



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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October 27, 2014

MEMORANDUM

TO: The Honorable Terence R. McAuliffe
Governor of Virginia

The Honorable Charles J. Colgan
Co-Chairman, Senate Finance Committee

The Honorable Walter A. Stosch
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

FROM: Cynthia B. Jones

A handwritten signature in black ink that reads "Cynthia B. Jones".

Subject: Biennial Report of the Board of Medical Assistance Services

Section 32.1-324 of the *Code of Virginia* establishes the Board of Medical Assistance Services and requires the Board to submit a biennial report to the Governor and the General Assembly. Attached is the Board's report for the years 2013-2014. Should you have questions regarding this report, please feel free to contact me at 786-8099.

CBJ/
Enclosure

cc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

Biennial Report of the
Board of Medical Assistance Services



Department of Medical Assistance Services
October 2014

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INTRODUCTION

Section 32.1-324 of the *Code of Virginia* requires the Board of Medical Assistance Services (BMAS) to submit a biennial report to the Governor and the General Assembly. This report provides an overview of the Board and the Department of Medical Assistance Services and its activities during the past two years.

OVERVIEW OF THE BOARD

The Board of Medical Assistance Services is established in Section 32.1-324 of the *Code of Virginia* to oversee the Medicaid program. The duties assigned to the Board include the development of the *State Plan for Medical Assistance* and promulgating rules and regulations for the administration of the Medicaid program. Appointed by the Governor for four year terms, the 11 Board members must include five health care providers and six individuals that are not health care providers; the members elect the Board's chairman and vice chair. The terms are staggered and members may not serve more than two consecutive terms.

House Bill 184 (Chapter 137, 2012 Acts of Assembly) requires that at least two members of the Board of Medical Assistance Services be individuals with significant professional experience in the detection, investigation, or prosecution of health care fraud. The current members and past and future meeting dates are listed in Table 1.

During the Board meetings, the Department of Medical Assistance Services' (DMAS) staff briefed the members on changes to the Medicaid/FAMIS program, legislative and budget developments, and DMAS administrative issues. In addition, the Board provides for a public comment period at each meeting in order to hear from the general public regarding any Medicaid-related issues. A full list of the agenda topics are in Appendix A.

Table 1 – Board Members and Meeting Dates

Current Members	
<u>Providers</u>	<u>Non-Providers</u>
Joseph W. Boatwright, III, MD, Vice Chair	Mirza Z. Baig
Maureen S. Hollowell	Michelle Collins-Robinson
McKinley L. Price, DDS	Brian H. Ewald
Karen S. Rheuban, MD, Chair	Maria Jankowski
Marcia Wright Yeskoo	Peter R. Kongstvedt, MD, FACP
	Erica L. Wynn, MD
Meeting Dates	
<u>CY 2013</u>	<u>CY 2014</u>
April 9, 2013	April 8, 2014
June 11, 2013	June 17, 2014
September 24, 2013	September 9, 2014
December 10, 2013	December 9, 2014

During the past two years, the Board continued to take actions to improve both the Board's procedures and the administration of the Medicaid program as well as continued to be active in participating in or attending various DMAS Committees and advisory groups, such as the Family Access to Medical Insurance Security (FAMIS)/Children's Health Insurance Advisory Committee, the Pharmacy and Therapeutics Committee, and the Virginia Health Reform Initiative.

OVERVIEW OF THE VIRGINIA MEDICAID PROGRAM

Medicaid is an entitlement program authorized under Title XIX of the Social Security Act that provides coverage of medical services for certain disabled and low-income individuals. Medicaid is financed jointly by the state and federal governments and administered by the states, within guidelines established and approved at the federal level. Federal financial assistance is provided to states in the form of matching funds, and the federal match rate is based on the state's per capita income.

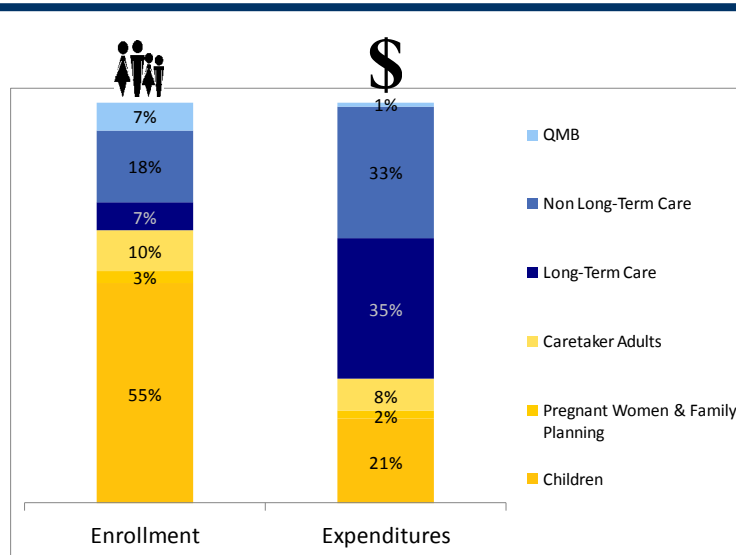
The federal match rate for Virginia is currently at 50 percent (the federal minimum), meaning that for every dollar expended in the Medicaid program, 50 cents comes from the federal government and 50 cents comes from the state's general fund.

While Medicaid was created to assist individuals with low incomes, coverage is dependent upon other criteria as well. Individuals who are eligible for Medicaid primarily fall into particular groups such as children living in households with low-income, pregnant women, elderly, individuals with disabilities, and parents or caregiver relatives of dependent children. Within federal guidelines, states set their own income and asset eligibility criteria for Medicaid. This results in a great variation of eligibility criteria among the states.

The Virginia Medicaid population in FY13 was comprised of 877,395 individuals per month (on average) with annual expenditures of \$7.6 billion (approximately 49% from federal funding). Children and adult caregivers make up about 70 percent of the Medicaid beneficiaries, but they account for only 35 percent of Medicaid spending. The elderly and persons with disabilities, while a minority in terms of recipients served (30 percent), account for the majority (65 percent) of Medicaid spending because of their intensive use of acute and long-term care services (Figure 1).

Figure 1 – 2013 Enrollment & Expenditures

Medicaid Enrollment v. Spending



The Virginia Medicaid program covers a broad range of services with nominal cost sharing for some of the beneficiaries, as permitted under federal law. The Virginia Medicaid program covers all federally mandated services and also provides some services at the state’s option. These services are listed in Table 2.

Table 2 – Mandatory and Optional Services Covered by Virginia Medicaid

Mandatory Services	Optional Services
<ul style="list-style-type: none"> • 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) • Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for children • Routine dental care for persons under age 21 	<ul style="list-style-type: none"> • Certified pediatric nurse and family nurse practitioner services • 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 • Non-traditional mental health services • Non-traditional substance abuse services • Intermediate care facilities for individuals with intellectual disabilities and related conditions

Health care services are provided to Medicaid recipients through two general models: fee-for-service (FFS) – the standard Medicaid program where providers are reimbursed directly by DMAS for services rendered; and managed care – where DMAS contracts with managed care

organizations (MCOs) that pay providers directly (Virginia pays MCOs a “per member per month” fee through a full risk contract to manage the majority of the recipients’ care).

In FY 2013, 66 percent of total Medicaid beneficiaries were enrolled in managed care and 34 percent of total Medicaid beneficiaries were enrolled in the FFS program. Figure 2 (see the next page) presents the proportion of healthcare expenditures by the major service area during FY 2013. It is important to note that the "Managed Care" expenditure total represents the expenditure to the participating health plans, with plans paying providers for services provided to their enrollees.

OVERVIEW OF THE VIRGINIA CHIP PROGRAM

The Family Access to Medical Insurance Security (FAMIS) program was established in the summer of 2001 as Virginia’s Title XXI Children’s Health Insurance Program (CHIP), replacing Children’s Medical Security Insurance Plan (CMSIP) in Virginia. Prior to FY 2003, all of the children enrolled in Virginia’s Title XXI plan were enrolled in the FAMIS program (or previously the CMSIP program). Beginning in FY 2003, children age six through age 18 and in families with income between 100% and 133% of the federal poverty level (FPL) were enrolled in the Medicaid program. This change was made in order to standardize the Medicaid FPL for all children under 19 and to prevent families from having children enrolled in two different programs (i.e., children under the age of six enrolled in Medicaid and children age six and over in the same family enrolled in FAMIS). Although these children were transitioned to Medicaid, Virginia continues to receive enhanced federal funding under the federal CHIP program for this population. This program is referred to as the CHIP Medicaid “Expansion;” however, this program has no relation to the expansion of Medicaid eligibility for adults available through the Patient Protection and Affordable Care Act (PPACA).

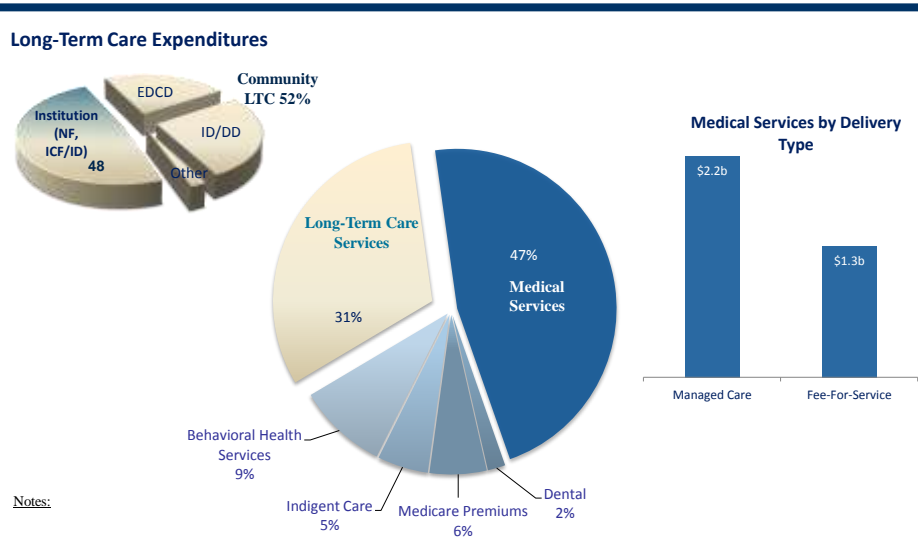
On August 1, 2005, Virginia’s CHIP program was expanded under a demonstration waiver to include coverage of pregnant women with family income above the Medicaid limit of 133% FPL but less than or equal to 150% FPL. The intent of this program expansion, called FAMIS MOMS, was to provide vital prenatal care to uninsured women living within the CHIP income range and likely to give birth to a child eligible for FAMIS. The income eligibility limit for the FAMIS MOMS program increased incrementally over the years to 200% FPL effective July 1, 2009.

At any point in time in the year, Virginia’s Title XXI CHIP program provides health care coverage for approximately 6% of all children in the Commonwealth or approximately 19% of all children covered by the Department through Medicaid and FAMIS. Over half (56%) of the individuals covered by Virginia’s Title XXI CHIP program are children enrolled in the FAMIS program. An additional 43% are children enrolled in the CHIP Medicaid Expansion. Pregnant and postpartum women enrolled in the FAMIS MOMS program made up the remaining 1%.

The FAMIS program is supported by a combination of federal and state funds. During FY 2014, the federal share of program funds was 65 percent. The Commonwealth’s share of program funding came from the FAMIS Trust Fund and the state general fund.

