Virginia Medicaid Managed Care Operational Report

July 1, 2020 - June 30, 2021

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 State Fiscal Year (SFY) 2021. 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.

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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 Commonwealth's Medicaid MCOs. Medicaid provides health care financing for over 1.5 million low-income and medically vulnerable Virginians, and in SFY 2021 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 560,000 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.
- Vaccine rollout to Medicaid members beginning December 2020.
- Increased usage of telehealth by members and providers.
- Continued DMAS and MCO operations in a work-from-home model.
- Preparations to implement six high quality, high intensity and evidence-based behavioral health services as part of interagency partnership for project BRAVO (Behavioral Health Redesign for Access, Value, & Outcomes)
- Initiated efforts to consolidate managed care programs to Cardinal Care Managed Care program to go live in SFY23

MEDICAID MANAGED CARE 2020-2021

Managed care is a service delivery model where contracted private health plans coordinate care to fulfil member needs and control costs through full-risk, capitated agreements. In SFY2021, 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, over 90% of Medicaid enrollees received their benefits through a managed care organization. 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 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: Aetna Better Health of Virginia, Anthem HealthKeepers, Molina Healthcare, Inc., Optima Health, United Healthcare, and Virginia Premier. Molina Healthcare, Inc. acquired the Magellan Complete Care line of business of Magellan Health, Inc. on December 31, 2020. This change will take full effect on July 1, 2021. Members will not lose any coverage options.

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. The current program, 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, children and youth with special health care needs, and Medicaid expansion adults. During the COVID-19 pandemic, many new Medicaid members joined under Medallion 4.0, and the below numbers reflect their continued enrollment pursuant to the public health emergency rules.

Medallion 4.0 Overview

76%
of Medicaid & FAMIS enrollees in program

1,402,972
Medallion 4.0 members as of July 1, 2021

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

15%
of Medicaid & FAMIS enrollees in program

274,328
CCC Plus members as of July 1, 2021

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

MEDICAID EXPANSION

Medicaid expansion continues in the commonwealth 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:

New Health Coverage for Adults

Reporting Period
July 1, 2021

Program
All

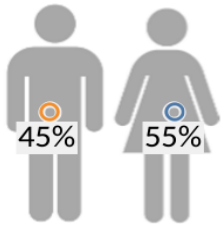
Health Plan
All

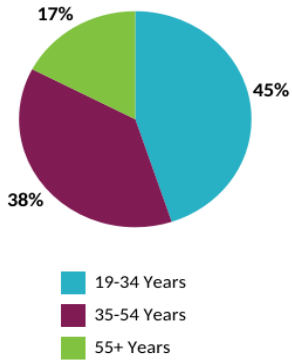
Overall Enrollment

562,530 adults newly enrolled in Medicaid

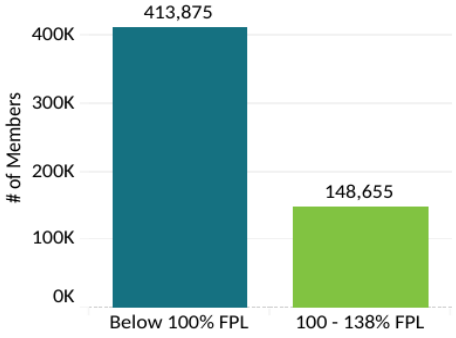
144,140 newly enrolled adults are parents

Gender and Age



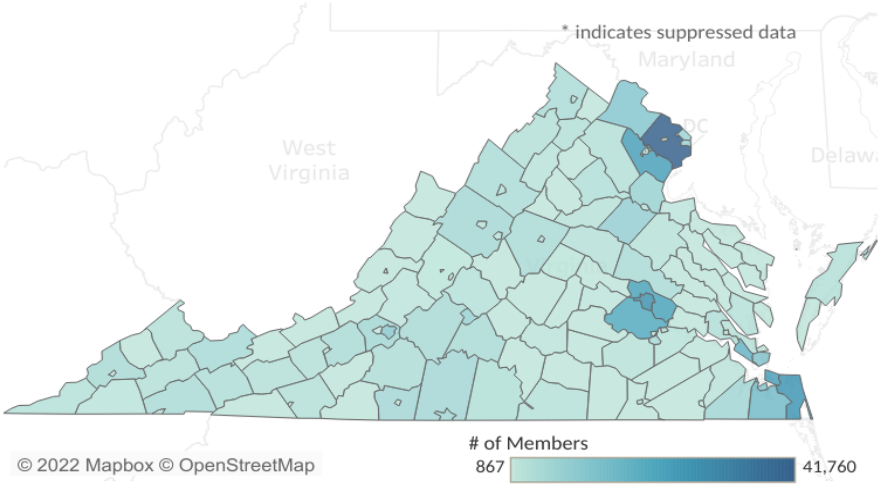


Family Income



The federal poverty level is $12,140 annually for a single person or $20,780 annually for a family of 3.

Locality of Residence



Medicaid Region

Central Region	146,967
Charlottesville Western Region	70,530
Northern & Winchester Region	118,351
Roanoke/Alleghany Region	56,868
Southwest Region	40,491
Tidewater Region	129,323
Grand Total	562,530

* indicates suppressed data

MANAGED CARE BENEFITS

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

- Addiction Recovery and Treatment Services (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.

Details about each program's current benefits can be found on their respective DMAS websites:

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

CCC Plus
Commonwealth Coordinated Care Plus

MEDALLION 4.0
Growing Strong

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 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 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

Molina
https://www.molinahealthcare.com/members/va/en-us/mem/medicaid/medicaid.aspx

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

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

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

CHANGES TO MANAGED CARE

In SFY2021, there were a number of changes approved in our managed care contracts. Effective July 1, 2020, 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. Allowing qualified nursing facility staff to complete LTSS screenings for individuals who apply for or request LTSS and who are receiving non-Medicaid skilled nursing services in an institutional setting following discharge from an acute care hospital.
2. Requiring MCOs to prohibit spread pricing in their pharmacy benefit manager (PBM) contracts. Medicaid PBMs must use pass-through pricing that more accurately reflects their administrative costs.
3. Broadening the definition of "telehealth" to account for new technologies and requiring MCOs to provide telemedicine and telehealth services regardless of the originating site and regardless of whether the member is accompanied by a provider at the time of service.
4. Requiring MCOs to adhere to NCQA standards for service authorizations and report on their compliance thereto.
5. Providing electronic visit verification (EVV) flexibility to live-in attendants.
6. Allowing reimbursement for Medicaid-covered services delivered via audio-only equipment until the end of the Commonwealth's public health emergency.
7. Increasing case management for high-risk maternity members and collaborating with DMAS on programs addressing racial disparities in maternity care.
8. Requiring MCOs to make every reasonable attempt to ensure pregnant and postpartum members receive a screening, brief intervention, and referral to treatment for substance use.
9. Providing outreach and care coordination for members discharged from inpatient detoxification programs within seven days of discharge notice, including naloxone treatment options and associated prescription instructions.
10. Instructing the MCOs to work with DMAS on COVID-19 activities for members and providers in accordance with Department-issued guidance.

New Adult Dental

Governor Ralph Northam signed into his budget funds to provide dental services for adults enrolled in Virginia Medicaid. Despite some funding challenges due to the Covid-19 pandemic, the Virginia General Assembly allocated funds for these services in a special session in September 2020. The services emphasize oral health care to positively impact overall health and well-being.

The DAC, the agency's dental advisory committee, and several stakeholders designed an adult benefit package that went into effect July 1, 2021. 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).

