COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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MEMORANDUM

TO: Members of the General Assembly

FROM: Jennifer S. Lee, M.D., Director
Virginia Department of Medical Assistance Services

SUBJECT: Annual Managed Care Organization Spending and Utilization Trends Report

The 2018 Appropriation Act, Item 307 (E)(3) states: The Department of Medical Assistance Services shall report to the General Assembly on spending and utilization trends within Medicaid managed care, with detailed population and service information and include an analysis and report on the underlying reasons for these trends, the agency's and MCOs' initiatives to address undesirable trends, and the impact of those initiatives. The report shall be submitted each year by September 1.

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

JSL/

Enclosure

pc: The Honorable Daniel Carey, MD, Secretary of Health and Human Resources

Annual Managed Care Organization Spending and Utilization Trends Report

A Report to the Virginia General Assembly

September 1, 2018

Report Mandate:

2018 Appropriation Act, Item 307 (E)(3) states: The Department of Medical Assistance Services shall report to the General Assembly on spending and utilization trends within Medicaid managed care, with detailed population and service information and include an analysis and report on the underlying reasons for these trends, the agency's and MCOs' initiatives to address undesirable trends, and the impact of those initiatives. The report shall be submitted each year by September 1.

Executive Summary

A key focus of the Department of Medical Assistance Services (DMAS or the Department) is the strategic initiative to increase the Department's collection of comprehensive financial and utilization metrics, while ensuring top quality data standards with a changing managed care population. In order to accomplish these goals, DMAS is leveraging key partnerships and utilizing available data to create new, innovative solutions in crucial subject areas such as behavioral health and chronic conditions. DMAS will work on enhancing data quality and collaborating on financial and utilization metrics to facilitate actionable change in the managed care population.

Background

In December 2016, the Joint Legislative Audit and Review Commission (JLARC) completed a final report as a part of an overall study of Virginia's Medicaid Program. The report, *Managing Spending in Virginia's Medicaid Program*, produced thirty-five (35) recommendations, including increased reporting requirements and contractual obligations. As a result of the JLARC report findings and the mandate set forth by the Virginia General Assembly (noted above), DMAS took initial steps in 2017 to manage spending, including soliciting a Request for Information (RFI 2017-01). DMAS outlined those steps in last year's report.

Building upon that foundation, DMAS took the following actions in the last year:

- Expansion of resources, monitoring, and collaboration in the Medicaid managed care programs for the purpose of identifying spending and utilization trends and the underlying reasons for those trends
- Further development of data and reporting requirements, including utilizing available population health metrics and service information
- Enhancement of financial reporting requirements and oversight necessary to empower DMAS to identify and address undesirable spending trends

About DMAS and Medicaid

DMAS's 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.

Analysis of Utilization and Spending:
Building Blocks

DMAS began analyzing managed care organization (MCO) utilization and spending last year by posting the Request for Information (RFI 2017-01), which provided DMAS with critical information. The RFI included next steps and challenges for the Department to address, including the challenge of monitoring multiple populations across different managed care plans, ensuring data quality as a critical element for accurate monitoring, and emphasizing the need for analytic tools to monitor complex financial and utilization trends.

This report details DMAS's efforts to address the challenges associated with changing populations, meeting increased data quality standards, and mitigating undesirable financial and utilization trends. This report also discusses DMAS's use of population-specific metrics to guide oversight of the managed care population, increase financial oversight over MCOs, and identify the reasons behind spending and utilization trends.

Development of Current and Future Resources
Data Collection, Timing, and Changing Populations within Managed Care

DMAS oversees the data collection of the current Medicaid managed care population under Commonwealth Coordinated Care Plus (CCC Plus) and the Medallion programs. Commonwealth Coordinated Care (CCC) was a CMS dual-eligible demonstration project that operated over a span of 3 years. DMAS built upon the lessons learned from CCC to develop CCC Plus. CCC Plus is the Medicaid managed care long-term services and supports (LTSS) program serving individuals with complex care needs through an integrated delivery model across the continuum of care. CCC Plus has operated statewide since January 2018 for those qualifying populations.

