Virginia Medicaid Managed Care Operational Report

July 1, 2019 - June 30, 2020

VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION • QUALITY • VALUE

Overview

Pursuant to federal regulations found in 42 CFR § 438.66(e), the Department of Medical Assistance Services, hereafter referred to as the Department or DMAS, has compiled this annual report on managed care operations for Virginia for SFY2020. This report includes information on and assessment of the operation of Virginia's managed care programs in the following areas:

- Financial performance of each Managed Care Organization (MCO), including medical loss ratio (MLR) experience.
- Encounter data reporting by each MCO.
- Enrollment and service area expansion (if applicable) of each MCO.
- Modifications to and implementation of MCO benefits covered under the contract with the State.
- Grievance, appeals, and State fair hearings for the managed care program.
- Availability and accessibility of covered services within MCO contracts, including network adequacy standards.
- Evaluation of MCO performance on quality measures, including as applicable, consumer report card, surveys, or other reasonable measures of performance.
- Results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO to improve performance.
- Activities and performance of the beneficiary support system.
- Any other factors in the delivery of Long Term Support Services (LTSS) not otherwise addressed, as applicable.

Table of Contents

THE VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS)

The mission of the Virginia Department of Medical Assistance Services is to continue to provide statewide access to a comprehensive system of high-quality, cost effective healthcare as we seek to partner with the the Commonwealth's Medicaid MCOs. Medicaid provides health care financing for over 1.5 million low-income and medically vulnerable Virginians, and in State Fiscal Year 2020 DMAS experienced a number of impacts, changes, and innovations to the Medicaid program. Highlights include:

- Continuing Medicaid Expansion from its effective date of January 1, 2019, to current enrollment of over 500,000 Virginia adults eligible for health coverage.
- Addressing impacts of COVID-19 Public Health Emergency (PHE) on Medicaid members and MCOs therefore providing flexibilities to providers in light of new health care delivery environment.
- Increased usage of telehealth by members and providers.
- The transition of DMAS and MCO staff to a work-from-home model.
- Virginia Premier's transition to joint ownership by VCU Health System & Sentara Healthcare.
- Molina Complete Care's acquisition of Magellan Complete Care of Virginia.
- Addressing behavioral health issues of members through programs such as Addiction and Recovery Treatment Services (ARTS), Community Mental Health Rehabilitative Services (CMHRS), and the new Behavioral Health Enhancement (BHE).

MEDICAID MANAGED CARE 2019-2020

Managed care is a service delivery model where contracted private health plans coordinate care to ensure member needs are met and control costs through full-risk, capitated agreements. In SFY2020, Virginia's two Medicaid managed care programs were Medallion 4.0 and Commonwealth Coordinated Care (CCC Plus). Individuals identified as medically complex were enrolled into the CCC Plus program, while individuals classified as non-medically complex were covered under the Medallion 4.0 program.

In Virginia, 96% of Medicaid enrollees received their benefits through a Managed Care Organization (MCO) and 4% of enrollees participated through the Fee-For-Service (FFS) program. Virginia has been increasing its use of the MCO programs because of the value it provides to Medicaid members across the Commonwealth. Managed care provides budgetary predictability and can also include benefits to members such as care coordination, enhanced provider networks, and access to 24/7 call centers.

The Medallion 4.0 and CCC Plus programs continue to operate statewide through contracts with the same six (6) MCOs, including: Aetna Better Health of Virginia, Anthem HealthKeepers, Magellan Complete Care of Virginia, Optima Health, UnitedHealthcare, and Virginia Premier.

Medallion 4.0

DMAS has built upon and revised Virginia's Medicaid managed care programs. Over the past two decades, the Department has continued to strengthen the foundation of the Medallion and Family Access to Medical Insurance Security (FAMIS) programs throughout Medallion, Medallion II, and Medallion 3.0. Medallion 4.0 has continued the efforts by providing services to Medicaid and FAMIS eligible members of the following populations: infants, children, foster care and adoption assistance, teens, Low-Income Families with Children (LIFC) adults, pregnant women, and Children and Youth with Special Health Care Needs (CYSHCN).

The Medallion 4.0 program grew to include newly carved in services and populations such as Early Intervention (EI), Community Mental Rehabilitation Services and Behavioral Therapy, individuals with other health insurance as primary and Medicaid expansion populations.

Medallion 4.0 Overview

83%
of Medicaid & FAMIS enrollees in program

1,348,119
Medallion 4.0 members as of February 2020

Children & Youth • Pregnant Women • Foster Care & Adoption Assistance • Parents & Caretaker Relatives • Expansion Adults

CCC Plus

The CCC Plus program is the Department's mandatory integrated care program for certain qualifying individuals, including dual eligible individuals and individuals receiving LTSS. The CCC Plus program includes individuals who receive services through Nursing Facility (NF) care, or from four (4) of the Department's five (5) Home and Community-Based Services (HCBS) 1915(c) waivers.

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

CCC Plus Overview

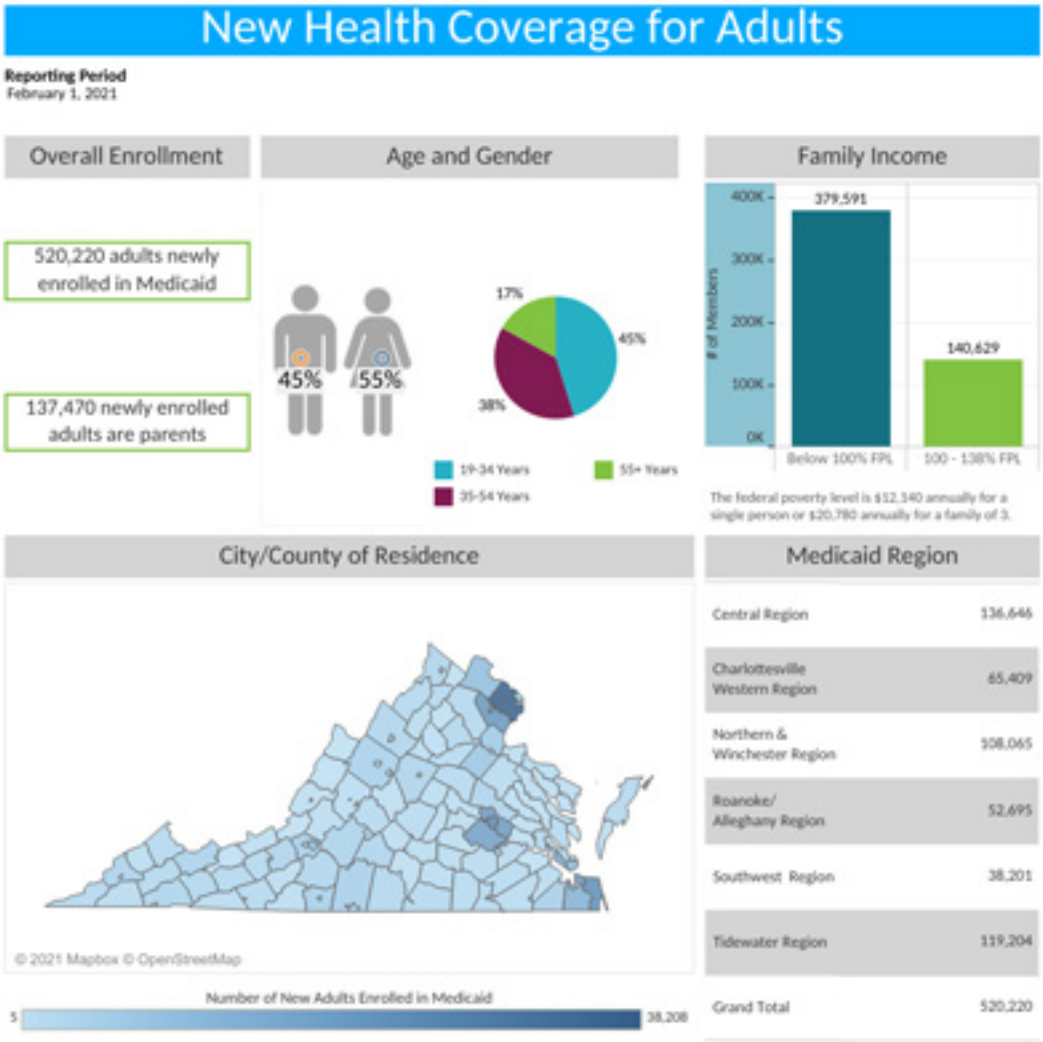
17%
of Medicaid & FAMIS enrollees in program

269,398
CCC Plus members as of February 2020

Adults & Children with Disabilities • Individuals Ages 65 and Older • Individuals Eligible for Medicare & Medicaid (Dual Eligible) • Members in Developmental Disabilities Waiver • Non-Dual Eligible Receiving LTSS

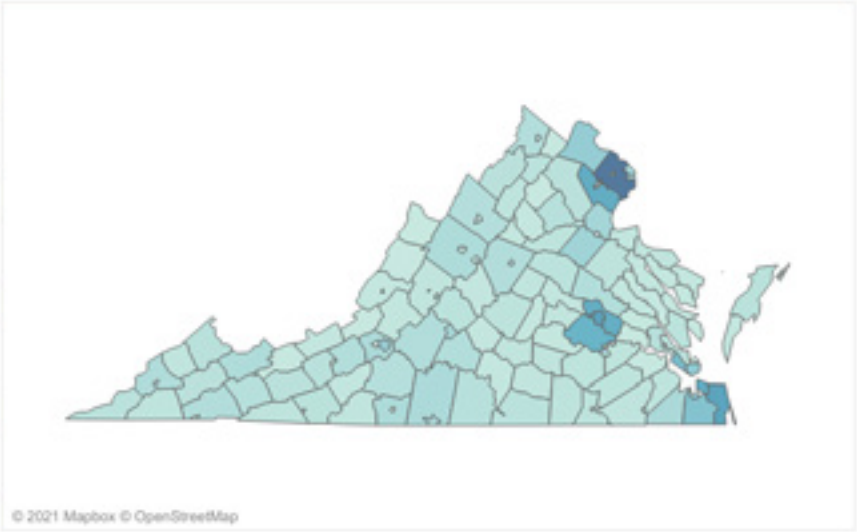
MEDICAID EXPANSION

Medicaid expansion continues in the state of Virginia in light of the COVID-19 PHE. Enrollment and eligibility flexibilities have provided a safety net for many Virginians who have been affected by COVID-19. Medicaid expansion continues to generate cost savings that benefit the overall state budget. The Department operates two dashboards featuring Medicaid expansion outcomes on the agency website: 1) enrollment, and 2) service utilization and access to care:



