Agency Strategic Plan

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Biennium: 2008-10

Mission and Vision

Mission Statement
To provide access to a comprehensive system of high quality and cost effective health care services to qualifying Virginians.

Vision Statement
DMAS will become a recognized leader in the administration of health care programs in Virginia and among state Medicaid agencies.

Agency Values

- Demonstrate integrity, respect, responsiveness and competency in our actions and communications.
- Encourage innovation and require accountability.

Executive Progress Report

Service Performance and Productivity

- *Summary of current service performance*

During the past four years, the priority objective for the Department of Medical Assistance Services (DMAS) was to increase enrollment in Virginia's health insurance programs for children. DMAS has met this challenge. As a result of administrative and operational improvements in the programs and intense outreach efforts, more than 142,000 additional children have been enrolled in either Medicaid or the Family Access to Medical Insurance Security (FAMIS) program. Based on current estimates, 98% of the children eligible for these programs are now insured.

In addition to turning around children's health insurance, DMAS has been working to make Medicaid a more cost-effective program. Pharmacy expenditures represented the fastest growing component of Medicaid spending in previous years. To control these costs, DMAS successfully implemented several cost-containment programs that reduced the annual increase in prescription drug costs from 12% to 3%. Equally important, our customers continue to receive high quality prescription drug coverage. Also, DMAS has expanded its managed care programs by approximately 34,568 customers in the Northern Virginia and Winchester areas to control costs and improve quality of care. Other programs that are being implemented to improve the level and quality of services provided to our customers include a new pediatric dental program, a disease state management program, and new and expanded programs for special populations, known as "waiver programs."

DMAS also has been working diligently to improve its customer service. We have made great strides in working with and involving various stakeholders (e.g., providers and advocacy groups) in the development and implementation of agency programs and activities. In addition, the performance of the agency's call center has improved markedly in the past several years, which enables the agency to provide better customer service to providers and enrollees.

For the future, the agency and the Commonwealth's resources dedicated to its programs will continue to be pressed. In 1995, Virginia Medicaid provided coverage to approximately 681,000 recipients, representing about 27% of all persons who lived below 200% of the federal poverty level (FPL). Within twelve years, coverage increased to include more than 873,000 recipients, representing approximately 30% of all persons living below 200% FPL. Efforts to control costs while maintaining quality health care coverage will continue to be a high priority for the Department.

- *Summary of current productivity*

DMAS strives to be an efficient and effective organization. Currently, DMAS uses several high level measures to track the overall productivity of our agency. These measures well-illustrate DMAS' increased efficiency in recent years.

Medicaid Recipients per DMAS Employee
• Purpose and explanation: This statistic shows the number of people actually receiving services in a given year in the Medicaid program compared to the maximum number of DMAS employees, as measured by the maximum employment level (MEL).

• Results: This measure has increased from 1,828 recipients per employee in FY 1998 to 2,511 in FY 2007. This is a 37.0% overall increase in customers per employee in the nine year period. With the number of employees remaining relatively constant, this illustrates our overall increased efficiency of work over this period.

Net Administrative Expenditures per Total Expenditures
• Purpose and explanation: This measure shows Medicaid administrative expenditures by year compared to the total Medicaid expenditures.

• The net administrative expenditures excludes intergovernmental transactions (IGT) /revenue maximization.

• Results: Net administrative expenditures per total expenditures have decreased from 2.36% in FY 1999 to 1.94% in FY 2007. This reflects a 17% decrease in this important overall measure. We are efficiently using our resources.

Medical Expenditures per Net Administrative Expenditures
• Purpose and explanation: This measure is similar to the above; however, it illustrates the ratio of medical expenditures only to the net administrative expenditures, defined above.

• Results: Medical expenditures to net administrative expenditures have increased from a factor of 48.2 in FY 1999 to a factor of 67.1 in FY 2007. This is a 39% increase.

Initiatives, Rankings and Customer Trends

- *Summary of Major Initiatives and Related Progress*

The Medicaid program is very large and complex and has many different components and activities. DMAS has implemented several major initiatives to improve the quality and cost-effectiveness of Medicaid as well as FAMIS. DMAS will be embarking on several additional initiatives in 2008 and beyond.

Behavioral Pharmacy Management Services (BPMS)

The Department's newest pharmacy quality initiative, whose focus is on behavioral health medications, identifies prescribing patterns that appear to deviate from best practices. Providers are informed of the variations that relate to

their patients and are offered expert consultation, if desired. The initial analysis of behavioral pharmacy claims resulted in letters being sent to outlier prescribes that involved over 37,000 recipients (39% of all recipients receiving designated behavioral health medications), and more than $17 million in drug spending (40% of total spending for these drugs). It is too early to identify any specific quality interventions or savings from this program.

Smiles for Children Dental Program

DMAS implemented its new Smiles for Children dental program on July 1, 2005. Smiles for Children consolidates dental services provided to Medicaid and FAMIS children under a single administrator to improve access to and utilization of pediatric dental services. Numerous other changes were included in the new program to make it more “provider-friendly” and to reflect industry-standard processes for administering dental benefits. The new program has been highly successful: an additional 971 dentists have enrolled; the percentage of Medicaid/FAMIS children receiving dental services is 38% in FY 2007; and initial utilization data indicate more children are accessing dental services.

FAMIS MOMS

Effective August 1, 2005, DMAS implemented a new program called FAMIS MOMS that expands Virginia's Title XXI program to pregnant women. The 2005 General Assembly appropriated funding to expand coverage from the current Medicaid income level (133% FPL) to 150% FPL. Women enrolled in FAMIS MOMS will receive Medicaid benefits for the duration of their pregnancies and for two months postpartum. Women can apply for FAMIS MOMS by phone through the FAMIS Central Processing Unit (CPU), on-line at www.FAMIS.org, or through their local departments of social services. Most women will receive medical services from a contracted managed care organization and early and continuous prenatal care will be strongly encouraged. As of FY 2007, a total of 1807 women have received services from the program.

Long Term Care Waivers

As a result of actions taken by the 2005 General Assembly, DMAS has implemented two new waiver programs, a Day Support Waiver and Alzheimer’s Waiver. The Day Support Waiver, which was implemented on July 1, 2005, provides day support and prevocational services to 300 people with mental retardation who could otherwise be admitted to Intermediate Care Facilities for the Mentally Retarded. The Alzheimer’s Assisted Living Waiver provides services in assisted living facilities for 200 people who are 55 and older, who have Alzheimer’s, who receive an Auxiliary Grant, and who might otherwise be admitted to nursing facilities. There are three approved providers for this waiver. DMAS currently is beginning the process of notifying providers and potential recipients of the start up of this waiver.

Disease State Management (DSM) Program

DMAS implemented its DM program, Healthy ReturnsSM on January 13, 2006, for persons enrolled in its fee-for-service program who have one or more of the following chronic health conditions: asthma, diabetes, congestive heart failure (CHF), or coronary artery disease (CAD), and chronic obstructive pulmonary disease (COPD). Healthy ReturnsSM provides patient-focused services to help members manage their chronic health condition(s), avoid more costly treatments, and remain healthy.

Healthy ReturnsSM was first implemented as a pilot program in June 2004. Health Management Corporation, a wholly owned subsidiary of Anthem Health Plans, offered the pilot program at no cost to DMAS for eligible Medicaid fee-for-service participants diagnosed with CAD and/or CHF. Clinical outcomes indicated that the Healthy ReturnsSM pilot program positively affected members’ health status and utilization of services. Overall, the level of members’ health quality improved in nine of twelve clinical outcomes. Members made improvements in their ability to manage their own self-care and in their clinical test scores. The Healthy ReturnsSM pilot program encouraged optimization of service utilization by supporting drug regimen adherence and preventive care. Improvements in service utilization were indicated by a 5% reduction in hospital inpatient admissions and an 11% decline in the number of days members spent in the hospital.

Managed Care Expansions

DMAS continued to increase the number of persons enrolled in managed care plans. Effective September 1, 2005, AMERIGROUP began operations in Northern Virginia adding 19,038 clients to the total number of managed care enrollees. In addition, there were 6,455 additional clients that enrolled with the existing Northern Virginia managed care plan during the expansion. On December 1, 2005, DMAS extended managed care to another 9,075 enrollees in the Winchester area of the state. In addition to the Northern Virginia and Winchester expansions, DMAS will be increasing the number of enrollees in its managed care program through planned expansions in other parts of the state during 2007 and 2008. DMAS also plans to increase the different types of enrollees participating in managed care such as those in long-term care settings.

Medicaid Reform

Controlling the growth of Medicaid expenditures and maintaining high quality care for those eligible for Medicaid have received significant attention within the Commonwealth and across the nation. DMAS convened a Medicaid Revitalization Committee in 2006 to comply with General Assembly legislation. This committee recommended potential reforms to Medicaid that included the following: DMAS should seek funding and approval to: 1) expand population-based disease management programs, 2) provide access to enhanced benefit accounts, or a similar mechanism, 4) implement a web-based claims submission system available free of charge to all healthcare providers, 5) continue working toward the goal of expanding managed care into new regions and across additional eligibility categories where feasible, 6) study the potential impact of modifications to existing programs for public subsidy of employer-sponsored or other private health insurance coverage for Medicaid-eligible individuals, including the impact of switching from mandatory to voluntary enrollment in these subsidy programs,7) expand, where feasible, “buy in” programs to allow expanded participation in the Medicaid and FAMIS programs, including the program authorized as the Family Opportunity Act, to the extent such expanded participation can be shown to be cost effective / cost neutral to the Commonwealth.

On the national level, the Deficit Reduction Act of 2005 includes numerous substantial changes to state Medicaid programs. Some of the changes are mandatory while others are optional for the states. A key initiative for DMAS during 2006 will be to develop proposed strategies that respond to the state and national calls for Medicaid reform.

Integration of Acute Care and Long-Term Care

One of Governor Kaine’s key initiatives for DMAS is to develop a blueprint for integrating acute care and long-term care services for Medicaid clients. The plan was developed in 2006 with the input of all major stakeholders and Phase I was implemented in 2007. Concurrent with the development of the long-range plan, DMAS will move forward with two models of care: (i) establishment of Program for All inclusive Care for the Elderly (PACE) sites across Virginia; and (ii)

regional managed care plans that include acute and long-term care services. The goal of integrated acute and long-term care services is to provide the right service at the right time to the right person and to make appropriate services more accessible to participants. Other goals of integrated care include decreasing the number of avoidable hospital admissions and the unnecessary use of nursing home care, and lower the amount. Phase II of the Integration of Acute and Long-Term Care is integrating managed care and long-term care to offer participants better coordination and quality of care. To accomplish this, DMAS is integrating populations and services previously excluded from managed care into managed care. This will be piloted in Tidewater and Greater Richmond area beginning August 2008. Tidewater will launch in August 2008 and Greater Richmond will follow in January of 2009.

Increased Emphasis on Electronic Processing Systems and Program Integrity

Increasing the efficiency of the Virginia Medicaid program by maximizing the use of electronic systems to process claims, reimburse providers, prior-authorize services, and perform other administrative tasks will be a major focus for DMAS during 2008 and beyond. The agency will continue to pursue automated means to increase the number of providers able to submit claims and receive reimbursement electronically. By the end of state fiscal year 2007, the Department had implemented several web-based systems for providers to facilitate their processing of pharmacy and medical prior-authorization services in addition to a tool that provides eligibility inquiry information.

In fiscal year 2006 and 2007, DMAS made major strides to increase its program integrity efforts. New contracts were awarded to conduct compliance audits for home health, home infusion services, pharmacy, durable medical equipment, and other services. These efforts provide a significant “return on investment” and improve the integrity of Medicaid payments in this area.

Implementation of Agency Risk Management and Internal Control Standards

In October 2005 the Virginia Department of Accounts issued its Directive Number 3-05: Required Implementation of Agency Risk Management and Internal Control Standards. In accordance with the Directive, each Virginia State agency must plan and take systematic, proactive measures to (a) plan, develop, and implement a comprehensive and cost effective risk management program to support its performance management program; (b) assess the adequacy of internal controls in all agency services, operations, and activities; (c) identify needed improvements; (d) take corresponding preventative and corrective actions; and (e) report annually on internal control. In November, 2006, DOA issued Directive Number 1-07 to replace the previously issued Directive Number 3-05. This directive requires the implementation and annual assessment of agency internal control systems in order to provide reasonable assurance of the integrity of all fiscal processes that impact the Commonwealth Accounting and Reporting System (CARS), financial statement information, compliance with laws and regulations and stewardship over the Commonwealth's assets. The mandates included in this directive are similar to the mandates required of publicly traded companies from the Sarbanes-Oxley Act of 2002.

Phase I - Agency-level Internal Control Assessment - is due by September 30, 2007. DMAS successfully completed Phase I by the required due date.

Phase II - Process and Transaction-Level Internal Control Assessment - is due by March 31, 2008. The agency is on pace to meet the March deadline.

Phase III - Correction Action Plan (if needed) is due by June 30, 2008. To-date the agency has not identified any significant weaknesses.

An Agency Risk Management (ARM) Team has been established and is overseeing the implementation of Directive 1-07. It is anticipated that the agency will require the assistance of external auditors and/or consultants to assist with Phase 2 of this project.

- *Summary of Virginia's Ranking*

  Virginia Ranking and Trends
  Virginia Medicaid historically has been one of the leanest programs in the nation. Data gathered from the Henry J. Kaiser Family Foundation’s State Health Facts showed the following:

  • Compared to other states, Virginia was ranked 24th in the nation in terms of Medicaid enrollment during FY 2004 and 9th within the 12 southeastern states. For Medicaid payments per enrollee in FY 2004, Virginia was ranked 28th in nation and 4th within the 12 southeastern states.

  • Medicaid acute care and long-term care costs for FY 2006 were $2.6 billion and $1.9 billion or 55.5% and 41.1% of total Medicaid expenditures, respectively. Consequently, Virginia ranked 21st and 17th in acute and long-term care spending nationwide, and 6th and 4th within the 12 southeastern states. Note: A first place ranking is assigned to the state with the highest costs.

  • In FY 2005, total Medicaid expenditures were approximately 17.4% of overall state expenditures. Virginia ranked 21st in the U.S. with respect to Medicaid costs as a percentage of total state expenditures. Note: A first place ranking is assigned to the state with the greatest percent of overall state expenditures devoted to Medicaid.

  It should be noted that due to the wide variations among state Medicaid programs and reporting methods, there are inherent limitations with any national rankings. The above rankings must be viewed in this context.

- *Summary of Customer Trends and Coverage*

  The Department provided services to over 1,000,000 persons during fiscal year 2007. General population growth in Virginia and especially the growth of the aging population are key factors affecting the Department’s customer base. The number of Virginians age 65 and older is projected to increase dramatically over the next ten years – over five times faster than the state’s total population growth. An aging population within the state will place increased demands for services on Medicaid, especially in the areas of long-term care and waiver services.

  Access to medical care for uninsured children has been a priority of DMAS. Since 2002, the number of children served through the FAMIS and FAMIS Plus (Medicaid for Children) programs has grown over 40% as a result of program reforms and aggressive outreach campaigns. Given the fact that approximately 98% of eligible children are now covered under FAMIS and FAMIS Plus, DMAS expects future growth in the program to be slower.

  The enhanced ability of medical technology to treat severe illnesses and disabilities and prolong life will increase the Department’s customer base.

  Economic conditions also affect the number of individuals eligible for medical assistance services and other programs administered by the Department. Should there be continued economic growth in the Commonwealth, there would be a countervailing trend that would be expected to reduce the number of low-income Virginians, and, in turn, the number of

individuals needing medical assistance and other services provided by DMAS.

DMAS' recent enrollment trends show slowing growth in the number of persons covered by the Medicaid program with an actual decline in enrollment in FY 2007. This decline is attributed to the implementation of federal Deficit Reduction Act citizenship and identity requirements of 2006. The trends in enrollment growth are as follows: 9.1% in FY 2004; 7.6% in FY 2005; 4.9% in FY 2006; and a decrease of (0.4%) in FY 2007.

Future Direction, Expectations, and Priorities

- *Summary of Future Direction and Expectations*

The future direction for DMAS will be to monitor the effectiveness and impact of recent program enhancements and initiatives, and to be proactive in the administration of the program by adjusting current activities and implementing new enhancements that improve the services we provide to our customers.

There are several factors that will impact Virginia Medicaid in the future including: (i) the aging population, especially those age 85 and older; (ii) an increase in the number of persons with disabilities seeking services; (iii) new technology requirements; such as: web-based claims submission, electronic prescriptions, and web-based enrollment application processing, electronic health records, HIPAA (Health Insurance Portability and Accountability Act) compliance, and (iv) continued growth in overall program enrollees and costs.

Perhaps the most significant issue is the current Medicaid reform efforts underway both in Virginia and in Washington. The 2006 Session of the General Assembly has directed DMAS to convene a Medicaid Revitalization Committee to make recommendations on various Medicaid reform strategies. Also, the federal Deficit Reduction Act of 2005 includes numerous changes to Medicaid programs across the country. Many of the federal reform changes are mandatory, and states must enact them. In addition, there are a number of "optional" changes that states may implement. Two of the optional changes that have the potential to significantly impact the operation of Medicaid in Virginia are increased cost sharing and potential benefit reductions. Regarding cost sharing, unlike the current co-payment policies, states have the option of making co-payments enforceable. This means that if a recipient does not pay, the provider will have the option to deny services. Virginia will need to weigh the advantages of charging higher co-payments and offering limited benefit packages against the disadvantages that would likely manifest in care access problems for Medicaid recipients and greater use of emergency rooms for routine care. The future direction of Virginia's Medicaid program will depend largely on decisions that are made in response to the call for Medicaid reform.

Agency Priorities

The following are among the top priorities for DMAS in the future.
• Responding to state and national Medicaid reform issues;
• Proceeding with integrating acute and long-term care services;
• Expanding managed care enrollment to include new geographic areas and populations;
• Increasing retention efforts to keep eligible children enrolled in Medicaid and FAMIS;
• Enhancing the Department's capabilities and activities in preventing, identifying, and eliminating fraud and abuse;
• Improving the effectiveness of waiver programs serving the elderly, and persons with mental retardation or other disabilities, and developing Program for All Inclusive Care for the Elderly (PACE) sites;
• Monitoring the new dental program and making any needed adjustments to improve access to care;
• Increasing the use of electronic systems to improve internal processes and administrative efficiencies;
• Improving SWaM Contracting and Purchasing and
• Develop a comprehensive Agency Risk Management program which will assist agency management in administering DMAS' programs while adequately protecting the Commonwealth's resources.

- *Summary of Potential Impediments to Achievement*

Expenditures

Total fund expenditures for the Medicaid and FAMIS health care programs have increased from $2.7 billion in FY 2000 to $4.8 billion in FY 2007, an average annual rate of increase of 11 percent. This increase has occurred despite several savings initiatives that were implemented to reduce costs. As these programs continue to grow and represent an even larger share of the state budget, it will be difficult for the Commonwealth to continue to provide full funding for the program. However, without these resources, the agency will be unable to maintain the level of services offered to its customers.

Maximum Employment Level (MEL)

As the agency's programs continue to grow, there is an increased strain on DMAS' limited administrative resources, particularly its staff. The number of clients served has swelled over the past several years; however, the agency's MEL has remained relatively constant. This has placed extreme hardships on current staff that is asked to do more and more with little or no additional help. Without an increase in MEL, it will be exceedingly difficult for DMAS to meet its current service obligations, and nearly impossible to expand existing programs or add new services or activities.

Provider Reimbursement

DMAS relies on its contracted health care providers to deliver services to our customers. While there are some provider groups that often receive some level of increase in reimbursement (e.g., hospitals and nursing homes) and some that recently have received substantial increases in reimbursement (e.g., physicians providing obstetrics/gynecology services, dentists), some provider groups have received very modest increases over the past several years. Without increases in reimbursement for several provider groups, access to care will decline for our patients as providers make business decisions to no longer participate in Medicaid or FAMIS. Also, even for those providers who have received increases, they are still paid well below the amounts paid by commercial insurers. Without an annual inflation factor or other type of routine adjustment, provider reimbursement will continue to be an impediment to providing needed services to our customers.

Service Area List

Service Number	Title
602 321 07	Reimbursements for Medical Services Related to Involuntary Mental Commitments
602 446 02	Reimbursements for Medical Services Provided Under the Family Access to Medical Insurance Security Plan
602 456 07	Reimbursements to State-Owned Mental Health and Mental Retardation Facilities
602 456 08	Reimbursements for Mental Health and Mental Retardation

	Services
602 456 09	Reimbursements for Professional and Institutional Medical Services
602 456 10	Reimbursements for Long-Term Care Services
602 459 01	Reimbursements to Acute Care Hospitals Providing Charity Care in Excess of the Median Level of Charity Care Costs
602 461 05	Regular Assisted Living Reimbursements for Residents of Adult Homes
602 464 01	Reimbursements to Localities for Residents Covered by the State and Local Hospitalization Program
602 464 03	Insurance Premium Payments for HIV-Positive Individuals
602 464 05	Reimbursements from the Uninsured Medical Catastrophe Fund
602 466 01	Reimbursements for Medical Services Provided to Low-Income Children
602 499 00	Administrative and Support Services

Agency Background Information

Statutory Authority

Statutory Authority

DMAS comprises 13 specific service areas to accomplish the mission of the agency. The statutory authorities under which the service areas exist are presented below.