Figure 3 – FY 2013 Medical Expenditures Composition

Composition of Virginia Medicaid Expenditures – SFY 2013



2013 & 2014 ACHIEVEMENTS

Health Care Reform

The 2014 General Assembly, Appropriations Act (Chapter 2), Item 801 states that DMAS shall “seek federal authority through any necessary waiver(s) and/or State Plan authorization under Titles XIX and XXI of the Social Security Act to implement a comprehensive value-driven, market-based reform of the Virginia Medicaid/FAMIS programs. “ The goals of Medicaid reform include:

- *Coordinated Service Delivery*
DMAS provides a health system where services are coordinated, innovation is rewarded, costs are predictable, and provider compensation is based on the quality of the care.
- *Efficient Administration*
DMAS is efficient, streamlined, and user-friendly. Tax payer dollars are used effectively and for their intended purposes.
- *Beneficiary Engagement*
Beneficiaries take an active role in the quality of their health care and share responsibility for using Medicaid dollars wisely.

Reform shall be implemented in three phases as outlined below:

Phase One

- Implementation of a Medicare-Medicaid Enrollee (dual eligible) Financial Alignment demonstration called Commonwealth Coordinated Care (CCC);
- Enhancement of program integrity and fraud prevention efforts;
- Inclusion of children enrolled in foster care in managed care;
- Implementation of a new eligibility and enrollment information system for Medicaid and other social services;
- Improvement to access to Veterans services;
- Tightening of standards, services limits, provider qualifications, and licensure requirements for community behavioral health services.

Phase Two

- Implementation of value-based purchasing reforms for all recipients subject to the Modified Adjusted Gross Income (MAGI) methodology for program eligibility and any other recipient categories not excluded from the Medallion 3.0 managed care program. Such reforms shall, at a minimum, include:
 - (i) services and benefits provided are the types of services and benefits provided by commercial insurers and may include appropriate and reasonable limits on services such as occupational, physical, and speech therapy, and home care with the exception of non-traditional behavioral health and substance use disorder services;
 - (ii) reasonable limitations on non-essential benefits such as non-emergency transportation are implemented; and
 - (iii) patient responsibility is required, including reasonable cost-sharing and active patient participation in health and wellness activities to improve health and control costs.

Phase Three

- Implementation of reforms to include all remaining Medicaid populations and services, including long-term care and home and community-based waiver services, into cost-effective, managed and coordinated delivery systems.

PHASE ONE

Medicare-Medicaid Financial Alignment Demonstration ~ Commonwealth Coordinated Care (CCC)

In August of 2011, the Centers for Medicare and Medicaid Services (CMS) Office of Medicare and Medicaid Integration offered an opportunity for states to participate in the Medicare-Medicaid Financial Alignment Demonstration. The Demonstration seeks to test models to integrate Medicare and Medicaid services, rules and payments under one delivery system for individuals who are eligible for both Medicare and Medicaid (dual eligible individuals). A high portion of dual eligible individuals have chronic health conditions and functional impairments and receive services through two separate but overlapping programs that are uncoordinated and result in fragmented, sub-optimal care and outcomes. The Demonstration seeks to test programs that align the two systems under a unified delivery model.

The goals of CCC include: reducing fragmentation; providing high-quality and coordinated care; improving the health and lives of enrolled individuals; reducing the need for avoidable services, such as hospitalization and emergency room use; encouraging individual participation in treatment decisions; and supporting the goal of providing treatment in the least restrictive, most integrated setting.

As proposed by CMS, the Demonstration allows for a capitated model and a managed FFS model. Virginia submitted a proposal to participate under the capitated model, which was approved in May 2013. Under the capitated model, CMS, DMAS and three Medicare Medicaid Plans (MMPs) contracted to provide all Medicare Part A, B, and D benefits (Inpatient, Outpatient, Professional, and Prescription Drugs, respectively) and the majority of Medicaid benefits to CCC enrollees, including medical services, behavioral health services and both institutional and community-based long term care services and supports (LTSS) including those provided through consumer-direction. Additionally, through the three-way contract the MMPs are encouraged to implement unique and innovative care practices and provide enhanced benefits, such as behavioral health homes, partnerships with Area Agencies on Aging, and extended dental care in order to improve health outcomes. MMPs receive a blended capitated premium payment (payment from both CMS for Medicare services and DMAS for Medicaid services) that takes into account expected savings resulting from care coordination activities and uses quality withholds that can be earned back by the MMPs that meet specified performance goals.

CCC will operate for three years in addition to the initial enrollment year. Individuals over the age of 21 years who have full Medicare and Medicaid benefits are eligible to participate in CCC. CCC is a completely voluntary program, and as such allows the individual the ability to ‘opt out’ at any time. Under this method, upon becoming eligible, individuals are provided information through initial letters on the program options available to them (enroll in a CCC plan, opt out and remain in their current FFS plan or choose another available option, such as the Program for All Inclusive Care). If no selection is made, the individual will be passively enrolled in CCC but will have the ability to opt out at any time.

The CCC program has been implemented in five regions (Central Virginia, Northern Virginia, Tidewater, Charlottesville/West Region and the Roanoke area). Voluntary enrollment into CCC began March 1, 2014 in the Central Virginia and Tidewater regions. For the remaining regions (Northern Virginia, Charlottesville/West Region and the Roanoke area) voluntary enrollment began May 1, 2014. As of September, 2014, a total of 20,824 individuals have enrolled in CCC and 17,481 have opted out.

CCC includes a strong, person-centered service coordination/care management component, integration with an array of providers for continuity of care, outreach and education, and ongoing stakeholder participation in order to ensure that ongoing program innovation meets the needs of the dual population

Each enrollee shall receive, and be an active participant in, a timely and comprehensive Health Risk Assessment (HRA) of medical, behavioral health, LTSS, and social needs completed by the MMP’s care management team within specified time frames after enrollment. Relevant and comprehensive HRA data sources include the enrollee, providers, and family/caregivers. Results of the HRA will be used for determining the needed level of care coordination and as the basis for developing the plan of care. Care coordination is a person-centered process. The care coordinator will work with the enrollee, their family members, if appropriate, their providers and anyone else involved in their care to ensure they receive the services and supports that they need.

To ensure program goals are met, CMS and DMAS have established over 100 quality measures, including quality measures tied to premium withholds, that the contracted MMPs are responsible for reporting. Furthermore, a comprehensive evaluation is being conducted by DMAS and George Mason University staff in order to gauge stakeholder (provider groups and enrollees) satisfaction and the overall success of the program.

Enhancement of Program Integrity and Fraud Prevention Efforts

Recovery Audit Contractors

As a result of the Affordable Care Act becoming federal law in 2010, States are required to establish programs to utilize Recovery Audit Contractors (RACs) to audit payments to Medicaid providers. RACs are paid on a contingency fee basis, receiving a percentage of the improper overpayments and underpayments they identify and collect from providers. Pursuant to language in Virginia's FY 2011-2012 budget bill, DMAS contracted with a RAC beginning in July 2012. During the first year of the contract, the RAC identified and began collection efforts on over \$1 million in overpayments.

Medicaid Fraud and Abuse Detection through Data Mining

As a part of DMAS' commitment to the continuous improvement of its program integrity tools, DMAS contracted for development of a Medicaid Fraud and Abuse Detection (MFAD) system beginning in July 2012. The system has created a series of tests that identify improper billings based on known patterns, issues, and scenarios as well as using statistical models to identify anomalies, outliers and trends. During the first year of the contract, the system identified approximately \$44M in potential recoveries for DMAS that are currently being evaluated to determine the viability of recovery.

Service Authorization & Medicaid Management Information System (MMIS) Claims Processing Edits

The combined program integrity efforts of DMAS identified and/or prevented \$246.8 million in improper expenditures in the Virginia Medicaid program in FY 2013. The vast majority of these dollars (\$220 million) were savings from prepayment activities such as service authorization and MMIS claims processing edits, which stop improper payments before they are made.

Medicaid Fraud Control Unit

DMAS and the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General continue to maintain an effective relationship. In FY 2013 and FY 2014, DMAS submitted 176 referrals to MFCU of which 35 were accepted for investigation. In FY 2013, MFCU obtained convictions of 23 health care providers. Those cases resulted in a total of \$5,806,449 in court-ordered fines, penalties, and restitution to the Virginia Medicaid program. In addition, each of the 23 health care providers was barred for life from participating in the Medicaid program. Several cases referred to the MFCU are still pending investigation and may result in further prosecutions.

Payment Error Rate Measurement

The federal government conducts the Payment Error Rate Measurement (PERM) review every three years in each state to measure improper payments in state Medicaid programs. The findings of the PERM project are used to determine how Virginia performs on a national level in the area of payment accuracy. The PERM review for federal FY 2012 was completed in the fall of 2013. Two distinct reviews were conducted as a part of this project: one to determine the accuracy of Medicaid eligibility determinations and the other to determine the accuracy of payment for claims submitted by Medicaid providers. For the Medicaid eligibility review, the estimated Medicaid PERM rate was determined by CMS to be 0.47%. In the area of claims payment accuracy, the estimated Medicaid PERM rate was 2.2%, below the national error rate of 3.4% for this PERM cycle.

Foster Care and Adoption Assistance Program

The Department successfully transitioned 300 children in foster care from FFS into managed care in 2011 on a pilot basis. This transition was supported by the Governor and the General Assembly. The goal of the transition was to provide improved access to preventive and coordinated health care. The pilot proved to be successful; therefore, the Governor and the General Assembly endorsed transitioning all children in foster care into managed care utilizing a phased regional expansion approach.

Preparation to ensure a seamless transition began in 2012 and focused on three major areas: 1) information system changes at DMAS and Virginia Department of Social Services (VDSS) were made to allow for proper identification and location of children; 2) targeted outreach to local DSS staff, child placement agencies, foster care and adoptive parents became a priority; and 3) innovative trainings and communications were offered to local directors, supervisors, eligibility workers and permanency workers. Adoptive and foster parents also attended the trainings, as well as staff members from local therapeutic foster homes and staff members from local CSA offices. To ensure that the transition process went well, numerous planning and implementation meetings were held that covered topics such as managed care services, enrollment and transition, Medicaid FFS carved-out services, and youth who would be excluded from managed care.

The transition was given a high priority and involved participation of DMAS staff across the agency. Due to the complexity of the transition and the foster care program, the Department hired a new staff member with local DSS experience to manage and monitor this program. Collaborative efforts took place with the MCOs, the enrollment broker (Maximus), the service authorization contractor (KePRO), the transportation vendor (Logisticare), the dental contractor (DentaQuest) and the Xerox helpline.

The expansion began with the regional transition in the Tidewater area in September 2013, and concluded with the Southwest region on June 1, 2014. Outreach efforts to local child welfare

agencies and parents were at the forefront during the transition period. As the expansion was implemented into each region, the Department contacted the local DSS directors to provide updates on the transition, offered training and provided support. Trainings were made available via webinars and face-to-face sessions for eligibility workers, service workers, foster care and adoption assistance parents, group homes and licensed child placing agencies.

Nearly 70 training sessions were held statewide during the expansion process. In each training session, case managers from each MCO were present. Representatives from the MCOs provided information about their provider network, offered assistance in navigating their health care system, discussed their network services and provided beneficial feedback to DMAS. Each MCO designated foster care liaisons that help resolve urgent matters and are available for local DSS staff members and parents. The MCO presence at each training session was extremely advantageous for both the local DSS staff members and foster parents.

