



2026–2028 Quality Strategy



Commonwealth of Virginia
Department of Medical
Assistance Services

The Virginia Quality Strategy was submitted to the Centers for Medicare & Medicaid Services in December 2025.

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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
BAC	Beneficiary Advisory Council
BMI	Body Mass Index
BRAVO	Behavioral Health Redesign for Access, Value, and Outcomes
CAHPS ^{®1}	Consumer Assessment of Healthcare Providers and Systems
CANS	Comprehensive Assessment of Needs and Strengths
CAP	Corrective Action Plan
CC	Community Coaching
CCC Plus (MLTSS)	Commonwealth Coordinated Care Plus
CCS	Cardinal Care Smiles
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
CPST	Community Psychiatric Support and Treatment
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

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

ED.....	Emergency Department
EDCC	Emergency Department Care Coordination
EDCD	Elderly or Disabled With Consumer Direction
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
FFP	Federal Financial Participation
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
ILOS	In Lieu of Service
IMD	Institution for Mental Disease
IT	Information Technology
JLARC	Joint Legislative Audit and Review Commission
LDSS	Local Department of Social Services
LEP	Limited English Proficiency
LPN.....	Licensed Practical Nurse
LTSS.....	Long-Term Services and Supports

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

MAC.....	Member Advisory Committee
MAT.....	Medication-Assisted Treatment
MCH.....	Maternal and Child Health
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
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
NASHP.....	National Academy for State Health Policy
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
OBAT.....	Office-Based Addiction Treatment
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
SED	Serious Emotional Disturbance
SFY.....	State Fiscal Year
SHCN	Special Health Care Needs
SMART	Specific, Measurable, Attainable, Relevant, and Time-bound
SMI	Serious Mental Illness
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 2024, 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 July 1, 2024, the Virginia Medicaid managed care program is called the Cardinal Care program and serves approximately 1,895,258 members.

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 630,267 enrolled³ in Medicaid and approximately 94,786 enrolled⁴ in the Children's Health Insurance Program (CHIP). Other eligible populations include people with disabilities, older and low-income adults, and pregnant women. In Virginia, Medicaid also covered approximately 39,843 births⁵ in 2025, with enrollees being predominately White and African American.⁶

Virginia's Medicaid managed care organization (MCO) budgets expend approximately 90.0 percent of their funds on medical services and 10.0 percent on administrative expenses during 2024.⁷ 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 219,237 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

³ Virginia Department of Medical Assistance Services. Medicaid/FAMIS/PACE Enrollment. Available at: <https://dmas.virginia.gov/data-reporting/eligibility-enrollment/medicaid-famis-pace-enrollment/>. Accessed on: Aug 14, 2025.

⁴ Department of Medical Assistance Services. DMAS Enrollment Report, July 2024. Available at: https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.dmas.virginia.gov%2Fmedia%2Fvb2l2rjt%2Fdmas-enrollment-report-jul2024_.xlsx&wdOrigin=BROWSELINK. Accessed on: Aug 14, 2025.

⁵ Virginia Department of Medical Assistance Services. Medicaid/FAMIS/PACE Enrollment. Available at: <https://dmas.virginia.gov/data-reporting/eligibility-enrollment/medicaid-famis-pace-enrollment/>. Accessed on: Aug 14, 2025.

⁶ Ibid.

⁷ Ibid.

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.

DMAS Strategic Vision

Virginia has embarked on a reinvigorated new strategic vision to serve and improve 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 2026–2028 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, and between 2021 and 2022 DMAS implemented 10 new rehabilitative services as part of Project BRAVO (Behavioral Health Redesign for Access, Value, and Outcomes), including crisis services aligned with the Crisis Now Model, two clinic-based intensive community services (Intensive Outpatient Program and Partial Hospitalization Program), and three evidence-based programs for youth (Multisystemic Therapy and Functional Family Therapy) and adults (Assertive Community Treatment). In the new strategy, DMAS continues this work by focusing on replacing the remaining legacy services with evidence-based alternatives and implementing a statewide Level of Need model as part of a planned Serious Mental Illness 1115 waiver program. 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 with additional coordination with the new Foster Care Specialty plan. Additional information about behavioral health enhancements can be found in the Quality Strategy Interventions section, starting on page 39.

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.

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 4, 2022, the Virginia Secretary of Health and Human Resources announced that the Commonwealth's Medicaid agency plans to launch a transformational new procurement 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 evaluated 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 hired nationally recognized consultants with expertise in the managed care field to assist in drafting the request for proposals. The agency also sought 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 occurred 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.

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

<https://www.dmas.virginia.gov/media/ibjjoec0/2024-cardinal-care-annual-technical-report.pdf>



The Medicaid State Plan

<https://www.dmas.virginia.gov/about-us/mission-and-values/state-plan/>



Medicaid Managed Care Organization Contracts and Amendments

<https://www.dmas.virginia.gov/about-us/mission-and-values/office-of-quality-and-population-health/additional-resources/>

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 CMS National Quality Strategy (NQS) that includes equity and engagement, outcomes and alignment, safety and resiliency, and interoperability and scientific advancement.⁸
- 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, 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.

⁸ Centers for Medicare & Medicaid Services. National Quality Strategy. April 2023. Available at: <https://www.cms.gov/files/document/cms-national-quality-strategy-handout.pdf>. Accessed on : Dec 8, 2025.

- 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.

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
 <p>Goal 1: Enhance the Member Care Experience</p>	<p>Objective 1.1: Increase Member Engagement and Outreach</p> <p>Objective 1.2: Improve Member Satisfaction</p>
 <p>Goal 2: Promote Access to Safe, Gold-Standard Patient Care</p>	<p>Objective 2.1: Ensure Access to Care</p> <p>Objective 2.2: Promote Patient Safety</p> <p>Objective 2.3: Promote Effective Communication and Care Coordination</p>
 <p>Goal 3: Support Efficient and Value-Driven Care</p>	<p>Objective 3.1: Focus on Paying for Value</p> <p>Objective 3.2: Promote Efficient Use of Program Funds</p>
 <p>Goal 4: Strengthen the Health of Families and Communities</p>	<p>Objective 4.1: Improve Utilization of Wellness, Immunization, and Prevention Services for Members</p> <p>Objective 4.2: Improve Outcomes for Maternal and Infant Members</p> <p>Objective 4.3: Improve Home and Community-Based Services</p>
 <p>Goal 5: Providing Whole-Person Care for Vulnerable Populations</p>	<p>Objective 5.1: Improve Outcomes for Members with Chronic Conditions</p> <p>Objective 5.2: Improve Outcomes for Nursing Home Eligible Members</p> <p>Objective 5.3: Improve Outcomes for Members with Substance Use Disorders</p> <p>Objective 5.4: Improve Behavioral Health and Developmental Services of Members</p>

Note: Each goal has targeted metrics to measure progress, as well as outlined interventions to advance the goals. See Appendix B.

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.

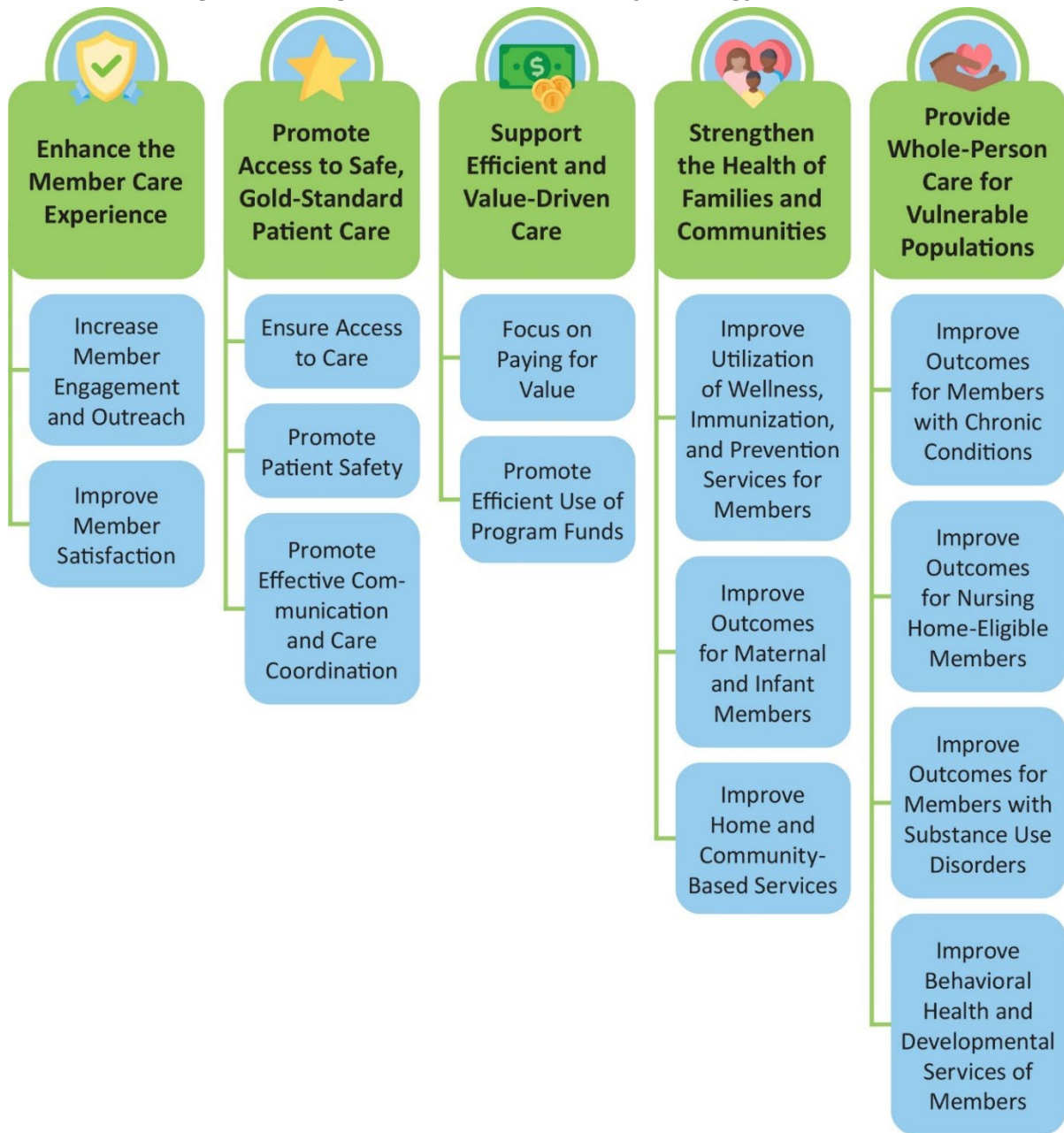
The DMAS Quality Strategy aligns with the NQS, which was launched on April 12, 2022.⁹ The NQS includes three aims: Better Care, Healthy People/Healthy Communities, and Affordable Care. To advance these aims, the NQS focuses on seven priorities: safer care, patient engagement, communication, care coordination, 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 NQS.

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).

⁹ 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: Aug 5, 2025.

Figure 1—Virginia’s 2026–2028 Quality Strategy Framework



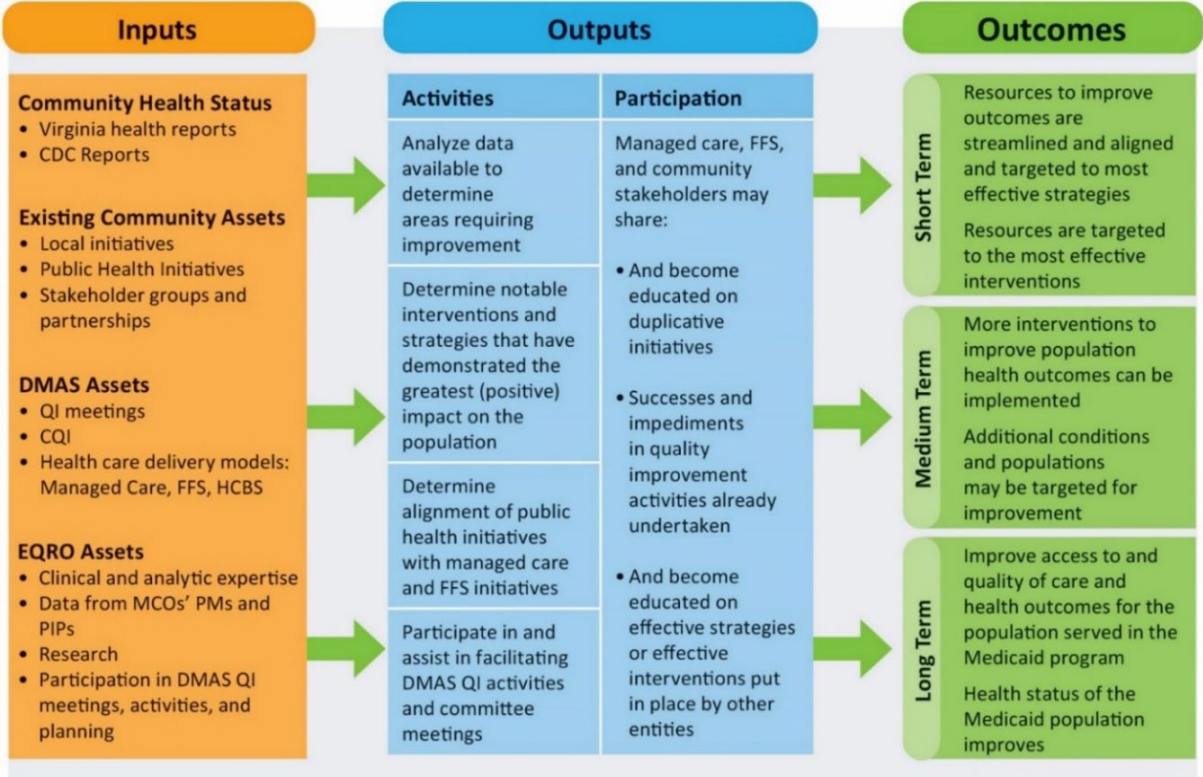
Strategy for Meeting Goals

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 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.

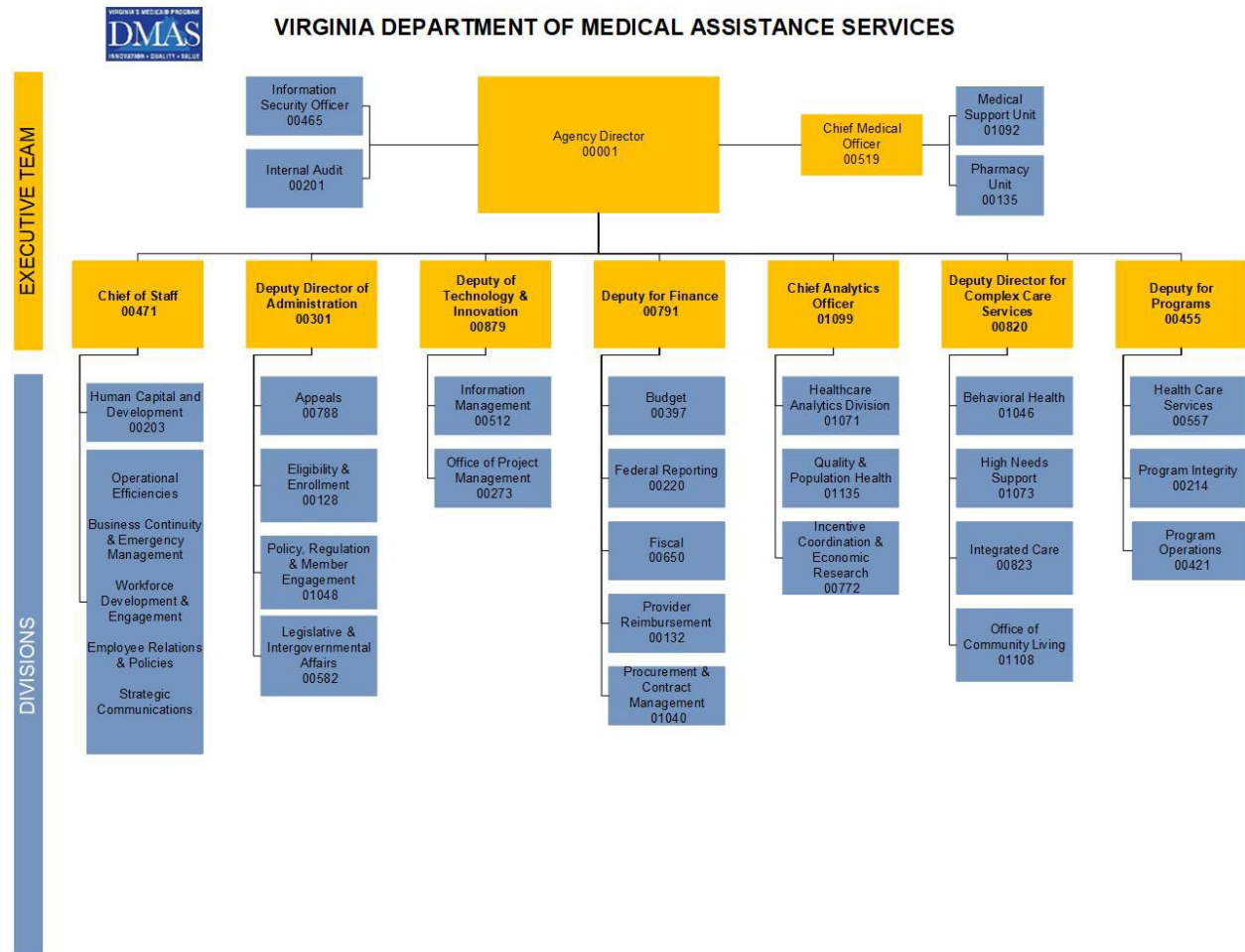
DMAS maintains the following values while operating its mission to the Commonwealth:

- **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

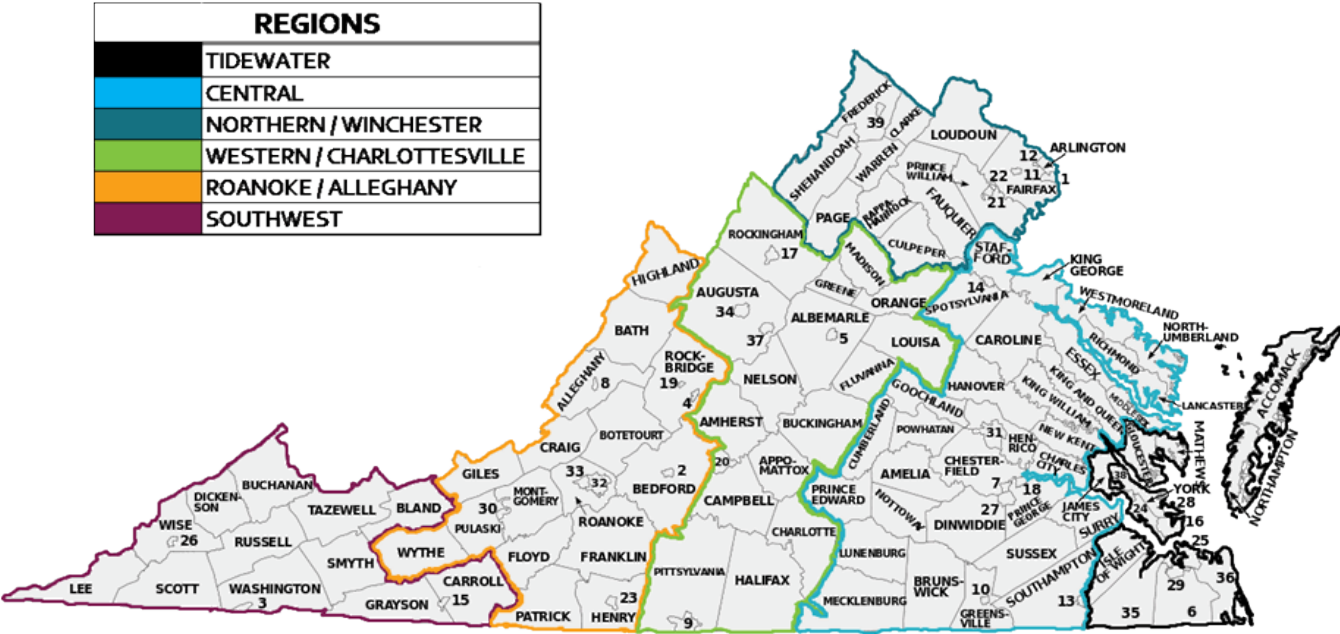
The DMAS Medicaid Director has overall responsibility for ensuring that DMAS meets the established goals of the Quality Strategy and ensures the organization maintains the administrative infrastructure to meet the needs of DMAS. The Medicaid Director works in collaboration with DMAS’ Executive Leadership 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 2024. 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/ls2d51i3/fye25-annual-dmas-organizational-report-07-01-2025.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.¹⁰ Virginia has the following CMS-approved waivers:

- **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.
- **CCC Plus Waiver:** The CCC Plus waiver is DMAS' HCBS waiver that covers a range of community support services offered to older adults, individuals who have a disability, and individuals who are chronically ill or severely impaired, having experienced loss of a vital body function, and who require substantial and ongoing skilled nursing care. The individuals, in the absence of services approved under this waiver, would require admission to a nursing facility, or a prolonged stay in a hospital or specialized care nursing facility. The CCC Plus HCBS waiver has two benefit plans: the standard benefit plan and the technology-assisted benefit plan. Individuals who are enrolled in the technology-assisted benefit plan are technology dependent and have experienced loss of a vital body function, and require substantial and ongoing skilled nursing care.
- **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.

¹⁰ Virginia Department of Medical Assistance Services. 1115 Demonstration Waiver. Building and Transforming Coverage, Services, and Supports for a Healthier Virginia. Available at: <https://www.dmas.virginia.gov/about-us/1115-demonstration-waiver/>. Accessed on: Sept 8, 2025.

- **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. 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 women. 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 MLTSS and 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.

Acute

The Acute program ensured 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. Acute included 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 Acute population included children, low-income parents and caretaker relatives living with children, pregnant women, and current and former foster care and adoption assistance children. The Acute program ended on September 30, 2023. Members were transitioned into the Cardinal Care program on October 1, 2023.



Acute focused 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 MLTSS program is DMAS’ mandatory integrated care initiative for certain qualifying individuals, including dual-eligible individuals and individuals receiving LTSS. The MLTSS program included individuals who received services through nursing facility care, or from four of DMAS’ five HCBS 1915(c) waivers. 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 MLTSS, such as the ABD adult and child populations. The MLTSS program ended on September 30, 2023. Members were transitioned into the Cardinal Care program on October 1, 2023.

All MLTSS members received care coordination through a person-centered program design, which was an integrated delivery model that included medical and behavioral health services with LTSS.

Participation was mandatory for eligible populations, which included:

- Individuals age 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)

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).

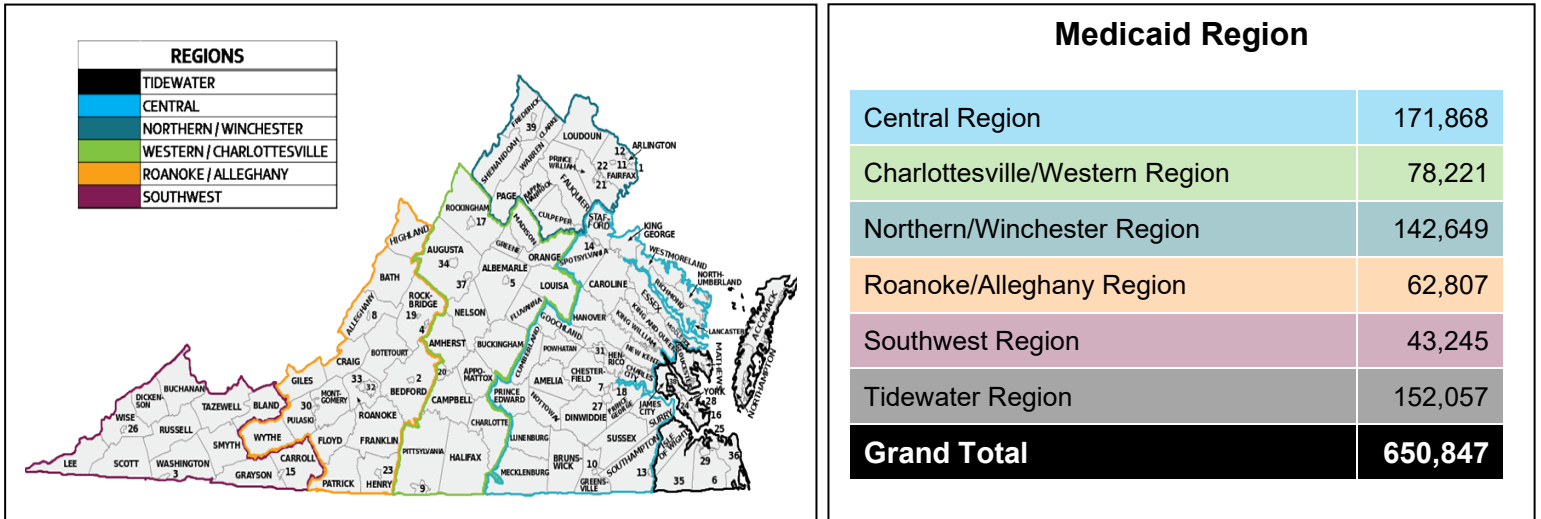


As of July 1, 2025, Medicaid expansion statistics showed:¹¹

- 650,847 adults newly enrolled in Medicaid.
- 135,479 newly enrolled adults who were parents.
- 48 percent were men.
- 52 percent were women.
- 45 percent were 19 to 34 years of age.
- 38 percent were 35 to 54 years of age.
- 17 percent were 55 plus years of age.
- 498,763 were below 100 percent FPL.
- 152,084 were between 100 and 138 percent of the FPL.

Figure 5 shows the number of Medicaid expansion members enrolled in each Medicaid Region.

Figure 5—Medicaid Regions¹²

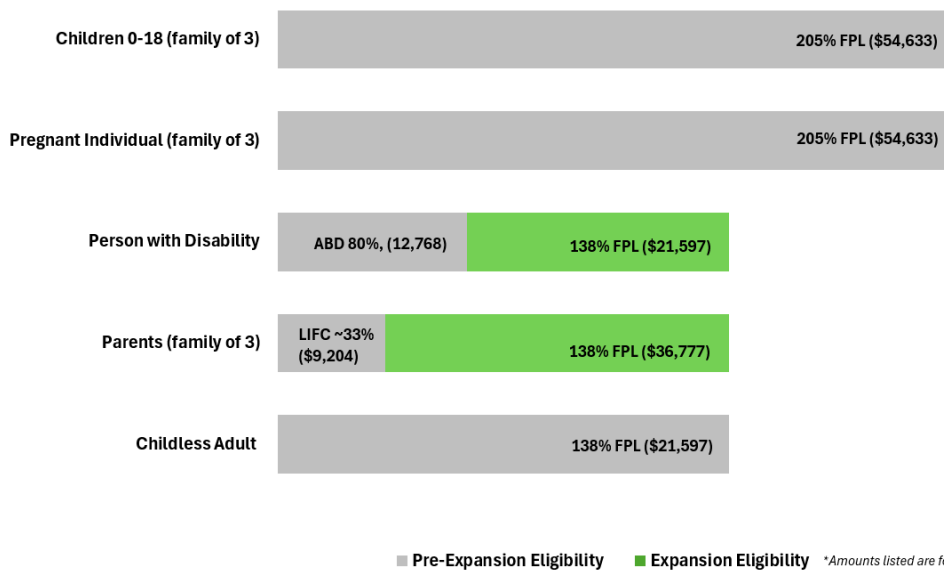


¹¹ Virginia Department of Medical Assistance Services. Medicaid/FAMIS/PACE Enrollment. Available at: <https://dmas.virginia.gov/data-reporting/eligibility-enrollment/medicaid-famis-pace-enrollment/>. Accessed on: Aug 14, 2025.

¹² Ibid.

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.

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. As of July 1, 2024, there were 2,140 participants enrolled in PACE programs.¹³ 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

¹³ Virginia Department of Medical Assistance Services. Medicaid/FAMIS/PACE Enrollment. Available at: <https://dmas.virginia.gov/data-reporting/eligibility-enrollment/medicaid-famis-pace-enrollment/>. Accessed on: Aug 14, 2025.

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 July 1 2025, approximately 220,196 members, or 11.6 percent, are served under FFS management.¹⁴ 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.

¹⁴ Ibid.

- 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 2020.¹⁵ 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.¹⁶

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 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings and treatments.¹⁷ 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 through community contact to protect the most vulnerable populations. Table 2 describes some of the flexibilities allowed during the pandemic.

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.

¹⁵ 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 15, 2025.

¹⁶ 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 15, 2025.

¹⁷ 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: Aug 15, 2025.

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. As of September 4, 2025, 99.88 percent of all unwinding redeterminations were complete. The redetermination results were:¹⁸

- 2,621 redeterminations needed
- 740,628 coverage closed
- 1,423,131 coverage renewed and continued
- Of the members completing redetermination:
 - 35 percent were 0 to 18 years of age
 - 56 percent were 19 to 64 years of age
 - 9 percent were 65 years of age or older
 - 54 percent were female
 - 45 percent were male
 - 54 percent were White
 - 35 percent were Black or African American
 - 5 percent were some other race
 - 5 percent were Asian
 - 1 percent were Native Hawaiian or Pacific Islander
 - 1 percent were American Indian or Alaskan Native
 - 96 percent were Not Hispanic or Latino
 - 4 percent were Hispanic or Latino

¹⁸ Virginia Department of Medical Assistance Services. Eligibility Redetermination Tracker. Available at: <https://www.dmas.virginia.gov/data-reporting/eligibility-enrollment/eligibility-redetermination-tracker/>. Accessed on: Aug 14, 2025.

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 2026–2028 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, 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 National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (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 2026–2028. 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.¹⁹



In addition, CMS issued the 2024 Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality; the 2024 Ensuring Access to Medicaid Services Final Rule; and the 2024 CMS Interoperability and Patient Access Final Rule, which signals CMS' commitment to the vision set out in the 21st Century Cures Act. The federal regulations expand the scope of the Quality Strategy to address additional requirements in the following five areas:²⁰

- 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

¹⁹ 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-medicare-and-childrens-health-insurance-program-chip-managed-care>. Accessed on: Aug15, 2025.

²⁰ Ibid.

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:

- 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 Medicaid 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.

DMAS solicited feedback from the MPMCLC in the fall of 2025 through email communication to ensure every MPMCLC member received the draft 2026–2028 Quality Strategy. The agency received feedback from several MPMCLC provider members. As a result of feedback from MPMCLC members, DMAS made several changes to the Quality Strategy, including adding clarity regarding EPSDT and pediatric quality measure importance, aligning contract references to the American Academy of Pediatrics (AAP) and Bright Futures in the EPSDT section and medical necessity definitions, and updating quality measure references.

Beneficiary Advisory Council

DMAS obtains input from the Beneficiary Advisory Council (BAC). The BAC includes Medicaid beneficiaries, their family members, and/or their caregivers. The BAC has crossover membership with the MAC, with 25 percent of MAC members also being BAC members. MAC and BAC 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
- Upper 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 2026–2028 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..²¹

²¹ 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 15, 2025.

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®)²² 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 to DMAS:

- All quality data, at minimum, annually to DMAS.
- All accreditation reports.

²² CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

- All information required by the EQRO, in compliance with the protocols set forth by CMS.²³

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	Intervention Objectives													
	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
Behavioral Health Redesign (Project Bravo - Right Help Right Now)	X	X	X	X	X				X				X	X
Foster Member and Provider Engagement	X	X	X		X									

²³ 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: Aug 16, 2025.

Intervention Categories	Intervention Objectives														
	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	
Value-Based Purchasing			X	X	X	X	X	X	X	X	X	X	X	X	
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								
Cardinal Care Smiles 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	

The following paragraphs describe in more detail each of the interventions listed in the Quality Strategy RACI chart.



Right Help, Right Now

Virginia created a transformational behavioral health plan for Virginians, the *Right Help, Right Now* initiative, 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 (EDs). 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* initiative includes specialized resources for individuals with substance use disorders (SUDs) or who have a high risk of overdosing. Virginians should have immediate access to all the resources they need anytime and anywhere.

The 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.

“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.”

The 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 Year 2 budget is:²⁴

- \$307 million to provide 3,440 waiver slots, a slot per person on the Priority 1 Waitlist.
- \$23 million to expand access to school-based mental health services for children, including telehealth services.
- \$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 to 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 the law enforcement burden, including expanding alternative transportation.
- \$58 million for building a best-in-class behavioral workforce through salary increases in state hospitals, behavioral health loan repayment, and more clinical training sites and residency slots.

²⁴ Virginia Secretary of Health and Human Resources. Right Help. Right Now.: Transforming Behavioral Health Care for Virginians, Year 1 Report, December 2022–December 2023. Available at: <https://www.hhr.virginia.gov/media/governorvirginiagov/secretary-of-health-and-human-resources/pdf/behavioral-health/1-Year-Update-RHRN-FINAL-complete-Feb2024.pdf>. Accessed on: Aug 14, 2025.

- \$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 disorders.

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:



Year 1 key accomplishments of the *Right Help, Right Now* plan:²⁵

Pillar 1—Same-Day Care:

- Surpassed the initial goal of 70 publicly funded mobile crisis teams, and began development of or had a project groundbreaking on 159 crisis receiving center chairs and 114 crisis stabilization unit beds.
- Established 988 high-tech call centers with an average response time of under 25 seconds and with over 90 percent of calls answered by Virginia operators.
- Developed Virginia Crisis Connect for efficient data linkage and real-time connections.

Pillar 2—Law Enforcement Support:

- Established the Prompt Placement Task Force to facilitate efficient state hospital bed placement for individuals under a Temporary Detention Order (TDO).
- Implemented alternative transportation programs for individuals under TDOs.
- Conducted trainings for Community Services Board pre-screeners to standardize and improve understanding of changes to the TDO process, including use of a medical TDO.

Pillar 3—Capacity Expansion:

- Expanded existing services, creating 13 new Assertive Community Treatment (ACT) teams.

²⁵ Ibid.

- Advanced integrated behavioral health through the Virginia Mental Health Access Program and early development of the Adult Psychiatric Access Line.
- Assigned 561 of 600 new waiver slots from the Priority 1 Waiver List within 90 days.

Pillar 4—Substance Use Disorder (SUD) Support:

- Launched public-private education campaigns to prevent youth opioid addiction.
- Supported naloxone availability and cross-agency planning for evidence-based treatment.
- Implemented the 10 directives of Executive Order 26 (May 9, 2023): Crushing the Fentanyl Epidemic (Strengthening Virginia’s Interdiction and Enforcement Response to Fentanyl Crisis) through three main areas: Prevention and Treatment, Public Safety and Drug Interdiction, and Organization of Government and Data Collection.

Pillar 5—Workforce Development:

- Increased the number of licensed clinical social workers by 51.4 percent and licensed professional counselors by 12.5 percent in one year (data from the Virginia Healthcare Workforce Data Center).²⁶
- Expanded capabilities of non-behavioral health providers through crisis intervention training.
- Created a public campaign to attract individuals to behavioral health roles, particularly through educational pathways starting in high school.

Pillar 6—Service Innovations:

- Reprocured Medicaid MCO contracts, prioritizing health as a key outcome.
- Virginia is leading the nation by requiring commercial insurance coverage of mobile crisis response teams and crisis stabilization units.

