COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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November 15, 2024

MEMORANDUM

TO: The Honorable Mark D. Sickles
Chair, Joint Subcommittee on Health and Human Resources Oversight

The Honorable R. Creigh Deeds
Vice Chair, Joint Subcommittee on Health and Human Resources Oversight

FROM: Cheryl Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: Report on Supplemental Payment Program Quality Measures and Outcomes

This report is submitted in compliance with Item 288.OO.11 of the 2024 Appropriations Act which states:

The Department of Medical Assistance Services shall periodically assess the quality measures that are submitted to the Centers for Medicare and Medicaid Services for supplemental payments to ensure that appropriate quality measures are being included for supplemental payments such that the additional funding is improving the Medicaid program's quality and delivery of health care services. The department shall report on quality measures and outcomes for the programs to the Joint Subcommittee for Health and Human Resources Oversight no later than November 15, 2024.

Should you have any questions or need additional information, please feel free to contact me at 804-664-2660.

CR/wf
Enclosure

Pc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources

Supplemental Payment Program Quality Measures and Outcomes Report

November 2024

Report Mandate

Item 288.OO.11 of the 2024 Appropriation Act states: The Department of Medical Assistance Services shall periodically assess the quality measures that are submitted to the Centers for Medicare and Medicaid Services for supplemental payments to ensure that appropriate quality measures are being included for supplemental payments such that the additional funding is improving the Medicaid program's quality and delivery of health care services. The department shall report on quality measures and outcomes for the programs to the Joint Subcommittee for Health and Human Resources Oversight no later than November 15, 2024.

Supplemental Payment Program Quality Measures and Outcomes Report

Virginia Medicaid has two delivery systems: fee-for-service and managed care. The fee-for-service delivery system includes base payments for services and supplemental payments for certain provider classes that are lump sum payments for a specific period.[i] Under the managed care delivery system, the Department of Medical Assistance Services (DMAS) pays managed care organizations (MCOs) capitation rates per member per month and is authorized to require MCOs pay certain directed payments targeted to specific provider classes. These payments include uniform rate increases, minimum fee schedules, and value-based purchasing. The Centers for Medicare and Medicaid Services (CMS) requires "directed payments be tied to utilization and delivery of services under the managed care contract, be distributed equally to specified providers under the managed care contract, advance at least one goal in the state's managed care quality strategy, and not be conditioned on provider participation in intergovernmental transfer (IGT) agreements (42 CFR 438.6(c))."[i]

DMAS is required to submit annual renewal applications to CMS for each of the payment arrangements currently in effect for managed care, including an evaluation of quality measures. The quality measures are initially approved by CMS and are required by regulation (42 C.F.R. § 438.340) to directly further the goals of the Agency's Quality Strategy. In the following list are the current payment arrangements that DMAS administers that include the uniform rate increases and minimum fee schedules. The new 2024 payment arrangement for Private Acute Care Hospital Enhanced Payments is not final as of this report, but it has been included in the list.

1. Uniform Rate Increase for Physicians Affiliated with an Academic Medical Center
2. Uniform Rate Increase for Physicians Affiliated with a Non-State Government Owned Hospital

3. Uniform Rate Increase for Inpatient and Outpatient Services to Private Acute Care Hospitals
4. Uniform Rate Increase to Non-State Government Owned Hospitals for Inpatient and Outpatient Services and State Government Owned Nursing Facilities
5. Uniform Rate Increase for Physicians who Participate in Children's Specialty Group Affiliated with the Children's Hospital of the King's Daughters (CHKD)
6. Minimum Fee Schedule for Durable Medical Equipment (DME)
7. Uniform Rate Increase for Private Acute Care Hospital Enhanced Payments (2024)

Quality Measures and Outcomes

This section outlines the approved quality measures and most current evaluation outcomes from the most recent application cycle for each of the payments submitted to CMS in Spring 2024. These measures were selected based on their ability to further goals of the Agency's Quality Strategy (42 C.F.R. § 438.340) and were able to be tracked by DMAS. Earlier in 2024, CMS released new guidelines under the Managed Care Final Rule that updated provisions related to quality measurement and oversight. DMAS has already begun work to update and modernize the quality measures and evaluation process to meet those new criteria that will go into effect over the next few years.

