INTERIM REPORT OF
THE JOINT LEGISLATIVE
AUDIT AND REVIEW COMMISSION

Review of the Virginia Medicaid Program

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 27

COMMONWEALTH OF VIRGINIA
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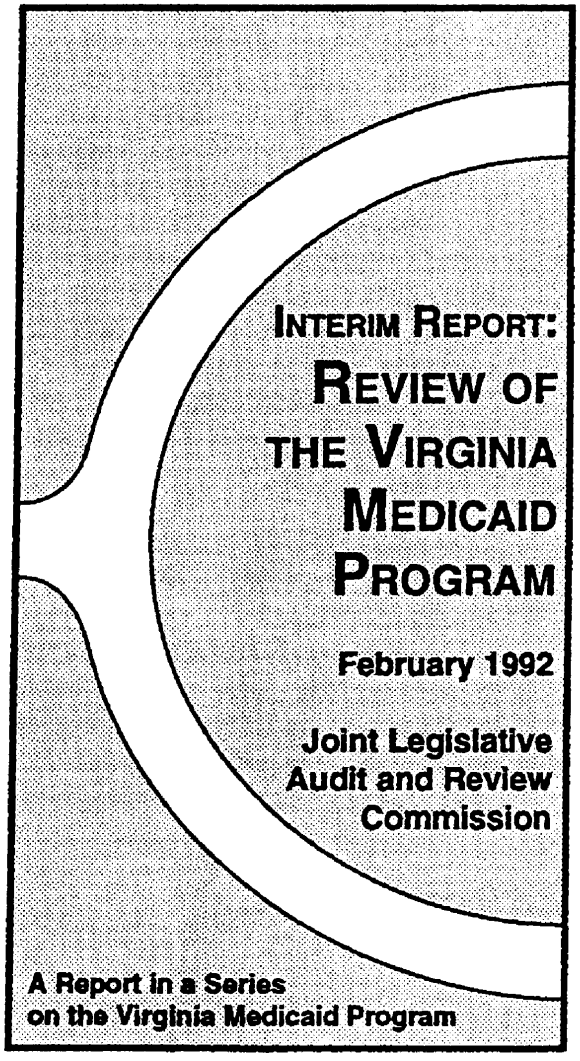
JLARC Report Summary



The Virginia Medical Assistance Program, more commonly known as Medicaid, is the largest health care financing program available to indigent persons in Virginia. As such, it provides reimbursement for a variety of health care services on behalf of qualified indigent persons. In FY 1991, the program provided reimbursement for 428,650 recipients at a total cost of about $1.3 billion (including administrative expenses). Since FY 1987, the number of Medicaid recipients has grown by about 35 percent, from 318,026 to 428,650. At the same time, the cost of the program has increased approximately 85 percent, from $717 million to $1.3 billion.

The rapid growth in the cost of the Medicaid program and the significant amount of State general funds expended on it have fueled legislative concern. During the 1991 Session of the General Assembly, questions were raised about whether the Virginia Medicaid program could be implemented in a more cost-effective manner. Senate Joint Resolution (SJR) 180 was passed to address this issue.

SJR 180 directed the Joint Legislative Audit and Review Commission (JLARC) to conduct a comprehensive review of the Medicaid program. SJR 180 mandated that JLARC: (1) provide interim reports to the Commission on Health Care for All Virginians and the 1992 Session of the General Assembly, and (2) complete the review and present findings and recommendations to the Governor and 1993 Session of the General Assembly.

This interim report is the first in a series on the Virginia Medicaid program. It provides a general description of the program. Information presented in the report focuses on Medicaid expenditures, eligibility for Medicaid, services reimbursed by the program, service providers, and the structure for funding services.

Recent changes to the program are also examined, along with their effects on program costs and eligibility. Specific items mandated by SJR 180 are addressed, including: (1) preliminary research on the sufficiency of certain reimbursement rates and (2) a review of the Medicaid forecast and budget process.

Funding of the Medicaid Program

The Medicaid program is jointly financed by the states and federal government. The federal government's financial participation rate is based on a per-capita income funding formula. Currently, in Virginia, the State funds about 50 percent of the program (up from 43.5 percent in 1980). In FY 1991, the State share of the program totaled about $646 million, approximately 10 percent of the general fund budget.

On the federal level, the Health Care Financing Administration (HCFA), part of the U.S. Department of Health and Human Services, has oversight responsibility for state Medicaid programs. In Virginia, the Department of Medical Assistance Services (DMAS) has responsibility for administering the Medicaid program.

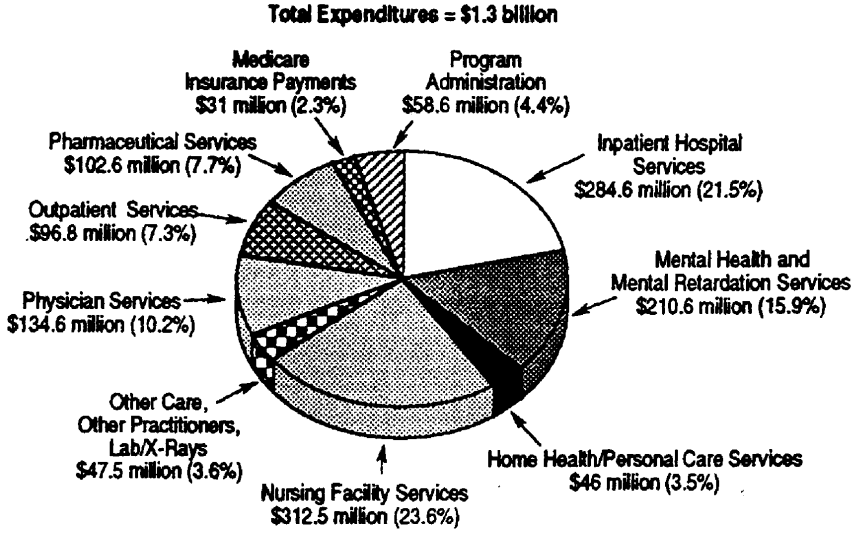
DMAS expended a total of $1.3 billion to administer the Medicaid program in FY 1991. Medicaid program reimbursements for five types of medical services accounted for almost 80 percent of the total program expenditures in FY 1991. These reimbursements were for nursing facility services, inpatient hospital services, mental health and mental retardation services, physician services, and pharmaceutical services. Expenditures for nursing facility services and inpatient hospital services accounted for the largest portion of program expenditures (24 and 21 percent, respectively).

In FY 1991, eligible children (age 20 and younger) and adults with children comprised more than two-thirds of all program recipients. (Program recipients are defined as persons enrolled in the program who actually received Medicaid services.) However, these recipients incurred less than one-third of Medicaid expenditures for medical care. The majority of Medicaid expenditures were for care of aged and disabled recipients in institutional settings. In FY 1991, almost $493 million was spent on medical care for these institutionalized recipients.

Recent Medicaid Changes Have Resulted in Significant Program Growth

Some growth in the Medicaid program is expected, because it is an entitlement program. However, the program's growth since FY 1987 is unprecedented. Some of this growth has been the result of deliberate

FY 1991 Medicaid Expenditures



program expansions at the federal and State level. However, additional factors, including elements beyond the control of the program, have contributed to the program's growth.

Impact of Federally-Mandated Medicaid Changes. Federal program expansions have focused primarily on adding new eligibility classifications. The Medicaid program was originally intended to serve targeted groups of indigent persons who participated in other public assistance programs (primarily Aid to Dependent Children and the Supplemental Security Income programs). However, the U.S. Congress has recently passed several initiatives to mandate program expansions to provide health care to indigent pregnant women and children. In addition, federal mandates require Medicaid programs to pay the costs of Medicare insurance premiums, deductible amounts, and coinsurance for qualified Medicare beneficiaries.

Federal mandates have expanded Medicaid coverage to certain eligible two-parent families during periods of unemployment. In addition, Medicaid coverage was extended for certain families who lose their eligibility for assistance from the Aid to Dependent Children (ADC) program and who meet federal income guidelines. Other federal mandates have expanded service coverage for children, required additional training for nurse aides who work in nursing facilities, and dictated reimbursement rate adjustments for hospitals that serve a disproportionate share of Medicaid and indigent patients.

The Virginia Department of Planning and Budget (DPB) estimated that the total cost of funding federally-mandated Medicaid changes has been about $85 million over the last five fiscal years. DPB also estimated that the State may incur additional costs of approximately $58 million between FY 1992 and FY 1995 as a result of these existing federal mandates.

While federally-mandated expansions have contributed to the increasing costs of the Virginia Medicaid program, many of these expansions seem reasonable because they offer opportunities for long-term cost savings. The average cost to provide Medicaid-reimbursed services to indigent pregnant women and children is low compared to the long-term costs associated with lack of routine and preventive health care. Payment of Medicare benefits for qualified Medicare beneficiaries may offset the costs which could be incurred by the Medicaid program if these impoverished individuals were not able to retain their Medicare coverage.

Impact of State Policies on the Medicaid Program. Despite federal requirements and recent federal expansions, the State has some flexibility in structuring program coverage. To some extent, the State has used this flexibility to contain Medicaid program costs. However, some of these State policies may have magnified the impact of federal mandates. Also, in some cases, State policies for the Medicaid program have resulted in program growth.

The State applies restrictive eligibility criteria to its ADC program, which is used to determine eligibility for many Medicaid enrollees. Because the income limits for ADC have not changed since 1986, growth in the number of individuals who could become eligible for the program over time has been controlled and the costs associated with Medicaid coverage of this group have also been contained.

Nevertheless, State ADC income limits and payment standards may have exacerbated the impact of recent federally-mandated eligibility expansions. The maximum ADC payment standard is equivalent to about 31 percent of the federal poverty income level. However, recent federal expansions have been targeted at individuals with incomes equivalent to 133 percent (or less) of the federal poverty income level.

State policies to increase provider reimbusement rates have also contributed to growing program costs. For example, physician reimbursement rates for certain services have been increased several times in the past six years, as part of an effort to increase provider participation and thereby enhance enrollee access to care.

Finally, State efforts to increase Medicaid coverage for programs previously funded solely through general funds contribute to overall increases in Medicaid costs. However, providing Medicaid coverage for these programs ultimately reduces the State's general fund burden, because State funds are matched by federal Medicaid funds.

Other Factors Which Impact Medicaid. A number of other factors over which the State has little control have contributed to Medicaid growth. For example, inflation of health care costs affects how much the Medicaid program pays for medical services. Worsening economic conditions, increasing numbers of frail elderly individuals, and increases in the number of uninsured citizens influence the number of people who may qualify for the program.

State Approach to Medicaid Coverage of Individuals Is Modest

The State's approach to providing Medicaid coverage is relatively modest. The Medicaid program covers categorically and medically needy individuals. However, compared to other states, Virginia applies strict income and resource eligibility standards for public assistance programs, which impact the ability of these public assistance recipients (and others whose eligibility is based on these standards) to obtain Medicaid coverage. In addition, to control costs, Virginia has chosen to comply with only the minimum federal requirements for providing Medicaid coverage to indigent pregnant women and children.

Virginia Coverage of Categorically and Medically Needy Individuals. The Virginia Medicaid program is required to provide services to individuals who are "categorically needy." In addition, the State has opted to provide Medicaid coverage for individuals who are deemed to be "medically needy."

Categorically needy individuals either receive or are deemed to be receiving public assistance through the ADC program or the Supplemental Security Income (SSI) program. Two additional groups are also considered categorically needy: (1) indigent pregnant women who have incomes at or below 133 percent of the federal poverty income level and (2) indigent children younger than age eight whose family income is at or below 133 percent of the federal poverty income level.

In 1970, Virginia chose to provide optional Medicaid coverage to individuals who are determined to be medically needy. These individuals have countable income and/or resources which exceed the limits set for categorical eligibility. They often must reduce their countable resources and/or "spend down" their excess income by sustaining medical expenses in order to qualify for coverage.

In FY 1991, approximately 91 percent of all Medicaid recipients were classified as categorically needy (390,407 of 428,650 recipients). The remaining nine percent were classified as medically needy.

Virginia Limits Coverage of Categorically and Medically Needy Individuals By Applying Strict Eligibility Standards. The State is able to limit the number of categorically and medically needy persons covered by the Medicaid program by setting relatively strict income limits and payment standards for the ADC program. Virginia also limits the number of SSI-related individuals who qualify for Medicaid by implementing more restrictive resource criteria for these applicants.

The ADC income limits and payment standards are used to determine Medicaid

eligibility for categorically needy individuals who are receiving or deemed to be receiving ADC. The State has set the maximum ADC payment standard or grant amount to a level equivalent to about 31 percent of the federal poverty income level ($231 per month for a family of two residing in the City of Richmond). In addition, federal statute limits the income level for individuals qualifying as medically needy to 133 percent of a state's ADC payment standard (the maximum monetary grant amount paid to ADC recipients). Consequently, a medically needy individual in Virginia has to spend down excess income to a level equivalent to approximately 41 percent of the federal poverty income level to qualify for Medicaid in Virginia.

If an individual is receiving SSI, eligibility for Medicaid is not automatic because the State imposes more restrictive resource limits for purposes of determining Medicaid eligibility. For example, the SSI program allows an individual to exclude his home and all contiguous property in determining eligibility. However, for purposes of Medicaid eligibility, the maximum value of the contiguous property which can be excluded is $5,000.

While the Medicaid program appears to comply with minimum federal requirements for eligibility expansions, the State has not chosen to provide broader coverage for indigent pregnant women and children as allowed by the federal government. Virginia could provide Medicaid coverage to indigent pregnant women with incomes up to 185 percent of federal poverty income levels. All states adjoining Virginia and the District of Columbia provide coverage above the federal minimum requirement of 133 percent.

In addition, Virginia could provide Medicaid coverage to indigent children up to age 19 whose family income is at or below 100 percent of the federal poverty income level. However, Virginia has chosen to phase in coverage of these children over the next 11 years, largely due to the added cost of serving this group and the State's severe budget problems.

Complement of Covered Health Care Services Is Similar to Other States

The Medicaid program offers a variety of health care services to its enrollees. The complement of Medicaid services available in Virginia appears to mirror services available in many other states. The services covered by the program provide basic health care and do not appear extravagant.

The program provides a number of services which are mandated by the federal government for categorically needy enrollees. These include inpatient and outpatient hospital services, nursing facility services, physician services, diagnostic laboratory and x-ray services, and family planning services, among others. The program also provides coverage for a number of optional services, such as pharmaceutical services, and limited dental, optometry, and podiatry services. Certain optional services are not available to all enrollees, however.

Virginia has chosen to provide a similar package of services to both its categorically needy and medically needy enrollees, within certain limits. Children and pregnant women receive a broader array of mandatory and optional medical services than other enrollees. Generally, adults who are not pregnant receive less extensive service coverage than children because the program imposes more limits on services offered to them. Additional limits are imposed on the services medically needy enrollees receive. Qualified Medicare beneficiaries are treated somewhat differently. Medicaid pays the Medicare premiums, deductible amounts, and coinsurance for these qualified beneficiaries.

In FY 1991, the Medicaid program spent approximately $320 million on optional services. This accounted for about 25 percent of medical care expenditures. The most

costly optional services provided were pharmaceutical services (almost $103 million) and nursing facility services for medically needy individuals (about $94 million). In fact, most expenditures for optional services were for health care for medically needy enrollees (about $300 million).

Health Care Providers and Reimbursement

The Medicaid program does not directly provide health care services to its enrollees. Instead, the program provides financial reimbursement to enrolled providers for approved medical services. More than 21,300 health care providers have agreements with DMAS to provide medical services to Medicaid enrollees. The types of providers who are enrolled in the program include: physicians, pharmacies, transportation providers, dental care providers (dentists and clinics), hospitals, nursing facilities, home health care providers, clinics, laboratories, other practitioners (such as nurse practitioners, optometrists, and podiatrists), and medical supply and equipment providers. Approximately 20 percent of these providers are located in other states.

Several different reimbursement methodologies are used to reimburse providers for services rendered to Medicaid enrollees. This interim report does not assess these reimbursement methodologies. However, additional research and analysis will be conducted during 1992 to evaluate current reimbursement methodologies and rates for Medicaid providers.

Problems in the Timeliness of Medicaid Eligibility Determinations Reflect Strain on Social Service System

DMAS contracts with the Department of Social Services (DSS) for Medicaid eligibility processing. DSS administers this process through local social services departments. The numerous rules and regulations guiding eligibility decisions for families and children are continuously being revised. In addition, spousal support requirements and transfer of assets rules used to determine eligibility for the aged and other institutionalized individuals have changed recently. To complicate the process further, federal regulations related to the changes have not been published or distributed in a timely manner. These factors, along with the lack of an automated system to efficiently track eligibility decisions, have made it difficult for local social services departments to make timely eligibility decisions.

The federal government requires that Medicaid eligibility determinations be completed within specified time frames. In addition, State policies require certain Medicaid applications to be processed within established time frames. DSS data on initial Medicaid applications and redeterminations for FY 1991 indicate that eligibility determinations were not made within federal and State time limits for almost 24 percent of the cases. Redeterminations receive an even lower priority, causing severe system backlogs.

Local eligibility workers are currently concentrating their efforts on processing initial applications for the program. Eligibility redeterminations have been given a low priority, because delays in making redeterminations will not cause individuals to lose eligibility. Therefore, the current emphasis on processing initial applications appears appropriate.

The Secretary of Health and Human Resources provided additional funding for 49 localities to help them administer their public assistance programs. These additional resources should also assist localities in meeting the deadlines for Medicaid application processing.

Recommendation. *The Secretary of Health and Human Resources should continue to monitor efforts by local social services departments to conduct initial Medicaid eligibility determinations and Medicaid*

redeterminations within federal and State time limits. Further assistance should be provided to local departments if compliance with requirements for application processing does not improve.

Lagging Enrollment Among Indigent Pregnant Women and Children May Indicate Inadequate Outreach Efforts

Program expansions for indigent pregnant women and children appear to be an appropriate and cost-effective emphasis of the Medicaid program. However, enrollment of these new groups appears to be lagging behind projected program expansions. This may indicate problems in the current outreach efforts to encourage enrollment among the targeted groups.

Enrollment of indigent pregnant women and children in the Medicaid program may have a number of long-term benefits. A number of studies have demonstrated that increased access to prenatal care can reduce the incidence of low birth-weight infants, reduce the number of sick mothers and babies, and reduce infant mortality. In addition, preventive care for children can result in substantial long-term savings for the State.

One initiative to enhance enrollment of these groups, the BabyCare program, appears to be meeting with some early success. As part of the initiative, DMAS is providing funding for eligibility workers from local social services departments to colocate at ten local health departments. These workers are able to enroll indigent pregnant women in Medicaid when they initially visit the health departments and receive results of pregnancy tests.

Local administrators are pleased with the early success of this program; however, the precise impact of the program is not clear. DMAS currently intends to continue the program through the 1992-1994 biennium. However, no plans exist to expand the program to additional sites. Efforts should be made to evaluate this program for possible future expansion.

Recommendation. *The Department of Medical Assistance Services should review its projections of indigent pregnant women and children, compare them with actual enrollees and recipients, and determine if these projections are accurate. In addition, the Department of Medical Assistance Services should ensure the Department of Social Services expands its efforts to increase the number of locations equipped to accept Medicaid applications from indigent pregnant women and children. At a minimum, these efforts should include increasing the number of disproportionate share hospitals and federally qualified health centers participating in the outstationing program.*

Recommendation. *The Department of Medical Assistance Services should evaluate the success of placing eligibility workers at local health departments as part of the BabyCare program. At a minimum, this evaluation should include the collection and analysis of the following data: enrollment increases, pregnancy stage at enrollment, and number of prenatal visits. The evaluation should also assess application processing times and the feasibility of expanding the pilot effort to additional sites. Findings and recommendations should be presented to the General Assembly prior to the 1994 Session.*

Medicaid Enrollees Experience Difficulties in Accessing Primary Care

Several studies have documented problems with access to primary care for all Virginians, due to the existence of an uneven distribution of primary care physicians throughout the State. Many of these studies have suggested that inadequate Medicaid reimbursement rates are related, at least in part, to the access problems experienced by Medicaid enrollees. Because SJR 180 re-

quires JLARC to determine the sufficiency of reimbursement rates, it was necessary to first examine Medicaid enrollee access to primary care. Research scheduled next year will further examine the adequacy of provider reimbursement.

Although problems in the supply and distribution of primary care physicians within the State affect all citizens, preliminary findings indicate that Medicaid enrollees experience greater difficulties in accessing primary care physicians than many other citizens. All licensed primary care physicians are not enrolled in the Medicaid program. In addition, almost 50 percent of those who are enrolled do not routinely provide care to Medicaid enrollees.

Because access to primary care physicians is problematic, Medicaid enrollees may have to rely on local health department clinics to obtain needed care, rather than primary care physicians located in their communities. Also, some enrollees may not seek necessary early treatment at times when it is more cost effective to do so, because they do not have an ongoing relationship with a primary care physician. Consequently, many enrollees may wait to obtain care until their condition deteriorates to a level requiring more extensive treatment. They may use hospital outpatient and emergency departments which could result in more expensive, sporadic care.

Ensuring access to primary health care for Medicaid enrollees is especially important because the costs associated with primary care are low relative to potential costs if routine, preventive care is not widely available or appropriately accessed. The Virginia Department of Health defines primary care as the first-level contact by individuals for routine consultations, diagnosis, and treatment of an acute medical problem or for treatment of a chronic condition. It may also include preventive care such as periodic screening for early detection of disease, immunizations, counseling about health risks, and prenatal and post-partum care for pregnant women. Low participation levels by primary care physicians enrolled in the Medicaid program may have long-term negative consequences.

Some of the access problems are related to primary care physician distribution problems and are not unique to those experienced by Medicaid enrollees. Therefore, long-term solutions and broad strategies to address problems with primary care physician supply and geographic distribution will be required. In addition, more research needs to be conducted to determine ways in which the Medicaid program can alleviate access problems experienced by its enrollees. These research efforts will continue during the upcoming year as JLARC staff proceed to examine issues regarding provider reimbursement.

Medicaid Forecasting and Budget Practices Are Sound

Rapidly increasing Medicaid program expenditures over the past few years have raised concerns about the State's ability to anticipate and meet the increased costs to operate the program. Accordingly, the Medicaid forecast and budget process was assessed to determine the adequacy of the current process. Review of the Medicaid forecast and budget process in Virginia revealed that the process is sound. Recent forecasts produced by the executive branch have generally been accurate. In addition, Virginia's forecast accuracy compares favorably with national forecasts and those produced by other states in the mid-Atlantic and southeastern regions.

Some minor problems in past forecasts of specific Medicaid expenditures were noted during this review. The roles of the three agencies currently involved in developing expenditure estimates are appropriate. However, additional review of Medicaid expenditures estimated by one agency — the Department of Mental Health, Mental

Retardation and Substance Abuse Services — is needed by DMAS.

JLARC staff also reviewed the adequacy of technical aspects of the forecast process. The forecast model substantially meets the criteria established for the review. Some minor weaknesses were found in certain components of the current model and with model documentation. However, some of these weaknesses will be addressed if planned improvements to the model are completed.

Because Medicaid funding has significantly increased, the General Assembly may wish to consider options for enhanced legislative monitoring and oversight of the technical components of the forecast process. However, overall findings in this area do not suggest that an enhanced level of oversight is warranted at this time. The following recommendations are made in this area:

Recommendation. *The Department of Medical Assistance Services should review the methodology used by the Department of Mental Health, Mental Retardation and Substance Abuse Services to develop the mental health and mental retardation portion of the Medicaid budget. This review should include at least one meeting between the two agencies prior to the Department of Mental Health, Mental Retardation and Substance Abuse Services' formal submission of revenue projections to the Department of Medical Assistance Services. In addition, the Department of Mental Health, Mental Retardation and Substance Abuse Services should provide written documentation, for reference and review purposes, to the Department of Medical Assistance Services on the methods used to estimate the mental health and mental retardation revenues related to the Medicaid budget.*

Recommendation. *The Department of Medical Assistance Services should ensure that sufficient and timely documentation exists for each component of the Medicaid forecast. In the event that judgmental adjustments are made to the baseline components of the forecast, or the anticipated effects of policy changes are added to the forecast, these adjustments or changes should be identified in the forecast documentation.*

Recommendation. *The Department of Medical Assistance Services forecast review panel should be expanded to include Department of Mental Health, Mental Retardation and Substance Abuse Services staff as appropriate. Participation should include a presentation and review of the methods used to develop the State mental health and mental retardation services component of the Medicaid forecast at least once each year.*

Recommendation. *Given the relative accuracy of recent Medicaid forecasts and the overall adequacy of the forecast model and process, increased legislative monitoring of the Medicaid forecast and expenditures is not required at this time.*

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I. Introduction

The State helps fund health care for indigent persons through a variety of programs. The largest of these programs — both in terms of numbers served and funding — is the Virginia Medical Assistance Program, more commonly known as Medicaid. Medicaid makes health care services available to qualifying citizens who do not have the financial resources to obtain them. Over the past decade, the federal government has expanded the Medicaid program by legislating mandated coverage of additional groups of indigent citizens.

During FY 1991, there were more than 490,000 enrollees (those deemed eligible for Medicaid) in Virginia's Medicaid program. Further, the program provided reimbursement for medical services on behalf of more than 428,000 recipients (enrollees that received Medicaid-reimbursed services) at a total cost of more than $1.3 billion (including administrative expenses).

The number of program enrollees and recipients, as well as program costs, has grown significantly. Over the past five years the number of Medicaid enrollees and recipients has grown by approximately 32 and 35 percent, respectively. However, the costs of the program have grown by about 85 percent over the same period.

The significant growth in the program, and the fact that the cost of the program represents substantial general fund outlays for the State, resulted in legislative concern about how well the Medicaid program operates in Virginia. The 1991 General Assembly passed Senate Joint Resolution (SJR) 180 to address these concerns. SJR 180 requires the Joint Legislative Audit and Review Commission (JLARC) to conduct a review of the Medicaid program and to assess whether Virginia has implemented the program in the most cost effective and efficient manner. SJR 180 directs JLARC to provide interim reports to the Commission on Health Care for All Virginians and to the 1992 Session of the General Assembly. Findings and recommendations are to be presented to the Governor and the 1993 Session of the General Assembly.

This interim report is the first in a series on the Virginia Medicaid program. It provides a general description of the program, focusing on program eligibility and recent program changes. It also presents preliminary findings on Medicaid enrollee access to primary care and the methods used to forecast and budget Medicaid program expenditures.

Other reports in the Medicaid series will focus on issues related to ambulatory care, hospital care, long-term care, management of the Medicaid program, and funding of indigent health care in Virginia. These reports will be completed in 1992 and presented to the 1993 General Assembly.

THE MEDICAID PROGRAM IN VIRGINIA

The Medicaid program is a joint federal-state program authorized under Title XIX of the Social Security Act. Participation in Medicaid is optional at the state level. However, each state and U.S. territory that chooses to participate must do so within established federal guidelines. The Health Care Financing Administration (HCFA), part of the U.S. Department of Health and Human Services, has oversight responsibility for state and territorial programs.

In 1966, one year after creation at the federal level by the U.S. Congress, the Virginia General Assembly authorized the establishment of a Medicaid program in the Commonwealth. However, because of federal requirements for development and approval of a state plan, Virginia's program did not become operational until 1969.

The Department of Medical Assistance Services (DMAS) currently has responsibility for administering the Medicaid program in Virginia. This responsibility was shifted to DMAS in 1985, when the department was created. Prior to that, administration of Medicaid was carried out by the Virginia Department of Health.

The costs of the Medicaid program are shared by the federal government and participating states. The federal government financial participation rate ranges from a low of 50 percent to a high of 83 percent, inversely based on a per-capita income funding formula. Enhanced matching rates are available for certain administrative functions and demonstration projects. Currently, Virginia is one of 18 states and U.S. territories that contribute 50 percent to their overall Medicaid budgets.

An individual can be determined eligible for Medicaid only if he or she fits into one of several eligibility categories. Most of these categories have been in place since the program's inception. All state Medicaid programs are required to cover indigent persons who are entitled to benefits due to their participation in federally-supported public assistance programs. These include:

- aged (age 65 and older), blind, or disabled individuals (including children) who receive Supplemental Security Income (SSI) assistance

- families with dependent children who receive Aid to Dependent Children (ADC) assistance.

Both public assistance programs make cash payments to qualified individuals who have limited income and resources. The SSI program is administered by the Social Security Administration. The ADC program is administered by the Virginia Department of Social Services (DSS). In addition, certain aged, blind, disabled, and ADC-related individuals who do not receive public assistance payments but who meet certain income and resource requirements must also be covered by Medicaid.

Recently, the federal government has required states to cover indigent pregnant women, infants (children younger than age one), and children born after September 30, 1983, who are at or below specified federal poverty income levels. In addition, the federal government now requires state Medicaid programs to pay the costs associated with ensuring Medicare coverage for certain impoverished Medicare beneficiaries.

State Medicaid programs must also provide federally-mandated services including, but not limited to, ambulatory care services (such as physician services, diagnostic laboratory and X-ray services, outpatient surgery, and family planning services), inpatient hospital services, and certain long-term care services within limits. Additional services, such as pharmaceutical services, may be included at a state's option. Most covered services must be provided to all individuals who meet the eligibility criteria. However, states are required to provide a greater complement of services for certain individuals who receive Medicaid, including children and pregnant women.

In Virginia, local social services departments are responsible for determining eligibility and enrolling individuals in the program. Enrollees receive a Medicaid card each month, which they present to Medicaid providers prior to receiving health care services. Recipients may be required to pay a small amount (copayment) to Medicaid providers for certain medical services.

The Medicaid program functions as a third party payer of medical services for eligible individuals. As such, it reimburses health care professionals and facilities for covered services provided to those enrolled in the program. The Medicaid program does not provide direct financial assistance to recipients.

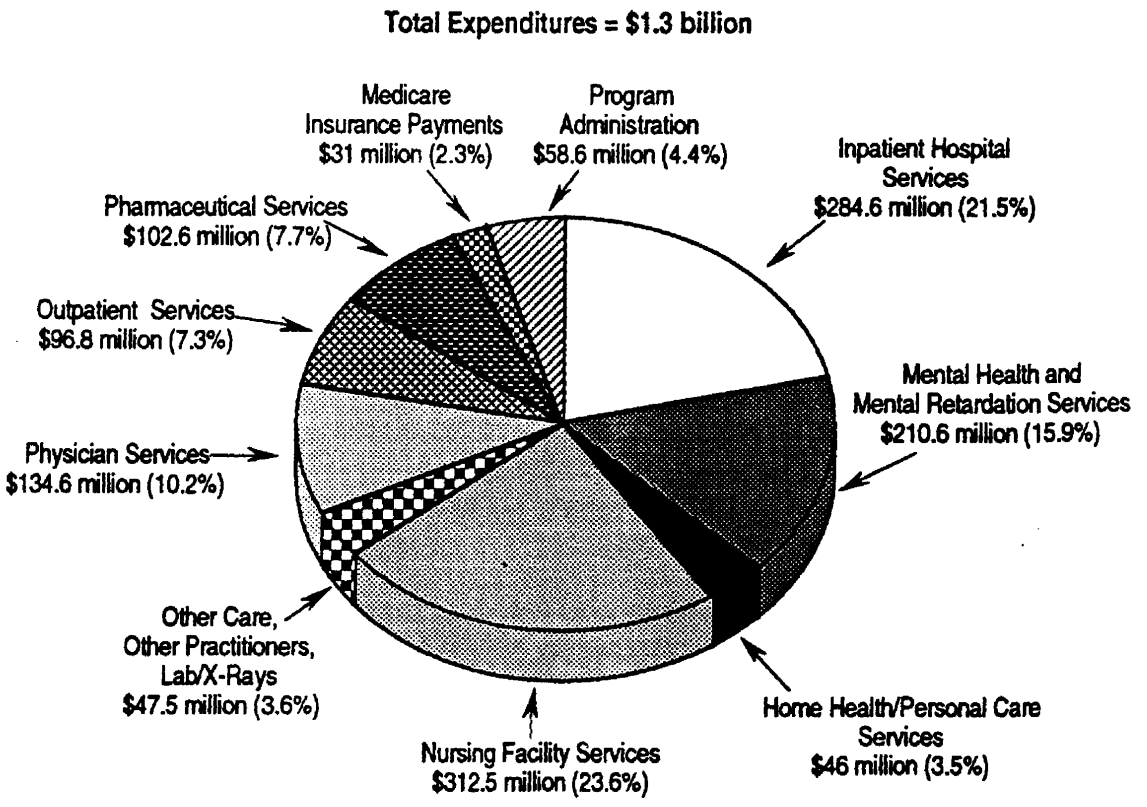
CURRENT MEDICAID PROGRAM EXPENDITURES

Currently, the Medicaid program is the fourth largest program in Virginia when federal and State financial contributions are considered. In terms of State general fund expenditures, however, the Medicaid program is actually the third largest State program. Total expenditures for the Medicaid program in FY 1991 were more than $1.3 billion. This included almost $1.27 billion in medical care expenditures for 428,650 recipients and $59 million in expenditures for program administration. Figure 1 depicts Medicaid program costs by major categories of expenditures.

In FY 1991, reimbursement for five types of services accounted for almost 80 percent of total program expenditures. These were reimbursements for nursing facility services, inpatient hospital services, mental health and mental retardation services, physician services, and pharmaceutical services. Expenditures for nursing facility services and inpatient hospital services accounted for the largest portion of expenditures (24 and 21 percent, respectively). Expenditures for mental health and mental retardation services accounted for the next largest expenditure category (about 16 percent in FY 1991).

Figure 1

FY 1991 Medicaid Expenditures



Source: JLARC staff analysis of FY 1991 DMAS unaudited financial statements and DMAS records of payments made to the Department of Social Services for eligibility determination and contractual obligations in FY 1991. Percentages may not add to 100 due to rounding.

Majority of Medicaid Costs Are for Services Provided to Aged and Disabled Recipients

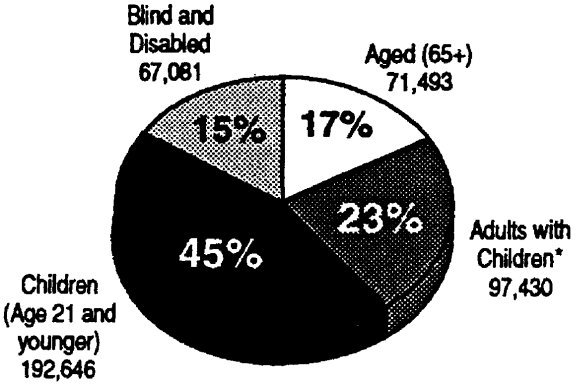
The majority of program expenditures (71 percent) during FY 1991 were directed towards care of the aged and disabled, though they accounted for only 17 and 15 percent of the total number of recipients, respectively (Figure 2). Conversely, less than one-third of total program expenditures were spent on adults with children (primarily women) and children (age 20 and younger), who comprised about two-thirds of Virginia's Medicaid recipients in FY 1991.

Average costs per recipient reflected these differences in total program expenditures. On average, disabled recipients had the highest cost for Medicaid-reimbursed services, about $6,250 per person in FY 1991 (Table 1). The cost to provide services to aged individuals was slightly lower, averaging about $6,035 per person. In contrast, the

Figure 2

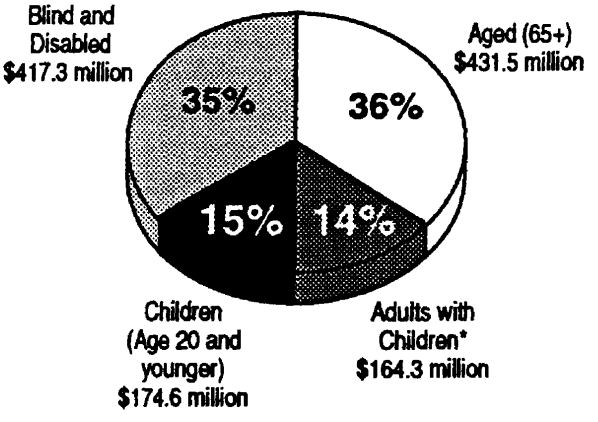
Number and Type of Medicaid Recipients Compared to Expenditures for Each Recipient Group FY 1991

Medicaid Recipients



Total Recipients = 428,650

Medical Care Expenditures by Recipient Groups



Total Medical Care Expenditures = $1,187,699,179**

*This group includes pregnant women and ADC-related adults.

**Total does not include medical care expenditures made as a result of year-end cost settlements with health care providers.