DentaQuest

Smiles For Children
Improving Dental Care for Children and Adults

MATERNAL AND CHILD HEALTH (MCH)

DMAS is a key agency in providing funding for pregnant and postpartum women. Title XIX of the Medicaid State Plan provides funding to serve pregnant women with incomes up to 143 percent of the federal poverty line (FPL). The FAMIS MOMS program uses Title XXI of 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 37,000 births in 2020.

Overall Births	CY 2018		CY 2019		CY 2020	
	Number	Percent	Number	Percent	Number	Percent
Overall Births						
Total Births	34,403	100.0%	38,317	100.0%	37,316	100.0%
Multiple Gestation Births	1,248	3.6%	1,350	3.5%	1,255	3.4%
Singleton Births	33,155	96.4%	36,967	96.5%	36,061	96.6%

Baby Steps VA

DMAS is committed to providing access to comprehensive care for pregnant and postpartum women and their babies enrolled in one of Virginia Medicaid's health coverage programs. To achieve this, DMAS developed a team to support program initiatives and advance innovation in maternal and reproductive health. 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.

Newborn Enrollment

It is essential that newborns of mothers enrolled in Medicaid or FAMIS are correctly enrolled with their own Medicaid ID number to timely ensure they receive their full program benefit. To help facilitate this, in January 2020, the Managed Care Program Administration team along with the Systems and Reporting team, Office of Data Analytics, Cover Virginia and the DMAS Eligibility and Enrollment Newborn Unit worked together to devise an internal operational process called the DMAS Newborn Enrollment Enhancement- E213 LIVE Birth Report.

The teams worked to ensure that the MCOs reported all live births from enrolled mothers. The DMAS Eligibility and Enrollment Newborn Unit works to ensure that all E213s submitted by the MCOs are entered correctly and that all newborns and moms demographic information is correct. In addition, the Eligibility and Enrollment Newborn Unit works with external partners such as the Local Department of Social Services (DSS) to verify that all newborns are tied to the correct mother. The DMAS Enrollment Enhancement E213 process has maintained a 99% entry success rate.

TOTAL NEWBORNS RECEIVED MEDICAID ID FROM DMAS NEWBORN ENROLLMENT ENHANCEMENT (E213 LIVE BIRTHS REPORT PROJECT) BY FILE SENT MONTH FOR 2021									
MCO	JAN '21	FEB '21	MAR '21	APR '21	MAY '21	JUN '21	JUL '21	MCO Submitted	% Entry Success
MCO1	16	15	7	16	16	14	18	102	99.5%
MCO2	24	28	22	17	12	14	14	131	99.7%
MCO3	8	5	5	7	11	7	3	46	100%
MCO4	34	31	14	11	20	20	37	167	100%
MCO5	5	15	4	12	14	12	14	76	99.3%
MCO6	26	27	21	25	36	27	29	191	99.7%
Total	113	121	73	88	109	94	115	713	

Managed Care Births

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

	CY 2018		CY 2019		CY 2020	
Overall Births	Number	Percent	Number	Percent	Number	Percent
Medicaid Delivery System						
FFS	5,888	19.2%	3,827	11.8%	3,025	9.4%
Managed Care	24,858	80.8%	28,617	88.2%	29,205	90.6%

Doula Services Study

On December 1, 2020, DMAS, various state agencies, and stakeholders released a report from a workgroup tasked with making recommendations for a Virginia Medicaid Doula benefit. The U.S. maternal mortality rate remains elevated, and doulas have been shown to improve a variety of maternal and child health outcomes, with multiple studies indicating that doula services can be cost-effective and cost saving. Ultimately, the workgroup recommended that Virginia Medicaid provide a doula benefit through a state plan amendment. The recommended benefit provides reimbursement for eight perinatal visits and attendance at delivery and linkage-to-care incentive payments. The workgroup set suggested reimbursement rates after examining rates in other states and rates for analogous maternal health services provided by clinical providers. Virginia Medicaid will seek approval for a state plan amendment to include doula services as a preventive service under the state plan.

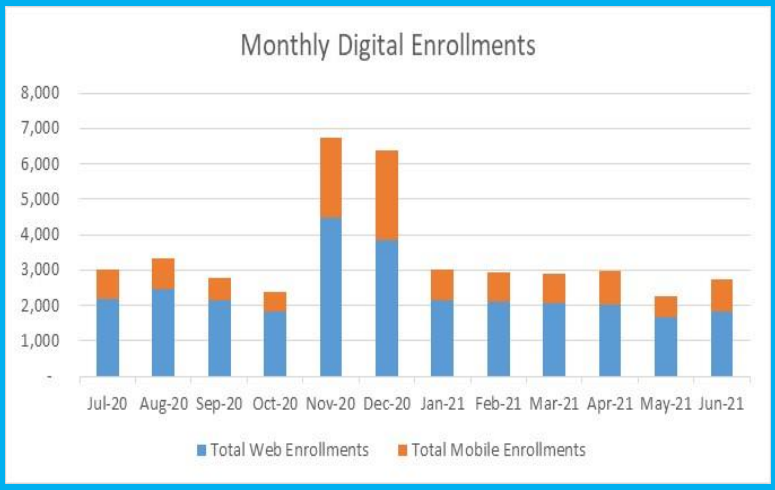
MANAGED CARE ENROLLMENT

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. See below for monthly enrollment figures by plan.

Health Plan Name	Jul 2021	Jun 2021	May 2021	Apr 2021	Mar 2021	Feb 2021	Jan 2021	Dec 2020	Nov 2020	Oct 2020	Sep
Anthem	506,015	502,195	498,698	494,772	490,009	485,957	477,770	471,600	466,827	460,900	45
Virginia Premier	329,144	327,154	325,100	323,134	320,302	317,996	313,868	310,150	307,484	304,223	30
Optima	321,316	318,773	316,286	313,377	310,207	307,422	302,336	298,004	294,890	291,385	28
Aetna	227,696	225,646	223,780	221,629	218,832	216,417	211,151	207,316	204,488	201,000	19
Fee For Service (FFS)	177,716	177,748	177,265	176,103	176,377	175,943	187,222	183,605	176,170	177,871	17
United Healthcare	176,074	173,799	171,486	169,209	166,788	165,063	161,455	158,193	156,136	153,434	15
Molina	117,055	115,773	114,612	113,484	111,807	110,730	108,998	106,654	105,170	103,293	10
Grand Total	1,855,016	1,841,088	1,827,227	1,811,708	1,794,322	1,779,528	1,762,800	1,735,522	1,711,165	1,692,106	1,67

Medallion 4.0 Member Enrollments Through Website and Smartphone Applications

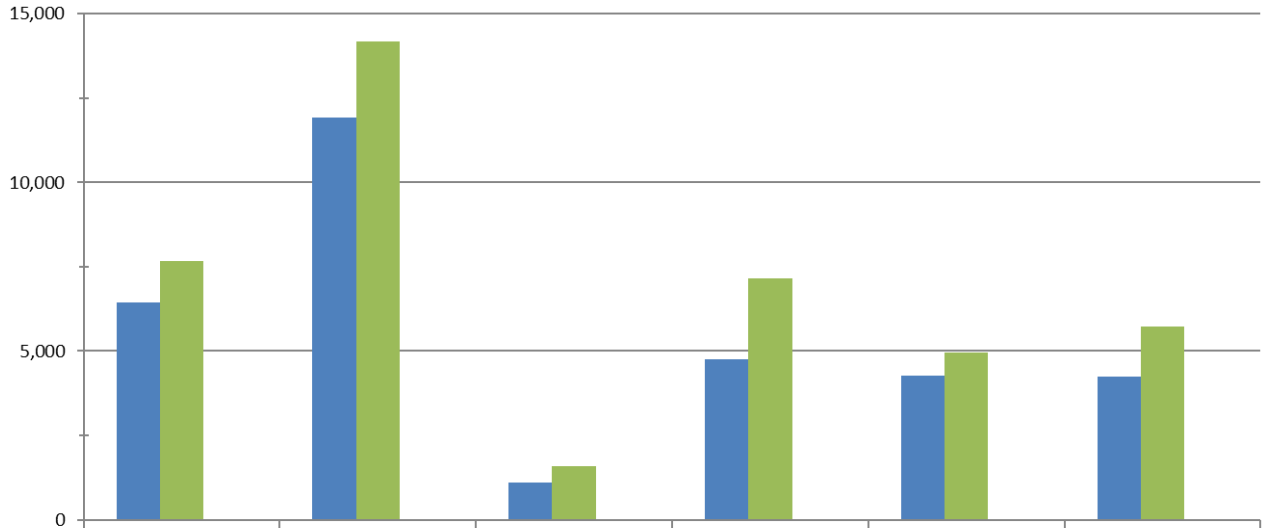
National surveys indicate that a majority of Medicaid members have smartphones and utilize their phones and phone applications for making decisions about health care choices. In response, DMAS implemented Android and Apple smartphone applications, as well as updated the website with comprehensive plan 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 of 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 74,077. There were 32,774 new enrollments and 41,303 90-day transfer enrollments.

