COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

KAREN KIMSEY
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786/7933
800/343-0634 (TDD)
www.dmas.virginia.gov

August 13, 2020

MEMORANDUM

TO: The Honorable Janet D. Howell
Chairman, Senate Finance and Appropriations Committee

The Honorable Luke E. Torian
Chairman, House Appropriations Committee

Daniel Timberlake
Director, Department of Planning and Budget

FROM: Karen Kimsey KK
Director, Virginia Department of Medical Assistance Services

SUBJECT: Item 317.C of the 2020 Appropriation Act

This report is submitted in compliance with the Virginia Acts of the Assembly – Item 317.C of the 2020 Appropriation Act, which states:

"The Department of Medical Assistance Services shall report a detailed accounting, annually, of the agency's organization and operations. This report shall include an organizational chart that shows all full- and part-time positions (by job title) employed by the agency as well as the current management structure and unit responsibilities. The report shall also provide a summary of organization changes implemented over the previous year. The report shall be made available on the department's website by August 15 of each year."

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

KK/

Pc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources

AUGUST 15, 2020

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS) ANNUAL ORGANIZATIONAL REPORT FOR FYE 2020

VIRGINIA'S MEDICAID PROGRAM
DMAS

DMAS Annual Organizational Report FYE 2020

August 15, 2020

Report Mandate:
Item 317 (DMAS) Administrative and Support Services, 2020 Appropriation Act

C. The Department of Medical Assistance Services shall report a detailed accounting, annually, of the agency's organization and operations. This report shall include an organizational chart that shows all full- and part-time positions (by job title) employed by the agency as well as the current management structure and unit responsibilities. The report shall also provide a summary of organization changes implemented over the previous year. The report shall be made available on the department's website by August 15 of each year.

Summary

The following annual report provides a detailed accounting of the agency's organization and operations through fiscal year end 2020.

The report provides summary information by each Division/Office along with unit responsibilities and/or core functions. An organizational chart for each Division/Office follows each summary. The organizational chart displays all of the full and part-time positions including a position number just below the position name. Each position number is five characters in length, and all part-time positions begin with a 'W'. Part-time positions, also referred to as Wage positions, are utilized to supplement the classified (or full time) positions and are restricted to 1500 hours per year.

Finally, the report provides a summary of all organizational changes made throughout fiscal year 2020. This includes organizational structure changes in addition to staff changes regarding filled positions and separations.

About DMAS and Medicaid

DMAS's mission is to improve the health and well-being of Virginians through access to high-quality health care coverage.

DMAS administers Virginia's Medicaid and CHIP programs. Through the Medallion 4.0 and Commonwealth Coordinated Care (CCC) Plus managed care programs, more than 1 million Virginians access primary and specialty health services, inpatient care, behavioral health, and addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

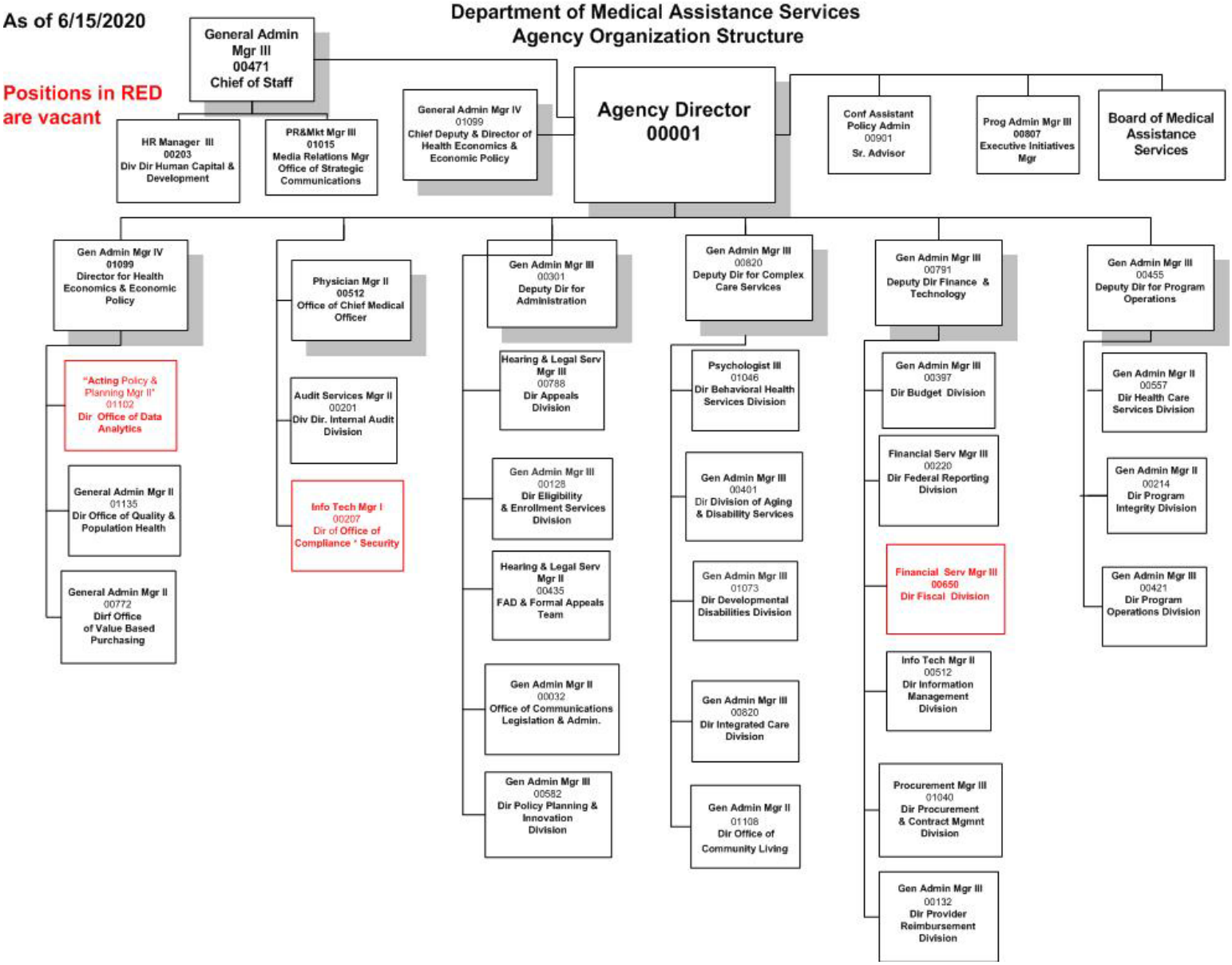
Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to over 400,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives a dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90 percent for newly eligible adults, generating cost savings that benefit the overall state budget.

As of 6/15/2020

Positions in RED are vacant

Department of Medical Assistance Services
Agency Organization Structure



Appeals Division

The Appeals Division reports to the Deputy Director of Administration. The mission of the Appeals Division is to provide a neutral forum where Virginians and healthcare providers can understand and challenge adverse decisions made by DMAS or its contractors and receive due process in a fair and just manner. The purpose of Appeals is to provide due process to applicants, members, and providers; afford an opportunity to be heard; guarantee a neutral review of agency action; and to render a decision in accordance with state and federal law. The Appeals Division has two core functions/units of responsibility: Client Appeals and Provider Appeals.

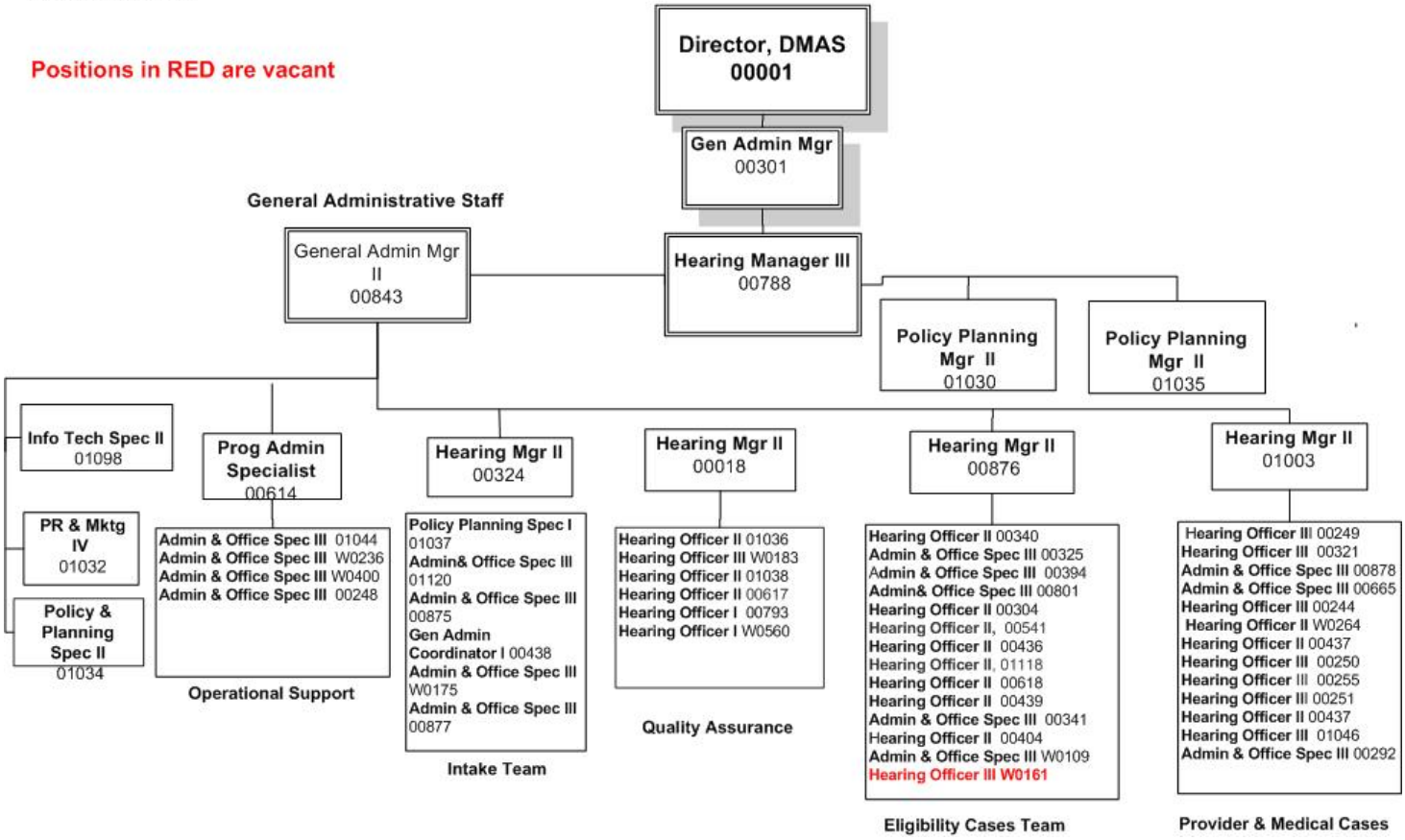
- **Client Appeals**
  There are over 1.5 million Medicaid and FAMIS clients in Virginia. Client appeals involve eligibility for Medicaid or FAMIS benefits and medical necessity for every service / equipment that Medicaid covers. Client appeals include individuals enrolled with Virginia Medicaid or seeking enrollment, and case types include eligibility for Medicaid and medical benefits. There is one level of appeal with DMAS for eligibility appeals, and the first level of appeal is conducted by the Managed Care Organization (MCO) for medical appeals.

- **Provider Appeals:**
  Provider appeals occur after services have already been rendered and the provider is seeking payment. Provider appeals involve every type of provider with whom the agency contracts, including physicians, hospitals, residential treatment facilities, nursing homes, adult care residences, home health agencies, durable medical equipment suppliers, pharmacists, etc. Provider appeals stem from providers who are enrolled with Virginia Medicaid or are seeking enrollment. The case types include service authorization, billing, and audits. There are two levels of appeal with DMAS: Informal and Formal appeals.

Virginia Department of Medical Assistance Services
Appeals Division

As of 6/15/2020

Positions in RED are vacant



Behavioral Health Division

The Behavioral Health (BH) Division is comprised of two units: Mental Health and Substance Use. These units are responsible for statewide policy development and implementation related to behavioral health (mental health and substance use) related services. The responsibilities of this division and its composite units are as follows:

Provide statewide oversight of Medicaid-funded behavioral health services, which includes:

- Serving as agency subject matter experts for behavioral health policy to support internal and external initiatives
- Establish, update, and clarify behavioral health policy for managed care organizations (MCOs) and the Behavioral Health Services Administrator (BHSA)
- Facilitate communications between behavioral health stakeholders, BHSA and MCO entities regarding systems concerns
    - Provide technical assistance and training for MCOs
    - Respond to stakeholder comments and inquiries
    - Manage the Community Services Board (CSB) help email account and work collaboratively with other divisions to manage CSB-specific issues
- Track and analyze the impact of Virginia legislative initiatives in coordination with the Policy Division and the Office of Communications, Legislation and Administration.
- Work closely with leadership of other major behavioral health initiatives, including the Family First Prevention Services Act (FFPSA; Department of Social Services and Office of Children's Services) and System Transformation Excellence and Performance (STEP-VA; Department of Behavioral Health and Disability Services) to assure alignment in systems reform efforts
- Provide interagency leadership and support for the Department of Behavioral Health and Disability Services in the development of the Behavioral Health Enhancement project
    - Manage stakeholder engagement through implementation workgroups, community presentations, and ongoing communications effort
    - Collaborate with contractors to provide subject matter expertise within rate study and fiscal impact analysis
    - Oversee project plan, implementation, and manage collaborative deliverables with other state agencies
    - Update agency regulations, state plan amendments, provider manuals, provider memos and other policies or policy communications related to BH
    - Produce strategic communications and presentations for stakeholder groups
- Monitor BHSA contract for administering fee-for-service community mental health and Addiction and Recovery Treatment Services (ARTS) services
    - Reimburse contractor for their payments to providers
    - Process contractor per member per month (PMPM) administrative payments
    - Provide contractor with technical assistance as indicated
    - Train contractor staff on new policies
    - Monitor contractor compliance
    - Provide systems support for claims and authorization since contractor's system does not interface with Virginia's Medicaid Management Information System (MMIS)

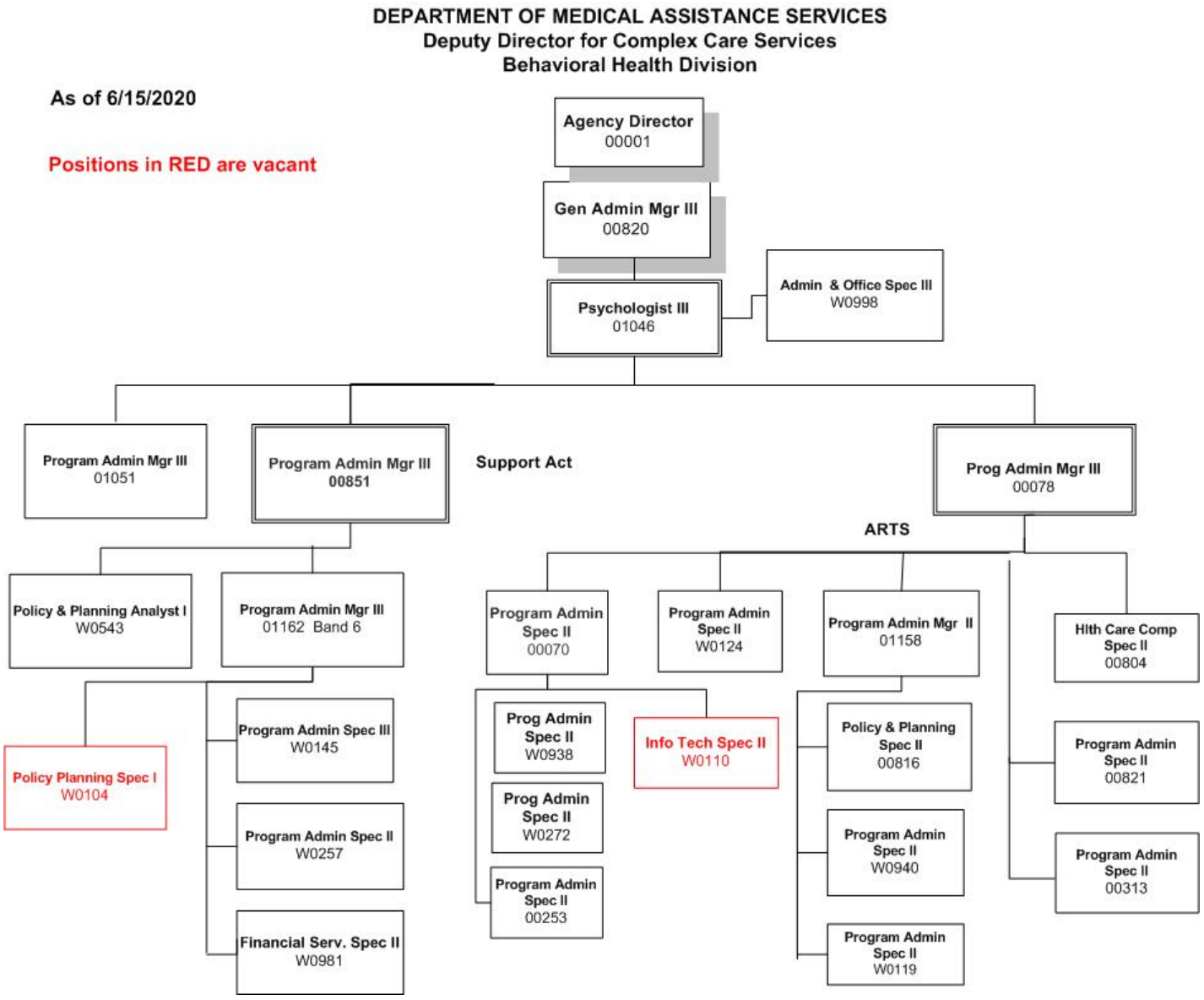
Providing statewide oversight of the Addiction Recovery Treatment Services waiver (ARTS), which includes:

- Management of the required waiver evaluation with the evaluation contractor
- Preparation and submission of required CMS Reports
- Monitoring of the contractor that conducts ARTS provider credentialing
- ARTS stakeholder engagement
- Provide regular updates and briefings to Virginia Secretary of Health and Human Resources
- Present ARTS best practices to national audiences

- ARTS Quality Management Reviews
- Collaborate with Program Integrity Division to review provider qualifications and ensure provider compliance

Providing statewide oversight of the $4.8 Million SUPPORT Act Grant, which includes:

- Conducting a comprehensive needs assessment of substance use disorder (SUD) treatment for the Commonwealth
- Completing a strengths-based assessment to identify communities' positive SUD-related outcomes
- Implementing medication assisted treatment and peer recovery services at five emergency departments
- Developing a telemedicine curriculum for SUD treatment providers
- Overseeing a pilot for linking recently incarcerated Medicaid members to community-based treatment
- Training and technical assistance for SUD treatment providers



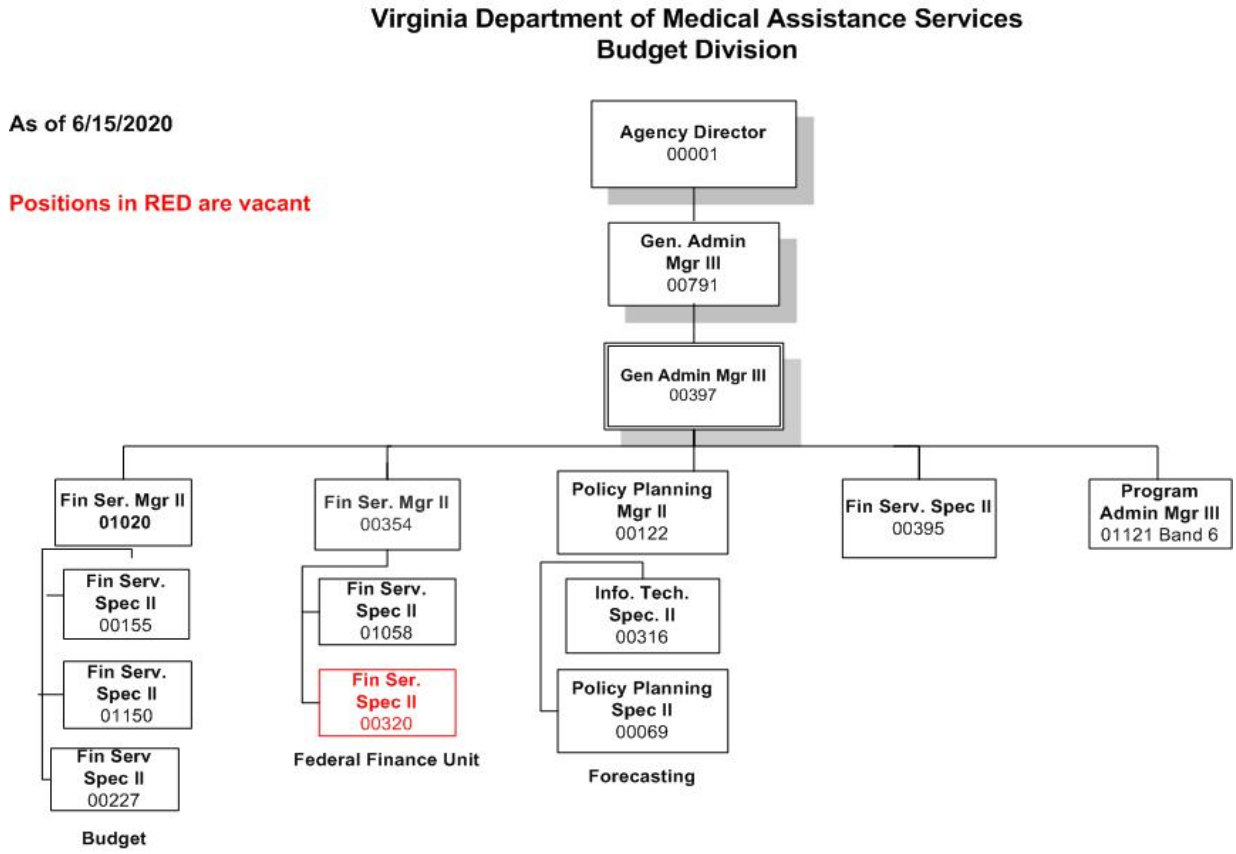
Budget Division

The Budget Division reports to the Deputy Director of Finance and Technology. The Budget Division's primary role is to support the agency's mission by securing and managing appropriations in compliance with state and federal regulations and providing well-informed, timely and accurate budgetary information to all stakeholders. The Budget Division is comprised of three units: Budget Operations, Federal Finance and the Forecast and Cost Estimate Unit.