Medicaid Expansion Access and Health Services

Report Date
February 1, 2021

Current Member Enrollment	Access and Health Services by Locality
520,220	
Any Service Received	
515,256	
At Least One Office Visit	
416,523	
At Least One Prescription	
423,083	
Treated for High Blood Pressure	
85,026	
Treated for Diabetes	
44,420	
Treated for Asthma	**Treated for Chronic Obstructive Pulmonary Disease (COPD)**
20,678	13,459
Treated for Cancer	**Received Addiction and Recovery Treatment Services (ARTS)**
10,717	42,530

Footnotes
1. The number of members served is not displayed for localities with fewer than 20,000 residents or when totals for a given service are fewer than 10 members per Department policy to protect the privacy of members.
2. Addiction and Recovery Treatment Services (ARTS) are services based on the American Society of Addiction Medicine continuum of care and includes office-based opioid treatment, outpatient opioid treatment, counseling, intensive outpatient programs, partial hospitalization, residential treatment, withdrawal management, care coordination, and peer support.
3. The total number of members served is cumulative and includes members enrolled at any point since January 1, 2019.
4. The number of members served is identified through paid claims submitted to the Department as of the most recent update. Due to lag in claims submission, additional services may have occurred but are not represented here.

MANAGED CARE BENEFITS

Details about each program's current benefits can be found on the respective DMAS website:

- CCC Plus: https://cccplusva.com
- Medallion 4.0: https://www.virginiamanagedcare.com/home

Each managed care program offers a suite of benefits to its respective members. These benefits are available to all managed care members of the program for which they qualify, regardless of the MCO they select. The following is a list of the basic health services offered to managed care members, regardless of MCO. Members also access MCO-specific details of their benefits through the Member Handbooks provided by each MCO.

Summary of Benefits

- ARTS.
- Behavioral (mental) health services, counseling and 24/7 crisis line.
- Care coordination services (where applicable).
- Diagnostic services including x-ray, lab and imaging.
- Durable Medical Equipment (DME) and supplies.
- Emergency and urgent care.
- Family planning services.
- Health care for children including checkups, immunizations (shots) and screenings.
- Hospital and home health services.
- Interpreter and translation services.
- Maternity and high-risk pregnancy care.
- Medical transportation services.
- No co-pays except patient pay towards long-term services and supports and any Medicare Part D drug co-pays.
- Physical, occupational and speech therapies and audiology services.
- Prescription drugs and over-the-counter medications (when prescribed by doctors).
- Preventive and regular medical care.
- Routine eye exams and glasses for children and routine eye exams for adults.
- Team approach (interdisciplinary care).
- 24/7 nurse advice line.
- Women's health services.

Enhanced Services/Added Benefits

While each MCO provides the core benefits that all managed care members have access to within CCC Plus or Medallion 4.0, an MCO can offer enhanced services, beyond the core benefits, to its members. These enhanced services, also called added benefits, are another way to offer choice to the managed care members to find the MCO that meets their needs.

Each year, Medallion 4.0 and CCC Plus updates a comparison chart for the members that is available publicly on the DMAS website, as well as, the website of the enrollment broker, Maximus. This comparison chart is one of several tools offered to the members to allow the members to make an informed choice when selecting their MCO. Some examples of enhanced services include:

Medallion 4.0 Enhanced Services:

- Adult dental and vision (partial benefit)
- Smartphones and online tools (apps, texts, etc.)
- Wellness programs such as fitness centers and smoking cessation
- Non-medical transportation (grocery stores, food banks, farmers markets)

CCC Plus Enhanced Services:

- Adult dental and vision (partial benefit)
- Personal care attendant support
- Assistive technology devices
- Home delivered meals

MCO Websites:

Aetna
https://www.aetnabetterhealth.com/virginia/

Anthem
https://mss.anthem.com/va/virginia-home.html

Magellan
https://www.magellanofvirginia.com/

Optima
https://www.optimahealth.com/plans/medicaid/

United
https://www.uhccommunityplan.com/va

Virginia Premier
https://virginiapremier.com/medicaid/

CHANGES TO MANAGED CARE

In SFY20, there were a number of changes approved in our managed care contracts. Effective July 1, 2019, DMAS had the authority to include the following modifications to the Commonwealth Coordinated Care Plus and the Medallion 4.0 contracts. The following list was reviewed by DPB, approved by the Governor and/or the General Assembly as contract amendments that we worked on in conjunction with our health plans:

1. Expanding care coordination for adoption assistance members that mirrors services currently provided to foster care children, as both need special assistance.

2. Requiring foster care children receive physician and dental visit within the first 30 days of plan enrollment.

3. Providing cultural competency training and case management initiatives specific to LGBTQIA community.

4. Requiring Patient Utilization Management and Safety (PUMS), which keeps a member, with either a history of prescription drug abuse or other utilization abuse, with one provider. Requires PUMS Program "lock-in" re-evaluations for members changing plans.

5. Requiring additional care coordinators for EI population as we continue to mature the program.

6. Developing advisory groups for member feedback and engagement surrounding maternal, child, and women's health as part of our work on the Governor's maternal projects.

7. Developing strategies to keep mom and baby together during residential SUD treatment as studies show that there are clinical and behavioral benefits of keeping mom and baby together.

8. Identifying and addressing racial disparities in maternal, reproductive and child health, as part of the Governor's charge to eliminate disparity by 2025.

9. Improving care coordination of the high-risk maternity programs as we develop more initiatives.

10. Requiring maternal Screening, Brief Intervention and Referral to Treatment (SBIRT).

11. Require maternal screenings for mental health.

12. Requiring CCC Plus plans to upgrade from Medicare Dual Special Needs Plans (DSNPs) to Medicare Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs).

13. Waiving the signature requirement for non-emergency transportation providers in support for transportation options such as Uber and Lyft.

14. Establishing payment targets for the total portion of medical spending covered under a value based payment arrangement.

MOLINA ACQUISITION OF MAGELLAN

Molina Healthcare, Inc. announced its acquisition of Magellan Complete Care line of business of Magellan Health, Inc. closed on December 31, 2020. This change will take full effect on July 1, 2021. Members will continue to work with the same administrators and providers. Members will not lose any coverage options.

NEW ADULT DENTAL

Governor Ralph Northam signed into his budget funds to provide dental services for adults enrolled in Virginia Medicaid. The services emphasize oral health care to positively impact overall health and well-being.

Adults over age 21 who are enrolled in Medicaid and FAMIS are eligible to receive appropriate comprehensive dental benefits (excluding Orthodontia) through Virginia's dental program, ***Smiles for Children*** (SFC).

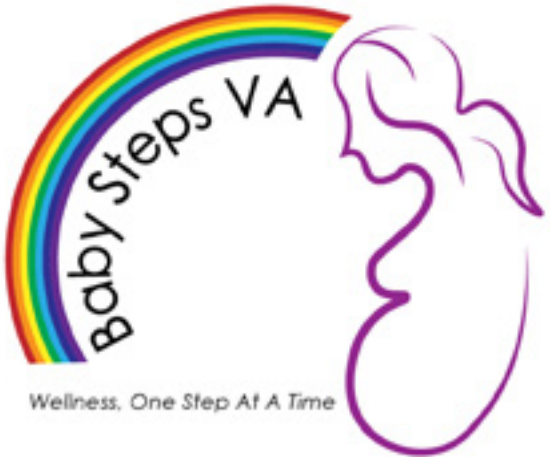
Starting July 1, 2021, dental services for adults enrolled in Medicaid will include:

- X-rays and examinations
- Cleanings
- Fillings
- Root canals
- Gum related treatment
- Partials and dentures
- Tooth extractions and other oral surgeries, and
- Other appropriate general services such as anesthesia

MATERNAL AND CHILD HEALTH (MCH)

Baby Steps VA

DMAS is committed to providing access to comprehensive care for pregnant and postpartum women and their babies enrolled in any one of Virginia Medicaid's health coverage programs. To achieve this, DMAS has developed a team to support program initiatives and advance innovation in maternal and reproductive health. In 2019, Governor Ralph Northam announced a goal to eliminate racial disparities in the maternal mortality rate across Virginia by 2025. To accomplish these goals, DMAS revamped the Healthy Birthday Virginia initiative to "Baby Steps VA" in 2020. Baby Steps VA is a program that includes five teams focused on strategies to support member access to care while addressing health disparities. Virginia Medicaid recognizes the importance of addressing infant and maternal health in a holistic way.



DMAS is a key agency in providing funding for pregnant and post partum women. Title XIX of the Medicaid State Plan provides funding to serve pregnent women with incomes up to 143 percent of the federal poverty line (FPL). The FAMIS MOMS program uses Title XXI of the the CHIP Demonstration Waiver to provide funding for women with incomes up to 200 percent of the FPL. As seen in the table below, Virginia Medicaid covered approximately 39,00 births in 2019.

	CY 2017		CY 2018		CY 2019	
Overall Births	Number	Percent	Number	Percent	Number	Percent
Total Births	31,708	100.0%	35,002	100.0%	38,648	100.0%
Multiple Gestation Births	*566*	*1.8%*	*1,276*	*3.6%*	*1,367*	*3.5%*
Singleton Births	*31,142*	*98.2%*	*33,726*	*96.4%*	*37,281*	*96.5%*

MCH Eligibility and Enrollment Initiatives

Medicaid continues to cover 1 in 3 births in Virginia and 35% of children are covered by Medicaid and CHIP services. DMAS continues to streamline the enrollment process and give pregnant women near real time eligibility determinations, so they can be connected with doctors and other medical care without delay. In September 2019 DMAS automated pregnant women redetermination in order to ensure that all pregnant women eligible for Medicaid following their 2-months postpartum continued their coverage automatically in another aid category. This prevented them from losing any continuity of care with their MCO.