Source: JLARC staff analysis of HCFA 2082, *Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services*, DMAS State FY 1991.

Table 1

Medical Care Cost Per Recipient by Type — FY 1991

Recipient Type	Average Cost Per Recipient
Disabled	$6,250
Aged	6,035
Blind	4,525
Adults with children*	1,687
Children age 20 and younger	906
All Recipient Types	**$2,771**

*This group includes pregnant women and ADC-related adults.

Source: JLARC staff analysis of HCFA 2082, *Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services*, State FY 1991.

cost to provide Medicaid services to children age 20 and younger was the lowest, averaging $906 per child.

The higher average costs associated with medical care for aged and disabled Medicaid recipients may be due to the nature of the care many of them receive. In FY 1991, about one-quarter of aged Medicaid recipients received institutional care in nursing facilities and/or hospitals, and about seven percent of disabled Medicaid recipients received this type of care.

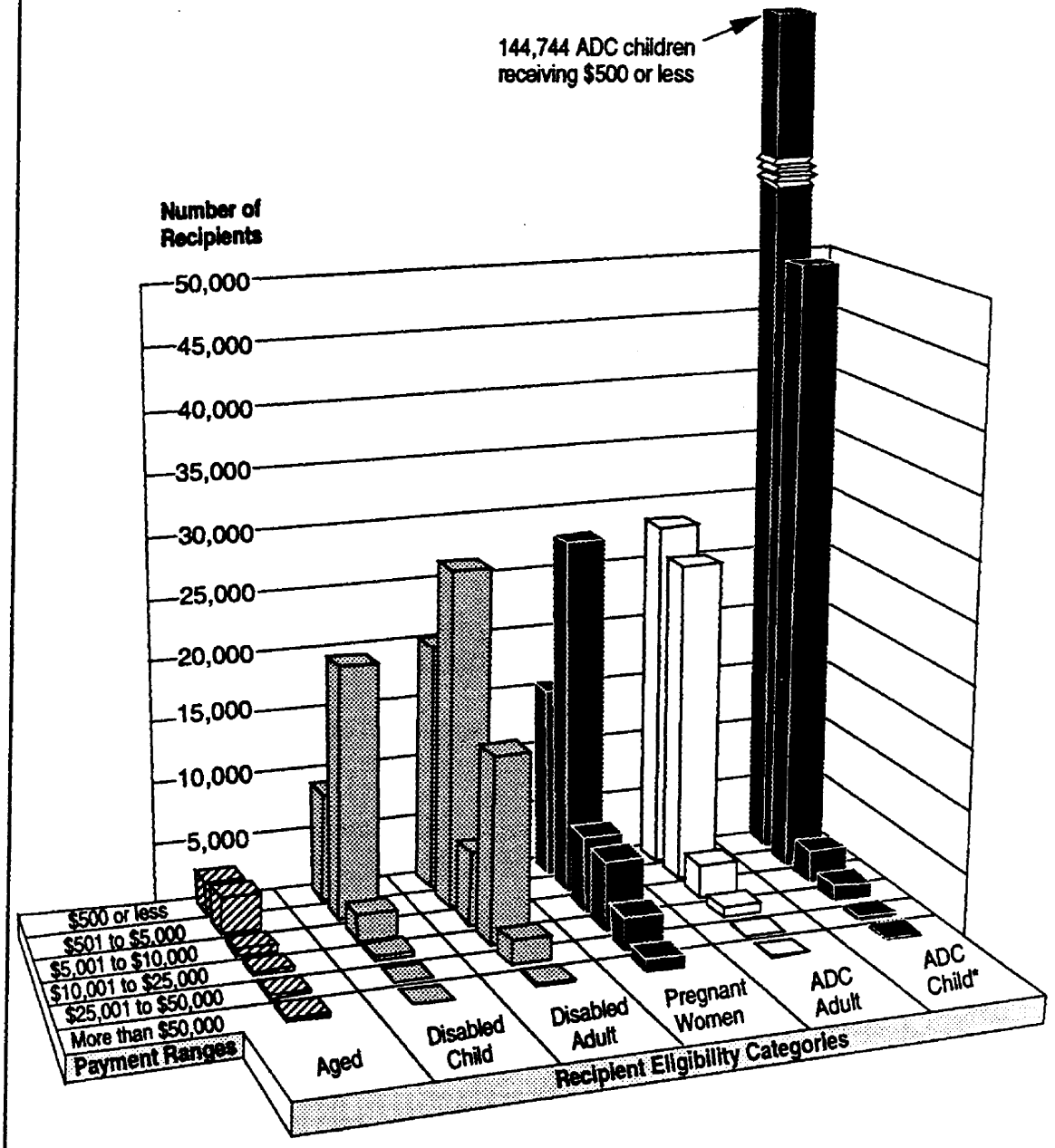
The cost of providing one year of institutionalized care for these recipients averaged about $16,995 per aged recipient and $35,285 per disabled recipient. This includes all costs associated with their care in an institution, such as physician services, pharmaceutical services, and nursing facility services. Nursing facility services for these recipients appear to be the most costly component of this institutional care. The average cost of nursing facility services for an individual aged, blind, or disabled recipient ranged from about $13,900 to almost $16,300 in FY 1991.

Despite the high average costs for aged, blind, and disabled recipients, medical care expenditures for most Virginia Medicaid recipients (51 percent) averaged less than $500 per person in FY 1991. Figure 3 compares the levels of payment made by the Medicaid program by type of recipient. Medical costs incurred by more than 70 percent of the children and almost 50 percent of adults with children were less than $500 per person. This may be due to the preventive nature of the care they received.

About 28 percent of aged recipients incurred less than $500 per person in Medicaid expenditures in FY 1991. These low payments on behalf of aged recipients are probably due to Medicaid payments for their Medicare premiums, deductible amounts, and coinsurance.

Figure 3

Number and Type of Recipients by Medicaid Payment Levels Fiscal Year 1991



* Includes ADC-related children and indigent children eligible under federal provisions related to specified poverty income levels.

Source: JLARC staff depiction of data on recipients and payments in FY 1991, as prepared by DMAS for House Appropriations Committee staff.

JLARC REVIEW

Increasing gaps in health care coverage experienced by the general population have fueled concerns about citizens' access to basic health care. This has led to increased reliance on the Medicaid program as a vehicle for expanding health care coverage to larger numbers of the poor on both a national and state basis. Dramatic growth in the costs of providing this expanded coverage through the Medicaid program has resulted in additional scrutiny of state Medicaid programs for ways in which program costs can be contained, while preserving essential health care services.

This JLARC review of the Virginia Medical Assistance Program is a result of legislative concerns over the growth of Virginia's Medicaid program. The Commission on Health Care for All Virginians sponsored SJR 180, requesting that JLARC review the Medicaid program and assess whether Virginia has implemented the program in the most cost-effective and efficient manner. Numerous research activities have been implemented to conduct this assessment.

Study Issues

Senate Joint Resolution 180 outlines specific issue areas to be addressed in the JLARC review of the Medicaid program. Research activities are being conducted to address the following:

- assess the cost savings and health policy implications of limiting the scope or duration of optional services or adjusting recipients' contributions to care
- examine the State's interpretation of federal requirements to determine if they have been implemented in the most effective and least costly manner
- determine the effectiveness of current utilization review procedures in controlling costs and explore additional options
- evaluate reimbursement methods to determine if they adequately encourage cost effective delivery of services
- determine the sufficiency of reimbursement rates to provide quality care at the lowest required cost
- review forecast and budget methods to ensure that they adequately identify and project the cost of policy changes, service utilization, and new mandates
- determine how the legislative branch could increase its capacity to more closely monitor Medicaid forecasts and expenditures
- explore the costs of alternative administrative methods for implementing program requirements and options

- examine the relationship with other State programs to promote optimal utilization of State funds

- identify options for using Medicaid funds for services currently supported solely with general funds

- review the eligibility, scope of services, and reimbursement rates for indigent care at the University of Virginia Medical Center, the Medical College of Virginia Hospitals, and the Medical College of Hampton Roads, and determine the appropriateness of general fund and Medicaid allocation methodologies for these institutions.

Due to the broad nature and complexity of the issues set forth in SJR 180, the issues have been divided among three research teams according to distinct components of care provided by the Medicaid program. These teams are focusing specific research issues around three major topical areas: (1) ambulatory care, (2) hospital care, and (3) long-term care. Issues have also been structured around two other topical areas: management of the Medicaid program and funding of the indigent health care system in Virginia.

Research Activities

A number of research activities have been undertaken to assess the Medicaid program. Some research activities served to provide more focus to the study and structure the research. Other activities were conducted specifically to provide preliminary information on the Medicaid program and analyze issues related to program costs, eligibility, enrollee access to primary care, and forecast and budget methods.

Meetings with Health Care Experts. JLARC staff met with several individuals with expertise in health care and Medicaid–related issues. The purpose of these meetings was to become familiar with the Medicaid program and obtain information which would assist staff in focusing the study issues and structuring more specific research activities. Meetings were held with: (1) staff responsible for Medicare and Medicaid evaluations in the U.S. General Accounting Office (GAO) Human Resources Division, (2) staff of the Physician Payment Review Commission of the U.S. Congress, (3) Rand Corporation staff, and (4) staff of the Urban Institute.

Document Reviews. Numerous documents pertaining to the Medicaid program and health care issues have been collected and reviewed for information on the current health care environment, Medicaid program costs, eligibility, access to care, Medicaid forecast and budget techniques, and other issues related to the Medicaid program. A comprehensive list of these documents has not been included in this interim report. However, documents that provided important information on the Medicaid program included:

- *The State Plan for the Medical Assistance Program Under Title XIX of the Social Security Act,* DMAS

- Medicaid manuals, published by HCFA

- *Assistance Program Manual*, Volume XIII, Virginia Department of Social Services

- *Code of Federal Regulations* Part 430 to 435

- *Code of Virginia*, Sections 20-88.01 and 63.1 et seq.

- *Statistical Report On Medical Care: Eligibles, Recipients, Payments, and Services*, HCFA 2082 Report, State Fiscal Years 1987-1991

- HCFA Medicaid program financial management reports.

In addition, several other reports were obtained and reviewed to gather information for this interim report. Congressional budget conference reports pertaining to past legislative mandates for the Medicaid program were collected, as well as Omnibus Budget Reconciliation Acts of 1986, 1987, 1989, and 1990. The Medicare Catastrophic Coverage Act of 1988 was also reviewed. A number of reports issued by GAO on the Medicaid and Medicare programs were also obtained and reviewed. State budget documents and DMAS unaudited financial statements for the last five fiscal years were assessed, along with reports by the U.S. Office of Management and Budget and HCFA on Medicaid expenditure forecast and budget methods.

Structured Interviews. JLARC staff conducted structured interviews with staff in State agencies, local agencies, and one federal agency. Information was collected on all aspects of the Medicaid program, as well as issues related to program funding, forecasting and budgeting expenditures, enrollees, recipients, providers, services, reimbursement, administration of the program, and potential cost containment measures.

The study team conducted structured interviews with staff in the following State departments: Medical Assistance Services; Planning and Budget; Social Services; Visually Handicapped; Mental Health, Mental Retardation and Substance Abuse Services; and Rehabilitative Services. Staff in local social services departments were interviewed for information on Medicaid eligibility requirements and processes. As part of the structured interviews, site visits were made to four local social services departments. Finally, one staff member in the Richmond Office of the Social Security Administration was interviewed for information concerning the relationship between the Medicaid program and the SSI program, and qualified Medicare beneficiaries.

Conference Attendance. Research activities included attending two conferences related to the Medicaid program. These conferences covered a number of issues related to the administration of the Medicaid program, and specific information on forecast and budget methods for public assistance programs.

Secondary Data Analyses. Data were collected from a variety of sources and analyzed using several different computer software packages. Secondary data analyses

were conducted to assess: current Medicaid program expenditures and increases over time, the accuracy of the Medicaid forecast and budget process, the distribution of Medicaid enrollees and providers in Virginia, and access to care for Medicaid enrollees.

Analyses of Medicaid program expenditures were conducted using several data sources collected from DMAS and HCFA. HCFA 2082 reports were collected from DMAS for State and federal fiscal years 1987 through 1991. In addition, comparative state Medicaid data tables were collected from HCFA 2082 reports for similar years along with Medicaid financial management reports and reports of State Medicaid budget forecasts. Finally, DMAS unaudited financial statements for FY 1987 through FY 1991 were collected and analyzed.

Data for the assessment of the Medicaid forecast and budget process were collected from budget documents, working papers, and forecast documentation maintained by the DMAS budget division and the health and human resources section of the Department of Planning and Budget. These documents contained data on program base expenditures, policy adjustments, expenditure projections, and forecast methodology. In addition, data from State budget transactions were reviewed to make this assessment.

The analysis of Medicaid enrollees, providers, and access to primary care relied on the compilation of several data sources. To conduct these analyses secondary data on licensed health care providers were collected from the Virginia Department of Health Professions, the Medical College of Virginia (MCV) Department of Family Practice, and a JLARC/MCV survey of obstetrical services available at general hospitals. Virginia population data from the U.S. Census Bureau were collected to make demographic comparisons between Medicaid enrollees and the general State population. In addition, data on Medicaid enrollees and providers for the last three fiscal years were collected from DMAS. These data were analyzed using a statistical software package and the General Assembly's geographic information system.

Survey of Selected States. A survey of other states was conducted to assess the forecast and budget process for the Medicaid program. Nine states were surveyed about the processes they use to forecast Medicaid program expenditures and the role of their legislatures in the forecast process. These states were selected based on proximity to Virginia and the sophistication of their forecast methods.

Report Organization

This chapter has presented a brief introduction to the Medicaid program and its current program costs in Virginia. The next chapter presents a more detailed overview of the program in Virginia, including a discussion of Medicaid eligibility, covered services, and service providers. Chapter III discusses the changes in the Medicaid program over the last five years, including changes in program expenditures and eligibility criteria, and whether Virginia is implementing some of these required changes as intended. Chapter IV presents an analysis of Medicaid enrollee access to primary care in Virginia. The final chapter discusses the adequacy and accuracy of current DMAS methods to forecast and budget Medicaid expenditures.

II. Overview of the Virginia Medicaid Program

The Virginia Medical Assistance Program makes health care services available to qualified citizens who do not have the financial resources to obtain them. However, federal program requirements restrict enrollment to individuals who fall within certain eligibility classifications. Eligibility for Virginia's Medicaid program is even more restrictive than most other states due to income and resource limits set by the State for certain eligibility categories. Therefore, many low-income Virginians are not eligible for Medicaid — particularly single, young adults who are not pregnant, blind, or disabled.

While the State's approach to eligibility for Medicaid is relatively restrictive, services provided through the Medicaid program seem to cover many basic health care needs. The program offers federally-mandated services, such as inpatient and outpatient hospital services, nursing facility services, physician services, diagnostic laboratory and X-ray services, and family planning services, among others. The program also provides coverage for a number of optional services, such as pharmaceutical services and limited dental, optometry, and podiatry services. The mandatory and optional services provided to Virginia's Medicaid enrollees appear to reflect those that other states offer.

However, many enrollees do not have access to the full complement of mandated and optional services due to limitations set by the Virginia Medicaid program. Medicaid services are more comprehensive for some groups of enrollees, but are more restrictive for others. In general, children (age 20 and younger) receive the largest complement of services. Adults and medically needy enrollees have access to more limited services. Approximately 87 percent of the more than 490,000 individuals who were enrolled in the Virginia Medicaid program during a portion or all of FY 1991 received Medicaid-reimbursed medical services.

In FY 1991, almost $1.3 billion was paid to health care professionals and facilities for care rendered to Medicaid enrollees. Most Medicaid payments are made to enrolled providers. However, Virginia also reimburses "non-enrolled" out-of-state providers that occasionally render services to Virginia Medicaid enrollees. Reimbursement for mandatory services comprised about 75 percent of these medical care expenditures, while the cost to provide optional Medicaid services totaled about $320 million, or about 25 percent of medical care expenditures. Most of the optional services expenditures were for care of medically needy recipients.

MEDICAID PROGRAM ELIGIBILITY

As an entitlement program, Medicaid must provide services to all who are found eligible. However, citizens must enroll in order to receive health care coverage through the program. They must submit an application to their local department of social services

and their financial status must be evaluated. The Virginia Medicaid program utilizes fairly restrictive financial criteria in determining eligibility. Because enrollment is not permanent, eligibility is reevaluated every six or 12 months, depending on the enrollee's particular eligibility classification.

Medicaid Eligibility Classifications

To become enrolled in the Medicaid program, an individual must fall within established eligibility classifications. Each Medicaid enrollee is classified as a member of one category and one class. Category distinguishes the unique characteristic which applies to a certain group of enrollees and is descriptive in nature, while class indicates the level of need.

The federal government has recently expanded Medicaid eligibility classifications by requiring states to cover certain categories of individuals who have specified poverty income levels. In addition, the federal government allows states to expand these mandated categories within broad poverty income parameters. Current Virginia Medicaid eligibility classifications conform to minimum federal requirements for serving new categories of individuals. While Virginia could expand coverage by adding categories or modifying certain income and resource limits, the State has not chosen to do so. Implementation of these expansions would increase the cost of the Medicaid program.

Categories of Eligibility. Before Medicaid eligibility can be assessed, an applicant must match the profile of one of several categories. Although only six major categories will be discussed in the body of this report, Appendix B contains a comprehensive list of all eligibility classifications within the Virginia Medicaid program.

Four of the six major categories are related to a person's status as a participant in two public assistance programs: Aid to Dependent Children (ADC) and Supplemental Security Income (SSI). The four categories related to these public assistance programs are: (1) ADC-related enrollees, (2) aged enrollees, (3) blind enrollees, and (4) disabled enrollees (Exhibit 1). Applicants who fall in the last three categories can qualify for Medicaid as SSI-related enrollees and/or as qualified Medicare beneficiaries (QMBs). QMBs are Medicare enrollees with incomes at or below 100 percent of the federal poverty income level. For QMBs, Medicaid pays the cost of Medicare premiums, deductible amounts, and coinsurance.

The other two major eligibility categories which have been added recently through federally-mandated program expansions are indigent pregnant women and children. These individuals must have incomes at or below specific federal poverty income levels to qualify for Medicaid.

In instances in which applicants fit the description of multiple categories, the category with the most generous service coverage is usually selected. For example, when

Exhibit 1

Major Categories of Medicaid Eligibility

ADC-related enrollees:

- All ADC recipients are automatically eligible for Medicaid.
- ADC eligibility is based upon income criteria set by the General Assembly.
- The ADC income limit varies according to family size and locality of residence.
- The ADC payment standard or maximum grant amount is about 90 percent of the ADC income limit and is equivalent to about 31 percent of federal poverty income guidelines ($2,052 for one person).
- Deprivation must be a factor for ADC eligibility (at least one parent is either absent, disabled, or unemployed).

Aged, blind, or disabled enrollees:

SSI-related enrollees:

- Individuals who receive SSI or would be eligible but for excess income above the SSI level.
- Individuals who receive SSI must meet more restrictive resource requirements in Virginia (for example, contiguous property is limited to a value of $5,000).

QMBs:

- Medicare enrollees with incomes at or below 100 percent of the federal poverty income guidelines ($6,620 for one person).
- If QMBs also qualify for Medicaid, they are considered "dually eligible" and receive additional Medicaid services not covered by Medicare.

Indigent pregnant women:

- Single or married pregnant women with incomes at or below 133 percent of the federal poverty income guidelines ($8,805 for one person).
- In computing the eligibility of pregnant women, income is considered but resources are not counted.

Indigent children:

- Children younger than age six with family incomes at or below 133 percent of the federal poverty income guidelines ($8,805 for one person).
- Children age six and older born after September 30, 1983, with family incomes at or below 100 percent of the federal poverty income guidelines ($6,620 for one person).
- Deprivation is not a factor — children can qualify as indigent with both parents in the home.

Source: JLARC staff analysis of interviews with Virginia Department of Medical Assistance Services and Department of Social Services staff on eligibility, and review of "Medicaid Eligibility Overview," May 16, 1991, provided by DMAS.

one or more children are part of an application, an attempt is made to determine whether they can become eligible under the ADC-related category, since this is the broadest category of Medicaid coverage for families. In addition, QMBs are evaluated to determine if they may be "dually eligible," that is, eligible to receive Medicaid-reimbursed services not covered through the Medicare program.

Classes of Eligibility. There are two classes of Medicaid enrollees: categorically needy and medically needy. Most categorically needy individuals participate in other public assistance programs, typically ADC or SSI, though indigent pregnant women and children have recently been added to this class. In addition, most categorically needy Medicaid coverage is mandated by federal statute. However, Virginia began covering selected optional categorically needy groups in 1970 (see Appendix B for a listing of these optional groups).

The Virginia Medicaid program also provides coverage to those who are classified as medically needy. Medically needy eligibility profiles are consistent with those for the categorically needy. As such, these enrollees must be part of a family, aged, blind, disabled, pregnant, or born after September 30, 1983. However, medically needy enrollees have countable incomes and/or resources which exceed the limits set for categorical eligibility. Most medically needy enrollees must reduce their countable resources and/or "spend down" excess income by sustaining medical expenses in order to qualify for Medicaid coverage. Income represents the dollar amount that an enrollee receives on a regular basis, including salary, retirement payments, and child support. Resources represent the dollar value of real or personal property owned by the enrollee. However, public assistance benefits are exempted in calculating an individual's countable income and resources, including ADC payments, auxiliary grants, SSI payments, food stamps, and fuel assistance.

The State elected to provide medically needy coverage in 1970. Currently, Virginia is one of 40 states and U.S. territories which provide Medicaid coverage to medically needy individuals.

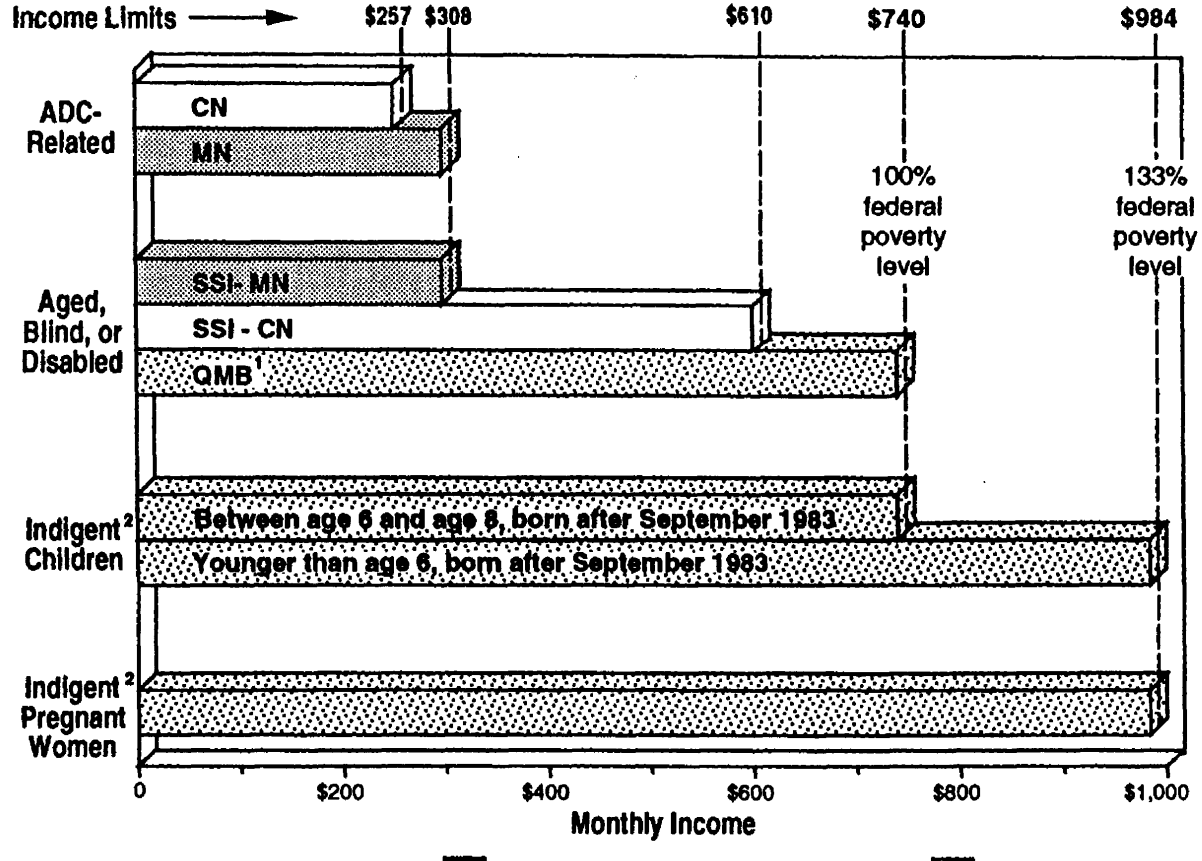
Medicaid Income and Resource Limits Vary By Eligibility Category and Class

Medicaid income and resource limits vary according to enrollee category and class of eligibility. Figure 4 lists the income limits for most eligibility classifications. Much of the difference can be attributed to federal statute. For example, all enrollees must meet specified income limits, but two categories are exempted from resource limits due to federal requirements: indigent children and pregnant women. However, some of the variation in income limits is due to the State's ability to control certain income and resource criteria established for the ADC and SSI programs.

Recent efforts to change the State ADC income limits and payment standards (or grant amounts) would have affected the Medicaid program. In addition to increasing the number of persons eligible for ADC, these attempts would have altered Medicaid

Figure 4

Virginia's Monthly Income Limits for Medicaid Enrollees by Major Categories and Classes*



Key: Categorically needy (CN) income limit applies. Medically needy (MN) income limit applies. Mandated level of federal poverty applies.

* Example provided is for a family of two living in the City of Richmond.

[1] Income level used to determine QMB eligibility. Some QMBs may also qualify under another category and be dually-eligible.

[2] Medically needy income limits for indigent pregnant women and children are the same as the categorically needy income limits for these groups. However, the medically needy groups must use excess income to offset medical bills and spend down to the poverty level.

Source: JLARC staff analysis of "Medicaid Eligibility Overview," May 16, 1991, provided by the Virginia Department of Medical Assistance Services.

income limits for the medically needy class. However, changes have not been made to the ADC income limits or payment standards since 1986.

Income and Resource Limits For Categorically Needy Individuals. Historically, Virginia has limited the number of persons covered as categorically needy under Medicaid in several ways. First, categorical coverage is limited by setting relatively restrictive income eligibility criteria for the ADC program. For those individuals who do not receive ADC monetary payments, the ADC income limits are used as income criteria for eligibility. An applicant whose income is at or below this level and who meets the other eligibility criteria for this category may qualify as categorically needy.

It is important to note, however, that ADC income limits in Virginia vary by locality. Generally, rural localities have lower ADC income limits than urban localities. Consequently, ADC-related individuals residing in rural areas may be excluded from obtaining Medicaid eligibility because the income criteria applied in their localities are lower than those of most urban localities.

Virginia further restricts the number who could qualify as categorically needy because the State can implement more restrictive resource criteria for SSI-related applicants for the purposes of determining Medicaid eligibility. For example, to qualify for SSI, an applicant can exclude the value of his home and all contiguous property. However, the Virginia Medicaid program caps the value of contiguous property that can be excluded for SSI-related applicants at $5,000 in determining Medicaid eligibility.

Income and Resource Limits for Medically Needy Individuals. The number of persons who could be covered by the Medicaid program as medically needy is limited due to provisions set forth in federal statute. Medically needy income limits must be equal to or less than 133 percent of a state's ADC payment standard (the maximum monetary grant amount established to cover all allowable maintenance needs of ADC recipients). As with the categorically needy, the income limits for the medically needy class vary by locality of residence because they are tied to ADC income limits.

Because ADC is not indexed to inflation, the real value of ADC benefits has eroded over time. According to the Congressional Budget Office, Virginia's maximum ADC benefits fell by 49 percent in real terms between 1970 and 1989. Nationally, there was a 37 percent decline in the real value of maximum ADC benefits during the same time period.

Currently, Virginia's ADC income limits rank 48th in comparison with other states and the District of Columbia (Table 2). Therefore, most other states which provide medically needy coverage probably have broader coverage of medically needy individuals. Virginia's low ADC income limits result in increased spend-down amounts for persons who qualify for Medicaid as medically needy. In addition, the low ADC income limits may result in postponement of needed medical care.

The elderly are particularly impacted by low ADC income limits. For example, many elderly may receive Social Security benefits. While these benefits may represent

Table 2

Aid to Dependent Children Monthly Income Limits and Medically Needy Coverage

State	ADC Income Limits	Coverage of Medically Needy	State	ADC Income Limits	Coverage of Medically Needy
Vermont	$865	✔	Nevada	$450	
Hawaii	$807	✔	Rhode Island	$449	✔
Washington	$794	✔	Idaho	$446	
Alaska	$792		Maryland	$439	✔
Florida	$702	✔	Minnesota	$437	✔
Ohio	$637		Utah	$431	✔
Illinois	$589	✔	Iowa	$421	✔
Wyoming	$585		West Virginia	$401	✔
Arkansas	$560	✔	Oregon	$380	✔
California	$560	✔	Oklahoma	$364	✔
District of Columbia	$560	✔	Montana	$362	✔
Wisconsin	$550	✔	Georgia	$356	✔
Alabama	$509		South Carolina	$350	
Arizona	$494		South Dakota	$340	
Texas	$493	✔	Colorado	$331	
Massachusetts	$486	✔	North Dakota	$326	✔
Maine	$485	✔	New Jersey	$322	✔
Connecticut	$473	✔	Tennessee	$316	✔
Michigan	$473	✔	Kansas	$312	✔
Louisiana	$472	✔	Mississippi	$293	
North Carolina	$472	✔	Nebraska	$293	✔
New York	$469	✔	Delaware	$270	
Pennsylvania	$461	✔	**VIRGINIA**	**$257**	✔
Kentucky	$460	✔	Indiana	$255	
New Hampshire	$451	✔	Missouri	$250	
			New Mexico	$247	

Note: Income limits are for a family of two.

Sources: "State Coverage of Pregnant Women and Children", National Governor's Association, January 1991 and "Medicaid Services State By State", Health Care Financing Administration, October 1, 1990.

fixed incomes, they may include annual cost-of-living allowances which increase their income and widen the gap between their income and their ability to qualify for medically needy Medicaid coverage.

The link between the medically needy income limits and the State ADC income limits impacts different categories of applicants in different ways. Because of the low State ADC income limits and payment standards established by the General Assembly, it is easier for ADC-related applicants to obtain Medicaid eligibility under medically needy requirements than categorically needy requirements. Consequently, individuals with incomes that may disqualify them for an ADC monetary payment can still obtain Medicaid eligibility under requirements for medically needy individuals. For example:

> *The income limit for a family of two residing in Richmond City and receiving ADC is $257 per month. A family that qualifies for ADC will automatically receive Medicaid coverage under categorically needy requirements. However, the medically needy income limit for a family of two residing in Richmond is $308 per month. Hence, a family with monthly income in excess of $257 per month but less than $308 per month would qualify for Medicaid under medically needy requirements, even though they would not be eligible for ADC. A spend-down amount would only be calculated for families with monthly income in excess of $308 or resources in excess of $1,000.*

For aged, blind, or disabled SSI-related applicants, the reverse is true. With SSI, it is easier to obtain Medicaid eligibility under categorically needy requirements than medically needy requirements. This is because the categorical SSI income limits are set higher than the medically needy income limits (133 percent of the State ADC payment standard). To illustrate:

> *The categorically needy SSI-related income limit for an individual is $407 per month. If a SSI-related applicant from Richmond City receives more than $407 per month, he can only qualify for Medicaid under the medically needy requirements. However, the medically needy income limit for an individual residing in Richmond City is $250 per month. Hence, the SSI-related applicant whose income exceeds $407 per month will have to incur at least $825 in medical expenditures to meet the required spend-down amounts prior to receiving Medicaid coverage for medical services for a six-month period. Once the spend-down amount is met, the applicant will be enrolled for the remainder of that six-month period, at which point the spend-down process will begin again.*

State Options Considered in Revising Medically Needy Criteria. Virginia can alter the medically needy income limits by revising its ADC income limits and payment standards. Currently, 133 percent of the State ADC payment standard is approximately 41 percent of the federal poverty income level. Consequently, the medically needy income limit for a family of two in Richmond would be about $3,687 per year (the federal poverty

income level for a two-person family is $8,880 per year). However, by increasing the State ADC income limits and payment standards, additional Virginians would be eligible both for ADC and Medicaid. Recently, consideration was given to revising the State ADC income limits and payment standards; however, no change was made.

During the 1991 Session of the Virginia General Assembly, the budget submitted by the Senate included a proposal to increase the State ADC income limits and payment standards by four percent. Staff from the Senate Finance Committee estimated that as a result of this proposal, an additional 4,000 persons would have been eligible for Medicaid as ADC-related. The projected cost of providing Medicaid services for these new enrollees was estimated as $6.6 million. Because the Virginia Medicaid program has a 50 percent federal financial participation rate, the State would have been responsible for contributing $3.3 million on behalf of these enrollees. This proposal was ultimately rejected. Given the present economic climate, it is unlikely that the State ADC income limits and payment standards will be increased in the immediate future.

Virginia could also eliminate the more restrictive resource limits for SSI recipients. In 1990 the Department of Medical Assistance Services (DMAS) estimated the impact of extending Medicaid coverage to all SSI recipients. For FY 1991 and FY 1992, an estimated 20,020 additional SSI recipients would have been eligible for Medicaid, requiring an extra $70 million ($35 million in general funds and $35 million in matching federal funds). This total was based upon a projected expenditure per enrollee of $3,396 in FY 1991 and $3,634 in FY 1992.

Medicaid Eligibility Process

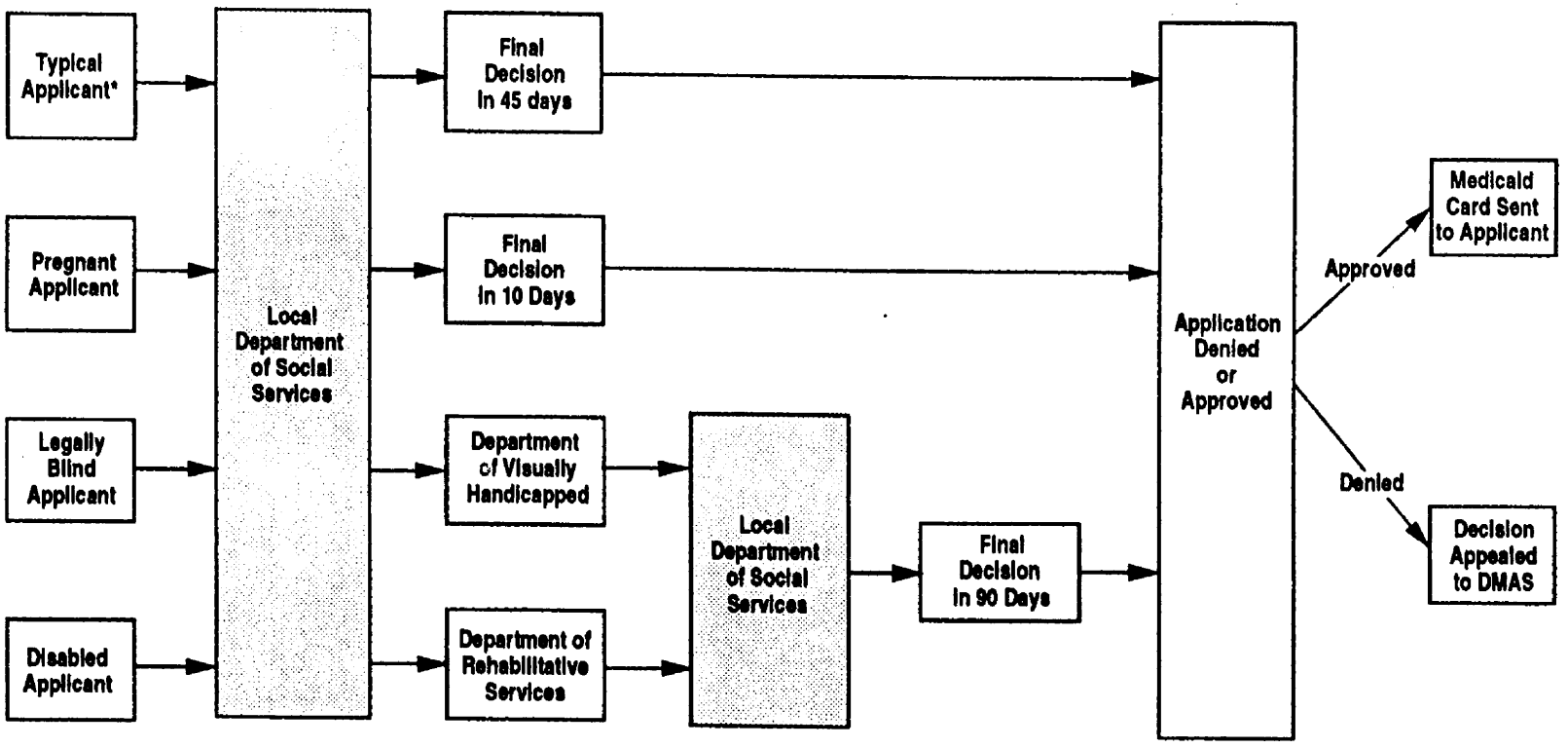
The Department of Medical Assistance Services has responsibility for administering the Virginia Medicaid program. DMAS contracts with the Department of Social Services (DSS) to conduct eligibility determinations. Applications for Medicaid coverage must be made at the appropriate local department of social services. Local departments also work with other agencies in making eligibility decisions. These decisions must be made within certain federally-mandated and State-required time limits.

