Biennial Report
Board of Medical Assistance Services

Department of Medical Assistance Services

December, 2004

INTRODUCTION

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

OVERVIEW OF THE BOARD

The Board of Medical Assistance Services is established in Section 32.1-324 of the *Code of Virginia* to oversee the Medicaid program. The duties assigned to the Board include the development of the State Plan and promulgating rules and regulations for the administration of the Medicaid program.

Appointed by the Governor, the 11 board members must include five health care providers and six individuals that are not health care providers; the members elect the Board's chairman. The terms are staggered and members may not serve more than two consecutive terms. The Board meets quarterly with a biennial retreat. The current members and meeting dates are listed in Table 2.

During the Board meetings, DMAS staff has briefed the members on changes to the Medicaid/FAMIS program, new initiatives, legislative and budget developments, and DMAS administrative issues. Other speakers have included the Secretary of Health and Human Resources, staff from the Office of the Attorney General, health experts, provider groups, and various other interested parties. In addition, the Board provides for a public comment period at each meeting in order to hear from the general public regarding any Medicaid related issues.

Table 2
Board Members and Meeting Dates

Current Members

Providers	Non-Providers
Manikoth G. Kurup, M.D., *Chair*	Aneesh P. Chopra
Elmer E. Neil, M.D.	Rose C. Chu
Robert D. Voogt, Ph.D., C.R.C., *Vice Chair*	Phyllis L. Cothran
Michael E. Walker	Terone B. Green
Dorn V. Williams, Sr.	Indira Moran
	Marc Wheat

Meeting Dates

April 14, 2003	April 13, 2004
May 13, 2003	July 13, 2004
September 9, 2003	September 14, 2004
December 9, 2003 (Retreat)	December 14, 2004

During the past two years, the Board has taken several specific actions to improve both the Board's procedures and the administration of the Medicaid program. Several of those actions are listed below:

- The Board reviewed the bylaws and amended them twice since 2002.
- The Board addressed the issue of absenteeism and successfully argued to the Governor to have a member removed and replaced for lack of participation.
- The Board recommended that a Medicaid Physician Advisory Committee (MPAC) be formed to provide a forum for identifying and discussing issues affecting physicians participating in the Medicaid program. DMAS formed the MPAC and its first meeting was held on April 24, 2003.
- In December 2003, a majority of the Board members signed and sent a letter to the Governor in support of his proposed tax reform package.
- In October 2004, a majority of the Board members signed and sent a letter to the Governor supporting the home health providers' request for a 40 percent increase in reimbursement rates.
- The Board has become more active in participating in various DMAS committees and advisory groups such as the Department's Pharmacy & Therapeutics Committee, the Medicaid Transportation Advisory Committee, the Medicaid Physician Advisory Committee, the FAMIS/Children's Health Insurance Advisory Committee, the Managed Care Committee, and others.

Overview of the Virginia Medicaid Program

Medicaid is a jointly funded cooperative venture between the federal and state governments for the purpose of providing medical care for certain groups of low-income individuals who are aged, blind or disabled; members of families with children; and pregnant women. Within frequently changing federal guidelines, each state designs and administers its own program, a practice that creates substantial variation among state programs in terms of persons covered, types and scope of benefits offered, and the amount of payments for services.

Since the start of the Medicaid program in 1965, the U.S. Congress has enacted a steady stream of mandates that have greatly expanded the program beyond the scope envisioned by its founders. Originally, eligibility for Medicaid was only linked to "categorical" relationships to two cash assistance programs: Supplemental Security Income (SSI) for low-income aged, blind, and disabled persons and Aid to Families with Dependent Children (AFDC). Federal mandates have expanded eligibility to also include "medically needy" persons, such pregnant women, children under age 19, and certain low-income Medicare beneficiaries.

In Virginia, the Medicaid program is administered by the Department of Medical Assistance Services (DMAS). Medicaid is the largest health care financing program in the state for indigent persons. In FY 2003, the Virginia Medicaid program covered services for 572,000 recipients at a cost of $3.6 billion. As most of the services covered are subject to 49.9 percent federal participation rate, the Virginia general fund share of the costs last state fiscal year was approximately $1.8 billion.

