Medallion 3.0 Managed Care
Annual Report 2015

Making The Next Move

The Department of Medical Assistance Services
Health Care Services Division

Director's Letter

The Department of Medical Assistance Services (DMAS, Agency) currently serves more than one million Virginians through the Medicaid and FAMIS programs, and strives to ensure our members receive the right care in the right place at the right time. The Agency has had an exciting year providing access to high quality, comprehensive health care services to those Virginians who qualify for our programs.

This year the Agency established and implemented the Governor's Access Plan (GAP)—*A Healthy Virginia* initiative. GAP is a benefit plan that assists qualifying individuals with serious mental illness access to behavioral and primary health services in order to help them recover, live, work, parent, learn, and participate in their communities. This program signifies Virginia's dedication in moving health care forward in Virginia.

For over 18 years, Virginia's Medallion 3.0 Managed Care Organizations (MCOs) have successfully provided quality-driven healthcare and high-quality provider access for members while effectively controlling costs. Over the past year (2014-2015), significant steps have been made as the Agency strengthened existing managed and coordinated care programs and established the Commonwealth Coordinated Care (CCC) program—the Agency's newest managed care program for dually eligible Medicaid and Medicare members. Virginia's two full-risk contracted Medicaid managed care programs are Medallion 3.0 and CCC. The Program for the All-Inclusive Care for the Elderly (PACE) is a care coordination program administered by the Agency. Additionally, these programs had a very successful year in member service, broadening membership and strengthening stakeholder and provider partnerships.

Virginia is dedicated to the process of transforming the Medicaid program into a value-based payment and delivery system where quality, efficiency, and cost effectiveness is rewarded. Through the MCOs, Virginia has more than ten years of developing value-based purchasing programs that support a patient-centered health care system while allowing the health plans to create innovative programs to engage providers and promote quality of care. During the upcoming years, DMAS and the MCOs will work together to increase the percent of Medicaid members cared for by providers engaged in some form of pay-for-value program and to share data on the quality and outcomes of these programs. Details and updates on value-based, quality incentiv-

Director's Letter

ized models of care and service integration such as patient-centered medical homes, Medallion Care System Partnerships (MCSP), and other value-based approaches are included in this report. Also highlighted are achievements in quality management; Expedited Enrollment; MCO Behavioral Health Homes; selected initiatives of *A Health Virginia*; interagency collaborations and workgroups; program integrity endeavors; the Maternal and Infant Improvement Project; and future initiatives for Virginia's Medicaid program.

We are dedicated to ensuring that Agency vision and values guide our daily activities and our long-term mission of public service. I hope that you find this report to be helpful and informative. Throughout this report we have added hyperlinks that may provide helpful information regarding the highlighted text.

Thank you,

Cindi B. Jones
Director of Department of Medical Assistance Services

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Overview

This Managed Care Annual Report serves to provide information on the Medallion 3.0 Medicaid managed care program and highlight the progress the Agency and its six contracted Medallion 3.0 Medicaid Managed Care Organizations (MCOs) made over the past fiscal year (July 1, 2014—June 30, 2015) in the provision of health care services to members of Medicaid and the Children's Health Insurance Program (CHIP), also known as Family Access to Medical Insurance Security (FAMIS). This document further serves to provide a more in-depth understanding of Virginia's dedication to the Medicaid managed care delivery system and how it delivers on the goals and mission of the Commonwealth.

The Agency has been directed to transition most populations into a managed care service delivery model. Managed care or coordinated care are service delivery models through which teams of health care professionals work together to ensure that members' health needs are being met. Managed care, for the purposes of this document, specifically refers to an approach to integrating care and controlling costs through full-risk, capitated contracts with MCOs. It is through these full-risk contracts that Virginia benefits from a combination of unique MCO attributes that drive the success of Virginia's managed care programs.

Unique Attributes of MCOs:

These attributes are highlighted and described in detail in this report. By investing in Virginia's successful and established Medicaid Managed Care delivery system and developing new managed care programs, the Commonwealth continues to deliver on its pledge to provide access to quality health care services and to remain conscientious stewards in the use of taxpayer funds.

Medallion 3.0 Managed Care Highlights

MCOs
- All Medallion 3.0 MCOs are NCQA Accredited

Enrollment
- Expedited Enrollment: Shortens Assignment Period For Faster Access to Managed Care

HAP
- Health and Acute Care Program – Over 8,300 Members with Community-Based Waivers Now Receive Acute Care from MCOs – 1st Interdisciplinary, Multi Divisional Implementation Collaboration for HCS and LTC

MCOs
- 10 Years of MCO Value-Based Purchasing (VBP) initiatives and payment models such as patient-centered medical homes, enhanced care management, and shared savings

Pharmacy
- MCO Pharmacy Rebates Yielded Over $312M* in Cost Savings

Behavioral Health
- Development of MCO Behavioral Health Home Pilot Program to Assure Behavioral Health and Acute Care Coordination**

Quality
- Performance Incentive Award (PIA)Pilot Year Underway – HEDIS ® and Administrative Based Measures Incentivized Program Rewards Care and Service Quality

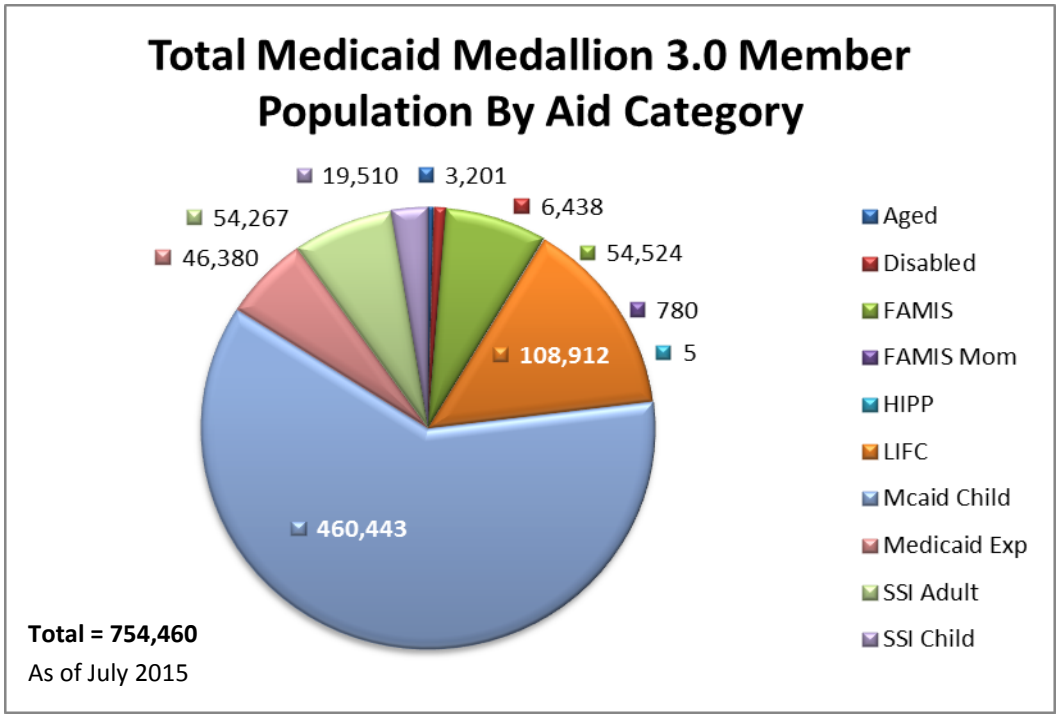
Care Access
- More than 90% of children visited a PCP at least once during 2014 and 95% of FC youth saw a physician within the first year of enrollment into a Medallion MCO

* Over fiscal year 2014-2015

** Governor's initiative A Healthy Virginia

Medallion 3.0 Member and Health Plan Profiles

Among the 1,123,653 members who rely on Virginia Medicaid for healthcare, as of July 2015 there are approximately 754,460 members who receive Medicaid managed health care services through contracted Managed Care Organizations (MCO). Of these members 415,123 are female and 339,337 are male.