Enrollments by Plan

Exhibit 9

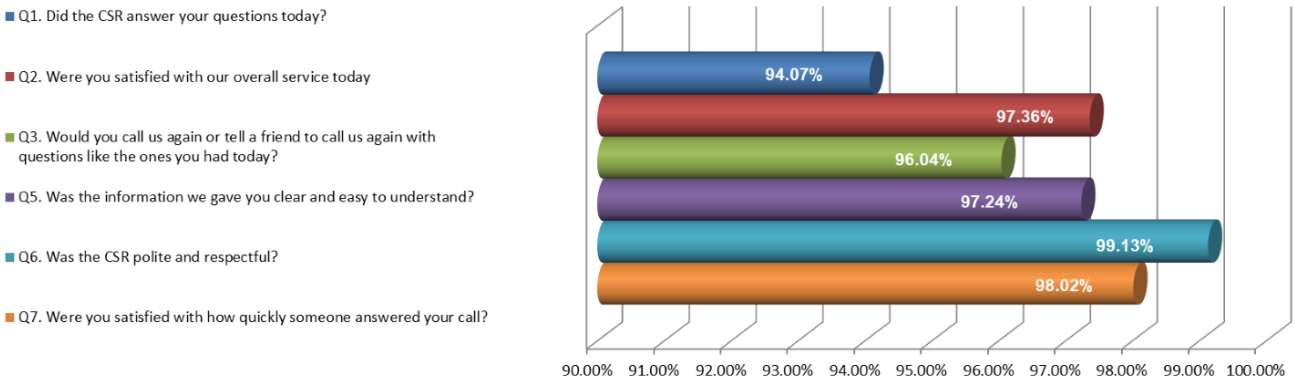


	AETNA BETTER HEALTH	HEALTHKEEPERS	MAGELLAN COMPLETE CARE OF VIRGINIA	OPTIMA HEALTH PLAN	UNITED HEALTHCARE COMMUNITY PLAN OF VA	VIRGINIA PREMIER HEALTH PLAN
New Enrollment	6,452	11,932	1,108	4,765	4,266	4,251
Transfer Enrollment	7,682	14,184	1,589	7,151	4,961	5,736
Total Enrollments	14,134	26,116	2,697	11,916	9,227	9,987

Below, the Customer Satisfaction Survey shows the percentage of favorable responses by survey question for the state's Enrollment Broker call center. Callers completed 11,550 surveys during the reporting period with overall responses 96.81% favorable.

Customer Satisfaction Survey

Exhibit 18



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 – SFY2021				
Total Calls Answered	Average Calls Handled Per Month	Highest Call Volume (Month)	Lowest Call Volume (Month)	Overall Abandonment Rate
130,153	**10,846**	**December**	**May**	**3.33%**

MCO FINANCIAL PERFORMANCE

In managed care, MCOs enter into 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 2021) 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.

In July 2020, DMAS published two new dashboards that provide details on the expenditures and financial performance of the managed care organizations (MCOs) that serve the vast majority of Medicaid members. The MCO expenditure dashboard breaks down Virginia Medicaid expenditures by program as well as service category to help identify sectors and services that drive spending. The MCO financials dashboard shows the operating margins, administrative expenses and medical loss ratios for the two Medicaid managed care programs as well as for each of the six MCOs to show what those companies spend on Medicaid members and how they perform as organizations.

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 are charts summarizing MLR by plan and by program (Medallion 4.0 and CCC Plus).

Aggregate (both Medallion 4.0 & CCC Plus

Aggregate MCO Financial Performance Summary SFY2021						
MCO	Aetna	Anthem	Molina	Optima	United	VA Premier
MLR	88.8%	82.8%	84.6%	88.5%	86.5%	85.8%
Net: Gain or Loss	Gain	Gain	Gain	Gain	Gain	Gain

Medallion 4.0

Medallion 4.0 Financial Performance Summary SFY2021						
MCO	Aetna	Anthem	Molina	Optima	United	VA Premier
MLR: <85%	No	Yes	No	No	No	No
Net: Gain or Loss	Gain	Gain	Gain	Gain	Gain	Gain

CCC Plus

CCC Plus Financial Performance Summary SFY2021						
MCO	Aetna	Anthem	Molina	Optima	United	VA Premier
MLR: <85%	No	Yes	Yes	No	Yes	No
Net: Gain or Loss	Gain	Gain	Gain	Gain	Gain	Gain

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.
- Insurance policies are of high quality, understandable and 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.

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 a performance withhold program

Quality Strategy

In accordance with 42 CFR §438.340, DMAS implemented a 2020–2022 written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCOs to Virginia Medicaid and Virginia CHIP members under the Virginia Managed Care Program. The Quality Strategy provides the roadmap to accomplish its dynamic approach to achieving its overarching goal of designing, implementing, improving, and assessing the quality of healthcare and services furnished through Virginia's coordinated and comprehensive system. The Quality Strategy promotes the identification of creative initiatives to

continually monitor, assess, and improve access to care, and quality, satisfaction, and timeliness of services for Virginia Medicaid and CHIP members.

With input provided by Virginia Medicaid MCOs, internal stakeholders, sister agencies and tribal organizations (among others), DMAS identified goals and objectives for the Virginia Medicaid program across all population and product lines. Those goals are supported by performance measures (each performance measure serves as a metric) used to measure performance in achieving the goals identified in the Quality Strategy. The Quality Strategy is available on the DMAS website.

NCQA Accreditation

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).

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. NCQA will use the better of the Overall Rating score between Health Plan Ratings 2019 and Health Plan Ratings 2021, for plans with a current Accredited, Provisional and Interim status.

Clinical Efficiencies Program

Beginning in SFY 2021, DMAS established the Clinical Efficiency (CE) Program under both Medallion 4.0 and CCC Plus. Under the CE Program, MCOs earn 0.25% of their capitation rates based on performance against three metrics tracking potentially preventable, avoidable, and/or medically unnecessary emergency room visits, hospital admissions, and hospital readmissions. Each MCO receives performance improvement targets specific to its baseline performance and can earn back all, or a portion, of the CE withhold by effectively managing member care to reduce utilization on each of the measures below designated performance targets. This structure rewards those MCOs that are able to leverage their networks and care management processes to effectively and efficiently manage member care in a way that improves health and avoids negative health outcomes.

Results from the SFY 2021 Clinical Efficiency Program Level Results are available here: https://www.dmas.virginia.gov/media/4346/all-mco-sfy-2021-ce-results.pdf.

