COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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June 1, 2024

MEMORANDUM

TO: The Honorable Louise L. Lucas
Chair, Senate Finance and Appropriations Committee

The Honorable Luke E. Torian
Chair, House Appropriations Committee

The Honorable Mark D. Sickles
Chair, Joint Subcommittee on Health and Human Resources

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

SUBJECT: The Inventory of Managed Care Contract Changes Report

This report is submitted in compliance with Item 304.BBBBB. of Chapter 1 of the 2024 Appropriation Act, which states:

BBBBB. The Department of Medical Assistance Services shall develop an inventory of all proposed changes to the Commonwealth's managed care contract to be included in the reprocurement for Cardinal Care Managed Care program awarded under RFP 13330 as compared to the existing managed care contract. This inventory shall include a description of how each change will impact the Medicaid program, the legal authorization for such change, and any fiscal impact. The department shall report this information to the Department of Planning and Budget, the Chairs of the House Appropriations and Senate Finance and Appropriations Committees and the Joint Subcommittee for Health and Human Resources by no later than June 1, 2024.

Should you have any questions or need additional information, please feel free to contact me at 804-664-2660.

CR/wf
Enclosure
Pc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources

CardinalCare
Virginia's Medicaid Program

DMAS

Report on Changes to the Medicaid Managed Care Contract Included in the Reprocurement for Cardinal Care Managed Care Program Awarded Under RFP 13330

June 2024

Report Mandate:

Item 304.BBBBB. of Chapter 1 of the 2024 Appropriation Act states: The Department of Medical Assistance Services shall develop an inventory of all proposed changes to the Commonwealth's managed care contract to be included in the reprocurement for Cardinal Care Managed Care program awarded under RFP 13330 as compared to the existing managed care contract. This inventory shall include a description of how each change will impact the Medicaid program, the legal authorization for such change, and any fiscal impact. The department shall report this information to the Department of Planning and Budget, the Chairs of the House Appropriations and Senate Finance and Appropriations Committees and the Joint Subcommittee for Health and Human Resources by no later than June 1, 2024.

Report on Changes to the Cardinal Care Managed Care (CCMC) Contract as result of the procurement (RFP 13330)

The table beginning on page two of this report includes all the changes made to the CCMC Contracts as part of the procurement and includes a description of each change and the authority the Department has to make the change. These changes have been made with approval from the Department of Planning and Budget, in pursuance with Item 288(E) of the 2024 Appropriation Act.

Regarding the fiscal impact, the Department requested the Medicaid actuary, Mercer, to determine if any changes would result in a fiscal impact. Mercer has affirmed that they do not anticipate any of these changes resulting in a material fiscal impact. Additionally, apart from general contract cleanup and clarifications, all the changes to the contract are contained within Item 288 of Chapter 2 of the 2024 Appropriations Act. No appropriation was requested or provided for these changes; therefore, the Department does not consider any of the changes to have a fiscal impact. DMAS did receive funding for three additional positions to help with MCO monitoring and oversight.

The Department looks forward to continuing to work with the Administration and General Assembly on refining the Medicaid program to ensure Medicaid enrollees receive the highest quality health care.

Inventory of All Changes to the CCMC Contract Related to the Reprocurement

Contract Section	Description of Change	Authority
1.3.6	Removed language related to Partnership for Petersburg.	Item 288(T)(6)(a)(4) and (b)(2)
2.7	Added language describing Readiness Review (ensuring MCOs are prepared to go live) process and requirements.	Item 288(T)(6)(a)(5)
2.10.	Revised MCO staffing requirements for Key Staff and to clarify roles and remove duplication. MCOs are still required to have staff that perform key functions, this revision will allow the MCOs more flexibility to determine who performs them.	Item 288(T)(6)(a)(1)
2.13, 3.4 and throughout	Requires MCOs' Dual Eligible Special Needs Plans (a Medicare Advantage Plan that members can choose to enroll in for their Medicare services) to operate with exclusively aligned enrollment starting January 1, 2025. This revision is required by federal rule.	Item 288(T)(6)(a)(2)
3.5	Revised member intelligent assignment process so DMAS may suspend random assignments to a MCO if the MCO has 40 percent of enrolled lives within an operational region.	Item 288(T)(6)(a)(3)
3.6 and throughout	Adding Foster Care Specialty Plan. The Foster Care Specialty Plan will provide enhanced case management and services for qualified members.	Item 288(T)(6)(a)(6)
4.2	Require MCOs to invite DARS Ombudsman representative to Member Advisory Committee meetings.	Item 288(T)(6)(a)(7)
5.2.1	Require MCOs to annually submit a plan to DMAS on how they will coordinate with the Dental Benefit Administrator.	Item 288(T)(6)(b)(4)

