COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

2020–2022 Quality Strategy

The Virginia draft Quality Strategy was submitted to the Centers for Medicare & Medicaid Services on April 1, 2020.

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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. Medicaid is delivered to individuals through two models. As of December 2019, more than 90 percent of Medicaid enrollees received their benefits through the managed care model and less than 10 percent of enrollees participated in Medicaid through the fee-for-service (FFS) model. The Medicaid managed care populations in Virginia are organized into two programs: Medallion 4.0, which began in August 2018, and Commonwealth Coordinated Care Plus (CCC Plus), which began in August 2017.

Medicaid plays a critical role in the lives of over a million Virginians, providing access to healthcare for the most vulnerable populations. In Virginia, Medicaid covers one in three births and black women are three times more likely than their white counterparts to suffer pregnancy-related deaths due to natural causes. As such, Virginia's Governor, Ralph Northam, established a Commonwealth goal to eliminate racial disparity in pregnancy-related deaths by 2025.[1]

The impact of Medicaid extends far beyond traditional health coverage, to include comprehensive services such as long-term services and supports (LTSS). Medicaid is the primary payer for LTSS, making it possible for thousands of aged, blind, and disabled (ABD) Virginians to remain in their homes or to access residential care when needed.[2] Most of Virginia's Medicaid dollars are spent on care for older adults and individuals with disabilities.

Medicaid is also 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.

Virginia's Medicaid budget expends 97.4 percent of its funds on medical services, 0.3 percent on health information technology incentive payments, and 2.3 percent on administrative expenses.[3] 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 65,000 enrolled providers. Virginia continues to build upon its investment successes to achieve even more—innovating and evolving to improve the health of Virginians.

DMAS developed this Quality Strategy in accordance with the Code of Federal Regulations (CFR), at 42 CFR §438.200 et. seq. DMAS developed the Quality Strategy to continually monitor, assess, and improve the timeliness and delivery of quality healthcare to all Medicaid

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[1] O'Connor, K. Virginia Medicaid zeroes in on plans to address maternal mortality. *The Virginia Mercury*. July 1, 2019. Available at: https://www.virginiamercury.com/blog-va/virginia-medicaid-zeroes-in-on-plans-to-address-maternal-mortality/. Accessed on: March 19, 2020.

[2] Virginia Department of Medical Assistance Services. 2019 Medicaid at a Glance. Available at: https://www.dmas.virginia.gov/files/links/221/2019%20MAG%20Draft%20(01.07.2019).pdf. Accessed on: Oct 23, 2019.

[3] 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: http://sfc.virginia.gov/pdf/health/2018/010818_No1_Jones_DMAS%20Budget%20Briefing.pdf. Accessed on: March 19, 2020.

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 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:
http://www.dmas.virginia.gov/#/med4reports

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

The Medicaid State Plan

https://www.medicaid.gov/CHIP/Downloads/VA/VACurrentStatePlan.pdf

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 managed care organization (MCO) 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.

This Quality Strategy aims to guide Virginia's Medicaid program by establishing clear aims and 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 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.

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 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 managed care and CHIP 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 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 quality improvement.

Strategic Overview

Quality Strategy Aims and Goals

The Quality Strategy is intended to guide Virginia's Medicaid managed care program by establishing clear aims and 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, health equity, provider supports, and steps to address health-related unmet resource needs. This vision is distilled into four central aims:

1. Enhance member care experience
2. Effective patient care
3. Smarter spending
4. Improve population health

Included within each of these four aims is a series of goals, intended to highlight key areas of expected progress and quality focus. Together, as is shown in Table 1 below, 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 aims and goals were designed to align closely with CMS's 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 standards may be found in Appendix B.

Table 1—Quality Strategy Aims and Goals
September 25, 2019

Aims	Goals
Aim 1: Enhanced Member Care Experience	**Goal 1.1:** Increase Member Engagement and Outreach
	Goal 1.2: Improve Member Satisfaction
	Goal 1.3: Improve Home and Community-Based Services
Aim 2: Effective Patient Care	**Goal 2.1:** Enhance Provider Support
	Goal 2.2: Ensure Access to Care
	Goal 2.3: Reduce Patient Harm
Aim 3: Smarter Spending	**Goal 3.1**: Focus on Paying for Value
	Goal 3.2: Focus on Efficient Use of Program Funds

Aims	Goals
Aim 4: Improved Population Health	**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members
	Goal 4.2: Improve Outcomes for Members with Substance Use Disorders
	Goal 4.3: Improve Utilization of Wellness, Screening, and Prevention Services for Members
	Goal 4.4: Improve Health for Members with Chronic Conditions
	Goal 4.5: Improve Outcomes for Nursing Home Eligible Members
	Goal 4.6: Improve Outcomes for Maternal and Infant Members

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

To accomplish the goals, specific performance measures are used to track the progress of the implementation of interventions. 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 Aims and Goals

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.

Each of the 14 goals are 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)(2), these interventions are tied to a set of metrics by which progress is assessed.

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).

Figure 1—Virginia's 2020–2022 Quality Strategy Framework

- **Enhanced Member Care Experience**
  - Increase Member Engagement and Outreach
  - Improve Member Satisfaction
  - Improve Home and Community-Based Services
- **Effective Patient Care**
  - Enhance Provider Support
  - Ensure Access to Care
  - Reduce Patient Harm
- **Smarter Spending**
  - Focus on Paying for Value
  - Focus on Efficient Use of Program Funds
- **Improved Population Health**
  - Improve Behavioral Health and Developmental Services of Members
  - Improve Outcomes for Members with Substance Use Disorders
  - Improve Utilization of Wellness, Screening, and Prevention Services for Members
  - Improve Health for Members with Chronic Conditions
  - Improve Outcomes for Nursing Home Eligible Members
  - Improve Outcomes for Maternal and Infant Members

Strategy for Meeting Goals

The methods employed by DMAS to achieve these goals include:

- Developing and maintaining collaborative strategies among State agencies, community resources, and external partners to improve health education and health outcomes, manage vulnerable and at-risk members, 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.

- Improving health information technology 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

Inputs

Community Health Status
- Virginia health reports
- CDC Reports

Existing Community Assets
- Local initiatives
- Public Health Initiatives
- Stakeholder groups and partnerships

DMAS Assets
- QI meetings
- CQI
- Health care delivery models: Managed Care, FFS, HCBS

EQRO Assets
- Clinical and analytic expertise
- Data from MCOs' PMs and PIPs
- Research
- Participation in DMAS QI meetings, activities, and planning

Outputs

Activities	Participation
Analyze data available to determine areas requiring improvement	Managed care, FFS, and community stakeholders may share:
Determine notable interventions and strategies that have demonstrated the greatest (positive) impact on the population	• And become educated on duplicative initiatives • Successes and impediments in quality improvement activities already undertaken
Determine alignment of public health initiatives with managed care and FFS initiatives	• And become educated on effective strategies or effective interventions put in place by other entities
Participate in and assist in facilitating DMAS QI activities and committee meetings	

Outcomes

Short Term
- Resources to improve outcomes are streamlined and aligned and targeted to most effective strategies
- Resources are targeted to the most effective interventions

Medium Term
- More interventions to improve population health outcomes can be implemented
- Additional conditions and populations may be targeted for improvement

Long Term
- Improve access to and quality of care and health outcomes for the population served in the Medicaid program
- Health status of the Medicaid population improves

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

DMAS understands that 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, in which the agency's focus on quality is emphasized, 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:

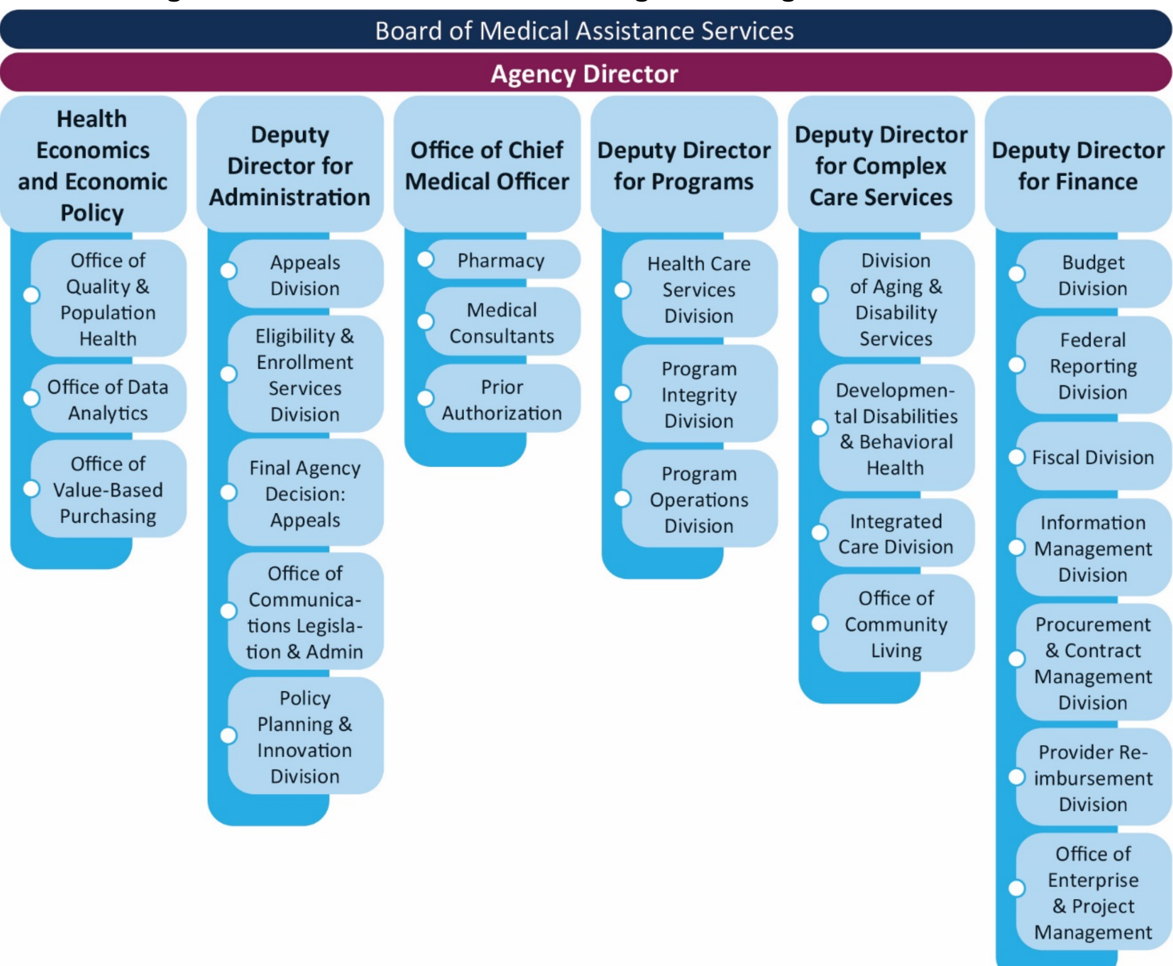
- ***Service****: We are committed to serving all who are touched by our system with caring, integrity, and respect.*
- ***Collaboration****: We value professional, respectful cooperation to achieve common goals. Everyone's input is welcome.*
- ***Trust****: We are continuously building a culture that 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 Management 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 non-healthcare 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 1.4 million Virginia Medicaid members.

Chief Medical Officer

The Chief Medical Officer is a key position within DMAS Executive Leadership. The Chief Medical Officer works collaboratively across DMAS divisions, providing oversight of the quality and delivery of healthcare services. The Chief Medical Officer is responsible for the development and approval of DMAS' medical policy.

Office of Health Economics and Economic Policy

The Office of Health Economics and Economic Policy is responsible for the systematic and rigorous examination of the problems faced in Virginia in promoting health for the Medicaid population. The Office of Health Economics and Economic Policy applies economic theories of consumer, producer, and social choice. The Office also aims to understand the behavior of individuals, healthcare providers, and public and private organizations in decision-making. DMAS' health economic principals are focused on addressing global health issues such as obesity, access to care and services, disparities, and healthcare competition and regulation to inform decisions and policy development on the most efficient, cost-effective, and equitable course of action. The Office of Health Economics and Economic Policy research includes the evaluation of new technologies; investment strategies; and strategic behaviors, such as the impact of healthcare and preventive services on promoting healthy lifestyles. The Office of Health Economics and Economic Policy develops policies to promote healthy lifestyles and positive health outcomes.

Office of Quality and Population Health

The Office of Quality and Population Health (QPH) is responsible for instilling a culture of quality, innovation, and continuous improvement throughout the Medicaid program. The focus of QPH is on measuring performance, strategy alignment, and improving operations. The QPH office understands that quality is an agency-wide endeavor with cross-functional teams working collaboratively to build a culture of quality. The cross-functional teams work together to integrate DMAS' goals, using interdepartmental monitoring processes and activities, such as referring quality of care and risk management concerns, member and practitioner complaints, grievances and appeals, and using business application systems and databases to support quality and population health. The QPH team's mission is to build organizational value, improve performance through innovation, and earn community respect by monitoring MCO performance to achieve better care, lower costs, improve patient experience, and provide more efficient operations.

Office of Data Analytics

The Office of Data Analytics is responsible for DMAS' business intelligence, reporting, and analytical processing, which supports DMAS' ability to make informed business decisions. The Office of Data Analytics collects data from different source systems, such as providers and MCOs, and combines the data using data integration processes. The Office of Data Analytics' initiatives assist DMAS in increasing efficiencies and effectiveness, promoting operational efficiency, and responding quickly to healthcare trends with the goal of improving performance. The Office of Data Analytics works with data from providers and MCOs to identify patterns and relationships in the

data. The Office of Data Analytics performs advanced data analytics, which involves sorting through large data sets to conduct predictive data analytics and also looking at data to prevent fraud, waste, and abuse. The Office of Data Analytics conducts quantifiable data analyses that provide DMAS with actionable information about key performance indicators, quality of care and services, and business operations.

Office of Value-Based Purchasing

The Office of Value-Based Purchasing focuses on the promotion of policies that encourage the effective and efficient provision of care to Medicaid members. These efforts include a broad set of performance-based strategies that link financial and non-financial incentives to MCO and provider performance. DMAS evaluates this performance by applying expectations to a range of performance measures including National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®),[4] CMS Adult and Child Core, and measures developed by Virginia. DMAS uses the results to evaluate performance of stakeholders within the healthcare system and allocate financial incentives based on this performance, thus setting and enforcing an expectation for the level of care members are to receive under the Medicaid program. Examples of such policies include the Performance Withhold Program (PWP) and Clinical Efficiency (CE) Program, which evaluate both the quality and efficiency of care furnished to Medicaid managed care members. The Office of Value-Based Purchasing is constantly working across DMAS to ensure that the agency promotes policy and programs that drive improvement in the quality and efficiency of care provided to Medicaid members in a focused and data-driven way.

Fraud, Waste, and Abuse—Program Integrity Division

The Program Integrity Division (PID) has created the External Provider Audit & Policy Unit (EPAP) to fulfill commitments of providing oversight of DMAS' managed care partners through audits of MCO providers and on-site reviews of the MCOs' program integrity activities. EPAP's goal is to strengthen partnerships with MCOs, satisfy CMS requirements, and maintain DMAS' Program Integrity (PI) compliance. Such activities include providing guidance and clarification to MCO partners, collaborating around known program vulnerabilities, and auditing MCOs to ensure policy is adhered to. Specifically, PID achieves the following:

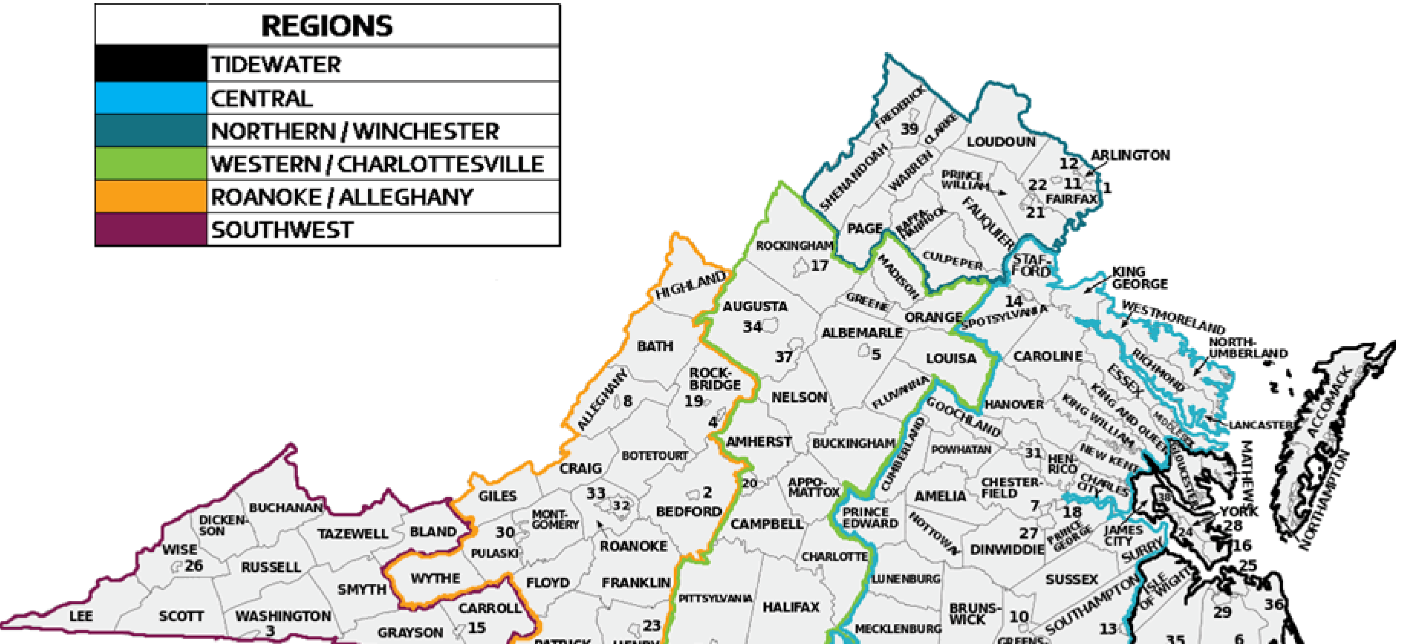
- Collaborative meetings: Managed Care PID Collaborative meetings provide both MCOs and DMAS the opportunity to share information regarding program integrity issues. These quarterly meetings also provide a forum to identify problematic providers as well as trending fraudulent schemes. Additionally, successful approaches to mitigate and avoid abusive schemes are shared. Representatives from the Attorney General's Medicaid Fraud Control Unit (MFCU) attend these meetings and provide updates on fraud investigations.
- Quarterly Reviews: During quarterly reviews, MCO's must demonstrate that they are meeting DMAS program integrity requirements. The PI analysts visit onsite and perform dozens of audits and tests to ensure the MCOs are meeting state and federal PI standards. A quarterly report is generated to document the review. This quarterly audit process is cutting edge and a national best practice.