- **Budget Operations Unit**
  The Budget Operations Unit is responsible for budget development, which includes coordinating the development and submission of decision packages, coordinating the completion of fiscal impact statements and monitoring/implementing General Assembly actions. In addition, the Budget Operations Unit is responsible for budget administration. This includes monitoring/reporting medical and administrative revenues/expenditures; monitoring of contracts and invoices to ensure proper accounting/funding; and monitoring cash to ensure agency spending is below appropriation.

- **Federal Finance Unit**
  The Federal Finance Unit is responsible for Advanced Planning Documents (APDs). This involves ensuring costs are accurately monitored/reported within state/federal budgets and complying with federal regulations, as well as ensuring adequate funding is available. This unit also prepares quarterly reports to meet the federal reporting requirements.

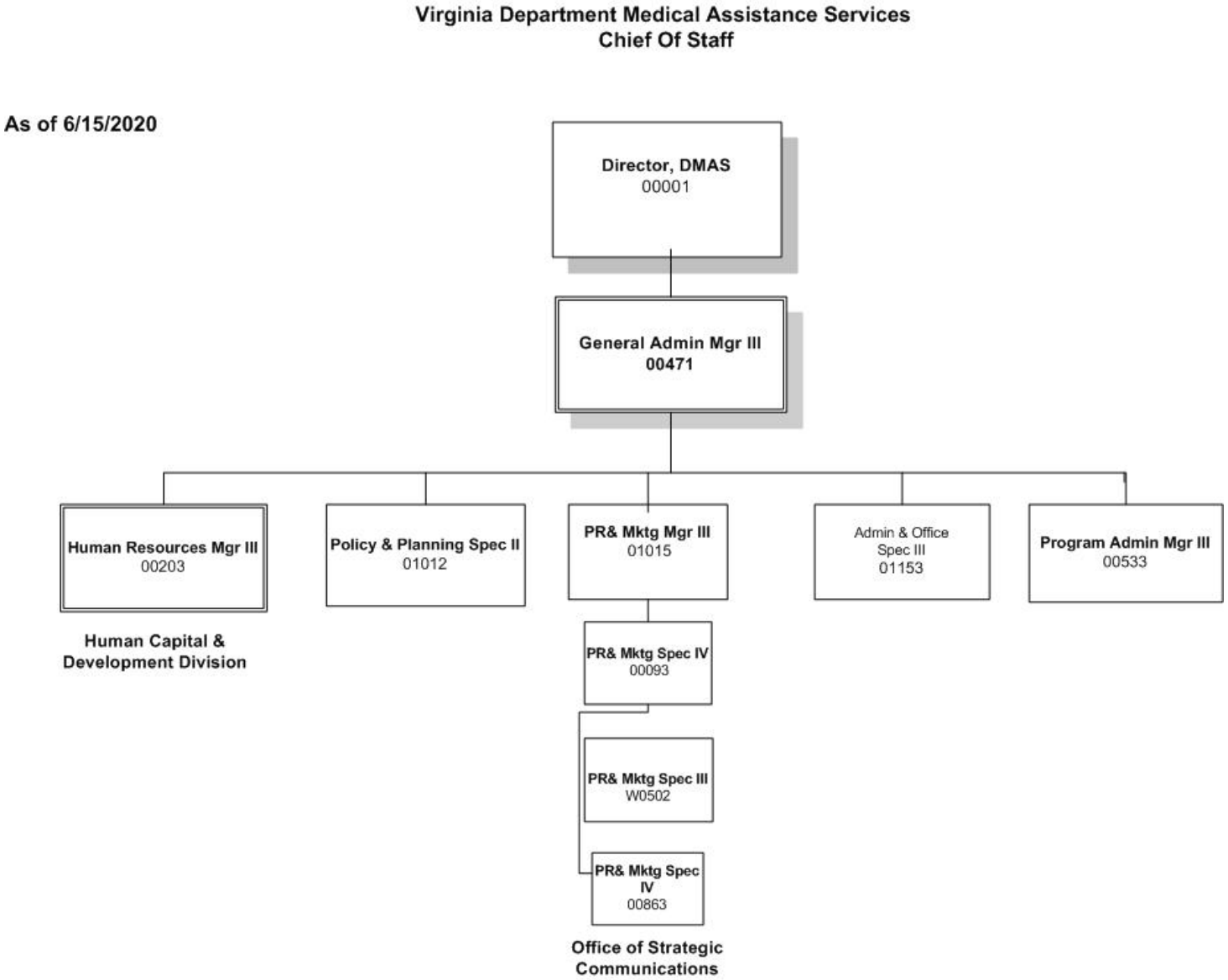
- **Forecast and Cost Estimate Unit**
  The Forecast and Cost Estimate Unit is responsible for developing the agency forecast and monitoring funding needs for all medical services. The unit is also responsible for providing medical cost estimates as needed for internal and external requests along with data management, which entails collecting, managing and reporting expenditure and member data.



Chief of Staff Office

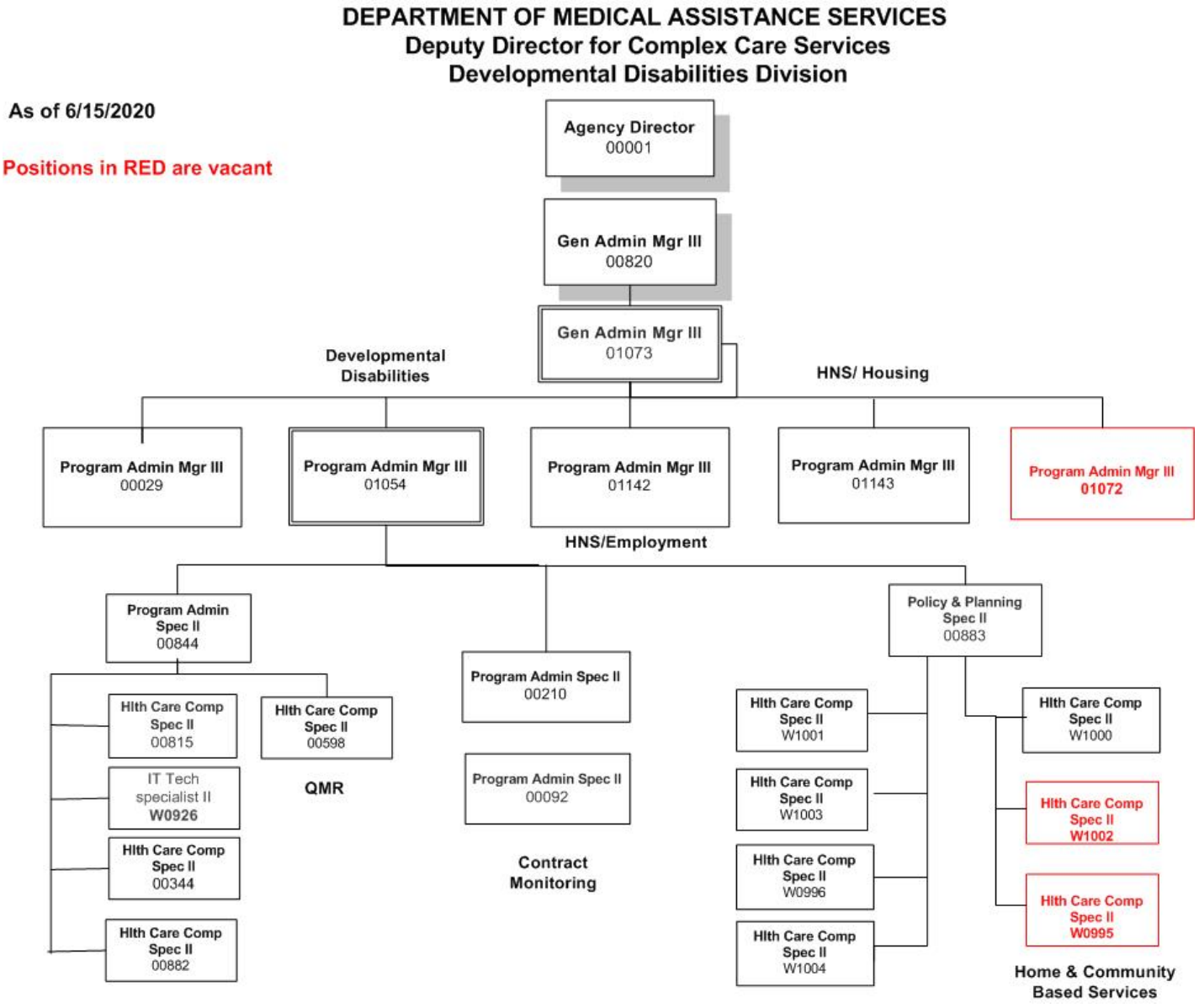
The Chief of Staff reports to the DMAS agency Director and is responsible for providing coordinated oversight of all operations and projects within the agency, with a particular focus on workforce development, business continuity, and strategic communications. Core functions of the Chief of Staff office include, managing the priorities of the Director's Office, overseeing the Human Capital and Development Division, overseeing agency performance and major initiatives, and leading strategic communications. The office ensures streamlined activities within the agency based on the priorities of the agency Director.

The Chief of Staff strengthens the DMAS workforce by ensuring a safe physical environment, promoting workforce development, and advancing diversity and inclusion. The Chief of Staff enhances DMAS business functions through strategic planning, resource planning and business continuity planning. As the agency lead for strategic communications, the Director of Strategic Communications provides communications on behalf of the Chief of Staff Office. This includes providing support to the Director, Chief of Staff and all ELT members on high-priority issues, handles all media inquiries and events, and social media for the agency. The Chief of Staff works with the Strategic Communications Director to promote “one voice” with internal and external stakeholders, increasing transparency and awareness across the agency.



Developmental Disabilities Division

The Developmental Disabilities Division reports to the Deputy Director of Complex Care Services. The Division of Developmental Disabilities is responsible for the statewide oversight of the Developmental Disabilities Waivers (DDW), statewide policy related to developmental disabilities and oversight of housing and employment services with in DMAS. This division develops all federal amendments, regulation, provider manuals and Medicaid memos for the DDW services, as well as case management services. It also provides Quality Management Reviews from the DDWs across all provider categories and assures compliance with the home and community based services (HCBS) settings rule through those waivers. It provides administrative oversight and technical assistance related to the DDWs to the Department of Behavioral Health and Developmental Services who provides operational oversight.



Division of Aging and Disability Services

The Division for Aging and Disability Services (DADS) reports to the Deputy Director of Complex Care Services. DADS is responsible for agency directed long-term services, supports and programs statewide. This includes the agency's fee-for-service components. Within the division, there are numerous staff members that form teams of expertise on a variety of programs.

- **Program of All Inclusive Care for the Elderly (PACE)**
  The division provides oversight, review, technical assistance and training for existing PACE programs and the establishment of new programs.

- **Screening for Long-Term Services and Supports**
  The division develops the regulatory standards, training and oversight for the screening process that determines functional eligibility for Medicaid long-term services such as nursing home placement and access to the Commonwealth Coordinated Care Plus program and the PACE programs.

- **Civil Money Penalty Funds (CMP)**
  The division manages the use of Virginia's Civil Money Penalties through an annual Request for Application Process for programs to improve the quality of life for individuals in nursing facilities within the Commonwealth. These evidence-based programs identify best practices to improve the quality of care in nursing facilities.

- **Policy Unit**
  The division is responsible for regulatory and policy development, revisions and maintenance to nursing facility, screening, durable medical equipment, hospice and other provider manuals and handbooks. The division also provides written and verbal policy clarifications, legislative support, and internal and external policy training.

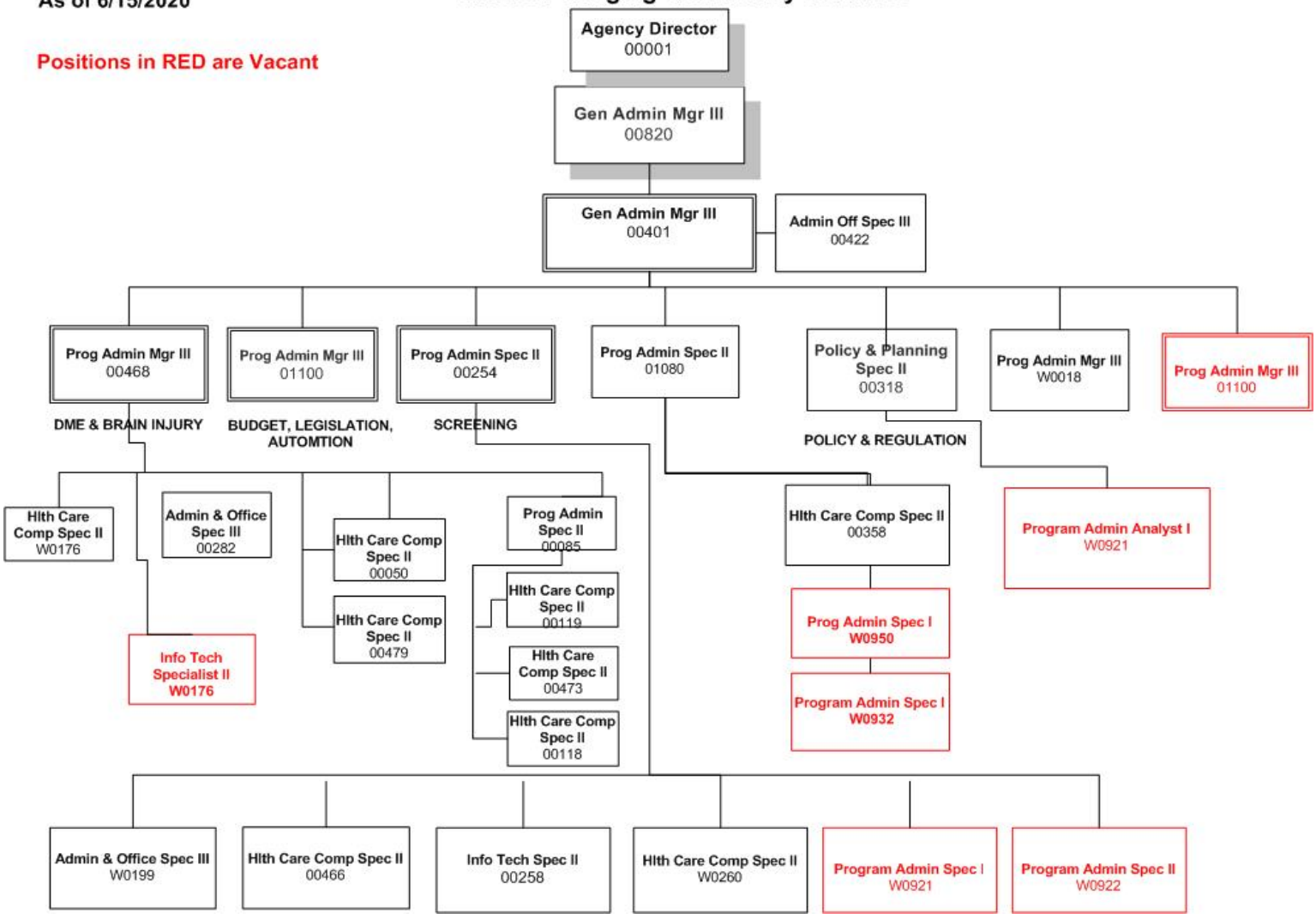
- **Level of Care (LOC)**
  The division is responsible for the annual reassessment process that assures Medicaid members continue to meet functional criteria to receive an array of Medicaid long-term services and supports. Standards on functional criteria are established through regulations, information system enhancements, and extensive training on the requirements.

- **Electronic Visit Verification (EVV)**
  The division is responsible for developing the regulations, process and provider outreach needed to implement EVV for Agency Directed personal care, respite care, and companion services beginning October 1, 2019.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Deputy Director for Complex Care Services
Division of Aging & Disability Services

As of 6/15/2020

Positions in RED are Vacant



Eligibility and Enrollment Division

The Division of Eligibility and Enrollment reports to the Deputy Director of Administration. It brings together all activities related to Medicaid/FAMIS Eligibility and Enrollment in a single division staffed with a coordinated, expert team. The division is comprised of four units, each with a distinct function: Eligibility Policy Unit, Enrollment Unit, Cover Virginia, and the Eligibility Performance Management Program (EPMP).

- **Eligibility Policy Unit**
  The Eligibility Policy Unit is responsible for Medicaid/FAMIS eligibility policy development, revising and maintaining the Medicaid Eligibility Policy Manual, Medicaid and FAMIS Member Handbooks, and providing written and verbal policy clarifications. The unit provides legislative support, internal and external policy training and assistance in resolving systems issues related to eligibility. Staff in this unit work with Department of Social Services (DSS) staff to develop requirements for systems changes and perform testing before changes related to Medicaid or FAMIS eligibility are implemented. Staff in this unit also work with the DMAS Information Management Division and selected vendors on developing requirements and testing for the new Medicaid Enterprise System (MES).

- **Enrollment Unit**
  The Enrollment Unit is responsible for enrollment coverage corrections in the Medicaid Management Information System (MMIS) based on requests from local DSS agencies; patient pay corrections in MMIS based on requests from local agencies/providers; cancellation of coverage for deceased individuals based on reporting from the Virginia Department of Health (VDH); processing returned mail; adding eligibility for deemed newborns; research and correction of duplicate enrollments; researching and resolving monthly enrollment reports related to Social Security number discrepancies, open ended coverage for Medically Needy individuals, and other related issues.

