Virginia Medicaid Managed Care Operational Report

July 1, 2018 - June 30, 2019

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 SFY2019. This report includes information on and an assessment of the operation of Virginia's managed care programs in the following areas:

- Financial performance of each MCO, including 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 LTSS not otherwise addressed, as applicable.

THE VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS)

The Virginia Department of Medical Assistance Services plays a critical role in improving the health and well-being of Virginians by providing access to high-quality health care coverage. Medicaid provides health care financing for over one million poor and medically vulnerable Virginians, and in state fiscal year 2019 DMAS experienced a number of major changes and innovations to the Medicaid program. Highlights include:

- Implementation of the Medallion 4.0 program, beginning in August 2018.
- Medicaid Expansion, effective January 1, 2019, making close to 400,000 Virginia adults eligible for health coverage.
- The one-year anniversary for both the Commonwealth Coordinated Care Plus program for medically complex individuals as well as for Virginia's nationally-renowned Substance Use Disorder benefit, the Addiction and Recovery Treatment Services program.
- Renewal of the FAMIS program and submissions of State Plan Amendments to CMS to increase covered services for FAMIS and FAMIS MOMS populations.
- Opportunities to learn about managed care and Virginia's Medicaid programs through Managed Care 101 & Managed Care 102 workshops available to DMAS staff and stakeholders.

MEDICAID MANAGED CARE 2018-2019

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. Virginia's Medicaid managed care programs in SFY2019 were Medallion 4.0 and Commonwealth Coordinated Care (CCC) Plus. Individuals identified as medically complex are enrolled into the CCC Plus program, while individuals classified as non-medically complex are covered under the Medallion 4.0 program.

In Virginia, 90% of Medicaid enrollees received their benefits through a Managed Care Organization (MCO) and 10% of enrollees participated through the Fee for Service (FFS) program. Virginia has been increasing its use of the MCO programs because of the value it provides to enrollees and the Commonwealth. Managed care provides budgetary predictability and can also include benefits to members such as care coordination, enhanced provider networks, and access to 24/7 call centers.

Through a competitive procurement, in SFY19 the transition from Medallion 3.0 to Medallion 4.0 resulted in a change of managed care organizations serving the Virginia Medicaid populations. Magellan Complete Care of Virginia was selected as a new health plan and UnitedHealthCare acquired INTotal Health that had previously operated through Medallion 3.0. The roll-out of Medallion 4.0 began in August 2018, and now both the Medallion 4.0 and CCC Plus programs operate statewide through contracts with the same MCOs, including: Aetna Better Health of Virginia, Anthem HealthKeepers Plus, Magellan Complete Care of Virginia, Optima Family Care, UnitedHealthcare, and Virginia Premier.

Medallion 4.0

Medallion 4.0 is a statewide mandatory Medicaid program that operates under a CMS §1915(b) waiver, last renewed July 1, 2019. 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 expansion adults.

Medallion 4.0 Overview

73%
of Medicaid & FAMIS enrollees in program

1,008,853
Medallion 4.0 members as of June 2019

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 long term services or supports (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 program design, and is an integrated delivery model that includes medical and behavioral health services with LTSS.

CCC Plus Overview

18%
of Medicaid & FAMIS enrollees in program

243,429
CCC Plus members as of June 2019

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

Populations currently ineligible for CCC Plus include, but are not limited to: psychiatric residential treatment center (RTC) facility programs, individuals enrolled in the Commonwealth's Medallion and Title XXI CHIP programs (FAMIS, FAMIS MOMS), individuals enrolled in a PACE program, dual eligible individuals without full Medicaid benefits, individuals with temporary coverage or who are in limited coverage groups.

