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Managing Spending in Virginia's Medicaid Program

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JLARC
JOINT LEGISLATIVE AUDIT
AND REVIEW COMMISSION

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JLARC Report 489

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COMMONWEALTH of VIRGINIA

Joint Legislative Audit and Review Commission
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February 2, 2017

The Honorable Robert D. Orrock Sr., Chair
Joint Legislative Audit and Review Commission
General Assembly Building
Richmond, Virginia 23219

Dear Delegate Orrock:

In 2015, the General Assembly directed the Joint Legislative Audit and Review Commission (JLARC) to conduct a study of Virginia's Medicaid program (HJR 637 and SJR 268). As part of the study, JLARC staff produced a series of three reports. This third and final report, *Managing Spending in Virginia's Medicaid Program*, was briefed to the Commission and authorized for printing on December 12, 2016.

On behalf of Commission staff, I would like to express appreciation for the cooperation and assistance of the staff of the Department of Medical Assistance Services, the Department of Behavioral Health and Developmental Services, and the Department of Health.

Sincerely,

Hal E. Greer
Director

Contents

Abbreviations

ABD ..... Aged, blind, or disabled
ADL ..... Activities of Daily Living
ASO ..... Administrative Service Organization
CCC ..... Commonwealth Coordinated Care
CCEA ..... Contract Compliance Enforcement Action
CMS ..... Center for Medicare and Medicaid Services
CSB ..... Community Services Board
DARS ..... Department of Aging and Rehabilitative Services
DBHDS ..... Department of Behavioral Health and Developmental Services
DD ..... Developmental Disability Waiver
DMAS ..... Department of Medical Assistance Services
DS ..... Day Support Waiver
DSS ..... Department of Social Services
ED ..... Emergency Department
EDCD ..... Elderly and Disabled with Consumer Direction
FFS ..... Fee-for-service
HCBS ..... Home and community based services
HEDIS ..... Healthcare Effectiveness Data and Information Set
ICF ..... Intermediate Care Facility
ID ..... Intellectual Disability Waiver
IDD ..... Intellectually or Developmentally Disabled
LTSS ..... Long-term services and supports
MCO ..... Managed care organization
MES ..... Medicaid Enterprise System
MLR ..... Medical Loss Ratio
MLTSS ..... Managed long-term services and supports
MMIS ..... Medicaid Management Information System
PACE ..... Program for All-Inclusive Care for the Elderly
PAS ..... Pre-Admission Screening
PIA ..... Performance Incentive Award
PIP ..... Performance Improvement Project
PPACA ..... Patient Protection and Affordable Care Act
QMR ..... Quality Management Review
SIS ..... Supports Intensity Scale
UAI ..... Uniform Assessment Instrument
VDH ..... Virginia Department of Health

Summary: Managing Spending in Virginia's Medicaid Program

WHAT WE FOUND

Medicaid spending growth continues to pressure general fund budget, but spending per enrollee has been flat, accounting for inflation

Total inflation-adjusted growth of Medicaid spending per enrollee in Virginia was nearly flat—just 0.36 percent, adjusted for inflation—over the past five years (FY11–FY15). Total spending increased due to rising enrollment (16.5 percent enrollment increase). Enrollment growth was due to a variety of factors, including increased program awareness and additional waiver slots for individuals with intellectual and developmental disabilities.

Medicaid spending places increasing pressure on the state general fund budget, even though per enrollee spending growth has been flat in real terms. Medicaid general fund spending has grown by an average of 8.9 percent annually over the past 10 years, while total general fund spending increased by just 1.3 percent. Medicaid spending comprised 22 percent of the general fund budget in FY16, increasing from 14 percent in FY07.

WHY WE DID THIS STUDY

The General Assembly directed JLARC to review the cost-effectiveness of Virginia's Medicaid program. Medicaid spending increases have outpaced total state budget growth over the past 10 years, requiring a greater portion of the Virginia's budget resources.

ABOUT VIRGINIA'S MEDICAID PROGRAM

The Virginia Medicaid program provides medical, long-term care, and behavioral health services to more than one million individuals each year. The Department of Medical Assistance Services (DMAS), which administers the program, paid $8.2 billion for services in FY15, half of which was from the general fund.

LTSS eligibility screening process creates risk of unreliable results

The current process to determine functional eligibility for long-term services and supports (LTSS), and inadequate DMAS oversight, create the risk of unreliable screening results. The cost of services for this population is high ($2.35 billion in FY15), and reliable eligibility screening is critical to ensure equitable access to services for only eligible individuals. The tool used to screen applicants has never been validated for use on children, who comprise an increasing number of LTSS applicants and recipients. There are also more than 200 entities that perform screenings in Virginia, including hospitals and community-based teams, but consistent training for these teams is not provided or required. There is significant variation in screening results across these entities, with approval rates across community-based teams ranging from a low of 37 percent to a high of 98 percent in FY16.

Opportunities exist to provide more cost-effective LTSS services in the community

Once individuals are determined to be eligible for LTSS, they need to be provided appropriate services in the most cost-effective setting. Virginia has demonstrated success in recent years keeping recipients in the community (known as rebalancing), rather than in higher-cost institutional settings, but there are opportunities for further rebalancing. MCOs will be responsible for many aspects of rebalancing following the implementation of MLTSS. Other states use strong incentives for MCOs to serve recipients in lower cost community settings.

Under the current fee-for-service system, a conflict of interest exists for providers, who determine type and amount of LTSS services. A provider's financial interest may conflict with the state's interest in ensuring cost-effective and appropriate care. This conflict of interest will continue to some extent after DMAS transitions to its managed LTSS program.

DMAS has not prioritized opportunities to control spending in its managed care program

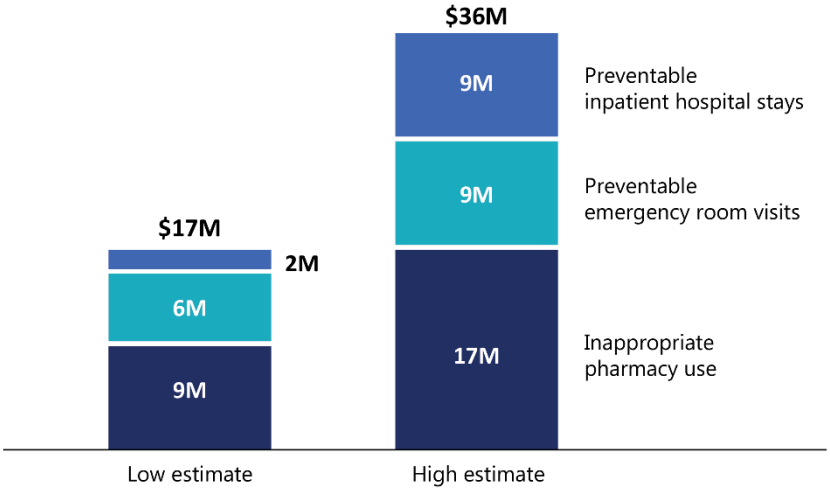
DMAS has historically taken a passive approach to MCO financial oversight, instead prioritizing efforts to oversee managed care quality. Focusing on quality can produce long-term cost savings, but this needs to be balanced with strategies to more directly control spending. DMAS has not maximized opportunities to control spending, and as a result, MCOs earn higher profits in Virginia than in other states.

DMAS currently does not obtain and analyze sufficient data to effectively oversee MCO spending. This limits its ability to ensure that capitation rates are not higher than necessary and that profit caps are effectively enforced. DMAS has also not enforced a majority of sanctions under its new contract compliance process.

DMAS has paid MCOs more than necessary and Virginia's profit cap is more lenient than other states

DMAS has not strategically set capitation rates paid to MCOs to ensure they are not higher than necessary, leading to larger than anticipated MCO profits. DMAS has not identified and adjusted MCO capitation payments for inefficient spending on preventable emergency room visits, hospital stays, and inappropriate pharmacy use. In FY16, Virginia could have saved $17–36 million by not paying MCOs for the inefficient provision of services. DMAS also does not adjust administrative spending for enrollment increases, and these adjustments would have reduced spending by as much as $8 million in FY16.

Virginia could have saved $17–36 million by not paying MCOs for inefficient health care services (FY16)



SOURCE: JLARC staff analysis of 2011-2015 MCO reports to Virginia's Bureau of Insurance, Milliman reports on Medicaid MCO financial performance, and interviews with DMAS staff.

DMAS uses a profit cap, but Virginia's cap is more lenient than other states. The profit cap is an effective tool to retroactively ensure the state does not overpay MCOs and limit the state's risk if capitation payments are higher than necessary. Virginia MCOs have made profits that are, on average, above actuarial and national benchmarks. Three other states use a profit cap similar to Virginia's, and all three require MCOs to repay funds at lower profit levels than Virginia.

WHAT WE RECOMMEND

Legislative action

- Direct DMAS to develop a comprehensive training curriculum for individuals who screen applicants for LTSS eligibility and amend the Code of Virginia to require all screeners be trained and certified.
- Direct DMAS to identify the steps required to ensure that LTSS screenings performed by hospitals are done consistently and do not lead to unnecessary institutional placements.
- Direct DMAS to implement a more stringent, tiered profit cap for the Medallion program and implement a profit cap for the MLTSS program.

Executive action

- DMAS should strengthen oversight to ensure reliability of LTSS functional screenings.

- DMAS should implement a strong incentive, through a blended capitation rate, for MLTSS MCOs to serve recipients in the community.
- DMAS and its actuary should adjust Medallion capitation rates for expected efficiencies.
- DMAS should obtain and use robust spending, utilization, and population-specific data to improve its oversight of MCOs.

The complete list of 35 recommendations is available on page v.

Recommendations: Managing Spending in Virginia's Medicaid Program

RECOMMENDATION 1

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to formally validate the children's criteria used with the Uniform Assessment Instrument to determine eligibility for Medicaid long-term services and supports. (Chapter 3)

RECOMMENDATION 2

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to develop a single, comprehensive training curriculum on the Uniform Assessment Instrument for all screeners who conduct preadmission screenings for Medicaid long-term services and supports. (Chapter 3)

RECOMMENDATION 3

The General Assembly may wish to consider amending § 32.1-330 of the Code of Virginia to require screeners to be trained and certified on the Uniform Assessment Instrument prior to conducting preadmission screenings for Medicaid long-term services and supports. (Chapter 3)

RECOMMENDATION 4

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to design and implement an inter-rater reliability test for the preadmission screening process. (Chapter 3)

RECOMMENDATION 5

The Department of Medical Assistance Services should strengthen oversight of the preadmission screening process to ensure that all screeners are trained and certified; that screenings are performed reliably; and that problems in the screening process are promptly addressed. (Chapter 3)

RECOMMENDATION 6

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to work with relevant stakeholders to (i) assess whether hospital screening teams are making appropriate recommendations regarding placement in institutional care or home and community-based care; (ii) determine whether hospitals should have a role in the screening process; (iii) determine what steps must be taken to ensure the Uniform Assessment Instrument is implemented consistently and does not lead to unnecessary institutional placements; and (iv) report to the General Assembly on steps taken to address the risks associated with hospital screenings, including any statutory or regulatory changes needed. (Chapter 3)

RECOMMENDATION 7

The Department of Medical Assistance Services should implement a blended rate with established target mixes under the contract for managed long-term services and supports to incentivize MCOs to rebalance enrollment away from institutional care and toward home and community-based care. (Chapter 3)

RECOMMENDATION 8

The Department of Medical Assistance Services should require MCOs to develop the portion of the plan of care addressing the type and amount of long-term services and supports that each recipient needs. (Chapter 3)

RECOMMENDATION 9

The Department of Medical Assistance Services (DMAS) should work with its actuary to identify potential inefficiencies in the Medallion program and adjust capitation rates for expected efficiencies, effective no later than FY19. DMAS and its actuary should phase in this adjustment over time based on the portion of identified inefficiencies that MCOs can reasonably reduce each year. (Chapter 4)

RECOMMENDATION 10

The Department of Medical Assistance Services and its actuary should monitor Medallion medical spending for related-party arrangements and adjust historical medical spending when necessary to ensure that capitation rates do not cover spending above market value. (Chapter 4)

RECOMMENDATION 11

The Department of Medical Assistance Services and its actuary should adjust Medallion capitation rates to account for a portion of expected savings for initiatives required by the state. (Chapter 4)

RECOMMENDATION 12

The Department of Medical Assistance Services (DMAS) and its actuary should allow negative historical trends in medical spending to be carried forward when setting Medallion capitation rates, if DMAS and its actuary continue to project future trends based primarily on historical trends. (Chapter 4)

RECOMMENDATION 13

The Department of Medical Assistance Services and its actuary should annually rebase administrative expenses per member per month for projected enrollment changes beginning in FY19. (Chapter 4)

RECOMMENDATION 14

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to require in its next Medallion contract that MCOs return at least a portion of underwriting gain in excess of three percent of Medicaid premium income, and increase the percentage of excess underwriting gain that must be returned as the underwriting gain level increases. (Chapter 4)

RECOMMENDATION 15

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to annually incorporate findings on unallowable administrative expenses from audits of MCOs into its calculations of underwriting gain and administrative loss ratio for the purposes of ongoing financial monitoring, including enforcement of the underwriting gain cap. (Chapter 4)

RECOMMENDATION 16

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to adjust its calculations of underwriting gain and medical loss ratio by classifying as profit medical spending that is higher than market value due to related-party arrangements. (Chapter 4)

RECOMMENDATION 17

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to keep the underwriting gain cap in the next Medallion contract, rather than replace it with a provision that uses a minimum medical loss ratio to recoup excess funds from MCOs. (Chapter 4)

RECOMMENDATION 18

The Department of Medical Assistance Services should include additional financial and utilization reporting requirements in its next Medallion contract and Managed Care Technical Manual. Reported data should include (i) detailed income statements that show expenses by rate cell and detailed service category, (ii) balance sheets, (iii) related party transactions, and (iv) service utilization metrics. (Chapter 4)

RECOMMENDATION 19

The Department of Medical Assistance Services (DMAS) should regularly monitor, on at least a quarterly basis, detailed spending and utilization trends in managed care. Undesirable trends or concerns that are identified by DMAS should be further examined, addressed with the MCO, and addressed through the Medallion contract and rate-setting process as necessary. (Chapter 4)

RECOMMENDATION 20

The General Assembly may wish to consider including language in the Appropriation Act requiring the Department of Medical Assistance Services (DMAS) to report to the General Assembly annually on spending and utilization trends within Medicaid managed care, with detailed population and service information. DMAS should analyze 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. (Chapter 4)

RECOMMENDATION 21

The Department of Medical Assistance Services (DMAS) Compliance Unit should reassess the reasons for which the state will mitigate or waive sanctions and amend the Medallion contract to specify these reasons. DMAS should consider limiting the basis for mitigating or waiving sanctions to the following reasons: (i) for an infraction due to unforeseen circumstances beyond the MCO's control; (ii) during the first year of the MCO's operation; (iii) for instances when the MCO self-reports an infraction; and (iv) the first time the MCO incurs the infraction. (Chapter 4)

RECOMMENDATION 22

The Department of Medical Assistance Services should only mitigate or waive sanctions for reasons explicitly stated in the contract and report all reasons for waiving sanctions in its monthly compliance reports, referencing the applicable section of the contract. (Chapter 4)

RECOMMENDATION 23

The Department of Medical Assistance Services should annually review the results of its contract compliance enforcement action process and include the results in its Medallion annual report. The report should include, for each MCO, the percentage of points and fines mitigated or waived and the reasons for mitigating or waiving them. (Chapter 4)

RECOMMENDATION 24

The Department of Medical Assistance Services should incrementally increase the amount of the Performance Incentive Award to create a stronger incentive for MCO improvement and retain at least one metric related to chronic conditions. (Chapter 5)

RECOMMENDATION 25

The Department of Medical Assistance Services should share the MCO report cards directly with new enrollees as part of their enrollment communication. (Chapter 5)

RECOMMENDATION 26

The Department of Medical Assistance Services should regularly analyze its spending on chronic conditions and service utilization by recipients with chronic conditions, and use this information to better understand MCO performance and develop incentives targeting the opportunities for greatest improvement in recipient outcomes and reductions in spending. (Chapter 5)

RECOMMENDATION 27

The Department of Medical Assistance Services should require Medallion MCOs, after behavioral health services are included in the program, to report their policies and processes for identifying behavioral health providers who provide inappropriate services and the number of such providers that are disenrolled. (Chapter 6)

RECOMMENDATION 28

The Department of Medical Assistance Services should allow Medallion MCOs to determine utilization controls but should monitor the impact of utilization controls on utilization rates and spending to assess their effectiveness. (Chapter 6)

RECOMMENDATION 29

The Department of Medical Assistance Services should include language in the MLTSS contract requiring MCOs to provide a plan that establishes: (i) a standardized process to determine members' capacity to self-direct; (ii) criteria for determining when a member is no longer fit for consumer-direction; and (iii) the roles and responsibilities of services facilitators, including requirements to regularly verify that appropriate services are provided. (Chapter 6)

RECOMMENDATION 30

The Department of Medical Assistance Services should review utilization and spending data on long-term services and supports (LTSS) across MCOs, once the managed LTSS program is implemented, and work with MCOs to make necessary changes to their prior authorization and Quality Management Review processes when undesirable trends are identified. (Chapter 6)

RECOMMENDATION 31

The Department of Medical Assistance Services should include financial and utilization reporting requirements in the managed long-term services and supports (LTSS) contract and Technical Manual and use the reports to monitor spending and utilization trends for managed LTSS, address those trends with relevant MCOs, and address identified issues through the managed LTSS contract or rate-setting process as necessary. These reports should include detailed income statements that show expenses by rate cell and detailed service category, balance sheets, related party transactions, and service utilization metrics. (Chapter 6)

RECOMMENDATION 32

The Department of Medicaid Assistance Services should include additional behavioral health-specific metrics in the Medallion contract and Technical Manual and use these metrics to identify undesirable trends in service utilization, assess the effectiveness of MCO utilization controls, and work with MCOs to address identified issues. (Chapter 6)

RECOMMENDATION 33

The Department of Medical Assistance Services should include additional LTSS-specific metrics in the MLTSS contract and Technical Manual and use these metrics to identify differences between models of care, assess progress and challenges to keeping more recipients in community-based care, and work with MCOs to address identified issues. (Chapter 6)

RECOMMENDATION 34

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to require in the MLTSS contract that MCOs return at least a portion of underwriting gain in excess of three percent of Medicaid premium income, and increase the percentage of excess underwriting gain that must be returned as the underwriting gain level increases. (Chapter 6)

RECOMMENDATION 35

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services (DMAS) to assess and report on additional or different resources needed to implement recommendations in the JLARC report *Managing Spending in Virginia's Medicaid Program*. DMAS should submit its report to the House Appropriations and Senate Finance Committees no later than November 1, 2017. (Chapter 6)

OPTION 1

The General Assembly could consider including language in the Appropriation Act directing the Department of Medical Assistance Services to evaluate the potential cost savings and impact to recipients of narrowing the eligibility criteria for the Medicaid program by lowering the income threshold for, or eliminating, optional eligibility categories. (Chapter 2)

OPTION 2

The General Assembly could consider including language in the Appropriation Act directing the Department of Medical Assistance Services to develop a plan to implement cost-sharing requirements based on family income for individuals eligible for long-term services and supports through the optional 300 percent of SSI eligibility category, and apply to the Centers for Medicare and Medicaid Services for approval to implement the cost-sharing plan. (Chapter 2)

1 Overview of Virginia's Medicaid Program

SUMMARY Virginia's Medicaid program provides traditional acute care, behavioral health services, and long-term services and supports to low-income Virginians and those with disabilities. The Department of Medical Assistance Services (DMAS) is charged with establishing Medicaid policy and overseeing the program's implementation within federal guidelines. DMAS currently performs this role across several different delivery systems, including a managed care program that primarily serves families and children and a fee-for-service system that primarily serves the aged, disabled, and recipients of long-term services and supports. Virginia's Medicaid program is undergoing significant changes with the implementation of managed long-term services and supports and the redesign of three waiver programs for individuals with intellectual or developmental disabilities. A relatively large proportion of Medicaid spending is concentrated in health care for a minority of recipients, including the aged, disabled, and those with chronic health conditions.

In 2015 the General Assembly directed JLARC to review Virginia's Medicaid program. The mandate specifically called for a review of the eligibility determination process and whether appropriate services are provided in a cost-effective manner. (See Appendix A, the mandate for this study.) This report presents research and findings related to the cost-effectiveness of Medicaid in Virginia, with a focus on Virginia's efforts to manage Medicaid spending. JLARC previously issued two other reports under the study mandate, addressing Medicaid eligibility determination (November 2015) and non-emergency transportation services (December 2015). Both of these reports also included recommendations to improve cost-effectiveness by ensuring only eligible recipients are approved for services and limiting the state's financial risk under its contract for non-emergency transportation services.

A variety of research activities were conducted to evaluate Virginia's efforts to manage Medicaid spending. JLARC contracted with a consulting firm with extensive Medicaid program experience, Mercer Health and Benefits (Mercer), to assist with many aspects of the study. JLARC and Mercer staff conducted interviews with state agency staff who are responsible for setting and implementing Medicaid policy, and with contractors such as managed care organizations that implement many aspects of the program. Data analysis was conducted to understand the factors driving Virginia's Medicaid spending, and research into other state Medicaid programs provided insight into opportunities for improvement in Virginia. (See Appendix B for the research methods used in this study.)

Medicaid pays for a variety of services to individuals who meet eligibility criteria

The Medicaid program is designed as a safety net for individuals with low incomes and those with severe disabilities. Most eligible recipients can receive acute care and behavioral health services, and those with qualifying needs may be eligible for long-term services and supports.

Virginia provides Medicaid benefits to families, children, and the aged or disabled who meet financial eligibility criteria

Virginia's Medicaid program provides benefits to five main populations, or eligibility categories:

- children (under age 19),
- parents or legal guardians of a dependent child,
- pregnant women,
- aged (65 or older), and
- disabled or blind.

Belonging to one of these categories does not guarantee eligibility, but it is necessary to be enrolled in the program. Adults without children are not eligible for full Medicaid benefits unless they are aged, blind, or disabled. There are other partial benefit categories, including family planning services for adults and limited Medicare cost-sharing benefits for some Medicare-eligible individuals.

Individuals in these categories must also meet financial criteria that are specific to the corresponding eligibility category. States are required to cover each of the populations, but also have flexibility, within federal minimums, to determine the financial eligibility criteria for each one. Each recipient must have income below the appropriate percentage of the federal poverty level (Table 1-1). The income thresholds in Virginia range from 24-48 percent of the federal poverty level for able-bodied parents to 143 percent of the federal poverty level for children and pregnant women. In 2015, the federal poverty level for a family of three was $20,090. Virginia's income thresholds, particularly for parents and pregnant women, are low compared to many other states, and Virginia employs the minimum income threshold permitted under federal law for three of the five primary eligibility categories. There are three different financial eligibility pathways for aged, blind, or disabled individuals.

TABLE 1-1
Virginia's income thresholds are low compared to other states and federal minimums

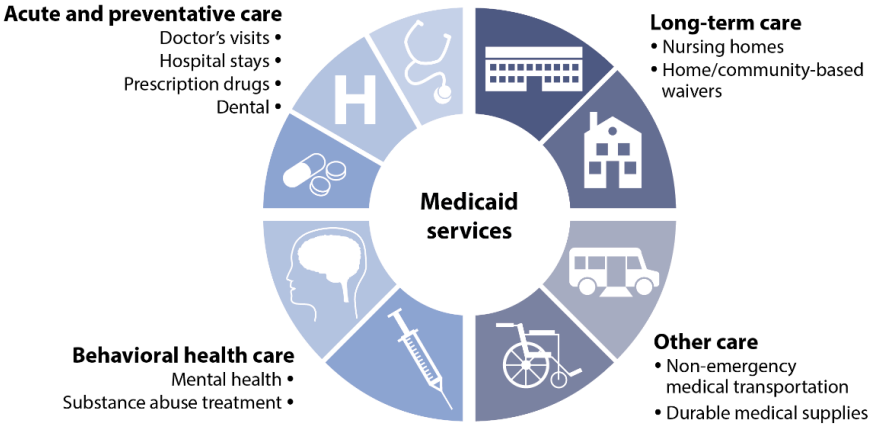
Primary eligibility category	Income threshold (% of federal poverty level)	Income threshold national rank	Mandatory/ Optional
Parents	24-48%	42nd (federal min)	Mandatory
Children	143%	19th – 43rd (federal min)	Mandatory
Pregnant women	143%	45th (federal min)	Mandatory
Aged/Blind/Disabled			
SSI recipients [a]	75%		Mandatory
<80% of federal poverty level	80%	19th of 21 states	Optional
<300% of SSI [b] (if LTSS eligible)	300% of SSI	Federal maximum (40 states use federal max)	Optional

SOURCE: JLARC staff analysis of documents from Centers for Medicare and Medicaid Services and Kaiser Family Foundation.
NOTE: Income threshold for parents varies by locality. Other states' income threshold for children varies by age. Virginia is at the federal minimum income threshold for parents, children, and pregnant women yet is higher than some other states due to differences in income calculation methodologies between states.
[a] Virginia is a "209(b)" state that uses more restrictive criteria than SSI, therefore SSI eligibility does not guarantee Medicaid eligibility in Virginia. [b] The 300% of SSI category is for recipients who are eligible based on functional need for LTSS but are not financially eligible through another category with a lower income threshold.

Medicaid recipients receive acute care and behavioral health services, and some are eligible for LTSS

Medicaid recipients can access a variety of services, including acute care, long-term services and supports (LTSS), and behavioral health services. The cost of these services is split evenly between state and federal funds. Acute care services include all traditional health care services that are typically provided under a private or employer-sponsored health insurance plan, from hospital stays to physician visits and prescription drugs (Figure 1-1). Long-term services and supports (LTSS) include both traditional nursing facility care, where individuals live and receive necessary services in a nursing facility, as well as home- and community-based services, where individuals live at home and receive necessary services either at home or in the community where they live. Behavioral health includes services that are not always provided in a typical health insurance plan, such as intensive in-home and day treatment therapies.

FIGURE 1-1
Medicaid provides acute, long-term, and behavioral health services



DMAS establishes Medicaid policies within federal standards and oversees implementation in Virginia

The Department of Medical Assistance Services (DMAS) administers the Medicaid program in Virginia. Federal law requires each state to designate a state agency responsible for administering, or supervising the administration of, all aspects of the Medicaid program. This role requires DMAS to work with the General Assembly to establish Virginia Medicaid policy within federal guidelines. DMAS must then work with state agencies, contractors, and stakeholders to ensure the effective implementation of the program.

DMAS establishes Medicaid policy within federal requirements

DMAS is responsible for establishing and implementing Medicaid policy within federal guidelines. Medicaid is a jointly funded program between the federal government and the state, and most of the populations served and services provided are required under federal law. Within this framework, states are responsible for establishing the criteria for Medicaid eligibility, what services eligible recipients may receive, and how those services will be delivered. Major decisions regarding service delivery include major policy choices such as the use of managed care versus a fee-for-service system as well as detailed decisions such as reimbursement rates for providers and limits on particular services.

DMAS oversees the implementation of a fee-for-service and managed care delivery system

Implementing the delivery of services requires extensive organizational processes and systems that differ depending on whether services are provided through Virginia's managed care or fee-for-service delivery system. For its fee-for-service system, DMAS must enroll and manage a network of providers, review and pay claims, and oversee

the quality and integrity of services. DMAS contracts out these core functions to managed care organizations (MCOs) in its managed care delivery system, but DMAS is responsible for overseeing MCOs to ensure that their processes and systems are appropriately implementing the program. This oversight of managed care is limited by federal law in that states may not direct the spending of MCOs, such as dictating the use of a particular provider, but states may require MCOs to implement programs for specific populations, to have adequate systems and administrative processes in place, and provide reports on their processes, systems, and spending.

Virginia's Medicaid program is undergoing significant changes

DMAS is in the process of implementing significant changes to the delivery system for many Medicaid services. These changes include the upcoming launch of managed long-term services and supports (MLTSS) and the ongoing redesign of three home and community-based waivers. Work to bring about these changes has been ongoing for several years, and both changes will be moving into implementation in 2017 and 2018.

Almost all Medicaid populations and services will be transitioned to managed care by FY18

Virginia introduced **Medicaid managed care** in 1992, and was the second state to require all of its MCOs to be accredited by the National Committee for Quality Assurance.

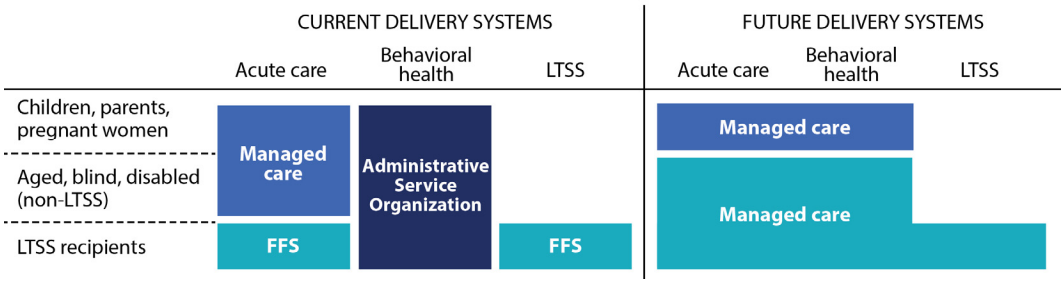
Virginia's Medicaid program is transitioning from multiple delivery systems for different populations and services to two comprehensive managed care systems. Currently, the Medallion managed care program provides acute care services to nearly all children, parents, and pregnant women, as well as an increasing number of aged, blind, or disabled recipients (Figure 1-2). Six MCOs are paid a flat capitation rate, similar to a health insurance premium, to provide these services to Medicaid recipients. Long-term services and supports are currently provided through DMAS's fee-for-service system to recipients who are eligible for those services. Behavioral health services are provided through an administrative services organization model, in which a contractor performs prior authorization, case management, and utilization review functions but services are paid on a fee-for-service basis instead of through a risk-based capitation rate.

In 2017, DMAS will transition **LTSS** (long-term services and supports) to a managed care delivery model, **MLTSS** (managed long-term services and supports).

The MLTSS program is scheduled to begin in July 2017 with the goal of improving access, quality, and efficiency of services to the aged, blind, disabled and LTSS recipients. The program will pay MCOs a flat capitated rate to provide all Medicaid services (acute care, LTSS, and behavioral health) and will ultimately include a majority of Medicaid spending. DMAS started a federal demonstration program, Commonwealth Coordinated Care, two and a half years ago that will be the model for MLTSS. LTSS services under the newly redesigned waivers for individuals with intellectual or developmental disabilities will initially be carved out of MLTSS. The MLTSS population will include more than 20 percent of Medicaid recipients, whose care accounts for two thirds of total Medicaid spending.

Following the launch of MLTSS, DMAS plans to rebid the contract for the Medallion program. The new contract will focus on the remaining populations in Medallion, namely, children, parents, and pregnant women, and it will include the full range of Medicaid acute and behavioral health services. The Medallion program will include most Medicaid recipients but these recipients account for approximately 30 percent of Medicaid spending.

FIGURE 1-2
Virginia's Medicaid program is transitioning to two comprehensive managed care delivery systems



SOURCE: JLARC staff analysis of DMAS documents.

DMAS and DBHDS are in the midst of redesigning three primary Medicaid waivers

Under the **Olmstead settlement agreement**, Virginia increased the number of Medicaid waiver slots for individuals with intellectual and developmental disabilities, in order to comply with the Americans with Disabilities Act.

DMAS and the Department of Behavioral Health and Developmental Services (DBHDS) are redesigning the three intellectual and developmental disability waivers in order to meet standards of integration required by a 2012 Department of Justice settlement agreement (sidebar). The three existing waivers are the Day Support (DS) waiver, the Intellectual Disability (ID) waiver, and the Individual and Family Developmental Disability (DD) waiver. Currently, individuals are eligible for specific waivers based on diagnosis, and ID waivers are granted based on priority need while DD waivers are granted on a first-come, first-served basis. Access to services is complicated by the multiple entry points to apply for waivers. For example, an individual with an intellectual disability must apply for the ID waiver through a Community Service Board, but an individual with a developmental disability must apply through a Virginia Department of Health child development clinic.

The new waivers will replace each of the existing waivers and address current challenges in the system. The Building Independence waiver will replace the DS waiver, the Family and Individual Supports Waiver will replace the DD waiver, and the Community Living waiver will replace the ID waiver. Individuals will be placed in one of these waivers based on level of need rather than specific diagnosis. Access to services will be streamlined for recipients and their families by having Community Services Boards serve as the single point of entry for all three waivers. There will also be a new

single, statewide waiting list that serves all individuals eligible for one of the three waivers.

The majority of these changes took effect September 2016 through phase one of the redesign. Phase two of the waiver redesign will continue in 2017 with a focus on aligning services packages to the support needs of recipients. Specifically, reimbursement will be tied to a recipient's Supports Intensity Scale score to ensure that recipients with similar needs receive similar levels of services. Once phase two is complete, consideration can be given to including these waiver services in MLTSS. The intellectual and developmental disability waiver population will receive acute care and behavioral health services through MLTSS initially, but their waiver services will be carved out.

Virginia's Medicaid spending is driven by acute care and LTSS for a minority of recipients

Medicaid provides services to many diverse populations, from children to the disabled to the elderly, and each population requires different levels and types of care. As with most health insurance programs, health care for a minority of Virginia's Medicaid recipients with the costliest, most complex needs tends to drive the majority of spending. Understanding these dynamics is important to focus efforts to manage spending where they can have the greatest impact. While this report is focused solely on managing Medicaid spending, many Medicaid recipients are eligible for other state-funded or administered programs, and this is important context for understanding the full impact of these recipients on the state budget.

Medicaid spending is primarily for acute care and long-term services and supports

Acute care and long-term services and supports (LTSS) were the two largest drivers of Medicaid spending in FY15 (Table 1-2). The vast majority (74 percent) of acute care spending was on inpatient hospital care, physician visits, and prescription drugs. Home and community based services such as attendant care make up $1.4 billion (58 percent of long-term services and supports) and nursing facilities account for another $763 million (32 percent).

TABLE 1-2
Acute care and long-term services and supports account for a majority of Medicaid spending (FY15)

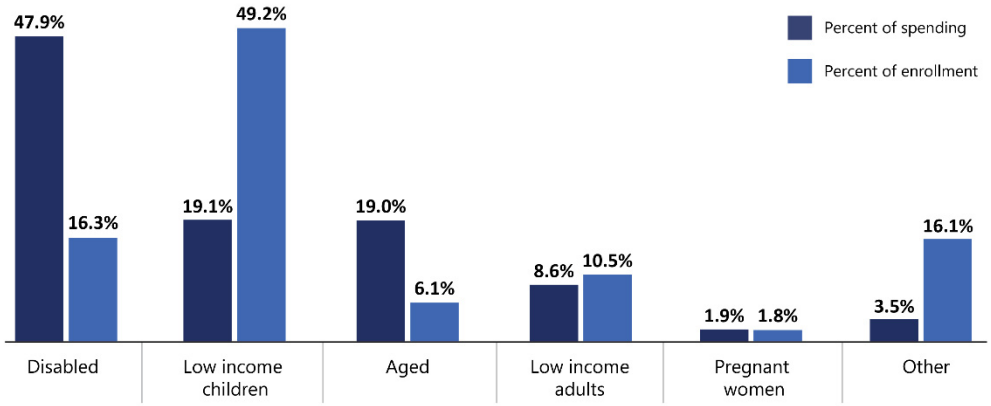
Service category	FY15 spending ($M)	Percentage of service category spending	Percentage of total spending
Inpatient hospital	1,102	32%	15%
Physicians	733	21	10
Prescription drugs	705	21	9
Outpatient hospital	518	15	7
Other acute care	376	11	5
Total acute care services	**$3,438**	**100%**	**46%**
Attendant care	679	29	9
Habilitation services	611	26	8
Other home and community based services	84	4	1
Subtotal home and community based services	*$1,374*	*58*	*18*
Nursing facilities	763	32	10
Intermediate care facilities	217	9	3
Subtotal institutional services	*$980*	*42*	*13*
Total long-term services and supports	**$2,355**	**100%**	**31%**
Community-based behavioral health services	587	80	8
Institutional behavioral health services	147	20	2
Total behavioral health services	**$735**	**100%**	**10%**
Other services	**963**	**100%**	**13%**
Total spending on services	**$7,479**		**100%**

SOURCE: JLARC and Mercer staff analysis of DMAS and MCO claims data.
NOTE: Analysis excludes administrative spending. Traditional behavioral health services, such as outpatient therapy, are included in the acute care category. Numbers may not add due to rounding.

Services for disabled and aged recipients drive Medicaid spending

Virginia's Medicaid spending is largely driven by three categories of recipients: children, aged, and disabled. Disabled recipients account for nearly half (49 percent) of total Medicaid spending while aged recipients and children each account for 19 percent of spending (Figure 1-3). Although disabled and aged recipients account for 67 percent of total spending they make up just 22 percent of total recipients.

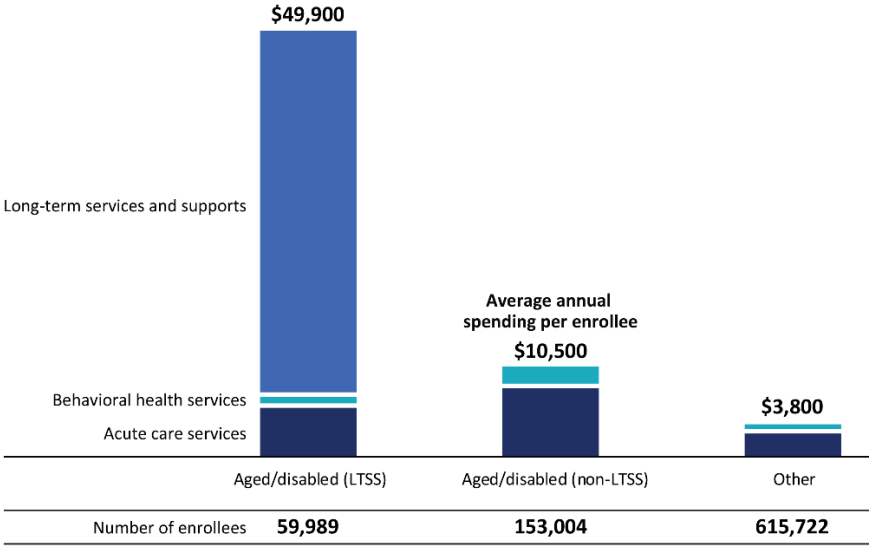
FIGURE 1-3
Services for disabled and aged recipients account for large proportion of Medicaid spending relative to enrollment (FY15)



SOURCE: JLARC staff analysis of DMAS statistical record.
NOTE: "Other" category includes Plan First, Foster Care children, and Qualifying Medicare Beneficiaries.

Services for disabled and aged recipients account for a disproportionate amount of Medicaid spending. More than 30 percent of these recipients require long-term services and supports (LTSS), and Medicaid spends an average of about $50,000 each year providing services to these individuals (Figure 1-4). Health care for the remaining disabled and aged recipients who do not need LTSS costs an average of about $10,500 annually, more than twice as much as services for all other full-benefit Medicaid recipients, which cost an average of just over $3,800 each year.

FIGURE 1-4
Large proportion of spending is on services for disabled and aged recipients, who have higher needs (FY15)



SOURCE: JLARC and Mercer staff analysis of DMAS claims and enrollment data.

Virginia's high levels of spending for disabled and aged recipients is in line with nationwide Medicaid spending. These two populations also account for a majority of national Medicaid spending, and Virginia's spending per disabled and aged enrollee is in line with or below national averages (Table 1-3).

TABLE 1-3
Virginia spending per disabled and aged enrollee is in line with national average (FY11)

	Disabled	Aged	Children	Adults
Virginia Medicaid	$18,952	$16,367	$2,696	$4,781
National average	$18,518	$17,522	$2,492	$4,141
Virginia rank	22nd	32nd	19th	14th

SOURCE: JLARC staff analysis of data on Medicaid spending per enrollee by state from Kaiser Family Foundation.
NOTE: Figures only include full-benefit Medicaid enrollees.

Chronic conditions account for a significant proportion of Medicaid spending

Chronic conditions are long-lasting diseases that require ongoing treatment and have the potential to limit daily functioning. Inadequate medical care and unhealthy behaviors can exacerbate these conditions.

Chronic conditions such as asthma, diabetes, and serious mental illness account for a significant amount of Medicaid spending, because they are common among Medicaid recipients and expensive to treat. A condition is typically considered chronic if it lasts more than 12 months. More than 20 percent of Medicaid recipients in Virginia have one or more impactable, chronic conditions, and these recipients accounted for 63 percent of total Medicaid spending in FY15 (Table 1-4). This trend has been consistent over the past five years. Individuals with chronic conditions have six times higher total health care costs on average than those without chronic conditions.