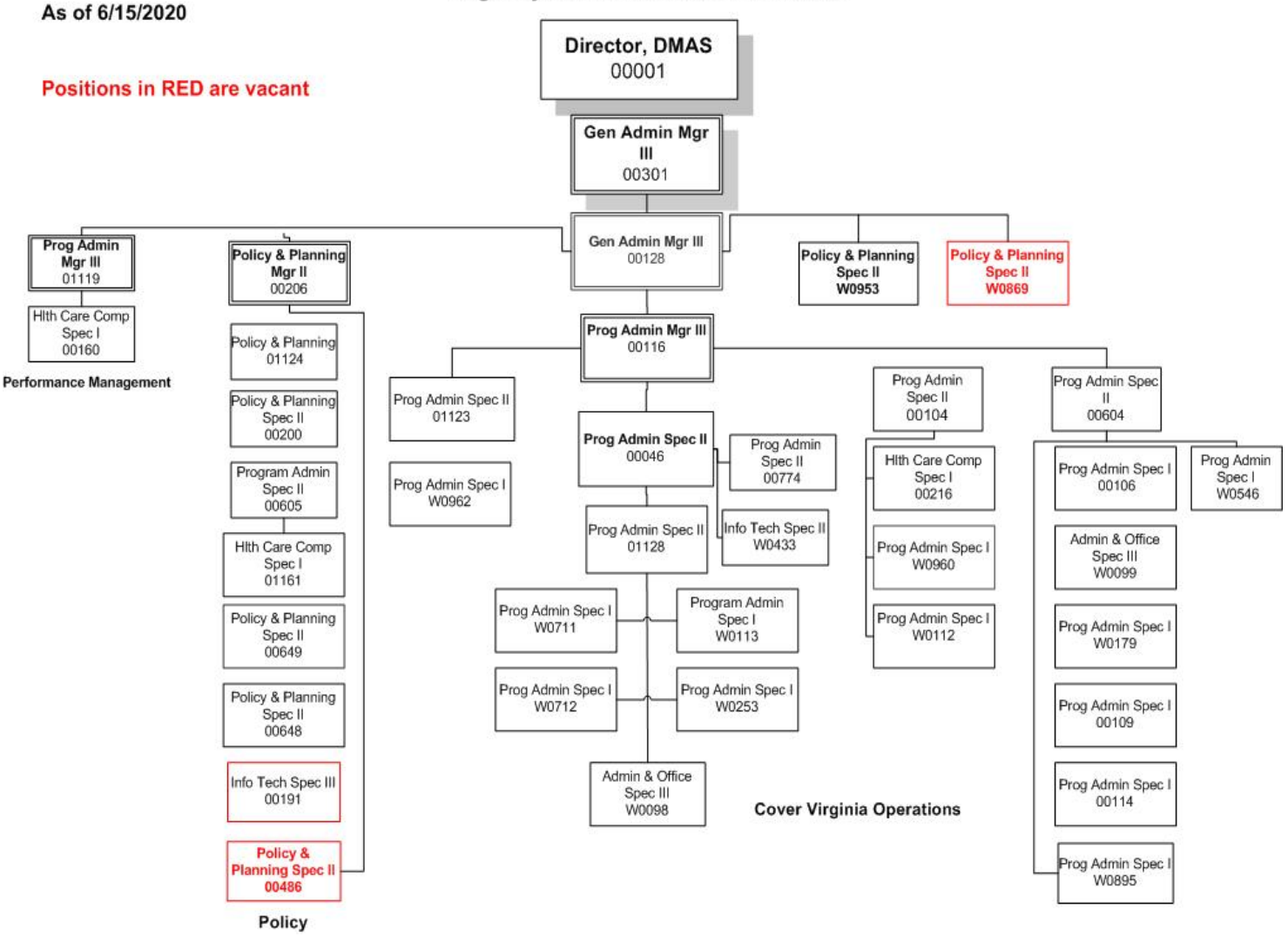
- **Cover Virginia**
  Cover Virginia is both a central site for acceptance and processing of Medicaid/FAMIS applications as well as a site for co-located DMAS staff to monitor the Cover Virginia contract and resolve complex case issues. The Cover Virginia central site includes a call center, central processing unit, a mailroom, and a quality assurance unit. There is also a central site for acceptance and processing of applications for incarcerated individuals. This unit also is responsible for ongoing case maintenance and re-entry case processing for these individuals.

- **Eligibility Performance Management Program (EPMP)**
  The Eligibility Performance Management Program (EPMP) was legislatively mandated for DMAS to work with VDSS and other stakeholders to develop performance measures to be followed by both local departments of social services and the Cover Virginia central site. The purpose is to improve accountability for DMAS, as the single state Medicaid agency, in ensuring that local departments of social services, as well as Cover Virginia are accurately and timely determining, enrolling and re-determining eligibility for qualified individuals.

Virginia Department Medical Assistance Services
Eligibility & Enrollment Services Division

As of 6/15/2020

Positions in RED are vacant



Fiscal Division

The Fiscal Division reports to the Deputy Director for Finance / Chief Financial Officer. The division consists of six units: Accounts Payable & Disbursements, Accounts Receivable, Cash Management, General Ledger & Reporting, Grants Management and Third Party Liability. The Fiscal Division is the agency's center for business transactions. The division is responsible for overseeing, evaluating and reporting on agency financial accountability and compliance with the Department of Accounts' Commonwealth Accounting Policies and Procedures (CAPP), with the goal of assisting managers and staff of DMAS in meeting their responsibilities for protecting the resources of the Commonwealth.

- **Accounts Payable (AP) & Disbursements**
  The Fiscal Division's AP & Disbursements Unit is primarily responsible for processing agency payments. This includes processing all vendor payments, travel reimbursements, wire transfers, revenue refunds and petty cash transactions. The unit is responsible for processing the weekly remittance of claims paid by the fiscal agent and the processing of administrative add-pays through the Medicaid Management Information System (MMIS). The unit is also responsible for the review and certification of the agency's payroll.

- **Accounts Receivable**
  The Accounts Receivable (AR) Unit is a part of DMAS' Fiscal Division. Its objective is to properly manage accounts receivable in order to account, report, and collect funds due to the agency, ensuring proper internal control in accordance with federal (CFA §433.300) and state (CAPP §20505) regulations. The AR Unit manages the agency's accounts receivable and debt recovery efforts (excluding Third Party Liability) in accordance with state and federal regulations.

- **Cash Management**
  The Cash Management Unit manages agency recording and reporting of general cash receipts including requested and volunteer refunds (miscellaneous and TPL Health Insurance Provider), Taxation Debt Set-off Program, TPL Casualty Recovery Application, Electronic Health Record-Incentive(EHR), Provider Enrollment Fees, and Civil Money Penalties. The unit manages fiscal agent processing of Provider and Payee MMIS Remittance checks and EFT Stop Pays (Reissues and Voids) and Advance Payment Requests across all benefit programs. The unit also validates Provider Registration Fee Deposits and Refunds and reviews Provider and Payee Annual 1099 files.

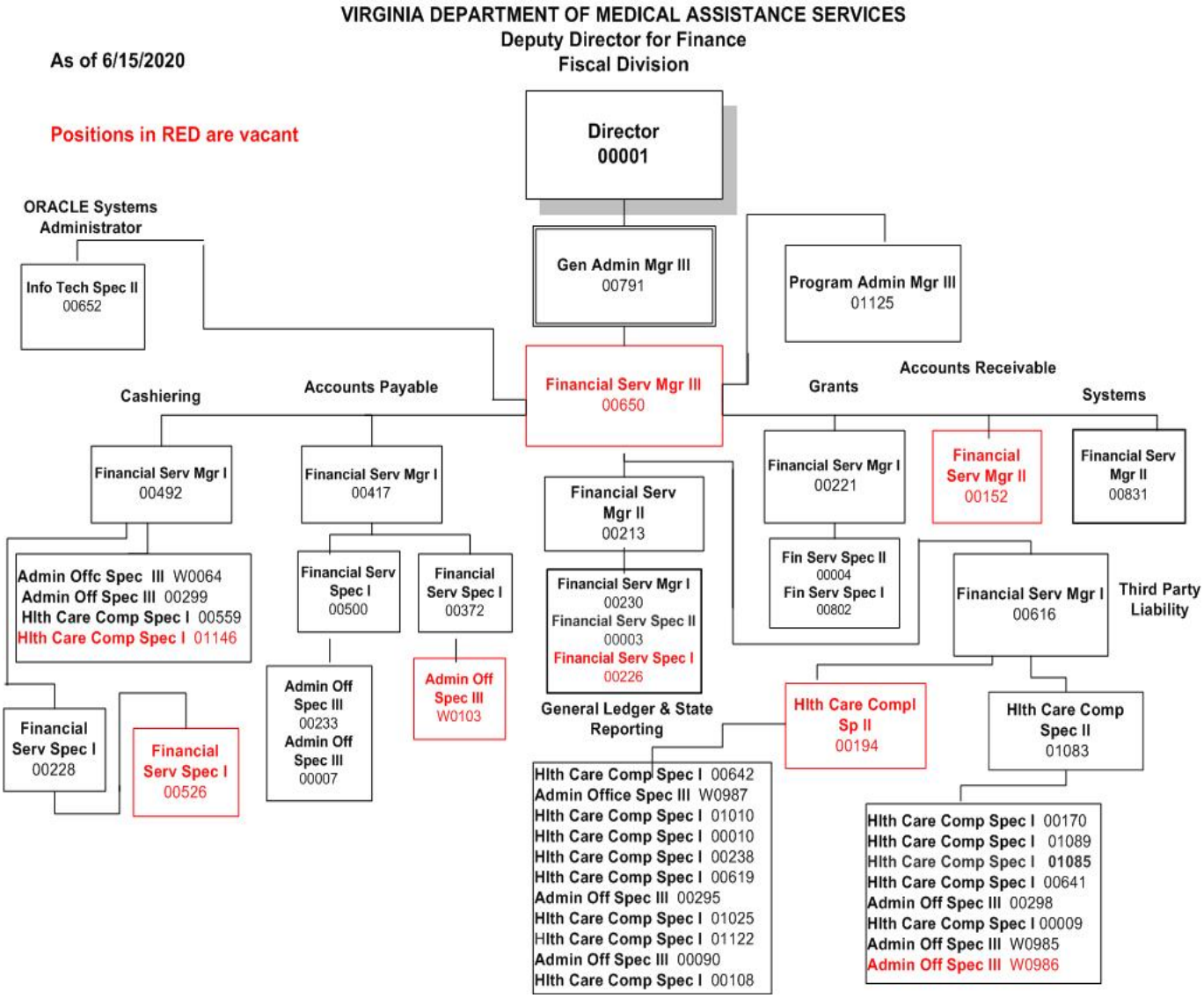
- **General Ledger & State Reporting**
  This unit reconciles all accounts in the Cardinal Accounting System to Agency's Oracle Accounting System monthly and certifies to Department of Accounts. The unit analyzes and reconciles agency expenditures by program, fund and expense code monthly. It manages processes for monthly and fiscal year-end close of accounting systems in accordance with directive from the State Comptroller. The unit prepares and submits year-end financial schedules and other requested data to Department of Accounts for preparation of the Comprehensive Annual Financial Report (CAFR).

- **Grants Management**
  On a quarterly basis, the Grants Management Unit prepares, certifies, and submits the Federal Financial Report (FFR or SF-425), which includes all quarterly federal cash receipts, as well as, the cumulative federal cash disbursements (by Grant Award Sub-Account), to Department of Payment Management (DPM) through the DPM - Payment Management System (PMS). As part of the Annual Statewide Interest Liability Calculation, the unit prepares, coordinates, and submits Cash

Management Improvement Act (CMIA) reporting requirements to DOA specifically for Medicaid and CHIP Federal Grant Awards. Federal schedules are completed and submitted to DOA for preparing the Annual Statewide Schedule of Expenditures of Federal Awards (SEFA) for the Single Audit Report Amendments of 1996 and Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

- **Third Party Liability (TPL)**

  Medicaid is the payer of last resort. The Third Party Liability Unit, works in partnership with HMS (outside vendor), who performs data matches with insurance carriers to update the member's third party resource information to pursue recoveries from primary insurance carriers. The unit also processes referrals related to member's primary health insurance verifications to ensure they are able to enroll in programs and receive services needed. In addition, the unit performs daily and monthly accounts receivable reconciliations between TPLRS and the Oracle Financial system for recovery cases established by the TPL unit.



Formal Appeals and Final Agency Decision Unit

The Formal Appeals and Final Agency Decision Unit reports to the DMAS Deputy Director of Administration. The primary responsibility of the unit is to process formal (second-level) provider appeals within the framework and timelines afforded under the laws and regulations governing DMAS provider appeals. The unit works closely with the Office of the Attorney General ("OAG") to ensure Final Agency Decisions are issued in accordance with the law and also works with the OAG throughout the court appeal process, during which staff of the unit file the case record and the OAG represents DMAS in the court proceedings.

The main tenets of the unit are to meet all deadlines, produce excellent quality work-product that is understandable by the public, respond promptly to the public, and serve as good colleagues within DMAS and other agencies. The core responsibilities of the unit are:

- **Intake of provider formal appeals**: Confirm request is a formal appeal; update case-tracking software; assign case to Formal Appeals Representative; obtain Hearing Officer assignment from Executive Secretary of Virginia Supreme Court; notify Hearing Officer of assignment and send Hearing Officer engagement letter once assignment is accepted.

- **Represent DMAS in formal appeals:** Prepare and file documentary evidence within 21 days of receipt of appeal request; prepare witnesses for testimony; advocate as the agency's attorney during formal hearing; write post-hearing briefs outlining DMAS's legal arguments and proposed findings for Hearing Officer; file exceptions to Hearing Officer's Recommended Decision.

- **Draft Final Agency Decisions:** The Hearing Officer appointed by the Supreme Court submits a Recommended Decision to the DMAS Director following the hearing and review of the briefs. The Final Agency Decision must be issued within 60 days of receipt of the Hearing Officer's Recommended Decision. The Medicaid Appeals Specialist reviews the Recommended Decision to determine if it is in accordance with DMAS law and policy. After the Medicaid Appeals Specialist drafts the Final Agency Decision, it is reviewed by the Unit Supervisor and Appeals Division Director, then sent to the OAG at least 17 calendar days prior to the issuance deadline. The OAG submits written comments to the Unit Supervisor at least three business days prior to the issuance deadline. A hard copy of the draft with accompanying transmittal letters is then sent to the DMAS Director for review and signature.

- **Process Circuit Court appeals:** Following the final administrative appeal decision, providers and clients have the right to appeal to the court system. Appellants must follow a two-step process to perfect the appeal to the circuit court. First, a notice of appeal must be filed with the DMAS Director within 33 days of the decision being issued. Then, within 30 days after filing that notice, a petition for appeal must be filed with the Circuit Court, requesting service on DMAS. This unit notifies the OAG when a notice of appeal and petition are received by DMAS. Additionally, the unit compiles and files the administrative case record with the Circuit Court.

- **Ensure DMAS complies with Court Orders:** At the conclusion of the Court case, the Court enters an Order. This Unit notifies the appropriate DMAS staff of the result of the case and also ensures that any follow-up action required by the Court's Order is taken.

- **Review requests for attorneys' fees and costs:** The Code of Virginia and the DMAS provider appeal regulations permit payment of attorneys' fees when the provider substantially prevails in the

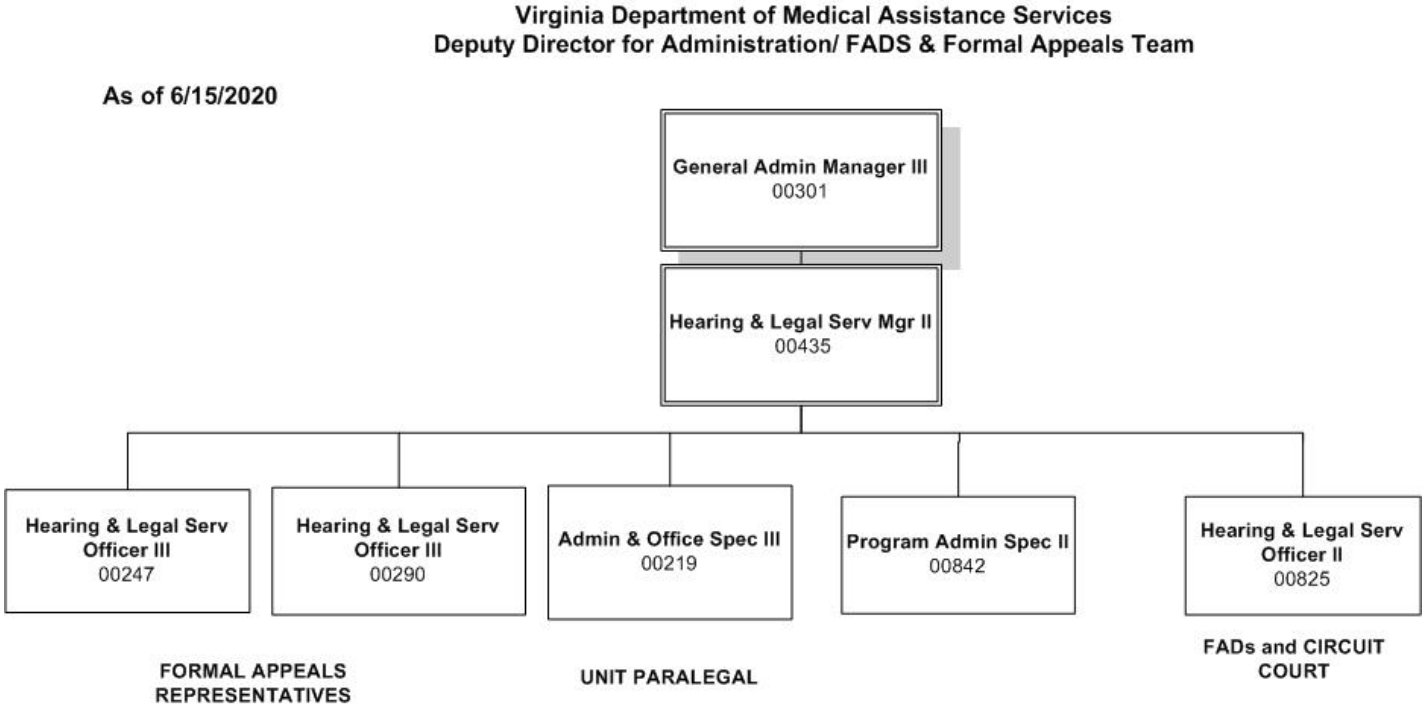
appeal and other conditions are met. The attorneys in this unit assist DMAS Executive Management with the review of these requests by drafting a memorandum outlining the facts and legal analysis. Once the Director has made a decision, this unit drafts the decision letter and forwards the package to the OAG for review.

- **Assist DMAS Executive Management with review of settlement proposals:** For settlements received during the administrative appeal process, the assigned Formal Appeals Representative prepares a memorandum to DMAS Executive Management setting forth the facts of the case and discussing the pros and cons of the settlement offer. If Executive Management wishes to pursue the settlement, the Formal Appeal Representative negotiates the settlement, drafts the agreement, and forwards the package to the OAG for review. Additionally, some cases are settled during the court process. For those cases, the unit assists the Policy Director with reviewing the facts of the case and, once the settlement is signed, notifies DMAS staff of the action that must be taken to comply with the terms.

- **Track appeal trends:** The unit monitors appeal trends and discusses with appropriate DMAS personnel to determine if further action needs to be taken. Many of the issues involve either audit points that have been unsuccessful on appeal or clarifications to DMAS policy.

- **Assist DMAS Executive Management with reviewing proposed legislation and drafting regulations:** The unit supervisor works closely with DMAS Executive Management and the Appeals Division Director to review the impact of legislation related to the appeals process. Additionally, the unit supervisor attends the public meetings of the Administrative Law Advisory Committee.

- **Ensure Compliance with All Civil Rights Requirements:** The DMAS Civil Rights Coordinator serves as the agency resource to make sure that DMAS is complying with the laws and regulations pertaining to language access and disability access.



Health Care Services Division

The Health Care Services (HCS) Division reports to the Deputy Director of Programs. The mission of HCS is to deliver Medicaid Managed Care to eligible Medallion members by collaborating with key stakeholders, providers, sister agencies and DMAS divisions to support consistent, high quality, cost effective, compassionate health care across the Commonwealth. The division's core function is to provide support to Medallion 4.0 members and providers. The division facilitates member case management, oversees and administers the managed care organization contracts, focuses on improving maternal and child health, compliance enforcement, and systems and reporting support for managed care. HCS also oversees the Virginia Medicaid dental program.

- **Member and Provider Solutions**
  Provides Medallion member and Medallion managed care providers support and service. Provides case management to members.

- **Maternal and Child Health**
  Oversees policy and program management seeking to improve the health and well-being of Medicaid eligible mothers and children.

- **Contract Administration**
  Oversee the provisions of the managed care contracts and manages the operational relationship between DMAS and the managed care organizations

- **Compliance**
  Manages and enforces Medallion managed care contract compliance standards and requirements.

- **Policy**
  Provides oversight of related policy and contractual implications of new program initiatives.