Behavioral Health Redesign

Behavioral Health Redesign is a two-year project that began in July 2024 to redesign legacy Medicaid rehabilitative services. The project was authorized by the General Assembly through the 2024 Appropriations Act (Item 288.XX) and is part of the *Right Help, Right Now* Plan to transform Virginia’s behavioral health system. Year 1 of the project focused on research, stakeholder input, policy and service design, a rate study, and a fiscal impact study. The authorizing language requires that this project retire legacy rehabilitative services (intensive in-home, therapeutic day treatment, mental health skill building, and psychosocial rehabilitation, and targeted case management for mental health), replacing them with an array of evidence-based, trauma-informed services. It requires that all changes made are budget neutral. Results of the rate study yielded actuarial sound rates for a number of additional services that will be implemented July 1, 2026.

Services for the July 1, 2026, implementation include: Community Psychiatric Support and Treatment (CPST) for adults and youth, a Comprehensive Assessment of Needs and Strengths

²⁶ Ibid.

(CANS) for the implementation of a level of need model, Coordinated Specialty Care for First Episode Psychosis, and Clubhouse International Model of Psychosocial Rehabilitation.

Finally, aligned with *Right Help, Right Now*'s focus on crisis care, Virginia submitted a Section 1115 Medicaid demonstration waiver to add a serious mental illness (SMI) program. This SMI/serious emotional disturbance (SED) demonstration opportunity allows states, upon CMS approval of their demonstrations, to receive Federal Financial Participation (FFP) for services furnished to Medicaid beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as institutions for mental disease (IMDs) if those states are also taking action, through these demonstrations, to ensure good quality of care in IMDs and to improve access to community-based services.

The full waiver application submitted to CMS can be found on DMAS' website:

<https://www.dmas.virginia.gov/about-us/1115-demonstration-waiver/>
<https://www.dmas.virginia.gov/media/rmeltcm3/final-111-smi-submit.pdf>

The amendment application proposes the following enhancements to the array of inpatient service options for adults aged 21–64 with SMI by adding service settings that may:

- Cover short-term inpatient psychiatric treatment for members 21–64 who meet medically necessary criteria in psychiatric facilities that meet the definition of an IMD.
- Cover short-term residential crisis stabilization for members 21–64 who meet medically necessary criteria in residential crisis stabilization units that meet the definition of an IMD.

Inpatient psychiatric treatment and short-term residential crisis stabilization services are covered by Virginia's Medicaid Plan, but coverage is limited either by age or by settings for the main adult population aged 21–64 due to the federal IMD exclusion. Currently, DMAS contracts with MCOs to cover these services in IMDs in certain situations as "in lieu of service" (ILOS), but the ILOS provision has a number of specific restrictions that limit effective service delivery for the SMI population, as the ILOS option is not a required service delivery option, ILOS cannot be used for involuntary treatment such as inpatient treatment or residential crisis stabilization under a temporary detention order (TDO), and ILOS cannot be used for members in FFS Medicaid.

Currently, DMAS is meeting monthly with CMS to clarify aspects of the implementation plan and complete the baseline availability assessment. The availability assessment is a comprehensive assessment of community-based services in the Commonwealth, which is a requirement for the SMI 1115 waiver. Appendices B and D include identification of Quality Strategy metrics that align with the critical metrics for this waiver.

Additional Funding and Waiver Slots for Virginians with Developmental Disabilities, Enhancing Support

Virginia 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. Virginia provided 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. The Virginia Secretary of Health and Human Resources 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 □

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 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 ED 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.

Project BRAVO is a multifaceted collaborative approach to enhancing the behavioral healthcare continuum across the lifespan of Medicaid members.²⁷ The vision for Project BRAVO is to keep Virginians well and thriving in their communities, shift Virginia's system's current need to focus on crisis by investing in prevention and early intervention for mental health and SUD comorbidities, and support comprehensive alignment of services across the systems that serve Medicaid members. Nine new behavioral health services were launched in 2021 to strengthen crisis response, prevention, and early intervention to help members avoid inpatient admissions and find support in the community after a hospital stay.

Services for Youth Ages 11–18

- Multisystemic Therapy (MST): Intensive family and community-based treatment for youth with significant disruptive mental health disorders and SUDs.
- Functional Family Therapy (FFT): Short-term family-based treatment for youth with significant disruptive behaviors who have received referrals from juvenile justice, behavioral health, school, or child welfare systems.

Services for Youth and Adults

- Mental Health Partial Hospitalization Program (MH-PHP): Highly structured clinical programs designed to provide services that are similar to an inpatient program but on a less than 24-hour basis while individuals continue to live in their communities.
- Mental Health Intensive Outpatient (MH-IOP): Highly structured clinical programs designed to provide a combination of interventions that are less intensive than partial hospitalization programs, though more intensive than traditional outpatient psychiatric services.

²⁷ Virginia Department of Medical Assistance Services. Project BRAVO: Enhanced Behavioral Health Services for Virginia Medicaid. Available at: <https://www.dmas.virginia.gov/media/qz4p1ij1/project-bravo-arts-enhancement-resource-2-7-2024.pdf>. Accessed on: Aug 15, 2025.

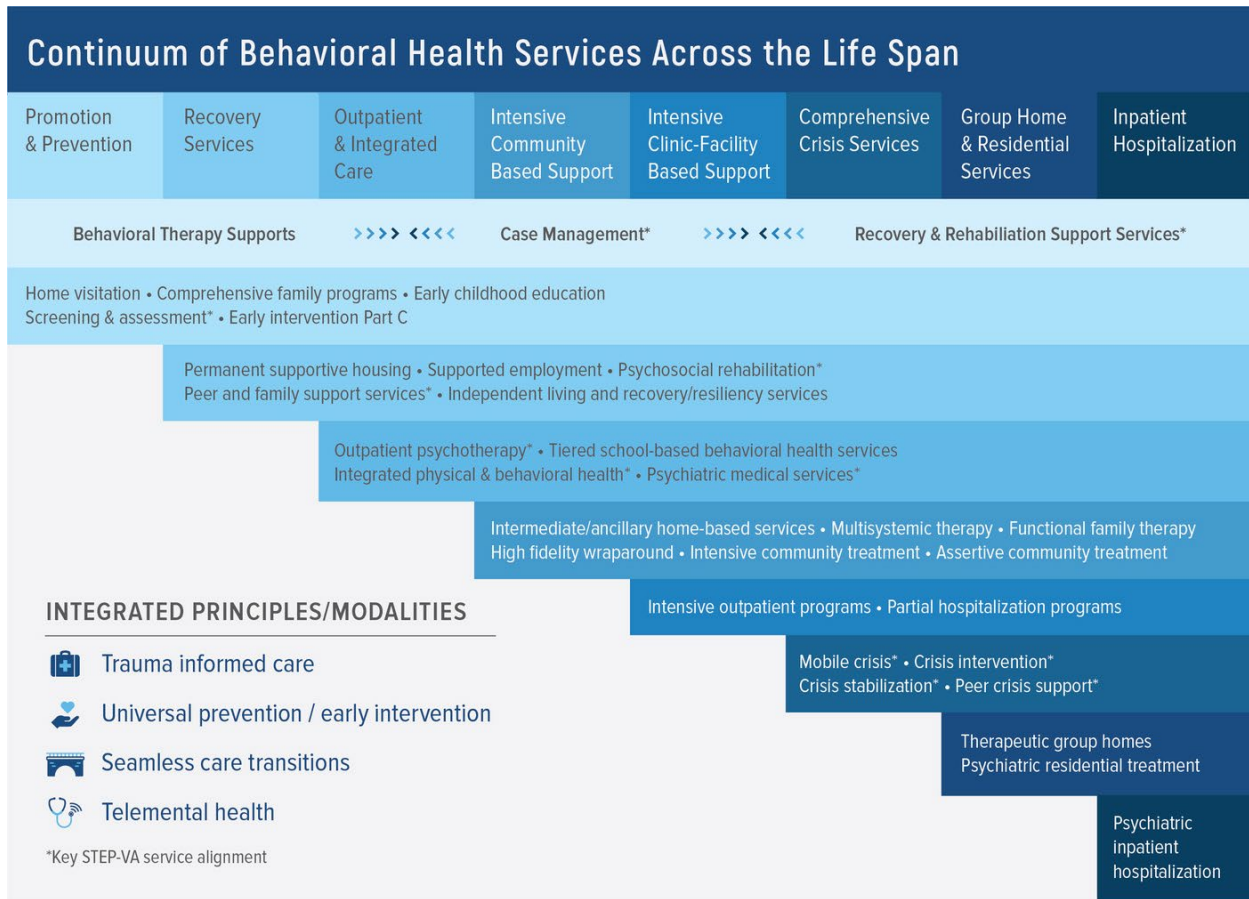
- **Mobile Crisis Response:** A 24/7 rapid response team that provides assessment and early intervention for individuals experiencing a mental health crisis or SUD crisis.
- **Community Stabilization:** Short-term support for individuals who recently required mental health or SUD crisis services or who need assistance to avoid escalation to more intensive mental health or SUD treatment models.
- **23-Hour Crisis Stabilization:** Up to 23 hours of crisis stabilization services in a DBHDS-approved community-based crisis stabilization clinic setting for members experiencing an acute mental health or SUD emergency.
- **Residential Crisis Stabilization Unit:** Short-term, 24/7 residential evaluation and intervention for mental health and substance use crises. This new service enables some individuals to avoid inpatient admission and offers stepdown support for others who require hospitalization.

Services for Adults

- **ACT:** Individuals with serious mental illness receive care through a single team that works closely together to support the individual and is available 24/7.

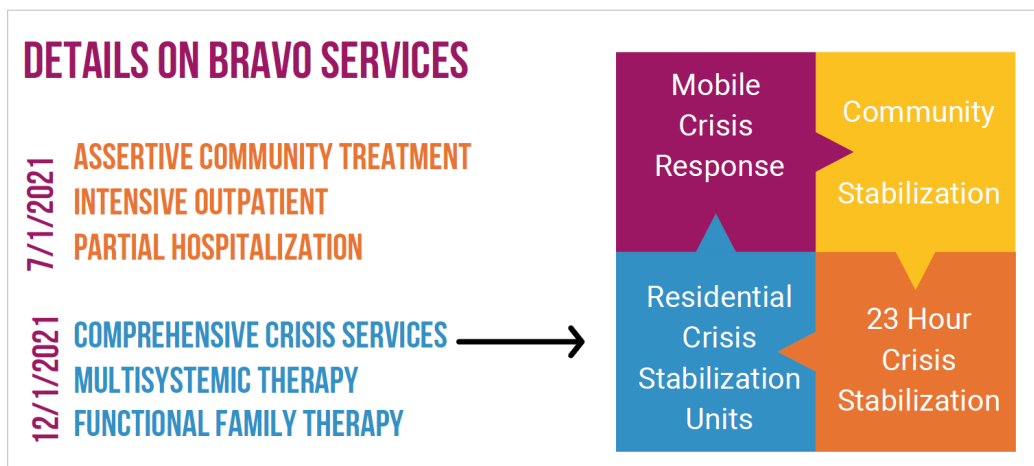
DMAS is also committed to the continued expansion of access to BRAVO services by implementing new services and engaging the communities to support these services. Project BRAVO is a comprehensive, General Assembly supported vision that details a “north star” continuum of services and a preliminary set 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 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 increased precipitously between late 2019 and early 2022, peaking at around 108,000 deaths nationally and about 2,600 in Virginia.²⁸ This represents a 51 percent increase nationally and a 69 percent increase in Virginia between December 2019 and December 2021. Although the increase began before the COVID-19 pandemic, economic and social stress related to the pandemic, disruptions in access to health services, and greater availability of more lethal forms of opioids, such as fentanyl, are considered the primary reasons for the surge in overdoses. Since late 2021, the increase in overdose deaths has leveled off, and even decreased in Virginia and other states that are part of the Appalachian region. Between June 2021 and June 2022, overdose deaths are estimated to have decreased by 1.5 percent in Virginia, while increasing nationally by 5.5 percent.²⁹

As a result of the expansion of treatment services through the Addiction and Recovery Treatment Services (ARTS) benefit in April 2017, and increases in eligibility for these services through Medicaid expansion beginning in 2019, Virginia Medicaid was better prepared for the increased prevalence in SUDs than in previous years. The federal government and DMAS also implemented several initiatives and procedural flexibilities to offset COVID-related access barriers to treatment, including increased use of telemedicine, allowing take-home dosages of methadone and buprenorphine for up to 28 days, allowing for 90-day prescriptions for buprenorphine products, and allowing a member's home to serve as the originating site for prescription of buprenorphine.

The most recent evaluation of the ARTS program indicated:

- Increased prevalence of SUDs in Virginia.
- Increase in treatment providers.
- Increase in pharmacies dispensing buprenorphine, although one fourth of all pharmacies did not dispense any buprenorphine for treatment of opioid use disorder (OUD).
- Increased use of ARTS services.
- Among members who used ARTS services in SFY 2021, only 9 percent utilized residential treatment services (American Society of Addiction Medicine [ASAM] 3), with an average length of stay of 15.5 days.
- Treatment gaps in transitions from EDs remain, for example, many members who had OUD-related ED visits do not receive follow-up care or medications for opioid use disorder (MOUD) treatment. Only 27 percent of members with an OUD-related ED visit received MOUD treatment within seven days of the visit, and 37 percent received MOUD within 30 days of the ED visit. Receipt of MOUD following the ED visit was especially low among those who were not receiving treatment prior to the ED visit.

To continue to address treatment gaps and meet the SUD-related treatment needs of Virginians, three primary initiatives are planned:

1. DMAS received funding from Virginia's Opioid Abatement Authority to support hospitals and health groups in the implementation of Discharge Bridge programs by offering financial and technical assistance and training. Discharge Bridge programs strengthen connections to

²⁸ U.S. Centers for Disease Control and Prevention, National Vital Statistics System. Provisional Drug Overdose Death Counts. Available at: <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>. Accessed on: Sept 9, 2025.

²⁹ Ibid.

community-based treatment for members who present to an ED for an overdose emergency.

2. On site, annual quality reviews of office-based addiction treatment (OBAT) programs are being implemented by managed care health plans in Virginia, planned to begin in 2026.
3. Virginia will transition service descriptions and expectations to the Fourth Edition of the ASAM continuum of care.

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://dmas.virginia.gov/about-us/language-and-disability-access-plan/?utm_content=20250818&utm_medium=email&utm_source=govdelivery. The two main overarching principles in the Plan are:

1. That LEP individuals with disabilities be made aware that certain language assistance services and auxiliary aids are available free of charge.
2. That the services and aids be provided in a timely manner.

The Plan includes the Four Factor Analysis that evaluates the following for the Virginia Medicaid program: (1) Demographics: the number or proportion of LEP persons and individuals with disabilities eligible to be served or likely to be encountered; (2) Frequency of contact: The

regularity with which LEP individuals interact with the organization/program; (3) Nature: The importance of the program/service/activity to peoples' lives; and (4) Availability of resources and costs: The balance between achieving meaningful access without creating excessive financial burdens on the organization.

In addition, the Plan includes five strategic initiatives:

- *Language and Disability Access Training:* Develop language and disability access-related training, as well as linguistic and cultural competency training, for DMAS staff to ensure effective communication with LEP individuals and individuals with disabilities.
- *Accessibility, Quality Control and Technology:* DMAS will institute procedures to assess the accessibility, accountability, quality of language assistance activities, and adoption of new technology to improve language and disability access.
- *Plan Dissemination to Internal Staff and External Stakeholders:* Establish methods for communicating to employees, external stakeholders, Medicaid members, and potential enrollees the availability of the Language and Disability Access Plan, its policies and procedures, and related LEP and disability population trends.
- *Monitoring Trends in the Need of Language Access:* To collect and update data by "language spoken/used," and disability, in order to assess the effectiveness of the Medicaid program and services for LEP and disability populations served.
- *Stakeholder Consultation:* DMAS will consult with partners and stakeholders, including individuals with LEP and people with disabilities and their families, in identifying LEP and disability population needs in order to assess and develop strategies on an ongoing basis to enhance language and disability access to Medicaid programs and services.

The Language and Disability Access Plan shows DMAS' commitment to improve the health and wellbeing of Virginians by removing any communication barriers among the LEP and disability communities. The Plan also provides guidance to DMAS to meet legal federal and Commonwealth requirements that prohibit discrimination on the basis of race, color, national origin, sex, age, disability, and religion. The Plan is reviewed annually to ensure DMAS is consistently in compliance with those regulations.

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 Acute and 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

DMAS prioritizes 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 providers serving Virginia Medicaid members. 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 providers, 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 these key areas through withholds under the Cardinal Care program, whereby each MCO can earn back a portion of its capitation payments through demonstrated performance against key metrics. In 2021, the VA General Assembly directed DMAS to establish a nursing facility value-based purchasing (NF VBP) program that targeted adequate staffing levels and the avoidance of negative care events such as pressure ulcers and ED visits. The program’s performance measures and targets are reviewed and modified on a regular basis to ensure that NF quality continues to improve.

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 §438.236, medical necessity guidelines must be evidence-based and at a minimum:

1. Based on valid and reliable clinical evidence or a consensus of providers in the particular field;
2. Adopted in consultation with contracting healthcare professionals in the MCO’s service area;
3. Developed in accordance with standards adopted by national accreditation organizations;
4. Updated at least annually or as new treatments, applications, and technologies are adopted as generally accepted professional medical practice; and
5. Applied in a manner that considers the individual healthcare needs of the member.

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

The Partnership for Petersburg initiative was launched with State, local, community, and faith leaders. With support from the Commonwealth's resources, the Partnership's mission is to help Petersburg become one of the best cities to live, work, and raise a family. The "Partnership for Petersburg" is 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.

Over the past decade, Petersburg has been consistently ranked as the unhealthiest locality in Virginia by the University of Wisconsin's Population Health Institute. Virginia's Secretary of Health and Human Resources 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.

Partnership for Petersburg Achievements³⁰

- Urban Baby Beginnings opened the maternal health hub in April 2023, providing one-stop access to a range of maternal health services with support from a grant from the Anthem Blue Cross & Blue Shield Foundation.
- 210 pregnant women received free prenatal and postpartum care through a targeted campaign to promote available maternal health services.
- Completed \$8 million, 75,000-square-foot Park and Ride facility that opened under-budget in Fall 2022 and has grown ridership 10 percent since opening.
- Debuted a third roundtrip on the DC-Petersburg-Norfolk train route; ridership has since grown by over 50 percent on the route and by 11 percent year-over-year at Petersburg Ettrick Station.
- Opened the Virginia Community Resource Center in downtown Petersburg to provide state and local support to the region's veteran population and community at large, with resources for education, health, workforce, housing, and more.
- Virginia was awarded \$1.5 billion of federal monies to deploy broadband access and increase service affordability in underserved areas. Virginia was the first state in the nation to submit all required planning, expediting the state's ability to serve Petersburg residents.
- Distributed 4,100 toothbrush kits to children in all Petersburg City Public Schools.
- Medicaid MCOs, DentaQuest, and Conexus, participated in over 236 community health-related events and mobile clinics in the City of Petersburg since August 2022.
- Partnered with Conexus Vision and United Healthcare to donate eyeglasses to 51 children at Lakemont Elementary School. Conexus performed digital vision screenings of 1,055

³⁰ Governor of Virginia. Partnership for Petersburg. Available at: <https://www.pfp.governor.virginia.gov/achievements/>. Accessed on: Aug 15, 2025.

Petersburg students, ultimately providing free in-person eye exams and prescription glasses to 440 students through its mobile clinic.

- \$16 million in state resources funded the creation of 193 new affordable housing units through the Affordable and Special Needs Housing program or private activity bond allocations.
- The Petersburg Health Department reopened its Men’s Health clinic ‘Monday Night Checkups’ in September 2022, providing free educational, counseling, testing, and treatment services to 66 adult men.
- \$5 million state investment dedicated to advance pharmaceutical manufacturing and support production of essential medicine ingredients.
- Established the Brightpoint pharmaceutical manufacturing program, yielding up to 125 training certifications, 30 of which have been issued.
- The Petersburg Health Department commenced an additional immunization clinic in September 2022, providing free services to over 410 clients since it opened on September 1.
- The Petersburg-based Molina One Stop Resource Center launched in July 2023, creating a central location for advisory group meetings, member and community education, as well as offering health clinics and telemedicine kiosks and other resources.

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 offering a series of trainings and opportunities for targeted technical assistance focusing on the areas of person-centered care, dementia care, improvement in VBP metrics, and other areas to be determined.

DMAS will seek CMS approval for use of the funds for this proposed program through a series of applications. The first application to CMS has received approval, and a person-centered care trauma-informed training will be launching soon. Additional applications for the other elements of the program are under development.

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

An initiative was launched 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. The task force was formed 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.

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.

Cardinal Care Smiles

Cardinal Care Smiles (CCS) is Virginia's Medicaid and FAMIS dental program. CCS 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. The CCS benefit also provided a 3 percent increased rate reimbursement for providers.



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

DMAS developed a series of strategies to improve maternal and infant outcomes among its members, with a particular administrative focus on ensuring women receiving timely postpartum care after giving birth. DMAS recently implemented coverage expansions that will improve access to healthcare 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 healthcare access for pregnant women 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 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 and Quality in Postpartum Care in Medicaid and CHIP

In August 2023, CMS released the Increasing Access and Quality 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 women 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 women; 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 women 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.³¹

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 woman 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.

Baby Steps VA

Virginia continues to improve maternal health outcomes for all pregnant and postpartum women and works to eliminate racial disparities and maternal mortality through the development of

³¹ Virginia Department of Medical Assistance Services. Community Doula Program. Available at: <https://www.dmas.virginia.gov/for-members/benefits-and-services/maternal-and-child-health/community-doula-program/>. Accessed on: Aug 15, 2025.

Baby Steps VA. DMAS outlined Baby Steps VA strategies to identify best practices to improve the wellbeing for all Medicaid members, from pregnancy to postpartum, and their babies. Baby Steps VA is committed to using member and provider voices to leverage focus areas to enhance services and care delivered daily.

DMAS strives to address birth outcomes, social determinants of health, barriers to care, and member/provider engagement. DMAS' Baby Steps VA continues as the foundation of maternal health as DMAS pursues new policies and initiatives to ensure optimal care for members.

DMAS continues to create strategies to streamline newborn and maternity enrollment by working with the eligibility and enrollment team and external partners such as Local Departments of Social Services (LDSSs) and MCOs. These strategies include:

- Implementation of a newborn bot (an automated technology feature), reducing the need for worker intervention and resulting in most newborn enrollments occurring on the day the birth is reported.
- Streamline newborn enrollment and develop ongoing reports for newborn visibility
- Cover all newborns born under managed care for the “Birth Month Plus Two” policy
- Increase early access, availability, and adequacy of care for prenatal and postpartum members

Baby Steps VA also uses communication, outreach, and collaborations to keep members and providers informed on Medicaid efforts, services, and enhancement of benefits from preconception to postpartum. Examples of DMAS collaborations and initiatives include:

- National Academy for State Health Policy (NASHP)—Maternal and Child Health (MCH) PIP project
- MCOs—quarterly meetings focused on increasing pre/postnatal care utilization
- Birth in Color—Richmond, VA—Black maternal health summit
- March of Dimes—Maternal Infant Health Equity—D.C., Maryland, and Virginia coalition focused on addressing disparities and improving health outcomes for moms and babies

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 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. DMAS requires that the medical record indicate which age-appropriate screening was provided in accordance with the AAP and Bright Futures periodicity schedule and all EPSDT-related services whether provided by the PCP or another provider.

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.³²

³² Center for Urban Population Health. Population Health Framework. Available at: <https://www.cuph.org/population-health-framework.html>. Accessed on: Aug 20, 2025.

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.³³ According to NCQA, at a minimum, PHM addresses the needs of the member by focusing on the following key areas:³⁴

- 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 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

³³ The American Hospital Association Center for Health Innovation. Population Health Management. Available at: <https://www.aha.org/center/population-health-management>. Accessed on: Aug 15, 2025.

³⁴ The National Committee for Quality Assurance. Population Health Management Resource Guide.

- 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.³⁵ 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

³⁵ 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 15, 2025.

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.

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. 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.
- 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 religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; geographic location; or other characteristics historically linked to discrimination or exclusion.³⁶
- 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 opportunities to address diversity. 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.³⁷



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

³⁶ 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: Aug 15, 2024.

³⁷ 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.

QI principles in designing initiatives to reduce health disparities. DMAS updates initiatives and 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 CCC Plus 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.

CCC Plus 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, and 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 placed 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.

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, 2020.³⁸ DMAS delivers one in three births in the Commonwealth or approximately 37,000 births 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	<p>FAMIS MOMS (Eligibility category 005) Medicaid for Pregnant Women (Eligibility categories 091, 097)</p> <p>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.</p>
Medicaid Delivery System	<p>FFS Managed Care</p>
<p>Maternal Region of Residence</p> <p>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.</p>	<p>Central Charlottesville Far Southwest Halifax/Lynchburg Northern/Winchester Roanoke/Alleghany Tidewater</p>

³⁸ 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 15, 2025.

Demographic Category	Category Values
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 8 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						
MLTSS	3,742	1,164	31.11%	2,540.9823	67.90%	0.46
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

Stratification	Facility Admissions	Observed Numerator	Observed Rate	Expected Numerator	Expected Rate	O/E Ratio*
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
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

Stratification	Facility Admissions	Observed Numerator	Observed Rate	Expected Numerator	Expected Rate	O/E Ratio*
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 *Screening for Depression and Follow-Up Plan (CDF)* performance measure. DMAS contracted with HSAG in 2024 to calculate the *Screening for Depression and Follow-Up Plan (CDF)* PM following the FFY 2024 CMS Core Set of Adult Health Quality Measures for Medicaid and Core Set of Children's Health Care Quality Measures for Medicaid and the Children's Health Insurance Program (CHIP) Technical Specifications and Resource Manuals.^{39,40} Table 6 and Table 7 display the CY 2024 CDF Child Core Set PM results and Adult Core Set PM results, respectively, stratified by Medicaid program, Medicaid delivery system, MCO, geographic region, and select demographics (e.g., gender and race).

Table 6—CDF Child Core Set PM Results

Stratifications	Num	Denom	Rate
Virginia Total	19,441	839,052	2.32%
Child Core Set Total (12–17 Years)	10,005	176,449	5.67%
Medicaid Program			
Medicaid [^]	8,407	153,349	5.48%
Separate CHIP	1,598	23,100	6.92%
Medicaid Delivery System			
Fee-for-Service	24	928	2.59%

³⁹ Centers for Medicare & Medicaid Services. FFY 2024 Adult Core Set Measures Technical Specifications and Resource Manual. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf?t=1736123649>. Accessed on: Jan 8, 2025.

⁴⁰ Centers for Medicare & Medicaid Services. FFY 2024 Child Core Set Measures Technical Specifications and Resource Manual. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf?t=1717523300>. Accessed on: Jan 8, 2025.

Stratifications	Num	Denom	Rate
Managed Care	9,258	160,759	5.76%
More than One Delivery System	723	14,762	4.90%
MCO			
Aetna	526	14,604	3.60%
HealthKeepers	5,047	57,642	8.76%
Molina	386	5,532	6.98%
Sentara*	2,278	65,554	3.47%
United	908	15,295	5.94%
More than One MCO	113	2,132	5.30%
Geographic Region			
Central	753	42,483	1.77%
Charlottesville/Western	81	20,045	0.40%
Northern & Winchester	5,592	51,654	10.83%
Roanoke/Alleghany	63	16,028	0.39%
Southwest	S	S	S
Tidewater	3,509	35,954	9.76%
Unknown	S	S	S
Gender			
Male	5,239	93,100	5.63%
Female	4,766	83,349	5.72%
Unknown	0	0	NA
Race			
White	4,605	90,158	5.11%
Black/African American	3,466	59,114	5.86%
Asian	779	9,238	8.43%
Southeast Asian/Pacific Islander	147	1,919	7.66%
Hispanic	596	9,669	6.16%
More than One Race/Other/Unknown	412	6,351	6.49%

[^]Medicaid is inclusive of Medicaid expansion CHIP.

* Rates for Sentara include members enrolled with Optima or VA Premier during CY 2023.

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

NA indicates a small denominator.

Table 7—CDF Adult Core Set PM Results

Stratifications	Num	Denom	Rate
Virginia Total	19,441	839,052	2.32%
Adult Core Set Total	9,436	662,603	1.42%
Medicaid Program			
Medicaid [^]	9,131	651,493	1.40%
Separate CHIP	305	11,110	2.75%
Medicaid Delivery System			
Fee-for-Service	225	21,125	1.07%
Managed Care	8,010	546,703	1.47%
More than One Delivery System	1,201	94,775	1.27%
MCO			
Aetna	769	82,244	0.94%
HealthKeepers	2,690	159,207	1.69%
Molina	1,703	37,217	4.58%
Sentara*	1,499	195,177	0.77%
United	1,169	62,484	1.87%
More than One MCO	180	10,374	1.74%
Geographic Region			
Central	2,723	164,038	1.66%
Charlottesville/Western	494	80,217	0.62%
Northern & Winchester	3,217	162,319	1.98%
Roanoke/Alleghany	859	65,196	1.32%
Southwest	669	43,469	1.54%
Tidewater	1,474	147,336	1.00%
Unknown	0	28	NA
Age			
18–64 Years	7,179	589,900	1.22%
65+ Years	2,257	72,703	3.10%
Total (18+ Years)	9,436	662,603	1.42%
Age by Program			
18–64 Years—Medicaid [^]	6,874	578,790	1.19%
18–64 Years—Separate CHIP	305	11,110	2.75%
65+ Years—Medicaid [^]	2,257	72,703	3.10%

Stratifications	Num	Denom	Rate
65+ Years—Separate CHIP	0	0	NA
Gender			
Male and Unknown†	3,673	250,563	1.47%
Female	5,763	412,040	1.40%
Race			
White	4,455	323,795	1.38%
Black/African American	3,029	229,518	1.32%
Asian	1,138	42,628	2.67%
Southeast Asian/Pacific Islander	58	3,667	1.58%
Hispanic	264	19,171	1.38%
More than One Race/Other/Unknown	492	43,824	1.12%

[^]Medicaid is inclusive of Medicaid expansion CHIP.

^{*} Rates for Sentara include members enrolled with Optima or VA Premier during CY 2023.

NA indicates a small denominator.

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

[†] To avoid suppression, HSAG combined the Male and Unknown gender groups together

Overall, only 2 percent of Virginia Medicaid members received a screening for depression and, if positive, had a follow-up plan documented in CY 2023. Children ages 12 to 17 years received depression screenings at higher rates than adults in Virginia, with a rate approximately 4 percentage points higher than the rate for adults. For the MCOs, HealthKeepers had the highest rate for children, while Molina had the highest rate for adults. Both Aetna and Sentara adult and child members had the lowest rates of depression screenings compared to other MCOs. Adult and child members in the Northern & Winchester geographic region had the highest rates, while adult and child members in the Charlottesville/Western geographic region had the lowest rates. Of note, Asian and Southeast Asian/Pacific Islander child and adult members had the highest rates of depression screenings and follow-up plans compared to any other racial group members. Please note, this measure requires the use of age-appropriate, standardized, and validated depression screening tools. Therefore, it is possible that depression screenings and follow-up plans are happening; however, they may not be occurring using the appropriate tools, or the information may not be captured in administrative data.

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.⁴¹

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,

⁴¹ Ibid.

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.⁴² 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 8 displays the CY 2021 colorectal cancer screening performance measure results stratified by Medicaid program, MCO, geographic region, and select demographics (i.e., age, gender, and race).

Table 8—Colorectal Cancer Screening PM Results

Rate Stratification	CY 2021 Results
Virginia Total	32.73%
Medicaid Managed Care Program	
MLTSS	40.35%
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%

⁴² Ibid.

Rate Stratification	CY 2021 Results
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%
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. Influence health, healthcare, and public policy in order to reduce health disparities.
4. 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 backgrounds, disabilities, or gender.

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 42 CFR §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 requires MCOs to track and report performance measures, including measure stratifications specified in the CMS Child and Adult Core Sets and the HEDIS measure specifications. 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 9):

Table 9—Assignment of CMS Core Set Performance Measures to the Quality of, Access to, and Timeliness of Care Domains

Performance Measure	Quality	Access	Timeliness
Primary Care Access and Preventive Care			
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i>	✓		
<i>Chlamydia Screening in Women Ages 16 to 20</i>	✓		✓
<i>Childhood Immunization Status</i>	✓	✓	✓
<i>Well-Child Visits in the First 30 Months of Life</i>	✓	✓	✓
<i>Immunizations for Adolescents</i>	✓	✓	✓
<i>Developmental Screening in the First Three Years of Life</i>	✓		✓
<i>Child and Adolescent Well-Care Visits</i>	✓	✓	✓
<i>Lead Screening in Children</i>	✓		✓
Maternal and Perinatal Health			
<i>Live Births Weighing Less Than 2500 Grams</i>	✓	✓	✓
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care</i>	✓	✓	✓
<i>Contraceptive Care—Postpartum Women Ages 15 to 20</i>	✓		✓
<i>Contraceptive Care—All Women Ages 15 to 20</i>	✓		✓
<i>Prenatal Immunization Status</i>	✓		✓
<i>Low-Risk Cesarean Delivery: Under Age 20</i>	✓		
Care of Acute and Chronic Conditions			
<i>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years</i>	✓		
Dental and Oral Health Services			
<i>Oral Evaluation, Dental Services</i>	✓	✓	✓
<i>Topical Fluoride for Children</i>	✓	✓	✓
<i>Sealant Receipt on Permanent First Molars</i>	✓	✓	✓
<i>Oral Evaluation During Pregnancy: Ages 15 to 20</i>	✓	✓	✓
Experience of Care			
<i>CAHPS Health Plan Survey 5.1H—Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items</i>	✓	✓	✓

Performance Measure	Quality	Access	Timeliness
Provisional Child Core Set Measures			
<i>Postpartum Depression Screening and Follow-Up: Under Age 21</i>			
<i>Prenatal Depression Screening and Follow-Up: Under Age 21</i>			

DMAS posts the quality measures and performance outcomes annually online in the following location:



The Annual EQR Technical Report

<https://www.dmas.virginia.gov/media/ibjjoec0/2024-cardinal-care-annual-technical-report.pdf>

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

<https://www.dmas.virginia.gov/data-reporting/cardinal-care/hedis-dashboard/https://www.dmas.virginia.gov/data-reporting/cardinal-care/hedis-dashboard/>

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.