Post-implementation calls were held at 30 and 60 day intervals with the local DSS directors and staff members after each regional implementation. Diligent efforts made by DMAS, local agencies and the MCOs allowed for approximately 10,700 youth to be successfully enrolled into managed care statewide.

Although Southwest Virginia was the last region to transition children in foster care into managed care on June 1, 2014, ongoing work statewide will take place post-expansion. Refresher trainings will be offered statewide during the latter part of 2014 and conclude in early 2015. Training materials are available through a webinar posted on the DMAS website as an additional resource for local DSS staff members and parents. Utilization of the fostercare@dmass.virginia.gov email is a valuable resource for local DSS staff members and parents and is used to address inquiries and resolve urgent matters.

Collaboration with the MCOs addressing this population will continue with quarterly case management meetings. One of the Department's future goals for the Foster Care and Adoption Assistance program is to establish outcome measures, determine if proper assessments were completed, and verify that individuals are assigned properly to a primary care provider. The Department will also furnish a foster care and adoption assistance resource guide.

The Department participates in the *Three Branch Institute on Child Social and Emotional Well-Being* and the *Health Planning Advisory Committee* (HPAC). The Three Branch Institute is an interdisciplinary group composed of individuals from the executive, judicial and legislative branches of state government. The group facilitates coordination and collaboration to provide support for youth receiving services from Virginia's welfare system in order to improve their social and emotional well-being.

The purpose of the HPAC is to advise and make recommendations to VDSS and DMAS on improving health outcomes for children in foster care across the Commonwealth. It provides

oversight to ensure children in foster care receive appropriate services to meet their health needs, including developmental, medical, dental, mental health, and substance abuse needs.

New Eligibility and Enrollment Information System for Medicaid and Other Social Services

In early 2013, DMAS staff began working with VDSS and Deloitte to develop and implement a new eligibility and enrollment system. The new system, known as VaCMS (Virginia Case Management System) became operational on October 1, 2013. During the summer of 2013, DMAS received waiver approval from CMS to begin using the new Modified Adjusted Gross Income (MAGI) eligibility rules mandated by the Affordable Care Act on October 1, 2013, in conjunction with the implementation of the new system and to coincide with the beginning of the open enrollment period for the federal health exchange.

Improved Access to Veterans Services through Creation of the Veterans Benefit Enhancement Program

In October 2012, the Eligibility and Enrollment Unit implemented the Veterans Benefit Enhancement Program in conjunction with the VDSS and the Virginia Department of Veterans Services as mandated by the Virginia Legislature. This outreach program is designed to assist veterans and their families navigate and apply for services through the Federal Veterans Affairs Agency. This coordination results in the appropriate redirection of medical and financial support services from the state to the federal government. With this change, veterans and their families should see a higher level of services. The Commonwealth should have a corresponding reduction in the service metrics for this population.

Non-Traditional Community Behavioral Health Services

DMAS continues to diligently work to improve enrollee access to quality behavioral health services and address the appropriateness of the rapid utilization growth of these services. Several initiatives were implemented over the last biennium that helped to improve the efficiency and effectiveness of the delivery of behavioral health treatment.

Care coordination was identified as a missing element in the behavioral health care system that often leads to fragmented and circuitous treatment planning. Given these concerns, and as part of Medicaid reform initiatives, DMAS was granted the authority through the 2011 through 2013 Appropriations Act to implement a coordinated care model for individuals in need of behavioral health services that are not currently provided through a MCO. DMAS issued a Request for Proposals in 2011 and awarded a contract to Magellan Behavioral Health Services as the DMAS Behavioral Health Services Administrator (BHSA) in 2013. The contract was implemented on December 1, 2013.

Magellan administers all the behavioral health services for members in the Medicaid/FAMIS FFS programs. For members enrolled in a MCO, Magellan administers the non-traditional services such as community-based services and services received from providers who are licensed through the Department of Behavioral Health and Developmental Services (DBHDS). Through a care coordination model, Magellan is contracted to perform service authorizations, care management services, network development and claims processing, which allows all benefit administration functions to be streamlined into one centralized point of contact and operation. Magellan Care management services provide coordination among multiple providers, assists with timely access to appropriate care, and facilitates communication between providers and the MCOs.

DMAS saw an impact of the new model within the first six months of the Magellan contract operations. One notable feature is the Magellan Call Center located in Glen Allen, Virginia. The Call Center offers members personalized assistance with information, referrals, outreach and education. Magellan's Call Center has been utilized by members and providers alike, totaling over 21,000 calls. Magellan also provides a crisis call-in line 24 hours a day for seven days of the week for members who are in need of urgent care. Callers are immediately able to speak with a licensed clinician for assessment and referral to services as clinically indicated. Since December 1, 2013, there have been nearly 100 crisis calls handled by Magellan.

Operation of the Medicaid behavioral health provider network has also been transitioned to Magellan. Magellan contracts with and credentials all behavioral health providers. In addition, Magellan conducts quality reviews to ensure adherence to clinical practice guidelines. Education and training opportunities related to covered services, service authorization requirements and various clinical topics are provided to contracted providers, as well as individualized assistance with network or claim issues.

Magellan is building collaborative working relationships with stakeholders across Virginia's behavioral health care system including DBHDS, the Office of Comprehensive Services, Community Services Boards, private provider associations, and advocacy groups. Stakeholder representatives are invited to participate in Magellan projects and committee work that address quality improvement, member services, and a consumer and family stakeholder advisory group, to name a few.

Quality initiatives are underway involving a pilot peer support program, psychotropic medication use by children, and an integrated care study related to atypical antipsychotic medications.

DMAS also began developing regulatory changes as part of Medicaid reform initiatives and in response to behavioral health services audit findings. Audit findings revealed the need for more detailed program requirements to help improve the quality of services. Three regulatory

packages are being developed or have been approved by the Governor as of this writing. These packages and their status include:

- Mental Health Skill Building Services, which is a program that offers skills training for individuals seeking to live independently in the community – approved by the Governor and implemented by Magellan on December 1, 2013. Regulatory changes clarified the program definition and service eligibility criteria to ensure appropriateness of this training to qualified members who are transitioning toward independent living.
- Community Mental Health Rehabilitation Services (includes Mental Health Skill Building Services, Intensive In-Home Services, Therapeutic Day Treatment and Psychosocial Rehabilitation in addition to other non-traditional behavioral health services) – final regulations are in review at the Office of the Attorney General.
- Institutions for Mental Disease – Emergency/Final Regulations were published on June 2, 2014. These regulations are related to the new billing requirements for IMDs to bring DMAS into compliance with CMS expectations and requirements.

Moving forward, DMAS and Magellan will continue to implement the new care coordination model, along with quality initiatives, pilot projects and clinical studies. While the quality of services is paramount, member outreach and treatment outcomes will be the focus of the work ahead. DMAS and Magellan will continue to seek member feedback and participation in improving behavioral health care delivery in Virginia. Magellan, in partnership with DMAS and stakeholders, continues to ensure the provision of appropriate, consumer-focused, and quality-driven behavioral and substance abuse services, rendering better health outcomes for Virginia's Medicaid and FAMIS beneficiaries.

PHASE TWO

Modified Adjusted Gross Income (MAGI)

During the summer of 2013, DMAS received waiver approval from CMS to begin using the new Modified Adjusted Gross Income (MAGI) eligibility rules mandated by the Affordable Care Act on October 1, 2013, in conjunction with the implementation of the new eligibility determination system and to coincide with the beginning of the open enrollment period for the federal health exchange.

Commercial-Like Benefit Package

Managed Care

The managed care program was impacted by a number of new approaches to the way Medicaid is administered in Virginia. As of June 12, 2014, the number of individuals enrolled in a Medicaid MCO was 707,040 out of an overall Medicaid population of 1,022,571 (69%), while the number of individuals enrolled in a FAMIS MCO was 61,590 out of an overall FAMIS population of 64,883 (95%).

In 2012, the two MCOs operating in Northern Virginia, Anthem and AmeriGroup, merged. Federal regulation requires that individuals receiving Medicaid have a choice of at least two MCOs, in order to mandatorily enroll individuals into managed care. The merger of Anthem and AmeriGroup would reduce the number of MCOs in the area to one. In order to address this issue, it was determined that the AmeriGroup Virginia health plan must be severed from the National acquisition. The AmeriGroup Virginia business was purchased by INOVA Health system and was later officially named *INTotal Health*. Anthem HealthKeepers retained its service areas in Northern Virginia.

Kaiser Permanente expanded its Medicaid product into selected areas of Northern Virginia in 2013. Thus, Northern Virginia is now served by three health plans. Kaiser's quality improvement results are the best in the nation and will serve as a benchmark for managed care in Virginia.

During this period, one MCO, MajestaCare, left the DMAS network, while two new MCOs contracted with DMAS to participate in the Medicaid/FAMIS managed care programs - Kaiser Permanente and INTotal Health, bringing the total number of MCOs that operate Medicaid products across the Commonwealth to six. These partners are: Anthem HealthKeepers Plus, Optima, CoventryCares, Virginia Premier, Kaiser Permanente and INTotal Health.

Medallion 3.0

In 2013 the managed care contract was significantly revised and reorganized as part of overall Medicaid reform in Virginia. A technical manual was developed to clarify data reporting requirements, new populations were enrolled (including children in foster care), MCOs were required to form provider partnership pilots, and a quality payment incentive program was developed. The *Technical Manual* communicates standardized requirements to the MCOs pertaining to encounter data submissions, which reflect utilization of services by Medicaid members. Encounter data is vital to agency operations and may be used for program integrity investigations, pharmacy rebate collection, capitation rate-setting, focused quality studies and reporting to CMS.

In recognition of these changes, the Department implemented a program name change from Medallion II to Medallion 3.0 effective July 1, 2014. This change reflects the progression of Virginia's managed care delivery system and the ongoing emphasis on providing high-quality health care to Virginia Medicaid members.

Expedited Enrollment

After more than a year in the planning and development process, all members who qualify for enrollment into the Medicaid Managed Care program will use the new expedited enrollment process that began August 1, 2014. Expedited enrollment shortens the period between Medicaid eligibility determination and enrollment into a MCO. The new process streamlines enrollment in a MCO while providing adequate time to select and/or change plans. This enrollment process provides faster member access to care coordination, 24-hour nurse advice lines and specialty care.

Additional changes are being made to reduce enrollment disruption. Members who change addresses receive notification of all the plans available in the new locality and are given the opportunity to change plans while maintaining health plan coverage.

Limited Provider Networks and Medical Homes

Medallion Care System Partnership Pilot

To improve quality of service and promote cost savings, the Medallion Care System Partnerships (MCSP) were required by the new Managed Care Contract in 2013. The MCSP pilot program was established to improve member health and encourage provider partnerships and participation in innovative approaches to integrated health care service delivery, also known as Medical Homes.

