VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION • QUALITY • VALUE

MEDICAID EXPENDITURE UPDATE

Presentation to:

External Finance Review Council

October 14, 2020

Topics

- Medicaid Accuracy Report
- Variance Analysis

Category	Base Medicaid						
	FY 2021 Official Forecast	Funding Adjustments	FY 2021 Adjusted Budget	Adjusted Budget Through August	Expenditures through August FY 2021	$ Variance (over) / under Budget	% Variance
General Medical Care: MCOs	**7,394,801,595**	**69,258,168**	**7,464,059,763**	**1,180,326,006**	**1,068,045,648**	**112,280,358**	**-10%**
Capitation Payments: Low-Income Adults & Child	2,542,289,501	(39,273,931)	2,503,015,570	405,696,461	387,204,727	18,491,734	-5%
Capitation Payments: Aged, Blind & Disabled	103,859,035	-	103,859,035	16,709,823	15,607,964	1,101,859	-7%
Capitation Payments: Duals/CCC Program	-	-	-	-	-	-	
Capitation Payments: CCC+ Program	5,053,763,217	108,532,099	5,162,295,316	841,042,538	835,074,505	5,968,033	-1%
MCO Pharmacy Rebates	(305,110,158)	-	(305,110,158)	(83,122,816)	(169,841,548)	86,718,732	104%
General Medical Care: Fee-For-Service	**1,311,336,736**	**12,438,300**	**1,323,775,036**	**232,345,686**	**182,854,259**	**49,491,427**	**-21%**
Inpatient Hospital	234,333,013	-	234,333,013	44,206,703	30,708,623	13,498,080	-31%
Outpatient Hospital	41,388,253	-	41,388,253	7,848,421	5,096,550	2,751,871	-35%
Physician/Practitioner Services	53,855,543	3,694,880	57,550,423	10,596,580	7,367,599	3,228,981	-30%
Clinic Services	85,655,762	-	85,655,762	14,117,579	13,563,193	554,386	-4%
Pharmacy	11,821,647	-	11,821,647	2,291,102	1,931,598	359,504	-16%
FFS Pharmacy Rebates	(6,685,552)	-	(6,685,552)	-	-	-	
Medicare Premiums Part A & B	366,081,490	-	366,081,490	59,619,159	62,496,900	(2,877,741)	5%
Medicare Premiums Part D	285,838,600	-	285,838,600	46,550,952	27,547,602	19,003,350	-41%
Dental	151,501,623	8,743,420	160,245,043	31,941,239	23,778,032	8,163,208	-26%
Transportation	49,836,119	-	49,836,119	8,352,962	4,413,929	3,939,033	-47%
All Other	37,710,238	-	37,710,238	6,820,989	5,950,234	870,755	-13%
Behavioral Health & Rehabilitative Services	**46,614,585**	**8,086,647**	**54,701,232**	**10,298,802**	**10,764,064**	**(465,262)**	**5%**
MH Case Management	1,753,862	-	1,753,862	329,413	287,089	42,325	-13%
MH Residential Services	18,250,553	8,086,647	26,337,200	4,877,856	6,470,835	(1,592,979)	33%
MH Rehabilitative Services	8,799,588	-	8,799,588	1,771,832	1,324,920	446,912	-25%
Early Intervention & EPSDT-Authorized Services	17,810,582	-	17,810,582	3,319,701	2,681,221	638,480	-19%
Long-Term Care Services	**1,478,757,007**	**59,802,159**	**1,538,559,166**	**276,100,527**	**262,238,200**	**13,862,326**	**-5%**
Nursing Facility	128,572,097	-	128,572,097	23,652,970	19,349,708	4,303,262	-18%
Private ICF/MRs	124,044,353	-	124,044,353	22,368,708	22,371,602	(2,894)	0%
PACE	71,500,688	-	71,500,688	11,916,781	12,981,471	(1,064,690)	9%
HCBC Waivers: Personal Support	179,658,440	-	179,658,440	31,710,623	31,601,304	109,320	0%
HCBC Waivers: Habilitation	869,498,603	59,005,404	928,504,007	167,020,684	157,728,018	9,292,666	-6%
HCBC Waivers: Nursing, EM/AT, Adult Day Care,	39,239,632	796,755	40,036,387	7,393,589	7,041,828	351,761	-5%
HCBC Waivers: Case Management & Support	66,243,194	-	66,243,194	12,037,171	11,164,269	872,903	-7%
Hospital Payments	479,042,481	13,704,766	492,747,247	76,581,385	60,420,950	16,160,435	**-21%**
Supplemental Rate Assessment Payments	877,003,536	-	877,003,536	273,354,159	156,993,405	116,360,754	**-43%**
Total Forecasted Medicaid Expenditures	**11,587,555,940**	**163,290,040**	**11,750,845,980**	**2,049,006,563**	**1,741,316,526**	**307,690,037**	**-15%**
Federal Funds	5,687,400,667	127,403,738	5,814,804,405		971,566,140		
Rate Assessment	438,501,768	-	438,501,768		68,763,110		
Coverage Assessment	-	-	-		-		
Virginia Health Care Fund	472,802,840	-	472,802,840		-		
State Funds	4,988,850,665	35,886,302	5,024,736,967		700,987,276		

