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

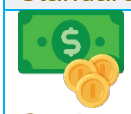
The Quality Strategy is intended to guide Virginia's Medicaid managed care program by establishing clear goals to drive improvements in care delivery and outcomes, and the metrics by which progress will be measured. The Quality Strategy sets a clear direction for priority interventions and details the 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.

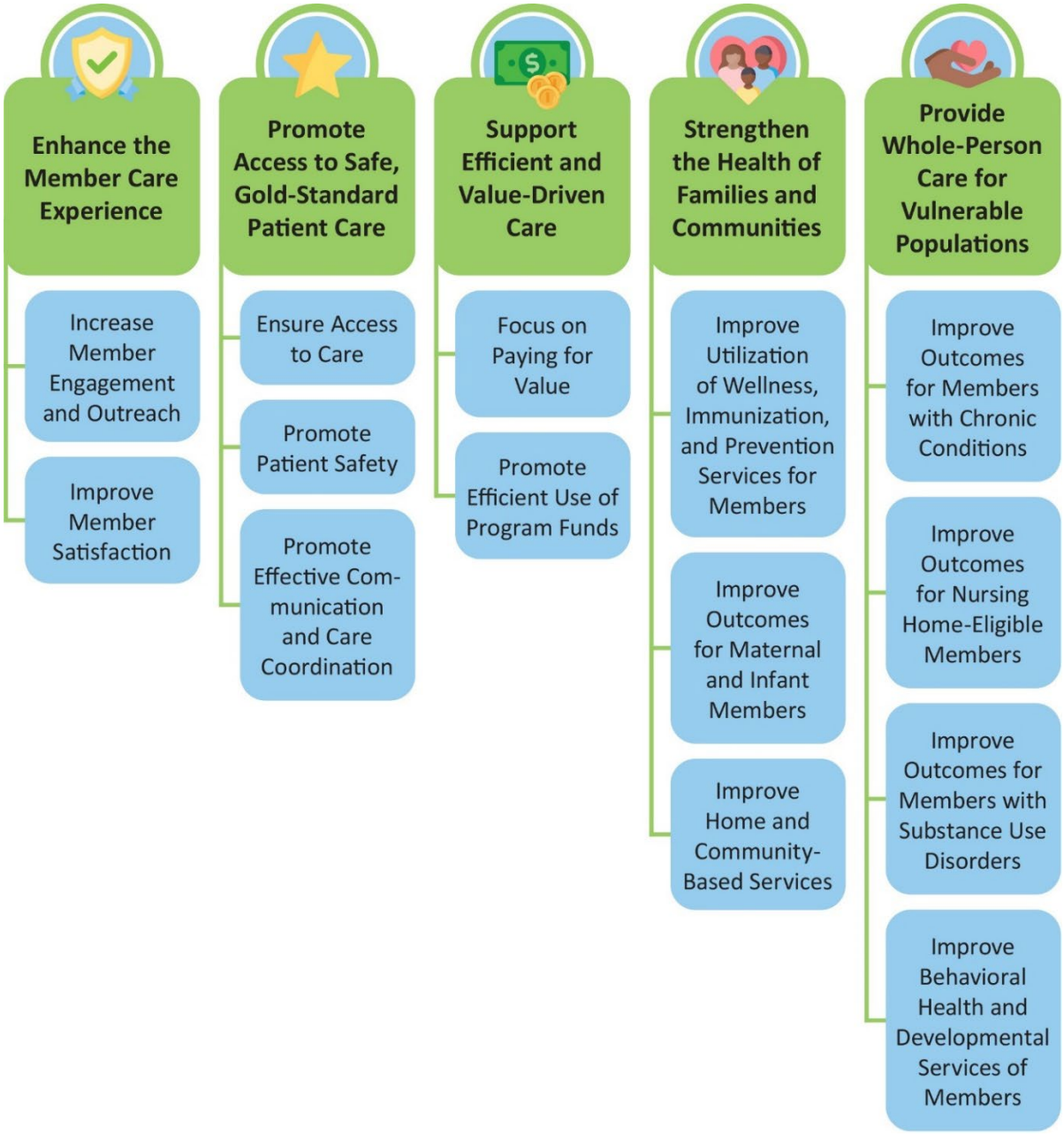
The DMAS Quality Strategy aligns with the NQS, which was launched on April 12, 2022.[5] The NQS includes three aims: Better Care, Healthy People/Healthy Communities, and Affordable Care. To advance these aims, the NQS focuses on seven priorities: safer care, patient engagement, communication, care coordination, 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