DMAS began phasing its Medallion 3.0 program into Medallion 4.0 in August 2018. DMAS will fully implement the Medallion 4.0 program statewide by December 2018. Medallion 4.0 covers additional services compared to Medallion 3.0, including community mental health services. Medallion 4.0 covers a different population compared to Medallion 3.0, as complex care members have transitioned into CCC Plus. The populations for both CCC Plus and Medallion 4.0 will increase in early 2019 when the Medicaid expansion population begins enrollment into these programs. This will bring a new population of some of the neediest Virginians who previously were ineligible for coverage, such as adults with incomes at or below the 138 percent of the federal poverty level (FPL). Childless adults that meet income eligibility requirements will also be eligible for coverage. As DMAS has just began the process of implementing the new Medallion 4.0 program and is just over a year into the CCC Plus program, the collection of quality data is in the early stages and is critical for the development of accurate utilization and financial reporting. Enhanced data quality oversight is included in both managed care programs and includes the development of a Data Quality Scorecard.

DMAS is utilizing the Encounter Processing System (EPS), which is part of the new overall Medicaid Enterprise System (MES) and designed to enhance data quality through implementation of program specific business rules. Medallion 3.0 is still utilizing a legacy information system. CCC Plus, as well as Medallion 4.0, will utilize the EPS.

Key Collaborative Partnerships

DMAS is strengthening key partnerships and collaborations, both internally across divisions and externally with the managed care health plans to improve data collection and analysis. The divisions of DMAS that administer the CCC Plus and Medallion programs are collaborating to streamline communication with the managed care plans, including one-on-one meetings with individual MCOs. DMAS is also allocating additional staffing resources for these enhanced efforts, including a new Chief Health Economist to oversee data and financial analytics and business tools.

While there are population differences across the programs, the same six (6) MCOs participate in both Medallion 4.0 and CCC Plus. The managed care health plans are providing feedback about the data collection and analysis processes that are currently in place for Medallion 3.0 and CCC Plus and those that they will utilize for Medallion 4.0. Communication pathways are in place between the plans and DMAS for regular collaboration on the JLARC recommendations referenced earlier in this report, and these pathways will expand as each program matures.

Complex Analytic Tool Development

Several of the responses to the RFI stressed the importance of analytic tools, rather than static reporting

from the MCOs, to enable stronger data analysis and to identify spending and utilization trends. DMAS is addressing the need for enhanced analytic tools in several ways. The MES will help to enhance encounter data quality from both CCC Plus and Medallion 4.0. The MES includes the Enterprise Data Warehouse System (EDWS), a component that will significantly enhance DMAS's ability to analyze MCO data.

Within the EDWS, there are powerful management, analytic, and visualization tools that will allow DMAS to review and monitor plans with increased oversight and detail. As the EDWS is coming online in late 2019, DMAS staff across divisions have been working to develop reporting measures, including financial and utilization metrics. DMAS will utilize these measures to generate dashboards to identify spending and utilization trends and their root causes.

The EDWS will allow DMAS to combine a variety of data metrics, beyond encounter data, to enrich the data analytics and monitoring of the MCOs. DMAS plans that this will include information from clinical data (i.e. laboratory results) to social determinants of health (i.e. housing status), as well as information from other agencies, including the Virginia Department of Health and the Virginia Department of Social Services. More inclusive and complete data will allow DMAS to create data-driven initiatives aimed at reversing unwanted spending trends.

Review of Current Utilization Metrics and Data and Future Development

While the EDWS is under development and testing, DMAS is using existing resources as a starting point for financial and utilization metrics that will inform dashboard development. DMAS has initiated enhanced reporting requirements as part of the new managed care programs. In addition, existing monitoring tools, such as the Patient Utilization Management and Safety (PUMS) program, are still in place in both managed care programs to coordinate member care and promote proper medical management. However, data quality and the changing managed care population are still key issues to be addressed when the EDWS is implemented.

While current resources may not fully address utilization monitoring concerns moving forward, understanding the current population will give DMAS the ability to leverage known metrics while developing more in the future. DMAS will adapt and adjust as the managed care programs and Medicaid expansion shift the population.

Healthcare Effectiveness Data and Information Set (HEDIS®)

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool to monitor health plans by measuring performance in key areas of health plans across the country. These metrics encompass care and service (for some examples, see Appendix A). The National Committee for Quality Assurance (NCQA) oversees HEDIS®, and ensures all the measures have detailed specifications and apply uniformly to the health plans. Utilizing a nationally recognized tool, such as HEDIS® ensures metrics are comparable across different health plans.

Under Medallion 3.0 and CCC Plus, the MCOs submit this data annually to NCQA. DMAS can then access the results for Virginia MCOs and compare the results across plans and nationally developed benchmarks.