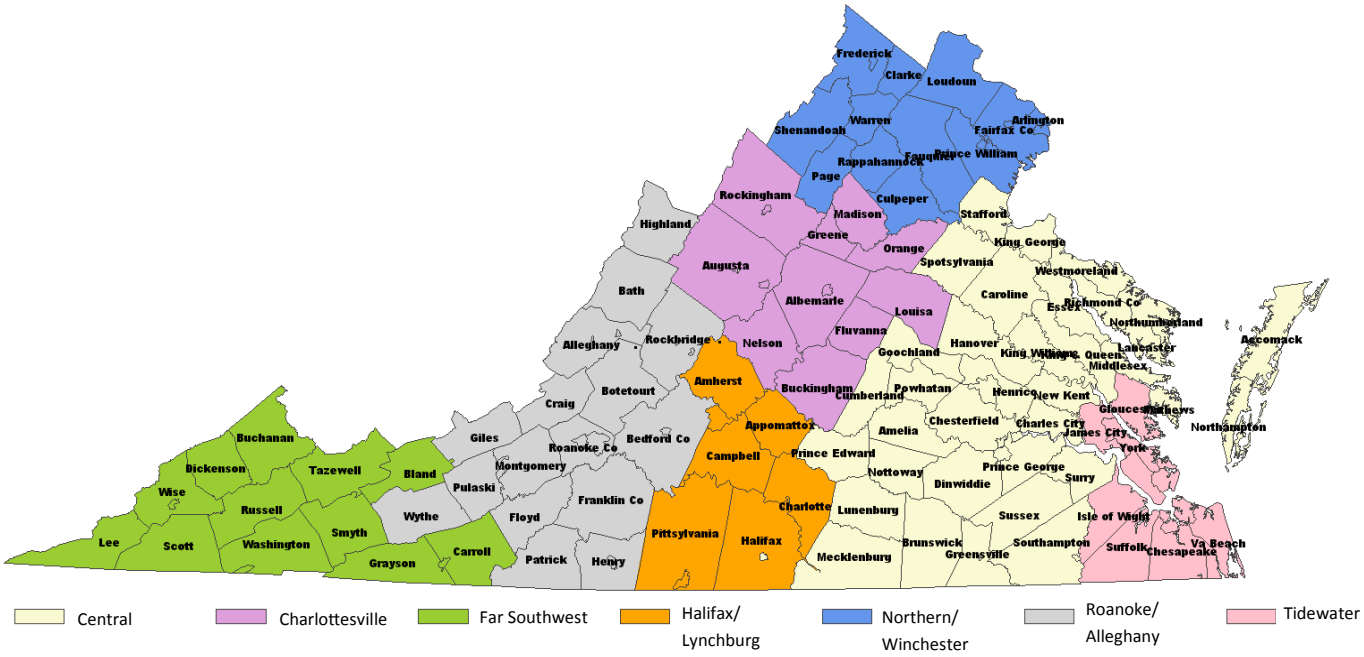
For a detailed explanation of the Medicaid aid (eligibility) groups please click here.

Health Plan Profiles

There are six MCOs across the regions of the Commonwealth that are contracted for the provision of Medicaid Medallion 3.0 and FAMIS health care services. Today, these MCOs serve more than 80% of all Medicaid members.

Medallion 3.0 Health Plan Profiles

Medallion 3.0 MCO Regional Coverage and Total Regional Membership

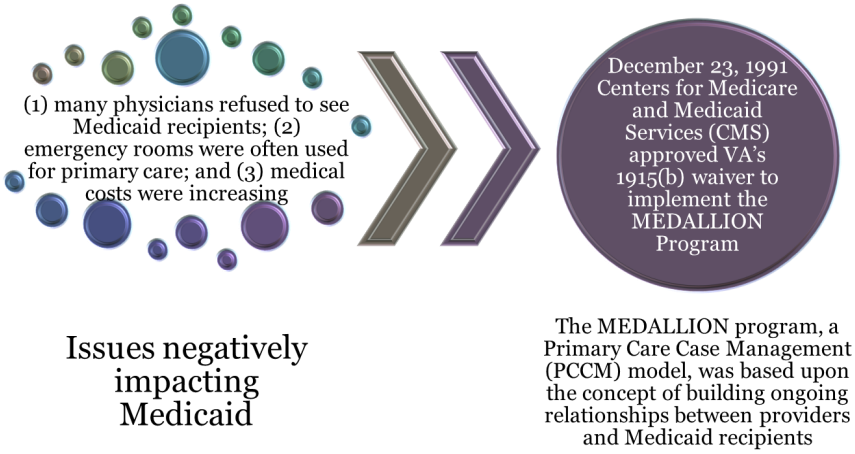


#Members : #MCOs	198,351 : 4	47,174 : 5	51,250 : 5	43,423 : 5	174,409 : 5	74,708 : 5	163,952 : 3

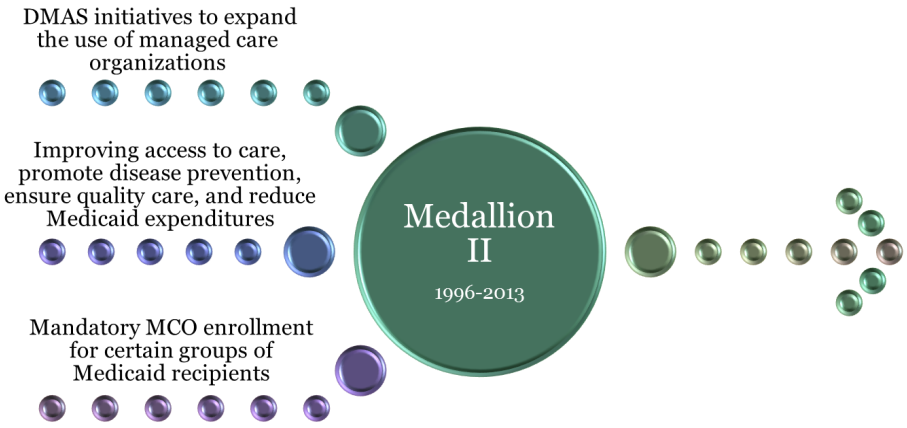
Last year, MajestaCare of the Carillion Health System discontinued its provision of services through the Medallion 3.0 Medicaid and FAMIS managed care programs. Medallion 3.0 MCOs are highly represented in the Far South West and Roanoke areas. Due to the exceptionally organized and cooperative partnerships with the MCOs, the overall care transition was seamless and the enrollment of members to one of the five other health plans was well received and successful.

Medallion 3.0 Core History

The development of Virginia's first Medicaid Managed Care program was introduced to improve member access, quality of health care services and costs. The program a—Primary Care Case Management (PCCM) model of service—was named MEDALLION. The MEDALLION program was implemented in the Tidewater region of Virginia and included four cities and counties in January 1992. The program defined eligibility for Virginia's Medicaid managed care population and positively changed the Medicaid member and provider relationship. The MEDALLION program operated from 1992-2012.