Category	Medicaid Expansion						
	FY 2021 Official Forecast	Funding Adjustments	FY 2021 Adjusted Budget	Adjusted Budget Through August	Expenditures through August FY2021	$ Variance (over) / under Budget	% Variance
General Medical Care: MCOs	**3,149,157,321**	**(3,574,330)**	**3,145,582,991**	**494,158,291**	**501,144,176**	**(6,985,885)**	**1%**
Capitation Payments: Low-Income Adults & Child	2,343,718,442	(2,036,243)	2,341,682,199	367,083,319	373,002,026	(5,918,707)	2%
Capitation Payments: Aged, Blind & Disabled	-	-	-	-	-	-	
Capitation Payments: Duals/CCC Program	-	-	-	-	-	-	
Capitation Payments: CCC+ Program	805,438,879	(1,538,087)	803,900,792	127,074,972	128,142,150	(1,067,178)	1%
MCO Pharmacy Rebates	-	-	-	-	-	-	
General Medical Care: Fee-For-Service	**494,497,870**	**14,658,086**	**509,155,956**	**82,557,376**	**59,398,774**	**23,158,602**	**-28%**
Inpatient Hospital	317,299,943	-	317,299,943	51,485,488	40,228,202	11,257,286	-22%
Outpatient Hospital	74,778,356	-	74,778,356	12,082,023	6,396,411	5,685,612	-47%
Physician/Practitioner Services	48,399,033	-	48,399,033	7,922,618	5,731,508	2,191,110	-28%
Clinic Services	11,192,789	-	11,192,789	1,795,556	1,426,103	369,453	-21%
Pharmacy	11,105,463	-	11,105,463	1,850,911	1,278,296	572,615	-31%
FFS Pharmacy Rebates	-	-	-	-	-	-	
Dental	20,775,062	14,658,086	35,433,148	5,689,915	2,936,655	2,753,260	-48%
Transportation	4,159,544	-	4,159,544	693,257	608,192	85,066	-12%
All Other	6,787,680	-	6,787,680	1,037,609	793,406	244,202	-24%
Behavioral Health & Rehabilitative Services	**6,857,534**	**-**	**6,857,534**	**6,857,534**	**1,194,973**	**5,662,561**	**-83%**
MH Case Management	-	-	-	-	117,214	(117,214)	
MH Residential Services	-	-	-	-	12,199	(12,199)	
MH Rehabilitative Services	-	-	-	-	1,038,072	(1,038,072)	
Long-Term Care Services	**34,802,923**	**560,963**	**35,363,886**	**5,349,235**	**4,448,255**	**900,980**	**-17%**
Nursing Facility	20,882,272	-	20,882,272	3,149,693	899,338	2,250,355	
Private ICF/MRs	-	-	-	-	296,853	(296,853)	
PACE	-	-	-	-	164,308	(164,308)	
HCBC Waivers: Personal Support	-	-	-	-	738,245	(738,245)	
HCBC Waivers: Habilitation	13,920,651	-	13,920,651	2,106,048	2,044,048	62,000	
HCBC Waivers: Nursing, EM/AT, Adult Day Care,	-	560,963	560,963	93,494	113,897	(20,403)	
HCBC Waivers: Case Management & Support	-	-	-	-	191,565	(191,565)	
Hospital Payments	43,479,652	-	43,479,652	1,488,966	2,697,919	(1,208,953)	**81%**
Supplemental Rate Assessment Payments	386,432,899	-	386,432,899	71,112,515	130,977,697	(59,865,182)	**84%**
Total Forecasted Medicaid Expenditures	**4,115,228,199**	**11,644,719**	**4,126,872,918**	**661,523,917**	**699,861,793**	**(38,337,877)**	**6%**
Federal Funds	3,704,183,750	10,491,508	3,714,675,258		629,866,276	(629,866,276)	
Rate Assessment	38,643,290	-	38,643,290		13,097,769	(13,097,769)	
Coverage Assessment	372,401,159	1,153,211	373,554,370		56,897,749	(56,897,749)	

