Connecting Care

2017 Medallion 3.0 Annual Report

VIRGINIA'S MEDICAID PROGRAM

DMAS

INNOVATION • QUALITY • VALUE

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COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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Dear Stakeholders,

The Virginia Department of Medical Assistance Services (DMAS) is dedicated to providing quality care to our members at a sustainable rate of investment by the Commonwealth's taxpayers. The Medallion program is key to achieving this important goal. This Annual Report highlights the achievements of this important program to date and the innovations that our members can expect in the coming year.

Medallion was launched 20 years ago as the first statewide Medicaid managed care program in Virginia and one of the nation's first primary care case management initiatives. Medallion's success is built on a partnership that brings together the Commonwealth, managed care organizations and, most importantly, the men, women and children we serve. This collaborative approach provides an extensive network of credentialed providers while encouraging accountability, innovation, efficiency and budget predictability.

Currently, more than 750,000 Virginians who are covered through Medicaid and Family Access to Medical Insurance Security (FAMIS) are served through a Medallion managed care program. In 2017, DMAS moved many of its remaining members into managed care through the new Commonwealth Coordinated Care Plus (CCC Plus) initiative.

Moving forward, DMAS will continue its efforts to align Medallion and CCC Plus, while transitioning individuals who qualify as Aged, Blind and Disabled, and those who receive managed care through the Health and Acute Care Services Program from Medallion 3.0 to CCC Plus.

The redesigned Medallion 4.0 program will continue to serve pregnant women, parents and children with a focus on preventive care. As the Medallion program evolves, we remain committed to improvements in members' experience with the health care system, and we will continue to strive for better health outcomes.

Sincerely,

Jennifer S. Lee, MD

Jennifer S. Lee, M.D.
Director

ABOUT MEDICAID AND MEDALLION 3.0

MEDICAID

Medicaid plays a critical role in the lives of over a million Virginians, financing health care for the poor and medically vulnerable. The impact of Medicaid extends far beyond the financing of traditional health coverage to include comprehensive services such as behavioral health and long-term supports and services (LTSS) and addiction recovery and treatment services. Medicaid coverage is primarily available to Virginians who meet specific income thresholds and other eligibility criteria. Children, pregnant women, parents, older adults, and individuals with disabilities make up a significant portion of Virginians enrolled in Medicaid. The Department of Medical Assistance Services (DMAS) is the agency responsible for administering the Medicaid program in Virginia.

MEDALLION 3.0: SERVING VIRGINIANS FOR 20 YEARS

The original Medallion program was Virginia's first managed care program and dates back to 1996. Over the past 20 years, the Medallion program has provided acute and primary care services for enrolled members including: pregnant women, low income families with children (LIFC), those receiving temporary assistance for needy families (TANF), and aged, blind and disabled (ABD) and children. The Medallion program established a commitment to continuous improvement and is now in its third and best evolution yet, Medallion 3.0.

MEDALLION 3.0 MANAGED CARE ORGANIZATIONS

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 contracts. The six Medallion 3.0 Managed Care Organizations (MCOs) are:

- Aetna Better Health
- Anthem Healthkeepers Plus
- INTotal Health
- Kaiser Permanente
- Optima Family Care
- Virginia Premier

Managed care provides budgetary predictability and services not available from the fee-for-service (FFS) model, such as: a call center with 24/7 access, care coordination, additional technology, and enhanced provider networks.

Over 100,000 providers of all types are serving members at more than 300,000 sites across the Commonwealth, including Virginia's twelve major health systems. When building their networks, MCOs ensure that there is sufficient provider participation to meet the specific needs of their members, including the option to create single case agreements with out-of-network providers for special member circumstances.

WHO AND HOW WE HELP

Over 1.1 million Virginians are enrolled in Medicaid and FAMIS and 68%, or approximately 783,000 of those enrollees, receive managed health care services through Medallion 3.0 MCOs.

MATERNITY

- Early Prenatal Care
- Case Management
- Post Partum Care
- Support for Full-term Deliveries
- Breast Feeding Care
- Family Planning
- Outreach and Education
- Oral Health

INFANTS (0-3)

- Immunizations
- Well Visits
- Early Assessments
- Safe Sleep Education
- Support for Neonatal Abstinence Syndrome
- Preventing Infant Death (Three Branch Workgroup)
- Early Intervention
- Oral Health

CHILDREN AND ADOLESCENTS (3-18)

- Oral Health
- Vision
- Well Visits
- Early and Periodic Screening, Diagnosis and Treatment
- Support for Special Needs
- Foster Care Services
- Focus on Trauma Informed Care
- Community Mental Health Services
- Adolescent Focused Care

AGED, BLIND AND DISABLED/ADULTS

- Wellness
- Chronic Disease Support
- Family Planning/LARC
- Addiction Recovery Treatment Services
- Behavioral Health and Community Mental Health Rehabilitative Services

WHO AND HOW WE HELP

CARE THROUGH STRONG PROGRAMS

Medallion 3.0 members meet different eligibility criteria to qualify for Medicaid and service delivery is different for these diverse populations. Therefore, Medallion 3.0 has diverse programs designed to administer and monitor service delivery in a way that is tailored to different populations. The chart below illustrates which Medallion 3.0 programs are available to different members.

