Department of Medical Assistance Services (602)

Agency Plan

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.

Values

Customer Service:Operate with a high degree of customer service.
Responses:Demonstrate integrity, respect, responsiveness and competency in our actions and communications
Collaboration:Foster an atmosphere of effective collaboration with our customers and stakeholders
Innovation & Accountability:Encourage innovation and require accountability

Information Technology

Current Operational IT Investments

The following acronyms are used in the Information Technology section below:

- eHHR-Electronic Health and Human Resources program
- PPACA-Patient Protection and Affordable Care Act
- HIPAA-Health Insurance Portability and Accountability Act
- VITA/NG-Virginia Information Technologies Agency/Northrop Grumman
- CMS-Centers for Medicare & Medicaid Services
- CMSO-Center for Medicaid and State Operations
- ARRA-American Recovery and Reinvestment Act
- FAMIS-Family Access Medical Insurance Security

The Department of Medical Assistance Services (DMAS) is a key participant in the eHHR 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 HHR infrastructure, improve services to citizens, and prepare the Commonwealth for the eligibility determination and enrollment of the citizens who will become eligible for insurance coverage under the PPACA. DMAS Information Management 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.

In conjunction with its Medicaid Management Information System (MMIS) fiscal agent Xerox, DMAS continues to implement systems enhancements to support federal and state mandates and program initiatives. DMAS also continues to develop online web-based services to improve services to the citizen and provider communities. Initiatives implemented or under development include:

- Completed the federally mandated upgrade to the HIPAA-mandated standard transactions for electronic data exchange by the January 1. 2012 mandated compliance date.
- Initiated a project to comply with the HIPAA mandate to upgrade to ICD-10 codes by October 1, 2014.
- Implemented functionality to pay incentive payments to providers for adoption of electronic health record technology.
- Implemented functionality for use by members and providers to search for providers.
- Implemented MMIS functionality to support DMAS program initiatives, including managed care expansion in Southwest Virginia and drug rebates on pharmacy encounters.
- Continued initiatives to transition providers to use of electronic transactions. As part of these initiatives, DMAS made significant strides in the reduction of paper claims. During the past 12 months, paper claims have been reduced from 10% of total fee for service claims to 5%. Online provider enrollment and online level of care assessments are under development.

DMAS completed the transformation of its information technology infrastructure to the VITA/NG partnership in August 2012.

DMAS operates a mission-critical function using the Oracle Government Financials System (GFS). Agency staff supports the system through required maintenance and enhancements, as well as product upgrades. The GFS application was upgraded to v.11 in August 2011. The final database upgrade was completed in October 2011. DMAS is planning to complete the next upgrade to v.12 by the end of 2013.

Factors Impacting the Current Agency IT

The 2012 U.S. Supreme Court decision made the PPACA-mandated Medicaid expansion optional for states. The Governor and the Legislature will determine the direction for Virginia, but details will not be known until April 2013. Virginia state government does not currently have the business processes or technology capacity to support self-directed services as envisioned for the Health Benefit Exchange. In addition, CMS issued a final rule that considers eligibility and enrollment systems as part of the MMIS, thereby becoming eligible for enhanced federal funding. Medicaid Information Technology Architecture (MITA), a joint initiative between CMS and CMSO, is intended to foster integrated business and information technology transformation across the national Medicaid enterprise that will enable successful administration of the Medicaid program. Using the MITA State Self-Assessment, Virginia identified the future state agency capabilities needed to meet the CMS objectives, and a series of enterprise-level information technology projects that will support those capabilities.

The Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification requires ongoing compliance with standardized transactions and code sets. The PPACA included four phases of new HIPAA requirements to be implemented between January 1, 2013 and January 1, 2016. The PPACA also included mandates for

provider screening and national claims coding.

Proposed IT Solutions

ARRA, PPACA, and eligibility and enrollment system funding under the MMIS present significant funding opportunities to improve the quality and value of Virginia healthcare. By developing new systems based on MITA, and using the enhanced federal funding match rates available under ARRA, PPACA, and MMIS funding for eligibility and enrollment systems, the return on Virginia's information technology investments for the Medicaid program is sound. The federal funding available provides opportunities to achieve the following outcomes for Virginia:

- Build on current health reform efforts
- Modernize information technology infrastructure as an enabler for future business transformation
- Provide a technical environment where standards-based interoperability is possible between new and legacy systems
- Provide to all Virginians a web-based, self-directed service option for health and human services
- Reduce the need for large administrative and operational staff for federal and state programs
- Reduce overall long-term technology costs for federal and state programs
- Provide an enterprise technology environment that is accessible on a pay-for-use basis by federal, state, and local governments as well as non-government organizations, community based-services, and commercial interests as allowed by policy.

ARRA and PPACA have many interdependencies and commonalities between them. Together they present significant opportunities to establish technical foundations for the future transformation of government services. The primary impact to DMAS is leveraging the SOA infrastructure to include enterprise data management and the replacement of the eligibility systems that ultimately will trigger the retirement of the MMIS member subsystem and the FAMIS eligibility determination system.

Based on the MITA Transition Plan, the MMIS will begin a long term strategic process to align with MITA and the HHR IT Strategic Plan. The more significant architectural changes will be targeted in conjunction with the re-procurement of the MMIS Fiscal Agent Services contract.

In addition to Medicaid expansion, PPACA included several other mandates that will require significant changes to the MMIS. The mandates include enhanced screening of providers, national claims coding initiatives, unique identification numbers for health plans, and enhancement of the standard transactions for electronic data interchange.

DMAS' Information Management Division will maintain and enhance the Oracle GFS 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. In addition, the Information Management Division is in the process of re-developing aging client-based applications and replacing them with web-based technology.

The Information Management Division will continue to work with the VITA/NG IT Partnership on the transition of its DMAS-housed datacenter to the Commonwealth-housed datacenter.

Financial Overview

The Base Budget in the table is the Fiscal Year 2012 appropriation as reflected in Chapter 890 of the 2011 Appropriation Act. Adjustments to this base reflect the annual utilization and inflation forecast and other amendments contained in the 2013 Virginia Acts of Assembly - Chapter 806.

DMAS' base budget is currently funded with approximately 46% state general funds and 54% non-general funds. 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 currently 50%.

Budget Component	2013 GF	2013 NGF	2014 GF	2014 NGF
Base	3,483,587,161	4,108,627,754	3,483,587,161	4,108,627,754
Changes to Base	64,174,151	416,495,796	367,057,395	620,588,994
Total	3,547,761,312	4,525,123,550	3,850,644,556	4,729,216,748

Agency Goals

• 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 the Department of Medical Assistance Services' (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 providers and to eligible and enrolled individuals who ultimately benefit from these important services.

Long Term Goal

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

Societal Indicator: Health Insurance

• 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.

Long Term Goal

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

Societal Indicator: Health Insurance

• 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, the agency plays a significant role in ensuring that those who are eligible for its services receive quality health care. DMAS believes that a focus on care coordination and prevention-based strategies will reap positive health benefits for its clients and sound fiscal benefits for taxpayers.

Long Term Goal

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

Societal Indicator: Life Expectancy

• 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.

Long Term Goal

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

Societal Indicator: Government Operations

• 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 are essential for protecting these resources. DMAS will continue to rigorously examine the way it operates to reduce waste and to prevent fraud and abuse.

Long Term Goal

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

Societal Indicator: Government Operations

• 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 searches for best practices within and outside of the health care industry and state government and strives to develop innovative approaches for delivering services to its clients.

Long Term Goal

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

Societal Indicator: Government Operations

• 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. The agency will continue to seek out SWaM vendors as procurement opportunities arise.

