COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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October 26, 2021

MEMORANDUM

TO: The Honorable Janet D. Howell
Chair, Senate Finance and Appropriations Committee

The Honorable Luke E. Torian
Chair, House Appropriations Committee

The Honorable Mark D. Sickles
Vice Chair, House Appropriations Committee

Daniel Timberlake
Director, Virginia Department of Planning and Budget

FROM: Karen Kimsey
Director, Virginia Department of Medical Assistance Services (DMAS)

SUBJECT: Operational Savings and Costs for Consolidating the Department of Medical Assistance Services Medicaid Managed Care Programs

This report is submitted in compliance with the Virginia Acts of the Assembly – Item 313.EE.3 of the 2021 Appropriations Act, which states:

"The Department of Medical Assistance shall undertake a review of current contracts and staffing to determine the operational savings that would result from merging the Commonwealth Coordinated Care Plus and Medallion 4.0 managed care programs. The department shall report on its review of such administrative cost savings and merger-related costs by October 1, 2021 to the Department of Planning and Budget and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees.

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

Karen Kimsey
Enclosure

Pc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources

Operational Savings and Costs for Merging the Department of Medical Assistance Services Medicaid Managed Care Programs

A Report to the Virginia General Assembly — *October 1, 2021*

Report Mandate:

HB 1800 (Chapter 552) Item 313.EE.3: *"The Department of Medical Assistance shall undertake a review of current contracts and staffing to determine the operational savings that would result from merging the Commonwealth Coordinated Care Plus and Medallion 4.0 managed care programs. The department shall report on its review of such administrative cost savings and merger-related costs by October 1, 2021 to the Department of Planning and Budget and the Chairs of the House Appropriations and Senate Finance and Appropriations Committees."*

Report Summary:

DMAS will unify the contracts for the Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0 managed care programs effective July 1, 2022 through its Cardinal Care initiative. Consolidating the programs under one contract will enable the Department to ensure better continuity of care for members, eliminate redundancies, and improve the programs' focus on the diverse and evolving needs of the populations served. Cardinal Care will require some upfront investment for systems, operational development, and communications costs. Over time, Cardinal Care is expected to bring administrative efficiencies, which will provide DMAS with enhanced capacity to focus on strengthening and refining its monitoring and oversight policies, processes, and systems. This report provides relevant background information and describes the anticipated costs, savings, and benefits associated with the Cardinal Care initiative. The report includes the following sections:

- Section 1 provides relevant background information describing the Department's current and future managed care delivery models.
- Section 2 describes DMAS's operational expenses.
- Section 3 describes MCO operational expenses.
- Section 4 examines benefits realized through Cardinal Care.
- Section 5 describes other recommended program alignment.
- Section 6 provides a summary conclusion and highlights next steps.

Related Reports

- The Department's Proposed Plan for Merging its Managed Care Programs, November 24, 2020: https://rga.lis.virginia.gov/Published/2020/RD567/PDF
- Combining Minimum MLRs and Underwriting Gain Limits for Medallion 4.0 and CCC Plus, November 15, 2020: https://rga.lis.virginia.gov/Published/2020/RD689/PDF
- The Department's analysis of the impact of merging the separate Family Access to Medical Insurance Security (FAMIS) population into a single Children's Health Insurance Program children's eligibility group under Medicaid, per Item 313.EE.2: https://budget.lis.virginia.gov/item/2021/2/HB1800/Enrolled/1/313/

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 for nearly 1.9 million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as 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 more than 500,000 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.

Section 1: Background

The Virginia Department of Medical Assistance Services (DMAS) plays an essential role in the Commonwealth's health care system by offering lifesaving coverage to one in five Virginians, including more than 580,000 newly eligible adults through the Medicaid expansion benefit. Similar to national trends, managed care has emerged as the primary delivery system in Virginia, providing coordinated care to Medicaid members and providing budget predictability to the Commonwealth.[1] Over the past 25 years, DMAS has expanded its managed care programs to cover members residing throughout the Commonwealth, while adding new eligibility populations and including additional services. Virginia's managed care organizations (MCOs) have worked collaboratively with DMAS to implement many high-priority initiatives, including addiction and recovery treatment services (ARTS) program, Medicaid expansion, the response to COVID-19, and many other important initiatives aiming to improve the health and well-being of Virginians. As the managed care delivery system continues to mature, DMAS has worked to establish more real-time and data-driven oversight and monitoring processes as well as implement new programs aimed to ensure maximum value for managed care dollars the Commonwealth spends.

Nearly 95% of full-benefit Medicaid and Family Access to Medical Insurance Security (FAMIS) members currently receive services through MCOs. DMAS currently operates two separate managed care programs: Medallion 4.0, which largely includes children, pregnant individuals, and expansion adults; and CCC Plus, which includes medically complex populations, such as members receiving long-term services and supports (LTSS), those with severe mental illness, and dual Medicare-Medicaid eligible members. Although two separate programs with two separate contracts, the same six MCOs participate in each program, resulting in a total of twelve MCO contracts.[2] As they exist today, the contracts are generally similar, but have notable differences in contractual requirements around compliance and oversight, reporting, care coordination activities (often referred to as the "model of care"), provider network focuses, and quality and value-based purchasing programs and metrics, as further described in Appendix 1.