The Medical Home is a model for delivery of primary and complex health services providing patient-centered, coordinated health care by selected providers. Current MCSP Pilots include:

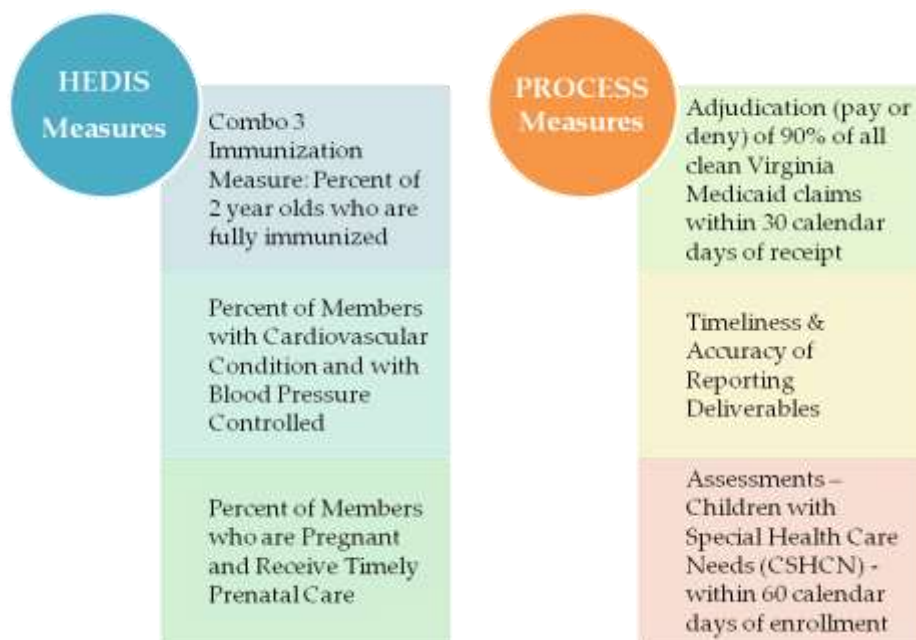
- Asthma Improvement Pay for Performance
- Diabetes Improvement Pay for Performance
- Behavioral Health/Medical Care Coordination
- Asthma, Diabetes, ER Utilization Pay for Performance
- Wholly-owned Patient Centered Medical Home Model

Performance Measure Incentive Program

One of the Virginia Medicaid program’s top priorities is improving the health of members while controlling health care costs. The Performance Measure Incentive Program provides financial incentives for improved quality and cost containment. The goal of the program is to use financial incentives to promote MCO focus on providing high quality health care. The program consists of obtaining metrics from the plans and comparing them to benchmarks on an annual basis and will be implemented in three phases.

The Performance Measure Incentive Program was created by joint effort of the Health Care Services Division and Provider Reimbursement Divisions of DMAS, the MCOs, and the Virginia Health Plan Association which brought to Virginia representatives from the state of Michigan to assist the program development team. The evaluation tool, which is in the final phases of development, includes assessments of performance on three HEDIS outcome metrics and three process metrics (see Figure 1). Fiscal awards will be proportionate to the extent that the MCO achieves benchmarks for each measure. The program will be implemented in a three-year phased-in schedule.

Figure 3: Performance Measure Incentive Program Metrics



PHASE THREE

In the third phase of reform, DMAS shall seek reforms to include all remaining Medicaid populations and services, including long-term care and home and community-based waiver services into cost-effective, managed and coordinated delivery systems. The department shall begin designing the process and obtaining federal authority to transition all remaining Medicaid beneficiaries into a coordinated delivery system.

The following projects are in process and are on-track:

ID/DD Waiver Redesign

DMAS has been charged with building a more robust, sustainable community system of supports for individuals with intellectual and/or developmental disabilities (ID/DD). DMAS and DBHDS completed phases one and two of the study in October 2013 and July 2014. The goal is the development of new waivers, which not only provide the financial resources, but also provide a framework to unify Virginia's system of services for individuals with ID/DD into a single, community-based system. Additional revisions to the ID/DD Waiver systems are to be implemented as needed by July 2015.

All Non-Dual EDCD Waiver Enrollees in Managed Care for Medical Needs

DMAS has been working with CMS, MCOs and stakeholders since January 2014 to prepare for moving these individuals into MCOs. DMAS will move non-dual EDCD waiver enrollees into one of the six MCOs for medical needs by October 2014. Home and community-based waiver services remain carved out of managed care until 2016 and continue to be provided through FFS.

All Inclusive Coordinated Care for LTC Beneficiaries (coordinated delivery for all LTC services)

DMAS will complete the transition of all non-dual waiver recipients and their community long term care services into coordinated care networks by July 2016.

Complete Statewide Commonwealth Coordinated Care (CCC), including children

After the CCC demonstration period is complete, expand statewide with all the remaining dual populations and all their medical, behavioral, and long term care services by July 2018.

Ensuring Quality and Integrity of the Medicaid Program

The Department of Medical Assistance Services is strongly committed to improving the quality of services provided to beneficiaries and to ensuring program integrity. The following sections highlight key examples of these initiatives that were not discussed in a previous section.

Program Integrity Initiatives

Recipient Audit Unit

The Program Integrity Division investigates allegations of acts of fraud or abuse committed by recipients of Medicaid and Family Access to Medical Insurance Security (FAMIS) benefits. These allegations typically involve recipient eligibility issues such as: knowingly providing false information in the Medicaid application; illegal use/sharing of a Medicaid card; uncompensated transfer of property; excess resources or income; or fraudulent household composition. In FY 2013 and FY 2014, the Program Integrity Division investigated 4,214 recipient referrals and uncovered a total of \$11,355,607 in improper payments. Of the total amount, \$5,450,526 was submitted for administrative recovery, which involve instances where the intent to defraud is not present. During this same period, 64 individuals were convicted of fraudulently obtaining benefits and ordered to pay \$471,267 in restitution. These recipients also are banned from the Medicaid program for one year (the maximum time allowed under federal law,) and can be subject to jail time.

Managed Care Program Integrity Collaborative

The majority of Medicaid recipients are enrolled in managed care organizations (MCOs) that receive a contracted monthly rate for each enrolled member and pay providers directly for their medical services. MCOs are required to have policies and procedures in place to prevent, detect and investigate allegations of fraud, waste and abuse. DMAS works closely with our managed care partners to encourage and facilitate their program integrity efforts. Since FY 2011, DMAS has held quarterly Managed Care Program Integrity Collaborative meetings that provide a venue where program integrity staff from the MCOs and DMAS can share information about their program integrity functions and identify opportunities to improve overall Medicaid program integrity.

The collaborative has been identified as a national best practice by the Centers for Medicare and Medicaid Services in their 2012 Annual Summary Report of Comprehensive Program Integrity Reviews, and DMAS staff members have presented the model to Medicaid staff from other states at a variety of national conferences. In FY 2013, representatives from the Medicaid Fraud Control Unit (MFCU) began to regularly attend these meetings, facilitating an open discussion on developing fraud cases and contributing to a better, more coordinated relationship between MCOs and the MFCU.

Internal Audit

During the two-year period from 2013 through 2014, the DMAS Internal Audit Division (IA) successfully conducted a program of concurrent audit testing (internal audits of business processes), internal control monitoring, and information technology security compliance reviews.

Additionally, IA performed five State Fraud, Waste, and Abuse Hotline investigations referred by the Office of the State Inspector General, coordinated federal and state external audits, and tracked and monitored the resolution of corrective action plans. Highlights are discussed in the sections below.

Completion of the DMAS Security Compliance Audit

IA completed the federally mandated biennial review of the DMAS Information Technology (IT) operating environment and security business practices. The scope of the review addressed compliance with information security standards as required by the recently revised Virginia Information Technology Agency (VITA) Information Security Standard, Version 7.1 (SEC501-7.1). The Standard was significantly expanded to include security best practices aligned with the National Institute of Standards and Technology (NIST) security standards, specifically NIST Special Publication SP800-53. Additionally, the review evaluated security policies and procedures implemented to meet federal HIPAA Security Rule standards for the protection of Electronic Protected Health Information. HIPAA standards are structured in four broad categories: Organizational Requirements, Administrative Safeguards, Physical Safeguards, and Technical Safeguards. IA issued the final audit report in January 2014. IA continues to monitor the completion of corrective action for all security audit findings.

The prior security compliance audit was completed in June 2012. The corrective action is complete for all but one finding – DMAS has an outdated Disaster Recovery Plan that needs to be reviewed, revised, and tested. The finding was repeated in this year’s DMAS Security Compliance Audit Report. The Information Management Division (IM) estimates the completion of the tasks on the new corrective action plan by December 31, 2014.

APA Audit Report for Fiscal Year End 2013

DMAS received the Virginia Auditor of Public Accounts (APA) final consolidated HHR agencies audit report in February 2014. The report included two DMAS findings, one of which was listed as a material weakness. IM responded quickly to the audit finding and recommendation, which enabled a rapid resolution to the most significant aspect of the security weakness. IA implemented corrective action plans and is monitoring their completion. Notably, DMAS continues to have very few APA findings for an agency of its size and complexity, in comparison to other agencies under the HHR Secretariat.

APA Vulnerability Assessment and Network Penetration Test

In 2013, IA worked with IM and the Office of Compliance and Security (OCS) to resume the biennial Vulnerability Assessment and Network Penetration Test. Network Penetration Tests were being completed routinely through 2009. After 2009, Penetration Testing was suspended because of the transfer of DMAS’ IT equipment and services to VITA as part of the Commonwealth

Strategic IT Plan. IM and OCS management concluded that penetration testing of an IT environment in a state of flux would not provide information that was actionable. The transfer to VITA took significantly longer than envisioned (or anticipated) because of negotiations between the agencies to ensure that VITA understood and could meet federal Medicaid requirements that are unique from other state agency requirements.

The APA completed its Vulnerability Assessment and Network Penetration Test and issued its Penetration Test draft report in November 2013. The results were very positive; six issues (one critical and five important) were identified that need to be addressed through updates or technical coding solutions. The APA issued a public report, which contains information about the nature of the review but does not include any details regarding network vulnerabilities. DMAS provided a response to the public report in December 2013. IA is monitoring completion of corrective action plan.

HHS, OIG Office of Audit Services – Audits of Medicaid Administrative Costs including the Resource Mothers Program

IA facilitated and monitored an audit of the CMS 64 Report¹ that was completed by the HHS, Office of Inspector General (OIG) Office of Audit Services. The audit reviewed the Medicaid administrative costs claimed on Line 22 (Inter-agency Costs) and Line 29 (Other) of the quarterly CMS 64 Reports for State fiscal years 2010-2012. The audit also reviewed the DMAS Medicaid Cost Allocation Plan (CAP) to ensure that costs being reported on the CMS 64 report were properly authorized (including costs that are passed through from other state agencies). The audit also verified that there are appropriate Memoranda of Understandings documenting the relationships between DMAS and other state agencies and the agreed upon services. The audit began in October 2012 and ended in September 2013.

The OIG also extensively reviewed the Resource Mothers Program under the Medicaid Administrative Cost audit project. Resource Mothers is a maternal outreach program that is administered by the Virginia Department of Health but receives pass-through Medicaid funding from DMAS. On September 12, 2013, DMAS was informed that the OIG was closing the Medicaid Administrative Cost Audit and would not issue a report under the assigned number for the project. DMAS was also informed by the OIG that it planned to issue an audit report on the Resource Mothers Program under a new audit number. On January 28, 2014, DMAS received formal OIG email notification that it was discontinuing its audit of the Resource Mothers Program and would not issue a draft report; no reason was provided to DMAS.

During the 11 month review period that ended with no formal audit report, the Agency expended extensive staff time and effort to: address the auditors' questions during numerous interviews; coordinate and attend meetings with other state agencies that receive pass-through Medicaid

¹ The CMS 64 report is a detailed schedule of DMAS expenditures used to draw down Federal matching funds.

funds from DMAS; provide examples and demonstrations illustrating operating and reporting processes; and prepare/provide extensive financial and program documentation, data, and reports.