Medicaid Accuracy Report – August 2020
Variance Analysis

Lower FFS utilization due to COVID

BASE MEDICAID

Category	$Variance	%Variance
Inpatient Hospital	13,498,080	-31%
Outpatient Hospital	2,751,871	-35%
Physician/ Practitioner	3,228,981	-30%
Dental	8,163,208	-26%
All Other	870,755	-13%

MEDICAID EXPANSION

Category	$Variance	%Variance
Inpatient Hospital	11,257,286	-22%
Outpatient Hospital	5,685,612	-47%
Physician/ Practitioner	2,191,110	-28%
Dental	2,753,260	-48%
All Other	244,202	-24%
Clinic Services	369,453	-21%

Medicaid Accuracy Report – August 2020
Variance Analysis

Lower FFS utilization due to MOE continuous coverage in MCO

BASE MEDICAID

Category	$Variance	%Variance
Pharmacy	359,504	-16%
Mental Health Case Mgmt	42,325	-13%
Mental Health Rehabilitative	446,912	-25%
Early Intervention	638,480	-19%
Nursing Facility	4,303,262	-18%

MEDICAID EXPANSION

Category	$Variance	%Variance
Pharmacy	572,615	-31%
Behavioral Health & Rehabilitative Services	5,662,551	-83%
Long-Term Care Services (NF/PACE/HCBS)	900,980	-17%

Medicaid Accuracy Report – August 2020
Variance Analysis

Payment Timing

BASE MEDICAID

Category	$Variance	%Variance
Transportation	3,939,033	-47%
Hospital Payments	16,160,435	-21%
Supplemental Rate Assessment Payment	116,360,754	-43%

MEDICAID EXPANSION

Category	$Variance	%Variance
Transportation	85,066	-12%
Hospital Payments	(1,208,953)	81%
Supplemental Rate Assessment Payment	(59,865,182)	84%

Medicaid Accuracy Report – August 2020
Variance Analysis

All Other

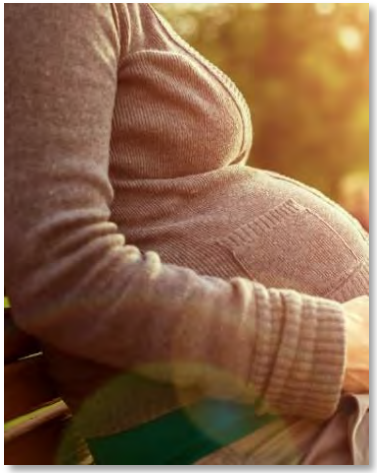
BASE MEDICAID

Category	$Variance	%Variance
Managed Care	112,280,358	-10%
Managed Care Pharmacy Rebates	(169,841,548)	104%
Medicare Premium Part D	19,003,350	-41%
Mental Health Rehabilitative Services	(1,592,979)	33%