Long Term Goal

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

Societal Indicator: Civic Engagement

Programs and Service Areas for Agency

- 32107: Reimbursements for Medical Services Related to Involuntary Mental Commitments
- 40703: Grants for Improving The Quality of Health Services
- 44602: Reimbursements for Medical Services Provided Under the Family Access to Medical Insurance Security Plan
- 45607: Reimbursements to State-Owned Mental Health and Intellectual Disabilities Facilities
- 45608: Reimbursements for Behavioral Health Services
- 45609: Reimbursements for Medical Services
- 45610: Reimbursements for Long-Term Care Services
- 46403: Insurance Premium Payments for HIV-Positive Individuals
- 46405: Reimbursements from the Uninsured Medical Catastrophe Fund
- 46601: Reimbursements for Medical Services Provided to Low-Income Children
- 499: Administrative and Support Services

Customers

Pre-Defined Customer Group	User Specified Customer Group	Customers Served Annually	Potential Annual Customers	Projected Trend in # of Customers
Low-Income	FAMIS	104,197	0	Increase
Low-Income	Medicaid Expansion Program	88,063	0	Increase
Low-Income	Involuntary Mental Commitment Fund	9,302	0	Stable
Low-Income	Electronic Health Records (EHR) Assistance	120	0	Increase
Low-Income	HIV Premium Assistance Program	46	0	Stable
Low-Income	Uninsured Medical Catastrophe Fund	13	0	Stable
Low-Income	Medicaid (adults) and FAMIS Plus (children)	1,096,470	0	Increase

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.

Products and 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.

Trends

Rankings & Customer Trends

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.

Trend Name	Trend Area
Complexity of recipient needs	Increase
Number and type of providers	Increase
Number and age of population	Increase

Performance Highlights: Service Performance & Productivity Initiatives

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.

Management Discussion & Analysis

Future Direction, Expectations, and Priorities

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.

32107: Reimbursements for Medical Services Related to Involuntary Mental Commitments

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

Mission Alignment and Authority

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.

Customers for this Service Area

Anticipated Changes to Customers Base

The number of clients placed under an involuntary mental commitment will be affected by efforts to augment services and change length of stay guidelines. Increased access to health care coverage under PPACA beginning January 1, 2014 may reduce the need for public coverage of these services.

Current Customer Base

Pre-Defined Customer Group	User Specified Customer Group	Customers Served Annually	Potential Annual Customers	Projected Trend in # of Customers
Low-Income	Beneficiaries / Clients	9,302	0	Stable

Partners for this Service Area

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

The number of clients placed under an involuntary mental commitment will be affected by efforts to augment services, changs in length of stay guidelines, and the take up rate in insurance of insurance available through the Health Benefits Exchange in 2014.

Anticipated Changes to the Products and/or Services

No significant changes are anticipated for this program.

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

Financial Overview

Budget Component	2013 GF	2013 NGF	2014 GF	2014 NGF
Base	12,335,627	0	12,335,627	0
Changes to Base	48,359	0	595,134	0
Total	12,383,986	0	12,930,761	0

Objectives for this Service Area

Objective
Ensure that providers treating TDO (Temporary Detention Order) clients continue to be compensated for the allowable services they provide and ensure that these services are within the timeframe of the commitment order.

Description
Reimburse providers for the services provided to the client who is detained under the involuntary mental commitment.

Objective Strategies
- • Maintain up to date TDO billing instructions. • Provide training for providers on the TDO process and responsibility.

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

Measures
- Percentage of accurate reimbursement payments processed within 30 calendar days of receipt of clean claim at the Department of Medical Assistance Services (DMAS)

Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Stable | Frequency: Quarterly

Data Source and Calculation

Reports from the Virginia Medicaid Management Information System (VaMMIS) and a manual log maintained by Department of Medical Assistance Services (DMAS) Program Operations staff. These reports capture: the date of claim without errors as received by DMAS, date of processing by DMAS' fiscal agent contractor, date the claim adjudicated for payment, and the actual remittance advice date.

40703: Grants for Improving The Quality of Health Services

Description

As of July 2012, federal funding is available to qualifying providers in the state to enable them to implement technology needed to produce and use electronic health records (EHR). This service area represents efforts of the Department of Medical Assistance Services (DMAS) to implement and administer a Medicaid Provider Incentive program in Virginia for EHR. This includes payments to contractors for systems changes (entirely federal funded) and program administration. Contracted efforts include but are not limited to determining provider payment eligibility, processing incentive payments, conducting outreach, and providing technical support.

Mission Alignment and Authority

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 health services, information, and records are available.

Customers for this Service Area

Anticipated Changes to Customers Base

The customers for this service area program are Virginia Medicaid service providers eligible to receive Electronic Health Records (EHR) assistance and payments. The population for this group is estimated to be 2000.

Current Customer Base

Pre-Defined Customer Group	User Specified Customer Group	Customers Served Annually	Potential Annual Customers	Projected Trend in # of Customers
Health Care	Medicaid Providers	120	2,000	Increase

Partners for this Service Area

Partner	Description
Industry Associations	Assistance with outreach and training
VHQC (Virginia Health Quality Center)	Assistance with outreach and training
Federally approved contractors	Assistance with outreach and training

Products and Services

Factors Impacting the Products and/or Services

Factors impacting this new national program include changes in federal guidance and deadlines.

Anticipated Changes to the Products and/or Services

Listing of Products and / or Services

Processing incentive payments for eligible providers to integrate their systems

Conducting outreach to eligible providers

Providing technical support to eligible providers

Financial Overview

Budget Component	2013 GF	2013 NGF	2014 GF	2014 NGF
Base	0	20,000,000	0	20,000,000
Changes to Base	0	0	0	28,810,945
Total	0	20,000,000	0	48,810,945

Objectives for this Service Area

Objectives for this Service Area

Objective
Ensure appropriate and timely Electronic Health Record (EHR) Incentive Program payments to participating practitioners and facilities

Description

To ensure appropriate and timely payments to eligible practitioners and facilities.

Objective Strategies

- Continue marketing efforts to educate providers of available assistance and resources
- Ensure payments are made in a timely manner

Alignment to Agency Goals

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

Measures

- Percentage of accurate reimbursement payments to eligible Electronic Health Record (EHR) Incentive program participants processed within 45 days of approved application

  Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Stable | Frequency: Quarterly

  Data Source and Calculation

  The Centers for Medicare & Medicaid Services (CMS) requires that all payments be made within 45 days of approval. The Department of Medical Assistance Services (DMAS) tracks the weekly payments as approved. The number of payments beyond 45 days is divided by the total number for the quarter to obtain the percentage paid in a timely manner.

44602: Reimbursements for Medical Services Provided Under the Family Access to Medical Insurance Security Plan

Description

The Family Access to Medical Insurance Security (FAMIS) program is part of Virginia's Title XXI Child Health Insurance Program - CHIP) for uninsured children and pregnant women living below 200% 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.

Mission Alignment and Authority

FAMIS carries out the mission of DMAS (Department of Medical Assistance Services) 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.

Customers for this Service Area

Anticipated Changes to Customers Base

Factors that affect the number of customers would include changes in the Virginia economy, private insurance market forces that result in increases or decreases in rates of uninsurance, a significant increase in the under 19 or low-income child-bearing population, or policy changes affecting program eligibility.

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.

Footnotes to Customer Base Listing Tab:
* Number of children enrolled in FAMIS at any time in state fiscal year 2012.
**The number of pregnant women enrolled in FAMIS MOMS at any time in state fiscal year 2012.