Medallion 3.0 Populations	Foster Care	Health and Acute Care Program	Oral Health	Disease Case Management
Infants	✓		✓	✓
Children	✓	✓	✓	✓
Pregnant Women		✓	✓	✓
Adults	✓	✓		✓
Aged, Blind and Disabled	✓	✓	✓	✓

April's Success Story

After I found out I was pregnant, I noticed my teeth hurting. I didn't think I had dental coverage, but my case worker explained all about my dental benefits through Medicaid. When I went to the dentist, I found out I had quite a few teeth that needed fillings. In addition to the fillings, I was able to have my teeth cleaned—something I hadn't been able to do in years. It felt so good to get this taken care of before the baby is born. Now, I don't have to worry about the pain or how to pay for dental care. I can just concentrate on having a healthy baby!

This is the story of a real Virginian whose name and photographic image are protected under HIPAA.

QUICK FACTS

- 1 in 8 Virginians rely on Medicaid
- More than 1.1 Million Virginians are covered by Medicaid/FAMIS
- Virginia Medicaid covers 1 of every 3 births

WHO AND HOW WE HELP

The chart below explains the features and benefits of the strong Medallion 3.0 programs and highlights 2017 achievements of each program.

Program	Features	Benefits	SFY 2017 Highlights
Foster Care	Medallion 3.0 serves 81% of the 13,414 Foster Care and Adoption Assistance (FC/AA) members.	FCAA members are assigned a Foster care professional from their MCOs who will work collaboratively with DMAS and the Department of Social Services to address member needs.	Interventions have resulted in over 97% of FC children seeing a primary care physician and over 87% received a dental examination.
Health and Acute Care Program	HAP provides integrated care coordination for 8,409 members enrolled in both Medallion 3.0 and a home and community-based waiver for long-term services and supports.	The MCO offers Intra-Disciplinary Team (IDT) case management for problem resolution with medical, pharmacy, or long-term care services.	Increased HAP case management participation, promoting stable MCO enrollment and continuity of care.
Oral Health	Medallion 3.0 collaborates with DentaQuest as the Dental Benefits Administrator for the ***Smiles For Children*** program.	Medallion 3.0 connects members to oral health providers, raising awareness of oral health issues, and providing quality dental care for Medicaid and FAMIS members; redesigned DMAS Oral Health website to help better serve Providers and Members.	This program year, approximately 2,420 dental providers participate in the ***Smiles For Children*** (***SFC***) network, representing approximately 28% of the 7,171 licensed dentists in Virginia. Fifty-seven percent (57.22%) of eligible Medicaid members are participting in the ***SFC*** program. This is an increase from SFY 2016, where fifty-five percent (55.33%) of eligible Medicaid members ages 0-20 years are accessing dental services through the ***SFC*** program. Over 14,000 pregnant women enrolled in Medicaid and FAMIS MOMS received comprehensive dental care. There was a 76.6% increase in the application of fluoride varnish by non-dental providers for children ages 1-3 years of age.
Disease Case Management	Each Managed Care Organization (MCO) offers disease case management programs to allow members and their families access to a greater understanding of their disability or disease process.	MCOs provide an assessment of their members' current state of health and develop treatment plans to improve their quality of life through the use of nursing assessments, or interventions, educational materials and access to appropriate community resources.	Newly enrolled members in Managed Care have benefitted from having case management programs available to help them make informed decisions about the care delivered to them or their familiy member. This model has been widely implemented for many years with much success.

WHO AND HOW WE HELP

CONTINUOUSLY IMPROVING MEMBER CARE

Virginia became a full managed care state in July 2012. With the "statewide" expansion complete, the Department began the addition of populations normally excluded. Foster care and qualified home and community-based waiver enrollees were included. The Special Populations Unit (SPU), one of seven units within the Division of Health Care Services (HCS), was created to oversee these new populations' transition into managed care and to work collaboratively within the Agency and with external parties to ensure their access to care. With a reorganization of the Agency, the Maternal and Child Health (MCH) Unit became part of HCS as most of the women, pregnant women, children and adolescents received coverage through one of the six managed care organizations. This broadened the activities of the SPU beyond foster care and waiver members, and the name changed to the Maternal and Child Health Unit. Roles and responsibilities of staff were modified and new staff were hired. The MCH Unit now has responsibility for the following programs provided under both the fee-for-service and managed care delivery systems

FOSTER CARE

- **Collaboratives** – Three Branch Policy Institute, Child Welfare Advisory Committee, State and Local Departments of Social Services, State and Local Health Departments, Medicaid contracted managed care organizations
- **Operations** – Program policy, reporting, compliance, claims issues, management of complex cases, focus studies, utilization dashboards
- **Training** – Local partners and agencies, foster care parents, stakeholders, MCOs, internal DMAS divisions
- **New Initiatives** – Former Foster Care, Fostering Futures, Commonwealth Coordinated Care (CCC) Plus transition

MATERNAL AND CHILD HEALTH

- **Collaboratives** – NASHP, NAMD, State and Local Departments of Social Services, State and Local Health Departments, Medicaid contracted managed care organizations
- **Programs** and Operations – Early Intervention (EI); Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT); BabyCare
- **New Initiatives** – CCC Plus transition, newborn enrollment, cross-divisional projects

OPERATIONS AND PERFORMANCE MANAGEMENT

The DMAS Medallion 3.0 team ensures members receive high-quality care in the most appropriate setting by monitoring MCO operations and providing direct support to providers and members who may need assistance.