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), Health Services Advisory Group, 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 2021–2022

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*	Doctors' Communication	Getting Care	Keeping Kids Healthy	Living With Illness	Taking Care of Women
Aetna	Accredited	★★★	★★★	★★★	★★★★★	★★★★★	★
HealthKeepers	Accredited	★★★★★	★★★	★★★	★★★★★	★★★	★★★★★
Molina**	Accredited	★	★★	★★★	★	★	★
Optima	Accredited	★★★★	★★★★	★★★	★★★★	★	★★★★★
United	Accredited	★★	★★	★★	★★★★★	★★★★★	★
VA Premier	Accredited	★★★★★	★★★	★★★	★★★★	★★★★	★★★★

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

VIRGINIA MEDICAID MANAGED CARE QUALITY

CCC PLUS CONSUMER DECISION SUPPORT TOOL 2021–2022

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	Taking Care of Children	Living With Illness
Aetna	Accredited	★★★	★	★★★	★★★	★★★★	★★★★★
HealthKeepers	Accredited	★★★	★★★	★★★	★★★★	★★★★★	★★★★★
Molina**	Accredited	★	★★★	★★	★	★★	★
Optima	Accredited	★★★★	★★★★★	★★★	★★	★★★	★
United	Accredited	★★★	★★	★★★	★★★	★★	★★★★★
VA Premier	Accredited	★★★★★	★★★★	★★★★★	★★★★★	★★★	★

*This rating includes all categories, as well as how the member feels about their MCO, their MCO's customer service, and the healthcare they received.
**Formerly Magellan.

HEDIS Overview

During SFY2021, QPH developed and published a Managed Care HEDIS dashboard depicting Measurement Year (MY) 2019 to provide transparency to Virginia Medicaid members and regulatory bodies while demonstrating accountability to members. The dashboard consists of seven HEDIS categories; including access and availability of care, behavioral health, care for children and adolescents, effectiveness of care for adults, maternal and prenatal, preventive care for adults, and substance use and monitoring. Within the seven HEDIS categories there are 35 measures displayed on the dashboard. The measures are identified by using a consistent color scheme by MCO for all measures reported. Each quality measure is reported by the Managed Care Organizations and includes the state average and national 50th percentile rate. The Managed Care HEDIS dashboards is located at https://www.dmas.virginia.gov/data/managed-care-hedis-dashboards/.

The impact of the COVID-19 pandemic is demonstrated in HEDIS data starting in MY2019. On the recommendation of the data steward for HEDIS National Committee for Quality Assurance (NCQA), DMAS allowed the plans to submit the better rate of either MY2018 or MY2019 for the hybrid measures to NCQA in MY2019 due to limitations in retrieving medical charts from provider locations for the public health emergency that year. DMAS continues to evaluate rate performance changes during this time. As the pandemic continues to impact quality measure performance for the MCOs, NCQA advises caution when performing trending using the MY2019, MY2020 and MY2021 data compared to previous years.

Additional information can be located on the DMAS website: https://www.dmas.virginia.gov/media/3184/ccc-plus-2020-annual-technical-report.pdf
https://www.dmas.virginia.gov/media/3205/2020-21-external-quality-review-technical-report-medallion-40.pdf

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 operated 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.

The PWP program measures are designed to evaluate managed care quality by setting performance standards and expectations driven by member health. The PWP has replaced what was formerly the PIA program.

Quality Next Steps

The Office of Quality and Population Health is continuing its efforts 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. The Office of Quality and Population Health is also working to enhance internal data analytic capabilities and monitoring of MCO performance across both managed care programs in the Enterprise Data Warehouse System (EDWS), the agency's data warehouse, including the HEDIS dashboard..

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:

2020 CCC Plus PIP Projects: Ambulatory Care Emergency Department Visits (clinical) and Follow-Up After Hospital Discharge (non-clinical)

2020 Medallion 4.0 PIP Projects: Timeliness of Prenatal Care - Subpopulation, Race, Ethnicity, Geographic Area (clinical) and Tobacco Cessation in Pregnant Women (non-clinical)

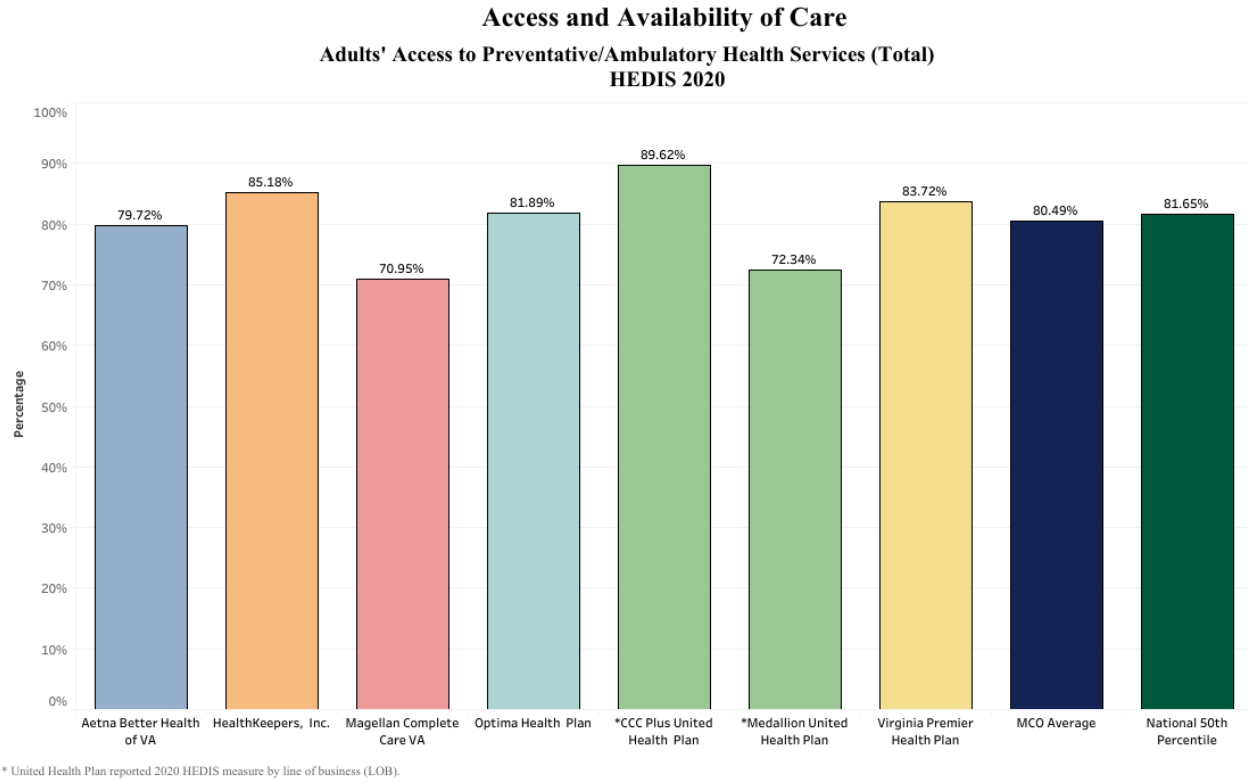
Network Accessibility and Availability

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

Virginia Medicaid is committed to working toward continuous quality improvement goals to ensure that Virginia Medicaid members have timely access to quality health care. These dashboards are an important part of our effort to demonstrate the value of managed care to the Virginia Medicaid program.



* United Health Plan reported 2020 HEDIS measure by line of business (LOB).

Measurement Definition

This HEDIS measure is the percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.

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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. For managed care members, they may do so after exhausting an MCO's internal appeals process. In SFY2021, the Appeals Division received 3,937 requests for State Fair Hearings, 370 from MCO decisions. As far as provider appeals, in SFY2021 5,822 appeals were received, of which 1,073 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. In addition, DMAS shortened the deadline for MCOs to render an appeals decision from 30 days to 14 days.