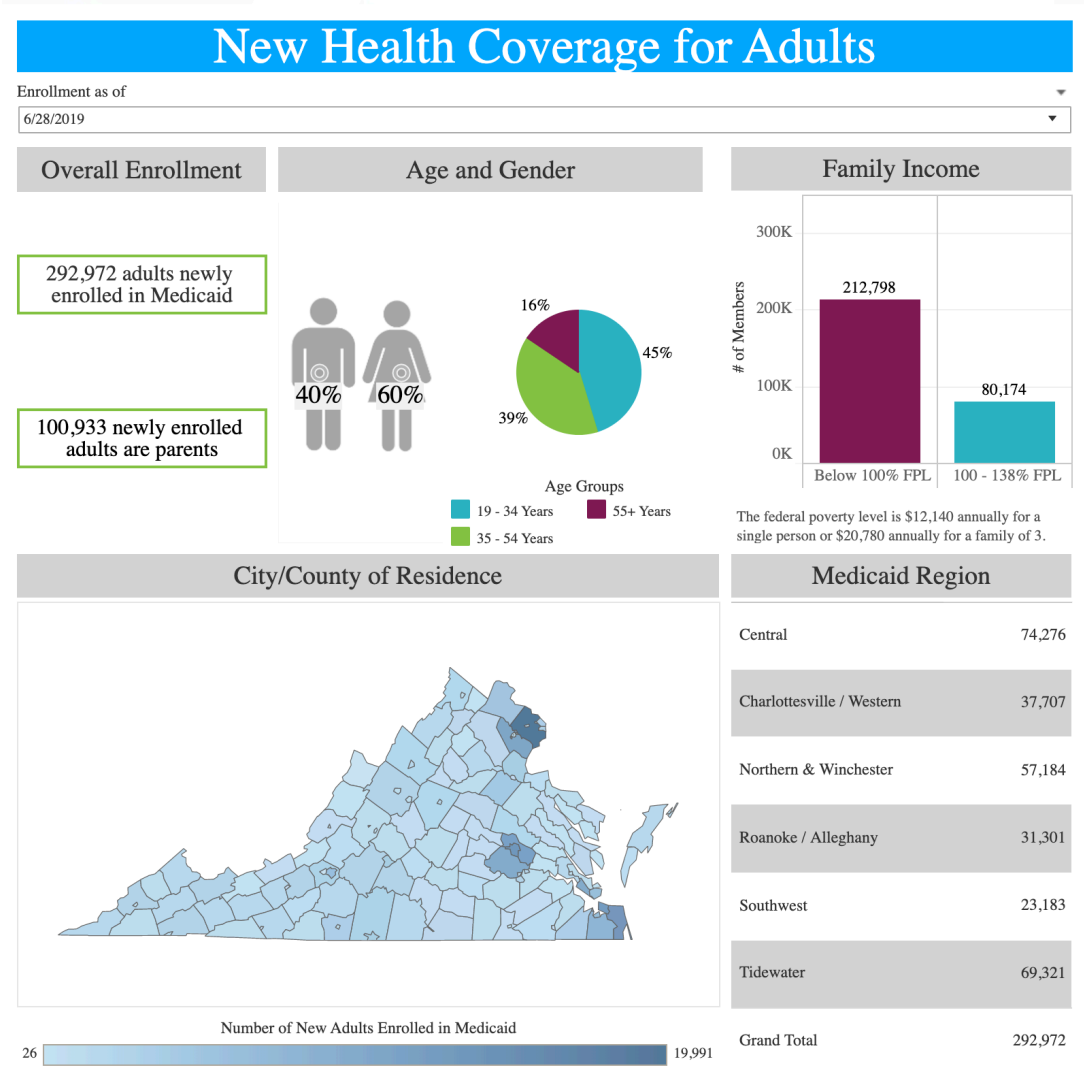
In SFY19, Medallion 4.0 and CCC Plus rolled in services that were previously carved out of mandatory managed care, including community mental health rehabilitative services (CMHRS), early intervention services, consumer directed personal care, and third party liability (TPL) members.

MEDICAID EXPANSION

Medicaid expansion is generating cost savings that benefits the overall state budget. The new eligibility rules are also changing the face of the Medicaid program as more parents and single adults gain health coverage. Virginia adults may now be eligible if they are between the ages of 19 and 64, are not receiving or eligible to receive Medicare, and meet income eligibility rules. The decision to expand Medicaid eligibility qualifies the Commonwealth for a federal funding match of no less than 90 percent for the newly eligible adults. The state's share is covered by a provider assessment on certain Virginia hospitals that stand to benefit from a decline in the number of uninsured patients receiving charitable care.

Medicaid Expansion Program Selection Process Through MCO Member Health Screening (MMHS)

DMAS developed a two-part screening tool to both assess medical complexity (Part One, determining enrollment in either the CCC Plus or Medallion 4.0 program) as well as to identify member social needs through a social determinants of health (SDOH) assessment (Part Two). The MMHS can be conducted in a variety of ways (through the mail, over the phone, in person), and MCOs are asked to screen all new members within 90 days of plan enrollment.