As required by the 2020 General Assembly Appropriations Act, DMAS examined the programs as a whole to identify opportunities to derive greater value from its managed care delivery system, publishing its plan for merging its managed care programs in a legislative report last fall.[3] As shared in its plan, DMAS will aim to reduce confusion about its various programs by rebranding the Virginia Medicaid program as Cardinal Care for a clearer identity and a more unified agency voice. Members transitioning between programs were often confused by the two separate programs; rebranding and unification will reduce this confusion and improve continuity of care for members as their health evolves over time. The 2021 Appropriations Act authorizes and provides funding for DMAS to combine the CCC Plus and Medallion 4.0 contracts effective July 1, 2022.[4]

Beginning July 1, 2022, DMAS will operate as a single managed care program through one managed care contract. While this initiates the Cardinal Care managed care program, additional integration and contract improvements will require a phased approach as described in the "Report on DMAS Plan to Merge Managed Care Programs."[5] This initial phase will focus on consolidating contract language, establishing a single oversight system for all populations, and developing a model of care that sets care coordination requirements based on the health risks and needs of the member. This initial phase will include minimal system changes for July 1, 2022. These will be sufficient in scope to adequately support the consolidated program, in a manner that mitigates risk to the Department's Medicaid Enterprise System (MES) testing activities and launch date. Continued improvements for a more complete integration of the two programs will continue to occur in 2023 and 2024, including enhanced systems capacity for expedited and continuous managed care enrollment, improved care management, and more effective data-driven oversight and monitoring activities. Changes will occur gradually, depending on staffing resources, systems capacity, funding, and a deliberative and strategic plan to ensure that the program functions to deliver the best care at the best value to its members. DMAS has also contracted

[1] The risk-based nature of managed care contracts, in which DMAS pays the MCOs the same monthly capitation rate regardless of actual utilization, provides the state with fixed per-member-per-month expenditures, resulting in greater budget certainty.

[2] Medallion 4.0 contract: https://www.dmas.virginia.gov/#/med4information; CCC Plus contract: https://www.dmas.virginia.gov/#/cccplusinformation

[3] https://rga.lis.virginia.gov/Published/2021/RD337

[4] https://budget.lis.virginia.gov/item/2021/2/HB1800/Enrolled/1/313/

[5] https://rga.lis.virginia.gov/Published/2020/RD567/PDF

with Manatt Health, a national consulting firm with extensive Medicaid expertise, to bring national best-practices to the Cardinal Care program design and contract language, as well as gather relevant stakeholder input, examine reporting deliverables, and develop a comprehensive model of care for the consolidated contract. Additional details on contract consolidation focus areas are provided in Appendix 1. Manatt's scope of work also includes an evaluation of the Department's overall system of monitoring MCO performance and compliance. As part of this evaluation, Manatt Health will provide recommendations for how DMAS can streamline its MCO reporting deliverables and strengthen its operational infrastructure to ensure effective reporting, monitoring, and oversight to drive continuous quality improvement.

As directed in the 2021 Appropriations Act, the following is DMAS's report on its review of current contracts and staffing to determine the related costs and operational savings anticipated from merging the Commonwealth Coordinated Care Plus and Medallion 4.0 managed care programs.

Section 2: DMAS Operational Expenses

As part of the unification of Medallion 4.0 and CCC Plus through Cardinal Care, DMAS will need to modify the Department's IT systems and organizational structure to appropriately support the unified managed care delivery system, improve capacity for effective monitoring and oversight, and drive state priorities for value based care and improved health outcomes. Such modifications will require upfront investments, especially for DMAS IT systems changes, as described in Appendix 2. Costs also include funding for consultant services (Manatt Health) to help merge the contract language and identify contract and organizational improvement areas and effective solutions. Other costs include stakeholder communications, member materials, and other vendor costs. Similarly, MCOs will have upfront administrative costs, which would be included in the administrative component of their capitation payment. These MCO costs are described in the section 3.

Implementation of this initiative is expected to cost just over $1,000,000 in general funds in state fiscal year 2022, as allotted by the General Assembly. DMAS expects that in SFY 2023, an additional $421,498 in general funds ($1,188,142 in nongeneral funds) will be required to ensure systems changes are implemented and that managed care oversight is maintained and improved. Additional details regarding the use of currently allotted and requested funds is detailed in Appendix 3.

Administrative Contracts

DMAS examined its current contracts to compare the cost-related elements and potential for operational savings that would result from unification of the Commonwealth Coordinated Care Plus and Medallion 4.0 managed care programs. These contracts include the enrollment broker, external quality review organization, actuary, and mailing vendor. As the populations and services covered under Cardinal Care managed care will not change, impacts on these vendors are expected to be minimal. While some deduplication of services may generate savings, the number of members will remain stable, requiring similar staffing and services for mailings and enrollment. Additionally, higher risk populations served through the combined Cardinal Care MCO contract will continue to require specialized services and quality reviews. Slight savings may be generated long-term due to a reduction in enrollment changes associated with members switching programs from Medallion 4.0 to CCC Plus or vice versa. However, these savings are likely to be modest and long-term in nature. Furthermore, DMAS expects modest upfront costs to the enrollment broker contract, due to necessary structure and system changes to ensure correct enrollment.

