2014-16 Strategic Plan

Department of Medical Assistance Services [602]

Mission

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

Vision

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

Finance

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%.

Biennial Budget

	2015 General Fund	2015 Nongeneral Fund	2016 General Fund	2016 Nongeneral Fund
Initial Appropriation for the Biennium	4,042,529,444	4,932,041,502	4,155,548,851	5,061,791,637
Changes to Initial Appropriation	0	0	0	0

(Changes to Initial Appropriation will be 0 when the plan is created. They will change when the plan is updated mid-biennium.)

Customers

Anticipated Changes to Customer Base

Current Customer List

Predefined Group	User Defined Group	Number Served Annually	Potential Number of Annual Customers	Projected Customer Trend
Health Care	Medicaid Providers	0	0	Increase
Low-Income	Beneficiaries / Clients	0	0	Stable
Low-Income	Beneficiaries / Clients*	0	0	Increase
Low-Income	Beneficiaries / Clients: Low-income, Aged, and Disabled Virginians with Mental Health or Intellectua	0	0	Decrease
Low-Income	Clients / Beneficiaries – Low-income, aged, or disabled Virginians with a diagnosis of HIV+	0	0	Increase
Low-Income	Clients / Beneficiaries: Low-income, Aged, and Disabled adults and children with a MH diagnosis	0	0	Stable
Low-Income	FAMIS MOMS - Uninsured pregnant women with income > 133% FPL and < 200% FPL**	0	0	Increase
Low-Income	Recipients • Seniors and persons with disabilities who meet eligibility requirements	0	0	Increase

Low-Income	Uninsured children age 6 to 19 with family income between 100% and 133% FPL	0	0	Increase
Low-Income	Uninsured children under 19 with family income >133% FPL (federal poverty level) and < 200% FPL*	0	0	Increase

Partners

Name	Description
Federal agencies	Center for Medicaid and Medicare Services (CMS)
Federally approved contractors	Assistance with outreach and training
Health care professionals, organizations, and facilities	
Industry Associations	Assistance with outreach and training
Private business firms	
State and local entities	Virginia Department of Social Services; Virginia Department of Health; Virginia Department of Education
State government officials Federal agencies State and local entities Private business firms Health care professionals, organizations, and facilities State government officials	
State government officials	
Advocacy groups	Virginia Health Care Foundation (VHCF); Virginia Poverty Law Center (VPLC)
Boards and committees	Children's Health Insurance Advisory Committee (CHIPAC)
VHQC (Virginia Health Quality Center)	Assistance with outreach and training

Agency Goals

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

  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.

  Objectives

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

  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.

  Objectives

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

  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.

  Objectives

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

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.

Objectives

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

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.

Objectives

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

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.

Objectives

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

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.

Objectives

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.

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.

Staffing

Authorized Maximum Employment Level (MEL)	427
Salaried Employees	378
Wage Employees	76
Contracted Employees	41

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.

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.

Estimate of Technology Funding Needs

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.

Supporting Documents

Title	File Type

Reimbursements for Medical Services Related to Involuntary Mental Commitments [32107]

Description of this Program / Service Area

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

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.

Products and Services

Description of Major Products and 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

Anticipated Changes

No significant changes are anticipated for this program.

Factors Impacting

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.

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.

Biennial Budget

	2015 General Fund	2015 Nongeneral Fund	2016 General Fund	2016 Nongeneral Fund
Initial Appropriation for the Biennium	0	0	0	0
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title	File Type

Grants for Improving The Quality of Health Services [40703]

Description of this Program / Service Area

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

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.

Products and Services

Description of Major Products and Services

Processing incentive payments for eligible providers to integrate their systems

Conducting outreach to eligible providers

Providing technical support to eligible providers

Anticipated Changes

Factors Impacting

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

Financial Overview

The Base Budget in the table is the Fiscal Year 2012 appropriation as reflected in Chapter 890 of the 2011 Appropriation Act. This Electronic Health Records (EHR) program is entirely federal funded and is for the incentive payments to eligible providers. Adjustments include additional non-general fund appropriation provided for the program in the 2013 Virginia Acts of Assembly - Chapter 806.

Biennial Budget

	2015 General Fund	2015 Nongeneral Fund	2016 General Fund	2016 Nongeneral Fund
Initial Appropriation for the Biennium	0	0	0	0
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title	File Type

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

Description of this Program / Service Area

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

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.

Products and Services

Description of Major Products and 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

Anticipated Changes

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).

Factors Impacting

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

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.

The FMAP (Federal Medical Assistance Participation) rate for this program area has been and is currently 65%. Non-general funds are comprised of Federal Funds and the Family Access to Medical Insurance Plan Trust Fund.

Biennial Budget

	2015 General Fund	2015 Nongeneral Fund	2016 General Fund	2016 Nongeneral Fund
Initial Appropriation for the Biennium	0	0	0	0
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title	File Type

Service Area Plan

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

Description of this Program / Service Area

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

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.

Products and Services

Description of Major Products and Services

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

Anticipated Changes

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.