For the arrangements below, DMAS uses Healthcare Effectiveness and Data Information Set (HEDIS) measures, which are nationally recognized quality measures owned by the National Committee on Quality Assurance (NCQA). DMAS also uses Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI) as noted in the tables below. Performance thresholds were set based on the Agency Quality Strategy, which identified the National 50th Percentile as the performance threshold across the spectrum for the HEDIS measures, with a secondary target of National 75th Percentile. During the evaluation years, performance trends of improvement of rates indicated progress towards measure goals.

1. Uniform Rate Increase for Physicians Affiliated with an Academic Medical Center

University of Virginia, Virginia Commonwealth University and Eastern Virginia Medical School each serve a unique region of the State – Western, Central, and Eastern Virginia, respectively. In addition to training and employing primary care physicians, they are also some of the largest providers of specialty physician services to their respective regions, including each region's largest tertiary care hospital and Virginia's only children's hospital. This payment arrangement is to encourage continued participation of these physicians in serving the healthcare needs of

Medicaid recipients and to ensure that adequate resources are available to support the provision of quality care, including the effective management of those with chronic conditions.

The table below outlines the quality measures that were approved by CMS for the application of this payment arrangement. DMAS elected to use nationally recognized healthcare quality measures that align state priority measures in the Quality Strategy to the priority measures identified by CMS in the Adult and Child Core Sets.

Approved Quality Measures
HEDIS: Adults' Access to Primary Care (Preventative/Ambulatory Health Services)
HEDIS: Children and Adolescent Access to Primary Care
HEDIS: Ambulatory Care- Emergency Department visits/1000 Member Years
HEDIS Comprehensive Diabetes Care, Poor Control
HEDIS: Controlling High Blood Pressure
HEDIS: Follow up After Emergency Department visit for mental illness
HEDIS: Initiation and engagement of substance use disorder, alcohol, and other drug dependence treatment (Total)
HEDIS: Follow up After Emergency Department visit for alcohol and other drug dependence
PQI-08: Heart Failure Admission Rate
PQI-05: Chronic Obstructive Pulmonary Disorder (COPD) and Asthma in Older Adults Admissions Rate
DMAS: Network Adequacy Maps and Scorecards
DMAS: Primary Care Provider (PCP) network

Evaluation of Outcomes

Evaluation Data								
Metric Name	Baseline Year	Baseline Statistic	Performance Target	2020	2021	2022	2023	2024
HEDIS: Adults' Access to Primary Care (Preventative/Ambulatory Health Services); NQF # (NA)	CY2019	80.49	Increase year over year measure rate to meet NCQA Quality	75.23	74.62	71.42	Fall 2024	Fall 2025

Evaluation Data								
Metric Name	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**2020**	**2021**	**2022**	**2023**	**2024**
			Compass 50th and 75th percentile targets					
HEDIS: Ambulatory Care-Emergency Department visits/1000 Member Years; NQF # (NA).	CY2019	835.68	Decrease year over year measure rate to meet NCQA Quality Compass 50th and 75th percentile targets	584.64	639.96	682.02	Fall 2024	Fall 2025
HEDIS: Comprehensive Diabetes Care, Poor Control; NQF # 0059	CY2019	47.30	Decrease year over year measure rate to meet Performance Withhold Program performance targets	49.55	49.72	43.96	Fall 2024	Fall 2025
HEDIS: Controlling High Blood Pressure; NQF # 0018	CY2019	52.76	Increase year over year measure rate to meet NCQA Quality Compass 50th and 75th percentile targets	47.20	50.20	54.79	Fall 2024	Fall 2025
HEDIS: Initiation and engagement of substance use disorder, alcohol, and other drug dependence treatment; NQF #0004	CY2019		Increase year over year measure rates to meet Performance Withhold Program performance targets				Fall 2024	Fall 2025
Initiation (Total)		47.96		47.79	48.37	49.22		
Engagement (Total)		16.58		17.31	17.79	19.77		
HEDIS: Follow-up After Emergency Department visit for Substance Use Disorder; NQF # 2605	CY2019		Increase year over year measure rates to meet Performance Withhold Program performance targets				Fall 2024	Fall 2025
30 Days		18.76		21.22	21.89	36.95		
7 Days		12.33		13.09	13.92	25.74		
HEDIS: Follow-up After Emergency Department	CY2019		Increase year over year				Fall 2024	Fall 2025

