COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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September 15, 2023

MEMORANDUM

TO: The Honorable C. Todd Gilbert
Speaker, Virginia House of Delegates

The Honorable Richard L. Saslaw
Majority Leader, Senate of Virginia

FROM: Cheryl Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: Managed Care Spending and Utilization Trends in SFY23

This report is submitted in compliance with the Virginia Acts of the Assembly – Item 308.G.3. of the 2023 Appropriations Act, 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) 664-2660.

CR/wrf
Enclosure

Pc: The Honorable John Littel, Secretary of Health and Human Resources

Managed Care Spending and Utilization Trends in SFY23 (Item 308.G.3.)

A Report to the Virginia General Assembly *September 15, 2023*

Report Mandate:

Item 308.G.3. of the 2023 Appropriation Act, states, "3. 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."

Spending and Utilization Trends in SFY23

This report provides a review of overall medical spend and utilization by Virginia's Managed Care Organizations (MCOs) for Fiscal Year (FY) 2023 (July 1, 2022, through March 31, 2023; partial year due to claims lag and runout). We see Medallion 4 per member per month (PMPM) costs increased 6.0% from FY2022 (July 1, 2021, through June 30, 2022) to FY23. Similarly, for the CCC Plus program, PMPM increased 8.7% from FY22 to FY23. By reviewing costs through PMPM, we can standardize enrollment changes and provide better year to year comparisons; this is especially important for these time periods as the Public Health Emergency (PHE) resulted in more Virginians receiving Medicaid coverage beginning in late FY20 and continuing until unwinding efforts began in April 2023.

Specifically, Medallion 4 PMPM cost increases in FY2023 are caused by Emergency Department (ED) costs being up 30.0% as well as Outpatient medical spend increasing 29.6% due to the agency distributing incorrect Outpatient Enhanced Ambulatory Patient Grouper (OEAPG) rates for more than half of the fiscal year; similarly, CCC Plus PMPM costs had 38.6% and 27.6% increases in Outpatient and ED services, respectively, for the same reason as the other program. This root cause is evident by decreases or no change in utilization per 1,000 members and increases in cost per claim consistent with PMPM. Managed Care claims paid at the higher OEAPG rates may be adjusted downward upon final claim adjudication with hospital providers. DMAS will utilize the correct OEAPG rates when developing future managed care rates.

Medical expense categories that can be associated with preventative healthcare, and therefore helping reduce costlier place of service care like Inpatient hospitalizations or ED visits, such as Physician Services and Pharmacy experienced increases in utilization from FY2022 to FY2023: Medallion 4 Physician Services utilization increased by 1.1% and scripts per member also

About DMAS and Medicaid

The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage.

The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid and CHIP programs for over 2 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 600,000 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% for newly eligible adults, generating cost savings that benefit the overall state budget.

increased 5.5%; CCC Plus had near identical service volume changes as Physician Services increased 0.9% while Pharmacy was up 5.0%.

Comparing to FY2020—where three quarters of the year was not impacted by COVID related costs or utilization changes—FY2023 PMPM is up 3.7% for Medallion 4 and 13.6% for CCC Plus. The increase in Medallion 4 is reasonable given the aforementioned cost per claim changes for ED and Outpatient expenses in addition to three years of medical inflation. CCC Plus's biggest changes occur in Outpatient (+39%) and Pharmacy (+12%) in addition to any inflation which historically can be assumed/estimated around 3% annually.

Addressing undesirable trends: Initiatives and Outcomes

Throughout SFY2023, the Department of Medical Assistance Services (DMAS) and Virginia's MCOs monitored spending and utilization trends and addressed undesirable trends. In November 2021, one MCO implemented a Program to provide comprehensive care management to address medical, behavioral, and social needs for high-risk moms who may need extra support and services. A local care team seeks to engage and empower mothers by providing education, supporting them in their care plan, removing barriers to prenatal and postpartum care, and linking them to resources. For some, this might also mean housing, substance use disorder treatment or outpatient opioid treatment.

Starting January 2022, one MCO began reviewing prior authorization requests for extensions earlier. By performing a concurrent review seven days after the previous review date—instead of 14 days after the previous review date—the MCO reduced the costs of Physical Health Inpatient claims by 2%. Similarly, in September 2022, an MCO implemented a partnership with a Health System in Northern Virginia to improve experience and quality with care transitions. The MCO and their partner are working to reduce avoidable hospital delays, readmissions, unnecessary ED utilization due to transition gaps and working to identify SDOH opportunities to provide a greater safety net for our members in the community.

One MCO altered its reimbursement policy in accordance with DMAS' budget neutral methodology for procedure codes that were not priced by DMAS (listed as "IC" Individual Consideration) to improve Professional Service costs. Prior to the change, the MCO was reimbursing 40% of billed charges for the Individual Consideration (IC) codes. Another MCO implemented an incentive program for participating primary care providers to earn additional compensation for closing gaps on selected quality measures. Measures are selected on a yearly basis and focus on gaps such as: Adults Access to preventative/Ambulatory Health Services, Asthma Medication Ratio and Comprehensive Diabetes Care measures. Overall, there has been strong engagement from participating providers, and the program is directionally driving quality improvement.

