Biennial Report of the Board of Medical Assistance Services

Department of Medical Assistance Services

December, 2006

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 past meeting dates are listed in Table 1.

During the Board meetings, DMAS staff has briefed the members on changes to the Medicaid/FAMIS program, new initiatives such as the *Healthy Returns* disease management program, legislative and budget developments, and DMAS administrative issues. Other speakers have included staff from the Office of the Attorney General and representatives from the *Healthy Returns* contractor. In addition, the Board provides for a public comment period at each meeting in order to hear from the general public regarding any Medicaid related issues. A full list of the agenda topics are in Appendix A.

Table 1
Board Members and Meeting Dates

Current Members	
Providers	**Non-Providers**
Monroe E. Harris, Jr., D.M.D.	Phyllis L. Cothran
Patsy Ann Hobson	Rose C. Chu
Manikoth G. Kurup, M.D. (Chair)	Terone B. Green
Michael Walker	Kay C. Horney
Robert D. Voogt, Ph.D. (Vice Chair)	David Sylvester
	Barbara H. Klear
Meeting Dates	
CY 2005	**CY 2006**
March 8, 2005	April 11, 2006
June 14, 2005	June 13, 2006
September 13, 2005	September 12, 2006
December 13, 2005	December 12, 2006

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:

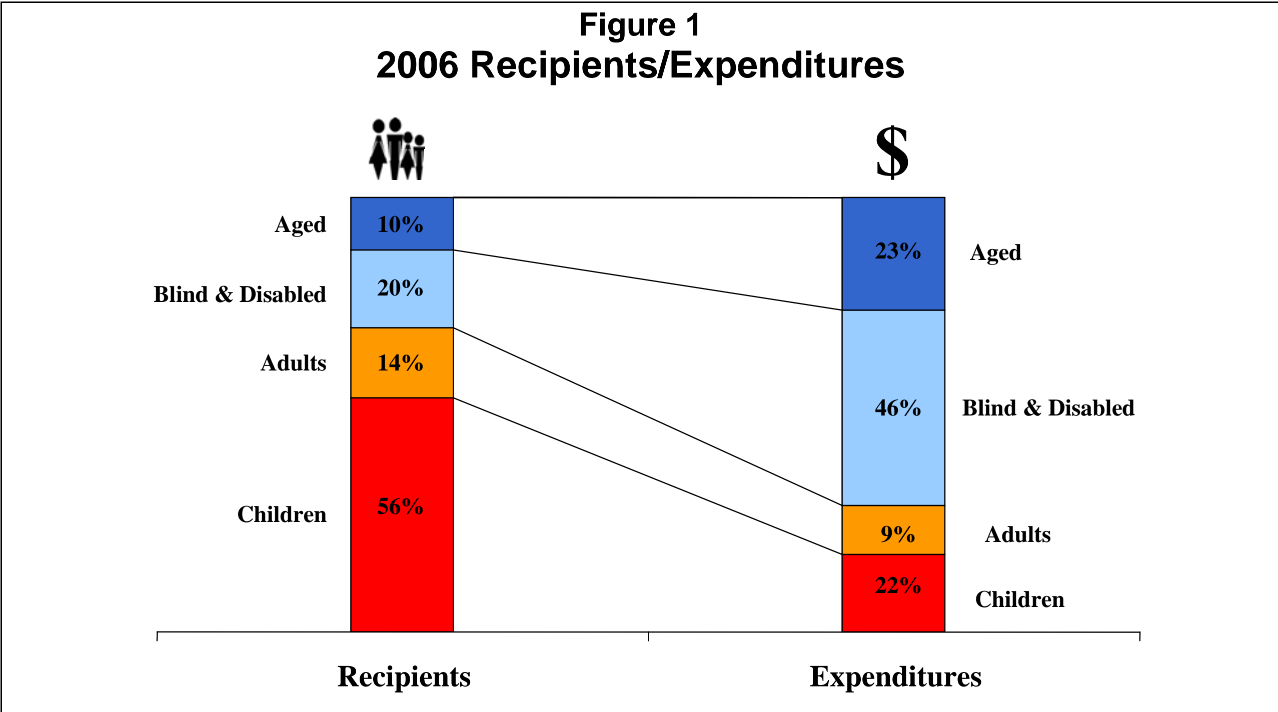
- The Board reviewed the bylaws and amended them in 2006.
- The Board provided input into policy and program issues, such as Bariatric Surgery Centers of Excellence and Medicaid coverage of erectile dysfunction drugs.
- The Board created a subcommittee to meet with transportation providers and review concerns on payment rates.
- The Board continues to be active in participating in various DMAS Committees and advisory groups such as the Department's Pharmacy & Therapeutics Committee, the Medicaid Transportation Advisory Committee, the Family Access to Medical Insurance Security (FAMIS)/Children's Health Insurance Advisory Committee, the Managed Care Committee, the Medicaid Revitalization Committee and the Integration of Acute and Long Term Care Committee to name a few.