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 step rigorous process:

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 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. CCC Plus and Medallion 4.0 assess progressive sanctions on a monthly basis based on two different tiered point systems.

CCC Plus

Progressive sanctions are based on the number of points accumulated at the time of the most recent compliance violation or incident, per the CCC Plus contract with MCOs. 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 addition 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

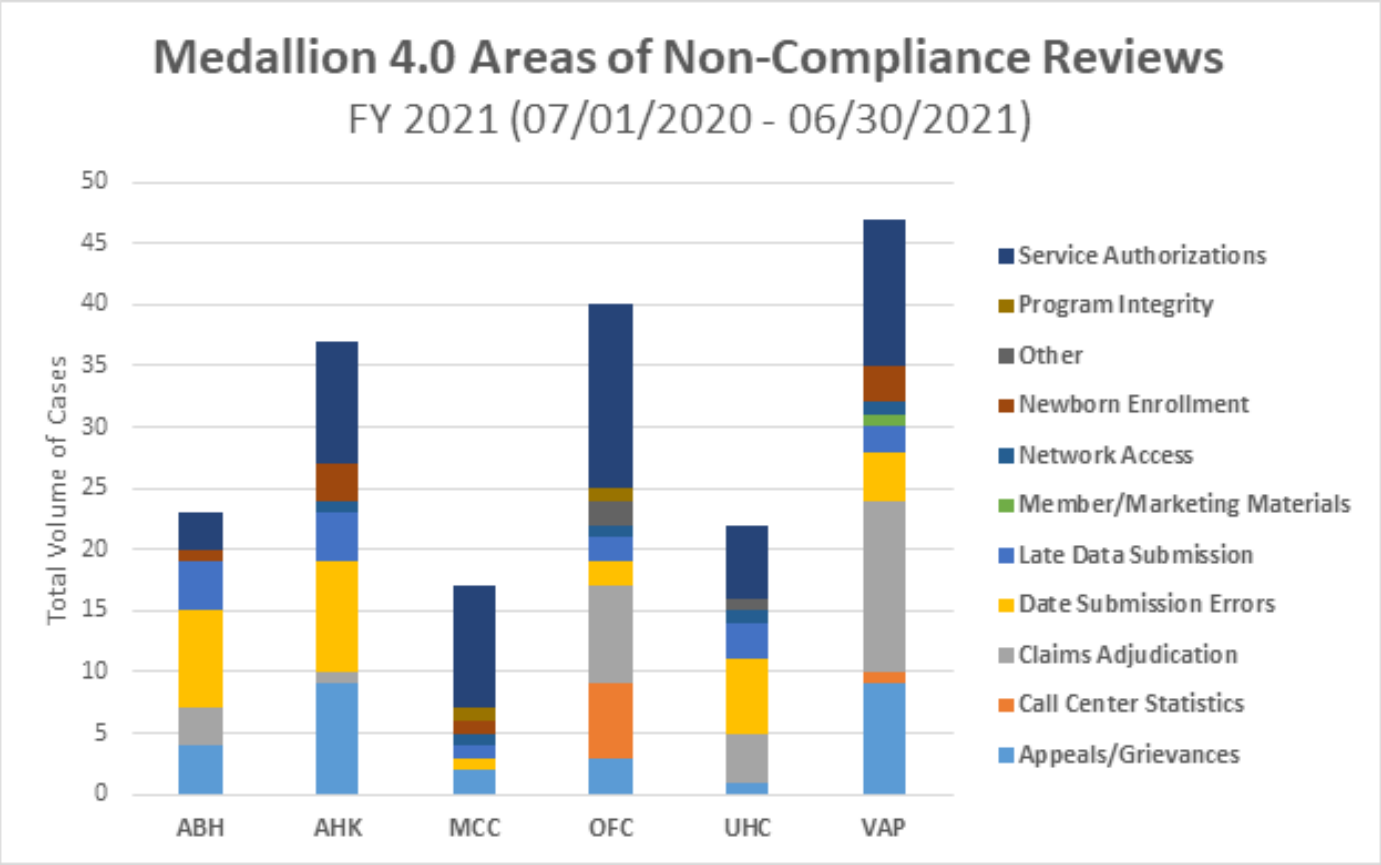
Progressive sanctions are based on the number of points accumulated at the time of the most recent compliance violation or incident, per the Medallion 4.0 contract with MCOs. Compliance violations are at the Department's discretion based on some key factors. These include the severity of the incident, the likelihood of incident recurrence, and the totality of circumstances surrounding the incident. Financial sanctions are imposed per infraction type. A CAP may also be imposed in addition 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

During SFY2021, the Health Care Services (HCS) Managed Care Compliance Unit monitored the six contracted health plan (MCOs) performance and overall compliance with the Medallion 4.0 contract. Due to the ongoing COVID-19 pandemic, and the Centers of Medicare and Medicaid Services' issued 1135 waiver flexibilities under the Social Security Act, the HCS Compliance Unit extended flexibilities in enforcement actions on the MCOs, and used its discretion to waive financial sanctions. The HCS Compliance Unit, however, continued to review, investigate, and identify over 180 instances involving non-adherence to contractual obligations, Service Level Agreements not met and potential areas of concern.

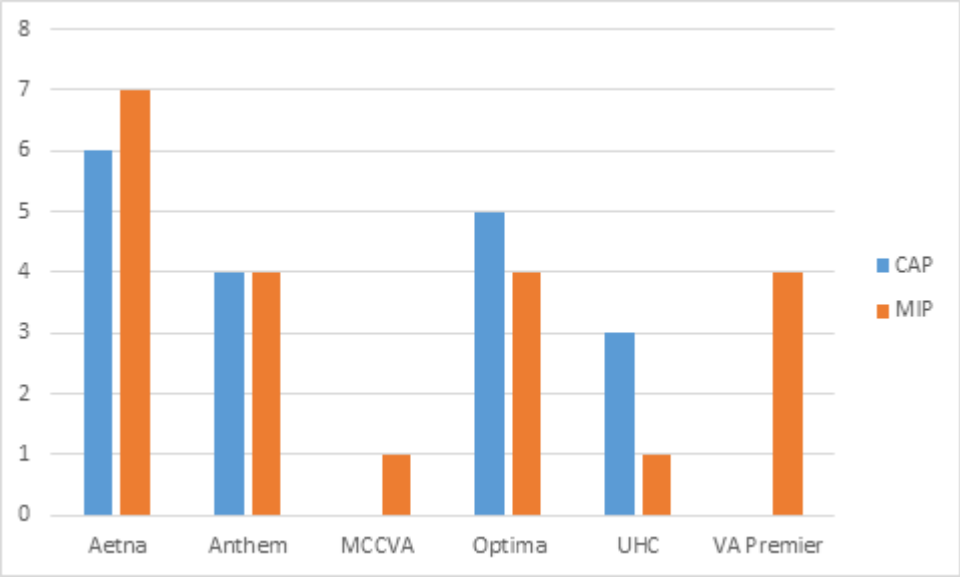
Overall, the HCS Compliance Unit addressed 162 instances of contract non-compliance, leading to the issuance of Deficiency Notifications, Notices of Non-Compliance, and Warning Letters with detailed information on all contract violations or performance metrics not met. Financial Sanctions were waived throughout the calendar year 2020 under CMS 1135 waiver flexibilities, however, the issuance of financial sanctions were reconvened on identified contract violations as of January 01, 2021. Since then, the HCS Compliance Unit's issued enforcement actions resulted in MCO capitation payment withholdings of up to $110,000 in financial sanctions.