Access Dashboard

Medicaid Expansion Access and Health Services

Current Member Enrollment
382,762

Any Service Received
342,046

At Least One Office Visit
263,468

At Least One Prescription
267,852

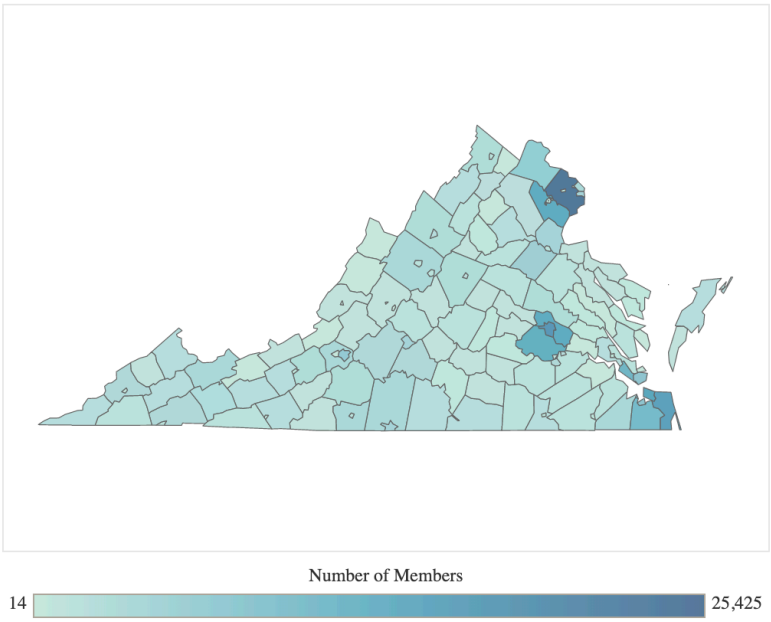
Treated for High Blood Pressure
48,517

Treated for Diabetes
27,168

Treated for Asthma
10,734

Treated for Cancer
6,107

Access and Health Services by Locality



Treated for Chronic Obstructive Pulmonary Disease (COPD)
7,927

Received Addiction and Recovery Treatment Services (ARTS)
23,494

Footnotes

1. The number of members served is not displayed for localities with fewer than 20,000 residents or when totals for a given service are fewer than 10 members per Department policy to protect the privacy of members.
2. Addiction and Recovery Treatment Services (ARTS) are services based on the American Society of Addiction Medicine continuum of care and includes office-based opioid treatment, outpatient opioid treatment, counseling, intensive outpatient programs, partial hospitalization, residential treatment, withdrawal management, care coordination, and peer support.
3. The total number of members served is cumulative and includes members enrolled at any point since January 1, 2019 to February 1, 2020. Members may no longer be enrolled as of the most recent update.
4. The number of members served is identified through paid claims submitted to the Department as of the most recent update. Due to lag in claims submission, additional services may have occurred but are not represented here

MANAGED CARE BENEFITS

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

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

Each managed care program offers a suite of benefits to its enrollees. 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 and by program.

Summary of Benefits

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

Enhanced Services/Added Benefits

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

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

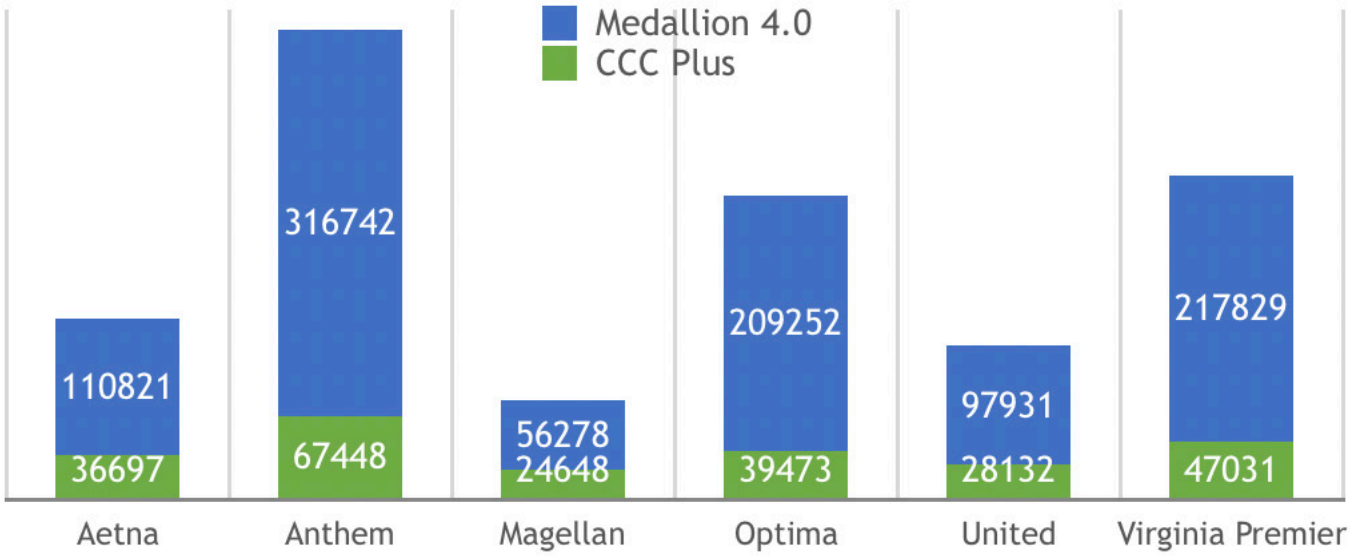
Medallion 4.0 Enhanced Services

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

CCC Plus Enhanced Services

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

MCO Enrollment by Managed Care Program



In this graph, the total population of Medallion 4.0 and CCC Plus members is broken down by MCO. This data reflects the population as of June 3, 2019.

MANAGED CARE ENROLLMENT

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

Medallion 4.0 Member Enrollments Through Website and Smart Phone 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. In SFY19, 35% of Medallion 4.0 enrollments were through the website or app, with utilization of these technologies increasing over time.