While HEDIS® data provides a starting point for identifying potential areas for utilization review, the data is published a year after it is collected, and therefore is not fully up to date. Additionally, currently available data does not include CCC Plus information, but will in the next reporting cycle. The change in the managed care population caused by the introduction of the Medicaid expansion population will also cause shifts in HEDIS® data trends. DMAS will need enough submitted encounter data (at least one complete year) to use HEDIS® data, or any other analytics, to enhance its understanding of critical issues raised by the expansion population.

In the meantime, Medallion 3.0 HEDIS® metrics give DMAS a solid foundation to work with the health plans in identifying spending and utilization trends. In the future, within the EDWS, DMAS will be able to review metrics similar to those collected by HEDIS®, and the metrics available within that system will provide for more timely monitoring. With these analytic tools on the horizon, HEDIS® makes a logical starting point.

Medallion 3.0 MCO Utilization Metrics

HEDIS® has measures across areas that cover both care and service within health plans. Of those many measures, twenty-nine (29) are specific to Medicaid lines of business. Some of these metrics overlap with JLARC focus areas, including behavioral health, chronic conditions, and service utilization. In Appendix A, there are examples of HEDIS® metrics covering adolescent well care visits, HbA1c diabetic testing, adult access to preventative/ambulatory health services, and follow up

care for children prescribed ADHD medication. The data covers three years of trends and compares Virginia Medicaid average rates to national Medicaid averages for Medallion 3.0. The data in Appendix A provides a sample of the HEDIS® measures that DMAS reviews to determine potential areas of concern. These examples demonstrate areas in which DMAS and the MCOs can use enhanced data analysis to improve patient outcomes and cost drivers of health care.

Enhancement of Financial Oversight

JLARC recommended enhanced financial oversight, and both the Medallion and CCC Plus programs are updating reporting requirements to address these needs. Medallion 4.0 adds contractual requirements for the MCOs that increase financial oversight and continue to expand performance incentive awards. The CCC Plus contract adds the Quality Performance Incentive Program, which grants incentive payments to the MCOs for meeting certain performance metrics in CY2019. These metrics are currently under development.

Financial Reporting Changes

Mercer, DMAS's contracted actuary, is working to create additional financial reporting templates, including alignment with the following JLARC recommendations:

- Detailed income statements that show expenses by rate cell and detailed service category;
- Balance sheets;
- Related party transactions; and
- Service utilization metrics

When these templates are final, they will be incorporated into both the Medallion 4.0 and CCC Plus technical manuals. Additionally, DMAS is working with Mercer to review areas of high cost to the managed care programs, including potentially preventable emergency department (ED) utilization.

Medicaid Innovation Accelerator Program

The Centers for Medicare and Medicaid Services (CMS) selected DMAS for a grant known as the Medicaid Innovation Accelerator Program. This program helps reduce costs and improve health by assisting states as they undergo payment and delivery system reforms. The grant focuses on capacity building in target areas, with technical support, tool development, and cross-state learning opportunities.

This grant support provides DMAS with tools to collect data and develop policy in order to identify and address spending and utilization trends associated with the treatment of behavioral health and chronic conditions. Through the grant, DMAS has worked with National Opinion Research Center (NORC) researchers to gather data on the impact a behavioral health diagnosis or a chronic condition has on Medicaid members and program spending in these areas, as well as policy options to improve associated outcomes.

This work supports a number of policies currently under development, which address undesirable spending and utilization trends using value based payment and performance accountability on quality and cost outcomes associated with care furnished to members with behavioral health and chronic conditions.

Summary

DMAS is making progress in building upon the foundation that began last year following JLARC's recommendations and the associated Budget mandate. DMAS is working to address the needs and challenges listed in the industry's responses to RFI 2017-01. These challenges include monitoring multiple populations across different managed care plans, ensuring data quality for accurate monitoring, and emphasizing the need for analytic tools as a requirement for monitoring complex financial and utilization trends.
DMAS will face a great deal of change over the next year, and with it comes the opportunity to innovate, expand, and to test the reporting framework for enhanced oversight. Over the next year, DMAS will focus on three areas:

- Ensuring that data quality initiatives are underway, as data collection of the new managed care population information will be critical in identifying undesirable spending trends within specific populations and services.
- Continuing to collaborate with MCOs and other contractors to create meaningful and actionable metrics to hold MCOs accountable for the quality and efficiency of care they provide and to mitigate any unwanted spending trends.
- Refining dashboard monitoring and reporting, and as data for the managed care populations is available, incorporating analysis of the new data moving into the following year, which will empower DMAS to identify and address new spending trends.

Appendix A: Examples of DMAS Medallion 3.0 MCO HEDIS® Performance Metrics