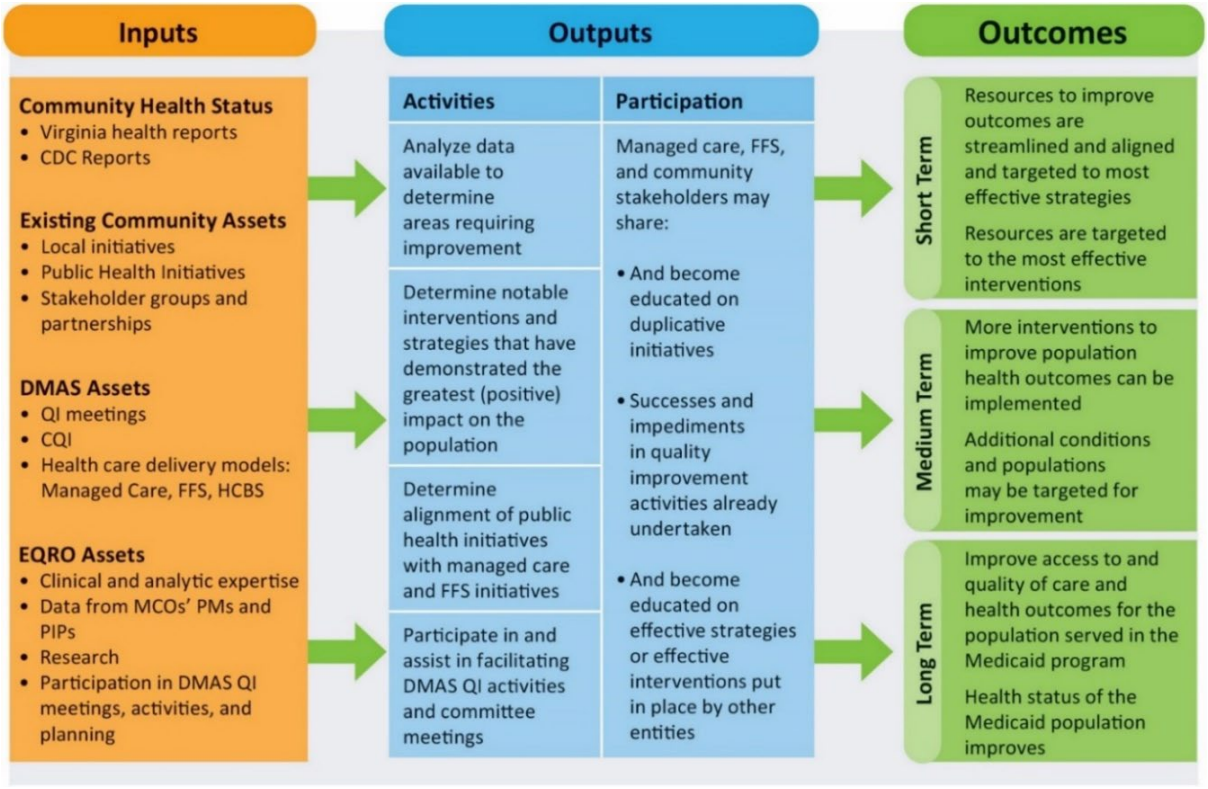
Strategy for Meeting Goals

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.