OVERVIEW OF THE VIRGINIA MEDICAID PROGRAM

Medicaid is an entitlement program authorized under Title XIX of the Social Security Act that provides coverage of medical services for certain disabled and low income individuals. Medicaid is financed jointly by the state and federal governments and administered by the states, within guidelines established and approved at the federal level. Federal financial assistance is provided to states and the federal match rate is based on the state's per capita income. The federal match rate for Virginia is currently 50 percent, meaning that for every dollar expended in the Medicaid program, 50 cents is from the federal government and 50 cents is from the state's general fund.

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

In state fiscal year (FY) 2006, the Medicaid program served an average of over 731,000 recipients per month with annual expenditures of $4.8 billion (approximately one-half from federal funding). Children and adult caretakers make up about 70 percent of the Medicaid beneficiaries, but they account for only 31 percent of Medicaid spending. The elderly and persons with disabilities, while a minority in terms of recipients served (30 percent), account for the majority (69 percent) of Medicaid spending because of their intensive use of acute and long-term care services (Figure 1).



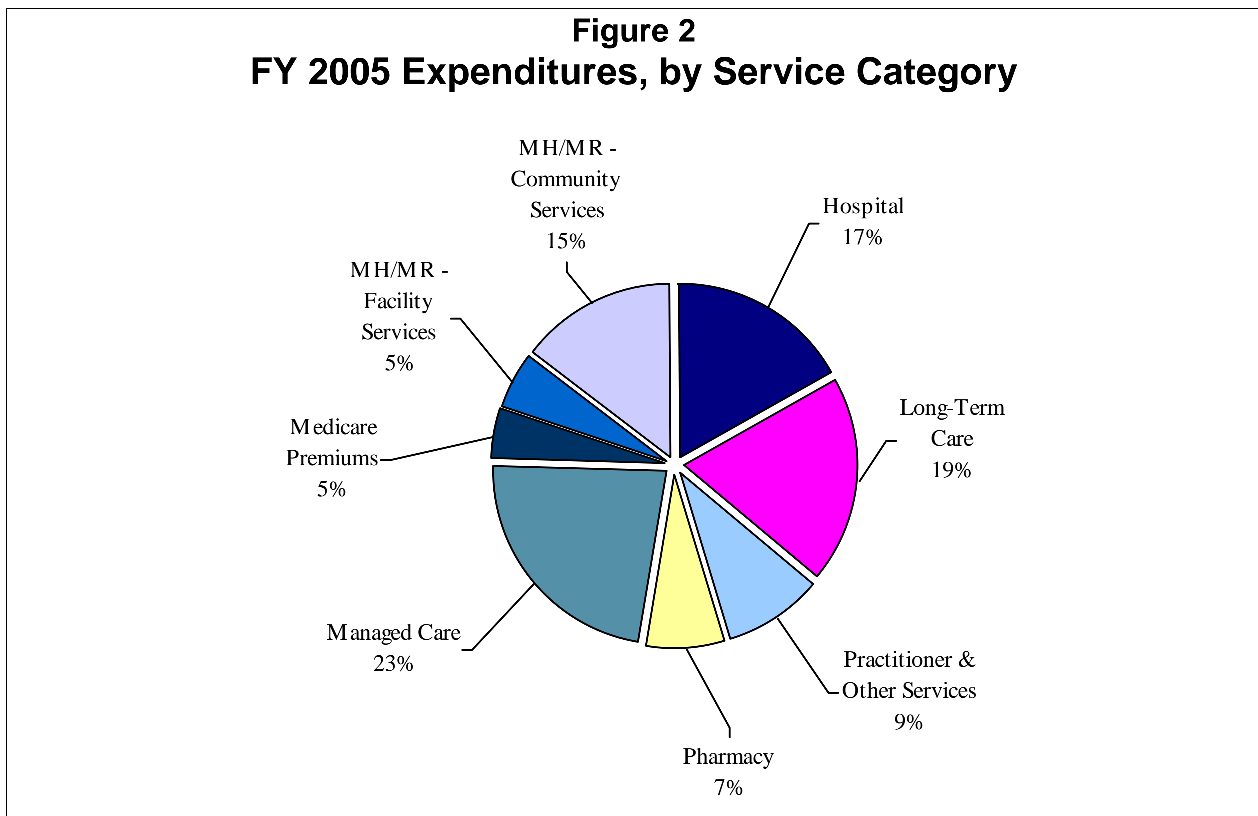
The Virginia Medicaid program covers a broad range of services with nominal cost sharing for some of the beneficiaries as permitted under federal law. The Virginia Medicaid program covers all federally mandated services and Virginia Medicaid also provides some services at the state's option. These services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

