Trends

No Data Available

Legend:
Increase, Decrease, Steady

Key Performance Areas

No Data Available

Productivity

No Data Available

Legend:
Improving, Worsening, Maintaining

For more information on administrative key, and productivity measures, go to www.vaperforms.virginia.gov/agencylevel/index.cfm

EXECUTIVE PROGRESS REPORT

March 2014

Background & History

The Department of Medical Assistance Services (DMAS) administers a variety of health care programs for qualifying Virginians. Medicaid, an entitlement program authorized under Title XIX of the Social Security Act, is financed by the state and federal governments and administered by the states. The Children's Health Insurance Program (CHIP), authorized under Title XXI of the Social Security Act, is also jointly financed by the state, but unlike Medicaid is not an entitlement program.

While Medicaid was created to assist persons with low income, coverage is dependent upon other criteria as well. Eligibility is primarily for those persons falling into particular categories, such as low income children, pregnant women, the elderly, persons with disabilities, and parents meeting specific income thresholds. Within federal guidelines, states set their own income and asset eligibility criteria for Medicaid, which results in a large variation among the states as to those deemed eligible. In Virginia, income and resource requirements vary by category.

Primary Product & Services

As permitted under federal law, the Virginia Medicaid program covers a broad range of services, with nominal cost sharing for most beneficiaries. The Virginia Medicaid program covers all of the federally mandated services, which include, but are not limited to: inpatient and outpatient hospital services, emergency hospital services, physician and nurse midwife services, federally qualified health centers and rural health clinic services, laboratories and x-ray services, transportation services, family planning services and supplies, nursing facility services, home health services (nurse, aide), and the Early and Periodic Screening, Diagnosis, and Treatment program for children (“EPSDT”).

Virginia Medicaid also covers several optional services, including, but not limited to: certified pediatric nurse and family nurse practitioner services, routine dental care for persons under age 21, prescription drugs, rehabilitation services such as physical therapy (PT), occupational therapy (OT), and speech language pathology (SLP) services, home health services (PT, OT, SLP), hospice, some mental health services, some substance abuse services; and intermediate care facilities for persons with developmental and intellectual disabilities and related conditions.

Medicaid beneficiaries also receive coverage through home and community-based “waiver” programs. These waivers provide community-based long-term care services as an alternative to institutionalization. The following waiver programs are available to Medicaid beneficiaries who meet the level of care criteria: Alzheimer's waiver, Day Support for Persons with Intellectual Disabilities waiver, Elderly or Disabled with Consumer-Direction waiver, Intellectual Disabilities waiver, Technology Assisted waiver, and Individual and Family Developmental Disabilities Support waiver.

Customer Base

DMAS provides health care coverage to individuals through two general care delivery models: 1) a model utilizing contracted managed care organizations (MCO) to coordinate care and 2) a fee-for-service (FFS) model, whereby service providers are reimbursed directly by DMAS.

The MCO program started in 1996 and is now available in all regions of the state. As of October 2012, there were 684,489 Medicaid and CHIP beneficiaries receiving their health care coverage through the MCO program (69 percent of total beneficiaries) and 303,398 beneficiaries were enrolled in the FFS program (31 percent of total beneficiaries). Another “managed care” option for long-term care recipients is the expansion of the Program for All-Inclusive Care for the Elderly (PACE) across the Commonwealth. PACE is designed to allow Medicaid-eligible individuals aged 55 or older who have been assessed as meeting nursing facility level-of-care to avoid more costly institutionalization by providing

coordinated care in their homes and communities.

The Patient Protection and Affordable Care Act (PPACA) will have a significant impact on recipient populations served under the programs administered by DMAS. While the now optional PPACA-expansion of coverage would magnify this impact should the Commonwealth decide to expand, irrespective of the decision to expand, the individual mandate for health care coverage is expected to bring additional individuals into our programs when they decide to seek health coverage for themselves or their families (the woodwork effect). Furthermore, the availability of subsidized private coverage offered through the Exchange necessitates that DMAS examine the need for current programs offering some level of coverage to individuals in the income range who will be eligible for the subsidized private coverage, such as certain current enrollees in Plan First and FAMIS MOMS. Changes to these programs based on the broader PPACA reform may also impact the covered population for DMAS going forward.

Customer Listing

No Data Available

Key Agency Statistics

Children and parents or caretakers of children make up almost 70 percent of Medicaid beneficiaries, but they account for less than a third of Medicaid spending. Persons who are elderly or who have disabilities account for the majority of Medicaid spending because of their intensive use of acute and long-term care services.