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

Virginia Medicaid Regions

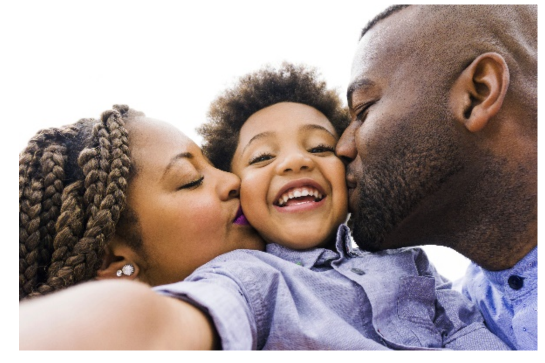
The map of Virginia in Figure 4 is color coded to delineate the counties included in each of the six distinct regions established for the delivery of Medicaid MCO services provided by the two MCO models: Medallion 4.0 and CCC Plus.

Figure 4—Virginia Healthcare Service Regions



Populations Served in Managed Care

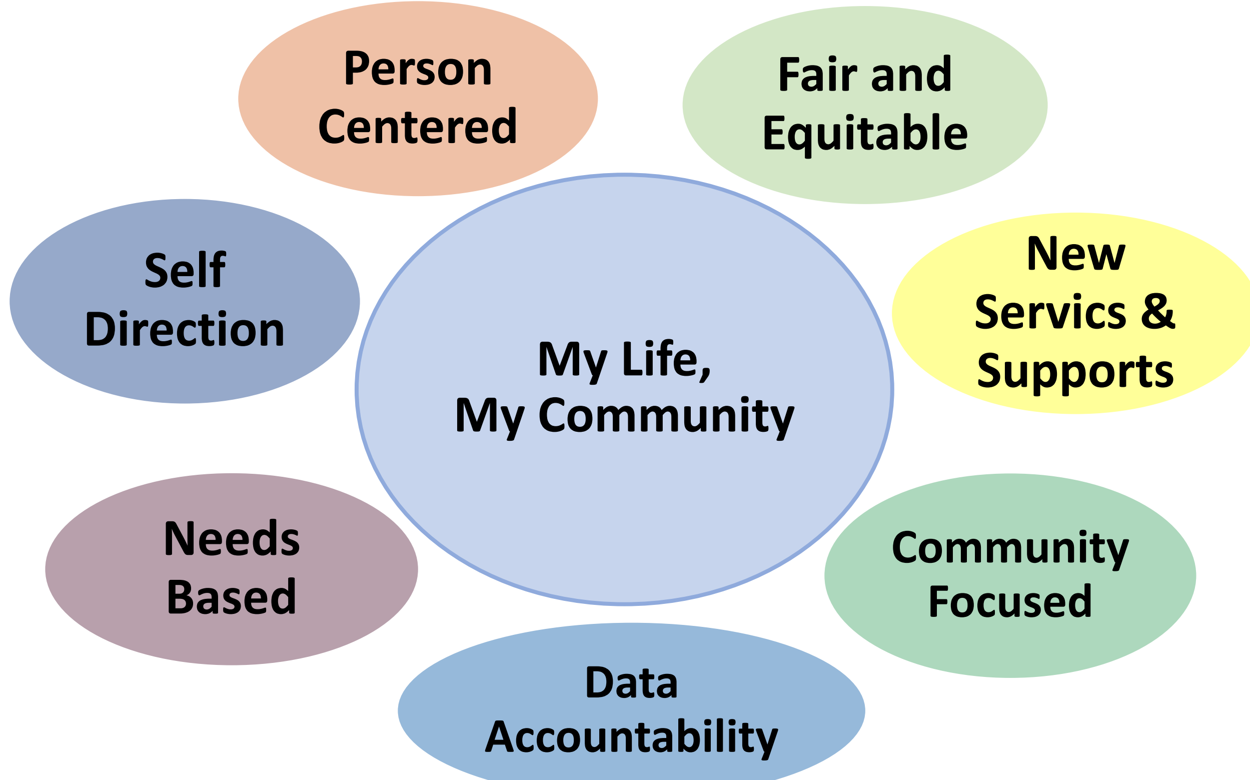
Waivers



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. Virginia has the following CMS-approved waivers:

- **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 non-traditional 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.

- **1115(a): FAMIS MOMS and FAMIS Select:** The FAMIS MOMS waiver program provides healthcare coverage for pregnant women. Good healthcare during pregnancy is important for the mom and the baby. FAMIS MOMS encourages pregnant women to get early and regular prenatal care to increase the likelihood for a healthy birth outcome. FAMIS MOMS provides comprehensive healthcare and dental benefits during pregnancy and for two months following the baby's birth. FAMIS Select helps families pay for employer-sponsored health insurance. It offers families with children enrolled in FAMIS more healthcare coverage options. The FAMIS Select program allows families to choose between covering their children through FAMIS or through an employer-sponsored health plan.
- **1915 (b1), 1915(b4), 1915 (c): CCC Plus:** The CCC Plus waiver program provides home- and community-based services (HCBS) and transition services for aged individuals 65 years and over, physically disabled individuals 0–64 years of age, individuals with other disabilities 0–64 years of age, and technology dependent individuals of all ages.
- **1915 (c): Virginia Community Living:** The Community Living waiver is focused on maximizing each individual with developmental disabilities or intellectual disabilities' life in his or her community with increased flexibility, new options, and improved access. It provides individuals and families with more targeted, needs-based services; increased flexibility in service options; easier navigation through the waiver process; and the ability to more easily change options as needs change. The Community Living waiver also gives providers enhanced service delivery options; increased flexibility in service design; rates that better ensure qualified, well-trained staff members to support individuals' changing needs; and rates that incentivize and support smaller, more community-integrated residential settings.



- **1915 (c): Virginia Family and Individual Support:** The Family and Individual Support waiver assists individuals with autism, developmental, or intellectual disabilities of any age and their families with accessing person-centered and family-centered resources, supports, services and other assistance.

- **1915 (c): Virginia Building Independence:** The Building Independence waiver provides support in the community rather than in an Intermediate Care Facility (ICF) for individuals with autism and intellectual disability or developmental disabilities for individuals of all ages.

DMAS Programs

Medallion 3.0

For over 20 years, the Medallion 3.0 program provided acute and primary care services for enrolled members including pregnant women, low-income families with children (LIFC), those receiving temporary assistance for needy families (TANF), ABD, and children. The program added two other groups through its duration, including children in foster care and adoption assistance (FC/AA) and the health and acute care program (HAP) populations. The Virginia Medallion 3.0 program provided healthcare coverage statewide to Medicaid members through mandatory enrollment in MCOs. The primary exclusions were members dually eligible for Medicare and Medicaid, who had comprehensive private insurance as primary payers, who resided in nursing homes, and some members who received services under a home and community-based waiver. The Medallion 3.0 program transitioned to the Medallion 4.0 program during 2018.

Medallion 4.0

The Medallion 4.0 program is intended to ensure the delivery of acute and primary care services, prescription drug coverage, and behavioral health services for most of Virginia's Medicaid Title XIX members and for all members of FAMIS, Virginia's Title XXI CHIP. Medallion 4.0 rolled in 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, FAMIS members, and current and former foster care and adoption assistance children. This program covers approximately 1 million lives as of December 2019.

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 (CCC)

The CCC managed care program blended and coordinated Medicare and Medicaid benefits for dual-eligible members ages 21 and older who lived in designated regions around the Commonwealth. Individuals receiving LTSS through nursing facilities and the elderly or disabled with a Consumer Direction Waiver were also eligible to participate in the CCC managed care program. The CCC managed care program included provisions for person-centered care planning, interdisciplinary care teams, care coordination services, provider credentialing, access to services, unified appeals and grievances, and closely monitored quality of services. At the inception of the CCC dual demonstration, a three-way contract was executed among CMS, DMAS, and each Medicare-Medicaid Plan (MMP). The CCC managed care program in Virginia ended in 2017.

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

The CCC Plus program, which began in 2017, is DMAS' mandatory integrated care initiative for certain qualifying individuals, including dual-eligible individuals and individuals receiving long-term services or supports (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 includes members that transitioned from Medallion 3.0 and CCC into CCC Plus, such as the ABD adult and children 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. This program covers approximately 18 percent of the Medicaid and FAMIS enrollees, or about 245,000 lives, as of December 2019.[5]

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)
- Non-dual eligible members receiving LTSS (facility and community-based)
- Members in the Developmental Disabilities waiver (for non-waiver services only)

Populations currently not eligible for CCC Plus include, but are not limited to, the following (for a full list of excluded populations, please see the CCC Plus MCO contract[6]):

- Psychiatric Residential Treatment Center (RTC) facility programs
- Individuals enrolled in the Commonwealth's Medallion 4.0 and Title XXI CHIP programs (FAMIS, FAMIS MOMS)
- Individuals enrolled in a Program of All-Inclusive Care for the Elderly (PACE)
- Dual eligible individuals without full Medicaid benefits

[5] Virginia Department of Medical Assistance Services. CCC Plus M4 Demographic Population Report, July 2019.

[6] Virginia Department of Medical Assistance Services. CCC Plus: Information. Available at: http://www.dmas.virginia.gov/#/cccplusinformation. Accessed on: March 23, 2020.

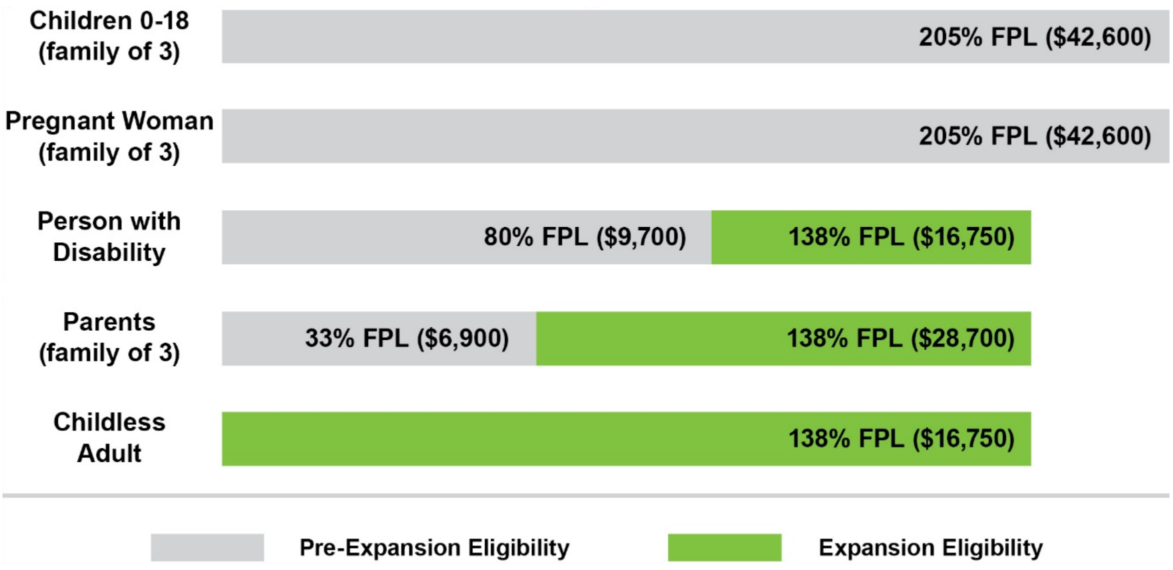
- Individuals with temporary coverage or who are in limited coverage groups

The CCC Plus program emphasizes transitioning the members with complex needs from FFS to managed care. The focus areas include, but are not limited to, the following:

- *Continuity of care:* The continuity of care period was initially 90 days for the implementation of CCC Plus program. This required MCOs to pay for members to see their current care providers (even those that were out of network) and to maintain existing services. Therefore, MCOs inherited authorized services from the FFS model. MCOs were required to maintain these services for 90 days or until the health risk assessment was completed.
- *Service authorizations:* Intensive stakeholder facilitation was utilized to create and implement streamlined authorization processes across all six CCC Plus MCOs to minimize disruption of care of the members.
- *Care coordination:* Members with complex needs assigned care coordinators help them and their caregivers navigate their care. These care coordinators were hired and trained by the MCOs to provide this service.
- *Health Risk Assessments:* These assessments identified the current health needs, services and gaps in care. Using the assessment results, care coordinators assisted members to address gaps in care. This included addressing needs through connecting members to specialists, new equipment, new services or initiating services that had lapsed.
- *Engagement and Collaboration:* The CCC Plus MCOs engaged and collaborated closely with the DMAS Program Operations and Transportation Divisions to ensure the complex needs of members were met.

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). In addition, women that are 60 days postpartum may remain eligible for coverage as an expansion member. Over 60 percent of expansion members are women. Poverty levels for each population are detailed in Figure 5.



Most eligible individuals will be enrolled in managed care, in either the Medallion 4.0 or the CCC Plus program. Individuals may be in Medicaid fee-for-service briefly before enrolling in managed care. The CCC Plus program provides care coordination services for Medicaid expansion individuals with more pronounced medical needs and serves as the delivery system that provides coverage for expansion individuals who are deemed to be medically complex. Medically complex individuals include individuals who have a complex medical or behavioral health condition and a functional impairment, or an intellectual or developmental disability. The Medallion 4.0 program serves as the delivery system for expansion individuals who are determined not to be medically complex.

Program of All-Inclusive Care for the Elderly (PACE)

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 11 individual PACE sites serving over 1,400 participants. The PACE program oversight is conducted by both CMS and DMAS.[7] The eleven locations include:

- Big Stone Gap
- Cedar Bluff

[7] Virginia Department of Medical Assistance Services. Programs of All-Inclusive Care for the Elderly (PACE). An Overview of PACE for Potential Participants and Families. Available at: http://www.dmas.virginia.gov/files/links/675/PACE%20in%20Virginia%2011.2018.pdf. Accessed on: March 19, 2020.

- Charlottesville
- Farmville
- Gretna
- Lynchburg
- Newport News
- Norfolk
- Portsmouth
- Richmond
- Roanoke

PACE is an integrated system of care for individuals ages 55 and over who 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
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 "Uniform Assessment Instrument" administered by a member's local Department of Social Services.

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

Fee-for-Service (FFS)

While the vast majority of Virginia's Medicaid populations are managed under an MCO, approximately 10 percent are 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 managed care program and 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 (HIPP) or FAMIS Select.
- Anyone who lives on Tangier Island.
- Anyone enrolled in the Medicaid hospice covered group (if the member is already enrolled in CCC Plus when hospice enrollment occurs, the member remains in the CCC Plus 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 (ICF/ID) or a state ICF for Mental Health (ICF/MH).
- Anyone who resides at Piedmont, Catawba, Hiram Davis, and Hancock State facilities operated by the Department of Behavioral Health and Developmental Services.
- Anyone participating in the Independence at Home demonstration.

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 2020–2022 Quality Strategy. The mechanisms for assessing quality, timeliness, and access to care will vary across the Medicaid programs in Virginia; therefore, the Quality Strategy is tailored to incorporate these variances while ensuring an integrated strategy overall. The Quality Strategy requires a succession of incremental steps that DMAS will pursue to achieve these quality objectives. The actions and plans outlined herein lay the necessary groundwork for an evolving approach by establishing a strong foundation for quality governance.

With input provided by Virginia Medicaid MCOs, external stakeholders, and the Medical Care Advisory Committee, DMAS identified goals and objectives for the Virginia Medicaid program across all populations and product lines. Those goals are supported by performance measures (each performance measure serves as a metric) used to measure performance in achieving the goals identified in the Quality Strategy. DMAS uses the 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. This fourth edition of the Quality Strategy

aligns with the requirements detailed in the revised federal regulations, specifically 42 CFR §438.340.

This document is the fourth edition of DMAS' Medicaid and CHIP Managed Care Quality Strategy for CYs 2020–2022. It builds upon the Quality Strategy currently in place as an extension to the 2017–2019 DMAS Quality Strategy, third edition. This fourth edition aligns with the requirements detailed in the revised federal regulations, 42 CFR §438.340. The final rule issued by CMS, Health and Human Services (HHS) was published in the Federal Register on May 6, 2016 and is hereinafter referred to as the "federal regulations." This final rule was updated with changes to continue the commitment to promote flexibility, strengthen accountability, and maintain and enhance program integrity 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):

… modernizes the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems. The final rule aligns, where feasible, many of the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans;
implements statutory provisions; strengthens actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; and promotes the quality of care and strengthens efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. It also ensures appropriate beneficiary protections and enhances policies related to program integrity. This final rule also implements provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and addresses third party liability for trauma codes.[8]

The federal regulations expand the scope of the Quality Strategy to address the additional requirements in the following five areas:[9]

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

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

For purposes of updating and revising the Quality Strategy, "significant change" is defined as:

[8] The Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: March 20, 2020.

[9] The Centers for Medicare & Medicaid Services. Medicaid and CHIP Managed Care Final Rule. Available at: https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-final-rule/index.html Accessed on: March 23, 2020.

- 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 State 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 online.

Updates and Revision of the Quality Strategy

42 CFR §438.340

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.

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, State, 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

DMAS has several processes to obtain and consider public comment on the Quality Strategy. The Medical 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 June 18, 2020, through July 25, 2020. DMAS did not receive any public comments to consider prior to finalizing the Quality Strategy.

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 June 18, 2020, for their review and to encourage tribal input. DMAS followed up with the tribes on July 25, 2020, when feedback was not received. The tribal consult period was closed on July 25, 2020. DMAS did not receive any tribal input to consider prior to finalizing the Quality Strategy.

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 Pediatricians—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 Office of the Chief Medical Officer. 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

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 at least 60 days prior to the State's submission of any Medicaid or CHIP State Plan Amendment, 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

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 provides written acknowledgement on its website to all stakeholders that provide written feedback during the public comment period. All 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

CMS Review and Approval

If significant changes are made to the 2020–2022 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

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.[10]

[10] Virginia Department of Medical Assistance Services. 2017–2019 Quality Strategy. Available at: http://www.dmas.virginia.gov/files/links/416/DMAS%2020172019%20Quality%20Strategy.pdf. Accessed on: March 23, 2020.

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 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 6.

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.

Figure 6—PDSA Cycle

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®)[11] survey results and other satisfaction survey data to determine how satisfied Virginia Medicaid members are with the care and services they receive.
- 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.
- Provide all information required by the EQRO, in compliance with the protocols set forth by CMS.

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

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 non-medical drivers of health. These interventions drive progress towards the Quality Strategy aims and goals, described in Table 1. DMAS developed a Responsible, Accountable, Consulted, Informed (RACI) chart, depicted in Table 2, to clarify and define the roles and responsibilities of its cross-functional efforts focused on achieving the aims and goals contained in the Quality Strategy.