Evaluation Data								
Metric Name	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**2020**	**2021**	**2022**	**2023**	**2024**
visit for mental illness; NQF # 2605			measure rates to meet Performance Withhold Program performance targets					
30 Days		59.97		58.40	56.81	51.58		
7 Days		44.89		45.06	43.44	38.03		
PQI 08: Heart Failure Admissions Rate; NQF # 0277	CY2019	118.31	Decrease year over year measure rate to meet Performance Withhold Program performance targets	123.34	117.76	107.63	Fall 2024	Fall 2025
PQI 05: COPD and Asthma in Older Adults Admissions Rate; NQF # 0275	CY2019	130.77	Decrease year over year measure rate to meet Performance Withhold Program performance targets	95.11	73.35	71.62	Fall 2024	Fall 2025

Overall, there has been some progress towards the performance measure goals in this payment arrangement. The following measures saw performance meet the desired threshold (either meeting the National 50th Percentile or demonstrating year over year improvement) between CY2021 and CY2022:

- Initiation and engagement of substance use disorder, alcohol, and other drug dependence treatment - Total Initiation Rate and Total Engagement Rate
- Follow-up After Emergency Department visit for substance use disorder
- Emergency Department Visits per 1000 Member Years
- Controlling high blood pressure
- Comprehensive Diabetes Care: Poor Control
- Follow-up After Emergency Department visit for substance use disorder (30 and 7 days)
- Heart Failure Admissions Rate
- COPD and Asthma in Older Adults Admissions Rate

There were two evaluation metrics that did not see progress, either with hitting a performance

benchmark or meeting a trending goal:

- Adults' Access to Primary Care (Preventative/Ambulatory Health Services); however, it is important to note that this measure saw a national decrease in average performance of 3.59% which is a trend Virginia mirrored as well (3.15%), indicating larger scale issues with access in the measure.
- Follow-up After Emergency Department visit for Mental Illness- this does not match national trends and indicates an area of opportunity for DMAS to improve.

Network adequacy scorecard review by managed care program (Medallion 4.0 on a quarterly basis and CCC Plus monthly) has allowed DMAS to determine that there are no unaddressed provider network gaps in the identified provider categories during this year's payment evaluation period. Ensuring continued enrollment of key provider groups is an important component of this payment arrangement. This is especially true for state Medicaid programs. Considering nationwide medical staffing shortages, this arrangement allows for participation of these key providers in Virginia's Medicaid network.

2. Uniform Rate Increase for Physicians Affiliated with a Non-State Government Owned Hospital

Like the payment arrangement above, this next payment arrangement is to encourage continued participation of these physicians in Tidewater Region serving the healthcare needs of Medicaid recipients and to ensure that adequate resources are available to support the provision of quality care, including the effective management of those with chronic conditions. The table below outlines the quality measures that were approved by CMS for this payment arrangement.

