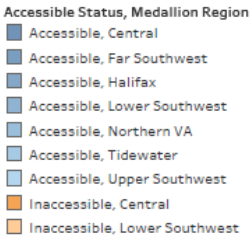
Figures 11: ARTS Network Adequacy Maps[3]

ASAM Level 2.1: Intensive Outpatient

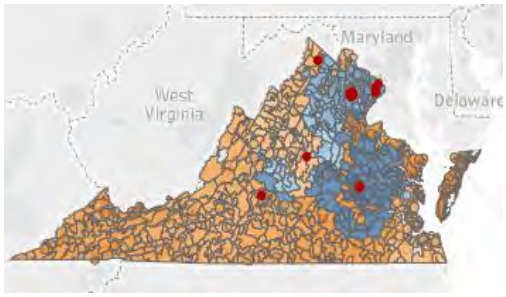


ASAM Level 2.5: Partial Hospitalization

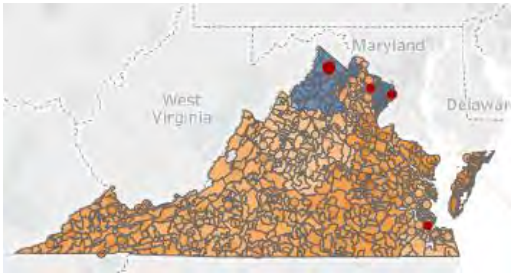




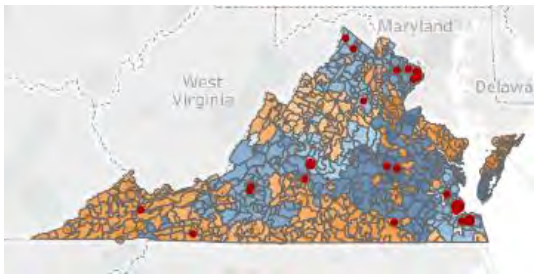
ASAM Level 3.1: Group Home



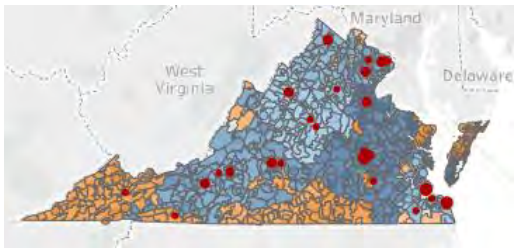
ASAM Level 3.3: Clinically Managed Residential (RTS)



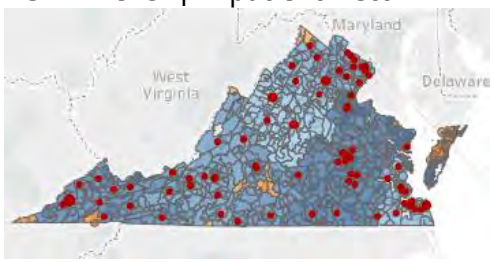
ASAM Level 3.5: Clinically Managed RTS



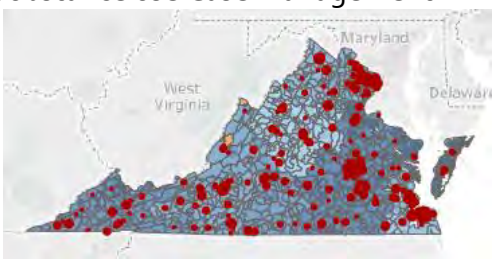
ASAM Level 3.7: Medically Monitored RTS



ASAM Level 4: Inpatient Detox

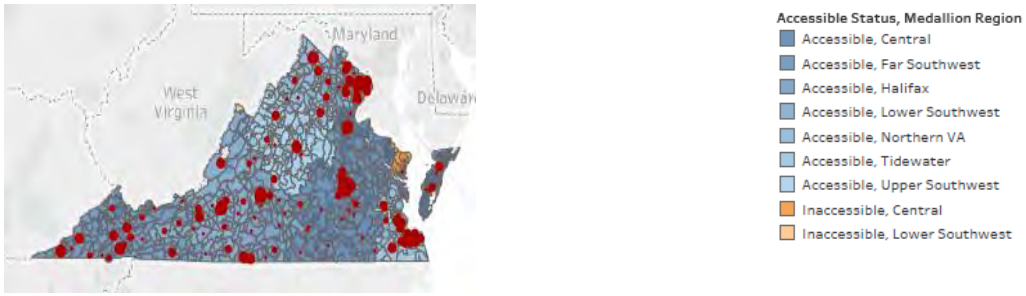


Substance use Case Management



[3] Map based on Longitude (generated) and Latitude (generated) and Latitude (generated) broken down by ASAM Level of Care. For pane Latitude (generated): Color shows details about Color and Region. Details are shown for Member Zip Code. For pane Latitude (generated) (2): Size shows distinct count of providers. The data is filtered on Provider Record Validation Status, File Submission Date and the National Provider Identifier (NPI) of the provider.

Opioid Treatment Programs: Office Based Opioid Treatment (OBOT) & Opioid Treatment Providers (OTP)



The data below (Figure 12) shows an increase in service authorizations for Intensive Outpatient Services (ASAM Level 2.1) compared to services approved based on medical necessity utilizing ASAM Criteria. This service did not require a service authorization prior to ARTS. Peer Recovery Support Services require registration or service authorization and are shown in Figure 13. The MCOs and Magellan of Virginia are providing outreach and training to providers regarding ASAM Criteria to further improve appropriateness of authorization requests.

Figure 12: Service Authorization for ASAM Level 2.1 to 4.0

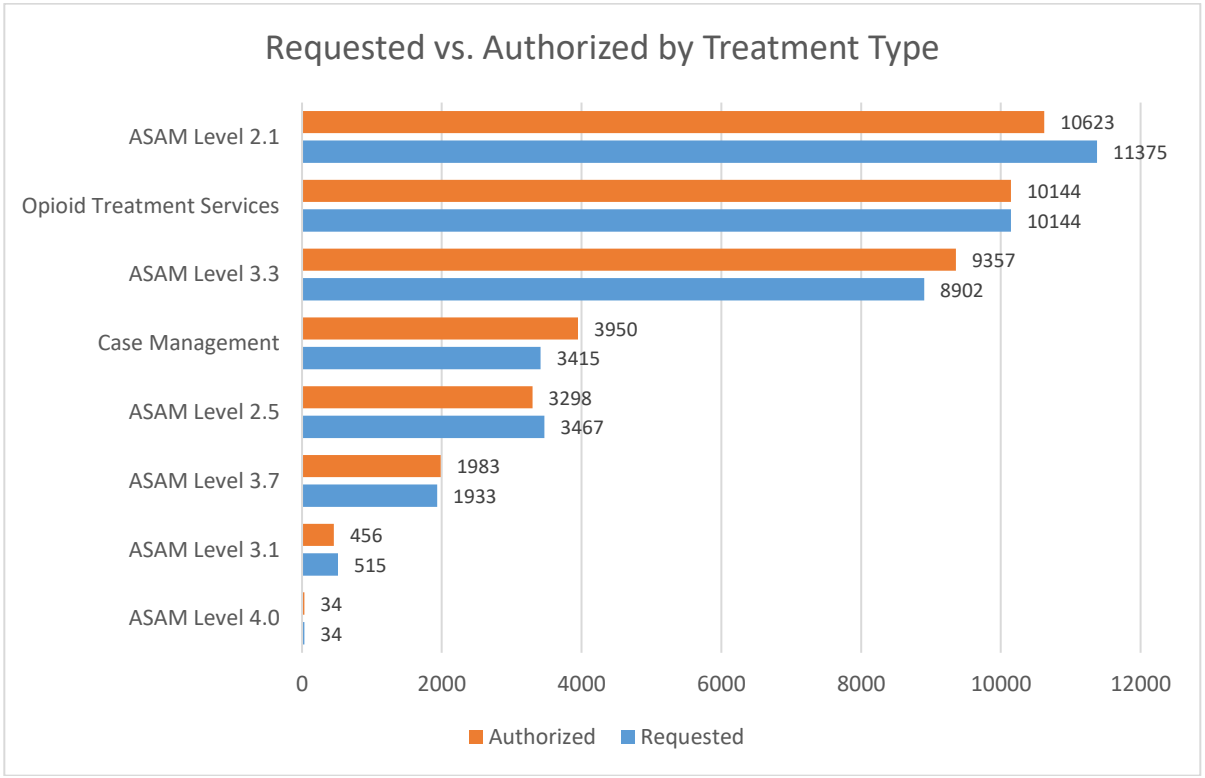
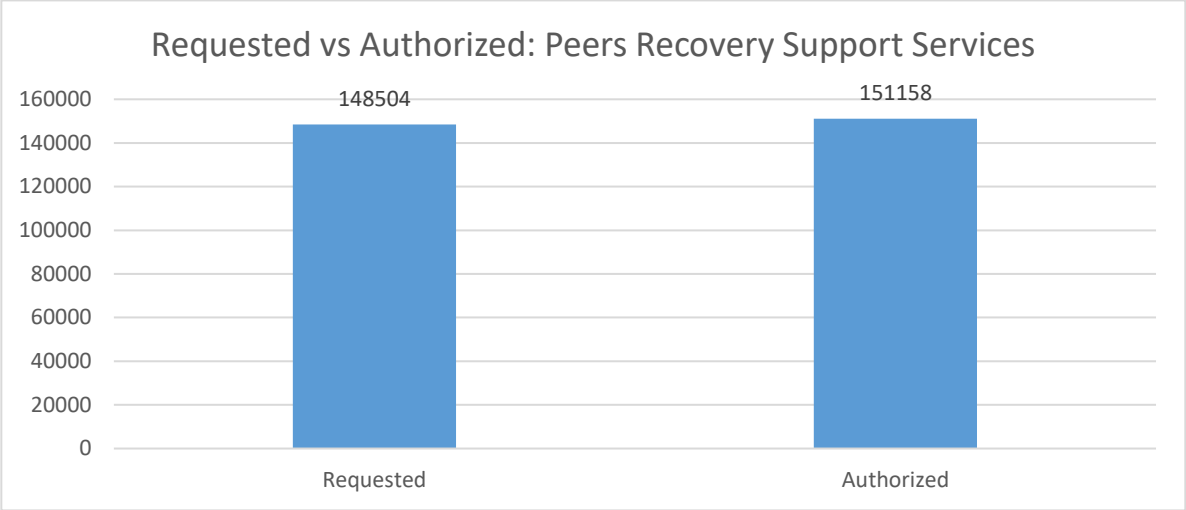


Figure 13: Service Authorizations or Registrations for Peer Recovery Support Services



BUDGET NEUTRALITY AND FINANCIAL REPORTING

There are no financial/budget neutrality developmental issues to date noted for ARTS.

CONSUMER ISSUES

Consumers continue to note lack of residential care for pregnant woman and the ability to access in-network providers in rural areas for buprenorphine prescriptions. While there has been an increase in providers coming into network there are still some identified gaps in coverage. The MCOs and Magellan of Virginia continue to reach out to licensed providers to encourage them to become in-network and continue to work with members to help connect them to in-network providers. If there are no in-network providers available close to the member the MCOs will work with the member to get the closest out of network provider and also work with that out of network provider to bring them in-network. DMAS has also been contacted by three out-of-state organizations that provide SUD treatment. DMAS has facilitated several meetings to share network needs in the State. DMAS continues to work with the MCOs and Magellan of Virginia to ensure that any issues that may surface are documented and resolved.

CONTRACTOR REPORTING REQUIREMENTS

DMAS recently updated its reporting requirements to ensure reporting is streamlined and consistent among all the MCOs. Contract revisions have been developed and are currently being reviewed for the MCOs and Magellan of Virginia. DMAS has been working to update the Medicaid state plan, state regulations and provider manuals, to clarify current standards of care for ARTS that incorporate industry standard benchmarks from ASAM that define medical necessity criteria, covered services and provider qualifications.

The MCOs and Magellan of Virginia contracts are currently being modified to clarify program requirements, add the need for addressing SUD with special populations, which include pregnant

woman, and individuals recently released from incarceration. The contract modification clarified the need for continued and ongoing care coordination structures that are in line with evidenced based criteria.

DMAS continues to require monthly reporting from the MCOs on service authorization, provider network, appeal and grievances and patient utilization management (PUMS) related to ARTS. The MCOs and Magellan of Virginia continue to utilize standardize service authorization form to ensure align with ASAM Criteria.

The DMAS vendor contracted to perform the ASAM site visits for residential treatment providers performed one new site visit and approval for a level 3.1 provider. The enrollment of residential providers for SUD treatment continues to be slower than expected. DMAS continues to work with providers and MCOs to develop means to recruit more SUD residential in-network providers.

DMAS's physician review panel continues to review the applications for Preferred OBOT Providers to ensure they meet the ASAM Criteria. As of this reporting period, there are a total of 107 Preferred OBOT Providers approved. During this reporting period there were four newly recognized Preferred OBOTs.

The table (Figure 14) below represents the current network by ASAM Level of Care and change in numbers of Medicaid enrolled providers for this reporting period.

Figure 14: Provider Network Counts

Addiction Provider Type	# of Providers before ARTS	# of Providers after ARTS	% Increase in Providers
Inpatient Detox (ASAM 4.0)	Unknown	103	NEW
Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)	4	96	↑ 2250%
Partial Hospitalization Program (ASAM 2.5)	0	22	NEW
Intensive Outpatient Program (ASAM 2.1)	49	137	↑178%
Opioid Treatment Program	6	39	↑ 550%
Preferred Office-Based Opioid Treatment Provider	0	107	NEW

DMAS worked with VDH to gather needed data for the Google maps. The map was successfully completed and added to the ARTS webpage. DMAS continues to work to update the google map on a quarterly basis. The map may be located: https://www.google.com/maps/d/viewer?mid=1px9XvltnM7rXZ6vrTgXgPGIHTew&hl=en&usp=sharing

LESSONS LEARNED AND OUTREACH

DMAS continues to receive positive feedback from members, community leaders, providers, the MCOs and Magellan of Virginia on the transparency, outreach and willingness to engage feedback for a successful implementation, as well as the resolution of any concerns. DMAS has received positive feedback from community leaders and members who have received services.

During this reporting period, DMAS continued to receive several claims and network issues reported by providers. DMAS worked with individual providers, MCOs and Magellan of Virginia to ensure all claims issues were addressed in a timely fashion.

DMAS values working with stakeholders and diverse providers in order to get first-hand knowledge of how the services are utilized in the community and how the regulations and requirements are implemented from the provider's point of view. This has allowed DMAS to make revisions to the ARTS manual to ensure that services requirements not only meet regulatory standards but also can be appropriately implemented in the community.

DMAS has also been recognized nationally and staff has presented at the National Adult Medicaid (NAM) conference, the Association of State and Territorial Health Officials (ASTHO) NatCon19 conference as well as the Health Resources and Services Administration (HRSA) Expert Review Work Group Meeting for the Regional Opioid Consultation Initiative project this quarter. DMAS also provided guidance to other states interested in learning how Virginia implemented the 1115 Substance Use Disorder Demonstration Waiver, and the process for developing fee schedules and program requirements for ARTS. Finally, DMAS staff attended the required Immersion training in order to obtain rights to utilize Project ECHO. Project ECHO will be used as the platform to hold ongoing Learning Collaborative with clinical staff of Preferred OBOT providers and OTP providers.

DMAS was also invited to present at several state and national conferences in the 2nd quarter including: Rx Drug Abuse and Heroin Summit; the American Society of Addiction Medicine annual conference; the National Association of State Health Policy (NASHP) Federally Quality Health Center conference; the Virginia-SBIRT Policy Steering Committee; the Medicaid Evidence-based Decisions Project (MED) conference; and the Governor's Substance Abuse Services Council (SASC).

DMAS was invited to present at the Virginia Recovery Initiative (VRI) on policy and regulations related to Peer Recovery Support Services in order to help others to understand some of the barriers to increasing access to this service. During the VRI the provider associations voiced concerns about reimbursement rates being too low to sustain the use of Peer Recovery Specialists within their practices. VDH has partnered with VCU to complete analysis on the barriers to care for Peer Recovery Support Services.

Workforce issues related to Certified Substance Abuse Counselors (CSACs) were addressed. DMAS worked with the Board of Counseling to put out guidance documents for providers to help clarify the roles of CSACs.

EVALUATION ACTIVITIES AND INTERIM FINDINGS

DMAS continues to meet regularly with the VCU research team. Currently VCU is working on the 24 month evaluation report for DMAS and the report has not yet been finalized. Within the last 1115 Demonstration Waiver annual report DMAS reported on the first 15 months evaluation, which is available in the Appendix of this report. DMAS is working with VCU on the current year agreement and looking at special populations and evaluation activities surrounding those populations.

CONCLUSION

DMAS continues to work with providers, MCOs and Magellan of Virginia to identify issues and foster the lines of communication between these parties. DMAS is committed to finalizing the VCU evaluation and have the 24 month evaluation available for the next quarterly reporting.

DMAS continues to track outcomes for providers assessing members and facilitating access to MAT along the addiction continuum. DMAS also is focusing efforts to further decrease overdose deaths across the state through encouraging MAT during and after release from institutional settings, including hospitals, emergency departments, jails, and inpatient rehabilitation.

Former Foster Care Youth

INTRODUCTION

Individuals in foster care face a number of challenges upon the termination of their state custodianship, including access to health care. The "Former Foster Care Child Under Age 26 Years" Medicaid covered group provides an opportunity for this population to continue receiving Medicaid coverage until age 26, allowing these individuals time to transition into managing the responsibilities of living independently.

BACKGROUND

On March 23, 2010, the Affordable Care Act (ACA) was signed into law, making a number of changes to Medicaid eligibility effective January 1, 2014. To further the overall goal of expanding health coverage, the ACA included section 2004, which added a new mandatory Medicaid covered group at section 1902(a)(10)(A)(i)(IX) of the Act to provide an opportunity for former foster care youth to obtain Medicaid coverage until age 26 from the state responsible for the individual's foster care. DMAS initially received approval from CMS to cover former foster care youth who received their foster care and Medicaid in Virginia, as well as former foster care youth who received their foster care and Medicaid from another state but who are now living in Virginia.

In November 2016, CMS notified states that they could no longer cover the former foster care youth who received their services from another state but are now living in Virginia under the State Plan. States who wished to continue covering this population could do so under a Section 1115 Demonstration waiver.

In May 2017, DMAS submitted an amendment to the GAP Demonstration Waiver to request approval to provide Medicaid coverage to former foster care youth who were enrolled in Medicaid and foster care in another state and who are now living in Virginia and are applying for Virginia Medicaid. Approval of the waiver amendment was received on September 22, 2017.

GOALS

Virginia's overall goal for the FFCY benefit is to provide former foster care youth with the access to health services they need, through the GAP Demonstration Waiver.

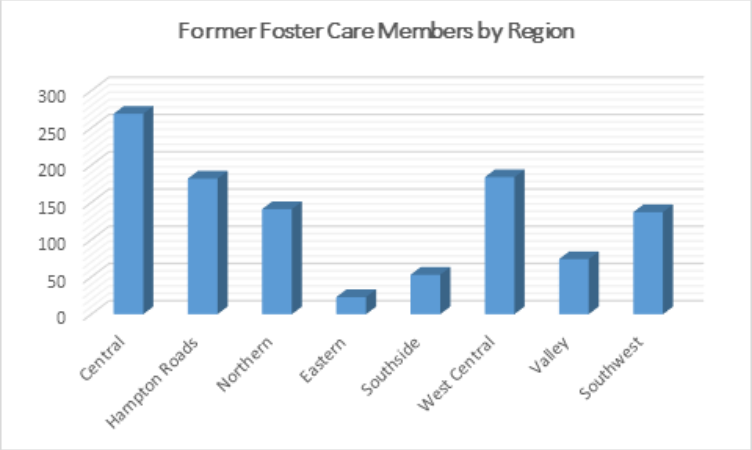
The goals of the FFCY demonstration are: (1) to increase and strengthen coverage of former foster care youth who were in Medicaid and foster care in a different state and (2) to improve or maintain health outcomes for these youth.

ELIGIBILITY AND BENEFIT INFORMATION

Individuals eligible in this demonstration group are those former foster care youth who: (1) were in the custody of another state or American Indian tribe, (2) were receiving foster care and Medicaid services until discharge from foster care upon turning age 18 or older, (3) are not eligible in a

mandatory Medicaid coverage group, and (4) are under the age of 26. All individuals in the Former Foster Care Child Under Age 26 covered group receive the full Medicaid benefit package, including long-term supports and services, if medically necessary.

ENROLLMENT COUNTS FOR YEAR TO DATE



OPERATIONAL UPDATES

The waiver amendment to add the former foster care youth from out of state was approved in September 2017. Since approval, there have been no policy or administrative difficulties in operation for this piece of the demonstration waiver. There have been no challenges or issues.

PERFORMANCE METRICS

By implementing the demonstration, Virginia anticipated increasing healthcare coverage for former foster care youth, while improving health outcomes. The design for evaluating the first demonstration year was approved by CMS and covered the September 2017 to December 2019 time period, representing the start and end dates of the demonstration year. The evaluation addressed three questions:

1. Does/did the demonstration provide Medicaid coverage to former foster care individuals?
2. How do/did former foster care individuals in the demonstration use Medicaid-covered healthcare services?
3. What do/did health outcomes look like for individuals in the demonstration?

DMAS has requested guidance on the continuation of the evaluation design from CMS. No changes to the evaluation design are planned pending the receipt of guidance from CMS. The approved evaluation design from 2018 is contained in Appendix B.

COLLECTION & VERIFICATION OF UTILIZATION & ENROLLMENT DATA

The first evaluation evaluated administrative data (enrollment, claims, and encounters) available in the MMIS at the end of the first (fall 2018) demonstration year. The evaluation was conducted using existing administrative data, and no prospective data (e.g., beneficiary surveys, interviews, focus groups, or other quantitative or qualitative data) was collected due to resource limitations.

The evaluation did not include pretest (or baseline) data because DMAS only has access to data on individuals in the demonstration after they receive Medicaid coverage. The next evaluation will be completed at the end of the second demonstration year (winter 2020). DMAS has requested guidance on the continuation of the evaluation design from CMS. No changes to the evaluation design are planned pending the receipt of guidance from CMS.

BUDGET NEUTRALITY AND FINANCIAL REPORTING

ELIGIBILITY GROUP	Budget Neutrality DY 3 Full year estimate	1/4 of Full Year Estimate		DEMONSTRATION YEAR 5 (CALENDAR YEAR 2018) QUARTER 1 January 2018	February 2018	March 2018	TOTAL QUARTER
Pop Type:	Expansion			Former Foster Care Transfers from Out of State			
Eligible Member Months	830	208		69	73	71	213
PMPM Cost	$ 508.28	$ 508.28		$ 528.91	$ 547.66	$ 607.34	$ 561.48
Total Expenditure	$ 421,869	$ 105,467		$ 36,494	$ 39,979	$ 43,121	$ 119,595

CONSUMER ISSUES

Benefits are provided through the state's fee-for-service and managed-care delivery systems. No complaints or issues have been identified to date. There have been no appeals filed related to this population.

CONTRACTOR REPORTING REQUIREMENTS

No contracts needed to be amended when the FFCY component was added to this waiver. These individuals were previously covered under the Medicaid State Plan; therefore, no changes needed to be made when the waiver was approved.

RECOVERY NAVIGATORS

The FFCY demonstration does not utilize Recovery Navigators.

LESSONS LEARNED

There is nothing to report at this time.

EVALUATION ACTIVITIES

The evaluation of the first demonstration year covered the September 2017 to December 2019 time period. The design for evaluating the demonstration was approved by CMS, and interim evaluation findings were submitted to CMS in March 2019 in a separate document. DMAS has requested guidance on the continuation of the evaluation design from CMS. No changes to the evaluation design are planned pending the receipt of guidance from CMS.

CONCLUSION

The demonstration was implemented as a measure to continue Medicaid coverage for former foster care youth who received their services in another state but who are now living in Virginia. This group was formerly covered in Virginia under the State Plan; the change in the authority mechanism did not necessitate any changes to the application process for these individuals or how they receive Medicaid coverage.

ENCLOSURES

- Appendix A GAP, ARTS and FFCY Budget Neutrality Reports

STATE CONTACT(S)

If there are any questions about the ARTS related contents of this report, please contact:

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804-625-3667

Attachment 6

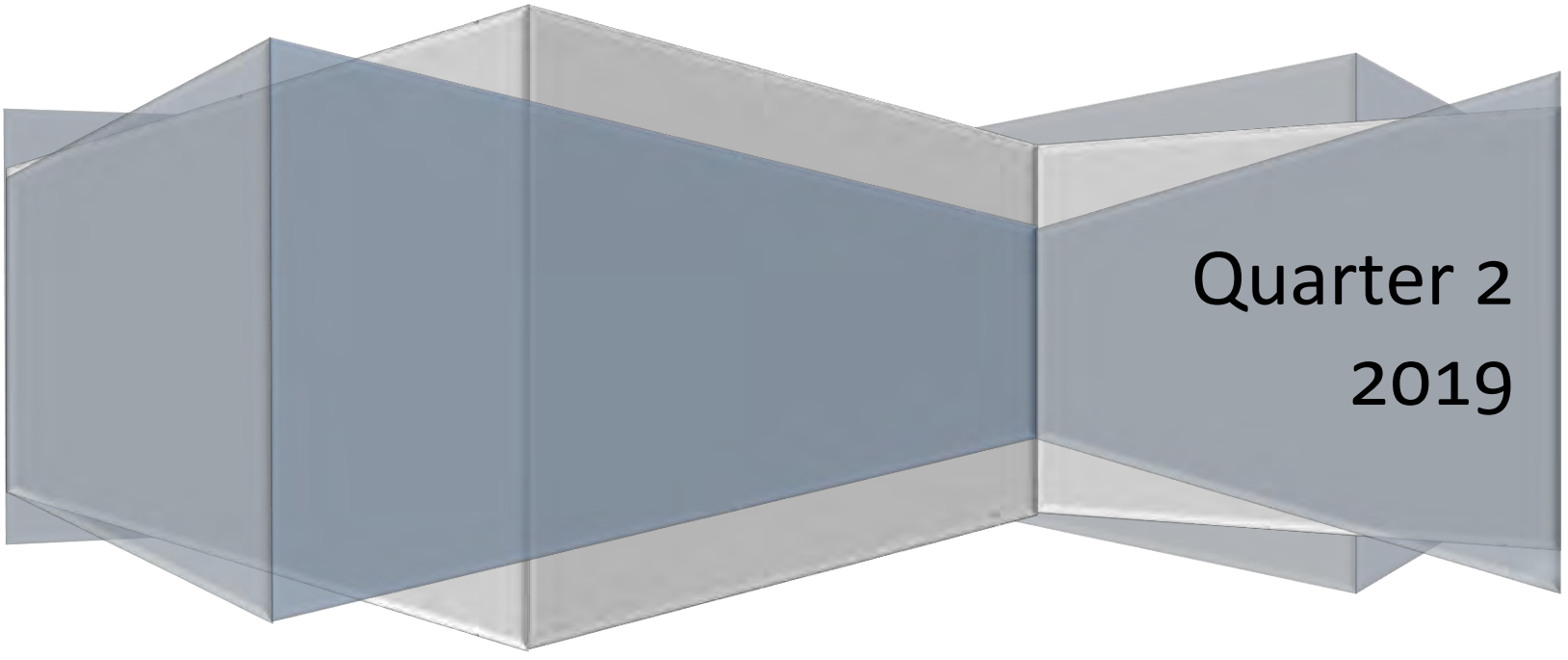
Virginia 1115 Demonstration
State Quarterly Report April-June 2019

Virginia Department of Medical Assistance Services

The Virginia Addiction and Recovery Treatment Services (ARTS), and Former Foster Care Youth (FFCY) Delivery System Transformation

Section 1115 Quarterly Report
Demonstration Waiver 1115
Project 11-W-00297/3

Demonstration Year: 5 (01/01/2019 – 12/31/2019)
Quarter 2 (04/01/2019-06/30/2019)
Approval Period (1/12/2015-12/31/2019)



Addiction and Recovery Treatment Services

INTRODUCTION

In September 2014, to address the prescription drug and heroin overdoses taking the lives of thousands of Virginians, Governor McAuliffe signed Executive Order 29 creating the Governor's Task Force on Prescription Drug and Heroin Abuse. Dovetailing with Virginia's concern, in July 2015, CMS issued the CMS State Medicaid Director letter, #15-003 to Medicaid Directors that highlighted new service delivery and funding opportunities for Medicaid members experiencing a Substance Use Disorder (SUD). The CMS opportunities significantly aligned with the Governor's Task Force conclusions. In 2016, the Virginia General Assembly and Governor McAuliffe authorized the Department of Medical Assistance Services (DMAS) to make changes to its existing substance use disorder treatment services. Under this authority, DMAS and the Department of Behavioral Health and Disability Services (DBHDS) worked with stakeholders (Virginia Department of Health, Department of Health Professions, the managed care organizations and others) to develop an enhanced and comprehensive benefit package to cover addiction and recovery treatment services. DMAS also submitted an application for and received CMS 1115 Demonstration waiver authority to waive the limits for using Medicaid federal dollars to fund individuals seeking treatment in Institutions for Mental Diseases (IMDs) for SUD related residential services. Virginia continued efforts to address the number of opioid fatalities and in November 2016, the State Health Commissioner declared a Public Health Emergency for Virginia as a result of the opioid addiction epidemic. Efforts to continue the momentum to combat the epidemic in the Commonwealth continued. In December 2017, Governor McAuliffe established an Executive Leadership Team on Opioids and Addiction to implement recommendations of the Task Force. In September 2018, Governor Northam established the Governor's Commission on Opioids and Addiction.

This report highlights progress made with the State's implementation of the system transformation of the SUD treatment services: Addiction and Recovery Treatment Services (ARTS).

BACKGROUND

Virginia's Medicaid members are disproportionately impacted by the substance use epidemic. Nationally, Medicaid members are four times more likely than people with private insurance to have ever used heroin or had pain reliever dependence[1]. Medicaid members are also prescribed opioids at twice the rate of non-Medicaid members and are at three-to-six times the risk of prescription opioid overdose. In 2014, Virginia spent $44 million on Medicaid members with a primary or secondary diagnosis of SUD who were admitted to hospitals or Emergency Departments. Due to the overwhelming impact of SUD for Medicaid members, the Governor's Task Force on Prescription Drug and Heroin Addiction made a recommendation to increase access to treatment for opioid addiction by increasing Medicaid reimbursement rates for SUD treatment services. As part of the Governor's Task Force recommendations, DMAS initiated a large stakeholder workgroup to develop the comprehensive benefit for SUD treatment services, resulting in the ARTS benefit, which implemented on April 1, 2017. As of June 1, 2019, Virginia Medicaid has

[1] *MACPAC (June 2017), Report to Congress on Medicaid & CHIP, Chapter 2: Medicaid and the Opioid Epidemic.*

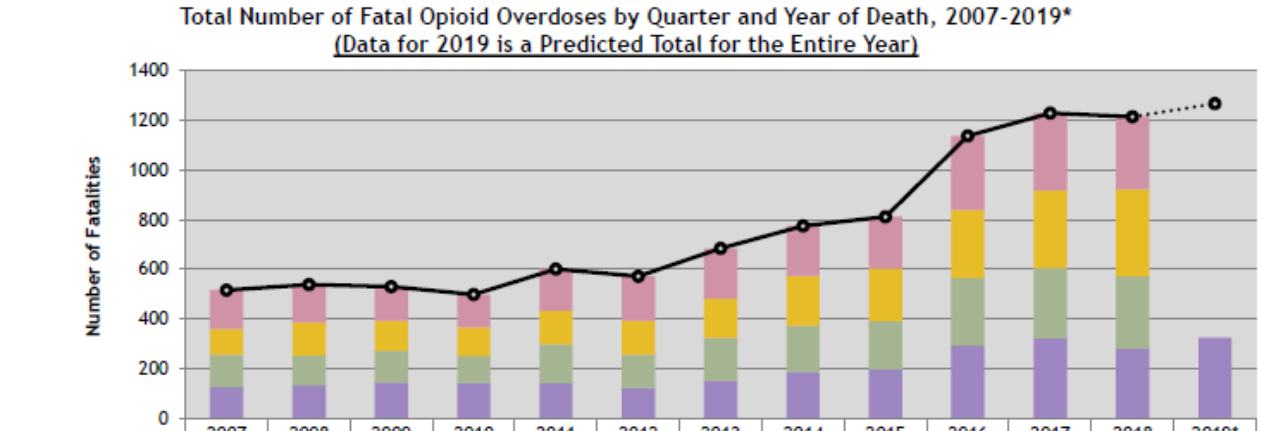
over 1.38 million individuals enrolled in its program who have access to the ARTS benefit. This includes members eligible for Medicaid Expansion which implemented January 2019.

In 2013, fatal drug overdose became the leading method of unnatural death in the Commonwealth. This trend has continued to worsen at a greater magnitude due mainly to illicit opioids (heroin, illicit fentanyl, and fentanyl analogs). From 2007-2015, opioids (fentanyl, heroin, U-47700, and/or one or more prescription opioids) made up approximately 75% of all fatal drug overdoses annually in Virginia. However, this percentage is increasing each year due to the significant increase in fatal fentanyl and/or heroin overdoses that began in late 2013 and early 2014. Fatal opioid overdoses increased by 8.0% in 2017 when compared to 2016.

The Virginia Department of Health (VDH) reported that 1,215 Virginians died from opioid overdoses in 2018, nearly doubling since 2011 (see Figure 1). Projected estimates for 2019 (entire year) are calculated based upon initial counts by quarter, average toxicology turnaround time at the time of the report, the date of data analysis, and previous quarter fatality trend review.

Even after the initiation of the ARTS benefit, Virginia continues to feel the impact of the opioid epidemic. As Figure 1 shows below, the trend for opioid fatalities statewide had begun to level off. However, estimates for 2019 show an increase compared to 2018. Fentanyl (prescription, illicit, and/or analogs) caused or contributed to death in nearly 55% of all fatal overdoses in 2018.

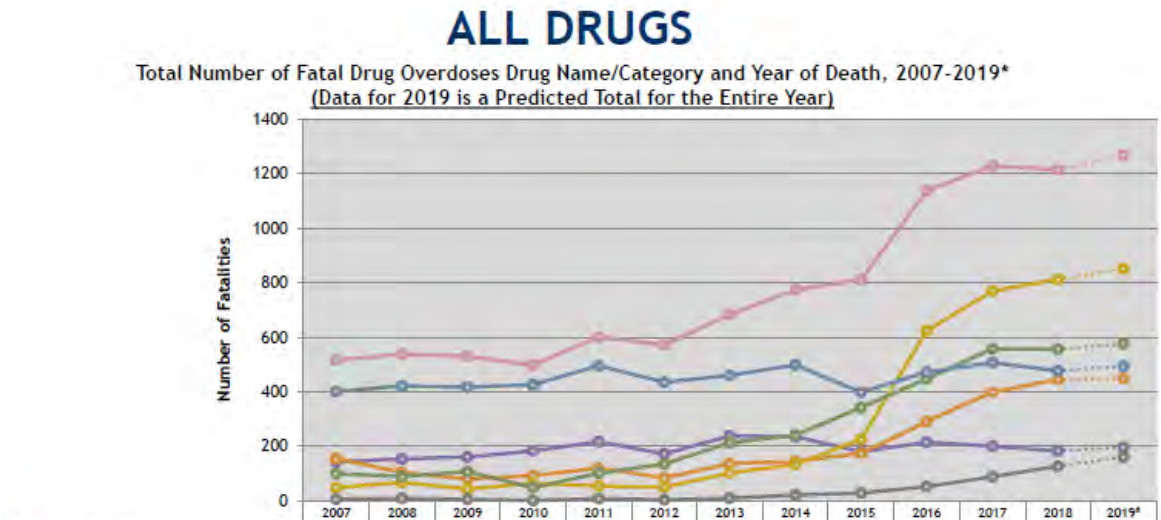
Figure 1: Total Number of Fatal Opioid Overdoses in Virginia as of June 2019



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*
Q4	156	151	136	131	168	179	202	201	208	298	312	292	
Q3	104	134	122	116	136	137	158	202	213	275	312	351	
Q2	130	120	128	109	156	134	173	185	195	272	284	292	
Q1	126	133	144	142	141	122	151	187	196	293	322	280	324
Total Fatalities	516	538	530	498	601	572	684	775	812	1138	1230	1215	1268

Further, there are variances in substance use patterns depending on the community in comparison to overall statewide numbers regarding all drug-related fatalities. There have been many efforts directed at opioids both nationally and within the state, however, Virginia is experiencing increases in fatal overdoses of non-opioid substances such as cocaine and methamphetamine. VDH reports that fatal non-opioid illicit drug overdoses are on the rise. In 2018 compared to 2017, fatal cocaine overdoses increased 11.5% and fatal methamphetamine overdoses increased 44.3% (Figure 2). This reinforces the fact that Virginia is experiencing a crisis of addiction and not just one of opioids.

Figure 2: Total Number of Fatal Overdoses in Virginia as of June 2019



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*
Benzodiazepines	142	154	161	183	217	172	238	236	180	215	200	183	196
Cocaine	155	104	80	93	120	84	137	145	174	292	399	445	450
Fentanyl	48	68	43	64	54	50	102	134	225	624	770	813	852
Heroin	100	89	107	48	101	135	213	241	342	448	558	556	577
Methamphetamine	6	9	5	1	8	4	10	21	29	52	88	127	160
Prescription Opioids (excluding Fentanyl)	401	422	417	426	496	435	460	499	398	472	507	477	494
All Opioids	516	538	530	498	601	572	684	775	812	1138	1230	1215	1268

GOALS

Virginia's overall goal for the ARTS benefit is to improve quality of care, to offer a continuum of care across the benefit plan, improved population health, and decreased costs for the Medicaid population with SUD. DMAS' specific objectives for this benefit are outlined below in Figure 3:

Figure 3: DMAS's Objectives of the ARTS Benefit

Improve quality of care and population health outcomes for the Medicaid population.

- Improve quality of addiction treatment (as measured by performance on identified quality measures).
- Reduce prescription opioid drug abuse (measured by Pharmacy Quality Assurance opioid performance measures).
- Decrease fatal and non-fatal drug overdoses among Medicaid members.

Increase Medicaid members' access to and utilization of community-based and outpatient addiction treatment services.

- Increase the percentage of Medicaid members living in communities with an adequate supply of clinicians offering addiction treatment services to Medicaid members.
- Increase the quantity of community-based and outpatient addiction treatment services used by Medicaid members with SUD.

Decrease utilization of high-cost Emergency Department and hospital services by Medicaid members with SUD.

- Decrease ED visits, inpatient admissions, and readmissions to the same level of care or higher for a primary diagnosis of SUD.
- Decrease inappropriate utilization for other physical and behavioral health care services for other conditions such as chronic diseases and serious mental illness.

Improve care coordination and care transitions for Medicaid members with SUD.

- Improve the coordination of addiction treatment with other behavioral and physical health services.
- Improve care transitions to outpatient care, including hand-offs between levels of care within the SUD care continuum and linkages with primary care upon discharge.

Increase the number and type of health care clinicians providing SUD services to Medicaid members with SUD.

- Increase number of addiction treatment providers providing all ASAM Levels of Care in each region of the Commonwealth.
- Increase the number of buprenorphine-waivered physicians and the number of physicians providing Medication Assisted Treatment.
- Increase the number of clinicians with substance abuse training and the number of behavioral health clinicians providing addiction treatment .

ELIGIBILITY AND BENEFIT INFORMATION

The ARTS benefit expands access to a comprehensive continuum of addiction treatment services for all enrolled members in Medicaid, in Virginia's CHIP-Family Access to Medical Insurance Security (FAMIS) and FAMIS MOMS. (Note: FAMIS and FAMIS MOMS are programs covered by the Child Health Insurance Program (CHIP) benefit).) The Governor's Access Plan (GAP) sunsetted in March 2019 and the majority of members are eligible for Medicaid Expansion. The ARTS benefit is covered through the fee for service, Medallion 4.0 Managed Care, and Commonwealth Coordinated Care Plus (CCC Plus) Medicare/Medicaid Programs. All MCOs and Magellan of Virginia are covering the full range of ARTS services. The full continuum of the ARTS benefit is listed in Figure 4:

Figure 4: ARTS Continuum of Care

Expansion of the administration of community-based addiction and recovery treatment services

- Transition through the DMAS contracted MCOs including Medallion 4.0, Commonwealth Coordinated Care (CCC) Plus.
- The DMAS contracted Behavioral Health Services Administrator (BHSA), Magellan of Virginia, covers the ARTS benefit for those members who are enrolled in the full coverage Fee-For-Service (FFS).

Expansion of Community-based addiction and recovery treatment services for all members

- Residential Treatment,
- Partial Hospitalization,
- Intensive Outpatient Treatment,
- Medication Assisted Treatment/Opioid Treatment Services (includes individual, group counseling and family therapy and medication administration), and
- Substance Use Case Management.

Allowing for coverage of inpatient detoxification and inpatient substance use disorder treatment for all members

- For all full-benefit Medicaid and FAMIS enrolled members.
- DMAS expanded coverage of residential detoxification and residential SUD treatment for all full-benefit Medicaid enrolled members.

ENROLLMENT COUNTS FOR YEAR TO DATE

DMAS provides SUD treatment services and co-occurring substance use and mental health disorder treatment services to all 1.38 million members enrolled in Medicaid, Medicaid Expansion, FAMIS and FAMIS MOMS. Virginia expanded Medicaid effective January 1, 2019. As a result, adults with incomes ≤ 138% federal poverty limit (FPL) could now be eligible for Medicaid. Virginia has enrolled over 292,972 newly eligible adults as of June 28, 2019. Medicaid Expansion could enable as many as an estimated 60,000 uninsured Virginians to gain access to SUD treatment services, including an estimated 18,000 with opioid use disorder (OUD).

DMAS contracted with Virginia Commonwealth University (VCU) to conduct an independent evaluation of the ARTS program. Highlights of the first fifteen months of evaluation outcomes covering April 1, 2017 to June 1, 2018 were provided in the previous quarterly report. The next evaluation for the second year post ARTS implementation is targeted to be completed in September 2019. Preliminary data for Medicaid (non-expansion) versus Medicaid Expansion population who have diagnosis of SUD, OUD or alcohol use disorder (AUD) compared to those in treatment is show in Figure 5 and 6.

Figure 5: Substance Use Disorder Prevalence and Treatment Rates among Non-Expansion Population – April 2018 to March 2019.

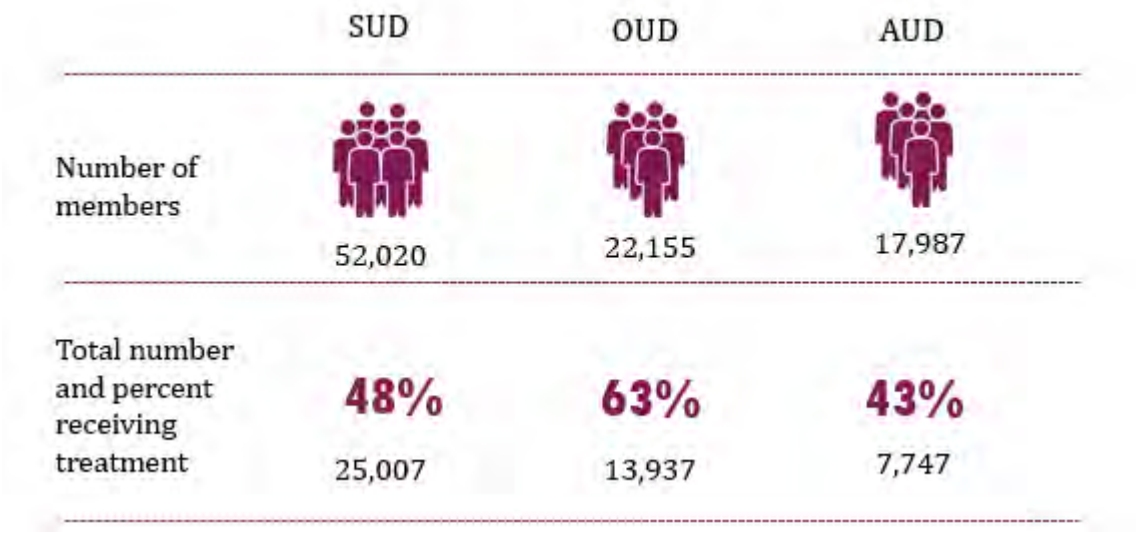
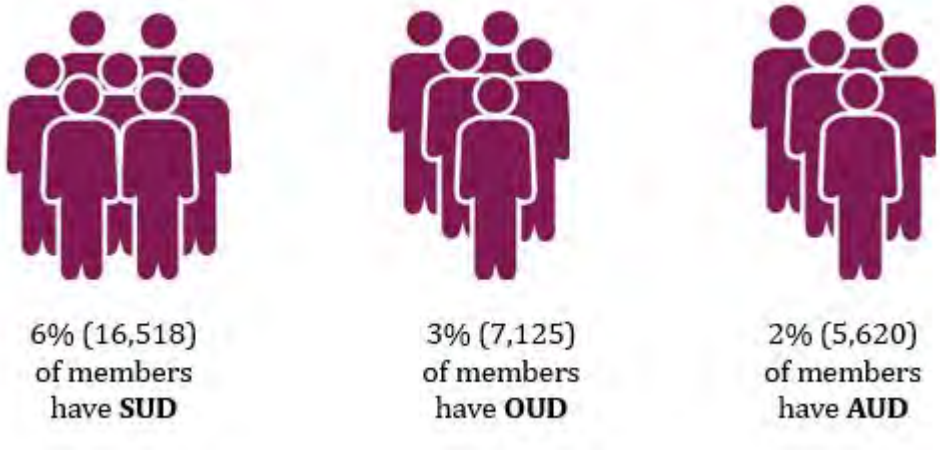


Figure 6: Substance Use Disorder Prevalence and Treatment Rates among Medicaid Expansion Population – January 2019 to March 2019.



OPERATIONAL UPDATES

During Quarter 2 of year three post ARTS implementation, DMAS continued to monitor activity with the MCOs and Magellan of Virginia to determine if there were any significant operational, policy, systems, or fiscal developmental issues. DMAS tracks all emails and calls related to the ARTS benefit to ensure any concerns or issues are addressed.

DMAS has identified low claims activity for care coordination within the Opioid Treatment Program and the Preferred Office Based Opioid Treatment (OBOT) levels of care. To increase provider activity and claims, DMAS is currently developing a training on Substance Use Care Coordination for providers in order to encourage the use of ARTS Care Coordination.

During the second quarter of 2019, DMAS continued to monitor the MCOs and Magellan of Virginia to ensure contractual compliance with operations, system readiness, provider network adequacy

and claims processing. MCOs and Magellan of Virginia continue to show compliance with all areas; although there are some claims issues that present themselves. Each claim issue is handled on a case by case basis and DMAS works closely with the provider and MCO to track and follow up with all claims issues to resolution.

DMAS continues to work to update ARTS regulations, provider manuals and increase access to ARTS services. The current DMAS regulations for ARTS are still under review and once final, DMAS will follow with an update to the ARTS provider manual to reflect changes and clarifications to policies. DMAS' goal is to minimize treatment barriers for members who have a SUD, while ensuring these members with OUD obtain access to high quality Medication Assisted Treatment (MAT) and other proven therapies.

DMAS staff completed two OBOT Quality Reviews in which staff from Program Integrity worked with staff who oversee the ARTS benefit to perform onsite reviews. The purpose of the provider reviews is to gain an understanding of how the Preferred OBOT model is being applied across providers within the community. DMAS provided letters to providers outlining the findings on the review as well as providing an opportunity for providers to receive technical assistance to help further enhance the OBOT model across providers.

PERFORMANCE METRICS

Each MCO and Magellan of Virginia are to use, and expand as necessary, their existing quality improvement infrastructures, quality improvement processes and performance measurement data systems to ensure continuous quality improvement of ARTS. At a minimum, each MCO and Magellan of Virginia must have an Annual Quality Management Plan that includes their plan to monitor the service delivery capacity as evidenced by a description of the current number, types and geographic distribution of SUD services. Monitoring of performance includes determining and analyzing the root causes for performance issues.

DMAS has begun conversations with the external quality review organization (EQRO) contract to focus on ARTS quality metrics to evaluate the outcomes of the program as well as analyze outcomes of individual MCOs.

DMAS has submitted the final version of the new monitoring protocol to CMS and awaits final approval.

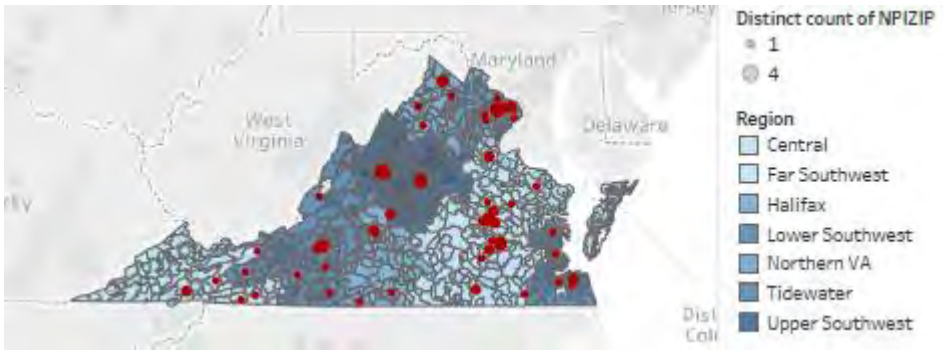
COLLECTION & VERIFICATION OF UTILIZATION & ENROLLMENT DATA

DMAS has collected data submitted from the MCOs and Magellan of Virginia on network and service authorizations for ARTS services. The Special Terms and Conditions (STCs) require the state to report on residential levels of care, at least one sublevel level of care is required to be available to members upon implementation within each MCO and Magellan of Virginia network. The STCs also require access standards and timeliness requirements, including number of days to first ARTS service at appropriate level of care after referral. This is specified in the ARTS Network Development Plans and the ARTS Network Readiness Plans and referenced in the relevant contracts.

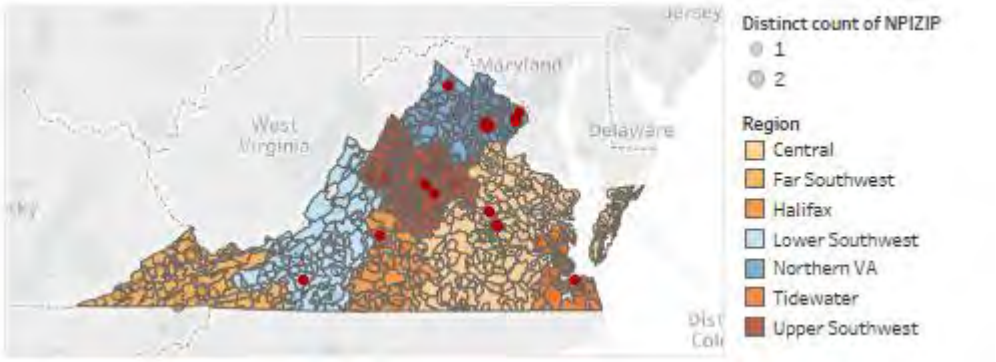
The following maps show network adequacy for this quarter. The orange shaded areas of the map are areas in which provider needs are the greatest. Currently network adequacy is based on a 30 mile radius in urban areas and 60 mile radius in rural areas.

Figures 11: ARTS Network Adequacy Maps[2]

ASAM Level 2.1: Intensive Outpatient

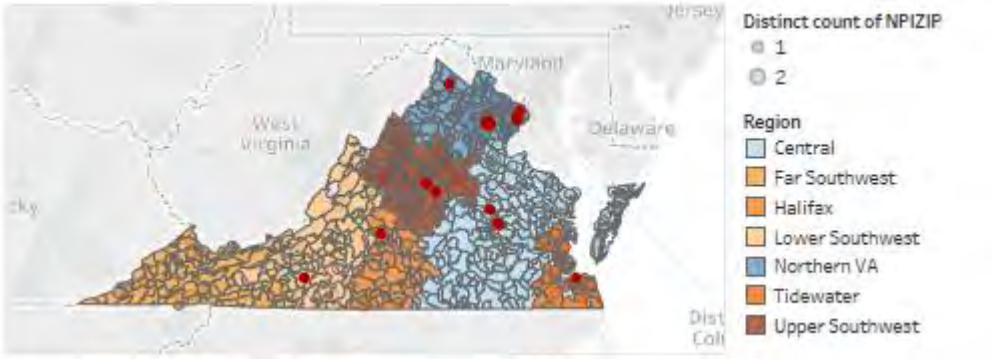


ASAM Level 2.5: Partial Hospitalization

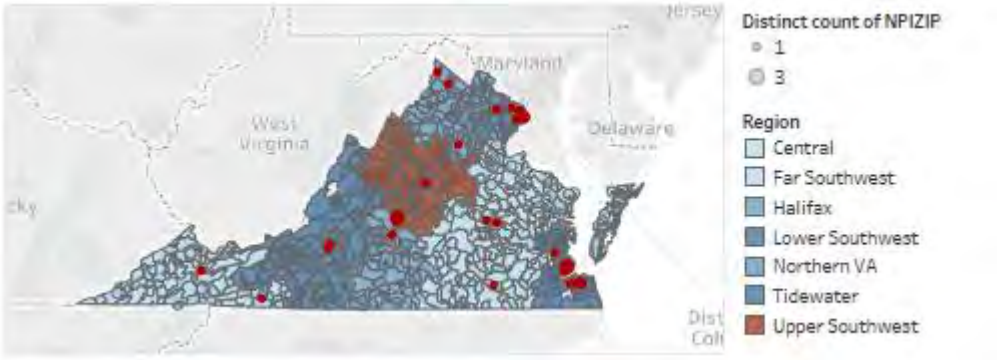


[2] Map based on Longitude (generated) and Latitude (generated) and Latitude (generated) broken down by ASAM Level of Care. For pane Latitude (generated): Color shows details about Color and Region. Details are shown for Member Zip Code. For pane Latitude (generated) (2): Size shows distinct count of providers. The data is filtered on Provider Record Validation Status, File Submission Date and the National Provider Identifier (NPI) of the provider.

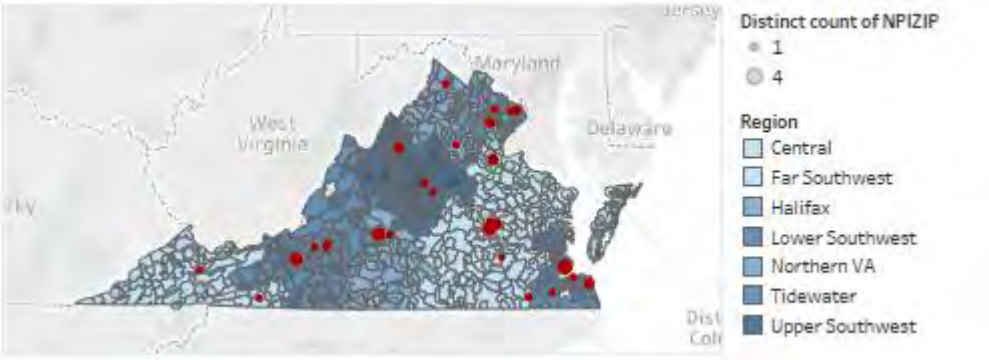
ASAM Level 3.1: Group Home



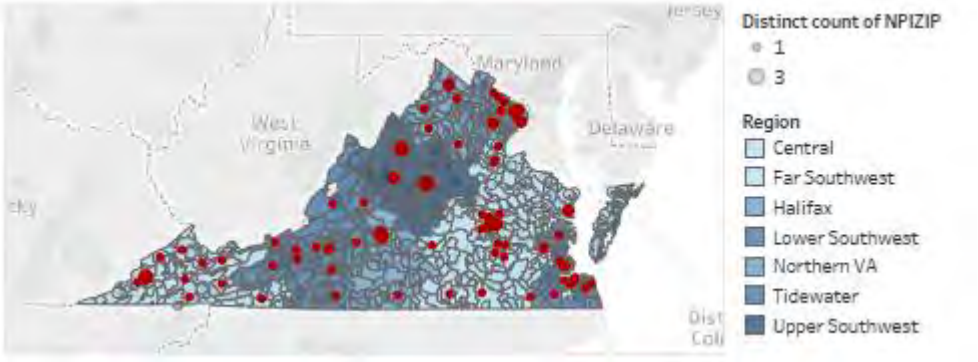
ASAM Level 3.3: Clinically Managed Residential (RTS) / ASAM Level 3.5: Clinically Managed RTS



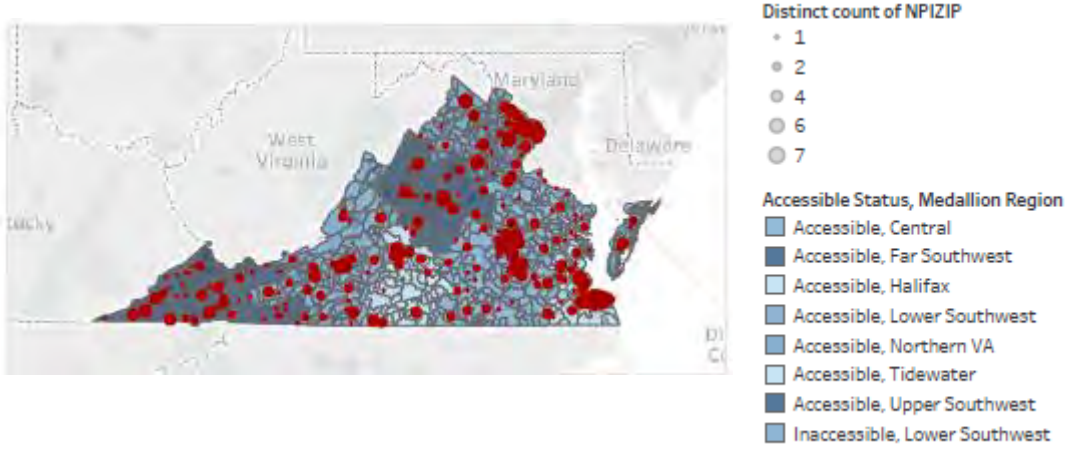
ASAM Level 3.7: Medically Monitored RTS



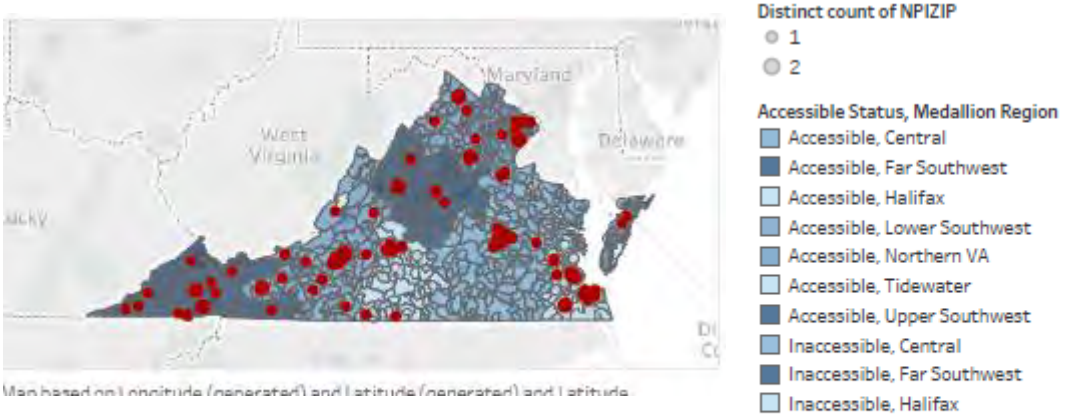
ASAM Level 4: Inpatient Detox



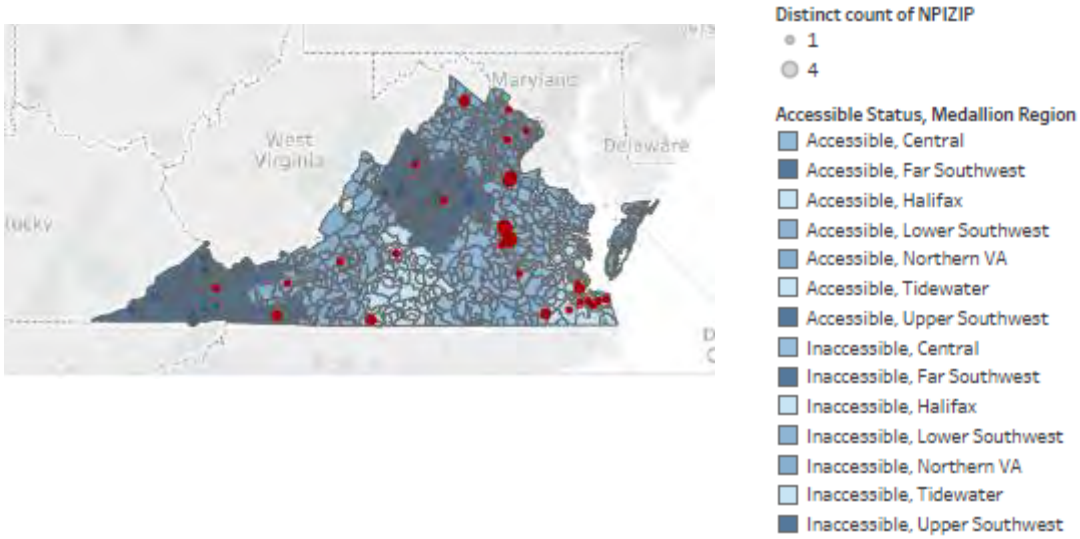
Substance use Case Management



Office Based Opioid Treatment (OBOT)



Opioid Treatment Providers (OTP)



The American Society of Addiction Medicine (ASAM) levels of care and service authorization requirements are as follows:

ASAM Level of Care	ASAM Description	Service Authorization Required?
4.0	Medically Managed Intensive Inpatient	Yes
3.7	Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-Intensity Inpatient Services (Adolescent)	Yes
3.5	Clinically Managed High-Intensity Residential Services (Adults)/Medium Intensity (Adolescent)	Yes
3.3	Clinically Managed Population-Specific High-Intensity Residential Services (Adults)	Yes
3.1	Clinically Managed Low-Intensity Residential Services	Yes
2.5	Partial Hospitalization Services	Yes
2.1	Intensive Outpatient Services	Yes
1.0	Outpatient Services	No
OTS	Opioid Treatment Program (OTP)	No
OTS	Office-Based Opioid Treatment (OBOT)	No
0.5	Early Intervention/Screening Brief Intervention and Referral to Treatment (SBIRT)	No
n/a	Substance Use Case Management	Yes (or Registration)
n/a	Peer Recovery Support Services	Yes (or Registration)

The data below (Figure 12) shows an increase in service authorizations for Intensive Outpatient Services compared to services approved based on medical necessity utilizing ASAM) Criteria.

This Intensive Outpatient Program did not require a service authorization prior to ARTS. Peer Recovery Support Services require registration or service authorization and are shown in Figure 13. The MCOs and Magellan of Virginia are providing outreach and training to providers regarding ASAM Criteria to further improve appropriateness of authorization requests.

Figure 12: Service Authorization for ASAM Level 2.1 to 4.0

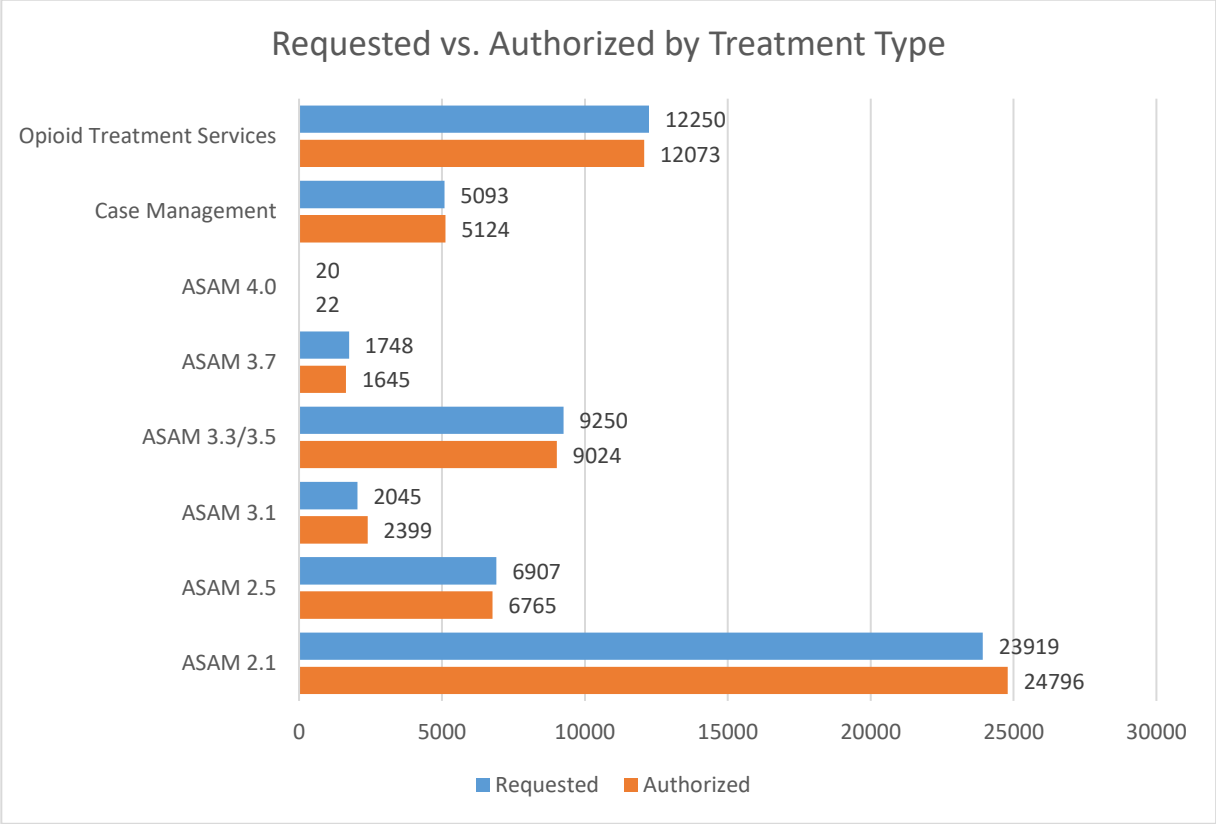
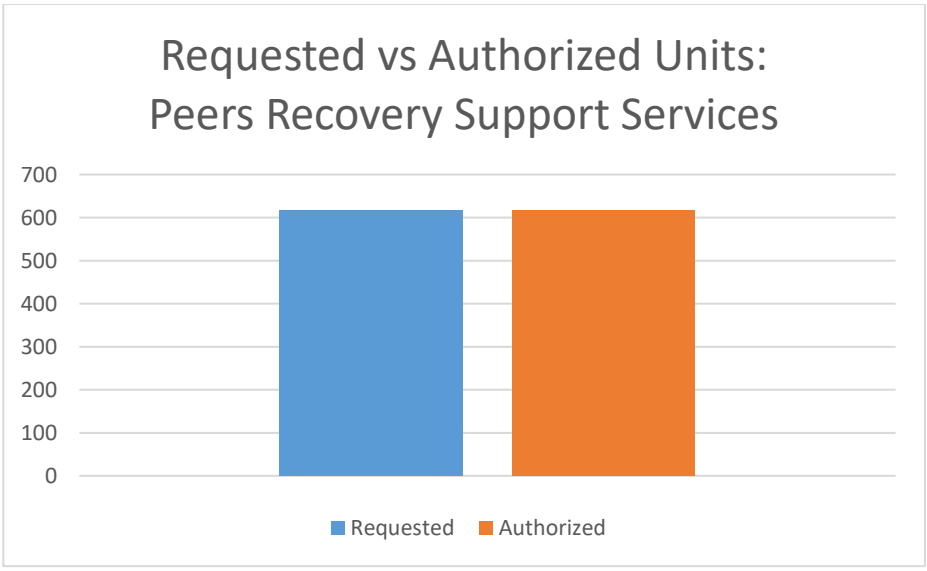


Figure 13: Service Authorizations or Registrations for Peer Recovery Support Services, April – June 2019



BUDGET NEUTRALITY AND FINANCIAL REPORTING

There are no financial/budget neutrality developmental issues to date noted for ARTS.

CONSUMER ISSUES

There were no significant consumer issues reported during the second quarter.

CONTRACTOR REPORTING REQUIREMENTS

DMAS recently updated its reporting requirements for August data to ensure reporting is streamlined and consistent among all the MCOs.

DMAS requires monthly reporting from the MCOs on service authorization, provider network, appeal and grievances and patient utilization management (PUMS) related to ARTS. The MCOs and Magellan of Virginia continue to utilize standardize service authorization form to ensure align with ASAM Criteria. DMAS has developed a new PUMS report that is sent out to the MCOs that report all members who participate in PUMS to ensure smooth transition among MCOs.

The DMAS vendor contracted to perform the ASAM site visits for residential treatment providers performed one new site visit and approval for a level 3.1 provider. DMAS continues to work with providers and MCOs to develop means to recruit more SUD residential in-network providers.

DMAS's physician review panel continues to review the applications for Preferred OBOT Providers to ensure they meet the ASAM Criteria. As of this reporting period, there are a total of 115 Preferred OBOT Providers approved. During this reporting period there were four newly recognized Preferred OBOTs.

The table (Figure 14) below represents the current network by ASAM Level of Care and change in numbers of Medicaid enrolled providers for this reporting period.

Figure 14: ARTS Provider Network Counts

Addiction Provider Type	# of Providers before ARTS	# of Providers after ARTS	% Increase in Providers
Inpatient Detox (ASAM 4.0)	Unknown	103	NEW
Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)	4	87	↑ 2075%
Partial Hospitalization Program (ASAM 2.5)	0	22	NEW
Intensive Outpatient Program (ASAM 2.1)	49	137	↑180%
Opioid Treatment Program	6	38	↑ 533%
Preferred Office-Based Opioid Treatment Provider	0	108	NEW

DMAS continues to work to update the google map on a quarterly basis. The map may be located: https://www.google.com/maps/d/viewer?mid=1px9XvltnM7rXZ6vrTgXgPGIHTew&hl=en&usp=sharing

LESSONS LEARNED AND OUTREACH

DMAS continues to receive positive feedback from members, community leaders, providers, the MCOs and Magellan of Virginia on the transparency, outreach and willingness to engage feedback for a successful implementation, as well as the resolution of any concerns. DMAS has received positive feedback from community leaders and members who have received services.

DMAS is working with the Department of Health Professions to promote the utilization of telemedicine and medication assisted treatment. DMAS has drafted a provider bulletin and is currently in review internally at DMAS prior to posting publicly. DMAS consulted with the regional contact at the Drug Enforcement Agency (DEA) to review the bulletin to confirm it meets the policy requirements of the DEA.

DMAS staff met with Peer Recovery Support Services (PRSS) stakeholders to discuss some potential barriers that may be hindering the use of these services across providers. Stakeholders mentioned the requirements as major barriers: 1) the Peer Wellness and Resiliency Plan (treatment plan) is too cumbersome; 2) requirement of a licensed professional to provide supervision; and 3) reimbursement being too low to support all the requirements by DMAS. DMAS worked to address some of the barriers and provided further clarity to the PRSS Provider Manual Supplement which was finalized and posted during this reporting period. DMAS staff continue to work towards establishing a PRSS workgroup to address other barriers.

DMAS staff continues to attend and present at various conferences to discuss the ARTS benefit and how it can assist members in recovery. This included presentations at the 2019 Rx Drug Abuse and Heroin Summit, the National Association of State Health Policy (NASHP) Federally Qualified Health Center (FQHC) Summit, Medicaid Evidence-based Decisions Project (MED) conference, the 2019 Carilion Women's Health and Perinatal Conference, Opioid Use Disorders in Primary & Specialty Care Conference facilitated by a local FQHC, among other local events.

EVALUATION ACTIVITIES AND INTERIM FINDINGS

DMAS continues to meet regularly with the VCU research team. Currently VCU is working on the 24 month evaluation report for DMAS and is estimated to be finalized in August 2019. DMAS reported on the first 15 months evaluation in the last 1115 Demonstration Waiver annual report. DMAS is working with VCU on the current year agreement and looking at special populations to include re-entry and pregnant woman.

CONCLUSION

DMAS continues to work with providers, MCOs and Magellan of Virginia to identify issues and foster the lines of communication between these parties. DMAS is committed to finalizing the VCU evaluation and have the 24 month evaluation available for the next quarterly report.

DMAS continues to track outcomes for providers assessing members and facilitating access to MAT along the continuum of care. DMAS also is focusing efforts to further decrease overdose deaths across the state through encouraging MAT during and after release from institutional settings, including hospitals, emergency departments, jails, and inpatient rehabilitation.

STATE CONTACT(S)

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Former Foster Care Youth

INTRODUCTION

Individuals in foster care face a number of challenges upon the termination of their state custodianship, including access to health care. The "Former Foster Care Child Under Age 26 Years" Medicaid covered group provides an opportunity for this population to continue receiving Medicaid coverage until age 26, allowing these individuals time to transition into managing the responsibilities of living independently.

BACKGROUND

On March 23, 2010, the Affordable Care Act (ACA) was signed into law, making a number of changes to Medicaid eligibility effective January 1, 2014. To further the overall goal of expanding health coverage, the ACA included section 2004, which added a new mandatory Medicaid covered group at section 1902(a)(10)(A)(i)(IX) of the Act to provide an opportunity for former foster care youth to obtain Medicaid coverage until age 26 from the state responsible for the individual's foster care. DMAS initially received approval from CMS to cover former foster care youth who received their foster care and Medicaid in Virginia, as well as former foster care youth who received their foster care and Medicaid from another state but who are now living in Virginia.

In November 2016, CMS notified states that they could no longer cover the former foster care youth who received their services from another state but are now living in Virginia under the State Plan. States who wished to continue covering this population could do so under a Section 1115 Demonstration waiver.

In May 2017, DMAS submitted an amendment to the GAP Demonstration Waiver to request approval to provide Medicaid coverage to former foster care youth who were enrolled in Medicaid and foster care in another state and who are now living in Virginia and are applying for Virginia Medicaid. Approval of the waiver amendment was received on September 22, 2017.

GOALS

Virginia's overall goal for the FFCY benefit is to provide former foster care youth with the access to health services they need, through the GAP Demonstration Waiver.

The goals of the FFCY demonstration are: (1) to increase and strengthen coverage of former foster care youth who were in Medicaid and foster care in a different state and (2) to improve or maintain health outcomes for these youth.

ELIGIBILITY AND BENEFIT INFORMATION

Individuals eligible in this demonstration group are those former foster care youth who: (1) were in the custody of another state or American Indian tribe, (2) were receiving foster care and Medicaid services until discharge from foster care upon turning age 18 or older, (3) are not eligible in a mandatory Medicaid coverage group, and (4) are under the age of 26. All individuals in the Former

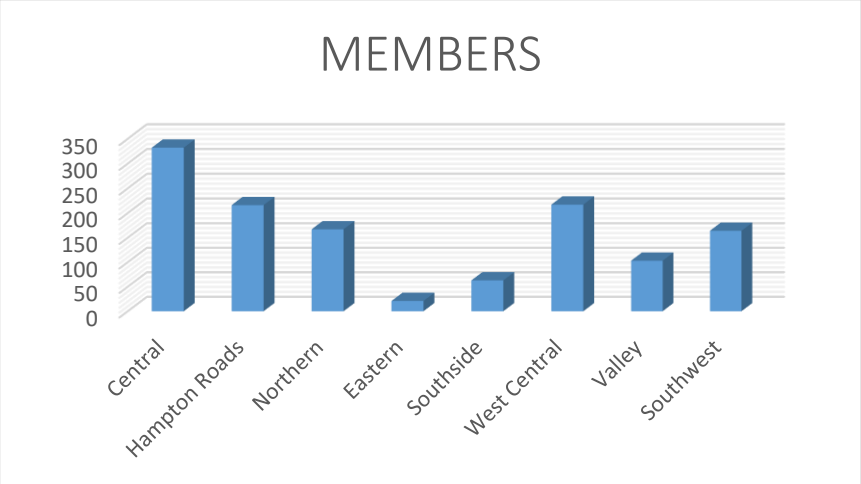
Foster Care Child Under Age 26 covered group receive the full Medicaid benefit package, including long-term supports and services, if medically necessary.

ENROLLMENT COUNTS FOR YEAR TO DATE

ELIGIBILITY GROUP	CALENDAR YEAR 2019 QUARTER 2			TOTAL QUARTER MEMBER MONTHS	TOTAL QUARTER UNIQUE MEMBERS
	April 2019	May 2019	June 2019		
Former Foster Care					
Eligible Member Months	1,260	1,286	1,283	3,829	1,354

AS OF DATE	6/30/2019
MEMBER AGE	MEMBER COUNT
18	38
19	189
20	248
21	232
22	194
23	152
24	121
25	109

REGION	MEMBERS
Central	332
Hampton Roads	216
Northern	167
Eastern	21
Southside	63
West Central	217
Valley	103
Southwest	164



OPERATIONAL UPDATES

The waiver amendment to add the former foster care youth from out of state was approved in September 2017. Since approval, there have been no policy or administrative difficulties in operation for this piece of the demonstration waiver. There have been no challenges or issues.

PERFORMANCE METRICS

By implementing the demonstration, Virginia anticipated increasing healthcare coverage for former foster care youth, while improving health outcomes. The design for evaluating the first demonstration year was approved by CMS and covered the September 2017 to December 2019 time period, representing the start and end dates of the demonstration year. The evaluation addressed three questions:

1. Does/did the demonstration provide Medicaid coverage to former foster care individuals?
2. How do/did former foster care individuals in the demonstration use Medicaid-covered healthcare services?
3. What do/did health outcomes look like for individuals in the demonstration?

DMAS has requested guidance on the continuation of the evaluation design from CMS. No changes to the evaluation design are planned pending the receipt of guidance from CMS. The approved evaluation design from 2018 is contained in Appendix A.

COLLECTION & VERIFICATION OF UTILIZATION & ENROLLMENT DATA

The first evaluation evaluated administrative data (enrollment, claims, and encounters) available in the MMIS at the end of the first (fall 2018) demonstration year. The evaluation was conducted using existing administrative data, and no prospective data (e.g., beneficiary surveys, interviews, focus groups, or other quantitative or qualitative data) was collected due to resource limitations. The evaluation did not include pretest (or baseline) data because DMAS only has access to data on individuals in the demonstration after they receive Medicaid coverage. The next evaluation will be completed at the end of the second demonstration year (winter 2020). DMAS has requested guidance on the continuation of the evaluation design from CMS. No changes to the evaluation design are planned pending the receipt of guidance from CMS.

BUDGET NEUTRALITY AND FINANCIAL REPORTING

DEMONSTRATION WITH WAIVER (WW) BUDGET REPORT: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	Budget Neutrality DY 3 Full year estimate	1/4 of Full Year Estimate		DEMONSTRATION YEAR 5 (CALENDAR YEAR 2019) QUARTER 2 April 2019	May 2019	June 2019	TOTAL QUARTER
Pop Type:	Expansion			Former Foster Care Transfers from Out of State			
Eligible Member Months	830	208		77	74	72	223
PMPM Cost	$ 508.28	$ 508.28		$ 565.10	$ 762.07	$ 757.06	$ 692.44
Total Expenditure	$ 421,869	$ 105,467		$ 43,513	$ 56,393	$ 54,508	$ 154,414

CONSUMER ISSUES

Benefits are provided through the state's fee-for-service and managed-care delivery systems. No complaints or issues have been identified to date. There were no appeals filed related to this population during this reporting period.

CONTRACTOR REPORTING REQUIREMENTS

No contracts needed to be amended when the FFCY component was added to this waiver. These individuals were previously covered under the Medicaid State Plan; therefore, no changes needed to be made when the waiver was approved.

RECOVERY NAVIGATORS

The FFCY demonstration does not utilize Recovery Navigators.

LESSONS LEARNED

There is nothing to report at this time.

EVALUATION ACTIVITIES

The evaluation of the first demonstration year covered the September 2017 to December 2019 time period. The design for evaluating the demonstration was approved by CMS, and interim evaluation findings were submitted to CMS in March 2019 in a separate document. DMAS has requested guidance on the continuation of the evaluation design from CMS. No changes to the evaluation design are planned pending the receipt of guidance from CMS.

CONCLUSION

The demonstration was implemented as a measure to continue Medicaid coverage for former foster care youth who received their services in another state but who are now living in Virginia. This group was formerly covered in Virginia under the State Plan; the change in the authority mechanism did not necessitate any changes to the application process for these individuals or how they receive Medicaid coverage.

ENCLOSURES

- Appendix A- FFCY Draft Evaluation Design

STATE CONTACT(S)

If there are any questions about the Former Foster Care contents of this report, please contact:

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Attachment 7

Virginia 1115 Demonstration
Addiction and Recovery Treatment Services Access, Utilization, and Quality of Care 2016 – 2019

VCU School of Medicine
Health Behavior and Policy

Addiction and Recovery Treatment Services

Access, Utilization, and Quality of Care 2016 - 2019

July, 2021

Author Statement: This report was produced by the ARTS evaluation team in the Department of Health Behavior and Policy, VCU School of Medicine. Primary contributors to this report were Peter Cunningham, Ph.D., Megan Mueller, Erin Britton, MPH, Huyen Pham, MPH, Lauren Guerra, Heather Saunders, MSW, Xue Zhao, MSc, Andrew Barnes, Ph.D., and Vimbainashe Dihwa, MBA.

Acknowledgements: We would like to thank the Department of Medical Assistance Services for providing technical expertise on the Medicaid claims data and the ARTS program. We would also like to thank Caitlin E. Martin, MD, MPH, Department of Obstetrics & Gynecology at VCU School of Medicine for her expertise and assistance with the analysis of opioid use disorder treatment for women before and after childbirth.

Disclaimer: The conclusions in this report are those of the authors, and no official endorsement by the Virginia Commonwealth University School of Medicine or Virginia Department of Medical Assistance Services is intended or should be inferred.

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Executive Summary

To increase access to and quality of treatment and recovery services for Medicaid members with substance use disorders (SUD), Virginia implemented the Addiction and Recovery Treatment Services (ARTS) benefit in April 2017. On January 1, 2019, Virginia expanded Medicaid eligibility for adults with family incomes up to 138% of the federal poverty level, thereby increasing access to ARTS and other Medicaid benefits to more low-income Virginians.

The Department of Medical Assistance Services (DMAS) contracted with Virginia Commonwealth University School of Medicine to conduct an independent evaluation of the ARTS benefit. Prior evaluation reports showed large gains in access to and utilization of addiction treatment services among Medicaid members in the year following implementation of ARTS, as well as decreases in emergency department visits and acute inpatient stays related to SUD.

The objective of this report is to examine SUD treatment services utilization, access and quality of care among Medicaid members through calendar year 2019, the first year of Medicaid expansion. The report examines changes in prevalence, treatment, and utilization of ARTS between 2016 and 2019, which includes more than two years following implementation of the ARTS benefit in April 2017. The report also includes estimates of the quality of care for opioid use disorders (OUD) based on an analysis of episodes of outpatient treatment services for OUD; the patient experience with care based on a survey of Medicaid members who used ARTS for OUD treatment; comparisons with other states in OUD treatment; and an analysis of disparities in OUD treatment by race and other social factors.

The major findings of the report include the following:

As expected with increased enrollment, ARTS utilization increased dramatically in 2019, the first year of Medicaid expansion.

- In total, 96,000 Medicaid members had a SUD diagnosis in 2019, including about 42,000 members enrolled through Medicaid expansion. This represents a 62% increase in the number of Medicaid members with a SUD diagnosis from 2018, and double the number in 2016 (the year before ARTS implementation). This trend is consistent with experiences in other expansion states.

- There were 46,500 members who used ARTS in 2019, a 79% increase from 2018. Services that experienced especially large increases included Preferred Office-Based Opioid Treatment (OBOT), Outpatient Treatment Providers (OTPs), care coordination services at OBOT and OTP providers, and SUD residential treatment centers.

- More than 23,000 members received Medications for Opioid Use Disorder (MOUD) treatment in 2019, more than double the number receiving MOUD treatment in 2018. However, rates of MOUD did not increase substantially. Instead, members newly enrolled through Medicaid expansion account for most of the increase.

- Almost 3,500 members with SUD had a stay at a residential treatment center in 2019, 3.3 times the number of members with residential stays in 2018. The percent of members with SUD who had a stay at a residential treatment center in 2019 (3.6%) more than doubled from 2018 (1.8%).

Supply of addiction treatment providers continues to increase.

- In 2019, 1,133 practitioners in Virginia had federal authorization to prescribe buprenorphine, including 278 nurse practitioners and physician assistants. While the number of waivered prescribers has more than doubled since 2016, the overall number of prescribers in Virginia is low relative to neighboring states. In addition, only 40% of prescribers treated any Medicaid patients in 2019. Nurse practitioners were more likely than physicians to treat Medicaid members.[i]

- Almost 4,900 outpatient practitioners of all types billed for ARTS in 2019, a 31% increase from 2018, and quadruple the number of practitioners billing for addiction treatment services in 2016. The number of Preferred OBOT providers increased from 38 sites at the beginning of the ARTS benefit to 153 sites by September 2020.

Treatment rates for SUD and OUD continue to increase for base Medicaid eligibles.

- Among base Medicaid members (members not enrolled in Medicaid expansion), 47.4% of members with SUD received some type of treatment in 2019, compared to 44.4% in 2018 and 19.9% in 2016 (the year before ARTS).

- Among base Medicaid members with OUD, 65.9% received some type of treatment in 2019, compared to 61.1% in 2018 and 32.1% in 2016. This finding is critical because it suggests that even as a significant number of members joined the program, provider capcity was sufficient to maintain access for members during the period of growth.

- While utilization of all forms of MOUD treatment continued to increase in 2019, the use of methadone treatment increased the most, from 2.4% of members with OUD in 2016 to 18.5% in 2019. Increases in methadone treatment rates are the primary driver of increases in MOUD treatment rates between 2016 and 2019.

MOUD treatment increased among members in the 12 months after childbirth.

- Medicaid expansion allows more members to retain Medicaid health coverage following childbirth. The median number of months of Medicaid coverage in the 12 months following childbirth increased from 4 months in 2017 to 12 months in 2019.

- Following expansion, for pregnant members with diagnosed OUD, MOUD treatment rates increased in both the 12 months before birth and the 12 months following birth of the child. The length of time on MOUD treatment after childbirth increased between 2016 and 2019.

[i] Saunders H, Britton E, Cunningham P, Saxe-Walker L, Harrell A, Scialli A, Lowe J. Medicaid participation among Buprenorphine waivered prescribers. *Journal of Substance Use Treatment.* June, 2021. . https://doi.org/10.1016/j.jsat.2021.108513

OUD treatment for Medicaid members increased to a greater extent in Virginia after ARTS implementation (and before Medicaid expansion) than for Medicaid members in 10 other states.

- MOUD treatment rates among Medicaid members in Virginia were considerably lower in 2016 (33.6%) compared to other states participating in the Medicaid Outcomes Distributed Research Network (48.7%), a network of states conducting Medicaid SUD-related research. By 2018, MOUD treatment rates among Medicaid members in Virginia (55.0%) were comparable to other states (57.3%) in the research network, indicating a much greater relative increase in treatment rates in Virginia following implementation of ARTS in 2017. At the time of this report, post-expansion analysis was not yet available in all states.

- The use of counseling services by Virginia Medicaid members with OUD increased by 73% between 2016 and 2018, a dramatic increase compared to an 8% increase for Medicaid members in other states.

Emergency department visits for SUD and OUD increased in 2019, following a decrease seen immediately after implementation of ARTS in 2017.

- OUD-related emergency department (ED) visits decreased by 26% between 2016 and 2018, while all SUD-related ED visits decreased by 4%. By contrast, all other ED visits increased by 5% between 2016 and 2018.

- ED visits for SUD and OUD increased sharply in 2019, even for base Medicaid eligibles. Part of the increase reflects an overall increase in ED visits among Medicaid members, but it may also be related to an overall increase in drug overdoses and OUD-related ED visits in Virginia and nationally between 2018 and 2019.

More members are getting treatment following an ED visit or stay at a SUD residential treatment center.

- Most members with OUD are receiving some type of follow-up treatment within 30 days of discharge from SUD residential treatment centers (87%). MOUD treatment rates within 30 days of discharge increased from 40.1% in 2017 to 64.1% in 2019.

- Members receiving treatment within 30 days of an OUD-related ED visit increased from 38.2% in 2017 to 53.5% in 2019, mostly due to increases in MOUD and outpatient visits.

Members receiving care at Preferred OBOTs and OTPs were more likely to received MOUD.

- Out of about 8,000 episodes of outpatient treatment for OUD initiated between January 1, 2018, and June 30, 2019, more than half involved Preferred OBOT and OTP providers, while 47% of OUD treatment episodes occurred entirely at other outpatient providers.

- Rates of MOUD use were higher during episodes of treatment at Preferred OBOT and OTP providers (81% and 89%, respectively), compared to other outpatient providers (56%).

- While the American Society of Addiction Medicine (ASAM) recommends that MOUD treatment last at least six months, the median length of MOUD treatment during outpatient episodes was only four months, which was relatively consistent across different provider types.

- The use of urine drug screens, counseling services, and care coordination services were higher at Preferred OBOT and OTP providers compared to other outpatient providers.

Co-prescribing of opioid pain medication and benzodiazepines declined for members receiving treatment for OUD, but opioid prescribing is still high for those receiving methadone treatment.

- Between 2016 and 2018, the rate of co-prescribing for opioid pain medications and benzodiazepines declined for Medicaid members receiving MOUD treatment.

- For members receiving treatment at OTPs, 20.8% received a prescription for opioid pain medications during their episode of treatment, compared to 7.6% of those receiving treatment at Preferred OBOT and 13.1% at other outpatient providers. OTPs are not required to report methadone dispensing to the prescription drug monitoring program due to federal confidentiality regulation (42 CFR Part II).

- About 13% of members received a prescription for benzodiazepines during an episode of outpatient treatment for OUD, which was slightly lower at Preferred OBOT and OTP providers.

Most Medicaid members using ARTS for OUD report favorable experiences with their treatment.

- A survey of Medicaid members who used ARTS for OUD treatment showed that most had favorable experiences with their treatment, including communication with and trust in treatment providers, as well as their level of involvement with their treatment.

- Less favorable experiences with treatment were reported by those who were polysubstance users, had serious psychological distress, or reported fair or poor health. These members were also more likely to report inability to access care as quickly as desired.

- About 17% of survey respondents reported that they had stopped treatment in the past year against the advice of their doctor or counselor. Respondents who reported more favorable experiences with treatment providers were less likely to discontinue their treatment.

- Most survey respondents reported positive changes in their lives as a result of receiving treatment services, including greater confidence in not being dependent on drugs or alcohol, getting along better with family members, and improvements in their housing and employment situation.

Racial disparities in treatment rates persist

- Overall treatment rates for SUD are higher for Medicaid members who are White (56%) compared to Black (40%). While both Black and White members are about equally likely to initiate treatment following a diagnosis of OUD (about 44%), White members are more likely to have two or more additional treatment services compared with Black members.

- Similarly, Black members tend to have shorter episodes of outpatient treatment for OUD (median of 86 days) compared to White members (median of 99 days). Compared to White members, Black members with OUD are only slightly less likely to receive any MOUD treatment, but are more likely to use methadone treatment (versus buprenorphine) when they do receive MOUD.

- Based on the survey of members who used ARTS services, Black members have somewhat less favorable experiences with treatment providers compared to White members. However, less favorable patient experiences are more strongly associated among both Black and White members who have housing or food insecurity, are unemployed, and have less social support.

In sum, the combination of enhanced benefits through ARTS and expanded eligibility through Medicaid expansion resulted in a dramatic increase in the utilization of addiction treatment services by Virginia Medicaid members between 2016 and 2019. While diagnosed prevalence of SUD and OUD also increased, treatment rates among those with a diagnosis of SUD and OUD steadily increased between 2016 and 2019. Increases in MOUD treatment rates in Virginia outpaced those of other states, providing further evidence of the impact of ARTS on access to MOUD treatment services. The quality of MOUD treatment services continues to improve along with the utilization of Preferred OBOT and OTP providers for outpatient treatment, and most members receiving ARTS services report positive experiences with treatment.

Despite substantial evidence of improved access to and quality of addiction treatment services through the ARTS benefit, some gaps remain. Virginia has fewer buprenorphine waivered prescribers relative to the population compared with other states, such as West Virginia and Maryland. Co-prescribing of opioid pain medications – despite decreases – continues to be high for members receiving treatment at OTPs exempt from prescription drug monitoring programs (42 CFR Part 2). After a decrease following implementation of ARTS, ED visits related to SUD and OUD increased sharply in 2019, which is consistent with the statewide and national trend in drug overdoses in 2019. Finally, disparities between Black and White Medicaid members persist in SUD treatment rates, quality of care, and patient experiences with treatment. Lower rates of initiation and engagement with treatment following OUD diagnosis, as well as shorter episodes of treatment among Blacks compared to Whites, are of particular concern.

Introduction

Substance use disorders (SUD) – including dependence on or misuse of alcohol and other legal and illegal drugs – continue to be a major public health concern in the Commonwealth of Virginia and the U.S. overall. The number of fatal drug overdoses more than doubled in Virginia between 2007 and 2017, from 721 fatalities in 2007 to 1,526 in 2017.[1] After decreasing by 3% in 2018, fatal overdoses increased to 1,626 in 2019, a 9.4% increase between 2018 and 2019.[2] More than 80% of fatal drug overdoses in 2019 were due to prescription or illicit opioids, with heroin and fentanyl driving the increase in fatalities in recent years. While national and state efforts often focus on opioid use disorders (OUD), fatal overdoses due to cocaine and methamphetamines have also risen sharply in Virginia in recent years.

Many health officials are concerned that the COVID-19 pandemic will increase fatal drug overdoses and SUD in general due to the economic recession and high unemployment, psychological stresses arising from greater social isolation, and more restricted access to treatment providers. In Virginia, 5,134 emergency department visits were related to drug overdoses (fatal and nonfatal) between July and September, 2020, a 42% increase from the same three months in 2019.[3]

Aside from overdose fatalities, substance use disorders exact a much broader human and societal cost, affecting the economic and social well-being of families and entire communities, as well as individuals' ability to lead productive and fulfilling lives.[4] The National Institute of Drug Abuse estimated the annual national costs associated with misuse of alcohol, illicit drugs, and prescription drugs to be $520 billion, reflecting lost wages, foregone economic opportunities, and private and public sector spending to prevent and control substance use.[5] Social costs associated with SUD include family breakup and other declines in family and personal well-being, increased involvement with the criminal justice system, and placement of children in social services and foster care when their parents are experiencing severe disorders.[6]

Both nationally and in Virginia, Medicaid is more likely to cover members with SUD compared to private insurance. In Virginia, Medicaid members are more than twice as likely to report dependence or misuse of alcohol or illicit drugs (13%) compared to people with private insurance (6%).[7] Also, Virginia Medicaid members are 2.75 times more likely to report dependence or misuse of opioids compared to Virginians with private insurance. Importantly, Medicaid members with SUD are also more likely to receive addiction treatment for their diagnosis compared to people insured by private insurers.[8]

To increase access to SUD treatment services for its members, the Virginia Medicaid agency implemented the Addiction and Recovery Treatment Services (ARTS) benefit in April 2017. ARTS expanded coverage of many addiction treatment services for Medicaid members, including community-based services, short-term residential treatment and inpatient detoxification services. The Centers for Medicare and Medicaid Services (CMS) approved a Section 1115 Demonstration Waiver for SUD in December 2016 to allow federal Medicaid payment for addiction treatment services provided in inpatient and short-term residential facilities. ARTS also increased provider reimbursement rates for many existing services and introduced a new care delivery model, the Preferred Office-Based Opioid Treatment (OBOT) provider, which integrated medications for OUD with behavioral and physical health by incentivizing increased use of care coordination activities. The six Medicaid managed care organizations, which oversee medical and behavioral health benefits for all Medicaid members, administer SUD treatment services, offering a comprehensive care delivery system that further increases integration of addiction treatment services with other health services covered by Medicaid.