Table 2—Quality Strategy RACI Chart

Intervention Categories	**1.1** Increase member engagement and outreach	**1.2** Improve member satisfaction	**1.3** Improve home and community-based services	**2.1** Enhance provider support	**2.2** Ensure access to care	**2.3** Reduce patient harm	**3.1** Focus on paying for value	**3.2** Focus on efficient use of program funds	**4.1** Improve behavioral health and developmental services of members	**4.2** Improve outcomes for members with substance use disorders	**4.3** Improve utilization of wellness, screening, and prevention services for members	**4.4** Improve health for members with chronic conditions	**4.5** Improve outcomes for nursing home eligible members	**4.6** Improve outcomes for maternal and infant members
ARTS Program	X	X		X	X	X			X	X				X
Member and Provider Experience Assessments	X	X	X	X	X									
Member Outreach and Engagement	X	X									X			
Provider Outreach and Engagement				X	X	X		X						
Value-Based Purchasing			X	X	X	X	X	X	X	X	X	X	X	X
Assessments of Essential Services and Vulnerable Populations			X			X	X	X	X	X	X	X	X	X

Intervention Categories	**1.1** Increase member engagement and outreach	**1.2** Improve member satisfaction	**1.3** Improve home and community-based services	**2.1** Enhance provider support	**2.2** Ensure access to care	**2.3** Reduce patient harm	**3.1** Focus on paying for value	**3.2** Focus on efficient use of program funds	**4.1** Improve behavioral health and developmental services of members	**4.2** Improve outcomes for members with substance use disorders	**4.3** Improve utilization of wellness, screening, and prevention services for members	**4.4** Improve health for members with chronic conditions	**4.5** Improve outcomes for nursing home eligible members	**4.6** Improve outcomes for maternal and infant members
Connecting to Care		X		X	X									
Management of At-Risk Children						X			X	X	X	X	X	X
Financial Transparency and Accountability							X	X						
Smiles for Children Program					X		X				X			X
Maternity Improvements and Disparities	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.

Addiction and Recovery Treatment Services

Medicaid members are prescribed opioids at twice the rate of non-Medicaid members and are at three-to-six times the risk of prescription opioid overdose. On April 1, 2017, Virginia's Medicaid program launched an enhanced SUD treatment benefit known as Addiction and Recovery Treatment Services (ARTS). The 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 a SUD. Critical elements of the ARTS transformation include:

1. Providing a continuum of care modeled after the American Society of Addiction Medicine Criteria (ASAM Criteria) for SUD treatment services.
2. Implementing policy and program measures to ensure providers meet the standards of care, including integrating SUD treatment services into a comprehensive managed care delivery system for managed care members.

3. Increasing provider capacity and member access to services through enhanced reimbursement rates for SUD treatment services.
4. Implementing strategies to improve the quality of care through evidence-based best practices.

This approach is expected to provide Medicaid members with access to the 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 the 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.

To further support the transformational integration of behavioral and physical health, the Commonwealth of Virginia was selected by the Robert Wood Johnson Foundation as one of three states to receive programmatic support by a team of policy and research experts at the University of Colorado Eugene S. Farley, Jr. Health Policy Center.

The first full year of the demonstration was 2018. The demonstration extends access to certain behavioral and physical health services to uninsured low-income adults with a diagnosis of serious mental illness (SMI). The goal of the demonstration is to use a targeted benefit package to prevent people with SMI diagnoses from becoming fully and permanently disabled. The ARTS component of the demonstration, which contributes to a comprehensive statewide strategy to combat prescription drug abuse and opioid use disorders (OUDs), seeks to expand the SUD benefits package to cover the full continuum of SUD treatment, including short-term residential and inpatient services to all Medicaid-eligible members. The demonstration amendment also expanded Medicaid coverage to former foster care youth who aged out of foster care under the responsibility of another state and were applying for Medicaid in the Commonwealth of Virginia.

Member and Provider Experience Assessments

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.

In order to improve member access to programs and services, DMAS created the Civil Rights Coordinator position in November 2019 to ensure that limited English and disabled individuals have meaningful access to programs and services. This position serves the critical function of ensuring continued compliance with federal and Commonwealth 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. The Civil Rights Coordinator is in the process of writing a language and disability access plan, which will be available to internal and external staff members, as well as to the public. The plan will include a Four Factor Analysis to assess the LEP and disabled populations, the frequency of contact, the nature of the program and services, and the availability of resources and costs.

Member Outreach and Engagement

All member outreach, marketing, and 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 member correspondence, in order to ensure compliance with regulations, readability, interpretation and translation availability, and format accessibility to all members. DMAS is updating the Cover Virginia and DMAS agency websites across the different programs and divisions in order to provide detailed information to members. The goal of these updates is to improve members' understanding of their rights and responsibilities, including appeals, as well as to support members' choices during the enrollment process. DMAS is reviewing and updating all member letters generated by the agency. Finally, DMAS has completed a review and overhaul of all member eligibility notices to ensure compliance with federal law, readability, updated appeals language, as well as language taglines and non-discrimination inserts.

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. DMAS is updating the agency website across the different programs and divisions in order to provide detailed information to providers. The goal of these updates is to support the understanding of provider processes, appeals, credentialing, education and trainings, and payment systems.

Value-Based Purchasing

Value-based purchasing (VBP) includes a broad set of policies and strategies intended to improve healthcare quality, outcomes, and efficiency by linking financial and non-financial 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 Medallion 4.0 and CCC Plus programs, whereby each MCO must earn back a portion of its capitation payments through demonstrated performance against key metrics.

DMAS is also developing the capacity to evaluate potentially preventable, avoidable, and/or medically unnecessary utilization in high-acuity settings of care. 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.

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, each MCO develops and maintains a 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; developmental disability 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 non-emergency 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 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.

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 will seek more transparency in its forecast and rate-setting processes by holding quarterly meetings with staff members from various legislative committees as well as JLARC, the Department of Planning and Budget, and the Secretary of Health and Human Resources to review key policy changes.

Smiles for Children

Smiles For Children (SFC) is Virginia's Medicaid and FAMIS dental program. SFC provides comprehensive dental benefits to members under 21 years of age, medically appropriate dental benefits to pregnant members, and limited benefits to non-pregnant members over 21 years of age. Pregnant women who are 21 years old and older in Medicaid or FAMIS are able to receive dental benefits.

Evidence-based practice and research show that receiving dental care during pregnancy can reduce periodontal disease and periodontal pathogens. Pregnant women receiving dental care may potentially reduce the transmission of oral bacteria from mother to unborn child. This plan was placed into action to decrease dental emergencies and increase the likelihood of mothers delivering healthy babies. This program gave pregnant members the ability to receive appropriate benefits covered by the SFC program, including diagnostic, preventive, restorative, endodontic, and periodontics and prosthodontic services, along with access to nonemergency transportation services to receive dental care and medically necessary oral surgeries. Orthodontics are not covered under the SFC pregnant women's benefit.

The MCOs, under the Medallion 4.0 and CCC Plus programs, offer enhanced dental benefit services. The MCOs are also 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.

Maternity Improvements and Disparities Virginia

DMAS, upon the direction of Governor Ralph Northam, developed a series of strategies to end maternal and infant mortality among its members by 2025. DMAS is working to implement policy and program improvements to streamline enrollment of pregnant women, increase access to treatment for expecting mothers with a SUD, and strengthen accountability for prenatal and postpartum managed care services. Under previous eligibility rules, most women had access to Medicaid coverage for only a narrow window of time during their pregnancy and for 60 days postpartum. Medicaid expansion enables more low-income women to receive quality healthcare before, during, and after their pregnancy. Additional strategies adopted by DMAS to improve maternal and infant health outcomes include continuity of coverage, 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 the Virginia Department of Health (VDH) and Virginia Behavioral Health and Disability Services on initiatives to improve birth outcomes.

Additional Core Quality Improvement Activities

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. African-American mothers in Virginia have consistently died at more than twice the rate of White mothers during and after pregnancy. 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 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). Since 77 percent of infants born with NAS were covered by Medicaid in 2015, 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.

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 (EHRs) will be integrated with the Prescription Monitoring Program and the Advanced Health Directory. This sharing of information will allow 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. Five percent of patients account for nearly 25 percent of all ED visits in the United States.[12] 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 will 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 will be supported and strengthened, leading to improved adherence to treatment recommendations and continuity of care. Reinforcement of the proper use of the healthcare delivery system teaches and enables participants to have their needs met by making informed decisions and directly accessing appropriate care.

[12] Virginia Department of Health. Annual Report: Emergency Department Care Coordination Program. November 1, 2017. Available at: https://www.connectvirginia.org/wp-content/uploads/2018/05/Attachment-4-Nov-1-2017-ED-Care-Coordination-Annual-Report.pdf. Accessed on: March 19, 2020.

Plan to Address Health Disparities

DMAS uses the Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO) **definitions for health equity**:[13,14]

- Social determinants of health (SDOH)—Defined by WHO as "the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics."
- Health disparity and health inequity—Health disparity is defined as the difference in health outcomes between groups within a population. While the terms may seem interchangeable, "health disparity" is different from "health inequity." "Health disparity" denotes differences, whether unjust or not. "Health inequity," on the other hand, denotes differences in health outcomes that are systematic, avoidable, and unjust.

Health disparities are the metrics DMAS uses to measure progress toward achieving health equity.

- Health equity is the principle underlying a commitment to reduce—and, ultimately, *eliminate*—disparities in health and in its determinants, including SDOH.
- Health equity means social justice in health (i.e., no one is denied the possibility to be healthy for belonging to a group that has historically been economically/socially disadvantaged).

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 inequity, DMAS established an internal health equity workgroup. 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 health equity is adapted from the Institute for Healthcare Improvement's white paper titled *Achieving Health Equity: A Guide for Health Care Organizations*.[15]

[13] Centers for Disease Control and Prevention. Health Disparities Among Youth, September 14, 2020. Available at: https://www.cdc.gov/healthyyouth/disparities/index.htm. Accessed on: Sept 23, 2020.
[14] World Health Organization. Health equity. Available at: https://www.who.int/topics/health_equity/en/. Accessed on: Sept 23, 2020.
[15] 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: Sept 23, 2020.

In order for DMAS to develop an agency strategy, the work group will address the following questions:

- What is DMAS currently doing to reduce and eliminate health disparities?
- What does health equity look like in Virginia in terms of access to care, coverage of care, and quality of services?
- What are the key equity issues that affect Medicaid members and providers?
- How should DMAS address those key equity issues?
- What is DMAS doing to address health equity disparities in its response to the coronavirus disease 2019 (COVID-19) pandemic, given that the crisis is disproportionally impacting African-American and Hispanic communities?
- What can DMAS learn from other state Medicaid agencies, federal efforts, community leaders, advocacy groups, and others to address health equity issues?

DMAS Short-Term Goals/Initiatives

Goal	Interventions
Member Engagement & Communications	Engage MAC and other stakeholders regularly to receive feedback on health disparity issue, in trying to access care, request coverage for care, or receive quality services
Policies & Services	Create an inventory of projects to catalog current projects focused on equity
	Evaluate system capabilities to update or add new data elements
	Conduct state research to learn and understand how other states are addressing health disparities
	Review and standardize MCO annual health equity report
	Review any cultural competency trainings provided by DMAS and the MCOs
	Evaluate MCO contracts to assess for heath equity concerns and areas of improvement
Data Quality & Measurement	Develop an inventory of all available SDOH data
	Develop health equity performance measure for Medicaid program
	Review quality measures for health equity

DMAS Long-Term Goals/Initiatives

Goal	Interventions
Member Engagement & Communications	Develop a comprehensive outreach and communication strategy to engage community members and leaders, advocacy groups, and other stakeholders to gather feedback and disseminate program information
Policies & Services	Develop a framework for health equity with SDOH factor that can be used to improve health and eliminate health disparities
	Develop strategies to promote health equity above regulatory requirements for MCOs and DMAS policy developments
Data Quality & Measurement	Data analysis by age, race, ethnicity, gender, sexual orientation, disability, neighborhood, and other sociodemographic characteristics
	Establish long-term, annual metrics to assess changes in health disparity issues (e.g., access to care, quality of services, use of coverage, etc.

Plan to Reduce Health Disparities

DMAS identifies member characteristics including age, race, ethnicity, sex, primary language, 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 will update 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:

Age

- *Identify Disparity:* DMAS will use results from disparity sensitive performance measures to identify age health disparities. DMAS will stratify data from the following performance measures to identify age health disparities:
  - NCQA HEDIS: *AAP—Adults' Access to Preventive/Ambulatory Health Services*
  - CMS Adult Core Set: *HPC-AD—Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*
- *Evaluate Disparity:* DMAS will complete 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 will use 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 will use results from the following disparity sensitive performance measures to identify racial health disparities:
  - 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 will complete 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 will use 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 will use results from the following disparity sensitive performance measure to identify ethnicity health disparities:
  - CMS Adult Core Set: *CBP-AD—Controlling High Blood Pressure*
  - CMS Adult Core Set: *IET-AD—Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*
- *Evaluate Disparity:* DMAS will complete 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 will use 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 will use results from the following disparity sensitive performance measures to identify sex health disparities:
  - 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 will complete 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 will use 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 will use 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 will complete 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 will use 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.

Disability Status

- *Identify Disparity:* DMAS will use results from the following disparity sensitive performance measures to identify disability status disparities:
  - *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 will complete a formative evaluation to determine the best approach and to assess progress that are inclusive and reflective of the unique aspects of disability status disparities.
- *Reduce Disparity:* DMAS will use 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 Equity

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 State. 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 inequities and their root causes and promote equitable opportunities to be healthy. The office develops programs and partnerships to empower racial and ethnic minority communities to promote awareness of health inequities. 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 inequities through a focus on SDOH as a key strategy to eliminate health inequities that exist by socioeconomic status, race/ethnicity, geography, gender, immigrant status, and other social classifications. There are five United States (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

Quality Collaborative Focus on Health Equity

DMAS hosts MCO Quality Collaboratives that serve as the main platform for the MCOs, the EQRO, and DMAS to share lessons learned, best practices, and potential solutions to common opportunities for improvement. In July of 2019 the Quality Collaborative was strategically planned and held off-site at a low-income community center in an area where DMAS members resided. The title of the July Medicaid Quality Collaborative was "Moving From Healthcare to Health With a Focus on Health Equity and Social Determinants of Health." The July Quality Collaborative was symbolic of change, but more importantly, it was symbolic of transformation. The fact that DMAS held a meeting off-site, in a low-income neighborhood, and not at the Virginia Medicaid office building, is a reflection of the agency's commitment to fully engage with the community, DMAS' many partners, and its members.

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

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

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

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 will use 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 substance use disorder (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 ranked 26th among states with a rate of 5.9 deaths per 1,000 live births, according to the CDC National Center for Health Statistics, 2017.[16] 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 Virginia Behavioral Health and Disability Services on initiatives to improve birth outcomes. 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, and disability status in birth outcomes, DMAS conducts an annual study of Medicaid and CHIP prenatal care and associated birth outcomes. The purpose of the study is to determine the extent that women receive early and adequate prenatal care, and the clinical outcomes that are associated with the Medicaid-paid births. Overall, a higher percentage of women in the study population received early and adequate prenatal care compared to women who were not continuously enrolled in Medicaid prior to delivery. Additionally, there was a lower percentage of births to women in the study population prior to 37 completed weeks of gestation (i.e., preterm) or weighing less than 2,500 grams (i.e., low birth weight [LBW]) when compared to births to women who were not continuously enrolled in Medicaid prior to delivery. The most promising study indicator results were identified among births to women in FAMIS MOMS. Though limited in number, births to these women had the highest rate of early and adequate prenatal care, the lowest rates of preterm birth or LBW, and the highest rate of non-NICU singleton births with two or more office visits with a primary care provider (PCP) in the 30 days following birth. Demographic categories included the following:

Table 3—Demographic Categories

Demographic Category	Category Values
Medicaid Program	FAMIS MOMS (Eligibility category 005) Medicaid for Pregnant Women (Eligibility categories 091, 097) The "other Medicaid" category will include births paid by Medicaid that do not fall within the FAMIS MOMS or Medicaid for Pregnant Women program categories.
Medicaid Delivery System	Fee-for-Service (FFS) Managed Care

[16] Virginia Department of Medical Assistance Services. 115 Compass Waiver Update. Board of Medical Assistance Services (BMAS) 6/4/2019. Available at: http://www.dmas.virginia.gov/files/links/3941/Final%20Agenda,,%20presentations,%20reg%20update%206.4.19.pdf. Accessed on: Sept 24, 2020.

Demographic Category	Category Values
Maternal Region of Residence Note: Maternal region of residence will be defined based on members' county of residence at time of delivery using the Virginia Managed Care Regions Map and Federal Information Processing Standards (FIPS) codes defined in Appendix A of the EQRO Request for Proposal (RFP).	Central Charlottesville Far Southwest Halifax/Lynchburg Northern/Winchester Roanoke/Alleghany Tidewater
Race/Ethnicity Note: Race/ethnicity will be defined based on maternal non-Hispanic race (i.e., White, non-Hispanic) classification with Hispanic members of any race being reported in the HISPANIC category.	White African American Asian Hispanic Other
Maternal Age	15 years and younger 16 years through 17 years 18 years through 20 years 21 years through 24 years 25 years through 29 years 30 years through 34 years 35 years through 39 years 40 years through 44 years 45 years and older
Maternal Immigration Status	U.S. Citizen (Citizenship Status = "C", "N") Documented immigrant (Citizenship Status = "E", "I", "P", "R") Undocumented immigrant (Citizenship Status = "A") Other (Citizenship Status = "V")
Maternal Emergency Only Coverage	Emergency Only Benefits Not Emergency Only Benefits

Social Determinants of Health

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

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

DMAS, working with the MCOs, is addressing the SDOH that are impacting members in several ways, including but not limited to:

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

Progress in Reducing Disparities

Performance Measurement Disparity Stratifications

An example of how DMAS stratifies performance measure data to identify, evaluate, and reduce—to the extent practicable—health disparities based on age, race, ethnicity, sex, primary language, and disability status is the *Asthma Admission Rate* performance measure. DMAS contracted with HSAG in 2019 to calculate the Agency for Healthcare Research and Quality's (AHRQ's) Pediatric Quality Indicator (PDI) 14: *Asthma Admission Rate* (PDI 14) to evaluate inpatient admissions for asthma for children ages 2 to 17 years for the 2018 measurement period. The PDI 14 performance measure results are calculated for the Virginia FAMIS and Medallion populations, stratified by managed care geographic region, age, gender, race, gender/race, gender/age, physician management (i.e., outpatient visit with a PCP), active asthma medications on admission by therapeutic classification, and asthma medications prescribed during admission or within 7 days of discharge by therapeutic classification.

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

Rate Stratifications	Results (CY 2018)
Virginia Total Rate (Admissions Per 100,000 Member Months [MM])	
Virginia Total Rate	7.85
Rates by Region (Admissions Per 100,000 MM)	
Central Virginia	14.27
Far Southwest Virginia	—
Halifax	9.00
Lower Southwest Virginia	5.94
Northern Virginia	4.96
Tidewater	5.84
Upper Southwest Virginia	6.97
Rates by Age Group (Admissions Per 100,000 MM)	
2–4 Years	12.63
5–11 Years	8.19

Rate Stratifications	Results (CY 2018)
12–17 Years	4.23
Rates by Gender (Admissions Per 100,000 MM)	
Male	9.34
Female	6.33
Rates by Race Category (Admissions Per 100,000 MM)	
White	5.06
Black/African American	12.35
Asian	—
Southeast Asian/Pacific Islander	—
Hispanic	—
More than One Race/Other/Unknown	13.23
Rates by Gender and Race Category (Admissions Per 100,000 MM)	
Male	
White	5.85
Black/African American	14.86
Asian	—
Southeast Asian/Pacific Islander	—
Hispanic	—
More than One Race/Other/Unknown	—
Female	
White	4.26
Black/African American	9.85
Asian	—
Southeast Asian/Pacific Islander	—
Hispanic	0.00
More than One Race/Other/Unknown	—
Rates by Gender and Age Group (Admissions Per 100,000 MM)	
Male	
2–4 Years	15.94
5–11 Years	9.29
12–17 Years	5.04
Female	
2–4 Years	9.17
5–11 Years	7.08
12–17 Years	3.43
Rates by Physician Management	
No Visit	17.81%
Visit Within 1 Month	30.43%
Visit Within 1–3 Months	21.74%
Visit Within 3–6 Months	15.32%
Visit Within 6–12 Months	14.70%
Rates by Active Asthma Medications on Admission	
Controller	

Rate Stratifications	Results (CY 2018)
No Medication	80.75%
Any Controller	19.25%
Reliever	
Short-Acting Inhaled Beta-2 Agonists	13.04%
No Medication	86.96%
All Medications	
Any Medication	25.26%
No Medication	74.74%
Rates by Asthma Medications Prescribed During Admission and Within 7 Days of Discharge	
Controller	
No Medication	55.90%
Any Controller	44.10%
Reliever	
Short-Acting Inhaled Beta-2 Agonists	37.68%
No Medication	62.32%
All Medications	
Any Medication	53.42%
No Medication	46.58%

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

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

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 equitable access to quality healthcare and providers.
3. Empower communities to promote health equity.