• Involuntary Mental Commitment Fund (32107) - Code of Virginia §37.1 – 67.4, §37.2 – 809 allows DMAS to set rates

• FAMIS (44602 & 46601) - Federal: CFR 42 part 457; Code of Virginia §32.1-351

• State Mental Health and Mental Retardation Facilities (45607) - Federal Legislation: Title XIX of the Social Security Act and CFR 42 part 440; Code of Virginia: Chapter 32.1, Chapter 10

• Mental Health Mental Retardation Services (45608) - Federal Legislation: Title XIX of the Social Security Act and CFR 42 part 440; Code of Virginia: Chapter 32.1, Chapter 10
Professional & Institutional Medical Services (45609) Federal Legislation: Title XIX of the Social Security Act; Code of Virginia: Chapter 32.1, Chapter 10

• Long Term Care Services (45610) - Code of Virginia: Title 32.1, Chapter 10

• Regular Assisted Living Program (46105) - 12 VAC30-120-460 (450 – 480)

• State and Local Hospitalization Program (46401) - Code of Virginia: Title 32.1 (§32.1 – 343 through 32.1 – 350), Chapter 12 Insurance Premium Payments for HIV-Positive Individuals (46403) - Code of Virginia: § 32.1-321.2 through 32.1-321.4, and § 63.1-124

• Uninsured Medical Catastrophe Fund (46405) - Code of Virginia §32.1-324.3 and 12VAC 30 -150

• Administrative & Support Services (49900) - §32.1 -325 provides general authority to the Board of Medical Assistance Services

Customers

Customer Group	Customers served annually	Potential customers annually
FAMIS	63,580	0
HIV Premium Assistance Program	77	0
Involuntary Mental Commitment Fund	8,600	0
Medicaid (adults) and FAMIS Plus (children)	873,934	0
Medicaid Expansion Program	57,658	0
Regular Assisted Living Program	1,278	0
State/Local Hospitalization Program	5,081	0
Uninsured Medical Catastrophe Fund	15	0

Anticipated Changes To Agency Customer Base

Note for Agency Customer Base Listing tab: Customer figures represent the number of unduplicated enrollees or recipients for whom claims were paid during state fiscal year 2007. The potential number of customers is equivalent to the number of individuals who meet eligibility criteria (e.g., age, income level, medical condition) for each program. These figures are not known.

• Medicaid Program
Approximately 87% of the DMAS customer base is served through the Medicaid program. The trends in enrollment growth are as follows: 6% in FY 2003, 9.1% in FY 2004; 7.6% in FY 2005; 4.9% in FY 2006; and a decrease of (0.4%) in FY 2007. The Department's 2006 consensus forecast projects 5% growth in FY 2009 and 2010 based solely on historical trends.

In addition, the number of Virginians age 65 and older is projected to increase dramatically over the next ten years, over five times faster than the state's total population growth. This growth, in turn, will increase the number of individuals receiving long-term care services and Medicare premium assistance through Virginia's Medicaid program. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established the Medicare Prescription Drug Program, known as Medicare Part D, which provides prescription drug coverage to Medicare beneficiaries. Virginians applying for Medicare Part D may find that they also qualify for Medicaid, which will increase the number of individuals served.

The increased ability of medical technology to treat severe illnesses and disabilities and prolong life will increase the Department's customer base. Statistics show that the life expectancy at age 65 has increased 12% for males and 3% for females since 1980.

The aging of our population is creating new opportunities for the Commonwealth and for DMAS. To ensure that the Department is in the best position to meet the service needs of this population DMAS has enhanced the strategic plan to allow for continuous assessment of this population and targeting of resources to meet changing needs.

Economic conditions also affect the number of individuals eligible for medical assistance services. According to the Virginia Employment Commission, the final numbers for 2004 showed strong economic growth for both the U.S. and Virginia. Continued economic growth can be expected to have somewhat of a countervailing effect on the trends noted above regarding the number of low-income Virginians needing medical assistance services.

• FAMIS, FAMIS Plus (Medicaid for Children), and Medicaid Expansion
As of July 2005, over 416,000 of the estimated 432,773 uninsured children in Virginia were enrolled in one of the Department's child health insurance programs. Since 2002, the number of children served through the FAMIS and FAMIS Plus programs has grown over 40% as a result of program reforms and aggressive outreach campaigns. While this trend is expected to continue, the growth rate is expected to slow considerably as the percentage of eligible children covered under these programs nears 100%.

• State and Local Hospitalization Program (SLH)
The number of recipients served through the State and Local Hospitalization Program has declined 11 percent over the past five years and this trend is likely to continue due to rising costs of medical services and the capped amount of state and local government funding available through the program.

• Involuntary Mental Commitment Fund
The number of individuals placed under an involuntary mental commitment has remained relatively constant over the past five years and no significant change in this population is anticipated.

• Regular Assisted Living Program
Increases in an auxiliary grant administered by the Department of Social Services will increase the eligibility for Regular Assisted Living services.

• HIV Premium Assistance Program
While there has been a decline in the number of participants over the past years, it appears it is almost entirely a result of double-digit premium increases in insurance costs and not a decrease in need for the program. Additional funding provided for FY 2006 was quickly exhausted as a large number of applications for this program had been received. A waiting list for this program has been reestablished.

• Uninsured Medical Catastrophe Fund
It is anticipated that the number of individuals served through the Uninsured Medical Catastrophe Fund will increase in future years due to three key factors: 1) a newly dedicated staff position who can manage program activities, 2) current initiatives to streamline the regulations and application process, and 3) additional funding ($125,000) provided for FY 2006. However, this is a very small program and the number of persons served is limited by the available funding.

• Indigent Health Care Trust Fund
No changes in this customer base are anticipated.

Partners

Partner	Description
Advocacy groups	Advocacy groups that represent provider organizations or recipient groups on matters related to DMAS programs and services
Boards and committees	Boards and committees, established by statute or created by DMAS, serving in an advisory capacity in an area of subject matter expertise and/or providing assistance in the formulation of program policy
Federal agencies	Federal agencies that provide funding and oversight for the Medicaid and Title XXI programs as well as the Medicare program
Health care professionals, organizations, and facilities	Health care professionals, organizations, and facilities rendering medical services to clients of Medicaid, FAMIS, or other indigent health care programs administered by DMAS
Private business firms	Private business firms, contracted by DMAS, providing program functions including claims processing, recipient enrollment, prior authorization of medical services, brokered transportation services, cost settlement and audit reviews, managed care enrollment, and actuarial services
State and local entities	State and local entities providing medical services covered and reimbursed by Medicaid or FAMIS programs or performing various program functions (e.g., recipient enrollment)
State government officials	State government officials in both the executive and legislative branches of government who are responsible for setting agency priorities, determining health care policy, assisting DMAS deliver its services, setting DMAS' appropriation levels and enacting legislation

Products and Services

- *Description of the Agency's Products and/or Services:*
  DMAS, in coordination with its partners, provides a wide spectrum of services to enable the successful operation of the agency's health care programs. For organizational purposes DMAS has identified five broad classifications of services. Long Term Care, Special Programs and FAMIS, Administration, and Operations.

  • Long Term Care (LTC) and Waiver Programs
  DMAS provides long term care services including coverage for nursing home care, and the development and management of waiver programs (e.g., home and community based waivers, and mental retardation waivers) that provide access to health care for special populations.

• Special Programs Not Covered by Medicaid
DMAS is responsible for several programs that have different funding and administration streams than Medicaid. These programs include a health insurance premium payment program, an indigent health care trust fund, an uninsured medical catastrophe fund, and a state and local hospitalization program.

• FAMIS – Family Access to Medical Insurance Security
FAMIS is the state's health insurance program that covers traditional health care services to uninsured children in families with incomes that exceed Medicaid levels. This program has a federal match that is separate from the Medicaid program and also has a separate state plan. Along with the provision of medical services, the program includes outreach, eligibility determination, enrollment, and policy development.

• Administration – Several administrative services support management and staff in carrying out the mission of the organization: human resources, procurement, strategic planning, workforce development, training, contract development and management, and property management.

• Operations
Health care services – DMAS provides traditional health insurance products and programs for hospital stays, outpatient services, pharmacy, labs/x-rays, mental health, dental, vision, ancillary services, equipment and supplies. DMAS also provides transportation services for Medicaid recipients.

Enrollment and member services – These services include recipient call centers, mailings to recipients, membership enrollment, and a process for recipient appeals.

Provider enrollment, services and reimbursement – These services include claims processing and reimbursement, education and training, medical support and consultation, provider call centers, mailings to providers, prior authorizations, provider and customer service, provider enrollment, network analysis, and provider appeals.

Program integrity – Functions include a) provider and recipient audits, b) compliance, fraud and utilization reviews, c) internal audits and reviews, and d) reengineering and process improvement.

Financial service – In order to manage a multi-billion dollar program, the department has established several financial functions including accounting, budget development, forecasting, rate development, financial analysis, fund management, fiscal operations, and reporting. The department also contracts with an actuarial firm to provide highly technical financial analyses.

Policy analysis and information dissemination – DMAS provides policy analysis and development; development and promulgation of state and federal regulations, state plans and waivers; evaluation of programs; development of studies, position papers, surveys and research; quality reviews; grants development; legislative tracking and development; constituent communication; briefings to the Governor, Secretary Health and Human Resources and Legislature; website administration; media requests and interviews; and Freedom of Information Act (FOIA) requests.

- *Factors Impacting Agency Products and/or Services:*
The scope of the products and services provided by DMAS continues to be effected by changes taking place in the health care sector in general. These changes include, new health care technologies, the continued emphasis on treating individuals in an outpatient setting or in the community as opposed to treating individuals in the facilities, and the increasing use of care management programs to manage and improve health outcomes especially for individuals with specific conditions.

  The largest factor impacting the provision of administrative services and operations is the use of technology enhancements to increase the efficiency of the programs, expedite the services that are provided by the agency and increase the access to information needed to perform policy analysis and program integrity.

- *Anticipated Changes in Products or Services:*
It is expected that the provision of Long Term Care (LTC) and Waiver Programs services will continue to increase. In recent years numerous new waiver programs have been proposed which target individuals based on a specific condition/diagnosis. In addition, as the number of citizens in the Commonwealth over the age of 65 increases there will be increased demand for community based care services.

  For primary health care services DMAS expects to continue to increase the number of customers who receive their health care through private managed care organizations as opposed to the Medicaid fee-for-service system.

  The aging of our population is creating new opportunities for the Commonwealth and for DMAS. To ensure that the Department is in the best position to meet the service needs of this population DMAS has enhanced the strategic plan to allow for continuous assessment of this population and targeting of resources to meet changing needs.

  DMAS continues to emphasize technology improvements, both through DMAS' internal operations and through companies contracted with DMAS' to provide support services to improve services provided under DMAS' operations. Specific improvements which have occurred recently or will occur in the near future are in the operation of the provider call center, the membership enrollment processes and the prior authorization process.

Finance

- *Financial Overview:*
DMAS' budget is currently funded with approximately 46% state general funds, 54% federal or Nongeneral funds (5% special funds are included with federal or Nongeneral funds). The special funds are comprised of the Family Access to Medical Insurance Security Plan Trust Fund, Virginia Health Care Fund and Civil Money Penalties.

  The Base Budget is the FY 2008 appropriation as reflected in Chapter 847 of the Appropriation Act.

- *Financial Breakdown:*

	FY 2009		FY 2010	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$2,633,127,039	$3,126,849,770	$2,617,975,429	$3,119,049,770
Change To Base	$12,281,423	$69,522,818	$174,613,421	$233,181,026
Agency Total	$2,645,408,462	$3,196,372,588	$2,792,588,850	$3,352,230,796

This financial summary is computed from information entered in the service area plans.

Human Resources

- *Overview*

  Service Area Human Resources Overview
  The Department of Medical Assistance Services is a highly professional organization with 349 authorized classified positions. As of September 12, 2007, 332 of these positions are filled and 17 are vacant. Four of the classified employees are located in the Roanoke Office; one is located in Manassas, and one is in Virginia Beach. Because of increasing program requirements, the Department has had to use increasing numbers of hourly employees. Most of the contract employees work in the Information Management Division and play a critical role in the maintenance of the Virginia Medicaid Management Information System and any programmatic changes. The Department has 15 divisions/offices, which include the Office of the Director. Forty-two role titles are used and the most prevalent are the Health Care Compliance Specialist II (16.1%), Health Care Compliance Specialist I (13.9%), Program Administration Specialist II (13.6%) and Administrative and Office Specialist III (10.5%). We also employ workers from temporary employment agencies, such as Caliper.

  Additional Information for the Human Resource Levels Tab:

  Temporary Agency Workers - 5

- *Human Resource Levels*

Effective Date	9/12/2007	
Total Authorized Position level	349	
Vacant Positions	-17	
Current Employment Level	**332.0**	
Non-Classified (Filled)	3	
Full-Time Classified (Filled)	329	*breakout of Current Employment Level*
Part-Time Classified (Filled)	0	
Faculty (Filled)	0	
Wage	97	
Contract Employees	24	
Total Human Resource Level	**453.0**	*= Current Employment Level + Wage and Contract Employees*

- *Factors Impacting HR*

  Increased programmatic requirements continue to necessitate the extensive hiring of wage employees. The wage employees serve a vital role and require the same level of training as full-time employees. However, most of these employees seek other employment with benefits. Thus, the turnover rate among the wage workforce is considerably higher than the classified workforce. The restriction of 1500 work hours per year for wage workers also has a negative impact on productivity and retention.

  There is some concern regarding the aging workforce. The average age of the DMAS classified workforce is 48.8 years. As of August 31, 2007, twelve (12) employees are eligible for full retirement being age 50 with 30 years of service; three additional employees can retire with full benefits based on age. Eighty-five (85) employees (26% of the classified workforce) are in the 50 to 60 age group and they have obtained 10 years of service which would allow them to retire with partial benefits. Generally, most employees would prefer to retire with full benefits. The positions range from upper level management to support staff. During the next five years, eighteen (18) employees in the 50 to 60 age group identified above will become eligible for full retirement. Also, during this time period it is expected that a minimum of sixty three (63) additional employees will have obtained 10 years of experience and will be in this age group. These figures do not include employees who have purchased prior service and may be eligible for retirement much sooner.

  The turnover rate for classified employees leaving the Department for fiscal year 2007 (July 1, 2006 to June 30, 2007) was 6.10 % (18). Turnover is defined by DHRM as employees leaving state service. Most of these employees left the Department for advancement reasons. Of this number, 9 resigned for advancement, 5 retired, 3 were terminated based on the Standards of Conduct Policy, and 1 death.

- *Anticipated HR Changes*

  With adequate funding, it is hoped that the employee training program will be enhanced even more than it has since the Employment and Training Manager position was authorized and filled. To date, DMAS is increasing the amount of employee training opportunities. Emphasis will be placed on project management, supervisory/leadership, performance management, computer software training and employee health and safety. This type of training is being scheduled for future training during the current fiscal year. In addition, it is planned to continue the DMAS Supervisory and Leadership Institute presented by the Community College Workforce Alliance; it will begin in October 2007 with a series of comprehensive supervisory and leadership classes.

  There will be greater use of the Learning Management System both internally and with the programs offered by the Department of Human Resource Management. The Learning Management System is a Web-based system designed to present learning and knowledge sharing opportunities to its users. It promotes learning through online course offerings, classroom course registration, and a consolidated transcript of all learning events for individual users. Currently, we are members of the DHRM LMS Users group and will continue implementing on-line access to the DHRM LMS Knowledge Center.

  It is anticipated that there will be improvement in automated databases provided by the Department of Human Resource Management and the Department of Accounts (DOA). The Recruitment Management System (RMS) should be enhanced for better reporting capabilities. It is hoped that DOA will expand the capability of a paperless employee leave system.

  The Maximum Employment Level was recently raised from 338 to 349 positions, but there is a continuing need to use wage employees to meet programmatic needs. Of the current seventeen (17) vacant classified positions, most are in some stage of the recruitment and selection process or under classification review. A high frequency rate of internal transfers and promotions seems to keep the vacancy rate consistently high.

  Even though the turnover rate is not as high in DMAS as in some other agencies, retention of highly skilled employees must be emphasized through effective employee recognition programs, training, and fair and consistent compensation practices.

Information Technology

- *Current Operational IT Investments:*

  The current period of the Medicaid Management Information System (MMIS) fiscal agent contract will end on June 30, 2009. There is one remaining option year under the contract. Procurement for a new fiscal agent contract to be effective July 1, 2010 is in progress.

  The Centers for Medicare and Medicaid Services (CMS) published new Medicaid Information Technology Architecture (MITA) guidelines and requirements with which all Medicaid agencies must begin complying in order to continue to receive enhanced federal funding. DMAS has completed the required state self-assessment and will submit its initial transition plan to CMS in the fall of 2008. Transition will begin with the new fiscal agent contract and continue over a 10+ year period.

  The Third Party Liability System Recovery System (TPLRS) hardware platform has been upgraded with a state-of-the-art system that increases maintainability and efficiency and reduces risk of hardware failure. The system will be moved to production in August 2008.

  DMAS operates a mission-critical function using the Oracle Government Financials system. The agency needs to support the system through required maintenance and enhancements as well as any product upgrades. A database upgrade is in progress and will be followed by an upgrade to the application.

  The network infrastructure, servers, desktop workstations, and applications that are used by DMAS staff must be maintained and kept current. This makes up the Information Retrieval Platform (IRP) at DMAS, which is a component of the MMIS. With the exception of the application support, support for the IRP will be transitioned to VITA in conjunction with the new fiscal agent contract beginning July 1, 2010.
  In order to comply with federal and state security requirements (including HIPAA) and to secure its protected health information and other sensitive data, a number of security-related initiatives have, and will continue to be, addressed, including security of DMAS' data center, data encryption, and secure transmission of data.

- *Factors Impacting the Current IT:*

  HIPAA Transactions, Code Sets and Identifiers Rules require ongoing compliance to standardization of electronic data interchange (EDI). The following actions relate to this issue.

  System changes to support use of the National Provider ID (NPI) were implemented in March 2007, and use of NPIs by providers for all MMIS transactions became mandatory in May 2008.

  HIPAA will be requiring migration to updated versions of the Transactions and Code Sets. Although the final compliance date has not yet been published, use of the new Transactions Sets will likely be required by October 2010, followed six months later by use of the new Code Sets

- *Proposed IT Solutions:*

  The procurement for a new fiscal agent to operate the MMIS will result in a contract for take-over of DMAS' existing MMIS. Transition will begin in the spring of 2009 in order to have sufficient time for a smooth transition.

  DMAS will complete its MITA Transition Plan and begin undertaking initiatives to transition to the MITA architectural requirements. Initiatives will focus on inter-operability, modular components, and data sharing with the ultimate goal of moving to a Service Oriented Architecture (SOA). DMAS will work with other agencies with which we share data to standardize and optimize processes.

  Under a Productivity Investment Fund (PIF) grant, DMAS will procure and implement a web-based claims direct data entry application for use by small/medium-sized providers in submitting claims electronically. This will improve service to providers and reduce the volume of paper claims submitted by providers, ultimately reducing the unit cost of processing claims. DMAS will also work cooperatively with the Virginia Healthcare Exchange Network (VHEN) to leverage this application and other electronic transactions, including eligibility inquiry, to develop a multi-payer provider web portal.

  The Information Management Division will maintain and enhance the Oracle Government Financials system to support the requirements of the agency and Commonwealth. Vendor upgrades to the software application will also be monitored and upgrades will be evaluated, scheduled, and performed as needed.

  The Information Management Division will continue to maintain the network infrastructure, servers, desktop hardware and software used by DMAS staff. Upgrades to IT resources will be evaluated, recommended, procured, and applied as needed to meet DMAS' mission and changing technology.

- *Current IT Services:*

  Estimated Ongoing Operations and Maintenance Costs for Existing IT Investments

	Cost - Year 1		Cost - Year 2	
	General Fund	Non-general Fund	General Fund	Non-general Fund
Projected Service Fees	$1,333,266	$1,142,070	$1,353,265	$1,159,201
Changes (+/-) to VITA Infrastructure	$0	$0	$0	$0
Estimated VITA Infrastructure	$1,333,266	$1,142,070	$1,353,265	$1,159,201
Specialized Infrastructure	$574,368	$574,368	$597,343	$597,343
Agency IT Staff	$0	$0	$0	$0
Non-agency IT Staff	$0	$0	$0	$0
Other Application Costs	$3,093,010	$7,369,704	$3,232,934	$7,713,102
Agency IT Current Services	$5,000,644	$9,086,142	$5,183,542	$9,469,646

  Comments:

  [Nothing entered]

- *Proposed IT Investments*

Estimated Costs for Projects and New IT Investments

	Cost - Year 1		Cost - Year 2	
	General Fund	Non-general Fund	General Fund	Non-general Fund
Major IT Projects	$805,381	$2,191,142	$2,698,889	$8,951,668
Non-major IT Projects	$227,913	$498,165	$128,135	$120,260
Agency-level IT Projects	$0	$0	$0	$0
Major Stand Alone IT Procurements	$0	$0	$0	$0
Non-major Stand Alone IT Procurements	$312,500	$312,500	$460,000	$460,000
Total Proposed IT Investments	$1,345,794	$3,001,807	$3,287,024	$9,531,928

- *Projected Total IT Budget*

	Cost - Year 1		Cost - Year 2	
	General Fund	Non-general Fund	General Fund	Non-general Fund
Current IT Services	$5,000,644	$9,086,142	$5,183,542	$9,469,646
Proposed IT Investments	$1,345,794	$3,001,807	$3,287,024	$9,531,928
Total	$6,346,438	$12,087,949	$8,470,566	$19,001,574

Appendix A - Agency's information technology investment detail maintained in VITA's ProSight system.

Capital

- *Current State of Capital Investments:*
  [Nothing entered]
- *Factors Impacting Capital Investments:*
  [Nothing entered]
- *Capital Investments Alignment:*
  [Nothing entered]

Agency Goals

Goal 1

Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

Goal Summary and Alignment

The mission of the Department of Medical Assistance Services (DMAS) is to provide eligible individuals with access to needed health care. DMAS plays an important role in providing this access and in influencing policies that extend access to those most in need.

Goal Alignment to Statewide Goals

- Inspire and support Virginians toward healthy lives and strong and resilient families.

Goal 2

Promote better health outcomes through prevention-based strategies and improved quality of care.

Goal Summary and Alignment

Although DMAS does not directly provide health care services, it does have a role in ensuring that those who are eligible for its services receive quality health care. DMAS believes that a focus on prevention-based strategies will reap positive health benefits for its clients and sound fiscal benefits for taxpayers.

Goal Alignment to Statewide Goals

- Inspire and support Virginians toward healthy lives and strong and resilient families.

Goal 3

Enhance the delivery of health care services by improving communication and relationships with customers and partners.

Goal Summary and Alignment

Effective communication is vital to ensure that DMAS' partners understand the administrative/legal aspects of DMAS services, as well as the outcomes DMAS is striving to achieve on behalf of its clients. Equally important is the dissemination of information to eligible and enrolled individuals who ultimately benefit from these important services.

Goal Alignment to Statewide Goals

- Inspire and support Virginians toward healthy lives and strong and resilient families.

Goal 4

Create a positive work environment that promotes staff development and training, facilitates effective communications and rewards high levels of performance.