TABLE 1-4
Health care for chronic conditions is disproportionately expensive (FY15)

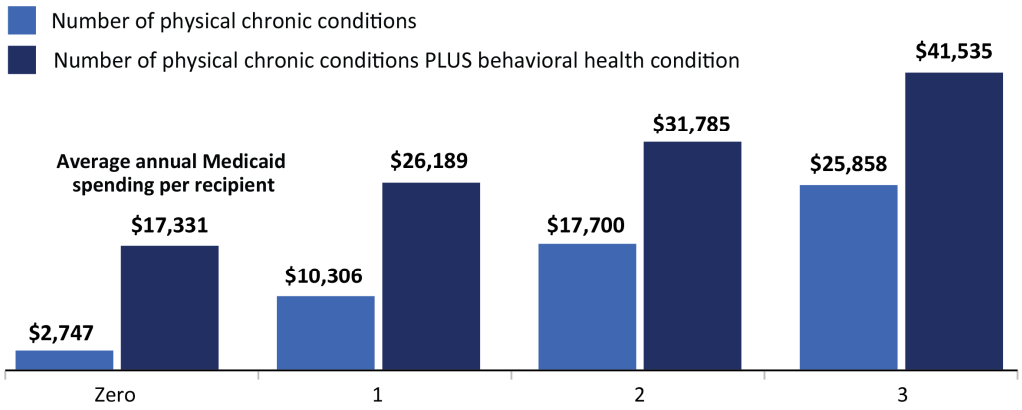
Condition	Percentage of population	Percentage of costs
Heart disease	10%	37%
Diabetes	5	19
Asthma	6	12
Chronic obstructive pulmonary disease	3	12
Serious mental illness	7	29
Substance abuse	5	14
At least one chronic condition	**22%**	**62%**
Zero chronic conditions	**78%**	**38%**

SOURCE: JLARC staff analysis of Medicaid data.
NOTE: Individuals diagnosed with a chronic condition at any point during the fiscal year are classified as having the condition during the entire year. Conditions are examples of chronic diseases. Columns do not sum to 100% because individuals can have multiple chronic conditions.

Care of chronic conditions is more expensive than some other types of care because it requires greater use of costlier services. Recipients with chronic conditions use more hospital and emergency department services than recipients with other conditions. Chronic conditions also tend to require services for a longer period of time, unlike acute medical conditions such as injuries or infections that do not require long-term treatment.

The cost of providing services for an individual increase significantly when that person has more than one chronic condition. This is because the conditions can contribute to or exacerbate the others. For example, an individual with diabetes who is not able to consistently control their blood sugar due to a mental health issue. Each additional chronic condition increases the total costs, driven primarily by increased spending on inpatient hospital services (Figure 1-5). Virginia's disproportionate spending on health care for chronic conditions is common among other state Medicaid programs and payers. Because of this, health insurance plans often target chronic conditions for health interventions in an attempt to reduce spending by improving health outcomes. (See Chapter 5 on incentivizing MCOs to successfully manage chronic conditions.)

FIGURE 1-5
Care of multiple chronic conditions, including behavioral health conditions, requires increased spending (FY15)



SOURCE: JLARC staff analysis of Medicaid data.
NOTE: Data reflects the physical and behavioral health conditions highlighted in Table 1-4 and is not comprehensive of all chronic conditions.

2 Major Drivers of Medicaid Spending

SUMMARY Virginia's Medicaid spending grew faster than general fund spending over the past decade, placing increasing pressure on the state budget. However, in recent years, spending has been flat, adjusted for inflation and enrollment. Increasing enrollment accounts for nearly all spending growth, adjusted for inflation. The enrollment growth is due to a variety of factors, such as increased program awareness and the creation of more waiver slots for individuals with intellectual and developmental disabilities. Virginia has limited options to address the growth in Medicaid enrollment but could evaluate the potential cost savings and impact on recipients of narrowing eligibility criteria and requiring cost sharing for families of some recipients. Although spending per enrollee has been flat in real terms, spending has shifted toward managed care and community-based LTSS, and DMAS should focus efforts to control future spending in these areas.

Understanding the factors driving Medicaid spending can help focus the state's efforts to control those costs. Because states are required by federal law to provide Medicaid benefits to certain populations, some cost drivers for Virginia's Medicaid program are out of the state's control. It is nevertheless important to understand what is driving Medicaid spending, how those drivers impact the state budget, and what options may be available to address those cost drivers.

Despite pressure on state general fund, Medicaid spending is flat, accounting for inflation and enrollment

Even though the federal government funds approximately half of Virginia's Medicaid program, the state still spent more than $4 billion in general funds on the program in FY16. Because of its high rate of growth, Medicaid is now the second largest general-funded program behind K-12 education, consuming more than one-fifth of all general funds. However, Virginia Medicaid spending per enrollee has remained about the same, in inflation-adjusted terms, over the past five years.

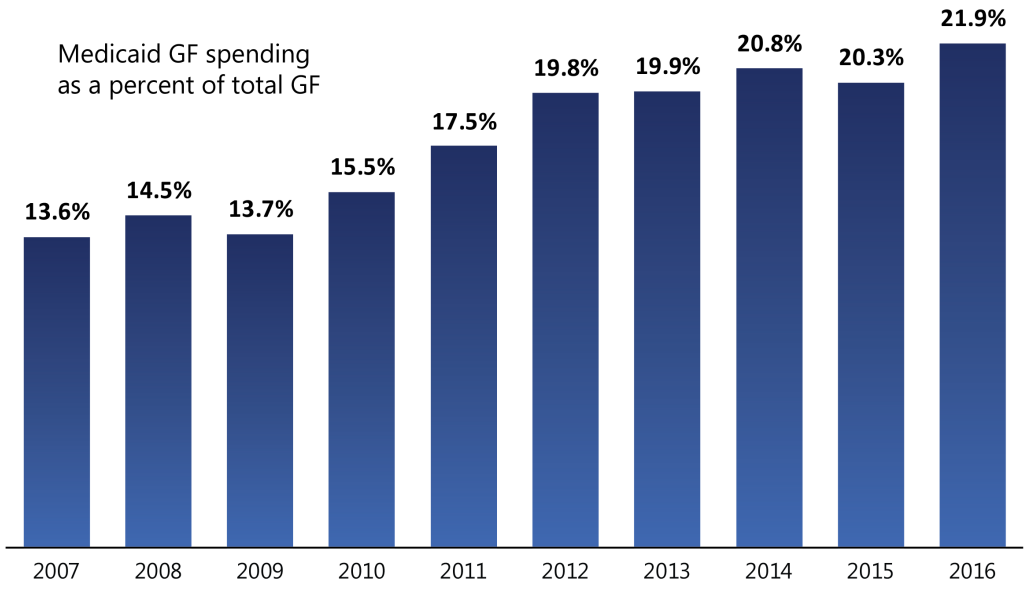
Virginia's Medicaid growth outpaced the general fund but grew slower than other health care programs

Virginia's Medicaid spending growth is placing increasing pressure on the state budget because it has outpaced growth in the general fund. Medicaid spending grew nearly seven times faster than total general fund spending during the past 10 years (8.9 per-

cent vs. 1.3 percent, respectively). This higher Medicaid spending growth was especially evident immediately following the Great Recession. Medicaid spending grew about 20 percent in FY11 and FY12, years in which the general fund grew by less than five percent.

Medicaid now accounts for more than one-fifth of Virginia's total general fund spending. Medicaid spending was 13.6 percent of general fund spending just 10 years ago. Because its rate of growth has been so much higher than total general fund growth, Medicaid accounted for 21.9 percent in FY16 (Figure 2-1).

FIGURE 2-1
Medicaid spending is requiring more of the state general fund



Source: JLARC staff analysis of data from the Department of Planning and Budget.

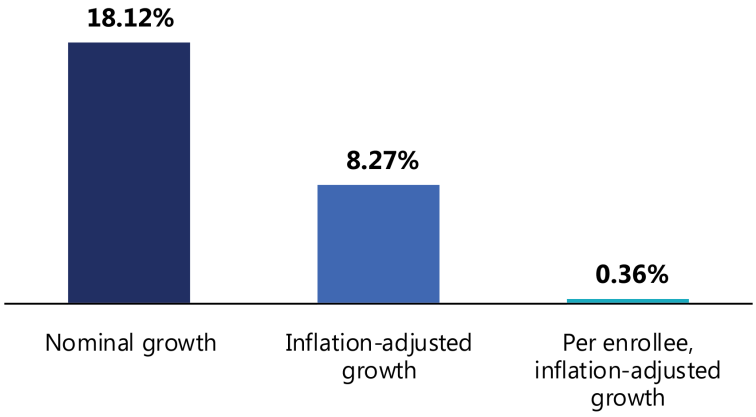
Virginia's Medicaid spending growth has been less than comparable health care programs and similar to growth in other states. Virginia ranked 29th nationally in spending growth per Medicaid enrollee between 2002 and 2011 (the most recent 10 years for which comparable data is available). Virginia's spending per enrollee increased by an average of 2.4 percent annually during that time period, less than the 2.7 percent nationwide. Nationally, Medicaid spending per enrollee increased by an average of 1.5 percent annually between 2005 and 2014. This growth rate was lower than both Medicare (4.5 percent annually) and private insurance (4.7 percent annually).

Medicaid spending growth is largely flat, accounting for enrollment and inflation

During the past five years, Medicaid spending increased by just 0.36 percent, accounting for inflation and enrollment growth (Figure 2-2). The average inflation-adjusted

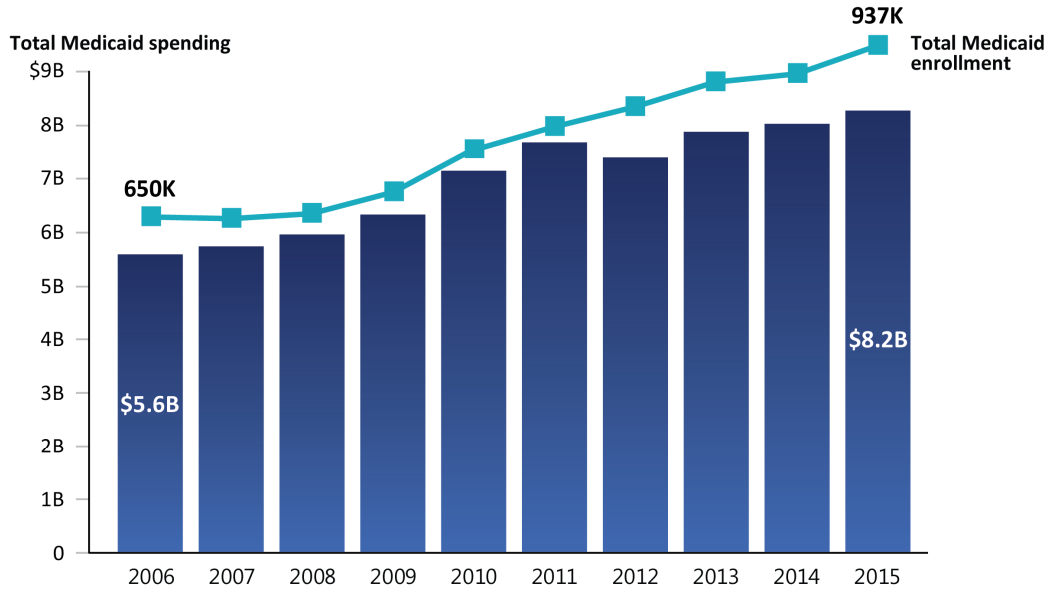
cost for each of Virginia's Medicaid enrollees rose by $27, from $8,431 in FY11 to $8,458 in FY15. Increasing enrollment accounted for nearly all of inflation-adjusted spending growth over the past five years. This trend is consistent over time, with Medicaid spending growing along with enrollment (Figure 2-3).

FIGURE 2-2
Recent Medicaid spending growth has been flat, adjusted for inflation and enrollment (FY11–FY15)



SOURCE: JLARC staff analysis of DMAS statistical record.
NOTE: Spending analysis excludes administrative spending.

FIGURE 2-3
Enrollment is a primary driver of Medicaid spending growth



SOURCE: JLARC staff analysis of DMAS Statistical Record.

The rising cost of health care services due to inflation accounted for half of total spending growth between FY11 and FY15. Inflation led to the cost of Medicaid services in Virginia increasing by an average of 2.3 percent annually over the past five years, according to JLARC estimates. Overall health care inflation was higher, increasing at 3.0 percent annually over the same time period. Virginia has been able to partially mitigate the impact of inflation by setting rates for fee-for-service Medicaid services and paying below market value for services.

Enrollment accounted for nearly all of inflation-adjusted spending growth over the past five years, as average monthly enrollment increased for every eligibility category except the aged. Overall, enrollment increased 16.5 percent, from 804,186 in FY11 to 937,306 in FY15. Low-income adults (43 percent), the disabled (28 percent), and children (27 percent) accounted for nearly all of the increased enrollment among recipients eligible for full Medicaid benefits (Table 2-1). Health care for disabled recipients had the largest impact on spending, though, because of the higher average cost per recipient.

Many factors appear to have contributed to this enrollment growth, including economic declines, federal legislation, and state policy decisions. Spikes in enrollment following the Great Recession contributed to growth in FY11 and FY12. Increased awareness of the Medicaid program following passage of the Patient Protection and Affordable Care Act likely led to more recent enrollment growth. Growth in Virginia's aging population also contributed to enrollment increases. While enrollment in the aged eligibility category actually declined, one-third of the increase in disabled recipients were over 65 years old. Virginia also increased the number of waiver slots available for individuals with intellectual and developmental disabilities, so that there were more than 2,100 additional users of ID, DD, and Day Support waiver services in FY15 than there were in FY11.

TABLE 2-1
Disabled recipients account for the largest amount of enrollment-driven spending increase (FY11–FY15)

	Increased enrollment	Percentage of total enrollment increase	Associated spending increase ($M)
Children	23,031	43.4%	$80.3
Disabled	14,580	27.5	355.7
Adults	14,397	27.1	104.7
Pregnant women	1,895	3.6	20.7
Foster care	879	1.7	9.7
Aged	(1,700)	(3.2)	(40.7)
Total	**53,082**	**100.0%**	**$530.5**

SOURCE: JLARC staff analysis of DMAS statistical records.
NOTE: Data includes only enrollees who are eligible for full Medicaid benefits.

Few options exist to reduce spending through eligibility changes

Increasing enrollment in Virginia's Medicaid program is a primary driver of spending growth, but there are limited options available to reduce spending in this area. Ensuring accurate and reliable eligibility determinations would limit enrollment growth to only eligible recipients. (See Chapter 3 for recommendations to improve LTSS eligibility screening. See also JLARC's 2015 report, *Eligibility Determination in Virginia's Medicaid Program*). Enrollment growth could also be reduced by narrowing Virginia's eligibility criteria, which are already narrow. (Virginia ranked 47th of the 50 states in Medicaid spending per capita in FY16.)

Virginia could consider narrowing eligibility and implementing cost-sharing requirements for certain eligibility categories, but these decisions involve trade-offs that would limit access to health care and shift some of the cost of long-term services and supports (LTSS) to the families of recipients. These policy changes would require federal approval, and they would have to be determined allowable within current federal maintenance of effort requirements for children under 19 and Virginia's settlement with the Department of Justice requiring the expansion of community-based services to individuals with intellectual and developmental disabilities. All of these potential impacts would need to be further explored and considered prior to implementing these options.

Virginia could potentially reduce spending by narrowing eligibility criteria

Virginia could potentially narrow Medicaid eligibility criteria in three optional categories, by either reducing the income threshold or eliminating the categories altogether. Most of the major eligibility categories that Virginia covers are federally required, and Virginia's income limits are at the federal minimum. (See Appendix C on optional eligibility categories.) There are three optional eligibility categories that Virginia covers: aged or disabled individuals with income less than 80 percent of federal poverty level (Optional ABD), individuals eligible for LTSS with income up to 300 percent of the SSI benefit level (Optional LTSS), and individuals eligible for limited family-planning services (Plan First).

Narrowing the eligibility criteria by either reducing the income threshold or eliminating coverage for optional eligibility categories may reduce spending on Medicaid services in the short term, but the exact impact on Medicaid spending and the total state budget is unknown. The amount of potential savings would depend on:

- whether and how much the income threshold for each eligibility category is reduced;
- the number of recipients who would remain eligible for Medicaid through another mandatory category; and

- the impact to other areas of the state budget, such as services provided through Community Services Boards that would no longer be reimbursed by Medicaid.

It is not possible to reliably estimate the impact of reducing the income threshold for the optional eligibility categories without having detailed data on recipient incomes, or to reliably estimate the potential impact on other areas of the state budget. Virginia spent more than $1.6 billion on services for recipients in these eligibility categories in FY15, the vast majority of which ($1.5 billion) was in the Optional LTSS category. However, all of this spending does not represent potential savings for several reasons. For example, enrollment in the ID or DD waivers would likely remain the same because of the number of eligible recipients currently on a waiting list, and the majority of recipients in the Optional ABD and Optional LTSS categories would remain eligible for at least partial Medicaid benefits. Medicaid would still pay for Medicare premiums and co-pays for many recipients, and most would likely become eligible under a "Medically Needy" category, which provides full Medicaid services but requires individuals to spend down their income before Medicaid pays for services each month.

Narrowing eligibility criteria could have an adverse impact on up to 235,000 recipients who might not otherwise have access to health care, and in some cases, this change could increase long-term Medicaid spending. Research indicates that inadequate access to care can lead to adverse health outcomes, because individuals are unable to receive preventive screenings, manage chronic conditions, and effectively treat serious health episodes. Long-term Medicaid spending could increase if individuals on the ID or DD waivers choose institutional care, which is more costly than community-based services, in order to become eligible under a "Medically Needy" category. (There is no Medically Needy category for ID or DD waivers.) Research also indicates that states with expanded access to family planning services such as Plan First are generally successful in reducing unplanned births and associated long-term Medicaid costs for pregnant women and children.

OPTION 1

The General Assembly could consider including language in the Appropriation Act directing the Department of Medical Assistance Services to evaluate the potential cost savings and impact to recipients of narrowing the eligibility criteria for the Medicaid program by lowering the income threshold for, or eliminating, optional eligibility categories.

Virginia may be able to offset some spending by requiring cost sharing for higher-income families

Virginia could explore ways to implement cost-sharing requirements for some Medicaid recipients whose families have higher incomes. Under current policy, in the Optional LTSS category, only the individual's income is considered when determining financial eligibility for LTSS. Income from a child's parents or an adult's spouse are not

considered. Instead, the individual is treated as a "family of one" for Medicaid eligibility purposes. This means that individuals from families with higher incomes are treated the same under the Medicaid program as those from families living in poverty. Virginia could develop a plan that would maintain the "family of one" policy for determining eligibility but, once an individual is eligible, require cost-sharing based on family income. LTSS recipients in Virginia are currently required to pay for some of their care under federal rules, but the amount of the payment is based solely on the recipient's income, not their families.

Two states, Arkansas and Minnesota, currently require cost sharing for some families when the family's income is not considered for eligibility purposes. Arkansas and Minnesota apply the cost sharing to some families of children with physical disabilities receiving services, when those children are eligible through a specific eligibility category that also includes a "family of one" policy. Virginia does not cover this specific eligibility category but could explore the possibility of applying the same cost-sharing concept to individuals eligible through the Optional LTSS category, which also uses the "family of one" policy. Because Virginia would be applying cost sharing to a different population that includes individuals with intellectual and developmental disabilities as well as aged and physically disabled individuals, it is unknown whether such a plan would receive federal approval.

Implementing cost-sharing requirements in Virginia would require developing affordable levels of cost sharing based on family income. This is a policy decision, regarding who pays for part of their Medicaid services and how much they pay. Arkansas and Minnesota both calculate a progressive "premium" based on family income, but the states use different approaches (Table 2-2).

TABLE 2-2
Two states require cost sharing based on family income but at different levels

	Arkansas	Minnesota
Lowest cost-sharing requirements		
Income for lowest cost sharing	$25,000	$69,225
Lowest percentage for cost sharing	1%	2.23%
Amount of lowest monthly premium	$21	$126
Highest cost-sharing requirements		
Income for highest cost sharing	$200,000	$239,325
Highest percentage for cost sharing	2.75%	10.13%
Amount of monthly premium	$458	$2,000

SOURCE: JLARC staff analysis of waiver and eligibility documents in Arkansas and Minnesota.
NOTE: Arkansas would only require cost sharing at $25,000 for a family of two, because there is no cost sharing if household income is below 150% of the federal poverty level. Minnesota example is based on a household size of four where the eligible child lives with the parents.

Virginia could develop a plan and apply to CMS for approval to implement cost sharing based on family income for LTSS recipients. Establishing an appropriate level of cost sharing requires considering the trade-off between the potential revenue generated and the impact on the families paying the premium. Setting the cost sharing too high could make it unaffordable for families, and research indicates that this can cause individuals to dis-enroll from Medicaid. Setting it too low would negate the potential financial benefit to the state. This approach would potentially impact spouses of adults as well as the families of children in Virginia because both children and adults are eligible through the Optional LTSS eligibility category. There were more than 5,300 children and 41,700 adults (not all of whom are married) who would have been potentially subject to the cost-sharing requirements in FY15. The number of recipients impacted and the amount of premiums collected would depend on the level of cost sharing, the incomes of the families and spouses, and how many of the adult recipients are married.

OPTION 2

The General Assembly could consider including language in the Appropriation Act directing the Department of Medical Assistance Services to develop a plan to implement cost-sharing requirements based on family income for individuals eligible for long-term services and supports through the optional 300 percent of SSI eligibility category, and apply to the Centers for Medicare and Medicaid Services for approval to implement the cost-sharing plan.

DMAS should focus on controlling spending in managed care and long-term services and supports

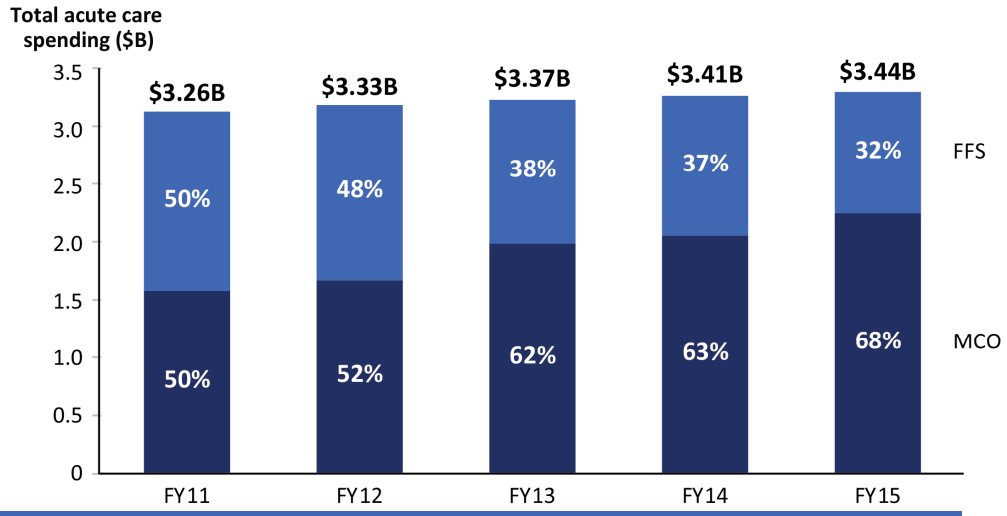
A significant amount of spending shifted over the past five years toward Virginia's managed care delivery system and toward community-based services, even as overall spending per enrollee remained flat. This report focuses on these areas because they represent the greatest opportunities to control costs. Some of the recommendations in the chapters that follow could lead to direct cost savings, while others represent opportunities to improve administrative processes in an effort to improve long-term cost-effectiveness. Some recommendations, specifically those directed at improving the cost-effectiveness of Virginia's managed care programs, may need to be considered together and phased in over time to avoid placing too much financial pressure on MCOs.

Managed care spending increased due to more enrollees with higher needs

Capitation payments to MCOs have increased over the past five years as additional populations shifted from fee-for-service to managed care. Many of the populations that were new to the Medallion managed care program also had higher needs and associated spending, including recipients in southwest Virginia and LTSS recipients on the Elderly and Disabled with Consumer Direction (EDCD) waiver. This results in

higher overall spending through managed care, as more individuals are enrolled in the program, and an increase in the per enrollee capitation rates, because those individuals require more services. Increased spending through managed care, which currently provides only acute care services, was largely offset by decreases in fee-for-service acute care spending. Acute care spending was split evenly between fee-for-service (50 percent) and managed care (50 percent) in FY11, shifting to nearly 70 percent managed care in FY15 (Figure 2-4). The shift toward increased spending through managed care underscores the need for DMAS to focus on maximizing the incentives it places on MCOs to effectively control spending. (See Chapter 4 on using incentives and financial oversight to maximize the cost-saving potential of MCOs.)

FIGURE 2-4
Managed care spending has increased as recipients who need more services have transitioned to managed care



FFS					
Average enrollment	231,776	240,800	223,846	218,578	202,079
Spending per enrollee	$6,978	$6,462	$5,793	$5,794	$5,401
MCO					
Average enrollment	536,053	546,618	585,484	590,823	628,305
Spending per enrollee	$3,069	$3,196	$3,547	$3,627	$3,737
Total					
Average enrollment	767,829	787,418	809,330	809,401	830,384
Spending per enrollee	$4,249	$4,228	$4,168	$4,212	$4,142

SOURCE: JLARC and Mercer staff analysis of DMAS claims and enrollment data.
NOTE: Inflation-adjusted FY15 dollars.

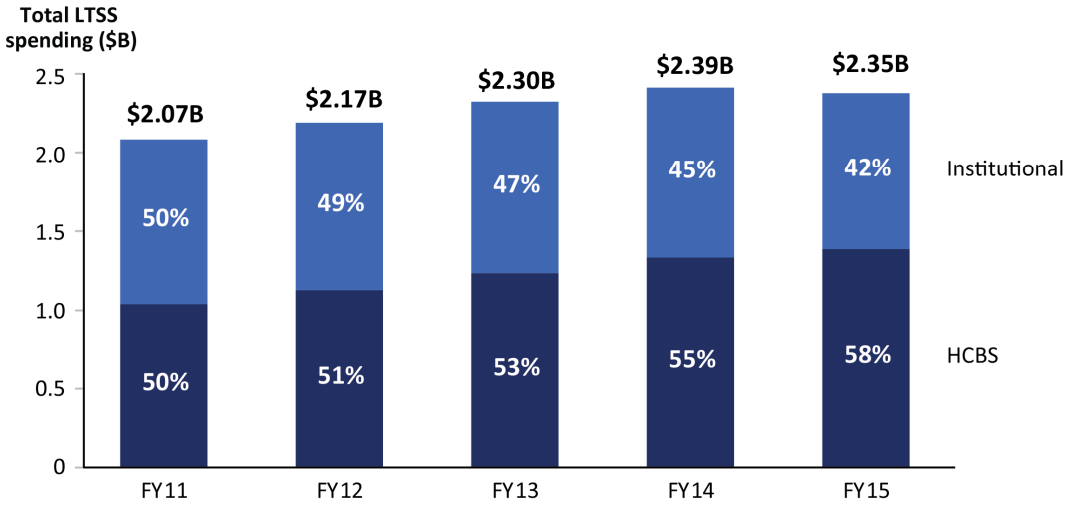
Spending on home and community-based services increased as more recipients chose to receive services in the community

Spending on long-term services and supports shifted toward community-based services, as more recipients chose to receive LTSS in the community rather than in institutions. This shift is driven by increasing enrollment in the uncapped EDCD waiver, and by the decision to increase the number of waiver slots for individuals with intellectual or developmental disabilities. As a result, the share of spending on community-based services increased from 50 percent in FY11 to 58 percent in FY15 (Figure 2-5). Serving recipients in the community is less expensive on average, leading to an overall decrease in the average cost for each LTSS recipient from $41,752 in FY11 to $38,137 in FY15. The number of recipients who chose community-based services increased by more than 12,800, and the number of recipients in institutional care decreased by about 600. The average spending for each institutional recipient remained relatively flat, while average spending per community-based recipient decreased by $2,400 per year. These trends demonstrate the need for a strong process to screen recipients for LTSS eligibility, ensure that they are served in the most cost-effective setting, and ensure appropriate utilization of services in that setting. (See Chapter 3.)

Behavioral health spending was largely stable while spending per recipient increased

Spending on behavioral health services stabilized over the past five years, after a period of significant growth prior to FY11. The stabilization in spending was due in large part to several steps taken by DMAS to ensure that only recipients truly in need of behavioral health services were able to access the appropriate type and amount of those services. Total spending on behavioral health services did increase from $624 million in FY11 to $735 million in FY15, driven largely by an increase in spending on community-based services. This growth was driven by increased spending per recipient, which was partially offset by fewer individuals receiving services. While overall spending has stabilized, the increasing spending per recipient underscores the importance of ensuring that individuals receive the appropriate type and amount of services based on their needs. (See Chapter 6.)

FIGURE 2-5
LTSS spending shifted to community-based services as more recipients elect to stay in their homes



Institutional					
Average enrollment	19,944	19,783	19,441	19,246	19,332
Spending per enrollee	$51,916	$53,443	$55,413	$55,415	$50,685
HCBS					
Average enrollment	29,552	32,530	35,952	38,880	42,414
Spending per enrollee	$34,893	$34,289	$33,956	$33,990	$32,417
Total					
Average enrollment	49,496	52,313	55,392	58.126	61,746
Spending per enrollee	$41,752	$41,533	$41,486	$41,084	$38,137

SOURCE: JLARC and Mercer staff analysis of DMAS claims and enrollment data.
NOTE: Numbers are not adjusted for inflation due to minimal unit cost increases for the largest HCBS service categories. Increase in institutional spending per enrollee is due in part to rising unit cost.

3 Providing Cost-Effective Long-Term Services and Supports

SUMMARY Several key processes for determining eligibility and appropriate services for costly long-term services and supports (LTSS) can be improved to ensure more cost-effective spending. Enrollment growth has been a significant contributor to spending growth. Individuals must have sufficiently high needs on a medical and functional screening to be eligible for LTSS, so screenings must be reliable to ensure only eligible individuals can receive these costly services. The current screening process creates the risk of unreliable and inconsistent results, and oversight of reliability is insufficient. As a result, there is risk that some of the eligibility determinations are inappropriate. Once an individual is determined to be eligible for LTSS, Virginia has generally been successful in its efforts to shift, or "rebalance," LTSS spending away from high-cost institutional care and toward lower-cost home and community-based care. However, providers currently develop the plan of care for recipients of home and community-based care, and providers have a conflict of interest that could result in unnecessary spending. DMAS needs to take several steps to improve the reliability of the preadmission screening process, and as these services transition to a managed care delivery system, several opportunities exist to ensure that recipients receive the appropriate amount of services in the most cost-effective setting.

Enrollment in home and community-based services (HCBS) is driving most of the spending growth of Medicaid long-term services and supports (LTSS), making it critical that appropriate and cost-effective services are provided to the right Medicaid enrollees. Processes for enrolling individuals and identifying needed services can be improved to reduce spending and create more equitable access to services. There is a risk that preadmission screening is conducted unreliably, meaning screening teams may assess individuals differently, and this creates the possibility of wasted or inappropriate spending when individuals are not truly eligible for services. Alternatively, unreliable screenings could result in eligible individuals being denied services altogether. LTSS spending can be further reduced by ensuring that the appropriate and least restrictive care setting is selected during the screening process, as the cost of institutional care is significantly higher than home and community-based care. Further, LTSS spending may be higher than necessary because providers determine the type and amount of services enrollees receive through the plan of care process. Removing providers from this process would eliminate the financial conflict of interest that exists and could result in spending that more closely correlates with recipients' needs.

Processes for determining eligibility for LTSS may produce unreliable results

There are several processes that need to be improved to ensure that the right individuals are eligible for LTSS and that they receive the appropriate type and quantity of services. This discussion focuses on the Elderly or Disabled Consumer Direction (EDCD) waiver, which is the largest and fastest growing HCBS waiver, and nursing facilities.

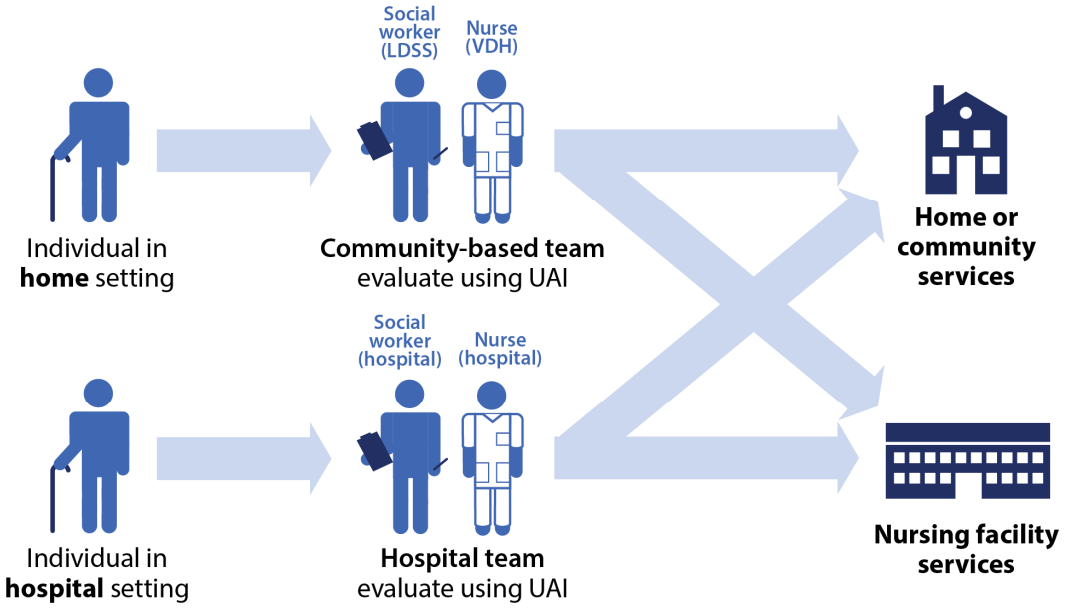
The Uniform Assessment Instrument (UAI) tool that is used to determine eligibility for LTSS services during the preadmission screening (PAS) process has never been validated for children. Prior to November 2016, screening teams could screen children as adults possibly resulting in inappropriate eligibility determinations. There is also a risk of unreliable results because training for PAS teams for screening both children and adults is neither mandatory nor consistent. Not only are teams not required to receive training, but there are over 200 entities involved in the PAS process, which exacerbates the risk. DMAS can take steps to address these shortcomings as well as to provide broader oversight of the PAS process.

Individuals seeking LTSS must meet both the standard financial eligibility criteria for Medicaid recipients and additional medical and functional criteria. To be medically and functionally eligible, individuals must meet a nursing facility level of care even though they ultimately may choose to receive care in their home or community. To meet a nursing facility level of care, individuals must be dependent in multiple Activities of Daily Living (ADLs), have ongoing medical nursing needs, and be at risk of institutional placement. The eligibility threshold for LTSS in Virginia is higher than in most other states, and consequently, Virginia's LTSS population is less healthy and has greater needs than LTSS populations in other states.

The UAI assesses an individual's ability to complete **Activities of Daily Living (ADLs)** either independently, with some assistance, or with full assistance. ADLs include bathing, dressing, toileting, transferring, bowel control, bladder control, and eating/feeding.

Virginia's preadmission screening process is implemented by both community-based and hospital screening teams to determine medical and functional eligibility for services (Figure 3-1). Screening teams utilize the Uniform Assessment Instrument (UAI) to assess the extent to which individuals can perform activities of daily living (ADLs) on their own, such as bathing and dressing. The UAI also collects information about medical issues and other important needs (e.g., psychosocial). There is a degree of subjectivity involved in determining medical and functional eligibility even with nurses and social workers, who have medical expertise, conducting screenings, and it is possible that two different screeners assessing the same individual could arrive at different outcomes. If individuals disagree with the outcome, they have the right to appeal. The possibility that different screeners may arrive at different outcomes during the PAS process underscores the importance of improving the reliability of screening.

FIGURE 3-1
Virginia's PAS process determines eligibility for Medicaid LTSS



SOURCE: JLARC analysis of DMAS regulations and interviews.

Without re-screening applicants, it is not possible to determine if individuals who do not meet the criteria are getting into the program or if individuals who do meet the criteria are being denied access to the program. Nonetheless, weaknesses in the current PAS process and in oversight functions suggest there is a risk that these circumstances could occur. In addition to concerns about equity of access to LTSS services, there may be financial costs: nearly $20,000 per individual per year, on average, half of which is paid with general funds.

A valid tool for screening children would provide greater assurance that access and spending are appropriate

The UAI is used to determine whether individuals of all ages are medically and functionally eligible for LTSS, but it has never been tested for validity in children. Validity testing is critical for ensuring that the LTSS screening instrument accurately measures the concepts it is intended to measure, such as whether a person can perform each activity of daily living independently. The UAI's criteria were designed for adults and are based on well-established research on the aging population. Although ADLs are widely accepted and used in LTSS screenings for adults, Virginia's ADLs were not originally tailored to children. Children have different developmental stages than adults, and children typically have a caregiver (a parent or guardian) who can assist them with ADLs.

Virginia developed the **Uniform Assessment Instrument (UAI)** in the 1990s to function as a single, standardized instrument for assessing individuals' social well-being, physical health, mental health, and functional abilities. Though the UAI is essential for Medicaid LTSS, the instrument is also used by other public human services agencies for care planning.

In 2013, DMAS led a collaborative group that developed children-specific criteria for screeners to use when administering the UAI. These criteria include developmental activities appropriate for children of various ages. For example, children ages one to four years old should participate in dressing themselves but might need some supervision. DMAS based criteria on information from the American Academy of Pediatrics, but it was not specifically tied to ADLs and has not been formally validated. It is therefore unknown whether the new criteria have improved the validity of screenings. State agencies acknowledge that further improvements to children's screenings are needed, and screening teams continue to report difficulty in using the UAI to screen children.

Validity testing is critical because if the supplemental children's criteria are not valid, then children who may not be eligible could be approved for services; alternately, children who are eligible could be denied access to LTSS. This has the potential to impact as many as 3,000 children screened each year. Recently, DMAS made changes to improve children's screenings, and validity testing should be part of this broader effort. For example, prior to November 2016, the children's supplemental criteria were optional for screening teams to use, which resulted in some children being screened as adults. When children were screened on their ability to independently perform activities that are normally expected of adults, they are more likely to be found eligible for services because the role of the parent in assisting the child is not considered (case study). DMAS has also contracted with VDH to conduct all children's screenings in an effort to improve the consistency of results.

CASE STUDY

The challenge of screening children with the UAI

A three-year old boy diagnosed with autism lives with his mother and father. He has been denied continuing care at two daycare centers because he is not toilet trained and he is disruptive. His mother reports that she bathes and dresses him, although he will cooperate and lift his arms to help "when he wants to." He has been receiving speech and occupational therapies and now communicates with a limited vocabulary of single words. His mother is requesting EDCD waiver services for respite care.

Prior to November 2016 when the children's supplemental criteria were optional, two different outcomes would have been possible. If the screening team applied the children's criteria, the boy would not be eligible because the parents are able to manage his care. However, if the screening team applied the adult criteria, the boy would be deemed functionally dependent because he needs someone—regardless of whether it is a parent—to assist him.

SOURCE: Case study example provided by VDH.

To ensure that access to services is equitable and spending is appropriate, it is essential that DMAS improves the screening of children by formally validating the screening criteria. DMAS has indicated that undertaking this effort would require additional resources.

RECOMMENDATION 1

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to formally validate the children's criteria used with the Uniform Assessment Instrument to determine eligibility for Medicaid long-term services and supports.

Training for screening teams is not mandatory or consistent

Training for screening teams on how to apply the UAI to determine eligibility for both adults and children is neither required nor consistent. Training is optional, and community-based teams have had more opportunities to receive training than hospital teams. Even when teams do receive training, the content of that training is inconsistent. Three agencies—VDH, DARS, and DSS—cover different material in their training programs. For example, the training provided by DSS, which many screeners have taken, primarily addresses how to fill out the UAI form, not how to ask questions and probe for accurate information. The lack of a standard and mandatory training process significantly increases the risk of unreliable results from the PAS process.

Some states mandate training and also require certification of screeners to promote a more reliable process. For example, both Tennessee and Wisconsin require screeners to be trained and certified before making eligibility determinations. DMAS indicated they would like to develop a single PAS training for all screeners. To be most effective, this training must be mandatory, and there should be a certification process that requires all screeners to demonstrate a reliable application of UAI criteria before conducting their first screening. DMAS indicated they would need one full-time employee to design and implement a standard training process.

RECOMMENDATION 2

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to develop a single, comprehensive training curriculum on the Uniform Assessment Instrument for all screeners who conduct preadmission screenings for Medicaid long-term services and supports.

RECOMMENDATION 3

The General Assembly may wish to consider amending § 32.1-330 of the Code of Virginia to require screeners to be trained and certified on the Uniform Assessment Instrument prior to conducting preadmission screenings for Medicaid long-term services and supports.