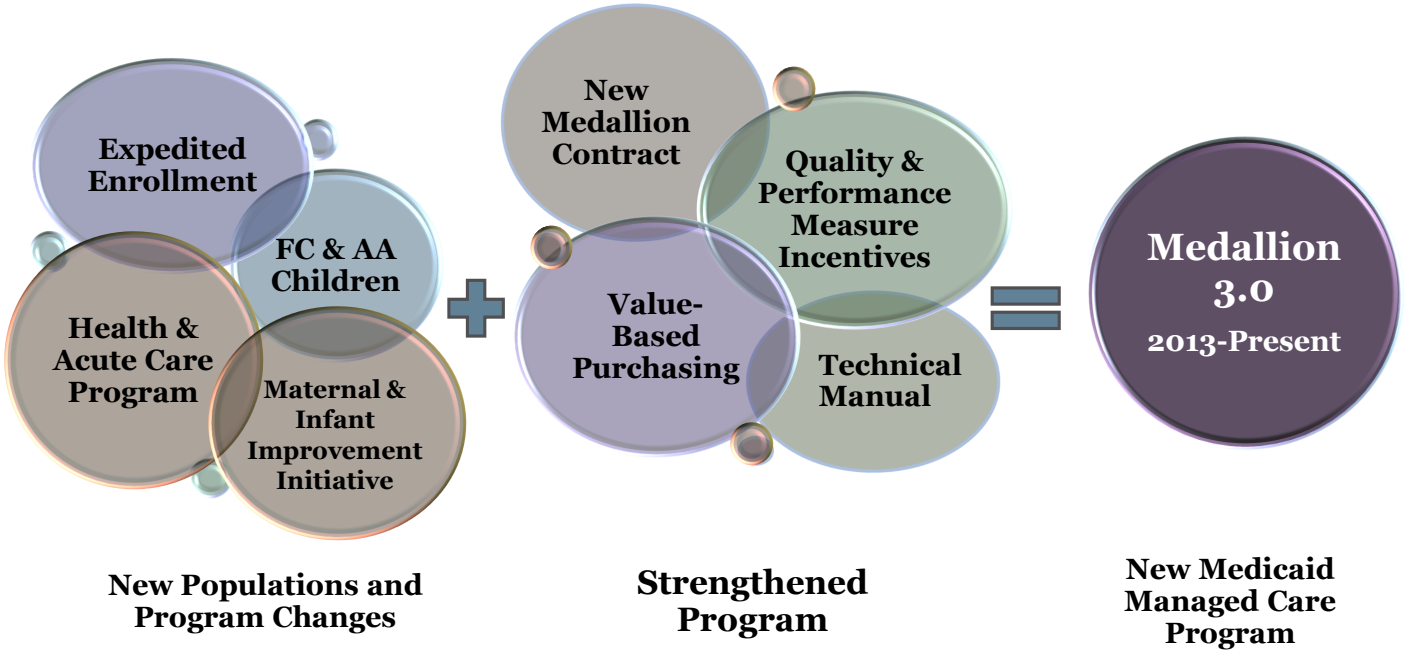
As a result of the well-received response from members and providers regarding the MEDALLION program, the Centers for Medicare and Medicaid Services (CMS) allowed the Commonwealth to implement a statewide phased-in and broadened program—Medallion II. The program began services in January 1996 and underwent numerous geographic expansions and waiver revisions until 2012 when the program became available in all 95 counties and 39 cities across the state. The Medallion II program and its expansion efforts are a national model for other state's Medicaid managed care initiatives.



Medallion 3.0 Core History

In 2013, the Medallion II Managed care program and contract were significantly revised and strengthened. In recognition of the substantial improvements and evolution of the program and contract, the Agency implemented a program name change—Medallion 3.0.

The Medallion 3.0 program aims to enhance access, service, quality and health care with a special focus on accountability, flexibility, transparency of operations, compliance and reporting, and value-based quality-driven programs and services.



The Medallion 3.0 new populations, program changes and enhancements are discussed in later in the publication.

Care Delivery and Value in Motion

The Medallion 3.0 managed care program is centered on ensuring that patient-centered care is provided in the right place at the right time and that members receive the most clinically - appropriate and cost-effective care services. The program improves member access to care, focuses on prevention, and is well-established in the provision of quality integrated care services.

Provider Networks

Medallion 3.0 MCO provider networks are robust and sophisticated and target provider enrollment based on member needs. The MCOs are able to develop specially designed individual provider agreements in cases where a member has special needs, requests, or circumstances. Through the Medallion MCOs there are over 100,000 providers serving members at more than 300,000 sites across the state! All 13 major health systems in Virginia participate in the Medallion 3.0 program signifying the full-scale support across the Commonwealth in serving Virginia's Medicaid members

Expedited Enrollment

Beginning August 1, 2014, the Agency shortened the period of time between becoming Medicaid eligible and enrollment into a health plan. This process allowed members to return to an MCO quickly after an enrollment file change which reduced member churn and service disruption while assisting the provider community in ensuring timely services.

The previous pre-assignment process required individuals to receive coverage for approximately 30 -60 days through the Agency's fee-for-service program before enrolling with one of the Medallion MCOs. Expedited Enrollment allows more time for plan selection while reducing program churn, disruptions of care, and member and provider confusion. Shortening the assignment period expedites member access to care coordination, disease management, 24-hour nurse call lines, and access to specialty care. This is especially important for chronic care populations, pregnant women, and foster care children who need access to care quickly.

Care Delivery and Value in Motion

Care Management

Care coordination and disease management is at the heart of the Medallion 3.0 MCO approach to care delivery. Care coordination is a service delivery model where teams of health care providers work together to ensure that members' health needs are being met effectively. The MCOs coordinate care through primary care coordination and disease management programs. In both programs, care is provided through a multidisciplinary team that may include PCPs, specialist physicians, nurses, therapists, nutritionists, and pharmacists. These care programs address numerous health conditions, including diabetes, behavioral health, prenatal/postnatal care, asthma, and complex health conditions. The MCOs possess capabilities in program flexibility with seasoned analytic skills in assessing member needs. These programs are discussed in further detail later.

Medical Management and Utilization Teams

MCOs have medical management teams that develop protocols, review variances, and develop programs to control both over and under utilization of health care services. This allows for ease in forecasting utilization trends and identifying opportunities for both clinical and administrative improvements. These teams provide unprecedented insight into member care from which numerous cutting-edge initiatives, pilots and program innovations are established and implemented.

Medallion MCO Provider Incentive Programs

Medallion 3.0 MCOs each have numerous in-house provider incentive programs that promote quality, improve care, manage cost of care and are patient-centered. These provider incentive programs are beyond the contractual requirements.

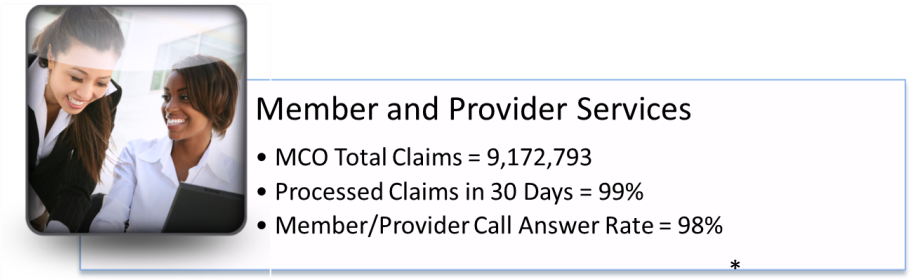
Newborn Reconciliation

In 2014, the Agency implemented a new automated process for reconciliation of newborn enrollment and capitation. This process improved the timeliness and accuracy of newborn enrollment and service reimbursement ensuring that our youngest and most fragile members have access to the care and services that they need.

Medallion 3.0 MCO Operations

Member and Provider Services

There are over 100,000 providers in over 300,000 locations across the Commonwealth of Virginia through the Medallion 3.0 MCOs. With large dedicated teams, the Medallion MCOs are able to quickly address member and provider appeals, process claims, and quickly respond to inquiries or concerns ensuring that matters are addressed and resolved to the satisfaction of all parties. Each MCO is accredited through the National Committee for Quality Assurance (NCQA), licensed through the Bureau of Insurance and in good standing with the Virginia Department of Health's (VDH) Managed Care Health Insurance Plan (MCHIP).



As of July 30, 2015
*Average 2% Abandonment Rate

Pharmacy Rebates

The Medallion 3.0 MCO pharmacy benefit covers medically necessary FDA approved prescription and non-prescription drugs for members. Proper pharmaceutical treatments and cost effectiveness continues to be at the forefront of the Agency and MCO's strategy in support of the broader goals to ensure measurably better quality, value, and care.

