COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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November 24, 2020

MEMORANDUM

TO: The Honorable Ralph S. Northam
Governor, Commonwealth of Virginia

The Honorable Janet D. Howell
Chair, Senate Finance and Appropriations Committee

The Honorable Luke E. Torian
Chair, House Appropriations Committee

The Honorable Mark D. Sickles
Vice Chair, House Appropriations Committee

FROM: Karen Kimsey
Director, Virginia Department of Medical Assistance Services (DMAS)

SUBJECT: Report on DMAS Plan to Merge Managed Care Programs

This report is submitted in compliance with the Virginia Acts of the Assembly – Item 313.E.8 of the 2020 Appropriations Act, which states:

> *"The Department of Medical Assistance Services shall develop a plan to merge the Commonwealth Coordinated Care Plus and Medallion 4.0 programs. The department shall submit the plan with a feasible timeline for such a merger to the Governor and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by November 15, 2020."*

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

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Enclosure

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

The Department of Medical Assistance Services' Proposed Plan for Merging its Managed Care Programs

A Report to the Virginia General Assembly

November 15, 2020

Report Mandate:

HB 30 (Chapter 1289) Item 313.E.8: *"The Department of Medical Assistance Services shall develop a plan to merge the Commonwealth Coordinated Care Plus and Medallion 4.0 programs. The department shall submit the plan with a feasible timeline for such a merger to the Governor and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by November 15, 2020."*

Report Summary:

Should it be the desire of the General Assembly, DMAS would propose to merge the Commonwealth Coordinated Care Plus and Medallion 4.0 managed care programs on July 1, 2022. The following report details how DMAS would effectuate a single, streamlined managed care program that links seamlessly with its fee-for-service program, ensuring an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality, equitable care to our members and adds value for our providers and the Commonwealth. Specifically, the report includes the following sections:

- Section 1 provides relevant background information and an overview of the proposed plan, including its value proposition
- Section 2 provides a brief history of managed care in Virginia and an overview of the current Virginia Medicaid delivery system
- Section 3 outlines key components of streamlining and aligning the managed care contracts
- Section 4 details other proposed overarching programmatic improvements, including rebranding the program and streamlining benefits and managed care enrollment processes where feasible
- Section 5 outlines the federal and state authority changes needed to achieve a unified program
- Section 6 provides an overview of other work streams and changes that would be necessary for implementation, such as IT system changes and updates to member and provider communications

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 for more than 1.6 million Virginians. Members have access to primary and specialty health services, inpatient care, and behavioral health as well as 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 more than 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.

Section 1: Background and Overview of Proposed Plan

Overview of Proposed Plan

With over 96% of full-benefit Medicaid[1] members currently served through managed care, DMAS has been directed by the General Assembly to evaluate the current state of the administration of its Medicaid delivery systems in order to produce a plan for establishing a combined Medicaid managed care program. Our current Medicaid delivery system includes two unique managed care programs, Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus). Members are enrolled in one of these programs based on medical need and population-specific criteria. Both programs contract with the same six managed care organizations (MCOs).

As of October 1, 2020, over 1.5 million of the nearly 1.7 million Medicaid members were enrolled in a managed care program. Medallion 4.0 serves nearly 1.3 million individuals and CCC Plus serves approximately 263,000 individuals. In general, Medallion 4.0 serves infants, children, adolescents, pregnant women, parents/caretaker adults, and adults newly eligible under Medicaid Expansion, while CCC Plus serves older adults, children and adults with disabilities, medically complex newly eligible adults, and individuals with Medicare and Medicaid.

As part of this assessment, DMAS reviewed our current managed care contracts and benefits, regulatory authorities, information technology (IT) systems, and other processes; researched best practices from other states; and engaged key stakeholders, including individuals across the Department and Administration, our managed care organizations and other key contractors, and the Centers for Medicare and Medicaid Services (CMS).

DMAS worked with internal stakeholders and the MCOs to determine a feasible timeline for moving to a single managed care program. Both managed care contracts are renewed annually for an effective date of July 1, and any major changes should be synced with the contract renewal date. Accounting for a variety of other current federal and state mandates and Commonwealth priorities, including the Department and MCOs' ongoing response to COVID-19 and implementation of the new Medicaid Enterprise System (MES), DMAS would be able to move to one managed care program effective July 1, 2022.

This report details DMAS's proposed approach for merging the managed care programs, including the following specific recommendations:

1. Continue ongoing work to align managed care contracts for July 1, 2021 contract effective date
2. Implement streamlined, single managed care program on July 1, 2022 contract effective date
3. Secure upfront investments to enable staff to adequately combine and modernize programs
4. Revise compliance and reporting requirements to reduce administrative burden and improve program monitoring and oversight
5. Implement improved continuous care management and quality oversight based on population-specific needs, rather than programmatic distinctions
6. Rebrand the fee-for-service[2] and managed care programs under a single name to achieve a more cohesive agency voice and member experience
7. Leverage upcoming procurements and the capabilities of new Medicaid systems to make future improvements to managed care enrollment processes

Value of Merging Managed Care Programs

The populations served by the Virginia Medicaid program and its managed care delivery systems have evolved over the past 25 years, as outlined in Section 2. Our managed care programs have matured through experience, and, at the instruction of the 2020 Appropriations Act, the Department examined the programs as a whole to identify opportunities to derive greater value from our managed care delivery system. **The ultimate goal of this proposed initiative, called**

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[1]Throughout this report, unless otherwise noted or delineated, "Medicaid" is meant to refer to the program as a whole, inclusive of all beneficiaries served by DMAS, including those enrolled in the Family Access to Medical Insurance Security (FAMIS) program.

[2]The fee-for-service program provides coverage for individuals and services excluded from managed care, for which DMAS or its contractor pays the claims directly. Additionally, individuals are enrolled in fee-for-service when they become eligible for Medicaid before enrolling in an MCO.

"Project Cardinal" after the state bird, would be to effectuate a single, streamlined managed care program that links seamlessly with our fee-for-service program, ensuring an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality, equitable care to our members, and adds value for our providers and the Commonwealth.

First, at its core, combining the managed care programs would entail merging the two managed care contracts, which DMAS currently maintains and manages separately with the same six MCOs.[3] These contractual vehicles are the foundation of the Virginia Medicaid managed care program. As they exist today, the contracts are generally similar, but have notable differences in definitions and terminology, contractual requirements, level of detail, and overall structure. As part of Project Cardinal, DMAS would streamline and combine the contracts, while maintaining appropriate considerations for specific populations, such as the more intensive care coordination requirements for the complex populations primarily served by CCC Plus. **This effort to move to one streamlined contract, combined with the alignment of our internal processes for contract oversight, would give DMAS the ability to operate a more efficient and effective managed care program, allowing us to derive greater value from our program.** Section 3 contains more detail on this effort.

DMAS would also propose additional changes to further improve and streamline the managed care delivery system and ensure members have access to equitable services and care, as outlined in greater detail in Section 4. These changes include:

- Merging the Family Access to Medical Insurance Security (FAMIS) program into the children's Medicaid program to create further operational efficiencies and ensure all children served by DMAS have access to the same level of services;
- Exploring cost-effective ways to expedite enrollment into managed care so that members do not have lengthy waiting periods in the fee-for-service program, which cause disruptions in care that affect both members and providers; and
- Eliminating the various program names that have been added incrementally (Medallion 4.0, CCC Plus, FAMIS, etc.) in favor of "Cardinal Care Virginia" to better reflect the program's modern role as the health insurer for one in five Virginians.

Benefits to Members

As currently administered, the separate managed care programs can be confusing for members and can result in discontinuity of care if members move from one program to another. Having one managed care program would reduce confusion, simplify the member experience in engaging with the Medicaid program, improve continuity of care, and streamline the managed care enrollment experience. Members would no longer see the arbitrary distinction between CCC Plus and Medallion 4.0, a fact that may improve member experience in Medicaid overall. Indeed, examining member complaint data indicates that some members feel stigmatized by being placed in CCC Plus and do not like being considered "disabled" or "medically complex." Operating as one managed care delivery system promotes equity, as all members are considered part of the same program.

Benefits to Providers

The existence of two separate managed care programs can be an unnecessary complication for providers. Having one unified managed care program would reduce confusion and administrative burden for providers, and potentially improve provider participation in Medicaid.[4] One managed care program would simplify the contracting and billing processes for providers, and, in general, streamline the provider experience in working with the MCOs.

Benefits to MCOs

Although all six MCOs participate in both Medallion 4.0 and CCC Plus, health plans must maintain two separate contracts with DMAS, one for each program. While much of the contractual language is the same or similar, the contracts vary in a few key areas, including reporting requirements, quality measurement, provider network requirements, and

[3] Medallion 4.0 contract: https://www.dmas.virginia.gov/#/med4information; CCC Plus contract: https://www.dmas.virginia.gov/#/cccplusinformation

[4] Providers list administrative complexity as the second most important barrier to Medicaid participation. https://hbp.vcu.edu/media/hbp-dev/pdfx27s/policy-briefs/StateofPrimaryCare_ACC.pdf

financial distinctions. Feedback from the MCOs obtained for this report suggests that streamlining these areas would significantly reduce administrative burden for the plans, allowing them to more efficiently administer the unified program.

Financially, a single program and contract would result in combining medical loss ratio requirements and maximum allowable underwriting gains, as discussed in Section 3. The merged program would allow health plans to have a larger risk pool in which to manage the year-to-year uncertainty. Additional guardrails, including quality measures and value-based programs, could be added to ensure plans are spending appropriate amounts for a given population and not subsidizing losses or gains at the detriment of member care.

Benefits to the Commonwealth

DMAS's recommendation to streamline and combine the managed care programs would ultimately reduce the administrative burden for all parties and allow for more effective and efficient program administration, a critical component of DMAS's role as a key steward of taxpayer dollars. Furthermore, aligning programs would provide many opportunities to improve care equity, continuity of care, and quality of care for one in five Virginians.