On January 1, 2019, Virginia expanded Medicaid eligibility for adults ages 19-64 with household incomes up to 138% of the federal poverty level. As of July, 2021, about 560,000 low-income Virginians were newly enrolled through Medicaid expansion.[9] Medicaid expansion increases access to ARTS for many low-income adults who had SUD prior to enrolling in Medicaid. Prior to Medicaid expansion, prevalence of SUD among the uninsured in Virginia (18%) was higher than for Medicaid members (13%).[10] Among Virginians who reported dependence or misuse of opioids prior to Medicaid expansion, more than half were uninsured.

Objectives of the report

The Department of Medical Assistance Services contracted with Virginia Commonwealth University School of Medicine to conduct an independent evaluation of the ARTS benefit. The evaluation is conducted by faculty and staff from the Department of Health Behavior and Policy.

This report examines SUD treatment prevalence, access, utilization, and quality of treatment between 2016 and 2019, which includes two full years following implementation of the ARTS benefit and the first full year of Medicaid expansion. This report updates and expands on prior reports that examined changes in access to and utilization of ARTS services in the year following the program's implementation.[11]

Prior reports showed substantial gains in the number of addiction treatment providers serving the Medicaid population, as well as large increases in the percentage of members with SUD receiving various types of treatment, including medications for opioid use disorder (MOUD). Moreover, there were significant decreases in hospital emergency department and acute inpatient use for members with SUD after ARTS relative to other Medicaid members, suggesting improved access to care.[12] In addition to increased access to treatment services through ARTS, substantial declines in opioid prescribing in Medicaid may have also contributed to improved outcomes among Medicaid members.[13]

This report shows that utilization of ARTS treatment services expanded rapidly in 2019 relative to 2018. While much of this change reflects increased enrollment through Medicaid as a result of Medicaid expansion, the findings show continued increases in utilization and treatment rates among base Medicaid eligibles – that is, members eligible for Medicaid based on criteria prior to 2019.

The report provides additional details on the quality of outpatient addiction treatment services that Medicaid members receive, including services received at Preferred OBOT programs. The report also assesses quality of care from the perspective of members who received ARTS services, based on a survey of Medicaid members who used ARTS services. The report assesses differences in OUD prevalence and MOUD treatment between Medicaid members in Virginia and Medicaid members in other states based on analysis from the Medicaid Outcomes Distributed Research Network (MODRN).[14] Virginia is a member of the network. Finally, we assess potential sources of disparities in treatment for SUD and OUD by race/ethnicity and geographic area, as well as social factors related to housing and food insecurity, unemployment, social isolation, and involvement with the criminal justice system, that may fuel such disparities.

Methodology

The findings in this report are based on a number of data sources, including Medicaid administrative claims, information on the supply of substance use treatment providers, and a survey of Medicaid members who used ARTS. For most estimates of diagnosed prevalence, treatment, and utilization of services based on Medicaid claims, we compare estimates of paid claims in 2016 (the year prior to ARTS

implementation) to 2017 (the year of ARTS implementation), 2018, and 2019. These estimates exclude claims for services during the study period that had not yet been submitted or paid at the time of the analysis, as well as unpaid claims and services not covered by Medicaid. Note that since ARTS was implemented in April, 2017, estimates of utilization for 2017 reflect the full range of ARTS benefits for only part of the year (from April to December). From January to March, 2017, utilization is based on Medicaid covered services prior to ARTS, similar to 2016.

As mentioned previously, a major policy change during the second full year of the ARTS benefit was expanded eligibility for Medicaid coverage, beginning January 2019. This policy resulted in more than 400,000 additional Medicaid members during 2019 compared to prior years, a change that also affects estimates of diagnosed prevalence and treatment for SUD. In addition, members with SUD enrolled through Medicaid expansion may differ from other members with SUD in ways that affect their utilization of services, such as differences in age, gender, race/ethnicity and health status.

The report includes members newly enrolled in Medicaid expansion in estimates of the number of members with diagnosed SUD and assessments of who used various treatment services during 2019. However, to ensure comparability with the years prior to Medicaid expansion, analyses that show *changes in rates of utilization and treatment* between the second year of ARTS and earlier years include only the base Medicaid population, that is, members enrolled in Medicaid through traditional eligibility criteria. For these analyses, we also include members enrolled through the Governor's Access Plan (GAP), even though most of these members were transitioned to full Medicaid coverage by March 2019. Prior to Medicaid expansion, GAP provided coverage for ARTS and other behavioral health services to people who did not qualify for full Medicaid benefits. Members with limited benefits, such as those receiving only emergency services or family planning, are excluded since they are not eligible for the ARTS benefit.

ARTS Member Survey

As part of the evaluation of the ARTS benefit, a survey of Medicaid members who were either diagnosed with an OUD or who had received ARTS was conducted. The purpose of the ARTS member survey was to obtain the patient perspective on the quality of treatment services they are receiving, the impact of treatment on their personal lives, and circumstances regarding their housing and food security, employment, living situation, social support, recent involvement with incarceration, types of substances used in the past year, and mental health comorbidities.

Survey respondents were randomly selected from Medicaid enrollment files based on their utilization of ARTS in the six months prior to the sample draw (identified through Medicaid claims data). To compare member experiences with different treatment providers, the sample was stratified based on utilization of Preferred OBOT providers, utilization of Outpatient Treatment Providers (OTP), and utilization of other outpatient treatment providers. Part of the sample also included members who had been diagnosed with OUD in the past year, but had no Medicaid claims indicating utilization of ARTS treatment services.

Survey questions were adapted from a number of sources, including the CAHPS Experience of Care & Health Outcomes (ECHO) Survey, a version of the CAHPS developed for assessing patient experience with behavioral health care,[15] and the National Survey of Drug Use and Health, conducted by the Substance Abuse and Mental Health Services Administration.[16] In addition, we obtained questions that ask patients to assess the impact of treatment on their lives from a survey of patients receiving services at Centers for Excellence treatment centers in Pennsylvania.[17] The survey was conducted by mail.

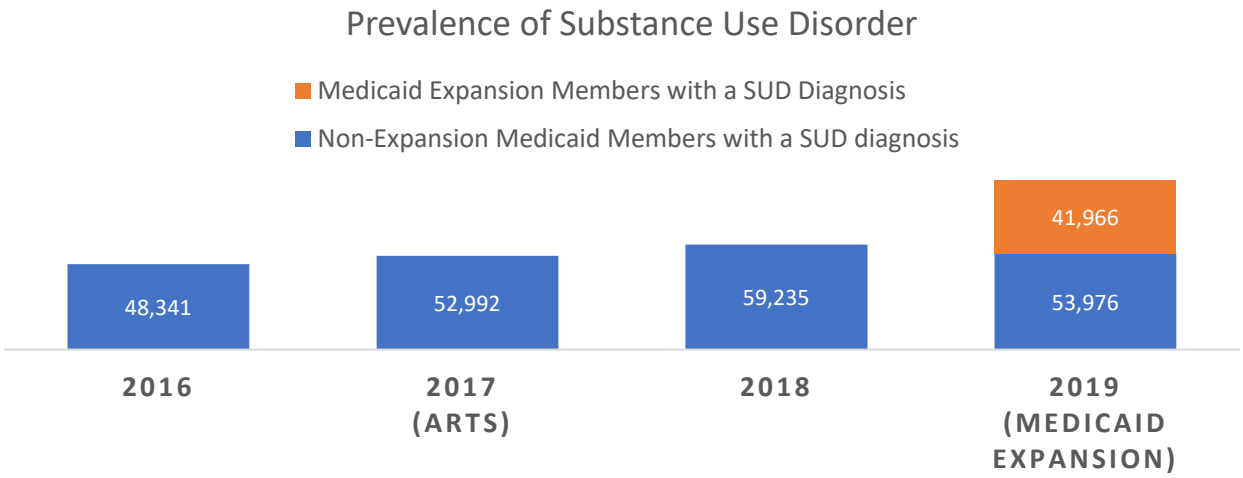
The results in this report represent approximately the first 1,100 completed surveys, conducted primarily from January through May, 2020. During this period, the response rate was about 20 percent. After a temporary pause due to COVID-19 pandemic restrictions, fielding of additional waves of the survey continued through June 2021, but was not available at the time of this report. A final sample of about 1,800 completed surveys is expected.

Medicaid Outcomes Distributed Research Network (MODRN).

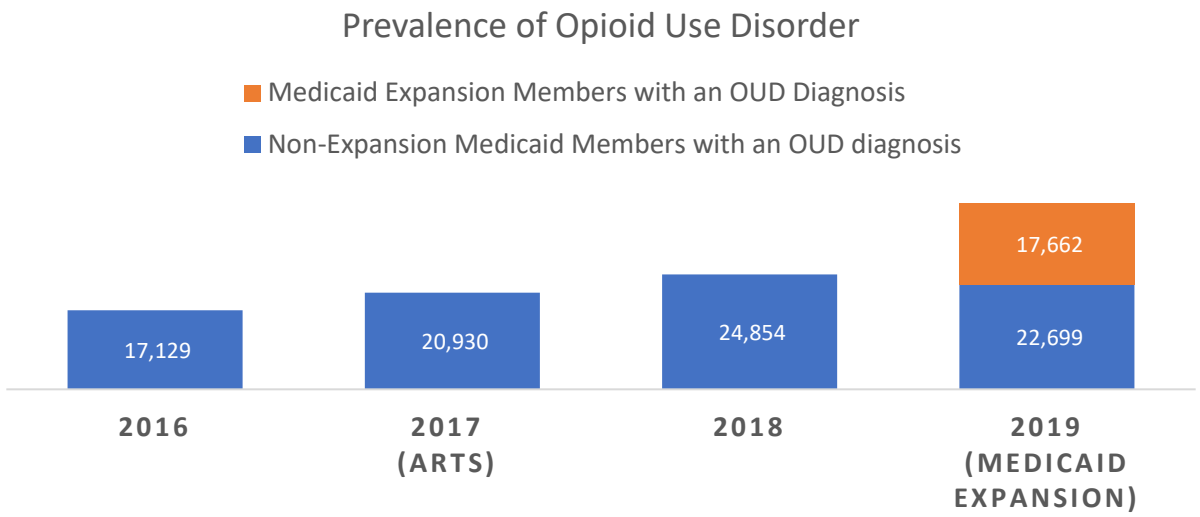
Comparisons between Virginia Medicaid members and Medicaid members in other states are based on analysis from the MODRN, a collaborative effort consisting of state-university partnerships across 13 states to facilitate learning among Medicaid agencies, and to profile the opioid epidemic among the Medicaid population.[18] MODRN employs a common data model to standardize estimates of OUD prevalence, treatment, and quality of care derived from state Medicaid claims and enrollment data. Measures of OUD treatment and quality are consistent with the American Society of Addiction Medicine (ASAM) guidelines, and include measures developed by the National Quality Forum and used by the Centers for Medicare and Medicaid Services for the purposes of evaluating state Medicaid programs. Analysis from the MODRN is funded by a grant from the National Institute on Drug Abuse.

Diagnosed Prevalence of Substance Use and Opioid Use Disorders

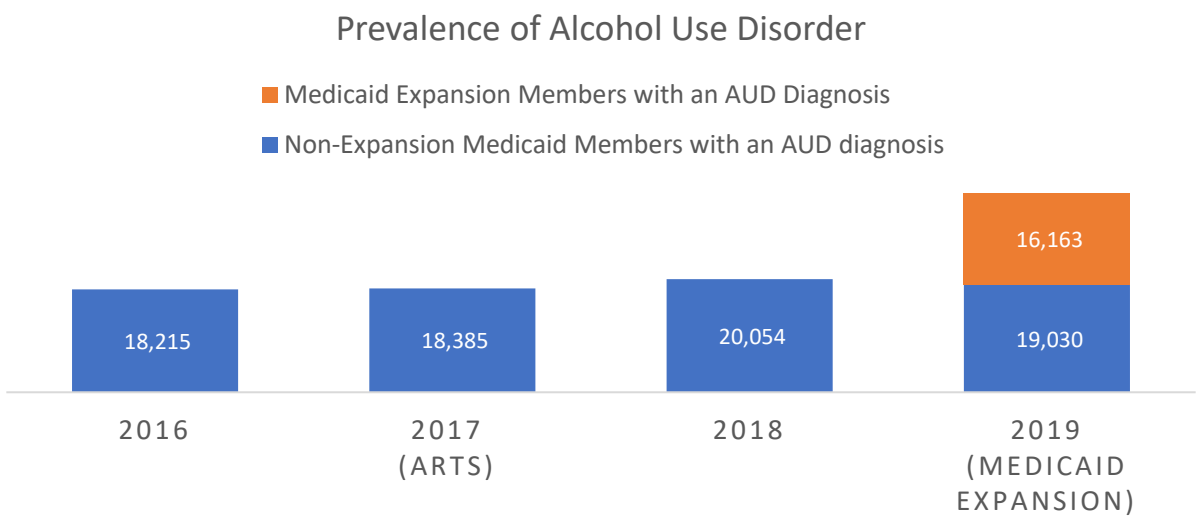
There were about 96,000 Medicaid members who had a diagnosis of SUD in 2019. This represents an increase of almost 37,000 members with diagnosed SUD from 2018, and about double the number since the year before ARTS (2016). Of those with SUD in 2019, about 42,000 (44%) had enrolled through Medicaid expansion. Although Medicaid expansion members exclude those who transitioned from the GAP program, it is likely that some Medicaid members with SUD had been enrolled in prior years through other eligibility categories.



There were over 40,000 members with diagnosed OUD in 2019, an increase of about 15,000 members with OUD in 2018, and more than double the number in 2016. Among those with an OUD diagnosis in 2019, 44% were enrolled through Medicaid expansion (excluding GAP members who transitioned to Medicaid expansion in 2019).



There were over 35,000 members with diagnosed alcohol use disorder (AUD) in 2019, an increase of about 15,000 from 2018, and almost double the number in 2016. Among those with AUD in 2019, 46% had enrolled in Medicaid expansion (excluding GAP members who transitioned to Medicaid expansion in 2019).



Diagnosed prevalence of other SUD among Medicaid members also increased between 2016 and 2019. In particular, prevalence of SUD related to methamphatimine use (identified as "other stimulants" in diagnosis codes) has more than tripled, from 2,169 members in 2016 to 9,544 members in 2019. Diagnosed prevalence of SUD related to cocaine and cannibinoids also doubled over the time period. Although opioids are still responsible for the vast majority of fatal overdoses, the rate of fatal overdoses due to methampheatimes and cocaine increased at a faster rate than fatal overdoses due to opioids between 2016 and 2019.[19]

Diagnosed prevalence of substance use disorders

	2016	2017	2018	2019	Percent change 2016-19
Any SUD	48,341	52,992	59,235	95,942	98.5%
OUD	17,129	20,930	24,854	40,361	135.6%
AUD	18,215	18,385	20,054	35,193	93.2%
Other stimulants[1]	2,169	2,822	4,250	9,544	340%
Cocaine	5,756	6,515	7,369	13,564	135.6%
Cannabinoids	13,325	14,034	15,710	26,905	101.9%

[1]Refers primarily to methamphetamines

Rate of diagnosed prevalence of SUD.

Of the 1.78 million people who were enrolled in Medicaid at some point during 2019, 5.4% had a diagnosed SUD of any type (see table on following page). The prevalence rate was highest for OUD (2.3%) followed by AUD (2.0%) and cannibinoids (1.5%). Despite increases in recent years, diagnosed prevalence of SUD due to methamphetamines and cocaine was less than one percent.

Prevalence of diagnosed SUD is higher for males (6.2%) compared to females (4.7%). Members in the 45-64 age group had by far the highest diagnosed prevalence compared to other ages, while adolescents (ages 12-17) had the lowest diagnosed prevalence. Variation in diagnosed OUD by demographic characteristics was similar, except that females have similar prevalence (2.3%). Males generally have higher rates of SUD diagnosis for cannibinoids and cocaine than females, although rates for methamphetmines are more similar by gender.

Among racial/ethnic groups, prevalence of diagnosed SUD is lower among members identifying as Black (4.8%), Hispanic (1.1%) and other racial/ethnic minorities (2.3%) compared to White members (6.3%). This differs from national data, which indicates that self-reported prevalence of SUD across racial and ethnic groups is more similar.[20] As treatment rates are also considerably lower for Black members and other racial/ethnic minorities (see below), it is possible that SUD is underdiagnosed for these groups.

Racial/ethnic variation in prevalence of diagnosed OUD is similar to overall SUD. Prevalence of SUD due to methamphetamine is higher for White members (0.8%) compared to Black members (0.2%), while SUD due to cocaine is higher for Black members (1.1%) compared to White members (0.6%).

Diagnosed prevalence of SUD and OUD is highest in the Southwest region (9.1% and 5.9% of Medicaid members, respectively) and lowest in the Northern region. However, diagnosed prevalence of cocaine abuse is highest in the Central and Tidewater regions (1% of Medicaid members for each region) and lowest in the Southwest region (0.3% percent of Medicaid members).

Co-occurrence of Substance Use Disorders with Physical and Mental Health Problems

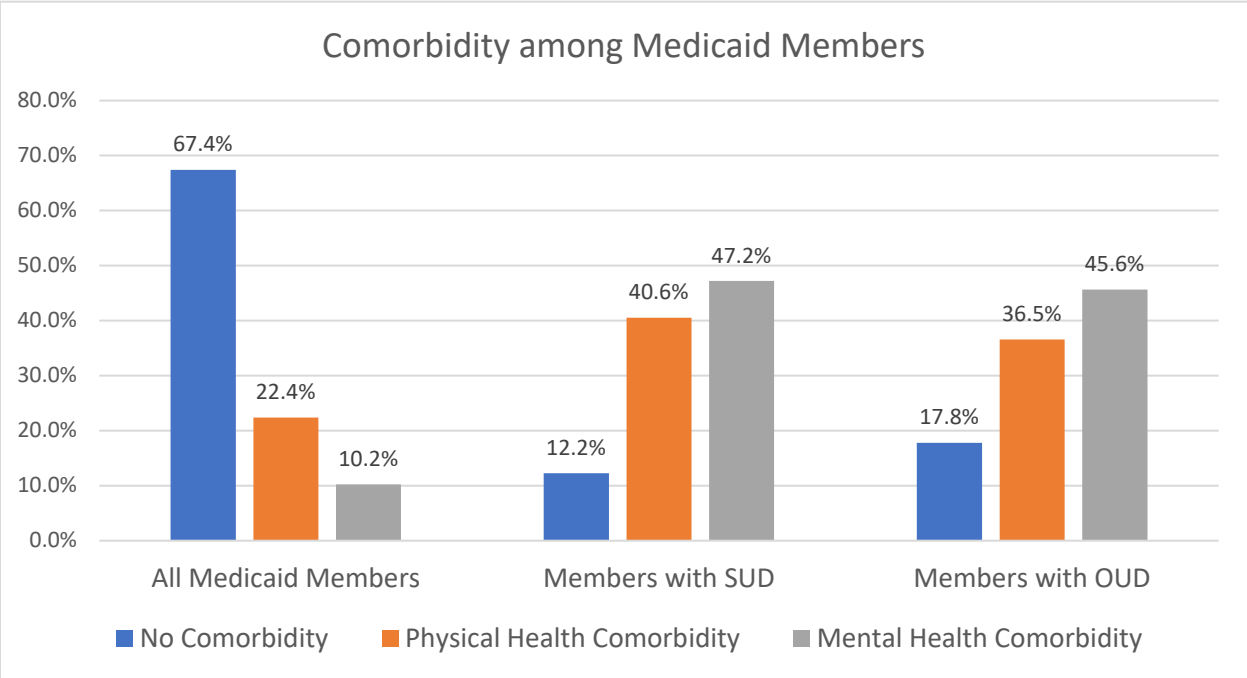
Substance use disorders are often accompanied by other co-occurring physical conditions and mental health disorders. These conditions may both contribute to addiction among members as well as complicate effective treatment of SUD.[21] We examine co-occurring conditions using the Elixhauser Comorbidity Index, one of the most widely used indicators of comorbidity in studies involving administrative data.[22] The index includes a list of 30 health conditions, including both chronic diseases, SUD and mental disorders.

Compared to all Medicaid members, those with SUD are more likely to have other comorbid conditions, including other mental health disorders. Among Medicaid members with SUD, 40.6% had a physical health comorbidity, while 47.2% had a mental health co-morbidity. Only 12.2% of members with SUD had no comorbidities based on the Elixhauser Index. Rates of comorbidities are also high among members with OUD and largely similar to those with any SUD.

Percent of Medicaid members (1.78 million) with diagnosed substance use disorders, 2019

Member Characteristics	Number of members	% Any SUD	% OUD	%AUD	% Meth-amphetamines	% Cocaine	% Cannabinoids
All members	1,784,433	5.4%	2.3%	2.0%	0.5%	0.8%	1.5%
Gender							
Female	1,004,168	4.7%	2.3%	1.3%	0.5%	0.6%	1.3%
Male	780,281	6.2%	2.3%	2.8%	0.6%	0.9%	1.8%
Race/Ethnicity							
Black	632,967	4.8%	1.4%	2.0%	0.2%	1.1%	1.7%
White	975,561	6.3%	3.1%	2.2%	0.8%	0.6%	1.5%
Hispanic	8.462	1.1%	0.2%	0.4%	0.0%	0.1%	0.5%
Other	167,482	2.3%	0.8%	1.0%	0.2%	0.3%	0.7%
Age							
12-17	229,227	1.2%	0.1%	0.2%	0.1%	0.03%	0.9%
18-44	584,969	8.9%	4.3%	2.4%	1.2%	1.2%	3.1%
45-64	292,500	11.9%	4.5%	6.0%	0.7%	2.1%	2.2%
65+	152,383	3.7%	1.2%	2.0%	0.0%	0.3%	0.3%
Region							
Central	446,624	5.6%	2.3%	2.1%	0.3%	1.0%	1.6%
Charlottesville	220,814	5.5%	1.9%	2.1%	0.7%	0.7%	1.4%
Northern	406,312	3.3%	1.2%	1.4%	0.2%	0.4%	1.0%
Roanoke	183,937	7.2%	3.3%	2.4%	1.3%	0.7%	1.7%
Southwest	125,010	9.1%	5.9%	2.1%	2.1%	0.3%	2.0%
Tidewater	401,347	5.2%	1.8%	2.2%	0.2%	1.0%	1.7%

Source: Paid Medicaid claims data from the Department of Medical Assistance Services.



Prevalence of SUD by Eligibility Category

Among the approximately 464,000 members enrolled in Medicaid expansion in 2019, 9% had a diagnosed SUD, while 3.8% had a diagnosed OUD (see table on following page). This is somewhat higher than for other nondisabled adults enrolled through traditional Medicaid (6.5% with SUD), but much lower than the prevalence among adults with disabilities (16.3%) and members previously enrolled in the GAP (39.9%).

Former Foster Care Youth (FFCY) are members who aged out of foster care under the responsibility of another state and are allowed to apply for Virginia Medicaid under an amendment to the 1115 Demonstration Waiver. There were 4,221 members who enrolled through a foster care eligibility category in 2019. About 5% have any SUD, and only 27 of these members (0.6%) had a diagnosed OUD in 2019.

Prevalence for other SUD diagnoses follow similar patterns. Compared to other nondisabled members, members enrolled through Medicaid expansion have somewhat higher diagnosed prevalence rates for OUD (3.8%), AUD (3.5%), methamphetamines (1.0%), cocaine (1.3%) and cannibinoids (2.5%). Former GAP members have the highest rates of diagnosed prevalence of each of these substances, consistent with the focus of the program on members with behavioral health problems.

Percent of members with SUD for adult Medicaid members, by eligibility group

	Number of members	% any SUD	% OUD	%AUD	% Meth-amphetamines	% Cocaine	% Cannabinoids
Medicaid expansion	463,687	9.0%	3.8%	3.5%	1.0%	1.3%	2.5%
Nondisabled adults	426,643	6.5%	3.2%	2.1%	0.7%	0.8%	1.7%
Disabled adults	139,525	16.3%	6.3%	7.0%	1.2%	2.9%	4.3%
Governor's Access Plan (GAP)[1]	18,713	39.9%	23.9%	14.0%	6.7%	7.4%	10.6%
Foster Care	4,221	4.9%	0.6%	0.8%	0.4%	0.2%	3.2%

[1]Members enrolled in GAP were transitioned to Medicaid expansion coverage in 2019, but are identified separately in this table

Characteristics of Medicaid expansion members with SUD

Expansion members with SUD differ somewhat from other adult nonelderly members. Compared to base Medicaid members, expansion members with SUD are more likely to be male (57.2%), other or unknown racial/ethnic groups (6.1%) and less likely to be in the 55-64 age group. Expansion members with SUD are also less likely to have a mental health co-morbidity (39%) than base Medicaid members with SUD, but slightly more likely to have other physical health comorbidities (45.7%).

Characteristics of Medicaid members ages 19-64 with substance use disorders, 2019

	Members enrolled through Medicaid expansion	Base Medicaid members
All members ages 19-64 with SUD	41,460	36,920
Percent of all members with SUD	9.2%	10.4%
Gender		
Female	42.8%	58.7%
Male	57.2%	41.3%
Race/Ethnicity		
White	64.6%	63.0%
Black	29.3%	35.0%
Hispanic	0.02%	0.1%
Other	6.1%	1.9%
Age		
19-25	12.5%	9.2%
26-34	27.9%	23.6%
35-54	44.9%	42.1%
55-64	14.6%	25.1%
Comorbidity		
No comorbidity	15.3%	9.1%
Mental health comorbidity	39.0%	53.6%
Other comorbidity	45.7%	37.2%

The Supply of Addiction Treatment Providers Increased After ARTS

A broad range of addiction treatment facilities and practitioners are available to Medicaid members along the continuum of care, as defined by the ASAM placement criteria.[23] These include hospital-based intensive inpatient facilities, residential treatment centers, and outpatient providers of varying types and treatment intensity. The ARTS benefit also introduced a new model of care delivery, the Preferred OBOT program that pays significantly higher reimbursement rates to qualified providers for medication-assisted treatment (including pharmacotherapy and behavioral health therapy) and coordination with other medical and social needs. Since ARTS was implemented in April 2017, Virginia has seen substantial increases across all types of addiction treatment providers and facilities that serve Medicaid members.

Medicaid addiction treatment providers before and after ARTS implementation

Addiction Provider Type	# of Providers before ARTS	# of Providers as of Sept. 2020
Inpatient Detox (ASAM 4.0)	N/A	103
Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)	4	106
Partial Hospitalization Programs (ASAM 2.5)	N/A	22
Intensive Outpatient Programs (ASAM 2.1)	49	136
Opioid Treatment Programs	6	39
Preferred Office-Based Opioid Treatment Providers	N/A	158

Source: Department of Medical Assistance Services

ARTS Continuum of Care

Medically Managed Intensive Inpatient Programs (ASAM Level 4)
Also referred to as inpatient detoxification, ASAM level 4 facilities provide medically directed acute withdrawal management along with other intensive medical and psychiatric services. Services in Virginia are provided in an acute care general hospital.

Short-term Residential Treatment Services (ASAM Level 3)
ASAM level 3 facilities provide a range of intensities of treatment services in a structured setting staffed 24 hours daily. Service level intensity (identified by ASAM levels 3.1, 3.3, 3.5, and 3.7) varies depending on the severity of the addiction problem and the patient's other medical, emotional or behavioral needs. Medicaid coverage of limited group home/residential services prior to ARTS was available only to pregnant members and adolescents and was limited by federal restrictions on payment for institutions for mental diseases (IMD).[ii] The Section 1115 Demonstration Waiver requested federal authority to waive these IMD limitations and expand access to these services at facilities with more than 16 beds.

[ii]CMS defines Institutions for Mental Diseases as hospitals, nursing facilities, or other institutions of more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services.

The number of providers serving Medicaid members increased from four providers before ARTS to 106 providers by 2019. This additional coverage is an objective of the Section 1115 Demonstration Waiver permitting federal Medicaid payment for these services in facilities with greater than 16 beds. ARTS also expanded coverage of short-term residential treatment services to include all members. In addition, ARTS substantially increased reimbursement for the group home level residential treatment services (ASAM Level 3.1).

Partial Hospitalization and Intensive Outpatient Programs (ASAM Level 2)
ASAM level 2 programs provide a higher level of treatment intensity for patients whose conditions are less stable than for patients receiving outpatient treatment, and involve a team of counselors, psychologists, physicians, and other credentialed addiction treatment providers. Intensive outpatient programs (ASAM level 2.1) provide an average of 9-19 hours per week of treatment, while partial hospitalization programs provide 20 hours or more of treatment per week.[iii]

Medicaid coverage of partial hospitalization services began with the ARTS program, and there are now 22 such providers. While Medicaid covered intensive outpatient programs prior to ARTS, Medicaid payment for these services increased substantially through ARTS. The number of intensive outpatient Medicaid providers increased from 49 before ARTS to 136 currently.

Opioid Treatment Programs
Opioid Treatment Programs (OTP) are the sole providers of methadone treatment for patients with OUD. Regulated by both federal and state agencies, OTPs directly administer MOUD treatment, including methadone and buprenorphine, to patients on a daily basis, and include care coordination and other services. While Virginia Medicaid previously covered methadone and buprenorphine treatment at OTPs , ARTS increased reimbursement rates for the service. In addition, OTPs are now allowed to bill for other services similar to Preferred OBOTs , such as care coordination services. The number of OTPs participating in Medicaid has increased from six clinics prior to ARTS, to all licensed OTPs in Virginia, totalling 39 clinics.

Preferred Office-Based Opioid Treatment Programs
To expand access to high-quality treatment for OUD in the community, ARTS initiated Preferred OBOT programs. Comprised of Community Services Boards, Federally Qualified Health Centers, private outpatient addiction treatment centers, private psychiatric clinics, and primary care clinics, Preferred OBOTs are incentivized to provide high-quality evidenced-based medications for OUD through higher rates for individual and group opioid counseling, a monthly rate for care coordination of addiction treatment services with other medical and social needs, and other services such as peer recovery support services. Providers must be certified as Preferred OBOTs by meeting staffing and facility requirements set by DMAS. The number of Preferred OBOT providers has increased from 38 sites at the beginning of ARTS (April 2017) to 158 sites at the time of this report.

Other Outpatient Providers (ASAM Level 1)

[iii] For more details on defintions of ARTS service providers, see Virginia Law Administrative Code https://law.lis.virginia.gov/admincode/title12/agency30/chapter130/section5020/

Many other licensed practitioners provide outpatient addiction treatment services to Medicaid members, including counselors, social workers, psychologists, physicians who specialize in addiction disorders, as well as primary care physicians. In 2019, there were 4,888 practitioners who billed Medicaid for outpatient services related to SUD. This reflects a 457% increase in the number of practitioners billing for addiction treatment services in 2016, the year prior to ARTS. The increases were largest for physicians and nurse practitioners.

Similarly, there were more than 2,200 practitioners who billed Medicaid for outpatient services related to the treatment of OUD, a 400% increase since 2016.

Practitioners Billing Medicaid for Outpatient Addiction Treatment Services

	2016	2017 (ARTS)	2018	2019 (Medicaid Expansion)
Substance use disorder (SUD) Outpatient Practitioners				
Total	1,068	2,800	3,729	4,880
Physicians	250	1,429	1,879	2,388
Nurse practitioners	19	167	270	414
Counselors and social workers	300	427	703	1,015
Other	500	789	954	1,227
Opioid use disorder (OUD) Outpatient Practitioners				
Total	562	1,286	1,726	2,232
Physicians	126	544	800	957
Nurse practitioners	9	60	106	165
Counselors and social workers	141	243	354	587
Other	287	447	514	621

Source: Paid Medicaid claims data from the Department of Medical Assistance Services.
Note: Outpatient practitioners refer to ASAM Level 1 practices, which are defined as outpatient services that consist of less than 9 hours of treatment per week.

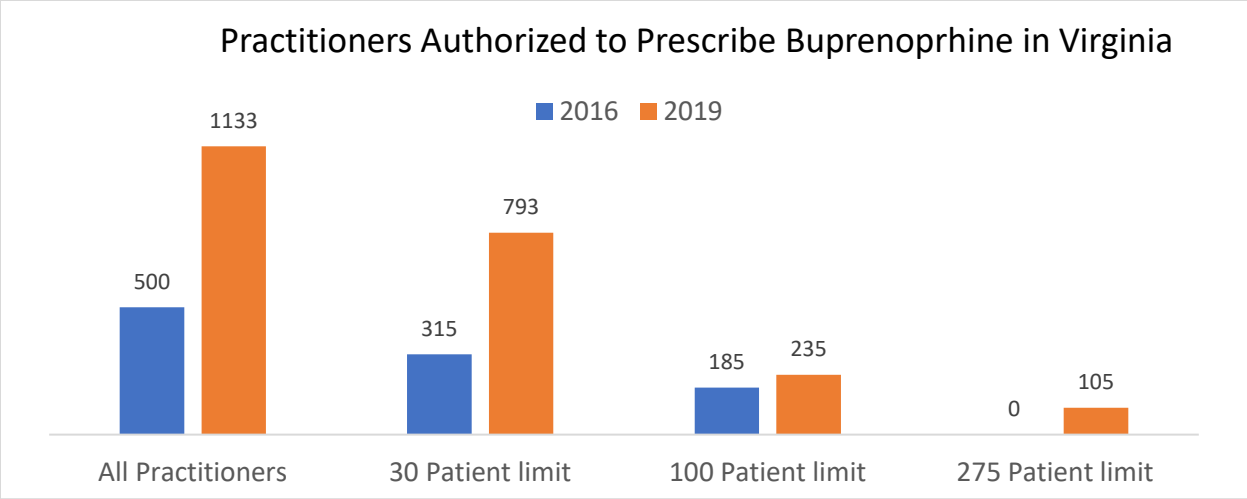
Buprenorphine waivered prescribers

There are three Food and Drug Administration (FDA) approved medications for treatment of OUD: methadone, naltrexone, and buprenorphine. Under federal requirements, methadone can only be dispensed in specially licensed clinics for the treatment of OUD. In Virginia these are the 39 licensed OTPs. Because buprenorphine treatment for OUD does not require that medication be administered at OTPs, it allows for greater access to MOUD treatment in a wider variety of treatment settings, provider types, and specialties. Virginia Medicaid has promoted the prioritization of patient choice in the selection of evidence-based medication for treatment of OUD. The agency pursued a targeted effort in 2017 to increase access to buprenorphine treatment through newly implemented Preferred OBOTs – an integrated care model that receives enhanced reimbursement for OUD treatment. More recently, DMAS eliminated the need for prior authorization for buprenorphine prescribing by practitioners in MCO

networks. Prior to ARTS implementation, DMAS and the Virginia Department of Health (VDH) conducted sessions to train and encourage more practitioners to become buprenorphine prescribers and also coordinated buprenorphine waiver trainings at no cost to practitioners.

Overall, the number of buprenorphine waivered prescribers in Virginia has more than doubled, from 500 in 2016 to 1,133 in 2019, a 127% increase.[24] Geographic coverage of the state also increased between 2016 and 2019, from 71 counties that had at least one buprenorphine prescriber in 2016 (53%) to 91 counties with at least one prescriber in 2019 (68% of counties). Still, 42 counties or independent cities in Virginia had no waivered prescribers as of 2019.

About half of the increase in waivered prescribers between 2016 and 2019 reflects 278 nurse practitioners and physician assistants who received waivers following the passage of the federal Comprehensive Addiction and Recovery Act (CARA) of 2016. Also of significance in Virginia, the Board of Medicine amended the law to allow nurse practitioners with five or more years of experience to apply to practice independently from a supervising physician, further increasing the supply of buprenorphine-waivered prescribers in Virginia who were able to serve Mediciad members.



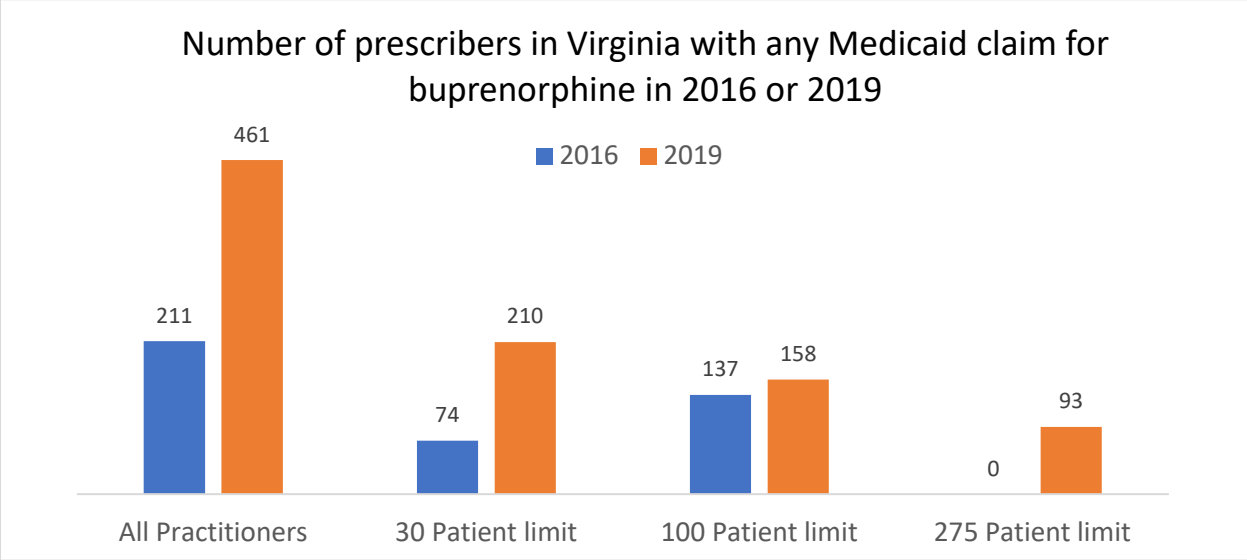
Additionally, the total prescribing capacity has increased because physicians may now apply to treat up to 275 patients at a time, in contrast to previous limits of up to 30 or 100 patients in 2016. Thus, the total prescribing capacity based on patient limits has increased by 173%, from 27,950 patients in 2016 to 76,165 patients in 2019. However, prescribers rarely treat patients up to their full capacity. Research from other states has shown that the monthly patient census was only four patients for 30-patient waivered prescribers, and 43 patients for 100-patient prescribers.[25]

Despite the increase in the number of prescribers, overall supply of prescribers is relatively low compared to most other states in the South Atlantic region. Virginia has 13.8 prescribers per 100,000 people in the state, which is less than half of the number in West Virginia (32.8 prescribers per 100,000 people) and Maryland (35.2 prescribers per 100,000 people). Among South Atlantic states, only Georgia has fewer prescribers than Virginia relative to the population (10.3 prescribers per 100,000 people in Georgia).

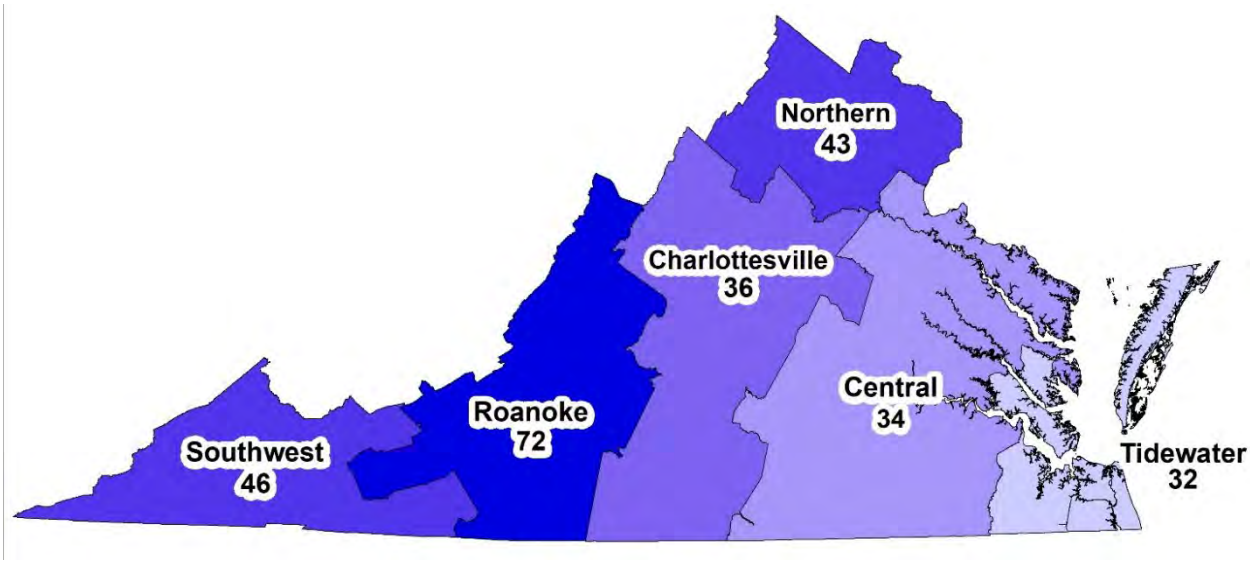
In addition, not all prescribers treat Medicaid recipients. Based on linkage of waivered prescribers to Medicaid medical and pharmacy claims data, 461 practitioners (about 40% of the total number of waivered prescribers) treated Medicaid recipients in 2019, a rate that is unchanged since before ARTS.[26]

Nevertheless, the number of prescribers treating Medicaid patients has more than doubled, reflecting the overall increase in waivered prescribers.

Regionally, the relative number of prescribers treating Medicaid patients is highest in the Roanoke region (72 Medicaid prescribers per 100,000 Medicaid members), and lowest in the Tidewater (32 Medicaid prescribers per 100,000 members), Central (34 Medicaid prescribers per 100,000 members), and Charlottesville regions (36 Medicaid prescribers per 100,000 people).



Number of Physicians Authorized to Prescribe Buprenorphine Who Treated Medicaid Patients, per 100,000 Medicaid Members



Medicaid Members Treated for Substance Use Disorders

Coverage of SUD services provided by ARTS is based on the ASAM National Practice Guidelines, which comprise a continuum of care from Early Intervention/Screening, Brief Intervention, and Referral to Treatment (SBIRT / Level 0.5) to medically managed intensive inpatient services (Level 4).[27] ARTS also emphasizes evidence-based treatment for OUD, which combines pharmacotherapy and counseling. In July 2017, DMAS added peer recovery support services, which facilitate recovery from SUD, as covered services through ARTS. Care coordination services provided by Preferred OBOT and Opioid Treatment Programs facilitate integration of addiction treatment services with physical health and social service needs.

In 2019, the second year of ARTS, about 48,000 members – half of those diagnosed with SUD – received some type of treatment for SUD. About 28,000 members received treatment for an OUD, comprising 68.9% of those with a diagnosed OUD.

SUD and OUD treatment rates, by member characteristics, 2019

Member Characteristics	SUD treatment rate[1]	OUD treatment rate[1]
All members	50.0%	68.9%
Gender		
Male	48.9%	69.2%
Female	51.2%	68.7%
Race/Ethnicity		
White	55.5%	71.5%
Black	39.8%	60.8%
Hispanic	47.9%	70.6%
Other	44.7%	62.3%
Age		
12-17	36.6%	33.0%
18-44	56.6%	76.8%
45-64	46.1%	61.1%
65 years and higher	21.6%	28.2%
Comorbidity		
No comorbidity	71.6%	80.2%
Mental health comorbidity	51.4%	66.6%
Other comorbidity	41.9%	66.3%

[1]Reflects the percentage of members with SUD (or OUD) who received any ARTS treatment services for that condition. Note: Services include those performed in an OBOT or Opioid Treatment Program setting, psychotherapy or counseling, physician evaluation or management, intensive outpatient, partial hospitalization, residential treatment, medically managed intensive inpatient services and pharmacotherapy.

Treatment rates for SUD tend to be highest among those in the 18-44 age group, individuals identifying as White, and those with no comorbidities. Variation in treatment rates for OUD are generally similar. SUD treatment rates among Black members (38%) are considerably lower than for White members (55%). Treatment rates for Hispanics (51%) and other racial/ethnic groups (46%) are also lower than for White members.

Among members enrolled in Medicaid expansion, 53.4% received treatment for a diagnosed SUD, while 72.8% received treatment for a diagnosed OUD – similar to the treatment rates for nondisabled adults who qualify through pre-expansion income eligibility levels. Treatment rates are highest for members formerly enrolled in the GAP program. Only about 5% percent with SUD who were enrolled through foster care programs received any treatment, while there were too few foster care members with OUD to estimate a treatment rate.

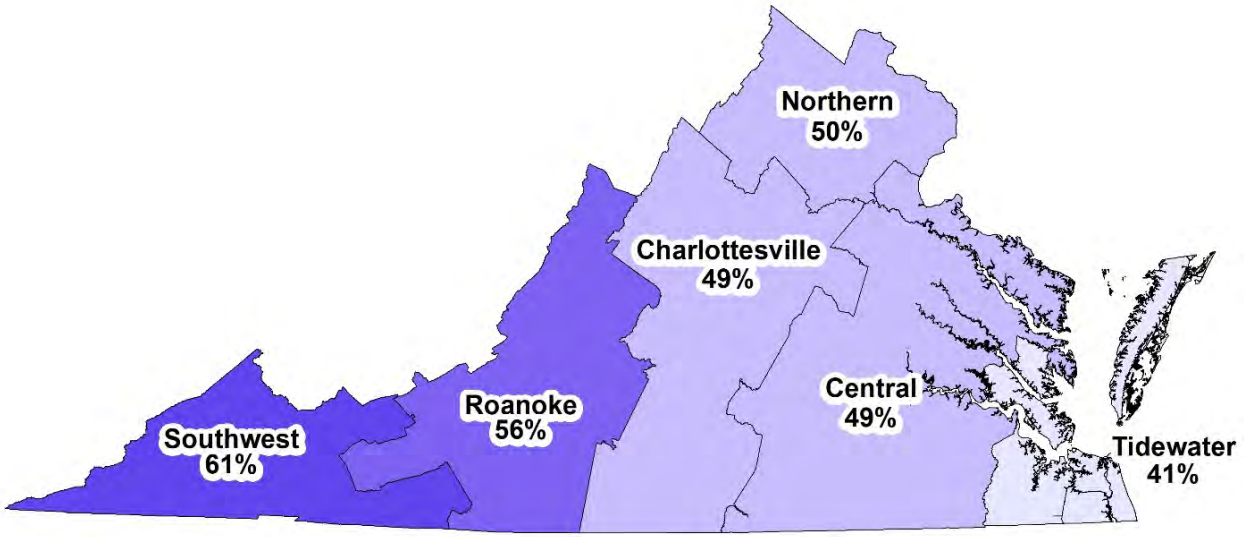
SUD and OUD treatment rates for Medicaid members, by eligibility group

	SUD treatment rate[1]	OUD treatment rate[2]
Medicaid expansion	53.4%	72.8%
Nondisabled adults	52.7%	72.8%
Disabled adults	42.7%	57.1%
Governor's Access Plan (GAP)[3]	72.4%	81.6%
Foster Care	4.9%	Not reportable

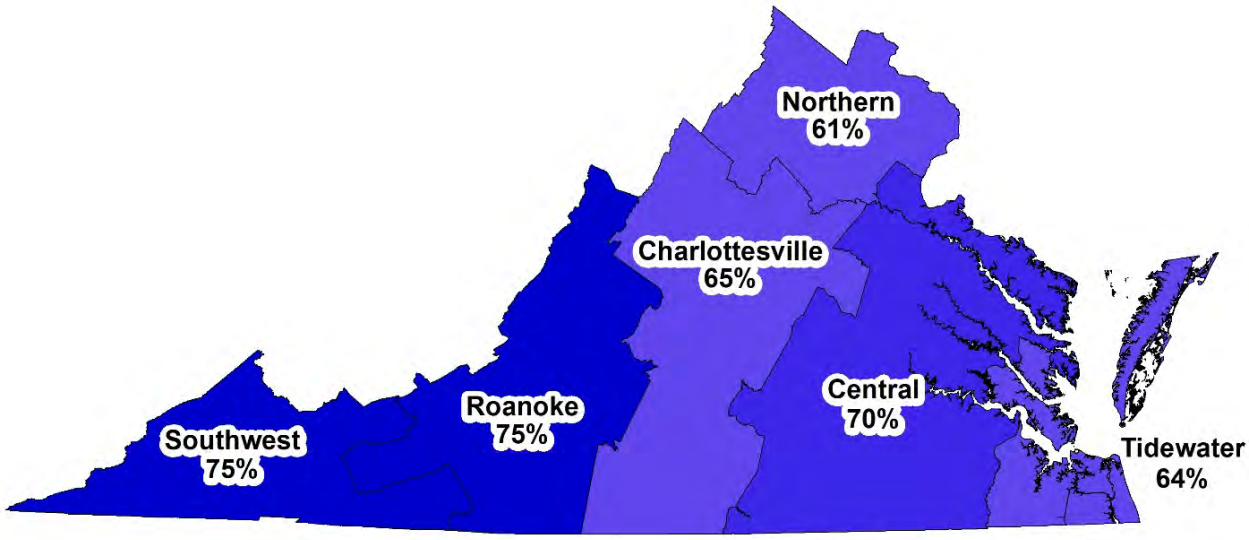
[1]Reflects the percentage of members with SUD (or OUD) who received any ARTS treatment services for that condition. Note: Services include those performed in an OBOT or Opioid Treatment Program setting, psychotherapy or counseling, physician evaluation or management, intensive outpatient, partial hospitalization, residential treatment, medically managed intensive inpatient services and pharmacotherapy.
[3]Members enrolled in GAP were transitioned to Medicaid expansion coverage in 2019 but are identified separately in this table

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

SUD treatment rates for members in 2019, all members



OUD treatment rates for members in 2019, all members



Treatment Rates Continue to Increase in 2019

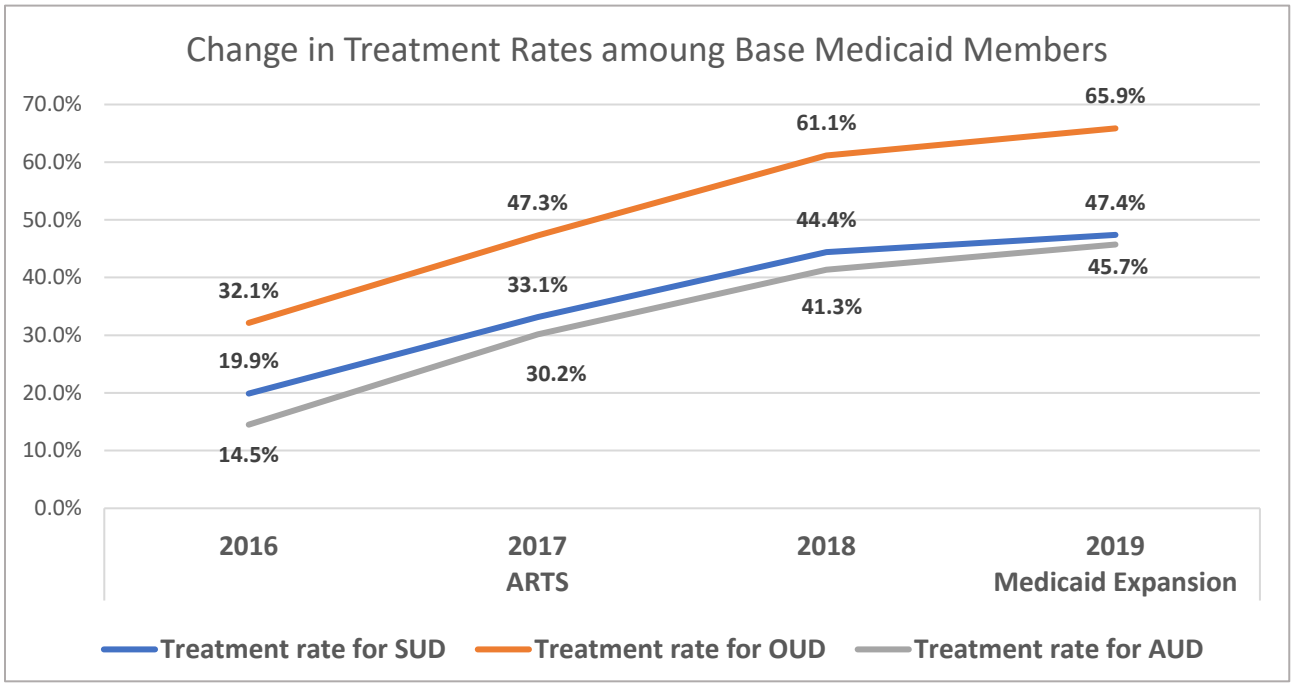
Prior ARTS evaluation reports showed large increases in treatment rates for SUD in the first two years following implementation of ARTS.[28] Despite the increase in members with SUD in 2019 due to Medicaid expansion, treatment rates continued to increase between 2018 and 2019. Among members with any diagnosed SUD who did not enroll through Medicaid expansion, treatment rates increased from 44.4% in 2018 to 47.4% in 2019. Since the year before ARTS (2016), SUD treatment rates have increased 138% as of 2019. Treatment rates for OUD and AUD also increased between 2018 and 2019. Overall, OUD treatment rates have increased by more than 100% since 2016, while AUD treatment rates have increased 215%.

Changes in treatment rates for substance use disorders among base Medicaid members.[1]

	2016	2017 (ARTS)	2018	2019 (Medicaid Expansion)	Percentage change in treatment rate since before ARTS
Treatment rate for any substance use disorder	19.9%	33.1%	44.4%	47.4%	138.3%
Treatment rate for opioid use disorder	32.1%	47.3%	61.1%	65.9%	104.9%
Treatment rate for alcohol use disorder	14.5%	30.2%	41.3%	45.7%	215.4%

[1]Members enrolled through Medicaid expansion are excluded to maintain comparability with prior years

Note: Services include those performed in an OBOT or Opioid Treatment Program setting, psychotherapy or counseling, physician evaluation or management, intensive outpatient, partial hospitalization, residential treatment, medically managed intensive inpatient services and pharmacotherapy.



Service Utilization by ASAM Levels of Care for Substance Use Disorders

Use of services in 2019 increased greatly across all ASAM levels of care, as might be expected given the increase in members through Medicaid expansion. In 2019, 46,520 members used a treatment service categorized within an ASAM level of care, a 79% increase from 2018, and a 172% increase since 2017 (the first year of ARTS). There were increases in utilization across all levels of services, but increases between 2018 and 2019 were especially notable for early screening and interventions, residential treatment services (ASAM 3), the use of OTP and Preferred OBOT providers, and the use of care coordination services at Preferred OBOTs.

- Screening, Brief Intervention, and Referral to Treatment (SBIRT/ASAM Level 0.5) is used to screen for SUD in any health care setting, including primary care settings. In 2019, 2,288 members had screenings for SUD, a 359% increase from 2017, with much of the increase occurring between 2018 and 2019.

- In 2019, 9,558 members received services through Preferred OBOT or OTPs . This is more than 2.6 times the number of members using Preferred OBOT and OTP services in 2018, and 15 times the number in 2017.

- Outpatient services (ASAM Level 1), such as psychotherapy or physician evaluations, are by far the most frequently used services. In 2019, about 34,000 members with a primary diagnosis of a SUD had psychotherapy or a physician evaluation, an 84% increase from 2018, and a 179% increase from 2017.

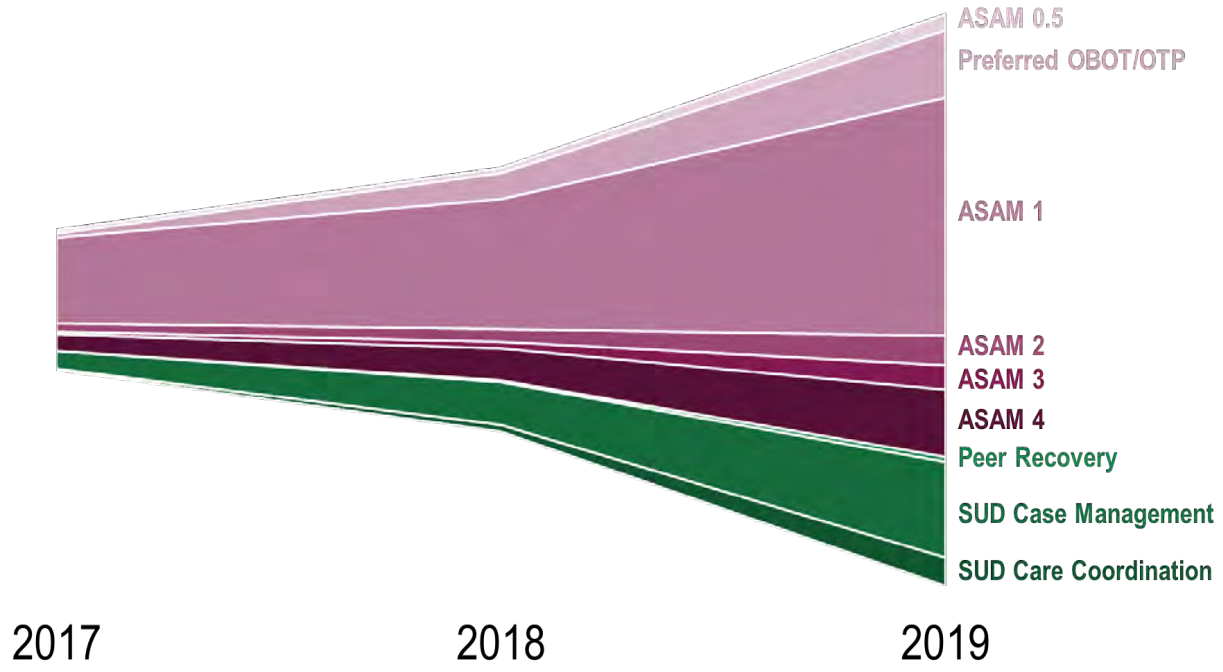
- ASAM Level 2 includes partial hospitalization and intensive outpatient services. In 2019, 4,096 members used these services, a 267% increase since 2017.

- ARTS added coverage for short-term residential treatment services (ASAM Level 3) and medically managed inpatient services (ASAM Level 4), which was made possible by a Section 1115 Demonstration Waiver for SUD that permits federal Medicaid payments for residential facilities with greater than 16 beds. Use of residential treatment services increased greatly in 2019, from 1,049 members who used such services in 2018 to 3,483 using residential treatment in 2019. Also, 9,569 members used medically managed inpatient services for SUD, more than double the number using these services in 2018.

- ARTS also covered new services, including peer recovery support services, case management and care coordination for substance use. In 2019, 4,048 members received care coordination services at Preferred OBOTs and OTP providers, almost quadruple the number receiving these services in 2018. Also, 13,604 members used substance use case management services, more than double the number from 2018. Although the use of peer recovery support services has increased greatly between 2017 and 2019, there is still relatively little billing for peer recovery support services.

Members who used ARTS services for substance use disorders from 2017 to 2019

	2017	2018	2019	Percentage change, 2017 to 2019
Members who had any ASAM level of service	17,120	25,923	46,520	172%
ASAM Level 0.5, Early Intervention	498	710	2,288	359%
Preferred Office-Based Opioid Treatment/ Outpatient Treatment Providers	630	3,686	9,558	1417%
ASAM Level 1, Outpatient Services	12,208	18,498	34,077	179%
ASAM Level 2, Intensive Outpatient/Partial Hospitalization	1,115	1,807	4,096	267%
ASAM Level 3, Residential/Inpatient Services	388	1,049	3,483	798%
ASAM Level 4, Medically Managed Intensive Inpatient Services	2,350	4,441	9,569	307%
Peer Recovery Support Services	67	320	775	1057%
Substance Use Case Management	2,483	6,038	13,604	448%
Substance Use Care Coordination at Preferred OBOTs and OTPs	209	1,024	4,048	1837%



Use of Medications for Opioid Use Disorders

Medications for opioid use disorder (MOUD) include the use of buprenorphine, methadone and naltrexone as part of evidence-based care. This method is considered the gold standard of care for treating OUD. In 2019, more than 23,000 members received MOUD treatment, more than double the number who received MOUD treatment in 2018. Overall, the number of Medicaid members receiving MOUD treatment has increased by 286% since 2016, the year prior to ARTS implementation.

Buprenorphine treatment was the most common form of MOUD treatment in 2019, accounting for 56% (about 13,000 members) of those receiving such treatment. However, methadone treatment has increased dramatically since the ARTS program began – from just 419 members receiving methadone treatment in 2016 to 7,945 members receiving treatment in 2019. The number of members treated by naltrexone also increased greatly between 2016 and 2019.

Medicaid members with OUD who received MOUD treatment

	2016	2017 (ARTS)	2018	2019 (Medicaid Expansion)	% Change 2016 to 2019
Members who received any MOUD	6,031	8,233	11,806	23,257	286%
Members who received buprenorphine treatment	4,972	6,089	7,212	13,099	163%
Members who received methadone treatment	419	1,325	3,544	7,945	1796%
Members who received naltrexone or other medication treatment	686	968	1,496	3,238	372%

Among base Medicaid members, MOUD treatment rates (that is, the percent of members with diagnosed OUD who receive MOUD treatment) have continued to increase, from 47.5% in 2018 to 53.1% in 2019. Overall, MOUD treatment rates among base eligibles have increased by 50% between 2016 and 2019.

The increase in MOUD treatment rates was driven primarily by increases in methadone treatment rates, from 2.4% of base Medicaid members with OUD in 2016 prior to ARTS to 18.5% by 2019 (a 655% increase). Although the number of members receiving buprenorphine increased steadily between 2016 and 2019, the percent of members with OUD receiving buprenorphine has remained steady at about 30% throughout the period. The percent of members with OUD receiving naltrexone treatment increased from 4% in 2016 to 7.1% in 2019.

MOUD treatment rates among base Medicaid members with OUD.[1]

Base Medicaid members with OUD receiving MOUD	2016	2017 (ARTS)	2018	2019 (Medicaid Expansion)	% Change 2016 to 2019
Percent who received any MOUD for opioid use disorder	35.2%	39.3%	47.5%	53.1%	50.7%
Percent received any buprenorphine treatment	29.0%	29.1%	29.0%	30.0%	3.3%
Percent received any methadone treatment	2.4%	6.3%	14.3%	18.5%	655.3%
Percent received naltrexone or other medication treatment	4.0%	4.6%	6.0%	7.1%	78.3%

[1]Members enrolled through Medicaid expansion are excluded to maintain comparability with prior years

Emergency Department Use Related to Substance Use Disorders

Previous ARTS evaluation reports have shown a substantial decrease in utilization of emergency departments (EDs) related to SUD.[29] A difference-in-difference analysis of acute hospital use for Medicaid members with SUD and OUD following ARTS implementation accounted for general changes in ED utilization, as well as changes in characteristics of members with SUD. [30] The results showed that following implementation of the ARTS benefit, the likelihood of having an ED visit decreased by 9.4 percentage points (a 21.1% relative decrease) among members with OUD, compared to 0.9 percentage points among beneficiaries with no SUD. Similarly, the likelihood of having an inpatient hospitalization declined among members with an OUD.

These early trends are reflected in the table below. Between 2016 and 2018, SUD and OUD-related ED visits decreased, while ED visits for all other conditions increased. OUD-related visits decreased the most – from 34.8 visits per 100 persons with OUD in 2016 to 25.9 visits in 2018 – a 25.5% decrease. By contrast, non-SUD related ED visits ***increased*** from 66.3 visits per 100 persons in 2016 to 69.6 visits in 2018, a 5% increase in utilization.

Number of emergency department visits per 100 base Medicaid members[1]

	2016	2017	2018	2019	Percentage change 2016-2019
All ED visits per 100 Medicaid members	66.2	63.3	69.3	74.2	12.1%
Non-SUD related ED visits per 100 Medicaid members	66.3	63.7	69.6	74.2	11.9%
SUD-related ED visits per 100 Medicaid members with SUD	62.9	52.2	60.1	73.5	16.9%
OUD-related ED visits per 100 Medicaid members with OUD	34.8	24.2	25.9	33.3	-4.3%

[1]Members enrolled in Medicaid expansion in 2019 are excluded in order to maintain comparability with prior years.

ED utilization increased sharply in 2019 overall as well as for members with SUD and OUD. SUD-related ED visits increased from 60.1 visits per 100 persons with SUD in 2018 to 73.5 visits, a 22% increase. OUD-related ED visits increased from 25.9 visits per 100 persons with OUD in 2018 to 33.3 visits, a 28.6% increase. Despite the increase between 2018 and 2019, there was still a 4.3% overall decrease in OUD-related ED visits between 2016 and 2019.

While the increase in SUD and OUD-related ED visits between 2018 and 2019 may be related in part to the more general increase in ED utilization, the trend is also consistent with the statewide and national increase in fatal drug overdoses and ED-related drug overdoses during this period. Between 2018 and

2019, the number of fatal drug overdoses increased by 9.4% in Virginia, from 1,486 deaths in 2018 to 1,626 deaths in 2019.[31] All drug-related overdoses (fatal and nonfatal) at EDs also increased, from 13,388 ED-related drug overdoses in 2018 to 14,542 overdoses in 2019.[32]

In sum, while the decrease in SUD and OUD-related ED visits following ARTS implementation indicated increased access to treatment, these early gains may have been offset by an apparent worsening of the prevalence of overdoses among all residents in Virginia in 2019, which is consistent with national trends.[33] It should also be noted that the impacts of COVID-19 on mental health and ED utilization is not shown in this report.

Drug overdoses in Virginia, 2016-2019

	2016	2017	2018	2019	Percentage change 2018-2019
All fatal drug overdoses[1]	1,428	1,537	1,486	1,626	9.4%
All ED-related drug overdoses (fatal and nonfatal) [2]	14,481	14,550	13,388	14,542	8.6%

[1]Virginia Department of Health. Fatal Drug Overdose Quarterly Report: 1rst quarter 2020
[2]Virginia Department of Health. Emergency Department Visits for Unintentional Drug Overdoses.

Transitions Following Emergency Department Visits and Stays in Residential Treatment

Follow-up within 30 Days of an ED Visit Related to SUD or OUD.

It is important that patients with an ED visit related to SUD either obtain treatment or continue with ongoing treatment in order to avoid overdoses, relapses, or return visits to EDs. EDs are also increasingly becoming key points of entry into the addiction treatment system, either by referring patients to residential treatment or other providers, or by starting patients on MOUD. Prior research has found that MOUD treatment initiated in the ED increased engagement in addiction treatment services within 30 days and reduced self-reported illicit drug use, compared to those who were not started on this treatment while at the hospital.[34] Some hospitals in the Commonwealth – such as Carilion Memorial Hospital in Roanoke – have started to initiate pharmacotherapy treatment in the ED for people presenting with an opioid overdose or withdrawal symptoms, and then connected patients to outpatient treatment.[35] Such programs – known as ED-Bridge programs – are also being heavily promoted in other states.[36]

Treatment within seven or 30 days of an ED visit is a commonly used threshold.[37] Among Virginia Medicaid members who had an ED visit with a principal diagnosis of a SUD, receipt of some type of ARTS addiction treatment services has increased since ARTS implementation. Use of pharmacotherapy within 30 days of an ED visit increased from 5.6% in 2017 after ARTS implementation, to 12.2% by 2019. Use of outpatient, residential treatment and medically managed inpatient treatment has also increased. Nevertheless, 41.1% of members with a SUD-related ED visit still had no treatment services within 30 days of the visit in 2019.

Follow-up after ED visit with a primary diagnosis of SUD[1]

	2017 (April 1 or after)	2018	2019
Total number of emergency department visits with a primary diagnosis of SUD	4,849	7,313	16,054
Service use within 30 days of the ED visit with primary Dx of SUD			
Pharmacotherapy	5.5%	7.5%	12.1%
Outpatient at OBOT, OTP or other provider	30.6%	43.6%	45.8%
Intensive outpatient or partial hospitalization	0.6%	2.0%	2.5%
Residential treatment	2.0%	4.3%	5.8%
Medically managed intensive inpatient	15.5%	19.4%	24.2%
Any of the above	41.0%	53.0%	58.5%

[1]Includes ED visits for which there were no overnight hospital stays, a principal diagnosis of SUD and the member did not disenroll from Medicaid in the month after the visit.

Trends in ARTS service utilization are similar for members with an ED visit with a primary diagnosis of OUD. Use of pharmacotherapy, outpatient, and residential treatment increased considerably between 2017 and 2019. Despite these gains, many members were still not receiving any ARTS services in the 30 days following ED visits in 2019 – only 26.9% received pharmacotherapy (MOUD treatment), while slightly more than half received any treatment services within 30 days of the visit.

Follow-up after ED visit with a primary diagnosis of OUD[1]

	2017 (April 1 or after)	2018	2019
Total number of emergency department visits with a primary diagnosis of OUD	760	945	2,081
Service use within 30 days of the ED visit with primary Dx of OUD			
MOUD treatment	10.9%	16.7%	26.9%
Outpatient at OBOT, OTP or other provider	26.7%	32.2%	40.9%
Intensive outpatient or partial hospitalization	1.0%	3.2%	3.5%
Residential treatment	2.5%	6.3%	5.7%
Medically managed intensive inpatient	11.8%	9.7%	12.6%
Any of the above	38.2%	44.1%	53.5%

[1]Includes ED visits for which there were no overnight hospital stays, a principal diagnosis of SUD and the member did not disenroll from Medicaid in the month after the visits.

Services Received Following Discharge from Residential Treatment Centers

For members with SUD who require short-term residential treatment (ASAM Levels 3) and inpatient acute care settings (ASAM Level 4), it is important that treatment continues following discharge from these facilities. Otherwise, lack of follow-up care may increase the risk of relapse and readmission to high-intensity service utilization, including acute hospital utilization.

Most members receive some type of treatment service within 30 days of being discharged from residential treatment services, and the percent of members receiving any treatment has increased since ARTS implementation. Among all residential stays involving SUD, most follow-up services are for some type of outpatient or intensive outpatient services. The percent receiving any treatment services increased from 68.6% in 2017 to 79.1% in 2019.

Among residential treatment stays for OUD, the percent receiving any treatment service increased from 77.1% in 2017 to 87.3% in 2019, with almost all of the increase occurring between 2018 and 2019. MOUD treatment rates within 30 days of discharge increased from 40.4% in 2017 to 64.1% in 2019.

Follow-up after discharge from residential treatment center (ASAM 3), primary diagnosis of any SUD[1]

	2017 (April 1 or after)	2018	2019
Total number of stays in a residential treatment center (ASAM 3) with primary Dx of SUD	590	2,399	5,996
Service use within 30 days of discharge from a treatment center (ASAM 3) with a primary diagnosis of any SUD			
Pharmacotherapy[1]	26.4%	33.8%	45.0%
Outpatient at OBOT, OTP or other provider	48.6%	38.3%	46.9%
Intensive outpatient or partial hospitalization	20.7%	33.3%	34.9%
Lower level of residential treatment	10.0%	12.6%	11.9%
Any of the above	68.6%	70.9%	79.1%

[1]Includes any pharmacotherapy obtained during the index ASAM 3 stay.

Follow-up after discharge from residential treatment center (ASAM 3), primary diagnosis of OUD[1]

	2017 (April 1 or after)	2018	2019
Total number of stays in a residential treatment center (ASAM 3) with primary Dx of OUD	223	1,050	2,692
Service use within 30 days of discharge from a treatment center (ASAM 3) with a primary diagnosis of OUD			
MOUD[1]	40.4%	47.0%	64.1%
Outpatient at OBOT, OTP or other provider	53.8%	41.5%	50.3%
Intensive outpatient or partial hospitalization	22.0%	32.2%	38.9%
Lower level of residential treatment	12.1%	13.5%	13.4%
Any of the above	77.1%	76.5%	87.3%

[1]Includes any MOUD obtained during the index ASAM 3 stay.

Treatment for OUD among Members Before and After Childbirth

Increase in postpartum Medicaid coverage following Medicaid expansion.

Most pregnant members enrolled in Medicaid have historically been covered through Medicaid due to their pregnancy, which limits eligibility to pregnant individuals with family incomes up to 133% of the federal poverty level. The FAMIS MOMS program uses Title XXI (Children's Health Insurance Program) to cover pregnant individuals who are not Medicaid eligible and whose family incomes are up to 205% of the federal poverty level. Eligibility for Medicaid coverage through these programs ends at the end of the month following the 60th day of the end of the pregnancy. Unless individuals can continue with their Medicaid coverage by qualifying for another eligibility group after this 60 day period, they will no longer be covered by Medicaid, thereby increasing the risk that they will lack access to care for health problems they experience during the postpartum period, including SUD. Recently passed state legislation will expand eligibility through 12 months following child birth in 2021.

Addressing the postpartum coverage gap is crucial for members with OUD, as both prior research and Virginia Medicaid claims data indicate that opioid-related drug overdoses are more likely to occur in the postpartum period, especially in the 6 to 12 month period after birth.[38] Among Virginia Medicaid members with live deliveries between July 2016 and June 2019, there were 54 opioid-related overdoses in the 12 months **prior to delivery**, with the highest rate of overdoses (5.4 per 10,000 Medicaid members who gave birth) occurring 10-12 months prior to birth. There were twice as many opioid-related overdoses in the **12 months after delivery**, with the highest rate occurring in the 10 to 12 month period after birth (5.2 overdoses per 10,000 members enrolled in full Medicaid coverage).

Medicaid enrollment and opioid-related overdoses in the 12 months before and after delivery: Medicaid menbers with live delivieries between July 2016 through June 2019.

	Members enrolled in full Medicaid coverage in the time period before and after live delivery[1]	Opioid-related overdoses (rate per 10,000 members enrolled in full Medicaid)
Time period prior to birth		
10-12 months prior to birth	36,288	21 (5.8)
7-9 months	64,081	12 (1.9)
4-6 months	76,947	12 (1.6)
3 months to birth	89,294	9 (1.0)
Time period after birth		
Birth to 3 months after birth	90,706	35 (3.9)
4-6 months	55,400	21 (3.8)
7-9 months	56,511	23 (4.1)
10-12 months	59,651	31 (5.2)

[1]Includes members with live deliveries who were enrolled in full Medicaid coverage in the specified time period before and after delivery.

Medicaid expansion addresses the postpartum coverage gap by allowing more members with family incomes up to 138% of poverty to continue with Medicaid coverage following the end of the pregnancy. Medicaid coverage for individuals in the prenatal period may also increase because Medicaid expansion allows more individuals to qualify for Medicaid coverage before they become pregnant.

The table below shows the average number of months that Medicaid members had full Medicaid coverage in the 12 months before birth, and the 12 months following birth of the child. It should be noted that estimates for 2019 – the year of Medicaid expansion – include only the first six months. The average number of months with Medicaid coverage in the prenatal period increased from 6.6 months in 2016 to 7 months in 2019. The median number of months of prenatal coverage remained steady at 8 months.

Number of months on full Medicaid coverage in the 12 months before and after delivery for the mother.

	2016[1]	2017	2018	2019[2]
All members with deliveries	18,724	36,691	35,640	16,332
Medicaid coverage in the 12 months before delivery				
Average number of months of coverage	6.6	6.7	6.8	7.0
Median number of months of coverage	8	8	8	8
Medicaid coverage in the 12 months after delivery				
Average number of months of coverage	6.0	6.2	7.4	7.9
Median number of months of coverage	4	4	9	12

Postpartum Medicaid coverage increased to a much greater extent, and most of this gain is likely due to increased eligibility through Medicaid expansion. The average number of months of Medicaid coverage in the year after birth increased from 6 months in 2016 to 7.9 months in 2019, with most of the increase occurring in 2018 and 2019. The increase is even greater when observing median number of months of postpartum Medicaid coverage – from 4 months in 2016 to 12 months in 2019. Further analysis showed that postpartum coverage increased steadily during the four quarters of 2018 – that is, postpartum coverage increased the most in the third and fourth quarter of 2018 as members' postpartum period increasingly overlapped with the beginning of Medicaid expansion (findings not shown).

Increase in OUD treatment in the year before and after delivery.

In 2017, the ARTS program expanded treatment services available to Medicaid members, including pregnant individuals covered by Medicaid in the prenatal and postpartum period. Medicaid expansion further increased access to treatment by increasing the time before and after birth that individuals are covered by Medicaid, especially in the postpartum period.

Diagnosed SUD, OUD, and MOUD treatment rates among individuals in the 12 months before and after childbirth.

	2016-2017 (18 months)	2017-2018 (24 months)	2018-2019 (18 months)
Number of members with live deliveries	55,415	72,331	51,972
Number with any SUD diagnosis			
12 months before delivery	3,529	5,037	3,873
12 months after delivery	2,849	4,215	3,354
Number with any OUD diagnosis			
12 months before delivery	1,234	1,678	1,260
12 months after delivery	1,283	1,896	1,485
MOUD treatment in 12 months prior to delivery			
Percent with any MOUD treatment	52.4%	57.0%	62.1%
Average number of months with any MOUD treatment before delivery	5.0	5.1	5.4
MOUD treatment in 12 months after delivery			
Percent with any MOUD treatment	69.5%	71.0%	74.5%
Average number of months with any MOUD treatment after delivery	5.9	6.4	7.0

MOUD treatment rates increased in the 2 year period before and after childbirth between 2016 and 2019 (two-year averages are computed due to small numbers of members with OUD diagnoses). Among members with an OUD diagnosis in the 12 months prior to delivery, MOUD treatment rates increased from 52.4% in 2016-17 to 62.1% in 2018-19. Among those receiving MOUD treatment, the average number of months with any MOUD in the 12 months prior to delivery increased from 5 months in 2016-17 to 5.4 months by 2018-19.

MOUD treatment rates are higher in the 12 months after delivery than the 12 months prior to delivery. Among members with an OUD diagnosis in the 12 months following delivery, the percent receiving MOUD treatment increased from 69.5% in 2016-17 to 74.5% in 2018-19. Among those receiving MOUD treatment, the number of months of MOUD treatment increased from 5.9 months in 2016-17 to 7 months by 2018-19.

Discontinuation of MOUD treatment following delivery has been identified as a potential risk factor for relapse and overdose,[39] although there is little research on the rate at which treatment is discontinued. Among members enrolled in Medicaid in 2018-19, most who had MOUD treatment in the 12 months prior to delivery continued with MOUD treatment at some point in the 12 months after delivery (85%), which was a slight increase from the 2016-17 period.

Continuation of MOUD treatment following delivery

	2016 - 2017	2018 - 2019
Percent of members with MOUD treatment in 12 months after delivery		
Among member with any OUD diagnosis in 12 months before delivery	55.7%	66.4%
Among members with MOUD treatment in 12 months before delivery	82.8%	85.0%

Neonatal Abstinence Syndrome

Opioid use and treatment with opioid agonist therapy during pregnancy can result in symptoms of drug withdrawal among newborns, known as neonatal abstinence syndrome (NAS), which can lead to additional neonatal health problems and greater use of high cost health services for newborns. NAS incidence among newborns covered by Medicaid has increased somewhat, from 2.6% of newborns diagnosed with NAS in the last six months of 2016 to 3.3% in the first six months of 2019.

Diagnoses of Neonatal Abstinence Syndrome among Medicaid covered newborns.

	2016 (July-December)	2017	2018	2019 (January-June)
All newborns	19,036	37,292	36,263	16,612
NAS diagnoses (percent)[1]	491 (2.6%)	1094 (2.9%)	1149 (3.2%)	543 (3.3%)
Of births with NAS diagnoses, percent to mothers with OUD diagnosis and MOUD treatment in 12 months prior to birth				
No SUD or OUD diagnosis of mother in prenatal period	36.9%	40.6%	36.0%	29.5%
No OUD diagnosis of mother in prenatal period	56.8%	61.7%	59.4%	50.0%
OUD diagnosis, no MOUD treatment	22.2%	17.6%	14.2%	12.2%
Had MOUD treatment	21.0%	20.7%	26.4%	37.8%

[1]Includes NAS diagnoses in the 12 months after birth.

Increased incidence of NAS among newborns is likely related to increases in MOUD treatment of the mother in the prenatal period, potentially as a result of greater screening of newborns among mothers known to be receiving treatment. Prior research has shown that NAS diagnosis is higher among newborns whose mothers were receiving MOUD treatment in the prenatal period compared to both mothers who had untreated OUD, as well as mothers with no OUD diagnosis.[40] Given this, it is difficult

to ascertain whether increases in MOUD treatment due to ARTS is related to less actual incidence of NAS.

Nevertheless, it is noteworthy that an increasing number of births with NAS diagnoses are to members who received some diagnosis or treatment for MOUD in the 12 months prior to delivery. In 2017, 61.7% of births with NAS diagnoses were to members who had no OUD diagnosis or treatment in the 12 months prior to delivery. By 2019, about half of births with NAS diagnosis were to members with no OUD diagnosis or treatment in the 12 months before delivery. Still, that half of births with NAS diagnosis are to members who have no recent OUD diagnostic or treatment history suggests that there are still substantial gaps in the diagnosis and treatment of pregnant members with OUD.

Quality of Treatment for Opioid Use Disorder

Treatment of OUD in the ARTS program was based on ASAM's National Practice Guidelines.[41] Along with guidelines for MOUD treatment, ASAM recommends a number of practices in combination with MOUD treatment, such as regular toxicology testing, assessment of and referral for psychosocial needs, testing for HIV and hepatitis C, and prescribing of naloxone. ASAM also recommends against the prescribing of opioid pain medications or benzodiazepine medications during MOUD treatment. Although ASAM does not specify a minimum length of MOUD treatment, six months of continuous treatment has frequently been used as a minimum threshold, although many clinicians recommend even longer treatment periods.

As mentioned previously, Virginia Medicaid is promoting and incentivizing high quality treatment through a new model of care, the Preferred OBOT programs, of which there are now over 150 throughout the Commonwealth. Similar standards of care are also being promoted at the 39 Outpatient Treatment Programs that dispense Methadone and buprenorphine for OUD treatment. Treatment of OUD may also be provided by other outpatient practitioners who are part of MCO networks, such as private psychiatric or primary care practices.

To examine quality of care, we identified episodes of treatment for OUD at outpatient providers. An outpatient "episode" of treatment is defined as a single continuous period of outpatient treatment for OUD, beginning with the first claim for MOUD or other outpatient treatment for OUD with no other claim in the prior 90 days, and ending with the last claim for outpatient or MOUD treatment after which there are no additional treatment claims for at least 90 days. Episodes were also required to meet two other criteria: (1) the member had continuous Medicaid enrollment in the 90 days before and after the index claim, with no more than a 14 day break; (2) there are at least two claims for ARTS services in the episode (that is, episodes comprised of only a single claim are excluded). Based on this definition, we identified all episodes of outpatient treatment that began between January 1, 2018 and June 30, 2019.

In the analysis of the episodes of outpatient treatment, we further distinguish between episodes that largely occurred at Preferred OBOT providers, OTP providers, and other outpatient providers of OUD treatment. These distinctions are made based on the treatment received in the first 60 days of treatment. Therefore, Preferred OBOT episodes include those in which claims during the first 60 days occurred at Preferred OBOT providers, and there were no claims for OTP providers. OTP episodes include those in which claims during the first 60 days include only those for Methadone treatment or other claims for OTP providers, and no other claims for Preferred OBOT or other outpatient treatment providers. Episodes at other outpatient treatment providers are defined based on claims for the outpatient treatment for OUD at providers other than Preferred OBOTs and OTPs during the first 60 days of treatment. As there is often switching between treatment providers among patients, it should be noted that these definitions are intended to reflect the primary source of treatment during the first 60 days, although treatment received during an episode may reflect that of multiple providers.

Overall length of treatment.

There were 8,053 outpatient treatment episodes for OUD that began between January 1, 2018 and June 30, 2019. About one-fourth of these episodes began at Preferred OBOT providers (25.6%), while 27.2% of episodes began at OTP providers. Almost half of outpatient episodes began at outpatient providers other than Preferred OBOTs and OTPs.

The median length of the episode was 93 days, or just over 3 months. However, there was wide variation in the length of the episode. While 25% of episodes lasted 38 days or less, 25% lasted 242 days or longer. Episodes at OTPs lasted substantially longer (median of 136 days) than episodes at Preferred OBOT providers (median of 78 days), while the median length at other outpatient providers was 92 days.

Episodes of outpatient care for OUD for episodes that began between 1/1/18 and 6/30/19.

		Primary source of treatment in first 60 days		
	All Episodes	Preferred OBOT[1]	OTP/ Methadone clinic[2]	Other outpatient[3]
Number of episodes[+]	**8,053**	**2,063**	**2,192**	**3,798**
Median number of days in treatment	93	78	136	92
25th and 75th percentile values for length of treatment	38-242	35-191	49-296	37-236
Percent with any MOUD treatment	71.5%	80.8%	89.1%	56.2%
Any Buprenorphine	48.4%	77.9%	13.5%	52.5%
Any Methadone	23.8%	2.2%	78.9%	3.7%
Any Naltrexone	1.4%	2.3%	0.5%	1.3%
Median number of months with any MOUD treatment, among those with MOUD	4	3	4	4
25th and 75th percentile values for months on MOUD treatment	2-9	2-6	2-9	2-10
Percent with any claim for Naloxone	17.3%	30.5%	6.4%	16.5%

[+]Episodes are defined as a continuous period of outpatient or MOUD treatment for OUD with at least 2 claims for ARTS services. The index claim for an episode reflects the first claim for outpatient or MOUD after a 90 day period or longer with no such treatment. The end of an episode is defined as the last claim for which there were no additional claims for outpatient or MOUD treatment for at least 90 days. Members are required to be continuously enrolled in Medicaid for 90 days before and after the index claim, with no longer than a 14 day break.

[1]Had Preferred OBOT, but no OTP provider claims in first 60 days.

[2]Had OTP provider claims and no Preferred OBOT or other outpatient provider claims, or had Methadone treatment only in first 60 days.

[3]Had no Preferred OBOT, OTP, or Methadone claims in first 60 days.

MOUD treatment

Among all outpatient episodes of treatment for OUD, 71.5% involved the use of some type of MOUD, including buprenorphine (48.4%), methadone (23.8%) or naltrexone (1.4%). MOUD treatment was more frequently used at Preferred OBOT and OTP providers (80.8% and 89.1%, respectively) compared to other outpatient treatment providers (56.2%). As expected, Methadone was much more frequently used at OTP providers compared to Buprenorphine, while Buprenorphine treatment (vs naltrexone) was used at Preferred OBOT and other outpatient providers.

Among those who received MOUD treatment, the median length of treatment was 4 months, based on the consecutive number of months during the episode in which there were any claims for any type of MOUD treatment. Length of MOUD treatment varied considerably, lasting only 2 months or less for 25% of episodes, and 9 months or longer for another 25 percent of episodes. Length of MOUD treatment was somewhat longer for those receiving MOUD treatment at OTP providers (median of 4 months) compared to those receiving treatment at Preferred OBOT (median of 3 months).

Naloxone was prescribed during 17.3% of episodes, with higher prescribing rates during Preferred OBOT episodes (30.5%) compared to OTP (6.4%) and other outpatient episodes (16.5%).

Use of counseling or psychotherapy for treatment of OUD.

Counseling or psychotherapy for the treatment of OUD was used for 61.5% of episodes. Counseling/psychotherapy was used more often at OTP providers (78.8%), compared to 67.2% of episodes at Preferred OBOT providers, and 48.3% for other outpatient providers. Among episodes involving counseling or psychotherapy, the median number of visits was 6, or about 2 visits per month based on the median length of treatment. The number of visits was somewhat lower at Preferred OBOT providers compared to OTP and other outpatient providers.

Claims for urine drug screens (UDS)

At least one claim for UDS occurred for 80.9% of episodes, with episodes at Preferred OBOTs having a higher percentage of any UDS claim (88.7%) compared to OTP (74.9%) and episodes at other outpatient providers (80.2%). Among episodes with a UDS claim, the median number of UDS claims was 6, averaging about 2 per month. The number of UDS claims (for episodes with any) was somewhat lower at other outpatient providers compare to Preferred OBOT and OTP.

Other services received during the episode

More than one-third of episodes (36.9%) involved at least one claim for care coordination services. Rates of care coordination were higher for episodes that began at Preferred OBOT and OTP providers (40.8% and 50.1%, respectively) than episodes that began at other outpatient providers (27.3%). Claims for peer recovery services were rare, involving only 2.9% of episodes.

Use of psychotherapy, counseling, urine drug screens, and other services

		Primary source of treatment in first 60 days		
	All Episodes	Preferred OBOT[1]	OTP/ Methadone clinic[2]	Other outpatient[3]
Number of episodes[+]	**8,053**	**2,063**	**2,192**	**3,798**
Percent with any claim for psychotherapy, counseling related to OUD	61.5%	67.2%	78.8%	48.3%
Median number of claims for psychotherapy or counseling, among those with at least one claim	6	5	7	7
Percent with any claim for UDS during episode	80.9%	88.7%	74.9%	80.2%
Median number of UDS claims during episode, among those with any those with at least one claim	6	6	6	5
Percent with any care coordination claim	36.9%	40.8%	50.1%	27.3%
Percent with any peer recovery support service claims	2.9%	6.6%	0.2%	2.4%

[+]Episodes are defined as a continuous period of outpatient or MOUD treatment for OUD with at least 2 claims for ARTS services. The index claim for an episode reflects the first claim for outpatient or MOUD after a 90 day period or longer with no such treatment. The end of an episode is defined as the last claim for which there were no additional claims for outpatient or MOUD treatment for at least 90 days. Members are required to be continuously enrolled in Medicaid for 90 days before and after the index claim, with no longer than a 14 day break.
[1]Had Preferred OBOT, but no OTP provider claims in first 60 days.
[2]Had OTP provider claims and no Preferred OBOT or other outpatient provider claims, or had Methadone treatment only in first 60 days.
[3]Had no Preferred OBOT, OTP, or Methadone claims in first 60 days.

Co-prescribing of opioids and benzodiazepines

Members received at least one prescription for opioid pain medications during 13.8% of episodes. However, opioid prescribing was considerably higher during episodes of treatment at OTP providers (20.8%) compared to 7.6% during episodes at Preferred OBOT providers and 13.1% at other outpatient providers. Higher opioid co-prescribing rates at OTP providers may reflect in part the fact that Methadone treatment is not reported on Virginia's Prescription Drug Monitoring Program (PDMP), a database that allows physicians and other providers to check for the use of controlled substances by their patients. Therefore, some practitioners may be prescribing opioids to patients without knowing that they are receiving Methadone treatment for OUD, combined with screening practices for opioid use by some OTPs. Benzodiazepines are prescribed for 13.1% of episodes, with higher prescribing rates (15.4%) occurring during episodes at other outpatient providers.

Co-prescribing of prescription opioids and benzodiazepines during an episode of treatment for OUD.

	All episodes	Primary source of treatment in first 60 days		
		Preferred OBOT[1]	OTP/Methadone clinic[2]	Other outpatient[3]
Number of episodes[+]	**8,053**	**2,063**	**2,192**	**3,798**
Percent with any opioid prescription during episode	13.8%	7.6%	20.8%	13.1%
Percent with any prescription for benzodiazepines during episode	13.1%	11.9%	10.3%	15.4%

[+]Episodes are defined as a continuous period of outpatient or MOUD treatment for OUD with at least 2 claims for ARTS services. The index claim for an episode reflects the first claim for outpatient or MOUD after a 90 day period or longer with no such treatment. The end of an episode is defined as the last claim for which there were no additional claims for outpatient or MOUD treatment for at least 90 days. Members are required to be continuously enrolled in Medicaid for 90 days before and after the index claim, with no longer than a 14 day break.

[1]Had Preferred OBOT, but no OTP provider claims in first 60 days.

[2]Had OTP provider claims and no Preferred OBOT or other outpatient provider claims, or had Methadone treatment only in first 60 days.

[3]Had no Preferred OBOT, OTP, or Methadone claims in first 60 days.

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

Comparisons with other states are important for understanding whether changes in treatment for SUD and OUD observed for Virginia may reflect more general trends nationally, as well as how Virginia Medicaid compares with other states on measures of treatment utilization and quality. Cross-state comparisons of service utilization using administrative claims data have historically been challenging, since definitions of services, billing codes, and data structures often differ across state Medicaid agencies.

To enhance cross-state comparisons, VCU and DMAS participate in the MODRN, a collaboration of state-university partnerships through AcademyHealth established for the purpose of comparing state Medicaid programs on key measures of SUD and OUD treatment access and quality of care based on a common data model.[42] Funded by a grant from the National Institute on Drug Abuse, MODRN currently includes 13 states (DE, KY, MD, MA, ME, MI, NC, OH, PA, UT, VA, WV, WI). The analysis below includes results from 11 states in the MODRN (including Virginia) that account for over 16 million Medicaid enrollees (about one-fourth of enrollees nationally) as well as 6 of the 10 states with the highest drug overdose rates.

In this chapter, we compare Virginia Medicaid members on selected measures of OUD prevalence, MOUD treatment, and MOUD quality of care developed through the MODRN. Estimates for Virginia may differ to some extent from comparable measures reported in previous sections of this report due to differences in the definition of measures and sample inclusion criteria. For example, the MODRN analysis is restricted to members ages 12-64, with 6 months or more of continuous enrollment, and excludes dual Medicare/Medicaid eligibles.

Diagnosed prevalence of MOUD.

Diagnosed prevalence of OUD is considerably lower among Virginia Medicaid members compared to members in other MODRN states. Some of this difference may reflect the somewhat higher rate of prevalence among members enrolled in Medicaid expansion: most other states in MODRN had expanded Medicaid prior to 2019. The difference may also reflect the high overdose and prevalence rates in many of the MODRN states, relative to Virginia.[43] Both Virginia and the other MODRN states observed small increases in diagnosed prevalence of OUD between 2016 and 2018.

Diagnosed prevalence of OUD among Virginia Medicaid members ages 12-64 compared to Medicaid members in other MODRN states.

	2016	2017	2018	Percentage point change 2016 - 2018
Percent of members with a diagnosis of OUD				
Virginia	1.5%	1.9%	2.2%	+0.7
Other MODRN states	4.7%	5.0%	5.2%	+0.5

[1]Includes members with OUD diagnosis.

There are some notable differences between Virginia and other MODRN states in the characteristics of members with an OUD diagnosis. Virginia Medicaid members with an OUD are somewhat older, much more likely to be female compared to males, more likely to be black compare to white, and somewhat more likely to be living in rural areas compared to other MODRN states. While over half of members with an OUD in other MODRN states are enrolled through Medicaid expansion, Virginia Medicaid members were much more likely to be enrolled through adult disabled and non-disabled categories in the year prior to Medicaid expansion.

Characteristics of Medicaid members with an OUD diagnosis in 2018

	Percent of members with OUD diagnosis	
	Virginia	Other MODRN states
All Members	2.2%	5.2%
Age Group		
12-20	1.2%	1.5%
21-34	35.1%	41.9%
35-44	28.7%	29.4%
45-54	19.3%	16.9%
55-64	15.7%	10.3%
Gender		
Female	66.3%	51.2%
Male	33.7%	48.8%
Race/Ethnicity		
Non-Hispanic White	79.1%	76.2%
Non-Hispanic Black	19.4%	13.8%
Hispanic	0.1%	2.9%
Other/Unknown	1.4%	7.1%
Eligibility Group		
Pregnant	5.1%	5.6%
Youth	1.1%	1.4%
Disabled Adults	41.1%	17.1%
Non-Disabled	52.7%	24.6%
Medicaid Expansion Adults	Not applicable	51.3%
Living Area		
Urban	69.0%	73.3%
Rural	31.0%	26.4%
Missing Urban/Rural Category	0%	0.2%

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

Rate of MOUD treatment among Virginia Medicaid members ages 12-64 compared to Medicaid members in other MODRN states.