SFY19 Medallion 4.0 Enrollments by Type						
App	Phone	Website	Total	App & of Total	Phone % of Total	Web % of Total
18,946	179,698	78,345	276,989	7%	65%	28%

MCO FINANCIAL PERFORMANCE

In managed care, MCOs enter a fully capitated, risk-based contract to administer each program. DMAS pays the MCOs per member, per month (PMPM) capitation rates developed annually by the DMAS actuary (Mercer during SFY 2019) and these rates may be modified during the annual contract renewal process. The MCOs are responsible for paying providers for covered services utilized by the member.

Minimum Medical Loss Ratio (MLR)

To ensure rates paid by the Department are utilized to pay for covered services, the MCOs are subject to a minimum medical loss ratio (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% then the MCO must repay DMAS an amount equal to the deficiency percentage applied to the amount of adjusted premium revenue. The MCOs are required to report this annually, as well as provide DMAS with all of the necessary data to calculate and verify the MLR within eleven (11) months of the end of the reporting year (which is the contract year). Below is a summary of the financial performance of each MCO in SFY2019. The Net Gain or Loss row is determined by whether or not an MCO's total revenues were greater than (gain) or less than (loss) the total expenses of that MCO.

Aggregate MCO Financial Performance Summary SFY2019

MCO	Aetna	Anthem	Magellan	Optima	United	VA Premier
MLR	92.6%	91.2%	96.4%	94.9%	92.4%	92.7%
Net: Gain or Loss	Loss	Gain	Loss	Loss	Loss	Loss

Medallion 4.0 Financial Performance Summary, SFY2019

MCO	Aetna	Anthem	Magellan	Optima	United	VA Premier
MLR: <85%	No	No	No	No	Yes	No
Net: Gain or Loss	Gain	Gain	Gain	Gain	Gain	Loss

CCC Plus Financial Performance Summary, SFY2019						
MCO	Aetna	Anthem	Magellan	Optima	United	VA Premier
MLR: <85%	No	No	No	No	No	No
Net: Gain or Loss	Loss	Gain	Loss	Loss	Loss	Loss

Bureau of Insurance (BOI) Oversight

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

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

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

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

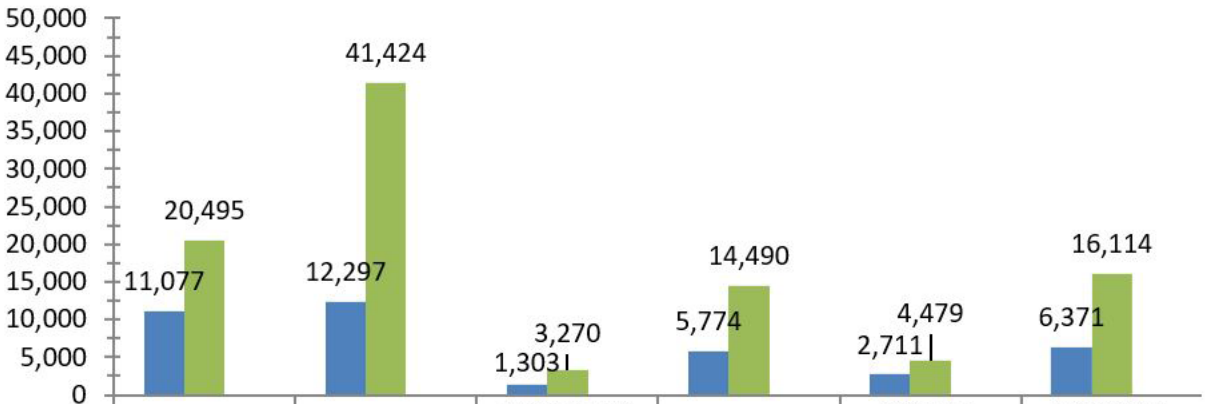
BENEFICIARY SUPPORT SYSTEM (MAXIMUS)

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 a helpline and website, with the aim to educate and assist Medicaid members and the public with managed care topics.

Virginia Managed Care Helpline Activity Summary Report - July 2018 - June 2019				
Total Calls Answered	Average Calls Handled Per Month	Highest Call Volume (Month)	Lowest Call Volume (Month)	Overall Abandonment Rate
219,672	18,306	January	July	8.45%

The following chart, Enrollments by Plan and MCO, represents enrollment activity for each the MCOs. The chart shows the number of new enrollments and 90-day transfers for each MCO. The total number of enrollments the Helpline processed into MCO's during this reporting period was 139,805. There were 39,533 new enrollments and 100,272 90-day transfer enrollments.