Quality Assurance Review (QAR) Project

In October 2013, IA utilized a state contract established by the Office of the State Inspector General to complete a Quality Assurance Review (QAR) of the Internal Audit Division. The QAR is performed every five years to ensure that internal audit functions generally comply with the standards established by the Institute of Internal Auditors as required by the Office of the State Inspector General's Directive 001, dated April 15, 2013. The QAR Report gave IA a "Generally Conforms" rating, which is the highest of a three-level conformance rating system. "Generally Conforms" means that the internal audit department has policies, procedures, and a charter in place, and follows practices that were judged to be in accordance with applicable professional standards.

Administrative Efficiencies and Improvements

Acute Services Managed Care for Individuals Receiving Community-Based Long Term Services

The Department will enroll individuals in the Elderly or Disabled with Consumer-Direction (EDCD) waiver into managed care for acute care services. MCOs will provide acute and primary medical care services, pharmacy related services and transportation to medical appointments. Long Term Care waiver services continue to be administered under the current fee-for-service long-term care processes. This initiative allows the Commonwealth to expand principles of care coordination to additional populations not currently receiving coordinated care.

Quality

Ensuring that members of Medicaid managed care receive the highest possible level of quality of care is at the center of quality care management efforts. Through the contract with the MCOs, the Department requires each plan to obtain and maintain accreditation with the National Committee for Quality Assurance (NCQA) - the most widely recognized health plan accreditation body in the country.

To assess the performance level of each MCO, the DMAS Health Care Services (HCS) unit reviews performance measures captured through NCQA's Quality Compass—a tool used to measure, evaluate and benchmark plan performance. Two sets of data are used: *Healthcare Effectiveness Data and Information Set* (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures. The MCO contract requires that MCOs meet the 50th percentile for specific quality of care metrics as reported through NCQA's Quality

Compass. CAHPS measures capture member experiences with health care and services.

To ensure that managed health care provided by the MCOs meets acceptable standards for quality, access and timeliness, DMAS contracts with the Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO). Following federal requirements for an annual assessment, Delmarva assesses each MCO's performance relative to quality of care, timeliness of services, and accessibility of services.

In 2012, the Virginia MCOs met or exceeded the 50th percentile benchmark for the following measures:

- Antidepressant Medication Management
- Breast Cancer Screening
- Cholesterol Management for Patients With Cardiovascular Conditions
- Comprehensive Diabetes Care - HbA1c Testing
- Comprehensive Diabetes Care - HbA1c Control (<8.0%)
- Comprehensive Diabetes Care- Blood Pressure Control (<140/80mm Hg)
- Use of Appropriate Medications-Asthma (Ages 5-11, Ages12-18, and Total)
- Prenatal and Postpartum Care- Timeliness of Prenatal Care
- Well-Child Visits in the First 15 Months of Life (Six or more visits)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life

Smiles for Children Program

The ***Smiles For Children*** program, which began in 2005, is recognized as one of the top Medicaid dental programs in the nation. Goals of the program include increasing the number of children who have preventive dental visits and increasing the number of participating dentists. The ***Smiles For Children*** program is one of seven state Medicaid dental programs chosen by the Center for Health Care Strategies (CHCS) and CMS to participate in a National Oral Health Learning Collaborative.

Under ***Smiles For Children***, dental service utilization continued to increase from 2005-2014; ***Smiles For Children*** service utilization doubled while provider participation tripled. The program surpassed the national average for annual dental visits among children, and since 2005, the number of participating dental providers has increased from 620 to 1,900 general dentists and specialists.

Preventistry ^(SM) Sealant Program strengthens the ***Smiles For Children*** dental program by promoting the application of sealants to prevent dental disease and reduce the risk for dental carries. In 2013, DMAS began the Early Dental Home Pilot Program in the Richmond metropolitan area, which establishes successful relationships between dentists and ***Smiles For Children*** members to address all aspects of oral health care.

Provider Reimbursement

The following provider reimbursement activities were accomplished over the last two years:

- Provider payment rates were annually updated on July 1, as prescribed in regulation or as directed by the Appropriations Act.
- Capitation rates for Medallion 3.0, FAMIS, FAMIS MOMS and PACE were developed annually based on federal regulations.
- A new reimbursement system for hospital outpatient services was implemented, effective January 1, 2014, replacing outdated cost based reimbursement with a methodology that promotes efficiency and payment certainty.
- Implemented the primary care rate increase mandated by the Affordable Care Act for CY13 and CY14.
- Developed, in response to losing an appeal in US District Court, a compliance plan for paying non-facility services furnished to members residing in Institutions for Mental Disease, which are freestanding psychiatric hospitals and residential training centers.
- Developed CY14 capitation rates for the Commonwealth Coordinated Care (CCC) program, in collaboration with CMS. Provider Reimbursement developed the Medicaid portion of the Medicare-Medicaid blended capitation rate paid to participating MCOs and a Member Enrollment Mix Adjustment (MEMA) risk factor for members receiving long-term care services. The MEMA factor helps to ensure that MCOs are paid amounts that are sufficient to provide care to their enrolled populations without overpaying, based on the needs of the enrolled members.
- Completed new requirements for annual Upper Payment Limit demonstrations for nursing facility, inpatient hospital and outpatient hospital services.
- Completed rebasing for hospital inpatient services and worked with the Hospital Payment Policy Advisory Committee to develop proposals to implement APR-DRGs and new Disproportionate Share Hospital (DSH) methodology in FY15.
- Completed estimates of inmate and indigent care savings that could be realized if the coverage gap were closed. These estimates contributed to cost estimates for closing the coverage gap. Also estimated the size of the Disproportionate Share Hospital (DSH) shortfall at UVA and VCU that would occur if the coverage gap is not closed.

- Analyzed claims data to determine the number of members with Alzheimer's or other dementia for the Alzheimer's Commission.

Pharmacy

The Pharmacy program covers medically necessary prescription and non-prescription drugs for Medicaid FFS enrollees. The program is supported by the Drug Utilization Review (DUR) Board, the Pharmacy and Therapeutics Committee, and the Pharmacy Liaison Committee to ensure appropriate drug utilization and cost management.

Federal law now allows states to receive "rebates" from pharmaceutical manufacturers for drugs prescribed for both FFS and MCO Medicaid members. Dramatic increases in pharmacy rebates have produced revenue of nearly \$570 million since 2010.

In consultation with the DUR Board, the pharmacy staff is implementing service authorizations to improve management of atypical antipsychotics prescribed for children in the FFS program. The service authorizations will be extended to all children ages 6-18 in phases beginning on July 1, 2014 with ages 6-12 years.

Information Technology/Management

Tele-Medicine

During the past two years, DMAS has expanded the number of services and physicians who can provide services via telemedicine. A new provider specialty code was created to accommodate claims processing. The physician enrollment application was modified to determine if a physician was enrolling to provide telemedicine services. The reference subsystem was updated to accommodate payment to out of state physician telemedicine service providers. The claims subsystem was modified to ensure out of state physician telemedicine services were paid appropriately. Implementation took place on May 4, 2014.

Nursing Home Rate Algorithm Changes

Nursing home rate algorithm changes are planned for implementation by November 1, 2014 based on the Resource Utilization Grouping (RUG) pricing methodology following the current Medicare methodology.

Federal Mandates implemented include:

- The latest version of the federal HIPAA transaction code set which is used by providers to submit claims and receive payments was implemented. This includes the HIPAA ANSI X12 5010 code sets for all medical related data submissions and pharmacy point of sale type (i.e. NCPDP Pharmacy D.0.) As a result of this system upgrade, DMAS is now compliant with

the HIPAA regulation. This project was implemented on time, under budget and incorporated a 90-day grace period for providers to comply. 99.6% of Virginia Medicaid providers converted to HIPAA 5010 version transactions at the time of implementation from the previous 4010 and NCDPDP 5.1 standards.

- HIPAA operating rules 1, 2 and 3. The project was implemented in three phases: Project work efforts are based on new HIPAA-based requirements for administrative transactions for eligibility and claims processing established by the Administrative Simplification provisions under the Affordable Care Act. Virginia completed all three phases and could certify compliance with the rules. These rules provide better standards for electronic data interchange practices and result in less error processing.
- ICD 9 (International classification of diseases) is the federal standard for filing claims to any insurance payers and Medicaid and Medicare. Under HIPAA regulation, payers are expected to be compliant with the new regulation to accept ICD 10 instead of the ICD 9 starting October 1, 2015. This date has been moved twice by the federal government due to various reasons. DMAS upgraded the claims processing system to accept ICD 10 codes effective October 1, 2015. Until then, DMAS will continue to accept ICD 9 codes, process claims and pay providers. Virginia completed Interface Testing with vendors, Beta Partner Testing and started Trading Partner Testing.
- National correct coding initiative (NCCI): Virginia implemented the NCCI methodology in June of 2013. NCCI covers *medically unlikely* edits. Virginia tested the NCCI methodology and successfully implemented the Commercial of the Shelf (COTS) solution. A quarterly savings report is being generated and shared with CMS.
- Implementation of the provider screening regulations was accomplished on March 24, 2014 through the implementation of an IBM workflow solution. Providers are credentialed and checked against federal and state databases. Applications are streamlined, and providers can check the application status through the Virginia Medicaid portal administered by the DMAS fiscal agent. (<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal>).
- Transformation Medicaid Statistical Information System (T-MSIS) is a new CMS data reporting system that will allow for the standardization of data across states including eligibility, third party liability, claims, provider, and managed care organization information. Virginia is a beta partner with CMS to assist in the development of specifications, guidelines, and design of T-MSIS solutions. Virginia has participated on panels and in a national webinar sharing lessons learned. The project is still in progress and awaiting CMS completion of their new system.

Program Operations

DMAS made numerous business process and program improvements directly affecting members, providers, contractors and staff during the past two years. Some notable accomplishments include:

- The FFS non-emergency medical transportation (NEMT) program increased the field monitoring of transportation providers. Three part-time field monitors and a full-time supervisor make frequent unannounced, on-site safety inspections statewide, with emphasis placed on the most populous regions of Northern Virginia, Tidewater and Metro Richmond. The DMAS inspectors work closely with field monitors from the NEMT broker, LogistiCare, to ensure that:
 - Each driver has passed a criminal background check, driving record check and training program in defensive driving, passenger assistance and wheelchair securement;
 - Each vehicle is inspected every six months and is in good running condition with working lights, turn signals, heating and air conditioning, fire extinguishers, fully functional wheel chair lift and a radio or cell phone to use in case of an emergency.
- With the broker's new automated trip reminder system, riders now can be reminded by phone of trips they have scheduled for the next two days. Riders can press a button to opt out of the reminders, to reach a live operator or to reschedule a trip. Calls can be limited to a small area or group and used, for example, to notify riders of delays because a specific road is flooded.
- In 2013, seven regional Advisory Boards were created across Virginia to provide a forum for discussing common concerns among the diverse service providers who work with Medicaid members who need transportation. About 75 members were invited to meet quarterly and represent their Community Services Board (CSB), Center for Independent Living (CIL), Area Agency on Aging (AAA), dialysis center, and long-term care or residential facility. Their first major achievement was a successful retooling of the complaint process, making it more efficient and accurate.
- In June of 2013, Program Operations implemented the CMS National Correct Coding Initiative (NCCI), Procedure to Procedure (PTP), and Medically Unlikely Edits (MUE). This implementation was in response to directives in the Affordable Care Act, in which CMS required all state Medicaid agencies to implement the NCCI methodology. Physician, lab, DME and outpatient hospital claims are subject to this editing process. DMAS worked closely with CMS during the implementation phase to obtain some exceptions to these editing processes.
- In January 2013, DMAS changed its FFS reimbursement methodology for labor epidurals, defined in the Current Procedural Terminology (CPT) Manual as CPT code 01967. DMAS started to reimburse this procedure at a flat rate of \$197.60 rather than pay based on time

increments. This enhancement benefited providers by ending the requirement for sending medical records documenting actual time spent with the patient.