	2016	2017	2018	Percentage point change 2016 - 2018
MOUD treatment rate[1]				
Virginia	33.6%	44.1%	55.0%	+21.4
Other MODRN states	48.7%	52.9%	57.3%	+8.6

[1]Includes members with OUD diagnosis.

Quality of MOUD treatment. About half of Virginia Medicaid members receiving MOUD treatment in 2017-18 stayed on treatment continuously for at least 180 days or longer, which is slightly lower compared to members in other MODRN states. However, the percentage of Virginia Medicaid members with 180 day continuity of MOUD treatment decreased during the study period, from 60.7% in 2015-16 to 52.6% in 2017-2018. The decrease may be related to the large increase in the number of Virginia Medicaid members receiving MOUD treatment during this period (as shown above), as well as the increase in providers who are offering and providing MOUD treatment to Medicaid members. Rates of continuity of MOUD treatment could be lower for those patients who are relatively new to MOUD treatment, for example, if their addiction is less severe compared to utilizers of MOUD treatment in prior years.

Conversely, the percent of Virginia Medicaid members receiving counseling services during MOUD treatment increased by 32 percentage points between 2015-16 and 2017-18, compared to a 6.3 percentage point increase among members in other MODRN states. Co-prescribing for opioid pain medications and benzodiazepines have decreased in recent years among both Virginia Medicaid members and members in other states who are receiving MOUD treatment, although co-prescribing rates for benzodiazepines are still higher in Virginia compared to the other MODRN states.

Quality of treatment among Virginia Medicaid members receiving MOUD treatment, compared to Medicaid members in other MODRN states.

	2015 – 2016[1]	2016 – 2017[1]	2017 – 2018[1]	Percentage point change across 3 year period
Continuous MOUD treatment for 180 days or longer				
Virginia	60.7%	56.1%	52.6%	-8.1
Other states	56.1%	55.9%	56.0%	-0.1
Any urine drug screens				
Virginia	78.8%	83.3%	85.3%	+6.5
Other states	84.7%	86.2%	86.7%	+2.0
Any counseling services				
Virginia	43.7%	56.9%	75.8%	+32.1
Other states	78.2%	83.2%	84.5%	+6.3
Any prescription for opioids				
Virginia	50.7%	44.8%	38.2%	-12.5
Other states	50.7%	44.5%	35.4%	-15.3
Any prescriptions for benzodiazepines				
Virginia	46.1%	40.0%	30.8%	-15.3
Other states	28.5%	24.9%	21.5%	-7.0

[1]Reflects two year averages

Patient Experience With ARTS Services

Positive experiences and interactions with treatment providers among patients may have important implications for the quality of care they receive, including treatment adherence and treatment outcomes.[44] Use of survey tools to assess patient experience – such as the Consumer Assessment of Health Plans Survey (CAHPS) – have been used across a variety of medical settings, and is an important component of several value-based payment initiatives by the Centers for Medicare and Medicaid Services. [45]

The ARTS member survey included a number of questions assessing the patient experience with ARTS treatment services, adapted from a version of the CAHPS designed to assess behavioral treatment providers.[46] We compare patient experiences based on members' use of Preferred OBOT, OTP, and other outpatient treatment providers, identified based on Medicaid claims data at the time of survey sampling.

Selected results from the analysis of survey data are presented in this chapter. Results indicate that the majority of survey respondents have positive experiences with the treatment they are receiving. While patient experience is roughly similar for members using Preferred OBOT, OTP, and other outpatient providers, experiences differ considerably based on co-occurring health factors.

Timeliness, communication, and trust with providers

	Able to see someone as soon as you wanted, if needed[1]	Explains things in a way you could understand[1]	Shows respect for what you had to say[1]	Made you feel safe[1]
Total Responses	508	742	743	746
Responded Affirmatively	67.5%	83.6%	84.5%	90.1%
Type of provider				
Preferred OBOT	68.6%	85.6%[a]	87.7%[a]	90.3%[a]
OTP	65.9%	79.0%	81.1%	90.3%
Other	70.5%	88.8%	87.4%	93.5%

Source: ARTS member survey. [a]Group differences for measure are statistically significant at .05 level based on chi square tests. [1]Estimates reflect the percentage of sample persons who responded "usually" or "always" to each question, versus "never" or "sometimes".

Timeliness of care. About two-thirds of survey respondents reported that there was a time in the past 12 months when they needed treatment or counseling for their substance use (findings not shown). Among these, 67.5% reported that they were usually or always able to see someone as soon as they wanted. Timeliness of care did not vary by treatment setting.

Communication and trust. Most survey respondents reported strong communication with and trust in their providers, including 83.6% who reported that the provider usually or always explained things in a way that they could understand; 84.5% reported that the provider usually or always showed respect for what they had to say; and 90.1% reported that they usually or always felt safe with the people they went to for counseling or treatment. The level of communication and trust was high across all three provider types, although members using OTP services had somewhat lower levels on two of the three measures compared to OBOT and other outpatient providers.

Patient involvement with treatment. Survey respondents also reported a high level of involvement with their treatment, including 84.8% reporting that they were usually or always involved with their treatment as much as they wanted; 73.7% reported that they were given information about different types of counseling or treatment available; and 72.1% reported that they felt able to refuse a specific type of medicine or treatment. There were small differences in patient involvement by provider type.

Patient involvement in treatment, discontinuation of treatment

	Involved in treatment as much as you wanted[1]	Provided information about different treatment options[2]	Felt able to refuse a specific type of medicine or treatment[2]	Stopped treatment against advice of doctor[2]
Total Responses	741	749	749	734
Responded Affirmatively	84.8%	73.7%	72.1%	16.6%
Type of provider				
Preferred OBOT	86.9%[a]	72.8%	70.2%[a]	17.0%[a]
OTP	83.3%	72.5%	72.2%	11.5%
Other	88.3%	79.2%	78.0%	19.7%

Source: ARTS member survey. [a]Group differences for measure are statistically significant at .05 level based on chi square tests.
[1]Estimates reflect the percentage of sample persons who responded "usually" or "always" to the question.
[2]Estimates reflect the percentage of sample persons who responded "yes" to the question.

Discontinuation of treatment. About 17% of members using ARTS services reported that they had stopped their treatment in the past 12 months against the advice of their doctor or counselor. Survey respondents who were treated at OTP facilities were less likely to report stopping treatment (11.5%) compared to respondents who received treatment at Preferred OBOTs or other outpatient providers.

Survey respondents who had more positive treatment experiences with treatment providers were less likely to report discontinuing their treatment, compared to respondents who reported fewer positive experiences with treatment. To assess this, we summed responses to the six items relating to communication, trust, and patient involvement with treatment. Respondents who agreed with the statements on all six items were considered to have the most positive experiences with treatment providers, while those who agreed with only a few or no items had the least positive experience.

Respondents who had the least favorable experience with treatment providers (agreed on 3 or fewer items) were by far the most likely to stop treatment (32.4%) compared to those with the most positive experiences with treatment providers (agreed on all six items) (12.5%).

Discontinuation of treatment by extent of positive experiences with treatment providers

	Number of survey respondents	Percent who stopped treatment against the advice of their doctor
Total	708	16.6%
Most positive experience with providers (agreed on all 6 patient experience items)	353	12.5%
Moderately positive experience with providers (agreed on 4-5 patient experience items)	250	16.0%
Least positive experience with providers (agreed on 3 items or fewer)	105	32.4%

Source: ARTS member survey. Summary measure reflects the number of positive responses on (1) Explains things in a way you can understand; (2) Shows respect for what you had to say; (3) made you feel safe; (4) Involved in treatment as much as you wanted; (5) Provided information on different treatment options; (6) Felt able to refuse a specific type of treatment.

Survey respondents provided a variety of other reasons for stopping treatment, including the lack of effectiveness of treatment, convenience of being able to get to treatment providers, potential stigma associated with treatment (i.e. felt nervous or uncomfortable about treatment), and issues related to coverage and approval for treatment from their Medicaid health plans. However, no single reason stood out as to why members discontinued treatment.

Difference in patient experience by co-occurring health factors

Respondents with co-occurring health problems tended to have less favorable experiences with treatment and are more likely to discontinue their treatment. For example, respondents who reported that their health was "fair or poor" were almost twice as likely to report having discontinued with their treatment (20.8%) compared to members who reported excellent or good health (10.6%). Almost one-fourth of members with co-occurring psychological distress (23.2%) reported discontinuing their treatment, compared to only 4.2% of members who had no or mild psychological distress.[iv] Also, polysubstance users – survey respondents who reported using two or more addictive substances in the past year – were much more likely to report discontinuing treatment (23.0%) compared to those using one or no substances (8%).

[iv] The measure of psychological distress is based on the Kessler six item measure, which results in a score between 0 and 24. Consistent with recommendations and prior research, a score of 13 or higher is considered to indicate serious psychological distress.

Discontinuation of treatment by co-occurring health factors

	Number of survey respondents	Percent who stopped treatment against the advice of their doctor
Total	734	16.6
Polysubstance user[1]		
Yes	406	23.9%[a]
No	312	8.0%
General health status		
Excellent or very good	132	10.6%[a]
Good	290	16.6%
Fair or poor	289	20.8%
Serious psychological distress[2]		
Yes	461	23.2%[a]
No	240	4.2%

Source: ARTS member survey. [a]Group differences for measure are statistically significant at .05 level based on chi square tests. [1]Used two or more substances in the past year, including alcohol. [2]Based on a score of 13 or higher from the six item Kessler index of psychological distress.

Changes to personal and social life related to treatment

The ARTS member survey also assessed changes to respondent's personal, social, and employment circumstances as a result of having received treatment. These questions were adapted from a questionnaire used to assess substance use treatment services among providers participating in the Centers of Excellence program in Pennsylvania.[47] Most respondents reported positive impacts of treatment on a number of aspects of their lives. Among these findings (based on agreeing or strongly agreeing with the following statements):

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

There were few differences in respondent assessments of the impact of treatment by provider type. However, as with patient experience, treatment impact varied considerably by other respondent health factors. For example, among respondents who reported fair or poor health, 50.5% reported that their housing situation had improved, compared to 78.6% of those in excellent or very good health. Improvements in housing were lower among those with serious psychological distress (51.8%) compared

to those with no or mild distress (83.3%). Polysubstance users experienced less improvement in their housing (56.8%) compared to those who used none or one substance (70.2%).

Changes to personal life as a result of treatment - Percent who agree or strongly agree about the effects of treatment on their lives

	More confident about not being dependent on drugs or alcohol	Housing situation has improved	Employment situation has improved
Total Responses	730	734	699
Responded Affirmatively	81.6%	62.8%	42.8%
Type of provider			
OBOT	81.4%	62.8%	46.1%
OTP	83.5%	64.6%	39.9%
Other	81.9%	61.3%	42.4%
Polysubstance user[1]			
Yes	76.3%[a]	56.8%[a]	36.5%[a]
No	88.8%	70.9%	51.6%
General health status			
Excellent or very good	92.4%[a]	78.6%[a]	60.8%[a]
Good	85.8%	66.7%	50.5%
Fair or poor	72.6%	50.5%	25.1%
Serious psychological distress[2]			
Yes	75.9%[a]	51.8%[a]	30.3%[a]
No	94.5%	83.3%	66.8%

Source: ARTS member survey. [a]Group differences for measure are statistically significant at .05 level based on chi square tests. [1]Used two or more substances in the past year, including alcohol. [2]Based on a score of 13 or higher from the six item Kessler index of psychological distress.

Health Equity and Disparities in Substance Use Treatment Services among Medicaid Members

Protests against racial discrimination, promoting economic and social justice, and the persistent and often wide disparities that have been observed in health and health care by race/ethnicity, income, region, and other factors have intensified calls for the promotion of health equity as a major goal of health policy. Health equity refers to the goal "that everyone has a fair and just opportunity to be as healthy as possible."[48] "Health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups."[49]

Prevalence of illicit drug dependence or abuse in Virginia, ages 12 and older

	Percent with illicit drug dependence or abuse in past year
Virginians, ages 12 and older	2.5%
Race/ethnicity	
White, non-Hispanic	2.7%
Black, non-Hispanic	4.0%
Hispanic	1.5%
Other	0.8%
Income relative to federal poverty level (FPL)	
<100% FPL	4.4%
100-200% FPL	2.6%
>200% FPL	2.1%
Education	
Less than H.S.	5.9%
H.S. graduate	2.8%
Some college	3.0%
College degree or higher	0.8%
Employment	
Full-time	2.3%
Part-time	2.5%
Unemployed	7.3%
Not in labor force	2.2%

Source: National Survey of Drug Use and Health, 2017-18

Differences among individuals and communities in economic and educational opportunities, health care access, food and housing stability, and public safety likely contributes to increased incidence of SUD.[50] For example, rates of illicit drug dependence or abuse among Virginians are higher among those who are unemployed and have less than a high school education, compared to adults who are employed full time and have a college education.

Illicit drug dependence or abuse is also higher among those with family incomes below the poverty level relative to those with incomes above 200% of poverty. Black members have a slightly higher rate of illicit drug dependence or abuse compared to White members, although the difference is not statistically significant.

However, these same factors may also lead to widely different outcomes among individuals who experience SUD. As noted earlier, there are wide disparities in treatment rates for SUD and OUD among Medicaid members by race/ethnicity. Among members with any SUD diagnosis, 56% of White members received some type of treatment during 2019, compared to 40% of Black members, and 45% among other racial/ethnic groups. Among members with any OUD diagnosis, 61% of White members received MOUD treatment, compared to 48% of Black members and 54% among other racial/ethnic groups.

In this chapter, we explore in greater detail some of the possible sources of racial/ethnic disparities in treatment rates, including availability of treatment providers, differences in initiation and engagement with treatment, patient experiences, and quality of treatment. In addition, we examine the role of social factors in members' experience with treatment that may or may not be correlated with racial/ethnic disparities, including the high rate of housing and food insecurity, unemployment, social isolation, and involvement with the criminal justice system.

Differences in access to ARTS treatment providers among Virginia counties

Despite the expansion of treatment providers since implementation of the ARTS program, the distribution of treatment providers across Virginia counties and other localities is uneven. More than two-thirds of counties have at least one buprenorphine-waivered prescriber, one out of 5 counties has an OTP provider, and 46% of counties have an Preferred OBOT provider.

Not surprisingly, availability of treatment providers tends to vary the most by rural/urban areas. Counties in large metropolitan areas (1 million or people) are more likely to have waivered prescribers (79%), OTP providers (35%) and Preferred OBOT providers (54%) compared to rural areas. However, the number of waivered prescribers relative to the population tends to be higher in rural areas (16.2 prescribers per 100,000 people) compared to large metro areas (10.8 prescribers per 100,000), indicating that urban areas potentially have greater problems with treatment capacity.

There are differences in the availability of treatment providers across counties in metropolitan areas, but not necessarily along the lines that would suggest income and racial/ethnic-related disparities in access. Metropolitan counties with the lowest per capita income are more likely to have a waivered prescriber (92%), a higher relative number of waivered prescribers (19 per 100,000 people), and an OBOT provider (65%) relative to counties with the highest per capita income.

Availability of addiction treatment providers in Virginia counties

	Percent with any Buprenorphine waivered prescriber	Total waivered prescribers per 100,000 people	Percent of counties with any OTP	Percent of counties with any Preferred OBOT provider
All localities in VA	68%	13.9	21%	46%
Large metropolitan	79%	10.8	35%	54%
Small metropolitan	70%	14.9	24%	59%
Rural	56%	16.2	4%	27%
Per capita income (metro only)[1]				
< $22,668	92%	19.0	33%	65%
$22,668 - $32,648	65%	10.9	28%	52%
>$32,648	83%	12.6	33%	56%
Share of people in county who are Black (metro only)[1]				
<6.3%	76%	13.8	18%	58%
6.3% - 30%	71%	10.0	25%	53%
>30%	85%	18.1	55%	60%

[1]Categories based on quartile values of per capita income and percent black in the county.

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

Initiation and engagement with treatment

The rate at which individuals initiate and engage with treatment (IET), once they are diagnosed, was developed by the National Center for Quality Assurance (NCQA) and is included as a core measure for the Medicaid program.[51] The measure is useful for understanding disparities in members gaining entry to the system after receiving a diagnosis and engaging with timely treatment. The measure was developed as part of the multi-state Medicaid Outcomes Distributed Research Network (MODRN) (See Appendix), of which VCU and DMAS are participating members.

Virginia Medicaid members who initiated and engaged with treatment for SUD and OUD

	Percent initiated treatment	Percent initiated and engaged with treatment
All members receiving treatment for SUD	43.5%	13.5%
Race		
White	44.0%	16.6%
Black	42.9%	8.3%
Living Area		
Urban	43.9%	12.3%
Rural	42.5%	17.1%
All members receiving treatment for OUD	48.8%	26.1%
Race		
White	48.8%	28.2%
Black	48.8%	19.3%
Living Area		
Urban	50.5%	24.7%
Rural	45.3%	28.9%

Source: Medicaid Outcomes Distributed Research Network

Overall, about 44% of members initiated treatment within 14 days of a SUD diagnosis in 2018, a rate that is similar for Black members and White members, as well as for members living in urban and rural areas.

However, Black members are less likely to initiate *and engage* with treatment following an initial diagnosis, meaning they had two or more additional treatment services or MOUD within 34 days of the initiation visit. Among Black members with any SUD diagnosis, only 8% initiated and engaged with treatment, compared to 17% of White members. Members in rural areas are also more likely to initiate and engage with treatment (17.1%) compared to members in urban areas (12.3%). Differences by race and rural/urban residence in rates of initiation and engagement with treatment for OUD services were similar to overall SUD.

While rates of initiation were identical between Black members and White members, 19% of Black members with OUD initiated and engaged with treatment, compared to 28% of White members. Urban residents were somewhat more likely to initiate OUD treatment compared to rural residents, while the latter were somewhat more likely to initiate and engage with treatment than urban residents.

Racial and ethnic disparities in engaging with treatment may be driven by a number of factors, such as distance or transportation barriers to treatment providers, the ability to get appointments at a time that is convenient for patients, the quality of care received, and discrimination or biases against racial/ethnic minorities that may affect trust, communication, and confidence in the treatment providers.

Quality of outpatient treatment services

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

Characteristics of episodes of outpatient treatment for OUD

	White members	Black members
Number of outpatient episodes of OUD treatment	**6,431**	**1,490**
Provider type in first 60 days of treatment		
OBOT[1]	24.7%	29.1%
OTP/Methadone[2]	24.9%	37.8%
Other outpatient provider[3]	50.4%	33.2%
Median number of days in treatment	99	86
25th and 75th percentile	42-248	34-217
MOUD treatment		
Percent with any MOUD	72.0%	69.7%
Any Buprenorphine	51.0%	36.7%
Any Methadone	21.7%	33.6%
Any naltrexone	1.4%	1.2%
Median number of months with MOUD treatment, for those with any	4	3
25th and 75th percentile	2-9	2-8
Number with any claim for naloxone	18.1%	14.4%

	White members	Black members
Other treatment services		
Percent with any claim for psychotherapy or counseling (OUD as primary DX)	61.2%	63.1%
Median number of claims for psychotherapy or counseling, for those with any	7	5
Percent with any claim for UDS	83.4%	70.7%
Median number of UDS claims, for those with any	6	5
Percent with any care coordination claim	40.0%	24.6%
Co-prescribing		
Percent with any opioid prescription	13.2%	16.2%
Percent with any prescription for benzodiazepine	14.2%	8.5%

[1]Based on NPI of provider – had no OTP provider claims in first 60 days. [2]Based on NPI of provider – had no OBOT or other ASAM 1 provider claims in first 60 days or Methadone treatment only in first 60 days. [3]Had no OBOT or OTP claims in first 60 days

Race, social factors, and the patient experience with treatment

Disparities in SUD treatment by race/ethnicity may be related in part to different social and economic circumstances between White and Black Medicaid members. Findings from the ARTS Member Survey show that 16.2% of members receiving treatment reported not having housing or were concerned about losing housing (housing insecure), 69.5% reported food insecurity (not able to afford enough food to last) 35.1% were unemployed, and 9% having no social support (no one they could count on if they had serious problems). In addition, 17% of ARTS survey respondents reported that they had been in jail or prison for at least one night during the past 12 months.

Black Medicaid members were twice as likely as White members to report housing insecurity (27% of Black members were housing insecure compared to 14% for White members). An equal percentage of Black members and White members reported they had stayed overnight or longer in jail or prison during the past 12 months (17%). Black members also lacked social support to a greater extent than White members: 14% of Black members reported that they had no one they could count on if they had serious problems (compared to 8% for White members), although a higher percentage of Black members reported 3 or more close contacts compared to White members.

Differences in social factors, by race.

	All Respondents	Non-Hispanic White	Non-Hispanic Black
Housing insecure (p<.001)			
Yes	16.2%	13.5%	26.7%
No	83.8%	86.5%	73.3%
Food insecure (p=0.655)			
Yes	69.5%	69.2%	70.8%
No	30.5%	30.8%	29.2%
Employment status (p=0.556)			
Employed	23.8%	24.2%	22.4%
Unemployed	35.1%	34.2%	38.3%
Not in labor force	41.1%	41.5%	39.3%
Social support (p<0.001)			
None	9.0%	7.9%	14.2%
1 or 2	50.7%	54.9%	39.3%
3 or more	38.5%	37.2%	46.5%
Prison/jail stay (p=0.853)			
Yes	17.0%	17.1%	16.6%
No	83.0%	82.9%	83.4%

Source: ARTS member survey. p values reflect the results of chi-square tests of differences in characteristics between White members and Black members.

Patient experiences with treatment vary to some extent by race. Compared to White members, Black members receiving treatment were **less likely to agree** that; (1) the treatment provider showed respect for what they had to say; (2) made them feel safe; and (3) involved them in treatment as much as they wanted (see table on following page). The largest disparity was that fewer Black members felt able to refuse a specific treatment (59%) compared to White members (76%). Perhaps because of this, fewer Black members reported that they discontinued treatment against the advice of doctors (12%) compared to White members (17%), although the difference was not statistically significant. In sum, there is some indication that Black members are somewhat less satisfied than White members with the treatment they are receiving, but less likely to perceive that they have other options.

Social factors are more strongly associated with patient experiences than race/ethnicity. For example, respondents with insecure housing were twice as likely to report having discontinued treatment (28%) compared to those with housing security (14%). Similarly, those who lacked food security and had been incarcerated in the past year were more likely to discontinue treatment, relative to those with food security and had not been in jail or prison.

Experiences and perceptions about addiction treatment providers, by race/ethnicity and social factors.

	Able to see someone as soon as you wanted, if needed[1]	Explains things in a way you could understand	Shows respect for what you had to say	Made you feel safe	Involved in treatment as much as you wanted	Provided information about different treatment options	Felt able to refuse a specific type of medicine or treatment	Stopped treatment against advice of doctor
Race/ethnicity								
White, non-Hispanic	69.9%	85.9%	86.3%[a]	91.7%[a]	87.7%[a]	74.5%	76.1%[a]	17.4%
Black, non-Hispanic	61.4%	79.7%	83.8%	86.6%	78.2%	73.2%	58.7%	12.1%
Housing insecure								
Yes	63.9%	80.5%	82.7%	85.7%[a]	78.2%[a]	69.9%	67.7%	27.5%[a]
No	68.5%	85.1%	85.4%	91.5%	86.9%	74.9%	73.2%	14.2%
Food insecure								
Yes	62.9%[a]	80.3%[a]	81.9%[a]	88.7%[a]	81.7%[a]	71.8%[a]	71.7%	18.7%[a]
No	80.8%	92.1%	91.1%	93.6%	93.1%	79.5%	74.5%	11.0%
Employment status								
Employed	71.4%	85.8%	86.2%	94.7%[a]	86.8%	75.5%	80.7%[a]	13.5%
Unemployed	63.4%	80.9%	83.6%	87.8%	81.5%	74.4%	66.0%	18.9%
Not in LF	69.5%	88.3%	87.9%	91.1%	87.2%	73.8%	73.6%	16.9%
Social support								
None	44.2%[a]	64.9%[a]	67.5%[a]	70.5%[a]	61.5%[a]	50.0%[a]	62.3%	22.4%
1 or 2	66.2%	84.0%	83.4%	91.8%	86.6%	75.1%	72.8%	17.6%
3 or more	76.7%	88.8%	92.2%	94.4%	89.5%	78.8%	74.6%	14.2%
Jail/prison in past year								
Yes	57.7%[a]	80.7%	81.1%	87.9%	79.3%[a]	74.1%	71.6%	26.5%
No	71.6%	85.3%	85.7%	91.3%	87.1%	74.1%	72.5%	13.7%

Source: ARTS member survey. [1]Defined as reporting that they did not need treatment right away or that they needed it and usually or always were able to see someone as soon as possible. [a]Group differences for measure are statistically significant at .05 level based on chi square tests.

There were few statistically significant differences between Black members and White members in how they assessed the impact of treatment on their lives. For example, roughly equal percentages of White members and Black members reported that their housing situation had improved (63%). White members were somewhat were more likely to report that their employment situation had improved (44% for White members compared to 38% for Black members) although the difference was not statistically significant.

Social factors were more strongly associated with assessments of treatment outcomes, with those in more difficult circumstances reporting less favorable outcomes across all measures. For example, members who were housing and/or food insecure, unemployed, and lacking social support were much less likely to report that their housing and employment situation had improved as a result of treatment, compared to members with greater housing and food security, who were employed, and had greater social support.

Changes as a result of receiving treatment services

	More confident about not being dependent on drugs or alcohol	Housing situation has improved	Employment situation has improved
Race/ethnicity			
White, non-Hispanic	82.0%	63.1%	43.8%
Black, non-Hispanic	81.0%	63.8%	38.3%
Housing insecure			
Yes	72.9%[a]	33.3%[a]	25.6%[a]
No	83.7%	69.0%	46.5%
Food insecure			
Yes	80.0%[a]	59.1%[a]	38.4%[a]
No	86.6%	73.3%	54.4%
Employment status			
Employed	85.2%	71.7%[a]	77.3%[a]
Unemployed	78.4%	55.8%	25.4%
Not in labor force	82.5%	63.8%	33.9%
Social support			
None	72.0%[a]	51.3%[a]	31.4%[a]
1 or 2	80.2%	55.7%	37.6%
3 or more	87.1%	76.0%	53.1%
Prison/jail in past year			
Yes	78.4%	58.5%	38.8%
No	83.7%	64.4%	44.6%

Source: ARTS member survey. [a]Group differences for measure are statistically significant at .05 level based on chi square tests.

Conclusion

Medicaid expansion increased enrollment by over 400,000 nonelderly adults in 2019. Not surprisingly, Medicaid expansion led to a surge in members utilizing ARTS benefits in 2019, as new members enrolled through expansion had higher diagnosed prevalence of both SUD and OUD compared to members enrolled through traditional eligibility criteria. More than 46,000 members utilized ARTS services in 2019, a 79% increase from 2018. The number of members receiving MOUD treatment in 2019 (23,000 members) doubled from that of 2018. Preferred OBOTs, OTPs, and residential treatment centers also experienced especially large increases in utilization. Despite low levels of utilization in the first two years of ARTS, the percent of members receiving treatment at residential treatment centers in 2019 (3.6%) more than doubled from 2018. Due to expanded eligibility through Medicaid expansion, postpartum Medicaid coverage increased substantially for members who gave birth, likely contributing to an increase in MOUD treatment during the 12 months after birth for members with OUD.

Treatment rates for SUD and OUD continued to increase in 2019, even for base Medicaid eligibles. Since 2016 (the year before ARTS implementation), the percent of members with OUD who received some type of treatment has doubled, to about 66% by 2019. While MOUD treatment rates among Medicaid members have been increasing in other states, the increase in Virginia far outpaces that of other states, providing further evidence of the impact of the ARTS program. Thus, while MOUD treatment rates for Virginia in 2016 were well below that of many other states, Virginia is now roughly equivalent with other states in terms of MOUD treatment.

Continued improvements in many aspects of quality of care were observed. More members are receiving treatment within 30 days following SUD and OUD-related ED visits, as well as receiving follow-up care after discharge from residential treatment centers. For those with OUD, use of urine drug screens and counseling services has also been steadily increasing, while co-prescribing of opioid pain medications and benzodiazepines has decreased. Use of Preferred OBOTs and OTPs has increased to the point where they now comprise about half of all outpatient treatment episodes for OUD. Treatment episodes at OBOT and OTP providers generally include higher rates of MOUD treatment, urine drug screens, counseling, and care coordination services compared to other outpatient providers.

The report also included the first results from a survey of Medicaid members who used ARTS treatment services for OUD. Surveyed members generally report positive experiences with their treatment providers in terms of trust, communication, and level of involvement with their treatment. Having positive experiences with treatment providers is important, in part because it is strongly associated with fewer members discontinuing their treatment against the advice of their doctor or counselor. Members also report improvements in many aspects of their lives after receiving treatment, such as confidence in not being dependent on drugs or alcohol, getting along better in their social lives, and improvements in their housing or employment situation. Of concern is that treatment experiences were somewhat less favorable for members who reported other health problems, experiencing serious psychiatric distress, or were polysubstance users.

ED utilization for SUD and OUD had notably decreased following implementation of ARTS in 2017, strongly suggesting improved access to SUD and OUD treatment services. The spike in ED visits in 2019 may reflect the statewide and national increase in drug overdoses observed between 2018 and 2019. With COVID-19 potentially exacerbating problems with addiction in the Commonwealth in 2020, further examination is needed to identify potential gaps in treatment that may be related to avoidable ED visits.

Prior reports had noted wide disparities between Black and White Medicaid members in treatment rates for SUD and OUD. The report noted that these disparities continue, but also provided additional evidence on the nature of these disparities. Black and White members with SUD and OUD are equally likely to be initiated into treatment following a diagnosis. However, Black members are less likely than White members to follow-up with and continue this treatment once initiated. Consistent with this is that episodes of outpatient treatment tend to be considerably shorter for Black members than White members. This may reflect in part less favorable experiences with treatment among Black members relative to White members, which may be due to either differences in the quality of treatment providers that Black patients tend to see, or due to real or perceived discrimination on the part of treatment providers that affects trust and communication. Particularly noteworthy is that Black members felt much less able to refuse specific types of treatments compared to White members, which may explain why Black members were less likely to report discontinuing treatment against the advice of doctors relative to White members. Black members also experience greater housing insecurity and are less likely to have any social support compared to White members – factors which them at higher risk for less favorable experiences with treatment providers.

The analysis for this report preceded the COVID-19 pandemic, and therefore the results do not reflect any impact of COVID-19 on SUD prevalence, utilization, quality of care, and outcomes. Medicaid enrollment has increased due to higher unemployment and many Virginians losing their employer-sponsored coverage. As these and other Medicaid members struggle with the economic impact of the pandemic, as well as greater social isolation and potential disruptions in treatment, COVID-19 is likely to have a substantial impact on diagnosed prevalence and utilization of SUD treatment services among Medicaid members. Future analysis will be forthcoming that more explicitly examines changes in prevalence, treatment, quality of care, and outcomes before and after the beginning of the COVID-19 pandemic. The ARTS member survey is directly assessing patient experiences with COVID-19, as well as overall changes in the experience with treatment before and after the start of the pandemic.

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Attachment 8

Virginia 1115 Demonstration

Member Experiences with Opioid Use Disorder Treatment Services in the Virginia Medicaid Program Results from a survey of Medicaid members receiving treatment services through the Addiction and Recovery Treatment Services program

VCU School of Medicine
Health Behavior and Policy

Member Experiences with Opioid Use Disorder Treatment Services in the Virginia Medicaid Program

Results from a survey of Medicaid members receiving treatment services through the Addiction and Recovery Treatment Services program

April, 2022

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EXECUTIVE SUMMARY

This report presents findings from a survey of Virginia Medicaid members who received treatment for opioid use disorder (OUD) through the Addiction and Recovery Treatment Services (ARTS) benefit. ARTS was implemented in April, 2017 by the Virginia Department of Medical Assistance Services (DMAS). The survey is based on a stratified random sample of Medicaid members who were diagnosed and/or received treatment for OUD. The sample was identified through Medicaid enrollment and claims data, and was equally divided into the following four groups: (1) members who received treatment at Preferred Office-Based Opioid Treatment providers (OBOT) – a new model of care delivery created through the ARTS benefit; (2) members who received treatment through Opioid Treatment Programs (OTP), which provides methadone treatment for OUD; (3) members who received treatment at other outpatient providers which may include outpatient clinics or office-based providers that provide OUD treatment, and; (4) members who were diagnosed with OUD, but received no ARTS services based on paid claims.

The survey was conducted between January, 2020 and August, 2021, and therefore overlaps with the beginning of the COVID-19 pandemic. The survey was conducted by mail, and included $2 incentives. Out of a total 10,250 persons in the initial sample draw, about 1,845 returned completed surveys, for a survey response rate of 18%. Survey weights adjusted for differences between respondents and nonrespondents on age, sex, race/ethnicity, and Virginia region. In examining members' experiences with treatment, the analysis focuses on comparisons between the following subgroups, reflecting analytical priorities: (1) Differences between members using Preferred OBOT, OTP, other outpatient providers, and members receiving no treatment; (2) Differences by race/ethnicity, (3) Differences in treatment experiences between respondents interviewed prior to the onset of the COVID-19 pandemic, and those interviewed after the pandemic began and (4) Differences between members living in urban and rural areas. The results are summarized below.

Differences between treatment provider types.

- There were some differences in respondent experiences based on whether they received care at Preferred OBOT, OTP, or other outpatient providers. For example:
  - Respondents using Preferred OBOT providers were less likely to report any unmet need for treatment services, relative to other outpatient providers.
  - Respondents using Preferred OBOT and OTP providers were more likely to report receiving MOUD treatment compared to other outpatient providers.
  - Respondents using Preferred OBOT and other outpatient providers were more likely to receive help with other health or personal needs compared to OTP providers.
  - Respondents using OTP providers were less likely to report that they stopped treatment against the advice of doctors or counselors, compared to users of Preferred OBOT and other outpatient providers.
  - Respondents using Preferred OBOT and OTP providers were more likely to report that treatment helped them with a number of personal, social, and economic outcomes, compared to other outpatient providers.

Differences by race/ethnicity

- There were some notable differences between non-Hispanic White members and non-Hispanic Black members in experiences with treatment. Compared to non-Hispanic White members, non-Hispanic Black members:
  - Were more likely to have recently started treatment (within the past year).
  - Were less likely to receive help with other health or personal needs, a medical problem or a mental health problem from their treatment provider.
  - Had less favorable experiences with treatment providers, including being much less likely to believe they were able to refuse treatment.
  - Were less likely to agree that treatment had helped them with multiple personal, social, and economic outcomes.

Differences by urban/rural residence

- There were few differences between respondents living in urban and rural areas; some notable exceptions include:
  - Respondents who lived in rural areas were less likely to receive help with housing, food or employment, compared to those who lived in an urban classification.
  - The percent of respondents reporting unmet need for MOUD treatment was higher in rural areas compared to those in urban areas.
  - Respondents were less likely to use Alcoholics Anonymous or Narcotics Anonymous if they lived in a rural area, compared to urban areas.

Experiences during COVID

- Experiences with treatment did not differ greatly among respondents who completed the interview after the beginning of the COVID-19 pandemic, compared to respondents who were interviewed before the pandemic started. A few exceptions include:
  - Respondents who were interviewed during the pandemic were less likely to report needing treatment right away compared to those interviewed before the pandemic began.
  - Respondents who were interviewed during the pandemic were less likely to report receiving help with other health and personal needs compared to respondents interviewed before the pandemic.

- Among respondents surveyed after the pandemic began, the majority reported that the pandemic had not changed their ability to maintain treatment services and their recovery. In general, an equal or greater number of respondents reported that their treatment had improved during the pandemic, compared to the number reporting that their treatment had become "worse."

- Respondents generally had positive experiences using different modes of treatment, with only slightly less positive experiences among those having telephone or video calls with their providers.

Who are the diagnosed, untreated group?

One of the sampling strata in the survey included members who had received an OUD diagnosis in the year prior to the sample draw, but had no utilization of ARTS treatment services based on claims data. Survey findings about this "diagnosed, untreated" group reveal the following:

- The "diagnosed, untreated" group tend to be much older, not in the labor force, in poorer overall health, less likely to have serious mental illness (SMI), and less likely to be polysubstance users compared to sample persons who received ARTS treatment services. They are also much less likely to have spent time in jail or prison in the past 12 months compared to those receiving ARTS services.

- Overall, many in this group do no not perceive they are in need of treatment. Few of them self-reported receiving any type of treatment in the past 12 months. Also, they were less likely to report having any unmet need for drug or alcohol treatment compared to those who received treatment through other outpatient providers other than OBOT and OTP. This suggests that the main reason why they are not using treatment services is that they perceive less of a need for treatment, rather than they lack access or encounter barriers to treatment services.

Conclusion

The majority of survey respondents reported favorable experiences with their treatment, including their interactions with health care providers, and how treatment benefitted them personally, socially, and economically. A minority of respondents reported less favorable experiences with their treatment, including about 1 in 7 who reported unmet need for treatment in the past year. Even when there were differences in treatment experiences by provider type or race/ethnicity, the majority in each group reported favorable experiences. Differences between members living in urban and rural areas were minimal. Moreover, the onset of the COVID-19 pandemic did not appear to diminish these positive experiences with treatment, with few exceptions. Most survey respondents who completed the survey after COVID began reported that their ability to continue with various treatment services had either not changed since the pandemic, or had improved.

INTRODUCTION

In April 2017, the Department of Medical Assistance Services (DMAS) implemented the Addiction and Recovery Treatment Services (ARTS) benefit in order to increase access to treatment for substance use disorders (SUD) for Medicaid members. ARTS expanded coverage of many addiction treatment services for Medicaid members, including community-based services, short-term residential treatment and inpatient detoxification services. The Centers for Medicare and Medicaid Services (CMS) approved a Section 1115 Demonstration Waiver for SUD in December 2016 to allow federal Medicaid payment for addiction treatment services provided in inpatient and short-term residential facilities. ARTS also increased provider reimbursement rates for many existing services and introduced a new care delivery model, the Preferred Office-Based Opioid Treatment (OBOT) provider, which integrated medications for opioid use disorder (MOUD) with behavioral and physical health by incentivizing increased use of care coordination activities. The six Medicaid managed care organizations, which oversee medical and behavioral health benefits for all Medicaid members, administer SUD services, offering a comprehensive care delivery system that further increases integration of addiction treatment services with other health services covered by Medicaid.

DMAS contracted with Virginia Commonwealth University School of Medicine to conduct an independent evaluation of the ARTS benefit. Based largely on analyses of Medicaid claims data, the evaluation to-date has shown a large increase in access to and utilization of SUD treatment services for Medicaid members.[1] Use of many ARTS services more than doubled in 2019 following the expansion of Medicaid eligibility to 138% of the federal poverty level, as allowed under the Patient Protection and Affordable Care Act (ACA). Additional analyses related to the capacity of the SUD treatment system, SUD prevalence, and utilization of SUD services for vulnerable subpopulations were also conducted through a grant received by DMAS from the Center for Medicare and Medicaid Services (CMS) as part of the Substance Use-Disorder Prevent that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.

As part of the ARTS evaluation and SUPPORT Act, a survey was conducted in 2020 and 2021 to assess experiences in receiving ARTS services among Virginia Medicaid members with opioid use disorder (OUD). The results of the survey are presented in this report. Included in the survey were questions on unmet needs related to SUD treatment; other unmet health needs; utilization of various types of treatment services, including those not covered by Medicaid; assessment of quality of care from treatment providers; and assessments of how treatment affects members' personal, family, and social lives, as well as their ability to find employment and obtain stable housing. As the survey field period overlapped with the beginning of the COVID-19 pandemic, the survey also ascertained barriers to care as a result of COVID-19, as well as experiences with different treatment modes such as telehealth.

SURVEY METHODOLOGY

Sample Design. The ARTS member survey is based on a stratified random sample of Virginia Medicaid members who received treatment for OUD. Survey respondents ages 21 and over were randomly selected from Medicaid enrollment files based on their utilization of ARTS services (identified through Medicaid claims data). Sample selection was stratified to reflect analytical goals and priorities in comparing member experiences in using the new model of treatment delivery – Preferred OBOT providers – with use of Opioid Treatment Programs (OTPs), and other outpatient treatment providers. In addition, to better understand why some members with OUD diagnoses do not receive ARTS services, an additional sampling stratum selected Medicaid members with an OUD diagnosis, but no claims for SUD treatment services. Specifically, the four sampling strata were defined as follows:

1. **Utilized services at Preferred OBOT providers.** Members with OUD who had 2 or more claims at Preferred OBOT providers in the six months prior to sample selection.

2. **Utilized services at Opioid Treatment Programs (OTP).** Members with OUD who did not utilize Preferred OBOT providers, but had 2 or more claims at OTP providers in the six months prior to sample selection.

3. **Utilized other outpatient providers.** Members with OUD who did not utilize Preferred OBOT or OTP providers, but had 2 or more claims for other outpatient treatment services with a primary diagnosis of OUD in the six months prior to sample selection.

4. **Diagnosed, not treated.** Members with any primary or secondary diagnosis of OUD on any claim in the 12 months prior to sample selection, but with no claim for ARTS services, including outpatient, residential, intensive outpatient, or Medications for Opioid Use Disorder (MOUD) treatment.

Sampling criteria were based on paid claims only. Members under the age of 21, living in correctional facilities or other institutional settings, or deceased were excluded from the sample frame. Within each sampling strata, 2,500 members were randomly selected, for a total initial sample of 10,250 members. About half of the sample was drawn at the beginning of January, 2020, based on utilization of treatment services between July and December, 2019 as reported in claims data. The second half of the sample was drawn in January, 2021, and was based on utilization of treatment services between July and December, 2020.

Questionnaire Design. Survey questions were adapted from a number of sources, including the CAHPS Experience of Care & Health Outcomes (ECHO) Survey, a version of the CAHPS developed for assessing patient experience with behavioral health care,[2] and the National Survey of Drug Use and Health, conducted by the Substance Abuse and Mental Health Services Administration.[3] In addition, we obtained questions that ask patients to assess the impact of treatment on their lives from a survey of patients receiving services at Centers for Excellence treatment centers in Pennsylvania.[4]

Data Collection. The survey field period extended from January, 2020 through August, 2021, with a pause in data collection between May and August, 2020 due to COVID-19 pandemic related restrictions. Paper surveys were completed by mail, based on the mailing addresses included in Medicaid enrollment files. Questionnaires were mailed to sample persons on a rolling basis throughout the field period, comprising 13 separate waves of about 800 sample persons per wave. A $5 incentive was included with all surveys. Follow-up reminders were sent to sample persons who did not initially respond. Out of 10,250 surveys sent, there were a total of 1,845 responses, reflecting a response rate of 18.0%. As described in greater detail below, survey weights were developed to correct for potential nonresponse bias.

ANALYSIS FOR THIS REPORT

This report shows the overall findings from the ARTS member survey. Findings include characteristics of ARTS member survey respondents, including their demographic, health, and social needs regarding housing and food insecurity. Findings are also reported with respect to questions on access to care, types of treatment received, attributes of treatment, assessment of the quality of care received from providers, and the effectiveness of treatment related to personal, social, and socioeconomic outcomes. In addition, the report shows findings related to experiences receiving treatment during the COVID-19 pandemic for members who were surveyed between August, 2020 and August, 2021.

Major findings on treatment experiences are stratified by four factors that reflect key survey or evaluation goals. Consistent with the goal of the stratified sampling strategy, the analysis compares members who received treatment in Preferred OBOT, OTP, and other outpatient settings, as well as those with a diagnosis of OUD who did not receive any treatment (diagnosed, not treated). Second, the analysis is stratified by race/ethnicity in order to identify potential disparities in experiences with treatment. Third, because treatment experiences may have changed due to COVID-19 mitigation efforts as well as new treatment options becoming available – such as telehealth -- during the pandemic, the analysis is stratified based on whether the survey was completed before or after the beginning of COVID-19, defined based on whether surveys were returned before or after April, 2020. The fourth factor is whether the respondent lived in an urban or rural area, based on Rural-Urban Commuting Area (RUCA) classification developed by the federal government.

Means and proportions related to the stratified analysis are adjusted to control for other factors that may be correlated with treatment experiences, including age, gender, general perceived health, mental health co-morbidity, polysubstance use, and whether they had been in prison or jail in the past 12 months. Adjusted percentages are based on predicted probabilities derived from logistic regression analysis.

Use of survey weights. All analyses in this report are weighted to reflect the actual distribution of Medicaid members in the population defined to be in-scope for the survey. Survey weights were constructed specifically to make two adjustments: (1) to correct for differences between survey respondents and nonrespondents based on age, sex, race/ethnicity, rural/urban residence, and region; (2) to rebalance the four sampling strata to reflect the actual distribution of Medicaid members.

Survey nonresponse may lead to biased estimates to the extent that survey respondents differ from nonrespondents in ways that affect survey estimates. To partially correct for this, survey weights rebalance the sample of respondents to account for differences between respondents and nonrespondents on known characteristics. Because the sample was obtained from member enrollment data, data for age, sex, race/ethnicity, rural/residence, and region were available for both survey respondents and nonrespondents (see Appendix Table 1). Survey weights adjust survey estimates to reflect the distribution of the total sample, correcting for differences between respondents and nonrespondents on age, gender, race/ethnicity, urban/rural residence, and region. The propensity cell method was used to construct an initial weight for this purpose.

A second adjustment to the weight was performed so that the four sampling strata were rebalanced to reflect their actual distribution in the population. As shown in Appendix table 2, groups that were under-sampled relative to their actual proportion in the population (for example, the diagnosed untreated group) are weighted more heavily in estimates that involved the entire sample, while groups that were oversampled receive a lower weight value.

Section 1. Characteristics of survey respondents

A. Sociodemographic Characteristics

- Survey respondents who were in the "diagnosed, not treated" group tended to be older and likely retired compared to respondents who had received ARTS services in the past year. They were much more likely to be ages 55 and over (40.5% compared to 9.0% of Preferred OBOT respondents), not in the labor force (52.6%, compared to 25.3% for Preferred OBOT respondents), and less likely to have been in prison or jail in the past year (9.3% compared to 23.2% for Preferred OBOT respondents).

- Respondents who used Preferred OBOT providers were more likely to be female (51.5%) and non-Hispanic White (81.1%) compared to respondents who used OTP providers (42.6% female and 64.7% non-Hispanic White).

		OUD treatment location			
	Total Sample	Preferred OBOT	OTP	Other outpatient	Diagnosed, not treated
	n (%)				
n (%)	1,845 (100)	444 (100)	428 (100)	452 (100)	521 (100)
Age					
21-34	513 (31.3%)	39.2%	33.8%	46.6%	21.6%
35-54	860 (44.9%)	53.8%	53.8%	46.7%	37.9%
55+	472 (23.8%)	9.0%	12.4%	6.8%	40.5%
Gender					
Male	763 (44.7%)	48.5%	57.4%	39.0%	40.0%
Female	1,082 (55.3%)	51.5%	42.6%	61.0%	60.0%
Race/ethnicity					
Non-Hispanic White	1,377 (71.4%)	81.1%	64.7%	84.9%	65.2%
Non-Hispanic Black	338 (21.0%)	12.0%	27.7%	8.7%	26.5%
Other	75 (4.4%)	3.1%	4.5%	5.3%	4.7%
Missing	55 (3.1%)	3.8%	3.0%	1.1%	3.6%
Employment status					
Employed	406 (20.7%)	29.2%	24.5%	29.7%	12.4%
Unemployed	604 (33.3%)	40.1%	46.0%	39.7%	23.1%
Not in labor force	683 (37.2%)	25.3%	22.7%	24.0%	52.6%
Missing	152 (8.8%)	5.3%	6.8%	6.6%	11.9%
Jail/prison in past year					
Yes	310 (16.7%)	23.2%	18.9%	27.4%	9.3%
No	1,496 (81.4%)	74.8%	79.1%	72.1%	88.4%
Missing	39 (1.9%)	2.1%	2.0%	0.6%	2.3%

B. Health Status

- Survey respondents have high prevalence of co-occurring health problems, including 48.4% who reported "fair or poor" overall health, and 30.6% who reported a serious mental illness (SMI) based on the Kessler 6 scale of psychological distress. Respondents in the "no treatment" group were much more likely to report fair or poor health (58.9%) and less likely to report SMI (28.1%) compared to other respondents who received OUD treatment.

- Just under half of survey respondents (45.0%) reported that they had used multiple substances (including alcohol) in the past year and 13.3% had received Narcan or Naloxone in the past year to prevent or reverse an overdose. The "diagnosed, not treated" group were less likely to report polysubstance use (35.2%) and that they had received Narcan or Naloxone in the past year (13.3%) compared to those in the other treatment groups.

		OUD treatment location			
	Total Sample	Preferred OBOT	OTP	Other outpatient	Diagnosed, not treated
	n (%)				
Self-reported general health					
Excellent, very good	284 (16.1%)	20.1%	17.7%	20.5%	12.2%
Good	604 (31.6%)	35.1%	36.5%	39.2%	25.4%
Fair or poor	881 (48.4%)	40.4%	41.3%	35.8%	58.9%
Missing	76 (4.0%)	4.4%	4.6%	4.4%	3.4%
Had serious mental illness (based on K6)[1]					
Yes	552 (30.6%)	34.6%	30.4%	32.9%	28.1%
No	1165 (62.3%)	60.3%	62.6%	62.8%	62.9%
Missing	128 (7.1%)	5.1%	7.0%	4.4%	9.0%
Polysubstance user					
Yes	860 (45.0%)	51.8%	54.0%	54.6%	35.2%
No	985 (55.0%)	48.2%	46.0%	45.4%	64.8%
Received Narcan or Naloxone in the past 12 months to prevent or reverse an overdose					
Yes	256 (13.3%)	16.5%	12.0%	17.6%	11.0%
No	1537 (84.0%)	80.9%	84.7%	79.7%	86.5%
Missing	52 (2.7%)	2.7%	3.3%	2.7%	2.5%

[1]Based on having a score of 13 or higher on the Kessler 6 index of psychological distress, consistent with previous research. For more information, see Kessler, R.C., Barker, P.R., Colpe, L.J., Epstein, J.F., Gfroerer, J.C., Hiripi, E., Howes, M.J, Normand, S-L.T., Manderscheid, R.W., Walters, E.E., Zaslavsky, A.M. (2003). Screening for serious mental illness in the general population **Archives of General Psychiatry**. 60(2), 184-189.

C. Social needs.

- About one-fourth of survey respondents (26.0%) reported that it was sometimes or often true that the food they bought didn't last and they didn't have money to get more food (food insecurity). About one-third of respondents (34.0%) reported that they either do not have housing or they are worried about losing their housing in the future (housing insecure).

- One in five survey respondents (21.3%) lived alone, while 8.6% reported no social support (i.e. having no one close to them). Respondents in the "no treatment" group were more likely to live alone (27.8%) compared to respondents who received OUD treatment.

		OUD treatment location			
	Total Sample	Preferred OBOT	OTP	Other outpatient	Diagnosed, not treated
	n (%)				
Food insecure					
Yes	470 (26.0%)	25.6%	32.0%	24.9%	24.3%
No	1,332 (71.3%)	72.1%	65.6%	74.8%	72.1%
Missing	43 (2.6%)	2.3%	2.4%	0.4%	3.6%
Housing insecure					
Yes	632 (34.0%)	36.3%	46.3%	34.5%	28.0%
No	1,165 (63.2%)	61.6%	50.9%	64.3%	68.4%
Missing	48 (2.8%)	2.1%	2.8%	1.2%	3.7%
Current living arrangements					
Alone	389 (21.3%)	17.7%	14.4%	14.7%	27.8%
Partner	476 (24.6%)	28.7%	25.7%	26.7%	21.8%
Family/relative	626 (34.6%)	36.6%	38.8%	41.7%	29.7%
Friend or other nonrelative	210 (11.3%)	9.6%	14.6%	9.0%	11.6%
Community residential facility	77 (4.4%)	3.2%	3.0%	6.2%	4.7%
Missing	67 (3.8%)	4.3%	3.6%	1.8%	4.4%
Number of people close to you (social support)					
None	171 (8.6%)	12.2%	8.3%	7.6%	7.5%
1-2	920 (49.6%)	50.6%	53.6%	51.6%	46.9%
3-5	487 (27.2%)	23.5%	26.1%	28.7%	28.7%
5 or more	231 (12.6%)	12.3%	9.6%	11.2%	14.4%
Missing	36 (2.0%)	1.5%	2.4%	0.8%	2.4%

Section 2. SUD treatment service access and utilization.

A. Unmet need for SUD treatment and other health services.

- About 15 percent of survey respondents reported that they needed but did not receive some type of treatment for drug or alcohol use in the past year. This is a lower percentage than unmet need for other health services, including mental health counseling, prescription drugs, and medical care.
- Unmet need for SUD treatment was lower among the Preferred OBOT group followed by "diagnosed, no treatment group", at values of 8.1% and 8.4% respectively.
- Unmet need for SUD treatment was higher among the Non-Hispanic Black group and other races when compared to the Non-Hispanic White group.
- Unmet need for various health services did not differ between those who completed the survey prior to the COVID19 pandemic and those who completed the survey after the pandemic had started.

	Percent with unmet need in the past year for health services				
	Drug or alcohol counseling	Mental health counseling	Prescription drugs	Medical care	Dental care
All (n=1,845)	14.7%	22.5%	29.9%	27.8%	50.8%
Adjusted percentages[2]					
OUD treatment location					
Preferred OBOT	8.1%*	15.6%	24.0%	23.0%	56.9%*
OTP	10.7%	18.8%	28.6%	29.6%	53.7%
Other outpatient	13.6%	19.6%	27.8%	26.0%	49.1%
Diagnosed, not treated	8.4%*	20.9%	31.2%	27.4%	51.0%*
Race					
Non-Hispanic White	8.6%	18.9%	28.4%	27.1%	53.2%
Non-Hispanic Black	13.0%*	20.7%	29.7%	24.3%	50.5%
Other	12.1%*	16.7%	27.1%	30.3%	46.3%*
Survey period					
Before COVID	10.3%	19.3%	30.7%	28.5%	51.4%
During COVID	8.9%	19.0%	27.1%	25.3%	53.0%
RUCA Classification					
Urban	9.0%	19.5%	28.3%	26.5%	52.7%
Rural	10.9%	18.3%	29.2%	27.0%	51.4%

*Difference with reference groups (other outpatient, Non-Hispanic White, Before COVID, Urban classification) is statistically significant at .05 level.

[1]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, mental health co-morbidity, polysubstance use, rural/urban residence, and whether they had been in prison or jail in the past 12 months.

B. Self-reported receipt of treatment for drug or alcohol use in the past year.

- Overall, 57.3% of survey respondents self-reported that they received treatment for drug or alcohol use in the past year. Not surprisingly, those with claims experience for treatment were much more likely to self-report receiving treatment (between 73-77%) compared to those with no claims experience for treatment (16.1%)

		OUD Treatment Location			
	Total Sample	Preferred OBOT	OTP	Other outpatient	Diagnosed, not treated
Received treatment for drug or alcohol use in past year (n=1,845)					
Yes	1,057 (57.3%)	77.4%	72.7%	76.5%	16.1%
No	709 (38.4%)	16.3%	23.2%	20.3%	79.4%
Missing	79 (4.3%)	6.3%	4.2%	3.3%	4.4%

- The remaining analysis in Sections 2-6 is based on the sample of persons who self-reported receiving treatment. Consistent with the methodology used in the CAHPS and other surveys, individuals who self-reported that they did not receive treatment were not asked other questions on the details of their treatment. As only 64 respondents in the "no treatment" group reported receiving treatment, this group is excluded from the remaining analysis in Sections 2-6.

C. Specific services and other supports utilized in the 12 months prior to the survey

- Among those who reported receiving treatment, the most frequently used treatment service was MOUD (87.2%) followed by treatment in a doctor's office or clinic (81.4%). About one-third of survey respondents used Alcoholics Anonymous or Narcotics Anonymous.
- Users of Preferred OBOT and OTP providers, 92.6% and 95.6% respectively, were more likely to have received MOUD treatment compared to users of other outpatient providers (87.0%).
- Non-Hispanic Black members were less likely to receive treatment in a doctor's office or clinic (63.6%) compared to non-Hispanic White members (86.2%)/
- There were no statistically significant differences in services used before or during COVID-19.
- Respondents were less likely to use Alcoholics Anonymous or Narcotics Anonymous if they lived in a rural classification, compared to urban classification.

	Percent utilizing treatment sites or other supports in the past 12 months							
	AA/NA, self-help	Church or religious	Doctor's office/ clinic	Inpatient hosp.	Emergency dept.	Residential treatment	Prison/jail	MOUD
All (n=1,057)	31.1%	9.1%	81.4%	12.5%	8.4%	16.3%	5.7%	87.2%
Adjusted percentages[2]								
OUD treatment location								
Preferred OBOT	31.8%	6.1%	85.9%	9.1%	6.3%	16.9%	1.9%	92.6%*
OTP	28.5%	7.0%	84.4%	6.0%*	5.0%	15.8%	2.0%	95.6%*
Other outpatient	34.4%	9.9%	83.5%	11.7%	9.1%	15.5%	1.2%	87.0%
Race								
Non-Hispanic White	30.3%	9.0%	86.2%	10.7%	7.4%	15.7%	1.4%	91.4%
Non-Hispanic Black	32.3%	4.6%	63.6%*	5.5%	4.4%	14.9%	3.8%	88.0%
Other	41.7%	7.3%	88.3%	6.8%	1.2%*	20.3%	5.0%	84.8%
Survey period								
Before COVID	28.8%	7.8%	83.4%	8.4%	5.6%	13.7%	1.8%	91.8%
During COVID	32.7%	8.1%	83.9%	10.3%	7.0%	17.3%	1.7%	89.8%
RUCA Classification								
Urban	33.3%	8.0%	84.3%	9.6%	7.1%	16.3%	1.7%	90.7%
Rural	25.0%*	7.9%	81.9%	9.2%	4.6%	14.1%	1.8%	90.6%

*Difference with reference groups (other outpatient, Non-Hispanic White, Before COVID, Urban classification) is statistically significant at .05 level.

[1]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, mental health co-morbidity, polysubstance use, rural/urban residence, and whether they had been in prison or jail in the past 12 months.

D. Specific services needed or wanted to use, but not received.

- More than one-fourth of survey respondents (28.5%) reported that there was a specific service that they wanted or needed to use in the past year, but did not receive. MOUD treatment was the most frequently cited service that was needed but not received (15.9%).
- The percent of respondents who needed or wanted to use MOUD treatment was higher in rural areas (15.6%) compared to those in urban areas.
- The percent with unmet need for a specific service was higher among survey respondents during COVID-19 (25.6%) compared to those before COVID-19, but the difference was not statistically significant.

	Needed or wanted to use service, but not able to						
	AA/NA, self-help (%)	Church or religious (%)	Doctor's office/ clinic (%)	Inpatient hosp. (%)	Residential treatment (%)	MOUD (%)	Any of the above (%)
All (n=1,057)	5.9%	3.8%	10.1%	3.6%	6.2%	15.9%	28.5%
Adjusted percentages[2]							
OUD treatment location							
Preferred OBOT	3.9%	2.1%	11.2%	0.9%	4.4%	9.7%	23.3%
OTP	2.7%	3.2%	9.0%	2.9%	4.1%	12.3%	26.3%
Other outpatient	1.8%	1.1%	8.5%	1.2%	4.0%	11.6%	20.6%
Race							
Non-Hispanic White	2.4%	1.9%	9.5%	1.2%	3.6%	11.3%	23.1%
Non-Hispanic Black	3.5%	1.8%	6.2%	3.5%	5.3%	11.7%	25.2%
Other	12.2%	7.6%	15.1%	3.1%	9.8%	16.0%	31.6%
Survey period							
Before COVID	3.8%	1.7%	8.9%	1.2%	3.4%	12.0%	21.9%
During COVID	2.0%	2.3%	9.3%	1.8%	4.5%	11.0%	25.6%
RUCA Classification							
Urban	2.2%	1.5%	8.2%	1.2%	4.2%	10.1%	21.9%
Rural	4.5%	3.6%	11.8%	2.4%	3.4%	15.6%*	28.5%

*Difference with reference groups (other outpatient, Non-Hispanic White, Before COVID, Urban classification) is statistically significant at .05 level.

[1]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, mental health co-morbidity, polysubstance use, urban/rural residence, and whether they had been in prison or jail in the past 12 months.

E. Need for treatment right away

- 69.3% of survey respondents reported that there was a time in the past 12 months when they needed treatment for drug or alcohol use right away. Among those who needed treatment right away, 68.3% reported that they usually or always were able to see someone as soon as they wanted.

- Respondents interviewed during COVID-19 were less likely to report needing treatment right away (67.6%) compared to pre-COVID respondents.

	Percent needed treatment right away (n = 1,057)	Percent usually or always able to see someone as soon as wanted (n = 733)
All	69.3%	68.3%
Adjusted percentages[2]		
OUD treatment location		
Preferred OBOT	69.6%	74.0%
OTP	76.5%	71.3%
Other outpatient	71.0%	76.2%
Race		
Non-Hispanic White	69.9%	72.3%
Non-Hispanic Black	74.8%	63.3%
Other	77.3%	72.2%
Survey period		
Before COVID	75.5%	68.3%
During COVID	67.6%*	72.7%
RUCA Classification		
Urban	71.3%	70.7%
Rural	70.3%	71.1%

*Difference with reference groups (other outpatient, Non-Hispanic White, Before COVID, Urban classification) is statistically significant at .05 level.

[1]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, mental health co-morbidity, polysubstance use, urban/rural residence, and whether they had been in prison or jail in the past 12 months.

Section 3. Other characteristics of OUD treatment received

A. Length of time in treatment and out-of-pocket expenses

- Just under half of survey respondents (46.8%) had been in treatment for less than one year, while 29.8% had been in treatment for 2 or more years.

- Respondents who used Preferred OBOT, compared to "other outpatient" providers, were less likely to have recently started treatment (less than 1 year). Non-Hispanic Black members (compared to Non-Hispanic White) were more likely to have recently started treatment (less than 1 year).

- 18.7% of respondents reported that they had stopped treatment against the advice of doctors or counselors in the past year. Those using OTP providers were less likely to have stopped treatment, compared to "other outpatient" providers.

- Although ARTS services do not require copayments among members, almost 30% reported that they had paid out-of-pocket for some aspect of treatment, likely for services not covered through the ARTS benefit. Fewer respondents during COVID reported having out-of-pocket expenses (22.4%) compared to respondents prior to COVID (35.6%).

	In treatment for less than 1 year	In treatment for 2 or more years	Stopped treatment against advice of doctor or counselor	Paid out-of-pocket for treatment
All (n=1,057)	46.8%	29.8%	18.7%	28.8%
Adjusted percentages[2]				
OUD treatment location				
Preferred OBOT	42.6%*	28.1%	15.6%	21.6%*
OTP	50.8%	24.5%	11.7%*	28.9%
Other outpatient	49.8%	23.7%	17.4%	31.2%
Race				
Non-Hispanic White	44.8%	30.1%	16.1%	28.9%
Non-Hispanic Black	57.2%*	18.8%*	13.6%	21.2%*
Other	38.5%*	26.7%	14.3%	26.4%
Survey period				
Before COVID	47.6%	29.7%	14.4%	35.6%
During COVID	45.7%	26.6%	16.5%	22.4%*
RUCA Classification				
Urban	45.5%	28.3%	16.3%	27.1%
Rural	49.5%	26.7%	13.8%	28.4%

*Statistically significant difference at .05 level with reference groups (other outpatient, Non-Hispanic White, Before COVID, urban classification).

[1]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, serious mental illness, polysubstance use, urban/rural residence, and whether they had been in prison or jail in the past 12 months.

B. Assistance with other health and personal needs at treatment provider

- 59.6% of respondents received help with other health or personal needs at their treatment provider. Respondents received help with a mental health problem most frequently (38.2%), followed by help with a medical problem (25.6%), and assistance with social needs (17.9%).
- Respondents receiving treatment at OTP providers were less likely to receive assistance with other health or personal needs (49.1%), compared to respondents using "other outpatient" providers (69.1%).
- Non-Hispanic Black respondents were less likely to receive assistance with other health or personal needs (55.0%), receive help for a medical problem (21.3%) and receive help with a mental health problem (33.1%), compared to non-Hispanic White members.
- Members in the "other" racial/ethnic group were more likely to receive help with social needs (26.4%), compared to non-Hispanic White members (16.3%).
- Respondents were more likely to receive assistance with other health or personal needs before the COVID-19 pandemic (64.7%), compared to during the pandemic (57.2%).
- Respondents who lived in a rural classification were less likely to receive help with housing, food or employment (9.2%), compared to those who lived in an urban classification (19.7%).

	Received help with other health and social needs			
	Received any help with other health or personal needs	Received help for a medical problem	Received help with a mental health problem	Received help with housing, food, or employment
All (n=1,057)	59.6%	25.6%	38.2%	17.9%
Adjusted percentages[2]				
OUD treatment location				
Preferred OBOT	64.3%	30.6%	42.6%	17.1%
OTP	49.1%*	16.9%*	28.5%*	14.9%
Other outpatient	69.1%	29.4%	44.7%	13.7%
Race				
Non-Hispanic White	60.8%	25.8%	38.3%	16.3%
Non-Hispanic Black	55.0%*	21.3%*	33.1%*	14.9%
Other	71.7%*	16.1%*	39.6%	26.4%*
Survey period				
Before COVID	64.7%	24.8%	39.0%	15.7%
During COVID	57.2%*	24.4%	36.5%	16.9%
RUCA Classification				
Urban	60.2%	24.1%	37.3%	19.7%
Rural	60.8%	26.0%	38.1%	9.2%*

*Statistically significant difference at .05 level with reference groups (other outpatient, Non-Hispanic White, Before COVID, urban classification).

[1]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, serious mental illness, polysubstance use, urban/rural residence, and whether they had been in prison or jail in the past 12 months.

Section 4. Assessment of the quality of treatment

A. Assessment of treatment setting and interaction with providers.

- In general, respondents had positive assessments regarding their communication with providers and level of involvement and control over treatment. There were few differences in assessment of treatment quality by sample group. Treatment experiences during COVID-19 were also similar to treatment experiences before COVID-19.

- Assessments by non-Hispanic White members were generally higher than assessments by non-Hispanic Black members and members from other racial/ethnic groups. The largest difference occurred for perception of their ability to refuse treatment: 78.4% of non-Hispanic White members felt able to refuse treatment compared to 60.7% of non-Hispanic Black members.

	Perceptions of practitioners where treatment received					
	Explained things in a way you can understand[1]	Showed respect for what you had to say[1]	Often felt safe at place of treatment[1]	Involved as much as you wanted in your treatment[1]	Provided information on different kinds of counseling or treatment[2]	Felt able to refuse treatment[2]
All (n=1,057)	83.7%	85.2%	88.8%	84.4%	72.0%	74.2%
Adjusted percentages[3]						
OUD treatment location						
Preferred OBOT	87.0%	90.5%	93.0%	90.2%	76.0%	73.6%
OTP	84.4%	82.7%*	92.3%	86.7%	71.8%	75.3%
Other outpatient	86.7%	90.2%	93.1%	88.9%	74.0%	76.5%
Race						
Non-Hispanic White	86.9%	88.9%	92.6%	89.3%	75.4%	78.4%
Non-Hispanic Black	80.2%*	85.5%*	92.4%	83.0%*	68.2%*	60.7%*
Other	85.9%	74.4%	83.8%*	81.7%*	65.7%*	68.1%*
Survey period						
Before COVID	85.8%	86.5%	91.8%	87.7%	74.5%	74.3%
During COVID	86.1%	89.4%	92.8%	88.7%	73.6%	77.1%
RUCA Classification						
Urban	84.9%	87.7%	92.4%	88.2%	74.3%	76.7%
Rural	88.3%	88.9%	92.3%	88.4%	73.3%	73.5%

*Statistically significant difference at .05 level with reference groups (other outpatient, Non-Hispanic White, Before COVID, urban classification).

[1]Estimates reflect percent who responded "usually" or "always" to statement.

[2]Estimates reflect percent who responded "yes" to statement.

[3]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, mental health co-morbidity, polysubstance use, urban/rural residence, and whether they had been in prison or jail in the past 12 months.

Section 5. Outcomes of treatment

A. Personal outcomes.

- The majority of respondents had positive perceptions of how treatment benefitted them personally. About 79% were confident they were no longer dependent on alcohol or drugs, were able to deal more effectively with daily problems, and felt better about themselves. 72.8% of respondents believed they were better able to deal with a crisis.

- There were some differences in treatment outcomes by sample group, with users of OTP providers having slightly more positive experiences with outcomes of treatment compared to Preferred OBOT and other outpatient providers.

- There were some racial/ethnic differences in perceptions of treatment outcomes. In particular, non-Hispanic Black members were less likely to agree that they were able to deal more effectively with daily problems (74.5%) compared to non-Hispanic White members (84.2%).

	Respondent perceptions of how they were helped by treatment			
	Confident no longer dependent on alcohol or drugs[1]	Deal more effectively with daily problems[1]	Feel better about myself[1]	Better able to deal with a crisis[1]
All (n=1,057)	79.2%	79.2%	77.9%	72.8%
Adjusted percentages[2]				
OUD treatment location				
Preferred OBOT	86.1	83.3	85.1*	80.1*
OTP	84.6	86.5*	87.0*	83.5*
Other outpatient	81.9	78.6	78.9	70.6
Race				
Non-Hispanic White	84.8	84.2	84.2	78.3
Non-Hispanic Black	83.7	74.5*	79.8*	77.0
Other	80.2*	82.4	86.8	84.0*
Survey period				
Before COVID	86.0	83.7	84.4	77.9
During COVID	82.9	82.1	83.0	78.7
RUCA Classification				
Urban	84.4	82.0	83.3	77.0
Rural	84.8	85.0	84.8	81.3

*Statistically significant difference at .05 level with reference groups (other outpatient, Non-Hispanic White, Before COVID, urban classification).

[1]Estimates reflect percent who "strongly agree" or "agree" with statement.

[2]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, mental health co-morbidity, polysubstance use, urban/rural residence, and whether they had been in prison or jail in the past 12 months.

B. Social and economic outcomes.

- Most respondents also reported positive social and economic outcomes as a result of treatment, including 79.2% who were able to get along better with family, 65% doing better in social situations, 71.6% who were able to enjoy leisure activities, 60.1% with improved housing, and 43% with improved employment.

- In general, respondents who used Preferred OBOT or OTP providers reported more favorable social and economic outcomes, compared to respondents who used other outpatient providers.

- In general, non-Hispanic White members reported more favorable social and economic outcomes, compared to non-Hispanic Black members.

	Perceptions of how members were helped by counseling or treatment				
	Able to get along better with family[1]	Did better in social situations[1]	Able to enjoy leisure activities[1]	Housing situation improved[1]	Employment situation improved[1]
All (n=1,057)	79.2%	65.0%	71.6%	60.1%	43.0%
Adjusted percentages[2]					
OUD treatment location					
Preferred OBOT	82.6%*	71.0%*	76.4%	65.1%*	44.0%*
OTP	86.6%*	69.9%*	78.3%*	64.7%*	39.9%
Other outpatient	76.9%	62.3%	72.6%	53.8%	35.4%
Race					
Non-Hispanic White	84.4%	68.1%	76.5%	61.5%	40.1%
Non-Hispanic Black	72.9%*	64.4%*	73.6%	60.0%	38.3%
Other	82.3%	75.1%	74.7%	54.1%*	33.3%*
Survey period					
Before COVID	83.9%	67.9%	75.5%	59.1%	36.1%
During COVID	81.9%	67.9%	76.5%	62.8%	43.0%*
RUCA Classification					
Urban	83.7%	68.8%	73.8%	60.4%	40.8%
Rural	80.8%	65.8%	80.8%*	62.5%	36.8%

*Statistically significant difference at .05 level with reference groups (other outpatient, Non-Hispanic White, Before COVID, urban classification).

[1]Estimates reflect percent who "strongly agree" or "agree" with statement.

[2]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, mental health co-morbidity, polysubstance use, urban/rural residence, and whether they had been in prison or jail in the past 12 months.

Section 6. Experiences with treatment during COVID-19

A. Change in face-to-face meetings with providers after COVID-19 began

- Among those who responded to the questions on COVID-19, 46.3% were prohibited from meeting providers face-to-face after the pandemic started. Among these, 27.8% reported that the lack of a face-to-face meeting had a negative impact on their treatment.

	Total sample who responded to COVID-19 questions
n	437
Prohibited from meeting providers face-to-face after pandemic started	
Yes	46.3%
No	51.3%
Missing	2.4%
No face-to-face meeting had negative impact on treatment (sample restricted to "yes" above, n = 188)	
Yes	27.8%
No	62.8%
Missing	9.4%

B. Perceived change in treatment since COVID-19 pandemic began

- Most respondents reported that their ability to obtain various types of treatment had not changed since the beginning of the COVID-19 pandemic. Among those who reported a change, at least an equal number reported that their treatment was "better" as the number who reported that their treatment was "worse" than before the COVID-19 pandemic began. More respondents reported that their ability to fill prescriptions (20.8%) and maintain recovery (24.0%) had improved after the pandemic started than the number of respondents who reported that it had become worse (15.7% and 17.3%, respectively).

	Perceived change since COVID-19 started
Ability to talk to a doctor or counselor when you needed to:	
Better than before COVID-19	19.4%
Worse than before COVID-19	20.8%
Same	59.8%
Ability to keep appointments for treatment or counseling	
Better than before COVID-19	19.9%
Worse than before COVID-19	23.3%
Same	56.8%
Ability to fill prescription medications	
Better than before COVID-19	20.8%
Worse than before COVID-19	15.7%
Same	63.5%
Support from family, friends, peer counselors	
Better than before COVID-19	22.4%
Worse than before COVID-19	17.3%
Same	60.3%
Ability to maintain recovery	
Better than before COVID-19	24.0%
Worse than before COVID-19	18.6%
Same	57.4%

C. Experiences with different modes of treatment

- Respondents reported using multiple treatment modes during the pandemic, including over half who received treatment by telephone (55.2%) and video (56.9%). The majority of respondents (60.0%) preferred in-person visits, while about one-fifth preferred visits by video.

- In general, most respondents were very satisfied with treatment received in-person (66.5%), by telephone (54.7%), or video call (54.9%). A somewhat higher percentage of respondents were not satisfied with telephone calls (15.2%) or video calls (14.5%) compared to in-person visits (11.4%).

Treatment mode used in past 12 months (all that apply)	
Telephone	55.2%
Video by Zoom or other apps	56.9%
Email	9.1%
In-person	75.6%
Treatment mode preference	
Telephone	10.6%
Video	20.7%
Email	6.0%
In-person	60.0%
Missing	2.7%
Experiences with different treatment modes (among non-missing responses)	
In-person visit at doctor or counselor	
Very satisfied	66.5%
Somewhat satisfied	22.4%
Not satisfied	11.4%
Telephone call with doctor or counselor	
Very satisfied	54.7%
Somewhat satisfied	30.1%
Not satisfied	15.2%
Video call by Zoom or other internet apps	
Very satisfied	54.9%
Somewhat satisfied	30.6%
Not satisfied	14.5%

Conclusion

The ARTS benefit and Medicaid expansion has led to a large increase in the number of Virginia Medicaid members receiving treatment for OUD.[1] The ARTS member survey was designed to assess the patient experience with treatment, and to identify potential gaps and disparities in the patient experience by treatment setting, race/ethnicity, urban-rural residence, and other factors. In addition, the timing of the survey field period coincided with the beginning of the COVID-19 pandemic, allowing for an assessment of how the pandemic has affected member experiences with treatment. The major conclusions from this analysis are:

- Overall, member experiences with ARTS treatment services were favorable. A majority of members reported positive assessments of their interactions with treatment providers, and that treatment provided a number of positive personal, social, and economic benefits.

- Members using Preferred OBOTs and OTPs generally experienced better treatment outcomes regarding personal and family relationships, as well as more favorable social and economic outcomes compared to members using other outpatient providers. Members using Preferred OBOTs were also more likely to report receiving help with other health and personal needs, as well fewer unmet treatment needs relative to members using OTP and other outpatient providers.

- Racial/ethnic differences in assessment of treatment providers were identified, with non-Hispanic Black members reporting somewhat less favorable experiences in their interaction with providers and treatment outcomes compared to non-Hispanic White members on a number of measures. One especially large difference was that non-Hispanic Black members felt much less able to refuse treatment compared to non-Hispanic White members. This may suggest lower levels of trust with the treatment system among non-Hispanic Black members.

- Despite fears that COVID-19 would negatively impact treatment for members, there were few differences in treatment experiences between those surveyed before COVID and those surveyed after the onset of the pandemic. Increased access to telehealth and other measures taken to offset COVID-related barriers to care may have helped to prevent serious disruptions in treatment.

- There were few differences between urban and rural areas in experiences with treatment. Respondents in rural areas were more likely to experience unmet need for MOUD treatment, and were less likely to receive help with housing, food or employment compared to urban residents.

- Members who had been diagnosed with an OUD based on Medicaid claims data, but had no ARTS service utilization were distinctly different in a number of ways compared to members with OUD who used treatment services. Specifically, those “diagnosed, not treated” tend to be much older, likely retired, in generally poorer health, but with fewer mental health co-morbidities relative to members using treatment services.

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Appendix table 1. Characteristics of total sample, survey respondents, and nonrespondents.

	Total sample	Responders	Nonresponders
	12,250	1,845	10,405
Age			
21-34	37.1%	27.8%	39.2%
35-54	47.8%	46.6%	48.0%
55 and over	15.2%	25.6%	12.8%
Sex			
Female	54.2%	58.7%	53.2%
Male	45.8%	41.4%	46.8%
Race/ethnicity			
Non-Hispanic White	76.7%	77.7%	76.4%
Non-Hispanic Black	20.2%	19.4%	20.3%
Other	3.2%	2.9%	3.2%
Urban/rural residence			
Urban	72.3%	69.4%	73.7%
Rural	27.1%	30.4%	26.3%
Region			
Central	26.2%	23.3%	26.8%
Charlottesville/Western	10.7%	11.2%	10.6%
Northern/Winchester	12.0%	12.0%	12.0%
Roanoke/Alleghany	15.3%	15.9%	15.2%
Southwest	18.7%	21.4%	18.2%
Tidewater	16.8%	16.2%	16.9%

Appendix Table 2. Distribution of four sampling strata in sampling frame and survey sample.

	Sample frame	Sample
Total	21,557	10,250
	Percent distribution	
Preferred OBOT	20.1%	25.0%
OTP	18.0%	25.0%
Other outpatient	15.8%	25.0%
Diagnosed, not treated	46.1%	25.0%

Attachment 9

Virginia 1115 Demonstration

Addiction and Recovery Treatment Services Evaluation
Report for State Fiscal Years 2019 and 2020

VCU School of Medicine
Health Behavior and Policy

Addiction and Recovery Treatment Services

Evaluation Report for State Fiscal Years 2019 and 2020

May, 2022

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Disclaimer

The conclusions in this report are those of the authors, and no official endorsement by Virginia Commonwealth University or the Virginia Department of Medical Assistance Services is intended or should be inferred.

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Executive Summary

Fatal drug-related overdoses have surged during the COVID-19 pandemic, exceeding 100,000 overdoses in the U.S. and over 2,400 in Virginia in the year ending June 2021.[1] This represents a 20% increase nationally and 35% increase in Virginia, respectively, since the previous year. Pandemic-related economic and social stress, disruptions in access to health services, and greater availability of more lethal forms of opioids, such as fentanyl, are considered the primary reasons for the surge in overdoses, although no definitive causes have been identified.

As a result of the expansion of treatment services through the Addiction and Recovery Treatment Services (ARTS) benefit in April 2017, and increases in eligibility for these services through Medicaid expansion beginning in 2019, Virginia Medicaid was far better prepared for the increased prevalence in substance use disorders (SUD) than in previous years. The supply of treatment providers, the prevalence of members receiving SUD treatment, and the rate of treatment for diagnosed SUD increased dramatically after implementation of the ARTS benefit, and has continued through Medicaid expansion and the COVID-19 pandemic. While there was concern that COVID-19 related shutdowns and stay-at-home orders may negatively affect access to and use of SUD treatment services, the federal government and the Department of Medical Assistance Services (DMAS) implemented a number of initiatives and procedural flexibilities to offset these barriers, including increased use of telemedicine, allowing take-home dosages of methadone and buprenorphine for up to 28 days, allowing for 90 day prescriptions for buprenorphine products, and allowing a member's home to serve as the originating site for prescription of buprenorphine.

The objective of this report is to examine SUD prevalence, treatment utilization, and outcomes among Virginia Medicaid members during State Fiscal Years (SFY) 2019 and 2020, as well as the first two quarters of SFY 2021 (covering the period July 2018 through December 2020). Among the highlights of the report:

Increased prevalence of SUD

- About 100,000 Medicaid members had a diagnosed SUD in SFY 2020, an increase of almost 30% from SFY 2019. This reflects both an increase in enrollment from Medicaid expansion during the year, as well as a higher SUD prevalence rate, suggesting more members are being screened for SUD. SUD diagnoses increased from 5,218 per 100,000 members in SFY 2019, to 6,055 per 100,000 members in SFY 2020, a 16% increase.

- While opioid use disorder (OUD) continues to be the most frequently diagnosed SUD among Medicaid members (about 42% of all diagnosed SUD), the prevalence rate increased faster for other substances between SFY 2019 and 2020, including for hallucinogens (a 41% increase) and stimulants (a 33% increase).

Increase in the number of providers authorized to prescribe buprenorphine

- There were almost 1,500 practitioners authorized to prescribe buprenorphine (Substance Abuse Mental Health Services Administration (SAMHSA) authorized buprenorphine-waivered/ prescribers) in Virginia as of April-June, 2020, a 39% increase from the previous year, and a 246% increase from the period prior to the ARTS benefit. The recent surge in buprenorphine

waivered prescribers has been driven by an increase in waivered nurse practitioners and physician assistants, who became eligible for waivers in 2016.

- The number of waivered prescribers in Virginia is similar to other states in the South, but low compared to other regions in the U.S. ARTS and Medicaid expansion may have helped boost the supply of waivered providers, as the increase in Virginia exceeds that of other states in the South that did not expand Medicaid.

Increase in use of ARTS services

- There was a 30% increase in the number of members using ARTS services between SFY 2019 and 2020, even after accounting for increased Medicaid enrollment. Outpatient treatment and pharmacotherapy are the most frequently used services, although there were larger increases in the use of residential treatment, partial hospitalization, intensive outpatient services, and care coordination services.

- Members with OUD are more likely to use ARTS services (67%) compared to members who have other SUD (between 8% and 25%).

Increase in use of Medications for Opioid Use Disorder (MOUD)

- MOUD treatment rates for members with OUD increased from 62% in SFY2019 to 69% in 2020, continuing a trend of increased MOUD treatment rates that began after implementation of the ARTS benefit.

- MOUD treatment rates remained stable after the beginning of the COVID-19 pandemic. Furthermore, following the onset of the pandemic, there was no apparent decrease in the percent of members initiating MOUD treatment after being diagnosed. However, there was a slight decrease in the percent of members remaining in MOUD treatment for at least 90 days.

Increases in SUD-related emergency department visits and OUD-related overdoses

- There was a sizeable increase in SUD-related emergency department (ED) visits between SFY 2019 and 2020 (28%), while ED visits overall decreased by 2.3% during this period.

- Similarly, OUD-related overdose rates (fatal and nonfatal) increased 57% between SFY 2019 and 2020, similar to state and national trends. The overdose rate peaked during the height of the COVID-19 pandemic in 2020 (July-September) before decreasing in October-December, 2020.

- Of the Medicaid members diagnosed with an OUD-related overdose, 80% did not receive MOUD treatment in the month or year prior to their overdose. However, there was a small increase between SFY 2019 and 2020 in the percent of members with overdoses who were receiving MOUD treatment in the month prior to their overdose.

Medicaid expansion greatly increased the number of Virginians receiving treatment for SUD through the ARTS benefit. As other studies have shown, Medicaid members enrolled through expansion have higher SUD prevalence compared to other eligibility groups, and are at higher risk for overdoses.[2] It is likely that many members who enrolled through Medicaid expansion were previously uninsured and were not receiving adequate treatment for SUD, although there were no data available to confirm this. National data show that uninsured people with SUD have much higher levels of unmet need for treatment services compared to people enrolled in Medicaid.[3] By enrolling in Medicaid expansion, more Virginians gained access to the full continuum of outpatient, residential, inpatient, and pharmacotherapy services that are known to be effective in treating SUD, especially OUD.

Nevertheless, it is a paradox that OUD-related overdoses increased during a time that also saw gains in the supply of treatment services and increased rates of treatment for Medicaid members with a SUD diagnosis. Members with an OUD were initiating MOUD treatment at the same rate during the pandemic as before, although there was a small decrease in 90 day continuity of treatment after the pandemic started. The increase in overdose rates is not unique to Virginia Medicaid, but reflect statewide and national trends. The increase in overdoses likely reflects the changing nature of the opioid epidemic, from greater availability and use of more lethal forms of opioids – especially fentanyl – as well as higher levels of economic, social, and psychological distress during the COVID-19 pandemic that may be increasing the risk of recurrence and overdose.

Introduction

The COVID-19 pandemic has exacerbated problems with SUD in Virginia and the nation. In Virginia, fatal drug overdoses increased by 35% between State Fiscal Years (SFY) 2020 and 2021 (from 1,818 fatal overdoses in the year ending in June 2020 to 2,455 fatal overdoses in the year ending June 2021), and by 21% between SFY 2019 and 2020.[4] Nationally, fatal overdoses increased by 20% and 22% during the same period. While opioids continue to account for the vast majority of overdose deaths in the U.S. and Virginia (83% projected in 2021), there has been a marked shift in the type of opioids responsible for overdoses. Deaths from fentanyl overdoses more than doubled between SFY 2019 and 2021 in Virginia (from 884 to 1,900), while there was little change in deaths due to prescription opioids, and even a small decrease in deaths from heroin.[5] At the same time, overdose deaths in Virginia due to methamphetamines and cocaine increased by 219% and 73%, respectively, between SFY 2019 and 2021.[5] An increase in alcohol use disorder is also contributing to increased mortality from substance use, accounting for 95,000 deaths nationally and 22.1% of prescription opioid overdose deaths.[6,7]

There are a number of possible reasons for the surge in fatal overdoses and greater use of drugs and alcohol during the pandemic, including increases in the supply and availability of illicit drugs – especially fentanyl and methamphetamines – economic dislocation, unemployment, greater social isolation, and an increase in co-occurring mental health problems.[8] Also, access to addiction treatment services may have become more difficult due to COVID-related shutdowns and more restrictions on face-to-face meetings with licensed behavioral health and medical professionals and peer recovery specialists, a health system that has been severely strained by the pandemic, and growing shortages of behavioral health providers in Virginia and the nation.[9]

The onset of the COVID-19 pandemic follows a major expansion of treatment services for SUD in the Virginia Medicaid program. In April 2017, the Addiction and Recovery Treatment Services (ARTS) benefit was implemented. ARTS expanded coverage of many addiction treatment services for Medicaid members aligning with the American Society of Addiction Medicine (ASAM) levels of care, including community-based services, short-term residential treatment and inpatient withdrawal management services. To allow federal Medicaid payment for addiction treatment services provided in inpatient and short-term residential facilities with 16 or more beds, a Section 1115 Demonstration Waiver for SUD was approved in December 2016 by the Centers for Medicare and Medicaid Services (CMS). ARTS also increased provider reimbursement rates for many existing services, and introduced a new care delivery model for treatment of Opioid Use Disorders (OUD), the Preferred Office-Based Opioid Treatment (OBOT) provider, which integrated medications for OUD (MOUD) with co-located behavioral and physical health by incentivizing increased use of care coordination activities. To further increase integration of addiction treatment services with other health services covered by Medicaid, SUD services are administered by the six managed care organizations (MCOs) that manage medical and behavioral health benefits for all Medicaid members, offering a comprehensive care delivery system.

While ARTS greatly increased the availability and quality of treatment services to Medicaid members, eligibility for these services increased on January 1, 2019 when Virginia expanded Medicaid eligibility for adults ages 19-64 with family incomes of up to 138 percent of the federal

poverty level, as allowed for under the Patient Protection and Affordable Care Act. By December 2021, 493,662 low-income Virginians were enrolled through Medicaid expansion.[10] During the COVID-19 pandemic, Medicaid expansion provided an important safety net for many people who lost their job and their employer-based private health insurance coverage.

Prior evaluation reports on the ARTS benefit have documented the impact of ARTS and Medicaid expansion on utilization of ARTS services. The number of Medicaid members using ARTS treatment services more than doubled, from 17,120 in 2017 to 46,520 in 2019. [11] Among those with OUD, the percent using MOUD treatment increased from 35% in 2016 to 53% in 2019, an increase that was far greater than for Medicaid members in twelve other states.[11] At the same time, ED visits among those with OUD decreased (relative to Medicaid members who did not have OUD), although this analysis preceded the more recent surge in overdose deaths.[12]

Increased prevalence of SUD during the COVID-19 pandemic has likely increased the demand for ARTS services. To offset potential barriers to treatment access due to pandemic-related restrictions, DMAS implemented a number of new initiatives and procedural flexibilities that the federal government permitted as part of the emergency response to COVID-19. These include allowing take-home dosages of methadone and buprenorphine for up to 28 days (which otherwise must be administered at Opioid Treatment Programs (OTPs), allowing a member's home to serve as the originating site for prescription of buprenorphine, allowing a 90 day supply of buprenorphine, increased use of telehealth, waiver of drug copayments, and fewer restrictions on the use of certain unlicensed providers. In compliance with federal legislation, eligibility redeterminations and coverage cancellations have been suspended in order to increase continuity of coverage and prevent coverage lapses during the pandemic.

The objective of this report is to examine SUD prevalence, treatment utilization, and outcomes among Virginia Medicaid members during State Fiscal Year (SFY) 2019 and 2020, as well as the first two quarters of SFY 2021 (covering July 2018 through December 2020). This time period overlaps with the start of Medicaid expansion in January 2019 as well as the beginning of the COVID-19 pandemic in March 2020, which has led to substantial increases in the diagnosed prevalence and treatment of SUD among Medicaid members.

Methodology

Most of the analysis in this report is based on paid claims for services received by Virginia Medicaid members. As a consequence, the analysis excludes services received during periods in which individuals were not enrolled in Medicaid, services not covered by Medicaid, and claims that were submitted and denied or otherwise processed and not reimbursed at the time of data extraction and analysis for this report (October-December, 2021). In general, a "claims runout" period of 10-12 months is a sufficient period of time for the vast majority of claims to be processed for services received through December 2020.

Diagnosed prevalence of SUD is defined as a member having any claim during the study period with a primary or secondary diagnosis of SUD, based on ICD-10 codes. Measures of the utilization of ARTS services are based on the procedure codes and ICD10 diagnostic codes used by DMAS, MCOs, and treatment providers to bill for the various ARTS services. These services

correspond to the ASAM continuum of care, ranging from medically managed intensive inpatient services (ASAM level 4), residential care (ASAM 3), intensive outpatient and partial hospitalization (ASAM 2) and outpatient treatment services (ASAM levels 1 and 2).[13] Services received in Preferred OBOT and OTP providers are identified separately, as are services for peer recovery support, case management, and care coordination. Pharmacotherapy services are identified through pharmacy claims based on National Drug Codes and Generic Sequence Numbers for prescriptions used to treat OUD (buprenorphine, naltrexone) and Alcohol Use Disorder (AUD), as well as procedure codes for methadone treatment in OTPs.

SUD-related ED visits are defined as ED visits with a primary or secondary diagnosis of SUD, as described above. OUD-related overdoses include fatal as well as nonfatal overdoses based on ICD-10 diagnosis codes for overdoses and poisonings that have been previously validated.[14] It should be noted that only overdoses that are treated in health care settings and for which the submitted claim was reimbursed by Medicaid are included in this definition. Overdoses that occurred in the community, did not involve contact with health care providers nor receipt of a Medicaid claim are not included.

Supply of Addiction Treatment Providers

A broad range of addiction treatment facilities and practitioners are available to Medicaid members along the continuum of care, as defined by the ASAM placement criteria.[13] These include hospital-based intensive inpatient facilities, residential treatment centers, and outpatient providers of varying types and treatment intensity. The ARTS benefit also introduced a new model of care delivery, the Preferred OBOT program that pays significantly higher reimbursement rates to qualified providers for medication-assisted treatment (including pharmacotherapy and behavioral health therapy) and coordination with other medical and social needs. Since ARTS was implemented in April 2017, Virginia has seen substantial increases across all types of addiction treatment providers and facilities that not only serve Medicaid members, but also individuals with other insurances or uninsured. The expansion of the provider network supported through ARTS has benefited all individuals in the Commonwealth through increased access to treatment and recovery services based on the ASAM Criteria.

Providers for ARTS services

Addiction Provider Type	# of Providers before ARTS	# of Providers as of December. 2020
Inpatient Detox (ASAM 4.0)	N/A	51
Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)	4	123
Partial Hospitalization Programs (ASAM 2.5)	N/A	41
Intensive Outpatient Programs (ASAM 2.1)	49	252
Opioid Treatment Programs	6	40
Preferred Office-Based Opioid Treatment Providers	N/A	154
Outpatient practitioners billing for ARTS services (ASAM 1)	1,087	5,089

Buprenorphine waivered prescribers

There are three Food and Drug Administration (FDA) approved medications for treatment of OUD: methadone, naltrexone and buprenorphine. Methadone for the treatment of OUD is federally limited to being dispensed in specially licensed clinics, although these restrictions were loosened during the COVID-19 pandemic to allow take-home dosages of up to a 28 day supply. Because buprenorphine treatment for OUD does not require that medication be administered at OTPs, it allows for greater access to MOUD treatment in a wider variety of treatment settings, provider types, and specialties. Virginia Medicaid has promoted the prioritization of patient choice in the selection of evidence-based medication for treatment of OUD. This includes a targeted effort to increase access to buprenorphine treatment through newly implemented Preferred OBOTs in 2017 – an integrated care model that receives enhanced reimbursement for OUD treatment – and more recently by eliminating the need for prior authorization for buprenorphine prescribing for

practitioners regardless if they are enrolled with DMAS, it's contractors, or MCO networks. During the COVID-19 pandemic, DMAS also permits a member's home to serve as the originating site via telemedicine for a prescription of buprenorphine, both for induction and maintenance dosing (prior to the pandemic, buprenorphine prescriptions for inductions could only be obtained through a face-to-face meeting with authorized prescribers as required by Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Agency).

Prescriptions for buprenorphine can only be received from practitioners who apply for and receive waivers through SAMHSA. Since the federal Comprehensive Addiction and Recovery Act (CARA) of 2016, nurse practitioners and physician assistants are also permitted to obtain waivers to prescribe buprenorphine. Research has shown that increases in the number of practitioners who receive waivers are associated with increases in the quantity of prescribing, the number of patients served, and fewer overdoses.[15,16] Therefore, having an adequate supply of buprenorphine-waivered prescribers in the Commonwealth is crucial for patient access to OUD treatment and outcomes.

In April-June, 2020, Virginia had 1,495 buprenorphine-waivered prescribers, or 18.3 prescribers per 100,000 persons in the state. This includes 1,029 prescribers whose waiver limits them to treating no more than 30 patients (10.9 prescribers per 100,000 persons), and 466 prescribers with waiver limits of 100 or 275 patients (7.4 prescribers per 100,000 persons). The number of waivered prescribers in Virginia is similar to the South region on average, but below the national average of 27 total prescribers per 100,000 persons. In general, states in the South have fewer waivered prescribers compared to other regions, including the Northeast (45.4 prescribers per 100,000 persons), the West (30.5) and Midwest (23.2).