Newborn Enrollment

It is essential that newborns of mothers enrolled in Medicaid or an associated program are correctly enrolled with their own Medicaid ID number. Newborns directly enrolled in most instances will receive a Medicaid identification number that will facilitate newborns receiving their full program benefit, Managed Care Organization (MCO) assignment, and ensure appropriate reimbursement is received for the Medicaid covered services provided to the new member. One of the paths DMAS is pursuing is newborn enrollment. This initiative ensures that all babies are enrolled and have the benefits of that allow for more healthy outcomes.

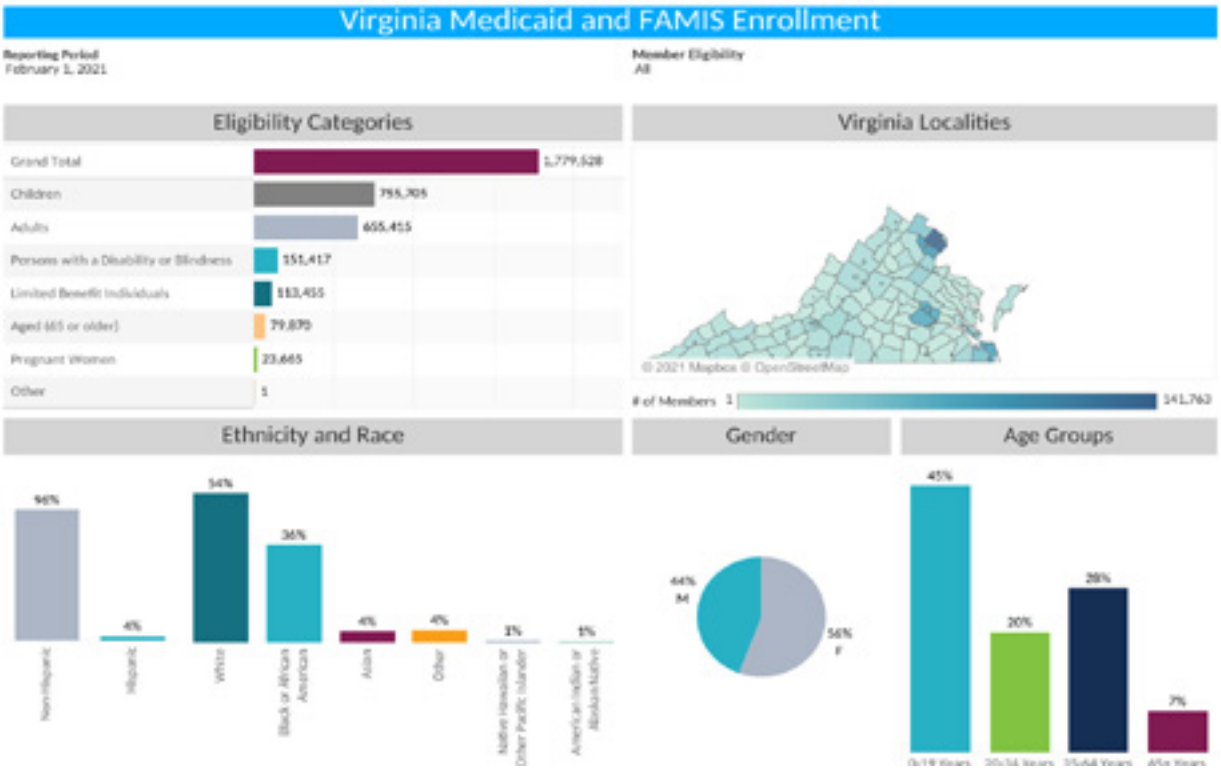
Teams from multiple DMAS divisions collaborated with outside stakeholders including all six participating MCOs to increase the number of infants enrolled in Medicaid coverage post-delivery. This effort has indentified efficiency and has ensured newborns of Medicaid mothers are enrolled expediently, ensuring the babies have coverage. The success of the group initiative can be seen below

TOTAL NEWBORNS RECEIVED MEDICAID ID FROM DMAS NEWBORN ENROLLMENT ENHANCEMENT (E213 LIVE BIRTHS REPORT PROJECT) BY FILE SENT MONTH															
JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEP	OCT	NOV	DEC	MCO Submitted	% Success	*Amt Sent	Not Submitted
17	10	5	7	2	6	11	3	8	11	13	7	100	100%	100	0
27	13	4	12	4	19	14	10	15	17	21	9	165	93%	177	12
7	1		2	1		2	1	3	3	9	8	37	100%	37	0
31	19	5	12	1	16	26	8	21	35	35	27	236	100%	236	0
2	2	1	4		8	11	2	5	8	9	7	59	100%	59	0
20	13	2	13	4	25	13	5	25	15	27	16	178	99%	179	1
104	58	17	50	12	74	77	29	77	89	114	74	775		788	13

Managed Care

Virginia's six MCOs continue to play a leading role in addressing the needs of the state's pregnant women and newborns. The health plans undertook a variety of initiatives aimed at improving quality outcomes in maternal health. The support and partnership from these MCOs has helped to strengthen data sharing as well as reporting of performance measures. See the share of births covered by managed care below.

Overall Births	CY 2017		CY 2018		CY 2019	
	Number	Percent	Number	Percent	Number	Percent
Medicaid Delivery System						
FFS	7,887	25.3%	8,868	26.3%	8,663	23.2%
Managed Care	23,255	74.7%	24,856	73.7%	28,618	76.8%

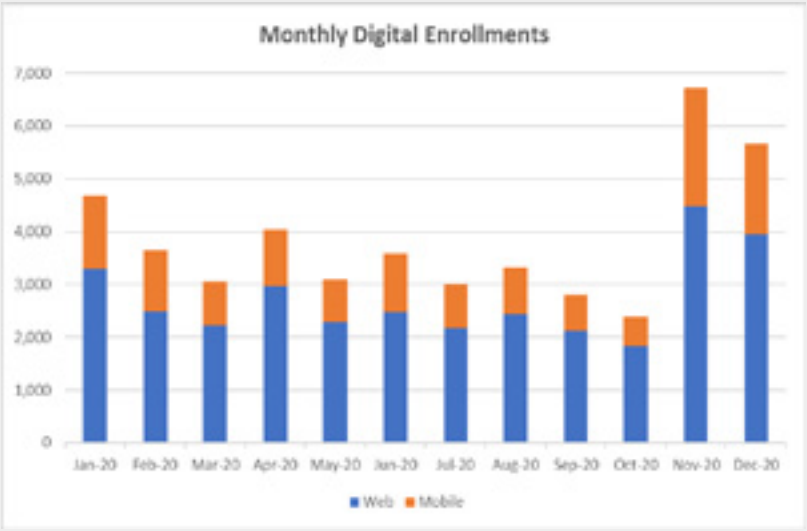


MANAGED CARE ENROLLMENT

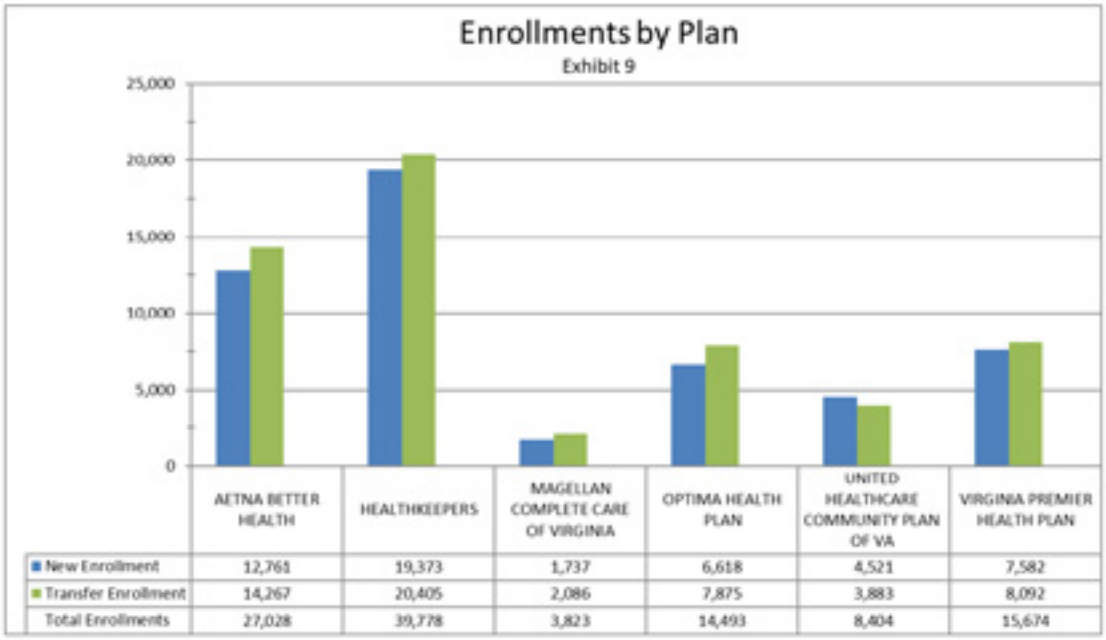
Both managed care programs have algorithms to determine enrollment based on a variety of factors, including case history, MCO location participation, or random assignment. Ultimately, however, each member has the power to change their MCO, either for a period after their initial enrollment and again during the annual open enrollment period, in order to find the MCO that best meets the member's needs.

Medallion 4.0 Member Enrollments Through Website and Smartphone Applications

National surveys indicate that a majority of Medicaid members have smartphones and utilize their phones and phone applications for making decisions about health care choices. In response, DMAS implemented Android and Apple smartphone applications, as well as updated the website with comprehensive plan information (including quality ratings, enhanced benefits, and provider networks) to assist individuals with both enrolling for Medicaid and selecting a managed care plan.



The following chart, Enrollments by Plan and MCO, represents enrollment activity for each the MCOs. The chart shows the number of new enrollments and 90-day transfers for each MCO. The total number of enrollments the Helpline processed into MCOs during this reporting period was 109,200. There were 52,592 new enrollments and 56,608 90-day transfer enrollments.