Approximately 85% of the DMAS customer base is served through the Medicaid program. The trends in enrollment growth are as follows: 6% in FY (Fiscal Year) 2003, 9.1% in FY 2004; 7.6% in FY 2005; 4.9% in FY 2006; a decrease of (0.4%) in FY 2007; 2.0% in FY 2008; 5.9% in FY 2009, 10.3% in FY 2010, 5% in FY 2011 and 4% in FY 2012. The Department’s 2011 consensus forecast projects 1.7% growth in FY 2013 and 1.0% growth in 2014 based solely on historical trends. 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. Factors that could affect the number of Medicaid customers would include changes in the Virginia economy, private insurance market forces that result in an increase in rates of uninsurance, or policy changes affecting program eligibility.

Finances

DMAS' base budget is currently funded with approximately 36% state general funds and 64% non-general funds for Fiscal Year (FY) 2013 and 40%/60% respectively for FY 2014. The non-general funds are comprised of Federal Funds, the Virginia Health Care Fund, the FAMIS Trust Fund and other special funds.

The Federal Medical Assistance Percentage (FMAP) rate for the Virginia Medicaid program is 50%.

The Base Budget in the table below is the FY 2012 appropriation as reflected in Chapter 890 of the 2011 Appropriation Act including technical adjustments directed by the Department of Planning and Budget (DPB).

Fund Sources

No Data Available

Revenue Summary Statement

The Agency's total revenue consists of two types of resources: the general fund and nongeneral funds. General fund revenues are derived from general taxes paid by citizens and businesses in Virginia. DMAS uses this revenue to provide matching state funds required by the federal government for federal grants. The Medicaid program is an example of a federal entitlement program that requires a state contribution.

Non-general funds from Federal funds and grants are the largest single source of nongeneral fund revenue for DMAS. About 88 percent of all revenue is from these Federal sources. The remaining non-general revenue is from various sources such as: funds returned due to cost settlements, audit collections and pharmacy rebates. In addition, a Master Settlement Agreement (MSA) was signed between major participating cigarette manufacturers and states on November 23, 1998 that releases participating manufacturers from smoking-

related claims in return for an annual cash payment to the states in perpetuity. The Virginia Health Care Fund receives 41.5 percent of the MSA allocation for the purposes of paying for various health care costs faced by the Commonwealth, including the Medicaid program. In Fiscal Year 2012, this revenue totaled over $49 million.

Key Risk Factors

DEMOGRAPHIC. The number of persons the department serves is increasing. This is placing increased demands for long-term care and home and community based program services. Also, the number of children served continues to grow as a result of changes in the economy.

NETWORK ACCESS. DMAS relies on its contracted health care providers to deliver services to customers. Some provider groups receive increases in reimbursement, but others receive very modest amounts. Without sufficient increases, access to care will decline as providers make business decisions to no longer participate in Medicaid or FAMIS (Family Access to Medical Insurance Security). Even with increases, most providers are still paid well below the amounts paid by commercial insurers.

FEDERAL CHANGES. Implementation of the Patient Protection and Affordable Care Act of 2010 (PPACA) continues to occupy significant agency efforts. Further, if the state chooses to implement the Medicaid expansion option, Medicaid enrollment could increase significantly. DMAS is coordinating with other State agencies to develop the business processes and technology capacity to manage these changes.

COORDINATION OF SERVICE. DMAS works with 23 other state agencies, 10 of which are involved in healthcare-related activities on DMAS's behalf. One is the department of Social Services that certifies costs exceeding $100 million annually on behalf of 121 local departments of social services. As the agency responsible for Medicaid, DMAS is accountable to federal authorities for resolving any issues or payments.

EXPENDITURES. Expenditures for the agency have increased from $2.8 billion in FY 2001 to $8.0 billion in FY 2012. This increase has occurred despite several significant savings initiatives.

Performance Highlights

DMAS has been working to make the Medicaid and FAMIS programs more cost-effective and quality-focused. The primary areas of focus to achieve this outcome revolve around care-coordination, improved business flow with enterprise-based information management, and program integrity. Specifically, the Department is working to bring care coordination principles to all populations and services under programs administered at DMAS. These include: 1) the expansion of Medallion II, the capitated MCO program, geographically and to new recipient types (foster care children and waiver recipients for their acute medical needs); 2) the use of independent assessments to assess children's needs for community mental health services, followed by development of a care coordination for community mental health services for both children and adults; 3) targeted case management for children being served under the Early Intervention program; and, 4) the examination and development of care coordination models to improve service delivery for Medicare-Medicaid enrollees.