Medicaid Accuracy Report – August 2020
Total

	Total Forecasted Base + Expansion				
	FY 2021 Official Forecast	Funding Adjustments	FY 2021 Adjusted Budget	Expenditures through August FY2021	% Spent
Total Forecasted Medicaid Expenditures	**15,702,784,139**	**174,934,759**	**15,877,718,898**	**2,441,178,320**	**15.4%**
Federal Funds	9,391,584,417	137,895,246	9,529,479,663	1,601,432,416	16.8%
Rate Assessment	477,145,058	-	477,145,058	81,860,879	17.2%
Coverage Assessment	372,401,159	1,153,211	373,554,370	56,897,749	15.2%
Virginia Health Care Fund	472,802,840	-	472,802,840	-	0.0%
State Funds	4,988,850,665	35,886,302	5,024,736,967	700,987,276	14.0%





MANAGED CARE CONTRACT UPDATE EXTERNAL FINANCIAL REVIEW COUNCIL OCTOBER 14, 2020

CHERYL J. ROBERTS
DEPUTY OF PROGRAMS AND OPERATIONS

TAMMY J. WHITLOCK
DEPUTY OF COMPLEX CARE

MCO UPDATES – FALL 2020

- End of Year for Health Plans:
  - Reminder, MCOs follow calendar year budget, therefore this is the last quarter for them to reconcile finances, develop budgets for next year, and submit accurate BOI reports
- Merger Updates:
  - Sentara/VA Premier – 80% of VA Premier is now owned by Sentara Health System – they operate as separate organizations
  - Molina/Magellan – BOI has approved merger – name changes and operational changes will occur next year
- Open Enrollment:
  - Begins in November and affects health plans, Cover VA, and members in the Exchange, Medicare, CCC Plus, Expansion
  - Plans typically offer new enhanced benefits for comparison charts
- Readmission and ER Triage:
  - Lawsuit against agency has been dismissed
  - Both fee-for-service and the MCOs have implemented the operational changes

MCO UPDATES – FALL 2020

- Appeals Process:
  - DeNovo change effective October 15, 2020
  - Process will allow members to bring new documentation to be reviewed up to the date of the appeal hearing
- Directed Payments:
  - Medallion 4.0 directed payments released for primary care providers
  - DMAS is monitoring the utilization and reimbursements
- Studies:
  - High Dollar Drugs – will be released soon - required by General Assembly to assess policies, procedures, reimbursement methods related to fast track drugs and emerging break-through technologies
  - Employment Assistance – study completed including information on the Workforce Data Trust and Referral Portal
  - Doulas – workgroup to review and make recommendations regarding doula benefit and rates for pregnant women covered by Medicaid
- Increasing Flu Immunizations
  - Partnering with the MCOs to determine their activities around flu vaccines
  - Working with VDH and MCOs on efforts/campaign to increase flu vaccines

COMPLEX CARE

- PPE:
  - Employers of Record for consumer-directed members can order masks, hand sanitizer and gloves at no cost through an online system developed with CARES Act funding
- Retainer Payments:
  - DMAS and MCOs provided retainer payments for Adult Day Health Centers and Day Support providers (March 13, 2020 – July 31, 2020)
- Civil Monetary Penalty Reinvestment:
  - Funds are available to Nursing Facilities to reduce the risk of COVID-19 transmission during in person visitation (up to $3000 for tents, plexiglass or dividers)
- EVV:
  - As of September 1, 2020, Electronic Visit Verification data elements are required for agency-directed personal care, respite and companion services claims