Organizational Structure

DMAS operates the Virginia Medicaid program, which provides healthcare coverage to nearly 1.9 million Virginians. Currently, the program is operated through 4 separate programs/delivery systems: 1) Medallion 4.0, 2) CCC Plus, 3) Fee-For-Service, and 4) FAMIS (Virginia's CHIP program). The operations of these programs is carried out by 508 full-time staff and 80 wage positions allotted to the agency and a $318 million administrative budget (1.8% of the

Department's total budget).[6] Detailed information about DMAS's organizational structure, including responsibilities and core functions by Division is provided in the Department's Annual Organizational Report to the General Assembly.[7]

DMAS currently operates its managed care programs through two separate divisions: Health Care Services, which oversees the Medallion 4.0 program, primarily serving children, pregnant individuals, and expansion adults; and Integrated Care, which oversees the CCC Plus program that serves medically complex populations, such as members receiving long-term services and supports (LTSS), those with severe mental illness, and dual Medicare-Medicaid eligible members. Additionally, as limited benefit members and all new enrollees enter Fee-for-Service for a period of time, DMAS must also ensure an adequate organizational structure for fee-for-service members. However, as the agency has shifted more towards a managed care framework, several DMAS divisions have evolved to support both fee-for-service and managed care programs. These support divisions include: the Appeals Division, Program Integrity Division, Provider Reimbursement Division, Behavioral Health Division, High Needs Supports Division, the Office of Quality and Population Health, Enrollment and Eligibility Services Division, the Office of Value-Based Purchasing, Information Management Division, Office of Strategic Communications, Office of the Chief Medical Officer, Policy and Regulations Division, Division of Constituent, Legislative, and Intergovernmental Affairs, and the Office of Data Analytics. Additionally, DMAS maintains a separate CHIP program, FAMIS, which currently operates only in the Medallion 4.0 program. DMAS must maintain separate contract standards, benefit structures, systems and expertise for this relatively small subset of the population of approximately 80 thousand of the 1.4 million Medallion 4.0 members. Section 5 describes DMAS recommendations for transitioning FAMIS into CHIP-funded children's Medicaid to create a unified Virginia Medicaid children's program, including how this transition is an important component of fully aligning the Department's managed care programs. Additional details regarding Medicaid and FAMIS populations covered through managed care are available in Appendix 4.

Under Cardinal Care, the managed care program will continue to serve the diverse needs of nearly 1.7 million of the 1.9 million Medicaid enrolled individuals.[8] Cardinal Care managed care will continue to include members with complex health conditions, and continues to provide coverage for most Medicaid covered benefits[9], including maternal and child health services, behavioral health services, nursing facility, community based long-term services and supports, pharmacy, home health, etc. DMAS believes that all current staffing resources remain necessary to implement and oversee the overall operations of the Cardinal Care managed care program. DMAS may require additional staffing, staff training, and new staff talent, to develop and maintain enhanced monitoring processes for the merged program, based on pending assessment and recommendations from Manatt. This also follows national recommendations, as summarized in a recent study by Mckinsey and Company, that ". . . *state Medicaid agencies are facing an increasingly complex and difficult set of challenges at a time when the expectations of multiple stakeholders—members, families, and advocates; providers and MCOs; the federal government, state leaders, and other state agencies—are rising. If Medicaid agencies are to address these challenges successfully, the role they play must evolve. . . These Agencies of the Future will have to be able to chart a strong strategic direction and execute the activities that follow both efficiently and effectively. To accomplish those goals, they will need to use a data-driven approach to program management, build new capabilities, and improve their organizational health."*[10]

A 2019 analysis by the Center for Health Care Strategies (CHCS) indicated that the current DMAS structure is aligned with other Medicaid agencies across the country. However, by national standards, it appears DMAS operates on an exceedingly narrow administrative margin, with just 1.8% of the total budget used for administration of the programs. By comparison, based on a 2013 Milbank Memorial Fund study, the typical Medicaid program devotes approximately 5% of its total expenditures to administration of the program.[11] MACPAC also noted concern related to this on average 5%

[6] https://www.dmas.virginia.gov/media/3294/bmas-orientation-04-26-2021.pdf

[7] Department of Medical Assistance Services (DMAS) Annual Organizational Report FYE 2021 – August 15, 2021 available here: https://rga.lis.virginia.gov/Published/2021/RD337

[8] "Medicaid" refers to the program as a whole, inclusive of all beneficiaries served by DMAS, including those enrolled in the Family Access to Medical Insurance Security (FAMIS) program.

