2023–2025 Quality Strategy

Commonwealth of Virginia
Department of Medical Assistance Services

The Virginia Quality Strategy was submitted to the Centers for Medicare & Medicaid Services in February 2023.

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Glossary of Acronyms

42 CFR ..... Title 42 of the Code of Federal Regulations
AAP ..... American Academy of Pediatrics
ABD ..... Aged, Blind, and Disabled
ACOG ..... American Congress of Obstetricians and Gynecologists
ADHD ..... Attention-Deficit/Hyperactivity Disorder
Adult Core Set ..... CMS Core Set of Adult Health Care Quality Measures for Medicaid
AHRQ ..... Agency for Healthcare Research and Quality
ARTS ..... Addiction and Recovery Treatment Services
ASAM ..... American Society of Addiction Medicine
AUD ..... Alcohol Use Disorder
BMI ..... Body Mass Index
BRAVO ..... Behavioral Health Redesign for Access, Value, and Outcomes
CAHPS®,[1] ..... Consumer Assessment of Healthcare Providers and Systems
CAP ..... Corrective Action Plan
CC ..... Community Coaching
CCC Plus ..... Commonwealth Coordinated Care Plus
CDC ..... Centers for Disease Control and Prevention
CE ..... Community Engagement
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 ..... Compliance Monitoring Process
CMS ..... Centers for Medicare & Medicaid Services
COPD ..... Chronic Obstructive Pulmonary Disease
COVID-19 ..... Coronavirus Disease 2019
CPT ..... Current Procedural Terminology
CQI ..... Continuous Quality Improvement
CY ..... Calendar Year
DBHDS ..... Department of Behavioral Health and Developmental Services
DD ..... Developmental Disability
DMAS ..... Department of Medical Assistance Services
DUR ..... Drug Utilization Review
ED ..... Emergency Department
EDCC ..... Emergency Department Care Coordination
EDCD ..... Elderly or Disabled With Consumer Direction
EDWS ..... Enterprise Data Warehouse System
EPAP ..... External Provider Audit & Policy Unit
EPS ..... Encounter Processing System

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

EPSDT ..... Early and Periodic Screening, Diagnostic and Treatment
EQR ..... External Quality Review
EQRO ..... External Quality Review Organization
FAMIS ..... Family Access to Medical Insurance Security
FC/AA ..... Foster Care and Adoption Assistance
FFCRA ..... Families First Coronavirus Relief Act
FFS ..... Fee-for-Service
FFY ..... Federal Fiscal Year
FMAP ..... Federal Medical Assistance Percentage
FMEA ..... Failure Mode and Effects Analysis
FPL ..... Federal Poverty Level
HbA1c ..... Hemoglobin A1c
HCBS ..... Home- and Community-Based Services
HCCI ..... Health Care Cost Institute
HEDIS®,[2] ..... Healthcare Effectiveness Data and Information Set
HHS ..... United States Department of Health and Human Services
HIPAA ..... Health Insurance Portability and Accountability Act of 1996
HIT ..... Health Information Technology
HMO ..... Health Maintenance Organization
HRSN ..... Health-Related Social Need
HSAG ..... Health Services Advisory Group, Inc.
ICF ..... Intermediate Care Facility
IDEA ..... Individuals with Disabilities Education Improvement Act of 2004
IEP ..... Individualized Education Plan
IT ..... Information Technology
JLARC ..... Joint Legislative Audit and Review Commission
LEP ..... Limited English Proficiency
LPN ..... Licensed Practical Nurse
LTSS ..... Long-Term Services and Supports
MAC ..... Member Advisory Committee
MCO ..... Managed Care Organization
MDS ..... Minimum Data Set
MEI ..... Member Efficiencies and Innovation
MES ..... Medicaid Enterprise System
MIP ..... MCO Improvement Plan
MLR ..... Medical Loss Ratio
MLTSS ..... Managed Long-Term Services and Supports
MM ..... Member Months
MMIS ..... Medicaid Management Information System
MODRN ..... Medicaid Outcomes Distributed Research Network

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

MOUD ..... Medications for Opioid Use Disorder
MY ..... Measurement Year
NAS ..... Neonatal Abstinence Syndrome
NCHS ..... National Center for Health Statistics
NCQA ..... National Committee for Quality Assurance
NF ..... Nursing Facility
NICU ..... Neonatal Intensive Care Unit
NQS ..... National Quality Strategy
NR ..... Not Reported
O/E ..... Observed/Expected
OB/GYN ..... Obstetrics and Gynecology
OBOT ..... Office-Based Opioid Treatment
OCMO ..... Office of the Chief Medical Officer
OHE ..... Office of Health Equity
OTP ..... Opioid Treatment Program
OUD ..... Opioid Use Disorder
PACE ..... Program of All-Inclusive Care for the Elderly
PAHP ..... Prepaid Ambulatory Health Plan
PAS ..... PreAdmission Screening
PCCM ..... Primary Care Case Management
PCP ..... Primary Care Provider
PDI ..... Pediatric Quality Indicator
PDSA ..... Plan-Do-Study-Act
PH ..... Population Health
PHE ..... Public Health Emergency
PHM ..... Population Health Management
PI ..... Program Integrity
PID ..... Program Integrity Division
PIHP ..... Prepaid Inpatient Health Plan
PIP ..... Performance Improvement Project
PM ..... Performance Measure
PMPM ..... Per Member Per Month
PMV ..... Performance Measure Validation
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
QS ..... Quality Strategy
RACI ..... Responsible, Accountable, Consulted, Informed
RN ..... Registered Nurse

RPM ..... Remote Patient Monitoring
SARS-CoV-2 ..... Severe Acute Respiratory Syndrome Coronavirus 2
SBE ..... State-Based Exchange
SBIRT ..... Screening, Brief Intervention, and Referral to Treatment
SDOH ..... Social Determinant of Health
SFC ..... Smiles For Children
SFY ..... State Fiscal Year
SHCN ..... Special Health Care Needs
SMART ..... Specific, Measurable, Attainable, Relevant, and Time-bound
SUD ..... Substance Use Disorder
TPL ..... Third-Party Liability
UAI ..... Uniform Assessment Instrument
U.S. ..... United States
UTI ..... Urinary Tract Infection
VA ..... Virginia
VAC ..... Virginia Administrative Code
VBP ..... Value-Based Purchasing
VCU ..... Virginia Commonwealth University
VDH ..... Virginia Department of Health

Introduction and Overview

Executive Summary

The Commonwealth of Virginia Department of Medical Assistance Services (DMAS) is the single State agency that administers all Medicaid and Family Access to Medical Insurance Security (FAMIS) health insurance benefit programs and is the gold-standard of health and human services. As of June 2022, more than 90 percent of Medicaid enrollees received their benefits through the managed care model and less than 10 percent of enrollees participated in Medicaid through the fee-for-service (FFS) model.

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 more than 800,000 members. Other eligible populations include people with disabilities, older and low-income adults, and pregnant individuals.[3] In Virginia, Medicaid also covered approximately 37,000 births in 2020 with enrollees being predominately White and African American.

Virginia's Medicaid managed care organization (MCO) budgets expend approximately 84.0 percent of their funds on medical services and 8.25 percent on administrative expenses.[4] Virginia has a strong record of investing in innovative programs, managing cost growth, boasting high rates of beneficiary participation in primary care medical homes, and enjoying strong provider participation with over 139,000 enrolled providers. Virginia continues to build upon its investment successes to achieve even more—innovation to improve the health of Virginians and to support individuals becoming and remaining self-sufficient.

In June 2021, the Virginia General Assembly mandated that DMAS rebrand the Department's FFS and managed care programs and effectively combine the Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0 programs under a single name, the Cardinal Care program. The combined program achieves a single streamlined system of care that links seamlessly with the FFS program. Cardinal Care will continue to offer members the same programs and services and will not reduce or change any existing coverage. The overarching program ensures a smoother transition for individuals whose healthcare needs evolve over time. The Cardinal Care program ensures an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality care to its members, and adds value for its providers and the Commonwealth.

New Strategic Vision for DMAS

Under the leadership of Governor Glenn Youngkin and Health and Human Resources Secretary John Littel, Virginia has embarked on a reinvigorated new strategic vision to serve and improve

[3] Virginia Department of Medical Assistance Services. Medicaid at a Glance 2022. Available at: https://www.dmas.virginia.gov/about-us/medicaid-at-a-glance/. Accessed on: Aug 3, 2022.
[4] Virginia Department of Medical Assistance Services. Overview of the Governor's Introduced Budget. Presentation to: Senate Finance Committee, Subcommittee on Health and Human Resources. January 8, 2018. Available at: https://www.dmas.virginia.gov/data/mco-financials/. Accessed on: Aug 3, 2022.

the lives of Virginians. DMAS, as the agency which oversees the Medicaid program in the Commonwealth, is focused on three core goals to assist with:

- Behavioral health enhancement
- Increasing access to healthcare
- Enhanced managed care delivery system

These strategic initiatives are woven into the foundation of the new 2023–2025 DMAS Quality Strategy to promote alignment and further support these vital efforts. Each agency is working with the administration to develop metrics and performance targets to achieve by 2025.

Behavioral Health Enhancement

Medicaid is the largest payer of behavioral health services in the Commonwealth. Medicaid provides inpatient and outpatient services that support quality of life in the community for those in need of behavioral health support. In the new strategy, increased focus is placed on behavioral health services and outcomes for Medicaid members. This includes efforts to reduce the burden on state psychiatric hospitals and emergency departments (EDs), with efforts including increasing use of mobile crisis response and reduction of ED utilization. DMAS is also committed to the continued expansion of access to BRAVO (Behavioral Health Redesign for Access, Value, and Outcomes) services by implementing new services and engaging the communities to support these services. Supporting Virginia's foster care youth is a main focus of the agency, and DMAS has committed to ensuring appropriate access to acute behavioral health services by working to carve in residential services into the managed care programs. Additional information about the behavioral health enhancement and BRAVO services can be found in the Quality Strategy Interventions section, starting on page 38.

Increasing Access to Healthcare

As highlighted by events such as the coronavirus disease 2019 (COVID-19) pandemic, ensuring Virginians have access to high quality healthcare coverage is a core mission of DMAS. To support the needs for increasing access, DMAS is committed to modernization processes for eligibility and enrollment. This includes the automation of eligibility enrollment and determination, improving enrollment in the State-Based Exchange (SBE) Marketplace, and modernization of self-service applications to make online changes and renewals more accessible to individuals looking to access or continue services. DMAS is also preparing for the redetermination of the over two million lives in Virginia Medicaid as part of the unwinding of COVID-19 rules that allowed members to retain necessary healthcare coverage during the public health emergency (PHE) and that will now be walked back as the emergency ends. Additional access-related initiatives for the Commonwealth include:

- Improving maternal outcomes by increasing the number of women receiving postpartum care.
- Automation of the collection of eligibility information.
- Reducing opioid-related deaths.

Enhanced Managed Care Delivery System

On October 4th, 2022, Virginia Secretary of Health and Human Resources John Littel announced that the Commonwealth's Medicaid agency plans to launch a transformational new

procurement next year to drive innovation and strengthen quality and accountability in its managed care program. The target implementation timeline for this $14 billion procurement is 2024. State leaders will evaluate commercial health plans that participate in the competitive procurement based on their use of data-driven strategies to address challenges in the rapidly evolving healthcare environment, including value-based care models that tie funding to measurable improvements in health outcomes. The Virginia Medicaid agency will hire nationally recognized consultants with expertise in the managed care field to assist in drafting the request for proposals. The agency also plans to seek approval from the General Assembly, as well as input from Medicaid members, healthcare providers, other State agency representatives and community stakeholders on the design and goals of the new managed care program. This re-procurement of the managed care programs will occur under the new, united Cardinal Care Program. Other key initiatives covered under this goal include:

- Expansion of the use of value-based purchasing (VBP) programs.
- Reduction in payment error rate.

To these ends and more, this Quality Strategy aims to guide Virginia's Medicaid program by establishing clear goals and objectives to drive improvement in care delivery and outcomes and establishes the metrics by which progress will be measured. The Quality Strategy sets a clear direction for priority interventions and details the standards and mechanisms for holding managed care entities accountable for desired outcomes. The Quality Strategy serves as the roadmap for developing a dynamic approach to assessing, monitoring outcomes, and improving the quality of healthcare and services furnished by the managed care and FFS entities and providers.

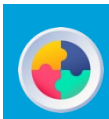
DMAS developed this Quality Strategy in accordance with Title 42 of the Code of Federal Regulations (42 CFR), at 42 CFR §438.340 et. seq. DMAS developed the Quality Strategy to continually monitor, assess, and improve the timeliness and delivery of quality healthcare to all Medicaid and Children's Health Insurance Program (CHIP) members served by the Virginia Medicaid managed care and FFS programs. DMAS' Quality Strategy provides the framework to accomplish DMAS' overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP system.

The Quality Strategy's purpose, goals, scope, assessment of performance, interventions, and annual high-level evaluation are detailed in this Quality Strategy. Documents referenced in the Quality Strategy include:

The Annual External Quality Review (EQR) Technical Report

Medallion 4.0:
https://www.dmas.virginia.gov/about-us/office-of-quality-and-population-health/quality-activities/

CCC Plus:
https://www.dmas.virginia.gov/about-us/office-of-quality-and-population-health/quality-activities/



The Medicaid State Plan

https://www.dmas.virginia.gov/about-us/state-plan/

Medicaid Managed Care Organization Contracts and Amendments

Medallion 4.0:
http://www.dmas.virginia.gov/#/med4information

CCC Plus:
http://www.dmas.virginia.gov/#/cccplusinformation

DMAS remains committed to a culture of quality. Across departments, attention to outcomes, process improvement, and sustainability are important to achieving the goals of the DMAS Quality Strategy. DMAS maintains ultimate authority and responsibility for the maintenance and annual evaluation of the Quality Strategy. DMAS updates the Quality Strategy as needed based on MCO performance; stakeholder input and feedback; achievement of goals; changes resulting from the General Assembly, Commonwealth, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Virginia Medicaid program.

To demonstrate compliance with the Centers for Medicare & Medicaid Services (CMS) Quality Strategy Toolkit for States, DMAS created a crosswalk (Appendix A) that lists each of the required and recommended elements of state quality strategies, and the corresponding section of the DMAS Quality Strategy and/or DMAS/MCO contract that addresses the required or recommended elements.

Purpose, Scope, and Goals of the Quality Strategy

Purpose of the Quality Strategy

Consistent with its mission, the purpose of DMAS' Quality Strategy is to:

- Establish a comprehensive quality improvement (QI) system that is consistent with the National Quality Strategy (NQS) and CMS Triple Aim, to enhance member care experiences, promote effective patient care, achieve smarter spending, and improve population health.
- Provide a proactive framework for DMAS to implement a coordinated and comprehensive approach to drive quality throughout the Virginia Medicaid and CHIP systems.
- Improve member satisfaction with care and services.
- Identify opportunities for improvement in the health outcomes of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.
- Identify opportunities to improve quality of care and quality of service and implement improvement strategies to ensure Virginia Medicaid and CHIP members have access to high quality and culturally appropriate care.
- Identify innovative and efficient models of care delivery that are best practices and make healthcare more affordable for individuals, families, and the State government.

Scope of the Quality Strategy

The following are included in the scope of the Quality Strategy:

- All Medicaid and CHIP managed care members in all demographic groups and in all service areas for which the MCOs are approved to provide Medicaid and CHIP managed care services.
- All aspects of care—including accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services covered by DMAS' Medicaid and CHIP managed care programs.
- All aspects of the MCOs' performance related to access to care, quality of care, and quality of service, including networking, contracting, and credentialing; and medical record-keeping practices.
- All services covered—including preventive care services, primary care, specialty care, ancillary care, emergency services, chronic disease, special needs care, dental services, mental health services, diagnostic services, pharmaceutical services, skilled nursing care, home healthcare, prescription drugs, and long-term services and supports (LTSS).
- All professional and institutional care in all settings, including inpatient, outpatient, and home settings.
- All providers and any other delegated or subcontracted provider type.

- All aspects of the MCOs' internal administrative processes related to service and quality of care—including customer services, enrollment services, provider relations, confidential handling of medical records and information, case management services, utilization review activities, preventive health services, health education, information services, and QI.

Strategic Overview

Quality Strategy Goals and Objectives

The Quality Strategy is intended to guide Virginia's Medicaid managed care program by establishing clear goals to drive improvements in care delivery and outcomes, and the metrics by which progress will be measured. The Quality Strategy sets a clear direction for priority interventions and details the standards and mechanisms for holding MCOs accountable for desired outcomes. The Quality Strategy is a roadmap through which DMAS will use the managed care infrastructure to facilitate improvements in health and healthcare through programmatic innovations, whole-person care, inclusive healthcare, provider supports, and steps to address health-related unmet resource needs. This vision is distilled into five central goals:

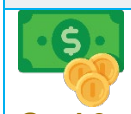
1. Enhance the member care experience
2. Promote access to safe, gold-standard patient care
3. Support efficient and value-driven care
4. Strengthen the health of families and communities
5. Provide whole-person care for vulnerable populations

Included within each of these five goals is a series of goals, intended to highlight key areas of expected progress and quality focus. These goals are inclusive of Governor Glenn Youngkin's identified priorities for the Medicaid program that focus on behavioral health enhancement, maternal health outcomes, and access to high quality healthcare services. Governor Glenn Youngkin's priorities are highlighted with gold font and a gold star (★).

Together, as is shown in Table 1, these create a framework through which Virginia defines and drives the overall vision for advancing the quality of care provided to Medicaid members in the Commonwealth. These goals and objectives were designed to align closely with CMS' Quality Strategy, adapted to address Virginia's local priorities, challenges, and opportunities for Virginia's Medicaid program. DMAS capitalizes on strategic community partnerships and leverage of MCOs to achieve the goals of the Quality Strategy. DMAS' quality measures and metrics can be found in Appendix B.

Table 1—Quality Strategy Goals and Objectives

Goals	Objectives
	**Objective 1.1:** Increase Member Engagement and Outreach

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

Note: Each goal has targeted metrics to measure progress, as well as outlined interventions to advance the goals. See Appendix B.
★ In alignment with Governor Glenn Youngkin's identified priorities for the Medicaid program.

Each of the 14 objectives is tied to focused interventions used to drive improvements within, and, in many cases, across the goals and objectives set forth in this Quality Strategy. To assess the impact of these interventions and continue to identify opportunities for improving the quality of care delivered under Medicaid managed care, and in compliance with the requirements set forth in 42 CFR 438.340(b)(3), these interventions are tied to a set of metrics by which progress is assessed. This approach provides for data-driven decision making to drive interventions, inform priority setting, and facilitate efficient and effective deployment of resources.

Development of the Quality Strategy Goals and Objectives

These goals reflect significant community and stakeholder input as well as thoughtful consideration of the quality issues that are most important in Virginia. DMAS additionally considered the quality areas of greatest importance to Virginia's Medicaid population, and where current data indicated an opportunity for targeted improvement. The goals are similarly aligned to ensuring beneficiary access to services.

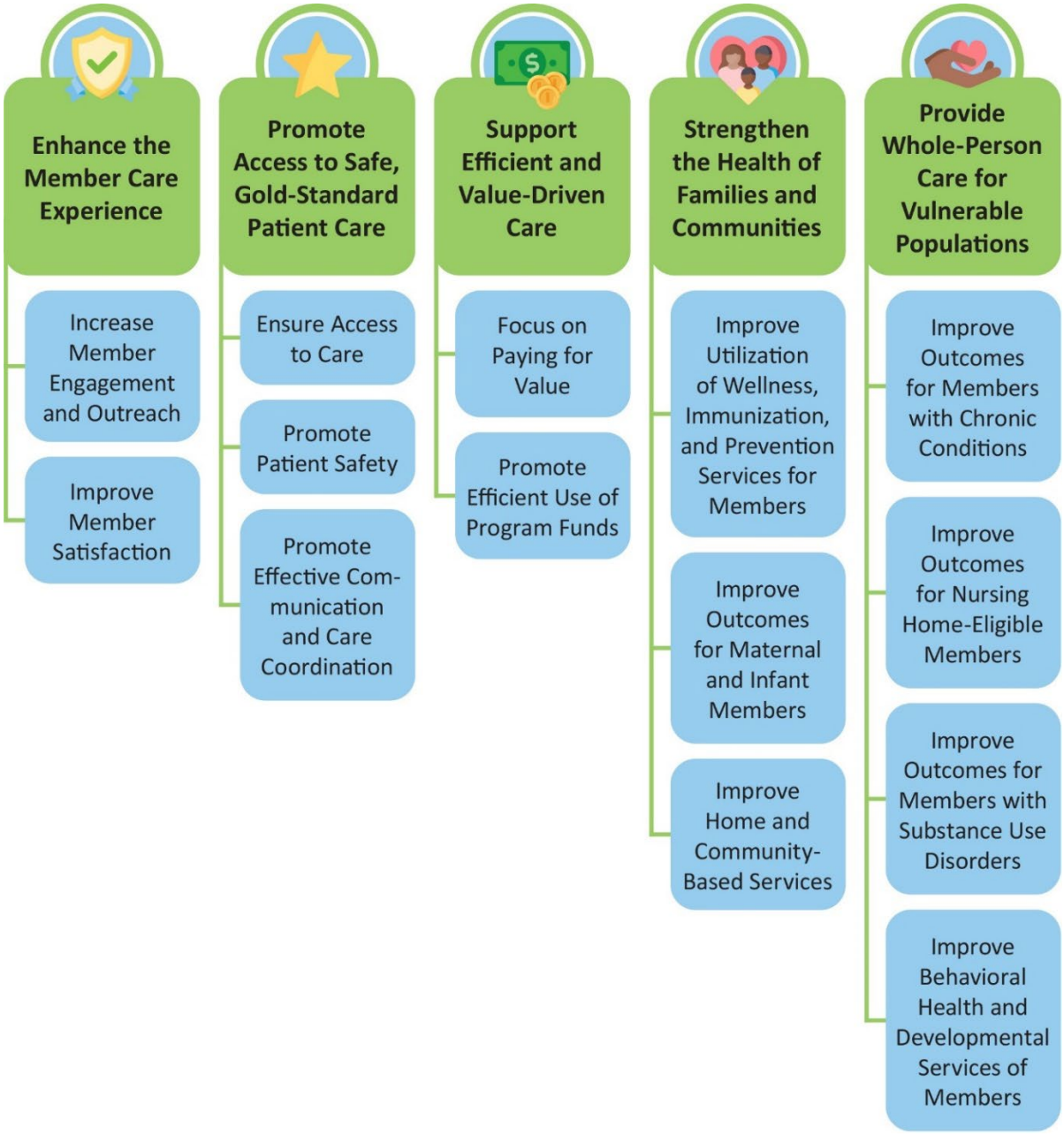
The DMAS Quality Strategy aligns with the new NQS, which was launched on April 12, 2022.[5] The NQS includes three aims: Better Care, Healthy People/Healthy Communities, and Affordable Care. To advance these aims, the NQS focuses on six priorities: safer care, patient engagement, communication, care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

As updated data related to the Medicaid program performance becomes available, DMAS intends to further refine these objectives to target specific improvement goals, including additional metrics that address disparities in health. MCOs are required to maintain systems that collect, analyze, integrate, and report encounter data that are timely, accurate, and complete. These data are used for several purposes and will be key to assessing the quality, access, and timeliness of Virginia's Medicaid managed care program. The external quality review organization (EQRO) will play a critical role in ensuring the validity of MCOs' reported encounter data, as well as in the validation and calculation of quality measures. DMAS is committed to using these reports to assess opportunities for continued improvement, and how priorities may evolve over time.

Together, this framework represents a comprehensive plan for delivering high quality, accessible, timely care to Medicaid managed care beneficiaries (Figure 1).

[5] Agency for Healthcare Research and Quality. About the National Quality Strategy, reviewed March 2017. Available at: https://www.ahrq.gov/workingforquality/about/index.html. Accessed on: Aug 3, 2022.

Figure 1—Virginia's 2023–2025 Quality Strategy Framework



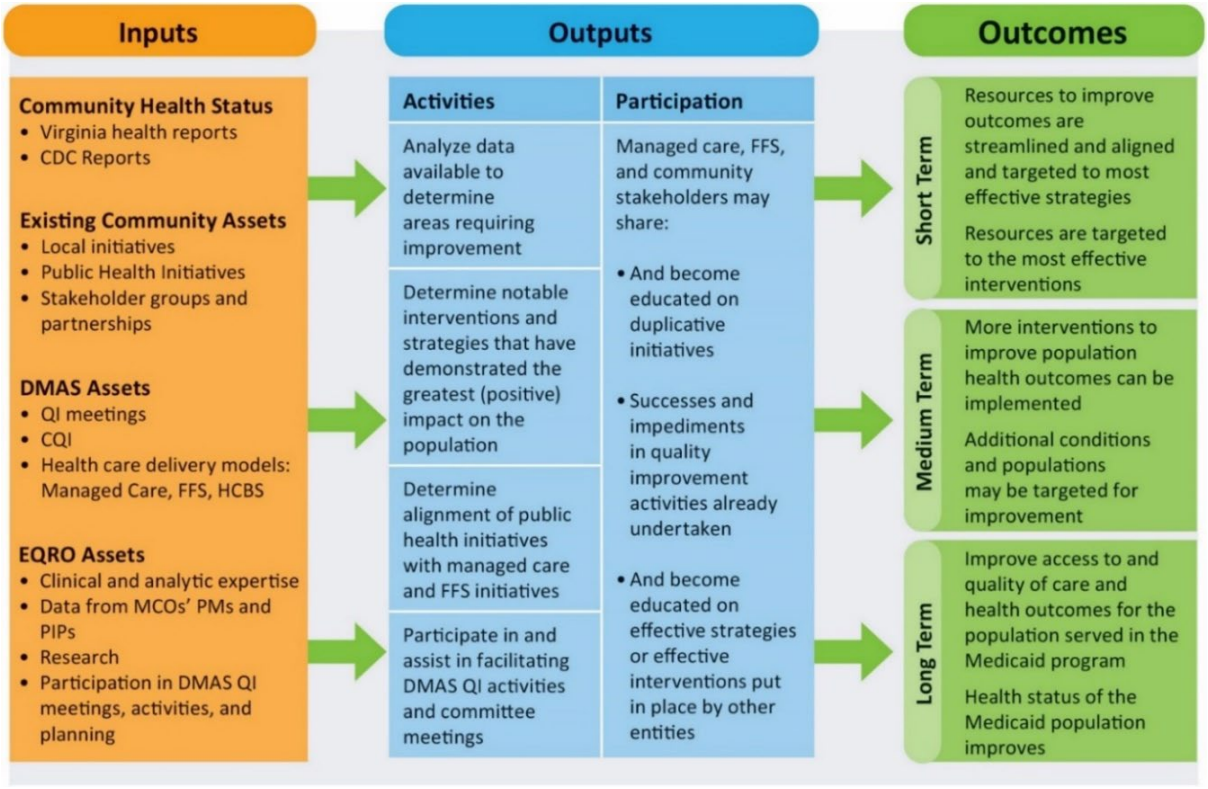
Strategy for Meeting Goals

The methods employed by DMAS to achieve these goals include:

- Developing and maintaining collaborative strategies among Commonwealth agencies, community resources, and external partners to improve health education and health outcomes, protect public health, safeguard vulnerable and at-risk citizens, and improve quality of care and access to services for all Virginia Medicaid members.
- Using additional performance measures, performance improvement projects (PIPs), contract compliance monitoring, and emerging practice activities to drive improvement in member healthcare outcomes.
- Strengthening evidence-based prevention, wellness, and health management initiatives to improve members' health status and achievement of personal health goals.
- Enhancing member services and member satisfaction with services.
- Identifying opportunities for improvement from grievances and other feedback to create efficiencies in how programs and services are structured and delivered.
- Improving health information technology (HIT) to ensure that information retrieval and reporting are timely, accurate, and complete.

The logic model contained in Figure 2 depicts the DMAS strategy for improving health outcomes.

Figure 2—Quality Strategy Logic Model



Abbreviations used in the logic model: CDC—Centers for Disease Control and Prevention; CQI—continuous quality improvement; HCBS—home- and community-based services; PM—performance measure

Background and Structure of Virginia's Medicaid Program

History of Medicaid in Virginia

Managed healthcare delivery system design is essential to improving outcomes for members while assuring that the care provided is of high quality and cost-effective and easy for members and families to access. Integrated MCOs that are able to address the whole health needs of Virginia's Medicaid population are essential to reducing system fragmentation and improving service delivery to members. DMAS continues to weave the service delivery system components together to create a more effective and efficient healthcare system. DMAS' efforts to integrate care delivery systems and properly align incentives are designed to transition the structure of the Medicaid program to improve health outcomes and better manage limited resources and result in a positive impact to the quality of healthcare delivered to Virginia's Medicaid and CHIP members.

Integration at the administrative and managed care levels is key in promoting and supporting efforts of providers to deliver integrated services through primary care, integrated clinics, health homes, and other models and the utilization of innovative reimbursement models are critical to a delivery system that can address the whole health needs of Medicaid members. DMAS looks to numerous initiatives to support providers in this effort, which will ultimately address the cost of care and service delivery, access to care and services, and the quality of care delivered.

DMAS Mission and Values

DMAS is committed to upholding its core mission and values. The mission of DMAS is:

To improve the health and well-being of Virginians through access to high-quality healthcare coverage.

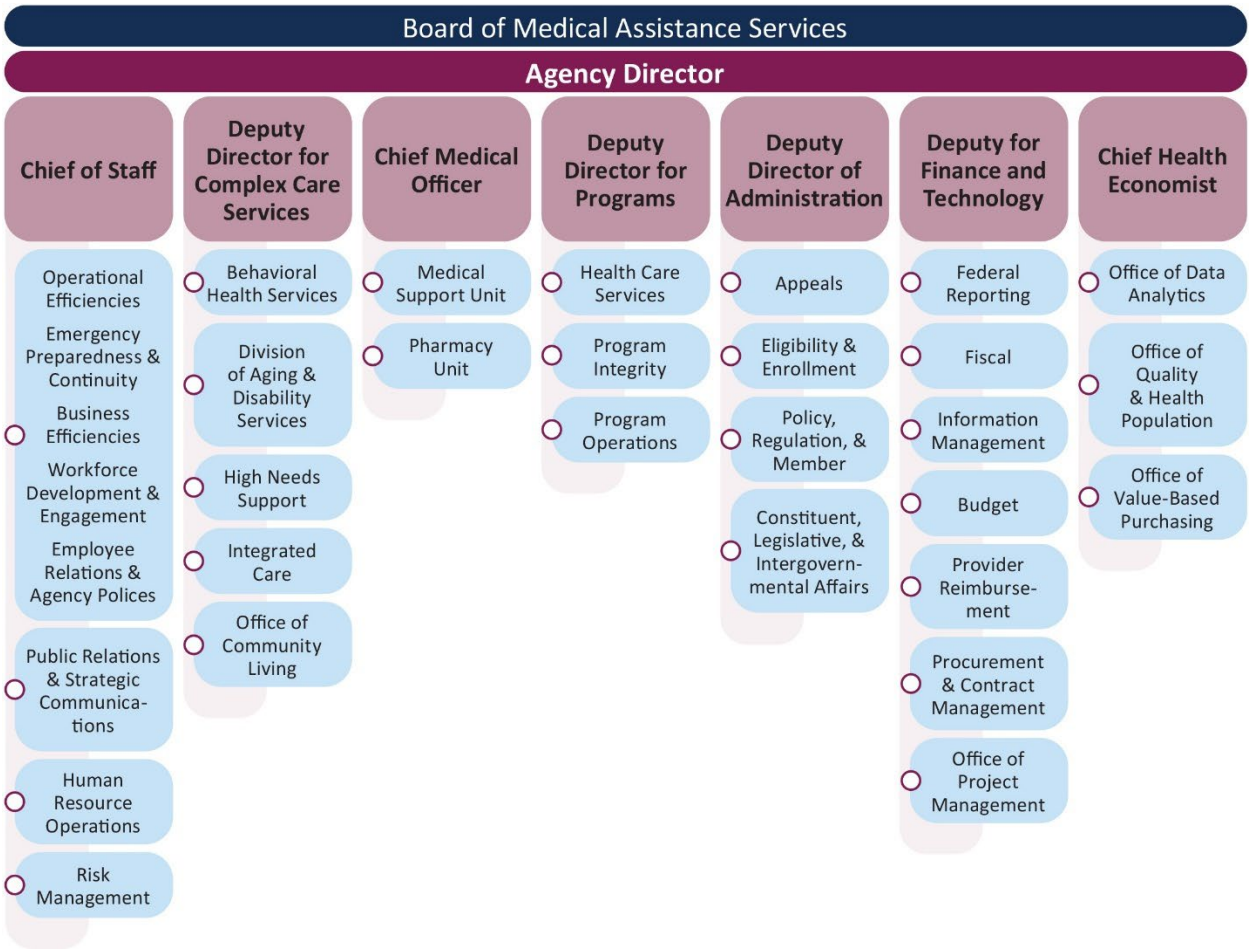
DMAS maintains the following values while operating its mission to the Commonwealth:

- ***Service****: We are committed to serving all who are touched by our system with caring, integrity, and respect.*
- ***Collaboration****: We value professional, respectful cooperation to achieve common goals. Everyone's input is welcome.*
- ***Trust****: We are continuously building a culture that is honest, supportive, and fosters integrity.*
- ***Adaptability****: We work together to anticipate and embrace change to meet Virginia's health care needs.*
- ***Problem solving****: We promote problem solving processes and respond to challenges with a forward-thinking approach.*

DMAS Organizational Structure

DMAS maintains a strong organizational structure that is committed to the implementation and oversight of programs that service DMAS members. The Quality Strategy's implementation is overseen by the DMAS Executive Leadership Team with specific responsibility assigned to the Chief Medical Officer and the Office of Quality and Population Health. DMAS' Administration and Management Organizational Chart is found in Figure 3.

Figure 3—Administration and Management Organizational Chart



Board of Medical Assistance Services

The State Board of Medical Assistance Services, as required by Virginia code, consists of 11 residents of the Commonwealth appointed by the Governor. Five Board members are healthcare providers; six Board members are nonhealthcare providers of which at least two are individuals with significant professional experience in the detection, investigation, or prosecution of healthcare fraud. The Board oversees DMAS.

The Medicaid Director and Executive Leadership Team

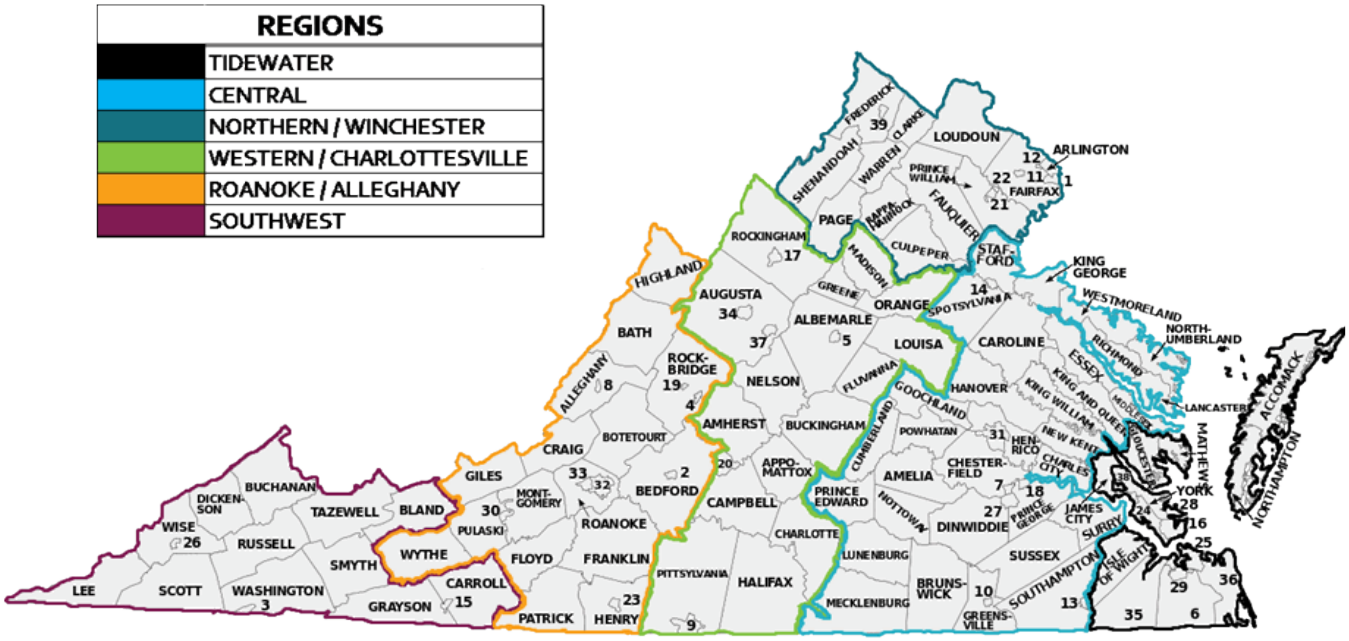
The DMAS Medicaid Director has overall responsibility for ensuring that DMAS meets the established goals of the Quality Strategy and ensures the organization maintains the administrative infrastructure to meet the needs of DMAS. The Medicaid Director works in collaboration with DMAS' Executive Leadership Team to manage the business and develop and implement administrative policies and procedures to support the delivery of quality care and services to over 2 million Virginia Medicaid members.

The DMAS annual report provides a detailed accounting of the Agency's organization and operations through fiscal year-end 2022. The report provides summary information by each Division/Office along with unit responsibilities and/or core functions. An organizational chart for each Division/Office follows each summary. The annual report is located at: https://www.dmas.virginia.gov/media/4853/308c__annual_dmas_organizational_report_fye_2022_final-7-22-2022.pdf.

Virginia Medicaid Regions

The map of Virginia in Figure 4 is color coded to delineate the counties included in each of the six distinct regions established for the delivery of Medicaid MCO services provided by the MCOs.