Table 2
Mandatory and Optional Services Covered by Virginia Medicaid

Mandatory Services	**Optional Services**
• 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)

Health care services are provided to Medicaid recipients through two general models: fee-for-service (FFS) - the standard Medicaid program where providers are reimbursed directly from DMAS for services rendered; and managed care - utilizing contracted managed care organizations which pay providers directly (Virginia pays private MCOs a “per member per month” fee through a full risk contract to manage the majority of the recipients’ care). Certain recipients (most notably those in long-term care programs) are currently excluded from participation in the MCO program. Additionally, Medicaid managed care is not yet available statewide due to market conditions. Recipients who would otherwise be eligible for managed care if plan coverage existed in their region are enrolled in a primary care case management program, but services remain reimbursed under the FFS methodology.

As of August 2006, nearly 55 percent of Medicaid/FAMIS recipients were enrolled in the MCO program, with approximately 45 percent of recipients in the FFS program. Figure 2 presents the proportion of healthcare expenditures by the major service area in FY 2006. It is important to note that the “Managed Care” expenditure total represents the expenditure to the participating health plans, with plans paying providers for services to their participants.



Despite Virginia’s relative affluence (7th in the nation in per capital income), Virginia remains ranked near the bottom among states in terms of the number of Medicaid recipients as a percentage of the population (47th in the nation) and the Medicaid expenditure per capita (49th in the nation). Based on these and other

statistics, Virginia's Medicaid program has long been described as a very lean program with very strict eligibility criteria and modest payment rates for services. Administrative costs of the Virginia Medicaid program represented only 1.8 percent of total Medicaid expenditures in 2005 (2006 data not yet available).

BOARD OF MEDICAL ASSISTANCE SERVICES 2005 & 2006 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:

KEY ACHIEVEMENTS

FAMIS Program Accomplishments

- Increased enrollment of children covered by Medicaid or FAMIS.

  - Between July 1, 2004 and July 1, 2006 the net enrollment of children covered by Medicaid and FAMIS increased by 47,570 (from January 1, 2002 until July 1, 2006, net enrollment increased by 144,641 children). This significant increase was largely due to continued aggressive outreach and improvements to the application and enrollment process.

    - On July 1, 2006 DMAS implemented new federal requirements that Medicaid applicants provide proof of both citizenship and identity. Unfortunately, this new barrier to enrollment has resulted in a net decrease of almost 12,000 covered children in Medicaid in just 4 months.

- Implemented a new program, FAMIS MOMS, to provide comprehensive coverage to more low-income pregnant women.