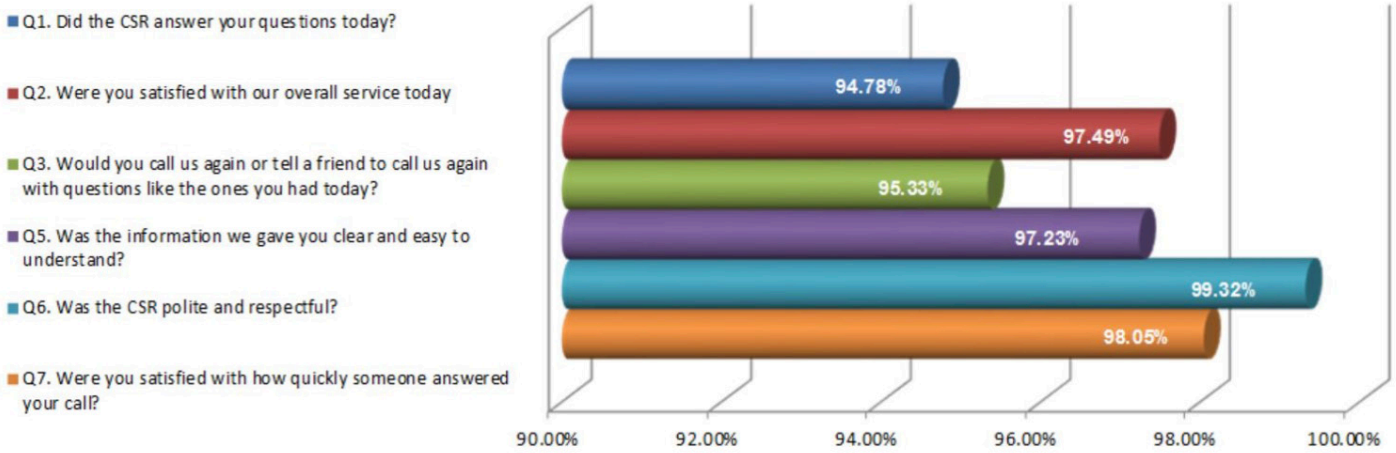
Enrolllments by Plan and MCO



	AETNA BETTER HEALTH	HEALTHKEEPERS	MAGELLAN COMPLETE CARE OF VIRGINIA	OPTIMA HEALTH PLAN	UNITED HEALTHCARE COMMUNITY PLAN OF VA	VIRGINIA PREMIER HEALTH PLAN
New Enrollment	11,077	12,297	1,303	5,774	2,711	6,371
Transfer Enrollment	20,495	41,424	3,270	14,490	4,479	16,114
Total Enrollments	31,572	53,721	4,573	20,264	7,190	22,485

Below, the Customer Satisfaction Survey shows the percentage of favorable responses by survey question for the current reporting period. Callers completed 11,700 surveys during the reporting period with overall responses 97.00% favorable.

CUSTOMER SATISFACTION SURVEY



QUALITY PERFORMANCE

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

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

DMAS also published the agency-wide quality strategy for 2017-2019 where it outlines the goals and initiatives for the managed care programs with a focus on quality improvement for all Medicaid members, regardless of program. The report is available publicly on the DMAS website (http://www.dmas.virginia.gov).

NCQA Accreditation

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

MEDICAID NCQA HEALTH INSURANCE PLAN RATINGS 2019 – 2020

NCQA Health Insurance Plan Ratings 2019-2020 - Summary Report (Medicaid)

Lower Performance ≤1.0 | 1.5 | 2.0 | 2.5 | 3.0 | 3.5 | 4.0 | 4.5 | 5.0 Higher Performance

Rating	Plan Name	States	Type	NCQA Accreditation	Consumer Satisfaction	Prevention	Treatment
3.5	HealthKeepers, Inc. (Medicaid)	VA	HMO	Yes	3.5	2.5	3.0
3.5	Optima Health Plan	VA	HMO	Yes	4.5	2.5	2.5
3.5	Virginia Premier Health Plan, Inc.	VA	HMO	Yes	4.0	2.5	2.5
3.0	Coventry Health Care of Virginia, Inc., dba Aetna Better Health of Virginia	VA	HMO	Yes	3.0	2.0	2.5
3.0	UnitedHealthcare of the Mid-Atlantic dba UnitedHealthcare Community Plan (VA Commonwealth Coordinated Care Plus)	VA	HMO	Yes (Interim)	3.0	1.5	3.0
2.5	Magellan Complete Care of Virginia, LLC	VA	HMO	Yes (Interim)	3.0	I	2.0
2.5	UnitedHealthcare of the Mid-Atlantic dba UnitedHealthcare Community Plan of Virginia	VA	HMO	Yes (Interim)	I	2.0	2.5

- NCQA Accreditation as of June 30, 2019.
- **I** = Insufficient data; **NC** = No Credit; **NA** = Not Applicable; **NP** = Not Publicly Reported

Consumer Decision Support Tool

DMAS works with its External Quality Review Organization (EQRO), HSAG, to produce annually a 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' website and Maximus's enrollment website.