Figure 4—Virginia Healthcare Service Regions



Populations Served in Managed Care

Waivers

CMS approves Section 1115 demonstrations and waiver authorities in section 1915 of the Social Security Act as vehicles that states may use to test new or existing ways to deliver and pay for healthcare services in the Medicaid and CHIP programs. 1915b waivers allow states to require Medicaid members to enroll in managed care and allow states to offer home- and community-based services (HCBS) to limited groups of enrollees as an alternative to institutional care. 1115 demonstration waivers give states additional flexibility to test program innovations that further the goals of Medicaid. Virginia has the following CMS-approved waivers:

- **1915(b): Cardinal Care Managed Care Waiver:** The waiver to administer a unified managed care delivery system for Medicaid (Title XIX) and FAMIS (Title XXI). The Cardinal Care Managed Care waiver combines the existing managed care programs (Medallion 4.0 and CCC Plus) to achieve a single streamlined system of care that links seamlessly with the Department's FFS program, ensuring an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality care to its members, and adds value for its providers and the Commonwealth. The consolidated program will enable DMAS to ensure better continuity of care for members, operate with improved administrative efficiency, and strengthen the focus on the diverse and evolving needs of the populations served.[6]
- **Medallion 4.0:** The waiver to administer a coordinated delivery system for Medicaid (Title XIX) and FAMIS (Title XXI). Medallion 4.0 services children, pregnant women, and parents; coordinates early intervention and nontraditional behavioral health services; and supports alternate payment methods. The Medallion 4.0 program is focused on improving the quality of life and health outcomes for enrolled individuals; providing a seamless, one-stop system of services; facilitating communication between providers to improve the quality and cost-effectiveness of care; providing system-wide monitoring and QI; ensuring the use of culturally, linguistically, and ability-appropriate consumer and family educational materials; and increasing appropriate use of screening and prevention services.
- **1915 (b1), 1915(b4), 1915 (c): CCC Plus:** The CCC Plus waiver program provides HCBS and transition services for individuals who would otherwise receive services in a nursing facility or specialized care facility regardless of age. The waiver provides supports and service options for successful community living, including personal care, nursing, respite, assistive technology, and environmental modifications.
- **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

[6] Upon CMS approval of the Cardinal Care Program waiver, the Cardinal Care Program will replace the Medallion 4.0 and CCC Plus Programs during the timeframe of the 2023-2025 Quality Strategy.

better ensure qualified, well-trained staff members to support individuals' changing needs; and rates that incentivize and support smaller, more community-integrated residential settings.

- **1915 (c): Virginia Family and Individual Support:** The Family and Individual Support waiver assists individuals with autism, developmental, or intellectual disabilities of any age and their families with accessing person-centered and family-centered resources, supports, services and other assistance.
- **1915 (c): Virginia Building Independence:** The Building Independence waiver provides support in the community rather than in an intermediate care facility (ICF) for individuals with autism and intellectual disability or developmental disabilities for individuals of all ages.
- **1115(a): FAMIS MOMS**, **FAMIS Select**, **and 12 Months Postpartum Coverage:** The FAMIS MOMS and FAMIS Select programs were established under 1115 authority in 2005. FAMIS MOMS provides healthcare coverage for uninsured pregnant women in the CHIP income eligibility range, offering comprehensive healthcare and dental benefits during pregnancy and following the baby's birth. FAMIS Select is a premium assistance program that helps families with FAMIS-enrolled children pay for employer-sponsored health insurance. In November 2021, CMS approved Virginia's application to amend the FAMIS MOMS and FAMIS Select waiver to add a new component to the demonstration extending 12 months postpartum continuous coverage for all Medicaid and FAMIS MOMS pregnant individuals. Full implementation of the 12 months postpartum continuous coverage took effect July 1, 2022.

DMAS Programs

Cardinal Care Program

The Cardinal Care program combines the Department's FFS and managed care programs, the CCC Plus and Medallion 4.0 programs, under a single name, the Cardinal Care program. The combined program achieves a single streamlined system of care that links seamlessly with the FFS program. The Cardinal Care program ensures an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality care to its members, strengthens families, safeguards vulnerable citizens, ensures individuals become and remain self-sufficient, adds value for its providers and the Commonwealth, and serves as the gold standard health and human services agency in Virginia.

Medallion 4.0

The Medallion 4.0 program ensures the delivery of acute and primary care services, prescription drug coverage, and behavioral health services for most of Virginia's Medicaid Title XIX members and for all members of FAMIS and FAMIS MOMS, Virginia's Title XXI CHIP programs. Medallion 4.0 includes services that were previously carved out of mandatory managed care, including community mental health services, early intervention services, and third-party liability (TPL)

members. The Medallion 4.0 population includes children, low-income parents and caretaker relatives living with children, pregnant women, and current and former foster care and adoption assistance children.

Medallion 4.0 focuses on the following priorities:

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

Commonwealth Coordinated Care Plus (CCC Plus)—Managed Long-Term Services and Supports

The CCC Plus program is DMAS' mandatory integrated care initiative for certain qualifying individuals, including dual-eligible individuals and individuals receiving LTSS. The CCC Plus program includes individuals who receive services through nursing facility care, or from four of DMAS' five HCBS 1915(c) waivers. CCC Plus rolled in services that were previously carved out of mandatory managed care, including community mental health services, early intervention services, consumer directed personal care, and TPL members. The program also included members that transitioned from Medallion 3.0 and CCC into CCC Plus, such as the ABD adult and child populations.

All CCC Plus members receive care coordination through a person-centered program design, which is an integrated delivery model that includes medical and behavioral health services with LTSS.

Participation is mandatory for eligible populations, which include:

- Individuals ages 65 and older
- Adults and children with disabilities
- Individuals eligible for Medicare and Medicaid (dual eligible)
- Nondual eligible members receiving LTSS (facility and community-based)
- Members in the Developmental Disabilities waiver (for nonwaiver services only)

Medicaid Expansion

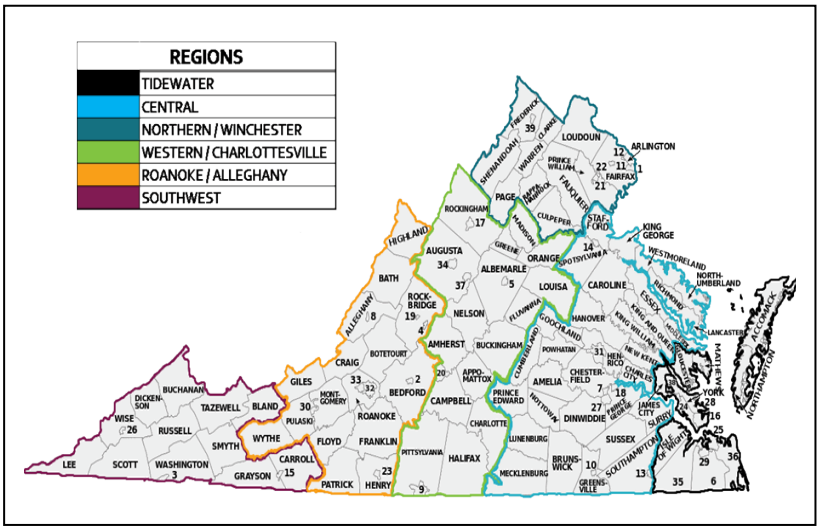
Beginning January 1, 2019, more adults living in Virginia gained access to quality, low-cost, health insurance through Virginia Medicaid expansion. The Medicaid expansion benefit plan includes all services currently covered by Medicaid for the existing populations as well as additional federally required 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 June 2022, Medicaid expansion statistics showed:

- 663,205 adults newly enrolled in Medicaid.
- 159,502 newly enrolled adults that were parents.
- 46 percent were men.
- 54 percent were women.
- 45 percent were 19 to 34 years of age.
- 37 percent were 35 to 54 years of age.
- 18 percent were 55 plus years of age.
- 492,385 were below the FPL.
- 170,820 were between 100 and 138 percent of the FPL.

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

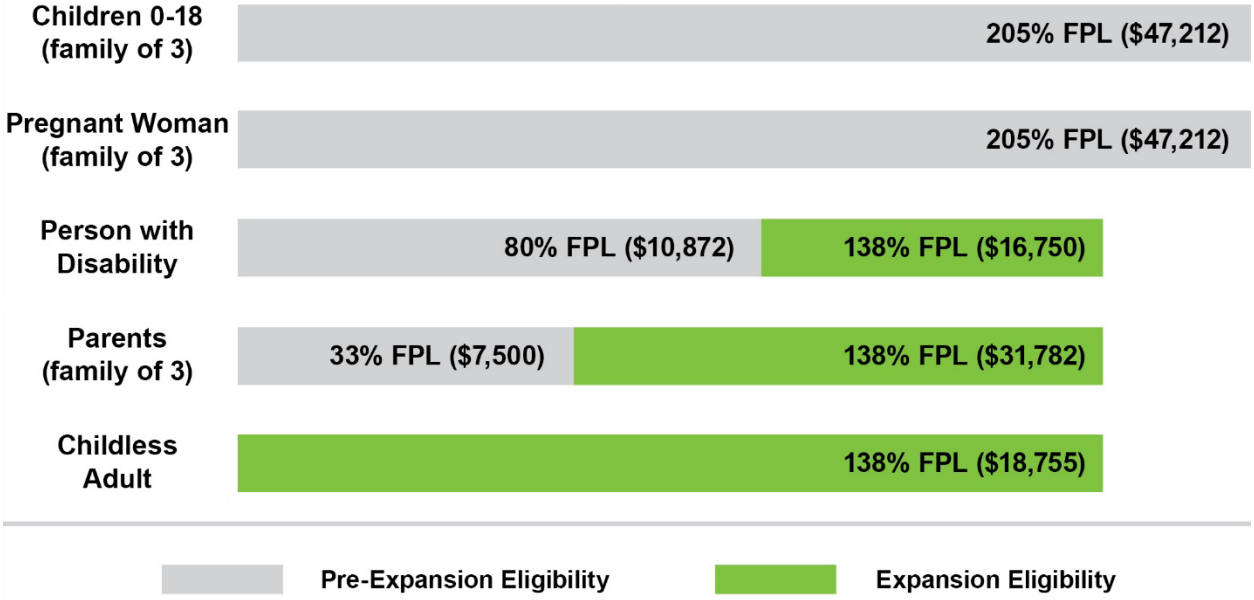
Figure 5—Medicaid Regions



Medicaid Region	
Central Region	172,145
Charlottesville/Western Region	81,434
Northern/Winchester Region	143,979
Roanoke/Alleghany Region	66,552
Southwest Region	46,255
Tidewater Region	152,840
Grand Total	**663,205**

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 currently serving over 1,600 participants. PACE program oversight is provided by both CMS and DMAS. The 12 sites include Alexandria, Richmond, Salem, Lynchburg, Gretna, Farmville, Norfolk, Portsmouth, Charlottesville, Big Stone Gap, Newport News, Marion, and Cedar Bluff.

PACE is an integrated system of care for individuals ages 55 and over who also meet the following criteria: (1) Reside within a PACE service area, (2) are certified as meeting the functional need for nursing facility level of care, and (3) are able to reside safely in the community with the help of PACE services.

In order to be certified as meeting the functional need for nursing facility level of care, a member must be evaluated using the LTSS screening administered by a certified screening team. PACE services include the following, as well as other services determined necessary by the PACE healthcare professional teams to improve and maintain overall health for members:

- Primary care
- Respite care
- Hospital care
- Medical specialty services
- Prescription medications
- Emergency services
- Home care
- Physical therapy
- Occupational therapy
- Adult day care
- Dentistry
- Social services
- Transportation
- Lab and radiology services
- Nursing facility care
- End-of-life care

- Other services to improve and maintain overall health for members may be provided as determined necessary by the PACE healthcare professional team

Fee-for-Service (FFS)

While the vast majority of Virginia's Medicaid populations are managed by an MCO, approximately 8.6 percent are served under FFS management. FFS is the traditional healthcare payment system in which physicians and other providers receive a payment for each unit of service they provide. DMAS is responsible for the clinical, administrative, and claims functions of the FFS population. The members of the FFS population include those Medicaid covered groups that are not in managed care, as well as those members who are awaiting managed care assignment and are temporarily placed in FFS until they are assigned to a participating MCO.

Populations Not Included in Managed Care

- Anyone enrolled in a PACE.
- Anyone who is enrolled in a Medicare Savings Plan or Plan First and anyone with temporary coverage.
- Anyone enrolled in premium assistance programs such as the Health Insurance Premium Program or FAMIS Select.
- Anyone who lives on Tangier Island.
- Anyone enrolled in the Medicaid hospice covered group (if the member is already enrolled in a managed care program when hospice enrollment occurs, the member remains in the managed 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.[7] 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.[8]

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

[7] Martin K, Kurowski D, Given P, et al. The Impact of COVID-19 on the Use of Preventive Health Care, Updated April 16, 2021. Available at: https://healthcostinstitute.org/hcci-research/the-impact-of-covid-19-on-the-use-of-preventive-health-care. Accessed on: Aug 3, 2022.

[8] Hoyert DL. Maternal Mortality Rates in the United States, 2020. NCHS Health E-Stats, February 23, 2022. Available at: https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/E-stat-Maternal-Mortality-Rates-2022.pdf. Accessed on: Aug 3, 2022.

and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings and treatments.[9] 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.[10]

Table 2—Virginia Medicaid is Taking Action to Fight COVID-19

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

DMAS also provided consumer-directed attendants who worked anytime between July 1, 2021, and September 30, 2021, with a COVID-19 supplemental support payment of $1,000.

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

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

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

[9] Georgetown University Health Policy Institute, Center for Children and Families. Redirecting Medicaid MCO Gains to Offset Network Provider Losses in the Time of COVID-19. Available at: https://ccf.georgetown.edu/2020/07/27/redirecting-medicaid-mco-gains-to-offset-network-provider-losses-in-the-time-of-covid-19/. Accessed on: July 14, 2022.

[10] Virginia Department of Medical Assistance Services. COVID-19 Response. Available at: https://www.dmas.virginia.gov/covid-19-response/. Accessed on: Aug 3, 2022.

Process for Quality Strategy Development, Review, and Revision

A Roadmap for the Future

DMAS developed this comprehensive Quality Strategy to continually improve the delivery of quality healthcare to all Medicaid and CHIP members served by the Virginia Medicaid managed care and FFS programs. DMAS' Quality Strategy provides the roadmap to accomplish its dynamic approach to achieving its overarching goal of designing, implementing, improving, and assessing the quality of healthcare and services furnished through Virginia's coordinated and comprehensive system. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, and quality, satisfaction, and timeliness of services for Virginia Medicaid and CHIP members.

DMAS' vision for quality extends beyond the 2023–2025 Quality Strategy. The mechanisms for assessing quality, timeliness, and access to care will vary across the Medicaid programs in Virginia; therefore, the Quality Strategy is tailored to incorporate these variances while ensuring an integrated strategy overall. The Quality Strategy requires a succession of incremental steps that DMAS will pursue to achieve these quality objectives. The actions and plans outlined herein lay the necessary groundwork for an evolving approach by establishing a strong foundation for quality governance.

With input provided by Virginia Medicaid MCOs, external stakeholders, and the Medical Care Advisory Committee, and in alignment with Governor Glenn Youngkin's strategic vision for the Commonwealth, DMAS identified goals and objectives for the Virginia Medicaid program across all populations and product lines. Those goals are supported by performance measures (each performance measure serves as a metric) used to measure performance in achieving the goals identified in the Quality Strategy. DMAS uses the NCQA HEDIS and the CMS Core Measure Sets to develop, collect, and report performance measures, in addition to DMAS-developed metrics.

Initial Quality Strategy and History

42 CFR §438.340

DMAS fosters a multidisciplinary approach to developing, reviewing, and revising the Quality Strategy. The approach involves input from the public, medical providers, stakeholders, member advocates, and outside partners who have a direct concern for—and impact on—access, quality of care, and quality of service. All stakeholders may comment on the development of quality goals and objectives highlighted in the Quality Strategy.

DMAS published its initial Quality Strategy in June 2005. The strategy was first updated in May 2011 to include the CHIP managed care delivery system and to provide a framework for the five-year period through 2015. In December 2015, DMAS issued Addendum 1 (Addendum) to the 2011–2015 Managed Care Quality Strategy as a companion to the previously published second edition. This Addendum was the result of the May 2015 release of the proposed rule to modernize and update the federal Medicaid managed care regulations. It addressed the progression of, and impending changes to, managed care quality in Virginia. The Addendum

served to extend the 2011–2015 DMAS Quality Strategy to cover the gap period until the third edition of the Quality Strategy was developed and approved. The third edition was finalized by DMAS on January 31, 2018, for calendar years (CYs) 2017 through 2019. DMAS completed a comprehensive update to the Quality Strategy, fourth edition, for CY 2020 through 2022. This edition of the Quality Strategy aligned with the requirements detailed in the revised federal regulations, specifically 42 CFR §438.340.

This document is the fifth edition of DMAS' Quality Strategy for CYs 2023–2025. It builds upon the Quality Strategy currently in place as an extension to the 2020–2022 DMAS Quality Strategy, fourth edition. This fifth 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.*[11]

The federal regulations expand the scope of the Quality Strategy to address additional requirements in the following five areas:[12]

- Plan for improving quality of care and services
- Standards for network adequacy and availability of services
- Transition of care policy
- Identifying, evaluating, and reducing health disparities
- Identifying persons needing LTSS and persons with special needs

DMAS submits both updates and revisions of its Quality Strategy to CMS for review and approval.

[11] The Centers for Medicare & Medicaid Services. Medicaid and CHIP Managed Care Final Rule. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: July 14, 2022.
[12] Ibid.

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 December 9, 2022, through January 7, 2023. DMAS reviewed and considered the public comments received, and incorporated public feedback into the draft Quality Strategy prior to submission to CMS.

Medical Care Advisory Committee

The DMAS Medical Care Advisory Committee is titled the Medicaid Physician and Managed Care Liaison Committee (MPMCLC). Committee membership includes, but is not limited to, representatives from the following organizations: Virginia Academy of Family Physicians, American Academy of Pediatrics—Virginia Chapter, Virginia College of Emergency Physicians, American College of Obstetrics and Gynecology—Virginia Section, American College of Radiology, Psychiatric Society of Virginia, Virginia Medical Group Management Association, and the Medical Society of Virginia. The committee includes representatives from each of DMAS' contracted MCOs and a representative from the Virginia Association of Health Plans.

The Medical Care Advisory Committee reviews and advises on the operations, programs, and planning for Virginia's Medicaid program. The committee provides feedback and input on policy, operations, and administrative issues of the Medicaid program, including issues of concern to the community. The committee operates in accordance with 42 CFR 431.12 and the State Medicaid Plan.

Beneficiary and Stakeholder Input

DMAS 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 OCMO. DMAS posts the final draft of the Quality Strategy on the DMAS website for public comment, allowing a minimum of 30 days for stakeholder input and written feedback. Internal and external public input and feedback is considered after the public comment period is closed.

Consulting With Tribes

42 CFR §438.340(c)(1)(ii)

DMAS understands that access to the decision-making process regarding the Medicaid and CHIP programs is especially critical for tribes for cultural, treaty, and statutory reasons. Therefore, DMAS' tribal consultation policy follows the federal requirements for tribal consultation. DMAS notifies the tribes in writing 30 days prior to the Commonwealth's submission of any Medicaid or CHIP State Plan Amendment, and at least 60 days prior to any waiver request, proposal for a demonstration project, policy or procedure, or Quality Strategy update that is likely to have a direct effect on Indians, Indian health programs, or urban Indian organizations. The Quality Strategy is shared with, and input solicited from, the following Virginia tribes:

- Pamunkey Indian Tribe
- Chickahominy Indian Tribe

- Chickahominy Indian Tribe, Eastern Division
- Monacan Indian Nation
- Nansemond Indian Tribe
- Rappahannock Tribe
- Mattaponi Tribe
- Indian Health Services
- Pamunkey Health Clinic

The notification describes the purpose and the anticipated impact on tribal members. It also describes a method for appropriate tribal representatives to provide official written comments and questions within an adequate time frame (at least 30 days) that allows time for DMAS' analysis, consideration of any issues that are raised, and discussion between DMAS and tribes responding to the notification.

DMAS consulted with tribes regarding the updates to the Quality Strategy by providing the draft Quality Strategy and a summary table of changes made to the Quality Strategy to tribes on October 15, 2022, for their review and to encourage tribal input. DMAS followed up with the tribes on November 15, 2022, when feedback was not received. The tribal consult period was closed on November 30, 2022. DMAS did not receive any tribal input to consider prior to finalizing the Quality Strategy.

DMAS provides written acknowledgement on its website to stakeholders that provide written feedback on the Quality Strategy during the public comment period. Recommendations are shared with appropriate departments within DMAS for consideration and are incorporated into the final version of the Quality Strategy as determined appropriate by DMAS. The recommendations and responses from DMAS are posted on the DMAS website.

Submitting the Quality Strategy to CMS

42 CFR §438.340(c)(3)

CMS Review and Approval

If significant changes are made to the 2023–2025 edition of the Quality Strategy, the revision(s) will include a public comment period, CMS review and approval, and a resultant new edition. Insignificant changes would not warrant the need for a new edition.

Posting the Final CMS-Approved Edition on the Website

42 CFR §438.340(d)

After review by CMS, DMAS provides members, providers, and other internal and external stakeholders access to the organization's Quality Strategy by posting the final version on DMAS' Virginia Medicaid portal, website, and other communication portals. The final version of the Quality Strategy can be found on the DMAS website.[13]

[13] Virginia Department of Medical Assistance Services. 2020–2022 Quality Strategy. Available at: https://www.dmas.virginia.gov/media/2649/2020-2022-dmas-quality-strategy.pdf. Accessed on: Aug 4, 2022.

Virginia's Quality Assessment and Performance Improvement

DMAS requires that MCOs, in compliance with 42 CFR 438.330 and additional DMAS requirements, establish and implement an ongoing comprehensive quality assessment and performance improvement (QAPI) program that is reviewed annually and approved by DMAS. DMAS requires that each MCO has in effect a process for a self-evaluation of the impact and effectiveness of its QAPI program. Each MCO's QAPI program includes:

- Completion of DMAS-specified PIPs (DMAS and MCO PIP topics are included in Appendix C).
- Collection and submission of all designated quality performance measurement data.
- Mechanisms to detect both underutilization and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care for beneficiaries with special health care needs (SHCN).
- Mechanisms to assess and address health disparities.
- Mechanisms to assess the quality and appropriateness of care provided to beneficiaries needing LTSS, including assessment of care between settings and a comparison of services and supports received with those set forth in the member's treatment/service plan.
- Participation in efforts by the Commonwealth to prevent, detect, and remediate critical incidents.

The DMAS QI program embodies a CQI process and problem-solving approach applied to specific and measurable performance indicators and operational activities. The CQI process is used to (1) monitor access to care, timeliness and quality of care, and operational performance; (2) identify opportunities for improvement that exist throughout the Virginia Medicaid program; (3) implement intervention strategies to improve outcomes and performance; (4) evaluate interventions to determine successfulness; and (5) reassess performance through measurement to identify new opportunities for improvement. To ensure that a consistent process for CQI is applied, DMAS has adopted the W. Edwards Deming cycle of performance improvement—Plan-Do-Study-Act (PDSA). The PDSA cycle follows a systematic series of steps for gaining knowledge about how to improve a process or outcome." The PDSA cycle is discussed below and depicted in Figure 7.

Figure 7—PDSA Cycle

1. **Plan:** Define the objective, interventions, questions, and hypotheses that will answer the following questions: *Who? What? Where? When?* Data collection should be targeted toward answering the questions.
2. **Do:** Carry out the plan (and interventions) by collecting data and beginning data analyses.
3. **Study:** Complete the data analysis and compare results to predictions to determine if interventions were successful or if opportunities for improvement still exist. Summarize what was learned.
4. **Act:** Plan the next cycle. If interventions were successful, plan to extend or standardize them. If interventions were not successful, replace them with new interventions intended to bring about truly improved processes or outcomes.

DMAS uses several key interventions to drive QI in the Virginia Medicaid program, which include:

- Maintaining a robust QI framework that encompasses a CQI approach, as described above.
- Using HEDIS and the CMS Core Measure Sets and other performance measures to continually assess each MCO's achievement of the DMAS goals.
- Implementing PIPs, which measure and assess targeted performance improvement interventions on specific topics.
- Monitoring Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[14] survey results and other satisfaction survey data to determine how satisfied Virginia Medicaid members are with the care and services they receive.
- Monitoring FFS Non-Emergency Medical Transportation survey results to determine how satisfied Virginia FFS Medicaid members are with transportation services.
- Monitoring the MCOs' QI activities and compliance with contractual requirements to verify if the MCOs are appropriately implementing federal and Commonwealth contractual standards.
- Facilitating cross-agency collaborative meetings to identify opportunities to improve service delivery and to leverage resources to achieve common goals.
- Trending performance measure results to ensure that the MCOs' performance is improving over time.
- Implementing other initiatives, as needed, to adhere to changes in federal policy.
- Studying the healthcare disparities among racial and ethnic groups to implement targeted and culturally competent interventions to ensure that Medicaid members have access to high-quality care.
- Studying the healthcare disparities among members with SHCN as well as by age, sex, or disability status to implement targeted interventions to ensure that all Medicaid members have access to high-quality care.

So that DMAS may monitor and ensure the accuracy of MCO reporting and assess performance against those measures on an MCO-specific and program-wide basis, the MCOs:

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

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

- Provide all information required by the EQRO, in compliance with the protocols set forth by CMS.[15]

MCOs develop a process to evaluate the impact and effectiveness of their own QAPI programs. A description of this MCO process is submitted to and approved by DMAS with submission of the QAPI program itself and is closely aligned to this Quality Strategy.

MCOs participate in ongoing cross-MCO meetings with DMAS and MCO quality directors, which are designed to exchange and build upon MCO-identified best practices, discuss arising issues, and plan for upcoming projects. MCOs are also required to participate in DMAS Quality Improvement Collaborative meetings. The Quality Improvement Collaborative serves as a key DMAS interface with MCOs and is driven by the data collected throughout the assessment process.

★ Quality Strategy Interventions ★

Virginia has developed a series of interventions aligned closely to this Quality Strategy and designed to build an innovative, person-centered, coordinated system of care that addresses both medical and nonmedical drivers of health. These interventions drive progress towards the Quality Strategy goals and objectives, described in Table 1. DMAS developed a Responsible, Accountable, Consulted, Informed (RACI) chart, depicted in Table 3, to clarify and define the roles and responsibilities of its cross-functional efforts focused on achieving goals and objectives contained in the Quality Strategy.

Table 3—Quality Strategy RACI Chart

Intervention Categories	**1.1** Increase member engagement and outreach	**1.2** Improve member satisfaction	**2.1** Ensure access to care	**2.2** Promote patient safety	**2.3** Promote effective communication and care coordination	**3.1** Focus on paying for value	**3.2** Focus on efficient use of program funds	**4.1** Improve utilization of wellness, immunization, and prevention services for members	**4.2** Improve outcomes for maternal and infant members	**4.3** Improve home and community-based services	**5.1** Improve Outcomes for Members with Chronic Conditions	**5.2** Improve Outcomes for Nursing Home Eligible Members	**5.3** Improve Outcomes for Members with Substance Use Disorders	**5.4** Improve Behavioral Health and Developmental Services of Members
Project BRAVO	X	X	X	X	X				X				X	X
Foster Member and Provider Engagement	X	X	X		X									
Value-Based Purchasing			X	X	X	X	X	X	X	X	X	X	X	X

[15] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols,* October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: July 20, 2022.

Intervention Categories	**1.1** Increase member engagement and outreach	**1.2** Improve member satisfaction	**2.1** Ensure access to care	**2.2** Promote patient safety	**2.3** Promote effective communication and care coordination	**3.1** Focus on paying for value	**3.2** Focus on efficient use of program funds	**4.1** Improve utilization of wellness, immunization, and prevention services for members	**4.2** Improve outcomes for maternal and infant members	**4.3** Improve home and community-based services	**5.1** Improve Outcomes for Members with Chronic Conditions	**5.2** Improve Outcomes for Nursing Home Eligible Members	**5.3** Improve Outcomes for Members with Substance Use Disorders	**5.4** Improve Behavioral Health and Developmental Services of Members
Telehealth	X	X	X		X			X	X		X		X	X
Management of At-Risk Children				X				X	X		X		X	X
Financial Transparency and Accountability						X	X							
Smiles for Children Dental Program		X	X			X		X	X		X	X	X	
Maternal and Family Health Initiatives	X	X	X	X	X	X	X	X	X		X		X	X

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

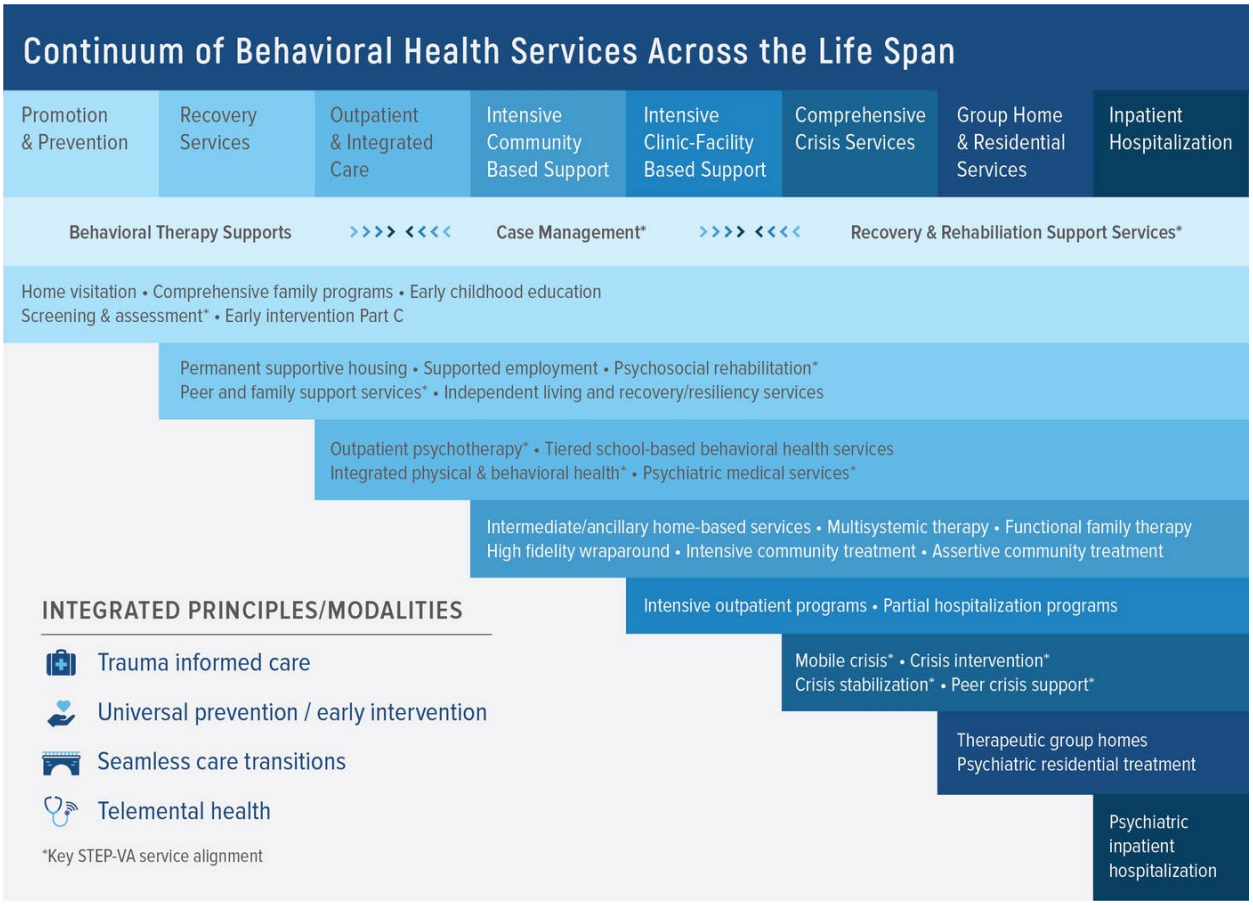
★ *Behavioral Health Enhancement and Project BRAVO* ★ [16,17]

Under Governor Glenn Youngkin, the Commonwealth is focused on improving behavioral health services. The vision for the Enhancement of Behavioral Health is to keep Virginians well and thriving in their communities, shift our system's current need to focus on crisis by investing in prevention and early intervention for mental health and substance use disorder (SUD) comorbidities, and support comprehensive alignment of services across the systems that serve Medicaid members. This includes efforts to reduce the burden on state psychiatric hospitals and EDs, with efforts including increasing use of mobile crisis response and reduction of emergency department utilization, as well as working to ensuring appropriate access to acute behavioral health services for foster care youths by working to carve in residential services into the managed care programs.

[16] ★ Governor Glenn Youngkin's identified priority for the Medicaid program that focuses on and access to high quality healthcare services. Objective 5.3: Improve Outcomes for Members with Substance Use Disorders.
[17] ★ Governor Glenn Youngkin's identified priority for the Medicaid program that focuses on and access to high quality healthcare services. Objective 5.4: Improve Behavioral Health and Developmental Services of Members.

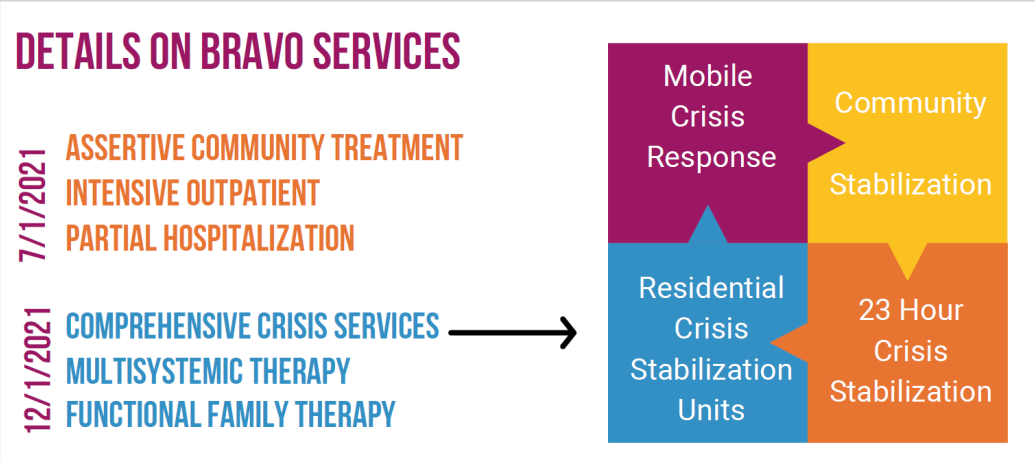
DMAS is also committed to the continued expansion of access to BRAVO services by implementing new services and engaging the communities to support these services. Project BRAVO is a comprehensive, General Assembly supported vision that details a "north star" continuum of services and a preliminary set of prioritized services to build out critical levels of care, including comprehensive crisis services. Figure 8 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 8—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 9 shows the services included in each Project Bravo implementation phase.

Figure 9—Project BRAVO Service Implementation Phases



Fatal drug-related overdoses surged during the COVID-19 pandemic, exceeding 100,000 overdoses in the U.S. and over 2,400 in Virginia in state fiscal year (SFY) 2021. This represents a 20 percent increase nationally and a 35 percent increase in Virginia, respectively, since the previous year. Pandemic-related economic and social stress, disruptions in access to health services, and greater availability of more lethal forms of opioids, such as fentanyl, are considered the primary reasons for the surge in overdoses, although no definitive causes have been identified. The demand for both mental health and SUD services have increased with the COVID-19 pandemic, and Virginia's drug overdose rates remain higher than ever before. In order to make the most of its Medicaid investments, Virginia needs to implement services that are evidence-based, trauma-informed, and support efforts to build and sustain a strong healthcare workforce.

Beginning in 2017, the Addiction and Recovery Treatment Services (ARTS) benefit provides treatment for members with SUDs across the state and provides access to addiction treatment services for all enrolled members in Medicaid, FAMIS, and FAMIS MOMS. A DMAS goal for the ARTS delivery system transformation includes ensuring that a full continuum of care is available, based on evidence-based practice, to effectively treat individuals with SUD. Primary drivers of the ARTS benefit to reduce the opioid-related overdose deaths include:

1. Increase the rates of initiation and engagement in treatment for opioid use disorder (OUD) and other SUDs.
2. Reduce utilization of ED and inpatient hospital settings for SUD treatment.
3. Improve adherence to treatment for OUD and other SUDs.
4. Reduce readmissions to the same or higher level of care for SUD treatment.
5. Improve access to care for co-morbid physical health conditions among beneficiaries with SUD.

This approach is expected to provide Medicaid members with access to the evidence-based care needed to achieve sustainable recovery. The MCOs work with DMAS, as required by contract, to ensure that their members' care needs for SUD treatment and recovery are met and include care coordination, utilization review, and a robust array of services and treatment methods to address immediate and long-term physical, mental, and SUD service needs. The ARTS provider network ensures member access to timely care through a sufficient network of high quality, credentialed, and knowledgeable providers in each level of care as well as

ensuring medications for treating OUD and alcohol use disorder (AUD) are available in all levels of care.

As a result of the expansion of treatment services through ARTS and increases in eligibility for these services through Medicaid expansion beginning in 2019, Virginia Medicaid was far better prepared for the increased prevalence in SUD than in previous years. The supply of treatment providers, the prevalence of members receiving SUD treatment, and the rate of treatment for diagnosed SUD increased dramatically after implementation of the ARTS benefit and has continued through Medicaid expansion and the COVID-19 pandemic. While there was concern that COVID-19 related shutdowns and stay-at-home orders may negatively affect access to and use of SUD treatment services, the federal government and DMAS implemented a number of initiatives and procedural flexibilities to offset these barriers, including increased use of telemedicine, allowing take-home dosages of methadone and buprenorphine for up to 28 days, allowing for 90-day prescriptions for buprenorphine products, and allowing a member's home to serve as the originating site for prescription of buprenorphine.

The ARTS four-year evaluation examined SUD prevalence, treatment utilization, and outcomes among Virginia Medicaid members during SFYs 2019 and 2020, as well as the first two quarters of SFY 2021 (covering the period July 2018 through December 2020).

Foster Member and Provider Engagement

DMAS has established the Medicaid Member Advisory Committee (MAC) in order to provide a formal method for members' voices to be included in the DMAS decision-making process and to inform DMAS change management strategies. The diverse committee is comprised of representatives from across the state and is entirely made up of Medicaid-enrolled individuals and individuals' authorized representatives. The MAC's purpose is to obtain the insight and recommendations of Virginia's Medicaid members in order to help the DMAS Medicaid Director improve the overall experience for all Virginia Medicaid applicants and members. The committee members examine and provide input on the impact of DMAS policy, services, and programs. Committee members serve for at least one year. Scheduled quarterly meetings are open to the public, with a comment period reserved in each meeting. Each MCO is also required to have a MAC to provide a platform for member input.

DMAS' provider committee is called the Medicaid Provider Managed Care Liaison Committee (MPMCLC). The MPMCLC meets quarterly to provide a forum for Medicaid providers, DMAS, and the MCOs to come together to discuss opportunities, provide feedback, and create alignment across Virginia's Medicaid managed care programs. DMAS also solicits feedback from providers and members through a variety of surveys, including secret shopper calls, to assess their experience in accessing and utilizing care, as well as to monitor the quality of care available to Virginia's Medicaid members.

DMAS created the Civil Rights Coordinator position in November 2019 to ensure that individuals with limited English proficiency (LEP) and individuals with disabilities have meaningful access to programs and services. This position serves the critical function of ensuring continued compliance with federal and Commonwealth of Virginia civil rights requirements and ensures that internal and external stakeholders have language and disability access resources available to improve communications with LEP individuals and those with disabilities.