Large number of screening entities in Virginia exacerbates the risk of unreliable screenings

The high number of screening teams increases the possibility that screenings produce unreliable results. In Virginia, over 200 different entities conduct preadmission screenings. Over half of these (117) are local DSS offices, which work with nurses from VDH to form community-based teams, and the remainder (91) are discharge planning teams in hospitals. All teams must perform screenings consistently in the absence of standardized, mandatory training. Administering the UAI requires some subjectivity and interpretation to accurately determine whether individuals meet criteria despite screeners having medical expertise as nurses and social workers. There is also no mechanism, such as inter-rater reliability testing, that would alert DMAS when screeners may be inconsistently applying the criteria.

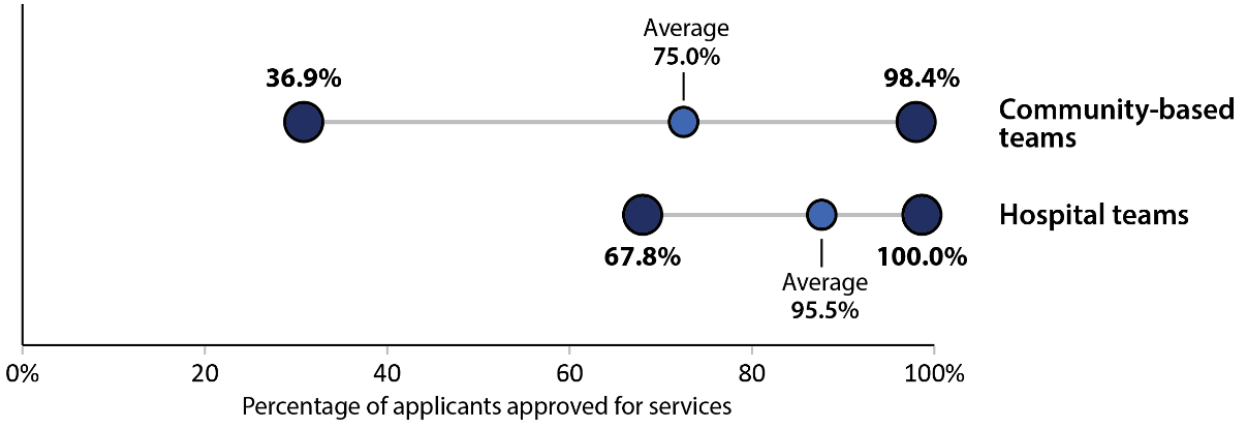
PAS screenings by team

Of the more than 36,000 screenings conducted in FY16, community-based teams screened 59.1 percent of individuals and hospitals screened 40.9 percent of individuals.

Variation in authorization rates across screening teams suggests teams may be applying the eligibility criteria differently. Authorization rates indicate whether individuals screened with the UAI met criteria and were approved for services. The variation in authorization rates may be reasonable, but DMAS has not established benchmarks or inter-rater reliability tests to determine how much variation is acceptable. Some variation across teams is likely due to differences in populations across the state. On average, community-based teams authorized 75 percent of all individuals screened in FY16, but authorization rates ranged from 37 percent to 98 percent across teams (Figure 3-2). Hospitals had a smaller range of authorization rates with 95 percent of individuals screened receiving services on average, meaning they deny far fewer individuals than community-based teams. This could be indicative of a lack of PAS training for hospital teams or of the reality that individuals screened in hospitals tend to have greater needs. Hospital staff have indicated that because an individual is in the hospital for a serious health problem, it is difficult to assess what the long-term needs will be after the immediate health condition has stabilized.

Unreliable screenings are particularly problematic for teams that screen a significant number of individuals for services, and spending may be inappropriate in localities where few individuals are denied services. For example, the Virginia Beach community-based teams screened nearly 850 individuals in FY16 and denied only 60 (7.1 percent). The Virginia Baptist Hospital team screened over 1,300 individuals and denied only 19 (1.4 percent). It is also possible that teams with high denial rates are limiting access to needed services.

FIGURE 3-2
Significant variation in authorization rates exists across screening teams



SOURCE: JLARC staff analysis of FY16 authorization data provided by DMAS.
NOTE: JLARC only included teams that screened at least 100 individuals in FY16. Authorization rates are based on total screenings administered by a locality's community-based team or by a hospital team. Typically, there is one designated screener for hospital teams and two screeners (one social worker and one nurse) for community-based teams.

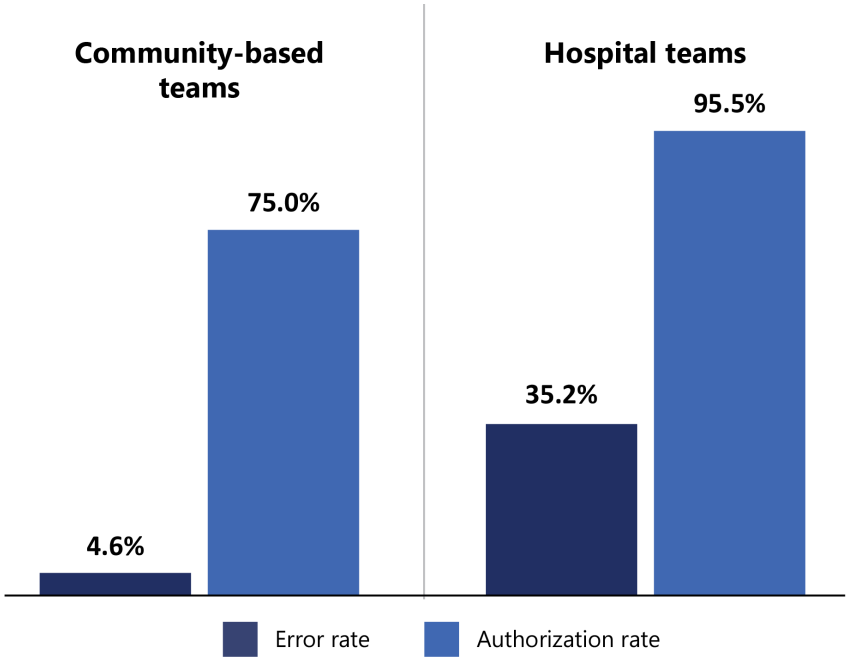
In addition, hospital teams have significantly more errors in completing and submitting the UAI form. For example, a UAI might be rejected by DMAS if the screening team leaves fields blank or if the team recommends services even though the individual is not dependent in enough ADLs. While community-based teams have an error rate of 4.6 percent, hospitals make mistakes 35.2 percent of the time (Figure 3-3). The high error rate may reinforce the need for more consistent and mandatory UAI training.

An inter-rater reliability process should be implemented to allow DMAS to test whether screeners are consistently interpreting and applying criteria from the UAI. Testing for inter-rater reliability must be rigorous and would require more than a post-screening review. A qualified individual should either screen alongside the screening team or screen the same individual shortly after the initial screening. Implementation of inter-rater reliability testing would require additional resources, and the amount will depend on the sample size, method, and frequency of testing. Rather than use a random sample of screeners, DMAS could intentionally review a higher percentage of certain screeners to target suspected problems with reliability. For example, DMAS might disproportionately sample hospital screeners to test whether their UAI results are reliable.

Tennessee tests for reliability on an ongoing basis after state staff discovered inconsistencies in preadmission screenings.

Initially, Tennessee sampled half of all screenings for testing until reliability improved. Now, the state tests 25 percent of all screenings, which is still significant in terms of sample size and the resources required.

FIGURE 3-3
Hospital teams have higher error and authorization rates



SOURCE: DMAS's electronic PAS data, FY16.

RECOMMENDATION 4

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to design and implement an inter-rater reliability test for the preadmission screening process.

DMAS made it a practice to waive UAI requirements for certain individuals entering nursing facilities via hospitals, even though statute requires that DMAS "shall require a preadmission screening of all individuals" (§32.1-330).

DMAS plans to implement a solution by July 1, 2017 to deny payment if a UAI is not on file. JLARC could not determine how long DMAS had been waiving this requirement or what the cost implication was.

DMAS oversight of the reliability of LTSS eligibility screenings is inadequate

As the single state agency with the responsibility for determining eligibility, DMAS can do more to ensure the reliability of PAS screenings for children and adults. Effective oversight of the preadmission screening process requires (1) establishing policy and regulations, (2) ensuring that all screeners are trained and certified, (3) monitoring that screenings are performed reliably, and (4) addressing problems as they are identified. Currently, multiple state agencies participate in the PAS process and are critical to its operations; however, oversight functions have become fragmented with multiple agencies taking on similar roles, and some of the oversight functions have not been performed at all. Several of the issues noted earlier in this chapter regarding reliability of screening results could have been prevented or remedied by better oversight. It should be noted that DMAS has made progress in overseeing and improving the timeliness of PAS screenings as required by the General Assembly. DMAS launched an electronic, automated screening system to achieve quicker processing of UAIs and

launched a dashboard to track results. These improvements need to also focus on oversight of the reliability of screenings.

DMAS should ensure that every screener participating in the PAS process has been trained and certified prior to conducting screenings. This requires the development of a standard curriculum that promotes reliability by teaching screeners to ask questions and probe for answers in similar ways (Recommendation 2). DMAS also needs to document the training and certification status of all screeners.

DMAS needs to monitor screenings performed by trained staff to confirm that they yield reliable results. Oversight of reliability should include at least three elements: technical assistance, analysis of PAS results, and inter-rater reliability testing. DMAS should augment current, informal efforts to analyze PAS authorization rates to identify screeners that may be outliers and provide proactive technical assistance to improve the reliability of results. Currently, DMAS relies on VDH to analyze PAS data and identify screeners to receive technical assistance, but VDH's role is informal and short-term. DARS also offers technical assistance to LDSS social workers, so different members of a screening team may receive conflicting guidance from different sources. Technical assistance needs to be standardized, and DMAS is positioned to be the agency that analyzes PAS data and provides guidance directly to screeners. Real time authorization data has only been available starting this year, which can facilitate improved oversight. DMAS should also be ultimately responsible for inter-rater reliability testing (Recommendation 4) even if this activity is outsourced to another agency or a contractor. DMAS should ensure that testing is conducted in a rigorous and timely manner and that staff are aware of unreliable results.

When issues are identified through data analysis or inter-rater reliability testing, DMAS needs to be responsible to make sure problems are addressed. In particular, when screeners are found to be contributing to unreliable PAS results, DMAS can first monitor the provision of technical assistance and then require more training or even recertification if necessary. As a last resort, DMAS could remove that screener from the process entirely.

This recommendation will require DMAS to take a stronger role in ensuring reliable screenings. DMAS staff do not have to execute all oversight activities themselves, but they do need to make it clear who is responsible, coordinate with those entities (VDH, DARS, contractors, and others), and ultimately be accountable for the outcomes.

RECOMMENDATION 5

The Department of Medical Assistance Services should strengthen oversight of the preadmission screening process to ensure that all screeners are trained and certified; that screenings are performed reliably; and that problems in the screening process are promptly addressed.

Use of home and community-based care is growing but can be increased further

Virginia's Medicaid recipients choose the setting of care that they prefer regardless of cost. While serving a recipient in their home could cost more than serving him or her in an institution, it is an unlikely scenario.

Over time Virginia has shifted a greater portion of spending toward more cost-effective home and community-based services (HCBS), but more can be done to ensure that less spending is allocated to higher-cost institutional services. Despite progress, more than 80 percent of individuals screened in hospitals are recommended for institutional services. DMAS needs to develop a strategy to better divert recipients toward community-based settings and transition more individuals out of institutions. Additionally, after the implementation of managed long-term services and supports (MLTSS), DMAS will need to use a strong financial incentive for MCOs to keep more recipients in the community.

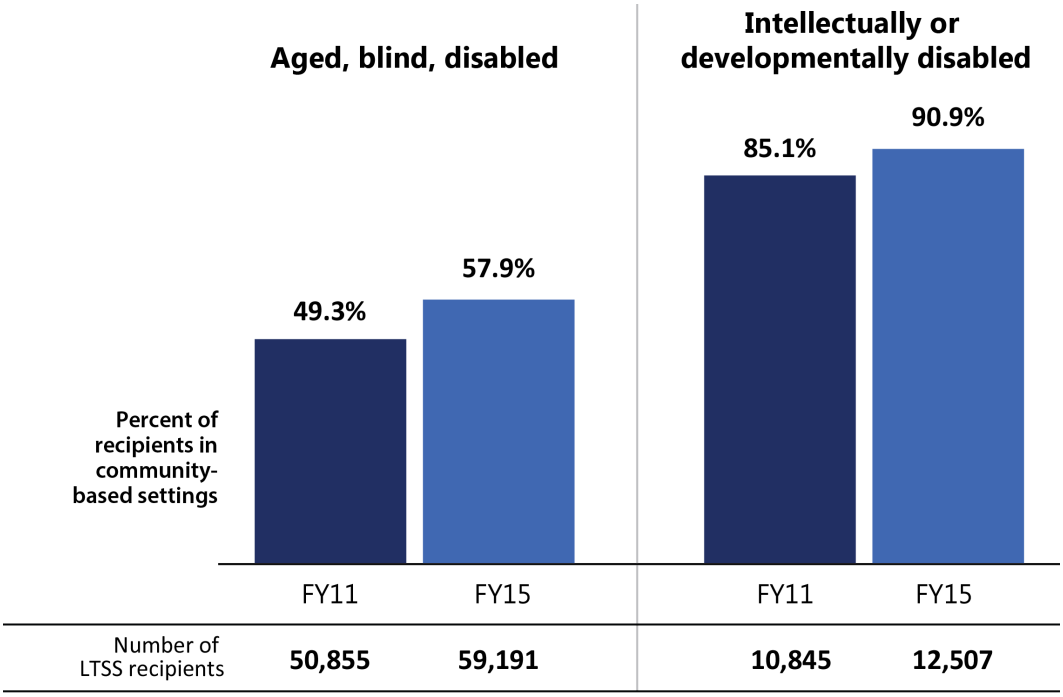
Encouraging Medicaid recipients to choose HCBS represents a significant opportunity to manage LTSS spending because they are less costly than comparable institutional care. If an additional one percent of recipients were served in the community (through the EDCD waiver) instead of nursing facilities in FY15, then Virginia could have saved approximately $7 million, assuming the length of Medicaid enrollment is not affected by HCBS. HCBS also promotes recipients' health and well-being by offering a less restrictive environment for those who wish to maximize their independence and maintain community connections while receiving care. For these reasons, Virginia has shifted LTSS spending over time toward HCBS. The shift reflects a national strategy known as "rebalancing." Rebalancing is important because federal Medicaid policy has an institutional bias, meaning proactive efforts are necessary to ensure enrollees do not default to institutional care. In particular, federal policy requires states to cover nursing facility services while HCBS is optional, and unlike institutional care, Medicaid policy does not allow states to use federal dollars to cover ongoing housing costs for HCBS.

Two-thirds of LTSS recipients in Virginia are served in their homes or communities rather than in institutions

Virginia has made significant progress in rebalancing LTSS spending. Compared to 10 years ago when HCBS spending comprised just 26.5 percent of total LTSS costs, Virginia now allocates 58.4 percent of spending to HCBS. Nearly two-thirds of LTSS recipients receive care in their homes or communities rather than in institutions. Movement toward HCBS has slowed in the past five years, but Virginia has demonstrated recent progress in rebalancing for both LTSS populations—the aged, blind or physically disabled and the intellectually or developmentally disabled. A greater percentage of recipients with intellectual or developmental disabilities live in their homes or communities (91 percent) than recipients who are aged, blind, or have a physical disability (58 percent). This is in line with national rebalancing trends (Figure 3-4). Compared to other states, Virginia performed near the national average and ranked 20th in FY14 for the proportion of LTSS spending for HCBS (Figure 3-5). However, other state

benchmarks demonstrate that there is room for improvement, as evidenced by states that have achieved rebalancing as high as nearly 80 percent of total LTSS spending.

FIGURE 3-4
Virginia has increased the percentage of recipients living in their homes or communities



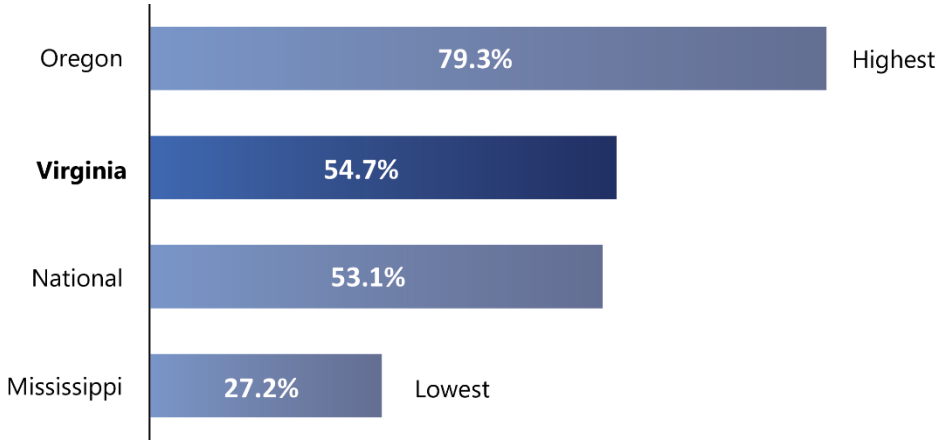
SOURCE: JLARC and Mercer staff analysis of Medicaid data.

DMAS attributes its rebalancing progress to multiple factors. New recipients, particularly those in the aged, blind, and disabled eligibility category, have increasingly chosen the EDCD waiver over nursing facilities when enrolling in LTSS. The 2012 U.S. Department of Justice settlement agreement requires Virginia to transition individuals with intellectual and developmental disabilities out of institutional settings over time. As a result, the Department of Behavioral Health and Developmental Services has closed two of the five public intermediate care facilities and has transitioned a majority of those individuals to HCBS settings. Since 2011, over half of public residents have left intermediate care facilities, and two additional intermediate care facilities are scheduled to close by 2020. Other factors that have led to progress in rebalancing include

- the 360 additional HCBS waiver slots added by the General Assembly;
- the implementation of specific HCBS-focused programs such as Money Follows the Person, and the Program of All-Inclusive Care for the Elderly (PACE) in 2007; and
- the EDCD waiver's uncapped capacity for new enrollees.

Research literature also suggests that seniors and individuals with disabilities generally prefer HCBS to institutional care, meaning even without states' efforts to rebalance, services are shifting toward HCBS.

FIGURE 3-5
Virginia is similar to the national average for percentage of LTSS spending on HCBS (FY14)



SOURCE: 2016 Truven Health Analytics report, "Improving the Balance: The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS), FY 1981-2014."

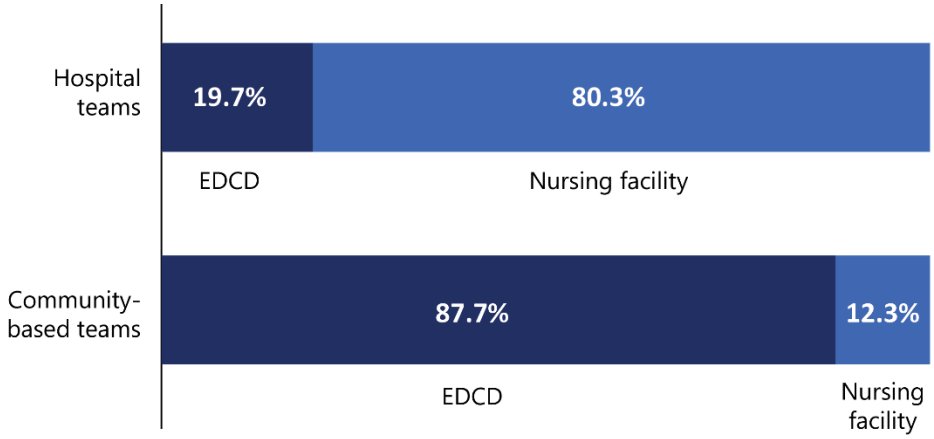
Virginia has multiple opportunities to serve more recipients in cost-effective community settings

Despite progress, Virginia has several opportunities to continue to rebalance in favor of lower-cost home and community-based services. Diverting new enrollees to HCBS is the easiest way to rebalance. Many individuals go to nursing facilities after having severe medical episodes, such as a heart attack or stroke, and transitioning these individuals back into HCBS is difficult but important to maximize the potential to rebalance LTSS spending. As DMAS implements MLTSS, it can develop strong incentives for MCOs to actively divert and transition recipients, and Virginia can do more to promote integration within HCBS, particularly for the IDD population.

DMAS can divert more individuals from institutional care and transition more individuals to HCBS

Virginia has generally performed well in diverting new Medicaid LTSS enrollees from unnecessary institutionalization, but individuals screened by hospitals are more likely to enter nursing facilities than those screened by community-based teams. In FY16, hospital teams recommended nursing facility care for 80 percent of enrollees compared to 12 percent of enrollees recommended by community-based teams (Figure 3-6). The higher rate of institutional placement by hospital screening teams may be appropriate because individuals assessed in acute care settings tend to have greater health needs, but it would be beneficial for DMAS to determine if this rate could be reduced.

FIGURE 3-6
Hospital screening teams recommend nursing facility placement for more than 80 percent of recipients



SOURCE: JLARC staff analysis of FY16 PAS data provided by DMAS.

There are many dynamics unique to hospitals that inhibit screening teams' ability to reliably screen individuals and promote home and community-based services, including a lack of training and the added challenge of predicting the long-term care needs of individuals who are in the hospital with acute medical conditions. Hospital teams are focused on ensuring that individuals are discharged to the next setting quickly and safely. This priority can conflict with the goal of identifying the best long-term placement. Hospital screening teams usually have less time to conduct screenings and are less knowledgeable of community resources, compared to community-based teams, so they may have more difficulty providing access to HCBS. Discharging individuals in HCBS requires identifying and coordinating multiple providers and addressing other barriers, such as making homes wheelchair-accessible. Also, in the hospital setting, it may be difficult to assess whether an individual can function safely at home. For hospital screening teams, institutional settings may seem safer for the recipient.

The high rate of nursing facility recommendations by hospital screening teams can lead to unnecessary institutionalizations, which may result in increased spending over the long term and negative impacts on the well-being of recipients. It is far more difficult to transition individuals back to their homes or communities once they have entered institutions leading to continuing higher levels of spending in the future. Hospital screenings might also be contributing to the relatively steady utilization rates of nursing facilities. Over the past five years, the number of Medicaid recipients in nursing facilities has declined only marginally. If hospital teams could divert more enrollees to HCBS during the PAS process, then Virginia could shift an even a greater percentage of spending away from costly institutional care.

DMAS and stakeholders should work collaboratively to determine if the rate of institutional recommendations by hospital screening teams can be lowered. If the rate is deemed too high, there are likely multiple solutions to address this complex problem,

each with advantages and disadvantages that must be carefully considered. In some states, hospitals are not involved in the PAS process at all; instead, community-based teams go to hospitals to conduct screenings. This would resolve the risk of unreliable hospital screenings and likely reduce the high level of institutional placement. However, more resources would be needed by community-based teams if hospitals were removed from Virginia's PAS process, at least in the short term. In the long term, these costs potentially could be offset by savings from avoiding unnecessary institutionalization. Other solutions could be developed that would focus on diversion and transition for recipients screened in the hospital. For example, hospital teams could report more detailed information to DMAS regarding where individuals transfer after discharge, and community-based teams could then make contact with recipients soon after to ensure they are informed about their choices for care setting.

RECOMMENDATION 6

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to work with relevant stakeholders to (i) assess whether hospital screening teams are making appropriate recommendations regarding placement in institutional care or home and community-based care; (ii) determine whether hospitals should have a role in the screening process; (iii) determine what steps must be taken to ensure the Uniform Assessment Instrument is implemented consistently and does not lead to unnecessary institutional placements; and (iv) report to the General Assembly on steps taken to address the risks associated with hospital screenings, including any statutory or regulatory changes needed.

Another rebalancing strategy is to transition individuals who already reside in institutional settings back to their homes or communities. This strategy is important in light of the institutional bias in federal Medicaid policy, as many individuals default to institutional care when they lack the information and support necessary to remain in HCBS. Transitioning recipients from institutions to HCBS is challenging. It is difficult to identify recipients in institutional care who wish to return home. Once identified, recipients may find it difficult to return home after they have cut ties with their community support network. For example, a lack of affordable housing is often a primary barrier to transitioning to a home setting.

Resource Utilization Groups (RUGs) are standard categories of service needs assigned to individuals in nursing facilities and are determined by the LTSS Minimum Dataset Set.

Identification of individuals who wish to transition to HCBS must be done proactively. In the past, DMAS relied on nursing facilities to identify individuals who wish to transition and communicate that information to state staff, but a conflict of interest exists because nursing facilities have a financial disincentive for transitioning individuals to HCBS. There are other ways to directly engage individuals who may wish to transition. For example, DMAS could require MCOs to identify nursing facility residents with lower levels of need based on their "RUG" score and to make in-person contact with those residents to inform them of their options.

Once individuals are identified, transitioning to HCBS requires ensuring that transition services are available to recipients before they leave an institution. DMAS has made

transition services—such as care coordination and assistance with one-time costs like security deposits—available to recipients including those eligible for the Money Follows the Person program. However, the federal government decided to end this demonstration program in FY17, and although transition services will still be available, they will not be accessible up to two months prior to transition, as they were before. This limitation will likely make it challenging to prepare individuals for transition and could result in failed transitions. While transition services cover many initial costs of returning to HCBS, they do not cover the ongoing costs of housing. Other states have developed strategic partnerships with housing agencies to increase access to affordable housing, and a few states even started rental subsidy programs. In Connecticut, for example, the state general funds pay for a portion of the monthly rent of individuals who have transitioned out of institutions, and despite the investment of state dollars, staff report cost savings to the state through avoidance of long-term institutional costs. DMAS should work to develop solutions to these challenges, including working in collaboration with MCOs following the transition to MLTSS.

Money Follows the Person is a national demonstration grant program established by Congress to give Medicaid recipients more choice in where they receive care and to incentivize states to rebalance. Virginia is one of 44 states to participate. Since 2007, Virginia has transitioned 1,000 individuals to HCBS.

MLTSS capitation rates can be structured to incentivize rebalancing

Following the transition to MLTSS, MCOs will be the entities most directly responsible for rebalancing LTSS spending through the diversion and transition of their recipients. The best way for DMAS to rebalance LTSS spending is to create a strong incentive for MCOs to keep recipients in the community through the capitation rate structure.

There are two primary methods for using MLTSS capitation rates to incentivize rebalancing: transitional rates and blended rates. With transitional rates, there are two separate rates, one for institutional care and one for HCBS. MCOs receive immediate financial incentives or penalties based on transitions between care settings. For example, MCOs are rewarded with the higher institutional rate for several months when a recipient moves from an institutional setting to HCBS. Conversely, MCOs are penalized with the lower HCBS rate for several months any time a recipient moves from HCBS to an institution. This incentive structure is short-term and does not push MCOs to work toward larger shifts in spending over time. Transitional rates can also set up a perverse incentive for MCOs to initially place recipients in institutions to obtain the higher reimbursement when they move to HCBS.

Blended rates offer stronger incentives than transitional rates by having one rate regardless of care setting and establishing target mixes for MCOs. The single rate is calculated based on the expected costs of services for an individual in either an institutional or community setting, and then developing the average, blended rate by setting a target percentage of recipients in each setting. Target mixes are aspirational but achievable goals for MCOs to reach higher proportions of HCBS enrollment. For example, a MCO with a baseline mix of 50 percent for both HCBS and institutional care could be incentivized to reach 52 percent HCBS and 48 percent institutional care by the end of the year.

Because blended rates provide a stronger incentive for rebalancing, CMS recommends that states adopt this approach for rate development. Other states using a blended rate have demonstrated strong results. Arizona Medicaid staff attributes most of their progress in rebalancing to their blended rate, and as of 2014, Arizona ranked fourth in the nation for HCBS spending as a percentage of total LTSS spending. Arizona's rate structure also has an annual reconciliation process to ensure that neither the state nor MCO are unnecessarily penalized if the actual mix varies substantially from the target mix. MCOs that exceed the target mix by a certain percentage get to keep a portion of their profits while MCOs that fall significantly short recoup a portion of their losses paid by the state.

Commonwealth Coordinated Care (CCC) began in 2014 as a managed care demonstration program for individuals who qualify for both Medicare and Medicaid. DMAS plans to incorporate lessons learned and best practices of CCC into MLTSS.

DMAS used a blended rate under the Commonwealth Coordinated Care program, a pilot managed care program that preceded MLTSS, but did not reap the full benefit of the rate because they did not set a target mix for MCOs. Instead, the goal in setting the CCC blended rate was to select a mix that would accurately reflect the population of each MCO. This significantly weakened the incentive and required frequent rate adjustments as populations shifted. Setting a target mix with a blended rate will provide the strongest incentive for MCOs to continue Virginia's progress in shifting LTSS spending toward more cost-effective HCBS.

RECOMMENDATION 7

The Department of Medical Assistance Services should implement a blended rate with established target mixes under the contract for managed long-term services and supports to incentivize MCOs to rebalance enrollment away from institutional care and toward home and community-based care.

HCBS need to be fully integrated to achieve maximum rebalancing success

Moving recipients in the community toward more fully integrated services is important to achieving success in rebalancing. Even HCBS services have the potential to be isolating in ways that are similar to institutional care. For example, an individual who receives services in the home may not leave to socialize or participate in community activities. Individuals who are isolated may experience poor health outcomes, which could have an impact on long-term Medicaid spending.

Congregate residential is just one of several **habilitation services** available to recipients of the ID waiver. Other services include in-home residential—recipients receive support in their home—and sponsored residential—recipients live with a host family.

These services cost less per recipient than congregate residential services and promote higher levels of community integration. Still, congregate residential is the most frequently used service and most expensive at nearly $70,000 per recipient.

Increased community integration is relevant to all HCBS populations but particularly so for individuals receiving intellectual disability (ID) waiver services. The most frequently used ID waiver service is congregate residential, formerly known as group homes. This is the most intensive and costly level of care among community habilitation services and in high-occupancy facilities may resemble institutional care. Newer facilities are limited to serving eight or fewer individuals but congregate residences that were grandfathered in have no occupancy limits. DBHDS is trying to transition as many recipients as possible from congregate residential services to more integrated community settings, such as in-home and sponsored residential services, but some recipients and their families prefer congregate residential facilities. In planning for the

waiver redesign, DBHDS is also encouraging providers to offer new services that promote integration, such as coaching, employment, and community engagement. Continuing this progress as waiver redesign is implemented will be critical to providing the most cost-effective care possible.

Services facilitators provide support to recipients as they direct their own care. Their responsibilities include making sure the recipient gets the services they need, training the recipient on their employer responsibilities, and serving as a liaison between the recipient and the program.

Conflict of interest in the plan of care process has the potential to increase Medicaid spending

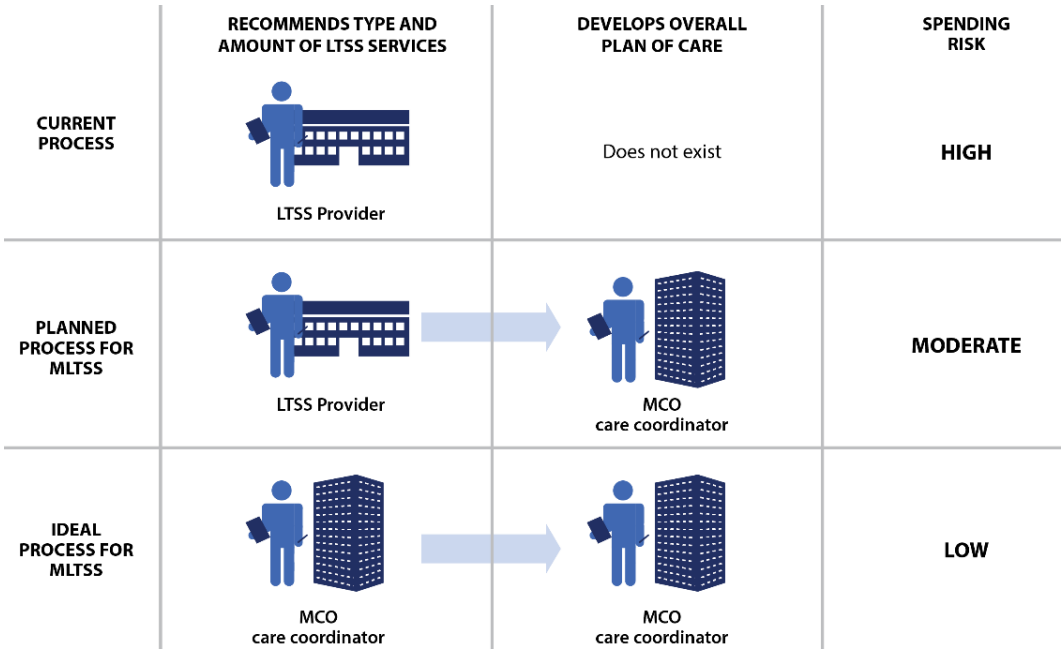
Virginia's LTSS providers determine the type and amount of services individuals receive through the plan of care process. Providers have a conflict of interest because they stand to profit if they overstate the quantity of services needed. This problem is particularly evident in the EDCD waiver, which lacks a case manager to serve as a buffer between the provider's interest to make a profit and the state's interest to be cost-effective. Determining whether, and to what extent, providers may be overstating the amount of services needed was beyond the scope of this study. However, for illustrative purposes, if the number of units of attendant care are inflated by one percent, then the cost to Virginia would be approximately $7 million, based on FY15 spending data.

For consumer-directed services, there is a different type of conflict of interest because services facilitators develop the plans of care. The primary responsibility of services facilitators is to assist recipients as they manage their own care. Unlike other LTSS providers, services facilitators do not have a financial conflict of interest, but well-intentioned efforts to help recipients may make it difficult to objectively determine the type and quantity of services needed. Further, services facilitators are typically not social workers or nurses and are therefore underqualified to perform the highly skilled job of developing the plan of care.

This conflict of interest can lead to increased Medicaid spending, and the problem is exacerbated by having the plan of care process separate from the screening process. Ideally, the provider would utilize the results of the UAI screening to ensure that the plan of care is reasonable in light of the individual's needs. Providers have access to the UAI but are not required to use it, so the plan of care could reflect a higher level of need than the UAI suggests. Despite federal regulations that prohibit financial conflicts of interest, states can allow providers to drive care planning if certain processes are in place to mitigate the risk, such as prior authorization for services and quality reviews after services have been rendered.

The conflict of interest will remain to some extent as DMAS transitions to MLTSS because providers will largely retain their current role in developing LTSS plans of care. The risk to spending will be mitigated to some degree by the role of the MCO care coordinator, who will incorporate the LTSS plan developed by the provider into a broader care plan that includes non-LTSS services (Figure 3-7). Additionally, MCO care coordinators will review existing plans of care for recipients when MLTSS is first implemented, to assess whether plans are appropriate. It is also important that DMAS

FIGURE 3-7
MCO care coordinators should develop LTSS plans of care



SOURCE: JLARC staff analysis of the plan of care process in Virginia and other states.
NOTE: During initial implementation of MLTSS, MCO care coordinators will review existing plans of care for recipients and assess whether they are appropriate.

monitor utilization data to ensure that MCOs do not authorize fewer services than recipients need in an effort to reduce spending.

States with mature MLTSS programs tend to require care coordinators to develop the full plan of care, including determining the type and amount of LTSS. For example, in Tennessee and Wisconsin, care coordinators go into the home to determine the type and quantity of services an individual needs and LTSS providers are brought in after the plan has been developed. It is also typical in consumer direction for services facilitators to serve only as the recipient's advocate and not develop plans of care.

Requiring care coordinators to develop LTSS plans of care would necessitate a change to DMAS regulations and potentially require additional resources. Regulations would have to be modified to discontinue the use of services facilitators in determining the type and amount of services recipients need. DMAS indicated that MCOs may not have the capacity among their care coordinators to perform this function, and the additional administrative expense would have to be accounted for in the capitation rates.

RECOMMENDATION 8

The Department of Medical Assistance Services should require MCOs to develop the portion of the plan of care addressing the type and amount of long-term services and supports that each recipient needs.

4 State Oversight of Overall Managed Care Spending

SUMMARY DMAS has not maximized the cost-saving potential of its managed care program. DMAS has historically focused on overseeing managed care quality, and while improving quality can reduce spending, states can more directly control spending by paying MCOs strategically and implementing strong financial oversight practices. Virginia could have saved up to $36 million in FY16 by ensuring that the capitation rates it pays managed care organizations (MCOs) do not cover unnecessary spending. Virginia can also limit excess spending by strengthening its cap on MCO profits. Virginia could have recovered between $3 million and $14 million by strengthening its profit cap to be more in line with other states. The state should be more proactive in its monitoring of managed care spending, through the collection and use of additional data from MCOs, and through stronger enforcement of contractual requirements.

States have increased their use of managed care delivery systems in an effort to reduce spending and improve quality, but the delivery system alone is not sufficient to achieve these goals. Like many other states, Virginia operates an "at-risk" managed care program, in which MCOs are paid a flat capitation rate for each member and therefore take on the financial risk if spending is higher than projected. The theory behind this model is that this financial risk, paired with flexibility for MCOs to innovate and enforcement of quality standards, creates incentives for MCOs to provide cost-effective services. However, as private entities aiming to maximize profits, some managed care organizations (MCOs) do not necessarily share the state's goals; instead they have an incentive to maximize capitation payments and limit the cost of services delivered. States need to effectively oversee managed care by appropriately paying MCOs and continually monitoring their performance.

Capitation rate is a flat rate that states pay MCOs per enrollee per month in exchange for providing health care services covered under the contract. The rate is determined by the state and its actuary at the beginning of each year.

JLARC contracted with Mercer Health and Benefits (Mercer), to assist with this review of Medallion, Virginia's managed care program. JLARC and Mercer worked together to review several aspects of the program, including capitation rate development and financial oversight, and developed recommendations to improve Virginia's ability to control spending through the Medallion managed care program.

DMAS has not prioritized cost savings through its managed care program

Until recently, DMAS's primary emphasis with regard to MCOs has been on overseeing quality of care. This emphasis has many benefits for the state over the long term, such as reducing long-term spending through better health outcomes and mitigating

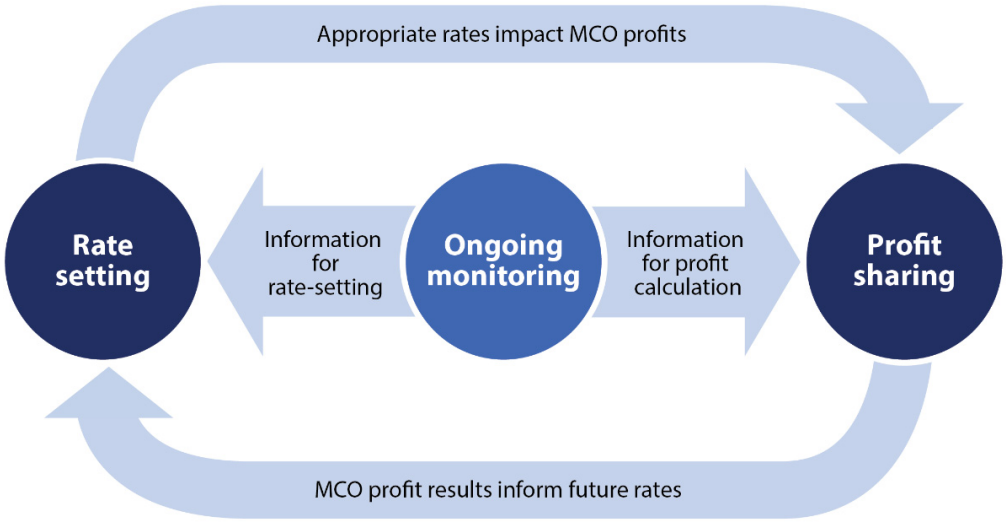
the risk that MCOs will unnecessarily deny services to increase profits. However, Virginia needs to balance its strong oversight of quality with more direct strategies to manage costs. According to DMAS staff, the agency is in the process of shifting its emphasis toward stronger financial oversight and contract compliance.

Historically, DMAS has used a more passive approach to financial oversight—primarily relying on the incentives created by capitation rates—to keep costs down. An MCO's profits or losses in a given year depend on how well it controls costs under the capitation rate. However, capitation rates also create a disincentive to reduce costs. Future rates are set on the basis of past spending, so that inefficient spending in one year is carried over into the next year's capitation rates, thus limiting MCOs' incentive to continuously improve.

There are several more direct ways for DMAS to control costs (Figure 4-1). DMAS has been using the following approaches to some degree, but could use them more effectively to control managed care spending:

- Set capitation rates that do not pay MCOs more than necessary;
- Maintain and strengthen the cap on MCO profits; and
- Use strong financial monitoring practices, including the collection and use of data and enforcement of contractual obligations.

FIGURE 4-1
States can control MCO spending in three primary ways



SOURCE: JLARC staff analysis.

Virginia has not set MCO rates to avoid unnecessary spending

DMAS and its actuary have not strategically set managed care capitation rates to further Virginia's goals of reducing spending and improving quality. Federal regulations give states the flexibility to use capitation rates to further state goals, as long as the rates are sufficient to cover "all reasonable, appropriate, and attainable costs" (42 C.F.R. §438.4). DMAS has focused more on ensuring capitation rates are sufficient to cover MCO costs and less on ensuring the rates do not cover unnecessary spending.