VIRGINIA MEDICAID MANAGED CARE QUALITY

CONSUMER DECISION SUPPORT TOOL 2018–2019

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

Highest Performance	★★★★★
High Performance	★★★★
Average Performance	★★★
Low Performance	★★
Lowest Performance	★

MCO	Accreditation Level	Doctors' Communication	Getting Care	Keeping Kids Healthy	Living With Illness	Taking Care of Women
Aetna	Accredited	★★★	★★★	★★★	★★	★★★
Anthem	Accredited	★★★★	★★★	★★★★	★★★	★★★★★
Optima	Accredited	★★★	★★★	★★	★★	★★★★★
UnitedHealthcare*	Accredited	★	★★	★★★	★	★
VA Premier	Commendable	★★★	★★★	★★★	★★★★★	★★★
Magellan	**New	**New	**New	**New	**New	**New

*Formerly INTotal.
**Due to Magellan being a new plan in 2018, data does not allow for comparisons to other plans. Magellan will be included in future tools.

What is Measured in Each Performance Area?

Doctors' Communication
- Doctors explain things well to members

Getting Care
- Members get the care they need, when they need it

Keeping Kids Healthy
- Children get regular checkups and important shots that help protect them against serious illness

Living With Illness
- Members with asthma, diabetes, high blood pressure, and depression get the care they need by getting tests, checkups, and the right medicine

Taking Care of Women
- Women get tests for breast and cervical cancer to help find these diseases early
- Moms get care before and after their baby is born to help keep mom and baby healthy

HEDIS® OVERVIEW

Healthcare Effectiveness Data and Information Set (HEDIS®)

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

First Full Year of Commonwealth Coordinated Care (CCC) Plus

Reporting year 2018 is the first full year of CCC Plus Virginia's new MLTSS program, with the inclusion of new carved-in services and new significant, high-risk populations into managed care. This includes the transition of existing higher acuity ABD and HAP members from Medallion 3.0 to CCC Plus effective 1/1/18, with emphasis on care coordination and continuity of care during the transition. CCC Plus carved in community mental health services, early intervention services, consumer- directed personal care and third party liability (TPL) members in 2018.

Transition from Medallion 3.0 to Medallion 4.0

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

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

Rate Impacts

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

Medallion 4.0 and HEDIS® Performance

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

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

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

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

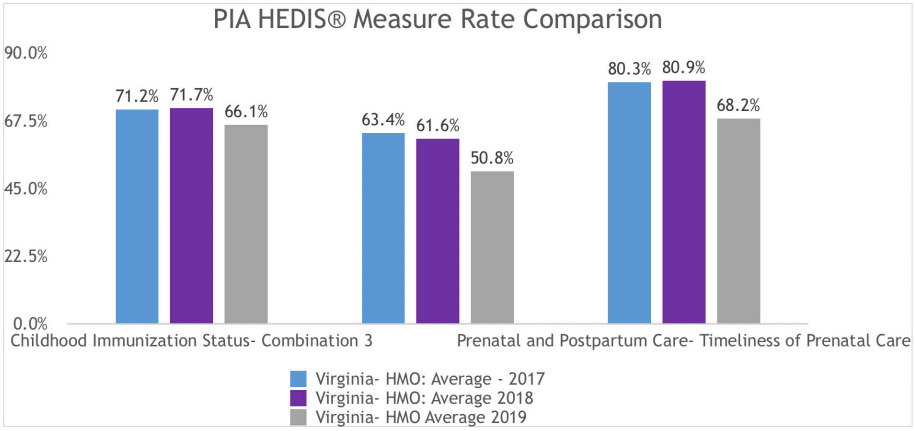
CCC Plus and HEDIS® Performance

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

Medallion 4.0 and the Performance Incentive Award (PIA)

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

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



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

Value Based Purchasing (VBP)

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

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

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

Quality Next Steps

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

Performance Improvement Projects (PIPs)

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

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

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

Network Accessibility and Availability

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

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

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

GRIEVANCES AND APPEALS

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

Member State Fair Hearings

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

MCO-Specific Appeals

As part of the State Fair Hearing process, Medicaid recipients who receive coverage through managed care may appeal full or partial service denials rendered by participating MCOs. In order to enter into this process, the appellant must have exhausted the participating MCO's appeal process and must meet the legal criteria for a state fair hearing. Providers enrolled in Virginia Medicaid or those seeking enrollment may also request a state fair hearing of a decision rendered by an MCO.

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 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 are specific to the Medallion or CCC Plus programs.
5. After being validated using the BRE, files either receive a pass or fail status. Failed encounters are reported to the MCO to be corrected by the submitter. Once an encounter has been completely validated, it is stored in a database for future use by other areas of DMAS.
6. DMAS holds the MCOs to stringent data submission standards, which are further outlined in each program's contract. If an MCO fails to submit timely, accurate, or complete data, including encounter data, it can be subject to compliance actions, as outlined in the next section.