Other Considerations

While there are many benefits of combining programs, there can be notable benefits of operating separate managed care programs for certain populations. For example, if there are MCOs that are especially qualified to care for individuals with complex medical or behavioral health needs (e.g., if a plan has differentiated, specialized networks and models of care), a state may prefer to contract with those health plans to care for their complex populations, while other plans may be better suited to manage chronic and acute conditions in less-specialized populations. It this case, the state would be able to separately competitively bid each of the program contracts and choose the best plans for each population type. Ultimately, this may result in different plans serving different programs, but with a more efficient outcome for the members. However, the managed care marketplace in the Commonwealth has evolved to include mature health plans with similar networks across programs with the ability to provide a full range of Medicaid services, including long-term services and supports (LTSS). While maintaining separate programs could allow health plans to differentiate themselves competitively in future procurements by offering tailored services for one of the Virginia Medicaid programs, to date, this has not been the scenario in Virginia.

Investments Required for Implementation

Moving forward with implementation of this proposed merger would require some up-front investment to cover IT systems changes for DMAS, the MCOs and other key vendors, such as the enrollment broker, and member and provider communications. A merger of the two programs would also require a significant human resource investment to ensure that the contracts are effectively and efficiently aligned to promote high quality, high value care, along with updating our systems and organizational structure. Implementation of this initiative is expected to cost $2,506,541 in general funds and $8,484,571 in total funds in state fiscal year 2022. Additionally, the Department would need authorizing Appropriations Act language and emergency regulatory authority to implement the combined managed care program effective July 1, 2022, discussed in greater detail in Section 5.

The rest of this report will outline the specific changes needed to effectuate a single, streamlined managed care program, including detail on combining the managed care contracts, revising contracts with other vendors, updating federal and state authorities, implementing IT systems changes, ensuring changes are reflected in managed care capitation rates, and engaging key stakeholders.

Section 2: Brief History of Managed Care in Virginia and Overview of Current DMAS Delivery System, in Context of National Landscape

Brief History of Managed Care in Virginia and Overview of Current Delivery System

DMAS has worked collaboratively with health plans, health systems, providers, and other key stakeholders for over 25 years to incrementally expand managed care to new geographical areas and new populations. Managed care provides an effective delivery model for improving access to care, promoting disease prevention, and ensuring quality care through credentialed providers, at a cost-predictable value for the Commonwealth.

Virginia's managed care system began in the 1990s, first as a primary care case management (PCCM) program, and later as a voluntary managed care program. These early programs introduced managed care concepts to members and providers and provided the framework and experience needed for expanding to more structured managed care programs. In 1995, the Medallion II program was developed as a way to offer managed Medicaid benefits through a public/private partnership between DMAS and the contracted MCOs. Virginia launched Medallion II in 1996 in seven localities of the Tidewater region. Medallion II operated with mandatory participation and primarily served pregnant women, children, low-income adults, and aged, blind, and disabled (ABD) individuals. Early managed care programs excluded community behavioral health services, LTSS, and individuals with other insurance, including "dual-eligible" individuals enrolled in both Medicare and Medicaid. Medallion proved to be a successful model and continued to expand geographically over the next 16 years until attaining the ultimate goal of statewide operations in 2012. Medallion focuses on maternal and infant care, children and youth services, disease prevention, wellness, and identifying and improving the health status of members with special health care needs.

In 2013, the General Assembly established a series of Medicaid reforms as part of a legislative pathway for Medicaid Expansion. One of these reforms directed DMAS to transition remaining fee-for-service populations, including individuals receiving LTSS, into managed care. In March 2014, Virginia launched the Commonwealth Coordinated Care (CCC) program, as part of a three-year, CMS Medicare-Medicaid Financial Alignment Demonstration (FAD) initiative; however, the voluntary nature of the program created significant member churn and service gaps, and added increased administrative burden for DMAS, providers and MCOs. Building on this knowledge and experience, in 2017, DMAS launched the Commonwealth Coordinated Care Plus (CCC Plus) managed long-term services and supports (MLTSS) program. CCC Plus strengthened the program through the use of mandatory enrollment, the addition of several populations, and the expansion of the program statewide. The six CCC Plus plans were selected as part of a competitive procurement specifically designed to select highly specialized plans with experience and capacity to manage complex populations and to operate as a dual special needs plan (D-SNP), allowing members to align their Medicare and Medicaid plans. Contracted plans were also required to demonstrate ability and readiness to operate using a person-centered, high-touch, fully integrated model of care. In an effort to facilitate smooth transitions for our most vulnerable populations, the launch used a phased approach, and began operating statewide in December 2018.

CCC Plus currently serves vulnerable populations, including older adults, disabled children, disabled adults, medically complex Medicaid Expansion adults, and members who receive Medicaid long-term services and supports (LTSS) in a facility or through special waivers. CCC Plus also includes over 122,000 dual eligible individuals enrolled in both Medicare and Medicaid.

In August 2018, DMAS launched the Medallion 4.0 program. The same six health plans participating in CCC Plus were selected for Medallion 4.0 participation as part of a competitive procurement: Aetna, Anthem, Magellan, Optima, UnitedHealthcare, and Virginia Premier. Medallion 4.0 expanded to include additional populations and services, including community behavioral health services.

The Medallion 4.0 program currently serves pregnant women, infants, children, parents/caregivers, and Medicaid Expansion adults. Medallion 4.0 also includes individuals enrolled in Virginia's State Children's Health Insurance Program (S-CHIP), called FAMIS, which provides vital coverage for pregnant women and children in families whose earnings are too high to qualify for Medicaid but cannot afford private insurance.

Most of the populations remaining in fee-for-service (i.e., individuals not enrolled in managed care for whom DMAS pays claims directly) are enrolled in limited benefits programs (86%), such as Plan First, the family planning

program (43,000 members); limited benefit Medicare savings programs (67,000 members); and coverage for incarcerated individuals (20,000). Another 13% of fee-for-service members are awaiting managed care enrollment in any given month. The table below provides a snapshot of the Medicaid and FAMIS populations covered in each program (Medallion, CCC Plus, and fee-for-service). Additional data for each managed care program is provided in Appendix 1.

Table 1: Medicaid and FAMIS participants by Delivery System (as of October 1, 2020)

	Medallion 4.0	CCC Plus	Fee-For-Service	PACE*	Total
Medicaid	1,192,622	262,676	154,112	1,457	1,610,867
FAMIS	78,410	0	470	0	78,880
Total	1,271,032	262,676	154,582	1,457	1,689,747

*PACE - Program of All-Inclusive Care for the Elderly is a community based managed care alternative to nursing facility care

Value of Managed Care as a Delivery Model and National Context

Virginia's multiyear transition to a majority managed care delivery system is consistent with national trends. As of December 2019, over two-thirds of Medicaid beneficiaries across all states receive their care through risk-based MCOs. Managed care is also emerging as a preferred delivery system for more complex populations and services, with the use of MLTSS programs more than doubling between 2012 and 2017.[5] MLTSS programs provide states with an effective option to better manage the growth of LTSS spending trends with care coordination and integrated care models.

Managed care has become the preferred delivery model for many states because, if managed effectively, MCOs can provide high quality, cost-predictable value for the state. The risk-based nature of managed care contracts, in which the MCOs are paid the same monthly capitation rate regardless of actual utilization, provides the state with fixed per-member-per-month expenditures, resulting in greater budget certainty. Additionally, federal rules allow MCOs to exercise flexibilities not allowed under Medicaid fee-for-service delivery systems, such as the ability to offer additional benefits beyond those outlined in the Medicaid State Plan (e.g., vision services for adults or wellness programs) and the ability to develop high-quality, selective provider networks, including the ability to pay providers above the Medicaid allowable rate.

[5]"The Growth of Managed Long-Term Services and Supports Programs: 2017 Update" Truven Health Analytics, January 29, 2018 https://www.medicaid.gov/media/3406

Section 3: Streamlining and Aligning Managed Care Contract Requirements

Over the course of the last two years, DMAS has worked to gradually align the managed care contract language for both programs. In addition, DMAS has a process in place to ensure alignment for any newly added requirements applicable to both contracts. As part of Project Cardinal, DMAS would initiate a comprehensive review of the managed care contracts and other supplemental materials, such as the Managed Care Technical Manuals (MCTMs), to develop combined, streamlined versions that fully support the requirements of the combined program. The overarching goal for the combined contract is that it fully support the Department's mission and goals on behalf of all populations served, and in a manner that achieves optimal efficiency and value. This process would include:

- Performing a deep-dive analysis of existing contract language, identifying language related to federal and state authorities and other guidance to form the foundation of the streamlined contract
- Identifying any sections or areas of the contracts/supplemental documents that should be eliminated, clarified, or updated to better align with current agency priorities and initiatives
- Aligning requirements, definitions, terminology, or level of detail, where the two programs currently differ, applying best practices from one of the programs, other states, and/or federal guidance in the merged contract
- Ensuring close consultation with the Department of Planning and Budget (DPB) per item 313.E1 of Chapter 1289 (HB 30) of the Appropriations Act
- Engaging key stakeholders on an ongoing basis, including MCOs, other key vendors, providers and members, for their awareness and feedback, as outlined in Section 6

Where possible, DMAS will work to align contract areas in the separate contracts for the July 1, 2021 renewal date, and proposes to move to one contract effective July 1, 2022. The CCC Plus contract affords DMAS the option to transition additional populations and services into the program in the future. Therefore, the Commonwealth would not be required to issue a new procurement in order to combine the two contracts. The unified contract would continue under the terms associated with the CCC Plus contract and procurement schedule. If all future renewal options were to be executed, the combined program would be re-procured for July 1, 2027.