[9] A few services are carved-out of managed care contracts and covered through fee-for-service, such as dental, school health services, developmental disability (DD) waiver and DD case management services, therapeutic foster care case management; members are also disenrolled from the MCO upon entry to certain facilities, such as psychiatric residential treatment, state mental health facilities, DD intermediate care facilities, government owned nursing facilities, and veteran's nursing facilities.

[10] https://healthcare.mckinsey.com/medicaid-agency-future-what-capabilities-and-leadership-will-it-need/

[11] https://www.milbank.org/wp-content/files/documents/Milbank_Memorial_Fund_Medicaid_Leadership_Executive_Summary.pdf

administrative estimate across Medicaid programs, as part of their report to Congress on Medicaid and CHIP, and further states that this estimate of 5% has remained relatively constant over time, and has not kept pace with the evolution and expansion of Medicaid programs. Moreover, MACPAC noted that administrative capacity constraints hinders states' ability to meet program requirements and to implement proactive activities in the areas of oversight, monitoring, quality, value based delivery system and financing reforms. [12]

Currently, as new initiatives are implemented through DMAS, staffing resources are scarce due to their multiple roles and program priorities. This has been particularly evident during the COVID-19 pandemic, during which staff were expected to maintain program operations while implementing critical policy changes to ensure adequate care, coverage, and provider payments were implemented. As a result, DMAS relied heavily on contractor support to supplement staffing shortages. DMAS expects unification of the two managed care programs to bring some efficiencies to program operations, which will enable staff to use their time more effectively to improve the experience for members, and improve oversight of MCOs. Additional staffing may be required to ensure more robust oversight and monitoring and to continue the numerous initiatives to improve the Medicaid health system, such as behavioral health enhancements through Project BRAVO[13], enrollment simplification, postpartum coverage, and dental services.

DMAS recognizes the need for ongoing improvements to ensure that the Cardinal Care program functions to deliver the best care at the best value to our members and the Commonwealth. The efficiencies realized through Cardinal Care will provide DMAS with enhanced capacity to focus on strengthening and refining its monitoring and oversight policies, processes, and systems. DMAS is working with Manatt to ensure the consolidated contract has sufficient levers for compliance monitoring and oversight, including around network adequacy. Manatt will also review and provide recommendations to DMAS on how it can adjust its organizational infrastructure to ensure proper oversight and monitoring processes are in place for the merged program, including processes that promote health plan compliance, performance, and accountability, with greater transparency.

Section 3: MCO Operational Expenses

The merge of the two programs is expected to minimally impact MCO capitation payments. Although capitation rates differ by program, the medical component of capitation rates are currently developed based on population-specific data. For instance, current population criteria taken into consideration for rate development include age, gender, region, eligibility category, and waiver or LTSS enrollment. Since combining the programs does not involve adding new populations to managed care, the impact to the rate setting process would be minimal. Merging the programs may require some updates to rate cells that currently incorporate some differences by program, such as Medicaid Expansion rates; however, the process for developing rates would be similar to any update in population or change in benefits that result following General Assembly policy changes in typical years.

MCO administrative costs are also included in capitation payments paid by the Department. These costs may include costs associated with member communications, systems, and personnel, among other items. This administrative component of capitation payments is updated annually as part of the rate-setting process.

DMAS consulted with Mercer, its actuary, on the potential for cost and savings. Initially, as MCOs are required to make system and programmatic updates to align their two lines of business, there will be some minimal upfront administrative costs to accomplish necessary systems changes, reporting changes, and development and mailing of revised membership and provider materials, including Member ID Cards, handbooks, and provider contracts. These expenses will be included in the administrative component of the capitation payment, but are not expected to materially increase capitation payments, and would be amortized over time.

[12] https://www.macpac.gov/wp-content/uploads/2014/06/Building-Capacity-to-Administer-Medicaid-and-CHIP.pdf

[13] As amended and reenacted under the 2020 Virginia Acts of Assembly, Chapter 56, Item 313 YYY (2020 Appropriations Act), Project BRAVO (Behavioral Health Redesign for Access, Value and Outcomes) is an interagency partnership effort between Department of Medical Assistance Services (DMAS) and Department of Behavioral Health & Developmental Services (DBHDS) that will implement an array of fully-integrated behavioral health services, that are evidence-based, trauma-informed and prevention-oriented, to provide a full continuum of behavioral health care to Medicaid members.

Following an initial investment, administrative costs are expected to decrease over time as MCOs gain efficiencies from reduced duplication, such as the reduction of reporting deliverables and alignment of staffing. These savings (described below) are expected to have minimal impact on capitation payments.