In 2021, the Civil Rights Coordinator completed the DMAS Language and Disability Access Plan, which is available to internal and external staff members, as well as to the public at: https://www.dmas.virginia.gov/about-us/2021-language-and-disability-access-plan/. The Plan includes the Four Factor Analysis that evaluates the following for the Virginia Medicaid program: (1) the number or proportion of LEP persons and individuals with disabilities eligible to be served or likely to be encountered, (2) the frequency of contact, (3) the nature of the program and services, and (4) the availability of resources and costs. The Plan will be evaluated each year to determine what strategic initiatives can further DMAS' commitment to serving the LEP and disabled populations. One of the most crucial initiatives identified in 2021 was to develop language and disability access related training, as well as linguistic and cultural competency training, for Agency staff to ensure effective communication with LEP individuals and individuals with disabilities. This training initiative launched in early 2022 and is required for all DMAS staff.

Provider Outreach and Engagement

All provider outreach, marketing, and promotional activities (including provider promotional activities) comply with relevant federal and Commonwealth laws. This includes both the Anti-Kickback Statute and the Civil Monetary Penalty law, which prohibits inducements to beneficiaries. DMAS is in the process of reviewing all provider O&E materials in order to ensure compliance with regulations, readability, and availability of technical documentation and support for Medicaid providers, especially with the transition to Cardinal Care. Cardinal Care will simplify provider contracting and credentialing processes during provider enrollment and renewal. With the retirement of Medallion 4.0 and CCC Plus, 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* ★ [18]

Under the administration of Governor Glenn Youngkin, there is a push for DMAS to increase the utilization of VBP arrangements with MCOs and providers. VBP includes a broad set of policies and strategies intended to improve healthcare quality, outcomes, and efficiency by linking financial and nonfinancial incentives to the performance of various stakeholders serving Virginia Medicaid members. Movement toward and achievement of these goals is measured through a set of defined metrics evaluating quality, cost, and patient-centered care. There is no "one-size-fits-all" approach to VBP, and DMAS' efforts focus on a range of healthcare stakeholders, populations, and care events that are important to members, specifically highlighting chronic conditions, maternity care, behavioral health, and prevention.

As part of these efforts, Virginia's Medicaid MCOs are held accountable for performance in key areas through PWPs under the managed care programs whereby each MCO must earn back a

[18] ★ Governor Glenn Youngkin's identified priority for the Medicaid program that focuses on maternal health outcomes. Goal 3: Support Efficient and Value-Driven Care.

portion of its capitation payments through demonstrated performance against key metrics. MCOs are held accountable for potentially preventable, avoidable, and/or medically unnecessary utilization in high-acuity settings of care through measures developed by DMAS. As part of this effort, DMAS contracted with its actuary to identify clinical efficiencies under its managed care programs. The first set of clinical efficiency analyses focused on medically unnecessary or potentially preventable spending for hospital admissions, hospital readmissions, and ED visits.

In 2021, the VA General Assembly directed DMAS to establish a nursing facility value-based purchasing (NF VBP) program. DMAS developed a provider-facing NF VBP targeting staffing measures, such as reducing the number of days facilities do not meet the CMS-mandated minimum number of staffed registered nurse (RN) hours and the weighted average of case-mix adjusted total nurse staffing hours, and avoidance of negative care events measures, such as reducing pressure ulcers, urinary tract infections (UTIs), hospitalizations, and ED visits. The program targets will continue to evolve over time.

Assessments of Essential Services and Vulnerable Populations

DMAS requires the MCOs to have mechanisms to detect under- and overutilization of care and services. The DMAS assessments of essential services provided by the MCOs include procedures to evaluate medical necessity, criteria used, information source, and the process used to review and approve or deny the provision of services. In accordance with 42 CFR §438.3(s)(4), each MCO develops and maintains a drug utilization review (DUR) program that complies with the DUR program standards as described in Section 1927(g) of the Social Security Act and 42 CFR §456 Subpart K, including prospective DUR, retrospective DUR, and the DUR Board. DMAS requires each MCO to demonstrate that all members have access to all services covered under its benefit in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services as provided under the FFS program. DMAS also requires MCOs to monitor and report critical incidents, as well as to implement plans to address potential and actual quality of care and/or health and safety issues in healthcare settings, including but not limited to nursing facilities and home- and community-based settings. DMAS includes but does not limit its definition of vulnerable populations to include individuals in a PACE; DD waiver members; and individuals with chronic illnesses, including both physical and/or behavioral health.

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* ★ [19]

Governor Glenn Youngkin launched an initiative aimed at creating safe housing placements for children in foster care. The Safe and Sound Task Force will bring together government agencies, the Virginia League of Social Services Executives, and other community partners to end the practice of children sleeping in local departments of social services, hotels, and emergency rooms. Governor Glenn Youngkin formed the task force to ensure that every child has a safe place to belong.

Virginia has a dire shortage of foster homes, kinship family placements, and beds in group homes and residential treatment centers. The Special Advisor for Children's Issues convenes State and local government agencies, residential facilities and hospitals, and community partners to collaboratively seek immediate solutions to this crisis. The Task Force objectives include finding safe placements for kids who are currently displaced, ensuring a reservoir of safe placements for kids who may need them in the future, and eventually making recommendations that go upstream to address policy and systemic changes.

The Virginia Secretary of Health and Human Resources, John Littel, appreciates how swiftly Governor Glenn Youngkin reacted to the concern and provided the leadership necessary to end

[19] ★ Governor Glenn Youngkin's identified priority for the Medicaid program that focuses on behavioral health enhancement. Goal 2: Promote Access to Safe, Gold-Standard Patient Care.

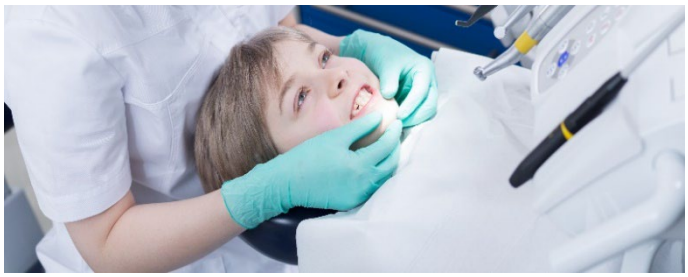
the practice. Secretary Little indicates that while there are a number of issues that created this untenable situation, it will require collaboration and creativity at both the local and State levels to solve it.

Financial Transparency and Accountability

DMAS continually evaluates its Medicaid programs to ensure that they are operating as efficiently and effectively as possible. To achieve this, DMAS: 1) deploys an internal financial scorecard to measure expenditures to budget, 2) deploys an external dashboard on utilization of finances to support Medicaid, and 3) updates its Medicaid forecast and rate-setting processes by implementing the recommendations of an external reviewer. DMAS includes transparency in its forecast and rate-setting processes by holding quarterly meetings with staff members from various legislative committees as well as the Joint Legislative Audit and Review Commission (JLARC), the Department of Planning and Budget, and the Secretary of Health and Human Resources to review key policy changes.

In addition, Virginia Secretary of Health and Human Resources John Littel announced that DMAS plans to launch a transformational new procurement next year to drive innovation and strengthen quality and accountability in its managed care program in 2024. State leaders will evaluate commercial health plans that participate in the competitive procurement based on their use of data-driven strategies to address challenges in the rapidly evolving healthcare environment, including value-based care models that tie funding to measurable improvements in health outcomes.

Smiles for Children



Smiles For Children (SFC) is Virginia's Medicaid and FAMIS dental program. SFC provides comprehensive dental benefits to three target populations. Members under 21 years of age receive comprehensive dental benefits. Pregnant members have access to a comprehensive list of medically appropriate dental procedures excluding orthodontics. Finally, effective July 1, 2021, non-pregnant members over 21 have access to a comprehensive list of dental benefits with the exception of orthodontics.

On July 1, 2021, DMAS launched the comprehensive dental benefit plan for adults. This dental benefit provides comprehensive coverage for approximately 960,000 adults in the Commonwealth of Virginia. Modeled after the DMAS pregnant women benefit, the adult dental benefit provides no annual maximums, no copayments, and no deductibles for covered adult procedures. The dental benefit was designed with the realization that oral health has a substantial impact on overall health. The focus of the comprehensive adult dental benefit is to support a healthy mouth and gums with routine preventive services. Beginning with preventive services will aid in improving systemic health concerns that may be in existence and prepare the member for success with additional treatment that may be needed. The goal of additional treatment allows extractions when necessary for a healthier mouth and restorations to preserve

fixable teeth. The adult dental plan also allows for up to three cleanings in a 12-month period by medical necessity and dentures for adults that lack teeth.

The MCOs are responsible for transportation and medication related to all covered dental services and are responsible for working closely with their respective Dental Benefits Administrator to coordinate medically necessary procedures for adults and children.

Adult Dental Coverage

Oral diseases, ranging from dental caries (cavities) to oral cancers, continue to cause pain and discomfort for millions of Americans. A growing body of evidence has linked oral health to several chronic diseases, including heart disease, endocarditis, and diabetes. DMAS understands the need for comprehensive dental benefits for all members program in the Commonwealth.

Prior to July 1, 2021, Virginians, age 21 years and older who were enrolled in Medicaid had limited dental benefits, covering medically necessary services only. With limited dental coverage, adult members lacked access to much needed preventive and diagnostic care. There have been various studies done linking a decrease in access to care to an increase in ED utilization. According to the Virginia Health Catalyst, in 2018, Virginia spent $3.31 million on 12,617 visits to the ED for dental-related pain and infection; however, no treatment was provided in the ED.

The comprehensive adult dental benefit became effective July 1, 2021. More than 960,000 members now have access to comprehensive dental benefits that make available each of the dental specialties. It was established on the premise that the dental treatment procedures would be prevention and control to keep the mouth disease free, and then restore it to healthy function. Beginning with preventive services will aid in improving systemic health concerns that may be in existence and prepare the patient for success with additional treatment that may be needed. The goal of additional treatment would focus on removing what cannot be saved and restoring what can be built around, therefore increasing longevity for any prosthetic appliances that may be in order. 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* ★ [20]

DMAS developed a series of strategies to improve maternal and infant outcomes among its members, with a particular administrative focus under Governor Glenn Youngkin on ensuring women receiving timely postpartum care after giving birth. DMAS recently implemented coverage expansions that will improve access to health care for pregnant and postpartum individuals and their infants. In July 2022, DMAS implemented 12 months postpartum continuous coverage under its approved Section 1115 demonstration amendment. Another coverage expansion broadening health care access for pregnant individuals was the July 2021

[20] ★ Governor Glenn Youngkin's identified priority for the Medicaid program that focuses on and access to high quality healthcare services. Objective 4.2: Improve Outcomes for Maternal and Infant Members.

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.

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. According to the Maternal Health Annual Report—Baby Steps VA, the maternal mortality rate is 15.6 per 100,000 pregnancies. 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 (47.2) is over two times higher than that for White women (18.1). DMAS listens to the voice of the member and talks with community-based organizations, advocates, and stakeholders to learn more about what is impacting birth outcomes and what can be done, by working together, to solve the problems.

Perinatal Quality Collaborative

Funding for the Perinatal Quality Collaborative was provided for the Virginia Department of Health (VDH) to establish and administer a learning collaborative to improve pregnancy outcomes for women and newborns by advancing evidence-based clinical practices and processes through CQI, with an initial focus on pregnant women with a SUD and infants impacted by neonatal abstinence syndrome (NAS). DMAS' participation is vital, both because of the ability to provide data to inform improvement efforts, and because of its ability to draw down matching federal Medicaid administrative funds to support the work.

The funding includes support for several administrative positions to run operations, and also memberships/connections for a limited number of pilot sites to the Vermont Oxford Network. Vermont Oxford Network data are collected from neonatal intensive care units (NICUs) across the country and are reported in accordance with national standards. The network provides resources for states and members on many topics relevant to perinatal care, including NAS.

FAMIS Prenatal Coverage

Effective July 1, 2021, uninsured pregnant individuals with income below 200 percent of the FPL now qualify for prenatal coverage regardless of immigration status. FAMIS Prenatal Coverage participants are enrolled in the managed care program and receive the same benefits as other pregnant individuals; comprehensive coverage, including doctor visits, prescription medication, prenatal screening and testing, dental care, behavioral health services, and more. Coverage spans prenatal, labor and delivery, and postpartum services, and is effective through the end of the month in which the 60th postpartum day occurs. FAMIS Prenatal Coverage members are not eligible for extended postpartum coverage under the 12 months postpartum demonstration.

12 Months Contraceptive Coverage

In 2021, DMAS began covering a 12-month supply of contraception for Medicaid and FAMIS members. Medicaid members may pick up a full year's supply of contraception at a single visit to their pharmacy. Contraception is most effective when used consistently and correctly. For patients using contraceptive pills, patches, rings, and self-administered injections, delays in prescription refills may result in missing doses, thus increasing the chance of pregnancy. A variety of barriers can prevent patients from routinely visiting their pharmacy, including having limited access to transportation, inflexible work schedules, and disruptions in childcare. When Medicaid members have the option to receive a 12-month supply of contraception, they are more likely to have access to the supplies they need to carry out their reproductive life plans.

Doula Project

At 17.4 deaths per 100,000 live births, the nation suffers from a higher rate of maternal mortality than any other developed country. Regardless of their income or education levels, America's maternal mortality rates are among the highest among Black women and Native American women. According to the Centers for Disease Control and Prevention (CDC), approximately 60 percent of these deaths are preventable. To combat maternal morbidity and unintended consequences of pregnancy that result in life-altering health challenges, DMAS placed emphasis on the need for community doula care for women during the perinatal period, at labor and delivery, and during the postpartum period. According to the American Pregnancy Foundation, doulas serve to reduce the number of Cesarean sections, which increase the risk of maternal death by infection and hemorrhage and reduce the duration of labor by a quarter. Virginia Medicaid introduced a model of care to include doula services as a cost-saving measure and an effective way to improve health outcomes. With the approval of its State Plan Amendment in October 2021, Virginia became the fourth state in the country to implement a doula Medicaid benefit.

Virginia is the fourth state in the nation to offer community doula services as a benefit for Medicaid members. Doulas in Virginia are State-certified and register with the Virginia Medicaid program. Doulas are trained, community-based, non-medical professionals who offer a broad set of nonclinical, continuous support services to pregnant individuals throughout pregnancy, at labor and delivery, and during the postpartum period. Community doulas provide support to pregnant and postpartum women through their grounding within the community, languages spoken, and shared value systems of the populations they serve. The emotional, physical, and informational support provided by doulas include childbirth education, lactation support, and referrals for health or social services. A State-certified community doula is certified by the Virginia Certification Board.[21]

VDH, through collaboration with DMAS and the Virginia Doula Task Force, established the minimum requirements to be a State-certified community doula in Virginia based on the core competencies for doula certification used by national organizations and community-based organizations in Virginia. These regulations were effective as of January 6, 2022. As defined by VDH, a “community-based doula" means a doula who often has shared lived experiences and is trained to provide extended, culturally congruent support to families throughout pregnancy to include antepartum, intrapartum, during labor and birth, and up to one year postpartum.

A State-certified community doula is a trained, community-based nonmedical professional who provides continuous physical, emotional, and informational support to a pregnant person during the antepartum or intrapartum period or during the period up to one year postpartum who has been certified by an approved entity recognized by the Board of Health and Virginia Certification Board. Community doulas provide the member with continuous physical, emotional, and support services. These support services are nonclinical, peer-to-peer activities that engage, educate, and support an individual's prenatal, antenatal, and postpartum self-care to improve the individual’s health and wellness.

Additional strategies adopted by DMAS to improve maternal and infant health outcomes include education and outreach, focus on special populations, increasing accountability and transparency, while strengthening partnerships with other stakeholders. DMAS’ strategy also strengthens early childhood interventions and curbs tobacco use among pregnant women. DMAS partners with VDH and DBHDS on initiatives to improve birth outcomes.

CMS Affinity Groups: State and Federal Partnership

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

[21] Virginia Department of Medical Assistance Services. Community Doula Program. Available at: https://www.dmas.virginia.gov/for-providers/maternal-and-child-health/community-doula-program/. Accessed on: July 20, 2022.

- *Infant Well Child Visits:* A workgroup designed to look into increasing the rate of infant well-child visits to improve overall child health, as they are more likely to receive appropriate screenings, vaccinations, and other needed services. This DMAS team is led by the Maternal and Child Health Unit, and includes MCOs and state provider partners.

EPSDT and Utilization

EPSDT services, Medicaid's comprehensive and preventive child health program for individuals under the age of 21, includes periodic screening, pediatric and adolescent preventive care and screenings, vision, dental and hearing services. The EPSDT benefit is geared to the early assessment of children's healthcare needs through periodic screenings. The goal of EPSDT is to ensure that health problems are diagnosed and treated as early as possible. In addition, Medicaid is required to provide any medically necessary healthcare to correct and ameliorate physical and mental conditions.

EPSDT Specialized Services are medically necessary treatment services for children that are not routinely covered through Virginia Medicaid. The six most commonly requested EPSDT Specialized Services are listed below. Determination of whether a service is medically necessary is made on a case-by-case basis, taking into account a particular child's needs.

- Assistive technology
- Hearing aids
- Private duty nursing
- Behavioral therapy
- Personal care
- Medical formula and nutritional supplements

DMAS is committed to monitoring the utilization of EPSDT services for Virginia Medicaid members, with a goal of increasing utilization of these services to ensure health and developmental concerns are diagnosed as early as possible, that the treatment is provided before problems become complex, and that medically justified services are provided to treat or correct identified problems.

Additional Core Quality Improvement Activities

Population Health

Population health is defined as the health of a population as measured by health status indicators and as influenced by social, economic, and physical environments; personal health practices; individual capacity and coping skills; human biology; early childhood development; and health services, as well as the distribution of such outcomes within the population.[22]

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

[22] Center for Urban Population Health. Population Health Framework. Available at: https://www.cuph.org/population-health-framework.html. Accessed on: July 14, 2022.

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.[23] According to NCQA, at a minimum, PHM addresses the needs of the member by focusing on the following key areas:[24]

- 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
- Sexually transmitted disease screenings
- Depression screenings

[23] The American Hospital Association Center for Health Innovation. Population Health Management. Available at: https://www.aha.org/center/population-health-management. Accessed on: July 14, 2022.
[24] The National Committee for Quality Assurance. Population Health Management Resource Guide.

- 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.[25] These high utilizers of ED services typically do not receive the right care, with the right provider, at the right time—or at the right price. High utilizers often present to the ED with low-acuity, chronic health concerns that are less appropriately addressed in the ED, which is designed to care for acute, episodic, and emergent health conditions.

Establishing comprehensive primary care relationships with these individuals may reduce ED visits and decrease hospital charges, while providing the right care in the best setting for the patient. Ultimately, a patient's relationship with his or her community-based, primary care provider (PCP) is supported and strengthened, leading to improved adherence to treatment recommendations and continuity of care. Reinforcement of the proper use of the healthcare

[25] Matsumoto CL, O'Driscoll T, Madden S, Blakelock B, Lawrance J, Kelly L. Defining "high-frequency" emergency department use: Does one size fit all for urban and rural areas?. Can Fam Physician. 2017;63(9):e395-e399. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5597030/. Accessed on: Aug 4, 2022.

delivery system teaches and enables participants to have their needs met by making informed decisions and directly accessing appropriate care.

★ *Families First Coronavirus Relief Act (FFCRA)* ★ [26]

To support states and promote stability of coverage during the COVID-19 pandemic, the Families First Coronavirus Relief Act (FFCRA) provided DMAS access to enhanced funding to support Medicaid members during the PHE. As one of several conditions of receiving the temporary Federal Medical Assistance Percentage (FMAP) increase under FFCRA, states are required to maintain enrollment of individuals in Medicaid until the end of the month in which the PHE ends (the continuous coverage requirement). The continuous coverage requirement applies to individuals enrolled in Medicaid as of March 18, 2020, or who were determined eligible on or after that date, and has allowed people to retain Medicaid coverage and get needed care during the pandemic. Since that time, the Medicaid population has grown from 1.5 million members to approximately 2.1 million members. When the federally declared PHE ends, DMAS and VDSS will be charged with evaluating the entire population for continued eligibility in the Medicaid program.

While most people will continue to be eligible for Medicaid or Marketplace coverage when the Commonwealth begins to redetermine eligibility again, the potential for loss of coverage for thousands of residents due to administrative reasons (e.g., failure to return the renewal form) is significant. Black, Latino(a), and other people of color will be most at risk, since they are significantly overrepresented in state Medicaid/ CHIP programs.

DMAS has begun work to transition Medicaid members back to normal operations once the continuous coverage requirements have ended. DMAS is collaborating with stakeholders across the Commonwealth to include sister agencies, health plans, advocates, application assisters, and providers to ensure a smooth transition for members and partners. Virginians who are no longer eligible for Medicaid will receive information they need to choose other health insurance options, and DMAS will provide these individuals with referrals to the Federal Marketplace. This includes collaboration with the health plans to reach out to members who do not complete the redetermination process to assist with enrollment in other health coverage. DMAS has developed toolkits for advocates, providers, legislators, health plans, and other key stakeholder partners to ensure a coordinated effort to educate Medicaid members about the upcoming redetermination process.

Plan to Address Health Disparities

DMAS defines health disparities and social determinants of health (SDOH) as:

- Health disparity is defined as a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health;

[26] ★ Governor Glenn Youngkin's identified priority for the Medicaid program that focuses on behavioral health enhancement. Goal 2: Promote Access to Safe, Gold-Standard Patient Care.

cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.[27]

- SDOH are defined as conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life risks and outcomes.

DMAS is committed to improving the health and well-being of all Virginians through access to high-quality healthcare coverage and services. In order to address health disparities, DMAS established an internal workgroup focused on diversity, opportunity, and inclusion. The workgroup's purpose is to develop an agency-wide strategy to ensure that DMAS provides access to quality services for all Medicaid members and providers.

DMAS' framework to achieve a reduction in health disparities is adapted from an Institute for Healthcare Improvement's white paper.[28]

Plan to Reduce Health Disparities

DMAS identifies member characteristics in pediatric and adult populations including age, race, ethnicity, sex, primary language, geographic location, and disability status and provides the information to the MCOs at the time of enrollment and in enrollment change files. DMAS applies QI principles in designing initiatives to reduce health disparities. DMAS updates initiatives and measures in consideration of best or evidence-based practices, as needed, to reduce health disparities. DMAS identifies, evaluates, and plans to reduce—to the extent practicable—health disparities as follows:

[27] U.S. Department of Health and Human Services. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I Report: Recommendations for the Framework and Format of Healthy People 2020 [Internet]. Section IV: Advisory Committee findings and recommendations [cited 2010 January 6]. Available at: http://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf. Accessed on: July 11, 2022.

[28] 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.

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.[29] DMAS delivers one-third of all babies born in the Commonwealth or approximately 33,000 deliveries per year. DMAS covers a full spectrum of services for pregnant women from prenatal care to opioid treatment. DMAS partners with the VDH and DBHDS on initiatives to improve birth outcomes. However, Virginia still has racial and health disparities.

To identify, evaluate, and reduce—to the extent practicable—health disparities based on age, race, ethnicity, sex, primary language, geographic location, and disability status in birth outcomes, DMAS conducts an annual study of Medicaid and CHIP prenatal care and associated birth outcomes. The purpose of the study is to determine the extent that women receive early and adequate prenatal care, and the clinical outcomes that are associated with the Medicaid-paid births. Overall, a higher percentage of women in the study population received early and adequate prenatal care compared to women who were not continuously enrolled in Medicaid prior to delivery. Additionally, there was a lower percentage of births to women in the study population prior to 37 completed weeks of gestation (i.e., preterm) or weighing less than 2,500 grams (i.e., low birth weight [LBW]) when compared to births to women who were not

[29] Centers for Disease Control and Prevention. Infant Mortality Rates by State, reviewed March 3, 2022. Available at: https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm. Accessed on: Aug 4, 2022.

continuously enrolled in Medicaid prior to delivery. The most promising study indicator results were identified among births to women in FAMIS MOMS. Though limited in number, births to these women had the highest rate of early and adequate prenatal care, the lowest rates of preterm birth or LBW, and the highest rate of non-NICU singleton births with two or more office visits with a PCP in the 30 days following birth. Demographic categories included the following:

Table 4—Demographic Categories

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

Demographic Category	Category Values
	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 *Prediabetes* performance measure. DMAS contracted with HSAG in 2021 to develop a custom PM related to identifying members with prediabetes who were prescribed metformin and adhered to metformin during the measurement year. Table 5 displays the CY 2019 and CY 2020 prediabetes PM results stratified by Medicaid program, MCO, geographic region, and select demographics (i.e., age, gender, and race).

Table 5—Prediabetes PM Results

Rate Stratification	CY 2019 Results	CY 2020 Results
Rate 1—Prevalence of Prediabetes		
Virginia Total	4.68%	4.04%
Medicaid Program		
CCC Plus	6.66%	6.11%
Medallion 4.0	3.58%	3.35%
More Than One Medicaid Program	6.98%	6.52%
MCO		
Aetna	4.88%	4.06%
HealthKeepers	4.89%	4.29%
Molina	4.51%	3.52%
Optima	4.50%	4.18%
United	4.58%	3.88%
VA Premier	4.30%	3.78%
More Than One MCO	6.37%	5.25%
Geographic Region		
Central	4.73%	4.03%
Charlottesville/Western	3.92%	3.67%
Northern & Winchester	4.88%	3.93%
Roanoke/Alleghany	4.24%	3.70%
Southwest	4.84%	4.20%
Tidewater	5.02%	4.43%
Age		
18–44 Years	3.01%	2.48%
45–60 Years	8.32%	7.63%
Gender		
Male	4.39%	3.56%
Female	4.83%	4.35%
Race		
White	4.46%	3.81%
Black/African American	4.97%	4.47%
Asian	5.82%	4.75%
Southeast Asian/Pacific Islander	4.02%	3.69%
Hispanic	2.74%	2.54%
More Than One Race/Other/Unknown	4.15%	3.19%
Rate 2—Metformin Use for Prediabetics		
Virginia Total	6.97%	7.37%
Medicaid Program		
CCC Plus	4.58%	4.53%
Medallion 4.0	8.77%	8.80%
More Than One Medicaid Program	8.89%	7.93%
MCO		
Aetna	7.61%	7.86%

Rate Stratification	CY 2019 Results	CY 2020 Results
HealthKeepers	6.80%	7.55%
Molina	6.70%	6.80%
Optima	6.09%	6.52%
United	6.13%	5.88%
VA Premier	8.05%	8.40%
More Than One MCO	7.48%	8.90%
Geographic Region		
Central	6.93%	7.44%
Charlottesville/Western	9.04%	8.60%
Northern & Winchester	6.66%	6.78%
Roanoke/Alleghany	8.18%	9.08%
Southwest	8.48%	9.85%
Tidewater	5.34%	5.75%
Age		
18–44 Years	10.02%	10.86%
45–60 Years	4.40%	4.65%
Gender		
Male	4.77%	4.51%
Female	8.00%	8.76%
Race		
White	7.20%	8.18%
Black/African American	6.55%	6.43%
Asian	5.00%	6.86%
Southeast Asian/Pacific Islander	*	*
Hispanic	*	*
More Than One Race/Other/Unknown	10.55%	7.39%
Rate 3—Adherence to Metformin		
Virginia Total	42.17%	45.22%
Medicaid Program		
CCC Plus	55.32%	49.66%
Medallion 4.0	35.23%	44.03%
More Than One Medicaid Program	54.69%	45.83%
MCO		
Aetna	46.90%	50.40%
HealthKeepers	40.86%	42.49%
Molina	35.29%	39.36%
Optima	39.16%	46.85%
United	38.96%	46.23%
VA Premier	45.45%	43.51%
More Than One MCO	46.34%	60.00%
Geographic Region		
Central	39.23%	44.44%
Charlottesville/Western	42.86%	42.86%

Rate Stratification	CY 2019 Results	CY 2020 Results
Northern & Winchester	41.51%	46.69%
Roanoke/Alleghany	48.31%	42.94%
Southwest	52.54%	47.34%
Tidewater	36.32%	46.71%
Age		
18–44 Years	38.02%	41.07%
45–60 Years	50.15%	52.77%
Gender		
Male	50.23%	50.34%
Female	39.92%	43.95%
Race		
White	47.21%	48.88%
Black/African American	35.14%	39.73%
Asian	46.15%	44.64%
Southeast Asian/Pacific Islander	*	*
Hispanic	*	*
More Than One Race/Other/Unknown	43.10%	48.68%

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

The Virginia total Prevalence of Prediabetes rates for CY 2019 and CY 2020 remained stable, with a rate ranging between 4 and 5 percent. According to a 2016 CDC estimate, 9 percent of adults in Virginia (among all payers) have been diagnosed with prediabetes, indicating that the prevalence of prediabetes may be underrepresented in the data used for measure calculation, as the CY 2020 rate was nearly half that of the CDC estimates.[30]

The Virginia total rate of Metformin Use for Prediabetics was stable between CY 2019 and CY 2020, with rates higher among those 18–44 years of age, females, and the White race. The lowest rates of Metformin Use for Prediabetics were for members 45–60 years of age, males, and the Black/African American population. According to research, approximately 14 individuals would need to receive metformin over a three-year period to prevent one individual from being diagnosed with diabetes.[31] 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.

[30] Ibid.
[31] Ibid.

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 6 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 6—Colorectal Cancer Screening PM Results

Rate Stratification	CY 2021 Results
Virginia Total	32.73%
Medicaid Managed Care Program	
CCC Plus	40.35%
Medallion 4.0	28.24%
More Than One Medicaid Program	35.80%
Medicaid Delivery System	
Managed Care	35.08%
Fee-for-Service	4.84%
More than One Delivery System	22.72%
Virginia Total	32.73%
MCO	
Aetna	31.10%
HealthKeepers	36.54%
Molina	25.72%
Optima	40.52%
United	31.36%
VA Premier	37.96%
More Than One MCO	39.01%
Virginia Total	32.73%
Geographic Region	
Central	31.90%
Charlottesville/Western	31.07%
Northern & Winchester	32.15%
Roanoke/Alleghany	32.62%
Southwest	31.61%
Tidewater	35.67%
Virginia Total	32.73%
Age	
51-64 Years	31.89%
65-75 Years	35.73%
Virginia Total	32.73%
Gender	
Male	28.40%
Female	36.07%
Virginia Total	32.73%

Rate Stratification	CY 2021 Results
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. Empower communities to promote health equity.
4. Influence health, healthcare, and public policy in order to reduce health disparities.
5. Enhance the capacity of public health and its partners to reduce health disparities.

MCO Level

Each MCO participates in DMAS' efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

DMAS requires its MCOs to submit an annual report outlining their efforts to address health disparities in the managed care populations. The MCOs are encouraged to refer to the VDH's OHE for information regarding health disparities in the Commonwealth of Virginia. At the level of the individual Medicaid or CHIP member, the MCOs are developing methods to stratify the data by high-risk disparate populations to identify whether any subset of the population is negatively or positively impacted. DMAS collaborates with the MCOs and OHE using DMAS' internal analysis of performance measure data at the population level, on OHE's many initiatives to reduce health disparities.

Healthy Opportunities—Health-Related Social Needs (HRSNs)

Central to the Commonwealth's effort to improve access, quality, and timeliness of care is a commitment to address the social and environmental factors that directly impact health outcomes and cost, or, the HRSNs. HRSNs disproportionately impact Medicaid members, increase the risk of developing chronic conditions, drive healthcare costs, and are closely tied to health outcomes.

The HRSNs include the environment and conditions in which people are born, grow, live, work, and age. Food insecurity, housing instability, safety, violence, trauma, and transportation challenges are considered critical barriers to an individual's health status.

DMAS, working with the MCOs, is addressing the HRSNs that are impacting members in several ways, including:

- Screening members for food insecurity, housing instability, transportation needs, and interpersonal violence.
- Providing resources and assistance in securing health-related services and resource navigation to members identified with unmet health-related needs.
- Supporting public-private evidence-based interventions designed to reduce costs and improve health by addressing eligible Medicaid members' housing instability, transportation insecurity, food insecurity, and interpersonal violence.
- Identifying areas of high disparity to guide resources and to work with communities to address HRSNs.
- Maintaining a resource platform accessible to members both online and through the MCO's call center.

Oversight and Governance of the Quality Strategy

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

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

Medicaid Managed Care Quality Collaborative

The Medicaid Managed Care Quality Collaborative has been active for more than a decade and continues to be the main platform for the MCOs, EQRO, and DMAS to share lessons learned, best practices, and potential solutions to common opportunities for improvement. The collaborative is facilitated by the DMAS Quality and Population Health staff members and meets approximately four times per year in Richmond. The Collaborative continues to be recognized as the pillar for managed care quality.

Reviewing and Evaluating the Effectiveness of the Quality Strategy

42 CFR §438.10 and 42 CFR §438.340

Data collection and analysis and other evaluation activities are used in the evaluation of the effectiveness of the interventions described in the Quality Strategy. Included within the analysis are trends and comparisons with established goals and benchmarks. Examples of these data include results of performance measures and PIPs, as well as other data from the FFS program and data reported by MCOs.

The Quality Strategy is considered a companion document to the EQR technical reports. The annual EQR technical reports encompass specific details of the assessment, results, and

recommendations related to the goals and strategies found in the Quality Strategy. This information is used to assess the ongoing effectiveness of the currently stated goals and strategies and provides a roadmap for potential changes and the development of new goals and strategies. Quality Strategy effectiveness, progress, and updates are also reported in Virginia's CMS mandatory waiver reports. Results of the review are made available on the DMAS website.

Annual EQR technical reports are required by CMS and include the EQRO's assessment of the effectiveness of the Quality Strategy. As such, the Quality Strategy is reviewed for its effectiveness annually by the EQRO. The EQRO findings on the quality, access, and timeliness of DMAS' managed care delivery system are included in the EQRO's annual technical report(s) for the managed care programs. An assessment of the effectiveness of the State's Quality Strategy and DMAS' progress on its Quality Strategy goals and objectives are found in Appendix F.

Community Involvement for Quality Development

Ensuring that the voice of the community is heard is important to DMAS. Quality is a community process that is continuously informed and shaped by the voices and choices made by internal and external stakeholders. DMAS ensures transparency and the inclusion of community feedback into its Quality Strategy development.

DMAS also employs a social media strategy to increase public access to information, generate positive public relations, interface with the media, support MCO community efforts, and gather information to increase business intelligence. DMAS distributes public-facing information about the DMAS programs using press releases, website content, public and media relations, email newsletters, and social media.

Medicaid Contract Provisions

42 CFR §438.66 and 438.340

Contract Compliance

DMAS monitors each MCO's compliance with its contract, and with the goals identified in the Quality Strategy, via an internal quality assurance program and through on-site operational systems reviews of compliance with various quality assessment and improvement standards. DMAS' EQRO conducts the operational systems reviews at least once every three years. The purpose of the reviews is to determine an MCO's understanding and application of the Final Rule and contractually required standards from a review of documents, observation, and interviews with key MCO staff members, as well as file reviews conducted during evaluation. The operational systems review also includes an assessment of each MCO's QI structure. This structure is necessary to facilitate QI and ongoing assessment of performance measures and PIPs. This process enables DMAS and the MCOs to assess each MCO's performance in achieving quality goals specified in the Quality Strategy. The operational systems review report enables each MCO to implement remediation plans to correct any areas of deficiency found during the operational systems review. The report also helps DMAS determine each MCO's compliance with the Final Rule and DMAS' contract and to identify areas of the contract that need to be modified or strengthened to ensure that an MCO complies with the requirements.

To assess the quality and appropriateness of care/services for members with routine and SHCN, DMAS also regularly reviews the MCOs' contractually required reports and deliverables.

DMAS monitors all aspects of the managed care program, including the performance of each MCO in at least the following areas:

- Administration and management
- Appeal and grievance systems
- Claims management
- Enrollee materials and customer services, including activities of the beneficiary support system
- Finance, including medical loss ratio (MLR) reporting
- Information systems, including encounter data reporting
- Marketing
- Medical management, including utilization management and case management
- Program integrity
- Provider network management, including provider directory standards
- Availability and accessibility of services, including network adequacy standards
- QI
- Other contract provisions, as needed

DMAS reviews all deliverables submitted by the MCOs and, as applicable, requires revisions. DMAS approves the deliverables as complete when fully compliant with the contract.

Use of National Performance Measures and Performance Measure Reporting

42 CFR 438.330

Performance Measure Reporting

DMAS uses HEDIS and the CMS Child and Adult Core Set whenever possible to measure the MCOs' performance with specific indices of quality, timeliness, and access to care. DMAS' EQRO conducts CMS Core Measure Sets and NCQA HEDIS Compliance Audits™ of the MCOs annually and reports the results to DMAS. DMAS is implementing processes and MCO requirements in order to report all CMS Child Core Set measures and all Adult Behavioral Health measures in the CMS Core Measure Set by 2024. As part of the annual EQR technical report, the EQRO trends each MCO's rates over time and also performs a comparison of the MCOs' rates and a comparison of each MCO's rates to selected national benchmarks. The EQRO uses trending to compare rates year-over-year when national benchmarks are not available to determine if improvement in the related measures is occurring.

