



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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

SUBJECT: Annual Managed Care Organization Spending and Utilization Trends Report

This report is submitted in compliance with the Virginia Acts of the Assembly – 2019 Appropriation Act, Item 307 (E)(3), which 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, M.D., Secretary of Health and Human Resources

Annual Managed Care Organization Spending and Utilization Trends Report

A Report to the Virginia General Assembly

September 1, 2019

Report Mandate:

2019 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

The Department of Medical Assistance Services (DMAS or the Department) continues to create, apply, and analyze comprehensive financial and utilization metrics based on high quality data. DMAS prioritizes efficient and effective detection of, and reaction to, spending and utilization trends. The Department has strengthened its ability to track such trends by improving information management infrastructure, enhancing data analysis capabilities, and standardizing compliance enforcement mechanisms. DMAS will continue to follow an innovative and collaborative approach to ensure that Medicaid members receive high quality care at a price beneficial to the Commonwealth.

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, DMAS took steps in 2017 & 2018 to manage spending. DMAS outlined those steps in previous reports.

Building upon that foundation, DMAS took the following actions throughout the last year in service to this charge:

- Foster collaborative partnerships and build resources, both internally and externally to improve communication and enhance problem solving capabilities,
- Strengthened managed care compliance, enforcement and oversight with enhanced reporting and data analytics,
- Targeted agency initiatives focused on value, including financial cost driver review, clinical efficiencies analyses, and dedication to using innovation to address healthcare needs in the Commonwealth.

About DMAS and Medicaid

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

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

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to close to 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.

A Changing Managed Care Landscape

Managed Care Population Overview

DMAS oversees the current Medicaid managed care population under both the Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0 programs. 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.

DMAS regionally implemented the Medallion 4.0 program, starting in August 2018 and completed in December 2018. The new program features additional services focused on its population of pregnant women and children, including foster care and adoption assistance members. Both managed care programs contract with the same six (6) managed care organizations (MCOs) across the Commonwealth.

Department Resources and Collaboration

DMAS remains committed to its core value of collaboration by working with a variety of partners in order to address the Medicaid population's complex health care needs. This commitment is also internal to the Department with increased alignment across all managed care programs, highlighting a wide range of problem solving capabilities and adaptability to best serve members.

Within the agency, DMAS created new offices and divisions for enhanced managed care oversight, including the Division of Health Economics and Economic Policy, under which are the Offices of Data Analytics and of Value-Based Purchasing. DMAS developed the division of Health Economics and Economic Policy to assist the agency in acquiring and transforming data into meaningful and useful information to guide policy-making and business operations. DMAS also created the Office of Quality and Population Health with the goal of supporting a healthier Virginia by improving Medicaid members' lives through high-quality cost effective care. That office led the development and execution of a comprehensive quality strategy, which is available on the DMAS website.

DMAS has also committed to increasing its data analytics capabilities. The new Encounter Processing System (EPS), which is part of the new overall Medicaid Enterprise System (MES), enhances data quality through implementation of program-specific business

rules. The new MES system will completely overhaul the existing systems framework and allow for increased data collection, analytic, oversight, and reporting functions for the Department. The MES includes the Enterprise Data Warehouse System (EDWS), a component that will significantly enhance DMAS' 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.

The EDWS will also allow DMAS to combine a variety of data metrics, beyond encounter data, to enrich the data analytics and monitoring of the MCOs. This will include information from clinical data (e.g., laboratory results) to social determinants of health (e.g., 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.

Managed Care Compliance and Enforcement

DMAS aligned the Medallion 4.0 and CCC Plus compliance programs in order to uniformly monitor MCO performance across all of Virginia managed care Medicaid. Both programs may issue warning letters, financial sanctions, and corrective action plans in response to non-compliance with contract terms. In instances of severe non-compliance, both programs have additional options such as the appointment of temporary management to an MCO, restriction of enrollment, and the termination of an MCO's contract.

The Medallion 4.0 and CCC Plus compliance programs have prioritized evaluating MCO performance using encounter data, developing an encounter data scorecard that will come into effect in Fall 2019. The scorecard includes six data quality measures, which allow DMAS to perform peer reviews between plans to determine if the number of transactions and amount paid are equivalent.

Strengthening Utilization and Financial Oversight

Review of Utilization of Medicaid Services and Costs

Appendix A shows the top drivers of cost in the Virginia Medicaid managed care programs for calendar year 2018, including Medallion 3.0, Medallion 4.0, Family Access to Medical Insurance Security (FAMIS), and

CCC Plus. Spending on these top services represents over 66% of total Medicaid medical service expenditures (out of forty different service categories). Appendix A reflects costs incurred by the MCOs. DMAS reimburses the MCOs using actuarially sound capitation rates based on forecasting. The services listed parallel some major national trends of drivers of healthcare costs, such as prescription drug costs. DMAS works collaboratively with the MCOs, federal and state government agencies, and key stakeholder groups to address targeted interventions in these areas.