Factors Impacting

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.

Financial Overview

The Base Budget in the table is the Fiscal Year 2012 appropriation as reflected in Chapter 890 of the 2011 Appropriation Act. There were no adjustments from the 2013 Virginia Acts of Assembly - Chapter 806.

Biennial Budget

	2015 General Fund	2015 Nongeneral Fund	2016 General Fund	2016 Nongeneral Fund
Initial Appropriation for the Biennium	0	0	0	0
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title	File Type

Service Area Plan

Reimbursements for Behavioral Health Services [45608]

Description of this Program / Service Area

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

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

Products and Services

Description of Major Products and 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

Anticipated Changes

Current efforts are aimed at utilization management and care coordination.

Factors Impacting

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.

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.

Biennial Budget

	2015 General Fund	2015 Nongeneral Fund	2016 General Fund	2016 Nongeneral Fund
Initial Appropriation for the Biennium	0	0	0	0
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title	File Type

Reimbursements for Medical Services [45609]

Description of this Program / Service Area

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

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.

Products and Services

Description of Major Products and 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)

Anticipated Changes

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.

Factors Impacting

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

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.

The Medicaid program is funded with a mixture of state and federal funds. The state match for the Medicaid program comes from a combination of state General Funds and the Virginia Health Care Fund. The federal match rate in Virginia is currently 50% state and 50% federal funds.

Biennial Budget

	2015 General Fund	2015 Nongeneral Fund	2016 General Fund	2016 Nongeneral Fund
Initial Appropriation for the Biennium	0	0	0	0
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title	File Type

Service Area Plan

Reimbursements for Long-Term Care Services [45610]

Description of this Program / Service Area

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

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.

Products and Services

Description of Major Products and 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

Anticipated Changes

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.

Factors Impacting

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

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.

Biennial Budget

	2015 General Fund	2015 Nongeneral Fund	2016 General Fund	2016 Nongeneral Fund
Initial Appropriation for the Biennium	0	0	0	0
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title	File Type

Insurance Premium Payments for HIV-Positive Individuals [46403]

Description of this Program / Service Area

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

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.

Products and Services

Description of Major Products and Services

Financial assistance for health insurance premiums

Anticipated Changes

The Department does not anticipate any changes to the products and services.

Factors Impacting

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.

Financial Overview

The Base Budget in the table is the Fiscal Year 2012 appropriation as reflected in Chapter 890 of the 2011 Appropriation Act. There were no changes from the 2013 Virginia Acts of Assembly - Chapter 806. The HIV Premium Assistance Program is funded with 100% state General Funds.

Biennial Budget

	2015 General Fund	2015 Nongeneral Fund	2016 General Fund	2016 Nongeneral Fund
Initial Appropriation for the Biennium	0	0	0	0
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title	File Type

Reimbursements from the Uninsured Medical Catastrophe Fund [46405]

Description of this Program / Service Area

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

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

Products and Services

Description of Major Products and 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.

Anticipated Changes

The department does not anticipate any product or service changes.

Factors Impacting

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.

Financial Overview

The Base Budget in the table is the Fiscal Year 2012 appropriation as reflected in Chapter 890 of the 2011 Appropriation Act. There were no adjustments related to the 2013 Virginia Acts of Assembly - Chapter 806.

Biennial Budget

	2015 General Fund	2015 Nongeneral Fund	2016 General Fund	2016 Nongeneral Fund
Initial Appropriation for the Biennium	0	0	0	0
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title	File Type

Reimbursements for Medical Services Provided to Low-Income Children [46601]

Description of this Program / Service Area

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

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.

Products and Services

Description of Major Products and 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

Anticipated Changes

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).

Factors Impacting

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

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.

The Medicaid expansion program is covered with a mixture of state and federal funds. On the federal level this program is covered through the Title XXI CHIP program that provides an enhanced federal match rate. The current match rate for Virginia is 35% state and 65% federal funds.

Biennial Budget

	2015 General Fund	2015 Nongeneral Fund	2016 General Fund	2016 Nongeneral Fund
Initial Appropriation for the Biennium	0	0	0	0
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title	File Type

Administrative and Support Services [499]

Description of this Program / Service Area

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

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.

Products and Services

Description of Major Products and 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

Anticipated Changes

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.

Factors Impacting

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.

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 reflect amendments contained in the 2013 Virginia Acts of Assembly - Chapter 806.

DMAS' administrative funding is comprised of approximately 66% federal funds, 33% state general (GF) funds, and 1% for several small grants that are paid from non-general funds (NGF). DMAS also serves as the pass-through agency for the transfer of federal funding to the Department of Social Services for Medicaid eligibility determinations. These amounts and other smaller federal pass-throughs to four other state agencies are not included in DMAS' appropriation figures.

Biennial Budget

	2015 General Fund	2015 Nongeneral Fund	2016 General Fund	2016 Nongeneral Fund
Initial Appropriation for the Biennium	0	0	0	0
Changes to Initial Appropriation	0	0	0	0

Supporting Documents

Title	File Type