Number of X-waivered prescribers, as of the April-June 2020.

	Number of X-waivered prescribers per 100,000 persons		
	Total	30 patient limit	100 and 275 patient limit
Virginia	18.3	10.9	7.4
Total U.S.	27.0	19.7	7.3
South	18.0	11.9	6.2
Northeast	45.4	33.5	11.8
Midwest	23.2	16.8	6.4
West	30.5	24.0	6.4

Increase in number of waivered prescribers

The expansion of benefits with ARTS, collaborative efforts with the Virginia Department of Health to train and encourage more providers to seek buprenorphine waivers, and the increase in Medicaid members eligible for ARTS services through Medicaid expansion has likely contributed to an increase in waivered prescribers. Prior research has shown that Medicaid expansion in other states led to an increase in buprenorphine prescribing capacity.[17]

The number of waivered prescribers in Virginia increased from 432 prescribers in 2015 to 1,495 in 2020 (a 246% increase).[i] This includes an 89.4% increase following implementation of the ARTS benefit in 2017, and an 82.8% increase following Medicaid expansion in 2019. Moreover, much of the increase since 2017 resulted from an increasing number of nurse practitioners and physician assistants receiving waivers. Between 2018 and 2020, buprenorphine-waivers among nurse practitioners increased by 283%, among physician assistants by 200%, and among medical doctors (MDs) by 54%. As of 2020, nurse practitioners and physician assistants comprise over one-fourth of waivered practitioners in the Commonwealth.

Number of X-waivered prescribers in Virginia (as of April-June for each year).

	2015	2016	2017	2018	2019	2020	% change 2015-18	% change 2018-20	% change 2015-20
All prescribers	432	491	621	818	1,074	1,495	89.4%	82.8%	246%
Patient limit									
30	288	320	411	570	763	1,029	97.9%	80.5%	257%
100 or 275	144	171	210	248	311	466	72.2%	87.9%	224%
License type									
MD	432	491	605	708	863	1090	63.9%	54.0%	152%
Nurse practitioner	0	0	13	90	181	345	NA	283%	NA
Physician assistants	0	0	3	20	30	60	NA	200%	NA

The growth in waivered prescribers among nurse practitioners is especially important, as research has shown they are twice as likely to treat Virginia Medicaid patients compared to MDs, and almost three times as likely to treat large numbers of Medicaid patients.[18] As only about 40% of buprenorphine-waivered prescribers treated any Medicaid patients in 2019, continued growth in nurse practitioners and physician assistants with waivers will likely help to address gaps in supply of and access to buprenorphine treatment among Medicaid members.

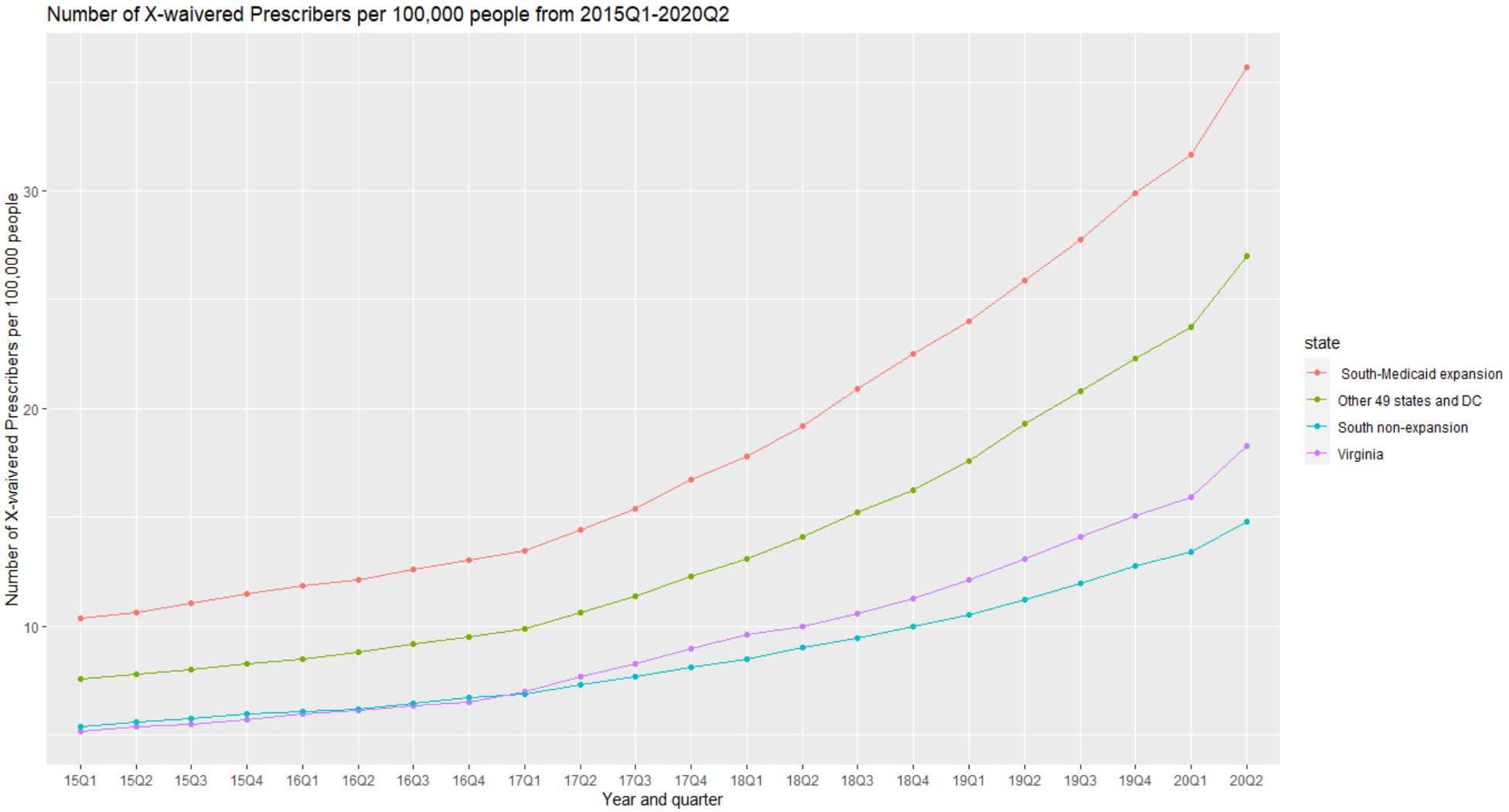
The increase in the supply of waivered prescribers in Virginia is similar to the average for other states (a 246% increase between 2015 and 2020). When compared to other states in the South, the supply of waivered prescribers in Virginia increased at a similar rate to states that had expanded Medicaid by 2015 (DE, MD, DC, WV, KY). Virginia's increase of 240% between 2015 and 2020 was far greater than for states in the South that had not expanded Medicaid by 2016 (166%). Between 2018 and 2020 (the year before and after Medicaid expansion in Virginia), the number of waivered prescribers increased 82% in Virginia, compared to 61% in Southern states that had not expanded Medicaid.

[i] Data on buprenorphine- waivered prescribers was obtained from the Drug Enforcement Agency through a Freedom of Information Act (FOIA) request. Inactive prescribers are not excluded from the counts, so the number who are actually treating patients is likely to be lower than is reported in these findings.

Number of buprenorphine-waivered prescribers per 100,000 persons (as of April-June for each year)

	2015	2016	2017	2018	2019	2020	% change 2015-18	% change 2018-20	% change 2015-20
Virginia	5.4	6.1	7.7	10	13.1	18.3	87.3%	81.8%	240.4%
Non-expansion states in South	5.6	6.2	7.3	9	11.2	14.8	61.3%	65.1%	166.3%
Expansion states in South	10.6	12.1	14.4	19.2	25.9	35.7	80.9%	86.2%	236.9%
Total U.S.	7.8	8.8	10.6	14.1	19.3	27	81.5%	90.8%	246.2%

The following chart graphically illustrates the increase in buprenorphine waivered prescribers in Virginia compared to other states for all 22 quarters between 2015 and 2020. While Virginia and other Southern states that had not expanded Medicaid by 2015 had roughly similar levels of waiver provider supply prior to 2017 (about 5.5 per 100,000 persons), the increase in waivered prescribers appears to accelerate in Virginia in April-June of 2017 (at the time of the implementation of Virginia's ARTS benefit) as well as Medicaid expansion in 2019. By April-June 2020, the increase in waiver supply since 2015 had clearly exceeded the increase for other states in the South that did not expand Medicaid during this period.


Number of X-waivered Prescribers per 100,000 people from 2015Q1-2020Q2
Number of X-waivered Prescribers per 100,000 people
30
20
10
15Q1
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19Q2
19Q3
19Q4
20Q1
20Q2
Year and quarter
state
South-Medicaid expansion
Other 49 states and DC
South non-expansion
Virginia

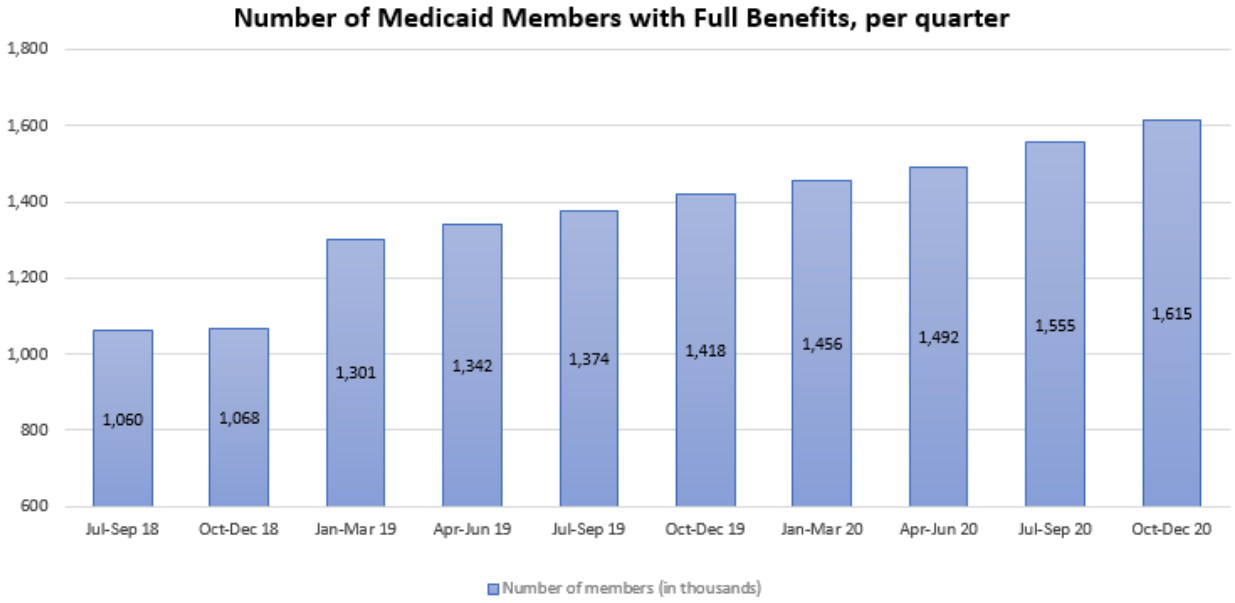
Medicaid Enrollment

There were 1,651,637 Virginians enrolled in full Medicaid benefits at some point during SFY 2020, a 12% increase from SFY 2019. Most of the increase occurred among those enrolling through Medicaid expansion, from 324,643 members in SFY 2019 to 505,666 members in SFY 2020, a 56 percent increase. Consistent with Medicaid expansion eligibility criteria, enrollment increases were concentrated among nonelderly adults ages 22-64. Increases were somewhat larger for males relative to females, and considerably larger among people reporting "other" racial/ethnic groups (non-White, non-Hispanic).

Enrollment in full Medicaid benefits at any time during the year.

	SFY 2019	SFY 2020	Percent change
Total number of Medicaid members	1,476,202	1,651,637	11.9%
Age			
LT 12	484,828	466,473	-3.7%
12-21	317,562	353,761	11.4%
22-34	233,800	293,885	25.7%
35-44	136,875	173,436	26.7%
45-54	106,041	133,810	26.2%
55-64	104,837	134,616	28.4%
65+	92,259	95,656	3.7%
Gender			
Male	638,411	723,019	13.3%
Female	841,731	930,939	10.6%
Race/Ethnicity			
White, non-Hispanic	766,331	853,091	11.3%
Black, non-Hispanic	531,970	580,863	9.2%
Hispanic	57,054	61,314	7.5%
Other	118,749	156,332	31.6%
Aid Category			
Medicaid Expansion	324,643	505,666	55.8%
Non-Disabled Adults	593,294	424,702	-28.4%
Pregnant Women	238,206	233,049	-2.2%
Low Income Children	775,969	784,336	1.1%
Aged Adults	90,293	92,639	2.6%
Blind/Disabled	173,469	166,581	-4.0%

On a quarterly basis, enrollment spiked at the start of Medicaid expansion in the third quarter of SFY 2019 (to around 1.3 million) and increased steadily thereafter. During the COVID-19 pandemic starting in January-March, 2020, quarterly enrollment increased by about 160,000 to around 1,652,000 by October-December 2020. Medicaid enrollment likely increased due to the loss of private insurance by those who became unemployed during the pandemic. Also, lapses in coverage likely decreased due to the suspension of eligibility redeterminations and coverage cancellations as part of the federal response to the pandemic emergency.



Diagnosed Prevalence of Substance Use Disorders

Just over 100,000 Medicaid members had a diagnosed SUD in SFY 2020, an increase of almost 30% from SFY 2019. As in prior years, OUD was the most frequently diagnosed SUD in SFY 2020 (40,465 members) followed by AUD (37,647 members), cannabis (27,290 members), and stimulants, which includes the use of methamphetamines (22,493 members).

Stimulant use is especially concerning given the almost 50% increase in Medicaid members with this diagnosis between SFY 2019 and 2020. During the same period, diagnosed OUD prevalence increased by 38.7%, AUD by 34%, and cannabis use by 38%. There was also a 58.4% increase in diagnoses related to hallucinogens, although overall prevalence of hallucinogens is still very low (only 822 members with diagnoses in SFY 2020).

The increase in SUD prevalence reflects in part increases in Medicaid enrollment between SFY 2019 and 2020, as noted earlier. However, the prevalence *rate* for SUD (calculated as the number of members with a SUD diagnosis per 100,000 members) increased by 16%, from 5,218 with a SUD diagnosis per 100,000 members in SFY 2019 to 6,055 per 100,000 members in SFY 2020. The increase in the prevalence rate was higher for SUD diagnoses related to stimulant use (33.8%), OUD (23.9%), AUD (19.8%), and cannabis use (23.4%).

Diagnosed prevalence of SUD, SFY 2019 and 2020

	Number of Medicaid members with diagnosis			Members with diagnosis per 100,000 members		
SUD diagnoses	**SFY 2019**	**SFY 2020**	**Percent change**	**SFY 2019**	**SFY 2020**	**Percent change**
Any SUD	77,030	100,005	29.8%	5,218	6,055	16.0%
Opioid use disorder (OUD)	30,520	42,317	38.7%	2,067	2,562	23.9%
Alcohol use disorder (AUD)	28,087	37,647	34.0%	1,903	2,279	19.8%
Cannabis	20,229	27,920	38.0%	1,370	1,690	23.4%
Hallucinogens	519	822	58.4%	35	50	41.6%
Inhalants	162	170	4.9%	11	10	-6.2%
Sedatives, hypnotics, etc.	3,659	4,725	29.1%	248	286	15.4%
Stimulants	15,021	22,493	49.7%	1,018	1,362	33.8%
"Other or unknown"	18,379	23,254	26.5%	1,245	1,408	13.1%

SUD prevalence rates are much higher among nonelderly adults compared to youth and elderly members. The percent of members with a diagnosed SUD ranges from 10.3% to 14.4% for members ages 22-64, compared to 2.2% for members ages 12-21, and 5.5% for members aged 65 and older. SUD prevalence rates are also higher for males compared to females, although OUD prevalence is similar for both gender groups. Diagnosed prevalence is also higher for White, non-Hispanic members (7.7%) compared to Black, non-Hispanic members (5.6%) and Hispanic members (2.5%), although the prevalence rate for cannabis diagnosis is higher for Black and Hispanic members compared to White members. Consistent with age-related differences in

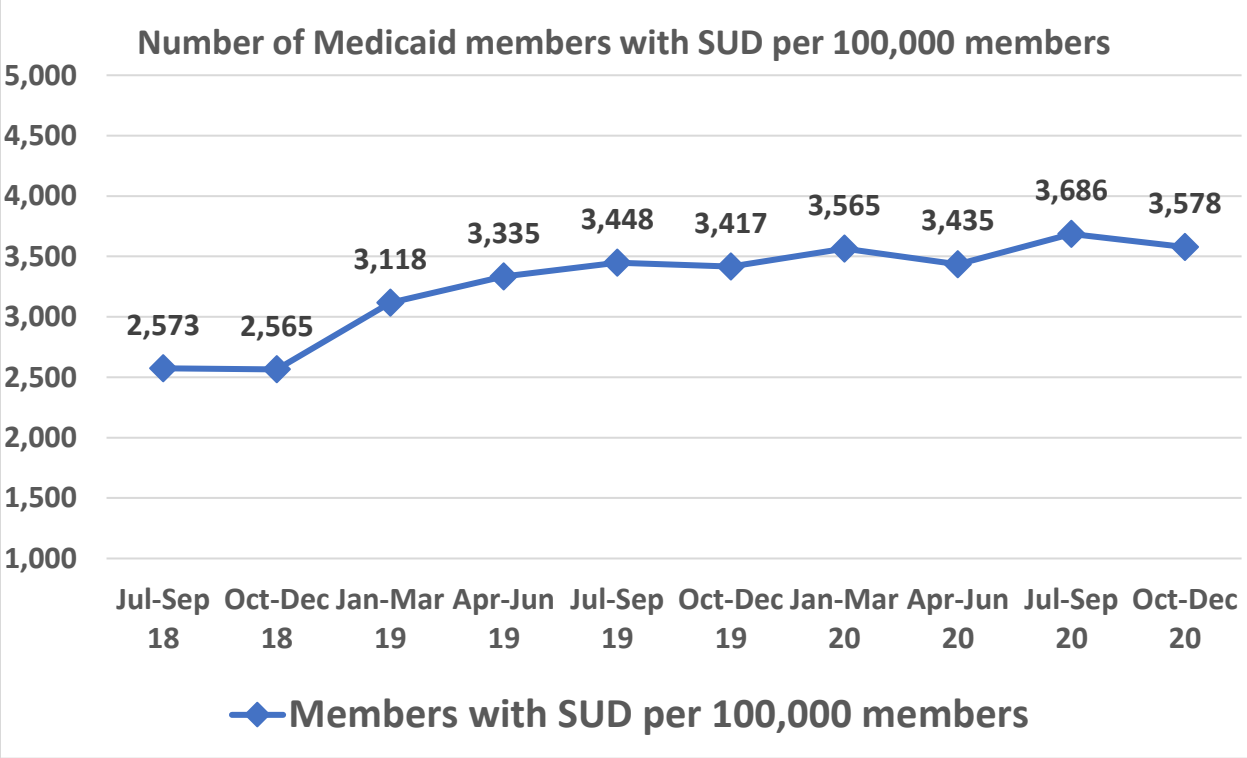
prevalence, prevalence rates are higher among Medicaid expansion and other non-disabled adults compared to members in other Aid categories.

It is important to note that differences by race/ethnicity, age, gender, and aid category are based on *diagnosed* prevalence of SUD, and does not account for the potential of underdiagnosis in some sub-populations. For example, racial/ethnic differences in access to treatment services, trust in providers due to historical discrimination and racism, stigma, and other factors may result in greater under-diagnosis of SUD among Black Medicaid members and other racial/ethnic minorities. By contrast, SUD prevalence based on patient self-reports (which does not depend on a clinician's diagnosis) shows little or no disparities by race/ethnicity.[19]

Prevalence of diagnosed SUD, by member characteristics, SFY 2020

	% with any SUD	% with OUD	% with AUD	% with cannabis diagnosis	% with stimulants diagnosis
All Medicaid members	6.1%	2.5%	2.3%	1.7%	1.4%
Age					
12-21	2.2%	0.3%	0.5%	1.5%	0.3%
22-34	10.3%	4.9%	2.9%	3.7%	2.7%
35-44	13.5%	7.1%	4.5%	3.5%	3.5%
45-54	14.3%	6.0%	6.5%	2.9%	3.5%
55-64	13.4%	4.1%	7.7%	2.1%	2.6%
65+	5.5%	1.9%	3.0%	0.4%	0.5%
Sex					
Male	7.4%	2.6%	3.4%	2.1%	1.7%
Female	5.4%	2.4%	1.6%	1.5%	1.2%
Race/ethnicity					
White, non-Hispanic	7.7%	3.6%	2.7%	1.8%	1.7%
Black, non-Hispanic	5.6%	1.5%	2.3%	2.0%	1.4%
Hispanic	2.5%	0.8%	0.9%	2.1%	0.5%
Other	2.6%	0.8%	1.2%	0.4%	0.5%
Aid category					
Medicaid expansion	10.8%	4.7%	4.3%	2.9%	2.7
Other non-disabled adults	9.1%	5.2%	2.1%	2.3%	1.9%
Pregnant members	6.0%	2.3%	0.7%	2.4%	1.1%
Low-income children	0.8%	0.1%	0.1%	0.3%	0.1%
Aged	4.9%	1.7%	2.7%	0.4%	0.5%
Blind/disabled	13.5%	5.0%	6.0%	3.7%	3.3%

On a quarterly basis, most of the increase in the SUD prevalence rate occurred between the October-December 2018 and July-September 2019 (corresponding to the first 9 months of Medicaid expansion). Since January-March 2020 at the start of the COVID-19 pandemic, changes in overall prevalence rates have been largely flat, even though the number of members with SUD continued to increase due to increasing enrollment during the pandemic. In sum, higher diagnosed SUD prevalence rates in recent years have been driven largely by the increase in nonelderly adults enrolled through Medicaid expansion, who tend to have much higher SUD prevalence rates compared to younger and older age groups. It is likely that many – if not most – of the Medicaid expansion members with SUD had pre-existing or undiagnosed SUD before enrolling. A prior report showed that in the first three months of Medicaid expansion in Virginia, over 12,000 expansion enrollees had a diagnosed SUD, comprising 4.4% of all new enrollees in the three months following the implementation of Medicaid expansion.[20]



Medicaid Members Treated for Substance Use Disorders

Trends in use of ARTS services

Coverage of SUD services provided by the ARTS benefit is based on the ASAM National Practice Guidelines, which comprise a continuum of care from Early Intervention/Screening, Brief Intervention, and Referral to Treatment (SBIRT / Level 0.5), outpatient treatment (ASAM 1), intensive outpatient treatment and partial hospitalization (ASAM 2), residential treatment services (ASAM 3) and medically managed intensive inpatient services (ASAM 4).[21] ARTS also emphasizes evidence-based treatment for OUD, which combines pharmacotherapy and counseling. In July 2017, DMAS added peer recovery support services as a covered service under the ARTS benefit, which serves to facilitate recovery from SUD. Care coordination services provided by Preferred OBOT and OTPs facilitate integration of addiction treatment services with physical health and social service needs.

Number of members using ARTS services, SFY 2019 and 2020.

	Number of members using services			Members using services per 100,000 members		
	SFY 2019	**SFY 2020**	**Percent change**	**SFY 2019**	**SFY 2020**	**Percent change**
Used any ARTS service	31,907	46,427	45.5%	2,161	2,811	30.1%
Type of service						
ASAM 1	23,278	36,159	55.3%	1,577	2,189	38.8%
OBOT/OTP	8,530	13,530	58.6%	578	819	41.8%
Care Coordination	5,542	9,543	72.2%	375	578	53.9%
ASAM 2	2,612	4,633	77.4%	177	281	58.5%
ASAM 3	2,517	4,300	70.8%	171	260	52.7%
ASAM 4	19	75	294.7%	1	5	252.8%
Pharmacotherapy	18,858	28,981	53.7%	1,277	1,755	37.4%
Case management	1,808	3,749	107.4%	122	227	85.3%
Peer recovery support services	601	1,124	87.0%	41	68	67.2%

In SFY 2020, 46,427 Medicaid members used some type of ARTS services, a 45.5% increase from SFY 2019. Most members who use ARTS services use ASAM 1 outpatient services (36,159 members, or 78 percent of all service users). Pharmacotherapy, almost all of which is MOUD treatment, is the second most frequently used service (28,981 members).

There was also a large increase (30.1%) in service use per 100,000 members, from 2,161 members per 100,000 using services in SFY 2019 to 2,811 members per 100,000 using services in SFY 2020. Increases in service use per 100,000 members was especially large for care coordination services (53.9%), ASAM 2 through ASAM 4 level services, and peer recovery support services (67.2%). Among members with a SUD diagnosis, the percent using any ARTS services increased from 41.4% in SFY 2019 to 46.4% in SFY 2020 (findings not shown).

Percent receiving any ARTS service, by type of diagnosis.

Members with OUD diagnoses are more likely to receive ARTS services compared to members with other SUD diagnoses. Among members with any OUD diagnosis, two-thirds (66.8%) used some type of ARTS service in SFY2020. ARTS utilization is considerably lower among members who had SUD diagnoses other than OUD, including 22.8% for those with AUD, 25.3% among those with a diagnosis of stimulant use disorder, and 12.1% among those with a diagnosis of cannabis use disorder. In contrast to OUD in which the clinical effectiveness of MOUD treatment has been well established, lower use of ARTS services among those with other SUD diagnoses may reflect less evidence about the effectiveness of treatment for other SUD, and greater reliance on non-medical treatment options, such as Alcoholics Anonymous and Narcotics Anonymous.

Number of members using ARTS services, by diagnosis

	Number of members	Members with any use of ARTS services[1]	Percent of members using ARTS services
All members	1,651,637	48,981	3.0%
Any SUD diagnosis	100,005	48,981	49.0%
Any OUD diagnosis	41,344	27,616	66.8%
No OUD diagnosis			
Had AUD diagnosis	32,182	7,322	22.8%
Had cannabis diagnosis	22,456	2,719	12.1%
Had stimulant diagnosis	13,207	3,335	25.3%
Had any other SUD diagnosis	16,006	1,297	8.1%

Use of Medications for Opioid Use Disorder

MOUD includes the use of buprenorphine, methadone and naltrexone as part of evidence-based treatment for OUD. This method is considered the gold standard of care for treating OUD, and has been found to be the most effective treatment in preventing OUD-related overdoses. A previous report showed MOUD treatment rates among members with OUD increased by over 20% following implementation of the ARTS benefit (from 33.6% in 2016 to 55.0% in 2018), compared to an 8.6% increase over the same time period for Medicaid members in other states that did not implement changes on the scale of the ARTS benefit.[11] To further increase access to buprenorphine treatment beginning in March 2019, DMAS removed prior authorization requirements for suboxone films for in-network prescribers.[22]

Members receiving MOUD treatment continued to increase during Medicaid expansion and the onset of the COVID-19 pandemic. In SFY2020, 28,981 members received MOUD treatment, a 53.7% increase from SFY2019. As in prior years, buprenorphine treatment was the most common form of MOUD treatment (17,295 members, or 60 percent of all members receiving MOUD), followed by methadone treatment and naltrexone (9,577 and 3,583 members, respectively). The largest increase in MOUD between SFY 2019 and 2020 was for naltrexone (81.1%), although this medication remains less frequently used than other MOUD.

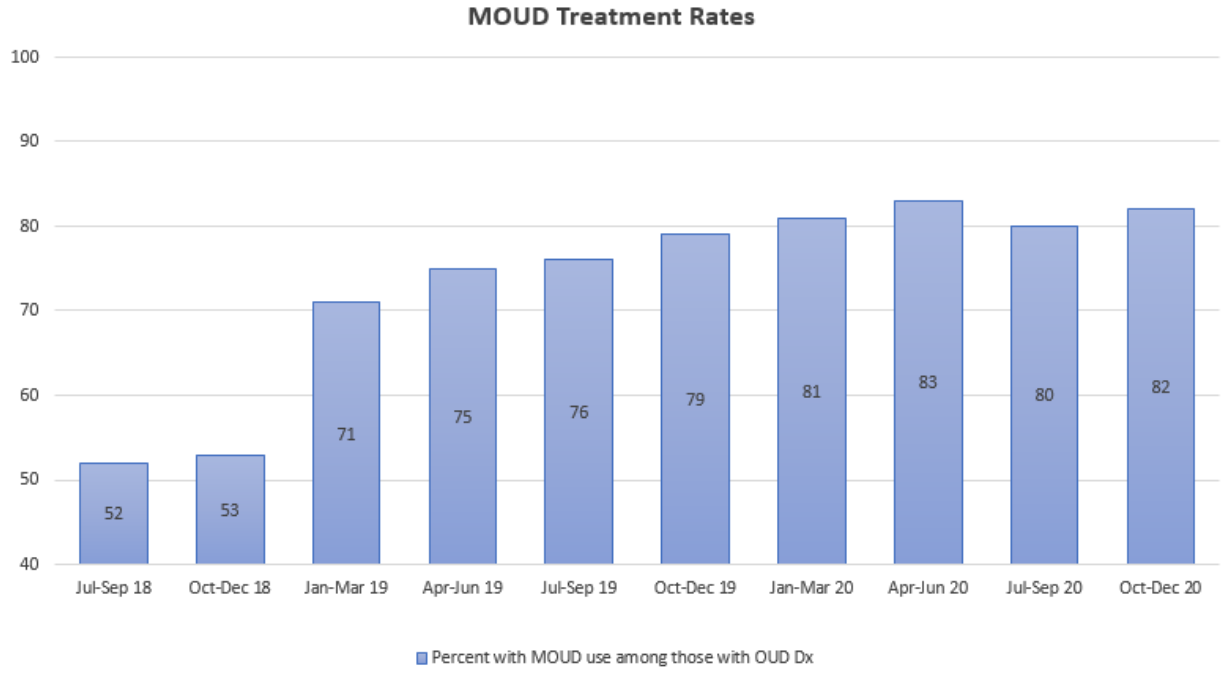
Medicaid members using MOUD treatment.

	SFY 2019	SFY 2020	Percent change
Number of members with any MOUD use*	18,858	28,981	53.7%
Buprenorphine	11,520	17,295	50.1%
Methadone	6,121	9,577	56.5%
Naltrexone	1,979	3,583	81.1%
MOUD treatment rate*	61.8	68.5	10.8%
Buprenorphine	37.7	40.9	8.3%
Methadone	20.1	22.6	12.8%
Naltrexone	6.5	8.5	30.6%

*Number of members with treatment / number of members with OUD diagnosis

MOUD treatment rates (the percent of members with OUD diagnoses who received MOUD treatment) also increased, from 61.8% in SFY 2019 to 68.5% in SFY 2020. As mentioned above, this is a continuation of a longer-term trend since implementation of the ARTS benefit in April, 2017.[11]

On a quarterly basis, MOUD treatment rates increased from 52% in July-September 2018 to 82% October-December 2020.[ii] MOUD treatment rates surged in January-March 2019 – at the start of Medicaid expansion – and increased steadily through 2020 before leveling off. It is possible that the removal of prior authorization requirements for prescribing of suboxone films in March 2019 also contributed to increases in MOUD treatment rates.



Changes in MOUD initiation and continuity of treatment during COVID-19.

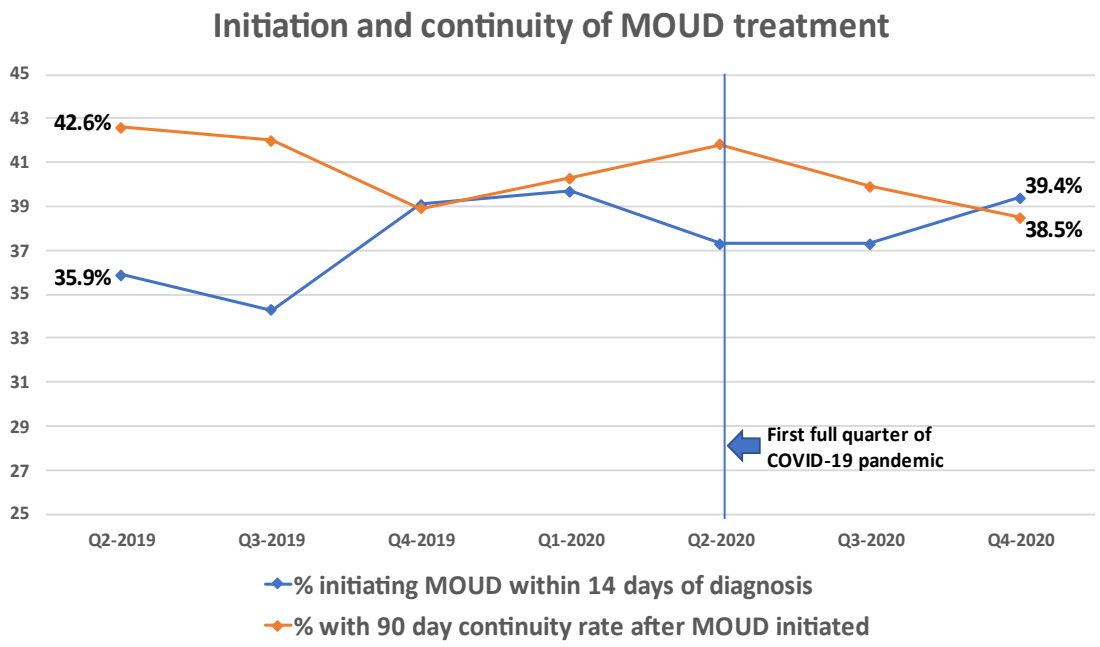
Additional analysis suggests there has been little change in MOUD treatment access and quality since the start of the COVID-19 pandemic. Since MOUD treatment usually requires in-person visits to treatment providers and clinics (e.g. for methadone administration and initiation of buprenorphine prescriptions), there was concern that pandemic-related shutdowns and the stay-at-home order issued by the Governor at the beginning of the pandemic to slow the rate of COVID transmission would limit face-to-face contact between patients and providers, leading to severe disruptions in access to MOUD and other SUD treatment. To mitigate against these potential barriers, the federal government and DMAS, with support from the Department of Health and Human Resources and the Governor, implemented a number of measures designed to allow greater flexibility on how treatment is initiated and received. These measures include allowing up to a 28 day supply of take-home dosages for methadone and buprenorphine dispensed at OTPs (which previously required patients to show up at the clinic for a daily dose), allowing a member's home to

[ii] Rates by quarter do not correspond to rates for state fiscal year because of different time periods used to compute numerators and denominators.

serve as the originating site for a prescription of buprenorphine via telemedicine (both inductions and maintenance), and allowing for a 90 day supply of buprenorphine prescriptions.

While our analysis did not directly test the effects of these new flexibilities on treatment, there was very little change in MOUD treatment initiation rates after the start of the pandemic.[iii] As of April-June 2019, 35.9% of members who had been diagnosed with OUD had initiated MOUD treatment within 14 days of the diagnosis. While there was some fluctuation from quarter to quarter, MOUD initiation rates did not noticeably decrease after the start of the pandemic, and were slightly higher by October-December 2020 (39.4%).

Among those who initiated MOUD treatment in April-June 2019, 42.6% were continuously in treatment for at least 90 days following initiation.[iv] While increasing slightly between January-March 2020 and April-June 2020, 90 day continuity rates decreased somewhat thereafter – from about 41% in April-June 2020 to 38.5% in October-December 2020. It is unclear to what extent this decrease was COVID-19 related or reflecting part of a seasonal trend. For example, there was a similar decrease in 90 day continuity rates during the same period in 2019, before the pandemic.



[iii] All results shown in the following chart are limited to members ages 18-64 with at least 90 days of continuous, full Medicaid eligibility as of the initial diagnosis. New diagnoses and MOUD claims required a 90 day "wash-out" period with no other OUD diagnoses or MOUD claims within 90 days of the index OUD diagnosis.

[iv] Continuity is defined as allowing no more than a 7 day gap between MOUD prescription refills or office dates of surplus.

Emergency Department Use Related to SUD

Hospital ED visits related to SUD include fatal and nonfatal overdoses as well as other acute events directly or indirectly related to SUD. Previous analyses of the ARTS benefit showed a marked decrease in ED visits among members with OUD following implementation of the ARTS benefit relative to members who did not have a diagnosed OUD,[12] suggesting improved access to SUD treatment services. However, SUD-related ED visits among Medicaid members have increased substantially in recent years.

In SFY 2020, there were 72,417 SUD-related ED visits, a 43.0% increase from SFY2019. In addition, there were 14,084 OUD-related ED visits, representing a 47.0% increase from the prior year. By comparison, ED visits for all causes increased only 9.3%, amounting to 1,170,313 visits in SFY 2020.

Emergency department visits among Medicaid members, SFY 2019 and 2020

	SFY 2019	SFY 2020	Percent change
ED visits (all cause)			
Number of members with a visit	503,983	544,884	8.1%
Total number of visits	1,070,703	1,170,313	9.3%
SUD-related ED visits			
Number of members with a visit	29,635	39,930	34.7%
Total number of visits	50,643	72,417	43.0%
OUD-related ED visits			
Number of members with a visit	7,009	9,858	40.6%
Total number of visits	9,578	14,084	47.0%
ED visits per 1,000 members (all cause)			
Number of members with visit	341.4	329.9	-3.4%
Total visits	725.3	708.6	-2.3%
SUD-related ED visits per 1,000 members			
Number of members with visit	20.1	24.2	20.4%
Total visits	34.3	43.8	27.8%
OUD-related ED visits			
Total members with visit	4.7	6.0	25.7%
Total visits	6.5	8.5	31.4%

SUD-related ED visits increased even after adjusting for increases in Medicaid enrollment during the period. There were 43.8 SUD-related ED visits per 1,000 members in SFY 2020, a 27.8% increase from the prior year. Also, there were 8.5 OUD-related ED visits per 1,000 members in SFY 2020, a 31.4% increase from the prior year. By comparison, the overall number of ED visits per 1,000 Medicaid members *decreased* by 2.3% between SFY 2019 and 2020.

On a quarterly basis, the largest increases in SUD-related ED visits per 1,000 members occurred during SFY 2019, and is therefore likely related to Medicaid expansion when large numbers of new adult members enrolled, of whom a disproportionately large number had SUD. Since the first quarter of SFY 2020 (July-September 2019), the rate of SUD-related ED visits per 1,000 members has leveled off, and even decreased in some quarters.

Since the onset of the COVID-19 pandemic (January-March, 2020), there has been little change in the rate of SUD-related ED visits. However, the overall number of ED visits per 1,000 members decreased sharply during the same time period, likely reflecting pandemic-related restrictions on access to hospital services. In sum, despite the lack of change, SUD-related ED visits increased *relative* to ED visits overall after the onset of the pandemic.

Emergency department visits per 1,000 members, by quarter.

	SFY 2019				SFY 2020				SFY 2021	
	JUL–SEP 2018	OCT-DEC 2018	JAN–MAR 2019	APR–JUNE 2019	JUL–SEP 2019	OCT–DEC 2019	JAN–MAR 2020	APR–JUNE 2020	JUL-SEP 2020	OCT–DEC 2020
All ED visits (all cause)										
Members with any ED visit	139.5	147.2	167.3	159.3	152.5	160.6	156.8	91.1	112.6	107.7
Total number of ED visits	206.4	211.1	241.5	232.6	225.0	233.8	227.7	132.6	165.8	156.4
SUD-related ED visits	`									
Members with any ED visit	6.2	5.9	8.5	9.6	9.7	8.9	9.0	8.5	9.4	8.3
Total number of ED visits	8.5	7.8	11.7	13.4	13.7	12.3	12.5	12.0	13.1	11.5
OUD-related ED visits										
Members with any ED visit	1.4	1.3	1.8	2.1	2.1	2.0	2.1	2.0	2.4	2.0
Total number of ED visits	1.6	1.6	2.1	2.6	2.5	2.4	2.5	2.4	2.8	2.4

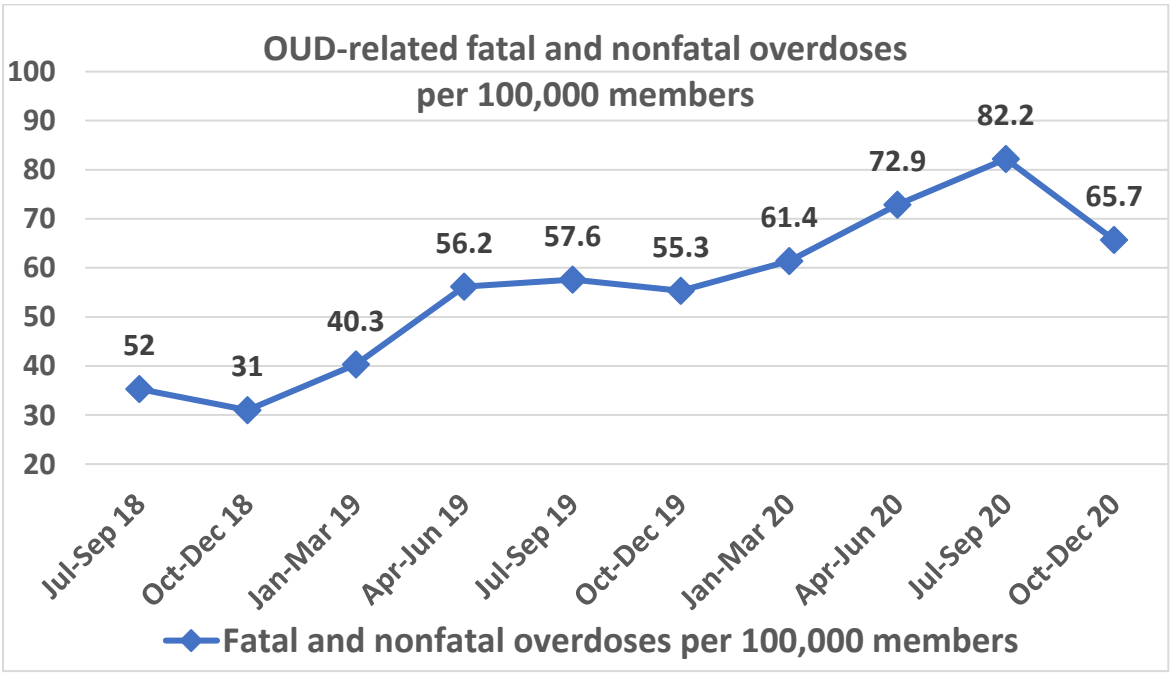
OUD-Related Overdoses

In SFY 2020, there were 3,292 opioid-related overdoses (fatal and nonfatal) among Medicaid members, as reported in the claims data. Consistent with state and national increases in overdose deaths, this represents a 75.7% increase from SFY 2019. The rate of opioid-related overdoses also increased by 57.1%, from 127 overdoses per 100,000 Medicaid members in SFY 2019 to 199 overdoses per 100,000 members in SFY 2020. Even among those who had an OUD diagnosis at some time during the year, the proportion with an overdose increased from 6.1% in SFY 2019 to 7.8% in SFY 2020.

OUD-related overdoses among Medicaid members, SFY 2019 and 2020

	SFY 2019	SFY 2020	Percent change
Number of OUD-related overdoses	1874	3292	75.7%
OUD-related overdoses per 100,000 members	126.9	199.3	57.1%
Percent with OUD-related overdose among those with OUD diagnosis	6.1%	7.8%	27.9%

A closer look at overdose rates by quarter shows a sharp increase in overdoses between the end of 2018 and the first two quarters of CY 2019, which reflects in part the increase in adult enrollment through Medicaid expansion, of whom a disproportionate number had OUD. Also, there was an additional surge beginning near the start of the COVID-19 pandemic in April-June, 2020. After peaking at 82.2 overdoses per 100,000 members in July-September 2020, the overdose rate decreased to 65.7 per 100,000 during October-December 2020. It is unknown whether this decrease is a temporary fluctuation or the beginning of a longer-term decrease.



Consistent with trends in OUD prevalence, overdose rates tend to be higher among nonelderly adults, males, and Non-Hispanic Whites. Among Medicaid eligibility categories, overdose rates are highest among Medicaid expansion members and other nondisabled adults (consistent with the higher rates among nonelderly adults) as well as members in the blind and disabled eligibility group. The overdose rate increased across most demographic groups and eligibility categories, with the exception of elderly members who experienced a 10.2% decrease in overdose rates between SFY 2019 and 2020. However, increases in overdose rates were by far the greatest among nonelderly adults, including a 174% increase in the overdose rate among members ages 35-44. In sum, the increase in the overall overdose rate among Medicaid members reflects both an increase in the number of nonelderly adults – who tend to have higher prevalence of OUD – and increases in the overdose rate among nonelderly adult members.

OUD-related overdoses, by member characteristics

	SFY 2019			SFY 2020			
	All Medicaid members	**Medicaid members with overdoses**	**Overdose rate per 100,000 members**	**All Medicaid members**	**Medicaid members with overdoses**	**Overdose rate per 100,000 members**	**Percent change in overdose rate between SFY 2019 and 2020**
All members[1]	1,476,202	1,871	126.7	1,651,637	3,292	199.3	72.6
Age							
< 12	484,828	55	11.3	466,473	32	6.9	-38.9
12-21	317,562	96	30.2	353,761	161	45.5	15.3
22-34	233,800	561	239.9	293,885	1,150	391.3	151.4
35-44	136,875	401	293.0	173,436	810	467.0	174.1
45-54	106,041	338	318.7	133,810	591	441.7	122.9
55-64	104,837	290	276.6	134,616	423	314.2	37.6
65+	92,259	130	140.9	95,656	125	130.7	-10.2
Sex							
Male	638,411	864	135.3	723,019	1,852	256.1	120.8
Female	841,731	1,001	118.9	930,939	1,432	153.8	34.9
Race/ethnicity							
White, NH	766,331	1,255	163.8	853,091	2,064	241.9	78.2
Black, NH	531,970	525	98.7	580,863	1,058	182.1	83.5
Hispanic	57,054	29	50.8	61,314	51	83.2	32.3
Other	118,749	55	46.3	156,332	119	76.1	29.8
Aid category							
Medicaid expansion	324,662	638	196.5	505,678	2,025	400.5	203.9
Other non-disabled adults	164,194	359	218.6	162,178	411	253.4	34.8
Pregnant women	50,141	27	53.8	47,204	25	53.0	-0.9
Low income children	626,486	82	13.1	635,922	84	13.2	0.1
Aged Adults	90,294	115	127.4	92,643	109	117.7	-9.7
Blind/Disabled	173,473	584	336.7	166,584	587	352.4	15.7

Most with overdoses were not receiving MOUD treatment.

Most members who had OUD-related overdoses were not receiving MOUD treatment prior to the overdose. Of the 3,285 overdoses in SFY 2020, 78.5% had not received any MOUD treatment in the 12 months prior to the overdose, while 88.5% did not receive MOUD treatment in the month prior to the overdose.

However, there was an increase in members with overdoses who had received MOUD treatment in the 12 months prior to the overdose, from 14.3% among overdoses that occurred in SFY 2019 to 21.6% in SFY 2020. There was a smaller increase in the proportion of members with overdoses who received MOUD in the month prior to the overdose, from 8.3% in SFY 2019 to 11.5% in SFY 2020. Of the total increase in 1,414 members with an OUD-related overdose between SFY 2019 and 2020, 31% of the increase is accounted for by members who received MOUD treatment in the 12 months prior to the overdose, while 16% is accounted for by members who received MOUD treatment in the month prior to the overdose.

OUD-related overdoses that involved MOUD treatment

	SFY 2019		SFY 2020	
	Number	Percent	Number	Percent
Total number of overdoses	1,871	100.0	3,285	100.0
Any MOUD use in 12 months prior to date of overdose				
Yes	267	14.3	708	21.6
No	1,604	85.7	2,577	78.5
Any MOUD use in 30 days prior to date of overdose				
Yes	156	8.3	378	11.5
No	1,715	91.7	2,907	88.5

Conclusion

Medicaid expansion greatly increased the number of Virginians receiving treatment for SUD through the ARTS benefit. As other studies have shown, Medicaid members enrolled through expansion have higher SUD prevalence compared to other eligibility groups, and are at higher risk of overdoses. It is likely that many members with SUD who enrolled through Medicaid expansion had pre-existing SUD for which they were not receiving adequate treatment, although there were no data available on diagnoses and utilization prior to enrolling in Medicaid to confirm this. National data clearly show that uninsured people with SUD have much higher levels of unmet need for treatment services compared to people enrolled in Medicaid.[3] By enrolling in Medicaid, more Virginians with SUD gained access to the full continuum of services offered through the ARTS benefit, including outpatient, residential, inpatient, and pharmacotherapy services.

Nevertheless, it is a paradox that OUD-related overdoses increased during a time that also saw gains in the supply of treatment services, increased rates of treatment for Medicaid members with a SUD diagnosis, and no observable disruptions in initiation of treatment after the beginning of the COVID-19 pandemic. Although there was only a small decrease in 90 day continuity for MOUD during COVID-19 during the study period, perhaps the more notable finding is that most members with an OUD diagnosis still do not get initiated into MOUD treatment within 14 days, and most who are initiated do not have at least 90 day continuity of MOUD treatment.

The effectiveness of MOUD treatment is demonstrated by the fact that most of the members with overdoses (almost 90%) did not receive MOUD treatment in the month prior to their overdose. On the other hand, the percent of members with overdoses who had been receiving MOUD treatment increased somewhat between SFY 2019 and 2020. This may suggest either an increase in the severity of addiction problems or disruptions in treatment not observed in the claims data. While MOUD continues to be highly effective in preventing overdoses, the changing nature of the opioid epidemic may be having an impact on the effectiveness of treatment. This may be due to the greater use and availability of more lethal forms of opioids – especially fentanyl – as well as higher levels of economic, social, and psychological distress that may increase the likelihood of recurrence of drug use among some members.

Although a crucial measure of treatment outcomes, overdoses do not tell the entire story of how members have benefitted from SUD treatment services through the ARTS program, as few members with an OUD diagnosis have an overdose. Surveys of members with OUD who received ARTS services show high levels of satisfaction with these services, and more than three-fourths report improvements in their personal, family, and social lives, as well as their ability to find employment and housing.[23] Moreover, experiences with treatment and the outcomes of treatment were just as positive among members interviewed during the COVID-19 pandemic as members who were interviewed prior to the pandemic.

In sum, this report found no major systematic disruptions in access to treatment during the COVID-19 pandemic that could explain the surge in overdose rates. Access to and utilization of ARTS treatment services continued to increase during the pandemic, and even though rates of initiation and continuity of treatment were largely maintained, significant gaps remain. As SUD prevalence rates continue to increase along with more lethal forms of opioids and other substances,

there will be a need for continued growth in the supply and availability of ARTS services to members, although greater supply and provision of services alone are unlikely to turn the tide of an increasing number of overdoses. Prevention efforts, interdiction of the supply of illegal drugs, and more person-centered treatment approaches that address the social and psychological risk factors for recurrence of drug use and overdose will also need to be considered.

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Attachment 10

Virginia 1115 Demonstration

Addiction and Recovery Treatment Services Evaluation Report for State Fiscal Years 2020, 2021, and the first half of 2022

VCU School of Medicine
Health Behavior and Policy

Addiction and Recovery Treatment Services

Evaluation Report for State Fiscal Years 2020, 2021, and the first half of 2022

April 2023

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Disclaimer

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Executive Summary

Fatal drug-related overdoses increased precipitously between late 2019 and early 2022, peaking at around 108,000 deaths nationally and about 2,600 in Virginia.[1] This represents a 51% increase nationally and 69% increase in Virginia between December 2019 and December 2021. Although the increase began before the COVID-19 pandemic, economic and social stress related to the pandemic, disruptions in access to health services, and greater availability of more lethal forms of opioids, such as fentanyl, are considered the primary reasons for the surge in overdoses. Since late 2021, the increase in overdose deaths has leveled off, and even decreased in Virginia and other states that are part of the Appalachian region. Between June 2021 and June 2022, overdose deaths are estimated to have decreased by 1.5% in Virginia, while increasing nationally by 5.5%.[1]

As a result of the expansion of treatment services through the Addiction and Recovery Treatment Services (ARTS) benefit in April 2017, and increases in eligibility for these services through Medicaid expansion beginning in 2019, Virginia Medicaid was better prepared for the increased prevalence in substance use disorders (SUD) than in previous years. The supply of treatment providers, the prevalence of members receiving SUD treatment, and the rate of treatment for diagnosed SUD increased dramatically after implementation of the ARTS benefit and has continued through Medicaid expansion and the COVID-19 pandemic.[2]

The federal government and the Department of Medical Assistance Services (DMAS) also implemented several initiatives and procedural flexibilities to offset COVID-related access barriers to treatment, including increased use of telemedicine, allowing take-home dosages of methadone and buprenorphine for up to 28 days, allowing for 90-day prescriptions for buprenorphine products, and allowing a member's home to serve as the originating site for prescription of buprenorphine. In addition, the federal Families First Coronavirus Response Act (FFCRA) of 2020 increased the federal share of most Medicaid spending on the condition that states meet certain maintenance of eligibility (MOE) requirements, including pausing eligibility redeterminations and Medicaid disenrollment. This has allowed Medicaid members to stay enrolled in Medicaid continuously since the beginning of the COVID-19 pandemic, increasing overall enrollment.

The Department of Health Behavior and Policy at Virginia Commonwealth University School of Medicine is conducting an independent evaluation of the ARTS benefit. The evaluation of the ARTS demonstration renewal has three main goals:

1) Extend the post-implementation period of the evaluation beyond the first two years of ARTS to include the years 2019-2024. In particular, the evaluation will examine and account for the impact of Virginia's Medicaid expansion in 2019 on SUD prevalence, access to and quality of treatment services, and outcomes among the Medicaid population.

2) To strengthen conclusions about the causal impact of ARTS on key measures of access and quality of care by comparing adjusted summary statistics in Virginia to other states using the Medicaid Outcomes Distributed Research Network (MODRN).

3) To examine the cumulative impact of ARTS and Medicaid expansion on addiction treatment services for the Virginia population, using national data sources that permit comparisons of treatment before and after expansion in Virginia, and between Virginia, other states, and the

overall U.S. on selected measures of SUD treatment access, utilization, quality of treatment, and rates of fatal overdoses.

The primary objective of this report is to examine SUD prevalence, treatment utilization, and outcomes among Virginia Medicaid members during State Fiscal Years (SFY) 2020, 2021, as well as the first two quarters of SFY 2022 (covering the period July 2019 through December 2022). Among the highlights of the report:

Increased prevalence of SUD

- 116,000 Medicaid members had a diagnosed SUD in SFY 2021, an increase of 14% from SFY 2020. On a per member basis, SUD prevalence increased by 6.5% to 6,567 members per 100,000 with a SUD diagnosis in SFY 2021. This represents a much lower rate of increase than observed between SFY 2019 and 2020 (30% overall and 16% per member increase, respectively), which was driven by Medicaid expansion and possibly the beginning of the COVID-19 pandemic.

- While opioid use disorder (OUD) continues to be the most frequently diagnosed SUD among Medicaid members (about 41% of all diagnosed SUD), the prevalence rate increased faster for other substances between SFY 2019 and 2020, especially for hallucinogens (a 45% increase).

Increase in treatment providers

- The number of buprenorphine waivered prescribers increased to over 1,500 prescribers in 2022, a 33% percent increase from 2021. Increases in waivered prescribers were especially large for nurse practitioners and physician assistants, who now comprise a greater number of waivered prescribers than physicians.

- The number of pharmacies dispensing buprenorphine to Medicaid members has increased 44% since the beginning of the ARTS benefit, although one-fourth of all pharmacies did not dispense any buprenorphine for treatment of OUD in 2021.[1] Access to buprenorphine-dispensing pharmacies may be more restricted in some areas of the state, such as the Southwest region.

Increased use of ARTS services

- Use of ARTS services continued to increase between SFY 2020 and SFY 2021, with a total of 53,614 members receiving any type of ARTS treatment service in SFY 2021 (a 24% increase from SFY 2020).

- Treatment rates (the percent of members with a diagnosed SUD who received any ARTS treatment service) are highest among members with an OUD diagnosis (69.4%) but lower among members with other SUD diagnoses, such as alcohol use disorder (27.1%), stimulant use disorder (34.3%) and cannabis use disorder (16.5%).

[1] Buprenorphine for treatment of pain was not included in this analysis.

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

Residential treatment and pharmacotherapy account for half of ARTS expenditures

- Among members who use ARTS services in SFY21, only 9% utilized residential treatment services (ASAM 3), with an average length of stay of 15.5 days. However, residential treatment services account for 26.3% of all expenditures for ARTS services.

- Medically managed intensive inpatient services (ASAM 4) are acute hospital or inpatient psychiatric admissions related to SUD, offering 24 hour nursing care and daily physician care for severe, unstable problems. While these services account for a small fraction of ARTS expenditures (2.5%), they are the most expensive on a per member basis ($50,562 per member who used ASAM 4 services in SFY 2021).

- While pharmacotherapy for MOUD is one of the most heavily utilized ARTS services and accounts for about one-fourth of ARTS expenditures, it has relatively low expenditures on a per member basis ($2,220 per member who utilized pharmacotherapy in SFY 2021).

Treatment gaps in transitions from emergency departments and residential treatment

- Many members who had OUD-related emergency department (ED) visits do not receive follow up care or MOUD treatment. Only 27% of members with an OUD-related ED visit received MOUD treatment within 7 days of the visit, and 37% received MOUD within 30 days of the ED visit. Receipt of MOUD following the ED visit was especially low among those who were not receiving treatment prior to the ED visit.

- More members receive follow up care after discharge from residential treatment, with 54% receiving MOUD within 30 days of discharge. However, follow up MOUD use was lower among those who had not been receiving MOUD treatment prior to the residential stay.

Recently incarcerated at greater risk for OUD and overdoses

- New Medicaid enrollees recently released from state prisons were four times as likely as other new Medicaid enrollees to receive an OUD diagnosis within 6 months of enrollment, and they were five times as likely to have had a fatal or nonfatal overdose.

- Once diagnosed with OUD, formerly incarcerated members tend to have higher rates of outpatient and MOUD treatment compared to other new Medicaid enrollees with OUD, and they are only slightly more likely to experience an overdose.

OUD-related overdose rates may have peaked.

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

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

The Commonwealth of Virginia has made substantial progress since the implementation of the ARTS benefit in 2017 in building a robust treatment infrastructure for Medicaid members, with the number of treatment providers, members using services, and treatment rates for those with SUD diagnoses increasing every year since 2017. Continued progress will depend in part on addressing ongoing gaps in treatment, especially care transitions following discharges from hospitals, residential treatment centers, and carceral settings, as well as addressing uneven access to providers and pharmacies in some areas of the state. System capacity to treat patients may also benefit in the future to the extent that COVID-19 related increases in SUD prevalence and overdoses have leveled off and continue to decrease.

Introduction

Fatal drug-related overdoses surged in Virginia and the nation during 2020 and 2021. Nationally, fatal drug overdoses peaked at around 108,000 deaths in the 12 months ending February, 2022, a 12% increase from the previous year, and a 43% increase from the year ending February 2020.[1] During the same two year period, fatal overdoses in Virginia increased 65%, to almost 2,600 deaths in February 2022.[1] Early reports indicate that fatal drug overdoses may have declined in 2022 in both Virginia and 7 and other states, although it is too early to know if this is temporary or the beginning of a longer-term trend.

Opioids continue to account for the majority of overdose deaths in the U.S. (75%) and Virginia (84%). However, there has been a marked shift in the type of opioids responsible for overdoses. In Virginia, deaths from fentanyl overdoses more than doubled between 2019 and 2022 (from 964 to 1,952), while there was little change in deaths due to prescription opioids, and even a small decrease in deaths from heroin.[3] Fentanyl accounted for 93% of opioid-related fatal overdoses in Virginia in 2022, compared to 74% in 2019 and 55% in 2016. At the same time, overdose deaths in Virginia due to methamphetamines and cocaine increased by 183% and 85%, respectively, between 2019 and 2022.[3] An increase in alcohol use disorder is also contributing to increased mortality from substance use, accounting for 95,000 deaths nationally and 22.1% of prescription opioid overdose deaths.[4,5]

There are a number of possible reasons for the surge in fatal overdoses and greater use of drugs and alcohol during the COVID-19 pandemic, including increases in the supply and availability of illicit drugs – especially fentanyl and methamphetamines – economic dislocation, unemployment, greater social isolation, and an increase in co-occurring mental health problems.[6] Also, access to addiction treatment services may have become more difficult due to COVID-related shutdowns and more restrictions on face-to-face meetings with clinicians and peer recovery specialists, a health system that has been severely strained by the pandemic, and growing shortages of behavioral health providers in Virginia and the nation.[7]

Although it is too early to know conclusively, the leveling off and slight decrease in fatal overdoses during 2022 in some states (including Virginia) may reflect in part an easing of the most severe social, economic, and health system pressures experienced during the height of the pandemic, along with greater public health awareness and efforts to educate the public about the dangers of fentanyl. Notably, the overall decrease in fatal drug overdoses in Virginia in 2022 is driven by a decrease in fentanyl-related overdose deaths, from 2,039 deaths in 2021 to a projected 1,952 in 2022.[3]

Virginia has benefitted from a major expansion of treatment services for SUD in the Virginia Medicaid program. In April 2017, the Addiction and Recovery Treatment Services (ARTS) benefit was implemented. ARTS expanded coverage of many addiction treatment services for Medicaid members, aligning with the American Society of Addiction Medicine (ASAM) levels of care, including community-based services, short-term residential treatment and inpatient withdrawal management services. To allow federal Medicaid payment for addiction treatment services provided in inpatient and short-term residential facilities with 16 or more beds, a Section 1115 Demonstration Waiver for SUD was approved in December 2016 by the Centers for Medicare and

Medicaid Services (CMS), and an extension of this demonstration through 2024 was approved by CMS in December 2019. ARTS also increased provider reimbursement rates for many existing services and introduced a new care delivery model for treatment of Opioid Use Disorders (OUD), the Preferred Office-Based Addiction Treatment (OBAT) provider. OBATs integrate medications for OUD (MOUD) with co-located behavioral and physical health by incentivizing increased use of care coordination activities. Per requirements of Item 313, section ZZZ of the 2020 Appropriations Act, DMAS expanded the OBAT model effective March 1, 2022, to allow for other primary SUDs in addition to OUD.[8]

To further increase integration of addiction treatment services with other health services covered by Medicaid, SUD services are administered by the contracted managed care organizations (MCOs) that manage medical and behavioral health benefits for all Medicaid members, offering a comprehensive care delivery system. During this reporting period, Virginia contracted with six managed care organizations through the two managed care programs: Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus). Medallion 4.0 serves children, pregnant women and adults. CCC Plus serves older adults, children, and adults with disabilities, and individuals receiving long-term services and supports (LTSS).

While ARTS greatly increased the availability and quality of treatment services to Medicaid members, eligibility for these services increased on January 1, 2019, when Virginia expanded Medicaid eligibility for adults ages 19-64 with family incomes of up to 138 percent of the federal poverty level, as allowed for under the Patient Protection and Affordable Care Act. By July 1, 2022, 671,000 members were enrolled through the ACA Medicaid expansion benefit.[9] During the COVID-19 pandemic, Medicaid expansion provided an important safety net for many people who lost their job and their employer-based private health insurance coverage.

Prior evaluation reports on the ARTS benefit have documented the impact of ARTS and Medicaid expansion on utilization of ARTS services. The number of Medicaid members using ARTS treatment services more than doubled, from 17,120 in 2017 to 46,520 in 2019.[10] Among those with OUD, the percent using MOUD treatment increased from 35% in 2016 to 53% in 2019, an increase that was far greater than for Medicaid members in twelve other states.[9] At the same time, ED visits among those with OUD decreased (relative to Medicaid members who did not have OUD), although this analysis preceded the more recent surge in overdose deaths.[11]

Increased prevalence of SUD during the COVID-19 pandemic increased the demand for ARTS services. To offset potential barriers to treatment access due to pandemic-related restrictions, DMAS implemented a number of new initiatives and procedural flexibilities that the federal government permitted as part of the emergency response to COVID-19. These include allowing take-home dosages of methadone and buprenorphine for up to 28 days (which otherwise must be administered at Opioid Treatment Programs (OTPs)), allowing a member's home to serve as the originating site for prescription of buprenorphine, allowing a 90-day supply of buprenorphine, increased use of telehealth, waiver of drug copayments, and fewer restrictions on the use of certain unlicensed providers. In compliance with federal legislation, eligibility redeterminations and coverage cancellations have been suspended in order to increase continuity of coverage and prevent coverage lapses during the pandemic. With the end of the federal Public

Health Emergency in May, 2023, eligibility redeterminations will resume, potentially resulting in more Medicaid members losing eligibility. Despite this, many of the access initiatives and procedural flexibilities implemented at the beginning of the pandemic will be maintained.

The objective of this report is to examine SUD prevalence, treatment utilization, and outcomes among Virginia Medicaid members during State Fiscal Year (SFY) 2020 and 2021, as well as the first two quarters of SFY 2022 (covering July 2019 through December 2021). This time period overlaps with the COVID-19 pandemic that began in March 2020, which has led to substantial increases in the diagnosed prevalence and treatment of SUD among Medicaid members. Some measures in the report related to the supply of treatment providers correspond to calendar year or other time periods.

Methodology

Most of the analysis in this report is based on paid claims for services received by Virginia Medicaid members. As a consequence, the analysis excludes services received during periods in which individuals were not enrolled in Medicaid, services not covered by Medicaid, and claims that were submitted and denied or otherwise processed and not reimbursed at the time of data extraction and analysis for this report (September through November 2022). In general, a "claims runout" period of 10-12 months is a sufficient period for the vast majority of claims to be processed for services received through December 2021.

Diagnosed prevalence of SUD is defined as a member having any claim during the study period with a primary or secondary diagnosis of SUD, based on ICD-10 codes. Measures of the utilization of ARTS services are based on the procedure codes and ICD-10 diagnostic codes used by DMAS, MCOs, and treatment providers to bill for the various ARTS services. These services correspond to the ASAM continuum of care, ranging from medically managed intensive inpatient services (ASAM level 4), residential care (ASAM 3), intensive outpatient and partial hospitalization (ASAM 2) and outpatient treatment services (ASAM levels 1 and 2).[12] Services received in Preferred OBAT and OTP providers are identified separately, as are services for peer recovery support, case management, and care coordination. Pharmacotherapy services are identified through pharmacy claims based on National Drug Codes and Generic Sequence Numbers for prescriptions used to treat OUD (buprenorphine, naltrexone) and Alcohol Use Disorder (AUD), as well as procedure codes for methadone treatment in OTPs.

SUD-related ED visits are defined as ED visits with a primary or secondary diagnosis of SUD, as described above. OUD-related overdoses include fatal as well as nonfatal overdoses based on ICD-10 diagnosis codes for overdoses and poisonings that have been previously validated.[13] Only overdoses that are treated in health care settings and for which the submitted claim was reimbursed by Medicaid are included in this definition. An overdose is excluded if it occurred in the community, did not involve contact with health care providers and was not reimbursed through a Medicaid claim.

Supply of Addiction Treatment Providers

A broad range of addiction treatment facilities and practitioners are available to Medicaid members along the continuum of care, as defined by the ASAM placement criteria.[12] These include hospital-based intensive inpatient facilities, residential treatment centers, and outpatient providers of varying types and treatment intensity. The ARTS benefit also introduced a new model of care delivery, the Preferred OBAT, that pays significantly higher reimbursement rates to qualified providers for medication-assisted treatment (including pharmacotherapy and behavioral health therapy) and coordination with other medical and social needs. The Preferred OBAT model initially was limited to individuals with primary OUD. However, DMAS expanded this benefit in 2022 to allow for reimbursement of other primary SUD. Although there was some decrease in residential treatment providers and intensive outpatient programs between 2020 and 2022, Virginia has seen substantial increases across all types of addiction treatment providers and facilities since ARTS was implemented in 2017. These providers serve not only Medicaid members, but also individuals with other insurance or who are uninsured. The expansion of the provider network supported through ARTS has benefited all individuals in the Commonwealth through increased access to treatment and recovery services based on the ASAM Criteria.

Providers for ARTS Services

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

Buprenorphine Waivered Prescribers

There are three Food and Drug Administration (FDA) approved medications for treatment of OUD: methadone, naltrexone and buprenorphine. Methadone for the treatment of OUD is federally limited to being dispensed in specially licensed clinics, although these restrictions were loosened during the COVID-19 pandemic to allow take-home dosages of up to a 28 day supply. Because buprenorphine treatment for OUD does not require that medication be administered at OTPs, it allows for greater access to MOUD treatment in a wider variety of treatment settings, provider types, and specialties. Virginia Medicaid has promoted the prioritization of patient choice in the selection of evidence-based medication for treatment of OUD. This includes a targeted effort to increase access to buprenorphine treatment through the Preferred OBATs in 2017 – an

integrated care model that receives enhanced reimbursement for OUD treatment – and eliminating the need for prior authorization for buprenorphine prescribing for practitioners regardless if they are enrolled with DMAS, its contractors, or MCO networks. During the COVID-19 pandemic, DMAS permits a member's home to serve as the originating site via telemedicine for a prescription of buprenorphine, both for induction and maintenance dosing. Prior to the pandemic, buprenorphine prescriptions for inductions could only be obtained through a face-to-face meeting with authorized prescribers as required by Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Agency.

Prior to 2023, prescriptions for buprenorphine could only be received from practitioners who apply for and receive waivers through SAMHSA. Research has shown that increases in the number of practitioners who receive waivers are associated with increases in the quantity of prescribing and the number of patients served, and fewer overdoses.[14,15] Therefore, having an adequate supply of buprenorphine-waivered prescribers in the Commonwealth is crucial for patient access to OUD treatment and outcomes.

The expansion of benefits with ARTS, collaborative efforts with the Virginia Department of Health to train and encourage more providers to seek buprenorphine waivers, and the increase in Medicaid members eligible for ARTS services through Medicaid expansion has likely contributed to an increase in waivered prescribers. Prior research has shown that Medicaid expansion in other states led to an increase in buprenorphine prescribing capacity.[16]

The number of waivered prescribers in Virginia has increased steadily each year since the ARTS benefit began. Between 2019 and 2022, the number of waivered prescribers in the state increased by 80.8%, from 852 prescribers in 2019 to 1,540 in 2022. However, most of the increase occurred among those with a limit of 30 patients (from 573 in 2019 to 1,132 in 2022), whereas the number with higher patient limits (100 or 275) increased more modestly. Research has shown that prescribers with 30 patient limits are less likely to treat Medicaid patients relative to those with higher limits.[17]

Number of X-waivered Prescribers in Virginia (As of June For Each Year)

	2019	2020	2021	2022	% change 2019-22
All prescribers	852	1017	1160	1540	80.8%
Patient limit					
30	573	730	794	1,132	97.6%
100 or 275	279	314	366	408	46.2%
License type					
MD or DO	617	628	614	750	21.6%
Nurse practitioner	200	330	458	642	221%
Physician assistants	35	59	88	148	322.9%

Increasingly important to the supply of waivered prescribers are nurse practitioners and physician assistants. Since the federal Comprehensive Addiction and Recovery Act (CARA) of 2016, nurse practitioners and physician assistants are also permitted to obtain waivers to prescribe buprenorphine. Nurse practitioners in Virginia can get approval to practice autonomously from physicians if they have 5 or more years of experience (it had been reduced to 2 or more years of experience starting July 2021, before reverting back to a minimum of 5 years starting July 2022). Since 2019, the number of waivered nurse practitioners has increased 221%, while the number of waivered physician assistants has increased 323% (compared to a 21.6% increase for MDs or DOs). While nonexistent prior to 2017, the combined number of waivered nurse practitioners and physician assistants now outnumber waivered physicians.

The growth in waivered prescribers among nurse practitioners is especially important, as research has shown they are twice as likely to treat Virginia Medicaid patients compared to MDs, and almost three times as likely to treat large numbers of Medicaid patients.[17] As only about 40% of buprenorphine-waivered prescribers treated any Medicaid patients in 2019, continued growth in nurse practitioners and physician assistants with waivers will likely help to address gaps in supply of and access to buprenorphine treatment among Medicaid members.

Pharmacies that dispense buprenorphine

Most buprenorphine prescriptions for treatment of OUD are obtained at retail pharmacies. However, some pharmacies do not dispense buprenorphine, while others often restrict the quantity of buprenorphine dispensing. A recent nationwide audit study of pharmacies in counties with a high opioid overdose rate found that one in five pharmacies did not dispense buprenorphine, with independent pharmacies and those in Southern states being more likely to restrict buprenorphine.[18] Pharmacies may decline to stock buprenorphine or limit dispensing for a number of reasons. Because of concerns that buprenorphine can be diverted for illicit purposes, federal law requires wholesalers to monitor controlled substance orders from pharmacies and report suspicious activity to the Drug Enforcement Agency (DEA). As this could trigger a DEA investigation, some pharmacies may decline to dispense buprenorphine, or place strict limits on the amount they dispense. Stigma towards patients with OUD and distrust of clinician prescribing patterns also may limit buprenorphine dispensing at pharmacies.[19,20] Members with OUD who do not have access to pharmacies that dispense buprenorphine, or who need to travel long distances to obtain new prescriptions or refills, may be less likely to initiate or continue with buprenorphine treatment.

We used Medicaid pharmacy claims to identify individual pharmacies that prescribed medications to Medicaid members, as well as pharmacies that specifically prescribed buprenorphine. In 2021, there were 1,604 pharmacies statewide that dispensed any type of medication to Medicaid members, out of which 1,180 (73.6%), dispensed buprenorphine to Medicaid members. Overall, there were 424 Virginia pharmacies in 2021 that did not dispense buprenorphine to Medicaid members, although it is possible that some of these pharmacies stock buprenorphine but did not receive any prescriptions for Medicaid members in that year.

Pharmacies Dispensing Buprenorphine for Medicaid Members

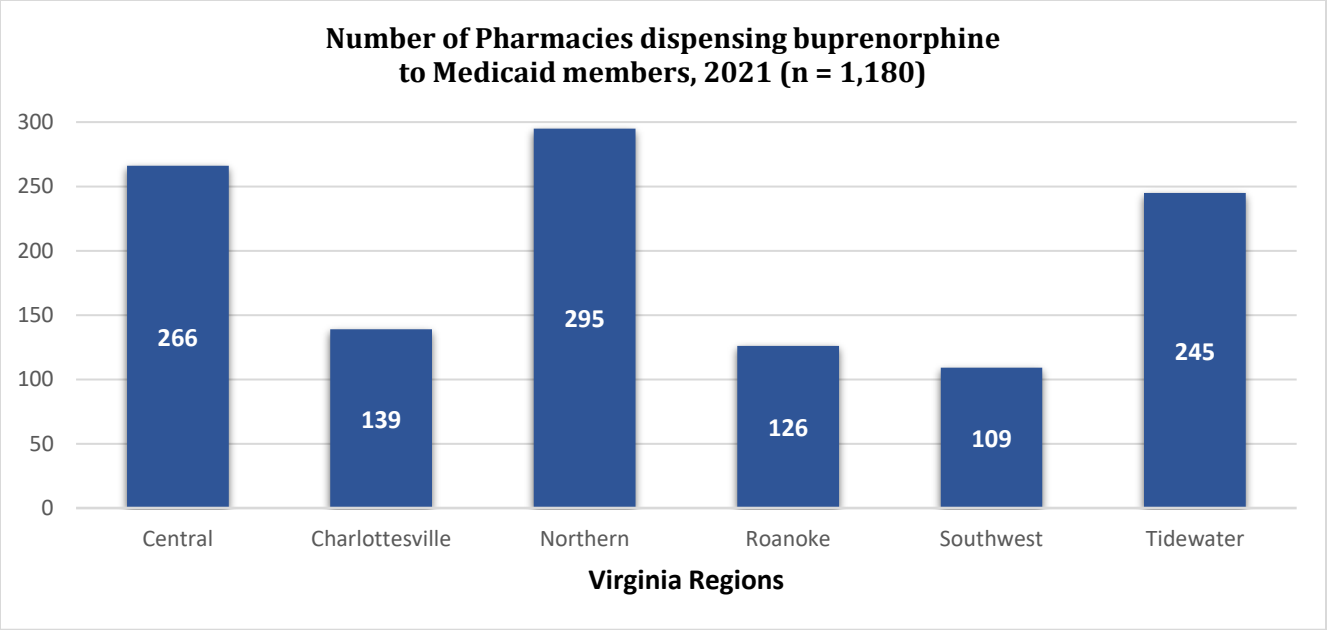
	2017	2019	2021	% change 2017-2021
Number of pharmacies with any Medicaid prescriptions	1,519	1,606	1,604	5.6%
Number of pharmacies with any prescription for buprenorphine	820	1,077	1,180	43.9%
Number of pharmacies with buprenorphine Rx, as a proportion of all pharmacies	54.0%	67.1%	73.6%	36.3%
Total number of buprenorphine prescriptions dispensed	67,980	162,636	278,516	309.7%
Average number of buprenorphine prescriptions per pharmacy	82.9	151.0	236.0	184.7%

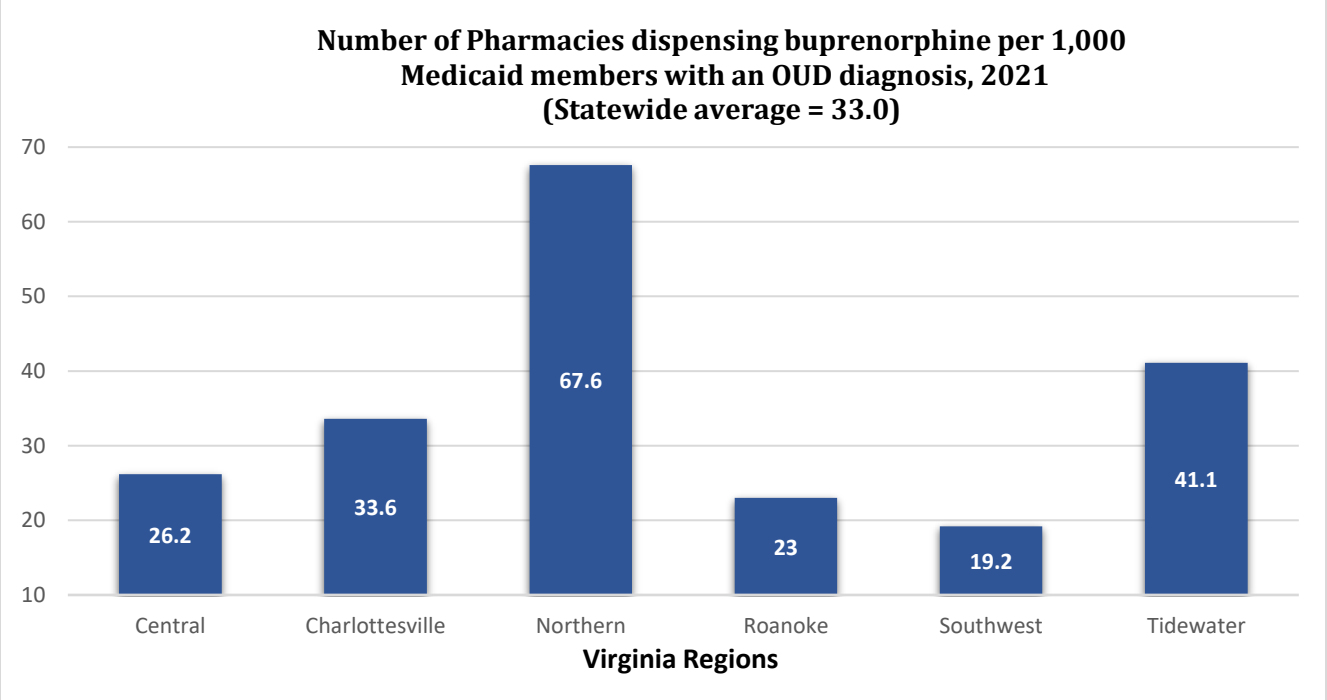
While the overall number of pharmacies prescribing to Medicaid members has remained relatively constant, the number of pharmacies dispensing buprenorphine has increased greatly, from 820 pharmacies in 2017 to 1,180 in 2021, a 44% increase. As a result, the share of pharmacies dispensing buprenorphine prescriptions increased from 54% in 2017 to 73.6% in 2021. The average number of buprenorphine prescriptions per pharmacy has also increased, from an average of 82.9 prescriptions per pharmacy in 2017, to 236 prescriptions per pharmacy in 2021, a 184.7% increase.

Regional Variation in Pharmacy Dispensing of Buprenorphine

The most heavily populated regions of the state – Northern, Central and Tidewater – have correspondingly the largest number of pharmacies that dispense buprenorphine (295, 266, and 245, respectively).

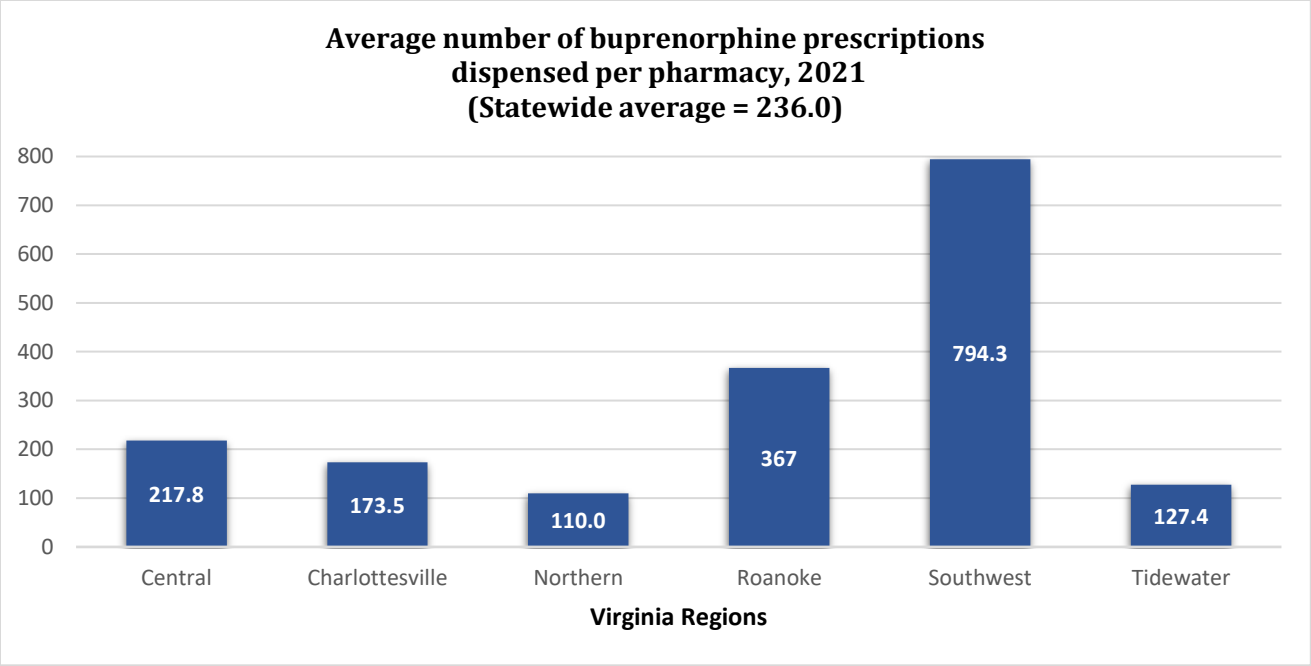
A more accurate assessment of regional variation in the number of buprenorphine-dispensing pharmacies accounts for differences in potential demand, as indicated by the number of members with a diagnosed OUD. By this measure, the Northern region has by far the largest number of buprenorphine-dispensing pharmacies, with 67.6 pharmacies per 1,000 Medicaid members with OUD. By contrast, the Roanoke and Southwest regions – which have some of the highest OUD prevalence rates among all regions – have relatively fewer pharmacies (23 and 19.2 pharmacies per 1,000 members with OUD, respectively).





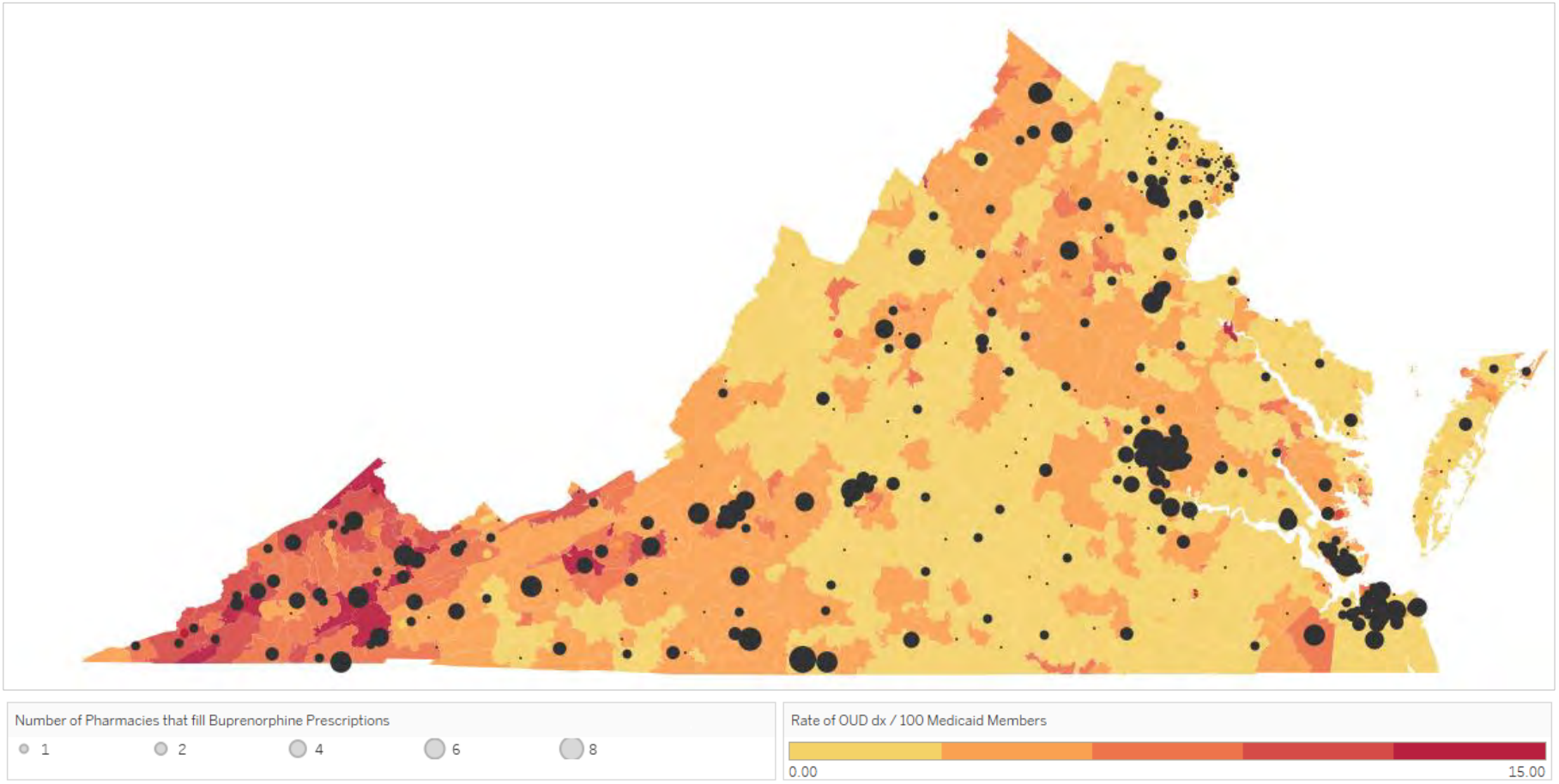
With fewer pharmacies that dispense buprenorphine, pharmacies in Southwest dispense much higher quantities of buprenorphine (794 buprenorphine prescriptions per pharmacy) compared to pharmacies in Northern (110 prescriptions per pharmacy) and other regions of the state. The limitations these pharmacies have on how much buprenorphine they are able and willing to dispense are unknown. Regardless, access to buprenorphine in Southwest could be more difficult not only because there are fewer pharmacies overall that dispense buprenorphine, but it is

likely that at least some of the pharmacies "max out" on how much buprenorphine they are able and willing to dispense over the course of the year.



The map below provides a more detailed depiction of the location of pharmacies that dispense buprenorphine to Medicaid members in Virginia. These locations are overlaid on top of OUD prevalence rates at the zip code level, with darker shaded areas indicating higher prevalence of OUD.

OUD Prevalence Rate with Count of Pharmacies per zip code



Diagnosed Prevalence of Substance Use Disorders

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

SUD diagnoses related to stimulant use and cannabis is concerning given the 19.4% and 26.9% increase, respectively, in Medicaid members with these diagnosis between SFY 2020 and 2021. During the same period, diagnosed OUD prevalence increased by 13.1% and AUD by 14.8%. There was also a 55.4% increase in diagnoses related to hallucinogens, although overall prevalence of hallucinogens is still very low (only 1,290 members with diagnoses in SFY 2021).

The increase in SUD prevalence is partially related to increases in Medicaid enrollment, from 1.48 million average monthly enrollment in SFY 2020 to 1.74 million average monthly enrollment in SFY 2021, a 17 percent increase.[9] However, the prevalence rate for SUD (calculated as the number of members with a SUD diagnosis per 100,000 members) increased by 6.5%, from 6,168 with a SUD diagnosis per 100,000 members in SFY 2020 to 6,567 per 100,000 members in SFY 2021.[ii] The increase in the prevalence rate was higher for SUD diagnoses related to hallucinogens use (44.8%), Cannabis (18.2%), Sedatives (12.6%), and stimulants use (11.2%).

Diagnosed prevalence of SUD, SFY 2020 and 2021

	Number of Medicaid members with diagnosis			Members with diagnosis per 100,000 members		
SUD diagnoses	**SFY 2020**	**SFY 2021**	**Percent change**	**SFY 2020**	**SFY 2021**	**Percent change**
Any SUD	101,875	116,451	14.3%	6,168	6,567	6.5%
Opioid use disorder (OUD)	42,435	48,008	13.1%	2,569	2,707	5.4%
Alcohol use disorder (AUD)	38,374	44,038	14.8%	2,323	2,483	6.9%
Cannabis	28,309	35,911	26.9%	1,714	2,025	18.2%
Hallucinogens	830	1,290	55.4%	50	73	44.8%
Inhalants	172	191	11.0%	10	11	3.4%
Sedatives, hypnotics, etc.	4,816	5,821	20.9%	292	328	12.6%
Stimulants	22,806	27,226	19.4%	1,381	1,535	11.2%
"Other or unknown"	23,583	26,071	10.5%	1,428	1,470	3.0%

SUD prevalence rates are much higher among nonelderly adults compared to youth and elderly members. The percent of members with a diagnosed SUD ranges from 10.5% to 12.9% for members ages 22-64, compared to 2.3% for members ages 12-21, and 5.3% for members aged 65 and older. SUD prevalence rates are also higher for males compared to females, although OUD prevalence is similar for both gender groups. Diagnosed prevalence is also higher for White, non-Hispanic members (7.9%) compared to Black, non-Hispanic members (6.0%) and Hispanic

[ii] For the purposes of computing prevalence rates and to be consistent with the way that annual prevalence was computed, Medicaid enrollment was computed as the number with full-benefit Medicaid coverage at any point in the State Fiscal Year. This differs from the average monthly enrollment numbers mentioned above.

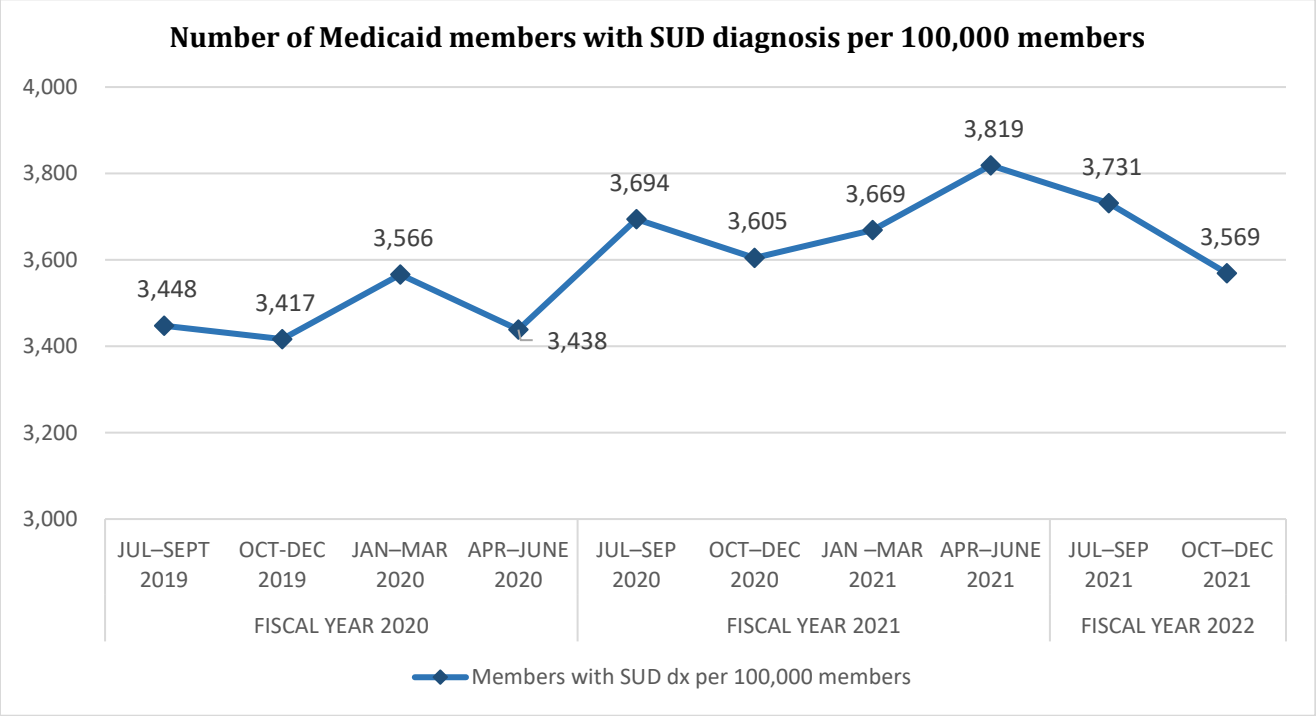
members (2.9%), although the prevalence rate for cannabis diagnosis is higher for Black and Hispanic members compared to White members. Consistent with age-related differences in prevalence, prevalence rates are higher among Medicaid expansion and other non-disabled adults compared to members in other Aid categories.