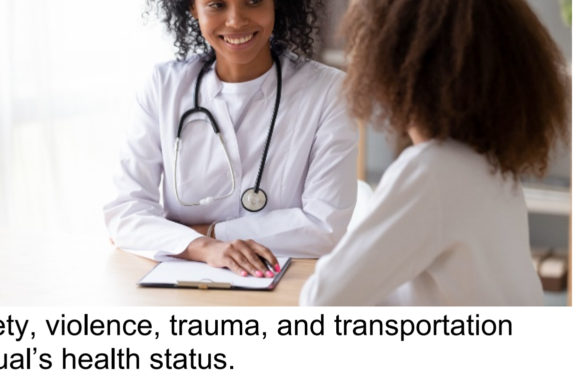
4. Influence health, healthcare, and public policy in order to promote health equity ("health equity in all policies").
5. Enhance the capacity of public health and its partners to promote health equity.

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 limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

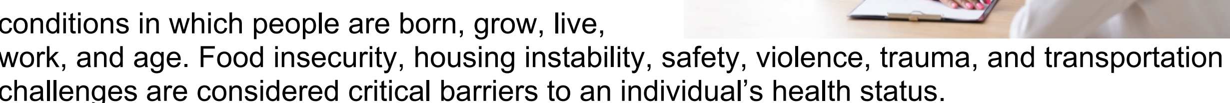
DMAS requires its MCOs to submit an annual report outlining their efforts to address health disparities in the Medallion 4.0 and CCC Plus populations. The MCOs are encouraged to refer to the VDH's OHE for information regarding health disparities in the Commonwealth of Virginia. At the level of the individual 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.

Health Equity

In collaboration with VDH, DMAS is developing interventions focused on reducing health inequities among Virginians of varying socioeconomic, racial and ethnic, and urban and rural backgrounds. DMAS draws upon the recommendations made in the VDH 2012 Virginia Health Equity Report for intersectional strategies and collaboration for promoting health equity in Virginia. The work is focused on providing a foundation for DMAS and its contracted MCOs to develop plans and strategies to address the HRSNs to promote health equity for Virginians enrolled in Medicaid.

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 Office of the Chief Medical Officer. The Quality Steering Committee operates under the direction of DMAS Senior Leadership.

The mission of the Quality Steering Committee is to provide cross-agency governance to support the quality delivery of healthcare to all of the Commonwealth's Medicaid programs [e.g., CCC Plus, Medallion 4.0, 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 reports for the Medallion 4.0 and CCC Plus 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 (IQAP) 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 CMS Managed Care 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 CMS Managed Care 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 5):

Table 5—Medallion 4.0 Assignment of Performance Measures to the Quality of, Access to, and Timeliness of Care Domains

HEDIS Performance Measure	Quality	Access	Timeliness
Children's Preventive Care			
Childhood Immunization Status—Combination 3	✓		
Well-Child Visits in the First 30 Months of Life	✓		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		
Women's Health			
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Prenatal and Postpartum Care—*Timeliness of Prenatal Care* and *Postpartum Care*	✓	✓	✓
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services—Total		✓	
Care for Chronic Conditions			
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*	✓		
Controlling High Blood Pressure	✓		
Medication Management for People With Asthma—Medication Compliance 75%—Total	✓		
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*	✓		
Behavioral Health			
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	✓	✓	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	✓		

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

Table 6—CCC Plus Assignment of Performance Measures to the Quality of, Access to, and Timeliness of Care Domains

HEDIS Performance Measures	Quality	Access	Timeliness
Adults' Access to Preventive/Ambulatory Health Services—Total		✓	
Adult BMI Assessment	✓		
Care for Older Adults—Advance Care Planning	✓		
Use of High-Risk Medications in the Elderly—At Least One Dispensing Event	✓		
Medication Reconciliation Post-Discharge	✓		✓
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8%) and *Eye Exam (Retinal) Performed*	✓		
Controlling High Blood Pressure	✓		
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation—Systemic Corticosteroid and *Bronchodilator*	✓		✓
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	✓	✓	✓
Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total—18–64 and *65+*	✓		

DMAS posts the Medallion 4.0 and CCC Plus quality measures and performance outcomes annually online in the following location:

The Annual External Quality Review (EQR) Technical Report

Medallion 4.0:

http://www.dmas.virginia.gov/#/med4reports

CCC Plus:

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

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. DMAS submits the Medicaid CHIP performance measure rates and other data to CMS 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 Medicaid and CHIP Program System Reporting (MACPro) system annually. DMAS continually works with CMS to report all available data as part of CMS' state quality reporting initiatives.

Quality Rating System

42 CFR §438.334

DMAS developed its MCO Quality Rating System to serve as DMAS' preferred alternative Medicaid Managed Care Quality Rating System. Prior to MCO contract year 2018, the Quality Strategy reflected 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 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 §438.330. 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 *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0. September 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 11 compliance standards are derived

from requirements in the CFR CMS Managed Care Rule. The 11 mandatory compliance standards are listed below:

- 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)
- Provider selection (42 CFR §438.214)
- Confidentiality (42 CFR §438.224)
- Grievance and appeal systems (42 CFR §438.228)
- Subcontractual relationships and delegation (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)

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:

- Accessibility, including 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 State 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 §438.340

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:

- Deploys 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, the Joint Legislative Audit and Review Commission (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

Both CCC Plus and Medallion 4.0 use an ongoing compliance monitoring process (CMP) to detect and respond to issues of MCO non-compliance 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. These points accumulate over a rolling 12-month schedule. Therefore, while active points roll over from previous contract years, any points that are more than 12 months old expire and no longer are counted. Program-specific progressive sanctions are assessed monthly based on the tiered point system described in Table 7—Medallion 4.0 Compliance Point System, and Table 8—CCC Plus Compliance Point System.

Table 7—Medallion 4.0 Compliance Point System

Medallion 4.0 Compliance Point System			
Level	**Point Range**	**Corrective Mechanism**	**Financial Sanctions/Fines**
1	0–10	—	None
2	11–25	CAP	$5,000.00
3	26–50	CAP	$10,000.00
4	51–70	CAP	$20,000.00
5	71–100	CAP	$30,000.00
6	101–150	Suspend Enrollment	N/A
7	>150	Possible Agreement Termination	N/A
Other	Specific Pre-Determined Sanctions	See Medallion 4.0 Contract	

Table 8—CCC Plus Compliance Point System

CCC Plus Compliance Point System			
Level	**Point Range**	**Corrective Mechanism**	**Financial Sanctions/Fines**
1	0–15	—	$1,000.0
2	16–25	CAP	$5,000.00
3	26–50	CAP	$10,000.00
4	51–70	CAP	$20,000.00
5	71–100	CAP	$30,000.00
6	101–150	Suspend Enrollment	N/A
7	>150	Possible Agreement Termination	N/A
Other	Specific Pre-Determined Sanctions	See CCC Plus Contract	

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 on the program 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 contracts for the respective managed care programs, available on DMAS' website.

Overview of Corrective Mechanisms

The compliance point table references two different types of corrective mechanisms.

1. The MCO Improvement Plan (MIP) is used to address minor compliance violations/failures/deficiencies in its Commonwealth of Virginia business, and is only used for issues that do not rise to the level of a formal CAP. For all other purposes, a MIP functions as a CAP. MIPs are only utilized by the Medallion 4.0 program.
2. CAPs address findings and observations that have been identified by DMAS. The CAP gives the MCO the opportunity to analyze and identify the root causes of the identified findings and observations, and to develop a plan to address the findings and observations to ensure future compliance with the MCO's contract and State/federal regulations. Both CCC Plus and Medallion 4.0 utilize this mechanism for compliance.

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 438.340. Accordingly, intermediate sanctions may be imposed if the MCO:

- Fails to substantially provide medically necessary items and services that are required (under law or under the MCO's contract with the State) to be provided to a member covered under the contract;
- Imposes premiums or charges members in excess of the premiums or charges permitted by Title XIX of the Social Security Act;
- Acts to discriminate among enrollees on the basis of their health status or requirements for healthcare services, including expulsion or refusal to re-enroll an individual, except as permitted by Title XIX of the Social Security Act, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the MCO by eligible individuals whose medical condition or history indicates a need for substantial future medical services; misrepresents or falsifies information that it furnishes to CMS or the state;
- Misrepresents or falsifies information that it furnishes to a member, a potential member, or a healthcare provider; or
- Fails to comply with the physician incentive requirements under Section 1903(m)(2)(A)(x) of the Social Security Act.

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 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.[17] 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, and the Governor signed, budget language to execute this recommendation. To implement this mandate, DMAS has contracted with its actuary to identify clinical efficiencies under its managed care programs. The first set of clinical efficiency analyses focus on medically unnecessary or potentially preventable spending for hospital admissions, hospital readmissions, and ED visits, as well as efficient utilization oversight and management of prescription drug dispensing and reimbursements. Beginning in state fiscal year (SFY) 2020, DMAS uses these analyses to adjust capitation rates under the Medallion 4.0 and CCC Plus programs.

Value-Based Payments

DMAS recognizes that the VBP program is of strategic importance to the Quality Strategy, which is why this program is one of the key interventions outlined in that section. DMAS describes VBPs as a broad set of payment strategies intended to improve healthcare quality, outcomes, and efficiency by linking financial 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 (HCPLAN) with a special emphasis on models in categories three and four.[18] Beginning in 2021, DMAS anticipates establishing targets in the MCOs' contracts for the total portion of medical spending governed under a VBP arrangement, as well as targets for adoption of more advanced VBP in future years, with the targets expected to increase annually. 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
- Reduced all-cause hospital readmissions
- Reduced hospital admissions for chronic disease complications

Performance Incentive Award (PIA) Program for Medallion 4.0 and FAMIS

From SFY 2016 through SFY 2018, DMAS implemented a PIA program for the Medallion 4.0 MCOs to assess managed care quality. MCO performance was evaluated using benchmarks and thresholds for various HEDIS measures and measures developed by Virginia that compared the relative level of performance against the performance of the other Virginia Medicaid MCOs. The PIA program was designed to be budget neutral (i.e., the total MCO awards were equal to the total MCO penalties). Beginning in SFY 2020, DMAS transitioned to a PWP to evaluate the quality of care received by Medicaid managed care members.

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[17] Virginia Joint Legislative Audit & Review Commission. Managing Spending in Virginia's Medicaid Program. Available at: http://jlarc.virginia.gov/medicaid-2016.asp. Accessed on: March 23, 2020.
[18] 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: March 17, 2020.

Performance Withhold Program for Medallion 4.0 and CCC Plus Programs

DMAS established the PWP for the Medallion 4.0 and CCC Plus MCOs to reinforce VBP principles by connecting financial incentives to the quality of care received by Virginia Medicaid managed care 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 per member per month [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.

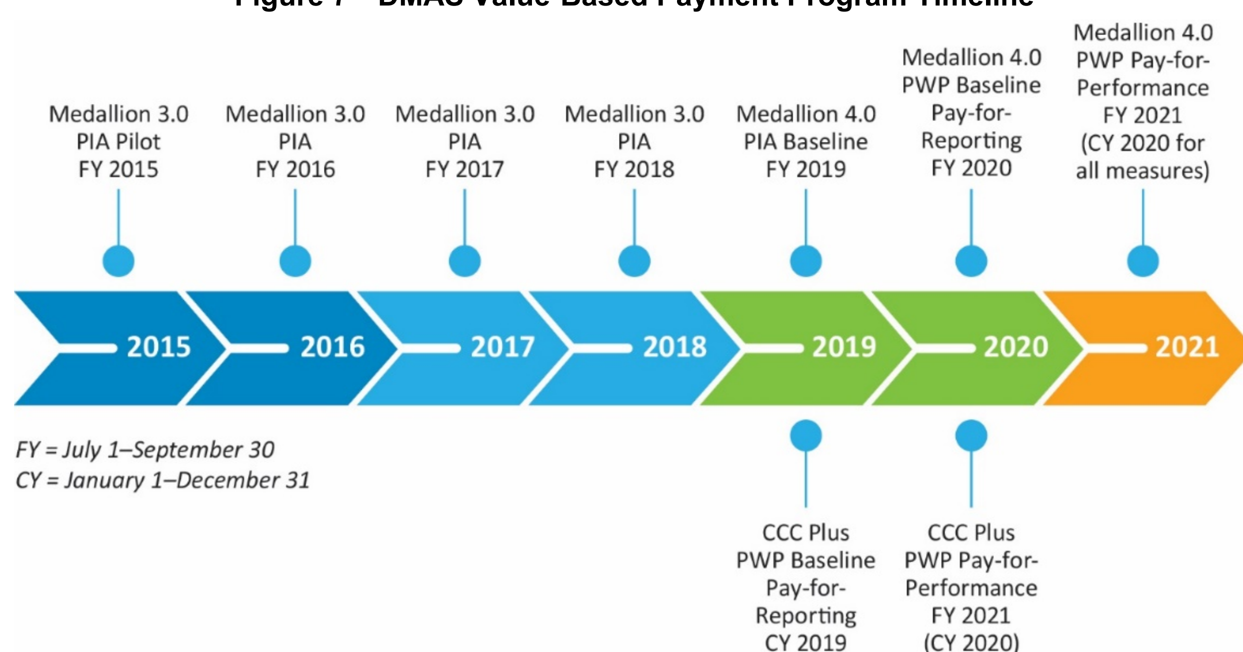
DMAS chose process and outcome performance measures that align with the goals of the respective managed care programs (i.e., Medallion 4.0 and CCC Plus) and the characteristics of the populations. PWP performance is evaluated on measures from the following organizations:

- NCQA's HEDIS
- CMS' Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)
- AHRQ's Pediatric Quality Indicators (PDIs)

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

The PWP was developed to allow a pay-for-reporting and baseline period in order for the MCOs to assess current performance levels. For the Medallion 4.0 MCOs, the PWP pay-for-reporting and baseline period is SFY 2020 and transitions to pay-for-performance in SFY 2021. For the CCC Plus MCOs, the PWP pay-for-reporting and baseline period was CY 2019 and transitioned to pay-for-performance in CY 2020. The timeline for the DMAS VBP programs is provided in Figure 7.

Figure 7—DMAS Value-Based Payment Program Timeline



VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION • QUALITY • VALUE

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

42 CFR §438.340

To comply with the regulatory requirement for state procedures for race, ethnicity, and primary language spoken (CFR §438.206–§438.210), 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 limited English proficiency (LEP) and those with diverse cultural and ethnic backgrounds. DMAS continually monitors how age, sex, race, ethnicity, 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, 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 includes FC/AA programs, children zero to three years of age receiving early intervention services, and children and adolescents with significant behavioral health needs.

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 Services

All eligible Medicaid and CHIP children may receive school-based services through the DMAS FFS program. School districts may serve as the medical provider by signing an inter-local agreement with DMAS, which makes payments directly to the school districts for services provided.

Eligibility

- Students must be eligible for Medicaid on the date of service
- Students must be 3 to 20 years of age
- Students must be eligible for IDEA special education, with treatment services written in the Individual Education Plan (IEP)
- All treatment services must relate to a medical diagnosis and be medically necessary

All services billed to Medicaid must be included in the current IEP. The IEP 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 §438.340; §438.350; §438.356; §438.358

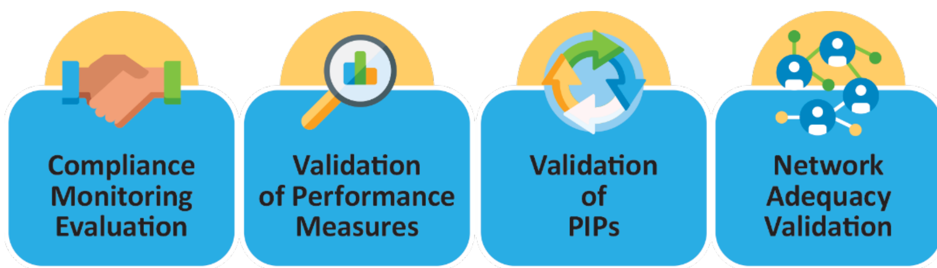
In accordance with 42 CFR §438.356, DMAS contracts with HSAG as its EQRO to conduct the mandatory and optional EQR activities as set forth in 42 CFR §438.358. HSAG has been DMAS' EQRO since 2014. HSAG's EQRO contract is for three years with consecutive one-year renewal options. The conducting of EQR 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. DMAS contracts with a CMS quality improvement organization (QIO), which is also a CMS Network of Quality Improvement and Innovation Contractor (NQIIC), to serve as the EQRO for Virginia. 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)(ii), DMAS requires MCOs to submit performance measurement data as part of their quality assessment and performance improvement (QAPI) programs. To comply with 42 CFR §438.358(b)(1)(ii), 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)(i), 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 rapid-cycle PIPs required by the State to comply with the requirements of 42 CFR §438.330(d). DMAS' EQRO validation determines if PIPs were designed to achieve improvement in clinical and nonclinical care, and if the PIPs would have a favorable effect on health outcomes and enrollee satisfaction.
- **Network adequacy validation.** In accordance with 42 CFR §438.358(b)(1)(iv), DMAS will be using 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.

Optional EQR Activities

42 CFR §438.358

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

- Development of consumer decision support tool
- Development of PWP
- Prenatal care and birth outcomes focused study
- Foster care focused study
- Performance measure incentive validation
- Quality measure set validation
- Calculation of incentive measures
- Calculation of performance measure incentive awards
- FAMIS CAHPS survey
- Quality strategy update
- Dental utilization in pregnant women data brief (focused study)
- Performance measure specification development
- Calculation of performance measures in addition to those reported by MCOs, at the direction of DMAS or as required for completion of the technical and/or disparity report
- Completion of studies on quality that focus on an aspect of clinical or nonclinical services at a point in time (e.g., specific assessment of the interventions described within this Quality Strategy), at the direction of DMAS
- Access to care, secret shopper surveys

EQR Technical Report

42 CFR §438.364

The Balanced Budget Act, Public Law 105-33, (aka CMS Managed Care Rule), last updated in 2016, 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 reports, which present all mandatory and optional EQR activities performed.