There are five main functions of Medallion 3.0 Operations and Performance Management:

- **Contracts and Administration** ensures MCO operations are consistent with the Medallion 3.0 contract requirements
- **Member and Provider Solutions** resolves service and care management concerns identified by members and providers
- **Quality Improvement** measures MCO performance against standard criteria, such as HEDIS, and facilitates focused quality projects to improve care for all Medallion 3.0 members
- **Compliance** oversees, develops and monitors MCO corrective action plans and sanctions
- **Systems and Reporting** manages data submissions from the MCOs in accordance with the DMAS Managed Care Technical Manual

MEDALLION 3.0 COMMITMENT TO QUALITY AND PERFORMANCE MANAGEMENT

DMAS prioritizes quality improvement as a fundamental tenet of the Medallion 3.0 program. The Medallion 3.0 contract requires each MCO to complete federal and state mandated quality improvement activities, such as: 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; and participation in a performance incentive award program.

Since July 2015, DMAS has been commited to the continuation of the Managed Care Compliance Program to ensure appropriate service delivery to Medicaid and FAMIS members. The Compliance Program aims to detect issues, collaborate with the MCOs, and enforce the Medallion 3.0 Contract requirements. The Compliance program was designed to identify and respond to program compliance and remedy contractual violations, if necessary. DMAS conducts compliance oversight of the MCOs in four major areas: deliverables, quality, systems and reporting, and contracts.

Most recently in 2016, DMAS established a Compliance Review Committee (CRC) comprised of managers from each major area listed above. The goal of this committee is to provide objectivity, consistency, and fairness to the Compliance Enforcement Action process to ensure all MCOs are equally evaluated.

CARE THROUGH STRONG PROGRAMS

PROGRAM INTEGRITY

State and federal regulations require MCOs to have vigilant program integrity systems in place to prevent, detect and investigate allegations of fraud, waste and abuse. DMAS and MCOs met quarterly this program year to collaborate on program integrity issues. In SFY 2017, MCO program integrity activities identified or avoided over $828 million of improper payments, including $752 million in prevented payments for items such as non-covered services, ineligible recipients, and improper claims. Audits by MCO Special Investigations Units and MCO contract auditors identified $9.9 million in improper payments.

SYSTEMS AND REPORTING

The Managed Care Reporting Technical Manual (MCTM) to standardize and automate MCO reporting was divided into an Encounters Manual and a Reporting Manual. These manuals were created as companion documents to the Medallion 3.0 contract which describe standard reporting formats and guide MCO reporting submissions.

OPERATIONS AND PERFORMANCE MANAGEMENT

The Systems and Reporting team contributed to several major improvements in 2017, including:

1. Implementation of new encounter data edits to improve rebate collection on physician-administered pharmacy services for the Agency.
2. Seamless transition of all Health and Acute Care Population (HAP) members from the Medallion 3.0 program into the new CCC Plus program.
3. Identification and documentation of detailed system requirements for the Medallion 4.0 program processes.
4. Participation in key roles as Subject Matter Experts (SME) on multiple critical Agency projects (e.g., Medicaid Enterprise System, Data Governance, Encounter Processing System)

HEDIS® HIGHLIGHTS

For the State Fiscal Year (SFY) 2017, the Agency deemed 29 Medicaid (HEDIS®) performance measures as priority. The MCOs are expected to assure annual improvement in these measures if they are performing below the 50th percentile nationally, sustain performance at this percentile and set goals to stretch to the 75th percentile. During HEDIS® year 2017 MCOs will continue to align with the National Committee for Quality Assurance (NCQA) requirements, by not rotating any (HEDIS®) measures. There were seventeen priority HEDIS® measures that improved from HEDIS® year 2016 to 2017:

HEDIS® Year 2017 Measures with Rate Increase
Adolescent Well-Care Visits
Adults' Access to Preventive/Ambulatory Health Services (Total)
Breast Cancer Screening
Children and Adolescents' Access To PCP (12-19 Years)
Children and Adolescents' Access To PCP (12-24 Months)
Children and Adolescents' Access To PCP (25 Months-6 Years)
Comprehensive Diabetes Care - HbA1c Testing
Controlling High Blood Pressure - Total
Follow Up After Hospitalization For Mental Illness - 30 days
HEDIS® Year 2017 Measures with Rate Increase (Continued)
Follow Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase
Follow Up Care for Children Prescribed ADHD Medication - Initiation Phase
Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers To Quit
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Medications
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Strategies
Medication Management for People With Asthma: Medication Compliance 75% (Total)
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

NCQA ACCREDITATION

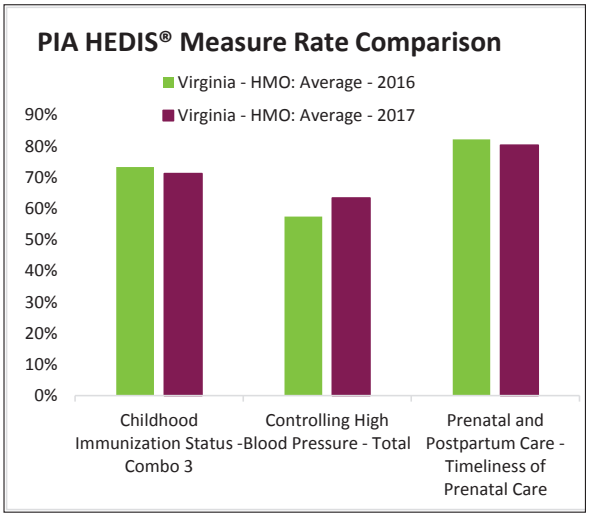
Ensuring that members of Medicaid managed care receive the highest level of quality of care is at the center of quality improvement efforts. Through the contract with the MCOs, the Department requires each plan to obtain and maintain accreditation with NCQA. Health plans can earn the following NCQA Accreditation status based on their performance against NCQA's rigorous requirements and their performance on HEDIS® and CAHPS measures: Excellent, Commendable, Accredited, Provisional, Interim, or Denied.