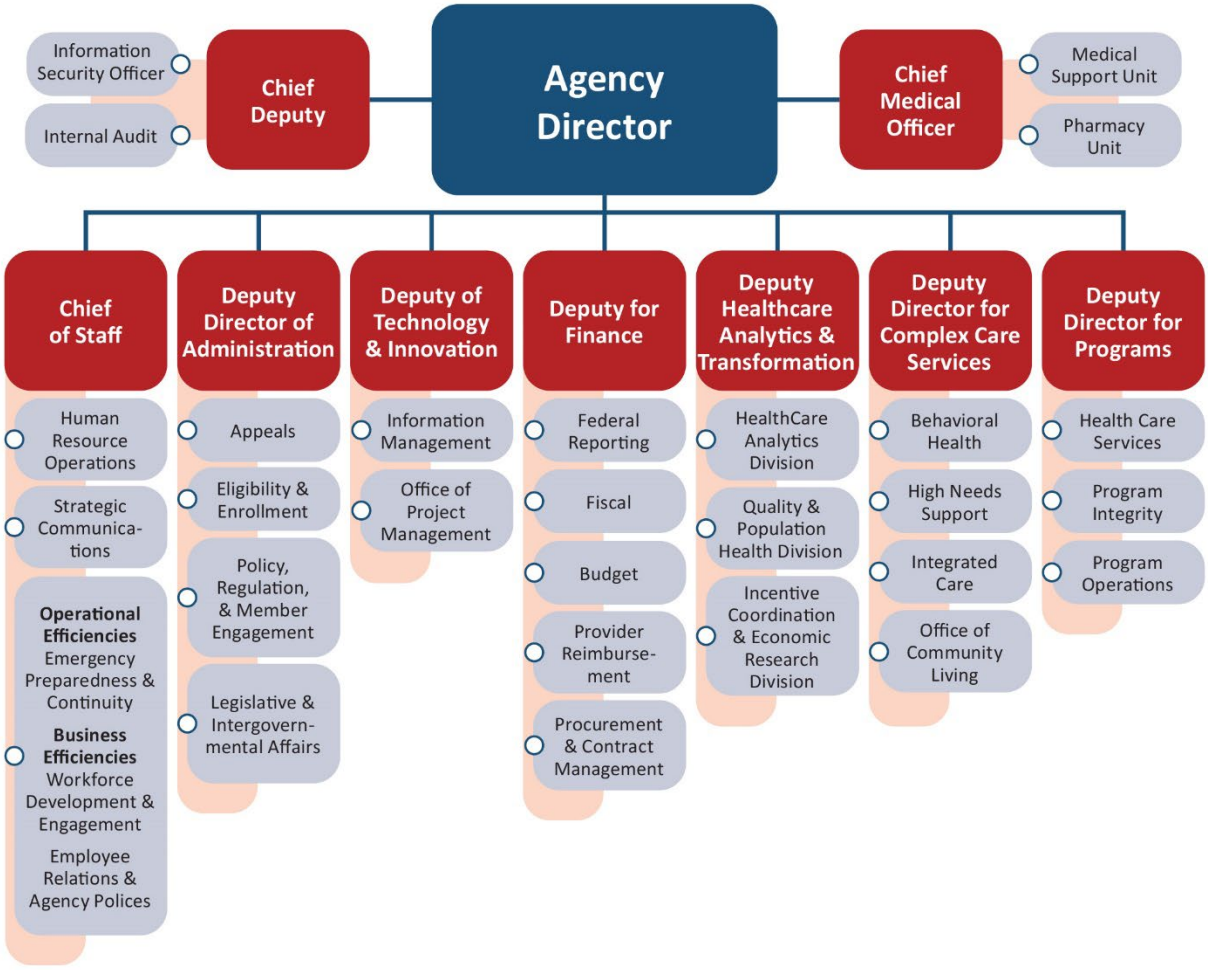
DMAS maintains the following values while operating its mission to the Commonwealth:

- ***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

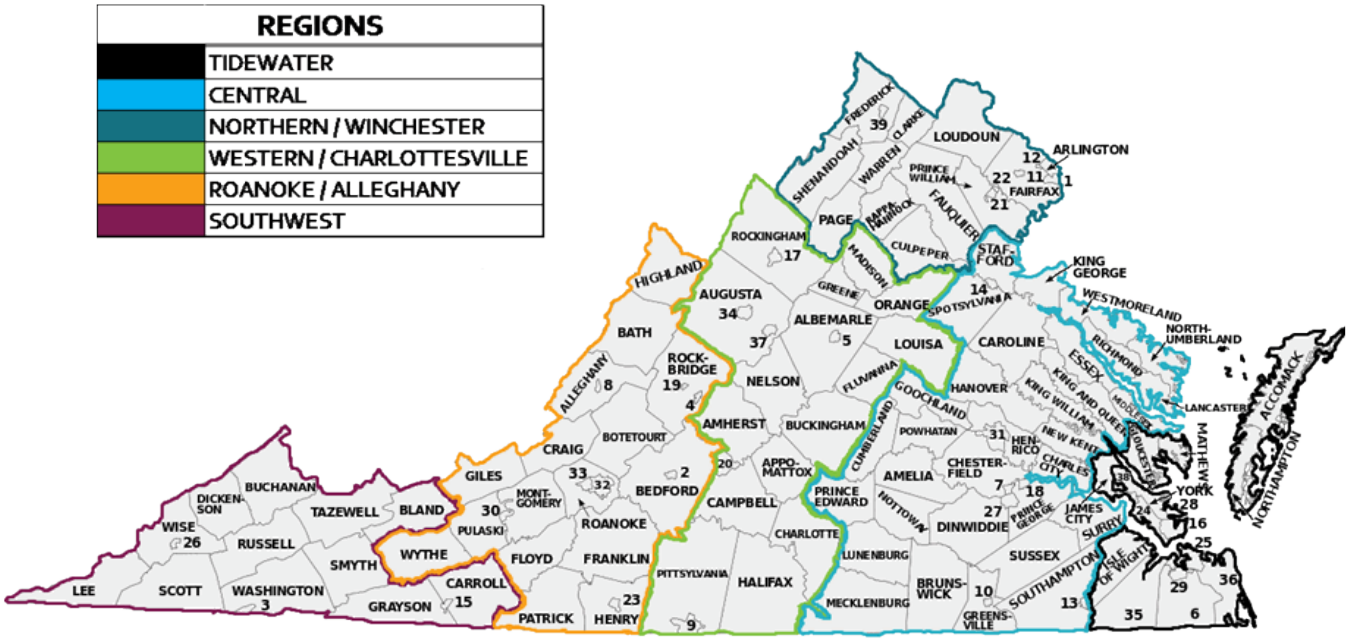
The DMAS Medicaid Director has overall responsibility for ensuring that DMAS meets the established goals of the Quality Strategy and ensures the organization maintains the administrative infrastructure to meet the needs of DMAS. The Medicaid Director works in collaboration with DMAS' Executive Leadership 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).

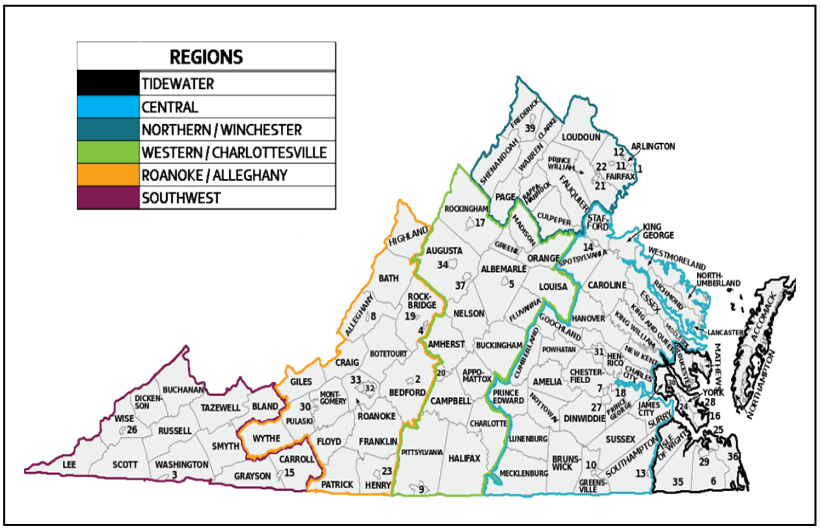
As of July 1, 2023, Medicaid expansion statistics showed:[7]

- 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.