Federal guidelines allow states to receive "rebates" or revenue from pharmaceutical manufacturers on certain drugs prescribed to Medicaid members. This program serves as a cornerstone of revenue generation for the Agency. Through improved encounter claims and data quality, increases in pharmacy rebate revenue are increasing. Over the past fiscal year the Agency received over $312Million from Medallion MCO pharmacy rebates.

Real Medallion 3.0 MCO Member Stories

Complex Diabetes Care

After several in-patient hospital stays, a member with diabetes and suffering with chronic and pervasive medical issues such as sepsis, fluid overload, hypertension, severe anxiety and renal failure was referred to a diabetes chronic care program by their MCO after seven inpatient stays. Since referral to the MCO's chronic disease management program, the member was assigned a home health aide and enrolled in pet therapy to assist with severe anxiety. Medication management was incorporated into the member's treatment regimen to improve medication compliance and improve prescription organization. The member received diabetes education and outreach through the program where the member learned to check blood sugar levels consistently and how to be treatment compliant. The member is now medically stabile, is thriving and has had no further hospital admissions.

Complex Prescriptions

A member with multiple medical conditions and challenges under treatment for chronic Hepatitis C with cirrhosis was unable to obtain the medication prescribed by the doctor despite obtaining an approved prior authorization for the medication. At each pharmacy fill attempt the prescription was rejected. A case manager contacted the member, the provider, the plan's medical director, supervisor, and the health plan's pharmacist and learned that the prescription needed to be sent to a specialty pharmacy. The case manager provided education on the use of specialty pharmacies. The prescription was successfully filled and the member enrolled in a medication care management program. Today the member regularly receives medications from the specialty pharmacy and is treatment compliant.

Chronic Pain Management

A member with chronic pain was having difficulty scheduling primary care physician (PCP) and pain specialist appointments. Upon receipt of the member call explaining the difficulties, the MCO case manager worked with the member to select a new PCP and expedited the appointment. The case manager then arranged for an appointment with a pain management specialist and coordinated the transfer of medical records to remove any barriers to the member receiving optimal care. The member was enrolled into on-going case management to provide a high-level of care coordination.

Quality On The Move

Quality Management

The Agency and the Medallion 3.0 MCOs are always on the move to improve the quality of care our members receive. Ensuring that members of the program receive the highest level quality of care is at the center of the Medallion 3.0 MCO quality care management efforts. The Agency requires each plan to obtain and maintain accreditation with the National Committee for Quality Assurance (NCQA) - the most widely recognized health plan accreditation program in the United States. To assess MCO quality performance measures are captured through NCQA's Quality Compass—a tool to measure, evaluate, and benchmark plan performance–and reviewed on an annual basis.

Two sets of MCO data are used by the NCQA for accreditation: Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures. HEDIS® measures are the nationally recognized gold standard for measuring performance on important dimensions of care and service. CAHPS measures capture member experiences in received health care and services. The Medallion 3.0 contract standard requires that MCOs meet the National 50th percentile each year on specific quality of care metrics. The plans are always focused on improving quality areas where thresholds did not meet business intensions which may be set above contractual requirements.

External Quality Review Organization (EQRO)

Health Services Advisory Group (HSAG) is the Agency's new EQRO contractor. The EQRO evaluates and conducts reviews to determine MCO compliance with Medicaid managed care standards and state contracts. The EQRO evaluates MCO quality outcomes and appropriateness, timeliness and access to services provided to Medicaid members.

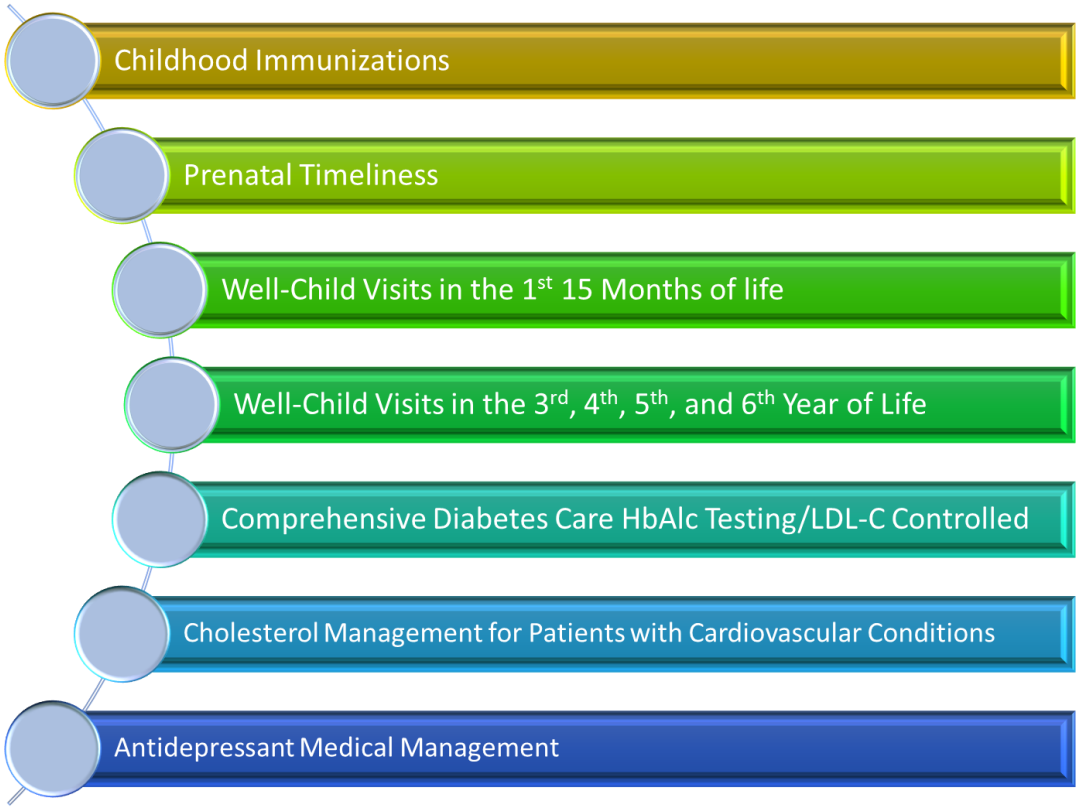
Quality On The Move

Primary HEDIS® Performance Measures Medallion 3.0 MCOs

The Medallion 3.0 MCOs' focus on patient-centered member health, preventative services, complex care needs, proper medication utilization and quality care management show year over year through their high-rankings on NCQA standards. Medallion 3.0 MCOs excelled beyond expectations in member health care and service in areas such as: 90% of Medallion children saw their PCP at least once in the past year.

For measurement year 2013 (HEDIS ® 2013), the Medallion 3.0 MCOs excelled in numerous areas as indicated in the chart below.

Medallion 3.0 HEDIS® Scores Above National 50th Percentile



Quality On the Move

NCQA Rankings

The Agency has continued to see the Medallion 3.0 MCOs excel in NCQA's national ranking for health plans. The MCOs made the list of the top 100 for NCQA's 2014-2015 Health Insurance Plan Rankings with Coventry Cares in the lead.

Best Quality Practices

The Medallion 3.0 Quality Collaborative is an annual forum for sharing present best practices, lessons learned, and address barriers to quality improvement. At this year's Best Practice collaborative, the MCOs presented quality initiatives that target and address the needs of their member population. Through these initiatives, the MCOs have successfully implemented numerous interventions to improve quality and care for members and increase value for the Commonwealth.