1. Reduction in the number of reporting deliverables – As the majority of reports are automated, upfront investments may be required to update automated reports. Savings to the MCO may come in the form of a few staff hours dedicated to report validation.
2. Alignment of staff and member/provider relations and personnel – As the volume of members covered and the complexity of services to be provided under the unified contract are not changing, MCOs will continue to need sufficient staffing to serve the same membership, to ensure adequate provider networks, provide care management for complex populations, and to meet consolidated contract standards.
3. Combining Medical Loss Ratios and Underwriting Gains - Under the current structure, health plans are required to spend at least 85% of capitation payments on clinical services or quality improvement initiatives. MCOs are required to calculate and report their Medical Loss Ratio (MLR), which is the ratio of spending on clinical services, and quality improvement expenditures divided by capitation revenue. If a health plan's MLR is less than 85%, then the health plan is required to make a payment to the Department equal to the deficiency percentage applied to the amount of capitation revenue. This percentage is contract-specific; therefore, even if the health plan spent more than 85% on medical costs for one program (CCC Plus or Medallion), the plan will still be required to make a payment to the Department for the insufficient medical spending in the other program (CCC Plus or Medallion). Under a combined contract, separate MLR calculations for each program will no longer be required, and DMAS will closely monitor MCO spending on vulnerable populations to ensure that adequate funds are used to care for members.

   Similarly, underwriting gain limits are also currently program-specific. Health plans with profits in excess of 3% are required to refund the Department some portion of the Medicaid premium income up to a 10% profit, at which point all underwriting gains in excess of 10% must be returned to the Department. As a result of limits being program-specific, a health plan may have losses in one line of business but excess gains in the other, resulting in a payment to the Department. This situation will not occur once the programs are combined.

   Combining the MLR and underwriting gain limits for the health plans will provide plans additional financial support by allowing for cross-subsidies, using profits from populations with lower-than-expected spending to pay for the expenditures of populations with higher-than-expected costs. This cross-subsidization could result in a cost to the Commonwealth when compared to current rules. More detail on the process and impact for combining the MLR and underwriting gain provisions can be found in DMAS's analysis on the costs and benefits of combining the MLRs and underwriting gain provisions report.[14]

Section 4 – Benefits Realized through Cardinal Care

Operating under a single contract provides DMAS the ability to operate a more efficient and effective managed care program and to derive greater value for our members, providers, and the Commonwealth. Participation data for each managed care program is provided in Appendix 4.

Benefits to Members

As currently administered, the separate managed care programs can be confusing for members and can result in discontinuity of care if members move from one program to another. Cardinal Care, a single managed care program model, will reduce confusion, simplify member engagement with the Medicaid program, improve continuity of care, and streamline the member's managed care enrollment. Members will no longer experience the distinction between CCC Plus and Medallion 4.0, a fact that may improve member experience in Medicaid overall.

Benefits to Providers

[14] DMAS companion analysis on the costs and benefits of combining the MLRs and underwriting gain provisions is available here: https://rga.lis.virginia.gov/Published/2020/RD689/PDF

The existence of two separate managed care programs can be an unnecessary complication for providers. Having one unified managed care program will reduce confusion and administrative burden for providers, and potentially improve provider participation in Medicaid. One managed care program would simplify the contracting and billing processes for providers, and, in general, streamline the provider experience in working with the MCOs.

Benefits to MCOs

Although all six MCOs participate in both Medallion 4.0 and CCC Plus, health plans must maintain two separate contracts with DMAS, one for each program. While much of the contractual language is the same or similar, the contracts vary in a few key areas, including reporting requirements, quality measurement, provider network requirements, and financial distinctions. Feedback from the MCOs obtained for this report suggests that streamlining these areas would reduce administrative burden for the plans, allowing them to more efficiently administer the unified program.

Financially, a single program and contract will result in combining medical loss ratio requirements and maximum allowable underwriting gains. The merged program would allow health plans to have a larger risk pool in which to manage the year-to-year uncertainty. Additional guardrails, including quality measures and value-based programs, are planned to ensure MCOs are spending appropriate amounts for a given population and not subsidizing losses or gains to the detriment of member care.

Benefits to DMAS and the Commonwealth

Operating under the streamlined and aligned contract requirements will enable DMAS to improve care equity, continuity of care, and the quality of care for one in five Virginians. The streamlined MCO data and reporting requirements will enhance DMAS's capacity to ensure its managed care delivery system operates with maximum value for the Commonwealth with greater transparency and oversight.

Section 5 - Other Recommended Program Alignment

Alignment of FAMIS and Medicaid Program Rules

DMAS administers the Virginia's State Children's Health Insurance Program (S-CHIP) in addition to the state Medicaid program. Virginia's CHIP program, called Family Access to Medical Insurance Security (FAMIS), provides vital coverage for children in families whose earnings are too high to qualify for Medicaid but cannot afford private insurance. Under federal law, states can choose to cover CHIP-eligible children in a separate CHIP program; in a CHIP-Medicaid expansion, which enrolls CHIP-eligible children into the state's child Medicaid program using CHIP/Title XXI dollars at the enhanced CHIP federal matching rate; or using a combination of the two approaches. Virginia currently operates a combination CHIP program. Since 2003, part of the Commonwealth's CHIP-eligible population—children ages 6 through 18 between 100 and 143% of the federal poverty limit (FPL)—has been enrolled in Medicaid at the CHIP match, while other children are covered in Virginia's separate CHIP program, FAMIS. [15]

FAMIS children do not currently have access to all of the benefits that Medicaid children receive, most notably the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. In addition, services for FAMIS children of all ages are subject to copays, while Medicaid children's services are not. DMAS must also maintain separate contract standards, benefit structure, systems and expertise for this relatively small subset of the population of approximately 80,000 of the 1.4 million Medallion 4.0 members. It is administratively burdensome for DMAS, its MCOs and other vendors, and providers to administer this small-scale, separate program with different requirements, benefits, cost sharing, and policies.

