2016-18 Executive Progress Report

Commonwealth of Virginia
Secretary of Health and Human Resources

Department of Medical Assistance Services

At A Glance

DMAS mission is to provide a system of high-quality and cost-effective health care services to qualifying Virginians and their families.

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

Financials Budget FY 2017, $9,923.37 million, 44.85% 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
- ↑ Prenatal 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) is one of 12 state agencies under the Health & Human Resources secretariat. It 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 Federal Medical Assistance Percentage (FMAP) rate for the Virginia Medicaid program is currently 50%. The Children's Health Insurance Program (CHIP), authorized under Title XXI of the Social Security Act, is also jointly financed by the state and federal governments, but unlike Medicaid is not an entitlement program. Virginia's CHIP program is known as FAMIS, Family Access to Medical Insurance Security.

While Medicaid was created to assist persons with low income, eligibility for coverage in Virginia is dependent upon other criteria as well. Medicaid coverage 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.

Enrollment in Virginia's Medicaid and FAMIS programs currently totals 1,106,920 individuals. Additionally, the average Virginia House district has 16% of its constituents enrolled in Medicaid, as does the average Virginia Senate district.

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. There are two types of services – those required by federal law and those left to the state's discretion. 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 (FQHC) and rural health clinic services; laboratory and x-ray services; transportation services; family planning services and supplies; nursing facility services; home health services with a nurse or aide; and the Early

and Periodic Screening, Diagnosis, and Treatment program for children (EPSDT).

In addition to required services, 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; comprehensive dental care (excluding orthodontia) for pregnant women; primary care and behavioral health services for uninsured individuals with a serious mental illness (SMI) diagnosis; prescription drugs; rehabilitation services such as physical therapy (PT), occupational therapy (OT), and speech language pathology (SLP) services, as well as rehabilitative home health services (PT, OT, SLP); hospice; certain mental health and 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 Assisted Living, Day Support, Elderly or Disabled with Consumer-Direction, Intellectual Disability, Technology Assisted, and Individual and Family Developmental Disabilities Support.

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 in which service providers are reimbursed directly by DMAS. Virginia has been increasing its use of the MCO program because of the value it provides to enrollees and to the Commonwealth. As of December 2015, just over 68% of Medicaid enrollees were in managed care.

The Medallion 3.0 MCO program is available in all regions of the state. This program includes the majority of Medicaid-enrolled children, pregnant women, low-income caretakers of children, and certain individuals who qualify for the "Aged, Blind, and Disabled" eligibility group. The Commonwealth's Medallion 3.0 plans are Anthem HealthKeepers, Virginia Premier, Optima Health, Kaiser Permanente, INTotal Health, and Aetna Better Health.

Another managed care option for long-term care recipients is the Program for All-Inclusive Care for the Elderly (PACE). 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 managed care initiative to better coordinate care for individuals who are currently covered 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.

Also in 2014, Governor McAuliffe requested that Secretary Hazel submit recommendations on how to improve health care in Virginia. Secretary Hazel responded with *A Healthy Virginia* – a plan that offers previously unavailable services and utilizes sources of coverage that are available but underutilized. As part of this initiative:

- Virginia launched the GAP program to provide primary care and behavioral health services for individuals in Virginia who are uninsured, have serious mental illness (SMI), and have incomes below 65% of the federal poverty level and, thus, improve access to care for uninsured Virginians with significant behavioral health needs, improve physical and behavioral health outcomes, and serve as a bridge to closing the coverage gap for uninsured Virginians with serious mental illness.
- DMAS collaborated with the Department of Behavioral Health & Developmental Services and the DMAS-contracted health plans to establish health homes that coordinate care for adults and children who are enrolled in Medicaid and who have a serious mental illness or a serious emotional disturbance.
- DMAS implemented comprehensive dental coverage for some 45,000 pregnant women enrolled in Medicaid and FAMIS MOMS since a pregnant woman's oral health is linked to delivery and her baby's health. Without access to comprehensive dental care, women may have undiagnosed or untreated dental health issues that may put their unborn babies in at risk.

Virginia also opened FAMIS to children of state workers with lower-income to improve their access to affordable, high-quality, comprehensive health care. Prior to the Affordable Care Act, federal law prohibited dependents of public employees from enrolling in the state's children's health insurance program, known as FAMIS in Virginia. Now, states can receive federal approval to enroll children of eligible state employees in these programs.

Customer Table

Predefined Group	User Defined Group	Number Served Annually	Potential Number of Annual Customers	Projected Customer Trend
Low-Income	Medicaid Providers	60,905	0	Increase
Low-Income	Total beneficiaries / clients in Medicaid and FAMIS (Titles XIX and XXI)	1,106,920	0	Increase
Low-Income	Low-income, Aged, and Disabled Virginians with Mental Health or Intellectual Disability in facilities (e.g., nursing facilities, ICF/MRs)	20,547	0	Decrease
Low-Income	Low-income, aged, or disabled Virginians with a diagnosis of HIV+	31	0	Stable
Low-Income	Recipients, seniors, and persons with disabilities who meet eligibility requirements	217,413	0	Increase
Low-Income	FAMIS MOMS – Uninsured pregnant women with income > 133% FPL and < 200% FPL	1,093	0	Increase
Low-Income	CHIP: Uninsured children age 6 to 19 with family income between 109% and 143% FPL	51,432	0	Increase
Low-Income	CHIP: Uninsured children under 19 with family income >143% FPL (federal poverty level) and < 200% FPL	58,863	0	Increase
Low-Income	Medicaid: Caretaker Adults	110,114	0	Increase
Low-Income	Medicaid: Pregnant women	16,533	0	Increase
Low-Income	Medicaid: Children	482,880	0	Increase
Low-Income	Medicaid: Family Planning (limited benefit)	106,786	0	Stable
Low-Income	Program of All-inclusive Care for the Elderly (PACE)	1,323	0	Increase
Low-Income	LTC in the community (waivers)	45,645	0	Increase
Low-Income	Low Income Aged Blind and Disabled not in Long Term Care	149,898	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 currently 50%. The budget table below reflects 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 2017	FY 2018
0100	General Fund	$3,846,847,641	$4,099,194,548
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	$430,248,427	$346,848,632
1000	Federal Trust	$4,341,032,367	$4,574,970,848

Revenue Summary

The Agency's total revenue consists of two types of resources: general funds (GF) and non-general funds (NGF). General fund revenues are derived from routine 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.

