Managed Care 101

The Virginia Department of Medical Assistance Services (DMAS) operates Virginia's Medicaid and Children's Health Insurance Program (CHIP) and provides access to health care for approximately 2 million individuals in the Commonwealth. Virginia Medicaid predominately uses a managed care delivery system in which the state contracts with privately-run health plans, referred to as Managed Care Organizations (MCOs), to provide benefits for Medicaid and CHIP members. Managed care provides Virginia the opportunity to improve quality of care and control costs. Virginia has operated managed care programs since 1996 and now covers 1.8 million Medicaid members through this delivery system, with annual spending of about $14 billion. DMAS is in the process of revamping its managed care program. This began with the launch of Cardinal Care Managed Care (CCMC) in 2023 and will continue with the completion of reprocuring the CCMC contracts in 2024.

Benefits of Managed Care

Historically, states provide health care services to Medicaid members through a "fee-for-service" model in which the Medicaid agency directly reimburses providers for each covered service. Federal flexibilities introduced in the 1990s allowed states to implement managed care delivery systems, in which health plans are paid a monthly "capitated" rate for each member served, similar to a health insurance premium. Nearly 40 states currently administer Medicaid benefits via managed care. The managed care delivery system provides states the following benefits:

- High quality services and supports
    - MCOs develop contracts and payment arrangements with networks of providers. These contracts outline eligible populations and covered services. Most services under the Medicaid and CHIP State Plans are provided by MCOs (DMAS covers the rest through FFS). In addition to required services, MCOs offer a variety of enhanced services.
- Care coordination and management
    - MCOs offer care coordination for all members to assist with access to services and community resources. All members are screened to determine the level of assistance needed. Those with more complex needs receive care management, which assists with ongoing support for the medical, behavioral, and social needs of the member.
- Cost control
    - States pay MCOs a per member per month amount, also known as the "capitation rate", to cover care for Medicaid members. Up front capitated payments allow more budget predictability than a traditional fee-for-service program. In accordance with the Affordable Care Act, MCOs have flexibility in how their spending is managed, with a maximum of 15% of the capitation rate allotted for non-medical expenses. In Virginia, MCOs also have a cap on their profits, with a portion returned to the state if they exceed the threshold.

Managed Care in Virginia

- Virginia Medicaid launched managed care in the 1990s with the Medallion program serving children, pregnant women and low-income parents. In 2017, Virginia launched the Commonwealth Coordinated Care Plus (CCC Plus) program to provide services to children and adults with disabilities, individuals dually eligible for Medicare and Medicaid and individuals with complex medical needs.
    - Additional services, including long term services and supports and community behavioral health services were added to managed care in recent years. The majority of Medicaid expansion adults are in managed care.
- The 2020 and 2021 General Assembly Appropriations Act required DMAS to develop and implement a plan to combine the CCC Plus and Medallion programs to provide a seamless Medicaid experience to members and avoid the need for them to switch programs as their health conditions changed.
    - In October 2023, Virginia received federal authority to merge the programs and implemented Cardinal Care Managed Care, one combined managed care program for members, regardless of population or health status. Currently, 96 percent of members are enrolled in one of five statewide MCOs.
- In October 2022, Secretary John Littel announced a plan to transform the managed care program with a focus on quality and accountability. In August 2023 DMAS released a request for proposals to reprocure managed care with a focus on innovation in the areas of behavioral health, foster care, and maternal and child health.

Cardinal Care Managed Care

Cardinal Care Managed Care (CCMC) is a single, streamlined managed care program that allows for improved care management and quality oversight based on population-specific needs. CCMC introduces a model of care in which members' needs and risks drive intensity of care management.

Cardinal Care Managed Care Services include:

- Addiction and recovery services
- Behavioral health services
- Long term services and supports in community and nursing facilities
- Maternal, newborn, and infant services
- Medical and preventative services
- Transportation

The following services are paid for by DMAS outside of managed care:

- Developmental disability waiver services
- Dental services
- Services for members enrolled in fee for service
- School health services