Current Customer Base

Pre-Defined Customer Group	User Specified Customer Group	Customers Served Annually	Potential Annual Customers	Projected Trend in # of Customers
Low-Income	FAMIS MOMS - Uninsured pregnant women with income > 133% FPL and < 200% FPL**	4,133	0	Increase
Low-Income	Uninsured children under 19 with family income >133% FPL (federal poverty level) and < 200% FPL*	100,064	0	Increase

Partners for this Service Area

Partner	Description
Advocacy groups	Virginia Health Care Foundation (VHCF); Virginia Poverty Law Center (VPLC)
Boards and committees	Children's Health Insurance Advisory Committee (CHIPAC)
Federal agencies	Center for Medicaid & Medicare Services (CMS)
Health care professionals, organizations, and facilities	
Private business firms	
State and local entities	Virginia Department of Social Services; Virginia Department of Health; Virginia Department of Education
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 FAMIS. Unlike Medicaid, FAMIS is not an entitlement program

Anticipated Changes to the Products and/or Services

In February 2009, the President signed Public Law 111-3, the Child Health Insurance Program Reauthorization Act (CHIPRA), which reauthorized the Children's Health Insurance Program (CHIP) through 2013. This law also expanded health coverage for children and establishes quality requirements and protections for both health and mental health care services. CHIPRA also altered how Medicaid and CHIP programs cover services for pregnant women. The Department has successfully implemented numerous CHIPRA provisions and in 2011 received a $26 million CHIPRA Performance Bonus in support of the ongoing and strong efforts to identify and enroll eligible children in Medicaid and CHIP coverage.

The Patient Protection and Affordable Care Act (PPACA) extends the current reauthorization period and funding of CHIP for two years, through 9/30/15. States are also required to maintain income eligibility levels for CHIP through September 30, 2019 and the ACA increases the CHIP match rate by 23 points from 65% to 88% beginning October 2015 (FFY 2016).

Listing of Products and / or Services

Coverage of comprehensive health care services through managed care or fee-for-service delivery models

Marketing and outreach services to promote enrollment

Application processing and enrollment

Claims processing and payment

Financial Overview

Budget Component	2013 GF	2013 NGF	2014 GF	2014 NGF
Base	34,631,511	110,230,491	34,631,511	110,230,491
Changes to Base	8,117,824	9,348,636	20,198,566	31,784,301
Total	42,749,335	119,579,127	54,830,077	142,014,792

Objectives for this Service Area

Objectives for this Service Area

Objective
Improve the immunization rate among FAMIS (Family Access to Medical Insurance Security Plan) and FAMIS Plus (Medicaid) children by increasing the percentage of two year olds who are fully immunized

Description
This objective will focus DMAS' (Department of Medical Assistance Services) efforts to improve health outcomes for children and reduce long-term health care costs by increasing the use of recommended vaccines from birth to 2 years of age.

Objective Strategies

- DMAS will monitor the annual data trends for individual managed care plans and as a statewide average.
- The managed care plans will continue to work towards increase the use of childhood vaccines for their members.

Alignment to Agency Goals

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

Measures

- Percentage of two year olds in managed care who are fully immunized

Measure Class: Agency Key Measure Type: Outcome Preferred Trend: Increase Frequency: Annually

Data Source and Calculation

This measures applies to children in all of DMAS' administered health care programs including Medicaid, FAMIS, and CHIP Medicaid Expansion. Immunizations are a priority for FAMIS and therefore are included as a measure for this population. Further, this measure is listed under FAMIS in order to comply with the structure of the Strategic Plan which is organized by funding source. All of Virginia's Medicaid/CHIP (Children's Health Insurance Program) managed care organizations are required to be accredited by the National Committee for Quality Assurance (NCQA). As such, they must calculate Healthcare Effectiveness Data and Information Set (HEDIS) scores on an annual basis. These measures of care are calculated using technical specifications set forth by the NCQA. The Childhood Immunizations Combo 3 is calculated using administrative data (claims) and abstraction of a random sample of medical records to ascertain the percentage of children who are fully immunized for vaccines recommended by age 2 years. The Combo 3 vaccination includes the following vaccines: DTAP, IPV, MMR, HiB, Hep B, VZV, and PCV. Only those managed care enrollees who receive all of these vaccines by age 2 years would be included in the numerator for this measure. Results are available around the end of each calendar year. The Measure Baseline is based on the Calendar Year (CY) 2010 rate which reflects services provided in CY 2009. The Measure Targets are focused on attaining the 75th percentile among national scores of Medicaid Managed Care Organizations reporting, as calculated from HEDIS values.

45607: Reimbursements to State-Owned Mental Health and Intellectual Disabilities Facilities

Description

This service area reimburses facilities owned and operated by the Department of Behavioral Health and Development Services (DBHDS) for medically necessary services provided to Medicaid eligible recipients residing in these facilities.

Virginia's public mental health, intellectual disability and substance abuse services system is comprised of 16 state facilities and 40 locally-run community services boards (CSBs) The CSBs and facilities serve children and adults who have or who are at risk of mental illness, serious emotional disturbance, intellectual disabilities, or substance use disorders.

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

Mission Alignment and Authority

DMAS is helping to ensure that a comprehensive system of high quality and cost effective health services are provided to qualifying Virginians in DBHDS managed facilities, a vulnerable population, by processing and reimbursing all appropriate Medicaid funding available.

Customers for this Service Area

Anticipated Changes to Customers Base

The average daily census at Virginia's state mental health facilities and state training centers for individuals with intellectual disabilities 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 13 percent at state mental health facilities and 34 percent at state training centers over the past ten years. In fiscal year 2012, the Virginia Medicaid program covered treatment services for 824 residents of state mental health facilities and 1,130 residents of state training centers.

Footnote to Service Area Customer Base Listing tab: *During the 2012-2014 biennium it is estimated there will be between 1.1 and 1.3 million 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.

Current Customer Base

Pre-Defined Customer Group	User Specified Customer Group	Customers Served Annually	Potential Annual Customers	Projected Trend in # of Customers
Low-Income	Beneficiaries / Clients: Low-income, Aged, and Disabled Virginians with Mental Health or Intellectua	1,954	0	Decrease

Partners for this Service Area

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). Virginia's state mental health facilities qualify as IMDs. The Code of Federal Regulations (CFR) prohibits covering individuals between age 22 through age 64 while residing in an IMD. This does not apply to individuals diagnosed with Intellectual Disabilities.

Total reimbursement to the facilities is limited by State appropriations.

Anticipated Changes to the Products and/or Services

A recent settlement between Virginia and the U.S. Department of Justice, regarding compliance with the ADA and the Olmstead decision, requires that Virginia gradually add 3,720 ID (Intellectual Disability) waiver slots and 450 DD (Developmental Disability) waiver slots by June 30, 2021. A portion of these slots are targeted for individuals discharging from state facilities. As they are discharged, occupancy at the facilities will decline, and therefore so will the expenditures in this service area.

Listing of Products and / or Services

Coverage of Mental Health and Mental Retardation Health Care Services; Rate Setting/Cost Analysis; Provider Enrollment; Claims Payments; Prior Authorization

Financial Overview

Budget Component	2013 GF	2013 NGF	2014 GF	2014 NGF
Base	131,564,491	131,564,490	131,564,491	131,564,490
Changes to Base	0	0	0	0
Total	131,564,491	131,564,490	131,564,491	131,564,490

Objectives for this Service Area

Objectives for this Service Area

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

Description
It is the Department of Medical Assistance Services' (DMAS) responsibility to provide timely and accurate Medicaid payments to DBHDS (Department of Behaviorial Health and Developmental Services) facilities, expending the state funds that are provided for this purpose and ensuring maximum feasible federal funding to the facilities.

Objective Strategies
No Strategies for this Objective

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

Measures
- Percentage of accurate reimbursement payments processed within 30 calendar days of receipt of clean claim at the Department of Medical Assistance Services (DMAS)

Measure Class Other Agency Measure Type Outcome Preferred Trend Stable Frequency Quarterly

Data Source and Calculation

The source for this measure is the Virginia Medicaid Management Information System (VaMMIS) Clean Claim report #MRM325. 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.

