COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

KAREN KIMSEY
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786/7933
800/343-0634 (TDD)
www.dmas.virginia.gov

July 23, 2020

MEMORANDUM

TO: The Honorable Janet D Howell
Chairman, Senate Finance Committee

The Honorable Luke E. Torian
Chairman, House Appropriations Committee

FROM: Karen Kimsey
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 2020 Appropriation Act, Item 317(G)(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.

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, 2020

Report Mandate:

2020 Appropriation Act, Item 317 (G)(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 the best available 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, facilitating increased transparency and oversight of financial trends, and standardizing mechanisms to enforce compliance and performance. DMAS will continue to follow an innovative and collaborative approach to ensure that Medicaid members receive high quality care at an appropriate price for 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 has taken additional steps in recent years to further manage spending. DMAS outlined those steps in previous reports.

Building upon that foundation, DMAS continues to reinforce and expand the following actions in service to this charge:

- Foster collaborative partnerships and build resources, both internally and externally to improve communication and enhance problem solving capabilities,
- Enhance the frequency and transparency of Medicaid financial data,

About DMAS and Medicaid

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. Through the Medallion 4.0 and Commonwealth Coordinated Care (CCC) Plus managed care programs, more than 1.6 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 over 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.

- Strengthen managed care compliance and performance mechanisms through enforcement and oversight with enhanced reporting and data analytics,
- Targeted agency initiatives focused on value, including financial cost driver review, analyses of inefficient utilization, and dedication to using innovation to address healthcare needs in the Commonwealth.

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 Long-Term Services and Supports (MLTSS) 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. The Medallion 4.0 program is the traditional Medicaid Managed Care program and provides coverage for pregnant women and children, including foster care and adoption assistance members, FAMIS enrollees, and most Medicaid Expansion eligible adults.

Calendar Year (CY) 2019 marked the first year of full implementation for both managed care programs (CCC+ and Medallion 4.0), and the Medicaid expansion members. Both managed care programs contract with the same six (6) managed care organizations (MCOs) across the Commonwealth.

Department Collaboration

DMAS remains committed to its core value of collaboration by working with a variety of partners 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 our members.

The Department has expanded its collaboration with stakeholders outside the agency through a number of public outreach and education efforts, including the following committee and educational forums:

- **Medicaid Managed Care Advisory Committee** – This committee brings together a diverse group of representatives from the health care provider community to offer feedback and input on a range of topics related to Virginia's Medicaid program. These meetings serve as an arena for updates from DMAS staff on the Medicaid program, including financial trends and analysis, as well as topics selected by the committee's provider membership for review and discussion.

- **Medicaid Provider Managed Care Liaison Committee** – This committee convenes both MCO and provider stakeholders with the intent of fostering discussion on specific topics of interest, including a mandate to investigate initiatives and policies to foster high quality, cost-effective care, increase provider participation in the Medicaid program, and to remove administrative barriers to achieving those goals.

- **Medicaid Member Advisory Committee** – This committee focuses exclusively on the views and experiences of Virginia Medicaid Members, providing a formal method for enrollee's voices to be included in the DMAS decision-making process and to inform DMAS change management strategies.

- **Forecasting, Rate Setting, and Managed Care Educational Meetings** – DMAS hosted a series of public meetings to increase education and awareness of the timelines, information, and processes the agency uses to establish multi-year forecasts for Medicaid utilization and spending, and set annual capitation rates for its managed care programs. DMAS also hosted presentations to educate health care stakeholders and the general public on what it means to administer the Virginia Medicaid program through managed care (i.e. Managed Care 101 and 102).

- **External Financial Review Committee** – This committee convenes key legislative and executive branch stakeholders in a public forum devoted to the presentation and open discussion of the most current data on spending and utilization trends in the Medicaid program. Additionally, DMAS invites the public to attend these meetings to facilitate enhanced education and transparency.

- **Forecast Cross-Functional Meetings** – DMAS collaborates across different divisions and with our colleagues at the Department of Planning and Budget to prepare the annual Official Medicaid Forecast for publication. Pursuant to the 2020 Appropriations Act, DMAS will submit a preliminary forecast by October 15 and the Official Forecast on November 1 after consultations with DPB and the House Appropriations and Senate Finance and Appropriations staff.