PROJECT CARDINAL:
MANAGED CARE PROGRAM MERGE
PROJECT DISCUSSION

EFRC Meeting

October 14, 2020

AGENDA

- Background
- 2020 Appropriations Act Directives
- Project Cardinal Value Proposition
- Next Steps: High-level Work Plan
- Key Focus Areas – Programmatic and Contractual Changes
- Implementation First Steps

Background: Virginia

- Consistent with national trends, capitated managed care is the dominant delivery system in Virginia.
- As of August 2020, Managed Care Organizations (MCOs) cover nearly 1.5 million Medicaid lives (1,234,634 Medallion 4.0 and 260,228 CCC Plus members).
- Virginia's managed care system started in the 1990s, primarily serving pregnant women, children, low-income adults, and non-dual aged, blind, and disabled (ABD) individuals. Early programs excluded community behavioral health and long term services and supports. The CCC Plus program was implemented in summer 2017.
- Over the course of the last 25 years, DMAS has worked to incrementally expand managed care to new geographical areas and new populations, with over 90% of Medicaid members currently served through managed care.

Appropriations Act Language

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."*

The 2020 Appropriations Act also includes a requirement for a report on the costs and benefits of combining the medical loss ratios (MLRs) and underwriting gain provisions (Item 313.E.7):

"The department shall conduct an analysis and report on the costs and benefits to amending the Commonwealth Coordinated Care Plus and Medallion 4.0 contracts to combine any applicable medical loss ratios and underwriting gain provisions to ensure uniformity in the applicability of those provisions to the Joint Subcommittee for Health and Human Resources Oversight. The report shall be completed by November 15, 2020."

Project Cardinal: Value Proposition

- **The ultimate goal of Project Cardinal is 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 care to our members and adds value for our providers and the Commonwealth**

  - **Adds value for members**
    - Moving to one managed care delivery system streamlines the process for members, eliminating the need for unnecessary transitions between the two managed care systems, avoids confusion for members with family members in both programs, and drives equity in a fully integrated, well-coordinated system of care
    - Allows for improved continuous care management and quality oversight based on population-specific needs
  - **Adds value for providers**
    - Streamlines the contracting, credentialing, and billing processes for providers
  - **Adds value for DMAS, its MCOs and the Commonwealth**
    - Merges the two managed care contracts, two managed care waivers, and streamlines the rate development and CMS approval processes. Moving to one streamlined contract, and combining our internal processes for contract oversight, will allow DMAS to operate with greater efficiency and effectiveness and provides enhanced opportunity for value-based payment activities to promote enhanced health outcomes

Next Steps - High-Level Work Plan: "Project Cardinal"

Develop the Plan

Research and information gathering

Working with DMAS executive leadership to develop overarching vision and feasible, phased milestones for implementation

Commence review of our current managed care contracts, 1915(b)/(c) waivers, and regulations to identify ways to combine and streamline them

High-level analysis of impact of combining programs on our IT systems, MCOs and other contractors and stakeholders

Development of budget request

July 2020 – November 2020

Phased Implementation

Phased implementation of the plan based on report findings, with required legislative and budget support from Administration/GA

Input and engagement from key stakeholders throughout the process

Implementation of Combined Program: July 2022 *(proposed)*

Additional changes, such as improvements to managed care enrollment, will be made at MES go-live.

Key Focus Areas: Programmatic and Contractual Changes

- Align MCO administrative tasks, such as reporting requirements and compliance and oversight responsibilities
- Strategic alignment for care management and models of care
  - Maintain high-touch care coordination, assessments, and interdisciplinary care planning for vulnerable/complex populations based on member need
- Streamline managed care enrollment at initial enrollment, open enrollment and renewal
  - Leverage upcoming systems updates and procurements to expedite initial managed care enrollment, keep eligible members enrolled with the health plan of their choice, and avoid disruptions in care management
- Streamline benefit enrollment for all populations
  - Transition FAMIS to enhanced match Medicaid group to ensure seamless merging of program benefits
- Implement MCO and provider-level quality and value based purchasing contract requirements that incentivize appropriate member health and program cost outcomes
- Set rates based on population characteristics as opposed to program

