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Department of Medical Assistance Services

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November 1, 2017

MEMORANDUM

TO: The Honorable Thomas K. Norment, Jr.
Co-Chairman, Senate Finance Committee

The Honorable Emmett W. Hanger, Jr.
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

FROM: Cynthia B. Jones Cynthia B. Jones
Director, Virginia Department of Medical Assistance Services

SUBJECT: Report on the Findings and Recommendations for Managing Spending in Virginia's Medicaid Program

The 2017 Appropriation Act, Item 310 (U)(5) states the Department of Medical Assistance Services shall assess and report on additional or different resources needed to implement recommendations in the Joint Legislative Audit and Review Committee (JLARC) report Managing Spending in Virginia's Medicaid Program. The department shall submit its report to the Chairmen of the House Appropriations and Senate Finance Committees no later than November 1, 2017.

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

CBJ/

Enclosure

pc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

Findings and Recommendations for Managing Spending in Virginia's Medicaid Program

A Report to the General Assembly

November 1, 2017

Report Mandate:

2017 Appropriation Act, Item 310 (U)(5) The Department of Medical Assistance Services shall assess and report on additional or different resources needed to implement recommendations in the Joint Legislative Audit and Review Committee (JLARC) report Managing Spending in Virginia's Medicaid Program. The department shall submit its report to the Chairmen of the House Appropriations and Senate Finance Committees no later than November 1, 2017.

Background

In 2015, the Virginia General Assembly directed the Joint Legislative Audit and Review Committee (JLARC) to conduct a study regarding the cost-effectiveness of Virginia's Medicaid program. JLARC issued three reports as part of this study, with the third and final report, *Managing Spending in Virginia's Medicaid Program*, published on December 12, 2016. The study found that total Medicaid spending increased by an average of 8.9 percent annually due to rising enrollment, though spending per enrollee was nearly flat when adjusted for inflation. The JLARC study identified strategies in which the Department of Medical of Assistance Services (DMAS or the Department) could implement potential cost-saving measures to offset the costs of rising enrollment. JLARC's recommendations align with many of the initiatives already in progress at DMAS that emphasize cost-effective and high quality services for the long-term services and supports (LTSS) population and managed care members. To address the high cost of services for the LTSS population, JLARC studied the current processes used to determine functional eligibility and appropriate services for LTSS, and considered opportunities for more cost-effective spending. JLARC recommended that DMAS develop a comprehensive training curriculum for LTSS screeners, and also recommended amending the Code of Virginia to require all screeners to be trained and certified. With more Medicaid enrollees transitioning to Medicaid managed care programs, JLARC assessed managed care cost-saving strategies. JLARC recommended that DMAS impose a stricter profit cap for the Medallion managed care program, as well as impose a profit cap for the Commonwealth Coordinated Care Plus (CCC Plus) program. Finally, JLARC recommended that DMAS use financial, utilization, and population data to improve its oversight of managed care organizations (MCOs) and to adjust capitation rates for expected inefficiencies and monitor spending.

About DMAS and Medicaid

DMAS' mission is to ensure Virginia's Medicaid enrollees receive high quality and cost effective health care.

Medicaid plays a critical role in the lives of over a million Virginians, providing health care for those most in need. Medicaid enrollees include children, pregnant women, parents and care takers, older adults and individuals with disabilities. Virginians must meet income thresholds and other eligibility criteria before qualifying to receive Medicaid benefits.

Medicaid covers primary health care services, inpatient and outpatients services that support individuals in need of behavioral health support including addiction and recovery treatment. Medicaid is also covers long term supports and services, making it possible for thousands of Virginians to remain in their homes or to access residential and nursing home care.

Quick Medicaid facts:

- Covers 1 in 8 Virginians
- Covers 1 in 3 births and 33% of children
- Supports 2 in 3 nursing facility residents

Virginia Medicaid and Children's Health Insurance Program (CHIP) are administered by the Department of Medical Assistance Services (DMAS) and is jointly funded by Virginia and the federal government under the Title XIX and Title XXI of the Social Security Act. Virginia generally receives $1 of federal matching funds for every $1 Virginia spends on Medicaid.

JLARC issued 35 recommendations in total. These recommendations have been incorporated in part in the 2017 Virginia Acts of Assembly, Chapter 836 (2016-18 Budget), as well as in House Bill 2304 (HB 2304), which amended the Code of Virginia at § 32.1-330. These legislative amendments have allocated needed resources for DMAS to implement these initiatives. DMAS has organized JLARC's recommendations into projects, and this report reflects the development of those projects. This report outlines the progress made by DMAS in implementing JLARC's recommendations.