Resource Development and Data Capabilities

DMAS continues to enhance its data analytics capabilities through establishment of the Enterprise Data Warehouse System (EDWS). The EDWS includes data management, analytics, and visualization tools that allow DMAS to review and monitor plans with increased oversight and detail. Additionally, DMAS can combine a variety of data metrics, beyond encounter data, to enrich the data analytics and monitoring of the MCOs. This includes 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 allows DMAS to create data-driven initiatives aimed at identifying undesirable spending and utilization trends. Most recently, DMAS used the EDWS to build MCO performance measures to evaluate potentially preventable and/or medically unnecessary service utilization for emergency department visits, hospital admissions, and hospital readmissions. Commonly referred to as Clinical Efficiency (CE) measures, these measures allow DMAS to track MCO performance in each of these areas, further facilitating sub-analysis for various demographic and geographic features of MCO membership and allowing DMAS to tailor appropriate exclusionary criteria for each measure.

Managed Care Compliance and Enforcement

DMAS continues to work toward aligning the Medallion 4.0 and CCC Plus programs. Compliance activities include updating contract language to be consistent where allowed and changes to compliance monitoring in order to uniformly enforce 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 encounter data performance by developing an encounter data scorecard that came 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. Both programs meet jointly with the MCOs wherever possible to ensure continuity in MCO performance, monitoring and messaging, where permissible, and to assure that the MCOs are able to implement changes consistently.

Managed Care Expenditures, CY 2019[1]			
Expenditure Rank	*Total Expenditures*	*Service Category*	*Annual Growth*
1	$1,677M	Outpatient Services	7.1%
2	$1,355M	Pharmacy Services	23.8%
3	$1,211M	Inpatient Services	3.6%

[1] Figure extrapolated from data included in the DMAS MCO Expenditures Dashboard available at: https://www.dmas.virginia.gov/#/mcoexpenditures.

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION • QUALITY • VALUE

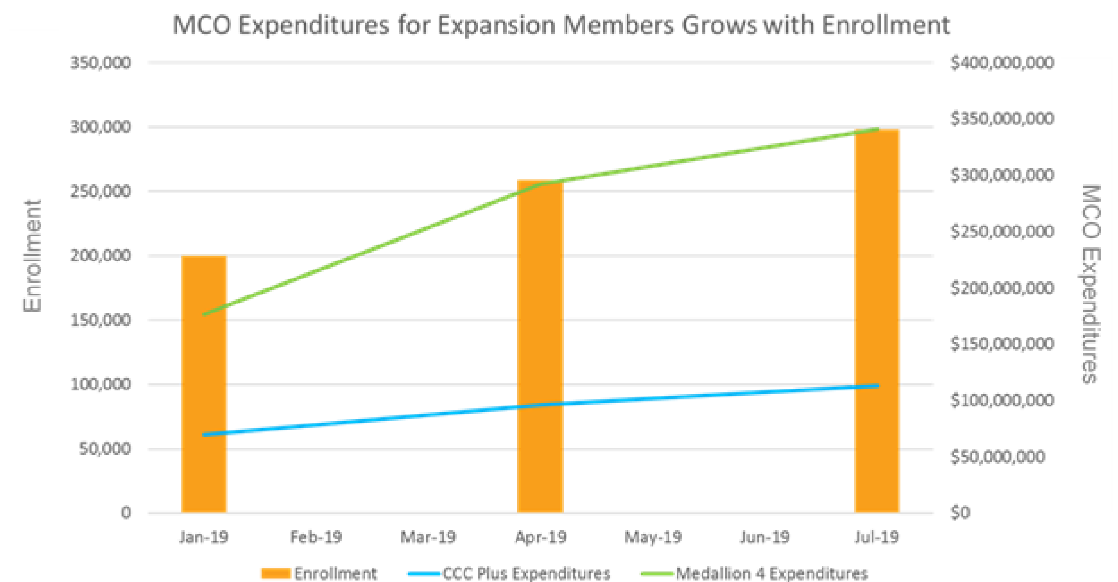
Strengthening Financial Transparency and Oversight

4	$956M	Physician Services	7.8%
5	$955M	Nursing Facility	18.4%
6	$914M	Home & Community Based Services	-1.6%
7	$571M	Community Mental Health & Rehabilitation Services	-12.5%
8	$330M	Other Services	12.3%
Growth Among All Services Categories			**8.1%**

As part of DMAS efforts to further enhance transparency around spending trends in the Medicaid program, over the past year DMAS has developed and published a number of dashboards that allow the public the ability to view, download, and analyze various components of program data, including spending and utilization data. Below are several examples of this functionality.