The EQR technical reports include 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

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:

http://www.dmas.virginia.gov/#/med4reports

CCC Plus:

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

Non-Duplication of Mandatory Activities—Methodology for Determining Comparability

42 CFR §438.350 and §438.360

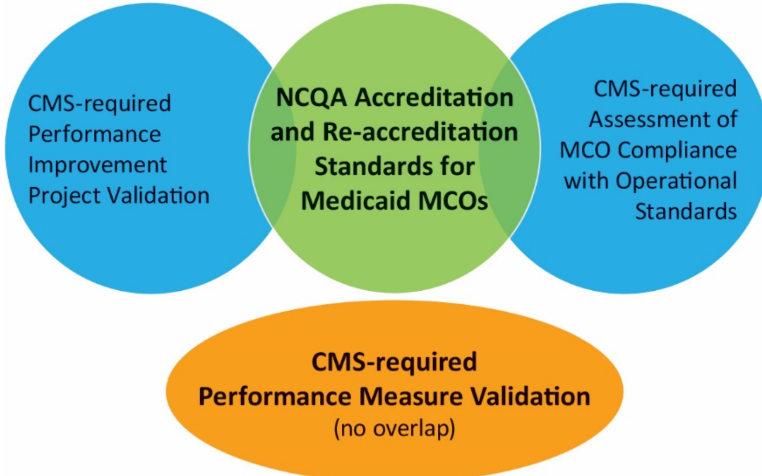
The CMS Managed Care Rule addresses the non-duplication of mandatory activities with Medicare or accreditation reviews. The CMS Managed Care Rule allows states to use information obtained from a Medicare or national accreditation review for the mandatory EQR activities when the state requires the MCOs 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.

Figure 8 depicts a snapshot of federally required EQR activities and the potential for duplication for each with NCQA accreditation standards.

When these overlaps are clear, 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 is supported in 42 CFR §438.360 (non-duplication of mandatory activities). CMS does not allow deeming of the performance measure validation activity.

Figure 8—CMS-Mandated EQR Activities Partially Overlap With NCQA Accreditation



Crosswalk of CMS EQR Standards and NCQA Accreditation Standards

42 CFR §430.360

NCQA annually publishes an updated crosswalk between the CMS quality standards and NCQA accreditation standards. While CMS does not formally endorse the crosswalk, CMS participates in the review process before the crosswalk is published. Therefore, DMAS views the crosswalk as a guide, not a determination of deeming.

DMAS and the EQRO conducted an in-depth review of the crosswalk in 2017 and used it as a guide for ascertaining which standards could be deemed as being "met" during the comprehensive reviews required by federal regulations. If there was any ambiguity in the crosswalk or any standards that, in the opinion of the EQRO and DMAS, should not be deemed, the standards in question were included in the comprehensive review. The commonality between those elements deemed as "not met" and needing to be reviewed by the EQRO are those that the CFR requires (and NCQA does not), and those for which the CFR enables states to define the policies and criteria.

Using NCQA Accreditation Results

42 CFR §438.360

The standards of the private accrediting agency, NCQA, were used for this deeming evaluation because DMAS requires the Medicaid MCOs in the Commonwealth of Virginia to be accredited by NCQA. HSAG used accreditation standards that were applicable to the federal standards and excluded standards and elements pertaining to an MCO's operations such as case management, disease management, and call center operations.

The 2016 NCQA Medicaid Managed Care Crosswalk and CFR were used as resources by HSAG to determine comparability. HSAG assessed whether each accreditation standard met the relevant regulation in the CFR in its entirety or if parts of the standard met the CFR. If an accreditation standard met only part of a CFR, HSAG determined the percentage of the CFR the standard met.

HSAG provided DMAS a summary table of NCQA standards that HSAG determined to be 100 percent comparable to the CFR requirements, a table view of HSAG's designation of the CFR requirements compared to NCQA standards, NCQA crosswalk tables detailing the results of HSAG's deeming evaluation, and comparative deeming findings of the SFY 2014 and SFY 2017 deeming reviews. HSAG used the CFR requirements as the authoritative source of requirements against which accreditation standards and Medicare regulations/standards were compared.

HSAG most recently reviewed the CFR requirements and NCQA's crosswalk under DMAS' direction in 2017. HSAG used the CFR requirements that were in place prior to May 2016 and, for informational purposes, HSAG also referenced those CFR requirements that changed significantly due to the May 2016 revisions (e.g., changed citations, are no longer included in one of the referenced subparts).

Findings

As demonstrated in Table 9, HSAG compared the CFR requirements eligible for deeming with NCQA standards to determine if any of the current standards produced 100 percent comparability with the CFR requirements in SFY 2017.

Table 9—Comparison of the CFR Requirements to NCQA Standards

CFR Requirement Area	Number of CFR Requirements Eligible for Deeming	Number of NCQA Standards 100% Comparable with CFR Requirements
42 CFR PART 438—Managed Care Subpart D—MCO Standards Subpart E—Quality Measurement and Improvement		
Availability of Services	11	7
Assurances of Adequate Capacity and Services	5	1
Coordination and Continuity of Care	10	0
Coverage and Authorization of Services	7	3
Provider Selection	6	1
Confidentiality	1	1
Grievance System	0	0
Subcontractual Relationships and Delegation	5	4
Practice Guidelines	4	1
Health Information Systems	2	0
Quality Assessment and Performance Improvement Program	7	2
Totals	58	20

The NCQA comparison worksheet contained designations for deeming of 42 CFR §438.114 Coverage and Authorization of Services for emergency and post-stabilization treatment. These regulations include requirements for coverage and authorization of services; however, CMS does not consider 42 CFR §438.114 as one of the CFR requirements that can be considered for

deeming. HSAG did not find any standards in 42 CFR §438.114 that yielded a 100 percent match with the CFR requirements.

Rationale for Determining Comparability to EQR Activities

DMAS determined that all standards found to be 100 percent comparable with the CMS Managed Care Rule were eligible for deeming for purposes of the 2017 comprehensive operational and systems review of the DMAS MCOs, with the following caveats:

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

State Standards for Access, Structure, and Operations

State Monitoring and Evaluation of MCO Requirements

42 CFR §438.340

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

42 CFR §438.330

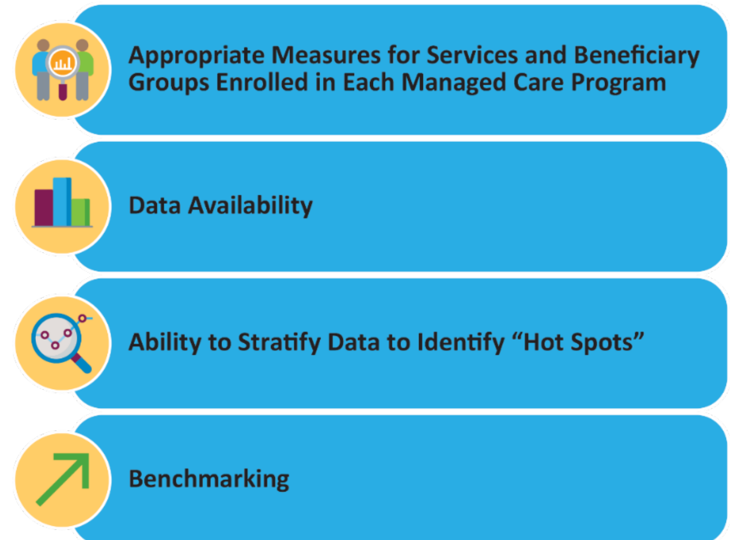
DMAS selected standard performance measures that MCOs are required to measure and report to DMAS. Consistent with DMAS' desire to benchmark its progress against other states' performance and assess key priorities to drive CQI efforts, nearly all of these measures are nationally recognized and include 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®.[19]

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 programs cover diverse populations—such as non-disabled children, pregnant women, disabled adults, and seniors—and the access metrics address each of these groups.

Performance measure selection is dependent on:



[19] Quality Compass® is a registered trademark of NCQA.

Standards for Access to Care

42 CFR §438.206–42 CFR §438.210

DMAS contracts with a qualified 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 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 CMS Managed Care 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.

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 is of strategic importance to the Quality Strategy, which is why these services are one of the key interventions outlined in that section. DMAS defines vulnerable populations served in the Medicaid programs as, but not limited to, individuals enrolled in a PACE, developmental disability 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

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 CCC Plus managed care model. Under the CCC Plus program, the MCOs are asked to stratify members to coordinate care and measure quality for different groups of persons with special needs such as the nursing facility population; waiver population; Early and Periodic, Screening, Diagnostic and Treatment (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. 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 monitors the network to determine compliance, takes corrective action when there is a failure to comply, and demonstrates 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. CCC Plus 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 CCC Plus 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 CMS Managed Care Rule. DMAS requires the MCOs to implement the following standards for structure and operations:

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

Provider Selection and Credentialing

42 CFR §438.68, 42 CFR 4§38.214; 42 CFR §440.170(a) and 12 Virginia Administrative Code (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 non-emergency transportation services to and from providers of covered medical, behavioral health, dental, LTSS, and rehabilitative medical services and supports needed.

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 MCO 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 10.

Table 10—Network Adequacy Standards

MCO Network Adequacy Standards	Medallion 4.0	CCC Plus
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	✓	✓

MCO Network Adequacy Standards	Medallion 4.0	CCC Plus
Availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions	✓	✓

Exceptions 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

DMAS encourages MCOs to implement the use of telehealth including electronic information and telecommunications to support remote and long-distance healthcare services. Telehealth is different from telemedicine in that it refers to the broader scope of remote healthcare services that include nonclinical services such as provider training, administrative public health sessions, and continuing medical education. 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

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

Enrollee Information

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 that materials are provided at an appropriate reading level.

Confidentiality

42 CFR §438.208(b)(4) and 42 CFR §438.224

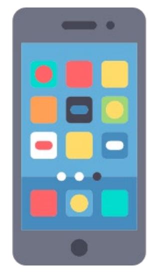
MCO contracts require that the MCO ensures that network providers and subcontractors comply with HIPAA and its implementing regulations, the Health Information Technology for Economic and Clinical Health Act of 2009 and its implementing regulations (collectively, “HITECH”), and all applicable federal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

Medallion 4.0 Medicaid Enrollment Application



Virginia Medallion 4.0 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 or Virginia Medallion 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. Non-members 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 Medallion 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, 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 no 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

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 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 §438.230; 42 CFR §438.236; 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 CMS Managed Care 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 child care 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:

- Laboratory Services: blood lead testing, hemoglobin (HGB), hematocrit (HCT), or free erythrocyte protoporphyrin (FEP) (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); Machine vision test (maximum of one covered).
- 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.
- The Contractor shall allow for an annual flu vaccine without limitations to age and without the requirement of meeting the CDC at-risk guidelines.
- 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.
- 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.

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 obstetric and gynecologic (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

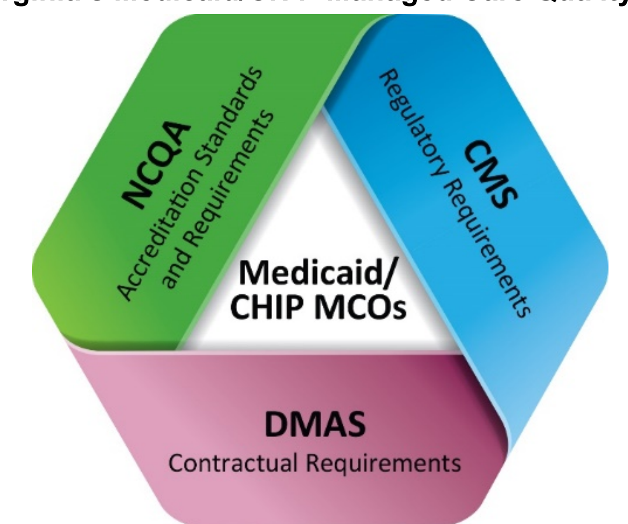
42 CFR §438.330

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.

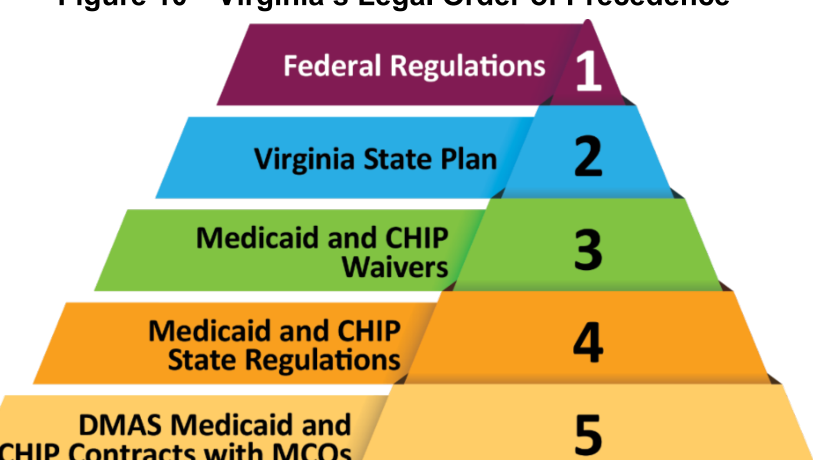
The requirements and standards serve as the basis for the Quality Strategy and are depicted in the framework in Figure 9.

Figure 9—Virginia's Medicaid/CHIP Managed Care Quality Framework



DMAS contracts with each MCO provide for the legal order of precedence, as shown in Figure 10:

Figure 10—Virginia's Legal Order of Precedence



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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 CCC Plus and Medallion 4.0 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 populations (e.g., CCC Plus versus Medallion 4.0), 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 achieve 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.

In 2014, DMAS' EQRO worked with CMS to develop a rapid-cycle PIP approach and, in 2016, this PIP approach was initiated with DMAS and the MCOs. Rapid-cycle PIPs place emphasis on improving healthcare processes and outcomes through the integration of QI science. The approach guides MCOs to use rapid-cycle improvement methods and continually test changes on a small scale rather than implementing one large transformation. Performing small tests of change should require fewer resources and allows more flexibility to make adjustments during the improvement process. By piloting on a smaller scale, MCOs can determine the effectiveness of changes prior to expanding interventions that are deemed successful.

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 linked to the QI strategies and activities conducted during the PIP. The EQRO's validation of PIPs includes the following key components:

- Evaluation of the technical structure to determine whether a PIP's initiation (i.e., topic rationale, PIP team, aims, key driver diagram, and data collection methodology) is based on sound methods and could reliably measure outcomes. Successful execution of this component helps ensure that reported PIP results are accurate and capable of measuring improvement.
- Evaluation of the QI activities conducted. Once designed, a PIP's effectiveness in improving outcomes depends on thoughtful and relevant intervention determination and intervention testing using Plan-Do-Study-Act (PDSA) cycles.
- Evaluation of whether the aim was achieved, that interventions tested for the PIP could be linked to the improvement, and the MCO's plan for sustaining and spreading the improvement.

During rapid-cycle PIPs, the EQRO continually assesses and validates the ongoing approaches used by the MCOs. 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.

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 information technology 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 information technology (IT) infrastructure and data analytics capabilities. DMAS' modernized technology system, the Medicaid Enterprise System (MES), will replace the current MMIS. The new system will completely overhaul the existing system's framework and allow for increased data collection, analytic, oversight, and reporting functions for DMAS. The MES includes the Enterprise Data Warehouse System (EDWS), a component that will significantly enhance 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

The following table lists the required and recommended elements for State Quality Strategies, per 42 CFR §438.340(b) and corresponding sections in the Virginia Quality Strategy which address each required and recommended element.

Section I: Introduction

Table 11—Introduction

Regulatory Reference	Description	Page Reference
Optional	Include a brief history of the state's Medicaid and CHIP managed care programs.	Page 12
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.?	Page 12
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.	Page 16
Optional	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".	Page 8 Appendix D
§438.340	Include a description of the formal process used to develop the quality strategy.	Page 24

Regulatory Reference	Description	Page Reference
§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.	Page 26
§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.	Page 26
§438.340(c)(2)(i)	Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually).	Page 52
§438.340(b)(11) and (c)(3)(ii)	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".	Page 25

Section II: Assessment

Table 12—Assessment

Regulatory Reference	Description	Page Reference
§438.330(3)(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.	Page 72
§438.330(e)(b)(4)	Include the state's definition of SHCN.	Page 64
§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.	Page 41 Page 64
Optional	Document any efforts or initiatives that the state or MCO/PIHP has engaged in to reduce disparities in health care.	Page 41

Table 13—National Performance Measures

Regulatory Reference	Description	Page Reference
§438.330(c)(1)(i)	Include a description of any required national performance measures and levels identified and developed by CMS in consultation with states and other stakeholders.	Page 54 Page 51
Optional	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.	Page 54 Appendix D

Table 14—Monitoring and Compliance

Regulatory 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). 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.	Page 53 and 85

Table 15—External Quality Review (EQR)

Regulatory Reference	Description	Page Reference
§438.350(a)	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.	Page 65
Optional	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.	Page 67
§438.350(c)	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 C.F.R. §438.204(g).	Page 68
438.360(a)(2)	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).	N/A

Section III: State Standards

Table 16—State Standards

Regulatory Reference	Description	Page Reference
§438.206	**Availability of Services**	
§438.206(b)(1)	Maintains and monitors a network of appropriate providers	Page 77
§438.206(b)(2)	Female members have direct access to a women's health specialist	Page 75
§438.206(b)(3)	Provides for a second opinion from a qualified health care professional	Page 75
§438.206(b)(4)	Adequately and timely coverage of services not available in network	Page 73
§438.206(b)(5)	Out-of-network providers coordinate with the MCO or PIHP with respect to payment	Page 73
§438.206(b)(6)	Credential all providers as required by §438.214	Page 77
§438.206(c)(1)(i)	Providers meet state standards for timely access to care and services	Page 78
§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	Page 73
§438.206(c)(1)(iii)	Services included in the contract available 24 hours a day, 7 days a week	Pages 35 and 73
§438.206(c)(1)(iv)-(vi)	Mechanisms to ensure compliance by providers	Page 77
§438.206(c)(2)	Culturally competent services to all members	Page 78
§ 438.207	**Assurances of Adequate Capacity and Services**	
§438.207(a)	Assurances and documentation of capacity to serve expected enrollment	Page 74
§438.207(b)(1)	Offer an appropriate range of preventive, primary care, and specialty services	Page 77
§438.207(b)(2)	Maintain network sufficient in number, mix, and geographic distribution	Page 77
§ 438.208	**Coordination and Continuity of Care**	
§438.208(b)(1)	Each member has an ongoing source of primary care appropriate to his or her needs	Page 75
§438.208(b)(2)	All services that the member receives are coordinated with the services the member receives from any other MCO/PIHP	Page 75

Regulatory Reference	Description	Page Reference
§438.208(b)(4)	Share with other MCOs, PIHPs, and PAHPs serving the member with SHCN the results of its identification and assessment to prevent duplication of services	Page 64
§438.208(b)(6)	Protect member privacy when coordinating care	Page 80
§438.208(c)(1)	State mechanisms to identify persons with SHCN	Page 64
§438.208(c)(2)	Mechanisms to assess members with SHCN by appropriate health care professionals	Page 64
§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	Page 64
§438.208(c)(4)	Direct access to specialists for members with SHCN	Page 64
§ 438.210	**Coverage and Authorization of Services**	
§438.210(a)(1)	Identify, define, and specify the amount, duration, and scope of each service	Page 76
§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	Page 35
§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	Page 76
§438.210(a)(3)(ii)	No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition	Page 76
§438.210(a)(4)(i)	Each MCO/PIHP may place appropriate limits on a service, such as medical necessity	Page 76
§438.210(C)(5)	Specify what constitutes “medically necessary services”	Page 76
§438.210(D)(b)(1)	Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services	Page 76
§438.210(D)(b)(2)(i)	Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions	Page 76
§438.210(D)(b)(d)	Any decision to deny or reduce services is made by an appropriate health care professional	Page 76
§438.210(D)(b)(d)	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	Page 76