MCO	Best Quality Practice Program
Anthem Health Keepers	Developed and implemented interventions targeting two CAHPS® composites (1) *How Well Doctors Communicate* and (2) *Rating of a Personal Doctor*, with a goal of achieving the 75th percentile or greater. The interventions focus on providing education to physicians and members on effective communication and improving customer service operations to improve member interactions with the MCO. For calendar year 2013, the plan was successful and achieved the 75th percentile in each measure.
Coventry Cares	Implemented a wrap-around approach to address prenatal and postpartum care. This includes the implementation of a perinatal program that provides high-risk case management, member education on self-management through newsletters and prenatal and postpartum written packets, provider education on evidenced-based practices. As a result of these initiatives, Coventry Cares' achievement on the Prenatal Care HEDIS® measure—percentage of deliveries of live births that had a prenatal care visit during the first trimester or within 42 days of enrollment—for year 2014 was 88%.

Quality On The Move

MCO	Best Quality Practice Program
Kaiser Permanente	Achieved high scores on the HEDIS® breast cancer screening measure for its commercial population through its implementation of a Chronic Care Program. Components of the program include the use of clinical practice guidelines, coordinated care, physician and staff communication, performance reporting and analysis, and member education. The program enables the MCO to provide targeted outreach to members and tailor educational information based on member's age, gender, and health conditions, and also allows members to track when they are due for lab work, screenings, and vaccines online. NOTE: Kaiser Permanente Virginia's success with breast cancer screening to date has been with its commercial population. The Chronic Care Program is currently being implemented with Medicaid members corresponding with the MCOs entry in the Virginia Medicaid program in November 2013. Data will be presented at the next Best Quality Practice Program in 2015.
INTotal Health	Implemented an integrated service delivery model to advance coordination of care between medical and behavioral healthcare providers. This resulted in members having better access to care and services and while achieving savings on healthcare costs. Further evaluation of the program's success is in progress and will focus on improvement in the level of ER utilization, inpatient medical and psychiatric care, medication adherence, and outpatient follow-up care. will be presented at the next Best Quality Practice Program in 2015.

Quality On The Move

MCO	Best Quality Practice Program
Optima Family Care	To assess effectiveness of diabetic improvement strategies through patient/provider education and to assess effectiveness of clinical guidelines for years 2011-2012. Interventions included: staff education, improved member educational materials, quarterly telephone calls to members with diabetes, follow-up with hospitalized diabetics upon discharge, targeted case management, and letters to providers when their members have not completed required diabetic screenings. The plan also implemented an electronic medical record system to capture member data regarding screenings and treatment. Diabetes Management initiative aimed to raise scores by 2% for each of the following diabetes HEDIS® measures: A1c testing, LDL-C screening rate, Dilated Eye Exam rate, and improve diabetic blood pressure rate. They were successful in achieving the 2% improvement in all measures.
Virginia Premier Health Plan	Collaboration with a specialty pharmacy to implement a clinical management program for members prescribed high-cost specialty drugs for complex chronic conditions. The goal of the program is to improve health outcomes for members through enhanced monitoring by dedicated specialty pharmacists. Since its inception the program has resulted in better coordinated medication management for members and saved the plan $18,159.00 in Pharmacy Costs in 2014.

Quality On The Move

Quality Workgroups, Councils and Panels

The Agency is heavily involved in numerous interagency and stakeholder workgroups that support and drive quality aspects of care services for millions of Medicaid members nationally. Some examples of these efforts are described below.

Centers for Medicare & Medicaid Services (CMS), Quality Technical Advisory Group (Q-TAG). The Q-TAG is composed of quality improvement representatives from each of the CMS regions and convenes monthly via as a platform for CMS to provide updates on its Division of Quality, Evaluation, and Health Outcomes. The group enables states to share best practices, lessons learned, and barriers experienced in quality improvement initiatives.

National Committee for Quality Assurance (NCQA), Public Sector Advisory Council meets twice annually to provide feedback to NCQA on the ongoing development and revisions to accreditation standards, HEDIS measures, and new NCQA products. Members include representation of Virginia and six other states, CMS, National Conference of State Legislators, MedPAC, National Association of Insurance Commissioners.

Quality Improvement Strategy, Technical Expert Panel (Booz, Allen, Hamilton, CMS) to fulfill the statutory and regulatory requirements of Section 1311 of the Affordable Care Act. The panel advises Booz Allen Team on the development of the quality improvement strategy for qualified health plans in the Marketplaces by providing stakeholder input and making recommendations at key points during the development, testing, and implementation of the QIS.

Quality On The Move

Performance Incentive Award

Over the past year, the Agency implemented the Performance Incentive Award (PIA) for the Medallion 3.0 MCOs. The intent of the program is to reward high-quality care and service for MCOs demonstrating excellence in quality care. The PIA includes three HEDIS® measures and three administrative measures that will drive the incentivized platform. The program is currently in the pilot phase and results are slated to be finalized December 2015. There are no awards or penalties applied during the pilot phase of the program. The Performance Incentive Program is scheduled to go live October 2016 with award and penalty impacts beginning in December 2016. Publication of the consumer report card is scheduled for May 2017.

Performance Incentive Awards Quality Measures

Member Care

Use of the National Committee for Quality Assurance "HEDIS" Measures :

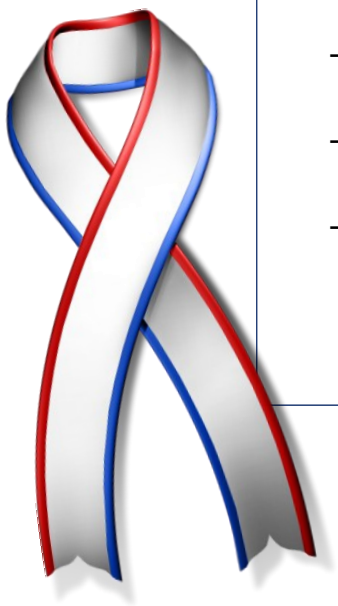
- Blood Pressure Control
- Childhood Immunizations
- Timely Prenatal Care

Managed Care Structure & Operations

Use of administrative measures developed by DMAS

PDSA cycle between DMAS/MCOs resulted in refinement of this measure from original measure

- Timely and complete assessment of children in foster care
- Timely payment of claims submitted by providers
- Timely and accurate monthly reporting to DMAS

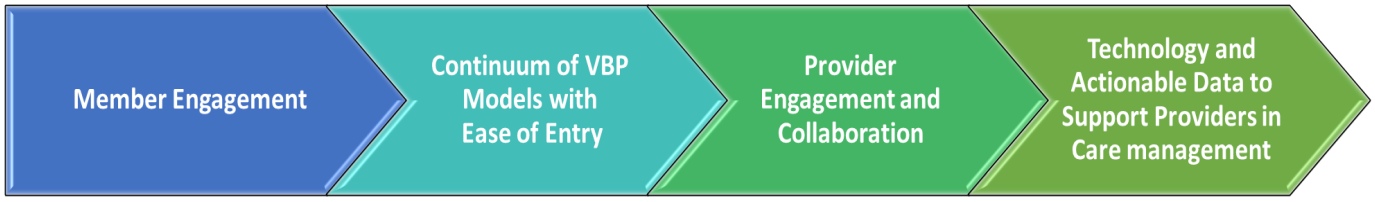


*Plan-Do-Study-Act (PDSA) is a tool to plan and document progress with tests of change conducted as part of chartered performance improvement projects (PIPs) .

Value-Based Purchasing Advances

Delivery system enhancements require a redesign of traditional payment models (Fee-For-Service) to align financial incentives and provide compensation for important care management and service coordination interventions that occur outside traditional methods of service delivery. Currently, through the MCOs, Virginia has value-based purchasing programs that support a patient-centered health care system that allows health plans to create innovative programs to engage providers and promote quality care. The Agency and MCOs recognize the importance of allocating adequate resources to support primary care and preventive health services efficiently, and work to properly align incentives to positively impact clinical, administrative and financial outcomes for the Virginia Medicaid Program. On-going assessments of geographic regions help determine the readiness and ability of local providers to transition to value-based purchasing service models. Careful evaluation and mutual success will encourage the adoption of value-based purchasing throughout the state.