The subsections below highlight major areas of the contracts, along with related processes, that will need to be aligned. **The process of merging the contracts would include a wholesale review and comprehensive alignment of all areas of the contracts; the list below features key focus areas and is not meant to be an exhaustive list of every proposed change.**

Compliance and Oversight

Currently, there are some differences in the programs' requirements and processes for monitoring compliance and providing oversight over the MCOs. For example, CCC Plus, as a much newer program serving highly complex members, requires that DMAS review and approve more of the health plans' materials and processes. There are also some differences in sanction/penalty amounts and internal processes for conducting monitoring and review activities.

As there are few population-based or other reasons for differences in the compliance and oversight components, these contract areas and processes should be aligned in the merged contract. Aligning these particular areas will result in greater efficiencies for DMAS and the MCOs and ensure that DMAS is able to provide targeted oversight of its health plans. Indeed, DMAS plans to work within the separate contracts to align areas related to compliance and oversight wherever feasible for the July 1, 2021 contracts as part of its ongoing effort to streamline the programs.

Reporting

The health plans are contractually required to report on a wide variety of initiatives, metrics, and other key items. Detailed reporting requirements are included in each program's separate Managed Care Technical Manual (MCTM). As part of the process for combining the managed care contracts, DMAS would combine and streamline the MCTMs, including identifying reports that should be eliminated or updated to reflect DMAS's current data analytics needs and capabilities. Appropriate population-specific reporting would be maintained. DMAS would also work to align the processes for report submission, analysis, and monitoring.

Care Coordination and Model of Care Components

Both contracts include principles of care coordination, especially for vulnerable, at-risk populations and require screenings, assessments, reassessments, and person-centered care planning activities, using an interdisciplinary approach. However, as Medallion 4.0 and CCC Plus serve different populations, the model of care requirements vary significantly between the two programs. Moving to one managed care delivery system would streamline processes and add value for members by eliminating the need for unnecessary transitions between the two managed care systems, maintaining consistent clinical staff assignments, and facilitating access to a fully integrated, well-coordinated system of care, fostering improved management of medically necessary care and progress updates towards improved health outcomes.

Under the combined program, DMAS would strategically align the model of care requirements to ensure access to care coordination and a comprehensive model of care relevant to the population, based on the member's needs and level of risk. Special populations identified from both managed care contracts include but are not limited to the following:

- Children and youth with special health care needs
- High-risk pregnant women and infants
- Long-term services and supports populations
- Children and adults with behavioral health and substance use disorders
- Individuals requiring high needs supports, such as employment or housing supports
- Individuals with high care utilization patterns and/or multiple chronic conditions

DMAS recognizes that significant revisions would be needed to achieve an effective model of care component that supports all populations under a unified contract. DMAS would work collaboratively with the MCOs and key stakeholders to design a member-focused model of care for the combined program that incorporates best practices from the Medallion 4.0 and CCC Plus programs, and works effectively and efficiently for the populations served. The model would also make use of historical utilization data to identify member need and level of risk to target clinically appropriate and timely interventions, make efficient and dedicated use of care coordination resources, and drive high-value care. These model of care enhancements would better support opportunities for proactive care planning and prevention of crisis and emergency services. DMAS has proposed a set of key guiding principles, as shown in Appendix 2, to be further refined in collaboration with MCOs and stakeholders as part of Project Cardinal implementation.

Network Adequacy

Each MCO is required to maintain adequate provider networks to meet the needs of the Medicaid population, as defined by the contracts. However, as the populations differ by contract, so too do the provider types subject to network adequacy requirements and some other provider-related requirements. As part of the process for combining the two contracts, DMAS would strengthen and align provider network adequacy standards and apply measurements consistently to ensure MCOs maintain adequate networks of critical provider types for each of the Medicaid populations. Similarly, DMAS would align reporting and other requirements to enable the ability to provide meaningful oversight to ensure members receive care from high-quality providers in a timely manner. An added benefit of combining the contracts may be that health plans are better able to recruit additional providers to participate in their networks due to reductions in administrative burden, further ensuring that members have sufficient access to care.

Quality and Value-Based Purchasing

DMAS requires all MCOs to maintain accreditation with the National Committee for Quality Assurance (NCQA) and report on related quality measures twice, once for the populations included in each program. DMAS is already undergoing efforts to align quality reporting, ensuring measures are consistent between the programs and that appropriate benchmarks are established by population. Appropriate benchmarking and population-specific metrics will be critical in the merging of the two contracts to ensure that high-quality care is provided to all Medicaid members and that plans are meeting reasonable accountability standards.

In addition to quality measure reporting required by DMAS, there are a number of federally required quality activities. DMAS is required to contract with an external quality review organization (EQRO) to monitor care activities for both programs. Currently, DMAS has to conduct two separate projects with the contractor for each required activity.

However, if the programs were combined, DMAS could streamline the projects and reduce resource burden on both DMAS and the MCOs by eliminating duplication.

Similar to special considerations needed for quality monitoring initiatives, performance metrics and benchmarks or target percentages for current value-based purchasing (VBP) programs would need to be carefully considered when combining the programs. For instance, some metrics used in the performance withhold program are specific to one program. Composite measures would need to be carefully reviewed to ensure that benchmarks are appropriate and that vulnerable populations are monitored. In combining the contracts, DMAS would need to consider new benchmarks and thresholds for performance to ensure that high quality, efficient care is provided to *all* Medicaid populations. Ultimately, while combining the programs would result in the short-term need to amend current VBP programs, monitoring and oversight efficiencies would allow for a greater focus on implementing financial and non-financial value based-incentive programs to improve health outcomes and value under the unified contract.

Capitation Rates

Although capitation rates differ by program, rates are developed based on population-specific data. For instance, current population criteria taken into consideration for rate development include age, gender, region, eligibility category, and waiver or LTSS enrollment. Since combining the programs does not involve adding new populations to managed care, the impact to the rate setting process would be minimal. Merging the programs may require some updates to rate cells that currently incorporate some differences by program, such as Medicaid Expansion rates; however, the process for developing rates would be similar to any update in population or change in benefits that DMAS has conducted numerous times over the years. Project Cardinal would also provide an opportunity to consider risk-adjustment methodologies for long-term care.

In addition to the medical component of capitation rates described above, rates also include an administrative component. Initially, as MCOs are required to make system and programmatic updates to align their two lines of business, there may be increased administrative costs. However, following an initial investment, administrative costs are expected to decrease over time as MCOs gain efficiencies from reduced duplication, such as with reporting and member communication materials.

Medical Loss Ratios and Underwriting Gains

Under the current structure, health plans are required to spend at least 85% of capitation payments on clinical services or quality improvement initiatives. MCOs are required to calculate and report their Medical Loss Ratio (MLR), which is the ratio of spending on clinical services and quality improvement expenditures divided by capitation revenue. If a health plan's MLR is less than 85%, then the health plan is required to make a payment to the Department equal to the deficiency percentage applied to the amount of capitation revenue. This percentage is contract-specific; therefore, even if the health plan spent more than 85% on medical costs for one program, the plan will still be required to make a payment to the Department for the insufficient medical spending in the other program. Under a combined contract, separate MLR calculations for each program would no longer be required, and DMAS would need to closely monitor MCO spending on vulnerable populations to ensure that adequate funds are used to care for members.

Similarly, underwriting gain limits are also currently program-specific. Health plans with profit in excess of 3% are required to refund the Department some portion of the Medicaid premium income up to a 10% profit, at which point all underwriting gains in excess of 10% must be returned to the Department. As a result of limits being program-specific, a health plan may have losses in one line of business but excess gains in the other, resulting in a payment to the Department. This situation would not occur if the programs are combined.

Combining the MLR and underwriting gain limits for the health plans would provide plans additional financial support by allowing for cross-subsidies, using profits from populations with lower-than-expected spending to pay for the expenditures of populations with higher-than-expected costs. This cross-subsidization could result in a cost to the Commonwealth when compared to current rules. More detail on the process and impact for combining the MLR and underwriting gain provisions can be found in the required companion report on these topics (per Item 313.E.7).

Section 4: Other Overarching Program Changes

The following subsections include other proposed programmatic changes related to Project Cardinal that reach beyond the managed care contracts to improve the overarching Medicaid delivery system, including updating and streamlining branding, aligning fragmented benefit programs for children, and working to improve the managed care enrollment processes.

Branding and Program Name Changes

Project Cardinal presents an opportunity for Virginia Medicaid to begin the process of decoding its current disjointed array of branding and messaging to members, providers, health care advocates, and other stakeholders.

Historically, DMAS has developed and branded individual initiatives without consideration for how they fit into the Department's larger identity. As a result, members may not know which managed care program they are in, and they are often not even aware that they are Medicaid members. This lack of clarity serves as a barrier to outreach to Virginians who are newly eligible under the 2019 Medicaid Expansion, and impedes communication with individuals within eligibility categories that have existed for generations.

In an increasingly complex health care ecosystem, it is essential for the Virginia Medicaid agency to strengthen our relationship with current and potential members through clearer brand identity and a commitment to meaningful two-way communications. To achieve a more cohesive agency voice and member experience, DMAS recommends rebranding the fee-for-service and managed care programs under a single name: Cardinal Care Virginia.

As part of the rebranding campaign, DMAS would develop a visual identity (including logo), vision, and message that connect with the DMAS mission, promote equity, and communicate the value of Virginia's managed care model. As part of the due diligence for this report, DMAS has checked both the U.S. Patent and Trademark Office's trademark database and the Virginia State Corporation Commission database to ensure the name is not in use by another organization or company.

The new brand would offer many benefits including:

1. Creating an overarching umbrella that makes it easier to tell the Virginia Medicaid story in a compelling, consistent manner across all channels;
2. Equipping staff to speak with a unified voice during interactions with members, providers, and the public; and
3. Reducing confusion about the Department's programs and creating a clear connection between each member's health care coverage, DMAS, and the Commonwealth.