	AETNA BETTER HEALTH	HEALTHKEEPERS	MAGELLAN COMPLETE CARE OF VIRGINIA	OPTIMA HEALTH PLAN	UNITED HEALTHCARE COMMUNITY PLAN OF VA	VIRGINIA PREMIER HEALTH PLAN
New Enrollment	12,761	19,373	1,737	6,618	4,521	7,582
Transfer Enrollment	14,267	20,405	2,086	7,875	3,883	8,092
Total Enrollments	27,028	39,778	3,823	14,493	8,404	15,674

Below, the Customer Satisfaction Survey shows the percentage of favorable responses by survey question for the state's Enrollment Broker call center. Callers completed 18,224 surveys during the reporting period with overall responses 96.92% favorable.

BENEFICIARY SUPPORT SYSTEM (MAXIMUS)

DMAS contracts with Maximus as the beneficiary support system and enrollment broker for both Medallion 4.0 and CCC Plus. Maximus operates enrollment services via the Managed Care Helpline and website, with the aim to educate and assist Medicaid members and the public with managed care topics.

Medallion 4.0 Website
https://www.virginiamanagedcare.com/

CCC Plus Website
https://www.cccplusva.com/home

Virginia Managed Care Helpline Activity Summary Report - SFY20				
Total Calls Answered	Average Calls Handled Per Month	Highest Call Volume (Month)	Lowest Call Volume (Month)	Overall Abandonment Rate
173,889	14,491	December	May	2.98%

Bureau of Insurance (BOI) Oversight

The Virginia Bureau of Insurance (BOI) licenses, regulates, investigates and examines insurance companies, agencies and agents on behalf of the citizens of the Commonwealth of Virginia. Its mission is to ensure:

- Citizens of the Commonwealth are provided with adequate and reliable insurance protection;
- Insurance companies selling policies are financially sound to support payment of claims;
- Agents selling company policies are qualified and conduct their business according to statutory and regulatory requirements, as well as acceptable standards of conduct; and
- Insurance policies are of high quality, are understandable and are fairly priced.

Medallion 4.0 and CCC Plus MCOs are required to submit quarterly and annual filings to both the BOI and DMAS. DMAS reserves the right to require that MCOs engage the services of an independent contractor to audit the plan's major managed care functions performed on behalf of DMAS.

The MCOs also agree to work with the Provider Reimbursement division of DMAS to develop a financial report that details medical expenditure categories, total member months related to the expenditures, Incurred but Not Reported (IBNR) amounts, and all associated administrative expenses.

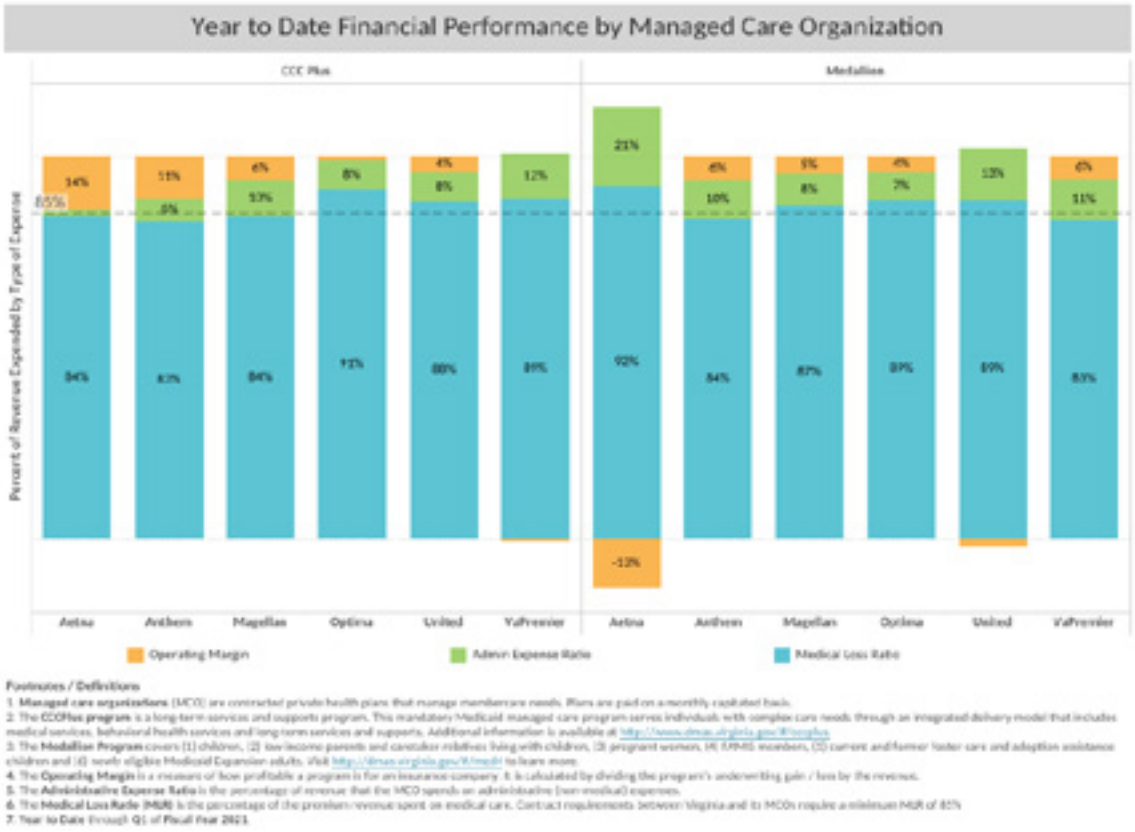
MCO FINANCIAL PERFORMANCE

In managed care, MCOs enter a fully capitated, risk-based contract to administer each program. DMAS pays the MCOs Per Member, Per Month (PMPM) capitation rates developed annually by the DMAS actuary (Mercer during SFY 2020) and these rates may be modified during the annual contract renewal process. The MCOs are responsible for paying providers for covered services utilized by the member.

Minimum Medical Loss Ratio (MLR)

To ensure rates paid by the Department are utilized to pay for covered services, the MCOs are subject to a minimum MLR of 85%. The MLR is calculated by determining the following ratio: incurred claims plus expenditures for activities that improve health care quality plus expenditures on activities to comply with certain program integrity requirements divided by adjusted premium revenue.

If the MLR for a reporting year is less than 85%, the MCO must repay DMAS an amount equal to the deficiency percentage applied to the amount of adjusted premium revenue. The MCOs are required to report this annually, as well as provide DMAS with all of the necessary data to calculate and verify the MLR within eleven (11) months of the end of the reporting year (which is the contract year). Below is a summary of the financial performance of each MCO in SFY2020. The Net Gain or Loss row is determined by whether or not an MCO's total revenues were greater than (gain) or less than (loss) the total expenses of that MCO.



Footnotes / Definitions

1. **Managed care organizations** (MCO) are contracted private health plans that manage members' care needs. Plans are paid on a monthly capitated basis.
2. The **CCCPlus program** is a long-term services and supports program. This mandatory Medicaid managed care program serves individuals with complex care needs through an integrated delivery model that includes medical services, behavioral health services and long-term services and supports. Additional information is available at http://www.dmas.virginia.gov/#/cccplus
3. The **Medallion Program** covers (1) children, (2) low-income parents and caretaker relatives living with children, (3) pregnant women, (4) FAMIS members, (5) current and former foster care and adoption assistance children and (6) newly eligible Medicaid Expansion adults. Visit http://dmas.virginia.gov/#/medd to learn more.
4. The **Operating Margin** is a measure of how profitable a program is for an insurance company. It is calculated by dividing the program's underwriting gain / loss by the revenue.
5. The **Administrative Expense Ratio** is the percentage of revenue that the MCO spends on administrative (non-medical) expenses.
6. The **Medical Loss Ratio (MLR)** is the percentage of the premium revenue spent on medical care. Contract requirements between Virginia and its MCOs require a minimum MLR of 85%
7. Year to Date through Q1 of Fiscal Year 2021.

QUALITY PERFORMANCE

DMAS prioritizes quality improvement in all managed care programs. As such, the Department requires each MCO in each managed care program to complete federal and state mandated quality improvement activities. These include:

- Participation in a quarterly collaborative
- Reporting of Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data
- Participation in performance improvement projects
- Measure validation activities
- Participation in either a performance incentive award program (Medallion 4.0) or quality withhold program (CCC Plus)

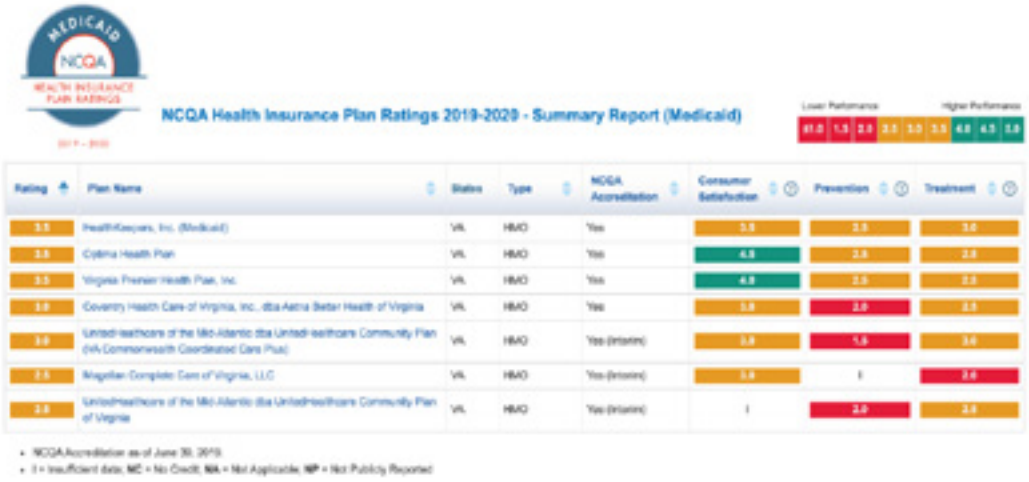
Quality Strategy

DMAS has updated its Quality Strategy for the period 2020-2022. Specifically, DMAS is providing notice about this amended Quality Strategy that is required by CMS to be updated every three years (42 CFR §438.340). The Quality Strategy outlines DMAS' vision to meet all mandated federal Medicaid quality improvement activities for 2020-2022. The Quality Strategy is available on the DMAS website.