45608: Reimbursements for Behavioral Health Services

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. 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 Department of Behavioral Health and Development Services (DBHDS), the Community Services Boards and community providers and advocates, continues to work to ensure access to needed mental health services in the most appropriate setting.

Mission Alignment and Authority

By providing coverage for mental health services we are ensuring needed medical care for a vulnerable population.

Customers for this Service Area

Anticipated Changes to Customers Base

In fiscal year 2012, the Virginia Medicaid program covered fee-for-service inpatient treatment services for 274 residents in private mental health facilities and fee-for-service outpatient mental health services for 66,653 individuals. This represents significant growth over the number of individuals served a decade ago but a decrease over the number served last year. The growth and subsequent reduction 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. In addition, 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. DMAS audit results identified improper billing, application of program eligibility and marketing practices among behavioral health providers. DMAS implemented and enforces strict marketing requirements to disallow inappropriate solicitation of recipients into treatment programs. DMAS also implemented an independent clinical assessment program in July 2011 to verify program eligibility criteria for individuals under age 21. The program's first year of operation is showing a favorable impact on utilization management. New regulations are under development with stakeholders to address program eligibility for adults.

Footnotes for Service Area Customer Base Listing tab: *During the 2012-2014 biennium it is estimated there will be between 1.1 and 1.3 million 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.

Current Customer Base

Pre-Defined Customer Group	User Specified Customer Group	Customers Served Annually	Potential Annual Customers	Projected Trend in # of Customers
Low-Income	Clients / Beneficiaries: Low-income, Aged, and Disabled adults and children with a MH diagnosis	66,927	0	Stable

Partners for this Service Area

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. DMAS audit results identified improper billing, application of program eligibility and marketing practices among behavioral health providers. DMAS implemented and enforces strict marketing requirements to disallow inappropriate solicitation of recipients into treatment programs. DMAS also implemented an independent clinical assessment program in July 2011 to verify program eligibility criteria for individuals under age 21. The program's first year of operation is showing a favorable impact on utilization management. New regulations are under development with stakeholders to address program eligibility for adults.

Anticipated Changes to the Products and/or Services

Current efforts are aimed at utilization management and care coordination.

Listing of Products and / or Services

Coverage of Behavioral Health Care Services; Establishment of policies and standards and dissemination of information; Rate Setting and Financial Analysis; Claims processing and payment

Financial Overview

Budget Component	2013 GF	2013 NGF	2014 GF	2014 NGF
Base	290,200,798	337,426,499	290,200,798	337,426,499
Changes to Base	37,453,382	-1,717,485	72,158,320	25,853,552
Total	327,654,180	335,709,014	362,359,118	363,280,051

Objectives for this Service Area

Objectives for this Service Area

Objective
Assure appropriate access to outpatient and community-based mental health services

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. DMAS is focused on ensuring access to the most appropriate level of services with appropriate utilization management.

Objective Strategies
No Strategies for this Objective

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

Measures
- Percentage of children's mental health expenditures for high intensity services

Measure Class: Other Agency Measure Type: Outcome Preferred Trend: Decrease Frequency: Annually

Data Source and Calculation

Based on a Virginia Medicaid Management Information System (VaMMIS) special statistical program report generated by the Budget Division. This report program determines the total expenditures for mental health services provided to children during the Fiscal Year. Expenditures for high intensity services, defined as Intensive In Home and Therapeutic Day Treatment, are then calculated as a percentage of that total.

45609: Reimbursements for Medical Services

Description

This service area represents expenditures associated with coverage of general medical services in the Title XIX Medicaid program. General medical services include inpatient and outpatient hospital services, physician and clinic services, prescribed drugs, lab and xray services, dental, transportation services, as well as many others. General medical services are provided through two delivery models in the Virginia Medicaid program - capitated managed care and fee-for-service.

Mission Alignment and Authority

By providing coverage of general medical services, DMAS promotes access to a comprehensive system of high quality and cost effective health care services to our customers.

Customers for this Service Area

Anticipated Changes to Customers Base

Approximately 85% 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; 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 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.

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.

Footnote for Service Area Customer Base Listings:
* Served represents enrolled individuals in Medicaid in FY 2012.

Current Customer Base

Pre-Defined Customer Group	User Specified Customer Group	Customers Served Annually	Potential Annual Customers	Projected Trend in # of Customers
Low-Income	Beneficiaries / Clients*	1,096,470	0	Increase

Partners for this Service Area

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:
• Federal policy changes and Medicaid reform initiatives
• Health care cost inflation (technology)
• 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

There are several factors that will impact Virginia Medicaid in the future including: (i) an increase in the number of beneficiaries 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.

Listing of Products and / or Services

Coverage of General Medical Services; Rate Setting/Cost Analysis; Provider Enrollment; Claims Payments; Capitation Payments to Contracted Health Plans; Prior Authorization; Special provider Reimbursement Projects (e.g.Revenue Maximization, Teaching Hospital DSH)

Financial Overview

Budget Component	2013 GF	2013 NGF	2014 GF	2014 NGF
Base	1,897,616,178	2,270,640,767	1,897,616,178	2,270,640,767
Changes to Base	-83,127,178	342,110,266	103,930,234	410,090,883
Total	1,814,489,000	2,612,751,033	2,001,546,412	2,680,731,650

Objectives for this Service Area

Objectives for this Service Area

Objective
Improve the oral health and increase the utilization of appropriate preventative care of FAMIS (Family Access to Medical Insurance Security Plan) and FAMIS Plus (Medicaid) enrolled children

Description
This objective will focus DMAS' efforts to improve the oral health of Medicaid and FAMIS enrolled children by increasing the utilization of appropriate preventative dental services.

Objective Strategies

- Promote utilization of preventive pediatric dental visits by children covered by Medicaid and FAMIS
- The managed care plans will continue to work towards increase the use of childhood dental services for their members.

Alignment to Agency Goals

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

Measures

- Number of Medicaid/FAMIS (Family Access to Medical Insurance Security Plan) enrolled children who received at least one dental service

Measure Class: Other Agency Measure Type: Outcome Preferred Trend: Increase Frequency: Quarterly

Data Source and Calculation

This measures applies to children in all DMAS' administered health care programs including Medicaid, FAMIS, and Medicaid Expansion. However, this measure is listed under Medicaid in order to comply with the structure of the Strategic Plan which is organized by funding source. The 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 through twenty receiving routine dental care visits. 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. Historical values indicated for this measure represent the cumulative year-end for each State Fiscal Year.

Objective
Improve the quality, coordination of care and associated health outcomes to Medicaid/FAMIS participants diagnosed with chronic conditions.

Description
This objective will focus DMAS' efforts to prevent costly medical procedures and improve quality of care to participants with chronic conditions.

FAMIS is Family Access to Medical Insurance Security Plan.

Objective Strategies

- Develop and implement disease management programs through managed care providers. • 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.
- Develop strategies, including the development of outreach campaigns, designed to significantly increase knowledge of programs.
- Identify, evaluate, and manage the targeted disease state(s) as well as all co-morbid conditions of individuals.

Alignment to Agency Goals

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

Measures

- Percentage of members in managed care with cardiovascular disease who have blood presure controlled at less than 140/90

Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Increase | Frequency: Annually

Data Source and Calculation

Each calendar year, the Department of Medical Assistance Services' (DMAS') contracted external quality review organization (EQRO) collects, synthesizes, and reports on several measures, including cardiovascular disease. The EQRO uses the methodology that the National Committee for Quality Assurance (NCQA) delineated through its published HEDIS (Healthcare Effectiveness Data and Information Set) technical specifications for calculating this measure. The rates are calculated using administrative data and medical record abstraction for data collections. The work of the EQRO is monitored by the Division of Health Care Services at DMAS. The percent result is available at or around the end of each calendar year based on services provided in the prior calendar year.