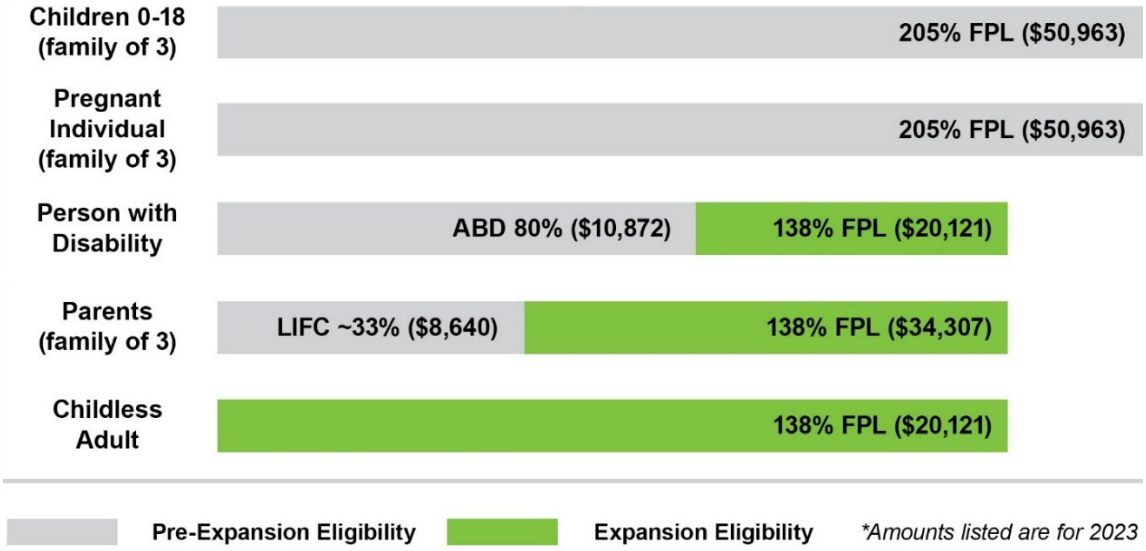
Figure 5—Medicaid Regions[8]



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]

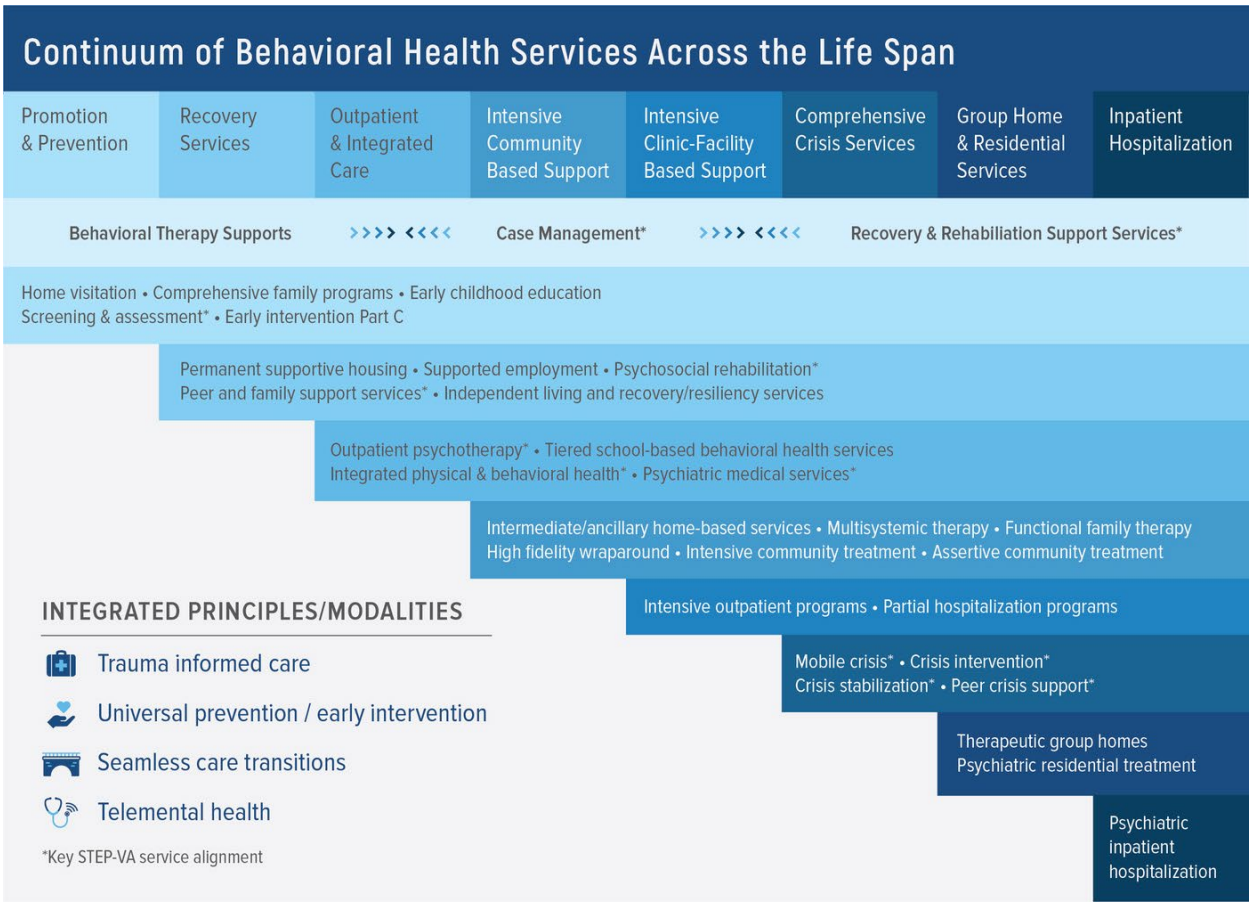
Under Governor Glenn Youngkin, the Commonwealth is focused on improving behavioral health services. The vision for the Enhancement of Behavioral Health is to keep Virginians well and thriving in their communities, shift our system's current need to focus on crisis by investing in prevention and early 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.