Four core factors for health care delivery advancement:



Medallion 3.0 MCOs health care advancements are driven by four core objectives: member engagement, provider engagement and collaboration, new technologies and use of actionable data and increasing the percent of Medicaid members cared for by providers engaged in some form of pay-for-value program. Medallion 3.0 MCOs have developed and implemented value-based purchasing (VBP) initiatives and payment models such as patient-centered medical homes, enhanced care management, and shared savings opportunities for 10 years. The MCOs are always seeking ways to increase the quality and value of the services provided through their networks.

Value-Based Purchasing Advances

Examples of MCO VBPs are:

Shared Savings Program

- Contractual shared-risk arrangements with providers to meet medical cost target goals

Shared-Risk Arrangements

- Provider assumes risk of total medical cost if target is not met OR receives additional payments if target is met

Care Management Fees

- Reimbursement fee to PCPs for providing care management services such as Health Homes

Provider Quality Incentive Programs

- Programs aimed to improve HEDIS scores where met goals result in additional reimbursement

Specialist Programs

- Incentive programs for specialty providers w/established performance goals OR Episode-based bundled payments

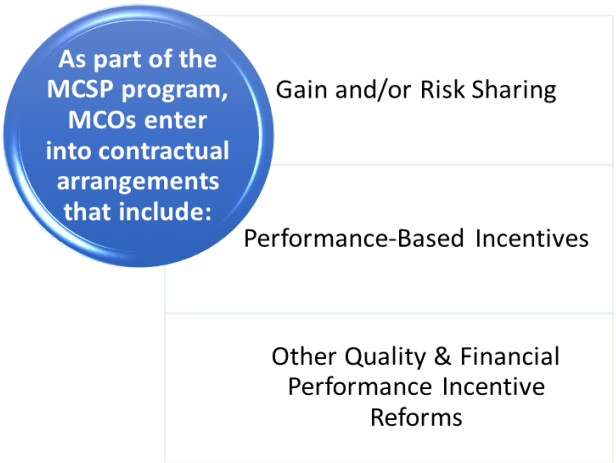
Other Value-Based Arrangements

- Non-Traditional delivery systems such as telemedicine or staff/clinical model delivery systems

Source: Virginia Association of Health Plans

Medallion Care System Partnerships

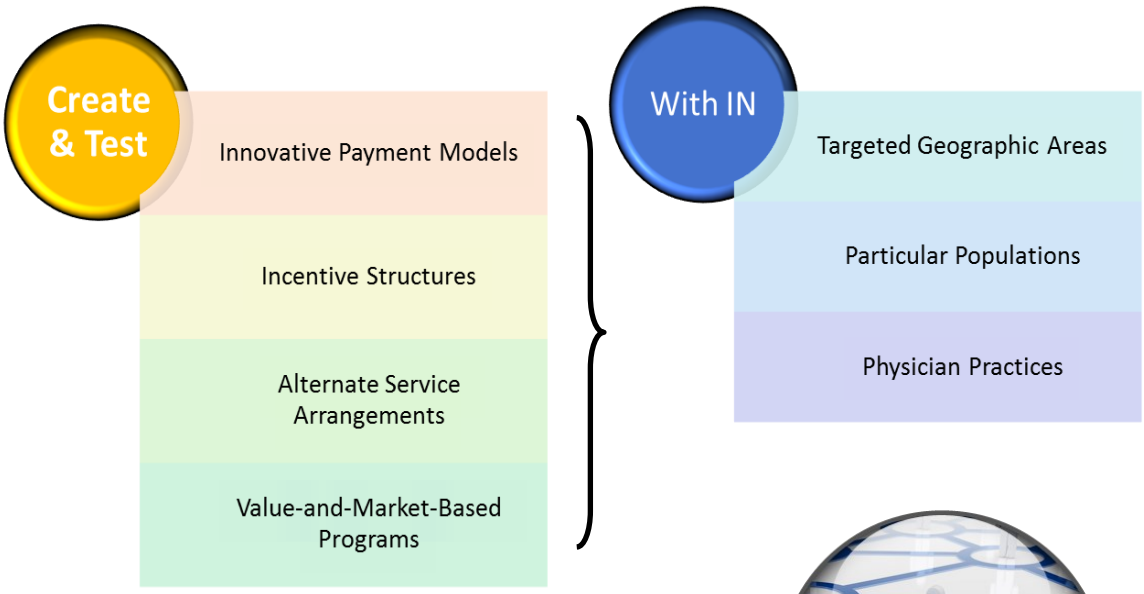
The Medallion Care System Partnership (MCSP) is an innovative Medallion 3.0 approach to member care that aims to improve health outcomes for members through the use of health home models or other approved arrangements. The quality-focused and contractually required MCSP programs use an integrative care model to determine how to best bend the cost curve while improving overall quality.



Value-Based Purchasing Advances

Medallion 3.0 MCOs form partnerships with providers and health care systems in an effort to increase participation in the integrated care delivery model and align administrative systems to improve member experience and increase overall program efficiency. Outcomes are measured through quality metrics appropriate to the MCSP population.

The MCSP program allows MCOs flexibility to:



*The MCO MCSP Performance Report is due at the end of 2015.

Pregnant Women, Children & Infants

Maternal and Infant Improvement Project (MIIP)

In the fall of 2014, the Agency developed a cross divisional team to improve efficiency and effectiveness of strategies, policies, procedures to positively impact maternity care for members—called the Maternal and Infant Improvement Project (MIIP).

The goal of MIIP is to carry out Agency strategies to increase enrollment and maximize access to maternity care for Medicaid and FAMIS MOMS members through low barrier, rapid cycle implementation strategies.

MIIP Accomplishments	Developed new contract language that strengthen maternal and infant programs and increased accountability
	Close collaboration with Virginia Department of Health
	Established coalition with Virginia Hospital and Healthcare Association (VHHA) and Virginia Section of the American Congress of Obstetricians and Gynecologists (ACOG) to increase effective communication with providers on strategies to improve quality and access to maternity care
	Outreach efforts to promote WIC nutrition services - over 190,000 enrolled members
	Participation in Collaborative Improvement & Innovation Network (COIIN), Centers for Medicare and Medicaid Services (CMS), and National Association of Medical Directors (NAMD) maternal and infant improvement efforts
	Outreach and eligibility education for legally residing immigrants
	Best practice research and recommendations to leadership for preventing early elective deliveries
	Rapid enrollment of eligible pregnant women in Medicaid and FAMIS MOMs
	Improved relationships with providers and stakeholders through increased communication and site visits

Pregnant Women, Children & Infants

Foster Care and Adoption Assistance Children

This past year was an exciting time for the Agency's Foster Care and Adoption Assistance Program. The program experienced huge successes and accomplishments since 2014, most notably, the transition of 4,600 foster care (FC) and 5,900 adoption assistance (AA) youth into the Medallion managed care program between September 2013 through June 2014. Unlike other states that offer Medicaid coverage through Fee-For-Service or one managed care health plan, Virginia is the only state to offer FC/AA children choice through six MCOs. Enrollment into Medallion 3.0 managed care has provided this special needs population increased access to care, specialized services, one-on-one case management and comprehensive health risk assessments. The Medallion 3.0 program's MCOs affords the opportunity for foster care and adoption assistance youth to receive quality care from credentialed providers in addition to appointing FC/AA liaisons as points of contacts to assist with service needs.

Program Collaboratives

The Agency's divisions of Health Care Services and Maternal and Child Health, VDH, VDSS and the Medallion 3.0 MCOs are very dedicated to ensuring that children in the foster care and adoption assistance programs are receiving the highest level of care access and quality health care services. Interagency collaboration and team dedication are key to the continued successes of the program across the Commonwealth.

Three Branch Policy Institute: National Governors Association grant with leadership from the three branches of government: Executive, Legislative, and Judicial. Goal – to improve health, mental health, and educational outcomes for children in foster care. Three Branch grant has ended, however the activities will continue under the Child Welfare Advisory Committee (CWAC). CWAC advises the Director of the Division of Services on child welfare issues. It helps ensure that all child welfare activities are child-centered, family- focused and community-based.