Goal Summary and Alignment

A good work environment helps to create satisfied employees who, in turn, create satisfied customers and partners.

DMAS strives to provide the best possible work environment for its staff members by recognizing accomplishments, expanding the knowledge base of staff members and maintaining open lines of communication to ensure the workforce has the information it needs to effectively accomplish the organization's goals.

Goal Alignment to Statewide Goals

- Be recognized as the best-managed state in the nation.

Goal 5

Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

Goal Summary and Alignment

DMAS is responsible for managing a multi-billion dollar enterprise. Sound fiscal management and strict compliance with accepted financial standards and controls is essential for protecting these resources. DMAS will continue to rigorously examine the way it operates to reduce waste and to prevent fraud and abuse.

Goal Alignment to Statewide Goals

- Be recognized as the best-managed state in the nation.

Goal 6

Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.

Goal Summary and Alignment

A hallmark of any well-managed organization is its desire to continually examine the way it works in order to find ways to improve effectiveness and efficiency. To accomplish this, DMAS will search for best practices within and outside of the health care industry and state government and will strive to develop innovative approaches for delivering services to its clients.

Goal Alignment to Statewide Goals

- Be recognized as the best-managed state in the nation.

Goal 7

Encouraging support of minority business development throughout the Commonwealth and strive to continue improving direct and indirect minority business relationships in the future.

Goal Summary and Alignment

Executive Order 33 (2006) directs cabinet secretaries and all executive branch entities to increase small, women and minority-owned business participation throughout the Commonwealth. DMAS - in its Annual SWaM Procurement Plan - set a goal of 50% SWaM participation overall (5% with prime contractors and 45% with subcontractors). The agency will continue to seek out SWaM vendors as procurement opportunities arise.

Goal Alignment to Statewide Goals

- Be recognized as the best-managed state in the nation.

Goal 8

We will strengthen the culture of preparedness across state agencies, their employees and customers.

Goal Summary and Alignment

This goal ensures compliance with federal and state regulations, polices and procedures for Commonwealth preparedness, as well as guidelines promulgated by the Assistant to the Governor for Commonwealth Preparedness, in collaboration with the Governor's Cabinet, the Commonwealth Preparedness Working Group, the Department of Planning and Budget and the Council on Virginia's Future.

Goal Alignment to Statewide Goals

- Protect the public's safety and security, ensuring a fair and effective system of justice and providing a prepared response to emergencies and disasters of all kinds.

Service Area Strategic Plan

Department of Medical Assistance Services (602) 3/13/2014 8:56 am

Biennium: 2008-10

Service Area 1 of 13

Reimbursements for Medical Services Related to Involuntary Mental Commitments (602 321 07)

Description

An Involuntary Mental Commitment, also known as a Temporary Detention Order (TDO), is the detainment of an individual who a) has been determined to be mentally ill and in need of hospitalization, b) presents an imminent danger to self or others as result of the mental illness or is so seriously mentally ill as to be substantially unable to care for self, and c) is incapable of volunteering or unwilling to volunteer for treatment. A magistrate issues the TDO. The duration of the order shall not exceed 48 hours prior to a commitment hearing. If the 48-hour period terminates on a Saturday, Sunday or legal holiday, such person may be detained until the next business day.

DMAS determines the allowable eligibility period for the client who is under an involuntary mental commitment and enrolls the client in the involuntary mental commitment program. DMAS ensures that all other available payment resources have been exhausted prior to payment by this program, which is funded only through state funds. Once this is completed, DMAS processes and adjudicates claims for the allowable services provided to clients under an involuntary mental commitment.

Background Information

Mission Alignment and Authority

- *Describe how this service supports the agency mission*
  This service area is in line with DMAS' mission to provide access to a comprehensive system of high quality and cost effective health care services to qualifying Virginians. By ensuring that appropriate services are provided to eligible persons, DMAS provides access to needed care for this population of clients.
- *Describe the Statutory Authority of this Service*
  Code of Virginia §37.1 – 67.4: This section provides the process for an individual who is in danger of harming himself/herself or others to have a mental health evaluation to determine the correct plan of action and treatment. Should this evaluation result in the issuance of an involuntary detention order, the timeframe for the detainment is outlined and the payer of the services provided during the detention is identified.

Customers

Agency Customer Group	Customer	Customers served annually	Potential annual customers
Involuntary Mental Commitment Fund	Beneficiaries / Clients	8,600	0

Anticipated Changes To Agency Customer Base
The number of clients placed under an involuntary mental commitment has remained relatively constant over the past five years and no significant change in this population is anticipated at this time.

Partners

Partner	Description
Health care professionals, organizations, and facilities	
Private business firms	
State and local entities	
State government officials	

Products and Services

- *Factors Impacting the Products and/or Services:*
  Provider knowledge of the involuntary commitment process and the timely filing of claims for their services impacts whether these services are used.

  In addition, DMAS has received ongoing concerns regarding the lack of providers willing to accept and treat TDO clients within their facilities. DMAS' responsibility for this program does not encompass the process of placing TDOs within facilities; however, the lack of access for these services does impact the amount of expenditures incurred for this program.
- *Anticipated Changes to the Products and/or Services*
  No changes are anticipated, unless there is legislative action that would increase or decrease the services.
- *Listing of Products and/or Services*
  - Operations (Enrollment & Member Services) – Determination of the involuntary mental commitment eligibility and enrollment for providers and clients
  - Operations (Provider Enrollment, Services and Reimbursement) – Determination of the per diem rate of reimbursement for all services provided
  - Operations (Health Care Services) – Coverage for involuntary mental commitment services

Finance

- *Financial Overview*
  The Involuntary Mental Commitment program is funded 100% with state General Fund.

  The budget for FY 2009 and 2010 is the FY 2008 Base Budget appropriation (as reflected in Chapter 847 of the Appropriation Act) plus changes incorporated during the 2008 General Assembly spring session (that resulted in Chapter 879 of the 2008 Appropriation Act).
- *Financial Breakdown*

FY 2009		FY 2010		FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	F 20
General	Nongeneral	General	Nongeneral																

	Fund	Fund	Fund	Fund
Base Budget	$11,549,689	$0	$11,549,689	$0
Change To Base	-$1,020,313	$0	-$796,166	$0
Service Area Total	$10,529,376	$0	$10,753,523	$0
Base Budget	$11,549,689	$0	$11,549,689	$0
Change To Base	-$1,020,313	$0	-$796,166	$0
Service Area Total	$10,529,376	$0	$10,753,523	$0
Base Budget	$11,549,689	$0	$11,549,689	$0
Change To Base	-$1,020,313	$0	-$796,166	$0
Service Area Total	$10,529,376	$0	$10,753,523	$0
Base Budget	$11,549,689	$0	$11,549,689	$0
Change To Base	-$1,020,313	$0	-$796,166	$0
Service Area Total	$10,529,376	$0	$10,753,523	$0
Base Budget	$11,549,689	$0	$11,549,689	$0
Change To Base	-$1,020,313	$0	-$796,166	$0
Service Area Total	$10,529,376	$0	$10,753,523	$0
Base Budget	$11,549,689	$0	$11,549,689	$0
Change To Base	-$1,020,313	$0	-$796,166	$0
Service Area Total	$10,529,376	$0	$10,753,523	$0
Base Budget	$11,549,689	$0	$11,549,689	$0
Change To Base	-$1,020,313	$0	-$796,166	$0
Service Area Total	$10,529,376	$0	$10,753,523	$0
Base Budget	$11,549,689	$0	$11,549,689	$0
Change To Base	-$1,020,313	$0	-$796,166	$0
Service Area Total	$10,529,376	$0	$10,753,523	$0
Base Budget	$11,549,689	$0	$11,549,689	$0
Change To Base	-$1,020,313	$0	-$796,166	$0
Service				

Area Total	$10,529,376	$0	$10,753,523	$0
Base Budget	$11,549,689	$0	$11,549,689	$0
Change To Base	-$1,020,313	$0	-$796,166	$0
Service Area Total	$10,529,376	$0	$10,753,523	$0
Base Budget	$11,549,689	$0	$11,549,689	$0
Change To Base	-$1,020,313	$0	-$796,166	$0
Service Area Total	$10,529,376	$0	$10,753,523	$0
Base Budget	$11,549,689	$0	$11,549,689	$0
Change To Base	-$1,020,313	$0	-$796,166	$0
Service Area Total	$10,529,376	$0	$10,753,523	$0
Base Budget	$11,549,689	$0	$11,549,689	$0
Change To Base	-$1,020,313	$0	-$796,166	$0
Service Area Total	$10,529,376	$0	$10,753,523	$0

Human Resources

- *Human Resources Overview*
  [Nothing entered]
- *Human Resource Levels*

Effective Date		
Total Authorized Position level	0	
Vacant Positions	0	
Current Employment Level	**0.0**	
Non-Classified (Filled)		
Full-Time Classified (Filled)		*breakout of Current Employment Level*
Part-Time Classified (Filled)		
Faculty (Filled)		
Wage		
Contract Employees		
Total Human Resource Level	**0.0**	*= Current Employment Level + Wage and Contract Employees*

- *Factors Impacting HR*
  [Nothing entered]
- *Anticipated HR Changes*
  [Nothing entered]

Service Area Objectives

- Ensure that providers that are treating TDO clients continue to be compensated for the allowable services they provide and ensure that these services are within the timeframe of the commitment order.

  Objective Description

  Provide reimbursement for the services provided to the client who is detained under the involuntary mental commitment.

  Alignment to Agency Goals

  - Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

    Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families.

  Objective Strategies

- Revise and update TDO billing instructions. • Provide training for providers on the TDO process and responsibility. • Revise the inpatient activity and outpatient activity, professional and locality court reports to include year-to-date information as well as the recent month data that is currently shown.

Link to State Strategy

- nothing linked

Objective Measures

- Percentage of accurate reimbursement payments processed within 30 calendar days of receipt at DMAS

  Measure Class: Other Measure Type: Outcome Measure Frequency: Quarterly Preferred Trend: Maintain

  Measure Baseline Value: 92 Date: 6/30/2008

  Measure Baseline Description: 92% in FY 2008

  Measure Target Value: 94 Date: 6/30/2010

  Measure Target Description: 94% in FY 2009 & 2010

  Data Source and Calculation: VaMMIS reports and a manual staff log will be used to capture the date a clean claim was received at DMAS, Julian date of processing by First Health, date adjudicated for payment, and actual remittance advice date.

Service Area Strategic Plan

Department of Medical Assistance Services (602) 3/13/2014 8:56 am

Biennium: 2008-10

Service Area 2 of 13

Reimbursements for Medical Services Provided Under the Family Access to Medical Insurance Security Plan (602 446 02)

Description

The Family Access to Medical Insurance Security (FAMIS) program is part of Virginia's Title XXI program for uninsured children and pregnant women living below 200% and 166% of the federal poverty level (FPL) respectively. The FAMIS program provides access to comprehensive health care services for qualifying children through a benefit plan modeled on the state-employee health plan in areas where a contracted managed care organization is available; and through a Medicaid look-alike benefit plan in fee-for-service areas. FAMIS requires family cost sharing through co-payments for services and provides a premium assistance option for private/employer-sponsored insurance.

Background Information

Mission Alignment and Authority

- *Describe how this service supports the agency mission*
  FAMIS carries out the mission of DMAS by providing access to a comprehensive system of high quality and cost effective health care services to uninsured children whose families earn too much to qualify for Medicaid but too little to afford private health insurance.
- *Describe the Statutory Authority of this Service*
  Statutory Authority
  CFR: 42 part 457
  §32.1-351 Code of Virginia

Customers

Agency Customer Group	Customer	Customers served annually	Potential annual customers
Medicaid (adults) and FAMIS Plus (children)	Uninsured children under 19 with family income >133% FPL (federal poverty level) and < 200% FPL*	71,589	0
Medicaid (adults) and FAMIS Plus (children)	Uninsured pregnant women with income > 133% FPL and < 185% FPL**	631	700

Anticipated Changes To Agency Customer Base
The customer base of children eligible for the FAMIS program is likely to remain approximately the same for the next several years. Factors that could affect the number of customers would include a downturn in the Virginia economy, private insurance market forces that result in an increase in rates of uninsurance, a significant increase in the under 19 population, or policy changes affecting program eligibility.

The customer base for the new FAMIS MOMS program for pregnant women is likely to grow in the next few years as the program matures. Similar to FAMIS, economic and population demographics will also impact the customer base for FAMIS MOMS.

Footnotes to Customer Base Listing Tab:
* Number of children served in FAMIS at any time in FY 2007. It is currently estimated that approximately 16,000 children could qualify for Medicaid (FAMIS Plus) or FAMIS but are not enrolled. It is unknown how many of these children would qualify solely for FAMIS.

**The number of pregnant women served in FAMIS MOMS at any time in FY 2007 from August 1, 2005 through July 1, 2006.

Partners

Partner	Description
Advocacy groups	
Boards and committees	
Federal agencies	
Health care professionals, organizations, and facilities	
Private business firms	
State and local entities	
State government officials	

Products and Services

- *Factors Impacting the Products and/or Services:*
  Federal and state appropriations and regulations impact the nature and scope of the services than can be provided through FAMIS. Unlike Medicaid, FAMIS is not an entitlement program
- *Anticipated Changes to the Products and/or Services*
  Congress must reauthorize Title XXI no later than September 30, 2007. It is likely the federal funding formula that determines Virginia's annual allotment will be revised.
- *Listing of Products and/or Services*
  - FAMIS & FAMIS MOMS Coverage for comprehensive health care services through managed care or fee-for-service Marketing and outreach to promote enrollment Application processing and enrollment Claims payment

Finance

- *Financial Overview*
  Non General Funds in FY2009 and FY2010 is comprised of Federal Funds and the Family Access to Medical Insurance Plan Trust Fund.

The budget for FY 2009 and 2010 is the FY 2008 Base Budget appropriation (as reflected in Chapter 847 of the Appropriation Act) plus changes incorporated during the 2008 General Assembly spring session (that resulted in Chapter 879 of the 2008 Appropriation Act).

- *Financial Breakdown*

FY 2009 FY 2010 FY 2009 FY 2010 FY 2009 FY 2010 FY 2009 FY 2010 FY 2009 FY 2010 FY 2009 FY 2010 FY 2009 FY 2010 FY 2009

	FY 2009		FY 2010	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$20,862,022	$79,009,414	$20,862,022	$79,009,414
Change To Base	$6,193,707	$11,424,446	$12,339,874	$22,838,757
Service Area Total	$27,055,729	$90,433,860	$33,201,896	$101,848,171
Base Budget	$20,862,022	$79,009,414	$20,862,022	$79,009,414
Change To Base	$6,193,707	$11,424,446	$12,339,874	$22,838,757
Service Area Total	$27,055,729	$90,433,860	$33,201,896	$101,848,171
Base Budget	$20,862,022	$79,009,414	$20,862,022	$79,009,414
Change To Base	$6,193,707	$11,424,446	$12,339,874	$22,838,757
Service Area Total	$27,055,729	$90,433,860	$33,201,896	$101,848,171
Base Budget	$20,862,022	$79,009,414	$20,862,022	$79,009,414
Change To Base	$6,193,707	$11,424,446	$12,339,874	$22,838,757
Service Area Total	$27,055,729	$90,433,860	$33,201,896	$101,848,171
Base Budget	$20,862,022	$79,009,414	$20,862,022	$79,009,414
Change To Base	$6,193,707	$11,424,446	$12,339,874	$22,838,757
Service Area Total	$27,055,729	$90,433,860	$33,201,896	$101,848,171
Base Budget	$20,862,022	$79,009,414	$20,862,022	$79,009,414
Change To Base	$6,193,707	$11,424,446	$12,339,874	$22,838,757
Service Area Total	$27,055,729	$90,433,860	$33,201,896	$101,848,171
Base Budget	$20,862,022	$79,009,414	$20,862,022	$79,009,414
Change To Base	$6,193,707	$11,424,446	$12,339,874	$22,838,757
Service Area	$27,055,729	$90,433,860	$33,201,896	$101,848,171

Total				
Base Budget	$20,862,022	$79,009,414	$20,862,022	$79,009,414
Change To Base	$6,193,707	$11,424,446	$12,339,874	$22,838,757

Service Area Total	$27,055,729	$90,433,860	$33,201,896	$101,848,171
Base Budget	$20,862,022	$79,009,414	$20,862,022	$79,009,414
Change To Base	$6,193,707	$11,424,446	$12,339,874	$22,838,757

Service Area Total	$27,055,729	$90,433,860	$33,201,896	$101,848,171
Base Budget	$20,862,022	$79,009,414	$20,862,022	$79,009,414
Change To Base	$6,193,707	$11,424,446	$12,339,874	$22,838,757

Service Area Total	$27,055,729	$90,433,860	$33,201,896	$101,848,171
Base Budget	$20,862,022	$79,009,414	$20,862,022	$79,009,414
Change To Base	$6,193,707	$11,424,446	$12,339,874	$22,838,757

Service Area Total	$27,055,729	$90,433,860	$33,201,896	$101,848,171

Human Resources

- *Human Resources Overview*
  [Nothing entered]
- *Human Resource Levels*

Effective Date		
Total Authorized Position level	0	
Vacant Positions	0	
Current Employment Level	**0.0**	
Non-Classified (Filled)		*breakout of Current Employment Level*
Full-Time Classified (Filled)		
Part-Time Classified (Filled)		
Faculty (Filled)		
Wage		
Contract Employees		
Total Human Resource Level	**0.0**	*= Current Employment Level + Wage and Contract Employees*

- *Factors Impacting HR*
  [Nothing entered]
- *Anticipated HR Changes*
  [Nothing entered]

Service Area Objectives

- We will work to improve the immunization rate among Medicaid and FAMIS children by increasing the percentage of two year olds in Medicaid and FAMIS who are fully immunized

  Objective Description

  This objective will focus DMAS' efforts to improve health outcomes for children and reduce long-term health care costs by improving the timely and appropriate utilization of preventive health care services. The American Academy of Pediatrics (AAP) recommends that children visit their pediatrician for a well- child check-up as a newborn, by one month, at two, four, six, nine, twelve, fifteen, eighteen, and twenty-four months, and once a year from ages three to twenty-one. Well-child care for infants are of particular importance during the first year of life, when an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination and social and emotional growth. The American Academy of Pediatrics (AAP) also recommends six well-child visits in the first year of life: the first within the first month of life, and then at around 2, 4, 6, 9, and 12 months of age. Comprehensive well child exam documentation measures the percentage of children who had one, two, three, four, five, six or more well-child visits by the time they turned 15 months of age.

  Alignment to Agency Goals

- Agency Goal: Promote better health outcomes through prevention-based strategies and improved quality of care.

  Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families.

Objective Strategies

- Continue to promote appropriate childhood immunizations for the FAMIS population. • Promote utilization of well child check-ups covered by the FAMIS plan and remind providers of the importance of regular checkups, immunizations, and the coordination of information among providers. • Promote utilization of preventive pediatric dental visits by the FAMIS population.

Link to State Strategy

- nothing linked

Objective Measures

- Percentage of two year olds in FAMIS who are fully immunized

  Measure Class: Agency Key Measure Type: Outcome Measure Frequency: Annual Preferred Trend: Up

  Frequency Comment: Data results for the fiscal year are available by January

  Measure Baseline Value: 89.6 Date: 6/30/2005

  Measure Baseline Description: 89.6% in Fiscal Year (FY) 2005

  Measure Target Value: 92 Date: 6/30/2010

  Measure Target Description: 92% in FY's 2008, 2009 & 2010

  Data Source and Calculation: Each calendar year, the Department of Medical Assistance Services (DMAS) contracted external quality review organization (EQRO) collects, synthesizes, and reports immunization rates among children age 2 years old. Calculation: The EQRO uses the methodology that the National Committee for Quality Assurance (NCQA) delineates each year through its published technical specifications. The technical specifications for the childhood immunization rate consistently require the use of administrative data and medical record abstraction for calculating the rates. The immunization rate for a particular year actually reflects the preceding year's of service. For example, the 2008 immunization rate reflects the percentage of enrollees who turned age 2 during 2007 and who were fully immunized by their second birthday. The work of the EQRO is monitored by the Division of Health Care Services, DMAS. The immunization rate is available at or around the end of each calendar year.

- We will work to increase the utilization of appropriate preventative care of FAMIS and FAMIS Plus (Medicaid) enrolled children

Objective Description

This objective will focus DMAS' efforts to improve utilization of well child check-ups covered by the FAMIS plan and remind providers of the importance of regular checkups, immunizations, and the coordination of information among providers

Alignment to Agency Goals

- Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  Comment: Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families.

Objective Strategies

- Promote utilization of well child check-ups by the FAMIS population.

Link to State Strategy

- nothing linked

Objective Measures

- Percentage of 15 months-old children enrolled in the FAMIS program who received the recommended number of well-child screenings

  Measure Class: Agency Key Measure Type: Outcome Measure Frequency: Annual Preferred Trend: Up

  Frequency Comment: Data results for the State Fiscal Year are available by December

  Measure Baseline Value: 51 Date: 6/30/2005

  Measure Baseline Description: 51% for Fiscal Year (FY) 2005

  Measure Target Value: 53 Date: 6/30/2010

  Measure Target Description: Target was modified from 70% to 53% for FY 2010 due to methodology changes

  Data Source and Calculation: Source/Method: As determined from clinical review of a representative sample of medical records performed by the State's External Quality Review Organization (EQRO). The EQRO follows the methodology specified in current national HEDIS (Health Plan Employer Data and Information Set) reporting guidelines. The reported measure is the "participant ratio" or percentage of children eligible for a well-child screening who received at least one screening during the reporting period. This results in a measure of the percentage of children who received a well child visit. The target represents the 2008 National HEDIS Medicaid Mean.

- Percentage of 3-6 year-old children enrolled in the FAMIS program (Separate CHIP) who received the recommended number of well-child screenings

  Measure Class: Agency Key Measure Type: Outcome Measure Frequency: Annual Preferred Trend: Up

  Frequency Comment: Data results for the State Fiscal Year are available by December

  Measure Baseline Value: 61.5 Date: 6/30/2008

  Measure Baseline Description: 61.5% in Fiscal Year (FY) 2008

  Measure Target Value: 62 Date: 6/30/2010

  Measure Target Description: 62% in FY 2010

  Data Source and Calculation: Source/Method: As determined from clinical review of a representative sample of medical records performed by the State's External Quality Review Organization (EQRO). The EQRO follows the methodology specified in current national Health Employer Data and Information Set (HEDIS) reporting guidelines. The reported measure is the “participant ratio” or percentage of children eligible for a well-child screening who received at least one screening during the reporting period. This results in a measure of the percentage of children who received a well child visit.