The structure of Virginia's Medicaid program includes both managed care and fee-for-service models. Nearly one-half of the Medicaid recipients are enrolled in one of five Medicaid managed care organizations (MCOs) through the Medallion II program. The remaining recipients are either enrolled in MEDALLION (managed care through a primary care physician) or Medicaid fee-for-service. In Medallion II, each MCO receives a per member per month payment to manage the recipients' care. For recipients who are not in enrolled in MCOs, providers are reimbursed directly by the Commonwealth for services rendered based on a variety of payment methodologies.

Services covered by Virginia Medicaid are relevant to recipients enrolled in all three coverage arrangements listed above. Some services, such as inpatient hospital and transportation services, are required by federal law to be covered by all state Medicaid programs. In addition to the "mandatory" services, Virginia has elected to cover other, "optional" services, such as prescribed drugs and hospice services. A complete list of covered services is shown in Table 1.

The structure of the Medicaid program, eligibility guidelines, and service descriptions are defined in the Virginia State Plan. The Plan is developed, updated, and submitted for approval to the U.S. Secretary of the Department of Health and Human Services by Virginia's Board of Medical Assistance Services (the Board), with approval of the Governor. The Department of Medical Assistance Services (DMAS) administers the Medicaid program according to the approved Plan. The Director of DMAS acts with the authority of the Board while the Board is not in session.

Table 1
Mandatory and Optional Services Covered by Virginia Medicaid

Mandatory Services	Optional Services
• Hospital Inpatient, Outpatient, & Emergency Services • Nursing Facility Services • Physician Services • Medicare Premiums, copays and deductibles (Part A and Part B for Categorically Needy) • Certain Home Health Services (nurse, aide, supplies and treatment services) • Laboratory & X-ray Services • Early & Periodic Screening, Diagnostic & Treatment (EPSDT) Services • Nurse-Midwife Services • Rural Health Clinics • Federally Qualified Health Center Clinic Services • Family Planning Services & Supplies • Transportation	• Prescribed Drugs • Mental Health & Mental Retardation Services • Home & Community-Based Care Waiver Services • Skilled Nursing Facility Care for Persons under age 21 • Dental Services for Persons under age 21 • Physical Therapy & Related Services • Clinical Psychologist Services • Podiatrist Services • Optometrist Services • Services provided by Certified Pediatric Nurse & Family Nurse Practitioner • Home Health Services (PT, OT, and Speech Therapy) • Case Management Services • Prosthetic Devices • Other Clinic Services • Hospice Services • Medicare Premiums/copays/ deductibles (Part B for Medically Needy)

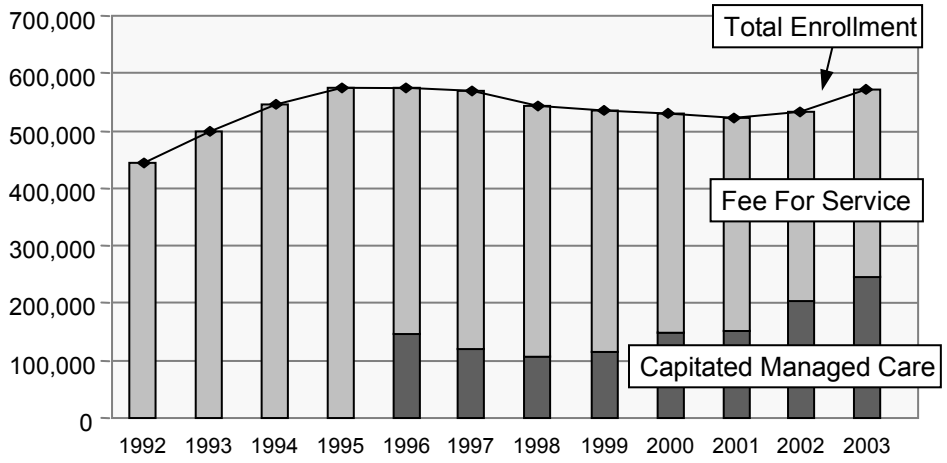
MEDICAID UTILIZATION AND COST TRENDS

Medicaid expenditures are driven by the services provided to enrolled recipients. Therefore, the Board monitors enrollment and service trends regularly. DMAS staff presents this information to the Board during the presentation of the budget annually. Those trends are presented in the graphics on the next few pages.