Involvement of Other Agencies in the Eligibility Process. If applicants claim blindness or medical disability as the basis for their eligibility, the local department of social services arranges for verification of their claims. These applications are referred for examination to one of two State agencies: the Department for the Visually Handicapped (DVH) or the Department of Rehabilitative Services (DRS). DVH makes determinations when an applicant is legally blind. For instances in which medical disability is the basis for eligibility, DRS makes the determination. DRS staff also work with applicants who have limited vision along with other disabilities, but who are not considered legally blind.

DVH and DRS submit their determinations on blindness and disability to the applicant's local department of social services. The local department completes the Medicaid eligibility determination process by evaluating the applicant's income and resources. Figure 5 illustrates this application process.

Figure 5

Medicaid Application Process



*Applicant is categorized as SSI-related, ADC-related, or as an indigent child.

Source: JLARC staff analysis of information provided by the Department of Medical Assistance Services, the Department of Social Services, local departments of social services, the Department of Visually Handicapped, the Department of Rehabilitative Services, and the Social Security Administration.

The Social Security Administration (SSA) is also indirectly involved in the Medicaid eligibility process. SSA contracts with DRS to obtain disability determinations for SSI-related disabled applicants. In addition, SSA provides income verification for Medicaid applicants who receive SSI. This information is transmitted through monthly listings sent to each local department of social services.

Time Limits for Determining Eligibility. Local department staff have 45 days to determine Medicaid eligibility for all categories of applicants, except for blind and disabled applicants. Local department staff have 90 days to make eligibility determinations for these applicants, because of the necessity for medical review and the involvement of other agencies.

The State has elected to notify pregnant women of their eligibility within ten days, in an effort to expedite appropriate prenatal care. Indigent pregnant women and children also have abbreviated enrollment forms. All applicants can appeal negative decisions to DMAS.

Redeterminations, which involve re-evaluating current enrollees' income and resources to determine whether they are still eligible to receive Medicaid services, are conducted every six months for ADC-related enrollees and all medically needy enrollees with spend-down amounts. The other Medicaid enrollees are reconsidered once a year. Current enrollees can gain or lose Medicaid eligibility based upon their eligibility for ADC and SSI, pregnancy status, age, changes in financial status, and the timeliness of meeting medically needy spend-down amounts.

SERVICES COVERED BY THE MEDICAID PROGRAM

The Virginia Medicaid program provides reimbursement for a broad package of medical services for its recipients. Some of these services are required by federal and State mandates. In addition, the Virginia program provides coverage for a number of optional services. Comprehensive coverage of mandatory and optional services is not provided to all Medicaid recipients, however. Besides providing optional services, states are able to influence Medicaid services by imposing certain limits on services and applying for waivers from certain federal requirements.

Examination of the services available through the program revealed that Virginia's service coverage appears to mirror that offered by most other states. States must cover federally-mandated services for categorically needy recipients. These include inpatient and outpatient hospital services, nursing facility services, physician services, diagnostic laboratory and X-ray services, and family planning services, among others.

Virginia is one of 40 states and U.S. territories that provides a complement of optional services to Medicaid recipients. The optional services covered by the Virginia Medicaid program do not appear to be extravagant and also appear to be similar to those

services provided by most other state Medicaid programs. Examples of optional services include pharmaceutical services (particularly prescription drugs), limited dental services, eyeglasses and optometry services (for children only), and podiatry services.

Virginia spent about $320 million on optional services in FY 1991 (about 25 percent of medical care expenditures). The most costly optional services were pharmaceutical services (almost $103 million) and nursing facility services for medically needy individuals (about $94 million). The majority of the expenditures for optional services were for the care of medically needy recipients, who comprise about nine percent of all Medicaid recipients.

Table 3 lists most mandatory and optional services available to Medicaid enrollees by their eligibility class. Virginia has opted to provide a similar complement of services to both categorically needy and medically needy individuals within certain limits. However, there are differences in coverage. The broadest array of Medicaid-reimbursed services is provided to children, followed by pregnant women. Reimbursement for services provided to other adults and medically needy recipients is more limited. In addition, Medicaid provides reimbursement for Medicare coverage on behalf of QMBs rather than providing reimbursement for direct medical care.

Limitations on Services

The Medicaid program includes provisions which are designed to elicit prudent utilization of services. First, many medically needy recipients are required to make small copayments or meet a deductible charge for certain services. However, federal regulations prohibit copayments for children age 18 and younger (Virginia has extended this provision to include children age 20 and younger), pregnant women, and institutionalized individuals, as well as for all recipients of emergency services and family planning services.

Second, the Medicaid program applies limits to certain services for many recipients. For example, all recipients except children are limited to 21 days of inpatient hospital care per episode. Routine dental examinations are only available to children, and these are limited to one visit every six months. Appendix C provides more extensive information on Medicaid service benefit limits for recipients.

Third, the Medicaid program emphasizes the provision of services that are medically necessary and provided in the most cost-effective setting. Medical necessity reviews are conducted by DMAS staff in an effort to encourage appropriate utilization of resources. In addition, DMAS has applied for waivers from certain federal requirements. Waivers allow states additional flexibility in structuring their Medicaid programs. They can be used to contain costs by providing services in different ways and by targeting certain groups of enrollees. A description of Medicaid waiver services available in Virginia is contained in Appendix C.

Table 3

Mandatory and Optional Services Available to Medicaid Enrollees by Class of Eligibility as of December 1991[1]

Service Type	Categorically Needy (CN)	Medically Needy (MN)	Cost Sharing Amount[2]
Ambulatory Care			
Case management	State mandate	optional	
Clinic services	optional	optional	$1 per visit CN/MN
Dental services	optional	optional	
EPSDT services	federal mandate	optional	
Eyeglasses	optional	optional	
Family planning services	federal mandate	optional	
Family and pediatric nurse practitioner services	federal mandate	optional	
Home health care: nurse, aide, supplies & equipment, physical & occupational therapy, speech & audiology	federal mandate	optional	
	optional	optional	
Lab and X-ray services	federal mandate	optional	
Nurse-midwife services	federal mandate	optional	
Optometry services	optional	optional	$1 per visit CN/MN
Pharmaceutical services (including prescribed drugs)	optional	optional	1 per Rx CN/MN
Physical therapy & related services	optional	optional	
Physician services	federal mandate	optional	$1 per office visit MN/$2 per inpatient visit
Podiatry services	optional	optional	$1 per office visit MN/$2 per inpatient visit
Expanded prenatal services	State mandate	State mandate	
Prosthetic devices	optional	optional	
Rehabilitative services	optional	optional	
Rural health clinic services	federal mandate	optional	1 per visit CN/MN
Transportation	optional	optional	
Hospital Care			
Emergency services	federal mandate	optional	
Inpatient services	federal mandate	optional	$30 deductible each admission MN
Outpatient services	federal mandate	optional	$2 per visit MN
Long-Term Care			
Hospice care	federal mandate	optional	
Nursing facility services	federal mandate	optional	Patient payment
Skilled nursing facility services for persons younger than age 21	optional	State mandate	Patient payment
Mental Health Services			
Clinical psychologist services	State mandate	optional	$1 per office visit MN/$2 per inpatient visit
Community mental health & mental retardation services	State mandate	State mandate	
IMDs — inpatient & nursing facility services[3]	optional	not provided	Patient payment
Intermediate care facility services for mentally retarded	optional	not provided	Patient payment

[1]Listing of services does not include services offered through home- and community-based waiver programs. These services and detail on Medicaid service benefit limits are described in Appendix C.

[2]Cost sharing requirements vary by eligibility classification and service type. Limits on the imposition and amount of copayments are guided by federal regulations. Some Medicaid recipients in long-term care facilities and other medical institutions may be required to offset the cost of care as a condition of receiving Medicaid-reimbursed services. However, these recipients are allowed to retain a minimal amount of income to pay for personal needs.

[3]Individuals must be age 65 or older and residing in a State facility designated as an Institution for Mental Diseases (IMD).

Source: *State Plan for the Medical Assistance Program Under Title XIX of the Social Security Act*, Department of Medical Assistance Services.

Waivers from Federal Requirements for Institutional Services. The Virginia Medicaid program has obtained waivers for a variety of home- and community-based services (HCBS). These waivers are directed at specific populations in an effort to reduce costs and improve recipients' quality of care. To obtain a HCBS waiver, a state must show that the cost to the Medicaid program for services for the targeted population will be less than or equal to the cost to the Medicaid program for institutional services for this group.

Virginia has received permission to operate a HCBS waiver program as an alternative to traditional long-term institutional care. Medicaid finances certain services in full or in part if these services, along with other medical and social services available in the community, will enable the recipient to remain in his or her home rather than being placed in a nursing facility or staying in a hospital indefinitely. The program has chosen to target these services to specific groups of enrollees, including AIDS patients and children who need special "technology-assisted" services, such as those who are ventilator-dependent. Services reimbursed through the HCBS waiver program include personal care services, respite care, adult day health care, private duty nursing, and case management.

Proposed Waiver from Federal Requirements to Manage Recipients' Care. Typically, Medicaid enrollees are given "freedom of choice" in selecting their health care provider from among enrolled providers. However, the Virginia Medicaid program has applied for a waiver from this requirement to implement a managed care pilot program. This pilot program, the Medallion program, was developed as a result of recommendations by the Commission on Health Care for All Virginians. The Medallion program will assign all ADC-related enrollees in four localities to a primary care physician. This physician will act as "gatekeeper" for their necessary care by delivering most services and making referrals for specialty care or inpatient treatment.

Generally, managed care programs are designed to coordinate primary care for recipients and ensure continuity of care, reduce unnecessary and inappropriate use of emergency room care, and reduce excessive prescriptions and laboratory tests. As part of the waiver request, DMAS has outlined three major goals: (1) to increase access to care for targeted Medicaid enrollees, (2) to improve the quality of care to these enrollees, and (3) to contain costs through better management of care. Additional information on Virginia's waiver programs will be collected during the upcoming year, and will be included in the JLARC report to the 1993 Session of the Virginia General Assembly.

Extended Services for Children

Children have access to more Medicaid services than any other enrollee group. First, all enrollees age 20 and younger are eligible for early and periodic screening, diagnostic, and treatment (EPSDT) services; routine physical examinations and eyeglasses; and unlimited inpatient hospital care. All other enrollees are limited to 21 days of inpatient hospital care per episode.

Second, Medicaid-covered dental services are provided primarily to this age group. Children receive dental services, including emergency treatment for the relief of

pain and infection, preventive treatment, and routine therapeutic services such as extractions and fillings. Of the 56,363 Medicaid-covered dental services provided to Medicaid recipients during FY 1991, 55,486 (98 percent) of these services were provided to children.

Finally, federal statute directs state Medicaid programs to provide eligible children with any medically necessary services identified during the course of an EPSDT screening, even if the services are not specifically covered through the Medicaid program. Examples of services that are not normally covered by Medicaid but must now be covered (due to new EPSDT provisions) include inpatient psychiatric hospitalization and substance abuse treatment.

Extended Services for Pregnant Women

Federal statute permits states to offer services to Medicaid-eligible pregnant women that are greater in amount, duration, or scope than services for other Medicaid enrollees. The only stipulation associated with these services is that they be pregnancy-related. In addition to services provided to other categorically needy recipients (including physician services, pharmaceutical services, diagnostic laboratory and x-ray services, physical therapy, and outpatient surgery), the Virginia Medicaid program provides additional coverage for educational, nutritional, and homemaker prenatal services for pregnant women if approved by a physician. However, Medicaid coverage for pregnant women ends 60 days following delivery unless they meet the requirements for another eligibility classification.

Medicaid Coverage of QMBs

Qualified Medicare beneficiaries receive very specific Medicaid coverage that is not available to all Medicaid enrollees. Medicaid will pay Medicare Part A (hospital insurance) and Part B (medical insurance) premiums, deductible amounts, and coinsurance for Medicare-covered services on behalf of QMBs. Further, QMBs who are determined to be "dually eligible" may receive additional Medicaid-reimbursed services which are not covered through the Medicare program. Generally, these services would include Medicaid-reimbursed pharmaceutical services (particularly prescription drugs) and long-term care in a nursing facility.

HEALTH CARE PROVIDERS

All Medicaid payments are made to health care providers, according to established criteria. Generally, reimbursement is made only to those health care providers that are properly enrolled in the Virginia Medicaid program. Enrolled providers must sign an agreement to accept Medicaid reimbursement as payment in full for services rendered to Medicaid recipients. Unless they are cancelled at the request of the provider,

because of death, or by DMAS, provider agreements are currently maintained for a five-year period. Several different methodologies are used to reimburse providers for services rendered.

Virginia Medicaid Providers

Providers practicing in Virginia and those in adjoining states that routinely see Virginia Medicaid recipients are required to be enrolled in order to receive reimbursement. However, Virginia also reimburses "non-enrolled" out-of-state providers that only occasionally render services to Virginia Medicaid recipients. In order to receive payment, these non-enrolled providers must file an agreement with DMAS. Providers have up to one year from the date of service to bill the Medicaid program.

Many providers maintain more than one agreement with DMAS. DMAS assigns each agreement a unique provider number for billing and reporting purposes. As of September 25, 1991, slightly more than 21,300 health care professionals or facilities had one or more agreements with DMAS to participate in the Virginia Medicaid program. Because most of the additional agreements maintained with providers are duplicative, JLARC staff collapsed the relevant information for each unique provider into one record in order to determine the actual number of unique agreements. In September 1991 a total of 21,828 unique Medicaid agreements were maintained with providers.

All providers do not routinely provide services to Medicaid recipients. However, more than 90 percent of the providers have agreements which authorize them to routinely provide services to Virginia Medicaid enrollees. These providers are classified as "enrolled" and are located in Virginia or neighboring states. As of September 25, 1991, they maintained a total of 20,137 unique agreements (Table 4). The majority of these agreements, 59 percent, are maintained by physicians. Pharmacies, transportation providers, and dental care providers combined constitute another 23 percent of enrolled provider agreements.

Other health care providers that maintain agreements with the Virginia Medicaid program do not routinely render services to Virginia Medicaid enrollees. Most of these providers (1,400) are located in more distant states or are classified as non-enrolled. Another 285 providers (that maintain a total of 291 unique agreements) have limited agreements with DMAS. They are classified as Medicare crossover providers because they accept Medicaid reimbursement for qualified Medicare beneficiary deductible amounts and coinsurance but do not accept Medicaid enrollees as patients.

Structure for Funding Services Provided to Medicaid Recipients

As mentioned earlier, the Medicaid program does not directly provide medical services to eligible individuals enrolled in the program. It provides financial reimbursement to health care professionals and institutions for providing approved medical services, products, and equipment to Medicaid enrollees. Several different methodolo-

Table 4

Number of Providers Enrolled in the Virginia Medicaid Program by Type of Unique Agreement Maintained

Provider Agreement Type	Number Enrolled	Percent of Total
General Hospital	103	0.51%
Mental Hospital	22	0.11
Other Hospital	19	0.09
Nursing Facility	243	1.21
Mental Nursing Facility	27	0.13
Home- and Community-Based Service Provider	443	2.20
Health Department Clinic	130	0.65
Mental Health Clinic	85	0.42
Other Clinic	28	0.14
Primary Care Physician[1]	6,219	30.88
Other Physician	5,735	28.48
Nurse Practitioner or Midwife	18	0.09
Other Practitioner[2]	1,182	5.87
Dental Care (dentists & clinics)	1,202	5.97
Pharmacy	1,596	7.93
Maternal Infant Care Coordinator	34	0.17
Laboratory	82	0.41
Transportation Provider	1,777	8.82
Outpatient Rehabilitation Provider[3]	62	0.31
Other[4]	1,130	5.61
	20,137	100%

[1]Includes family or general practice, internal medicine or preventive medicine, obstetrics and gynecology, and pediatric specialties.

[2]Includes clinical psychologists, chiropractors, podiatrists, optometrists, opticians, speech pathologists, audiologists, and nurse anesthetists.

[3]Includes facilities, rehabilitation agencies, and occupational and physical therapists.

[4]Includes hospices, ambulatory surgical centers, renal units, and providers of medical supplies or equipment.

Source: JLARC staff analysis of DMAS Medicaid Management Information System provider subsystem file in SAS format as of September 25, 1991, including enrolled providers located within Virginia, the District of Columbia, Kentucky, Maryland, North Carolina, Pennsylvania, South Carolina, Tennessee, and West Virginia.

ies are used to reimburse providers for services rendered. Exhibit 2 illustrates the types of services reimbursed by the Medicaid program and their respective method of reimbursement.

The program pays most Medicaid service providers (primarily health care professionals) a set fee for the specific type of service rendered to Medicaid enrollees (termed "fee-for-service" reimbursement). Payments are based on the lesser of the State's fee schedule, the actual charge, or federal Medicare allowances.

Exhibit 2

Medicaid Reimbursement Methods for Specific Services*

Type of Service	Reimbursement Methodology
Inpatient hospital services	Prospective per diem rate
Nursing facility services	Prospective per diem rate
Physician services	Fee-for-service
Pharmacy services	Reasonable cost or maximum allowable charge
Outpatient hospital services	Cost-based**
Rehabilitation outpatient services	Cost-based
Comprehensive outpatient rehabilitation facilities	Cost-based
Lab and x-ray services	Fee-for-service
Federally qualified health center services	Cost-based
Community mental health services	Fee-for-service
Dental services	Fee-for-service
Podiatry services	Fee-for-service
Nurse-midwife services	Fee-for-service
Optometry services	Fee-for-service
Home health care services	Fee-for-service
Hospice services	Fee-for-service
Durable medical equipment	Fee-for-service
Medical supplies and equipment	Fee-for-service
Transportation services	Fee-for-service

*This list is intended to be illustrative of the varying types of reimbursement methodology used by the Medicaid program to reimburse medical services provided to program enrollees. It may not be comprehensive of all Medicaid services reimbursed by the program.

**Reimbursement for outpatient hospital services are based on a proportion of actual costs to charges for these services as set by the Cost Settlement and Audit Division of the Department of Medical Assistance Services.

Source: *The State Plan Under Title XIX of the Social Security Act for Medical Assistance Program*, DMAS.

Other Medicaid service providers, such as institutional providers (primarily hospitals or nursing facilities), are reimbursed for services based on a prospectively-determined per diem amount. The prospective per diem amount is generally based on cost reports submitted to DMAS by the provider for its prior fiscal year and a medical inflation factor. The methodology used for nursing facility reimbursement also factors in the types of patients cared for in each facility.

Other service providers are reimbursed in one of two additional ways. First, four types of services are reimbursed based on the actual cost to provide them. Second, reimbursement for pharmaceutical services is based on defined reasonable cost allowances with a maximum charge.

Several assessments of program reimbursement methodologies are being conducted as part of JLARC's ongoing research of the Virginia Medicaid program. These assessments are in their preliminary stages at this time, however. Findings and recommendations regarding these reimbursement methodologies will be presented to the 1993 General Assembly.

III. Recent Changes in the Medicaid Program

State Medicaid programs have been operating in a rapidly changing health care environment for the past few years. In the last year alone, many states experienced dramatic increases in their Medicaid costs. The Virginia Medicaid program, like programs in other states, has had to be responsive to a number of changes due to federal and State policies. Program administrators have had to grapple with a burgeoning budget and increased caseloads as a result of mandated program changes and the entitlement nature of the program.

Virginia Medicaid costs increased by almost 30 percent from FY 1990 to FY 1991. The increase in Medicaid expenditures appears to be caused by the interplay of several factors. New federal mandates and changes in State policies are at least partly responsible for the increases. However, other factors beyond the control of program administrators, such as inflation in the cost of health care and increasing numbers of high-cost aged or disabled enrollees, also appear to have had a significant impact. Although it is difficult to determine the precise impact of various factors on program cost increases, this issue will continue to be a focus of the research effort as it continues through 1992.

Factors contributing to administrative pressures are more easy to identify and explain. New federal initiatives to expand eligibility have succeeded in increasing the number of individuals enrolled in Medicaid. While Virginia has complied with the minimum requirements of the new federal initiatives, the State has not chosen to provide the more extensive coverage allowed under federal statutes and implemented in many other states. Nevertheless, enrollment increases and increasingly complex eligibility requirements have placed the eligibility determination system operated by the Department of Social Services (DSS) under some strain. This system tension is evidenced by problems affecting the timeliness of eligibility determinations and redeterminations made by eligibility workers in local social services departments.

Notwithstanding increases in program costs and mounting pressure on the social services system, program expansions for indigent pregnant women and children offer the State opportunities for long-term cost savings. Virginia may not be taking full advantage of these potential savings. Medicaid-financed prenatal care for indigent pregnant women and preventive care for indigent children can help avoid future costs associated with adverse pregnancy outcomes, and undiagnosed or untreated illnesses and diseases. However, enrollment increases among these groups have failed to meet projections, which may indicate inadequate outreach efforts by the State.

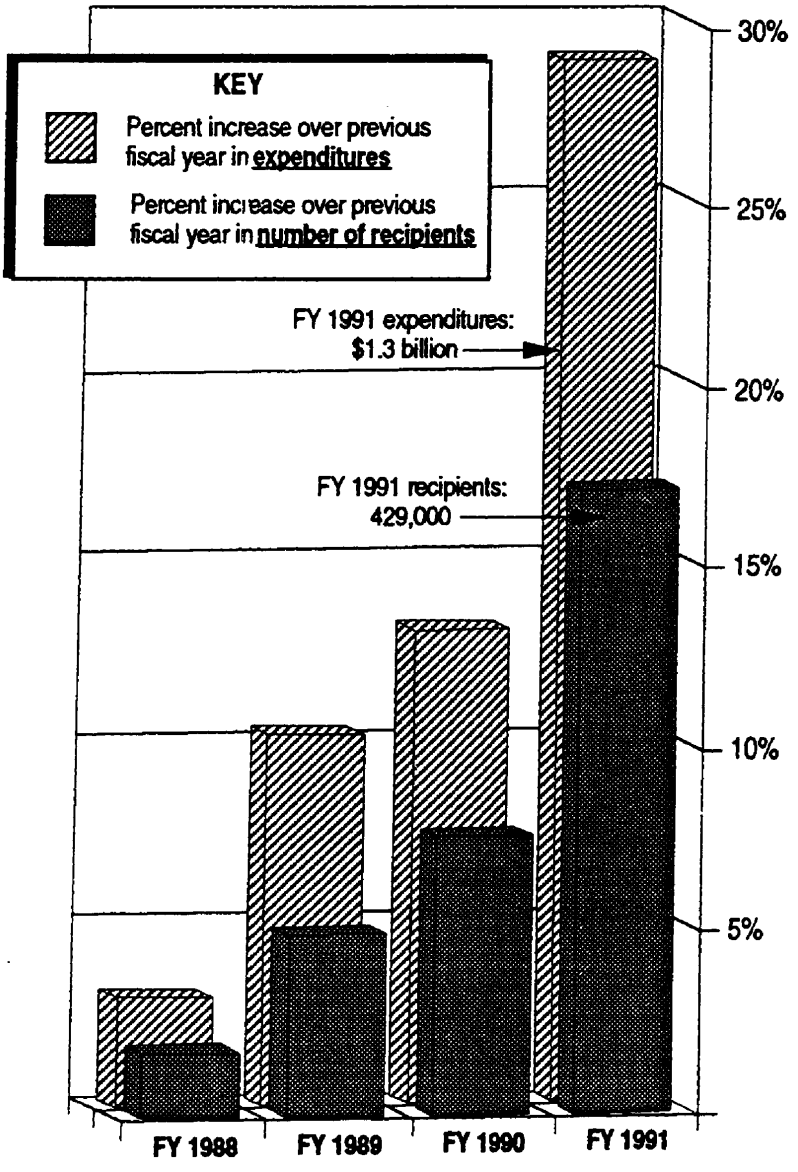
GROWTH IN MEDICAID PROGRAM COSTS

Since FY 1981, Medicaid expenditures for medical care have nearly tripled, from $432 million to almost $1.3 billion in FY 1991. However, much of the program's growth

has taken place in the last five fiscal years. Since FY 1987, the number of Medicaid recipients has grown about 35 percent, while the costs of the program have increased by approximately 85 percent (Figure 6). In the last fiscal year alone, the rate of growth for all Medicaid expenditures was almost 30 percent.

Figure 6

Growth in the Medicaid Program: Comparison of Expenditures to Recipients FY 1987 - FY 1991



Source: JLARC staff analysis of Department of Medical Assistance Services unaudited financial statements, FY 1987 - FY 1991; and HCFA 2082, *Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services*, State FY 1987 - FY 1991.

Not surprisingly, the rate of growth for the five largest expenditure categories for medical services mirrors overall program growth rates (Figure 7). The average annual nominal rate of growth from FY 1987 to FY 1991 for the five largest expenditure categories was about 9.5 percent. However, growth of these five expenditure categories from FY 1990 to FY 1991 was almost 27 percent.

This increase in program expenditures has been further magnified because the State has had to pay for an increasing share of total program costs. Because the State's per-capita income increased during that period, the federal share decreased due to the impact of the Medicaid funding formula. The federal government's share of the Virginia Medicaid program's overall costs has decreased from a rate of about 56.5 percent in 1980 to 50 percent in 1990.

The precise impact of a variety of other factors on increased program expenditures is somewhat more difficult to isolate. One frequently cited cause is recent federal eligibility expansions, which have resulted in more program recipients. These expansions have generally targeted indigent pregnant women and children, and qualified Medicare beneficiaries (QMBs), which are groups with low average medical costs.

State policies have also had an impact on increased program costs. The restrictive nature of the State's Aid to Dependent Children (ADC) program has exacerbated the impact of the federal mandates. Increased provider fees and attempts to obtain matching federal Medicaid funding for certain State-funded services have also caused growth in the overall Medicaid budget.

Finally, external factors, or factors that are difficult to control, could also play a major role in the expenditure increases. These factors include inflation of health care costs, worsening economic conditions, changing demographic characteristics, and a growing uninsured population.

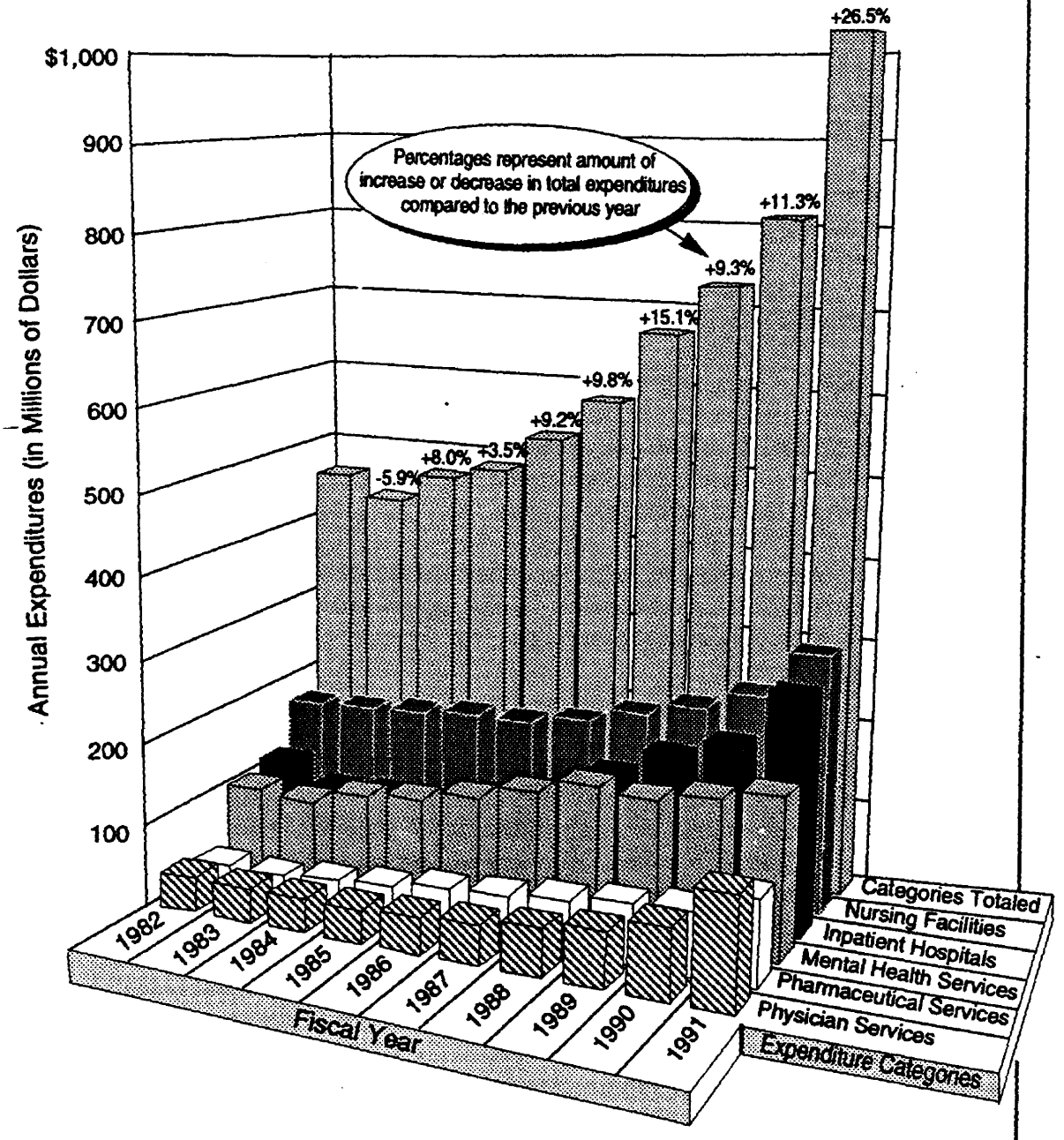
Federal Mandates Have Affected Program Growth

Recent federal mandates have significantly affected the costs of the Virginia Medicaid program. Federal mandates have included expansions in eligibility and service coverage, and changes in reimbursement. Consequently, additional financing has been required to implement the programmatic changes.

The Virginia Department of Planning and Budget (DPB) estimated that the total cost of funding federally-mandated changes for the Medicaid program over the last five fiscal years has been about $85 million (Figure 8). DPB also estimated that the State may incur additional costs of approximately $58 million between FY 1992 and FY 1995 as a result of existing federal mandates. When additional federally-mandated changes are phased-in, the impact on future program costs will be greater than the estimated $58 million. By FY 1995, DPB estimates the cumulative effect of these mandates will represent about 25 percent of the total Medicaid budget.

Figure 7

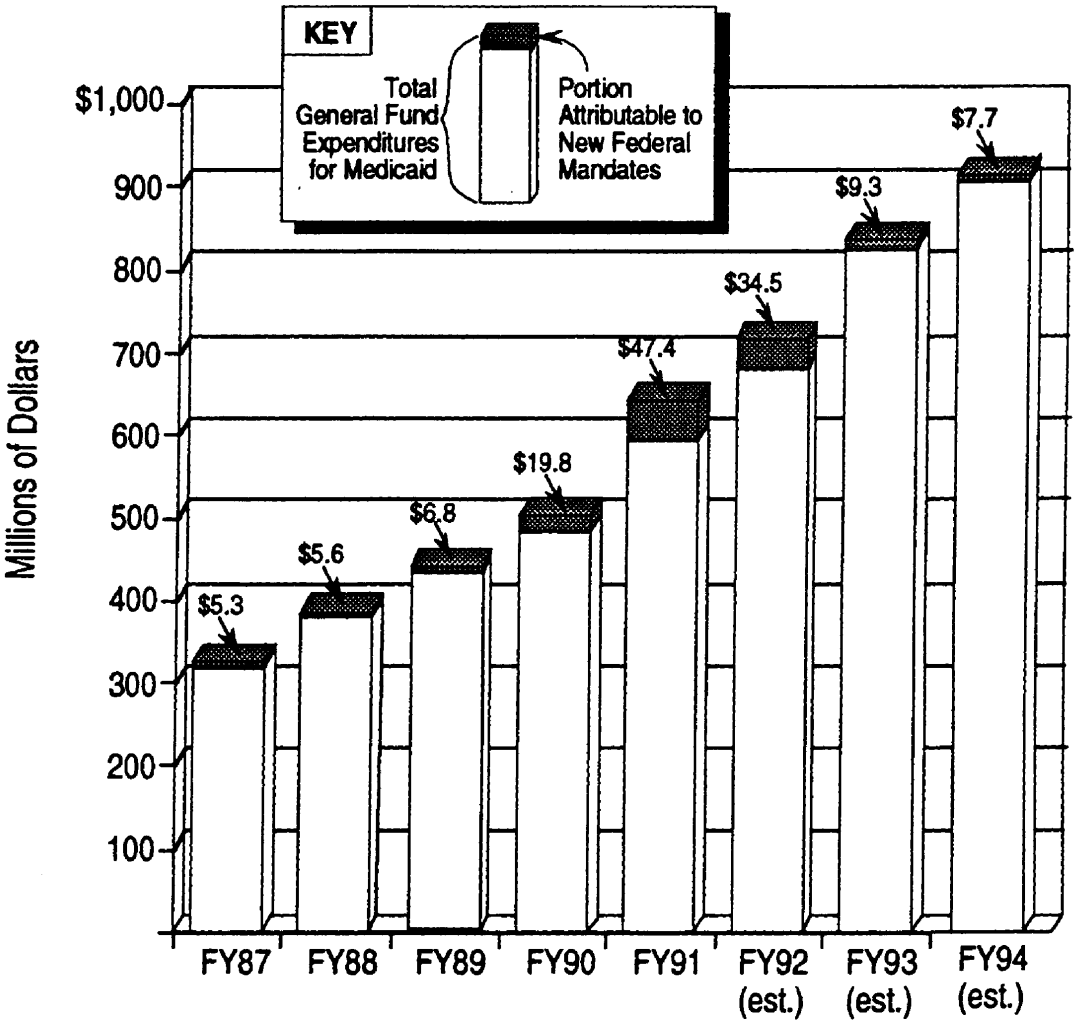
Comparison of Annual Medicaid Expenditures for the Five Largest Medical Care Categories FY 1982 - FY 1991



Source: JLARC staff depiction of Department of Medical Assistance Services medical care expenditure worksheet, FY 1982 - FY 1991, derived from unaudited financial statements.

Figure 8

Portion of General Fund Expenditures for Medicaid Attributable to Newly Implemented Federal Mandates Since 1987



Note: Federal Mandates depicted in this figure include federal legislative initiatives impacting the Medicaid program between FY 1987 and FY 1994, such as successive Omnibus Budget Reconciliation Acts from 1987, 1989, and 1990. Not included are the costs for implementing many ongoing federal requirements as set forth in federal and State Medicaid regulations. The portion shown as attributable to federal mandates each year is due to new initiatives only, and does not include the cumulative effects of previous initiatives.

Source: JLARC staff analysis of Department of Medical Assistance Services (DMAS) fiscal division report on general fund expenditures for FY 1987 - FY 1991; DPB analysis of federal legislative mandates, received 9/18/91; and DMAS preliminary forecast (November 7, 1991) of Medicaid expenditures for FY 1992, FY 1993, and FY 1994.

The following list illustrates the diverse nature of federal mandates on state Medicaid programs over the past several years.

- Federal changes to income and resource standards have resulted in expanded categories for program eligibility.