LTSS Eligibility Screening

Uniform Assessment Instrument and Children

DMAS has made significant progress with improving the reliability of the Medicaid eligibility screening process for LTSS. The Uniform Assessment Instrument (UAI) is currently used to determine eligibility for LTSS for adults and children. DMAS completed the validation of the adult criteria used for the LTSS screening process and is in the process of validating the children's screening criteria used with the UAI to determine eligibility for LTSS. Staff is collecting evidence to validate the use of the UAI, for determining eligibility for children. DMAS plans to contact other states that have inter-rater reliability tests to discuss the feasibility of adapting one of these approaches for use in Virginia Medicaid. An inter-rater reliability test consists of two or more individuals observing a member's healthcare needs and then recording scores for specific items on the UAI. Collecting evidence and developing a process to improve the reliability of Medicaid functional LTSS eligibility determinations for children may take approximately 12 months to complete.

Hospital Screening Teams

The Department is on schedule to issue the report addressing the risks associated with hospital screenings by December 1, 2017. The report will address stakeholder involvement and the steps taken to address issues raised by relevant stakeholders, such as data collection requirements and the lengths of the screening forms. The report will also discuss the development of standardized training for hospital screening teams.

Contract for Backup Screening Teams

Currently, only 11 percent of home and community based services (HCBS) screenings are conducted after 30 days of the date of application for LTSS, with late screenings typically concentrated within a few screening teams, which include representatives from local Departments of Social Services and the local health departments. A budget amendment package to fund a contractor to conduct additional screenings in these jurisdictions, beginning July 2018 and moving forward, has been submitted and is under review.

DMAS Oversight of Uniform Assessment Screener Certification

The Centers for Medicare and Medicaid Services (CMS) awarded funding to DMAS for the purpose of developing trainings on the UAI and a certification process for all individuals who administer LTSS eligibility screenings. DMAS subsequently entered into an agreement with Virginia Commonwealth University (VCU) to develop this training. DMAS convened a workgroup of stakeholders to begin the training's development. DMAS also reviewed processes and trainings developed in other states' Medicaid programs. DMAS is actively developing modules and curriculum for the training program with stakeholder input.

Rate Setting for Managed Care

DMAS will direct its actuary to incorporate JLARC's recommendations for rate setting in managed care for rate periods effective January 1, 2018, and thereafter. Listed below is the status of these recommendations.

Capitation Rate Adjustment from Required Initiatives in the Medallion Program

DMAS and its actuary will annually evaluate expected savings from initiatives for each of its managed care programs for which it is setting rates.

Negative Historical Trends in Medical Spending and Capitation Rates

Medallion 3.0 rate setting for State Fiscal Year 2018 (SFY18) used negative historical trends in medical spending for several service categories from covered members enrolled in home and community based services (HCBS) waivers. The actuary also described in detail all the factors taken into consideration in

determining trends.

Annually Rebase Administrative Expenses for Projected Enrollment Changes

DMAS requires more information to determine the portion of the administrative costs that is fixed, which will not increase or decrease proportionately with enrollment. DMAS requested more detailed administrative cost information from the Medallion 3.0 plans, which was due on September 30, 2017. DMAS plans to hire a financial analyst to assist in obtaining and analyzing administrative cost information in SFY18. DMAS also intends to expand its administrative cost audits in the future.

Deduct Unallowable Administrative Expenses

DMAS will obtain findings on unallowable administrative expenses as part of its administrative cost audits, which will occur annually beginning with the 2018 calendar year. DMAS excluded these unallowable administrative costs when calculating the underwriting gain in its CCC Plus and Medallion 3.0 managed care contracts. The 2017 Appropriations Act includes additional staff with experience in financial analysis and contract costs for additional audits.

Ensure Capitation Rates for CCC Plus for FY18 are Budget Neutral

DMAS estimates that the capitation rates developed for the first half of SFY18 and rates under development for the 2018 calendar year, which will include the second half of SFY18, will not exceed the cost of care for the enrolled population than what would have occurred in the Medicaid fee-for-service program. Therefore, the estimated capitation rates for SFY18 are budget neutral.

Financial Oversight of Managed Care

DMAS made significant developments towards JLARC's recommendations relating to financial oversight of managed care through contract provisions and by monitoring and controlling related party spending through the rate setting process.