During the late 1990s, Medicaid enrollment decreased steadily. However, in the last two years, enrollment has increased, and in FY 2003, 572,473 recipients were enrolled in Medicaid, a level similar to that of 1995 (Figure 1). Of those enrolled, about 57 percent are served through the fee-for-service program and the remaining 43 percent are enrolled in Medicaid managed care organizations (MCOs). The use of MCOs has grown dramatically since their inception in 1996, when only 25 percent of the Medicaid population was enrolled in managed care.

Figure 1

Medicaid Enrollment Trends

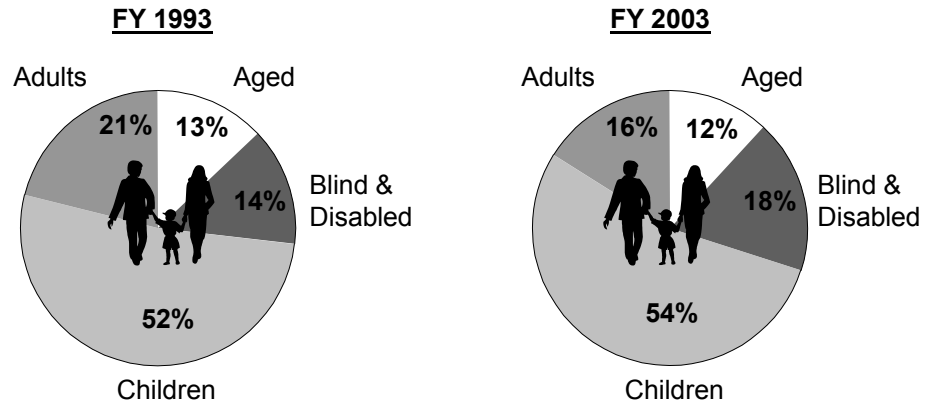


Note: Average monthly enrollment in the Virginia Medicaid Program capitated care consists of the Options and Medallion II programs.

Over the last ten years, enrollment has remained between 500,000 and 600,000 recipients, though the make-up of the enrolled population has shifted. The most notable shift has been the increase in the portion of the Medicaid population that is blind or disabled, which increased from 14 percent in FY 1993 to 18 percent in FY 2003. This is an increase of over 30,000 recipients. The other side of that shift was a decrease in the portion of the population who are adults (21 percent in FY 1993 to 16 percent in FY 2003). This was a decrease of 13,000 recipients. (Figure 2)

Figure 2

Medicaid Enrollment Trends by Eligibility Category



Note: Annual unduplicated enrollment in the Virginia Medicaid program.

In contrast to enrollment trends over the last decade, expenditures consistently increase each year (Figure 3). Since 1992, Medicaid expenditures have more than doubled to $3.9 billion in FY 2004. For the 43 percent of the population who were enrolled in MCOs in the last fiscal year, Medicaid paid MCOs over $800 million (or 21 percent of overall expenditures) to manage the recipients' care. The remaining 78 percent of expenditures were paid to providers on a fee-for-service basis. Figure 4 illustrates the growth of managed care, from no expenditures in FY 1993 to 22 percent of the Medicaid expenditures ten years later.