DMAS Initiatives to Address Cost Drivers

DMAS is committed to reforming targeted cost-driving areas using innovative methods. DMAS works closely with nursing facility stakeholders and engages in regular communication to improve care. DMAS contractually incentivizes the MCOs to design member care plans to include transitioning members from facility-based services back into their communities where possible, through programs such as the CCC Plus Discrete Incentive Program that went live in the spring of 2019.

DMAS is in the initial phases of comprehensively redesigning its behavioral health program, instituting changes aimed at moving away from intensive treatment services and towards a focus on outpatient and community-based services. This is important given that almost half of the Medicaid expansion population, which began enrollment in 2019, is estimated to have a behavioral health or substance-use diagnosis. The inclusion of these services into managed care is new, and must be carefully monitored to establish utilization baselines and identify trends.

It is also important to note that high utilization of a service does not necessarily highlight an area that requires improvement. For example, high utilization of primary care physician visits is a desired outcome for the Department (see Appendix A). Primary care visits demonstrate appropriate member access to and utilization of these services, which include preventative procedures such as immunizations and well-child visits.

The drivers addressed above are useful in the development of spending strategies and targeted initiatives. However, these drivers are subject to change based on Medicaid's rapidly changing population. DMAS will continue to monitor its most resource-intensive services in order to remain prepared for upcoming trends.

Financial Reporting Changes

JLARC recommended enhanced financial oversight, and both the Medallion and CCC Plus programs are continuing to update reporting requirements accordingly. DMAS hired the Milliman Medicaid Consulting Group to independently evaluate and provide improvement recommendations for the rate setting and forecasting processes. The agency has developed a plan to respond to the 10 recommendations to improve the forecasting process.

DMAS has expanded the financial reporting to include expenditure information by line of business, detailed service categories and administrative expense categories. DMAS will be exploring financial dashboards to understand financial performance.

Clinical Efficiencies Analyses

DMAS has also been working with Mercer to begin clinical efficiency analyses under the Medallion program to target medically unnecessary or potentially preventable usage in high-cost, high-acuity settings. The first set of clinical efficiency analyses focuses on Medicaid spending associated with emergency room visits, hospital admissions and readmissions, as well as efficient utilization and management of prescription drugs.

Consistent with JLARC's recommendation to adjust capitation rates for expected efficiencies and phase in such adjustments over time, DMAS will apply 20% of identified clinical efficiency dollars to the state fiscal year 2020 Medallion capitation rates. DMAS plans to conduct a similar analysis for the CCC Plus program, and will develop performance dashboards for each clinical efficiency area, so the MCOs may better understand their relative performance.

Summary

DMAS is committed to strengthening MCO performance through the careful review of robust financial and utilization metrics. DMAS will continue to maximize the value provided to the more than 1.3 million Virginians covered under Medicaid's managed care programs through clinical care models and delivery system payment reform, while promoting the delivery of high quality services within a sustainable budget. DMAS will continue to strengthen its oversight and reporting, and will utilize complex data analytic tools and metrics to improve the quality and value of the Medicaid program.

Appendix A: Summary of Utilization & Drivers of Cost in all Medicaid Managed Care Programs

List of Top Five Medical Service Expenditures for All Managed Care Programs*, CY2018	
Pharmacy & Prescription Drugs Nursing Facilities (tie)	14.0% (tie)
Inpatient: Medical & Surgery	10.6%
Outpatient- Other**	8.0%
Community Behavioral Health Personal Care (tie)	7.9% (tie)
Physician- Primary Care	4.5%
Subtotal of Top Five Medical Service Expenditures	66.9%
All Other Medical Service Expenditure Categories	33.1%

Note: High utilization does not necessarily equate to an area that needs improvement. For example, high utilization of primary care physician visits, which include well visits and preventative services, is a desired outcome for the Department across both managed care programs.

Key DMAS Initiatives to Address Healthcare Cost Drivers:

- Department resource expansion, including specialized personnel and coordinated compliance enforcement
- Comprehensive behavioral health redesign, moving from intensive treatment services and towards outpatient and community-based services
- Contractual incentives, like the CCC Plus Discrete Incentive Program, to potentially improve health status and quality of life at a lower cost by transitioning members, where possible, from facility-based services
- Collaborative relationships with nursing facilities, MCOs, and stakeholders to address member needs
- Financial reporting and oversight enhancements, including comprehensive and detailed reporting templates
- Clinical efficiency analyses to reduce potentially preventable utilization in high-cost, high-acuity settings

*Based on Per Member, Per Month (PMPM) costs expended by the MCOs, rounded to nearest whole dollar

**Outpatient- Other: is defined as all outpatient hospital services excluding emergency department, maternity, or psychiatric services.