DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

April 11, 2023

Karen Kimsey, Director
Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Karen Kimsey:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Virginia's submission of an amendment for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The amendment was received by CMS on March 8, 2023 and has a control name of VA_Fee_AMC_Amend_20210701-20220630.

Specifically, the following proposal amendment for delivery system and provider payment initiatives (i.e. state directed payment) is approved:

- The uniform increase established by the state for physicians affiliated with the practice plans of Virginia's three allopathic medical schools: University of Virginia, Virginia Commonwealth University, and Eastern Virginia Medical Center, for the rating period covering July 1, 2021 through June 30, 2022, incorporated in the capitation rates through a separate payment term of up to $185.1 million.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period(s), or any specific Medicaid financing mechanism used to support the provider payment arrangement. All other federal laws and regulations apply. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

The state is always required to submit a contract action(s) to incorporate the contractual obligation for the state directed payment and related capitation rates that include this payment arrangement.

Note that this payment arrangement and all state directed payments must be addressed in the applicable rate certifications. Therefore, CMS strongly recommends that states share this approval letter and the final approved preprint with the certifying actuary. Documentation of all state directed payments must be included in the initial rate certification as outlined in Section I, Item 4 of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification may cause delays in CMS review. CMS is happy to provide technical assistance to states and their actuaries.

As part of the preprint, the state indicated that this state directed payment will be incorporated into the state's rate certification through a separate payment term. As the payment arrangement is addressed through a separate payment term, CMS has several requirements related to this payment arrangement, including but not limited to the requirement that the state's actuary must certify the aggregate amount of the separate payment term and an estimate of the magnitude of the payment on a per member per month (PMPM) basis for each rate cell. Failure to provide all required documentation in the rate certification may cause delays in CMS review. As the PMPM magnitude is an estimate in the initial rate certification, no later than 12 months after the rating period is complete, the state must submit documentation to CMS that incorporates the total amount of the state directed payment into the rate certification's rate cells consistent with the distribution methodology described in the initial rate certification, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been known when the rates were initially developed. Please submit this documentation to statedirectedpayment@cms.hhs.gov and include the control name listed for this review along with the rating period.

The total dollar amount approved for the separate payment term for this state directed payment is $185.1 million within the Medallion 4.0 and CCC Plus managed care programs. If the total amount of the separate payment term is exceeded from what was approved under this preprint or, the payment methodology is changed from the approved preprint, CMS requires the state to submit a state directed payment preprint amendment. Please note that if the separate payment term amount documented within the rate certification exceeds the separate payment term amount approved under the preprint, then the state will be required to submit a rate certification amendment to address the inconsistencies between the rate certification and the approved preprint.

Lastly, CMS is able to approve this preprint with a requirement that the state provide the full Years 1, 2, and 3 evaluation results in the state's preprint submission for state fiscal year 2022-2023 for CMS prior approval under 42 CFR 438.6(c). Should the state have any questions or need technical assistance, please contact the CMS Division of Quality and Health Outcomes at ManagedCareQualityTA@cms.hhs.gov.

If you have questions concerning this approval or state directed payments in general, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

John F. Giles Jr -S

Digitally signed by John F. Giles Jr -S
Date: 2023.04.11 13:43:22 -04'00'

John Giles, MPA
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   July 1, 2021 - June 30, 2022
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* July 1, 2021
3. Identify the managed care program(s) to which this payment arrangement will apply:
   Medallion 4.0 and CCC Plus
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $185.1 Million
   a. Identify the estimated federal share of this state directed payment: $122.9 Million
   b. Identify the estimated non-federal share of this state directed payment: $62.2 Million

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☒ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☐ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☐ Quality Metric(s) / Benchmark(s) Change
☐ Other; please describe:

☒ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

Consistent with 42 CFR §438.6(c)(1)(iii)(C), the contracted Medallion and CCC Plus Medicaid health plans will provide a uniform percentage increase to the base health plan payments made to physicians affiliated with the practice plans of Virginia's three allopathic medical schools (University of Virginia (UVA), Virginia Commonwealth University (VCU) and Eastern Virginia Medical Center (EVMS)). The uniform percentage will be determined by the state based on the UPL (upper payment limit) gap, which is updated every three years in accordance with CMS requirements under the State plan. The uniform percentage increase for UVA and VCU for SFY22 is based on UPL gap analysis conducted in April 2020. the uniform percentage increase for EVMS for July-September 2021 is the percentage approved for the SFY21 directed payment. DMAS is completing a new UPL gap analysis for the EVMS uniform percentage increase that will apply October 2021 through the remainder of SFY22.

For example, if the base payment a Medicaid health plan has agreed to pay a physician for providing services is $1,000, and the applicable percentage increase for these services is 50%, then the calculated payment increase for these services would be $500, resulting in a total payment of $1,500 for that enrollee's specific service.

Medicaid health plan encounter data will be used to link payments to utilization by physician in each group. Medicaid health plans are required to submit encounter data to the Virginia Department of Medical Assistance Services in accordance with formatting and timeliness standards set forth in their contracts with the State. Upon completion of a quarter, DMAS will calculate each physician's payment increase by MCO and program type (Medallion and CCC Plus) using valid encounters received during the previous

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

Type 1 Physicians State Plan Page 6.3, Attachment 4.19-B, https://www.medicaid.gov/medicaid/spa/downloads/VA-20-0006.pdf

Medallion 4.0 (VA-03) 1915(b) Waiver:
https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/VA_Medallion-Medallion-II_VA-03.pdf

FY2022-FY2023 Medallion 4.0 Renewal to be sent pending submission and approval by CMS.

CCC Plus (VA-06) 1915(b) Waiver:
https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/VA_CCC-Plus_VA-06.pdf

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ■ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ■ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☒ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

The uniform percentage is based on the FFS average commercial rate (ACR) analysis for the upper payment limit (UPL) with adjustments, if any, for managed care. For SFY22, the resulting uniform percentage increase for physician services is 202%.of total Medicaid State plan reimbursement for UVA/VCU physicians and 76% of total Medicaid State plan reimbursement for EVMS physicians for July - September 2021. As described in the response to Q8, the uniform percentage increase will be revised based on the UPL gap calculation effective October 2021. The FFS UPL gap analysis will be evaluated every three years consistent with CMS requirements for the State plan.

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

Medicaid health plan encounter data will be used to link payments to utilization by physician in each group. Medicaid health plans are required to submit encounter data to the Virginia Department of Medical Assistance Services in accordance with formatting and timeliness standards set forth in their contracts with the State. Upon completion of a quarter, DMAS will calculate each physician's payment increase by MCO and program type (Medallion and CCC Plus) using valid encounters received during the previous quarter and sum those payments by physician group. DMAS will then issue a supplemental payment to each Medicaid health plan based on the increase calculated for the health plan's enrollees. Due to the uniform percentage increase being calculated after the encounter has been received, the directed payments will occur retroactively at the end of each quarter to each health plan for distribution to each physician group.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

The uniform percentage increase to base health plan negotiated rates is the same methodology used in all of Virginia's directed payment requests previously approved by CMS and will be comparable to reimbursement approved by CMS in Virginia's State Plan.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☐ inpatient hospital service
- ☐ outpatient hospital service
- ☒ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Physicians affiliated with the practice plans of Virginia's three allopathic medical schools (University of Virginia (UVA), Virginia Commonwealth University (VCU) and Eastern Virginia Medical Center (EVMS)).