COMPLIANCE

Both CCC Plus and Medallion 4.0 utilize an ongoing Compliance Monitoring Process to detect and respond to issues of non-compliance and remediate contractual violations when necessary through progressive sanctions based on the number of points accumulated at the time of the most recent compliance violation/incident. These points accumulate over a rolling 12-month schedule. Therefore, while active points will roll over from previous contract years, any points that are more than twelve (12) months old will expire and no longer be counted. Both CCC Plus and Medallion 4.0 assess progressive sanctions on a monthly basis based on the tiered point system below:

Level	Point Range	Corrective Mechanism	Financial Sanctions/Fines
1	0-10.5	MCO Improvement Plan (MIP), Corrective Action Plan (CAP), or neither, depending on severity	None
2	11-25.5	MIP, CAP, or neither, depending on severity	$5,000.00
3	26-50.5	MIP, CAP, or neither, depending on severity	$10,000.00
4	51-70.5	MIP, CAP, or neither, depending on severity	$20,000.00
5	71-100.5	MIP, CAP, or neither, depending on severity	$30,000.00
6	101-150	Suspend Enrollment	N/A
7	>150	Possible Agreement Termination	N/A

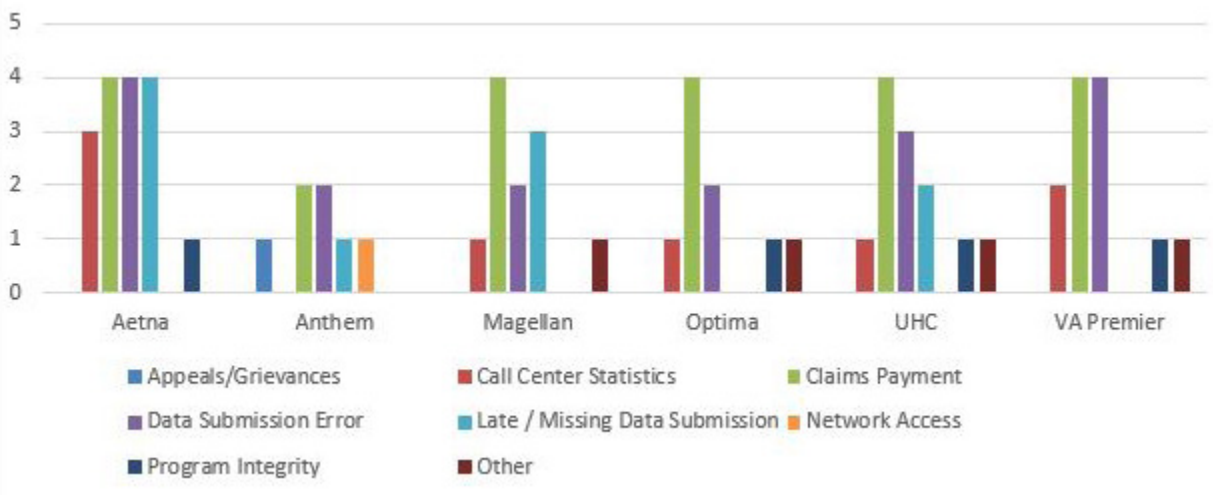
The MCOs can incur points for a variety of issues, including but not limited to those listed below. Each of the examples listed below increase not only in the severity of the violation, but also in the number of points assessed, from one (1) point infractions, five (5) point infractions, up to ten (10) point infractions.

- Encounter submission errors (1 point)
- Failure to use reporting format reflect in the program's Technical Manual (1 point)
- Failure to provide member materials to new members in a timely manner (5 points)
- Failure to staff 24-hour call in system with appropriately trained medical personnel (5 points)
- Discrimination among members based on health status or need for health care services (10 points)
- Failure to assist a member in accessing needed services in a timely manner after receiving a request from the member (10 points)

Intermediate sanctions may also be assessed on the MCO per federal regulations. For more details on compliance and sanctions, please refer to the contracts for the respective managed care programs, available on the DMAS website.