- The Family Support Act of 1988 expanded coverage for ADC-eligible two-parent families during periods of unemployment. It also mandated 12 months of extended Medicaid coverage for families that lose ADC eligibility due to increased earnings. In 1990, the Commission on Health Care for All Virginians estimated that 25,000 Virginians would be affected by these provisions at a cost of $22.7 million to the Commonwealth.

- Federal increases in Medicare premium amounts have increased Medicaid costs for QMBs. In addition, accelerated phase-in of higher income standards for these beneficiaries has increased the projected number of persons who could be eligible for Medicare premium payments.

- Federal requirements regarding early and periodic screening, diagnostic, and treatment (EPSDT) services for children have resulted in expanded service coverage for children.

- Federal nursing home reform legislation has resulted in increased costs for nursing homes to implement required nurse aide training. These increased costs have affected Medicaid reimbursement levels.

- Requirements that the State adjust reimbursement rates for hospitals serving a disproportionate share of Medicaid and indigent patients have increased reimbursement rates to many hospitals in the State.

State Policies Have Also Had an Impact on Program Growth

The combined impact of federal mandates has been significant in contributing to Medicaid program growth in Virginia. However, State policies have also contributed to Medicaid program growth in several ways. First, restrictive State policies regarding public assistance program eligibility have magnified the impact of federal mandates. Second, State policies regarding provider reimbursement rates have contributed to growing costs. Finally, State efforts to obtain federal financial participation for expanded optional Medicaid services have resulted in higher Medicaid program costs. Yet, overall State funding obligations for these services have often been reduced.

Restrictive ADC Income Limits Exacerbate Impact of Federal Mandates on Eligibility. To some extent, existing State policies regarding Medicaid program eligibility have exacerbated the impact of new federal mandates to expand Medicaid coverage to additional groups. As mentioned in the previous chapter, Virginia applies relatively strict income and resource eligibility standards for ADC. In addition, Virginia applies

more stringent resource standards for Supplemental Security Income (SSI) recipients in determining Medicaid eligibility. The Medicaid eligibility criteria for some categories are based on ADC income limits and payment standards which are set quite low (about 31 percent of the federal poverty income level). Therefore, any eligibility changes which are tied strictly to federal poverty income levels above the ADC income limits will result in program expansions.

Had Virginia set ADC income limits higher in the past, it is likely that the impact of recent federal program expansions would have been less dramatic. For example, some of these new enrollees might have already been covered by the program had ADC income limits been set at a level equal to 50 percent of the federal poverty income level.

Increases in Provider Reimbursement Rates Have Impacted Program Costs. Recently, the State has increased reimbursement rates to certain types of providers to encourage greater enrollment, and continued or enhanced acceptance of Medicaid enrollees as patients by existing providers. In addition, settlement of a lawsuit filed on behalf of hospitals in the State resulted in increased reimbursement rates for those providers.

Physician reimbursement rates have been increased four times in the last six years. In 1986, the State increased reimbursement rates for obstetrical services. In 1988, the State increased reimbursement rates for primary care procedures to encourage greater participation by primary care physicians in the program. Physician reimbursement rates were also increased in January 1990 for all services. This increase raised rates from the 10th percentile of average charges to the 15th percentile. Beginning October 1, 1991, physician reimbursement rates for obstetrical and pediatric services were further increased to the 25th percentile of average charges.

The State has also recently increased reimbursement rates to providers of home- and community-based waiver services to avert losing existing providers. This change went into effect beginning in FY 1992 and is projected to cost approximately $8.5 million during its first year of implementation.

The Medicaid program will also experience increased costs for hospital reimbursement rates beginning July 1, 1992, due to a recent legal challenge regarding the adequacy of hospital reimbursement rates. The suit was filed by the Virginia Hospital Association (VHA). The State's settlement with the VHA will require additional payments to hospitals each year through FY 1995, totaling about $100 million. The State will be responsible for funding at least one-half of this amount.

Efforts to Increase Federal Revenue Have Increased Program Expenditures. As the funding environment in the State has become more restrictive, efforts to utilize other sources of revenue for State services and programs have been increased. Some of the more significant efforts have focused on expanding the Medicaid program to cover eligible populations and services that were previously paid for solely with State and/or local funds. Providing coverage for these eligible populations and services through the

Medicaid program has the effect of reducing the State's general fund burden for these services, since State funds will be matched by federal Medicaid funds.

For example, the State has chosen to provide several community-based mental health and mental retardation services through the Medicaid program. General funds for these services are routed through the Department of Medical Assistance Services (DMAS), giving the appearance of increased Medicaid expenditures. However, since these funds are now being matched by federal revenue, the actual general fund burden for these services has been reduced.

Program Costs Are Affected by Several External Factors

Additional factors beyond the control of the Medicaid program have also influenced growth in program costs. Like other third party payers of medical expenditures, the program is affected by the overall rise in the cost of health care. The overall condition of the economy may also affect program costs. In addition, changing demographic characteristics, such as increases in the at-risk elderly population and the rising number of medically uninsured citizens, have increased reliance on the Medicaid program to cover larger numbers of indigent persons.

Health Care Cost Inflation Increases Program Expenditures. Inflation of health care costs has increasingly influenced the cost of the Medicaid program. Inflation of health care services, products, and equipment has generally out-paced inflation of other domestic goods and services as reflected in the Consumer Price Index (CPI). The medical care component of the CPI increased by an average of 7.5 percent over the last five years. This compares with about four percent for all goods and services measured by the CPI.

As the costs of health care have increased, Medicaid reimbursement levels for hospitals and nursing facilities have risen. This rise is due to the use of a reimbursement methodology which is based on facility costs plus an allowance for inflation. The prospective nature of the reimbursement methodology used by DMAS incorporates an inflation factor to calculate facility rates. Consequently, these Medicaid reimbursement rates are directly affected by inflation.

Economic Conditions Impact Medicaid Expenditures. Medicaid enrollment levels closely mirror the country's economic condition. If the country is experiencing a stable or prosperous period, Medicaid enrollments tend to stabilize. However, if the country is experiencing a recession, Medicaid enrollments and consequently expenditures will increase as more people become eligible for services. In fact, research indicates that increases in Medicaid enrollment (and enrollment in other public assistance programs) actually slightly precede defined recessionary periods, possibly because the populations that may need services tend to be affected more quickly and severely during economic downturns.

The recent recession was largely unanticipated by economic forecasters, so the impact of the additional enrollees was not built into most Medicaid budgets. The

resulting unexpected increase in utilization and expenditures was one of the factors leading to the large deficits experienced by Medicaid programs in several states.

Virginia, like other states, has experienced Medicaid enrollment increases which may reflect changing economic conditions. For example, between September 1990 and September 1991, the Virginia ADC caseload rose from 58,613 cases to 67,859 cases, an increase of 16 percent. DSS staff estimate that the average ADC case is comprised of a family of 2.6 persons. Hence, approximately 24,040 individuals were automatically eligible for the Medicaid program as a result of increased ADC caseloads.

Changing Demographics Influence Program Growth. Because Medicaid is an entitlement program, it continues to be impacted by changing societal demographic characteristics. For example, population projections for Virginia indicate that the number of persons age 65 and older will increase by almost 40 percent over the next 20 years. In 1990, about 22 percent of the elderly population were impaired to some degree (about 147,000 individuals), and about 18 percent of the impaired population resided in nursing facilities.

As the overall elderly population increases, the number of impaired elderly will also grow. Many of these persons may become eligible for Medicaid due to their frail physical conditions, fixed incomes, and the high cost of nursing facility care. As these individuals become eligible for and enrolled in the program, their nursing facility care will be financed by the Medicaid program.

Rising Rates of Medically Uninsured Impact Growth. Finally, increasing numbers of Virginia and U.S. citizens without health care insurance will continue to exert pressure on state Medicaid programs to fill the gap in existing health care insurance coverage. In Virginia alone, the number of uninsured citizens increased by 52 percent from 1986 to 1990. In 1986, the Commonwealth Poll conducted by Virginia Commonwealth University identified 578,000 Virginians with no health insurance coverage. By 1990, this number had grown to 880,000, with children comprising one-third of the uninsured in Virginia. Unless significant changes occur in the cost of medical care, the availability and affordability of health insurance, or the method of funding health care in the United States, the Medicaid program will most likely continue to be the vehicle used to fill gaps in health care coverage for poor, uninsured citizens.

EFFECTS OF MEDICAID ELIGIBILITY CHANGES

Eligibility for Medicaid has grown significantly in recent years for certain Virginians, particularly indigent pregnant women and children. Much of this growth can be attributed to recent federal mandates which have expanded Medicaid eligibility for this population. Virginia has chosen to comply with the minimum level of federal eligibility requirements for these new groups. In contrast, neighboring states have chosen to expand eligibility beyond the minimum federal requirements.

Although Virginia has chosen to meet only the minimum federal requirements, program expansions and new eligibility rules have nonetheless placed the DSS eligibility determination system under noticeable strain. Local social services departments are experiencing difficulty in making timely eligibility determinations and redeterminations. Local Medicaid eligibility determination staff expressed concerns about their increased caseloads, the number of federally-mandated changes in the program, the timeliness with which federal regulations related to those changes are published and distributed, and confusion associated with interpreting more complex eligibility requirements.

The program also appears to have problems enrolling new groups of indigent pregnant women and children, which could limit successful health outcomes for these groups and long-term cost savings for the program. Initial efforts by DSS to identify and establish Medicaid eligibility for these groups appear to have resulted in some increases in enrollment of these groups. However, the increases have not been as large as anticipated. This may indicate some weaknesses in the State's outreach efforts. Because prenatal and preventive care for indigent pregnant women and children may help to avert greater costs in the long run, outreach efforts may need to be enhanced to enroll these groups.

Virginia Complies with Minimum Requirements for Federal Program Expansions

A number of federal initiatives between 1986 and 1990 have expanded Medicaid coverage to indigent pregnant women and children (Exhibit 3). The new "indigent" classifications have fewer and less restrictive eligibility requirements than those for traditional coverage obtained by qualifying for ADC. In addition, the U.S. Congress mandated payment of Medicare premiums, deductible amounts, and coinsurance for QMBs through the Medicaid program.

Currently, the State complies with minimum federal requirements for Medicaid coverage of these groups. However, unlike neighboring states, Virginia has not chosen to expand coverage beyond the minimum level required by the federal government, particularly for indigent pregnant women and children.

According to published reports from the U.S. House of Representatives Committee on the Budget, the financing of pregnancy-related and pediatric services for low-income women and children is considered one of the highest priorities of the Medicaid program. The primary rationale behind these expansions is to reduce infant mortality and childhood morbidity.

As illustrated in Figure 9, Virginia provides coverage for pregnant women and infants up to the federally-mandated level of 133 percent of the federal poverty income level. In contrast, Tennessee and West Virginia provide coverage up to 150 percent of the federal poverty income level. Kentucky, Maryland, and North Carolina provide coverage up to the maximum allowed by federal statute, 185 percent of the federal poverty income

Exhibit 3

Federal Program Expansions Since 1986

Federal Legislation	Indigent Pregnant Women		Indigent Children		Qualified Medicare Beneficiaries	
	Option	Mandate	Option	Mandate	Option	Mandate
OBRA-86	100%		<age 5 at 100%		100%	
OBRA-87	185%		infant at 185% <age 8 born after 9/30/83 at 100%			
MCCA-88		75% (7/1/89)		infant at 75% (7/1/89)		100% (1/1/93)
OBRA-89		133% (4/1/90)		<age 6 at 133% (4/1/90)		
OBRA-90			≥ age 6 up to age 19 at 100%	≥ age 6 up to age 19 if born after 9/30/83 at 100% allows for phased in coverage (7/1/91)		100% (1/1/91)

Key:

OBRA: Omnibus Budget Reconciliation Act, passed in 1986, 1987, 1989, and 1990

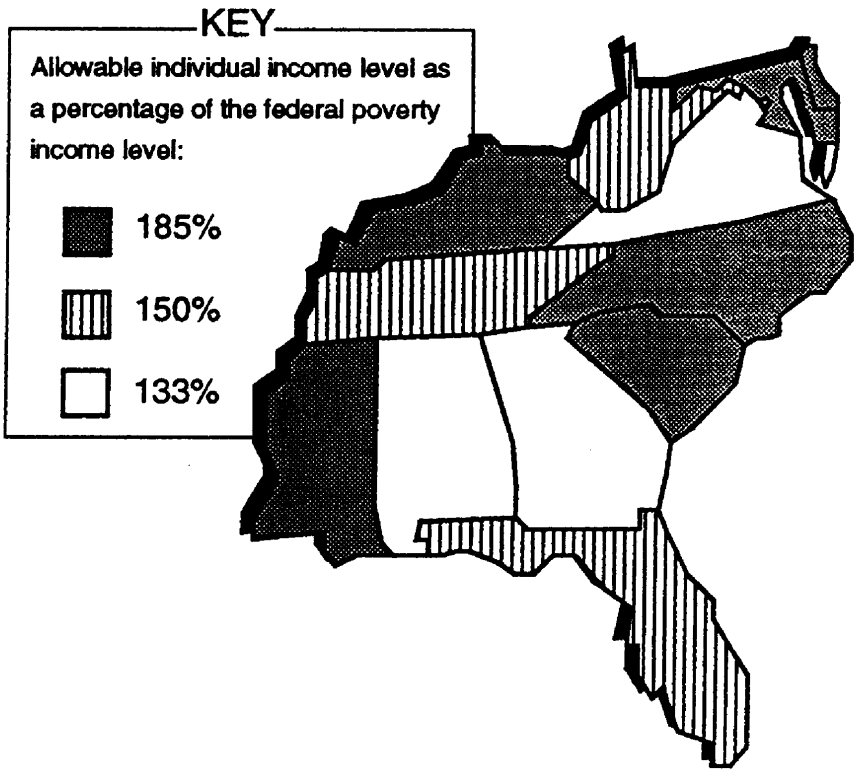
MCCA: Medicare Catastrophic Coverage Act, passed in 1988

Note: Percentages are based on proportions of federal poverty income level. Date indicates the effective date mandated by federal legislation. Infant indicates child younger than age one.

Sources: JLARC staff analysis of information provided by the Virginia Department of Medical Assistance Services, Office of Policy Research, April 9, 1991, and federal budget acts dated 1986 through 1990.

Figure 9

Poverty-Related Coverage of Indigent Pregnant Women and Children in Virginia and Surrounding States, January 1991



Source: JLARC staff adaptation of National Governors' Association *MCH Update*, "State Coverage of Pregnant Women and Children," January 1991.

level. In addition, the District of Columbia provides coverage at 185 percent of the federal poverty income level.

Virginia has not chosen to fully adopt several other options for expanding coverage for indigent pregnant women and children. For example, the OBRA-90 provisions for indigent children age six and older who were born after September 30, 1983, allow states to provide immediate coverage for all children between the ages of six and 19 with incomes at or below 100 percent of the federal poverty income level. Virginia has chosen to phase in coverage for these youths during the next 11 years.

Based upon 1990 census data, full, immediate implementation of this option (with no phase-in period) could provide Medicaid eligibility for approximately 174,000

Virginia children. However, the estimated cost of covering these children in FY 1992 is $130.5 million, based upon a DMAS cost estimate of $750 per year to provide Medicaid coverage to each child.

Changes in Eligibility Regulations and Increased Caseloads May Adversely Affect the Timeliness of Making Eligibility Determinations

The numerous rules and regulations guiding Medicaid eligibility decisions for families and children are being revised continuously. In addition, spousal support requirements and transfer of assets rules used to determine eligibility for the elderly and other institutionalized individuals have changed recently. These changes, along with the lack of an automated system which efficiently processes Medicaid applications, have complicated local efforts to make quick, accurate decisions on eligibility. In addition, federal regulations related to federally-mandated program changes are not always published prior to the required implementation date.

The eligibility changes, combined with the increasing caseloads resulting from program expansions, have placed the DSS eligibility determination system under considerable strain. Eligibility determinations were not made within federal and State time requirements for almost 24 percent of the cases in FY 1991, and redeterminations received an even lower priority, causing severe system backlogs.

Evaluating Eligibility for Families Is Now More Complicated. Staff from several local departments of social services commented on the difficulty of determining eligibility for families and children due to eligibility rule changes. An applicant who is denied ADC eligibility must still be evaluated to determine whether he or she is eligible for Medicaid. Every possible scenario for eligibility must be considered before the application is denied.

Local department staff must divide families into multiple family budget units and "deem" income in determining Medicaid eligibility. Deeming income involves dividing income among family members for the purpose of determining whether any members meet the Medicaid income requirements.

After dividing available resources among multiple family budget units, local department staff sometimes find that all children within a single family are not eligible for Medicaid as categorically needy. Therefore, coverage for these children as medically needy must be evaluated. However, if there is still excess income, the required spend-down amount is typically so high that certain family members are unable to qualify for medical services through the Medicaid program.

This problem primarily affects older children since age limits preclude them from obtaining eligibility except as ADC-related categorically or medically needy. However, children age eight and younger can be covered as indigent children. Exhibit 4 presents a case example in which two young siblings were determined to be eligible for Medicaid, but their teenage brother was denied Medicaid coverage.

Exhibit 4

Case Example: Determining Eligibility for an Indigent Pregnant Woman and Her Children

A woman applied for Medicaid for her family of five, which includes her husband, herself, her unborn child, her five-year-old child, and her teenage child. For the purposes of determining Medicaid eligibility, unborn children are treated as if they have been born. The father is employed at a salary of $1,400 per month. The mother works part time as a babysitter at a salary of $200 per month. Because both parents are in the home and both are employed, deprivation is not a factor. Hence, the family does not qualify for ADC, and the local social services staff is only evaluating their application for Medicaid eligibility.

Both parents are allowed a $90 income disregard, because both are employed. Hence, their total countable income per month is $1,420:

Husband's monthly income	$1,400
Wife's monthly income	+ 200
Subtotal	$1,600
Disregard allowed for couple ($90 x 2)	- 180
Total countable monthly income	$1,420

Federal law requires that indigent pregnant women and children younger than age six are eligible for Medicaid if their income is less than or equal to 133 percent of the federal poverty income level. In addition, resource limits are not permitted for this group. The five-person family monthly income allowance for indigent pregnant women and children younger than age six is $1,736. Because the monthly family income is less than the indigent income allowance, the pregnant mother, her unborn child, and her five-year-old child are eligible for Medicaid as categorically needy.

As long as the family income does not surpass $1,736 per month, the unborn child and the five-year-old child will be eligible for Medicaid as categorically needy until their sixth birthday. The income limit for indigent children between the ages of 6 and 8 who were born after September 30, 1983 is 100 percent of the federal poverty level. This is $1,305 per month for a five-person family, but the family currently earns $1,420 per month. However, these children could qualify as medically needy on their sixth birthday if they meet a specified spend-down amount for medical services.

The father is not eligible for Medicaid. He would only be eligible for Medicaid if he were a SSI recipient (aged, blind, or disabled), temporarily unemployed, or unemployed and a participant in the ADC-Unemployed Parent program. The teenage child is also ineligible for Medicaid, because he was born before September 30, 1983.

Source: JLARC review of a Medicaid eligibility case file, September 12, 1991.

Evaluating Eligibility for Institutionalized Elderly Enrollees Is Difficult for Local Eligibility Staff. Spousal support and transfer of assets rules have also been problematic for staff of local social services departments to implement. The Medicare Catastrophic Coverage Act of 1988 (MCCA-88) enacted new criteria for determining the eligibility of institutionalized individuals who have a spouse living in the community. The revisions are designed to ensure that spouses of nursing facility patients retain their home and receive an adequate income allowance.

However, the provisions often require that eligibility workers determine the value of resources available to a potential enrollee. Estimating the value of items that have been acquired by applicants during their lifetime — such as life insurance policies, burial funds, and other investments — can be a complicated and time-consuming process. Most local eligibility workers receive no special training in conducting this type of investigation and research.

In addition, more stringent transfer of assets guidelines have been developed as spousal impoverishment regulations have become more lenient for Medicaid applicants. The Tax Equity and Fiscal Responsibility Act of 1982 made it easier for states to restrict transfers, impose liens, and recover the costs of Medicaid-reimbursed services from the estates of Medicaid recipients. The Medicare Catastrophic Coverage Act of 1988 included additional restrictions related to transfer of assets. These restrictions were developed in response to numerous cases in which middle class individuals were qualifying for Medicaid assistance after disposing of their resources for less than the fair market value.

As of July 1, 1988, MCCA-88 specified that eligibility would be postponed for institutionalized individuals who disposed of resources for less than their fair market value within 30 months of their application for Medicaid. Staff of local social services departments are responsible for evaluating whether inappropriate transfers have taken place during the 30-month period prior to application. If this has occurred, the market value of the transferred assets must be computed, and the length of time that this excess amount would have financed private nursing facility care must be estimated.

Clearly, the new provisions have increased the complexity of the eligibility determination process. The details and implications of these new provisions are currently being researched by another study team as part of the research effort on issues related to long-term care. They will be presented at a later date.

Timeliness of the Eligibility Determination Process Has Suffered. The federal government requires that Medicaid eligibility determinations be completed within specified time frames. These requirements vary depending on the eligibility category into which the applicant can be placed. In addition, the State has imposed expedited time limits for processing Medicaid applications of pregnant women. Virginia Department of Social Services data on the timeliness of initial Medicaid applications and redeterminations for FY 1991 indicate that eligibility determinations were not made within federal and State time requirements for almost 24 percent of the cases.

The ability of local social services eligibility workers to evaluate applications is often hampered by the lack of access to revised federal regulations. Staff of DMAS, DSS,

and local social services departments assert that changes to federal regulations are not published or transmitted to them prior to the implementation date of the new provisions. Often local eligibility staff must interpret the impact of the changes from incomplete information, which can lead to processing delays and errors.

Because of increased caseloads and the increased amount of time required to evaluate each individual application initially, local departments of social services have had to make tradeoffs in the eligibility process. Consequently, local eligibility staff are currently concentrating their efforts on processing initial applications for the program in a timely manner. Eligibility redeterminations have been given a low priority because delays in processing redeterminations will not cause an individual to lose Medicaid eligibility.

Figure 10 summarizes the average quarterly percentages of initial Medicaid applications that were reviewed within federal time frames in seven regions and statewide during FY 1991. Statewide, initial Medicaid application decisions were made in a timely fashion only 76.1 percent of the time. The Southwest region had the highest average completion rate for timely initial application processing, almost 93 percent. The Tidewater region had the lowest average rate for timely completion of initial applications, almost 60 percent.

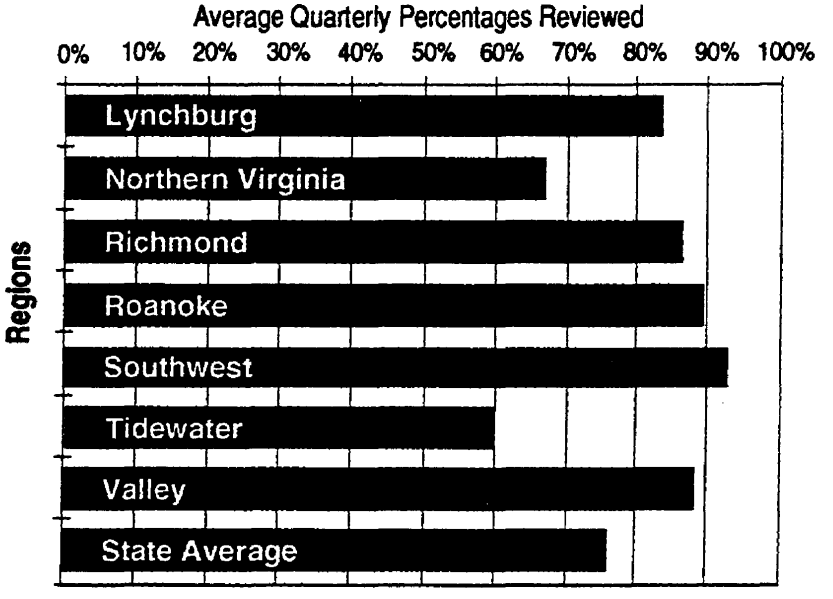
The data used for Figure 10 were self-reported by local departments of social services and were collected by DSS to assess the timeliness of initial eligibility determinations. At the time of this review, there was no other available source for measuring processing timeliness. However, inconsistency among the local departments in recording and reporting the data may have affected the accuracy for FY 1991. A standard definition has been developed for future reports. According to DSS, the timeliness of processing initial applications has improved in the current fiscal year.

During site visits to selected local departments of social services, Medicaid eligibility determination staff indicated that they utilize manual systems to monitor compliance with application processing deadlines. Currently, there is no central automated system with which the State can monitor whether local departments of social services are making initial Medicaid eligibility determinations within the allotted time limits. Department of Social Services central office staff said that an on-line system to track pending Medicaid applications is currently under development, and is scheduled to begin operation in July 1992.

Although initial Medicaid applications generally receive more attention than redeterminations, local staff must account for redetermination decisions that have not been made in a timely fashion. Redetermination decisions, unlike initial determinations, are monitored by DMAS and DSS. Each month, DMAS listings of upcoming and past due redeterminations are sent to each local department of social services. A review of the data on local redetermination decisions indicated that the Southwest region completed approximately 95 percent of its redeterminations within established time limits in FY 1991. In three of the regions, however, the redetermination backlog was so great that completion percentages could not be determined.

Figure 10

Average Quarterly Percentages of Initial Medicaid Applications That Were Reviewed Within Federal Time Frames (by Region, FY 1991)



Note: The data were manually collected by local social service departments and self-reported to the Department of Social Services.

Source: JLARC staff depiction of *Efficiency and Effectiveness Standards for Local Agencies*, DSS Quarterly Reports for FY 1991.

Redeterminations are frequently given low priority by local eligibility staff because overdue redeterminations do not cause enrollees to lose their eligibility. Local eligibility staff also request updated financial information from enrollees before conducting a redetermination. Enrollee failure to submit requested information in a timely fashion can also delay redetermination decisions.

Examination of the data indicates that local eligibility staff are handling increased workloads by focusing their efforts on enrolling persons in the Medicaid program instead of conducting timely redeterminations of eligibility. This focus appears appropriate. Because of the time that is required to enroll newly mandated populations and increased public assistance caseloads, less time is available for redeterminations.

The Medicaid program is only one of several programs for which staff at local social services departments must conduct eligibility determinations. Recently, the

Secretary of Health and Human Resources provided additional funding for 49 localities to administer their public assistance programs. This should assist localities in meeting federal requirements for Medicaid application processing. However, the Secretary should continue to monitor this area, and provide further guidance and assistance as necessary.

Recommendation (1). **The Secretary of Health and Human Resources should continue to monitor efforts by local social services departments to conduct initial Medicaid eligibility determinations and Medicaid redeterminations within federal and State time limits. Further assistance should be provided to local departments if compliance with requirements for application processing does not improve.**

Lagging Enrollment Among Indigent Pregnant Women and Children May Indicate Inadequate Outreach Efforts

Program expansions for indigent pregnant women and children appear to be an appropriate and cost-effective emphasis of the Medicaid program. However, enrollment of these groups appears to be lagging behind projected program expansions. This may indicate problems in the current outreach efforts to encourage enrollment among the targeted groups.

The Omnibus Budget Reconciliation Act of 1990 requires states to increase the number and types of sites at which an indigent pregnant woman can apply for Medicaid benefits. Virginia complies with the minimum requirements of this provision. However, the General Assembly may wish to consider requiring more widespread implementation of this provision to achieve potential long-term cost savings from enhancing Medicaid access for this group.

Program Emphasis on Enrolling Indigent Pregnant Women and Children Is Cost-Effective. Indigent pregnant women and children have consistently been among the target groups for program expansions over the years. Research has demonstrated that improving access to health care for pregnant women and children can have a variety of positive effects. For example, increased access can reduce the incidence of low birthweight infants, reduce the number of sick mothers and babies, and reduce infant mortality.

However, aside from the obvious societal benefits, there is evidence that improving access for these populations can have cost saving implications. As demonstrated in Chapter I, average costs for indigent pregnant women and children are significantly lower than average costs for other eligible groups, particularly the aged and disabled populations. In addition, the relatively small amounts spent on prenatal and preventive care for indigent pregnant women and children can result in substantial long-term savings for the program.

For example, according to a review conducted by the U.S. General Accounting Office, several studies have found the cost of providing comprehensive prenatal care to be less than the cost of providing medical care associated with poor birth outcomes, including neonatal intensive care. In addition, the National Academy of Science's Institute of Medicine found that for every dollar spent on prenatal care, $3.38 could be saved in the costs of care for low birth-weight infants.

Projections Appear to Overestimate New Eligible Groups. Recent projections of indigent pregnant women and children appear to overstate the impact of selected program expansions. JLARC staff examined selected projections produced by DMAS and DPB for the 1990 General Assembly session. The review focused on projections for expansions in these groups for FY 1991, which allowed comparison between projections and actual new enrollees.

The expansions for indigent pregnant women and children were mandated by OBRA-89. The new mandate required coverage of indigent pregnant women and children younger than age six with incomes up to 133 percent of the federal poverty income level. Prior to the implementation of the new mandate, which took effect in April 1990, Virginia was covering indigent pregnant women and children younger than age two with incomes up to 100 percent of the federal poverty income level.

Because OBRA-89 passed after DMAS budget submissions, DPB worked in consultation with DMAS to develop the estimates of newly eligible pregnant women and children. For FY 1991, DMAS and DPB projected that 3,973 indigent pregnant women and 26,251 indigent children would be eligible to receive Medicaid-reimbursed services as a result of the OBRA-89 requirements. However, according to data from the Medicaid Management Information System, only 2,624 additional pregnant women and 20,670 additional children enrolled in the program.

Overestimates Could Indicate Problems in Providing Outreach and Enrolling Newly Eligible Populations. It is difficult to determine whether the overestimates are a result of problems in the estimation methodology and data, or if they accurately reflect potential enrollees who are simply not enrolling in the program. However, assuming the methodology and data are sound, it appears that large numbers of indigent pregnant women and children may not be enrolling in the program. This increases the possibility that these eligible populations may enroll during an unexpected period in the future, causing budgetary problems.

More importantly, it may indicate that current outreach efforts are not sufficient. If eligible pregnant women are not aware of the new eligibility guidelines, the health and cost benefits that can be achieved by increasing access to this population may not be realized. Enhancing program outreach efforts could help increase program enrollment among indigent pregnant women and children to anticipated levels, and thereby reduce the costs to the State and Virginia citizens for care for these groups in the long-run.

Outreach Efforts to Reach Targeted Populations Should Be Enhanced. The U.S. Congress included language in OBRA-90 requiring that eligibility workers be placed in facilities which serve a large number of newly mandated groups. In addition, the State funded a pilot program to colocate local social services eligibility workers at selected local health departments to enhance enrollment of pregnant women. Because of the potential for long-term cost savings in enrolling and providing services to this group, efforts may need to be enhanced to achieve enrollment projections.

The Omnibus Budget Reconciliation Act of 1990 required states to "outstation" eligibility workers. As of July 1, 1991, states had to make provisions for the receipt of Medicaid applications by indigent pregnant women and children at locations other than local departments of social services. At a minimum, these locations must be hospitals which serve a disproportionate share of Medicaid recipients (DSHs) and federally qualified health centers. Public and private DSHs and health centers can participate in this program.

As with other federally-mandated provisions, the State has chosen to comply with the minimum requirements of the OBRA-90 outreach provision. The Department of Social Services is meeting the federal requirement by training hospital staff to accept Medicaid applications from indigent pregnant women and children.

Currently, there are 51 DSHs in Virginia. However, of the ten largest DSH hospitals that provided obstetrical and pediatric services in 1989, only two had hospital-based eligibility workers during FY 1991: the Medical College of Virginia Hospitals and the University of Virginia Medical Center. Additional DSH hospitals should be encouraged to accept Medicaid applications from indigent pregnant women and children in order to help the program reach these critical populations. DMAS contracts with DSS to perform these services. Therefore, DMAS should review projections for indigent pregnant women and children, compare them to actual enrollees, and ensure that DSS expands efforts to increase participation among DSHs and other providers.

One outreach effort underway in Virginia targets indigent pregnant women and high-risk infants (children younger than age one) who are eligible to receive Medicaid. According to local administrators it is achieving some early success. This program, termed BabyCare, is designed to provide physician, hospital, clinic, and nurse-midwife services for low-income women. In addition, risk assessment, nutrition counseling, patient education, and homemaker services are covered when prescribed by a physician. The program is a cooperative venture among DMAS, DSS, and the Virginia Department of Health (VDH). It is implemented through selected local health departments in the State, and is financed by the Medicaid program.

On a pilot basis, Medicaid eligibility determination staff have been placed in ten local health departments to accept Medicaid applications from indigent pregnant women who utilize the services of their local health departments. Therefore, during an initial visit to the health department, an indigent pregnant woman can receive the results of her pregnancy test and complete a Medicaid application on-site. Previously, health department workers referred pregnant women who appeared to be eligible for Medicaid to local

departments of social services, but many of the women did not follow up on these referrals to complete a Medicaid application.

Local social services department administrators who are involved with BabyCare appear to be pleased with the success of the program thus far. One director of a local department of social services commented that the program has provided services for many women in the locality. The BabyCare program is also viewed as a way to reduce the costs of health care for local governments. By ensuring that additional pregnant women enroll in Medicaid, more of their care is paid by federal and State Medicaid funds, rather than local and State general funds through local health department funding.

Currently, DMAS provides funding for local Medicaid eligibility determination staff involved in the BabyCare program with federal and State Medicaid funds. DMAS will continue funding the positions during the 1992-1994 biennium, which marks the end of the pilot stage of the project. However, there are no plans to expand the program to additional sites.

According to representatives of the agencies involved in the program (DMAS, DSS, and VDH), use of the BabyCare program to increase enrollment among pregnant women in the Medicaid program has been successful. A year-end review of the program conducted in January 1991 indicated that high percentages of pregnant applicants from five local health departments had enrolled in Medicaid. Based on that review, five additional local health departments were added to the program. However, data collected on the program are limited and more analysis is needed to measure the success of the program.

Enrollment increases may improve the quality and consistency of care provided to indigent pregnant women. In addition, enrollment increases among pregnant women should represent a direct cost savings to the Commonwealth and localities because services for the new enrollees are paid in part by federal funds, rather than solely with State and local funds. Therefore, the program should be further assessed to determine its impact on enrollment of indigent pregnant women. Specifically, it should be determined whether enrollments have increased at the pilots, at what stage of pregnancy women are enrolled, and the number of prenatal visits that are being made by the enrollees. Collection and analysis of these data are necessary to determine if future funding is warranted and whether the program should be expanded.

Recommendation (2). **The Department of Medical Assistance Services should review its projections of indigent pregnant women and children, compare them with actual enrollees and recipients, and determine if these projections are accurate. In addition, the Department of Medical Assistance Services should ensure the Department of Social Services expands its efforts to increase the number of locations equipped to accept Medicaid applications from indigent pregnant women and children. At a minimum, these efforts should include increasing the number of disproportionate share hospitals and federally qualified health centers participating in the outstationing program.**

Recommendation (3). **The Department of Medical Assistance Services should evaluate the success of placing eligibility workers at local health departments as part of the BabyCare program. At a minimum, this evaluation should include the collection and analysis of the following data: enrollment increases, pregnancy stage at enrollment, and number of prenatal visits. The evaluation should also assess application processing times and the feasibility of expanding the pilot effort to additional sites. Findings and recommendations should be presented to the General Assembly prior to the 1994 Session.**

IV. Access to Primary Care

Senate Joint Resolution (SJR) 180 directed the Joint Legislative Audit and Review Commission (JLARC) to determine the sufficiency of Medicaid reimbursement rates in providing quality care at the lowest required cost. In order to address the mandate, it was first necessary to examine Medicaid enrollee access to primary health care services. Research scheduled next year will test whether identified access problems could be a result of insufficient provider reimbursement or other factors.

Preliminary findings indicate that access to primary health care is problematic for all Virginians in certain areas of the State and for certain services. However, access to primary care is clearly more limited for Medicaid enrollees. While some of the gaps in care for Medicaid enrollees mirror those documented for the general population, enrollees appear to have fewer choices of providers.

Many primary care physicians enrolled in the Medicaid program do not routinely treat Medicaid enrollees as patients. Consequently, enrollees may have to rely on local health department clinics rather than primary care physicians located in their communities for their primary health care needs. They may also rely on alternative sources for primary care such as hospital outpatient and emergency departments, which could result in more expensive, sporadic care.