In addition to care coordination, the Department and our partners across the HHR (Health and Human Resources) Secretariat are taking advantage of unprecedented federal funding to modernize eligibility systems across the HHR spectrum. For DMAS, this will entail a new eligibility determination and enrollment system that will automate, to the extent possible, the eligibility process resulting in real-time determinations of eligibility for certain applicants of Medicaid and FAMIS.

Performance Measures

Management Discussion & Analysis

General Information about the Ongoing Status of the Agency

Virginia's Medicaid program is very large and complex and has many different components and activities. Several factors impacting Virginia Medicaid are: (i) an aging population, especially those age 65 and older; (ii) an increase in the number of persons with disabilities seeking services; (iii) health care reform and funding, (iv) new technology requirements; such as: electronic prescriptions, and electronic health records, and (iv) continued growth in overall program enrollees and costs.

DMAS must find innovative ways to ensure adequate provider/network access as well as strategies to bolster its own administrative capacity to handle a growing and changing client base. To be prepared, DMAS will need to monitor and act pro-actively by adjusting current activities and implementing new enhancements that provide effective and efficient services to our customers. DMAS will also need to work with Medicaid providers that must adjust to growing caseloads, stagnant or lower reimbursement rates, and new Medicaid population groups that will seriously challenge their ability to fully absorb the financial and operational impact on their practices and businesses.

Agency priorities include the following: Responding to state and national Medicaid and health care reform issues; Coordinating care for all covered individuals and services; Implementing an integrated delivery model for Medicare-Medicaid enrollees; Improving the effectiveness of home and community-based services for seniors and people with disabilities and increase the number of Program for All Inclusive Care for the Elderly (PACE) sites; Increasing retention efforts to keep eligible children enrolled in Medicaid and FAMIS; Enhancing the Department's capabilities and operations in preventing, identifying, and eliminating fraud and abuse; Improving SWaM (Small,Women, and Minority) contracting and purchasing; and Implementing efforts to oversee and manage behavioral health services.

Information Technology

The Department of Medical Assistance Services is a key participant in the eHHR (Electronic Health and Human Resources) program, which was formed to facilitate inter-agency collaboration on systems and data sharing. DMAS is the main source of funding for the systems that are being built in order to modernize eHHR infrastructure, improve services to citizens, and prepare for the eligibility determination and enrollment of the citizens who will become eligible for insurance coverage under the PPACA. DMAS staff created and staffed the eHHR Program Office. Under its auspices, a number of information technology projects have been initiated, including a Service Oriented Architecture (SOA) platform, customer authentication services, enterprise data management, and replacement of the eligibility and enrollment systems utilized by the Department of Social Services.

DMAS continues to implement systems enhancements to support federal and state mandates and program initiatives, plus on-line web-based services. Initiatives implemented or under development include: Federally mandated standard transactions and codes; Functionality to pay incentive payments to providers for adoption of electronic health record technology; MMIS functionality to support managed care expansion and drug rebates; and initiatives to transition providers to electronic transactions.

The 2012 U.S. Supreme Court decision made the PPACA-mandated Medicaid expansion optional for states.

Workforce Development

The Department of Medical Assistance Services is a highly professional and efficient organization. The Department has 16 divisions and offices including the Office of the Director. Overseeing all Medicaid activities and resources in these divisions for over 1 million customers are 425 authorized classified positions effective for State Fiscal Year 2014 with 352 filled as of August 2013. Also as of August 2013, due to increasing program requirements, the Department utilizes 83 authorized hourly employees that represent a significant component of the agency workforce. Finally, 41 contract employees support the Information Management Division as of August 2013 and play a critical role in maintaining the agency' s systems.

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, classified 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 agency minimizes this impact through selective assignments and seeking classified positions when permanency is justified.

There is some concern regarding the aging workforce. Potential retirements could have a significant impact on agency' s operations in terms of possible loss of experienced managers and agency staff. Retention of highly-skilled employees, evident by low employee turnover rates, continues to be emphasized through effective employee recognition programs, training, and fair and consistent compensation practices.

Physical Plant

The Department of Medical Assistance Services is located in a privately leased building at 600 E. Broad Street, Richmond, Va. 23219.