Figure 3

Medicaid Expenditure Trends

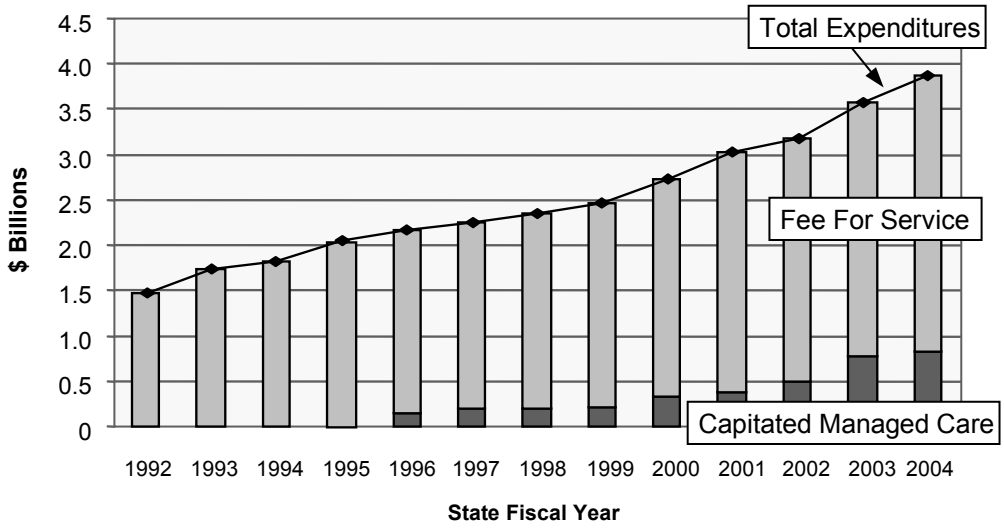
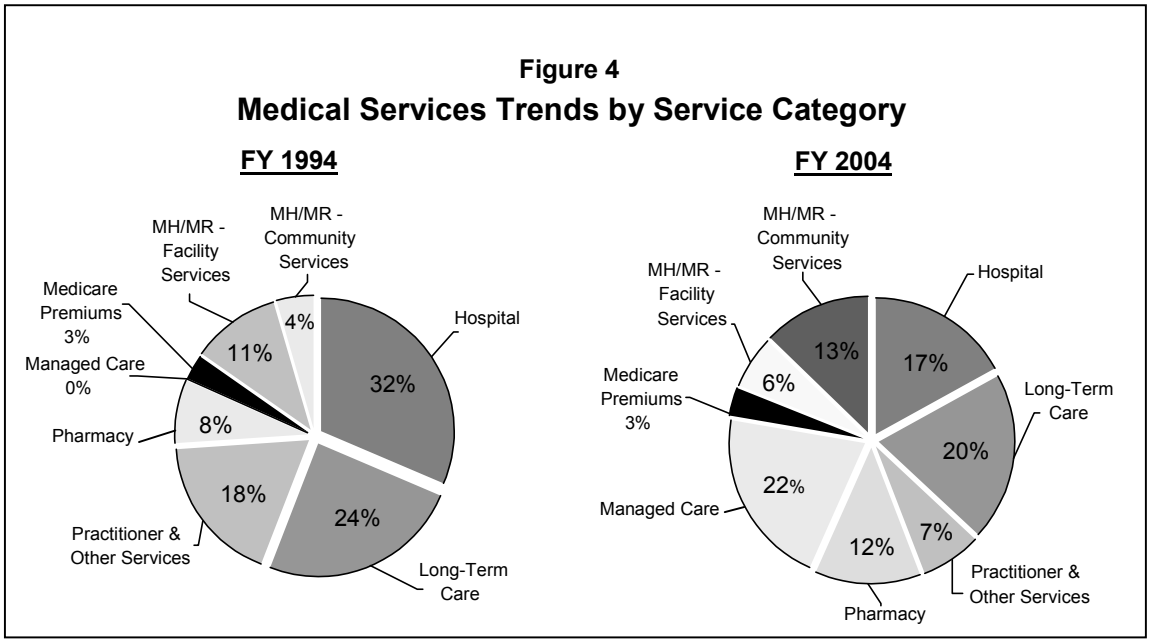


Figure 4

Medical Services Trends by Service Category



It is important to note that some of Medicaid's most costly recipients are excluded from managed care, such as those in long term care facilities and home and community based waivers, which contributes to the high percentage of costs associated with the fee-for-service population. As shown in Figure 5, adults and children accounted for 70 percent of the recipients but only 29 percent of the Medicaid costs in FY 2003. In contrast, aged, blind, and disabled recipients accounted for 30 percent of the Medicaid population and 71 percent of the costs. The cost of the aged, blind, and disabled groups has consistently been higher over the last decade, though the cost per enrollee for this group has increased at a faster rate than the cost per adult or child enrollee (Figure 6).