DMAS assigns the performance measures to the following domains of quality, timeliness, and access (Table 7):

Table 7—Assignment of Performance Measures to the Quality of, Access to, and Timeliness of Care Domains

Performance Measure	Quality	Access	Timeliness
Taking Care of Children			
Children and Adolescents' Access to Primary Care Practitioners	✓	✓	
Childhood Immunization Status—Combination 3	✓		
Well-Child Visits in the First 30 Months of Life	✓	✓	✓
Child and Adolescent Well-Care Visits	✓	✓	✓
Immunizations for Adolescents	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
Access and Preventive Health			
Breast Cancer Screening	✓		✓
Cervical Cancer Screening	✓		✓
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	✓		
Colorectal Cancer Screening	✓		✓
Adults' Access to Preventive/Ambulatory Health Services—Total		✓	
Living With Illness			
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, *HbA1c Control (<8.0%)*, *HbA1c Poor Control (>9.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*	✓		
Controlling High Blood Pressure	✓		
Asthma Medication Ratio	✓		
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*	✓		
Pharmacotherapy Management of COPD Exacerbation	✓		
Behavioral Health			
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓

Performance Measure	Quality	Access	Timeliness
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	✓	✓	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	✓		
Metabolic Monitoring for Children and Adolescents on Antipsychotics	✓		
Initiation and Engagement of Substance Use Disorder Treatment	✓		✓
Initiation and Engagement of Substance Use Disorder Treatment	✓		
Follow-up After Emergency Department Visit for Substance Use	✓		✓
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	✓		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	✓		
Outpatient Behavioral Health Encounter in the Last 12 Months for Population with Behavioral Health Condition	✓		✓
Follow-up After Emergency Department Visit for Mental Illness	✓		✓
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓		
Utilization Measures			
Use of Imaging Studies for Low Back Pain	✓		
Inpatient Utilization—General Hospital/Acute Care	✓		
Ambulatory Care—ED Visits	✓	✓	✓
Mental Health Utilization	✓		
Diabetes Short-Term Complications Admission Rate	✓		
Congestive Heart Failure Admission Rate	✓		
COPD and Asthma in Older Adults Admission Rate	✓		
Plan All-Cause Readmissions	✓		
Long-Term Care			
Use of High-Risk Medications in the Elderly	✓		
LTSS Enrollees Using Consumer-Directed Care	✓		
Nursing Facility Residents Hospitalization Rate	✓		
Nursing Facility Diversion Rate	✓		
Reassessments	✓		✓
Documentation of Care Goals	✓		
Advance Planning Directives	✓		

Performance Measure	Quality	Access	Timeliness
Members Who Re-Entered the Community After a Short-Term Nursing Facility Stay	✓		
Members Who Transitioned from a Nursing Facility to the Community Who Returned to the Nursing Facility Within 90 Days	✓		
Members Who Transitioned from a Nursing Facility to the Waiver and Remained in the Waiver for at Least One Year	✓		
Waiver Members Who Transitioned to a Nursing Facility and Remained in a Nursing Facility for at Least 180 Days	✓		
Follow-Up After Discharge Within 30 Days	✓	✓	✓
Prevalence of Pressure Ulcers Among LTSS Members	✓		
Injury Prevention	✓		
Use of Opioids			
Use of Opioids at High Dosage	✓		
Use of Opioids from Multiple Providers	✓		
Continuity of Pharmacotherapy for Opioid Use Disorder	✓		

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

The Annual EQR Technical Report

Medallion 4.0:

https://www.dmas.virginia.gov/about-us/office-of-quality-and-population-health/quality-activities/

CCC Plus:

https://www.dmas.virginia.gov/about-us/office-of-quality-and-population-health/quality-activities/

DMAS posts the MCO dashboards annually online in the following location:

The MCO Dashboard

https://www.dmas.virginia.gov/#/dashboards

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 as of 2022. 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

DMAS developed its MCO Quality Rating System to serve as DMAS' alternative Medicaid managed care quality rating system. The Quality Rating System 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 Quality Rating System updates geared toward enhancement of transparency and as a vehicle to assist members in MCO selection.

State Monitoring and Evaluation of MCOs' Contractual Compliance

42 CFR §438.66

Compliance (Operational Systems) Review

42 CFR §438.358 and §438.330

According to 42 CFR §438.358, which describes the activities related to EQRs, a state or its EQRO must conduct a review within a three-year period to determine a Medicaid MCO's compliance with standards established by the state for access to care, structure and operations, and quality measurement and improvement. The review must include those standards detailed in 42 CFR §438 Subpart D as well as those detailed in 42 CFR §438.56, §438.100, §438.114, and §438.330. To meet this requirement, DMAS contracts with its EQRO to perform a comprehensive review of compliance of the MCOs. Operational systems reviews adhere to guidelines detailed in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.

The purpose of the operational systems review is to determine the extent to which Medicaid and CHIP MCOs are in compliance with federal standards. The 14 compliance standards are derived from requirements in the Final Rule. The 14 compliance standards are listed below:

- Enrollment and Disenrollment (42 CFR §438.3; 42 CFR §438.56)
- Member Rights and Confidentiality (42 CFR §438.3; 42 CFR §438.10; 42 CFR §438.100; 42 CFR §438.128; 42 CFR §438.224)
- Member Information (42 CFR §438.10)
- Emergency and Poststabilization Services (42 CFR §438.10; 42 CFR §438.114; 42 CFR §422.113; 42 CFR §438.114)
- Subcontractual Relationships and Delegation (42 CFR §438.230)
- Adequate Capacity and Availability of Services (42 CFR §438.68; 42 CFR §438.206; 42 CFR §438.207)
- Coordination and Continuity of Care (42 CFR §438.208)
- Coverage and Authorization of Services (42 CFR §438.3; 42 CFR §438.210; 42 CFR §438.211; 42 CFR §438.213; 42 CFR §438.214; 42 CFR §438.404)
- Provider Selection (42 CFR §438.12; 42 CFR §438.206; 42 CFR §438.214; 42 CFR §438.230)
- Practice Guidelines (42 CFR §438.236)
- Health Information Systems (42 CFR §438.242)
- Quality Assessment and Performance Improvement Program (42 CFR §438.330)
- Grievance and Appeal Systems (42 CFR §438.42; 42 CFR §438.400; 52 CFR §438.402; 42 CFR §438.406; 42 CFR §438.408; 42 CFR §438.410; 42 CFR §438.414; 42 CFR §438.416; 42 CFR §438.420; 42 CFR §438.424)
- Program Integrity (42 CFR §438.10; 42 CFR §438.102; 42 CFR §438.106; 42 CFR §438.214; 42 CFR §438.602; 42 CFR §438.608; 42 CFR §438.610)

DMAS, with CMS encouragement, utilizes other monitoring processes, review of deliverables, and expands the scope of the reviews to cover compliance with federal and state requirements beyond those specified in 42 CFR §438. These include other state statutory, regulatory, or contractual requirements such as the following areas:

- Access to providers, including accurate provider directory, timeliness of available appointments, physical accessibility of service sites and medical and diagnostic equipment, accessibility of information (compliance with web-based information, literacy levels of written materials, and alternate formats), and other accommodations.
- Availability and use of HCBS as alternatives to institutional care, so individuals can receive the services they need in the most integrated setting appropriate.
- Credentialing or other selection processes for LTSS providers, including those required where the enrollee can choose their caregiver (such as verification of completion of criminal background checks).
- Person-centered assessment; person-centered care planning; service planning and authorization; service coordination and care management for LTSS, including authorization/utilization management for LTSS; and any beneficiary rights or protections related to care planning and service planning such as conflict-free case management, self-direction of services, and appeal rights related to person-centered planning.

- Integration of managed medical, behavioral, and LTSS.

Results from operational systems reviews assist DMAS in determining each MCO's compliance with federal and Commonwealth requirements. The operational systems review results also assist DMAS in identifying any areas of the contract that need modification or strengthening to ensure that the MCOs can achieve the goals identified in the Quality Strategy. DMAS' EQRO also assists DMAS with a review of corrective action plans (CAPs) submitted by the MCOs to correct areas found to be deficient in the operational systems review.

Using Incentives and Intermediate Sanctions to Drive Improvement

42 CFR §438 Subpart I

Financial Transparency and Accountability

DMAS seeks financial transparency and accountability in its Medicaid programs and continually evaluates the programs to ensure that they are operating as efficiently and effectively as possible. 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 (CMP) 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 8.

Table 8—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 MCO 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 CMP that includes a compliance review committee and a compliance collaborative.

Clinical Efficiencies

In December 2016, JLARC published a study titled Managing Spending in Virginia's Medicaid Program.[32] Among the study's recommendations, JLARC called for DMAS to work with its actuary to identify potential inefficiencies in the Medallion 4.0 and CCC Plus programs and adjust capitation rates to account for these efficiencies. The Virginia General Assembly subsequently enacted budget language to execute this recommendation. To implement this

[32] Virginia Joint Legislative Audit & Review Commission. Managing Spending in Virginia's Medicaid Program. Available at: http://jlarc.virginia.gov/medicaid-2016.asp. Accessed on: July 14, 2022.

mandate, DMAS contracted with its actuary to identify clinical efficiencies under its managed care program. The clinical efficiency measures focus on medically unnecessary, avoidable, or potentially preventable spending for hospital admissions, hospital readmissions, and ED visits, as well as efficient utilization and management of prescription drugs. Beginning in SFY 2020, DMAS used these analyses to apply a .25 percent withhold and to adjust capitation rates under the Medallion 4.0 and CCC Plus programs.

Value-Based Payments

The VBP program is of strategic importance to DMAS' Quality Strategy, which is why this program is one of the key interventions outlined in that section. Value-based purchasing is a broad set of strategies intended to improve healthcare quality, outcomes, and efficiency by linking financial and nonfinancial incentives to performance. Measurement is based on a set of defined outcome metrics of quality, cost, and patient-centered care. DMAS requires the MCOs to maintain a VBP strategy that follows the alternate payment model framework in the white paper developed by the Health Care Payment Learning & Action Network with a special emphasis on models in categories three and four.[33] The MCO will assure annual improvement in the level of VBP penetration until such time that the MCO has a minimum of 25 percent of its relevant spending for medical services governed under VBP arrangements. DMAS expects the MCO's VBP Plan to consider, but not be limited to, the following DMAS goals:

- Improved birth outcomes.
- Appropriate, efficient utilization of high-cost, high-intensity clinical settings.
- Improved MCO performance on DMAS Clinical Efficiency Performance Measures, including potentially preventable and/or avoidable ED visits, hospital admissions, and hospital readmission.

Nursing Facility Value-Based Purchasing

In 2021, the Virginia General Assembly directed DMAS to establish an NF VBP program designed to improve the quality of care furnished to Medicaid members. This program seeks to improve the quality and outcomes of care furnished to Medicaid members by enhancing performance accountability in the areas of staffing and avoidance of negative care events. DMAS has developed a provider-facing NF focused VBP program targeting specific performance measures for eligible NFs.

To prioritize simplicity and reduce administrative burden, DMAS selected PMs that are already standard reporting for Virginia nursing facilities through CMS' Minimum Data Set (MDS), Nursing Home (NH) Compare claims-based quality measures and Payroll Based Journal NF staffing measures. Utilizing these established measure sources allows Virginia nursing facilities to participate in the NF VBP program without additional reporting requirements. For SFY 2023, DMAS selected six performance measures that aligned with DMAS and the General Assembly's quality initiatives. The performance measures include staffing measures such as reducing the number of days NFs do not meet the CMS-mandated minimum number of staffed RN hours and the weighted average of case-mix adjusted total nurse staffing hours. The performance measures also include avoidance of negative care events measures such as reducing pressure

[33] Health Care Payment Learning & Action Network. Accelerating and Aligning Primary Care Payment Models. Available at: https://hcp-lan.org/workproducts/pcpm-whitepaper-final.pdf. Accessed on: July 14, 2022.

ulcers, UTIs, hospitalizations, and ED visits. The program targets will continue to evolve over time.

The performance measures are listed in Table 9. Performance measure tiers and improvement thresholds are included in Table 10.

Table 9—SFY 2023 NF VBP Performance Measures

Performance Measure	Description	Domain	NF VBP Performance Weight
Days without minimum RN hours	Facility reported RN staffing hours each day within a quarter Required standards addressed 42 CFR §483.35(b)	Staffing	20%
Total Nursing Hours per Resident Day (RN + licensed practical nurse [LPN] + nurse aide hours)—Case-Mix Adjusted[34]	Total nurse staffing hours per resident day within a quarter, adjusted for case mix.	Staffing	20%
Number of Hospitalizations per 1,000 Long-Stay Resident Days[35,36]	Number of unplanned inpatient admissions or outpatient observation stays that occurred during a one-year period among long-stay residents.	Avoidance of Negative Care Events	15%
Number of Outpatient ED Visits per 1,000 Long-Stay Resident Days[37]	Number of all-cause outpatient ED visits occurring in a one-year period while the individual is a long-term NH resident.	Avoidance of Negative Care Events	15%

[34] Data for the Total Nursing Hours per Resident Day—Case-Mix Adjusted measure is found in the NH Provider Info File PQDC, 2021. Available at: https://data.cms.gov/provider-data/dataset/4pq5-n9py. Accessed on: Aug 4, 2022.

[35] Long-stay resident quality measures show the average quality of care for certain care areas in an NH for those who stayed in an NH for 101 days or more.

[36] Data for the Number of Hospitalizations per 1,000 Long-Stay Resident Days performance measure is found in the NH Quality Measure MDS Claims File PQDC—MDS Quality Measures, 2021. Available at: https://data.cms.gov/providerdata/dataset/djen-97ju. Accessed on: Aug 4, 2022.

[37] Data for the Number of Outpatient ED Visits per 1,000 Long-Stay Resident Days performance measure is found in the NH Quality Measure MDS Claims File PQDC—MDS Quality Measures, 2021. Available at: https://data.cms.gov/providerdata/dataset/djen-97ju. Accessed on: Aug 4, 2022.

Performance Measure	Description	Domain	NF VBP Performance Weight
Percentage of Long-Stay High-Risk Residents With Pressure Ulcers[38]	Percentage of long-stay, high-risk residents with Stage II-IV or unstageable pressure ulcers.	Avoidance of Negative Care Events	15%
Percentage of Long-Stay Residents With a UTI[39]	Percentage of long-stay residents who have had a UTI within the past 30 days.	Avoidance of Negative Care Events	15%

Table 10—NF VBP 2023 Performance Measure Attainment and Improvement Thresholds

Performance Measure Tiers	Fair Thresholds	Better Thresholds	Best Thresholds	Improvement Thresholds
Days Without Minimum RN Hours	13.00–16.00	5.00–12.00	0.00–4.00	>5%; Up to the Best Tier*
Total Nurse Staffing Hours per Resident Day (RN, LPN, certified nursing assistant [CNA])—Case-Mix Adjusted	3.08–3.19	3.20–3.30	3.31+	>0.5%; Up to the Best Tier*
Number of Hospitalizations per 1,000 Long-Stay Resident Days	1.36–1.75	1.00–1.35	0–0.99	>5%
Number of Outpatient ED Visits per 1,000 Long-Stay Resident Days	0.64–0.95	0.39–0.63	0–0.38	>5%
Percentage of Long-Stay High-Risk Residents With Pressure Ulcers	8.06–10.92	5.43–8.05	0–5.42	>5%
Percentage of Long-Stay Residents With a UTI	2.39–4.36	1.31–2.38	0–1.30	>5%

[38] Data for the Percentage of Long-Stay High-Risk Residents With Pressure Ulcers performance measure is found in the NH Quality Measure MDS Claims File PQDC—MDS Quality Measures, 2021. Available at: https://data.cms.gov/providerdata/dataset/djen-97ju. Accessed on: Aug 4, 2022.

[39] Data for the Percentage of Long-Stay Residents With a UTI performance measure is found in the NH Quality Measure MDS Claims File PQDC—MDS Quality Measures, 2021. Available at: https://data.cms.gov/providerdata/dataset/djen-97ju. Accessed on: Aug 4, 2022.

Performance Withhold Program

DMAS established the PWP for the MCOs to reinforce VBP principles by connecting financial incentives to the quality of care received by Virginia Medicaid managed care members. The PWP includes measures designed to evaluate managed care quality by setting performance standards and expectations for the MCOs in key areas influencing member health and health outcomes. Annually, DMAS reviews and updates measures, as appropriate. The PWP utilizes a financial incentive structure withholding a set percentage of the MCO's per member per month (PMPM) capitation rate system payments that the MCO can subsequently earn back based on performance attainment or improvement against the designated measures. By tying financial incentives to MCO performance on designated quality measures, the PWP focuses performance attainment and improvement efforts on areas of high importance to members.

Annually, DMAS retains a quality withhold from each MCO that is equal to 1 percent of each MCO's total capitation amount (i.e., the PMPM capitation rate multiplied by the total MCO monthly membership). By successfully meeting or exceeding the performance standards and expectations developed by DMAS, MCOs are eligible to earn back all, or a portion of their quality withhold. DMAS established the performance thresholds to foster MCOs' high performance and continuous improvement.

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

- NCQA's HEDIS
- CMS' Adult Core Set
- CMS Child Core Set
- AHRQ's PDIs

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

Procedures for Age, Sex, Race, Ethnicity, Disability Status and Primary Language Data Collection and Communication

42 CFR §438.340(b)(6)

To comply with the regulatory requirement for State procedures for race, ethnicity, primary language, and disability status, DMAS requires the MCOs to participate in Virginia's efforts to promote the delivery of service in a culturally competent manner to all members, including those with LEP and those with diverse cultural and ethnic backgrounds. DMAS continually monitors how age, sex, race, ethnicity, geographic location, disability status, and the primary language of members are collected, coded, and entered into the system to ensure that this information is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and with CMS requirements to improve the delivery of services in a culturally competent manner. DMAS provides demographic information for age, sex, race, ethnicity, geographic location, disability status, and primary language spoken to the MCOs as part of the member eligibility file. MCOs are required to use the data in their efforts to identify and overcome health disparities.

Identification of Members With Special Health Care Needs

42 CFR §438.208 and §438.340

DMAS defines children and youth with SHCN as members from birth through 21 years of age who have or are at increased risk for chronic physical, developmental, behavioral, or emotional condition(s) who may need health and related services of a type or amount over and above those usually expected for the child's age. DMAS also includes FC/AA programs, children zero to three years of age receiving early intervention services, and children and adolescents with significant behavioral health needs in its definition of SHCN.

Virginia's early intervention services (as described in 20 U.S.C. §1471 and 34 CFR §303.12, Part C) provides services to children from birth through two years of age with a disability in any one or more of the following areas: physical, cognitive, communication, social or emotional, or adaptive development, based on federal regulations of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA). Children are eligible in Virginia if they have a 25 percent delay in one or more areas of development, atypical development, or a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

MCOs are required to ensure that members of any age with a SHCN are assessed by an appropriate healthcare professional. For members of all ages that are identified as having SHCN, the MCOs must develop treatment plans in collaboration with the member's PCP, with member participation, and in consultation with any specialists providing care and services to the member. DMAS requires MCOs to ensure that members have direct access to specialists able to treat their needs. The treatment or care plan must be approved in a timely manner by the MCO. DMAS requires the MCOs to share with other MCOs serving the member with SHCN the results of its identification and assessment to prevent duplication of services.

School-Based Health Services

Virginia's public schools provide a range of school-based health services to students with SHCN in order to ensure their safety, attendance, and academic performance in the school setting. Some of those students are covered by Virginia's Medicaid or CHIP program, and some of the school-based health services provided are covered under these programs as medically necessary services. School divisions that are defined under State law as Local Education Agencies may enroll with DMAS as providers and seek reimbursement on a cost basis for providing those covered services when rendered by appropriately qualified providers to students enrolled in Medicaid or FAMIS. Because schools are reimbursed based on actual reported costs of providing the services, these services are carved out of managed care. School divisions submit interim claims through the FFS system, as required by CMS for such programs.

Eligibility

- Students must be eligible for Medicaid or CHIP on the date of service.
- Students must be 3 to 20 years of age.
- Students must be eligible for IDEA special education, and the reimbursed services must be written in the student's Individualized Education Plan (IEP).
- All treatment services must relate to a medical diagnosis and be determined to be medically necessary by an appropriately qualified individual.
- Ongoing treatment services must be based on a written plan of care prepared by an appropriately qualified individual. The plan must contain the diagnosis (disability), desired outcome (goals), nature of treatment (type of therapy), frequency of treatment (minutes/number per week), and duration (length of time).

The MCOs coordinate healthcare services for Medicaid and CHIP members who are identified as children with SHCN and who remain voluntarily enrolled in the MCO.

External Quality Review and Annual Independent Review of Access to and Quality and Timeliness of Care

42 CFR §438.350–§438.358

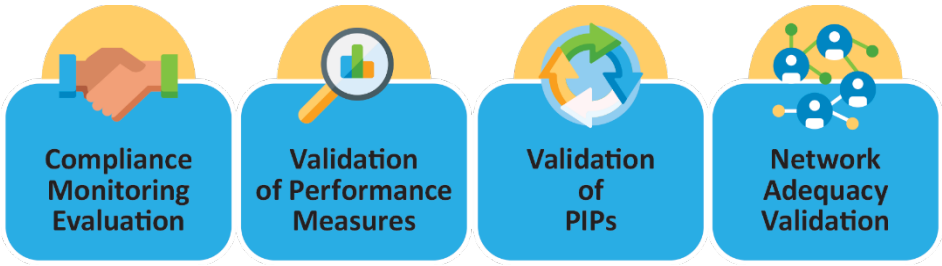
In accordance with 42 CFR §438.356, DMAS contracts with HSAG as its EQRO to conduct the mandatory and optional EQR activities as set forth in 42 CFR §438.358. DMAS contracts with a CMS QI organization, which is also a CMS Network of Quality Improvement and Innovation Contractor, to serve as the EQRO for Virginia. HSAG has been DMAS' EQRO since 2014. HSAG's EQRO contract is for four years with four consecutive one-year renewal options. The conducting of EQR activities is a core feature of Virginia's Medicaid

managed care quality initiative. The Medicaid managed care quality assessment activities are conducted for DMAS by its EQRO. Consistent with CMS guidance, the EQRO conducts the mandatory and optional activities using CMS published protocols.

Mandatory EQR Activities

42 CFR §438.358

To evaluate the quality and timeliness of, and access to, the services covered under the MCO contract, DMAS' EQRO conducts mandatory EQR activities for the Virginia Medicaid and CHIP programs. DMAS has determined that the mandatory activities completed by the EQRO do not duplicate activities performed through private accreditation. DMAS has contracted with its EQRO to perform the following mandatory activities:



- **Compliance monitoring evaluation.** DMAS' EQRO conducts comprehensive, on-site reviews of compliance, called operational systems reviews, of the MCOs at least once in a three-year period. DMAS' EQRO reviews MCO compliance with federal standards and those established by the State for access to care, structure and operations, and quality measurement and improvement. The State standards are as stringent as the federal Medicaid managed care standards described in 42 CFR §438.358(b)(iii), which address requirements related to access, structure and operations, and measurement and improvement. Compliance is also determined through a review of individual files to evaluate MCO implementation of standards.
- **Validation of performance measures.** In accordance with 42 CFR §438.340(b)(3)(i), DMAS requires MCOs to submit performance measurement data as part of their QAPI programs. To comply with 42 CFR §438.332, DMAS' requires the MCOs to be NCQA accredited and complete NCQA HEDIS Compliance Audits. DMAS' EQRO validates the non-HEDIS performance measures, including non-HEDIS CMS Child and Adult Core Set measures through MCO performance measure validation audits. The NCQA HEDIS Compliance Audits and the EQRO performance measure validation activities focus on the ability of the MCOs to accurately process claims and encounter data, pharmacy data, laboratory data, enrollment (or membership) data, and provider data. DMAS' EQRO validates the performance measures identified by the State to evaluate their accuracy as reported by, or on behalf of, the MCO. As part of EQRO performance measure validation audits, DMAS' EQRO also explores the issue of completeness of claims and encounter data to improve rates for the performance measures.
- **Validation of PIPs.** As described in 42 CFR §438.340(b)(3)(ii), DMAS requires MCOs to conduct PIPs in accordance with 42 CFR §438.330(d). PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention, and they must be designed to have a favorable effect on health outcomes and enrollee satisfaction. In accordance with 42 CFR

§438.358(b)(1)(i), DMAS' EQRO validates PIPs required by the State to ensure that the PIPs were designed, conducted, and reported in a methodologically sound manner, meeting all State and federal requirements.

- **Network adequacy validation.** In accordance with 42 CFR §438.68, DMAS uses its EQRO to perform validation of MCO network adequacy. The analysis will evaluate three dimensions of access and availability:
  - Capacity—provider-to-member ratios for Virginia's provider networks as defined by each MCO contract
  - Geographic network distribution—time/distance analysis for applicable provider specialties and average distance (miles) to the closest provider as defined by each MCO contract
  - Appointment availability—average length of time (number of days) to see a provider as defined by each MCO contract.
- **Annual technical report.** As described in 42 CFR §438.364, DMAS uses its EQRO to produce the annual EQR technical report. HSAG produces the annual technical report, which is an analysis and evaluation of information generated by the EQR-related activities regarding the quality, timeliness, and access to the healthcare services that an MCO, or its contractors furnish to beneficiaries. The report satisfies regulatory requirements and clearly and concisely indicates the methods that were used, the results that were achieved, and recommendations for future actions.

Optional EQR Activities

42 CFR §438.358

DMAS' EQRO conducts the following optional EQR activities for the Virginia Medicaid program:

- Consumer decision support tool
- Performance withhold program
- Population Focused Studies
  - Medicaid Maternal and Child Health Focused Study
  - Child Welfare Focused Study—Foster Care Study
- Calculate performance measures
- FAMIS CAHPS survey
- Quality strategy update
- Dental utilization in pregnant women data brief (focused study)
- ARTS measurement specification and reporting
- Appointment standards monitoring, prenatal care, and PCP secret shopper surveys
- Encounter data validation—information systems assessment and administrative profile

EQR Technical Report

42 CFR §438.364

The Final Rule, last updated in 2020, requires states to use an EQRO to prepare an annual technical report that describes the manner in which data were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care and services furnished by the states' MCOs. DMAS' EQRO produces the EQR technical report, which presents all mandatory and optional EQR activities performed.

The EQR technical report includes a review of members' access to care and the quality of services received by members of Title XIX, Medicaid, and Title XXI, CHIP. In accordance with 42 CFR §438.364, the report includes the following information for each mandatory activity conducted:

- Assessment of the quality and timeliness of, and access to the care furnished by the MCO
- Activity objectives
- Technical methods of data collection and analysis
- Description of data obtained
- Conclusions drawn from the data
- Assessment of MCO strengths and weaknesses, as well as recommendations for improvements
- Methodologically appropriate comparative information about all MCOs in the program
- An assessment of the degree to which each MCO has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR

DMAS uses the information obtained from each of the EQR activities, as well as the information presented in the EQR technical report, to make programmatic changes and modifications to the Quality Strategy. The EQR technical report also contains a description of the EQRO evaluation of the effectiveness of the Quality Strategy. Follow-up on EQR technical report recommendations can be found in Appendix E. The most recent EQR technical reports may be accessed at:

Medallion 4.0:

https://www.dmas.virginia.gov/about-us/office-of-quality-and-population-health/quality-activities/

CCC Plus:

https://www.dmas.virginia.gov/about-us/office-of-quality-and-population-health/quality-activities/

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 requires the

MCOs to be accredited by a private accrediting organization recognized by CMS, when the accreditation standards are at least as stringent as those required by CMS (§422.158); are comparable to standards established through the EQR protocols (§438.352 and §438.358); and the MCOs provide the state with all reports, findings and results of the private accreditation review activities.

DMAS requires all the Virginia Medicaid MCOs to be accredited by NCQA. As such, DMAS deems certain EQR-related activities that crosswalk to CMS requirements. There is some overlap between NCQA's quality standards the MCOs must meet to maintain accreditation and the three CMS-mandated quality activities performed by DMAS' contracted EQRO.

DMAS deems some of the duplicative CMS-EQR requirements as being met (hereafter referred to as "deeming") as long as the MCO meets the accreditation standards. The criteria for deeming are supported in 42 CFR §438.360 (non-duplication of mandatory activities).

Using NCQA Accreditation Results

42 CFR §438.360

CMS determines the CFR requirements that can be considered for deeming. HSAG uses the most current CFRs and compares the requirements to the most current NCQA Medicaid Managed Care Crosswalk to determine comparability. For de-duplication (deeming) purposes, HSAG assesses whether each accreditation standard met the relevant regulation in the CFR in its entirety.

DMAS requires the Medicaid MCOs in the Commonwealth of Virginia to be accredited by NCQA. HSAG reviews accreditation standards that are fully comparable with the federal standards pertaining to an MCO's operations. If the Commonwealth's MCO contract requirements are more stringent or include additional requirements than the Final Rule, HSAG compares the NCQA accreditation standard to the State-specific requirements.

Rationale for Determining Comparability to EQR Activities

DMAS determined that all standards found to be 100 percent comparable with the Final Rule are eligible for deeming with the following caveats:

- DMAS requires the MCOs to receive full (100 percent) compliance with the applicable accreditation element, standard, and/or CFR requirement.
- An NCQA standard was not eligible for deeming unless the standard was 100 percent compliant with the Medicaid CFR requirement.

State Monitoring and Evaluation of MCO Requirements

42 CFR §438.66

Performance Measures Used to Assess Members' Timely Access to Appropriate Healthcare

42 CFR §438.206(c)(1)

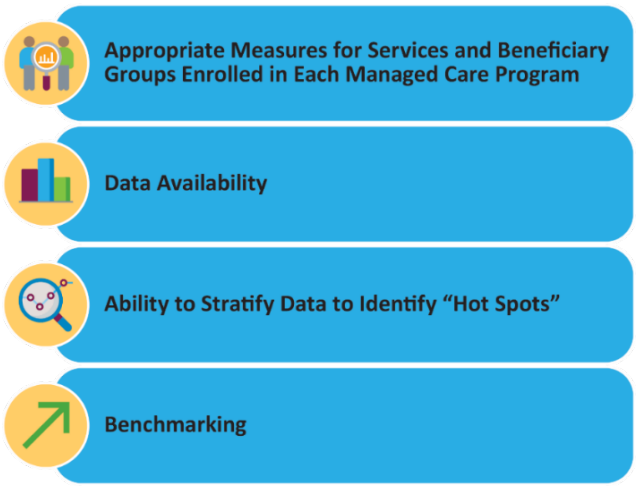
DMAS selected standard performance measures that MCOs are required to measure and report to DMAS. Consistent with DMAS' desire to benchmark its progress against other states' performance and assess key priorities to drive CQI efforts, nearly all of these measures are nationally recognized and include the NCQA HEDIS, CMS Child Core Set, and the CMS Adult Core Set measures. MCOs must attain annual improvement in the Medicaid HEDIS measures until such time that the MCO is performing at least at the 50th percentile for health maintenance organizations (HMOs) as reported in NCQA's Quality Compass®.[40]

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 Managed Long-Term Services and Supports (MLTSS) programs. The managed care program covers diverse populations—such as nondisabled children, pregnant women, disabled adults, and seniors—and the access metrics address each of these groups.

Performance measure selection is dependent on:



[40] 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, 7 days a week. DMAS also requires the MCOs to provide care as expeditiously as the member's health condition requires. MCOs are required to adequately and timely cover services that are not available within their managed care network. In cases where a member receives services from an out-of-network provider, DMAS requires the MCOs to coordinate with the provider for payment. The MCOs are required to meet the following appointment standards:

Emergency Services

Appointments for emergency services shall be made available immediately upon the member's request.

Urgent Medical Conditions

Appointments for urgent medical conditions shall be made within 24 hours of the member's request.

Routine Primary Care Services

Appointments for routine, primary care services shall be made within 30 calendar days of the member's request. This standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days, or for routine specialty services like dermatology, allergy care, etc.

Maternity Care Appointments

For maternity care, the MCO shall be able to provide initial prenatal care appointments for pregnant members as follows:

First trimester: Appointments shall be scheduled within seven calendar days of request.

Second Trimester: Appointments shall be scheduled within seven calendar days of request.

Third trimester: Appointments shall be scheduled within three business days of request.

High-Risk Pregnancies: Appointments shall be scheduled for high-risk pregnancies within three business days of identification of high risk to the MCO or maternity provider, or immediately if an emergency exists.

Mental Health Services

Behavioral health appointments must be made available as expeditiously as the member's condition requires and within no more than five business days from the Contractor's determination that coverage criteria are met.

LTSS

LTSS must be made available as expeditiously as the member's condition requires and within no more than five business days from the Contractor's determination that coverage criteria are met.

Assurances of Adequate Capacity and Services

42 CFR §438.207

Essential Services and Vulnerable Populations

42 CFR §438.3 and 42 CFR §456 Subpart K, Section 1927(g) of the Social Security Act

DMAS recognizes that the essential services for vulnerable populations are of strategic importance to the Quality Strategy, which is why these services are outlined as one of the key interventions. DMAS defines vulnerable populations served in the Medicaid programs as, but not limited to, individuals enrolled in a PACE, DD waiver members, and members diagnosed with a chronic physical and/or behavioral health condition.

DMAS reviews MCOs' policies, procedures, and processes used to evaluate medical necessity, the criteria used, the information source, and processes for approval and denial of essential services. DMAS also reviews the MCOs' mechanisms to detect under- and overutilization of care and services. DMAS requires the MCOs to develop and maintain a drug utilization review (DUR) program that consists of prospective and retrospective DUR. DMAS reviews the MCOs' implementation of their policies and procedures by requiring the MCOs to demonstrate that all members have access to all services covered under the Medicaid State Plan in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services as provided under the DMAS FFS Medicaid program.

DMAS considers quality to be the foundation of MCO health plan operations and requires the MCOs to monitor and report critical incidents and for QI plans to address potential and actual quality of care and/or health and safety issues.

Coordination and Continuity of Services

42 CFR §438.206; 42 CFR §438.208; and 42 CFR §438.210

Individuals who may be eligible for Medicaid LTSS are screened to determine their needs and eligibility for services. This screening is known as the Medicaid LTSS Screening and includes use of Virginia's Uniform Assessment Instrument (UAI); assessment of risk for institutionalization; preadmission screening (PAS) for mental illness, intellectual disability, and related conditions for NF admissions; documentation of an individual's choice of services; notification of appeal rights; and the Medicaid Authorization form for LTSS. Screeners may be staff members from the local departments of health and social services, hospitals, or nursing facilities. A physician must always review the screening results and be the final individual to approve authorization for services.

DMAS contracts with vendors to administer the Virginia Uniform Assessment Instrument that is used to determine eligibility for LTSS. Assessment vendors include hospitals, social service agencies, or other entities overseeing care of members. Additional services for members with SHCN or members who need LTSS are provided through the managed care model. The MCOs stratify members to coordinate care and measure quality for different groups of persons with special needs such as the nursing facility population; waiver population; EPSDT; foster care; members receiving early intervention services; and vulnerable subpopulations.

MCOs have overall responsibility for ensuring that all members have an ongoing source of care, according to their needs, and that they communicate this responsibility to the member along with an MCO point of contact. MCO contracts require the MCO to cover the same services as are required in Medicaid FFS. DMAS requires the MCOs to maintain and monitor a contracted provider network that is sufficient to provide adequate access to all services covered under the contract for all members, including those with LEP or physical or mental disabilities. Providers must maintain and share, as appropriate, a member health record in accordance with professional standards. MCOs are required to provide female enrollees with direct access to a women's health specialist within the provider network for women's routine and preventive healthcare services. MCOs are required to provide for a second opinion from a network provider or arrange for the member to obtain a second opinion outside the network, at no cost to the member. DMAS also requires the MCOs to coordinate care and service delivery with the services the member receives from any other MCO or prepaid inpatient health plan (PIHP).

The MCOs establish systems to monitor the provider network to ensure that the access standards are met, regularly monitor the network to determine compliance, takes corrective action when there is a failure to comply, and demonstrate that the access standards are met. MCOs expand provider networks to ensure access to care standards are met.

Accessing Continued Services Upon Transition in Care

42 CFR §438.62

DMAS makes its transition of care policy publicly available and provides instructions to members on how to access continued services during a transition when the member could suffer serious detriment to his or her health or be at risk of hospitalization or institutionalization upon transition from the FFS program to an MCO or from one MCO to another MCO. To ensure that there is no interruption of any covered service, DMAS requires the MCOs to allow members to use their current providers for up to 30 calendar days or for the duration of the service authorizations issued prior to the transition, and to receive continued prescription refills for at least 30 calendar days or through the expiration date of the prescription. DMAS also requires MCOs to transfer service authorizations and other pertinent information to an MCO to which the member is transitioning to ensure continuity of care and services. Members who are receiving LTSS services are able to stay in the residential facility regardless of the facility's contractual status with the member's new MCO.

Coverage and Authorization of Services

42 CFR §438.68 and 42 CFR §438.210

DMAS requires the MCOs to identify, define, and specify the amount, duration, and scope of each service. MCOs are required to furnish services in an amount, duration, and scope that is no less than those furnished to beneficiaries under Virginia's Medicaid FFS program. In addition, MCOs are required to ensure that the services are authorized in amount, duration, and scope so that they are reasonably expected to achieve the purpose for which they are furnished. DMAS ensures that the MCOs do not deny or reduce a service because of the member's diagnosis, type of illness, or condition. MCOs are, however, able to place appropriate limits on a service, such as due to a medical necessity determination. DMAS has provided the MCOs with a definition of what constitutes a medically necessary service. Medical necessity criteria are incorporated into the MCOs' prior authorization policies and procedures. MCOs have

implemented interrater reliability processes to ensure consistent application of authorization review criteria. MCO authorization processes also require an appropriate healthcare professional to make any decision to deny or reduce a service authorization request and to provide timely notice of the decision. MCOs are not allowed to compensate individuals or entities that conduct utilization management activities with incentives to deny, limit, or discontinue medically necessary services.

The managed care MCO contract requires MCOs to ensure that the MLTSS delivery system provides available, accessible, and adequate numbers of facilities, locations, and personnel for the provision of covered services. DMAS requires that the MCOs' networks meet or exceed federal network adequacy standards and have sufficient types and numbers of traditional and LTSS providers in their networks to meet historical need and that the MCOs add providers to meet increased member needs in specific provider types or geographic areas.

Standards for Structure and Operations

42 CFR §438.10; 42 CFR 438.54; 42 CFR 438.214; and 42 CFR 438.242

The contracts between DMAS and the MCOs detail Virginia's Medicaid standards for MCO structure and operations. DMAS' standards are at least as stringent as those specified in the Final Rule. DMAS requires the MCOs to implement the following standards for structure and operations:

- Provider selection (42 CFR §438.214)
- Information requirements (42 CFR §438.10)
- Confidentiality (42 CFR §438.224)
- Enrollment and disenrollment (42 CFR §438.54 and §438.56)
- Grievance and appeal systems (42 CFR §438.228 and 42 CFR §438 Subpart F)
- Subcontractual relationships and delegation (42 CFR §438.230)

Provider Selection

42 CFR §438.68, 42 CFR 4§38.214; 42 CFR §440.170(a) and 12 VAC 30-50-530

MCO provider networks include sufficient types and numbers of traditional and specialty providers to meet the historical need of members. MCOs continually assess their contracted provider network and, when needs are identified, MCOs add providers to meet increased member needs in specific geographic areas. MCOs select and credential providers following the NCQA credentialing requirements. DMAS has developed processes to assess MCO network adequacy by evaluating a number of factors, including:

- Number of providers
- Mix of provider types
- Hours of operation
- Ratio of providers not accepting new patients
- Accommodations for individuals with physical disabilities
- Barriers to communication
- Geographic proximity to members

To ensure access to care, MCOs provide emergency, urgent, and nonemergency transportation services to and from providers of covered medical, behavioral health, dental, LTSS, and rehabilitative medical services and supports needed. MCOs are also required to offer telehealth services, when appropriate, to ensure access to care requirements are met.

Development of Network Adequacy Standards

42 CFR §438.68; 42 CFR §438.207; 42 CFR §438.214; 42 CFR §438.340

DMAS works with the MCOs to ensure that their delivery systems provide adequate numbers of facilities, accessible locations, and qualified personnel for the provision of covered services, including emergency services 24 hours a day, 7 days a week.

DMAS ensures that MCOs maintain written policies and procedures for the selection and retention of providers that include documented, uniform credentialing and recredentialing policies. Credentialing and recredentialing policies, procedures, and provider contracts include processes to verify that providers excluded from federal healthcare programs do not contract with or provide services to MCO members. DMAS ensures that the MCOs' policies and procedures do not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.