- In January 2014, the Enhanced Ambulatory Patient Group (EAPG) process was implemented for all outpatient hospital claims. The new reimbursement methodology for outpatient procedures and ancillary services performed in an outpatient hospital setting takes into account patient characteristics and resource utilization. The EAPG determines a payment action based on the clinical logic included within the software and pays outpatient hospital claims accordingly. This enhancement stopped the need for hospitals to submit documentation when payment was denied due to lack of information to support that the service was provided for an emergent problem.
- DMAS launched the Electronic Health Record (EHR) Incentive Program in July 2012. This program provides Federally-funded incentive payments to eligible professionals, and hospitals, (including critical access hospitals) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in their first year of participation, and demonstrate meaningful use for the remaining participation years. Since implementation, a total of 2,987 provider registration files have been received by DMAS. Of this number, 2902 were Eligible Professionals (EPs) and 85 were Eligible Hospitals (EHs). In addition, a total of 2,524 payments were approved totaling \$123,733,382 in EHR incentive payments.

Maternal and Child Health Services

Family Access to Medicaid Insurance Security (*FAMIS*)

Due to changes in the eligibility process required by the Affordable Care Act, beginning October 1, 2013, new FAMIS applications are no longer processed at the FAMIS Central Processing Unit (CPU). The CPU continues to maintain existing FAMIS and FAMIS MOMS cases until all are transitioned to the local DSS agencies which maintain the new eligibility system. Beginning with renewals due in April 2014, FAMIS cases are:

- Converted monthly to the new eligibility system;
- Renewed by the Local Department of Social Services (LDSS) where the child resides; and
- Maintained by the LDSS where the child resides

While the FAMIS CPU will no longer exist in its former state, the current Cover Virginia call center (described below) will be expanded to include processing of certain Medicaid and FAMIS eligibility applications to a final determination in the late fall of 2014. This new entity is intended to reduce the burden on local departments of social services beginning with the second federal open-enrollment season from November 15, 2014 through February 2015.

The 2014 General Assembly approved the elimination of the four-month uninsured waiting period for FAMIS enrollees. DMAS submitted regulatory changes effective July 1, 2014. Beginning April 1, 2014, children who exceed the new Modified Adjusted Gross Income (MAGI) limit for Medicaid at eligibility renewal, due to rule changes in the treatment of income disregards, are provided coverage under FAMIS.

DMAS applied to renew the section 1115 demonstration waiver under the Children's Health Insurance Program (CHIP) to continue operating the FAMIS MOMS and FAMIS *Select* programs in June of 2012. A three year renewal was approved by CMS in May of 2013 effective July 1, 2013 through June 30, 2016.

Under the provisions of the Affordable Care Act, beginning January 1, 2014, most women in the FAMIS MOMS income range qualify for health insurance coverage that includes maternity care with a federally subsidized premium through the Health Insurance Marketplace (HIM). An amendment to the state's biennium budget directed DMAS to eliminate the FAMIS MOMS program in coordination with the availability of HIM subsidized coverage.

Accordingly, DMAS requested an amendment to the demonstration to phase out FAMIS MOMS beginning January 1, 2014. This amendment was approved by CMS on December 31, 2013. As a result, no new applications for FAMIS MOMS coverage were accepted after December 31, 2013. However, women eligible for FAMIS MOMS with a begin date of coverage on or before December 31, 2013, will retain eligibility for the duration of their pregnancy and post-partum period. During the 2014 General Assembly session, the Senate included a budget amendment to reinstate FAMIS MOMS effective July 1, 2014. DMAS has submitted another waiver amendment to reinstate the program.

CHIPRA Performance Bonus

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) established "Performance Bonuses" for States to support the enrollment and retention of eligible children in Medicaid and CHIP. Performance Bonuses provide additional federal funding for qualifying States that take specific steps to simplify Medicaid and Children's Health Insurance Program (CHIP) enrollment and renewal procedures and have also increased enrollment of children above a baseline level. Because of these efforts, Virginia was awarded \$19,973,322 for FFY 2012 and \$18,004,201 for FFY 2013.

Early Intervention

Early Intervention services encompass targeted case management and specialized rehabilitative services designed to meet the needs of children from birth to age three who have a developmental delay, atypical development or a diagnosed physical or mental condition resulting

in a developmental delay. DMAS reimburses for Early Intervention services delivered by an enrolled DMAS provider. As of May 2014, a total of 4,555 children were enrolled in both Early Intervention and Medicaid or FAMIS.

Plan First

Plan First covers birth control and family planning services for women and men. It is a limited coverage program and not considered full coverage Medicaid. DMAS has worked closely with the Virginia Department of Health (VDH) to promote Plan First across the state. In March 2013, DMAS also worked with VDH to promote smoking cessation by mailing *QuitNow* flyers to over 37,000 Plan First members.

As a result of the Affordable Care Act, the federal poverty level (FPL) for Plan First changed from 200% to 211% FPL on October 1, 2013. Due to the 2013 budget amendment which directed the Department to reduce Plan First eligibility levels in coordination with the availability of subsidized coverage on the Health Insurance Marketplace (HIM), eligibility for Plan First decreased to at or below 100% FPL effective January 1, 2014; individuals above this level are referred to the HIM. Even with the reduction in income level, however, Plan First enrollment continues to increase. As of May 2014, there were 54,067 members enrolled in Plan First, an increase of 41% from May 2013. The 2014 General Assembly reinstated the Plan First income eligibility level to 200% of the Federal Poverty Level. DMAS is in the process of submitting another Medicaid State Plan amendment to reinstate coverage at the FPL limit in alignment with the FAMIS MOMS program.

EPSDT (Early Periodic Screening Diagnosis and Treatment)

Early Periodic Screening Diagnosis and Treatment (EPSDT) provides preventative services, medically necessary services, and individualized treatment services to correct and ameliorate physical and mental health conditions, when the Medicaid state plan does not offer the needed treatment service.

EPSDT defines non-state plan services as “EPSDT Specialized Services”. The EPSDT clinical staff is responsible for processing service authorizations for Private Duty Nursing, Developmentally Disabled/Psychiatric/Neurological Inpatient, Residential and Substance Abuse services, Hearing Aids, Personal Care and Attendant Care Services, Assistive Technology, Group Home and In-Home Behavioral Therapy Services.

In November 2012, Assistive Technology, Hearing Aids, Private Duty Nursing, Personal Care and Attendant Care Services service authorizations transitioned to KePRO. The EPSDT clinical staff continues to review and authorize Developmentally Disabled/Psychiatric/Neurological Inpatient, Residential and Substance Abuse services as well as Group Home and In-Home Behavioral Therapy services.

Table 2: EPSDT Special Services

EPSDT Special Services	SFY2013	SFY 2014
Service Requests Received	3989	1764
Total Number of Members Served	2800	2461
Service Approvals	4292	2024
Service Authorizations Processed	7565	3397
Total Number of Providers	208	87

The DMAS Behavioral Health program manual was developed in collaboration with service providers in 2012. DMAS worked with the Department of Behavioral Health and Developmental Services (DBHDS) as well as the DMAS Provider Enrollment Unit to develop an Outpatient License specialty to accommodate DMAS enrollment of Applied Behavior Analysis Therapy (ABA) providers. DMAS has submitted proposed regulations for EPSDT ABA Services which are currently under review at the Secretary's office.

During SFY 2013, a total of 1,799 children were approved for behavioral therapy services and a total of 2,077 were approved for services in SFY 2014 through EPSDT. DMAS Maternal and Child Health staff worked closely with the DBHDS to transition these services to Magellan Health Services effective December 1, 2013. EPSDT clinical staff continues to review the Behavioral Therapy Group Home and Residential requests.

DMAS was recognized by the National Association of the State Medicaid Directors and the Center for Evidence-Based Policy in 2013 as a leading State in policy development and administration of behavioral therapies.

School Health Services

Virginia Local Education Agencies (LEAs) (a school district or entity which operates local public primary and secondary schools), enroll as DMAS providers for the reimbursement of select health services provided to children with FAMIS Plus (Children's Medicaid) or FAMIS coverage who are under the age of 23. DMAS benefits for children in special education are to be provided by the LEA according to the child's Individualized Education Program (IEP). The following services are reimbursable to qualified LEAs if in the child's IEP:

- Physical Therapy
- Occupational Therapy
- Speech-Language Pathology
- Audiology
- Nursing
- Psychiatry, Psychology, and Mental Health Services
- Medical Assessment

- Personal Care Services
- Medical Evaluations
- Specialized Transportation

There are currently 112 school divisions enrolled with DMAS. School divisions receive 50% of the cost for services in the IEP for students with Medicaid and 65% for students with Medicaid Expansion and FAMIS.

In an effort to ensure LEAs comply with state and federal regulations, and to prevent and/or reduce the number of overpayments, DMAS performs Quality Management Reviews. LEAs are selected at random, along with a number of randomly-selected Medicaid members in the school division, to submit IEPs and other requested documentation for review. During SFY 2013, DMAS performed Quality Management Reviews for three school districts.

In addition to Quality Management Reviews, DMAS provides quarterly and annual trainings to Medicaid Coordinators across Virginia. The annual *Medicaid in Schools* Conference was held in October 2013 in Charlottesville, Virginia. Over 300 providers of school Medicaid services were in attendance. In 2013, four quarterly meetings were held in Alexandria, Fredericksburg, Salem, and Staunton, Virginia. In 2014, two trainings were provided in Craig County, Virginia and Salem, Virginia.

The Maternal and Child Health Division keeps providers informed of current policies with provider memo updates and updates to the Local Education Provider Manual. The LEA provider manual was recently updated to clarify the definition of medical necessity in the IEP and to clarify the definition of a licensed qualified provider. These recent updates ensure that providers of school services are practicing within the scope of their licenses.

Cover Virginia

A statewide Helpline was required under the Affordable Care Act to be implemented on October 1, 2013. Under proposed regulations §435.1205 and §457.370, Medicaid and CHIP programs were required to align with the Affordable Care Act open enrollment period of October 1, 2013, and begin accepting the single streamlined application used to make determinations of eligibility and enrollment in all insurance affordability programs.

DMAS launched the new *Cover Virginia Call Center* on October 1, 2013. This call center supports telephonic application and signature for Medicaid and FAMIS families and children groups. The Cover Virginia Call Center encompasses two sites with 100+ staff. Effective January 1, 2014, the call center also processes hospital presumptive eligibility enrollments and electronic requests by hospitals for expedited enrollments of Medicaid and FAMIS deemed newborns. The call center answers eligibility and covered services questions for the general Medicaid and FAMIS population.

The Cover Virginia website (www.coverva.org) went live on October 1, 2013, to provide applicants information about Medicaid, FAMIS, and Health Insurance Marketplace options for health insurance coverage. The site includes an eligibility screening tool to help applicants decided on the best place to apply for coverage. The site includes information about how to apply by telephone, by mail, in person, or on-line.