Figure 5

Medicaid Enrollment and Expenditures
FY 2003

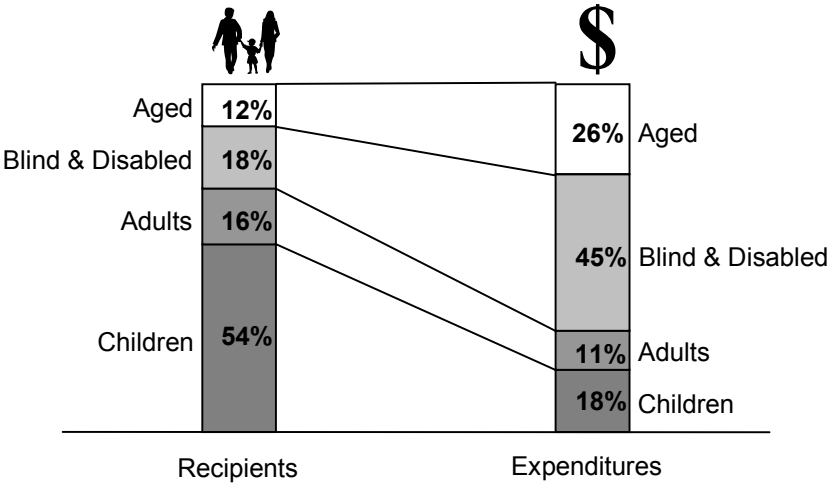
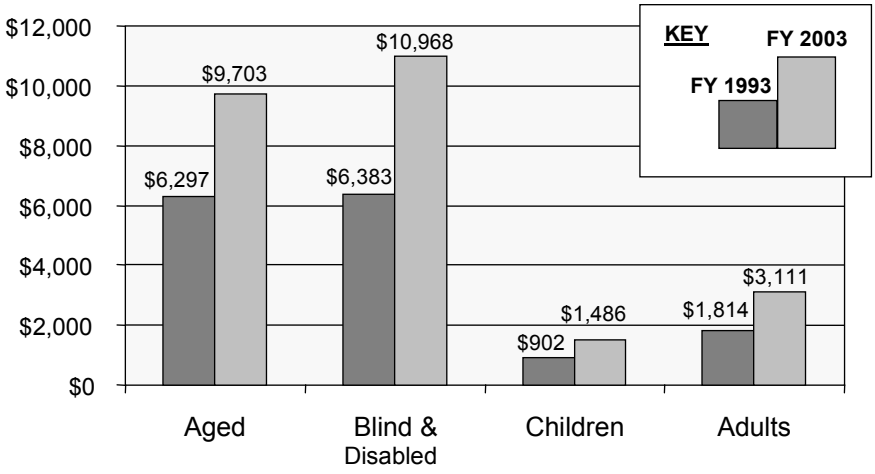


Figure 6

Medicaid Expenditure Trends
Average Annual Cost per Enrollee



Though Virginia's Medicaid expenditures have increased steadily over time, the Commonwealth still ranks low among other states in per capita and per recipient expenditures. As shown in Table 2, though Virginia is 12th in the nation in total population and 15th in per capita income, the Commonwealth is 49th in Medicaid expenditures per capita. Virginia is also 47th in the number of Medicaid recipients as a percent of statewide population.

Table 2
Virginia in Comparison to Other States

Measure	Rank
Total Population	12th
Per Capita Income	15th
Number of Medicaid Recipients	22nd
Number of Medicaid Recipients as a Percent of Population	47th
Expenditure Per Medicaid Recipient	28th
Medicaid Expenditure Per Capita	49th

Board and Department of Medical Assistance Services' Achievements

The Board and DMAS are proud of the achievements made in the improvement of services and service delivery for the Medicaid/FAMIS population during the past two years. Among the achievements are increased enrollment of children into the Medicaid and FAMIS programs, an increase in rates for obstetric providers, simplification of the enrollment process, and implementation/certification of a new Medicaid Management Information System. The following is a brief description of some of the key accomplishments:

- **Since September, 2002, More Than 100,000 Additional Children Have Health Insurance**

Since September, 2002, when Governor Warner implemented major changes in the program, more than 100,000 additional children have been enrolled in the Virginia Children's Health Insurance Program (FAMIS and FAMIS Plus). Virginia has been recognized by national health care organizations, including the Kaiser Commission on Medicaid and the Uninsured, the National Academy for State Health Policy, and the Robert Wood Johnson Foundation's *Covering Kids and Families Initiative*, for its accomplishments in this area. The BMAS has fully supported the Governor's efforts to improve the program and increase enrollment, and have actively participated in the FAMIS/Children's Health Insurance Advisory Group which advises the Department on various issues related to this program.

- **Implemented A New Medicaid Management Information System (VAMMIS) And Received Unconditional Federal Certification Of The New System**

DMAS implemented a totally new and redesigned Medicaid Management Information System (MMIS) on June 16, 2003. The new MMIS is one of the most complex information systems projects undertaken by the Commonwealth, and its successful implementation marks the culmination of a multi-year effort that began in 1998. In May, 2004, the federal Centers for Medicare & Medicaid Services (CMS) unconditionally certified Virginia's new MMIS. The certification is retroactive to June 16, 2003, the date the new system began operations. This decision resulted in receipt by the Commonwealth of 75 percent Federal Financial Participation back to the start of operations.