Regulatory Reference	Description	Page Reference
§438.210(d)	Provide for the authorization decisions and notices as set forth in §438.210(d)	Page 76
§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	Page 76

Table 17—Structure and Operations Standards

Regulatory Reference	Description	Page Reference
§438.214	**Provider Selection**	
§438.214(a)	Written policies and procedures for selection and retention of providers	Page 77
§438.214(b)(1)	Uniform credentialing and recredentialing policy that each MCO/PIHP must follow	Page 77
§438.214(b)(2)	Documented processes for credentialing and recredentialing that each MCO/PIHP must follow	Page 77
§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	Page 77
§438.214(d)	MCOs/PIHPs may not employ or contract with providers excluded from Federal health care programs	Page 77
§438.214(e)	Comply with any additional requirements established by the state	N/A
§438.10	**Member Information**	
§438.10	Incorporate member information requirements of §438.10	Page 80
§438.224	**Confidentiality**	
§438.224	Individually identifiable health information is disclosed in accordance with Federal privacy requirements	Page 80

Regulatory Reference	Description	Page Reference
§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	Page 80
§438.228	**Grievance Systems**	
§438.228(a)	Grievance systems meet the requirements of Part 438, subpart F	Page 81
§438.228(b)	If applicable, random state reviews of notice of action delegation to ensure notification of members in a timely manner	Page 81
§438.230	**Subcontractual Relationships and Delegation**	
§438.230(b)(1)	Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities	Page 82
§438.230(b)(1)	Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform	Page 82
§438.230(c)(1)(i)	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.	Page 82
§438.230(c)(1)(iii)	Monitoring of subcontractor performance on an ongoing basis	Page 82
§438.230(c)(1)(iii)	Corrective action for identified deficiencies or areas for improvement	Page 82

Table 18—Measurement and Improvement Standards

Regulatory Reference	Description	Page Reference
§ 438.236	**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.	Page 83
§438.236(c)	Dissemination of practice guidelines to all providers, and upon request, to members	Page 83

Regulatory Reference	Description	Page Reference
§ 438.330	**Quality Assessment and Performance Improvement Program**	
§438.330(a)(3)	Each MCO and PIHP must have an ongoing quality assessment and performance improvement program	Page 84
§438.330(b)(1)	Each MCO and PIHP must conduct PIPs List out PIPs in the quality strategy	Page 85 Appendix C
§438.330(b)(2)	Each MCO and PIHP must submit performance measurement data as specified by the state	Page 85
	List out performance measures in the quality strategy	Appendix B
§438.330(b)(3)	Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services	Pages 29 and 74
§438.330(b)(4)	Each MCO and PIHP must have mechanisms to assess the quality and appropriateness of care furnished to members with SHCN	Page 53
§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.	Page 29
§ 438.242	**Health Information Systems**	
§438.242(a)	Each MCO and PIHP must maintain a health information system that can collect, analyze, integrate, and report data	Page 87
§438.242(b)(2)	Each MCO and PIHP must collect data on member and provider characteristics and on services furnished to members	Page 87
§438.242(b)(2)	Each MCO and PIHP must ensure data received is accurate and complete	Page 87

Section IV: Improvement and Interventions

Table 19—Improvement and Interventions

Regulatory 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; 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.	1. Pages 10, 12, 30, 31, 37, 43, 44, 49, 50, and 51 2. Page 34 3. Page 68 4. Page N/A 5. Page 20 6. Page N/A 7. Pages 35 and 75
Optional	Describe how the state's planned interventions tie to each specific goal and objective of the quality strategy.	Appendix D

Table 20—Intermediate Sanctions

Regulatory Reference	Description	Page Reference
§438.340(b)(7)	For MCOs, detail how the state will appropriately use intermediate sanctions that meet the requirements of 42 C.F.R. Part 438, subpart I.	Page 59
Optional	Specify the state's methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems.	Page 59

Table 21—Health Information Technology

Regulatory Reference	Description	Page Reference
§438.340	Detail how the state's information system supports initial and ongoing operation and review of the state's quality strategy.	Page 87
Optional	Include any health information technology (HIT) initiatives that will support the objectives of the state's quality strategy.	Page 87

Section V: Delivery System Reforms

Table 22—Delivery System Reforms

Regulatory Reference	Description	Page Reference
Optional	Describe the reasons for incorporating this population/service into managed care. Include a definition of this population and methods of identifying members in this population.	12
Optional	List any performance measures applicable to this population/service, as well as the reasons for collecting these performance measures.	Appendix D
Optional	List any performance improvement projects that are tailored to this population/service. This should include a description of the interventions associated with the performance improvement projects.	Appendix C
Optional	Address any assurances required in the state's Special Terms and Conditions (STCs), if applicable.	N/A

Section VI: Conclusions and Opportunities

Table 23—Conclusions and Opportunities

Regulatory Reference	Description	Page Reference
Optional	Identify any successes that the state considers to be best or promising practices.	Pages 15, 31, and 37

Regulatory Reference	Description	Page Reference
Optional	Include a discussion of the ongoing challenges the state faces in improving the quality of care for beneficiaries.	N/A
Optional	Include a discussion of challenges or opportunities with data collection systems, such as registries, claims or enrollment reporting systems, pay-for-performance tracking or profiling systems, electronic health record (EHR) information exchange, regional health information technology collaborative, telemedicine initiatives, grants that support state HIT/EHR development or enhancement, etc.	N/A
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.	Appendix E

Appendix B. Performance Measure Metrics

Table 24—Performance Measure Metrics

Measure Name	*Data Source*	Measure Steward *(if applicable)*
AIM 1: Enhanced Member Care Experience		
Goal 1.1 Increase Member Engagement and Outreach		
Number of Outreach and Engagement (O&E) Activities Per Year	MCO Reporting	DMAS
Monitor Language and Disability Access Reports	MCO Reporting	DMAS
Monitor Member Language Counts	DMAS	DMAS
Goal 1.2 Improve Member Satisfaction		
Getting Care Quickly *Q6: Respondent Got Non-Urgent Appointment as Soon as Needed*	CAHPS	AHRQ
Enrollees' Ratings *Q8—Rating of all Health Care*	CAHPS	AHRQ
Timely Processing of Member Applications, Renewals, and Appeals	Eligibility and Enrollment Data	DMAS
Goal 1.3 Improve Home and Community-Based Services		
Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and Appropriate to Their Needs and Personal Goals	Waiver Member Record	DMAS
Number and Percent of Individuals Who Received Services in the Scope Specified in the Service Plan	Waiver Member Record	DMAS
AIM 2: Effective Patient Care		
Goal 2.1 Enhance Provider Support		
Enrollees' Ratings *Q16—Rating of Personal Doctor*	CAHPS	AHRQ
How Well Doctors Communicate *Q12—Doctor Explained Things in a Way That Was Easy to Understand*	CAHPS	AHRQ
Timeliness of Claims Processing	MCO Reporting	DMAS
Goal 2.2 Ensure Access to Care		
Monitor network adequacy by region and provider types	MCO Reporting	DMAS
Frequency and reasons for missed trips	MCO Reporting	DMAS
Getting Needed Care *Q18—Respondent Got Appointment With Specialists as Soon as Needed*	CAHPS	AHRQ
Goal 2.3 Reduce Patient Harm		
Frequency of Reported Critical Incidents by Number Classification	MCO Reporting	DMAS
Prevalence of Pressure Ulcers Among LTSS Members	MCO Reporting	DMAS
AIM 3: Smarter Spending		
Goal 3.1 Focus on Paying for Value		
Frequency of Potentially Preventable Admissions	DMAS Actuary	DMAS

Measure Name	*Data Source*	Measure Steward *(if applicable)*
Frequency of Emergency Department Visits	DMAS Actuary	DMAS
Frequency of Potentially Preventable Readmissions	DMAS Actuary	DMAS
Ambulatory Care: Emergency Department (ED) Visits	Claims	NCQA
Goal 3.2 Focus on Efficient Use of Program Funds		
Number of Administrative and Medical Deferrals and Disallowances	DMAS	DMAS
Percentage of Budget Carry Forward	DMAS	DMAS
Monitor Medical Loss Ratio (MLR) Annually by Managed Care Program and Aggregate Total	MCO Reporting	DMAS
AIM 4: Improved Population Health		
Goal 4.1 Improve Behavioral Health and Developmental Services of Members		
Follow-Up After Hospitalization for Mental Illness	Claims and Encounters	NCQA
Follow-Up After Emergency Department Visit for Mental Illness	Claims and Encounters	NCQA
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	Claims and Encounters	NCQA
Monitor Mental Health Utilization	Claims and Encounters	NCQA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Claims and Encounters	NCQA
Goal 4.2 Improve Outcomes for Members with Substance Use Disorders		
Monitor Identification of Alcohol and Other Drug Services	Claims and Encounters	NCQA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Claims and Encounters	NCQA
Use of Opioids at High Dosage in Persons Without Cancer	Claims and Encounters	Pharmacy Quality Alliance (PQA)
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Claims and Encounters	NCQA
Goal 4.3 Improve Utilization of Wellness, Screening, and Prevention Services for Members		
Percentage of Eligibles Who Received Preventive Dental Services	Claims and Encounters	CMS
Adults' Access to Preventive/Ambulatory Health Services	Claims and Encounters	NCQA
Adolescent Well-Care Visits	Claims and Encounters/ Medical Record Review	NCQA
Goal 4.4 Improve Health for Members with Chronic Conditions		
Heart Failure Admission Rate	Claims and Encounters	AHRQ
Asthma Admission Rate (Ages 2–17)	Claims and Encounters	AHRQ
COPD and Asthma in Older Adults' Admission Rate	Claims and Encounters	AHRQ
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Claims and Encounters/ Medical Record Review	NCQA
Controlling High Blood Pressure	Claims and Encounters/ Medical Record Review	NCQA
Goal 4.5 Improve Outcomes for Nursing Home Eligible Members		
Use of High-Risk Medications in Older Adults (Elderly)	Claims and Encounters	NCQA
Nursing Facility Residents Hospitalization Rate	MCO Reporting	DMAS

Measure Name	***Data Source***	**Measure Steward *(if applicable)***
CCC Plus Waiver Members Who Re-Entered the Community After a Short-Term Nursing Facility Stay	DMAS	DMAS
Members Who Transitioned from a Nursing Facility to the Community Who Returned to the Nursing Facility within 90 Days	DMAS	DMAS
Goal 4.6 Improve Outcomes for Maternal and Infant Members		
Prenatal and Postpartum Care: Postpartum Care	Claims and Encounters/ Medical Record Review	NCQA
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Claims and Encounters/ Medical Record Review	NCQA
Childhood Immunization Status	Claims and Encounters/ Medical Record Review	NCQA
Live Births Weighing Less than 2,500 Grams	Vital Statistics	CDC
Well-Child Visits in the First 15 Months of Life	Claims and Encounters/ Medical Record Review	NCQA

Appendix C. Performance Improvement Topics

Table 25—Performance Improvement Projects 2020

CCC Plus					
MCO	**PIP Topic**	**SMART Aim**	**SMART Aim Measure**	**Proposed Interventions**	**Intervention Effectiveness Measures**
Aetna Better Health of Virginia	Ambulatory Care—Emergency Department Visits	By 12/31/2020, decrease the percentage of African-American members in the Central VA region (zip code 23223) who had one ambulatory visit and two or more emergency department (ED visits from 47.3% to 43.7%.	African-American members in the Central VA region (zip code 23223) who had one outpatient visit and two or more ED visits.	• Improve Transportation • Outreach Members (Telephonic) • Educate Members	• African-American members in the Central VA region (zip code 23223) utilized transportation for a same day/next day primary care provider (PCP) appointment and attended the appointment. • African-American members in the Central VA region (zip code 23223) had one ambulatory visit and two or more ED visits and scheduled an appointment with a PCP after telephonic outreach. • African-American members in the Central VA region (zip code 23223) had one ambulatory visit and two or more ED visits and engaged in at least one additional ambulatory visit and no ED visits after the intervention.
	Follow-Up After Discharge	By 12/31/2020, increase the percentage of members aged 45–64 years in the Central VA region who had a post-hospitalization follow-up visit with a PCP or specialist within 30 days of discharge from 29.4% to 36.98%.	Members aged 45–64 years in the Central VA region who had an outpatient follow-up appointment with a PCP or specialist within 30 days of hospital discharge.	• Improve Transportation • Mail Educational Letter • Update to Outbound Calls	• Members aged 45–64 years in the Central VA region utilized transportation for 30-day post-hospitalization follow-up appointments with a PCP or specialist and attended the appointment. • Discharged members aged 45–64 years in the Central VA region who were unable to reach (UTR) for telephonic outreach, received an educational UTR letter, and attended a post-hospitalization follow-up appointment with a PCP or specialist within 30 days. • Discharged members aged 45–64 years in the Central VA region received

CCC Plus					
MCO	**PIP Topic**	**SMART Aim**	**SMART Aim Measure**	**Proposed Interventions**	**Intervention Effectiveness Measures**
					outbound case manager telephonic outreach and answered the call.
HealthKeepers, Inc.	Ambulatory Care—Emergency Department Visits	By 12/31/2020, decrease the percentage of members who have an ED visit among the Riverside Regional Medical Center—Brentwood population from 21.77% to 16.24%.	Members on the panel for Riverside Regional Medical Center specific to physicians at the Brentwood location who had at least one ED visit.	"Call us First" Campaign	Members with high ED utilization paneled to Riverside Regional Medical Center—Brentwood who had a PCP visit.
	Follow-Up After Discharge	By 12/31/2020, increase the percentage of members among the Riverside Regional Medical Center—Brentwood practice who have a follow-up visit within 30 days of discharge from 62.82% to 75%.	Members on the Riverside Regional Medical Center—Brentwood panel who had an ambulatory follow-up visit within 30 days of discharge to assess the member's health.	Engage Members—Improve Frequency of "Patient Insights"	Ambulatory follow-up visits within 30 days of discharge for members on the Riverside Regional Medical Center—Brentwood panel.
Magellan Complete Care of Virginia	Ambulatory Care—Emergency Department Visits	By 12/31/2020, reduce the percentage of members assigned to Dr. Diggs, Dr. Patel, and Dr. Bhowmik as a PCP who have >5 ED visits in 90 days from 14.1% to 9.1%.	Members with the highest amount of ED visits (>5 ED in 90 days) seen by Dr. Diggs, Dr. Patel, and Dr. Bhowmik.	Improve Accuracy of Member Contact Information (Monthly Claims Review)	Accurate contact information obtained for members seen by Dr. Diggs, Dr. Patel, and Dr. Bhowmik using a monthly claims check.
	Follow-Up After Discharge	By 12/31/2020, increase the percentage of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days in the Central region from 43.69% to 50.0%.	Inpatient discharges in the Central region with an ambulatory follow-up service within 30 days.	Outreach Members (Telephonic)	Discharged members in the Central region received a call from care coordination and were compliant with the 30-day follow-up visit with a PCP.
Optima Health Community Care	Ambulatory Care—	By 12/31/2020, decrease the rate of ED visits among	ED visits for a respiratory complaint by adult	• Call Members Post-discharge	Decreased utilization of the ED for a respiratory complaint by adult Tidewater

CCC Plus					
MCO	**PIP Topic**	**SMART Aim**	**SMART Aim Measure**	**Proposed Interventions**	**Intervention Effectiveness Measures**
	Emergency Department Visits	adult Tidewater regional members with chronic obstructive pulmonary disease (COPD), asthma, bronchitis, or emphysema from 1.90 to 1.71.	Tidewater regional members with a respiratory diagnosis (COPD, asthma, bronchitis, or emphysema).	• Use Care Coordinator Script	regional members with a respiratory diagnosis (COPD, asthma, bronchitis, or emphysema) after scripted post-discharge telephone call.
	Follow-Up After Discharge	By 12/31/2020, increase 30-day ambulatory follow-up visits with a practitioner among members who reside in the Tidewater region and have a hospital discharge from 68.57% to 75.43%.	Discharges of Tidewater regional members that had an ambulatory follow-up visit within 30 days to assess the member's health.	• Call Members Post-discharge • Use Care Coordinator Script	Tidewater regional members discharged from a non-Sentara facility and completed a follow-up appointment within 30 days after the scripted post-discharge telephone call.
UnitedHealthcare Community Plan of Virginia	Ambulatory Care—Emergency Department Visits	By 12/31/2020, decrease non-emergent ED visits among the Elderly or Disabled with Consumer Direction (EDCD) waiver population from 198.20 to 188.29 per 1,000 members.	Non-emergent ED visits for EDCD waiver members.	• Provide Educational Flyer • Follow-Up Visit Post-ED	• EDCD waiver members received a flyer and did not go to the ED for a non-emergent diagnosis. • EDCD waiver members received a follow-up call and did not return to the ED for a non-emergent visit within the next 90 days.
	Follow-Up After Discharge	By 12/31/2020, increase the percentage of members in the Tidewater and Roanoke regions that have a follow-up visit within 30 days of discharge from 54.13% to 58.23%.	Follow-up after Discharge (CCC Plus Technical Manual Appendix A 2.13) for members in the Tidewater and Roanoke regions.	• Oversight of Vendor Post-Hospital Assessments (PHA) • Implement Discharge Follow-up Process	• Completed PHAs by vendor health coaches for members in the Tidewater and Roanoke regions. • Members in the Tidewater and Roanoke regions with a completed PHA attended a follow-up visit within 30 days of discharge.
Virginia Premier	Ambulatory Care—Emergency Department Visits	By 12/31/2020, decrease the rate of ED visits among members 20–44 years old from 127.04 to 112.68.	ED visits for members 20–44 years old.	Partner with Collective Medical—Ensure Accurate and Timely Member ED Notification	• ED notifications for members 20–44 years old received from Collective Medical. • ED notifications for members 20–44 years old with follow-up care coordination.

CCC Plus					
MCO	**PIP Topic**	**SMART Aim**	**SMART Aim Measure**	**Proposed Interventions**	**Intervention Effectiveness Measures**
	Follow-Up After Discharge	By 12/31/2020, increase follow-up visits within 30 days of discharge for hospitalized members ages 18–64 years from 70% to 75%.	Discharges for members ages 18–64 years that had an ambulatory follow-up visit within 30 days to assess the member's health.	Partner with Collective Medical—Ensure Accurate and Timely Member Admission and Discharge Notification	• Admission notifications for members ages 18–64 years received from Collective Medical. • Admission notifications for members ages 18–64 years with follow-up care coordination.