- We will work to improve the oral health and increase the utilization of appropriate preventative care of FAMIS and FAMIS Plus (Medicaid) enrolled children

  Objective Description

  This objective will focus DMAS' efforts to improve oral health outcomes for children and reduce long-term health care costs by improving the timely and appropriate utilization of preventive health care services.

  Alignment to Agency Goals

  - Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

    Comment: Council on Virginia’s Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families.

  Objective Strategies

  - Promote utilization of preventive pediatric dental visits by the FAMIS population.

  Link to State Strategy

  - nothing linked

  Objective Measures

  - Percentage of enrolled children who utilize dental services

    Measure Class: Agency Key Measure Type: Outcome Measure Frequency: Annual Preferred Trend: Up

    Frequency Comment: There is a six months claims lag associated with the data. The final report is run six months after the last date of the reporting period.

    Measure Baseline Value: 35.93 Date: 6/30/2006

    Measure Baseline Description: 35.93% for Fiscal Year (FY) 2006

    Measure Target Value: 40 Date: 6/30/2010

    Measure Target Description: 40% for FY's 2008, 2009 & 2010

    Data Source and Calculation: Source: Department of Medical Assistance Services (DMAS) claims data are utilized to determine the number of children covered by Family Access to Medical Insurance Security Plan (FAMIS) or FAMIS Plus between the age of three and twenty-one receiving routine dental care visits. Calculation: This number is divided by the number of children in this age group enrolled in the program. The quarterly numbers are cumulative and calculated towards an annual percentage of children utilizing dental services. Due to the claim process, final results lag the closing period by about six months.

- Enroll all eligible children in the FAMIS and FAMIS Plus (Medicaid) programs

  Objective Description

  While enrollment of eligible children in the FAMIS program has increased dramatically, there are still uninsured children who could be covered and additional children who become uninsured every day. It is in the best interest of the children, their families and the Commonwealth to provide comprehensive health care coverage through the FAMIS program to this vulnerable population.

  Alignment to Agency Goals

  - Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

    Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families.

  Objective Strategies

  - Develop and implement a general marketing campaign specifically designed to retain current children and reach families with FAMIS eligible children. • Develop outreach activities and materials to reach traditionally “hard-to-reach” populations. • Increase the use of technology to improve customer service for interested families and to

facilitate application processing and enrollment.

Link to State Strategy

- nothing linked

Objective Measures

- Number of eligible children enrolled in FAMIS (Separate CHIP) program

  Measure Class: Other Measure Type: Output Measure Frequency: Quarterly Preferred Trend: Up

  Measure Baseline Value: 416548 Date: 6/30/2005

  Measure Baseline Description: 416,548 in FY 2005

  Measure Target Value: 430878 Date: 6/30/2008

  Measure Target Description: 430,878 in FY's 2008, 2009 & 2010

  Data Source and Calculation: Data from Virginia Medicaid Management Information System (VaMMIS) on the number of children enrolled on the first day of each month, following all cancellations that occur on the last day of each month, will be reported. Applicable children are in Family Access to Medical Insurance Security Plan (FAMIS) and the Medicaid aid category numbers:06,07,08,09

Service Area Strategic Plan

Department of Medical Assistance Services (602) 3/13/2014 8:56 am

Biennium: 2008-10

Service Area 3 of 13

Reimbursements to State-Owned Mental Health and Mental Retardation Facilities (602 456 07)

Description

The service area reimburses facilities owned and operated by the Department of Mental Health and Mental Retardation and Substance Abuse Services (DMHMRSAS) for medically necessary services provided to Medicaid eligible recipients residing in these facilities.

The DMHMRSAS operates 15 state mental health or mental retardation facilities that provide highly structured intensive inpatient treatment and habilitation services. The state mental health facilities provide a range of psychiatric, psychological, psychosocial rehabilitation, nursing, support, and ancillary services. The mental retardation training centers provide residential care and training in areas such as language, self-care, independent living, socialization, academic skills, and motor development. The Hiram Davis Medical Center provides medical care to state facility patients and residents.

DMAS works in partnership with the DMHMRSAS to ensure that services are medically necessary, provided in the most appropriate setting and that the reimbursement rates are sufficient to help maintain the financial viability of these state owned facilities.

Background Information

Mission Alignment and Authority

- *Describe how this service supports the agency mission*
  By providing coverage for the services provided through the Commonwealth's public MHMR facilities we are ensuring access to needed medical care for a vulnerable population.
- *Describe the Statutory Authority of this Service*
  Federal Legislation: Title XIX of the Social Security Act
  CFR: 42 part 440
  Code of Virginia: Chapter 32.1, Chapter 10

Customers

Agency Customer Group	Customer	Customers served annually	Potential annual customers
	Beneficiaries / Clients: Low-income, Aged, and Disabled Virginians with Mental Health/Mental Retardation Diagnoses	2,537	0

Anticipated Changes To Agency Customer Base
The average daily census at Virginia's state mental health facilities and state mental retardation training centers has declined steadily over the past 30 years due to various facility discharge and diversion projects and the increased use of atypical antipsychotic medications. This trend is evident in the Medicaid-funded utilization, which has declined 61 percent at state mental health facilities and 16 percent at state mental retardation training centers over the past ten years. In fiscal year 2007, the Virginia Medicaid program covered treatment services for 1,055 residents of state mental health facilities and 1,482 residents of state mental retardation training centers*. This represents a five percent decline over the 2,673 individuals served in fiscal year 2006.

Footnote to Service Area Customer Base Listing tab:
During the 2009-2010 biennium it is estimated there will be between 850,000 to 1,000,000 individuals enrolled in the Medicaid Program at some point during each fiscal year.

Partners

Partner	Description
Advocacy groups	
Federal agencies	
Health care professionals, organizations, and facilities	
Private business firms	
State and local entities	
State government officials	

Products and Services

- *Factors Impacting the Products and/or Services:*
  Federal regulations limit the types of individuals who are eligible to receive Medicaid coverage in Institutions for Mental Disease (IMD). The CFR prohibits covering individuals between age 22 through age 64 while residing in an IMD. This does not apply to individuals diagnosed with Mental Retardation.

  Total reimbursement to the facilities is limited by State appropriations.
- *Anticipated Changes to the Products and/or Services*
  It is anticipated that services will decrease in accord with the trend of a declining population.
- *Listing of Products and/or Services*
  - Operations (Health Care Services) – Coverage of Mental Health and Mental Retardation Health Care Services
  - Operations (Financial Services) – Rate Setting/Cost Analysis
  - Operations (Provider Enrollment, Services and Reimbursement) – Claims Payments; Prior Authorization

Finance

- *Financial Overview*
  Funding for the services is covered through the Medicaid program.

The budget for FY 2009 and 2010 is the FY 2008 Base Budget appropriation (as reflected in Chapter 847 of the Appropriation Act) plus changes incorporated during the 2008 General Assembly spring session (that resulted in Chapter 879 of the 2008 Appropriation Act).

- *Financial Breakdown*

	FY 2009		FY 2010	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Change To Base	$0	$0	$0	$0
Service Area Total	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Base Budget	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Change To Base	$0	$0	$0	$0
Service Area Total	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Base Budget	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Change To Base	$0	$0	$0	$0
Service Area Total	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Base Budget	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Change To Base	$0	$0	$0	$0
Service Area Total	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Base Budget	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Change To Base	$0	$0	$0	$0
Service Area Total	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Base Budget	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Change To Base	$0	$0	$0	$0
Service Area Total	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Base Budget	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Change To Base	$0	$0	$0	$0
Service Area Total	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Base Budget	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Change To Base	$0	$0	$0	$0
Service Area Total	$101,564,490	$101,564,490	$101,564,490	$101,564,490

FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 200

Base Budget	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Change To Base	$0	$0	$0	$0
Service Area Total	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Base Budget	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Change To Base	$0	$0	$0	$0
Service Area Total	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Base Budget	$101,564,490	$101,564,490	$101,564,490	$101,564,490
Change To Base	$0	$0	$0	$0
Service Area Total	$101,564,490	$101,564,490	$101,564,490	$101,564,490

Human Resources

- *Human Resources Overview*
  [Nothing entered]
- *Human Resource Levels*

Effective Date		
Total Authorized Position level	0	
Vacant Positions	0	
Current Employment Level	**0.0**	
Non-Classified (Filled)		
Full-Time Classified (Filled)		*breakout of Current Employment Level*
Part-Time Classified (Filled)		
Faculty (Filled)		
Wage		
Contract Employees		
Total Human Resource Level	**0.0**	*= Current Employment Level + Wage and Contract Employees*

- *Factors Impacting HR*
  [Nothing entered]
- *Anticipated HR Changes*
  [Nothing entered]

Service Area Objectives

- To ensure appropriate and timely Medicaid funding of services provided to Medicaid eligible individuals in the Department of Behavioral Health and Development Services (DBHDS) facilities.

  Objective Description

  It is DMAS' responsibility to provide Medicaid payments to DBHDS facilities, expending the state funds that are provided for this purpose and ensuring maximum feasible federal funding to the facilities.

  Alignment to Agency Goals

  - Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

    Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families.

  Objective Strategies

  - Monitor payments to the facilities throughout the year to ensure the state appropriated funds are all paid. • Perform an upper payment limit calculation and carry out a "certification" to draw down the maximum available federal funds.

  Link to State Strategy

  - nothing linked

  Objective Measures

  - Percentage of federal funds that are reimbursed to the Department of Behavioral Health and Development Services (DBHDS)

Measure Class: Other Measure Type: Outcome Measure Frequency: Quarterly Preferred Trend: Maintain

Measure Baseline Value: 99.9 Date: 6/30/2005

Measure Baseline Description: 99.9% in FY 2005

Measure Target Value: 99 Date: 6/30/2008

Measure Target Description: 99% in FY's 2008, 2009 & 2010

Data Source and Calculation: Source: DMAS (Department of Medical Assistance Services) generated expenditure report from CARS (Commonwealth Accounting & Reporting System) for Fund 1000 (federal funds) and program 45607 (for DBHDS). Budgeted/appropriated amounts used for determining the percentage used is obtained from the applicable year of the State Appropriation Act. Calculation: Federal program expenditures are divided by the applicable appropriation to determine a percentage of funds used.

- Percentage of state funds that are reimbursed to the Department of Behavioral Health and Development (DBHDS

Measure Class: Other Measure Type: Outcome Measure Frequency: Quarterly Preferred Trend: Maintain

Measure Baseline Value: 99.9 Date: 6/30/2005

Measure Baseline Description: 99.9% in FY 2005

Measure Target Value: 99 Date: 6/30/2008

Measure Target Description: 99% in FY's 2008, 2009 & 2010

Data Source and Calculation: Source: DMAS (Department of Medical Assistance Services) generated expenditure report from CARS (Commonwealth Accounting & Reporting System) for Fund 0100 (State funds) and program 45607 (for Department of Behavioral Health and Development services). Budgeted/appropriated amounts used for determining the percentage used are obtained from the applicable year of the State Appropriation Act. Calculation: State program expenditures are divided by the applicable appropriation to determine a percentage of funds used.

Service Area Strategic Plan

Department of Medical Assistance Services (602) 3/13/2014 8:56 am

Biennium: 2008-10

Service Area 4 of 13

Reimbursements for Mental Health and Mental Retardation Services (602 456 08)

Description

This service area reimburses providers, both public and private, for the treatment of mental illness, including long-term serious mental illness and short-term acute problems and for mental retardation case management services. Other mental retardation based services are provided in the long term care service area. Medicaid covers outpatient services, inpatient services under certain circumstances, and community-based mental health rehabilitative services to individuals who meet specified criteria for each service.

DMAS, in partnership with the DMHMRSAS, the Community Services Boards and community providers and advocates, continues to work to ensure access to needed MHMR services in the most appropriate setting.

Background Information

Mission Alignment and Authority

- *Describe how this service supports the agency mission*
  By providing coverage for these mental health and mental retardation case management services we are ensuring needed medical care for a vulnerable population
- *Describe the Statutory Authority of this Service*
  Federal Legislation: Title XIX of the Social Security Act
  CFR: 42, Part 440
  Code of Virginia: Chapter 32.1, Chapter 10

Customers

Agency Customer Group	Customer	Customers served annually	Potential annual customers
	Clients / Beneficiaries: Low-income, Aged, and Disabled Virginians with a MH/MR diagnosis	60,249	0

Anticipated Changes To Agency Customer Base
In fiscal year 2007, the Virginia Medicaid program covered fee-for-service inpatient treatment services for 334 residents in private mental health facilities and fee-for-service outpatient mental health services for 59,915 individuals. This represents a seven percent growth over the number of individuals served in fiscal year 2006. This growth is due to several factors including overall growth in enrollment in the Virginia Medicaid program and a trend towards community-based, rather than institutional treatment settings. These factors are likely to lead to continued growth in the number of individuals receiving Medicaid-covered mental health services.

In addition, as the population ages, the Medicaid program is likely to see an increasing number of individuals with mental illness who will require community-based services to enable them to reside avoid placement in a nursing home or assisted living facility.

Footnotes for Service Area Customer Base Listing tab: *During the 2009-2010 biennium it is estimated there will be between 850,000 to 1,000,000 individuals enrolled in the Medicaid program at some point during each fiscal year. All recipients are eligible for these services if they are medically necessary.

Partners

Partner	Description
Advocacy groups	
Boards and committees	
Federal agencies	
Health care professionals, organizations, and facilities	
Private business firms	
State and local entities	
State government officials Federal agencies State and local entities Private business firms Health care professionals, organizations, and facilities State government officials	

Products and Services

- *Factors Impacting the Products and/or Services:*
  Federal regulations, Virginia's State Plan and the Code of Virginia all address mental health services covered by Medicaid.

  In recent years there has been a significant increase in the number of mental health providers enrolled to participate in the Medicaid program.. This has increased access to the services and increased utilization.
- *Anticipated Changes to the Products and/or Services*
  Current trends toward new model of community-based care increase utilization of these services. In addition, current efforts are aimed at increasing flexibility to improve access.
- *Listing of Products and/or Services*
  - Operations (Health Care Services) - Coverage of Mental Health Care Services
  - Operations (Policy Analysis and Information Dissemination) - Establish policy and standards and disseminate information

- Operations (Financial Services) - Rate Setting and Financial Analysis
- Operations (Provider Enrollment, Services, And Reimbursement) - Claims processing and payment

Finance

- *Financial Overview*
  The budget for FY 2009 and 2010 is the FY 2008 Base Budget appropriation (as reflected in Chapter 847 of the Appropriation Act) plus changes incorporated during the 2008 General Assembly spring session (that resulted in Chapter 879 of the 2008 Appropriation Act).
- *Financial Breakdown*

	FY 2009		FY 2010		FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 200
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund															
Base Budget	$174,279,494	$174,279,495	$174,279,494	$174,279,495															
Change To Base	-$37,668,088	-$32,079,878	-$22,167,247	-$16,579,037															
Service Area Total	$136,611,406	$142,199,617	$152,112,247	$157,700,458															
Base Budget	$174,279,494	$174,279,495	$174,279,494	$174,279,495															
Change To Base	-$37,668,088	-$32,079,878	-$22,167,247	-$16,579,037															
Service Area Total	$136,611,406	$142,199,617	$152,112,247	$157,700,458															
Base Budget	$174,279,494	$174,279,495	$174,279,494	$174,279,495															
Change To Base	-$37,668,088	-$32,079,878	-$22,167,247	-$16,579,037															
Service Area Total	$136,611,406	$142,199,617	$152,112,247	$157,700,458															
Base Budget	$174,279,494	$174,279,495	$174,279,494	$174,279,495															
Change To Base	-$37,668,088	-$32,079,878	-$22,167,247	-$16,579,037															
Service Area Total	$136,611,406	$142,199,617	$152,112,247	$157,700,458															
Base Budget	$174,279,494	$174,279,495	$174,279,494	$174,279,495															
Change To Base	-$37,668,088	-$32,079,878	-$22,167,247	-$16,579,037															
Service Area Total	$136,611,406	$142,199,617	$152,112,247	$157,700,458															
Base Budget	$174,279,494	$174,279,495	$174,279,494	$174,279,495															
Change To Base	-$37,668,088	-$32,079,878	-$22,167,247	-$16,579,037															
Service Area Total	$136,611,406	$142,199,617	$152,112,247	$157,700,458															
Base Budget	$174,279,494	$174,279,495	$174,279,494	$174,279,495															
Change To Base	-$37,668,088	-$32,079,878	-$22,167,247	-$16,579,037															
Service Area Total	$136,611,406	$142,199,617	$152,112,247	$157,700,458															
Base Budget	$174,279,494	$174,279,495	$174,279,494	$174,279,495															
Change To																			

Base	-$37,668,088	-$32,079,878	-$22,167,247	-$16,579,037
Service Area Total	$136,611,406	$142,199,617	$152,112,247	$157,700,458
Base Budget	$174,279,494	$174,279,495	$174,279,494	$174,279,495
Change To Base	-$37,668,088	-$32,079,878	-$22,167,247	-$16,579,037
Service Area Total	$136,611,406	$142,199,617	$152,112,247	$157,700,458
Base Budget	$174,279,494	$174,279,495	$174,279,494	$174,279,495
Change To Base	-$37,668,088	-$32,079,878	-$22,167,247	-$16,579,037
Service Area Total	$136,611,406	$142,199,617	$152,112,247	$157,700,458

Human Resources

- *Human Resources Overview*
  [Nothing entered]
- *Human Resource Levels*

Effective Date		
Total Authorized Position level	0	
Vacant Positions	0	
Current Employment Level	**0.0**	
Non-Classified (Filled)		
Full-Time Classified (Filled)		*breakout of Current Employment Level*
Part-Time Classified (Filled)		
Faculty (Filled)		
Wage		
Contract Employees		
Total Human Resource Level	**0.0**	*= Current Employment Level + Wage and Contract Employees*

- *Factors Impacting HR*
  [Nothing entered]
- *Anticipated HR Changes*
  [Nothing entered]

Service Area Objectives

- Increase access to outpatient and community-based mental health services

  Objective Description

  Outpatient and community-based mental health services have proven to be a cost-effective alternative to inpatient placement and improve the quality of life for individuals in need of mental health treatment.

  Alignment to Agency Goals

  - Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

    Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families

  Objective Strategies

  - Continue to work with DMHMRSAS, the Community Service Boards, and community advocates and providers to identify barriers to access and implement changes to the extent allowed by federal and state regulations.

  Link to State Strategy

  - nothing linked

  Objective Measures

  - Percentage of community mental health service expenditures in relation to all mental health service expenditures

    Measure Class: Other Measure Type: Outcome Measure Frequency: Annual Preferred Trend: Up

    Measure Baseline Value: 70.6 Date: 6/30/2008

    Measure Baseline Description: Fiscal Year (FY) 2008 70.6%

    Measure Target Value: 75 Date: 6/30/2010

Measure Target Description: 73% in FY's 2008 and 2009 & 75% for 2010

Data Source and Calculation: Source: Department of Medical Assistance Services (DMAS) generated expenditure Commonwealth Accounting and Reporting System (CARS) report by applicable object codes. Calculation: Expenditures for community-based mental health services as a percentage of expenditures for all mental health services. Community-based Mental Health (MH) services costs are divided by all MH costs to determine an expense ratio.

Service Area Strategic Plan

Department of Medical Assistance Services (602) 3/13/2014 8:56 am

Biennium: 2008-10

Service Area 5 of 13

Reimbursements for Professional and Institutional Medical Services (602 456 09)

Description

This service area represents the largest single component of the Department's programs and activities, the Title XIX Medicaid program. The primary functions that the department performs in this area are: i) working with local departments of social services to enroll persons into the appropriate categories of eligibility; ii) providing support services to enrollees; iii) developing and maintaining provider networks and ensuring access to needed health services; iv) reimbursing providers for necessary and appropriate health care services; v) ensuring the program operates efficiently; and vi) developing new program features to improve the quality of care and control costs.

Background Information

Mission Alignment and Authority

- *Describe how this service supports the agency mission*
  By performing the functions within this service area, we are able to provide access to a comprehensive system of high quality and cost effective health care services to our customers.
- *Describe the Statutory Authority of this Service*
  Title XIX of the United States Code and Chapter 10 of Title 32.1 of the Code of Virginia

Customers

Agency Customer Group	Customer	Customers served annually	Potential annual customers
	Beneficiaries / Clients*	873,934	0

Anticipated Changes To Agency Customer Base
Approximately 87% of the DMAS customer base is served through the Medicaid program. The trends in enrollment growth are as follows: 6% in FY 2003, 9.1% in FY 2004; 7.6% in FY 2005; 4.9% in FY 2006; and a decrease of (0.4%) in FY 2007. The Department's 2006 consensus forecast projects 5% growth in FY 2009 based solely on historical trends.

In addition to average annual growth, the number of Virginians age 65 and older is projected to increase dramatically over the next ten years – over five times faster than the state's total population growth. This growth in turn will increase the number of individuals receiving Medicare premium assistance and long-term care services through Virginia's Medicaid program.

The increased ability of medical technology to prolong life will increase the department's customer base. Statistics show that the life expectancy at age 65 has increased 12% for males and 3% for females since 1980.

Outreach efforts to enroll additional children in FAMIS or Medicaid also will increase the customer base.

Economic conditions also affect the numbers of individuals eligible for medical assistance services. According to the Virginia Employment Commission, the final numbers for 2004 showed strong economic growth for both the U.S. and Virginia. Continued economic growth can be expected to produce a countervailing trend that may suppress the number of low-income Virginians and in turn the numbers of individuals needing medical assistance services.

Footnote for Service Area Customer Base Listings:
* Served represents enrolled individuals in Medicaid in FY 2007. During the 2009-2010 biennium it is estimated there will be between 850,000 to 1,000,000 individuals enrolled in the Medicaid program at some point during each fiscal year.