Approved Quality Measures
HEDIS: Ambulatory Care- Emergency Department visits/1000 Member Years
HEDIS: Follow up After Emergency Department visit for mental illness
DMAS: Network Adequacy Maps and Scorecards

Evaluation of Outcomes

				Evaluation Data				
Metric Name	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**2021**	**2022**	**2023**	**2024**	**2025**
HEDIS: Ambulatory Care-Emergency Department visits/1000 Member Years; NQF # (NA). Please note change from MM to MY reflected in data updated this year.	CY2020	584.64	Decrease year over year measure rate to meet NCQA Quality Compass 50th and 75th percentile targets	639.96	682.02	Fall 2024	Fall 2025	Fall 2026
HEDIS: Follow-up After Emergency Department visit for mental illness; NQF # 2605	CY2020		Increase year over year measure rates to meet Performance Withhold Program performance targets			Fall 2024	Fall 2025	Fall 2026

Overall, there has been some progress towards the performance of the measures in this payment arrangement. No measure in the payment arrangement hit the highest performance standard of the NCQA National 75h percentile benchmark. Virginia did have one measure that hit the first performance mark (NCQA National 50th percentile benchmark), Emergency Department Visits (per 1000 MY). The other evaluation metric that did not see progress, either with hitting a performance benchmark or meeting a trending goal, which was Follow-up After Emergency Department visit for Mental Illness. This does not match national trends and indicates an area of opportunity for DMAS to improve.

Network adequacy scorecard review by managed care program (Medallion 4.0 on a quarterly basis and CCC Plus monthly) has allowed DMAS to determine that there are no unaddressed provider network gaps in the identified provider categories during this year's payment evaluation period for the Tidewater Region. Ensuring continued enrollment of key provider groups is an important component of this payment arrangement. This is especially for state Medicaid programs and considering nationwide medical staffing shortages, this arrangement allows for participation of these key providers in Virginia's Medicaid network.

3. Uniform Rate Increase for Inpatient and Outpatient Services to Private Acute Care Hospitals

The purpose of this payment arrangement is to increase Medicaid reimbursement rates for inpatient and outpatient services to align more closely with Medicare and commercial insurance reimbursement. This increased rate allows for these providers to continue to serve Medicaid patients, which increases access to care. This access to care allows for more appropriate utilization of outpatient and/or inpatient services, and potentially reduces utilization of emergency services for members. The table below outlines the quality measures that were approved by CMS for this payment arrangement, which includes uniform rate increases for inpatient and outpatient services for private acute care hospitals.

Approved Quality Measures
HEDIS: Ambulatory Care-Emergency Department visits/1000 Member Years
PQI-08: Heart Failure Admission Rate
DMAS: Network Adequacy Maps and Scorecards

Evaluation of Outcomes

Evaluation Data								
Metric Name	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**2020**	**2021**	**2022**	**2023**	**2024**
HEDIS: Ambulatory Care-Emergency Department visits/1000 Member Years; NQF # (NA). Please note change from MM to MY reflected in data updated this year.	CY2019	835.68	Decrease year over year measure rate to meet NCQA Quality Compass 50th and 75th percentile targets	584.64	639.96	682.02	Fall 2024	Fall 2025
PQI 08: Heart Failure Admissions Rate; NQF # 0277	CY2019	118.31	Decrease year over year measure rate to meet Performance Withhold Program performance targets	123.34	117.76	107.63	Fall 2024	Fall 2025

Overall, there has been progress towards the performance of the measures in this payment

arrangement. No measure in the payment arrangement hit the highest performance standard of the NCQA National 75h percentile benchmark. Virginia did have both measures either hit the first performance mark (NCQA National 50th percentile benchmark) or showed year over year improvement from CY2021 to CY2022.

Network adequacy scorecard review by managed care program (Medallion 4.0 on a quarterly basis and CCC Plus monthly) has allowed DMAS to determine that there are no unaddressed provider network gaps in the identified provider categories during this year's payment evaluation period. Ensuring continued enrollment of key provider groups is an important component of this payment arrangement.

4. Uniform Rate Increase to Non-State Government Owned Hospitals for Inpatient and Outpatient Services and State Government Owned Nursing Facilities

The purpose of this payment is to act as an incentive for non-state government hospitals to work with the state and MCOs to reduce preventable admissions, readmissions, and emergency department visits, particularly for those with targeted chronic conditions. Each of the facilities eligible for a payment under this program represents a key piece of their geography's safety net. The table below outlines the quality measures that were approved by CMS for this payment arrangement.