  - On August 1, 2005, DMAS implemented the FAMIS MOMS program to provide coverage to pregnant women with income above the Medicaid limit but less than 150 percent of the federal poverty level. At the direction of the legislature, the income limit was raised to 166 percent FPL the following year. Enrollment in the new program has exceeded original projections and over 1,000 women have received prenatal care since the program began.

- Revamped the FAMIS Premium Assistance Program to Allow More Families to Participate while Streamlining Program Administration.

  - DMAS converted the former FAMIS premium assistance program, known as the Employer Sponsored Health Insurance (ESHI) program, into the new FAMIS Select program. FAMIS Select provides $100 per month/per FAMIS eligible child to families who choose to enroll their children in a private or employer sponsored health plan instead of FAMIS. In many cases this helps the family afford full family coverage and also allows a greater choice of providers. Enrollment in FAMIS Select is currently over 300 children, which represents more than 3 times the number enrolled in the old ESHI program. An additional 233 adults and non-FAMIS eligible children are also covered by the health plans that FAMIS Select helps families afford.

E-Medicaid Program Developed to Assist Victims of Hurricane Katrina

- On September 1, 2005, the Governor's office established an emergency task force to create a plan to meet the needs of displaced persons as a result of the Katrina Disaster. In response, DMAS developed an emergency Medicaid (E-Medicaid) program to meet the ongoing health care needs of individuals and families displaced to Virginia. The new program was fully functional within 36 hours with the ability to enroll recipients, pay claims and answer questions for persons being displaced. This program served 4,269 individuals at a cost of $3.5 million (most of these costs will be reimbursed by the federal government). In addition, the agency was the lead in the oversight of "Town Pickett" a temporary displacement center for Katrina Victims.

Implemented Changes to Support Medicare Part D Prescription-drug-coverage Requirements

- The Medicare Modernization Act (MMA) made available Medicare Part D prescription drug coverage for Medicare recipients, thereby ending Medicaid coverage of most drug costs for those dually eligible for both Medicare and Medicaid. As part of the new program, Medicaid programs are required to submit monthly records for Medicaid enrollees documented as having Medicare coverage. To help make certain the files we send to CMS are error-free, DMAS undertook a massive effort to correct thousands of records and to add data-quality edits aimed at ensuring the correctness of entered data. We also carefully analyzed and implemented claims-processing changes to ensure that we correctly pay only for prescription drugs which are not covered under Part D, but remain covered through Medicaid. While many states experienced considerable problems with their Part D implementation, DMAS' was remarkably smooth. Our error rate for records sent to CMS is consistently at or below 0.1 percent.

Implemented the DMAS Dental Program – *Smiles for Children*

- The Virginia Medicaid/SCHIP Dental Program experienced a major transformation during 2005 with dramatic changes due to the support of the Governor, General Assembly and Virginia's dental community. The new dental program brought a significant increase in payment rates, consolidated enrollment into one carved out benefit, and a single benefits administrator. After the first year of operation for the new dental program, the *Smiles For Children* program is making a difference in improving dental care across Virginia.

  - As of September 30, 2006, 235 new dentists have joined the dental network, representing a 38 percent increase; there are eight localities that previously had no participating dentists that now have access to dental services.

  - The utilization of dental services has significantly increased within the first year of program operations with over 40,000 additional children receiving dental services.

  - The streamlined administration of the program has resulted in prompt prior authorization and reimbursement for services and participating dentists report that the new program compares very favorably to commercial dental insurance plans. *Smiles For Children* is becoming a nationally recognized model for State Medicaid dental programs.