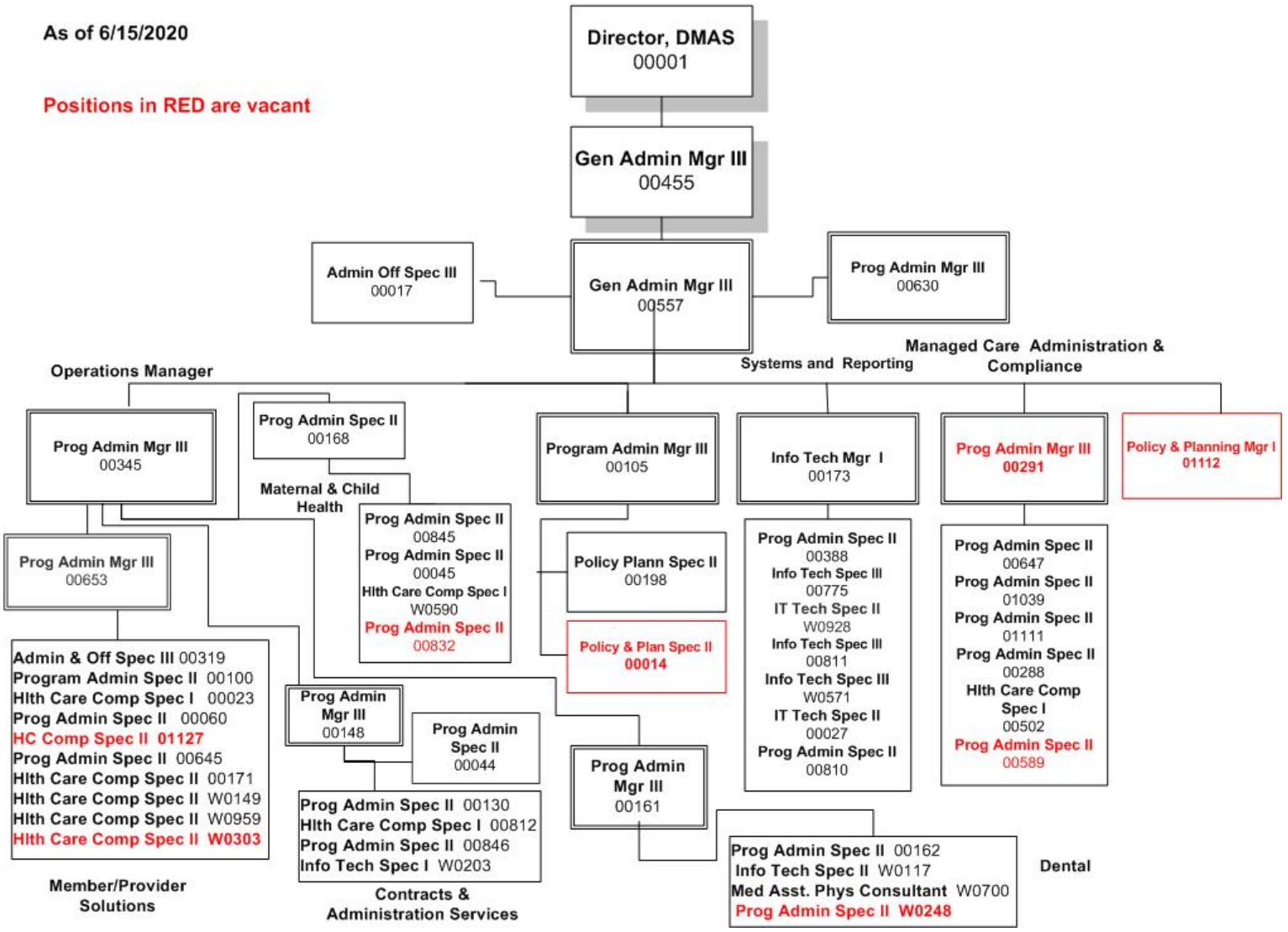
- **Dental**
  Manages the dental services contract for all Medicaid members and provides support to members and providers.

- **Systems and Reporting**
  Provide systems and reporting support for the Health Care Services Division including Medallion, dental and maternal and child health.

Virginia Department of Medical Assistance Services
Health Care Services Division

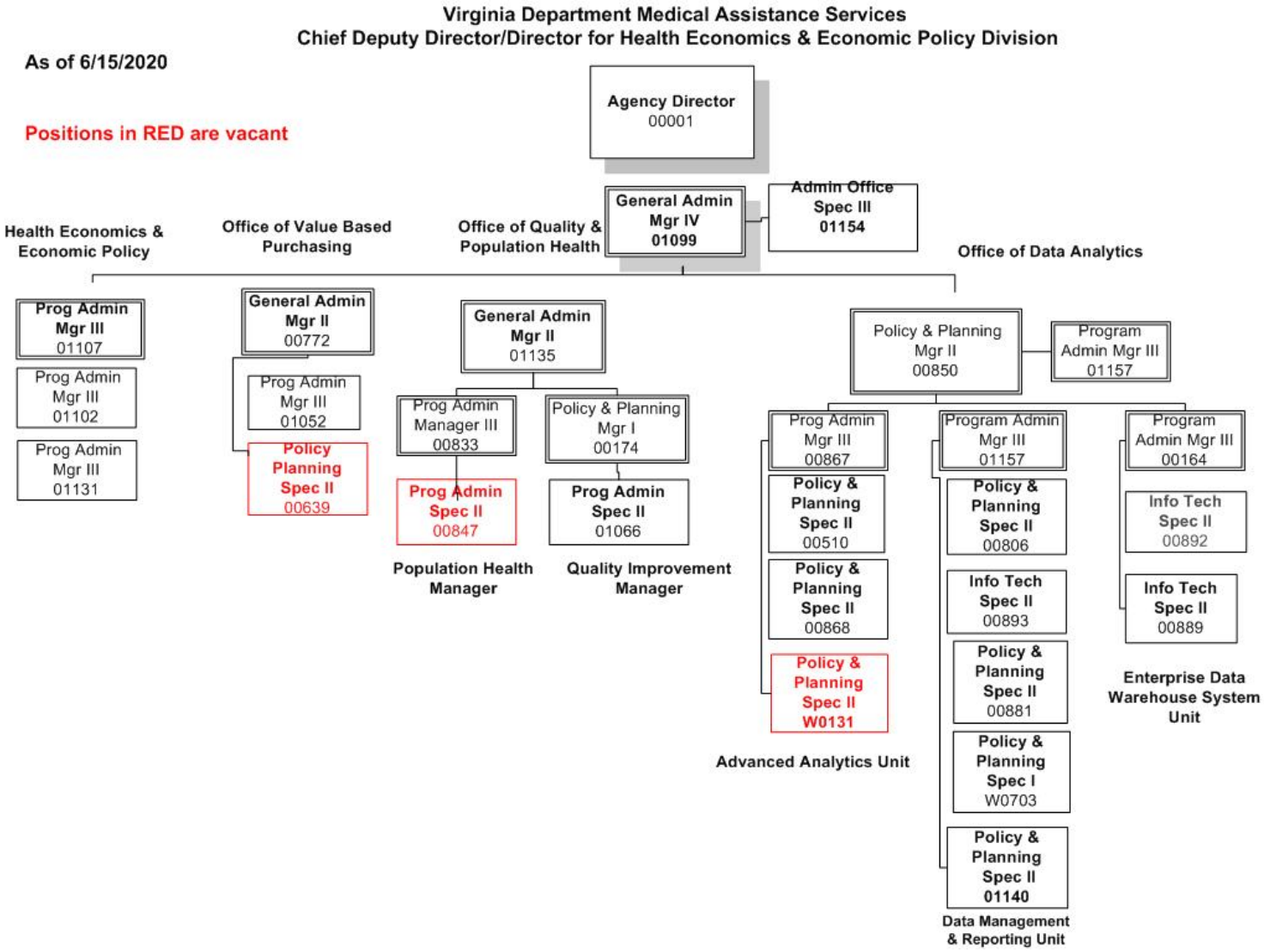
As of 6/15/2020

Positions in RED are vacant



Health Economics and Economic Policy

The Division of Health Economics and Economic Policy (HEEP) is led by the Chief Health Economist. The division includes the Office of Data Analytics, the Office of Value-Based Purchasing, and the Office of Quality and Population Health. HEEP and its team of economic, policy, and data analyst professionals provide analysis, policy development, and strategic guidance related to economic trends, insurance markets, service utilization and provider and insurer payment incentives to improve member outcomes and program efficiency.



Human Capital & Development Division

The Human Capital and Development (HCD) Division reports to the DMAS Chief of Staff. Human Capital and Development is dedicated to excellent, timely customer service in support of the agency's values and mission. The HCD team is comprised of trusted HR professionals available to provide guidance and assistance to staff on a myriad of HR programs and policies. The HCD Division consists of five units: Compensation and Classification, Talent Acquisition, Talent Development, Operations and Benefits, and DMAS Reception and HR Support. The Division Director is responsible for the overall management of the HR team, policy development, interpretation and guidance, legal compliance, investigating allegations of discrimination, employee relations matters requiring corrective action, and employee engagement.

- **Compensation and Classification Unit**
  The Compensation and Classification Unit is accountable for developing, managing and operating the classification, compensation and performance management functions at DMAS to ensure consistent application of agency pay practices in accordance with the Agency Salary Administration Plan, the state's compensation program and applicable state and federal laws. This unit ensures fair, consistent application of the Performance Management System, technical assistance for Performance Improvement Plans, recording performance ratings and ensuring that all Employee Work Profiles are up-to-date and accurate. The unit advises management team members of the proper procedures for position role changes, in-band salary adjustments and movement of staff within the agency. The unit ensures internal equity in compensation activities at DMAS while also enhancing the agency's external competitiveness in the market.

  Performance management is the systematic process of planning work and setting expectations continually while monitoring performance of core responsibilities, developing the capacity to perform and improve, periodically rating performance and rewarding consistent, successful performance. Under the Department of Human Resource Management (DHRM) Policy, all classified employees are evaluated on an annual basis in the performance management process. Although not required under policy, it is strongly recommended that wage employees are evaluated each year during the performance period.

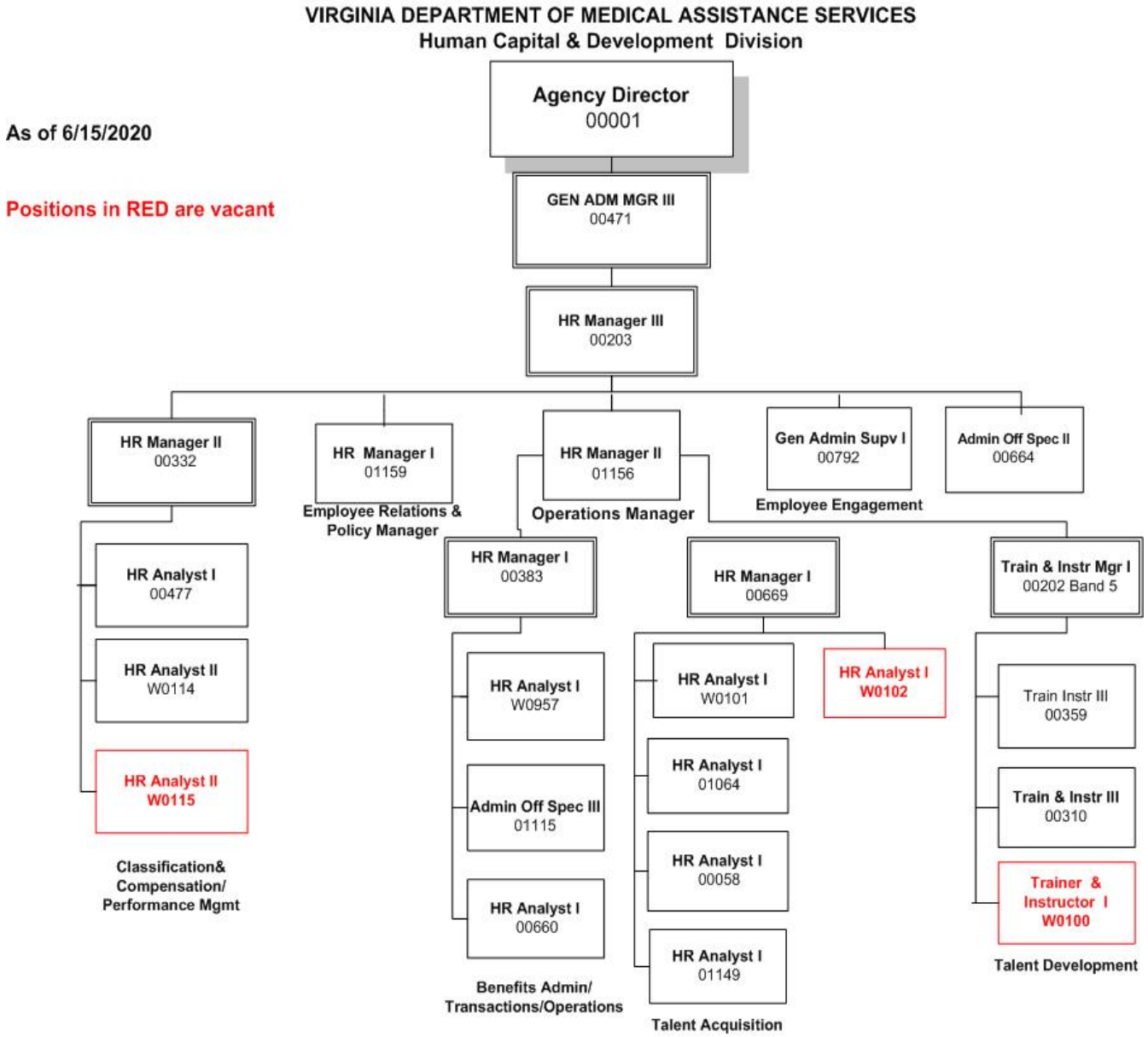
- **Talent Acquisition Unit**
  The Talent Acquisition (TA) Unit administers and directs all aspects of agency employment policies and practices. This function provides written (e.g., advertisements and postings) and verbal support to hiring managers regarding employment policies, practices, and procedures as well as providing tools to guide managers through recruitment and selection decisions. Employment support includes assisting applicants (internal and external), providing guidance to hiring managers, and finding alternate recruitment solutions. Talent Acquisition also handles administration of the state's Recruitment Management System (RMS) and tracking and updating applicant records.

- **Talent Development Unit**
  The Talent Development Unit is responsible for the effective development, coordination and presentation of training and development programs for all employees to include assessing agency-wide developmental needs to drive training initiatives, evaluating and measuring results, and identifying and arranging suitable training solutions for employees. Professional Development also includes administration of the agency Learning Management System (LMS) and tracking/maintaining training records for all employees. The Talent Development Unit administers online learning resources including LinkedIn Learning, the Virginia Learning Center (VLC), and tracks/maintains training records for all employees.

- **Operations and Benefits**
  The Operations and Benefits Unit is responsible for administration of state benefits programs such as group health insurance and the Virginia Sickness and Disability program and provides guidance and counsel on benefits inquiries/reports. This unit is the liaison to the Department of Accounts for

all payroll processing for the agency. The Operations and Benefits Unit conducts New Employee Orientation and announces all staff changes. This unit is responsible for ensuring I-9 compliance for United States Citizenship and Immigration Services via the E-Verify system. Operations is also accountable for leave administration and tracking in the Time, Attendance and Leave System (TAL), Workers Compensation, OSHA Reporting, Bureau of Labor Statistics reporting, Virginia Employment Commission (VEC) claims and hearings, managing employee recognition programs (e.g., state service awards) and all required personnel records retention ensuring compliance with Library of Virginia standards. The Physical Access Control Security (PACS) badge system is administered and controlled by HCD Operations. The Operations Unit updates and maintains the Personnel Management Information System (PMIS) with all personnel transactions and handles administration and reconciliations of the Virginia Retirement System for the Agency.

- **DMAS Reception and HR Support**
  The HR Division has responsibility for the 7th Floor Reception Area. The Receptionist is responsible for greeting and referring visitors and ensuring compliance with the Visitor Access Control Policy requirements. The Receptionist answers multiple telephone lines and refers callers to appropriate sources within and outside the agency while ensuring top-notch customer service to internal and external customers.



Information Management Division

The Division of Information Management (IM) reports to the Deputy Director of Finance and Technology. The IM Division is responsible for managing the day-to-day activities of Medicaid Management Information System (MMIS) with the fiscal agent. This includes provider enrollment, member enrollment, Fee-for-Service (FFS) and Encounter adjudication, payment to FFS providers and MCOs and administrative service organizations (ASOs) like consumer directed services vendor, dental, behavioral health services administrators and most all other vendors that do business with the agency. IM also supports federal reporting needs and manages the financials system that interface with Department of Accounts' Cardinal System. IM sends enrollment data to all the MCOs, ASOs and other vendors who needs it to run the daily operations. In addition, the IM Division also supports a provider call center and member call center related to enrollment and claims activity.

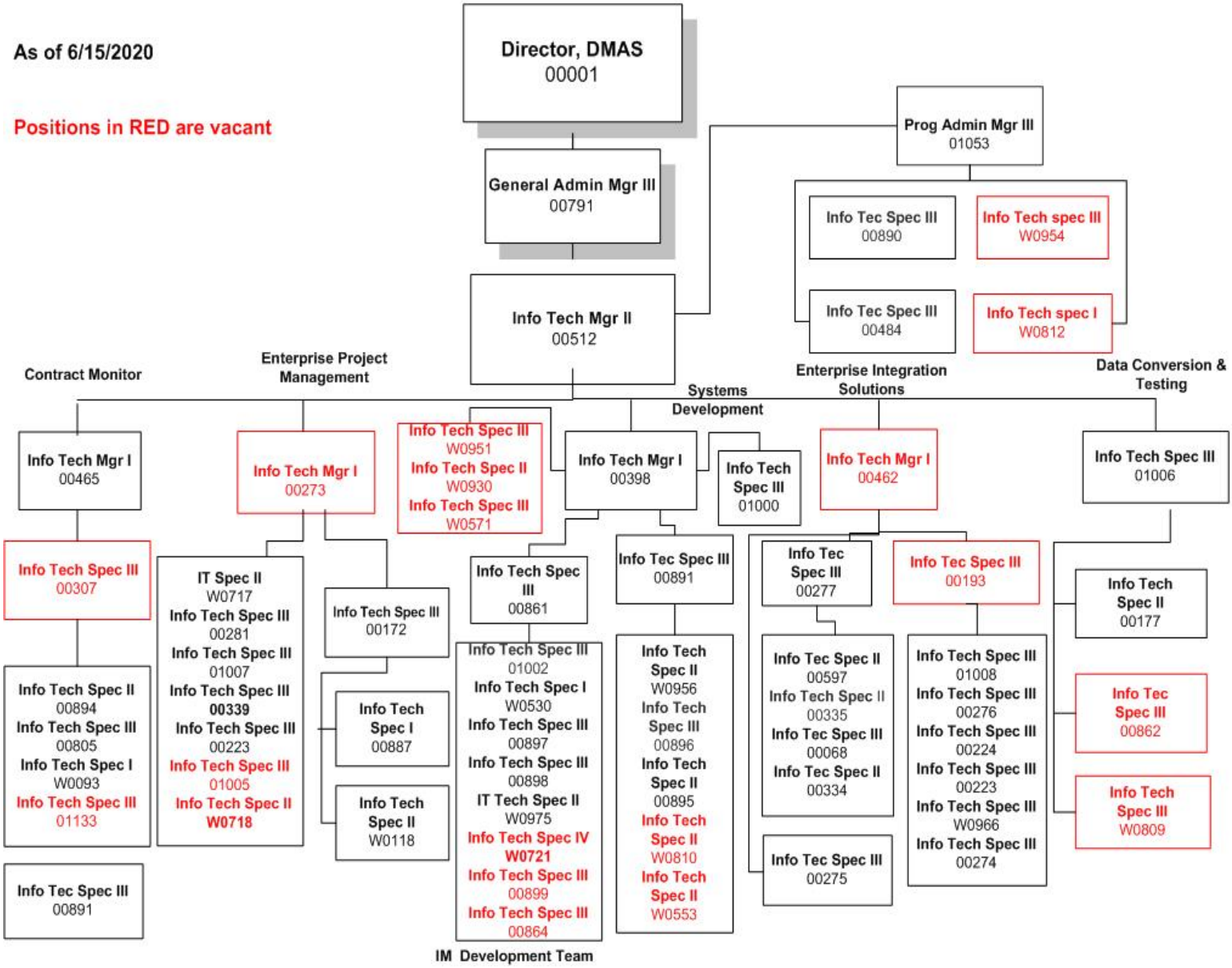
The IM Division manages an internal development shop in which automated workflows, intranet, Encounter processing system, Care Management System and multiple applications that support and feed MMIS are housed.