Virginia contracts with an actuarial firm to set capitation rates at the beginning of each year. Capitation rates are based primarily on historical MCO spending. Historical spending trends are used to project the amount that MCOs will spend in the future on medical and administrative expenses. After future spending is projected, the last step of the rate-setting process is adding a 1.5 percent allowance for MCO profits.

Virginia has paid MCOs for inefficient health care spending

One way for DMAS to ensure capitation rates do not cover unnecessary spending is to remove inefficient spending from historical data when setting rates. Otherwise, inefficient spending in previous years will be perpetuated in future capitation rates. Inefficient spending can result from insufficient care management or paying providers reimbursement rates above market value.

Virginia has paid MCOs for potentially avoidable health care services

Virginia has paid MCOs for health care services that MCOs could have avoided. MCOs in Virginia have limited incentive to pursue the efficient use of services because the state pays MCOs based on historical spending, regardless of whether that spending was efficient. Unlike Virginia, at least 10 other states adjust capitation rates to ensure they are not paying for inefficient care. States commonly adjust capitation rates for inefficient spending in three types of services: (1) emergency room, focusing on visits that could have been treated in less-expensive settings like urgent care facilities; (2) inpatient hospital, focusing on admissions or readmission that could have been prevented; and (3) pharmacy, focusing on inappropriate quantities or types of prescription drugs.

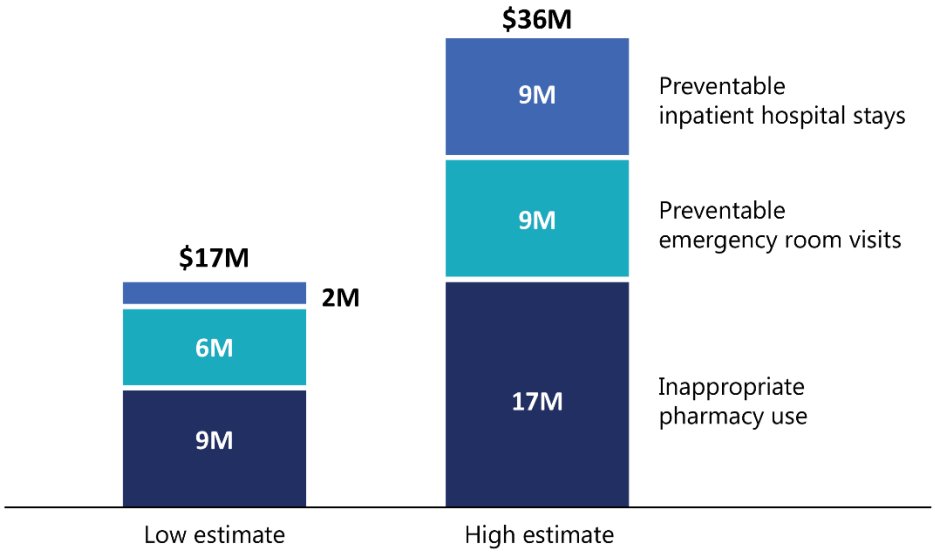
Virginia could have saved up to $36 million annually if it had reduced capitation rates for inefficient health care spending. By applying the percentage of capitation payments saved by other states to Virginia, Mercer found that potential savings in Virginia could range from $17 million to $36 million (Figure 4-2). These estimated savings are based on savings by other states, which may have different levels of inefficient spending than Virginia. While these estimated savings are based on other states which may or may not be similar to Virginia, the results are likely still applicable because a Mercer analysis of Virginia's emergency room spending found an opportunity for savings on the lower

Until recently, a **triage fee** allowed DMAS and the MCOs to reimburse hospitals at a substantially lower rate for emergency room visits that could have been treated in a less expensive setting, thus mitigating the cost of inefficient care.

The Generally Assembly discontinued the triage fee after FY15, because of concerns that the fee was too low.

end of the range experienced in other states. (See Appendix D for the potential savings.)

FIGURE 4-2
Virginia could have saved $17 million to $36 million by not paying MCOs for inefficient health care services (FY16)



SOURCE: JLARC and Mercer analysis of information from other states and Virginia's Medallion actuarial reports.

In order to reduce unnecessary spending, Virginia should work with its actuary to identify potential inefficiencies, identify what portion of these inefficiencies MCOs can reasonably reduce each year, and adjust the Medallion capitation rates accordingly. The state should phase in these adjustments because it will likely take time for Virginia to realize all potential savings, and not all MCOs can attain the same percentage reduction (sidebar). The adjustments can be aligned with the state's programmatic goals and supported by broader state initiatives when possible. Identifying potential inefficiencies and adjusting capitation rates accordingly would require additional resources.

There are **barriers to preventing all inefficient services,** and other states often adjust capitation rates for only 25 to 75 percent of identified savings to account for these challenges. For example, (i) MCOs need time to adjust to the new expectations; and (ii) more efficient MCOs cannot achieve the same percentage reduction as less efficient ones (but adjustments are typically applied on a statewide basis).

RECOMMENDATION 9

The Department of Medical Assistance Services (DMAS) should work with its actuary to identify potential inefficiencies in the Medallion program and adjust capitation rates for expected efficiencies, effective no later than FY19. DMAS and its actuary should phase in this adjustment over time based on the portion of identified inefficiencies that MCOs can reasonably reduce each year.

Virginia may have paid MCOs too much for services provided by related parties

Virginia is at risk of paying more than necessary for medical services because the state does not monitor contracts that MCOs have with related parties. For example, when an MCO subcontracts with its own health system, the relationship represents a related-party arrangement. The effect of related-party arrangements on MCO spending in Virginia is not known, but there may be some effect, given that three of Medallion's six MCOs operate their own health systems and another MCO directly employs its own providers. MCOs may have an incentive to pay more to related parties because MCOs can share in related parties' profits.

Related-party arrangements are between two entities that share a close relationship.

For example, an agreement between a health care provider and the MCO that owns or controls the provider is a related-party arrangement.

MCOs are allowed to pay higher rates to related parties, but the state is not obligated to pay MCOs above market value for any services. The state does not monitor medical spending for related-party arrangements with providers, even though the state regularly audits administrative spending for related-party arrangements and adjusts capitation rates accordingly. Most other states do not monitor related-party arrangements, but more are considering the approach as managed care expands.

RECOMMENDATION 10

The Department of Medical Assistance Services and its actuary should monitor Medallion medical spending for related-party arrangements and adjust historical medical spending when necessary to ensure that capitation rates do not cover spending above market value.

Virginia has paid MCOs more than necessary by overestimating future spending

Another way for DMAS to ensure that capitation rates cover only necessary spending is by more accurately projecting future spending. If the state overestimates future medical or administrative spending, the state pays unnecessarily high capitation rates and MCOs realize higher profits. If the state underestimates future medical or administrative spending, the MCOs may become unprofitable and have difficulty remaining financially solvent.

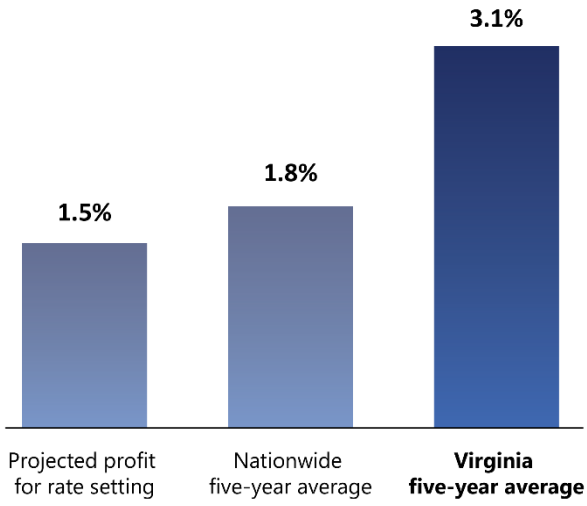
Two key measures of financial performance indicate that the state's rate-setting process has consistently overestimated future medical and administrative spending: (1) MCO profit margins compared to the profit margin Virginia builds into the capitation rates, and (2) MCO profit margins in Virginia compared to nationwide averages.

First, Virginia's MCOs have realized a five-year average profit margin that is twice as high as the margin assumed in the state's rate-setting process (Figure 4-3). Profits will typically be above or below the target in a given year, but the consistently high average over time indicates that capitation rates have consistently overestimated spending. In order to realize profits higher than the state's assumption, MCOs' medical and administrative spending had to be lower than what the state projected. The state could have saved up to an average $41 million annually from 2011 to 2015 if it had more accurately

projected MCO medical and administrative spending. (See Appendix B for the methodology used to estimate these savings.)

Second, Virginia's MCOs have realized five-year average profit margins (3.1 percent) that are 72 percent higher than the nationwide average (1.8 percent). This comparison indicates Virginia has been less accurate in projecting future MCO spending than other states, given that other states' rate-setting processes use profit margin assumptions that are similar to Virginia's.

FIGURE 4-3
State's MCOs have realized profits above actuarial and national benchmarks



SOURCE: JLARC staff analysis of 2011-2015 MCO reports to Virginia's Bureau of Insurance; Milliman reports on Medicaid MCO financial performance; interviews with DMAS staff.
NOTE: Numbers shown as a percent of total capitation payments.

Virginia is at risk of consistently overestimating future medical spending

Virginia is at risk of consistently overestimating future medical spending when setting capitation rates. Virginia projects future spending based on historical trends, which could under- or overestimate future spending in any given year. However, two aspects of Virginia's rate-setting process create a bias toward consistently overestimating future spending.

First, Virginia's rate-setting process overestimates future medical spending because it does not adjust for expected savings from statewide initiatives. Without an adjustment, MCOs keep any savings from the first two years because there is a two-year lag in historical medical spending data that the state uses to set capitation rates. According to DMAS staff, the MCOs are allowed to keep savings from the first two years so that they have incentive to improve implementation. However, MCOs would still be incentivized to improve if they were able to keep only a portion of the savings. Most other

states adjust capitation rates for at least a portion of expected savings. However, according to DMAS staff and staff in other states, it is difficult to accurately project the amount and timing of expected savings. When expected savings can be reasonably quantified for future statewide initiatives, Virginia should adjust capitation rates for a portion of the expected savings.

RECOMMENDATION 11

The Department of Medical Assistance Services and its actuary should adjust Medallion capitation rates to account for a portion of expected savings for initiatives required by the state.

Second, DMAS and its actuary are at risk of consistently overpaying MCOs because they use upward medical spending trends, but not all downward trends, in their spending projections. This approach assumes that only upward trends will continue into the future and increases the risk that future capitation rates will overestimate actual spending. To reduce the risk of paying higher-than-necessary capitation rates, Virginia should allow downward trends in medical spending to be reflected when setting capitation rates.

RECOMMENDATION 12

The Department of Medical Assistance Services (DMAS) and its actuary should allow negative historical trends in medical spending to be carried forward when setting Medallion capitation rates, if DMAS and its actuary continue to project future trends based primarily on historical trends.

Virginia has overestimated future administrative spending in recent years

Virginia has overestimated administrative spending, and therefore overpaid MCOs, because the state does not adjust for projected enrollment changes, unlike at least six other states. Virginia estimates administrative spending per enrollee in the capitation rate using enrollment data from 1.5 years prior, rather than projected enrollment for the year in which the capitation rate will be in effect. Given that a portion of administrative spending is fixed, projected enrollment growth would result in lower administrative spending per enrollee because the same total spending would be spread among more enrollees.

Fixed administrative spending does not vary substantially from year to year based on enrollment. Examples: spending on office rental and technology.

Variable administrative spending varies based on enrollment. Example: spending on call enters.

Virginia could consider adjusting administrative spending for recent enrollment changes. If Virginia had accounted for the average annual enrollment growth of four percent in recent years, the state could have potentially saved $8 million in FY16. (See Appendix B for the methodology used to estimate potential savings.) Savings would have likely been higher in previous years when average annual enrollment was growing at a faster rate of eight percent. This approach may increase state spending in the short term, since Medallion enrollment will decline when aged, blind, and disabled enrollees are transitioned

to the forthcoming managed long-term services and supports program. However, Medallion enrollment may continue to grow over the long term. Adjusting administrative spending for recent enrollment changes may require additional resources.

RECOMMENDATION 13

The Department of Medical Assistance Services and its actuary should annually rebase administrative expenses per member per month for projected enrollment changes beginning in FY19.

Profit cap limits excess spending, in recent years but Virginia is more lenient than other states

Virginia can further control spending by requiring MCOs to return a portion of excess capitation payments at the end of the year. If capitation rates are higher than necessary, a strong profit cap limits a state's risk of unnecessary spending. Virginia and at least three other states already use a profit cap, but Virginia's is more lenient and needs to be strengthened to limit excessive profits.

Virginia's profit cap is more lenient than other states' profit caps

Virginia is more lenient with its profit cap than other states are, because of two key policy decisions. First, Virginia allows MCOs to keep a higher percentage of revenue as profit than the three other states with profit caps. Second, Virginia's calculation of profit levels excludes some profit that is misclassified as medical or administrative spending, thus underestimating actual profit levels. Strengthening Virginia's profit cap to be more in line with other states would mitigate the state's risk when capitation rates are higher than necessary.

DMAS allows MCOs to keep more profit than other states

Virginia allows MCOs to keep more profit than the three other states with profit caps allow (Table 4-1). Virginia allows MCOs to keep up to eight percent of revenue as profit. Florida, the least strict of the other states, allows MCOs to keep up to six percent as profit, and half of any remaining profit up to 10 percent of revenue. New Mexico, the strictest of the other states, allows MCOs to keep up to three percent of revenue as profit, and half of any remaining profit.

Virginia's MCOs have not had to return any funds to the state in the past five years, but they would have if Virginia's profit cap had been structured like that in other states. Returned funds would have ranged from an annual average of $2.8 million for the past five years, if the state had followed Florida's approach, to $13.7 million, if the state had followed New Mexico's approach. (See Appendix B for the methodology used to calculate savings.)

TABLE 4-1
Virginia allows MCOs to keep more profit than other states with profit caps

	Percentage of revenue kept by MCO as profit			
Realized profit (% of revenue)	**Virginia**	**Florida[a]**	**Texas**	**New Mexico[b]**
3.0%	3.0%	3.0%	3.0%	3.0%
5.0	5.0	5.0	4.6	4.0
7.0	7.0	6.5	5.8	5.0
9.0	8.0	7.5	6.6	6.0
11.0	8.0	8.0	7.0	7.0

SOURCE: JLARC and Mercer staff analysis of managed care contracts in Virginia, Florida, and Texas.
NOTE: Shaded cells indicate instances in which another state allows MCOs to retain less profit than Virginia allows.
[a] These profit caps are contingent on MCOs meeting certain quality metrics. The profit caps are somewhat lower if MCOs do not meet the quality metrics, although still more lenient than other states. [b] This profit cap does not apply to low-income parents and childless adults with incomes up to 133 percent of the federal poverty level who are eligible through the Affordable Care Act.

Virginia should decrease the amount of profit MCOs can keep through two changes. First, Virginia should decrease the profit margin above which MCOs must return funds. This lower profit cap would better limit the state's financial exposure when capitation rates overestimate spending in a given year, and it would bring Virginia more in line with the three other states that have profit caps. It is reasonable to begin requiring MCOs to return funds when they realize profits greater than the nationwide average, which was approximately three percent in 2015. Two other states require profit sharing starting at three percent. Second, Virginia should increase the portion of profit that MCOs must return as profit margins increase, rather than require all profit above the cap to be returned. This approach will help to ensure that MCOs still have an incentive to reduce spending because they would be allowed to keep some of the resulting profit.

RECOMMENDATION 14
The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to require in its next Medallion contract that MCOs return at least a portion of underwriting gain in excess of three percent of Medicaid premium income, and increase the percentage of excess underwriting gain that must be returned as the underwriting gain level increases.

Virginia underestimates MCOs' profit margins

DMAS underestimates profit margins because it does not adjust for certain administrative expenses, such as income taxes and charitable gifts, that should be classified as profit for the purpose of the state's profit cap. At least two of the three other states with profit caps make these adjustments. If DMAS had used findings from its regular audits of administrative spending to reclassify certain administrative spending as profit, some

MCOs' profits would have been substantially higher in 2014 (Table 4-2). For example, DMAS calculated a profit of $935,000, or less than one percent of revenue, for one MCO, Coventry Cares. However, the MCO's actual profit, after adjusting for profit that was classified as administrative expenses, was about $11 million, or more than seven percent of revenue. Actual profit levels for three MCOs only marginally differed from DMAS's calculations. Despite some substantial miscalculations, no MCOs would have been required to return funds based on Virginia's eight percent profit cap in 2014.

TABLE 4-2
DMAS underestimates profit by not adjusting for profit that was categorized as administrative expenses (CY 2014)

	Profit, when...					
MCO	not properly calculated (% of revenue)		properly calculated (% of revenue)		Difference	
Coventry Cares	$935,000	(0.6%)	$11,104,000	(7.1%)	$10,169,000	(6.5%)
Virginia Premier	−$2,249,000	(−0.3%)	$21,043,000	(2.6%)	$23,291,831	(2.9%)
Anthem	$26,009,000	(2.8%)	$29,194,000	(3.1%)	$3,185,000	(0.3%)
INTotal	−$4,130,000	(−2.3%)	−$4,130,000	(−2.3%)	$20,000	(0.0%)
Kaiser	−$665,000	(−3.5%)	−$664,974	(−3.5%)	$400	(0.0%)
Optima	$46,387,000	(6.8%)	$46,711,000	(6.8%)	$324,000	(0.0%)

SOURCE: JLARC staff analysis of 2014 MCO reports to Virginia's Bureau of Insurance and 2014 Myers & Stauffer audits.

RECOMMENDATION 15
The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to annually incorporate findings on unallowable administrative expenses from audits of MCOs into its calculations of underwriting gain and administrative loss ratio for the purposes of ongoing financial monitoring, including enforcement of the underwriting gain cap.

Virginia also does not reclassify as profit any inflated medical spending that results from related-party contracts. The extent of related-party arrangements in Virginia is currently unknown, but it is likely they exist due to MCOs' relationships with major health systems and providers. While MCOs are allowed to pay related parties more than non-related parties, the state can classify any spending above market value as profit. Virginia should ensure that inflated medical spending from related-party arrangements is classified as profit.

RECOMMENDATION 16
The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to adjust its calculations of underwriting gain and medical loss ratio by classifying as profit medical spending that is higher than market value due to related-party arrangements.

Virginia should keep its profit cap despite new federal regulations that encourage use of the minimum medical loss ratio

States have limited excess profits by using two primary approaches: the profit cap and the minimum medical loss ratio. The profit cap limits the percentage of revenue that MCOs can keep as profit. Profit above the limit is considered excess and returned to the state. The minimum MLR requires MCOs to spend a minimum percentage (typically 85 percent) of their revenue on medical services, and return any difference if they do not meet the minimum. The MCO then divides the remaining revenue between administrative spending and profit. Virginia and at least three other states currently use a profit cap, and 20 states use minimum MLRs as of July 2016.

In response to recent federal regulations, DMAS plans to replace the state's profit cap with a minimum MLR. The new regulations require states to set capitation rates so that MCOs spend at least 85 percent of their revenue on medical expenses and allocate no more than 15 percent to administrative spending and profit. The regulations also encourage, but do not require, MCOs to return funds to the state if they do not spend at least 85 percent of their revenue on medical expenses, in alignment with existing federal requirements for Medicare and commercial health plans. However, according to federal Medicaid staff, both the profit cap and the minimum MLR are considered reasonable, and the new regulations do not prohibit states from requiring MCOs to return funds based on a profit cap.

The shift from profit cap to minimum MLR is not likely to benefit the state, for a number of reasons. The profit cap is a more direct way for the state to limit profits than the minimum MLR. In setting a profit cap, the state directly decides what profit level it considers excessive. In setting a minimum MLR (sidebar), the state decides how much MCOs should spend on medical care and only indirectly affects how much revenue MCOs keep as profit.

The profit cap is also more effective because it creates fewer disincentives for MCOs to control spending than the minimum MLR does. Both the profit cap and the minimum MLR create a disincentive by penalizing MCOs if they are able to reduce spending below a certain amount. A minimum MLR creates an additional disincentive that a profit cap does not, by encouraging MCOs to limit spending on administrative activities as much as possible in order to maximize profit. Administrative spending can be reduced by gaining administrative efficiencies, but MCOs may also cut spending in less effective ways, by reducing or eliminating important administrative activities such as fraud prevention or services not covered under the state contract.

Implementing a minimum MLR in Virginia will likely have little impact on MCO profits. All but one MCO already met an 85 percent minimum MLR in 2015, as defined by DMAS (Table 4-3). These MLRs will be impacted by some upcoming changes (sidebar), but MCOs will still likely meet an 85 percent minimum MLR in the future. Even though Virginia's MCOs have already met an 85 percent minimum MLR, they have consistently realized profits above the national average.

Setting a minimum MLR is a complex decision that must account for a variety of factors:

1. State's definition of medical spending
2. Types of enrollees—some types tend to use substantially more or less medical services
3. Program maturity—new programs tend to have higher administrative spending
4. Size of MCO—smaller MCOs, unable to leverage economies of scale, tend to spend a greater percentage of revenue on administrative expenses

Two potentially **offsetting changes will impact Medallion MLRs** in the future. First, using CMS's new definition of a MLR will likely result in higher MLRs because it allows the inclusion of additional spending on "quality improvement activities." Second, the transition of aged, blind, and disabled enrollees from Medallion to MLTSS will likely reduce MLRs because the remaining enrollees require a substantially smaller portion of revenue to be spent on medical expenses.

TABLE 4-3
Most of Virginia's MCOs have consistently exceeded a minimum 85 percent MLR

MCO	2011	2012	2013	2014	2015
Amerigroup	78.0%	80.8%	–	–	–
Anthem	90.7	91.2	92.8%	88.7%	85.0%
Coventry	85.6	84.3	86.7	87.6	84.4
INTotal	–	–	85.1	89.3	86.5
Kaiser	–	–	–	100.2	101.7
Majestacare	–	89.9	96.9	91.2	–
Optima	87.0	92.6	90.5	87.9	92.1
VA Premier	84.3	89.8	91.9	91.5	91.7
All MCOs	87.1	90.1	91.2	89.4	88.7

SOURCE: JLARC and Mercer staff analysis of Bureau of Insurance data provided by DMAS.
NOTE: These medical loss ratios would have been higher if they had been calculated using CMS's definition of medical loss ratio, which includes additional spending on quality improvement activities.

RECOMMENDATION 17
The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to keep the underwriting gain cap in the next Medallion contract, rather than replace it with a provision that uses a minimum medical loss ratio to recoup excess funds from MCOs.

Virginia has not collected sufficient data to effectively oversee managed care spending

Virginia has limited insight into how MCOs spend the state's funds, which limits its ability to ensure that capitation rates are set appropriately and profit caps are effectively enforced. The state will need to collect and use additional data in order to implement the improvements recommended in this chapter, and to monitor program spending on an ongoing basis.

Virginia collects less financial and utilization information from MCOs than many other states (Table 4-4). Virginia collects just one financial report from MCOs, which contains high-level information on Medallion revenues and expenses. (See Appendix E for the MCO financial report.) Other states collect revenue and expense information with more detail on population and service categories. Other states also collect balance sheets and information on related-party arrangements. Virginia collects only two service utilization reports, on pharmacy authorization requests and atypical drug utilization. Other states collect more service utilization data, such as the average number of prescriptions per enrollee, average number of inpatient hospital visits per enrollee, and average length of stay per inpatient hospital visit.

TABLE 4-4
Virginia collects less financial and utilization information than other states

Examples of information collected from MCOs in other states	Collected in Virginia?
Financial reports	
Income statement listing revenues and expenses	Partially
Balance sheet listing assets and liabilities	No
Related-party arrangements and transactions	No
Health care utilization reports	
Pharmacy authorization requests	Yes
Pharmacy utilization	Partially
Emergency room utilization	No
Inpatient hospital utilization	No
Mental health utilization	No
Outpatient hospital utilization	No
Physician utilization	No

SOURCE: JLARC staff analysis of managed care contracts in other states and interviews with other state staff.

More detailed data would better enable DMAS to identify undesirable spending and utilization trends and understand their underlying causes. Some states identify undesirable trends using standard benchmarks. For example, New Jersey compares recent data to utilization benchmarks that the state sets based on historical data, such as the number of primary care physician visits per 1,000 enrollees. Arizona and Pennsylvania require MCOs to explain any trends that exceed a certain annual percentage change. Unlike these states, Virginia is unable to set meaningful benchmarks in order to identify unusual trends given the limited spending and utilization information it obtains. Once an unusual trend is identified, other states often try to determine the underlying cause by talking to the MCOs and further exploring the data to determine whether a specific service, population, or geographic region is causing the trend. Compared to other states, Virginia has to rely more on the MCOs to identify the underlying reasons for a trend because the state's limited data does not enable further analysis.

Once DMAS is able to use data to identify undesirable spending or utilization trends, it can take several actions to incentivize an MCO to change its approach. First, DMAS could provide formal or informal feedback to MCOs. For example, the District of Columbia and Pennsylvania tell MCOs if they are performing worse than the state's other MCOs because the capitation rate, which is based on average spending across all MCOs, incentivizes MCOs to be more cost-effective than their competitors. Second, DMAS can use trend information to inform the rate-setting process and profit-sharing mechanisms. For example, DMAS could incorporate information on related-party arrangements into its calculations of medical spending and profit margins. Third, DMAS could leverage performance information in contract and rate negotiations. For example, Pennsylvania staff said they were able to successfully deny an MCO's request to

increase capitation rates by pointing out that the MCO was spending more than necessary on a related-party contract. Fourth, if the problem is concrete and measurable, DMAS can implement sanctions such as a corrective action plan or an enrollment freeze until the MCO fixes the problem.

Virginia should require MCOs to submit additional financial and utilization reports on a regular basis in order to improve the state's ability to oversee managed care spending. Virginia should regularly monitor these reports to identify undesirable trends and work with MCOs to address these trends as necessary. States should ideally use encounter data to monitor managed care spending, but challenges in obtaining good encounter data have caused Virginia and many other states to instead rely on MCO reports. Virginia is in the process of improving its encounter data. Once DMAS is able to obtain complete and accurate encounter data from MCOs on a regular basis, reports should be generated automatically in order to reduce the administrative burden on DMAS and the MCOs. (See Appendix F for ongoing efforts to improve managed care encounter data.)

Encounter data is records of medical services that MCOs provide their enrollees.

RECOMMENDATION 18

The Department of Medical Assistance Services should include additional financial and utilization reporting requirements in its next Medallion contract and Managed Care Technical Manual. Reported data should include (i) detailed income statements that show expenses by rate cell and detailed service category, (ii) balance sheets, (iii) related party transactions, and (iv) service utilization metrics.

RECOMMENDATION 19

The Department of Medical Assistance Services (DMAS) should regularly monitor, on at least a quarterly basis, detailed spending and utilization trends in managed care. Undesirable trends or concerns that are identified by DMAS should be further examined, addressed with the MCO, and addressed through the Medallion contract and rate-setting process as necessary.

DMAS should be required to submit annual reports on managed care spending trends to ensure that DMAS obtains data and uses it effectively to oversee managed care spending. DMAS currently submits quarterly expenditure reports to the General Assembly for state budgeting purposes, but these reports provide little insight into factors that are increasing spending within managed care because they only report total managed care spending. This limitation will be exacerbated once additional enrollees are transitioned into the forthcoming managed long-term services and supports program. Information on trends within managed care, and the reasons for these trends, could help DMAS and the General Assembly better oversee the program.

RECOMMENDATION 20

The General Assembly may wish to consider including language in the Appropriation Act requiring the Department of Medical Assistance Services (DMAS) to report to the General Assembly annually on spending and utilization trends within Medicaid managed care, with detailed population and service information. DMAS should analyze 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.

Greater enforcement of Virginia's new contract compliance process is needed

DMAS has a compliance process to ensure MCOs fulfill contract requirements but has not enforced a majority of sanctions. As a result, MCOs have limited incentive to comply. Contract requirements subject to the compliance process include those related to reporting, data quality, and operational performance. These requirements are only useful if DMAS enforces them through, for example, penalties for noncompliance.

> *"Too many states take a hands-off approach [to compliance], essentially writing a blank check to managed care companies."*
>
> – **National expert**

DMAS recently established a process to monitor MCO compliance, consistent with national best practices

DMAS implemented a process in July 2015 to monitor and enforce MCO compliance with contract requirements. This contract compliance enforcement action (CCEA) process authorizes DMAS to assess noncompliance points, and require improvement plans, when a managed care organization does not fulfill contract requirements. These points accumulate over time for each MCO, resulting in more stringent sanctions such as monetary fines, corrective action plans, and contract termination once certain point levels are reached. The points expire 12 months after issuance.

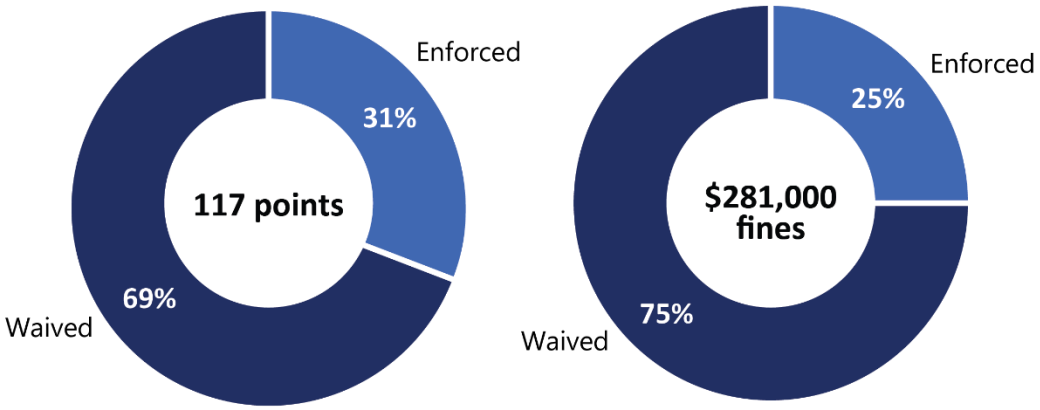
The CCEA process has improved compliance in its first year, according to DMAS staff, who indicated that DMAS had not historically treated MCOs as vendors responsible for fulfilling their contracts. DMAS and MCO staff report that MCOs are paying more attention to, and have a better understanding of, contract requirements. For example, since implementation of the CCEA process and its accompanying Managed Care Technical Manual (sidebar), more reports are meeting formatting requirements.

The **Managed Care Technical Manual** provides guidance to MCOs on contractual reporting requirements so that MCOs fully understand the state's expectations. The use of this type of manual is considered a national best practice.

DMAS has not enforced majority of sanctions authorized in contract

DMAS waived the majority of sanctions in the first year of the CCEA process. MCOs incurred over 80 infractions by submitting reports late or with errors, by submitting encounter data that does not meet quality standards, and by not meeting operational performance standards. (See Appendix G for types of MCO noncompliance.) In FY16 DMAS waived 69 percent of noncompliance points and 75 percent of fines, or $210,000, that it could have enforced for these infractions (Figure 4-4). The 25 percent of fines that were enforced, or $71,000, were for two infractions that were subject to automatic fines outside of the standard CCEA process.

FIGURE 4-4
DMAS waived 69 percent of noncompliance points and 75 percent of fines (FY16)



SOURCE: JLARC staff analysis of DMAS's monthly compliance dashboards, monthly compliance reports, monthly deliverable report cards, and discussions with DMAS staff.
NOTE: Excludes sanctions for infractions that were (i) later determined to be a DMAS error, (ii) being tracked in the CCEA process but not yet subject to sanctions, and (iii) still undergoing DMAS review. (See Appendix B for more information on methodology used to analyze the CCEA process.)

Most of DMAS's stated reasons for waiving sanctions are not explicitly included in the contract. The contract notes that all enforcement is at DMAS's discretion, but it also says DMAS will enforce sanctions unless the MCO can sufficiently demonstrate that

- the infraction was unexpected and completely out of the MCO's control, such as a natural disaster; or
- the infraction was the responsibility of a subcontractor whom the MCO sufficiently notified of requirements; and
- the MCO took immediate and appropriate action to correct the infraction and ensure it will not recur.

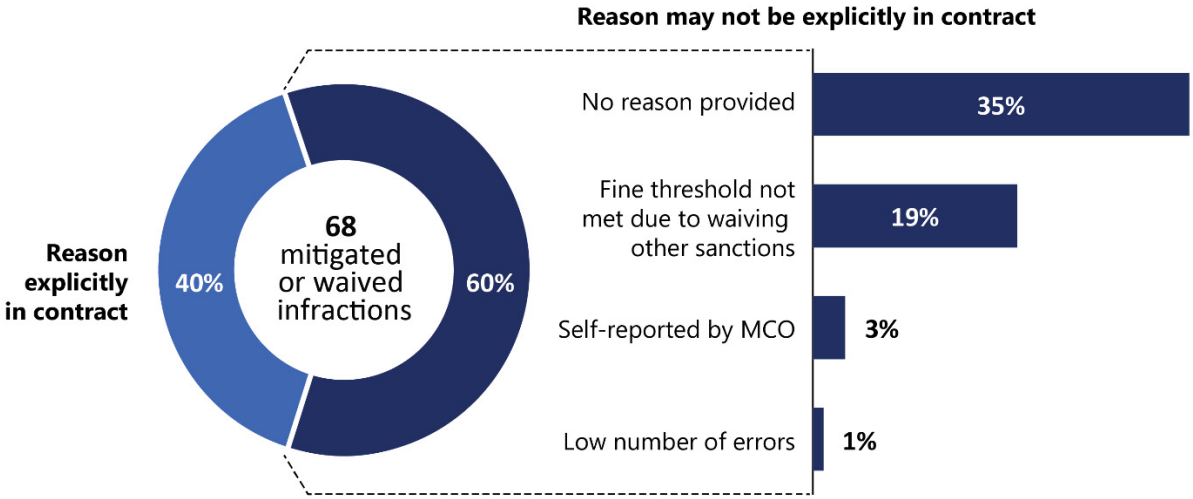
MCOs must submit **MCO improvement plans** to address a compliance issue. It is similar to a corrective action plan, except that MCOs do not have to disclose it when bidding on other contracts for entities outside Virginia.

However, DMAS mitigated or waived up to 60 percent of infractions for other reasons (Figure 4-5). In many cases, DMAS provided no reason for waiving fines and non-compliance points. In other cases, DMAS assessed points but indirectly waived fines because it had previously waived points for other infractions. Waiving points for one infraction impacts the sanctions for a future infraction because more stringent sanctions are only assessed once an MCO has accumulated a certain number of points.

Virginia's approach has not resulted in progressively severe sanctions as designed, likely limiting its effectiveness in preventing future infractions. Because DMAS waived the majority of noncompliance points, no MCO came close to accumulating enough points by the end of the year to trigger a fine of any level. Therefore, any severe infractions would have likely only been subject to an MCO improvement plan. Minimal sanctions may not be sufficient to incentivize MCOs to comply with more rigorous contract requirements. Even though it is difficult to assess the relative effectiveness of

various compliance processes across states and what factors contribute to their success, progressive sanctions are important for preventing severe infractions, according to staff in several other states.

FIGURE 4-5
Most reasons for not fully assessing sanctions were not explicit in the contract



SOURCE: JLARC staff analysis of DMAS's monthly compliance dashboards, monthly compliance reports, monthly deliverable report cards, and other information from DMAS staff.
NOTE: Of the 68 infractions for which sanctions were not fully assessed. Excludes infractions that were (i) later determined to be a DMAS error, (ii) being tracked in the CCEA process but not yet subject to sanctions, and (iii) still undergoing DMAS review. (See Appendix B for more information on the methodology used to analyze the CCEA process.)

Other states appear to progressively sanction MCOs through two main approaches, neither of which Virginia takes. First, some states like Ohio prefer relatively small but frequent fines that escalate over time. Virginia's CCEA process is based on Ohio's process, but Virginia waives sanctions much more frequently, preventing escalation. Ohio assessed $39 million in fines in FY16 ($21 million of which is refundable if MCOs comply within 12 months), substantially more than the $71,000 Virginia assessed. Second, other states like Arizona require corrective action plans for minor infractions and assess large fines for severe infractions. These states believe larger but fewer fines will better incentivize MCOs to fix problems rather than simply accept smaller fines as a cost of doing business. Arizona assessed over $2 million in fines, also substantially more than the $71,000 Virginia assessed. DMAS staff share the concern that small, frequent fines could give MCOs a disincentive to fix problems, but Virginia's CCEA process is not designed to save large fines for more severe infractions.

If continued past the first year of the CCEA process, DMAS's apparent reluctance to assess sanctions could hinder the state's goal of improving contract compliance and limit its ability to obtain sufficient data for financial oversight. It is reasonable for states to waive more sanctions during the first year of a compliance process to give the state

and MCOs time to adjust to expectations. Waiving most sanctions in the long term, however, would signal to MCOs that the state is not serious about enforcing contract compliance. DMAS should reassess the reasons for which it will waive sanctions, and amend the Medallion contract accordingly, to ensure it waives sanctions only when appropriate. DMAS could consider limiting its reasons to those that other states appear to commonly use to waive sanctions:

- for infraction due to unforeseen circumstances beyond the MCO's control;
- during the first year of the MCO's operation;
- for instances when the MCO self-reports an infraction; and
- the first time the MCO incurs the infraction.

DMAS should only waive sanctions for reasons stated in the contract. Unique circumstances that are not explicitly addressed by the contract can be considered during the appeals process.

RECOMMENDATION 21

The Department of Medical Assistance Services (DMAS) Compliance Unit should reassess the reasons for which the state will mitigate or waive sanctions and amend the Medallion contract to specify these reasons. DMAS should consider limiting the basis for mitigating or waiving sanctions to the following reasons: (i) for an infraction due to unforeseen circumstances beyond the MCO's control; (ii) during the first year of the MCO's operation; (iii) for instances when the MCO self-reports an infraction; and (iv) the first time the MCO incurs the infraction.

RECOMMENDATION 22

The Department of Medical Assistance Services should only mitigate or waive sanctions for reasons explicitly stated in the contract and report all reasons for waiving sanctions in its monthly compliance reports, referencing the applicable section of the contract.

DMAS should annually review the results of its CCEA process in order to ensure the process is effectively implemented. DMAS currently produces monthly reports, which are shared with the MCOs, that summarize infractions and sanctions assessed in a given month. These reports are helpful for tracking compliance on a monthly basis and making the process more transparent to MCOs. However, the reports do not enable DMAS to assess its overall approach to enforcing contract compliance because they only focus on a given month, and some infractions can take several months to resolve. Further, the reports do not clearly identify the percentage of eligible sanctions that DMAS waived.

RECOMMENDATION 23

The Department of Medical Assistance Services should annually review the results of its contract compliance enforcement action process and include the results in its Medallion annual report. The report should include, for each MCO, the percentage of points and fines mitigated or waived and the reasons for mitigating or waiving them.

5 Incentives for MCOs to Manage Care of Chronic Conditions

SUMMARY Chronic conditions account for a high amount of spending in Virginia's Medicaid program. Effective monitoring and treatment can improve or stabilize these conditions, reducing Medicaid spending. DMAS requires MCOs to address chronic conditions through multiple programs, which have not thus far resulted in improved health outcomes. DMAS's new financial incentive and MCO report card should further focus MCOs on health care for chronic conditions.

Chronic conditions are long-lasting diseases that often require costly care and drive high Medicaid spending. They include diabetes, heart disease, and serious mental illness. At least one in five Medicaid enrollees has a chronic condition. (See Chapter 1.) Over half of recipients with chronic conditions are currently enrolled in the Medallion managed care program and will remain in Medallion after the implementation of MLTSS. This chapter provides recommendations to strengthen incentives for MCOs in the Medallion program to better manage health care for chronic conditions.

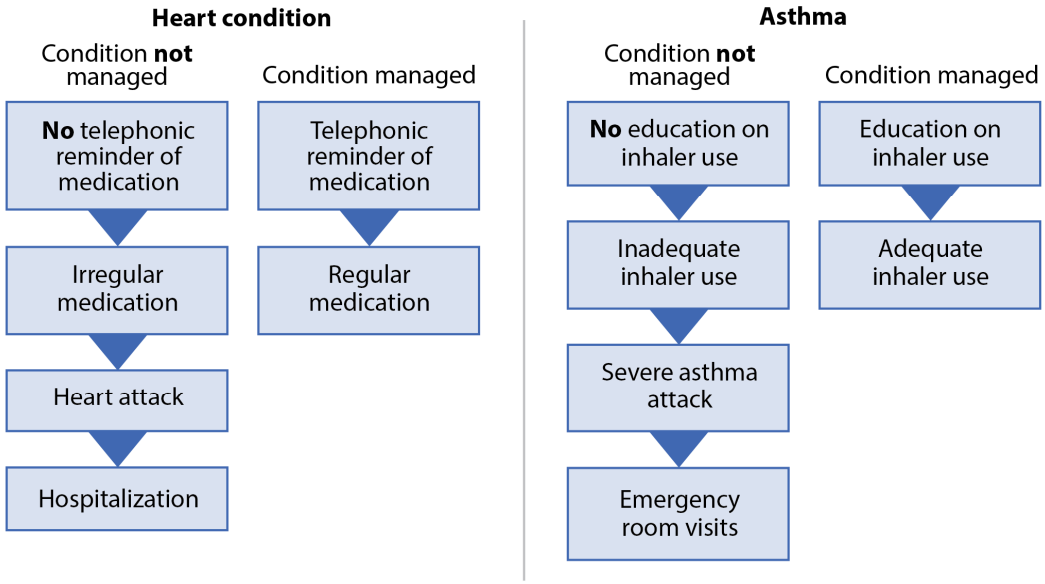
Spending on chronic conditions can be reduced by improving health outcomes

Improving health care for individuals with chronic conditions can lead to Medicaid cost savings. Chronic conditions can be better managed through monitoring and interventions by health professionals. DMAS requires MCOs to operate programs for individuals with chronic conditions, but outcomes have not improved measurably.