Although additional increases in reimbursement rates might improve Medicaid enrollee access, the sufficiency of these rates has not yet been examined. It is possible that factors other than reimbursement may be of equal or greater importance in influencing primary care physician participation in the Medicaid program. For example, other studies suggest that provider perceptions of the Medicaid program and Medicaid enrollees may contribute significantly to low participation. Research efforts to be conducted in 1992 will more fully explore the relationship between reimbursement rates and access to care. In particular, JLARC staff will attempt to determine the effect of recent reimbursement rate increases on primary care physician participation.

Ensuring access to primary health care for Medicaid enrollees should be a high priority for the program and the State. Costs associated with primary care are low relative to potential costs if routine, preventive care is not widely available or appropriately utilized. Delayed medical treatment or detection of disease could cause enrollee medical conditions to deteriorate to levels which require more extensive and costly care. Health care research has shown that the provision of preventive care is particularly important for children and for pregnant women. Early prenatal care generally improves birth outcomes and reduces the need for costly neonatal intensive care.

PARTICIPATION OF PRIMARY HEALTH CARE PROVIDERS IN THE MEDICAID PROGRAM

According to the Virginia Department of Health (VDH), primary care refers to the first-level contact for routine consultation, diagnosis, and treatment of an acute medical problem or for treatment of a chronic condition. Primary care also includes preventive care such as periodic screening for early detection of disease, immunizations, counseling about health risks, and for pregnant women, prenatal and post-partum care.

Typically, the providers of primary care are private practice physicians with a specialty in general or family practice, internal medicine, pediatrics, or obstetrics and gynecology (OB/GYN). Primary care physicians generally coordinate all aspects of patient care, thereby providing continuity and reducing unnecessary or inappropriate visits and duplication of diagnostic procedures.

Other health care professionals and facilities also provide primary care. Nurse practitioners (including certified nurse midwives under physician supervision) and local health department clinics may render routine treatment and preventive care. In addition, outpatient and emergency departments of hospitals are used as primary care providers.

Although most localities in the State have at least one of these types of primary care providers enrolled in the Medicaid program, Medicaid providers are concentrated in urban areas of the State and, to a lesser extent, Southwest Virginia. However, enrollment figures overstate actual provider participation in the Medicaid program.

While local health department clinics do provide routine treatment and preventive care, it is important to note that these clinics are only required to provide certain medical services related to communicable diseases, maternal and child health, and family planning services. Therefore, many of them do not provide services which could be routinely utilized by male adults and the aged.

Enrolled Primary Health Care Providers are Concentrated in Urban Areas of the State

The majority of primary care providers enrolled in the Virginia Medicaid program as of September 1991 were located in urban areas of the State (Table 5). Nearly 23 percent of the enrolled providers that had active agreements to render care to Virginia Medicaid enrollees on a routine basis were located in neighboring states. The largest provider base outside of the State was in Tennessee. The District of Columbia and North Carolina had similar, but slightly lower, levels of primary care providers enrolled.

Figure 11 more clearly illustrates the distribution of primary care providers enrolled in the Virginia Medicaid program. Not surprisingly, the largest concentrations are found in the Richmond, Northern Virginia, and Hampton Roads areas. There are also

Table 5

Locations and Numbers of Primary Care Providers Enrolled in the Virginia Medicaid Program, by Type as of September 1991

Location	Primary Care Physicians				Health Dept. Clinic	Nurse Practi-tioner	Total
	FP	IM	OB/GYN	PED			
Within Virginia:							
Rural Areas	532	203	57	53	83	5	933
Urban Areas	897	1,973	467	589	47	10	3,983
Other States:							
District of Columbia	10	138	37	120	0	0	305
Kentucky	17	37	5	15	0	0	74
Maryland	11	130	8	27	0	1	177
North Carolina	68	164	33	36	0	0	301
Pennsylvania	3	34	2	38	0	0	77
South Carolina	2	13	1	1	0	0	17
Tennessee	89	202	32	59	0	2	384
West Virginia	31	60	9	16	0	0	116
Total	1,660	2,954	651	954	130	18	6,367

Key:

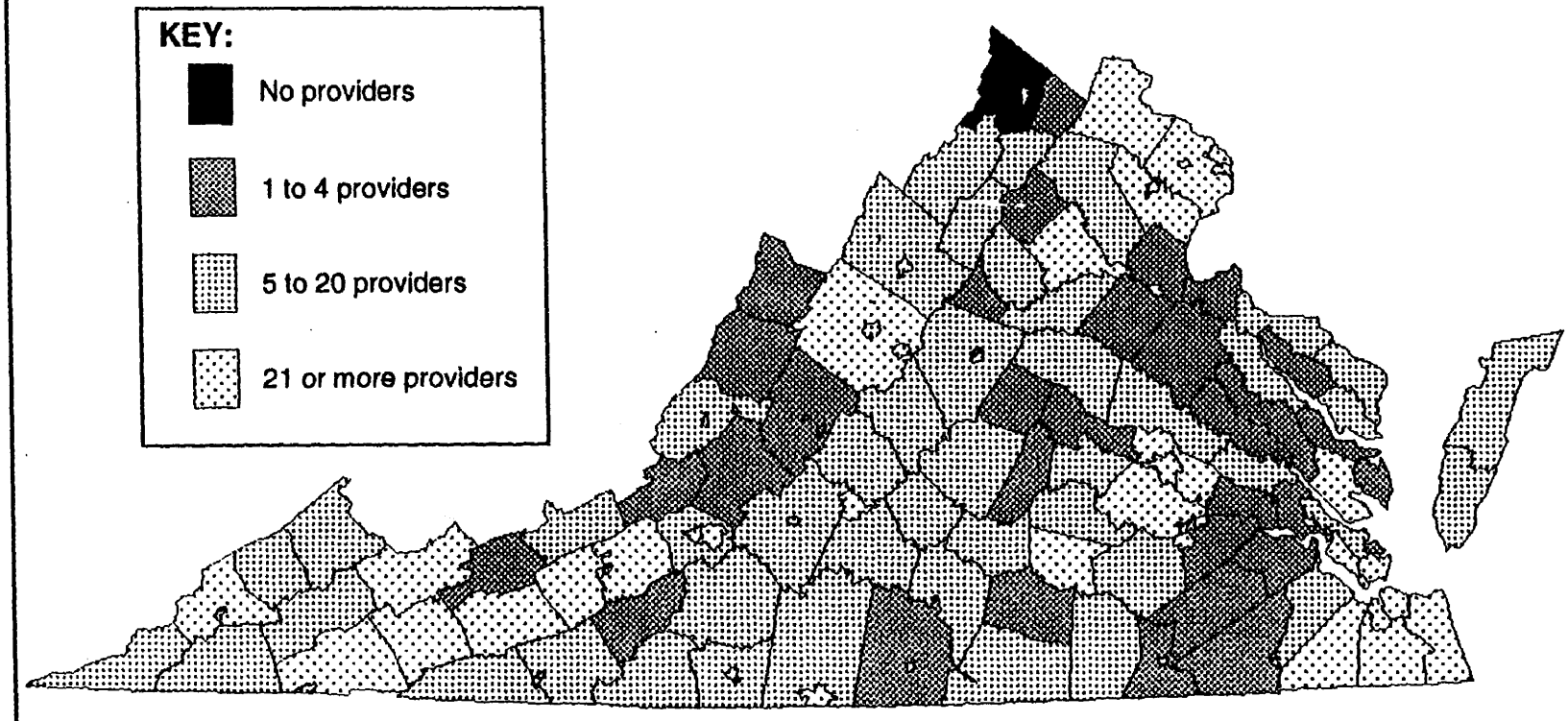
FP = family practice
IM = internal medicine
OB/GYN = obstetrics and gynecology
PED = pediatrics

Note: Rural areas are defined as all counties in Virginia except Arlington, Chesterfield, Hanover, Henrico, and Prince William. Urban areas include all cities and the counties named above.

Source: JLARC staff analysis of Department of Medical Assistance Services Medicaid Management Information System provider subsystem file in SAS format as of September 25, 1991.

Figure 11

Number of Primary Care Providers Enrolled in Virginia's Medicaid Program Within Each Locality



Note: Includes primary care physicians, nurse practitioners, and local health department clinics. Each unique provider is assigned a total count of one. If a provider is enrolled in multiple localities, the provider is weighted proportionally in each locality according to the number of enrollment agreements maintained by that provider. Enrolled satellite facilities of local health department clinics are each counted as a unique provider for the locality in which they are located.

Source: JLARC staff analysis of DMAS, MMIS provider subsystem file in SAS format as of September 25, 1991.

relatively large concentrations in Southwest Virginia. The lowest concentrations are in the Alleghany Highlands, South Central, and Northern Neck areas of the State.

The types of providers enrolled vary considerably among localities. For example, six localities do not have a primary care physician enrolled. Another ten localities have only one primary care physician enrolled. Twelve localities do not have an enrolled local health department clinic. However, all but two of them have cooperative community health agreements with adjoining localities. Only 15 nurse practitioners in the State are enrolled as Medicaid providers, although many more may participate as staff of local health department clinics. (Additional information on the geographic distribution of primary care providers and Medicaid enrollees is contained in Appendix D.)

General hospitals are enrolled as Medicaid providers in 62 of the 68 localities where they are located. The lack of an enrolled general hospital could explain why other types of providers that depend on hospitals for supplementing their practice are not enrolled or located in particular localities. For example, according to a survey conducted by the Medical Society of Virginia (MSV), OB/GYNs who deliver babies tend to practice where there is a hospital with delivery services. Provider enrollment statistics confirm these survey results. Ninety-six percent of the 524 enrolled OB/GYNs in Virginia are located in localities which have a general hospital. The remaining 21 OB/GYNs have practices in localities which adjoin localities with a general hospital.

Primary Care Provider Enrollment Figures Overstate Provider Participation in the Medicaid Program

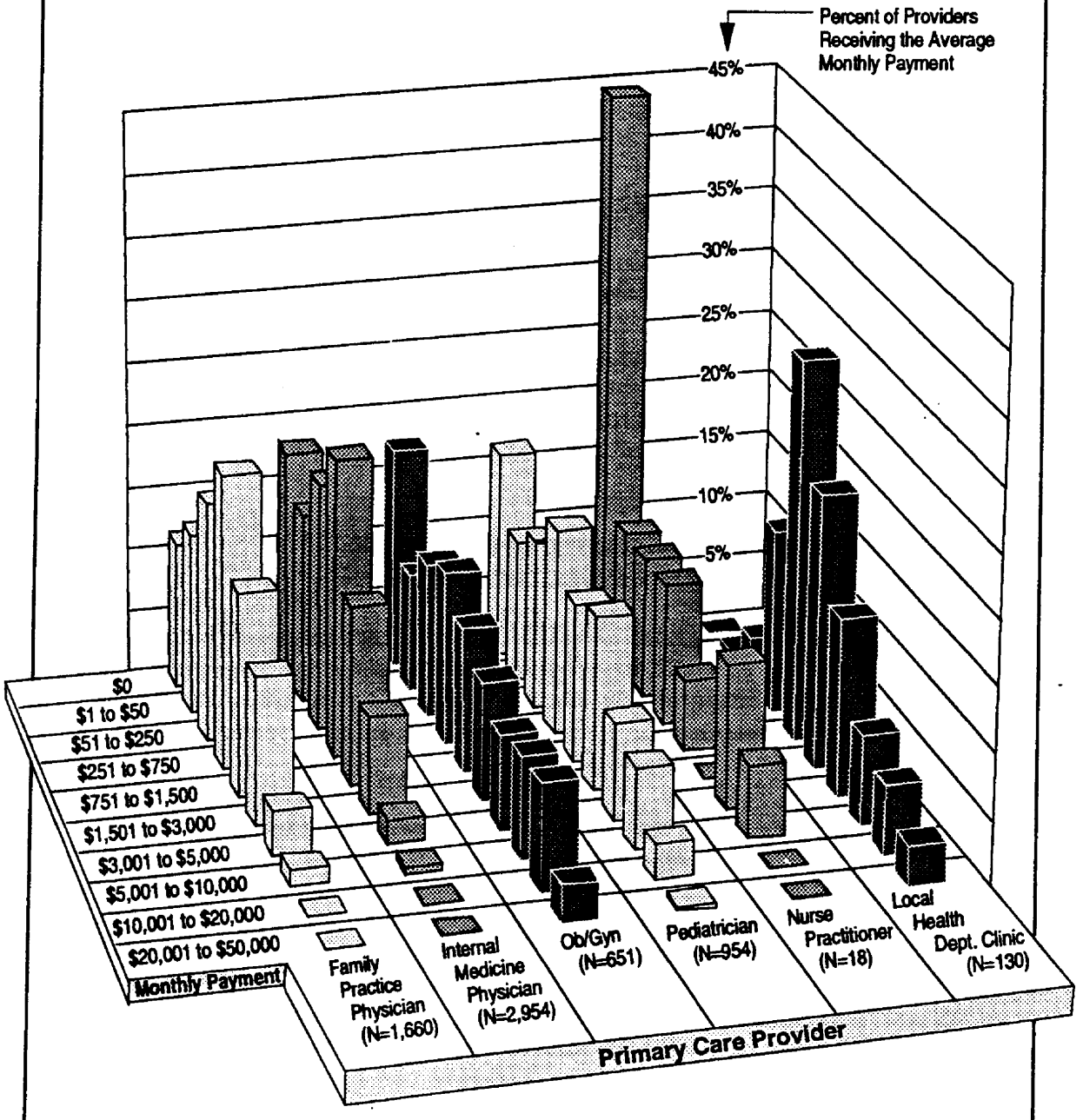
Approximately 47 percent of all enrolled primary care providers do not routinely treat Medicaid patients. In addition, participation among enrolled primary care physicians varies geographically and by specialty. Although greater numbers of primary care physicians are located in urban areas, generally smaller percentages of them actively treat Medicaid enrollees as patients.

Conversely, rural areas have relatively few enrolled primary care physicians, but greater levels of active participation in the Medicaid program. Rural family practice physicians are more likely to treat Medicaid enrollees than other enrolled primary care physicians. Other studies support the finding that rural primary care physicians are more active than their urban counterparts in treating indigent patients.

Nearly One-Half of All Enrolled Primary Care Providers Do Not Routinely Treat Medicaid Patients. Average monthly payments to enrolled primary care providers by the Virginia Medicaid program vary considerably (Figure 12). Approximately 16 percent of all enrolled primary care providers have not received any payments for care rendered to Medicaid enrollees since January 1990. Clearly they do not routinely treat Medicaid enrollees. Another 31 percent have very low levels of payments (more than 13 percent and 17 percent received average monthly payments between $1 and $50 and between $51 and $250, respectively). Therefore, approximately 47 percent of all enrolled primary care providers either render no care to Medicaid enrollees or provide very low levels of care.

Figure 12

Average Monthly Payments for Treating Medicaid Enrollees By Type of Primary Care Provider



Source: JLARC staff analysis of DMAS MMIS provider subsystem file in SAS format as of September 25, 1991.

Most of these providers have been enrolled for more than one year. Therefore, they should have submitted at least one bill to the Medicaid program for services rendered and received payment if they routinely treat enrollees as patients. According to the Department of Medical Assistance Services (DMAS), providers typically bill the program within two to four weeks of rendering services. Payment usually takes another week or two.

Urban Primary Care Physicians Generally Have Lower Medicaid Participation Rates than their Rural Counterparts. Primary care physician participation in the Medicaid program varies considerably across the State. Figure 13 illustrates various percentages of primary care physicians enrolled in Medicaid who routinely render care to Medicaid enrollees. Rural localities generally have the best participation rates (noted by the dot pattern).

However, rural areas are also more likely to have no primary care physician participating in the program (noted by black shading) than urban localities. Rural localities which lack or have few licensed primary care physicians will have problems with access for Medicaid enrollees regardless of the physician activity level, because access is problematic for all residents in localities with insufficient numbers of licensed physicians.

As Figure 13 also illustrates, lower participation rates (noted by gray shading) tend to be clustered in urban areas which have large concentrations of enrolled physicians. For example, in Northern Virginia localities, less than 50 percent of the enrolled physicians routinely participate in the Medicaid program. Since this urban area has a relatively large concentration of Medicaid enrollees but relatively low primary care physician participation rates, access for Medicaid enrollees may be especially problematic.

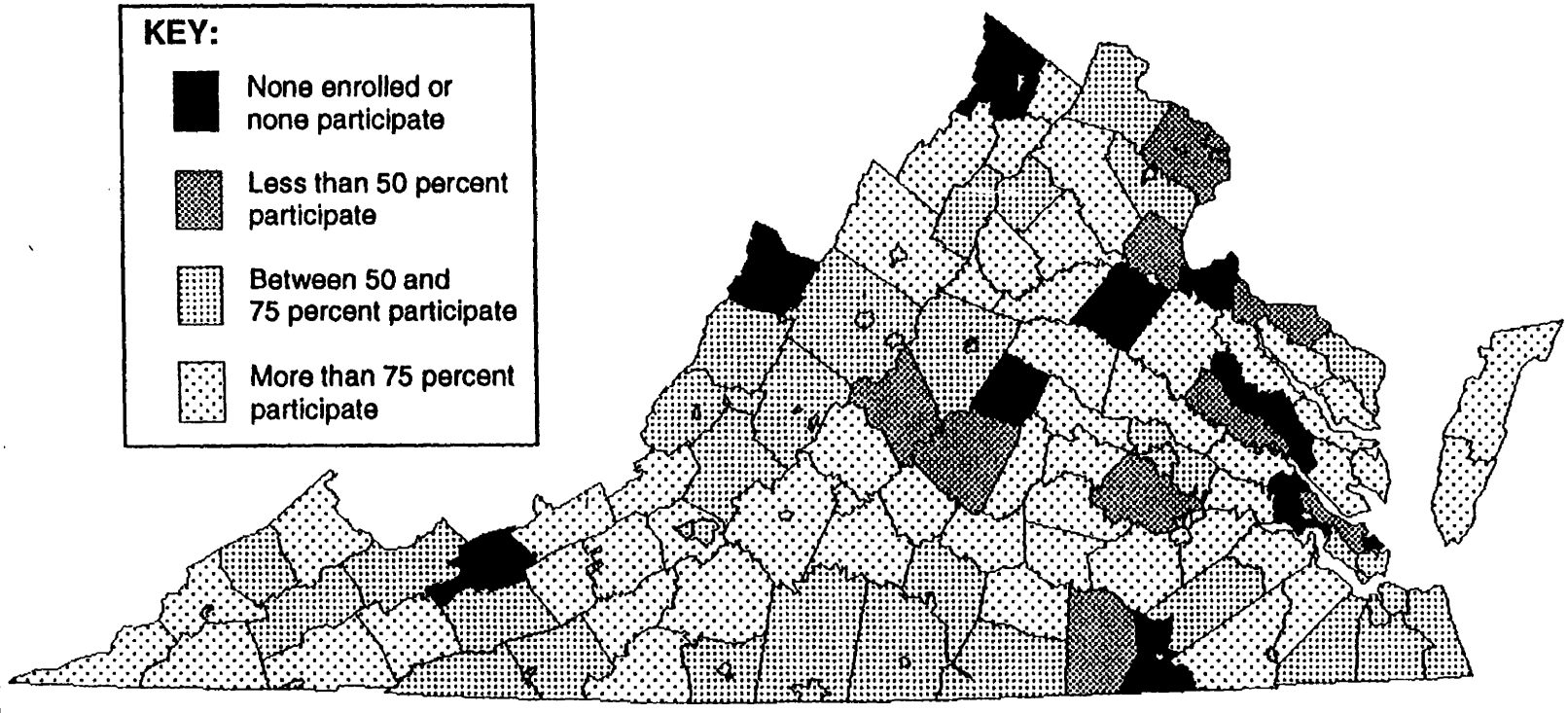
This urban/rural pattern of Medicaid primary care physician enrollment and participation generally mirrors physician distribution for the general population. The most recent VDH needs assessment indicates that while cities tend to have a surplus of primary care physicians, access can be very limited for Medicaid enrollees and other indigent citizens. Many rural localities continue to have deficiencies in the supply of primary care physicians, although many of these physicians do treat Medicaid enrollees.

Rural Family Practice Physicians Are More Likely to Treat Medicaid Enrollees than Other Primary Care Physicians. As noted above, rural primary care physicians are more likely than their urban counterparts to treat Medicaid enrollees as patients. And, primary care physicians in neighboring states are the least likely to treat Virginia enrollees. However, the specialty of the primary care physician also appears to affect participation levels.

Family practitioners appear more likely to render care to Medicaid enrollees than other primary care physicians, since a higher percentage of them have average payment levels above $250 per month. Most of their average monthly payments are between $251 and $1,500. This level of activity could approximate treatment for 11 to

Figure 13

Percentage of Enrolled Primary Care Physicians Who Actively Participate in the Virginia Medicaid Program



Note: Active participation is defined as receiving Medicaid reimbursement of more than $250 each month, on average. Each unique provider is assigned a total count of one. If a provider is enrolled in multiple localities, the provider is weighted proportionally in each locality according to the number of enrollment agreements maintained by that provider. Enrolled satellite facilities of local health department clinics are each counted as a unique provider for the locality in which they are located.

Source: JLARC staff analysis of DMAS, MMIS provider subsystem file in SAS format as of September 25, 1991.

65 Medicaid enrollees each month if one assumes that most of their patient visits are for intermediate office visits by established patients. This was the most frequent type of Medicaid claim submitted by providers in FY 1991. During calendar years 1990 and 1991 (through September), physicians were reimbursed $23 per intermediate office visit.

Family practice physicians with average monthly Medicaid payments that exceed $1,500 are typically located in rural Virginia. Their higher levels of service, as indicated by the higher average monthly Medicaid payments, may be related to their closer community ties and perceptions of being the only available provider for Medicaid enrollees in their communities.

Average monthly payment levels for internal medicine physicians are less varied than for family practice physicians. While more internal medicine physicians enrolled in the Medicaid program are located in urban areas of the State, those who are located in rural areas are more likely to actively participate.

Enrolled OB/GYNs and pediatricians appear less likely to treat Medicaid enrollees than other primary care physicians. However, when they do, their average monthly payments are usually higher than those of family practitioners or internal medicine physicians. Approximately 35 and 30 percent of OB/GYNs and pediatricians, respectively, have average monthly payments ranging from $1,501 to $39,000. Higher payments could, however, be related to more costly procedures for obstetrical care and to the higher expected annual visit levels for pediatric patients.

A similar urban/rural participation distinction is identified for these two specialties. However, even fewer OB/GYNs and pediatricians are located in rural areas than other primary care physicians. This exacerbates access problems for those Medicaid enrollees needing their services. The problem in accessing obstetrical care may be further demonstrated by the fact that use of physicians in neighboring states by Virginia Medicaid enrollees, particularly Tennessee, is greatest for obstetrical care.

Other Studies Support Findings that Rural Physicians More Actively Treat Medicaid Enrollees than their Urban Counterparts. The January 1990 Medical Society of Virginia report *Problems and Solutions to Access to Primary Care, Virginia Physicians Respond* included self-reported statistics by primary care physicians on their participation in the Medicaid program. This report cited survey responses by primary care physicians with specialties in family practice, internal medicine, or pediatrics. Most of the physicians responding to the survey stated that they had accepted Medicaid patients at some point in their careers.

Survey responses suggested that approximately 84 percent of the primary care physicians in Virginia with those three specialties participated in the Medicaid program in 1989, when the survey was conducted. However, only 64 percent of the primary care physicians that responded were accepting Medicaid enrollees as new patients. One-third of them reported that they were restricting the number of Medicaid patients accepted. Physicians cited several reasons for limiting acceptance of Medicaid enrollees, including low levels of patient compliance with physician orders, high-risk patients, relatively low reimbursement levels, and high administrative paperwork burdens.

As with the Medicaid enrolled provider average monthly payments, self-reported participation levels by primary care physicians varied considerably between rural and urban physicians. The report showed that rural physicians were much more likely to participate and to accept Medicaid enrollees as new patients than their urban counterparts.

Geographic distinctions, such as those found in the MSV survey, have been documented elsewhere and for other programs. For example, a recent study by the Urban Institute on differences in urban and rural physician care also found that rural physicians were more likely to accept Medicare beneficiaries as patients than their urban counterparts.

MEETING MEDICAID ENROLLEE PRIMARY CARE NEEDS

At the very least, one can assume that the primary care needs of Medicaid enrollees are similar to those of the general population. Based on national primary care visit rates and the number of individuals enrolled in the Medicaid program as of September 1991, it appears that more than 1.2 million primary care physician visits are needed by Virginia Medicaid enrollees annually. About 46 percent of the overall need for care (or 560,000 of the 1.2 million visits) is for pediatric care to serve children in various eligibility categories. Another 28 percent is for routine gynecological care to meet the needs of female adolescent and adult enrollees. (About 12 percent of these female enrollees are pregnant and also in need of obstetrical care.) And finally, 26 percent of the need, as defined by visits, is for health care for other adolescent and adult enrollees, particularly those in the aged category who have remained in their homes.

Statewide, it appears that approximately 500 full-time equivalent primary care physicians could serve the Medicaid enrollee population, if Medicaid enrollees comprised one-half of their patient case mix on average. Depending on the mix of primary care physicians and the assumptions about enrollee population needs, the full-time equivalent number could range from a low of about 430 to a high of about 660. However, these estimates probably greatly understate the actual need for primary care physicians to serve the Medicaid program, since it is unlikely that enrollees would comprise such a large percentage of physician practices.

Medicaid enrollees comprise approximately six percent of the State population. Therefore it seems more reasonable to assume that they would comprise a similar proportion of primary care physician practices if all physicians participated equally. In the MSV survey on primary care access, Medicaid enrollees were reported to comprise between 5.4 and 32 percent of primary care physician practices, depending on the geographic location and physician specialty.

Given this information, it appears that the number of enrolled Medicaid primary care physicians in Virginia may not be sufficient to meet the needs of Medicaid enrollees. And, when the participation levels of these providers are considered, it is clear

that a sufficient number are not currently enrolled. In addition, the distribution of these primary care physicians does not match the needs suggested by Medicaid enrollee distribution. Even if all enrolled primary care physicians treated Medicaid enrollees, access problems would persist for certain types of care and in certain geographic areas. Furthermore, expected increases in the number of Medicaid enrollees are likely to exacerbate the access problem.

In Many Areas of the State, Pediatric Care Needs Are Not Being Met by Specialists

Pediatric care is a critical component of the primary care provided through the Medicaid program because of the number of children enrolled and the benefits associated with ensuring such care. However, pediatricians are enrolled as primary care physicians in less than 45 percent of Virginia localities and actively participate in the program in even fewer localities. Consequently, most pediatric care is provided by other primary care providers.

Children younger than age 21 currently comprise approximately 55 percent of all Medicaid enrollees (Table 6). However, the number of children enrolled and the need for pediatric care will continue to increase due to federally-mandated expansions to phase-in children up to age 19 who are at or below federal poverty income levels. Because of these federal program expansions, more than one-third of all enrollees are children younger than age eight. Most enrolled children (about 139,500) are currently eligible because they receive Aid to Dependent Children (ADC) or meet criteria for the ADC-related category. However, another 45,409 enrolled children are eligible because they fall below specified federal poverty income levels for indigent children.

Health care research has determined that the costs associated with providing routine, preventive pediatric care may be dramatically less than the costs for providing care for conditions left undiagnosed and untreated. For example, the U.S. General Accounting Office (GAO) noted that failure to obtain routine immunization for measles can result in lifetime institutional care for a child in its report *Early Intervention Strategies for At-Risk Families*. Such institutional care was estimated by GAO to cost from $500,000 to $1 million for each child's lifetime.

A recent report on health programs for poor, young children further underscores the need for pediatric care by Medicaid-enrolled children. It suggests that children born and raised in poverty have greater needs for medical care, especially preventive medical care. Indigent children are more likely to experience death due to premature birth, acute illnesses, injuries, lead poisoning, nutrition-related problems, and chronic illnesses. Many of these conditions can be prevented.

Pediatric care needs for impoverished children are recognized as critical by the federal government. Medicaid programs are required to provide early and periodic screening, diagnostic, and treatment (EPSDT) services for all enrolled children. In addition, Medicaid programs must provide any medically necessary services to treat

Table 6

Gender and Race of Enrollees in the Medicaid Program by Age as of September 1991

	Gender		*Race*			
Age	Male	Female	White	Black	Other	Total
< 1	12,542	12,422	11,173	12,203	1,588	24,964
1 - 6	48,029	46,720	37,394	53,708	3,647	94,749
7 - 8	9,610	9,302	6,518	11,867	527	18,912
9 - 14	21,939	21,619	14,876	27,506	1,176	43,558
15 - 21	9,484	25,367	14,421	19,179	1,251	34,851
22 - 44	15,380	65,608	36,332	42,733	1,923	80,988
45 - 64	10,914	20,263	17,408	13,018	751	31,177
65 - 84	13,454	39,143	28,779	20,013	3,805	52,597
85 +	2,255	11,259	9,215	4,076	223	13,514
Total	143,607	251,703	176,116	204,303	14,891	395,310

Note: Other includes American Indian or Alaskan native, Oriental or Asian, Spanish American or Hispanic, and other unspecified races.

Source: JLARC staff analysis of DMAS MMIS eligibility subsystem file in SAS format as of September 23, 1991.

conditions identified during EPSDT screenings, regardless of whether the service is covered under the state plan. Virginia is required to improve the percentage of Medicaid children who receive preventive care through the program from a current estimate of approximately 58 percent to 80 percent by 1995.

Routine pediatric care and EPSDT services could be provided by pediatricians, family practitioners, or nurse practitioners. In rural areas, children must rely on clinics for their care or go to family practitioners since pediatricians are generally only located in urban areas.

In fact, within the Virginia Medicaid program, EPSDT services are predominantly provided by local health department clinics. Approximately 82 percent of local health department clinics are authorized by the Medicaid program to provide and bill for EPSDT services. Less than six percent of primary care physicians and none of the individually enrolled nurse practitioners are authorized to do so. However, it is also possible that EPSDT diagnostic and preventive procedures are provided by primary care physicians during office visits but are not billed as EPSDT services. The extent to which this occurs is not clear at this time.

The Largest Gap between Enrollee Needs and Medicaid Providers Appears To Be for Care Related to Pregnancy

Most of the pregnant women enrolled in the Medicaid program can probably be classified as medically high-risk patients. In fact, a physician survey conducted by the Medical Society of Virginia found that nearly 95 percent of the responding obstetricians perceived their Medicaid patients as being medically higher risk and less likely to seek preventive care than their other patients. More than 70 percent of these obstetricians perceived Medicaid patients as less likely to comply with physician orders than other patients.

Because of their risks, adequate and early prenatal care is especially important for pregnant Medicaid enrollees. It is more likely to ensure positive birth outcomes and relatively lower costs for delivery. However, the extent to which these pregnant women are currently obtaining prenatal care is not known. Nevertheless, it is clear that in certain areas of the State, the only available source for prenatal care is the local health department clinic or possibly a family practice physician, since OB/GYNs are primarily located in urban areas.

Because of the distribution and number of physicians who currently practice obstetrics, the problem of access to care during pregnancy is not limited to Medicaid enrollees (Figure 14). A JLARC/Medical College of Virginia survey of general hospitals determined that 30 percent of the licensed OB/GYNs in Virginia have eliminated obstetrics from their practices. Survey results also indicate that only five percent of licensed family practice physicians in Virginia currently provide delivery services.

However, access problems for pregnant Medicaid enrollees are exacerbated by self-imposed physician limits on their obstetrics practices and physician perceptions of the Medicaid program and its enrollees. In addition, some hospitals are not enrolled as Medicaid providers. Consequently, pregnant Medicaid enrollees may have to travel long distances to deliver their babies, especially in rural areas.

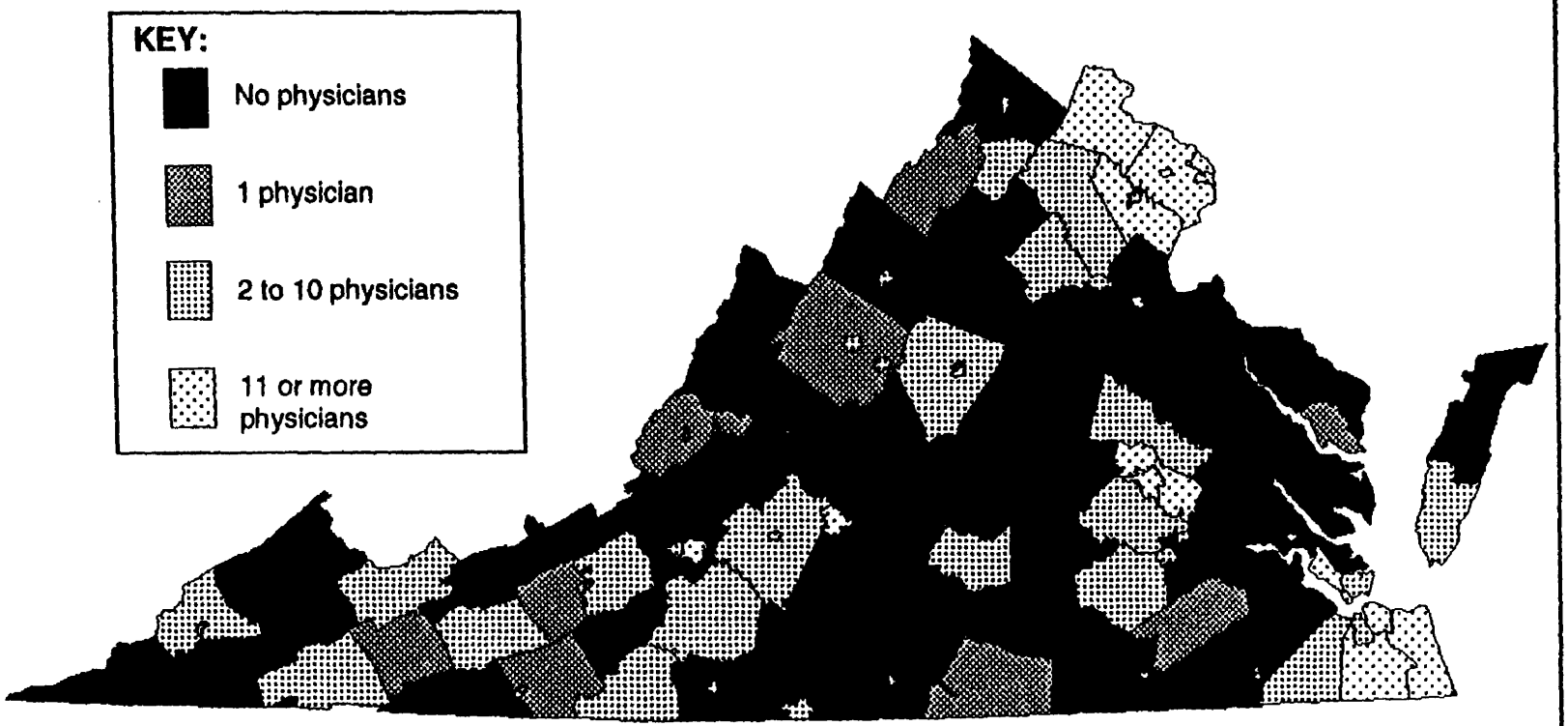
Obstetrical care and delivery services are needed by approximately 13,000 pregnant women enrolled in the Medicaid program as of September 1991. Almost 99 percent of these women were eligible for Medicaid under criteria for the indigent pregnant women category. Another 127 women eligible for Medicaid through other eligibility categories were also pregnant at that time.

It is unlikely that the need for obstetrical care will decrease in the future since Medicaid coverage for indigent pregnant women is mandated by the federal government. In addition, adolescent and adult females in their childbearing years comprise approximately one-quarter of all Medicaid enrollees.

The cost-effectiveness of prenatal care for high-risk, low-income, minority and adolescent females has been well-documented in health care literature and government studies. For example, a 1987 GAO report on prenatal care noted that "for every dollar spent on prenatal care for high-risk women, over three dollars could be saved in the cost

Figure 14

Number of Licensed Physicians Who Practice Obstetrics in Each Virginia Locality



Note: Includes Virginia licensed OB/GYNs and family practice physicians only. Physicians who practice in more than one locality are weighted proportionally in each locality where they maintain a practice.