IM also manages the new Medicaid Enterprise System (MES) which includes procurement, design, development and implementation. MES is replacing the MMIS module by module and works closely with the Office of Attorney General (OAG), Virginia Information Technologies Agency (VITA) and the Centers for Medicare and Medicaid (CMS).

Virginia Department of Medical Assistance Services
Deputy Director for Finance & Information Management Division

As of 6/15/2020

Positions in RED are vacant



Integrated Care Division

The Integrated Care Division reports to the Deputy Director for Complex Care Services. This division provides direct oversight and management of the Commonwealth Coordinated Care Plus (CCC Plus) Program which began in August 2017. The CCC Plus Program is an integrated health care delivery model that includes medical services, behavioral health services and long-term services and supports (LTSS). The CCC Plus Program also encompasses care coordination services to develop a person-centered plan of care that addresses the needs of members with disabilities and medically complex members to ensure timely access to appropriate services. The Integrated Care Division's core functions include support to CCC Plus members, providers and contractors; oversight and administration of the CCC Plus contracts; focus on care coordination to improve the quality of life for our members; compliance monitoring and enforcement; and, systems and reporting support including data exchange between DMAS and the health plans.

- **Contract Refinement**
  - Coordinate contract revisions as changes to business processes, initiatives, or regulations necessitate
  - Assess impact of changes in legislation, policy, or the insurance market on CCC Plus contract

- **Contract Monitoring**
  - Identify and document all CCC Plus contract deliverables (Contract Monitoring Plan)
  - Update the Contract Monitoring Plan with each contract revision
  - Regularly interact with contractors to monitor progress towards deliverables
  - Respond to ad hoc stakeholder concerns (internal and external)

- **Contract Compliance**
  - Monitor MCO data to identify performance issues
  - Enforce and oversee corrective action plans to improve performance

- **Enrollment Broker Contract**
  - Develop and update Enrollment Broker contract
  - Monitor Enrollment Broker deliverables and compliance
  - Provide technical assistance to Enrollment Broker
  - Provide ad hoc operational support

- **Data and Operations**
  - Evaluate and monitor the quality of contractor encounter data (encounter scorecard)
  - Use encounter data to monitor contractor performance by analyzing trends
  - Ensure MMIS is functioning appropriately and correct enrollment file inaccuracies
  - Perform ad hoc MMIS or EPS queries

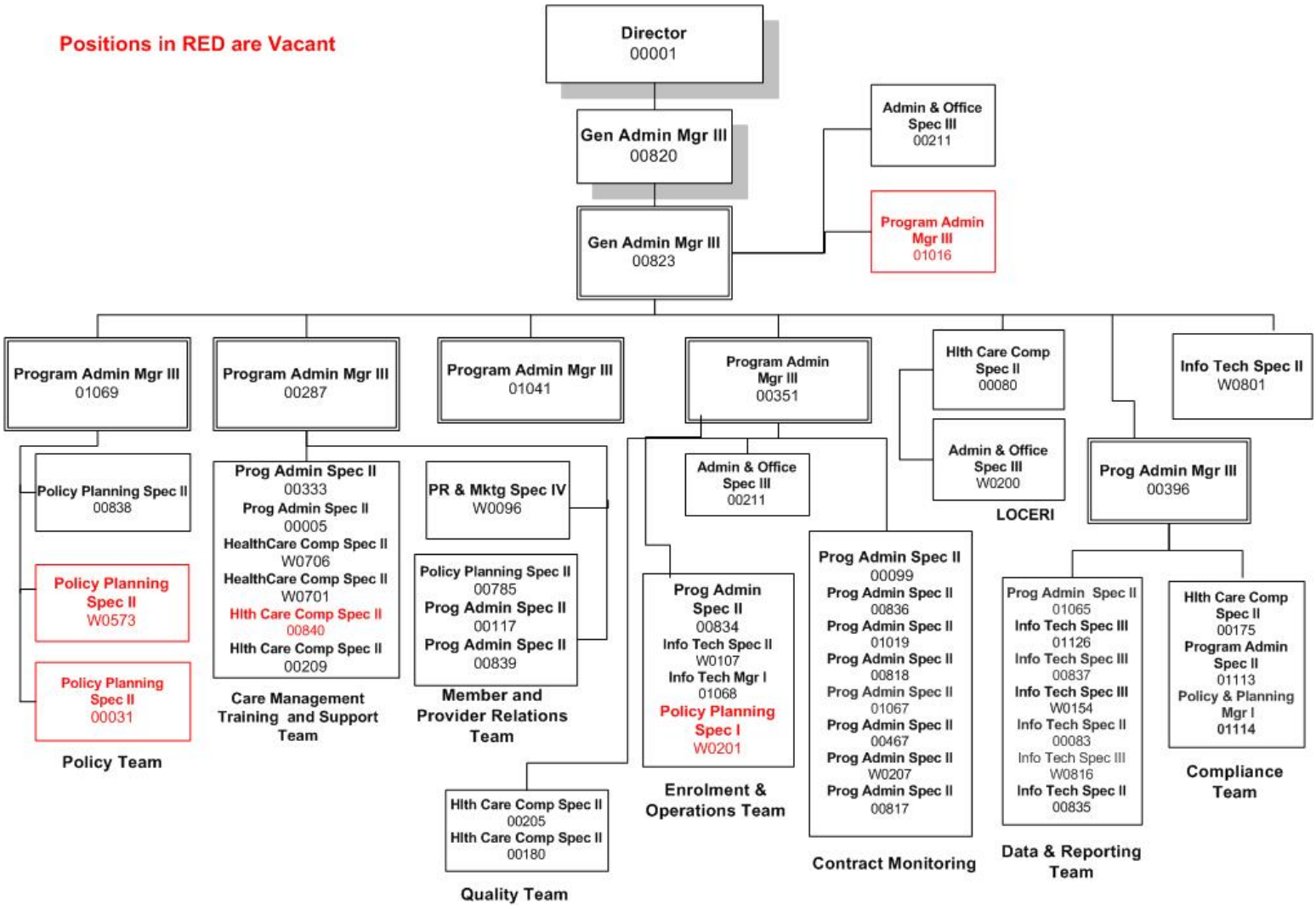
- **Care Coordination Training and Support**
  - Provide training and support for contractor care coordination
  - Clarify contract requirements
  - Share best practices and resources
  - Facilitate opportunities for problem-solving and learning

- **Member and Provider Relations**
  - Triage and respond to all CCC Plus related inquiries (member and provider)

Department of Medical Assistance Services
Deputy Director for Complex Care Services
Integrated Care

As of 6/15/2020

Positions in RED are Vacant



Internal Audit Division

The Internal Audit Division reports directly to the Agency Director. The purpose of the Internal Audit Division is to provide independent and objective assurance and consulting services that are designed to add value and improve operations. Internal Audit assists DMAS in accomplishing its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of the agency's risk management, control, and governance processes.

The five primary business functions of the division are summarized below:

- **Internal Audits**
  Internal Audit conducts various types of audits (including financial, compliance, information technology, operational, fraud, operational, program performance, and contractual) as appropriate on DMAS business processes and in accordance with its Audit Plan.

- **IT Security Audits**

  Internal Audit performs or coordinates third-party performance of IT Security Audits of DMAS systems to assess the effectiveness of system controls and measure compliance with the Commonwealth of Virginia Information Security Standard and other applicable federal and state regulations.

- **Audit Finding Resolution**

  Internal Audit tracks all internal and external DMAS audit findings and recommendations, monitors the status of Corrective Action Plans (CAPS) for unresolved findings and recommendations until resolution, and reports on the status of the CAPS.

- **External Audit Liaison**

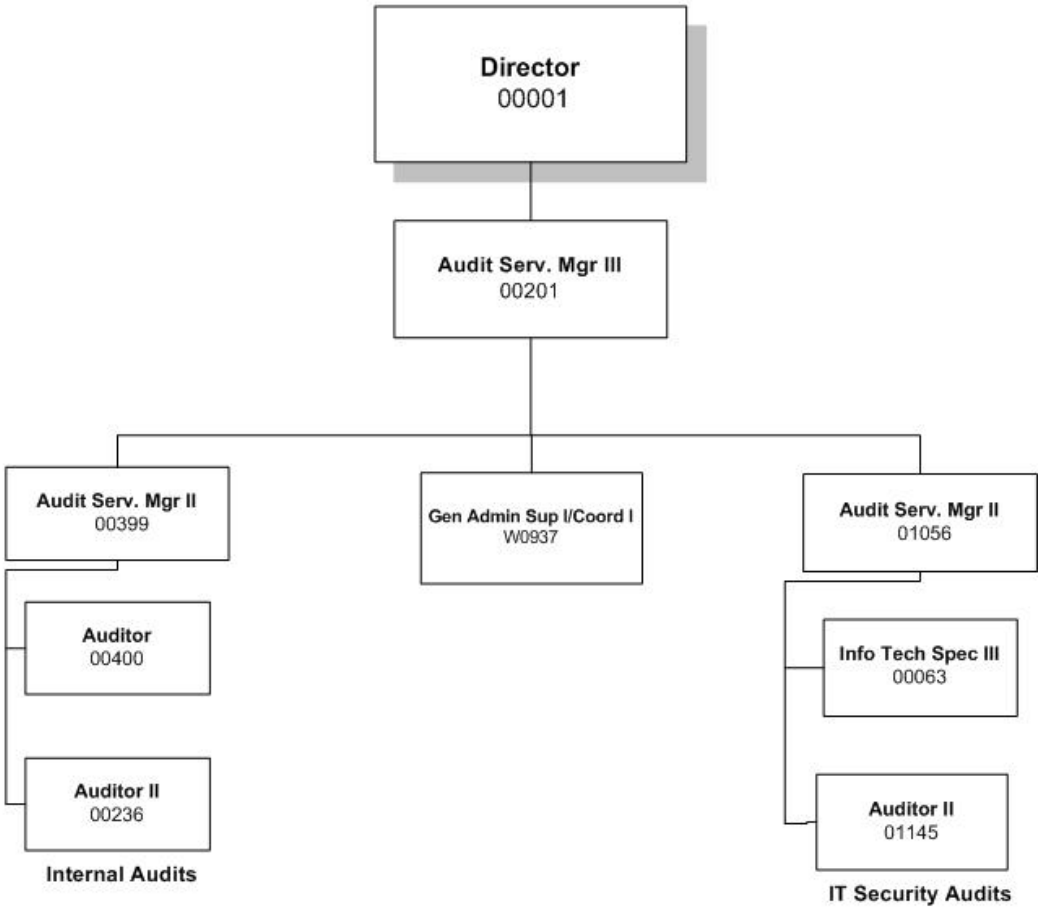
  Internal Audit serves has the initial DMAS contact point for external audits such as Auditor of Public Accounts, Department of Accounts, Office of Inspector General, Centers of Medicare and Medicaid.

- **State Fraud, Waste, and Abuse Hotline**

  Internal Audit investigates cases referred from the State Fraud, Waste, and Abuse Hotline and issues a report to the Office of State Inspector General. Cases that involve Medicaid providers or members are referred to the Program Integrity Division or another applicable division. Internal Audit tracks the referral responses and results to ensure the cases are properly addressed.

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Internal Audit Division

As of 6/15/2020



The Office of Communications, Legislation and Administration

The Office of Communications, Legislation, and Administration (OCLA) reports to the Deputy Director of Administration. The mission of OCLA is to provide excellent customer service to our internal and external customers to ensure DMAS fulfills its mission. The office is comprised of three main units: Communications, Legislation and Compliance and Administration.

- **Communications**
  The primary functions of the Communications Unit are:
  - Constituent and member services
  - Outreach and consumer communication, including maintenance of the Cover Virginia website
  - Design and publications
  - Web applications development and management of the agency website

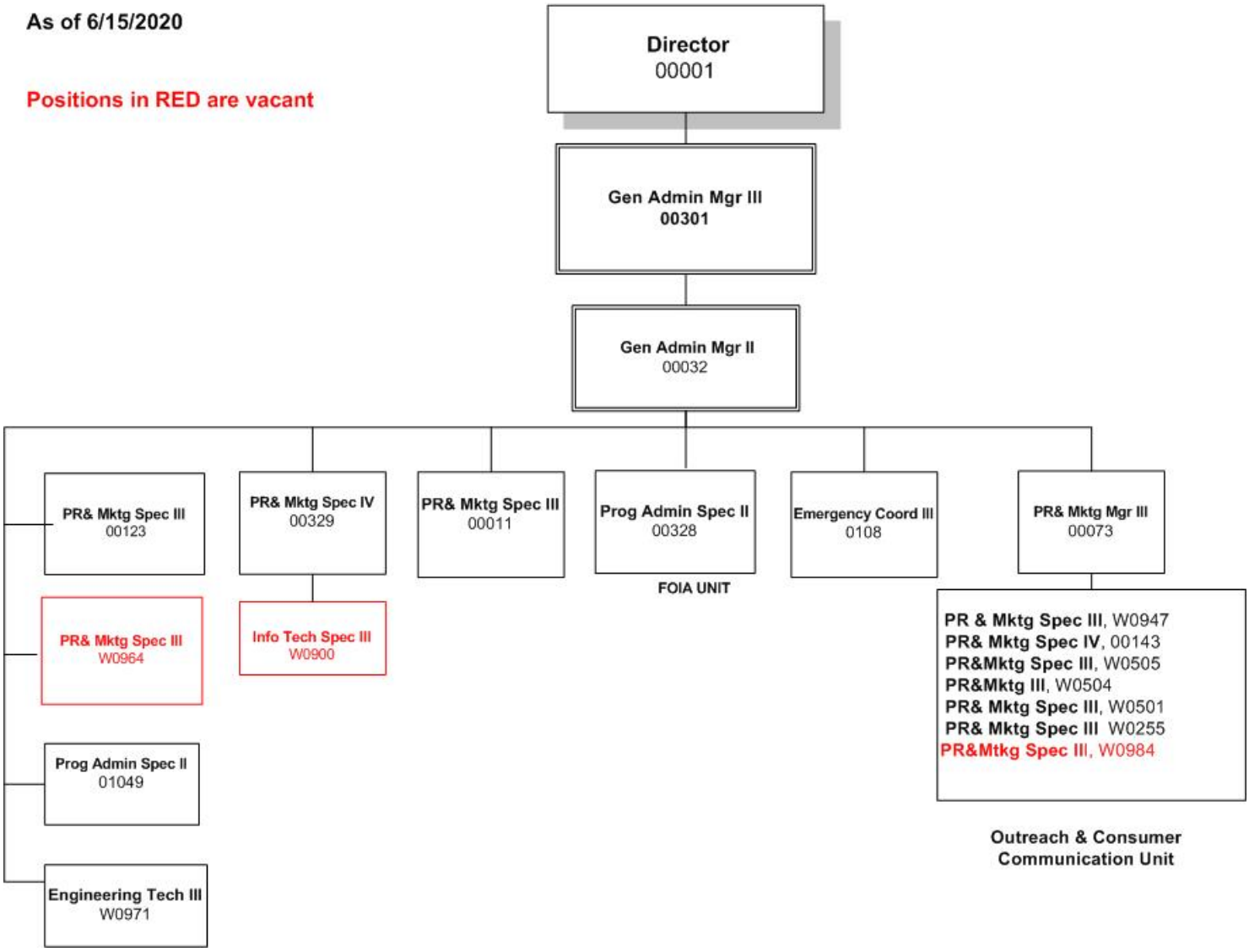
- **Legislation & Compliance**
  The primary functions of the Legislation and Compliance Unit are:
  - FOIA and records
  - Legislative services and reports
  - Board of Medical Assistance Services

- **Administration**
  The primary functions of the Administration Unit are:
  - Facilities management
  - Emergency coordination

Virginia Department of Medical Assistance Services
Office of Communications, Legislation, & Administration

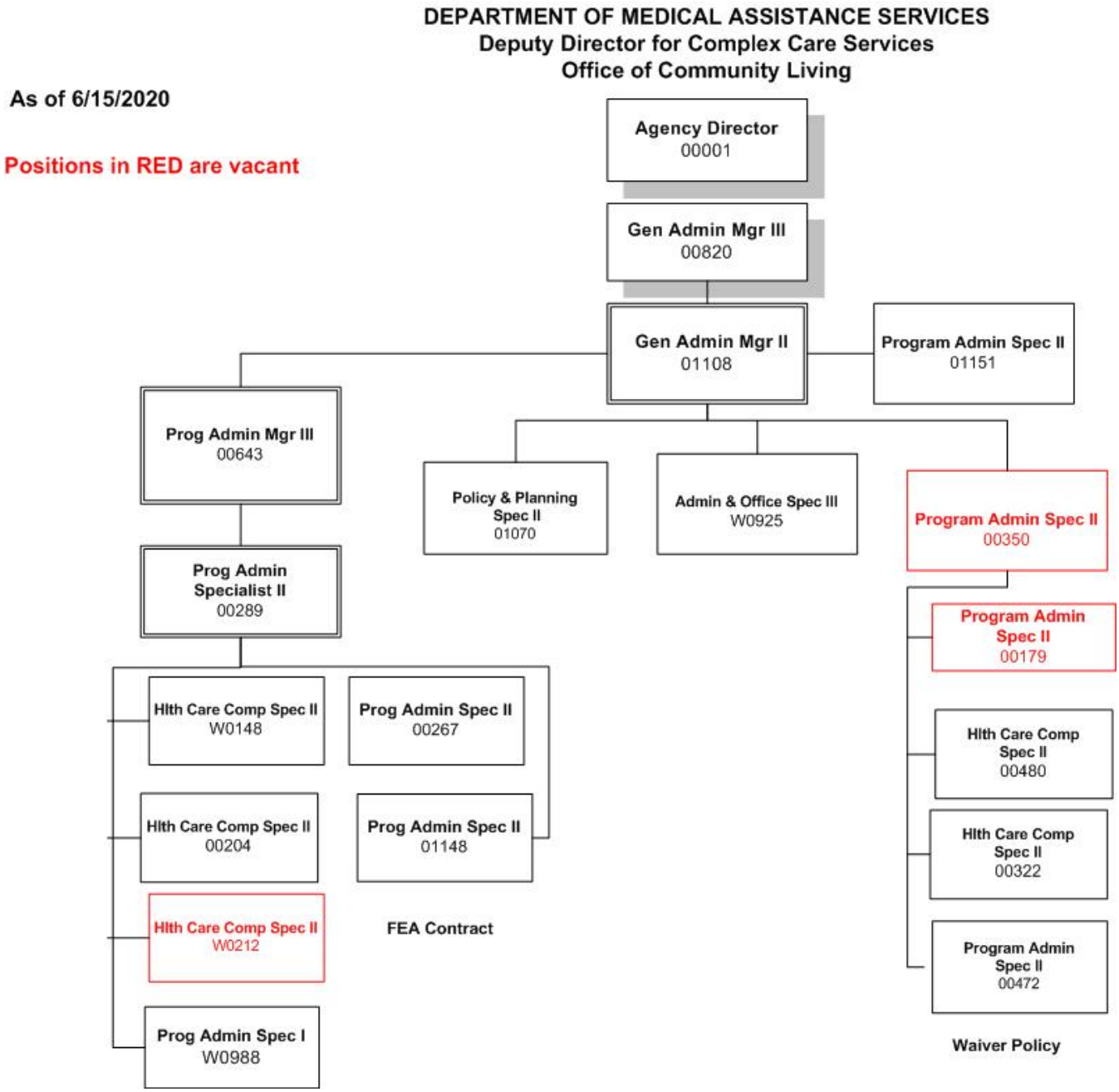
As of 6/15/2020

Positions in RED are vacant



Office of Community Living

The Office of Community Living (OCL) reports to the Deputy Director of Complex Care Services. The Office of Community Living provides administrative oversight of the Commonwealth's 1915 (c) home and community based waivers. Additionally, OCL provides program operations for the Commonwealth Coordinated Care Waiver and consumer directed services. OCL serves as the contract administrator for the fiscal employer agent for consumer direction.



Office of the Chief Medical Officer

The Office of the Chief Medical Officer reports to the Agency Director for DMAS. The primary responsibility of the Office of the Chief Medical Officer (OCMO) is to improve the health and well-being of those in the Medicaid Program. The office achieves this goal through four distinct functions: clinical consultation and guidance, pharmacy policy and operations, healthcare quality, and innovation. The Office of the Chief Medical Officer is comprised of two units: The Medical Support Unit (MSU) and the Pharmacy Unit.