Effective health care interventions can lead to cost savings

Adequately monitoring and treating individuals with chronic conditions can decrease their need for intensive, costly medical services (Figure 5-1). States and MCOs are experimenting with many approaches to better care for recipients with chronic conditions. One type of approach is directed at recipients: connecting them to community resources, arranging transportation to appointments, and encouraging medication adherence, for example. Another type of approach is directed at providers: implementing technology to improve information sharing between providers, and disseminating monthly lists of recipients in need of crucial services, for example. The goal of these activities is to improve health by delaying or preventing disease progression and complications.

FIGURE 5-1
Examples of successful interventions for individuals with chronic conditions



SOURCE: JLARC staff literature review and interviews with MCOs.

Research literature indicates that cost savings are possible from effective programs for Medicaid enrollees, but identifying "lessons learned" from such programs is difficult. Examples of effective programs include Minnesota's certified medical health homes, which had 12 percent lower Medicaid spending per enrollee in the program, and Vermont's case management initiative, which reduced spending by eight percent compared to projections. While neither of these programs was limited to individuals with chronic conditions, care for chronic conditions was a focus. Effective programs incorporate many different approaches, and it is difficult to identify which approach is responsible for effectiveness. For example, employing case managers is a common approach, but the education level of case managers and frequency of contact with recipients that are needed to be effective are unknown. Rather than mandate a particular approach, the state could focus on incentives for MCOs to innovate and develop successful programs.

While effective health care will improve health outcomes, cost savings may only be realized by the Medicaid program for certain recipients or conditions. Some cost savings will occur in the long term or after the individual is no longer enrolled in Medicaid. The time lag between interventions and changes in service utilization makes it challenging to quantify the Medicaid cost savings due to effective interventions. Additionally, while regular and high-quality health care is important for all chronic conditions, research literature recognizes a subset of chronic conditions for which health care is likely to improve the recipient's health and reduce their utilization of intensive services. These conditions are the focus of this chapter.

MCOs operate programs for chronic conditions, but programs have not improved population outcomes

DMAS requires MCOs to operate four main programs for recipients with chronic conditions through its Medallion contract (Table 5-1).

1. MCOs must administer "care management programs that focus on identifying and improving the health status" of recipients with five particular conditions, including four chronic conditions. DMAS allows MCOs complete flexibility in designing and implementing these programs.

2. DMAS requires MCOs to conduct annual Performance Improvement Projects, as federally mandated. DMAS selects a topic, and MCOs are responsible for designing and implementing projects to improve performance.

3. Beginning in 2014, MCOs must use value-based purchasing for medical health homes serving individuals with "chronic or complex" conditions.

4. Beginning in 2015, MCOs must operate behavioral health homes to provide team-based services, care coordination, and connection to community resources for adults with Serious Mental Illness, such as severe depression or schizophrenia.

Beyond the Medallion requirements, MCOs operate their own initiatives to manage health care for chronic conditions.

TABLE 5-1
Multiple Medallion programs address chronic conditions

	Medallion MCO program			
	Care management programs[a]	Performance Improvement Projects[b]	Medical health homes[c]	Behavioral health homes
Heart	✓			
Diabetes	✓			
Respiratory	✓		✓	
Behavioral health	✓	✓	✓	✓

SOURCE: JLARC staff analysis of DMAS documents and Medallion 3.0 contract.

[a] Conditions required since at least FY12, with the exception of behavioral health, added in FY14. Current requirement to focus on children with diabetes and respiratory conditions. [b] The two focuses were adolescent well-child visits and clinical follow-up within 30 days after hospitalization for mental illness since FY12, and will transition to diabetes in FY17, using a "rapid cycle" approach of frequent evaluations prompting program redesign. [c] Four of the nine medical health homes developed by MCOs chose to target recipients with chronic conditions and seven reported metrics specific to chronic conditions.

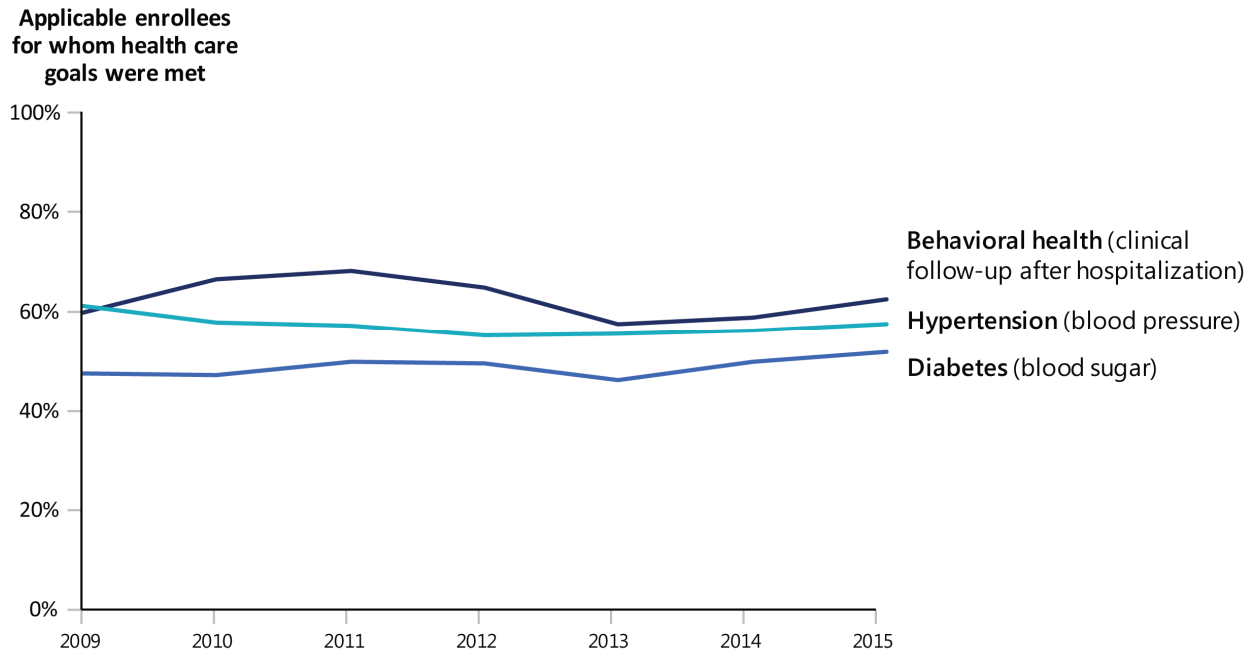
HEDIS (Healthcare Effectiveness Data and Information Set) metrics include provider activities (e.g., screenings, medication) and recipient health outcomes (e.g., immunizations, cholesterol levels).

Because the metrics are technically defined and data is audited, HEDIS is commonly used to compare health plans.

Until the implementation of the Performance Incentive Award, the only formal mechanism for holding MCOs accountable for delivering care to recipients with chronic conditions was a corrective action plan, to be created and implemented by MCOs that fell below the 50th percentile nationally for selected Healthcare Effectiveness Data and Information Set (HEDIS) metrics. No other formal mechanisms existed to penalize MCOs for poor care of individuals with chronic conditions or reward them for strong performance. Moreover, DMAS did not establish required outcomes for the four mandatory Medallion programs described above. DMAS considers frequent communication with MCOs and a quarterly work group as key elements in its overall approach to quality assurance, but neither of these provide specific incentives for MCO improvement.

The current approach has not led to notable improvement in MCOs' care for recipients with chronic conditions. While similar to the national Medicaid median, performance of the Virginia MCOs has not improved since 2009 (Figure 5-2). On the 13 metrics relevant to chronic conditions reported by DMAS, the average MCO score was below the national median for eight metrics and above the national median for five metrics in FY15. DMAS cited the ineffectiveness of the corrective action plan as the reason for the elimination of that policy and the development of financial incentives in FY14.

FIGURE 5-2
MCOs' performance on selected metrics for chronic conditions have not improved over time



SOURCE: JLARC staff analysis of DMAS documents.

MCOs face barriers to improving health outcomes. In the Medicaid population, unstable employment, low-quality housing, lack of transportation, and inadequate social support significantly contribute to poor health. For example, lack of air conditioning exacerbates asthma, and lack of transportation to grocery stores leads to poor nutrition, which exacerbates diabetes. In interviews, Virginia MCOs described other challenges, including inaccurate contact information for recipients, distrust of care managers by recipients, and short durations of Medicaid eligibility.

DMAS should strengthen incentives for MCOs to improve health outcomes and achieve savings

Implementing a financial incentive and MCO report card has the potential to prompt improvement of MCOs' care for individuals with chronic conditions, creating potential Medicaid cost savings. These mechanisms should focus on population-wide metrics, in order to allow MCOs to create innovative models, direct resources where they are most effective, and encourage an integrated approach to interventions.

Financial incentives and report cards enable the state to set priorities for MCOs while allowing MCOs operational flexibility. The metrics chosen by the state for incentives and report cards establish its priorities for MCOs. However, each MCO is responsible for designing a cost-effective approach to improving performance on those metrics, using its expertise and resources. For example, an MCO may identify two populations that are driving down its performance on a diabetes metric, and implement a wellness program to target the first population and a value-based payment program to target the second population.

New financial incentive in place to improve MCO performance, but the amount is lower than incentives in other states

Financial performance incentives are a helpful mechanism to encourage MCOs to focus on health care for chronic conditions. These incentives can be implemented to complement rate-setting adjustments that focus on preventable service utilization or requiring savings from new programs. (See Chapter 4 for more information about rate-setting adjustments.) While incentives can be used to further any goals for MCO behavior, such as administrative responsibilities or care for vulnerable populations, enrollees with chronic conditions are a common target for incentives among states because of the expected cost savings. Like contractual requirements for MCOs to operate particular programs for chronic conditions, incentives are a mechanism for states to establish priorities and expectations for MCOs. While such contractual requirements mandate MCO processes, financial incentives mandate outcomes and allow the MCOs to develop the processes.

Financial incentives are mechanisms used by some states to make a portion of payments dependent on MCO performance. States select metrics and define goals for each metric. MCOs must meet these goals in order to receive the financial incentive, which may be

established as an existing percentage of their payment or a bonus supplementing their payment. Incentives vary in number and type of metrics, ambitiousness of performance goals, size of the financial incentive, and other aspects. At least 10 other states use financial incentives, of which at least eight include metrics for enrollees with chronic conditions. (See Appendix H for information on incentives in other states.)

DMAS implemented a federally required **financial incentive in the Commonwealth Coordinated Care** program. The financial withhold was 1% of capitation rates in its first year, increasing to 2% in its second year. Six of the 12 second year metrics related to chronic or behavioral health conditions. DMAS indicated that MLTSS will include a financial incentive, but the design, amount, and metrics are not yet finalized.

The Performance Incentive Award (PIA) is the Medallion program's first use of a financial performance incentive for MCOs. Following a pilot, DMAS implemented the PIA in FY16 and will determine results by February 2017. The metrics in the PIA consist of three metrics for MCOs' internal administrative processes, two metrics for provider activities, and one metric for recipient health outcomes. One of the six metrics is relevant to recipients with chronic conditions: blood pressure levels for individuals with hypertension. DMAS could increase the focus on chronic conditions by including additional metrics, but this has to be weighed against other program priorities. The PIA's design is budget-neutral for DMAS and limits any particular MCO's gain or loss to 0.15 percent of its capitation rates. The PIA puts a total of $4.6 million at risk, spread across all six MCOs (based on FY15 capitation payments). The amount at risk for each MCO varies from $40,000 to $1.7 million, depending on the MCO's size. Whether an MCO earns a penalty or incentive, and the amount, depends on its performance relative to the other MCOs.

The amount of Virginia's incentive, 0.15 percent of the capitation payment, is the smallest incentive amount of states with similarly structured incentives. Other states' incentive amounts vary, up to five percent of capitation rates, which is the federal maximum. Several state-specific factors, and federal requirements, affect the level of financial incentive that is appropriate. In interviews, Medicaid staff in other states noted that the amount of incentives depended on state characteristics such as the competitiveness of MCO procurement and policies regarding MCO profit levels. Additionally, federal rules mandate that capitation rates be actuarially sound even if the MCO does not receive the financial incentive.

The PIA's design is reasonable for its early years of implementation, but the award should be strengthened in future contracts by increasing the amount of the incentive. The amount should be sufficient to push MCOs to improve but not so high that it puts too much financial strain on MCOs. DMAS should consider MCO profit levels and other factors that affect capitation rates in determining the appropriate amount of the PIA. If the PIA had been one percent or five percent of capitation rates, the total amount at risk across all six MCOs would have been $30.6 million or $153.2 million, respectively. DMAS should ensure the incentive continues to include a metric relating to chronic conditions, along with metrics that reflect other DMAS priorities.

RECOMMENDATION 24

The Department of Medical Assistance Services should incrementally increase the amount of the Performance Incentive Award to create a stronger incentive for MCO improvement and retain at least one metric related to chronic conditions.

Planned MCO report card will increase transparency on MCO care of chronic conditions

In 2017, DMAS will join the growing number of states that publish MCO "report cards." Compared to other sources of publicly available information about MCOs, report cards are brief and consumer-friendly in design. (See Appendix I for descriptions and examples of other states' MCO report cards.) DMAS is developing an MCO report card to be released in spring of 2017.

Report cards are intended to increase transparency and ultimately incentivize MCOs to improve their performance. Other states make the report cards available to new enrollees to inform their selection of an MCO. Enrollees can select an MCO with higher performance on metrics that are priorities for them. MCOs have a financial incentive to improve their performance on the report card metrics because their revenue increases with their number of enrollees. Additionally, the report cards create publicity for MCOs, so they have a business interest in performing well on those metrics. As such, DMAS staff described MCOs as highly invested in the report card results. A limiting factor to the impact of report cards is that most enrollees do not select an MCO (in which case they are auto-assigned) or select an MCO based on other priorities such as continuing care with their current provider.

States will be required to use **report cards** as part of a federal rating system for Medicaid MCOs or to design their own, effective in 2021.

Publicly available information about MCO performance is already extensive, but DMAS's new report card will add value for enrollees. Current information is difficult for Medicaid recipients to interpret because it consists of hundreds of metrics and often uses clinical terminology. In contrast, DMAS's new report card will consist of only a few composite metrics, enabling an at-a-glance and comprehensive understanding of MCO performance. For example, the draft chronic condition metric reflects metrics of provider activities such as eye exams and antibiotics use as well as metrics of recipient health outcomes such as blood sugar and cholesterol levels.

DMAS can strengthen the impact of its new report card by sharing it directly with new enrollees. DMAS already provides MCO comparison charts to new enrollees, but these charts do not contain information on the quality of health care. DMAS plans to publish the report card online but has not yet decided whether to share the report card directly with new enrollees.

RECOMMENDATION 25

The Department of Medical Assistance Services should share the MCO report cards directly with new enrollees as part of their enrollment communication.

DMAS has not conducted regular analyses of data on chronic conditions

DMAS has not used data to understand the prevalence and associated spending of populations with chronic conditions. It is important for staff to regularly analyze such data statewide and across MCOs to inform the design of incentives and contractually required interventions. Staff regularly review HEDIS data on recipient outcomes and provider health activities, and this review should incorporate data on service utilization and spending. For example, a large difference in performance on a particular metric between MCOs with similar populations indicates opportunity for improvement by some MCOs. Such a metric is likely appropriate for use in developing a financial incentive and measuring performance relative to other MCOs. A statewide trend of increased spending due to a particularly prevalent condition could indicate the need for a statewide public health initiative.

DMAS should conduct regular analyses of chronic conditions and other conditions that drive Medicaid spending. It should systematically use this data to assess the degree and potential causes of variation between MCOs, as well as overall trends. The following analyses are basic metrics that should be analyzed statewide and by MCO, for each condition:

- Prevalence of the condition;
- Health care spending per recipient with the condition; and
- Emergency department and hospital use per recipient with the condition.

While upcoming agency initiatives will improve DMAS's ability to analyze data, DMAS already has access to some data that would be useful for analyzing the impact of chronic conditions on Medicaid spending. DMAS regularly receives MCO claims data, but its current information management system is not built to process MCO claims data. (See Appendix F.) After planned improvements are made to its systems and processes for receiving and checking claims data, DMAS will have the ability to conduct condition-specific analyses on reliable, real-time claims data. In the meantime, DMAS could use the final claims data that is collected for setting MCO rates. This data may not be current, but it could be used for condition-specific analysis of the impact of chronic conditions on Medicaid spending.

RECOMMENDATION 26

The Department of Medical Assistance Services should regularly analyze its spending on chronic conditions and service utilization by recipients with chronic conditions, and use this information to better understand MCO performance and develop incentives targeting the opportunities for greatest improvement in recipient outcomes and reductions in spending.

6 Effectively Transitioning New Populations and Services into Managed Care

SUMMARY DMAS needs to implement strong oversight of MCOs to successfully transition to MLTSS and integrate behavioral health services into managed care. There are opportunities for improvement in the current fee-for-service system for both behavioral health services and LTSS that DMAS should focus on as it oversees the implementation of a more comprehensive managed care system. DMAS needs to ensure that MCOs effectively manage behavioral health provider networks, establish clear roles when recipients choose to direct their own LTSS services, and implement strong utilization management practices for behavioral health and LTSS services. DMAS should also incorporate some of the lessons learned from the Medallion program as it implements MLTSS. Obtaining and using robust data from MCOs will enable DMAS to identify and address potential issues. Implementing a cap on MCO profits will ensure that Virginia is not spending more than is necessary to provide appropriate services to Medicaid recipients. Sufficient staff with the appropriate skills will be required to effectively oversee MCOs following these transitions.

Overseeing MCOs will be DMAS's primary mechanism to manage program spending after the launch of MLTSS in May 2017 and the inclusion of community-based behavioral health services into managed care in the coming years. Effectively overseeing the MLTSS program and the integration of behavioral health services will require strong strategic direction from DMAS leadership and oversight of many different program components, including contract development and compliance, provider network adequacy, quality improvement, beneficiary relations, and rate-setting and financial oversight.

This report does not address DMAS's performance across all of these functions because the study occurred prior to the transition. However, there are several examples of challenges under the current fee-for-service system that DMAS should focus on as it oversees the implementation of MLTSS and the integration of behavioral health services into the Medallion managed care program. There are several lessons learned from the review of financial oversight of the Medallion program that should be leveraged to strengthen the implementation of MLTSS.

Community-based behavioral health services, referred to as behavioral health services in this chapter, include therapeutic day treatment, intensive in-home, and mental health skill building services

DMAS is transitioning these services to managed care over the coming years.

Strong oversight required to successfully transition new populations and services into managed care

Managing future spending will require strong oversight of how MCOs administer Medicaid services. Following the inclusion of behavioral health services in the Me-

dallion program and the implementation of MLTSS, MCOs will take over responsibility for many processes that DMAS or other contractors currently perform to ensure the cost-effective delivery of services. Some of these processes are particularly important to cost-effectiveness and quality of care, and should be areas of focus for DMAS.

DMAS must ensure that MCOs effectively manage behavioral health provider network and service utilization

Many of the mechanisms used to oversee spending on behavioral health services will change when those services are included in managed care. DMAS currently uses an Administrative Service Organization to manage the behavioral health provider network, authorize services, and review service provision to ensure it is appropriate. Some of these mechanisms were put in place when behavioral health spending began to increase significantly in FY05. Behavioral health spending has stabilized in the past five years, but ensuring strong oversight during the transition to managed care is essential to maintain this progress. DMAS needs to ensure that there is adequate oversight of behavioral health services included in the Medallion program, where more than half of spending on behavioral health services is expected to be incurred.

Oversight of behavioral health provider networks

DMAS made several policy changes in response to the steady rise in behavioral health spending over the past decade. DMAS attributed the spending rise to the inclusion of private providers in the Medicaid program in 2000, to comply with federal law. According to DMAS, the Department of Behavioral Health and Developmental Services (DBHDS), and provider associations, some providers used the opportunity to provide services inappropriately, meaning to enrollees whose behavioral health needs did not truly meet the intent of these intensive services. In response, DMAS implemented policies to better manage utilization of these services, including adding prior authorization requirements, contracting out post-payment reviews, requiring service-specific documentation, narrowing definitions of services, increasing credentialing requirements of those who could provide services and assess recipients, and forbidding aggressive marketing to enrollees. Additionally, DMAS contracted with an Administrative Service Organization to increase the state's capacity to oversee utilization. The Administrative Service Organization can now require an interim review of the service's effectiveness for a specific individual, or direct recipients to a more appropriate service if the provider's prior authorization request doesn't align with the individual's needs.

Some providers may still be providing inappropriate services, but the extent of this problem is unclear. It is not possible to determine if services are provided inappropriately without performing a clinical review of each case; however, DMAS staff, DBHDS staff, and provider associations indicated that some providers are still serving individuals inappropriately. The wide variation in utilization rates across the state is

another potential indicator of this problem. In Northern Virginia, two percent of Medicaid enrollees receive behavioral health services, while in West Central Virginia, five percent of enrollees receive these services. The regions with higher utilization also tend to have more providers per enrollee. While the higher utilization in these regions may be appropriate and due to better access, it is also possible that providers are driving unnecessary utilization in some cases.

MCOs will have greater flexibility to manage the behavioral health provider networks once these services are included in the Medallion contract. Under federal law, fee-for-service systems must allow all qualified providers to participate in Medicaid. They can establish participation criteria, such as state licensure and no criminal history, but cannot exclude providers that meet the participation criteria, unless they are convicted of fraud. It is therefore legally and administratively difficult to disenroll a particular Medicaid provider for inappropriately providing services. In contrast, MCOs have extensive discretion in restricting their provider networks as long as they maintain sufficient access for recipients.

DMAS should carefully monitor MCOs' management of behavioral health providers. States that have included behavioral health in managed care allow MCOs control over their provider networks, and this is in line with DMAS's approach to services already administered through managed care. This approach allows MCOs to address providers who inappropriately provide services, whether through education, disenrollment, or other sanctions. Prevention of inappropriate utilization depends on an MCO's ability to identify providers that repeatedly serve individuals who would be more appropriately served through less intensive services. For example, an MCO might conduct record reviews of intensive services to assess if a recipient's needs align with the services provided.

Utilization controls are administrative policies or practices that are intended to ensure alignment between the type and amount of services and the recipients' medical needs.

States must balance utilization controls with the goals of timely access to services and reasonable administrative burden on providers.

MCOs already report to DMAS on the number of providers they disenroll from networks. Further specifying the number of behavioral health providers would increase DMAS's understanding of whether and how well each MCO is able to identify providers of inappropriate services. If DMAS determines that a particular MCO's methods are especially effective at identifying or addressing these providers, DMAS could require that all MCOs use those methods.

RECOMMENDATION 27

The Department of Medical Assistance Services should require Medallion MCOs, after behavioral health services are included in the program, to report their policies and processes for identifying behavioral health providers who provide inappropriate services and the number of such providers that are disenrolled.

Oversight of behavioral health service utilization

DMAS's current utilization controls are reasonable compared to other states. There are no nationally accepted standards or best practices for utilization controls, and the

details of utilization management processes are often proprietary to MCOs. However, Virginia uses several of the controls commonly used by the other 11 states that have included behavioral health services in managed care (Table 6-1). Recent federal regulations prohibiting more restrictive barriers to behavioral health services than physical health services may prompt changes in states' utilization controls.

TABLE 6-1
DMAS currently requires many utilization controls common in other states

Timing	Mechanisms common in other states	Virginia requirement
Before service provision	Documentation of diagnosis	✓
	Prior-authorization	✓
	Standardized assessment determines service	
	Independent clinical assessment [a]	
	Definition of medical necessity	✓
During service provision	Re-assessment required after designated duration	✓
	Written treatment plan	✓

SOURCE: JLARC staff analysis.

[a] Virginia required an independent clinical assessment (VICAP) for children's services between July 2011 and November 2016.

States vary in the degree to which they establish centralized requirements for MCOs' utilization controls, as opposed to allowing each MCO to determine its own controls. States note that administrative simplification for providers, streamlined state oversight of MCOs, and prevention of unnecessary barriers to access are advantages of the more prescriptive approach. On the other hand, enabling innovation by MCOs while holding them accountable for effective utilization management are advantages of providing MCOs with more flexibility.

DMAS should allow MCOs flexibility in establishing behavioral health utilization controls after these services are carved into the Medallion program, but closely monitor that they are implemented effectively. Granting MCOs flexibility will enable innovation and responsiveness to plan-specific and regional issues. DMAS should compare behavioral health utilization and spending data across MCOs to assess the impact of each MCO's utilization management practices over time. If DMAS identifies particular utilization management policies as more effective in achieving appropriate utilization, it could require those policies to be used by all MCOs.

RECOMMENDATION 28

The Department of Medical Assistance Services should allow Medallion MCOs to determine utilization controls but should monitor the impact of utilization controls on utilization rates and spending to assess their effectiveness.

DMAS must monitor MCOs to ensure appropriate utilization of services in MLTSS

When DMAS transitions to MLTSS in FY17, several oversight functions will need to change to account for the role of MCOs in service delivery. These oversight functions include the prior authorization process, the Quality Management Review process, the plan of care process, and monitoring processes related to consumer-direction, some of which should be improved in MLTSS. For two and a half years DMAS has been operating the Commonwealth Coordinated Care (CCC) program, which is a managed care program providing full acute, LTSS, and behavioral health services and will be the model for MLTSS. DMAS will transition its CCC oversight functions, which covered 40,000 individuals in FY15, to overseeing the MLTSS program, which is projected to cover 210,000 individuals.

Oversight of consumer-directed attendant care services

Oversight of all attendant care services is important because these services totaled $679 million, or half of all home and community-based (HCBS) spending, in FY15. However, additional oversight is required of consumer-directed attendant care for three reasons: (1) consumer-direction spending is growing at a faster rate than agency-direction spending; (2) consumer-direction has risks specific to the model that are not present in agency-direction; and (3) there are unique types of providers and requirements for consumer-direction that do not exist in agency-direction.

Under the **consumer-directed care model,** recipients of EDCD, ID, and DD waivers have the option of directing their own attendant care. This model empowers recipients who know their needs best to function as employer—or to appoint a representative as the employer—with responsibilities that include hiring, firing, and managing an attendant, who is often someone they know and trust, such as a family member or neighbor.

Spending on consumer-directed services in Virginia has outpaced the growth of agency-directed services as more recipients have chosen to manage their own health care (Table 6-2). Consumer-direction costs slightly less than agency-direction on a per recipient basis, but recipients of consumer-direction tend to receive more hours of service while the cost per hour is lower. Utilization rates also tend to increase when recipients switch from agency-direction to consumer-direction.

Consumer-direction also involves several risks that are not present in agency-direction. Recipients are typically new to the responsibilities required of employing their own providers, and they tend to be more isolated from regular monitoring by state agencies and licensed provider agencies. Consumer-direction also imposes lower supervision and training standards than agency-direction. For example, consumer-direction lacks nurse supervision of service delivery, whereas agencies employ nurses to ensure recipients' needs are being met. This risk will be mitigated in MLTSS with the addition of MCO care coordinators who must be nurses or social workers. Another difference is that attendants in consumer-direction receive minimal training, whereas attendants employed by agencies must complete 40 hours of professional training and be licensed through the agency.

TABLE 6-2
Growth in agency- and consumer-directed attendant care is driven by more recipients choosing consumer-direction

	FY11	FY15	Total growth	Annualized growth
Agency-direction				
Recipients[a]	16,427	18,842	2,415	3.5%
Cost per recipient	$17,155	$18,036	$881	1.3
Units per recipient[b]	1,305	1,317	12	0.2
Total spending	$281,809,985	$339,832,206	$58,022,222	4.8
Consumer-direction				
Recipients[a]	11,547	19,459	7,912	13.9%
Cost per recipient	$17,405	$17,964	$559	0.8
Units per recipient[b]	1,647	1,693	46	0.7
Total spending	$200,975,931	$349,563,319	$148,587,388	14.8

SOURCE: Mercer staff analysis of Medicaid claims data.
NOTE: Total spending does not include the costs of PPL fiscal services (for consumer-direction) or reimbursement services provided by Xerox (for agency-direction). A unit is equal to one hour.
[a] The number of recipients is an unduplicated count and excludes services facilitation. [b] Figures do not include services facilitation.

Consumer-direction features unique roles and requirements that necessitate additional oversight of services, but to date DMAS has not taken steps to enhance the monitoring of consumer-direction. Enhancements should include:

1. **Ensuring that recipients who wish to direct their own care have the capacity to do so, and if they do not, ensuring that a representative is appointed.** Virginia lacks a standardized process for determining if recipients have the capacity to direct their own care. The form used to assess the capacity to serve as an employer is optional, and there are no criteria to objectively determine when a representative should be appointed instead. This determination is critical to ensuring that the recipient, or someone appointed by the recipient, can successfully carry out the responsibilities required of an employer in the consumer-direction model.
2. **Ensuring that the recipient, or the appointed representative, effectively fulfills the role of employer.** Recipients of consumer-directed services are technically employers. They manage their own health care and the individual providing that care, ensuring the number of hours and services performed are appropriate. In some cases, a representative is appointed to take on the employer role when the recipient lacks the capacity to direct their own care. Ensuring that the employer—whether the recipient or a representative—properly oversees care is important to protect health and wellbeing and guarantee appropriate spending, because the consumer-direction model carries some risk of both insufficient service and excessive service. Recipients who consistently report fewer services than are authorized might not be getting services they need and may not be capable of directing their own care. Conversely, recipients might submit timesheets for more hours—and

thus more spending—than necessary. To address these risks, DMAS could develop conditions to be included in the MLTSS contract that trigger intervention by MCOs. Intervention initially may consist of additional training or assistance but could ultimately involve removal from consumer-direction and a return to agency-direction. To date, DMAS has never removed someone from consumer-direction.

3. **Ensuring services facilitators effectively perform their role to oversee and assist the employer.** Without staff from a licensed agency in the home on a regular basis to observe care, services facilitators are the providers that identify and address problems as they arise. In Virginia, unlike in most states, services facilitators function independently; there is no entity to monitor their performance or to offer guidance when challenging situations arise. Under MLTSS, DMAS plans to allow MCOs discretion in determining how services facilitation is performed. However, DMAS could require that MCOs enact certain oversight provisions or submit plans to address certain risks. For example, services facilitators could be required to document and report health and spending-related issues above a certain risk threshold to MCOs. Services facilitators could also be required to schedule more frequent phone calls to recipients (e.g., monthly as opposed to quarterly) and to conduct unannounced visits to ensure attendants are showing up for work. Furthermore, services facilitators could be required to develop monitoring plans, which could serve as a basis for MCOs to assess performance.

Services facilitators provide support to recipients as they direct their own care. Their responsibilities include making sure the recipient gets the services they need, training the recipient on their employer responsibilities, and serving as a liaison between the recipient and the program.

With MCOs as the direct overseers of consumer-direction in MLTSS, it will be important for DMAS to require specific monitoring activities and reporting in contract language. Currently, DMAS intends to allow MCOs discretion in structuring many aspects of consumer-direction, particularly the role of services facilitators. Going forward DMAS should identify the areas of consumer-direction that pose the greatest risk and require MCOs to standardize oversight practices to a reasonable extent.

DMAS's authority to conduct oversight of consumer-direction is somewhat constrained by Virginia's decision not to act as a third-party employer. According to federal labor policies, if DMAS were to assert oversight responsibilities typical of an employer—such as greater control over how services facilitators and attendants do their jobs—then DMAS would be forced to meet overtime requirements, adding significant costs. In spite of this limitation, DMAS can improve oversight of consumer-direction by requiring MCOs to focus on overseeing the unique elements of consumer-direction.

RECOMMENDATION 29

The Department of Medical Assistance Services should include language in the MLTSS contract requiring MCOs to provide a plan that establishes: (i) a standardized process to determine members' capacity to self-direct; (ii) criteria for determining when a member is no longer fit for consumer-direction; and (iii) the roles and responsibilities of services facilitators, including requirements to regularly verify that appropriate services are provided.

Oversight of LTSS service utilization

DMAS's current oversight mechanisms to ensure the appropriate utilization of services will change in MLTSS. Currently, DMAS requires prior authorization of all HCBS services. This process is performed by a contractor whose medical staff reviews requests for services submitted by providers and either approves or denies the amount and type of services an individual can receive. After services have been rendered, DMAS performs a federally required Quality Management Review process on a sample of claims to ensure that waiver services provided are in accordance with the authorized amount. These utilization controls are particularly important because Virginia's process for developing plans of care is led by providers, which have an incentive to increase the amount of services used. (See Chapter 3 on conflicts of interest in the care planning process.)

In MLTSS, both prior authorization and Quality Management Review (QMR) processes will be carried out by MCOs. DMAS intends to grant MCOs broad discretion in deciding how to design prior authorization processes or even whether to have a process at all. Because QMR is federally required, MCOs will have to follow specific guidelines when conducting reviews. DMAS staff will oversee MCOs as they perform reviews to ensure accuracy and adherence to guidelines.

DMAS will need to closely monitor how the prior authorization and Quality Management Review processes are executed in MLTSS. DMAS staff should review utilization data to identify outliers and then work with MCOs to address issues, which could include changes to the prior authorization process. DMAS staff will also need to ensure that MCO staff are effectively trained on the Quality Management Review guidelines, that identified issues are tracked consistently, and that those issues result in appropriate corrective actions.

RECOMMENDATION 30

The Department of Medical Assistance Services should review utilization and spending data on long-term services and supports (LTSS) across MCOs, once the managed LTSS program is implemented, and work with MCOs to make necessary changes to their prior authorization and Quality Management Review processes when undesirable trends are identified.

Leveraging strong oversight practices from existing managed care program will improve transition

Leveraging oversight practices that have been identified as valuable for the Medallion program will enable DMAS to implement robust oversight of the MLTSS program. While the two programs will cover different populations and services, many of the areas for improvement in the financial oversight of the Medallion program are also applicable to MLTSS, including the profit cap and the use of more robust data (Rec-

ommendations 31 and 34). (See Chapter 4 on financial oversight of MCOs and Appendix J for the relevance of all Medallion financial oversight recommendations to MLTSS.)

DMAS will need to obtain and use data effectively to oversee MLTSS and behavioral health service integration

It is essential that DMAS obtain and use robust data to support strong oversight of MCOs. DMAS has not historically required sufficient financial reporting of MCOs in the Medallion program, and with the inclusion of behavioral health and the implementation of MLTSS, there will be additional types of reporting necessary to fully understand whether MCOs are operating effectively. Effectively using financial data as well as behavioral health and LTSS-specific reporting will enable DMAS to identify potential statewide and MCO-specific challenges and work with MCOs to develop solutions.

Using robust data to inform oversight of MLTSS utilization and spending

Obtaining robust data on spending and utilization will enable DMAS to identify potentially undesirable trends, understand their root causes, and work with MCOs to address those challenges. DMAS needs to obtain additional spending data from MCOs in the Medallion program to enable strong financial oversight, and align these reporting requirements across Medallion and MLTSS, as several other states do. (See Chapter 4 on financial oversight of MCOs.) Arizona and Florida operate two separate managed care programs for acute care and LTSS, similar to Virginia, and require similar financial reporting for both programs, with the population and service categories tailored to the appropriate program.

DMAS needs to obtain and use robust data for the MLTSS program to understand spending trends and address challenges as they arise. The type of information reported for MLTSS should be aligned with the elements described for the Medallion program, such as revenue and expense information by population and service categories, balance sheets, and utilization reporting. The information required for MLTSS will need to be tailored to the populations and services covered.

RECOMMENDATION 31

The Department of Medical Assistance Services should include financial and utilization reporting requirements in the managed long-term services and supports (LTSS) contract and Technical Manual and use the reports to monitor spending and utilization trends for managed LTSS, address those trends with relevant MCOs, and address identified issues through the managed LTSS contract or rate-setting process as necessary. These reports should include detailed income statements that show expenses by rate cell and detailed service category, balance sheets, related party transactions, and service utilization metrics.

Using data to inform oversight of behavioral health services

DMAS should leverage data to enhance oversight of MCOs once behavioral health is included in the Medallion contract. DMAS currently receives extensive information from Magellan regarding utilization and utilization controls, which it should continue to require of MCOs. There are additional metrics that DMAS should collect on Medicaid enrollees, utilization trends, and MCOs' utilization controls to identify potentially inappropriate utilization and ineffective MCO processes (Table 6-3).

DMAS should actively use this data to understand variation between MCOs and assess the effectiveness of their utilization management practices. DMAS should compare the data to prior years and between MCOs within the same region to help isolate the impact of particular MCO policies. When trends and outliers are identified, DMAS should work with the MCOs to understand the root causes and develop solutions. One state that routinely analyzes MCO data reported an instance when an MCO, after being notified that it was an outlier in its denial rates, changed its utilization control policies.

TABLE 6-3
Suggested behavioral health-specific metrics to enhance DMAS's oversight of MCOs

Category	Metric	Purpose of metric
Utilization	Potentially preventable admissions and re-admissions due to behavioral health	Assess effectiveness of preventative care
	Duration of service	Identify potential over-utilization of appropriate services
	Utilization rate by service	Identify potential utilization of inappropriate services
	Percentage of recipients of behavioral health services with and without Serious Mental Illness or Serious Emotional Disturbance diagnoses	Identify potential utilization of inappropriate services
Utilization controls	Number of times that record reviews find service or service duration to be inappropriate	Identify proven utilization of inappropriate services

SOURCE: JLARC staff analysis of Texas, Kentucky, and Nevada documents.

RECOMMENDATION 32

The Department of Medicaid Assistance Services should include additional behavioral health-specific metrics in the Medallion contract and Technical Manual and use these metrics to identify undesirable trends in service utilization, assess the effectiveness of MCO utilization controls, and work with MCOs to address identified issues.

Using data to inform oversight of LTSS

DMAS can leverage data to become informed about LTSS-specific spending and utilization trends and to hold MCOs accountable for meeting performance goals. There are no nationally recognized standard LTSS metrics, and states tend to identify and use the metrics they view as most valuable for overseeing their priorities. DMAS staff have developed a substantial list of metrics that they plan to either track in-house or require MCOs to track and report. Many of these metrics address issues raised in this report, such as rebalancing and oversight of consumer-directed services. For example, DMAS intends to track the number of transitions between care settings and the percentage of new members that opt for HCBS over institutional care. DMAS also plans to track increases and decreases in authorized service hours for agency- and consumer-directed services, which is important given the growing enrollment, and therefore spending, in attendant care.

DMAS could incorporate additional metrics into the MLTSS contract to further enhance oversight of LTSS services (Table 6-4). DMAS can use this information to track MCO management of agency- and consumer-directed services, progress in serving more recipients in the community, and to ensure that all LTSS recipients have been approved for services. For example, identifying specific regions, MCOs, or populations with higher levels of institutionalization could allow DMAS to work proactively with MCOs to target efforts to divert and transition those recipients to more cost-effective community settings.

Table 6-4
Suggested LTSS-specific metrics to enhance DMAS's oversight of MCOs

Category	Metric	Purpose of metric
Agency- and consumer-direction	Average spending and utilization per recipient between agency-direction and consumer-direction	Track differences between models that could indicate a lack of cost-effectiveness.
	Changes in authorization levels when members switch between agency- and consumer-direction	Identify instances of potential under- or over-service.
PAS process	Percentage of UAIs authorized in the MMIS system prior to payment of LTSS services	Ensure that LTSS services are not provided unless individuals have been assessed with a UAI and authorized for services.
Rebalancing	Number of recipients of HCBS costing more than the institutional average, by waiver	Enable DMAS to work with MCOs to manage the health care of higher-cost recipients.
	Percent of recipients and cost per recipient in each care setting by population and by region	Assess rebalancing progress at a more detailed level and to target interventions in areas that are lagging behind.
	Number of low acuity members in nursing facilities (based on RUG scores)	Target individuals with low acuity who could be capable and interested in transitioning to HCBS services.

SOURCE: JLARC staff analysis.

RECOMMENDATION 33

The Department of Medical Assistance Services should include additional LTSS-specific metrics in the MLTSS contract and Technical Manual and use these metrics to identify differences between models of care, assess progress and challenges to keeping more recipients in community-based care, and work with MCOs to address identified issues.