Objective

Improve birth outcomes and increase the utilization of appropriate prenatal care of pregnant women enrolled in Medicaid and FAMIS MOMS (Family Access to Medical Insurance Security Plan)

Description

This objective serves to improve birth outcomes by increasing the utilization of appropriate prenatal care of pregnant women enrolled in Medicaid and FAMIS MOMS.

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

Alignment to Agency Goals

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

Measures

- Percentage of pregnant women in managed care who receive timely prenatal care

Measure Class: Agency Key | Measure Type: Outcome | Preferred Trend: Increase | Frequency: Annually

Data Source and Calculation

This measures applies to pregnant women in all DMAS' administered health care programs including Medicaid and FAMIS MOMS. However, this measure is listed under Medicaid in order to comply with the structure of the Strategic Plan which is organized by funding source. Each calendar year, the Department of Medical Assistance Services' (DMAS')-contracted external quality review organization (EQRO) collects, synthesizes, and reports on pregnant women who receive care. The EQRO uses the methodology that the National Committee for Quality Assurance (NCQA) delineated through its published HEDIS (Healthcare Effectiveness Data and Information Set) technical specifications for calculating this measures. The rates are calculated using administrative data and medical record abstraction for data collections. The work of the EQRO is monitored by the Division of Health Care Services at DMAS. The percent receiving care is available at or around the end of each calendar year based on services provided in the prior calendar year.

Objective

Extend a coordinated model of care to all Medicaid/FAMIS (Family Access to Medical Insurance Security Plan) covered services

Description

Many individuals have complex health care needs, including chronic conditions,behavioral health needs, and disabling conditions. The Department of Medical Assistance Services is working to coordinate care available from all Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) programs supporting the efficient and effective management of the Medicaid program.

Objective Strategies

- Structure departments and personnel to facilitate and assist individuals with care coordination

Alignment to Agency Goals

- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.
- Enhance the delivery of health care services by improving communication and relationships with customers and partners.

Measures

- Percentage of expenditures for acute/medical services paid via capitated payments versus fee-for-service claims

Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Increase | Frequency: Annually

Data Source and Calculation

The measure is based on expenditures as reported in the Commonwealth Accounting and Reporting System by multipurpose code, identifying the multipurpose codes associated with capitated managed care payments as a percentage of all expenditures for this service area.

- Percentage of clients served through a capitated care program for coverage of their acute/medical services

Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Increase | Frequency: Annually

Data Source and Calculation

The measure is based on a Virginia Medicaid Management Information System (VaMMIS) special statistical program report generated by the Forecast and Cost Estimation Unit of the Budget Division. This report program determines the annual unduplicated number of individuals receiving care through capitated managed care organization as a percentage of the total annual unduplicated enrollment.

- Percent of total Medicaid expenditures paid via capitated PMPM (Per Member Per Month) or otherwise actively managed

Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Increase | Frequency: Annually

Data Source and Calculation

The measure is based on expenditures as reported in the Commonwealth Accounting and Reporting System by multipurpose code, identifying the multipurpose codes associated with capitated managed care payments (including the Program for All Inclusive Care for the Elderly - PACE), non-emergency transportation services, and dental expenditures calculated as a percentage of all expenditures for this budget program 456. Expenditures for Indigent Care and Medicare Premiums are excluded from the calculation as those payments are pre-determined and not applicable for care coordination.

45610: Reimbursements for Long-Term Care Services

Description

Provide access to a system of high-quality facility and community-based long-term care services for seniors and persons with disabilities to ensure health, safety, and welfare.

Mission Alignment and Authority

By assisting seniors and persons with disabilities to obtain high-quality, cost-effective long-term care services in the least restrictive environment that meets their needs, the Commonwealth saves money over more costly and more restrictive placements.

Customers for this Service Area

Anticipated Changes to Customers Base

In fiscal year 2011, the Virginia Medicaid program provided nursing facility care for 27,688 individuals, care for 422 individuals in private ICF/MRs and home and community-based care for 34,489 individuals.

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

Footnote to Service Area Customer Base Listing tab: *During the 2012-2014 biennium it is estimated there will be between 1.1 and 1.3 million 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.

Current Customer Base

Pre-Defined Customer Group	User Specified Customer Group	Customers Served Annually	Potential Annual Customers	Projected Trend in # of Customers
Low-Income	Recipients • Seniors and persons with disabilities who meet eligibility requirements	62,599	0	Increase

Partners for this Service Area

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 Department's focus on care coordination across all areas of the Medicaid program will affect the delivery of long term care services.

Anticipated Changes to the Products and/or Services

A recent settlement between Virginia and the U.S. Department of Justice, regarding compliance with the ADA and the Olmstead decision, requires that Virginia gradually add 3,720 ID (Intellectual Disability) waiver slots and 450 DD (Developmental Disability) waiver slots by June 30, 2021. As these slots are filled, expenditures in this service area can be expected to increase.

Listing of Products and / or Services

Coverage of Long-Term Care & Waiver Programs (Nursing facility care; Home and community-based services); Rate Setting/Cost Analysis; Provider Enrollment; Claims Payments; Prior Authorization

Financial Overview

Budget Component	2013 GF	2013 NGF	2014 GF	2014 NGF
Base	1,027,339,274	1,053,354,540	1,027,339,274	1,053,354,540
Changes to Base	100,943,727	74,928,461	167,930,632	141,915,367

Total	1,128,283,001	1,128,283,001	1,195,269,906	1,195,269,907

Objectives for this Service Area

Objectives for this Service Area

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

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.

Objective Strategies
No Strategies for this Objective

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

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

Measure Class Other Agency Measure Type Output Preferred Trend Increase Frequency Quarterly

Data Source and Calculation

This measure is based the number of Virginia Medicaid recipients receiving long-term care services through a Program for All Inclusive Care for the Elderly (PACE) program or receiving their acute care service through a capitated managed care organization through the ALTC-I (Acute Long Term Care) pilot program as a percentage of all Virginia Medicaid recipients receiving community-based long term care services.

Objective
Increase the proportion of long-term care recipients served in home-and-community settings versus institutional facilities

Description
Given the high and increasing cost of institutional care, DMAS focuses on strengthening strategies to encourage the use of less costly and less restrictive home and community based placement.

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

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

Measures
- Percentage of individuals eligible for nursing facility (NF) placement who are served in the community

Measure Class Other Agency Measure Type Outcome Preferred Trend Increase Frequency Annually

Data Source and 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 served in the Elderly and Disabled with Consumer Direction (EDCD) waiver calculated as a percentage of all individuals eligible for Nursing Facility placement, which is determined as the annual unduplicated number of individuals served in a nursing facility and those served in the EDCD waiver.

- Percentage of individuals eligible for ICF/MR (Intermediate Care Facilities/Mental Retardation) placement who are served in the community

Measure Class Other Agency Measure Type Outcome Preferred Trend Increase Frequency Annually

Data Source and 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 served in the Intellectual Disabilities (ID) waiver calculated as a percentage of all individuals eligible for ICF/MR placement, which is determined as the annual unduplicated number of individuals served in a ICF/MR and those served in the ID waiver.

- Number of individuals transitioned into the community through the Money Follows the Person program

Measure Class Other Agency Measure Type Output Preferred Trend Increase Frequency Annually

Data Source and Calculation

Based on cumulative tracking report maintained by the Money Follows the Person Unit within the Department of Medical Assistance Services Long-Term Care Division.