Non-general funds are obtained from federal funds, and grants are the largest single source of non-general fund revenue for DMAS. About 88% of all NGF 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 released 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% of the MSA allocation to Virginia for the purposes of paying for various health care costs faced by the Commonwealth, including the Medicaid program. In Fiscal Year 2015, this revenue totaled over $48 million.

Performance

Performance Highlights

DMAS continuously strives to make the Medicaid and FAMIS programs even 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, DMAS is working to bring care coordination principles to all populations and services under programs that it administers. This includes the examination and development of care coordination models to improve service delivery for Medicare-Medicaid dual enrollees. In addition to care coordination, DMAS and our partners across the Health and Human Resources (HHR) 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 (VaCMS) 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

DEMOGRAPHICS – As the number and age of persons DMAS serves increases, there are increased demands for long-term care and home and community based service programs.

NETWORK ACCESS – DMAS relies on its contracted health care providers to deliver services to customers. While periodically some provider groups receive increases in reimbursement, others receive only modest amounts. Even with these occasional increases, many providers are still paid well below the amounts paid by commercial insurers. Without sufficient increases, access to care may decline as providers make business decisions to no longer accept Medicaid or FAMIS patients.

FEDERAL CHANGES – Implementation of the Patient Protection and Affordable Care Act of 2010 (PPACA) continues to require substantial agency efforts. If the state chooses to implement the Medicaid expansion option, Medicaid enrollment would increase significantly.

COORDINATION OF SERVICE – DMAS works with 23 other state agencies, 10 of which are involved in healthcare-related activities on DMAS' behalf. One is the Virginia Department of Social Services (VDSS) that provides enrollment services for Medicaid and FAMIS applicants through 121 local departments of social services (LDSS) with costs exceeding $100 million annually. As the agency responsible for Medicaid, DMAS is accountable to federal authorities for resolving any issues of non-performance or payment.

EXPENDITURES – Expenditures for the agency have increased from $4.9 billion in SFY 2006 to over $8.5 billion in SFY 2015. This increase has occurred despite a number of major savings and reform initiatives. Over this same time period, average monthly enrollment in Medicaid/FAMIS has increased from 729,049 to 1,047,704 individuals and the service benefit package was enhanced as well.

Agency Statistics

Statistics Summary

Children and parents or caretakers of children comprise almost 70% of Medicaid beneficiaries, but they account for less than a third of Medicaid

total 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. Factors that could affect the number of Medicaid customers include changes in the Virginia economy, private insurance market forces that result in an increase in the rate of the un-insured, or federal/state policy changes affecting program eligibility.

Statistics Table

Description	Value

Management Discussion

General Information About Ongoing Status of Agency

Several factors impacting Virginia Medicaid are: (i) an aging population, especially those aged 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 (v) the overall continued growth in 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 trends and be proactive in adjusting current activities and in implementing improvements that increase effective and efficient services to our customers. DMAS will also need to work with Medicaid providers who must adjust to growing patient 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 Programs of All-Inclusive Care for the Elderly (PACE) sites; Increasing retention efforts to keep eligible children enrolled in Medicaid and FAMIS; Enhancing DMAS' capabilities and operations in preventing, identifying, and eliminating fraud and abuse; Improving small, women, and minority (SWaM) contracting and purchasing; Implementing efforts to oversee and manage behavioral health services; Pursuing a Delivery System Reform Incentive Payment (DSRIP) program to incorporate alternative payment methodologies; and Developing a statewide program to include long-term services and supports, medical care, and behavioral health services into the managed care program format.

Information Technology

DMAS was a key participant in the Electronic Health and Human Resources (eHHR) program, which facilitated inter-agency collaboration on systems and data sharing, until its expiration in December 2015. DMAS was the main source of funding for the systems being built in order to modernize eHHR infrastructure, improve services to citizens, and prepare for the eligibility determination and enrollment of individuals who were to become eligible for insurance coverage under the PPACA. DMAS created and staffed the eHHR Program Office, and a number of information technology projects were initiated under its auspices, including a Service Oriented Architecture (SOA) platform, customer authentication services, enterprise data management, and replacement of the eligibility and enrollment systems utilized by VDSS that benefit DMAS' operations today.

Drawing upon eHHR's advancements, DMAS continues to implement systems enhancements to support federal and state mandates and program initiatives. 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. DMAS has 20 divisions and offices, including the Executive Management Team. Overseeing all Medicaid activities and resources in these divisions for over 1 million beneficiaries are 460 authorized classified positions (for SFY2016) with an average of 390 filled or in recruitment. DMAS also utilizes about 100 hourly and contract employees to supplement the agency workforce.

DMAS' Information Management Division plays 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 seeks authorization for classified positions when permanency is justified.

There is some concern regarding the aging workforce. Potential retirements could have a significant impact on the agency's operations in terms of the loss of experienced managers and other key 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

DMAS is located in a privately leased building at 600 E. Broad Street, Richmond, VA 23219.