Implementation First Steps

Alignment of programs requires an upfront investment in order to improve the efficiency and value of the program

1. Funding for appropriate organizational structure
   - In order to keep pace with evolving Medicaid program changes, ensure proper oversight, and to forge ahead with value-driven payment initiatives, additional staffing will be required
2. IT system changes
   - Internal systems will need to be updated to effectuate the planned programmatic and contractual changes
   - Funds will also be required for updates to MCO systems, enrollment broker systems, and other vendors to combine and align contracts and processes
3. Communication materials
   - Member materials will need to be updated to reflect the single program, as well as other communication materials necessary to prepare providers and other key stakeholders for changes to the program
4. Medical costs associated with aligning contract requirements
   - As contracts are aligned and benefits updated by population, shifts in utilization and expenditures may occur

APPENDIX

VIRGINIA'S MEDICAID PROGRAM
DMAS
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Managed Care Expansion Timeline: 1993 - 2019

1993 – 2013

PCCM, Options, and Medallion II

- 1993 -Medallion primary care case management (PCCM), fee-for-service (FFS) medical home payment model
- 1995 -*Options;* MCO capitated payment model, optional enrollment,
- 1996 -Medallion II; Virginia's first mandatory, fully-capitated MCO program; phased geographically:
  - *1996 -2000 – Tidewater, Central regions*
  - *2001 -2005 – Charlottesville, Roanoke and Northern regions (PCCM in some rural areas) 2007 – Lynchburg and surrounding areas*
  - *2009 – Recession; MCOs exit some regions*
  - *2012 – Medallion II operates statewide*
- 2007 -Health & Acute Care Program; MCO covered acute services; FFS covered waiver services
- 2011-Foster Care/Adoption Assistance Pilot; began in City of Richmond
- 2013 -Medicaid Innovation Reform Commission (MIRC); 3 phases of reforms on legislative pathway to Medicaid Expansion

2014 - 2017

Commonwealth Coordinated Care

- CCC tested managed care delivery for long term services and supports (LTSS);
- MIRC Phase I Reform initiative;
- Three-year demonstration; operated under a 3-way contract with DMAS, CMS, and 3 CCC MCOs;
- Served approximately 30k dually eligible adults (on annual average)
- Fully-integrated model with care coordination, including LTSS and community behavioral health, proven as effective for LTSS populations;
- Voluntary nature promoted excessive churn and led to increased service gaps and administrative burden

2017 – 2018

CCC Plus

- Maintains coordinated/ integrated model of care; MCOs operate as D-SNP
- Statewide, with mandatory participation; achieves greater stability/ mitigates coverage gaps
- Serves all dual and non-dual aged, blind, disabled (ABD), including ABD from Medallion
- Includes community behavioral health (BH), addiction and recovery treatment services (ARTS), Common core formulary (CCF) and Emergency Department Care Coordination
- Satisfied MIRC phase 3 on legislative path to Medicaid Expansion

2017-2018

Medallion 4.0

- Maintains Medallion 3.0 best practices and MIRC reform initiatives
- Includes new populations & services,
- Aligns with CCC Plus for ARTS, CCF, BH and ED Care Coordination system
- Same 6 health plans and regions as CCC Plus
- Having statewide managed care system helped to ensure preparedness for Medicaid Expansion

2018-2019

MedEx, Refine & Align

- Jan 1, 2019 - Phased in the MedEx population; including the Governor's Access Plan (GAP) for seriously mentally ill (SMI)
- Complex MedEx individuals (including former GAP) served through CCC Plus, non-complex served through Medallion
- Continued to refine the programs and correct post start-up issues, including behavioral health
- Continued Medallion 4.0/CCC Plus alignment work

Work Plan Overview: Project Cardinal Report

Strategic Planning, Research and Analysis

- Define areas of opportunity across delivery systems (including FFS) and understand dependencies/constraints for moving forward with combining the programs