- Percentage of long-term care recipients who are served in the community

Measure Class: Agency Key | Measure Type: Outcome | Preferred Trend: Increase | Frequency: Annually

Data Source and 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 served in any of the agency's Home and Community Based (HCB) long term care (LTC) waivers. This measure calculates the percentage of all individuals in institutional or HCB placements that are receiving LTC services.

46403: Insurance Premium Payments for HIV-Positive Individuals

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 1) be a resident of Virginia, 2) be able to provide documentation from a physician verifying disability within three months due to HIV+ diagnosis, 3) have family income no greater than 250% of the poverty level, 4) have countable liquid assets no more than $10,000, 4) not be eligible for Medicaid and 5) be eligible for and have availability of continuing health insurance. Department of Medical Assistance Services (DMAS) staff determines eligibility for the program and assumes the responsibility of providing health insurance premium payment in a timely manner.

Mission Alignment and Authority

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.

Customers for this Service Area

Anticipated Changes to Customers 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 not aware of the waiting list. The waiting list is necessary due to the capped amount of funding.

Current Customer Base

Pre-Defined Customer Group	User Specified Customer Group	Customers Served Annually	Potential Annual Customers	Projected Trend in # of Customers
Low-Income	Clients / Beneficiaries – Low-income, aged, or disabled Virginians with a diagnosis of HIV+	46	0	Increase

Partners for this Service Area

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. 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

Financial assistance for health insurance premiums

Financial Overview

Budget Component	2013 GF	2013 NGF	2014 GF	2014 NGF
Base	556,702	0	556,702	0
Changes to Base	0	0	0	0
Total	556,702	0	556,702	0

Objectives for this Service Area

Objectives for this Service Area

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

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

Objective Strategies

- Continue to pay for services as required by State law

Alignment to Agency Goals

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

Measures

- Percent of available funds expended

Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Stable | Frequency: Quarterly

Data Source and Calculation

A DMAS (Department of Medical Assistance Services) expenditure report from CARS (Commonwealth Accounting & Reporting System) is generated for state funds (0100) under this report (46403). Budgeted/appropriated amounts for this measure are obtained from the applicable State Appropriation Act. This is a State funded only program. Expenditures are divided by the budget to determine a percentage of funds used. The goal is to pay out 100% of available funds, however, this is contingent on premiums paid on behalf of eligible individuals and claims processing system schedules.

46405: Reimbursements from the Uninsured Medical Catastrophe Fund

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 and funding is expended until appropriation is exhausted.

Mission Alignment and Authority

Individuals determined eligible for services under the program are provided access to life-saving health care services.

Customers for this Service Area

Anticipated Changes to Customers Base

It is anticipated that the number of individuals served through the Uninsured Medical Catastrophe Fund will remain relatively the same or increase. There are variances in the number of customers served based on the availability of funds relative to the cost per recipient. Increases in medical costs will affect the availability of funds. Other variances affecting customers include: eligibility requirements, medical necessity, and the timely submission of the contract and any other necessary documents.

Current Customer Base

Pre-Defined Customer Group	User Specified Customer Group	Customers Served Annually	Potential Annual Customers	Projected Trend in # of Customers
Low-Income	Beneficiaries / Clients	13	0	Stable

Partners for this Service Area

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

The department does not anticipate any product or service changes.

Listing of Products and / or Services

Life-saving health care services based on Medicaid rates; eligibility determination, treatment plan approval, and determination of treatment plan costs.

Contract with providers for services approved on the treatment plan; verify services rendered and initiate payment to the provider.

Financial Overview

Budget Component	2013 GF	2013 NGF	2014 GF	2014 NGF
Base	225,000	40,000	225,000	40,000
Changes to Base	0	0	0	0
Total	225,000	40,000	225,000	40,000

Objectives for this Service Area

Objectives for this Service Area

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

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.

Objective Strategies

- Review and streamline application processes to accommodate for the timeliness necessary for life-threatening conditions.

Alignment to Agency Goals

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

Measures

- Percent of completed applications processed within 45 days

Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Stable | Frequency: Quarterly

Data Source and Calculation

The Department of Medical Assistance Services (DMAS) Program Operations Division tracking document of initial applications and approval/denial documents is the source of data for this measure. 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 The number of applications expressed as a percent of the total, approved within 45 days/total applications.

46601: Reimbursements for Medical Services Provided to Low-Income Children

Description

The expansion of Medicaid eligibility for uninsured children from age 6 to 19 is part of Virginia's Title XXI Child Health Insurance Program (CHIP) program for uninsured children living below 200% of the federal poverty level (FPL). Prior to this expansion, children under age 6 with family income up to 133% FPL could qualify for Medicaid benefits but children from 6 to 19 would only qualify for Medicaid with family 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 CHIP Medicaid Expansion receive full Medicaid benefits but are funded with the enhanced Title XXI match rate.

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

Mission Alignment and Authority

The CHIP 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.

Customers for this Service Area

Anticipated Changes to Customers Base

Factors that could affect the number of customers would include changes 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.

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.

As of January 2014, this eligibility category will be incorporated into the Title XIX Medicaid program per a provision of the PPACA; however CMS has has confirmed that services provided to these individuals will continue to be reimbursed at the enhanced CHIP match rate.

Footnote for Service Area Customer Base Listing: Number of children served at anytime during FY 2012.

Current Customer Base

Pre-Defined Customer Group	User Specified Customer Group	Customers Served Annually	Potential Annual Customers	Projected Trend in # of Customers
Low-Income	Uninsured children age 6 to 19 with family income between 100% and 133% FPL	88,063	0	Increase

Partners for this Service Area

Partner	Description
Advocacy groups	Virginia Health Care Foundation (VHCF); Virginia Poverty Law Center (VPLC)
Boards and committees	Children's Health Insurance Advisory Committee (CHIPAC)
Federal agencies	Center for Medicaid and Medicare Services (CMS)
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 CHIP Medicaid Expansion. Unlike Medicaid, the CHIP Expansion is not an entitlement program

Anticipated Changes to the Products and/or Services

In February 2009, the President signed Public Law 111-3, the Child Health Insurance Program Reauthorization Act (CHIPRA), which reauthorized the Children's Health Insurance Program (CHIP) through 2013. This law also expanded health coverage for children and establishes quality requirements and protections for both health and

mental health care services. CHIPRA also altered how Medicaid and CHIP programs cover services for pregnant women. The Department has successfully implemented numerous CHIPRA provisions and in 2011 received a $26 million CHIPRA Performance Bonus in support of the ongoing and strong efforts to identify and enroll eligible children in Medicaid and CHIP coverage.

The Patient Protection and Affordable Care Act (PPACA) extends the current reauthorization period and funding of CHIP for two years, through 9/30/15. States are also required to maintain income eligibility levels for CHIP through September 30, 2019 and the ACA increases the CHIP match rate by 23 points beginning October 2015 (FFY 2016).

Listing of Products and / or Services

Coverage for comprehensive health care services through managed care or fee-for-service delivery models; Marketing and outreach to promote enrollment; Application processing and enrollment; Claims payment

Financial Overview

Budget Component	2013 GF	2013 NGF	2014 GF	2014 NGF
Base	45,845,456	85,141,562	45,845,456	85,141,562
Changes to Base	-4,237,533	-6,462,824	632,693	4,106,016
Total	41,607,923	78,678,738	46,478,149	89,247,578

Objectives for this Service Area

Objectives for this Service Area

Objective
Increase the utilization of appropriate preventative care of FAMIS (Family Access to Medical Insurance Security Plan) and FAMIS Plus (Medicaid) enrolled children

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

Objective Strategies
No Strategies for this Objective

Alignment to Agency Goals
- Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.
- Promote better health outcomes through prevention-based strategies and improved quality of care.