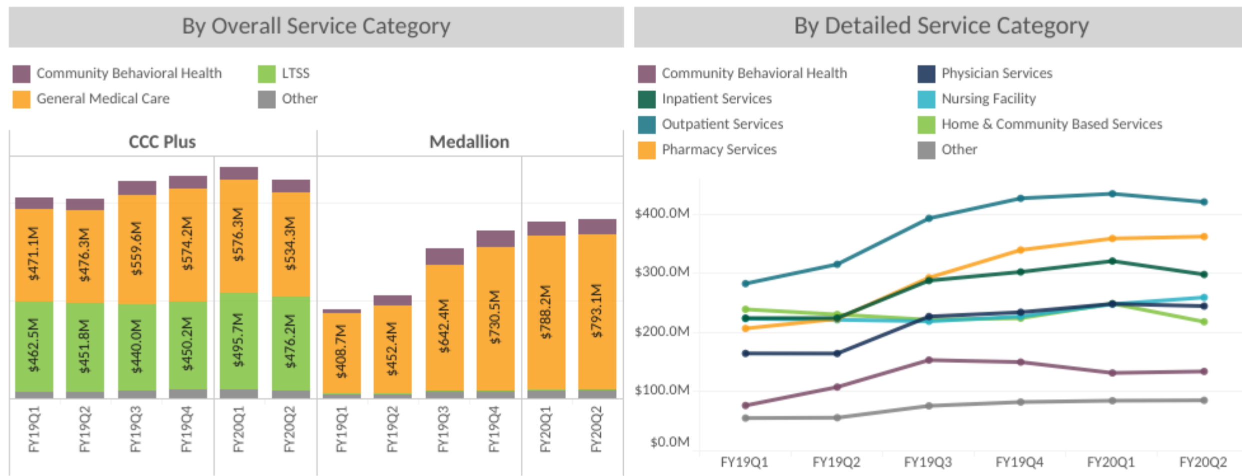
Review of Medicaid Service Expenditures

This table and graphics below highlight data extracted from the DMAS MCO Expenditures Dashboard to illustrate the top drivers of MCO spending in the Virginia Medicaid managed care programs for CY 2019, including Medallion 4.0, FAMIS, and CCC Plus.[1] Spending on these top services represents approximately 96% of total Medicaid medical service expenditures under managed care. This data reflects costs incurred by the MCOs. DMAS makes payments to the MCOs using actuarially sound capitation rates. The services listed reflect spending increases driven largely by steadily increasing enrollment within the expansion population, as illustrated by the graph above shared with the External Financial Review Committee. Spending growth analysis on a population- and per capita- basis are under development by the department and will be deployed during FY 2021.



VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION • QUALITY • VALUE

These figures also parallel some major national trends of drivers of healthcare costs, such as rising prescription drug costs, as well as services more specific to the Medicaid population, such as community mental health and rehabilitation services. DMAS works collaboratively with the MCOs, federal and state government agencies, and key stakeholder groups to address targeted interventions in these areas.