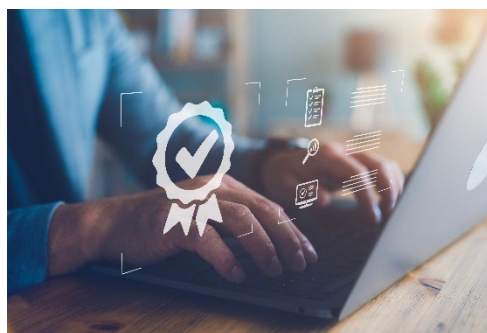
State Monitoring and Evaluation of MCOs' Contractual Compliance

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 15 compliance standards are derived from requirements in the Final Rule and include:

- Disenrollment Requirements and Limitations (42 CFR §438.3; 42 CFR §438.56; 42 CFR §457.1212)
- Member Rights and Member Information (42 CFR §438.10; 42 CFR §438.100; 42 CFR §457.1207; 42 CFR §457.1220)
- Emergency and Poststabilization Services (42 CFR §438.114; 42 CFR §457.1228)
- Availability of Services (42 CFR §438.206; 42 CFR §457.1230[a])
- Assurances of Adequate Capacity and Services (42 CFR §438.207; 42 CFR §457.1230[b]; 42 CFR §457.1218)
- Coordination and Continuity of Care (42 CFR §438.208; 42 CFR §457.1230[c])
- Coverage and Authorization of Services (42 CFR §438.210; 42 CFR §457.1230[d])
- Provider Selection (42 CFR §438.214; 42 CFR §457.1233[a])
- Confidentiality (42 CFR §438.224; 42 CFR §457.1233[e])
- Grievance and Appeal Systems (42 CFR §438.228; 42 CFR §457.1260)
- Subcontractual Relationships and Delegation (42 CFR §438.230; 42 CFR §457.1233[b])
- Practice Guidelines (42 CFR §438.236; 42 CFR §457.1233[c])
- Health Information Systems (42 CFR §438.242; 42 CFR §457.1233[d])
- Quality Assessment and Performance Improvement Program (42 CFR §438.330; 42 CFR §457.1240)
- Practice Guidelines (42 CFR §438.23)
- Program Integrity (42 CFR §438.608; 42 CFR §457.1280)

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.

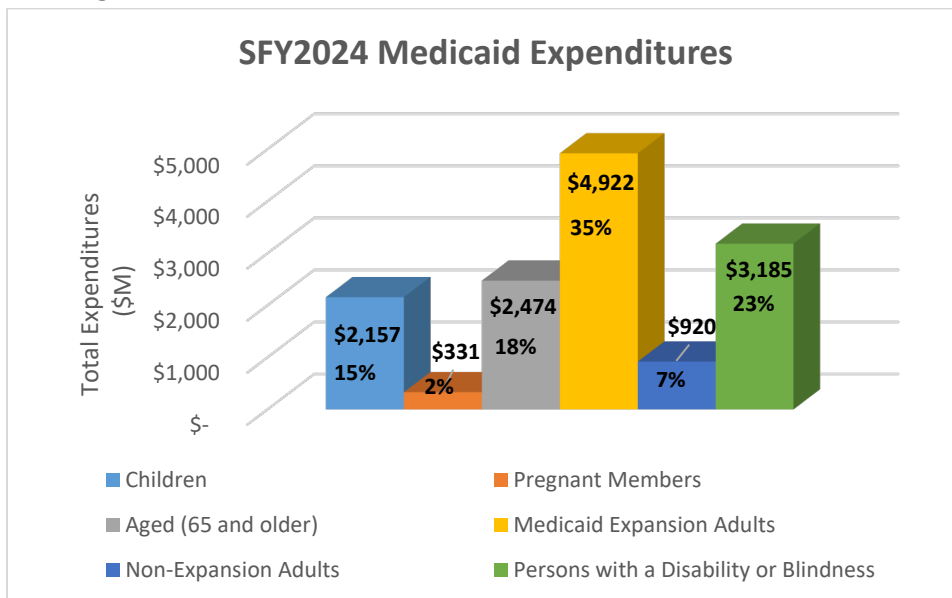
Using Incentives and Intermediate Sanctions to Drive Improvement

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 2024



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 10.

Table 10—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.

Value-Based Payments

The VBP program is of strategic importance to DMAS' Quality Strategy. VBP is a broad set of strategies intended to improve healthcare quality, outcomes, and efficiency by linking financial and nonfinancial incentives to performance. 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 developed by the Health Care Payment Learning & Action Network with an emphasis on models in categories three and four.⁴³ 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 residing in nursing facilities. This program seeks to improve the quality and outcomes of care by enhancing performance accountability in the areas of staffing and avoidance of negative care events. DMAS developed a provider-facing NF VBP program with performance measures. To reduce administrative burden, DMAS selected PMs that are 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 CMS-established measure sources allows Virginia nursing facilities to participate in the NF VBP program without additional reporting requirements. For SFY 2026, DMAS selected performance measures that aligned with DMAS' and the General Assembly's quality initiatives. The staffing measures include the weighted average of case-mix adjusted total nurse staffing hours. The avoidance of negative care events measures include reducing pressure ulcers, hospitalizations, and ED visits. The program measures and targets will evolve over time to reflect data availability and stakeholder input.

⁴³ Health Care Payment Learning & Action Network. APM Framework. Available at: <https://hcp-lan.org/apm-framework/>. Accessed on: Aug 6, 2025.

Performance Withhold Program (PWP)

DMAS established the PWP to reinforce VBP principles by connecting financial incentives to the quality of care received by Virginia Medicaid managed care members. The PWP measures reflect standards in key areas influencing member health and health outcomes. DMAS annually reviews and updates measures and performance targets. The PWP withholds a percentage of the MCO's per member per month (PMPM) capitation rate payments that the MCO can subsequently earn back based on performance attainment or improvement. Currently, 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. PWP performance is evaluated on measures from the following measure sets:

- NCQA's HEDIS
- CMS' Adult Core Set
- CMS' Child Core Set
- The Agency for Healthcare Research and Quality's (AHRQ's) Pediatric Quality Indicators (PDIs)

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

Clinical Efficiencies

In December 2016, JLARC published a study titled "Managing Spending in Virginia's Medicaid Program."⁴⁴ The Virginia General Assembly subsequently enacted budget language to execute the recommendations in this report. As part of this mandate, DMAS identified clinical efficiencies in high-acuity settings of care under its managed care program and developed a withhold based on several performance measures. The clinical efficiency measures focus on medically unnecessary, avoidable, or potentially preventable spending for hospital admissions, hospital readmissions, and ED visits. DMAS applies a 0.25 percent withhold to capitation rates under the Cardinal Care managed care program.

⁴⁴ Virginia Joint Legislative Audit & Review Commission. Managing Spending in Virginia's Medicaid Program. Available at: <http://jlarc.virginia.gov/medicaid-2016.asp>. Accessed on: Aug 6, 2025.

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 various 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 United States Code §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.
- 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

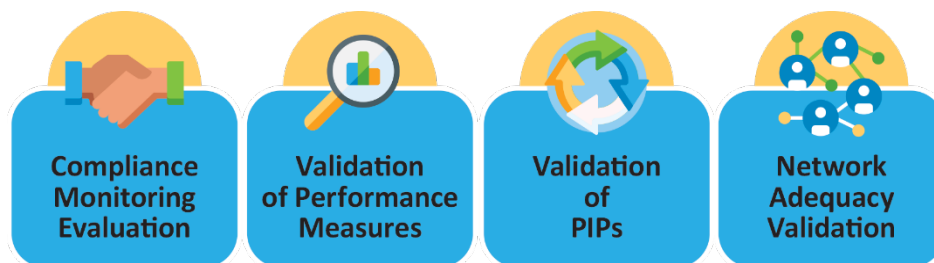
In accordance with 42 CFR §438.356, DMAS contracts with HSAG as its EQRO to conduct the mandatory and optional EQR activities as set forth in 42 CFR §438.358. DMAS contracts with a CMS QI organization, which is also a CMS Network of Quality Improvement and Innovation Contractor, to serve as the EQRO 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: <https://www.dmas.virginia.gov/media/ibjjoec0/2024-cardinal-care-annual-technical-report.pdf>.

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 healthcare 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 (42 CFR §422.158); are comparable to standards established through the EQR protocols (42 CFR §438.352 and 42 CFR §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 Standards for Access, Structure, and Operations

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)

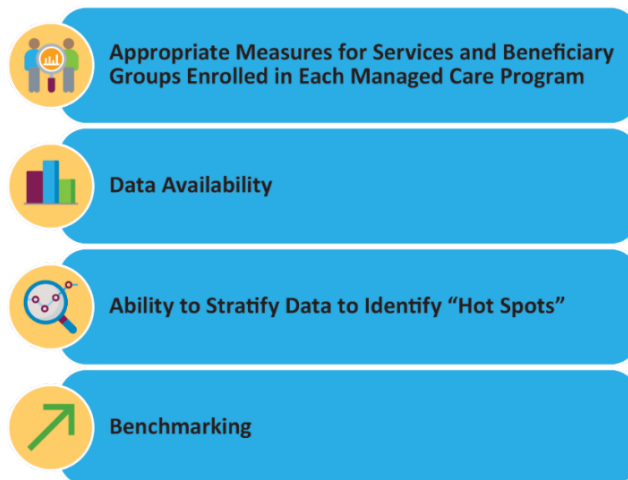
DMAS selected standard performance measures that MCOs are required to measure and report to DMAS. Consistent with DMAS' desire to benchmark its progress against other states' performance and assess key priorities to drive CQI efforts, nearly all of these measures are nationally recognized and include 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[®].⁴⁵

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 disadvantaged 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:



⁴⁵ 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 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, 42 CFR 438.340(b)(5) and 457.1240(e)

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. Information on transitions of care can be found in Sections 8.10 and 8.11 of the Cardinal Care Managed Care contract (<https://www.dmas.virginia.gov/media/jtuhlgt/sfy-2026-ccmc-contract-07-01-2025.pdf>) as well as the DMAS Member Handbook ([medical-assistance-handbook-en-final-06-03-25.pdf](https://www.dmas.virginia.gov/media/jtuhlgt/medical-assistance-handbook-en-final-06-03-25.pdf)).

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 §438.214; 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 CCS 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 11.

Table 11—Network Adequacy Standards

MCO Network Adequacy Standards	MCO Contract Requirement
<i>Anticipated Medicaid enrollment</i>	
<i>Expected utilization of services</i>	
<i>Characteristics and healthcare needs of specific Medicaid populations covered in the MCO contract</i>	
<i>Numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services</i>	
<i>Numbers of network providers who are not accepting new Medicaid patients</i>	
<i>Geographic location of network providers and Medicaid enrollees, considering distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees</i>	
<i>Ability of network providers to communicate with limited English-proficient enrollees in their preferred language</i>	
<i>Ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities</i>	
<i>Availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions</i>	

Exception Process

42 CFR §438.66 and 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' 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.

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 SUD 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.

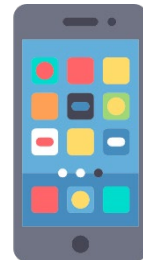
Enrollment and Disenrollment

42 CFR §438.54 and 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 MCO 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 MCO enrollment and disenrollment requirements.

Managed Care 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 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

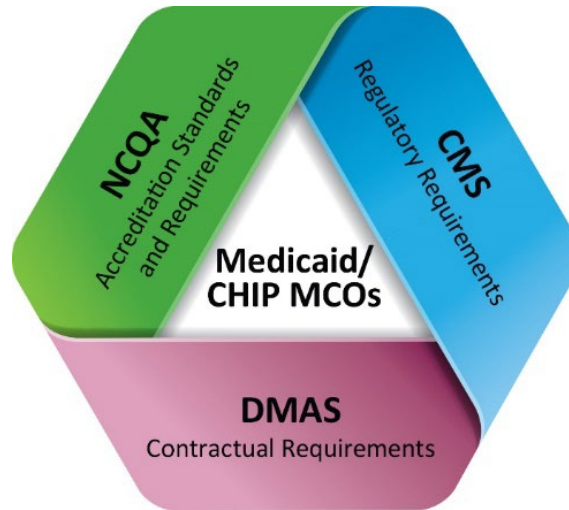
42 CFR §438.330

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.

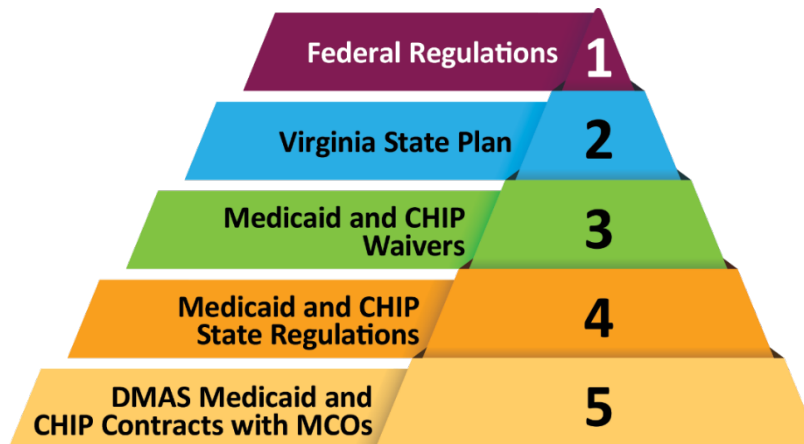
The requirements and standards serve as the basis for the Quality Strategy and are depicted in the framework in Figure 12.

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 MCOs to track and report performance measures, including measure stratifications specified in the CMS Core Set and HEDIS measure specifications. 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 and 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:

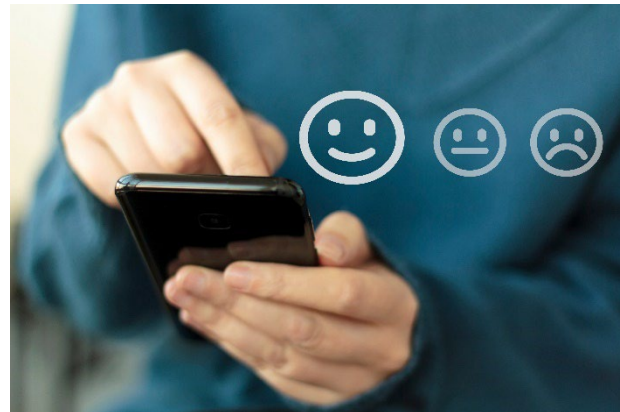
- The technical structure of the PIP to ensure that the MCO designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements.

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. Measures for the MLTSS population include a focus on quality of life, rebalancing, and community integration for individuals receiving LTSS. 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 12—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)	<p>2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:</p> <p>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.</p> <p>Toolkit Requirement:</p> <ul style="list-style-type: none"> 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.	8–10 12

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
<p><i>Note: Not all requirements in the CFR are included in the Quality Strategy Toolkit.</i></p>	<p>42 CFR §438.340(a), applicable also to CHIP managed care programs per 42 CFR §457.1240(e)</p>	<p>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.</p> <p>Toolkit Requirement:</p> <ul style="list-style-type: none"> 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. 	<p>18 21–24</p>
<p>42 CFR §438.340(b)(3)(i); 42 CFR §457.1240(e); §438.330(c)(1)(ii)</p>	<p>II.E.3 LTSS Performance Measures 42 CFR §438.340(b)(3)(i); 42 CFR §457.1240(e); §438.330(c)(1)(ii)</p>	<p>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.</p> <p>Toolkit Requirement:</p> <ul style="list-style-type: none"> Indicate in the quality strategy whether the state delivers LTSS through managed care. 	<p>21–24 Appendix B Appendix D</p>

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		<ul style="list-style-type: none"> 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)	<p>II.D. Goals and Objectives</p> <p>42 CFR §438.340(b)(2), applicable also to CHIP managed care programs per 42 CFR §457.1240(e).</p>	<p>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.</p> <p>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.”</p> <p>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.</p> <p>2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit: Include measurable goals and objectives in the quality strategy.</p> <ul style="list-style-type: none"> 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
		<ul style="list-style-type: none"> 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.	33–36
§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.	33–36
§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.	34–35
§438.340(c)(2)(i)		Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually).	33
§438.340(b)(10) and (c)(3)(ii)	<p>III.A.1 Updates for State-Defined Significant Changes</p> <p>§438.340(b)(10) and (c)(3)(ii), §457.1240(e)</p>	<p>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.”</p> <p>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.</p> <p>2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:</p> <ul style="list-style-type: none"> 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. 	32–33

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)	<p>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.</p> <p>2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit: No details provided in the toolkit.</p>	33
§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).	<p>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.</p> <p>2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:</p> <ul style="list-style-type: none"> • 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. 	33–35

Assessment

Table 13—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.	37–39
§438.330(b)(4)		Include the state’s definition of SHCN.	94
<i>Note: Not required but supports the above requirement.</i>			
§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: <ul style="list-style-type: none"> 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 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.	67–69 Appendix D

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.340(b)(6); §457.1240(e) <i>Note: The CFR does not include the level of detail included in the Quality Strategy Toolkit</i>	II.E.6 Disparities Plan 42 CFR §§438.340(b)(6); 457.1240(e)	<p>Document any efforts or initiatives that the state or MCO/PIHP has engaged in to reduce disparities in health care.</p> <p>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.</p> <p>2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:</p> <ul style="list-style-type: none"> • 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 14—National Performance Measures

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.330(c)(1)(i)	<p>II.E.1 Quality Metrics and Performance Targets Exhibit 3</p> <p>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)</p>	<p>Include a description of any required national performance measures and levels identified and developed by CMS in consultation with states and other stakeholders.</p> <p>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.</p> <p>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.</p>	84–86 Appendix B Appendix D
§438.340(b)(3) §438.330(c)	<p>II.E.1 Quality Metrics and Performance Targets</p> <p>42 CFR §438.340(b)(3)(i), applicable also to CHIP managed</p>	<p>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.</p>	84–86 Appendix B Appendix D

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
	<p>care programs per 42 CFR §457.1240(e), cross-referencing §438.330(c)</p>	<p>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.</p> <p>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.</p> <p>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.</p>	
<p>§§438.340(b)(3)(i); 457.1240(e)</p>	<p>II.E.2 Public Posting of Quality Measures and Performance Outcomes</p> <p>§§438.340(b)(3)(i); 457.1240(e)</p>	<p>CFR Description: The state must identify which quality measures and performance outcomes it will publish at least annually on its website.</p> <p>2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:</p> <ul style="list-style-type: none"> • 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. 	<p>84–86</p>

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		<ul style="list-style-type: none"> 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)	<p>2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:</p> <p>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.</p> <p>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.</p>	84–86 Appendix B Appendix D

Monitoring and Compliance

Table 15—Monitoring and Compliance

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.66		<p>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).</p> <p>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:</p>	87–89 100–117

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		<ul style="list-style-type: none"> (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. <p>(c) The State must use data collected from its monitoring activities to improve the performance of its managed care program, including at a minimum:</p> <ul style="list-style-type: none"> (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
		<p>(4) Findings from the State's External Quality Review process.</p> <p>(5) Results from any enrollee or provider satisfaction survey conducted by the State or MCO, PIHP, or PAHP.</p> <p>(6) Performance on required quality measures.</p> <p>(7) Medical management committee reports and minutes.</p> <p>(8) The annual quality improvement plan for each MCO, PIHP, PAHP, or PCCM entity.</p> <p>(9) Audited financial and encounter data submitted by each MCO, PIHP, or PAHP.</p> <p>(10) The medical loss ratio summary reports required by § 438.8.</p> <p>(11) Customer service performance data submitted by each MCO, PIHP, or PAHP and performance data submitted by the beneficiary support system.</p> <p>(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.</p> <p>Some examples of mechanisms that may be used for monitoring include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 16—External Quality Review (EQR)

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.350(a) and §340(b)(4)		<p>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.</p> <p>Identify what entity will perform the EQR and for what period of time.</p>	95–99
<p>§438.350(a) and §340(b)(4)</p> <p><i>Note: The CFR does not include the detailed requirements included in the Quality Strategy Toolkit</i></p>	<p>II.G.1 EQR Arrangements</p> <p>42 CFR §438.340(b)(4), 42 CFR §§457.1240(e), 438.350, 457.1250</p>	<p>Identify what, if any, optional EQR activities the state has contracted with its External Quality Review Organization (EQRO) to perform.</p> <p>The five optional activities include:</p> <ol style="list-style-type: none"> 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. <p>2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:</p> <p>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.</p> <p>Toolkit Requirement:</p> <ul style="list-style-type: none"> • 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. 	97

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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).	98–99
§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	98–99

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		<p>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:</p> <ul style="list-style-type: none"> • 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. <p>Toolkit Requirement:</p> <ul style="list-style-type: none"> • 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 17—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: <ul style="list-style-type: none"> 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. 	32 54 101-102 106-109
§438.206(b)(1)		Maintains and monitors a network of appropriate providers	101–102
§438.206(b)(2)		Female members have direct access to a women's health specialist	104
§438.206(b)(3)		Provides for a second opinion from a qualified health care professional	104
§438.206(b)(4)		Adequately and timely coverage of services not available in network	101
§438.206(b)(5)		Out-of-network providers coordinate with the MCO or PIHP with respect to payment	101
§438.206(b)(6)		Credential all providers as required by §438.214	105–106
§438.206(b)(7)		Demonstrate that network includes sufficient family planning providers to ensure timely access to covered services	104
§438.206(c)(1)(i)		Providers meet state standards for timely access to care and services	101–102

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	101
§438.206(c)(1)(iii)		Services included in the contract available 24 hours a day, 7 days a week	101 106
§438.206(c)(1)(iv)-(vi)		Mechanisms to ensure compliance by providers	101–106
§438.206(c)(2)		Culturally competent services to all members	81 94 107
§438.206(c)(3)		Ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities	88 107
§438.207 Subpart D Requirements		Assurances of Adequate Capacity and Services	
§438.207(a)		Assurances and documentation of capacity to serve expected enrollment	106–107
§438.207(b)(1)		Offer an appropriate range of preventive, primary care, and specialty services	105
§438.207(b)(2)		Maintain network sufficient in number, mix, and geographic distribution	105
§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	104
§438.208(b)(2)		All services that the member receives are coordinated with the services the member receives from any other MCO/PIHP	104
§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

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.208(b)(5)		Provider maintains and shares, as appropriate, an enrollee health record in accordance with professional standards	104
§438.208(b)(6)		Protect member privacy when coordinating care	110
§438.208(c)(1)		State mechanisms to identify persons with SHCN	93
§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	104
§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”	104
§438.210(b)(1)		Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services	104–105
§438.210(b)(2)		Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions	105

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.210(b)(3)		Any decision to deny or reduce services is made by an appropriate health care professional	105
§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	105
§438.210(d)		Provide for the authorization decisions and notices as set forth in §438.210(d)	111
§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	105
§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)	<p>CFR Description: The state must include a description of its transition of care policy.</p> <p>2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit: Review the transition of care policy to ensure the following requirements are addressed:</p> <ul style="list-style-type: none"> • 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. • The process for the electronic exchange of beneficiary data. 	104

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		<ul style="list-style-type: none"> 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 18—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
§438.214(b)(1)		Uniform credentialing and recredentialing policy that each MCO/PIHP must follow	106
§438.214(b)(2)		Documented processes for credentialing and recredentialing that each MCO/PIHP must follow	106
§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	106
§438.214(d)		MCOs/PIHPs may not employ or contract with providers excluded from Federal health care programs	106
§438.214(e)		Comply with any additional requirements established by the state	106
§438.10		Information Requirements	
§438.10		Incorporate member information requirements of §438.10	109

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.224 Subpart D Requirements		Confidentiality	
§438.224		Individually identifiable health information is disclosed in accordance with Federal privacy requirements	110
§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	110
§438.228 Subpart D Requirements		Grievance and Appeal Systems	
§438.228(a)		Grievance systems meet the requirements of Part 438, subpart F	111–112
§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	112
§438.230(b)(1)		Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform	112
§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.	112
§438.230(c)(1)(iii)		Monitoring of subcontractor performance on an ongoing basis	112
§438.230(c)(1)(iii)		Corrective action for identified deficiencies or areas for improvement	112

Measurement and Improvement Standards

Table 19—Measurement and Improvement Standards

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
Practice Guidelines			
§438.236 Subpart D Requirements			
§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.	113–114
§438.236(c)		Dissemination of practice guidelines to all providers, and upon request, to members	113–114
§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.	113–114
Quality Assessment and Performance Improvement Program			
§438.330(a)(3)		An ongoing quality assessment and performance improvement program	114–116
§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	114–117 Appendix C

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
	42 CFR §§457.1240(e); 438.330(d); 457.1240(b)	<p>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.</p> <p>Toolkit Requirement:</p> <ul style="list-style-type: none"> 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)		<p>Conduct performance improvement projects, including any performance improvement projects required by CMS, that focus on both clinical and nonclinical areas:</p> <ul style="list-style-type: none"> 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 	114–117 Appendix C
§438.330(d)(3)		Report the status and results of each project conducted, not less than once per year	116–117
§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	100 115–116
§438.330(c)(i)		Identify standard performance measures, including those performance measures that may be specified by CMS	115–116 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	116 Appendix D
§438.330(b)(3)		Mechanisms to detect both underutilization and overutilization of services	37
§438.330(b)(4)		Mechanisms to assess the quality and appropriateness of care furnished to members with SHCN	37

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.330(b)(5)(i) §438.330(b)(5)(ii)		<p>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</p> <p>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).</p>	103–104
§438.330(e)		<p>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:</p> <ul style="list-style-type: none"> • 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 • <i>May</i> require a developed process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program 	39 116–117
§ 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	118
§438.242(b)(2)		Each MCO and PIHP must collect data on member and provider characteristics and on services furnished to members	118

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§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	118
§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	118
§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	117
§438.242(c)(3)		Each MCO submits enrollee encounter data, including allowed amount and paid amount, to the state	118
§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	118
Optional		Include any health information technology (HIT) initiatives that will support the objectives of the state's quality strategy.	118

Improvement and Interventions

Table 20—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: <ol style="list-style-type: none"> 1. Cross-state agency collaborative; 2. Pay-for-performance or value-based purchasing initiatives; 3. Accreditation requirements; 	10 38 41–43 51–55 60 89–90

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		4. Grants; 5. Disease management programs; 6. Changes in benefits for members; 7. Provider network expansion, etc.	92–93
Optional		Describe how the state’s planned interventions tie to each specific goal and objective of the quality strategy.	10 13–17

Intermediate Sanctions

Table 21—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.	89–92
Optional		Specify the state’s methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems.	91
§438.340(b)(7) 42 CFR Part 438, subpart I <i>Note: The CFR does not include the level of detail that is included in the Quality Strategy Toolkit.</i>	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: <ul style="list-style-type: none"> 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 reasons. The state can determine whether to describe the sanctions it applied at the MCP level or the aggregate level. 	225–226

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		<ul style="list-style-type: none"> 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 22—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.	Appendix F
Optional		Include a discussion of the ongoing challenges the state faces in improving the quality of care for beneficiaries.	13 27–30 40–49 231
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 23—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 Number of Outreach and Engagement (O&E) Activities Per year	MCO Reporting	DMAS
1.1.2 Monitor Language and Disability Access Reports	DMAS	DMAS
1.1.3 Monitor Member Language Counts	DMAS	DMAS
Objective 1.2 Improve Member Satisfaction		
1.2.1 Enrollees' Ratings Q8-Rating of all Health Care	CAHPS CMS Child Core Set CMS Adult Core Set	AHRQ
1.2.2 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 Getting Care Quickly Q6	CAHPS CMS Child Core Set CMS Adult Core Set	AHRQ
2.1.2 Respondent Got Non-Urgent Appointment as Soon as Needed	CAHPS CMS Child Core Set CMS Adult Core Set	AHRQ
2.1.3 Getting Needed Care	CAHPS CMS Child Core Set CMS Adult Core Set	AHRQ
Objective 2.2 Promote Patient Safety		
2.2.1 Prevalence of Pressure Ulcers Among LTSS Members	DMAS	DMAS
2.2.2 Monitor the Frequency of Reported Critical Incidents by Member Classification	DMAS	DMAS
Objective 2.3 Promote Effective Communication and Care Coordination		
2.3.1 How Well Doctors Communicate	CAHPS CMS Child Core Set CMS Adult Core Set	AHRQ
2.3.2 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 Frequency of Potentially Preventable Admissions	Clinical Efficiency Measures	DMAS
3.1.2 Frequency of Emergency Department Visits	Clinical Efficiency Measure	DMAS
3.1.3 Frequency of Potentially Preventable Readmissions	DMAS	DMAS
3.1.4 Ambulatory Care: Emergency Department (ED) Visits	Clinical Efficiency Measures HEDIS CMS Child Core Set	DMAS NCQA
3.1.5 Days Without Minimum RN Hours	DMAS VBP Reporting Team CMS Payroll Based Journal	DMAS
3.1.6 Total Nurse Staffing Hours Per Resident Day (RN, LPN, CAN)—Case-Mix Adjusted	DMAS VBP Reporting Team CMS Nursing Home Compare	DMAS
3.1.7 Percentage of Long-Stay Resident with a Urinary Tract Infection (UTI)	DMAS VBP Reporting Team CMS Nursing Home Compare	DMAS
3.1.8 Number of Hospitalizations per 1,000 Long-Stay Resident Days	DMAS VBP Reporting Team CMS Nursing Home Compare	DMAS
3.1.9 Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days	DMAS VBP Reporting Team CMS Nursing Home Compare	DMAS
3.1.10 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 Monitor Medical Loss Ratio	DMAS—MCO Financials https://www.dmas.virginia.gov/data-reporting/cardinal-care/mco-financials-data/	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 Adults' Access to Preventive/Ambulatory Health Services	HEDIS	NCQA
4.1.2 Child and Adolescent Well-Care Visits	HEDIS	NCQA
4.1.3 Childhood Immunization Status	HEDIS	NCQA
4.1.4 Immunizations for Adolescents	HEDIS CMS Child Core Set	NCQA
4.1.5 Flu Vaccinations for Adults 18–64	CAHPS	AHRQ
Objective 4.2 Improve Outcomes for Maternal and Infant Members		
4.2.1 Prenatal and Postpartum Care: Postpartum Care	HEDIS	NCQA
4.2.2 Prenatal and Postpartum Care: Timeliness of Prenatal Care	HEDIS	NCQA
4.2.3 Live Births Weighing Less than 2,500 Grams	CDC Wonder State Vital Statistics CMS Child Core Set	CMS

Measure Name	Data Source	Measure Steward (if applicable)
4.2.4 Well-Child Visits in the First 30 Months of Life	HEDIS CMS Child Core Set	NCQA
4.2.5 Low-Risk Cesarean Delivery	CMS Child Core Set	CDC
Objective 4.3 Improve Home and Community-Based Services		
4.3.1 Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and Appropriate to Their Needs and Personal Goals	QMR	DMAS
4.3.2 Number and Percent of Individuals Who Received Services in the Scope Specified in the Service Plan	QMR	DMAS
4.3.3 Can get an appointment to See or Talk to Their PCP When Needed	NCI-AD Survey	ADvancing States
4.3.4 Have Enough Help With Everyday Activities	NCI-AD Survey	ADvancing States
Goal 5: Providing Whole-Person Care for Vulnerable Populations		
Objective 5.1 Improve Outcomes for Members with Chronic Conditions		
5.1.1 PQI 08: Heart Failure Admission Rate	CMS Adult Core Set	AHRQ
5.1.2 PDI 14: Asthma Admission Rate (Ages 2–17)	Performance Measure	AHRQ
5.1.3 PQI 05: COPD and Asthma in Older Adults' Admission Rate	AHRQ PDI	AHRQ
5.1.4 Diabetes Care: <ul style="list-style-type: none"> Blood Pressure Control for Patients With Diabetes—Total Eye Exam for Patients With Diabetes—Total Glycemic Status Assessment for Patients With Diabetes (2 Indicators) <ul style="list-style-type: none"> Glycemic Status <8.0%—Total Glycemic Status > 9.0%—Total 	HEDIS	NCQA
5.1.5 Controlling High Blood Pressure	HEDIS	NCQA
Objective 5.2 Improve Outcomes for Members with Substance Use Disorders		
5.2.1 Monitor Identification of Alcohol and Other Drug Services	DMAS	DMAS
5.2.2 Follow-Up After Emergency Department Visit for Substance Use	HEDIS	NCQA
5.2.3 Initiation and Engagement of Substance Use Disorder Treatment	HEDIS	NCQA
Objective 5.3 Improve Behavioral Health and Developmental Services for Members		
5.3.1 Follow-up After Hospitalization for Mental Illness	HEDIS	NCQA
5.3.2 Follow-Up After Emergency Department Visit for Mental Illness	HEDIS	NCQA
5.3.3 Monitor Mental Health Utilization	DMAS	NCQA

Measure Name	Data Source	Measure Steward (if applicable)
5.3.4 Outpatient Behavioral Health Encounter in the Last 12 Months for Population With Behavioral Health Condition	DMAS	DMAS
5.3.5 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics ¹	HEDIS	NCQA
5.3.6 Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS	NCQA
5.3.7 Medical Assistance With Smoking and Tobacco Use Cessation	MCS Adult Core Set	CMS
5.3.8 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS CMS Adult Core Set	NCQA
5.3.9 Adherence to Antipsychotic Medications for Individuals With Schizophrenia	HEDIS CMS Adult Core Set	NCQA

¹ Measures that align with the SMI Midpoint Assessment are identified with blue font.

Table 24—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		
1.2.3 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		
2.1.4 Monitor Network Adequacy by Region and Provider Types	MCO Reporting	DMAS
2.1.5 Monitor Frequency and Reasons for Missed Trips	MCO Reporting	DMAS
2.1.6 Cervical Cancer Screening	HEDIS CMS Adult Core Set	NCQA
2.1.7 Chlamydia Screening in Women Ages 21 to 24	HEDIS CMS Adult Core Set	NCQA
2.1.8 Colorectal Cancer Screening	HEDIS CMS Adult Core Set	NCQA
2.1.9 Breast Cancer Screening	HEDIS CMS Adult Core Set	NCQA
2.1.10 Contraceptive Care—Postpartum Women Ages 21 to 44	CMS Adult Core Set	OPA
2.1.11 Contraceptive Care—All Women Ages 21 to 44	CMS Adult Core Set	OPA

Measure Name	Data Source	Measure Steward (if applicable)
2.1.12 Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 18 and Older	HEDIS CMS Adult Core Set	NCQA
2.1.13 HIV Viral Load Suppression	CMS Adult Core Set	HRSA
2.1.14 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		
3.2.2 Number of Administrative and Medical Deferrals and Disallowances;	DMAS—MCO Financials https://www.dmas.virginia.gov/data-reporting/cardinal-care/mco-financials-data/	DMAS
3.2.3 Diabetes Short-Term Complications Admission Rate	CMS Adult Core Measure Set	AHRQ
3.2.4 Heart Failure Admission Rate	CMS Adult Core Measure Set	AHRQ
3.2.5 Asthma in Younger Adults Admission Rate	CMS Adult Core Measure Set	AHRQ
3.2.6 Plan All-Cause Readmission Rate	HEDIS CMS Adult Core Measure Set	NCQA
Goal 4: Strengthen the Health of Families and Communities		
Objective 4.1: Improve the Utilization of Wellness, Immunization, and Prevention Services for Members		
4.1.6 Topical Fluoride for Children	NCQA HEDIS (TFC) Child Core Set: TFL-CH CMS 416	NCQA/CMS
4.1.7 Oral Evaluation, Dental Services	NCQA HEDIS (OED) Child Core Set: OEV-CH CMS 416	NCQA/CMS
4.1.8 Sealant Receipt on Permanent First Molars	Child Core Set: SFM-CH CMS 416	NCQA/CMS
4.1.9 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA HEDIS (WCC) CMS Child Core Set (WCC-CH)	NCQA
4.1.10 Chlamydia Screening in Women Ages 16 to 20 Years	NCQA HEDIS (CHL) CMS Child Core Set (CHL-CH)	NCQA
4.1.11 Lead Screening in Children	NCQA HEDIS (LSC) CMS Child Core Set (LSC-CH)	NCQA/CMS
Goal 5: Providing Whole-Person Care for Vulnerable Populations		
Objective 5.1 Improve Outcomes for Members with Chronic Conditions		
5.1.6 Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years	NCQA HEDIS (AAB) CMS Child Core Set: AAB-CH	NCQA

Measure Name	Data Source	Measure Steward (if applicable)
Objective 5.2 Improve Outcomes for Members with Substance Use Disorders		
5.2.4 Use of Pharmacotherapy for Opioid Use Disorder	CMS Adult Core Set: OUD-AD	CMS
Objective 5.3 Improve Behavioral Health and Developmental Services for Members		
5.3.10 Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	NCQA HEDIS (ADD) Child Core Set: ADD-CH	NCQA
5.3.11 Screening for Depression and Follow-Up Plan: Ages 18 and Over	Adult Core Set <ul style="list-style-type: none"> • MLTSS: <ul style="list-style-type: none"> – Ages 18–64: 1.2% – 65+: 3.1% • Acute: <ul style="list-style-type: none"> – Ages 18–64: 1.2% – 65+: 3.1% 	CMS
5.3.12 Diabetes Care for People With Serious Mental Illness: Glycemic Status ¹	NCQA HEDIS (HPCMI) CMS Adult Core Set: HPCMI-AD	NCQA
Objective 5.4 Improve Outcomes for Nursing Home Eligible Members		
5.4.1 Use of High-Risk Medications in Older Adults	HEDIS	NCQA

¹ Measures that align with the SMI Midpoint Assessment are identified with blue font.

