2014-16 Executive Progress Report

Commonwealth of Virginia
Secretary of Health and Human Resources

Department of Medical Assistance Services

At A Glance

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

Staffing 378 Salaried Employees, 41 Contracted Employees, 427 Authorized, and 76 Wage Employees.

Financials Budget FY 2015, $8,974.57 million, 45.04% from the General Fund.

Trends
- ↑ Complexity of recipient needs
- ↑ Number and type of providers
- ↑ Number and age of population

Legend ↑ Increase, ↓ Decrease, → Steady

Key Perf Areas
- ↑ Managed care
- ↑ Community care
- ↑ Immunizations for children

Productivity Legend ↑ Improving, ↓ Worsening, → Maintaining

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

Background and History

Agency Background Statement

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

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

Major 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.

Customers

Customer Summary

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 2014, there were 728,784 Medicaid and CHIP beneficiaries receiving their health care coverage through the MCO program (70 percent of total beneficiaries) and 313,574 beneficiaries were enrolled in the FFS program (30 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. In 2014, the agency implemented the Commonwealth Coordinated Care program (“CCC”), a new initiative to coordinate care for individuals who are currently served by both Medicare and Medicaid. The program is designed to be Virginia’s single program to coordinate delivery of primary, preventive, acute, behavioral, and long-term services and supports. In this way, the individual receives high quality, person centered care that is focused on their needs and preference.

Customer Table

Predefined Group	User Defined Group	Number Served Annually	Potential Number of Annual Customers	Projected Customer Trend
Health Care	Medicaid Providers	60,905	0	Increase
Health Care	Beneficiaries / Clients	1,186,059	0	Increase

Finance and Performance Management

Finance

Financial Summary

DMAS’ base budget is currently funded with approximately 45% state general funds and 55% 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 50%.

The Base Budget in the table below is the FY 2014-2016 appropriation as reflected in Chapter 2 of the 2014 Appropriation Act including technical adjustments directed by the Department of Planning and Budget (DPB).

Fund Sources

Fund Code	Fund Name	FY 2015	FY 2016
0100	General Fund	$4,042,529,444	$4,155,548,851
0210	Nursing Facility Sanctions-Civil Money Penalties	$300,000	$300,000
0220	Medicaid Intergovernmental Transfer Fund	$1,265,000	$1,265,000
0903	Va Children'S Medical Security Insurance Plan	$14,065,627	$14,065,627
0910	Uninsured Medical Catastrophe Fund	$40,000	$40,000
0949	Virginia Health Care Fund	$375,991,838	$366,283,980
1000	Federal Trust	$4,540,379,037	$4,679,837,030

Revenue Summary

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

Non-general funds from Federal funds and grants are the largest single source of nongeneral fund revenue for DMAS. About 88 percent of all revenue is from these Federal sources. The remaining non-general revenue is from various sources such as: funds returned due to cost settlements, audit collections and pharmacy rebates. In addition, a Master Settlement Agreement (MSA) was signed between major participating cigarette manufacturers and states on November 23, 1998 that releases participating manufacturers from smoking-related claims in return for an annual cash payment to the states in perpetuity. The Virginia Health Care Fund receives 41.5 percent of the MSA allocation for the purposes of paying for various health care costs faced by the Commonwealth, including the Medicaid program. In Fiscal Year 2014, this revenue totaled over $48 million.

Performance

Performance Highlights

DMAS has been working to make the Medicaid and FAMIS programs more cost-effective and quality-focused. The primary areas of focus to achieve this outcome revolve around care-coordination, improved business flow with enterprise-based information management, and program integrity. Specifically, the Department is working to bring care coordination principles to all populations and services under programs administered at DMAS. These include: 1) the expansion of 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 entails a new eligibility determination and enrollment system that automates, to the extent possible, the eligibility process resulting in real-time determinations of eligibility for certain applicants of Medicaid and FAMIS.

Selected Measures

Measure ID	Measure	Alternative Name	Estimated Trend
M602SA12002	Percentage of clients served through a capitated care program for coverage of their acute/medical services	Managed care	Improving
M602SA12030	Percentage of long-term care recipients who are served in the community	Community care	Improving
M602SA12028	Percentage of pregnant women in managed care who receive timely prenatal care	Prenatal care	Improving
M602SA12001	Percentage of two year olds in managed care who are fully immunized	Immunizations for children	Improving
60249900.006.002	Unit cost of processing Medicaid claims	Cost per claim	Maintaining

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.

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. 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.

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 $4.0 billion in FY 2004 to $8.4 billion in FY 2014. This increase has occurred despite several significant savings and reform initiatives.

Agency Statistics

Statistics Summary

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

Approximately 85% of the DMAS customer base is served through the Medicaid program. Statistics show that the life expectancy at age 65 has increased 12% for males and 3% for females since 1980. Factors that could affect the number of Medicaid customers would include changes in the Virginia economy, private insurance market forces that result in an increase in rates of uninsurance, or policy changes affecting program eligibility.

Statistics Table

Description **Value**

Management Discussion

General Information About Ongoing Status of Agency

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

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

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

Information Technology

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

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

Workforce Development

The Department of Medical Assistance Services is a highly professional and efficient organization. The Department has 16 divisions and offices including the Office of the Director. Overseeing all Medicaid activities and resources in these divisions for over 1 million customers are 427 authorized classified positions effective for State Fiscal Year 2015 with 410 filled or in recruitment as of October 2014. Also as of October 2014, due to increasing program requirements, the Department utilizes 76 authorized hourly employees that represent a significant component of the agency workforce. Finally, 41 contract employees support the Information Management Division and play a critical role in maintaining the agency's systems. Increased programmatic requirements continue to necessitate the extensive hiring of wage employees. The wage employees serve a vital role and require the same level of training as full-time, classified employees. However, most of these employees seek other employment with benefits. Thus, the turnover rate among the wage workforce is considerably higher than the classified workforce. The agency minimizes this impact through selective assignments and seeking classified positions when permanency is justified.

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

Physical Plant

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