Footnotes / Definitions

1. **Managed care organizations** (MCO) are contracted private health plans that manage membercare needs. Plans are paid on a monthly capitated basis.
2. The **CCCPlus program** is a long-term services and supports program. This mandatory Medicaid managed care program serves individuals with complex care needs through an integrated delivery model that includes medical services, behavioral health services and long-term services and supports. Additional information is available at http://www.dmas.virginia.gov/#/cccplus.
3. The **Medallion Program** covers (1) children, (2) low income parents and caretaker relatives living with children, (3) pregnant women, (4) FAMIS members, (5) current and former foster care and adoption assistance children and (6) newly eligible Medicaid Expansion adults. Visit http://dmas.virginia.gov/#/med4 to learn more.
4. The **Service Category** is the type of medical care provided.
5. **Community Behavioral Health** includes services such as behavioral therapy, day treatment and partial hospitalization, community treatment, and other mental health services.
6. **General Medical Care** includes services such as inpatient and outpatient care, pharmacy services, and physician services.
7. **Long-Term Services and Supports** are for members who are elderly or have a chronic disability that requires ongoing services and supports in order to meet their functional needs. LTSS under Medicaid include, but are not limited to, Personal Care, Respite Care, Companion Care, Adult Day Care, nursing, and other rehabilitative and habilitative services and supports that help maximize their independence.
8. The **Other** service category includes services such as non-emergency medical transportation and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for children.
9. **Expenditures** are based on the date a service was provided per submitted claims. To account for lag time between when a service was rendered and claim submission, quarter expenditures are presented 4 months after the end of the quarter.

Medicaid Expansion Access and Utilization

Given the high level of interest in the size and utilization of the Medicaid Expansion population, DMAS released a publicly available dashboard for Medicaid Expansion Access and Health Services.[2] The agency updates the underlying data in this dashboard on the 1st and 15th of every month, allowing reviewers to see the most current data. The dashboard includes features that allow external entities to track not only total enrollment, but also high-level service use and the prevalence of select conditions and treatments within the expansion population. Additionally, the dashboard allows the user to select and isolate certain counties and extract data for the selected location or the entire Commonwealth.

Medicaid Expansion Access and Health Services

Report Date
6/15/2020

Measure	Members
Current Member Enrollment	431,096
Any Service Received	411,978
At Least One Office Visit	323,467
At Least One Prescription	337,476
Treated for High Blood Pressure	62,312
Treated for Diabetes	33,788
Treated for Asthma	14,826
Treated for Chronic Obstructive Pulmonary Disease (COPD)	10,220
Treated for Cancer	7,804
Received Addiction and Recovery Treatment Services (ARTS)	31,018

Access and Health Services by Locality

© 2020 Mapbox © OpenStreetMap

Number of Members: 5 – 29,888

Footnotes

1. The number of members served is not displayed for localities with fewer than 20,000 residents or when totals for a given service are fewer than 10 members per Department policy to protect the privacy of members.
2. Addiction and Recovery Treatment Services (ARTS) are services based on the American Society of Addiction Medicine continuum of care and includes office-based opioid treatment, outpatient opioid treatment, counseling, intensive outpatient programs, partial hospitalization, residential treatment, withdrawal management, care coordination, and peer support.
3. The total number of members served is cumulative and includes members enrolled at any point since January 1, 2019 to June 15, 2020. Members may no longer be enrolled as of the most recent update.
4. The number of members served is identified through paid claims submitted to the Department as of the most recent update. Due to lag in claims submission, additional services may have occurred but are not represented here.

[2] DMAS Open Data, Medicaid Expansion Access and Health Services Dashboard available at: https://www.dmas.virginia.gov/#/accessdashboard

DMAS Initiatives to Address Cost Drivers

DMAS is committed to reforming targeted cost-driving areas using innovative methods. One example is in the CCC Plus program where, in addition to working closely with nursing facility stakeholders and engaging in regular communications to improve care, DMAS also contractually incentivizes the MCOs to design member care plans to include transitioning members from facility-based services back into their communities when clinically appropriate, through programs such as the CCC Plus Discrete Incentive Program that went live in the July 2019. Both DMAS managed care programs also include Performance Withhold Programs (PWP), which place one percent of MCO capitation payments at risk based on MCO performance against six key metrics relevant to the Medallion 4.0 and CCC Plus populations (see table below). The PWPs include a range of metrics focusing on high-acuity utilization, active member follow-up, and use of high-value, preventive services. 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. Primary care visits demonstrate appropriate member access to and utilization of these services, which include preventative procedures such as immunizations and well-child visits.