HEALTH PLAN	NCQA ACCREDITATION	LEVEL
aetna AETNA BETTER HEALTH® OF VIRGINIA	✓	ACCREDITED
Anthem HealthKeepers Plus Offered by HealthKeepers, Inc.	✓	COMMENDABLE
INTotal Health An Inova Health Plan	✓	ACCREDITED
KAISER PERMANENTE®	✓	EXCELLENT
OptimaHealth Family Care	✓	COMMENDABLE
VA Premier Health Plan, Inc.	✓	ACCREDITED

PERFORMANCE INCENTIVE AWARDS PROGRAM (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 3.0 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
3. Prenatal and Postpartum Care-Timeliness of Prenatal Care



HSAG calculated and finalized PIA results for all six MCOs in Virginia in December 2017. The Program Year 2 PIA results indicated that four MCOs were assessed for awards and two MCOs were assessed for penalties for their performance in state fiscal year 2017. All MCOs were notified of their final PIA results in December 2017, which provided an opportunity for all MCOs to review and provide feedback on the results. The table below represents the funds allocation results derived from the PIA scores for each MCO.

FUNDS ALLOCATION RESULTS

MCO	Final Award	Final Penalty	Final Award/Penalty Percentage
Plan A	$58,583.36	–	0.03%
Plan B	$424,097.99	–	0.04%
Plan C	–	$(237,610.93)	-0.12%
Plan D	$18,329.92	–	0.04%
Plan E	–	$(557,118.41)	-0.07%
Plan F	$293,718.08	–	0.03%
All MCO Total	**$794,729.34**	**$(794,729.34)**	

CONSUMER DECISION SUPPORT TOOL

DMAS works with its External Quality Review Organization (EQRO), HSAG, annually to produce a Consumer Decision Support Tool, using Virginia Medicaid MCOs' performance measure data as its basis. Specifically, HEDIS 2017 performance measure results and 2017 CAHPS data were combined and analyzed to assess MCOs' performance as related to certain areas of interest to consumers. The Consumer Decision Support Tool's inclusion of the MCO accreditation level emphasizes the standard of quality and integrity expected in being a contracted MCO in Virginia. Virginia was among the first states to require that contracted MCOs achieve and maintain health plan accreditation by NCQA. Health plan accreditation involves a rigorous evaluation of the quality of health care and services provided, along with an assessment of clinical and member satisfaction performance measures (HEDIS and CAHPS). NCQA accreditation levels include Excellent, Commendable, Accredited, Provisional, and Interim.

The tool was developed to help support DMAS' public reporting of MCO performance information to be used by consumers to make informed decisions about their health care. It is among the first to be used in the nation for Medicaid. The tool evaluated individual MCO performance (e.g., how well doctors involved members in decisions about their care, and if children regularly received checkups and important shots that helped protect them against serious illness); therefore, consumers had the opportunity to be better informed in certain areas of interest. Additionally, the tool provided a three-level rating scale with an easy-to-read "picture" of quality performance across MCOs and presented data in a manner that clearly emphasized meaningful differences between MCOs (i.e., one-to-three-star rating) to assist consumers when selecting a health plan. The Consumer Decision Support Tool was made publicly available on DMAS' website in December 2017, and is updated annually.

VIRGINIA MEDICAID MANAGED CARE QUALITY

CONSUMER DECISION SUPPORT TOOL 2017-2018

Comparing Virginia Medicaid Managed Care Organizations

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

Key
Above Virginia Medicaid MCO Average
Virginia Medicaid MCO Average
Below Virginia Medicaid MCO Average

MCO	Accreditation Level	Doctors' Communication	Getting Care	Keeping Kids Healthy	Living With Illness	Taking Care of Women
Aetna*	Accredited	★★	★★	★★	★★	★
Anthem	Commendable	★★	★★	★★	★	★★★
INTotal	Accredited	★★	★	★	★	★
Kaiser Permanente	Excellent	—	★★	★★	★★	★★★
Optima	Commendable	★★	★★	★	★★	★
VA Premier	Accredited	★★	★★★	★★	★★	★★

*formerly CoventryCares
— indicates the MCO did not have enough data to receive a rating.

ACCELERATING HEALTH AND HEALTHCARE QUALITY THROUGH RAPID-CYCLE IMPROVEMENTS

The Medicaid managed care performance improvement project (PIP) validation activity has been useful for measuring adherence to industry standards for planning healthcare quality improvement projects. Since the development of the PIP requirements there have been a number of advancements in quality improvement practices that have been tested, refined, and replicated across the industry. As a result, best practices in quality improvement have evolved into models that produce better health and healthcare.