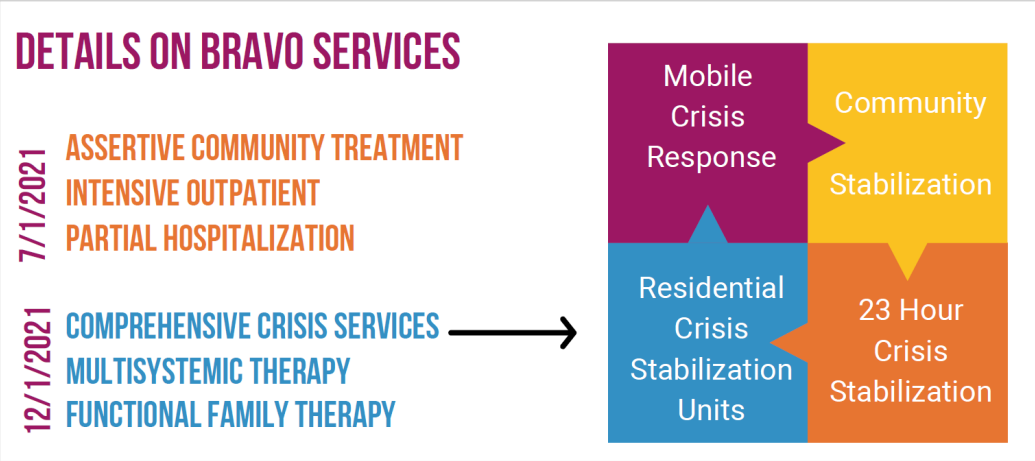
demonstrated success and value to individuals across the nation that will provide care in the community to ultimately avoid inpatient hospital stays.

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.

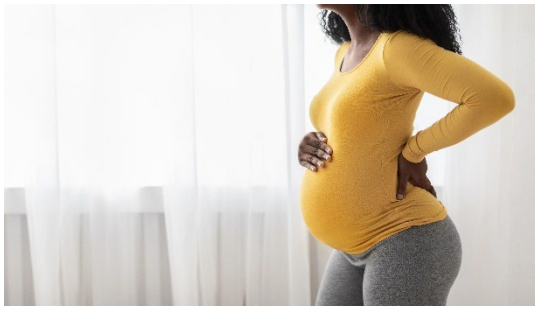
12 Months Postpartum Coverage

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

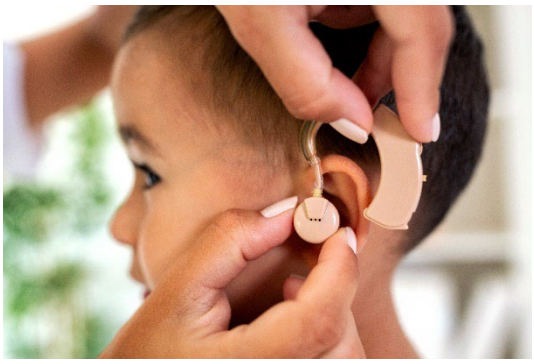
DMAS is currently participating in several affinity groups led by CMS and its vendor, Mathematica, to create state and federal workgroups designed to target specific issues of

[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.