DMAS should implement a profit cap as part of its efforts to manage spending through MLTSS

Implementing a tiered profit cap enables the state to retrospectively manage spending if capitation rates paid to MCOs significantly exceed the cost of administering the program and providing services to recipients. (See Chapter 4 on the advantages of the profit cap.) DMAS is currently planning to use a minimum MLR of 85 percent for its MLTSS program, but a profit cap is a more direct way to oversee MCO profits. The planned 85 percent MLR also may not be very effective because MLRs are typically higher for an MLTSS program given that the higher need populations require greater medical spending relative to administrative costs.

At least three states that use a profit cap for their acute managed care programs, which are similar to Medallion, use the same profit cap for their MLTSS programs. Florida and Texas operate separate acute managed care and MLTSS programs, as Virginia plans to, and use the same profit cap for both programs. New Mexico includes all populations and services in one managed care program with a single profit cap. Staff from Florida and Texas indicated that their profit cap was effective in limiting excessive profits under both their acute managed care and MLTSS programs. Each state also indicated that for MCOs that participate in both programs, total profit is calculated across both lines of business. This eliminates the risk that MCOs will shift administrative costs between lines of business; it also avoids penalizing MCOs that earn higher profits in one program while taking a loss the other program.

RECOMMENDATION 34

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services to require in the MLTSS contract that MCOs return at least a portion of underwriting gain in excess of three percent of Medicaid premium income, and increase the percentage of excess underwriting gain that must be returned as the underwriting gain level increases.

Strong oversight requires appropriate organization and sufficient staff with necessary skills

Having a sufficient number of staff with the appropriate financial, procurement, and policy expertise is essential to managing Virginia's growing and changing Medicaid program. DMAS leadership report difficulty being able to successfully recruit and retain high quality staff, especially in key areas such as procurement, managed care quality oversight, and information technology.

Any current staffing challenges at DMAS will likely be made more complex by the pending transition to a full managed care delivery system. DMAS is currently organized and staffed to oversee the Medallion managed care program, the LTSS FFS program, and the behavioral health program that operates as an Administrative Service Organization model. As all of these programs, populations, and services are being streamlined into Medallion and MLTSS, DMAS will in some cases need different organizational structures and staff with different skills.

In addition to current staffing challenges and the complexity of transitioning to managed care, this report makes more than 30 recommendations to improve the cost-effectiveness of the Medicaid program, but many of them entail process changes and additional administrative effort. DMAS should examine this report's recommendations in the context of the current transition to a more integrated managed care delivery system and determine how they will be implemented and the resources that will be required. In some cases, additional funds will not be necessary, but staff with different or enhanced skills will be needed. In other cases, additional personnel funding (to either pay higher salaries, hire more staff, or award contracts for specific functions) or information technology funds may be needed to implement certain process changes or improvements.

RECOMMENDATION 35

The General Assembly may wish to consider including language in the Appropriation Act directing the Department of Medical Assistance Services (DMAS) to assess and report on additional or different resources needed to implement recommendations in the JLARC report *Managing Spending in Virginia's Medicaid Program*. DMAS should submit its report to the House Appropriations and Senate Finance Committees no later than November 1, 2017.

Appendix A: Study mandates

HOUSE JOINT RESOLUTION NO. 637
and
SENATE JOINT RESOLUTION NO. 268

Directing the Joint Legislative Audit and Review Commission to study the Commonwealth's Medicaid program.

Agreed to by the Senate, February 27, 2015
Agreed to by the House of Delegates, February 27, 2015

WHEREAS, the Commonwealth's program of medical assistance services, also known as the Medicaid program, is the largest program in the Commonwealth's budget, accounting for more than $8 billion in combined state and federal funds in fiscal year 2014; and

WHEREAS, the Commonwealth's Medicaid program has become increasingly complex as coverage has expanded to include services related to long-term care, behavioral health, and developmental disabilities; and

WHEREAS, elderly Virginians and Virginians with disabilities represent a minority of enrollees in the Medicaid program but account for the majority of expenditures for medical assistance services and generally receive services through a fee-for-service rather than a managed care system; and

WHEREAS, a review of the eligibility process, particularly for long-term care services, could lead to strategies that strengthen the integrity of the program, improve efficiencies, and ensure that limited financial resources are directed to the individuals and families who most require assistance; and

WHEREAS, in light of budgetary pressures facing states across the nation, promising models of care and administrative processes have been implemented to lower costs associated with medical assistance services while maintaining and improving patient outcomes; and

WHEREAS, a comprehensive and analytical review of the Medicaid program should build upon and not duplicate the knowledge and findings from completed studies; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Legislative Audit and Review Commission be directed to study the Commonwealth's Medicaid program. In conducting its study, the Joint Legislative Audit and Review Commission shall review (i) the processes used to determine eligibility, including the financial eligibility screening process for long-term care services, whether asset sheltering could be further prevented and asset recoveries improved, and the effectiveness of existing fraud and abuse detection and prevention efforts; (ii) whether the most appropriate services are provided in a cost-effective manner; (iii) evidence-based practices and strategies that have been successfully adopted in other states and could be used in the Commonwealth; and (iv) other relevant issues, and make recommendations as appropriate.

Technical assistance shall be provided to the Joint Legislative Audit and Review Commission by the Office of the Secretary of Health and Human Resources and the Department of Medical Assistance

Services. All agencies of the Commonwealth shall provide assistance to the Joint Legislative Audit and Review Commission for this study, upon request.

The Joint Legislative Audit and Review Commission shall complete its meetings for the first year by November 30, 2015, and for the second year by November 30, 2016, and the chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the next Regular Session of the General Assembly for each year. Each executive summary shall state whether the Joint Legislative Audit and Review Commission intends to submit to the General Assembly and the Governor a report of its findings and recommendations for publication as a House or Senate document. The executive summaries and reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Appendix B: Research activities and methods

JLARC staff conducted the following primary research activities throughout 2015 and 2016:

- analysis of findings and recommendations provided by a consulting firm that assisted JLARC with various aspects of the study;
- structured interviews with state agency staff, DMAS contractors including Medallion 3.0 managed care organizations, state Medicaid stakeholders, other states, and national Medicaid experts;
- attendance at stakeholder meetings;
- quantitative analysis of Medicaid spending and pre-admission screening data; and
- review of documents and research literature.

Analysis of findings and recommendations provided by Mercer

Given the highly complex and technical nature of state Medicaid programs, JLARC contracted with Mercer Health and Benefits, a firm providing consulting services for several state Medicaid programs. Over 25 Mercer consultants assisted in the review, including several with actuarial and clinical expertise. Mercer's primary research activities included assisting JLARC staff with some of the structured interviews with DMAS staff, informing JLARC staff of how other states generally approach certain aspects of Medicaid oversight, conducting certain quantitative analyses as noted throughout this appendix, and formulating potential findings and recommendations.

JLARC staff closely reviewed Mercer's findings and recommendations to ensure they were based on sound evidence. In order to verify and expand upon Mercer's findings and recommendations, JLARC staff supplemented Mercer's research with numerous other interviews, attendance at stakeholder meetings, quantitative analyses, and reviews of the documents and research literature as discussed throughout this appendix.

Structured interviews

Structured interviews were a key research method that JLARC staff used to review the cost-effectiveness of Virginia's Medicaid program. JLARC staff conducted 140 structured interviews throughout its review including the Secretary of Health and Human Resources, state agency staff, DMAS contractors, state Medicaid stakeholders, other states, and national Medicaid experts.

Structured interviews of state and local agency staff

JLARC staff conducted 39 structured interviews with DMAS staff across multiple divisions, including the divisions of Health Care Services, Budget and Contract Management, Provider Reimbursement, Integrated Care and Behavioral Health, Long-Term Care, Program Integrity, and the Office of Analytics. The purpose of these interviews varied but was generally to understand Medicaid spending trends over the past five years, DMAS's current approach to ensuring the program's cost effectiveness, and DMAS's perspective on how, if at all, the program could be more cost-effective.

JLARC staff conducted 11 interviews with the Department of Behavioral Health and Developmental Services (DBHDS) on waiver services for individuals with intellectual and developmental disabilities

and behavioral health services. The interviews covering waiver services focused on the redesign of the intellectual and developmental disability waivers, spending trends for waiver and institutional services, and efforts to rebalance spending toward home and community-based services. Additionally, JLARC staff interviewed DBHDS regarding behavioral health services, including the agency's oversight of private providers and Community Service Boards, regional variation in need and utilization of behavioral health services, and sources of public funding for behavioral health services beyond Medicaid.

JLARC conducted 11 interviews with other state and local agencies involved in the preadmission screening process. JLARC interviewed staff from the Virginia Department of Health (VDH) the Department for Aging and Rehabilitation (DARS) to discuss their role in implementing the PAS process, including any challenges they experienced and the types of technical assistance provided to screeners. JLARC interviewed staff from the Department of Social Services to understand their role in providing training to individuals who conduct preadmission screenings. JLARC interviewed community-based screening teams in 7 local departments of social services. These interviews focused on the process to conduct screenings and the most challenging parts of performing reliable screenings.

Structured interviews of DMAS contractors

JLARC staff conducted 12 interviews with all six Medallion 3.0 managed care organizations: Aetna, Anthem, INTotal, Kaiser, Optima, and Virginia Premier. JLARC staff used these interviews to understand each managed care organization's spending trends over the past five years, what initiatives the managed care organization had undertaken to improve cost effectiveness, and the managed care organizations' perspective on changes the state could make to improve cost effectiveness.

JLARC staff also conducted 6 interviews with several other entities that DMAS contracts with for the Medicaid program. JLARC staff interviewed DMAS's actuary, PricewaterhouseCoopers, to understand managed care spending trends over the past five years, how the state currently sets managed care capitation rates, and PricewaterhouseCoopers' perspective on changes to the rate-setting process that could improve cost effectiveness. JLARC staff interviewed DMAS's enrollment broker, Maximus about its communications with new enrollees. JLARC staff interviewed DMAS's Administrative Service Organization for behavioral health services, Magellan, to understand their role in ensuring cost-effective behavioral health services, including their processes for utilization management and provider network management.

Structured interviews of state Medicaid stakeholders

JLARC staff conducted 7 interviews with several other state Medicaid stakeholders. The purpose of these interviews varied but was generally to understand any concerns they have with the state's current approach to the Medicaid program and their perspectives on changes the state could make to improve cost effectiveness. The following individuals and organizations were interviewed:

- Caliber Virginia
- Virginia Association of Community-Based Providers
- Virginia Association of Community Service Boards
- Virginia Association of Health Plans
- Virginia Association of Personal Care Providers

- Virginia Center for Health Innovation
- Virginia Hospital and Healthcare Association

Structured interviews with other states

JLARC staff conducted 33 interviews with 18 states on a variety of topics (Table B-1). JLARC staff selected other states to interview on long-term services and supports based on good practices identified by national experts as well as the length of time that the MLTSS program had been in existence. JLARC staff selected other states to interview on acute managed care based primarily on whether the (i) research literature or Mercer identified the state as a best practice, and (ii) the state had similar eligibility criteria, service coverage, and maturity of its managed care program, based on a Mercer analysis. JLARC staff selected other states to interview on MCO incentives based on whether states used a financial incentive in FY16 or had finalized plans for future incentives to obtain a cross-section of states that used different incentive models and structures. JLARC staff selected other states to interview on behavioral health based on whether those states operate managed care plans that had already carved-in behavioral health services. JLARC limited these interviews to managed care plans covering adults and children in order to be comparable to Virginia's Medallion program, and therefore did not research separate managed care plans for individuals with more intensive needs such as disabilities or serious mental illness (i.e. equivalent to Virginia's MLTSS).

Table B-1
Topics addressed during other state interviews

Interview topic	AZ	CT	DE	DC	FL	GA	KS	KY	LA	MA	MN	NJ	NV	OH	PA	TN	TX	WI
Long-term services and supports (Chapters 3 & 6)																		
Pre-admission screening					✓							✓				✓		✓
Rebalancing	✓	✓								✓								
Consumer-direction					✓							✓				✓		✓
Care planning					✓							✓				✓		✓
Rate setting	✓				✓							✓				✓		✓
State financial oversight of acute managed care (Chapter 4)																		
Rate setting				✓	✓				✓			✓		✓	✓	✓	✓	
Profit sharing mechanisms	✓			✓	✓				✓			✓		✓	✓	✓	✓	
Financial reporting	✓			✓	✓				✓			✓		✓	✓	✓	✓	
Contract compliance	✓				✓				✓			✓		✓	✓	✓	✓	
Incentives to improve chronic conditions (Chapter 5)																		
Financial incentives						✓	✓				✓					✓	✓	
Report cards							✓										✓	
Behavioral health services (Chapter 6)																		
Provider network			✓					✓		✓	✓		✓			✓	✓	
Utilization management			✓					✓		✓	✓		✓			✓	✓	

NOTE: JLARC staff interviewed Arizona, Texas, and Florida regarding their profit sharing mechanisms for both acute managed care and MLTSS.

Structured interviews with national Medicaid experts

JLARC staff conducted 14 interviews with several Medicaid experts throughout the course of the study to understand nationwide Medicaid spending trends and best practices in state Medicaid oversight. The following experts were interviewed:

- Center for Health Care Strategies,
- Centers for Medicare & Medicaid Services,
- Community Catalyst,
- Government Accountability Office,
- Health Management Associates,
- Kaiser Family Foundation,
- Mathematica,
- National Association of Medicaid Directors,
- National Conference of State Legislatures,
- National Governors Association, and
- National Resource Center for Participant-Directed Services, and
- OPEN MINDS.

Attendance at stakeholder meetings

JLARC staff attended several stakeholder meetings including meetings for the DMAS managed care financial work group, DMAS managed care quality improvement collaborative, DMAS managed care program integrity, DMAS pharmacy and therapeutics committee. JLARC attended these meetings in order to understand how DMAS oversees the managed care program, how DMAS solicits and uses feedback from managed care organizations. JLARC staff also attended meetings of Magellan's Governance Board, quality improvement committee, utilization management committee, and provider sessions. JLARC attended these meetings in order to learn about Magellan's initiatives, relationships with stakeholders, and oversight activities.

Quantitative analysis

JLARC staff analyzed a vast amount of data from DMAS to understand the state's Medicaid spending trends over the past five years, the impact of the state's current approach to overseeing certain aspects of the program such as pre-admission screenings for long-term care services and managed care contract compliance, and the impact of potential changes to the state's Medicaid program. Data sources included eligibility data, monthly fee-for-service claims data, annual managed care claims data submitted to PWC, managed care organizations' financial statements, long-term care pre-admission screening data, and DMAS's annual Statistical Record. Mercer assisted JLARC in some of these analyses.

Medicaid cost drivers (Chapter 2)

Mercer staff collected and analyzed Medicaid claims and eligibility data for FY11 through FY15. This included fee-for-service acute, behavioral health and LTSS claims from DMAS as well as acute care managed care claims used for rate-setting from PricewaterhouseCoopers. It also included files containing data on the demographics and benefit plans for all eligibility Medicaid recipients. Mercer

consolidated these files into annual claims files based on the date of service and annual eligibility files based on each recipient's eligibility segments.

Mercer and JLARC staff analyzed this data to understand the factors driving costs in Virginia's Medicaid program and within specific programs and services. Claims data was used to calculate expenditures, recipients, and units for each program area and service (Table B-2). Eligibility data was used to calculate enrollment and member months across eligibility categories and benefit plans. These metrics were calculated across different categories of service and specific services as defined in the DMAS Statistical Record. Metrics were also calculated by eligibility category, type of waiver, region, delivery system (fee-for-service versus managed care), age, and populations with specific diagnoses.

TABLE B-2
Spending and enrollment metrics calculated to analyze cost drivers

Metric	Definition
Claims data	
Expenditures	Total payment amount for each claim, summed by service, group of service, or population
Recipients	Number of unique recipients of a particular service or group of services
Cost per recipient	Total expenditures for a given service divided by the number of recipients of that service
Penetration rate	Number of unique recipients of a particular service divided by the number of total enrollees
Units	Number of units associated with each claim, as defined in the original claims data
Cost per unit	Total expenditure for a given service divided by the total number of units
Eligibility data	
Enrollees	Number of unique, eligible individuals in a given year
Member months	Number of months of eligibility for an individual in a given year
Average enrollment	Total member months divided by 12 (also full year equivalent enrollees)

JLARC estimated the percentage of spending growth between FY11 and FY15 attributable to inflation, enrollment, and service utilization by using cost variance analysis based on data in the DMAS Statistical Record. This was done using the following steps:

- The impact of inflation was estimated by using JLARC's estimate of Medicaid inflation in Virginia over the five-year period of 9.1 percent. This inflation factor was used to adjust FY11 spending across all eligibility categories to FY15 dollars.
- Calculating the average cost per enrollee, using average monthly enrollment, for inflation-adjusted FY11 and FY15 spending.
- The impact of enrollment growth was estimated by calculating the growth in spending based on the change in enrollment growth and mix across each eligibility category between FY11 and FY15, assuming cost per enrollee remained unchanged.
- The impact of service utilization was estimated by calculating growth in spending per enrollee across each eligibility category between FY11 and FY15, while holding the mix of enrollees constant.

Impact of recipients with chronic conditions on Medicaid spending (Chapter 2)

Mercer selected the seven conditions on which JLARC focused its analyses: asthma, Chronic Obstructive Pulmonary Disease, heart disease, diabetes, chronic liver disease, substance abuse

disorders, and severe mental illness. These seven conditions are all considered "ambulatory care sensitive conditions," (ACSC) meaning that coordinated and timely health care can reduce condition severity and therefore reduce inpatient and emergency department visits. These conditions serve as examples of common chronic and impactable conditions.

Mercer flagged recipients with these conditions in FY11 through FY15 Medicaid claims data using ICD-9 diagnoses codes. JLARC and Mercer then analyzed the prevalence of these conditions within the Medicaid population and the level of spending for recipients with these conditions. This included an analysis of the impact of co-occurring conditions. In these analyses, JLARC examined total spending, spending on Emergency Department services, and spending on inpatient services.

Impact of inflation on Virginia Medicaid spending (Chapter 2)

Adjusting for inflation normally involves choosing the appropriate national price index or deflator. However, national price indexes for medical care, such as the CPI for medical care or the PCE deflator for health care services, are likely to overstate the effect of inflation on Medicaid spending, because Virginia exercises some control over payment rates. Virginia sets rates separately for about a dozen major categories of services, using different approaches.

For the ten categories of service with the largest spending in FY15, JLARC calculated the annual change in unit costs (spending divided by the number of units of service provided), and used this as an estimate of inflation for FY11-FY15. For all services but MCOs, unit costs were estimated from monthly spending and units data used by DMAS's budget division to forecast Medicaid spending. Unit costs for services provided by MCOs are based on detailed claims data that is used to set capitation rates, compiled by Mercer. JLARC calculated the change in unit cost by service, then calculated a weighted average increase in unit costs, weighted by units, for all MCO services. JLARC then calculated the average change in unit cost for the 10 largest service categories and then calculated a weighted average, weighted by total spending, to estimate an inflation factor for the entire Medicaid program.

Units vary by service category. For example, for nursing homes the unit is the per diem spending for operating expenses per recipient. For attendant care, the unit is an hour of labor by a care provider. For prescription drugs, the units vary depending on the type of drug and can be the number of prescriptions or the volume (number of pills or days) in the prescription.

Changes in unit costs can be influenced not just by inflation but also by changes in the composition of services, the composition of enrollees, and technology. Based in part on interviews with DMAS rate setting staff, we assume inflation is the largest component of changes in unit costs.

JLARC's overall weighted average estimate of inflation from FY11 to FY15 is 9.1%, or about 2.3% per year. This is less than the change in the national CPI for medical care, but similar to the GDP implicit price deflator.

Authorization and approval rates for pre-admission screenings (Chapter 3)

JLARC staff received FY16 electronic preadmission screening data from DMAS. The data included approval and authorization rates available by screening team (hospital team or community-based team) and by adults versus children. JLARC staff limited the analysis of authorization rate ranges to teams that screened a minimum of 100 individuals in FY16. The rates of placement in nursing facilities

versus the EDCD waiver were based on the total number of authorized UAI applications as opposed to the total number of UAI applications received.

Potential savings from adjusting managed care capitation rates for potentially preventable health care services (Chapter 4)

Mercer estimated potential savings for Virginia from adjusting capitation rates for potentially preventable health care services, based on analyses of other states' managed care programs. The analyses used proprietary algorithms to identify three types of potentially preventable health care services (Table B-3). For each type of potentially preventable health care services, Mercer used results from at least ten other states to identify the range of the percentage of total medical spending that was inefficient, excluding outliers. The analyses accounted for the cost of alternative services that would have been more appropriate, such as primary care physician visit rather than an emergency room visit. Mercer then applied the minimum and maximum percentages to Virginia's total medical spending in 2013, upon which the FY16 capitation rates are based. While Virginia's managed care organizations may be more or less efficient than those in other states, the analysis provides a useful benchmark for Virginia.

TABLE B-3
Mercer analyzed three types of potentially preventable health care services in other states

Preventable services	Description	Identification
Emergency room visits		
Preventable care setting or condition	Emergency room visits that could have been prevented by either providing care in a lower-acuity setting, such as an urgent care facility, or providing preventive services beforehand	Proprietary Mercer methodology based on research literature and approaches used in other states
Inpatient hospital stays		
Preventable admission	Inpatient admissions for health care conditions, such as diabetes or dehydration, that could have been avoided by following evidence-based care management protocols	Proprietary Mercer methodology based on a subset of the Agency for Healthcare Research and Quality's prevention quality indicators
Preventable readmission	Inpatient readmissions, within 30 days of being discharged for the same or similar condition, that could have been avoided through appropriate discharge planning and follow up	Proprietary Mercer methodology
Inappropriate pharmacy use		
Inappropriate given diagnosis	Medications that are inappropriate given the clinical diagnosis in the medical claims data. This analysis is limited to select medications that are more likely to be abused, are high-cost, or have safety concerns.	Proprietary Mercer methodology based on peer-reviewed literature and approved indicators by the Food and drug Administration
Inappropriate given other information	Medications that are for an inappropriate quantity are for an inappropriate duration, are duplicative, or are inappropriate given the individual's age and pregnancy status	Proprietary Mercer methodology based on research literature, industry standard practices, and approaches used in other states

SOURCE: JLARC staff analysis of information provided by Mercer.

In order to validate the applicability of other states' estimates to Virginia, Mercer also used Virginia-specific data to estimate potential savings for Virginia from adjusting capitation rates for potentially preventable emergency room spending. This analysis used both monthly fee-for-service and annual managed care claims data from DMAS for FY14. The analysis is only an estimate of potential savings

because it uses default assumptions that have not been validated by DMAS staff, such as the percentage of certain conditions that could have reasonably been prevented in a given year and the cost of alternative treatments. Nonetheless, the analysis provides a useful benchmark for Virginia.

Maximum savings from more accurately projecting future managed care spending when setting capitation rates (Chapter 4)

JLARC staff used CYs 2011 to 2015 managed care financial statements to calculate how much Virginia could have saved by more accurately projecting future managed care spending—medical and administrative—when setting capitation rates. In the first step, JLARC staff used the following formula to calculate what the state's capitation payments would have been each year if it had accurately projected managed care organizations' spending:

State capitation payments = (Actual medical spending + Actual administrative spending) / 0.985

Actual medical and administrative spending is divided by 0.985 because an additional 0.015 percent of the capitation payment is set aside for profit. In the second step, JLARC staff took the difference between the state's actual capitation payments each year and what the state would have paid if it had more accurately projected managed care spending. In the third step, JLARC staff calculated the average annual savings over the five-year period. The resulting savings represent the maximum that the state could have saved, but it is likely that Virginia would save less because it is unrealistic for states to predict future managed care spending with 100 percent accuracy in a given year. It is also possible for Virginia to save more because this analysis is based on spending data that is not adjusted for certain administrative expenses, such as income taxes and charitable gifts, that should be classified as profit. (See Chapter 4.)

Potential savings from adjusting managed care administrative spending projections for recent enrollment changes (Chapter 4)

Mercer staff estimated potential savings from adjusting managed care administrative spending projections in Virginia for recent enrollment changes. DMAS's actuary currently estimates administrative spending per enrollee in the capitation rate using enrollment data from 1.5 years prior, rather than projected enrollment for the year in which the capitation rate will be in effect. Mercer assumed three different annual enrollment growth rates during this 1.5-year lag in enrollment growth data:

1. Zero annual enrollment growth;
2. Average annual enrollment growth of 4.2 percent, as Virginia experienced in FY13 to FY15; and
3. Average annual enrollment growth of 7.7 percent, as Virginia experienced in FY11 to FY13.

Mercer then calculated total FY16 projected administrative spending for each of these three scenarios using FY14 financial statements and several default assumptions such as the percentage of administrative spending that was attributable to fixed versus variable costs. The difference between the first and second scenarios, or $8 million, represents the potential savings Virginia could have experienced in FY16 if average annual enrollment growth from FY14 to FY16 were similar to that in FY13 to FY15. The difference between the first and third scenarios, or $14 million, represents the

potential savings Virginia could have experienced in FY16 if average annual enrollment growth from FY14 to FY16 were similar to the higher growth rates from FY11 to FY13.

State savings under alternative profit cap structures (Chapter 4)

JLARC staff used three steps to calculate how much Virginia would have saved if it had structured its profit cap like that in other states. In the first step, JLARC staff used annual operating margin and revenue from capitation payments, as reported on CYs 2011 to 2015 managed care financial statements, to determine how much each managed care organization would have had to return if Virginia's profit cap had been structured like those in Florida, New Mexico, and Texas. Arizona's calculation included any additional money the state would pay managed care organizations that realized losses greater than three percent of capitation payments. JLARC staff excluded Kaiser from the analysis in 2013 because the MCO had just begun its operations. In the second step, JLARC staff calculated the state's net savings by subtracting any funds each managed care organization returned under Virginia's profit cap from the results of the first step. In the third step, JLARC staff calculated the average annual savings to the state, across all managed care organizations, over the five-year period. This analysis likely underestimates state savings because it is based on DMAS's underestimations of actual profit levels. (See Chapter 4.)

DMAS enforcement of sanctions authorized in the managed care contract (Chapter 4)

JLARC staff assessed the extent to which DMAS enforced eligible sanctions in the first year of its contract compliance enforcement action (CCEA) process. JLARC staff first documented each FY16 infraction noted in DMAS's monthly managed care compliance dashboards, monthly managed care compliance reports, monthly managed care deliverables report cards, and a separate list of enforcement actions that DMAS provided JLARC staff. JLARC staff excluded infractions that met the following criteria, based on the compliance reports and discussions with DMAS staff:

- Infractions that were later determined to be a DMAS error, rather than an error by a managed care organization, such as encounter data quality infractions that stemmed from problems with the state's Medicaid Management Information System (17 infractions);
- Infractions that were being preliminarily tracked in the CCEA process but were not yet subject to sanctions, such as the percentage of enrollees assessed within certain time periods (47 infractions); and
- Infractions that were still undergoing DMAS review as of June 2016 (1 infraction).

Second, JLARC staff assigned each infraction a number of compliance points that DMAS could have assessed based on the FY16 Medallion 3.0 contract and discussions with DMAS staff (Table B-4). In cases in which the contract explicitly allows for multiple levels of compliance points to be assessed, based on the severity of the infraction, JLARC staff assumed the lowest level of compliance points. For example, the contract and DMAS staff indicated that infractions related to encounter data quality could be assessed one or five points depending on severity, so JLARC assumed all such infractions would be eligible for one point.

TABLE B-4
Medallion 3.0 contract specifies eligible fines compliance points per infraction

Infraction	Compliance points
Duplicate encounters submitted	1 point
Encounter data quality	1 or 5 points, depending on severity
Infraction that affects the managed care organization's ability to deliver, or an enrollee's ability to access covered services	10 points
Late submission of annual report	1 point
Late submission of monthly report	0.5 points per day late
Reporting errors	1 point
Timeliness of answering enrollee and provider calls	5 points
Timeliness of claims adjudication	5 points

SOURCE: JLARC staff analysis of Virginia's FY16 Medallion 3.0 contract and discussions with DMAS staff.

Third, JLARC staff assigned each infraction a fine in accordance with the Medallion 3.0 contract (Table B-5). This assignment was based on the number of compliance points the managed care organization would have accumulated by that point in time had DMAS fully enforced all previous infractions, except for infractions that were excluded from the analysis.

TABLE B-5
Medallion 3.0 contract specifies eligible fines based on accumulated compliance points

Accumulated compliance points	Fine per infraction
0 – 15	None
16 – 25	$5,000
26 – 50	$10,000
51 – 70	$20,000
71 – 100	$30,000
101 or more	Possible contract termination

SOURCE: JLARC staff analysis of Virginia's FY16 Medallion 3.0 contract.

Fourth, JLARC staff documented the compliance points and fines that DMAS actually assessed for each infraction. JLARC staff also attempted to document the number of MCO improvement plans (MIP) or corrective action plans (CAP) that DMAS assessed, but was unable to do so because this information did not appear to be regularly included in the compliance reports. There was one documented instance in which DMAS assessed no compliance points or fines but did assess a MIP.

Fifth, JLARC staff calculated the percentage of eligible compliance points and fines that DMAS enforced. The percentage is a conservative estimate because JLARC staff assumed the lowest compliance point level, as previously discussed.

Sixth, JLARC staff documented any reasons for mitigating or waiving a sanction that DMAS staff noted in the compliance reports or discussions with JLARC staff. In some cases, the compliance reports did not explicitly state a reason but JLARC staff were able to infer one. For example, the compliance reports did not state a reason for waiving sanctions for one managed care organization's failure to comply with

claim adjudication requirements in August 2015 through January 2016. However, DMAS staff stated that they waived February–April 2016 claim adjudication infractions because the managed care organization was already under an improvement plan for committing the same infraction in July 2015. Therefore, JLARC staff inferred this rationale also applied to the August 2015 through January 2016 infractions. JLARC staff also noted instances in which DMAS assessed the full amount of points or fines that were eligible at the time, given the sanctions that DMAS had previously enforced, but which were still less than the full amount of eligible fines had DMAS fully enforced all previous sanctions. JLARC staff categorized this reason as "fine threshold not met due to waiving other sanctions."

Seventh, JLARC staff calculated the percentage of infractions that DMAS appeared to mitigate or waive for reasons explicitly included in the Medallion 3.0 contract. These reasons included the MCO is transitioning to a new subcontractor, the MCO is acting to correct the problem, and the MCO is acting to correct the problem because it is already under a MIP or CAP for previous noncompliance. All other reasons, and instances in which no reason was provided, were considered reasons that may not be explicitly noted in the contract.

Behavioral health provider analysis (Chapter 6)

JLARC staff compared the number of behavioral health providers to the penetration rates by region, for selected behavioral health services. This analysis used the eight regions used by DMAS for reporting Medicaid data in the DMAS Statistical Record. JLARC staff conducted these analyses for the three most-used behavioral health services (Intensive In-Home, Therapeutic Day Treatment, and Mental Health Skill-Building) as well as for overall behavioral health services. JLARC staff used data from Magellan to calculate the density of behavioral health providers by region, defined as the number of behavioral health providers for a particular service divided by the number of Medicaid enrollees in that region. Mercer provided penetration rate data, defined as the number of Medicaid enrollees using a particular service divided by the number of Medicaid enrollees in that region. JLARC staff then compared regional rankings for provider density to regional rankings for penetration rates to identify relationships between the two metrics.

Review of state documents and research literature

JLARC staff reviewed numerous state documents and research literature pertaining to the cost effectiveness of state Medicaid programs, including

- descriptions of the state's current Medicaid policies and procedures such as contracts for Medallion 3.0 and Commonwealth Coordinated Care, Request for Proposals for managed long-term services and supports, Medallion 3.0 capitation rates data book, Medallion 3.0 technical manual, annual reports, DMAS provider manuals, and DMAS memos to providers;
- federal and state statutes and regulations governing the Medicaid program, including CMS's April 2016 final rule on Medicaid managed care;
- national research literature on Medicaid spending trends nationwide and best practices for improving cost effectiveness; and
- descriptions of other states' Medicaid programs including their managed care contracts, financial reporting requirements, quality strategies, performance reports, and External Quality Review Organization reports.

Appendix C: Optional eligibility categories

Virginia can limit eligibility in three categories, as most of the major Medicaid eligibility categories are federally required, and Virginia's income limits for these categories are at the federal minimums (Table C-1). The mandatory eligibility categories are children, parents, pregnant women, aged or disabled individuals receiving federal SSI benefits, and certain qualifying Medicare beneficiaries who are only eligible for partial reimbursement of Medicare premiums and cost-sharing. There are three optional eligibility categories that Virginia covers, including aged or disabled individuals earning less than 80% of federal poverty level (not eligible for SSI), individuals eligible for long-term services and supports (LTSS) earning up to 300 percent of the SSI benefit level, and individuals eligible for limited, family planning services (Plan First). Current federal maintenance of effort requirements under the Patient Protection and Affordable Care Act also prohibit states from narrowing eligibility criteria for children (under age 19) until October 1, 2019. These restrictions apply to all children under 19, even if they are eligible under a different category such as the disabled category.

TABLE C-1
Virginia eligibility categories and income thresholds compared to other states

Eligibility category	Mandatory/ optional	States covering	Income threshold (% of FPL)	National rank	Virginia could restrict eligibility category
Children	Mandatory	51	143%	19th – 43rd (federal minimum)	No
Parents	Mandatory	51	24-48%	42nd (federal minimum)	No
Pregnant women	Mandatory	51	143%	45th (federal minimum)	No
Aged or disabled					
SSI recipients [a]	Mandatory	51	75%	N/A	No
<80% of FPL	Optional	21	80%	19th out of 21	Yes
<300% of SSI	Optional	44	300% of SSI	federal maximum (40 states use maximum)	Yes
Medicare-eligible					
QMB	Mandatory	51	100%	federal minimum	No
SLMB	Mandatory	51	120%	federal minimum	No
QI	Mandatory	51	135%	federal minimum	No
Plan First	Optional	24	200%	12th out of 24	Yes

SOURCE: JLARC staff analysis of the Kaiser Family Foundation reports on national Medicaid eligibility criteria.
NOTE: Income threshold for parents varies by locality. Other states' income threshold for children varies by age. Virginia is at the federal minimum income threshold for parents, children, and pregnant women yet is higher than some other states due to differences in income calculation methodologies between states.
[a] Virginia is a "209(b)" state that uses more restrictive criteria than SSI, therefore SSI eligibility does not guarantee Medicaid eligibility in Virginia.

Appendix D: Potentially preventable emergency room spending

Emergency room spending can sometimes be prevented in two ways. First, certain health care conditions could be treated in a lower-acuity setting such as an urgent care facility, which are typically less expensive than an emergency room. Second, certain health care conditions could be prevented through better health care provision beforehand.

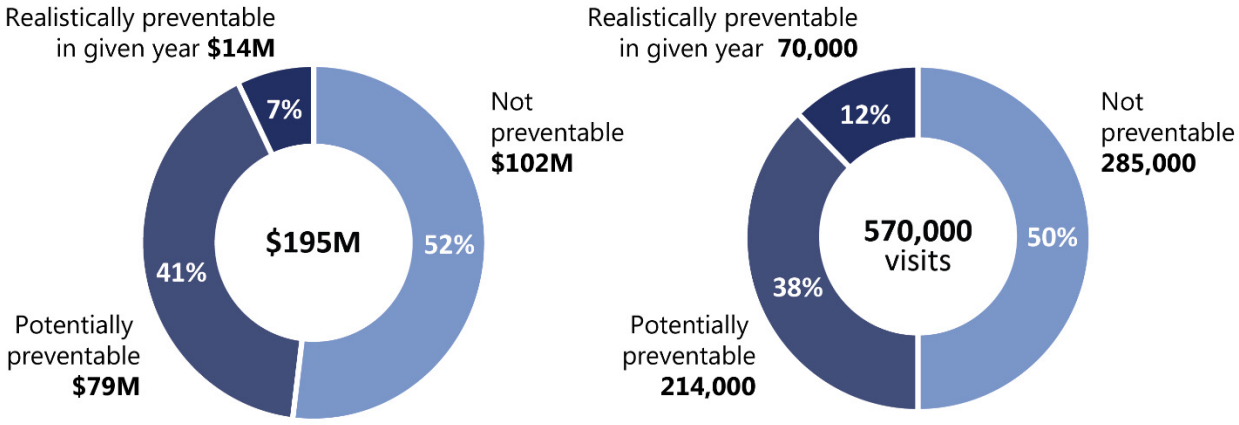
Mercer analyzed both fee-for-service and managed care claims data to identify potentially preventable emergency room spending in Virginia in FY14 (Appendix B). The analysis first identifies all emergency room spending that states can potentially prevent in the long term, then calculates the percentage that states could realistically prevent in a given year. The difference between the short- and long-term prevention recognizes that many factors impacting emergency room spending may be difficult for states or MCOs to influence quickly, like health care access or health literacy. The analysis is only an estimate of potential savings because it uses default assumptions that have not been validated by DMAS staff, such as the percentage of conditions that could have been realistically prevented in a given year and the cost of the alternative treatments. Nonetheless, the analysis provides a useful benchmark for Virginia.

Mercer's analysis found an opportunity for short- and long-term savings in Virginia through reduced emergency room use. The analysis found that 48 percent of Virginia's emergency room spending in 2014 was potentially preventable in the long term, although Virginia could have only realistically prevented 7 percent of emergency room spending in that year for estimated savings of $14 million (Figure D-1). Similarly, 50 percent of Virginia's emergency room visits in 2014 were potentially preventable, although Virginia could have only realistically prevented an estimated 12 percent of emergency room visits in that year.

Virginia's results are in the lower range of findings from other states. Typically, 45 to 55 percent of total emergency room spending in other states is potentially preventable, compared to the estimated 48 percent in Virginia. Similarly, a typical range of 55 to 65 percent of total emergency room visits are potentially preventable in other states, compared to the estimated 50 percent in Virginia.

FIGURE D-1

Virginia could have realistically prevented an estimated $14 million in emergency room spending in 2014, or 12 percent of total emergency room visits



SOURCE: Mercer analysis of fee-for-service and managed care claims data.
NOTE: These results are only an estimate of potential savings because it uses default assumptions that have not been validated by DMAS staff. Ninety-eight percent of emergency room spending was through managed care, and the remaining two percent through the fee-for-service delivery system.

Appendix E: MCO financial reporting to DMAS

For the quarter ended March 31, 2015

Analysis of Operations By Line Of Business

		Medallion Medicaid (Title XIX)	FAMIS & FAMIS MOMS SCHIP (Title XXI)	Commonwealth Coordinated Care (CCC)	All Other Lines of Business	Total
1	Net Premium Income					
	1a. Medicaid					
	1b. Medicare					
	1c. All Other Lines of Business					
	1d. Total					
2	Change In unearned premium reserves and reserve for rate credit					
3	Fee-for-Service (net of $0 medical expenses)					
4	Risk revenue					
5	Aggregate write Ins for other health care related revenues					
6	Aggregate write ins for other non-health care related revenues					
7	Total revenues (lines 1 through 6)					
8	Hospital/medical Benefits					
9	Other professional Services					
10	Outside referrals					
11	Emergency Room and Out of Area					
12	Prescription drugs					
13	Aggregate write-Ins for other hospital and medical					
14	Incentive pool, withhold adjustments and bonus amounts					
15	Subtotal (line 8 to 14)					
16	Net reinsurance recoveries					
17	Total hospital and medical (15 minus 16)					
18	Non-health claims (net)					
19	Claims adjustment expenses including cost containment expense					
20	General and administrative expenses					
21	Increase in reserves for life and A&H contracts					
22	Increase in reserve for life contracts					
23	Total underwriting deductions (Line 17 to 22)					
24	Net Underwriting gain or (loss) (Line 7 less 23)					

	Fully Insured Membership
	Fully Insured Member Months
	Premiums PMPM

Appendix F: Improving managed care encounter data

Complete and accurate spending data is essential for effective state oversight of managed care organizations (MCOs). Spending data is the basis of the state's rate-setting process and monitoring of trends. If data is incomplete or inaccurate, the state cannot be sure that it is appropriately paying MCOs and that MCOs are providing appropriate care.

DMAS receives two primary types of spending data from MCOs, one of which DMAS has had difficulty verifying for completeness and accuracy. First, DMAS receives administrative spending data which it regularly audits for completeness and accuracy. Second, DMAS receives medical spending data known as encounter data. DMAS has had challenges verifying the completeness and accuracy of the encounter data but is taking steps to address it, as discussed below.

DMAS currently cannot ensure encounter data is complete and accurate

Virginia currently cannot ensure that its encounter data is complete and accurate. The state's overall approach to validating encounter data primarily involves basic checks of reasonableness. While useful, these reasonableness checks do not ensure that the encounter data is a complete and accurate representation of the medical services that MCOs actually rendered.

DMAS checks monthly encounter data for reasonableness in two main ways. First, the state implemented an encounter data quality (EDQ) process in July 2015 to check for certain key issues such as timeliness and missing or invalid values. The EDQ process is part of the state's contract compliance enforcement action process, so MCOs incur sanctions if they do not comply. Second, the state performs ad hoc checks for completeness by, for example, comparing average utilization per enrollee over time. However, these checks do not ensure that all reported encounters accurately represent medical services that MCOs actually rendered, and that the encounter data includes all medical services rendered. DMAS recognizes these limitations but cannot presently expand the checks because its current data system, the Medicaid Management Information System (MMIS), was designed to process fee-for-service rather than managed care claims.