Medallion 4.0					
MCO	**PIP Topic**	**SMART Aim**	**SMART Aim Measure**	**Proposed Interventions**	**Intervention Effectiveness Measures**
Aetna Better Health of Virginia	Timeliness of Prenatal Care	By 12/31/2020, increase prenatal care visits among members ages 18–29 years in the Central VA region from 14.2% to 21.28%.	Deliveries for women ages 18–29 years in the Central VA region that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization.	• Improve Transportation • Outreach Members (Telephonic) • Pregnancy Support Flyer	• Members ages 18–29 years in the Central VA region identified as having attended addiction treatment and attended a 1st trimester OB/GYN appointment after the intervention. • Members ages 18–29 years in the Central VA region scheduled transportation for a prenatal visit and attended the visit.
	Tobacco Use Cessation in Pregnant Women	By 12/31/2020, decrease the percentage of identified smokers among pregnant members in the Central VA region from 3.1% to 0.4%.	Pregnant members in the Central VA region who were identified as a smoker during a prenatal visit.	• Outreach Members (Telephonic) • Member Newsletter • Provider Flyer with Billable Smoking Cessation Claim Codes	• Pregnant members in the Central VA region identified as smokers who either fill a prescription for pharmaceutical smoking cessation medication or report engagement in a nonpharmaceutical treatment/support program. • Telephonic outreach recipients in the Central VA region who either self-report that they quit smoking or are identified as non-smokers in post-outreach OB/GYN visit claims. • Providers who submit claim codes CPT 99406 or 99407 when providing smoking cessation counseling to members in the Central VA region.

Medallion 4.0					
MCO	**PIP Topic**	**SMART Aim**	**SMART Aim Measure**	**Proposed Interventions**	**Intervention Effectiveness Measures**
HealthKeepers, Inc.	Timeliness of Prenatal Care	By 12/31/2020, increase the percentage of members assigned to Dominion Women's Health who received timely prenatal care during the first trimester, on or before the enrollment start date, or within 42 days of enrollment from 68.94% to 75%.	A prenatal visit during the first trimester, on or before the enrollment start date, or within 42 days of enrollment for deliveries with a Dominion Women's Health provider.	Personalized Case Management and Provider Collaboration	Attended prenatal care visits from the provider list for deliveries with a Dominion Women's Health provider.
	Tobacco Use Cessation in Pregnant Women	By 12/31/2020, increase the percentage of members who were identified as pregnant tobacco users, screened for tobacco use, and received tobacco cessation interventions from 10.5% to 30%.	Pregnant members identified as tobacco users, who were screened for tobacco use and received tobacco cessation intervention counseling, pharmacotherapy, or both.	Personalized Case Management and Provider Collaboration	Members successfully contacted by case management regarding tobacco cessation and correctly coded in claims for receiving a tobacco cessation intervention.
Magellan Complete Care of Virginia	Timeliness of Prenatal Care	By 12/31/2020, increase the percentage of members seen by the top five selected providers receiving a prenatal visit within their first trimester, on the enrollment date, or within 42 days of enrollment from 31.5% to 81%.	Members seen by the top five providers meeting the PPC criteria, who had a prenatal visit as defined by the NCQA 2019 HEDIS® PPC Technical Specifications.	Prenatal Care Incentive Program	Members seen by the top five providers who agreed to participate in the Prenatal Incentive Program and had one or more prenatal visits in the first trimester.
	Tobacco Use Cessation in Pregnant Women	By 12/31/2020, increase the percentage of pregnant women identified as smokers or tobacco users who receive smoking cessation treatments, including medication and/or counseling from 94% to 99%.	Pregnant women who received tobacco cessation treatments (medication or education/counseling) while pregnant.	Tobacco Use Cessation Incentive Program	Pregnant women enrolled in the Tobacco Cessation Incentive Program.

Medallion 4.0					
MCO	**PIP Topic**	**SMART Aim**	**SMART Aim Measure**	**Proposed Interventions**	**Intervention Effectiveness Measures**
Optima Health Plan	Timeliness of Prenatal Care	By 12/31/2020, increase timely prenatal visits among pregnant members in Norfolk from 43.49% to 53.49%.	Member deliveries in Norfolk that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the health plan.	Pregnancy Care Incentive Program	Members in Norfolk participated in the pregnancy incentive program and received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the health plan.
	Tobacco Use Cessation in Pregnant Women	By 12/31/2020, decrease tobacco use among pregnant members in Norfolk from 28% to 20%.	Claims with the maternal smoking code for Optima-insured pregnant women in Norfolk.	• Identify Pregnant Tobacco Users via a Survey • Educate Providers on Maternal Smoking Codes	• Pregnant smokers in Norfolk identified based on the survey. • Members in Norfolk with a maternal pregnancy smoking code(s) from providers who received education.
UnitedHealthcare Community Plan of Virginia	Timeliness of Prenatal Care	By 12/31/2020, increase the percentage of women in the Northern & Winchester regions who receive a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date, or within 42 days of enrollment from 43.96% to 68.96%.	Women with live birth deliveries in the Northern and Winchester regions who received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date, or within 42 days of enrollment.	• Streamline Maternity Incentive Program • Develop a Robust Provider Submission Process and Provide Education on the Obstetrical Risk Assessment Form (OBRAF)	• Members in the Northern and Winchester regions enrolled in the maternity incentive program and received a reward for the first prenatal visit. • OBRAFs received from providers for members in the Northern and Winchester regions.
	Tobacco Use Cessation in Pregnant Women	By 12/31/2020, increase the percentage of pregnant women (identified as tobacco users) who receive advice to quit smoking, discussed, or were provided cessation methods/ strategies from 19.85% to 24.85%.	Pregnant members with tobacco use who received smoking cessation services during their pregnancy (nicotine replacement therapy or counseling services).	• Develop a Robust Process to Capture Smoking Cessation Information using the OBRAF • Integrate Pharmacy Data into Case Management Workflow	• OBRAFs received indicating a woman reported using tobacco during pregnancy and had 1) been advised of tobacco cessation resources by being referred, 2) received counseling on strategies by enrolling in a program, or 3) already completed a tobacco cessation program. • Pregnant members identified through the pharmacy report who subsequently

Medallion 4.0					
MCO	**PIP Topic**	**SMART Aim**	**SMART Aim Measure**	**Proposed Interventions**	**Intervention Effectiveness Measures**
					received smoking cessation counseling services from case management.
VA Premier	Timeliness of Prenatal Care	By 12/31/2020, increase timeliness of prenatal care in the Roanoke region from 55% to 65%.	Live births that member in the Roanoke region received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.	Educate Members and Providers	Increased participation in the Healthy Heart Beat (HHB) program in the Roanoke region.
	Tobacco Use Cessation in Pregnant Women	By 12/31/2020, decrease the percentage of pregnant members in the Roanoke region who did not receive counselling, medications, or advice on smoking cessation from 93% to 88%.	Pregnant members in the Roanoke region who smoke and have not received a smoking cessation intervention.	Increase Marketing for HHB and Quit Now (QN) Programs	Increased participation in the HHB and QN programs in the Roanoke region.

Appendix D. Goals Tracking Table

Table 26—Goals Tracking Table

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
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	*	CAHPS benchmarks	✔	
		Increase Member Satisfaction	**Metric 1.2.2:** Enrollees' Ratings	CMS Adult Core Set: CPA-AD	*	CAHPS benchmarks	✔	
		Increase Member Satisfaction with Care	**Metric 1.2.3:** Rating of All Health Care	CMS Adult Core Set: CPA-AD	*	CAHPS benchmarks	✔	
	Goal 1.3: 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%	✔	
		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%	✔	
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	*	CAHPS benchmarks	✔	
		Improve Health Communication	**Metric 2.1.2:** How Well Doctors Communicate	CMS Adult Core Set: CPA-AD	*	CAHPS benchmarks	✔	

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
	Goal 2.2: Ensure Access to Care							
		Increase Access to Care	**Metric 2.2.3:** Getting Needed Care	CMS Adult Core Set: CPA-AD	*	CAHPS benchmarks	✔	
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/PWP Performance Target	✔	✔
		Decrease Emergency Department Visits	**Metric 3.1.2:** Frequency of Emergency Department Visits	VBP Reporting Team	^	VBP/PWP Performance Target	✔	✔
		Decrease Potentially Preventable Readmissions	**Metric 3.1.3:** Frequency of Potentially Preventable Readmissions	VBP Reporting Team	^	VBP/PWP Performance Target	✔	✔
		Decrease Emergency Department Visits	**Metric 3.1.4:** Ambulatory Care: Emergency (ED) Visits	NCQA HEDIS	*	NCQA Quality Compass 50th and 75th percentile	✔	✔
	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 CMS Final Managed Care Rule	✔	✔
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	*	NCQA Quality Compass 50th and 75th percentile	✔	
		Increase Follow-Up Visits After Emergency	**Metric 4.1.2:** Follow-Up After Emergency	CMS Adult Core Set: FUM-AD	*	VBP/PWP Performance Target	✔	

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
		Department Visit for Mental Illness	Department Visit for Mental Illness					
		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	*	NCQA Quality Compass 50th and 75th percentile	✔	✔
		Increase Mental Health Utilization	**Metric 4.1.4:** Monitor Mental Health Utilization	NCQA HEDIS MPT	*	NCQA Quality Compass 50th and 75th percentile	✔	
		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	*	NCQA Quality Compass 50th and 75th percentile	✔	✔
	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	✔	
		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	*	VBP/PWP Performance Target	✔	
		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	✔	
		Increase Initiation and Engagement of Alcohol and Other Drug Abuse or	**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	✔	

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
		Dependence Treatment						
	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	✔	✔
		Increase Adults' Access to Preventive/Ambulatory Health Services	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services	NCQA HEDIS AAP	*	NCQA Quality Compass 50th and 75th percentile	✔	
		Increase Child and Adolescent Well-Care Visits	**Metric 4.3.4:** Child and Adolescent Well-Care Visits	CMS Child Core Set AWC-CH	New Measure***	VBP/PWP Performance Target**	✔	✔
	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**	✔	
		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**		
		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**	✔	
		Decrease Diabetes Poor Control	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	CMS Adult Core Set HPC-AD	*	VBP/PWP Performance Target**	✔	
		Increase Control of High Blood Pressure	**Metric 4.4.5:** Controlling High Blood Pressure	CMS Adult Core Set CBP-AD	*	NCQA Quality Compass 50th and 75th percentile	✔	

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
	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	✔	
	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	*	VBP/PWP Performance Target**	✔	✔
		Increase Timeliness of Prenatal Care	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care	CMS Child Core Set PPC-CH	*	VBP/PWP Performance Target**	✔	✔
		Increase Childhood Immunization Status	**Metric 4.6.3:** Childhood Immunization Status	CMS Child Core Set CIS-CH	*	VBP/PWP Performance Target**	✔	✔
		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	✔	✔
		Increase Well-Child Visits	**Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life	CMS Child Core Set W30-CH	New Measure***	NCQA Quality Compass 50th and 75th percentile	✔	✔

**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

Aspirational Goals

Table 27—Aspirational Goals Tracking Table

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Increase Member Engagement and Outreach	Improve Member Communication	**Metric 1.1.1:** Number of Outreach and Engagement (O&E) Activities Per Year	MCO Outreach Dashboard	Measure under development by DMAS	Measure under development by DMAS	✔	
		Provide Linguistically and Culturally Appropriate Care	**Metric 1.1.2:** Monitor Language and Disability Access Reports	Quarterly and/or Annual MCO Reports to DMAS	Measure under development by DMAS	Measure under development by DMAS	✔	✔
		Provide Linguistically and Culturally Appropriate Care	**Metric 1.1.3:** Monitor Member Language Counts	Quarterly and/or Annual MCO Reports to DMAS	Measure under development by DMAS	Measure under development by DMAS	✔	✔
	Goal 1.2: Improve Member Satisfaction	Increase Timely Access to Care	**Metric 1.2.4:** Timely Processing of Member Applications, Renewals, and Appeals	Eligibility and Enrollment Dashboard	Measure under development by DMAS	Measure under development by DMAS	✔	✔
Aim 2: Effective Patient Care	**Goal 2.1:** Enhance Provider Support	Maintain Provider Engagement	**Metric 2.1.3:** Timeliness of Claims Processing (30, 90 days) and Paid vs. Denied	Reports from MCO to DMAS	Measure under development by DMAS	Measure under development by DMAS	✔	✔
	Goal 2.2: Ensure Access to Care	Ensure Provider Network Adequacy	**Metric 2.2.1:** Monitor network adequacy by region and provider types	Report from MCOs to DMAS	Measure under development by DMAS	Measure under development by DMAS	✔	✔

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
		Increase Access to Necessary Transportation	**Metric 2.2.2:** Monitor frequency and reasons for missed trips	Report from MCOs to DMAS	Measure under development by DMAS	Measure under development by DMAS	✔	
	Goal 2.3: Reduce Patient Harm	Reduce Critical Incidents by Member Classification	**Metric 2.3.1:** Monitor the Frequency of Reported Critical Incidents by Member Classification	Report from MCOs to DMAS	Measure under development by DMAS	Measure under development by DMAS	✔	✔
		Decrease Prevalence of Pressure Ulcers Among LTSS Members	**Metric 2.3.2:** Prevalence of Pressure Ulcers Among LTSS Members	Report from MCOs to DMAS	Measure under development by DMAS	Measure under development by DMAS	✔	
Aim 3: Smarter Spending	**Goal 3.2:** Focus on Efficient Use of Program Funds	Ensure High-Value Appropriate Care	**Metric 3.2.1:** Number of Administrative and Medical Deferrals and Disallowances	Finance Team Reporting	Measure under development by DMAS	Measure under development by DMAS	✔	✔
		Ensure High-Value Appropriate Care	**Metric 3.2.2:** Percentage of Budget Carry Forward	Finance Team Reporting	Measure under development by DMAS	Measure under development by DMAS	✔	✔
Aim 4: Improved Population Health	**Goal 4.5:** Improve Outcomes for Nursing Home Eligible Members	Decrease Nursing Facility Residents Hospitalization Rate	**Metric 4.5.2:** Nursing Facility Residents Hospitalization Rate	Report from MCOs to DMAS	Measure under development by DMAS	Measure under development by DMAS	✔	
		Improve LTSS Members' Quality of Life	**Metric 4.5.3:** CCC Plus Waiver Members Who	Report from MCOs to DMAS	Measure under development by DMAS	Measure under development by DMAS	✔	

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
			Re-Enter the Community After a Short-Term Nursing Facility Stay					
		Improve LTSS Members' Quality of Life	**Metric 4.5.4:** Members Who Transitioned From a Nursing Facility to the Community Who Returned to the Nursing Facility Within 90 Days	Report from MCOs to DMAS	Measure under development by DMAS	Measure under development by 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. QI work conducted by the Commonwealth and the MCOs is included in each Annual Technical Report.

The following table includes the EQRO's findings, recommendations, and DMAS' intended follow-up actions on the recommendations.

Table 28—Medallion 4.0 EQRO Quality Strategy Recommendations

EQRO Findings	EQRO Recommendations	DMAS' Intended Action
Performance Measures		
Four of the five MCOs were below the 50th percentile for the measures within the Children's Preventive Care domain, indicating opportunities for improvement related to well-child/well-care visits and immunizations.	HSAG recommended that the MCOs implement QI initiatives aimed at identifying the barriers for children receiving well-care visits and immunizations. HSAG recommended that the MCOs identify best practices that have been successful in achieving sustained improvement in preventive health rates.	To focus MCOs on improving performance measure rates in the Children's Preventive Health domain, DMAS includes the following HEDIS measures in the Medallion 4.0 PWP to focus the MCOs' attention on improving rates and outcomes: • *Adolescent Well-Care Visits* • *Childhood Immunization Status—Combination 3* In its contract with the MCOs, DMAS requires the MCOs to consider the Children's Preventive Care domain measures as a priority. DMAS requires the MCO to assure annual improvement in the HEDIS measure until performing at least at the 50th percentile for "HMOs" as reported by NCQA's Quality Compass. The MCOs are also to establish goals to attain the 75th percentile. 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.

EQRO Findings	EQRO Recommendations	DMAS' Intended Action
The *Breast Cancer Screening* measure, in the Women's Health domain, demonstrated opportunities for improvement for all MCOs, as none of the MCOs exceeded the 50th percentile.	HSAG recommended that DMAS work with the MCOs to focus interventions—such as assistance with scheduling, transportation to appointments, and the completion of reminder calls—on removing barriers to completing the breast cancer screening appointment the day prior to the scheduled appointment.	In its contract with the MCOs, DMAS requires the MCOs to consider the *Breast Cancer Screening* measure as a priority. DMAS requires the MCO to assure annual improvement in the HEDIS measure until performing at least at the 50th percentile for "HMOs" as reported by NCQA's Quality Compass. The MCOs are also to establish goals to attain the 75th percentile.
Only one MCO exceeded the 50th percentile for the *Prenatal and Postpartum Care* measure rates, demonstrating opportunities for the MCOs to ensure women receive care during and after their pregnancies.	HSAG recommended that DMAS work with the MCOs to focus interventions—such as assistance with scheduling, transportation to appointments, and the completion of reminder calls—on removing barriers to prenatal and postpartum care visits the day prior to the scheduled appointment.	To focus MCOs on improving performance measure rates in the Women's Health domain, DMAS includes the following HEDIS measures in the Medallion 4.0 PWP to focus the MCOs' attention on improving rates and outcomes: • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* • *Prenatal and Postpartum Care—Postpartum Care* In its contract with the MCOs, DMAS requires the MCOs to consider the Prenatal and Postpartum Care measures as a priority. DMAS requires the MCO to assure annual improvement in the HEDIS measure until performing at least at the 50th percentile for "HMOs" as reported by NCQA's Quality Compass. The MCOs are also to establish goals to attain the 75th percentile. 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.
The Care for Chronic Conditions domain represented an area of opportunity for improvement for all of the MCOs, as none of the MCOs exceeded the 50th percentile for more than four of the 10 measure rates that	HSAG recommended that the MCOs identify the barriers members experience in receiving care for chronic conditions, such as comprehensive diabetes care. HSAG recommended that the MCOs identify best	To focus MCOs on improving measures in the Care for Chronic Conditions domain, DMAS includes the following HEDIS measures in the Medallion 4.0 PWP to focus the MCOs' attention on improving rates and outcomes:

EQRO Findings	EQRO Recommendations	DMAS' Intended Action
could be compared to benchmarks. MCO performance was particularly low for the *Comprehensive Diabetes Care* measure, with only one MCO exceeding the 50th percentile for the *HbA1c Testing* rate, while no other rates for any of the MCOs within the *Comprehensive Diabetes Care* measure exceeded the 50th percentile.	practices that have demonstrated success in improving the management of chronic conditions. HSAG recommended that the MCOs consider assigning members to a medical home with a provider who has expertise in a chronic condition and has demonstrated successful outcomes for members with the chronic condition. Other interventions for consideration may include increased use of telehealth options for monitoring and managing chronic disease and monitoring appointment standards.	• *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* • *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* • *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* • *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* • *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* In its contract with the MCOs, DMAS requires the MCOs to consider the Care for Chronic Conditions measures as a priority. DMAS requires the MCO to assure annual improvement in the HEDIS measure until performing at least at the 50th percentile for "HMOs" as reported by NCQA's Quality Compass. The MCOs are also to establish goals to attain the 75th percentile. 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.
The MCOs demonstrated opportunities for improvement for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*, with only one MCO exceeding the 50th percentile in the Behavioral Health domain.	HSAG recommended that the MCOs consider administrative or other processes to ensure children receive follow-up care when prescribed medications such as those for ADHD. HSAG recommended that the MCOs consider implementing a reminder for pharmacists and PCPs to connect with members to encourage families to schedule and complete a follow-up visit prior to the next refill of the prescription.	In its contract with the MCOs, DMAS requires the MCOs to consider the *Breast Cancer Screening* measure as a priority. DMAS requires the MCO to assure annual improvement in the HEDIS measure until performing at least at the 50th percentile for "HMOs" as reported by NCQA's Quality Compass. The MCOs are also to establish goals to attain the 75th percentile. DMAS makes the EQRO Annual Technical Report available to MCOs. Annually MCOs are required to

EQRO Findings	EQRO Recommendations	DMAS' Intended Action
		submit information on actions taken to address the recommendations contained in the EQRO Annual Technical Report.
Performance Improvement Projects		
Overall, the results of the MCOs' submission of PIP Module 1 and Module 2 indicated opportunities for improvement.	HSAG recommended that the MCOs ensure an understanding of the PIP rapid-cycle process, participate in trainings provided by the EQRO, and request technical assistance as often as needed to improve the success of the PIP process. HSAG also recommended the MCOs thoroughly review and address the initial validation findings prior to resubmitting the PIP modules.	DMAS requires the MCOs to participate in annual PIP training conducted by the EQRO during a Quality Collaborative meeting. During the training MCOs are encouraged to request technical assistance as often as needed to improve the success of the PIP process. 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.
	HSAG recommended that MCO leadership continue to be actively involved and demonstrate a commitment to QI throughout the organization. HSAG recommended that MCOs regularly review their data to identify opportunities for improvement early, and implement interventions, using the small tests of change process that is used for PIPs.	DMAS requires the MCOs' leadership teams to actively participate in QI activities, including DMAS quality meetings. DMAS includes in its MCO contract regular data review and reporting.
Member Experience of Care Survey		
One MCO scored statistically significantly lower in 2019 than in 2018 on one measure, *Getting Care Quickly*. Two MCOs scored statistically significantly lower than the 2018 NCQA adult and child Medicaid national average on one measure, *Customer Service*. Also, one MCO scored statistically significantly lower than the 2018 NCQA adult Medicaid national averages on the *Rating of Health Plan* and *Rating of All Health Care* measures.	HSAG recommended that the Medallion 4.0 MCOs focus QI efforts on measure scores that exhibited a decrease from 2018 to 2019 and were statistically significantly lower than the NCQA national averages. HSAG recommended that the MCOs monitor the measures to ensure there were no significant decreases in rates over time.	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.