ELT Vision Development and Determining Overarching Programmatic Changes

- Including but not limited to establishing feasible implementation timeline, vision for fee-for-service/potential changes to MCO enrollment, branding/program name changes

Contract Analysis

- Analyze both contracts and conduct best practices research to determine process and components of combined managed care contract (will include input from key SMEs across DMAS)

Waiver Analysis

- Identify process and components of combining waivers, also conduct analysis of pros and cons of effectuating managed care through waivers vs. SPA

Regulatory Analysis

- Review managed care regs to flag areas that may need to be updated/changed to support combined program

Organizational/Staffing Changes

- Determine what organizational structure would best support the program and identify any proposed changes, including phasing

IT Systems Changes Analysis

- Identify high-level systems changes needed to support the combined program and determine feasible implementation timeline and cost

MCO Rate Development and Other Financial Analysis

- Determine what changes will be needed to rates/rate setting process, MLR, underwriting gain, quality withholds, etc. *(link with 313.E.7 Report)*

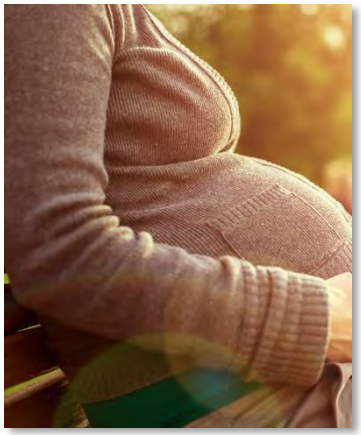
Analysis of Impacts to Other Vendors and Other DMAS Processes

- Understand impact of changes on other vendors (e.g., Maximus, HSAG, DMW, others) and other DMAS divisions/processes

Communications and Stakeholder Engagement Plan

- Establish list of public-facing communications that will need to be updated (e.g., websites, letters, etc.), create stakeholder list/high-level comms plan for implementation, assist ELT with key stakeholder engagement during planning phase





UTILIZATION AND EXPENDITURE TRENDS

EXTERNAL FINANCIAL REVIEW BOARD

October 14, 2020

Ellen Montz, PhD

Chief Deputy and Deputy for Health Economics and Economic Policy

Department of Medical Assistance Services

MCO Expenditure Dashboard

Medicaid and FAMIS Managed Care
Per Member Per Month (PMPM) Healthcare Expenditures

Select a Program or Member Eligibility Category filter to see details for the selected group:

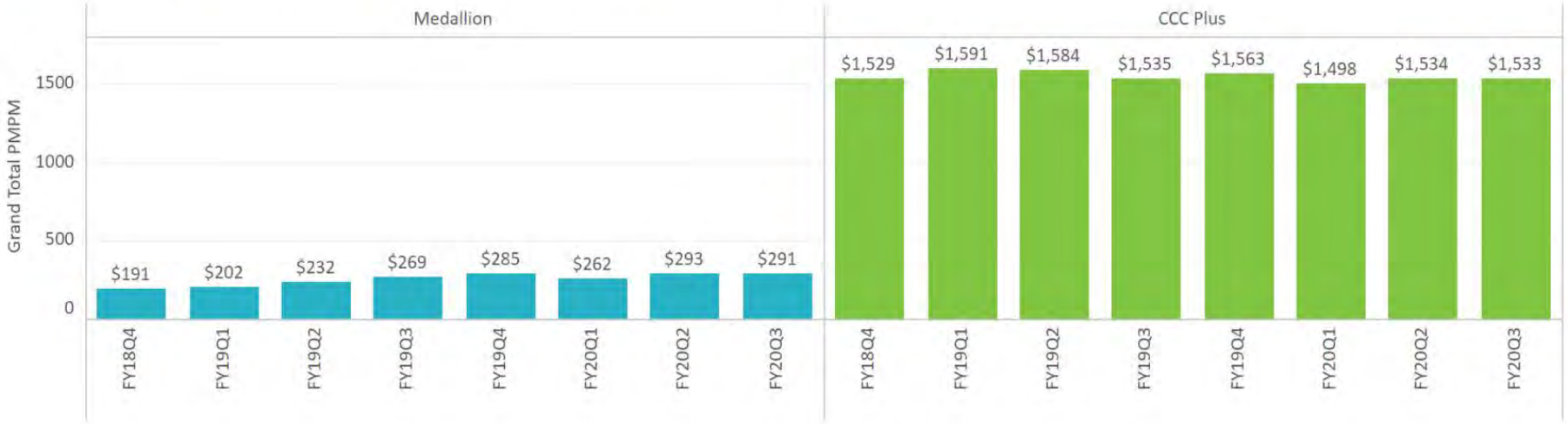
Program: (All)