Prevalence of diagnosed SUD, by member characteristics, SFY 2021

	% with any SUD	% with OUD	% with AUD	% with cannabis diagnosis	% with stimulants diagnosis
All Medicaid members	6.6%	2.7%	2.5%	2.0%	1.5%
Age					
12-21	2.3%	0.3%	0.5%	1.6%	0.3%
22-34	10.5%	4.9%	3.1%	4.2%	2.8%
35-44	14.0%	7.5%	4.6%	3.9%	3.8%
45-54	14.0%	6.2%	6.2%	3.0%	3.6%
55-64	12.8%	4.1%	7.4%	2.1%	2.5%
65+	5.3%	1.8%	3.0%	0.5%	0.6%
Sex					
Male	7.7%	3.2%	3.5%	2.4%	1.9%
Female	5.6%	2.4%	1.7%	1.8%	1.3%
Race/ethnicity					
White, non-Hispanic	7.9%	3.9%	2.8%	2.1%	1.9%
Black, non-Hispanic	6.0%	1.7%	2.5%	2.3%	1.5%
Hispanic	2.9%	0.9%	1.1%	1.2%	0.6%
Other	2.9%	0.9%	1.4%	1.0%	0.5%
Aid category					
Medicaid expansion	11.6%	5.1%	4.6%	3.4%	3.0%
Other non-disabled adults	10.0%	5.4%	2.5%	3.0%	2.2%
Pregnant members	5.8%	2.1%	0.7%	2.6%	1.1%
Low-income children	0.8%	0.1%	0.1%	0.4%	0.1%
Aged	5.2%	1.7%	2.9%	0.5%	0.5%
Blind/disabled	13.2%	5.0%	5.7%	3.8%	3.3%
Region					
Central	6.8%	2.9%	2.5%	2.1%	1.5%
Charlottesville	7.0%	2.4%	2.6%	2.1%	1.7%
Northern	4.1%	1.6%	1.9%	1.4%	0.8%
Roanoke	8.7%	3.8%	2.9%	2.4%	2.3%
Southwest	10.9%	6.7%	2.6%	2.6%	3.1%
Tidewater	6.3%	2.3%	2.7%	2.1%	1.4%

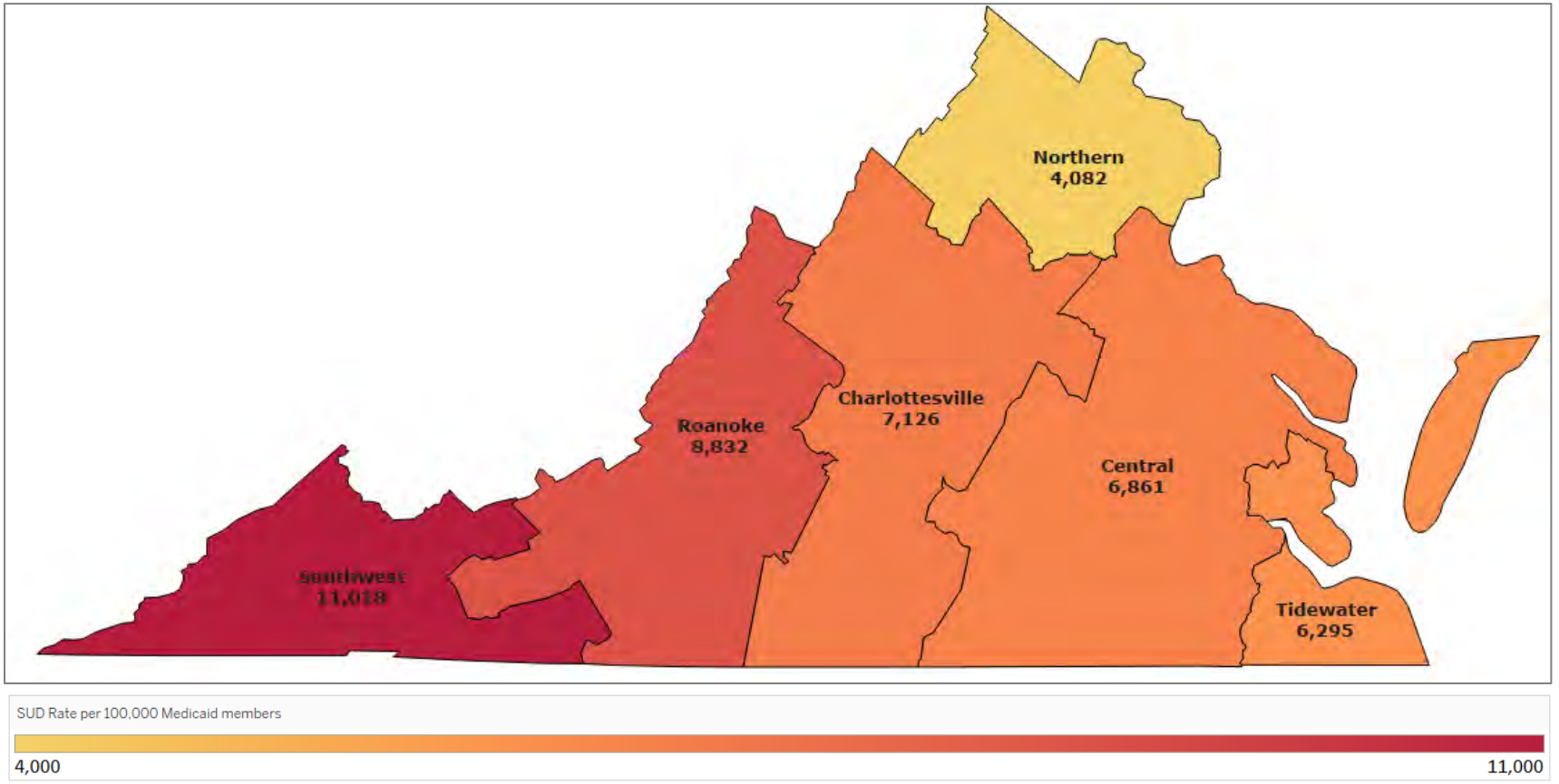
Differences by race/ethnicity, age, gender, and aid category are based on diagnosed prevalence of SUD and do not account for the potential for under-diagnosis in some sub-populations. For example, racial/ethnic differences in access to treatment services, trust in providers due to historical discrimination and racism, stigma, and other factors may result in greater under-diagnosis of SUD among Black Medicaid members and other racial/ethnic minorities. By contrast, SUD prevalence based on patient self-reports (which does not depend on a clinician's diagnosis) shows little or no disparities by race/ethnicity.[21]

On a quarterly basis, the increase in the SUD prevalence rate occurred primarily during calendar year 2020, peaking at 3,819 per 100,000 members with a SUD diagnosis in April-June 2021. The SUD prevalence rate decreased during the first two quarters of SFY2022, to 3,569 members with a SUD diagnosis by Oct-Dec 2021. This includes a decrease in the overall number of members with a SUD diagnosis between the first two quarters of SFY 2022, from 65,898 members in July-Sept 2021 to 64,795 members in Oct-Dec 2021. The reasons for the more recent decreased in SUD prevalence are unknown, nor whether these decreases are temporary or part of a longer-term trend.

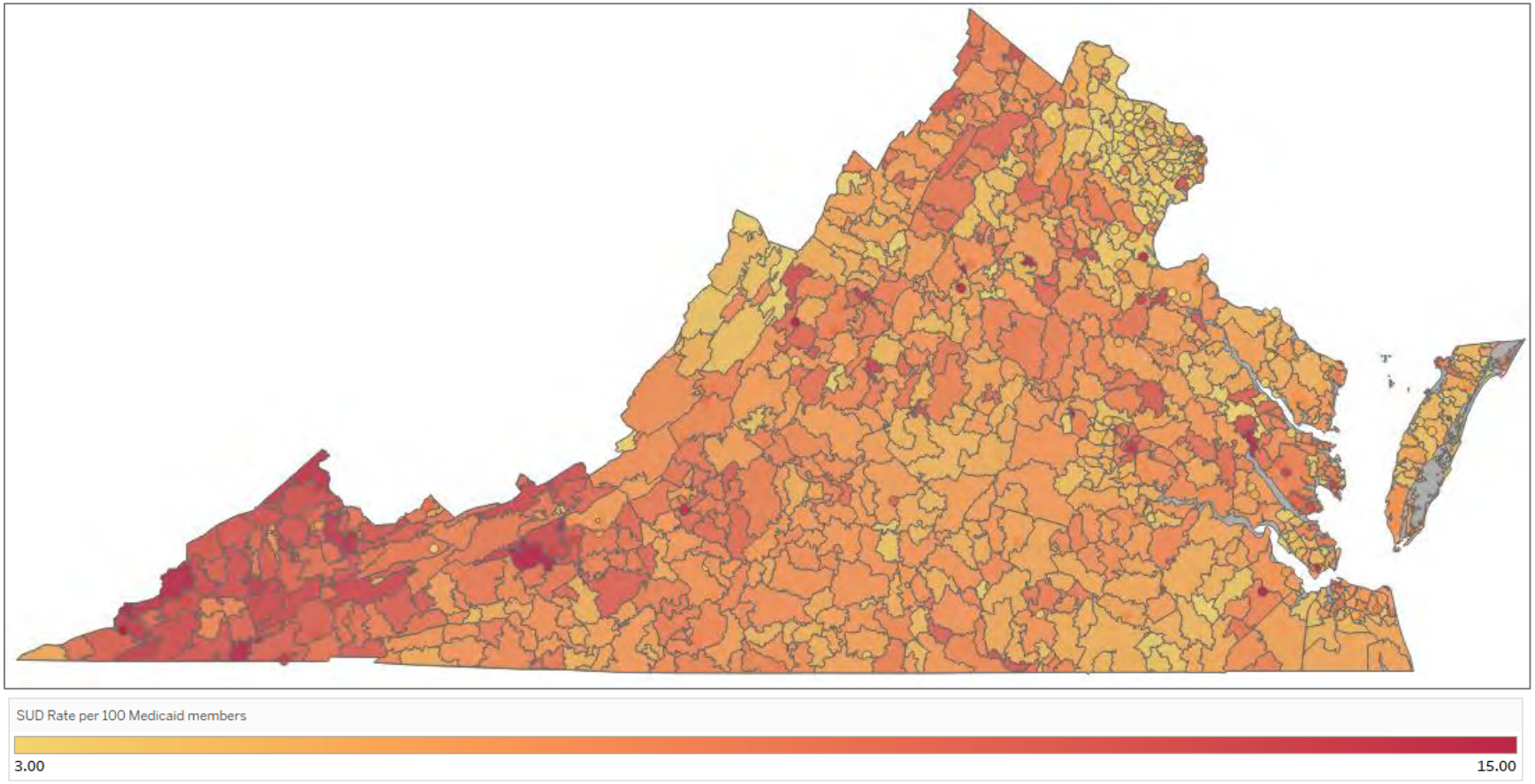


The following maps show regional variation in SUD and OUD prevalence rates. Southwest has the highest SUD and OUD diagnosed prevalence rates, while the Northern region has the lowest. However, prevalence rates computed at the zip code level show pockets of high prevalence in many areas, including some of the urban areas around Northern Virginia, Richmond, and Hampton Roads.

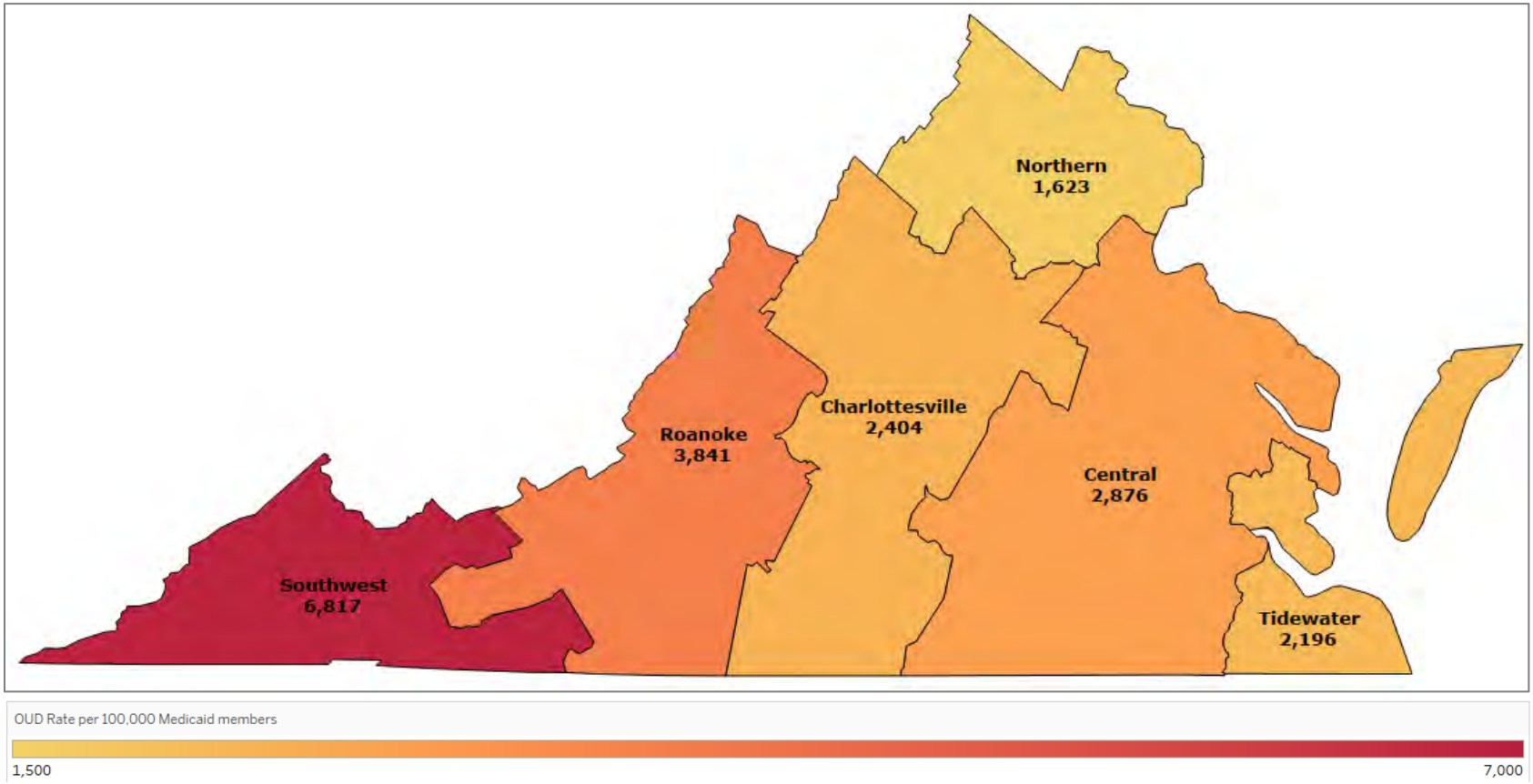
SUD Rate per 100,000 Medicaid members by Region



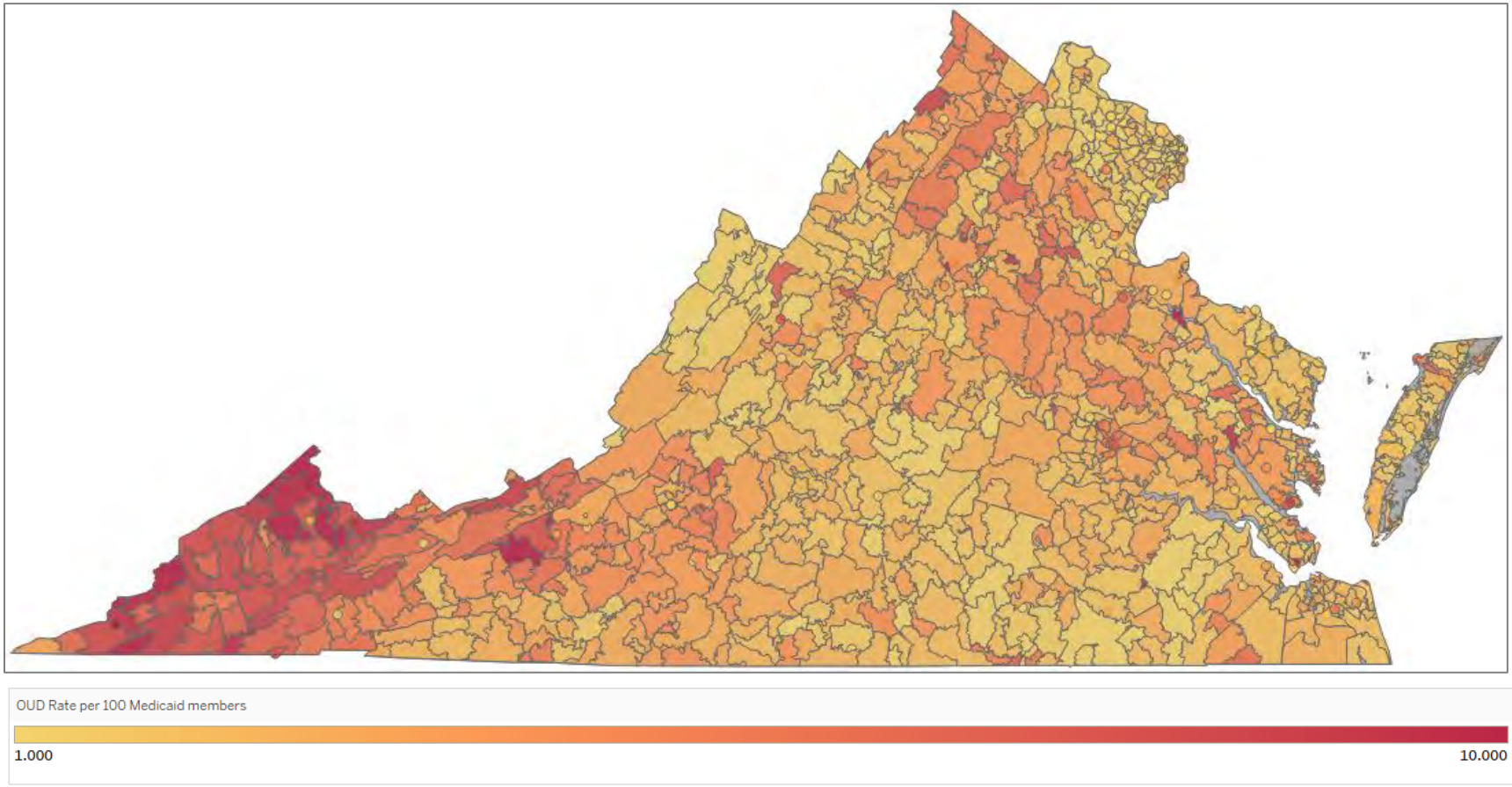
SUD Rate per 100 Medicaid members by Zip Code



OUD Rate per 100,000 Medicaid members by Region



OUD Rate per 100 Medicaid members by Zip Code



ARTS Service Utilization and Expenditures

Trends in use of ARTS services

Coverage of SUD services provided by the ARTS benefit is based on the ASAM National Practice Guidelines, which comprise a continuum of care from Early Intervention/Screening, Brief Intervention, and Referral to Treatment (SBIRT / Level 0.5), outpatient treatment (ASAM 1), intensive outpatient treatment and partial hospitalization (ASAM 2), residential treatment services (ASAM 3) and medically managed intensive inpatient services (ASAM 4).[22] ARTS also emphasizes evidence-based treatment for OUD, which combines pharmacotherapy and counseling. In July 2017, DMAS added peer recovery support services as a covered service under the ARTS benefit, which serves to facilitate recovery from SUD. Care coordination services provided by Preferred OBAT and OTPs facilitate integration of addiction treatment services with physical health and social service needs.

Number of members using ARTS services, SFY 2020 and 2021

	Number of members using services			Members using services per 100,000 members		
	SFY 2020	**SFY 2021**	**Percent change**	**SFY 2020**	**SFY 2021**	**Percent change**
Used any ARTS service	43,389	53,614	23.6%	2,627	2,912	10.8%
Type of service						
ASAM 1	35,709	43,299	21.3%	2,162	2,442	12.9%
OBAT/OTP	13,317	15,976	20.0%	806	901	11.8%
Care Coordination[1]	9,457	11,943	26.3%	573	674	17.5%
ASAM 2	4,611	5,301	15.0%	279	299	7.1%
ASAM 3	4,260	4,891	14.8%	258	276	6.9%
ASAM 4	71	144	102.8%	4	8	103.0%
Pharmacotherapy	27,050	32,724	21.0%	1,120	1,283	14.5%
Case management	3,726	4,136	11.0%	226	233	3.2%
Peer recovery support services	1,119	1,471	31.5%	68	83	22.0%

[1]Care coordination services are a subset of services also counted as part of OBAT/OTP services.

In SFY 2021, 53,614 Medicaid members used some type of ARTS services, a 23.6% increase from SFY 2020. Most members who use ARTS services use ASAM 1 outpatient services (43,299 members, or 81% of all service users). Pharmacotherapy, almost all of which is MOUD treatment, is the second most frequently used service (32,724 members).

There was also a 10.8% increase in service use per 100,000 members, from 2,627 members per 100,000 using services in SFY 2020 to 2,912 members per 100,000 using services in SFY 2021. Increases in service use per 100,000 members was especially high for ASAM 4 services (103%) and peer recovery support services (22%), although the overall use of such services is still relatively low. Care coordination services also increased by 17.5%, while pharmacotherapy increased by 14.5%.

Medicaid payment of residential treatment services (ASAM 3) is allowed under the Section 1115 Demonstration Waiver for SUD, approved in December 2016 by the Centers for Medicare and Medicaid Services (CMS) and extended in 2019. In SFY2021, 4,891 members used these services, comprising 9.1% of all members using ARTS services. The average length of stay for residential treatment was 15.5 days, which is within CMS requirements of 30 days or less for an average length of stay. The number of members using residential treatment increased 14.8% between SFY2020 and SFY2021, or a 6.9% increase of members using services per 100,000 members.

Members receiving any ARTS service, by type of diagnosis

Members with OUD diagnoses are more likely to receive ARTS services compared to members with other SUD diagnoses. Among members with any OUD diagnosis, more than two-thirds (69.4%) used some type of ARTS service in SFY 2021, compared to 43.3% of those with any SUD using any ARTS services. ARTS utilization is considerably lower among members who had SUD diagnoses other than OUD, including 27.1% for those with AUD, 34.3% among those with a diagnosis of stimulant use disorder, and 16.5% among those with a diagnosis of cannabis use disorder. In contrast to OUD, in which the clinical effectiveness of MOUD treatment has been well established, lower use of ARTS services among those with other SUD diagnoses may reflect less evidence about the effectiveness of treatment for other SUD, and greater reliance on non-medical treatment options, such as Alcoholics Anonymous and Narcotics Anonymous.

Number of members using ARTS services, by diagnosis, SFY 2021

	Members with any use of ARTS services[1]	Percent of members using ARTS services
All members	53,614	3.0%
Any SUD diagnosis	50,426	43.3%
Any OUD diagnosis	33,305	69.4%
No OUD diagnosis		
Had AUD diagnosis	11,922	27.1%
Had cannabis diagnosis	5,938	16.5%
Had stimulant diagnosis	9,341	34.3%
Had any other SUD diagnosis	4,670	17.9%

Expenditures for ARTS services

ARTS services accounted for over $294 million in SFY 2021 expenditures.[3] This is a 41% increase from SFY 2020 (not adjusted for inflation). Expenditures increased the most for ASAM 4 level services (216%) and peer recovery support services (66.7%), followed by ASAM 2, Care Coordination, and OBAT/OTP services.

Expenditures associated with ARTS utilization, SFY 2020 and 2021.

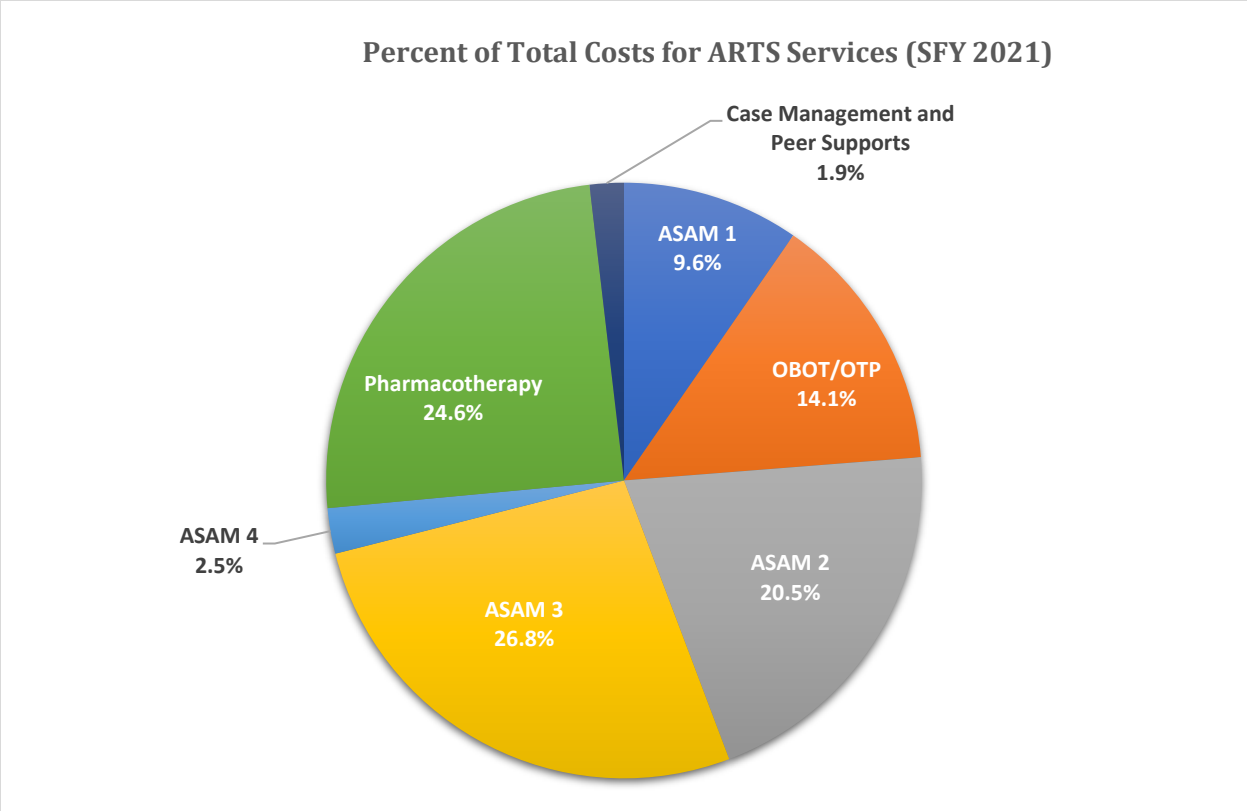
	Total expenditures for ARTS services		
	SFY 2020	**SFY 2021**	**Percent change**
Total costs for any ARTS service	$209,120,709	$294,494,664	41.0%
Type of service			
ASAM 1	$21,839,164	$28,377,952	29.9%
OBAT/OTP	$27,520,375	$41,684,324	51.5%
Care Coordination[1]	$13,728,883	$21,276,827	55.0%
ASAM 2	$38,689,539	$60,464,892	56.3%
ASAM 3	$61,398,876	$79,027,576	28.7%
ASAM 4	$2,304,281	$7,280,940	216.0%
Pharmacotherapy	$53,251,678	$72,652,777	36.4%
Case management	$3,713,463	$4,788,758	29.0%
Peer recovery support services	$403,335	$672,446	66.7%

[1]*Care coordination expenditures are a subset of expenditures for OBAT/OTP services.*

Although relatively few members utilize ASAM 3 services (residential treatment), they account for more than one-fourth of SFY 2021 ARTS expenditures (26.8%), while pharmacotherapy accounts for about another one-fourth of expenditures (24.6%) (see chart below). OBAT/OTP (which includes care coordinator services) and ASAM 1 services together account for about one-fourth of expenditures, while ASAM 4 and Case Management/Peer Support services account for small fractions.

ASAM 4 services – while infrequently utilized – are the most costly services on a per claim and per member basis, averaging $55,562 per member who used such services in SFY 2021. ASAM 3 services averaged $16,157 per user in SFY 2021, while ASAM 2 services averaged $11,406 per member. Pharmacotherapy – among the most frequently utilized ARTS services and which has demonstrated clinical effectiveness in the case of MOUD – averaged just $2,220 per member in SFY 2021.

[3] These estimates differ slightly from internal estimates from DMAS due to some differences in definition of services and the timing of when the computations were made.



Expenditures associated with ARTS utilization, SFY 2020 and 2021

	Average cost per ARTS service claim			Average cost per member using services		
	SFY 2020	**SFY 2021**	**Percent change**	**SFY 2020**	**SFY 2021**	**Percent change**
Type of service						
ASAM 1	$60	$54	**-9.4**	$612	$655	7.2%
OBAT/OTP	$21	$25	14.3	$2,067	$2,609	26.3%
Care Coordination	$237	$240	1.3	$1,452	$1,781	22.7%
ASAM 2	$362	$374	3.5	$8,391	$11,406	35.9%
ASAM 3	$611	$497	-18.7	$14,413	$16,157	12.1%
ASAM 4	$4,492	$3,810	-15.2	$32,455	$50,562	55.8%
Pharmacotherapy	$24	$26	10.3	$1,969	$2,220	12.8%
Case management	$235	$234	-0.6	$997	$1,158	16.2%
Peer recovery support services	$26	$26	-0.2	$360	$457	26.8%

Use of Medications for Opioid Use Disorder

MOUD includes the use of buprenorphine, methadone and naltrexone as part of evidence-based treatment for OUD. This method is considered the evidence-based standard of care for treating OUD and has been found to be the most effective treatment in preventing OUD-related overdoses. A previous report showed MOUD treatment rates among members with OUD increased by over 20% following implementation of the ARTS benefit (from 33.6% in 2016 to 55.0% in 2018), compared to an 8.6% increase over the same time period for Medicaid members in other states that did not implement changes on the scale of the ARTS benefit.[10] To further increase access to buprenorphine treatment beginning in March 2019, DMAS removed prior authorization requirements for suboxone films for in-network prescribers and revised Medicaid policies to ensure that members at any ASAM level of care are screened and referred for MOUD if they are in need and wish to receive this care.[23]

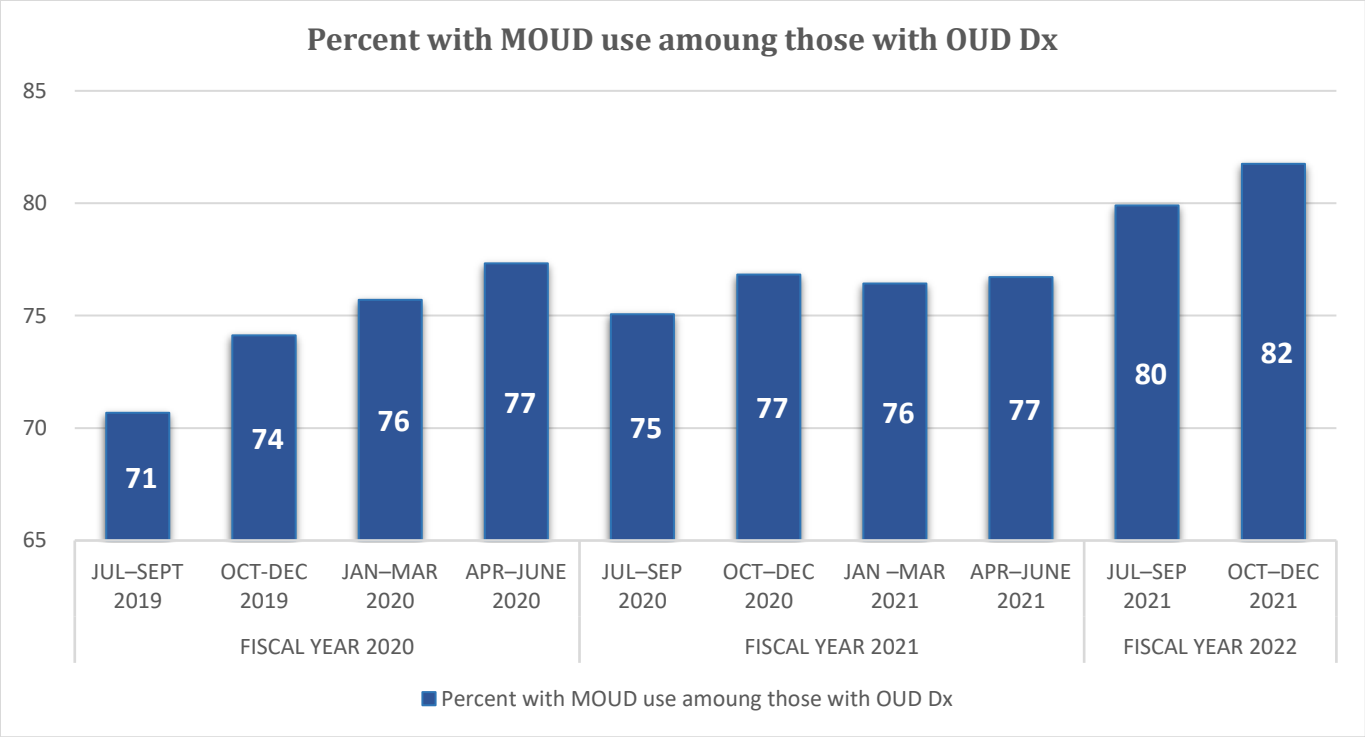
Members receiving MOUD treatment increased 21.0% from SFY 2020 to SFY 2021. As in prior years, buprenorphine treatment was the most common form of MOUD treatment (18,941 members, or 57% of all members receiving MOUD), followed by methadone treatment and naltrexone (11,278 and 4,227 members, respectively).

Medicaid members using MOUD treatment

	SFY 2020	SFY 2021	Percent change
Number of members with any MOUD use	27,254	32,964	21.0%
Buprenorphine	15,379	18,941	23.2%
Methadone	9,503	11,278	18.7%
Naltrexone	3,447	4,227	22.6%
MOUD treatment rate*	64.2%	77.7%	21.0%
Buprenorphine	36.2%	44.6%	23.2%
Methadone	22.4%	26.6%	18.7%
Naltrexone	8.1%	10.0%	22.6%

*Number of members with treatment / number of members with OUD diagnosis

MOUD treatment rates (the percent of members with OUD diagnoses who received MOUD treatment) also increased, from 64.2% in SFY 2020 to 77.7% in SFY 2021. This is a continuation of a longer-term trend since implementation of the ARTS benefit in April, 2017.[10] MOUD treatment rates continued to increase in the first two quarters of SFY 2022, to 82% for the quarter ending December 2021.


Percent with MOUD use amoung those with OUD Dx
85
80
75
70
65
71
74
76
77
75
77
76
77
80
82
JUL–SEPT 2019
OCT-DEC 2019
JAN–MAR 2020
APR–JUNE 2020
JUL–SEP 2020
OCT–DEC 2020
JAN –MAR 2021
APR–JUNE 2021
JUL–SEP 2021
OCT–DEC 2021
FISCAL YEAR 2020
FISCAL YEAR 2021
FISCAL YEAR 2022
Percent with MOUD use amoung those with OUD Dx

Emergency Department Use Related to SUD

Hospital ED visits related to SUD include fatal and nonfatal overdoses as well as other acute events directly or indirectly related to SUD. Previous analyses of the ARTS benefit showed a marked decrease in ED visits among members with OUD following implementation of the ARTS benefit relative to members who did not have a diagnosed OUD.[11] However, SUD-related ED visits increased substantially in recent years, from 70,987 visits in SFY 2020 to 80,426 visits in SFY 2021, a 13.3% increase. In addition, OUD-related ED visits increased 23.6% between SFY 2020 and SFY 2021. By comparison, ED visits for all causes decreased by 8.7%.

Emergency department visits among Medicaid members, SFY 2020 and 2021

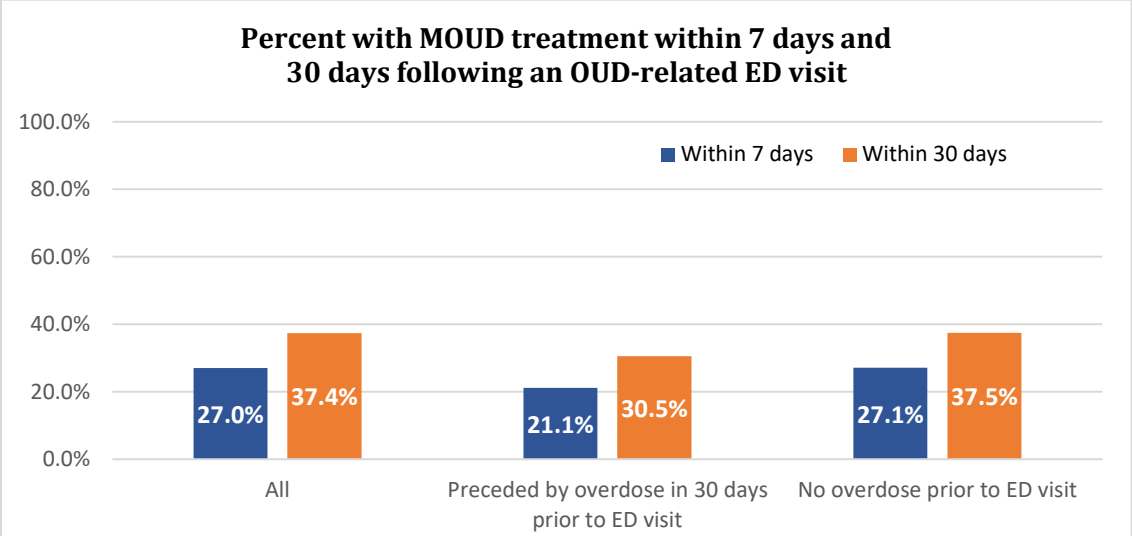
	SFY 2020	SFY 2021	Percent change
ED visits (all cause)			
Number of members with a visit	535,346	495,635	-7.4%
Total number of visits	1,154,685	1,054,744	-8.7%
SUD-related ED visits			
Number of members with a visit	38,829	44,915	15.7%
Total number of visits	70,978	80,426	13.3%
OUD-related ED visits			
Number of members with a visit	9,704	11,703	20.6%
Total number of visits	13,877	17,146	23.6%
ED visits per 1,000 members (all cause)			
Number of members with visit	324.1	279.5	-13.8%
Total visits	699.1	594.8	-14.9%
SUD-related ED visits per 1,000 members			
Number of members with visit	23.5	25.3	7.7%
Total visits	43.0	45.4	5.6%
OUD-related ED visits			
Total members with visit	5.9	6.6	11.9%
Total visits	8.4	9.7	15.5%

SUD-related ED visits have continued to increase, even after adjusting for increases in Medicaid enrollment during the period. There were 45.4 SUD-related ED visits per 1,000 members in SFY 2021, a 5.6% increase from the prior year. Also, there were 9.7 OUD-related ED visits per 1,000 members in SFY 2021, a 15.5% increase from the prior year. By comparison, the overall number of ED visits per 1,000 Medicaid members decreased by almost 15% from SFY 2020 to SFY 2021.

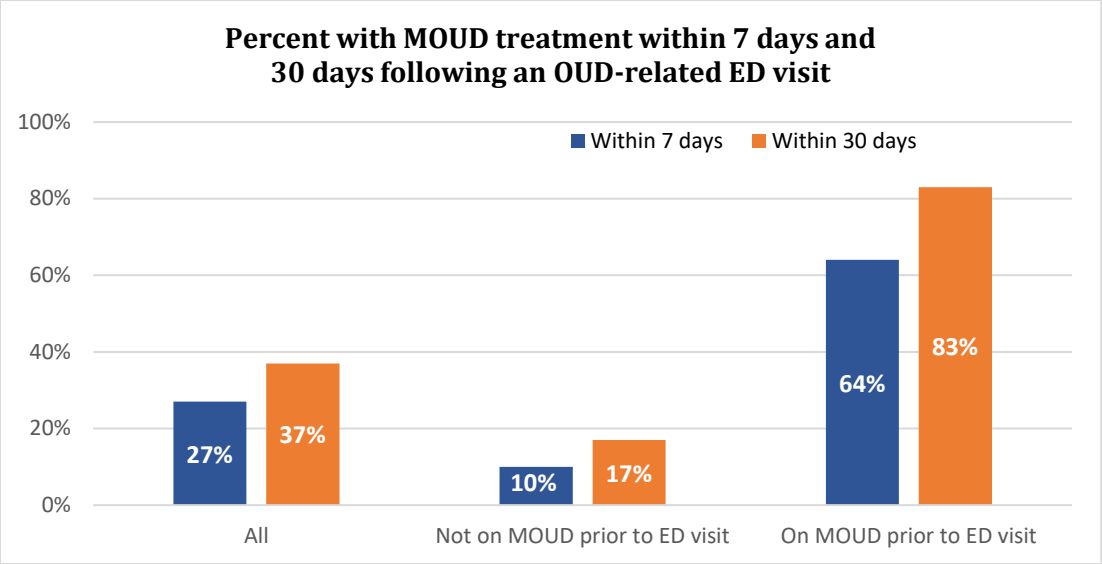
Care Transitions

Follow Up after OUD-Related Emergency Department Visits

Getting patients started on MOUD while at the ED or shortly thereafter is considered crucial for preventing overdoses. Receiving treatment within 7 days of an OUD-related emergency department visit is considered a key measure of treatment quality. From 2016 to 2018, only about 15 percent of Medicaid members in 11 states actually received a follow up visit within 7 days of an OUD-related ED visit.[24] The metric of an ED follow-up visit used by the National Committee for Quality Assurance (NCQA) does not explicitly identify MOUD as part of the follow up care.[25] However, a follow-up visit with a clinician may not be as effective in preventing future overdoses if it does not involve getting patients to initiate or continue with MOUD treatment. To this end, many health systems have started "ED-Bridge" programs that seek to get OUD patients started on buprenorphine treatment in the emergency department and provide them with a warm handoff to treatment providers in the community for follow up treatment and maintenance of MOUD after the ED visit.[26] For Medicaid members who had an ED visit with a primary diagnosis of OUD, 27% received MOUD treatment within 7 days of the visit, while 37% received MOUD treatment within 30 days of the visit.



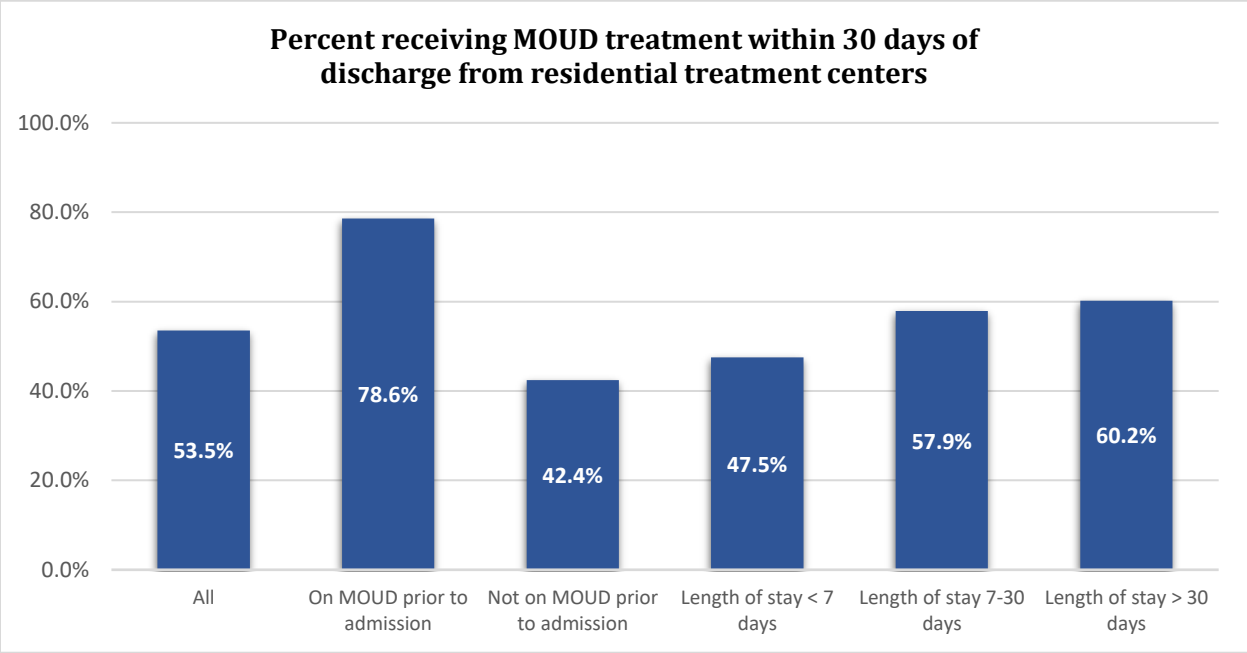
Members who had an overdose in the 30 days prior to the ED visit were somewhat less likely to receive MOUD treatment (21%) within 7 days compared to those who did not have an overdose prior to the ED visit (27%). Members who had not been receiving MOUD treatment prior to the ED visit were less likely to follow up with MOUD treatment compared to those who had been receiving MOUD treatment prior to the ED visit.



Follow Up after Residential Treatment for OUD

Successful transitions after discharge from residential treatment (ASAM level 3 stays) should also include either initiation or continuation of MOUD treatment. Relative to those who do not receive follow-up care after discharge, continuity of care after discharge is a significant predictor of: recovery,[27] remaining abstinent within a year post-discharge,[28] and lower likelihood of mortality within 2 years of discharge.[29] To help ensure continuity, DMAS requires residential treatment providers to document the transition plan on the service authorization for residential treatment.

In contrast to follow up after ED visits, more than half of members (53.5%) discharged from residential treatment centers received MOUD within 30 days of discharge. The rate of MOUD follow up was considerably higher among those who were receiving MOUD prior to admission to the facility (78.6%) compared to those not receiving MOUD prior to admission (42.4%). MOUD receipt was also higher among those with stays of greater than one week or more, compared to those with lengths of stay that lasted less than a week. Multi-state analyses utilizing multivariate methods also showed that prior receipt of MOUD and longer lengths of stay were significant predictors of follow-up treatment after discharge.[30]



OUD diagnosis and treatment following release from prison

Prior research has shown that formerly incarcerated individuals have higher prevalence of SUD and OUD. They are also at higher risk of both fatal and nonfatal overdoses after release from prison or jail, with the highest risk for death occurring immediately after incarceration.[31,32] Therefore, screening for SUD and OUD just before or immediately after release from incarceration is essential for getting formerly incarcerated individuals into treatment and preventing overdoses.

Individuals who are incarcerated can apply for Medicaid at any time. If they apply for Medicaid when their expected release date exceeds 45 days, they will be evaluated for Incarcerated Coverage (limited benefit hospitalization coverage). They can apply up to 45 days before their expected release date if they want coverage following release ("Reentry Application" through the Cover Virginia Incarcerated Unit (CVIU)). Medicaid expansion has increased eligibility for many formerly incarcerated adults through the CVIU mechanism.

By linking Virginia Department of Corrections data to Medicaid enrollment and claims data, the analysis identified Medicaid members recently released from prison, and examined their OUD prevalence, treatment, and rates of overdoses. The analysis is restricted to members released from state prisons and does not include those released from jails.

Of the 10,005 individuals ages 18-64 who were released from prison between July 2019 and June 2021, 8,253 (82.4%) enrolled in full Medicaid benefits within 6 months of release. Most of these individuals (82%) were enrolled in Medicaid within a few days of their release. In comparing formerly incarcerated Medicaid enrollees with other new Medicaid enrollees, those released from prison were more than four times as likely to be diagnosed with an OUD within 6 months of Medicaid enrollment compared to other new enrollees (132 diagnosed with OUD per 1,000 formerly incarcerated members compared to 32 for other new enrollees). Also, formerly

incarcerated were 4.75 times as likely to experience a fatal or nonfatal overdose within 6 months of enrollment compared to other new enrollees (11.4 overdoses per 1,000 formerly incarcerated members compared to 2.4 overdoses per 1,000 other new enrollees). About one-fourth of overdoses occurred within 2 weeks of release from prison among the formerly incarcerated (findings not shown).

OUD prevalence and overdoses among newly enrolled Medicaid members

	Released from prison and enrolled in Medicaid (7/1/19 – 6/30/21)	Other new enrollees not preceded by prison release (1/1/20 – 12/31/21)
Number released from prison	10,005	Not applicable
Number enrolled in Medicaid[1]	8,253	292,320
OUD diagnosis within 6 months, per 1,000 new enrollees	131.5	31.8
OUD-related overdose within 6 months, per 1,000 new enrollees (fatal and nonfatal)	11.4	2.4

[1]Includes Medicaid enrollment within 6 months of release for those released from prison during the study period. For new Medicaid enrollees not preceded by a prison release, excludes those who had any enrollment in full Medicaid benefits within 6 months of enrollment. Sample restricted to those ages 18-64 with 6 months continuous enrollment after Medicaid enrollment date.

Despite the higher OUD prevalence and overdose risk among formerly incarcerated, they tend to have higher treatment rates for OUD compared to other new Medicaid enrollees diagnosed with an OUD. For example, 83.4% of formerly incarcerated with an OUD diagnosis had an outpatient visit with a primary diagnosis of OUD, compared to 70.6% of other new enrollees with an OUD diagnosis. Similarly, 88.4% of formerly incarcerated with OUD received MOUD treatment, compared to 67.7% of other new enrollees with OUD. Residential treatment, emergency department, and inpatient treatment for OUD tended to be lower among the recently incarcerated compared to other new Medicaid enrollees. And despite the overall higher rates of overdoses, recently incarcerated with any OUD diagnosis had only slightly higher overdose rates (8.7%) compared to other new enrollees with an OUD diagnosis (7.7%). Although these findings suggest that many formerly incarcerated individuals are receiving treatment services once they are diagnosed, it is unknown to what extent under-diagnosis of SUD and OUD is greater among this population compared to other Medicaid members.

OUD diagnosis, treatment, and outcomes within 6 months of Medicaid enrollment.

	Released from prison and enrolled in Medicaid (7/1/19 – 6/30/21)	Other new enrollees not preceded by prison release (1/1/20 – 12/31/21)
Members with OUD diagnosis	1,085	9,306
Utilization of OUD-related services		
Outpatient visits with a primary diagnosis of OUD	905 (83.4%)	6,566 (70.6%)
MOUD use (buprenorphine, methadone, or naltrexone)	800 (88.4%)	6,304 (67.7%)
Residential treatment stay	44 (4.1%)	590 (6.3%)
ED visits with a primary diagnosis of OUD	51 (4.7%)	670
Inpatient hospitalization claim with a primary diagnosis of OUD	43 (4.0%)	577 (6.2%)
Opioid-related overdose	94 (8.7%)	713 (7.7%)

[1]Includes Medicaid enrollment within 6 months of release for those released from prison during the study period. For new Medicaid enrollees not preceded by a prison release, excludes those who had any enrollment in full Medicaid benefits within 6 months of enrollment. Sample restricted to those ages 18-64 with 6 months continuous enrollment after Medicaid enrollment date.

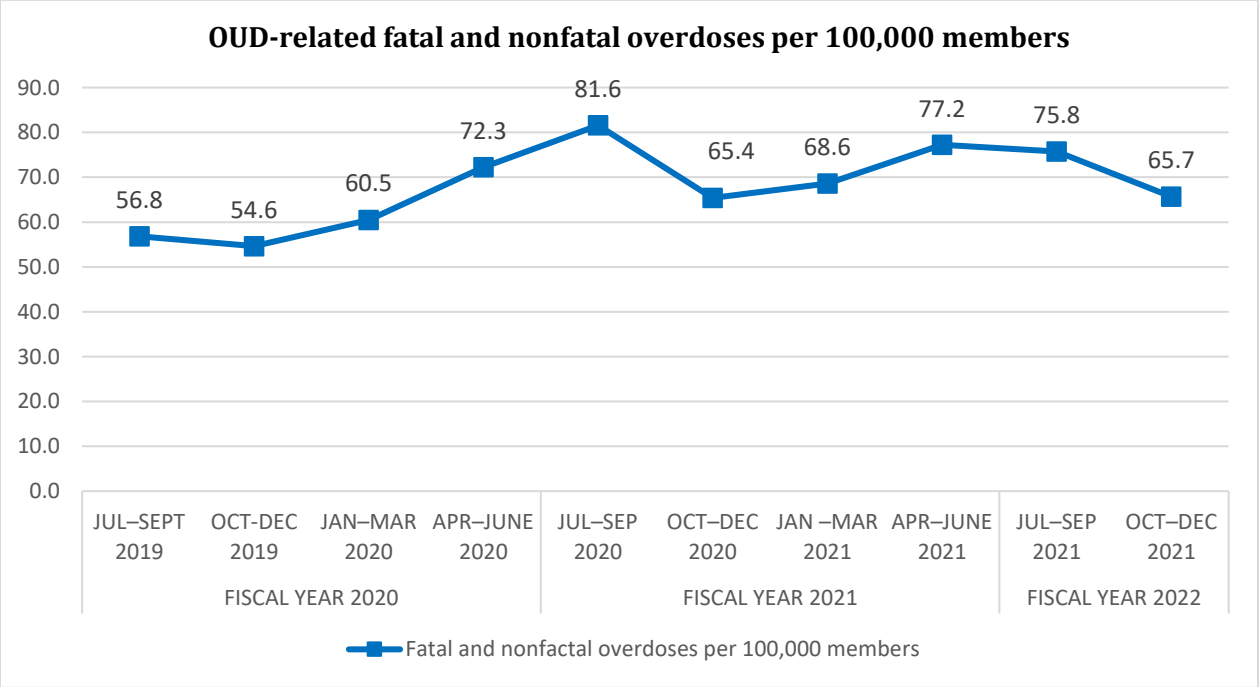
OUD-Related Overdoses

In SFY 2021, there were 4,362 opioid-related overdoses (fatal and nonfatal) among Medicaid members, as reported in the claims data. Consistent with state and national increases in overdose deaths, this represents a 34.1% increase from SFY 2020. Similarly, the rate of opioid-related overdoses per 100,000 members increased 24.9%, from 197 overdoses in SFY 2020 to 246 overdoses per 100,000 members in SFY 2021. Among those with an OUD diagnosis, the proportion with an overdose increased from 7.7% in SFY 2020 to 9.1% in SFY 2021.

OUD-related overdoses among Medicaid members, SFY 2020 and 2021

	SFY 2020	SFY 2021	Percent change
Number of OUD-related overdoses	3,252	4,362	34.1%
OUD-related overdoses per 100,000 members	196.9	246.0	24.9%
Percent with OUD-related overdose among those with OUD diagnosis	7.7%	9.1%	18.6%

A closer look at overdose rates by quarter shows a sharp increase in overdoses near the start of the COVID-19 pandemic in April through September 2020. After peaking at 81.6 overdoses per 100,000 members in July-September 2020, the overdose rate decreased to 65.4 per 100,000 during October-December 2020. Since December 2020, the number of overdoses has mostly held relatively steady between 65.7 and 77.2 per 100,000 members.



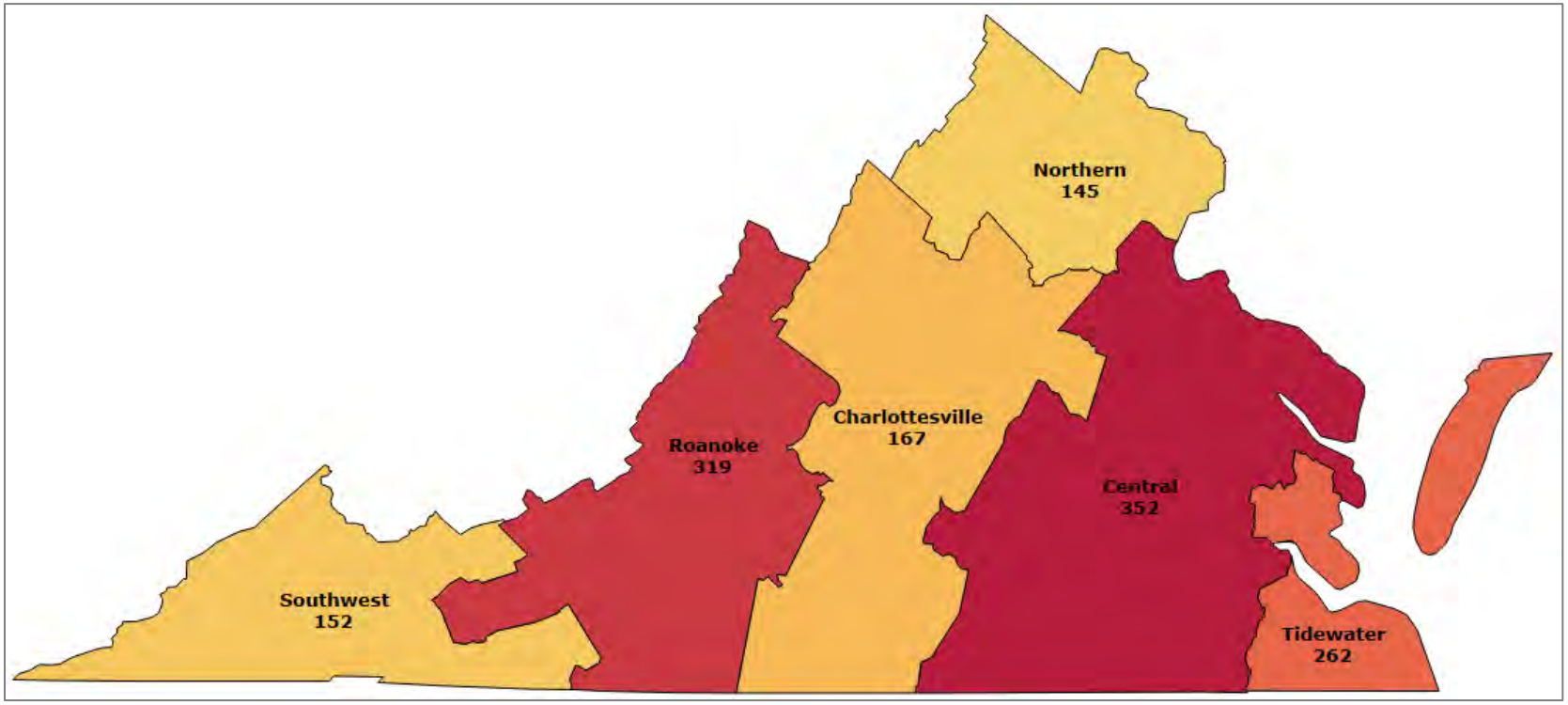
Consistent with trends in OUD prevalence, overdose rates tend to be higher among nonelderly adults, males, and Non-Hispanic Whites. Among Medicaid eligibility categories, overdose rates are highest among Medicaid expansion members and other nondisabled adults (consistent with the higher rates among nonelderly adults) as well as members in the blind and disabled eligibility group.

OUD-related overdoses, by member characteristics

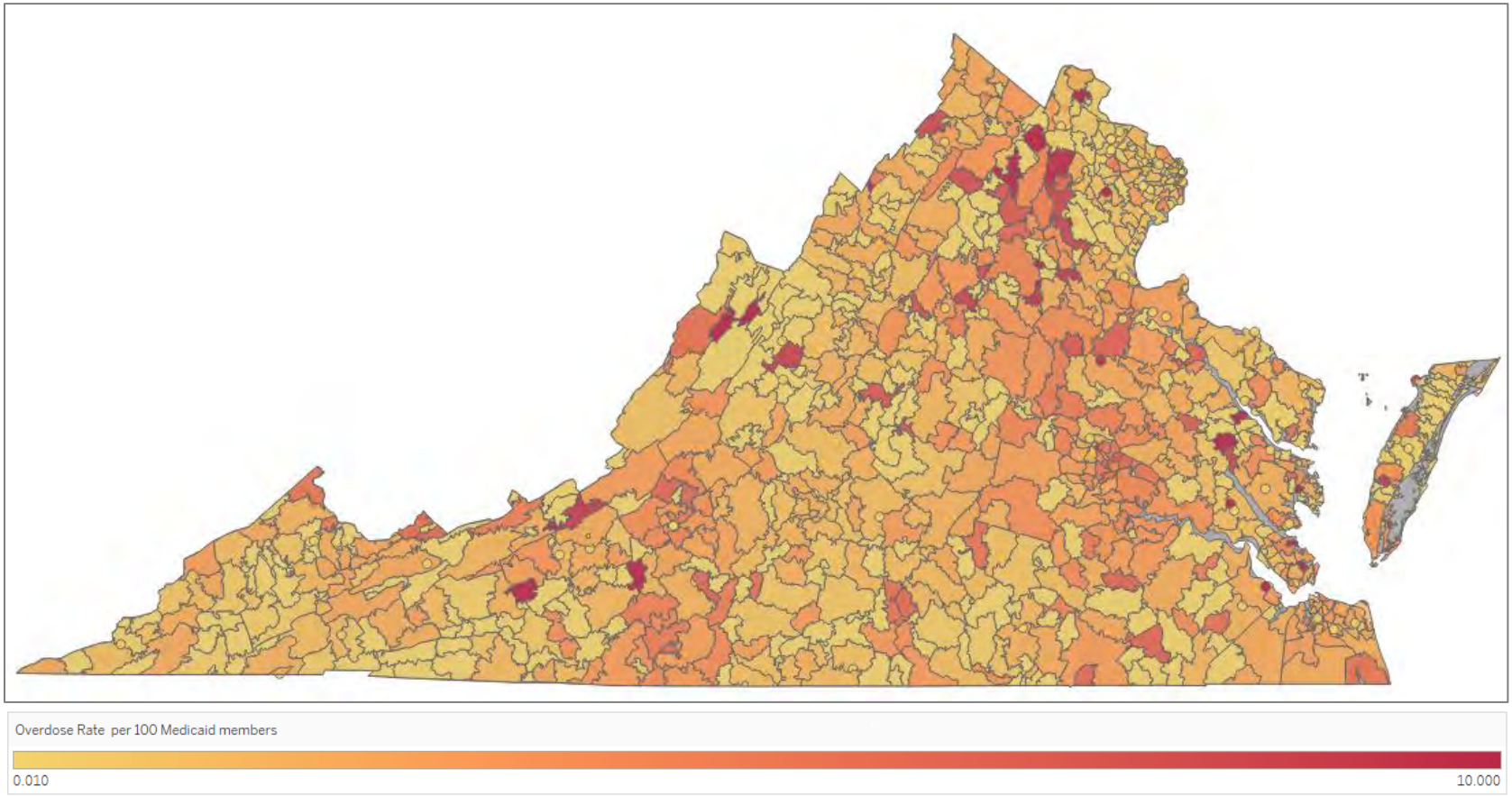
	Medicaid members with overdoses	Overdose rate per 100,000 members
All members[1]	4,362	246.0
Age		
12-21	242	63.2
22-34	1,493	446.6
35-44	1,072	537.1
45-54	784	525.9
55-64	603	396.7
65+	128	127.5
Sex		
Male	2,705	344.6
Female	1,659	167.4
Race/ethnicity		
White, NH	2,628	289.2
Black, NH	1,495	242.3
Hispanic	70	105.4
Other	169	93.3
Aid category		
Medicaid expansion	2,879	491.1
Other non-disabled adults	509	302.9
Pregnant women	40	89.9
Low income children	118	18.1
Aged Adults	116	125.1
Blind/Disabled	683	422.8

The maps below show OUD-related overdose rates by region, as well as by zip code area. While the Southwest region has the highest OUD prevalence rate, it has a lower overdose rate relative to Roanoke, Central, and Tidewater regions. It should be noted that counts of overdoses based on health care claims may be undercounted in rural areas (and heavily rural regions), where there are fewer providers and possibly more overdoses not observed by health care providers.

Overdose Rate per 100,000 Medicaid members by Region



Overdose Rate per 100 Medicaid members by Zip Code



Most Members with overdoses were not receiving MOUD treatment

Most members who had OUD-related overdoses were not receiving MOUD treatment prior to the overdose. Of the 4,362 overdoses in SFY 2021, 60.3% had not received any MOUD treatment in the 12 months prior to the overdose, while 83.8% did not receive MOUD treatment in the month prior to the overdose.

There was a small increase in the percent of members with overdoses who had received MOUD treatment in the 12 months prior to the overdose, from 35.9% among overdoses that occurred in SFY 2020 to 39.7% in SFY 2021. There was no change in the proportion of members with overdoses who received MOUD in the month prior to the overdose (16.2%). Of the total increase in 1,110 members with an OUD-related overdose between SFY 2020 and 2021, 50.9% of the increase is accounted for by members who received MOUD treatment in the 12 months prior to the overdose, while 16.3% is accounted for by members who received MOUD treatment in the month prior to the overdose.

OUD-related overdoses that involved MOUD treatment

	SFY 2020		SFY 2021	
	Number	As Percent of Total Overdoses	Number	As Percent of Total Overdoses
Total number of overdoses	**3,252**		**4,362**	
Any MOUD use in 12 months prior to date of overdose				
Yes	1,167	35.9%	1,732	39.7%
No	2,085	64.1%	2,630	60.3%
Any MOUD use in 30 days prior to date of overdose				
Yes	527	16.2%	708	16.2%
No	2,725	83.8%	3,654	83.8%

Conclusion

SUD prevalence among Medicaid members continued to increase between SFY 2020 and 2021, both in the overall number of Medicaid members with a diagnosed SUD as well as on a per member basis. However, the rate of increase in SUD prevalence (6.5% on a per member basis) was much lower than in prior years (16% between SFY 2019 and 2020) which was influenced by new Medicaid members with SUD enrolling through Medicaid expansion,[2] and possibly the early effects of the COVID-19 pandemic. Although OUD-related overdoses (fatal and nonfatal) increased between SFY 2020 and 2021, overdoses leveled off and declined somewhat during the first two quarters of SFY 2022 (July through December 2021). This is consistent with an apparent statewide decline in fatal overdoses projected for 2022 in Virginia, driven primarily by a leveling off of fentanyl-related overdoses.[1,3] While it is unclear whether the recent decrease in overdoses is temporary or part of a longer-term trend, it may signal an easing of the social, economic, and psychological stresses that contributed to a spike in overdoses during the early years of COVID-19.

Access to and use of ARTS services also continues to increase, as it has since the implementation of the ARTS benefit in 2017. Treatment providers of all types continued to increase in the past year, as well as utilization of ARTS services. Especially notable was the increase in MOUD treatment rates among those with an OUD diagnosis, from 64% in SFY 2020 to 78% in SFY 2021, with the increase continuing in the first two quarters of SFY 2022. Among Medicaid members who had an overdose in SFY 2021, only 16% were receiving MOUD treatment in the 30 days prior to the overdose. The increase in MOUD treatment likely reflects the increase in treatment providers, the removal of prior authorization requirements for suboxone films for in-network prescribers beginning in March 2019 and new initiatives and procedural flexibilities implemented at the beginning of the COVID-19 pandemic that made it easier to access buprenorphine and methadone from home. Greater acceptance and reduced stigma of MOUD treatment by patients, providers, and others in the community may also contribute to higher treatment rates.

Despite these gains, some gaps in treatment remain. While access to providers who prescribe buprenorphine may have increased, there is uneven access to pharmacies that dispense buprenorphine across the state. Retail pharmacies that dispense buprenorphine tend to be more available in urban areas of the state, while some rural areas with high OUD prevalence (Southwest region, for example) may have limited accessibility. There are fewer pharmacies dispensing buprenorphine in Southwest relative to OUD prevalence in this area. This could lead to some members having to travel excessively long distances to obtain buprenorphine medications, which may affect their willingness to initiate and continue with buprenorphine treatment.

Gaps in care transitions after discharge from hospital emergency departments and residential treatment centers for OUD remain, with only 37% and 54%, respectively, receiving MOUD treatment within 30 days of discharge. Treatment rates are relatively high following release from prison for former inmates who are diagnosed with OUD, although the analysis did not assess members who had shorter term stays in local jails. Relatively high Medicaid enrollment and treatment rates among those released from prison may reflect efforts by Department of Corrections officials to screen inmates who are about to be released for SUD and Medicaid eligibility. Finally, while OUD still is the most prevalent SUD diagnosis, prevalence has increased the most for SUD

diagnoses related to other substances, such as cannabis, hallucinogens, and simulants. Use of ARTS services for these other substances remains much lower than that related to OUD diagnoses, which may reflect the lack of pharmacological and other medical treatment options for these diagnoses.

The Commonwealth of Virginia has made substantial progress since the implementation of the ARTS benefit in 2017 in building a robust treatment infrastructure for Medicaid members, with the number of treatment providers, members using services, and treatment rates for those with SUD diagnoses increasing every year since 2017. Continued progress will depend in part on addressing ongoing gaps in treatment, especially care transitions following discharges from hospitals and residential treatment centers, as well as uneven access to providers and pharmacies in some areas of the state. System capacity to treat patients may also benefit in the future to the extent that COVID-19 related increases in SUD prevalence and overdoses have leveled off and continue to decrease.

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Attachment 11

Virginia 1115 Demonstration

Care Coordinator Experiences in the Virginia Medicaid Program Results from a survey of Virginia Medicaid Care Coordinators

VCU School of Medicine
Health Behavior and Policy

Care Coordinator Experiences in the Virginia Medicaid Program

Results from a survey of Virginia Medicaid Care Coordinators

May 2023

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The conclusions in this report are those of the authors, and no official endorsement by Virginia Commonwealth University or the Virginia Department of Medical Assistance Services is intended or should be inferred.

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1 EXECUTIVE SUMMARY

This report presents findings from a survey of care coordinators serving members in Virginia's Medicaid program. The survey was conducted by Virginia Commonwealth University School of Medicine on behalf of Virginia's Department of Medical Assistance Services. Medicaid care coordinators are employed by the six managed care organizations (MCOs) that are part of Virginia's Medicaid program including Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0. CCC Plus covers primarily older adults and individuals with a disability or long-term care needs. The Medallion 4.0 plan covers children, non-disabled adults and pregnant individuals. The Medicaid MCOs are responsible for managing their member's medical and behavioral health needs, including the Addiction and Recovery Treatment Services (ARTS) benefit for the treatment of substance use disorders (SUD).

At the request of DMAS, the MCOs provided lists of their care coordinator employees, along with contact information (including email addresses). Between May and July of 2022, a total of 1,318 care coordinators were contacted via email to complete the online survey. A total of 329 care coordinators completed the survey, for a response rate of 24%.

Care coordinators play a vital role in linking Medicaid members with necessary services to ensure that the needs of the Medicaid members are met. This survey focused on the background, training and professional experiences of care coordinators; care coordinators' normal work activities with Medicaid members; care coordinators work with members who have a SUD and specific activities commonly performed to assist members with SUD; the type of data and information used by these coordinators to support their duties and responsibilities; major barriers faced by care coordinators, and care coordinators feelings about their job. We highlight key findings here.

Care coordinator demographics, training, and professional experiences:

- Care coordinators overwhelmingly reported identifying as women; three-fifths were registered nurses (RNs), licensed practical nurses (LPNs) or licensed mental health professionals; two-thirds had a bachelor's degree or higher in a human service-related field.
- Care coordinators have a wealth of experience; over 70% had more than five years of experience as care coordinators and almost 80% had three or more years of experience working with Medicaid members.

Medicaid caseload and primary role

- Care coordinators report a median caseload of 143 members (Interquartile Range or IQR:88-208); two-thirds of care coordinators report that their caseload has increased "a lot" or "somewhat" in the past year.
- Over 85% of care coordinators report that most of their members are in CCC Plus; care coordinators report that over three-quarters of their clients had chronic health problems,

three-fifths have mild or moderate mental health problems, and two-thirds have functional limitations.

- 44 percent of care coordinators view their primary role as conducting health screenings or needs assessments for members; two-thirds of care coordinators report that they meet with their clients on average several times a year.

Care coordinators experiences with Medicaid members with SUD:

- Among care coordinators who work with members with SUD, 36% learned about their client's SUD diagnosis through a health risk assessment screening and 31% learn through a referral from the member's MCO.
- Relative to care coordinators who had a low SUD caseload, care coordinators who worked with a higher SUD caseload were more likely to report doing a wide variety of treatment activities, including locating treatment providers, scheduling appointments, following up with members, and facilitating care transitions and peer support services.

Tools that care coordinators use for tracking Medicaid members

- Care coordinators report using Emergency Department/Hospitalization data, electronic health records, health risk assessments and claims data as the most common methods of tracking Medicaid members in their caseload.

Major barriers faced by care coordinators

- Size of case load, administrative burden and paperwork and finding resources for social services were the three challenges most cited by case workers as major barriers to successfully performing their role.

Job satisfaction among care coordinators

- Over 92% of care coordinators generally feel their work is "moderately", "a lot" or "extremely" meaningful, while over 43% report feeling burned out from work once a week or more.

2 INTRODUCTION

In Virginia, the majority of Medicaid members are enrolled in one of six managed care organizations, each of which provides a care coordinator for its members. The care coordinator's main role is to help ensure that Medicaid members can access the services that they need. Virginia's Department of Medical Assistance Services has encouraged the expansion of the role of care coordinators in multiple Medicaid programs. For example, the Addiction and Recovery Treatment Services (ARTS) incentivizes the creation of Preferred Office-Based Addiction Treatment providers (OBAT) to integrate SUD treatment services with other physical health and social needs.

In Virginia's Commonwealth Coordinated Care Plus program (CCC Plus), a managed long-term services and supports program, care coordinators serve a pivotal role in integrating and coordinating care services. CCC Plus serves some of Medicaid's most vulnerable members, including dually-eligible members with functional limitations and serious mental illness. In all programs, care coordinators are charged with assessing member needs, helping facilitate transitions in care, ensuring access to needed prescriptions and durable medical equipment, locating health and social resources, and navigating pre-authorizations and referrals.

To better understand the experiences of care coordinators, the specific types of care they provide to members, and the challenges they face in providing this care, DMAS contracted with Virginia Commonwealth University School of Medicine to conduct a web-based survey of Medicaid care coordinators. This survey of care coordinators was conducted from May to July of 2022 to help improve care for Medicaid members in ARTS. The objective of the survey was to obtain information on care coordinators' personal and professional backgrounds; client characteristics including major challenges; care coordinator activities, both generally and for members with SUD; tools used by coordinators for data gathering; and barriers faced by coordinators. The results of this survey are presented in this report.

3 METHODS

Lists of care coordinators employed by the six MCOs and their contact information were obtained from each MCO. These lists included the universe of care coordinators employed by the MCOs to serve Medicaid members, a total of 1,318. These include care coordinators primarily serving members enrolled in the CCC Plus program, members receiving SUD treatment and recovery services through the Addiction and Recovery Treatment Services (ARTS) benefit, members with serious mental illness, and others.

A REDCap database was designed to send out a web questionnaire to the 1,318 care coordinators, designed to take no longer than 10-15 minutes to complete. Care coordinators were sent the survey via email and received follow up reminders after ~30 days if they did not respond. A total of three reminders were sent. Data collection began in late April 2022 and went through July 2022. We received 329 completed surveys for a response rate of 24%.

The REDCap database with the completed surveys was converted to a SAS file for the purpose of analysis. The report provides overall frequencies of the responses to the survey questions. Some questions allowed for "free responses" rather than a set choice of responses in order to allow for more in-depth understanding of certain responses. Verbatim answers for these free responses were recorded and analyzed. A selection of these responses is provided in Appendix A, with links to these responses included in the tables with the frequency results.

4.1 CARE COORDINATOR DEMOGRAPHICS, TRAINING, AND PROFESSIONAL EXPERIENCES

4.1.1 : Demographic characteristics of care coordinators who responded to the survey

- The vast majority of care coordinators are female; about one-third are racial/ethnic minorities, and the majority are married.

- Almost all care coordinators have annual household incomes of $50,000 or higher.

	N	%
Gender		
Female	275	94.5
Male	15	5.2
Other	1	0.3
Race		
White	196	67.4
Black or African American	72	24.7
Asian	10	3.4
Other	13	4.5
Hispanic		
No	285	97.9
Yes	6	2.1
Age (median (IQR))	45 (38-52)	
Marital Status		
Never Married	47	16.2
Married	180	61.9
Separated	6	2.1
Widowed	3	1.0
Divorced	55	18.9
Household Income		
$25,000 - $49,999	9	3.1
$50,000 - $99,999	175	60.1
$100,000 - $149,999	73	25.1
$150,000 and more	34	11.7

4.1.2 Care coordinator professional experience

- Almost 60 percent of care coordinators are credentialed as nurses or mental health practitioners, and two-thirds have a bachelor's degree of higher.

- Most care coordinators (90%) have three or more years of experience as care coordinators, and about three-fourths have three or more years of experience as Medicaid care coordinators

	N	%
RN, LPN, Licensed Mental Health Practitioner		
No	117	40.2
Yes	174	59.8
BA or Higher in Human Services or related field		
No	94	32.3
Yes	197	67.7
Care coordinator experience: all time		
Less than 1 year	15	5.2
1-2 years	14	4.8
3-5 years	58	19.9
5-10 years	77	26.5
10+ years	127	43.6
Care coordinator experience: Medicaid		
Less than 1 year	32	11.0
1-2 years	33	11.3
3-5 years	149	51.2
5-10 years	57	19.6
10+ years	20	6.9

4.2 How Care coordinators work with Medicaid members

4.2.1 Medicaid caseload characteristics

- A majority of care coordinators serve members in either small cities or towns (25.9%) or rural areas (30.6%).

- The vast majority of care coordinators (84.6%) serve members in CCC Plus.

- The median caseload is 143 members. Two-thirds of care coordinators report that their caseload has increased in the past year, with one-third reporting that their caseload increased a lot. (See verbatim responses in Appendix A as to why their caseload increased a lot).

- Just under half of members that care coordinators serve (47.5%) are age 65 and over. Care coordinators serve members with a variety of physical and behavioral health problems and disabilities.

- Almost two-thirds of care coordinators reported that their caseload had increased a lot (33%) or somewhat (32.3%) over the past year. Much fewer reported that their caseload had decreased a lot (2.8%) or somewhat (13.4%).

	N	%
Primary Medicaid member region of residence[1]		
Southwest	47	14.5
Roanoke/Alleghany	63	19.4
Charlottesville/Western	77	23.8
Northern/Winchester	79	24.4
Central	99	30.6
Tidewater	72	22.2
Primary Medicaid member residential area		
Large city	55	17.0
Suburb near a large city	68	21.0
Small city or town	84	25.9
Rural area	99	30.6
Not sure	18	5.6
Primary Medicaid program		
Members enrolled in Commonwealth Coordinated Care Plus (CCC Plus)	274	84.6
Members with substance use disorders receiving services through the Addiction and Recovery Treatment Services (ARTS) benefit	8	2.5
Members with mental health problems	27	8.3

[1] Multiple options allowed

	N	%
Members enrolled in Medallion 4.0	4	1.2
Other[2]	11	3.4
Number of members on case load		**N**
25th percentile		88
Median		143
75th percentile		208
Change in caseload over the past year (reasons for change included in Appendix A)	**N**	**%**
Caseload has increased somewhat	94	32.3
Caseload has increased a lot	96	33.0
Caseload has stayed the same	54	18.6
Caseload has decreased somewhat	39	13.4
Caseload has decreased a lot	8	2.8
Age distribution of Medicaid caseload		**mean %[3]**
Age 65 and over		47.5
Between 21 and 64		40.0
Less than age 21		11.4
Percent of Medicaid Caseload with		**mean %[4]**
Physical health problems, such as chronic conditions that require ongoing monitoring and treatment		77.1
Mild or moderate mental health problems, such as depression or anxiety		60.5
Severe mental health problems, such as bipolar disorder, schizophrenia, or other psychosis		40.1
Physical disabilities		62.9
Intellectual disabilities		28.5
Substance use disorders		30.7
Need for assistance with activities of daily life		66.4
Need for long-term services and supports		64.5

Other include: dsnp; ohcc no ltss; Medicaid no ltss; Mental health or community members; Patients enrolled in Commonwealth Coordinated Care Plus (CCC Plus) Patients with substance use disorders receiving services through the Addiction and Recovery Treatment Services (ARTS) benefit Patients with mental health problems; Patient enrolled in Medallion 4.0 with mental health problems; I am a supervisor of Care Coordinators who care for waivered members of the Commonwealth Coordinated Care Plus Plan. I do not have a caseload; All Lines of business. All caseloads listed; Emerging High Risk then Vulnerable Subpopulation with some Behavioral Health; Emerging High Risk then Vulnerable Subpopulation with some Behavioral Health

[2] Other include: dsnp; ohcc no ltss; Medicaid no ltss; Mental health or community members; Patients enrolled in Commonwealth Coordinated Care Plus (CCC Plus) Patients with substance use disorders receiving services through the Addiction and Recovery Treatment Services (ARTS) benefit Patients with mental health problems; Patient enrolled in Medallion 4.0 with mental health problems; I am a supervisor of Care Coordinators who care for waivered members of the Commonwealth Coordinated Care Plus Plan. I do not have a caseload; All Lines of business. All caseloads listed; Emerging High Risk then Vulnerable Subpopulation with some Behavioral Health; Emerging High Risk then Vulnerable Subpopulation with some Behavioral Health.

[3] Respondents indicated percent of Medicaid caseload with each of these characteristics; value is the mean of all responses

[4] Respondents indicated percent of Medicaid caseload with each of these characteristics; value is the mean of all responses

4.2.2 Care coordinator activities with Medicaid members

- The most frequent activities that care coordinators perform are health screenings or needs assessments (43.7%), work with members to identify specific health and service needs (25.2%), and monitor members' ongoing health problems and utilization of services (14.2%).

- Most care coordinators meet with members at least several times a year, communicate with them by email, and meet with members in their home as well as through telehealth.

	N	%
Primary role as care coordinate		
Review and/or approve requests for authorization of services by the MCO	4	1.3
Managing transitions to community-based care following discharge from a hospital stay, post-acute care, residential treatment center, or nursing facility (ask separately for each facility type).	19	6.0
Conduct health screenings or needs assessments for members	139	43.7
Work with members to identify specific health and service needs	80	25.2
Work with providers to identify specific health and social needs for members	4	1.3
Assist members with scheduling appointments with providers and arranging for transportation for them to get to their appointments.	2	0.6
Monitoring members' ongoing health problems and utilization of services	45	14.2
Other	25	7.9
Communicate with Medicaid members by email text message		
No	59	18.6
Yes	259	81.5
Percent of encounters in the last month with Medicaid members		**mean %[5]**
Going to the member's home and meeting with them in person		23.4
Visiting a member while there in a hospital, nursing facility, or other institutional setting		5.7
By telephone (audio only)		46.0
By video communications, such as Zoom (other typical telehealth apps)		25.5
Frequency of meetings with Medicaid members		**mean %[6]**
At least once a month		14.2
Several times a year		67.6
No more than once a year		15.4

[5] Respondents indicated percent of clients with each of these characteristics; value is the mean of all responses
[6] Respondents indicated percent of clients with each of these characteristics; value is the mean of all responses

4.3 CARE COORDINATORS EXPERIENCES WITH MEDICAID MEMBERS WITH SUBSTANCE USE DISORDER

4.3.1 Identifying Medicaid members with substance use disorder (SUD)

- Most care coordinators identify members with SUD either through a referral by the MCO (31.3%) or through a health risk assessment (35.6%). Fewer care coordinators report that members request help with SUD or they are referred by healthcare providers.

- Time to initial appointment and convenience of treatment providers are important factors in getting members engaged with SUD treatment, while support of family, friends, and peers also often play an important role.

	N	%
How care coordinators learn about Medicaid members having a substance use disorder		
Member is referred by the MCO	87	31.3
Member is referred by healthcare provider	42	15.1
Member screens positive during a health risk assessment	99	35.6
Member requests help	50	18.0
Most important factor for member engagement with treatment		
Convenience of treatment providers to home	30	11.5
Time to initial appointment	96	36.6
Member satisfaction with quality of care	38	14.5
Support of family, friends or peers	57	21.8
Overcoming stigma of having a substance use disorder or people finding out	16	6.1
Other	25	9.5
Use EDCC reports to identify Medicaid members in the ED due to an overdose		
Yes	105	37.6
No	37	13.3
Don't know what EDCC reports are	137	49.1

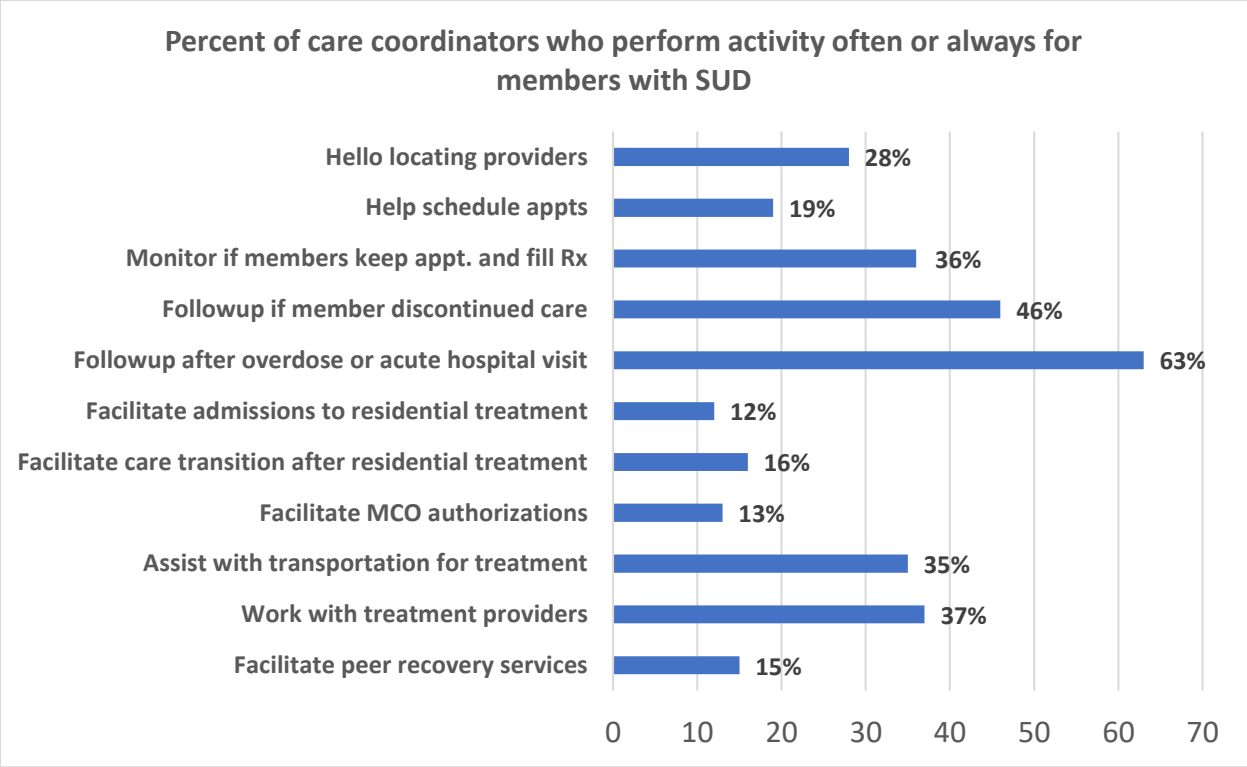
Free Responses to other questions included in Appendix A:

- Specific steps taken if Medicaid member is decompensating or at increased risk of relapse
- How often care coordinator successful in getting Medicaid members with SUD into treatment
- How often care coordinator successful in getting Medicaid members with SUD to engage and stay with treatment
- Specific steps taken if a Medicaid member with SUD has a complex medical condition

4.3.2 Frequency of activities of care coordinators for members with SUD

- Care coordinators report that their most frequent activity is following up with members after an overdose, ED or inpatient visit related to SUD; 63% do so "always" or "often".

- Care coordinators report that their least frequent activity is facilitating admissions to residential treatment and MCO authorization for treatment. Only 12% reported facilitating admissions for residential treatment often or always, while 13% reported facilitating MCO authorizations often or always.



4.3.3 Frequency of activities of care coordinators for members with SUD, by extent of SUD caseload

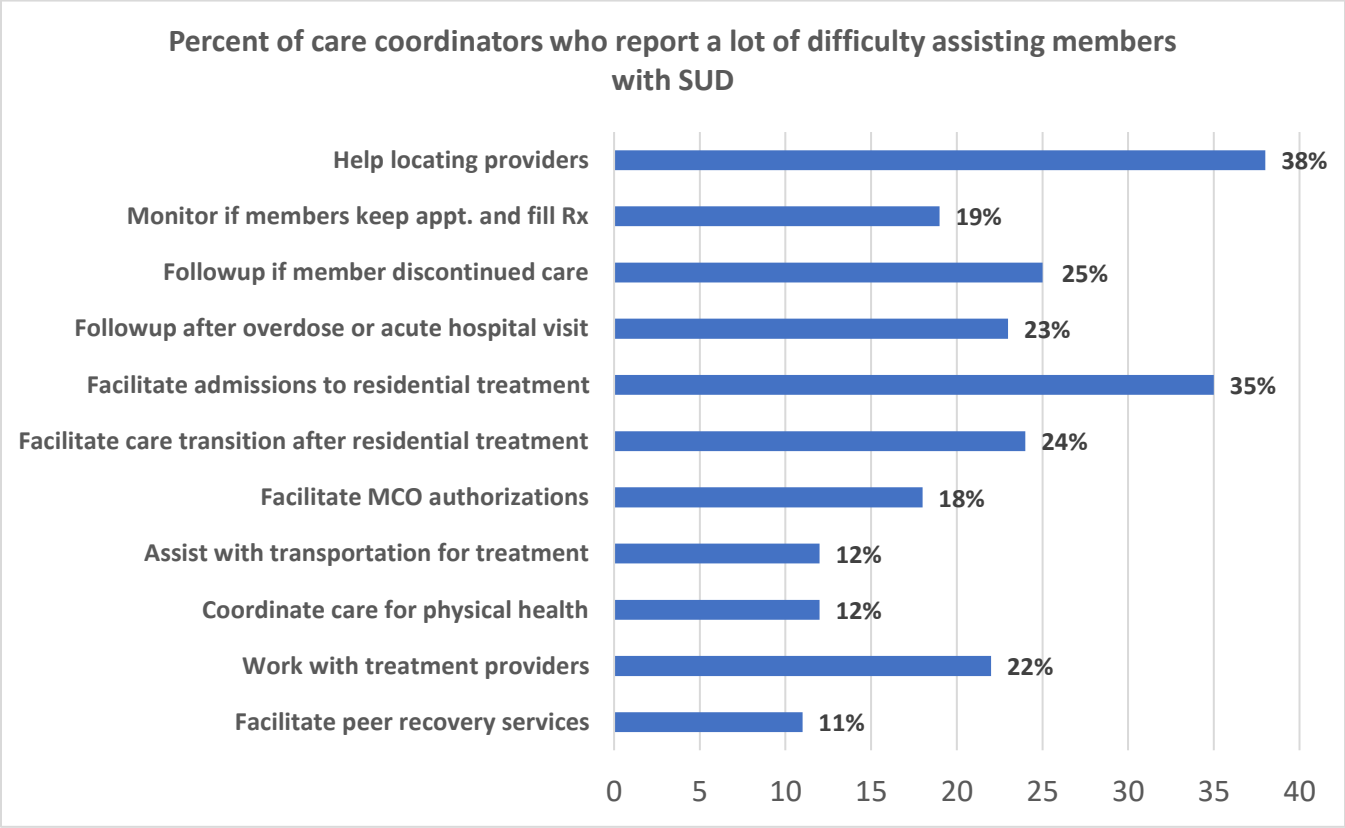
- Frequency of care coordinator activities is associated with SUD member caseload; care coordinators with a greater proportion of members with SUD (50% or more of total caseload) report performing SUD activities more frequently.

	Low SUD member load (<25% of members with SUD)		Medium SUD member load (25-45% of members with SUD)		High SUD member load (≥50% of members with SUD)		Overall	
	N	%	N	%	N	%	N	%
Help locating treatment provider or facility								
Never	18	14.6	10	15.2	6	7.4	34	12.6
Rarely	59	48.0	23	34.9	10	12.4	92	34.1
Sometimes	27	22.0	11	16.7	30	37.0	68	25.2
Often	12	9.8	19	28.8	30	37.0	61	22.6
Always	7	5.7	3	4.6	5	6.2	15	5.6
Help members schedule appointments with treatment providers								
Never	19	15.5	8	12.1	6	7.4	33	12.2
Rarely	48	39.0	25	37.9	15	18.5	88	32.6
Sometimes	38	30.9	23	34.9	37	45.7	98	36.3
Often	15	12.2	8	12.1	22	27.2	45	16.7
Always	3	2.4	2	3.0	1	1.2	6	2.2
Monitor if members are keeping appointments and filling prescriptions								
Never	18	14.6	8	12.1	5	6.2	31	11.5
Rarely	31	25.2	9	13.6	11	13.6	51	18.9
Sometimes	33	26.8	25	37.9	32	39.5	90	33.3
Often	31	25.2	21	31.8	23	28.4	75	27.8
Always	10	8.1	3	4.6	10	12.4	23	8.5
Follow-up with members if they have discontinued care or treatment								
Never	15	12.2	7	10.6	4	4.9	26	9.6
Rarely	31	25.2	5	7.6	15	18.5	51	18.9
Sometimes	26	21.1	21	31.8	23	28.4	70	25.9
Often	32	26.0	28	42.4	32	39.5	92	34.1
Always	19	15.5	5	7.6	7	8.6	31	11.5
Follow-up with members if they had an overdose, after an ED visit, or acute inpatient visit related to SUD								
Never	15	12.2	4	6.1	3	3.7	22	8.2
Rarely	23	18.7	10	15.2	4	4.9	37	13.7
Sometimes	16	13.0	10	15.2	15	18.5	41	15.2
Often	29	23.6	15	22.7	28	34.6	72	26.7
Always	40	32.5	27	40.9	31	38.3	98	36.3

	Low SUD member load (<25% of members with SUD)		Medium SUD member load (25-45% of members with SUD)		High SUD member load (≥50% of members with SUD)		Overall	
	N	%	N	%	N	%	N	%
Facilitate admissions to residential treatment								
Never	42	34.2	16	24.2	20	24.7	78	28.9
Rarely	48	39.0	30	45.5	23	28.4	101	37.4
Sometimes	21	17.1	14	21.2	25	30.9	60	22.2
Often	9	7.3	3	4.6	11	13.6	23	8.5
Always	3	2.4	3	4.6	2	2.5	8	3.0
Facilitating transition to outpatient treatment after discharge from residential treatment								
Never	44	35.8	19	28.8	13	16.1	76	28.2
Rarely	49	39.8	25	37.9	21	25.9	95	35.2
Sometimes	15	12.2	15	22.7	25	30.9	55	20.4
Often	9	7.3	3	4.6	19	23.5	31	11.5
Always	6	4.9	4	6.1	3	3.7	13	4.8
Facilitate MCO authorization process for treatment services								
Never	57	46.3	32	48.5	31	38.3	120	44.4
Rarely	36	29.3	18	27.3	22	27.2	76	28.2
Sometimes	17	13.8	7	10.6	15	18.5	39	14.4
Often	8	6.5	7	10.6	11	13.6	26	9.6
Always	5	4.1	2	3.0	2	2.5	9	3.3
Assist members in getting transportation to go to a treatment provider								
Never	18	14.6	3	4.6	4	4.9	25	9.3
Rarely	28	22.8	13	19.7	8	9.9	49	18.2
Sometimes	45	36.6	23	34.9	33	40.7	101	37.4
Often	24	19.5	20	30.3	30	37.0	74	27.4
Always	8	6.5	7	10.6	6	7.4	21	7.8
Work with treatment providers to coordinate needs (ie. housing, food, employment)								
Never	22	17.9	8	12.1	6	7.4	36	13.3
Rarely	36	29.3	13	19.7	8	9.9	57	21.1
Sometimes	31	25.2	21	31.8	25	30.9	77	28.5
Often	21	17.1	18	27.3	31	38.3	70	25.9
Always	13	10.6	6	9.1	11	13.6	30	11.1
Facilitate peer recovery support services								
Never	45	36.6	20	30.3	16	19.8	81	30.0
Rarely	45	36.6	19	28.8	20	24.7	84	31.1
Sometimes	21	17.1	19	28.8	24	29.6	64	23.7
Often	9	7.3	7	10.6	17	21.0	33	12.2
Always	3	2.4	1	1.5	4	4.9	8	3.0

4.3.4 Difficulties encountered assisting members with SUD

- Care coordinators experience the greatest difficulty in locating treatment providers and facilities for SUD patients (38%) and in facilitating their admission to residential treatment (35%)
- Care coordinators experience the least difficulty in assisting members with SUD getting transportation to a treatment provider (12%), coordinating care for physical health problems (12%) and facilitating peer recovery services (11%).