Contract Section	Description of Change	Authority
5.5.5.2	Require MCOs to work collaboratively with DMAS and other stakeholders for the redesign of behavioral health services.	Item 288(XX)(1)
5.8	Revised EPSDT sections to increase care coordination, reporting, member outreach and monitoring, working with community stakeholders to ensure quality of care and monitoring or providers.	Item 288(T)(6)(a)(8)
5.13	Implement changes to the Maternal and Child Health policies and processes, including, implementing CMS' Maternal Core Quality Measure set, increase VBP targets, require MCO outreach to members.	Item 288(T)(6)(b)(3)
7.1	Added reporting requirement on Network Adequacy/Access.	Item 288(T)(6)(b)(5)
7.1.2	Removed “time” from network adequacy measurement. Previously, DMAS used time and distance required to travel to a provider to assess if a MCO had an adequate number of providers in a given area. However, since we cannot pinpoint an individual’s experience or account for traffic at different times of the day, time to travel was not an effective standard.	Item 288(T)(6)(b)(5)
7.2.1	Added language that increases Access to Care requirements. Specifically, requires MCOs to remove providers from counting in their network adequacy calculations when that provider hasn't billed for services in a long period of time. Additionally, added BH and OB-Gyn's to provider types with tighter distance to travel standards. Previously only included PCPs and Pediatrics.	Item 288(T)(6)(b)(5)
7.3.4	Require MCOs to use the Council for Affordable Quality Healthcare (CAQH) standardized credentialing form if available for their provider type to reduce contracting/credentialing burden on the provider.	Item 288(T)(6)(a)(9)
7.4.1	Added requirement that MCOs must inform providers 30 priors to any policy or procedure change and must train providers on changes.	Item 288(T)(6)(a)(10)

Contract Section	Description of Change	Authority
8.0 and Throughout	Increase MCO care coordination screening requirements for Health Related Social Needs (formally SDOH), Behavioral Health and for individuals with cancer.	Item 288(T)(6)(a)(11)
8.17	Added language to require MCOs to account for specific needs and actions in the plan for identifying, assessing and engaging members on Health Related Social Needs as part of care coordination activities.	Item 288(T)(6)(a)(12)
12.1	Add requirement to timely processing of clean claims that MCOs must adjudicate (reject or process) clean claims within five days of receipt.	Item 288(T)(6)(b)(1)
12.1.7	Increase Value Based Payment models and requirements.	Item 288(T)(6)(a)(13)
15.2.7	Revise quality withhold program to increase the withhold amount from one percent to three percent as well. The withhold amount shall not exceed one percent in the first and second years of the contract. In years three and four of the withhold amount shall not exceed two percent. Beginning in year five, the withhold shall not exceed three percent.	Item 288(T)(6)(a)(14)
15.4	Revise underwriting gain section to add that if managed care organization underwriting gain percentage exceeds three percent up to six percent the MCO must return 50 percent of the Medicaid adjusted premium revenue, if the underwriting gain percentage exceeds six percent the MCO must return 75 percent of the Medicaid adjusted premium revenue up to eight percent, and 100 percent of Medicaid adjusted premium revenue above eight percent will be returned.	Item 288(T)(6)(a)(15)
Throughout	Revised contract as required by the Virginia Information Technology Agencies (VITA) and Office of Attorney General (OAG) high-risk reviews.	Item 288(T)(6)(a)(16)

Contract Section	Description of Change	Authority
Throughout	General Contract Clarifications and Cleanup. Examples include: - Revising Pharmacy coding error reporting requirements, - Removing conflicting language related to care coordination for individuals with brain injuries, - Removing conflicting MCO call center requirements, and - Require MCOs to collaborate with DMAS on future initiatives to streamline processes such as claims payment, prior authorization, and provider training in order to ease provider burden.	Regarding future initiatives to streamline processes, in accordance with Item 288(E), no contract change will be made without review by the Department of Planning and Budget and, if necessary, General Assembly authorization.

Fiscal Impact

2024 Appropriation Act Item	Description	**FY25** Total Appropriation	**FY26** Total Appropriation
288.T	Ensure Oversight for Reprocurement Implementation	1,200,000	1,700,000
292.EE	Funding for three positions to provide support for managed care contract operations	590,000	590,000

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 an approximate 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.