Medallion 4.0 Compliance Summary

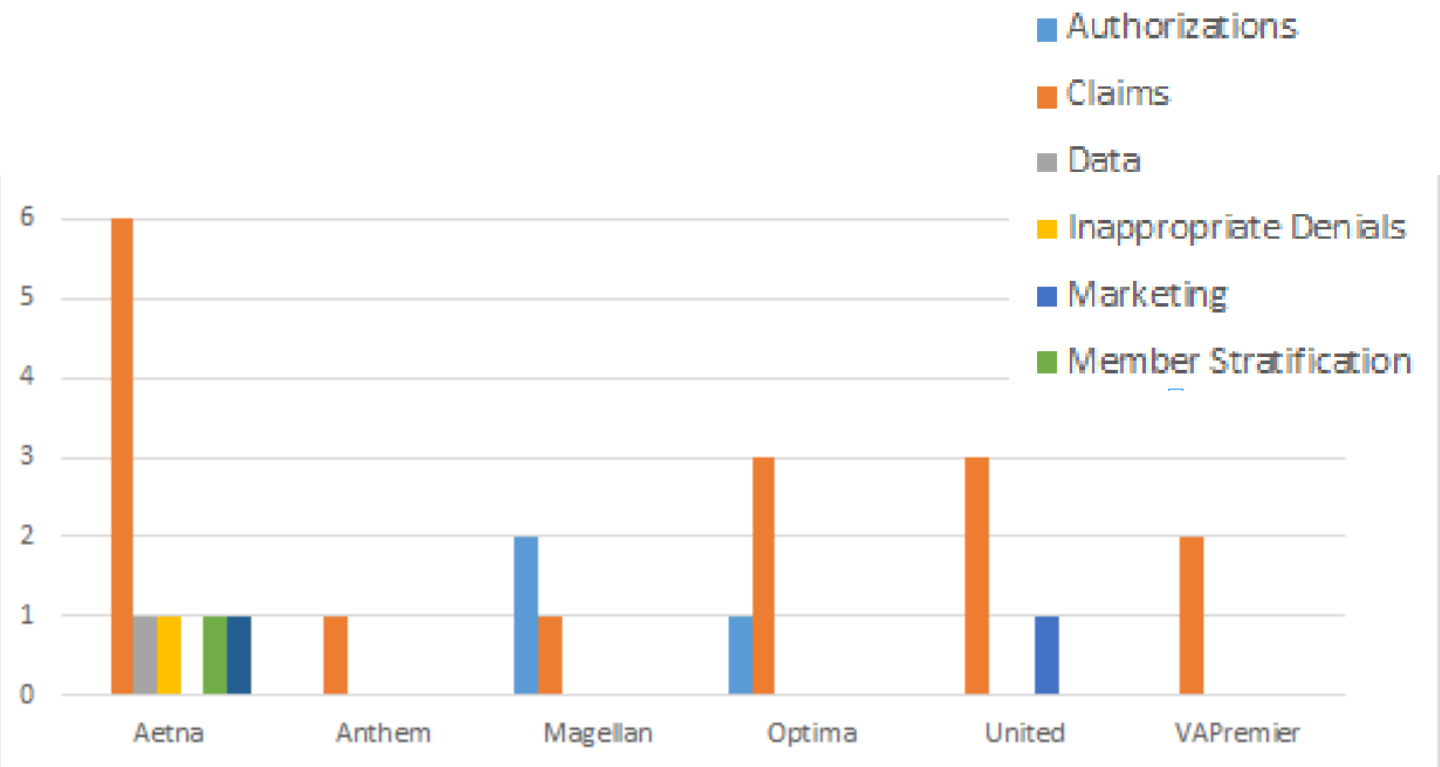
Below is a summary of compliance actions issued to the Medallion 4.0 MCOs since the Medallion 4.0 contract became active in August of 2018.



Since the initial effective date of the Medallion 4.0 program, the Medallion 4.0 compliance team investigated 83 instances of potential contract non-compliance. Those investigations have led to the issuance of 27 compliance points, $5,000 in financial sanctions, and over 60 enforcement letters. In 2019, the Medallion 4.0 compliance team also completed site visits with all six Medallion 4.0 MCOs, and applied a series of changes to the compliance program based on lessons learned from those site visits. Going forward, the Medallion 4.0 compliance team will continue to expand the methods it uses to detect incidences of contract non-compliance, and will increase its use of objective data—such as encounter data—to enforce contract compliance.

CCC Plus Compliance Summary

The following is a summary of compliance actions issued to the CCC Plus MCOs during SFY19.



In SFY2019, the CCC Plus program issued a total of 24 compliance actions. These compliance actions included 20 Managed Care Improvement Plans (MIP) and 4 Corrective Action Plans (CAP). 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 SFY2019, the 4 CAPs had resulted in 15 points and $2,000 being withheld from the MCOs.

PROGRAM INTEGRITY (PI)

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

Managed Care Collaborative meetings provide both MCOs and DMAS the opportunity to share information regarding program integrity issues. These quarterly meetings provide a forum to identify problematic providers as well as trending fraudulent schemes. Additionally, successful approaches to mitigate and avoid abusive schemes are shared. Representatives from the Attorney General's Medicaid Fraud Control Unit (MFCU) attend these meetings and provide updates on fraud investigations.

Key PI Accomplishments

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

ADDITIONAL MLTSS INFORMATION

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

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

SUMMARY

The managed care programs offered by DMAS continued to be improved and refined in state fiscal year 2019. Medallion 4.0 continued the program's twenty plus year history of high quality care and focus on innovation, and now access to care for most of the adult Medicaid Expansion population. CCC Plus continues to strengthen its integrated delivery model and person-centered program design for members with complex healthcare needs. DMAS is committed to promoting high quality and cost-effective care for Virginians, advancing value-based payment practices, and facilitating delivery system reform. Managed care program oversight and accountability is central to realizing these initiatives, and DMAS' stewardship of the CCC Plus and Medallion 4.0 programs continues to strengthen and grow.

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