4.3.5 Difficulties encountered assisting members with SUD, by size of SUD caseload

- Difficulties in assisting SUD members did not vary greatly by SUD member caseload

	Low SUD member load (<25% of members with SUD)		Medium SUD member load (25-45% of members with SUD)		High SUD member load (≥50% of members with SUD)		Overall	
	N	%	N	%	N	%	N	%
Help locating treatment provider or facility								
A lot of difficulty	29	34.1	15	30.6	33	47.1	77	37.7
Some difficulty	48	56.5	26	53.1	32	45.7	106	52.0
No difficulty	8	9.4	8	16.3	5	7.1	21	10.3
N/A	37		13		8		58	
Monitor if members are keeping appointments and filling prescriptions								
A lot of difficulty	14	16.7	16	31.4	9	12.7	39	18.9
Some difficulty	45	53.6	24	47.1	45	63.4	114	55.3
No difficulty	25	29.8	11	21.6	17	23.9	53	25.7
N/A	38		11		7		56	
Follow-up with members if they have discontinued care or treatment								
A lot of difficulty	20	23.3	17	32.7	15	22.1	52	25.2
Some difficulty	45	52.3	25	48.1	42	61.8	112	54.4
No difficulty	21	24.4	10	19.2	11	16.2	42	20.4
N/A	36		10		10		56	
Follow-up with members if they had an overdose, after an ED visit, or acute inpatient visit related to SUD								
A lot of difficulty	15	17.2	15	28.3	17	24.6	47	22.5
Some difficulty	48	55.2	24	45.3	43	62.3	115	55.0
No difficulty	24	27.6	14	26.4	9	13.0	47	22.5
N/A	35		9		9		53	
Facilitate admissions to residential treatment								
A lot of difficulty	17	35.4	13	37.1	17	32.1	47	34.6
Some difficulty	25	52.1	16	45.7	27	50.9	68	50.0
No difficulty	6	12.5	6	17.1	9	17.0	21	15.4
N/A	74		27		25		126	
Facilitating transition to outpatient treatment after discharge from residential treatment								
A lot of difficulty	14	25.5	10	27.8	11	19.3	35	23.6
Some difficulty	30	54.5	18	50.0	33	57.9	81	54.7
No difficulty	11	20.0	8	22.2	13	22.8	32	21.6
N/A	67		26		21		114	

	Low SUD member load (<25% of members with SUD)		Medium SUD member load (25-45% of members with SUD)		High SUD member load (≥50% of members with SUD)		Overall	
	N	%	N	%	N	%	N	%
Facilitating MCO authorization process for treatment services								
A lot of difficulty	8	16.0	6	22.2	7	17.5	21	17.9
Some difficulty	24	48.0	12	44.4	18	45.0	54	46.2
No difficulty	18	36.0	9	33.3	15	37.5	42	35.9
N/A	72		35		38		145	
Assist members in getting transportation to go to a treatment provider								
A lot of difficulty	11	12.4	5	9.4	9	12.5	25	11.7
Some difficulty	38	42.7	24	45.3	31	43.1	93	43.5
No difficulty	40	44.9	24	45.3	32	44.4	96	44.9
N/A	33		9		6		48	
Work with treatment providers to coordinate care for physical health problems								
A lot of difficulty	7	8.8	6	13.0	11	15.7	24	12.2
Some difficulty	37	46.3	22	47.8	37	52.9	96	49.0
No difficulty	36	45.0	18	39.1	22	31.4	76	38.8
N/A	42		16		8		66	
Work with treatment providers to coordinate needs (ie. housing, food, employment)								
A lot of difficulty	14	16.5	10	21.7	19	27.9	43	21.6
Some difficulty	41	48.2	19	41.3	31	45.6	91	45.7
No difficulty	30	35.3	17	37.0	18	26.5	65	32.7
N/A	37		16		10		63	
Facilitate peer recovery support services								
A lot of difficulty	6	11.3	4	11.4	6	10.0	16	10.8
Some difficulty	31	58.5	11	31.4	23	38.3	65	43.9
No difficulty	16	30.2	20	57.1	31	51.7	67	45.3
N/A	69		27		18		114	

4.4 TOOLS THAT CARE COORDINATORS USE TO ASSIST MEDICAID MEMBERS

4.4.1 Helpfulness of tools used to track Medicaid members in case load

- Care coordinators most commonly use ED and hospitalization data and health risk assessments to track Medicaid members
- Care coordinators rarely use ED care coordination and Medicaid discontinuation data
- Care coordinators find ED and hospitalization data, health risk assessments and electronic health records to be the most helpful tools

	Helpfulness of tool							
	Do not use		Very helpful		Somewhat helpful		Not helpful	
	N	%	N	%	N	%	N	%
Plan of Care/ICP	26	8.3	108	34.5	103	32.9	76	24.3
MTR data	57	18	140	44.3	97	30.7	22	7
ED Care Coordination	165	53.2	84	27.1	43	13.9	18	5.8
Electronic health records	49	15.6	184	58.4	59	18.7	23	7.3
Claims data	30	9.4	166	52.2	99	31.1	23	7.2
Health Risk Assessment	20	6.3	185	58.4	81	25.6	31	9.8
Medicaid discontinuation data	176	56.4	69	22.1	49	15.7	18	5.8
ED/Hospitalization data	13	4.1	210	65.6	74	23.1	23	7.2
High risk score	101	32.1	91	28.9	75	23.8	48	15.2
Own tracking system	121	39.8	136	44.7	26	8.6	21	6.9
Other[7]	130	93.5	5	3.6	2	1.4	2	1.4

Free Response included in Appendix A:

- Greatest information gaps or data needs that are essential for care coordinators to be able to track how Medicaid members are doing

[7] i keep up with members going to ED and all those referred to other depts; other report like SDOH, waiver report; these members do not want help; Prior assessments on known members; Prior assessments on known members; Collective Medical; I keep my own Spread sheet to help me stay organized

4.5 MAJOR BARRIERS FACED BY CARE COORDINATORS

4.5.1 Perceived barriers to performing care coordinator role

- Care coordinators say that the size of their caseload, the extent of administrative paperwork, and finding resources for social services are the greatest obstacles in assisting Medicaid members.

- While over three quarters of care coordinators report that non-COVID regulatory changes from DMAS are somewhat of a problem or a major problem, less than half of care coordinators say the same about COVID-related regulatory changes

	Major problem		Somewhat of a problem		Not a problem	
	N	%	N	%	N	%
COVID regulation changes	71	22.8	104	33.4	136	43.7
Accuracy of data on file and ability to reach members	123	38.2	132	41.0	67	20.8
Information transfers after member changes health plan	123	38.3	124	38.6	74	23.1
non-COVID frequently changing regulations from DMAS	114	35.5	127	39.6	80	24.9
COVID regulation changes	45	14.1	113	35.4	161	50.5
Administrative burden and paperwork	160	50.0	102	31.9	58	18.1
Size of caseload	186	57.9	67	20.9	68	21.2
Lack of integrated data systems for member social services	123	38.3	117	36.4	81	25.2
Finding resources for social services	147	45.8	116	36.1	58	18.1
Finding in-network specialists for physical health problems	132	40.9	112	34.7	79	24.5
Finding in-network providers for mental health treatment	135	42.1	117	36.4	69	21.5
Finding in-network providers for SUD treatment	121	37.8	111	34.7	88	27.5
Finding in-network providers for LTSS	116	36.3	108	33.8	96	30.0
Delays in appointments/admission to treatment facilities	118	37.3	128	40.5	70	22.2
Delays in authorization from MCO for services	54	16.8	119	37.1	148	46.1
Other	17	13.3	4	3.1	107	83.6

4.6 CARE COORDINATORS FEELINGS ABOUT THEIR JOBS

4.6.1 Satisfaction with being a care coordinator

- Over 85% of care coordinators find their work at least moderately meaningful and feel worthwhile at work

- Over 40% of care coordinators feel burned out from work on at least a weekly basis

	N	%
I feel worthwhile at work		
Not at all	15	4.7
Very little	31	9.7
Moderately	107	33.5
A lot	102	32.0
Extremely	64	20.1
My work is meaningful		
Not at all	2	0.6
Very little	22	6.9
Moderately	72	22.6
A lot	116	36.4
Extremely	107	33.5
I feel in control when dealing with difficult problems or people at work		
Not at all	16	5.0
Very little	39	12.2
Moderately	132	41.4
A lot	92	28.8
Extremely	40	12.5
I feel burned out from my work		
Never	26	8.2
A few times a year or less	86	27.0
Once a month or less	70	21.9
Once a week	48	15.1
A few times a week	48	15.1
Every day	41	12.9

APPENDIX A: SELECTED VERBATIM RESPONSES

Table 2: Reasons for change in caseload

Our team, and most teams, was carrying caseloads over ratio for the majority of the past couple of years; Virginia Premier was able to finally hire new care coordinators over the past few months, which helped tremendously. Our caseloads are now either at, or below, ratio. However, even with 155 members, it is still quite stressful and overwhelming, because Care Coordinators are now doing tasks that the Social Workers used to do (assisting with locating housing for example). We have been delegated significantly more job duties over the past year, and I think I can speak for most Coordinators when I say that we easily get burned out trying to stay caught up. It can be difficult at times to give excellent quality care, while at the same time keeping up with assessment requirements. I personally really enjoy talking with my members and allowing them the time they need; however, with the constant pressure of completing a certain number of assessments per week, this can often be hard to do. I just don't want my members to ever feel 'rushed' during conversations, nor, assessments. They deserve quality care and time....and in order to provide both, it is easy to fall behind on the countless other tasks.
Lack of staffing due to stress and low compensation for care coordinators that are not nurses, high caseloads, too many tasks put on the care coordinator and not being able to take care of members as we would like. Hard to manage EDCD waiver and SMI individuals with this high of a case load. My case load has been between 230-270.
Staff keep leaving, RNs are given ridiculously low caseloads even though the amount of tech waivers are near zero so caseloads should be equal, DMAS refuses to let DSNP members who are UTC or Refuse HRAs to be moved to telephonic case managers so they remain on our caseload, the current UTC process is impossible to meet with this caseload meaning members who could be transitioned off my caseload as UTC cannot be because I cannot get a drive by in within the 14 day timeframe as my caseload covers a large jurisdictional area. Members are noted as having MH issues and needing face to face CC when they have common diagnoses such as Depression/Anxiety and it is managed by their PCP, which should not be considered as MH needing face to face CC but is with the MMHS screenings
I now handle dual members which in some cases doubles the work and caseload
Partially due to needing more staff, and partially due to influx of members from Medicaid expansion. I work in SMI and have also seen an increase correlating with the pandemic as well.
No Medicaid disenrollment during the pandemic. More people struggling financially and qualifying for Medicaid. More individuals struggling with mental illness require assignment to my Behavioral Health team.
Not enough staff, unorganized caseloads, members being put in the incorrect populations
We had Care Coordinators resigning all the time. I'm in the Roanoke/Allegany region and I was covering 15 members near D/C and 11 more in the Southwest regions plus my own 75. We did this for over 9 months. It was so stressful. We were told to do the F2F over video chat instead of in person. If the member had no way to video chat we were supposed to report the member refuse to complete the assessment. We have been working 40 hours of overtime each month for about 9 months. My case load finally went back to 75 this month but we are all so far behind its crazy.
The number of individuals who now qualify for Medicaid has increased. Many of the medical and behavioral health needs has increased, though the services provided in the community, especially in my area of Roanoke, has not increased. Many go without the needed services for months, which then lead to increase in hospitalizations and/or ER visits.
We are short staffed and they just keep assigning certain care coordinators members. Some of our NCM's only have 135 members to my 211. There is another CC with 260+. It's truly unfair and does not help our members. I

feel that I cannot adequately do my job at this large of a caseload. I have expressed this, but only get excuses, no assistance. My mental health is being affected as well.
I believe it is due to the low amount of case worker at the moment causing my case load to increase significantly. The burnout rate of case workers is extremely high and has caused people to quit and the case load of current case workers to increase.

Table 4: Other activities performed by care coordinators for Medicaid members

ALL OF THE ABOVE: twice year assessments for eligibility/needs, working with providers to identify and ensure needs are meet, work with and follow up with members monthly/quarterly to assess if needs are met or any new needs have occurred.
As an IDDD coordinator I interpret coordination of benefits (Medicare, Tricare, ID/DD Waiver Vs Medicaid) to assist with medication, medical equipment, provide assistance with locating provider with appropriate insurance, navigation crossover rules (Medicaid copayment to Medicare CMS rules), assisting with authorizations and appeals, and explaining to providers the course for grievances.
Nursing facility members. Visiting the facilities, seeing the members, asking what their needs may be. Making sure they are having the best care for where they are. Some members cannot tell you what the needs are for them you have to observe and spend time helping them on an individual basis.
Conduct health screenings or needs assessments for patients Work with patients to identify specific health and service needs Work with providers to identify specific health and social needs for patients Assist patients with scheduling appointments with providers and arranging for transportation for them to get to their appointments. Monitoring patients' ongoing health problems and utilization of services

What specific steps do you take (if any) when you learn that a Medicaid member is decompensating or at an increased risk of relapse?

Notify providers, sometimes contact ED
I would reach out to member's support and providers to arrange treatment for member. I will refer member to treatment facilities and/ or meetings
In my territory, there are limited providers and those we have continue to utilize Telehealth which the majority of my members hate. They need F2F contact and are dying for attention. I encourage a home visit to conduct assessment and develop a care plan and address coping skills and environmental changes.
Seek to initiate contact with provider/member Look to increase Level of Care
Discuss with my manager for services and resources available
1. I facilitate a good rapport with member and their families as much as possible (or as much as they will allow) 2. I rely on family members at times to provide indicators of increased risk of relapse. 3. I monitor EDCC reports to check for high ED utilization 4. I call the providers as needed to ensure patient is attending apts as scheduled. 5. I schedule a F2F meeting with member or try to at least speak with them via telephone to get them reengaged with their providers and in compliance with necessary treatment.
I would connect the patient to crisis or get an ECO if needed.
If member on current caseload, then UM will identify, or ED case management identifies the risk then outreach is attempted
Immediate phone contact to member, 3 calls, send a letter, 3 more calls, a drive by, then a second letter.
I offer substance use treatment options I have a list of outpatient (CSB and Human Services) and inpatient facilities, the National substance use Hotline, Peer Supports and i will confer with my team of SMI CM's on possible resources for my member. I will offer mental health skill building if the member has been IP and I provide a list of providers. Also, I will present this member in rounds in order to get ideas or different approaches to help the member before the member has a relapse.
I request reassignment to the appropriate team.

How often do you believe you are successful in getting Medicaid members with SUD into treatment?

I have to rely on ARTS staff as I do not have time to dedicate to SUD patients due to high level of need of my other members. There is too much emphasis on doing assessments as we have a quota to reach each month and its become very stressful. There is limited bed availability and SA providers often do not work well with us as far as care coordination.
If the member is intrinsically motivated to engage in relevant SUD treatment services and provides informed consent for me to assist them with linkage to SUD services, getting the member into SUD treatment is typically successful, however this is rarely the case and the vast majority of the members identified as likely in need of SUD treatment whom we attempt to engage in care coordination assistance with are unable to be contacted, do not return our calls, are unwilling or unable to engage in some or all of the recommended SUD treatments and services available to them, or decline offers of assistance with linkage to SUD providers. It should also be noted though that the primary barriers that most of the members we serve who have significant BH, SUD, or co-occurring BH/SUD treatment needs face revolve around unstable and unmet SDOH needs, specifically housing insecurity/homelessness/financial insecurity/food insecurity/traumatic exposure, etc. I've been working with Virginia Medicaid patients and populations with BH/SUD needs for almost 20 years and am well-versed in all of the primary challenges impeding this population's ability to heal, transcend, and legitimately self-actualize. The only way this will ever be possible must begin with adequate access to affordable housing, food, and all other basic needs minimums humans require in order to survive. Evaluating SUD treatment linkage assistance success rates is therefore functionally meaningless as a metric unless we begin adequately addressing these primary underlying SDOH needs first.
Not very often, I would say 15% of the time. I have received a lot of push back from members regarding their SUD depending on their stage of addiction. Most members have stated housing being one of the biggest barriers and the lack of housing resources has made assisting difficult.
Rarely....we have very limited BH/ARTs assistance within our MCO. (ex: member who inquired about ETOH treatment/IP. BH/ARTS team provided a directory of facilities for the MEMBER to contact to inquire about admission. Member was actively utilizing ETOH and did not have the ability to reach out to facilities. If my caseload wasn't so overwhelming, I would have happily assisted.)
Not very. Facility bed placement is difficult to find, and members are often reluctant if they have already attempted treatment at a facility unsuccessfully.
45-50% of the time. The biggest problem is if members do not receive treatment immediately when ready to accept it, you can lose them and not be able to reach them for a while because they have relapsed and are not ready for treatment at that time.
The SUD treatment in my area is poor. The standard of care is to keep them in the Methadone or Suboxone program. Many of my members complain that they are substituting heroin etc...with methadone or suboxone. I don't feel successful at all, this is very depressing when you are boots on the ground and seeing such human suffering.
Most of the time when member is open to treatment it is hard to get connected with provider (especially when member is requesting IP treatment) before they back to precontemplation and decline treatment.
Maybe 20 % of the time. I have a homeless population that often leaves AMA from treatment centers and relapses

How often do you believe you are successful in getting Medicaid members with SUD to engage and stay with treatment?

It is not a very high success rate. I do not have time to follow up as needed and provide the care that these members need, this MCO dissolved the specific ARTS care coordination team that focused solely on members only with SUD needs
Very poor, many members struggling with SUDS, have children and can't go to outpatient treatment, 5 hours a day, 5 days per week. This population depends on Medicaid transport which is completely unreliable and word has spread quickly in my area. Many of my members complain that they receive judgement from the providers and are treated as sub human beings. The 'one size fits' all approach is not working with most
no attempts, a lot of members say they are open to treatment but will refuse services when offered
I have been very successful, if the resources are available and I encircle my members with a very strong support system from all realms of care, Medical, BH or SA.
I would say successful outcomes are difficult to assess, because SUD patients are difficult to remain in contact with. They are often do not answer the phone, do not keep their phone turned on, and have difficulty maintaining stability in a residence. We also refer member to different people within the organization for special follow up.
10% of the time. Usually if a member is unsuccessful I am not informed until they have already left their treatment program.
It is difficult to get members to continue to engage, as they often feel that they are successful upon completion of IP treatment and refuse to complete OP services to help maintain sobriety.
Maybe 5% but that is because they have decided that they have had enough of living with SUD and want to get better or they find housing or they get sick. Generally it is another life event that leads to a member staying engaged in SUD treatment. As a case manager for SMI i am there to provide resources and assistance but rarely do I personally have the ability to help a member stay in treatment. There are NOT enough treatment options for members and rarely is it even possible to get a member in treatment without them being hospitalized. There are not many outpatient options for members in Tidewater and often times there are waits and the members get the run around. Often members only get services when they go to the ED. Unfortunately, that is how the system is set up.
I feel that if a member actually goes to treatment or IOP programs, or behavioral health programs typically they have a good chance of staying active with the program because they have took that step and they feel supported.

Table 5: Most important factor for successful engagement- other

In my experience ,if the member is living in the community/not inpatient, they need a clinician to reach out very frequently, daily or every other day, for reminders/reassurance, redirection. There is not staff/funding/services available in our area to provide that level of support, unfortunately.
Self-motivation and the willingness to engage in treatment, The member can have all of the other things mentioned in place but nothing helps unless the member is a willing participant in their own treatment and goals.
All of the above are important factors, though the accessibility of treatment providers that accept Medicaid is the biggest barrier next to not having any beds available.
Patient desire to accept assistance and treatment
Patient with SUD wanting to seek treatment and it not being court or coercion from natural supports. It is also very important they go directly from hospital/detox to a residential treatment facility and have support following discharge.
If hierarchy of needs are met. In my area members are usually focused on meeting daily needs like food and housing before they can worry about treating their substance use issue.
There are multiple factors, but the top two would be how quickly they can get in, and how long the program lasts. Another is also whether or not they also offer high risk detox as well

What specific steps do you take when you learn that a Medicaid member with substance use disorder also has a complex medical condition? (ie. chronic physical or mental health problem - that requires ongoing attention and follow-up)

If the member is cooperative and will participate in care coordination, I assist member to schedule appointments and contact providers as needed. Education also plays a large role. Sometimes it is a chronic illness that will help member to get clean
We get notified of member admissions to EDCD program by the member's assigned CC or via the daily census. The CC will get notified of member and then refer to out EDCD LTSS program. Then I would pick up the member when admitted to the hospital or SNF
If pain is related to the chronic condition that must be addressed first. Using physical activity and medication management to engage them in their own health management at first. Frequent calls if receptive to contact.
Complete the face to face assessment to gather all information needed, set up ICT to collaborate with providers, staff the case with the team in rounds. Develop care plan with member and determine how frequently contact is needed.
Make sure that member reveals SUD to treating and prescribing physicians. Provide education about the danger of mixing prescription and recreational/street drugs. Part of our assessment asks the patient if we have their permission to share this kind of information with their primary care physician. If they say no- make that an ongoing goal to keep discussing and addressing barriers.
Address physical / mental health problems. A lot of members in pain self medicate with substances. Attempting to manage pain with pain specialist/peer supports etc. is beneficial.
Establishing a rapport with the member, completing an HRA assessment, developing service plan goals, and follow up.
Review clinical information when available (I rarely have access to discharge clinicals these days) to see if there is a treatment plan and/or follow-up appointments. Review the follow-up appointments with the member if I can get in contact with them for the post ER follow up call. Ensure member is aware of discharge appointments. Assess the member's understanding of their complex medical condition. Provide contact information for specialists if needed. Provide education re; the effects of alcohol or substance use on medication adherence, efficacy and possibility for adverse interactions. Review to see if member needs a referral to an internal program for chronic health conditions where a specialized care coordinator can discuss the specific impacts the alcohol or substance use have relative to the chronic or complex condition. New chronic conditions may require a triggering assessment and revision to the Plan of care and an ICT meeting
Review my concerns about worsening medical conditions if ongoing drug use. Review their level of support in the home and community and try and link to healthy supports. Provide hotlines for after hours.
There are a few facilities in this area who offer comprehensive care for SUD patients - they have providers on-site who can treat the whole person. This has been a valuable asset for this category of patients. I can also request a complex-care RN within the MCO to also follow the member's case to ensure all medical concerns are being addressed. Unfortunately, most of the time, I find when a patient has ongoing substance use disorder difficulty they remain less focused on the physical health needs and often engage in activities that continue to have a negative health effect.

Table 6: What specific steps do you take when you learn that a Medicaid member has been in the ED due to an overdose or other SUD-related problem?

Refer to ARTS, facilitate a provider for follow up or outpatient treatment facility. Assist in gathering resources like food and housing.
I obtain the discharge summary from the facility to see what was done medically for the member to stabilize the member. I also follow up with the behavioral health provider that the member was referred to. I check to see if the provider is in-network and if the provider can provide the correct services that the member is in need of. I will contact the provider to offer a history and to assist with safe discharge planning.
I read the notes from transition coordinator and read any hospital records and I also sometimes call the facility. I always call member after discharge and attempt to do a triggering assessment.
Contact the medical staff.
Attempt to reach facility to discuss dc planning needs, attempt to reach member within 30 days following dc to discuss discharge appointments (would like to be able to reach out to member within one week but due to case load, its typically near the end of the 30 day period), reach out to case manager at CSB to inquire about member follow up if unable to reach member. No BH assistance within MCO other than providing case managers with directories of in network specialist (which our MCO Case managers already have access to therefore we very rarely reach out to our BH case management team any longer. If we attempt to refer a member to our ARTs/BH care coordinators, we typically receive a message from our BH staff within the MCO stating that the ARTS/BH team will not accept the referral to work with the member due to the member NOT currently being enrolled in ARTS/BH services---which is the entire reason we were attempting to refer the member to the ARTs/BH team: for assistance connecting the member to BH/ARTS services).
Place call the member for follow up and offer assistance with locating services. Sometimes, I speak with providers at the ED to learn more about the nature of the problem
Talk to patient, assess motivation and desire for assistance. Provide education and information about substance abuse, specific dangers of their particular patterns of abuse, etc. Continue to track discussion and education despite initial resistance. If patient wants assistance, refer to health plan ARTS program and/or community services such as where to find 10-step programs.
Recommend psychiatric care services and help them find the services
Take case to high-risk rounds with Medical Director; contact and collaborate with outpatient and inpatient providers

What are the greatest information gaps or data needs that you believe are essential for care coordinators to have for keeping track of how Medicaid members are doing?

Valid member contact information is at the top of this list and far above most other needs. Discharge summaries. If would be great if Collective Medical tracked psychiatric and ARTS admissions.
From my perspective, we do not get enough Clinical Information (ex: MD progress notes from the hospital or SNF, Progress notes from HH, etc) The information is supposed to be in the Collective Medical/Pre-Manage system, but there never is anything from the hospitals to review. Also not having all the clinical information and authorization info in one place doesn't help efficiency.
We really need a SINGLE system or database that can show us, on every member: 1) number of hospitalizations (with details) or ER visits 2) medications as of last pharmacy fill 3) diagnoses 4) services in place 5) list of providers member has seen in the last 12 months This would GREATLY reduce administrative burden and double work.
When a patient has expired, there is no communication to the CC, which can cause trauma to the members family when calling to schedule an appointment or following up with a member
Data is documented; however care coordinators don't receive education regarding what all UM and claims definitions mean, or how to read and interpret what is documented; that would allow CC's to assist providers and members with updated information and the status of submitted requests.
lack of phone # in the system for calling hospital, doctors, mental health provider, and the member # of UTC population. Etc
Follow up reports from BH providers. Monthly or ongoing communication with BH providers with outside agencies would be very benefical
Biggest gaps are that so few members only have Medicaid as their insurance so they have 1-2 other primary insurances that we are unable to track the care and services billed through other insurances. routine touchpoints with members are helpful to document their input on their tx.
The main focus to do HRA/ICP is outdated and consumes the majority of CC's focus and time (90% of our day to day work flow) and takes away CC's from actually being available to members when they call in for urgent needs. CC's time would be better utilized focusing on outreaches associated with noncompliance and HEDIS measures and being more available for the members when they have needs to be addressed and assisted with.
We need access to Medicare records for our Dual Enrolled members. We miss a lot of information without having access to that side of the coin.
There needs to be a more logical and easy way to track hospitalizations/transfers. It is ridiculous how hard and time consuming it is to find out information on hospitalizations or discharge dates. I have often not found out until the member calls me, and the current systems are not updated.
Members discharged from NF to Hospital or home with no notification

Table 9: Barriers to performing care coordinator role- other

Transportation is a huge issue. Transportation providers are not held accountable when they fail to pick up a member. When a provider cancels a trip, they never let the members know. Only when members call back to say their provider hasn't come do they find out that there is no one available to take them. By then, it is too late and they miss appointments
Finding in-network providers for dental treatment
Caseloads are not manageable. It is unrealistic to have so many cases and be effective and provide quality services.
lack of providers willing to support members with intellectual and developmental disabilities
When a member is placed on a plan with an MCO such as the CCC+ waiver the UAI should be provided. All of these UAIs have to be uploaded via the DMAS portal - so they have them all yet we waste time having to track them down, especially when attempting to initiate services for new members.
Mixed caseloads: The division I work within at our MCO manages CCC plus, DSNP, and DSNP only--my caseload has so many different types of members with different types of benefits and waivers that it is impossible to remember all of the different documentation needs and benefits.

APPENDIX B: ANALYSIS OF ACTIVITIES REPORTED AS "NEVER" BEING DONE BY CARE COORDINATORS

Care coordinators were asked about the frequency of completing various activities for members with SUD. The results below show the **percentage of respondents who reported never performing the following activities**, among care coordinators who indicated that ARTS was their primary program or that they had at least one percent of members with SUD (Table 6):

- Help locating treatment provider or facility- *n*=34- 12.6%
- Help members schedule appointments- *n*=33- 12.2%
- Monitor if members are keeping appointments- *n*=31- 11.5%
- Follow up with members if they have discontinued care or treatment- *n*=26- 9.6%
- Follow up with members if they had an overdose, after an ED visit or acute inmember visit related to SUD- *n*=22- 8.2%
- Facilitate admission to residential treatment, *n*=78- 28.9%
- Facilitating transitions to outmember treatment after discharge from residential treatment, *n*=76- 28.2%
- Facilitate MCO authorization process for treatment services, *n*=120- 44.4%
- Assist members in getting transportation to go to a treatment provider, *n*=25- 9.3%
- Work with treatment providers to coordinate needs, *n*=36- 13.3%
- Facilitate peer recovery support services, n=81- 30%

Facilitating MCO authorization for treatment services, facilitating peer recover support services, facilitating admission to residential treatment and facilitating transitions to outmember treatment after discharge from residential treatment were the four activities that care coordinators reported never completing (28.2% to 40% reported "never" doing each of these activities). Table 1 shows the number of activities per care coordinator that care coordinators report "never" completing.

Table 1: Number of activities that care coordinators report never completing per coordinator

Number of "never" activities"	Frequency	Percent
0	118	41.7
1	55	19.4
2	31	11.0
3	16	5.7
4	19	6.7
5	9	3.2
6	9	3.2
7	5	1.8
8	3	1.1
9	3	1.1
10	6	2.1
11	9	3.2

58 percent of care coordinators report never completing at least 1 of the 11 queried activities. 28 percent of care coordinators reported never completing 3 or more activities. In comparing care coordinators who indicated they never completed 3 or more activities versus care coordinators who reported never completing 0, 1 or 2 activities, there were differences between these groups based on gender, race/ethnicity, marital status, income, professional

background, years of experience, size of caseload, change in caseload in the past year, or health plan. Additionally, no differences in any of these characteristics were seen comparing care coordinators who reported completing all activities versus those who reported not completing 3 or more activities.

Attachment 12

Virginia 1115 Demonstration

Substance Use Disorders Among Formerly Incarcerated Adults on Medicaid

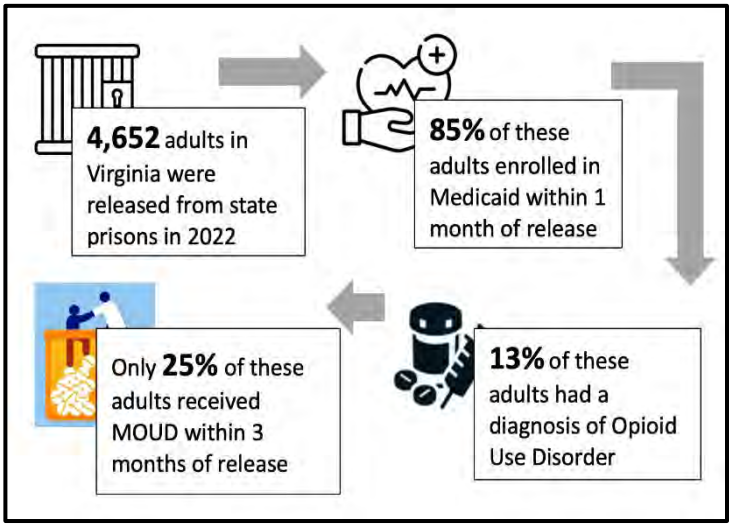
Prevalence of Substance Use Disorders Among Formerly Incarcerated Adults Who Enroll in Virginia Medicaid

VCU School of Population Health

Overview:

As many as 85% of individuals who are incarcerated nationally have substance use disorders (SUD), although fewer than 5% receive evidence-based treatment.[1] While individuals who are incarcerated can apply for Medicaid coverage at any time, the "inmate payment exclusion" means that most covered benefits – including for SUD treatment services – are unavailable to them until after their release. Incarcerated individuals can however apply for Medicaid coverage up to 45 days before their expected release date for coverage post-release through the Cover Virginia Incarcerated Unit (CVIU) program, as mandated by the Virginia General Assembly. In 2019, Virginia expanded Medicaid, greatly increasing the number of individuals who are eligible through the CVIU mechanism. Many individuals who were previously incarcerated and enroll in Medicaid need SUD treatment services. Using Department of Corrections data linked to Virginia Medicaid claims, this policy brief examines SUD prevalence among Virginia Medicaid enrollees who were formerly incarcerated and discusses policy options for treating carceral populations for SUD prior to their release.

Most Virginians Released from Incarceration Enroll in Medicaid, which Covers Evidence-based Substance Use Disorder Treatment.



Findings:

Among the 4,652 adults released from state prisons in 2022, 85% were enrolled in Virginia Medicaid within one month of release. Among these, 17% had seen health care providers and received a SUD diagnosis within three months of their release, including 13% with a diagnosis of Opioid Use Disorder (OUD). This is far lower than estimated SUD prevalence among carceral populations (85% based on national estimates).[1] Even for those who received an OUD diagnosis, only about 25% had received medications for opioid use disorder (MOUD) treatment through the Medicaid program, the evidence-based standard of care for OUD.[2] By comparison, among all Medicaid members with OUD in State Fiscal Year 2021, 78% received MOUD treatment (findings not shown).[3] The findings do not include treatment funded through other sources that previously incarcerated individuals may be receiving.

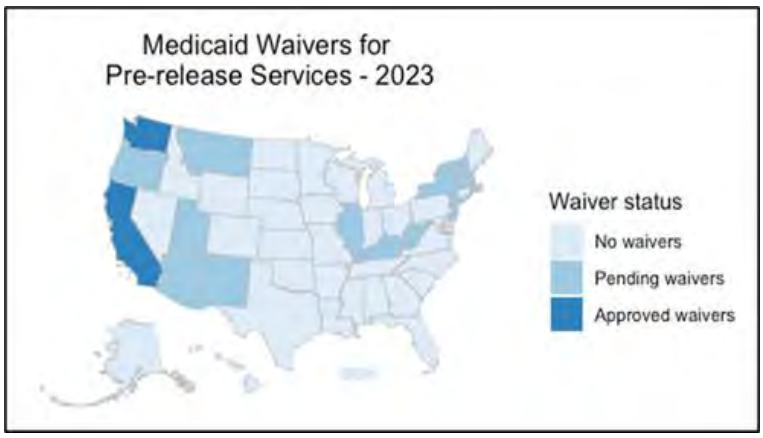
Policy Implications:

Diagnosing and initiating treatment for SUD for individuals while incarcerated may improve treatment for those returning to the community, reduce the risk of overdoses, improve other health outcomes, and reduce recidivism.[1] Currently, the federal government's "inmate payment exclusion" only allows for the use of federal Medicaid funds for individuals who are incarcerated for inpatient care lasting at least 24 hours.[4] Additionally, Medicaid-eligible adults leaving incarceration may also encounter difficulties activating and using Medicaid benefits due to the lack of post-release care coordination between providers. However, there are several new policy options for states hoping to improve health and well-being for Medicaid-eligible adults, especially those recently released from prison who need SUD treatment.

Recent changes to federal policy offer the potential to close the gap in SUD treatment for individuals who are incarcerated and for those leaving incarceration. In 2018, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act directed the Department of Health and Human Services (HHS) to improve care transitions for individuals leaving incarceration. As a result of lessons learned from states that participated in the SUPPORT Act, including Virginia, the Centers for Medicare and Medicaid Services (CMS)

Policy Implications (cont.)

released guidance to states on utilizing state and federal Medicaid funding within prison facilities. In April 2023, CMS outlined policies to allow state Medicaid programs to provide pre-release healthcare services to Medicaid-eligible individuals, improve continuity of care upon release, and enhance care coordination between prison facilities and healthcare providers.[5] These opportunities fall under the umbrella of a Section 1115 waiver, which can be used by states seeking to make changes to their Medicaid programs that augment federal benefit requirements. Two states, California and Washington have approved waivers as shown to the right. California has utilized a Section 1115 waiver to provide Medicaid services to individuals who are incarcerated up to 90 days prior to release. Preliminary estimates indicate that approximately 200,000 people each year will become eligible for pre-release Medicaid services in California.[6] Over fourteen additional states have pending waivers that would grant similar healthcare services to individuals who are incarcerated, including West Virginia and Kentucky. Although each state has its own policies and governance in relation to Section 1115 waivers, the shared objective is to improve pre-release services and maintain continuity of care upon release from prison. While states can add services to these, CMS requires states to provide Minimum Covered Services that include case management, MOUD, and 30-day supply of all prescription medications if they participate in the waiver. Financially, states are required to reinvest the total amount of federal matching received through the demonstration in the community. The demonstration pairs flexibility to adapt to the needs of each state with standards that ensure improved outcomes for community members leaving incarceration.



Similar policies could benefit the incarcerated population in Virginia. Most Virginians who are incarcerated (85%) are eligible and enroll for full Medicaid benefits upon release, helping to ensure continuity of pre-release treatment services. Justice-involved Medicaid members in Virginia are five times more likely to have an OUD-related overdose within 6 months of enrollment compared to other individuals who enroll in Medicaid.[3] Greater access to pre-release services may be lifesaving for Virginians who are justice-involved, particularly those with substance use disorders.

Previously incarcerated individuals were more likely to experience OUD-related overdose compared to other newly enrolled Virginia Medicaid members.

This policy brief was prepared by Peyton Bernstein, Department of Public Policy, College of William & Mary; David Zhu, VCU School of Medicine; and Sherline Pierre-Louis, Hannah Shadowen, Sarah Marks, Dani Montoya, Andrew Barnes, and Peter Cunningham, VCU School of Population Health.

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Attachment 13

Virginia 1115 Demonstration

Addiction and Recovery Treatment Services Interim Evaluation Report for Section 1115 Demonstration

VCU

School of Population Health

Addiction and Recovery Treatment Services

Interim Evaluation Report for Section 1115 Demonstration

January 2024

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Disclaimer

The conclusions in this report are those of the authors, and no official endorsement by Virginia Commonwealth University or the Virginia Department of Medical Assistance Services is intended or should be inferred.

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1. Executive Summary

To address a growing epidemic of opioid and other substance use disorders (OUD and SUD), Virginia Medicaid received approval from the Center for Medicare and Medicaid Services (CMS) in 2016 for a Section 1115 demonstration waiver that expands coverage of treatment services for SUD for Medicaid members. The Virginia Medicaid SUD benefit is called Addiction and Recovery Treatment Services (ARTS), and expanded coverage of community-based services, as well as short-term residential treatment that meets the definition of an Institution for Mental Diseases (IMD), and inpatient detoxification services. Since the ARTS demonstration began in April 2017, Virginia expanded eligibility for Medicaid in 2019 for adults with incomes up to 138% of the federal poverty level through the Affordable Care Act, greatly increasing eligibility for and utilization of ARTS services. In addition, CMS approved an extension of the waiver in December 2019, effective January 1, 2020 through December 31, 2024.

CMS requires an independent evaluation of the Section 1115 demonstration waiver that authorized the ARTS benefit, including the 2019 renewal. The Virginia Department of Medical Assistance Services (DMAS) contracted with Virginia Commonwealth University to conduct an independent evaluation of the ARTS benefit. The evaluation has been conducted by faculty and staff from the Department of Health Policy (previously the Department of Health Behavior and Policy) since 2017. This report represents the fourth interim evaluation report for the demonstration renewal, covering both the original demonstration period as well as the renewal period (2016-2022). The final evaluation report for this renewal period will be submitted in December 2024. Among the major findings in this interim report:

Increases in treatment providers.

- The number of buprenorphine waivered prescribers treating Medicaid members more than doubled in the first two years of the waiver renewal, from 913 prescribers in 2020 to 1,900 prescribers in 2022.

- The number of providers prescribing buprenorphine to Medicaid patients further increased in the first two quarters of 2023, following the removal of federal waiver requirements at the beginning of 2023.[1]

- Changes in the number of other SUD providers treating Medicaid patients between 2020 and 2022 were more mixed. While the number of American Society of Addiction Medicine (ASAM) Level 1, 2, and 3 providers increased, there was a decrease in Office-Based Addiction Treatment (OBAT) providers and Opioid Treatment Programs (OTP) as well as ASAM Level 4 providers.

- Difference-in-differences analyses show that the number of buprenorphine prescribers and SUD treatment facilities accepting Medicaid patients increased in Virginia after

[1] Waiver Elimination (MAT Act) | SAMHSA

ARTS implementation in 2017 and Medicaid expansion in 2019, relative to other Southern non-expansion states.

Increases in utilization of ARTS services

- The number of members using ARTS services continued to increase in the first two years of the renewal, from 2,655 members using ARTS services per 100,000 members in 2020 to 2,911 per 100,000 members in 2022, a 9.6% increase.

- Service use per 100,000 members increased between 2020 and 2022 for ASAM 3 residential/inpatient treatment services (33%), and ASAM 2 level services (29%), while remaining mostly unchanged for ASAM 1 outpatient services and OBAT/OTP services.

MOUD treatment rates continue to increase

- MOUD treatment rates (the percent of members with diagnosed OUD receiving MOUD treatment) continued to increase, from 69.7% in 2020 to 77.9% in 2022, a 12% increase.

- Since the year prior to ARTS implementation in 2017, MOUD treatment rates have increased from 43% in 2016 to 77.9% in 2022, an increase of 81%.

- While there were disproportionate larger increases in methadone and naltrexone treatment between 2016 and 2020 relative to buprenorphine treatment, the more recent increases in treatment rates have been driven by buprenorphine treatment

SUD-related ED and acute inpatient admissions stabilize in recent years

- The overall number of behavioral health-related acute inpatient admissions (for both SUD and mental illness) decreased in Virginia following implementation of the ARTS benefit in 2017, relative to admissions in North Carolina (which did not implement a similar benefit or Medicaid expansion). However, admissions in Virginia increased following Medicaid expansion 2019.

- After more than doubling between 2018 and 2020 (likely due to Medicaid expansion), the number of SUD and OUD-related ED visits among Medicaid members stabilized between 2020 and 2022.

- After increasing between 2018 and 2020, the number of SUD and OUD-related acute inpatient admissions among Medicaid members decreased between 2020 and 2022.

Care coordination and care transition services increase.

- Claims for care coordination services through OBAT and OTP providers increased 33% in the first two years of the renewal, from 11,085 claims in 2020 to 14,807 claims in 2022.

- Overall, 60% of respondents to a representative survey of members receiving ARTS services reported receiving assistance with other non-SUD services, including 26% who received help for a medical problem, 38% who received help with a mental health problem, and 18% who received help with housing, food, or employment.

- The percent receiving MOUD treatment within 7 days of an OUD-related emergency department (ED) visit increased from 20.4% in 2020 to 24.7% in 2022. In 2016 – the year prior to the implementation of the ARTS benefit – less than 5% of members with an OUD-related ED visit received MOUD treatment within 7 days of the visit.

- The percent receiving MOUD treatment within 30 days of discharge from residential treatment increased from 38.1% in 2020 to 40.3% in 2022. In 2017 – the first year of the ARTS benefit, 27.3% of members discharged from residential treatment facilities received MOUD treatment within 30 days of discharge from residential treatment.

Decrease in fatal and nonfatal OUD-related overdoses

- After rising precipitously between 2018 and 2020, the number of fatal and nonfatal OUD-related overdoses among Medicaid members decreased, from a high of 236 overdoses per 100,000 Medicaid members in 2021 to 208 overdoses per 100,000 members in 2022. The change in overdoses among Medicaid members during this period is similar to trends in fatal overdoses among all Virginians, as reported by the Virginia Department of Health and the Center for Disease Control and Prevention.

Since first implemented in April 2017, the evidence indicates that the ARTS benefit has transformed the SUD treatment system for Medicaid members, resulting in increases in treatment providers – both community-based and residential treatment –and MOUD treatment rates among members with OUD. These trends continued and were amplified through large increases in the number of Virginians eligible for ARTS services through Medicaid expansion and federal Maintenance of Effort requirements stemming from the COVID-19 Public Health Emergency, although treatment *rates* among Medicaid members also increased. Disruptions in services and treatment arising from the COVID-19 pandemic are not evident from the results of this study. Instead, increases in treatment providers, utilization of ARTS services, and MOUD treatment rates increased between 2020 and 2022, while OUD-related ED visits, acute inpatient stays, and overdoses either stabilized or decreased. Although residential treatment services were greatly expanded by the ARTS demonstration by allowing federal payment for these services, the share of total ARTS spending on residential treatment has not changed since the demonstration was implemented.

2. Background on Demonstration

Fatal drug-related overdoses surged in Virginia and the nation between 2020 and 2022. Nationally, fatal drug overdoses peaked at about 110,000 deaths in the 12 months ending January 2023, a 52 % increase since January 2020.[1] Fatal drug overdoses peaked at about 2,600 in Virginia in January 2022 but decreased to about 2,500 by January, 2023.[2]

Opioids continue to account for the majority of overdose deaths in Virginia (82%), as well as nationally.[3] However, there has been a marked shift in the type of opioids responsible for overdoses. In Virginia, deaths from fentanyl overdoses more than doubled between 2019 and 2022 (from 964 to 1,952), while there was little change in deaths due to prescription opioids, and even a small decrease in deaths from heroin.[4] Fentanyl accounted for 93% of opioid-related fatal overdoses in Virginia in 2022, compared to 74% in 2019 and 55% in 2016. At the same time, overdose deaths in Virginia due to methamphetamines and cocaine increased by 183% and 85%, respectively, between 2019 and 2022.[5] An increase in alcohol use disorder is also contributing to increased mortality from substance use, accounting directly for 140,557 deaths nationally, as well as contributing to 22% of prescription opioid overdose deaths.[6,7]

To increase access to SUD treatment services for Virginia Medicaid members, Virginia received approval from the Center for Medicare and Medicaid Services (CMS) in December 2016 for the Addiction and Recovery Treatment Services (ARTS) benefit. Implemented in April 2017, ARTS expanded coverage of treatment services for SUD for Medicaid members, including community-based services, short-term residential treatment that meet the definition of an Institution for Mental Diseases (IMD),[8] and inpatient detoxification services.

ARTS was approved as an amendment to an existing Section 1115 demonstration waiver, the Virginia Governors Access Plan (GAP), that had originally been approved in January 2015. This demonstration provided a limited package of behavioral and physical health services to childless adults and non-custodial parents aged 21 through 64 with household incomes at or below 100 percent of the federal poverty line, and who had been diagnosed with a serious mental illness. After the December 2016 amendment expanded SUD benefits through the ARTS program, there was an additional amendment to the demonstration in September 2017 which added coverage for former foster care youth (FFCY) who aged out of foster care under the responsibility of another state and are now applying for Medicaid in the Commonwealth of Virginia.

CMS approved an extension of Virginia's Section 1115 Demonstration in December 2019, effective January 1, 2020, through December 31, 2024. Under this extension, Virginia continues to have the authority to provide services to Medicaid members through the ARTS benefit, and the demonstration no longer includes a separate GAP program, as these beneficiaries were transitioned into full Medicaid coverage starting January 1, 2019, through Virginia's Medicaid expansion.

With the end of the GAP program, the name of the demonstration changed to "Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation" (Project Number 11-W-0029713). As most of the evaluation plan described below pertains to the ARTS benefit, we will use the term "ARTS" when describing the demonstration and evaluation activities.

The ARTS demonstration has the following goals that directly inform the evaluation analyses:

(1) Increase rates of identification, initiation and engagement in treatment for OUD and other SUDS
(2) Reduce utilization of emergency departments and acute inpatient stays through improved access to a continuum of care services
(3) Increase adherence to and retention in treatment
(4) Reduce preventable readmissions to the same level of care or higher
(5) Improve access to care for physical health conditions among beneficiaries
(6) Reduce overdose deaths, particularly those due to opioids

3. Evaluation Goals, Questions and Hypotheses

In July 2017, the Virginia Department of Medical Assistance Services (DMAS) contracted with Virginia Commonwealth University to conduct an independent evaluation of the ARTS benefit. The evaluation has been conducted by faculty and staff from the Department of Health Policy (previously the Department of Health Behavior and Policy) in the School of Population Health.

The VCU evaluation under the previous demonstration authority focused primarily on how the ARTS benefit affected (1) the number and type of health care practitioners providing ARTS services; (2) members' access to and utilization of ARTS services; (3) outcomes and quality of care, including hospital emergency department and inpatient visits; and (4) the performance of new models of care delivery, especially Preferred Office-Based Addiction Treatment (OBAT) programs (formerly known as Office-Based Opioid Treatment programs).

The results for the initial demonstration period found substantial increases in the supply and utilization of addiction treatment services among Virginia Medicaid members in the two years since the ARTS benefit was implemented (through March 2019).[9] This includes large increases in the number of providers across the continuum of care providing addiction treatment services to Medicaid members, including an almost four-fold increase in the number of outpatient practitioners submitting claims for ARTS services. In addition, the percent of members with SUD who received treatment increased from 24% before ARTS to almost 50 percent during the second year of ARTS. The use of medications for opioid use disorder (MOUD) treatment increased from 36 percent of those with opioid use disorder (OUD) before

ARTS, to 49 percent during the second year of ARTS. Evidence of improved quality of care and outcomes was shown by significant decreases in emergency department visits and inpatient stays for members with OUD, relative to other Virginia Medicaid members.[10]

Goals of the evaluation of ARTS demonstration renewal

The evaluation of the ARTS demonstration renewal has three main goals:

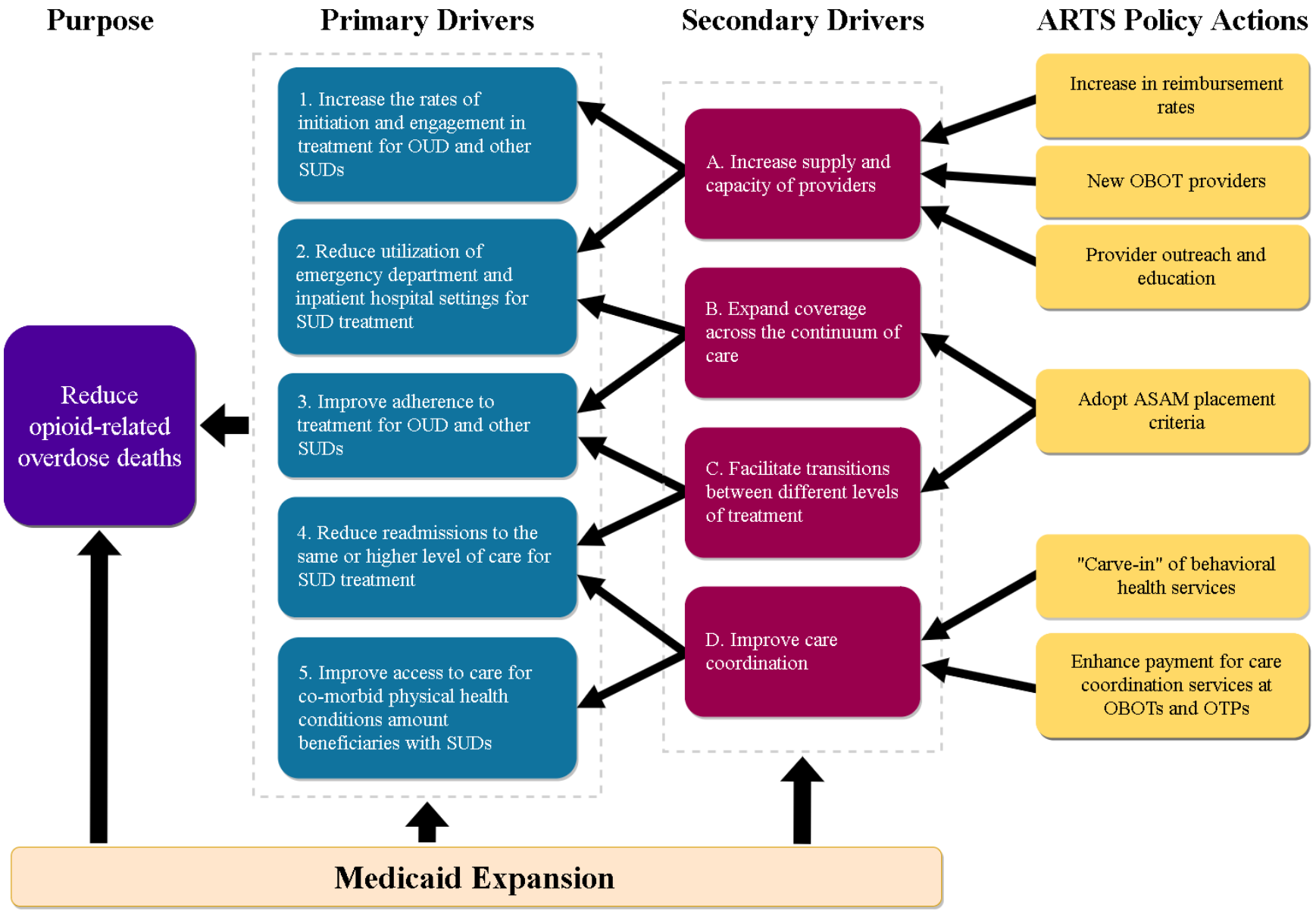
1) Extend the post-implementation period of the evaluation beyond the first two years of ARTS to include 2019-2023. In particular, the evaluation will examine and account for the impact of Virginia's Medicaid expansion in 2019 on SUD prevalence, access to and quality of treatment services, and outcomes among the Medicaid population.

2) To strengthen conclusions about the causal impact of ARTS on key measures of access and quality of care by comparing adjusted summary statistics in Virginia to other states using the Medicaid Outcomes Distributed Research Network (MODRN).

3) To examine the cumulative impact of ARTS and Medicaid expansion on addiction treatment services for the Virginia population, using national data sources that permit comparisons of treatment before and after expansion in Virginia with other states, and the overall U.S. on selected measures of SUD treatment access, utilization, quality of treatment, and rates of fatal overdoses.

Figure 1 conceptualizes the demonstration goals in terms of the overall purpose (reducing overdose deaths), the primary drivers that will directly lead to fewer overdose deaths (the other six goals of the ARTS demonstration), and secondary drivers that reflect the main mechanisms the ARTS demonstration uses to affect addiction treatment services and, ultimately, overdose deaths.

Figure 1. Driver Diagram for ARTS Demonstration Evaluation



The ARTS demonstration seeks to achieve its goals primarily through: (1) increasing the supply of addiction treatment providers serving Medicaid members; (2) increasing the capacity of existing treatment providers; (3) expanding services to cover the entire continuum of addiction treatment services, based on the American Society of Addiction Medicine (ASAM) criteria;[11] (4) facilitating transitions between different levels of treatment; and (5) improving the coordination of addiction treatment services with other physical health, mental health, and social service needs.

To increase the supply and capacity of addiction treatment providers, the ARTS benefit increased reimbursement rates for a number of services, such as residential treatment services, outpatient services, and MOUD treatment. To further increase outpatient capacity, the ARTS demonstration also established a new type of provider, the Preferred Office-Based Addiction Treatment model (Preferred OBAT) originally focusing on serving individuals with primary OUD but has since expanded to include all SUD. In addition, extensive provider training, outreach, and recruitment efforts by state agencies and managed care organizations are intended to increase provider participation in Medicaid addiction treatment services.

The ARTS demonstration also expanded Medicaid-covered services along the ASAM continuum of care, especially residential treatment services and medically managed intensive inpatient services, outpatient, as well as peer recovery support services. Improving transitions across different levels of care, and coordinating addiction treatment services with other physical, mental health, and social needs are to be accomplished by (1) shifting behavioral health services to a "carve-in" model so that they are provided by the same managed care organizations (MCOs) that provide other Medicaid services; (2) the use of licensed care coordinators by MCOs for addiction treatment services; and (3) enhanced payment for care coordination services by the new Preferred OBAT providers.

Finally, Medicaid expansion amplified the effects of the ARTS demonstration by extending access to treatment services to hundreds of thousands of Virginians, most of whom were uninsured prior to January 1, 2019, and did not have access to ARTS benefits. Additional coverage of people with SUD is expected to further decrease the rate of fatal overdoses in the Virginia population. In addition, greater coverage of addiction treatment services through Medicaid expansion is likely to strengthen the addiction treatment system by increasing the number and capacity of addiction treatment providers serving Medicaid patients.

The evaluation analyses and findings in this report are guided by four over-arching research questions related to each of the demonstration goals, around which specific hypotheses and measures were identified in the evaluation design. Table 1 summarizes the evaluation questions and hypotheses. Specific measures proposed to assess hypotheses are shown in the Evaluation Design for the ARTS Section 1115 Demonstration.[12]

Table 1. Evaluation questions, demonstration goals, and hypotheses.

Evaluation question 1: Does the demonstration increase access to and utilization of SUD treatment services?
Demonstration goal: Increased rates of initiation and engagement in treatment for OUD and other SUDS.
Hypothesis: The demonstration will increase the percentage of beneficiaries who are referred and engage in treatment for OUD and other SUDs
Demonstration goal: Reduce utilization of emergency departments and acute inpatient stays
Hypothesis: The demonstration will decrease the rate of emergency department visits and acute inpatient stays
Demonstration goal: Increase adherence to and retention in treatment
Hypothesis: The demonstration will increase adherence to and retention in treatment
Evaluation question 2: Does the demonstration improve quality of treatment through improved care coordination of services?
Demonstration goal: Reduce readmissions to the same or higher levels of care
Hypothesis: The demonstration will decrease the rate of readmissions to the same or higher level of care
Demonstration goal: Improve access to care for physical health conditions among beneficiaries
Hypothesis: The demonstration will increase the percentage of beneficiaries with SUD who receive treatment for co-morbid conditions.
Evaluation question 3: Are rates of opioid-related overdose deaths impacted by the demonstration?
Demonstration goal: Reduction in overdose deaths, particularly those due to opioids
Hypothesis: The demonstration will decrease the rate of overdose deaths due to opioids.
Evaluation question 4: How do costs for SUD-related and non-SUD related services change over the evaluation period?
Hypothesis: The demonstration will increase IMD SUD costs and outpatient SUD treatment costs and decrease SUD-related emergency room costs and inpatient stays

4. Methodology

The analysis for this interim report consists primarily of annual trends of key measures of SUD-related services, expenditures, and providers, emergency department and acute inpatient, and overdoses. Although the current demonstration renewal covers calendar years 2020-2024, the evaluation period covers the time period 2016 through 2022. This includes the beginning of the original ARTS benefit in April, 2017 and Medicaid expansion in 2019.

Analyses based on Virginia Medicaid claims

The primary data source used is Medicaid administrative claims and enrollment data maintained by DMAS. These data are used to compute measures of utilization and expenditures by ASAM level of care and MOUD treatment, the number of providers serving Medicaid members by each ASAM level of care, and SUD-related ED visits and inpatient stays. Analyses are restricted to paid claims for full-benefit Medicaid members.

Measures were derived both from the measure sets suggested by CMS, as well as measures developed internally by both DMAS and VCU, including measures based on the specific set of services that became available through the ARTS demonstration. For computing rates or proportions, denominators for some measures include all full-benefit Medicaid members who were enrolled at any point during the calendar year, as well as members with any diagnosis of OUD during the calendar year. The latter group also includes members who had any use of MOUD during the calendar year, even without a diagnosis of OUD.

For this report, analyses based on Medicaid claims are limited to descriptive trends. For the final evaluation report, we will include interrupted time series (ITS) analyses on a number of measures to control for changes in the characteristics of Medicaid members (e.g. age, race/ethnicity, gender, co-morbidities) that may also influence changes on key measures of utilization and outcomes. This is especially important when considering changes in member characteristics as a result of Medicaid expansion in 2019, as well as policy changes during COVID-19 that increased Medicaid enrollment between 2020 and 2022. For example, prior reports have shown that members enrolled through Medicaid expansion differ from members enrolled through non-expansion eligibility criteria in a number of ways, including higher prevalence of SUD and OUD.[13]

Analyses comparing changes in Virginia to other states.

While ITS improves estimates of change by controlling for changes in member characteristics, an evaluation should ideally include a comparison group that is similar to the "treatment" group, but were not exposed to the same policy interventions. Since both ARTS and Medicaid expansion were implemented statewide, it is not feasible to identify a comparison group of Virginia Medicaid members who did not potentially benefit from the policy changes. Typically, other states that are similar to Virginia – but did not implement similar policies during the study period – are used as comparison groups.

This evaluation does not identify a single state or group of states to compare with Virginia across all measures, due to the difficulty of obtaining comparable Medicaid claims data

from other states. Instead, the evaluation uses a number of strategies to compare changes in Virginia with other states when comparable data are available. Specific methods and data sources are described along with the findings, including:

- Changes in the number of buprenorphine waivered prescribers (BWP) between 2016 and 2020, which compares Virginia to other states in the U.S. South that did not expand Medicaid as of 2020. BWP for all states were obtained from the Substance Abuse and Mental Health Services Administration for 2002-2020 through a Freedom of Information Act request.

- Changes in the overall number of SUD treatment facilities in Virginia, as well as changes in the number of treatment facilities accepting Medicaid payment. These data are derived from the National Survey of Substance Use Treatment Services (N-SSATS) sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). The analysis compares Virginia with other Southern states on changes in treatment facilities before and after the ARTS demonstration was implemented, as well as Medicaid expansion.

- Changes in statewide acute inpatient admissions for substance use and behavioral health problems between 2016-2020, comparing Virginia with North Carolina. Admissions data for North Carolina were obtained through the Healthcare Cost and Utilization Project, while equivalent data for Virginia were obtained through Virginia Health Information.

- The Medicaid Outcomes Distributed Research Network (MODRN), comprised of 13 state-university partnerships (including Virginia), uses a common data model for the purpose of conducting analyses with state Medicaid claims. Analyses are conducted by using standardized data and code developed by the data coordinating center. Currently supported through a grant from the National Institute on Drug Abuse (NIDA), a version 3.0 of the Common Data Model is in development that will include the years 2016-2022. It is expected that comparisons between Virginia and other MODRN states on some evaluation measures will be included in the final evaluation report.

ARTS member survey

VCU conducted a survey of members receiving ARTS services in 2020 and 2021 to understand their experiences with treatment and the effects of treatment on their daily lives. The survey is based on a stratified random sample of Medicaid members who were diagnosed and/or received treatment for OUD. The sample was identified through Medicaid enrollment and claims data, and was equally divided into the following four groups: (1) members who received treatment at Preferred Office-Based Opioid Treatment providers (OBOT) – a new model of care delivery created through the ARTS benefit; (2) members who received treatment through Opioid

Treatment Programs (OTP), which provides methadone treatment for OUD in addition to buprenorphine and naltrexone; (3) members who received treatment at other outpatient providers which may include outpatient clinics or office-based providers that provide OUD treatment; and (4) members who were diagnosed with OUD, but received no ARTS services based on paid claims. The survey was conducted by mail, and included $2 incentives. Out of 10,250 persons in the initial sample draw, about 1,845 returned completed surveys, for a survey response rate of 18%. Survey weights adjusted for differences between respondents and nonrespondents on age, sex, race/ethnicity, and Virginia region. A full survey report includes additional detail on the survey design and analysis.[14]

Since the survey field period lasted from January 2020 through August 2021, we are able to compare early respondents to later respondents to assess changes in member experiences that correspond with the onset of the COVID-19 pandemic. Specifically, we compare survey responses received by April 2020 – which mostly includes experiences prior to the COVID pandemic – and survey responses received after August, 2020.

Survey of MCO Care Coordinators

In Virginia, the majority of Medicaid members are enrolled in an MCO, each of which offers care coordination for its members. Care coordination is to help ensure that Medicaid members can access the services that they need. DMAS has encouraged the expansion of the role of care coordination in multiple Medicaid programs. In the ARTS benefit, specific care coordinators play a key role in identifying members with a need for SUD services, facilitating entry into treatment, and following up after residential treatment stays or discontinuations with treatment. Therefore, care coordinators are in a unique position to comment on the strengths and challenges of the ARTS benefit in helping members with SUD.

To better understand the experiences of care coordinators, the specific types of care they provide to members, and the challenges they face in providing this care, VCU conducted a web-based survey of Medicaid MCO care coordinators from May to July of 2022. The objective of the survey was to obtain information on care coordinators' personal and professional backgrounds; client characteristics; care coordinator activities, both generally and for members with SUD; tools used by coordinators for data gathering; and barriers faced by coordinators.

The survey was conducted by obtaining lists of care coordinators employed by the six Medicaid MCOs who were contracted with DMAS at the time of this survey. These lists included the universe of care coordinators employed by the MCOs (not specifically dedicated to SUD) to serve Medicaid members; a total of 1,318 as of early 2022. These include care coordinators primarily serving members enrolled in the Commonwealth Coordinated Care Plus program, members receiving SUD treatment and recovery services through the ARTS benefit, members with serious mental illness, and others. While the survey did not focus entirely on ARTS care coordinators or SUD services, we identified care coordinators who provided services to members with SUD and asked specific questions about how they identified members with

SUD, and specific activities they performed for members with SUD. The survey was completed online between April and July of 2022. A total of 329 surveys were completed, for a response rate of 24%. A survey report includes additional detail on the survey design and analysis.[15]

5. Methodological Limitations

As stated previously, our analyses of measures based on Virginia Medicaid claims data are limited by the lack of comparison states, which limits our ability to make strong causal inferences about the effect of ARTS and Medicaid expansion for these measures. While the final report will include some comparisons with other states in the MODRN, these analyses will be descriptive in nature, and will not utilize formal difference-in-differences modeling.

In addition, the study period overlaps with the beginning of the COVID-19 pandemic in March 2020. Given the severe disruptions to the health care system caused by the pandemic, it is possible that changes due to both ARTS and Medicaid expansion are offset or confounded by changes due to the pandemic. While it is not possible to separate the effect of ARTS and Medicaid expansion from the effects of the pandemic, our analyses suggest that such pandemic effects were limited. For the most part, trends in provider supply and ARTS utilization that existed prior to the pandemic continued after the beginning of the pandemic. In addition, the ARTS member survey found few differences in patient experiences with care between members interviewed prior to the beginning of the pandemic and members interviewed after the beginning of the pandemic, suggesting only minimal effects on patient care due to the pandemic. Nevertheless, caution should be used in interpreting differences before and after 2020.

6. Results

The findings for the evaluation are reported based on the four over-arching evaluation questions, as described in the introduction and evaluation design.

6.1 *Evaluation question #1: Does the demonstration increase access to and utilization of SUD treatment services?*

This demonstration research question assesses whether ARTS has increased the capacity of the treatment system – primarily through the number of providers who accept and treat Medicaid patients – as well as utilization of ARTS services.

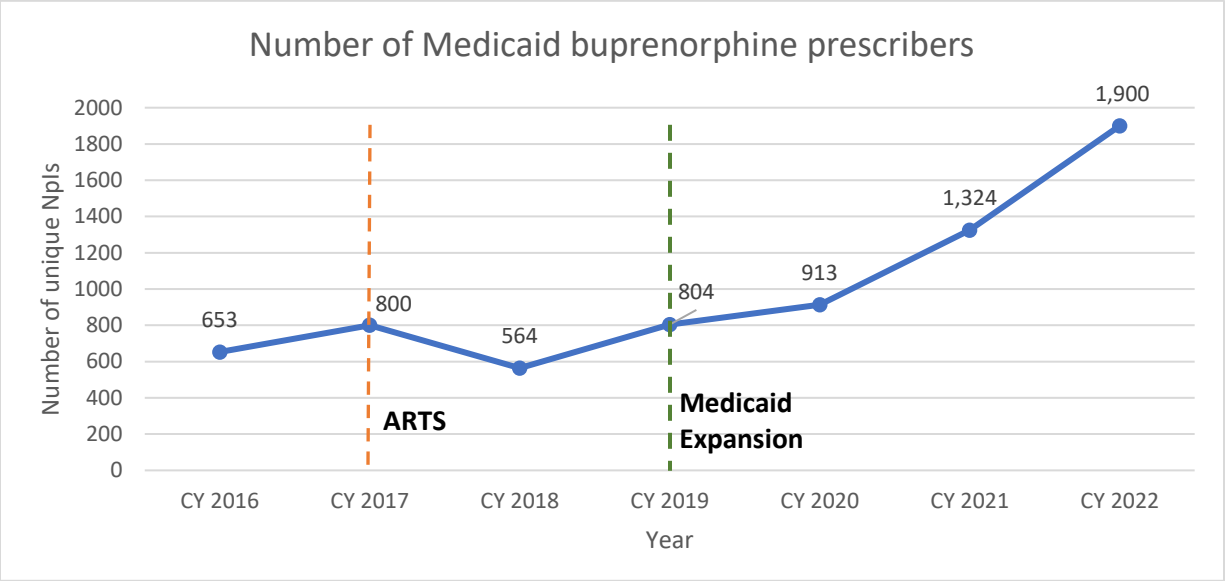
Buprenorphine prescribers. There are three Food and Drug Administration (FDA) approved medications for treatment of OUD: methadone, naltrexone and buprenorphine. Methadone for the treatment of OUD is federally limited to being dispensed in specially licensed clinics, although these restrictions were loosened during the COVID-19 pandemic to allow take-home dosages of up to a 28-day supply. Because buprenorphine treatment for OUD does not require that medication be administered at OTPs, it allows for greater access to MOUD treatment in a wider variety of treatment settings, provider types, and specialties. Virginia Medicaid has

promoted the prioritization of patient choice in the selection of evidence-based medication for treatment of OUD. This includes a targeted effort to increase access to buprenorphine treatment through the Preferred OBATs in 2017 – an integrated care model that receives enhanced reimbursement for OUD treatment – and eliminating the need for prior authorization for buprenorphine prescribing for practitioners regardless if they are enrolled with DMAS, its contractors, or MCO networks.[2] During the COVID-19 pandemic, DMAS permitted a member's home to serve as the originating site via telemedicine for a prescription of buprenorphine, both for induction and maintenance dosing. Prior to the pandemic, buprenorphine prescriptions for inductions could only be obtained through a face-to-face meeting with authorized prescribers as required by Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Agency.

The expansion of benefits with ARTS, collaborative efforts with the Virginia Department of Health to train and encourage more providers to seek buprenorphine waivers, and the increase in Medicaid members eligible for ARTS services through Medicaid expansion has likely contributed to an increase in waivered prescribers. Prior reports based on the ARTS evaluation have shown steady increases in the total number of buprenorphine waivered prescribers (BWP) in Virginia since the implementation of the ARTS demonstration and Medicaid expansion. The figure below shows the number of unique BWP who prescribed to Medicaid patients at any time during the calendar year, based on counts of unique National Provider Identifiers (NPI) of the prescribing provider on pharmacy claims for buprenorphine treatment. Despite a decrease in Medicaid prescribers in 2018, the number of prescribers increased each year beginning in 2019 (804 prescribers), with especially large increases in 2021 (1,324 prescribers) and 2022 (1,900 prescribers) (See Figure 2). Overall, the number of BWP prescribing to Medicaid members increased 191% between 2016 and 2022, including a 108% increase between 2020 and 2022.

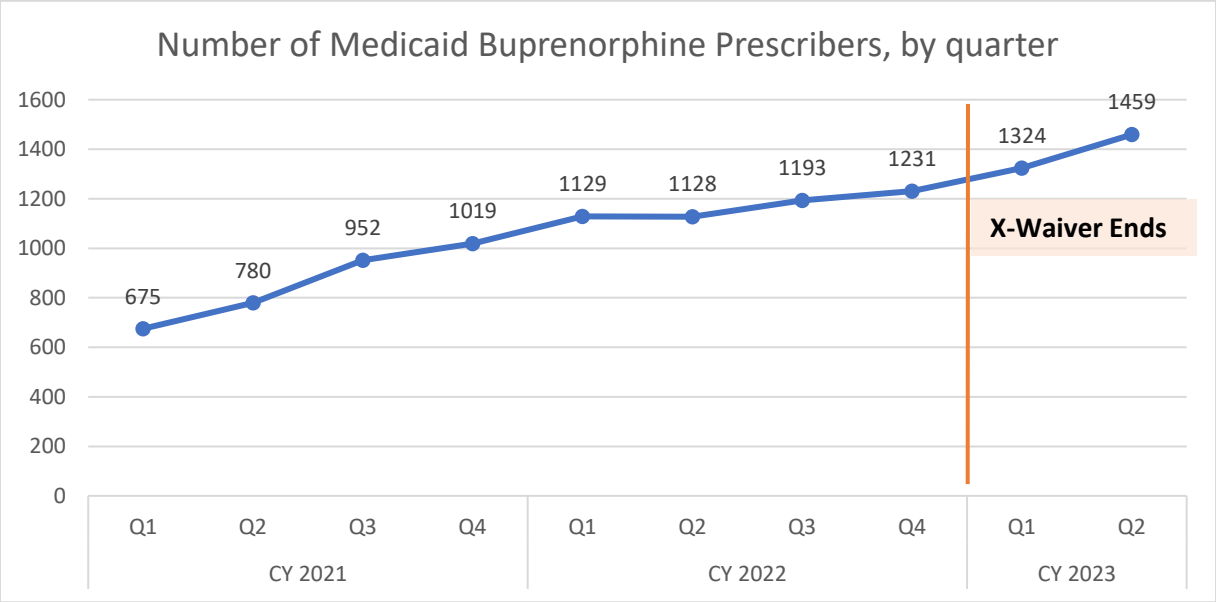
[2] First implemented in 2017 as Office-Based Opioid Treatment (OBOT) programs, they were expanded in March, 2022 to include treatment of other SUD and redesignated as Office-Based Addiction Treatment (OBAT) programs.

Figure 2: Medicaid buprenorphine prescribers



Beginning in 2023, waivers are no longer required to prescribe buprenorphine as a result of Section 1262 of the Consolidated Appropriations Act, 2023.[16] The legislation also removes other federal requirements associated with the waivers such as discipline restrictions, patient limits, and certification related to provision of counseling, although state laws regulating prescribing are still applicable. Removing federal waiver requirements has the potential to further increase the number of providers who prescribe buprenorphine to Medicaid members. The figure below shows counts of Medicaid buprenorphine prescribers on a quarterly basis from the beginning of 2021 through the second quarter of 2023. Following the removal of federal waiver requirements in 2023, the number of prescribers increased by about 200 between the last quarter of 2022 and the second quarter of 2023 (see Figure 3). As this may be part of a longer-term increase in the number of prescribers, it is too early to conclude that the removal of federal waiver requirements has increased the supply of prescribers.

Figure 3: BWP prescriber, by quarter



Changes in BWP supply in Virginia compared to other states. The evaluation also examined more systematically whether the combination of ARTS in 2017 and Medicaid expansion in 2019 increased the overall supply of BWP in Virginia, relative to other states in the U.S. South that did not expand Medicaid. The study period includes the first quarter of 2015 through the second quarter of 2020. Counts of BWP for all states and the District of Columbia were obtained from SAMHSA through a Freedom of Information Act (FOIA) request and are categorized by limits on the number of patients that waivered providers can prescribe buprenorphine to (30 or 100/275 patient limits). We obtained a de-identified comprehensive list of all waivered prescribers. The full study, including details of the data source, acquisition, and analytical methods are described elsewhere.[17]

A quasi-experimental design was employed that compares changes in BWP in Virginia to states that were similar to Virginia at baseline that did not implement Medicaid expansion or new SUD benefits similar to ARTS during the study period, such as a SUD Demonstration waiver. Therefore, comparison states consist of other non-expansion states in the U.S. South, including Alabama, Florida, Georgia, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, and Texas. We focus on states in the South due to historic similarity in Medicaid policies.

The main outcome of interest is the quarterly BWP rate per 100,000 residents for each waiver limit (overall 30 and 100/275 patients) calculated for each state. We combine counts of providers with waiver limits of 100 and 275, as it is not possible to distinguish these two groups based in the data.

In our main analysis, we fit a linear difference-in-difference (DD) model regressing quarterly BWP rates on state and intervention periods (Pre-interventions; Post-ARTS, Pre-Expansion; Post-ARTS and Expansion) fixed effects. To estimate the ARTS and Medicaid expansion intervention effects, we include an indicator variable for Virginia, the treatment state and interactions between Virginia and the Post-ARTS, Pre-Expansion and Post-ARTS and Expansion intervention periods. Due to the skewness in the distribution of BWP rates, all outcomes are log-transformed (see DD equation 1 below).

$$log(BWP/100{,}000\ residents) = \beta_0 + \beta_1(Virginia*Post\text{-}ARTS,\ Pre\text{-}Expansion) + \beta_2(Virginia*Post\text{-}ARTS\ and\ Expansion) + \beta_3 Virginia + \beta_4(Post\text{-}ARTS,\ Pre\text{-}Expansion) + \beta_5(Post\text{-}ARTS\ and\ Expansion) + \beta_6(Southern\ Non\text{-}expansion\ State) + \beta_7(Year) + \varepsilon$$

A Chi-square (χ^2) test is used to test the difference between the *Virginia*Post-ARTS, Pre-Expansion* and *Virginia*Post-ARTS and Expansion* intervention effects to assess the additional changes in BWP supply in Virginia occurring after Medicaid expansion compared to the period after ARTS implementation but prior to expansion. Pre-ARTS implementation trends in BWP supply between Virginia and comparator states appear similar (i.e., parallel), an assumption required for DD models to have statistical conclusion validity (see Supplementary Materials). Separate models are estimated for the overall BWP rate and for each BWP waiver limit. Standard errors are clustered by state.

Descriptive results are shown in Table 2. Rates of BWP per 100,000 people are generally similar in the Pre-ARTS policy period between Virginia and other states (5.95 BWP per 100,000 persons in Virginia compared to 6.36 in other southern non-expansion states). After ARTS implementation and Medicaid expansion, Virginia had a higher rate of increase in BWP providers (148%) compared to other southern non-expansion states (115%). The higher rate of increase in Virginia is similar for BWP at 30 patient limits and those with 100 or 275 patient limits.

Table 3 presents the adjusted estimates from our main regression model. In the overall model, no significant change in BWP rates in Virginia are observed after ARTS implementation or Medicaid expansion relative to the pre-interventions periods. Further, no intervention effects are significant in the 30 waiver limit model. However, in the 100/275 waiver limit model, results suggest that both ARTS and Medicaid expansion in Virginia are associated with increases in BWP supply and that the Post-Medicaid expansion increase is significantly larger than the increase in BWP occurring in the period after ARTS but before expansion. Specifically, the rate of 100/275 limit BWP provider increased by 7% in Virginia after ARTS, compared to the Pre-interventions period, and by 22% after expansion and ARTS compared to the Pre-interventions period ($p<0.05$ each). Post hoc tests indicate that the supply increase after Medicaid expansion in

Virginia (0.20) is significantly different than the increase after ARTS-implementation but before expansion (0.07; χ^2=5.63, p<0.05).

In sum, most states observed increases in BWP supply between 2015 and 2020, but the evidence suggests that Virginia's increase was greater than for comparable Southern states that did not implement Medicaid expansions or major SUD benefit increases, especially for BWP with higher waiver limits. It is not possible to fully differentiate between the effects of Medicaid expansion and the ARTS benefit, although it is reasonable to assume that providers are incentivized by both expansions in SUD benefits, as well as expansions in eligibility for these benefits. The end of federal waiver requirements for buprenorphine prescribing in 2023 may further increase the number of prescribers across all states, but coverage of buprenorphine and other SUD treatment services in Medicaid will still likely influence prescribing decisions by providers.

Table 2. Summary statistics of Buprenorphine waiver provider rate(per 100000) in VA and other southern non-expansion states overbefore ARTS implementation, after ARTS but before Medicaid expansion, and after Medicaid expansion for different patient limits.

Waiver limit	States	Pre-ARTS period (Q1,2015-Q1,2017)	Post-ARTS, Pre-Expansion period (Q2,2017-Q4,2018)	Post ARTS & Expansion Period (Q1,2019-Q2,2020)	Percentage change (Q1,2015-Q2,2020)
		Mean (SD)	Mean (SD)	Mean (SD)	
Total	**Virginia**	5.95 (.59)	9.48 (1.26)	14.76 (2.18)	148.07%
	Southern non-expansion states	6.36(1.83)	9.12 (2.31)	13.67 (3.84)	114.98%
Limit 30	**Virginia**	3.87 (.34)	6.52 (.98)	10.38 (1.43)	168.22%
	Southern non-expansion states	3.73 (.97)	5.55 (1.48)	8.95 (2.97)	139.95%
Limit 100/275	**Virginia**	2.08 (.26)	2.96 (.30)	4.38 (.75)	110.58%
	Southern non-expansion states	2.63 (1.06)	3.56 (1.45)	4.72 (1.68)	79.47%

Table 3. Changes in Buprenorphine Waivered Provider Supply after ARTS and Medicaid Expansion.

	Total waiver limit			**Waiver limit 30**			**Waiver limit 100 and 275**		
	Estimate	SE	P-Value	Estimate	SE	P-Value	Estimate	SE	P-Value
Virginia	-0.20	0.04	**<0.01**	0.04	0.06	0.50	-0.55	0.02	**<0.01**
Pre-ARTS implementation	Ref	--	--	Ref	--	--	Ref	--	--
Post-ARTS, Pre-Expansion	0.48	0.06	**<0.01**	0.52	0.09	**<0.01**	0.39	0.03	**<0.01**
Post-ARTS & Expansion	0.91	0.12	**<0.01**	1.01	0.14	**<0.01**	0.74	0.08	**<0.01**
Virginia*Post-ARTS, Pre- Expansion	0.10 (+11%)	0.06	0.09	0.12 (+13%)	0.09	0.17	**0.07 (+7%)**	**0.03**	**0.03**
Virginia*Post-ARTS & Expansion	0.16 (+17%)	0.12	0.16	0.14 (+15%)	0.14	0.31	**0.20 (+22%)**	**0.08**	**0.01**
Difference in Post- ARTS, Pre-Expansion and Post-ARTS & Expansion treatment effects	*0.06(+6%)*			*0.02(+2%)*			***0.13(+14%)***		
Chi-sq (1 df)	*1.20*			*0.13*			***5.63***		
p-value	*0.27*			*0.72*			***0.02***		
Southern Non-expansion States									
Florida	0.04	<0.01	**<0.01**	0.26	<0.01	**<0.01**	-0.28	<0.01	**<0.01**
Georgia	-0.26	<0.01	**<0.01**	-0.02	<0.01	**<0.01**	-0.63	<0.01	**<0.01**
Mississippi	-0.30	<0.01	**<0.01**	-0.33	<0.01	**<0.01**	-0.26	<0.01	**<0.01**
North Carolina	-0.03	<0.01	**<0.01**	0.17	<0.01	**<0.01**	-0.33	<0.01	**<0.01**
Oklahoma	-0.30	<0.01	**<0.01**	-0.03	<0.01	**<0.01**	-0.74	<0.01	**<0.01**
South Carolina	-0.14	<0.01	**<0.01**	0.04	<0.01	**<0.01**	-0.41	<0.01	**<0.01**
Tennessee	0.15	<0.01	**<0.01**	0.06	<0.01	**<0.01**	0.24	<0.01	**<0.01**
Texas	-0.67	<0.01	**<0.01**	-0.41	<0.01	**<0.01**	-1.09	<0.01	**<0.01**
Year									
2015	-0.13	0.01	**<0.01**	-0.11	0.02	**<0.01**	-0.17	0.02	**<0.01**
2016	Ref	--	--	Ref	--	--	Ref	--	--
2017	-0.23	0.03	**<0.01**	-0.29	0.05	**<0.01**	-0.13	0.01	**<0.01**
2019	-0.20	0.02	**<0.01**	-0.21	0.01	**<0.01**	-0.20	0.03	**<0.01**
Intercept	**1.98**	**0.04**	**<0.01**	**1.35**	**0.05**	**<0.01**	**1.34**	**0.02**	**<0.01**

Note: All effects are on log scale. Percentage changes obtained by using antilogarithm are in parenthesis. standard errors are clustered by state. Some effects could not be predicted due to collinearity. All the bold p-values are significant at 5% level. df=degrees of freedom.

Supply of specialty treatment providers. A broad range of addiction treatment facilities and practitioners are available to Medicaid members along the continuum of care, as defined by the ASAM placement criteria.[18] These include hospital-based intensive inpatient facilities, residential treatment centers, and outpatient providers of varying types and treatment intensity. The ARTS benefit also introduced a new model of care delivery, the Preferred OBAT, that pays significantly higher reimbursement rates to qualified providers for medication-assisted treatment (including pharmacotherapy and behavioral health therapy) and coordination with other medical and social needs. The Preferred OBAT model initially was limited to individuals with primary OUD. However, DMAS expanded this benefit in 2022 to allow for reimbursement of other primary SUD.

Prior to ARTS implementation in 2017, there were few SUD treatment providers, other than ASAM level 1 outpatient providers and some services were not covered as a Medicaid benefit (OBAT, care coordination, ASAM 4). Since implementation of ARTS in 2017, the number of providers treating Medicaid patients has increased greatly across all provider types, and for most years through 2022. Residential/Inpatient treatment facilities (ASAM 3) treating Medicaid members increased from 4 in 2016 to 75 by 2022 (see Table 4). ASAM 2 facilities increased from 49 in 2016 to 270 by 2022. By 2022, there were over 6,088 outpatient providers treating Medicaid members for ASAM 1 level services, as well as 202 OBAT and OTP facilities.

Table 4: Number of providers treating Medicaid members for SUD.

	Calendar Year						
	2016	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
Type of Service							
ASAM 1	1,087	2,574	3,339	4,526	5,058	5,703	6,088
OBAT/OTP[1]	6	52	94	175	245	225	202
Care Coordination	N/A	24	49	90	166	160	142
ASAM 2	49	89	139	233	231	254	270
ASAM 3	4	15	22	37	52	72	75
ASAM 4	N/A	3	2	15	15	13	8

[1]Includes only OTP providers in 2016.

Increases in treatment facilities accepting Medicaid patients compared to other states. The evaluation also examined more systematically the impact of ARTS and Medicaid expansion on: (1) changes in the percent of SUD treatment facilities in Virginia accepting Medicaid payment, relative to a group of comparison states; and (2) changes in the total number of SUD treatment facilities per 100,000 persons in Virginia, relative to a group of comparison states. The full analysis is described elsewhere and is summarized below for the purposes of this report.[19]

The analysis is based on data from the 2013-2019 National Survey of Substance Abuse Treatment Services (N-SSATS), which is an annual census of substance use treatment facilities conducted by the Substance Abuse and Mental Health Service Administration's (SAMHSA). The survey includes all public and private treatment facilities in SAMHSA's Inventory of Behavioral Health Services and facilities newly identified during the first three to five months of the field period. More detail about the survey and data collection methods is described elsewhere.[20]

The control group consisted of 13 non-expansion states that had not implemented an 1115 SUD waiver by 2019, including nine Southern states (Alabama, Florida, Georgia, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, and Texas), two Midwestern states (Missouri and South Dakota), and two Western states (Idaho and Wyoming). Difference-in-differences regression was used to estimate the treatment effect of the ARTS benefit (implemented in 2017) and Medicaid expansion (implemented in 2019) on the probability of facility acceptance of Medicaid relative to states without similar changes in SUD benefits or Medicaid expansion. Treatment effects were estimated using a linear probability model of the form:

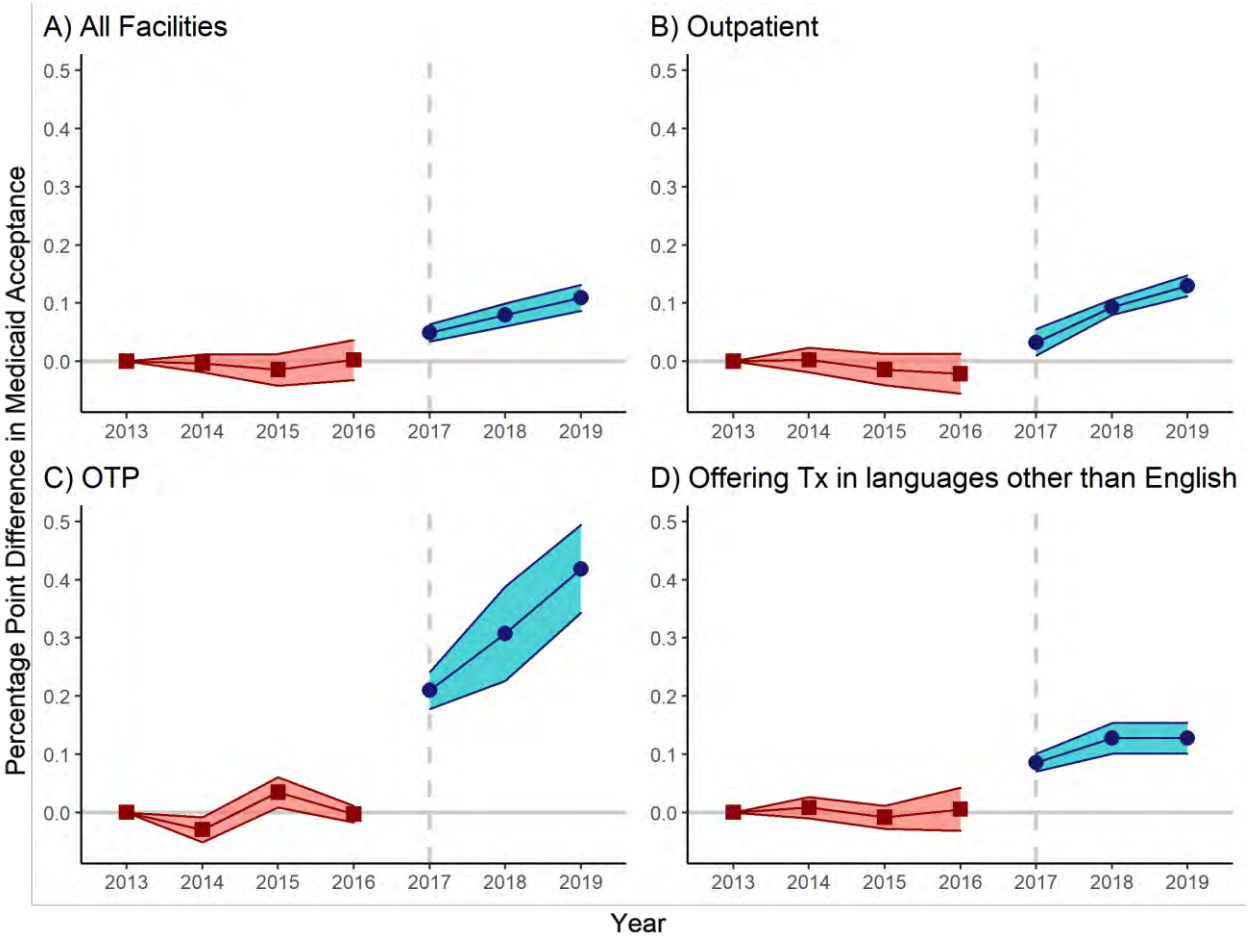
$$y_{st} = \beta_0 + \beta_1 VA * year_{17} + \beta_2 VA * year_{18} + \beta_3 VA * year_{19} + \beta_4 VA + \alpha_t + \delta_s + \boldsymbol{X}_{st}\gamma + \boldsymbol{Z}_{ist}\lambda + \varepsilon_s$$

The intercept β_0 represents the mean outcome among control states without SUD benefit expansions in the baseline year. The parameters β_1 through β_3 represent the parameters of interest as separate treatment effects by interacting the Virginia indicator with year dummy variables for each post-treatment year, 2017–2019. Fixed effects for year and state were included to account for secular trends and time-invariant state differences, respectively represented by α and δ. The parameter γ represents a vector of pre-treatment, state-level characteristics, and λ represents a vector of facility-level characteristics, including ownership status (private, for-profit, private non-profit, or government-owned); other forms of payment accepted, including private insurance, other non-Medicaid forms of public insurance (e.g., Medicare, Tricare, or other state-financed health insurance), self-pay, and charity care; and SUD treatment services offered, including outpatient, residential, hospital inpatient, or MOUD. Annual state-level factors associated with the SUD provider supply and demand for SUD services were included from the ACS and CDC WONDER, including sex, age, race/ethnicity, level of urbanization, educational

attainment, percentage of the state population below the poverty level, unemployment rate, and age-adjusted overdose death rate in the baseline year.

At baseline (years 2013-2016), there were a total of 897 SUD treatment facilities in Virginia, and 12,689 in the comparison states (findings not shown). Sixty percent of SUD treatment facilities in Virginia accepted Medicaid payment in the 2013-2016 period, compared to 58% of treatment facilities in the comparison states. Based on the difference-in-differences analysis described above, year-by-year percentage point differences in Medicaid acceptance between Virginia and the comparison states are shown in Figure 4 for all facilities as well as by facility type. These results show little difference in Medicaid acceptance rates between Virginia and other states prior to the implementation of ARTS in 2017. Following ARTS implementation, however, Medicaid acceptance rates increase in Virginia relative to the other states, with the gap generally widening each year. Changes in Medicaid acceptance rates following ARTS implementation were statistically significant.

Figure 4. Changes in SUD treatment facilities in Virginia accepting Medicaid patients, relative to other states.



Additional analysis examined changes in the total number of SUD treatment facilities per 100,000 people in the state after ARTS implementation, relative to the comparison states. However, the results showed that the number of treatment facilities in Virginia did not increase following ARTS implementation in 2017 relative to the comparison states.

Utilization of ARTS services. Coverage of SUD services provided by the ARTS benefit is based on the ASAM National Practice Guidelines, which comprise a continuum of care from Early Intervention/Screening, Brief Intervention, and Referral to Treatment (SBIRT / Level 0.5), outpatient treatment (ASAM 1), intensive outpatient treatment and partial hospitalization (ASAM 2), residential/inpatient treatment services (ASAM 3) and medically managed intensive inpatient services (ASAM 4).[21] ARTS also emphasizes evidence-based treatment for OUD, which combines pharmacotherapy and counseling. In July 2017, DMAS added peer recovery support services as a covered service under the ARTS benefit, which serves to facilitate recovery from SUD. Care coordination services provided by Preferred OBAT and OTPs facilitate integration of addiction treatment services with physical health and social service needs.

Utilization of ARTS services across the continuum of care has increased every year since implementation of the benefit. In 2022, 60,846 members used ARTS services, a sixfold increase since the benefit was implemented in 2017 (See Figure 5 and Table 5). In particular, the number of members using ARTS services more than doubled in the first year of Medicaid expansion, from 15,780 members in 2018 to 37,577 members in 2019.

Figure 5. Total number of Medicaid members using any ARTS services by year

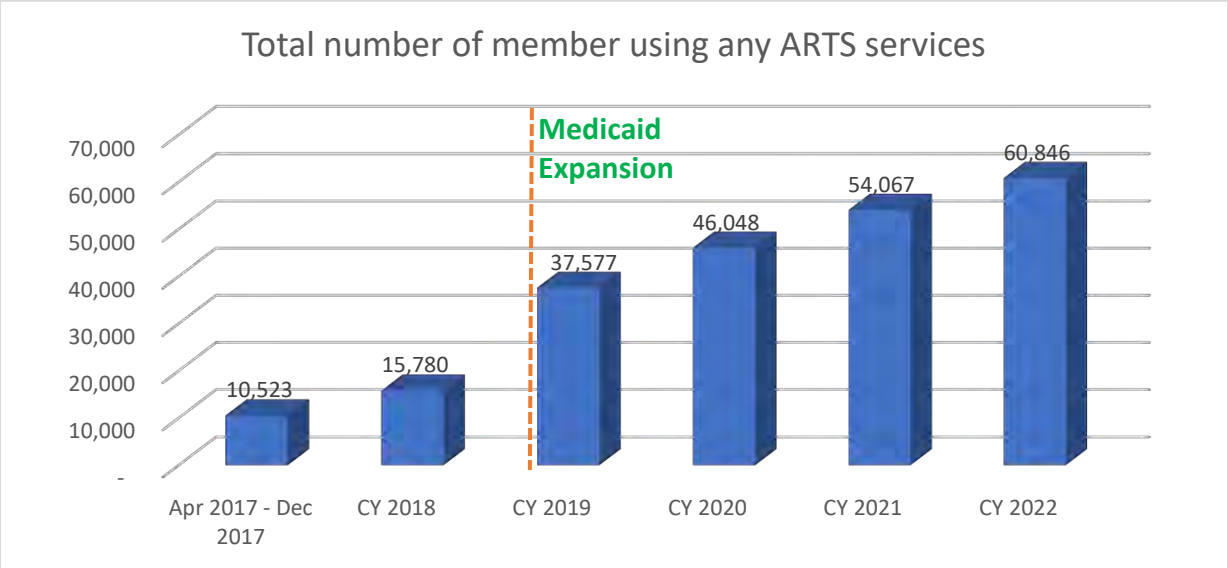


Table 5. Number of Medicaid members using ARTS services, by type of service and year.