Approved Quality Measures
PQI-05: COPD and Asthma in Older Adults Admissions Rate
HEDIS: Comprehensive Diabetes Care, Poor Control
HEDIS: Ambulatory Care- Emergency Department visits/1000 Member Years
HEDIS: Controlling High Blood Pressure

Evaluation of Outcomes

				Evaluation Data				
Metric Name	Baseline Year	Baseline Statistic	Performance Target	2020	2021	2022	2023	2024
HEDIS: Ambulatory Care-Emergency Department visits/1000 Member Years; NQF # (NA). Please note change from	CY2019	835.68	Decrease year over year measure rate to meet NCQA Quality Compass 50th	584.64	639.96	682.02	Fall 2024	Fall 2025

				Evaluation Data				
Metric Name	Baseline Year	Baseline Statistic	Performance Target	2020	2021	2022	2023	2024
MM to MY reflected in data updated this year.			and 75th percentile targets					
HEDIS: Comprehensive Diabetes Care, Poor Control; NQF # 0059	CY2019	47.30	Decrease year over year measure rate to meet Performance Withhold Program performance targets	49.55	49.72	43.96	Fall 2024	Fall 2025
HEDIS: Controlling High Blood Pressure; NQF # 0018	CY2019	52.76	Increase year over year measure rate to meet NCQA Quality Compass 50th and 75th percentile targets	47.20	50.20	54.79	Fall 2024	Fall 2025
PQI 05: COPD and Asthma in Older Adults Admissions Rate; NQF # 0275	CY2019	130.77	Decrease year over year measure rate to meet Performance Withhold Program performance targets	95.11	73.35	71.62	Fall 2024	Fall 2025

Overall, there has been some progress towards the performance of the measures in this payment arrangement. No measure in the payment arrangement hit the highest performance standard of the NCQA National 75h percentile benchmark. Virginia did have all four measures either hit the first performance mark (NCQA National 50th percentile benchmark) or showed year over year improvement from CY2021 to CY2022.

5. Uniform Rate Increase for Physicians who Participate in Children's Specialty Group Affiliated with the Children's Hospital of the King's Daughters (CHKD)

This payment arrangement is to encourage continued participation of these physicians in serving the healthcare needs of Medicaid recipients and to ensure that adequate resources are available to support well-child visits for infants and well-care visits for toddlers. The table below

outlines the quality measures that were approved by CMS for this payment arrangement.

Approved Quality Measures
HEDIS: Well-Child Visits in the First 30 Months of Life
HEDIS: Child and Adolescent Well-Care Visits

Evaluation of Outcomes

This payment arrangement went into effect in January 2024, therefore DMAS will have an evaluation of progress on this payment arrangement in the following years.

6. Minimum Fee Schedule for Durable Medical Equipment (DME)

This payment arrangement is specifically to encourage participation of provider groups who may not be as familiar with managed care and negotiating managed care contracts. The table below outlines the quality measures that were approved by CMS for the application of the payment arrangement for the minimum fee schedule for durable medical equipment (DME).

Approved Quality Measures
DMAS: Network Adequacy Maps and Scorecards

Evaluation of Outcomes

Network adequacy scorecard review by managed care program (Medallion 4.0 on a quarterly basis and CCC Plus monthly) has allowed DMAS to determine that there are no unaddressed provider network gaps in the identified provider categories during this year's payment evaluation period. Ensuring continued enrollment of key provider groups is an important component of this payment arrangement. This is especially for true state Medicaid programs. Considering nationwide medical staffing shortages, this arrangement allows for participation of these key providers in Virginia's Medicaid network.

About DMAS and Medicaid

The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage. The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid and CHIP programs for approximately two million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health

as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 600,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives an approximate dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90% for newly eligible adults, generating cost savings that benefit the overall state budget.

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[i] *Issue Brief: Directed Payments in Medicaid Managed Care*. MACPAC. June 2023. https://www.macpac.gov/wp-content/uploads/2023/06/Directed-Payments-in-Medicaid-Managed-Care.pdf