DMAS collects a separate set of encounter data from MCOs on an annual basis for the rate-setting process, in recognition of the challenges with the monthly encounter data, but DMAS's actuary only performs two main reasonableness checks on this data. First, the actuary requires MCOs to reconcile this annual encounter data with annual financial statements they submit to the Virginia Bureau of Insurance. Second, the actuary removes certain encounters such as those that were for ineligible individuals or were a duplicate of another encounter. However, these checks do not ensure that all reported encounters accurately represent medical services that MCOs actually rendered, and that the encounter data includes all medical services rendered.

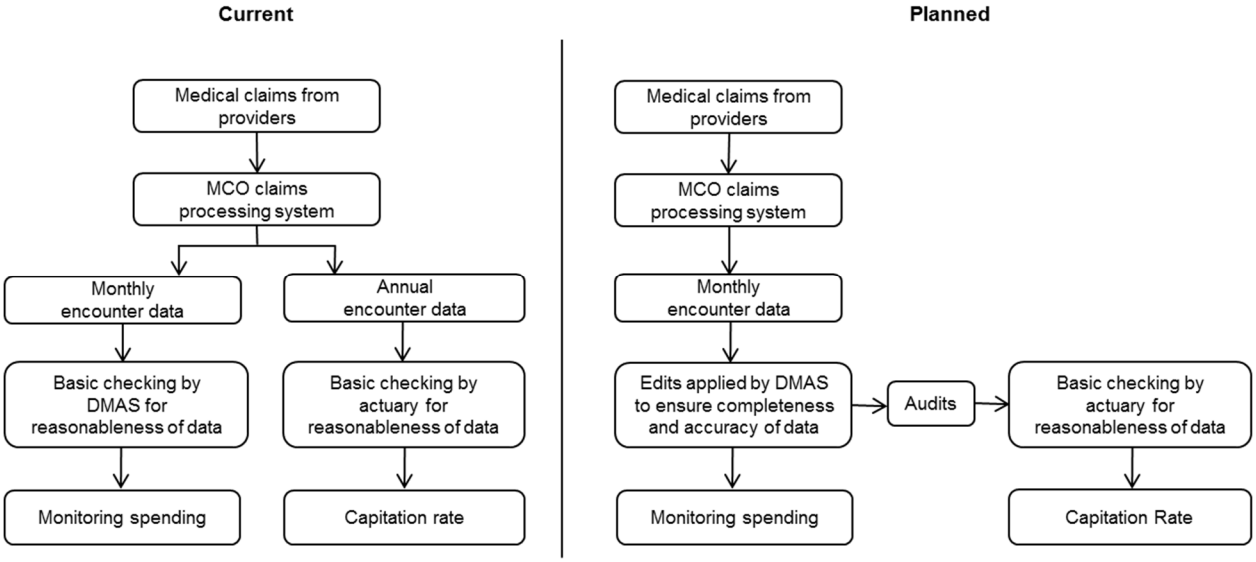
The monthly and annual encounter data do not match each other, and the state does not know which data set is more accurate. Attempts to reconcile the two data sets have had limited success, according to a draft independent study by the Health Care Services Advisory Group in 2016. One reason for the limited success is that there are no common variables to compare across the two data sets. A second reason is the data sets represent different snapshots in time, but MCOs process claims, including making necessary adjustments, over time. Therefore, one claim might be listed as $100 in the monthly

encounter data but only $75 in the annual encounter data because the MCO later adjusted its payment amount. The annual encounter data only includes final claims, not any original claims that were later adjusted or voided, making it difficult to understand any differences between the annual and monthly encounter data sets.

Upcoming changes should substantially strengthen encounter data quality

Several changes planned for the coming years, many of which will implement recommendations from the 2012 JLARC study Mitigating the Risk of Improper Payments in the Virginia Medicaid Program, should substantially strengthen the quality of managed care encounter data. These changes are intended to enable the state to use monthly encounter data, rather than annual encounter data that has been separately collected, as the basis for financial reporting and rate setting (Figure F-1). Using encounter data to set capitation rates will incentivize MCOs to improve the quality of its monthly encounter data because the state may otherwise set inappropriate capitation rates. The improved encounter data will also enable DMAS to analyze detailed managed care spending and utilization trends.

FIGURE F-1
Complete and accurate monthly encounter data will be used to set rates once DMAS implements planned system and process changes



SOURCE: JLARC staff analysis of information from DMAS, interviews with DMAS staff, and CMS regulations.

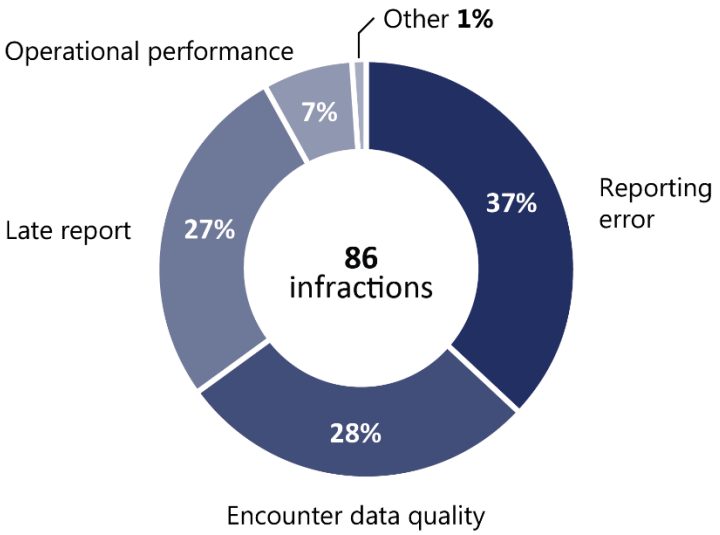
The state will be implementing four primary changes in the coming years. First, the state is procuring a Medicaid Enterprise System (MES) to replace MMIS. The MES' Encounter Processing System, scheduled to be implemented in July 2017, will allow the state to systematically check that managed care encounter data is accurate and complete at the time of submittal. One of these checks will be a reconciliation of the encounter data to MCOs' records of provider payments, called 835 forms, which MMIS was not capable of reading. Second, new CMS regulations will require the state to validate the accuracy and completeness of the monthly encounter data it submits to CMS. CMS has not yet

specified particular validation methods, but noted that the method should have "sufficient analytic rigor" and could include random claims sampling or reconciliation of the encounter data with general ledgers. Third, new CMS regulations will also require an independent audit of encounter data at least every three years to ensure accuracy and completeness. Fourth, DMAS is using recommendations from a 2016 independent study by the Health Services Advisory Group to improve its EDQ process to hold MCOs accountable for submitting accurate and complete data.

Appendix G: MCO noncompliance with Medallion contract

MCOs incurred infractions for a variety of reasons during the first year of DMAS's contract compliance enforcement action process (Figure G-1). Over one-third of infractions were due to reporting errors such a miscalculating a reporting measure. Over one-quarter of infractions were due to the MCO's encounter data not meeting certain quality standards such as missing data or submitting duplicate data. Another 27 percent of infractions were due to the MCO submitting late monthly or annual reports. Seven percent of infractions were due to an MCO's failure to meet operational performance standards in the contract for call center performance or paying claims in a timely manner. The remaining infraction was for an MCO's failure to renew its managed care health insurance plan license in a timely fashion.

FIGURE G-1
MCOs incurred infractions for various reasons in FY16



SOURCE: JLARC staff analysis of DMAS's monthly compliance dashboards, monthly compliance reports, monthly deliverable report cards, and discussions with DMAS staff.
NOTE: Excludes sanctions for infractions that were (i) later determined to be a DMAS error, (ii) being tracked in the CCEA process but not yet subject to sanctions, and (iii) still undergoing DMAS review. See Appendix B for more information.

Appendix H: Financial incentives in other states

At least 10 other states use financial incentives, of which at least eight include metrics for enrollees with chronic conditions. All of the incentives discussed in this appendix are applicable to acute managed care programs for children and adults. Incentives were fairly new to the states, with only Michigan completing more than two cycles of awards.

Financial incentives are mechanisms used by states to make a portion of payments to Medicaid MCOs dependent on their performance. Incentives consist of metrics on which each MCO is assessed based on its performance against pre-established goals. A typical approach is calculating a score for each MCO, which translates into the amount of payment they receive from the state. While states' incentives differ in their priorities and methodologies, they are all variations on the same elements.

It is difficult to draw conclusions about the effectiveness of incentives based on their particular elements. Many incentives are new, so little data exists on their results and the elements are still being modified. In interviews, Medicaid staff in other states noted that design elements and the incentives' effectiveness may depend on state-specific factors such as budgetary flexibility, the number of MCOs, relationships with MCOs, statewide public health goals, or data availability.

Primary elements of financial incentives used in other states

The overwhelming majority of incentive **metrics** fall within the categories of provider activities and recipient health outcomes, which are sometimes supplemented by other metrics. *Provider activities* consist of clinical activities performed by doctors or other health care professionals, such as eye-exams, well-child visits, and medication reviews. *Recipient health outcomes* indicate the quality of an individual's health, such as blood sugar and blood pressure. Another common category of metric is *recipient satisfaction* with providers or the MCO. Additionally, some states use metrics assessing *MCO administrative activities*, such as timeliness of assessments and quality of claims data. Several states include a *hospital re-admissions metric* for the percentage of individuals re-admitted to hospitals within a specified amount of time after discharge, a common clinical indicator of sufficient health care. Less-common metrics include the number of patient-centered medical homes in an MCO's network, recipients' participation in state programs, utilization of ED and inpatient psychiatric services, and socio-economic indicators.

Most metrics are based on definitions developed by the National Committee for Quality Assurance, which require externally-validated MCO data. Other sources of definitions include the National Vital Statistics and National Outcome Measures. Because these entities provide clinically specific and standardized definitions, they enable states to compare their own data to national benchmarks. States can develop their own definitions, which allows for customization but not national benchmarking. Regardless of the source for the definition, states usually obtain data for metrics from claims databases, health care records, and recipient surveys.

States varied in the number of metrics incorporated into the incentive and their reasons for choosing particular metrics. Some states chose to limit the number of metrics to a small sub-set, while others preferred a longer list to comprehensively reflect population health. The number of metrics incorporated into the financial incentive ranged from nine to over 53. Two states preferred not to

modify their metrics because they take time for MCOs to impact, while another state is legislatively required to regularly change its metrics. In interviews, states mentioned guiding principles in selecting metrics, such as representing a cross-section of MCO population, reflecting a population large enough for statistical validity, being subject to external validation, enabling national benchmarking, or already being collected by MCOs. States often choose metrics for which sustaining or improving performance was a priority. Other state-specific reasons for selecting particular conditions included alignment with public health initiatives and research linking it to poor outcomes.

The assessment methods and benchmarks are related decisions that can vary by metric. For the **assessment method**, states can require *in-year performance*, *improvement* from the prior year's performance, either, or both. States using the improvement assessment method can define improvement as (1) a fixed percentage of change from the prior year, (2) a fixed percentage of improvement between the prior year and the benchmark, or (3) a number of percentage points that depends on the prior year's performance, with greater amounts of change from the prior year required for worse performance in the prior year (established using a statistical methodology). Focusing on in-year performance allows new plans to participate and establishes clear state expectations, but focusing on improvement accounts for starting differences between MCOs. States can define **benchmarks** as *absolute* benchmarks, benchmarks that are relative to Medicaid MCOs *statewide*, or goals that are relative other Medicaid MCOs *nationwide*.

States can choose from three types of **models** to structure the financial component of the incentive: withholds, recoupments, and bonuses. A *withhold* means the state sets aside a portion of funds that would otherwise contractually be paid to the MCO and only pays these funds once the MCO has met the incentive's requirement. A *recoupment* means the state will recover funds that had already been paid to MCOs, if MCOs fail to meet the incentive's requirements. A *bonus* means funds are available to be earned by the MCO beyond the established capitation payments. (Terminologies for these types of incentives are inconsistent in states' contracts and in research literature).

Most states set the incentive **amount** at a fixed percentage of capitation rates. Of the states highlighted in this appendix, two increased their amounts over time; one state explained a higher rate as reasonable to track with growing MCO experience with its population, and the other state wanted MCOs to hold greater risk. One state shifted from a withhold to recoupment in order to allow MCOs more operating cash. All but one state defined the at-risk amount as a percentage of capitation rates. Of the states reviewed by JLARC, 5% of capitation rates are the highest amount that is at-risk (withhold or recoupment models) and 3% of capitation rates are the largest possible bonus. Some states reported modification (or consideration of modification) of incentives to comply with CMS's final regulations on managed care published in the summer of 2016. CMS required that capitation rates be actuarially sound even if an MCO fails to receive the financial incentive.

Other states vary in how they design financial incentives

JLARC selected six states for in-depth profiles of their financial incentives. The states described below were selected to represent a mix of state characteristics and incentive designs. The descriptions reflect the most recent or upcoming year for which information was available (Table H-1).

Georgia

Georgia will implement its first withhold in CY 2017. All its metrics are from NCQA. Most metrics use the in-year performance assessment method, but the number of metrics using the improvement assessment method increase in the second and third year of the incentive. Metrics using the performance assessment method have a mixture of absolute and national benchmarks, with the latter established as the 50th or 75th percentile depending on the metric and year. All but one metrics' national benchmark increases over time. Metrics using the improvement assessment method require a 10% to 15% increase from the baseline year. MCOs cannot partially achieve a benchmark. However, the percentage of the 5% withhold they can earn back is equal to the percentage of the total metrics that they achieve. MCOs must share half of the withhold they receive with their providers.

Kansas

Kansas implemented its financial incentive in CY 2013. Metrics were limited to MCO administrative activities for its first year, then shifted to provider and recipient metrics as originally planned. Beginning the second year, the four types of metrics are physical health, behavioral health, LTSS and HCBS. Most of the metrics are from NCQA, but some are NCQA metrics limited to long-term care populations and some behavioral health metrics are from National Outcomes Measures (developed by the Substance Abuse and Mental Health Services Administration). MCOS are considered to have achieved the metric if they meet either assessment method's benchmark: 5% improvement from the prior year or the 50th national percentile in the current year. Kansas changed its original incentive by reducing the percentage of capitation payments at-risk. It had planned to increase from 3% to 5% after the first year, but later decided to decrease the amount to 2-2.5% in the second year and 2% in the third year. It also changed from a withhold to a recoupment. MCOs earned back 56-69% of the withhold for the first year and approximately two-thirds for the second year.

Kentucky

Kentucky implemented a points-based withhold in FY16. It incorporates all NCQA measures for which data is available. Kentucky uses both types of assessment method; each method accounts for half of the withhold. In-year performance is scored against national benchmarks, with more points awarded for MCOs falling within higher percentile ranges (0-25th, 25-50th, 50-75th, 75-90th, or 90-100th). The improvement assessment method uses an absolute benchmark, with more points awarded to MCOs for every two percentage points of improvement compared to the prior year. The most amount at-risk is 1% of capitation in the first year, which will increase annually by 0.25% until reaching 2%. Each MCOs can earn back more or less than its 1% share of withheld funds, depending on how its points for in-year performance and improvement compare to other MCOs in the state. The results for the first year of the incentive are not yet available.

Michigan

After legislation in 2013, Michigan expanded the scope and size of its withhold. The five types of the incentive's metrics are relevant to (1) women, children, and individuals with chronic conditions, (2) the general population, (3) recipient satisfaction, (4) the expansion eligibility group, and (5) MCO compliance. Respectively, these categories account for 40%, 10%, 20%, 20%, and 10% of the incentive payment. In-year performance is the primary assessment method, but plans are considered to have

partially achieved a metric if they improved by at least 10%. (The improvement assessment method will only apply to the expansion eligibility group metrics in future years.) The in-year performance assessment method uses national benchmarks for most metrics, with performance over the 90th percentile considered fully achieving the metric and performance over the 75th percentile considered partial achievement. Michigan uses absolute benchmarks for the expansion population metrics. Legislation passed in 2013 increased the amount of at-risk capitation payments from .19% to 1%. Michigan does not make the results of its withhold publically available.

Minnesota

Since at least CY 2004, Minnesota has implemented a withhold. The most recent version consists of seven metrics, of which three were determined by legislation effective CY 2011. Half of the metrics are based on NCQA definitions. Two metrics use the in-year assessment method and absolute benchmarks. The remaining metrics use the improvement assessment method, with some requiring 10% improvement in the difference between the prior year and an absolute benchmark, and others requiring 5 or 10% improvement from the prior year. Six of the 7 metrics recognize partial achievement by MCOs. For their performance in 2014, MCOs earned back between 37% and 89% of the 5% withhold.

Tennessee

Tennessee's bonus incentive will be implemented in CY 2017. The state recently restructured its incentives so that MCOs will be assessed on their own performance rather than cumulative statewide performance. MCOs suggested the change and proposed preliminary metrics, with a goal of increasing consistency in requirements for providers. All but one metric is based on NCQA definitions. All but one metric uses the improvement assessment method, with a statistical methodology in which the percentage points of improvement required depends on the prior year's performance. The metric using the in-year performance assessment method has an absolute benchmark. It differs from the other metrics in having been monitored due to a court order. The amount of the financial incentive available to be received by MCOs is $0.03 per member per month for each measure that they achieve.

Table H-1
States vary in their design of financial incentives

Financial incentive element		GA	KS	KY	MI	MN	TN	VA
Model	Withhold	✓		✓	✓	✓		
	Recoupment		✓					✓
	Bonus						✓	✓
Metrics: categories	Provider activities	✓	✓	✓	✓	✓	✓	✓
	Recipient health outcomes	✓	✓	✓	✓		✓	✓
	Recipient satisfaction	✓			✓			
	MCO administrative activities				✓	✓		✓
	Hospital re-admissions		✓		✓	✓		
Metrics: number relevant to chronic conditions		4 of 14	16 of 32	TBD	7 of at least 54	0 of 9	8 of 13	1 of 6
Assessment method	In-year performance	✓	✓	✓	✓	✓	✓	✓
	Improvement	✓	✓	✓	✓	✓	✓	✓
Benchmark	Absolute	✓	✓	✓	✓	✓	✓	
	Relative to statewide							✓
	Relative to national	✓	✓	✓				✓
Highest at-risk amount (relative to capitation rate)		5%	2-2.5%	1%	1%	5%	$0.65	0.15%

SOURCE: JLARC staff analysis of other states' documents and interviews with other states.

Appendix I: MCO report cards in other states

Report cards are a tool used to increase transparency and ultimately incentivize MCOs to improve performance. Reports cards consist of one or two page documents that tend to use a simple rating system to enable easy comparison of MCOs across metrics (Figure I-1). Aside from these metrics, other information on report cards sometimes includes the MCO's accreditation status or unique programs for their members. States can disseminate the report cards by publication online or inclusion in new members' enrollment packages. The discussion in this appendix is limited to the report cards from five states (Table I-1): Florida, Kentucky, Maryland, Michigan, and Texas.

Primary elements of report cards used in other states

Metrics used in report cards fall within three primary categories: *provider activities*, *recipient health outcomes*, and *recipient satisfaction* with the MCO (e.g., access to care, customer service) and provider (e.g., helpfulness of staff). None of the metrics relate to MCO administrative activities. While some metrics are general, others focus on women and children. The sources for definitions of metrics tends to be the National Committee for Quality Assurance, which requires externally-validated MCO data, which are subject to rigorous national definitions and external validation. The data for the metrics derives from claims databases, health care records, and recipient surveys.

All report cards include at least one metric relevant to individuals with **chronic conditions**. Two states use a composite metric that combines information about multiple specific metrics. For example, Maryland's "Care for Adults with Chronic Illness" metric reflects multiple specific metrics of provider activities such as eye exams and antibiotics use as well as multiple specific metrics of recipient health outcomes such as blood sugar and cholesterol levels. Two states present only specific metrics, and one state presents both composite and specific metrics.

In determining the rating for each metric, which is often a number of stars, states choose one of two **benchmark** methods. Benchmarking the MCO *relative to statewide* performance means the number of stars depends on the MCO's performance compared to the average of Medicaid MCOs in the state. This method produces more useful results for Medicaid enrollees, but can indicate a poorly performing plan is actually performing well, or vice-versa. Benchmarking the MCO *relative to national* performance means the number of stars depends on the MCO's performance compared to the average of Medicaid MCOs in the nation. This method is a more accurate depiction of the MCO's performance, but can hide differences between the state's MCOs. No states base the MCOs rating on its absolute performance.

In terms of **rating system**, *stars* are the most common, with only one state quantifying the metrics through *percentages*. None of the report cards combine all the metrics into a summary rating. The meaning of the number of stars awarded varies by state. For example, an MCO whose performance is equivalent to the national average would earn five of five stars in Florida but only three of five stars in Kentucky.

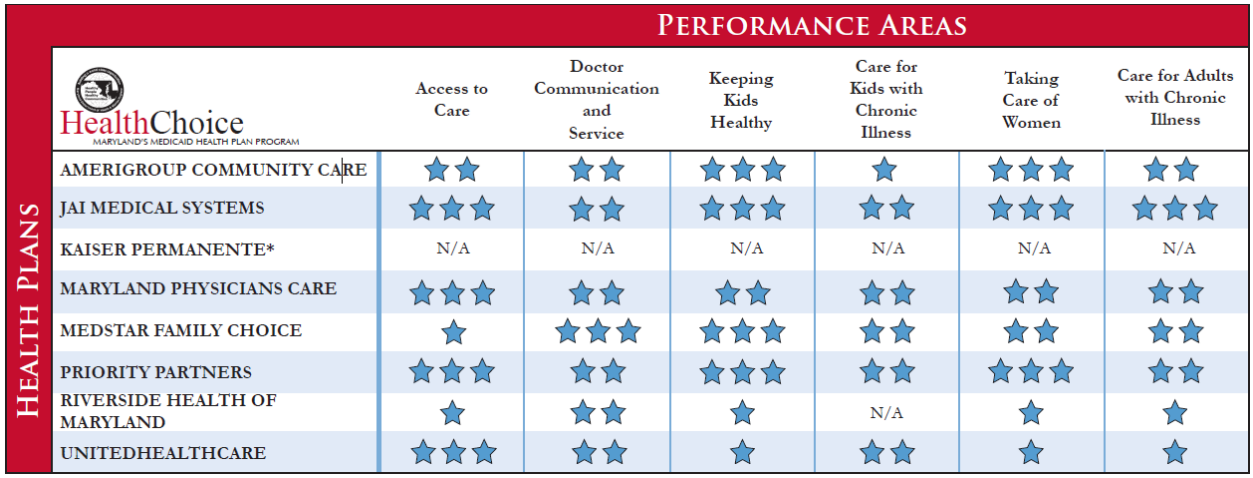
Table I-1
States vary in their design of report cards

Report card element		Florida	Kentucky	Maryland	Michigan	Texas
Metrics: categories	Provider activities	✓	✓	✓	✓	✓
	Recipient health outcomes	✓		✓	✓	✓
	Recipient satisfaction		✓	✓	✓	✓
Metrics: relevant to chronic conditions	Composite	✓		✓	✓	
	Specific	✓	✓			✓
	Number (out of total)	9 of 29	1 of 14	2 of 6	1 of 5	3 of 18
Benchmark	Relative to statewide			✓	✓	✓
	Relative to national	✓	✓			
Rating system	Stars (levels)	✓(5)	✓(5)	✓(3)	✓(3)	✓(3)
	Percentage	✓				

SOURCE: JLARC staff analysis of other states' documents.

FIGURE I-1
Examples of other states' report cards

Composite metrics example (Maryland)



HEALTH PLANS	PERFORMANCE AREAS					
HealthChoice MARYLAND'S MEDICAID HEALTH PLAN PROGRAM	Access to Care	Doctor Communication and Service	Keeping Kids Healthy	Care for Kids with Chronic Illness	Taking Care of Women	Care for Adults with Chronic Illness
AMERIGROUP COMMUNITY CARE	★★	★★	★★★	★	★★★	★★
JAI MEDICAL SYSTEMS	★★★	★★	★★★	★★	★★★	★★★
KAISER PERMANENTE*	N/A	N/A	N/A	N/A	N/A	N/A
MARYLAND PHYSICIANS CARE	★★★	★★	★★	★★	★★	★★
MEDSTAR FAMILY CHOICE	★	★★★	★★★	★★	★★	★★
PRIORITY PARTNERS	★★★	★★	★★★	★★	★★★	★★
RIVERSIDE HEALTH OF MARYLAND	★	★★	★	N/A	★	★
UNITEDHEALTHCARE	★★★	★★	★	★★	★	★

Specific metrics example (Kentucky)

PREVENTIVE CARE							
Health Plan	Childhood Immunizations	Well-Child Visits in the First 15 Months of Life	Well-Child Visits Ages 3 to 6	Diabetes Testing HbA1c	Tobacco Use Cessation	Cervical Screening	Prenatal Care
Aetna Better Health of Kentucky	★★	★★	★	★★	★	★	★★
Anthem BCBS Medicaid	★	★	★	★★★	★	★	★★
Humana - CareSource	★	★	★	★★★	★	★	★★
Passport Health Plan	★★★★★	★★★★	★★	★★	★★	★★	★★★
WellCare of Kentucky	★	★★	★	★★★	★★★	★	★★★

GETTING HELP WHEN NEEDED							
Health Plan	Getting Child Care Quickly	Child Customer Service	Parent Overall Satisfaction with Child's Health Plan	21 and Under Dental Visits	Getting Adult Care Quickly	Adult Customer Service	Adult Overall Satisfaction with Health Plan
Aetna Better Health of Kentucky	★★★★★	★★★	★	★★★	★★	★	★
Anthem BCBS Medicaid	★★★★	★★★	★	★	★★★★	★★★★	★★★
Humana - CareSource	★★★	★★★	★	★★	★★★★	★★	★★★★
Passport Health Plan	★★	★★★	★★★★	★★	★★★	★★★★★	★★★★★
WellCare of Kentucky	★★★★★	★	★★★	★★★★	★★★★	★★★	★★★★★

SOURCE: Maryland and Kentucky Medicaid program websites.

Appendix J: Applicability of Medallion financial oversight recommendations for MLTSS

Some of the recommendations in this report to improve DMAS's financial oversight of the Medallion managed care program may be applicable to the MLTSS program once it is implemented. The Medallion and MLTSS programs will cover substantially different populations that have different needs, and therefore not all of the recommendations will be applicable. The Medallion program will provide services to parents, children, and pregnant women while the MLTSS program will provide services to the aged, blind, and disabled, including those requiring LTSS. Due to the differences in populations and their service needs, it is difficult to assess if each recommendation should be applied to the MLTSS program. JLARC worked with Mercer to identify which recommendations should at least be considered by DMAS as they implement MLTSS. Any of the recommendations that should be considered for MLTSS will likely need to be adapted and tailored to the MLTSS program once it is implemented.

Recommendations to improve rate-setting

Chapter 4 includes five recommendations to better use the Medallion rate-setting process to control managed care spending. These recommendations include several ways to adjust historical data to ensure DMAS is not paying for inefficient utilization and spending as well as changes to mitigate the risk of overestimating future spending. The recommendation for DMAS and its actuary to adjust historical data for inefficient use of emergency room, inpatient hospital, and pharmacy utilization, has not been shown to be useful for LTSS recipients who are also eligible for Medicare but could be used for the aged, blind, or disabled populations in MLTSS who are not also Medicare-eligible. Medicare is the primary payer for those services, and therefore Medicaid spending on those services, and the potential savings from efficiency adjustments, are much smaller. Many of the other recommendations to improve the rate-setting process should be considered under MLTSS (Table J-1).

TABLE J-1
Applicability of Medallion rate-setting recommendations to MLTSS

Recommendation #	Explanation for Medallion	Applicability to MLTSS
Recommendation 10 (page 44)	Adjust historical rate-setting data for inefficient emergency department, inpatient hospital, and pharmacy utilization	DMAS should only consider this recommendation for MLTSS populations who are not also eligible for Medicare. These clinical efficiency adjustments have not been shown to be material for dual-eligible MLTSS populations because they focus on services for which Medicare is the primary payer. The most impactful way to use the MLTSS rate-setting process is to incentivize MCOs to keep recipients in the community (Chapter 3).

Recommendation #	Explanation for Medallion	Applicability to MLTSS
Recommendation 11 (page 45)	Monitor spending for services by related-party providers and adjust capitation rates when necessary	DMAS should consider this recommendation for MLTSS. It is unknown to what extent MLTSS MCOs will contract with related-party providers, but monitoring these payments to ensure that capitation rates do not include inflated payments to related-parties will help DMAS ensure it isn't paying more than market-value for services.
Recommendation 12 (page 46)	Adjust capitation rates to account for expected savings from new required initiatives when realistic savings estimates are possible	DMAS should only consider this recommendation for MLTSS after the program matures enough to provide stable, baseline spending levels. This concept would apply to MLTSS rate-setting, but several challenges exist to implementing it. Similar to Medallion, a realistic estimate of expected savings is necessary. This will be even more difficult in the beginning of the MLTSS contract because the program will need to be mature enough to have a stable baseline spending level for use in estimating future cost savings.
Recommendation 13 (page 47)	Do not set negative historical spending trends to zero when using historical trends to develop expected future spending trends	DMAS should consider this recommendation for MLTSS. This recommendation would apply to developing trends for MLTSS capitation rates to avoid overestimating future spending based on historical trends.
Recommendation 14 (page 47)	Rebase the administrative component of the capitation rate for projected enrollment changes.	DMAS should consider this recommendation for MLTSS. The impact of rebasing administrative expenses under MLTSS will be different than for Medallion because MLTSS will likely require a different amount of fixed versus variable administrative costs. However, if enrollment in MLTSS increases over time, rebasing administrative spending will reduce spending.

SOURCE: Mercer analysis based on experience in other states.

Recommendations to maintain and improve the cap on MCO profits

Chapter 4 includes four recommendations to maintain and strengthen the Medallion program's cap on MCO profits. These recommendations are aimed at keeping a profit cap in the Medallion program, strengthening the profit cap level and structure, and improving the way Virginia calculates MCO profits. All of these recommendations are applicable to MLTSS, including implementing a strong profit cap for the MLTSS program, but DMAS should consider incorporating allowances into its MLTSS profit cap because it is a new program. (See Chapter 6 on using a profit cap for MLTSS.) Other states have done this by allowing MCOs to roll forward a loss in the first year of the program

when calculating profit in the second year, or selecting an appropriate profit cap but only monitoring it in the first year before requiring that MCOs remit funds to the state (Table J-2).

TABLE J-2
Applicability of Medallion profit cap recommendations to MLTSS

Recommendation #	Explanation for Medallion	Applicability to MLTSS
Recommendation 15 (page 49)	The General Assembly should require DMAS to require MCOs to return at least a portion of profits in excess of 3% and phase in profit sharing as profits increase	The General Assembly should consider this recommendation for MLTSS. However, DMAS may want to incorporate allowances during the first year of MLTSS implementation.
Recommendation 16 (page 50)	Incorporate findings from administrative audits into its calculation of MCO profits and administrative loss ratio	DMAS should consider this recommendation for MLTSS if they implement a profit cap.
Recommendation 17 (page 50)	Adjust calculations of MCO profits and medical loss ratio for higher medical spending resulting from related-party provider contracts	DMAS should consider this recommendation for MLTSS if they implement a profit cap
Recommendation 18 (page 52)	Maintain a profit cap instead of switching to a minimum medical loss ratio	DMAS should consider this recommendation for MLTSS. This would be a new requirement for MLTSS, as opposed to maintaining an existing requirement.

SOURCE: Mercer analysis based on experience in other states and JLARC review of managed care contracts and interviews with other states.

Recommendations to improve the use of data to oversee managed care spending

Chapter 4 includes three recommendations to improve DMAS's use of data to oversee spending in the Medallion program. These recommendations include requiring MCOs to report more detailed data on spending and utilization, analyzing that data to identify undesirable trends, and working with MCOs to understand and address their root causes. These recommendations also include the need for DMAS to report to the General Assembly each year on spending and utilization trends within managed care. All of these recommendations should be considered under MLTSS (Table J-3).

TABLE J-3
Applicability of Medallion financial reporting recommendations to MLTSS

Recommendation #	Explanation for Medallion	Applicability to MLTSS
Recommendation 19 (page 54)	Require MCOs to report additional financial and utilization data, including income statements by rate cell and detailed service category, balance sheets, related party transactions, and service utilization metrics	DMAS should consider this recommendation for MLTSS. The populations and services covered in the financial and utilization reports will need to be tailored to the MLTSS populations and services, but the type of reporting should be the same across Medallion and MLTSS programs (Chapter 6).
Recommendation 20 (page 54)	Monitor spending and utilization trends and work with MCOs to address undesirable trends when they are identified	DMAS should consider this recommendation under MLTSS. Analyzing robust financial and utilization reporting to identify concerning trends, understand their root causes, and work with MCOs to fix them is an important part of managed care oversight regardless of the populations and services covered.
Recommendation 21 (page 55)	The General Assembly should require DMAS to report annually on trends in managed care spending	The General Assembly should consider this recommendation for MLTSS. Identifying trends will not be possible until a baseline is established, but providing transparency over spending trends, the underlying reasons for those trends, and what is being done to fix it will help DMAS and the General Assembly improve oversight of the MLTSS program.

SOURCE: Mercer analysis based on experience in other states and JLARC review of managed care contracts from other states.

Recommendations to improve the managed care compliance process

Chapter 4 includes three recommendations to improve the contract compliance process for the Medallion program. These recommendations include evaluating the reasons for which DMAS will waive a compliance sanction and including those reasons in the contract, only waiving sanctions for reasons that are stated in the contract, and assessing and reporting on the results of the compliance process each year. Implementing a strong compliance process is applicable to the MLTSS program. However, DMAS could consider providing a grace period for the enforcement of most sanctions when the program initially starts, and the details of the compliance process will likely need to be refined over time as the program matures and DMAS and MCOs are able to identify the most important issues to address through the process (Table J-4).

TABLE J-4
Applicability of Medallion contract compliance recommendations to MLTSS

Recommendation #	Explanation for Medallion	Applicability to MLTSS
Recommendation 22 (page 58)	Reassess the reasons for which the state will mitigate or waive sanctions and amend the manage care contract accordingly	DMAS should consider this recommendation as the MLTSS program matures. DMAS intends to implement a compliance process under MLTSS, and while clearly articulating the reasons for waiving sanctions in the contract is important, flexibility should be provided at the onset of the contract to adapt the MLTSS compliance process to address the most meaningful elements of MLTSS contract compliance.
Recommendation 23 (page 58)	Only mitigate or waive compliance sanctions for reasons explicitly stated in the contract	DMAS should consider this recommendation as the MLTSS program matures. Flexibility should be provided at the onset of the MLTSS program for operational requirements. However, DMAS should consider if any requirements impacting critical areas such as patient safety or provider payment should be enforced immediately.
Recommendation 24 (page 58)	Review the results of the compliance process each year and include those results in the Medallion annual report	DMAS should consider this recommendation under the MLTSS program. DMAS should assess the results of the MLTSS compliance process each year to evaluate its effectiveness and make necessary improvements as the program matures. Reporting on the results of the compliance process from the beginning will provide a useful benchmark to assess improvement as the program matures.

SOURCE: Mercer analysis based on experience in other states.

Appendix K: Spending trends for long-term services and supports

JLARC staff collaborated with Mercer consultants to analyze Medicaid claims data for long-term services and supports from the five most recent years, FY11–FY15. The tables in this appendix summarize data on LTSS spending and utilization trends.

Spending and utilization trends by waiver and type of institution

Tables K-1 through K-3 highlight spending and utilization trends for LTSS by home and community-based (HCBS) waiver and by institutional facility from FY11 to FY15. Intermediate care facilities, or ICFs, are institutions that serve individuals with intellectual or developmental disabilities. In response to the Department of Justice settlement agreement, several public ICFs have closed and those recipients have either transferred to HCBS or to private ICFs.

TABLE K-1
Spending by waiver and facility, FY11–FY15

	FY11	FY15	Total change	Annualized change
HCBS waivers				
EDCD	$440,863,612	$622,930,635	$182,067,023	9.0%
ID	537,274,741	689,844,319	152,569,578	6.4
DD	17,523,022	28,665,045	11,142,024	13.1
Day Support	3,666,701	3,707,209	40,508	0.3
Technology Assisted	31,084,885	29,001,487	(2,083,398)	(1.7)
Alzheimer's Assisted Living	745,780	784,463	38,683	1.3
Subtotal	*1,031,158,741*	*1,374,933,159*	*343,774,417*	*7.5*
Institutional facilities				
Public ICFs	194,113,856	123,192,387	(70,921,469)	(10.7)
Private ICFs	58,822,549	93,924,508	35,101,959	12.4
Nursing facilities	782,457,745	762,717,128	(19,740,617)	(0.6)
Subtotal	*1,035,394,149*	*979,834,022*	*(55,560,127)*	*(1.4)*
Total	**2,066,552,890**	**2,354,767,181**	**288,214,291**	**3.3**

SOURCE: Mercer analysis of Medicaid claims data.

TABLE K-2
Recipients by waiver and facility, FY11–FY15

	FY11	FY15	Total change	Annualized change
HCBS waivers				
EDCD	24,615	33,858	9,243	8.3%
ID	8,350	10,173	1,823	5.1
DD	594	918	324	11.5
Day Support	280	274	(6)	(0.5)
Technology Assisted	410	345	(65)	(4.2)
Alzheimer's Assisted Living	62	70	8	3.1
Subtotal	*34,158*	*45,500*	*11,342*	*7.4*
Institutional facilities				
Public ICFs	1,198	611	(587)	(15.5)
Private ICFs	423	531	108	5.8
Nursing facilities	25,768	24,918	(850)	(0.8)
Subtotal	*27,376*	*26,022*	*(1,354)*	*(1.3)*
Total	**59,751**	**69,487**	**9,736**	**3.8**

SOURCE: Mercer analysis of Medicaid claims data.
NOTE: The total number of recipients is an unduplicated count of recipients.

TABLE K-3
Cost per recipient by waiver and facility, FY11–FY15

	FY11	FY15	Total change	Annualized change
HCBS waivers				
EDCD	$17,910	$18,398	$488	0.7%
ID	64,344	67,811	3,467	1.3
DD	29,500	31,226	1,726	1.4
Day Support	13,095	13,530	435	0.8
Technology Assisted	75,817	84,062	8,245	2.6
Alzheimer's Assisted Living	12,029	11,207	(822)	(1.8)
Subtotal	*30,188*	*30,218*	*30*	*0.0*
Institutional facilities				
Public ICFs	162,032	201,624	39,593	5.6
Private ICFs	139,060	176,882	37,822	6.2
Nursing facilities	30,365	30,609	244	0.2
Subtotal	*37,821*	*37,654*	*(167)*	*(0.1)*
Total	**34,586**	**33,888**	**(698)**	**(0.5)**

SOURCE: Mercer analysis of Medicaid claims data.

Spending and utilization trends by major home and community-based services

Tables K-4 through K-6 show changes in spending and utilization by major categories of HCBS. Attendant care and habilitation services are the largest spending categories of all home and community-based waiver services.

TABLE K-4
Spending by major service category, FY11–FY15

Major service category	FY11	FY15	Total change	Annualized change
Attendant care – agency directed	$282,841,044	$340,710,968	$57,869,924	4.8%
Attendant care – consumer directed	195,290,633	338,726,930	143,436,297	14.8
Habilitation services	492,471,982	611,210,317	118,738,335	5.5
Skilled/private duty nursing	46,334,502	47,822,630	1,488,128	0.8
EPSDT skilled nursing	5,515	16,532,264	16,526,749	639.9
Consumer facilitation	4,570,173	8,888,300	4,318,127	18.1
Adult day care services	5,550,597	7,413,478	1,862,881	7.5
Other waiver services	4,094,295	3,628,271	(466,024)	(3.0)
Total	**1,031,158,741**	**1,374,933,159**	**343,774,417**	**7.5**

SOURCE: Mercer analysis of Medicaid claims data.

Table K-5
Recipients by major service category, FY11–FY15

Major service category	FY11	FY15	Total change	Annualized change
Attendant care – agency directed	16,465	18,865	2,400	3.5%
Attendant care – consumer directed	11,612	19,519	7,907	13.9
Habilitation services	8,117	9,784	1,667	4.8
Skilled/private duty nursing	823	752	(71)	(2.2)
EPSDT skilled nursing	5	403	398	199.6
Consumer facilitation	11,405	19,238	7,833	14.0
Adult day care services	779	838	59	1.8
Other waiver services	9,241	11,279	2,038	5.1
Total	**34,158**	**45,500**	**11,342**	**7.4**

SOURCE: Mercer analysis of Medicaid claims data.
NOTE: The total number of recipients is an unduplicated count of recipients.