	Post – ARTS (Calendar Year)						
	Apr 2017-Dec 2017	**2018**	**2019**	**2020**	**2021**	**2022**	**% change 2018-2022**
Used any ARTS service	10,523	15,780	37,577	46,048	54,067	60,846	74.1%
Type of Service							
ASAM 1	8,991	13,215	31,273	39,129	46,300	51,901	74.5%
OBAT/OTP	1,805	4,012	11,447	15,007	17,014	17,941	77.6%
Care Coordination[1]	795	2,515	7,921	11,085	13,436	14,807	83.0%
ASAM 2	584	1,285	4,018	4,825	5,964	7,507	82.9%
ASAM 3	556	1,261	3,876	4,377	5,686	7,028	82.1%
ASAM 4	6	5	47	100	152	78	93.6%
Pharmacotherapy	8,382	12,516	24,300	30,959	37,608	43,234	71.1%
Case Management	641	930	2,842	3,975	4,241	4,445	79.1%
Peer Recovery Support Services	33	275	886	1,247	1,652	1,768	84.4%

[1]Refers to care coordination services through OBAT/OTP providers.

In terms of members using services per 100,000 members, utilization of ARTS services increased from 1,282 per 100,000 members using services in 2018 to 2,911 in 2022, a 125% increase (See Figure 6 and Table 6). ASAM 2 and ASAM 3 services – which few members used before or just after ARTS implementation in 2017 – increased over 200% during the same period while ASAM 1 level services – still the most frequently used service – increased by 131%.

Figure 6. Number of Medicaid members using any ARTS services, per 100,000 total members.

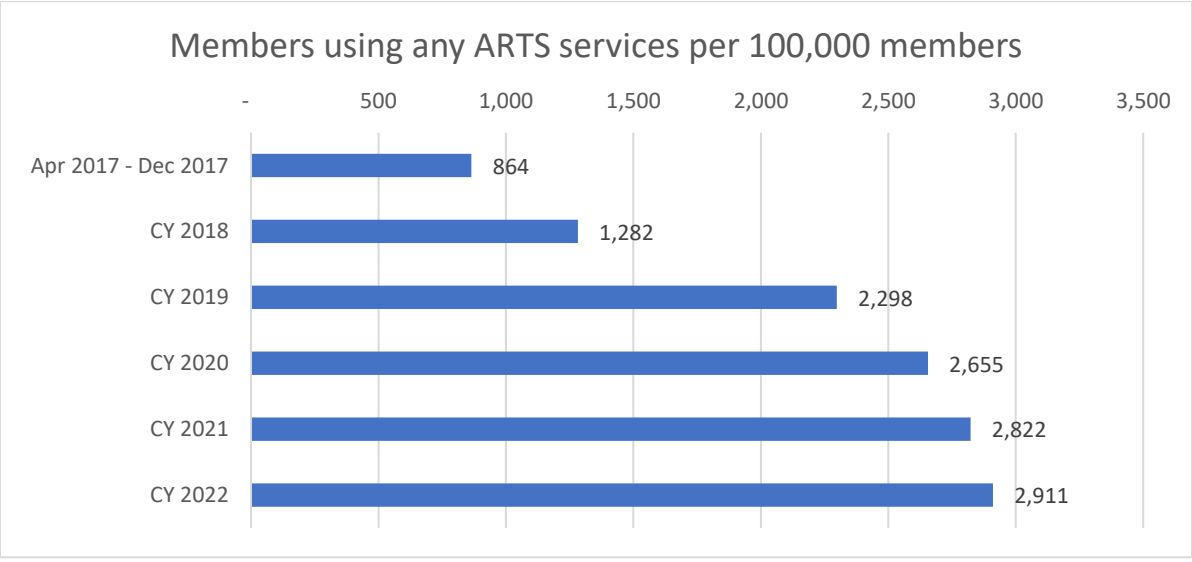


Table 6. Number of ARTS services user per 100,000 Medicaid members, by type of service and year.

Post – ARTS (Calendar Year)							
	Apr 2017 - Dec 2017	2018	2019	2020	2021	2022	% change 2018-22
Used any ARTS service	864	1,282	2,298	2,655	2,822	2,911	127.0%
Type of Service							
ASAM 1	739	1,074	1,913	2,256	2,417	2,483	131.2%
OBAT/OTP	148	326	700	865	888	858	163.3%
Care Coordination	65	204	484	639	701	708	246.6%
ASAM 2	48	104	246	278	311	359	243.9%
ASAM 3	46	102	237	252	297	336	228.1%
ASAM 4	0.5	0.4	3	6	8	4	818.4%
Pharmacotherapy	689	1,017	1,486	1,785	1,963	2,068	103.4%
Case Management	53	76	174	229	221	213	181.4%
Peer Recovery Support Services	3	22	54	72	86	85	278.5%

Use of MOUD. MOUD includes the use of buprenorphine, methadone and naltrexone as part of evidence-based treatment for OUD. This method is considered the evidence-based standard of care for treating OUD and has been found to be the most effective treatment in preventing OUD-related overdoses. The number of members receiving MOUD treatment has increased almost four-fold since the year prior to ARTS implementation, from 14,505 members receiving treatment in 2016 to 55,481 members in 2022 (see Figure 7 and Table 7). While MOUD use has increased every year since 2016, there was an especially large increase in the first year of Medicaid expansion, from 22,661 members receiving MOUD treatment in 2018 to 37,233 members in 2019.

MOUD treatment rates – the percentage of those with OUD who received MOUD treatment – have also increased every year, from 43% in 2016 to 78% by 2022 (see Figure 8 and Figure 8). Buprenorphine has consistently been the most frequently used MOUD treatment throughout the study period, from 34% of members with OUD in 2016 to 47% in 2022. However, the largest increases in treatment rates were for methadone and naltrexone. While less than 5% of members with MOUD received methadone and naltrexone treatment in 2016, this increased to 25.5% for methadone and 11.2% for naltrexone by 2022.

Figure 7. Number of Medicaid members with any MOUD use, by year

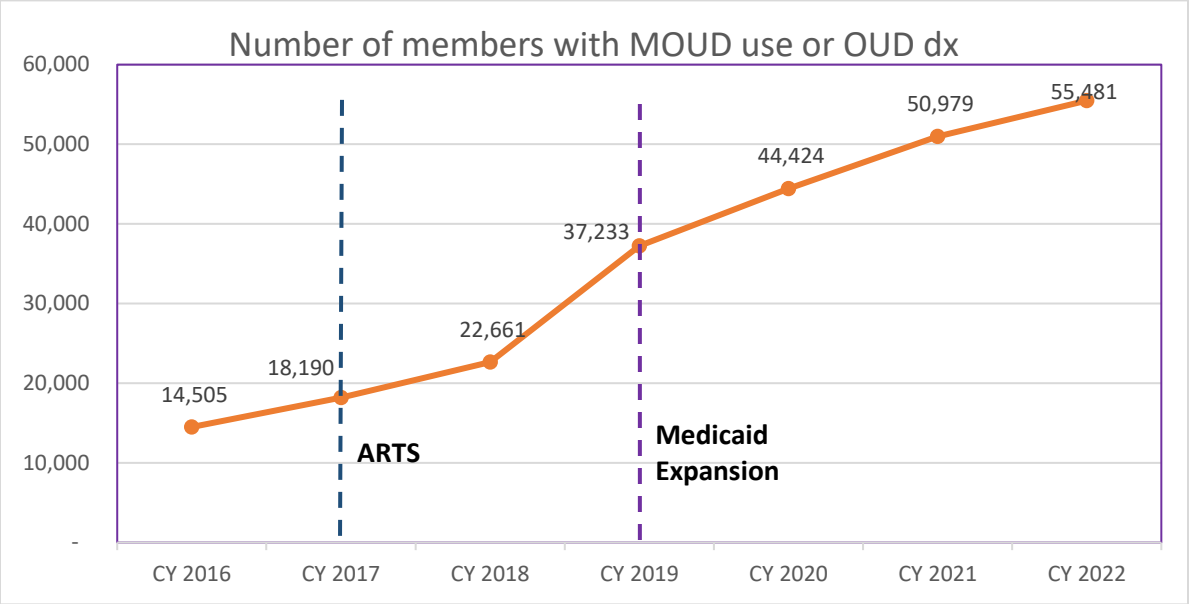


Table 7. Number of Medicaid members with MOUD utilization, by calendar year

	Calendar Year						
	2016	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
Members with MOUD use or OUD dx	14,505	18,190	22,661	37,233	44,424	50,979	55,481
Type of MOUD use							
Any MOUD	6,244	9,070	12,516	24,300	30,959	37,608	43,234
Buprenorphine	4,968	6,093	7,240	13,281	17,175	21,702	26,025
Methadone	709	2,402	4,719	9,878	12,506	13,740	14,175
Naltrexone	645	932	1,472	3,173	4,037	5,191	6,206

Figure 8. MOUD treatment rates (percent of those with OUD who used any MOUD, by year.

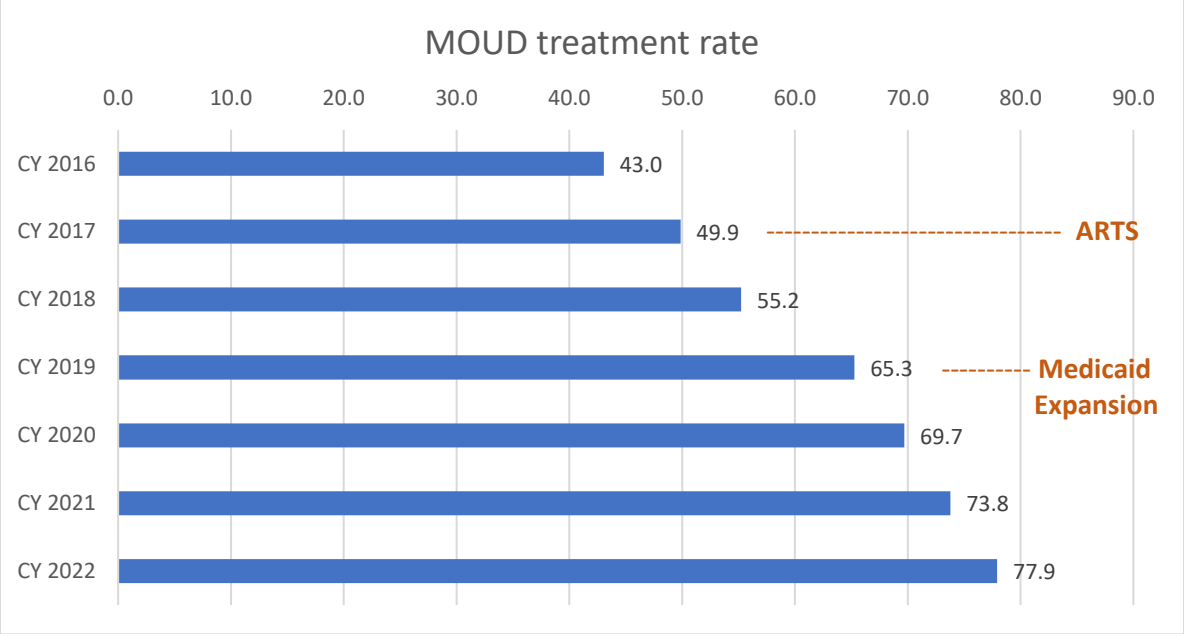


Table 8: MOUD treatment rate, by type of MOUD and calendar year.

	Calendar Year						
MOUD treatment rate**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
Any MOUD	43.0	49.9	55.2	65.3	69.7	73.8	77.9
Buprenorphine	34.3	33.5	31.9	35.7	38.7	42.6	46.9
Methadone	4.9	13.2	20.8	26.5	28.2	27.0	25.5
Naltrexone	4.4	5.1	6.5	8.5	9.1	10.2	11.2

**Number of members with the specified MOUD use/ Number of members with MOUD use or OUD dx

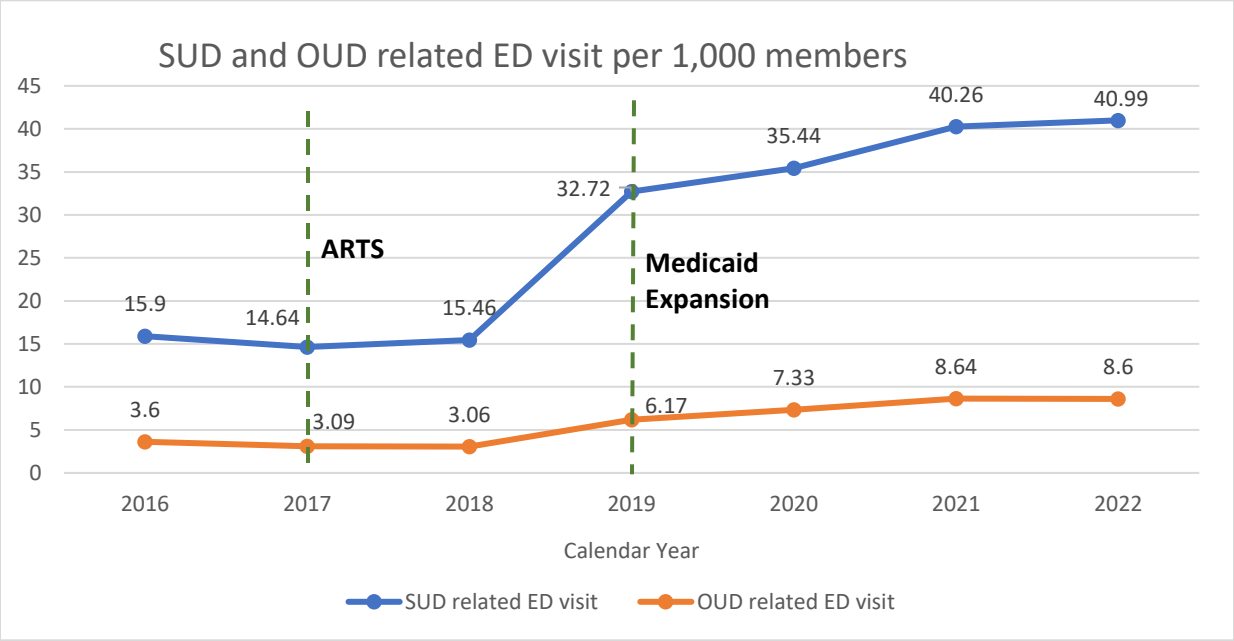
Emergency department (ED) visits. SUD and OUD-related ED visits declined initially in the year after ARTS implementation, but then increased greatly following the implementation of Medicaid expansion in 2019. ED visits with any SUD diagnosis decreased from 15.9 visits per 1,000 members in 2016 to 14.6 visits in 2017, and 15.5 visits in 2018 (see Figure 9). ED visits with any OUD diagnosed decreased from 3.6 visits per 1,000 members in 2016 to 3.1 visits in 2017 and 2018. Other evaluation research confirmed that ED visits among members with OUD decreased between 2016 and 2018, relative to members who did not have SUD or OUD diagnoses.[22]

SUD and OUD-related visits per 1,000 members doubled between 2018 and 2019, the first year of Medicaid expansion. SUD-related ED visits increased from 15.5 visits per 1,000 members in 2018 to 32.7 visits per 1,000 members in 2019, reaching almost 41 visits by 2022.

OUD-related ED visits increased from 3.1 visits per 1,000 members in 2018 to 6.2 visits per 1,000 members in 2019, reaching 8.6 visits by 2021 and 2022.

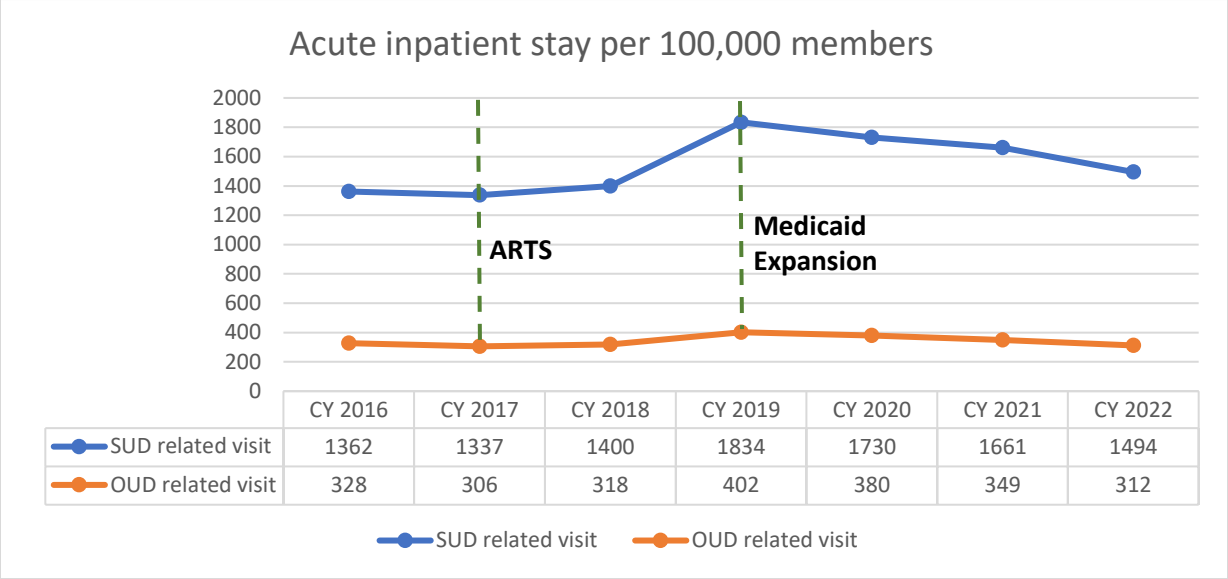
The large increase in SUD and OUD-related ED visits since 2018 likely reflects the increase in Medicaid enrollment among members who have higher prevalence of SUD and OUD. Previous reports have shown that members enrolled through expansion and other nondisabled adults have much higher prevalence of SUD and OUD diagnoses compared to members enrolled through other eligibility categories.[23] In other words, the characteristics of Medicaid members changed after expansion in ways that increased prevalence of SUD and OUD, which also increased ED utilization for these diagnoses. In addition, the increase in SUD and OUD-related ED visits since 2019 likely reflects in part the overall increase in SUD prevalence in Virginia during this period, as indicated by a surge in fatal overdoses among all Virginians and nationwide. For these reasons, it is difficult to draw firm conclusions as to how ARTS has affected SUD and OUD-related ED visits since 2019.

Figure 9: SUD and OUD related ED visit per 1,000 members.



Acute inpatient admissions. SUD and OUD-related acute inpatient admissions have also fluctuated over the study period, increasing sharply at the beginning of Medicaid expansion in 2019 and decreasing after expansion. SUD-related acute inpatient stays increased from 1,400 per 100,000 members in 2018 to 1,834 in 2019, and decreasing steadily after that to 1,494 admissions per 100,000 members in 2022 (See Figure 10). A similar pattern was shown for OUD-related inpatient admissions. It is possible that the initial decrease in 2020 and 2021 reflects in part the overall decrease in hospital admissions during the early months of the pandemic – both for elective as well as acute illness admissions.[24] However, overall hospital admissions rebounded close to pre-pandemic levels by late 2020 and early 2021.

Figure 10: Acute inpatient stay per 100,000 members



Changes in behavioral health related inpatient admissions in Virginia compared to North Carolina. The evaluation also assessed the cumulative effects of ARTS and Medicaid expansion on overall changes in behavioral-health related acute inpatient admissions in Virginia, using an all-payer database that includes all inpatient admissions to acute care hospitals throughout the state. A quasi-experimental event study regression analysis was used to assess changes in both SUD-related and mental illness-related acute inpatient admissions in Virginia between 2016 and 2019, relative to changes in inpatient admissions in North Carolina, a neighboring state that did not expand Medicaid nor implement major changes in SUD benefits during the study period. The details of this analysis are described elsewhere.[25]

Data on inpatient admissions from Virginia were obtained from Virginia Health Information's (VHI) Patient Level Data, while data from North Carolina were obtained from the Agency for Healthcare Research and Quality's (AHRQ) Healthcare Cost and Utilization Project (HCUP) Central Distributor. VHI was used as the source for inpatient admissions in Virginia because such data are not available through the HCUP Central Distributor. However, VHI and North Carolina HCUP data are essentially comparable in content and structure, especially as it relates to this study. Analysis for this study was restricted to adults between 18 and 64 years old admitted to general, acute, short-term hospitals with any diagnosis of behavioral health disorders (primary or secondary), including both SUD-related and mental-illness related. SUD and mental illness-related admissions are examined together and separately since the two conditions often co-occur. Also, a major objective of ARTS is to coordinate SUD treatment with other mental and physical health problems.

The analysis aggregates behavioral health-related inpatient admissions by county (and independent cities in VA) and quarter, so that the unit of analysis is the county/quarter. For Virginia, this results in a total of 2,128 observations—133 (95 counties and 38 independent

cities) by 16 quarters- (January 2016 through December 2019). For North Carolina, there are 1600 observations—100 counties by 16 quarters.

The analysis uses Poisson fixed-effect event study regression to examine the number of behavioral health-related inpatient admissions in the quarters before and after ARTS and Medicaid expansion in Virginia, and comparing these trends to the same quarters in North Carolina. This analysis expands the difference-in-difference analyses by creating a separate parameter for each quarter of interest. To control for time-invariant characteristics of counties and independent cities, we include county-level fixed effects in all multivariate analyses. We also include time dummies and a quarter-specific measure of the uninsured percentage under 65 years old as a time varying measure (obtained from the United States Census Bureau's Small Area Health Insurance Estimates (SAHIE) Program. The formal model is specified as:

$$\text{Inpatient admission}_{it} = b_0 + Y_t + b_j (\text{state}_t * Y_t) + x_{it} + \alpha_i + u_{it}$$

Where Y_t represents a full set of quarterly dummy variables (1 quarter is a reference + 15 dummy variables). $\text{State}_t * Y_t$ represents the set of interactions between a dummy variable for VA and the quarterly dummies starting with the first quarter of 2016 to the fourth quarter of 2019 with indication of second quarter of 2017 as a reference when ARTS came into effect. x_{it} is the percentage of uninsured. α_i is the county fixed effect. u_{it} notates the error term.

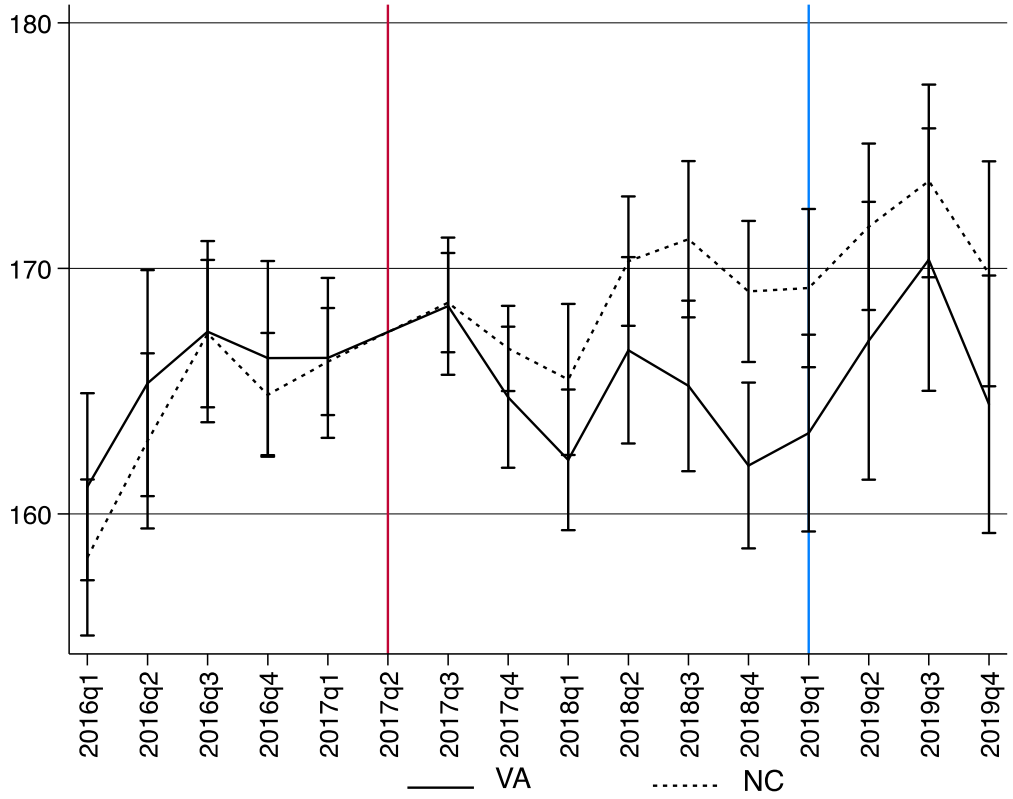
Table 9 shows descriptive changes in average quarterly inpatient admissions per county in Virginia and North Carolina, divided into the Pre-ARTS period (January 2016 to March, 2017), the period between ARTS and Medicaid expansion (April 2017 to December 2018) and Post-Medicaid expansion (2019). In Virginia, there was little change in behavioral health-related admissions, from an average of 334 admissions in the Pre-ARTS period to an average of 337 admissions in the Post-Medicaid expansion period. While there was little change for mental-illness related admissions, SUD inpatient admissions increased slightly during the three time periods. By contrast, behavioral health-related admissions increased in North Carolina, from an average of 666 admissions in the Pre-ARTS period to an average of 700 admissions in the Post-Medicaid expansion period (a 5% increase). There were increases in both mental illness-related and SUD-related inpatient admissions in North Carolina.

Table 9. Mean Number of County-Quarter Inpatient admissions Before ARTS, Between ARTS and Medicaid Expansion and After Medicaid Expansion

Virginia	**Pre-ARTS (5 quarters)**	**Between ARTS and Medicaid expansion (7 quarters)**	**Post-Medicaid expansion (4 quarters)**
Total admissions (average for counties)	797	788	780
All behavioral health-related inpatient admissions (%)	334 (41.9)	335 (42.5)	337 (43.2)
Mental illness inpatient admissions (%)	293 (36.8)	293 (37.2)	295 (37.8)
SUD inpatient admissions (%)	117 (14.7)	119 (15.1)	123 (15.8)
North Carolina	**Pre-ARTS (5 quarters) in VA**	**Between ARTS and Medicaid expansion (7 quarters) in VA**	**Post-Medicaid expansion (4 quarters) in VA**
Total admissions (average for counties)	1326	1320	1318
All behavioral health-related inpatient admissions (%)	666 (49.1)	685 (51.9)	700 (53.1)
Mental illness inpatient admissions (%)	582 (43.9)	599 (45.4)	613 (46.5)
SUD inpatient admissions (%)	234 (17.7)	241 (18.3)	249 (18.9)

The results of the event-study regression for all behavioral health-related admissions are depicted in Figure 11. While admissions in Virginia and North Carolina were essentially equivalent in the Pre-ARTS period (that is, before Q2-2017), admissions decreased in Virginia after ARTS implementation and before Medicaid expansion, while admissions increased in North Carolina. Following Medicaid expansion in 2019, however, behavioral health-related admissions increased in both states.

Figure 11. Changes in behavioral health-related inpatient admissions in VA and NC



The decrease in admissions in Virginia relative to North Carolina is most apparent for mental-illness-related admissions, as shown in Figure 12, but less so for SUD-related admissions, as shown in Figure 13. Relative to the Pre-ARTS period, the change in admissions in Virginia during the Post-ARTS and Pre-Medicaid expansion period was statistically significant at the $p < .01$ level for all behavioral health-related admissions, as well as for mental illness-related admissions. However, changes in SUD-related admissions during the Post-ARTS and Pre-Medicaid expansion period (relative to Pre-ARTS) were not statistically significant. In addition, changes in admissions after Medicaid expansion (relative to the Pre-ARTS period) were not statistically significant across all three admission types.

In sum, the findings suggest that implementation of ARTS resulted in an initial decrease in behavioral health-related inpatient admissions, especially mental illness-related admissions (which may or may not have also included a SUD diagnosis). However, the period following Medicaid expansion appears to have interrupted that trend, perhaps due to pent-up demand for inpatient care among members newly enrolled in Medicaid who had pre-existing behavioral health problems, or because of the increasing prevalence of SUD that began affecting both states in 2019. It is possible that this initial increase in admissions after Medicaid expansion would have tapered off (as evidenced by the decrease in Medicaid admissions beginning in 2020, as shown in Figure 10).

Figure 12. Changes in mental illness-related inpatient admissions

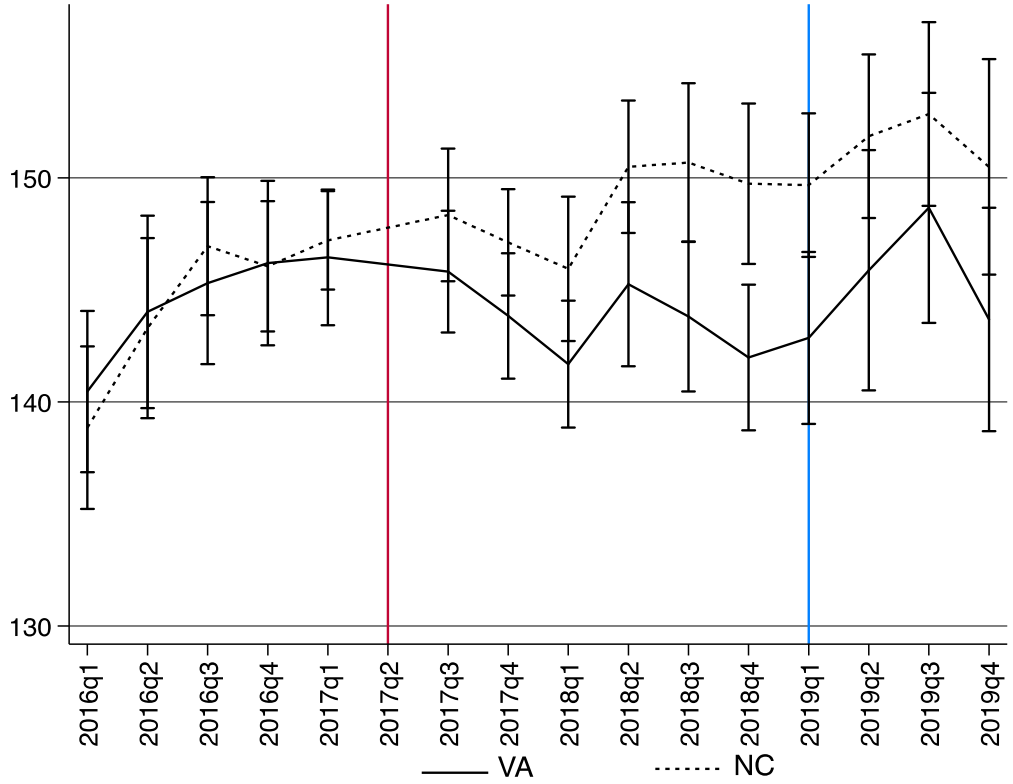
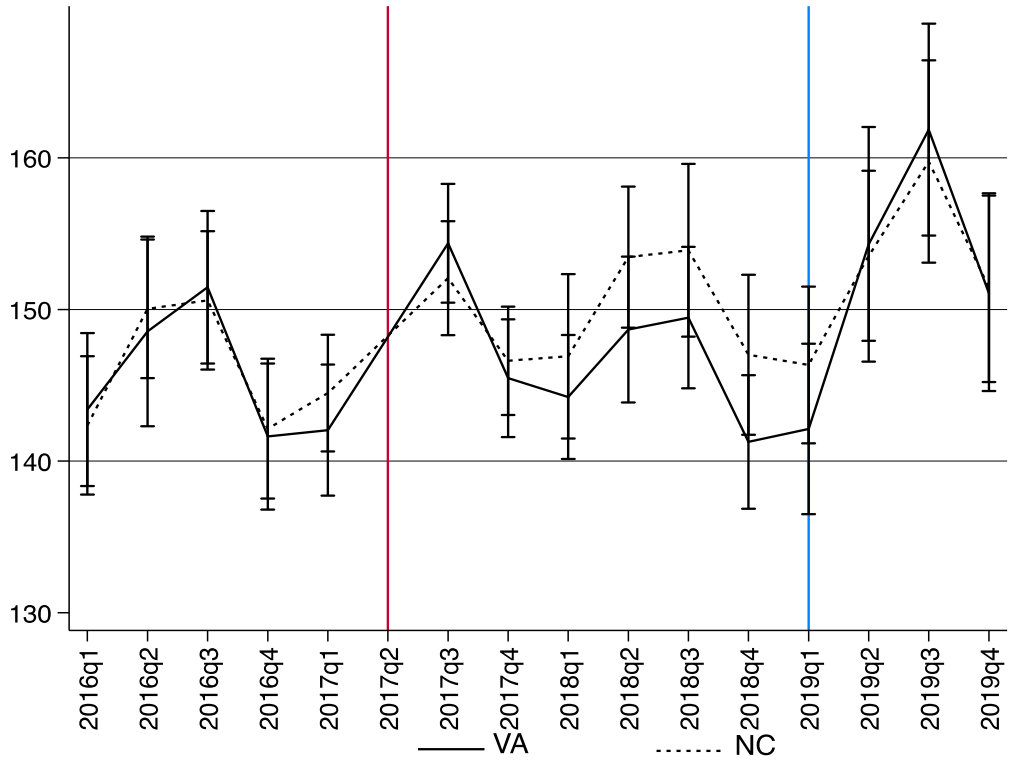


Figure 13. Changes in SUD-related inpatient admissions.

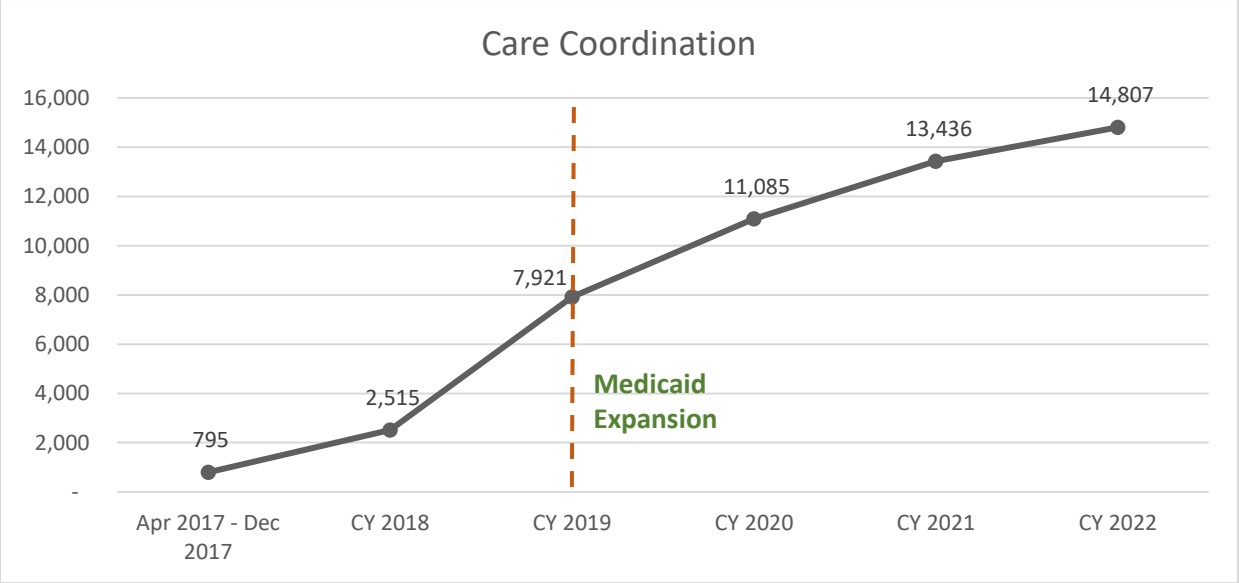


6.2 *Evaluation question #2: Does the demonstration improve quality of treatment through improved care coordination efforts?*

An important goal of the ARTS demonstration is to improve transitions across different levels of care, and coordinating addiction treatment services with other physical, mental health, and social needs. This is to be accomplished by, (1) shifting behavioral health services to a "carve-in" model so that they are provided by the same managed care organizations (MCOs) that provide other Medicaid services; (2) the use of licensed care coordinators by MCOs for addiction treatment services; and (3) enhanced payment for care coordination services by the new Preferred OBAT providers.

Use of care coordination services. Enhanced payment for care coordination services through Preferred OBAT and OTP providers is central to the objective of increasing coordination with other physical and mental health services, and improving transitions of care. Introduced with the ARTS benefit in 2017, the number of claims for care coordination services through OBATs has increased exponentially, from 795 claims in 2017 to almost 15,000 by 2022 (see Figure 14).

Figure 14: Number of claims for new care coordination services, by year



Assistance with other health and personal needs. The ARTS member survey conducted in 2020-21 asked respondents whether they had received assistance with other health and personal needs at their OUD treatment provider (though not necessarily through a care coordinator) Overall, 60% of respondents receiving OUD treatment reported receiving assistance with other non-SUD services, including 26% who received help for a medical problem, 38% who received help with a mental health problem, and 18% who received help with housing, food, or employment (see Table 10). Assistance reported by respondents decreased during the COVID-19 pandemic relative to before the pandemic, and was lower among Non-Hispanic Black respondents compared to Non-Hispanic White respondents.

Table 10. Assistance with other health and social needs.

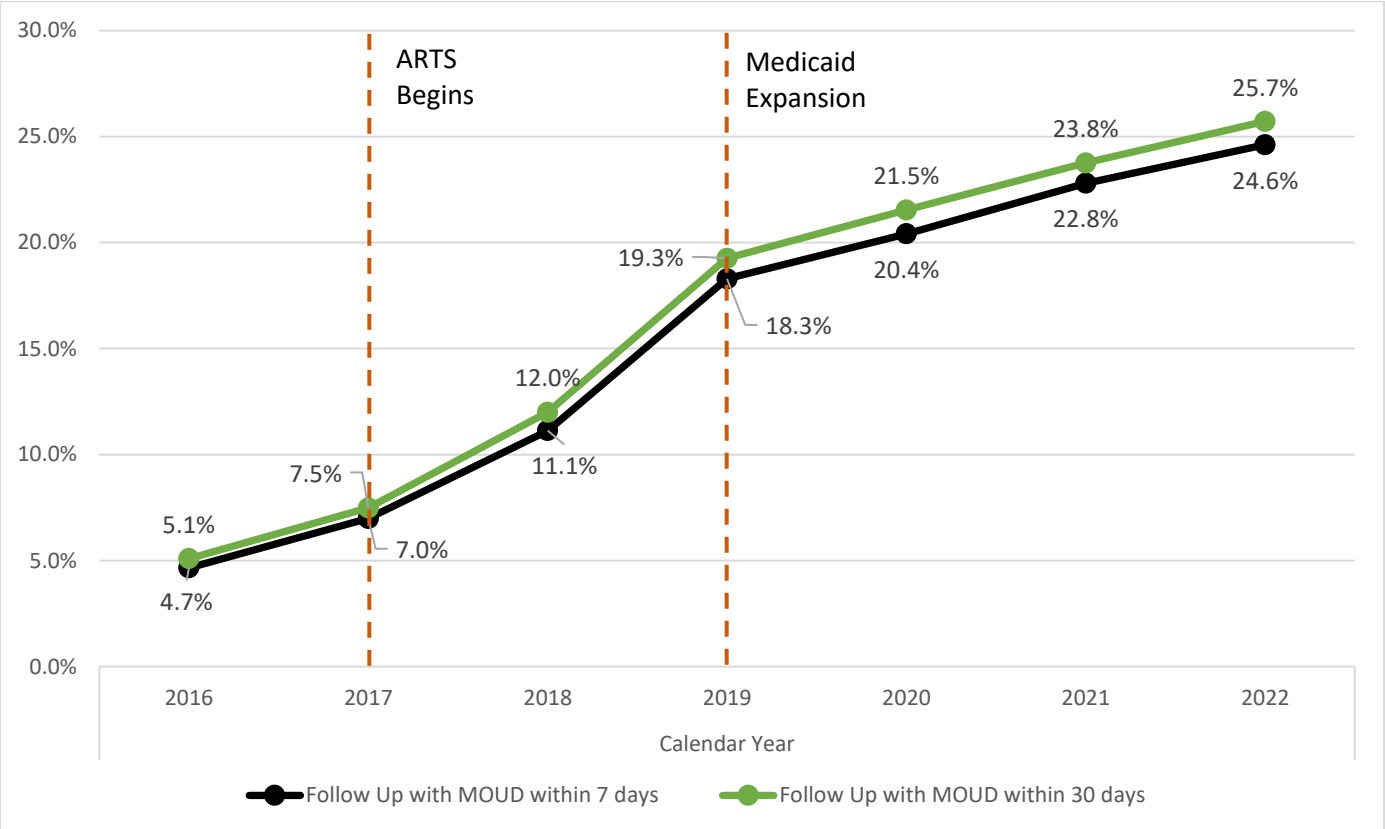
	Received help with other health and social needs			
	Received any help with other health or personal needs	Received help for a medical problem	Received help with a mental health problem	Received help with housing, food, or employment
All (n=1,057)	59.6%	25.6%	38.2%	17.9%
Adjusted percentages[2]				
OUD treatment location				
Preferred OBOT	64.3%	30.6%	42.6%	17.1%
OTP	49.1%*	16.9%*	28.5%*	14.9%
Other outpatient	69.1%	29.4%	44.7%	13.7%
Race				
Non-Hispanic White	60.8%	25.8%	38.3%	16.3%
Non-Hispanic Black	55.0%*	21.3%*	33.1%*	14.9%
Other	71.7%*	16.1%*	39.6%	26.4%*
Survey period				
Before COVID	64.7%	24.8%	39.0%	15.7%
During COVID	57.2%*	24.4%	36.5%	16.9%
RUCA Classification				
Urban	60.2%	24.1%	37.3%	19.7%
Rural	60.8%	26.0%	38.1%	9.2%*

*Statistically significant difference at .05 level with reference groups (other outpatient, Non-Hispanic White, Before COVID, urban classification).

[1]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, serious mental illness, polysubstance use, urban/rural residence, and whether they had been in prison or jail in the past 12 months.

MOUD treatment within 7 days of OUD-related ED visit. A crucial role for care coordination is to assist with care transitions from hospitals and other institutional settings. Getting patients started on MOUD while at the ED or shortly thereafter (within 7 days) is considered crucial for preventing overdoses. Many health systems have started "ED-Bridge" programs that seek to get OUD patients started on buprenorphine treatment in the emergency department and provide them with a warm handoff to treatment providers in the community for follow-up treatment and maintenance of MOUD after the ED visit.[26,27] Prior research has shown that a seven day follow-up after an OUD-related ED visit is generally low among Medicaid members, although there is considerable variation across states.[28] Nevertheless, the percent of Virginia Medicaid members receiving MOUD treatment within seven days of an OUD-related ED visit has increased from less than 5% prior to the ARTS demonstration in 2016, to 18% by 2019, and almost 25% by 2022 (see Figure 15). MOUD treatment with 30 days of an ED visit showed similar trends.

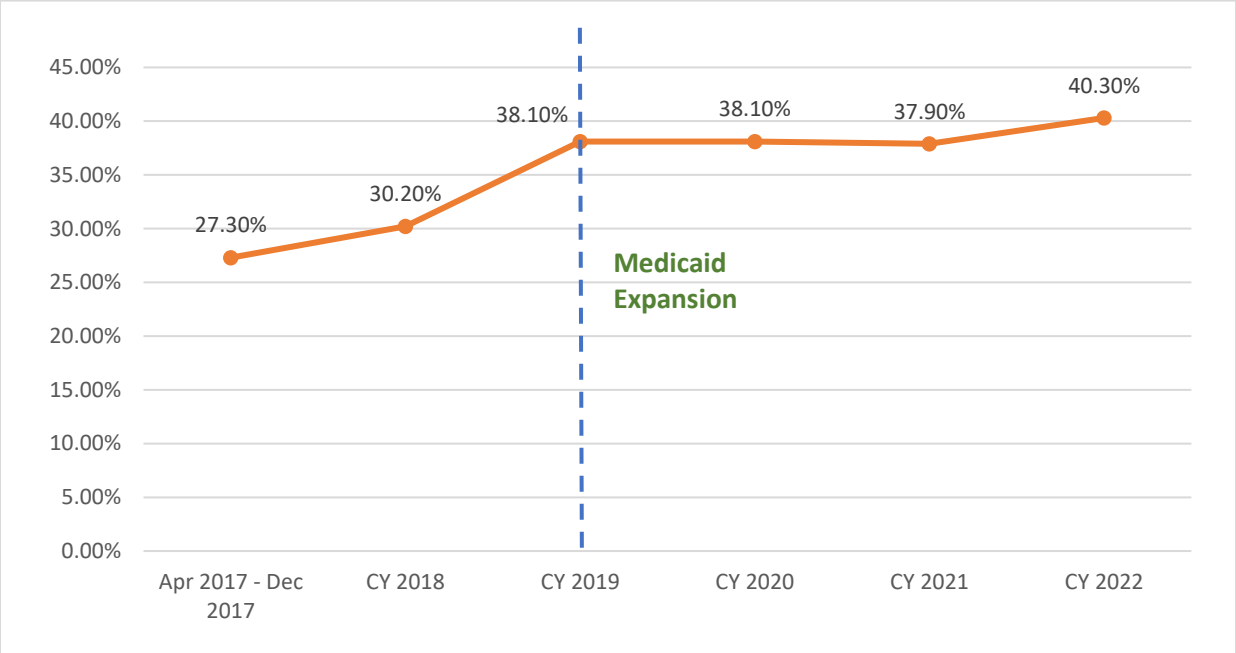
Figure 15: MOUD treatment within 7 days and 30 days of OUD-related ED visit.



MOUD treatment within 30 days of discharge from residential treatment. Another crucial transition is starting or continuing members on MOUD treatment following discharge from residential treatment. The percent of members on MOUD within 30 days of discharge from residential treatment increased from 27% in 2017 to 38% by 2020 and 40% by 2022 (see Figure

16). Despite the increases, less than 50% of members discharged from residential treatment are on MOUD within 30 days of discharge.

Figure 16: Percent of members on MOUD within 30 days of discharge from residential treatment facility



Results from Survey of Care Coordinators. The 2021 survey of Medicaid MCO care coordinators describes the processes of identifying Medicaid members with SUD, engaging them with treatment, the most frequent activities performed for members with SUD, and the most common obstacles involved in getting assistance for members with SUD. About 46% of care coordinators reported that less than 25% of their caseload included members with SUD, while 30% of care coordinators reported that 50% or more of their caseload included members with SUD (findings not shown).

Most care coordinators reported that they identify members with SUD either through a referral by the MCO (31.3%) or through a health risk assessment (35.6%) (see Table 11). Many care coordinators (38%) also report identifying members who overdosed through the Emergency Department Care Coordination (EDCC) program, which is a statewide real-time communication and collaboration program among healthcare providers and health plans. Although DMAS requires the MCOs to participate in the EDCC program per the contract with the State, almost half of MCO care coordinator respondents were unfamiliar with these reports.

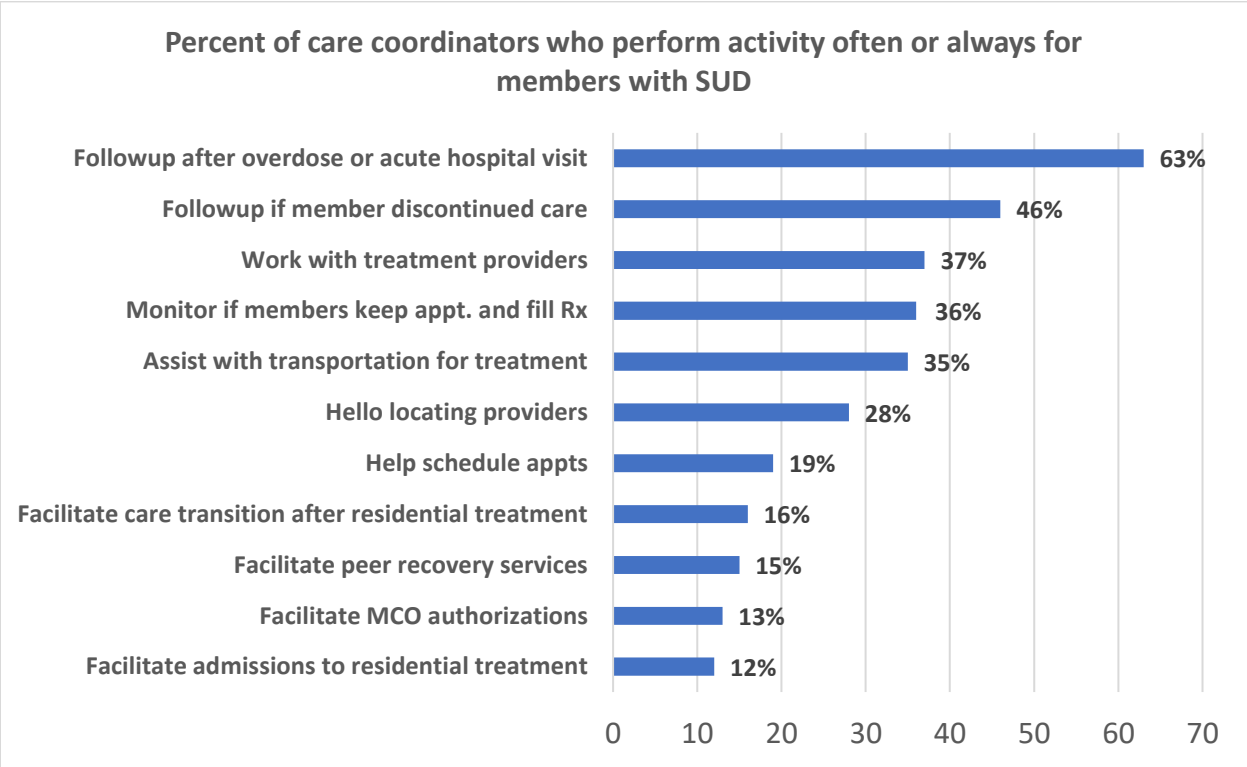
Care coordinator survey respondents report that the most important factors in getting members engaged with SUD treatment are time to initial appointment (37%), and having the support of family, friends, or peers (22%). Somewhat surprisingly, fewer report that convenience of treatment providers (12%) and overcoming stigma (10%) are the most important factors for getting members engaged with treatment.

Table 11. Care coordinator survey findings on identifying members with SUD and engaging them in treatment.

	Number	%
How care coordinators learn about Medicaid members having a substance use disorder		
Member is referred by the MCO	87	31.3
Member is referred by healthcare provider	42	15.1
Member screens positive during a health risk assessment	99	35.6
Member requests help	50	18.0
Most important factor for member engagement with treatment		
Convenience of treatment providers to home	30	11.5
Time to initial appointment	96	36.6
Member satisfaction with quality of care	38	14.5
Support of family, friends or peers	57	21.8
Overcoming stigma of having a substance use disorder or people finding out	16	6.1
Other	25	9.5
Use EDCC reports to identify Medicaid members in the ED due to an overdose		
Yes	105	37.6
No	37	13.3
Don't know what EDCC reports are	137	49.1

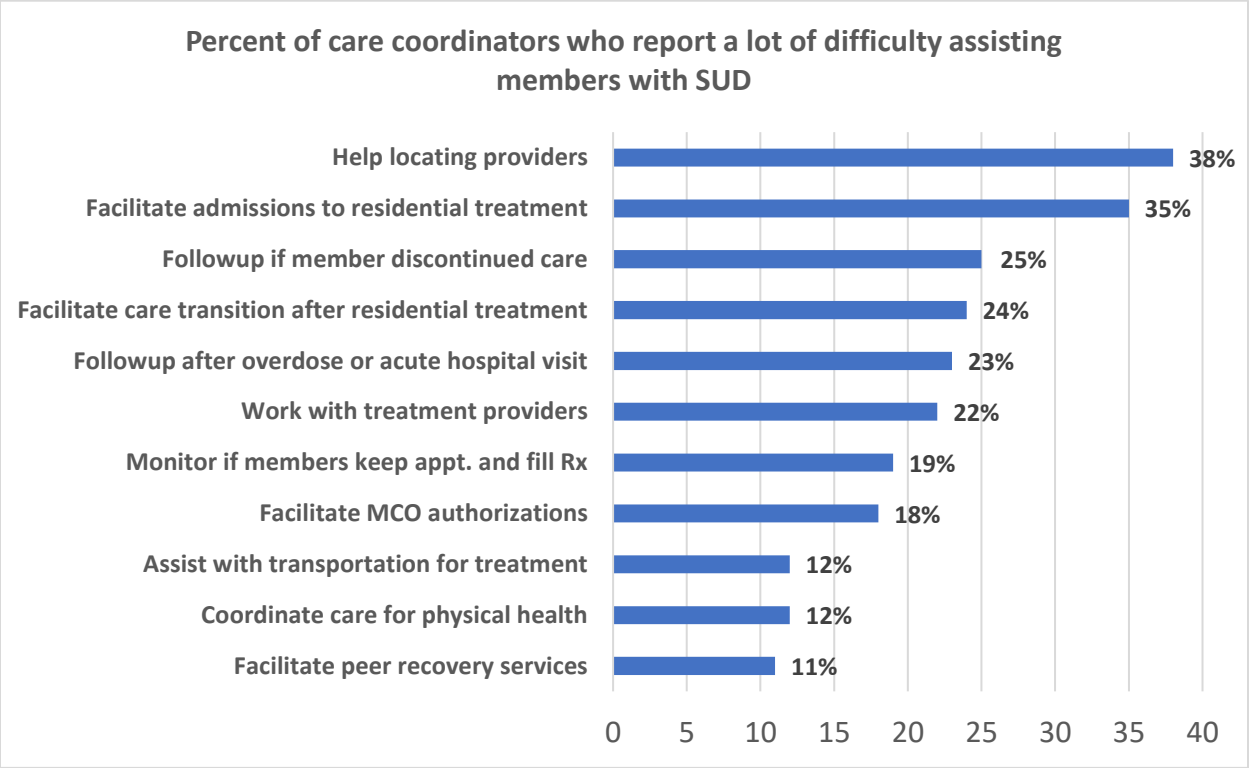
Care coordinators provide a wide range of activities for members with SUD (see Figure 17). Among the activities they provide the most frequently include following up after an overdose or acute hospital visit (63%), following up if the member discontinued care (46%), working with treatment providers (37%), monitoring whether members are keeping appointments and filling prescriptions (36%), and assisting with transportation to treatment providers (35%).

Figure 17. Frequency of activities for members with SUD performed by care coordinators



Survey respondents also report a number of obstacles and barriers in assisting Medicaid members, including assistance in locating treatment providers (38%), facilitating admissions for residential treatment (35%), facilitating care transitions after discharge from residential treatment (24%), and working with treatment providers (22%) (see Figure 18).

Figure 18. Barriers for care coordinators to assisting members with SUD.

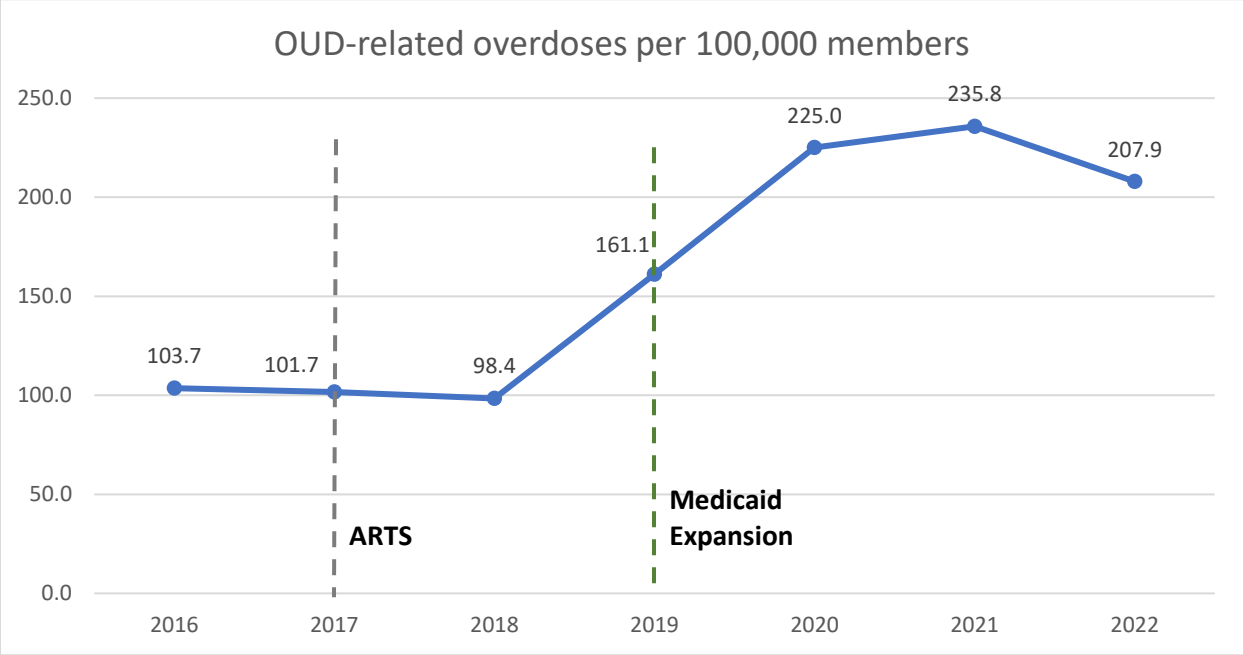


6.3 *Evaluation question #3: Are rates of opioid-related overdose deaths impacted by the demonstration?*

Fatal and nonfatal overdoses among Virginia Medicaid members. Based on Medicaid claims data, OUD-related overdoses decreased after ARTS implementation and before Medicaid expansion, from 104 overdoses per 100,000 members in 2016 to 98 overdoses per 100,000 members by 2018 (see Figure 19). However, overdoses surged to 161 per 100,000 members following Medicaid expansion in 2019, increasing to 236 overdoses per 100,000 members by 2021. Similar to the trends for OUD-related ED and acute inpatient visits, the increase following Medicaid expansion likely reflects changes in the characteristics of Medicaid members, including members who had a SUD prior to enrolling in Medicaid. The decrease in overdoses between 2021 and 2022 marks the first decrease since the 2017-2018 period.

Given the changes that have occurred since ARTS implementation in 2017, including Medicaid expansion in 2019, the COVID-19 pandemic starting in 2020, and the worsening of the opioid epidemic nationally, it is difficult to assess the impact of ARTS on fatal overdose mortality among Medicaid members based on these data. Linkages of cause of death data to Medicaid administrative data will permit assessment of whether Medicaid members with OUD who received ARTS treatment services (e.g. MOUD treatment) were less likely to experience fatal overdoses compared to members with OUD who did not receive treatment.

Figure 19: OUD related overdoses among Virginia Medicaid members by year



6.4 *Evaluation question #4: How do costs for SUD-related and non-SUD related services change over the evaluation period?*

Expenditures for ARTS services. Based on actual payment amounts in the Medicaid claims data, spending on ARTS services totaled $284.6 million in 2022, about 5.5 times the spending in the first full year of the ARTS demonstration ($51.9 million in 2018), and more than double the first year of Medicaid expansion ($128.3 million in 2019) (see Table 12). Pharmacotherapy (MOUD) was the single largest spending item in 2022 ($96.9 million) comprising about one-third of total spending on ARTS services. Residential treatment services are the second largest spending item ($48.2 million), comprising about 17% of total spending on ARTS services. Spending has increased across all ARTS services since 2018, with spending on peer recovery services increasing the most (2824% increase).

Table 12: Total cost of ARTS services by year (in thousands)

	Calendar Year						
	Apr 2017 - Dec 2017	**2018**	**2019**	**2020**	**2021**	**2022**	**% change from 2018-2022**
Total Cost	$28,208	$51,897	$128,262	$186,851	$251,936	$284,560	
Type of service							
ASAM 1	$2,820	$5,569	$15,448	$21,467	$28,184	$34,728	524%
OBAT/OTP	$2,796	$6,771	$17,741	$27,531	$36,954	$36,454	438%
Care Coordination	$783	$3,067	$10,949	$16,695	$22,829	$24,508	699%
ASAM 2	$2,858	$4,513	$12,792	$19,081	$30,244	$37,474	730%
ASAM 3	$6,022	$8,484	$27,089	$29,393	$44,275	$48,235	469%
ASAM 4	$49	$24	$481	$2,251	$2,623	$563	2212%
Pharmacotherapy	$12,449	$22,673	$41,115	$66,053	$81,563	$96,924	328%
Case Management	$429	$774	$2,485	$4,142	$4,854	$5,080	556%
Peer Recovery Support Services	$1.4	$20.3	$162	$239	$410	$593	2824%

ARTS spending has also increased for most services for members using specific ARTS services. Spending on pharmacotherapy services increased from an average of 1,812 per member using pharmacotherapy in 2018 to $2,242 in 2022, a 23.8% increase (see Table 13). Spending per user on peer recovery services – while the lowest among ARTS services – increased the most, from $74 per person using peer recovery in 2018 to $335 in 2022, a 355% increase. While overall utilization and spending on residential treatment services increased between 2018 and 2022, spending per user increased only 2% (from $6,728 in 2018 to $6,863 in 2022).

Table 13. Average cost of ARTS service per member using services.

	Calendar Year						
	2017 (Apr – Dec)	**2018**	**2019**	**2020**	**2021**	**2022**	**% change from 2018-2022**
Type of service							
ASAM 1	$314	$421	$494	$549	$609	$669	58.8%
OBAT/OTP	$1,549	$1,688	$1,550	$1,835	$2,172	$2,032	20.4%
Care Coordination	$985	$1,220	$1,382	$1,506	$1,699	$1,655	35.7%
ASAM 2	$4,894	$3,512	$3,184	$3,955	$5,071	$4,992	42.1%
ASAM 3[1]	$10,830	$6,728	$6,989	$6,715	$7,787	$6,863	2.0%
ASAM 4[1]	$8,212	$4,873	$10,234	$22,507	$17,259	$7,222	48.2%
Pharmacotherapy	$1,485	$1,812	$1,692	$2,134	$2,169	$2,242	23.8%
Case Management	$670	$832	$874	$1,042	$1,145	$1,143	37.3%
Peer Recovery Support Services	$42	$74	$183	$192	$248	$335	354.9%

[1]Reflects payments to the facility, not for professional services that are billed separately.

6.5 *ARTS Member Survey Findings on the Patient Experience with Treatment*

Unmet need for health services. Medicaid members with OUD were asked about their ability to obtain treatment for drug or alcohol use: "Was there any time in the past 12 months that they needed but did not receive treatment for drug or alcohol use." Similar questions were also asked regarding other health services, including mental health counseling, prescription drugs, medical care, and dental care.

Overall, 15% of survey respondents reported that they had an "unmet need" with respect to treatment for drug or alcohol use. Although there are no pre-ARTS estimates of unmet need, survey respondents reported less difficulty accessing drug and alcohol treatment compared to other health services. For example, 22.5% reported unmet need for mental health counseling, 29.9% reported unmet need for prescription drugs, 27.8% for general medical care, and 50.8% for dental care (see Table 14). Levels of unmet need for drug and alcohol use did not differ significantly for members surveyed prior to the beginning of the COVID-19 pandemic compared to members surveyed during the pandemic.

Table 14. Member survey results on perceived unmet needs for health services.

	Percent with unmet need in the past year for health services				
	Drug or alcohol counseling	**Mental health counseling**	**Prescription drugs**	**Medical care**	**Dental care**
All (n=1,845)	14.7%	22.5%	29.9%	27.8%	50.8%
Adjusted percentages[2]					
Race					
Non-Hispanic White	8.6%	18.9%	28.4%	27.1%	53.2%
Non-Hispanic Black	13.0%*	20.7%	29.7%	24.3%	50.5%
Other	12.1%*	16.7%	27.1%	30.3%	46.3%*
Survey period					
Before COVID	10.3%	19.3%	30.7%	28.5%	51.4%
During COVID	8.9%	19.0%	27.1%	25.3%	53.0%
RUCA Classification					
Urban	9.0%	19.5%	28.3%	26.5%	52.7%
Rural	10.9%	18.3%	29.2%	27.0%	51.4%

Source: 2020-21 ARTS Member Survey
*Difference with reference groups (other outpatient, Non-Hispanic White, Before COVID, Urban classification) is statistically significant at .05 level.
[1]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, mental health co-morbidity, polysubstance use, rural/urban residence, and whether they had been in prison or jail in the past 12 months.

Survey respondents receiving SUD treatment also reported on specific SUD services that they needed but were unable to use (see Table 15). About 6% reported unmet need for residential treatment services in 2020-2021. This compares with 10.1% having unmet need for doctor's office or clinic, 3.6% of inpatient hospitalization, and 15.9% for MOUD. Unmet need for residential treatment was somewhat higher during COVID than before COVID, among racial/ethnic minorities, and patients in urban areas. However, none of the differences were statistically significant.

Table 15. Member survey results on self-report unmet need for SUD services.

	Needed or wanted to use service, but not able to						
	AA/NA, self-help (%)	**Church or religious (%)**	**Doctor's office/ clinic (%)**	**Inpatient hosp. (%)**	**Residential treatment (%)**	**MOUD (%)**	**Any of the above (%)**
All (n=1,057)	5.9%	3.8%	10.1%	3.6%	6.2%	15.9%	28.5%
Adjusted percentages[2]							
Race							
Non-Hispanic White	2.4%	1.9%	9.5%	1.2%	3.6%	11.3%	23.1%
Non-Hispanic Black	3.5%	1.8%	6.2%	3.5%	5.3%	11.7%	25.2%
Other	12.2%	7.6%	15.1%	3.1%	9.8%	16.0%	31.6%
Survey period							
Before COVID	3.8%	1.7%	8.9%	1.2%	3.4%	12.0%	21.9%
During COVID	2.0%	2.3%	9.3%	1.8%	4.5%	11.0%	25.6%
RUCA Classification							
Urban	2.2%	1.5%	8.2%	1.2%	4.2%	10.1%	21.9%
Rural	4.5%	3.6%	11.8%	2.4%	3.4%	15.6%*	28.5%

Source: 2020-21 ARTS member survey

*Difference with reference groups (other outpatient, Non-Hispanic White, Before COVID, Urban classification) is statistically significant at .05 level.

[1]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, mental health co-morbidity, polysubstance use, urban/rural residence, and whether they had been in prison or jail in the past 12 months.

Member Satisfaction with Treatment Services. Survey respondents receiving treatment for SUD services reported high levels of satisfaction with their treatment providers. Members responded "usually" or "always" to the following statements (see Table 16):

- Explained things in a way you can understand (84%)
- Showed respect for what you had to say (85%)
- Often felt safe at place of treatment (89%)
- Involved you as much as you wanted in your treatment (84%)
- Provided information on different kinds of treatment (72%).

In addition, 74% of survey respondents reported that they felt able to refuse treatment.

Table 16. Survey respondents who replied "usually" or "always" to statements about treatment quality.

	Perceptions of practitioners where treatment received					
	Explained things in a way you can understand[1]	Showed respect for what you had to say[1]	Often felt safe at place of treatment[1]	Involved as much as you wanted in your treatment[1]	Provided information on different kinds of counseling or treatment[2]	Felt able to refuse treatment[2]
All (n=1,057)	83.7%	85.2%	88.8%	84.4%	72.0%	74.2%
Adjusted percentages[3]						
OUD treatment location						
Preferred OBOT	87.0%	90.5%	93.0%	90.2%	76.0%	73.6%
OTP	84.4%	82.7%*	92.3%	86.7%	71.8%	75.3%
Other outpatient	86.7%	90.2%	93.1%	88.9%	74.0%	76.5%
Race						
Non-Hispanic White	86.9%	88.9%	92.6%	89.3%	75.4%	78.4%
Non-Hispanic Black	80.2%*	85.5%*	92.4%	83.0%*	68.2%*	60.7%*
Other	85.9%	74.4%	83.8%*	81.7%*	65.7%*	68.1%*
Survey period						
Before COVID	85.8%	86.5%	91.8%	87.7%	74.5%	74.3%
During COVID	86.1%	89.4%	92.8%	88.7%	73.6%	77.1%
RUCA Classification						
Urban	84.9%	87.7%	92.4%	88.2%	74.3%	76.7%
Rural	88.3%	88.9%	92.3%	88.4%	73.3%	73.5%

*Statistically significant difference at .05 level with reference groups (other outpatient, Non-Hispanic White, Before COVID, urban classification).

[1]Estimates reflect percent who responded "usually" or "always" to statement.

[2]Estimates reflect percent who responded "yes" to statement.

[3]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, mental health co-morbidity, polysubstance use, urban/rural residence, and whether they had been in prison or jail in the past 12 months.

In addition, survey respondents generally reported positive perceptions of how they were helped by treatment (see Tables 17 and 18). Members "agreed" or "strongly agreed" with the following statements:

- Confident they were no longer dependent on alcohol or drugs (79%).
- Able to deal more effectively with daily problems (79%)
- Felt better about themselves (78%)
- Better able to deal with a crisis (73%)
- Able to get along better with family (79%)
- Do better in social situations (65%)
- Able to enjoy leisure activities (72%)
- Improved housing situation (60%)
- Improved employment situation (43%)

Table 17. Percent of survey respondents who "agree" or "strongly agree" with statement on personal outcomes related to treatment.

	Respondent perceptions of how they were helped by treatment			
	Confident no longer dependent on alcohol or drugs[1]	Deal more effectively with daily problems[1]	Feel better about myself[1]	Better able to deal with a crisis[1]
All (n=1,057)	79.2%	79.2%	77.9%	72.8%
Adjusted percentages[2]				
OUD treatment location				
Preferred OBOT	86.1	83.3	85.1*	80.1*
OTP	84.6	86.5*	87.0*	83.5*
Other outpatient	81.9	78.6	78.9	70.6
Race				
Non-Hispanic White	84.8	84.2	84.2	78.3
Non-Hispanic Black	83.7	74.5*	79.8*	77.0
Other	80.2*	82.4	86.8	84.0*
Survey period				
Before COVID	86.0	83.7	84.4	77.9
During COVID	82.9	82.1	83.0	78.7
RUCA Classification				
Urban	84.4	82.0	83.3	77.0
Rural	84.8	85.0	84.8	81.3

*Statistically significant difference at .05 level with reference groups (other outpatient, Non-Hispanic White, Before COVID, urban classification).

[1]Estimates reflect percent who "strongly agree" or "agree" with statement.

[2]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, mental health co-morbidity, polysubstance use, urban/rural residence, and whether they had been in prison or jail in the past 12 months.

Table 18. Percent of survey respondents who "agree" or "strongly agree" with statement on social and economic outcomes of treatment.

	Perceptions of how members were helped by counseling or treatment				
	Able to get along better with family[1]	Did better in social situations[1]	Able to enjoy leisure activities[1]	Housing situation improved[1]	Employment situation improved[1]
All (n=1,057)	79.2%	65.0%	71.6%	60.1%	43.0%
Adjusted percentages[2]					
OUD treatment location					
Preferred OBOT	82.6%*	71.0%*	76.4%	65.1%*	44.0%*
OTP	86.6%*	69.9%*	78.3%*	64.7%*	39.9%
Other outpatient	76.9%	62.3%	72.6%	53.8%	35.4%
Race					
Non-Hispanic White	84.4%	68.1%	76.5%	61.5%	40.1%
Non-Hispanic Black	72.9%*	64.4%*	73.6%	60.0%	38.3%
Other	82.3%	75.1%	74.7%	54.1%*	33.3%*
Survey period					
Before COVID	83.9%	67.9%	75.5%	59.1%	36.1%
During COVID	81.9%	67.9%	76.5%	62.8%	43.0%*
RUCA Classification					
Urban	83.7%	68.8%	73.8%	60.4%	40.8%
Rural	80.8%	65.8%	80.8%*	62.5%	36.8%

*Statistically significant difference at .05 level with reference groups (other outpatient, Non-Hispanic White, Before COVID, urban classification).

[1]Estimates reflect percent who "strongly agree" or "agree" with statement.

[2]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, mental health co-morbidity, polysubstance use, urban/rural residence, and whether they had been in prison or jail in the past 12 months.

7. Conclusion

The ARTS demonstration combined with Medicaid expansion has transformed the SUD treatment system for Virginia Medicaid members, resulting in increases in treatment providers, utilization of various treatment services, and MOUD treatment rates among members with OUD. Comparisons with other states that did not implement similar benefits suggest that the demonstration increased the number of buprenorphine prescribers and other treatment providers that accepted Medicaid patients beyond what would have occurred without the demonstration. Furthermore, evidence suggests that SUD-related ED visits and inpatient stays decreased in the early years of ARTS, although these downward trends were disrupted by Medicaid expansion, the worsening of the opioid epidemic nationally, and the COVID-19 pandemic.

Medicaid expansion in 2019 amplified many of these trends by increasing the number of Medicaid members eligible to receive treatment through the ARTS benefit. An exception was an increase in SUD-related ED visits and inpatient stays at the beginning of Medicaid expansion, which may have coincided with a worsening of the opioid epidemic nationally, as well as "pent-up" demand for acute care services for newly enrolled Medicaid members. It is possible that these increases were temporary, and would have abated over time as newly enrolled members gained access to MOUD and outpatient treatment services. SUD-related ED and acute inpatient stays decreased between 2020 and 2022, although it is likely that much of this is related to the COVID-19 pandemic, rather than ARTS and Medicaid expansion. Nevertheless, concerns about large-scale disruptions in treatment with the COVID-19 pandemic did not materialize. In fact, the supply of treatment providers, utilization of ARTS services, and MOUD treatment rates increased between 2020 and 2022.

The ultimate goal of the ARTS demonstration is to reduce fatal drug overdoses, especially those related to opioids. The final report will include a more complete assessment of the impact of the ARTS demonstration and Medicaid expansion on fatal overdoses. Such an analysis is complicated by the changing nature of the opioid epidemic, which saw a surge in fatal overdoses between 2020 and 2023 that affected nearly every state, as well as the predominance of fentanyl that has driven the recent surge in overdoses. Fatal and nonfatal overdoses have decreased slightly in the past few years in Virginia, although it is too early to conclude whether this is only temporary, or the beginning of a longer-term trend.

Regardless, the evaluation results so far show that far more Medicaid members with OUD are receiving treatment than prior to the demonstration, and close to 80% of members with diagnosed OUD are receiving MOUD, the standard of care for OUD that has been shown to reduce overdoses. More members with OUD who are being discharged from hospital EDs and residential treatment centers are continuing with or being started on MOUD, although there are still large gaps in such care transitions.

Finally, the Section 1115 waiver that allows federal payment for residential/inpatient treatment also requires a robust continuum of care offered to patients, especially outpatient and community-based services. Although a key part of the continuum of care, the inclusion of residential/inpatient treatment services is not intended to replace outpatient services or become

the dominant form of treatment service. While residential/inpatient treatment capacity has expanded greatly since the ARTS demonstration began, and utilization of residential/inpatient treatment services increased 82% between 2018 and 2022, the share of total ARTS spending on residential/inpatient treatment has stayed fairly constant at about 16%. Growth in the capacity and utilization of outpatient services has matched or exceeded growth in residential/inpatient treatment, thereby alleviating concerns that waiving the Institution of Mental Disease (IMD) exclusion may inadvertently make residential treatment services a more preferred option for OUD treatment. Combining the IMD waiver along with an enhancement of other services along the continuum of care has contributed to strong and balanced growth in the SUD treatment infrastructure in Virginia Medicaid.

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Attachment 14

Virginia 1115 Demonstration

Virginia Medicaid Section 1115 Demonstration Waiver for the Addiction and Recovery Treatment Services (ARTS) Program Midpoint Assessment

VCU School of Medicine
Health Behavior and Policy

Virginia Medicaid Section 1115 Demonstration Waiver for the Addiction and Recovery Treatment Services (ARTS) Program

Midpoint Assessment

June 2023

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Executive Summary

Virginia's Addiction and Recovery Treatment Services (ARTS) Demonstration was enacted to provide an expanded package of Medicaid benefits for the treatment of substance use disorders (SUD). ARTS expanded SUD benefits along the entire continuum of care – including coverage of inpatient detoxification and residential treatment services – implemented measures to improve quality of care through evidence-based best practices; ensure that providers meet the highest standards of care; and redesigned the delivery system to emphasize integration and coordination of SUD treatment with other mental health, physical health, and social needs. Initially approved by the Center for Medicare and Medicaid Services (CMS) in December 2016, the Demonstration that includes the ARTS program was approved by CMS for renewal in December 2019, and extends through December 2024.

As part of the demonstration renewal, CMS requires Virginia to conduct an independent midpoint assessment to examine implementation progress, identify factors and risks affecting milestone completion, and provide recommendations for state actions. This report presents the analysis and conclusions from the midpoint assessment that was conducted by Virginia Commonwealth University's Department of Health Behavior and Policy (HBP).

The assessment was conducted based on the guidelines issued by CMS for conducting mid-point assessments for Section 1115 SUD Demonstrations. The primary source of information for the assessment was a review of critical metrics identified by CMS and the state, as well as various action items undertaken by the state to achieve the six milestones over the course of the demonstration. In addition, we used results from the ongoing independent evaluation of the ARTS benefit being conducted by Virginia Commonwealth University to assess consistency with critical metrics, provide more in-depth understanding on interpretation of metric trends, and to assess consistency with trends established prior to the renewal period. To assess progress, we compared metrics for 2020 (the baseline year of the renewal) to 2021, the latest year for which complete data on critical metrics were available from the state at the time of report preparation.

The primary goal of the assessment is to assess the risk if the state does not achieve each of the six milestones required for SUD demonstrations during the reporting period. The results for each of the milestones are summarized in the following table. In sum, we conclude that the state is at low risk for not achieving 5 of the 6 milestones, based on most of the critical metrics being on target, completion of action items by the state, and supporting evidence from the ARTS evaluation. For Milestone 4 (Sufficient Provider Capacity at Each Level of Care), we assess the state is at medium risk for not achieving the milestone, based on slow

growth of provider capacity at a time of increased demand for SUD treatment services. While ARTS evaluation results show that Virginia has made substantial effort and progress in increasing provider capacity since implementation of the ARTS demonstration in 2017 and Medicaid expansion in 2019, the state is constrained by a more general shortage of behavioral health providers, as well as the dearth of SUD treatment capacity that existed prior to the ARTS benefit. Recent changes to federal regulations that make it easier for practitioners to prescribe buprenorphine treatment may present new opportunities for the state to increase SUD treatment capacity.

Table 1. Summary of Risk Assessment at Midpoint

Milestone	Critical metrics on target	Action items on target	Survey and other evaluation results	Risk Assessment
1. Access to Critical Levels of Care for OUD and other SUDS	6 of 7 (86%)	4 of 4 (100%)	Member survey self-reported access to SUD treatment relative to other health services	Low
2. Use of Evidence-Based, SUD-Specific Patient Placement Criteria	2 of 2 (100%)	4 of 4 (100%)	Member survey self-reported unmet need for residential treatment and other SUD services	Low
3. Residential and ASAM requirements	Not applicable	5 of 5 (100%)	Assessment by Manatt concluded that ARTS offered strong benefit that covered the full spectrum of ASAM levels of care	Low
4. Sufficient Provider Capacity at Each Level of Care	1 of 2 (50%)	5 of 5 (100%)	Fewer buprenorphine waivered prescribers relative to other states. Not every county has providers representing all ASAM levels of care.	Medium
5. Implementation of Comprehensive Treatment and Prevention Strategies	3 of 3 (100%)	4 of 4 (100%)	Member survey respondents report high levels of satisfaction with treatment providers and positive outcomes of treatment	Low
6. Improved Care Coordination and Transitions between Levels of Care	10 of 13 (77%)	3 of 3 (100%)	Member survey respondents report receiving help with other mental, physical, and social needs. Care coordinators report providing a wide range of activities for members with SUD.	Low

Background

On April 1, 2017, Virginia's Department of Medical Assistance Services (DMAS) launched the ARTS demonstration to enhance SUD treatment services for all Virginia Medicaid members. The ARTS benefit was approved in December 2016 as an amendment to Virginia's section 1115 demonstration, "The Virginia Governor's Access Plan" (Project No. 11-W-00297/3), which was subsequently renamed to "The Virginia Governor's Access Plan (GAP) and Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation."[1] CMS approved a renewal of the ARTS program for a 5-year period that expires in December 2024, as part of the "Building and Transforming Coverage, Services, and Supports for a Healthier Virginia" Demonstration (Project Number 11-W-00297/3) (originally approved in December 2019 and amended in July 2020).[2] The ARTS demonstration and extension were enacted to provide an expanded SUD benefit package to all Medicaid recipients and introduces policy, practice and system reforms consistent with the CMS State Medicaid Director (SMD) letter #17-003 of November, 2017.[3]

The ARTS benefit promotes sustainable recovery and treatment for Medicaid members by improving access to comprehensive and high-quality SUD care. The five-year extension of the demonstration through December 2024 includes continued access to treatment services and the authority to provide the following services:

- Expanded community-based addiction and recovery treatment services and coverage of inpatient detoxification and residential SUD treatment;
- Providing a continuum of care modeled after the American Society of Addiction Medicine Criteria (ASAM Criteria) for SUD treatment services;
- Improve the health of Medicaid recipients while decreasing other health care system (such as ED and inpatient hospital) costs;
- Implementing policy and program measures to ensure providers meet the standards of care;
- Integrating SUD treatment services into a comprehensive managed care delivery system for those recipients receiving managed care;
- Increasing reimbursement rates for SUD treatment services to increase provider capacity and access to services for members;
- Implementing strategies to improve the quality of care through evidence-based best practices; and

In alignment with SMD letter #17-003, key goals of the ARTS demonstration are to:

Goals

1. Increase rates of identification, initiation, and engagement in treatment;
2. Increase adherence to and retention in treatment;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduce utilization of ED and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
6. Improved access to care for physical health conditions among beneficiaries.

In pursuit of these goals, CMS requires the state to achieve certain milestones over the course of the demonstration, and to maintain progress during the renewal period. These milestones include:

Milestones

1. Access to critical levels of care for OUD and other SUDs.
2. Widespread use of evidence-based, SUD-specific patient placement criteria.
3. Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications.
4. Sufficient provider capacity at each level of care.
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.
6. Improved care coordination and transitions between levels of care.

Midpoint Assessment. As part of CMS' approval of the demonstration renewal, the state is required to conduct an independent midpoint assessment to report on progress towards achieving the milestones identified above. The midpoint assessment was conducted by Virginia Commonwealth University's Department of Health Behavior and Policy (HBP). The objectives of the assessment are:

Objective 1. To quantitatively assess whether progress is being made towards achieving or maintaining the ARTS benefit milestones, based on having achieved monitoring metric targets at the demonstration midpoint.

Objective 2. To assess progress on Action Items engaged in by the state under each milestone.

Objective 3. To use findings from the ongoing independent evaluation of the ARTS program to support, explain, or further understand progress on achieving milestones based on findings from objective's 1 and 2.

The below section details the methodology used for this assessment, followed by a progress assessment towards each milestone and the risk of not meeting the milestones. Recommendations are included for the state to consider in the event a medium or high risk is assessed.

Methodology

A mixed methods approach was used to conduct the midpoint assessment. The primary sources of data are the monitoring metrics computed by DMAS that are consistent with the metrics identified in the CMS technical assistance document for midpoint assessments.[4] DMAS also provided implementation action items for each milestone, as well as whether these items were completed. To complement the assessment of monitoring metrics and action items, we also included results from the ongoing independent evaluation of the ARTS benefit being conducted by Virginia Commonwealth University. Evaluation results discussed in this assessment are available in evaluation reports and published papers.

Data Sources

The primary data sources are the critical metrics constructed by the state for monitoring the demonstration. The critical metrics correspond to Milestones 1,2 and 4-6 of the demonstration, and are listed below in Table 1. There are no metrics for Milestone 3.

Table 2. Critical Metrics for Assessing Progress for the Midpoint Assessment

METRIC NUMBER AND DESCRIPTION	
Milestone #1. Access to critical levels of care for OUD and other SUDs	
7	Early Intervention[1]
8	Outpatient Services[1]
9	Intensive Outpatient and Partial Hospitalization Services[1]
10	Residential and Inpatient Services[1]
11	Withdrawal Management[1]
12	Medication Assisted Treatment[1]
22	Continuity of Pharmacotherapy for Opioid Use Disorder
Milestone #2. Use of evidence-based, SUD-specific patient placement criteria	
5	Medicaid Beneficiaries Treated in an IMD for SUD [2]
36	Average Length of Stay in IMDs (in days/year)[2]
Milestone #4. Sufficient provider capacity at each level of care	
13	Provider Availability[2]
14	Provider Availability – MAT [2]
Milestone #5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD	
18	Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940) [1]
21	Concurrent Use of Opioids and Benzodiazepines (NQF #3175) [1]

23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries [1]
Milestone #6. Improved care coordination and transitions between levels of care	
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004)
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (NQF #2605).
17(2)	Follow-up after Emergency Department Visit for Mental Illness (NQF #2605).
25	Readmissions Among Beneficiaries with SUD

[1] The baseline and midpoint measures are for the calendar years 2020 and 2021 respectively.

[2] The baseline measures are for Demonstration Year 4 (April 2020 – March 2021), and the midpoint measures are for Demonstration Year 5 (April 2021 – March 2022).

As required by CMS, the baseline year for most metrics is the first 12 months of the extension, or calendar year 2020. The follow up period is calendar year 2021. For metrics 5, 13, 14, and 36, the baseline year is April 2020 through March 2021, while the follow up year is April 2021 through March 2022.

The baseline year coincides with the outbreak of the COVID-19 pandemic as well as actions taken by the federal and state governments in response to the Public Health Emergency (PHE) declared on January 31, 2020 by the Secretary of the United States Department of Health and Human Services. As described in the CMS document, "Implications of COVID-19 for Section 1115 Demonstration Monitoring: Considerations for States,"[5] the onset of the pandemic and the PHE may affect reporting metrics as well as comparability with future time periods based on changes in the way the metrics were computed (e.g. including billing codes for telehealth visits). Furthermore, metrics may be affected by increases in Medicaid enrollment due to maintenance of effort (MOE) requirements as part of the federal Families First Coronavirus Response Act (FFCRA) of March 2020.

While CMS guidance permits consideration of an alternate baseline period to avoid overlapping with the onset of COVID-19 and PHE, there is no obvious alternative baseline period for this assessment, since the demonstration extension began at the beginning of 2020. It is not possible to use calendar year (CY) 2021 as the baseline period (with CY 2022 as follow up year), as 2021 is the latest available year for most metrics at the time of the report preparation. The year before the demonstration began (CY 2019) is also a possibility, since reporting metrics are available for that year. However, this does not resolve the potential problem of skewed trends due to changes in billing and enrollment noted above. In addition, 2019 was the beginning of Medicaid expansion in Virginia, which greatly increased the number of members receiving SUD services over the course of the year.

We will assess potential bias in trends between CY 2020 and 2021 in several ways. First, when results for individual metrics are discussed, we will note any changes in the way these metrics were computed in 2020 and 2021, and discuss potential implications of these changes on the trends observed (2020 metrics are based on Version 4.0 of the Technical Specifications for Monitoring Metrics, while 2021 are based on Version 5.0). Second, we will draw upon other analyses conducted as part of the evaluation of the ARTS demonstration to provide additional insight on the changes observed in the metrics, as well as to assess potential COVID-19 effects.

ARTS member survey. VCU conducted a survey of members receiving ARTS services in 2020 and 2021 to understand their experiences with treatment and the effects of treatment on their daily lives. The survey is based on a stratified random sample of Medicaid members who were diagnosed and/or received treatment for OUD. The sample was identified through Medicaid enrollment and claims data, and was equally divided into the following four groups: (1) members who received treatment at Preferred Office-Based Opioid Treatment providers (OBOT) – now referred to as Office-Based Addiction Treatment (OBAT) providers – a new model of care delivery created through the ARTS benefit; (2) members who received treatment through Opioid Treatment Programs (OTP), which provides methadone treatment for OUD; (3) members who received treatment at other outpatient providers which may include outpatient clinics or office-based providers that provide OUD treatment, and; (4) members who were diagnosed with OUD, but received no ARTS services based on paid claims. The survey was conducted by mail, and included $2 incentives. Out of a total 10,250 persons in the initial sample draw, about 1,845 returned completed surveys, for a survey response rate of 18%. Survey weights adjusted for differences between respondents and nonrespondents on age, sex, race/ethnicity, and Virginia region. A survey report includes additional detail on the survey design and analysis.[6]

Results from the survey are used to complement findings for Milestone's 1, 2, and 6. In addition, since the survey field period lasted from January 2020 through August 2021 – roughly the same time period as the assessment – we are able to compare early responders to later responders to assess changes in member experiences that correspond with the onset of the COVID-19 pandemic. Specifically, we compare survey responses received by April 2020 – which mostly includes experiences prior to the COVID pandemic – and survey responses received after August, 2020. The survey field period was suspended between April and August, 2020 due to the pandemic. We also discuss variation in survey responses by race/ethnicity and urban/rural residence.

Survey of MCO Care Coordinators. Results from a survey of care coordinators employed by the Managed Care Organizations (MCOs) are used to

complement findings for Milestone #6. In Virginia, the majority of Medicaid members are enrolled in one of six MCOs, each of which provides a care coordinator for its members per the contract with DMAS. The care coordinator's main role is to help ensure that Medicaid members can access the services that they need. DMAS has required the MCOs to expand of the role of care coordinators. In the ARTS benefit, care coordinators play a key role in identifying members with a need for SUD services, facilitating entry into treatment, and following up after residential treatment stays or discontinuations with treatment. Therefore, care coordinators are in a unique position to comment on the strengths and challenges of the ARTS benefit in helping members with SUD.

To better understand the experiences of care coordinators, the specific types of care they provide to members, and the challenges they face in providing this care, VCU conducted a web-based survey of Medicaid care coordinators from May to July of 2022. The objective of the survey was to obtain information on care coordinators' personal and professional backgrounds; client characteristics; care coordinator activities, both generally and for members with SUD; tools used by coordinators for data gathering; and barriers faced by coordinators.

The survey was conducted by obtaining lists of care coordinators employed by the six MCOs and their contact information. These lists included the universe of care coordinators employed by the MCOs to serve Medicaid members, a total of 1,318. These include care coordinators primarily serving members enrolled in the Commonwealth Coordinated Care Plus program, members receiving SUD treatment and recovery services through the ARTS benefit, members with serious mental illness, and others. While the survey did not focus entirely on ARTS care coordinators or SUD services, we identified care coordinators who provided services to members with SUD, and asked specific questions about how they identified members with SUD, and specific activities they performed for members with SUD. The survey was completed online between April and July, 2022. A total of 329 surveys were completed, for a response rate of 24%. A survey report includes additional detail on the survey design and analysis.[7]

Analysis of buprenorphine waivered prescribers. VCU used original analyses of buprenorphine waivered prescribers to complement the findings for Milestone #4.[8] As part of the evaluation of the ARTS benefit, VCU used a Freedom of Information Act request to obtain national historical data on buprenorphine waivered prescribers from the Drug Enforcement Administration. The objective of the analysis was to examine changes in the number of prescribers in Virginia compared to other states and the overall U.S. Specifically, the analysis assessed whether the combination of the ARTS demonstration in 2017 and Medicaid expansion in 2019 increased the supply of buprenorphine waivered prescribers to a

greater extent than a group of comparison states. While the time period for this analysis (2015-2020) precedes the current demonstration renewal period, the historical analysis provides important context for understanding provider capacity during the renewal period. We also report on more recent changes in the number of prescribers during 2020-2022.

Analytic Methods

To assess progress on the monitoring metrics, we calculated changes between the baseline period and the follow-up period, using the formula from the CMS Mid-Point Assessment Technical Assistance document:[9]

$$\text{Percent change} = \frac{\text{Value of metric at midpoint} - \text{value of metric at baseline}}{\text{Value of metric at baseline}}$$

The critical monitoring metrics are the primary source of data used to assess progress towards each milestone, and to assess overall risk of not meeting the milestone. Following CMS guidance, we used the above analysis to assess risk for not meeting milestones as low, medium, or high based on the share of critical metrics that show change in the direction of their goals. We assess the risk level based on the following criteria:

- Low risk for not achieving milestone: State is moving in the expected direction relative to its goals for at least 75% of the monitoring metrics.

- Medium risk for not achieving milestone: State is moving in the expected direction relative to its goals for 25% to 75% of the relevant monitoring metrics.

- High risk for not achieving milestone: State is moving in the expected direction relative to its goals for 25% or fewer of the relevant monitoring metrics.

The assessment of risk also takes into account the completion status of action items at the midpoint, identifying whether each action item had been completed on time. The percentage of action items completed on time is computed for each milestone. For example, if the state was moving in the expected direction for 75% or more of the monitoring metrics within a certain milestone, but had completed less than 50% of action items, then the risk level for not meeting the milestone goals could be judged to be "medium risk" instead of "low risk."

Finally, we also consider findings from the ARTS evaluation (described above) in the assessment of risk. In general, these supplemental analyses will not change our assessment of risk based on the monitoring metrics and action items, but they can provide important context if the state is at risk for not meeting certain milestones. These additional analyses are especially important to consider given that this assessment covers only the first year of the renewal (between 2020 and 2021) and does not cover the time period between implementation of the ARTS demonstration (2017) and the renewal period. In some cases, it is important to consider whether the trends in monitoring metrics at midpoint of the renewal is consistent with longer term trends based on prior evaluation analyses of the ARTS program.

Milestone 1: Access to Critical Levels of Care for OUD and Other SUDS

The first milestone is to improve access to critical levels of care for OUD and SUD across the continuum of care. During the preceding demonstration period (2016-2020), a major expansion of SUD treatment benefits was implemented in April 2017 as part of the ARTS benefit. ARTS expanded coverage of many addiction treatment services for Medicaid members aligning with the American Society of Addiction Medicine (ASAM) levels of care, including community-based services, short-term residential treatment and inpatient withdrawal management services. The Section 1115 demonstration waiver under which ARTS was enacted (and approved by CMS in December, 2016), allows federal Medicaid payment for addiction treatment services provided in inpatient and short-term residential facilities with 16 or more beds (Institutions of Mental Disease, or IMDs). ARTS also increased provider reimbursement rates for many existing services, and introduced a new care delivery model for treatment of Opioid Use Disorders (OUD), the Preferred Office-Based Opioid Treatment (OBOT) provider, which integrated medications for OUD (MOUD) with co-located behavioral and physical health services by incentivizing increased use of care coordination activities. To further increase integration of addiction treatment services with other health services covered by Medicaid, SUD services are administered by the six MCOs that manage medical and behavioral health benefits for all Medicaid members, offering a comprehensive care delivery system.