CCC Plus Compliance Summary

In SFY2021, the CCC Plus program issued 39 compliance actions. These compliance actions included 21 Managed Care Improvement Plans (MIP) and 18 CAPs. Within CCC Plus, only a CAP results in points and sanctions. However, a MIP functions the same as a CAP in all other aspects. At the close of SFY2021, the 18 CAPs resulted in 141 points and $100,000 being withheld from the MCOs.

CCC+ SFY 21 CAP & MIP Summary



Program Integrity

Amid the chaos of a global health crisis, program integrity (PID) efforts remain vital to maintaining the financial integrity of the healthcare safety net.

DMAS Program Integrity Division (PID) staff conduct over 3,000 member and provider audits per year. Issues identified in these reviews include undisclosed member resources, illegal use/sharing of Medicaid card. Inappropriate/fraudulent provider billing and missing provider records. Investigations may result in the identification of misspent funds, administrative recoveries, or criminal prosecution. The division also conducts drug diversion reviews and joint investigations performed with various law enforcement entities (Virginia State and Local Police, Federal Bureau of Investigations, etc.), as well as the Social Security administration. In SFY 2020 PID audits led to criminal convictions of over 40 health care providers by the Medicaid Fraud Control Unit (MFCU). Those cases resulted in a total of $6,013,799 in court-ordered restitution to the Virginia Medicaid program.

To strengthen collaborative efforts with our MCO partners, PID implemented bi-weekly meetings and quarterly onsite visits with the MCOs. The onsite visits affords the MCOs with an opportunity to provide DMAS a detailed explanation of program integrity programs and processes /systems issues. Through this constant feedback and collaboration, plans are able to evaluate and modify their program integrity goals which they detailed in their Annual Program Plan for each contract.

ADDITIONAL MLTSS INFORMATION

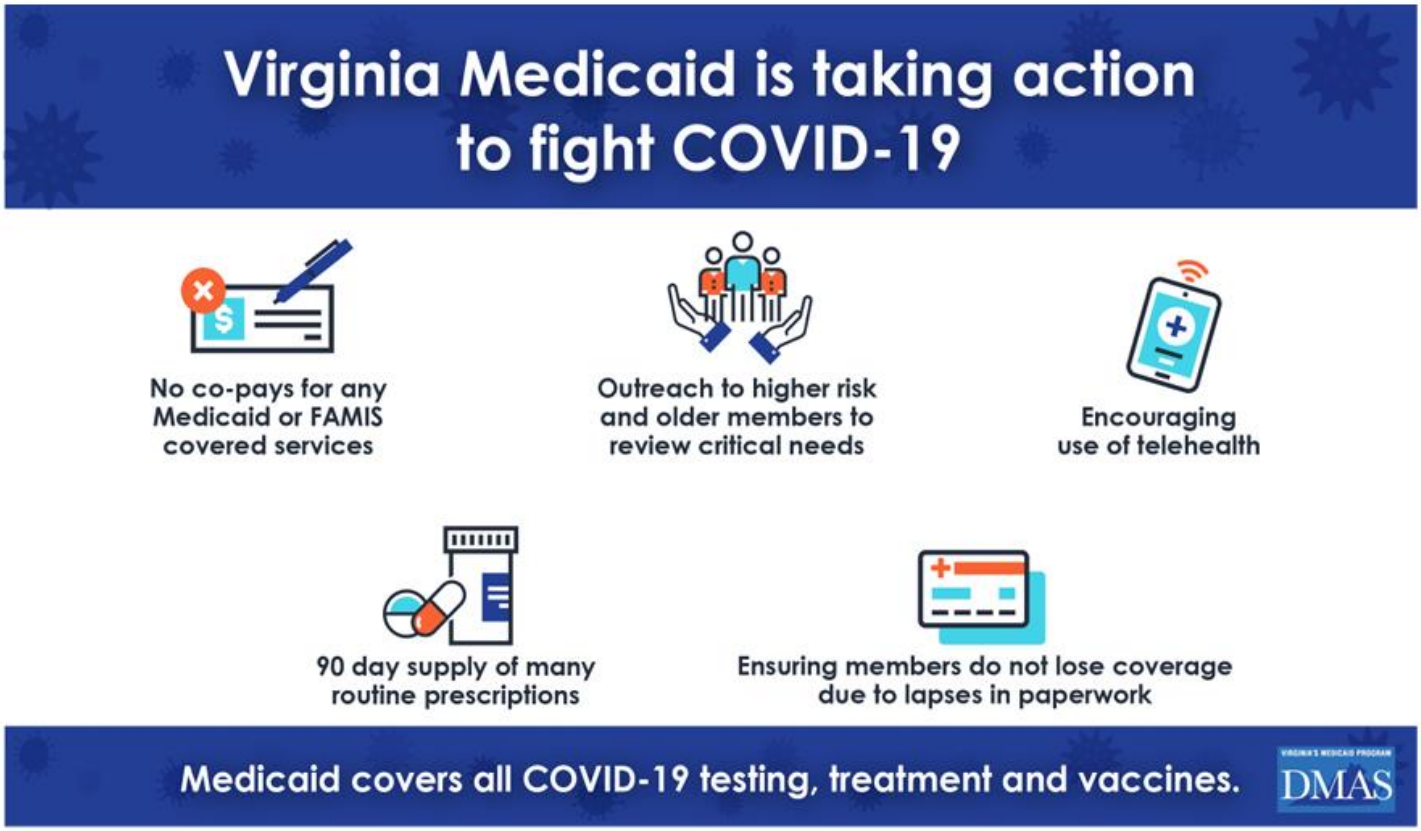
CCC Plus, as Virginia Medicaid's managed long-term services and supports (MLTSS) program, serves Medicaid members with complex needs. These members belong to vulnerable populations, including older adults in need of LTSS, disabled children, disabled adults including the aged, blind, and disabled, waiver populations, and dual eligible individuals. 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 to ensure seamless transitions between levels of care and care settings.
- Service authorizations: Streamlined authorization processes exist across all six CCC Plus health plans to minimize disruption of care of the members.
- Person-centered care coordination: MCOs assign Care Coordinators to help members with complex needs and their caregivers navigate care.
- Comprehensive Health Risk Assessments, individualized care planning, and interdisciplinary care team involvement to identify health needs, services and gaps in care.

COVID-19 PUBLIC HEALTH EMERGENCY

The 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. For the benefit of providers and members, DMAS also expanded coverage of telehealth as a method of service delivery. Many of the policies for providers remained in place until the Commonwealth's public health emergency orders expire on June 30, 2021.

During SFY 2021, the agency continued to enroll thousands of Virginians who sought Medicaid coverage and protected all members from losing coverage per the federal public health emergency. 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. Upon federal approval for COVID-19 vaccines, the agency began sustained outreach efforts to vaccinate Medicaid members, including the most vulnerable populations. To that end, DMAS worked with the Virginia Department of Health and local health districts to provide vaccines for high-risk, homebound members.



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. DMAS used federal Coronavirus Aid, Relief, and Economic Security (CARES) Act dollars to provide additional payments to providers in two significant ways during SFY2021. Virginia allocated $25 million from the CARES Act to fund monthly retainer payments for day support programs that provide services for Virginians with developmental disabilities. These programs offer day support, community engagement, and community coaching to individuals who are receiving Medicaid's developmental disability waiver services. Because of the pandemic, many day support programs have had to change their service delivery models and limit the services they provide and the number of clients they are able to serve. This has had an impact on their budgets and ability to remain open. New budget language extended the ability of the DMAS to offer similar payments to cover the period from August 1 through the end of December 2020, using this CARES Act funding. DMAS determined eligibility for these funds and administered the payments.