The brand would also allow DMAS to integrate the "Cardinal Care" name into other programs and eligibility groups. For example, children's programs could become "Cardinal Care Kids" while adult fee-for-service programs could become "Cardinal Care Medicaid." Decisions on how we brand programs geared to special populations and sub-programs would be evaluated as plans for the merger are finalized.

The rebranding process would involve updates to a wide range of digital platforms and hard-copy materials, including those maintained and shared by the MCOs. DMAS would coordinate this process with all relevant divisions and staff to ensure a smooth, efficient transition. Recognizing that MCOs and other contractors maintain a stock of printed materials, we would provide time to phase out old materials and transition to the new brand. A rebranding initiative of this scale must be carefully planned and managed throughout each stage. We would plan to implement the new brand in three stages: 1) Internal DMAS employees; 2) Sister agencies, MCOs, and high-priority stakeholders; and 3) Externally to all members, stakeholders, providers, media, and the general public. More detail on the technical aspects of the brand implementation plan and stakeholder engagement strategy can be found in Section 6.

Alignment of FAMIS and Medicaid Program Rules

DMAS administers the Virginia's State Children's Health Insurance Program (S-CHIP) in addition to the state Medicaid program. Virginia's CHIP program, called Family Access to Medical Insurance Security (FAMIS), provides vital coverage for children in families whose earnings are too high to qualify for Medicaid but cannot afford private insurance. Under federal law, states can choose to cover CHIP-eligible children in a separate CHIP program; in a CHIP-Medicaid expansion, which enrolls CHIP-eligible children into the state's child Medicaid program using CHIP/Title XXI dollars at the enhanced CHIP federal matching rate; or using a combination of the two approaches. Virginia currently operates a combination CHIP program. Since 2003, part of the Commonwealth's CHIP-eligible population—children ages 6 through 18 between 100 and 143% of the federal poverty limit (FPL)—has been enrolled in Medicaid at the CHIP match, while other children are covered in Virginia's separate CHIP program, FAMIS. [6] FAMIS is comprised of children of all ages between 143 and 205% FPL. DMAS proposes to move the entire FAMIS population—average monthly enrollment of approximately 75,000—into CHIP-funded Medicaid coverage. As of 2017, 14 states plus the District of Columbia have made this transition.[7] Other states report that a full transition to CHIP-funded Medicaid achieves operational efficiencies by streamlining two separate programs with different benefits and policies into a single program for children.

FAMIS children do not currently have access to all of the benefits that Medicaid children receive, most notably the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. In addition, services for FAMIS children of all ages are subject to copays, while Medicaid children's services are not. It is administratively burdensome for DMAS, its MCOs and other vendors, and providers to administer this small-scale, separate program with different requirements, benefits, cost sharing, and policies.

To support Project Cardinal's goals of achieving administrative efficiencies and aligning benefits and program features wherever possible, DMAS recommends transitioning FAMIS into CHIP-funded children's Medicaid to create a unified Virginia Medicaid children's program. This transition is an important component of fully aligning the Department's managed care programs. DMAS would need to file a CHIP State Plan Amendment and take legislative and regulatory steps to effectuate this transition, as outlined in Section 5. Critically, from a financial perspective, this transition preserves the enhanced CHIP federal matching rate Virginia currently receives for its FAMIS population, and allows the state to access sizeable drug rebates currently not available under the separate CHIP program.

[6] Historically, the enhanced federal medical assistance percentage (e-FMAP) for Title XXI/CHIP funding for Virginia is 65 percent. (Medicaid is federally matched at 50 percent in the Commonwealth.) A 4.34 percentage point boost has been added to this CHIP matching rate effective retroactively to January 1, 2020, the calendar quarter in which the COVID-19 federal public health emergency (PHE) was declared. Currently, a total rate of 69.34% is effective from October 1, 2020, until the end of the calendar quarter in which the PHE expires (through at least March 31, 2021, as of the submission of this report).

[7] Cara Orfield, Sean Orzol, and Lauren Hula, "An Implementation Analysis of States' Experiences in Transitioning 'Stairstep' Children from Separate CHIP to Medicaid," Mathematica Policy Research/Medicaid and CHIP Payment and Access Commission [MACPAC], September 3, 2015, available at https://www.macpac.gov/wp-content/uploads/2015/09/Analysis-of-Stairstep-Children-Transitions.pdf. As of federal fiscal year 2017, a greater share of the nationwide Title XXI-funded population was enrolled in CHIP-funded Medicaid expansion programs than in separate CHIP programs—approximately 59%/41%. (MACPAC, Fact Sheet: State Children's Health Insurance Program, February 2018, available at https://www.macpac.gov/wp-content/uploads/2018/02/State-Children%E2%80%99s-Health-Insurance-Program-CHIP.pdf)

Streamlining Managed Care Enrollment

The current processes for members to enroll in managed care, choose or change their MCO, and re-enroll in managed care if they experience a lapse in Medicaid coverage can be complicated and disjointed. Members may experience extended waiting periods in fee-for-service while awaiting managed care enrollment, confusion stemming from numerous Open Enrollment periods, and disruptions in enrollment, with more than 5% of members experiencing a break in coverage within a 12-month time period, having to move into fee-for-service for some period of time before they can re-enroll with their MCO. The complicated nature of the current managed care enrollment processes causes confusion for members and providers and can result in significant disruptions in care. In fact, a significant number of member and provider complaints are related to managed care enrollment. Detail on DMAS' current processes for initial managed care enrollment, Open Enrollment, and annual renewals can be found in Appendix 3.

As part of Project Cardinal, DMAS recommends leveraging upcoming systems updates and procurements to improve and modernize the overall enrollment process, including streamlining and reducing redundant enrollment systems, processes, and related communication materials; enrolling and re-enrolling members into managed care more quickly; and maintaining continuity of members' MCO enrollment. The subsections below detail specific managed care enrollment processes that DMAS would align, along with some value-added opportunities to streamline the processes in the combined program. These improvements would simplify and streamline the experience for members and providers and support continuity of care for the 1.5 million individuals served through managed care.

Changes to Enrollment for Certain Populations

The current Medicaid system attempts to facilitate seamless transitions for members moving between the two managed care programs by avoiding the need for an interim fee-for-service enrollment period. However, there are some complex circumstances where this is not possible. Operating under one managed care delivery system would streamline and enhance continuity of care for members and add value for providers by eliminating the need for unnecessary transitions between programs.

One example relates to populations moving from Medallion 4.0 to CCC Plus when they begin receiving LTSS. In some cases, members, previously enrolled in Medallion 4.0, must receive care and services through fee-for-service briefly prior to being re-enrolled with their health plan under CCC Plus. Another example includes newborns of CCC Plus mothers, where, after birth, the baby is covered through fee-for-service before being enrolled in Medallion 4.0. In either example, this brief MCO enrollment lapse complicates the transition and has the potential to create access to care issues for members, especially when the members' providers do not participate in the fee-for-service program. It also causes disruption to claims processing for providers. These concerns lead to member and provider complaints that require significant staff time to research and resolve. These unnecessary rules, and the related disruptions to health plan enrollment, would be eliminated under a single managed care delivery system.

Expediting Managed Care Enrollment

Given the relatively low percentage of members who actively select an MCO at initial enrollment, and the fact that members have 90 days to change their plan after auto-assignment, DMAS plans to identify ways to expedite enrollment into managed care. DMAS piloted a successful expedited enrollment approach during Medicaid Expansion. Enrollment for Medicaid Expansion began on November 1, 2018, with coverage starting on January 1, 2019. All individuals who were enrolled in Medicaid by December 18, 2018, were auto-assigned a health plan so they would start their coverage in managed care on January 1, 2019, with no waiting period in fee-for-service. This pilot worked well and reduced confusion for new beneficiaries.

Additionally, as outlined in Appendix 3, DMAS, in conjunction with the Virginia Department of Social Services (VDSS), has made significant improvements over the last few years to ensure that eligible members do not lose coverage at their annual renewal. However, even with these ongoing improvements, there will always be members who experience lapses in coverage and, therefore, lapses in managed care enrollment.

Expediting the member's enrollment into managed care enables quicker enrollment into a health plan where the member has faster access to care coordination, complex care management, 24-hour nurse advice lines, enhanced

provider networks, and specialty care. For members who are dis-enrolled from their MCO due to a lapse in coverage, it also ensures that they can quickly resume receiving services with their providers, preventing significant disruptions in care. Awaiting managed care enrollment/re-enrollment (which can take approximately a month as outlined in Appendix 3) can lead to uncertainty for members and providers, especially regarding scheduling critical follow-up treatments, such as cancer treatments or medical procedures. These services may need to be transitioned to or possibly rescheduled with network providers once members are enrolled or re-enrolled with their health plan.

DMAS is currently on a multiyear journey to transform its information systems from the current mainframe Medicaid Management Information System (MMIS) to the modular based, highly configurable, Medicaid Enterprise System (MES). DMAS plans to further explore options to streamline, expedite, and facilitate continuity of managed care enrollment once its new system is fully operational. Specifically, rather than the current monthly enrollment process outlined in Appendix 3, DMAS will examine the use of more frequent managed care enrollment processes employed in other states, such as daily or weekly enrollment. DMAS will work with its MES vendors and enrollment broker to balance the expediency of managed care enrollment with the necessity of preserving members' choice of their MCO.

Additionally, DMAS will explore the availability of other solutions to expedite managed care re-enrollment to prevent managed care enrollment "churn" for members who lose coverage briefly during the renewal process.

Streamlining Open Enrollment

As outlined in Appendix 3, DMAS currently has seven different Open Enrollment periods, during which members have an annual opportunity to change their MCO (note—individuals can apply for and enroll in Medicaid at any time). The open enrollment periods were designed to spread out call volumes to the enrollment broker throughout the year. However, more members are electing to change their plan via non-telephonic methods. For example, from September 2019 – August 2020, 48% of Medallion 4.0 members and 30% of CCC Plus members who changed plans did so via online methods rather than via phone.