- **Medical Support Unit (MSU)**
  The Medical Support Unit (MSU) is responsible for the review of the following service authorization requests: out of state medical care, out of state Outpatient (O/P) scans (MRI, CT, PET), organ transplants, private duty nursing, specific physician administered drugs (not pharmacy related), molecular genetic testing, and continuous glucose monitoring.

  We provide evidence-based reviews of products not currently covered by DMAS, new CPT/HCPCS codes, and existing services in the Medicaid program.

  The Office of the Chief Medical Officer provides clinical guidance and leadership on a wide range of topics including public health emergencies, maternal/child health, the opioid epidemic, hepatitis C, the ED Care Coordination tool, the Diabetes Prevention Program, physician-administered drugs, telehealth, and health equity.

- **Pharmacy Unit**
  The DMAS Pharmacy Program has five major areas of responsibility:
  - Support the mission and goals of the Pharmacy and Therapeutics Committee including the development and administration of the DMAS Preferred Drug List (PDL).
  - Administration of a Drug Utilization Review program that complies with 42 CFR 456, Subpart K.
  - Administration of the Medicaid Drug Rebate Program including the collection of federal and supplemental drug rebates on drugs dispensed to members enrolled in both FFS and managed care.
  - Oversight of the managed care organizations' pharmacy programs to ensure compliance with Medallion 4 and CCC Plus contract requirements including the Common Core Formulary, MCO DUR programs and universal pharmacy policies.
  - Oversight of DMAS' Pharmacy Benefit Administrator.

  The costs of pharmaceutical interventions are growing at rates exponential to other healthcare costs. While new life-saving therapies are being released, this fact requires that the Medicaid program take a proactive approach to the management of pharmaceutical coverage and costs.

  The DMAS Pharmacy and Therapeutics Committee evaluates clinical evidence and cost to determine which drugs are the highest value to the Commonwealth and should be included on the DMAS Preferred Drug List PDL. In 2017, DMAS implemented a "Common Core Formulary," which requires all the Medicaid health plans in the CCC Plus and Medallion 4.0 programs to cover all the preferred drugs on the DMAS Preferred Drug List without any additional prior authorizations. This formulary will increase care continuity for members who can remain on the same medications when they switch between health plans and the Fee-for-Service program and significantly decrease administrative burden for providers without any additional cost to the Commonwealth. The DMAS Pharmacy Unit monitors MCO compliance with the Common Core Formulary and assists members with issues/complaints related to drug access.

The Drug Utilization Review (DUR) Program: The DUR Program is responsible for ensuring the health and safety of patients through the appropriate use of drugs. The DUR Program an expert panel comprised of physicians, pharmacists and nurse practitioners appointed by the DMAS Director known as the DUR Board. The DUR Board defines the parameters of appropriate medication use within federal and state guidelines; meets periodically to review, revise and approve new criteria for the use of prescription drugs; and, develops drug utilization review criteria by addressing situations in which potential medication problems may arise, such as high doses, drug-drug interactions, drug-diagnosis interactions, adverse drug reactions, and therapeutic duplication.

DMAS's DUR efforts include two primary programs: (1) the prospective DUR (ProDUR) and (2) the retrospective DUR (RetroDUR). The intent of both programs is to help ensure the health and safety of patients.

The ProDUR program involves a review of patients' drug therapy history prior to prescription orders being filled. The ProDUR program allows pharmacy claims to be evaluated at the time claims are submitted. Specifically, the ProDUR program is an interactive on-line, real-time process in which pharmacy claims are evaluated for potential problems related to established criteria for appropriate use (e.g., drug-drug interactions). Due to the short turn-around time associated with point-of-sale processing (30 seconds or less per transaction), immediate alert messages are sent to pharmacists on the most serious potential concerns based on a hierarchy of risks that is continually reviewed by the DUR Board. A pharmacist, based on clinical judgment, can override ProDUR alerts. In these cases, the pharmacist is required to provide justification for the override or the claim will be denied.

Unlike the ProDUR program which is prospective in nature, the RetroDUR program is a retrospective program. The RetroDUR program examines a history of medication used to identify certain patterns of use. After a computer analysis of claims data, an expert panel of reviewers evaluates a sampling of records, identifies potential problems and requests the generation of educational intervention letters in appropriate circumstances.

Managed Care Oversight: The DMAS Pharmacy Unit is responsible for aligning pharmacy policies including clinical guidelines, standards and controls across all Medicaid programs (i.e., FFS, Medallion 4.0 and CCC Plus). The team drafts contract language and technical manual requirements for pharmacy related services and drug coverage as needed. It also monitors MCO compliance with the Common Core Formulary and uniform pharmacy policies

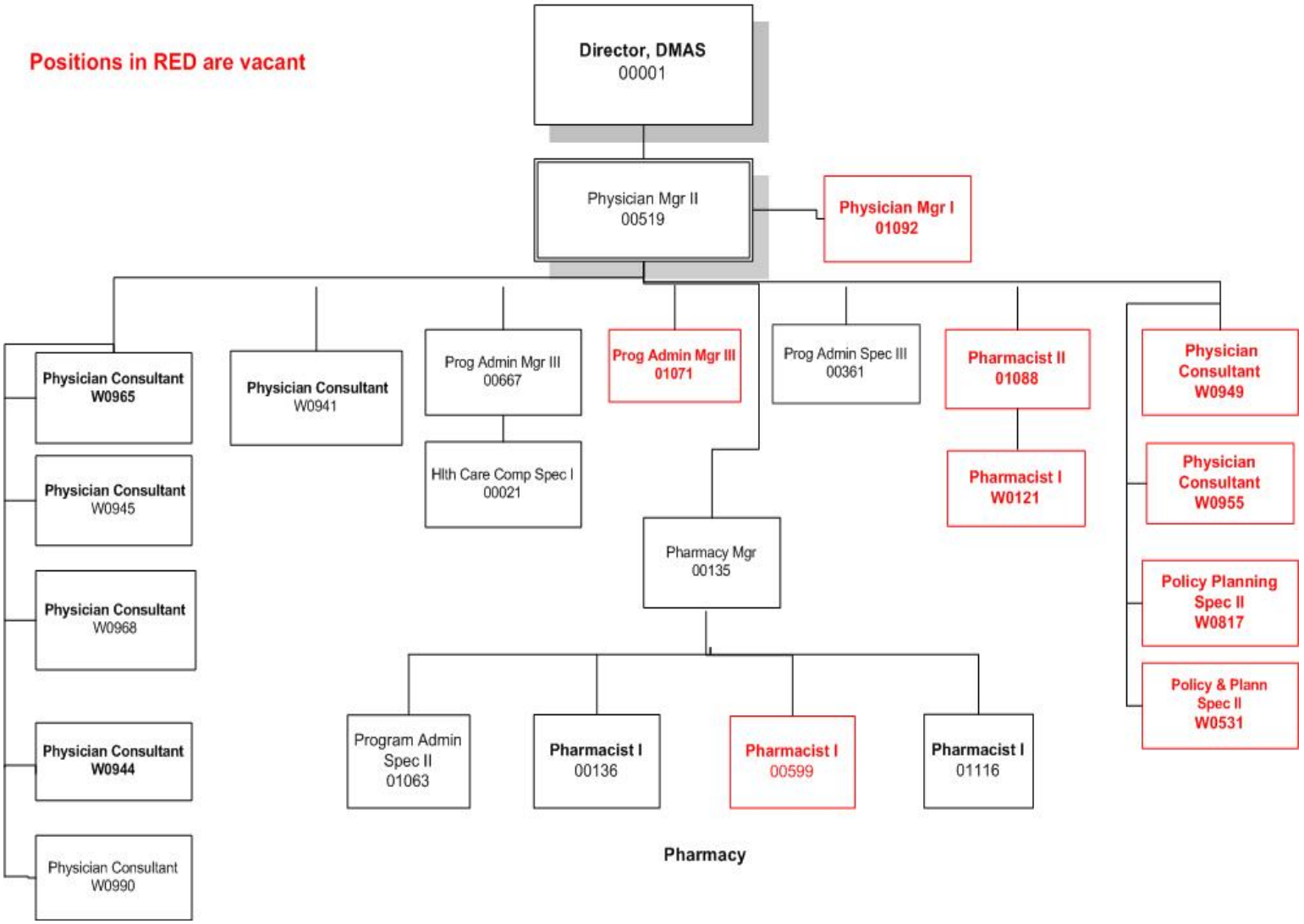
Drug Rebate Program - DMAS administers an aggressive drug rebate program in accordance to 42 U.S.C. § 1396r-8 that seeks out all available drug rebates and discounts available from all pharmaceutical manufacturers. DMAS is currently invoicing over $600 million per year in drug rebates. The collected drug rebate dollars are split with the federal government in accordance to Virginia FFP.

Pharmacy Benefit Administrator: The Pharmacy Unit is responsible for the oversight of the Pharmacy Benefit Administrator (PBA) which provides the interface for functionalities such as electronic Prior Authorizations for medications, and also an ocean of powerful operational data. The PBA's pharmacy data warehouse will obtain and store laboratory data for Medicaid Fee-for-Service and Managed Care members, which will help inform future DMAS Office of the CMO initiatives to improve clinical and pharmacy outcomes for the over one million Virginia Medicaid members.

Virginia Department of Medical Assistance Services
Office of Chief Medical Officer

As of 6/15/2020

Positions in RED are vacant



Pharmacy

Office of Compliance and Security

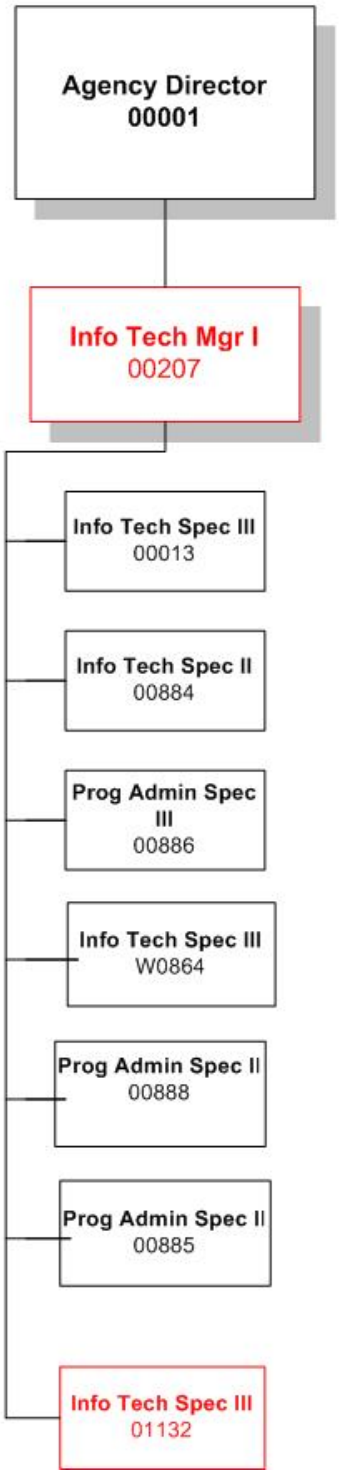
The Office of Compliance and Security (OCS) reports to the Agency Director. The mission of the Office of Compliance and Security (OCS) is to provide guidance to all DMAS divisions to mitigate risks to the availability, confidentiality, and integrity of all DMAS information and to ensure compliance with all applicable federal and state legislation. OCS is responsible for planning, governance, incident reporting, and oversight of a comprehensive privacy, information security, and physical security program for the agency. OCS's core functions and/or responsibilities are:

- Maintain a Risk Management Plan in compliance the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule, 45 CFR Parts 160, 162, and 164 Health and Insurance Reform: Security Standards: Final Rule February 20, 2003, Office of Civil Rights (OCR) Final Rule March 26, 2013, or later, and requirements of the Virginia Information Technologies Agency (VITA).
- HIPAA compliance through the OCS Privacy Office.
- Governance and policy responsibility for Information Security Officer (ISO) functions for the security of all DMAS information to comply with security policies and standards of VITA.
- Administer the Security Awareness Training required for all DMAS employees, contractors, and temp workers.
- Participation in the agency's Continuity of Operations Plan (also known as COOP).
- Collaborating with Human Resources to ensure compliance with the DMAS Code of Ethics and Business Conduct.
- Collaborating with the Information Management Division, Internal Audit Division, Office of Communications, Legislation, and Administration, and other agency divisions as needed.
- Administering access control for COV, VAMMIS, VaCMS and other accounts.

Virginia Department of Medical Assistance Services
Office of Compliance & Security

As of 6/15/2020

Positions in RED are vacant



Office of Data Analytics

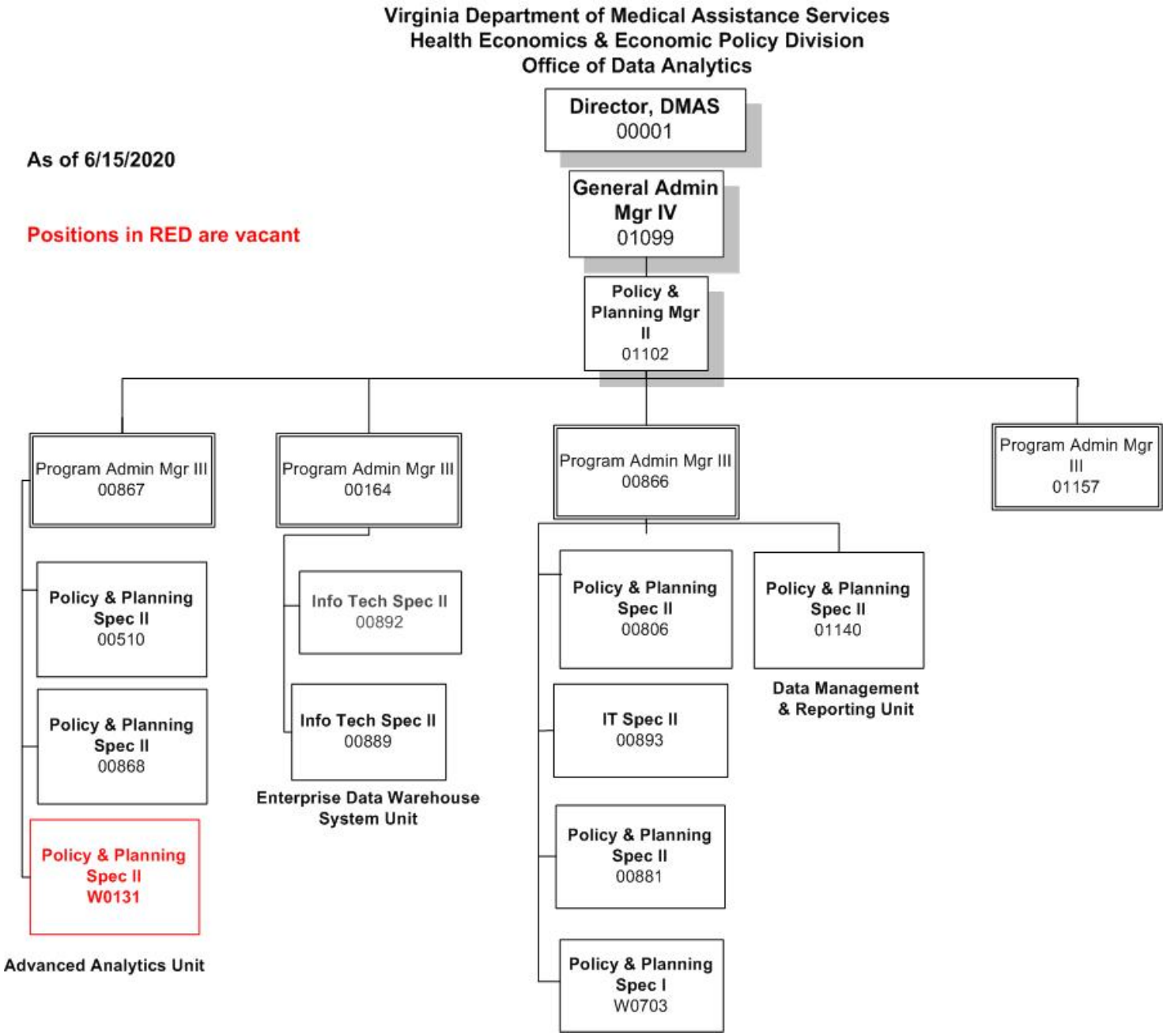
The Office of Data Analytics (ODA) reports to the Chief Health Economist as part of the Health Economics and Economic Policy Division. The mission of the Office of Data Analytics is to empower data-driven decision-making.

The Office of Data Analytics is comprised of three units: (1) the Data Management Unit, (2) the Advanced Analytics Unit and (3) the Data Warehouse Unit.

The ODA engages in two key functions: analysis and analytics. The analysis focuses on understanding the past, and the Data Management Unit provides critical historic analyses essential to understanding the impact of agency activities on our members, providers and sister agencies. Such ad hoc analyses answer the 'what happened' questions that drive policy evaluation and performance improvement. The Data Management Unit also provides technical support of the SAS analytics platform.

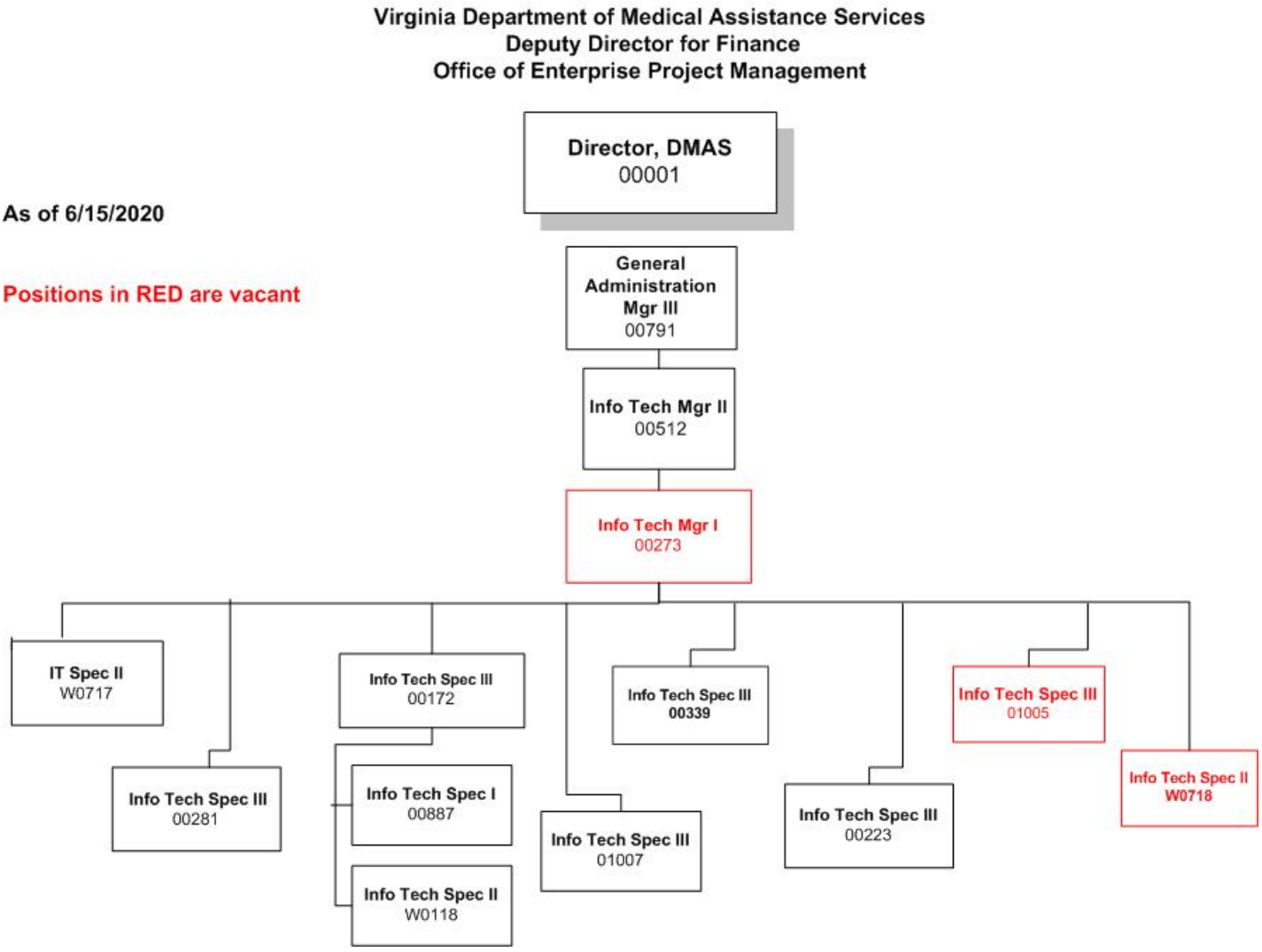
Analytics focuses on why a phenomenon has occurred and what may happen next. The Analytical Projects Unit provides the business intelligence necessary for understanding current and predictive views of agency operations. Analytics is at the connective tissue between data and effective decision making by our leadership.