Partners

Partner	Description
Advocacy groups	
Boards and committees	
Federal agencies	
Health care professionals, organizations, and facilities	
Private business firms	
State and local entities	
State government officials	

Products and Services

- *Factors Impacting the Products and/or Services:*
  The following factors will impact the services provided within this service area:
  • The Governor's emphasis on enrolling additional children in Medicaid;
  • Aging population
  • Changes in economic conditions
  • Health care cost inflation (technology)
  • Federal policy changes and Medicaid reform initiatives
  • Impact of low reimbursement on provider participation
  • Managed care penetration by geographic area and population type
  • Legislative initiatives/priorities
  • Budgetary/resource restraints
  • Growing emphasis on cost containment and program integrity
- *Anticipated Changes to the Products and/or Services*
  [Nothing entered]
- *Listing of Products and/or Services*
  - Operations (Enrollment and Member Services)
  - Operations (Provider Enrollment, Services, and Reimbursement) – Special provider Reimbursement Projects

(E.G., Revenue Maximization, Teaching Hospital DSH)

- Operations (Program integrity) – Quality Assurance
- Operations (Healthcare Services) – Operational support; New Program Development (e.g., ED 2, DSM, Dental)

Finance

- *Financial Overview*
  The Medicaid program is funded with a mixture of state and federal funds. The current match rate for Virginia is 50% state and 50% federal funds. The state match for the Medicaid program comes from a combination of the funding from the state General Fund and the Virginia Health Care Fund. The federal funds come from the federal Centers for Medicare & Medicaid Services. In FY2009 and FY2010 the non general funds in the table below are comprised of Federal Funds and the Virginia Health Care Fund. The Base Budget is the SFY 2008 appropriation as reflected in Chapter 847.

  The budget for FY 2009 and 2010 is the FY 2008 Base Budget appropriation (as reflected in Chapter 847 of the Appropriation Act) plus changes incorporated during the 2008 General Assembly spring session (that resulted in Chapter 879 of the 2008 Appropriation Act).
- *Financial Breakdown*

	FY 2009		FY 2010	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$1,472,473,243	$1,884,014,937	$1,472,473,243	$1,884,014,937
Change To Base	$17,806,413	$58,319,831	$137,419,355	$169,891,036
Service Area Total	$1,490,279,656	$1,942,334,768	$1,609,892,598	$2,053,905,973
Base Budget	$1,472,473,243	$1,884,014,937	$1,472,473,243	$1,884,014,937
Change To Base	$17,806,413	$58,319,831	$137,419,355	$169,891,036
Service Area Total	$1,490,279,656	$1,942,334,768	$1,609,892,598	$2,053,905,973
Base Budget	$1,472,473,243	$1,884,014,937	$1,472,473,243	$1,884,014,937
Change To Base	$17,806,413	$58,319,831	$137,419,355	$169,891,036
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FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	F 20

Service Area Total	$1,490,279,656	$1,942,334,768	$1,609,892,598	$2,053,905,973
Base Budget	$1,472,473,243	$1,884,014,937	$1,472,473,243	$1,884,014,937
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Service Area Total	$1,490,279,656	$1,942,334,768	$1,609,892,598	$2,053,905,973

Human Resources

- *Human Resources Overview*
  [Nothing entered]
- *Human Resource Levels*

Effective Date		
Total Authorized Position level	0	
Vacant Positions	0	
Current Employment Level	**0.0**	
Non-Classified (Filled)		
Full-Time Classified (Filled)		*breakout of Current Employment Level*
Part-Time Classified (Filled)		
Faculty (Filled)		
Wage		
Contract Employees		
Total Human Resource Level	**0.0**	*= Current Employment Level + Wage and Contract Employees*

- *Factors Impacting HR*
  [Nothing entered]
- *Anticipated HR Changes*
  [Nothing entered]

Service Area Objectives

- We will work to increase the utilization of appropriate preventative care of FAMIS and FAMIS Plus (Medicaid) enrolled children

  Objective Description

  While enrollment of eligible children in the FAMIS program has increased dramatically, there are still uninsured children who could be covered and additional children who become uninsured every day. It is in the best interest of the children, their families and the Commonwealth to provide comprehensive health care coverage through the FAMIS program to this vulnerable population.

  Alignment to Agency Goals

  - Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

    Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families.

  Objective Strategies

  - Develop and implement a general marketing campaign specifically designed to retain current children and reach families with FAMIS eligible children. • Develop outreach activities and materials to reach traditionally “hard-to-reach” populations. • Increase the use of technology to improve customer service for interested families and to facilitate application processing and enrollment.

  Link to State Strategy

  - nothing linked

  Objective Measures

  - Percentage of 15 months-old children enrolled in the FAMIS Plus (Medicaid) program who received the recommended number of well-child screenings

    Measure Class: Agency Key Measure Type: Outcome Measure Frequency: Annual Preferred Trend: Up

Frequency Comment: Data results for the State Fiscal Year are available by December

Measure Baseline Value: 61.5 Date: 6/30/2008

Measure Baseline Description: 61.5% for Fiscal Year (FY) 2008

Measure Target Value: 62 Date: 6/30/2010

Measure Target Description: 62% for FY 2010

Data Source and Calculation: Source/Method: As determined from clinical review of a representative sample of medical records performed by the State's External Quality Review Organization (EQRO). The EQRO follows the methodology specified in current national Health Employer Data and Information Set (HEDIS) reporting guidelines. The reported measure is the “participant ratio” or percentage of children eligible for a well-child screening who received at least one screening during the reporting period. This results in a measure of the percentage of children who received a well child visit.

- Percentage of 3-6 year-old children enrolled in the FAMIS Plus (Medicaid) program who received the recommended number of well-child screenings

  Measure Class: Agency Key Measure Type: Outcome Measure Frequency: Annual Preferred Trend: Up

  Frequency Comment: Results for the fiscal year are available in December

  Measure Baseline Value: 61.5 Date: 6/30/2008

  Measure Baseline Description: 61.5% for Fiscal Year (FY) 2008

  Measure Target Value: 62 Date: 6/30/2010

  Measure Target Description: 62% for FY 2010

  Data Source and Calculation: Source/Method: As determined from clinical review of a representative sample of medical records performed by the State's External Quality Review Organization (EQRO). The EQRO follows the methodology specified in current national Health Employer Data and Information Set (HEDIS) reporting guidelines. The reported measure is the “participant ratio” or percentage of children eligible for a well-child screening who received at least one screening during the reporting period. This results in a measure of the percentage of children who received a well child visit.

- We will work to improve the immunization rate among FAMIS Plus (Medicaid) children by increasing the percentage of two year olds who are fully immunized

  Objective Description

  DMAS serves persons who utilize a wide range of health care services. This objective will focus DMAS' efforts to improve the level of preventive care and quality of life for young children. The American Academy of Pediatrics (AAP) recommends that children visit their pediatrician for a well- child check-up as a newborn, by one month, at two, four, six, nine, twelve, fifteen, eighteen, and twenty-four months, and once a year from ages three to twenty-one. Well-child care for infants are of particular importance during the first year of life, when an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination and social and emotional growth. The American Academy of Pediatrics (AAP) also recommends six well-child visits in the first year of life: the first within the first month of life, and then at around 2, 4, 6, 9, and 12 months of age. Comprehensive well child exam documentation measures the percentage of children who had one, two, three, four, five, six or more well-child visits by the time they turned 15 months of age.

  Alignment to Agency Goals

  - Agency Goal: Promote better health outcomes through prevention-based strategies and improved quality of care.

    Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families.

  Objective Strategies

  - Track the number of children receiving necessary immunizations. • Develop education efforts to remind providers of the importance of regular checkups, immunizations, and the need to coordinate patient information flow.

  Link to State Strategy

  - nothing linked

  Objective Measures

  - Percentage of two year olds in FAMIS Plus (Medicaid) who are fully immunized

    Measure Class: Agency Key Measure Type: Outcome Measure Frequency: Annual Preferred Trend: Up

    Frequency Comment: Based on an annual report available after the Calendar Year.

    Measure Baseline Value: 87 Date: 6/30/2005

    Measure Baseline Description: 87% for Fiscal Year (FY) 2005

    Measure Target Value: 92 Date: 6/30/2010

    Measure Target Description: 92% for FY's 2009 & 2010

    Data Source and Calculation: Source: Annual Report conducted each Fall by the contracted external quality

review organization (formerly Delmarva Foundation as of SFY 2008, Michigan Peer Review Organization) monitored by Quality Analyst in the Healthcare Services Division Calculation: Unit of Analysis: Based on Health Employer Data and Information Set (HEDIS) methodology for Childhood Immunization Status measure

- We will work to improve the oral health and increase the utilization of appropriate preventative care of FAMIS and FAMIS Plus (Medicaid) enrolled children

Objective Description

DMAS serves persons who utilize a wide range of health care services. This objective will focus DMAS' efforts to enhance the delivery of healthcare services and increase access to care.

Alignment to Agency Goals

- Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families.

Objective Strategies

- Administer the Smiles For Children Dental Program effective July 1, 2005. • Expand the Department's dental provider network, including specialists. • Develop strategies, including the development of outreach campaigns, designed to significantly increase Medicaid/FAMIS Plus and FAMIS enrollee utilization of pediatric dental services. • Implement an effective case management program with Doral Dental to reduce patient "no shows" and increase overall utilization.

Link to State Strategy

- nothing linked

Objective Measures

- Percentage of enrolled children who utilize dental services

  Measure Class: Agency Key Measure Type: Outcome Measure Frequency: Quarterly Preferred Trend: Up

  Frequency Comment: Providers have six months to submit their claims from the date of service. The final report is run six months after the last date of the reporting period.

  Measure Baseline Value: 35.93 Date: 6/30/2006

  Measure Baseline Description: Measure Baseline Description: Fiscal Year (FY) 2006

  Measure Target Value: 40 Date: 6/30/2010

  Measure Target Description: 40% for FY's 2008, 2009 & 2010

  Data Source and Calculation: Source: Department of Medical Assistance Services (DMAS) claims data are utilized to determine the number of children covered by Family Access to Medical Insurance Security Plan (FAMIS) or FAMIS PLUS between the age of three and twenty-one receiving routine dental care visits. Calculation: This number is divided by the number of children in this age group enrolled in the program. The quarterly numbers are cumulative and calculated towards an annual percentage of children utilizing dental services. Due to the claim process, final results lag the closing period by about six months.

- We will work to improve birth outcomes in the Medicaid population by increasing the percentage of Medicaid/FAMIS covered births which are normal birth weight, rather than below normal birth weight

Objective Description

DMAS serves persons who utilize a wide range of health care services. This objective will focus DMAS' efforts to ensure the effective delivery of covered healthcare services.

Alignment to Agency Goals

- Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families.

Objective Strategies

- Develop approaches that will publicize the availability of Medicaid for eligible women so that a higher percentage can begin appropriate prenatal care in their first trimester. • Streamline Medicaid's administrative and enrollment practices and provide an expedited eligibility process for pregnant women and process their applications within 10 days

Link to State Strategy

- nothing linked

Objective Measures

- Percentage of Medicaid/FAMIS covered births which are normal birth weight

  Measure Class: Agency Key Measure Type: Outcome Measure Frequency: Annual Preferred Trend: Up

  Frequency Comment: Based on an annual report available after the end of the Calendar Year

  Measure Baseline Value: 90 Date: 6/30/2005

  Measure Baseline Description: 90% for CY 2005

Measure Target Value: 92 Date: 6/30/2010 Measure Target Description: 92% for FY's 2008, 2009 & 2010

Data Source and Calculation: Source: Each calendar year, the Department of Medical Assistance Services' (DMAS')-contracted external quality review organization (EQRO) collects, synthesizes, and reports on birth weight among Medicaid/FAMIS (Family Access to Medical Insurance Security Plan) covered births. Calculation: The EQRO uses the methodology that the National Committee for Quality Assurance (NCQA) delineated in 1995 through its published technical specifications for calculating birthweight measures. These measures have since been retired by the NCQA; however, DMAS recognizes the importance of tracking birthweight measures and continues to have the EQRO calculate the birth weight measures annually. The rates are calculated using administrative data only, with no need for medical record abstraction. The work of the EQRO is monitored by the Division of Health Care Services, DMAS. The percent calculation of normal birth weight babies is available at or around the end of each calendar year.

- Facilitate access to member healthcare services by building and retaining a sufficient network of diverse providers to deliver covered services

Objective Description

DMAS serves persons who utilize a wide range of health care services. This objective will ensure enrollees can access services from providers.

Alignment to Agency Goals

- Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families.

- Agency Goal: Promote better health outcomes through prevention-based strategies and improved quality of care.

  Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families.

Objective Strategies

- Identify and monitor regional areas where provider ratios are unfavorable. • Review and, if required, implement new policies to assist in increasing provider participation. • Maintain a website with provider enrollment information.

Link to State Strategy

- nothing linked

Objective Measures

- Number of enrolled dentist in the network

  Measure Class: Other Measure Type: Output Measure Frequency: Annual Preferred Trend: Up

  Measure Baseline Value: 971 Date: 6/30/2007

  Measure Baseline Description: Fiscal Year (FY) 2007

  Measure Target Value: 1050 Date: 6/30/2010

  Measure Target Description: 1050 for FY 2010

  Data Source and Calculation: The number of enrolled dentists are tracked, reported, and provided to the Department of Medical Assistance Services (DMAS), Health Care Services Division, by Doral Dental) USA (the contractor used by DMAS). The number represents individual dentists (not dental locations) who have contracted with Doral.

- Build and sustain an effective and innovative operation that utilizes technology and industry standards

Objective Description

DMAS serves persons who utilize a wide range of health care services. This objective will focus DMAS' efforts to improve operational efficiencies.

Alignment to Agency Goals

- Agency Goal: Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.

  Comment: Council on Virginia's Future Long-Term Goal: To be recognized as the best-managed state in the nation.

Objective Strategies

- Identify and target potentially inefficient billing procedures. • Educate providers on common billing errors. • Review and, if required, implement new policies and/or procedures to reduce inappropriate billing.

Link to State Strategy

- nothing linked

Objective Measures

- Percent of clean claims paid in 30 days

  Measure Class: Other Measure Type: Outcome Measure Frequency: Quarterly Preferred Trend: Maintain

  Measure Baseline Value: 100 Date: 6/30/2009

  Measure Baseline Description: 100% Fiscal Year (FY)09

  Measure Target Value: 100 Date: 6/30/2010

  Measure Target Description: 100% in FY 2010

Data Source and Calculation: : Source: Virginia Medicaid Management Information System (VaMMIS) Clean Claim report #MRM325 Calculation: This report produces counts based on the type of claim (physician, hospital, capitation, etc.) and the average number of days from when the claim is received to the date considered paid.

- Enhance current systems that monitor quality assurance and program integrity

Objective Description

DMAS serves persons who utilize a wide range of health care services. This objective will help to ensure the Medicaid program is as efficient as possible and is protected from fraud and abuse.

Alignment to Agency Goals

- Agency Goal: Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  Comment: Council on Virginia's Future Long-Term Goal: To be recognized as the best-managed state in the nation.

Objective Strategies

- Identify and target potentially inappropriate billing by providers. • Review and, if required, implement new policies and/or programs to reduce inappropriate billing. • Increase use of CS-SURS to identify provider fraud and abuse. • Refer potential fraud cases to the Medicaid Fraud Control Unit.

Link to State Strategy

- nothing linked

Objective Measures

- The number of providers, recipients, and medical record reviews completed each year

  Measure Class: Other Measure Type: Output Measure Frequency: Annual Preferred Trend: Maintain

  Measure Baseline Value: 1999 Date: 6/30/2008

  Measure Baseline Description: 1999 in Fiscal Year (FY) 2008

  Measure Target Value: 2129 Date: 6/30/2010

  Measure Target Description: 2129 in FY 2010

  Data Source and Calculation: Source: This measure involves quality reviews conducted and tracked by several divisions at the Department of Medical Assistance Services (DMAS). Quality Management Reviews (QMR) reviews are performed and tracked by the Long Term Care Division. Recipient Audit Unit (RAU) and Provider Review Unit (PRU) reviews are performed and tracked by the Program Integrity Division. Calculation: The sum of all reviews comprises the value numbers.

- Improve the quality, coordination of care and associated health outcomes to Medicaid/FAMIS participants diagnosed with asthma, diabetes, congestive heart failure and coronary artery disease, and chronic obstructive pulmonary disease

Objective Description

DMAS serves persons who utilize a wide range of health care services. This objective will focus DMAS' efforts to prevent costly medical procedures and improve quality of care.

Alignment to Agency Goals

- Agency Goal: Promote better health outcomes through prevention-based strategies and improved quality of care.

  Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families.

Objective Strategies

- Contract with a disease management program administrator (DMPA) to implement and administer the disease management program. • Identify, evaluate, and manage the targeted disease state(s) as well as all co-morbid conditions of all participants included in the project. • Develop strategies, including the development of outreach campaigns, designed to significantly increase knowledge of the program.

Link to State Strategy

- nothing linked

Objective Measures

- Percentage of eligible clients who are participating in Disease Management

  Measure Class: Other Measure Type: Outcome Measure Frequency: Quarterly Preferred Trend: Up

  Measure Baseline Value: 21 Date: 12/31/2007

  Measure Baseline Description: 21% for Calendar Year (CY) 2007

  Measure Target Value: 25 Date: 12/31/2010

  Measure Target Description: 25% in CY 2010

  Data Source and Calculation: Source: The Department of Medical Assistance Services (DMAS) contracts with Health Management Corporation (HMC) to administer the disease management program to eligible fee-for-service Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) participants. Calculation: Based on reports submitted by HMC, DMAS determines the percentage of eligible clients participating in the disease management program each quarter.

- Enroll all eligible children in the FAMIS and FAMIS Plus (Medicaid) programs

Objective Description

While enrollment of eligible children in the FAMIS program has increased dramatically, there are still uninsured children who could be covered and additional children who become uninsured every day. It is in the best interest of the children, their families and the Commonwealth to provide comprehensive health care coverage through the FAMIS program to this vulnerable population.

Alignment to Agency Goals

- Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families.

Objective Strategies

- Develop and implement a general marketing campaign specifically designed to retain current children and reach families with FAMIS eligible children. • Develop outreach activities and materials to reach traditionally “hard-to-reach” populations. • Increase the use of technology to improve customer service for interested families and to facilitate application processing and enrollment.

Link to State Strategy

- nothing linked

Objective Measures

- The number of children enrolled in the FAMIS or FAMIS Plus (Medicaid) programs

  Measure Class: Other Measure Type: Output Measure Frequency: Quarterly Preferred Trend: Up

  Measure Baseline Value: 416548 Date: 6/30/2005

  Measure Baseline Description: 416,548 in FY 2005

  Measure Target Value: 430878 Date: 6/30/2008

  Measure Target Description: 430,878 in FY's 2008, 2009 & 2010

  Data Source and Calculation: : Data Source: Data from Virginia Medicaid Management Information System (VaMMIS) on the number of children enrolled on the first day of each month, following all cancellations that occur on the last day of each month, will be reported. Applicable children are in FAMIS (Family Access to Medical Insurance Security) Plus (Medicaid),; Medicaid aid category numbers: 094

Service Area Strategic Plan

Department of Medical Assistance Services (602) 3/13/2014 8:56 am

Biennium: 2008-10

Service Area 6 of 13

Reimbursements for Long-Term Care Services (602 456 10)

Description

Provide access to a system of high-quality long-term care services to the elderly and persons with disabilities to ensure health, safety, and welfare.

Background Information

Mission Alignment and Authority

- *Describe how this service supports the agency mission*
  By assisting the elderly and persons with disabilities to obtain long-term care services that are of high-quality, cost-effective, and provided in the least restrictive environment that meets their needs.
- *Describe the Statutory Authority of this Service*
  Title 32.1 Chapter Code of Virginia

Customers

Agency Customer Group	Customer	Customers served annually	Potential annual customers
	Recipients • The elderly and persons with disabilities who meet eligibility requirements	49,151	0

Anticipated Changes To Agency Customer Base
In fiscal year 2006, the Virginia Medicaid program provided nursing facility care for 28,869 individuals and home and community-based care for 20,282 individuals.

The baby-boomers are aging. Medical advances have led to increasing number of persons with chronic conditions and those with developmental disabilities living longer and more productive lives. The Department anticipates the number of customers receiving long-term care services to rapidly increase over the next 15-20 years.

Footnote for Service Area Customer Base Listing:
During the 2007-2010 biennium it is estimated there will be between 850,000 to 1,000,000 individuals enrolled in the Medicaid program at some point during each fiscal year.

Partners

Partner	Description
Advocacy groups	
Boards and Committees	
Federal Agencies	
Health care professionals, organizations, and facilities	
Private business firms	
State and local entities	

Products and Services

- *Factors Impacting the Products and/or Services:*
  The growth of the population of the elderly and persons with disabilities, together with low reimbursement rates which diminish the number of available providers at both the institutional and community level will exert greater pressures on the service delivery system.
- *Anticipated Changes to the Products and/or Services*
  There must be an expansion of community-based care services to address the growing numbers of persons who will likely seek Medicaid-financed long-term care services.
- *Listing of Products and/or Services*
  - Long-Term Care & Waiver Programs – Nursing facility care; Home and community-based services

Finance

- *Financial Overview*
  The budget for FY 2009 and 2010 is the FY 2008 Base Budget appropriation (as reflected in Chapter 847 of the Appropriation Act) plus changes incorporated during the 2008 General Assembly spring session (that resulted in Chapter 879 of the 2008 Appropriation Act).
- *Financial Breakdown*

	FY 2009		FY 2010		FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2010
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund															
Base Budget	$771,511,320	$771,511,320	$771,511,320	$771,511,320															
Change To Base	$17,884,189	$17,884,189	$37,022,135	$37,022,135															
Service																			

Area Total	$789,395,509	$789,395,509	$808,533,455	$808,533,455
Base Budget	$771,511,320	$771,511,320	$771,511,320	$771,511,320
Change To Base	$17,884,189	$17,884,189	$37,022,135	$37,022,135
Service Area Total	$789,395,509	$789,395,509	$808,533,455	$808,533,455
Base Budget	$771,511,320	$771,511,320	$771,511,320	$771,511,320
Change To Base	$17,884,189	$17,884,189	$37,022,135	$37,022,135
Service Area Total	$789,395,509	$789,395,509	$808,533,455	$808,533,455
Base Budget	$771,511,320	$771,511,320	$771,511,320	$771,511,320
Change To Base	$17,884,189	$17,884,189	$37,022,135	$37,022,135
Service Area Total	$789,395,509	$789,395,509	$808,533,455	$808,533,455
Base Budget	$771,511,320	$771,511,320	$771,511,320	$771,511,320
Change To Base	$17,884,189	$17,884,189	$37,022,135	$37,022,135
Service Area Total	$789,395,509	$789,395,509	$808,533,455	$808,533,455
Base Budget	$771,511,320	$771,511,320	$771,511,320	$771,511,320
Change To Base	$17,884,189	$17,884,189	$37,022,135	$37,022,135
Service Area Total	$789,395,509	$789,395,509	$808,533,455	$808,533,455
Base Budget	$771,511,320	$771,511,320	$771,511,320	$771,511,320
Change To Base	$17,884,189	$17,884,189	$37,022,135	$37,022,135
Service Area Total	$789,395,509	$789,395,509	$808,533,455	$808,533,455
Base Budget	$771,511,320	$771,511,320	$771,511,320	$771,511,320
Change To Base	$17,884,189	$17,884,189	$37,022,135	$37,022,135
Service Area Total	$789,395,509	$789,395,509	$808,533,455	$808,533,455

Human Resources

- *Human Resources Overview*
  [Nothing entered]
- *Human Resource Levels*

Effective Date		
Total Authorized Position level	0	
Vacant Positions	0	
Current Employment Level	**0.0**	
Non-Classified (Filled)		
Full-Time Classified (Filled)		*breakout of Current Employment Level*
Part-Time Classified (Filled)		

Faculty (Filled)	
Wage	
Contract Employees	
Total Human Resource Level	**0.0** *= Current Employment Level + Wage and Contract Employees*

- *Factors Impacting HR*
  [Nothing entered]
- *Anticipated HR Changes*
  [Nothing entered]

Service Area Objectives

- We will increase the number of long-term care recipients served in home-and-community settings by increasing the percentage of spending for community based on long care services as compared to all Medicaid long term care service expenditures

  Objective Description

  Given the high and increasing cost of institutional care, DMAS will need to strengthen strategies to encourage the use of less costly and less restrictive home and community based placement.