NCQA Accreditation

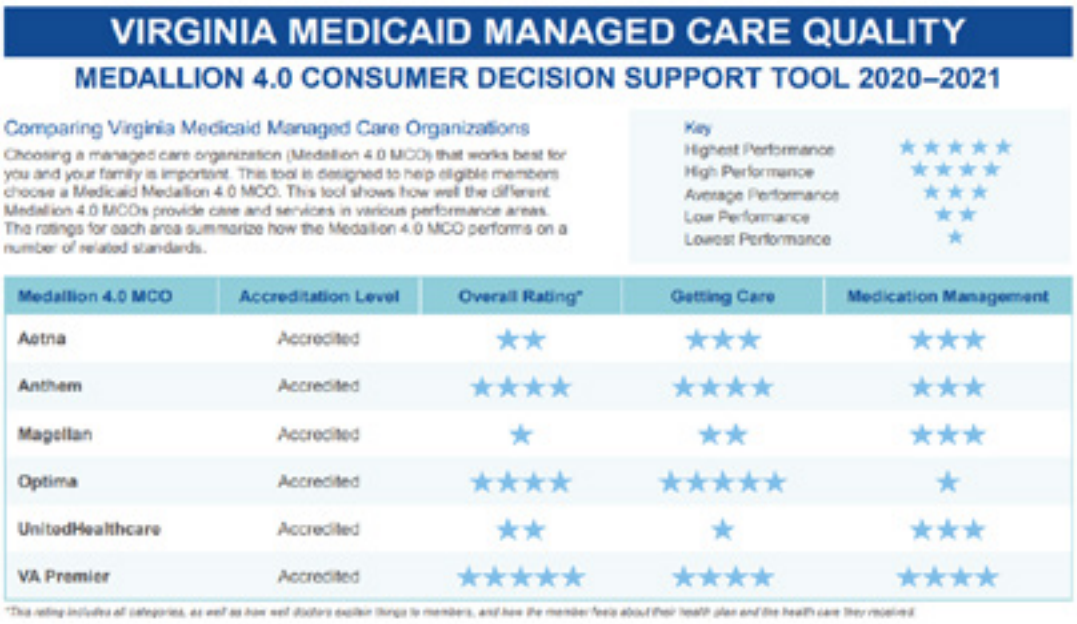
In light of the COVID-19 PHE, NCQA did not release 2020-2021 Health Plan Ratings for any product line. Accredited commercial and Medicaid plans still submitted the required HEDIS and CAHPS measures in order to meet annual reporting requirements; however, organizations will not be rated on measure results.

Below is the SFY19 NCQA Accreditation status for both the Medallion 4.0 and CCC Plus MCOs. DMAS requires that all contracted MCOs be accredited with NCQA. Any new MCOs have a timeline and benchmarks they must meet while they are in the process of becoming NCQA accredited (if they are not already accredited). These MCOs are designated below with an accreditation status of "interim".



Consumer Decision Support Tool

As required by 42 CFR § 438.354 and 42 CFR § 438.358, DMAS works with its External Quality Review Organization (EQRO), HSAG, to produce an annual Consumer Decision Support Tool, using Virginia Medicaid MCOs' performance measure data as its basis. The tool was developed to report MCO performance information to the public and to assist consumers in making informed decisions about their health care. The tool provides a three-level rating scale with an easy-to-read "picture" of quality performance across MCOs and presents data in a manner that clearly emphasizes meaningful differences between MCOs to assist consumers when selecting a health plan. This tool is available on both DMAS and Maximus' enrollment websites.



VIRGINIA MEDICAID MANAGED CARE QUALITY

MEDALLION 4.0 CONSUMER DECISION SUPPORT TOOL 2020–2021

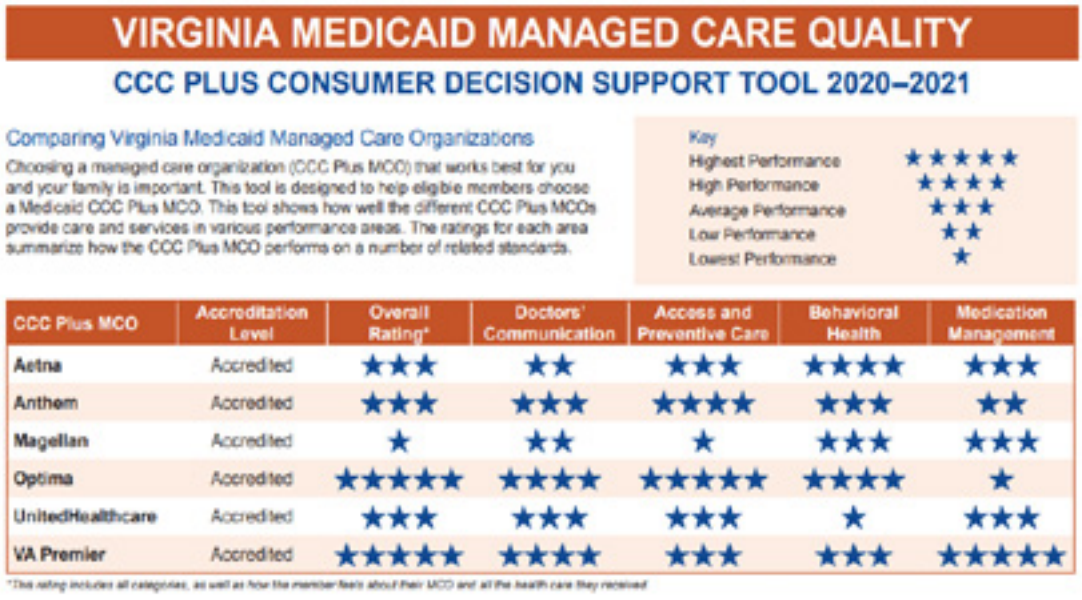
Comparing Virginia Medicaid Managed Care Organizations

Choosing a managed care organization (Medallion 4.0 MCO) that works best for you and your family is important. This tool is designed to help eligible members choose a Medicaid Medallion 4.0 MCO. This tool shows how well the different Medallion 4.0 MCOs provide care and services in various performance areas. The ratings for each area summarize how the Medallion 4.0 MCO performs on a number of related standards.

Key
- Highest Performance ★★★★★
- High Performance ★★★★
- Average Performance ★★★
- Low Performance ★★
- Lowest Performance ★

Medallion 4.0 MCO	Accreditation Level	Overall Rating*	Getting Care	Medication Management
Aetna	Accredited	★★	★★★	★★★
Anthem	Accredited	★★★★	★★★★	★★★
Magellan	Accredited	★	★★	★★★
Optima	Accredited	★★★★	★★★★★	★
UnitedHealthcare	Accredited	★★	★	★★★
VA Premier	Accredited	★★★★★	★★★★	★★★★

*This rating includes all categories, as well as how well doctors explain things to members, and how the member feels about their health plan and the health care they received.



VIRGINIA MEDICAID MANAGED CARE QUALITY

CCC PLUS CONSUMER DECISION SUPPORT TOOL 2020–2021

Comparing Virginia Medicaid Managed Care Organizations

Choosing a managed care organization (CCC Plus MCO) that works best for you and your family is important. This tool is designed to help eligible members choose a Medicaid CCC Plus MCO. This tool shows how well the different CCC Plus MCOs provide care and services in various performance areas. The ratings for each area summarize how the CCC Plus MCO performs on a number of related standards.

Key
- Highest Performance ★★★★★
- High Performance ★★★★
- Average Performance ★★★
- Low Performance ★★
- Lowest Performance ★

CCC Plus MCO	Accreditation Level	Overall Rating*	Doctors' Communication	Access and Preventive Care	Behavioral Health	Medication Management
Aetna	Accredited	★★★	★★	★★★	★★★★	★★★
Anthem	Accredited	★★★	★★★	★★★★	★★★	★★
Magellan	Accredited	★	★★	★	★★★	★★★
Optima	Accredited	★★★★★	★★★★	★★★★★	★★★★	★
UnitedHealthcare	Accredited	★★★	★★★	★★★	★	★★★
VA Premier	Accredited	★★★★★	★★★★	★★★	★★★	★★★★★

*This rating includes all categories, as well as how the member feels about their MCO and all the health care they received.

HEDIS® OVERVIEW

Healthcare Effectiveness Data and Information Set (HEDIS®)

The 2018 state fiscal year saw a number of major changes and innovations to the Virginia Medicaid program, particularly with managed care. The magnitude of changes, outlined below, to Virginia's Medicaid managed care programs necessitates a break in trending for all reported measures from previous years.

First Full Year of Commonwealth Coordinated Care (CCC Plus)

Reporting year 2018 was the first full year of CCC Plus, Virginia's new MLTSS program, with the inclusion of new carved-in services and new significant, high-risk populations into managed care. This includes the transition of existing higher acuity Aged, Blind, or Disabled (ABD) and Health and Acute Care Program (HAP) members from Medallion 3.0 to CCC Plus effective 1/1/18, with emphasis on care coordination and continuity of care during the transition. CCC Plus carved in CMHRS, EI services, consumer-directed personal care and TPL members in 2018.

Transition from Medallion 3.0 to Medallion 4.0

Data from reporting year 2018 was affected by the regional rollout of Medallion 4.0 from Medallion 3.0, which started 8/1/18 and ended 12/1/18. The transition to Medallion 4.0 included newly carved-in services and populations. Like CCC Plus, Medallion 4.0 carved in community mental health services, EI services, consumer- directed personal care, and TPL members.

Additionally, the Medallion 4.0 contracts were re-procured, changing the participating MCOs in the program. A brand new MCO entered into Medallion, and another new MCO acquired an existing Medallion 3.0 MCO, merging businesses alongside the regional rollout. In 2018, one Medallion 3.0 MCO exited the Medicaid business in Virginia. Due to these changes, some members underwent reassignment of their MCO during the transition to Medallion 4.0.

Rate Impacts

Due to these changes, two MCOs were not able to report aggregate Medallion 4.0 and CCC Plus rates for CY2018, resulting in an overweight for more acute populations in CCC Plus in the overall Virginia rates. Additionally, the loss of an MCO during 2018 meant that those rates were not included in the Virginia rate calculations for the year.