MCOs develop and enforce network adequacy standards that include time and distance standards for provider types, which include adult and pediatric primary care, obstetrics and gynecology, behavioral health, adult and pediatric specialists, hospitals, enhanced dental benefits, and pharmacies. DMAS delegates the oversight of the time and distance standards for SFC members to the State's Dental Benefits Administrator.

MCOs maintain a network of providers sufficient in number, mix, and geographic distribution to meet the needs of their members. MCOs offer an appropriate range of preventive, primary care, and specialty services.

DMAS determines the demand for specific services on utilization patterns derived from Medicaid and CHIP claims and encounter data available for previous periods in DMAS' Medicaid Management Information System (MMIS). For existing managed care programs, DMAS uses MCO encounter data from the past two or three years to determine the demand for specific services. For new managed care programs, FFS claims are the primary source of data for analyzing previous service use.

Provider-Specific Time and Distance Standards

42 CFR §438.68 and 42 CFR §438.207

In addressing standards for network adequacy and availability requirements, DMAS takes into consideration elements supporting the member's choice of provider and strategies supporting community integration of the member. In addition, other elements in the best interest of members who need LTSS are taken into consideration. Travel time and distance are defined per line of business and as urban versus rural. For urban areas, each member has a choice of at least two providers of each service type located within no more than 30 minutes travel time from any member unless the MCO has a DMAS-approved alternative time or distance standard.

DMAS developed time and distance standards to ensure that all covered Medicaid services delivered through contracted MCOs are available and accessible to members with an adequate MCO provider network. The standards address providing access to covered services through providers who are within reasonable travel time, provide the full scope of Medicaid and CHIP services, have timely access to services, and provide services in a culturally competent manner.

DMAS establishes time and distance standards based on provider type and the characteristics and special needs of specific Medicaid populations as illustrated in Table 11.

Table 11—Network Adequacy Standards

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

Exception Process

42 CFR §438.66, 42 CFR §438.68

If DMAS permits an exception to any of the provider-specific network standards, the standard by which the exception will be evaluated and approved is specified in the MCO contract based on the number of providers in that specialty practicing in the MCO service area. If DMAS grants an exception, member access to that provider type is monitored on an ongoing basis and the findings are included in the managed care program assessment report submitted to CMS.

Telehealth

Telehealth means the use of telecommunications and information technology to provide access to medical and behavioral health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth encompasses telemedicine—defined as two-way, real-time interactive electronic communication—as well as a broader umbrella of services that includes the use of such technologies as telephones, interactive and secure medical tablets, remote patient monitoring devices, and store-and-forward devices.

DMAS supports the delivery of services by telehealth to cost-effectively improve access to and quality of services. Specifically, telehealth may help to increase and sustain members' equitable access to services, improve member engagement and participation in treatment plans and services, maintain quality of services by appropriately covering selected services delivered via telehealth, and reduce Medicaid costs for covered services by intervening earlier and/or more efficiently acting on identified physical and behavioral health needs. When delivering services via telehealth, providers are required to adhere to the same standards of clinical practice and record keeping that apply to other covered services.

Starting with the beginning of the COVID-19 pandemic, DMAS extended telehealth and telemedicine benefits to members to ensure access to care during the public health emergency. The use of these modalities of care has continued to grow, and DMAS has released long-term guidance to members and providers about the use of telehealth, including standardized definitions and details on covered services. Providers are required to get informed consent from members for telehealth services and use appropriate equipment and technology to ensure confidentiality. Any information shared during telehealth services must be consistent with applicable federal and State laws and regulations and DMAS policy. HIPAA confidentiality requirements are applicable to telemedicine encounters.

DMAS encourages MCOs to implement the use of telehealth, including electronic information and telecommunications to support remote and long-distance healthcare services. Telehealth includes services delivered in the dental health setting (i.e., teledentistry), and telehealth policies for dentistry are also covered. DMAS encourages MCOs to ensure their networks include behavioral health professionals performing addiction and recovery treatment service assessments via telehealth, particularly in rural and other hard to access areas. MCOs are also able to conduct member health risk assessments via telehealth as an accepted means of face-to-face communication.

Telemedicine

Telemedicine is a means of providing services through the use of two-way, real time interactive electronic communication between the member and the Provider located at a site distant from the member. This electronic communication must include, at a minimum, the use of audio and video equipment. Telemedicine does not include an audio-only telephone.

DMAS requires the MCO to provide coverage for telemedicine services as medically necessary, and within at least equal amount, duration, and scope as is available through the Medicaid FFS program. DMAS defines telemedicine as the real-time or near real-time two-way transfer of medical data and information using an interactive audio/video connection for the purpose of medical diagnosis and treatment services. Telemedicine services are provided in a manner that meets the needs of vulnerable and emerging high-risk populations and are consistent with

integrated care delivery. Telemedicine services may be provided in the home or at another location.

Telemedicine remote providers include physicians, nurse practitioners, certified nurse midwives, clinical psychiatric nurse specialists, clinical psychologists, clinical social workers, licensed and professional counselors, licensed marriage and family counselors, licensed substance abuse practitioners, and credentialed addiction treatment providers. DMAS covers the following telemedicine services:

- Teleretinal screening for diabetic retinopathy
- Teledermatology
- Teleradiology
- Remote patient monitoring (vital signs such as weight, blood pressure, blood sugar, and heart rate), especially for members with one or more chronic conditions, such as congestive heart failure, cardiac arrhythmias, diabetes, pulmonary diseases, or the need for anticoagulation
- Telepsychiatry

Remote Patient Monitoring

Remote patient monitoring (RPM) involves the collection and transmission of personal health information from a member in one location to a provider in a different location for the purposes of monitoring and management. This includes monitoring of both patient physiologic and therapeutic data.

Clinicians use their clinical judgment to determine the appropriateness of service delivery via telehealth, considering the needs and presentation of each individual. Covered services can include prenatal and postpartum care visits, radiology, speech language therapy, and a variety of mental health and substance use disorder services.

Information Requirements

42 CFR §438.10

To ensure the capacity for Medicaid managed care education, DMAS procured an enrollment broker to facilitate outreach, education, and consumer assistance to members and potential members. Informational materials developed by the Commonwealth, the enrollment broker, the Ombudsman Program, and MCOs are available in formats and languages that ensure their accessibility, including providing materials at an appropriate reading level.

Confidentiality

42 CFR §438.208(b)(6) and 42 CFR §438.224

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

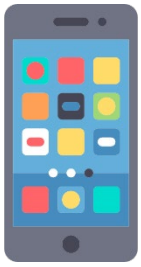
applicable federal and state privacy laws that are more restrictive. Individually identifiable health information is disclosed only in accordance with federal privacy requirements. Accordingly, members are notified of any inappropriate disclosures as required by law. MCOs and providers are required to protect member privacy when coordinating care.

Enrollment and Disenrollment

42 CFR §438.54, 42 CFR §438.56

In designing the managed care enrollment and disenrollment policies, Virginia recognizes the importance of ensuring Medicaid applicants and their families experience a simple, streamlined eligibility and enrollment process that ensures a timely and accurate determination of Medicaid eligibility and a user-friendly MCO and PCP selection process. The Commonwealth and the enrollment broker maintain responsibility for effectuating enrollment and disenrollment requirements.

Medicaid Enrollment Application



Virginia managed care members are able to choose an MCO using a no-cost application (app) available for download for iPhone or for android users. Users only need to search for Virginia Managed Care in the App Store or Google Play and download the app. After downloading the app, members log in using a two-step identification process, Medicaid identification number and date of birth or social security number and date of birth. Nonmembers can log in as guests.

The app allows members to view their profile, compare MCOs, choose and enroll in an MCO, search for providers, and more. Members can choose a PCP and then select an MCO based on the networks in which their PCP participates. Members may also choose their preferred MCO and then choose from the list of participating in-network providers.

The Virginia Managed Care mobile app is designed to make it simple to find and enroll in an MCO.

Other features of the app include:

- Compare health insurance plans easily
- Find driving directions to nearby providers, hospitals, and pharmacies quickly
- For use on a phone or tablet
- Available in Spanish

Grievance and Appeal Systems

42 CFR §438.228 42 CFR §438.230 Subpart F 42 CFR §438.400, 42 CFR §438.402

DMAS is committed to ensuring that members are able to address their problems quickly and with minimal burden. The DMAS contracts with MCOs do not allow delegation of member notice of adverse benefit determinations. Virginia is committed to honoring and supporting the right of members to pursue a formal appeal of an adverse benefit determination through their MCO, or

upon exhaustion of the MCO appeal process, through timely access to a State fair hearing. Additionally, members and applicants are also able to appeal enrollment and disenrollment determinations made by the enrollment broker under a similar process. Members are provided the opportunity to file a grievance with their MCO to express their dissatisfaction with any issue that does not relate to an adverse benefit determination (e.g., concerns and expressions of dissatisfaction). DMAS requires MCOs to report on their appeal and grievance processes and outcomes and monitors MCO performance to ensure compliance with related requirements and addresses any issues that may arise.

Adverse Benefit Determination

42 CFR §438.210; 42 CFR §438.400; 42 CFR §438.404

MCOs are required to notify members of an adverse benefit determination and explain the reasons for the determination. The notice of adverse benefit determination must be provided by the MCO as expeditiously as the member's condition requires but may not exceed 14 calendar days following the receipt of the request for service, unless an extension is allowed, and is in the best interest of the member.

Member Grievances

42 CFR §438.402; 42 CFR §438.406; §438.408

Members may file a grievance with an MCO at any time, either orally or in writing. MCOs are required to acknowledge receipt of each grievance and must resolve the grievance within 90 calendar days from the date the MCO receives the grievance. In instances in which the grievance relates to the denial of an expedited appeal request, MCOs are required to resolve the grievance and provide notice to all affected parties within five calendar days from the date the MCO received the grievance.

Member Civil Rights Grievances

DMAS and its contractors do not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities. To ensure that allegations or complaints of discrimination receive prompt attention, DMAS has established a procedure to review and resolve discrimination complaints in a timely manner and in accordance with applicable federal and State civil rights laws and regulations, as well as other DMAS policies, procedures, and contract requirements. Members may file a civil rights grievance with DMAS either orally or in writing. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought. DMAS civil rights complaint forms can be accessed by the public by contacting the DMAS Civil Rights Coordinator or a complaint can be filed by directly emailing the DMAS Civil Rights Coordinator. Members may also directly file a nondiscrimination grievance with HHS, Office for Civil Rights.

Member Appeals

42 CFR §438.402; 42 CFR §438.406; 42 CFR §438.408; 42 CFR §438.420

Federal law establishes the specific standards for member rights for appeals which all MCOs are expected to follow. Specifically, in Virginia, members or authorized representatives may appeal a notice of adverse benefit determination within 60 calendar days from the date on the notice of adverse benefit determination. The MCO resolves and provides notice to the member as expeditiously as the member's health condition requires, and no longer than 30 calendar days from the initial date of receipt of the appeal.

Expedited Appeals

42 CFR §438.402; 42 CFR §438.406; 42 CFR §438.408; 42 CFR §438.420

DMAS requires MCOs to maintain an expedited appeal process in cases when a member requests or the provider indicates that the time expended in a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. DMAS requires the MCOs to issue decisions for expedited appeals as expeditiously as the member's health condition requires but may not exceed 72 hours from the initial receipt of the appeal.

Subcontractual Relationships and Delegation

42 CFR §438.230

MCOs remain accountable for all contract terms which are performed by subcontractors or through delegation agreements. MCOs are required to complete pre-delegation assessments or reviews prior to the delegation effective date to assess the subcontractor's readiness to perform the subcontracted or delegated functions. MCO delegation subcontractor agreements specify the activities and report responsibilities delegated to the subcontractor and provides for revocation of delegation or imposing sanctions if the subcontractor's performance is inadequate. DMAS confirms that MCOs have the necessary policies, procedures, and documents to demonstrate compliance, including processes for periodically performing audits of the subcontractor's and delegate's compliance, implementing corrective actions for identified deficiencies or identified areas of improvement during the term of the contract.

Standards for Measurement and Improvement

42 CFR §438.236; 42 §438.330; 42 CFR §438.242

The contracts between DMAS and the MCOs detail Virginia's Medicaid standards for measurement and improvement. DMAS' standards are at least as stringent as those specified in the Final Rule. The MCOs are required to implement the following standards for measurement and improvement:

- Practice guidelines (42 CFR §438.236)
- Quality assessment and performance improvement program (42 CFR §438.330)
- Health information systems (42 CFR §438.242)

Practice Guidelines

42 CFR §438.236

DMAS includes in its MCOs' contracts required evidence-based clinical practice guidelines. Examples of the evidence-based clinical practice guidelines include:

Well Baby and Well Child Care: All routine well baby and well childcare must be provided according to the recommendations by the American Academy of Pediatrics (AAP) Advisory Committee, including routine office visits with health assessments and physical exams, as well as routine lab work and age-appropriate immunizations, and ensure provision of services meets EPSDT requirements. The following services are rendered for the routine care of a well child:

- Unclothed Physical Exam: Regularly scheduled, comprehensive, full-body exams including weight, length, head measurement; BMI percentile; and blood pressure.
- Anticipatory Guidance: Newborn care, safety, development, nutrition, feeding, exercise, growth, healthy habits, emotional and mental health, substance use, alcohol use, skin cancer risks, tobacco use, school performance, and parent and family health and well-being.
- Laboratory Services: Blood lead testing, hemoglobin, hematocrit, or free erythrocyte protoporphyrin (maximum of two, any combination); Tuberculin test (maximum of three covered); Urinalysis (maximum of two covered); Pure tone audiogram for ages 3–5 (maximum of one).
- Well-child visits rendered at home, office, and other outpatient provider locations are covered at birth and months, according to the AAP recommended periodicity schedule.
- Immunizations: According to the Advisory Committee on Immunization Practices (ACIP). In addition, the Contractor shall also allow for an annual flu vaccine without limitations to age and without the requirement of meeting the CDC at-risk guidelines.
- Vision Screening: Machine vision test.
- Psychosocial/Behavioral Health Assessment: Depression screening, emotional and mental health, substance use, alcohol use, and tobacco use.
- Developmental Testing: Approved tools include Parents' Evaluation of Developmental Status (PEDS), Ages & Stages Questionnaire (ASQ), Bayley Infant Neurodevelopmental Screener (BINS), and focused screening for health conditions such as the Modified Checklist for Autism in Toddlers (M-CHAT), cognitive Adaptive Test/Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CLAMS) for general developmental delays, Language Development Survey for identifying language delays, and CLAMS for identification of language delays.
- Hearing Services: All newborn infants will be given a hearing screening before discharge from the hospital after birth. Those children who did not pass the newborn hearing screening, those who were missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist. In addition, newborns who fail their newborn hearing screening must be tested for congenital cytomegalovirus.
- Periodic auditory assessments appropriate to age, health history, and risk, which include assessments by observation (subjective) and/or standardized tests (objective). At a minimum, these services shall include diagnosis of and treatment for defects in hearing, including hearing aids.

- Dental Home/Assess Oral Risks: Oral examination, fluoride supplementation, fluoride varnish when teeth start coming in (usually around 6 to 24 months old), dietary counseling, and counseling for nonnutritive habits.

Depression Screenings and Referrals: Pregnant women must be screened for maternal mental health concerns, including but not limited to, postpartum depression in accordance with the American Congress of Obstetricians and Gynecologists (ACOG) or AAP standards.

Obstetric and Gynecologic Services: Routine and medically necessary obstetrics and gynecology (OB/GYN) healthcare services must be provided and include the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system in accordance with the most current published recommendations of the ACOG.

Colorectal Cancer Screening: Colorectal cancer screening must be provided in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.

In addition, DMAS ensures that the MCO practice guidelines are based on valid and reliable clinical evidence or a consensus of providers in the particular field; consider the needs of members; are adopted in consultation with contracting healthcare professionals; and are reviewed and updated periodically, as appropriate. MCOs disseminate practice guidelines to all providers, and upon request, to members.

Quality Assessment and Performance Improvement Program

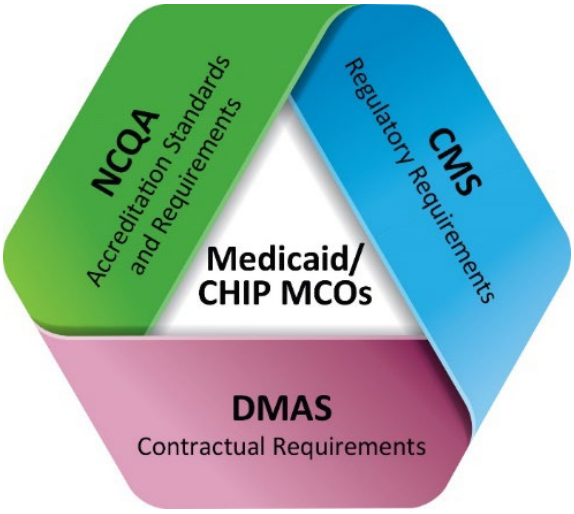
42 CFR §438.330

Each MCO is required to have an ongoing QAPI program. DMAS developed and uses a quality framework that leverages existing sets of standards and requirements for providing and continuously improving the quality of its managed care delivery system.

There are two fundamental sets of requirements from CMS and DMAS and one set of NCQA standards that converge for a bold quality framework for Virginia's Medicaid/CHIP managed care delivery system. Some of the requirements and standards overlap, resulting in resource efficiencies for assessing quality; however, each set provides for a different and important perspective on the quality of managed care.

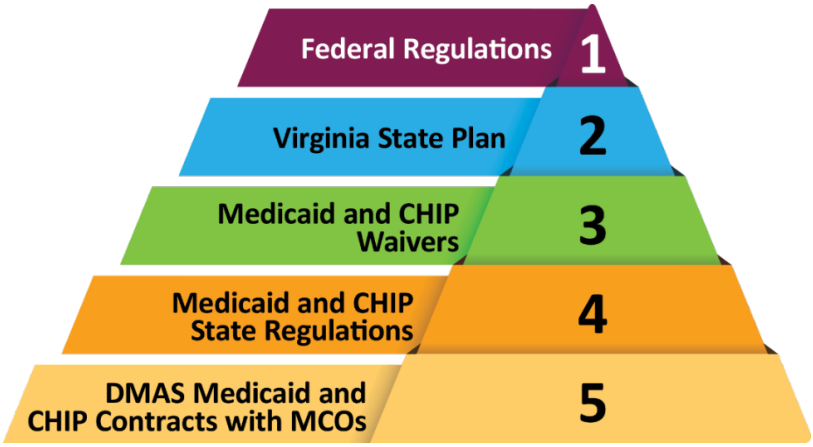
The requirements and standards serve as the basis for the Quality Strategy and are depicted in the framework in Figure 10.

Figure 10—Virginia's Medicaid/CHIP Managed Care Quality Framework



DMAS contracts with each MCO provide for the legal order of precedence, as shown in Figure 11:

Figure 11—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 programs. DMAS includes a subset of HEDIS measures to track and trend MCO performance and to establish benchmarks for improving the health of Medicaid and CHIP populations served through the managed care delivery system. The measures listed in the DMAS Quality Dashboard are prioritized for continuous improvement and selected based on the needs of the populations served and the favorable health outcomes that result when relevant clinical guidelines are adhered to by each MCO's provider network. Additionally, when selecting

measures for the specific needs of the managed care program, DMAS takes into consideration the availability and reliability of the data that are used to calculate the measures.

DMAS selects the same measures for a number of years to enable statistically sound trending of data. Trending provides DMAS and the MCOs the opportunity to further realize the impact of ongoing QI initiatives, rather than basing the effectiveness on just one year's worth of data.

DMAS and the MCOs recognize that effective QI includes:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing and sustaining improvement.

DMAS requires the MCOs to achieve annual improvement in HEDIS performance measures until the MCO is performing at least at the 50th percentile for HMOs as reported in NCQA's Quality Compass. Thereafter, DMAS requires the MCOs to sustain performance at the Medicaid 50th percentile and encourages the MCOs to set goals to attain the 75th percentile for each of the HEDIS measures. NCQA's Quality Compass report provides up to three years of performance trending of HEDIS and CAHPS measures for publicly reporting plans and includes comparative and descriptive performance information on hundreds of commercial, Medicaid, and Medicare health plan submissions as well as national, regional, and state benchmarks.

Ongoing Review of Performance Improvement

42 CFR §438.330; 42 CFR §438.358

DMAS uses multiple approaches to review the Quality Strategy on an ongoing basis. The MCOs are required to track their own ongoing performance and to report achievements and opportunities for improvement in an MCO quality evaluation, which is submitted annually to DMAS by each MCO.

DMAS requires the MCOs to conduct PIPs annually. PIPs must be designed to have the potential for achieving significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention, and to have a favorable effect on health outcomes and enrollee satisfaction. DMAS' EQRO validates the PIPs that are required by the Commonwealth annually. DMAS selects PIP topics that address CMS requirements and have the potential to impact the quality and timeliness of, and/or access to care and services.

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

- The technical structure of the PIP to ensure that the MCO designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. The implementation of the PIP. Once designed, a MCO's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, the identification of barriers, and development of interventions.

The results of the MCO PIP validation are reported to DMAS in an annual report. DMAS uses PIP results to assess each MCO's achievement of goals and to make any necessary modifications to the Quality Strategy based on each MCO's performance. PIP topics, PIP Aim statements, PIP population, PIP measures, and a description of the PIP status and any results that are available are included in Appendix C.

Member Satisfaction with Experience of Care

Annually, the EQRO administers a CAHPS survey. The primary objective of the CAHPS survey is to obtain information on the level of satisfaction members have with their healthcare experiences. CAHPS surveys ask members to report on and evaluate their experiences with healthcare; these surveys cover topics important to members, such as the communication skills of providers and the accessibility of services.

The EQRO conducts a CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the Children with Chronic Conditions measurement set for a statewide sample of FAMIS members, which is representative of the entire population of children covered by Virginia's Title XXI CHIP, members in the FFS, or managed care programs. DMAS uses CAHPS survey information to measure MCO and provider performance, member satisfaction with services provided and program characteristics, member access to care, and member expectations. DMAS' EQRO summarizes the findings of each CAHPS survey and incorporates the summary in the annual EQR technical report.

National Core Indicators—Aging and Disabilities Survey

Annually, DMAS administers the National Core Indicators for Aging and Disabilities© (NCI-AD) survey. The NCI-AD survey includes standard measures used to assess the quality of life and outcomes of seniors and adults with physical disabilities—including traumatic or acquired brain injury—who are accessing publicly-funded services through Virginia's Medicaid program. The NCI-AD surveys are coordinated by ADvancing States (formerly the National Association of States United for Aging and Disabilities [NASUAD]) and Human Services Research Institute (HSRI). NCI-AD data are gathered through the yearly administration of in-person adult consumer surveys of a statistically representative sample of each MCO's membership. NCI-AD data measure the performance at the statewide Medicaid level and of the DMAS contracted MCOs' LTSS systems and member outcomes. DMAS uses the results of the NCI-AD survey to help prioritize QI initiatives, engage in thoughtful decision making, and conduct futures planning with valid and reliable LTSS data.

Health Information Systems and Information Technology

42 CFR §438.242

Virginia's HIS and other technology initiatives support the overall operation and review of the Quality Strategy. The Commonwealth's IT approach is based on a strategy that spans all

stakeholders and takes into consideration current and future plans, policies, processes, and technical capabilities.

DMAS is committed to increasing its IT infrastructure and data analytics capabilities. DMAS' modernized technology system, the Medicaid Enterprise System (MES), replaced the MMIS. The new system completely overhauled the existing system's framework and allowed for increased data collection, analytic, oversight, and reporting functions for DMAS. The MES includes the Enterprise Data Warehouse System (EDWS), a component that significantly enhanced DMAS' ability to analyze MCO data. Within the EDWS, there are powerful management, analytic, and visualization tools that allow DMAS to review and monitor MCOs with increased oversight and detail. The new Encounter Processing System (EPS), which is another component of the MES, enhances data quality through implementation of program-specific business rules.

MCO Health Information Technology

42 CFR §438.242

MCOs maintain health information systems that collect data and ensure that data are accurate, valid, reliable, and complete. Virginia requires each MCO to maintain a health information system that collects, analyzes, integrates, and reports encounter data and other types of information to support utilization, 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. MCO health information systems also support effective and efficient care management and coordination.

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)	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** The state must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by each MCO, PIHP, PAHP, and PCCM entity it contracts with. **Toolkit Requirement:** • Indicate in the footer of the cover page of the initial quality strategy the date when the state submitted the quality strategy to CMS for comment and feedback. If the quality strategy is a revision of a previous version, indicate when the state published the previous version. Also indicate whether the quality strategy is an initial version or a revised version.	Cover page
§§438.340(a), 457.1240(e)	II.C. Exhibit 1	Include a brief history of the state's Medicaid and CHIP managed care programs.	12 18

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
Note: Not all requirements in the CFR that are included in the Quality Strategy Toolkit.	42 CFR §438.340(a), applicable also to CHIP managed care programs per 42 CFR §457.1240(e)	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** The state must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by each MCO, PIHP, PAHP, and PCCM entity it contracts with. **Toolkit Requirement:** • Describe the types of MCPs (such as MCOs and PIHPs) that the state contracts with to deliver services to beneficiaries; the managed care authorities, including relevant state plans (for example Medicaid, CHIP) and waiver types (such as Section 1115 demonstrations), that the state uses for each MCP. • The types of benefits (such as LTSS and dental) that each MCP provides to beneficiaries. • Specify which populations are addressed; children with disabilities may be included with children or people with disabilities. • Use this information to ensure that the quality strategy addresses all plans and populations in the state's managed care programs. • Indicate whether the state's CHIP program type is expansion, separate, or combined; whether the state provides CHIP benefits through managed care; and which MCPs provide CHIP benefits. If the state provides CHIP benefits through managed care, indicate whether the quality strategy addresses the state's CHIP program.	21-24
42 CFR §438.340(b)(3)(i); 42 CFR §457.1240(e); §438.330(c)(1)(ii)	II.E.3 LTSS Performance Measures 42 CFR §438.340(b)(3)(i); 42 CFR §457.1240(e); §438.330(c)(1)(ii)	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** If the state contracts with MCOs, PIHPs, PAHPs, and/or PCCM entities to provide LTSS, the state must describe the standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving LTSS. If the state does not provide LTSS through managed care, this requirement does not apply. **Toolkit Requirement:** • Indicate in the quality strategy whether the state delivers LTSS through managed care.	21-24

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		• For concurrent managed care and home and community-based services (HCBS) authorities, review HCBS quality assurance provisions required for HCBS for those programs with and without an institutional level of care found at 42 CFR 441.302(a)-(c), 441.303(a)-(e) 441.715(a) and 441.745(b).	
Optional		Include an overview of the quality management structure that is in place at the state level. For example, how is the leadership team structured, are there any quality task forces, an MCO collaborative, etc.	19-20
Optional		Include general information about the state's decision to contract with MCOs/PIHPs (e.g., to address issues of cost, quality, and/or access). Include the reasons why the state believes the use of a managed care system will positively impact the quality of care delivered in Medicaid and CHIP.	8-10
§438.340(b)(2)	II.D. Goals and Objectives 42 CFR §438.340(b)(2), applicable also to CHIP managed care programs per 42 CFR §457.1240(e).	Include a description of the goals and objectives of the state's managed care program. This description should include priorities, strategic partnerships, and quantifiable performance driven objectives. These objectives should reflect the state's priorities and areas of concern for the population covered by the MCO/PIHP contracts. For example, "the state will demonstrate a 10 percent improvement in childhood immunization rates over the next three years" or "through expansion of the primary care network, as evidenced by geographical reporting, the state will demonstrate a 5 percent improvement in member access to primary care." **CFR Description:** The state must identify its goals and objectives for continuous quality improvement. These goals and objectives must be measurable and take into consideration the health status of all populations served by the state's MCPs. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** Include measurable goals and objectives in the quality strategy. • Goals are defined as high-level managed care performance aims that provide direction.	13-14 Appendix B Appendix D

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		• Objectives are defined as measurable steps toward meeting the state's goals, and typically include quality measures. • Link each goal to one or more objectives. Together, CMS recommends that the goals and objectives be specific, measurable, attainable, relevant, and time-bound (SMART) • Crosswalk the goals and objectives to the populations and plans included in the state's managed care program to ensure that the goals and objectives address each population and plan.	
Optional		Include a description of the formal process used to develop the quality strategy.	30-32
§438.340(c)(1)(i)		Include a description of how the state obtained the input of beneficiaries and other stakeholders in the development of the quality strategy.	32-35
§438.340(c)(1)		Include a description of how the state made (or plans to make) the quality strategy available for public comment before adopting it in final.	32-33
§438.340(c)(2)(i)		Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually).	32
§438.340(b)(10) and (c)(3)(ii)	III.A.1 Updates for State-Defined Significant Changes §438.340(b)(10) and (c) (3)(ii), §457.1240(e)	Include a timeline for modifying or updating the quality strategy. If this is based on an assessment of "significant change," include the state's definition of "significant change." **CFR Description:** The state must include in its quality strategy a definition for a "significant change" for the purpose of revising the quality strategy. If such a significant change occurs, the state must update its quality strategy. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** • Consider factors to define as a significant change, such as, but not limited to: • Adding or removing goals and objectives. • Changes that trigger public comment, tribal consultation, and input from the state's Medical Care Advisory Committee. • Substantive changes to the state's managed care quality laws.	31-32

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.340(b)(10)	III.A.2 Updates for Significant Changes That Occur Within the State's Medicaid Program §438.340(c)(3)(ii), §457.1240(e)	**CFR Description:** In addition to updates made to reflect significant changes as defined by the state, the state must also update its quality strategy whenever significant changes occur within the state's Medicaid program. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** No details provided in the toolkit.	32
§438.340(c)(1)	IV.A. Public and Tribal Comment Process Exhibit 18 42 CFR §§438.340(c)(1)(i), 438.340(c)(1)(ii), cross-referencing 42 CFR §431.12, §457.1240(e).	**CFR Description:** The state must make the strategy available for public comment before submitting the strategy to CMS for review, including by obtaining input from its Medical Care Advisory Committee (Medicaid only), beneficiaries, and other stakeholders. In addition, the state must consult with Tribes in accordance with the state's Tribal consultation policy established pursuant to 1902(a)(73) of the Social Security Act, if the state enrolls American Indians and Alaska Natives (AI/Ans) in any of its MCPs. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** • Indicate whether the state enrolls AI/ANs in managed care and whether the state has officially recognized Tribes; comply with the state's Tribal consultation policy. • Detail the public and Tribal comment process or provide a link in the quality strategy to a document posted on the state's website that details how the state addressed this requirement. • Consider including comments received during the public comment and Tribal consultation period as an appendix to the quality strategy. • Indicate when the state made the quality strategy available for public comment and Tribal consultation. If the state has not made its quality strategy available for public comment and Tribal consultation, indicate when it will do so. • Describe comments and input received, along with whether and how the state refined its quality strategy based on the comments and input.	32-34

Assessment

Table 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.	33 36-39
§438.330(b)(4) *Note: Not required but supports the above requirement.*		Include the state's definition of SHCN.	34-35
§438.330 (b)(8) §438.208(c)(1)	II.E.7 Identification of Persons Who Need LTSS or Persons with Special Health Care Needs 42 CFR §438.340(b)(8), 42 CFR §457.1240(e), §§438.208(c)(1), 457.1230(c)	**CFR Description:** The state must describe its mechanisms to identify persons who need LTSS or persons with special health care needs. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** • Indicate in the quality strategy whether the state provides LTSS benefits through managed care. • In the description of the mechanisms the state uses to identify persons who need LTSS or persons with special health care needs, indicate whether the state uses its staff, the state's enrollment broker, or the state's MCPs to identify these persons.	22-23 31 43
§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.	55-56 Appendix D

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.340(b)(6); §457.1240(e) *Note: The CFR does not include the level of detail included in the Quality Strategy Toolkit*	II.E.6 Disparities Plan 42 CFR §§438.340(b)(6); 457.1240(e)	Document any efforts or initiatives that the state or MCO/PIHP has engaged in to reduce disparities in health care. **CFR Description:** The state must include its plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. The state must include in this plan the state's definition of disability status and how the state will make the determination that a Medicaid enrollee meets the standard. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** • Include the following elements for each disparity factor (age, race, ethnicity, sex, primary language, and disability status): • Disparity identification and evaluation method, such as an analysis of health plan information, beneficiary and provider outreach, and stratifying quality metrics by eligibility and enrollment demographic data. • A description of the state's plan to reduce disparities, by target programs and populations, such as CHIP, LTSS, and beneficiaries with behavioral health needs. • A description of the state's progress towards reducing disparities. • A description of the state's progress on any initiatives described in its previous quality strategy. • Coordinate to the extent practicable with public health authorities on plans for disparities reduction implement outside of the state Medicaid and CHIP agencies. • Identify and use measures that pertain to health care conditions and/or Medicaid and CHIP populations marked by a high degree of health disparities – for instance, by linking to other available data sources such as eligibility and enrollment demographic data to stratify by race, ethnicity, sex, language, disability status, or geography. States can also collect information on sociodemographic characteristics and then stratify the measure to detect disparities. • Capture data on social determinants of health and chronic conditions associated with disability when feasible.	

National Performance Measures

Table 14—National Performance Measures

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.330(c)(1)(i)	II.E.1 Quality Metrics and Performance Targets Exhibit 3 42 CFR §438.340(b)(3)(i), applicable also to CHIP managed care programs per 42 CFR §457.1240(e), cross-referencing §438.330(c)	Include a description of any required national performance measures and levels identified and developed by CMS in consultation with states and other stakeholders. **CFR Description:** The state must include a description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, or PCCM entity with which it contracts. This must include, but is not limited to, the state's QAPI metrics. After consulting with states and other stakeholders, and providing public notice and opportunity to comment, CMS may specify national performance measures. The state must include a description of these measures in its quality strategy. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** If CMS specifies performance measures, include them in the EQR performance measure validation activity. Through its EQR report, the state can reference information on these measures. The state may request an exemption from including these measures by submitting a written request to CMS explaining the basis for the request.	70-73 Appendix B Appendix D
§438.340(b)(3) §438.330(c)	II.E.1 Quality Metrics and Performance Targets 42 CFR §438.340(b)(3)(i), applicable also to CHIP managed	**CFR Description:** The state must include a description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, or PCCM entity with which it contracts. This must include, but is not limited to, the state's QAPI metrics. After consulting with states and other stakeholders, and providing public notice and opportunity to comment, CMS may specify national performance measures. The state must include a description of these measures in its quality strategy.	70-73 Appendix B Appendix D

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
	care programs per 42 CFR §457.1240(e), cross-referencing §438.330(c)	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** Indicate whether the state plans to voluntarily collect any of the CMS core performance measures for children and adults in Medicaid/CHIP. If so, identify state targets/goals for any of the core measures selected by the state for voluntary reporting. **CFR Description:** The state must include a description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, or PCCM entity with which it contracts. This must include, but is not limited to, the state's QAPI metrics. After consulting with states and other stakeholders, and providing public notice and opportunity to comment, CMS may specify national performance measures. The state must include a description of these measures in its quality strategy. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** Use measure results to monitor progress toward meeting the state's goals and objectives. CMS recommends that the state also review measure results when revising its quality strategy and address areas of poor performance in its goals and objectives.	
§§438.340(b)(3)(i); 457.1240(e)	II.E.2 Public Posting of Quality Measures and Performance Outcomes §§438.340(b)(3)(i); 457.1240(e)	**CFR Description:** The state must identify which quality measures and performance outcomes it will publish at least annually on its website. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** • Include a link in the quality strategy to where the state publishes measures and performance outcomes online. • Consider which measures are most meaningful and responsive to stakeholders and which would best illustrate progress on the quality strategy. • Consider selecting from measures for public posting that pertain to health conditions and/or Medicaid and CHIP populations marked by a large degree of health disparity, such as sickle cell disease in children or unnecessary cesarean section for pregnant women.	73

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		• Ensure that appropriate translation services are available and that websites are accessible in order to provide all information needed by beneficiaries.	
§438.340(b)(3)(i)	II.E.3 LTSS Performance Measures 42 CFR §438.340(b)(3)(i); 42 CFR §§457.1240(e); 438.330(c)(1)(ii)	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** If the state contracts with MCOs, PIHPs, PAHPs, and/or PCCM entities to provide LTSS, the state must describe the standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving LTSS. If the state does not provide LTSS through managed care, this requirement does not apply. **Toolkit Requirement:** Use measure results to monitor progress toward meeting the state's goals and objectives. CMS recommends that the state also review measure results when revising its quality strategy and address areas of poor performance in its goals and objectives.	70-73 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		Detail procedures that account for the regular monitoring and evaluation of MCO and PIHP compliance with the standards of subpart D (access, structure and operations, and measurement and improvement standards). The State's system must address all aspects of the managed care program, including the performance of each MCO, PIHP, PAHP, and PCCM entity (if applicable) in at least the following areas:	70-74 74-76 104-106

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		(1) Administration and management. (2) Appeal and grievance systems. (3) Claims management. (4) Enrollee materials and customer services, including the activities of the beneficiary support system. (5) Finance, including medical loss ratio reporting. (6) Information systems, including encounter data reporting. (7) Marketing. (8) Medical management, including utilization management and case management. (9) Program integrity. (10) Provider network management, including provider directory standards. (11) Availability and accessibility of services, including network adequacy standards. (12) Quality improvement. (13) Areas related to the delivery of LTSS not otherwise included in paragraphs (b)(1) through (12) of this section as applicable to the managed care program. (14) All other provisions of the contract, as appropriate. (c) The State must use data collected from its monitoring activities to improve the performance of its managed care program, including at a minimum: (1) Enrollment and disenrollment trends in each MCO, PIHP, or PAHP. (2) Member grievance and appeal logs. (3) Provider complaint and appeal logs.	

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		(4) Findings from the State's External Quality Review process. (5) Results from any enrollee or provider satisfaction survey conducted by the State or MCO, PIHP, or PAHP. (6) Performance on required quality measures. (7) Medical management committee reports and minutes. (8) The annual quality improvement plan for each MCO, PIHP, PAHP, or PCCM entity. (9) Audited financial and encounter data submitted by each MCO, PIHP, or PAHP. (10) The medical loss ratio summary reports required by § 438.8. (11) Customer service performance data submitted by each MCO, PIHP, or PAHP and performance data submitted by the beneficiary support system. (12) Any other data related to the provision of LTSS not otherwise included in paragraphs (c)(1) through (11) of this section as applicable to the managed care program. Some examples of mechanisms that may be used for monitoring include, but are not limited to: • Member or provider surveys; • HEDIS results; • Report Cards or profiles; • Required MCO/PIHP reporting of performance measures; • Required MCO/PIHP reporting on performance improvement projects; • Grievance/Appeal logs, etc.	