  Alignment to Agency Goals

  - Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

    Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families

  Objective Strategies

  - Develop a comprehensive automated UAI database that captures information and can be shared across agencies. • Conduct standardized training for PAS teams on the availability and appropriate use of DMAS' home and community based care waivers.

  Link to State Strategy

  - nothing linked

  Objective Measures

  - Proportion of total Medicaid long term care expenditures for home and community based services.

    Measure Class: Agency Key Measure Type: Outcome Measure Frequency: Quarterly Preferred Trend: Up

    Measure Baseline Value: 36.2 Date: 6/30/2006

    Measure Baseline Description: 36.2% in Fiscal Year (FY) 2006

    Measure Target Value: 40 Date: 6/30/2010

    Measure Target Description: 38% in FY's 2008, 2009 & 40% for 2010

    Data Source and Calculation: Source: The source is the Department of Medical Assistance Services (DMAS) generated expenditure report (Summary of Medicaid Long-Term Care Expenditure Data) from Commonwealth Accounting and Reporting System (CARS) for applicable Health Care Financing Administration (HCFA)/Centers for Medicare and Medicaid Services (CMS) and Home Health category/object codes. Calculation: Home Health costs are divided by HCFA/CMS costs to determine a community long-term care percentage. The quarterly number results are cumulative through the fiscal year.

- Ensure that all recipients receiving home and community-based services meet the functional level of care criteria

  Objective Description

  Quality management and level of care reviews must demonstrate that only those who meet functional criteria and utilize waiver services remain in the waiver program. Some waiver recipients may use waiver services solely as a route to other Medicaid services (e.g., prescription drug coverage), for which they would not otherwise be eligible but for their enrollment in the waiver program.

  Alignment to Agency Goals

  - Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

    Comment: Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services. • Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families

  Objective Strategies

  - Train staff to use VAMMIS for purposes of identifying inappropriate waiver use • Establish process to notify and remove persons from the waiver programs who are inappropriately using these services

  Link to State Strategy

  - nothing linked

  Objective Measures

  - Percent of level of care reviews performed on all current eligible waiver recipients

    Measure Class: Other Measure Type: Outcome Measure Frequency: Quarterly Preferred Trend: Maintain

    Measure Baseline Value: 100 Date: 6/30/2009

Measure Baseline Description: 100% in Fiscal Year (FY) 2009

Measure Target Value: 100 Date: 6/30/2010

Measure Target Description: 100% in FY's 2008, 2009 & 2010

Data Source and Calculation: Source/Calculation: The Department of Medical Assistance Services (DMAS) data system LOCRE (Level of Care Review Evaluation System) managed by the Division of Long Term Care conducts waiver eligibility reviews annually on all active waiver participants to ensure that they continue to meet level of care criteria for the waiver in which they are enrolled. The Level of Care Review Instrument form, DMAS 99-C, is based on the Virginia Uniform Assessment Instrument (UAI) and determines if the participant meets nursing facility criteria , as well as other eligibility requirements that may be required for that particular waiver The information on each active waiver participant is received from Medicaid providers who are providing services.

- Integrate managed care as a service delivery model within the long-term care environment.

Objective Description

Appropriate services can be delivered more effectively through a managed care model. Presently most all long-term care services are paid for through fee-for-service.

Alignment to Agency Goals

- Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families

Objective Strategies

- Market the concept of managed care to stakeholders. • Design and test the program. • Implement the program. • Develop a blueprint for managed care.

Link to State Strategy

- nothing linked

Objective Measures

- Number of long-term care recipients who are moved from fee-for-service into managed care

  Measure Class: Other Measure Type: Outcome Measure Frequency: Quarterly Preferred Trend: Up

  Measure Baseline Value: 3.6 Date: 6/30/2008

  Measure Baseline Description: 3.6% for Fiscal Year (FY) 2008

  Measure Target Value: 5.0 Date: 6/30/2010

  Measure Target Description: 2.5% for FY's 2008, 2009 & 5.0% for 2010

  Data Source and Calculation: Source: Agency data system Calculation: Based on a Virginia Medicaid Management Information System (VaMMIS) special statistical program report generated by the Budget and Forecast Division. This report program determines the number of individuals receiving long term care services through managed care as a percentage of all persons receiving long-term care services. Information about this report should be directed to the Budget & Forecast Division.

Service Area Strategic Plan

Department of Medical Assistance Services (602) 3/13/2014 8:56 am

Biennium: 2008-10

Service Area 7 of 13

Reimbursements to Acute Care Hospitals Providing Charity Care in Excess of the Median Level of Charity Care Costs (602 459 01)

Description

The purpose of the Indigent Health Care Trust Fund is to equalize the burden of charity care among non-state-owned hospitals, and to reimburse those among these hospitals with high charity care for part of this cost. Note: VCU and UVA hospitals are not included in the trust fund as they are state-affiliated facilities.

Background Information

Mission Alignment and Authority

- *Describe how this service supports the agency mission*
  By increasing the funding available for charity care, the Indigent Health Care Trust Fund (IHCTF) increases access to health care for Virginians who qualify under the IHCTF charity care criteria.
- *Describe the Statutory Authority of this Service*
  The ICHTF was created and is authorized by the Code of Virginia § 32.1-332 et seq. There is no other statutory or regulatory authority governing the IHCTF.

Customers

Agency Customer Group	Customer	Customers served annually	Potential annual customers
	Beneficiaries / Clients	0	0

Anticipated Changes To Agency Customer Base
The number of uninsured persons below the poverty level is affected by a number of factors, and DMAS does not forecast changes in this number. The Trust Fund's operation is not affected by changes in the customer base. The amount it collects from hospitals, and the amount it pays to other hospitals is fixed by state law, and is not affected by changes in the customer base.

Footnote for Service Area Customer Base Listing:
The exact number of customers is not known. The ICHTF pays some hospitals part of their charity care costs, with the object of reducing but not eliminating the burden on hospitals of providing charity care. The goal is to make hospitals more able to provide charity care, and therefore make charity care more available to all qualifying persons. Therefore, the customers could not include all persons who quality for charity care. Under the terms governing the Trust Fund, this group is made up of persons with income below the poverty level, with no private insurance or Medicaid coverage. The amount of charity care cost incurred by non-state-owned hospitals was $101,038,007 in 2003/2004. The amount of funds paid by the Trust Fund based on this calculation was $7,119,789. Of this, $2,833,058 was collected from other hospitals and $4,285,831 was appropriated from the General Fund.

Partners

Partner	Description
Advocacy groups	
Health care professionals, organizations, and facilities	
Private business firms	
State and local entities	
State government officials	

Products and Services

- *Factors Impacting the Products and/or Services:*
  Changes in the Virginia economy and in employers' propensity to offer health insurance to employees affects the number of persons who may need to depend on charity care that is partially funded by the Trust Fund. However, the operation of the Trust Fund would not be directly affected by such a change.
- *Anticipated Changes to the Products and/or Services*
  None
- *Listing of Products and/or Services*
  - Operations (Financial Services) – DMAS determines the amount individual hospitals pay to or receive from the Trust Fund, and collects and pays these amounts.

Finance

- *Financial Overview*
  Funding for the IHCTF comes from assessments billed to hospitals and general fund appropriations. For each of FY 2007 and 2008, the hospital funds appropriated are $5 million, and the general funds are $4,285,831. The hospital funds are an estimate, as the final amount depends on the application of a formula to actual hospital data each year. The formula determines which hospitals pay into the IHCTF, and which hospitals will be recipients of the funds.

  Funding for FY 2010 was eliminated.

  The budget for FY 2009 and 2010 is the FY 2008 Base Budget appropriation (as reflected in Chapter 847 of the Appropriation Act) plus changes incorporated during the 2008 General Assembly spring session (that resulted in Chapter 879 of the 2008 Appropriation Act).
- *Financial Breakdown*

FY 2009		FY 2010		FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010
General	Nongeneral	General	Nongeneral												

	Fund	Fund	Fund	Fund
Base Budget	$4,285,831	$5,000,000	$0	$0
Change To Base	$0	-$1,800,000	$0	$0
Service Area Total	$4,285,831	$3,200,000	$0	$0
Base Budget	$4,285,831	$5,000,000	$0	$0
Change To Base	$0	-$1,800,000	$0	$0
Service Area Total	$4,285,831	$3,200,000	$0	$0
Base Budget	$4,285,831	$5,000,000	$0	$0
Change To Base	$0	-$1,800,000	$0	$0
Service Area Total	$4,285,831	$3,200,000	$0	$0
Base Budget	$4,285,831	$5,000,000	$0	$0
Change To Base	$0	-$1,800,000	$0	$0
Service Area Total	$4,285,831	$3,200,000	$0	$0
Base Budget	$4,285,831	$5,000,000	$0	$0
Change To Base	$0	-$1,800,000	$0	$0
Service Area Total	$4,285,831	$3,200,000	$0	$0
Base Budget	$4,285,831	$5,000,000	$0	$0
Change To Base	$0	-$1,800,000	$0	$0
Service Area Total	$4,285,831	$3,200,000	$0	$0
Base Budget	$4,285,831	$5,000,000	$0	$0
Change To Base	$0	-$1,800,000	$0	$0
Service Area Total	$4,285,831	$3,200,000	$0	$0

Human Resources

- *Human Resources Overview*
  [Nothing entered]
- *Human Resource Levels*

Effective Date		
Total Authorized Position level	0	
Vacant Positions	0	
Current Employment Level	**0.0**	
Non-Classified (Filled)		
Full-Time Classified (Filled)		*breakout of Current Employment Level*
Part-Time Classified (Filled)		

Faculty (Filled)		
Wage		
Contract Employees		
Total Human Resource Level	**0.0**	*= Current Employment Level + Wage and Contract Employees*

- *Factors Impacting HR*
  [Nothing entered]
- *Anticipated HR Changes*
  [Nothing entered]

Service Area Objectives

- Fund a portion of the charity care provided by Virginia hospitals

  Objective Description

  There are many persons in Virginia who are medically indigent. While the Trust Fund cannot pay for all the care they need, this goal is to reduce the burden on hospitals by paying for a portion of it.

  Alignment to Agency Goals

  - Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

    Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families

  Objective Strategies

  - Continue to collect and pay funds as required by state law.

  Link to State Strategy

  - nothing linked

  Objective Measures

  - Dollars collected from and paid to hospitals

    Measure Class: Other Measure Type: Outcome Measure Frequency: Quarterly Preferred Trend: Maintain

    Measure Baseline Value: 100 Date: 6/30/2006

    Measure Baseline Description: 100% in FY 2006

    Measure Target Value: 99 Date: 6/30/2008

    Measure Target Description: 100% in FY's 2008, 2009. Funding for FY 2010 was eliminated through the General Assembly

    Data Source and Calculation: Source: DMAS generated revenue report from CARS (MR 1671) by IHCTC revenue source code 06250, fund 0242 and the CARS expenses for the same (Budget balance file). Calculation: Revenues (funds collected) are divided by the expenditures paid to determine a percentage of funds used. All payments are made during the last SFY quarter.

Service Area Strategic Plan

Department of Medical Assistance Services (602) 3/13/2014 8:56 am

Biennium: 2008-10

Service Area 8 of 13

Regular Assisted Living Reimbursements for Residents of Adult Homes (602 461 05)

Description

This service pays for 30 minutes of personal care (at $3/day per eligible recipient), for eligible people who receive an Auxiliary Grant. This is a State-only program. The Auxiliary Grant is the state supplement to Supplemental Security Income (SSI), which is paid to eligible individuals who reside in assisted living facilities.

Background Information

Mission Alignment and Authority

- *Describe how this service supports the agency mission*
  By assisting people to get additional personal care, we help them get access to health care services.
- *Describe the Statutory Authority of this Service*
  12VAC30-120-460: Outlines regular assisted living and gives eligibility requirements.

Customers

Agency Customer Group	Customer	Customers served annually	Potential annual customers
Regular Assisted Living Program	Beneficiaries / Clients	1,278	5,858

Anticipated Changes To Agency Customer Base
When increases in the Auxiliary Grant are approved, more people could be eligible for Regular Assisted Living services. Increases in the auxiliary grant rate above the normal inflation adjustment are normally authorized through the Appropriation Act.

Partners

Partner	Description
Advocacy groups	
Health care professionals, organizations, and facilities	
Private business firms	
State and local entities	
State government officials	

Products and Services

- *Factors Impacting the Products and/or Services:*
  The number of providers accepting Auxiliary Grant payments is a factor in the level and quality of care delivered
- *Anticipated Changes to the Products and/or Services*
  None
- *Listing of Products and/or Services*
  - Long-Term Care and Waiver Programs – Long-Term Care Healthcare Services
  - Operations (Program Integrity) – Utilization Review
  - Provider Enrollment, Services and Reimbursement – Claims Payments

Finance

- *Financial Overview*
  The budget for FY 2009 and 2010 is the FY 2008 Base Budget appropriation (as reflected in Chapter 847 of the Appropriation Act) plus changes incorporated during the 2008 General Assembly spring session (that resulted in Chapter 879 of the 2008 Appropriation Act).
- *Financial Breakdown*

	FY 2009		FY 2010		FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund										
Base Budget	$1,400,000	$0	$1,400,000	$0										
Change To Base	$0	$0	$0	$0										
Service Area Total	$1,400,000	$0	$1,400,000	$0										
Base Budget	$1,400,000	$0	$1,400,000	$0										
Change To Base	$0	$0	$0	$0										
Service Area	$1,400,000	$0	$1,400,000	$0										

Total				
Base Budget	$1,400,000	$0	$1,400,000	$0
Change To Base	$0	$0	$0	$0
Service Area Total	$1,400,000	$0	$1,400,000	$0
Base Budget	$1,400,000	$0	$1,400,000	$0
Change To Base	$0	$0	$0	$0
Service Area Total	$1,400,000	$0	$1,400,000	$0
Base Budget	$1,400,000	$0	$1,400,000	$0
Change To Base	$0	$0	$0	$0
Service Area Total	$1,400,000	$0	$1,400,000	$0
Base Budget	$1,400,000	$0	$1,400,000	$0
Change To Base	$0	$0	$0	$0
Service Area Total	$1,400,000	$0	$1,400,000	$0

Human Resources

- *Human Resources Overview*
  [Nothing entered]
- *Human Resource Levels*

Effective Date		
Total Authorized Position level	0	
Vacant Positions	0	
Current Employment Level	**0.0**	
Non-Classified (Filled)		*breakout of Current Employment Level*
Full-Time Classified (Filled)		
Part-Time Classified (Filled)		
Faculty (Filled)		
Wage		
Contract Employees		
Total Human Resource Level	**0.0**	*= Current Employment Level + Wage and Contract Employees*

- *Factors Impacting HR*
  [Nothing entered]
- *Anticipated HR Changes*
  [Nothing entered]

Service Area Objectives

- Maximize the potential of the program to cover as many eligible individuals as possible within available funding

  Objective Description

  Enrollment in this program provides vital continuing healthcare for eligible individuals at a lower cost to the state

  Alignment to Agency Goals

  - Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

    Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families

  Objective Strategies

  - Continue to pay for services as funding is available

  Link to State Strategy

- nothing linked

Objective Measures

- Percentage of available program funds expended by the end of the fiscal year

  Measure Class: Other Measure Type: Outcome Measure Frequency: Quarterly Preferred Trend: Up

  Measure Baseline Value: 66 Date: 6/30/2008

  Measure Baseline Description: 66% in Fiscal Year (FY) 2008

  Measure Target Value: 60 Date: 6/30/2010

  Measure Target Description: 60% for FY2010

  Data Source and Calculation: : Source: A DMAS (Department of Medical Assistance Services) expenditure report from CARS (Commonwealth Accounting & Reporting System) is generated for state funds (0100) under the Assisted Living program (46105). Budgeted/appropriated amounts for this measure are obtained from the applicable State Appropriation Act. This is a State funded only program. Calculation: Expenditures are divided by the budget to determine a percentage of funds used.

Service Area Strategic Plan

Department of Medical Assistance Services (602) 3/13/2014 8:56 am

Biennium: 2008-10

Service Area 9 of 13

Reimbursements to Localities for Residents Covered by the State and Local Hospitalization Program (602 464 01)

Description

This service area provides coverage for inpatient and outpatient hospitalization, ambulatory surgical centers and local health department clinic visits to eligible, indigent Virginians who are not eligible for Medicaid. A person may be eligible for the State and Local Hospitalization (SLH) Program whether employed or unemployed, insured or uninsured, if the person meets the income and resource criteria established for the program. SLH is not an entitlement program. Once a locality's funds are exhausted, no further benefits are offered until the next year's allocation is received.

Background Information

Mission Alignment and Authority

- *Describe how this service supports the agency mission*
  Individuals determined eligible for services under the program are provided access to high quality and cost effective health care services
- *Describe the Statutory Authority of this Service*
  Title 32.1, Chapter 12, Code of Virginia

Customers

Agency Customer Group	Customer	Customers served annually	Potential annual customers
State/Local Hospitalization Program	Beneficiaries / Clients	5,081	12,789

Anticipated Changes To Agency Customer Base
The number of recipients served through SLH has declined 11 percent over the past five years. This trend is likely to continue due to the rising cost of medical services and the capped level of funding in the program

Footnote for Service Area Customer Base Listing:
Individuals may qualify for the State and Local Hospitalization program if they do not qualify for full Medicaid benefits, have countable income equal to or less than 100 percent, and have resources equal to or less than the then current resource standards of the federal Supplemental Security Income Program.

This figure represents the number of clients who were enrolled and had claims paid plus the number of clients enrolled with no claims paid because funds were exhausted. The potential customer base would be higher if funding were increased. Local Departments of Social Services are required to take applications until October 30th each year. If funds are exhausted after that date, no additional applications are taken. Many localities exhaust their funds on or before this date, therefore, the potential client base is higher than indicated.

Partners

Partner	Description
Advocacy groups	
Boards and committees	
Health care professionals, organizations, and facilities	
Private business firms	
State and local entities	
State government officials	

Products and Services

- *Factors Impacting the Products and/or Services:*
  The following factors will impact the services provided within this service area:
  • Limited funding for the program, which has not increased since the inception of the SLH program in 1990
  • Health care cost inflation
  • Implementation of Diagnostic Related Groups (DRG – a reimbursement payment methodology) in 2004 resulted in higher reimbursements per hospitalization. Therefore, fewer clients were able to receive services
- *Anticipated Changes to the Products and/or Services*
  Regulatory changes are anticipated that will remove the eligibility determination requirement that bases the income and resource methodology on the former cash payment program Aid to Dependent Children (ADC). This policy is cumbersome for the Local Department of Social Services workers who determine eligibility, as ADC policy is no longer in existence. Additional policy changes are anticipated that will allow women determined eligible for limited Medicaid coverage under Family Planning Services to also be evaluated and enrolled in SLH. Currently, anyone eligible for Medicaid cannot be enrolled in SLH.
- *Listing of Products and/or Services*
  - Special Programs – Coverage for Inpatient and Outpatient Hospitalization, Ambulatory Surgical Centers and Health Department Clinic Visits
  - Operations (Financial Services) – Rate Setting; Calculation of Locality Allocations, Billing Localities and Collecting Locality Share
  - Operations (Provider Enrollment, Services and Reimbursement) – Claims Processing

Finance

- *Financial Overview*
  The SLH program is financed entirely by state and local funds with the state providing at least 75% of the cost by allocating the amount of funds appropriated to each locality on the basis of current estimated demand for covered services. Funds allocated to a locality can be used to pay for services provided to residents of that locality only.

The budget for FY 2009 is the FY 2008 Base Budget appropriation (as reflected in Chapter 847 of the Appropriation Act) plus changes incorporated during the 2008 General Assembly spring session (that resulted in Chapter 879 of the 2008 Appropriation Act).

Funding was eliminated for FY 2010.