Medallion 4.0 and HEDIS® Performance

For SFY2019, DMAS deemed improvement in 29 Medicaid HEDIS® performance measures as a priority for Medallion 4.0. The MCOs are expected to assure annual improvement in these measures if they are performing below the 50th percentile nationally, sustain performance in or above the 50th percentile and set goals to perform in the 75th percentile. During HEDIS® year 2019 MCOs aligned with the National Committee for Quality Assurance (NCQA) requirements, by not rotating any HEDIS® measures.

Five (5) Medallion 4.0 priority HEDIS® measures improved from HEDIS® year 2018 to 2019:

HEDIS® Year 2019 Measures with Rate Increase
Antidepressant Medication Management- Effective Acute Phase Treatment
Antidepressant Medication Management- Effective Continuation Phase Treatment
Medication Management for People with Asthma- Medication Compliance 75% (Total)
Adult Survey - Flu Vaccinations for Adults Ages 18-64
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Total)

Of note, these rates are combined between both Medallion 4.0 and CCC Plus to create an aggregate Virginia rate for CY2018.

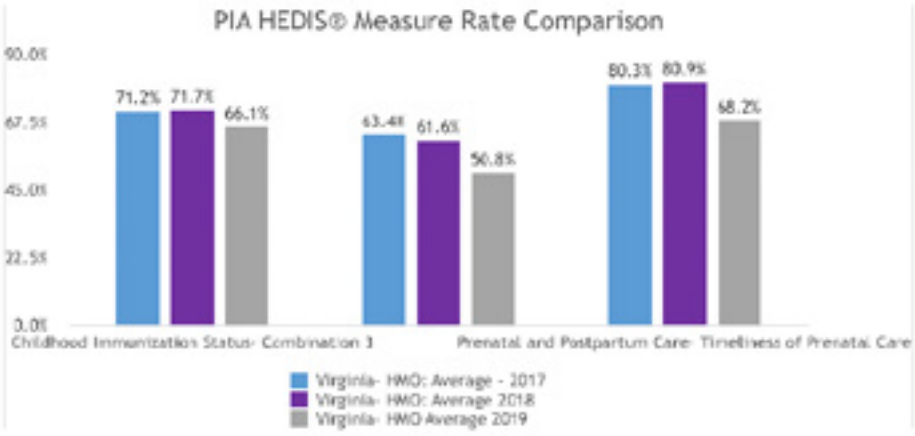
CCC Plus and HEDIS® Performance

SFY2019 marks the first full year of HEDIS® reporting for the CCC Plus program. The CCC Plus contract outlines several HEDIS® measures as Key Performance Indicators for the MCOs. The MCOs must have internal reporting data quality review and compliance process in place for the measures, as well as any standards required for NCQA Accreditation. As this is the first full year of reporting, DMAS does not have any benchmarks to note performance improvement for SFY2019.

Medallion 4.0 and the Performance Incentive Award (PIA)

In alignment with goals and objectives of managed care quality improvement in Virginia, the PIA program was created to improve health outcomes for members in the FAMIS and Medallion 4.0 populations as well as to promote and incentivize MCOs' high performance on six measures representing two measurement domains. For the first domain, administrative measures, DMAS selected the following administrative measures, assessments of Foster Care Population, MCO Claims Processing, Monthly Reporting Timeliness and Accuracy, and the following HEDIS® measures:

1. Child Immunization Status—Combination 3
2. Controlling High Blood Pressure* (*significant change in definition in HEDIS® 2019)
3. Prenatal and Postpartum Care—Timeliness of Prenatal Care



HSAG calculated and finalized PIA results for all six MCOs in Virginia in December 2019. Because this was the first full year of Medallion 4.0 and the last year for the PIA, the reporting year had no financial penalties assessed. Starting in SFY 2020, Medallion 4.0 will establish a Performance Withhold Program to align with the program that began with CCC Plus in 2018 as outlined in the next section.

Value Based Purchasing (VBP)

Value Based Purchasing is a broad term that describes policies and strategies that reward strong performance and improvement. VBP policies use financial and non-monetary incentives to improve quality and health outcomes, rewarding plans and providers for the provision of high-quality, efficient care to Medicaid Members. Measurement is based on a set of defined outcome metrics of quality, cost, and patient-centered care.

Both CCC Plus and Medallion 4.0 require the contracted MCOs to establish a VBP strategy that follows the Alternative Payment Model (APM) framework developed by the Health Care Payment Learning and Action Network (HCP-LAN) with special emphasis on categories 3 and 4. The contracts also require each MCO to submit additional details on the types of VBP arrangements they have in place with providers.

Performance Withhold Programs

As part of an effort to align with DMAS VBP initiatives, both CCC Plus and Medallion 4.0 are implementing performance withhold programs (PWP). Under the PWPs, MCOs earn 1% of their capitation rates based on performance against designated measures representing key areas for each program's member population (e.g. follow-up after an emergency room visit for select conditions). MCOs can earn back all or a portion of their 1% capitation withhold based on strong performance and improvement in these areas.

Beginning in SFY 2020, DMAS established a Performance Withhold Program (PWP) under the Medallion program. The PWP program is an evolution for the Medallion Performance Incentive Award Program (PIA). Similar to the PIA, the PWP will include measures designed to evaluate managed care quality by setting performance standards and expectations driven by member health. To date, the PWP has replaced what was formerly the PIA program.

Quality Next Steps

DMAS is working to provide updated technical specifications to ensure timely and accurate data reporting, as well as working collaboratively with the MCOs to ensure monitoring of HEDIS® and other quality measures. DMAS is also working to enhance internal data analytic capabilities and monitoring of MCO performace across both managed care programs in the Enterprise Data Warehouse System (EDWS), the agency's data warehouse. While CY2018 brought significant operational changes to managed care in Virginia, HEDIS® reporting moving into CY2019 should not face the same level of challenges.

Performance Improvement Projects (PIPs)

Annually, the MCOs must perform at least one clinical and one non-clinical PIP. The focus areas of each include the following:

2019 CCC Plus PIP Projects: Ambulatory Care Emergency Department Visits (clinical) and Follow-Up After Hospital Discharge (nonclinial)

2019 Medallion 4.0 PIP Projects: Timeliness of Prenatal Care - Subpopulation, Race, Ethnicity, Geographic Area (clinical) and Tobacco Cessation in Pregnant Women (non-clinical)

Network Accessibility and Availability

DMAS holds the MCOs in both managed care programs to time and distance standards for the network providers to ensure members have access to care within a reasonable radius for the members. DMAS monitors the MCOs in both programs by requiring regular submission of provider network files from each MCO and the files are reviewed and analyzed to monitor member accessibility and provide oversight for any potential access issues.

MCOs are required to provide members with the services they need within the travel time and distance standards described in the table below. These standards apply for services that members travel to receive from network providers. These standards do not apply to providers who provide services to members at home.

Standard	Distance	Time
• PCPs • Other Providers including Specialists	15 Miles 30 Miles	30 Minutes 45 Minutes
Rural • PCPs • Other Providers including Specialists	30 Miles 60 Miles	45 Minutes 75 Minutes
Standards for Roanoke/Alleghany & Southwest Regions (CCC Plus Only)		
Urban and Rural • PCPs • Other Providers including Specialists	30 Miles 60 Miles	45 Minutes 75 Minutes

GRIEVANCES AND APPEALS

DMAS' Appeals Division receives fair hearing requests from Medicaid enrollees who receive coverage through managed care operations and those who receive coverage through fee-for-service operations. It also receives fair hearing requests from Medicaid providers.

Member State Fair Hearings

Medicaid enrollees and applicants can request a State Fair Hearing to appeal a denial or termination of Medicaid coverage, or a full or partial denial of a requested Medicaid service. In SFY2019, the Appeals Division received 9,382 requests for State Fair Hearings, 442 from MCO decisions. As far as provider appeals, in SFY19 3,790 appeals were received, of which 579 were from MCO decisions.

MCO-Specific Appeals

As part of the State Fair Hearing process, Medicaid recipients who receive coverage through managed care may appeal full or partial service denials rendered by participating MCOs. As a response to the COVID-19 PHE, DMAS received approval for an 1115 waiver that allowed the department to provide flexibilities related to these appeals. Deadlines were extended for members and applicants to file Medicaid appeals. These appeals were processed as long as the Medicaid member or applicant gave appropriate verbal authorization of legal representation even if the paperwork for the appointment of representation was incomplete.

Grievances

Medicaid enrollees who receive coverage through managed care may file a grievance with their MCO when they are dissatisfied with any aspect of their Medicaid coverage other than an adverse benefit determination (which would go through the appeal process described above). Possible subjects of grievances include (but are not limited to) quality of care or services provided, aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the member's rights. The MCOs are required to track trends in grievances and incorporate that information into the quality improvement process and follow all relevant state and federal regulations.

ENCOUNTER DATA PROCESSING

The Encounter Data Processing System (EPS) was the first module to become operational as part of a larger DMAS system upgrade, known as the DMAS Medicaid Enterprise System (MES). As other modules of the Medical Enterprise System become operational, validated encounters will be stored in the Enterprise Data Warehouse. The upgrade of the DMAS encounter system is part of a larger, agency-wide commitment to improving data quality and ensuring all data are timely, accurate, and complete.

When an MCO transmits encounter files to the EPS system, it undergoes the following six tep rigorous process. Refer to next page.

1. When the MCO transmits encounter files to the EPS, the system checks to make sure that the data is in the exact format needed for further processing.
2. The system then performs four levels of compliance checks, including a check to ensure that the data meets HIPAA mandated electronic transaction standards, and automatically accepts, rejects, or partially rejects the submitted files.
3. Rejected files are reported to the MCO to correct and re-submit. Accepted files then move to the next stage, where they are inspected by the DMAS Business Rules Engine (BRE), which checks each file to ensure that the encounter meets DMAS business requirements.
4. The business rules are important for validating the type of encounter submitted and the business rules the files are subjected to are specific to the Medallion or CCC Plus programs.
5. After being validated using the BRE, files either receive a pass or fail status. Failed encounters are reported to the MCO to be corrected by the submitter. Once an encounter has been completely validated, it is stored in a database for future use by other areas of DMAS.
6. DMAS holds the MCOs to stringent data submission standards, which are further outlined in each program's contract. If an MCO fails to submit timely, accurate, or complete data, including encounter data, it can be subject to compliance actions, as outlined in the next section.