Appendix C. Performance Improvement Topics

Table 25—Performance Improvement Projects 2025

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
Aetna Better Health of Virginia	Developmental Screening in the First Three Years of Life	Do the targeted interventions increase the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday?	The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	The MCO will report interventions in CY 2026.
	Screening for Depression and Follow-Up Plan, 18 and Older	Do targeted interventions increase the percentage of members 18 years of age and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter.	The percentage of members 18 years of age and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter.	The MCO will report interventions in CY 2026.
	Timeliness of Prenatal Care	Do targeted interventions increase the percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the	The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that	The MCO will report interventions in CY 2026.

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
		measurement year 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?	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.	
	Controlling High Blood Pressure	Do targeted interventions increase the percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm/Hg) during the measurement year?"	The percentage of members who were hospitalized and had an ambulatory follow-up visit with a primary care provider or licensed provider within 30 days of discharge.	The MCO will report interventions in CY 2026.
	Follow-Up After Emergency Department Visit for Substance Use (Addiction, Recovery, Treatment Services [ARTS])	TBD—Submission due 10/3/2025	The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 30-days.	The MCO will report interventions in CY 2026.
HealthKeepers, Inc.	Developmental Screening in the First Three Years of Life	Does initiating target interventions increase the percentage of Cardinal Care Managed Care children beneficiaries screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding	The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	The MCO will report interventions in CY 2026.

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
		or on their first, second, or third birthday?		
	Screening for Depression and Follow-Up Plan, 18 and Older	Do targeted interventions improve the percentage of beneficiaries ages 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen?	The percentage of members 18 years of age and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter.	The MCO will report interventions in CY 2026.
	Timeliness of Prenatal Care	Does initiating target interventions increase the percentage of pregnant Cardinal Care Managed Care members who receive a prenatal visit within 42 days of confirmation of pregnancy?	The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year 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.	The MCO will report interventions in CY 2026.
	Controlling High Blood Pressure	Does initiating target interventions increase the percentage of members whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year?	The percentage of members who were hospitalized and had an ambulatory follow-up visit with a primary care provider or licensed provider within 30 days of discharge.	The MCO will report interventions in CY 2026.

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
	Follow-Up After Emergency Department Visit for Substance Use (ARTS)	TBD—Submission due October 3, 2025	The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 30-days.	The MCO will report interventions in CY 2026.
Humana*	Developmental Screening in the First Three Years of Life	PIP deferred until 2026	The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	The MCO will report interventions in CY 2027.
	Screening for Depression and Follow-Up Plan, 18 and Older	PIP deferred until 2026	The percentage of members 18 years of age and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter.	The MCO will report interventions in CY 2027.

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
	Timeliness of Prenatal Care	PIP deferred until 2026	The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year 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.	The MCO will report interventions in CY 2027.
	Controlling High Blood Pressure	PIP deferred until 2026	The percentage of members who were hospitalized and had an ambulatory follow-up visit with a primary care provider or licensed provider within 30 days of discharge.	The MCO will report interventions in CY 2027.
	Follow-Up After Emergency Department Visit for Substance Use (ARTS)	TBD—Submission due October 3, 2025	The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 30-days.	The MCO will report interventions in CY 2026.

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
Sentara	Developmental Screening in the First Three Years of Life	Do targeted interventions increase the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday during the measurement period?	The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	The MCO will report interventions in CY 2026.
	Screening for Depression and Follow-Up Plan, 18 and Older	Do targeted interventions increase the percentage of beneficiaries age 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter during the measurement period?	The percentage of members 18 years of age and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter.	The MCO will report interventions in CY 2026.
	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 days of enrollment in the organization during the measurement period?	The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42	The MCO will report interventions in CY 2026.

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
			days of enrollment in the organization.	
	Controlling High Blood Pressure	Do targeted interventions increase the percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year?	The percentage of members who were hospitalized and had an ambulatory follow-up visit with a primary care provider or licensed provider within 30 days of discharge.	The MCO will report interventions in CY 2026.
	Follow-Up After Emergency Department Visit for Substance Use (ARTS)	TBD—Submission due October 3, 2025	The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 30-days.	The MCO will report interventions in CY 2026.
UnitedHealthcare Community Care Plan	Developmental Screening in the First Three Years of Life	Do targeted interventions increase the percentage of children in the entire eligible population who had claim with CPT code 96110 (screened for risk of developmental, behavioral, and social delays using a standardized tool) in the 12 months preceding or on their first, second, or third birthday during the reported remeasurement period?	The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	The MCO will report interventions in CY 2026.

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
	Screening for Depression and Follow-Up Plan, 18 and Older	Do targeted interventions increase the percentage of members 18 years and older who complete the screening for depression and follow-up plan during the reported measurement period?	The percentage of members 18 years of age and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter.	The MCO will report interventions in CY 2026.
	Timeliness of Prenatal Care	Do targeted interventions increase the percentage of pregnant women who receive a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment during the reported remeasurement period?	The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year 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.	The MCO will report interventions in CY 2026.
	Controlling High Blood Pressure	Do targeted interventions increase the percentage of members with controlled blood pressure during the reported measurement period?	The percentage of members who were hospitalized and had an ambulatory follow-up visit with a primary care provider or licensed provider within 30 days of discharge.	The MCO will report interventions in CY 2026.
	Follow-Up After Emergency	TBD—Submission due October 3, 2025	The percentage of emergency department	The MCO will report interventions in CY 2026.

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions
	Department Visit for Substance Use (ARTS)		(ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up within 30-days.	

**Humana will submit PIPs in CY 2026, except for the FUA PIP.*

Appendix D. Goals Tracking Table

Table 26—Goals Tracking Table

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
Goal 1: Enhance the Member Care Experience	Objective 1.1 Increase Member Engagement and Outreach	1.1.1. Number of Outreach and Engagement (O&E) Activities Per year	DMAS Cover Virginia	<p>Cover Virginia 2025: Spanish Calls Taken by Spanish-Speaking Bilingual Staff:</p> <p>Cover Virginia 2025: Calls Taken with Language Assistance Services:</p> <p>2025 DMAS Website Translation Requests 2025:</p>	<p>Increase by a minimum of 1 percent the Cover Virginia Spanish language calls taken by Spanish-speaking bilingual staff</p> <p>Increase by a minimum of 1 percent the Cover Virginia calls taken with language assistance by 2028</p> <p>Increase by a minimum of 1 percent the Cover Virginia call center language calls taken by 2028</p> <p>Increase by a minimum of 1 percent the translation requests taken by 2028</p>	<p>Cover Virginia 2028: Spanish Calls Taken by Spanish-Speaking Bilingual Staff:</p> <p>Cover Virginia 2028: Calls Taken with Language Assistance Services:</p> <p>2028 DMAS Website Translation Requests 2028:</p>
		1.1.2 Monitor Language and Disability Access Reports	DMAS	Cardinal Care:	Increase by a minimum of 1 percent the Language and Disability Access report monitoring	Cardinal Care:
		1.1.3 Monitor Member Language Counts	DMAS	Cardinal Care:	Increase by minimum of 1 percent the Member Language Counts reported:	Cardinal Care:
	Objective 1.2 Improve Member Satisfaction	1.2.1 Enrollees' Ratings Q8- Rating of all Health Care	CAHPS—AHRQ Adult Core Set: CPA-AD Child Core Set: CPC-CH	2025 Adult CAHPS: % 2025 Child CAHPS: %	Increase the Cardinal Care annual CAHPS overall Rating of <i>all Health Care</i> to perform at or above the CAHPS 50th percentile by 2028: <ul style="list-style-type: none"> Adult: Child: 	<ul style="list-style-type: none"> 2028 Adult CAHPS: % 2028 Child CAHPS: %
		1.2.2 Rating of Personal Doctor	CAHPS—AHRQ Adult Core Set: CPA-AD Child Core Set: CPC-CH	2025 Adult CAHPS: % 2025 Child CAHPS: %	Increase the Cardinal Care annual CAHPS overall Rating of <i>Personal</i>	<ul style="list-style-type: none"> 2028 Adult CAHPS: %

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
					<p>Doctor to perform at or above the CAHPS 50th percentile by 2028:</p> <ul style="list-style-type: none"> Adult: Child: 	<ul style="list-style-type: none"> 2028 Child CAHPS: %
Goal 2: Promote Access to Safe, Gold-Standard Patient Care	Objective 2.1 Ensure Access to Care	2.1.1 Getting Care Quickly Q6	CAHPS—AHRQ Adult Core Set: CPA-AD Child Core Set: CPC-CH	2025 Adult CAHPS: % 2025 Child CAHPS: %	Increase the Cardinal Care annual CAHPS overall Rating of <i>Getting Care Quickly</i> to perform at or above the CAHPS 50th percentile by 2028: <ul style="list-style-type: none"> Adult: Child: 	<ul style="list-style-type: none"> 2028 Adult CAHPS: % 2028 Child CAHPS: %
		2.1.2 Respondent Got Non-Urgent Appointment as Soon as Needed	CAHPS—AHRQ Adult Core Set: CPA-AD Child Core Set: CPC-CH	2025 Adult CAHPS: % 2025 Child CAHPS: %	Increase the Cardinal Care annual CAHPS overall Rating of <i>Got Non-Urgent Appointment as Soon as Needed</i> to perform at or above the CAHPS 50th percentile by 2028: <ul style="list-style-type: none"> Adult: Child: 	<ul style="list-style-type: none"> 2028 Adult CAHPS: % 2028 Child CAHPS: %
		2.1.3 Getting Needed Care	CAHPS—AHRQ Adult Core Set: CPA-AD Child Core Set: CPC-CH	2025 Adult CAHPS: % 2025 Child CAHPS: %	Increase the Cardinal Care annual CAHPS overall Rating of <i>Getting Needed Care</i> to perform at or above the CAHPS 50th percentile by 2028: <ul style="list-style-type: none"> Adult: Child: 	<ul style="list-style-type: none"> 2028 Adult CAHPS: % 2028 Child CAHPS: %
	Objective 2.2 Promote Patient Safety	2.2.1 Prevalence of Pressure Ulcers Among LTSS Members	DMAS	2025 Benchmark: <ul style="list-style-type: none"> Long-Term Nursing Facility: %² Short-Term Nursing Facility: %² CCC Plus Waiver Members: %² 	Decrease the prevalence percentage of LTSS members with pressure ulcers by a minimum of 1 percent over 2025 benchmark by 2028: <ul style="list-style-type: none"> Long-Term Nursing Facility: Short-Term Nursing Facility: CCC Plus Waiver Members: 	<ul style="list-style-type: none"> Long-Term Nursing Facility: Short-Term Nursing Facility: CCC Plus Waiver Members:
		2.2.2 Monitor the Frequency of Reported Critical Incidents by Member Classification	DMAS	2025 Benchmark: <ul style="list-style-type: none"> CCC Plus Waiver w/o PDN: CCC Plus Waiver: 	Increase the number and percentage of Cardinal Care program members without PDN critical incidents reported by a minimum of 1 percent over 2025 benchmark by 2028:	<ul style="list-style-type: none"> CCC Plus Waiver w/o PDN: CCC Plus Waiver: DD Waiver:

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
				<ul style="list-style-type: none"> • CCC Plus Waiver W PDN: • DD Waiver: • Emerging Vulnerable: • Minimal Need: • Nursing Facility: • Other: • Total:³ 	<ul style="list-style-type: none"> • CCC Plus Waiver w/o PDN: • CCC Plus Waiver: • DD Waiver: • Emerging Vulnerable: • Minimal Need: • Nursing Facility: • Other: • Total: 	<ul style="list-style-type: none"> • Emerging Vulnerable: • Minimal Need: • Nursing Facility: • Other: • Total:
	Goal 2.3 Promote Effective Communication and Care Coordination	2.3.1 How Well Doctors Communicate	CAHPS—AHRQ Adult Core Set: CPA-AD Child Core Set: CPC-CH	2025 Adult CAHPS: % 2025 Child CAHPS: %	Increase the Cardinal Care annual CAHPS overall Rating of <i>How Well Doctors Communicate</i> to perform at or above the CAHPS 50th percentile by 2028: <ul style="list-style-type: none">• Adult:• Child:	<ul style="list-style-type: none"> • 2028 Adult CAHPS: % • 2028 Child CAHPS: %
		2.3.2 Service Authorizations	DMAS https://www.dmas.virginia.gov/data-reporting/cardinal-care/mco-service-authorization-performance-dashboard/ https://www.dmas.virginia.gov/data/mco-service-authorization-performance/	MCO Reporting 2025 Benchmark:	Maintain or Increase by a minimum of 1% service authorizations adjudicated timely over the 2025 benchmark by 2028:	Service authorizations adjudicated timely:
Goal 3: Support Efficient and Value-Driven Care	Objective 3.1 Focus on Paying for Value	3.1.1 Frequency of Potentially Preventable Admissions	DMAS Clinical Efficiency (CE) Measures	Clinical Efficiency Measures 2025 Benchmarks: SFY 2025 PPA Measure Rate: <ul style="list-style-type: none">• PQI 08 Heart Failure: %• PQI 01 COPD/Asthma: %• PQI 05 Diabetes L-T: %	Decrease by 10% Potentially Preventable Admissions from the CE benchmarks included on the DMAS website:	PPA Measure Rate:

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
				<ul style="list-style-type: none"> • PQI 11 Community-Acquired PNEU: % • PQI 07 Hypertension: % • PDI 14 Asthma: % • PQI 16 Lower-Extremity Amputation: % • PQI 12 UTI: % • PQI 14 Uncontrolled Diabetes: % • PQI 15 Asthma in Younger Adult: % • PDI 15 Diabetes S-T Compl: % • PDI 16 Gastroenteritis: % • PDI 18 UTI: % 		
		3.1.2 Frequency of Emergency Department Visits	DMAS Clinical Efficiency Measure	<p>Clinical Efficiency Measures</p> <p>All MCOs SFY 2025 PPED Rate:</p> <ul style="list-style-type: none"> • J069 acute upper respiratory infection: % • J029 Acute pharyngitis: % • J020 Streptococcal Pharyngitis: % • R112 Nausea with vomiting: % • J101 Influenza due to other: % • N390 Urinary tract infection: % 	Decrease by 2% the Potentially Preventable, Avoidable, and/or Medically Unnecessary Emergency Department Visits from the CE benchmarks included on the DMAS website:	PPED Rate:

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
				<ul style="list-style-type: none"> • K529 Noninfective gastroenteritis and colitis: % • R109 Unspecified abdominal pain: % • K047 Periapical abscess without sinus: % • R42 Dizziness and giddiness: % • J45901 Unspecified asthma with (acute) exacerbation: % • R1084 Generalized abdominal pain: % • R21 Rash and other non-specified skin eruption: % • J209 Acute bronchitis, unspecified: % • J189 Pneumonia, unspecified: % • R1110 Vomiting, unspecified: % • R1013 Epigastric pain: % • H6691 Otitis media, unspecified, right ear: % • N3000 Acute cystitis without hematuria: % • I10 Essential (primary) hypertension: % 		

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
				<ul style="list-style-type: none"> • H6692 Otitis media, unspecified, left ear: % • N760 Acute vaginitis: % • R197 Diarrhea, unspecified: % • M542 Cervicalgia: % • R1031 Right lower quadrant pain: % 		
		3.1.3 Frequency of Potentially Preventable Readmissions	DMAS Clinical Efficiency Measure	<p>Cardinal Care: All MCOs SFY 2025 READ Measure Rate: %</p> <ul style="list-style-type: none"> • F33 Major depressive disorder: % • F25 Schizoaffective disorders: % • F10 alcohol related disorders: % • F31 Bipolar disorder: % • A41 Other sepsis: % • E10 Type 1 diabetes Mellitus: % • F20 Schizophrenia: % • I13 Hypertensive heart and Chronic Kidney Disease: % • F11 Opioid related disorders: % • D57 Sickle-cell disorders: % • F32 Major depressive disorder: % • E11 Type 2 diabetes mellitus: % 	Decrease by 8% Potentially Preventable Readmissions Within 30 Days from the CE benchmarks included on the DMAS website:	READ Measure Rate:

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
				<ul style="list-style-type: none"> • F14 Cocaine related disorders: % • F15 Other stimulant related disorders: % • T81 Complications of procedure, not elsewhere classified: % • J96 Respiratory failure, not elsewhere classified: % • K85 acute pancreatitis: % • I11 Hypertensive heart disease: % • K70 Alcoholic liver disease: % • F43 Reaction to severe stress, and adjustment disorders: % • F19 Other psychoactive substance related disorders: % • F34 Persistent mood (affective) disorders: % • N17 acute kidney failure: % • 099 Other maternal diseases classified elsewhere but comp pregnancy/child birth: % • J44 Other chronic obstructive pulmonary diseases: % 		

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
		3.1.4 Ambulatory Care: Emergency (ED) Visits	DMAS Clinical Efficiency Measures NCQA HEDIS (AMB) CMS Child Core Set: AMB-CH	Clinical Efficiency Measures Cardinal Care: HEDIS MY 2025 Cardinal Care: % Child Core Set Cardinal Care:	Decrease the HEDIS Ambulatory Care: Emergency Department (ED) Visit measure rate to perform at or above the 2025 HEDIS 50th percentile by 2028: <ul style="list-style-type: none">Cardinal Care Program HEDIS:Cardinal Care Program Child Core Set:Less than 1 Year:1–9 Years:10–19 Years:Total: Decrease the CMS Child Core Set Ambulatory Care: Emergency Department (ED) Visit measure rate to perform at or above the HEDIS 50th percentile by 2028: <ul style="list-style-type: none">Cardinal Care Program HEDIS:Cardinal Care Program Child Core Set:Less than 1 Year:1–9 Years:10–19 Years:Total:	Ambulatory Care—ED Visits—Total—MY 2028:
		3.1.5 Days Without Minimum RN Hours ⁵	DMAS VBP Reporting Team CMS Payroll Based Journal	NF VBP Program 2025 Cardinal Care: <ul style="list-style-type: none">Best: %Better: %Fair: %Below: %	NF VBP Decrease by X% the number of nursing facility days without minimum RN hours. Best: 0–4.00 Better: 5.00–12.00 Fair: 13.00–16.00	Best: Better: Fair:

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
		3.1.6 Total Nurse Staffing Hours Per Resident Day (RN, LPN, CAN)—Case-Mix Adjusted ⁵	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2025 Cardinal Care: <ul style="list-style-type: none"> Best: % Better: % Fair: % Below: % 	NF VBP Increase by X% the number of days with total nurse staffing hours per resident day meeting minimum requirements. Best: 3.84+ Better: 3.46–3.83 Fair: 3.16–3.45	Best: Better: Fair:
		3.1.7 Percentage of Long-Stay Resident with a Urinary Tract Infection (UTI) ⁵	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2025 Cardinal Care: <ul style="list-style-type: none"> Best: % Better: % Fair: % Below: % 	NF VBP Decrease by X% Long-Stay Residents with a Urinary Tract Infection. Best: 0–1.30 Better: 1.31–2.38 Fair: 2.3–4.36	Best: Better: Fair:
		3.1.8 Number of Hospitalizations per 1,000 Long-Stay Resident Days ⁵	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2025 Cardinal Care: <ul style="list-style-type: none"> Best: % Better: % Fair: % Below: % 	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. Best: 0–0.99 Better: 1.0–1.35 Fair: 1.36–1.75	Best: Better: Fair:
		3.1.9 Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days ⁵	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2025 Cardinal Care: <ul style="list-style-type: none"> Best: % Better: % Fair: % Below: % 	NF VBP Decrease by X% the number of outpatient ED visits that occurred among long-stay residents of a nursing home. Best: 0–0.38 Better: 0.39–0.63 Fair: 0.64–0.95	Best: Better: Fair:
		3.1.10 Percentage of Long-Stay High-Risk Residents	DMAS VBP Reporting Team	NF VBP Program 2025 Cardinal Care: <ul style="list-style-type: none"> Best: % 	NF VBP	Best: Better: Fair:

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
		with Pressure Ulcers ⁵	CMS Nursing Home Compare	<ul style="list-style-type: none"> Better: % Fair: % Below: % 	Decrease by X% Long-Stay High-Risk Residents with Pressure Ulcers. Best: 0–5.42 Better: 5.43–8.05 Fair: 8.06–10.92	
	Objective 3.2 Promote Efficient Use of Program Funds	3.2.1 Monitor Medical Loss Ratio	DMAS—MCO Financials https://www.dmas.virginia.gov/data-reporting/cardinal-care/mco-financials-data/	Cardinal Care:	Maintain compliance with MLR requirements	Cardinal Care:
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 Adults' Access to Preventive/Ambulatory Health Services	NCQA HEDIS (AAP)	HEDIS MY 2025 Cardinal Care: %	Increase the HEDIS Adults' Access to Preventive/Ambulatory Health Services measure rate to perform at or above the HEDIS 50th percentile by 2028:	Adults' Access to Preventive/Ambulatory Health Services— Total—MY 2028: %
		4.1.2 Child and Adolescent Well-Care Visits	NCQA HEDIS (WCV) Child Core Set: WCV-CH	HEDIS MY 2025 Cardinal Care: % Child Core Set Cardinal Care:	Increase the HEDIS Child and Adolescent Well-Care Visits measure rate to perform at or above the HEDIS 50th percentile by 2028: Increase the CMS Child Core Set Child and Adolescent Well-Care Visits measure rate to perform at or above the CMCS 50th percentile by 2028:	Child and Adolescent Well-Care Visits— Total—MY 2028: %
		4.1.3 Childhood Immunization Status	NCQA HEDIS (CIS) <ul style="list-style-type: none"> Combo 3 	HEDIS MY 2025 Cardinal Care: %	Increase the HEDIS Childhood Immunization Status measure rate	PWP target Childhood Immunization Status

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
			Child Core Set: CIS-CH	Child Core Set Cardinal Care:	to perform at or above the HEDIS 50th percentile by 2028: Increase the CMS Child Core Set Child and Adolescent Well-Care Visits measure rate to perform at or above the CMCS 50th percentile by 2028:	Combination 3—MY 2028: %
		4.1.4 Immunizations for Adolescents	NCQA HEDIS (IMA) <ul style="list-style-type: none"> • Combo 1 • Combo 2 Child Core Set: IMA-CH	HEDIS MY 2025 Combo 1 Cardinal Care: % Combo 2 Cardinal Care: % Child Core Set Cardinal Care:	Increase the HEDIS Immunization for Adolescents measure rate to perform at or above the HEDIS 50th percentile by 2028: <ul style="list-style-type: none"> • 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 2028: <ul style="list-style-type: none"> • Combo 1: • Combo 2: 	PWP target Immunizations for Adolescents MY 2028: <ul style="list-style-type: none"> • Combo 1: % • Combo 2: %
		4.1.5 Flu Vaccinations for Adults 18-64	AHRA CAHPS Adult Core Set: CPA-AD	2025 Adult CAHPS: % 2025 Child CAHPS: %	Increase the CAHPS Flu Vaccinations for Adults 18–64 Years measure rate to perform at or above the CAHPS 50th percentile by 2028: <ul style="list-style-type: none"> • 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 2028: <ul style="list-style-type: none"> • Cardinal Care Program: 	Vaccinations for Adults 18-65 Years measure rate:

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
	Objective 4.2 Improve Outcomes for Maternal and Infant Members	4.2.1 Prenatal and Postpartum Care: Postpartum Care	NCQA HEDIS (PPC) Adult Core Set: PPC-AD	HEDIS MY 2025 Postpartum Care Cardinal Care: Adult Core Set Postpartum Care Cardinal Care:	Increase the HEDIS Prenatal and Postpartum Care: Timeliness of Prenatal Care measure rate to perform at or above the HEDIS 50th percentile by 2028: <ul style="list-style-type: none"> 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 2028: <ul style="list-style-type: none"> Cardinal Care Program—Total: 	Use PWP target Prenatal and Postpartum Care—MY 2028: Postpartum Care: %
		4.2.2 Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA HEDIS (PPC)	HEDIS MY 2025 Timeliness of Prenatal Care Cardinal Care:	Increase the HEDIS Prenatal and Postpartum Care: Postpartum Care measure rate to perform at or above the HEDIS 50th percentile by 2028: <ul style="list-style-type: none"> Cardinal Care Program 	Use PWP target Prenatal and Postpartum Care—MY 2028: Timeliness of Prenatal Care: %
		4.2.3 Live Births Weighing Less than 2,500 Grams	Child Core Set: LBW-CH CDC Wonder State Vital Records	CMS 2025 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 2028: <ul style="list-style-type: none"> Cardinal Care Program—Total: 	Use national mean (9.9) from 2028 CDC Wonder data or most recent available
		4.2.4 Well-Child Visits in the First 30 Months of Life	NCQA HEDIS (W30) Child Core Set: W30-CH	HEDIS MY 2025 Cardinal Care: % Child Core Set Cardinal Care:	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 2028: <ul style="list-style-type: none"> 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	MY 2028 Well-Child Visits in the First 15 Months—Six or More Well-Child Visits: % MY 2028 Well-Child Visits in the Age 15 Months—30 Months—Two or More Well-Child Visits: %

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
					perform at or above the CMCS 50th percentile by 2028: <ul style="list-style-type: none"> Cardinal Care Program First 15 Months: 15–30 Months 	
		4.2.5 Low-Risk Cesarean Delivery	Child Core Set: LRCD-CH CDC Wonder State Vital Records	Child Core Set CMS 2025 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 2028: <ul style="list-style-type: none"> Cardinal Care Program—Total: <i>Note: Lower rate is better.</i>	Use national mean (23.2%) from 2025 CDC Wonder data or most recent available
	Objective 4.3 Improve Home and Community-Based Services <i>Measures for the LTSS population focused on quality of life, rebalancing, and community integration for individuals receiving LTSS</i>	4.3.1 Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and Appropriate to Their Needs and Personal Goals ⁵	QMR	FY 25 Q1: 80.3% Q2: 95.0% Q3: 95.0%	Increase the number and percentage of waiver individuals who have service plans that are adequate and appropriate to their needs and personal goals by 5% by 2028: <ul style="list-style-type: none"> Cardinal Care Program—Total: 	FY28 Q1: Q2: Q3:
		4.3.2 Number and Percent of Individuals Who Received Services in the Scope Specified in the Service Plan ⁵	QMR	FY 25 Q1: 100% Q2: 100% Q3: 100%	Maintain the number and percentage of individuals who received services in the scopes specified in their service plan by 5% by 2028: <ul style="list-style-type: none"> Cardinal Care Program—Total: 	FY28 Q1: Q2: Q3:
		4.3.3 Can Get an Appointment to See or Talk to Their PCP When Needed ⁵	NCI-AD Survey	FY 24 77.0%	Increase the percentage of individuals who respond they were able to get an appointment to see or talk to their PCP when needed by 5% by 2028:	Can Get an Appointment to See or Talk to Their PCP When Needed: 2028 Virginia Rate:

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
					<ul style="list-style-type: none"> Cardinal Care Program—Aggregate 	
		4.3.4 Have Enough Help With Everyday Activities ⁵	NCI-AD Survey	FY 24 76.0%	Meet the weighted NCI-AD average by 2028: <ul style="list-style-type: none"> Cardinal Care Program—Aggregate 	Have Enough Help With Everyday Activities: 2028 Virginia Rate:
Goal 5: Providing Whole-Person Care for Vulnerable Populations	Objective 5.1 Improve Outcomes for Members with Chronic Conditions	5.1.1 PQI 08: Heart Failure Admission Rate	Adult Core Set: PQI08-AD	Adult Core Set Cardinal Care:	Decrease the CMS Adult Core Set Heart Failure Admission measure rate to perform at or above the CMCS 50th percentile by 2028: <ul style="list-style-type: none"> Cardinal Care Program—Total: <i>Note: Lower rate is better.</i> 	Heart Failure Admission Rate (Per 100,000 Member Months) MY 2028: 40–64 Years: 65+ Years: Total:
		5.1.2 PDI 14: Asthma Admission Rate (Ages 2–17)	AHRQ PDI: PQI15-AD	AHRQ PDI Cardinal Care:	Decrease the CMS Adult Core Set Asthma Admission measure rate to perform at or above the CMCS 50th percentile by 2028: <ul style="list-style-type: none"> Cardinal Care Program—Total: <i>Note: Lower rate is better.</i> 	Asthma Admission Rate (Per 100,000 Member Months) MY 2028:
		5.1.3 PQI 05: COPD and Asthma in Older Adults' Admission Rate	Adult Core Set: PQI105-AD	Adult Core Set Cardinal Care: %	Decrease the CMS Adult Core Set Asthma in Older Adults' Admission measure rate to perform at or above the CMCS 50th percentile by 2028: <ul style="list-style-type: none"> Cardinal Care Program—Total: <i>Note: Lower rate is better.</i> 	COPD or Asthma in Older Adults Admission Rate (Per 100,000 Member Months) MY 2028:
		5.1.4 Diabetes Care				Increase the HEDIS Diabetes measure rates to perform at or above the HEDIS 50th percentile by 2028: <ul style="list-style-type: none"> Cardinal Care Program
		Blood Pressure Control for Patients With Diabetes—Total	NCQA HEDIS (HPC)	HEDIS MY 2025 Cardinal Care: %		

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
		Eye Exam for Patients With Diabetes—Total Glycemic Status Assessment for Patients with Diabetes (2 Indicators) <ul style="list-style-type: none"> Glycemic Status <8.0%—Total Glycemic Status >9.0%—Total 				Patients with Diabetes (2 Indicators) <ul style="list-style-type: none"> Glycemic Status <8.0%—Total: % Glycemic Status >9.0%—Total
		5.1.5 Controlling High Blood Pressure	NCQA HEDIS (CBP) Adult Core Set: CBP-AD	HEDIS MY 2025 Cardinal Care: % Adult Core Set Cardinal Care:	Increase the HEDIS Controlling High Blood Pressure measure rate to perform at or above the HEDIS 50th percentile by 2028: <ul style="list-style-type: none"> 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 2028: <ul style="list-style-type: none"> Cardinal Care Program—Total: 	Controlling High Blood Pressure—Total—MY 2028: %
	Objective 5.2 Improve Outcomes for Members with Substance Use Disorders	5.2.1 Monitor Identification of Alcohol and Other Drug Services	DMAS	Cardinal Care:	Increase the percentage of members with Identification of Alcohol and Other Drug Services by 5% by 2028.	Cardinal Care:
		5.2.2 Follow-Up After	NCQA HEDIS (FUA)	HEDIS MY 2025 Cardinal Care	Increase the HEDIS Follow-Up After Emergency Department Visit for	Follow-Up After Emergency

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
		Emergency Department Visit for Substance Use		<ul style="list-style-type: none"> 7-Day: % 30-Day: % 	Substance Use measure rate to perform at or above the HEDIS 50th percentile by 2028: <ul style="list-style-type: none"> Cardinal Care Program 	Department Visit for Substance Use—MY 2028: <ul style="list-style-type: none"> 7-Day Follow-Up—Total: % 30-Day Follow-Up—Total: %
		5.2.3 Initiation and Engagement of Substance Use Disorder Treatment	NCQA HEDIS (IET)	HEDIS MY 2025 Cardinal Care: <ul style="list-style-type: none"> 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 2028: <ul style="list-style-type: none"> Cardinal Care Program 	Initiation and Engagement of Substance Use Disorder Treatment—MY 2028: <ul style="list-style-type: none"> Initiation of SUD Treatment: % Engagement of SUD Treatment: %
	Goal: 5.3 Improve Behavioral Health and Developmental Services for Members	5.3.1 Follow-Up After Hospitalization for Mental Illness	NCQA HEDIS (FUH)	HEDIS MY 2025 Cardinal Care: <ul style="list-style-type: none"> 7-Day: % 30-Day: % 	Increase the HEDIS Follow-Up After Hospitalization for Mental Illness measure rate to perform at or above the HEDIS 50th percentile by 2028: <ul style="list-style-type: none"> Cardinal Care Program 6 Years and Older Within 7 Days Within 30 Days 	Follow-Up After Hospitalization for Mental Illness—MY 2028: <ul style="list-style-type: none"> 7-Day Follow-Up—Total: % 30-Day Follow-Up—Total: %
		5.3.2 Follow-Up After Emergency Department Visit for Mental Illness ⁴	NCQA HEDIS (FUM)	HEDIS MY 2025 Cardinal Care: <ul style="list-style-type: none"> 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 2028: <ul style="list-style-type: none"> Cardinal Care Program 6 Years and Older Within 7 Days Within 30 Days 	Follow-Up After Emergency Department Visit for Mental Illness—MY 2028: <ul style="list-style-type: none"> 7-Day Follow-Up—Total: % 30-Day Follow-Up—Total: %

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
		5.3.3 Monitor Mental Health Utilization	DMAS	DMAS Cardinal Care:	Increase the percentage of members receiving mental health services by 3% by 2028.	Percentage of members receiving mental health services—MY 2028: • Total:
		5.3.4 Outpatient Behavioral Health Encounter in the Last 12 Months for Population With Behavioral Health Condition	DMAS	DMAS Cardinal Care:	Increase the percentage of members with an outpatient behavioral health encounter in the last 12 months for population with behavioral health condition by 3% by 2028	Percentage of members with a behavioral health condition with an outpatient behavioral health encounter in the last 12 months—MY 2028 • Total:
		5.3.5 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA HEDIS (APP) Child Core Set: APP-CH	HEDIS MY 2025 Cardinal Care: % Child Core Set Cardinal Care:	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 2028: • 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 2028: • Cardinal Care Program—Ages 1–17 Years	Use of First-Line Psychosocial Care For Children and Adolescents on Antipsychotics— Total—MY 2028: %
		5.3.6 Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA HEDIS (APM) CMS Child Core Set: APM-CH	HEDIS MY 2025 Cardinal Care: • Blood Glucose Testing—Total:	Increase the HEDIS Metabolic Monitoring for Children and Adolescents on Antipsychotics measure rate to perform at or above the HEDIS 50th percentile by 2028:	Metabolic Monitoring for Children and Adolescents on Antipsychotics -MY 2028:

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
				<ul style="list-style-type: none"> Cholesterol Testing—Total: % Blood Glucose and Cholesterol Testing—Total: % <p>Child Core Set Cardinal Care:</p>	<ul style="list-style-type: none"> Cardinal Care Program—Ages 1–17 Years <p>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 2028:</p> <ul style="list-style-type: none"> Cardinal Care Program—Ages 1–17 Years 	<ul style="list-style-type: none"> Blood Glucose Testing—Total: % Cholesterol Testing—Total: % Blood Glucose and Cholesterol Testing—Total: %
		5.3.7 Medical Assistance with Smoking and Tobacco Use Cessation	CMS Adult Core Set: MSC-AD	Adult Core Set Cardinal Care:	<p>Increase the HEDIS Medical Assistance with Smoking and Tobacco Use Cessation measure rate to perform at or above the HEDIS 50th percentile by 2028:</p> <ul style="list-style-type: none"> Cardinal Care Program 3 Months–17 Years 18–64 Years 65 and Older Total <p>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 2028:</p> <ul style="list-style-type: none"> Cardinal Care Program 18–64 Years 65 and Older 	Medical Assistance with Smoking and Tobacco Use Cessation:
		5.3.8 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using	NCQA HEDIS (SSD) CMS Adult Core Set: SSD-AD	HEDIS MY 2025: Cardinal Care: % Adult Core Set Cardinal Care:	Increase the HEDIS Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications measure rate to	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic

Goal	Objective	Measure Name ¹	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
		Antipsychotic Medications			<p>perform at or above the HEDIS 50th percentile by 2028:</p> <ul style="list-style-type: none"> • Cardinal Care Program • 18–64 Years <p>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 2028:</p> <ul style="list-style-type: none"> • Cardinal Care Program • 18–64 Years 	Medications—Total—MY 2028: %
		5.3.9 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA HEDIS (SAA) CMS Adult Core Set: SAA-AD	<p>HEDIS MY 2025: Cardinal Care: %</p> <p>Adult Core Set Cardinal Care:</p>	<p>Increase the HEDIS Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure rate to perform at or above the HEDIS 50th percentile by 2028:</p> <ul style="list-style-type: none"> • Cardinal Care Program • 18 to 39 Years <p>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 2028:</p> <ul style="list-style-type: none"> • Cardinal Care Program • 18–39 Years 	Adherence to Antipsychotic Medications for Individuals with Schizophrenia—Total—MY 2028: %

¹ CMS retired Use of Opioids at High Dosage in Persons Without Cancer and Antidepressant Medication Management measures from the 2026 Adult Core Set. To align with CMS, DMAS has removed these measures from the goals tracking table.