Of Note: Since the transition in 2014, the Medallion 3.0 program the pregnancy rate for FC children decreased from 23 pregnancies to 7. This is below the national average for the FC population.

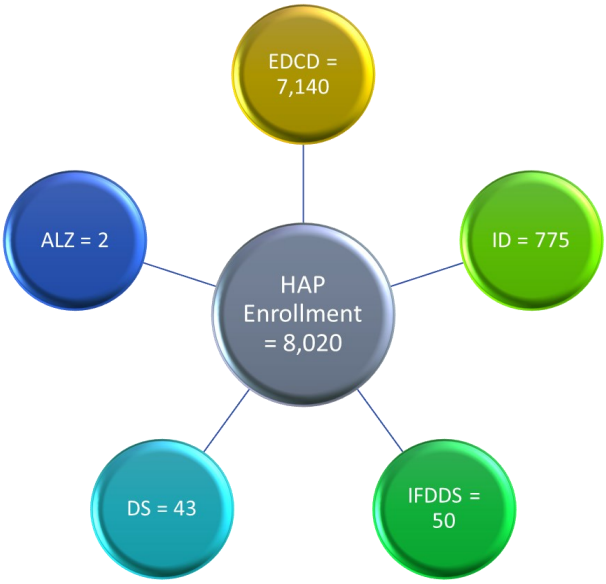
Medicaid Managed Care Moving Forward

Since 2007, the state's Medicaid managed care delivery system has grown from Medallion 3.0—serving pregnant women, children —to include new populations among elderly and disabled members. The divisions of Long Term Care and Integrated Care and Behavioral Health Division (ICBH) also encompass managed care programs which are detailed later.

Health and Acute Care Program (HAP)

The Medallion 3.0 MCOs provide acute care coverage for approximately 8,200 home and community-based services (HCBS) waiver individuals through the Health and Acute Program (HAP). The HAP program is an interdivisional team Agency effort and has had a very low disenrollment request rate. HAP includes Medicaid individuals who are concurrently enrolled in the managed care delivery system and one of five home and community-based waivers. This includes recipients of the following waivers: Elderly or Disabled with Consumer Direction (EDCD), Intellectual Disability (ID), Individuals and Family Developmental Disabilities Support (IFDDS), Day Support (DS), and Alzheimer's Assisted Living (AAL).

This initiative allows eligible HCBS waiver individuals to receive their acute and primary medical care through one of the managed care health plans with access to an assigned case manager, care coordination, 24-hour nurse call centers, member education and outreach among numerous other Medallion MCO benefits. The individual's home-and-community based care waiver services, including transportation to the waivered services, is paid through the Medicaid fee-for-service system as a "carved out" service.



Medicaid Managed Care Moving Forward

Program of All-Inclusive Care for the Elderly (PACE)

The PACE program is one of the Agency's three care coordination delivery models and is administered through the Division of Long Term Care. PACE provides all Medicaid and Medicare health services and needs for its members and is anchored by an adult day health center. The program was established in 2007 for qualifying adults, age 55 and over, to remain living in their homes and communities. PACE is centered on the belief that it is best for the well-being of seniors, with chronic care needs, and their families to be served in the community whenever possible. PACE services are coordinated through an interdisciplinary team (IDT) with the full involvement of the individual and their family or significant other. Services are person-centered designed and delivered in a personal manner taking care of the individual's complete medical services and supports. Virginia currently has eight provider organizations and twelve PACE operating sites. As of July 2015 there were 1,326 PACE members.

Commonwealth Coordinated Care (CCC)

The development of Commonwealth Coordinated Care began in 2011 when the Virginia General Assembly directed the Agency to develop a program that would better meet the needs of Virginians receiving both Medicare and Medicaid benefits. Implementation of this program represents a major move forward for Virginia Medicaid signifying the readiness of the Agency to take the next step in member care by coordinating the benefits of Medicare and Medicaid into a single, person-centered program. The Integrated Care and Behavioral Health (ICBH) Division oversees the implementation and administration of the CCC demonstration program. The CCC program provides Medicare Part A, B and D benefits and Medicaid benefits (excluding those carved out) to CCC members. The CCC program is voluntary and allows Medicaid members to 'opt out' at any time. As July 2015 there were approximately 28,000 members in the CCC program.

Commonwealth Coordinated Care
Medicare & Medicaid working together for you

A Healthy Virginia – Encouraging Progress

A Healthy Virginia

Governor Terry McAuliffe's– *A Healthy Virginia*- plan aims to address numerous health related concerns for Medicaid members. Virginia covers approximately 580,000 children, including SSI and Children and Youth with Special Health Care Needs (CYSHCN), in the Medallion 3.0/FAMIS programs. Gov. McAuliffe projects that there are over 100,000 more children who are eligible for these programs but who remain uninsured. As such, an aggressive outreach campaign to reach the uninsured was put in place.

The Agency continues to revamp its outreach materials, including: full color FAMIS flyers in multiple languages for statewide distribution; member incentives; and developing a new FAMIS information outreach to be disseminated among 63 districts. Additionally, community outreach coordinators continue their efforts among local health departments, departments of social services, community health centers, public schools and libraries, among other venues.

Smiles For Children (SFC)

Governor McAuliffe said, "Since a pregnant woman's oral health is linked to delivery and her baby's health, lack of comprehensive dental care may allow undiagnosed or untreated dental issues to put unborn babies at risk."

As such, the Agency implemented comprehensive dental coverage for pregnant women enrolled in Medicaid and FAMIS MOMS through Virginia's nationally recognized *Smiles For Children (SFC)* dental program. As of March 1, 2015, pregnant women enrolled in Medicaid and FAMIS MOMS programs who are 21 years of age and older are eligible to receive appropriate dental benefits covered through the *SFC* program. Approximately 2,000 pregnant women have been served since the program's inception.

SFC began in 2005 with 620 participating general dentists and specialist and has grown to approximately 2,000 participating providers in 2014. Program highlights include:

- 39.6% increase in enrollees under age 3 years received fluoride varnish treatment
- Surpassed national average for children participating in an annual dental visit.

A Healthy Virginia— Encouraging Progress

Behavioral Health Home Regional Pilots

The Agency and the Department of Behavioral Health and Developmental Services share the belief that it is important to the medical and behavioral health needs of individuals with serious mental illness to assure the right care in the right place at the right time. The Behavioral Health Home Pilot Initiative supports this belief.

As a part of Governor McAuliffe's—A Healthy Virginia plan, the Agency is excited to announce the implementation of five regional behavioral health home (BHH) pilot programs that went live on July 1, 2015. The initial BHH pilots will coordinate care for 350 selected members with serious mental illness (SMI) who received $9M in Medicaid benefits through the Medallion 3.0 Medicaid program in 2014.

The BHH pilots adopt the "whole person" philosophy of treatment that calls for a team-based approach to health care including primary, acute, behavioral health, and some substance abuse services. MCO enthusiasm for the health home model of care and improving the lives of people with SMI drove the development and design of the pilots. The pilots aim to improve care quality and decrease care costs for the selected individuals enrolled in the pilots. This program marks the first time the MCOs will coordinate community-based mental health services for select Medallion members. Four of the MCOs will coordinate services with Magellan; One MCO will provide all services directly for members. The Agency and DBHDS believe that focusing on SMI will ensure that the 350 pilot members receive better care at a lower cost. BHH pilots will be evaluated annually.