While ARTS greatly increased the availability and quality of treatment services to Medicaid members, eligibility for these services increased on January 1, 2019 when Virginia expanded Medicaid eligibility for adults ages 19-64 with family incomes of up to 138 percent of the federal poverty level, as allowed for under the Patient Protection and Affordable Care Act. By December 2021, 610,729 low-income Virginians were enrolled through Medicaid expansion.[10]

Evaluation of the ARTS benefit conducted under the Section 1115 waiver demonstration has documented the impact of ARTS and Medicaid expansion on access to and utilization of ARTS services. The number of Medicaid members using ARTS treatment services more than doubled, from 17,120 in 2017 to 46,520 in 2019.[11] Among those with OUD, the percent using MOUD treatment increased from 35% in 2016 to 53% in 2019, an increase that was far greater than for Medicaid members in twelve other states. At the same time, ED visits among those with OUD decreased (relative to Medicaid members who did not have OUD).[12]

Both the ARTS benefit and Medicaid expansion were in place at the time that renewal of the demonstration was approved by CMS (December 2019), and before the start of the COVID-19 pandemic in March 2020. To offset potential barriers to

treatment access due to pandemic-related restrictions, DMAS implemented a number of new initiatives and procedural flexibilities that the federal government permitted as part of the emergency response to COVID-19. These include allowing take-home dosages of methadone and buprenorphine for up to 28 days (which otherwise must be administered at Opioid Treatment Programs (OTPs)), allowing a member's home to serve as the originating site for prescription of buprenorphine, allowing a 90-day supply of buprenorphine, increased use of telemedicine, waiver of drug copayments, and fewer restrictions on the use of certain unlicensed providers. In compliance with federal legislation, eligibility redeterminations and coverage cancellations were suspended in order to increase continuity of coverage and prevent coverage lapses during the pandemic. While continuous coverage provisions have been discontinued with the end of the federal PHE, many of the access initiatives and procedural flexibilities will be maintained.

Performance on Monitoring Metrics

Critical Metrics. Milestone 1 Critical Metrics are summarized in Table 3. The expectation of the demonstration renewal is that there will be continued increases in access to critical levels of care, as indicated by increases in the number of members using different services under metrics 7-12, and continued increases in members with greater continuity of MOUD treatment as shown by metric #22. Despite the uncertainties and potential barriers to access due to the onset of the COVID-19 pandemic, expectations of increases in members with utilization were met on seven of eight metrics, with the largest increase between baseline and mid-point time periods reported for metric #22 – continuity of pharmacotherapy for OUD (27.7%). Increases in utilization for metrics #8-12 ranged from 16.5% (#8 outpatient services) to 21.9% (#12 medication assisted treatment).

A decrease in utilization was observed only for metric #7 (early intervention), which decreased 15.9% between baseline and midpoint. It should be noted that utilization of early intervention services overall is very low, from 88 members using these services at baseline to 74 members using these services at mid-point. It is possible that many providers are providing early intervention services to members but not submitting claims for reimbursement.

There were changes in the technical specifications for two metrics that may have some impact on the results. Most significantly, telehealth was added to outpatient services for the 2021 version of metric #8 (outpatient services). As use of telehealth services increased with the start of the COVID-19 pandemic in 2020, this change likely accounts for at least some of the increase in the use of outpatient services. For metric #10 (residential and inpatient services), the specifications for 2021 included greater clarification of the claims to use for residential treatment, although it is less clear what impact this had on the results.

Table 3. Performance on Monitoring Metrics for Milestone 1.

Metric	Name	Baseline	Mid-point	Change	% change	State Target	Direction at midpoint	Progress
7	Early Intervention	88	74	14	-15.9%	Increase	Decrease	No
8	Outpatient services	20,078	23,395	3,317	+16.5%	Increase	Increase	Yes
9	Intensive outpatient and partial hospitalization services	1,823	2,090	267	+14.6%	Increase	Increase	Yes
10	Residential and inpatient services	902	1,052	150	+16.6%	Increase	Increase	Yes
11	Withdrawal management	1,145	1,351	206	+18.0%	Increase	Increase	Yes
12	Medication Assisted Treatment	18,872	23,005	4,133	+21.9%	Increase	Increase	Yes
22	Continuity of pharmacotherapy for opioid use disorder	15,662	20,003	4,341	+27.7%	Increase	Increase	Yes

Action items. Milestone 1 Action items are summarized in Table 4. All five items were completed to coincide with the beginning of the demonstration in 2017 and included receiving approval from CMS for the waiver and coverage of other services not included in the waiver; regulatory changes; updating managed care contracts with the SUD benefits; and increasing reimbursement rates for existing SUD services. All actions were completed on time well before the demonstration renewal.

Table 4. Status of State Action Items for Milestone 1.

Milestone and Description	Status
Milestone 1: Access to critical levels of care for OUD and other SUDs	CMS approved Virginia's 1115 SUD waiver to allow for coverage in an institution of mental disease on 12/16/2016. **COMPLETE** CMS approved the state plan including coverage of the full continuum of care for services not included in the 1115 SUD Demonstration on 8/25/2017. **COMPLETE** DMAS implemented regulatory changes and developed the policy manual effective 4/1/2017. **COMPLETE** DMAS updated the managed care contracts starting 4/1/2017 to carve-in the SUD benefit for the MCOs to manage networks and ensure access to the full continuum of care. **COMPLETE** Increased rates starting 4/1/2017 for existing SUD treatment services currently covered by Medicaid including SUD Case Management, SUD

Milestone and Description	Status
	Partial Hospitalization (ASAM Level 2.5), SUD Intensive Outpatient (ASAM Level 2.1), and Opioid Treatment – counseling component of MAT to align with current industry standards. **COMPLETE**

Changes in Utilization Based on ARTS Billing Codes

The independent evaluation of the ARTS demonstration includes an analysis of changes in utilization based on the billing codes used for the ARTS program, which are similar but not identical to the above metrics. These analyses also have the advantage that the measure specifications are identical for the time periods being compared (including telehealth codes), and they are adjusted for changes in Medicaid enrollment.

Table 5 shows the number of members using ARTS services per 100,000 members for State Fiscal Years 2020 and 2021 (comparing July 2019-June 2020 to July 2020-June 2021). Even when adjusting for increases in enrollment and the inclusion of telehealth, utilization increased across all service types at similar levels to the monitoring metrics shown above.

Table 5. Number of members using ARTS services per 100,000 members, State Fiscal Years 2020 and 2021.

	Members using services per 100,000 members		
	SFY 2020	**SFY 2021**	**Percent change**
Used any ARTS service	2,627	2,912	10.8%
Type of service			
ASAM 1	2,162	2,442	12.9%
OBOT/OTP	806	901	11.8%
Care Coordination[1]	573	674	17.5%
ASAM 2	279	299	7.1%
ASAM 3	258	276	6.9%
ASAM 4	4	8	103.0%
Pharmacotherapy	1,120	1,283	14.5%
Case management	226	233	3.2%
Peer recovery support services	68	83	22.0%

[1]Care coordination services are a subset of services also counted as part of OBOT/OTP services.

Member Survey Findings

Survey respondents were asked about their ability to obtain treatment for drug or alcohol use: "Was there any time in the past 12 months that you needed but did not receive treatment for drug or alcohol use." Similar questions were also asked regarding other health services, including mental health counseling, prescription drugs, medical care, and dental care.

Overall, 14.7% of survey respondents reported that they had "unmet need" with respect to treatment for drug or alcohol use, as shown in Table 6. Although there are no pre-ARTS estimates of unmet need, survey respondents reported less difficulty accessing drug and alcohol treatment compared to other health services. For example, 22.5% reported unmet need for mental health counseling, 29.9% reported unmet need for prescription drugs, 27.8% for general medical care, and 50.8% for dental care. Levels of unmet need for drug and alcohol use did not differ significantly for members surveyed prior to the beginning of the COVID-19 pandemic compared to members surveyed during the pandemic.

Table 6. Member survey results on perceived unmet needs for health services.

	Percent with unmet need in the past year for health services				
	Drug or alcohol counseling	Mental health counseling	Prescription drugs	Medical care	Dental care
All (n=1,845)	14.7%	22.5%	29.9%	27.8%	50.8%
Adjusted percentage[#]					
Race					
Non-Hispanic White	8.6%	18.9%	28.4%	27.1%	53.2%
Non-Hispanic Black	13.0%*	20.7%	29.7%	24.3%	50.5%
Other	12.1%*	16.7%	27.1%	30.3%	46.3%*
Survey period					
Before COVID	10.3%	19.3%	30.7%	28.5%	51.4%
During COVID	8.9%	19.0%	27.1%	25.3%	53.0%
RUCA Classification					
Urban	9.0%	19.5%	28.3%	26.5%	52.7%
Rural	10.9%	18.3%	29.2%	27.0%	51.4%

Source: 2020-21 ARTS Member Survey

*Difference with reference groups (other outpatient, Non-Hispanic White, Before COVID, Urban classification) is statistically significant at .05 level.

[#]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, mental health co-morbidity, polysubstance use, rural/urban residence, and whether they had been in prison or jail in the past 12 months.

Overall Risk Assessment for Milestone 1: LOW

Table 7. Summary of Overall Risk of Not Achieving Milestone 1.

% of monitoring metric goals met	% of Action items completed	Results from surveys and other evaluation analyses	Risk level	Independent assessor's recommendation if medium or high risk	State responses and planned modifications
86%	100%	Self-reported access to SUD services is good relative to other health services	Low	Not applicable	Not applicable

Milestone 2: Use of Evidenced-Based, SUD-Specific Patient Placement Criteria.

Milestone 2 involves the use of national ASAM guidelines for treatment placement,[13] especially regarding placement in IMDs (ASAM 3 level facilities) as permitted by the Demonstration Waiver.

DMAS is partnering with the Virginia Department of Behavioral Health and Developmental Services (DBHDS) and the MCOs to ensure that licensing aligns with ASAM, Medicaid providers are credentialed using ASAM criteria, and providers are trained to deliver Medicaid SUD services with fidelity to ASAM criteria.

Performance on Monitoring Metrics

Critical Metrics. Milestone 2 metrics are shown in Table 8. The number of Medicaid beneficiaries treated in an IMD for SUD increased from 3,773 at baseline to 4,379 at midpoint, a 16.1% increase. Utilization of IMDs was low in the initial period after implementation of the ARTS benefit and IMD waiver in 2017 due in part to relatively few facilities available to Medicaid beneficiaries for this purpose. There were only 4 residential treatment providers billing Medicaid prior to the ARTS demonstration, compared to 95 as of 2022.[14]

The demonstration waiver requires an average length of stay of less than 30 days at IMD facilities per CMS. Based on metric #36, the average length of stay slightly increased between baseline (13.03 days on average) and midpoint (13.56 days). Although a 4.1% increase, it is still well within the demonstration requirements and DMAS targets. With greater availability of residential treatment facilities, it is possible that greater capacity has reduced waiting lists leading to longer lengths of stay.

Table 8. Performance on Monitoring Metrics for Milestone 2.

Metric	Name	Baseline	Mid-point	Change	% change	State Target	Direction at midpoint	Progress
5	Medicaid Beneficiaries treated in an IMD for SUD	3,773	4,379	+606	+16.1%	Increase	Increase	Yes
36	Average length of stay in IMDs	13.03	13.56	+0.53	4.1%	No change	Increase	Yes

Action items. Milestone 2 Action Items are shown in Table 9. All four action items were completed on time and at the time of the demonstration implementation in 2017.

Table 9. Status of Action Items for Milestone 2.

Milestone and Description	Status
Milestone 2: Use of evidence-based, SUD-specific patient placement criteria	ASAM and Medicaid SUD benefit trainings offered over to Providers starting October 2016 through April 2017 with Continuing Education Credits as incentive. Completed over 30 trainings across the Commonwealth before implementation. **COMPLETE** 25 ASAM Train the Trainers to target clinical experts in field 2017. **COMPLETE** Added ASAM requirements to the MCO contracts April 2017. **COMPLETE** Worked with Program Integrity to add these services to the audit plan starting in 2017. **COMPLETE**

Member Survey Findings

Survey respondents receiving OUD treatment also reported on specific services that they needed but were unable to use (Table 10). About 6% reported unmet need for residential treatment services in 2020-2021. This compares with 10.1% having unmet need for doctor's office or clinic, 3.6% for inpatient hospitalization, and 15.9% for MOUD. Unmet need for residential treatment was somewhat higher during COVID than before COVID, among racial/ethnic minorities, and patients in urban areas. However, none of the differences were statistically significant.

Table 10. Member survey results on self-report unmet need for SUD services.

	Needed or wanted to use service, but not able to						
	AA/NA, self-help (%)	Church or religious (%)	Doctor's office/ clinic (%)	Inpatient hosp. (%)	**Residential treatment (%)**	MOUD (%)	Any of the above (%)
All (n=1,057)	5.9%	3.8%	10.1%	3.6%	**6.2%**	15.9%	28.5%
Adjusted percentages[#]							
Race							
Non-Hispanic White	2.4%	1.9%	9.5%	1.2%	**3.6%**	11.3%	23.1%
Non-Hispanic Black	3.5%	1.8%	6.2%	3.5%	**5.3%**	11.7%	25.2%
Other	12.2%	7.6%	15.1%	3.1%	**9.8%**	16.0%	31.6%
							Survey period
Before COVID	3.8%	1.7%	8.9%	1.2%	**3.4%**	12.0%	21.9%
During COVID	2.0%	2.3%	9.3%	1.8%	**4.5%**	11.0%	25.6%
RUCA Classification							
Urban	2.2%	1.5%	8.2%	1.2%	**4.2%**	10.1%	21.9%
Rural	4.5%	3.6%	11.8%	2.4%	**3.4%**	15.6%*	28.5%

Source: 2020-21 ARTS member survey

*Difference with reference groups (other outpatient, Non-Hispanic White, Before COVID, Urban classification) is statistically significant at .05 level.

[#]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, mental health co-morbidity, polysubstance use, urban/rural residence, and whether they had been in prison or jail in the past 12 months.

Overall Risk Assessment for Milestone 2: LOW

Table 11. Summary of Overall Risk of Not Achieving Milestone 1

% of monitoring metric goals met	% of Action items completed	Results from surveys and other evaluation analyses	Risk level	Independent assessor's recommendation if medium or high risk	State responses and planned modifications
100%	100%	Low rate of self-reported unmet need for residential treatment services relative to other services	Low	Not applicable	Not applicable

Milestone 3: Provider Qualifications for Residential Treatment Facilities.

Milestone 3 is the use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications. DMAS is requiring ASAM Criteria to be used in residential levels of care. DMAS is also requiring residential providers to assess and refer members for MOUD treatment.

Performance on Monitoring Metrics

Critical Metrics. This milestone does not have Critical Metrics

Action Items. Milestone 3 action items are shown in Table 12. All four Action Items were completed on time. Two of the Action Items were implemented after the demonstration renewal, including actions affecting the licensing of providers, training webinars, and a process for technical assistance to providers. In addition, Virginia contracted with two organizations to conduct an assessment of provider adherence to ASAM placement criteria, utilization management, prior authorization priorities, and strategies to improve care coordination strategies.

Table 12. Status of Action Items for Milestone 3.

Milestone and Description	**Status**
Milestone 3: Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities	DMAS contracted with a vendor in 2017 to perform reviews and site visits for SUD Residential providers to certify them if they met the ASAM Criteria for the particular ASAM Level of Care they were attesting to meet. **COMPLETE** DMAS issues a policy memorandum effective 12/1/2018 requiring providers to ensure that members with OUD admitted to any level of care have access to evidence-based MOUD, including buprenorphine. **COMPLETE.** DMAS revised the managed care contracts to require ASAM Criteria is met and ensure coverage of MOUD in all levels of care. **COMPLETE**. The Department of Behavioral Health and Developmental Services (DBHDS) was mandated by the General Assembly to implement the ASAM Criteria into licensing regulations. Emergency actions were published 2/1/21 and effective 2/20/21 and implemented 7/1/21. DMAS also updated regulations and policies to align with licensing. **COMPLETE** Between March 2020 to March 2022, DMAS had hosted 235 SUD training webinars to promote evidence-based practices for SUD treatment and recovery, that were attended by more than 12,750 individuals. Some of the most popular events were:

	• A series of trainings developed specifically for Department of Social Services staff, • A series of trainings reviewing ASAM criteria, • Individual webinars focused on: o ARTS care coordination for MCOs, o HCV care provision, o Opioids and Stimulants, o SUD Treatment Basics o Suicide Assessment, Screening, and Intervention o Client Engagement, o Buprenorphine (provided to Virginia Pharmacists Association), o Incorporating PRSS, and o Racial Trauma and Incorporating Culturally Sensitive Practices. In addition to these webinars, DMAS also developed a process for providers to request provider-specific technical assistance. Over two rounds of requests, DMAS received 22 applications and provided tailored, specific technical assistance to 16 SUD providers. As part of the work performed by Manatt Health described above, Manatt and State Health Partners completed an assessment of Virginia SUD residential treatment options, including a review of payment rates for residential treatment, provider fidelity to the ASAM level of care criteria, and utilization management and prior authorization policies. This review found DMAS offered a strong benefit (ARTS) that covered the full spectrum of ASAM levels of care. Manatt also analyzed MCO contracting strategies, with a focus on improving care coordination between MCOs and providers. Manatt also presented a webinar to public behavioral health providers and MCO care coordinators regarding collaboration, data sharing, and privacy. **COMPLETE**

Overall Risk Assessment for Milestone 3: LOW

Table 13. Summary of Overall Risk of Not Achieving Milestone 3

% of monitoring metric goals met	% of Action items completed	Results from surveys and other evaluation analyses	Risk level	Independent assessor's recommendation if medium or high risk	State responses and planned modifications
Not applicable	100%	Assessment by Manatt concluded that ARTS offered strong benefit that covered the full spectrum of ASAM levels of care	Low	Not applicable	Not applicable

Milestone 4: Sufficient Provider Capacity at Each Level of Care

Milestone 4 is to ensure sufficient provider capacity at each level of care. To ensure sufficient provider capacity, DMAS utilized the managed care contracts to be responsible for managing their network and ensuring access to appropriate care. Specifically, DMAS requires the MCOs by contract, to monitor and assure that the MCO's behavioral health network, including SUD, is adequate (in terms of service capacity and specialization) to serve child, adolescent, and adult populations timely and efficiently for all behavioral health services covered by the MCO. DMAS monitors the MCO's inpatient and outpatient networks to verify that the levels of capacity and specialization are adequate in terms of service.

DMAS and DBHDS also conducted extensive outreach and training sessions with a variety of treatment providers prior to implementation of ARTS in 2017, and they also explored the needs within the provider community to address concerns and issues in being a Medicaid provider. Virginia also received a grant from the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (or the SUPPORT Act) for Patients and Communities Act of 2018 to further develop initiatives to enhance provider capacity, including additional trainings and outreach.

Critical Metrics. Milestone 4 Critical Metrics are shown in Table 14. There was an overall decrease in SUD certified providers between the baseline and mid-point, from 4,789 providers in 2020 to 4,633 providers in 2021, a 3.3% decrease. However, the number of certified MOUD providers increased by 1.3%.

Table 14. Performance on Monitoring Metrics for Milestone 4.

Metric	Name	Baseline	Mid-point	Change	% change	State Target	Direction at midpoint	Progress
13	Provider availability	4,789	4,633	-156	-3.3%	Increase	Decrease	No
14	MAT Provider availability	3,375	3,418	+43	1.3%	Increase	Increase	Yes

The relative lack of change in provider availability at midpoint of the renewal is in contrast to the large increases in all types of SUD providers observed during the initial demonstration period. Based on analysis conducted by VCU for the ARTS evaluation, there were relatively few Medicaid providers at all ASAM levels of care in 2016 (prior to implementation of ARTS), although the number of providers increased greatly by 2020 (Table 15).

Table 15. Changes in ARTS service providers before and after initial demonstration period.

Addiction Provider Type	# of Providers before ARTS (2017)	# of Providers in 2020
Inpatient Detox (ASAM 4.0)	N/A	51
Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)	4	123
Partial Hospitalization Programs (ASAM 2.5)	N/A	41
Intensive Outpatient Programs (ASAM 2.1)	49	252
Opioid Treatment Programs (OTP)	6	40
Preferred Office-Based Opioid Treatment Providers (OBOT)	N/A	154
Outpatient practitioners billing for ARTS services (ASAM 1)	1,087	5,089

Action items. Milestone 4 Action Items are shown in Table 16. All four Action Items have been completed or are ongoing. Since the demonstration renewal, DMAS initiated World Café events in different regions of Virginia and attended by 115 stakeholders, as part of the Support Act Grant. The ongoing evaluation of the ARTS program show large and continuing increases in DEA-waivered buprenorphine prescribers, with especially large increases in nurse practitioner and physician assistant prescribers since passage of the Comprehensive Addiction and Recovery Act of 2016.

Table 16. Status of Action Items for Milestone 4.

Milestone and Description	Status
Milestone 4: Sufficient provider capacity at each level of care	DMAS carved in SUD treatment services to manage care in 2017. The MCOs are required to meet or exceed Federal network adequacy standards at 42 CFR § 438.68. **COMPLETE** DMAS implemented a public facing Provider Network map using Google Maps in 2017 and updated on a quarterly basis. **COMPLETE** DMAS initiated six World Cafes events in 2020, in different regions of Virginia – Abingdon (southwestern region), Charlottesville (central), Manassas (northern), Norfolk (eastern), Richmond (central), and Roanoke (western). These sessions were held to better understand the depth, breadth, and nuance of the issues facing both Medicaid members with SUD, as well as SUD service providers. In all, over 115 stakeholders attended these meetings. **COMPLETE** Independent evaluations performed by VCU to report number of providers by levels of care. **ONGOING**

	DMAS partnered with VCU Department of Health Behavior and Policy (DHBP) to perform an analysis of Drug Enforcement Administration (DEA) data concerning buprenorphine waivered prescribers (BWPs). Results of this analysis are discussed below. **COMPLETE**

Trends in buprenorphine waivered prescribers.

On a per capita basis, the number of prescribers per 100,000 persons in Virginia increased from 5.4 in 2015 to 18.3 in 2020, a 240% increase that is comparable to the total U.S (Table 17). However, a more meaningful comparison may be with other states in the same region that had not expanded Medicaid during the 2015-2020 period (i.e. similar states that did not take the same policy actions as Virginia). In 2015, Virginia and these comparison states had almost identical numbers of buprenorphine prescribers per 100,000 people (5.4 in Virginia and 5.6 in the other states). Starting in 2017 (the year of ARTS implementation), Virginia began to see higher increases in the number of prescribers, continuing after Medicaid expansion. By 2020, Virginia had 18.3 prescribers per 100,000 people compared to 14.8 in the comparison states. In total, the number of prescribers increased 240% in Virginia vs. 166% in other Southern non-expansion states.

Table 17. Number of buprenorphine-waivered prescribers per 100,000 persons (as of April June for each year.

	2015	2016	2017	2018	2019	2020	% change 2015-18	% change 2018-20	% change 2015-20
Virginia	5.4	6.1	7.7	10	13.1	18.3	87.3	81.8	240.4
Non-expansion states in South	5.6	6.2	7.3	9	11.2	14.8	61.3	65.1	166.3
Expansion states in South	10.6	12.1	14.4	19.2	25.9	35.7	80.9	86.2	236.9
Total U.S.	7.8	8.8	10.6	14.1	19.3	27	81.5	90.8	246.2

Moreover, much of the increase since 2017 resulted from an increasing number of nurse practitioners and physician assistants receiving waivers, permitted under the federal Comprehensive Addiction and Recovery Act of 2016. Between 2018 and 2020, buprenorphine-waivers among nurse practitioners increased by 283%, among physician assistants by 200%, and among medical doctors (MDs) by 54% (Table 18). As of 2020, nurse practitioners and physician assistants comprise over one-fourth of waivered practitioners in the Commonwealth.

Table 18. Number of buprenorphine waivered prescribers in Virginia (as of April-June for each year).

	2015	2016	2017	2018	2019	2020	% change 2015-18	% change 2018-20	% change 2015-20
All prescribers	432	491	621	818	1,074	1,495	89.4%	82.8%	246%
Patient limit									
30	288	320	411	570	763	1,029	97.9%	80.5%	257%
100 or 275	144	171	210	248	311	466	72.2%	87.9%	224%
License type									
MD	432	491	605	708	863	1090	63.9%	54.0%	152%
Nurse practitioner	0	0	13	90	181	345	NA	283%	NA
Physician assistants	0	0	3	20	30	60	NA	200%	NA

More recent estimates show this trend continuing through the pandemic. The number of waivered prescribers increased 51% between 2020 and 2022, driven primarily by an increase in nurse practitioner prescribers (95% increase) and physician assistants (151%) (findings not shown).

Despite these increases, Virginia still lags behind the overall U.S. in terms of the number of waivered prescribers (27 per 100,000 persons nationally compared to 18.3 in Virginia). While the supply of prescribers has surpassed other states in the U.S. South that did not expand Medicaid by 2020, Virginia has only about half the number of prescribers among other states in the U.S. South that expanded Medicaid. In addition, 37.8% of respondents to the MCO Care Coordinator survey reported that finding in-network providers for SUD treatment was a "major problem", while another 34.7% reported that it was "somewhat of a problem." [15] However, the level of difficulty in finding SUD providers was no greater than other Medicaid providers, suggesting more general issues regarding provider capacity in Virginia Medicaid.

The state acknowledges that Virginia is experiencing a behavioral workforce shortage not only for SUD but also mental health. DMAS is collaborating with DBHDS and other state agencies to address the shortage. For example, to address more serious shortage areas in the state, there has been a process in place since April 2017 where DMAS can request that DBHDS move applications for licenses up in the queue for providers in these shortage areas. The state is also focusing on provider recruitment and training for their Project BRAVO (Behavioral Health Redesign for improved Access, Value, and Outcomes) initiative implemented in 2021, which is an interagency partnership to align systems for developing an evidence-based, trauma-informed and prevention-oriented array of behavioral health services.

Also, as of January 2023, practitioners are no longer required to apply for federal waivers to prescribe buprenorphine as a result of Section 1262 of the Consolidated Appropriations Act, 2023. By removing this administrative barrier to prescribing buprenorphine, this change presents an opportunity for the state to provide additional outreach and education to potential new prescribers. An assessment of the impact of the ending of the federal waiver requirement on the number of prescribers will be included in the ongoing evaluation of the ARTS benefit.

Overall Risk Assessment for Milestone 4: Medium

Table 19. Summary of Overall Risk of Not Achieving Milestone 4.

% of monitoring metric goals met	% of Action items completed	Results from surveys and other evaluation analyses	Risk level	Independent assessor's recommendation if medium or high risk	State responses and planned modifications
50%	100%	ARTS evaluation analyses show large increase in buprenorphine waivered prescribers since ARTS and Medicaid expansion implementation	Medium	Continue to offer provider education and training on ARTS billing and MOUD, and to increase awareness of federal end of requirement for waiver application. Use ARTS evaluation to assess impact of the end of federal requirement for waiver application in ARTS evaluation.	DMAS will update the state plan, Virginia Administrative Code and provider manuals to reflect the removal of the buprenorphine waiver requirement. DMAS will schedule meetings with the MCOs to address increasing capacity for prescribers.

Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Milestone 5 is the implementation of comprehensive treatment and prevention strategies to address OUD. DMAS explored opportunities to enhance efforts through managed care and revising language in policies and contracts to include appropriate prescribing of opioids for pain management. DMAS also explored additional opportunities with the Prescription Drug Monitoring Program (PDMP) and Patient Utilization Management Service (PUMS) to increase prescriber's ability to identify patients at high risk for opioid abuse.

Critical Metrics. All three metrics decreased from the baseline and midpoint, consistent with expectations. The share of members without cancer using opioids at high dosage decreased 24%, while the percent with concurrent use of opioids and benzodiazepines decreased 3.4%. It is possible that some of this decrease may reflect changes in the technical specifications for the metrics in 2021, which added palliative care to the list of exclusions from the measure. Emergency department use for SUD per 1,000 Medicaid beneficiaries also decreased by 6.3%, from 3.22 visits per 1,000 members in 2020 to 3.02 visits in 2021.

Table 20. Performance on Critical Metrics for Milestone 5.

Metric	Name	Baseline	Mid-point	Change	% change	State Target	Direction at midpoint	Progress
18	Use of Opioids at High Dosage in Persons Without Cancer (%)	5.0%	3.8%	-1.2%	-24%	Decrease	Decrease	Yes
21	Concurrent use of opioids and benzodiazepines (%)	11.9%	11.5%	-0.4%	-3.4%	Decrease	Decrease	Yes
23	ED visits for SUD per 1,000 Medicaid beneficiaries	3.22	3.02	-0.20	-6.3	Decrease	Decrease	Yes

Action items. Table 21 shows the status of the action items for Milestone 5. All four action items have been completed. Two of these actions were initiated before the demonstration renewal, while two activities were initiated after the renewal. Of the latter, DMAS contracted with two organizations as part of the SUPPORT Act to identify best practices and work with DMAS to assess key strengths and opportunities to build on SUD treatment access and delivery.

Table 21. Action Items for Milestone 5

Milestone and Description	Status
Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD	In February 2019, DMAS issues an Evidence-Based Practices and Medication Assisted Treatment for OUD memo and facilitated a provider training. **COMPLETE** From July 2020 through August 2021, DMAS contracted with Manatt Health and State Health Partners who completed the following activities: • Assessed SUPPORT Act and federal and state SUD-related policy requirements and opportunities; • Interviewed 44 stakeholders, consisting mostly of providers and advocates; • Identified promising practices implemented in other states related to access and delivery of SUD services; • Conducted monthly working sessions with DMAS, other state agencies, and additional stakeholders on opportunities to strengthen access to and quality of SUD services in the state; • Hosted a webinar on privacy considerations for coordinating care for patients with SUD; • Presented project findings and recommendations to DMAS leadership and stakeholders; and • Provided ongoing technical assistance to DMAS as questions and issues arose. Manatt identified a series of key strengths and opportunities that the state can build on to strengthen SUD treatment access and service delivery for Medicaid beneficiaries. DMAS's strengths include: • Offering a benefits package that covers the full spectrum of the ASAM levels of care for SUDs; • Having an ongoing focus on seeking to better understand and address the full scope of SUDs (e.g., polysubstance use and the recent rise in deaths due to methamphetamines and cocaine use); • Leveraging data to better understand racial/ethnic disparities and inform future priorities; developing strategies to enroll eligible justice-involved individuals in Medicaid coverage; and • Offering ongoing support to providers (e.g., training and webinars) to increase SUD knowledge and improve service delivery. **COMPLETE** DMAS updated PUMS language in the managed care contracts in 2018 addressing high use of opioids, lock in programs, and care coordination. **COMPLETE**

	DMAS executed an Interagency Agreement with the Virginia Department of Health Professions (DHP) to match Medicaid prescribers who have reported to the PDMP. Effective July 1, 2021 to June 30, 2022. **COMPLETE**

Member Survey Findings

Positive experiences with treatment by members are also crucial for preventing recurrence of illicit opioid use and overdoses. Member survey respondents receiving treatment for SUD services reported high levels of satisfaction with their treatment providers. For example, members responded "usually" or "always" to the following statements:

- Explained things in a way you can understand (84%)
- Showed respect for what you had to say (85%)
- Often felt safe at place of treatment (89%)
- Involved you as much as you wanted in your treatment (84%)
- Provided information on different kinds of treatment (72%).

In addition, 74% of survey respondents reported that they felt able to refuse treatment. Survey findings in Table 22 also showed there were no statistically significant differences in member satisfaction between those surveyed before the COVID-19 pandemic and those surveyed during the pandemic. However, Non-Hispanic Black respondents had somewhat less positive perceptions of their treatment providers compared to Non-Hispanic White respondents.

Table 22. Survey findings on satisfaction with treatment providers.

	Perceptions of practitioners where treatment received					
	Explained things in a way you can understand[1]	Showed respect for what you had to say[1]	Often felt safe at place of treatment[1]	Involved as much as you wanted in your treatment[1]	Provided information on different kinds of counseling or treatment[2]	Felt able to refuse treatment[2]
All (n=1,057)	83.7%	85.2%	88.8%	84.4%	72.0%	74.2%
Adjusted percentages*						
Race						
Non-Hispanic White	86.9%	88.9%	92.6%	89.3%	75.4%	78.4%
Non-Hispanic Black	80.2%*	85.5%*	92.4%	83.0%*	68.2%*	60.7%*
Other	85.9%	74.4%	83.8%*	81.7%*	65.7%*	68.1%*
Survey period						
Before COVID	85.8%	86.5%	91.8%	87.7%	74.5%	74.3%
During COVID	86.1%	89.4%	92.8%	88.7%	73.6%	77.1%
RUCA Classification						
Urban	84.9%	87.7%	92.4%	88.2%	74.3%	76.7%
Rural	88.3%	88.9%	92.3%	88.4%	73.3%	73.5%

Source: 2020-21 ARTS Member Survey

*Statistically significant difference at .05 level with reference groups (other outpatient, Non-Hispanic White, Before COVID, urban classification).

[1]Estimates reflect percent who responded "usually" or "always" to statement.

[2]Estimates reflect percent who responded "yes" to statement.

*Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, mental health co-morbidity, polysubstance use, urban/rural residence, and whether they had been in prison or jail in the past 12 months.

In addition, survey respondents generally reported positive perceptions of how they were helped by treatment. Members "agreed" or "strongly agreed" with the following statements:

- Confident they were no longer dependent on alcohol or drugs (79%).
- Able to deal more effectively with daily problems (79%)
- Felt better about themselves (78%)
- Better able to deal with a crisis (73%)
- Able to get along better with family (79%)
- Do better in social situations (65%)
- Able to enjoy leisure activities (72%)
- Improved housing situation (60%)
- Improved employment situation (43%)

Somewhat surprisingly, more respondents reported an improved employment situation during COVID (43%) than before COVID (36%). Non-Hispanic Black

respondents reported somewhat less positive outcomes on five of the nine measures.

Overall Risk Assessment for Milestone 5: LOW

Table 23. Summary of Overall Risk of Not Achieving Milestone 5

% of monitoring metric goals met	% of Action items completed	Results from surveys and other evaluation analyses	Risk level	Independent assessor's recommendation if medium or high risk	State responses and planned modifications
100%	100%	ARTS member survey respondents report high levels of satisfaction with treatment providers and positive outcomes of treatment	Low	Not applicable	Not applicable

Milestone 6: Improved Care Coordination and Transitions Between Levels of Care

Milestone 6 is improved care coordination and transitions between levels of care. Care coordinators employed by the six MCOs serving Virginia Medicaid members play a vital role in linking Medicaid members with necessary services, including treatment for SUD, mental health, physical health, and social needs. In addition, DMAS has explored the Emergency Department Care Coordination (EDCC) system for identifying overdoses through a statewide real-time communication and collaboration program among healthcare providers and health plans. DMAS has also added discharge planning requirements for providers.

Performance on Monitoring Metrics

Critical Metrics. Milestone 6 critical metrics are summarized in Table 24, and are broadly consistent with DMAS goals that reflect greater care coordination and transitions between levels of care. The four measures of treatment initiation showed little change or small decreases, while the four measures of treatment engagement showed increases of between 8.7% and 56.6%. Rates of follow-up after discharge from the ED for mental illness or SUD also showed increases of between 10.0% and 29.9%. Readmission rates among beneficiaries with SUD decreased by 2.4%.

Table 24. Critical Metrics for Milestone 6.

Metric	Name	Baseline	Mid-point	Change	% Change	State Target	Direction at Midpoint	Progress
15	*AOD treatment initiation*							
15	Alcohol (%)	41.5%	42.6%	+1.1%	+2.7%	Increase	Increase	Yes
15	Opioid (%)	63.5%	63.5%	0%	0%	Increase	No change	No
15	Other (%)	45.6%	43.8%	-1.8%	-3.9%	Increase	Decrease	No
15	Total (%)	47.3%	46.3%	-1.0%	-2.1%	Increase	Decrease	No
15	*AOD treatment engagement*							
15	Alcohol (%)	7.6%	11.9%	+4.3%	+56.6%	Increase	Increase	Yes
15	Opioid (%)	39.2%	42.6%	+3.4%	+8.7%	Increase	Increase	Yes
15	Other (%)	8.4%	13.0%	+4.6%	+54.8%	Increase	Increase	Yes
15	Total	16.6%	19.2%	+2.6%	+15.7%	Increase	Increase	Yes
17	*Followup after Discharge for alcohol or opioid use disorder*							
17	Within 30 days (%)	18.0%	22.0%	+4.0%	+22.2%	Increase	Increase	Yes
17	Within 7 days (%)	10.7%	13.9%	+3.2%	+29.9%	Increase	Increase	Yes
17	Followup after discharge from ED for mental illness							
17	Within 7 days	28.8%	32.7%	+3.9%	+13.5%	Increase	Increase	Yes
17	Within 30 days	41.8%	46.0%	+4.2%	+10.0%	Increase	Increase	Yes
25	Readmission rate among beneficiaries with SUD	21.1%	20.6%	-0.5%	-2.4%	Decrease	Decrease	Yes

Action items. Table 25 shows action items for Milestone 6. All three action items have been completed, including training programs for providers and health systems, encouraging discharge planning, and requirements that MCOs have addiction care specialists as care coordinators.

Table 25. Status of Action Items for Milestone 6.

Milestone and Description	Status
Milestone 6: Improved care coordination and transitions between levels of care	DMAS facilitated a training with Medicaid MOUD providers and health systems in 2020 on the EDCC program. This was done to help facilitate relationships for bridging members from health system to community providers. **COMPLETE** DMAS added discharge planning to the service authorization as well as the policy manual in 2018. This encourages the provider to communicate the discharge plan to the MCO in order for the service to be approved. **COMPLETE** DMAS carved in the SUD benefit to managed care and required the MCOs to have a licensed clinician who specializes in addiction care to serve as the care coordinator to help with transitions of care for their members. **COMPLETE**

Member Survey Findings

The ARTS member survey asked respondents whether they had received assistance with their other health and personal needs from their SUD treatment provider (see Table 26). Overall, 60% of respondents receiving SUD treatment reported receiving assistance with other non-SUD services, including 26% who received help for a medical problem, 38% who received help with a mental health problem, and 18% who received help with housing, food, or employment. Assistance reported by respondents decreased during the pandemic relative to before the pandemic, and was also lower among Non-Hispanic Black respondents compared to Non-Hispanic White respondents.

Table 26. Survey findings on members with OUD receiving help with other health and social needs from treatment providers

	Received help with other health and social needs			
	Received any help with other health or personal needs	Received help for a medical problem	Received help with a mental health problem	Received help with housing, food, or employment
All (n=1,057)	59.6%	25.6%	38.2%	17.9%
Adjusted percentages[1]				
Race				
Non-Hispanic White	60.8%	25.8%	38.3%	16.3%
Non-Hispanic Black	55.0%*	21.3%*	33.1%*	14.9%
Other	71.7%*	16.1%*	39.6%	26.4%*
Survey period				
Before COVID	64.7%	24.8%	39.0%	15.7%
During COVID	57.2%*	24.4%	36.5%	16.9%
RUCA Classification				
Urban	60.2%	24.1%	37.3%	19.7%
Rural	60.8%	26.0%	38.1%	9.2%*

Source: 2020-21 ARTS member survey

*Statistically significant difference at .05 level with reference groups (other outpatient, Non-Hispanic White, Before COVID, urban classification).

[1]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, serious mental illness, polysubstance use, urban/rural residence, and whether they had been in prison or jail in the past 12 months.

Care Coordinator Survey Findings

Most care coordinators reported that they identify members with SUD either through a referral by the MCO (31.3%) or through a health risk assessment (35.6%) (Table 27). Many care coordinators (38%) also report identifying members who overdosed through the EDCC program, which is a statewide real-time communication and collaboration program among healthcare providers and health plans.

Care coordinator survey respondents report that the most important factors in getting members engaged with SUD treatment are time to initial appointment (37%), and having the support of family, friends, or peers (22%). Somewhat surprisingly, fewer report that convenience of treatment providers (12%) and overcoming stigma (10%) are the most important factors for getting members engaged with treatment.

Table 27. Care coordinator survey findings on identifying members with SUD and engaging them in treatment.

	Number	%
How care coordinators learn about Medicaid members having a substance use disorder		
Member is referred by the MCO	87	31.3
Member is referred by healthcare provider	42	15.1
Member screens positive during a health risk assessment	99	35.6
Member requests help	50	18.0
Most important factor for member engagement with treatment		
Convenience of treatment providers to home	30	11.5
Time to initial appointment	96	36.6
Member satisfaction with quality of care	38	14.5
Support of family, friends or peers	57	21.8
Overcoming stigma of having a substance use disorder or people finding out	16	6.1
Other	25	9.5
Use EDCC reports to identify Medicaid members in the ED due to an overdose		
Yes	105	37.6
No	37	13.3
Don't know what EDCC reports are	137	49.1

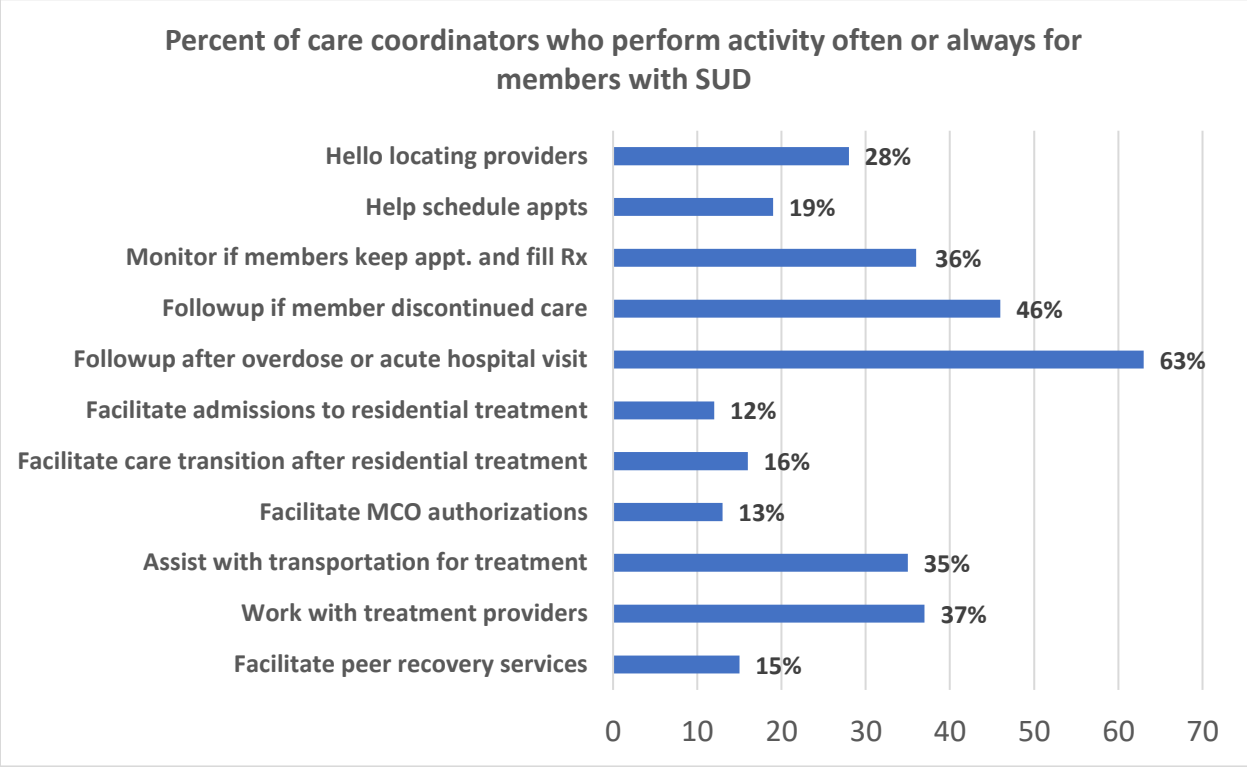
The survey also asked an open-ended question on the steps they take when they learn that a patient with SUD also has complex mental or physical health conditions. Below is a sampling of responses:

If the member is cooperative and will participate in care coordination, I assist member to schedule appointments and contact providers as needed. Education also plays a large role. Sometimes it is a chronic illness that will help member to get clean
We get notified of member admissions to EDCD program by the member's assigned CC or via the daily census. The CC will get notified of member and then refer to out EDCD LTSS program. Then I would pick up the member when admitted to the hospital or SNF
If pain is related to the chronic condition that must be addressed first. Using physical activity and medication management to engage them in their own health management at first. Frequent calls if receptive to contact.
Complete the face to face assessment to gather all information needed, set up ICT to collaborate with providers, staff the case with the team in rounds. Develop care plan with member and determine how frequently contact is needed.
Make sure that member reveals SUD to treating and prescribing physicians. Provide education about the danger of mixing prescription and recreational/street drugs. Part of our assessment asks the patient if we have their permission to share this kind of information with their primary care physician. If they say no- make that an ongoing goal to keep discussing and addressing barriers.
Address physical / mental health problems. A lot of members in pain self medicate with substances. Attempting to manage pain with pain specialist/peer supports etc. is beneficial.

Establishing a rapport with the member, completing an HRA assessment, developing service plan goals, and follow up.
Review clinical information when available (I rarely have access to discharge clinicals these days) to see if there is a treatment plan and/or follow-up appointments. Review the follow-up appointments with the member if I can get in contact with them for the post ER follow up call. Ensure member is aware of discharge appointments. Assess the member's understanding of their complex medical condition. Provide contact information for specialists if needed. Provide education re; the effects of alcohol or substance use on medication adherence, efficacy and possibility for adverse interactions. Review to see if member needs a referral to an internal program for chronic health conditions where a specialized care coordinator can discuss the specific impacts the alcohol or substance use have relative to the chronic or complex condition. New chronic conditions may require a triggering assessment and revision to the Plan of care and an ICT meeting
Review my concerns about worsening medical conditions if ongoing drug use. Review their level of support in the home and community and try and link to healthy supports. Provide hotlines for after hours.
There are a few facilities in this area who offer comprehensive care for SUD patients - they have providers on-site who can treat the whole person. This has been a valuable asset for this category of patients. I can also request a complex-care RN within the MCO to also follow the member's case to ensure all medical concerns are being addressed. Unfortunately, most of the time, I find when a patient has ongoing substance use disorder difficulty they remain less focused on the physical health needs and often engage in activities that continue to have a negative health effect.

Care coordinators provide a wide range of activities for members with SUD (see Figure 1). Among the activities they provide the most frequently include following up after an overdose or acute hospital visit (63%), follow up if the member discontinued care (46%), working with treatment providers (37%), monitor if members are keeping appointments and filling prescriptions (36%), and assist with transportation to treatment providers (35%).

Figure 1. Frequency of activities for members with SUD performed by care coordinators



The survey also asked an open-ended ended question on the specific steps that care coordinators take when they learn that a Medicaid member has been in the ED due to an overdose or SUD-related problem. Below are examples of these responses:

Refer to ARTS, facilitate a provider for follow up or outpatient treatment facility. Assist in gathering resources like food and housing.
I obtain the discharge summary from the facility to see what was done medically for the member to stabilize the member. I also follow up with the behavioral health provider that the member was referred to. I check to see if the provider is in-network and if the provider can provide the correct services that the member is in need of. I will contact the provider to offer a history and to assist with safe discharge planning.
I read the notes from transition coordinator and read any hospital records and I also sometimes call the facility. I always call member after discharge and attempt to do a triggering assessment.
Contact the medical staff.
Attempt to reach facility to discuss dc planning needs, attempt to reach member within 30 days following dc to discuss discharge appointments (would like to be able to reach out to member within one week but due to case load, its typically near the end of the 30 day period), reach out to case manager at CSB to inquire about member follow up if unable to reach member. No BH assistance within MCO other than providing case managers with directories of in network specialist (which our MCO Case managers already have access to therefore we very rarely reach out to our BH case management team any longer. If we attempt to refer a member to our ARTs/BH

care coordinators, we typically receive a message from our BH staff within the MCO stating that the ARTS/BH team will not accept the referral to work with the member due to the member NOT currently being enrolled in ARTS/BH services---which is the entire reason we were attempting to refer the member to the ARTs/BH team: for assistance connecting the member to BH/ARTS services).
Place call the member for follow up and offer assistance with locating services. Sometimes, I speak with providers at the ED to learn more about the nature of the problem
Talk to patient, assess motivation and desire for assistance. Provide education and information about substance abuse, specific dangers of their particular patterns of abuse, etc. Continue to track discussion and education despite initial resistance. If patient wants assistance, refer to health plan ARTS program and/or community services such as where to find 10-step programs.
Recommend psychiatric care services and help them find the services
Take case to high-risk rounds with Medical Director; contact and collaborate with outpatient and inpatient providers

Survey respondents also report a number of obstacles and barriers in assisting Medicaid members, including caseload size (58%), finding in-network providers for SUD treatment (38%), and delays in appointments or admissions to treatment facilities (37%) (findings not shown). A smaller percentage (17%) reported delays in authorization from the MCO for services as a barrier to treatment.

Overall Risk Assessment for Milestone 6: LOW

Table 28. Summary of Overall Risk of Not Achieving Milestone 6

% of monitoring metric goals met	% of Action items completed	Results from surveys and other evaluation analyses	Risk level	Independent assessor's recommendation if medium or high risk	State responses and planned modifications
77%	100%	ARTS member survey respondents report receiving help with other mental, physical, and social needs. Care coordinators report providing a wide range of activities for members with SUD.	Low	Not applicable	Not applicable

Discussion

This report assesses progress on the renewal of the ARTS demonstration. Initially approved in December, 2016 as an amendment to Virginia's section 1115 demonstration, "The Virginia Governor's Access Plan" (Project No. 11-W-00297/3), CMS approved a renewal of the ARTS program for a 5 year period from January 2020 through December 2024, as part of the "Building and Transforming Coverage, Services, and Supports for a Healthier Virginia" Demonstration (Project Number 11-W-00297/3).

The assessment was conducted based on the guidelines issued by CMS for conducting mid-point assessments for Section 1115 SUD Demonstrations. The primary source of information for the assessment was a review of critical metrics for the six milestones, as well as various action items undertaken by the state to accomplish the goals and objectives of the demonstration. In addition, we used results from the ongoing independent evaluation of the ARTS benefit being conducted by Virginia Commonwealth University, Department of Health Behavior and Policy, to complement the findings from critical metrics, provide more context to the findings, and to assess consistency with trends established prior to the renewal period. Specifically, we used information from the ARTS member survey conducted in 2020-21, the survey of MCO Care Coordinators conducted in 2021-2022, and analyses of buprenorphine waivered prescribers.

The table below summarizes progress on each milestone based on the findings of the assessment. In sum, our findings show that the state was at low risk of not achieving milestones 1-3, 5, and 6, and was at medium risk of not achieving milestone #4. For milestone #1 in particular, we observed large increases in the number of members receiving various SUD treatment services that were started, expanded, or enhanced as part of the ARTS Demonstration, including residential treatment services (16.6% increase between 2020 and 2021) and medication assisted treatment (21.9% increase between 2020 and 2021).

Table 29. Summary of Assessment of Risk on Milestones

Milestone	Critical metrics on target	Action items on target	Survey and other evaluation results	Risk Assessment
1. Access to Critical Levels of Care for OUD and other SUDS	6 of 7 (86%)	4 of 4 (100%)	Member survey self-reported access to SUD treatment relative to other health services	Low
2. Use of Evidence-Based, SUD-Specific Patient Placement Criteria	2 of 2 (100%)	4 of 4 (100%)	Member survey self-reported unmet need for residential treatment and other SUD services	Low
3. Residential and ASAM requirements	Not applicable	5 of 5 (100%)	Assessment by Manatt concluded that ARTS offered strong benefit that covered the full spectrum of ASAM levels of care	Low
4. Sufficient Provider Capacity at Each Level of Care	1 of 2 (50%)	5 of 5 (100%)	Despite increases, still fewer buprenorphine waivered prescribers relative to other states. Not every county has providers representing all ASAM levels of care.	Medium
5. Implementation of Comprehensive Treatment and Prevention Strategies	3 of 3 (100%)	4 of 4 (100%)	Member survey respondents report high levels of satisfaction with treatment providers and positive outcomes of treatment	Low
6. Improved Care Coordination and Transitions between Levels of Care	10 of 13 (77%)	3 of 3 (100%)	Member survey respondents report receiving help with other mental, physical, and social needs. Care coordinators report providing a wide range of activities for members with SUD.	Low

Greater access to and use of SUD treatment services should be consistent with reductions in misuse of opioids and adverse outcomes related to SUD, as shown in Milestone #5. Indeed, the use of opioids at high dosage decreased 28.8% between 2020 and 2021, concurrent use of opioids and benzodiazepines decrease 7.6%, while SUD-related ED visits decreased 6.2%.

It is possible that the increase in the number of members using treatment services may be in part an artifact of an increase in enrollment due to the Maintenance of Effort requirement, which required state Medicaid programs to suspend eligibility redeterminations during the federal Public Health Emergency (PHE) (which ended in May, 2023). While enrollment did increase during the PHE, analysis from the ongoing independent evaluation of the ARTS benefit for approximately the same time period showed that utilization of ARTS services on a per member basis also increased. In sum, the increase in utilization was not driven primarily by an increase in enrollment.

It is also possible that changes in other critical metrics between 2020 and 2021 were affected by the COVID-19 pandemic. Ideally, the baseline and follow up periods for the assessment would not have overlapped with the beginning of the pandemic, although there were few alternatives given the start of the renewal period on January 2020, and the availability of critical metric data only through 2021 for the purposes of this report. Nevertheless, we do not believe that the pandemic affected the change in metrics between the baseline and follow up periods to a significant degree. As evidence, the ARTS member survey showed few changes before and after the start of the pandemic on self-reported measures of access, utilization, quality, and outcomes among members with OUD.

Milestone 4 was the only milestone for which we assessed there was a medium risk for not achieving the milestone. Metric #13 (Provider Availability) decreased by 3.3% between 2020 and 2021, while MAT Provider Availability increased by only 1.3%. Evaluation analyses of the supply of buprenorphine waivered prescribers show that Virginia has a relatively low supply compared to other states, although similar to other states in the U.S. South that had not expanded Medicaid prior to 2017. With the increase in demand for ARTS services (and MAT in particular), there is an ongoing risk of provider shortages. We do note that the state has made considerable effort in recruiting and training SUD providers, and evaluation analyses has shown large gains in buprenorphine waivered provider supply since implementation of the ARTS benefit in 2017 and Medicaid expansion in 2019. In many respects, the state is still trying to catch up from the dearth of SUD treatment capacity that existed prior to the ARTS benefit. The lifting of the federal waiver requirement for prescribing buprenorphine may present new opportunities for the state to increase supply by attracting other practitioners who may have previously viewed the waiver requirement as an administrative barrier.

Overall, the findings in this report show positive gains on almost all of the milestones, and in most respects is a continuation of the gains in SUD treatment access, utilization, and the supply of treatment providers that was observed during

the original demonstration period. Reports from the independent ARTS evaluation shows that a major transformation of the Medicaid system for treating SUD has occurred through the ARTS demonstration, and that the combination of ARTS and Medicaid expansion has more than tripled the number of Medicaid members receiving treatment services through the ARTS benefit. Qualitatively, some providers have referred to ARTS as representing a major "cultural shift" in the state's approach to treating Medicaid members with SUD, with the expansion of services, increased payments, new forms of care delivery, and outreach and training to providers as signifying a major and ongoing commitment by the state to addressing SUD among some of its most vulnerable residents.[16]

The state also reported several opportunities for growth and improvement of the ARTS demonstration, including: (1) Strengthening the role of Medicaid for justice involved populations by working with the Department of Corrections to strengthen Medicaid enrollment processes and linkages to post-release care; (2) strengthening and evolving the current care coordination system by increasing information sharing and taking a more coordinated and consistent approach; (3) Increasing the use of peer recovery support services; (4) Working with MCOs and community-based organizations to address racial/ethnic disparities, and; (5) Advancing the use of telehealth for SUD treatment by building on the flexibilities implemented during the COVID-19 pandemic.

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Attachment 15

Virginia 1115 Demonstration

Virginia GAP Waiver Q4 2019 Quarterly Report

Medicaid Section 1115 SUD Demonstration Monitoring Report – Part B
[Virginia] [1115 Waiver]
[Demonstration Year] – [April 1, 2019-March 31, 2020]
[Reporting Period] – [October-December 31, 2019]
Submitted on [March 13, 2020]

1. Title Page for the State's SUD Demonstration or SUD Components of Broader Demonstration

The state should complete this Title Page at the beginning of a demonstration and submit as the title page of all SUD Monitoring Reports. The content of this l table should stay consistent over time.

State	*Virginia*
Demonstration name	*1115 Waiver*
Approval date for demonstration	*December 15, 2016*
Approval period for SUD	*December 15, 2016 through December 31, 2019.*
Approval date for SUD, if different from above	Click here to enter text.
Implementation date of SUD, if different from above	*April 1, 2017*
SUD (or if broader demonstration, then SUD - related) demonstration goals and objectives	*•Promote strategies to ID Medicaid individuals with SUD* *•Enhance clinical practices and promote guidelines and decision making tools for serving youth and adults with SUD* *•Build after care and recover supports (like recovery coaching)* *•Coordinate SUD treatment with Primary care and Long Term Care* *•Coordinate with other sources of local, state and federal funds for an efficient use of resources consistent with program objectives* *•Encourage increased use of quality and outcome measures to inform benefit design and payment models* *•Identify strategies to address prescription and illicit opioid addiction, consistent with efforts to curb epidemic.*

2. Executive Summary

The Department of Medical Assistance Services (DMAS) kicked off the Centers for Medicare and Medicaid Services (CMS) "Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act" grant activities by facilitating the first two of six regional World Cafés. Over 30 stakeholders participated in these World Cafés, which offer stakeholders the opportunity to participate in a conversational process for knowledge sharing pertaining to substance use disorder (SUD) treatment and recovery, concentrating on strengths and needs in their communities, with a focus on pregnant and parenting members and those member who are justice involved. DMAS is developing seven contracts for procurement to carry out SUPPORT Act grant activities.

DMAS collaborated with Virginia Commonwealth University (VCU) to complete the second year post-implementation evaluation of the ARTS benefit. The evaluation shows continued decreases in emergency department visits and acute inpatient admissions related to SUD between the first and second years of ARTS. Additional analysis shows the decrease in acute hospital use, for members with SUD, was significantly larger than compared to members with other health conditions. Treatment rates, including Medication Assisted Treatment (MAT), counseling, and case management services, continued to show increased rates of utilization; however, data might imply members receiving inpatient detoxification and short-term residential treatment may not have received follow-up care at a lower level of treatment within 30 days of discharge. DMAS will begin working to determine steps to improve transitions of care.

DMAS will begin to engage with external stakeholders including state agencies, providers and advocacy organizations to assess potential enhancements to the Peer Recovery Support Services (PRSS), as utilization has been lower than expected since implementation. The goal is to identify potential barriers and solutions to increase utilization of PRSS in residential, outpatient, and hospital settings, with a focus on improving transitions of care.

DMAS approved three new Preferred Office-Based Opioid Treatment (OBOT) programs to initiate integrated services to individuals with opioid use disorders. DMAS facilitated two Project ECHO platforms on best practices to provide care coordination within the Preferred OBOT model and appropriate utilization of the DMAS Preferred OBOT REDCap survey.

DMAS collaborated with Virginia Health Information to promote the application of the Emergency Department Care Coordination (EDCC) online platform that allows providers and managed care organizations (MCOs) to track members' with SUD utilization of hospitals and emergency facilities. Utilization of this platform allows for real time communication across providers and MCOs that promote continuity of care coordination for the member.

DMAS plans to facilitate MCO collaborative meetings aimed to foster communication and problem solving on common issues, including EDCC utilization, critical incident reporting and tracking, inpatient transitions of care for members leaving SUD residential treatment, and post inpatient discharge follow up.

3. Narrative Information on Implementation, by Milestone and Reporting Topic

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
1.2 Assessment of Need and Qualification for SUD Services			
1.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services.	*EXAMPLE: The number of beneficiaries with a SUD diagnoses treated in an IMD in the last quarter decreased by 5% due to the closure of one IMD in the state.*	*Insert the first measurement period in which the current trend (+ or – two percent) was reported.* *EXAMPLE: 01/01/2018-03/31/2018*	*Insert the metric related to the trend reported.* *EXAMPLE: #8: Medicaid beneficiaries with SUD diagnosis treated in an IMD*
☒ The state has no metrics trends to report for this reporting topic.			
1.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) The target population(s) of the demonstration ☐ ii) The clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration	*For implementation updates, insert annual or quarterly report in which the updated was first reported.* *EXAMPLE:* *ii) The state is expanding the clinical criteria to include X diagnoses.*	*Insert the measurement period in which the update was first reported.* *EXAMPLE:* *ii) 01/01/2018-03/31/2018*	*Insert the metric related to the reported update (if any) or write "N/A".* *EXAMPLE:* *ii) N/A*
☒ The state has no implementation update to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
☐ The state expects to make other program changes that may affect metrics related to assessment of need and qualification for SUD services	*EXAMPLE: The state projects an x% increase in beneficiaries with an SUD diagnosis due to an increase in the FPL limits which will be effective on X date.*	*EXAMPLE: 01/01/2019-03/31/2019*	*EXAMPLE: #6 and 7: Medicaid beneficiaries with SUD diagnosis (monthly)*
☒ The state has no implementation update to report for this reporting topic.			
2.2 Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)			
2.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1			
☒ The state has no metrics trends to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
2.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g. outpatient services, intensive outpatient services, medication assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management) ☐ ii) SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication assisted treatment services provided to individuals in IMDs			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 1			
☒ The state has no implementation update to report for this reporting topic.			
3.2 Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)			
3.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2			
☐ The state has no trends to report for this reporting topic.			
☒ The state is not reporting metrics related to Milestone 2.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
3.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria ☐ ii) Implementation of a utilization management approach to ensure (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, or (c) use of independent process for reviewing placement in residential treatment settings			
☐ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 2			
☐ The state has no implementation update to report for this reporting topic.			
☒ The state is not reporting metrics related to Milestone 2.			
4.2 Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)			
4.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3			
☐ The state has no trends to report for this reporting topic.			
☒ The state is not reporting metrics related to Milestone 3.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
4.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards ☐ ii) State review process for residential treatment providers' compliance with qualifications standards ☐ iii) Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site			
☐ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 3			
☐ The state has no implementation update to report for this reporting topic.			
☒ The state is not reporting metrics related to Milestone 3.			
5.2 Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)			
5.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4			
☒ The state has no trends to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
5.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ Planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 4			
☒ The state has no implementation update to report for this reporting topic.			
6.2 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)			
6.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 5			
☒ The state has no trends to report for this reporting topic.			
6.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD ☐ ii) Expansion of coverage for and access to naloxone			
☒ The state has no implementation update to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
☐ The state expects to make other program changes that may affect metrics related to Milestone 5			
☒ The state has no implementation update to report for this reporting topic.			
7.2 Improved Care Coordination and Transitions between Levels of Care (Milestone 6)			
7.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 6			
☒ The state has no trends to report for this reporting topic.			
7.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ Implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Milestone 6			
☒ The state has no implementation update to report for this reporting topic.			
8.2 SUD Health Information Technology (Health IT)			
8.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its Health IT metrics			
☒ The state has no trends to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
8.2.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☒ Use of Opioid Utilization-Members and Opioid Utilization-Providers report (dashboard reports from OTAAS Project) -Number of members, utilization rates, total #of prescriptions (member and provider), opioid days supply, total opioid cost ($) -Opioid measures stratified by cities and counties and by age groups ☒ Monthly updates of the ARTS provider network submitted by the managed care organizations are de-duplicated and uploaded in a google map dedicated to show providers by the American Society of Addiction Medicine (ASAM) Level of Care. ☒ Use of OTAAS data to measure Peer Recovery Support Services utilization. -Number of members and claims for Peer Recovery Support Services using relevant procedure codes (T1012 and S9445). -Analyze the use of Peer Recovery Support Services and utilization in conjunction with other services.	The state is unable to report as required to the size of the document. The dashboards are visualizations with interactive features that present lots of data in a compact form. The state can export parts of the dashboard to pdf and upload separately with the workbook.		
☒ The state has no implementation update to report for this reporting topic.			
☐ The state expects to make other program changes that may affect metrics related to Health IT			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
☒ The state has no implementation update to report for this reporting topic.			
9.2 Other SUD-Related Metrics			
9.2.1 Metric Trends			
☐ The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to other SUD-related metrics			
☒ The state has no trends to report for this reporting topic.			
9.2.2 Implementation Update			
☐ The state expects to make other program changes that may affect metrics related to other SUD-related metrics			
☒ The state has no implementation update to report for this reporting topic.			
10.2 Budget Neutrality			
10.2.1 Current status and analysis			
☐ If the SUD component is part of a broader demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality as a whole. Describe the current status of budget neutrality and an analysis of the budget neutrality to date.			
10.2.2 Implementation Update			
☐ The state expects to make other program changes that may affect budget neutrality			
☒ The state has no implementation update to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
11.1 SUD-Related Demonstration Operations and Policy			
11.1.1 Considerations			
☐ States should highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively affect beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.			
☒ The state has no related considerations to report for this reporting topic.			
11.1.2 Implementation Update			
Compared to the demonstration design and operational details, the state expects to make the following changes: ☐ i) How the delivery system operates under the demonstration (e.g. through the managed care system or fee for service) ☐ ii) Delivery models affecting demonstration participants (e.g. Accountable Care Organizations, Patient Centered Medical Homes) ☐ iii) Partners involved in service delivery			
☒ The state has no implementation update to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
☐ The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities			
☒ The state has no implementation update to report for this reporting topic.			
☐ The state is working on other initiatives related to SUD or OUD			
☒ The state has no implementation update to report for this reporting topic.			
☐The initiatives described above are related to the SUD or OUD demonstration (States should note similarities and differences from the SUD demonstration)			
☒ The state has no implementation update to report for this reporting topic.			
12. SUD Demonstration Evaluation Update			
12.1. Narrative Information			
☒ Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.			
☐ The state has no SUD demonstration evaluation update to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
☒ Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.	The state received all monthly deliverables due from the managed care organizations timely throughout the quarterly reporting period. When reporting appeals and grievances data the state will need to revise current MCO reporting requirements to separate out grievances from appeals as they are currently reported together. The state has updated the reporting specifications for MCOs and will be able to report separated data during the second quarter of 2020 reporting period.	*04/01/2017-03/31/2018*	*33 & 34*
☒ The state has no SUD demonstration evaluation update to report for this reporting topic.			
☐ List anticipated evaluation-related deliverables related to this demonstration and their due dates.			
☐ The state has no SUD demonstration evaluation update to report for this reporting topic.			
13.1 Other Demonstration Reporting			
13.1.1 General Reporting Requirements			
☐ The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol			
☒ The state has no updates on general requirements to report for this reporting topic.			
☐ The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes			
☒ The state has no updates on general requirements to report for this reporting topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
Compared to the demonstration design and operational details, the state expects to make the following changes to: ☐ i) The schedule for completing and submitting monitoring reports ☐ ii) The content or completeness of submitted reports and/or future reports			
☒ The state has no updates on general requirements to report for this reporting topic.			
☐ The state identified real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation			
☒ The state has no updates on general requirements to report for this reporting topic.			
13.1.2 Post-Award Public Forum			
☐ If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual report.			
☒ No post-award public forum was held during this reporting period and this is not an annual report, so the state has no post-award public forum update to report for this topic.			

Prompt	State response	Measurement period first reported (MM/DD/YYYY - MM/DD/YYYY)	Related metric (if any)
14.1 Notable State Achievements and/or Innovations			
14.1 Narrative Information			
☐ Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.			
☒ The state has no notable achievements or innovations to report for this reporting topic.			

Note: Licensee and states must prominently display the following notice on any display of Measure rates:

The IET-AD, FUA-AD, FUM-AD, and AAP measures (metrics #15, 17 (1), and 17 (2), and 32) are Healthcare Effectiveness Data and Information Set ("HEDIS®") measures that are owned and copyrighted by the National Committee for Quality Assurance ("NCQA"). NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications.

The measure specification methodology used by CMS is different from NCQA's methodology. NCQA has not validated the adjusted measure specifications but has granted CMS permission to adjust. Calculated measure results, based on the adjusted HEDIS specifications, may be called only "Uncertified, Unaudited HEDIS rates."

Certain non-NCQA measures in the CMS 1115 Substance Use Disorder Demonstration contain HEDIS Value Sets (VS) developed by and included with the permission of the NCQA. Proprietary coding is contained in the VS. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of the VS with the non-NCQA measures and any coding contained in the VS.

Attachment 16

Virginia 1115 Demonstration

Notice of Application posted on
Virginia Regulatory Town Hall

Attachment 17

Virginia 1115 Demonstration
Emails Sent to Electronic Mailing Lists

Attachment 18

Virginia 1115 Demonstration
Comments received from Public on Application

Attachment 19

Virginia 1115 Demonstration

DMAS' Response to Comments received from Public on Application

Attachment 20

Virginia 1115 Demonstration
Original and Updated Tribal Consultations

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CHERYL ROBERTS
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219

March 27, 2024

Cheryl Roberts, Director
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

SUBJECT: Notice of Opportunity for Tribal Comment – Building and Transforming Coverage, Services, and Supports for a Healthier Virginia 1115 Demonstration Renewal

Dear Tribal Leader:

This letter is to notify you that the Department of Medical Assistance Services (DMAS) is planning to submit a renewal with the Centers for Medicare and Medicaid Services (CMS) for the "Building and Transforming Coverage, Services, and Supports for a Healthier Virginia" 1115 Demonstration. With this application (link to full text) Virginia seeks to extend the substance use disorder (SUD) institutions of mental disease (IMD) and Former Foster Care Youth (FFCY) components the Commonwealth's current 1115 demonstration. The "High Needs Supports" component of this 1115 Demonstration that consisted of housing and employment supports was not implemented as no funding was allotted due to competing priorities during the COVID-19 public health emergency. Therefore, DMAS is requesting to sunset the "High Needs Supports" benefit. DMAS will continue to collaborate with stakeholders and the Virginia legislature to pursue appropriations for a new benefit package at a future date. The SUD IMD and FFCY components of this 1115 demonstration is currently set to expire on December 31, 2024. Therefore, this demonstration extension, Virginia's demonstration "Building and Transforming Coverage, Services, and Supports for a Healthier Virginia" will:

- Continue to provide essential SUD services to all Medicaid enrollees, including those in an IMD, through the Medicaid benefit;
- Maintain authority for coverage of FFCY who aged out of foster care in another state and turned 18 prior to January 1, 2023;
- Sunset the High Needs Supports components of the demonstration.

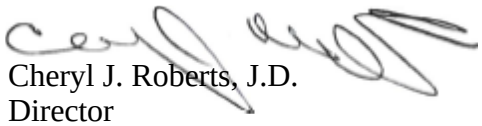
42 CFR 431.408 requires for applications extending existing demonstration projects that have a direct effect on Indians, tribes, Indian health programs, and urban Indian health organizations in the State, the State must demonstrate that it has conducted consultation activities with tribes and sought advice from Indian health programs and urban Indian health organizations prior to submission of such application. The federal rules provide for a 30-day public notification and comment period for these types of applications. DMAS intends to submit the proposed renewal to CMS no later than June 30, 2024, and asks that comments related to this notice be provided no later than the end of the day on May 26, 2024.

You may submit your comments directly to Ashley Harrell, Senior Program Advisor, Behavioral Health Division, by phone (804) 972-5406, or via email: Ashley.Harrell@dmas.virginia.gov If you prefer regular mail you may send your comments or questions to:

Virginia Department of Medical Assistance Services
1115 Demonstration Waiver, Tribal Comment
Attn: Ashley Harrell
600 East Broad Street
Richmond, VA 23219

Please forward this information to any interested party.

Sincerely,



Cheryl J. Roberts, J.D.
Director

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CHERYL ROBERTS
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219

May 30, 2024

Cheryl Roberts, Director
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

SUBJECT: Notice of Opportunity for Tribal Comment – Building and Transforming Coverage, Services, and Supports for a Healthier Virginia 1115 Demonstration Renewal

Dear Tribal Leader:

On March 27, 2024, the Department of Medical Assistance Services (DMAS) sent you a letter notifying you that DMAS was planning to submit a renewal application with the Centers for Medicare and Medicaid Services (CMS) for the "Building and Transforming Coverage, Services, and Supports for a Healthier Virginia" 1115 Demonstration.

DMAS has made significant updates to the application, and the revised application is being re-posted for public comment. Please go to 1115 Demonstration Waiver | Virginia Medicaid to view more information about the renewal, including a full copy of the public notice and a full copy of the draft application.

With this application, DMAS is requesting that CMS extend for five years the existing 1115 Demonstration (which is scheduled to expire on December 31, 2024) to:

- Continue to provide substance use disorder (SUD) benefits, including SUD treatment services to Medicaid beneficiaries who are short-term residents in residential treatment facilities that meet the definition of an Institution for Mental Disease (IMD).

- Update the authority to specify that DMAS provides Medicaid coverage for former foster care youth up to age 26 who aged out of foster care in another state and now reside in Virginia, provided the member turned 18 *prior* to January 1, 2023.

- Sunset the High Needs Supports benefits that consisted of housing and employment

supports, which was not implemented as no funding was allotted due to competing priorities during the COVID-19 public health emergency. DMAS will continue to collaborate with stakeholders and the Virginia legislature to pursue appropriations for a new benefit package at a future date.

DMAS intends to submit the proposed renewal to CMS no later than July 31, 2024, and asks that comments related to this notice be provided no later than 11:59 p.m. on June 29, 2024. All comments will be reviewed and summarized in the final application that is submitted to CMS.

You may submit your comments directly to Jason Lowe, Behavioral Health Integration Advisor, Behavioral Health Division, by phone (804) 659-8732, or via email: Jason.Lowe@dmas.virginia.gov If you prefer regular mail, you may send your comments or questions to:

Virginia Department of Medical Assistance Services
1115 Demonstration Waiver, Tribal Comment
Attn: Jason Lowe
600 East Broad Street
Richmond, VA 23219

Please forward this information to any interested party.

Sincerely,

Cheryl J. Roberts, JD
Director

Attachment 21

Virginia 1115 Demonstration
Full Public Notice

Building and Transforming Coverage, Services, and Supports for a Healthier Virginia 1115 Demonstration Renewal

Pursuant to 42 CFR §431.408, notice is hereby given that the Virginia Department of Medical Assistance Services (DMAS) is seeking to extend for five years its Medicaid Section 1115 Demonstration entitled "Building and Transforming Coverage, Services, and Supports for a Healthier Virginia." (No. 11-W-0029713).

The demonstration is scheduled to expire on December 31, 2024. Through this amendment, Virginia is requesting a five-year extension in order to:

- Continue to provide to provide short-term residential substance use disorder (SUD) treatment services in facilities that meet the definition of an "Institution for Mental Disease" (IMD).
- Continue to provide Medicaid coverage for former foster care youth and children (FFCY) up to age 26 who aged out of foster care in another state and now reside in Virginia. The demonstration will be updated to reflect that this coverage will apply to individuals who turned 18 prior to January 1, 2023, as individuals who turned 18 after that date are now covered under the State Plan.
- Sunset the High Needs Supports benefits because the Virginia General Assembly has not provided funding to implement these services.

These changes reflect the limits of existing state authority for this demonstration waiver.

DMAS is providing an opportunity for the public to review and provide input on the Demonstration amendment application from May 30, 2024 through June 29, 2024. To view the draft renewal application, please visit the DMAS website at [http://www.dmas.virginia.gov/#/1115waiver].

A. **The program description, goals, and objectives to be implemented or extended under the demonstration project, including a description of the current or new beneficiaries who will be impacted by the demonstration.**

On December 30, 2019, the Centers for Medicare and Medicaid Services (CMS) approved a five-year extension of Virginia's Medicaid demonstration, Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation (Project Number 11-W-0029713). Under the approved Special Terms and Conditions (STCs) DMAS provides SUD benefits to Medicaid beneficiaries, including SUD treatment services provided to individuals who are short-term residents in residential treatment facilities that meet the definition of an IMD. Virginia also provides coverage to FFCY up to age 26 who aged out of foster care in another state and now reside in Virginia.

On July 9, 2020, CMS approved Virginia's request to provide a High Needs Support benefit that included supportive employment and housing as a new Medicaid feature within Virginia's 1115 demonstration extension application, otherwise approved on December 30, 2019. CMS also approved the section 1115 demonstration name change from Addiction and Recovery Treatment Services Delivery System Transformation to

Building and Transforming Coverage, Services, and Supports for a Healthier Virginia to better encompass the current ARTS and former foster youth coverage provisions, the new High Needs Supports program and any potential future programs.

This demonstration extension will continue the ARTS program, whereby DMAS will continue to provide SUD benefits to Medicaid beneficiaries, including SUD treatment services provided to individuals who are short-term residents in residential treatment facilities that meet the definition of an IMD. In Virginia, the ARTS benefit provides access to a full continuum of care for SUD treatment based on the American Society of Addition Medicine (ASAM) criteria to ensure Medicaid members with substance use disorders are matched to the right level of care to meet their evolving needs as they enter and pass through treatment. This includes expanded outpatient and community-based addiction and recovery treatment services and coverage of inpatient detoxification and residential substance use disorder treatment.

This demonstration will also update the authority to specify that Virginia provides Medicaid coverage for former foster care youth (FFCY) up to age 26 who aged out of foster care in another state and now reside in Virginia (provided the member turned 18 prior to January 1, 2023).

Finally, DMAS is proposing to sunset the High Needs Supports benefits because the Virginia General Assembly has not provided funding that has enabled these services to be implemented. These services were planned to include:

- A work and community engagement program for certain adult populations;
- A Health and Wellness program that included premiums and cost-sharing designed to promote healthy behavior for certain adult populations between 100 and 138 percent of the federal poverty level; and
- A housing and employment supports benefit for high-need populations.

B. Proposed health care delivery system and eligibility requirements, benefit coverage and cost sharing (premiums, co-payments and deductibles) required of individuals that will be impacted by the demonstration, and how such provisions vary from the State's current program features

Demonstration Eligibility - ARTS

The Medicaid eligibility groups affected by this portion of the demonstration are illustrated in the table below. State plan groups derive their eligibility through the Medicaid state plan, and coverage for these groups is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as waived in this demonstration.

Medicaid Eligibility Groups Affected by the Demonstration			
Demonstration	**Eligibility Group**	**Citations**	**Income Level**

Feature			
Addiction and Recovery Treatment Services (ARTS)	New adult group	• 1902(a)(10)(A)(i)(VIII) • 42 CFR 435.119	133% FPL
	Aged, blind, and disabled	• 42 CFR 435.121	80% FPL
	Parents and other caretaker relatives	• 1902(a)(10)(A)(i)(I) • 1931 (b) and (d) • 42 CFR 435.110	Group 1: $307/month (~24% FPL) Group 2: $402/month (~32%) Group 3: $603/month (~48%)
	Pregnant women	• 42 CFR 435.116	143% FPL
	Out of state FFCY	• Expenditure Authority • 1902(a)(10)(A)(i)(IX)	N/A, no income limit
	Children with Title IV-E adoption assistance, foster care, or guardianship care	• 473(b)(1) • 1902(a)(10)(A)(i)(I) • 42 CFR 435.145	N/A, no income limit.
	Children under age 19	• 1902(a)(10)(A)(ii)(XIV) • 1905(u)(2)(B) • 42 CFR 435.229 and 435.4	143% FPL
	Transitional medical assistance	• 1902(a)(52) • 1902(e)(l) • 1925(a)(b)(c) • 42 CFR 435.112	185% FPL
	Extended Medicaid due to spousal support collections	• 408(a)(11)(B) • 1902(a)(10)(A)(i)(I) • 1921(c) • 42 CFR 435.115	No limit so long as the reason the family no longer meets the income limit is due to increased spousal support.

	Former foster care youth up to age 26 who aged out of foster care in Virginia	• 42 CFR 435.150 • 1902(a)(10)(A)(i)(IX)	N/A, no income limit

Demonstration Benefits - ARTS

Virginia is not requesting any changes to the ARTS benefits as part of this extension. Beneficiaries who are eligible for the demonstration will receive the same benefits as set forth in the Medicaid state plan. Additionally, Virginia will provide the SUD benefits established under the ARTS portion of the demonstration. Specifically, Virginia will provide SUD treatment services to individuals who are short-term residents in residential treatment facilities that meet the definition of an IMD.

As illustrated in the Table below, these benefits include ASAM Levels of Care 3.1, 3.3, 3.5, and 3.7. Continuing these benefits will enable all of Virginia's 2.1 million Medicaid enrollees[1] to continue to have access to the full continuum of ARTS services.

ASAM Level of Care	ASAM Description
3.1	Clinically Managed Low Intensity Residential
3.3	Clinically managed Population-Specific High Intensity Residential
3.5	Clinically Managed High Intensity Residential Services (Adults) Clinically Managed Medium Intensity Residential Services (Adolescents)
3.7	Medically Monitored Intensive Inpatient Services (Adults) – only for services provided in a residential setting. (Does not include services provided in an inpatient setting.) Medically Monitored High-Intensity Inpatient Services (Adolescents) – only for services provided in a residential setting. (Does not include services provided in an inpatient setting.)

Demonstration Cost-Sharing Requirements - ARTS

Cost sharing requirements do not differ from the Medicaid State Plan.

[1] DMAS Monthly Enrollment Report (virginia.gov)

Delivery System and Payment Rates for Services - ARTS

Virginia is not requesting any changes to the delivery system or payment rates as part of this extension. The health care delivery system for demonstration participants is no different than the delivery system in place for the Virginia Medicaid population. The demonstration will utilize the current statewide managed care delivery system and fee-for-service delivery system. Beneficiaries may be enrolled in FFS prior to being enrolled into managed care.

Payment rates for residential treatment services provided under the demonstration are illustrated in the table below.

ASAM Level of Care	ASAM Description	Current Rate (subject to change for future dates)
3.1	Clinically Managed Low Intensity Residential	1 unit = 1 day Current rate of $196.88 set on 7/1/21
3.3	Clinically managed Population-Specific High Intensity Residential	1 unit = 1 day Rates are based on individual considerations. Maximum daily rate for PRTFs = $460.89 Maximum daily rate for other residential facilities = $518.86
3.5	Clinically Managed High Intensity Residential Services (Adults) Clinically Managed Medium Intensity Residential Services (Adolescents)	1 unit = 1 day Rates are based on individual considerations. Maximum daily rate for PRTFs = $460.89 Maximum daily rate for other residential facilities = $518.86
3.7	Medically Monitored Intensive Inpatient Services (Adults) – only for services provided in a residential setting. (Does not include services provided in an inpatient setting.) Medically Monitored High-Intensity Inpatient Services (Adolescents) – only for services provided in a residential setting.	1 unit = 1 day Rates are based on individual considerations. Maximum daily rate for PRTFs = $460.89 Maximum daily rate for other residential facilities = $518.86

	(Does not include services provided in an inpatient setting.)	

Demonstration Eligibility - FFCY
The population affected by this demonstration is FFCY who are under age 26 who were in foster care under the responsibility of another state and enrolled in Medicaid at age 18 or when they "aged out," and moved to Virginia and are not eligible in any other mandatory Medicaid group. The demonstration extension seeks to update the authority to specify that the FFCY has to have turned 18 years old prior to January 1, 2023. There is no income or resource test for this group.

Eligibility Chart Mandatory State Plan Groups

Eligibility Group	Social Security Act and CFR Citations	Income level
FFCY up to age 26 who aged out of foster care in another state and now reside in Virginia, provided the member turned 18 prior to January 1, 2023	1115 Demonstration	N/A

Standards and methodologies do not differ from what is already in the Virginia State Plan for Medical Assistance. The projected number of individuals who will be eligible for the demonstration is approximately 86 per month. The projection is based on the current number of enrollees under the Medicaid State Plan. There are no changes to eligibility procedures for this population.

Demonstration Benefits and Cost-Sharing Requirements - FFCY
Benefits provided to the FFCY population are the same benefits provided to Virginia's current Medicaid population under the State Plan. Cost sharing requirements do not differ from the Medicaid State Plan.

Delivery System and Payment Rates for Services - FFCY
The health care delivery system for demonstration participants is no different than the delivery system in place today for the Virginia Medicaid population. The demonstration will utilize the current statewide managed care delivery system and fee-for-service (FFS) delivery system. Beneficiaries may be enrolled in FFS prior to being enrolled into managed care.

C. **Estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary**

data, if applicable. This includes a financial analysis of any changes to the demonstration requested by the State in its extension request

The Tables below summarize historic and projected enrollment and expenditure data.

Historical ARTS Data Without Waiver

	DY5	**DY 6**	**DY 7**	**DY 8**	**DY 9**
Member Months	1,090	711	1,354	1,354	5,980
Per Member Per Month (PMPM)	$3,909.24	$3,315.77	$4,341.16	$4,341.16	$4,429.18
Total Expenditures	$4,261,076	$2,357,512	$5,877,936	$5,877,936	$26,486,471

Historical ARTS Data With Waiver

	DY5	**DY 6**	**DY 7**	**DY 8**	**DY 9**
Member Months	1,090	711	1,354	1,354	5,980
Per Member Per Month (PMPM)	$3,909.24	$3,315.77	$4,341.16	$4,341.16	$4,429.18
Total Expenditures	$4,261,076	$2,357,512	$5,877,936	$5,877,936	$26,486,471

ARTS Program Projections Without Waiver

	DY 11	**DY 12**	**DY 13**	**DY 14**	**DY 15**
Member Months	7,118	7,262	7,410	7,560	7,713
Per member Per Month (PMPM)	$5,469.69	$5,625.89	$5,786.55	$5,951.80	$6,121.77
Total Expenditures	$38,933,253	$40,855,213	$42,878,336	$44,995,608	$47,217,212

ARTS Program Projections With Waiver

	DY 11	**DY 12**	**DY 13**	**DY 14**	**DY 15**
Member Months	7,118	7,262	7,410	7,560	7,713
PMPM	$5,469.69	$5,625.89	$5,786.55	$5,951.80	$6,121.77
Total Expenditures	$38,933,253	$40,855,213	$42,878,336	$44,995,608	$47,217,212

Historical Out-of-State FFCY Data Without Waiver

	DY5	**DY 6**	**DY 7**	**DY 8**	**DY 9**
Member Months	925	1,212	1,332	1,437	1,255
Per Member Per Month (PMPM)	$631.86	$586.96	$549.83	$647.45	$960.75
Total Expenditures	$584,474	$711,400	$732,378	$930,391	$1,205,737

Historical Out-of-State FFCY Data With Waiver

	DY5	**DY 6**	**DY 7**	**DY 8**	**DY 9**
Member Months	925	1,212	1,332	1,437	1,255
Per Member Per Month (PMPM)	$631.86	$586.96	$549.83	$647.45	$960.75
Total Expenditures	$584,474	$711,400	$732,378	$930,391	$1,205,737

Historical Out-of-State FFCY Enrollment Data

	DY 5	**DY 6**	**DY 7**	**DY 8**	**DY 9**
FFCY Members from Out of State	65	82	95	91	91

Out-of-State FFCY Projections Without Waiver

	DY 11	**DY 12**	**DY 13**	**DY 14**	**DY 15**
Member Months	1,964	2,164	2,383	2,625	2,892
Per Member Per Month (PMPM)	$768.26	$800.92	$834.97	$870.46	$907.47
Total Expenditures	$1,509,112	$1,732,948	$1,989,985	$2,285,146	$2,624,087

Out-of-State FFCY Projections-With Waiver

	DY 11	**DY 12**	**DY 13**	**DY 14**	**DY 15**
Member Months	1,964	2,164	2,383	2,625	2,892
Per Member Per Month (PMPM)	$768.26	$800.92	$834.97	$870.46	$907.47
Total Expenditures	$1,509,112	$1,732,948	$1,989,985	$2,285,146	$2,624,087

D. **Hypothesis and evaluation parameters of the demonstration**

The hypothesis and evaluation parameters of the demonstration extension are outlined below.

ARTS

ARTS Benefit			
Hypothesis	**Evaluation Approach**	**Data Sources**	**Summary of Findings to Date**
The demonstration will increase the percentage of beneficiaries who are referred and engage in treatment for OUD and other SUDS.	Analyze changes in the supply of treatment providers as well as changes in rates of treatment initiation and engagement.	• Claims/MODRN • DEA list of waivered prescribers N-SSATS	• ARTS and Medicaid expansion have increased supply of waivered prescribers and other treatment providers • ARTS increased IET rates relative to other states
The demonstration will decrease the rate of emergency department and acute inpatient stays.	Analyze changes in SUD-related ED and inpatient use, use of ARTS services, and MOUD treatment rates	• Claims data • MODRN	• ARTS and Medicaid expansion increased utilization of all SUD treatment services. • ARTS decreased ED and acute inpatient use among members with SUD, relative to other members.

The demonstration will increase adherence to and retention in treatment	Analyze changes in continuity of MOUD treatment for members with OUD	• Utilization and cost data	• Continuity of MOUD treatment did not increase initially after ARTS, possibly due to changes in the characteristics of members receiving MOUD treatment
The demonstration will decrease the rate of readmissions to the same or higher level of care.	Analyze changes in readmissions to ASAM 3 and 4 levels of care, as well as number of members who receive follow-up care after ED visit and residential treatment	• Claims data • MODRN	• Analysis in progress
The demonstration will increase the percentage of beneficiaries with SUD who receive treatment for co-morbid conditions.	Analyze changes in use of preventive care, screening for HIV/HCV/HBV, counseling for mental health condition	• Claims data	• Analysis in progress
The demonstration will decrease the rate of overdose deaths due to opioids.	Analyze changes in the rate of fatal overdoses among people enrolled in Medicaid	• Cause of death data linked to Medicaid claims	• To be completed in 2024 when cause of death data become available
The demonstration will increase IMD SUD costs and outpatient SUD treatment costs and decrease SUD-related	Examine changes in spending on residential treatment services, other ARTS services, and SUD-related	• Medicaid claims and cost data	• Spending on residential treatment and other ARTS services has greatly increased after both ARTS and Medicaid expansion

emergency room visit and inpatient stay costs	ED and inpatient services		

The ARTS-related evaluation activities for the new demonstration period will include:

- A review of fatal overdose to examine trends related to Medicaid members versus fata overdoses that had no Medicaid involvement.
- A review of costs for SUD-related and non-SUD-related services, to identify potential trends in cost variations for different types of ARTS services (outpatient, residential, pharmacotherapy), as well as costs for SUD-related emergency department and acute care services.
- A comparison of Virginia versus other states on key measures such as MOUD treatment rates, continuity of pharmacotherapy, and use of other SUD-related services.

FFYC

Demonstration Goal 1: Expand access to Medicaid for former foster care youth who were in foster care and Medicaid in another state and are now applying for Medicaid in the Virginia					
Evaluation Component	Evaluation Question	Evaluation Hypotheses	Measure [Reported for each Demonstration Year]	Recommended Data Source	Analytic Approach
Process	Does the demonstration provide continuous health insurance coverage?	Beneficiaries will be continuously enrolled for 12 months.	Number of beneficiaries continuously enrolled/ total number of enrollees	Administrative data – enrollment data	Descriptive statistics (frequency and percentage)
	How did beneficiaries utilize health services?	Beneficiaries will access health services.	Number of beneficiaries who had an ambulatory care visit/ Total number of beneficiaries	Administrative data – Medicaid claims	Descriptive statistics (frequencies and percentages)

	Number of beneficiaries who had an emergency department visit/ Total number of beneficiaries	
	Number of beneficiaries who had an inpatient visit/ Total number of beneficiaries	
	Number of beneficiaries who had a behavioral health encounter /Total number of beneficiaries	

E. **Specific waiver and expenditure authorities that the State believes to be necessary to authorize the demonstration**

The specific waiver and expenditure authorities Virginia requests include:

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver Request?
§1902(a)(8) and §1902(a)(10) Provision of Medical Assistance and Eligibility	To limit the state plan group coverage to former foster care youth who were in Medicaid and foster care in a different state	Yes

Expenditures related to ARTS	Expenditures not otherwise eligible for federal financial participation may be claimed for otherwise covered services furnished to otherwise eligible individuals (eligible under the State Plan or Former Foster Care Youth components of this demonstration), including services for individuals who are short-term residents in facilities that would otherwise meet the definition of an Institute of Mental Disease (IMD) for the treatment of SUD and withdrawal management.	Yes

ii. Location and Internet address where copies of the demonstration application are available for public review and comment

Copies of the demonstration application are available for public review and comment on the Demonstration page of the DMAS website at:
http://www.dmas.virginia.gov/#/1115waiver

iii. Postal and Internet email addresses where written comments may be sent and reviewed by the public, and the minimum 30-day time period in which comments will be accepted

The public can provide comment on the demonstration application at the Virginia Regulatory Town Hall, available here:

Comments can also be submitted via postal mail, telephone, and email to:

Virginia Department of Medical Assistance Services
Building and Transforming Coverage, Services, and Supports for a Healthier Virginia Demonstration Renewal
Attn: Jason Lowe
600 East Broad Street
Richmond, VA 23219
804-659-8732
jason.lowe@dmas.virginia.gov

The 30-day time period in which comments will be accepted is May 30, 2024 through 11:59 pm on June 29, 2024.

iv. The location, date and time of at least two public hearings convened by the State to seek public input on the demonstration application

Two public hearings will be held to seek public input on the demonstration application. These meetings satisfy the requirements of 42 CFR 431.408 (a)((3)(iv).

The details of the hearings are as follows:

Public Hearing #1:
Board of Medical Assistance Services Meeting
Tuesday, June 18, 2024
10:00 am – 12:00 pm
In person attendance: Conference Rooms 102 A&B, 600 East Broad Street, Richmond, Virginia 23219
Virtual attendance:
https://covaconf.webex.com/weblink/register/rba760d03940653afe731b1cffd21c2e1
Christine Minnick, Child Welfare Program Specialist, and Jason Lowe, Behavioral Health Integration Advisor, will provide an overview of the Demonstration extension application during the Board of Medical Assistance Services public meeting. Individuals can also access this public meeting by teleconference and webinar. This meeting will be recorded and transcribed.

Public Hearing #2:
ARTS and Former Foster Care 1115 Renewal - Public Hearing
Wednesday, June 26, 2024
10:00-11:00 am
In-person attendance: Libbie Mill Library, LM Meeting Room, 2100 Libbie Lake East Street, Henrico, Virginia 23230
Virtual attendance: Meeting link. ID: 239 640 294 851, Passcode: fPKSG2
Dial in by phone: +1 434-230-0065 Phone conference ID: 641 906 294#
Christine Minnick, Child Welfare Program Specialist, and Jason Lowe, Behavioral Health Integration Advisor, will provide an overview of the Demonstration extension application to individuals who are invited to attend in-person, by teleconference, and by webinar. This meeting will be recorded.

Public Comment

The 30-day public comment period for the demonstration is from May 30, 2024 to June 29, 2024. All comments must be received by 11:59 p.m. (Eastern Time) on June 29, 2024.

Public comments may be submitted via the Virginia Regulatory Town Hall public comment page at this link: https://townhall.virginia.gov/L/Forums.cfm (Scroll down to the Department of Medical Assistance Services and click on “View and Enter Comments.”)

Comments may also be submitted by e-mail to jason.lowe@virginia.gov or by regular mail or in person at the address below.

Virginia Department of Medical Assistance Services
Building and Transforming Coverage, Services, and Supports for a Healthier Virginia

Demonstration Renewal
Attn: Jason Lowe
600 East Broad Street
Richmond, VA 23219

After considering public comments about the proposed demonstration renewal application, DMAS will make final decisions about the demonstration and submit a revised application to CMS. The summary of comments, as well as copies of written comments received, will be posted for public viewing on the DMAS website along with the demonstration extension application when it is submitted to CMS.

Information regarding the “Building and Transforming Coverage, Services, and Supports for a Healthier Virginia” Renewal Application can be found on the DMAS website at http://www.dmas.virginia.gov/#/1115waiver. DMAS will update this website throughout the public comment and application process.

For more information about the “Building and Transforming Coverage, Services, and Supports for a Healthier Virginia” Demonstration, which the Commonwealth is seeking to extend, please visit the CMS website at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83451.

Section 1115 of the Social Security Act gives the U.S. Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of Medicaid and the Children’s Health Insurance Program (CHIP). Under this authority, the Secretary may waive certain provisions of Medicaid or CHIP to give states additional flexibility to design and improve their programs. To learn more about Section 1115 demonstrations, please visit the CMS website at https://www.medicaid.gov/medicaid/section-1115-demo/index.html.

Contact Information

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