The Department of Medical Assistance Services (DMAS) has transitioned from the traditional PIP to a more proactive and outcome-oriented model of improvement. This unique collaborative approach to quality improvement in Virginia's Medicaid managed care delivery system places greater emphasis on improving outcomes using rapid-cycle improvement methods to pilot small changes. DMAS chose to focus the PIP efforts on diabetes, and each MCO chose a specific

diabetes sub measure for their PIP activity. The MCOs have received a high-level overview training on the rapid-cycle PIP process and more specific training on each Module's submission requirements. In addition, at the request of MCOs, DMAS' EQRO provided one-on-one technical assistance to answer questions and provide additional guidance on PIP methodology, the rapid-cycle process, and clarification on any feedback or recommendations HSAG has provided to the MCO after review of its submission for validation. MCOs are at various phases of their module submissions, and the first year will be an 18-month project.

COMPLIANCE

The established Managed Care Compliance Program adheres to an eight-step process (Figure 1) and a tiered point system to track enforcement of the MCO's contractual compliance.

The types of infractions identified throughout the contract cycle are tracked and sorted by Issue Type (Figure 2). This allows the Department to identify the most common types of issues the MCOs are experiencing and determine if other actions are required to resolve these issues.

In addition, the Compliance Enforcement System has six levels of classification based on the number of compliance infractions an MCO has acquired (Figure 3). Levels two through six include associated financial penalties and corrective action. Interested stakeholders will find additional details in Section 13.2 of the Medallion 3.0 contract.

Figure 1

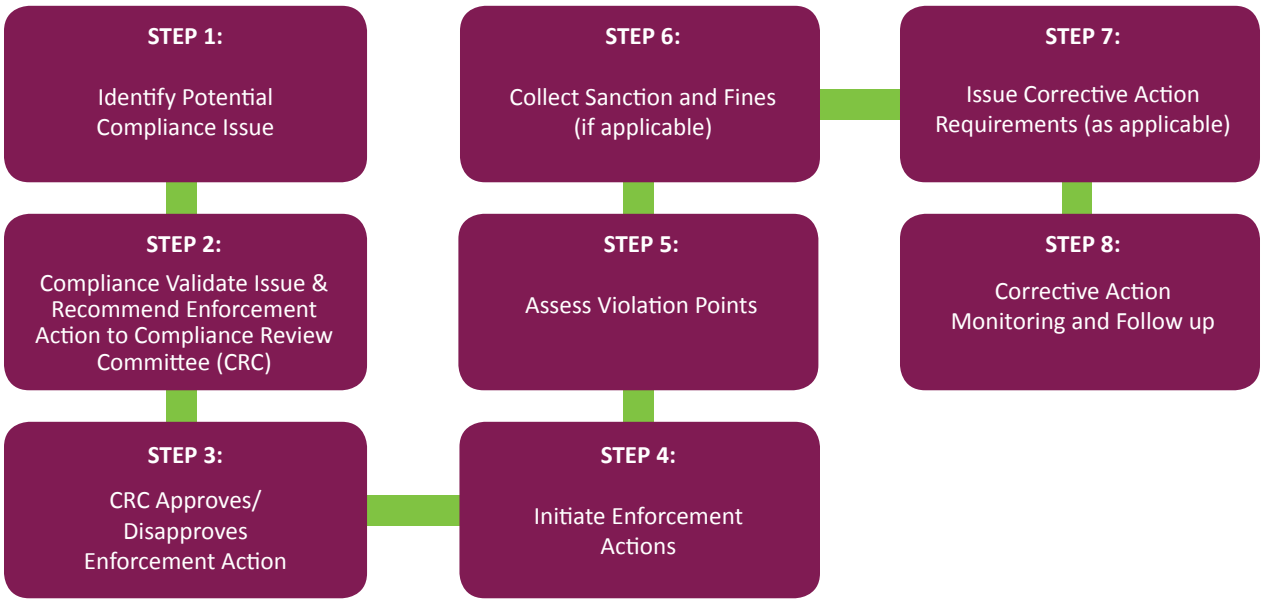
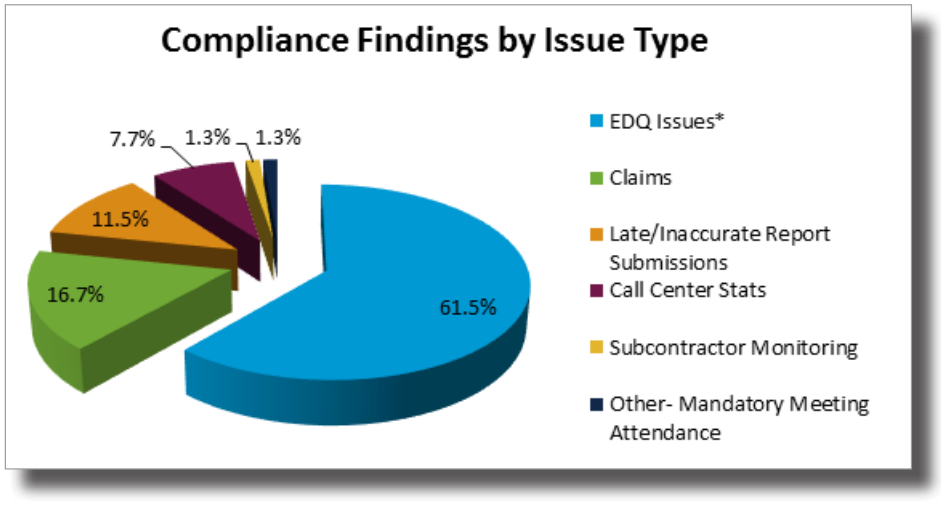


Figure 2



ENFORCEMENT PROCESS SCHEDULE

Figure 3

Level	Points	Action	Fine
1	0-15	MIP	No Fine
2	16-25	CAP	$5,000
3	26-50	CAP	$10,000
4	51-70	CAP	$20,000
5	71-100	CAP	$30,000
6	100+	Possible Contract Termination	-

*The compliance program initiated 77 sanction activities during this state fiscal year. These sanctions represent compliance violations across all six MCOs and include both financial penalties, points, assessments and corrective action plans.