BHH Key Points

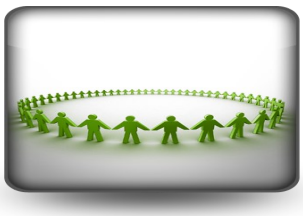
Pilot structure assures adults with SMI benefit from coordinated behavioral health and medical care
Each plan offers a unique pilot care model in different regions of the state with a variety of partners
Team-based care coordination driven by providers who consult one another and are dedicated to improving the lives of people suffering with SMI
Consistent with the Commonwealth Coordinated Care (CCC) program that provides coordinated behavioral health and medical care for dually eligible members

Regional Pilot Areas

Central—Coventry & Anthem
Northern VA—INTotal
Tidewater—Optima
Roanoke/Alleghany—VA Premier

A Healthy Virginia— Encouraging Progress

MCO	Medallion Behavioral Health Home Pilot Programs
Anthem Health Keepers	Enhanced Care Coordination (CCC model): Includes case management, care coordination, health promotion, transition of care, individual and family support, referral to community support services, HIT links where possible.
Coventry Cares	In-house and/or co-located partnership model of integrated care. Program includes a single point of contact with behavioral home health team, Gold Care prior authorization, community and social support referrals, health promotion services, and comprehensive transitional care planning.
INTotal Health	Case Management Health Home model. Member-centered, collaborative care program pilot revolves around the care needs of identified members and their primary care providers, care managers and psychiatric consultants.
Optima Family Care	Blended model of in-house, co-located and facility referral system to integrate care services. Service to include continuing care strategies, intensive care management, community supports and resources, community mental health services and transitional care from the hospital/facility to the community.
VA Premier Health Plan	Primary Care Physician (PCP) assignment to members being seen in the BHH pilot program. Focus on preventative health and wellness. Transition of care services across settings with participation in discharge planning and community transition. Weekly interdisciplinary care management planning rounds. Enhanced access to care including open scheduling, expanded hours and use of telemedicine and telehealth services.



A Healthy Virginia— Encouraging Progress

Patient Utilization Management and Safety Program (PUMS)

Virginia aims to significantly reduce the number of deaths due to the misuse of prescription drugs that supports the opioid task force of the Governor's initiative–*A Healthy Virginia.* To that end, the contractually required Medallion 3.0 Patient Utilization Management and Safety Program (PUMS) was created to address all controlled substances including opioids. The PUMS Program is a utilization control and case management program designed to promote proper medical management of essential health care. The MCOs will coordinate medication management care and ensure that members are accessing and utilizing prescription services in an appropriate manner. In the event an MCO discovers that a member may be accessing or utilizing the medication benefit inappropriately, that member may be placed into the PUMS program for a period of 12 months. At the end of the 12 month period, the member will be re-evaluated by the MCO to determine if the member continues to display behavior or patterns that indicate continued misuse or inappropriate use of the prescription benefit.

The new utilization approach is slated to begin in 2016.

Interventions to Prevent Controlled Substance Abuse (Report)

Medallion 3.0 MCOs submit an annual report that details its comprehensive opioid and prescription abuse prevention and reduction programs. The PUMS report includes actions taken by the MCO to prevent the inappropriate use of controlled substances, including but not limited to, any clinical treatment protocols, detailed definition of what, if any substances the MCO targets that are not scheduled substances under the Controlled Substances Act (21 U.S.C. § 801 et seq.) but may place a member at risk for abuse, prior authorization requirements, quantity limits, poly-pharmacy considerations, and related clinical edits, as specified in the Managed Care Technical Manual.

Strides in Managed Care Program Integrity

The Agency is committed to protecting the integrity of Virginia's Medicaid program and we feel a personal sense of responsibility to ensuring members receive the quality services that they need. As we strive to build strong, effective business partnerships with our health care providers and other contractors who help us meet our program objectives, the Agency focuses on program integrity efforts such as continually identify and prevent improper expenditures as well as fraud identification. We also work with the Medicaid Fraud Control Unit (MFCU) at the Office of the Attorney General to identify and prosecute fraudulent providers as necessary. Through the first three quarters of 2015, MCO program integrity activities avoided or recovered more than $950M.

Program Integrity Compliance Audit (PICA)

The Program Integrity Compliance Audit (PICA) is an annual audit that serves as a mid-year assessment providing the Agency with an overall snapshot of program integrity efforts by each MCO. This is an evaluation process of their compliance efforts to prevent, detect and address fraud, waste and abuse. The PICA also serves as a platform for the MCOs to formally showcase their PI best practices. Additionally, the Agency ensures that MCO's PI processes and protocols are in compliance by conducting annual desk-top assessments as another quality assurance measure. Due to improved standardization of reporting methods, a template and associated spreadsheet was developed to ensure that requested metrics are clearly detailed in order to acquire improved data responses and to better assess the MCO's program integrity and compliance efforts. The new tool was implemented this year and the first round of results are slated to be released in 2016.

Program Integrity Collaborative

The Agency hosts a mandatory quarterly meeting attended by Special Integrity Unit (SIU) staff from each of the MCOs and the Medicaid Fraud Control Unit (MFCU) to freely discuss emerging issues as well as opportunities for collaboration on other issues. The confidential nature of these meetings allow both the MCO and MFCU representatives to present trends and schemes they are currently investigating in order to mitigate and avoid these wasteful practices and ensure that all managed care partners are aware of program integrity best practices.

Upcoming Initiatives in Medicaid Managed Care

Managed Long Term Care Services and Supports

Consistent with Virginia General Assembly directives in years 2011 through 2015, over the next couple of years, the Agency will develop initiatives to transition the majority of individuals served through the Medicaid fee-for-service system into more coordinated and integrated care models. One of these initiatives is known as managed long-term services and supports (MLTSS). MLTSS offers the Commonwealth a broad and flexible set of program design options.

Managed Long Term Services and Supports (MLTSS) refers to the delivery of long-term services and supports through risk-based, capitated Medicaid managed care programs. Increasing numbers of States are using MLTSS as a strategy for expanding home and community-based services (HCBS), promoting community inclusion, ensuring quality and increasing efficiency.

MLTSS populations include individuals who receive Medicaid long-term services and supports and also individuals who are dually eligible for both Medicare and Medicaid coverage. The goal of MLTSS is to provide a coordinated system of care that focuses on improving quality, access, and efficiency. The Agency respects the strong interest of stakeholder groups and values their input into how best to achieve the overall goals and mandates of the Virginia General Assembly. The Agency will work closely with stakeholders, sister agencies, and contractors to ensure the best proposed plan is identified and successfully implemented.

For more information about these new programs, visit the DMAS MLTSS website or Medicaid.gov. For questions, contact the MLTSS program via: VAMLTSS@dmas.virginia.gov.

CMS Proposed Managed Care Regulations

The Agency has been actively involved in the review and comment process for the proposed CMS Medicaid Managed Care regulations which seek to modernize oversight of Medicaid Manage Care programs and make health care delivery more consistent with other governmental and commercial programs. The Agency champions the regulatory efforts and is working directly with the National Association of Medicaid Directors (NAMD) and CMS to encourage thoughtful and measured regulatory change that supports Medicaid members and providers. Virginia has been an active managed care state for 19 years with many of the proposed changes are already operationalized. The Agency will continue to work with CMS, MCOs and stakeholders to implement any necessary revisions to the Commonwealth's managed care delivery system when CMS issues the final regulations which are anticipated in 2016.

A Letter to Medallion MCOs

Dear Medallion 3.0 and FAMIS MCO Partners,

The Health Care Services division would like to acknowledge the hard work and dedication of the Department of Medical Assistance Services Divisions of Maternal, Child and Health; Program Operations; Policy and Research; Provider Reimbursement; Integrated Care and Behavioral Services; and Program Integrity, and of the Medallion Managed Care Organizations, all of whom, over the past year, played a significant role in helping us achieve Agency and legislative goals.

The success of the Health Care Services division is driven by strong, effective partnerships. It's because of your continued dedication, partnership and commitment to serving the Commonwealth's most vulnerable citizens that our year was successful.

Sincerely,

Cheryl J. Roberts, Deputy Director of Programs

Bryan Tomlinson, Health Care Services Division Director

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

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RESOURCES

Department of Medical Assistance Services
Board of Medical Assistance Services
Centers for Medicare and Medicaid Services

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