PWP Performance Measures	
Medallion 4.0	*CCC Plus*
Adolescent well-care visits	Follow-up after emergency department visit for alcohol or other drug dependence
Childhood immunization status – combo 3	Initiation and engagement of alcohol and other drug dependence treatment
Prenatal and postpartum care	Heart failure admissions rate
Asthma admission rate	COPD and asthma in older adults admissions rate
Follow-up after emergency department visit for mental illness	
Comprehensive diabetes care	

Prior to COVID-19 and the un-allotment of funding for the enhancement of behavioral health services, DMAS was in the initial phases of submitting draft service definition proposals to CMS, establishing rates, and operationalizing medical necessity criteria for behavioral health services designed to provide comprehensive community behavioral health supports and treatment. The enhanced behavioral health system aims to move away from an over-reliance on intensive, inpatient treatment services and towards a focus on building a more robust outpatient and community-based continuum of care. This is important given that the Medicaid expansion population includes many of those members previously covered through the Governor's Accelerated Program, a coverage group focused on those with significant behavioral health needs. The inclusion of these services into managed care is new, and must be carefully monitored to establish utilization baselines and identify trends.

The data on spending and utilization 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.

Clinical Efficiencies Analyses

As referenced earlier, DMAS' work on CE analyses continued over the past year with the creation of three performance measures targeting medically unnecessary and/or potentially preventable usage in high-cost, high-acuity settings (emergency room visits, hospital admissions and readmissions). With the completion of these measures, DMAS can now track MCO performance in each of these areas relative to performance improvement targets set by the Department. More information on the CE performance measure rates and methodologies, including demographic and diagnostic breakdowns, exclusionary criteria, and other relevant context for how these measures apply to MCO performance are on the "About Medicaid" section of the DMAS website. Below are top-line rates for each DMAS managed care program based on CY 2019 performance. CY 2019 will serve as the baseline year against which DMAS will evaluate CE measure improvement.

Clinical Efficiency Performance Measure Rates for CY 2019		
CE Measures	*Medallion 4.0 Rates*	*CCC Plus Rates*
Low-Acuity Non-Emergent (LANE) Emergency Room Visits	27.0 LANE ER visits per 1,000 member months	43.1 LANE ER visits per 1,000 member months

Hospital Readmissions	6.4% rate of hospital readmission	18.8% rate of hospital readmission
Potentially Preventable Hospital Admissions (PPA)	0.27 PPAs per 1,000 member months	2.94 PPAs per 1,000 member months

Under the CE program, MCOs have a portion of their capitation payments withheld to potentially earn back by achieving targeted utilization reductions in these key areas. This evolution of the CE analyses allows DMAS to meet a JLARC recommendation to adjust capitation rates for expected efficiencies, while also rewarding those MCOs that are successful in removing inefficient utilization from the system through improved member care outcomes. Each MCO receives detailed reports on the CE performance measures, specific to its enrollment, including information on performance targets, overall measure performance, performance within various demographic and geographic sub-groups, and key diagnoses and conditions driving inefficient utilization. The CE program exists in both the Medallion and CCC+ starting in SFY 2021.

Financial Reporting Changes

JLARC recommended enhanced financial oversight, and both the Medallion and CCC Plus programs are continuing to update reporting requirements accordingly. The Finance and Office of Data Analytics teams also hold regular meetings to track utilization and enrollment in DMAS programs and collaborate on specialized data requests.

Additionally, as discussed earlier, DMAS has expanded the financial reporting to include expenditure information by line of business, detailed service categories and administrative expense categories. This information can be found in publicly available dashboards for MCO Expenditures and Financials available on the DMAS website (https://www.dmas.virginia.gov/#/dashboards). Beginning in the first quarter of CY 2019, MCOs are separately reporting experience for the Medicaid base and expansion populations separately.

DMAS will continue to transition static reporting data into dynamic dashboards to improve public transparency and understanding. In addition to MCO financials, DMAS has released an updated Forecast to Actuals Dashboard based on DMAS's monthly Medicaid Expenditures report. The DMAS Financial Reports website will help visitors find information on expenditures, enrollment, MCO performance, past Forecasts, and a wide selection of other Finance Reports (https://www.dmas.virginia.gov/#/financereports).

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 1.6 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.