² DMAS Cumulative data from MCO quarterly reports 1/1/2024–3/31/2025.

³ MCO critical incident data reported to DMAS for calendar year 2025.

⁴ Measures that align with the SMI Midpoint Assessment are identified with blue font.

⁵ Measures for the LTSS population focused on quality of life, rebalancing, and community integration for individuals receiving LTSS.

*The baseline measure rate is the final validated 2021 HEDIS, performance measure rate or CAHPS reported in the 2026 Annual Technical Report and posted to the DMAS website.

**Target established in the CY 2025 PWP Methodology.

***The baseline measure rate is the final validated MY 2025 HEDIS rate reported in the 2026 Annual Technical Report and posted to the DMAS website.

^The baseline measure rate is the final MY 2025 rate calculated by HSAG for the PWP.

^^The baseline measure rate is the final CY 2025 rate reported by DMAS for the Quality Management Review.

^^^The baseline measure rate is the final CY 2025 rate reported by the DMAS Finance Team

▲ Statistically significantly higher in 2025 than in 2024.

▼ Statistically significantly lower in 2025 than in 2024.

Table 27—Aspirational Goals Tracking Table

Goal	Objective	Measure Name	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
Goal 1: Enhance the Member Care Experience	Objective 1.2 Improve Member Satisfaction	1.2.3 Timely Processing of Member Applications, Renewals, and Appeals	DMAS	DMAS:		DMAS:
		2.1.4 Monitor network adequacy by region and provider types	DMAS	MCO Reporting:		MCO Reporting:
Goal 2: Promote Access to Safe, Gold-Standard Patient Care	Objective 2.1 Ensure Access to Care	2.1.5 Monitor frequency and reasons for missed trips	DMAS	MCO Reporting:		MCO Reporting:
		2.1.6 Cervical Cancer Screening	NCQA HEDIS (CCS) CMS Adult Core Set: CCS-AD	HEDIS MY 2025 Cardinal Care: % Adult Core Set Cardinal Care:		HEDIS MY 2028 Cardinal Care: % Cervical Cancer Screening—MY 2028: %
		2.1.7 Chlamydia Screening in Women Ages 21 to 24	NCQA HEDIS (CHL) CMS Adult Core Set: CHL-AD	HEDIS MY 2025 Cardinal Care: Adult Core Set Cardinal Care:		HEDIS MY 2028 Cardinal Care: %
		2.1.8 Colorectal Cancer Screening	NCQA HEDIS (COL) CMS Adult Core Set: COL-AD	HEDIS MY 2025 Cardinal Care:		HEDIS MY 2028 Cardinal Care: %

Goal	Objective	Measure Name	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
				Adult Core Set Cardinal Care:		
		2.1.9 Breast Cancer Screening	NCQA HEDIS (BCS) CMS Adult Core Set: BCS-AD	HEDIS MY 2025 Cardinal Care: % Adult Core Set Cardinal Care:		HEDIS MY 2028 Cardinal Care: % Breast Cancer Screening—MY 2028: %
		2.1.10 Contraceptive Care— Postpartum Women Ages 21 to 44	CMS Adult Core Set: CCP-AD	Adult Core Set Cardinal Care:		Adult Core Set Cardinal Care:
		2.1.11 Contraceptive Care— All Women Ages 21 to 44	CMS Adult Core Set: CCW-AD	Adult Core Set Cardinal Care:		Adult Core Set Cardinal Care:
		2.1.12 Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Age 18 and Older	NCQA HEDIS (AAB) CMS Adult Core Set: AAB-AD	HEDIS MY 2025 Cardinal Care: % Adult Core Set Cardinal Care:		HEDIS MY 2028 Cardinal Care: % Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis— Total—MY 2028: %
		2.1.13 HIV Viral Load Suppression	CMS Adult Core Set: HVL-AD	Adult Core Set Cardinal Care:		Adult Core Set Cardinal Care:
		2.1.14 Concurrent Use of Opioids and Benzodiazepines	CMS Adult Core Set: COB-AD	Adult Core Set Cardinal Care:		Adult Core Set Cardinal Care:
Goal 3: Support Efficient and Value-Driven Care	Objective 3.2 Promote Efficient Use of Program Funds	3.2.2 Number of Administrative and Medical Deferrals and Disallowances	DMAS	DMAS		DMAS:
		3.2.3 Diabetes Short-Term Complications Admission Rate	CMS Adult Core Set: PQI01-AD	Adult Core Set Cardinal Care:		Adult Core Set Cardinal Care:
		3.2.4 Heart Failure Admission Rate	CMS Adult Core Set: PQI08-AD	Adult Core Set Cardinal Care:		Adult Core Set Cardinal Care:
		3.2.5 Asthma in Younger Adults Admission Rate	CMS Adult Core Set: PQI15-AD	Adult Core Set Cardinal Care:		Adult Core Set Cardinal Care:

Goal	Objective	Measure Name	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
		3.2.6 Plan All-Cause Readmission Rate	NCQA HEDIS (PCR) CMS Adult Core Set: PCR-AD	<p>HEDIS MY 2025 Cardinal Care</p> <ul style="list-style-type: none"> Observed Readmissions—Total: % O/E Ratio—Total: <p>Adult Core Set Cardinal Care:</p>		<p>HEDIS MY 2028 Cardinal Care</p> <ul style="list-style-type: none"> Observed Readmissions: % O/E Ratio Total: <p>HEDIS MY 2028 Plan All-Cause Readmission Rate:</p> <ul style="list-style-type: none"> Observed Readmissions: % O/E Ratio Total:
Goal 4: Strengthen the Health of Families and Communities	Objective 4.1 Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	4.1.6 Topical Fluoride for Children	NCQA HEDIS (TFC) Child Core Set: TFL-CH CMS 416	<p>HEDIS MY 2025 Cardinal Care:</p> <p>Child Core Set Cardinal Care:</p> <ul style="list-style-type: none"> CMS 416 2025 	<p>Increase the HEDIS Topical Fluoride for Children measure rate to perform at or above the HEDIS 50th percentile by 2028:</p> <p><i>Note: MY 2028 Year 1 measure percentile rankings may not be available.</i></p> <ul style="list-style-type: none"> Cardinal Care Program—Total: <p>Increase the CMS Child Core Set Topical Fluoride for Children measure rate to perform at or above the CMCS 50th percentile by 2028:</p>	<p>HEDIS MY 2028: Cardinal Care:</p> <p>Child Core Set Cardinal Care:</p>

Goal	Objective	Measure Name	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
					<ul style="list-style-type: none"> Cardinal Care Program: <p><i>Note: Need to determine target for a CMS 416 measure.</i></p>	
		4.1.7 Oral Evaluation, Dental Services	NCQA HEDIS (OED) Child Core Set: OEV-CH CMS 416	<p>HEDIS MY 2025 Cardinal Care:</p> <p>Child Core Set Cardinal Care:</p> <ul style="list-style-type: none"> CMS 416 2025 	<p>Increase the HEDIS Oral Evaluation, Dental Services measure rate to perform at or above the HEDIS 50th percentile by 2028:</p> <p><i>Note: MY 2028 Year 1 measure percentile rankings may not be available.</i></p> <ul style="list-style-type: none"> Cardinal Care Program <p>Increase the CMS Child Core Set Evaluation, Dental Services measure rate to perform at or above the CMCS 50th percentile by 2028:</p> <ul style="list-style-type: none"> Cardinal Care Program—Total: <p><i>Note: Need to determine target for a CMS 416 measure.</i></p>	<p>HEDIS MY 2028: Cardinal Care:</p> <p>Child Core Set Cardinal Care:</p> <ul style="list-style-type: none"> CMS 416 2028:
		4.1.8 Sealant Receipt on Permanent First Molars	Child Core Set: SFM-CH CMS 416	Child Core Set Cardinal Care:	Increase the HEDIS Sealant Receipt on Permanent First	HEDIS MY 2028 Cardinal Care: Total:

Goal	Objective	Measure Name	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
				<ul style="list-style-type: none"> CMS 416 2025 	<p>Molars measure rate to perform at or above the HEDIS 50th percentile by 2028:</p> <p><i>Note: MY 2028 Year 1 measure percentile rankings may not be available.</i></p> <ul style="list-style-type: none"> Cardinal Care Program <p>Increase the CMS Child Core Set Sealant Receipt of Permanent First Molars measure rate to perform at or above the CMCS 50th percentile by 2028:</p> <ul style="list-style-type: none"> Cardinal Care Program—Total: <p><i>Note: Need to determine target for a CMS 416 measure.</i></p>	<p>Child Core Set Cardinal Care:</p> <ul style="list-style-type: none"> CMS 416: 2028:
		4.1.9 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA HEDIS (WCC) CMS Child Core Set (WCC-CH)	<p>HEDIS MY 2025 Cardinal Care:</p> <ul style="list-style-type: none"> BMI—Total: % Nutrition—Total: % Physical Activity—Total: % <p>Cardinal Care:</p> <ul style="list-style-type: none"> BMI—Total: % 	<p>Increase the HEDIS Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure rate to perform at or above</p>	<p>HEDIS MY 2028 Cardinal Care:</p> <ul style="list-style-type: none"> BMI—Total: % Nutrition—Total: % Physical Activity—Total: % <p>Child Core Set</p>

Goal	Objective	Measure Name	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
				<ul style="list-style-type: none"> Nutrition—Total: % Physical Activity—Total: % 	<p>the HEDIS 50th percentile by 2028: Cardinal Care Program</p> <ul style="list-style-type: none"> BMI Percentile Documentation Counseling for Nutrition Counseling for Physical Activity <p>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 2028:</p> <ul style="list-style-type: none"> Cardinal Care Program—Total: BMI Percentile Documentation Counseling for Nutrition Counseling for Physical Activity 	<p>Cardinal Care:</p> <ul style="list-style-type: none"> BMI—Total: % Nutrition—Total: % Physical Activity—Total: %
		4.1.10 Chlamydia Screening in Women Ages 16 to 20 Years	NCQA HEDIS (CHL) CMS Child Core Set (CHL-CH)	<p>HEDIS MY 2025 Cardinal Care:</p> <p>Child Core Set Cardinal Care:</p>	<p>Increase the HEDIS Chlamydia Screening in Women Ages 16–20 measure rate to perform at or above</p>	<p>HEDIS MY 2028 Cardinal Care:</p> <p>Child Core Set Cardinal Care:</p>

Goal	Objective	Measure Name	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
					<p>the HEDIS 50th percentile by 2028:</p> <ul style="list-style-type: none"> Cardinal Care Program <p><i>Note: HEDIS measure age is 16–24 Years.</i></p> <p>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 2028:</p> <ul style="list-style-type: none"> Cardinal Care Program—Total 	<ul style="list-style-type: none"> Ages 16–20 Years
		4.1.11 Lead Screening in Children	NCQA HEDIS (LSC) CMS Child Core Set (LSC-CH)	<p>HEDIS MY 2025 Cardinal Care:</p> <p>Child Core Set Cardinal Care:</p>	<p>Increase the HEDIS Lead Screening in Children measure rate to perform at or above the HEDIS 50th percentile by 2028:</p> <ul style="list-style-type: none"> Cardinal Care Program <p>Increase the CMS Child Core Set Lead Screening in Children measure rate to perform at or above the CMCS</p>	<p>HEDIS MY 2028 Cardinal Care:</p> <p>Child Core Set Cardinal Care:</p>

Goal	Objective	Measure Name	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
					50th percentile by 2028: <ul style="list-style-type: none"> Cardinal Care Program—Total: 	
Goal 5: Providing Whole-Person Care for Vulnerable Populations	Objective 5.1 Improve Outcomes for Members with Chronic Conditions	5.1.6: Asthma Medication Ratio: Age 5 to 18 Years*	NCQA HEDIS (AMR) CMS Child Core Set AMR-CH	HEDIS MY 2025 Cardinal Care: % Child Core Set Cardinal Care:	Increase the HEDIS Asthma Medication Ratio: Age 5 to 18 Years measure rate to perform at or above the HEDIS 50th percentile by 2028: <ul style="list-style-type: none"> Cardinal Care Program—Total: % 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 2028: <ul style="list-style-type: none"> Cardinal Care Program—Total: % 	HEDIS MY 2028 Asthma Medication Age 5 to 18 Years Ratio—Total: % Child Core Set Asthma Medication Age 5 to 18 Years <ul style="list-style-type: none"> Ratio—Total: %
		5.1.7 Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years	NCQA HEDIS (AAB) CMS Child Core Set: AAB-CH	HEDIS MY 2025 Cardinal Care: % Child Core Set Cardinal Care:	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	HEDIS MY 2028 Cardinal Care: <ul style="list-style-type: none"> 3 Months to 17 Years: 18–64 Years: 65 Years and Older: Total:

Goal	Objective	Measure Name	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
					50th percentile by 2028: <ul style="list-style-type: none"> Cardinal Care Program <i>Note: Recommend dropping the 18–64, 65 years and older, and total.</i> 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 2028: <ul style="list-style-type: none"> Cardinal Care Program—Total: 3 Months to 17 Years 	Child Core Set Cardinal Care: <ul style="list-style-type: none"> Cardinal Care 3 Months to 17 Years: Total:
	Objective 5.2 Improve Outcomes for Members with Substance Use Disorders	5.2.5 Use of Pharmacotherapy for Opioid Use Disorder	CMS Adult Core Set: OUD-AD	Adult Core Set Cardinal Care: %	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 2028: <ul style="list-style-type: none"> Cardinal Care Program—Total: 	Adult Core Set Cardinal Care: Total—%

Goal	Objective	Measure Name	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
					<i>If not available, use 1% as a minimum performance improvement.</i>	
	<p>Objective 5.3 Improve Behavioral Health and Developmental Services for Members</p>	<p>5.3.10 Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication</p>	<p>NCQA HEDIS (ADD) Child Core Set: ADD-CH</p>	<p>HEDIS MY 2025 Cardinal Care:</p> <ul style="list-style-type: none"> Initiation: Continuation: <p>Child Core Set Cardinal Care:</p> <ul style="list-style-type: none"> Initiation: Continuation: 	<p>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 2028:</p> <ul style="list-style-type: none"> Cardinal Care Program—Ages 6–12 Years Initiation Phase: Continuation and Maintenance Phase: <p>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 2028:</p>	<p>HEDIS MY 2028 Cardinal Care:</p> <ul style="list-style-type: none"> Initiation Phase: % Continuation and Maintenance Phase: % <p>Child Core Set Cardinal Care: Ages 6–12 Years</p> <ul style="list-style-type: none"> Initiation Phase: % Continuation and Maintenance Phase: %

Goal	Objective	Measure Name	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
					<ul style="list-style-type: none"> Cardinal Care Program—Ages 6–12 Years Initiation Phase: Continuation and Maintenance Phase: 	
		5.3.11 Screening for Depression and Follow-Up Plan: Ages 18 and Over	CMS Adult Core Set: CDF-AD	Adult Core Set Cardinal Care: <ul style="list-style-type: none"> Ages 18–64: % 65+: % 	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 2028: <ul style="list-style-type: none"> Cardinal Care Program <i>If not available, use 1% as a minimum performance improvement.</i>	Adult Core Set Cardinal Care: <ul style="list-style-type: none"> 28–64 Years: 65+ Years:
		5.5.1 Diabetes Care for People with Serious Mental Illness: Glycemic Status ¹	NCQA HEDIS (HPCMI) CMS Adult Core Set: HPCMI-AD	HEDIS MY 2025 Cardinal Care: Adult Core Set Cardinal Care:	Increase the HEDIS Diabetes Care for People with Serious Mental Illness: Glycemic Status measure rate to perform at or above the HEDIS 50th percentile by 2028: <ul style="list-style-type: none"> Cardinal Care Program 18 to 75 Years 	HEDIS MY 2028 Cardinal Care: <ul style="list-style-type: none"> 18–75 Years: Adult Core Set Cardinal Care: <ul style="list-style-type: none"> 18–64 Years: % 65–75 Years: %

Goal	Objective	Measure Name	Metric specifications	MY 2025 Baseline Performance	Performance Measure Target	MY 2028 Remeasurement Aggregate Rate
					<p>Increase the CMS Adult Core Set Diabetes Care for People with Serious Mental Illness: Glycemic Status measure rate to perform at or above the CMCS 50th percentile by 2028:</p> <ul style="list-style-type: none"> • Cardinal Care Program • 18–64 Years • 65–75 Years 	
	<p>Objective 5.5 Improve Outcomes for Nursing Home Eligible Members</p>	<p>5.5.1 Use of High-Risk Medications in Older Adults (Elderly)</p>	<p>NCQA HEDIS (DAE)</p>	<p>HEDIS MY 2025: Cardinal Care: %</p>	<p>Decrease the HEDIS Use of High-Risk Medications in Older Adults (Elderly) measure rate to perform at or above the HEDIS 50th percentile by 2028:</p> <ul style="list-style-type: none"> • Cardinal Care Program—Total: <p><i>Note: Lower rate is better.</i></p>	<p>HEDIS MY 2028 Cardinal Care—Total: %</p>

*The measure will be retired by NCQA in MY 2026. DMAS will review for replacement in future QS updates.

¹ Measures that align with the SMI Midpoint Assessment are identified with blue font.

Appendix E. EQRO Findings and Recommendations

EQR Annual Technical Report Recommendations

DMAS makes the EQR Annual Technical Report available to MCOs. Annually, MCOs are required to submit information on actions taken to address the recommendations contained in the EQR 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 *2024 External Quality Review Technical Report* (dated April 2025)⁴⁶ are summarized in Table 28.

Table 28—April 2024 Cardinal Care Quality Strategy Recommendations For the Virginia Medicaid Managed Care Program

Program Recommendations	
Recommendation	Associated Virginia 2023–2025 QS Goal, Objective, and Measure
<p>Within the Access to Care and Women’s Health domains, all five MCOs’ rates fell below the 50th percentile for the <i>Cervical Cancer Screening—Total PM</i> indicator and the <i>Colorectal Cancer Screening—Total PM</i> indicator.</p> <p>To improve program wide performance in support of Goal 2: Promote Access to Safe, Gold-Standard Patient Care, Objective 2.1: Ensure Access to Care, HSAG recommends that MCOs consider whether there are health disparities within the plans’ populations that contributed to less access to care. HSAG recommends that MCOs implement interventions to reduce barriers to care, including engaging with community providers and CHWs in planning educational materials and outreach activities. MCOs should also communicate with eligible members through multimodal approaches including outreach through phone calls and text messages to promote women’s screenings. MCOs should also consider including incentives for PCPs to provide the needed services and to increase their access and outreach to eligible assigned members. MCOs should also monitor and implement interventions, if needed, for providers in communicating with members with scheduled reminders utilizing personalized outreach for overdue patients. DMAS should review MCO communication messages to ensure clear and concise information.</p>	<p>Goal 2: Promote Access to Safe, Gold-Standard Patient Care</p> <p>Objective 2.1: Ensure Access to Care</p> <p>Measure: 2.1.1.6: <i>Cervical Cancer Screening</i></p> <p>Measure: 2.1.1.8: <i>Colorectal Cancer Screening</i></p>
<p>Within the Behavioral Health domain, four of the five MCOs’ rates fell below the 50th percentile for both <i>Follow-Up After Hospitalization for Mental Illness</i> PM indicators. Additionally, at least four of the five MCOs’ rates fell below the 50th percentile for both <i>Follow-Up After Emergency Department Visit for Mental Illness</i> PM indicators. All five MCOs’ rates fell</p>	<p>Goal 5: Providing Whole-Person Care for Vulnerable Populations</p>

⁴⁶ Virginia Department of Medical Assistance Services. 2024 External Quality Review Technical Report. Available at: <https://www.dmas.virginia.gov/media/ibjjoec0/2024-cardinal-care-annual-technical-report.pdf>. Accessed on: Oct 1, 2025.

Program Recommendations

below the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* PM indicator.

To improve program wide performance in support of **Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4: Improve Behavioral Health and Developmental Services for Members**, HSAG recommends that DMAS work with the MCOs to meet with hospitals to improve the understanding of the importance of follow-up care and discuss tips on scheduling patients in the hospital or ED. The MCOs should be encouraged to work with hospital discharge planners to gain insight into the challenges they face in setting up follow-up visits before member discharge. HSAG recommends that DMAS work with the MCO to collaborate with outpatient providers on solutions to these challenges. Additionally, HSAG recommends that DMAS encourage MCOs to establish processes for outpatient providers to send direct messages to patients with canceled visits or who do not show for scheduled appointments. HSAG recommends that MCOs ensure telehealth services for follow-up visits are covered, available, and that providers and patients are made aware of telehealth follow-up visit options. HSAG recommends that MCOs analyze mental health integration between providers, including primary care and mental health specialists. This, coupled with improved monitoring, has been shown to improve medication adherence.

Objective 5.4: Improve Behavioral Health and Developmental Services for Members

Measure 5.4.1.1: *Follow-Up After Hospitalization for Mental Illness*

Measure 5.4.1.2: *Follow-Up After Emergency Department Visit for Mental Illness*

Measure 5.4.1.8: *Antidepressant Medication Management*

Within the Children’s Preventive Care domain, three of the five MCOs’ rates fell below the 50th percentile for the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* PM indicator. Additionally, all five MCOs’ rates fell below the 50th percentile for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index* and *Counseling for Physical Activity* PM indicators.

To improve program wide performance in support of **Goal 4: Strengthen the Health of Families and Communities, Objective 4.1: Improve the Utilization of Wellness, Immunization, and Prevention Services for Members**, HSAG recommends that DMAS work with the MCOs to address whether providers are recording any vaccinations patients receive outside of provider care, such as at a pharmacy. HSAG recommends that MCOs survey providers regarding barriers encountered for the cases wherein BMI was not measured or counseling was not provided such as lack of resources, time, or training to provide appropriate counseling.

Goal 4: Strengthen the Health of Families and Communities

Objective 4.1: Improve the Utilization of Wellness, Immunization, and Prevention Services for Members

Measure 4.1.1.4: *Immunizations for Adolescents*

Measure 4.1.1.9: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*

The general child 2024 top-box score was statistically significantly lower than the 2023 NCQA general child Medicaid national average for *How Well Doctors Communicate*.

Goal 2: Promote Access to Safe, Gold-Standard Patient Care

Program Recommendations

To improve program wide member experience and program satisfaction and in support of **Goal 2: Promote Access to Safe, Gold-Standard Patient Care, Objective 2.3: Promote Effective Communication and Care Coordination**, HSAG recommends that the MCOs evaluate the process of care delivery to identify if there are any operational issues contributing to access to care for members, as well as identify and resolve dissatisfaction in customer and clinical services by addressing and providing solutions to customer service complaints. HSAG also recommends that the MCOs conduct root cause analyses of study indicators that have been identified as areas of low performance. In addition, HSAG also recommends that the MCOs continue to monitor the measures to ensure that significant decreases in scores over time do not continue to occur.

Objective 2.3: Promote Effective Communication and Care Coordination

Measure 2.3.1.1: *How Well Doctors Communicate*

From the overall findings of the Cardinal Care prior year CY 2023 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Cardinal Care program. The recommendations provided to DMAS for the EQR activities in the *2024 External Quality Review Technical Report* (dated April 2025), specific to the MLTSS program, are summarized in Table 29. Table 29 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 29—Prior Year Recommendations and Actions Taken—MLTSS Program Overall

Recommendation—Cardinal Care MLTSS		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	Objective 5.	Measure(s): 5.1.1.5: Controlling High Blood Pressure
<p>HSAG Recommendation: To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.1 and improve outcomes for members with chronic conditions, HSAG recommends that DMAS:</p> <ul style="list-style-type: none"> Work with MCOs to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to manage and maintain their chronic conditions, and to make appropriate health decisions. HSAG continues to recommend that DMAS monitor MCOs to ensure that the MCOs analyze their data and consider if there are disparities within the MCOs’ populations that contributed to lower rates in controlling high blood pressure, including members diagnosed with diabetes. In addition, HSAG recommends that DMAS monitor the MCOs to ensure implementation of interventions that address disparities and reflect identified opportunities for improvement. 		
DMAS’ Response		
<p>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):</p> <ul style="list-style-type: none"> DMAS included the measure Blood Pressure Control for Patients with Diabetes in its PWP which provides an incentive to MCOs to increase performance and close gaps. 		
<p>Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed:</p>		

Recommendation—Cardinal Care MLTSS

Measure: *Blood Pressure Control for Patients with Diabetes*

MY 2022: 55.31%

MY 2023: 61.74%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Cardinal Care MLTSS

Goal 5: Providing Whole-Person Care for Vulnerable Populations

Objective 5.4: Improve Behavioral Health and Developmental Services for Members

Measure(s):

5.4.1.1: Follow-Up After Hospitalization for Mental Illness

5.4.1.5: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

5.4.1.10: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

HSAG Recommendation: To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4 and improve behavioral health and developmental services for members, HSAG recommends that DMAS consider the MCO opportunities related to measures within the Behavioral Health domain:

- Work with the MCOs to identify best practices for ensuring follow-up care is completed for members hospitalized for mental illness. HSAG recommends that the MCOs identify and implement interventions based on completed root cause analyses which identified barriers their members experience in accessing care and services to monitor cardiovascular disease in members diagnosed with cardiovascular disease and schizophrenia. Additionally, HSAG recommends that MCOs evaluate providers' barriers to the use of first-line psychosocial care for children and adolescents on antipsychotics, then implement targeted interventions to address these barriers.

DMAS' Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- DMAS has improved its ability to track MCO required monthly data submissions

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Measure: *Follow-Up After Hospitalization for Mental Illness*

MY 2022: 7-Day: 29.00%; 30-Day: 52.02%

MY 2023: 7-Day: 33.91%; 30-Day: 56.34%

Measure: *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*

MY 2022: 37.18%

MY 2023: 63.48%

Recommendation—Cardinal Care MLTSS

Measure: *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

MY 2022: 82.49%

MY 2023: 81.79%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Cardinal Care MLTSS

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

Measure(s):

4.1.1.2: Child and Adolescent Well-Care Visits

4.1.1.3: Childhood Immunization Status

4.1.1.4: Immunizations for Adolescents

4.1.1.9: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

4.2.1.4: Well-Child Visits in the First 30 Months of Life

HSAG Recommendation: To improve the accuracy of provider information available to members in support of Goal 4: Strengthen the Health of Families and Communities, Objectives 4.1 and 4.2 and improve accessibility and timeliness of preventive services and well-child visits for members under the age of 21 years, HSAG recommends that DMAS:

- Work with the enrollment broker to address the data deficiencies identified during the survey (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify the location’s address and appropriate provider type and specialty. Additionally, DMAS may also consider requesting the MCOs to provide evidence of training offered by the MCO to providers’ offices regarding the MCO plan names and benefit coverage. Evidence should demonstrate that the office staff responsible for scheduling appointments have been educated on the MCO names and benefit coverage, and that the offices have a plan in place for educating new staff in the event of staff turnover.

DMAS’ Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Specific initiatives were not provided.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Measure: *Child and Adolescent Well-Care Visits Total*

Recommendation—Cardinal Care MLTSS

MY 2022: 44.15%

MY 2023: 50.88%

Measure: *Childhood Immunization Status*

MY 2022: 64.63%

MY 2023: 66.64%

Measure: *Immunizations for Adolescents*

MY 2022: Combo 1: 79.96; Combo 2: 30.96%

MY 2023: Combo 1: 84.20; Combo 2: 35.30%

Measure: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*

MY 2022: BMI: 67.97%; Nutrition Total: 60.34%; Physical Activity Total: 51.75%

MY 2023: BMI: 75.44%; Nutrition Total: 66.47%; Physical Activity Total: 60.09%

Measure: *Well-Child Visits in the First 30 Months of Life*

MY 2022: Not measured in the Cardinal Care MLTSS program

MY 2023: First 15 Months: 61.18%; 15 Months–30 Months: 70.36%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Cardinal Care MLTSS

Goal 5: Providing Whole-Person Care for Vulnerable Populations

Objective

Measure(s):

Measure 5.1.1.5: Controlling High Blood Pressure

HSAG Recommendation: To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.1 and improve outcomes for members with chronic conditions, HSAG recommends that DMAS:

- Work with MCOs to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to manage and maintain their chronic conditions, and to make appropriate health decisions. HSAG continues to recommend that DMAS monitor MCOs to ensure that the MCOs analyze their data and consider if there are disparities within the MCOs’ populations that contributed to lower rates in controlling high blood pressure, including members diagnosed with diabetes. In addition, HSAG recommends that DMAS monitor the MCOs to ensure implementation of interventions that address disparities and reflect identified opportunities for improvement.

DMAS’ Response

Describe initiatives implemented based on recommendations (include a brief summary of activities

that were either completed or implemented, and any activities still underway to address the finding

that resulted in the recommendation):

- DMAS included the measure Blood Pressure Control for Patients with Diabetes in its PWP which provides an incentive to MCOs to increase performance and close gaps.

Recommendation—Cardinal Care MLTSS

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Measure: *Blood Pressure Control for Patients with Diabetes*

MY 2022: 56.55%

MY 2023: 61.74%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Cardinal Care MLTSS

Goal 5: Providing Whole-Person Care for Vulnerable Populations

Objective 5.4: Improve Behavioral Health and Developmental Services for Members

Measure(s):
5.4.1.1: Follow-Up After Hospitalization for Mental Illness
5.4.1.5: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
5.4.1.10: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

HSAG Recommendation: To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4 and improve behavioral health and developmental services for members, HSAG recommends that DMAS consider the MCO opportunities related to measures within the Behavioral Health domain:

- Work with the MCOs to identify best practices for ensuring follow-up care is completed for members hospitalized for mental illness. HSAG recommends that the MCOs identify and implement interventions based on completed root cause analyses which identified barriers their members experience in accessing care and services to monitor cardiovascular disease in members diagnosed with cardiovascular disease and schizophrenia. Additionally, HSAG recommends that MCOs evaluate providers’ barriers to the use of first-line psychosocial care for children and adolescents on antipsychotics, then implement targeted interventions to address these barriers.

DMAS’ Response

Describe initiatives implemented based on recommendations (include a brief summary of activities)

Recommendation—Cardinal Care MLTSS

that were either completed or implemented, and any activities still underway to address the finding

that resulted in the recommendation):

- DMAS included the measure Follow-Up After Emergency Department Visit for Mental Illness in its PWP which provides an incentive to MCOs to increase performance and close gaps.
- DMAS will begin collecting data for the measure Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics and Diabetes Monitoring for People with Diabetes and Schizophrenia to begin monitoring MCO performance in the future.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Measure: *Follow-Up After Hospitalization for Mental Illness*

MY 2022: 7-Day: 29.00%; 30-Day: 52.02%

MY 2023: 7-Day: 33.91%; 30-Day: 56.34%

Measure: *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*

MY 2022: 37.18%

MY 2023: 63.48%

Measure: *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

MY 2022: 82.49%

MY 2023: 81.79%

Identify any barriers to implementing initiatives:

Barriers were not identified.

HSAG Assessment:



Recommendation—Cardinal Care MLTSS

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

Measure(s):

4.1.1.2: Child and Adolescent Well-Care Visits

4.1.1.3: Childhood Immunization Status

4.1.1.4: Immunizations for Adolescents

4.1.1.9: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

4.2.1.4: Well-Child Visits in the First 30 Months of Life

HSAG Recommendation: To improve the accuracy of provider information available to members in support of Goal 4: Strengthen the Health of Families and Communities, Objectives 4.1 and 4.2 and improve accessibility and timeliness of preventive services and well-child visits for members under the age of 21 years, HSAG recommends that DMAS:

- Work with the enrollment broker to address the data deficiencies identified during the survey (e.g.,

Recommendation—Cardinal Care MLTSS

incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify the location's address and appropriate provider type and specialty. Additionally, DMAS may also consider requesting the MCOs to provide evidence of training offered by the MCO to providers' offices regarding the MCO plan names and benefit coverage. Evidence should demonstrate that the office staff responsible for scheduling appointments have been educated on the MCO names and benefit coverage, and that the offices have a plan in place for educating new staff in the event of staff turnover.

DMAS' Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- DMAS included the measure Child and Adolescent Well-Care Visits in its PWP which provides an incentive to MCOs to increase performance and close gaps.
- DMAS included the measure Childhood Immunization Status in its PWP which provides an incentive to MCOs to increase performance and close gaps.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Measure: *Child and Adolescent Well-Care Visits Total*

MY 2022: 44.15%

MY 2023: 50.88%

Measure: *Childhood Immunization Status*

MY 2022: 64.63%

MY 2023: 66.64%

Measure: *Immunizations for Adolescents*

MY 2022: Combo 1: 96%; Combo 2: 30.96%

MY 2023: Combo 1: 84.20; Combo 2: 35.30%

Measure: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*

MY 2022: BMI: 67.97%; Nutrition Total: 60.34%; Physical Activity Total: 51.75%

MY 2023: BMI: 75.44%; Nutrition Total: 66.47%; Physical Activity Total: 60.09%

Measure: *Well-Child Visits in the First 30 Months of Life*

MY 2022: Not measured for the Cardinal Care MLTSS program

MY 2023: First 15 Months: 61.18%; 15 Months–30 Months: 70.36%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.