To support Cardinal Care goals of achieving administrative efficiencies and aligning benefits and program features wherever possible, DMAS recommends transitioning FAMIS into CHIP-funded children's Medicaid to create a

[15] Historically, the enhanced federal medical assistance percentage (e-FMAP) for Title XXI/CHIP funding for Virginia is 65 percent. (Medicaid is federally matched at 50 percent in the Commonwealth.) A 4.34 percentage point boost has been added to this CHIP matching rate effective retroactively to January 1, 2020, the calendar quarter in which the COVID-19 federal public health emergency (PHE) was declared. Currently, a total rate of 69.34% is effective from October 1, 2020, until the end of the calendar quarter in which the PHE expires.

unified Virginia Medicaid children's program. This transition is an important component of fully aligning the Department's managed care programs. Critically, from a financial perspective, this transition preserves the enhanced CHIP federal matching rate Virginia currently receives for its FAMIS population, and allows the state to access sizeable drug rebates currently not available under the separate CHIP program. More detail on the process and impact for transitioning FAMIS into CHIP-funded children's Medicaid can be found in the required companion report on these topics (per Item 313.EE.2).[16]

Section 6 - Conclusion and Next Steps

Cardinal Care will bring positive outcomes for DMAS, the Commonwealth and its members. Combining the two managed care contracts will help DMAS to operate with greater focus on meaningful results and improved capacity to achieve its agency mission to improve the health and well-being of Virginians through access to high-quality health care coverage. Cardinal Care will promote a population-based approach to care, mitigating managed care enrollment gaps and allocating care management resources equitably across populations served, based on the member's clinical status and health risk, and accounting for health-related triggering events. The contract merger will also streamline and eliminate unnecessary reporting and will ensure effective controls are in place for improved compliance monitoring and oversight.

The consolidated contract will require upfront investment, especially for costs such as IT systems changes for DMAS, member and provider communications, and funding for the Cardinal Care Consulting Services Contractor. While MCOs will achieve savings over time, these savings are not expected to be substantial enough to significantly impact MCO administrative costs. DMAS anticipates it will realize some operational efficiencies, and will leverage and reinvest these efficiencies to implement enhanced monitoring and oversight policies, processes, and systems. DMAS has also contracted with a national Medicaid policy expert, Manatt, to serve as its Cardinal Care Consulting Services vendor, including to provide recommendations for organizational infrastructure changes. Based on Manatt's pending analysis and recommendations, additional staffing, staff training, and staff expertise may be required to best support effective oversight and monitoring practices and to ensure the Cardinal Care managed care delivery system is delivering the highest possible value for the Commonwealth.

[16] https://budget.lis.virginia.gov/item/2021/2/HB1800/Enrolled/1/313/

Appendix 1: Cardinal Care Contract Consolidation Focus Areas

Compliance and Oversight

Currently, there are some differences in the programs' requirements and processes for monitoring compliance and providing oversight over the MCOs. For example, CCC Plus, as a much newer program serving highly complex members, requires that DMAS review and approve more of the health plans' materials and processes. There are also some differences in sanction/penalty amounts and internal processes for conducting monitoring and review activities.

As there are few population-based or other reasons for differences in the compliance and oversight components, these contract areas and processes should be aligned in the merged contract. Aligning these particular areas will result in greater efficiencies for DMAS and the MCOs and ensure that DMAS is able to provide targeted oversight of its health plans. Indeed, DMAS plans to work within the separate contracts to align areas related to compliance and oversight wherever feasible for the July 1, 2022 contracts as part of its ongoing effort to streamline the programs.

Network Adequacy

Each MCO is required to maintain adequate provider networks to meet the needs of the Medicaid population, as defined by the contracts. However, as the populations differ by contract, so too do the provider types subject to network adequacy requirements and some other provider-related requirements. As part of the process for combining the two contracts, DMAS will strengthen and align provider network adequacy standards and apply measurements consistently to ensure MCOs maintain adequate networks of critical provider types for each of the Medicaid populations. Similarly, DMAS will align reporting and other requirements to enable the ability to provide meaningful oversight to ensure members receive care from high-quality providers in a timely manner. An added benefit of combining the contracts may be that health plans are better able to recruit additional providers to participate in their networks due to reductions in administrative burden, further ensuring that members have sufficient access to care.

Reporting

The health plans are contractually required to report on a wide variety of initiatives, metrics, and other key items. Detailed reporting requirements are included in each program's separate Managed Care Technical Manual (MCTM). As part of the process for combining the managed care contracts, DMAS plans to combine and streamline the MCTMs, including identifying reports that should be eliminated or updated to reflect DMAS's current data analytics needs and capabilities. Appropriate population-specific reporting will be maintained. DMAS will also work to align the processes for report submission, analysis, and monitoring.