Measures
- Percentage of adolescents in managed care with at least one comprehensive well-visit per year

Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Increase | Frequency: Annually

Data Source and Calculation

This measures applies to adolescents in all DMAS' administered health care programs including Medicaid, FAMIS, and CHIP Medicaid Expansion. However, this measure is listed under CHIP Medicaid Expansion in order to comply with the structure of the Strategic Plan which is organized by funding source. All of Virginia's Medicaid/CHIP (Children's Health Insurance Program) managed care organizations are required to be accredited by the National Committee for Quality Assurance (NCQA). As such, they must calculate Healthcare Effectiveness Data and Information Set (HEDIS) scores on an annual basis. These measures of care are calculated using technical specifications set forth by the NCQA. The Adolescent Well Visit measure is calculated using administrative data (claims) and abstraction of a random sample of medical records to ascertain the percentage of adolescents (ages 12-21 years) who received a comprehensive well child visit during the calendar year. Comprehensive must include a health and developmental history, a physical exam, and health education/anticipatory guidance. All of these must have occurred in order to "count" as a comprehensive well child visit. Results are available around the end of each calendar year. The Measure Baseline is based on the Calendar Year (CY) 2010 rate which reflects services provided in CY 2009. The Measure Targets are focused on attaining the 75th percentile among national scores of Medicaid Managed Care Organizations reporting, as calculated from 2010 HEDIS values.

499: Administrative and Support Services

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.

Mission Alignment and Authority

By performing the functions within this service area, DMAS is able to provide access to a comprehensive system of high quality and cost effective health care services to our customers to qualifying Virginians.

Customers for this Service Area

Anticipated Changes to Customers Base

Approximately 85% 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; 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 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.

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.

Footnote for Service Area Customer Base Listings:
* Served represents enrolled individuals in Medicaid in FY 2012.

Current Customer Base

Pre-Defined Customer Group	User Specified Customer Group	Customers Served Annually	Potential Annual Customers	Projected Trend in # of Customers
Low-Income	Beneficiaries / Clients	1,298,211	0	Increase

Partners for this Service Area

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 Medicaid Reform and Electronic Health Records.

Anticipated Changes to the Products and/or Services

The Department must remain flexible and adapt to new programs and priorities to maintain the quality and timeliness of all recipient services. Sufficient funding and staffing resources are vital for the agency to maintain these services.

Listing of Products and / or Services

Financial Services – Fiscal and accounting services

Policy Analysis – Policy and research services

Information Management - Computer support services

Program Integrity - Quality assurances services including provider and recipient audits

Program Operations - Provider enrollment, claims processing and reimbursement services

Appeals - Client and provider appeals of audits and other agency decisions

Human Resources - Personnel services and training

Health Reform - Coordinating health reform systems and services throughout the Commonwealth

Office of Behavioral Health - Behaviorial services

Communications and Legislative liaison - Information dissemination services and legislative coordination services

Budget and Contract Management services

Compliance, Security, and Internal Auditing - Services to ensure the integrity of data and information

Long Term Care - Services for the aged population and individuals with disabilities

Maternal and Child Health - Providing health related services for children and pregnant women

Financial Overview

Budget Component	2013 GF	2013 NGF	2014 GF	2014 NGF
Base	43,272,124	100,229,405	43,272,124	100,229,405
Changes to Base	4,975,570	-1,711,258	1,611,817	-21,972,071
Total	48,247,694	98,518,147	44,883,941	78,257,334

Objectives for this Service Area

Objectives for this Service Area

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

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 continues to ensure that it has a recruitment process that will attract the highest level of skilled candidates and retain these workers once hired, in addition to a recognition program that contributes to a positive work environment.

Objective Strategies

- Emphasize the retention of highly-skilled employees through effective employee recognition programs, training, and fair and consistent compensation practices.
- Greater use of the Learning Management System both internally and with the programs offered by the Department of Human Resource Management
- Increase the amount of employee training opportunities

Alignment to Agency Goals

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

Measures

- Employee turnover rate

Measure Class: Other Agency Measure Type: Outcome Preferred Trend: Decrease Frequency: Quarterly

Data Source and Calculation

The Department of Medical Assistance Services (DMAS) Human Resources (HR) Division tracks and reports employee retention information. The calculation for this measure is based on Personnel Management Information System (PMIS) data and Human Resources Manpower reports wheras the total number of separations during quarter is divided by the average number of filled classified employees during the quarter. Quarterly values are summed together to produce an annual total retention rate.

Objective
Improve communications and relationships with customers and partners

Description
The Virginia Medicaid, FAMIS (Family Access to Medical Insurance Security Plan) and FAMIS Plus (Medicaid) programs serve over 1 million customers and to help manage it, the Department of Medical Assistance Services (DMAS) relies on a close reltionship and clear communication with many partners (refer to list in the Partner section), including over 70,000 enrolled providers of health care services.

Objective Strategies
No Strategies for this Objective

Alignment to Agency Goals
- Enhance the delivery of health care services by improving communication and relationships with customers and partners.

Measures
- Percent of providers who respond 'satisfied' or 'very satisfied' with Provider Enrollment Services

  Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Increase | Frequency: Semi-Annually

  Data Source and Calculation

  The Department of Medical Assistance Services (DMAS) Program Operations Division conducts a bi-annual Provider Satisfaction Survey to obtain input from providers on numerous areas of Medicaid operations including provider enrollment services. This measure reports the percent of providers that are enrolling and reenrolling as a Medicaid or FAMIS provider who are satisfied or very satisfied with the process.

- Percent Compliance of Breach Notifications for Unsecured Protected Health Information

  Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Stable | Frequency: Annually

  Data Source and Calculation

  As a covered entity under the Health Insurance Portability and Accountability Act (HIPAA), DMAS is responsible for the safeguarding of protected health information. Any applicable breach of protected health information must be reported to the Federal Department of Health and Human Services as required in 45 CFR (Code of Federal Regulations), Parts 160 and 164, adopted August 2009. The Department of Medical Assistance Services tracks the reporting of any instance where an applicable breach has occured. A breach not reported would be in violation of this CFR. A value of 100% significance full compliance with all reporting requirements.

- Proportion of Provider Helpline calls answered within 120 seconds

  Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Increase | Frequency: Quarterly

  Data Source and Calculation

  The Fiscal Agent for the Department of Medical Assistance Services (DMAS) operates a Provider Help Line and maintains and provides statistics of weekly operations for call center activity. This measure of incoming calls is measured using automated system technology. Providers are physicians and businesses that provide Medicaid-covered services.

- Proportion of Member Helpline calls answered within 120 seconds

  Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Increase | Frequency: Quarterly

  Data Source and Calculation

  The Fiscal Agent for the Department of Medical Assistance Services (DMAS) operates a Member Help Line and maintains and provides statistics of weekly operations for call center activity. This measure of incoming calls is measured using automated system technology. Members are individuals who receive Medicaid-covered services.

- Percentage of FAMIS (Family Access to Medical Insurance Security Plan) Helpline calls answered within 90 seconds

  Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Increase | Frequency: Quarterly

  Data Source and Calculation

  DMAS contracts with a vendor to operate a Centralized Processing Unit that receives and processes applications for the FAMIS and FAMIS MOMS programs. In addition, the contract includes a call center for FAMIS members. This measure is calculated using automated technology systems that measure the number of calls answered within the specified time period out of the total number of incoming calls. The data is reported monthly on the FAMIS Call Center Report.

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

Description
DMAS offers alternatives to institutional-based long-term care services for the elderly and individuals with disabilities through seven (7) home and community-based care waivers. DMAS conducts Level of Care reviews, Service Plan reviews and “continuous” monitoring of health and welfare of waiver recipients in order to ensure the health, safety and welfare of the individuals served through the home and community-based waviers and to ensure appropriate utilization, prevent abuse, and promote improved and cost efficient medical management of essential Medicaid client health care.