CONTINUOUSLY IMPROVING OPERATIONS & PERFORMANCE MANAGEMENT

ENROLLMENT

In November 2016, Maximus, the Department's Education and Enrollment Broker, launched an updated, interactive website. In an effort to ensure a smooth transition to a Managed Care Organization, The Department worked with Maximus to develop and launch www.virginiamangedcare.com as a means to provide additional support and resources for members to enhance their enrollment experience and to further engage in the enrollment and health plan selection process. Members can create user profiles and:

1. Look up MCOs and participating providers by location
2. Enroll or change plans during allowable periods

The Department is also working with Maximus to develop a strategy to enroll members into the new Medallion 4.0 program when it launches in August 2018. Maximus will begin this work in 2018 to develop an interactive smart phone application that will allow members to change their health plan, update their contact information, and find network providers. The application will be available for both iPhone and Android. DMAS and Maximus will work to ensure the transition for members is as seamless as possible.

Wright Family Success Story

We endured a difficult pregnancy where we didn't know what to expect in terms of our daughter's health. We were told if she lived, her quality of life would be poor. From day one, our Managed Care team joined the fight. Our daughter's care was coordinated with Occupational Therapists, Physical Therapist and Vision Therapist. She has been able to bear weight on her legs and use her stander to watch her siblings! We can remember crying the day they delivered her medical equipment. It was the first time she was able to sit with us at the table as a family of five. We are thankful for Managed Care!

This is the story of a real Virginian whose name and photographic image are protected under HIPAA.

OPERATIONS AND PERFORMANCE MANAGEMENT

NEWBORN ENROLLMENT

It is essential that newborns are correctly enrolled in the Virginia Medicaid program as soon as possible, preferably prior to discharge from a hospital. Over the late summer and fall of 2017, this Agency initiative significantly increased the amount of newborn applications submitted to the COVERVA call center and corresponding newborn enrollments. Newborns directly enrolled in the Medicaid program receive a unique Medicaid identification number assigned to the case of the mother, which facilitates newborns receiving their full Medicaid benefit, assignment to a Medicaid Managed Care Organization (MCO) if eligible, and appropriate reimbursement for the Medicaid covered services provided to newborns of Medicaid enrolled mothers.

In order to increase accountability and reduce the time required to enroll newborn children of Medicaid enrollees into the Medicaid program, DMAS worked directly with Medicaid MCOs, hospital discharge planners, eligibility workers and other health care providers who assist Medicaid enrolled mothers with obtaining Medicaid eligibility for their newborns to submit Medicaid/FAMIS newborn eligibility notification information directly to the COVERVA Commonhelp website. Beginning in August, DMAS held several webinars to train hospitals and certified professional midwives on how to submit the DMAS E-213. Providers and support staff are submitting the notification forms electronically through the Commonhelp web site, rather than the local Departments of Social Services (DSS). The number of newborns who do not get enrolled in Medicaid is decreasing.

PRESCRIPTION MONITORING PROGRAM (PMP)

MCO physicians and pharmacists are authorized access to the PMP database to obtain specific member information to determine service eligibility and to coordinate care for members participating in the PUMS or a similar program. In 2017 legislation allowed for additional MCO staff to have authorized access to a clinical designee. The designee must hold a multistate licensure and be privileged to practice nursing or a license issued by a health regulatory board within the Department of Health Professions and be employed by the Virginia Medicaid managed care program. PMP seeks to assure that members are safely accessing prescribed medication.

CENTERS FOR MEDICARE AND MEDICAID (CMS) MEDICAID MANAGED CARE REGULATIONS

The provisions of the CMS Medicaid Managed Care final rule, the majority of which became effective as of July, 2017, required significant revisions by DMAS to the current MEDALLION 3.0 contract and the recent MEDALLION 4.0 procurement in order to comply with these new requirements. The Final Rule made significant revisions to state Medicaid managed care operations in contracting, provider enrollment, external quality review, patient protections, and Managed Care Organization (MCO) plan oversight. DMAS is in full compliance with the sections of the CMS final rule that became effective in July through the implementation of new program requirements in the CCC Plus and MEDALLION 3.0 programs through contract modifications and a new procurement of MEDALLION. These program enhancements further align DMAS Medicaid managed care programs with Medicare managed care and commercial health plans.

PROGRAM OVERSIGHT

Virginia's Joint Legislative Audit and Review Commission (JLARC) conducted a study of Medicaid Managed Care which was completed in December 2016. JLARC's report titled, Managing Spending in Virginia's Medicaid Program made a number of recommendations which focused on improving utilization monitoring and control including enhanced oversight of members with chronic diseases (COPD, diabetes, obesity and heart disease). JLARC also recommended additional DMAS oversight of financial and encounter data, as well as the use of alternative cost containment strategies. These recommendations impact not only Health Care Services but across the divisions within the Agency. New managed care programs such as Medallion 4.0 and CCC Plus will incorporate many of those recommendations. DMAS is adding additional staff, to support JLARC processes and recommendations.