- *Financial Breakdown*

	FY 2009		FY 2010		FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund								
Base Budget	$10,865,779	$2,800,000	$0	$0								
Change To Base	$0	-$800,000	$0	$0								
Service Area Total	$10,865,779	$2,000,000	$0	$0								
Base Budget	$10,865,779	$2,800,000	$0	$0								
Change To Base	$0	-$800,000	$0	$0								
Service Area Total	$10,865,779	$2,000,000	$0	$0								
Base Budget	$10,865,779	$2,800,000	$0	$0								
Change To Base	$0	-$800,000	$0	$0								
Service Area Total	$10,865,779	$2,000,000	$0	$0								
Base Budget	$10,865,779	$2,800,000	$0	$0								
Change To Base	$0	-$800,000	$0	$0								
Service Area Total	$10,865,779	$2,000,000	$0	$0								
Base Budget	$10,865,779	$2,800,000	$0	$0								
Change To Base	$0	-$800,000	$0	$0								
Service Area Total	$10,865,779	$2,000,000	$0	$0								

Human Resources

- *Human Resources Overview*
  [Nothing entered]
- *Human Resource Levels*

Effective Date		
Total Authorized Position level	0	
Vacant Positions	0	
Current Employment Level	**0.0**	
Non-Classified (Filled)		breakout of Current Employment Level
Full-Time Classified (Filled)		
Part-Time Classified (Filled)		
Faculty (Filled)		
Wage		
Contract Employees		
Total Human Resource Level	**0.0**	*= Current Employment Level + Wage and Contract Employees*

- *Factors Impacting HR*
  [Nothing entered]

- *Anticipated HR Changes*
  [Nothing entered]

Service Area Objectives

- Ensure transactions are processed in an accurate and timely manner

  Objective Description

  Accurate and timely processes prevent costly rework.

  Alignment to Agency Goals

  - Agency Goal: Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.

    Comment: Council on Virginia's Future Long-Term Goal: To be recognized as the best-managed state in the nation.

  Objective Strategies

  - Examine the billing instructions and the SLH manual for improvement opportunities

  Link to State Strategy

  - nothing linked

  Objective Measures

  - Percent of funds expended at the end of program period.

    Measure Class: Other Measure Type: Outcome Measure Frequency: Quarterly Preferred Trend: Up

    Measure Baseline Value: 92 Date: 6/30/2008

    Measure Baseline Description: 92% in FY 2008

    Measure Target Value: 92 Date: 6/30/2008

    Measure Target Description: 92% in FY's 2008, 2009. Funding for FY 2010 was eliminated.

    Data Source and Calculation: Source: DMAS generated expenditure report from CARS (Budget balance file) by program 46401 for funds 0100 and 0204. In addition, the budgeted amounts for this is obtained from the Appropriation Act. Calculation: Expenditures are divided by the budget to determine a percentage of funds used.

Service Area Strategic Plan

Department of Medical Assistance Services (602) 3/13/2014 8:56 am

Biennium: 2008-10

Service Area 10 of 13

Insurance Premium Payments for HIV-Positive Individuals (602 464 03)

Description

This service area ensures that HIV clients are able to maintain their medication protocol. The program provides reimbursement for health insurance premium payments to ensure that those approved individuals are able to maintain and utilize their private health insurance.

In order to qualify an individual must be 1) a resident of Virginia, 2) able to provide documentation from a physician verifying disability within three months due to HIV+ diagnosis, and 3) eligible for and have availability of continuing health insurance. DMAS determines eligibility for the program and assumes the responsibility of providing health insurance premium payment in a timely manner

Background Information

Mission Alignment and Authority

- *Describe how this service supports the agency mission*
  By providing financial assistance for recipients' health insurance premiums, the program enables recipients to maintain maximum comprehensive health care benefits and deflect the expenses away from the Medicaid program. If these individuals do not maintain their private health insurance coverage they will likely become Medicaid eligible due to the significant costs for HIV pharmacy products.
- *Describe the Statutory Authority of this Service*
  Code of Virginia § 32.1-321.2 through 32.1-321.4,and § 63.1-124

Customers

Agency Customer Group	Customer	Customers served annually	Potential annual customers
	Clients / Beneficiaries – Low-income, aged, or disabled Virginians	77	0

Anticipated Changes To Agency Customer Base
The Department expects the number of eligible enrollees to increase. There are many individuals who are already eligible, but have not heard of the program nor applied for it because their case managers were aware of the waiting list. The waiting list is necessary due to the capped amount of funding.

Partners

Partner	Description
Advocacy groups	
Health care professionals, organizations, and facilities	
State government officials	

Products and Services

- *Factors Impacting the Products and/or Services:*
  The services provided by the HIV Unit are extremely important to eligible enrollees and is limited only by funding options. There has always been a waiting list and the funding for this area needs to increase on an annual basis. There is a growing need for insurance continuation for this population as the drug therapies improve. Complicating this situation is the fact that premiums for commercial insurance have been increasing yearly at double- digit rates.
- *Anticipated Changes to the Products and/or Services*
  The Department does not anticipate any changes to the products and services.
- *Listing of Products and/or Services*
  - Special Programs – financial assistance for health insurance premiums

Finance

- *Financial Overview*
  The HIV Premium Assistance Program is funded with 100% state General Funds.

  The budget for FY 2009 and 2010 is the FY 2008 Base Budget appropriation (as reflected in Chapter 847 of the Appropriation Act) plus changes incorporated during the 2008 General Assembly spring session (that resulted in Chapter 879 of the 2008 Appropriation Act).
- *Financial Breakdown*

	FY 2009		FY 2010		FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund						
Base Budget	$556,702	$0	$556,702	$0						
Change To Base	$0	$0	$0	$0						
Service Area Total	$556,702	$0	$556,702	$0						
Base Budget	$556,702	$0	$556,702	$0						

Change To Base	$0	$0	$0	$0
Service Area Total	$556,702	$0	$556,702	$0
Base Budget	$556,702	$0	$556,702	$0
Change To Base	$0	$0	$0	$0
Service Area Total	$556,702	$0	$556,702	$0
Base Budget	$556,702	$0	$556,702	$0
Change To Base	$0	$0	$0	$0
Service Area Total	$556,702	$0	$556,702	$0

Human Resources

- *Human Resources Overview*
  [Nothing entered]
- *Human Resource Levels*

Effective Date		
Total Authorized Position level	0	
Vacant Positions	0	
Current Employment Level	**0.0**	
Non-Classified (Filled)		
Full-Time Classified (Filled)		*breakout of Current Employment Level*
Part-Time Classified (Filled)		
Faculty (Filled)		
Wage		
Contract Employees		
Total Human Resource Level	**0.0**	*= Current Employment Level + Wage and Contract Employees*

- *Factors Impacting HR*
  [Nothing entered]
- *Anticipated HR Changes*
  [Nothing entered]

Service Area Objectives

- Maximize the potential of the program to cover as many eligible individuals as possible within available funding

  Objective Description

  Enrollment in this program provides vital continuing healthcare for eligible individuals at a lower cost to the state.

  Alignment to Agency Goals

  - Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

    Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families

  Objective Strategies

  - Continue to pay for services as required by State law

  Link to State Strategy

  - nothing linked

  Objective Measures

  - Percent of HIV program available funds expended at the end of the state fiscal year

    Measure Class: Other Measure Type: Outcome Measure Frequency: Quarterly Preferred Trend: Up

    Measure Baseline Value: 99.1 Date: 6/30/2009

    Measure Baseline Description: 99.1% in Fiscal Year (FY) 2009

    Measure Target Value: 99 Date: 6/30/2010

    Measure Target Description: 92% FY 2010

    Data Source and Calculation: Source: A DMAS (Department of Medical Assistance Services) expenditure report

from CARS (Commonwealth Accounting & Reporting System) is generated for state funds (0100) under the HIV-Positive program (46403). Budgeted/appropriated amounts for this measure are obtained from the applicable State Appropriation Act. This is a State funded only program. Calculation: Expenditures are divided by the budget to determine a percentage of funds used.

Service Area Strategic Plan

Department of Medical Assistance Services (602) 3/13/2014 8:56 am

Biennium: 2008-10

Service Area 11 of 13

Reimbursements from the Uninsured Medical Catastrophe Fund (602 464 05)

Description

This service area provides payment for medical services to eligible, uninsured Virginians diagnosed with a life-threatening medical catastrophe. Eligibility is based on income, legal residency in the Commonwealth of Virginia, life threatening injury or illness and an approved treatment plan. Applications are taken on a first come, first served basis.

Background Information

Mission Alignment and Authority

- *Describe how this service supports the agency mission*
  Individuals determined eligible for services under the program are provided access to life-saving health care services.
- *Describe the Statutory Authority of this Service*
  Code of Virginia §32.1-324.3 and § 32.1-325

Customers

Agency Customer Group	Customer	Customers served annually	Potential annual customers
Uninsured Medical Catastrophe Fund	Beneficiaries / Clients	15	0

Anticipated Changes To Agency Customer Base
It is anticipated that the number of individuals served through the Uninsured Medical Catastrophe Fund will increase in future years due to three key factors: 1) a newly dedicated staff position who can manage program activities, 2) current initiatives to streamline the regulations and application process, and 3) additional funding ($125,000) provided in FY 2006. However, this is a very small program and the number of persons served is limited by the available funding.

Partners

Partner	Description
Advocacy groups	
Boards and committees	
Health care professionals, organizations, and facilities	
State and local entities	
State government officials	

Products and Services

- *Factors Impacting the Products and/or Services:*
  There a number of administrative and operational factors that affect the products and services of the UMCF, including application requirements, provider agreements and requirements, payment methodology, regulatory restrictions and limited funding.
- *Anticipated Changes to the Products and/or Services*
  None
- *Listing of Products and/or Services*
  - Special programs – Life-saving health care services based on Medicaid rates
  - Operations (Enrollment and Member Services) – Determine eligibility, approve treatment plan, and determine treatment plan costs.
  - Operations (Provider Enrollment, Services and Reimbursement) – Contract with providers for services approved on the treatment plan; verify services rendered and initiate payment to the provider.

Finance

- *Financial Overview*
  The program was funded entirely with private contributions and donations until FY 06 when the General Assembly allocated $125,000 in one time funding for the program. These funds were placed in DMAS' administrative budget to be transferred to the UMCF.

  The budget for FY 2009 and 2010 is the FY 2008 Base Budget appropriation (as reflected in Chapter 847 of the Appropriation Act) plus changes incorporated during the 2008 General Assembly spring session (that resulted in Chapter 879 of the 2008 Appropriation Act).
- *Financial Breakdown*

	FY 2009		FY 2010		FY 2009	FY 2010	FY 2009	FY 2010
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund				
Base Budget	$0	$30,000	$0	$30,000				
Change To Base	$225,000	$10,000	$225,000	$10,000				
Service Area Total	$225,000	$40,000	$225,000	$40,000				
Base Budget	$0	$30,000	$0	$30,000				
Change To	$225,000	$10,000	$225,000	$10,000				

Base				
Service Area Total	$225,000	$40,000	$225,000	$40,000
Base Budget	$0	$30,000	$0	$30,000
Change To Base	$225,000	$10,000	$225,000	$10,000
Service Area Total	$225,000	$40,000	$225,000	$40,000

Human Resources

- *Human Resources Overview*
  [Nothing entered]
- *Human Resource Levels*

Effective Date		
Total Authorized Position level	0	
Vacant Positions	0	
Current Employment Level	**0.0**	
Non-Classified (Filled)		
Full-Time Classified (Filled)		*breakout of Current Employment Level*
Part-Time Classified (Filled)		
Faculty (Filled)		
Wage		
Contract Employees		
Total Human Resource Level	**0.0**	*= Current Employment Level + Wage and Contract Employees*

- *Factors Impacting HR*
  [Nothing entered]
- *Anticipated HR Changes*
  [Nothing entered]

Service Area Objectives

- Facilitate access to health care services to qualified uninsured Virginians who have been diagnosed with a life-threatening injury or illness

  Objective Description

  Uninsured individuals cannot always access required medical services to treat life-threatening injuries or illness. This program allows eligible individuals to receive medical treatment for a condition that otherwise left untreated, could result in death.

  Alignment to Agency Goals

  - Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

    Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families

  Objective Strategies

  - Review and streamline application processes to accommodate for the timeliness necessary for life-threatening conditions. • Explore the creation of a pre-approved regional list of providers willing to provide treatment under the conditions of the UMCF. • Educate and contact providers before a medical crisis occurs with information on both the UMCF and instructions to properly complete patient treatment plans in order to prevent costly delays.

  Link to State Strategy

  - nothing linked

  Objective Measures

  - Percent of completed applications processed within 45 days

    Measure Class: Other Measure Type: Outcome Measure Frequency: Quarterly Preferred Trend: Maintain

    Measure Baseline Value: 100 Date: 6/30/2009

    Measure Baseline Description: 100% in Fiscal Year (FY) 2009

    Measure Target Value: 100 Date: 6/30/2010

    Measure Target Description: 100% in FY's 2008, 2009 & 2010

    Data Source and Calculation: Source: The Department of Medical Assistance Services (DMAS) Program Operations Division tracking document of initial applications and approval/denial documents. Applicants must complete an application to include personal information, income information and information about the medical condition. A treatment plan signed by the attending physician must also be included with the initial application. The initial application must be mailed to DMAS. The application and related guidelines can be found on the DMAS website: www.dmas.virginia.gov Calculation: Number of applications expressed as a percent of the total, approved within 45 days/total applications. The target was changed to 45 days instead of 60 in 2008.

Service Area Strategic Plan

Department of Medical Assistance Services (602) 3/13/2014 8:56 am

Biennium: 2008-10

Service Area 12 of 13

Reimbursements for Medical Services Provided to Low-Income Children (602 466 01)

Description

The expansion of Medicaid eligibility for uninsured children from age 6 to 19 is part of Virginia's Title XXI program for uninsured children living below 200% of the federal poverty level (FPL). Prior to this expansion, children under age 6 could qualify for Medicaid benefits with family income up to 133% FPL but children from 6 to 19 would only qualify for Medicaid with income less than or equal to 100% FPL. Children from 6 to 19 with income between 100% FPL and 133% FPL might qualify for the FAMIS program instead; but this meant children in the same family would be enrolled in different programs and families would have to navigate two different systems of care. In September 2002, Virginia's Title XXI program was split into FAMIS for children 0 – 19 with income greater than Medicaid but less than or equal to 200% FPL; and the SCHIP Medicaid Expansion for children age 6 – 19 with income greater than 100% FPL but less than or equal to 133% FPL. Children covered by the SCHIP Medicaid Expansion receive full Medicaid benefits but are funded through Title XXI at a lower state-matching rate Than Title XIX (Medicaid).

In 2004, The Virginia General Assembly renamed Medicaid for children, including the SCHIP Medicaid Expansion program, to FAMIS Plus.

Background Information

Mission Alignment and Authority

- *Describe how this service supports the agency mission*
  The SCHIP Medicaid Expansion carries out the mission of DMAS by providing access to a comprehensive system of high quality and cost effective health care services to uninsured children age 6 to 19 with income between 100% FPL and 133% FPL.
- *Describe the Statutory Authority of this Service*
  CFR: 42 part 457
  Code of Virginia §32.1-351

Customers

Agency Customer Group	Customer	Customers served annually	Potential annual customers
Medicaid Expansion Program	Beneficiaries / Clients: Uninsured children age 6 to 19 with family income greater than 100% FPL and less than or equal to 133% FPL	57,658	0

Anticipated Changes To Agency Customer Base
The customer base of children eligible for the SCHIP Medicaid Expansion program is likely to remain approximately the same for the next several years. Factors that could affect the number of customers would include a downturn in the Virginia economy, private insurance market forces that result in an increase in rates of uninsurance, a significant increase in the 6 to 19 population, or policy changes affecting program eligibility.

Footnote for Service Area Customer Base Listing:
Number of children served at anytime during FY 2005.

It is currently estimated that approximately 16,000 children could qualify for Medicaid (including the SCHIP Medicaid Expansion) or FAMIS but are not enrolled. It is unknown how many of these children would qualify for the SCHIP Medicaid Expansion.

Partners

Partner	Description
Advocacy groups	
Boards and committees	
Federal agencies	
Health care professionals, organizations, and facilities	
Private business firms	
State and local entities	
State government officials	

Products and Services

- *Factors Impacting the Products and/or Services:*
  Federal and state appropriations and regulations impact the nature and scope of the services that can be provided through the SCHIP Medicaid Expansion. Unlike Medicaid, the SCHIP Expansion is not an entitlement program
- *Anticipated Changes to the Products and/or Services*
  Congress must reauthorize Title XXI no later than September 30, 2007. It is likely the federal funding formula that determines Virginia's annual allotment will be revised.
- *Listing of Products and/or Services*
  - SCHIP Medicaid Expansion • Coverage for comprehensive health care services through managed care or fee-for-service • Marketing and outreach to promote enrollment • Application processing and enrollment • Claims payment

Finance

- *Financial Overview*
  The Medicaid expansion program is covered with a mixture of state and federal funds. On the federal level this program is covered through the Title XXI SCHIP program that provides an enhanced federal match rate. The current match rate for Virginia is 35% state and 65% federal funds. The state match for the Medicaid expansion program comes from the state General Fund. The federal funds come from the federal Centers for Medicare & Medicaid

Services.

The budget for FY 2009 and 2010 is the FY 2008 Base Budget appropriation (as reflected in Chapter 847 of the Appropriation Act) plus changes incorporated during the 2008 General Assembly spring session (that resulted in Chapter 879 of the 2008 Appropriation Act).

- *Financial Breakdown*

	FY 2009		FY 2010		FY 2009	FY 2010
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund		
Base Budget	$25,948,070	$48,198,135	$25,948,070	$48,198,135		
Change To Base	$4,104,160	$7,613,150	$6,154,115	$11,420,208		
Service Area Total	$30,052,230	$55,811,285	$32,102,185	$59,618,343		
Base Budget	$25,948,070	$48,198,135	$25,948,070	$48,198,135		
Change To Base	$4,104,160	$7,613,150	$6,154,115	$11,420,208		
Service Area Total	$30,052,230	$55,811,285	$32,102,185	$59,618,343		

Human Resources

- *Human Resources Overview*
  [Nothing entered]
- *Human Resource Levels*

Effective Date		
Total Authorized Position level	0	
Vacant Positions	0	
Current Employment Level	**0.0**	
Non-Classified (Filled)		
Full-Time Classified (Filled)		*breakout of Current Employment Level*
Part-Time Classified (Filled)		
Faculty (Filled)		
Wage		
Contract Employees		
Total Human Resource Level	**0.0**	*= Current Employment Level + Wage and Contract Employees*

- *Factors Impacting HR*
  [Nothing entered]
- *Anticipated HR Changes*
  [Nothing entered]

Service Area Objectives

- We will work to improve the oral health and increase the utilization of appropriate preventative care of FAMIS and FAMIS Plus (Medicaid) enrolled children

  Objective Description

  This objective will focus DMAS' efforts to improve oral health outcomes for children and reduce long-term health care costs by improving the timely and appropriate utilization of preventive health care services.

  Alignment to Agency Goals

  - Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

    Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families.

  Objective Strategies

  - Promote utilization of preventive pediatric dental visits by children covered by Medicaid

  Link to State Strategy

  - nothing linked

  Objective Measures

  - Percentage of enrolled children who utilize dental services

    Measure Class: Agency Key Measure Type: Outcome Measure Frequency: Quarterly Preferred Trend: Up

    Measure Baseline Value: 35.93 Date: 6/30/2006

    Measure Baseline Description: 35.93% in Fiscal Year 2006

    Measure Target Value: 40 Date: 6/30/2010

    Measure Target Description: 40% in FY's 2008, 2009 & 2010

Data Source and Calculation: Source: Department of Medical Assistance Services (DMAS) claims data are utilized to determine the number of children covered by Family Access to Medical Insurance Security Plan (FAMIS) or FAMIS PLUS between the age of three and twenty-one receiving routine dental care visits. Calculation: This number is divided by the number of children in this age group enrolled in the program. The quarterly numbers are cumulative and calculated towards an annual percentage of children utilizing dental services. Due to the claim process, final results lag the closing period by about six months.

- Enroll all eligible children in the FAMIS and FAMIS Plus (Medicaid) programs

Objective Description

While enrollment of eligible children in the FAMIS program has increased dramatically, there are still uninsured children who could be covered and additional children who become uninsured every day. It is in the best interest of the children, their families and the Commonwealth to provide comprehensive health care coverage through the FAMIS program to this vulnerable population.

Alignment to Agency Goals

- Agency Goal: Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

  Comment: Council on Virginia's Future Long-Term Goal: Inspire and support Virginians toward healthy lives and strong and resilient families.

Objective Strategies

- Develop and implement a general marketing campaign specifically designed to retain current children and reach families with FAMIS eligible children. • Develop outreach activities and materials to reach traditionally “hard-to-reach” populations. • Increase the use of technology to improve customer service for interested families and to facilitate application processing and enrollment.

Link to State Strategy

- nothing linked

Objective Measures

- Number of eligible children enrolled in FAMIS Plus (Children's Medicaid) program

  Measure Class: Other Measure Type: Output Measure Frequency: Quarterly Preferred Trend: Up

  Measure Baseline Value: 416548 Date: 6/30/2005

  Measure Baseline Description: 416,548 in Fiscal Year (FY) 2005

  Measure Target Value: 430878 Date: 6/30/2010

  Measure Target Description: 430,878 in FY 2009 & 2010

  Data Source and Calculation: Data Source: Data from Virginia Medicaid Management System (VaMMIS) on the number of children enrolled on the first day of each month, following all cancellations that occur on the last day of each month, will be reported. Applicable children are in Family Access to Medical Insurance Security Plan (FAMIS), FAMIS Plus (Medicaid), and the Medicaid aid category numbers: 071, 072, 073, 074, 075, 076, 081, 082, 083, 085, 086, 088, 090, 091[children 6 and under], 092, 093, 098, 099).

Service Area Strategic Plan

Department of Medical Assistance Services (602) 3/13/2014 8:56 am

Biennium: 2008-10

Service Area 13 of 13

Administrative and Support Services (602 499 00)

Description

This service area includes the manpower, administrative support, policy and research and contractual services necessary to successfully operate the Agency's programs and activities.

Background Information

Mission Alignment and Authority

- *Describe how this service supports the agency mission*
  Our system of administrative support to all the operational areas of the agency allows us to provide access to a comprehensive system of high quality and cost effective health care services to qualifying Virginians.
- *Describe the Statutory Authority of this Service*
  Title 32.1, Chapters 9 &10, Code of VA: PL89-87m, as amended, Title 19, Social Security Act, Federal Code

Customers

Agency Customer Group	Customer	Customers served annually	Potential annual customers
	Beneficiaries / Clients	1,010,223	0

Anticipated Changes To Agency Customer Base
In order to keep pace with and better serve the increasing eligible population, there is a need to increase the Agency's maximum employment level to reduce our dependence on the use of hourly and contract personnel.