COMPLIANCE

Both CCC Plus and Medallion 4.0 utilize an ongoing Compliance Monitoring Process to detect and respond to issues of non-compliance and 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 will roll over from previous contract years, any points that are more than twelve (12) months old will expire and no longer be counted. CCC Plus and Medallion 4.0 assess progressive sanctions on a monthly basis based on two different tiered point systems.

CCC Plus

Progressive sanctions will be based on the number of points accumulated at the time of the most recent compliance violation or incident. Compliance violations are at the Department's discretion based on some key factors. These include the severity of the incident, the likelihood of incident recurrence, and the totality of circumstances surrounding the incident. Financial sanctions are imposed per infraction type. A Corrective Action Plan (CAP) may also be imposed in addtion to the fines listed below. These values are specific to the CCC Plus program:

Level	Point Range	Corrective Mechanism	Financial Sanctions/Fines
1	1-15	See 18.2.3	$ 1,000
2	16-25	See 18.2.3	$ 5,000
3	26-50	See 18.2.3	$10,000
4	51-70	See 18.2.3	$20,000
5	71-100	See 18.2.3	$30,000
6	101-150	Suspend Enrollment	N/A
7	> 150	Possible Termination	N/A

Medallion 4.0

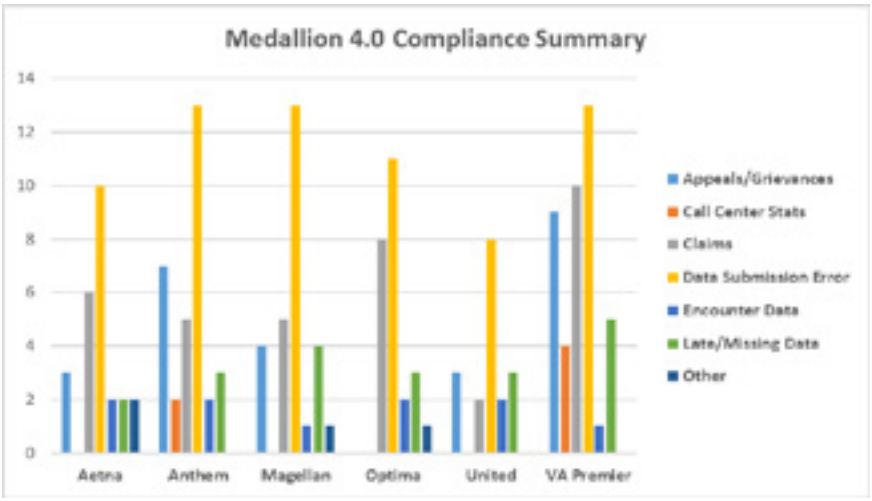
Progressive sanctions will be based on the number of points accumulated at the time of the most recent compliance violation or incident. Compliance violations are at the Department's discretion based on some key factors. These include the severity of the incident, the likelihood of incident recurrence, and the totality of circumstances surrounding the incident. Financial sanctions are imposed per infraction type. A Corrective Action Plan (CAP) may also be imposed in addtion to the fines listed below. These values are specific to the Medallion 4.0 program:

Level	**Point Range**	**Corrective Mechanism**	**Financial Sanctions/Fines**
1	0-10	See 10.1.E	None
2	11-25	See 10.1.E	$5,000
3	26-50	See 10.1.E	$10,000
4	51-70	See 10.1.E	$20,000
5	71-100	See 10.1.E	$30,000
6	101-150	Suspend Enrollment	N/A
7	> 150	Possible Agreement Termination	N/A
Other	Specific Pre-Determined Sanctions	See Section 10.1.E.d, as the situation requires.	See Section 10.1.E.d.

Medallion 4.0 Compliance Summary

Since the Medallion 4.0 contract became active in August of 2018, Medallion 4.0 MCOs have been issued compliance enforcement actions in various areas. Below is a summary of enforcement actions taken during SFY 2020 (07/01/2019 - 06/30/2020).

Over the course of the year, the Medallion 4.0 compliance team investigated close to 200 instances of potential contract non-compliance. This is an increase from the previous year of 83 instances of potential contract non-compliance. Completed investigations led to the issuance of 49 compliance points, resulting in up to $90,000 in financial sanctions, and 170 compliance enforcement letters. In the fall of 2019, the Medallion 4.0 compliance team also completed site visits with the Medallion 4.0 MCOs for a review of the annual HSAG audit. The Medallion 4.0 compliance team will continue to monitor the health plans for incidences of contract non-compliance, and will expand areas of monitoring to include Pharmacy Prior Authorizations and CMHRS Service Authorizations.



PROGRAM INTEGRITY (PI)

The DMAS Program Integrity Division provides oversight of our managed care partners through audits of MCO providers and onsite reviews of the MCOs' program integrity activities. Such activities include providing guidance and clarification to MCO partners, collaborating around known program vulnerabilities, and auditing MCOs to ensure compliance with policy.

Managed Care Collaborative meetings provide both MCOs and DMAS the opportunity to share information regarding program integrity issues. These quarterly meetings 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.

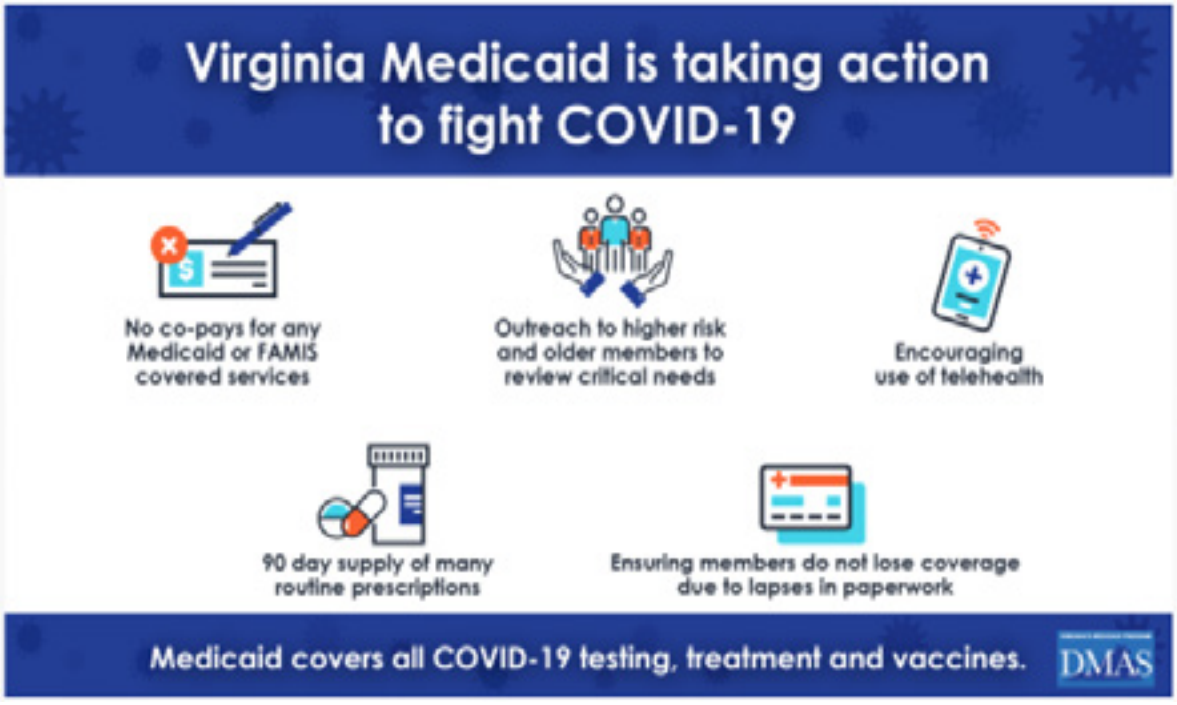
Key PI Accomplishments

The Program Integrity Unit implemented the Fraud and Abuse Detection System (FADS) from Optum. This software mines provider, member and claims data for potential fraud, waste and abuse, provides research tools, and tracks subsequent investigation activity. FADS also contains a case tracking system.

COVID-19 PUBLIC HEALTH EMERGENCY

The Virginia Department of Medical Assistance Services responded rapidly to the COVID-19 health care emergency by initiating a series of policy changes that ensured members had access to care and providers had the supports they needed during the PHE. These policies included protections to ensure that no Medicaid member lost coverage during the health emergency and the elimination of co-payments on all Medicaid and FAMIS covered services. The Department also implemented strategies, including retainer payments and staffing flexibilities, to support health care providers, who were critical to the Commonwealth's ability to recover from the crisis.

With devastating health and economic impacts, the COVID-19 pandemic presented a multifaceted challenge to the Commonwealth, and one that the Virginia Medicaid agency was uniquely positioned to address. In the early days of the crisis, DMAS acted swiftly to develop and implement policies that strengthened access to care for 1.7 million members. The agency announced that no Medicaid member would lose coverage during the health emergency due to lapses in paperwork. Outreach initiatives reassured members that they had access to no-cost testing and treatment for COVID-19 to help address the spread of the novel coronavirus. The agency simultaneously ramped up capacity in preparation for increased enrollment volume as tens of thousands of Virginians who had lost their jobs and health insurance sought Medicaid coverage. Recognizing that a sustainable network of providers is crucial to preserving access to care for members, DMAS launched a series of initiatives to offer targeted funding for key community-based services and greater flexibility in addressing staffing needs. The agency continued to work closely with the Centers for Medicare and Medicaid Services (CMS) to secure increased federal funding to support members, providers, and the Commonwealth.



Regulatory Waivers for the VA Medicaid and FAMIS Programs

On May 20, 2020, DMAS announced that it had received federal approval for an emergency 1135 waiver giving the Department the authority to take additional steps to ensure access to care for members and to address priority needs identified by health care providers.

The waiver allowed Virginia to streamline the process for health care providers to enroll in the Medicaid program and receive reimbursement for services to members. New staffing flexibilities granted under the waiver supported access to home health and hospice aides.

The emergency waiver completed the approval process for a new policy announced in March of 2020 that allowed Medicaid members to receive many critical health services and medical devices without waiting for authorization from the Department or managed care health plans. The policy automatically extended some existing authorizations to prevent interruptions in medical services. These flexibilities are outlined below:

Support for Medicaid Members

Access to Services
•No pre-approvals required for many critical medical services and devices, and some existing approvals were automatically extended.
•Some rehabilitative services were permitted to be provided via telehealth.