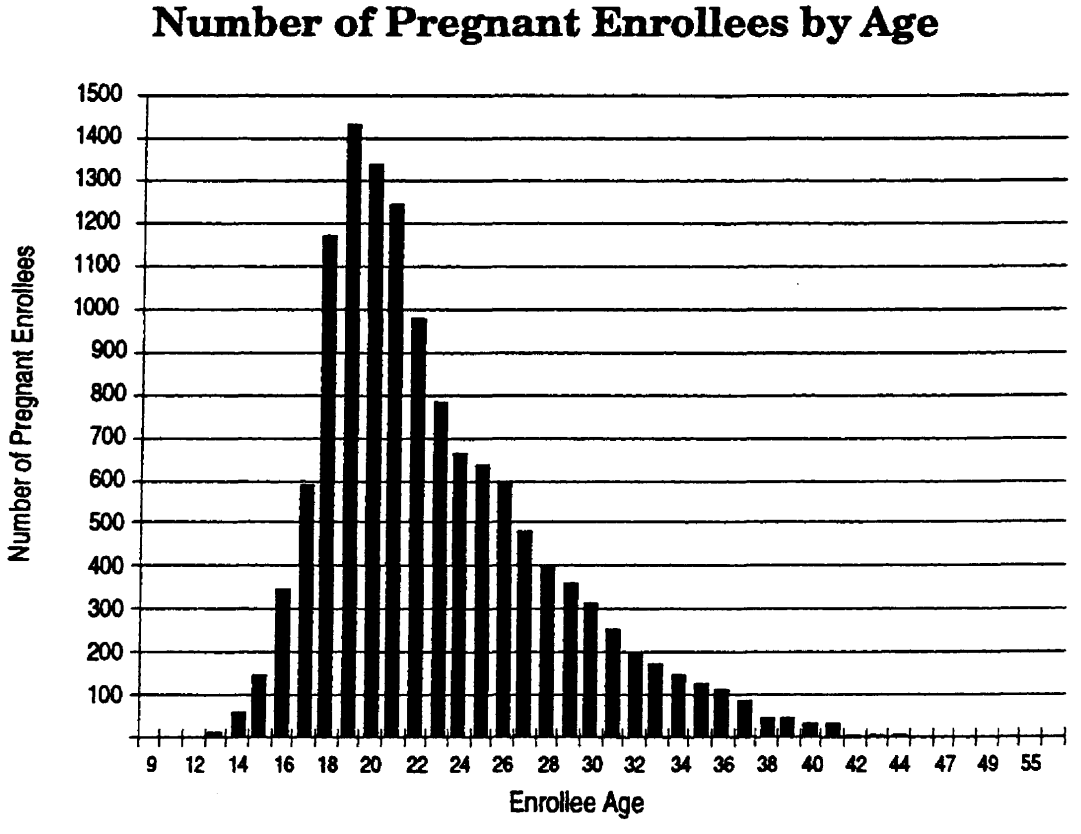
Source: JLARC staff analysis of MCV files of licensed primary care physicians and JLARC/MCV survey of general hospitals on obstetrical and delivery services.

of care for low birth-weight infants." In addition, the report noted that the "vast majority of newborn intensive-care costs are incurred for low birth-weight infants."

Since most of the pregnant women enrolled in the Medicaid program meet the high-risk profile, ensuring that they obtain early and adequate prenatal care may be critical to avoiding adverse pregnancy outcomes. Indeed, Medicaid expansion of coverage to indigent pregnant women was mandated by the federal government in order to improve birth outcomes.

As Figure 15 illustrates, most of the pregnant Medicaid enrollees are between age 17 and 26. Females between the ages of nine and 16 comprise another five percent. In addition, 34 percent of these pregnant women are black. Health statistics indicate that the incidence of low birth weight among black infants is higher than that of the general population and the number of black infants with low birth weights has increased in recent years. In addition, black females — even young black females — have a greater susceptibility to hypertension than other persons, which could further complicate pregnancies. Available literature also suggests that hypertension among black females is often more serious.

Figure 15



Source: JLARC staff analysis of DMAS MMIS eligibility subsystem file in SAS format as of September 23, 1991.

Increasing Primary Care Needs for the Aged May Exacerbate Access Problems for All Enrollees

Projected increases in the elderly population will undoubtedly result in greater numbers of Virginians becoming eligible for Medicaid coverage under the aged category. Medicaid enrollees classified as aged can be expected to have or develop chronic medical conditions and to need an ongoing relationship with a primary care physician. As reported by the Task Force on Indigent Virginians and Their Access to Primary Medical Care in 1989:

> Increases in the number of older Virginians will have a large impact on the need for primary medical care. The elderly are large consumers of health care services due to the incidence and prevalence of chronic illnesses requiring continuous treatment. Approximately 15.8 percent of all physician visits by the year 2000 will be made by persons age 65 and older.

Because of increased numbers of elderly on Medicaid and their increased need for care, access to primary care for all enrollees could become increasingly problematic. Since many enrolled providers do not actively participate in the Medicaid program, it is not clear which providers will fill this gap. Local health department clinics are not required to provide primary care services which are targeted to male adults and the aged. In addition, many primary care physicians that participate in the Medicaid program limit the number of Medicaid enrollees they will accept as patients. However, it is possible that these self-imposed limits may affect other categories of enrollees more than the aged since many of the elderly may be established patients of primary care physicians.

Approximately 70 percent of Medicaid enrollees classified as aged reside at home and are likely to have or need a primary care physician to manage their health care needs. Another four percent of aged Medicaid enrollees receive home- or community-based services, an alternative to institutional placement, or receive community mental health or mental retardation services. Although daily personal and medical care needs for these enrollees are typically provided through nurses or nurse aides, their overall care should be supervised by a primary care physician.

CONCLUSION

Access to primary care is particularly problematic for the Medicaid population. Some of the limited access problems reflect a broader problem of physician availability in Virginia. Nevertheless, participation levels of enrolled providers clearly indicate that Medicaid enrollees experience greater access problems than the general population.

The access problems encountered by Medicaid enrollees need to be addressed, especially since primary care for the Medicaid population appears to be cost-effective. It

can save the State long-term costs associated with extended illness or disability due to the lack of adequate treatment.

These access problems will require long-term solutions and broad strategies to address problems with Medicaid enrollee access as well as the overall problem of primary care physician supply and geographic distribution. The continued shortage of primary care physicians underscores the need to cultivate alternative primary care providers who can deliver care to Medicaid enrollees and provide continuity in the care rendered. Virginia must also educate Medicaid enrollees about appropriate utilization of providers.

As research efforts continue during 1992, JLARC staff will explore ways in which the Medicaid program can alleviate access problems. One area which will be examined is the sufficiency of current reimbursement rates. In addition, staff will identify and evaluate strategies to better link enrollees with providers of care and methods to increase provider participation in the program.

Over the past two decades, many governmental actions have been taken in an attempt to identify access problems and increase the supply of primary care physicians for the general population in Virginia. However, more needs to be done within the Medicaid program to ensure access. Some steps are being initiated to address access problems, but an evaluation on the success of these initiatives may not be completed prior to the end of this study. For example, a Medicaid managed care pilot program, the Medallion program, has been developed for implementation in four localities during a two-year period. It will be important to monitor the managed care program and determine its effect on enrollee access to care.

V. The Medicaid Forecast and Budget Process

Expenditures for the Medicaid program have increased dramatically over the past several years, particularly during FY 1991. These rapid changes have resulted in concern among members of the General Assembly regarding the State's ability to predict the impact of the increases and respond accordingly. In order to address these concerns, it is necessary to evaluate the process used to forecast and budget Medicaid program funding. Therefore, Senate Joint Resolution (SJR) 180 specifically directed the Joint Legislative Audit and Review Commission (JLARC) to review Medicaid forecast and budget methods "to ensure they adequately identify and project the cost of policy changes, service utilization, and new mandates."

The Department of Medical Assistance Services (DMAS) plays a central role in developing the Medicaid forecast and budget and estimating the impact of policy changes and new mandates. However, two other executive branch agencies — the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and the Department of Planning and Budget (DPB) — are important participants in the Medicaid forecast and budget process. Examination of these interagency relationships suggests that a more structured, formal relationship should be established between DMAS and DMHMRSAS so DMAS can more closely review and provide input in DMHMRSAS estimates. On the other hand, DPB's direct involvement in forecasting Medicaid expenditures and the resulting relationship between DMAS and DPB are appropriate and should remain unchanged.

Recent budget bills and other budget documents indicate that the forecasts produced through the executive branch forecast process have generally been accurate. However, some estimation problems in past forecasts were found. In addition, Virginia's forecast accuracy compares favorably with national forecasts and those produced by other states in the southeastern region.

The adequacy of technical aspects of the DMAS forecast model and the overall forecast process were also examined. The forecast model substantially meets the criteria established for the review. However, minor weaknesses were found in certain components of the current model and with model documentation.

Similarly, the process used to forecast and budget for the Medicaid program appears to be sound, but legislative involvement in the process is limited. Due to the increasing significance of funding for the Medicaid program, the General Assembly may wish to consider options for increasing legislative monitoring and oversight of the forecast process. However, the results of this review do not indicate a need for increased legislative involvement at this time.

DEVELOPMENT OF THE MEDICAID FORECAST AND BUDGET

Over the past several years, DMAS has undertaken efforts to enhance the agency's forecasting and budgeting capabilities. For example, the budget division was established as a separate entity from the fiscal division in 1989. Division staffing has increased from four professional staff to a current complement of ten, with emphasis on technical skills related to forecasting and budget execution. These efforts are reflected in the increasingly sophisticated methods being used to project Medicaid funding needs.

The development of the Medicaid forecast has two primary components: (1) projecting baseline expenditures (assuming there are no policy changes or new mandates) and (2) estimating the fiscal impact of policy changes and new mandates. DMAS budget staff develop separate baseline forecasts for discrete elements of the Medicaid budget, focusing efforts on larger expenditure categories. Estimates of funding required for policy changes and new mandates are developed and combined with the baseline forecasts to arrive at the final forecast for the DMAS budget proposal.

Throughout this chapter, the phrases "policy changes" and "new mandates" are used interchangably because they present very similar types of estimation problems. However, policy changes are generally defined as program changes initiated within the State. For example, an increase in physician fees proposed by the executive branch and approved by the General Assembly would be considered a policy change. New mandates are generally defined as program changes initiated by the federal government. For example, the Omnibus Budget Reconciliation Act of 1990 (OBRA-90) requirement that infants under 133 percent of the federal poverty income level be covered by Medicaid throughout their first year of life would be considered a new mandate.

The Medicaid budget is affected by at least two other agencies before it is introduced to the legislature. First, DMAS relies on DMHMRSAS to provide estimates for mental health and mental retardation facilities and community-based services that qualify for Medicaid reimbursement. Past estimation problems experienced by DMHMRSAS suggest that DMAS should more closely review and provide input in the DMHMRSAS estimation process.

Second, DPB develops the final budget bill based on its review of DMAS budget proposals and its own forecast of Medicaid expenditures. The maintenance of a separate forecast for Medicaid expenditures represents an extraordinary level of direct involvement in the DMAS budget development process, compared with most other executive branch agencies. However, due to the size and complexity of the Medicaid budget, this role is appropriate.

Development of Baseline Forecast Utilizes a Variety of Methods

DMAS budget staff develop forecasts for at least 36 separate expenditure codes, which reflect different types of program services (e.g., general hospital, skilled nursing

facility, dental, and outpatient clinic). These separate forecasts are adjusted to account for the impact of policy changes and new mandates, and are ultimately combined to develop the overall budget for the Medicaid program.

Most of the DMAS forecasts are based purely on past expenditure data and utilize either moving average or other more sophisticated smoothing techniques to forecast the baseline expenditures (which do not include new policy changes). A moving average takes the average of a predetermined number of past expenditure data points. The average "moves" as more recent data points replace past data points to project expenditures into the future. Averaging the data has the effect of "smoothing" out large seasonal trends in the data, if they exist. More sophisticated smoothing methods allow the forecaster to weight recent data points more heavily or account for seasonal shifts.

The forecast efforts primarily focus on four specific expenditure codes: nursing facilities (including both skilled and intermediate care facilities), hospitals, physicians, and pharmaceutical services. These four expenditure codes accounted for 77 percent of Medicaid expenditures in FY 1991, excluding administrative costs and most mental health and mental retardation expenditures. Forecasts for these expenditure codes generally use more sophisticated exponential smoothing techniques to project expenditures on the basis of service units and costs per service unit.

One of the more complex forecasts among the four major expenditure codes is developed for nursing facility expenditures. The nursing facility forecast uses a multiple regression technique to project future payments to nursing facilities in the State. Multiple regression attempts to find the best representation of the behavior of a "dependent" variable (in this case, nursing facility expenditures). This representation is based on "independent" variables that may have an impact on, or relationship to, the dependent variable of interest.

Key independent variables used in the nursing facility regression equation include estimates of future service utilization and estimates of fluctuations in the Consumer Price Index. A similar model for hospital expenditures has been developed and is being tested for future use.

At least two separate forecasts are developed for each of the four major expenditure codes, using differing methods or data sources. For example, in addition to the regression-based forecast model for nursing facility expenditures, the budget division develops a comparison forecast using an exponential smoothing technique. The forecasts are compared to actual expenditures. In addition, information may be obtained from program staff who have direct knowledge about program implementation and possible utilization trends. These comparisons and supplemental information are used to arrive at the final baseline forecast for a particular budget category.

Estimating the Impact of Policy Changes and New Mandates Is Difficult

Once the base forecasts have been developed, DMAS budget staff must attempt to factor in the impact of policy changes and new mandates that will take effect during

the fiscal year. Although specific methods for estimating the impact of policy changes vary, depending on the specific type of policy change involved, staff generally follow three basic steps to derive these estimates. Staff must first estimate the size of the affected eligible population. Next, the degree to which the eligible population will utilize the services must be estimated. Finally, the anticipated number of recipients is multiplied by an estimate of the unit cost for the services to arrive at an estimated total cost for the policy change.

Budget staff at both DMAS and DPB acknowledge that projecting the impact of policy changes and new mandates is one of the most difficult aspects of budgeting for the program. They cited four primary reasons for this difficulty. First, because new mandates are frequently intended to serve new eligible populations, there may be little data from which to generate a cost estimate. DMAS budget staff acknowledge they frequently must use whatever data and information are available to make their "best guess" of the impact of the policy change. For example, OBRA-90 required Virginia to cover all children age six and older who were born after September 30, 1983 in families with incomes below the federal poverty income level. DMAS utilized a multi-step process to estimate the number of children who would be affected by the new mandate. The process included several different factors, such as:

- estimating the number of affected children age six and older who were born in Virginia after September 30, 1983
- applying a population growth rate for future fiscal years
- determining the number of children who would fall under the federal poverty income level, including consideration of family income disregards, average family size, and working vs. non-working mothers
- excluding the number of children already covered by Medicaid through other provisions
- estimating the participation rate among the eligible children.

Second, budget staff must determine how policy changes will be added to the baseline forecast. Depending on the type of policy change, the fiscal impact of the change may occur almost immediately. For example, the implementation of a provider fee increase will probably have a one-time, predictably-timed impact. On the other hand, the impact of the policy change may occur over the course of several months. If so, whenever the program begins covering a new group of eligible clients, several issues must be considered, including the speed with which new eligible groups will become enrolled, how quickly they will begin actually utilizing services, and when claims billings will begin reflecting the change.

The forecaster must consider these types of issues in order to estimate how the impact of the policy change should be phased in over the initial implementation period.

Again, although some information may be available to help the forecaster estimate the phase-in period, the process typically involves several subjective judgments.

Third, budget staff must determine the rate at which the data used for the baseline forecasts will capture the impact of the new policy changes. For example, a forecaster may estimate that a policy change that takes effect at the beginning of a fiscal year (July 1) ultimately will have a $100,000 impact on the budget. A baseline forecast produced during the fiscal year, for example in October, would include some of the impact of that policy change. However, the data for the October forecast would only include three months during which the policy change is in effect. Consequently, the data probably would not reflect the full impact of the change. Thus, a time lag normally associated with the implementation of a new policy could affect the quality of the data.

If the forecaster were to add the full $100,000 impact to the October baseline forecast, the forecast could overstate funding needs. Therefore, a certain amount of the anticipated impact of the policy change must be subtracted from the original $100,000 estimate before it is added to the most recent (October) baseline forecast. A simple method to determine the amount by which to reduce the policy change impact would be to assume that the $100,000 should be reduced by 25 percent (to $75,000), since one quarter of the year has passed. However, this method also assumes that expenditures will be equal each month, which may not be realistic. Utilization can be expected to fluctuate significantly from month to month for certain services.

The forecaster faces a similar dilemma when projecting funding needs for future fiscal years. Some policy changes take effect in the middle of a fiscal year, so their full impact must be estimated over the course of at least two fiscal years. When developing the budget for the second fiscal year, the forecaster must attempt to estimate how much the effects of a particular policy change were felt during the first year. Within DMAS, the responsibility for making these determinations is distributed among the budget division's forecasters according to their expenditure code forecast duties.

Fourth, evaluating the accuracy with which policy changes are estimated is problematic because it is difficult to isolate the effects of particular policy changes from other changes in the baseline forecasts. For example, DMAS may anticipate an increase in hospital expenditures due to covering a new eligible population. However, if hospital expenditures do in fact increase, it is difficult to determine how much of the increase is due to covering the new eligible group and how much is due to other factors, such as inflation or increases in utilization by other groups.

The DMAS budget director stated that the division is working toward a more systematic way of prospectively accounting for certain policy changes in the baseline forecasts, rather than projecting them separately and then adding them to the forecast. In other words, the baseline forecast would be used more as a tool for projecting overall increases in program expenditures, including selected policy changes. This would make the forecast error more meaningful in assessing both the baseline forecasts and policy changes that can be anticipated within the baseline forecasts.

Certain External Agency Roles Require Review

The development of the DMAS Medicaid forecast is only one step in the process for developing the overall Medicaid budget. DMHMRSAS and DPB also play significant roles in the development and review of the Medicaid budget. Analysis of these roles indicates that a more structured, formal relationship is needed between DMAS and DMHMRSAS. This would allow DMAS to more closely review and provide input in projections provided by DMHMRSAS. However, DPB's role should remain unchanged.

DMAS Should Review DMHMRSAS Projections More Closely. DMHMRSAS staff project expenditures for most program components for mental health and mental retardation services that are eligible for Medicaid reimbursement. These projections are subsequently added to the DMAS budget proposals. By far, the largest projected component is mental health and mental retardation facility expenditures, which amounted to about $178.7 million in program expenditures in FY 1991. Review of the methodology and for these facility expenditure projections and the forecast performance did not reveal problems.

DMHMRSAS also provides projections for community-based mental health and mental retardation programs, which amounted to about $15.5 million in program expenditures in FY 1991. Problems with the estimates for community-based mental health and mental retardation programs indicate DMAS should be more active in reviewing these estimates.

Funding received from the Medicaid program is projected as a revenue source by DMHMRSAS budget staff. Therefore, if projections of the number of clients and services that qualify for Medicaid reimbursement are overestimated by budget staff, the program experiences a revenue shortfall. To compensate for the shortfall, either additional funding is required or services must be reduced.

This occurred in FY 1991, when DMHMRSAS began implementation of the "Community Medicaid Initiative." One purpose of the initiative was to seek federal Medicaid matching funds for a variety of community mental health and mental retardation services that were traditionally covered solely by State and local funds. The federal matching funds were pursued primarily through amendments to the state Medicaid plan.

In anticipation of receiving federal matching funds for services through the initiative, State general funds flowing directly from DMHMRSAS to the local community service boards (CSBs) were reduced. Instead, State general funds were sent through DMAS to be matched by federal funds. CSBs were then required to bill DMAS for reimbursement of covered services.

Original estimates projected that $60.8 million in services would be eligible for Medicaid reimbursement over the 1990-1992 biennium. In essence, this would mean only $30.4 million in general funds would be required to fund the eligible services, due to the expected receipt of Medicaid federal matching funds. The other $30.4 million in general funds earmarked for the eligible services would be available for other uses.

However, the impact of the initiative was overestimated by DMHMRSAS. As a result, projections of the number of mental health and mental retardation recipients qualifying for Medicaid reimbursement (and the estimated receipt of federal revenues associated with those recipients) were too high. Consequently, CSBs faced a revenue shortfall of $8.5 million ($4.3 million State general funds) in FY 1991 and $11.1 million ($5.5 million State general funds) in FY 1992. Despite the shortfall, DMHMRSAS staff point out that implementation of the initiative still resulted in the replacement of $8 million in general funds with federal revenue in FY 1991 and an estimated $13 million in FY 1992.

In a status report on the progress of the Community Medicaid Initiative, four sources for the overestimate were presented:

- there were fewer eligible clients than anticipated
- the Health Care Financing Administration (HCFA) disallowed coverage of certain services or restricted the scope of the services that could be covered
- the decision to cover certain substance abuse services was deferred
- the number of claims processed and covered in the first year of the initiative was overestimated.

DMHMRSAS staff noted that this represented their first attempt to estimate the number of Medicaid-eligible mental health and mental retardation home- and community-based recipients and the amount of services that qualified for Medicaid reimbursement. Therefore, they had little data or program experience on which to base the estimates.

In addition, because the decision to implement the initiative was not made until July 1989, DMHMRSAS staff had a short time frame in which to develop the estimates. Consequently, the process to develop the estimates was rushed and the CSBs were not included in the initial budget development process. According to DMHMRSAS staff, this exclusion from the initial budget development process led to some difficulties in implementing the initiative. Problems and delays with the process for billing DMAS for services were also encountered by the CSBs.

DMHMRSAS staff stated that three steps have been taken to improve the estimation process. First, they are obtaining more information directly from the CSBs regarding the anticipated number of Medicaid clients. Second, data are now available directly from DMAS on the amounts and historical trends of actual billings, which will improve the ability of DMHMRSAS budget staff to estimate future billings. Third, confusion among the CSBs regarding which services are covered under the initiative has been minimized, which should improve the timeliness of the overall billing and reimbursement process.

Currently, DMAS budget staff make a limited effort to verify the estimates provided by DMHMRSAS. In the past, this practice may have been sufficient because

Medicaid reimbursements were primarily related to clients in State mental health and mental retardation facilities, a population that remained relatively stable.

However, as the new funding initiative is being implemented, funding obligations are more dynamic, particularly for community mental health and mental retardation services. Funds for Medicaid services projected by DMAS are not directly affected if there is an overestimate of DMHMRSAS Medicaid clients. Nevertheless, an underestimate could result in the need to shift funds from other program priorities to cover CSB billings.

Due to the current restrictions on budget growth in the State, continued emphasis on seeking federal Medicaid funding for covered mental health and mental retardation services is anticipated. In fact, the Community Medicaid Initiative originally proposed including substance abuse services. However, implementation of funding these services through the Medicaid program was delayed.

DMHMRSAS and DMAS budget staff assert that a strong working relationship exists between the two agencies. However, as the size of the mental health and mental retardation portion of the Medicaid budget increases, DMAS staff should work more closely with DMHMRSAS staff to enhance the accuracy of the estimates for these services.

Recommendation (4). **The Department of Medical Assistance Services should review the methodology used by the Department of Mental Health, Mental Retardation and Substance Abuse Services to develop the mental health and mental retardation portion of the Medicaid budget. This review should include at least one meeting between the two agencies prior to the Department of Mental Health, Mental Retardation and Substance Abuse Services' formal submission of revenue projections to the Department of Medical Assistance Services. In addition, the Department of Mental Health, Mental Retardation and Substance Abuse Services should provide written documentation, for reference and review purposes, to the Department of Medical Assistance Services on the methods used to estimate mental health and mental retardation revenues related to the Medicaid budget .**

DPB Role Appears Appropriate. DPB staff review DMAS budget proposals, comparing the DMAS forecast estimates to an in-house model of Medicaid expenditures. This information is used, in conjunction with any program initiatives approved by the Governor, to develop the budget bill which is submitted to the General Assembly. DPB does not typically maintain forecasts for State agency programs. However, the DPB Medicaid forecast appears to foster necessary interaction with DMAS budget staff and represents sound forecasting practice for such a significant portion of the State budget.

The DPB forecast model uses an autoregressive integrated moving average technique (ARIMA) to project future baseline expenditures using past expenditure data. Briefly, ARIMA projects data, in this case expenditure data, based on past data values and fluctuations. Adjustments for policy changes and new mandates are reviewed by the

DPB analyst assigned to DMAS and the manager of the health and human services section. They are then added to the baseline forecast.

Expenditures are forecast for four major expenditure categories (hospitals, nursing facilities, physicians, and pharmaceutical services) and an inclusive "other" category, which is intended to capture all other expenditure categories. These figures are compared to DMAS estimates submitted through the budget process. Areas for which there are significant differences are isolated and agency representatives consult with each other regarding those differences. DPB also analyzes DMAS addendum requests (or budget amendment requests for odd-year sessions) to determine which will be funded and at what level. Ultimately, figures for the baseline forecast and approved addenda (or approved budget amendments) are combined to arrive at the final figures in the Governor's budget bill.

Generally, DPB staff only review State agency forecast methodologies and budget submissions. However, separate forecasts are conducted at the agency level for two major expenditure areas: (1) corrections and (2) Medicaid. These two areas are among the largest expenditure areas for the State and utilize a significant portion of available discretionary funds each year. (Special forecasts are also conducted for the Criminal and Involuntary Mental Commitment Fund and ADC caseload. In addition, a forecast of kindergarten through twelfth grade educational expenditures is maintained primarily for policy analysis purposes.)

As a joint state-federal entitlement program, in which State funding obligations are guaranteed, Medicaid represents a spending area that can be volatile and over which the State exercises relatively little control. In the current budgetary environment, DPB's active role in the forecasting of Medicaid expenditures is particularly appropriate. Forecasting literature suggests having more than one independently-derived forecast is desirable. It allows for comparison among differing sets of reasonable assumptions in order to help determine which forecast is most accurate.

Furthermore, forecasting literature suggests that if more than one forecast appears reasonable, it is valid to average these forecasts. In fact, forecasting research indicates that combining forecasts results in better performance on average than the individual methods. According to DPB staff, this situation occurred last year, when the DMAS and DPB forecasts projected different figures for hospital expenditures. When the agencies were unable to resolve the difference, DPB simply averaged the two forecasts together to arrive at the figure for the Governor's budget bill.

In addition, analysis of past DMAS budget submissions and DPB reviews of those submissions indicates at least three other positive effects of maintaining separate forecasts. First, DPB's forecast provides an enhanced level of scrutiny and oversight of projections made for the program. The two agencies often make significantly different, yet independently reasonable, assumptions in estimating the impact of policy changes. Again, given the problems associated with estimating the impact of policy changes, it is better to have two groups generating estimates than one.

Second, separate independent forecasts encourage interaction and information exchange between the two agencies in the development of a significant and dynamic portion of the State budget. Third, documentation of methods used to produce forecasts and estimate policy changes has become more detailed over time, which leads to easier understanding and better accountability of the techniques being used.

ACCURACY OF THE MEDICAID FORECAST AND BUDGET

From the perspective of the General Assembly, the most important consideration regarding the Medicaid forecast and budget is the accuracy with which the budget reflects funding needs for the program. Forecasting is an inexact science and forecast errors are inevitable. However, given the size of the Medicaid budget, even minor errors can result in large budget shortfalls. Two key issues were examined to assess the accuracy of the Medicaid forecast and budget process:

- How well does the information provided to the General Assembly project funding needs for the program?

- How does the performance of Virginia's forecast process compare with forecasts produced by other states?

The Governor's budget bill reflects the executive branch's best estimate of anticipated funding needs for the Medicaid program. Analysis of recent budget bill submissions indicates that from a forecasting standpoint, budget bills have been accurate reflections of funding needs for the program. However, budget shortfalls in FY 1987, FY 1988, and FY 1991 demonstrate that some problems have been encountered in projecting Medicaid expenditures in the past. Increased emphasis on communication and information exchange between DPB and DMAS may help decrease forecast errors in the future.

Virginia's forecasts have generally been more accurate than other states in the mid-Atlantic and southeastern regions and the performance of the overall national forecast. Possible reasons for this success include interaction between DMAS budget staff and program staff, flexibility in adjusting the forecast to reflect changes in the funding environment, and the utilization of a successful forecast methodology.

Budget Shortfalls Indicate Need for Increased Communication Between DPB and DMAS

Comparison of budget bill submissions for the past three fiscal years with actual expenditures for program components (excluding administrative costs) indicates the mean absolute percentage error for the three years examined was only 1.2 percent (Table 7). In forecasting, it is assumed that errors will occur. The goal is to minimize the size of the errors as much as possible.

Table 7

Comparison of Budget Bills to Actual Expenditures for Medicaid, FY 1989 - FY 1991*

Fiscal Year	Budget Bill Projection**	Actual Expenditures	Percent Error
1991	$1,237,774,284	$1,266,436,406	-2.3
1990	979,006,864	972,268,899	.7
1989	870,793,412	864,447,024	.7

*Excludes administrative expenditures.

**Fund amounts listed in the budget bill submitted just prior to the beginning of a fiscal year were used for the analysis. For example, the budget bill submitted for the 1988 General Assembly Session provided the estimates of funding needs for FY 1989.

Sources: JLARC staff analysis of budget bills, FY 1988 - FY 1990, and DMAS unaudited financial statements, FY 1989 - FY 1991.

However, the amount of error that can be tolerated also depends on the consequences of the error. For example, the relatively small percentage underestimate for FY 1991 (-2.3 percent), which was addressed through budget amendments in the 1991 General Assembly Session, still amounted to a shortfall in excess of $28 million.

It is difficult to compare budget bills and actual expenditures prior to FY 1989, due to differences in the budget bill formats for that period. However, a review of budget documents for FY 1987 and FY 1988 also revealed estimation problems during those years. During the last quarter of FY 1987, DMAS requested and received transfers totaling $7.9 million in State general funds from the Governor's contingency fund to cover program liabilities. Including matching federal funds of more than $8.9 million, the total shortfall for FY 1987 was expected to be almost $17 million, or roughly 2.9 percent of the overall FY 1987 Medicaid budget.

More significantly, DMAS was forced to request a deficit treasury loan in FY 1988 of $18 million in State general funds. Matching federal funds for the loan totaled $16.1 million, bringing the total shortfall to more than $34 million, or about 5.2 percent of the overall FY 1988 Medicaid budget. According to DPB staff and available documentation, the underestimate was largely a result of:

- the inability to fully determine the impact of a change in the inflation factor used for hospital and nursing facility reimbursement rates
- unanticipated increases in hospital utilization, lengths of stay, and other unexpected increases in service utilization and inflation

- unaccounted for imbalance in the general fund contribution required for Medicare Part B premiums (a 70 percent general fund match was required instead of the anticipated 48 percent)

- additional impact of liabilities carried forward from FY 1987.

DPB staff asserted that the impact of the inflation factor change and increased utilization were difficult to project because they lacked sufficient data to precisely forecast the changes. Further, DPB staff stated in the deficit loan decision brief submitted to the Governor that they were unaware of the increased general fund requirements for Medicare Part B premiums. No documentation was available regarding the cause of the continued impact of FY 1987 liabilities.

Again, although the percentage shortfalls for FY 1987 and FY 1988 seem relatively small, the funding consequences for a program the size of Medicaid can be substantial. One method for continuing to improve the accuracy with which Medicaid expenditures are forecast would be to encourage information exchange and collaboration between DPB and DMAS budget staff through an established, regular forum.

As will be described in more detail later, DMAS has established a forecast review group which includes key DMAS staff and a representative from DPB. This group attempts to meet on a quarterly basis, according to the DMAS budget director. In addition, DPB staff stated that they now have an open invitation to attend weekly DMAS forecast and budget planning meetings. These appear to be positive steps toward minimizing miscommunication between the agency staffs and improving staff interaction concerning the Medicaid forecast.

Comparison with Other State Medicaid Forecasts Indicates Virginia's Forecasts Have Been More Accurate

All state Medicaid agencies, including DMAS, are required to submit quarterly forecast reports to HCFA to project future funding needs. Using these forecasts as benchmarks (compared either to actual expenditures or the most recent forecast), Virginia's error rate has been lower than the national average over the past two federal fiscal years (Table 8). In addition, with the exception of federal fiscal year (FFY) 1987, Virginia has consistently been more accurate than states in its own region (HCFA Region III) and states in a neighboring region composed mostly of other southeastern states (HCFA Region IV).

The Virginia forecast performed particularly well during FFY 1991, when Medicaid program costs experienced a dramatic increase that was largely unanticipated by most states and the federal government. During FFY 1991, national forecasts had to be revised upward by 16 percent from the November 1989 forecast to account for unanticipated increases in Medicaid program costs. In contrast, Virginia's November 1989 forecast was 7.2 percent higher than projected FFY 1991 expenditures and the May 1990 forecast was within 5.4 percent of projected FFY 1991 expenditures.

Table 8

Percentage Forecast Errors From Selected Quarterly Submissions FFY 1987 - 1991 to HCFA for Virginia, HCFA Regions III and IV, and the Nation*

Submission	Virginia	HCFA Region III**	HCFA Region IV***	Nation
FFY 1991				
November 1989	7.2%	-20.9%	-17.1%	-15.8%
May 1990	-5.4	-17.9	-8.6	-11.6
FFY 1990				
November 1988	2.6	-4.4	-6.4	-5.7
May 1989	4.0	-2.8	-4.3	-4.4
FFY 1989				
November 1987	3.4	-3.2	-3.9	-3.2
May 1988	3.4	-2.8	-2.3	-1.5
FFY 1988				
November 1986	-4.2	-6.7	-5.4	-3.1
May 1987	3.9	-3.8	-3.9	-2.3
FFY 1987				
November 1985	-7.0	-6.6	1.3	-2.7
May 1986	-9.0	-7.5	2.0	-2.7

*Forecast errors were calculated by subtracting actual expenditures from projections (or, in the case of FFY 1991, subtracting the most recent projection from past projections).

**HCFA Region III: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia

***HCFA Region IV: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

Source: JLARC staff analysis of HCFA State-Specific Waterfall Charts, FFY 1987 - 1991.

The forecasts submitted to HCFA are generated entirely by DMAS and are not reviewed by other State agencies, including DPB. It is important to note that these forecast reports are produced for federal government use and do not have a direct relationship to the State budget process.

The two submissions provided for comparison are particularly important in the federal budget development process: the November submission and the May submission

for the subsequent fiscal year. For example, the November 1990 submission and the May 1991 submission are used to develop the federal Medicaid budget for FFY 1992. The November submission is used to develop the Medicaid portion of the President's budget. The May submission is used to update the President's budget and is typically used by the U.S. Congressional appropriations committees to set the federal Medicaid appropriation for the upcoming federal fiscal year.

The U.S. Department of Health and Human Services (HHS) and the Office of Management and Budget (OMB) formed a special task force to investigate possible causes of the generally poor forecasts and isolate effective forecast practices among states that were more successful (Exhibit 5). Information collected by JLARC staff through document analysis and interviews with DMAS staff indicate that the forecast process within DMAS generally incorporates the six effective practices identified by the HHS/ OMB task force.

Exhibit 5

Effective State Medicaid Forecasting Practices Identified by HHS/OMB Task Force

- A direct link between a state's budget and estimates submitted to the federal government on the HCFA-25 forms improves the accuracy of federal estimates.
- The forecast process should be open. Budget office staff should be aware of program changes and judgmental adjustments should be openly reviewed.
- Sound budget concepts should be employed. When possible, the framework on which the forecast and budget are based should be flexible enough to allow changes in the estimates.
- Automated systems should be sufficient to handle large amounts of data.
- Budget staff should have a combination of quantitative, analytic, and programming skills.
- A successful forecast methodology should be employed. In particular, separate estimates should be developed for baseline spending and program changes. Forecasts for major expenditure categories should typically use the classic expenditure model:

Expenditures = Caseload x Average Utilization x Price.

Source: HHS/OMB Medicaid Management Review, Team Reports, 1991.

First, the expenditure categories used by the DMAS budget office for forecast purposes closely reflect those of the HCFA-25 form, which is used to report forecast estimates to the federal government. Second, there appears to be frequent contact between DMAS budget staff and DMAS program staff regarding program changes that may have a fiscal impact.

Third, because the HCFA-25 submissions are not directly tied to the State budget process, DMAS has the flexibility to unilaterally adjust the estimates submitted to the federal government. In other states, the submissions may reflect "official" estimates, such as budget documents, which may not be accurate reflections of what the Medicaid agency staff believe will happen. For example:

> *In one of the states reviewed by HHS/OMB staff, the budget submitted to the legislature was consistently less than the actual projections. The governor of this state used this strategy to allow him to request additional funds for other programs because the legislature had a history of approving all supplemental funding requests for Medicaid. If the intentionally low budget figures were submitted to the federal government on the HCFA-25, substantial errors would result.*

Fourth, budget staff indicate that computer resources are adequate to handle the large amounts of data necessary for analysis and budget development. Most analysis is performed on personal computers with data that are extracted from the State's mainframe.