Additionally, one MCO partnered with a vendor to deliver a clinically integrated "buy and bill" solution for physician practices that eliminates manual work, complexity, and financial loss. This assists providers with vaccination inventory to improve immunizations. Based on the 2022 HEDIS rates from this MCO (the latest HEDIS rates that are available), childhood immunization rates increased 5.7% and adolescent immunization rates among Black/African American members increased 6.7% over the previous year's results.

Other initiatives and program innovations by MCO's

Petersburg- the Partnership for Petersburg Polypharmacy project targets members taking multiple medications (>/= 10 or more chronic/maintenance medications OR >/= 6 or more chronic/maintenance medications with >/= 10 or more prescribers) or seeing multiple providers for clinical pharmacist consultation. The Population Health Clinical Pharmacist provides member outreach with the goal of improving health literacy and assessing opportunities to deprescribe where clinically appropriate.

Preferred Provider Program – 15 quality providers identified and contracted to bypass the clinical review process (public and private providers)

Metrics

Big 3 By Cost Category

Program: MEDALLION4 | Healthplan: (All) | Eligibility Category: (All)

		SFY2021	SFY2022	SFY2023	% Difference
Grand Total	PMPM	$283	$290	$307	6.0%▲
	Cost Per Claim	$168	$165	$171	3.4%▲
	Claims Per 12K Members	20,241	21,065	21,605	2.6%▲
ER	PMPM	$14	$16	$20	30.0%▲
	Cost Per Claim	$124	$123	$155	25.9%▲
	Claims Per 12K Members	1,321	1,515	1,565	3.3%▲
In-Patient	PMPM	$58	$58	$52	-9.0%▼
	Cost Per Claim	$8,914	$8,693	$7,797	-10.3%▼
	Claims Per 12K Members	78	79	81	1.4%▲
Nursing Facility	PMPM	$0	$0	$0	64.8%▲
	Cost Per Claim	$2,879	$2,492	$3,494	40.2%▲
	Claims Per 12K Members	0	0	0	17.5%▲
Other Facility	PMPM	$5	$4	$5	22.4%▲
	Cost Per Claim	$1,146	$1,069	$1,244	16.3%▲
	Claims Per 12K Members	49	48	51	5.2%▲
Out-Patient	PMPM	$34	$33	$43	29.6%▲
	Cost Per Claim	$408	$390	$550	40.9%▲
	Claims Per 12K Members	996	1,014	933	-8.0%▼
Pharmacy	PMPM	$72	$73	$79	7.4%▲
	Cost Per Claim	$109	$107	$109	1.8%▲
	Claims Per 12K Members	7,964	8,235	8,689	5.5%▲
Physician Services	PMPM	$100	$106	$108	1.6%▲
	Cost Per Claim	$122	$125	$126	0.5%▲
	Claims Per 12K Members	9,832	10,173	10,287	1.1%▲

Big 3 By Cost Category

Program: CCCPLUS | Healthplan: (All) | Eligibility Category: (All)

		SFY2021	SFY2022	SFY2023	% Difference
Grand Total	PMPM	$1,542	$1,649	$1,792	8.7%▲
	Cost Per Claim	$187	$197	$210	6.7%▲
	Claims Per 12K Members	98,998	100,426	102,261	1.8%▲
ER	PMPM	$20	$22	$28	27.6%▲
	Cost Per Claim	$82	$85	$107	25.5%▲
	Claims Per 12K Members	2,954	3,037	3,088	1.7%▲
In-Patient	PMPM	$179	$184	$174	-5.5%▼
	Cost Per Claim	$7,370	$7,424	$6,839	-7.9%▼
	Claims Per 12K Members	292	298	305	2.6%▲
Nursing Facility	PMPM	$338	$344	$392	14.1%▲
	Cost Per Claim	$4,108	$4,566	$5,389	18.0%▲
	Claims Per 12K Members	988	904	874	-3.3%▼
Other Facility	PMPM	$27	$28	$31	10.5%▲
	Cost Per Claim	$533	$545	$594	9.1%▲
	Claims Per 12K Members	615	628	636	1.3%▲
Out-Patient	PMPM	$82	$82	$114	38.6%▲
	Cost Per Claim	$358	$362	$509	40.5%▲
	Claims Per 12K Members	2,762	2,723	2,687	-1.3%▼
Pharmacy	PMPM	$245	$250	$269	7.6%▲
	Cost Per Claim	$120	$125	$128	2.5%▲
	Claims Per 12K Members	24,508	24,099	25,307	5.0%▲
Physician Services	PMPM	$650	$739	$783	6.1%▲
	Cost Per Claim	$117	$129	$136	5.1%▲
	Claims Per 12K Members	66,880	68,737	69,364	0.9%▲