External Quality Review (EQR)

Table 16—External Quality Review (EQR)

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.350(a) and §340(b)(4)		Include a description of the state's arrangements for an annual, external independent quality review of the quality, access, and timeliness of the services covered under each MCO and PIHP contract. Identify what entity will perform the EQR and for what period of time.	84-86
§438.350(a) and §340(b)(4) *Note: The CFR does not include the detailed requirements included in the Quality Strategy Toolkit*	II.G.1 EQR Arrangements 42 CFR §438.340(b)(4), 42 CFR §§457.1240(e), 438.350, 457.1250	Identify what, if any, optional EQR activities the state has contracted with its External Quality Review Organization (EQRO) to perform. The five optional activities include: 1. Validation of encounter data reported by an MCO or PIHP; 2. Administration or validation of consumer or provider surveys of quality of care; 3. Calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO; 4. Conduct of performance improvement projects (PIPs) in addition to those conducted by an MCO or PIHP and validated by an EQRO; and 5. Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** The state must provide a description of its arrangements for annual, external, independent reviews of the quality outcomes, timeliness of, and access to the services covered under each MCO, PIHP, PAHP, and PCCM entity. **Toolkit Requirement:** • Describe what mandatory and optional tasks the EQRO will perform and whether the state contracts with a separate EQRO for certain types of managed care, such as behavioral health.	84-87

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		• Identify the EQRO that will perform the EQR and the length of the EQRO's contract. • Review prior EQR technical reports, paying special attention to areas of low performance. • Ensure that performance measures, PIPs, and standards related to elements in 42 CFR 438 subpart D and 438.330 are validated and then reported by an EQRO per 42 CFR 438.364.	
§438.360; and §438.340(c)(2)(iii)	III.B.2 EQRO Recommendations 42 CFR §§438.340(c)(2)(iii), 457.1240(e), cross-referencing §438.364(a)(4) and 457.1250(a).	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** The state must ensure that updates to the quality strategy take into consideration the recommendations provided by an EQRO and should describe how updates to the quality strategy take those recommendations into consideration. **Toolkit Requirement:** • Review findings and recommendations from the state's EQR reports to develop and monitor progress toward meeting its goals and objectives. • Summarize findings and recommendations from the state's latest EQR reports and describe how the quality strategy has been updated to address them.	Appendix E
§438.350(c) and §438.360		Identify the standards for which the EQR will use information from Medicare or private accreditation reviews. This must include an explanation of the rationale for why the Medicare or private accreditation standards are duplicative to those in 42 CFR §438.204(g).	87-88
§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	87-88

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		the annual EQR instead of conducting one or more of the mandatory EQR-related activities described in 438.358(b)(1)(i) through (iii), the state's quality strategy must: • Identify the EQR-related activities for which it has exercised this option. • Explain the rationale for its determination that the Medicare review or private accreditation activity is comparable to such EQR-related activities. **Toolkit Requirement:** • It is recommended that all states indicate in their quality strategies whether the state does or does not leverage the non-duplication option. A state that does leverage the non-duplication option must include the information discussed under the regulatory requirements section in its quality strategy. • If a state does leverage the non-duplication option, it should consider including sufficient information to establish that all information relied upon for the purposes of non-duplication meets the conditions identified in 42 CFR 438.360(a)(1) and (a)(3) in addition to the required explanation of the rationale for the determination required by 438.360(a)(2).	

State Standards

Table 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:** • 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.	86 90-91 94-96
§438.206(b)(1)		Maintains and monitors a network of appropriate providers	94-96
§438.206(b)(2)		Female members have direct access to a women's health specialist	93
§438.206(b)(3)		Provides for a second opinion from a qualified health care professional	93
§438.206(b)(4)		Adequately and timely coverage of services not available in network	90
§438.206(b)(5)		Out-of-network providers coordinate with the MCO or PIHP with respect to payment	90
§438.206(b)(6)		Credential all providers as required by §438.214	94-95
§438.206(b)(7)		Demonstrate that network includes sufficient family planning providers to ensure timely access to covered services	95
§438.206(c)(1)(i)		Providers meet state standards for timely access to care and services	95-98

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	95
§438.206(c)(1)(iii)		Services included in the contract available 24 hours a day, 7 days a week	95
§438.206(c)(1)(iv)-(vi)		Mechanisms to ensure compliance by providers	92 95
§438.206(c)(2)		Culturally competent services to all members	96
§438.206(c)(3)		Ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities	75 96
§438.207 Subpart D Requirements		**Assurances of Adequate Capacity and Services**	
§438.207(a)		Assurances and documentation of capacity to serve expected enrollment	92-93
§438.207(b)(1)		Offer an appropriate range of preventive, primary care, and specialty services	95
§438.207(b)(2)		Maintain network sufficient in number, mix, and geographic distribution	95
§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	93
§438.208(b)(2)		All services that the member receives are coordinated with the services the member receives from any other MCO/PIHP	93
§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	83
§438.208(b)(5)		Provider maintains and shares, as appropriate, an enrollee health record in accordance with professional standards	93
§438.208(b)(6)		Protect member privacy when coordinating care	99

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.208(c)(1)		State mechanisms to identify persons with SHCN	83
§438.208(c)(2)		Mechanisms to assess members with SHCN by appropriate health care professionals	83
§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	83
§438.208(c)(4)		Direct access to specialists for members with SHCN	83
§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	93
§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	93
§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	93
§438.210(a)(3)(ii)		No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition	93
§438.210(a)(4)		Each MCO/PIHP may place appropriate limits on a service, such as medical necessity	93
§438.210(a)(5)		Specify what constitutes “medically necessary services”	93
§438.210(b)(1)		Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services	93
§438.210(b)(2)		Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions	94
§438.210(b)(3)		Any decision to deny or reduce services is made by an appropriate health care professional	94

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§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	94
§438.210(d)		Provide for the authorization decisions and notices as set forth in §438.210(d)	93-94
§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	94
§340(b)(5)		**Transition of Care Policy**	
42 CFR §438.340(b)(5), 42 CFR §457.1240(e), cross-referencing §438.62(b)	II.E.5 Transition of Care Policy 42 CFR §438.340(b)(5), 42 CFR §457.1240(e), cross-referencing §438.62(b)	**CFR Description:** The state must include a description of its transition of care policy. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** Review the transition of care policy to ensure the following requirements are addressed: • The beneficiary has access to services consistent with the access that the beneficiary previously had and is permitted to retain a current provider for a period of time if that provider is not in the MCO, PIHP, or PAHP network. • The beneficiary is referred to appropriate providers of services that are in the network. • The state (if the beneficiary was enrolled in fee-for-service (FFS) (Medicaid), or an MCO, PIHP, PAHP, PCCM, or PCCM entity will fully and timely comply with requests for historical utilization data from the new MCO, PIHP, PAHP, PCCM or PCCM entity. • Consistent with federal and state law, the enrollee's new providers are able to obtain copies of the enrollee's medical records, as appropriate. • The process for the electronic exchange of beneficiary data. • Any other necessary procedures, as specified by the state, to ensure continued access to services to 1) prevent serious detriment to the enrollee's health or 2) reduce the risk of hospitalization or institutionalization.	93

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	95
§438.214(b)(1)		Uniform credentialing and recredentialing policy that each MCO/PIHP must follow	95
§438.214(b)(2)		Documented processes for credentialing and recredentialing that each MCO/PIHP must follow	95
§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	95
§438.214(d)		MCOs/PIHPs may not employ or contract with providers excluded from Federal health care programs	95
§438.214(e)		Comply with any additional requirements established by the state	95
§438.10		**Information Requirements**	
§438.10		Incorporate member information requirements of §438.10	75 98
§438.224 Subpart D Requirements		**Confidentiality**	
§438.224		Individually identifiable health information is disclosed in accordance with Federal privacy requirements	98-99
§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	99

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.228 Subpart D Requirements		**Grievance and Appeal Systems**	
§438.228(a)		Grievance systems meet the requirements of Part 438, subpart F	99-100
§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	101
§438.230(b)(1)		Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform	101
§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.	101
§438.230(c)(1)(iii)		Monitoring of subcontractor performance on an ongoing basis	101
§438.230(c)(1)(iii)		Corrective action for identified deficiencies or areas for improvement	101

Measurement and Improvement Standards

Table 19—Measurement and Improvement Standards

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.236 Subpart D Requirements		**Practice Guidelines**	
§438.236(b)		Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of members; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate.	102
§438.236(c)		Dissemination of practice guidelines to all providers, and upon request, to members	102
§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.	102
§ 438.330		**Quality Assessment and Performance Improvement Program**	
§438.330(a)(3)		An ongoing quality assessment and performance improvement program	103
§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	104-105 Appendix C

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
	42 CFR §§457.1240(e); 438.330(d); 457.1240(b)	beneficiaries enrolled in an MCO, PIHP, PAHP, or PCCM entity. If CMS has specified a PIP, the state must include a description of PIPs required by CMS. **Toolkit Requirement:** • For each PIP that MCPs implement, consider including information on the PIP topic, aim, and intervention. • All PIPs should be included in the EQR PIP validation activity. Therefore, the state can reference its EQR reports for information on them.	
§438.330(d)		Conduct performance improvement projects, including any performance improvement projects required by CMS, that focus on both clinical and nonclinical areas: • Measurement of performance using objective quality indicators • Implementation of interventions to achieve improvement in the access to and quality of care • Evaluation of the effectiveness of the interventions based on the performance measures in the quality strategy • Planning and initiation of activities for increasing or sustaining improvement	104-105 Appendix C
§438.330(d)(3)		Report the status and results of each project conducted, not less than once per year	104-105
§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	89 104
§438.330(c)(i)		Identify standard performance measures, including those performance measures that may be specified by CMS	104
§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	105-106 Appendix D
§438.330(b)(3)		Mechanisms to detect both underutilization and overutilization of services	36 44

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.330(b)(4)		Mechanisms to assess the quality and appropriateness of care furnished to members with SHCN	69-70
§438.330(b)(5)(i) §438.330(b)(5)(ii)		For MCOs, PIHPs, or PAHPs providing long-term services and supports: Mechanisms to assess the quality and appropriateness of care furnished to enrollees using long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan, if applicable; and Participate in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare that are based, at a minimum, on the requirements on the State for home and community-based waiver programs per §441.302(h).	92
§438.330(e)		Annual review by the state of each quality assessment and performance improvement program. If the state requires that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program, indicate this in the quality strategy. The review must include: • Performance on the measures on which it is required to report • The outcomes and trended results of performance improvement projects • The results of any efforts to support community integration for enrollees using long-term services and supports • *May* require a developed process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program	85-886 105-106
§ 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	106

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.242(b)(2)		Each MCO and PIHP must collect data on member and provider characteristics and on services furnished to members	106
§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	106
§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	106
§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	15 106
§438.242(c)(3)		Each MCO submits enrollee encounter data, including allowed amount and paid amount, to the state	15
§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	15
Optional		Include any health information technology (HIT) initiatives that will support the objectives of the state's quality strategy.	17 106

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: 1. Cross-state agency collaborative;	23 50-51 88 90

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		2. Pay-for-performance or value-based purchasing initiatives; 3. Accreditation requirements; 4. Grants; 5. Disease management programs; 6. Changes in benefits for members; 7. Provider network expansion, etc.	
Optional		Describe how the state's planned interventions tie to each specific goal and objective of the quality strategy.	68-69

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.	76-78
Optional		Specify the state's methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems.	76
§438.340(b)(7) 42 CFR Part 438, subpart I *Note: The CFR does not include the level of detail that is included in*	II.F.3 Intermediate Sanctions 42 CFR §438.340(b)(7), 42 CFR §457.1240(e), Part 438 Subpart I	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** For MCOs, the state must include appropriate use of intermediate sanctions that, at a minimum, meet the sanctions requirements in Part 438 subpart I. **Toolkit Requirement:** • Indicate whether the state applied any intermediate sanctions to any MCP in the past three years, the number and types of those sanctions, and for what	76-78

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
the Quality Strategy Toolkit.		reasons. The state can determine whether to describe the sanctions it applied at the MCP level or the aggregate level. • Describe other actions taken in the past three years to enforce MCP compliance with state and federal rules, such as corrective action plans.	

Conclusions and Opportunities

Table 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.	39-40
Optional		Include a discussion of the ongoing challenges the state faces in improving the quality of care for beneficiaries.	28-29 49 61
Optional		Include recommendations that the state has for ongoing Medicaid and CHIP quality improvement activities in the state. Highlight any grants received that support improvement of the quality of care received by managed care members, if applicable.	NA

★ Appendix B. Performance Measure Metrics ★

Table 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		
1.1.1.1. Number of Outreach and Engagement (O&E) Activities Per year	MCO Reporting	DMAS
1.1.1.2 Monitor Language and Disability Access Reports	DMAS	DMAS
1.1.1.3 Monitor Member Language Counts	DMAS	DMAS
Objective 1.2 Improve Member Satisfaction		
1.2.1.1 Enrollees' Ratings Q8-Rating of all Health Care	CAHPS CMS Child Core Set CMS Adult Core Set	AHRQ
1.2.1.2 Rating of Personal Doctor	CAHPS CMS Child Core Set CMS Adult Core Set	AHRQ
★ Goal 2: Promote Access to Safe, Gold-Standard Patient Care ★		
Objective 2.1 Ensure Access to Care		
2.1.1.1 Getting Care Quickly Q6	CAHPS CMS Child Core Set CMS Adult Core Set	AHRQ
2.1.1.2 Respondent Got Non-Urgent Appointment as Soon as Needed	CAHPS CMS Child Core Set CMS Adult Core Set	AHRQ
2.1.1.3 Getting Needed Care	CAHPS CMS Child Core Set CMS Adult Core Set	AHRQ
Objective 2.2 Promote Patient Safety		
2.2.1.1 Prevalence of Pressure Ulcers Among LTSS Members	DMAS	DMAS
2.2.1.2 Monitor the Frequency of Reported Critical Incidents by Member Classification	DMAS	DMAS
Objective 2.3 Promote Effective Communication and Care Coordination		
2.3.1.1 How Well Doctors Communicate	CAHPS CMS Child Core Set CMS Adult Core Set	AHRQ
2.3.1.2 Service Authorizations	MCO Reporting https://www.dmas.virginia.gov/data/mco-service-authorization-performance/	DMAS

Measure Name	Data Source	Measure Steward *(if applicable)*
★ Goal 3: Support Efficient and Value-Driven Care ★		
Objective 3.1 Focus on Paying for Value		
3.1.1.1 Frequency of Potentially Preventable Admissions	Clinical Efficiency Measures	DMAS
3.1.1.2 Frequency of Emergency Department Visits	Clinical Efficiency Measure	DMAS
3.1.1.3 Frequency of Potentially Preventable Emergency Department Visits	Clinical Efficiency Measures	DMAS
3.1.1.3 Frequency of Potentially Preventable Readmissions	DMAS	DMAS
3.1.1.4 Ambulatory Care	HEDIS	NCQA
3.1.1.5 Ambulatory Care: Emergency Department (ED) Visits	Clinical Efficiency Measures HEDIS CMS Child Core Set	DMAS NCQA
3.1.1.6 Days Without Minimum RN Hours	DMAS VBP Reporting Team CMS Payroll Based Journal	DMAS
3.1.1.7 Total Nurse Staffing Hours Per Resident Day (RN, LPN, CAN)—Case-Mix Adjusted	DMAS VBP Reporting Team CMS Nursing Home Compare	DMAS
3.1.1.8 Percentage of Long-Stay Resident with a Urinary Tract Infection (UTI)	DMAS VBP Reporting Team CMS Nursing Home Compare	DMAS
3.1.1.9 Number of Hospitalizations per 1,000 Long-Stay Resident Days	DMAS VBP Reporting Team CMS Nursing Home Compare	DMAS
3.1.1.10 Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days	DMAS VBP Reporting Team CMS Nursing Home Compare	DMAS
3.1.1.11 Percentage of Long-Stay High-Risk Residents with Pressure Ulcers	DMAS VBP Reporting Team CMS Nursing Home Compare	DMAS
Objective 3.2 Promote Efficient Use of Program Funds		
3.2.1.1 Monitor Medical Loss Ratio	DMAS—MCO Financials https://www.dmas.virginia.gov/data/mco-financials/	DMAS
Goal 4: Strengthen the Health of Families and Communities		
Objective 4.1 Improve the Utilization of Wellness, Immunization, and Prevention Services for Members		
4.1.1.1 Adults' Access to Preventive/Ambulatory Health Services	HEDIS	NCQA

Measure Name	Data Source	Measure Steward *(if applicable)*
4.1.1.2 Child and Adolescent Well-Care Visits	HEDIS CMS Child Core Set	NCQA
4.1.1.3 Childhood Immunization Status	HEDIS CMS Child Core Set	NCQA
4.1.1.4 Immunizations for Adolescents	HEDIS CMS Child Core Set	NCQA
4.1.1.5 Flu Vaccinations for Adults 18–64	CAHPS CMS Adult Core Set	AHRQ
4.1.1.6 Topical Fluoride for Children	CMS 416 CMS Child Core Set	CMS
4.1.1.7 Oral Evaluation, Dental Services	CMS 416 CMS Child Core Set	CMS
4.1.1.8 Sealant Receipt on Permanent First Molars	CMS Child Core Set CMS Child Core Set	CMS
4.1.1.9 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	HEDIS CMS Child Core Set	NCQA
4.1.1.10 Chlamydia Screening in Women Ages 16 to 20	HEDIS CMS Child Core Set	NCQA
4.1.1.11 Lead Screening in Children	HEDIS CMS Child Core Set	NCQA
★ Objective 4.2 Improve Outcomes for Maternal and Infant Members ★		
4.2.1.1 Prenatal and Postpartum Care: Postpartum Care	HEDIS CMS Adult Core Set	NCQA
4.2.1.2 Prenatal and Postpartum Care: Timeliness of Prenatal Care	HEDIS CMS Child Core Set	NCQA
4.2.1.3 Live Births Weighing Less than 2,500 Grams	CDC Wonder State Vital Statistics CMS Child Core Set	CMS
4.2.1.4 Well-Child Visits in the First 30 Months of Life	HEDIS CMS Child Core Set	NCQA
4.2.1.5 Low-Risk Cesarean Delivery	CMS Child Core Set	CDC
Objective 4.3 Improve Home and Community-Based Services		
4.3.1.1 Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and Appropriate to Their Needs and Personal Goals	QMR	DMAS
4.3.1.2 Number and Percent of Individuals Who Received Services in the Scope Specified in the Service Plan	QMR	DMAS
Goal 5: Providing Whole-Person Care for Vulnerable Populations		
Objective 5.1 Improve Outcomes for Members with Chronic Conditions		

Measure Name	Data Source	Measure Steward *(if applicable)*
5.1.1.1 PQI 08: Heart Failure Admission Rate	Performance Measure CMS Adult Core Set	AHRQ
5.1.1.2; PQI 14: Asthma Admission Rate (Ages 2–17)	Performance Measure	AHRQ
5.1.1.3 PQI 05: COPD and Asthma in Older Adults' Admission Rate	Performance Measure CMS Adult Core Set	AHRQ
5.1.1.4 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	HEDIS CMS Adult Core Set	NCQA
5.1.1.5 Controlling High Blood Pressure	HEDIS	NCQA
5.1.1.6 Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years	HEDIS CMS Child Core Set	NCQA
5.1.1.7 Asthma Medication Ratio: Ages 5 to 18 Years	HEDIS CMS Child Core Set	NCQA
Objective 5.2 Improve Outcomes for Nursing Home Eligible Members		
5.2.1.1 Use of High-Risk Medications in Older Adults (Elderly)	HEDIS	NCQA
★ Objective 5.3 Improve Outcomes for Members with Substance Use Disorders ★		
5.3.1.1 Monitor Identification of Alcohol and Other Drug Services	DMAS	DMAS
5.3.1.2 Follow-Up After Emergency Department Visit for Substance Use	HEDIS CMS Child Core Set CMS Adult Core Set	NCQA
5.3.1.3 Use of Opioids at High Dosage in Persons Without Cancer	HEDIS CMS Adult Core Set	NCQA
5.3.1.4 Initiation and Engagement of Substance Use Disorder Treatment	HEDIS CMS Adult Core Set	NCQA
5.3.1.5 Use of Pharmacotherapy for Opioid Use Disorder	CMS Adult Core Set	CMS
★ Objective: 5.4 Improve Behavioral Health and Developmental Services for Members ★		
5.4.1.1 Follow-Up After Hospitalization for Mental Illness	HEDIS	NCQA
5.4.1.2 Follow-Up After Emergency Department Visit for Mental Illness	HEDIS CMS Adult Core Set	NCQA
5.4.1.3 Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	HEDIS CMS Child Core Set	NCQA
5.4.1.4 Monitor Mental Health Utilization	DMAS	DMAS

Measure Name	Data Source	Measure Steward *(if applicable)*
5.4.1.5 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	HEDIS CMS Child Core Set	NCQA
5.4.1.6 Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS CMS Child Core Set	NCQA
5.4.1.7 Medical Assistance with Smoking and Tobacco Use Cessation	CAHPS CMS Adult Core Set	NCQA
5.4.1.8 Antidepressant Medication Management	HEDIS CMS Adult Core Set	NCQA
5.4.1.9 Screening for Depression and Follow-Up Plan: Ages 18 and Older	CMS Adult Core Set	CMS
5.4.1.10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS CMS Adult Core Set	NCQA
5.4.1.11 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	HEDIS CMS Adult Core Set	NCQA
5.4.1.12 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	HEDIS CMS Adult Core Set	NCQA

★ These goals are inclusive of Governor Glenn Youngkin's identified priorities for the Medicaid program that focus on behavioral health enhancement, maternal health outcomes, and access to high quality healthcare services.

Table 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		
1.2.1.3 Timely Processing of Member Applications, Renewals, and Appeals	DMAS	DMAS
Goal 2: Promote Access to Safe, Gold-Standard Patient Care		
Objective 2.1 Ensure Access to Care		
2.1.1.4 Monitor Network Adequacy by Region and Provider Types	MCO Reporting	DMAS
2.1.1.5 Monitor Frequency and Reasons for Missed Trips	MCO Reporting	DMAS
2.1.1.6 Cervical Cancer Screening	HEDIS CMS Adult Core Set	NCQA
2.1.1.7 Chlamydia Screening in Women Ages 21 to 24	HEDIS CMS Adult Core Set	NCQA

Measure Name	Data Source	Measure Steward *(if applicable)*
2.1.1.8 Colorectal Cancer Screening	HEDIS CMS Adult Core Set	NCQA
2.1.1.9 Breast Cancer Screening	HEDIS CMS Adult Core Set	NCQA
2.1.1.10 Contraceptive Care—Postpartum Women Ages 21 to 44	CMS Adult Core Set	OPA
2.1.1.11 Contraceptive Care—All Women Ages 21 to 44	CMS Adult Core Set	OPA
2.1.1.12 Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 18 and Older	HEDIS CMS Adult Core Set	NCQA
2.1.1.13 Asthma Medication Ratio: Ages 19 to 64	HEDIS CMS Adult Core Set	NCQA
2.1.1.14 HIV Viral Load Suppression	CMS Adult Core Set	HRSA
2.1.1.15 Concurrent Use of Opioids and Benzodiazepines	CMS Adult Core Set	PQA
Goal 3: Support Efficient and Value-Driven Care		
Objective 3.2 Promote Efficient Use of Program Funds		
3.2.1.1 Number of Administrative and Medical Deferrals and Disallowances;	DMAS—MCO Financials https://www.dmas.virginia.gov/data/mco-financials/	DMAS
3.2.1.3 Diabetes Short-Term Complications Admission Rate	CMS Adult Core Measure Set	AHRQ
3.2.1.4 Heart Failure Admission Rate	CMS Adult Core Measure Set	AHRQ
3.2.1.5 Asthma in Younger Adults Admission Rate	CMS Adult Core Measure Set	AHRQ
3.2.1.6 Plan All-Cause Readmission Rate	HEDIS CMS Adult Core Measure Set	NCQA
Objective 5.2 Improve Outcomes for Nursing Home Eligible Members		
5.2.1.2 Nursing Facility Residents Hospitalization Rate	DMAS	DMAS
5.2.1.3 CCC Plus Waiver Members Who Re-Enter the Community After a Short-Term Nursing Facility Stay	DMAS	DMAS
5.2.1.4 Members Who Transitioned from a Nursing Facility to the Community Who Returned to the Nursing Facility Within 90 Days	DMAS	DMAS

Measure Name	Data Source	Measure Steward *(if applicable)*
5.2.1.5 Long-Term Services and Supports Comprehensive Care Plan and Update	HEDIS CMS Adult Core Set	NCQA
5.2.1.6 National Core Indicators Survey	Survey	National Association of State Directors of Development Disabilities Services/HSRI

Appendix C. Performance Improvement Topics

Table 25—Performance Improvement Projects 2022

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions	Intervention Effectiveness Measures
Aetna Better Health of Virginia	Timeliness of Prenatal Care	TBD	TBD	TBD	TBD
	Tobacco Use Cessation in Pregnant Women	TBD	TBD	TBD	TBD
	Ambulatory Care—Emergency Department Visits	TBD	TBD	TBD	TBD
	Follow-Up After Discharge	TBD	TBD	TBD	TBD
HealthKeepers, Inc.	Timeliness of Prenatal Care	TBD	TBD	TBD	TBD
	Tobacco Use Cessation in Pregnant Women	TBD	TBD	TBD	TBD
	Ambulatory Care—Emergency Department Visits	TBD	TBD	TBD	TBD
	Follow-Up After Discharge	TBD	TBD	TBD	TBD
Molina	Timeliness of Prenatal Care	TBD	TBD	TBD	TBD
	Tobacco Use Cessation in Pregnant Women	TBD	TBD	TBD	TBD
	Ambulatory Care—Emergency Department Visits	TBD	TBD	TBD	TBD

MCO	PIP Topic	Aim Statement	Performance Indicator	Proposed Interventions	Intervention Effectiveness Measures
	Follow-Up After Discharge	TBD	TBD	TBD	TBD
Optima Health Community Care	Timeliness of Prenatal Care	TBD	TBD	TBD	TBD
	Tobacco Use Cessation in Pregnant Women	TBD	TBD	TBD	TBD
	Ambulatory Care—Emergency Department Visits	TBD	TBD	TBD	TBD
	Follow-Up After Discharge	TBD	TBD	TBD	TBD
UnitedHealthcare Community Plan of Virginia	Timeliness of Prenatal Care	TBD	TBD	TBD	TBD
	Tobacco Use Cessation in Pregnant Women	TBD	TBD	TBD	TBD
	Ambulatory Care—Emergency Department Visits	TBD	TBD	TBD	TBD
	Follow-Up After Discharge	TBD	TBD	TBD	TBD
Virginia Premier	Timeliness of Prenatal Care	TBD	TBD	TBD	TBD
	Tobacco Use Cessation in Pregnant Women	TBD	TBD	TBD	TBD
	Ambulatory Care—Emergency Department Visits	TBD	TBD	TBD	TBD
	Follow-Up After Discharge	TBD	TBD	TBD	TBD

Note: Proposed PIP interventions will be identified and initiated during calendar year 2023.

Appendix D. Goals Tracking Table

DMAS continues to monitor the impact of the COVID-19 pandemic on health plan business operations, including its potential effect on medical record data collection, limited access to provider offices, and quarantines and risk to staff. DMAS placed the health and well-being of healthcare workers and members as its top priority.

However, the pandemic had a significant impact on delivery of healthcare services. Many provider offices were closed and offered limited telehealth services. Initially, COVID-19 resulted in a lack of demand for healthcare services. Families deferred going to the doctor's office for routine, nonemergency care. DMAS required MCOs to extend authorizations and expanded the use of telehealth. DMAS also implemented flexibilities for care and services for members receiving LTSS. DMAS allowed flexibilities for specific face-to-face visit requirements and other HCBS. The flexibilities were designed to maintain provider staffing, maximize access to care, and minimize viral spread through community contact to protect the most vulnerable populations.

Decreased access and lack of scheduling of routine and preventive services, may have negatively impacted rates. The impact from COVID-19 was an environmental factor that was beyond DMAS' control and may have an impact on the overall achievement of goals and outcomes anticipated from the implementation of the Quality Strategy.

Table 26—Goals Tracking Table

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
Goal 1: Enhance the Member Care Experience	**Objective 1.1** Increase Member Engagement and Outreach	1.1.1.1. Number of Outreach and Engagement (O&E) Activities Per year	DMAS Cover Virginia	**Cover Virginia 2021:** Spanish Calls Taken by Spanish-Speaking Bilingual Staff: 73,088 **Cover Virginia 2021:** Calls Taken with Language Assistance Services: 50,902		

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Medallion 4.0 Call Center Language Calls 2021: 7,551 **CCC Plus** Call Center Language Calls 2021: 545 **2021 DMAS Website** Translation Requests 2021: 3,489		
		1.1.1.2 Monitor Language and Disability Access Reports	DMAS	• CCC Plus: • Medallion 4.0:		
		1.1.1.3 Monitor Member Language Counts	DMAS	• CCC Plus: • Medallion 4.0:		
	Objective 1.2 Improve Member Satisfaction	1.2.1.1 Enrollees' Ratings Q8-Rating of all Health Care	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus: 68.5% • Medallion 4.0: 75.7% Adult: • CCC Plus: 58.7% • Medallion 4.0: 55.8%		

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		1.2.1.2 Rating of Personal Doctor	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus: 79.5% • Medallion 4.0: 77.7% Adult: • CCC Plus: 72.8% • Medallion 4.0: 68.0%		
★ **Goal 2:** Promote Access to Safe, Gold-Standard Patient Care	**Objective 2.1** Ensure Access to Care	2.1.1.1 Getting Care Quickly Q6	CAHPS – AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus: 89.7% • Medallion 4.0: 86.0% Adult: • CCC Plus: 85.0% • Medallion 4.0: 81.1%		
		2.1.1.2 Respondent Got Non-Urgent Appointment as Soon as Needed	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus: % • Medallion 4.0: % Adult: • CCC Plus: % • Medallion 4.0: %		

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		2.1.1.3 Getting Needed Care	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	AHRQ CAHPS 2021 Child: • CCC Plus: 87.3% • Medallion 4.0: 84.6% Adult: • CCC Plus: 86.1% • Medallion 4.0: 82.9%		
	Objective 2.2 Promote Patient Safety	2.2.1.1 Prevalence of Pressure Ulcers Among LTSS Members	DMAS	Long-Term Nursing Facility: 3.3%[1] Short-Term Nursing Facility: 7.1%[1] CCC Plus Waiver Members: 1.9%[1]		
		2.2.1.2 Monitor the Frequency of Reported Critical Incidents by Member Classification	DMAS	• CCC Plus Waiver w/o PDN: 694 • CCC Plus Waiver: 26 • CCC Plus Waiver W PDN: 30 • DD Waiver: 9 • Emerging Vulnerable: 349 • Minimal Need: 107		

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Nursing Facility: 446 • Other: 732 • Total: 2,393[2]		
	Goal 2.3 Promote Effective Communication and Care Coordination	2.3.1.1 How Well Doctors Communicate	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus: 93.9% • Medallion 4.0: 93.7% Adult: • CCC Plus: 94.2% • Medallion 4.0: 93.3%		
		2.3.1.2 Service Authorizations	DMAS https://www.dmas.virginia.gov/data/mco-service-authorization-performance/	MCO Reporting		
★ **Goal 3:** Support Efficient and Value-Driven Care	**Objective 3.1** Focus on Paying for Value	3.1.1.1 Frequency of Potentially Preventable Admissions	DMAS Clinical Efficiency Measures	Clinical Efficiency Measures		
		3.1.1.2 Frequency of Emergency Department Visits	DMAS Clinical Efficiency Measure	Clinical Efficiency Measures		
		3.1.1.3 Frequency of Potentially Preventable Readmissions	DMAS Clinical Efficiency Measure	CCC Plus: Medallion 4.0		
		3.1.1.4 Ambulatory Care	NCQA HEDIS	HEDIS MY 2020 • CCC Plus: 77.45 • Medallion 4.0:		
		3.1.1.5 Ambulatory Care: Emergency (ED) Visits	DMAS Clinical Efficiency Measures NCQA HEDIS (AMB) CMS Child Core Set: AMB-CH	Clinical Efficiency Measures • CCC Plus:		

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0: HEDIS MY 2020 • CCC Plus: 77.45% • Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0		
		3.1.1.6 Days Without Minimum RN Hours	DMAS VBP Reporting Team CMS Payroll Based Journal	NF VBP Program 2019 • CCC Plus:	NF VBP	
		3.1.1.7 Total Nurse Staffing Hours Per Resident Day (RN, LPN, CAN) – Case-Mix Adjusted	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus:	NF VBP	
		3.1.1.8 Percentage of Long-Stay Resident with a Urinary Tract Infection (UTI)	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus:	NF VBP	
		3.1.1.9 Number of Hospitalizations per 1,000 Long-Stay Resident Days	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus:	NF VBP	
		3.1.1.10 Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus:	NF VBP	
		3.1.1.11 Percentage of Long-Stay High-Risk Residents with Pressure Ulcers	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 • CCC Plus:	NF VBP	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
	Objective 3.2 Promote Efficient Use of Program Funds	3.2.1.1 Monitor Medical Loss Ratio	DMAS—MCO Financials https://www.dmas.virginia.gov/data/mco-financials/	• CCC Plus: • Medallion 4.0:		
Goal 4: Strengthen the Health of Families and Communities	**Objective 4.1** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	4.1.1.1 Adults' Access to Preventive/Ambulatory Health Services	NCQA HEDIS (AAP)	HEDIS MY 2020 • CCC Plus: 87.12% • Medallion 4.0: 72.75%		
		4.1.1.2 Child and Adolescent Well-Care Visits	NCQA HEDIS (WCV) Child Core Set: WCV-CH	HEDIS MY 2020 • CCC Plus: 39.86% • Medallion 4.0: 46.57% Child Core Set • CCC Plus: • Medallion 4.0:		
		4.1.1.3 Childhood Immunization Status	NCQA HEDIS (CIS) • Combo 3 Child Core Set: CIS-CH	HEDIS MY 2020 • CCC Plus: 65.58% • Medallion 4.0: 65.82% Child Core Set • CCC Plus: • Medallion 4.0:		
		4.1.1.4 Immunizations for Adolescents	NCQA HEDIS (IMA) • Combo 1 • Combo 2 Child Core Set: IMA-CH	HEDIS MY 2020 Combo 1 • CCC Plus: 64.10% • Medallion 4.0: %		

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Combo 2 • CCC Plus: 26.02% • Medallion 4.0: % Child Core Set • CCC Plus: • Medallion 4.0:		
		4.1.1.5 Flu Vaccinations for Adults 18-64	AHRA CAHPS Adult Core Set: CPA-AD	CAHPS 2021: ND Adult Core Set • CCC Plus: • Medallion 4.0:		
		4.1.1.6 Topical Fluoride for Children	NCQA HEDIS (TFC) Child Core Set: TFL-CH CMS 416	HEDIS MY 2020 • CCC Plus: • Medallion 4.0: Child Core Set • CCC Plus: • Medallion 4.0: CMS 416 2021		
		4.1.1.7 Oral Evaluation, Dental Services	NCQA HEDIS (OED) Child Core Set: OEV-CH CMS 416	HEDIS MY 2020 • CCC Plus: • Medallion 4.0: Child Core Set • CCC Plus: • Medallion 4.0: • CMS 416 2021		

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		4.1.1.8 Sealant Receipt on Permanent First Molars	Child Core Set: SFM-CH CMS 416	Child Core Set • CCC Plus: • Medallion 4.0: CMS 416 2021		
		4.1.1.9 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA HEDIS (WCC) CMS Child Core Set (WCC-CH)	HEDIS MY 2020 CCC Plus: • Blood Glucose Testing-Total: 41.33% • Cholesterol Testing—Total: 28.59% • Blood Glucose and Cholesterol Testing-Total: 27.05% • Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0:		
		4.1.1.10 Chlamydia Screening in Women Ages 16 to 20	NCQA HEDIS (CHL) CMS Child Core Set (CHL-CH)	HEDIS MY 2020 • CCC Plus: NR • Medallion 4.0: NR Child Core Set • CCC Plus:		

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0:		
		4.1.1.11 Lead Screening in Children	NCQA HEDIS (LSC) CMS Child Core Set (LSC-CH)	HEDIS MY 2020 • CCC Plus: NR • Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0:		
	★ **Objective 4.2** Improve Outcomes for Maternal and Infant Members	4.2.1.1 Prenatal and Postpartum Care: Postpartum Care	NCQA HEDIS (PPC) Adult Core Set: PPC-AD	HEDIS MY 2020 Postpartum Care • CCC Plus: NR • Medallion 4.0: 66.52% Adult Core Set Postpartum Care • CCC Plus: • Medallion 4.0:		
		4.2.1.2 Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA HEDIS (PPC) Child Core Set: PPC-CH	HEDIS MY 2020 Timeliness of Prenatal Care • CCC Plus: NR • Medallion 4.0: 73.00% Adult Core Set Timeliness of Prenatal Care • CCC Plus:		

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0:		
		4.2.1.3 Live Births Weighing Less than 2,500 Grams	Child Core Set: LBW-CH CDC Wonder State Vital Records	CMS 2021 Child Core Set Reported Rate—CDC Wonder Data:		
		4.2.1.4 Well-Child Visits in the First 30 Months of Life	NCQA HEDIS (W30) Child Core Set: W30-CH	HEDIS MY 2020 • CCC Plus: 71.81% • Medallion 4.0: 72.10% Child Core Set • CCC Plus: • Medallion 4.0:		
		4.2.1.5 Low-Risk Cesarean Delivery	Child Core Set: LRCD-CH CDC Wonder State Vital Records	Child Core Set CMS 2021 Reported Rate—CDC Wonder Data:		
	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%		
		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%		

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.1** Improve Outcomes for Members with Chronic Conditions	5.1.1.1 PQI 08: Heart Failure Admission Rate	Adult Core Set: PQI08-AD	Adult Core Set • CCC Plus: • Medallion 4.0:		
		5.1.1.2 PQI 14: Asthma Admission Rate (Ages 2–17)	Adult Core Set: PQI15-AD	Adult Core Set • CCC Plus: • Medallion 4.0:		
		5.1.1.3 PQI 05: COPD and Asthma in Older Adults' Admission Rate	Adult Core Set: PQI105-AD	Adult Core Set • CCC Plus: 41.04% • Medallion 4.0:		
		5.1.1.4 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	NCQA HEDIS (HPC) Adult Core Set: HPC-AD	HEDIS MY 2020 • CCC Plus: 51.42% • Medallion 4.0: 41.04% Adult Core Set • CCC Plus: • Medallion 4.0:		
		5.1.1.5 Controlling High Blood Pressure	NCQA HEDIS (CBP) Adult Core Set: CBP-AD	HEDIS MY 2020 • CCC Plus: 48.07% • Medallion 4.0: 46.91% Adult Core Set • CCC Plus: • Medallion 4.0:		
		5.1.1.6 Avoidance of Antibiotic Treatment for	NCQA HEDIS (AAB)	HEDIS MY 2020		