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

Type 1 Physicians State Plan Page 6.3, Attachment 4.19-B,
https://www.medicaid.gov/medicaid/spa/downloads/VA-20-0006.pdf

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

Under this payment arrangement, all physicians in the class providing services to Medicaid managed care enrollees will receive a uniform percentage increase for physician services. Health plan encounter data will be used to link payments to utilization of physician services for plan enrollees using the same methodology across the class.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. UVA/VCU	33.11%	66.89%			100.00%
b. EVMS	56.82%	43.18%			100.00%
c.	0.00%	0.00%			0.00%
d.	0.00%	0.00%			0.00%
e.	0.00%	0.00%			0.00%
f.	0.00%	0.00%			0.00%
g.	0.00%	0.00%			0.00%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☒ Other; Please define: Average Commercial Rate

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

The data sources and methodology for this analysis are the same data sources and methodology described in the response to question 19b. The values in Table 2 are Medicaid payment levels as a percentage of the Average Commercial Rate.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

DMAS confirms that the base rates and the total reimbursement with directed payments are expected to equal the average commercial rate in Virginia for physician services, as approved in the State Plan.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☐ Yes ☒ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

b. If no, please estimate when the state will be submitting the contract actions for review.

Before July 1, 2021.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☐ Yes ☒ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

06/30/2021

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i.			
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

N/A

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☒ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

The reimbursement levels for physician services rendered by the provider class reflects the importance of these providers to Virginia's Medicaid program and such reimbursement levels may exceed negotiated rates between the health plans and other physicians. Maintaining the separate payment term approach mitigates concerns that health plans will divert utilization to other physician practices and supports network participation of these critical physician practices. If the value of the directed payment was incorporated in base capitation rates, there is the concern that utilization patterns for physician services will be negatively impacted and jeopardize the network status of the provider class.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☒ State general revenue
- **b.** ☒ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ☐ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i. Eastern Virginia Medical School	EVMS is a political subdivision of the Commonwe	$ 2,990,000.00	No	30,365,881	Yes
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☒ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

EVMS has an interagency agreement (IAG433) with DMAS for the payment of the non-federal share of supplemental payments. The IAG is attached. DMAS is not aware of any other written agreements.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i.						
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ■ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ■ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://www.dmas.virginia.gov/media/2966/2020-2022-dmas-quality-strategy.pdf
- **b.** The effective date of quality strategy. October 2, 2020

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. See Attachment for Table 7		
b.		
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

The medical schools noted each serve a unique region of the State – eastern, central and western Virginia. In addition to training and employing primary care physicians, they are also 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 hospitals. 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. Moreover, the state will utilize the network analysis that Virginia requires from each plan and DMAS' network adequacy results for the CCC Plus program and Medallion 4.0 program to ensure that sufficient networks are maintained. DMAS will evaluate the effectiveness of this plan at least annually to determine if any corrective action needs to be taken by the MCOs.

Monthly provider network files are submitted with requirements outlined in the CCC Plus Network Requirements Submission Manual utilizing a methodology developed to determine adequacy in specific FIPS codes and aligning with contractual standards for time and distance. Quarterly provider network files are submitted for Medallion 4.0 with similar requirements. Network scorecards are then developed by county/city, which are reviewed internally, documenting strengths and weaknesses of each MCO's individual networks, and the summarized findings are provided back to the MCOs. Separate scorecards are created for CCC Plus and Medallion 4.0 networks specific to provider types that are key for each program's populations.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes**[1]
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. See Attachment for Table 8				
ii.				
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

DMAS will assess the degree to which the arrangement advances the goals and objectives described in above by measuring the annual utilization of the providers in these physician groups, including the reimbursement received (as measured by DMAS encounter data) compared to historical utilization of these groups. DMAS believes this strategy will encourage participation among the physicians named in our response to question eight above, and that the strategy will help the MCOs maintain a network of providers that is sufficient in number, specialty mix, and geographic distribution to provide high-quality care to all managed care members in a cost effective manner.