Fifth, DMAS budget staff appear to possess the combination of skills recommended by the HHS/OMB task force. As part of the effort to increase staffing in the DMAS budget division, special attention has been given to hiring candidates with extensive quantitative skills and computer backgrounds.

Sixth, the methodology used by DMAS incorporates the components suggested by the task force report. As noted earlier, baseline spending and program changes are estimated separately. In addition, the classic expenditure model recommended by the HHS/OMB task force is used for estimating the major expenditure codes and most policy changes.

ADEQUACY OF DMAS FORECAST MODEL AND PROCESS

As part of this review, criteria were established to evaluate: (1) the adequacy of the DMAS forecast model and (2) the overall forecast process. Criteria to assess the adequacy of the forecast model were used to examine the more technical aspects of the model and its administration, such as the degree to which staff understand model assumptions, the definition and measurement of model variables, and the mathematical soundness of forecast equations. The criteria used to evaluate the overall forecast process focused on such concerns as personnel and data adequacy, regular reporting of forecast errors, and outside review of forecast methodology.

The DMAS forecast model and overall process meet most criteria identified by JLARC staff. However, some limitations were noted in certain components of the model, model documentation, data available for forecasting purposes, and provisions for expanded forecast review. In addition, legislative involvement in the current process is limited. The General Assembly may wish to consider options for increasing legislative involvement in the Medicaid forecast process.

DMAS Should Continue Improvements to Forecast Model and Documentation

The criteria for evaluating forecast models were adapted from the JLARC review titled *Revenue Forecasting in the Executive Branch: Process and Models*, which was released in January 1991. Although there are some differences in specific requirements for revenue forecast models, many of the same principles apply to forecasts of any type.

Exhibit 6 summarizes the criteria and the compatibility of the DMAS forecast with those criteria. The DMAS model substantially conforms with four of the six identified criteria (criteria 1, 3, 4, and 5). However, the model and its administration could be improved in at least two areas. First, DMAS should continue steps to move toward unit-based forecasts. Second, although process documentation exists, some of the documentation should be updated to reflect current practices and policy adjustments.

DMAS Model Conforms with Most Forecast Model Criteria. Interviews with DMAS budget staff and review of model documentation indicate a clear understanding of the assumptions built into the model (criterion 1). This includes a healthy skepticism of the model and cross-checking of major components with other models to determine reasonableness.

JLARC staff also examined the formats used to develop forecasts for the four major expenditure categories to determine if the equations used are mathematically sound (criterion 3). The physician and pharmaceutical services forecasts utilize spreadsheets that compile appropriate data and perform an exponential smoothing technique. The spreadsheet equations appear to accurately reflect documentation of the technique. Equations used for development of the nursing facility forecast and proposed for use in developing the hospital forecast are incorporated in a nationally-recognized software package.

The DMAS model also conforms with criterion 4, accounting for regional conditions. Although regional conditions are not explicitly considered in the forecast model, differences are implicitly accounted for in the model. This is achieved, at least for institutional providers, because the expenditure data used in the forecast reflect reimbursement rates based in part on individual provider cost reports. Therefore, if an institutional provider in Northern Virginia has higher costs, these costs are accounted for in its reimbursement rate and the expenditures for that facility.

Exhibit 6

Criteria for Evaluating Forecast Models and their Administration

	DMAS Model
1. Model assumptions are clearly understood by participants and periodically reviewed.	✔
2. Predictor variables used in models' equations are sufficient, accurately measured, and the best information available at the time.	?
3. Equations are mathematically sound and tested to ensure mathematical precision.	✔
4. Different regional conditions are taken into account sufficiently.	✔
5. Forecast errors are analyzed on an ongoing basis.	✔
6. Forecast models are reviewed and documented well, including any judgmental or policy adjustments	?

Key:

✔ = **Meets criterion** X = **Does not meet criterion.**

? = **Question concerning whether fully meets criterion**

Source: Adapted from *Revenue Forecasting in the Executive Branch: Process and Models*, JLARC, 1991.

Furthermore, the audit and cost settlement division produces forecasts for nursing facilities and hospitals, which are used by the budget division for comparison to other forecasts. The cost settlement and audit division forecasts also account for differences among individual providers.

DMAS conforms with criterion 5, which requires that forecast errors be analyzed on an ongoing basis. Since August 1990, the budget division has produced a monthly forecast tracking report, which provides a summary of forecast predictions as compared to actual expenditures for each object code. Budget analysts monitor forecast errors in their specific areas of responsibility.

DMAS Efforts to Improve Forecast Model Should Continue. The DMAS forecast model does not fully conform with the criterion related to the sufficiency, accuracy, and adequacy of the variables used in forecast model equations (criterion 2). The forecast model may not sufficiently account for factors that affect program expenditures. However, methodological changes already implemented or proposed by the budget division should address this shortcoming.

Most components of the model rely heavily on past expenditure data to predict future expenditures. Although data appear to accurately reflect actual expenditures, over-reliance on expenditure data can be a weakness, particularly during a period of rapidly increasing or decreasing inflationary pressures. Past expenditure data would not necessarily account for these types of adjustments. In addition, it is difficult to separate the effects of inflation and utilization. For example, inflation may occur at a relatively stable and predictable pace, but an unanticipated increase in utilization may cause expenditures to jump unexpectedly.

This potential weakness highlights the significance of the budget division's attempt to move toward unit-based forecasts, particularly for the major expenditure categories. Documentation of model components indicates that the budget division plans to utilize unit-based forecasts for the expenditure codes when appropriate. These efforts are still in the early stages, but should receive a high priority in order to improve the comprehensiveness of the overall forecast model.

Documentation of Forecast Model and Policy Changes Should Be Updated. Criterion 6 requires that forecast models be reviewed and documented, including any judgmental or policy adjustments. JLARC staff reviewed documentation maintained for forecast model components. The documentation comprehensively described methods for performing baseline projections for specific expenditure codes. However, methodological documentation for several expenditure codes was dated and no longer reflected current practice. In addition, documentation of judgmental inputs or policy changes is not routinely maintained for outside review.

Detailed documentation is important for at least two reasons. First, documentation provides a historical record of past methods and adjustments. This record can be particularly important if turnover occurs in key forecasting positions and it is necessary to compare past methods with newer methods. Second, detailed documentation provides an increased degree of accountability. Therefore, decisions made about forecast components can be tracked to specific analysts if methodological questions arise.

Recommendation (5). **The Department of Medical Assistance Services should ensure that sufficient and timely documentation exists for each component of the Medicaid forecast. In the event that judgmental adjustments are made to the baseline components of the forecast, or the anticipated effects of policy changes are added to the forecast, these adjustments or changes should be identified in the forecast documentation.**

Continued Improvements in Data and Forecast Review Could Enhance Overall Forecast Process

Criteria were identified and adapted from a variety of sources to assess the overall process for developing the Medicaid forecast, from its inception at DMAS to final inclusion in the budget bill (Exhibit 7). The assessment indicated the process fully conforms with three of the five criteria.

Problems noted with the process are relatively minor. First, the data available to make unit-based forecasts have a relatively short data history. Second, although a

Exhibit 7

Criteria for Evaluating Forecasting Processes

	Virginia Process
1. The degree of uncertainty associated with forecasts should be understood by process participants.	✔
2. The agency making forecasts should have the data and personnel required to generate a good estimate.	?
3. Regular reports on actual expenditures and their variance from forecasts should be developed and available to agency staff and interested external participants, as appropriate.	✔
4. The process should maintain the flexibility to respond to dramatic changes in recipient utilization and program expenditures by revising the forecasts.	✔
5. The process should include a mechanism requiring some level of expanded review of the forecasts.	?

Key:

✔ = Meets criterion X = Does not meet criterion.

? = Question concerning whether fully meets criterion

Source: Adapted from *Revenue Forecasting in the Executive Branch: Process and Models*, JLARC, 1991.

mechanism exists for expanded review of the Medicaid forecast, DMHMRSAS involvement is limited. Provisions should be made to include DMHMRSAS staff on the review panel as appropriate.

In addition, the General Assembly may wish to consider options for increasing legislative involvement in the Medicaid forecast process. SJR 180 requests JLARC to determine "how the legislative branch could increase its capacity to more closely monitor Medicaid forecasts and expenditures." Options include maintaining a limited review role, engaging in a stronger technical assessment role, or developing an independent legislative role.

Overall Process Conforms with Three Process Criteria. The process used to forecast Medicaid expenditures fully meets process criteria 1, 3, and 4. Interviews with representatives involved in the development of the Medicaid forecast indicate that participants are cognizant of the potential weaknesses of the forecast methodologies (criterion 1). Forecast methodologies generally rely on past data experience to project future data behavior. Many forecast methodologies can successfully project data in the short term.

However, the longer the period between forecast development and the event being forecast, the more likely error is to occur. Furthermore, because of the reliance on past data, forecasts are unable to account for unanticipated "shocks" in the data. For example, a forecast based on data from past periods could not have anticipated the increase in Medicaid utilization due to the recent recession.

In addition, regular reports of forecast performance are developed by DMAS staff and are available to other DMAS staff and DPB staff (criterion 3). For example, forecast tracking reports and other information are obtained by DPB budget staff from DMAS budget staff for several months beyond the formal date for agency budget submissions. This allows DPB staff to use the most up-to-date DMAS information in their development of the budget bill.

Finally, the DMAS forecast allows for adjustments to be made in response to changes in service utilization and/or expenditures (criterion 4). The monthly review of forecast errors by DMAS budget staff allows them to isolate and investigate the sources of large errors. According to the DMAS budget director, this generally involves contacting DMAS program staff to determine if there have been unanticipated fluctuations in utilization, claims processing delays, client enrollment problems, or some other problem that could explain the error. The budget staff can then determine if these problems should be accounted for in future forecasts.

Data History for Unit-Based Forecasts Is Limited. Criterion 2 asserts that the agency generating a forecast should have the data and personnel required to generate a good estimate. Staffing increases at DMAS and the DPB staff resources dedicated to Medicaid forecasting appear to address a portion of this criterion. However, the data may be somewhat limited due to the lack of historical information.

Depending on the forecast methodology being used, forecasting literature recommends a minimum of 50 data points or observations. Substantially longer data histories (96 to 120 observations, or eight to ten years of monthly data) are recommended, when possible. The data set utilized for the unit-based forecasts produced by DMAS was developed slightly more than three years ago, in August 1988. Data are produced on a monthly basis, which means that the data set is composed of fewer than 40 observations.

This is not a major concern because there are valid statistical techniques available to "initialize" or manipulate the data to account for short data histories. DMAS staff recognize the relatively short data history as a potential shortcoming and closely monitor the data for unexpected changes or anomalies.

DMHMRSAS Representative Should Be Included in Forecast Review Process. The current overall forecast process provides for expanded review of the methodologies used in the forecast. However, participation in this review is limited to selected staff from DMAS and DPB. Provisions should be made to include DMHMRSAS budget staff in the review, when appropriate.

During the spring of 1991, the DMAS budget director formed a forecast review panel to establish a consistent forum for review of the methods used in the DMAS forecast. The panel consists of both DMAS deputy directors, the DMAS budget division director, the policy division director, the fiscal division director, and a representative from DPB. The panel attempts to meet quarterly and has met three times in 1991.

According to the DMAS budget director, meetings typically deal with technical aspects of forecasting major components of the DMAS forecast. Smaller components of the DMAS forecast and mental health and mental retardation components are not currently included in the review. However, as mentioned in the previous section, mental health and mental retardation program components projected by DMHMRSAS comprised 15 percent of the total Medicaid budget in FY 1991. In addition, Medicaid funds will continue to be pursued as a revenue source for expanded mental health and mental retardation services.

Since DMHMRSAS budget staff are not involved in the development of the overall budget, a permanent position on the review panel may not be necessary. However, the methods used to develop the State mental health and mental retardation component should be exposed to an expanded review.

Recommendation (6). **The Department of Medical Assistance Services forecast review panel should be expanded to include Department of Mental Health, Mental Retardation and Substance Abuse Services staff as appropriate. Participation should include a presentation and review of the methods used to develop the State mental health and mental retardation services component of the Medicaid forecast at least once each year.**

Additional Legislative Monitoring of the Medicaid Forecast and Expenditures Does Not Appear Necessary at this Time. Beyond the normal scrutiny of the budget that occurs during General Assembly sessions, legislative monitoring of the Medicaid forecast and expenditures is limited to reviews conducted by staff to the Senate Finance Committee and the House Appropriations Committee. SJR 180 requests that JLARC explore methods for increasing this monitoring capacity.

There are at least three ways in which legislative monitoring and oversight of the Medicaid forecast and budget could be implemented. First, the current method of limited review conducted by selected legislative staff could be continued. One of the main advantages of this method is that no additional staff time or resources would be required. Given that the JLARC staff review found only relatively minor problems with the forecast, a more substantial role may not be needed. The primary disadvantage is that the legislative branch would continue to have a limited capacity for monitoring these expenditures, despite the rapid increases being experienced in the Medicaid program. As illustrated earlier, even minor errors can result in large shortfalls in the program, about which the General Assembly may not be notified until relatively late in the budget development process.

Second, the legislative branch could engage in a stronger technical assessment role. This could be achieved through periodic review of Medicaid forecast methodologies by legislative staff, possibly staff from the legislative money committees, as part of the existing review panel. This option has several advantages, including providing a mechanism for early information exchange between the legislative branch and the executive branch regarding the Medicaid budget. In addition, it would provide the opportunity for legislative input in the forecast and budget development process, at least in an advisory capacity. Finally, oversight of the Medicaid budget and forecast process would be significantly increased.

One disadvantage of this option is the increase in staff time and resources required to participate and prepare for the reviews. In addition, although legislative staff are periodically requested to review funding policies, there is no precedent for the proposed level of legislative staff involvement in the review of the technical components of the Medicaid forecast.

The third option is the development of an independent legislative forecast for the Medicaid program. This would provide the General Assembly with the strongest position for monitoring Medicaid budget requests, as well as earlier notification of potential problems in funding the Medicaid program. In addition, there is the presumption that having a third independent forecast to factor into the process would further enhance the accuracy of the forecast.

However, there are several disadvantages to this option. First, developing an independent legislative Medicaid forecast would require substantial staff time and resources. Additional staff could be required to perform this function. Second, it could delay the legislative appropriations process while there is debate over which forecast figure should be used.

Third, development of an independent legislative forecast on a regular basis for an executive branch program is unprecedented in the State. Furthermore, a JLARC survey of nine other state Medicaid programs (California, Kentucky, Maryland, New York, North Carolina, Pennsylvania, Tennessee, Texas, and West Virginia) revealed that only three of these states (Maryland, New York, and Texas) develop independent legislative forecasts. Texas has a legislative agency specifically dedicated to developing an alternative legislative budget.

However, forecasts developed by states with independent legislative forecasts have generally not been more accurate than Virginia's forecast, particularly for FFY 1991. The mean average percentage error for those states in FFY 1991 (using the May 1990 submission to HCFA) was 16.9 percent, compared to 5.4 percent for Virginia.

The overall findings of the review do not suggest an enhanced level of legislative oversight is warranted at this time, especially if additional legislative staff resources are required. Recent forecasts have generally been accurate, and relatively minor problems were found with the forecast model and process. In addition, planned improvements should address several of the shortcomings noted during the review. Nevertheless, the General Assembly may wish to direct JLARC staff to continue monitoring the Medicaid forecast and budget process during the remainder of the study, which is scheduled to conclude prior to the 1993 General Assembly session.

Recommendation (7). **Given the relative accuracy of recent Medicaid forecasts and the overall adequacy of the forecast model and process, increased legislative monitoring of the Medicaid forecast and expenditures is not required at this time.**

Appendixes

Appendix A

Senate Joint Resolution No. 180

Requesting the Joint Legislative Audit and review Commission to study the Commonwealth's Medicaid program and the indigent care appropriations to the state teaching hospitals and the Medical College of Hampton Roads.

Agreed to by the Senate, February 19, 1991
Agreed to by the House of Delegates, February 15, 1991

WHEREAS, a goal of the Commission on Health Care for All Virginians is to provide access to basic health care for all Virginians; and

WHEREAS, approximately 330,000 persons in Virginia are eligible for the Medicaid program, but an estimated 300,000 additional Virginians in poverty have no health insurance; and

WHEREAS, the number of Virginians eligible for Medicaid has increased by only 10 percent during the last 10 years, but Medicaid expenditures in Virginia have tripled during that period; and

WHEREAS, costs in the 1990-92 biennium are expected to be more than 40 percent greater than the costs in the 1988-90 biennium; and

WHEREAS, the Medicaid program now represents about 12 percent of the Commonwealth's general fund budget, with an estimated $1.4 billion (general fund) cost for the 1990-92 biennium; and

WHEREAS, Medicaid costs will continue to escalate at a rapid rate as inflation in health care costs far surpasses other goods and services; and new federal mandates are likely to continue as Congress expands health insurance for the elderly, disabled, and poor through Medicare and Medicaid; and

WHEREAS, federal mandates establish the core of the Medicaid program, but states can partially shape the benefits and costs through policy adjustments in reimbursement rates for service providers; services offered to recipients; utilization review to ensure appropriate care; and eligibility for groups of persons, and to some extent, how much recipients pay for their own care; and

WHEREAS, University of Virginia Medical Center, Medical College of Virginia Hospitals, and the Medical College of Hampton Roads provide a significant amount of care to low-income persons and receive state support for this care through Medicaid and direct general fund appropriations; now therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Legislative Audit and Review Commission be requested to study the Virginia Medicaid program and the indigent care appropriations to the state teaching hospitals and the Medical College of Hampton Roads.

The study shall include, but not be limited to:

1. Assessment of the cost savings and health policy implications of limiting the scope or duration of optional services, or adjusting recipients' contributions to their care;

2. Examination of the interpretation of federal requirements to determine if they have been implemented in the most effective and least costly manner;

3. Determination of the effectiveness of current utilization review procedures in controlling costs and exploration of additional options;

4. Evaluation of reimbursement methods to determine if they adequately encourage cost effective delivery of services;

5. Determination of the sufficiency of reimbursement rates to provide quality care at the lowest required cost;

6. Review of budget and forecasting methods to ensure that they adequately identify and project the cost of policy changes, service utilization, and new mandates;

7. Determination of how the legislative branch could increase its capacity to more closely monitor Medicaid forecasts and expenditures;

8. Exploration of the costs of alternative administrative methods for implementing program requirements and options;

9. Examination of the relationship with other State programs to promote optimal utilization of State funds;

10. Identification of options for using Medicaid funds for services currently supported with general funds; and

11. Review of eligibility, scope of services, and reimbursement rates for indigent care at University of Virginia Medical Center, Medical College of Virginia Hospitals, and the Medical College of Hampton Roads, and a determination of the appropriateness of general fund and Medicaid allocation methodologies.

All agencies of the Commonwealth shall provide assistance upon request to the study as appropriate.

The Joint Legislative Audit and Review Commission shall complete its work in time to submit its findings and recommendations to the Governor and to the 1993 Session of the General Assembly, and shall provide interim reports to the Commission on Health Care for All Virginians and to the 1992 Session of the General Assembly and at other times as appropriate, using the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix B

Classification of Virginia Medicaid Enrollees

Chapter II of this interim report provides information on six major categories of eligibility for Medicaid enrollees:

(1) ADC-related enrollees

(2) SSI-related aged enrollees

(3) SSI-related blind enrollees

(4) SSI-related disabled enrollees

(5) indigent pregnant women

(6) indigent children.

Applicants must meet the profile of one of these categories before their eligibility for Medicaid can be assessed. Within each major category, however, there are several discrete groups of enrollees. Some of these enrollees receive mandatory coverage through federal statute, while others are optional groups that the State elected to cover beginning in 1970. The table for this appendix includes a comprehensive list of all eligibility categories which are covered through the Virginia Medicaid program. In addition, the table also provides the year that Virginia initiated coverage of each group, and the number of enrollees in each category as of September 23, 1991.

Classification of Virginia Medicaid Enrollees

Classification	Date Coverage Added	Number of Enrollees 9/23/91
Mandatory Categorically Needy		
Individuals receiving or deemed to be receiving ADC		
ADC money payment	1969	174,288
ADC-Unemployed Parent	1990	2,080
Title IV-E children	1981	3,151
Individuals receiving or deemed to be receiving SSI		
Aged	1969	34,148
Blind	1969	900
Disabled	1969	49,446
Categorically needy non-money payment ADC or SSI	1969	22,246
Children younger than age 2 born to Medicaid-eligible mother	1984	6,093
Children younger than age 6	1990	35,424
Pregnant women	1985	12,784
Children age 6 and older born after 9/30/83*	1988	3,043
Qualified Medicare Beneficiaries	1989	10,143
Qualified Disabled and Working Individuals	1990	3
Optional Categorically Needy		
Individuals in institutions or community-based care waiver programs at a special income level	1982	5,004
Auxiliary Grant recipients	1974	5,841
Children younger than age 21 in a nursing facility	1972	36
Optional Categorically Needy (continued)		
Children in state/locally funded subsidized adoptions	1986	197
Corrections children	1976	224
Foster care children		2,832
Public agency	1970	
Private agency	1984	
Optional Medically Needy		
Aged	1970	16,015
Blind	1970	80
Disabled	1970	3,308
Corrections children	1976	10
Foster care/adoption assistance children	1970	289
ADC and ADC-Unemployed Parent	1970**	5,929
Pregnant women	1984	80
Children younger than age 8 born after 9/30/83	1988	708
Children younger than age 2 born to Medicaid-eligible mother	1984	141
Refugees	mid-1970's	867
TOTAL		**395,310**

*This group became mandatory on 7/1/91. Previously some of them were classified as medically needy.

**ADC coverage was added in 1970 but ADC-Unemployed Parent was added in 1990.

Source: JLARC staff analysis of DMAS MMIS eligibility subsystem file in SAS format as of September 23, 1991.

Appendix C

Medicaid Service Benefit Limits and Waiver Services

SERVICE BENEFIT LIMITS

The following is a listing of some of the most common Medicaid service benefit limits provided by the Department of Medical Assistance Services as of March 29, 1991.

General Exclusions from Coverage

- experimental procedures
- acupuncture
- autopsy examinations
- unkept appointments

Inpatient Hospital

Limited to 21 days in a spell of illness for adult patients when the patient's condition meets the intensity of service criteria. Excluded are admissions for:

- organ transplants other than kidney and cornea
- surgery when the procedure could be performed on an outpatient basis
- alcoholism and drug abuse rehabilitation

Physician Services

Limited to:

- 26 sessions of individual psychotherapy without pre-authorization
- one annual comprehensive office visit
- one annual extended office visit
- pap smears once each six months
- house calls only for patients who are bedridden and for whom a trip to a physician's office is inadvisable

Physician Services (continued)

- one nursing home visit (intermediate and extended) per month
- abortions only when the life or health of the woman is endangered
- sterilizations only for individuals older than age 21 who are mentally competent and who give informed consent in advance
- surgery for morbid obesity only under limited conditions
- mandatory second surgical opinions for designated procedures is required

Physician services are not covered for the following:

- cosmetic surgery
- elective surgery unless preauthorized
- transplant surgery except for kidneys and corneas
- experimental surgery
- inpatient surgery that could be performed on an outpatient basis

In most cases, individual consideration may be requested if the physician feels that there is medical justification for coverage differing from the above limits.

Dental Services

Services are limited to children except for limited oral surgery for adults. Exclusions include:

- bleaching of teeth
- pulp vitality tests
- occlusal adjustments
- gingeval curettage
- cavity liners and intermediate bases under restorations
- minor scaling associated with routine prophylaxis
- prescriptions, biologicals or supplies
- local anesthesia

Pharmacy

Limited to legend drugs except for:

- insulin
- needles and syringes for diabetics
- glucose test strips for children
- family planning drugs and supplies
- specific therapeutic categories for nursing home patients

Exclusions include the following:

- anorexiant drugs for weight loss
- transdermal delivery systems
- DESI drugs
- investigational/experimental drugs or drugs which have been recalled
- dietary or nutritional supplements that are not legend drugs
- vaccines for routine immunizations
- drugs whose manufacturer does not have a rebate agreement with the federal government

Optometry Services

Services are limited to children only. In addition, the following limits apply:

- eyeglasses provided once every two years
- inpatient visits for the number of days approved for the hospital stay only

Maternal and Infant Care Coordination

Services are limited to high risk pregnant women and children up to age one.

Nursing Facility Care

Services are limited to individuals approved by the Nursing Home Preadmission Screening Committee.

Early and Periodic Screening, Diagnostic, and Treatment Services

Services are limited to individuals under 21 years of age. Comprehensive screenings are covered when scheduled according to the Periodicity Schedule.

Laboratory Services

The following exclusions apply to laboratory services:

- sensitivity studies when a culture growth shows no growth or urine cultures with containment growth (10^3 or less) - payment will only be made for the culture
- syphilis testing — specimens should be sent to the State Laboratory, payment will only be made for specimen handling and/or conveyance
- forensic tests

Mental Health Clinic Services

The following exclusions apply:

- remedial education
- day care
- social behavior modification
- psychological testing done for purpose of educational diagnosis, school or institution admission, and/or placement, or on court order
- rehabilitative alcoholism and drug abuse therapy
- socialization
- play therapy
- occupational therapy

Mental Health Clinic Services (exclusions continued)

- inpatient care
- telephone consultations
- mail order prescriptions

Podiatry Services

Services are limited to treatment of diseases of the foot — amputation of the foot or toes is not covered. The following limits apply:

- X-rays above the foot and ankle are not covered
- routine palliative trimming of corns, warts or calluses is generally not covered (exception when pathological condition is present)

Prosthetic Devices

These are limited to artificial arms and legs, and the items necessary for attaching the prostheses, when preauthorized. Exclusions include:

- orthotic devices, spinal, cervical, thoracic, or sacral
- orthopedic footwear or modifications
- breast prostheses
- trusses

Special Prenatal Services

Services are limited to the following:

- patient education — six sessions of group education
- nutritional education — limited to initial assessment and two follow-up visits
- homemaker education — not to exceed four hours per day for 28 days

All waiver services are federal options. However, the General Assembly has mandated the development of a full range of waiver services. A general limitation applied to all waiver services is that these services are available only to individuals who would be institutionalized at Medicaid expense except for the waiver services. Individual service limits are spelled out in each waiver.

Elderly and Disabled Waiver

This waiver program covers the provision of personal care services, adult day health care, and respite care.

Personal Care Services:

- instituted in 1982
- designed to provide home based personal care services to elderly and disabled individuals who are determined to be at risk of nursing home placement
- covered services include assistance with activities of daily living (bathing, feeding, dressing, toileting, mobility, etc.), minimal housekeeping services and meal preparation, shopping, bowel and bladder programs, routine wound care, range of motion exercises, and supervision
- services are limited to those activities that can be safely performed by a nurse aide

Adult Day Health Care:

- instituted in July 1989
- designed to provide personal care services in a congregate daytime setting to elderly and disabled individuals who are determined to be at risk of nursing home placement
- covered services include assistance with activities of daily living, nursing care, coordination of physician ordered rehabilitation services (physical therapy, occupational therapy, and speech-pathology therapy), nutrition (one meal a day must be provided), emergency transportation to or from the center, care coordination, and recreational/socialization activities

Elderly and Disabled Waiver (continued)

Respite Care:

- instituted in July 1989

- designed to provide personal care and nursing services in the home on a temporary basis to elderly or disabled individuals who are at risk of nursing home placement when the live-in caregiver requires a temporary relief or respite

- covered services include assistance with activities of daily living, minimal housekeeping services and meal preparation, supervision, bowel and bladder programs, range of motion exercises, routine wound care, skilled nursing services that can be provided by a licensed practical nurse, registered nurse supervision

Technology Assisted Children Waiver

Technologically assisted children waiver services were instituted in 1988 as a waiver program covering ventilator dependent children. The waiver was extended in 1990 to cover a broader group of technologically assisted children.

- designed to provide private duty nursing in the home to children (age 20 and younger) who are chronically ill or severely impaired and require mechanical ventilation at least part of the day or prolonged intravenous administration of nutritional substances or drugs, or have daily dependence on other device-based respiratory or nutritional support, and who are at risk of admission or prolonged stay in a hospital, nursing facility, or other long-term care facility

- covered services include private duty nursing, respite care, medical supplies and equipment not otherwise available under the State Plan for Medical Assistance

Mental Retardation Waiver

- implemented in January 1991

- designed to provide training, residential support, day support, and case management to mentally retarded individuals who are at risk of institution-alization

- covered services include training, assistance and supervision to enable the individual to maintain or improve his/her health, development and physical condition (monitoring of health status, medication and need for medical

Mental Retardation Waiver (continued)

assistance), assistance and training in performing activities of daily living, training and use of community resources (shopping, transportation, social and recreational events), training in intellectual, sensory, motor and affective social development, consultation for caregivers in implementation of an individual program plan, and case management services

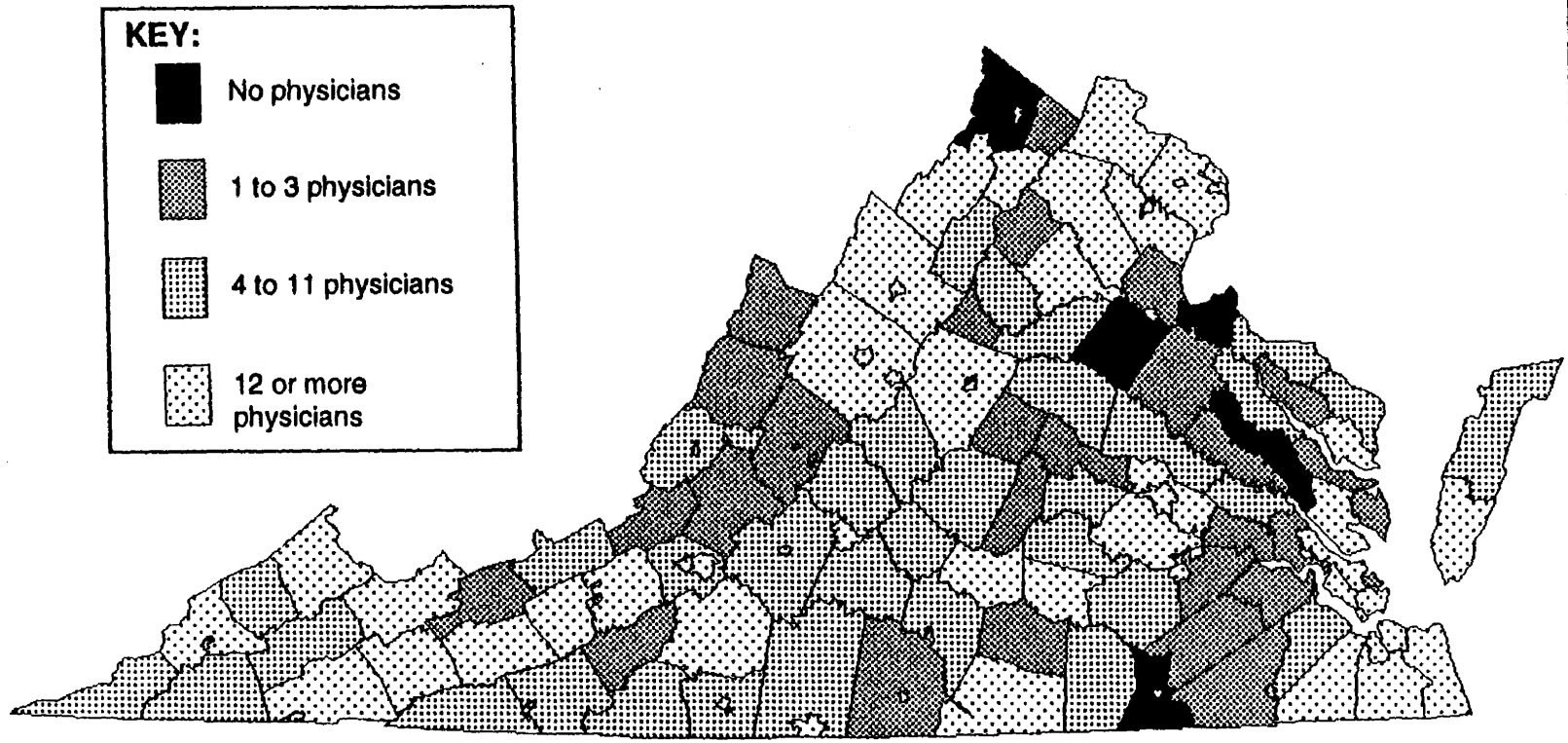
AIDS/AIDS-Related Complex Waiver

- implemented January 1991
- designed to provide case management, personal care services, and private duty nursing to adults and children diagnosed with HIV and who are at risk of institutionalization
- covered services include case management, assistance with activities of daily living, minimal housekeeping services and meal preparation, shopping, day health care services in a congregate setting, nutrition counseling, respite care, and private duty nursing

Appendix D

Geographic Distributions of Medicaid Enrollees and Physicians Related to Primary Care Access

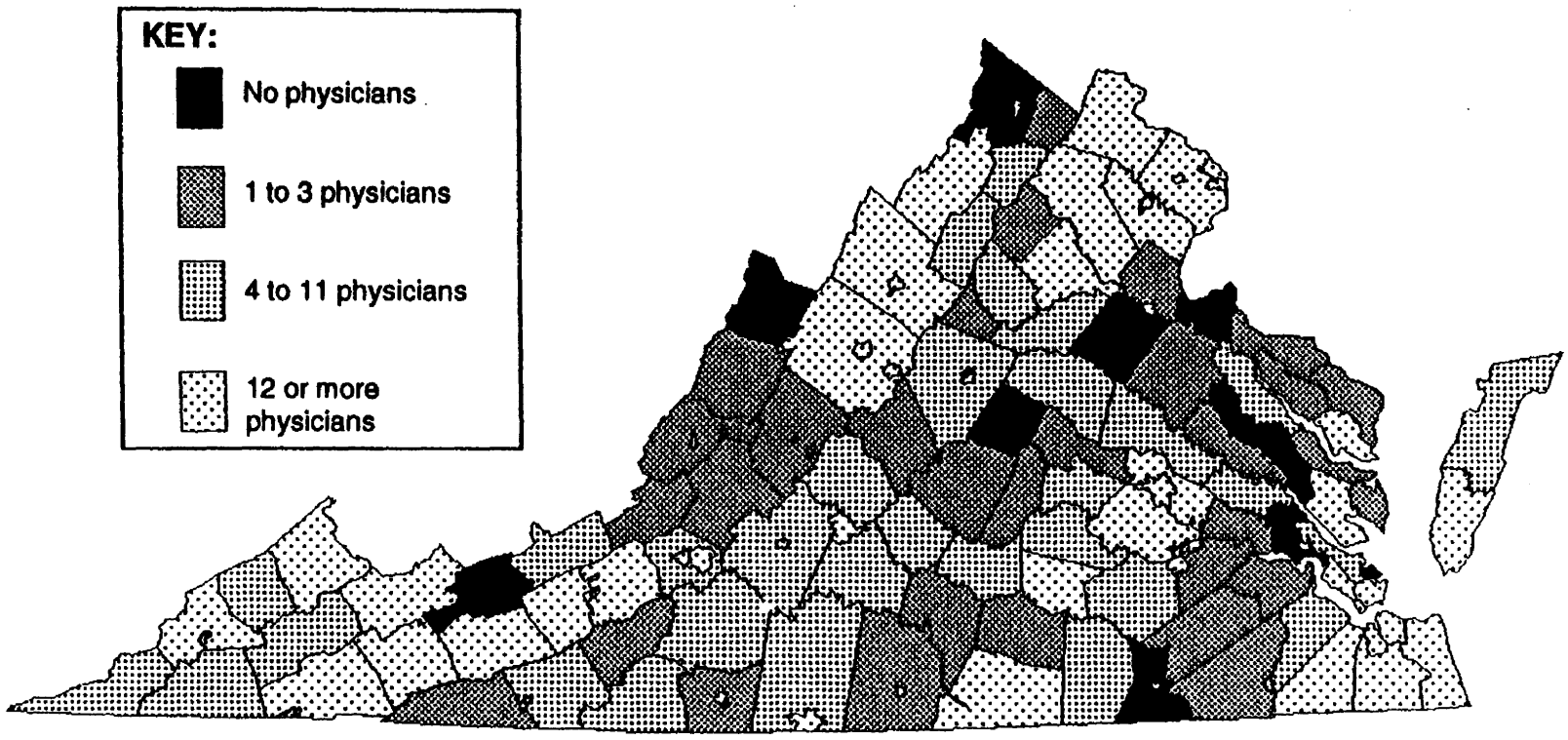
Number of Primary Care Physicians Enrolled in the Medicaid Program Within Each Virginia Locality as of September 25, 1991



Note: Includes physicians who declared their primary specialty as family practice, internal medicine, OB/GYN, or pediatrics. Each unique provider is assigned a total count of one. If a provider is enrolled in multiple localities, the provider is weighted proportionally in each locality according to the number of enrollment agreements maintained by that provider.