Contract Provisions

DMAS incorporated a contract provision regarding changes to the limit on the underwriting gain in its current Medallion 3.0 and CCC Plus contracts. This provision requires the MCOs to return one-half of the underwriting gain in excess of three percent of Medicaid premium income up to ten percent. DMAS plans to include in future contracts additional financial statement reporting requirements. DMAS is in the process of hiring additional staff with expertise in MCO financial reporting and intends to receive assistance from its actuary and audit contractors.

Monitoring and Controlling Related Party Spending through Rate Setting

In order to monitor medical spending for related party arrangements, DMAS hired a contractor to perform an audit of Medallion 3.0 medical spending in SFY15 and SFY16 for related party arrangements to be completed by the end of the 2017 calendar year. The audit will identify any excessive related party costs for the actuary to exclude from the historical spending. The actuary will use historical spending data to set capitation rates for Medallion 4.0 in SFY19. DMAS will also evaluate the audit results to determine its future audit plans for both Medallion and CCC Plus plans and how to exclude these excessive related party costs in the determination of underwriting gain for DMAS' managed care contracts. Additional staff will be responsible for monitoring the audits and directing the DMAS actuarial contractor.

DMAS also implemented a process to identify administrative expenses and enrollment changes, and to evaluate the cost impact of these changes on participating managed care plans. DMAS did not identify any administrative changes with a material cost impact as part of the Medallion 3.0 SFY18 rate setting. DMAS will continue this process for future rate setting for Medallion 4.0 and CCC Plus managed care plans.

Trend Impact and Managed Care Organizations

JLARC recommended that for rate periods effective January 1, 2018 and thereafter, DMAS direct its actuary as part of the rate setting process to adjust the capitation rate for inefficiencies. DMAS plans to hire a Director of Health Economics and Business Intelligence to be responsible for identifying potential inefficiencies in the Medallion and CCC Plus programs. Additionally, DMAS is in the process of hiring two data analysts who will assist with this process.

DMAS initiated the development of a process that allows MCOs to review utilization control measures, and also

includes monitoring the impact of utilization controls on utilization rates and spending. DMAS initiated a Request for Information (RFI) soliciting information for the development of enhanced financial reporting and cost management strategies for both managed care programs, CCC Plus and Medallion 3.0.

DMAS will issue a report, *Annual Managed Care Organization Spending and Utilization Trends Report*, that outlines the RFI response themes; DMAS' preliminary steps of data collection and analysis of utilization and spending; the review of current MCO processes to monitor utilization trends; and DMAS' next steps to improve utilization and spending reports for the managed care population.

Managed Care Performance Incentives, Reporting, Compliance and Sanctions

MCO Performance Incentive Awards

Medallion 3.0 has an active Performance Incentive Award (PIA) program, with its first payment penalty and award this past year. A PIA program requires contracted MCOs to meet specific performance requirements in order to receive incentive payments over the course of the contract. The PIA awards and penalties are proportionate to the extent by which the MCO's performance compares with benchmarks for each performance measure and the relative performance as compared against other MCOs. Total awards for all MCOs will equal total penalties for all MCOs. The MCO must comply with all DMAS incentive measures while maintaining satisfactory performance on all other contract requirements before receiving any incentive payments. The PIA program includes three operational measures and three Healthcare Effectiveness Data and Information Set (HEDIS) measures, with at least one metric pertaining to chronic conditions. The PIA program will continue through the end of Medallion 3.0, and be adjusted accordingly for Medallion 4.0.

Like Medallion 3.0, CCC Plus also includes a PIA program. The CCC Plus program is currently working with an external organization, Health Services Advisory Group (HSAG), to develop specific performance incentive program methodologies and benchmarks.

Annual MCO Report Card

For Medallion 3.0, there is an existing member-focused, quality-based consumer support reporting tool. This reporting tool reports on each MCO by National Committee for Quality Assurance (NCQA) accreditation level, and ranks MCOs based on a star rating system that includes doctors' communication, disease management, quality of children's health care, and women's health care. Medallion 3.0 enrollees have access to this tool online via the managed care help line and on the DMAS website.

As CCC Plus only commenced operations on August 1, 2017, there is insufficient data available to produce an MCO report card. DMAS staff is in the early stages of developing a report card specific to the CCC Plus program. In order to create consistency across the programs, the CCC Plus report card will be similar to the Medallion 3.0 reporting tool, but focus on LTSS. The CMS Managed Care final rule, 81 Federal Register 27497 (42 CFR Parts 431, 433, 438, et al.) requires all states to implement a report card or MCO rating system by July 2019. DMAS will ensure all report card tools comply with CMS requirements.