The various Open Enrollment periods are frequently confusing to members, and DMAS receives multiple inquiries related to Open Enrollment throughout the year. This can be especially confusing for families with members participating in multiple programs. For example, one family could have up to three different Open Enrollment periods; both parents could be enrolled in Medicaid Expansion in the Medallion 4.0 program and have an Open Enrollment period of November 1 – December 31; one child could be enrolled in Medallion 4.0 with an Open Enrollment period that tracks with the family's residence in Tidewater of February 19 – April 30; and another child could be enrolled in CCC Plus with an Open Enrollment of October 1 – December 18. Even keeping up with one Open Enrollment period can be challenging, as members may not know in which program they are enrolled.

Preliminary research shows that other state Medicaid programs employ various methodologies for scheduling their Open Enrollment periods, including employing one statewide Open Enrollment period, conducting rolling Open Enrollments by member renewal dates, and operating regionally based Open Enrollment periods. DMAS is beginning its enrollment broker re-procurement process and plans to utilize this opportunity to explore options for streamlining its current Open Enrollment periods based on industry best practices and discussions with other states.

The ultimate goal of these improvements to managed care enrollment would be for members and providers to have a seamless Medicaid experience wherever possible, expediting initial managed care enrollment and keeping eligible members enrolled with the health plan of their choice to curb confusion and prevent delays and disruptions in care. DMAS will leverage upcoming procurements and the capabilities of its new system to explore ways to make future improvements, which will better link the fee-for-service program with the combined managed care program.

Section 5: Federal and State Authority Changes

As part of our research and analysis, DMAS reviewed all federal and state managed care authorities to determine where changes would be needed to effectuate a single managed care program per the changes detailed in Sections 3 and 4. The subsections below detail the findings from this analysis and the proposed plan for making changes to each authority, where required. A complete listing of all federal and state authorities pertaining to managed care is available in Appendix 4.

Outline of Proposed Changes to Managed Care Waivers

DMAS currently operates its managed care programs through two 1915(b) waivers, one for Medallion 4.0 and one for CCC Plus. These waivers serve as the “contract” between the Centers for Medicare and Medicaid Services (CMS) and the state to operate the Virginia managed care programs in accordance with all federal and state laws.

Some states operate their managed care programs via 1932(a) State Plan Amendments (SPAs) or 1115 demonstration waivers, rather than 1915(b) waivers. As part of Project Cardinal, DMAS researched available options to determine if there were any opportunities to streamline its federal authorities under the combined managed care program. Based on the current authority structure in Virginia, DMAS explored two potential options: combining its 1915(b) waivers or transitioning to a SPA in combination with a 1915(b) waiver.

Based on best practices research and conversations with CMS, DMAS determined that combining its existing 1915(b) waivers would be the most efficient and effective method to administer a single managed care program.[8] The CCC Plus 1915(b) waiver will reach its five-year renewal date on July 1, 2022. CMS has advised that DMAS could move its Medallion 4.0 1915(b) populations into the CCC Plus 1915(b) waiver to achieve one managed care program at that time. CMS would treat the process as a regular renewal, with no special requirements. Since the dual eligible population would be a part of the unified 1915(b) waiver, the combined waiver would only require renewal every five years. (Currently, the Medallion 4.0 1915(b) waiver must be renewed biannually since it does not include the dual eligible population.)

As outlined in Section 4, DMAS already covers part of its FAMIS population in children’s Medicaid (children ages 6 through 18 between 100 and 143% of the FPL). This population, called the “CHIP-Medicaid expansion children’s group,” is currently included in the Medallion 4.0 1915(b) waiver and would remain covered in the newly combined waiver. Because this group is already covered in the 1915(b) waiver, the combined 1915(b) waiver authority would also extend to these children when DMAS transitions the rest of its separate FAMIS child population into this group via a CHIP State Plan Amendment (as outlined below). In short, no significant changes to the 1915(b) waiver would be required to accomplish the transition of FAMIS children into CHIP-funded Medicaid.

Having a single, combined 1915(b) waiver would result in greater efficiency for waiver maintenance, renewals, and federal reporting submissions, including for Virginia’s CHIP State Plan.

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[8]While SPAs do not require periodic renewal from CMS (unlike waivers), SPA authority does not allow states to operate mandatory managed care enrollment for certain populations, including dual eligible individuals (individuals with Medicare and Medicaid coverage), American Indians, and children with special health care needs. Under the 1915(b) waiver, states can receive CMS approval to require all populations to participate in managed care, but they must submit detailed reporting to demonstrate that services through the waiver are as cost effective as they would be through the SPA, and must conduct periodic waiver renewals (every 2 years for non-dual programs and every 5 years for dual programs). DMAS discussed with CMS the option of using a combination of the SPA along with the 1915(b) waiver authority. Using this option, the waiver would only include the small subset of populations prohibited from mandatory managed care enrollment through the SPA. CMS cautioned that in its experience with other states that had tried this approach, states had encountered difficulties in two areas: meeting the separate complex reporting requirements for the SPA and waiver and demonstrating cost effectiveness when the 1915(b) waiver includes predominantly complex, potentially high-cost population groups.

Outline of Other Regulatory Changes to Support Combined Program

Medicaid and CHIP State Plans

Because DMAS would continue to operate its managed care programs via a single 1915(b) waiver rather than a Medicaid State Plan Amendment (SPA), as outlined above, the Department does not anticipate that any Medicaid SPAs would be needed to implement the changes.

Under the proposed plan, DMAS would file an amendment to its CHIP State Plan to reflect the transition of the separate FAMIS children into CHIP-funded Medicaid under the 1915(b) waiver, as outlined above.

Code of Virginia

DMAS's in-depth review of the Code of Virginia did not identify any substantive changes that would be needed to combine the Medallion 4.0 and CCC Plus Medicaid programs. If the General Assembly elects to move forward with the proposed plan during the 2021 General Assembly Session, DMAS would submit a legislative request for the 2022 General Assembly Session to update Title 32.1, Chapter 13 of the Code of Virginia to reflect the changes in the FAMIS program.

Appropriations Act

DMAS's review of the Appropriations Act identified one section that is out-of-date. The language below (HB 30 (Chapter 1289) Item 313.EE) authorized the implementation of CCC Plus and the expansion of the principles of care coordination. Now that nearly all Medicaid members are enrolled in managed care, this language is no longer needed, but it can be built upon to authorize the merger of the managed care programs. DMAS would require authorizing language and emergency regulatory authority to effectuate a single managed care program effective July 1, 2022. The proposed Appropriations Act language is included below, with new language in red and outdated requirements in strikethrough:

> ***HB 30 (Chapter 1289) Item 313.EE:*** *The Department of Medical Assistance Services shall seek federal authority through the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to merge the Commonwealth Coordinated Care Plus, Medallion 4.0, and FAMIS managed care programs into a single, streamlined managed care program that links seamlessly with the fee-for-service program, ensuring an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality care to its members and adds value for providers and the Commonwealth. Such changes shall include CHIP State Plan and waiver amendments and other necessary authorities to align the children's programs by transitioning the separate CHIP/FAMIS population to a CHIP-Medicaid expansion children's group. The department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change.* ~~*expand principles of care coordination to all geographic areas, populations, and services under programs administered by the department. The expansion of care coordination shall be based on the principles of shared financial risk such as shared savings, performance benchmarks, or risk and improving the value of care delivered by measuring outcomes, enhancing quality, and monitoring expenditures. The department shall engage stakeholders, including beneficiaries, advocates, providers, and health plans, during the development and implementation of the care coordination projects. Implementation shall include specific requirements for data collection to ensure the ability to monitor utilization, quality of care, outcomes, costs, and cost savings. The department shall report by November 1 each year to the Governor and Chairmen of the House of Appropriations and Senate Finance Committees detailing implementation progress, including, but not limited to, the number of individuals enrolled in care coordination, the geographic areas, populations and services affected and cost savings achieved. Unless otherwise delineated, the department shall have authority to implement necessary changes upon federal approval and prior to the completion of any regulatory process undertaken in order to effect such change. The intent of this Item may be achieved through several steps, including, but not limited to, the following:*~~
>
> ~~*a. In fulfillment of this Item, the department and the Department of Behavioral Health and Developmental Services, in collaboration with the Community Services Boards and in consultation with appropriate stakeholders, shall develop a blueprint for the development and implementation of a care coordination model for individuals in need of behavioral health services not currently provided through a managed care organization. The overall goal of the project is to improve the value of behavioral health services purchased by the Commonwealth of Virginia without compromising access to behavioral health services for vulnerable populations. Targeted case*~~

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~~*management services will continue to be the responsibility of the Community Services Boards. The blueprint shall: (i) describe the steps for development and implementation of the program model(s) including funding, populations served, services provided, timeframe for program implementation, and education of clients and providers; (ii) set the criteria for medical necessity for community mental health rehabilitation services; and (iii) include the following principles:*~~

~~*1. Improves value so that there is better access to care while improving equity.*~~

~~*2. Engages consumers as informed and responsible partners from enrollment to care delivery.*~~

~~*3. Provides consumer protections with respect to choice of providers and plans of care.*~~

~~*4. Improves satisfaction among providers and provides technical assistance and incentives for quality improvement.*~~

~~*5. Improves satisfaction among consumers by including consumer representatives on provider panels for the development of policy and planning decisions.*~~

~~*6. Improves quality, individual safety, health outcomes, and efficiency.*~~

~~*7. Develops direct linkages between medical and behavioral services in order to make it easier for consumers to obtain timely access to care and services, which could include up to full integration.*~~

~~*8. Builds upon current best practices in the delivery of behavioral health services.*~~

~~*9. Accounts for local circumstances and reflects familiarity with the community where services are provided.*~~