To support these objectives, the Enterprise Data Warehouse Solution provides quality data, in a timely fashion, from various sources and presents it in such a manner as to maximize the value of that data. It includes a suite of technologies that provide data storage, documentation, and visualization/dashboards. The Data Warehouse Unit ensures that these solutions are functioning effectively so that agency can effectively report as well as perform advanced analytics to make informed decisions.


Virginia Department of Medical Assistance Services
Health Economics & Economic Policy Division
Office of Data Analytics
As of 6/15/2020
Positions in RED are vacant
Director, DMAS
00001
General Admin Mgr IV
01099
Policy & Planning Mgr II
01102
Program Admin Mgr III
00867
Policy & Planning Spec II
00510
Policy & Planning Spec II
00868
Policy & Planning Spec II
W0131
Advanced Analytics Unit
Program Admin Mgr III
00164
Info Tech Spec II
00892
Info Tech Spec II
00889
Enterprise Data Warehouse System Unit
Program Admin Mgr III
00866
Policy & Planning Spec II
00806
IT Spec II
00893
Policy & Planning Spec II
00881
Policy & Planning Spec I
W0703
Policy & Planning Spec II
01140
Data Management & Reporting Unit
Program Admin Mgr III
01157

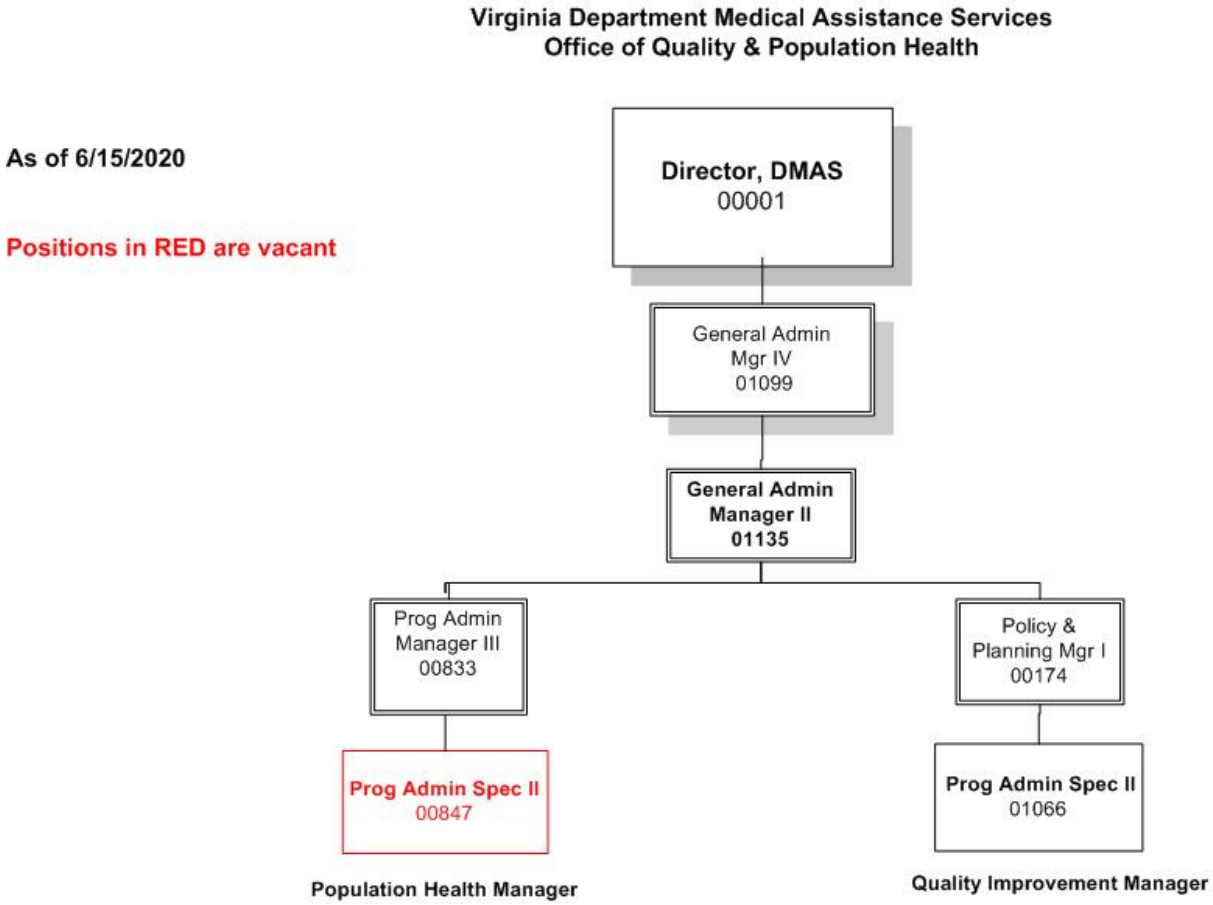
Office of Enterprise Project Management

The Office of Enterprise Project Management reports to the Information Management Director / Chief Information Officer. The Enterprise Project Management Office (PMO) is comprised of a PMO Director, a team of Project Managers, and a support team consisting of a Deliverable Manager, a Technical Writer, and Business Analysts. The mission of the PMO is to provide an enterprise wide approach to identify, prioritize, and successfully execute and manage a technology portfolio of programs and projects that are aligned with and support the agency's strategic business plan. The PMO is governed by the Virginia Information Technologies Agency that sets standards and approval processes for initiation and planning, execution and control, implementation and project closeout phases. The PMO provides technical services to procurements and contracts, project advisory consultation to budget for advanced planning documents, vendor management and project management best practices to DMAS staff and vendor project teams. The PMO acts as a technical liaison for projects involving the Office of the Attorney General, Auditor of Public Accounts, the Centers for Medicare and Medicaid (CMS) Services, and to an independent verification and validation contractor for CMS system certifications. In addition to internal customers, the PMO provides services to provider and Managed Care Organizations as well as our sister agencies (Department of Social Services (DSS), Virginia Department of Health (VDH), Department of Behavioral Health & Developmental Services (DBHDS) and the Department of Corrections (DOC) for cross-agency and state projects.



Office of Quality and Population Health

The Office of Quality and Population Health (OQPH) reports to the Chief Deputy Director. The office advises the Chief Deputy on strategic policy initiatives that improve quality and population health outcomes and reduce the cost of care for the over 1.4 million members of Virginia's Medicaid program. The program provides executive leadership, strategic planning, and overall direction to the agency's quality and population health programs. The team acts as an advocate and supports the Commonwealth of Virginia Department of Medical Assistance Services (DMAS) quality and population health business by serving as a quality champion through measuring and monitoring the quality and effectiveness of the care and services provided to our members. OQPH provides oversight of quality programs throughout the agency and spearheads projects that enable DMAS to measure, monitor, and improve the quality of the care and services provided to its members. The Office consults across functional areas to influence and promote change in order to continually deliver quality, equitable services to our internal and external customers. The team is also responsible for coordinating, leading, and managing multiple functional areas including accountability for business/financial results related to the following as appropriate: Health Plan and Employer Data Information Sets (HEDIS) reporting, quality of care, National Committee for Quality Assurance (NCQA) accreditation activities, and member satisfaction Consumer Assessments of Healthcare Providers and Systems (CAHPS).



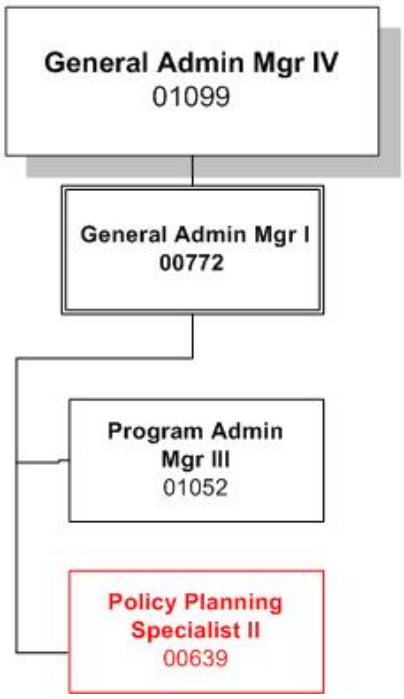
Office of Value-Based Purchasing

The Office of Value-Based Purchasing (OVBP) is a division of the Health Economics & Economic Policy (HEEP) Department and reports to the Deputy Director/Chief Health Economist. The OVBP is responsible for the development and execution of policies that encourage effective and efficient provision of care to Medicaid members through both financial and non-financial incentives. This includes systemic payment and contract policy innovations that integrate performance accountability into various facets of Virginia Medicaid, including managed care plans, providers, and delivery systems.

Virginia Department of Medical Assistance Services
Office of Value-Based Purchasing

As of 6/15/2020

Positions in RED are vacant



Policy, Planning & Innovation Division

The Policy, Planning & Innovation Division (PPID) reports to the Deputy Director of Administration. The division's core function is to promote an efficient, effective, and proactive agency response to federal and state policy requirements. The division includes two main units: The Policy Analysis Unit and the Regulations and Manuals Unit.

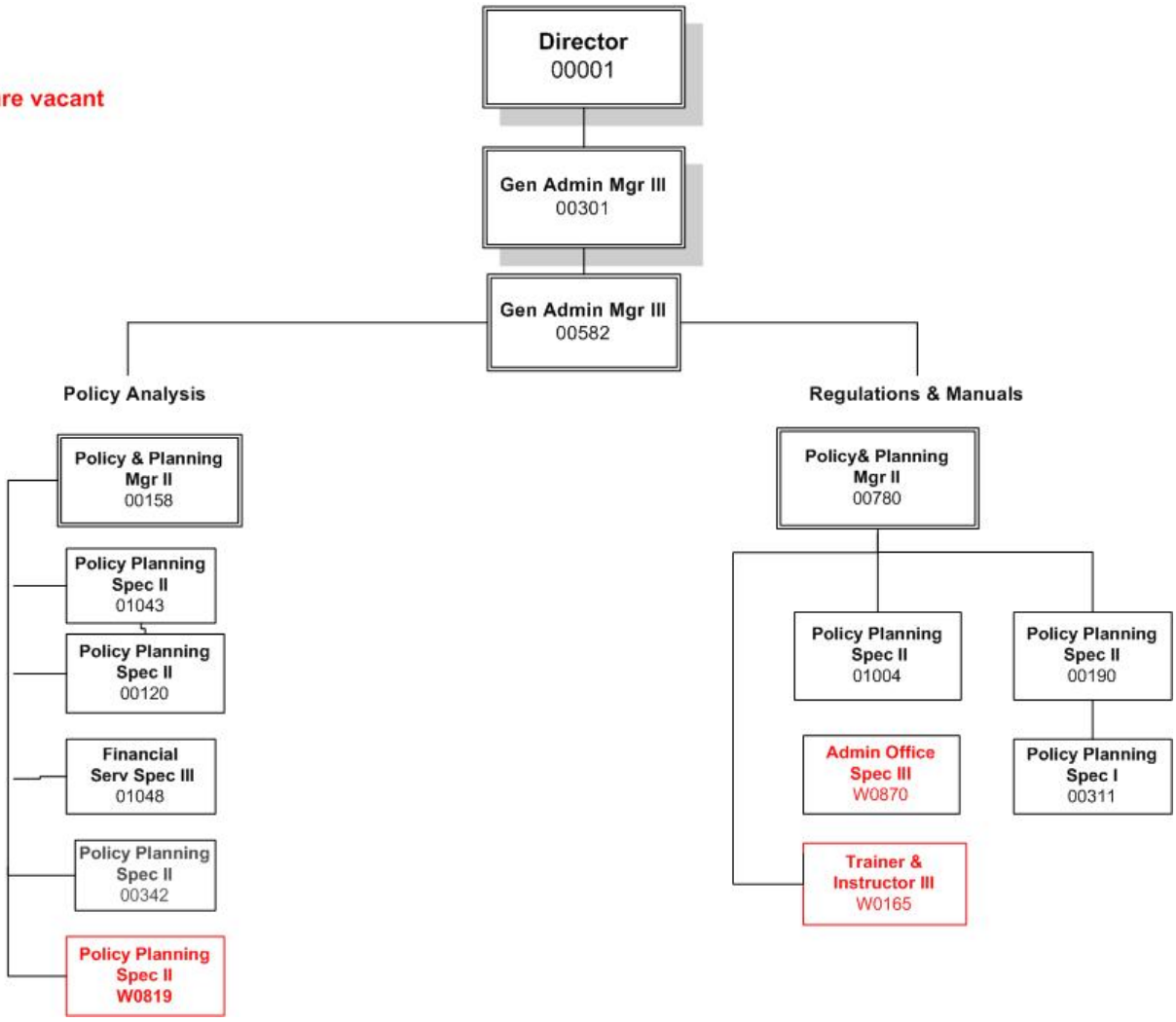
- **Policy Analysis Unit**
  The Policy Analysis Unit supports the Executive Management Team (EMT) by gathering, analyzing and archiving policy information in addition to providing decision options and recommendations on cross-agency initiatives. The team provides legislative support in the form of completing Legislative Action Summaries (LAS) and reviewing/editing General Assembly (GA) required reports. Such reports include maternal and child health policy and reporting, school health services, CHIP (FAMIS) required reporting, HIFA waiver (FAMISMOMS, FAMIS Select) reporting, and Children's Healthcare Advisory Committee (CHIPAC) coordination. The Policy Analysis Unit also manages special projects such as telemedicine, mental health parity and DMAS policy connections. The unit also conducts policy advisement on contracts, trains staff in legislative processes, and oversees several workgroups that include the appeals stakeholders, electronic visit verification, mental health parity, managed care final rule, and durable medical equipment/face-to-face requirements.

- **Regulations and Manuals Unit**
  The Regulations and Manuals Unit supports the agency by managing the numerous processes to include state plan amendments, regulation development, guidance documents such as Medicaid manual revisions, and Medicaid memos. In addition, this unit also manages processes for obtaining CMS authority through state plan amendments (SPA), and waivers. The Regulation and Manuals Unit also works on state authority for regulations, manuals, and memos. The unit has the authority to make changes throughout the year unless state funds are needed.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Policy Planning & Innovation Division

As of 6/15/2020

Positions in RED are vacant



Procurement & Contract Management Division

The Procurement & Contract Management (PCM) Division reports to the Deputy Director for Finance / Chief Financial Officer (CFO). The PCM directs the agency's procurement and contracting activities with third parties, and all agreements between the agency and other state entities. PCM assures contracting actions are completed in accordance with all governing authorities including the Virginia Public Procurement Act and the Agency Purchasing and Surplus Property Manual, as well as federal law and regulations. Work is completed through four (4) subunits: Procurement, Contract Management, Financial Management, and Small Purchasing.

- Procurement
  The Procurement Unit develops and awards new contracts through requests for proposals (RFP) and invitations for bids (IFB).

- Contract Management
  The Contract Management Unit is responsible for modifications to current third-party contracts and interagency agreements.

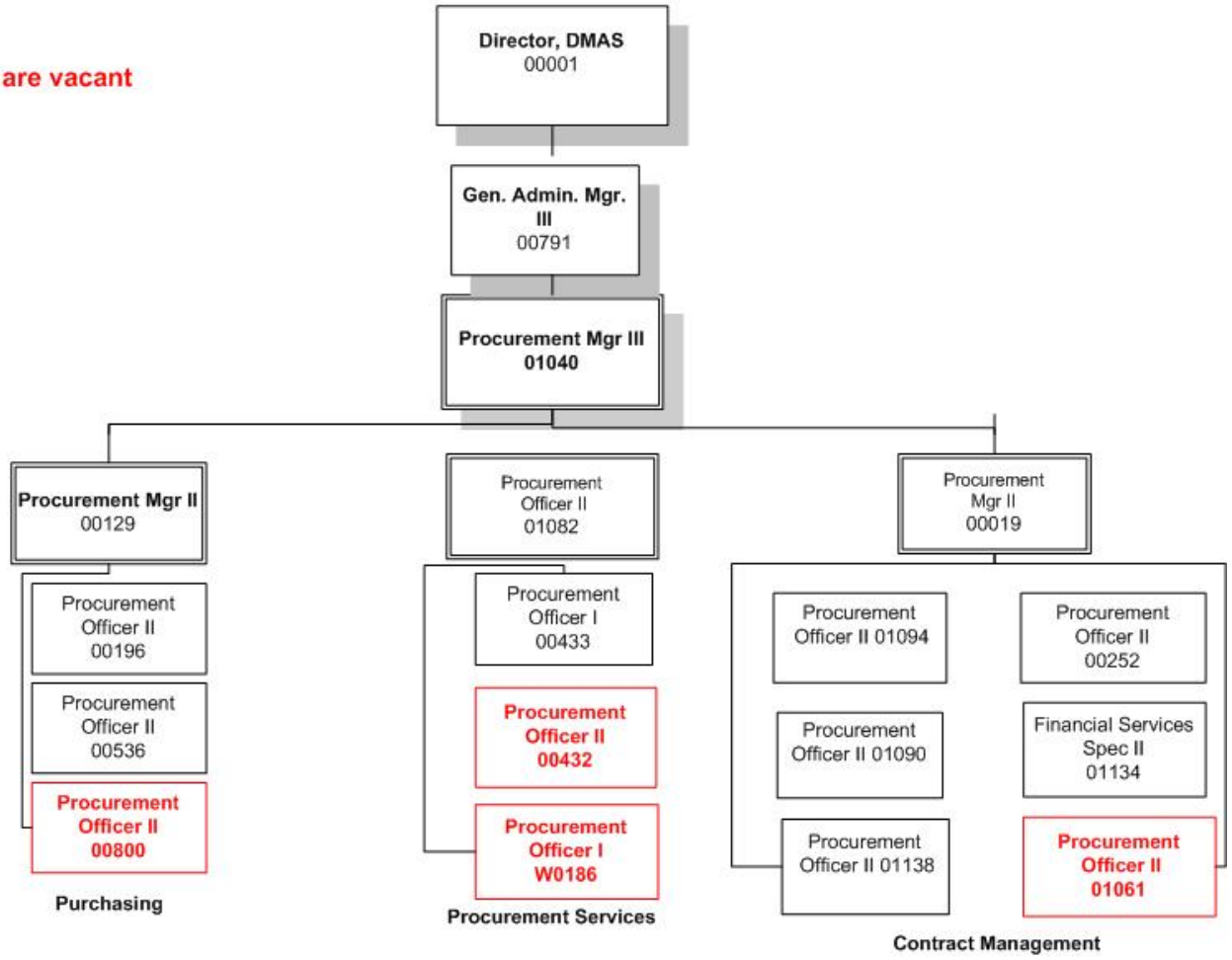
- Financial Management
  The Financial Management Unit manages the costing and pricing component of the agency's contracts and interagency agreements.

- Small Purchasing
  The Small Purchasing Unit and The Department of General Services direct the actions related to procurement under $100K, utilization of state contracts, telecommunications, mail services, rental cars, and other general services.

Virginia Department Medical Assistance Services
Deputy Director for Finance
Procurement & Contract Management Division

As of 6/15/2020

Positions in RED are vacant



Program Integrity Division

The Program Integrity Division reports to the Deputy Director of Programs. The Program Integrity Division (PID) is entrusted with the responsibility of identifying fraud, waste and abuse within the Virginia Medicaid program and referring potentially fraudulent providers and recipients to the proper law enforcement entity. The PID is comprised of two main units: the Recipient Review Unit (RAU) and the Provider Review Unit.

- **Recipient Review**

  To fulfill its mission, PID engages in the following member focused integrity activities:

  - RAU collaborates with local DSS agencies on alleged acts of criminal welfare fraud and referrals to local Commonwealth Attorneys.
  - Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) programs measure improper payments and review eligibility efficiencies.
  - Public Assistance Reporting Information System (PARIS) identifies members potentially receiving benefits in multiple states.