HSAG Assessment:



The recommendations provided to DMAS for the prior year EQR activities in the *2024 External Quality Review Technical Report* (dated April 2025), specific to the Acute program, 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—Acute Program Overall

Recommendation—Cardinal Care Acute		
<p>Goal 5: Providing Whole-Person Care for Vulnerable Populations</p>	<p>Objective 5.4: Improve Behavioral Health and Developmental Services for Members</p>	<p>Measure(s): 5.4.1.1: Follow-Up After Hospitalization for Mental Illness 5.4.1.2: Follow-Up After Emergency Department Visit for Mental Illness</p>
<p>HSAG Recommendation: To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4 and improve BH and developmental services for members, HSAG recommends that DMAS:</p> <ul style="list-style-type: none"> • 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 ED visits 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 Collaborative¹-materials to identify potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care. • Continue work on the Follow-Up After Emergency Department Visit for Mental Illness measure through the PWP. 		
<p>DMAS’ Response</p>		
<p>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):</p> <ul style="list-style-type: none"> • DMAS included the measure Follow-Up After Emergency Department Visit for Mental Illness in its PWP which provides an incentive to MCOs to increase performance and close gaps. 		
<p>Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: Measure: Follow-Up After Hospitalization for Mental Illness MY 2022: 7-Day: 32.11%; 30-Day: 53.76% MY 2023: 7-Day: 33.91%; 30-Day: 56.34% Measure: Follow-Up After Emergency Department Visit for Mental Illness MY 2022: 7-Day: 37.90%; 30-Day: 50.96% MY 2023: 7-Day: 38.56%; 30-Day: 53.53%</p>		
<p>Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing the initiatives.</p>		
<p>HSAG Assessment:</p> 		

Recommendation—Cardinal Care Acute

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

Measure(s):

4.1.1.2: Child and Adolescent Well-Care Visits

4.1.1.3: Childhood Immunization Status

4.2.1.1: Prenatal and Postpartum Care—Timeliness of Prenatal Care

4.2.1.4: Well-Child Visits in the First 30 Months of Life

HSAG Recommendation: To improve the accuracy of provider information available to members in support of Goal 4: Strengthen the Health of Families and Communities, Objectives 4.1 and 4.2 and improve access and timeliness of well-child visits and preventive healthcare 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 PCP and prenatal care secret shopper surveys (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify 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 providers' 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 that 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 healthcare, 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.

DMAS' Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- DMAS included the measure Child and Adolescent Well-Care Visits in its PWP which provides an incentive to MCOs to increase performance and close gaps.
- DMAS included the measure Childhood Immunization Status in its PWP which provides an incentive to MCOs to increase performance and close gaps.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Measure: *Child and Adolescent Well-Care Visits*

MY 2022: 48.66%

MY 2023: 50.88%

Measure: *Childhood Immunization Status*

MY 2022: 64.49%

MY 2023: 64.49%

Measure: *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Recommendation—Cardinal Care Acute

MY 2022: 77.10%

MY 2023: 66.64%

Measure: *Well-Child Visits in the First 30 Months of Life*

MY 2022: Not measured for the Cardinal Care Acute program

MY 2023: First 15 Months: 61.18%; 15 Months–30 Months: 70.36%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Cardinal Care Acute

Goal 5: Providing Whole-Person Care for Vulnerable Populations

Objective 5.4: Improve Behavioral Health and Developmental Services for Members

Measure(s):

Measure 5.4.1.1: Follow-Up After Hospitalization for Mental Illness

Measure 5.4.1.2: Follow-Up After Emergency Department Visit for Mental Illness

HSAG Recommendation: To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4 and improve BH 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 ED visits 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 Collaborative¹-materials to identify potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care.
- Continue work on the Follow-Up After Emergency Department Visit for Mental Illness measure through the PWP.

DMAS' Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Specific initiatives were not provided.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Measure: *Follow-Up After Hospitalization for Mental Illness*

MY 2022: 7-Day: 32.11%; 30-Day: 53.76%

MY 2023: 7-Day: 33.91%; 30-Day: 56.34%

Measure: *Follow-Up After Emergency Department Visit for Mental Illness*

MY 2022: 7-Day: 37.90%; 30-Day: 50.96%

Recommendation—Cardinal Care Acute

MY 2023: 7-Day: 38.56%; 30-Day: 53.53%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Cardinal Care Acute

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

Measure(s):

Measure 4.1.1.2: Child and Adolescent Well-Care Visits

Measure 4.1.1.3: Childhood Immunization Status

Measure 4.2.1.1: Prenatal and Postpartum Care—Timeliness of Prenatal Care

Measure 4.2.1.4: Well-Child Visits in the First 30 Months of Life

HSAG Recommendation: To improve the accuracy of provider information available to members in support of Goal 4: Strengthen the Health of Families and Communities, Objectives 4.1 and 4.2 and improve access and timeliness of well-child visits and preventive healthcare 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 PCP and prenatal care secret shopper surveys (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify 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 providers' 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 that 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 healthcare, 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.

DMAS' Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Specific initiatives were not provided.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

Recommendation—Cardinal Care Acute

PMV results showed:

Measure: *Child and Adolescent Well-Care Visits*

MY 2022: 48.66%

MY 2023: 50.88%

Measure: *Childhood Immunization Status—Combo 3*

MY 2022: 64.49%

MY 2023: 64.49%

Measure: *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

MY 2022: 77.10%

MY 2023: 73.71%

Measure: *Well-Child Visits in the First 30 Months of Life*

MY 2022: Not measured for the Cardinal Care Acute program

MY 2023: First 15 Months: 61.18%; 15 Months–30 Months: 70.36%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Cardinal Care Acute

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

Measure(s):

Measure 4.1.1.2: Child and Adolescent Well-Care Visits

Measure 4.1.1.3: Childhood Immunization Status

Measure 4.2.1.1: Prenatal and Postpartum Care—Timeliness of Prenatal Care

Measure 4.2.1.4: Well-Child Visits in the First 30 Months of Life

HSAG Recommendation: To improve the accuracy of provider information available to members in support of Goal 4: Strengthen the Health of Families and Communities, Objectives 4.1 and 4.2 and improve access and timeliness of well-child visits and preventive healthcare 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 PCP and prenatal care secret shopper surveys (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify 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 providers' 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 that 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

Recommendation—Cardinal Care Acute

for members seeking well care, preventive healthcare, 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.

DMAS' Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- Specific initiatives were not provided.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Measure: *Child and Adolescent Well-Care Visits*

MY 2022: 48.66%

MY 2023: 50.88%

Measure: *Childhood Immunization Status—Combo 3*

MY 2022: 64.49%

MY 2023: 64.49%

Measure: *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

MY 2022: 77.10%

MY 2023: 73.71%

Measure: *Well-Child Visits in the First 30 Months of Life*

MY 2022: Not measured for the Cardinal Care Acute program

MY 2023: First 15 Months: 61.18%; 15 Months–30 Months: 70.36%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



Recommendation—Cardinal Care Acute

Goal 5: Providing Whole-Person Care for Vulnerable Populations

Objective 5.4: Improve Behavioral Health and Developmental Services for Members

Measure(s):

Measure 5.4.1.1: Follow-Up After Hospitalization for Mental Illness

Measure 5.4.1.2: Follow-Up After Emergency Department Visit for Mental Illness

Measure: 4.2.1.4: Well-Child Visits in the First 30 Months of Life

Recommendation—Cardinal Care Acute

HSAG Recommendation: To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4 and improve BH 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 ED visits 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- materials to identify potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care.
- Continue work on the Follow-Up After Emergency Department Visit for Mental Illness measure through the PWP.

DMAS' Response

Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

The DMAS BH team continues to work on the following initiative to improve Medicaid funded behavioral healthcare across Virginia including the following efforts:

- DMAS has been instrumental in the planning and implementation of the Right Help, Right Now plan which aims to achieve the goal that all Virginians will, i) be able to access behavioral healthcare when they need it; ii) have prevention and management services personalized to their needs, particularly for children, youth and families; iii) know who to call, who will help and where to go when in crisis; and iv) have paths to reentry and stabilization when transitioning from a crisis. DMAS is an integral partner and stakeholder within this plan.
- In December, 2022, a six-pillar plan was announced to transform Virginia's behavioral health system: the Right Help. Right Now. Plan. (RHRN). As plans developed under Pillar 3 (increasing community capacity) and Pillar 6 (service innovations), initiatives to redesign Medicaid legacy community mental health rehabilitative services (CMHRS)(Intensive In-Home, Therapeutic Day Treatment, Mental Health Skill Building, Psychosocial Rehabilitation and Targeted Case Management) for both adults and youth emerged as significant needs within the system. The current 2024-2026 biennium budget includes Item 288, XX which provides DMAS the authority to replace our CMHRS services and case management service. In collaboration with DBHDS and DHP, DMAS will be launching a two-year project (July 2024-June 2026) to replace our CMHRS services and case management service and this webinar is an opportunity to find out more about the project.
- A collaboration and partnership among health and human services state agencies in Virginia, came together to form 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. The Center and state agencies have developed an interagency agreement regarding Assertive Community Treatment and monitoring the fidelity of this service through the Tool for the Measurement of ACT (TMACT) Assessment as well as the development of a strategic plan to monitor the fidelity of High Fidelity Wrap Around services in Virginia.
- In addition, DMAS established a more robust outcome-based payment strategy that holds MCOs accountable for providing high quality behavioral health services to Virginia Medicaid members and researched additional behavioral health/crisis service utilization measures, including other state

Recommendation—Cardinal Care Acute

programs and commercial and Medicaid/Medicare metrics, that can be considered for inclusion in the performance withhold program (PWP) to assess MCO quality performance.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Measure: *Follow-Up After Hospitalization for Mental Illness*

MY 2022: 7-Day: 32.11%; 30-Day: 53.76%

MY 2023: 7-Day: 33.91%; 30-Day: 56.34%

Measure: *Follow-Up After Emergency Department Visit for Mental Illness*

MY 2022: 7-Day: 37.90%; 30-Day: 50.96%

MY 2023: 7-Day: 38.56%; 30-Day: 53.53%

Measure: *Well-Child Visits in the First 30 Months of Life*

MY 2022: Not measured for the Cardinal Care Acute program

MY 2023: First 15 Months: 61.18%; 15 Months–30 Months: 70.36%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing the initiatives.

HSAG Assessment:



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 Cardinal Care Medicaid managed care program. DMAS is the Commonwealth of Virginia’s single State agency that administers all Medicaid and CHIP health insurance benefit programs in the Commonwealth. Medicaid is delivered to individuals through two models, managed care and fee-for-service (FFS). Table 31 displays the average annual program enrollment during CY 2025.

Table 31—CY 2025 Average Annual Program Enrollment⁴⁷

Program	Enrollment as of 8/1/2025*
Title XIX Medicaid	1,657,015
Title XXI CHIP	194,479
Fee-for-Service	211,152
Total Served	2,062,646

**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 MLTSS and 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 ensures 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 enables DMAS to ensure better continuity of care for members, operate with improved administrative efficiency, and strengthen the focus on the evolving needs of the populations served. The Cardinal Care program ensures a smoother transition for individuals whose healthcare needs evolve over time.

Virginia’s 2023–2025 Quality Strategy provides the framework to accomplish DMAS’ overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP programs. 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 is measured.

⁴⁷ Cardinal Care, Virginia’s Medicaid Program, Department of Medical Assistance Services. Medicaid/FAMIS/PACE Enrollment. Available at: <https://dmas.virginia.gov/data-reporting/eligibility-enrollment/mcicaid-famis-pace-enrollment/>. Accessed on: Aug 15, 2025.

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.

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 in support of the DMAS mission. This vision is distilled into five central goals:

1. Enhance the member care experience
2. Promote access to safe, gold-standard patient care
3. Support efficient and value-driven care
4. Strengthen the health of families and communities
5. Provide whole-person care for vulnerable populations

DMAS contracted with five MCOs through September 30, 2025. The five MCOs contracted with DMAS, are displayed in Table 32. These MCOs pay for Medicaid benefits and services included in the Virginia Medicaid State plan, State statutes, administrative rules, and Medicaid policy and procedure manuals.

Table 32—Cardinal Care MCOs in Virginia

MCO Name	MCO Short Name
Aetna Better Health of Virginia	Aetna
HealthKeepers, Inc.	HealthKeepers
Humana Healthy Horizons of Virginia*	Humana
Sentara Health Plans	Sentara
United Healthcare of the Mid-Atlantic, Inc.	United




**Humana's DMAS Medicaid contract began on July 1, 2025.*


Goals and Objectives

The Virginia 2023–2025 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.

Virginia’s Quality Strategy identifies the following five goals and associated objectives:

Table 33—Quality Strategy Goals and Objectives

Goals	Objectives
 <p>Goal 1: Enhance the Member Care Experience</p>	<p>Objective 1.1: Increase Member Engagement and Outreach</p> <p>Objective 1.2: Improve Member Satisfaction</p>
 <p>Goal 2: Promote Access to Safe, Gold-Standard Patient Care</p>	<p>Objective 2.1: Ensure Access to Care</p> <p>Objective 2.2: Promote Patient Safety</p> <p>Objective 2.3: Promote Effective Communication and Care Coordination</p>
 <p>Goal 3: Support Efficient and Value-Driven Care</p>	<p>Objective 3.1: Focus on Paying for Value</p> <p>Objective 3.2: Promote Efficient Use of Program Funds</p>
 <p>Goal 4: Strengthen the Health of Families and Communities</p>	<p>Objective 4.1: Improve Utilization of Wellness, Immunization, and Prevention Services for Members</p> <p>Objective 4.2: Improve Outcomes for Maternal and Infant Members</p> <p>Objective 4.3: Improve Home and Community-Based Services</p>

Goals	Objectives
 <p>Goal 5: Providing Whole-Person Care for Vulnerable Populations</p>	<p>Objective 5.1: Improve Outcomes for Members with Chronic Conditions</p>
	<p>Objective 5.2: Improve Outcomes for Nursing Home Eligible Members</p>
	<p>Objective 5.3: Improve Outcomes for Members with Substance Use Disorders</p>
	<p>Objective 5.4: Improve Behavioral Health and Developmental Services of Members</p>

Note: Each goal has targeted metrics to measure progress, as well as outlined interventions to advance the goals. See Appendix B.

Each of the 14 objectives are 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 used 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 used to enforce these standards and to identify ongoing opportunities for improvement.

Performance Measures

DMAS required MCOs to report annually on patient quality, access, timeliness, and outcomes performance measures, including HEDIS 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), CAHPS measures, and Commonwealth-specified quality measures. The MCO performance measures aligned 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 assessed if MCO performance measures met target objectives or improvement objectives.

Cardinal Care

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 the five Cardinal Care MCOs’ MY 2023 rates met or exceeded the 75th percentile for the *Immunization for Adolescents—Combination 1 (Meningococcal; Tdap)* PM indicator. In addition, children in foster care had higher rates of appropriate healthcare utilization than comparable controls for the majority study indicators in MY 2022, MY 2021, and MY 2020. Among study indicators where children in foster care had higher rates, MY 2022 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 14.9, 15.6, 15.6, and 9.8 percentage points, respectively), the *Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics* indicator (by 17.1 percentage points), and the *Behavioral Health Encounters—CMH Services, Behavioral Health Encounters—Traditional Services, and Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* indicators (by 15.3, 13.3, and 13.3 percentage points, respectively). Rate differences between children in foster care and controls across study indicators persisted even after matching on many demographic and health characteristics.

Progress was made toward achieving DMAS’ Quality Strategy goal of providing whole-person care for vulnerable populations in the Care for Chronic Conditions domain. All five Cardinal Care MCOs’ MY 2023 rates met or exceeded the 50th percentile for the *Asthma Medication Ratio—Total* PM indicator. 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 also had rates for the *Preterm Births (<37 Weeks Gestation)* and *Newborns With Low Birth Weight (<2,500 grams)* study indicators that outperformed the national benchmarks for all three measurement periods, despite having rates for the *Births With Early and Adequate Prenatal Care* study indicator that did not meet the national benchmark. Similarly, the FAMIS Prenatal Coverage program had the lowest rates of *Births With Early and Adequate Prenatal Care*, but had the lowest rates for the *Preterm Births (<37 Weeks Gestation)* and *Newborns With Low Birth Weight (<2,500 grams)* study indicators, which outperformed national benchmarks in CY 2021 and CY 2022. Of note, the Other Aid Categories rates for all three study indicators underperformed in comparison to the national benchmarks for all three measurement periods.

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 as all five Cardinal Care MCOs’ MY 2023 rates met or exceeded the 50th percentile for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Total*, both indicators for *Initiation and Engagement of Substance Use Disorder Treatment*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* PM indicators.

Additional evidence of progress toward achieving the Quality Strategy goals was found in the

Cascade of Care for Members With OUD—High-Risk Members With OUD Diagnosis indicator which assessed identification of members with an OUD. Findings showed that this rate increased from 5.1 percent to 5.6 percent from CY 2021 to CY 2022. However, this rate had previously increased from 3.8 percent to 5.1 percent from CY 2020 to CY 2021, indicating that improvement has slowed.

Several study indicators found that initiation of SUD treatment increased for every relevant indicator except *Preferred OBAT Compliance—Counseling From an OBAT Provider*. For example, 48.3 percent of members diagnosed with OUD initiated any OUD treatment (i.e., pharmacotherapy or other treatment) within 14 days of OUD diagnosis in CY 2022, and this rate increased by 4.0 percentage points from CY 2021 and by 9.0 percentage points from CY 2020. The rate change from CY 2020 to CY 2021 was driven by an increase in members initiating pharmacotherapy (by 6.2 percentage points), while the rate change from CY 2021 to CY 2022 was driven by increases in both pharmacotherapy and other OUD treatment initiation (by 3.0 and 3.5 percentage points, respectively). Among members who had an initiation visit with an OBAT provider, receipt of OUD medication within seven days of medication-assisted treatment (MAT) initiation increased by 3.1 percentage points to 22.4 percent, and receipt of care coordination within 30 days of MAT initiation increased by 3.9 percentage points to 19.3 percent from CY 2021 to CY 2022. However, since CY 2020 the percentage of members receiving counseling from an OBAT provider following their initial visit declined by 4.6 percentage points.

Seven study indicators assessed the receipt of naloxone, a medication to reverse opioid overdose, which can help reduce overdose deaths. Prescribing of naloxone improved in CY 2022 for six out of seven indicators, in alignment with ARTS benefit goals. These indicators suggest that most members who were receiving opioids through the healthcare system were receiving naloxone. In CY 2022, 54.8 percent of members prescribed high-dose opioids received naloxone, and since CY 2020 this rate has increased by 4.9 percentage points. Additionally, 71.7 and 60.3 percent of members with a history of chronic opioid use and concurrent benzodiazepine and opioid use, respectively, received naloxone, and these rates increased since CY 2020 by 5.1 and 2.8 percentage points.

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. Three of the five Cardinal Care MCOs’ MY 2023 rates fell below the 50th percentile for the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* PM indicator. The DMAS Quality Strategy goal of strengthening the health of families and communities also had opportunities for improvement in the Access to Care domain with all five Cardinal Care MCOs’ rates falling below the 50th percentile for the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*, *Colorectal Cancer Screening—Total*, *Use of Imaging Studies for Low Back Pain—Total*, and *Plan All-Cause Readmissions—Observed Readmissions* PM indicators. The Quality Strategy goal of promoting access to safe, gold-standard patient care also demonstrated opportunities for improvement in preventive screenings. All five Cardinal Care MCOs’ rates fell below the 50th percentile for the *Cervical Cancer Screening—Total* PM 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, all five Cardinal Care MCOs’ MY 2023 rates fell below the 50th percentile for the *Medical Assistance With Smoking and Tobacco Use Cessation* PM indicators.

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 behavioral health conditions or SUDs. All five Cardinal Care MCOs' MY 2023 rates fell below the 50th percentile for the *Follow-Up After Emergency Department 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. In addition, naloxone receipt was notably lower among other members at high risk of overdose. Only 42.3 percent of members diagnosed with OUD received naloxone. Also, only 46.7 percent of members with a history of overdose received naloxone.

In addition, rate differences among racial/ethnic groups varied across study indicators; however, rates for Asian members and Black/African American members tended to be lower than other racial/ethnic groups. Asian members prescribed high-dose opioids or with diagnosed OUD were less likely to receive naloxone than other racial/ethnic groups, and Asian members at high risk of OUD were least likely to be diagnosed with OUD. Additionally, Asian members were least likely to initiate and engage in HIV care. Among those with SUD, Black/African American members with hepatitis C or HIV were less likely to receive treatment for hepatitis C. Additionally, Black/African American members were less likely to initiate pharmacotherapy or other OUD treatment in a timely manner.

By region, the Central region had the highest rate of OUD diagnoses, yet some of the lowest rates for initiation of pharmacotherapy and other treatment. The Southwest region continued to have the highest rate of hepatitis C diagnoses. However, while the Southwest region also had the lowest rate for initiation of DAA treatment in CY 2021, this rate greatly improved in CY 2022. The Southwest region had the lowest rates for several other indicators for the *Cascade of Care for Members with OUD* measure during CY 2022, such as *High-Risk Members with OUD Diagnosis* and *Members Identified as Having OUD Who Initiated OUD Treatment: Both Pharmacotherapy and Other Treatment*.

CAHPS

DMAS required the external quality review organization (EQRO) to administer a CAHPS survey according to the NCQA HEDIS Specifications for Survey measures. This activity assessed member experience with an MCO and its providers and the quality of care members received. 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*.

Cardinal Care 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 Cardinal Care 2024 Adult member CAHPS 5.1 Adult Medicaid Health Plan Survey score for one MCO met or exceeded the national Medicaid benchmarks in the NCQA Quality Compass for the Global indicator *Getting Needed Care*, two MCOs met or exceeded the national Medicaid benchmarks in *Rating of Personal Doctor*, and one MCO met or exceeded the national Medicaid benchmark in *Rating of Specialist Seen Most Often*. Composite measure results showed one MCO having met or

exceeded the NCQA Quality Compass Composite for the *Getting Needed Care* indicator. No indicator rates were statistically lower in 2024 than in 2023.

Cardinal Care Child Survey

The Cardinal Care program's 2024 top-box scores were not statistically significantly lower than the 2023 NCQA child Medicaid national average for any Child Global top box scores. For the Composite Top-Box Scores, one MCO scored statistically significantly lower than the 2023 NCQA national Medicaid averages in *Getting Needed Care* and in *Customer Service*, while two MCOs scored statistically significantly lower in *How Well Doctor's Communicate*.

FAMIS Program Child Survey

Although not a metric in the Quality Strategy, the FAMIS general child and Children with Chronic Conditions 2024 CAHPS scores in the Composite measure, *How Well Doctors Communicate* and *Customer Service*, identified top-box scores that were statistically significantly lower than the 2023 top-box scores. The Children with Chronic Conditions 2024 top-box scores were not statistically higher or lower than the 2023 top-box scores. 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 played a critical role in reporting MCOs' performance in several required areas (federal regulations require that these activities be completed by the EQRO) and some optional areas (the Commonwealth 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 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 34. 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 34—DMAS-Approved MCO PIPs

PIP Topic Area
<i>Timeliness of Prenatal Care</i> 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 2024 <i>Prenatal and Postpartum Care (PPC)</i> Technical Specifications. (Quality Strategy goal: Strengthen the Health of Families and Communities; objective: Improve Outcomes for Maternal and Infant Members.)
<i>Tobacco Use Cessation in Pregnant Women</i> rates for all pregnant women, as defined by the HEDIS MY 2024 <i>PPC</i> 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.)
<i>Ambulatory Care—Emergency Department Visits</i> rates for the percentage of members in the entire eligible population aligned with the HEDIS MY 2024 Technical Specifications <i>Ambulatory Care (AMB)</i> measure specifications and who had more than one emergency department visit. (Quality Strategy goal: Support Efficient and Value-Driven Care; objective: Focus on Paying for Value.)
<i>Follow-Up After Discharge</i> 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 conducted the *EQR Protocol 4. Validation of Network Adequacy* activity in 2024. 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 required the MCOs to conduct various activities to assess the adequacy of their networks as well as maintain provider and beneficiary data sets that allowed monitoring of their networks’ adequacy. DMAS required 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

HSAG obtained from DMAS a list of the Commonwealth’s quantitative network adequacy standards, by provider and plan type, as specified in the Commonwealth’s contract with the MCOs. DMAS also provided a description of the network adequacy data and documentation that MCOs submitted to the Commonwealth 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.

Overall, the MCOs had well-defined processes and procedures in place to ensure the efficient and accurate collection of member and provider data to support network adequacy calculation and reporting. The MCOs also demonstrated dedicated efforts to identify gaps in provider networks throughout their service areas and identified ways to improve the accessibility and timeliness of care for members. Opportunities identified were in ensuring MCO understanding of all provider types that were required to be reported.

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 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 provided 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 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 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.

Phantom Network Analysis

HSAG also conducted a phantom network analysis to collect information on the percentage of providers within the network that were not rendering services to Medicaid members or accepting new patients. The phantom network analysis provided 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. Overall, the percentage of phantom providers contracted with an MCO ranged from 10.8 percent providers to 52.3 percent of BH providers. Across all MCOs, BH providers had the highest percentage of phantom providers, which aligned with previous reports on phantom networks in other states. HSAG assessed differences between active and non-active providers and found minimal differences between the geographic regions, urbanities, languages spoken, and active status. Additionally, HSAG assessed the geographic locations of the phantom providers using the time and distance a member would travel to the nearest provider using the full network of providers and the active network of providers. Again, HSAG noted minimal differences in the travel time and distances for the providers. The phantom providers did not seem to be dramatically different from the active providers based on these categories. In fact, they seemed to be distributed relatively proportionally to the active providers. Lastly, HSAG assessed the patient load for the provider categories. In general, OBGYNs, PCPs, and Pediatric providers were most likely to see more than 16 members over the course of the year, with pediatricians and OB/GYNs also the most likely to see more than 100 members over the year.

Compliance Monitoring

During 2024, 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:

- Disenrollment: Requirements and Limitations: 438.56
- Member Rights and Member Information: 438.100; 438.10
- Emergency and Poststabilization Services: 438.114
- Availability of Services: 438.206
- Assurance of Adequate Capacity and Services: 438.207
- Coordination and Continuity of Care: 438.208
- Coverage and Authorization of Services: 438.210
- Provider Selection: 438.214
- Confidentiality: 438.224
- Grievance and Appeal Systems: 438.228
- Subcontractual Relationships and Delegation: 438.230
- Practice Guidelines: 438.236
- Health Information Systems (including ISCA): 438.242

- Quality Assessment and Performance Improvement: 438.330
- Program Integrity: 438.608
- Model of Care: Social Security Act; Section 1859
- EPSDT Services: 441.50 Section 1902 of the SSA

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 2023–2025 review period, DMAS continued to work diligently, in collaboration with the MCOs, to operationalize community engagement and health disparities 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:

- ARTS Internal Metrics Dashboard Improvements: The ARTS team continued to work with DMAS' Healthcare Analytics Division to publish a public-facing version of the ARTS dashboard so that it could provide information similar to the external dashboard for mental health disorder services. This allowed the ARTS team more capability to perform real-time data analysis and quality assurance/improvement work.
- Newborn Bot Enrollment: The newborn enrollment process incorporated newborn auto enrollment using an automated process in the form of a "newborn bot." The bot processed newborn enrollments from hospitals through the Medicaid enrollment process. The bot was an attended bot. The newborn enrollment unit is moving toward an unattended bot, which will process more cases per day. Cases not processed through the bot were captured in an exception file that flagged cases where there was a redetermination or where a case change had been made. Messaging for members remained the same for families to call CoverVA or work with LDSS to enroll their newborns.

- **Development of Maternal and Child (MCH) Dashboards:** The MCH Health Team engaged in a collaborative effort with internal teams to design and implement sophisticated dashboards aimed at improving the review and analysis processes for MCH contract deliverables submitted by DMAS' MCOs. These dashboards provided a high-level summary of MCOs' self-reported claims data to create a picture of pregnant/postpartum enrollment numbers, members assigned as high risk, results of outreach and engagement efforts, and utilization of services by high-risk members. Analysts tracked the results for trends and outliers. Analysts reached out to MCOs with questions and concerns. The information also was used to inform policy and programming changes, as needed.
- **CMS Infant Well-Child Visit Learning Collaborative:** The learning collaborative offered technical assistance to state Medicaid and Children's Health Insurance Program (CHIP) agencies and their partners (MCOs and other partners), DMAS and its partners received technical assistance in designing and implementing a quality improvement project aimed at identifying ways to increase participation in well-child visits. The collaborative initiated interventions with providers in Roanoke, Winchester, Tidewater Area, Petersburg, and Southwest Virginia. The initiative started in March 2021 and concluded in December 2023. Initiatives focused on enrollment processes (newborn), member education, and consistent messaging across MCOs regarding enrollment.
- **Baby Steps of Virginia:** Baby Steps Virginia was the vehicle with which Virginia Medicaid brought together sister agencies, other key partners and stakeholders, and the voice of the member, with the focus of sharing information on and fostering collaboration to improve maternal health outcomes and eliminate racial disparity in outcomes and maternal mortality. With the myriad of initiatives, workgroups, taskforces, new programs, etc. addressing maternal health, it was imperative to have a mechanism to keep partners and stakeholders informed. In addition to bimonthly virtual meetings, DMAS distributed bimonthly newsletters, an annual report, and ad hoc email blasts on key announcements.
- **Community Doula Program:** As of July 31, 2025, 174 doulas received State certification. Of the 174 State-certified doulas, 137 were approved and enrolled as Medicaid Doula Providers. There were 226 doula-supported births to Medicaid members and over 437 birthing families received doula services through Virginia Medicaid. Feedback continued to be positive from families who received care and support from a doula. DMAS continued to focus on community and provider engagement, data collection and analysis to evaluate benefit utilization, and increase of network of doula providers.
- **DMAS was awarded funding from the Opioid Abatement Authority to support expansion of the Emergency Department Bridge Clinic model throughout the Commonwealth and provide training and technical assistance to hospitals and health groups that implemented this model.**
- **Through numerous efforts, including the SUPPORT Act Grant, DMAS worked with stakeholders to identify ways to increase engagement and retention in substance use disorder treatment. This included supporting the Emergency Department Bridge Clinic model, supporting providers looking to provide peer recovery support services, providing technical assistance on the ASAM multidimensional assessment to providers, and other initiatives. DMAS also explored ways to support members with SUD who were being released from legal/carceral settings by exploring options to strengthen supports provided during that transition.**
- **Partnership for Petersburg:** This program 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 was 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, Humana, Sentara 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.

- 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 healthcare service being measured (initial comprehensive medical examination within 30 days of a child entering foster care). By the end of the two-year Affinity Group, the team identified barriers to accessing timely healthcare services for the foster care member population, as well as utilized 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 healthcare 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 two days after entering foster care. The team then scaled the pilot up statewide and tested a less labor-intensive 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 percent of members in Bedford County receiving initial medical examinations within 30 days of entering custody for the final seven months of the test.

MCO Cardinal Care Program Contract Language

DMAS included disparity requirements in the Cardinal Care program MCO contract. The MCO contract requires that the MCO consider the importance of addressing health 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 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 reducing 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 Commonwealth, 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 a membership that includes but is not limited to analyzing significant healthcare 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 2030, 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 Disparity Initiatives

- Convening a quality collaborative to address best practices, review results of performance measures, and performance improvement projects that focused on 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 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 during CY 2025:

- An MCO received a member on the 834-enrollment file with an effective date of January 1, 2022. An SNF admission (exception indicator 2) date of November 1, 2021, for this member

was erroneously entered prior to the member's enrollment with the MCO. DMAS received a request on July 7, 2023, to void the November 1, 2021, level 2 line as it was determined by the MCO that this member had never resided in the SNF facility. The SNF line was voided by DMAS on July 7, 2023.

- Untimely waiver portal entry (18 months) resulting in significant capitation overpayment.
- Failure to submit a CAP.
- Failure to complete a level of care review assessment face-to-face.
- On January 26, 2023, all health plans were given a timeline to clean up care management system (CRMS) rejected data that remained outstanding for dates July 2020 through December 2022. The deadline for data quality clean-up was April 30, 2023.
- On September 25, 2023, a follow-up review revealed minimal to no progress of data quality clean-up. Rejected CRMS data was data that DMAS did not have, which had a direct impact on the Medical Transition Report and data analysis (e.g., DMAS website).
- 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 managed file transfer 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 Federal Insurance Contributions Act (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 this financial arrangement. The PWP assesses CY PM data to determine what portion, if any, of the MCOs' quality withhold will be earned back. The CCMC MCOs can earn all or a portion of their one percent quality withhold based on performance for PWP measures. The PWP scores are based on comparisons to the NCQA Quality Compass national Medicaid HMO percentiles for all HEDIS measures and those measures 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 were powerful management, analytic, and visualization tools that allowed DMAS to review and monitor MCOs with increased oversight and detail.

Quality Initiatives

Virginia 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 in the following paragraphs.

Right Help, Right Now

The *Right Help, Right Now* was created to reform Virginia’s behavioral health system and to support individuals in crisis. The goal of *Right Help, Right Now* was to support Virginians before, during, and after a behavioral health crisis occurs. The *Right Help, Right Now* plan aims to ensure that there is 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 also serves to reduce the criminalization of mental health in Virginia. The *Right Help, Right Now* plan included 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

The Youth Mental Health Strategy was unveiled 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.

In year two of *Right Help, Right Now* action was taken to better equip parents and support Virginia’s young people through budget proposals, legislation, and executive action, and the Youth Mental Health Strategy, addressed critical components and harmful aspects of social media on Virginia’s youth. The strategy included 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 healthcare settings—family empowerment and rights

Additional Developmental Disabilities Waiver Slots

DMAS is 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. An additional \$300 million over the biennium was provided 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 gave Virginians with disabilities the supports and services they needed to live their best lives in their communities. Through these improvements, Virginians with disabilities were provided supports and services they needed to live their best lives in their communities. The Virginia Secretary of Health and Human Resources 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 partnered with a variety of stakeholders including DMAS MCOs to improve quality maternity outcomes. All of these efforts 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 quality maternity outcomes and reduce health disparities. From 2023 through 2025, 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 was 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 included 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 was 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 ARTS benefit provided treatment for members with SUDs across the state and provided access to addiction treatment services for all enrolled members in Medicaid, FAMIS, and FAMIS MOMS. A DMAS goal for the ARTS delivery system transformation included ensuring that a full continuum of care was available, based on evidence-based practice, to effectively treat individuals with SUD.

This approach was expected to provide Medicaid members with access to the evidence-based care needed to achieve sustainable recovery. The MCOs worked with DMAS, as required by contract, to ensure that their members' care needs for SUD treatment and recovery were met and included 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 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 committee was comprised of representatives from across the state and was entirely made up of Medicaid-enrolled individuals and individuals' authorized representatives. The MAC's purpose was 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 met 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 had meaningful access to programs and services. This position served the critical function of ensuring continued compliance with federal and Commonwealth of Virginia civil rights requirements and ensured

that internal and external stakeholders had language and disability access resources available to improve communications with LEP individuals and those with disabilities.