For both the Medallion 4.0 and CCC Plus programs, DMAS worked with its actuary to conduct an analysis of its rate-setting data to identify potentially preventable, avoidable, and/or medically unnecessary ER visits, hospital admissions, and hospital readmissions (i.e. Clinical Efficiency [CE]) analysis). This identified medical spending associated with inefficient utilization. Rather than applying identified inefficiencies as a capitation rate adjustment, DMAS is developing a measurement methodology to promote a more targeted approach to improving performance in these three specific areas. DMAS is moving to a methodology that uses performance measures for each of these areas to track MCO and, eventually, hospital performance. Once developed, DMAS will apply inefficiency adjustments through a withhold methodology, where MCOs can earn back a portion of withheld funds based on performance against metrics in each CE area. This significantly improves incentives to alter behavior and improve performance because the MCOs must avoid preventable and medically unnecessary utilization in targeted areas in order to earn back the withheld funds.

In late SFY 2020, DMAS distributed performance reports that allow for assessment of individual MCO performance in the areas of preventable and/or medically unnecessary ER visits, hospitalizations, and readmissions. This process also included the development of technical specifications for these metrics. The MCO withhold methodology was also implemented for SFY 2021. DMAS continues work to develop comparable measures to track performance at the hospital level.

As detailed in the Medicaid Expansion Network Adequacy Readiness Review, completed in December 2018, DMAS has established network standards, evaluation, and monitoring oversight of provider networks for the participating health plans. DMAS provides monthly and quarterly network adequacy maps and scorecards to the health plans (by program). In addition, DMAS intends to study additional network evaluation activities, including a review of open and closed panels, in-depth review of the primary care provider (PCP) network, and new specialty providers that DMAS considers critical. The Virginia MCOs are also going to be undergoing the three year compliance review during CY2021 to review, at a minimum, all applicable federal and state regulatory requirements including network adequacy standards.

Relative to the establishment of measurements and performance targets for the current quality goals, DMAS worked with Health Services Advisory Group (HSAG) to amend the three year DMAS agency wide quality strategy that covers the Medallion 4.0 Program, the Commonwealth Coordinated Care (CCC) Plus Program and DMAS fee-for-service (FFS). Benchmarks have been set to be consistent with current contract standards for the MCOs within the Quality Strategy and this application. DMAS continues to work with internal stakeholders to develop processes to continuously evaluate the effectiveness of the quality strategy through the creation of short- and long-term goals and regular progress review.

DMAS currently does not have any evaluation findings of this payment arrangement, as determination of baseline information is underway for calendar year 2019 data (the first full year of Medicaid Expansion). The information included above shows the data available for the first reporting year (baseline) and aligns with the current 2020-2022 Quality Strategy. The Quality Strategy measures were selected to evaluate quality performance on the managed care program level for Virginia and direct comparison to hospital or provider level performance is limited at this time. In order for the measure to have a baseline for Medicaid expansion, the baseline year will have to be calendar year 2019 (HEDIS reporting year 2020) as the previous reporting years do not include the Expansion population and therefore is not appropriate for baseline determination alone. This is consistent with previous applications, as DMAS intends to use the CY2019 (HEDIS 2020) reporting year as a baseline for evaluation due to the high degree of change in the Virginia Medicaid managed care populations in 2017 and 2018.

#899

Memorandum of Understanding
IAG #419 Project #70039

Interagency Agreement between the Eastern Virginia Medical School (hereinafter "EVMS") and the Department of Medical Assistance Services (DMAS)

It is hereby agreed:

I. PURPOSE

The purpose of this agreement is for Eastern Virginia Medical School (hereinafter "EVMS") to transfer to the Virginia Department of Medical Assistance Services (hereinafter "DMAS") the state share for the supplemental capitation payments for the Tidewater Physician Access Adjustment paid to the Medallion 3.0 plans so that they can increase payments to physicians affiliated with a medical school in Eastern Virginia/Tidewater that is a political subdivision of the Commonwealth.

II. PERIOD

Covers all supplement capitation payments for the Tidewater Physician Access Adjustment on or after July 1, 2015.

III. AGREEMENT

DMAS is contractually obligated by the State Plan to make physician supplement payments to physicians affiliated with EVMS. EVMS agrees to transfer funds to DMAS to fund the state share of these payments.