Hospital Presumptive Eligibility (HPE)

Effective January 1, 2014, under the Affordable Care Act, qualified hospitals have the opportunity to determine presumptive eligibility for certain Medicaid eligible groups. A qualified hospital is a hospital that participates as a Medicaid provider, notifies DMAS of its election to make HPE determinations, and agrees to make those determinations consistent with DMAS policies and procedures. Hospitals can temporarily enroll individuals in Medicaid, which will ensure compensation for Medicaid covered services and provide patients access to medical care, as well as a pathway to ongoing Medicaid coverage. Since implementation, over 450 individuals have been determined presumptively eligible for Medicaid by hospitals.

Text4Baby

MCH worked in cooperation with the Centers for Disease Control and Prevention (CDC) and VDH to promote the Text4Baby initiative. Text4Baby is a free mobile telephone information service providing timely health information to pregnant women and new mothers during pregnancy and through a baby's first year. Virginia was the only state in the country to pilot Text4Baby and serves as the model for the nation. Led by the National Healthy Mothers Healthy Babies Coalition, Text4Baby is a public-private collaboration to bring together government, business, non-profits and academic institutions to launch and evaluate innovative new models for using mobile phones and the mobile phone infrastructure to address critical health care challenges.

Text4Baby aims to demonstrate the potential of mobile health technology to address a critical national health priority, reach underserved populations with health information, and decrease the number of premature births among low-income women. DMAS provides Text4Baby information to pregnant women in the Medicaid and FAMIS MOMS programs by monthly letters mailed to newly enrolled pregnant women. MCH worked in cooperation with CMS and the National Healthy Mothers Healthy Babies Coalition, to publicize the Text4Baby initiative through FaceBook as well as the FAMIS.org and CoverVa.org websites.

Behavioral Health for Women

MCH worked with DBHDS and VDH to develop a screening tool for women of childbearing age called “Behavioral Health Risk Screening Tool for Pregnant and Postpartum Women”. This tool screens for substance use, mental health issues and intimate partner violence, which are risks associated with poor birth outcomes. MCH staff developed billing guidance for providers for administering the screening under the women’s benefit as well as the infant’s benefit. MCH also coordinated with the MCOs’ use of this tool. MCH staff have promoted this tool via the DMAS website as well as with Centering Pregnancy providers in Virginia.

Maternal Mortality Review (MMR) Team

The Commonwealth MMR reviews all maternal deaths that occur during pregnancy or within one year of the end of a pregnancy. The review is conducted to understand the causes of maternal death within the context of women’s lives and the circumstances surrounding injury and disease patterns. These reviews are used to educate, identify needed changes, and to recommend interventions to reduce maternal deaths. The team member come from multiple state agencies, including but not limited to DMAS, VDH, Medical Society of Virginia, Perinatal Councils, DSS, ACOG – Virginia Chapter, ACNM- Virginia Chapter, Chief Medical Examiner.

Strong Start – Centering Pregnancy

DMAS supported the Virginia Commonwealth University (VCU) Strong Start for Mothers and Newborns grant from CMS totaling more than \$1 million. This translational research project, aimed at adopting best practices, is examining the effectiveness of the Centering Pregnancy® model of care in reducing poor birth outcomes among high risk Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries.

The Strong Start for Mothers and Newborns initiative, a joint effort between CMS, the Health Resources and Services Administration and the Administration of Children and Families, aims to test the effectiveness of specific enhanced prenatal care approaches. Preterm births cost the American health care system more than \$26 billion annually. The goals of the initiative are to determine if these approaches of care can: 1) reduce preterm births; 2) improve the health outcomes of pregnant women and newborns; 3) decrease the cost of medical care of pregnancy and delivery; and 4) reduce the cost of care of the infant during the first year of life.

The project was proposed by VCU in partnership with The March of Dimes Virginia Chapter, DMAS, Centering Healthcare Institute, VDH and four provider organizations. Members from each organization serve on an advisory committee to monitor and guide the implementation of the four-year grant. The four provider sites awarded the grant include the Richmond Health

District, Manassas Midwifery Women's Health Center, Greater Prince William Community Health Center and Shenandoah Women's Healthcare.

Health Commissioner's Workgroup to Reduce Infant Mortality

DMAS has partnered with VDH Commissioner's Workgroup to reduce the infant mortality rate in Virginia. DMAS participated in the National Governors Association grant led by VDH which focused on reducing infant mortality in Virginia. The State's goal is to (1) reduce Infant Mortality to 5.7 deaths/1000 live births by 2018, and (2) reduce African-American/White Infant Mortality gap to zero by 2018.

Home Visiting Consortium

As a result of the Governor's Early Childhood Initiative, Virginia developed the Home Visiting Consortium which links home visiting services, medical services and childcare within the State. DMAS is involved due to the various programs which are reimbursed with Medicaid funds, such as BabyCare, Medicaid MCOs' high risk maternity and infant programs, and Resource Mothers. The Home Visiting Consortium, along with VDH oversees the Maternal Infant Early Childhood Home Visiting (MIECHV) funding which is authorized through the Affordable Care Act. Some of the MIECHV funds were allocated to hire a research firm to assess the availability of Medicaid funds for home visiting programs in Virginia. DMAS has played an integral role in providing the firm information about Medicaid services for the development of their report to the Home Visiting Consortium.

Grants

Robert Wood Johnson Foundation's Maximizing Enrollment: Transforming State Health Coverage Grant

The Maximizing Enrollment grant was awarded in February 2009 and ended in August 2013. The goal of the project was to increase enrollment and retention of eligible children in Medicaid and CHIP by helping states streamline their systems, policies and procedures and to measure the impact of these changes.

Virginia pursued a number of projects over the years to achieve this goal including:

- The development and implementation of the Executive Support System Data Warehouse and Cognos reporting tool under the Medicaid Management Information System (MMIS) contract to improve the Department's data analytical capacity. This data warehouse combines application and eligibility data from the Department of Social Services' ADAPT eligibility system, application and eligibility data from the FAMIS Central Processing

Unit's CHAMPS eligibility system, and enrollment, claims, encounter and provider data from the Department's MMIS system;

- LDSS Eligibility Worker focus groups;
- Training on existing Medicaid ex-parte process, new telephonic renewal policy, and ACA related policy and system changes;
- A new administrative renewal process at the FAMIS Central Processing Unit;
- Development of electronic communications forms to facilitate better case maintenance between LDSS and the FAMIS CPU;
- Implementation of e-signature for online applications and the ability for applicants to upload verification documents electronically;
- Implementation of pre-filled online renewal forms;
- Implementation of telephonic signatures for applicants at the CHIP central processing unit call center;
- Expedited deemed newborn enrollment pilot project; and
- Text messaging reminders for FAMIS renewals.

Through these efforts, by 2013 approximately 62% of families renewing FAMIS eligibility submitted their renewal on-line. In 2013, approximately 45% of renewing families utilized the administrative renewal process, which uses a prefilled renewal application with their most recent income information on file. This is sent to the member to self-attest that the information is correct and that they will be enrolled without any additional paper verifications. In 2013, approximately 20% of new applicants applied and signed their application by phone with an additional approximately 55% submitting their application on-line.

The expedited deemed newborn enrollment pilot project was so successful that the Department decided to expand it statewide effective January 1, 2014. During the first three months, over 3,000 deemed newborns have been enrolled through the electronic reporting process.

Improvements to Care for the Elderly and Persons with Disabilities

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) provides a capitated, comprehensive coordinated, system of home and community-based care for individuals over age 55 who are enrolled in both Medicare and Medicaid. PACE, a joint state and federal program, was created as a model of care in 1973 that provides the elderly, their family and caregivers flexibility to meet their health care needs and to enable them to continue to live in the community rather than in an institution. PACE services include comprehensive medical, health, and social services. These services are furnished in a variety of community settings including the person's home, inpatient facilities, and the PACE center. Transportation is a key component of the PACE

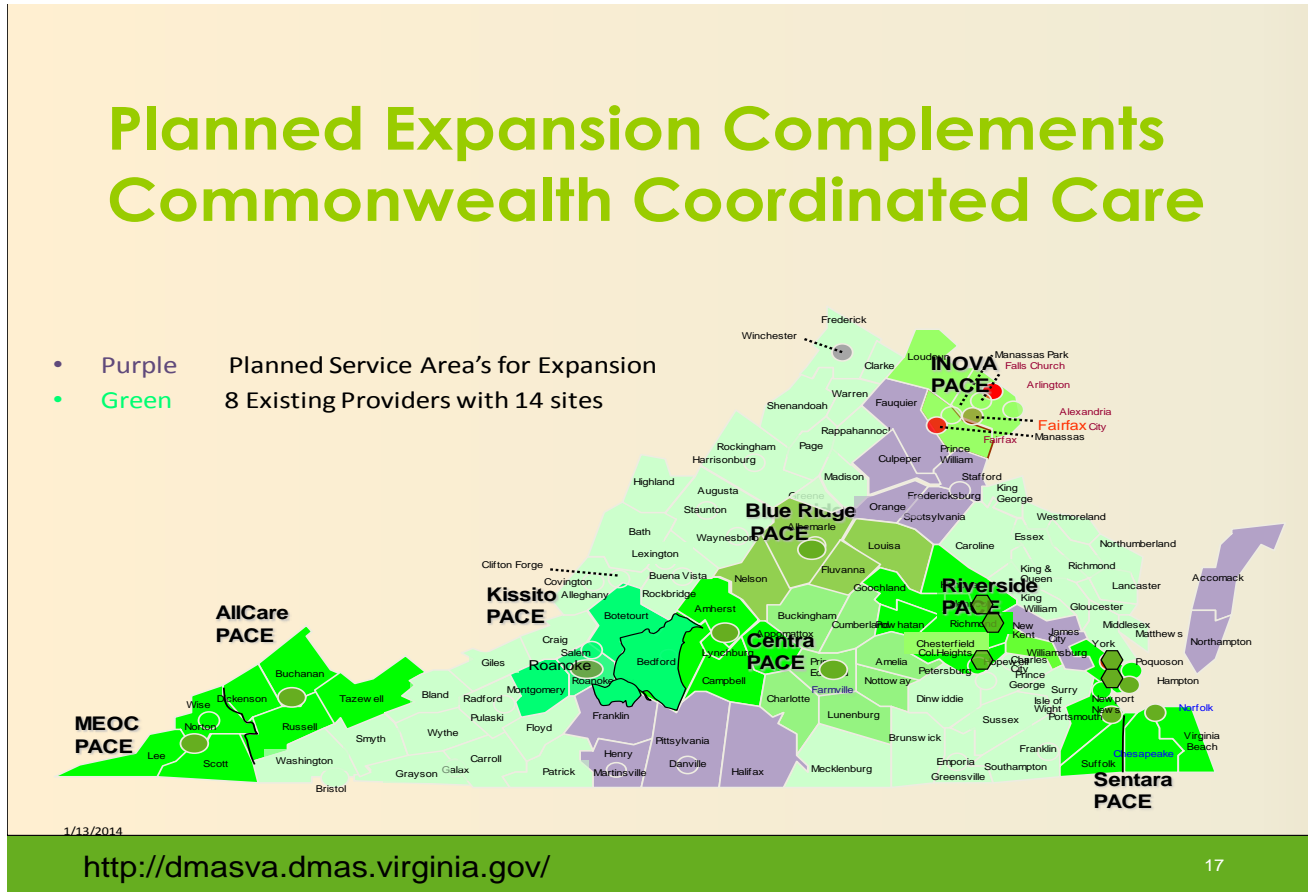
model, and this service is tailored to manage the special mobility needs of individuals enrolled in PACE.