Model of Care Components

Both contracts include principles of care coordination, especially for vulnerable, at-risk populations and require screenings, assessments, reassessments, and person-centered care planning activities, using an interdisciplinary approach. However, as Medallion 4.0 and CCC Plus serve different populations, the model of care requirements vary significantly between the two programs. Moving to one managed care delivery system will streamline and add value for members by eliminating the need for unnecessary transitions between the two managed care systems, maintaining consistent clinical staff assignments, and facilitating access to a fully integrated, well-coordinated system of care, fostering improved management of medically necessary care and progress updates towards improved health outcomes.

Under the combined program, DMAS will strategically align the model of care requirements to ensure access to care coordination and a comprehensive model of care relevant to the population, based on the member's needs and level of risk. Special populations identified from both managed care contracts include but are not limited to the following:

- Children and youth with special health care needs
- High-risk pregnant women and infants
- Long-term services and supports populations
- Children and adults with behavioral health and substance use disorders
- Individuals requiring high needs supports, such as employment or housing supports
- Individuals with high care utilization patterns and/or multiple chronic conditions

DMAS recognizes that significant revisions are needed to achieve an effective model of care component that supports all populations under a unified contract. DMAS will work collaboratively with the MCOs and key stakeholders to design a member-focused model of care for the combined program that incorporates best practices from the Medallion 4.0 and CCC Plus programs, and works effectively and efficiently for the populations served. The model will also make use of historical utilization data to identify member need and level of risk to target clinically appropriate and timely interventions, make efficient and dedicated use of care coordination resources, and drive high-value care. These model of care enhancements will better support opportunities for proactive care planning and prevention of crisis and emergency services.

Quality and Value-Based Purchasing

DMAS requires all MCOs to maintain accreditation with the National Committee for Quality Assurance (NCQA) and report on related quality measures twice, once for the populations included in each program. DMAS is already undergoing efforts to align quality reporting, ensuring measures are consistent between the programs and that appropriate benchmarks are established by population. Appropriate benchmarking and population-specific metrics will be critical in the merging of the two contracts to ensure that high-quality care is provided to all Medicaid members and that plans are meeting reasonable accountability standards.

In addition to quality measure reporting required by DMAS, there are a number of federally required quality activities. DMAS is required to contract with an external quality review organization (EQRO) to monitor care activities for both programs. Currently, DMAS has to conduct two separate projects with the contractor for each required activity. However, if the programs were combined, DMAS could streamline the projects and reduce resource burden on both DMAS and the MCOs by eliminating duplication.

Similar to special considerations needed for quality monitoring initiatives, performance metrics and benchmarks or target percentages for current value-based purchasing (VBP) programs would need to be carefully considered when combining the programs. For instance, some metrics used in the performance withhold program are specific to one program. Composite measures will need to be carefully reviewed to ensure that benchmarks are appropriate and that vulnerable populations are monitored. In combining the contracts, DMAS would need to consider new benchmarks and thresholds for performance to ensure that high quality, efficient care is provided to *all* Medicaid populations. Ultimately, while combining the programs would result in the short-term need to amend current VBP programs, monitoring and oversight efficiencies would allow for a greater focus on implementing financial and non-financial value based-incentive programs to improve health outcomes and value under the unified contract.

Appendix 2: Overview of DMAS Cardinal Care IT Systems Changes

As part of the Cardinal Care initiative, DMAS will make changes to its IT systems to support the combined managed care program. DMAS is in the process of developing and implementing a new Medicaid Enterprise System (MES) to replace its current MMIS. For this reason, the systems implementation of Cardinal Care will use a multi-phased approach, as outlined below. This approach will allow DMAS to implement the merged program July 1, 2022, while minimizing changes in the short term to allow for the successful implementation of its MES, and then to leverage the full-scale MES implementation to provide a modernized technical solution that fully supports the IT needs of the unified managed care program. These IT systems changes will provide enhanced capacity for expedited and continuous managed care enrollment, improved care management, and more effective data-driven oversight and monitoring activities, toward ensuring maximum managed care program value to the Commonwealth.

Phase 1 – Anticipated go-live July 1, 2022

- Continuing to utilize current system processes where feasible, while removing all references to Medallion 4.0 and CCC Plus
- Revising member facing communications to reflect the new combined managed care benefit and branding, including Member ID cards, eligibility verification systems used by providers, member enrollment notices, websites, etc.
- Anticipated cost: $215,000

Phase 2 – Anticipated to be phased in over 2023 and 2024

- A clean rebuild of the system that supports the combined program with maximum efficiency
- Shoring-up system processes to facilitate expedited and uninterrupted managed care enrollment for improved continuity of care, such as members transitioning to long term services and supports (LTSS) levels of care and expedited newborn coverage.
- Facilitating seamless transitions across health plans and between the managed care and fee-for-service programs
- Enrolling and re-enrolling populations in managed care quickly, such as through a weekly or daily auto-assignment process
- Enhanced IT solutions for data-driven, care management, including automated data solutions that promote effective use of limited care management resources, timely and effective screening, assessments, and care planning, and ultimately to ensure the right care at the right time for members
- Strengthen automated solutions for health plan monitoring and oversight, including for network adequacy and improved access to care, health outcomes and quality of care.
- Anticipated cost: $3.3 million.