~~*10. Develops service capacity and a payment system that reduces the need for involuntary commitments and prevents default (or diversion) to state hospitals.*~~

~~*11. Reduces and improves the interface of vulnerable populations with local law enforcement, courts, jails, and detention centers.*~~

~~*12. Supports the responsibilities defined in the Code of Virginia relating to Community Services Boards and Behavioral Health Authorities.*~~

~~*13. Promotes availability of access to vital supports such as housing and supported employment.*~~

~~*14. Achieves cost savings through decreasing avoidable episodes of care and hospitalizations, strengthening the discharge planning process, improving adherence to medication regimens, and utilizing community alternatives to hospitalizations and institutionalization.*~~

~~*15. Simplifies the administration of acute psychiatric, community mental health rehabilitation, and medical health services for the coordinating entity, providers, and consumers.*~~

~~*16. Requires standardized data collection, outcome measures, customer satisfaction surveys, and reports to track costs, utilization of services, and outcomes. Performance data should be explicit, benchmarked, standardized, publicly available, and validated.*~~

~~*17. Provides actionable data and feedback to providers.*~~

~~*18. In accordance with federal and state regulations, includes provisions for effective and timely grievances and appeals for consumers.*~~

~~*b. The department may seek the necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to develop and implement a care coordination model, that is consistent with the principles in Paragraph a, for individuals in need of behavioral health services to be effective July 1, 2019. This model may be applied to individuals on a mandatory basis. The department shall have authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment date of this Act.*~~

Virginia Administrative Code

DMAS also conducted a thorough review of its regulations pertaining to managed care in the Virginia Administrative Code (VAC). DMAS has determined that under the emergency regulatory authority proposed above, the Department would repeal the specific regulations pertaining to Medallion 4.0, CCC Plus, and FAMIS and replace them with new regulations for the combined managed care program. Similar to the managed care contract changes, the new

regulations would be a streamlined composite of the current regulations. DMAS would also make changes to other related regulations where necessary. A full list of planned VAC changes can be found in Appendix 5.

Changes to the VAC for Project Cardinal would follow the usual process. To meet the July 1, 2022 effective date, DMAS would begin to draft the new regulations in the summer of 2021.

Section 6: Other Workstreams and Changes Needed to Support Implementation

The following subsections detail other work streams and changes that would need to occur to effectuate the managed care program merger.

Communications Updates and Stakeholder Engagement Plan

Agency Communications Implementation

The Virginia Medicaid agency uses a wide array of communications tools – digital and print – to share information about its programs and policies. In the ever-evolving world of health care, change is a constant, and processes already exist to incorporate regular updates into agency communications materials. Combining the managed care programs would allow DMAS and its vendors to streamline and consolidate member-facing digital and print materials.

The scope of the rebranding project, introduced in Section 4, will guide the schedule for implementation, but the vast majority of changes could be integrated into regular programmatic updates. A high-level proposed timeline for the rebranding is included in Appendix 6.

Currently, DMAS operates an agency website using internal staff. Third party vendors manage additional websites, including the CoverVA and Cubre Virginia outreach websites, managed care enrollment websites, and provider portal. More portals are under development as part of the MES project. Print materials are produced by Virginia Correctional Enterprise and commercial firms. DMAS updates most outreach materials each January, when the federal government revises income eligibility guidelines, and rebranding could be coordinated with this annual process.

There are two general categories of notifications distributed by mail to Medicaid members: eligibility and enrollment notices. There are a multitude of system-generated eligibility notices, and the agency updated and improved these member notifications in the past year. These notices are not heavily branded, but the letterhead does contain the name of the Department of Medical Assistance Services. The agency revises enrollment materials annually, a process that begins in June in preparation for the fall Open Enrollment period. DMAS would necessarily revise these enrollment letters to reflect changes related to the unification of the two managed care programs, and rebranding could occur simultaneously.

Finally, DMAS produces a variety of policy documents, including provider memos and manuals, which include minimal branding and could be revised with simple updates to the existing templates.

DMAS would work with MCOs and other vendors to ensure there is an "off ramp" period for retirement of old materials and other public-facing information, and discontinuation of the Medallion 4.0 and CCC Plus names to minimize unnecessary costs and reduce confusion for members and providers.

Managed Care Organization Communications

DMAS would work closely with MCOs to develop consistent messaging about Project Cardinal so that members understand their health care benefits and options. DMAS would also create tool kits to assist MCOs in disseminating accurate information about Project Cardinal to their members and providers in a timely manner.

Currently, MCOs submit all member materials, marketing materials and planned outreach activities to DMAS for review. Medallion receives and reviews more than 1,000 documents, and CCC Plus reviews more than 700 documents annually. The DMAS managed care divisions use a rigorous review process to determine whether materials and programs meet specific contractual requirements, as well as state and federal regulations.

Project Cardinal and the aligned managed care contract would allow DMAS to build a joint, streamlined review process of these materials. The MCOs would update materials as necessary with new program information and consistent branding, and submit them for streamlined review. The overall goal is to ensure that members understand their health care benefits, services, and how to access care.

Stakeholder Engagement

DMAS demonstrated a strong commitment to stakeholder engagement throughout the large-scale implementations of CCC Plus, Medallion 4.0, and Medicaid Expansion. DMAS engaged a variety of stakeholders to gain buy-in, identify potential issues, and solicit feedback at key junctures. Clear, concise communication, outreach, and education were critical to these successful implementations. DMAS plans to build on these experiences and prioritize communication with stakeholders during Project Cardinal. DMAS would equip stakeholders with accurate information and encourage them to become advocates of these programmatic changes to improve health care delivery for Medicaid members, providers, and other stakeholders.

For Project Cardinal, DMAS would communicate messages that fall into three broad categories: 1) benefits of the streamlined program, 2) minor changes due to branding, and 3) changes to processes that require action. As DMAS communicates the new positive aspects of the program merge, we would assure stakeholders that members are not losing any Medicaid benefits or services. DMAS would employ targeted education and engagement tactics based on the audience segment (e.g. member, provider, and advocate) and the level of impact anticipated for each segment.

DMAS would first communicate Project Cardinal messages to the internal DMAS audience. Staff would be engaged in various work groups related to Project Cardinal and kept informed about programmatic changes and timelines through this cross-agency collaboration and through the agency newsletter. Staff will be important ambassadors in educating and building support for Project Cardinal.

DMAS external stakeholders include members, providers, advocates, legislators, sister agencies, contractors, and others. DMAS staff have evaluated the level of engagement required with various categories of stakeholders. The agency plans to leverage existing communication channels to deploy messages widely, including through advocate and provider newsletters and member email campaigns. DMAS would also develop toolkits, fact sheets, frequently asked questions, social media messages, press releases, and webinars targeted to key audiences.

Overview of IT Systems Changes

As part of the Project Cardinal initiative, DMAS would make changes to its IT systems to support the combined managed care program. As mentioned previously, DMAS is in the process of developing and implementing a new MES to replace its current MMIS. For this reason, the Project Cardinal IT solution would be implemented using a two-phased approach, as outlined below. This approach would allow DMAS to effectuate the merged program July 1, 2022, while minimizing changes in the short term to allow for the successful implementation of MES, and then to leverage the full-scale MES implementation to provide a modernized technical solution that fully supports the IT needs of the unified managed care program.

Phase 1 – Anticipated go-live July 1, 2022

- Continuing to utilize current system processes where feasible, while removing all references to Medallion 4.0 and CCC Plus
- Shoring-up system processes to facilitate and maintain enrollment for managed-care eligible populations, such as newborns and members receiving LTSS benefits
- Transitioning FAMIS to the enhanced match Medicaid group, aligning covered benefits and program administration with Medicaid managed care and fee-for-service rules, and maintaining Title XXI enhanced funding
- Revising all communications to reflect the new combined managed care benefit and branding, including eligibility verification systems used by providers, member enrollment notices, etc.

Phase 2 – Anticipated go-live 2023

- A clean rebuild of the system that supports the combined program with maximum efficiency
- Enrolling and re-enrolling populations in managed care quickly, such as through a weekly or daily auto-assignment process

- Facilitating seamless transitions across health plans and between the managed care and fee-for-service programs
- Preventing disruptions to the member's managed care enrollment coverage to the maximum extent possible

Overview of Impact to Other Vendors

As outlined in various sections of this report, DMAS would work in collaboration with all vendors to implement the Project Cardinal initiative.

DMAS' MMIS and MES IT system vendors, enrollment broker, and mailing vendor would be required to make significant changes to support the Project Cardinal implementation.

The following vendors may need to make changes to reflect the updated program name: the dental vendor, non-emergency transportation vendor, consumer-directed fiscal agent, and service authorization contractor.

Other vendors that would be impacted in some way by the program merge include DMAS' actuary and external quality review organization (EQRO). It is anticipated that changes for these vendors would be more about updating their regular processes with both programs (i.e., rate setting and performing annual quality reviews, respectively, as discussed in Section 3) to reflect a merged program, and therefore should result in efficiencies.

Additionally, in the future, as DMAS seeks to make changes to expedite and improve managed care enrollment as outlined in Section 4, other DMAS vendors may be required to make additional changes.

As with all large-scale implementations, DMAS' Procurement & Contracts Management Division, the contract administrators, and other key leadership and staff would work with the vendors to execute the needed system and programmatic changes and to make contract amendments where necessary.

Overview of Planned Organizational Changes

As DMAS has shifted away from the fee-for-service model, the Department has centralized the administration of key functions to support members, providers, and other key stakeholders across fee-for-service and its two managed care programs. Examples include the Appeals Division, Program Integrity Division, Provider Reimbursement Division, Behavioral Health Division, High Needs Supports Division, the Office of Quality and Population Health, and the Office of Value-Based Purchasing.