Value-Based Purchasing

DMAS was focused on increasing the use of value-based purchasing arrangements with MCOs and providers. VBP included 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 providers serving Virginia Medicaid members. Achievement of these goals was measured through a set of defined metrics evaluating quality, cost, and patient-centered care. There was no “one-size-fits-all” approach to VBP, and DMAS’ efforts focused on a range of healthcare providers, populations, and care events that were important to members, 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 brought 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 ensured that every child had a safe place to belong.

Adult Dental Coverage

The comprehensive adult dental benefit became effective July 1, 2021. More than 960,000 members had access to comprehensive dental benefits that made 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 aids 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 CMS 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 enabled 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 were able to 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 had 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 were 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 provided a single, statewide technology solution that connected 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 was integrated with the Prescription Monitoring Program and the Advanced Health Directory. This sharing of information allowed 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 Cardinal Care Medicaid members. 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 **35** includes 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 35—Cardinal Care Prior Year Recommendations and DMAS Responses

2021–2022 EQRO Recommendations	DMAS Actions
<p>Goal 5: Providing Whole-Person Care for Vulnerable Populations</p> <p>Objective 5.1: Improve Outcomes for Members with Chronic Conditions</p> <p>Measure: 5.1.1.5: Controlling High Blood Pressure</p> <p>To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.1 and improve outcomes for members with chronic conditions, HSAG recommends that DMAS:</p> <ul style="list-style-type: none"> • Work with MCOs to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to manage and maintain their chronic conditions, and to make appropriate health decisions. HSAG continues to recommend that DMAS monitor MCOs to ensure that the MCOs analyze their data and consider if there are disparities within the MCOs’ populations that contributed to lower rates in controlling high blood pressure, including members diagnosed with diabetes. In addition, HSAG recommends that DMAS monitor the MCOs to ensure implementation of interventions that address disparities and reflect identified opportunities for improvement. 	<p>DMAS included the measure Blood Pressure Control for Patients with Diabetes in its PWP which provides an incentive to MCOs to increase performance and close gaps.</p> <p>Measure: <i>Blood Pressure Control for Patients with Diabetes</i></p> <p>MY 2022: 55.31%</p> <p>MY 2023: 61.74%</p>
<p>Goal: Providing Whole-Person Care for Vulnerable Populations</p> <p>Objective 5.4: Improve Behavioral Health and Developmental Services for Members</p> <p>To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable</p>	<p>DMAS has improved its ability to track MCO required monthly data submissions</p> <p>Measure: <i>Follow-Up After Hospitalization for Mental Illness</i></p> <p>MY 2022: 7-Day: 29.00%; 30-Day: 52.02%</p> <p>MY 2023: 7-Day: 33.91%; 30-Day: 56.34%</p> <p>Measure: <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i></p> <p>MY 2022: 37.18%</p>

2021–2022 EQRO Recommendations	DMAS Actions
<p>Populations, Objective 5.4 and improve behavioral health and developmental services for members, HSAG recommends that DMAS consider the MCO opportunities related to measures within the Behavioral Health domain:</p> <ul style="list-style-type: none"> • Work with the MCOs to identify best practices for ensuring follow-up care is completed for members hospitalized for mental illness. HSAG recommends that the MCOs identify and implement interventions based on completed root cause analyses which identified barriers their members experience in accessing care and services to monitor cardiovascular disease in members diagnosed with cardiovascular disease and schizophrenia. Additionally, HSAG recommends that MCOs evaluate providers’ barriers to the use of first-line psychosocial care for children and adolescents on antipsychotics, then implement targeted interventions to address these barriers. 	<p>MY 2023: 63.48%</p> <p>Measure: <i>Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i></p> <p>MY 2022: 82.49%</p> <p>MY 2023: 81.79%</p>

Table 36—Acute Prior Year Recommendations and DMAS Responses

2021–2022 EQRO Recommendations	DMAS Actions
<p>Goal 4: Strengthen the Health of Families and Communities</p> <p>Objective 4.1: Improve Utilization of Wellness, Immunization, and Prevention Services for Members</p> <p>Objective 4.2: Improve Outcomes for Maternal and Infant Members</p> <p>To improve the accuracy of provider information available to members in support of Goal 4: Strengthen the Health of Families and Communities, Objectives 4.1 and 4.2 and improve accessibility and timeliness of</p>	<p>Measure: <i>Child and Adolescent Well-Care Visits Total</i></p> <p>MY 2022: 44.15%</p> <p>MY 2023: 50.88%</p> <p>Measure: <i>Childhood Immunization Status</i></p> <p>MY 2022: 64.63%</p> <p>MY 2023: 66.64%</p> <p>Measure: <i>Immunizations for Adolescents</i></p> <p>MY 2022: Combo 1: 79.96; Combo 2: 30.96%</p> <p>MY 2023: Combo 1: 84.20; Combo 2: 35.30%</p>

2021–2022 EQRO Recommendations	DMAS Actions
<p>preventive services and well-child visits for members under the age of 21 years, HSAG recommends that DMAS:</p> <ul style="list-style-type: none"> Work with the enrollment broker to address the data deficiencies identified during the survey (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify the location’s address and appropriate provider type and specialty. Additionally, DMAS may also consider requesting the MCOs to provide evidence of training offered by the MCO to providers’ offices regarding the MCO plan names and benefit coverage. Evidence should demonstrate that the office staff responsible for scheduling appointments have been educated on the MCO names and benefit coverage, and that the offices have a plan in place for educating new staff in the event of staff turnover. 	<p>Measure: <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</i> MY 2022: BMI: 67.97%; Nutrition Total: 60.34%; Physical Activity Total: 51.75% MY 2023: BMI: 75.44%; Nutrition Total: 66.47%; Physical Activity Total: 60.09%</p> <p>Measure: <i>Well-Child Visits in the First 30 Months of Life</i> MY 2022: Not measured in the Cardinal Care MLTSS program MY 2023: First 15 Months: 61.18%; 15 Months–30 Months: 70.36%</p>
<p>Goal 5: Providing Whole-Person Care for Vulnerable Populations Objective 5.1: Improve Outcomes for Members with Chronic Conditions</p> <p>To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.1 and improve outcomes for members with chronic conditions, HSAG recommends that DMAS:</p> <ul style="list-style-type: none"> Work with MCOs to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to manage and maintain their chronic conditions, and to make appropriate health decisions. HSAG continues to recommend 	<p>DMAS included the measure Blood Pressure Control for Patients with Diabetes in its PWP which provides an incentive to MCOs to increase performance and close gaps.</p> <p>Measure: <i>Blood Pressure Control for Patients with Diabetes</i> MY 2022: 56.55% MY 2023: 61.74%</p>

2021–2022 EQRO Recommendations	DMAS Actions
<p>that DMAS monitor MCOs to ensure that the MCOs analyze their data and consider if there are disparities within the MCOs’ populations that contributed to lower rates in controlling high blood pressure, including members diagnosed with diabetes. In addition, HSAG recommends that DMAS monitor the MCOs to ensure implementation of interventions that address disparities and reflect identified opportunities for improvement.</p>	
<p>Goal 5: Providing Whole-Person Care for Vulnerable Populations Objective 5.4: Improve Behavioral Health and Developmental Services for Members</p> <p>To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4 and improve behavioral health and developmental services for members, HSAG recommends that DMAS consider the MCO opportunities related to measures within the Behavioral Health domain:</p> <ul style="list-style-type: none"> Work with the MCOs to identify best practices for ensuring follow-up care is completed for members hospitalized for mental illness. HSAG recommends that the MCOs identify and implement interventions based on completed root cause analyses which identified barriers their members experience in accessing care and services to monitor cardiovascular disease in members diagnosed with cardiovascular disease and schizophrenia. Additionally, HSAG recommends that MCOs evaluate providers’ barriers to the use of first-line psychosocial care for children and adolescents on antipsychotics, then implement 	<ul style="list-style-type: none"> DMAS included the measure Follow-Up After Emergency Department Visit for Mental Illness in its PWP which provides an incentive to MCOs to increase performance and close gaps. DMAS will begin collecting data for the measure Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics and Diabetes Monitoring for People with Diabetes and Schizophrenia to begin monitoring MCO performance in the future. <p>Measure: <i>Follow-Up After Hospitalization for Mental Illness</i> MY 2022: 7-Day: 29.00%; 30-Day: 52.02% MY 2023: 7-Day: 33.91%; 30-Day: 56.34%</p> <p>Measure: <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i> MY 2022: 37.18% MY 2023: 63.48%</p> <p>Measure: <i>Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i> MY 2022: 82.49% MY 2023: 81.79%</p>

2021–2022 EQRO Recommendations	DMAS Actions
targeted interventions to address these barriers.	
<p>Goal 4: Strengthen the Health of Families and Communities</p> <p>Objective 4.1: Improve Utilization of Wellness, Immunization, and Prevention Services for Members</p> <p>To improve the accuracy of provider information available to members in support of Goal 4: Strengthen the Health of Families and Communities, Objectives 4.1 and 4.2 and improve accessibility and timeliness of preventive services and well-child visits for members under the age of 21 years, HSAG recommends that DMAS:</p> <ul style="list-style-type: none"> • Work with the enrollment broker to address the data deficiencies identified during the survey (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify the location’s address and appropriate provider type and specialty. Additionally, DMAS may also consider requesting the MCOs to provide evidence of training offered by the MCO to providers’ offices regarding the MCO plan names and benefit coverage. Evidence should demonstrate that the office staff responsible for scheduling appointments have been educated on the MCO names and benefit coverage, and that the offices have a plan in place for educating new staff in the event of staff turnover. 	<ul style="list-style-type: none"> • DMAS included the measure Child and Adolescent Well-Care Visits in its PWP which provides an incentive to MCOs to increase performance and close gaps. • DMAS included the measure Childhood Immunization Status in its PWP which provides an incentive to MCOs to increase performance and close gaps.
<p>Goal 5: Providing Whole-Person Care for Vulnerable Populations</p> <p>Objective 5.4: Improve Behavioral Health and Developmental Services for Members</p>	<p>DMAS included the measure Follow-Up After Emergency Department Visit for Mental Illness in its PWP which provides an incentive to MCOs to increase performance and close gaps.</p>

2021–2022 EQRO Recommendations	DMAS Actions
<p>To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4 and improve BH and developmental services for members, HSAG recommends that DMAS:</p> <ul style="list-style-type: none"> • 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 ED visits 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 materials to identify potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care. • Continue work on the Follow-Up After Emergency Department Visit for Mental Illness measure through the PWP. 	<p>Measure: <i>Follow-Up After Hospitalization for Mental Illness</i> MY 2022: 7-Day: 32.11%; 30-Day: 53.76% MY 2023: 7-Day: 33.91%; 30-Day: 56.34%</p> <p>Measure: <i>Follow-Up After Emergency Department Visit for Mental Illness</i> MY 2022: 7-Day: 37.90%; 30-Day: 50.96% MY 2023: 7-Day: 38.56%; 30-Day: 53.53%</p>
<p>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</p> <p>To improve the accuracy of provider information available to members in support of Goal 4: Strengthen the Health of Families and Communities,</p>	<ul style="list-style-type: none"> • DMAS included the measure Child and Adolescent Well-Care Visits in its PWP which provides an incentive to MCOs to increase performance and close gaps. • DMAS included the measure Childhood Immunization Status in its PWP which provides an incentive to MCOs to increase performance and close gaps. <p>Measure: <i>Child and Adolescent Well-Care Visits</i> MY 2022: 48.66%</p>

2021–2022 EQRO Recommendations	DMAS Actions
<p>Objectives 4.1 and 4.2 and improve access and timeliness of well-child visits and preventive healthcare for members under the age of 21 years, and the timeliness of pregnancy-related care, HSAG recommends that DMAS:</p> <ul style="list-style-type: none"> • Work with the enrollment broker to address the data deficiencies identified during the PCP and prenatal care secret shopper surveys (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify 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 providers' 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 that 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 healthcare, 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 	<p>MY 2023: 50.88%</p> <p>Measure: <i>Childhood Immunization Status</i></p> <p>MY 2022: 64.49%</p> <p>MY 2023: 64.49%</p> <p>Measure: <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i></p> <p>MY 2022: 77.10%</p> <p>MY 2023: 66.64%</p> <p>Measure: <i>Well-Child Visits in the First 30 Months of Life</i></p> <p>MY 2022: Not measured for the Cardinal Care Acute program</p> <p>MY 2023: First 15 Months: 61.18%; 15 Months–30 Months: 70.36%</p>

2021–2022 EQRO Recommendations	DMAS Actions
<p>that DMAS monitor MCOs to ensure that the MCOs analyze their data and consider if there are disparities within the MCOs' populations.</p>	
<p>Goal 5: Providing Whole-Person Care for Vulnerable Populations</p> <p>Objective 5.4: Improve Behavioral Health and Developmental Services for Members</p> <p>To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4 and improve BH and developmental services for members, HSAG recommends that DMAS:</p> <ul style="list-style-type: none"> • 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 ED visits 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 Collaborative¹ materials to identify potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care. • Continue work on the Follow-Up After Emergency Department Visit for Mental Illness measure through the PWP. 	<p>Measure: <i>Follow-Up After Hospitalization for Mental Illness</i> MY 2022: 7-Day: 32.11%; 30-Day: 53.76% MY 2023: 7-Day: 33.91%; 30-Day: 56.34%</p> <p>Measure: <i>Follow-Up After Emergency Department Visit for Mental Illness</i> MY 2022: 7-Day: 37.90%; 30-Day: 50.96% MY 2023: 7-Day: 38.56%; 30-Day: 53.53%</p>
<p>Goal 4: Strengthen the Health of Families and Communities</p>	<p>Measure: <i>Child and Adolescent Well-Care Visits</i> MY 2022: 48.66%</p>

2021–2022 EQRO Recommendations	DMAS Actions
<p>Objective 4.1: Improve Utilization of Wellness, Immunization, and Prevention Services for Members</p> <p>Objective 4.2: Improve Outcomes for Maternal and Infant Members</p> <p>To improve the accuracy of provider information available to members in support of Goal 4: Strengthen the Health of Families and Communities, Objectives 4.1 and 4.2 and improve access and timeliness of well-child visits and preventive healthcare for members under the age of 21 years, and the timeliness of pregnancy-related care, HSAG recommends that DMAS:</p> <ul style="list-style-type: none"> • Work with the enrollment broker to address the data deficiencies identified during the PCP and prenatal care secret shopper surveys (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify 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 providers' 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 that 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 healthcare, 	<p>MY 2023: 50.88%</p> <p>Measure: <i>Childhood Immunization Status—Combo 3</i></p> <p>MY 2022: 64.49%</p> <p>MY 2023: 64.49%</p> <p>Measure: <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i></p> <p>MY 2022: 77.10%</p> <p>MY 2023: 73.71%</p> <p>Measure: <i>Well-Child Visits in the First 30 Months of Life</i></p> <p>MY 2022: Not measured for the Cardinal Care Acute program</p> <p>MY 2023: First 15 Months: 61.18%; 15 Months–30 Months: 70.36%</p>

2021–2022 EQRO Recommendations	DMAS Actions
<p>childhood immunizations, and pregnancy-related care.</p> <ul style="list-style-type: none"> 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. 	
<p>Goal 5: Providing Whole-Person Care for Vulnerable Populations Objective 5.4: Improve Behavioral Health and Developmental Services for Members</p> <p>To improve program-wide performance in support of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4 and improve BH and developmental services for members, HSAG recommends that DMAS:</p> <ul style="list-style-type: none"> 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 ED visits 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- materials to identify 	<p>The DMAS BH team continues to work on the following initiative to improve Medicaid funded behavioral healthcare across Virginia including the following efforts:</p> <ul style="list-style-type: none"> DMAS has been instrumental in the planning and implementation of the Right Help, Right Now plan which aims to achieve the goal that all Virginians will, i) be able to access behavioral healthcare when they need it; ii) have prevention and management services personalized to their needs, particularly for children, youth and families; iii) know who to call, who will help and where to go when in crisis; and iv) have paths to reentry and stabilization when transitioning from a crisis. DMAS is an integral partner and stakeholder within this plan. In December, 2022, a six-pillar plan was announced to transform Virginia’s behavioral health system: the Right Help. Right Now. Plan. (RHRN). As plans developed under Pillar 3 (increasing community capacity) and Pillar 6 (service innovations), initiatives to redesign Medicaid legacy community mental health rehabilitative services (CMHRS)(Intensive In-Home, Therapeutic Day Treatment, Mental Health Skill Building, Psychosocial Rehabilitation and Targeted Case Management) for both adults and youth emerged as significant needs within the system. The current 2024-2026 biennium budget includes Item 288, XX which provides DMAS the authority to replace our CMHRS

2021–2022 EQRO Recommendations	DMAS Actions
<p>potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care.</p> <ul style="list-style-type: none"> Continue work on the Follow-Up After Emergency Department Visit for Mental Illness measure through the PWP. 	<p>services and case management service. In collaboration with DBHDS and DHP, DMAS will be launching a two-year project (July 2024-June 2026) to replace our CMHRS services and case management service and this webinar is an opportunity to find about more about the project.</p> <ul style="list-style-type: none"> A collaboration and partnership among health and human services state agencies in Virginia, came together to form 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. The Center and state agencies have developed an interagency agreement regarding Assertive Community Treatment and monitoring the fidelity of this service through the Tool for the Measurement of ACT (TMACT) Assessment as well as the development of a strategic plan to monitor the fidelity of High Fidelity Wrap Around services in Virginia. In addition, DMAS established a more robust outcome-based payment strategy that holds MCOs accountable for providing high quality behavioral health services to Virginia Medicaid members and researched additional behavioral health/crisis service utilization measures, including other state programs and commercial and Medicaid/Medicare metrics, that can be considered for inclusion in the performance withhold program (PWP) to assess MCO quality performance. <p>Measure: <i>Follow-Up After Hospitalization for Mental Illness</i> MY 2022: 7-Day: 32.11%; 30-Day: 53.76% MY 2023: 7-Day: 33.91%; 30-Day: 56.34%</p> <p>Measure: <i>Follow-Up After Emergency Department Visit for Mental Illness</i> MY 2022: 7-Day: 37.90%; 30-Day: 50.96% MY 2023: 7-Day: 38.56%; 30-Day: 53.53%</p> <p>Measure: <i>Well-Child Visits in the First 30 Months of Life</i></p>

2021–2022 EQRO Recommendations	DMAS Actions
	MY 2022: Not measured for the Cardinal Care Acute program MY 2023: First 15 Months: 61.18%; 15 Months–30 Months: 70.36%

Strengths and Recommendations

Strengths

DMAS considered the Virginia 2026–2028 Quality Strategy to be its roadmap for the future. DMAS' Quality Strategy provided 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 promoted 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 represented an effective tool for measuring and improving the quality of Virginia's Medicaid managed care services. The Quality Strategy promoted 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 tied to the Quality Strategy goals, and objectives. The Virginia Medicaid Quality Strategy strived to ensure members received high-quality care that was safe, efficient, patient-centered, timely, value and quality-based, and data-driven.

DMAS conducted oversight of the MCOs in coordination with the Quality Strategy to promote accountability and transparency for improving health outcomes. DMAS had an MCO contract requirement that the MCO should be committed to quality improvement and its overall approach and specific strategies were used to advance Virginia Medicaid's Quality Strategy and incentive-based quality measures. In addition, each MCO was required to be NCQA accredited and to conduct HEDIS performance measure reporting.

Recommendations

The EQRO identified the following recommendations for the Quality Strategy:

To improve program-wide performance in support of **Goal 2: Promote Access to Safe, Gold-Standard Patient Care**, **Objectives 2.1** and ensure access to care, HSAG recommends that DMAS: Work with the MCOs to consider whether there are health disparities within the plans' populations that contributed to less access to care. HSAG recommends that MCOs implement interventions to reduce barriers to care, including engaging with community providers and CHWs in planning educational materials and outreach activities. MCOs should also communicate with eligible members through multimodal approaches including outreach through phone calls and text messages to promote women's screenings. MCOs should also consider including incentives for PCPs to provide the services needed and to increase their access and outreach to eligible assigned members. MCOs should also monitor and implement interventions, if needed, for providers in communicating with members with scheduled reminders utilizing personalized outreach for overdue patients. DMAS should review MCO communication messages to ensure clear and concise information.

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 of members, HSAG recommends that DMAS:

- Work with the MCOs to meet with hospitals to improve the understanding of the importance of follow-up care and discuss tips on scheduling patients in the hospital or ED. The MCOs should be encouraged to work with hospital discharge planners to gain insight into the challenges they face in setting up follow-up visits before member discharge. HSAG recommends that DMAS work with the MCO to collaborate with outpatient providers on solutions to these challenges. Additionally, HSAG recommends that DMAS encourage MCOs to establish processes for outpatient providers to send direct messages to patients with canceled visits or who do not show for scheduled appointments. HSAG recommends that MCOs ensure telehealth services for follow-up visits are covered, available, and that providers and patients are made aware of telehealth follow-up visit options. HSAG recommends that MCOs analyze mental health integration between providers, including primary care and mental health specialists. This, coupled with improved monitoring, has been shown to improve medication adherence.

To improve receipt of preventive and screening services by members in support of **Goal 4: Strengthen the Health of Families and Communities, Objective 4.1** and improve the utilization of wellness, immunization, and prevention services for members, HSAG recommends that DMAS: Work with the MCOs to address whether providers are recording any vaccinations patients receive outside of provider care, such as at a pharmacy. HSAG recommends that MCOs survey providers regarding barriers encountered for the cases wherein BMI was not measured or counseling was not provided, such as lack of resources, time, or training to provide appropriate counseling. To improve program-wide performance in support of **Goal 2: Promote Access to Safe, Gold-Standard Patient Care, Objective 2.3** and promote effective communication and care coordination, HSAG recommends that DMAS:

- Work with the MCOs to evaluate the process of care delivery to identify if there are any operational issues contributing to access to care for members, as well as identify and resolve dissatisfaction in customer and clinical services by addressing and providing solutions to customer service complaints. HSAG also recommends that the MCOs conduct root cause analyses of study indicators that have been identified as areas of low performance. In addition, HSAG recommends that the MCOs continue to monitor the measures to ensure that significant decreases in scores over time do not continue to occur.

Quality Strategy Evaluation Methodology

Evaluation Methodology Description

Review Period

The evaluation period focuses on the 12-month performance period of January 1, 2024–December 31, 2024.

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 an 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 tracked 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 in the 2023–2025 Virginia Quality Strategy and categorized by the State’s associated goals and objectives, along with baseline rates. The most recent MY rates were compared to baseline rates, targets, and improvement objectives.

Quality Strategy Evaluation Virginia Medicaid Goals Tracking Table

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 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	<p>Cover Virginia 2021: Spanish Calls Taken by Spanish-Speaking Bilingual Staff 2021: 73,088</p> <p>Cover Virginia 2021: Calls Taken with Language Assistance Services 2021: 50,902</p> <p>Medallion 4.0 (Acute) Call Center Language Calls 2021: 7,551</p> <p>CCC Plus (MLTSS) Call Center Language Calls 2021: 545</p> <p>2021 DMAS Website Translation Requests 2021: 3,489</p>	<p>Increase by a minimum of 1 percent the Cover Virginia Spanish language calls taken by Spanish-speaking bilingual staff</p> <p>Increase by a minimum of 1 percent the Cover Virginia calls taken with language assistance by 2025</p> <p>Increase by a minimum of 1 percent the Medallion 4.0 call center language calls taken by 2025</p> <p>Increase by a minimum of 1 percent the CCC Plus call center language calls taken by 2025.</p> <p>Increase by a minimum of 1 percent the translation requests taken by 2025</p>	<p>Cover Virginia 2024: Spanish Calls Taken by Spanish-Speaking Bilingual Staff: 118,835</p> <p>Cover Virginia 2024: Calls Taken with Language Assistance Services: 225,226</p> <p>2024 DMAS Website Translation Requests 2024: 1,298,495</p>
		1.1.1.2 Monitor Language and	DMAS	<ul style="list-style-type: none"> • CCC Plus (MLTSS): NR 	Increase by a minimum of 1 percent the Language and	NR

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
		Disability Access Reports		<ul style="list-style-type: none"> Medallion 4.0 (Acute): NR 	Disability Access report monitoring: Cardinal Care Program:	
		1.1.1.3 Monitor Member Language Counts	DMAS	<ul style="list-style-type: none"> CCC Plus (MLTSS): Medallion 4.0 (Acute): NR 	Increase by a minimum of 1 percent the Member Language Counts reported: Cardinal Care Program:	Cardinal Care: 2,999,438
	Objective 1.2 Improve Member Satisfaction	1.2.1.1 Enrollees' Ratings Q8- <i>Rating of All Health Care</i>	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: <ul style="list-style-type: none"> CCC Plus (MLTSS): 68.5% Medallion 4.0 (Acute): 75.7% Adult: <ul style="list-style-type: none"> CCC Plus (MLTSS): 58.7% Medallion 4.0 (Acute): 55.8% 	Increase the Cardinal Care annual CAHPS overall <i>Rating of All Health Care</i> to perform at or above the CAHPS 50th percentile by 2025: <ul style="list-style-type: none"> Adult: Child: 	Adult: 58.84% Child: 72.67%
		1.2.1.2 <i>Rating of Personal Doctor</i>	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: <ul style="list-style-type: none"> CCC Plus (MLTSS): 79.5% Medallion 4.0 (Acute): 77.7% Adult: <ul style="list-style-type: none"> CCC Plus (MLTSS): 71.8% Medallion 4.0 (Acute): 68.0% 	Increase the Cardinal Care annual CAHPS overall <i>Rating of Personal Doctor</i> to perform at or above the CAHPS 50th percentile by 2025: <ul style="list-style-type: none"> Adult: Child: 	Adult: 70.98% Child: 76.18%
Goal 2: Promote Access to Safe, Gold-	Objective 2.1 Ensure Access to Care	2.1.1.1 <i>Getting Care Quickly</i> Q6	CAHPS—AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: <ul style="list-style-type: none"> CCC Plus (MLTSS): 89.7% 	Increase the Cardinal Care annual CAHPS overall Rating of <i>Getting Care Quickly</i> to perform at or above	Adult: 81.07% Child: 84.49%

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
Standard Patient Care				<ul style="list-style-type: none"> Medallion 4.0 (Acute): 86.0% Adult: CCC Plus (MLTSS): 85.0% Medallion 4.0 (Acute): 81.1% 	the CAHPS 50th percentile by 2025: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> CCC Plus (MLTSS): NR Medallion 4.0 (Acute): NR Adult: <ul style="list-style-type: none"> CCC Plus (MLTSS): NR Medallion 4.0 (Acute): NR 	Increase the Cardinal Care annual CAHPS overall Rating of <i>Got Non-Urgent Appointment as Soon as Needed</i> to perform at or above the CAHPS 50th percentile by 2025: <ul style="list-style-type: none"> Adult: Child: 	Adult: NR Child: NR
		2.1.1.3 Getting Needed Care	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	AHRQ CAHPS 2021 Child: <ul style="list-style-type: none"> CCC Plus (MLTSS): 87.3% Medallion 4.0 (Acute): 84.6% Adult: <ul style="list-style-type: none"> CCC Plus (MLTSS): 86.0% Medallion 4.0 (Acute): 82.9% 	Increase the Cardinal Care annual CAHPS overall Rating of <i>Getting Needed Care</i> to perform at or above the CAHPS 50th percentile by 2025: <ul style="list-style-type: none"> Adult: Child: 	Adult: 81.42% Child: 80.51%
	Objective 2.2 Promote Patient Safety	2.2.1.1 Prevalence of Pressure Ulcers Among LTSS Members	DMAS	Long-Term Nursing Facility: 3.3% Short-Term Nursing Facility: 7.1% CCC Plus (MLTSS) Waiver Members: 1.9%	Decrease the prevalence percentage of LTSS members with pressure ulcers by a minimum of 1 percent	NR

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
					over 2022 benchmark by 2025: <ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 	Increase the number and percentage of Cardinal Care program members without PDN critical incidents reported by 2025: <ul style="list-style-type: none"> CCC Plus Waiver w/o PDN: CC Plus Waiver: DD Waiver: Emerging Vulnerable: Minimal Need: Nursing Facility: Other: Total: 	NR
	Goal 2.3 Promote Effective Communication and Care Coordination	2.3.1.1 <i>How Well Doctors Communicate</i>	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: <ul style="list-style-type: none"> CCC Plus (MLTSS): 93.9% Medallion 4.0 (Acute): 93.7% Adult: <ul style="list-style-type: none"> CCC Plus (MLTSS): 94.2% Medallion 4.0 (Acute): 93.3% 	Increase the Cardinal Care annual CAHPS overall Rating of <i>How Well Doctors Communicate</i> to perform at or above the CAHPS 50th percentile by 2025: <ul style="list-style-type: none"> Adult: Child: 	Adult: 92.41% Child: 94.04%

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
		2.3.1.2 Service Authorizations	DMAS https://www.dmas.virginia.gov/data/mco-service-authorization-performance/	MCO Reporting 2021 Benchmark	Maintain or Increase by a minimum of 1% service authorizations adjudicated timely over the 2022 benchmark by 2025: Cardinal Care Program:	NR
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 2022 Benchmarks: SFY 2023 PPA Measure Rate: 0.397 <ul style="list-style-type: none"> PQI 08 Heart Failure: 27.2% PQI 01 COPD/Asthma: 17.4% PQI 05 Diabetes L-T: 10.4% PQI 11 Community-Acquired PNEU: 7.4% PQI 07 Hypertension: 5.3% PDI 14 Asthma: 4.8% PQI 16 Lower-Extremity Amputation: 4.0% PQI 12 UTI: 3.5% PQI 14 Uncontrolled Diabetes: 2.3% PQI 15 Asthma in Younger Adult: 2.0% PDI 15 Diabetes S-T Control: 2.0% PDI 16 Gastroenteritis: 1.9% PDI 18 UTI: 0.7% 	Clinical Efficiency Measures CCC Plus (MLTSS): NR Medallion 4.0 (Acute): NR	Decrease by 10% Potentially Preventable Admissions from the CE benchmarks included on the DMAS website: Cardinal Care Program:	NR
		3.1.1.2 Frequency of Emergency Department Visits	DMAS Clinical Efficiency Measure All MCOs SFY 2023 PPA Rate: 20.072 <ul style="list-style-type: none"> J069 acute upper respiratory infection: 10.6% J029 Acute pharyngitis: 3.9% 	Clinical Efficiency Measures CCC Plus (MLTSS): NR Medallion 4.0 (Acute): NR	Decrease by 1% the Potentially Preventable, Avoidable, and/or Medically Unnecessary Emergency Department Visits	NR

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
			<ul style="list-style-type: none"> • J020 Streptococcal Pharyngitis: 3.8% • R112 Nausea with vomiting: 3.7% • J101 Influenza due to other: 3.3% • N390 Urinary tract infection: 3.1% • K529 Noninfective gastroenteritis and colitis: 2.0% • R109 Unspecified abdominal pain: 1.9% • K047 Periapical abscess without sinus: 1.7% • R42 Dizziness and giddiness: 1.5% • J45901 Unspecified asthma with (acute) exacerbation: 1.5% • R1084 Generalized abdominal pain: 1.4% • R21 Rash and other non-specified skin eruption: 1.4% • J209 Acute bronchitis, unspecified: 1.3% • J189 Pneumonia, unspecified: 1.3% • R1110 Vomiting, unspecified: 1.2% • R1013 Epigastric pain: 1.2% • H6691 Otitis media, unspecified, right ear: 1.2% • N3000 Acute cystitis without hematuria: 1.1% • I10 Essential (primary) hypertension: 1.1% • H6692 Otitis media, unspecified, left ear: 1.1% • N760 Acute vaginitis: 1.0% 		<p>from the CE benchmarks included on the DMAS website:</p> <p>Cardinal Care Program:</p>	

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
			<ul style="list-style-type: none"> R197 Diarrhea, unspecified: 1.0% M542 Cervicalgia: 1.0% R1031 Right lower quadrant pain: .9% 			
		3.1.1.3 Frequency of Potentially Preventable Readmissions	<p>DMAS Clinical Efficiency Measure All MCOs SFY 2023 READ Measure Rate: 9.95%</p> <ul style="list-style-type: none"> F33 Major depressive disorder: 8.4% F25 Schizoaffective disorders: 7.4% F10 alcohol related disorders: 7.4% F31 Bipolar disorder: 6.0% A41 Other sepsis: 4.8% E10 Type 1 diabetes Meletus: 2.6% F20 Schizophrenia: 2.4% I13 Hypertensive heart and Chronic Kidney Disease:2.4% F11 Opioid related disorders: 2.3% D57 Sickle-cell disorders: 2.0% F32 Major depressive disorder: 1.9% E11 Type 2 diabetes mellitus: 1.9% F14 Cocaine related disorders: 1.8% F15 Other stimulant related disorders: 1.6% T81 Complications of procedure, not elsewhere classified: 1.4% J96 Respiratory failure, not elsewhere classified: 1.3% K85 acute pancreatitis: 1.2% I11 Hypertensive heart disease: 1.2% K70 Alcoholic liver disease: 1.2% F43 Reaction to severe stress, and adjustment disorders: 1.2% 	CCC Plus (MLTSS): NR Medallion 4.0 (Acute): NR	<p>Decrease by 8% Potentially Preventable Readmissions Within 30 Days from the CE benchmarks included on the DMAS website:</p> <p>Cardinal Care Program:</p>	NR

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
			<ul style="list-style-type: none"> F19 Other psychoactive substance related disorders: 1.2% F34 Persistent mood (affective) disorders: 1.2% N17 acute kidney failure: 1.1% 099 Other maternal diseases classified elsewhere but comp pregnancy/childbirth: 1.0% J44 Other chronic obstructive pulmonary diseases: 0.9% 			
		3.1.1.4 Ambulatory Care	NCQA HEDIS	HEDIS MY 2021 percentile benchmark <ul style="list-style-type: none"> CCC Plus (MLTSS): 77.45 Medallion 4.0 (Acute): NR 	Decrease the HEDIS Ambulatory Care: Emergency Department (ED) Visit measure rate to perform at or above the 2022 HEDIS 50th percentile by 2025: Cardinal Care Program:	Ambulatory Care—ED Visits—Total—MY 2023: 689.26
		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 <ul style="list-style-type: none"> CCC Plus (MLTSS): NR Medallion 4.0 (Acute): NR HEDIS MY 2021 <ul style="list-style-type: none"> CCC Plus (MLTSS): 86.22% Medallion 4.0 (Acute): NR Child Core Set <ul style="list-style-type: none"> CCC Plus (MLTSS): NR Medallion 4.0 (Acute): NR 	Decrease the HEDIS Ambulatory Care: Emergency Department (ED) Visit measure rate to perform at or above the 2022 HEDIS 50th percentile by 2025: Cardinal Care Program HEDIS: Cardinal Care Program Child Core Set: <ul style="list-style-type: none"> Less than 1 Year: 	Ambulatory Care—ED Visits—Total—MY 2024 TBD

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
					<ul style="list-style-type: none"> 1-9 Years: 10-19 Years: Total: <p>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:</p> <p>Cardinal Care Program HEDIS:</p> <p>Child Core Set:</p> <ul style="list-style-type: none"> 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 2021 MLTSS: <ul style="list-style-type: none"> Best: 72.73% Better: 13.64% Fair: 2.65% Below: 10.98% 	NF VBP Decrease by 1% the number of nursing facility days without minimum RN hours. Cardinal Care Program: Fair: 13.00-16.00 Better: 5.00-12.00 Best: 0-4.00	NR