INNOVATION

MEDALLION 4.0 – THE VEHICLE DRIVING DELIVERY SYSTEM CHANGE

DMAS posted a Request for Proposals on July 17, 2017 for the Medallion 4.0 program. The competitive bidding process for MCOs that want to contract with the new program has begun. The program is set to launch in the Tidewater region beginning August 1, 2018 and will continue to roll out regionally through December 1, 2018. The new Medallion 4.0 program with its contracted MCOs will be the vehicle through which DMAS will drive innovations in service delivery and payment models for over 737,000 Medicaid members.

This program builds upon CCC Plus and is a part of the Agency's long-term goal to move our populations to integrated and coordinated care. Over the past two decades, the Agency has continued to strengthen the foundation of the Medicaid and Family Access to Medical Insurance Security (FAMIS) programs through MEDALLION, Medallion II and Medallion 3.0.

Medallion 4.0 has evolved from the Medallion 3.0 and will serve approximately 737,000 Medicaid lives. The program engaged Health Systems and Stakeholders that will provide holistic and integrated care.

PAYMENT

VALUE BASED PAYMENT

Payment models that realign financial incentives to reward health care providers for the delivery of high-quality, efficient care, rather than simply paying based on service volume, are called value-based payment (VBP) models. Medallion 3.0 currently encourages MCOs to include value-based payment arrangements in their provider contracts. DMAS is working with MCOs to advance existing alternative payment models, pilot new payment models, and progressively increase the percentage of provider payments that qualify as VBP arrangements. MCOs collaborate with providers across the delivery system to test innovative incentive programs that reward the provision of high-quality, efficient care.

SERVICES & MODELS OF CARE

ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)

On April 1, 2017, Virginia's Medicaid program launched an enhanced substance use disorder treatment benefit - Addiction and Recovery Treatment Services (ARTS). The ARTS benefit provides treatment for those with substance use disorders across the state. The ARTS benefit expands access to a comprehensive continuum of addiction treatment services for all enrolled members in Medicaid, FAMIS, FAMIS MOMS and the Governor's Access Plan (GAP), including expanded community-based addiction and recovery treatment services and coverage of inpatient detoxification and residential substance use disorder treatment.

The ARTS benefit increases access to Medication Assisted Treatment, the evidence-based combination of medication, counseling, and psychosocial supports that results in the highest chances of recovery by recognizing Preferred Office-Based Opioid Treatment (OBOT) Providers. DMAS has recognized 37 Preferred OBOTs across the Commonwealth that have licensed behavioral health professionals providing co-located counseling and "high touch" care coordination at the same clinic as buprenorphine-waivered practitioners to members with opioid use disorder.

DMAS is strongly encouraging the health plans to assign members receiving buprenorphine to a Preferred OBOT Provider or any other in-network providers if a Preferred OBOT Provider is not available and accessible. The health plan will cover all the members' addiction treatment services (e.g., physician visit, lab tests, counseling, medication, etc.) instead of members needing to pay out of pocket at out-of-network providers. This increased access to Preferred OBOT Providers will ensure that the member receives the counseling and "high touch" care coordination that will result in the best outcomes.

Medicaid health plans have the contractual authority to deny coverage of buprenorphine prescribed by out-of-network providers and will not pay for buprenorphine prescribed by out-of-network providers beginning November 1, 2017.

INNOVATION

PATIENT UTILIZATION MANAGEMENT AND SAFETY PROGRAM (PUMS)

All contracted Medicaid managed care plans including Medallion 3.0 and Commonwealth Coordinated Care Plus (CCC Plus) are required to have a Patient Utilization & Safety Management Program (PUMS). The PUMS program is intended to coordinate care and ensure that members are accessing and utilizing services in an appropriate manner in accordance with all applicable rule and regulations. The PUMS Program is a utilization control and case management program designed to promote proper medical management of essential health care. Upon the member's placement in the PUMS, the Contractor must refer members to appropriate services based upon the member's unique situation. Members identified for placement in the PUMS program may also be evaluated for referral to ARTS. Members may be placed into a PUMS program for a period of twelve (12) months when either of the following trigger events occurs:

1. The Contractor's specific utilization review of the member's past twelve (12) months of medical and/or billing histories indicates the member may be accessing or utilizing health care services inappropriately, or in excess of what is normally medically necessary, including the minimum specifications found in the Managed Care Technical Manual (MCTM).
2. Medical providers or social service agencies provide direct referrals to the Department or the Medicaid managed care health plan (MCO).

IMPLEMENTATION OF CDC OPIOID PRESCRIBING GUIDELINES

In March 2016 the U.S. Centers for Disease Control and Prevention (CDC) published the **Guideline for Prescribing Opioids for Chronic Pain**. This guideline addresses 1) when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up and discontinuation; 3) assessing risk and addressing harms of opioids use. The Guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. In addition to the CDC Guideline, the Virginia Board of Medicine recently promulgated regulations on the prescribing of opioids for pain and buprenorphine for treatment of substance abuse in response to the escalating opioid crisis in Virginia.