- **One of the First Medicaid Programs to Comply with the Health Insurance Portability and Accountability Act (HIPAA)**

Virginia's Medicaid program was one of only 10 Medicaid programs that achieved compliance with the HIPAA transaction standards by the mandated date of October 16, 2003. In fact, compliance was achieved on June 16, 2003 when the new MMIS began operations. Virginia has been recognized as a leader among the various states in its efforts to comply with HIPAA.

- **Expanded Medicaid funded Community-Based Treatment Services for Children**

On July 1, 2004, new Community-Based Residential Treatment Services were added to the Virginia Medicaid State Plan. The new service allows Virginia to obtain a federal share for services that are currently provided by the Comprehensive Services Act. This allows children to obtain Medicaid funding for services that are less intense than the traditional residential treatment services.

- **Simplified Medicaid Eligibility Criteria for Families and Children**

The Centers for Medicare and Medicaid Services approved Virginia's efforts to simplify and streamline the eligibility criteria for families and children. The cumbersome and labor intensive requirements for families having income less than 24 percent of poverty to verify their resources have been eliminated. As a result, eligibility determinations have been simplified, making it easier for families to apply for coverage and for local department of social services eligibility workers to determine Medicaid eligibility. Increased numbers of low-income families with children have been enrolled as a result of this change.

- **Implemented a New Disease State Management Program for Medicaid Clients with Congestive Heart Failure or Coronary Artery Disease**

DMAS implemented a disease state management pilot project in collaboration with Anthem on June 1, 2004. This project is being administered by the Health Management Corporation, a subsidiary of Anthem, and will operate through May 31, 2005. The goal of this project is to improve health outcomes and decrease Medicaid expenditures for Medicaid fee-for-service recipients diagnosed with Congestive Heart Failure and/or Coronary Artery Disease.

- **Improved Access to Obstetrical Care by Raising Medicaid Rates 34 Percent**

The Commonwealth of Virginia is facing a health care crisis, as many women in rural areas have limited access to necessary obstetrical care. To address this problem, Governor Warner signed Executive Directive 2, which directed the Secretary of Health and Human Resources to convene and chair the Rural Obstetrical Services Work Group. In the July 1, 2004 interim report, the Workgroup recommended the Medicaid Physician Fee schedule be increased by approximately 45 percent for OB services to bring Medicaid rates up to the "Medicare equivalent" rate. In response to the recommendation, Governor Warner issued an emergency directive authorizing DMAS to implement a 34 percent increase to OB professional rates. DMAS staff, as well as staff of the Medicaid-contracted managed care organizations (MCOs), focused energies to get the regulations developed, rates set and loaded, and information out to the providers. The newly increased rates were effective September 1, 2004, for both the fee-for-service and managed care programs under Medicaid. The work group offered other recommendations across six policy areas in their final report to the Governor on October 29, 2004.

BMAS members attended "town hall" meetings that were held across the state and supported the work of the Governor's task force.

- **Initiated Improvements to Dental Care Access for Medicaid/FAMIS Children**

The 2004 Appropriations Act, authorized the Department of Medical Assistance Services (DMAS) to consolidate and administer dental services under a single, fee-for-service program. DMAS is securing a contract for a single statewide Dental Benefits Administrator to administer the dental benefit program for Medicaid/FAMIS Plus and FAMIS children, and for limited medically necessary oral surgery coverage for adults age 21 and over. A request for proposals (RFP) is being issued in December, 2004, with a scheduled implementation date of June 1, 2005.

BMAS members will be working with the Department to ensure a successful implementation of the new program. BMAS members will be meeting with dentists in their respective areas of the state to advise them of the new program and encourage their participation. The BMAS also plans to meet with the Board of Dentistry to promote the new program.

- **Increased Awareness of Well Child Visits and Special Services Available to Children under the Medicaid Program**

The Department has developed and revised enrollee materials, specifically as it relates to the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) program for children. The purpose of these notification and training activities was to increase awareness of important preventive care as well as special health care services that may be available for children under the Medicaid program.

- **Implemented Major Pharmacy Initiatives in the Medicaid Program to Improve Patient Care and Control Costs**

The Department implemented five major pharmacy initiatives in the past year. The programs included quality of care and/or cost containment initiatives.