DMAS was also able to devote a portion of its CARES Act funding to provide hazard pay to home health personal care attendants who served high-risk populations during the early months of the COVID-19 pandemic. DMAS made available a one-time, pre-tax payment of $1,500 to an estimated 43,500 home health care workers who provided personal care and who served Medicaid members between March 12 and June 30, 2020. Home health care workers provide services that are critical in enabling older Virginians or people with disabilities to continue living in their own homes. In addition to the hazard payments, the state budget included a seven percent pay raise over two years for home health workers, and the Department of Medical Assistance Services worked to provide those workers with personal protective equipment, including masks, gloves and hand sanitizer.

Regulatory Waivers for Va. Medicaid and FAMIS

On July 15, 2020, DMAS announced that it had received federal approval for an 1115 waiver to offer housing and employment support services for Medicaid members who have significant behavioral and physical health needs.

The Virginia Medicaid agency will offer housing and employment services through its managed care program to individuals who meet criteria based on health needs and risk factors, including diagnosis of a developmental disability, serious mental illness or substance use disorder; chronic homelessness; a history of institutional admissions; and frequent emergency department visits.

The Centers for Medicare and Medicaid Services (CMS) approved the new benefit through a section 1115 demonstration waiver. The approved benefit will create a statewide supportive housing program that builds on the existing programs and partnership with the Virginia Department of Behavioral Health and Developmental Services, the Virginia Department of Housing and Community Development, and Virginia Housing.

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 initiated an outreach program to combat COVID-19 Vaccine hesitancy by having care managers contact every member under our CCC+ program by phone to provide vaccine education, schedule vaccine appointments, inform members about community events, and provide a variety of resources to inform and encourage member vaccination. Additionally, Aetna awarded over $425,000 in gift cards as an incentive in our campaign to increase Covid-19 vaccinations.
- Aetna paid over $11,000 in wellness award incentives to members for completing various healthy initiatives, such as annual wellness exams, diabetic retinal exams, cancer screenings and mammograms.
- Aetna awarded over $80,000 to a variety of Virginia organizations, including but not limited to organizations aimed at supporting mental wellness, individuals with intellectual disabilities, and supporting foster care populations.
- Aetna Awarded over $10,000 in total to multiple community organizations committed to addressing food insecurities in the commonwealth such as the Allegheny Mountain Institute Farm to Table Initiative, and the New Beginnings Christian Community food bank in Charlottesville.

Anthem

Anthem. HealthKeepers Plus
Offered by HealthKeepers, Inc.

- Anthem associates reached out to thousands of its members to schedule and get members vaccinated. They collaborated with over 10 providers across the state to organize vaccine clinics.
- Anthem donated 44,000 grocery bags with groceries for food bank distribution.
- Partnered with large pediatric practices to provide COVID vaccinations and child wellness visits.
- Collaborated with eight providers to provide telehealth services including telehealth kits, iPads to additional IT equipment to providers to enable more telehealth functionality, and THOS (telehealth operating system). THOS is a user-friendly, HIPPA compliant system to facilitate telehealth appointments with members (audio and/or visual capabilities).
- Personal Attendant Care Quality Incentive Program (PACQIP): Incentive program that incentivizes providers to assist in reducing ER/Inpatient Admissions, provide quality care to our members and provide training to caregivers.

Molina, formerly Magellan

MOLINA HEALTHCARE
Molina Complete Care

- Molina partnered with Local Food Hub to provide fresh produce & eggs to YMCA childcare programs in the Western region.
- Molina provided, through United Way's WomenRise program, childcare scholarships to low-income mothers so they could attend school to complete their GEDs.
- Molina provided back-to-school backpacks & school supplies to Title 1 schools in the Roanoke region.
- Molina partnered with the Virginia Collaborative Extension to provide Healthy Kid Bucks for use at farmers markets in the Southwest region to increase access to fresh, local produce.

Optima

OptimaHealth

- Optima expanded their support of food insecurity and good nutrition by offering a program that provides two meals a day for seven days after an inpatient stay for Medicaid members.
- Optima launched a two-year pilot program with Virginia Supportive Housing to support members with housing instability and an acute mental health condition. Optima Health identifies permanent stable housing situations, obtains appropriate care for chronic and behavioral health conditions, and works to reduce non-emergency department visits and non-emergency psychiatric acute inpatient visits.

Optima, cont'd

- Partnership with Rainbow Puppets to provide puppet performances that emphasized the joy of reading and provided an age-appropriate book for every child in attendance to take home. In 2021, there were a total of 189 performances and 35,490 children served across the state of Virginia.

United

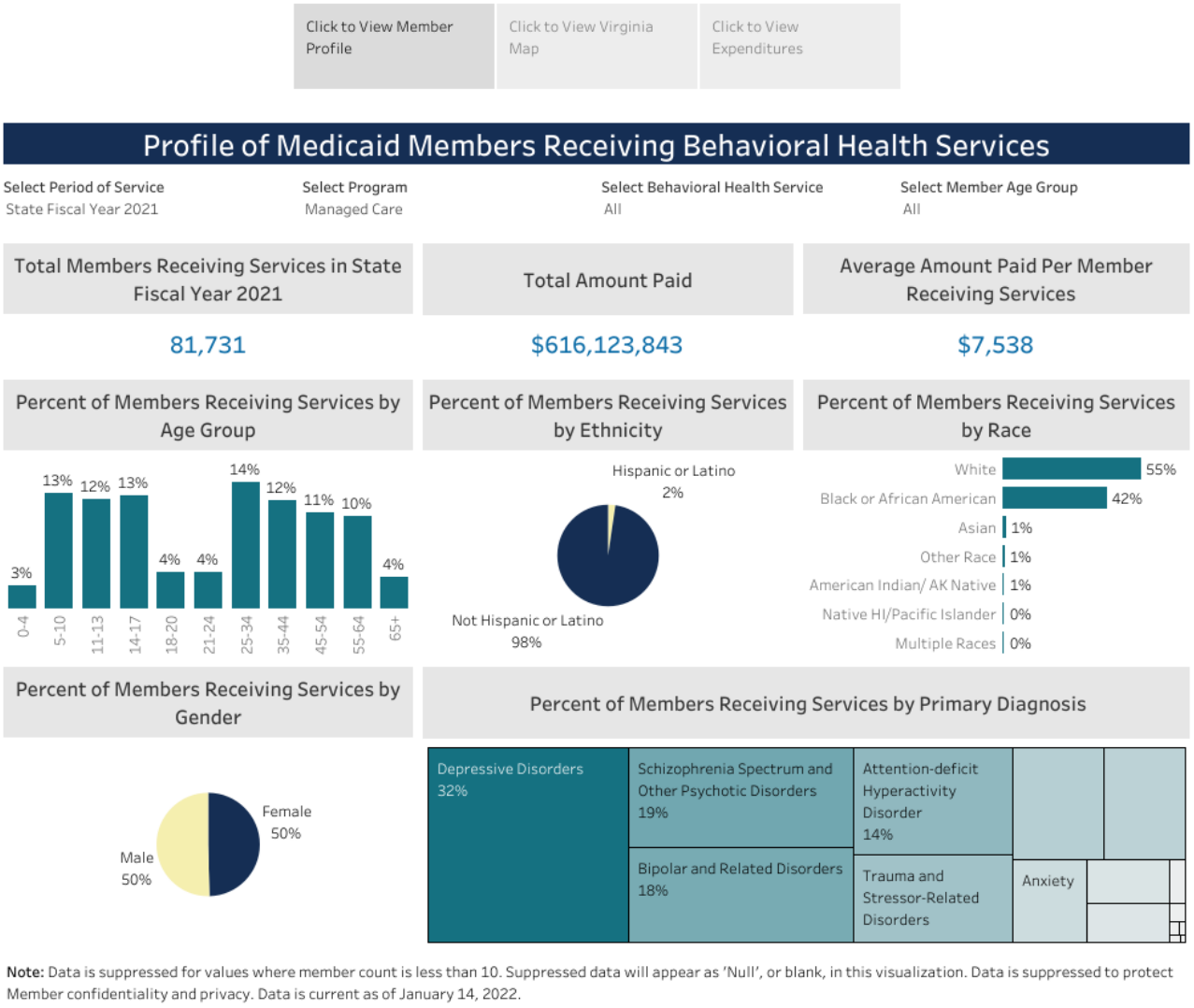
- United provided $900,000 in grant funding across the Commonwealth in support of doula training, food banks, pharmacy, senior mental health and youth mentoring programs.
- United organized special "Clinic Days" with key provider partners in support of childhood immunizations.
- United added a monthly food stipend benefit in support of DSNP members facing food insecurity.
- United created a "Sticks for Kicks" immunization incentive program rewarding members with gift cards from Footlocker.
- United co-sponsored a health fair with the local FQHC to support homeless individuals. Services included mobile medical, COVID vaccinations, childhood immunizations, health screening, health education and food.