Appendix 3: SFY 2022 - 2023 Cardinal Care Systems and Operational Costs

SFY 2022	Total	GF	NGF
2021 Appropriations Item EE.1	$2,520,000	$1,017,162	$1,502,838*
Cardinal Care Contractor Costs (Manatt)	$1,650,000	$825,000	$825,000
DMAS Systems Changes	$215,000	$53,750	$161,250
Stakeholder Communications	$200,000	$100,000	$100,000
Other vendor costs (actuary, ID Card vendor, etc.)	$76,824	$38,412	$38,412
Need	$0	$0	$0

SFY 2023	Total	GF	NGF
2021 Appropriations Item EE.1	$2,520,000	$1,017,162	$1,502,838*
Cardinal Care Contractor Costs	$1,550,000	$775,000	$775,000
DMAS System Changes	$2,504,640	$626,160	$1,878,480
Communications	$75,000	$37,500	$37,500
Remaining Appropriation	-$1,609,640	-$421,498	-$1,188,142
Need	$1,609,640	$421,498	$1,188,142

*Anticipates a 75% federal match for systems costs

Appendix 4: Medicaid and FAMIS Populations Served Through Managed Care

Commonwealth Coordinated Care Plus (CCC Plus)

CCC Plus currently serves approximately 281,000 individuals, including older adults, disabled children, disabled adults, medically complex Medicaid Expansion adults, and members who receive Medicaid long-term services and supports (LTSS) in a facility or through one of the home and community-based (HCBS) waivers. Individuals enrolled in the Community Living, the Family and Individual Support, and Building Independence waivers, known as the Developmental Disabilities (DD) waivers, are enrolled in CCC Plus for their non-waiver services only. Their DD waiver services are covered through Medicaid fee-for-service. CCC Plus also includes nearly 128,000 dual eligible individuals and over 50,000 medically complex Medicaid Expansion members. The table below provides data for populations by MCO.

CCC Plus MCOs	Aged, Blind, Disabled, and Complex Populations without LTSS*	Long Term Services and Supports Populations				Total
		CCC Plus Waiver	DD Waiver	Hospice	Nursing Facility	
Aetna	32,551	5,311	2,254	78	3,043	43,237
Anthem	56,599	14,148	5,033	117	3,778	79,675
Molina	20,944	2,755	1,215	78	2,268	27,260
Optima	34,632	6,191	2,532	65	2,401	45,821
UnitedHealthcare	26,633	4,130	1,430	59	2,858	35,110
Virginia Premier	37,330	6,523	2,533	108	2,824	49,318
Total	**208,689**	**39,058**	**14,997**	**505**	**17,172**	**280,421**

*Includes disabled adults and children, adults age 65 and older, and Medicaid Expansion adults with complex conditions
Source: DMAS Data as of September 2021

Medallion 4.0

The Medallion 4.0 program currently serves nearly 1.4 million individuals, including pregnant women, infants, children, parents/caregivers, and Medicaid Expansion adults. Children served through Medallion 4.0 may also be receiving foster care or adoption assistance or may be enrolled in the Early Intervention program, through the DBHDS Infant & Toddler Connection of Virginia. Early Intervention provides supports and services to infants and toddlers from birth through age two who are not developing as expected or who have a medical condition that can delay normal development. Medallion 4.0 also includes individuals enrolled in Virginia's State Children's Health Insurance Program (S-CHIP) program, called Family Access to Medical Insurance Security (FAMIS), which provides vital coverage for pregnant women (FAMIS MOMS) and children in families whose earnings are too high to qualify for Medicaid but cannot afford private insurance.

Medallion 4.0 MCOs	Medicaid and FAMIS Children				Medicaid and FAMIS Adults				Total
	Children*	FAMIS	Foster Care & Adoption Assistance	Early Intervention	FAMIS MOMS	Pregnant Women	Expansion Adults	Non-Expansion Adults	
Aetna	70,735	7,536	1,302	616	346	2,942	88,809	18,890	191,176
Anthem	231,542	30,264	4,163	1,448	870	6,537	122,983	42,398	440,205
Molina	32,513	3,474	723	272	230	1,605	46,762	8,602	94,181
Optima	141,206	14,155	3,014	853	406	4,003	90,176	29,385	283,198
United	65,587	8,678	1,016	462	394	2,185	58,011	11,847	148,180
Premier	144,209	15,612	3,918	897	446	3,540	91,559	27,685	287,866
Grand Total	**685,792**	**79,719**	**14,136**	**4,548**	**2,692**	**20,812**	**498,300**	**138,807**	**1,444,806**

Source: DMAS Data as of September 2021

**Children includes child populations other than FAMIS, Foster Care and Adoption Assistance, and Early Intervention, children, which are listed separately.*