PACE was the first long-term care program in Virginia to use a capitated model to provide comprehensive, coordinated services ranging from inpatient acute care through long-term care services specifically for the elderly. The PACE program strives to streamline service delivery in the community, improve health outcomes, and enhance the quality of life of individuals that would have otherwise been residing in nursing facilities. In order to be eligible to enroll in the PACE program, an individual must be age 55 years or older, meet the State level of care criteria for nursing facility services, reside in the service area of the PACE organization, and be able to live in the community without jeopardizing health or safety.

Over the years, PACE has grown in Virginia and has been successful largely due to the partnership between DMAS and the PACE providers who share the philosophy that coordinated community-based care is preferred over institutional care. DMAS is committed to continued development of PACE programs across the Commonwealth and currently has 14 PACE sites that are operating across the state.

PACE locations include the following: AllCare for Seniors PACE in Cedar Bluff, Blue Ridge PACE in Charlottesville, Centra PACE in Lynchburg and Farmville, InovaCares for Seniors PACE in Fairfax, Kissito PACE in Roanoke, Mountain Empire PACE in Big Stone Gap, Riverside PACE (Hampton, Newport News, Petersburg, and two sites in Richmond) and Sentara PACE in Virginia Beach and Portsmouth.

Figure 4: Pace Expansion Sites



Currently, PACE programs provide services to 36% of Virginia counties, and DMAS and CMS have given approval for four additional underserved areas for the development of PACE programs enhancing PACE coverage by 9% and raising the total state coverage to 45%. Future PACE expansion plans will bring coordinated care to regions of the state that are difficult to serve and typically last to receive new services. By offering PACE programs in underserved areas, Virginia is continuing its efforts to provide quality healthcare to one of our most vulnerable populations – the frail elderly.

Currently, there are over 1,087 participants enrolled in Virginia PACE programs. These individuals receive all Medicaid and Medicare covered services as required by their plan of care and authorized by their respective interdisciplinary team. Characteristics of PACE programs in Virginia include:

- Average age of participant is 76
- 72% are female
- Average number of chronic conditions is six, and
- 98% live in their own homes/apartments.

PACE organizations are monitored to evaluate the effectiveness of the wide range of services furnished in order to identify areas for improvement and maintain program performance for participants. The use of objective measures to demonstrate improved performance, such as decreased inpatient hospitalizations and outcome measures regarding quality of life makes a difference in quality care and identifies opportunities for quality improvement.

Consumer-Directed Model of Service Delivery

Individuals enrolled in certain home and community-based services (HCBS) waivers have the choice of receiving personal care, respite and companion services through an agency or through consumer-direction. Consumer-direction (CD) enables the individual to be the employer of their personal care attendant, having the ability to hire, train, supervise and fire their attendant. DMAS contracts with a fiscal employer/agent, Public Partnership, LLC (PPL), to perform payroll functions on behalf of the individual to ensure that all federal and state tax requirements are performed timely and accurately.

Since 2006, the number of individuals choosing the CD model grew by over 2,500 individuals to 13,582 as of December 2013. The number of qualifying attendants has grown from approximately 2,500 in 2007 to over 30,000 during 2013. The Consumer Recipient Satisfaction Survey 2013 Annual Report conducted by PPL documents an overall satisfaction rating of individuals using the CD model to be 3.3 out of a possible 4.0 rating. From the report, 99.1% of those responding indicated “I am satisfied with having the ability to choose who I want as my attendant.”

Money Follows the Person Rebalancing Demonstration

In 2008, DMAS joined other states in initiating a rebalancing demonstration program called Money Follows the Person (MFP). The program’s purpose is to assist eligible older adults and individuals with disabilities living in long-term care facilities with moving into the community. Eligible individuals who wish to leave long-term care institutions are provided individualized guidance and transition planning, as well as financial support, to purchase reasonable and necessary items for community living.

MFP supports 24/7 resource access through the 211 phone line, which is a free public service that provides information, works with local Area Agencies on Aging to ensure appropriate referral from nursing facilities, and coordinates services with local Centers for Independent Living and Community Services Boards. To date over 650 individuals have transitioned from an institution to the community using the MFP program, and over 200 more have been approved for MFP services who have not yet transitioned. This initiative supports Virginia's implementation of the Olmstead decision, which requires that services be provided in the most integrated

environment and compliments the efforts of the Aging and Disability Resource Centers (ADRCs) network, which is designed to streamline access to long-term care and integrate the full range of long-term supports and services systems.

MEDICAID WORKS

DMAS implemented *MEDICAID WORKS*, Virginia's Medicaid Buy-In program, in 2007. This voluntary Medicaid State Plan option is a work incentive opportunity for individuals with disabilities who are employed or who want to work. The program enables workers with disabilities to earn higher income and retain more in savings or resources than is usually allowed by Medicaid. It provides the support of continued health care coverage so that people can work, save and gain greater independence from public assistance programs while contributing to the tax base of the community and to the community's economic growth.

Other Achievements and Initiatives

Client and Provider Appeals

The Agency's Appeals Division processes all administrative appeals filed by clients and service providers of the programs administered by DMAS. As Medicaid enrollment and the number of offered programs increase, the number of appeals from Agency decisions continuously grows. The addition of new client services and the increase in the number and types of provider audits to discover waste and abuse have swelled the number of administrative appeals received by the Agency. The Appeals Division is mandated to provide each appellant timely due process of their appeals of Agency action. The Client Appeals Unit is court-ordered to maintain a case deadline compliance rate of 97%; all client appeals must be resolved within 90 days of the postmark of the appeal request. Some expedited client appeals must be heard and decided within 72 hours. Statutory deadlines govern the processing of appeals filed by Medicaid service providers of all types. The annual growth in appeals is demonstrated by considering that in 2000 there were less than 500 provider appeals filed and less than 1,500 client appeals. The number has been rapidly rising, and this past year those numbers grew to 3,708 client appeals and another 3,725 provider appeals. Nevertheless, the Client Unit was able to surpass the court mandate and achieve a compliance rate of 99.4% and the Provider Appeal Unit achieved a compliance rate of 100%.

In every validated appeal, the Appeals Division is mandated to provide due process, afford an opportunity for the appellant to be heard, guarantee a neutral review of agency action on appeal and render a decision in accordance with law. To stay abreast of the challenge and to fulfill this duty the Appeals Division, with only modest growth in manpower, has focused on the acquisition of electronic high speed scanning to reduce boxes of hard-copy evidence to a single CD-ROM disc, as well as the utilization of digital workflow technologies. The Agencies appeals

regulations are being upgraded to allow use of electronic media and to add administrative authority to streamline the processing of some appeals. A new database has been installed this past year which not only improves efficiencies by auto generating documentation that formerly required manual input, but also enables the Agency to track recurring issues with its services and audits that may need addressing.

Human Resources

DMAS has had numerous achievements in Human Resources over the past two years including:

- Agency-wide implementation of the Department of Human Resource Management (DHRM) new Time, Attendance and Leave System (TAL) to eliminate antiquated paper systems and improve efficiencies. Partnered with DMAS Budget to ensure proper time tracking and Cost Allocation time categories.
- Implemented new Physical Access ID Badge system for the agency to ensure employee safety and compliance with DMAS Physical Access Security Policy.
- Migrated to new state Global Meridian Learning Management System and launched a new version for the DMAS Knowledge Center.
- Conducted quarterly leadership/new supervisor training on HR Compliance & Processes designed to reduce costly employee relations issues, EEOC charges and litigation and support agency succession planning goals.
- Successfully recruited 103 staff members in FY 2012 and FY 2013.
- Won the DHRM Silver Star Award for two consecutive years for successfully increasing employee donations to the Commonwealth of Virginia Campaign.
- Maintained participation in the DMAS Alternate/Flexible Work Schedule Request program to enable employees to work varying schedules and reduce commuting costs, car emissions, etc. Current participation rate is 63%.
- DMAS continues to promote teleworking to support the state goals of traffic reduction, controlling pollution, and maximizing office space. The current percentage of employees eligible to telework who are teleworking is 41%.
- Updated key HR policies to ensure legal compliance and fair, equitable administration of HR Programs. Policies included: Business Conduct and Ethics, the EEO Statement, Employment Process, Physical Access Control and Visitor Access Control to comply with new IRS guidelines.

Small, Women-Owned, and Minority-Owned (SWaM) Business Efforts

DMAS remains committed to its efforts to provide opportunities to small, women and minority-owned (SWaM) businesses throughout the Commonwealth. For FY 2014, DMAS' participation percentage was 26.07%, which is below Governor's goal of 42% SWaM participation. DMAS will continue to explore new and creative ways to increase procurement of SWaM businesses by identifying opportunities and existing obstacles.

APPENDIX A

Board of Medical Assistance Services Agenda Items 2012-2014

2012 (June – December)

- Proposed Medicaid Expansion
- Medicaid Reform
- 2012 BMAS Biennial Report
- Performance Audit
- Eligibility Enrollment Project
- Medicare and Medicaid Financial Alignment Demonstration (Duals Eligibility)
- DMAS Budget/Budget Reductions
- Newborn Enrollment
- Impact of SCOTUS on Medicaid
- Managed Care Expansion
- Electronic Health Records
- Medicaid Forecast and Primary Care Providers Payment Rate Increase
- Affordable Care Act and Pending State Legislation
- Program Integrity Activities

2013 (January – December)

- Virginia Medicaid Managed Care 2012 Annual Report
- DMAS Budget
- General Assembly Update
- Newborn Enrollment
- Medicaid Reform
- Dual Demonstration Project
- Primary Care Rate Increase
- Communication Plan for the Patient Protection and Affordable Care Act
- Foster Care Children to Managed Care
- Medicaid Forecast
- Managed Care Program: Delivery and Quality
- Petition for Amending EDCD Regulations

2014 (January – June)

Medicaid Reform and Closing the Coverage Gap

2014 General Assembly Budget Actions

General Assembly Update – Regular Session Actions

Commonwealth Coordinated Care

Newborn Enrollment

Medicaid 101

APPENDIX B

Grants/Demonstrations and Awards during the 2013-2014 Time Period

Large Grants - Awarded during 2013-14 time frame

GRANT NAME	SFY 2013	SFY 2014
Medicaid -Medical Assistance Payments	3,856,209,000	4,131,884,000
Medicaid -Administrative Payments	198,523,000	249,527,000
Medicaid -Health Information Technology Administrative Payments	15,285,125	4,907,000
Medicaid -Health Information Technology Incentive Payments	133,654,000	123,255,247
CHIP -State Children's Health (FAMIS)	186,575,583	198,337,665

Small Grants/Demonstrations - Awarded during 2013-14 time frame

GRANT NAME	SFY 2013	SFY 2014
PRTF -Psychiatric Residential Treatment Facilities Demonstration Grant (Demonstration)	2,408,803	0
MFP -Money Follows the Person Demonstration	32,428,317	0
Cooperative Agreement to Support Establishment of the State Planning & Establishment Grant for the Affordable Care Act's Exchanges	1,000,000	0
Cooperative Agreement to Support Establishment of the Affordable Care Act's Health Insurance Exchanges	4,320,401	0
Private Grants:		
Robert Wood Johnson Foundation Supporting a Virginia Health Reform Initiative to Facilitate Affordable Care Act Implementation	150,000	0
Robert Wood Johnson Foundation Maximizing Enrollment for Kids	984,712	0