Member Eligibility Category: (All)

Managed Care Program PMPM

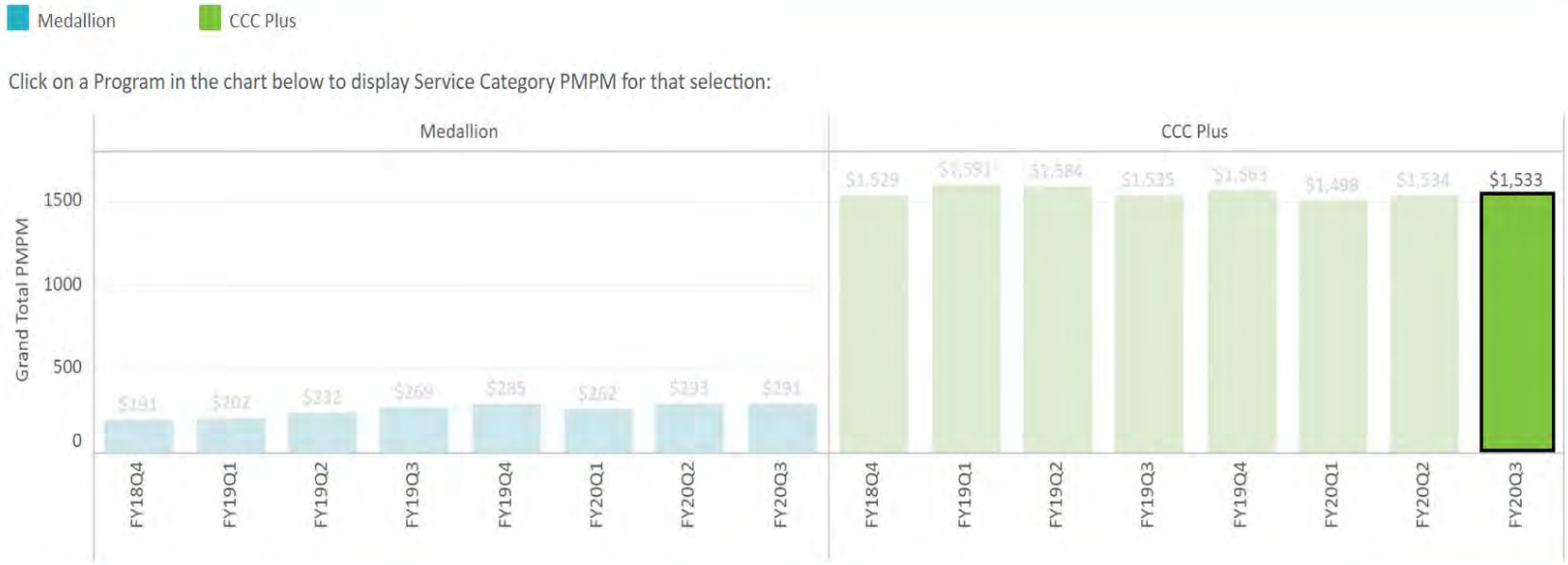
Medallion CCC Plus

Click on a Program in the chart below to display Service Category PMPM for that selection:



MCO Expenditure Dashboard

Managed Care Program PMPM



Service Category PMPM