Source: JLARC staff analysis of DMAS, MMIS provider subsystem file in SAS format as of September 25, 1991.

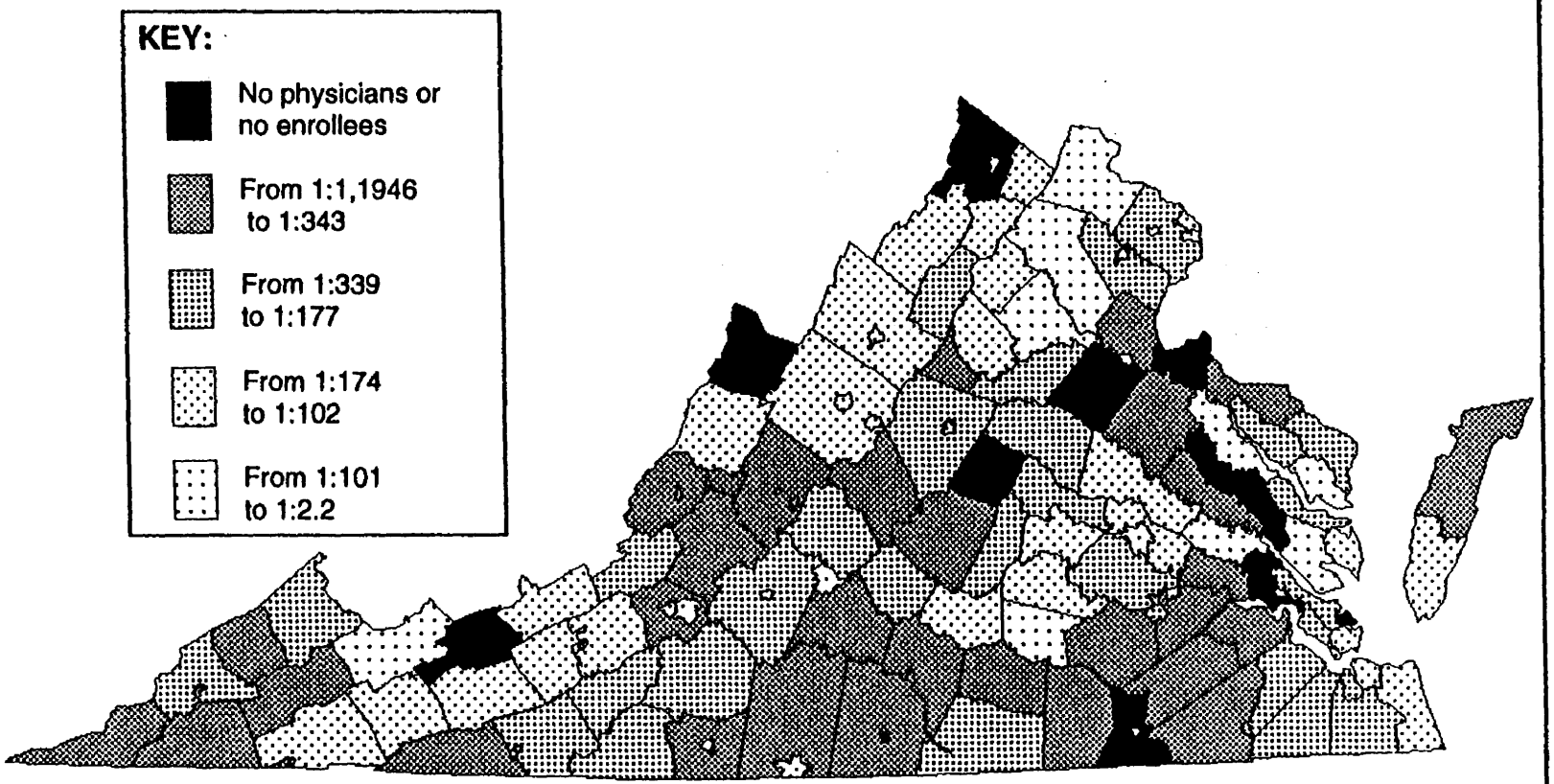
Number of Primary Care Physicians Who Actively Participate in the Virginia Medicaid Program Within Each Locality



Note: Includes physicians whose Medicaid payments exceeded $250 each month, on average, between 1/1/90 and 9/25/91. Each unique provider is assigned a total count of one. If a provider is enrolled in multiple localities, the provider is weighted proportionally in each locality according to the number of enrollment agreements maintained by that provider.

Source: JLARC staff analysis of DMAS, MMIS provider subsystem file in SAS format as of September 25, 1991.

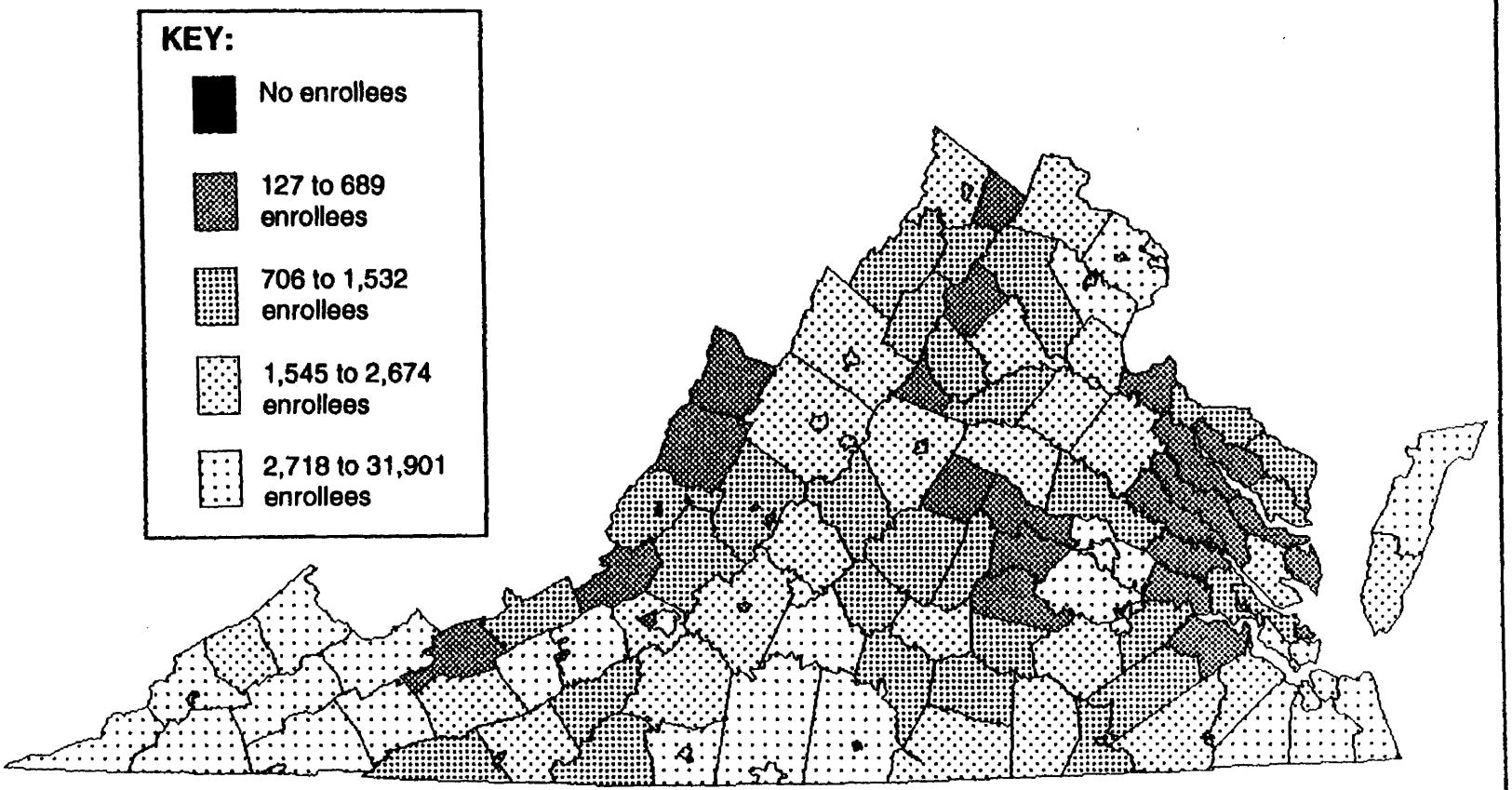
Ratio of Primary Care Physicians who Actively Participate in the Virginia Medicaid Program to Medicaid Enrollees in Each Locality



Note: Based on quartile analysis. Legend indicates one physician per indicated number of Medicaid enrollees. Each unique provider is assigned a total count of one. If a provider is enrolled in multiple localities, the provider is weighted proportionally in each locality according to the number of enrollment agreements maintained by that provider.

Source: JLARC staff analysis of DMAS, MMIS eligibility subsystem file in SAS format as of September 23, 1991; and DMAS, MMIS provider subsystem file in SAS format as of September 25, 1991.

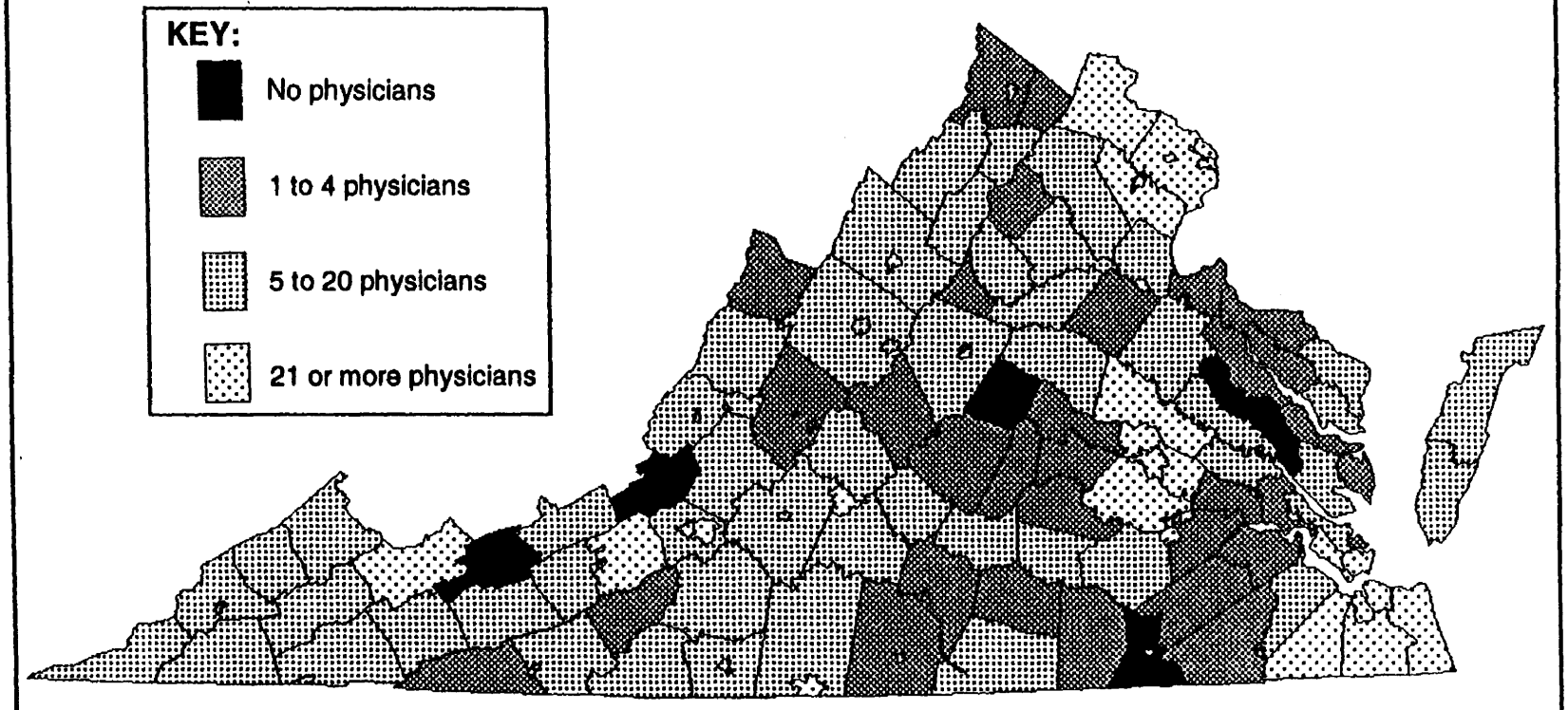
Number of Enrollees in the Virginia Medicaid Program within Each Locality as of September 23, 1991*



*Note: Based on quartile analysis of all eligibility classifications, except 3,160 enrollees in VA psychiatric institutions.

Source: JLARC staff analysis of DMAS, MMIS eligibility subsystem file in SAS format as of September 23, 1991.

Number of Licensed Physicians in VirginiaWho Practice a Primary Care Specialty Within Each Locality



Note: Based on verification and update of Board of Medicine lists of licensed Virginia physicians as of 12/31/90. Physicians who practice in more than one locality are weighted proportionally in each locality where they maintain a practice.

Source: JLARC staff analysis of MCV files of licensed primary care physicians and JLARC/MCV survey of general hospitals on obstetrical and delivery services.

Appendix E

Agency Responses

As part of an extensive data validation process, each State agency involved in a JLARC assessment effort is given the opportunity to comment on an exposure draft of the report. This appendix contains responses by the Department of Medical Assistance Services, the Department of Social Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Department of Planning and Budget.

Appropriate technical corrections resulting from the written comments have been made in this version of the report. Page references in the agency response relate to an earlier exposure draft and may not correspond to page numbers in this version of the report.

DEC 1 2 1991

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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December 12, 1991

Mr. Philip Leone
Director
Joint Legislative Audit and Review Commission
Suite 1100
General Assembly Building
Capitol Square
Richmond, Virginia 23219

Dear Mr. Leone:

We have reviewed the exposure draft, Interim Report: Review of the Virginia Medical Assistance Program and are pleased with the overall report. As requested, we have taken the liberty to both annotate the draft report where expedient as well as provide attachments with proposed comments and changes.

We appreciate the complexity of the Medicaid program and hope you will find our suggestions helpful.

Sincerely,

Pat Godbout jr

Bruce U. Kozlowski

BUK/tgj

Attachment

Comments Concerning the JLARC Exposure Draft:
"REVIEW OF THE VIRGINIA MEDICAL ASSISTANCE PROGRAM"

1. In the summary on page iv, fourth paragraph, the statement "They often must 'spend-down' their excess income and/or resources by sustaining medical expenses equal to the excess amount" may be misleading. The term spend-down applies only to excess income. Incurred medical expenses may not be used to reduce countable resources. An individual is ineligible as long as he owns excess resources. The resources must actually be spent before they are no longer countable.

2. On page v, the narrative gives the impression that the only more restrictive criteria is that affecting ownership of contiguous property. While it is the best known, it is <u>not</u> the only one. The more restrictive criterion that affects the most recipients is the requirement that institutionalized recipients may retain their former home for only six months.

3. On page 27, the last sentence in paragraph 2 mistakenly states that "If SSI recipients cannot meet the more restrictive criteria for Medicaid coverage as categorically needy, they must spend-down to become covered as medically needy." The 209(b) more restrictive criteria apply to both the categorically needy and the medically needy. Therefore, a person who does not meet the more restrictive criteria can not be eligible as either categorically or medically needy.

4. On page 30, the study states that the categorically needy SSI income limit is $610 per month. This is the limit for a couple. The SSI limit for one person is $407 per month.

5. On page 34, the first paragraph states that SSA subcontracts with DRS to obtain disability determinations for SSI-related disabled applicants. Actually, SSA contracts with DRS to provide disability determinations for both SSA and SSI applicants. DMAS contracts with DRS to provide disability determinations for SSI-related medically needy applicants.

6. On page 80, paragraph 2, the study describes "BabyCare" as a Virginia Health Department program. BabyCare is a DMAS program. It involves both eligibility criteria and expanded services. The Health Department is the primary provider of the expanded prenatal services and of Maternal and Infant Care Coordination, but the description is not accurate.

7. There are other statements in the report concerning eligibility determination and the BabyCare Health Department pilots which are not accurate. DSS is commenting on these in their response to the draft report.

8. On page 42, the report indicates that QMB's with dual eligibility are entitled to services not covered by Medicare but reimbursable by Medicaid, including long-term care. Medicare covers skilled nursing facility care, therefore, Medicaid would be responsible only for deductibles and for intermediate care.

9. On page 45, paragraph 2, the report states "Fees are based on the lesser of the State's fee...". The term should be "payments are based on...". The amount of the Medicaid fee is the same for all providers but the payment may be different because the provider does not charge the full fee.

10. On page 46 and 47, reimbursement for pharmacy services is described as "reasonable cost" or "maximum allowable charge". This statement may be misleading. Reimbursement is comprised of the payment for the reasonable cost of the drug as determined by the First Data Bank, a national pricing organization and a dispensing fee set by the Department. In Medicaid, the term "reasonable cost" is usually associated with reimbursement based on the reported costs of the provider.

11. On page 58, paragraph 3, the term, "home health care" must be replaced with the term "providers of home- and community-based waiver services". These are two distinct programs. The home health care providers would be quick to point out that they did not receive such a rate increase, nor did the Department have authority to provide such an increase.

12. On page 83, third paragraph, the report indicates that some recipients receive primary care in more expensive hospital settings. While it is true that some recipients do obtain non-emergency services inappropriately in these settings, it is not more expensive to the Medicaid program. Hospitals billing for non-emergency services delivered in an emergency setting are reimbursed at the same rate as if the services had been delivered in a physician's office.

13. On page 85, paragraph three, the sentence "Nurse practitioners..." must be modified to read, "Nurse practitioners under the supervision of a physicians". This is a federal requirement and the lack of physicians willing to provide such supervision is the reason so few nurse practitioners are enrolled in the program.

14. On page 108, the report indicates that access to care is particularly problematic for the Medicaid population. Federal regulations require the state to operate in such a manner as to assure that access for the Medicaid population is the same as access for the general population. HCFA has approved the state plan as meeting all applicable federal regulations, therefore, it may not be prudent to release a public document indicating that there is not equal access.

15. On page 133, paragraph three, the report indicated that there is no direct relationship between the forecasts submitted to the federal government and the forecasts used in the state budget process. The same models are used to make both forecasts; the only difference being the period covered by a fiscal year.

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LARRY D. JACKSON
COMMISSIONER

COMMONWEALTH *of* VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

DATE: December 12, 1991

TO: The Honorable Howard M. Cullum
Secretary of Health and Human Resources

FROM: Larry D. Jackson, Commissioner
Department of Social Services

SUBJECT: JLARC's Interim Report: Review of the Virginia Medical Assistance Program

Attached please find comments regarding changes and corrections that need to be made to the JLARC Interim Report of the Virginia Medical Assistance Program. The changes and corrections concern the eligibility determination process. Policy corrections were discussed with Ann Cook at the Department of Medical Assistance Services and will be reported by DMAS. Page numbers and suggested changes are listed in the order they appear in the draft report. If you have any questions, please contact Diana Salvatore, Program Manager, Medical Assistance Unit at 662-9048.

NDS/bb

**c: Ms. Deborah D. Oswalt
Mr. B. Norris Vassar**

Attachment

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INTERIM REPORT:

REVIEW OF THE VIRGINIA MEDICAL ASSISTANCE PROGRAM

COMMENTS

December 10, 1991

Page 30, Third paragraph:

"To illustrate:
The categorically needy SSI-related income limit is..." $407 not $610 as stated in the draft. $407 is the SSI amount for an individual; $610 is the SSI amount for a couple.

Page 68, First Paragraph:

"Eligibility requirements are not made within federal time requirements almost 24 percent of the time...." While this was true at the time the information was gathered, application processing times have improved. There was a discrepancy in the way the information was manually reported by local departments of social services. Local departments were instructed to examine the reports for accuracy and to correct any inaccurate reports in the month of September, 1991. The figures for October, 1991 which reflect timeliness of application processing show an increase to 90.7 percent statewide in timely processing. Therefore, as of October, eligibility determinations are not made within federal time requirements 9.3 percent of the time.

Page 72, Third Paragraph:

The figures listed are correct for FY '91. However, since that time, the manually reported statistics have been corrected. Based on the corrected figures in the month of October, initial Medicaid application decisions were made in a timely fashion 90.7 percent of the time. The Southwest region had the highest average completion rate for timely initial application processing, 95.9 percent. The Northern Virginia region had the lowest average rate for timely completion of initial applications, 87.5 percent.

Page 75, Second paragraph:

"Recently, the Secretary of Health and Human Resources provided additional funding for 23 localities to administer their public assistance caseloads." The funding for the 23 localities was for Food Stamp caseloads. In November, the Secretary provided additional funding for 49 localities for interim assistance for benefit programs.

Page 79, Third paragraph:

"The Department of Social Services is *attempting to meet* the requirement by training hospital staff to accept Medicaid applications..."(italics added). The phrase *attempting to meet* implies that this option is not acceptable according to federal guidelines. In fact, training of provider staff is fully acceptable as a means to implement Section 4602 of OBRA '90. I suggest this read, "The Department of Social Services is meeting the requirement by training hospital staff to accept Medicaid applications..."

Page 81, Fourth paragraph:

The last sentence states that no precise data have been collected to measure the success of placing workers on site at health departments. In fact, a year end review of the pilot project was completed in January, 1991 to measure the effectiveness of the Health Department Eligibility Worker Pilot Project. A copy of that report is attached.

Page 82, Recommendation (2):

..."In addition, the Department of Medical Assistance Services should ensure the Department of Social Services expands its efforts to increase the number of locations equipped to accept Medicaid applications from indigent pregnant women and children." The Department of Social Services has worked diligently with local departments of social services, the Virginia Hospital Association and the Virginia Primary Care Association to outstation workers. An outline of the outreach efforts follows.

OUTREACH EFFORTS:

<u>December 1, 1989.</u> A video teleconference about the BabyCare Program was jointly conducted by the Departments of Social Services, Medical Assistance Services and Health on December 1, 1989. The purpose of the teleconference was to give all workers a better understanding of the BabyCare Program and to train health department staff to take applications for Medically Indigent pregnant women and for Medically Indigent children.

<u>August 17, 1990.</u> On August 17, 1990 a meeting was held with directors of local departments of social services in areas where dsa hospitals were located to specifically inform them of the ability to place workers at hospitals. The directors were given copies of a possible contract to use and were given information about how to get computer equipment for use at the hospitals. The directors were encouraged to contact

hospital administrators in their areas to arrange for outstationing of workers.

May 31, 1991. Meetings were held with representatives of Primary Care Association which is the representative agency for federally qualified health centers and the Virginia Hospital Association. The first meeting was on May 31, 1991 to acquaint both associations with the proposals for training provider staff under the provisions of OBRA '90. Follow-up meetings were held with the Primary Care Association on August 8, 1991 and August 22, 1991. The August 22 meeting was a state-wide meeting of the Primary Care Association which was attended by representatives of all federally qualified health centers. Following the meeting on May 31, 1991, information about outstationing was placed in the Virginia Hospital Association newsletter.

Continuing efforts. Over the past two years, DSS staff have consulted individually with hospitals and local departments of social services about how to go about outstationing workers. Placement of a worker at Woodrow Wilson hospital is imminent. Also, one worker was placed at Hampton General Hospital in July, 1990 and three workers were placed at the Children's Hospital of the King's Daughters (CHKD) in December, 1990. Hampton General and CHKD are both dsa hospitals. There are other workers placed at various hospitals throughout the state, such as in Arlington, Prince William County, Fairfax, and Petersburg. Because the hospital pays the entire salary of the worker and the State DSS does not enter into the contract, the DSS does not track placement of all workers.

HEALTH DEPARTMENT ELIGIBILITY WORKER PILOT PROJECT

YEAR END REVIEW

January 24, 1991

The Health Department Eligibility worker Pilot Project began operation in January, 1990 as a cooperative venture between the Department of Medical Assistance Services (DMAS), the State Health Department and the Virginia Department of Social Services. The pilot was begun to determine the effectiveness of locating Medicaid workers on site at local health departments. The Department of Medical Assistance Services provided the non-federally matched portion of costs for the worker, the State Health Department provided space and equipment and the Virginia Department of Social Services provided supervision and training.

Workers were placed in four areas in January, 1990. They were Chesterfield-Colonial Heights, Pittsylvania-Danvillle, Lynchburg and Portsmouth. Petersburg was originally designated as a pilot site but because the local department of social services could not obtain initial operating funds, they had to be deleted as a site. Prince William Health District was added as the fifth pilot in July, 1990.

Effectiveness of the project was to be determined after one year of operation based on three measures.

1. The first effectiveness measure was the increased reimbursement by Medicaid due to increased Medicaid enrollment when compared to the one year period immediately prior to the effective date of the contract.

   Reimbursement figures were obtained from Robert Stroube, M.D, Deputy Commissioner for the State Health Department. Please see the attached table. All areas showed an increase in revenue collected, in some areas the increase was substantial. Part of this increase, however, resulted from a change in coding; it could not all be attributed to the pilot project.

   The revenue generated in the areas where the Medicaid workers were placed showed a dramatic increase when compared to the statewide average. For example, the revenue generated in Medicaid BabyCare showed an average increase of 118.9 percent for the pilot areas as compared to 28.85 percent statewide. The Maternal Case Management revenue showed an average increase of 165.1 percent for the pilot areas as compared to -.33 percent statewide. Total average BabyCare revenue for the pilot areas showed an increase of 137.4 percent as compared to the statewide totals of 6.65 percent. In calendar

year 1989, the percentage of BabyCare revenue for the pilot areas was 11.90 percent of the total collected statewide. This increased to 26.51 percent in calendar year 1990.

2. The second effectiveness measure was the increased numbers of BabyCare eligibles enrolled in Medicaid when compared to the one year period immediately prior to the effective date of the contract.

In April, 1990, the Medicaid income level for Medically Indigent pregnant women and children was raised from 100 percent to 133 percent of the poverty level. At the same time, the age level for children was raised from two to six. Because of this change in the income and age levels, the comparison to FY '89 cannot be used.

Even though these figures cannot be used exclusively as a measure of the effectiveness of the pilot projects, the Chesterfield Health District, for example, showed an increase from 62 percent of the income A's enrolled in Medicaid to 92 percent enrolled after the Medicaid worker was placed.

3. The third effectiveness measure was the increased numbers of BabyCare eligibles enrolled in Medicaid within 10 days of the date of application for Medicaid when compared to the one year period immediately prior to the effective date of the contract.

Since there was no computer tracking system for pending cases there were no figures for FY '89 to be used for comparison. However, one major reason for this pilot was the consensus on the part of all parties concerned that the ten day processing time frame was not being met in the pilot areas.

1990 figures were obtained from the local departments of social services and are noted below. The pilots are:

Chesterfield-Colonial Heights (CH/COL)
Pittsylvania-Danville (P/D)
Lynchburg (LYNCH)
Portsmouth (PORTS)
Prince William (PR WM)

Calendar Year (JAN-DEC) 1990

Local Departments of Social Services

	CH/COL	P/D	LYNCH	PORTS	PRWM*
Number of Referrals	600	744	273	483	272
Number of Applications Taken	600	623	273	468	258
Average Time from Application to Approval	7-9	26	15-20	10	23
Number of Cases Approved	497	477	234	411	184
Approval Rate (PERCENT)	82.8	76.5	85.7	87.8	71.3
Average Applications/Month	50	52	23	39	43
Cost per Application (DOLLARS)	44.14	28.87	49.97 **	32.12	26.55

* Prince William began operation in July, 1990.
**The cost for Lynchburg has not been confirmed. It may be slightly higher.

Primary reasons for denial: In all areas the primary reason for denial was failure to provide income information.

It also appears, although no data were kept to support the assumption, that women are being enrolled earlier in their pregnancies. Also, these women are bringing their children in for pediatric checkups.

The ten day turnaround time is being met in two pilot agencies, but not in the remaining three. In two of the agencies not meeting the time frame (Pittlsyvania-Danville and Prince William) the reason given was that the worker covers numerous clinics sites at different locations in the area served and the applications must be given to three local departments of social services. The third (Lynchburg) experienced a vacancy in this position from October through December and thus the average number of days for processing increased. In all three areas, the time frame in which the applicant submitted necessary information could account for the delay in average processing time. According to Medicaid policy, the applicant is given up to 45 days to bring in information before

the case is denied, although the worker is to take action within ten days when information is available.
In addition to the effectiveness measures noted in the contract, one other benefit should weigh heavily on the decision about whether or not to continue and to expand the pilots. This issue was raised in a letter from Dennis R. Swanson, M.D., District Health Director for the Pittsylvania-Danville Health District.

Dr. Swanson stated that the success of the pilot project in Pittsylvania-Danville has greatly influenced the ability of the Danville area to recruit two and, possible, three obstetricians. Given the three obstetricians, the Danville area should have adequate obstetrical coverage for the indigent patient population which accounts for approximately 500 deliveries a year. A copy of Dr. Swanson's letter is attached.

Recommendations:

1. Continue pilots in Pittsylvania-Danville, Chesterfield-Colonial Heights and Portsmouth as they are currently functioning. These pilots appear highly successful when looking at numbers of applicants enrolled and the increased revenue generated to the Health Department. The Prince William site will continue operation for one year before an effectiveness evaluation is completed.

2. Explore the feasibility of sharing the worker at the Lynchburg site with neighboring counties within the Health District. If this is not feasible, consideration should be given to either reducing the hours of the worker to one-half time of replacing this pilot with another area that shows the need for a full time worker.

   The numbers of applications for Lynchburg are very low when compared to the other pilots. It is also taking longer than the projected ten days to get applicants enrolled. The revenue generated to the Health Department increased although there is no way of knowing how much this worker contributed to the increase.

3. Expand this concept immediately into five additional Health Districts which will be agreed to by the Department of Medical Assistance Services, the State Health Department and the Virginia Department of Social Services. The Health Department proposes the following five areas be targeted for expansion: Alexandria, Fairfax, Richmond City, Norfolk and Newport News. Two additional areas, Hampton and Petersburg, were targeted if funds permit or if one of the five expansion agencies cannot participate.

COMMONWEALTH of VIRGINIA

DEPARTMENT OF

Mental Health, Mental Retardation and Substance Abuse Services

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COMMISSIONER

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December 10, 1991

The Honorable Howard M. Cullum
Secretary of Health and Human Resources
Ninth Street Office Building
Richmond, Virginia 23219

Dear Howard:

Thank you for the opportunity to comment on the Exposure Draft of the JLARC Medicaid Study. Based on my staff's review of the draft, I offer the following comments and suggestions.

The section titled 'DMAS Should Review DMHMRSAS Projections More Closely', beginning on page 121, is somewhat confusing because it groups the Department's institutional Medicaid reimbursement activities, which account for a major portion of some state facility budgets, with the Community Medicaid State Plan Option (SPO) initiative, which represents a relatively small share of the CSBs' budgets. Most of the discussion in this section of the study focuses on the SPO, yet the recommendation appears to include all DMHMRSAS Medicaid activities. It might help to clarify the concerns in the report if the two activities were addressed separately.

The study refers to the MR Home and Community Based Waiver several times. The Waiver and State Plan Option are distinct activities with fundamentally different effects on the services system. The Waiver, by its nature, did not contribute to the revenue shortfall in the first year of the State Plan Option, since it is not replacing State General funds like the SPO. Thus, references to the Waiver may further confuse the reader and should probably be deleted.

The paragraph on page 122 which discusses overestimation of the initiative's impact is correct. However, it would be more balanced if it noted that Community Services Boards (CSBs) were also involved in implementation decisions immediately after the initial decision to embark on the initiative. The Virginia Association of Community Services Boards and the Department

established the Medicaid Executive Committee in February, 1990 to address implementation issues and concerns. CSBs were also extensively involved through several surveys and in board by board negotiations about revised fee targets and the size of the anticipated revenue shortfall. This paragraph would also be more balanced if it acknowledged the substantial General Fund savings realized through the successful implementation of this initiative. Even though its impact was initially overestimated, the SPO still replaced more the $8 million of State General Funds with Federal Medicaid revenues in FY 1991 and is expected to replace almost $13 million in FY 1992.

The reasons on page 122 for the overestimate are not equally significant. By far, the most consequential reason for the shortfall was the large number of clients thought to be eligible for Medicaid who were found to be ineligible. The most frequent causes for ineligibility included:

- having too much income or too many resources,
- being a Qualified Medicare Beneficiary,
- coverage under a parent's health insurance policy, and
- personal or parental reluctance to apply for benefits.

Also, the decision to defer coverage for some substance abuse services did not cause the overestimation, it merely increased the size of the shortfall in the second year of the biennium. Finally, the last reason cited -- the number of claims processed and covered in the first year -- was not a reason, it was an effect of the first and second reasons.

The first paragraph on page 123 is accurate but not complete. As noted above, CSBs were involved extensively, through the Medicaid Executive Committee and several surveys, in the development of the initiative after the initial decision was made and the preliminary estimates were developed. It is reasonable to assume that the original estimates would have been more accurate if CSBs had been involved from the very beginning of the process. Clearly, their exclusion at the starting point caused some implementation problems, because of the lack of trust created by that exclusion. However, it would be accurate to indicate that this lack of trust no longer exists, due in large part to the successful operation of the Medicaid Executive Committee.

The last sentence in the middle paragraph on page 123 is not correct. All CSBs were already familiar with the process for billing DMAS for service claims, under the Clinic Option coverage for mental health outpatient services. What CSBs have become more familiar with are details of the State Plan Option services (e.g. covered services, eligibility criteria, staff and provider qualifications), the third step cited in the preceding sentence.

The concern raised at the end of the first paragraph on page 124, while possible, is not probable. Since the match for this initiative comes from the CSB appropriation, an underestimate of

clients (hence a need for greater reimbursement) would be handled by transferring more matching funds from the CSBs rather than from other Medicaid programs.

The implication, in the second paragraph on page 124, that DMAS staff were marginally involved in the estimates for the SPO services does not reflect the extensive involvement of DMAS staff from several offices in all phases of the development and implementation of this initiative. DMAS staff have met frequently with the Medicaid Executive Committee and have worked closely with DMHMRSAS staff from various offices. Those DMAS representatives received information about how the original and revised SPO fee targets were projected. The participation and assistance of the DMAS has been invaluable to the success of this initiative.

Finally, I concur with the recommendation on page 124. However, I want to note that a close working relationship already exists between DMAS and DMHMRSAS staffs. I would like to request that the following language be inserted after the first sentence of the recommendation:

> Currently, there is a strong working relationship between the DMAS and the DMHMRSAS which should become more structured to include formalized revenue projection reviews.

I would also like to reiterate my suggestion that comments and concerns about the two aspects of the Department's Medicaid billing activities, state facilities and Community Medicaid State Plan Option, should be discussed separately. Again, I appreciate the opportunity to review and comment on this exposure draft. Please call me if you have any questions about this letter.

Sincerely,

King E. Davis

KED/pg

pc: Bruce U. Kozlowski
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COMMONWEALTH of VIRGINIA

KAREN F. WASHABAU
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Department of Planning and Budget

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December 13, 1991

Mr. Philip A. Leone
Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building, Capitol Square
Richmond, Virginia 23219

Dear Phil:

I appreciate the opportunity to review and comment on Chapter V of the exposure draft report of the Virginia Medical Assistance Program. Generally, the report accurately describes DPB's role in the Medicaid forecasting process.

The following minor revisions are offered for your consideration:

Page 126, first paragraph, line 4. DPB does not forecast for education activities. However, we do forecast the Criminal and Involuntary Mental Commitment fund and ADC caseloads which were not included in the report.

Page 130, first bullet. I would like to substitute the phrase "the inability to fully determine" for "poor estimates of". This rewording more accurately explains the situation surrounding the inflation estimate.

Sincerely yours,

Karen F. Washabau

c: The Honorable Paul W. Timmreck
The Honorable Howard M. Cullum
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