Virginia Premier

- Virginia Premier maintained virtual provider visits and population health events to maintain open communication and continue to close care gaps and provided needed care.
- Virginia Premier utilized virtual member outreach events, such as virtual baby showers, to continue member engagement during the continued pandemic.
- Virginia Premier added Housing Specialist to SDOH team to mitigate housing disparities, improve health outcomes, and support overall member health.
- Virginia Premier implemented numerous member outreach activities and events to promote COVID-19 vaccinations for its members and the community.

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. Managed care behavioral health expenditures, utilization, and demographic data for SFY2021 are illustrated below.



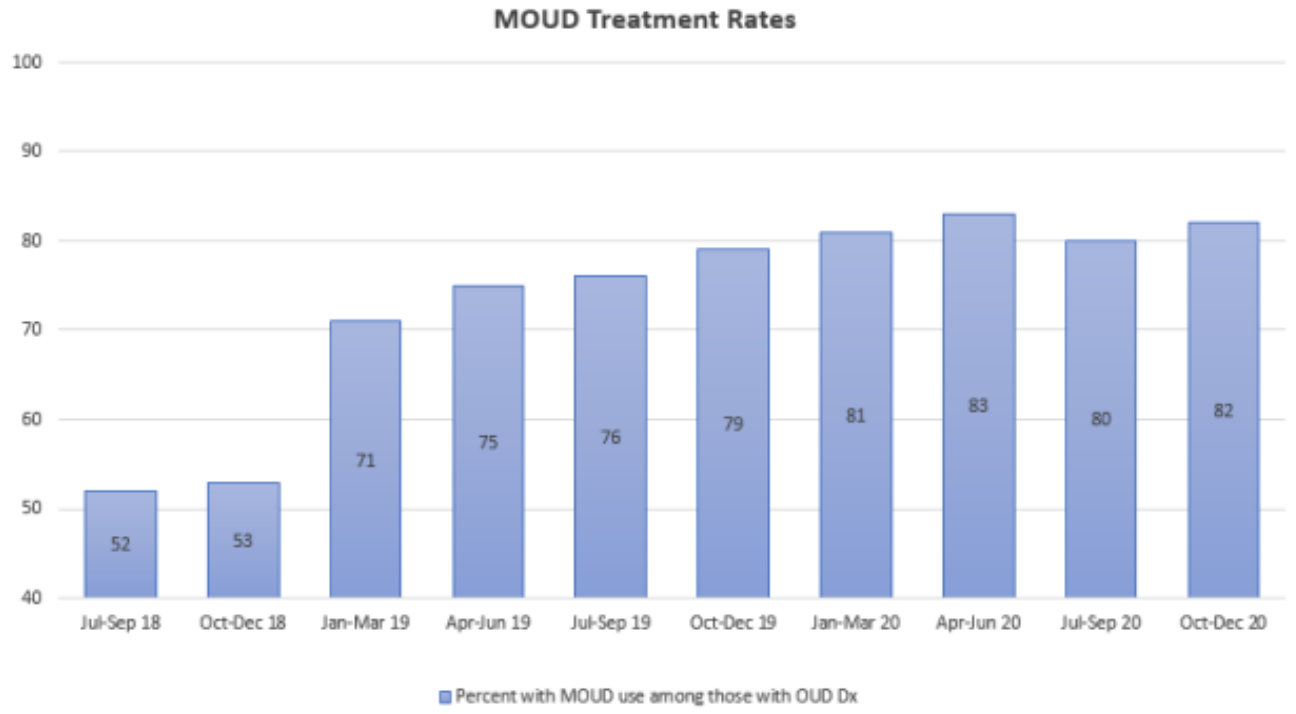
Note: Data is suppressed for values where member count is less than 10. Suppressed data will appear as 'Null', or blank, in this visualization. Data is suppressed to protect Member confidentiality and privacy. Data is current as of January 14, 2022.

Addiction & Recovery Treatment Services

Fatal drug-related overdoses have surged during the COVID-19 pandemic, exceeding 100,000 overdoses in the U.S. and over 2,400 in Virginia in the year ending June 2021. This represents a 20% increase nationally and 35% increase in Virginia, respectively, since the previous year. Pandemic-related economic and social stress, disruptions in access to health services, and greater availability of more lethal forms of opioids, such as fentanyl, are considered the primary reasons for the surge in overdoses, although no definitive causes have been identified. As a result of the expansion of treatment services through the Addiction and Recovery Treatment Services (ARTS) benefit in April 2017, and increases in eligibility for these services through Medicaid expansion beginning in 2019, Virginia Medicaid was far better prepared for the increased prevalence in substance use disorders (SUD) than in previous years. The supply of treatment providers, the prevalence of members receiving SUD treatment, and the rate of treatment for diagnosed SUD increased dramatically after implementation of the ARTS benefit, and has continued through Medicaid expansion and the COVID-19 pandemic

There was a 30% increase in the number of members using ARTS services between SFY 2019 and 2020, even after accounting for increased Medicaid enrollment. Outpatient treatment and pharmacotherapy are the most frequently used services, although there were larger increases in the use of residential treatment, partial hospitalization, intensive outpatient services, and care coordination services.

Medications for Opioid Use Disorder (MOUD) treatment rates for members with OUD increased from 62% in SFY2019 to 69% in 2020, continuing a trend of increased MOUD treatment rates that began after implementation of the ARTS benefit.



Project BRAVO

Project "BRAVO", or Behavioral Health Redesign for Access, Value, and Outcomes, is a multi-agency effort to implement six high quality, high intensity and evidence based services that have demonstrated impact and value to patients. The six services currently exist and are licensed in Virginia, but they are not covered by Medicaid or the service is not adequately funded through Medicaid.

The six services include

Phase 1

- Assertive Community Treatment
- Partial Hospitalization
- Intensive Outpatient Programs

Phase 2

- Multi-Systemic Therapy
- Functional Family Therapy
- Comprehensive Crisis Services

During SFY2021, DMAS and Virginia's Department of Behavioral Health & Developmental Services (DBHDS) engaged in Phase 1 of Project BRAVO by preparing to roll out Assertive Community Treatment, Partial Hospitalization, and Intensive Outpatient Program services. DMAS and DBHDS completed rate setting, provider bulletins on codes and rates, policy development, stakeholder engagement, provider manual trainings, accreditation orientations, and other system changes in preparation for Phase 1 services went into effect July 1, 2021. Phase 2 is scheduled for SFY2022 pending any legislative or budgetary changes.

SUMMARY

The managed care programs offered by DMAS continued to be improved and refined in state fiscal year 2021. Medallion 4.0 continued the program's 20 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.