EQRO Findings	EQRO Recommendations	DMAS' Intended Action
	HSAG recommended that the MCO efforts also focus on improving survey response rates. HSAG recommended that the MCOs also review their grievances, complaints, and other indicators to better understand the drivers of the lower score for the *Rating of Health Plan* measure.	
	HSAG recommended that MCOs include the members' perspectives whenever possible to gain a clear understanding of members' perceptions of care and service delivery and the challenges members encounter in receiving the MCOs' healthcare services.	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.
Focused Studies		
The VA SFC program provides pregnant women with a critically important opportunity to receive dental services provided by the DMAS dental vendor, DentaQuest; however, relatively few eligible women received prenatal and/or postpartum dental services.	HSAG recommended that the MCOs coordinate with the dental vendor to focus interventions on assisting women in successfully completing prenatal and postpartum dental visits. HSAG recommended that the MCOs consider interventions—such as assisting members with scheduling and transportation to appointments and reminder calls the day before a scheduled appointment—designed to remove barriers that may prevent members from keeping their appointments.	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. DMAS included the following HEDIS measures in the Medallion 4.0 PWP to focus the MCOs' attention on improving rates and outcomes: • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* • *Prenatal and Postpartum Care—Postpartum Care*

Table 29—CCC Plus EQRO Quality Strategy Recommendations

EQRO Findings	EQRO Recommendations	Commonwealth's Intended Action
Performance Measures		
The Virginia MCOs' aggregate rates fell below the 10th percentile for three measures: *Cervical Cancer Screening*, and *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*.	HSAG recommended that DMAS focus MCOs on improving results for percentiles for three measures: *Cervical Cancer Screening*, and *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*.	To focus MCOs on improving performance measure rates in the Care for Chronic Conditions domains, DMAS included the following HEDIS measures in the CCC Plus PWP to focus the MCOs' attention on improving rates and outcomes: • *Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)—Total* DMAS' implementation of PWPs provides an opportunity for overall improvement in HEDIS rates, which are indicators of access to and quality and timeliness of care and service delivery. 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.
The Virginia aggregate rates for HEDIS 2019 indicated opportunities for improvement, as 20 of 35 (57.1 percent) measure rates fell below the 50th percentile, with 11 of these rates (31.4 percent) falling below the 25th percentile.	HSAG recommended that DMAS focus MCOs on improving results for HEDIS aggregate rates that fell below the 50th percentile.	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. DMAS' implementation of PWPs provides an opportunity for overall improvement in HEDIS rates, which are indicators of access to and quality and timeliness of care and service delivery.
Performance Improvement Projects		
The MCOs' initial submission of PIP Module 1 and Module 2 indicated opportunities for	HSAG recommended that MCOs thoroughly review and address the initial PIP validation	DMAS requires the MCOs to participate in annual PIP training conducted by the EQRO during a Quality

EQRO Findings	EQRO Recommendations	Commonwealth's Intended Action
improvement. HSAG recommends that DMAS require that the MCOs participate in trainings provided by the EQRO.	findings prior to resubmitting the PIP modules and that DMAS require the MCOs to request and actively participate in technical assistance provided by the EQRO as often as needed to improve the success of the PIP process. HSAG recommended that MCO leadership be actively involved and demonstrate a commitment to QI throughout the organization. HSAG recommended that the MCOs regularly review their data to identify opportunities for improvement early and implement interventions, using the small tests of change process that is used for PIPs.	Collaborative meeting. During the training MCOs are encouraged to request technical assistance as often as needed to improve the success of the PIP process. 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.
Member Experience of Care Survey		
MCOs should focus on child members' experiences with their health plan as three MCOs scored statistically significantly lower than the 2018 NCQA child Medicaid national average for *Rating of Health Plan*. In addition, both *Rating of All Health Care* and *Customer Service* received statistically significantly lower scores than the 2018 NCQA child Medicaid national averages for one MCO.	HSAG recommended that the MCOs focus QI efforts on measure scores that were statistically significantly lower than the 2018 NCQA Medicaid national averages and continue to monitor the measures to ensure there are no significant decreases in rates over time. HSAG recommended that MCOs include the members' perspectives whenever possible to gain a clear understanding of members' perceptions of care and service delivery and the challenges members encounter in receiving the MCOs' healthcare services.	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.

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

2017–2019 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 2019.

Quality Strategy Goals and Objectives

As stated in the 2017–2019 Virginia Quality Strategy, DMAS' mission was to provide a system of high-quality and cost-effective healthcare services to qualifying Virginians and their families that far exceeded the industry standards for timeliness, access, and quality of care. DMAS' vision was to develop an outcomes-based quality program that focused on the member's health and encouraged innovation in healthcare services and programs. DMAS' values included:

- Customer Service—Operate with a high degree of customer service.
- Responses—Demonstrate integrity, responsiveness, and competency in agency actions and communications.
- Collaboration—Foster an atmosphere of effective collaboration with customers and stakeholders.
- Innovation and Accountability—Encourage agency innovation and require accountability.
- Results—Strive to ensure the provision of high-quality, efficient, patient-centered care.

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

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

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

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 33 details the progress made on the quality goals and objectives for the Virginia Medicaid managed care program.

Quality Strategy Evaluation

Measure Alignment

DMAS worked to align 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.

Table 30 includes Quality Strategy metrics outlined in the MCO's Medallion 4.0 contract:

Table 30—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: Hemoglobin A1C testing and control, retinal eye exam, 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)

Measure Name	*Measure Name*
**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)
**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	*^CAHPS Survey
^*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*

**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 31 includes Quality Strategy metrics outlined in the MCO's CCC Plus contract:

Table 31—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)
**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*

Measure Name	Measure Name
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 2017–2019 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 addiction and recovery treatment services. 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.

During the initial Quality Strategy time frame, DMAS received a CMS demonstration waiver to integrate care and services for its LTSS program that began in August of 2017. The CCC Plus program began as a new statewide Medicaid MLTSS program that served individuals with complex care needs, through an integrated delivery model, across the full continuum of care. DMAS integrated certain special needs populations into the CCC Plus program, including HAP and ABD populations previously served in the Medallion 3.0 program. The CCC Plus MCOs were contractually required to report HEDIS performance measures beginning in 2019 for measurement year 2018.

In 2017, DMAS also received CMS approval of a 1115 waiver demonstration that began in 2018, to provide a comprehensive addiction and recovery treatment services program that provided SUD, OUD, and alcohol use disorder (AUD) treatment and services. The Governor's Access Plan (GAP) was also included in the demonstration. The demonstration extended access to certain behavioral and physical health services to uninsured low-income adults with diagnosis of SMI. The goal of the GAP component of the demonstration was to use a targeted benefit package to prevent people with SMI diagnoses from becoming fully and permanently disabled. The ARTS component of the demonstration, which contributed to a comprehensive statewide strategy to combat prescription drug abuse and OUDs, expand the SUD benefits package to cover the full continuum of SUD treatment, including short-term residential and inpatient services to all Medicaid-eligible members. The demonstration was amended to address the substance use crisis impacting the GAP population by expanding coverage and adding services for GAP enrollees. The demonstration amendment also expanded Medicaid coverage to former foster care youth who aged out of foster care under the responsibility of another state and were applying for Medicaid in the Commonwealth of Virginia.

On June 7, 2018, Virginia's Governor, Governor Northam, signed the State budget, which included expanded eligibility under Medicaid for approximately 400,000 Virginia adults. 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 provides care coordination services for individuals with more pronounced medical needs and serves as the delivery system that provides coverage for expansion members who are deemed to be "medically complex." Medallion 4.0 serves as the delivery system for expansion members who are determined not medically complex. Medically complex individuals include individuals with a complex medical or behavioral health condition and a functional impairment, or an intellectual or developmental disability. 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.

Table 32 shows the number of performance measure rates reported, the number of reported rates that improved, the number of rates that stayed the same, and the number of rates that declined. The final row addresses the number of Quality Strategy performance metrics that were not reported due to programmatic changes.

Table 32—Quality Strategy Performance Metrics Results

Measure Name	Results
Number of performance indicators	65
Number of performance indicators that improved	11
Number of performance indicators that stayed the same	1
Number of performance indicators that declined	22
Number of performance indicators not reported due to it not being a covered benefit	1

The DMAS 2017–2019 Quality Strategy included performance metrics that were aspirational and in the development stage. The 2020–2022 Quality Strategy separates the performance metrics into two tables. One table includes performance metrics that will be reported, and the second table includes DMAS' aspirational performance metrics that are being developed by DMAS.

Table 33 provides data for performance measures included in the DMAS 2017–2019 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 33—Virginia Medicaid Progress on Goals and Objectives

Aim: Build a Wellness Focused, Integrated System of Care			
Goal	**Measure**	**2016 Baseline Rate**	**2019 Aggregate Rate**
Strengthen access to primary care network	HEDIS: *Adults' Access to Primary Care (Prevention/Ambulatory Health Services*)	86.48%	83.70%
	HEDIS: *Children and Adolescents' Access to Primary Care*	12–24 Months: 97.70% 25 Months–6 Years: 92.25% 7–11 Years: 94.30%	12–24 Months: 95.51% 25 Months–6 Years: 89.94% 7–11 Years: 92.59% 90.78%

Aim: Build a Wellness Focused, Integrated System of Care			
		90.78% 12–19 Years: 91.16%	12–19 Years: 90.78%
Decrease inappropriate utilization and total cost of care	*All-cause PQI Admission Rate*	NR	NR
	CMS/National Quality Form (NQF) #1768: *Plan All-Cause Readmissions*	NR	NR
	HEDIS: *Ambulatory Care—Emergency Department Visits*	64.19%	69.28%
	Per Capita Healthcare Expenditures (future measure)	NR	NR
Emphasize member experience of care	CAHPS/HEDIS/NQF #0006: *Member Rating of Health Plan*	78.37%	76.57%
Integration of behavioral, oral, and physical health	CMS/HEDIS/NQF #0004: *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* (two rates)	Initiation Total: ND Engagement Total: ND	Initiation Total: 43.73% Engagement Total: 13.25%
	CMS/NQF #1664: *SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge*	NR	NR
	HEDIS/NQF #0576: *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*	38.95%	30.29%
	CMS/NQF #2605: *Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence*	NR	The measure was updated to separate mental illness and alcohol and other drugs (AOD) between 2016 and 2019
	CMS: *Transition of Members Between SUD LOCs, hospitals, NF, and the Community*	NR	NR
Encourage appropriate management of prescription medications	*Use of High-Risk Medications in the Elderly*	NR	NR
	NCQA: *Use of Multiple Concurrent Antipsychotics in Children and Adolescents*	2.66%	2.53%

Aim: Build a Wellness Focused, Integrated System of Care			
	HEDIS: *Follow-up Care for Children Prescribed ADHD Medication—Initiation and Continuation/Maintenance Phases*	Initiation Phase: 43.97% Continuation and Maintenance Phase: 55.89%	Initiation Phase: 46.25% Continuation and Maintenance Phase: 61.44%
	HEDIS: *Antidepressant Medication Management—Effective Acute Phase Treatment, Effective Continuation Phase Treatment*	Effective Acute Phase Treatment: 53.70% Effective Continuation Phase: 38.52%	Effective Acute Phase Treatment: 53.40% Effective Continuation Phase: 37.51%
	PQA: *Use of Opioids at High Dosage in Persons Without Cancer*	NR	NR
	PQA: *Use of Opioids from Multiple Providers in Persons Without Cancer*	NR	NR
	PQA: *Use of Opioids at High Dosage and From Multiple Providers in Persons Without Cancer*	NR	NR

Aim: Focus on Screening and Prevention			
Goal	**Examples of Measures**	**2016 Baseline Rate**	**2019 Aggregate Rate**
Cancers are prevented or diagnosed at the earliest stage possible	HEDIS/NQF #2372: *Breast Cancer Screening*	52.11%	51.43%
	NQF #0034: *Colorectal Cancer Screening*	NR	NR
	HEDIS/NQF #0032: *Cervical Cancer Screening*	65.44%	56.36%
Prevention of nicotine dependency	AMA-PCPI/NQF #0027: *Tobacco Use—Screening and Cessation*	NR	Discussing Cessation Medications: 48.65% Discussing Cessation Strategies: 42.89%
Virginians protected against vaccine-preventable diseases	HEDIS: *Childhood Immunization Status (Combo 10)*	Combo 10: 40.54%	Combo 10: 36.55%
	HEDIS: *Immunizations for Adolescents*	Meningococcal: 59.67%	Meningococcal: 65.28% Tdap/Td: 90.22%

Aim: Focus on Screening and Prevention			
Goal	**Examples of Measures**	**2016 Baseline Rate**	**2019 Aggregate Rate**
		Tdap/Td: 88.93%	
	HEDIS: *Pneumococcal Vaccination Status for Older Adults*	NR	NR
	HEDIS: *Flu Vaccinations*	Adult: 43.92% Child: 56.33%	Adult: 48.71% Child: 52.55%
Support consistency of recommended pediatric screenings	CMS/HEDIS: *Annual Preventive Dental Visits*	ND	ND
	HEDIS: *Well-Child Visits, First 15 Months of Life*	62.06%	63.56%
	HEDIS: *Well-Child Visits in Third, Fourth, Fifth, and Sixth Years of Life*	74.13%	74.88%
	HEDIS: *Adolescent Well-Care Visits (12–21 years)*	50.30%	51.55%
	OHSU: *Developmental Screening in the First 3 Years of Life*	NR	NR

Aim: Achieve Healthier Pregnancies and Healthier Births			
Goal	**Measures**	**2016 Baseline Rate**	**2019 Aggregate Rate**
Virginians plan their pregnancies	NQF 2902/OPA: *Contraceptive Care—Postpartum Women Ages 15–44*	NR	NR
	HEDIS: *Postpartum Care Visit*	64.45%	61.84%
Improved pre-term birth rate	*Early Elective Deliveries Rate*	NR	NR
	HEDIS: *Timeliness of Prenatal Care*	82.22%	80.09%
	HEDIS: *Frequency of Ongoing Prenatal Care*	<20%: 28.52% 21–40%: 12.13% 41–60%: 74% 61–80%: 12.08% ≥81%: 38.53%	Retired HEDIS measure

Aim: Achieve Healthier Pregnancies and Healthier Births			
Goal	**Measures**	**2016 Baseline Rate**	**2019 Aggregate Rate**
	CMS/CDC/PQI: *Percent of Live Births <2,500 Grams*	NR	NR

Aim: Maximize Wellbeing Across the Lifespan			
Goal	**Measures**	**2016 Baseline Rate**	**2019 Aggregate Rate**
Effective management of chronic respiratory disease	PQI 14: *Asthma Admission Rate (Ages 2–17)*	NR	NR
	PQI 15: *Asthma in Younger Adults Admission Rate*	NR	NR
	CMS/PQI 05/NQF #0275: *COPD and Asthma in Older Adults Admission Rate* (two measures)	NR	NR
Comprehensive management of diabetes	HEDIS: *Comprehensive Diabetes Care*	Hemoglobin A1c (HbA1c) Testing: 87.37% HbA1c Poor Control (>9.0%): 40.76% HbA1c Control (<8.0%): 51.87% Eye Exam (Retinal) Performed: 55.05% Medical Attention for Nephropathy: 91.52% Blood Pressure Control (<140/90 mm Hg): 59.47%	Hemoglobin A1c (HbA1c) Testing: 86.33% HbA1c Poor Control (>9.0%): 50.94% HbA1c Control (<8.0%): 41.47 Eye Exam (Retinal) Performed: 45.48% Medical Attention for Nephropathy: 88.15% Blood Pressure Control (<140/90 mm Hg): 50.44%
	PQI 01/NQF #0272: *PQI Diabetes Short-Term Complication Admission Rate*	NR	NR
Effective management of cardiovascular disease	HEDIS/NQF #0018: *Controlling High Blood Pressure*	57.40%	55.61%

Aim: Maximize Wellbeing Across the Lifespan			
Goal	**Measures**	**2016 Baseline Rate**	**2019 Aggregate Rate**
Ensure quality of life for members with intensive healthcare needs	JLARC: *Nursing Facility Diversion—# and % of New Members Meeting Nursing Facility Level of Care Criteria Who Opt for Home & Community Based Services (HCBS) Over Institutional Placement*	NR	NR
	Quality of Life and Member Satisfaction Survey CMS-Specific	NR	NR
	Assessments and Reassessments	NR	NR
	Plan of Care and POC Revisions	NR	NR
	Documentation of Care Goals	NR	NR
	JLARC: *Transition of Members Between Community Well, LTSS and Nursing Facility—Services and Successful Retention in Lower Care Settings*	NR	NR
	JLARC: *Nursing Facility Residents Hospitalization and Readmission Rate*	NR	NR
	Fall Risk Management: Intervention/Managing Fall Risk	NR	NR
Provide support for End of Life	*% Enrollees with Advance Directives*	NR	NR

NR: Rates not reported.

ND: Not a covered benefit.