Objective Strategies
No Strategies for this Objective

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

Measures

- Percentage of level of care reviews on all current eligible waiver recipients

Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Stable | Frequency: Quarterly

Data Source and 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.

Objective

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

Description

This objective is to ensure that Department of Medical Assistance Services (DMAS) programs are managed effectively, utilize financial/personnel resources efficiently, and are implemented in manner consistent with applicable state and federal requirements.

Objective Strategies

- Continously evaluate the methods, processes, and results of program areas for efficiency and effectiveness
- Monitor and audit the finances of programs to ensure compliance

Alignment to Agency Goals

- Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.
- Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.

Measures

- Unit cost of processing Medicaid claims

Measure Class: Productivity | Preferred Trend: Decrease | Frequency: Quarterly

Data Source and Calculation

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).

- The number of recipient reviews completed each year

Measure Class: Other Agency | Measure Type: Output | Preferred Trend: Increase | Frequency: Annually

Data Source and Calculation

The Department of Medical Assistance Services (DMAS) conducts audits and reviews to ensure the integrity of its programs and services provided. The Recipient Audit Unit conducts reviews of recipients to determine if eligibility was properly assessed. This measure is calculated as the anual unduplicated number of recipients reviewed by the Recipient Audit Unit of the Agency's Program Integrity Division. Recipients are those individuals receiving Medicaid or FAMIS covered services.

- The number of Quality Management Reviews on recipients completed each year

Measure Class: Other Agency | Measure Type: Output | Preferred Trend: Stable | Frequency: Quarterly

Data Source and Calculation

The Department of Medical Assistance Services (DMAS) conducts audits and reviews to ensure the integrity of programs. Quality Management Review (QMR) are conducted by Agency and include reviews of Recipients, Providers and Medical Records. This measure is calculated based on the annual number of unduplicated recipients reviewed. QMR reviews evaluate the quality of service being provided to Medicaid recipients in facilities to ensure their health, safety, and welfare.

- The number of provider reviews completed each year

Measure Class: Other Agency | Measure Type: Output | Preferred Trend: Increase | Frequency: Annually

Data Source and Calculation

The Department of Medical Assistance Services (DMAS) conducts audits and reviews to ensure the integrity of programs. This measure is calculated as the number of providers reviewed each year by the DMAS Provider Review and Utilization Review Units as well as reviews completed by DMAS' contractors for audits of Inpatient Hospital Diagnosis Related Groupings (DRG), Pharmacy and Durable Medical Equipment (DME), Behavioral Health services, and ancillary provider services.

Objective

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

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.

Objective Strategies

- Annually submit an aggressive SWAM Plan with goals of increasing SWAM participation from one fiscal year to the next.
- 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
- Work with Department of Minority Business Enterprises (DBME) to streamline the certification process for vendors not registered with DMBE.

Alignment to Agency Goals

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

Measures

- Percentage of agency's discretionary contracting and purchasing through SWaM (Small, Women-owned, and Minority) vendors

Measure Class: Other Agency Measure Type: Outcome Preferred Trend: Increase Frequency: Quarterly

Data Source and Calculation

The source of information for this measure is the Agency Quarterly Small, Women, and Minority (SWaM) Expenditure Report as provided on the DMBE (Department of Minority Business Enterprises) Supplier Diversity Expenditure Report. The measure of SWaM purchasing and contracting reflects dollars paid on SWaM contracts divided by dollars paid for total applicable contracts and is calculated in accordance with the procedures adopted by the Department of Minority Business Enterprises (DBME) for Prime contractors.

Objective

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.

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.

Objective Strategies

No Strategies for this Objective

Alignment to Agency Goals

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

Measures

- Percentage of all Provider appeal decisions issued in full compliance

Measure Class: Other Agency Measure Type: Outcome Preferred Trend: Stable Frequency: Quarterly

Data Source and Calculation

The Department of Medical Assistance Services (DMAS) Appeals Division database tracks all provider and client appeal deadlines and results. The number of individual Provider appeals resulting in full compliance for the Department are divided by all Provider appeals to determine the measure value rate. Full compliance is defined as meeting all statuatory and regulatory timeline requirements.

- Percentage of all Client appeal decisions issued in full compliance

Measure Class: Other Agency Measure Type: Outcome Preferred Trend: Stable Frequency: Quarterly

Data Source and Calculation

The Department of Medical Assistance Services (DMAS) Appeals division database tracks all provider and client appeal deadlines and results. The number of individual Client appeals resulting in full compliance for the Department are divided by all Client appeals to determine the measure value rate. Full compliance is defined as meeting all statutory and regulatory timeline requirements.

Objective

To 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

Description

Emergency situations can affect customers, partners, and employees from a loss of system/automated information, access to services or facilities, and many other situations. The Department of Medical Assistance Services (DMAS) works to proactively prepare for these events to minimize disruptions and services.

Objective Strategies

- Develop and maintain written emergency procedures

- Train employees on how to respond to emergencies

Alignment to Agency Goals

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

Measures

- Passing Score of Agency Capability Assessment for Readiness

  Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Stable | Frequency: Annually

  Data Source and Calculation

  The Virginia Secretary of Veterans Affairs and Homeland Security (VAHS) calculates an annual score for each agency based on preparedness factors that includes the Agency Continuity of Operations Plan (COOP) required via Executive Order. Agency results are tabulated based on a percentage score from 100% using an annual survey completed by the agency, in addition to the COOP document. A "passing score" for an agency can vary based on VAHS criteria and statewide results. Results for the fiscal year are normally available by the end of the calendar year. 100% is "passing score"

Objective

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

Description

The Department of Medical Assistance Services (DMAS) continously seeks ways to provide services in the most effective and efficient manner. This is often accomplished by fully utilizing technology and industry standards.

Objective Strategies

- Modernize information technology infrastructure as an enabler for future business transformation
- Provide a technical environment where standards-based interoperability is possible between new and legacy systems
- Provide an enterprise technology environment that is accessible on a pay-for-use basis by federal, state, and local governments as well as non-government organizations, community based-services, and commercial interests as allowed by policy.
- Provide to all Virginians a web-based, self-directed service option for health and human services
- Reduce overall long-term technology costs for federal and state programs

Alignment to Agency Goals

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

Measures

- Percentage of claims submitted electronically

  Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Increase | Frequency: Quarterly

  Data Source and Calculation

  The number of claims submitted electronically versus paper through DMAS' Virginia Medicaid Management Information System (VaMMIS) is tracked weekly. The percentage is determined by computing the total number of electronic claims divided by the total.

- Percentage of the number of weekly remittance payments processed via Electronic Funds Transfer (EFT)

  Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Increase | Frequency: Quarterly

  Data Source and Calculation

  Expenditures for the weekly remittance, representing payment for claims adjudicated in the previous week, are tracked by disbursement method. Remittances to providers can be paid either by Electronic Funds Transfer (EFT) or by paper check. This measure calculates the number of remittances disbursed via EFT divided by the total number of payments processed.

- Percentage of weekly remittance expenditures paid via Electronic Funds Transfer (EFT)

  Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Increase | Frequency: Quarterly

  Data Source and Calculation

  Expenditures for the weekly remittance, representing payment for claims adjudicated in the previous week, are tracked by disbursement method. Remittances to providers can be paid either by Electronic Funds Transfer (EFT) or by paper check. The sum of expenditures paid via EFT is divided by the total payments to determine the measure value reported.

- Percent of clean claims paid in 30 days

  Measure Class: Other Agency | Measure Type: Outcome | Preferred Trend: Stable | Frequency: Quarterly

  Data Source and Calculation

  The source for this measure is the Virginia Medicaid Management Information System (VaMMIS) Clean Claim report #MRM325. 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.