Partners

Partner	Description
Advocacy groups	
Boards and committees	
Federal agencies	
Health care professionals, organizations, and facilities	
Private business firms	
State and local entities	
State government officials	

Products and Services

- *Factors Impacting the Products and/or Services:*
  Projects related to the work of DMAS operational areas determine the work that is performed in the administrative divisions. Changes in administrative services are the result of significant operational projects, including the Medicare Prescription Drug Program, Medicaid Reform, Electronic Health Records, Disease Management Program, and the National Provider Identifier project.
- *Anticipated Changes to the Products and/or Services*
  The Department must be flexible and adapt to new programs and priorities in order to best meet recipient service needs. It is critical that the agency's MEL be increased in order to continue current programs and implement significant new functions.
- *Listing of Products and/or Services*
  - Operations (Financial Services) – Fiscal Services
  - Operations (Policy Analysis and Information Dissemination) –Communications and Legislative Liaison Services
  - Operations (Information Management)
  - Operations (Program Integrity) – Internal Audit Services
  - Operations (Provider Enrollment, Services and Reimbursement) – Provider Reimbursement Services
  - Appeals - Client Appeals and Provider Appeals of Audits and Other Adverse Agency Decisions
  - Administration – Human Resources Services & Training
  - Operations (Program Integrity) –Quality Assurances Services
  - Operations (Enrollment and Member Services, Provider Enrollment, Services and Reimbursement) –Appeals Services
  - Operations (Policy Analysis and Information Dissemination) – Policy and Research Services

Finance

- *Financial Overview*
  DMAS' total administrative funding consists of federal funds at 62% and state general (GF) funds at 38%. There are also several small grants that are paid from non-general funds (NGF). These total administrative amounts include $2.5 million in GF and $4.9 million in NGF funds for DMAS to manage the FAMIS administrative program.

  DMAS also serves as the pass-through agency for the transfer of federal funding to the Department of Social Services for Medicaid eligibility determinations. These amounts and smaller pass-throughs to four other state agencies are not in the base budget figures. All requested changes to the base budget will be documented in the decision package, base adjustment and technical adjustment submissions in November.

  The budget for FY 2009 and 2010 is the FY 2008 Base Budget appropriation (as reflected in Chapter 847 of the Appropriation Act) plus changes incorporated during the 2008 General Assembly spring session (that resulted in

Chapter 879 of the 2008 Appropriation Act). Non general funds are composed of Federal Funds and special fund Civil Money Penalties.

- *Financial Breakdown*

	FY 2009		FY 2010	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$37,830,399	$60,441,979	$37,830,399	$60,441,979
Change To Base	$4,756,355	$8,951,080	$4,416,355	$8,577,927
Service Area Total	$42,586,754	$69,393,059	$42,246,754	$69,019,906

Human Resources

- *Human Resources Overview*
The Department of Medical Assistance Services is a highly professional organization with 349 authorized classified positions. As of September 12, 2007, 332 of these positions are filled and 17 are vacant. Four of the classified employees are located in the Roanoke Office; one is located in Manassas, and one is in Virginia Beach. Because of increasing program requirements, the Department has had to use increasing numbers of hourly employees. Most of the contract employees work in the Information Management Division and play a critical role in the maintenance of the Virginia Medicaid Management Information System and any programmatic changes. The Department has 15 divisions/offices, which include the Office of the Director. Forty-two role titles are used and the most prevalent are the Health Care Compliance Specialist II (16.1%), Health Care Compliance Specialist I (13.9%), Program Administration Specialist II (13.6%) and Administrative and Office Specialist III (10.5%). We also employ workers from temporary employment agencies, such as Caliper.

  Additional Information for the Human Resource Levels Tab:

  Temporary Agency Workers - 5

- *Human Resource Levels*

Effective Date	9/12/2007	
Total Authorized Position level	349	
Vacant Positions	17	
Current Employment Level	**332.0**	
Non-Classified (Filled)	3	*breakout of Current Employment Level*
Full-Time Classified (Filled)	329	
Part-Time Classified (Filled)	0	
Faculty (Filled)	0	
Wage	97	
Contract Employees	24	
Total Human Resource Level	**453.0**	*= Current Employment Level + Wage and Contract Employees*

- *Factors Impacting HR*
Increased programmatic requirements continue to necessitate the extensive hiring of wage employees. The wage employees serve a vital role and require the same level of training as full-time employees. However, most of these employees seek other employment with benefits. Thus, the turnover rate among the wage workforce is considerably higher than the classified workforce. The restriction of 1500 work hours per year for wage workers also has a negative impact on productivity and retention.

  There is some concern regarding the aging workforce. The average age of the DMAS classified workforce is 48.8 years. As of August 31, 2007, twelve (12) employees are eligible for full retirement being age 50 with 30 years of service; three additional employees can retire with full benefits based on age. Eighty-five (85) employees (26% of the classified workforce) are in the 50 to 60 age group and they have obtained 10 years of service which would allow them to retire with partial benefits. Generally, most employees would prefer to retire with full benefits. The positions range from upper level management to support staff. During the next five years, eighteen (18) employees in the 50 to 60 age group identified above will become eligible for full retirement. Also, during this time period it is expected that a minimum of sixty three (63) additional employees will have obtained 10 years of experience and will be in this age group. These figures do not include employees who have purchased prior service and may be eligible for retirement much sooner.

  The turnover rate for classified employees leaving the Department for fiscal year 2007 (July 1, 2006 to June 30, 2007) was 6.10 % (18). Turnover is defined by DHRM as employees leaving state service. Most of these employees left the Department for advancement reasons. Of this number, 9 resigned for advancement, 5 retired, 3 were terminated based on the Standards of Conduct Policy, and 1 death.

- *Anticipated HR Changes*
With adequate funding, it is hoped that the employee training program will be enhanced even more than it has since the Employment and Training Manager position was authorized and filled. To date, DMAS is increasing the amount of employee training opportunities. Emphasis will be placed on project management, supervisory/leadership, performance management, computer software training and employee health and safety. This type of training is being scheduled for future training during the current fiscal year. In addition, it is planned to continue the DMAS Supervisory and Leadership Institute presented by the Community College Workforce Alliance; it will begin in October 2007 with a series of comprehensive supervisory and leadership classes.

  There will be greater use of the Learning Management System both internally and with the programs offered by the Department of Human Resource Management. The Learning Management System is a Web-based system designed to present learning and knowledge sharing opportunities to its users. It promotes learning through online course offerings, classroom course registration, and a consolidated transcript of all learning events for individual users. Currently, we are members of the DHRM LMS Users group and will continue implementing on-line access to the DHRM LMS Knowledge Center.

  It is anticipated that there will be improvement in automated databases provided by the Department of Human Resource Management and the Department of Accounts (DOA). The Recruitment Management System (RMS) should

be enhanced for better reporting capabilities. It is hoped that DOA will expand the capability of a paperless employee leave system.

The Maximum Employment Level was recently raised to 349 positions, but there is a continuing need to use wage employees to meet programmatic needs. Of the current seventeen (17) vacant classified positions, most are in some stage of the recruitment and selection process or under classification review. A high frequency rate of internal transfers and promotions seems to keep the vacancy rate consistently high.

Even though the turnover rate is not as high in DMAS as in some other agencies, retention of highly skilled employees must be emphasized through effective employee recognition programs, training, and fair and consistent compensation practices.

Service Area Objectives

- Recruit, develop and retain a skilled, diverse and adequately sized, professional workforce

  Objective Description

  A highly skilled and stable workforce is essential for meeting the goals and mission of the Department. To ensure such a workforce is in place, the Department needs a recruitment process that will attract the highest level of skilled candidates and retain these workers once hired. In addition, The Department needs a recognition program that contributes to a positive work environment.

  Alignment to Agency Goals

  - Agency Goal: Create a positive work environment that promotes staff development and training, facilitates effective communications and rewards high levels of performance.

    Comment: Council on Virginia's Future Long-Term Goal: To be recognized as the best-managed state in the nation.

  Objective Strategies

  - Redesign and implement an exit interview process that better captures reasons for employee resignations. • Develop effective and consistent rewards, incentives and recognition to improve employee morale and better recognize outstanding performance. • Design and implement a system to effectively train and develop staff. • Design, administer and analyze the results of an employee survey. • Revise the recognition program, as needed, based on survey results. • Maintain a record of awards and analyze for consistency and cost between divisions. • Prepare and analyze quarterly reports that include selection and turnover data as well as exit interview results.

  Link to State Strategy

  - nothing linked

  Objective Measures

  - Employee turnover rate

    Measure Class: Other Measure Type: Outcome Measure Frequency: Quarterly Preferred Trend: Down

    Measure Baseline Value: 11 Date: 6/30/2006

    Measure Baseline Description: 11% for FY 2006

    Measure Target Value: 7.0 Date: 6/30/2010

    Measure Target Description: 7.0% for FY's 2008, 2009 & 2010

    Data Source and Calculation: Source: DMAS tracking and reporting within the H.R. Division Calculation: Based on the Recruitment and Selection Log Analysis and Human Resources Transaction Log Analysis

- Safeguard and protect the assets of the agency, ensuring that incidents of fraud, waste and abuse are identified and reduced

  Objective Description

  The purpose of this goal is to protect taxpayer assets in the custody of DMAS and to optimize their employment through a system of controls designed to prevent, detect and eliminate financial and other irregularities such as waste, loss, and unauthorized use or misappropriation.

  Alignment to Agency Goals

  - Agency Goal: Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

    Comment: Council on Virginia's Future Long-Term Goal: To be recognized as the best-managed state in the nation.

  Objective Strategies

  - Conduct concurrent audits of DMAS business processes (DMAS Internal Audit); thoroughly investigate all hot line tips. • Follow through on findings of 1) annual audits of the DMAS financial statements and the DMAS system of internal control conducted by the Virginia Auditor of Public Accounts, 2) quarterly reviews of DMAS operations conducted by CMS and other Federal oversight agencies, and 3) DMAS concurrent audits. • Strengthen the current system of internal controls designed to prevent waste, loss, unauthorized use and misappropriation of Agency resources. • Perform periodic vulnerability assessments and implement process/system changes based on vulnerability assessment findings. • Ensure adequate standards of business conduct are being observed and financial statements and reports comply with generally accepted business standards. • Ensure the timely and accurate posting of data into Agency systems.

  Link to State Strategy

  - nothing linked

  Objective Measures

  - The degree to which financial statements and reports are free of material misstatement

    Measure Class: Other Measure Type: Outcome Measure Frequency: Annual Preferred Trend: Maintain

Frequency Comment: Results computed annually

Measure Baseline Value: 85 Date: 6/30/2006

Measure Baseline Description: 85% in FY 2006

Measure Target Value: 90 Date: 6/30/2010

Measure Target Description: 90% in FY's 2008, 2009 & 2010

Data Source and Calculation: Source: In January of each year, the outcome of IA concurrent testing performed within Internal Audit's Business Process Review System is reported in the Internal Audit Annual Report. This measure is calculated based on the cumulative overall quantitative score results from outstanding APA findings. Findings are assigned a risk level that is then multiplied by the number of years since the audit to produce a value for the outstanding finding. The values for all outstanding findings are totaled and subtracted from a possible score of 100%.

- DMAS achievement of an audit score of no less than 85.00 out of a possible 100.00

  Measure Class: Other Measure Type: Outcome Measure Frequency: Annual Preferred Trend: Maintain

  Frequency Comment: Results computed annually

  Measure Baseline Value: 85 Date: 6/30/2006

  Measure Baseline Description: 85% in FY 2006

  Measure Target Value: 90 Date: 6/30/2010

  Measure Target Description: 90% in FY's 2008, 2009 & 2010

  Data Source and Calculation: Source: In January of each year, the outcome of IA concurrent testing performed within Internal Audit's Business Process Review System is reported in the Internal Audit Annual Report. This measure is calculated based on the cumulative overall quantitative score results from: 1. outstanding APA findings, 2. results of Control Self Assessments, and 3. outstanding Internal Audit findings and IA testing of the outcome of quality assurance assessments of providers and recipients. Findings are assigned a risk level that is then multiplied by the number of years since the audit to produce a value for the outstanding finding. The values for all outstanding findings are totaled and subtracted from a possible score of 100%. For business process scoring, individual tests is assigned a factor weight. Each test is scored on the basis of 1 to 100. The weighted score for each test is the percent correct multiplied by the factor weight.

- Ensure programs are evaluated and monitored for operational effectiveness and efficiency

  Objective Description

  DMAS is under an obligation to Virginia taxpayers to operate its programs so as to maximize its use of taxpayer provided resources while delivering the highest quality of care those resources will command.

  Alignment to Agency Goals

  - Agency Goal: Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.

    Comment: Council on Virginia's Future Long-Term Goal: To be recognized as the best-managed state in the nation.

  Objective Strategies

  - Conduct quality assurance and concurrent audits. • Resolve all audit findings identified by the Virginia Auditor of Public Accounts • Perform regularly concurrent tests of program operations based on risk assessment.

  Link to State Strategy

  - nothing linked

  Objective Measures

  - The number of incidents involving operational inefficiency/ineffectiveness reported by audit entities

    Measure Class: Other Measure Type: Outcome Measure Frequency: Annual Preferred Trend: Maintain

    Frequency Comment: Results are computed annually

    Measure Baseline Value: 85 Date: 6/30/2006

    Measure Baseline Description: 85% in FY 2006

    Measure Target Value: 90 Date: 6/30/2010

    Measure Target Description: 90% in FY's 2008, 2009 & 2010

    Data Source and Calculation: Source: In January of each year, the outcome of IA concurrent testing performed within Internal Audit's Business Process Review System is reported in the Internal Audit Annual Report. This measure is calculated based on the cumulative overall quantitative score results from the outstanding Internal Audit findings and IA testing of the outcome of quality assurance assessments of providers and recipients. For business process scoring, individual tests is assigned a factor weight. Each test is scored on the basis of 1 to 100. The weighted score for each test is the percent correct multiplied by the factor weight.

- Increase the Agency's utilization of small, women-owned and minority businesses (SWaM)

Objective Description

This objective will allow the agency to align itself with the Governor's initiative of increasing SWaM participation throughout the Commonwealth. Alignment: Encouraging support of minority business development throughout the Commonwealth and strive to continue improving direct and indirect minority business relationships in the future.

Alignment to Agency Goals

- Agency Goal: Encouraging support of minority business development throughout the Commonwealth and strive to continue improving direct and indirect minority business relationships in the future.

  Comment: Council on Virginia's Future Long-Term Goal: To be recognized as the best-managed state in the nation.

Objective Strategies

- Work with DMBE to streamline the certification process for vendors not registered with DMBE. • Pursue multiple sources (e.g. DMBE, Internet, newspaper) on a regular basis to identify SWAM vendors that provide the goods and services needed for ongoing operations • Annually submit an aggressive SWAM Plan with goals of increasing SWAM participation from one fiscal year to the next. • Work with DBME to develop a reporting process which more accurately reflects the agency's SWAM efforts.

Link to State Strategy

- nothing linked

Objective Measures

- Percentage of agency's discretionary contracting and purchasing through SWaM vendors

  Measure Class: Other Measure Type: Outcome Measure Frequency: Quarterly Preferred Trend: Up

  Measure Baseline Value: 40 Date: 6/30/2009

  Measure Baseline Description: 40% Based on the Governor's statewide benchmark

  Measure Target Value: 53 Date: 6/30/2010

  Measure Target Description: 50% for FY 2008, 52% FY 2009 and 53% for FY 2010

  Data Source and Calculation: Source: Agency Quarterly SWaM Expenditure Report as provided on the DMBE (Department of Minority Business Enterprises) Supplier Diversity Expenditure Report. Calculation: The measure of SWaM purchasing and contracting is calculated in accordance with the procedures adopted by the Department of Minority Business Enterprises (DBME) for Prime contractors.

- Provide a client and provider appeal process and issue resulting decisions that comply with procedural and substantive requirements of state and federal laws, regulations, policy, and court orders.

Objective Description

This objective is mandated by law. Client appeals are governed generally by 42 CFR § 431.200 et. seq. (Fair Hearings for Applicants and Recipients.) There is also a court order (Shifflett v. Kozlowski) that sets forth certain requirements for the Department's client appeals, such as that 97% of decisions must be issued within 90 days from receipt of the appeal request. Provider appeals are governed generally by Va. Code § 2.2-4000 et seq. (Administrative Process Act). There are also requirements in Va. Code § 32.1-325.1 regarding the issuance of 100% of initial provider appeal determinations within 180 days from receipt of the appeal request. The conduct of informal and formal administrative appeals is also regulated by a series of strict time limitations set forth in the Virginia Administrative Code at 12 VAC 30- 20-500 et. seq. Alignment: • To operate with a high degree of customer service, demonstrate responsiveness and competency, and require accountability. • Safeguard and protect the assets of the agency, ensuring that incidents of fraud, waste and abuse are identified and reduced. • Process transactions in a timely and accurate manner in accordance with all HIPAA standards.

Alignment to Agency Goals

- Agency Goal: Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

  Comment: Council on Virginia's Future Long-Term Goal: To be recognized as the best-managed state in the nation.

Objective Strategies

- Dedicate sufficient administrative support to data entry and monitoring within the appeals electronic case tracking database. • Continued emphasis upon proactive initial screening of incoming appeal requests to identify recurring issues that might be addressed and resolved without the costs of a lengthy appeal process. Replace key personnel, including hearing officers and administrative support, lost to lack of funding and attrition, in order to keep abreast of growing caseloads that must continue to meet the timetables and deadlines set in Medicaid laws, regulations, policy and court orders.

Link to State Strategy

- nothing linked

Objective Measures

- Percentage of all Client and Provider Appeal Decisions issued in full compliance

  Measure Class: Other Measure Type: Outcome Measure Frequency: Quarterly Preferred Trend: Maintain

  Measure Baseline Value: 100 Date: 6/30/2007

  Measure Baseline Description: 100% for Fiscal Year (FY) 2007

  Measure Target Value: 100 Date: 6/30/2010

  Measure Target Description: 100% for FY's 2008, 2009 & 2010

  Data Source and Calculation: DMAS Appeals Division database tracks all provider and client appeal deadlines

and results. The individual Client and Provider results are averaged to compute the performance values.

- We will be prepared to act in the interest of the citizens of the Commonwealth and its infrastructure during emergency situations by actively planning and training both as an agency and as individuals

Objective Description

Alignment: This goal ensures compliance with federal and state regulations, polices and procedures for Commonwealth preparedness, as well as guidelines promulgated by the Assistant to the Governor for Commonwealth Preparedness, in collaboration with the Governor's Cabinet, the Commonwealth Preparedness Working Group, the Department of Planning and Budget and the Council on Virginia's Future. The goal supports achievement of the Commonwealth's statewide goal of protecting the public's safety and security, ensuring a fair and effective system of justice and providing a prepared response to emergencies and disasters of all kinds.

Alignment to Agency Goals

- Agency Goal: We will strengthen the culture of preparedness across state agencies, their employees and customers.

  Comment: Council on Virginia's Future Long-Term Goal: To be recognized as the best-managed state in the nation.

Objective Strategies

- The agency Emergency Coordination Officer will stay in regular communication with the Office of Commonwealth Preparedness, the Virginia Department of Emergency Management, and other Commonwealth Preparedness Working Group agencies.

Link to State Strategy

- nothing linked

Objective Measures

- Agency Preparedness Assessment Results (% out of 100)

  Measure Class: Other Measure Type: Outcome Measure Frequency: Annual Preferred Trend: Up

  Measure Baseline Value: 77.65 Date: 6/30/2008

  Measure Baseline Description: Measure Baseline Description: 2008 Agency Preparedness Assessment Results (% out of 100)

  Measure Target Value: 75 Date: 6/30/2009

  Measure Target Description: 75% through FY 2010

  Data Source and Calculation: The Agency Preparedness Assessment is an all-hazards assessment tool that measures agencies' compliance with requirements and best practices. The assessment has components including Physical Security, Continuity of Operations, Information Security, Vital Records, Fire Safety, Human Resources, Risk Management and Internal Controls, and the National Incident Management System (for Virginia Emergency Response Team - VERT - agencies only).

- To ensure that resources are used efficiently and programs are managed effectively, and in a manner consistent with applicable state and federal requirements

Objective Description

To ensure that resources are used efficiently and programs are managed effectively, and in a manner consistent with applicable state and federal requirements.

Alignment to Agency Goals

- Agency Goal: Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.

  Comment: Council on Virginia's Future Long-Term Goal: To be recognized as the best-managed state in the nation.

Link to State Strategy

- nothing linked

Objective Measures

- Percent of administrative measures marked as "meets expectations" (green indicator) for the agency

  Measure Class: Other Measure Type: Outcome Measure Frequency: Annual Preferred Trend: Maintain

  Frequency Comment: Frequency Comment: Determined after the end of each fiscal year

  Measure Baseline Value: 80 Date: 6/30/2005

  Measure Baseline Description: 80% in Fiscal Year (FY) 2005

  Measure Target Value: 100 Date: 6/30/2010

  Measure Target Description: 100% in FY's 2008, 2009 & 2010

  Data Source and Calculation: Source: There are currently 13 administrative measures organized into five categories. Each measure has a different data source. Agencies refer to the administrative measures data source information table to locate the data source for each measure. The table is located in Virginia Performs/Agency Planning and Performance/Administrative Measures. Calculation: Agencies select the appropriate colored indicator (green, yellow, or red) for each measure, depending on results. A gray indicator is used for measures where data are unavailable. The agency administration measure is the percent of the administrative measures that have a green indicator (meets expectations). Items with a gray indicator are excluded from the calculation.

- Unit cost of processing Medicaid claims

  Measure Class: Productivity Measure Frequency: Quarterly Preferred Trend: Up

  Measure Baseline Value: 0.59 Date: 6/30/2009

  Measure Baseline Description: $0.59 Cumulative total cost for Fiscal Year 2009

  Measure Target Value: 0.59 Date: 6/30/2010

  Measure Target Description: $0.59 Cumulative total cost targets for Fiscal Year 2010

  Data Source and Calculation: Source The unit cost is calculated quarterly by factoring the following: The numerator is the total payment for all admin and systems support costs paid to the fiscal agent that processes claims on the agency's behalf, divided by a denominator that is the number of claims processed/encountered or adjudicated. Data sources include expenditures reported in CARS (Commonwealth Accounting and Reporting System) and claims reported through the agency's VaMMIS system (Virginia Medicaid Management Information System), DARS report MR-O-105