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
		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 2021 MLTSS: <ul style="list-style-type: none"> Best: 25.0951% Better: 25.0951% Fair: 24.7148% Below: 25.0951% 	NF VBP Increase by 1% the number of days with total nurse staffing hours per resident day meeting minimum requirements. Cardinal Care Program: Fair: 3.16–3.45 Better: 3.46–3.83 Best: 3.84+	NR
		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 2021 MLTSS: <ul style="list-style-type: none"> Best: 60.92% Better: 17.62% Fair: 15.33% Below: 6.13% 	NF VBP Decrease by 1% Long-Stay Residents with a Urinary Tract Infection. Cardinal Care Program Fair: 2.39–4.36 Better: 1.31–2.38 Best:0–1.30	NR
		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 2021 MLTSS: <ul style="list-style-type: none"> Best: 14.92% Better: 19.76% Fair: 29.84% Below: 35.48 Use% 	NF VBP Decrease by 1% the number of unplanned inpatient admissions or outpatient observations stays that occurred among long-stay residents of a nursing home.	NR

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
					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 2021 MLTSS: <ul style="list-style-type: none"> Best: 8.7.66% Better: 17.00% Fair: 24.90% Below: 49.41% 	NF VBP Decrease by 1% 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	NR
		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 2021 MLTSS: <ul style="list-style-type: none"> Best: 52.11% Better: 27.59% Fair: 16.86% Below: 3.45% 	NF VBP Decrease by 1% Long-Stay High-Risk Residents with Pressure Ulcers Fair: 8.06–10.92 Better: 5.43–8.05 Best: 0–5.42	NR
	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-reporting/cardinal-care/mco-financials-data/	<ul style="list-style-type: none"> CCC Plus (MLTSS): Medallion 4.0 (Acute): 	Maintain compliance with MLR requirements	NR
Goal 4: Strengthen the Health of Families and Communities	Objective 4.1 Improve the Utilization of Wellness, Immunization, and Prevention	4.1.1.1 <i>Adults' Access to Preventive/Ambulatory Health Services</i>	NCQA HEDIS (AAP)	HEDIS MY 2021 <ul style="list-style-type: none"> CCC Plus (MLTSS): 87.82% Medallion 4.0 (Acute): 72.15% 	Increase the HEDIS <i>Adults' Access to Preventive/Ambulatory Health Services</i> measure rate to perform at or above	HEDIS MY 2024 TBD %

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
	Services for Members				the HEDIS 50th percentile by 2025: Cardinal Care Program:	
		4.1.1.2 <i>Child and Adolescent Well-Care Visits</i>	NCQA HEDIS (WCV) Child Core Set: WCV-CH	HEDIS MY 2021 <ul style="list-style-type: none"> CCC Plus (MLTSS): 45.17% Medallion 4.0 (Acute): 50.27% Child Core Set <ul style="list-style-type: none"> CCC Plus (MLTSS): NR Medallion 4.0 (Acute): NR 	Increase the HEDIS <i>Child and Adolescent Well-Care Visits</i> measure rate to perform at or above the HEDIS 50th percentile by 2025: Cardinal Care Program: Increase the CMS Child Core Set <i>Child and Adolescent Well-Care Visits</i> measure rate to perform at or above the CMCS 50th percentile by 2025: Cardinal Care Program: <ul style="list-style-type: none"> 3-11 Years: 12-17 Years: 18-21 Years: Total: 	HEDIS MY 2024 Total: TBD%
		4.1.1.3 <i>Childhood Immunization Status</i>	NCQA HEDIS (CIS) <ul style="list-style-type: none"> Combo 3 Child Core Set: CIS-CH	HEDIS MY 2021 <ul style="list-style-type: none"> CCC Plus (MLTSS): 54.23% Medallion 4.0 (Acute): 63.22% Child Core Set <ul style="list-style-type: none"> CCC Plus (MLTSS): NR 	Increase the HEDIS <i>Childhood Immunization Status</i> measure rate to perform at or above the HEDIS 50th percentile by 2025:	HEDIS <i>Childhood Immunization Status</i> : MY 2024 TBD% HEDIS

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
				<ul style="list-style-type: none"> Medallion 4.0 (Acute): NR 	<p>Cardinal Care Program:</p> <p>Increase the CMS Child Core Set <i>Child and Adolescent Well-Care Visits</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program:</p>	<p><i>Child and Adolescent Well-Care Visits—Total: 50.88%</i></p>
		4.1.1.4 <i>Immunizations for Adolescents</i>	<p>NCQA HEDIS (IMA)</p> <ul style="list-style-type: none"> Combo 1 Combo 2 <p>Child Core Set: IMA-CH</p>	<p>HEDIS MY 2021</p> <p>Combo 1</p> <ul style="list-style-type: none"> CCC Plus (MLTSS): 70.70% Medallion 4.0 (Acute): NR <p>Combo 2</p> <ul style="list-style-type: none"> CCC Plus (MLTSS): 30.52% Medallion 4.0 (Acute): NR <p>Child Core Set</p> <ul style="list-style-type: none"> CCC Plus (MLTSS): NR Medallion 4.0 (Acute): NR 	<p>Increase the HEDIS <i>Immunization for Adolescents</i> measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <p>Cardinal Care Program:</p> <ul style="list-style-type: none"> Combo 1: Combo 2: <p>Increase the CMS Child Core Set <i>Child and Adolescent Well-Care Visits</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program:</p> <ul style="list-style-type: none"> Combo 1: Combo 2: 	<p>HEDIS MY 2024</p> <p>Combo 1: TBD%</p> <p>Combo 2: TBD%</p> <p>Total: TBD%</p>

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
		4.1.1.5 <i>Flu Vaccinations for Adults 18-64 Years</i>	AHRA CAHPS Adult Core Set: CPA-AD	CAHPS 2021: ND Adult Core Set <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR 	Increase the CAHPS <i>Flu Vaccinations for Adults 18-64 Years</i> measure rate to perform at or above the CAHPS 50th percentile by 2025: Cardinal Care Program: Increase the CMS Adult Core Set <i>Flu Vaccinations for Adults 18-64 Years</i> measure rate to perform at or above the CMCS 50th percentile by 2025: Cardinal Care Program:	NR
		4.1.1.6 <i>Topical Fluoride for Children</i>	NCQA HEDIS (TFC) Child Core Set: TFL-CH CMS 416	HEDIS MY 2021 <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR Child Core Set <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR • CMS 416 2021: NR 	Increase the HEDIS <i>Topical Fluoride for Children</i> measure rate to perform at or above the HEDIS 50th percentile by 2025: Cardinal Care Program—Total: Increase the CMS Child Core Set <i>Topical Fluoride for Children</i> measure rate to perform at or above	NR

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
					the CMCS 50th percentile by 2025: Cardinal Care Program:	
		4.1.1.7 <i>Oral Evaluation, Dental Services</i>	NCQA HEDIS (OED) Child Core Set: OEV-CH CMS 416	HEDIS MY 2021 <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR Child Core Set <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR • CMS 416 2021: NR 	Increase the HEDIS <i>Oral Evaluation, Dental Services</i> measure rate to perform at or above the HEDIS 50th percentile by 2025: Cardinal Care Program Increase the CMS Child Core Set <i>Evaluation, Dental Services</i> measure rate to perform at or above the CMCS 50th percentile by 2025: Cardinal Care Program—Total:	NR
		4.1.1.8 <i>Sealant Receipt on Permanent First Molars</i>	Child Core Set: SFM-CH CMS 416	Child Core Set <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): • CMS 416 2021: NR 	Increase the HEDIS <i>Sealant Receipt on Permanent First Molars</i> measure rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> • Cardinal Care Program Increase the CMS Child Core Set	NR

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
					<p><i>Sealant Receipt of Permanent First Molars</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program—Total:</p>	
		4.1.1.9 <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i>	NCQA HEDIS (WCC) CMS Child Core Set (WCC-CH)	<p>HEDIS MY 2021 CCC Plus (MLTSS):</p> <ul style="list-style-type: none"> • <i>BMI Percentile—Total</i>: 68.17% • <i>Counseling for Nutrition—Total</i>: 58.87% • <i>Counseling for Physical Activity Testing—Total</i>: 51.47% • Medallion 4.0 (Acute): <i>BMI Percentile—Total</i>: NR • <i>Counseling for Nutrition—Total</i>: NR • <i>Counseling for Physical Activity Testing—Total</i>: NR <p>Child Core Set</p> <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR 	<p>Increase the HEDIS <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i> measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <p>Cardinal Care Program</p> <ul style="list-style-type: none"> • <i>BMI Percentile Documentation</i> • <i>Counseling for Nutrition</i> • <i>Counseling for Physical Activity</i> <p>Increase the CMS Child Core Set <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i> measure rate to perform at or above</p>	<p>HEDIS MY 2024 <i>BMI</i>: TBD% <i>Nutrition</i>: TBD% <i>Physical Activity</i>: TBD%</p>

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
					<p>the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program—Total:</p> <ul style="list-style-type: none"> • <i>BMI Percentile Documentation</i> • <i>Counseling for Nutrition</i> • <i>Counseling for Physical Activity</i> 	
		4.1.1.10 <i>Chlamydia Screening in Women Ages 16 to 20</i>	NCQA HEDIS (CHL) CMS Child Core Set (CHL-CH)	<p>HEDIS MY 2021</p> <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR <p>Child Core Set</p> <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR 	<p>Increase the HEDIS <i>Chlamydia Screening in Women Ages 16-20</i> measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <p>Cardinal Care Program <i>Note: HEDIS measure age is 16-24 Years.</i></p> <p>Increase the CMS Child Core Set <i>Chlamydia Screening in Women Ages 16-20 Years</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program—Total</p>	NR
		4.1.1.11 <i>Lead Screening in Children</i>	NCQA HEDIS (LSC) CMS Child Core Set (LSC-CH)	HEDIS MY 2021	Increase the HEDIS <i>Lead Screening in</i>	NR

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
				<ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR Child Core Set <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR 	<i>Children</i> measure rate to perform at or above the HEDIS 50th percentile by 2025: Cardinal Care Program Increase the CMS Child Core Set <i>Lead Screening in Children</i> 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 <i>Prenatal and Postpartum Care: Postpartum Care</i>	NCQA HEDIS (PPC) Adult Core Set: PPC-AD	HEDIS MY 2021 <i>Postpartum Care</i> <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): 66.76% Adult Core Set <i>Postpartum Care</i> <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR 	Increase the HEDIS <i>Prenatal and Postpartum Care: Timeliness of Prenatal Care</i> measure rate to perform at or above the HEDIS 50th percentile by 2025: Cardinal Care Program Increase the CMS Adult Core Set <i>Prenatal and Postpartum Care: Timeliness of Prenatal Care</i> measure rate to perform at or above	HEDIS MY 2024 <i>Timeliness:</i> TBD%

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
					the CMCS 50th percentile by 2025: Cardinal Care Program—Total:	
		4.2.1.2 <i>Prenatal and Postpartum Care: Timeliness of Prenatal Care</i>	NCQA HEDIS (PPC) Child Core Set: PPC-CH	HEDIS MY 2021 <i>Timeliness of Prenatal Care</i> <ul style="list-style-type: none"> CCC Plus (MLTSS): NR Medallion 4.0 (Acute): 76.44% Adult Core Set <i>Timeliness of Prenatal Care</i> <ul style="list-style-type: none"> CCC Plus (MLTSS): NR Medallion 4.0 (Acute): NR 	Increase the HEDIS <i>Prenatal and Postpartum Care: Postpartum Care</i> measure rate to perform at or above the HEDIS 50th percentile by 2025: Cardinal Care Program Increase the CMS Child Core Set <i>Prenatal and Postpartum Care: Postpartum Care</i> measure rate to perform at or above the CMCS 50th percentile by 2025: Cardinal Care Program—Total:	HEDIS MY 2024 <i>Postpartum: TBD%</i>
		4.2.1.3 <i>Live Births Weighing Less than 2,500 Grams</i>	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 <i>Live Births Weighing Less than 2,500 Grams</i> measure rate to perform at or above the CMCS 50th percentile by 2025:	10.7%

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
					Cardinal Care Program—Total:	
		4.2.1.4 <i>Well-Child Visits in the First 30 Months of Life</i>	NCQA HEDIS (W30) Child Core Set: W30-CH	<p>HEDIS MY 2021 CCC Plus (MLTSS):</p> <ul style="list-style-type: none"> • <i>First 15 Months:</i> 26.28% • <i>15–30 Months:</i> 65.74% • Medallion 4.0 (Acute): <i>First 15 Months:</i> 62.04% • <i>15–30 Months:</i> 68.46% <p>Child Core Set</p> <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR 	<p>Increase the HEDIS <i>Well-Child Visits in the First 30 Months of Life</i> measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <p>Cardinal Care Program</p> <ul style="list-style-type: none"> • <i>First 15 Months:</i> • <i>15–30 Months</i> <p>Increase the CMS Child Core Set <i>Well-Child Visits in the First 30 Months of Life</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program</p> <ul style="list-style-type: none"> • <i>First 15 Months:</i> • <i>15–30 Months</i> 	<p>HEDIS MY 2024</p> <p><i>First 15 Months:</i> TBD%</p> <p><i>15–30 Months:</i> TBD%</p>
		4.2.1.5 <i>Low-Risk Cesarean Delivery</i>	Child Core Set: LRCD-CH CDC Wonder State Vital Records	Child Core Set CMS 2021 Reported Rate—CDC Wonder Data: NR	Decrease the CMS Child Core Set <i>Low-Risk Cesarean Delivery</i> measure rate to perform at or above the CMCS 50th percentile by 2025:	24.8%

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
					Cardinal Care Program—Total: <i>Note: Lower rate is better.</i>	
	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:	FY25 Q1: 80.3% Q2: 95.0% Q3: 95.0%
		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%	Maintain 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:	FY25 Q1: 80.3% Q2: 95.0% Q3: 95.0%
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: <i>Heart Failure Admission Rate</i>	Adult Core Set: PQI08-AD	Adult Core Set <ul style="list-style-type: none"> • CCC Plus (MLTSS): Total: 144.46 • Medallion 4.0 (Acute): NR 	Decrease the CMS Adult Core Set <i>Heart Failure Admission</i> measure rate to perform at or above the CMCS 50th percentile by 2025: Cardinal Care Program—Total:	Adult Core Set 58.18 Cardinal Care 18–64 Years: 25.14 65+ Years: 211.16 Total (18+ Years): 34.39

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
					PWP Target: Heart Failure Admission Rate (Per 100,000 Member Months) MY 2023: 40–64 Years: 65+ Years: Total: <i>Note: Lower rate is better.</i>	
		5.1.1.2 PDI 14: <i>Asthma Admission Rate (Ages 2–17)</i>	Adult Core Set: PQI15-AD	Adult Core Set <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR 	Decrease the CMS Adult Core Set <i>Asthma Admission measure rate</i> to perform at or above the CMCS 50th percentile by 2025: Cardinal Care Program—Total: <i>Note: Lower rate is better.</i>	Adult Core Set 4.63
		5.1.1.3 PQI 05: <i>COPD and Asthma in Older Adults' Admission Rate</i>	Adult Core Set: PQI105-AD	Adult Core Set <ul style="list-style-type: none"> • CCC Plus (MLTSS): Total: NR • Medallion 4.0 (Acute): NR 	Decrease the CMS Adult Core Set <i>Asthma in Older Adults' Admission measure rate</i> to perform at or above the CMCS 50th percentile by 2025: Cardinal Care Program—Total:	TBD

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
		5.1.1.4 <i>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)</i>	NCQA HEDIS (HPC)	<p>HEDIS MY 2021</p> <ul style="list-style-type: none"> • CCC Plus (MLTSS): • HbA1c Testing: NR • HbA1c Poor Control (>9.0%): NR • HbA1c Control (<8.0%): NR • Eye Exam (Retinal) Performed: NR • Medallion 4.0 (Acute): HbA1c Testing: 84.85% • HbA1c Poor Control (>9.0%): 47.45% • HbA1c Control (<8.0%): 42.20% • Eye Exam (Retinal) Performed: 45.78% <p>Adult Core Set</p> <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR 	<p><i>Note: Lower rate is better.</i></p> <p>Increase the HEDIS <i>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)</i> measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <p>Cardinal Care Program</p> <p>Increase the CMS Adult Core Set <i>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program—Total:</p>	<p>HEDIS MY 2024</p> <p><i>Hemoglobin A1c (HbA1c) Control (<8.0%): TBD %</i></p>
		5.1.1.5 <i>Controlling High Blood Pressure</i>	NCQA HEDIS (CBP) Adult Core Set: CBP-AD	<p>HEDIS MY 2021</p> <ul style="list-style-type: none"> • CCC Plus (MLTSS): 53.24% • Medallion 4.0 (Acute): 49.68% <p>Adult Core Set</p> <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR 	<p>Increase the HEDIS <i>Controlling High Blood Pressure</i> measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <p>Cardinal Care Program</p>	<p>HEDIS MY 2024</p> <p>TBD %</p>

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
				<ul style="list-style-type: none"> Medallion 4.0 (Acute): NR 	<p>Increase the CMS Adult Core Set <i>Controlling High Blood Pressure</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program—Total:</p>	
		5.1.1.6 <i>Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years</i>	NCQA HEDIS (AAB) CMS Child Core Set: AAB-CH	<p>HEDIS MY 2021</p> <ul style="list-style-type: none"> CCC Plus (MLTSS): 43.59% Medallion 4.0 (Acute): NR <p>Child Core Set</p> <ul style="list-style-type: none"> CCC Plus (MLTSS): NR Medallion 4.0 (Acute): NR 	<p>Increase the HEDIS <i>Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years</i> measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <p>Cardinal Care Program</p> <ul style="list-style-type: none"> 3 Months to 17 Years: 18–64 Years: 65 Years and older: Total: <p><i>Note: Recommend dropping the 18–64, 65 years and older, and total.</i></p> <p>Increase the CMS Child Core Set</p>	HEDIS MY 2024 TBD%

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
					<p><i>Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program—Total:</p> <ul style="list-style-type: none"> • <i>3 Months to 17 Years:</i> 	
		<p>5.1.1.7 <i>Asthma Medication Ratio: Age 5 to 18 Years</i></p>	<p>NCQA HEDIS (AMR) CMS Child Core Set: AMR-CH</p>	<p>HEDIS MY 2021</p> <ul style="list-style-type: none"> • CCC Plus (MLTSS): 67.98% • Medallion 4.0 (Acute): 69.62% <p>Child Core Set</p> <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR 	<p>Increase the HEDIS <i>Asthma Medication Ratio: Age 5 to 18 Years</i> measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <p>Cardinal Care Program</p> <p>Increase the CMS Child Core Set <i>Asthma Medication Ratio: Age 5 to 18 Years</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program—Total:</p>	<p>HEDIS MY 2024 TBD%</p>

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
	Objective 5.2 Improve Outcomes for Nursing Home Eligible Members	5.2.1.1 <i>Use of High-Risk Medications in Older Adults (Elderly)</i>	NCQA HEDIS (DAE)	HEDIS MY 2021: CCC Plus (MLTSS): NR%	Decrease the HEDIS <i>Use of High-Risk Medications in Older Adults (Elderly)</i> measure rate to perform at or above the HEDIS 50th percentile by 2025: Cardinal Care Program—Total: <i>Note: Lower rate is better.</i>	NR
	Objective 5.3 Improve Outcomes for Members with Substance Use Disorders	5.3.1.1 Monitor Identification of Alcohol and Other Drug Services	DMAS	<ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR 	Increase the percentage of members with Identification of Alcohol and Other Drug Services by 5% by 2025.	5%
		5.3.1.2 <i>Follow-Up After Emergency Department Visit for Substance Use</i>	NCQA HEDIS (FUA) Child Core Set: FUA-CH	HEDIS MY 2021 CCC Plus (MLTSS) <ul style="list-style-type: none"> • 7-Day: 14.55% • 30-Day: 22.57% Medallion 4.0 (Acute): <ul style="list-style-type: none"> • 7-Day: 13.69% • 30-Day: 21.61% Child Core Set CCC Plus (MLTSS) <ul style="list-style-type: none"> • 7-Day: NR • 30-Day: NR Medallion 4.0 (Acute): <ul style="list-style-type: none"> • 7-Day: NR • 30-Day: NR 	Increase the HEDIS <i>Follow-Up After Emergency Department Visit for Substance Use</i> measure rate to perform at or above the HEDIS 50th percentile by 2025: Cardinal Care Program Increase the CMS Child Core Set <i>Follow-Up After Emergency</i>	HEDIS MY 2024 7-Day: TBD% 30-Day: TBD%

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
					<p><i>Department Visit for Substance Use</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program—Total:</p>	
		5.3.1.3 <i>Use of Opioids at High Dosage in Persons Without Cancer</i>	NCQA HEDIS (OHD) Adult Core Set: OHD-AD	<p>HEDIS MY 2021</p> <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR <p>Adult Core Set</p> <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR 	<p>Decrease the HEDIS <i>Use of Opioids at High Dosage in Persons Without Cancer</i> measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <p>Cardinal Care Program</p> <p>Decrease the CMS Adult Core Set <i>Use of Opioids at High Dosage in Persons Without Cancer</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program—Total:</p>	HEDIS MY 2024 TBD%
		5.3.1.4 <i>Initiation and Engagement of Substance Use Disorder Treatment</i>	NCQA HEDIS (IET) Adult Core Set: IET-AD	<p>HEDIS MY 2021</p> <p>CCC Plus (MLTSS):</p> <ul style="list-style-type: none"> • Initiation: 45.22% • Engagement: 12.94% 	<p>Increase the HEDIS <i>Initiation and Engagement of Substance Use Disorder Treatment</i></p>	HEDIS MY 2024 Initiation: TBD% Engagement: TBD%

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
				Medallion 4.0 (Acute): <ul style="list-style-type: none"> Initiation: NR Engagement: NR Adult Core Set CCC Plus (MLTSS): <ul style="list-style-type: none"> Initiation: NR Engagement: NR Medallion 4.0 (Acute): <ul style="list-style-type: none"> Initiation: NR Engagement: NR 	measure rate to perform at or above the HEDIS 50th percentile by 2025: Cardinal Care Program Increase the CMS Adult Core Set <i>Initiation and Engagement of Substance Use Disorder Treatment</i> measure rate to perform at or above the CMCS 50th percentile by 2025: Cardinal Care Program—Total:	
		5.3.1.5 <i>Use of Pharmacotherapy for Opioid Use Disorder</i>	CMS Adult Core Set: OUD-AD	Adult Core Set <ul style="list-style-type: none"> CCC Plus (MLTSS): NR Medallion 4.0 (Acute): NR 	Increase the CMS Adult Core Measure rate <i>Use of Pharmacotherapy for Opioid Use Disorder</i> measure rate to perform at or above the CMCS 50th percentile by 2025: Cardinal Care Program—Total:	NR
	Goal: 5.4 Improve Behavioral	5.4.1.1 <i>Follow-Up After Hospitalization for Mental Illness</i>	NCQA HEDIS (FUH) Adult Core Set: FUH-AD Child Core Set: FUH-CH	HEDIS MY 2021 CCC Plus (MLTSS) <ul style="list-style-type: none"> 7-Day: 31.38% 	Increase the HEDIS <i>Follow-Up After Hospitalization for Mental Illness</i>	HEDIS MY 2025

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
	Health and Developmental Services for Members			<ul style="list-style-type: none"> 30-Day: 54.17% Medallion 4.0 (Acute): <ul style="list-style-type: none"> 7-Day: 33.95% 30-Day: 54.76% Adult Core Set CCC Plus (MLTSS) <ul style="list-style-type: none"> 7-Day: NR 30-Day: NR Medallion 4.0 (Acute): <ul style="list-style-type: none"> 7-Day: NR 30-Day: NR Child Core Set CCC Plus (MLTSS) <ul style="list-style-type: none"> 7-Day: NR 30-Day: NR Medallion 4.0 (Acute): <ul style="list-style-type: none"> 7-Day: NR 30-Day: NR 	measure rate to perform at or above the HEDIS 50th percentile by 2025: Cardinal Care Program 6 Years and Older <ul style="list-style-type: none"> Within 7 Days Within 30 Days Increase the CMS Adult Core Set <i>Follow-Up After Hospitalization for Mental Illness</i> measure rate to perform at or above the CMCS 50th percentile by 2025: Cardinal Care Program—18 and Older: <ul style="list-style-type: none"> Within 7 Days Within 30 Days Increase the CMS Child Core Set <i>Follow-Up After Hospitalization for Mental Illness</i> measure rate to perform at or above	<i>Follow-Up After Hospitalization for Mental Illness</i> 7-Day: TBD% 30-Day: TBD%

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
					<p>the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program ages 6-17 Years:</p> <ul style="list-style-type: none"> • <i>Within 7 Days</i> • <i>Within 30 Days</i> 	
		5.4.1.2 <i>Follow-Up After Emergency Department Visit for Mental Illness</i>	NCQA HEDIS (FUM) Adult Core Set: FUM-AD Child Core Set: FUM-CH	<p>HEDIS MY 2021 CCC Plus (MLTSS)</p> <ul style="list-style-type: none"> • 7-Day: 45.40% • 30-Day: 61.04% <p>Medallion 4.0 (Acute):</p> <ul style="list-style-type: none"> • 7-Day: 43.04% • 30-Day: 55.53% <p>Adult Core Set CCC Plus (MLTSS)</p> <ul style="list-style-type: none"> • 7-Day:NR • 30-Day: NR <p>Medallion 4.0 (Acute):</p> <ul style="list-style-type: none"> • 7-Day: NR • 30-Day: NR <p>Child Core Set CCC Plus (MLTSS)</p> <ul style="list-style-type: none"> • 7-Day: NR • 30-Day: NR <p>Medallion 4.0 (Acute):</p> <ul style="list-style-type: none"> • 7-Day: NR • 30-Day: NR 	<p>Increase the HEDIS <i>Follow-Up After Emergency Department Visit for Mental Illness</i> measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <p>Cardinal Care Program 6 Years and Older</p> <ul style="list-style-type: none"> • <i>Within 7 Days</i> • <i>Within 30 Days</i> <p>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:</p> <p>Cardinal Care Program—18 and Older:</p> <ul style="list-style-type: none"> • <i>Within 7 Days</i> 	<p>HEDIS MY 2024 7-Day: TBD% 30-Day: TBD%</p>

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
					<ul style="list-style-type: none"> • <i>Within 30 Days</i> <p>Increase the CMS Child Core Set <i>Follow-Up After Emergency Department for Mental Illness</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program ages 6–17 Years:</p> <ul style="list-style-type: none"> • <i>Within 7 Days</i> • <i>Within 30 Days</i> 	
		5.4.1.3 <i>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication</i>	NCQA HEDIS (ADD) Child Core Set: ADD-CH	<p>HEDIS MY 2021 CCC Plus (MLTSS)</p> <ul style="list-style-type: none"> • <i>Initiation:</i> NR • <i>Continuation:</i> NR <p>Medallion 4.0 (Acute)</p> <ul style="list-style-type: none"> • <i>Initiation:</i> 37.42% • <i>Continuation:</i> 53.82% <p>Child Core Set CCC Plus (MLTSS):</p> <ul style="list-style-type: none"> • <i>Initiation:</i> NR • <i>Continuation:</i> NR <p>CCC Plus (MLTSS):</p> <ul style="list-style-type: none"> • <i>Initiation:</i> NR • <i>Continuation:</i> NR 	<p>Increase the HEDIS <i>Follow-Up for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication</i> measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <p>Cardinal Care Program—Ages 6-12 Years</p> <ul style="list-style-type: none"> • <i>Initiation Phase:</i> • <i>Continuation and Maintenance Phase:</i> <p>Increase the CMS Child Core Set <i>Follow-Up for Children Prescribed Attention-</i></p>	<p>HEDIS MY 2024</p> <ul style="list-style-type: none"> • <i>Initiation:</i> TBD • <i>Continuation:</i> TBD

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
					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 <ul style="list-style-type: none"> Initiation Phase: Continuation and Maintenance Phase: 	
		5.4.1.4 Monitor Mental Health Utilization	DMAS	DMAS <ul style="list-style-type: none"> CCC Plus (MLTSS): NR Medallion 4.0 (Acute): NR 	Increase the percentage of members receiving mental health services by 1% by 2025.	NR
		5.4.1.5 <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i>	NCQA HEDIS (APP) Child Core Set: APP-CH	HEDIS MY 2021 <ul style="list-style-type: none"> CCC Plus (MLTSS): 42.72% Medallion 4.0 (Acute): 67.49% Child Core Set <ul style="list-style-type: none"> CCC Plus (MLTSS): NR Medallion 4.0 (Acute): NR 	Increase the HEDIS <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i> 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 <i>Use of</i>	HEDIS MY 2024 TBD%

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
					<p><i>First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program—Ages 1–17 Years</p>	
		5.4.1.6 <i>Metabolic Monitoring for Children and Adolescents on Antipsychotics</i>	NCQA HEDIS (APM) CMS Child Core Set: APM-CH	<p>HEDIS MY 2021 CCC Plus (MLTSS):</p> <ul style="list-style-type: none"> • <i>Blood Glucose Testing—Total:</i> 47.17 • <i>Cholesterol Testing—Total:</i> 33.11% • <i>Blood Glucose and Cholesterol Testing—Total:</i> 31.74% <p>Medallion 4.0 (Acute): NR</p> <p>Child Core Set</p> <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR 	<p>Increase the HEDIS <i>Metabolic Monitoring for Children and Adolescents on Antipsychotics</i> measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <p>Cardinal Care Program—Ages 1–17 Years</p> <p>Increase the CMS Child Core Set <i>Metabolic Monitoring for Children and Adolescents on Antipsychotics</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p>	<p>HEDIS MY 2024 <i>Glucose: TBD%</i> <i>Cholesterol: TBD%</i> <i>Blood Glucose and Cholesterol Testing Total: TBD%</i></p>

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
					Cardinal Care Program—Ages 1–17 Years	
		5.4.1.7 <i>Medical Assistance with Smoking and Tobacco Use Cessation</i>	CMS Adult Core Set: MSC-AD	<p>Adult Core Set</p> <ul style="list-style-type: none"> • CCC Plus (MLTSS): • Advising Smokers and Tobacco Users to Quit: 79.34% • Discussing Cessation Medications: 57.08% • Discussing Cessation Strategies: 48.74% • Medallion 4.0 (Acute): Advising Smokers and Tobacco Users to Quit: 70.84% • Discussing Cessation Medications: 46.89% • Discussing Cessation Strategies: 40.09% • 	<p>Increase the HEDIS <i>Medical Assistance with Smoking and Tobacco Use Cessation</i> measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <p>Cardinal Care Program</p> <ul style="list-style-type: none"> • 3 Months–17 Years • 18–64 Years • 65 and Older • Total <p>Increase the CMS Adult Core Set <i>Medical Assistance with Smoking and Tobacco Use Cessation</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program</p> <ul style="list-style-type: none"> • 18–64 Years • 65 and Older 	<p>CAHPS <i>Advising Smokers to Quit</i>: TBD%</p> <p><i>Discussing Cessation Medications</i>: TBD%</p> <p><i>Discussing Cessation Strategies</i>: TBD%</p>

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
		5.4.1.8 <i>Antidepressant Medication Management</i>	NCQA HEDIS (AMM) CMS Adult Core Set: AMM-AD	<p>HEDIS MY 2021: CCC Plus (MLTSS):</p> <ul style="list-style-type: none"> • <i>Effective Acute Phase Treatment</i>: 65.79% • <i>Effective Continuation Phase</i>: 51.01% <p>Medallion 4.0 (Acute):</p> <ul style="list-style-type: none"> • <i>Effective Acute Phase Treatment</i>: 61.64% • <i>Effective Continuation Phase</i>: 44.30% <p>Adult Core Set</p> <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR 	<p>Increase the HEDIS <i>Antidepressant Medication Management</i> measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <p>Cardinal Care Program</p> <ul style="list-style-type: none"> • 18 and Older • <i>Effective Acute Phase Treatment</i> • <i>Effective Continuation Phase Treatment</i> <p>Increase the CMS Adult Core Set <i>Antidepressant Medication Management</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program</p> <ul style="list-style-type: none"> • 18–64 Years • 65 and Older • <i>Total</i> • <i>Effective Acute Phase Treatment</i> • <i>Effective Continuation Phase Treatment</i> 	<p>HEDIS MY 2024 <i>Acute Phase</i>: 55.20% <i>Continuation Phase</i>: 40.65%</p>
		5.4.1.9 <i>Screening for Depression and</i>	CMS Adult Core Set: CDF-AD	Adult Core Set	Increase the CMS Adult Core Set	NR

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
		<i>Follow-Up Plan: Ages 18 and Older</i>		<ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR 	<p><i>Screening for Depression and Follow-Up Plan: Ages 18 and Older</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program</p>	
		5.4.1.10 <i>Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i>	NCQA HEDIS (SSD) CMS Adult Core Set: SSD-AD	<p>HEDIS MY 2021:</p> <ul style="list-style-type: none"> • CCC Plus (MLTSS): 81.03% • Medallion 4.0 (Acute): NR <p>Adult Core Set</p> <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR 	<p>Increase the HEDIS <i>Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i> measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <p>Cardinal Care Program</p> <ul style="list-style-type: none"> • 18–64 Years <p>Increase the CMS Adult Core Set <i>Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p>	HEDIS MY 2024 TBD%

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
					Cardinal Care Program • 18–64 Years	
		5.4.1.11 <i>Diabetes Care for People with Serious Mental Illness: Glycemic Status</i>	NCQA HEDIS (HPCMI) CMS Adult Core Set: HPCMI-AD	HEDIS MY 2021 • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR Adult Core Set • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR	Increase the HEDIS <i>Diabetes Care for People with Serious Mental Illness: Glycemic Status</i> 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 <i>Diabetes Care for People with Serious Mental Illness: Glycemic Status</i> measure rate to perform at or above the CMCS 50th percentile by 2025: Cardinal Care Program • 18–64 Years • 65–75 Years	NR
		5.4.1.12 <i>Adherence to Antipsychotic Medications for</i>	NCQA HEDIS (SAA) CMS Adult Core Set: SAA-AD	HEDIS MY 2021:	Increase the HEDIS <i>Adherence to Antipsychotic</i>	HEDIS MY 2024

Goal	Objective	Measure Name	Metric specifications	MY 2021 Baseline Performance	Performance Measure Target	MY 2024 Aggregate Rate
		<i>Individuals with Schizophrenia</i>		<ul style="list-style-type: none"> • CCC Plus (MLTSS): 67.12% • Medallion 4.0 (Acute): NR Adult Core Set <ul style="list-style-type: none"> • CCC Plus (MLTSS): NR • Medallion 4.0 (Acute): NR 	<p><i>Medications for Individuals with Schizophrenia</i> measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <p>Cardinal Care Program</p> <ul style="list-style-type: none"> • 18 to 39 Years <p>Increase the CMS Adult Core Set <i>Adherence to Antipsychotic Medications for Individuals with Schizophrenia</i> measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <p>Cardinal Care Program</p> <ul style="list-style-type: none"> • 18–39 Years 	TBD%