MCO Compliance and Sanctions

There is a compliance enforcement review process for the six contracted MCOs in the Medallion 3.0 program. The compliance enforcement review process includes reporting and enforcements (*i.e.* financial penalties, corrective action plans, etc.) which take into account mitigating factors.

The CCC Plus contract includes a thorough compliance enforcement review and sanctions program. The six CCC Plus MCOs will be routinely audited to ensure compliance with all contract requirements. If an MCO is determined to be out of compliance with one or more requirements, sanctions may be applied. Sanctions can include financial penalties; formal corrective action plans that may impact an MCO's star rating, and therefore their ability to conduct business in other states; and may also include termination of the contract.

Behavioral Health and Managed Care

JLARC recommended that, upon the inclusion of behavioral health care in managed care, DMAS shall include behavioral health utilization metrics and a behavioral health low performing provider report in its MCO contracts. CCC Plus contracts include behavioral health utilization metrics. These metrics include alcohol and drug dependence treatment, mental health services utilization, first-line psychosocial care for children and adolescents, opioid use, outpatient behavioral health encounters, and the transition of MCO members between substance abuse disorders levels of care,

including inpatient facilities and residential treatment facilities.

Beginning January 1, 2018, the CCC Plus contracts will require its MCOs to receive and utilize a DMAS report identifying low performing behavioral health providers. DMAS is identifying the tools and data needed to compile the report and furnish it to the MCOs. Currently, DMAS requires MCOs to consult the Office of the Inspector General (OIG) Listing of Excluded Individuals and Entities (LEIE) database to ensure that none of their network providers are prohibited from participating in any federally funded health program. DMAS requires MCOs to remove providers from their networks that are included on this list.

Additionally, the CCC Plus contracts will require the MCOs to establish procedures for identifying behavioral health providers who render services deemed inappropriate to meet the behavioral health needs of its members, and will also require MCOs to report the number of such providers that are dis-enrolled from the MCO's provider network. DMAS looks forward to collaborating with the MCOs to ensure all network providers meet the highest standard of care.

Managed Care and LTSS: LTSS Care Plan and Consumer Direction Oversight

LTSS Care Plan

The CCC Plus MCOs are required to develop a person-centered Integrated Care Plan (ICP) for each of its enrolled members. The MCOs tailor the ICPs to the member's needs and preferences within the contractually required timeframe. The ICPs are based on the results of the health risk assessment, which is also developed by the MCO and the member. CCC Plus requires the ICPs to address all the member's health needs, including LTSS.

The MCOs develop the ICP upon initial enrollment and at any significant change in a member's health status, such as hospitalization or a decline in a member's ability to complete activities of daily living. For members receiving personal care, adult day care, and private duty nursing services, the ICP must consider the applicable providers' Plan of Care.

MCO Consumer Direction Oversight

The CCC Plus MCOs are expected to maintain a Business Associate Agreement (BAA) with DMAS' designated Fiscal Employer Agent. The Fiscal Employer Agent provides financial management services to members who choose consumer-direction for eligible services. MCOs have a dedicated project manager for consumer directed services, and shall report updates to DMAS on the status of each task and deliverable, as defined by DMAS in the CCC Plus reporting technical manual, on a weekly basis.

300 Percent Cost Sharing Proposal

DMAS staff is in the research phase to develop a proposal for cost sharing requirements based on family income for individuals eligible for LTSS in the 300 percent of Supplemental Security Income (SSI) eligibility category. DMAS intends to have an outline of the proposal by fall 2017. CMS confirmed that only one state has a federally approved cost-sharing arrangement for the 300 percent SSI eligibility category. The approved plan is centered around a shared cost calculation on an income-based sliding scale. DMAS intends to create a plan that mirrors the existing approved model, but requires a substantial amount of data to support any proposed cost-sharing amounts. The primary challenge in developing the proposal is conducting the actuarial analysis to develop and support the amounts of the cost-sharing payments, on a sliding scale. Additionally, there is limited federal guidance on this issue.

Summary

As outlined in this report. DMAS has initiatives underway that support all of JLARC's recommendations. DMAS is actively working with relevant stakeholders to improve LTSS eligibility screenings. DMAS is developing processes and engaging with outside contractors to assist in the rate setting, financial oversight, and trend impact for MCOs. DMAS is on schedule to issue the reports requested by JLARC for 2017. The 2018 MCO contracts also include the relevant contract provisions recommended by JLARC. In addition, the allocation of remaining full time staff positions will enable DMAS to further address JLARC's recommendations. Over the next twelve months, DMAS will optimize the allocation of resources and determine whether any additional resources are needed to achieve these goals.