  The Eligibility Quality Review Program (EQRP) identifies statewide and locality specific error trends for analysis, review, and education. This state-initiated independent review program:

  - Utilizes highly-qualified, nationally recognized contractors.
  - Reviews monthly samples of newly eligible adults.
  - Determines if enrollees have been appropriately assigned to the expansion covered group.
  - Presents preliminary findings to interagency (DMAS and VDSS) Program Integrity Workgroup.

- **Provider Review**

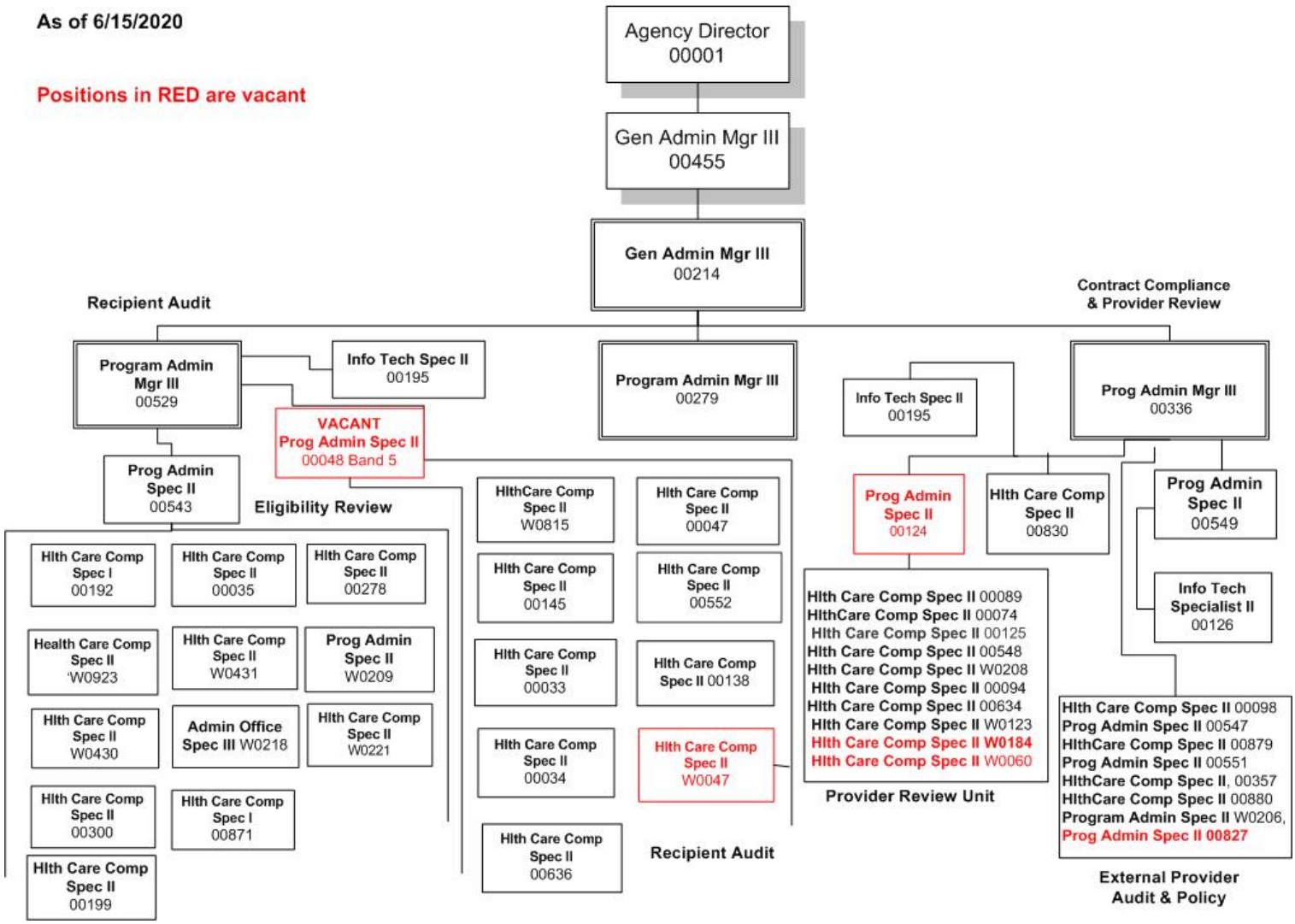
  The Program Integrity Division also engages in provider-focused program integrity activities and oversight to help fulfill its mission which includes:

  - The Fraud and Abuse Detections System (FADS) from Optum is a suite of complementary, web-based components that mine provider, member and claims data for potential fraud, waste and abuse (FWA). FADS also contains a case tracking system.
  - PID has engaged two nationally recognized audit vendors (HMS and Myers & Stauffer, LC) to perform additional provider audits.
  - PID policy staff represent PID interests in the annual General Assembly process in collaboration with the Office of Communications, Legislation & Administration. Policy staff also ensure correct state and federal regulations are used throughout our oversight process.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Program Integrity Division

As of 6/15/2020

Positions in RED are vacant



Program Operations Division

The Program Operations Division reports to the Deputy Director for Programs. The Program Operations Division is the operational backbone of the Virginia Medicaid Fee-for-Service (FFS) delivery system and serves as the gateway to managed care. Enrollees are placed in FFS at the beginning of their Medicaid enrollment and again when the plan assignment changes. Program Operations is divided into four units: Member Services, Provider Services, Service Authorization- Payment Processing and Systems and Reporting.

- **Member Services Unit**
  The Member Services Unit manages day-to-day operations of the Health Insurance Premium Payment (HIPP) program, Buy-In program, and Customer Service Non-emergency Medical Transportation (NEMT).

- **Provider Services Unit**
  The Provider Services Unit has responsibility for provider enrollment, provider training and mass mailing.

- **Service Authorization - Payment Processing Unit**
  The Service Authorization- Payment Processing Unit manages the Kepro service authorization contract and handles the day-to-day processing of pended claims for payment.

- **Systems and Reporting Unit**
  The Systems and Reporting Unit oversees systems implementations that affect operations, analyzes data and looks for efficiencies in operations. It leads the implementation of the Division's Medicaid Enterprise System (MES).

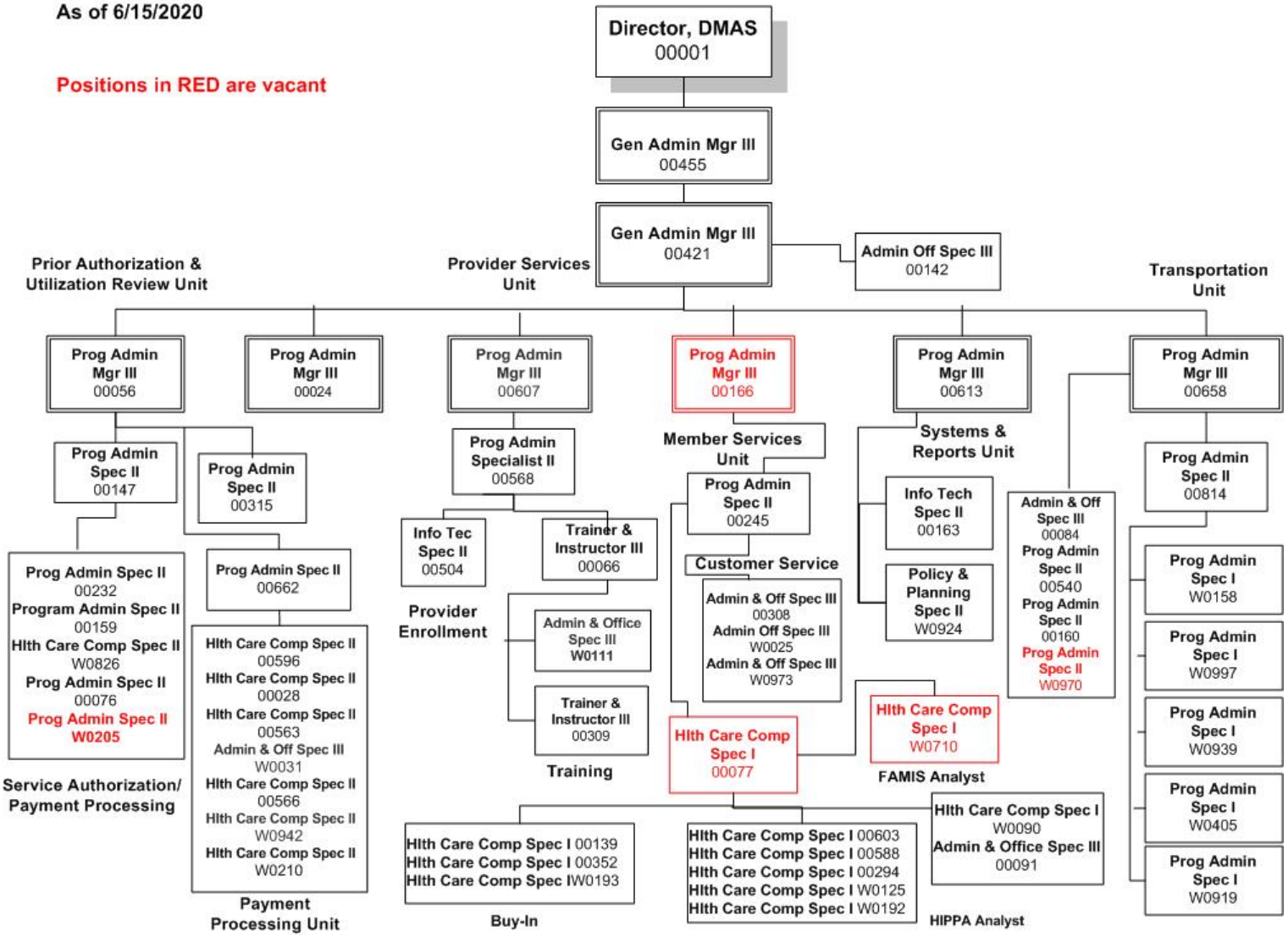
This organizational structure positions Program Operations to provide superior customer service to stakeholders, including Medicaid members, providers, DMAS staff and other state agencies. Program Operations also supports agency-wide efforts or major changes in programs relative to Medicaid expansion.

Program Operations also serves as the contract monitor for the fiscal agent's Member and Provider Call Center contract, Claims Processing contract, Provider Enrollment Services contract, the NEMT contract, a mass mailing contract, service authorization contract, a contract for provider training and three contracts for the Electronic Health Records Provider Incentive Payment program.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Program Operations Division

As of 6/15/2020

Positions in RED are vacant



Provider Reimbursement Division

The Provider Reimbursement Division (PRD) reports to the Deputy Director of Finance/Chief Financial Officer (CFO). The PRD is responsible for determining the payments for participating providers in Virginia Medicaid, including calculating, reviewing, and updating Medicaid capitation and provider payment rates. In addition, PRD calculates and administers supplemental payments to hospitals, nursing care facilities and physicians. An important part of this work includes the settlement and auditing of institutional providers' cost reports and utilizing both regulatory and market information to determine appropriate and allowable payments

There are three units within PRD (Provider Rate Setting, Managed Care Rate Setting, Cost Settlement and Audit) and a project management team that work collaboratively to accomplish this detailed and essential work. Also, as a result of Medicaid expansion, PRD now develops and implements provider assessments (calculating and implementing supplemental payments for enhanced hospital rates).

- Provider Rate Setting Unit

The Provider Rate Setting Unit is responsible for developing, implementing and maintaining rates for acute and long-term care services/providers; modeling the impact of proposed changes to payment policies and providing other analyses to support decision-making; assisting in the development of SPA and regulations to effectuate approved legislation; and working with providers and contractors to support accurate rate setting and payment.

Services for which rates are set include:

- Acute/rehabilitation/psychiatric hospitals (inpatient and outpatient)
- Ambulatory surgery centers
- Nursing facilities and hospices
- Physicians and other practitioners
- Community Mental Health/Addiction and Recovery Treatment Services (ARTS)
- Personal care and other home- and community-based care waiver service providers
- Home health agencies
- Outpatient rehabilitation agencies

Supplemental payments are calculated for:

- Graduate Medical Education (GME)
- Indirect Medical Education (IME)
- Disproportionate Share Hospitals (DSH)
- Indigent care at state teaching hospitals
- Private teaching hospitals
- Physicians affiliated with teaching or children's hospitals
- State & non-state owned clinics
- Non-state government owned nursing care facilities
- Private acute care hospitals

- Managed Care Rate Setting Unit

The Managed Care Rate Setting Unit has the same kinds of responsibilities as the Provider Rate Setting Unit as they apply to the provision of capitated services, including:

- Medallion 4.0 (acute care services for children, pregnant women and low-income caretakers and adults)
- CCC Plus long-term services and supports and acute care services for the aged, blind and disabled, including dual eligible
- Program for All-inclusive Care for the Elderly (PACE)

This unit manages a large contract with a national actuarial consultant to assist in setting Medicaid managed care rates. In addition, this unit is responsible for administration of Medicaid's:

- Pharmacy Reinsurance Program
- ARTS Stop Loss Insurance Program
- Health insurer fee payments
- Quality withhold and provider incentive payments

➢ Cost Settlement and Audit Unit

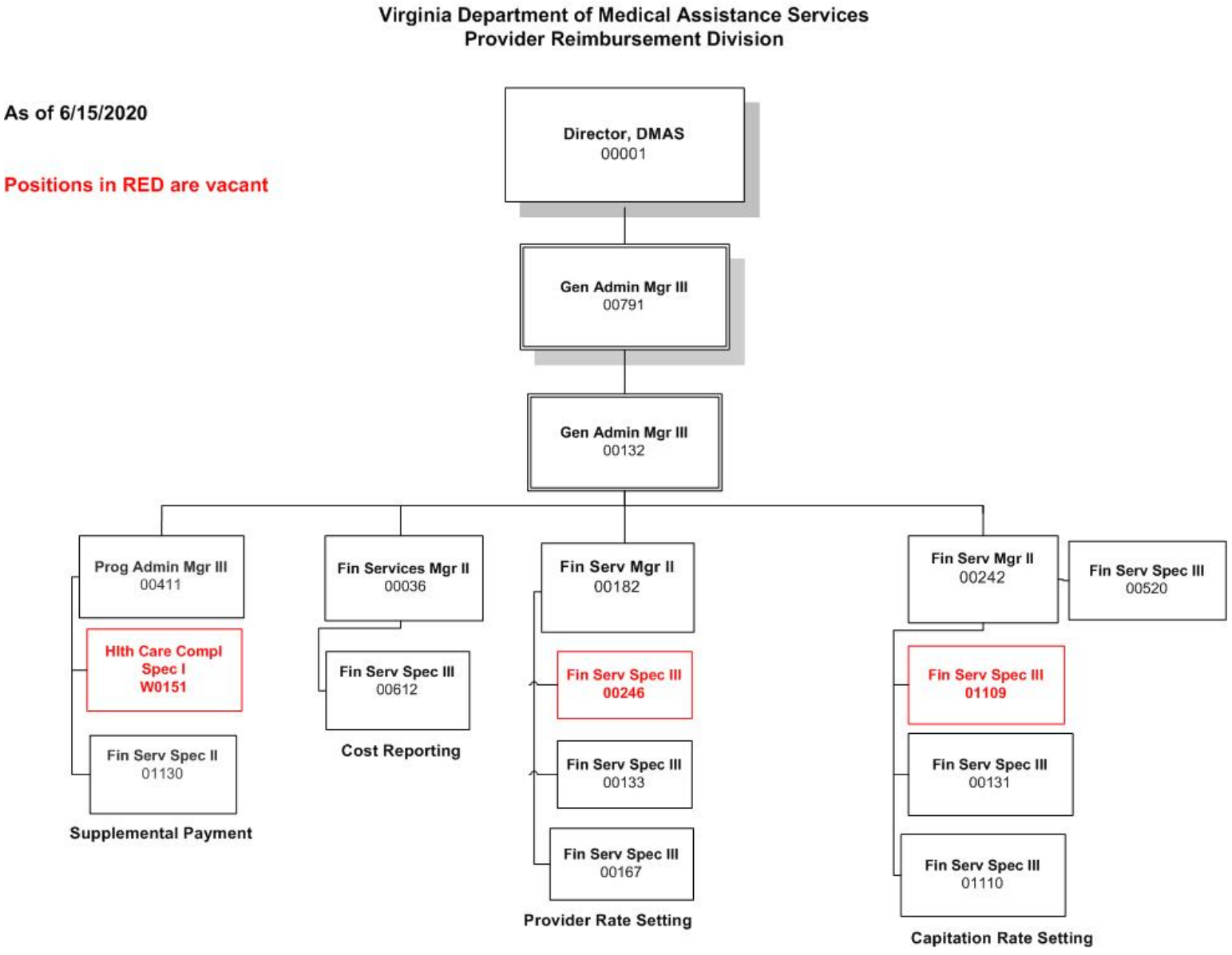
The Cost Settlement and Audit Unit is responsible for cost report related activities of institutional providers who file cost reports. Cost reports must be settled to ensure correct reimbursement for previous years, and for some provider types, their rate for the subsequent year. Financial information from cost reports is also used for rebasing certain rates. The unit also manages field audits to ensure that reported costs are correct and consistent with the Virginia Administrative Code and federal reimbursement principles.

Providers that file cost reports include:

- Hospitals
- Nursing facilities and specialized care facilities
- Outpatient rehabilitation agencies
- State and private intermediate care facilities for individuals with intellectual disabilities (ICF/IID)
- State psychiatric hospitals and training centers
- Federally Qualified Health Centers (FQHC)
- Rural health clinics (RHC)

Much of this unit's work involves managing a contract with an independent certified public accounting firm, including approval of work to be completed and budgeted hours, review of audit findings, approval of any special/supplemental payments, and oversight of other consulting services including those that monitor our contractual arrangements and payment of services provided by managed care organizations to Medicaid recipients. Moreover, this unit also oversees upper payment limit (UPL) demonstrations, DSH audits, school-based reimbursement for medical transportation and administrative services, and lump-sum payment transactions.

- **Project Management Team**
  PRD has a small team which leads and/or provides support to a number of PRD activities which include:
    - Administer private acute care hospital assessments
    - Administer most of DMAS' supplemental payments, including supporting CMS documentation and state regulations
    - Provide quarterly budget updates on supplemental payments and represent PRD at year-end budget meetings
    - Manage PRD review of proposed budget amendments and legislation
    - Provide Medicaid eligibility matching reports to external parties
    - Support the division's meetings, administrative activities and communication



Organizational Changes during Fiscal Year (FY) 2020

During the period July 1, 2019 – June, 30, 2020, DMAS made the following organizational changes:

- **Federal Reporting Division**
  The Federal Reporting Division manages and directs all aspects of the department's financial reporting to the federal government. The Federal Reporting Division was created to consolidate responsibility for the preparation, review, submission, and follow-up inquiries for DMAS's required federal financial reporting. The division is also responsible for the agency's Public Assistance Cost Allocation Plan (PACAP) which includes internal allocations and providing guidance and assistance to sister agencies regarding sub recipient agreements and PACAP requirements. These duties were previously shared between the budget and fiscal divisions. Consolidating responsibility improves the agency's ability to ensure timely, accurate reporting to the federal government and avoid deferrals and disallowances of federal matching funds for Virginia's Medicaid and CHIP programs.

- **Human Capital and Development Division** – New name for Human Resources Division

- **Office of Strategic Communications** – The Office of Strategic Communications was moved under the Office of the Chief of Staff due to the breadth of both external and internal communications for the agency.

- **The COMPASS Division** – This division was dissolved due to defunding.

- **Chief Deputy Director / HEEP** – Dr. Ellen Montz, DMAS Chief Health Economist, was named our Chief Deputy Director.

Below is a summary of DMAS Staffing Changes during Fiscal Year 2020 (7/1/2019 – 6/30/2020), as well as previous FY 2019 figures– These figures are a reflection of classified and wage positions filled and separations, not a reflection of our current Maximum Employment Level (MEL)	**FY 2019**	**FY 2020**
Classified Positions filled:	106	114
Internal Transfers:	37	29
External Hires:	69	85
Classified Positions Separations from DMAS:	40	34
Resignations:	23	21
Retirements:	9	9
Other:	8	4
Wage Positions filled: 46	46	37
External hires:	44	57
Internal transfer from one wage position to another wage position	2	0
Previous 6 month wage pos. ended/hired into new wage position	0	0
Wage position separations from DMAS:	33	34
Resignations:	13	14
Other separations:	20	20
Other separations breakdown:		
Wage hired as classified:	4	0
Wage term to temp pos:	4	0
Intern assign ended:	4	0
Terminations:	8	20
Total of other separations breakdown:	20	20

END OF REPORT