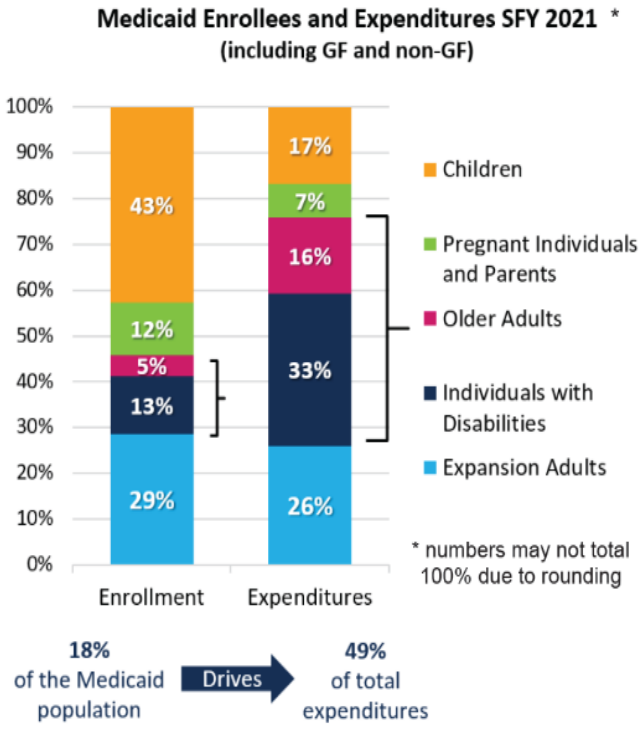
Using Incentives and Intermediate Sanctions to Drive Improvement

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

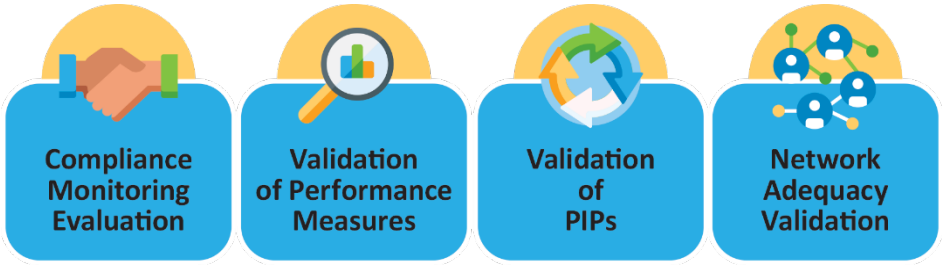
42 CFR §438.350–§438.358

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)

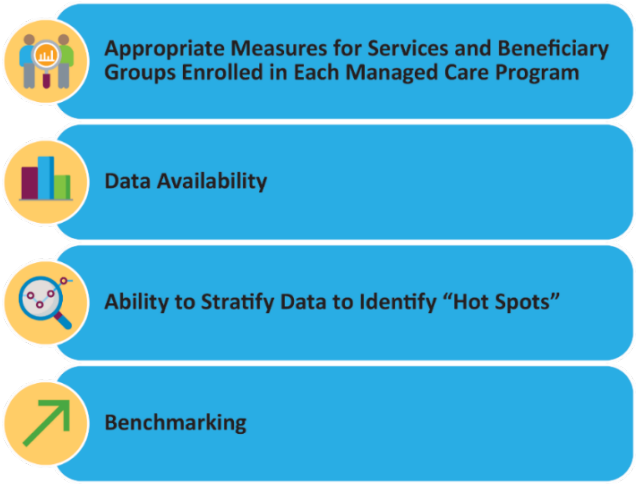
DMAS selected standard performance measures that MCOs are required to measure and report to DMAS. Consistent with DMAS' desire to benchmark its progress against other states' performance and assess key priorities to drive CQI efforts, nearly all of these measures are nationally recognized and include 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