At the beginning of each month, DMAS will calculate the tentative supplemental capitation payment amount for that month from the list of members sent to each plan that they are responsible for in that month and any settlement for the final supplemental capitation payment for the prior month. DMAS will request from EVMS the state share for this combined amount, which EVMS will transfer to DMAS by Friday before the last Friday of the month. DMAS will calculate the final supplemental capitation payment for the prior month based on the actual capitation payments at the same time that it calculates the tentative supplemental capitation payment amount for the current month. DMAS will provide documentation to EVMS of the paid Tidewater member months for each plan from the final supplemental capitation payment calculation for the prior month and the settlement of the tentative supplemental capitation payment at the same time that it requests the state share from EVMS for the current month. DMAS will only make the supplemental capitation payments once the funding of the state share has been furnished.

EVMS shall remit funds via check to the address below and include the following description as reference (EVMS MCO Contribution: GLA 902 45609 123831 Proj. 70039 100% Fund 0100):

Department of Medical Assistance Services
Attn: Rudy Brown, Accounts Receivable Manager
600 East Broad Street, Suite 1300
Richmond, VA 23219

III. TERMS AND CONDITIONS

A. Termination

If the Centers for Medicare and Medicaid Services (hereinafter "CMS") disapproves the Tidewater Physician Access Adjustment, this agreement is terminated. Otherwise, EVMS shall make the transfer as long as the Medallion 3.0 contracts require the MCOs to make Tidewater Physician Access Payments. If DMAS for any reason (e.g. disallowance by CMS) recoups capitation payments made to Medallion 3.0 MCOs that were funded by a transfer by EVMS, DMAS will return to EVMS the amount transferred by EVMS as the state share of the recouped payments.

B. Modification

This MOU cannot be modified in any manner except by written instrument which has been executed by the parties.

In witness of the foregoing, the parties have caused this agreement to be executed by the following duly authorized officials.

Cynthia Jones

Cynthia B. Jones, Director
Department of Medical Assistance Services

8/25/15
Date

Richard Homan, MD, President
Eastern Virginia Medical School

8/11/2015
Date

Proposal A, Table 7

Goal(s)	*Objective(s)* and Metrics (bullets)	Quality Strategy Page
Smarter Spending: Goal 3.1, Focus on Paying for Value	*Decrease Emergency Department Visits* • HEDIS: Ambulatory Care- Emergency Department visits/1000 Member Months	Page 112
Improve Population Health: Goal 4.1, Improve Behavioral Health and Developmental Services of Members	*Increase Follow-Up Visits After Emergency Department Visit for Mental Illness* • HEDIS: Follow-up After Emergency Department visit for mental illness	Page 112-113
Improve Population Health: Goal 4.2, Improve Outcomes for Members with Substance Use Disorders	*Increase Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* • HEDIS: Initiation and engagement of alcohol and other drug dependence treatment *Increase Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* • HEDIS: Follow-up After Emergency Department visit for alcohol and other drug dependence	Page 114
Improve Population Health: Goal 4.3, Improve Utilization of Wellness, Screening, and Prevention Services for Members	*Increase Adults' Access to Preventive/Ambulatory Health Services* • HEDIS: Adults' Access to Primary Care (Preventative/Ambulatory Health Services) *Increase Child and Adolescent Well-Care Visits* • HEDIS: Children and Adolescents' Access to Primary Care	Page 114
Improve Population Health: Goal 4.4, Improve Health for Members with Chronic Conditions	*Decrease Diabetes Poor Control* • HEDIS: Comprehensive Diabetes Care *Increase Control of High Blood Pressure* • HEDIS: Controlling High Blood Pressure *Decrease Heart Failure Admission Rate* • PQI 08: Heart Failure Admissions Rate *Decrease COPD and Asthma in Older Adults' Admission Rate* • PQI 05: COPD and Asthma in Older Adults Admissions Rate	Page 114
Effective Patient Care: Aspirational Goal 2.2, Ensure Access to Care	*Ensure Provider Network Adequacy* • Monthly and quarterly provider network adequacy review and scorecards	Page 116