Indeed, a 2019 analysis by the Center for Health Care Strategies (CHCS) of the DMAS organizational structure indicated that DMAS is aligned with Medicaid agencies across the country:

"Based on its understanding of Medicaid programs across the country and interactions with DMAS leadership and staff, CHCS concluded that the current structure of DMAS is consistent with other state Medicaid agencies. While there is great variety of organizational structures nationally within Medicaid programs, the current structure of DMAS is consistent with this range and a significant redesign of the organization may produce more disruption to functioning than it does to create greater efficiency. As such, efforts to improve organizational function and efficiency should focus largely on continuing to advance ongoing improvements in internal processes and workforce development efforts."

DMAS currently has two managed care divisions, Health Care Services, which oversees the Medallion 4.0 program, and Integrated Care, which oversees the CCC Plus program. Rather than simply combining the divisions to support the implementation of Project Cardinal, DMAS plans to continue its multi-year journey to holistically evolve its overall organizational structure to support a primarily managed care delivery system. This will involve continuing to centralize functions and processes where possible, while maintaining population- or service-specific functions where appropriate.

DMAS operates the $16.5 billion Medicaid program covering over 1.7 million Virginians with 530 full-time staff allotted to the agency and a $232 million administrative budget (1.4% of the Department's total budget). All current resources will be necessary to implement this proposed program merge and to maintain an effective new structure for monitoring and improving our unified managed care program. DMAS leadership will work in the coming months to identify specific changes and an implementation approach to best support the combined, streamlined program to increase efficiencies while minimizing disruption.

Conclusion

With a wealth of experience under its wing from 25 years of incremental managed care evolution, including the recent CCC Plus and Medicaid Expansion implementations, the Department is proposing to implement a unified managed care program effective July 1, 2022 to serve as a strong and equitable foundation on which to build the next 25 years and beyond of innovations and improvements. While these proposed changes come with some up-front costs to the state, the new Cardinal Care Virginia program will reduce administrative burden for all stakeholders, including members, providers, and MCOs; allow for more effective and efficient program administration; and provide opportunities to improve care for one in five Virginians.

Appendix 1: Managed Care Populations by Program

Commonwealth Coordinated Care Plus (CCC Plus)

CCC Plus currently serves approximately 263,000 individuals, including older adults, disabled children, disabled adults, medically complex Medicaid Expansion adults, and members who receive Medicaid long-term services and supports (LTSS) in a facility or through one of the home and community-based (HCBS) waivers. Individuals enrolled in the Community Living, the Family and Individual Support, and Building Independence waivers, known as the Developmental Disabilities (DD) waivers, are enrolled in CCC Plus for their non-waiver services only. Their DD waiver services are covered through Medicaid fee-for-service. CCC Plus also includes over 122,000 dual eligible individuals and nearly 38,000 medically complex Medicaid Expansion members. The table below provides data for populations by MCO.

CCC Plus MCOs	Aged, Blind, Disabled, and Complex Populations without LTSS*	Long Term Services and Supports Populations				Total
		CCC Plus Waiver	DD Waiver	Hospice	Nursing Facility or Long Stay Hospital	
Aetna	29,032	4,993	2,159	90	3,028	**39,302**
Anthem	51,971	13,748	4,763	104	3,894	**74,480**
Magellan	19,203	2,741	1,210	67	2,308	**25,529**
Optima	32,579	6,060	2,449	54	2,300	**43,442**
UnitedHealthcare	22,840	3,843	1,374	62	2,797	**30,916**
Virginia Premier	37,006	6,535	2,420	87	2,959	**49,007**
Total	**192,631**	**37,920**	**14,375**	**464**	**17,286**	**262,676**

*Includes disabled adults and children, adults age 65 and older, and Medicaid Expansion adults with complex conditions
Source: DMAS Data as of October 2020

Medallion 4.0

The Medallion 4.0 program currently serves nearly 1.3 million individuals, including pregnant women, infants, children, parents/caregivers, and Medicaid Expansion adults. Children served through Medallion 4.0 may also be receiving foster care or adoption assistance or may be enrolled in the Early Intervention program, through the DBHDS Infant & Toddler Connection of Virginia. Early Intervention provides supports and services to infants and toddlers from birth through age two who are not developing as expected or who have a medical condition that can delay normal development. Medallion 4.0 also includes individuals enrolled in Virginia's State Children's Health Insurance Program (S-CHIP) program, called Family Access to Medical Insurance Security (FAMIS), which provides vital coverage for pregnant women (FAMIS MOMS) and children in families whose earnings are too high to qualify for Medicaid but cannot afford private insurance.

Medallion 4.0 MCOs	Children				Adults				Total
	Children (not otherwise listed)	FAMIS	Foster Care & Adoption Assistance	Early Intervention	FAMIS MOMS	Pregnant Women	Expansion Adults	Non-Expansion Adults	
Aetna	62,726	6,743	1,219	500	184	2,378	75,033	16,324	**165,107**
Anthem	215,018	29,503	3,988	1,393	525	5,401	98,601	37,452	**391,881**
Magellan	28,273	3,093	657	207	110	1,399	38,668	7,168	**79,575**
Optima	131,413	13,752	2,917	772	243	3,572	72,378	26,084	**251,131**
United Healthcare	58,961	8,193	945	381	153	1,746	45,205	9,578	**125,162**
Virginia Premier	135,112	15,343	3,786	895	220	3,147	74,614	25,059	**258,176**
Total	**631,503**	**76,627**	**13,512**	**4148**	**1435**	**17,643**	**404,499**	**121,665**	**1,271,032**

Source: DMAS Data as of October 2020

Appendix 2: Proposed Model of Care Guiding Principles

As described in Section 3, under the combined program, DMAS would work collaboratively with the MCOs and key stakeholders to design a member-focused model of care for the combined program that incorporates best practices from the Medallion 4.0 and CCC Plus programs, and works effectively and efficiently for the populations served. DMAS has proposed the following key guiding principles, which will be further refined in collaboration with MCOs and stakeholders as part of Project Cardinal implementation.

1. Highest need populations will continue to require higher levels of care coordination demonstrated by smaller member-to-care coordinator ratios, assessments, care plans with interdisciplinary care team collaboration/coordination, and reassessments either routine or in response to a triggering event.
2. Model of care components will apply equitably across populations based on the member's current level of need and not based on their historical managed care program enrollment (CCC Plus or Medallion).
3. Model of care will include the use of advanced analytics and methods to target interventions and maximize the use of care management resources, including data-informed solutions for identifying and stratifying populations by member need/level of risk.
4. Model of care will use technical solutions available through the Care Review Management System (CRMS) module of the MES. Determination of CRMS data elements, functions, and targeted implementation dates is pending.
5. Model of care will specify which screening assessment and care plan elements are needed by risk level, i.e., members with high, moderate, or low-no risk, including the right care management mix for low risk, well-managed populations.
6. Model of care will consider movement of members between risk levels, especially based on health related, triggering events and intensity of needed services.
7. Model of care will specify tools to be used for screening, assessments, and care planning, including recommendations for standard assessment elements.
8. Model of care will establish efficient and effective care coordination ratios by risk group and will allow for flexible tiered levels of necessary care coordination engagement, based on a member's changing clinical status and needs.
9. Model of care will specify related deliverables for State and MCOs and other Contractors.
10. Model of care should be updated and refined based on Virginia's ongoing program experience, industry standards and evidence-based practices.

Appendix 3: Description of Current Managed Care Enrollment Processes

Overview of Initial Managed Care Enrollment Processes

Initial enrollment into both managed care programs includes a similar core set of business and systems processes, many stemming from federal and state requirements. Both Medallion 4.0 and CCC Plus require mandatory enrollment for managed care-eligible populations, and both currently use a monthly managed care assignment process.

Individuals can apply for Medicaid at any time.[9] Shortly after being determined eligible for Medicaid, members who are managed care-eligible receive an introductory letter with general information about their managed care program (Medallion 4.0 or CCC Plus) and information on how they can pre-select their managed care plan through the DMAS independent enrollment broker. The enrollment broker manages enrollment-related activities for both managed care programs and is a great resource for helping members to make an informed health plan selection utilizing health plan comparison data, provider network information, MCO added benefits, choice counseling services and more. The enrollment broker also provides the platforms for members to select or change their MCO, including via phone, online, or through a mobile application (Medallion 4.0 members only).

At initial enrollment, members are either enrolled with the MCO they preselected or with a health plan auto-selected for them, following a rules-based, intelligent, auto-assignment process that varies by population. The member's managed care coverage generally begins the first day of the coming month, but is sometimes delayed to the first of the next month, meaning members typically wait 15 to 45 days in the fee-for-service program before being enrolled with their MCO. Members may change their MCO for any reason within the initial 90 days of enrollment.

Some program differences are necessary and effective and will be carried forward in the merged program. One example includes the current technical solution used for health plan intelligent assignment, which has been built based on the needs of population groups, for example, to preserve existing provider-member relationships (nursing facility, adult day health care, primary care physician, etc.) using a comparison of the member's benefit or claims history information with MCO provider network information. Another example includes the assignment process for dual-eligible members (i.e., members enrolled in both Medicare and Medicaid), where the process aligns the member's Medicaid plan with their Medicare plan, where possible. Other examples include processes built to "keep families together" and enrolled in the same plan, and to re-enroll members based on their previous MCO enrollment history.

Overview of Open Enrollment Processes

Members may change their MCO for any reason at least once every 12 months during their annual "Open Enrollment" period. DMAS sends Open Enrollment notices to members explaining the process, which is also managed by the DMAS enrollment broker. The notice provides the contact information for the enrollment broker, a health plan comparison chart, and information on the platforms for members to change their MCO, including via phone, online, or through a mobile application (Medallion 4.0 members only).

The Medallion 4.0 and CCC Plus Open Enrollment timeframes and processes differ by program and population group. Virginia Medicaid currently operates seven different Open Enrollment periods based on population and region, as outlined in the table below.

