HSAG HEALTH SERVICES ADVISORY GROUP

HSAG Review of JLARC 2016 Commission Draft

HSAG appreciates the opportunity to review the Joint Legislative Audit and Review Commission Draft of the 2016 Report to the Governor and the General Assembly of Virginia on Managing Spending in Virginia's Medicaid Program (JLARC Report). HSAG has compiled the following very high-level feedback for DMAS

Quality Strategy

From a general quality perspective, many of the quality issues, including those tied to excessive spending, could be addressed in a more up-to-date, comprehensive quality strategy for Virginia's Medicaid Program, which DMAS is in the process of updating.

Beyond the development of a new comprehensive quality strategy, HSAG has the following feedback on areas of the JLARC Report.

LTSS Screening Instrument

The report outlines the limitation of the LTSS screening instrument, including that the tool has not been validated for use with children, is currently administered by over 200 entities, and is being used in the absence of consistent training of screeners. HSAG could work with DMAS to assist with the validation of the tool, develop standardized training, and monitor consistent use across the community of screening entities in order to ensure adequate oversight of the screening process.

HSAG has more than 15 years' experience conducting LTC level of care (LOC) determinations on behalf of a state Medicaid agency, and also assisted the state in its transition from fee-for-service (FFS) LTSS benefits to MLTSS benefits under 1115 waiver authority in 2009. In this continuing role, HSAG conducts LTSS determinations using the state's LOC criteria, based on the MCOs' and providers' functional and medical assessment instrument. With HSAG as an independent external entity, the process provides the state assurance of consistent application of its LOC criteria and oversight of the LTSS eligibility decision-making.

MLTSS Utilization

As noted, with the transition to MLTSS and the introduction of an MCO care coordinator, HSAG agrees with the JLARC Report's assertion that DMAS should monitor utilization to ensure that the level of utilization is consistent with the level of care required. HSAG can assist with utilization monitoring. HSAG would monitor utilization in the context of both cost and quality metrics to ensure that MCOs/providers are titrating utilization to the appropriate level of care without care unnecessary rationing that sacrifices quality.

DMAS Paid MCOs More Than Necessary

The report highlights how Virginia has paid MCOs for potentially avoidable health care services. The report estimates that between $17M and $36M could have been saved by not paying MCOs for the delivery of unnecessary services. The report proposes that DMAS work with its actuary to identify a strategy to address these inefficiencies via multi-year phased in adjustments to the capitation rates. HSAG can assist DMAS and the actuary with the identification of potentially avoidable events (PPEs) across the entire spectrum of healthcare services. As part of this process, HSAG can leverage the current approach it uses to identifying PPEs in other states. Furthermore, HSAG can assist DMAS in determining the potential unintended consequences to quality, access, and timeliness that may result from a phased in adjustment to capitation rates.

DMAS Collects Less Utilization Information than Other States

As of the time of the report was issued, DMAS collected only partial pharmacy utilization information and did not collect ED, inpatient, mental health, outpatient, of physician utilization information from its MCOs. Leveraging its experience across multiple Medicaid states, HSAG is capable of assisting DMAS with establishing the infrastructure necessary to accept and review the entire spectrum of utilization data. This includes the development of metrics (with associated benchmarks) to facilitate proper utilization monitoring.

MCOs Operate Programs for Chronic Conditions, but have Not Improved Outcomes

The report outlines the Medallion 3.0 contract requirements, including required care management programs, performance improvement projects, medical homes, and behavioral health homes. It also indicates that DMAS has implemented a performance incentive program based on select HEDIS measures. The described program is based on comparisons of MCO performance to the 50th percentile nationally. Both the measures and current methodology limit the likelihood that the performance incentive program will properly differentiate MCO performance and adequately incentivize MCO performance based on the current incentive structure. HSAG is able to work with DMAS to refine the performance incentive program measure selection to more effectively differentiate MCO performance on process and outcome measures across the common chronic condition areas (e.g., cardiac disease, diabetes, respiratory disease, and behavioral health).

Furthermore, HSAG would recommend incorporating a relative improvement component into DMAS' approach. HSAG has successfully worked with other states to broaden their performance incentive methodologies to include relative improvement in the incentive equation. HSAG is also able to work with DMAS and DMAS' actuary to ensure that the financial incentives are sufficient to encourage MCO engagement.

For those programs currently being employed by the MCOs (e.g., care management), HSAG is able to work with DMAS to design a formal evaluation strategy to determine the efficacy of these programs. HSAG has assisted other states with the formal evaluation of a wide array of programs (e.g., care management, health home, pharmacy coordinated services, etc.). Evaluating the efficacy of these programs may aid DMAS in morphing policy/program/contractual requirements over time to optimize the effectiveness of care being received by members with chronic conditions.

MCO Report Card

As part of its current EQRO work, HSAG has assisted DMAS with the development of a report card. HSAG agrees with the recommendation to make the report card available to the general public.

HSAG anticipates working with DMAS to broaden and enhance the composite metrics incorporated into the report card, focusing on those domains that are known to be most pertinent to consumer choice. HSAG looks forward to this continued work as part of its current EQRO contract.

Leveraging Data

Throughout the report, the importance of acquiring and leveraging data is emphasized. As the Virginia EQRO, HSAG is able to assist DMAS with developing an overall approach to data acquisition, management, and evaluation. HSAG has extensive experience developing and refining metrics (e.g., metrics that evaluating encounter data completeness, metrics that evaluate utilization patterns, financial metrics, etc.). HSAG also has experience assisting states and CMS with the leveraging of data and metrics to ensure proper program oversight, including implementing analytic processes that detect meaningful deviations in rates across MCOs. The identification of meaningful deviations on these metrics can then be leveraged by DMAS to take appropriate action.

HSAG has worked extensively with states to evaluate and improve the quality of spending data being reported by MCOs. These activities have focused on improving the completeness and accuracy of payment data submitted with monthly encounter data to eliminate the need for multiple data feeds and allow Federal reporting and rate setting activities to rely on a single source of data. Finally, once the overall quality of the State's encounter data is improved, HSAG recommends incorporating medical record review into encounter data monitoring programs to further assess the extent to which data systems contain omitted and surplus encounters.

Report Methodology

Throughout the report, actuarial comparisons are made between Virginia Medicaid and other state Medicaid programs. Although these comparisons are broadly informative, caution should be exercised when deriving conclusions from these simple rate comparisons given the known differences in population mix and benefit structure across these Medicaid programs. Rather than identifying comparative state(s) with a comparable mix of members, benefits, providers, health plans, etc. (or using more sophisticated matching techniques to identify a matched population across this hierarchy), it appears that the many of the comparison states in the JLARC Report were limited to the client base of Virginia's actuary (i.e., other Mercer clients). It may be informative to evaluate some of the areas in more depth using a more rigorously identified comparison group for DMAS' program. HSAG is able to assist with this process.

HSAG hopes this high-level feedback is helpful.