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		Acute Bronchitis: Ages 3 Months to 17 Years	CMS Child Core Set: AAB-CH	• CCC Plus: 47.93% • Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0:		
		5.1.1.7 Asthma Medication Ratio: Age 5 to 18 Years	NCQA HEDIS (AMR) CMS Child Core Set: AMR-CH	HEDIS MY 2020 • CCC Plus: 63.62% • Medallion 4.0: 71.00% Child Core Set • CCC Plus: • Medallion 4.0:		
	Objective 5.2 Improve Outcomes for Nursing Home Eligible Members	5.2.1.1 Use of High-Risk Medications in Older Adults (Elderly)	NCQA HEDIS (DAE)	HEDIS MY 2020: CCC Plus: 14.88%		
	★ **Objective 5.3** Improve Outcomes for Members with Substance Use Disorders	5.3.1.1 Monitor Identification of Alcohol and Other Drug Services	DMAS	• CCC Plus: • Medallion 4.0:		
		5.3.1.2 Follow-Up After Emergency Department Visit for Substance Use	NCQA HEDIS (FUA) Child Core Set: FUA-CH	HEDIS MY 2020 CCC Plus • 7-Day: 11.44% • 30-Day: 19.98% Medallion 4.0:		

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• 7-Day: 13.92% • 30-Day: 21.88% Child Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0: • 7-Day: • 30-Day:		
		5.3.1.3 Use of Opioids at High Dosage in Persons Without Cancer	NCQA HEDIS (OHD) Adult Core Set: OHD-AD	HEDIS MY 2020 • CCC Plus: • Medallion 4.0: Adult Core Set • CCC Plus: • Medallion 4.0:		
		5.3.1.4 Initiation and Engagement of Substance Use Disorder Treatment	NCQA HEDIS (IET) Adult Core Set: IET-AD	HEDIS MY 2020 CCC Plus: • Initiation: 46.41% • Engagement: 12.51% Medallion 4.0: • Initiation: • Engagement: Adult Core Set CCC Plus: • Initiation: • Engagement: • Medallion 4.0:		

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Initiation: • Engagement:		
		5.3.1.5 Use of Pharmacotherapy for Opioid Use Disorder	CMS Adult Core Set: OUD-AD	Adult Core Set • CCC Plus • Medallion 4.0:		
	★ **Goal: 5.4** Improve Behavioral Health and Developmental Services for Members	5.4.1.1 Follow-Up After Hospitalization for Mental Illness	NCQA HEDIS (FUH) Adult Core Set: FUH-AD Child Core Set: FUH-CH	HEDIS MY 2020 CCC Plus • 7-Day: 30.77% • 30-Day: 54.12% Medallion 4.0: • 7-Day: 35.63% • 30-Day: 56.84% Adult Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0: • 7-Day: • 30-Day: Child Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0: • 7-Day: • 30-Day:		

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		5.4.1.2 Follow-Up After Emergency Department Visit for Mental Illness	NCQA HEDIS (FUM) Adult Core Set: FUM-AD Child Core Set: FUM-CH	HEDIS MY 2020 CCC Plus • 7-Day: 47.03% • 30-Day: 62.83% Medallion 4.0: • 7-Day: 45.34% • 30-Day: 57.38% Adult Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0: • 7-Day: • 30-Day: Child Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0: • 7-Day: • 30-Day:		
		5.4.1.3 Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	NCQA HEDIS (ADD) Child Core Set: ADD-CH	HEDIS MY 2020 CCC Plus • Initiation: • Continuation: Medallion 4.0 • Initiation: 45.20%		

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Continuation: 58.61% Child Core Set CCC Plus: • Initiation: • Continuation: CCC Plus: • Initiation: • Continuation:		
		5.4.1.4 Monitor Mental Health Utilization	DMAS	DMAS • CCC Plus: • Medallion 4.0:		
		5.4.1.5 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA HEDIS (APP) Child Core Set: APP-CH	HEDIS MY 2020 • CCC Plus: 43.71% • Medallion 4.0: 69.58% Child Core Set • CCC Plus: • Medallion 4.0:		
		5.4.1.6 Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA HEDIS (APM) CMS Child Core Set: APM-CH	HEDIS MY 2020 CCC Plus: • Blood Glucose Testing—Total: 41.33 • Cholesterol Testing—Total: 28.59%		

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Blood Glucose and Cholesterol Testing—Total: 27.05% Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0:		
		5.4.1.7 Medical Assistance with Smoking and Tobacco Use Cessation	CMS Adult Core Set: MSC-AD	Adult Core Set • CCC Plus: • Medallion 4.0:		
		5.4.1.8 Antidepressant Medication Management	NCQA HEDIS (AMM) CMS Adult Core Set: AMM-AD	HEDIS MY 2020: CCC Plus: • Effective Acute Phase Treatment: 61.11% • Effective Continuation Phase: 48.29% Medallion 4.0: • Effective Acute Phase Treatment: 57.12% • Effective Continuation Phase: 42.02%		

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Adult Core Set • CCC Plus: • Medallion 4.0:		
		5.4.1.9 Screening for Depression and Follow-Up Plan: Ages 18 and Older	CMS Adult Core Set: CDF-AD	Adult Core Set • CCC Plus: • Medallion 4.0:		
		5.4.1.10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA HEDIS (SSD) CMS Adult Core Set: SSD-AD	HEDIS MY 2020: • CCC Plus: 77.18% • Medallion 4.0: NR Adult Core Set • CCC Plus: • Medallion 4.0:		
		5.4.1.11 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA HEDIS (HPCMI) CMS Adult Core Set: HPCMI-AD	HEDIS MY 2020 • CCC Plus: • Medallion 4.0 Adult Core Set • CCC Plus: • Medallion 4.0:		
		5.4.1.12 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA HEDIS (SAA) CMS Adult Core Set: SAA-AD	HEDIS MY 2020: • CCC Plus: 69.50% • Medallion 4.0: NR Adult Core Set • CCC Plus:		

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0:		

[1] DMAS Cumulative data from MCO quarterly reports 1/1/2020–3/31/2022.

[2] MCO critical incident data reported to DMAS for calendar year 2021.

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

***Target established in the CY2021 PWP Methodology.*

****The baseline measure rate is the final validated 2020 HEDIS rate reported in the 2021 Annual Technical Report and posted to the DMAS website.*

^*The baseline measure rate is the final 2021 rate calculated by HSAG for the PWP.*

^^*The baseline measure rate is the final 2021 rate reported by DMAS for the Quality Management Review.*

^^^*The baseline measure rate is the final 2021 rate reported by the DMAS Finance Team*

▲ *Statistically significantly higher in 2020 than in 2019.*

▼ *Statistically significantly lower in 2020 than in 2019.*

★ *These goals are inclusive of Governor Glenn Youngkin's identified priorities for the Medicaid program that focus on behavioral health enhancement, maternal health outcomes, and access to high quality healthcare services.*

Table 27—Aspirational Goals Tracking Table

Goal	Objective	Measure Name	Metric specifications	2021 Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
Goal 1: Enhance the Member Care Experience	**Objective 1.2** Improve Member Satisfaction	1.2.1.3 Timely Processing of Member Applications, Renewals, and Appeals	DMAS	DMAS		
Goal 2: Promote Access to Safe, Gold-	**Objective 2.1** Ensure Access to Care	2.1.1.4 Monitor network adequacy by region and provider types	DMAS	MCO Reporting		

Goal	Objective	Measure Name	Metric specifications	2021 Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
Standard Patient Care		2.1.1.5 Monitor frequency and reasons for missed trips	DMAS	MCO Reporting		
		2.1.1.6 Cervical Cancer Screening	NCQA HEDIS (CCS) CMS Adult Core Set: CCS-AD	HEDIS MY 2020 • CCC Plus: 41.86% • Medallion 4.0: 50.09% Adult Core Set • CCC Plus: • Medallion 4.0:		
		2.1.1.7 Chlamydia Screening in Women Ages 21 to 24	NCQA HEDIS (CHL) CMS Adult Core Set: CHL-AD	HEDIS MY 2020 • CCC Plus: • Medallion 4.0: Adult Core Set • CCC Plus: • Medallion 4.0:		
		2.1.1.8 Colorectal Cancer Screening	NCQA HEDIS (COL) CMS Adult Core Set: COL-AD	HEDIS MY 2020 • CCC Plus: • Medallion 4.0: Adult Core Set • CCC Plus: • Medallion 4.0:		
		2.1.1.9 Breast Cancer Screening	NCQA HEDIS (BCS) CMS Adult Core Set: BCS-AD	HEDIS MY 2020 • CCC Plus: 46.58% • Medallion 4.0: 48.82% Adult Core Set		

Goal	Objective	Measure Name	Metric specifications	2021 Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• CCC Plus: • Medallion 4.0:		
		2.1.1.10 Contraceptive Care—Postpartum Women Ages 21 to 44	CMS Adult Core Set: CCP-AD	Adult Core Set • CCC Plus: • Medallion 4.0:		
		2.1.1.11 Contraceptive Care—All Women Ages 21 to 44	CMS Adult Core Set: CCW-AD	Adult Core Set • CCC Plus: • Medallion 4.0:		
		2.1.1.12 Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Age 18 and Older	NCQA HEDIS (AAB) CMS Adult Core Set: AAB-AD	HEDIS MY 2020 • CCC Plus: 47.93% • Medallion 4.0: NR Adult Core Set • CCC Plus: • Medallion 4.0:		
		2.1.1.13 Asthma Medication Ratio: Ages 19 60 64	NCQA HEDIS (AMR) CMS Adult Core Set: AMR-AD	HEDIS MY 2020 • CCC Plus: 63.62% • Medallion 4.0: 71.00% Adult Core Set • CCC Plus: • Medallion 4.0:		
		2.1.1.14 HIV Viral Load Suppression	CMS Adult Core Set: HVL-AD	Adult Core Set • CCC Plus: • Medallion 4.0:		

Goal	Objective	Measure Name	Metric specifications	2021 Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		2.1.1.15 Concurrent Use of Opioids and Benzodiazepines	CMS Adult Core Set: COB-AD	Adult Core Set • CCC Plus: • Medallion 4.0:		
Goal 3: Support Efficient and Value-Driven Care	**Objective 3.2** Promote Efficient Use of Program Funds	3.2.1.2 Number of Administrative and Medical Deferrals and Disallowances	DMAS	DMAS		
		3.2.1.3 Diabetes Short-Term Complications Admission Rate	CMS Adult Core Set: PQI01-AD	Adult Core Set • CCC Plus: • Medallion 4.0:		
		3.2.1.4 Heart Failure Admission Rate	CMS Adult Core Set: PQI08-AD	Adult Core Set • CCC Plus: • Medallion 4.0:		
		3.2.1.5 Asthma in Younger Adults Admission Rate	CMS Adult Core Set: PQI15-AD	Adult Core Set • CCC Plus: • Medallion 4.0:		
		3.2.1.6 Plan All-Cause Readmission Rate	NCQA HEDIS (PCR) CMS Adult Core Set: PCR-AD	HEDIS CCC Plus • Observed Readmissions—Total: 11.42% • O/E Ratio—Total: 0.94 Medallion 4.0: NR Adult Core Set • CCC Plus: • Medallion 4.0:		

Goal	Objective	Measure Name	Metric specifications	2021 Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.2** Improve Outcomes for Nursing Home Eligible Members	5.2.1.2 Nursing Facility Residents Hospitalization Rate	DMAS	DMAS		
		5.2.1.3 CCC Plus Waiver Members Who Re-Enter the Community After a Short-Term Nursing Facility Stay	DMAS	DMAS		
		5.2.1.4 Members Who Transitioned from a Nursing Facility to the Community Who Returned to the Nursing Facility Within 90 Days	DMAS	DMAS		

Appendix E. EQRO Findings and Recommendations

EQR Annual Technical Report Recommendations

DMAS makes the EQRO Annual Technical Report available to MCOs. Annually, MCOs are required to submit information on actions taken to address the recommendations contained in the EQRO Annual Technical Report. Annually, DMAS' EQRO collects and reviews the actions taken by the Commonwealth and by the MCOs in relation to the EQR recommendations contained in the report. The recommendations provided to DMAS for the EQR activities in the *Calendar Year 2021 External Quality Review Technical Report* are summarized in Table 28. Table 28 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 28—Quality Strategy Recommendations For the Virginia Medicaid Managed Care Program

Program Recommendations	
Recommendation	**Associated 2020–2022 QS Goal and/or Objective**
To improve program-wide performance in support of Goal 4.3 and mitigate the barriers members experience related to access to care, HSAG recommends the following: • Require the MCOs to identify access-related PMs, such as *Child and Adolescent Well-Care Visits*, that fell below the NCQA Quality Compass national Medicaid HMO 50th percentile and focus QI efforts on identifying the cause and implementing interventions to improve access to care. • Require the MCOs to identify healthcare disparities within the access-related PM data to focus QI efforts on a disparate population.	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members **Objective:** Increase Child and Adolescent Well-Care Visits **Goal 4.6:** Improve Outcomes for Maternal and Infant Members **Objective:** Increase Child and Adolescent Well-Care Visits
To improve program-wide performance in support of Goal 4.4 and improve members' receipt of recommended care and services for better management of chronic conditions, HSAG recommends the following: • Require the MCOs to identify chronic health-related PMs that fell below the NCQA Quality Compass national Medicaid HMO 50th percentile and focus QI efforts on identifying the cause and implementing interventions to improve access to care. • Require the MCOs to identify healthcare disparities within the Care for Chronic Conditions domain PMs' data to focus QI efforts on a disparate population.	**Goal 4.4:** Improve Health for Members with Chronic Conditions **Objective:** Decrease Diabetes Poor Control **Objective:** Increase Control of High Blood Pressure
To improve program-wide performance in support of Goal 4.2 and improve members' receipt of follow-up services, HSAG recommends the following:	**Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders

Program Recommendations	
• Require the MCOs to identify healthcare disparities within the behavioral health follow-up PM data to focus QI efforts on a disparate population. • Require the MCOs to identify best practices to conduct follow-up with members discharged from the ED and ensure follow-up visits within seven days and 30 days are completed.	**Objective:** Increase Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
To improve program-wide performance in support of Goal 4.3 and mitigate the barriers members experience related to access to care, HSAG recommends the following: • Require the MCOs to identify access-related PMs, such as *Child and Adolescent Well-Care Visits*, that fell below the NCQA Quality Compass national Medicaid HMO 50th percentile and focus QI efforts on identifying the cause and implementing interventions to improve access to care. • Require the MCOs to identify healthcare disparities within the access-related PM data to focus QI efforts on a disparate population.	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members **Objective:** Increase Child and Adolescent Well-Care Visits **Goal 4.6:** Improve Outcomes for Maternal and Infant Members **Objective:** Increase Child and Adolescent Well-Care Visits
To improve program-wide performance in support of Goal 4.4 and improve members' receipt of recommended care and services for better management of chronic conditions, HSAG recommends the following: • Require the MCOs to identify chronic health-related PMs that fell below the NCQA Quality Compass national Medicaid HMO 50th percentile and focus QI efforts on identifying the cause and implementing interventions to improve access to care. • Require the MCOs to identify healthcare disparities within the chronic health PM data to focus QI efforts on a disparate population.	**Goal 4.4:** Improve Health for Members with Chronic Conditions **Objective:** Decrease Diabetes Poor Control **Objective:** Increase Control of High Blood Pressure

From the overall findings of the Medallion 4.0 CY 2020 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Medallion 4.0 program. The recommendations provided to DMAS for the EQR activities in the *Calendar Year 2021 External Quality Review Medallion 4.0 Technical Report* 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—Medallion 4.0 Program Overall

Recommendation—Performance Improvement Projects		
Aim 4: Improve population health	**Goal 4.6:** Improve Outcomes for Maternal and Infant Members	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care
• As the MCOs continued to test interventions until the PIP's SMART Aim end date and prepared to submit the final Module 4s and Module 5s for validation, HSAG recommended that the MCOs: • Continue to monitor and report any impact COVID-19 has had on the MCO's PIPs. • Address all the feedback and recommendations that HSAG provided in the Module 4 plan pre-validation reviews and Module 4 intervention progress check-ins. After reviewing the feedback and/or recommendations, the MCO should contact HSAG with any questions. • Follow the approved methodology for the PIP and report the PIP's data in alignment with the approved methodology. If the MCO has questions about the approved methodology, it should review the approved Module 2 submission form and contact HSAG. • Identify and test innovative, actionable changes for the PIPs. If the interventions are not effective, the MCOs should make rapid modifications to the interventions and continue collecting data. If the MCO needs to identify additional potential interventions for the PIP, it should review its process map and FMEA completed in Module 3 to design changes to address gaps and high-priority failures in the process. • Continually monitor the monthly SMART Aim measure and intervention effectiveness measure data. If the outcomes are not improving over time, the MCO should adjust intervention testing. • Attend the Module 4 and Module 5 webinar training that HSAG will schedule prior to the submission of these modules for validation. • Request PIP technical assistance from HSAG as often as needed.		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS MOMS coverage		

Recommendation—Performance Improvement Projects
• Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care 2019: NR 2020: 74.45%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improve population health	**Goal 4.6:** Improve Outcomes for Maternal and Infant Members	**Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life
• HSAG recommended that the MCOs conduct a root cause analysis to determine why some children have not received well-child visits or immunizations according to the well-visit schedule. • HSAG recommended that the MCOs analyze their data and consider if there are disparities within the MCOs' populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. • Upon identification of a root cause, HSAG recommended that the MCOs implement appropriate interventions to increase the number of children who receive a well-child visit or immunizations using interventions that address the root cause of the issue.		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs		

Recommendation—Performance Measure Validation
• Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS MOMS coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV rates showed: **Metric 4.6.3:** Childhood Immunization Status Combo 3: 2019: NR 2020:65.82% **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life: 2019: NR 2020: First 15 Months: 54.35%; 15 Months – 30 Months: 72.10%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improve population health	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Not included in the 2020–2022 Quality Strategy: • Cervical Cancer Screening • Breast Cancer Screening
• HSAG recommended that the MCOs conduct a root cause analysis or focus group to determine why women members were not receiving breast or cervical cancer screenings. • HSAG recommended that the MCOs consider if there were disparities within the MCOs' populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. • Upon identification of a root cause, HSAG recommended that the MCOs implement appropriate interventions to improve access to and timeliness of cancer screenings.		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):		

Recommendation—Performance Measure Validation
DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS MOMS coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV rates showed: Cervical Cancer Screening 2019: NR 2020: 50.09% Breast Cancer Screening 2019: NR 2020: 48.82%
Identify any barriers to implementing initiatives: DMAS did not identify any barrier to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 1: Enhance Member Care Experience	**Goal 2.2:** Ensure Access to Care	**Metric 2.2.3:** Getting Needed Care
• HSAG recommended that MCOs conduct a root cause analysis to determine why some adults and children were experiencing access to care issues. • HSAG recommended that the MCOs identify the best practices of the four MCOs that demonstrated strength in adults' and children's access to care.		

Recommendation—Performance Measure Validation
• HSAG recommended that the MCOs consider conducting a focus group to identify barriers that their members were experiencing in accessing care and services in order to implement appropriate interventions.
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS MOMS coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): CAHPS results showed: **Metric 2.2.3:** Getting Needed Care 2020: 83.3% 2021: 82.9%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.4:** Improve Health for Members with Chronic Conditions	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Recommendation—Performance Measure Validation		
		Metric 4.4.5: Controlling High Blood Pressure
• HSAG recommended that the MCOs conduct a root cause analysis to determine why members were not maintaining their chronic health condition at optimal levels. • Upon identification of a root cause, HSAG recommended that the MCOs implement appropriate interventions to improve the performance related to these chronic conditions. • HSAG also recommended that the MCOs work closely with public health and the MCOs' provider network to coordinate available resources related to quitting smoking and tobacco use and obtaining access to smoking cessation medications*. *Note: Smoking cessation is not a covered service for Medicaid except for pregnant women and for the Medicaid expansion population.		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS MOMS coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) 2019: NR 2020: 50.30% **Metric 4.4.5:** Controlling High Blood Pressure 2019: NR 2020: 46.91%		

Recommendation—Performance Measure Validation
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness **Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness

- HSAG recommended that Molina and VA Premier review their resources, interventions, and activities focused on follow-up care upon discharge for members receiving behavioral health services in the ED or an inpatient setting.
- HSAG recommended that the MCOs conduct a root cause analysis to determine barriers to follow-up with children prescribed ADHD medications.
- HSAG recommended that the MCOs consider if there were disparities within the MCOs' populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
- Upon identification of a root cause, HSAG recommended that the MCOs implement appropriate interventions to ensure appropriate follow-up on prescribing as well as ED and inpatient care to decrease inappropriate utilization.

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

DMAS is committed to promoting members. To address the EQRO recommendations, DMAS:

- Increased access to health coverage for lawful permanent residents
- Expanded Quality and Population Health Team
- Developed a dedicated QPH website and resources on the DMAS website
- Designed a tableau based HEDIS dashboard
- Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs
- Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices
- Received an extension of FAMIS MOMS coverage
- Added new adult dental benefit
- Added behavioral health service access points

Recommendation—Performance Measure Validation		
• Extended contraceptive benefit to 12 months postpartum		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness 2019: NR 2020: 7-Day: 35.63%; 30-Day: 56.84% **Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness 2019: NR2020: 7-Day: 45.34%; 30-Day: 57.38%		
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.		
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.		

Recommendation—Member Experience of Care Survey—Adult		
Aim 2: Effective Patient Care	**Goal 2.2:** Ensure Access to Care	**Metric 2.2.3:** Getting Needed Care
• HSAG recommended that the MCO conduct a focus group or other methods to receive direct information from members on their experience with access to care and receiving services, and the customer service they receive from the MCO. • Once the MCO gains an understanding of the member's experience, HSAG recommended that the MCO implement appropriate interventions to improve this experience when contacting the health plan and seeking care and services. • HSAG recommended that the MCO delve more deeply into those survey categories for which survey results are not only lower than the 2020 NCQA adult Medicaid national average but also where rates are declining.		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices		

Recommendation—Member Experience of Care Survey—Adult
• Received an extension of FAMIS MOMS coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric 2.2.3:** Getting Needed Care 2019: 83.3% 2020: 82.9%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey—Child		
Aim 2: Effective Patient Care	**Goal 2.2:** Ensure Access to Care	**Metric 2.2.3:** Getting Needed Care
• HSAG recommended that the MCOs conduct a focus group or use other methods to receive direct information from members on their experience with access to care and their interactions with the healthcare system. • Once an MCO gains an understanding of the member's experience, HSAG recommended that the MCO implement appropriate interventions to improve this experience when the member contacts the health plan or receives services from a personal doctor.		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS MOMS coverage		

Recommendation—Member Experience of Care Survey—Child
• Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): CAHPS results show: **Metric 2.2.3:** Getting Needed Care 2020: 85.8% 2021: 84.6%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Response HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

The recommendations provided to DMAS for the EQR activities in the *Calendar Year 2021 External Quality Review CCC Plus Technical Report* are summarized in Table 30. Table 30 also describes the interventions undertaken by DMAS to address the EQR recommendations, QI achieved as a result of the interventions, and identified barriers to implementing the interventions focused on addressing the recommendations, if applicable.

Table 30—Prior Year Recommendations and Actions Taken—CCC Plus Program Overall

Recommendation—Performance Improvement Projects		
Aim 3: Smarter Spending	**Goal 3.1:** Focus on Paying for Value	**Metric 3.1.3:** Frequency of Potentially Preventable Readmissions **Metric 3.1.4:** Ambulatory Care: Emergency Department (ED) Visits
As the CCC Plus MCOs continue to test interventions until the PIP's SMART Aim end date and prepare to submit the final Module 4s and Module 5s for validation, HSAG recommended that the MCOs: • Continue to monitor and report any impact COVID-19 has had on the MCO's PIPs. • Address all the feedback and recommendations that HSAG provided in the Module 4 plan pre-validation reviews and Module 4 intervention progress check-ins. After reviewing the feedback and/or recommendations, the MCO should contact HSAG with any questions. • Follow the approved methodology for the PIP and report the PIP's data in alignment with the approved methodology. If the MCO has questions about the approved methodology, it should review the approved Module 2 submission form and contact HSAG.		

Recommendation—Performance Improvement Projects
• Identify and test innovative, actionable changes for the PIPs. If the interventions are not effective, the MCOs should make rapid modifications to the interventions and continue collecting data. If the MCO needs to identify additional potential interventions for the PIP, it should review its process map and FMEA completed in Module 3 to design changes to address gaps and high-priority failures in the process. • Continually monitor the monthly SMART Aim measure and intervention effectiveness measure data. If the outcomes are not improving over time, the MCO should adjust intervention testing. • Attend the Module 4 and Module 5 webinar training that HSAG will schedule prior to the submission of these modules for validation. • Request PIP technical assistance from HSAG as often as needed.
DMAS' Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS Moms coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric 3.1.3:** Frequency of Potentially Preventable Readmissions 2019: NR 2020: NR **Metric 3.1.4:** Ambulatory Care: Emergency Department (ED) Visits

Recommendation—Performance Improvement Projects		
2019: 93.33 2020: 77.45		
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.		
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.		

Recommendation—Performance Measure Validation		
Aim 4: Improve population health	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.3.4:** Child and Adolescent Well-Care Visits

- HSAG recommended that the MCOs consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended screenings and to make appropriate health decisions.
- HSAG recommended that the MCOs analyze their data and consider if there are disparities within the MCOs' populations that contributed to lower screening rates for a particular race or ethnicity, age group, ZIP Code, etc.
- HSAG recommended that the MCOs implement appropriate interventions to increase the screening rates due to the low rates for both measures.

DMAS' Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)

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

DMAS is committed to promoting members. To address the EQRO recommendations, DMAS:

- Increased access to health coverage for lawful permanent residents
- Expanded Quality and Population Health Team
- Developed a dedicated QPH website and resources on the DMAS website
- Designed a tableau based HEDIS dashboard
- Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs
- Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices
- Received an extension of FAMIS Moms coverage
- Added new adult dental benefit
- Added behavioral health service access points
- Extended contraceptive benefit to 12 months postpartum

Recommendation—Performance Measure Validation
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services 2019: 90.51% 2020: 87.12% **Metric 4.3.4:** Child and Adolescent Well-Care Visits 2019: NR 2020: 39.86%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	**Metric 4.1.4:** Monitor Mental Health Utilization

- HSAG recommended that the MCOs develop processes to ensure providers understand and implement recommended care guidelines.
- HSAG recommended that the MCOs consider if there were disparities within the MCOs' populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
- Upon identification of a disparity-driven issue**,** HSAG recommended that the MCOs implement appropriate interventions to improve use of evidence-based practices in the provision of behavioral healthcare and services.

DMAS' Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)

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

DMAS is committed to promoting members. To address the EQRO recommendations, DMAS:

- Increased access to health coverage for lawful permanent residents
- Expanded Quality and Population Health Team
- Developed a dedicated QPH website and resources on the DMAS website
- Designed a tableau based HEDIS dashboard

Recommendation—Performance Measure Validation
• Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS Moms coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric 4.1.4:** Monitor Mental Health Utilization 2019: 28.00% 2020: 25.34%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.4:** Child and Adolescent Well-Care Visits
• HSAG recommended that the MCOs identify best practices for ensuring children receive all preventive and well-child services according to recommended schedules. • HSAG recommended that the MCOs consider conducting a root cause analysis to identify barriers that their members are experiencing in accessing care and services in order to implement appropriate interventions.		
DMAS' Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents		

Recommendation—Performance Measure Validation
• Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS Moms coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results show: **Metric 4.3.4:** Child and Adolescent Well-Care Visits 2019: NR 2020: 39.86%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improve population health	**Goal 4.4:** Improve Health for Members with Chronic Conditions	**Metric 4.4.4:** Comprehensive Diabetes Care, Hemoglobin A1c (HbA1c) Poor Control **Metric 4.4.5:** Controlling High Blood Pressure
• HSAG recommended that the MCOs conduct a root cause analysis to determine why members were not maintaining their chronic health conditions at optimal levels. • Upon identification of a root cause, HSAG recommended that the MCOs implement appropriate interventions to improve the performance related to these chronic conditions.		
DMAS' Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:		

Recommendation—Performance Measure Validation
• Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS Moms coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed the following: **Metric 4.4.4:** Comprehensive Diabetes Care, Hemoglobin A1c (HbA1c) Poor Control 2019: 50.36% 2020: 48.91% **Metric 4.4.5:** Controlling High Blood Pressure 2019: 53.28% 2020: 55.47%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey—Adult		
Aim 1: Enhanced Member Care Experience	**Goal 1.2:** Improve Member Satisfaction	**Metric 1.2.2:** Rating of Health Plan **Metric 1.2.3:** *Rating of all Health Care*
• HSAG recommended that overall, the CCC Plus MCOs should focus on maintaining and improving members' experiences of care as the MCO survey results indicated opportunities for improvement in *Rating of Health Plan* and *Rating of All Health Care* for the adult population when compared to the 2020 NCQA adult Medicaid national averages. • In addition, HSAG recommended that MCO efforts should focus on improving survey response rates.		
DMAS' Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)		

Recommendation—Member Experience of Care Survey—Adult
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS Moms coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): CAHPS results show: **Metric 1.2.2:** Rating of Health Plan 2020: 65.5% 2021: 64.7% **Metric 1.2.3:** *Rating of all Health Care* 2020: 57.5% 2021: 58.7%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey—Child		
Aim 1: Enhanced Member Care Experience	**Goal 1.2:** Improve Member Satisfaction	**Metric 1.2.2:** Rating of Health Plan **Metric 1.2.3:** *Rating of all Health Care*
• HSAG recommended that overall, the CCC Plus MCOs should focus on maintaining and improving members' experiences of care as the MCO survey results indicated opportunities for improvement in *Rating of Health Plan* and *Rating of All Health Care* measures for the child population when compared to the 2020 NCQA child Medicaid national averages.		

Recommendation—Member Experience of Care Survey—Child
• In addition, HSAG recommended that the MCO efforts should focus on improving survey response rates.
DMAS' Response (Note—The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting)
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS Moms coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): CAHPS results show: **Metric 1.2.2:** Rating of Health Plan 2020: 65.5% 2021: 64.7% **Metric 1.2.3:** *Rating of all Health Care* 2020: 57.5% 2021: 58.7%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Appendix F. Effectiveness of the State's Prior Quality Strategy

2020–2022 Virginia State Quality Strategy

The HHS CMS Medicaid managed care regulations at 42 CFR §438.340 require Medicaid state agencies that operate Medicaid managed care programs to develop and implement a written Quality Strategy to assess and improve the quality of healthcare services offered to Medicaid members. The written strategy must describe the standards that a state and its contracted MCOs and PIHPs must meet. This section outlines the annual evaluation of the Quality Strategy for SFY 2022.

Quality Strategy Goals and Objectives

As stated in the 2020–2022 Virginia Quality Strategy, DMAS' mission was to improve the health and well-being of Virginians through access to high-quality healthcare coverage. DMAS' values included:

- ***Service:*** We are committed to serving all who are touched by our system and 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.

Consistent with the Commonwealth's mission and DMAS' priority areas, the purpose of DMAS' Quality Strategy was to:

- Establish a comprehensive quality improvement (QI) system that is consistent with the National Quality Strategy and CMS Triple Aim to enhance member care experiences, promote effective patient care, achieve smarter spending, and improve population health.
- Provide a proactive framework for DMAS to implement a coordinated and comprehensive approach to drive quality throughout the Virginia Medicaid and CHIP systems.
- Improve member satisfaction with care and services.
- Identify opportunities for improvement in the health outcomes of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.
- Identify opportunities to improve quality of care and quality of service and implement improvement strategies to ensure Virginia Medicaid and CHIP members have access to high quality and culturally appropriate care.

- Identify innovative and efficient models of care delivery that are best practices and make healthcare more affordable for individuals, families, and the State government.

In its contract with the MCOs, DMAS required the MCOs to consider HEDIS performance measures as a priority. DMAS required the MCOs to assure annual improvement in the HEDIS measures until performing at least at the 50th percentile for "HMOs" as reported by NCQA's Quality Compass. The MCOs were also to establish goals to attain the 75th percentile. Also, consistent with the National Quality Strategy, DMAS established quality goals and objectives to improve the health and wellness of Virginia Medicaid and CHIP members. Table 34 details the results of the work conducted toward the quality goals and objectives for the Virginia Medicaid managed care program.

Quality Strategy Evaluation

Measure Alignment

DMAS continued to work toward aligning most of the goals, objectives, and quality metrics detailed in its Quality Strategy with MCO performance measure requirements outlined in the MCOs' contract with the Commonwealth. DMAS required the MCOs to be NCQA accredited and to conduct HEDIS performance measure reporting. In addition, DMAS required MCOs to undergo performance measure validation with the EQRO for CMS Core Set measures not included in HEDIS reporting. The MCO contracts also state that the MCO's quality initiatives must be designed to help achieve the goals outlined in the Virginia Medicaid Quality Strategy.

Table 31 includes Quality Strategy metrics outlined in the MCO's Medallion 4.0 contract:

Table 31—Medallion 4.0 MCO Contract Quality Metrics

Measure Name	*Measure Name*
**Childhood Immunization Status (Combo 3)*, each vaccine must be reported separately	^*Comprehensive Diabetes Care* including: HbA1c testing and control, retinal eye exam, medical attention for nephropathy, and blood pressure control
^*Controlling High Blood Pressure*	^*Medication Management for People with Asthma*
^*Postpartum Visits*	**Timeliness of Prenatal Care*
^*Breast Cancer Screening*	^*Antidepressant Medication Management* (Acute Phase and Continuation Phase)
**Follow-Up Care for Children Prescribed ADHD Medication* (initiations, continuations, and maintenance phases)	^*Follow-up after Hospitalization for Mental Illness* (seven [7] day follow up only)

Measure Name	*Measure Name*
**Well-Child Visits in the First 15 Months of Life*	**Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
**Adolescent Well-Care Visits*	^*Cervical Cancer Screening*
^*Medical Assistance with Smoking and Tobacco Use Cessation* (different facets include advising smokers to quit, discussing cessation medication, discussing cessation strategies)	**Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics*
Adults' Access to Preventative/Ambulatory Health Services	Children and Adolescents' Access to Primary Care Practitioners
^*Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence*	**Use of Multiple Concurrent Antipsychotics in Children and Adolescents*
^*Colorectal Cancer Screening*	^*Flu Vaccinations for Adults Ages 18–64*
Developmental Screening in the First 3 Years of Life	Early Elective Deliveries Rate
Percent of Live Births ≤ 2,500 Grams	Asthma Admission Rate (2–17)
Asthma in Younger Adults Admission Rate	COPD and Asthma in Older Adults Admission Rate
*^CAHPS Survey	

**CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP*
^CMS Core Set of Adult Health Care Quality Measures for Medicaid

Table 32 includes Quality Strategy metrics outlined in the MCO's CCC Plus contract:

Table 32—CCC Plus MCO Contract Quality Metrics

Measure Name	*Measure Name*
**Childhood Immunization Status (Combo 3)*, each vaccine must be reported separately	^*Comprehensive Diabetes Care* including hemoglobin A1C testing and control, retinal eye exam, and blood pressure control
^*Controlling High Blood Pressure*	*Immunizations for Adolescents*
^*Cervical Cancer Screening*	*Colorectal Cancer Screening*
^*Breast Cancer Screening*	^*Antidepressant Medication Management* (Acute Phase and Continuation Phase)

Measure Name	***Measure Name***
**Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*	**^Follow-up after Hospitalization for Mental Illness* (seven [7] day follow up only)
**Well-Child Visits in the First 15 Months of Life*	**Adolescent Well-Care Visits*
Adults' Access to Preventative/Ambulatory Health Services	*Follow-Up After Emergency Department Visit for Mental Illness*
^Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence	*Use of Multiple Concurrent Antipsychotics in Children and Adolescents*
^Plan All-Cause Readmissions	**Ambulatory Care—Emergency Department (ED) Visits*
^Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	*Use of High-Risk Medications in the Elderly*
Nursing Facility Residents Hospitalization Rate	*^Antidepressant Medication Management*
^Use of Opioids at High Dosage	*Use of Opioids from Multiple Providers*
Use of Opioids at High Dosage and from Multiple Providers in Persons without Cancer	*^COPD and Asthma in Older Adults Admission Rate*
^Diabetes Short-Term Complication Admission Rate	*Nursing Facility Diversion*
Documentation of Care Goals	*Re-assessments*
Advance Care Plan	*Documentation of Care Goals*

**CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP*
^CMS Core Set of Adult Health Care Quality Measures for Medicaid

Evaluation Methodology Description

The methodology used by DMAS to evaluate the effectiveness of the State's Quality Strategy included tracking and monitoring the MCOs' performance for the priority areas outlined in the DMAS Quality Strategy. To track the progress of achieving the goals and objectives outlined in the 2020–2022 Quality Strategy, DMAS tracked the aggregate annual results of contractual performance metrics that aligned with the performance measures included in the Quality Strategy to measure improvement.

DMAS' initial Quality Strategy reflected the time period of 2017 through 2019. During this time frame Virginia experienced significant programmatic changes that changed and expanded populations served, integrated care and services, and expanded ARTS. DMAS also transitioned to a VBP model that initially included performance incentive awards that further transitioned into a PWP that focused on driving

QI. The programmatic changes resulted in DMAS' reconsideration of its QI priorities and a need to reassess the goals, objectives, and performance metrics to better reflect the populations served and the programmatic changes. DMAS continued to evolve its Quality Strategy priorities and associated goals, objectives, and metrics based on achievement success, lack of progress, and relevancy based on programmatic and population changes.

DMAS updated its Quality Strategy for the time period of 2020 through 2022. During the 2020–2022 Quality Strategy time frame, Virginia experienced significant programmatic changes that changed and expanded populations served. DMAS continued to integrate care and services and enhanced the ARTS. DMAS also implemented Medicaid expansion on January 1, 2019, allowing more adults living in Virginia to gain access to quality, low-cost health insurance. The Medicaid expansion benefit plan included all services currently covered by Medicaid for the existing populations as well as additional federally required adult preventive care and disease management programs. Medicaid expansion provided coverage for adults ages 19–64 who were not Medicare eligible, who had income from 0 percent to 138 percent of the FPL, and who were not already eligible for a mandatory coverage group (e.g., children, caretaker adults, pregnant women, individuals over the age of 65, and individuals who were blind or had a disability). In addition, women that were 60 days postpartum were eligible for coverage as an expansion member.

ARTS Evaluation

On April 1, 2017, Virginia's Medicaid program launched an enhanced SUD treatment benefit known as ARTS. 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 an SUD.

To further support the transformational integration of behavioral and physical health, in 2019, DMAS and the DBHDS outlined a set of behavioral health services to serve Medicaid members. DMAS and DBHDS 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—referred to as Project BRAVO. 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 included crisis services for youth and adults support and stabilize the individual prior to, during and following a crisis.