[9] Information on how to apply for Medicaid coverage can be found at coverva.org/apply/

Population	Rationale	Dates
CCC Plus	Aligns with Medicare	October 1 – December 18
Medallion 4.0	Regionally based	Roanoke/Allegheny and Southwest Regions: -December 19 – February 28 Tidewater Region: -February 19 – April 30 Central Region: -April 19 – June 30 Northern Virginia Region: -June 19 – August 31 Charlottesville/Western Halifax Regions: -August 19 – October 31
Medicaid expansion Members (CCC Plus and Medallion 4.0)	Aligns with Health Insurance Marketplace	November 1 – December 31

Overview of Medicaid Renewal Processes

Medicaid eligibility must be renewed annually. To comply with the current COVID-19 federal Public Health Emergency (PHE) Maintenance of Effort (MOE) requirements, no Medicaid coverage is terminated for individuals who fail to return or complete their annual renewal form or who would no longer be eligible for coverage due to information reported on the renewal form, with a few exceptions as federally required. The following paragraphs detail the typical Medicaid renewal process outside of the PHE.

DMAS, in conjunction with the Virginia Department of Social Services (VDSS), has been working for several years to increase the number of Medicaid renewals that can be processed automatically via the "ex parte" process, in which the state's eligibility system utilizes electronic sources, such as the IRS and state quarterly wage databases, to re-verify eligibility for another 12 months, without any follow-up needed from the Medicaid member. Approximately 40% of all Medicaid renewals successfully complete the ex parte process each month; these members stay enrolled in Medicaid with their MCO, if applicable (with the ability to change plans during Open Enrollment, as outlined above). Maintaining managed care enrollment for eligible members is critical to ensure members continue receiving the services they need.

However, the remaining renewals must be processed manually, meaning these members receive a renewal packet in the mail that they must complete timely (by mail, phone or online) in order to maintain their Medicaid coverage and managed care enrollment, if applicable. Many of these members are aged, blind or disabled[10], as Medicaid eligibility for these individuals cannot be verified in the state's electronic sources, due to resource tests and other eligibility factors (with the exception of Supplemental Security Income, or SSI, recipients, whose renewals can be processed through ex parte). Manual renewals also include members for whom the state's system attempted to complete the ex parte process, but whose eligibility could not be electronically verified. If these Medicaid members, some of the most vulnerable individuals DMAS serves, do not complete their renewal packet on time, they lose their Medicaid coverage and are dis-enrolled from their MCO. Some members who experience these lapses in coverage ultimately return their renewal packet and are re-enrolled in Medicaid fee-for-service, but they then must wait between 15-45 days for re-enrollment in their MCO through the managed care assignment process. However, this process can take substantially longer. This so-called "churn" results in substantial disruptions in care, and is a key source of member and provider complaints.

Work is already underway to improve the manual renewal process. This year, DMAS completely redesigned and streamlined the renewal packet to improve timely response rates, making it member-friendly and highlighting that members have the ability to complete their Medicaid renewal online or by phone. In July 2019, DMAS began sharing a monthly data file with its MCOs that includes all members who will need to complete a manual renewal. Last year, DMAS began a pilot collaboration with Anthem to use this monthly data to engage with these members to increase the likelihood that they will complete their renewals timely and not lose their Medicaid coverage, and by extension, their managed care

[10]Approximately 75,000 individuals were enrolled in managed care in aged, blind or disabled eligibility groups as of October 2020.

enrollment. The outreach process, which includes phone calls and sending text messages and post cards to members, has been so successful that DMAS is currently working to establish similar processes with the remaining health plans.

Appendix 4: Overview of Managed Care Authorities in Virginia

Virginia's managed care program is governed by a multitude of federal and state authorities, as follows:

- Federal Managed Care Regulations and Guidance:
  - Title XIX and Title XXI of the Social Security Act
  - Title 42 of the Code of Federal Regulations (CFR), Part 438
  - State Guide to CMS Criteria for Medicaid Managed Care Contracts
- Federal Managed Care Waivers:
  - 1915(b) Waivers (DMAS currently has two 1915(b) waivers, one for Medallion 4.0 and one for CCC Plus, which allow for mandatory managed care enrollment for certain populations for whom mandatory managed care enrollment is not allowable under the Medicaid State Plan.)
  - 1915(c) Waiver: Home- and community-based waivers operated under the CCC Plus program
- Virginia's 1115 Demonstration Waivers:
  - FAMIS MOMS and FAMIS Select
  - Building and Transforming Coverage, Services, and Supports for a Healthier Virginia (includes the Addiction and Recovery Treatment Services (ARTS) benefit)
- State Law and Regulation:
  - Provisions of Titles 32.1 and 38.2 of the Code of Virginia
  - Virginia Public Procurement Act
  - Annual Appropriations Act Requirements
  - Virginia Administrative Code (VAC) Regulations
- Medallion 4.0 and CCC Plus MCO Contracts

The managed care contracts provide the foundation for the Medicaid managed care delivery system and include all requirements of the health plans for doing business with the Virginia Medicaid program. The contracts must meet CMS rules as outlined in Titles XIX and XXI of the Social Security Act, the State Guide to CMS Criteria for Medicaid Managed Care Contracts, Title 42 of the Code of Federal Regulations (CFR), Part 438, and state laws and regulations.

Appendix 5: Virginia Administrative Code Regulations to Be Repealed and/or Changed

Regulations to Be Repealed and Replaced

- Medallion Regulations:
  - 12VAC30-120-360 Definitions
  - 12VAC30-120-370 Medallion mandatory managed care members
  - 12VAC30-120-380 Medallion MCO responsibilities
  - 12VAC30-120-390 Payment rate for MCOs
  - 12VAC30-120-395 Preauthorized, emergency, and post-stabilization services and payment rate for care provided by out-of-network providers
  - 12VAC30-120-400 Quality control and utilization review
  - 12VAC30-120-410 Sanctions
  - 12VAC30-120-420 Member grievances and appeals
  - 12VAC30-120-430 Provider grievances, reconsiderations, and appeals
- CCC Plus: (Note: As of the time of this report, these regulations are not yet finalized.)
  - 12VAC30-120-600 Definitions
  - 12VAC30-120-610 CCC Plus mandatory managed care members; enrollment process
  - 12VAC30-120-615 CCC Plus providers; Medicaid enrollment process
  - 12VAC30-120-620 MCO responsibilities; sanctions
  - 12VAC30-120-625 Continuity of care
  - 12VAC30-120-630 Covered services
  - 12VAC30-120-635 Payment rates for MCOs
  - 12VAC30-120-640 State fair hearing process
  - 12VAC30-120-650 Appeal timeframes
  - 12VAC30-120-660 Pre state fair hearing decisions
  - 12VAC30-120-670 State fair hearing process and final decision
  - 12VAC30-120-680 Appeals Division records
  - 12VAC30-120-690 Provider appeals
- CCC+ Waiver: (Note: As of the time of this report, these regulations are not yet finalized.)
  - 12VAC30-120-900 Definitions
  - 12VAC30-120-905 Waiver description and legal authority
  - 12VAC30-120-920 Individual eligibility requirements
  - 12VAC30-120-924 Covered services; limits on covered services
  - 12VAC30-120-925 Respite coverage in children's residential facilities
  - 12VAC30-120-927 Exception criteria for personal care services
  - 12VAC30-120-930 General requirements for home and community-based participating providers
  - 12VAC30-120-935 Participation standards for specific covered services
  - 12VAC30-120-945 Payment for covered services
- FAMIS:
  - 12VAC30-141-10 Definitions
  - 12VAC30-141-20 Administration and general background
  - 12VAC30-141-30 Outreach and public participation
  - 12VAC30-141-40 Appeal of adverse actions or adverse benefit determinations
  - 12VAC30-141-50 Notice of adverse action or adverse benefit determination
  - 12VAC30-141-60 Request for appeal
  - 12VAC30-141-70 Appeal procedures
  - 12VAC30-141-100 General conditions of eligibility
  - 12VAC30-141-110 Duration of eligibility and renewal
  - 12VAC30-141-130 Nondiscriminatory provisions
  - 12VAC30-141-140 No entitlement
  - 12VAC30-141-150 Application requirements

- 12VAC30-141-160 Copayments for families not participating in FAMIS Select
- 12VAC30-141-175 FAMIS Select
- 12VAC30-141-180 Liability for excess benefits; liability for excess benefits or payments obtained without intent; recovery of FAMIS payments
- 12VAC30-141-200 Benefit packages
- 12VAC30-141-500 Benefits reimbursement
- 12VAC30-141-560 Quality assurance
- 12VAC30-141-570 Utilization control
- 12VAC30-141-600 Recipient audit unit
- 12VAC30-141-650 Provider review
- 12VAC30-141-660 Assignment to managed care

Regulations to be Changed

- 12VAC30-20-60 Definition of Medicaid State Plan Health Maintenance Organization – repeal
- 12VAC30-60-200 Ticket to Work and Work Incentives Improvement Act (TWIAA) Basic Coverage Group – delete paragraph F2

Appendix 6: Proposed Rebranding Communications Timeline

Fall 2020	Winter 2021	Spring 2021	Summer 2021	Fall-Winter 2021	Summer 2022

Fall 2020	Winter 2021	Spring 2021	Summer 2021	Fall-Winter 2021	Summer 2022
- Gain approval for the brand - Compile materials needing updates - Plan engagement goals and discussions	- Ensure buy-in from internal staff and MCOs - Preparations for MCO transitions - Final logo vote with staff	- Focus groups with stakeholders - Ensure buy-in and normalization from key stakeholders, including sister agencies, community organizations, legislators, and providers	- Gain approval for the brand - Compile materials needing updates - Plan engagement goals and discussions	- Begin printing and updating materials - Develop brand awareness plans (social media toolkits, talking points, digital communications campaigns, etc.)	- Announce brand to the public, including all members and the media

VIRGINIA'S MEDICAID PROGRAM DMAS