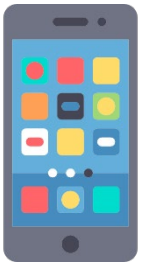
MCO contracts require that the MCO ensures that network providers and subcontractors comply with HIPAA and its implementing regulations, the Health Information Technology for Economic and Clinical Health Act of 2009 and its implementing regulations (collectively, "HITECH"), and all applicable federal 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

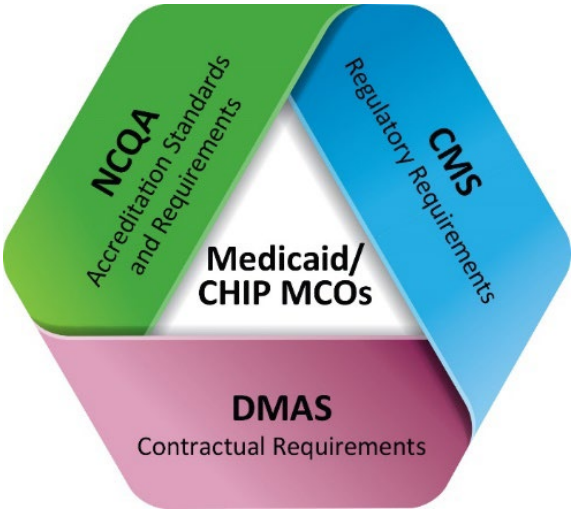
42 CFR §438.330

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.

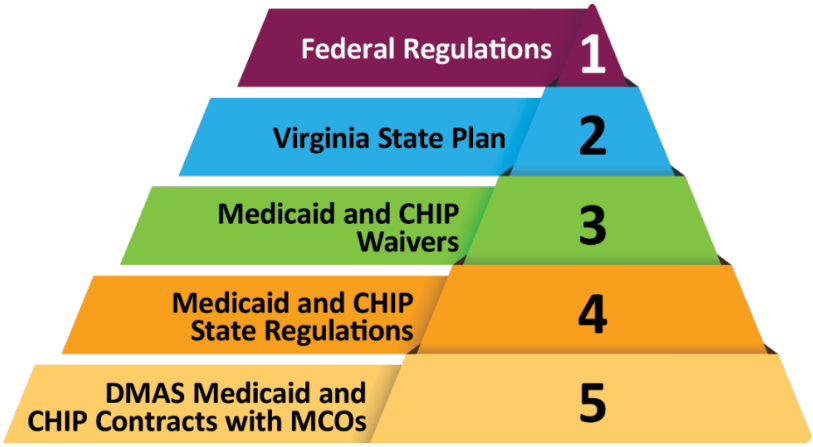
The requirements and standards serve as the basis for the Quality Strategy and are depicted in the framework in Figure 12.

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.

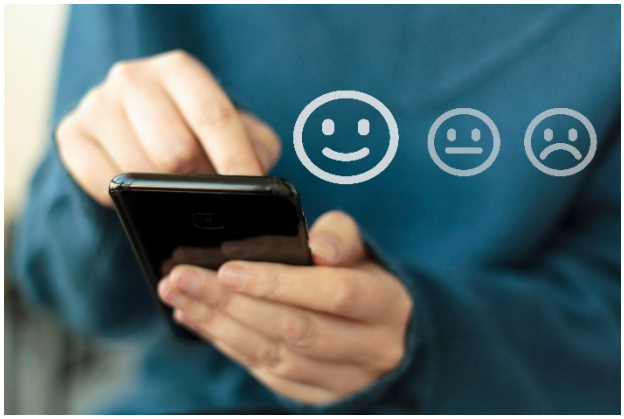
DMAS' EQRO validates PIPs required by the Commonwealth. The objective of PIP validation is to determine compliance with federal requirements and to ensure that DMAS, MCOs, and key stakeholders can have confidence that reported improvement can be reasonably linked to the QI strategies and activities conducted 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.*