❖ Preferred Drug List (PDL): The PDL program is a prior authorization plan that divides Medicaid covered prescription drugs into two categories: those that require prior authorization before they can be dispensed, and those that do not. The major goal of a PDL program is to educate physicians to appropriately prescribe high quality, less expensive medications that provide the same therapeutic benefit as more expensive drugs, when available. The PDL Program has been highly successful.

The BMAS Chairman has attended every meeting of the Pharmacy & Therapeutics (P&T) Committee and has provided strong support to this major initiative.

❖ Prospective Drug Utilization Review (ProDur): The ProDUR program is a quality improvement program that involves a prospective review of each prescription along with the patients' drug therapy history to determine if there are potential adverse effects including, but not limited to, drug therapy duplications, contraindications, interactions and early refills.

❖ Threshold/Polypharmacy: The Threshold/Polypharmacy program is intended to monitor drug profiles for clinically appropriate drug utilization, improve the health and safety of recipients, enhance opportunities to reduce severe adverse drug reactions, retrospectively monitor high drug utilization, enhance continuity and coordination of care, and identify clinical misuse and fraud.

❖ Mandatory Generic: The mandatory generic program was enhanced this past September; it helps ensure that pharmacists are utilizing brand name and generic drugs appropriately. In the state of Virginia, unless the Prescriber writes on the face of the prescription "Brand Necessary," the pharmacist should substitute the less costly generic equivalent.

- ❖ Maximum Allowable Costs (MAC): DMAS is implementing a new Maximum Allowable Costs program for multi-source generic drugs beginning December 1, 2004. The MAC program will set a maximum price for individual multi-source generic drugs to ensure proper payment to providers. The MAC program will ensure that providers prudently select multi-source generic products in terms of quality and price.

- **Improved Medicaid Funding to Both Hospital and Nursing Facilities**

DMAS was required this year to calculate entirely new rates from new cost data, for both hospital and nursing home providers. Rates were calculated in time for the expenditure impact to be incorporated in the agency's budget request, and rates were issued in advance of the effective date of July 1, 2004. The rate rebasing significantly improved funding to both hospitals and nursing homes, and will help to protect access to care as well as quality of care and quality of life for individuals who receive services from these institutions.

- **Successfully Implemented a Medicaid Administration Claiming Program for School Providers**

DMAS successfully implemented a Medicaid administrative claiming program for school divisions. As a result, the Commonwealth received an additional $8.8 million in federal funds in FY 2004. Half of this amount was distributed to 70 participating school divisions. DMAS anticipates that more school divisions will participate in the future.

BMAS members have monitored this program and have assisted DMAS by working with major school divisions such as Richmond City Schools, and encouraging them to increase their participation in the program.

- **Medicaid Implements Paperless Utilization Reviews**

DMAS has a nearly paperless utilization review (UR) process for reviews of providers conducted by the Long Term Care Division. When conducting utilization reviews, all necessary documentation is scanned and stored on laptop computers. The only copies that are made are items that will not scan properly. Very little paper is kept from these reviews, except for the letters to the providers and hard copies that are needed for appeals or investigations with the Office of the Attorney General.

- **Medicaid Home and Community Based Waivers Combined to Improve Access to Consumer Directed Services for the Elderly and Persons with Disabilities**

The Elderly or Disabled with Consumer Direction (EDCD) waiver is designed to provide individuals with flexible choices and it includes provisions for family members or caregivers to deliver covered services. This waiver was created in accordance with the 2003 Appropriations Act and Olmstead Task Force Recommendations. The waiver will be fully implemented in February 2005.

- **Spearheaded A Successful Campaign to Bring the 58th Annual Conference of the National Association of State Human Services Finance Officers to Virginia**

The Fiscal Division of the Department of Medical Assistance Services spearheaded a successful campaign to bring the 58th Annual Conference of the National Association of State Human Services Finance Officers (HSFO) to Williamsburg from July 31, 2005 through August 5, 2005. The HSFO is an association of state human service finance officers from throughout the country. We anticipate that the conference will generate approximately $500,000 to the local economy through food, lodging, travel, and miscellaneous spending by conference attendees and sponsors. To learn more about HSFO or the Williamsburg conference, visit the HSFO website at www.hsfo.com.

Additional information about the BMAS and the Medicaid program can be found on the agency's website: www.dmas.virginia.gov.