TABLE K-6
Cost per recipient by major service category, FY11–FY15

Major service category	FY11	FY15	Total change	Annualized change
Attendant care – agency directed	$17,178	$18,060	$882	1.3%
Attendant care – consumer directed	16,818	17,354	536	0.8
Habilitation services	60,672	62,470	1,799	0.7
Skilled/private duty nursing	56,300	63,594	7,294	3.1
EPSDT skilled nursing	1,103	41,023	39,920	147.0
Consumer facilitation	401	462	61	3.6
Adult day care services	7,125	8,847	1,721	5.6
Other waiver services	443	322	(121)	(7.7)
Total	**30,188**	**30,218**	**30**	**0.0**

SOURCE: Mercer analysis of Medicaid claims data.

Spending and utilization trends in agency- and consumer-directed attendant care

Tables K-7 through K-11 show spending and utilization trends for attendant care services. Spending on consumer-directed services outpaced the growth of agency-directed services due to an increased number of recipients, but the cost per recipient in consumer-direction remained mostly flat. Recipients of consumer-directed services used more units of service than recipients of agency-directed services; however, the unit cost of services for consumer-direction is less than for agency-direction.

Table K-7
Spending for attendant care services, FY11–FY15

Attendant care services	FY11	FY15	Total change	Annualized change
Agency-direction				
Personal assistance	$222,920,691	$292,225,718	$69,305,027	7.0%
Companion care	737,135	789,592	52,457	1.7
Respite care LPN	3,564,747	3,080,516	(484,231)	(3.6)
Respite care	54,587,411	43,736,380	(10,851,031)	(5.4)
Total	*281,809,985*	*339,832,206*	*58,022,222*	*4.8*
Consumer-direction				
Personal assistance	153,469,470	284,358,346	130,888,876	16.7
Companion care	3,761,517	5,878,139	2,116,622	11.8
Respite care	39,174,772	50,438,535	11,263,763	6.5
Services facilitation	4,570,173	8,888,300	4,318,127	18.1
Total	*200,975,931*	*349,563,319*	*148,587,388*	*14.8*

SOURCE: Mercer analysis of Medicaid claims data.

TABLE K-8
Recipients of attendant care services, FY11–FY15

Attendant care services	FY11	FY15	Total change	Annualized change
Agency-direction				
Personal assistance	15,456	17,655	2,199	3.4%
Companion care	66	65	(1)	(0.4)
Respite care LPN	534	587	53	2.4
Respite care	11,495	13,994	2,499	5.0
Total	*16,427*	*18,842*	*2,415*	*3.5*
Consumer-direction				
Personal assistance	10,849	18,828	7,979	14.8
Companion care	349	476	127	8.1
Respite care	8,037	14,635	6,598	16.2
Services facilitation	11,405	19,238	7,833	14.0
Total	*11,547*	*19,459*	*7,912*	*13.9*

SOURCE: Mercer analysis of Medicaid claims data.
NOTE: The total number of recipients for agency direction is an unduplicated count and excludes several smaller agency-directed services. The total number of recipients for consumer-direction is also an unduplicated count and excludes services facilitation.

TABLE K-9
Cost per recipient for attendant care services, FY11–FY15

Attendant care services	FY11	FY15	Total change	Annualized change
Agency-direction				
Personal assistance	$14,423	$16,552	$2,129	3.5%
Companion care	11,169	12,148	979	2.1
Respite care LPN	6,676	5,248	(1,428)	(5.8)
Respite care	4,749	3,125	(1,623)	(9.9)
Total	*17,218*	*18,083*	*864*	*1.2*
Consumer-direction				
Personal assistance	14,146	15,103	957	1.6
Companion care	10,778	12,349	1,571	3.5
Respite care	4,874	3,446	(1,428)	(8.3)
Services facilitation	401	462	61	3.6
Total	*17,009*	*17,507*	*498*	*0.7*

SOURCE: Mercer analysis of Medicaid claims data.
NOTE: The total cost per recipient for agency-direction excludes several smaller services. The total cost per recipient for consumer-direction excludes services facilitation.

TABLE K-10
Units per recipient for attendant care services, FY11–FY15

Attendant care services	FY11	FY15	Total change	Annualized change
Agency-direction				
Personal assistance	1,104	1,214	110	2.4%
Companion care	814	859	44	1.3
Respite care LPN	271	208	(63)	(6.4)
Respite care	364	229	(135)	(10.9)
Total	*1,308*	*1,322*	*14*	*0.3*
Consumer-direction				
Personal assistance	1,369	1,459	90	1.6
Companion care	1,060	1,212	152	3.4
Respite care	473	335	(137)	(8.2)
Services facilitation	5	7	2	8.8
Totals	1,647	1,693	46	0.7

SOURCE: Mercer analysis of Medicaid claims data.
NOTE: The unit is equal to one hour of service. The total units per recipient for agency-direction excludes several smaller services. The total units per recipient for consumer-direction excludes services facilitation.

TABLE K-11
Unit costs of attendant care services, FY11–FY15

Attendant care services	FY11	FY15	Total change	Annualized change
Agency-direction				
Personal assistance	$13.07	$13.64	$0.57	1.1%
Companion care	13.71	14.15	0.43	0.8
Respite care LPN	24.62	25.24	0.61	0.6
Respite care	13.06	13.65	0.59	1.1
Total	*13.17*	*13.68*	*0.51*	*1.2*
Consumer-direction				
Personal assistance	10.34	10.35	0.02	0.0
Companion care	10.17	10.19	0.02	0.0
Respite care	10.32	10.28	0.03	(0.1)
Services facilitation	74.55	69.07	5.48	(1.9)
Total	*10.33*	*10.34*	*0.01*	*0.0*

SOURCE: Mercer analysis of Medicaid claims data.
NOTE: The unit is equal to one hour of service. The average unit cost for agency direction excludes several smaller services. The average unit cost for consumer direction does excludes services facilitation.

Spending and utilization trends in habilitation services

Tables K-12 through K-14 highlight spending and utilization trends for habilitation services which are available on the ID, DD, and DS waivers. Sponsored residential services did not become available until FY15.

TABLE K-12
Spending on habilitation services, FY11–FY15

Habilitation services	FY11	FY15	Total change	Annualized change
Congregate residential	$350,061,419	$432,227,728	$82,166,308	5.4%
Day support	78,571,830	90,177,142	11,605,311	3.5
In-home residential	42,377,660	49,788,281	7,410,621	4.1
Sponsored residential	0	12,023,189	12,023,189	.
Supported employment	20,058,321	23,325,933	3,267,613	3.8
Other services	1,380,228	3,651,556	2,271,327	27.5
Total	**492,449,459**	**611,193,829**	**118,744,370**	**5.5%**

SOURCE: Mercer analysis of Medicaid claims data.

TABLE K-13
Recipients of habilitation services, FY11–FY15

Habilitation services	FY11	FY15	Total change	Annualized change
Congregate residential	5,067	6,188	1,121	5.1%
Day support	5,266	6,020	754	3.4
In-home residential	1,386	1,660	274	4.6
Sponsored residential	0	1,157	1,157	.
Supported employment	1,676	1,986	310	4.3
Other services	798	1,306	508	13.1
Total	**8,117**	**9,784**	**1,667**	**4.8%**

SOURCE: Mercer analysis of Medicaid claims data.
NOTE: The number of recipients for "other services" are duplicated. The total number of recipients for each year is an unduplicated count.

TABLE K-14
Cost per recipient of habilitation services, FY11–FY15

Habilitation services	FY11	FY15	Total change	Annualized change
Congregate residential	$69,087	$69,849	$762	0.3%
Day support	14,921	14,980	59	0.1
In-home residential	30,576	29,993	(583)	(0.5)
Sponsored residential	0	10,392	10,392	.
Supported employment	11,968	11,745	(223)	(0.5)
Other services	1,730	2,796	1,066	12.8
Total	**60,672**	**62,470**	**1,798**	**0.7**

SOURCE: Mercer analysis of Medicaid claims data.

Appendix L: Spending trends for behavioral health services

Community-based behavioral health services (referred to as "behavioral health services" in this appendix and Chapter 6) are a subset of behavioral health services covered by Virginia's Medicaid program. While traditional outpatient services are included in managed care in Virginia, community-based services are currently excluded from managed care's responsibility and capitation payment. Instead, they are provided by an Administrative Services Organization and funded through fee-for-service. Rather than an office or hospital, community-based behavioral health services tend to be provided in the recipient's home or school.

Community-based behavioral health services are intended for recipients with more severe behavioral health conditions than traditional outpatient. Examples of criteria to receive services are the behavioral health condition resulting in significant impairment to basic life functions, multiple interactions with social services, or high risk of psychiatric hospitalization or out-of-home placement.

FY15 spending and utilization

The three largest services account for majority of spending (80%) in FY15 (Table L-1). These three services also have the highest number of recipients. The percentage of total Medicaid enrollees that utilized a service in a given year (utilization rate) are relatively low, at less than 3% for all services. The spending per recipient is relatively high, almost reaching $12,000 for all behavioral health recipients.

TABLE L-1
Behavioral health services in FY15

	Spending	Recipients[a]	Spending per recipient	Utilization rate[b]	Unit cost[c]
Mental Health Skill Building	$188,009,083	13,870	$13,555	0.7%	$88
Therapeutic Day Treatment	173,363,689	17,040	10,174	0.9	37
Intensive In-Home	109,782,907	12,053	9,108	0.6	60
Early and Periodic Screening, Diagnosis, and Treatment	43,020,280	2,288	18,803	0.1	18
Psychosocial Rehabilitation	28,287,283	4,641	6,095	0.2	24
Crisis Stabilization	17,476,315	9,326	1,874	0.5	50
Residential Treatment Center (Levels A and B)	14,467,379	855	16,921	0	131
Intensive Community Treatment	11,232,648	1,277	8,796	0.1	145
Assessments	1,366,233	17,717	77	0.9	53
Other services[d]	244,766	3,410	72	0.2	23
Total	**587,250,583**	**49,272**	**11,919**	**2.6**	**46**

SOURCE: Mercer analysis of Medicaid data.
NOTE: Numbers are rounded.
[a] Numbers represent unduplicated recipients of each service. Medicaid enrollees can receive multiple services in a year. [b] Utilization rate equals the number of recipients for a service divided by the number of total Medicaid enrollees in the year. [c] Unit cost equals the spending for a service divided by the number of units utilized. The definition of one unit varies from a set number of minutes, hours, days, or months, depending on the service. [d] Includes substance abuse case management, substance abuse day treatment, substance abuse residential treatment for pregnant women, substance abuse crisis intervention, substance abuse intensive outpatient, and methadone treatment for opioid addiction.

Spending and utilization trends, FY11–FY15

Tables L-2 through L-6 show the changes in spending and utilization between FY11 and FY15. Total spending on behavioral health services increased from $501 million in FY11 to $587 million in FY15. Spending on the two largest services (Mental Health Skill Building and Therapeutic Day Treatment) also increased, while total spending for the third largest service (Intensive In-Home) decreased. The number of individuals receiving behavioral health services decreased between FY11 and FY15, while the average spending for each of these recipients increased.

TABLE L-2
Spending by behavioral health service, FY11–FY15

	FY11	FY12	FY13	FY14	FY15	Annualized change
Mental Health Skill Building	$137,368,565	$186,905,553	$226,706,068	$237,106,242	$188,009,083	10%
Therapeutic Day Treatment	159,112,579	138,722,481	143,302,288	154,087,485	173,363,689	3
Intensive In-Home	124,264,803	89,196,519	86,726,260	101,776,194	109,782,907	−1
Early and Periodic Screening, Diagnosis, and Treatment	*No data*	10,692	9,171,994	33,227,347	43,020,280	28,658
Psychosocial Rehabilitation	38,012,316	39,461,483	37,359,328	32,838,132	28,287,283	−7
Crisis Stabilization	13,755,880	17,700,879	18,291,995	15,765,663	17,476,315	7
Residential Treatment Center (Levels A and B)	17,164,213	14,588,137	14,260,448	14,585,485	14,467,379	−4
Intensive Community Treatment	10,225,911	10,305,920	10,707,816	11,376,128	11,232,648	2
Assessments	265	1,548	390,876	2,620,432	1,366,233	6,539
Other services[a]	1,130,698	1,056,484	1,192,234	1,107,789	244,766	−20
Total	**$501,035,232**	**$497,949,696**	**$548,109,306**	**$604,490,896**	**$587,250,583**	**4**

SOURCE: Mercer analysis of Medicaid data.
NOTE: Numbers are rounded and not adjusted for inflation. [a] Includes substance abuse case management, substance abuse day treatment, substance abuse residential treatment for pregnant women, substance abuse crisis intervention, substance abuse intensive outpatient, and methadone treatment for opioid addiction.

TABLE L-3
Recipients by behavioral health service, FY11–FY15

	FY11	FY12	FY13	FY14	FY15	Annualized change
Mental Health Skill Building	14,671	17,289	18,943	18,213	13,870	0%
Therapeutic Day Treatment	16,695	15,222	13,614	14,715	17,040	1
Intensive In-Home	15,671	11,076	9,306	10,369	12,053	−4
Early and Periodic Screening, Diagnosis, and Treatment	*No data*	13	1,090	1,858	2,288	2,793
Psychosocial Rehabilitation	4,592	4,818	4,974	4,835	4,641	0
Crisis Stabilization	10,135	10,879	10,621	9,997	9,326	−2
Residential Treatment Center (Levels A and B)	904	800	805	788	855	−1
Intensive Community Treatment	1,079	1,098	1,164	1,238	1,277	4
Assessments	3	22	5,509	28,702	17,717	6,489
Other services[a]	1,336	1,379	2,633	8,670	3,410	66
Total	**52,137**	**49,826**	**50,051**	**51,722**	**49,272**	**−1**

SOURCE: Mercer analysis of Medicaid data.
NOTE: Numbers are rounded and not adjusted for inflation. Numbers represent unduplicated recipients of each service. Medicaid enrollees can receive multiple services in a year.
[a] Includes substance abuse case management, substance abuse day treatment, substance abuse residential treatment for pregnant women, substance abuse crisis intervention, substance abuse intensive outpatient, and methadone treatment for opioid addiction.

TABLE L-4
Spending per recipient by behavioral health service, FY11–FY15

	FY11	FY12	FY13	FY14	FY15	Annualized change
Mental Health Skill Building	$9,363	$10,811	$11,968	$13,019	$13,555	10%
Therapeutic Day Treatment	9,531	9,113	10,526	10,471	10,174	2
Intensive In-Home	7,930	8,053	9,319	9,815	9,108	4
Early and Periodic Screening, Diagnosis, and Treatment	*No data*	822	8,415	17,883	18,803	347
Psychosocial Rehabilitation	8,278	8,190	7,511	6,792	6,095	−7
Crisis Stabilization	1,357	1,627	1,722	1,577	1,874	9
Residential Treatment Center (Levels A and B)	18,987	18,235	17,715	18,509	16,921	−3
Intensive Community Treatment	9,477	9,386	9,199	9,189	8,796	−2
Assessments	88	70	71	91	77	−2
Other services[a]	846	766	453	128	72	−41
Total	**9,610**	**9,994**	**10,951**	**11,687**	**11,919**	**6**

SOURCE: Mercer analysis of Medicaid data.
NOTE: Numbers are rounded and not adjusted for inflation.
[a] Includes substance abuse case management, substance abuse day treatment, substance abuse residential treatment for pregnant women, substance abuse crisis intervention, substance abuse intensive outpatient, and methadone treatment for opioid addiction.

TABLE L-5
Utilization rate by behavioral health service, FY11–FY15

	FY11	FY12	FY13	FY14	FY15	Annualized change
Mental Health Skill Building	0.9%	1%	1.1%	1%	0.7%	−4%
Therapeutic Day Treatment	1	0.9	0.8	0.8	0.9	−3
Intensive In-Home	1	0.6	0.5	0.6	0.6	−8
Early and Periodic Screening, Diagnosis, and Treatment	*No data*	0	0.1	0.1	0.1	2729
Psychosocial Rehabilitation	0.3	0.3	0.3	0.3	0.2	−4
Crisis Stabilization	0.6	0.6	0.6	0.6	0.5	−6
Residential Treatment Center (Levels A and B)	0.1	0	0	0	0	−5
Intensive Community Treatment	0.1	0.1	0.1	0.1	0.1	0
Assessments	0	0	0.3	1.6	0.9	6344
Other services[a]	0.1	0.1	0.1	0.5	0.2	61
Total	**3.2**	**2.9**	**2.8**	**2.9**	**2.6**	**−5**

SOURCE: Mercer analysis of Medicaid data.
NOTE: Numbers are rounded and not adjusted for inflation. Utilization rate equals the number of recipients for a service divided by the number of total Medicaid enrollees in the year.
[a] Includes substance abuse case management, substance abuse day treatment, substance abuse residential treatment for pregnant women, substance abuse crisis intervention, substance abuse intensive outpatient, and methadone treatment for opioid addiction.

TABLE L-6
Unit cost by behavioral health service, FY11–FY15

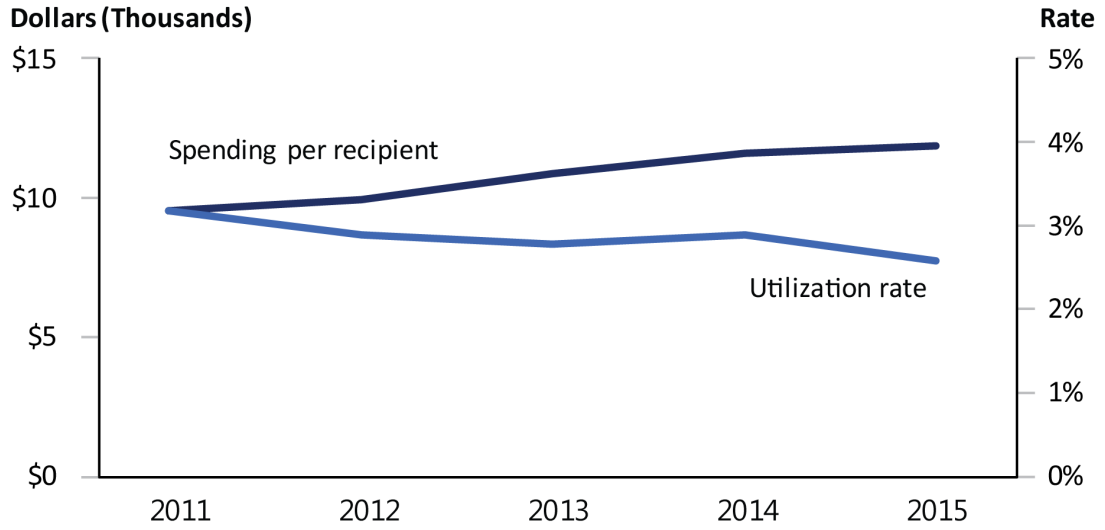
	FY11	FY12	FY13	FY14	FY15	Annualized change
Mental Health Skill Building	$88	$88	$88	$88	$88	0%
Therapeutic Day Treatment	38	36	36	36	37	−1
Intensive In-Home	60	60	60	60	60	0
Early and Periodic Screening, Diagnosis, and Treatment	*No data*	16	22	20	18	6
Psychosocial Rehabilitation	32	31	29	24	24	−7
Crisis Stabilization	49	51	45	43	50	1
Residential Treatment Center (Levels A and B)	138	133	133	132	131	−1
Intensive Community Treatment	143	144	141	145	145	0
Assessments	88	70	47	63	53	−9
Other services[a]	10	9	10	16	23	26
Total	**52**	**53**	**53**	**49**	**46**	**−3**

SOURCE: Mercer analysis of Medicaid data.
NOTE: Numbers are rounded and not adjusted for inflation. Unit cost equals the spending for a service divided by the number of units utilized. The definition of one unit varies from a set number of minutes, hours, days, or months, depending on the service.
[a] Includes substance abuse case management, substance abuse day treatment, substance abuse residential treatment for pregnant women, substance abuse crisis intervention, substance abuse intensive outpatient, and methadone treatment for opioid addiction.

Comparison of utilization rate and spending per recipient, FY11–FY15

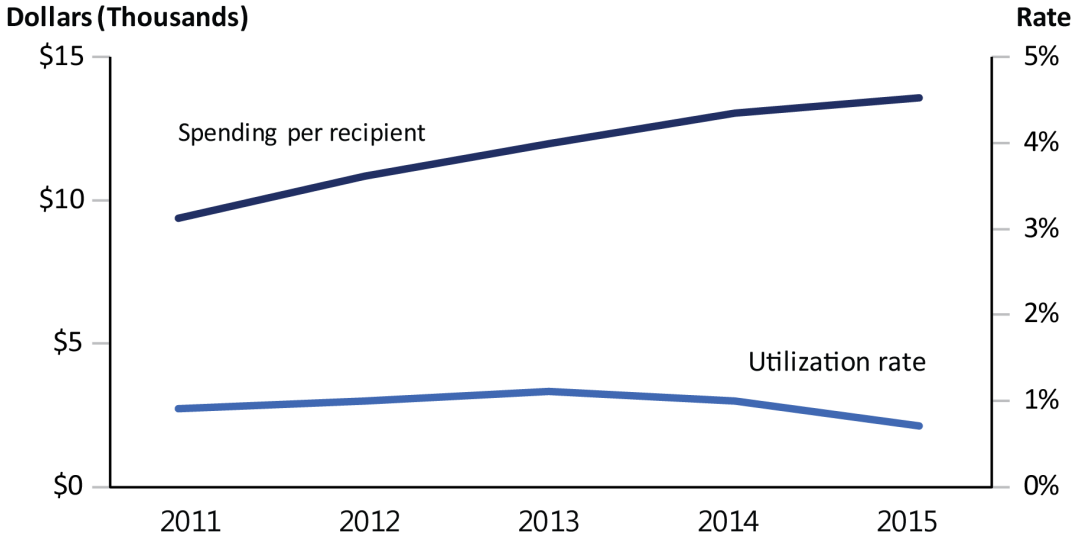
Overall, spending per recipient increased between FY11 and FY15, while utilization rate decreased in the same time period (Figures L-1 through L-4). The spending per recipient increased annually for Mental Health Skill Building. Spending per recipient somewhat fluctuated for Therapeutic Day Treatment and Intensive In-Home services, but FY15 amounts remain higher than FY11 amounts. In contrast, utilization rates decreased overall for behavioral health services. Utilization rates for the three largest services in FY15 are lower than FY11 amounts.

FIGURE L-1
Any behavioral health services: cost per recipient and utilization rate (FY11–FY15)



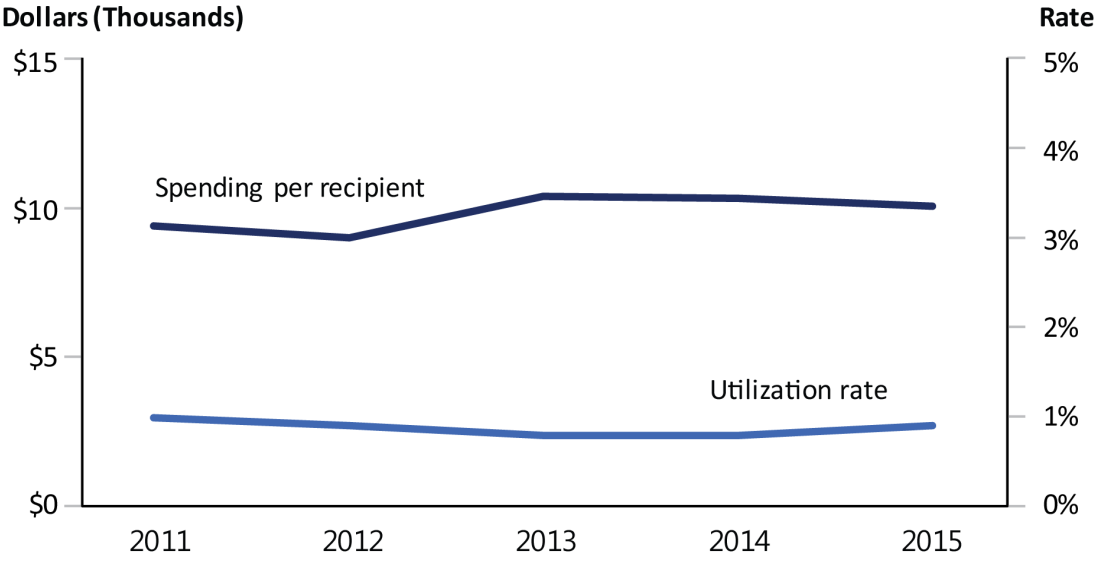
SOURCE: Mercer analysis of Medicaid data.
NOTE: Numbers are rounded and not adjusted for inflation. Utilization rate equals the number of recipients for a service divided by the number of total Medicaid enrollees in the year.

FIGURE L-2
Mental Health Skill Building service: cost per recipient and utilization rate (FY11–FY15)



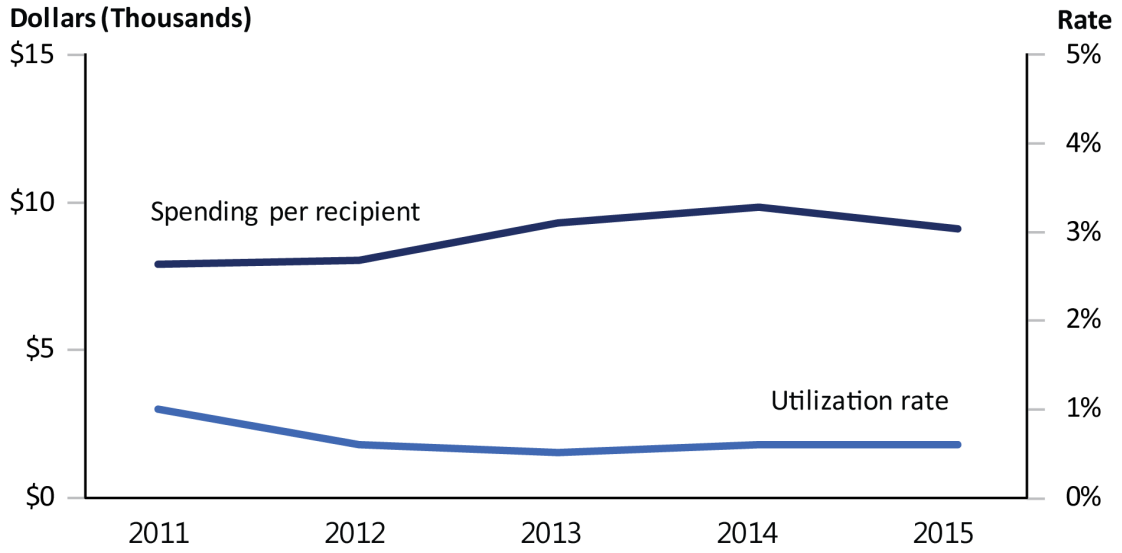
SOURCE: Mercer analysis of Medicaid data.
NOTE: Numbers are rounded and not adjusted for inflation. Utilization rate equals the number of recipients for a service divided by the number of total Medicaid enrollees in the year.

FIGURE L-3
Therapeutic Day Treatment service: cost per recipient and utilization rate (FY11–FY15)



SOURCE: Mercer analysis of Medicaid data.
NOTE: Numbers are rounded and not adjusted for inflation. Utilization rate equals the number of recipients for a service divided by the number of total Medicaid enrollees in the year.

FIGURE L-4
Intensive In-Home service: cost per recipient and utilization rate (FY11–FY15)



SOURCE: Mercer analysis of Medicaid data.
NOTE: Numbers are rounded and not adjusted for inflation. Utilization rate equals the number of recipients for a service divided by the number of total Medicaid enrollees in the year.

Appendix M: Agency responses

As part of an extensive validation process, the state agencies and other entities that are subject to a JLARC assessment are given the opportunity to comment on an exposure draft of the report. JLARC staff sent an exposure draft of this report to the Secretary of Health and Human Resources, the Department of Medical Assistance Services, the Department of Behavioral Health and Developmental Services, and the Virginia Department of Health. Appropriate corrections resulting from technical and substantive comments are incorporated in this version of the report.

This appendix includes response letters from the following:

Secretary of Health and Human Resources

Department of Medical Assistance Services

Department of Behavioral Health and Developmental Services

Virginia Department of Health

COMMONWEALTH of VIRGINIA

Office of the Governor

William A. Hazel, Jr., MD
Secretary of Health and Human Resources

December 2, 2016

Mr. Hal E. Greer, Director
Joint Legislative Audit and Review Commission
General Assembly Building, Suite 1100
201 North 9th Street
Richmond, Virginia 23219

Dear Mr. Greer:

I appreciate the opportunity to review the Exposure Draft of *Managing Spending in Virginia's Medicaid* Program and want to highlight JLARC's key finding: Medicaid spending growth has been flat after accounting for inflation and enrollment.

This comprehensive report, combined with the reports on *Performance and Pricing of Medicaid Non-Emergency Transportation* (November, 2015) and *Eligibility Determination in Virginia's Medicaid Program* (December, 2015) represent a recent and thorough top to bottom look into how this program is administered in Virginia. Given that over a million Virginians rely on Medicaid for health, behavioral health and long-term care and that it represents 21% of the current General Fund budget, such close scrutiny is expected. I generally agree with the analysis and recommendations therein; however, I do want to note what I consider limitations of this and other studies and audits conducted of the Medicaid program.

First, such studies often fail to recognize that Medicaid does not exist in a vacuum but is instead a fundamental underpinning of Virginia's larger human services network. Medicaid provides the primary financial support for Virginia's community mental health system and funds the majority of long term services and supports for the elderly and disabled, whether delivered in a nursing home or in the community. It currently pays for approximately one-third of births and provides health care for one in five of Virginia's children. Any proposed changes to the Medicaid program can have downstream impacts on individuals, families, localities, and other agencies from social services to corrections. Recommendations to narrow eligibility, change program requirements, or reduce funding must be viewed in the larger context and the overall cost-effectiveness of such moves closely examined.

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Second, this issue is a "wrong pocket" problem. Several of the JLARC recommendations are designed to reduce payments to managed care organizations in anticipation of savings from better management of patient care or a reduction in inefficiencies. In other words, an up-front administrative investment is often needed to achieve future savings that may take a year or more to achieve. While such improvements must be encouraged and directed, the savings will ultimately result from the medical care provided. In health care, such savings, if they materialize as projected, generally occur after the administrative investment is made. Squeezing payments in every way possible up front will not necessarily incentivize the innovation necessary to improve the overall system, but may result in plans limiting care or otherwise harming patient care.

This report also recommends that DMAS take on new or increased tasks. While many of these efforts would be beneficial to the administration of the program, no mention is made of the challenges the recommendations present nor the resources required to implement these new initiatives.

I see significant challenges in three specific areas. First, some of these recommended tasks require a sophisticated level of expertise generally only available through high-priced consultants or well-paid employees of private industry. While I continue to be impressed with the caliber and dedication of DMAS staff, state employee salaries are already depressed and DMAS is often challenged to attract the type of talent needed to administer a nine billion dollar health insurance and long-term care program. Second, much of this work must be based on the ability to collect and analyze accurate and comprehensive data from multiple sources. While DMAS is making great strides in improving its capacity for data analytics and is strengthening contractor requirements on providing data, current VITA requirements and restrictions on sharing data from sources outside of DMAS limit our ability to truly understand the impacts to clients and therefore design the best possible ways to help improve lives.

Finally, some of the recommendations in this report will likely receive strong pushback from stakeholders. If it is the will of the legislature to require changes to the rate-setting process or screening criteria for long term care services and supports, I strongly encourage the General Assembly to move cautiously but intentionally in that direction by specifically directing DMAS to do so. The public input that will be generated through the legislative process is invaluable to a successful outcome.

I will end on a positive note. Nothing in this report suggests a program that is fraught with error or broken as sometimes claimed by exaggerated rhetoric. Instead, we have a program that has undergone significant changes on multiple levels in recent years but continues to move steadfastly in the direction set by the General Assembly. In a few short months, the long-term care population will be transitioned into managed care resulting in approximately 96% of all full-benefit enrollees receiving services in a coordinated and integrated delivery system. As noted above, the cost per enrollee remains flat and growth in spending is driven by growth in enrollment. Many of the recommendations made by JLARC staff and associated consultants are already underway at DMAS and others can and will be implemented if the necessary resources are provided.

As documented in this report, there is always room for improvement. With sufficient resources I am confident we will continue to make these and other changes that will further strengthen the administration of the Medicaid program.

Sincerely,

William A. Hazel, Jr., M.D.

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CYNTHIA B. JONES
DIRECTOR

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December 2, 2016

Mr. Hal E. Greer, Director
Joint Legislative Audit and Review Commission
General Assembly Building, Suite 1100
201 North 9th Street
Richmond, Virginia 23219

Dear Mr. Greer:

Thank you for the opportunity to review and comment on the Exposure Draft of the JLARC report: *Managing Spending in Virginia's Medicaid Program*. This report represents an extensive and multi-faceted review of the Medicaid program and required enormous effort by JLARC, its consultants, and DMAS.

Over the last eleven months, staff from my department spent hundreds of hours in interviews, supplied thousands of pages of documents, and provided countless gigabytes of data as requested by your staff and associated consultants. I am pleased to note that as a result of all this work, JLARC's primary finding is that "Medicaid spending growth has been flat after accounting for inflation and enrollment . . ." I believe this positive news must be credited to the diligent stewardship provided by the dedicated staff at DMAS, under the leadership of the Secretary of Health and Human Resources, the legislature, and the Governor.

The Virginia Medicaid program, like Medicaid programs across the country, is in the midst of a significant transformation. The program is transitioning from its historic function of enrolling providers and paying claims through a fee-for-service system to becoming the largest purchaser of health care services in the Commonwealth. This shift not only requires the adoption of new business processes and skillsets, but also an overhaul of decision making tools and oversight functions. DMAS has made great strides in this transition – especially within the last five years. DMAS' culture of continuous improvement is adapting to these new demands on a daily basis, but there is still much to do.

DMAS agrees with the majority of the JLARC recommendations. In fact, many are consistent with new requirements reflected in the upcoming Commonwealth Coordinated Care Plus program, which is the new managed care program for Medicaid's most expensive population (the elderly and the disabled) and most expensive services (long term care and support services and behavioral health). These requirements will also be included in our Medallion 4.0 procurement this spring, which is the managed care program for children,

pregnant women, and low income parents. DMAS is also currently reviewing contract proposals for a data warehouse tool that will dramatically improve our ability to conduct the level of analytics needed to support the administration of such a large and complex enterprise. The data warehouse is on track to launch in 2017.

At this time I would like to address the key themes of JLARC's recommendations at a high-level: (i) improvements to the preadmission screening process for long term services and supports (PAS); and (ii) changes in how DMAS financially oversees and compensates managed care organizations (MCOs). However, I invite legislators to contact me directly if they are interested in pursuing specific recommendations for which the Department needs legislative authority or direction. My staff and I are ready and willing to continue our work with the General Assembly to ensure that DMAS is the highest quality and most cost effective Medicaid program in the country.

Improving the Preadmission Screening Process

Virginia was the first state in the country to implement a screening process to ensure that recipients meet the strict qualifications for Medicaid funded long term care services. As directed by the Joint Commission on Health Care in 1993, Virginia developed the Uniform Assessment Instrument (UAI). The UAI is a multidimensional and standardized screening tool for all publicly funded long term care services. It is the key document used in the PAS process for Medicaid funded long term care services. In order to qualify for Medicaid funded long term care services, Virginians must meet three criteria: (1) Must be a senior or an individual with a disability; (2) Must meet income eligibility; and (3) Must meet a high acuity level on day to day functioning, as documented in the UAI.

JLARC has several recommendations for strengthening oversight of the PAS process – a process considered critical to ensuring the integrity of Medicaid's long-term services and supports system. Preadmission screening, like a number of functions within Virginia's health and human services system, is jointly shared and administered by several state agencies and involves considerable resources from localities. The UAI is used for more than Medicaid services and DMAS does not currently have authority to make unilateral changes to the UAI or how it is used. While supportive of JLARC's recommendations to strengthen PAS, DMAS respectfully requests that, if the legislature seeks to implement these recommendations, the General Assembly clarify the specific actions it would like DMAS to take and provide the additional resources necessary to carry out that directive.

Managed Care Compensation

JLARC also cites a number of recommendations for tightening the managed care rate setting process and financial oversight of the MCOs. Some of these recommend actions are underway at DMAS– such as employing a blended rate in the Commonwealth Coordinated Care Plus program to encourage utilization of community services instead of institutionalization – but others will require further evaluation and analysis. DMAS works with a national actuarial firm to develop MCO capitation rates and actuaries do not always agree on methodologies.

DMAS greatly appreciates the analysis that JLARC and its actuarial contractor did to compare profits of Virginia Medicaid MCOs with national averages and is already looking into this. DMAS has benefited from the financial stability of most of its contracted MCOs and values the many benefits offered through managed care, such as robust provider networks, enhanced coordination of services, and budget predictability. However, this must be provided at a reasonable cost. Finally, DMAS will be in communication with the legislature regarding whether legislative support is needed to address this.

By 2018, DMAS will be in the final phase of transitioning full-benefit enrollees from fee-for-service to managed care. DMAS is also re-procuring managed care for children and pregnant women through the Medallion 4.0 procurement. A primary goal of these procurements is to further raise the bar for Medicaid managed care in Virginia. The contracts for these programs will include increased expectations for chronic condition management, transparency, data integrity, cost-effectiveness, utilization-management, and increased enforcement of sanctions.

As the legislature considers JLARC's recommendations, I would like to highlight a nuance in the DMAS budget of which many legislators are unaware. DMAS has separate budgets for its medical spending and administrative spending. Over ninety-seven percent of DMAS' funding is in its medical budget. In practice, administrative outlays can often result in savings which accrue to the medical budget. However, DMAS does not have authority to spend administrative funds unless they have been appropriated by the General Assembly for that specific purpose- even if it could result in savings. DMAS is also not authorized to transfer money between these two budgets. Therefore, DMAS needs explicit direction from the legislature to invest in cost-saving administrative opportunities. Note that implementation of many of these recommendations would likely require additional resources for contractor services, which must be authorized by the legislature.

DMAS has been studied from top to bottom. Over the past several years, JLARC has conducted three studies on DMAS and DMAS undergoes constant federal and state audits. DMAS appreciates the perspective and insight provided by this report and will work diligently to evaluate and implement the suggested program improvements. DMAS welcomes the legislature's partnership as we continue to raise the bar and increase expectations from our contractors and providers.

Thank you for the opportunity to respond and provide critical health, behavioral health, and long-term services and supports to over a million Virginians.

Sincerely,

Cynthia B. Jones

Cynthia B. Jones

COMMONWEALTH of VIRGINIA

JACK BARBER, M.D.
INTERIM COMMISSIONER

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December 2, 2016

Hal E. Greer, Director
Joint Legislative Audit and Review Commission (JLARC)
General Assembly Building, Suite 1100
201 N. 9th Street
Richmond, VA 23219

Dear Mr. Greer:

Thank you for allowing the Department of Behavioral Health and Developmental Services (DBHDS) to review excerpts from the exposure draft of JLARC's report, "Managing Spending in Virginia's Medicaid Program 2016." We have reviewed the chapters 1, 3 and 6 excerpts provided and do not have comments related to the report recommendations.

In regard to the "conflict of interest in the plan of care process," DBHDS is acutely aware of this issue in other areas as well as the not infrequent necessity of an agency such as a community services board providing both plans and services when providers are otherwise lacking. We have taken pains to "firewall" these functions within the agency as the best balance of competing needs. Fortunately, the U.S. Centers for Medicare & Medicaid Services (CMS) has made allowances for such provisions.

Again, I very much appreciate the opportunity to review the draft and look forward to the final report.

Sincerely,

Jack W. Barber, MD
Interim Commissioner

c: The Honorable William A. Hazel, Jr., MD
Joe Flores
Jeffrey Lunardi

COMMONWEALTH of VIRGINIA

Department of Health

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

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November 29, 2016

Hal E. Greer, Director
Joint Legislative Audit and Review Commission
201 North 9th Street
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Richmond, VA 23219

Dear Mr. Greer:

The Virginia Department of Health (VDH) would like to thank the staff of JLARC for the opportunity to view and provide comment on the report, *Managing Spending in Virginia's Medicaid Program*. We appreciate the dedication of JLARC staff in researching and evaluating the Medicaid funded long term services and supports program.

VDH has been a partner with the Department of Medical Assistance Services (DMAS) in providing formal training and additional education for community and hospital screening teams. Providing training and daily support to these teams reflects VDH's commitment to achieving consistency in screening results throughout the Commonwealth. We recognize that additional, flexible training methods need to be developed and support the allocation of additional resources to this end.

In December 2015, DMAS contracted with VDH to provide screenings for children who reside in the community. We recognize the difficulty of applying adult criteria to children and fully support and are committed to partnering with DMAS to develop and validate a Uniform Assessment Instrument (UAI) designed for children. VDH applauds DMAS for developing an updated Pre Admission Screening manual (released on November 22, 2016) that requires all screeners to use the current children's criteria, thereby encouraging greater consistency by teams throughout the Commonwealth.

Lastly, VDH recognizes that a family's decision to request long term care services is complex and often a very difficult family decision to make. Therefore, we are committed to working with our partner government and private agencies to provide services in a timely, consistent manner that provides reliable outcomes throughout the Commonwealth.

Sincerely,

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

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