Fatal drug-related overdoses surged during the COVID-19 pandemic, exceeding 100,000 overdoses in the U.S. and over 2,400 in Virginia during the year ending June 2021. This represented a 20 percent increase nationally and 35 percent increase in Virginia, respectively, since the previous year. Pandemic-related economic and social stress, disruptions in access to health services, and greater availability of more lethal forms of opioids, such as fentanyl, were considered the primary reasons for the surge in overdoses, although no definitive causes were identified.

As a result of the expansion of treatment services through ARTS and increases in eligibility for these services through Medicaid expansion beginning in 2019, Virginia Medicaid was far better prepared for the increased prevalence in SUD than in previous years. The supply of

treatment providers, the prevalence of members receiving SUD treatment, and the rate of treatment for diagnosed SUD increased dramatically after implementation of the ARTS benefit and has continued through Medicaid expansion and the COVID-19 pandemic. While there was concern that COVID-19 related shutdowns and stay-at-home orders may negatively affect access to and use of SUD treatment services, the federal government and DMAS implemented a number of initiatives and procedural flexibilities to offset these barriers, including increased use of telemedicine, allowing take-home dosages of methadone and buprenorphine for up to 28 days, allowing for 90 day prescriptions for buprenorphine products, and allowing a member's home to serve as the originating site for prescription of buprenorphine.

The ARTS four-year evaluation conducted by the Virginia Commonwealth University (VCU) titled *Addiction and Recovery Treatment Services, Access, Utilization, and Quality of Care 2016-2019,* dated July 2021, examined SUD prevalence, treatment utilization, and outcomes among Virginia Medicaid members during SFYs 2019 and 2020, as well as the first two quarters of SFY 2021 (covering the period July 2018 through December 2020). The following results were included in the VCU four-year evaluation. Data sources included Medicaid administrative claims, information on the supply of substance use treatment providers, and a survey of Medicaid members who used ARTS.

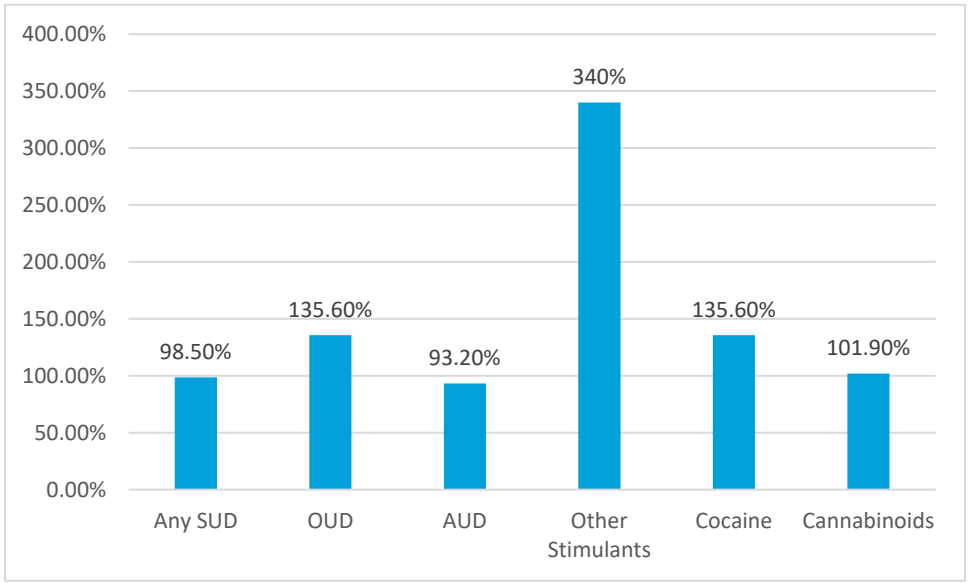
The following ARTS benefit information and findings were reported by VCU from the ARTS waiver evaluation.

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

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

The report stated that diagnosed prevalence of other SUD among Medicaid members increased between 2016 and 2019. In particular, prevalence of SUD related to methamphetamine use (identified as "other stimulants" in the following figure) more than tripled from 2,169 members in 2016 to 9,544 members in 2019. However, opioids remained responsible for the vast majority of fatal overdoses. The prevalence of SUDs are shown in Figure 12.

Figure 12—Diagnosed Prevalence of SUD

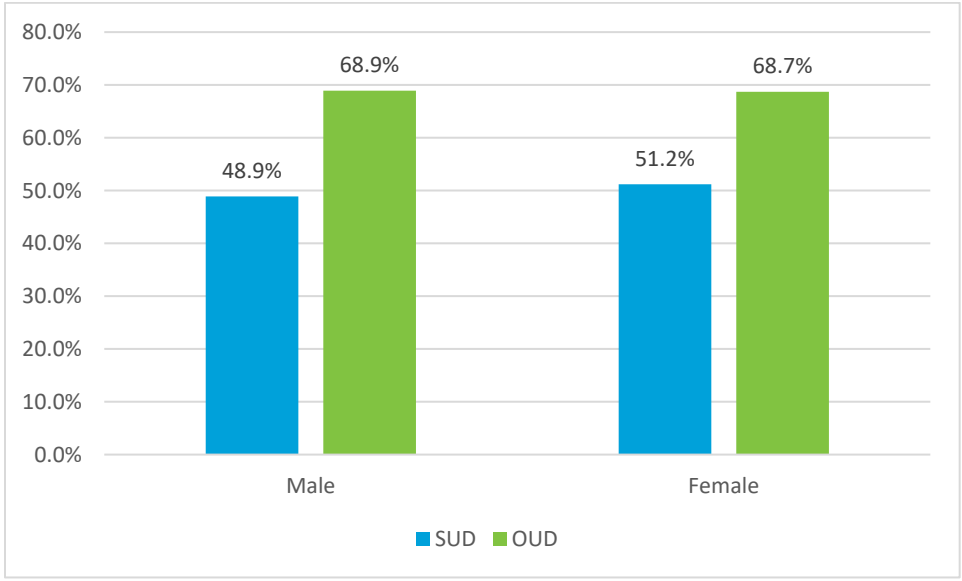


Note: Other Stimulants refers primarily to methamphetamines.

Member Characteristics

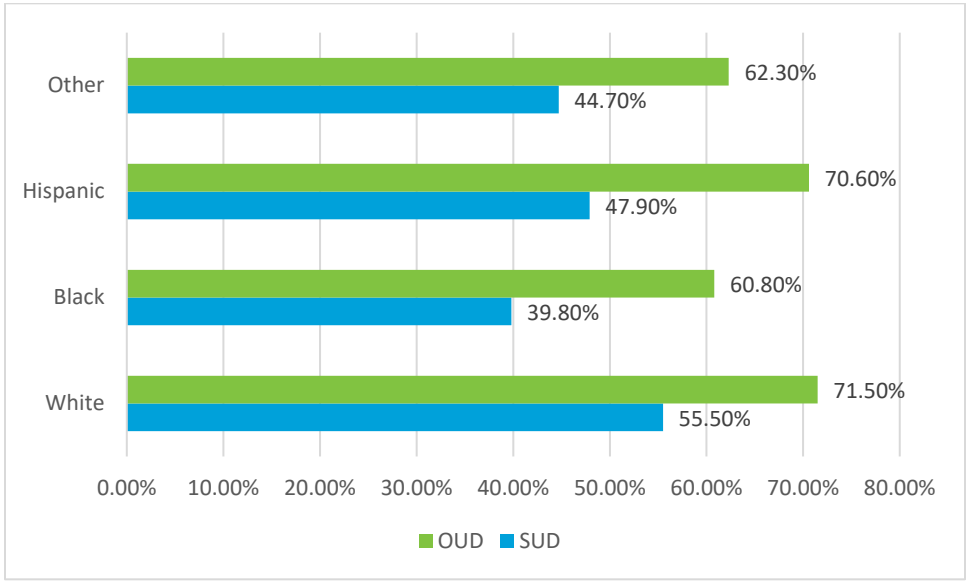
Members with a diagnosed SUD of any type represented 5.4 percent of the 1.78 million people in Virginia who were enrolled in Medicaid at some point in 2019. Figure 13 shows the prevalence, by gender, of members treated for SUD and OUD. Males were treated for an OUD at a higher rate than females. Females were treated for a SUD at a higher rate than males.

Figure 13—2019 Treatment Rates for SUD and OUD by Gender



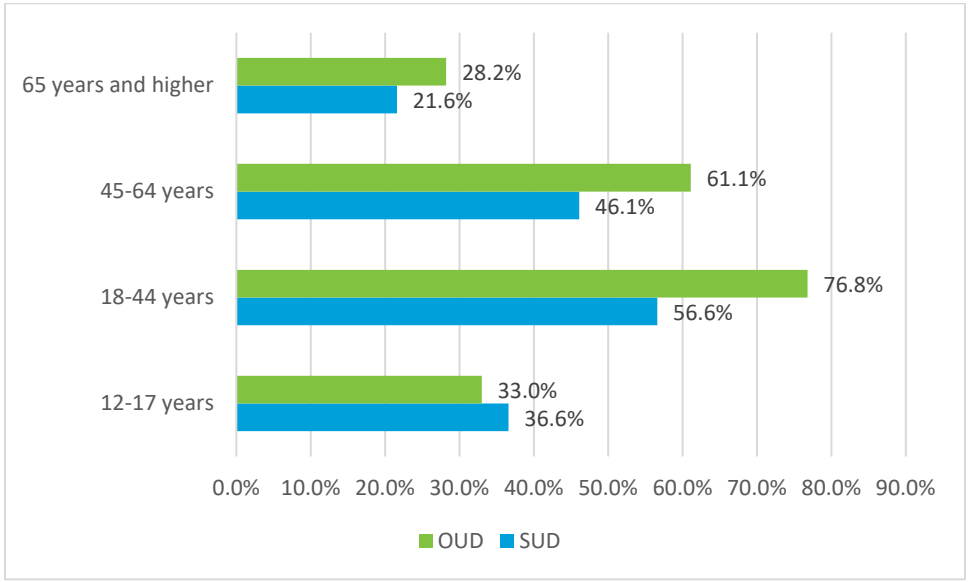
In reviewing the results published in the report, the prevalence of diagnosed SUD is lower among members identifying as Black (4.8 percent) and Hispanic (1.1 percent) compared to White members (6.3 percent). SUD and OUD treatment rates by race/ethnicity are depicted in Figure 14.

Figure 14—2019 Treatment Rates for SUD and OUD by Race/Ethnicity



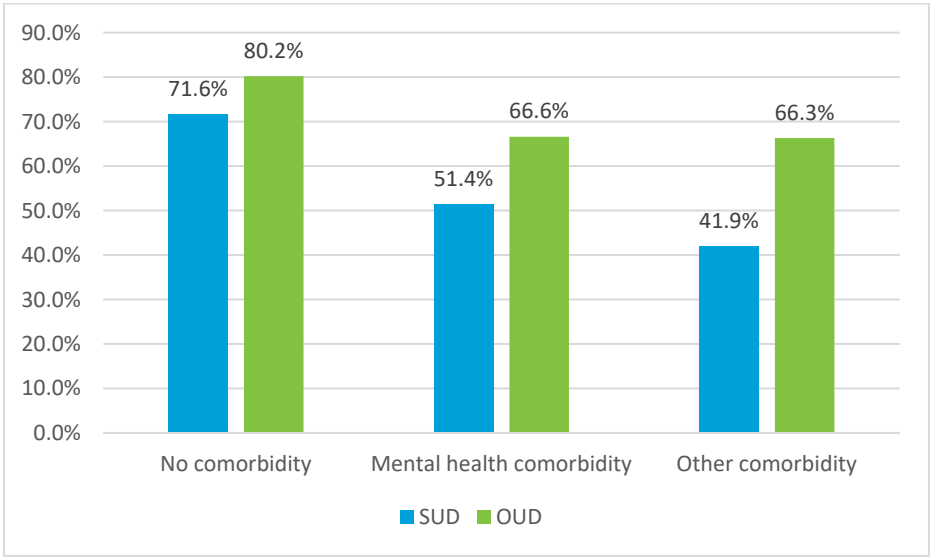
Variances in treatment rates for SUD and OUD were also identified by age group in the report. Members in the 45 to 64 age group had by far the highest diagnosed prevalence compared to other ages. Adolescents (ages 12 to 17) had the lowest diagnosed prevalence. Treatment for SUD and OUD by age are shown in Figure 15.

Figure 15—Treatment Rates for SUD and OUD by Age



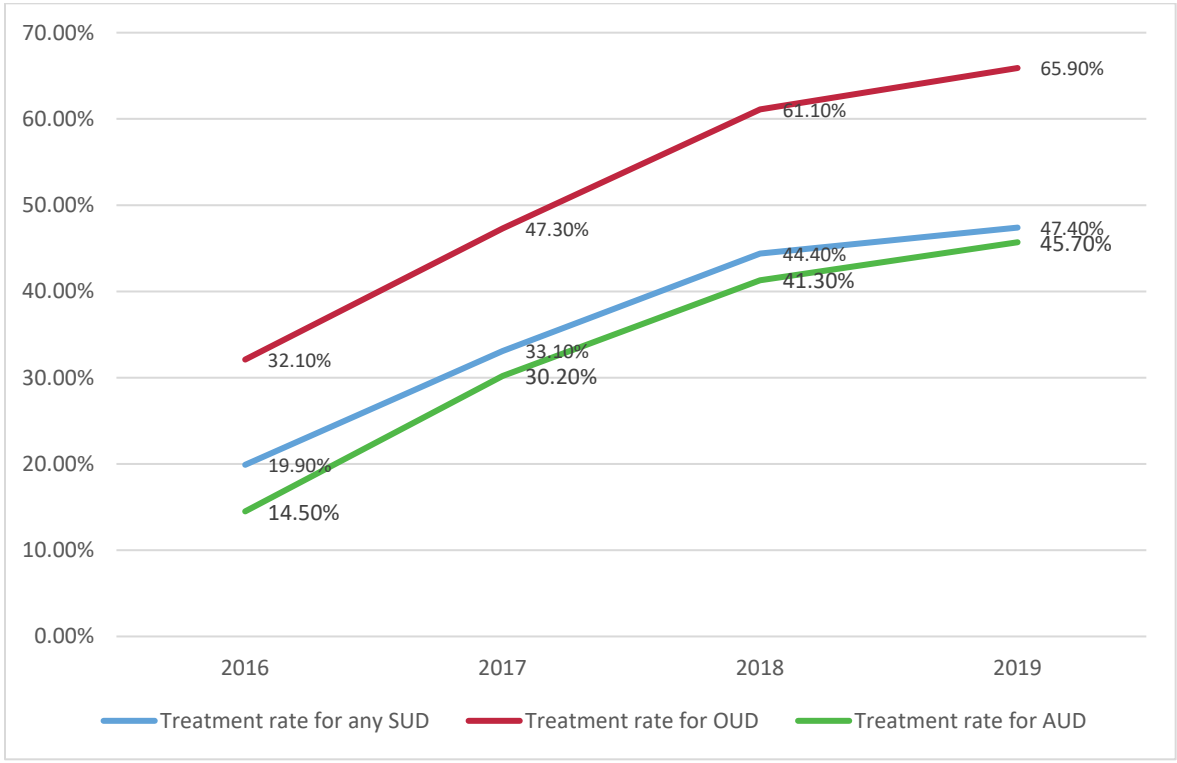
SUD are often accompanied by other co-occurring physical conditions and mental health disorders. Compared to all Medicaid members, those with SUD are more likely to have other comorbid conditions, including mental health disorders. Figure 16 shows the SUD and OUD treatment rates for members with diagnosed comorbidities.

Figure 16—Treatment Rates for SUD and OUD by Comorbidity



Treatment rates for any SUD, OUD, and AUD continued to increase each year since the implementation of the ARTS benefit. The changes in treatment rates for SUD among the base Medicaid member, which excludes Medicaid expansion members, are shown in Figure 17.

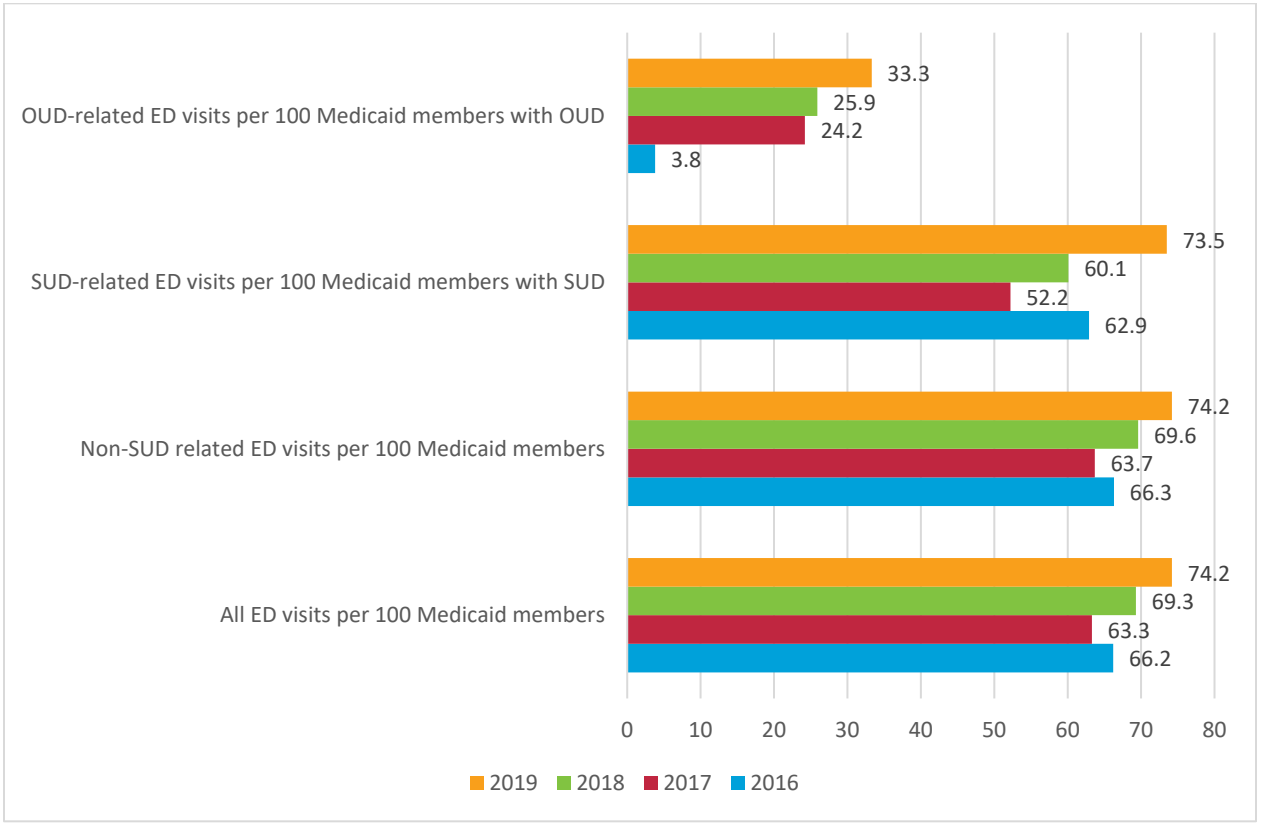
Figure 17—Change in Treatment Rates for SUD Among Base Members



Note: Base members exclude members enrolled through Medicaid expansion to maintain comparability with prior years.

The results in the report showed that following implementation of the ARTS benefit the likelihood of having an ED visit decreased by 9.4 percentage points (a 21.1 percent relative decrease) among members with OUD, compared to 0.9 percentage points among members with no SUD. A similar decline was noted in inpatient hospitalizations. Figure 18 shows the ED visits per 100 base Medicaid members.

Figure 18—ED Visits Per 100 Base Medicaid Members



Note: Base members exclude members enrolled through Medicaid expansion to maintain comparability with prior years.

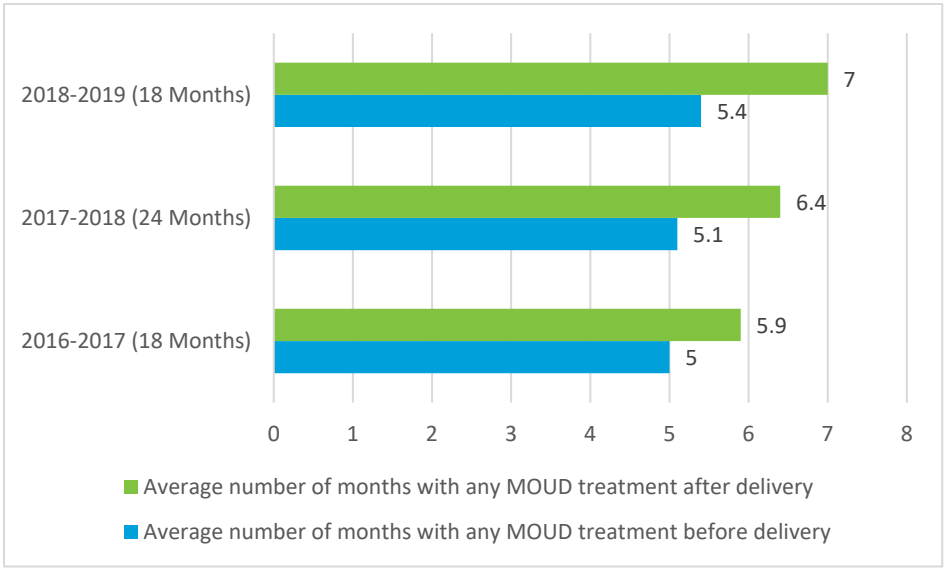
The report also states that use of services in 2019 increased across all ASAM levels of care. In 2019, 46,520 members used a treatment service categorized with an ASAM level of care, a 79 percent increase from 2018, and a 172 percent increase since 2017, the first year of ARTS. Increases in use included:

- SBIRT (ASAM Level 0.5) increased 359 percent from 2017 (2017: 498; 2019: 2,288).

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

The Virginia ARTS benefit expanded the treatment services available to Medicaid members, including pregnant individuals covered by Medicaid in the prenatal and postpartum period. MOUD treatment rates increased from 52.4 percent in 2016–2017 to 62.1 percent in 2018–2019, while the average number of months with any MOUD in the 12 months prior to delivery increased from 5 months in 2016–2017 to 5.4 months by 2018–2019. MOUD treatment rates were higher in the 12 months after delivery than the 12 months prior to delivery (69.5 percent in 2016–2017 to 74.5 percent in 2018–2019). The number of months of MOUD treatment increased from 5.9 months in 2016–2017 to 7 months by 2018–2019. Diagnosed SUD, OUD, and MOUD treatment rates 12 months before and after childbirth are shown in Figure 19.

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



DMAS shared an article written by WTVR that highlighted a case study with positive outcomes from the ARTS program.[2-41] The case study describes a member's journey battling addiction. After having lost two of her children soon after they were born, the member soon became pregnant with her third child. The little girl growing inside of her was enough motivation for her to get sober. Through the ARTS benefit, the obstetrical and addiction service providers worked to meet the member where she was. Program providers had an understanding of the challenges that pregnant women, and postpartum women, with an addiction struggle with and work to reduce the challenges. The member successfully delivered a healthy baby girl.

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

To enhance cross-state comparisons, VCU and DMAS participate in MODRN, a collaboration of state-university partnerships through AcademyHealth established for the purpose of comparing state Medicaid programs on key measures of SUD and OUD treatment access and quality of care. Table 33 displays characteristics of members receiving OUD treatment in Virginia compared to other states participating in MODRN.

Table 33—2018 OUD Treatment for Medicaid Members State Comparison

Member Characteristic	Percentage of Members with OUD Diagnosis	
	Virginia	Other MODRN States*
Age Group		
12–20	1.2%	1.5%
21–34	35.1%	41.9%
35–44	28.7%	29.%
45–54	19.3%	16.9%
55–64	15.7%	10.3%
Gender		
Female	66.3%	51.2%
Male	33.7%	48.8%
Race/Ethnicity		
Non-Hispanic White	79.1%	76.2%
Non-Hispanic Black	19.4%	13.8%
Hispanic	0.1%	2.9%

[41] WTVR. "After losing 2 children during addiction, mother gives birth to miracle baby." Available at: https://www.wtvr.com/news/local-news/after-losing-2-children-during-addiction-mother-gives-birth-to-miracle-baby. Accessed on: July 14, 2022.

Member Characteristic	Percentage of Members with OUD Diagnosis	
	Virginia	Other MODRN States*
Other/Unknown	1.4%	7.1%
Eligibility Group		
Pregnant	5.1%	5.6%
Youth	1.1%	1.4%
Disabled Adults	41.1%	17.1%
Non-Disabled	52.7%	24.6%
Medicaid Expansion Adults	Not Applicable	51.3%
Living Area		
Urban	69.0%	73.3%
Rural	31.0%	26.4%
Missing Urban/Rural Category	0%	0.2%

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

Member Experience with ARTS Services

The ARTS member survey, adapted from a version of the CAHPS survey, included a number of questions assessing the patient's experience with ARTS treatment services and was designed to assess behavioral treatment providers. The total number of survey respondents included 708 members. Results of the survey indicate that the majority of survey respondents have positive experiences with the treatment they are receiving. Of the survey respondents, 67.5 percent indicated that they were able to see someone as soon as they wanted, if needed. In addition, 83.6 percent or respondents indicated that providers explained things in a way they could understand, 84.5 percent indicated that providers showed respect for what the member had to say, and 90.1 percent indicated that the provider made them feel safe.

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

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

- 82 percent are more confident about not being dependent on drugs or alcohol

- 80 percent are able to deal more effectively with daily problems
- 73 percent are better able to deal with a crisis
- 81 percent are getting along better with their family
- 68 percent perform better in social situations
- 63 percent report that their housing situation has improved
- 43 percent report that their employment situation has improved

Medicaid Expansion

Medicaid expansion coverage began on January 1, 2019, and is administered through a comprehensive system of care. The Medicaid expansion program provides services that help keep people healthy, and services that focus on improving health outcomes. The CCC Plus program provided care coordination services for individuals with more pronounced medical needs and served as the delivery system that provided coverage for expansion members who were deemed to be “medically complex.” Medallion 4.0 served as the delivery system for expansion members who were determined not medically complex. Medically complex individuals included individuals with a complex medical or behavioral health condition and a functional impairment, or an intellectual or DD. Medicaid expansion provides coverage for eligible individuals, including adults ages 19 through 64 who are not Medicare eligible, who have income from 0 percent to 138 percent of the FPL, and who are not already eligible for a mandatory coverage group (i.e., children, caretaker adults, pregnant women, individuals over the age of 65, and individuals who are blind or have a disability).

The programmatic changes resulted in overweighting of more acute populations in the performance measure rate calculations. It is also important to note that some performance measure specifications, particularly the HEDIS specifications, experienced changes and updates that reduced, and in some cases, eliminated the ability to compare or trend rates from year-to-year. The performance measure rates were not able to be compared due to the significant changes in the Medallion and CCC programs previously described in this section.

COVID-19 Impact

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 SARS-CoV-2. The first confirmed case in Virginia was declared on March 7, 2020. A State of Emergency in the Commonwealth of Virginia was declared on March 12, 2020.

DMAS continues to monitor the impact of the COVID-19 pandemic on health plan business operations, including its potential effect on medical record data collection, limited access to provider offices, and quarantines and risk to staff. DMAS placed the health and well-being of healthcare workers and members as its top priority.

However, the pandemic had a significant impact on the delivery of healthcare services. Many provider offices were closed and offered limited telehealth services. The worldwide COVID-19 pandemic initially impacted demand on accessing healthcare services, with some families electing to defer routine, nonemergency care to adhere to widespread guidance on physical distancing. DMAS required the MCOs to extend authorizations and expanded the use of telehealth. DMAS also implemented flexibilities for care and services for members receiving LTSS. DMAS allowed flexibilities for specific face-to-face visit requirements and other HCBS. The flexibilities were designed to maintain provider staffing, maximize access to care, and minimize viral spread through community contact to protect the most vulnerable populations.

On July 2, 2020, DMAS directed each MCO to increase payments to network physicians and nonphysician practitioners by 29 percent for certain services provided between March 1 and June 30, 2020. The services included primary care; preventive care; telehealth visits; and EPSDT screens and treatments.[42]

Due to the COVID-19 pandemic, healthcare demand 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 to find 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.

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.

Decreased access and lack of scheduling of routine and preventive services may have negatively impacted rates. The impact from COVID-19 was an environmental factor that was beyond DMAS' control and may have an impact on the overall achievement of goals and outcomes anticipated from the implementation of the Quality Strategy.

[42] 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 4, 2022.

Quality Strategy Performance Measurement Results

Table 34 provides data for performance measures included in the DMAS 2020–2022 Quality Strategy. The table identifies the goals, measures, baseline rate, and the aggregate remeasurement rate. As noted previously, the reported rates are not comparable due to programmatic and population changes.

Table 34—Quality Strategy Performance Measure Results

AIM	Goal	Objective	Measure Name	Metric specifications	HEDIS 2020 Baseline Performance	Performance Measure Target	MY 2020 Aggregate Rate
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	Increase Timely Access to Care	**Metric 1.2.1:** Getting Care Quickly Q6	CMS Adult Core Set: CPA-AD	82.1%*	CAHPS benchmarks	ND
		Increase Member Satisfaction	**Metric 1.2.2:** Enrollees' Ratings Rating of Health Plan	CMS Adult Core Set: CPA-AD	62.5%*	CAHPS benchmarks	62.5%
		Increase Member Satisfaction with Care	**Metric 1.2.3:** Rating of All Health Care	CMS Adult Core Set: CPA-AD	59.0%*	CAHPS benchmarks	77.71%%
	Goal 1.2: Improve Home and Community-Based Services	Ensure Patient-Centered Care and Services	**Metric 1.3.1:** Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and Appropriate to Their Needs and Personal Goals	Quality Management Review (QMR)	^^	86%	Not Reported
		Ensure Access to Care	**Metric 1.3.2:** Number and Percent of Individuals Who Received Services in the Scope Specified in the Service Plan	Quality Management Review (QMR)	^^	86%	Not Reported
Aim 2: Effective Patient Care	**Goal 2.1:** Enhance Provider Support	Maintain Provider Engagement	**Metric 2.1.1:** Rating of Personal Doctor	CMS Adult Core Set: CPA-AD	71.3%*▲	CAHPS benchmarks	83.15%
		Improve Health Communication	**Metric 2.1.2:** How Well Doctors Communicate	CMS Adult Core Set: CPA-AD	94.6%*	CAHPS benchmarks	92.42%

AIM	Goal	Objective	Measure Name	Metric specifications	HEDIS 2020 Baseline Performance	Performance Measure Target	MY 2020 Aggregate Rate
	Goal 2.2: Ensure Access to Care						
		Increase Access to Care	**Metric 2.2.3:** Getting Needed Care	CMS Adult Core Set: CPA-AD	83.3%*	CAHPS benchmarks	80.58%
Aim 3: Smarter Spending	**Goal 3.1:** Focus on Paying for Value	Decrease Potentially Preventable Admissions	**Metric 3.1.1:** Frequency of Potentially Preventable Admissions	VBP Reporting Team	^	VBP/CE Performance Target	SFY21 M4-0.249 SFY21 CCC+-2.484
		Decrease Emergency Department Visits	**Metric 3.1.2:** Frequency of Emergency Department Visits	VBP Reporting Team	^	VBP/CE Performance Target	SFY21 M4-14.30% SFY21 CCC+-29.95%
		Decrease Potentially Preventable Readmissions	**Metric 3.1.3:** Frequency of Potentially Preventable Readmissions	VBP Reporting Team	^	VBP/CE Performance Target	SFY21 M4-6.62% SFY21 CCC+-18.40%
		Decrease Emergency Department Visits	**Metric 3.1.4:** Ambulatory Care: Emergency (ED) Visits	NCQA HEDIS	*	NCQA Quality Compass 50th and 75th percentile	Not Reported
	Goal 3.2: Focus on Efficient Use of Program Funds	Ensure High-Value Appropriate Care	**Metric 3.2.3:** Monitor MLR annually by managed care program and aggregate total	Finance Team Reporting	^^^	Minimum Loss Ration in Final Rule	Not Reported
Aim 4: Improved Population Health	**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	Increase Follow-Up Visits After Hospitalization for Mental Illness	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness	CMS Adult Core Set: FUH-AD	7-Day-Total: 38.74%* 30-Day-Total: 60.89%*	NCQA Quality Compass 50th and 75th percentile	7-Day-Total: 35.63% 30-Day-Total: 56.84%
		Increase Follow-Up Visits After Emergency Department Visit for Mental Illness	**Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness	CMS Adult Core Set: FUM-AD	7-Day-Total: 48.75%* 30-Day-Total: 61.31%*	VBP/PWP Performance Target	7-Day-Total: 45.34% 30-Day-Total: 57.38%

AIM	Goal	Objective	Measure Name	Metric specifications	HEDIS 2020 Baseline Performance	Performance Measure Target	MY 2020 Aggregate Rate
		Increase Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication	**Metric 4.1.3:** Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	CMS Child Core Set: ADD-CH	Initiation Phase: 39.00%* Continuation and Maintenance Phase: 55.33%*	NCQA Quality Compass 50th and 75th percentile	Initiation Phase: 45.20% Continuation and Maintenance Phase: 58.61%
		Increase Mental Health Utilization	**Metric 4.1.4:** Monitor Mental Health Utilization	NCQA HEDIS MPT	*	NCQA Quality Compass 50th and 75th percentile	13.04%
		Increase Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.	**Metric 4.1.5:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	CMS Child Core Set: APP-CH	Total: 72.83%*	NCQA Quality Compass 50th and 75th percentile	Total: 65.43%
	Goal 4.2: Improve Outcomes for Members with Substance Use Disorders	Increase Identification of Alcohol and Other Drug Services	**Metric 4.2.1:** Monitor Identification of Alcohol and Other Drug Services	NCQA HEDIS IAD	*	NCQA Quality Compass 50th and 75th percentile	Not Reported
		Increase Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	**Metric 4.2.2:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	CMS Adult Core Set: FUA-AD	7-Day-Total: 13.11%* 30-Day-Total: 20.04%*	VBP/PWP Performance Target	Medallion 4.0: 7-Day Total: 11.44% 30-Day Total: 21.31%
		Decrease Use of Opioids at High Dosage in Persons Without Cancer	**Metric 4.2.3:** Use of Opioids at High Dosage in Persons Without Cancer	CMS Adult Core Set: OHD-AD	*	NCQA Quality Compass 50th and 75th percentile	4.83%
		Increase Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	**Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	CMS Adult Core Set: IET-AD	*	VBP/PWP Performance Target	CCC+: Initiation: 46.41% Engagement: 12.51%

AIM	Goal	Objective	Measure Name	Metric specifications	HEDIS 2020 Baseline Performance	Performance Measure Target	MY 2020 Aggregate Rate
	Goal 4.3: Improve Utilization of Wellness, Screening, and Prevention Services for Members	Increase Percentage of Eligibles who Receive Preventive Dental Services	**Metric 4.3.1:** Percentage of Eligibles who Receive Preventive Dental Services	CMS Child Core Set: PDENT-CH	*	CMS Child Core Set Benchmark	Not Reported
		Increase Adults' Access to Preventive/Ambulatory Health Services	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services	NCQA HEDIS AAP	Total: 76.40%*	NCQA Quality Compass 50th and 75th percentile	Total: 72.75%
		Increase Child and Adolescent Well-Care Visits	**Metric 4.3.4:** Child and Adolescent Well-Care Visits	CMS Child Core Set AWC-CH	Total: 46.57%***	VBP/PWP Performance Target**	46.57%
	Goal 4.4: Improve Health for Members with Chronic Conditions	Decrease Heart Failure Admission Rate	**Metric 4.4.1:** PQI 08: Heart Failure Admission Rate	CMS Adult Core Set PQI08-AD	*	VBP/PWP Performance Target**	ND FFY 2020
		Decrease Asthma Admission Rate	**Metric 4.4.2:** PDI 14: Asthma Admission Rate (Ages 2–17)	AHRQ Quality Indicators PDI 14	^	VBP/PWP Performance Target**	Not Reported
		Decrease COPD and Asthma in Older Adults' Admission Rate	**Metric 4.4.3:** PQI 05: COPD and Asthma in Older Adults' Admission Rate	CMS Adult Core Set PQI05-AD	*	VBP/PWP Performance Target**	ND FFY 2020
		Decrease Diabetes Poor Control	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	CMS Adult Core Set HPC-AD	48.43%*	VBP/PWP Performance Target**	Medallion 4.0: 50.30% CCC+: 51.42%
		Increase Control of High Blood Pressure	**Metric 4.4.5:** Controlling High Blood Pressure	CMS Adult Core Set CBP-AD	44.09%*	NCQA Quality Compass 50th and 75th percentile	46.91%

AIM	Goal	Objective	Measure Name	Metric specifications	HEDIS 2020 Baseline Performance	Performance Measure Target	MY 2020 Aggregate Rate
	Goal 4.5: Improve Outcomes for Nursing Home Eligible Members	Decrease Use of High-Risk Medications in Older Adults (Elderly)	**Metric 4.5.1:** Use of High-Risk Medications in Older Adults (Elderly)	NCQA HEDIS DAE	*	NCQA Quality Compass 50th and 75th percentile	Not Reported
	Goal 4.6: Improve Outcomes for Maternal and Infant Members	Increase Postpartum Care	**Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care	CMS Adult Core Set PPC-AD	64.23%*	VBP/PWP Performance Target**	66.52%
		Increase Timeliness of Prenatal Care	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care	CMS Child Core Set PPC-CH	73.27%*	VBP/PWP Performance Target**	73.00%
		Increase Childhood Immunization Status	**Metric 4.6.3:** Childhood Immunization Status	CMS Child Core Set CIS-CH	Combo 3: 66.26%*	VBP/PWP Performance Target**	Combo 3: 65.82%*
		Decrease Low Birth Weight Babies	**Metric 4.6.4:** Live Births Weighing Less than 2,500 Grams	CMS Child Core Set LBW-CH	State Mean: 9.9	CDC Wonder Data from CMS benchmarks	Not Reported
		Increase Well-Child Visits	**Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life	CMS Child Core Set W30-CH	Six or More Visits: 54.35% Two or More Visits: 72.10%***	NCQA Quality Compass 50th and 75th percentile	Not Reported

**The baseline measure rate is the final validated 2020 HEDIS, performance measure rate or CAHPS reported in the 2021 Annual Technical Report and posted to the DMAS website.*

***Target established in the CY2021PWP Methodology.*

****The baseline measure rate is the final validated 2020 HEDIS rate reported in the 2022 Annual Technical Report and posted to the DMAS website.*

^The baseline measure rate is the final 2020 rate calculated by HSAG for the PWP.

^^The baseline measure rate is the final 2020 rate reported by DMAS for the Quality Management Review.

^^^The baseline measure rate is the final 2020 rate reported by the DMAS Finance Team

▲ *Statistically significantly higher in 2020 than in 2019.*

▼ *Statistically significantly lower in 2020 than in 2019.*