Access to Long-term Services and Supports
•Individuals who chose to move to a nursing facility directly from a hospital were allowed to be accepted without a long-term services and supports screening.

Access to Appeals and Fair Hearings
•Deadlines were extended for members and applicants to file Medicaid appeals.
•Appeals were processed as long as the Medicaid member or applicant gave appropriate verbal authorization of legal representation even if the paperwork for the appointment of representation was incomplete.

Support for Medicaid Providers

Staffing and Other Flexibilities for Long-term Services and Supports
•Home health and hospice aides were permitted to provide services without in-person supervision by a registered nurse every two weeks (telephonic supervision was encouraged).

Streamlined Enrollment and Screening
•Provider enrollment requirements were streamlined.
•Site visits, application fees and certain background checks were waived to temporarily enroll providers in the Medicaid program.
•Deadlines for revalidations of providers were postponed.
•Out-of-state providers were permitted to be reimbursed for services to Medicaid members.

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION • QUALITY • VALUE

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES CENTER FOR MEDICAID & CHIP SERVICES

HEALTH PLAN INITIATIVES

Virginia Medicaid's participating health plans played a large role in supporting their members throughout the COVID-19 PHE. Below are just a few ways that the MCOs were able to provide additional aid to members.

Aetna

aetna™

Aetna Better Health® of Virginia

•Aetna awarded $40,000 to Health Wagon, a mobile medical unit based in far Southwest Virginia, to help bolster their telemedicine capabilities during the COVID-19 pandemic.
•Aetna allocated $25,000 to the Federation of Virginia Foodbanks to assist food insecurity efforts during the COVID-19 pandemic.
•Aetna Better Health of Virginia contributions to community development and social determinants of health funding include more than $356,000 in SFY2020 to organizations such as Feeding America, Virginia Association of Free and Charitable Clinics, Virginia Institute of Autism, Special Olympics, ReadyKids, Virginia Summit on Childhood Trauma, National Alliance on Mental Illness, and the Richmond Behavioral Health Foundation et al.
•Aetna made a $10,000 Personal Protective Equipment donation to the Virginia Association of Free and Charitable Clinics which allowed the health clinics to test for COVID-19 in the community while providing safety to their dedicated volunteers and staff.

Anthem

Anthem. HealthKeepers Plus
Offered by HealthKeepers, Inc.

•Anthem delivered 200 care packages across VA to over 100 different providers amounting to 20,000 KN95 masks being donated.
•Anthem partnered with GA Foods to allocate meals for 1,500 of our most insecure LTSS members.
•Anthem is distributing 200 Chromebooks Laptops to older members enrolled in our Foster Care Program to help with school work during COVID related challenges.
•Anthem was awarded the 2020 NCQA Innovation Award for their Behavioral Health Home model program that focused on closing disease-specific gaps in care for persons with co-occurring behavioral health and chronic health conditions.

Magellan (*Now Molina*)

•Magellan partnered with other community resources to have groceries delivered to mem ber's homes during the COVID-19 pandemic.
•Magellan approved non-medical transportation trips for members to ensure they had the ability to get to grocery stores or pharmacies in order to pick up needed food and/or medications.
•Magellan initiated a collaborative management approach one of their largest health centers in the central region for their mutual members living with sickle cell disease. Multidisciplinary care teams and health plan staff met with participating members monthly in order to develop a management plan for their condition. This program has been replicated by other MCOs due

Optima

•Optima, Unite Us, and United Way of South Hampton Roads deployed a technology partner ship within a coordinated care network to address social determinants of health.
•Optima provided grants to community and faith-based organizations to support outreach programs for members during the COVID-19 pandemic. Examples include the Lynch- burg Community Action Group, God's Pit Crew, and Health Wagon Mobile Clinic.
•Optima transformed their in-person regional baby showers into statewide virtual events. This was an opportunity to educate and inform pregnant members on what to expect while delivering a baby in the COVID-19 pandemic.

United

•United accelerated payments and other financial support to health care providers on the front lines battling COVID-19. This helped address the financial challenges caused by COVID-19 so care provider partners could focus on delivering needed care.
•United provided meals to front line provider staff at offices throughout the Commonwealth to show our gratitude for their tireless service to our members and our communities.
•United Health Foundation donated funds to provide urgent support for people experiencing homelessness and food insecurity facing unprecedented hardships during the COVID-19 pandemic. United Community Plan of Virginia provided home-delivered food boxes with 14 meals to 100+ of our Dual Special Needs members facing food insecurity.
•United's FQHC Transformation Investment Program provided over $230K to invest in building care capacity for Virginia Medicaid members and the communities we mutually serve.

Virginia Premier

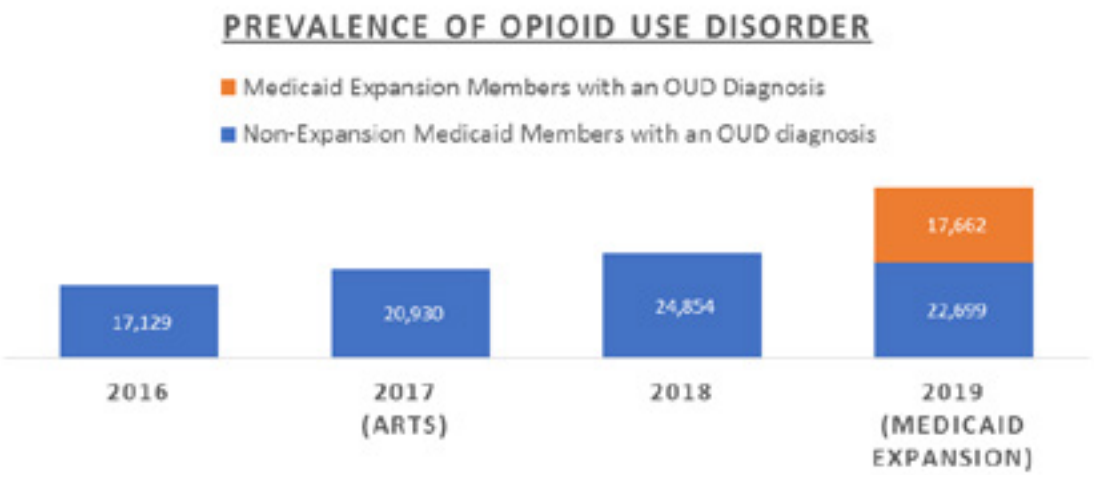
Virginia Premier:

•VA Premier ensured their providers had minimal impacts to their practices during the COVID-19 pandemic with initiatives such as effective and timely communication, reporting and claims oversight, modifications to authorization requirements, timely filing extensions, execution of SNF payments, and evaluating other retention payments to assist with the financial impacts to the provider community.
•VA Premier established virtual provider visits and population health events to maintain open communication and continue to close care gaps and provided needed care.
•VA Premier facilitated approval and delivery for blood pressure monitors for telehealth visits.
•VA Premier extended the GA food benefit for MLTSS to 30 days and offered mail order pharmacy benefit to ensure 30 day supply of prescriptions.

BEHAVIORAL HEALTH

Virginia Medicaid provides an array of mental health and addiction and recovery treatment services through Managed Care Organizations (MCOs) (through CCC Plus and Medallion 4.0), and through the Behavioral Health Services Administrator, which are contracted by DMAS.

Addiction and Recovery Treatment Services
To increase access to and quality of treatment and recovery services for Medicaid members with substance use disorders (SUD), Virginia implemented the ARTS benefit in April 2017. On January 1, 2019, Virginia expanded Medicaid eligibility for adults with family incomes up to 138 percent of the federal poverty level, thereby increasing access to ARTS services and other Medicaid benefits to more low-income Virginians. There were 46,500 members who participated in ARTS services in 2019, a 79 percent increase from 2018. The largest increases were in member participation with Preferred Office-Based Opioid Treatment (OBOT) providers, Outpatient Treatment Providers (OTPs), care coordination services at OBOT and OTP providers, and SUD residential treatment centers. More than 23,000 members participated in Medications for Opioid Use Disorder (MOUD) treatment in 2019, more than double the number participating in MOUD treatment in 2018. Members newly enrolled through Medicaid expansion account for most of the increase.



Community Mental Health Rehabilitation Services (CMHRS)
The managed care organizations began covering the Community Mental Health Rehabilitation Services (CMHRS) in 2018. The contractors are responsible for meeting the CMHRS network adequacy standards and implementing all CMHRS requirements, provider training goals and targeted programmatic improvements as directed by DMAS.

Over the last two years, the Managed Care Organizations have engaged in collaborative efforts to support and assist with the planning for implementation of Behavioral Health Enhancement (BHE). BHE is a strategic and progressive effort to build a full continuum of evidence-based, trauma-informed person-centered and prevention-oriented care that focuses on bolstering resiliency and recovery for our members.

ADDITIONAL MLTSS INFORMATION

CCC Plus, as Virginia Medicaid's managed long-term services and supports (MLTSS) program, serves Medicaid members with complex needs. As such, additional focus areas for delivery of the CCC Plus program include, but are not limited to, the following:

- Continuity of care: MCOs are required to pay for members to see existing health care providers (even those that were out of network) and to maintain existing services for 90 days or until the health risk assessment was completed.
- Service authorizations: Streamlined authorization processes exist across all six CCC Plus health plans to minimize disruption of care of the members.
- Care coordination: MCOs assign Care Coordinators to help members with complex needs and their caregivers navigate care.
- Health Risk Assessments: Identifies health needs, services and gaps in care.

SUMMARY

The managed care programs offered by DMAS continued to be improved and refined in state fiscal year 2020. Medallion 4.0 continued the program's twenty plus year history of high quality care and focus on innovation, and now access to care for most of the adult Medicaid Expansion population. CCC Plus continues to strengthen its integrated delivery model and person-centered program design for members with complex healthcare needs. DMAS is committed to promoting high quality and cost-effective care for Virginians, advancing value-based payment practices, and facilitating delivery system reform. Managed care program oversight and accountability is central to realizing these initiatives, and DMAS' stewardship of the CCC Plus and Medallion 4.0 programs continues to strengthen and grow.