DMAS worked with the Virginia Department of Health, Department of Health Professions, Medical Society of Virginia, and Medicaid health plans to develop uniform policies that align with the CDC Guideline and the Virginia BOM Regulations across all Medicaid health plans. These uniform policies have been phased in over the past year and will be effective for all Medicaid members effective July 1, 2017. These policies are described in the Medicaid Memo published on December 1, 2016 at www.virginiamedicaid.dmas.virginia.gov. Since the implementation of these policies in the Medicaid Fee-for-Service program in July 2016, DMAS has seen a 44% decrease in the total day supply of opioids and a 42% decrease in the total drug quantity dispensed. The number of patients receiving opioids has only decreased by 17%.

DMAS' six (6) managed health plans have seen similar results since implementing the CDC Guidelines for opioid-naive members on December 1, 2016. In the first quarter of 2017, the plans have seen a 16- 61% reduction in the quantity of drug dispensed and a similar reduction in the number of prescriptions or total days' supply while the number of patients receiving opioids decreased by 12-60%.

These actions are critically important to the Commonwealth's response to the opioid epidemic. We believe that by addressing the opioid crisis through expanded treatment options, promoting evidence-based best practices, and working with other state agencies and our Medicaid health plans to reduce misuse of prescription opioids that we can improve the quality of life for our citizens impacted by this crisis.

INNOVATION

MEDALLION CARE SYSTEM PARTNERSHIPS (MCSP)

DMAS established the Medallion Care System Partnership (MCSP) to improve health outcomes and bend the cost curve by requiring MCOs to develop and implement partnerships with a group of their MCO contracted providers to improve health outcomes by integrating primary, acute and complex health delivery. All MEDALLION 3.0 MCOs are required to form at least one MCSP that emphasizes the use of "health homes". MCSPs include the use of financial incentives for providers who improve predetermined quality metrics for patients using targeted patient education and disease management interventions. MCSP agreements allow MCOs the flexibility to test innovative payment models and incentive structures through Health Homes or other MCSP approved arrangements. MCSP models can be focused on a particular geographic area, population, or even a physician practice.

Under an MCSP arrangement, an MCO partners with providers to increase participation with integrated care models, improve member outcomes, and align administrative processes for better efficiency and member experience. MCO contract agreements with these provider partners may include financial incentives such as gain and risk sharing, performance-based incentives, or other incentive reforms tied to approved quality metrics.

BEHAVIORAL HEALTH HOMES PILOT PROJECT (BHH)

As a part of Governor McAuliffe's A Healthy Virginia plan, DMAS collaborated with DBHDS and MCOs to establish BHHs that coordinate care for adults with Serious Mental Illness (SMI) or emotional disturbance. Five Medallion 3.0 MCOs have regional BHH pilots that serve more than 200 eligible members.

Individuals living with SMI often face challenges accessing care and managing medication regimens. BHHs work to ensure members can access needed services and offer care coordination from a dedicated BHH care manager. BHH pilots are seeing success from care coordination with considerable outreach, decreases in hospitalizations, and strengthened relationships with members and their family.

As Medallion 3.0 BHHs finish their second year, MCOs have expressed interest to continue the pilots beyond the scheduled 2018 sunset. Due to the success of the program, the BHH program will include child members starting in January 2018.

Dean's Success Story

Dean, a Behavioral Health Home (BHH) pilot member, was not attending his medical follow up appointments due to his mental illness symptoms. We suggested to his Community Service Board (CSB) Case Manager and Mental Health Support Worker that they try to schedule a concurrent primary care exam and psychiatric appointment at the CSB. This dual appointment was successfully arranged with one of the physicians and Dean was seen at the CSB for his first physical exam in many years. His Mental Health Support Worker commented on how well the staff responded to Dean's behavioral health needs and ensured he was properly examined and felt comfortable in the process. The examination revealed high blood pressure levels that were uncontrolled and contributing to his symptoms of anxiety and paranoia. He received a new medication to help lower his blood pressure and was referred to a specialist. A BHH team member will attend the specialty appointment to support Dean.

This is the story of a real Virginian whose name and photographic image are protected under HIPAA.

IN SUMMARY

Beginning at its inception and over the course of the last twenty years, the Medallion program has evolved and continuously improved service delivery, operations, and performance management and program integrity. In 2016, Medallion 3.0 introduced a number of changes to improve the delivery of health care for members by increasing access to care like covering foster children up to age twenty-one, expanding family planning services and increasing case management services to Health and Acute Care Program (HAP) members.

Medallion 3.0 also improved operations and program performance management by enhancing the member enrollment process, implementing the PUMS programs at the MCO level to improve patient safety monitoring, transitioning to a rapid cycle PIP process for quality improvement, and implementing a new compliance program to manage and enforce MCO contractual compliance.

DMAS will continue working with stakeholders as the next phase of Medallion develops and launches over the next year. Medallion 4.0 will be the vehicle for realizing the vision of advancing value-based payment and delivery system reform that will improve care outcomes for approximately 740,000 individuals receiving their health coverage from the Medallion program. The success of Medallion means more Virginians can access the care they need to live a healthier life. DMAS thanks the many stakeholders who partner with Medallion to "Connect Care" and achieve high-quality and cost-effective health for Virginians.

We are driven by our mission and commitment to provide Virginia's Medicaid community the highest quality and access to care. Our strategic business partnerships with the health plans lead to the integration and alignment of services and connect us to the communities we serve.

- Cheryl J. Roberts, J.D.
Deputy Director of Programs & Operations

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