Proposal A, Table 8

Measure Name and NQF # (if applicable)	Baseline Year	Baseline Statistic	Performance Target	Notes
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 Compass 50th and 75th percentile targets	Virginia Medicaid Average rate is currently below National 50th Percentile (HMO)
HEDIS: Children and Adolescents' Access to Primary Care; NQF # (NA)	CY2019		Increase year over year measure rate to meet NCQA Quality Compass 50th and 75th percentile targets	Virginia Medicaid Average rates are currently below National 50th Percentile (HMO)
12-19 Years		83.68		
12-24 Months		94.25		
25 Months to 6 Years		86.54		
7-11 Years		88.68		
HEDIS: Ambulatory Care- Emergency Department visits/1000 Member Months; NQF # (NA)	CY2019	69.64	Decrease year over year measure rate to meet NCQA Quality Compass 50th and 75th percentile targets	Virginia Medicaid Average rate is currently above National 50th Percentile (HMO)
HEDIS: Comprehensive Diabetes Care, Poor Control; NQF # 0059	CY2019	47.30	Decrease year over year measure rate to meet Performance Withhold Program performance targets	None
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	Virginia Medicaid Average rate is currently below National 50th Percentile (HMO)

HEDIS: Initiation and engagement of alcohol and other drug dependence treatment; NQF #0004	CY2019		Increase year over year measure rates to meet Performance Withhold Program performance targets	None
Initiation (Total)		47.96		
Engagement (Total)		16.58		
HEDIS: Follow-up After Emergency Department visit for alcohol and other drug dependence; NQF # 2605	CY2019		Increase year over year measure rates to meet Performance Withhold Program performance targets	None
30 Days		18.76		
7 Days		12.33		
HEDIS: Follow-up After Emergency Department visit for mental illness; NQF # 2605	CY2019		Increase year over year measure rates to meet Performance Withhold Program performance targets	None
30 Days		59.97		
7 Days		44.89		
PQI 08: Heart Failure Admissions Rate; NQF # 0277	CY2019	121.52	Decrease year over year measure rate to meet Performance Withhold Program performance targets	Rate is for CCC Plus Population only
PQI 05: COPD and Asthma in Older Adults Admissions Rate; NQF # 0275	CY2019	131.21	Decrease year over year measure rate to meet Performance Withhold Program performance targets	Rate is for CCC Plus Population only
Quarterly Network Adequacy Maps and Scorecards (Medallion 4.0)	SFY2020	Percent of members with access to all other specified, non-exempt providers (non-PCP) in which the member travels to receive covered benefits within required time and distance standards.	At least 75% of members within a county must be able to access all other specified, non-exempt providers (non-PCPs, including acute care hospitals) within required time and distance standards established in the Medallion 4.0 contract.	This is an aspirational goal for DMAS, see Quality Strategy pg. 116

Monthly Network Adequacy Maps and Scorecards (CCC Plus)	SFY2020	Percent of members with access to all other specified, non-exempt providers (non-PCP) in which the member travels to receive covered benefits within required time and distance standards.	Determination of a performance target that is reasonable and actionable to hold the MCOs accountable to will be based on review of the baseline year of data for the CCC Plus Program.	This is an aspirational goal for DMAS, see Quality Strategy pg. 116
PCP network (Medallion 4.0)	SFY2020	Percent of members with access to PCP within required time and distance standards.	At least 80% of members within a county must be able to access primary care within required time and distance standards established in the Medallion 4.0 contract.	This is an aspirational goal for DMAS, see Quality Strategy pg. 116
PCP network (CCC Plus)	SFY2020	Percent of members with access to PCP within required time and distance standards.	Determination of a performance target that is reasonable and actionable to hold the MCOs accountable to will be based on review of the baseline year of data for the CCC Plus Program.	This is an aspirational goal for DMAS, see Quality Strategy pg. 116