Medicaid Revitalization Committee Report Completed for the Governor and the General Assembly

- DMAS hosted a series of meetings with the Medicaid Revitalization Committee (MRC), a committee made up of advocacy and constituency groups formed by the Virginia General Assembly to examine alternative and innovative approaches to healthcare delivery under Medicaid. DMAS completed a report of the committee's deliberations and recommendations (which is available on the DMAS web site). The Committee's seven recommendations addressed:

  - *Disease Management:* Expand population-based disease management programs to target high cost and/or high prevalence disease states

  - *Enhanced Benefit Accounts:* Implement an enhanced benefit accounts program in which recipients are rewarded for compliance with aspects of their care plan

  - *Electronic Funds Transfers:* Require electronic funds transfer for payment of healthcare services to all enrolled Medicaid providers

  - *Web-Based Claims Submission:* Implement a web-based claims submission system available free of charge to all healthcare providers for use in the

submission of Virginia Medicaid claims and for the receipt of electronic remittance advices

- *Managed Care:* Expand managed care into new regions and across additional eligibility categories where feasible.

- *Private Insurance Subsidy:* Study the potential impact of modifications to existing programs for public subsidy of employer-sponsored or other private health insurance coverage for Medicaid-eligible individuals.

- *Public Insurance Buy-In:* Expand, where feasible, "buy in" programs to allow expanded participation in the Medicaid and FAMIS programs to the extent such expanded participation can be shown to be cost effective / cost neutral to the Commonwealth

Program Integrity Increased Coordination and Focus

- The Department has coordinated its program integrity efforts and formalized a number of its existing integrity initiatives.

  - The Department consolidated its program integrity provider review resources across divisions. The Provider Integrity (PI) division utilizes sophisticated data mining software to identify providers whose billing practices appear aberrant in relation to their peers. In addition to using CS SURS software (as required by CMS), the division also instituted ACL software this year, and contracted with Thomson Medstat, a national firm, for a focused fraud detection.

  - The Department developed a two year agency program integrity plan. The two year program integrity audit plan includes both current and future initiatives, including an annual provider review plan developed for DMAS by a national audit firm. The purpose of the annual review plan is to assure that an appropriate number of providers are audited and to target provider types which have the potential to be problematic based on certain risk factors. The plan is developed using national data/trends regarding provider types and risk assessments that are prone to inappropriate billing and integrity issues. The two year plan features the use of additional contractors where technical expertise is needed to supplement desk audit fieldwork on complex audits. Two contracting firms, Clifton Gunderson and Meyers Stauffer, were hired in 2006 to handle supplemental services (e.g. ancillaries, hospice and other non physician services).

  - These efforts have doubled recoveries and tripled referrals to the Medicaid Fraud Control Unit at the Office of the Attorney General (compared to the previous year).

  - Overall, the Department had a record year in program integrity efforts form LTC quality reviews to cost settlement recoveries in excess of $19 million.

- This year, DMAS was selected to participate in the CMS national Payment Error Rate Measurement (PERM) project. Previously, CMS conducted a three year pilot program to develop estimates of the level of Medicaid payment and eligibility error. In FY 2004, (the second pilot year) Virginia was one of the participating pilot states and achieved a 91.66% compliance rate for fee-for-service and managed care. In FY 2005, Virginia had a 6.16% error rate for Medicaid (FFS & Managed care) and 12.86% (mostly eligibility errors) for SCHIP (FFS & Managed care).

Implemented the new *Healthy Returns* Disease Management program

- On January 13, 2006, the Department of Medical Assistance Services (DMAS) announced the expansion of the *Healthy Returns* disease management program.

  - *Healthy Returns* provides targeted services to patients diagnosed with coronary artery disease, congestive heart failure, asthma, and/or diabetes. The program is designed to help patients better understand and manage their condition(s) through prevention, education, lifestyle changes, and adherence to prescribed plans of care.

  - *Healthy Returns* is administered by Health Management Corporation (HMC) and offers care management, a 24-hour nurse call line, and evidence-based treatment protocols.

  - *Healthy Returns* is offered to all fee-for-service (non-MCO) Medicaid and FAMIS enrollees with the exception of Medicare dual eligibles and those who live in institutional settings or have third party insurance.

Expansion of Managed Care Coverage

- Coverage under the Medicaid contracted managed care organizations (MCOs) has increased approximately 25 percent from 306,959 in July 2004 to 385,497 in September 2006.

  - Effective September 1, 2005, the Department contracted with a new MCO, AMERIGROUP Community Care, to provide services in northern Virginia.

  - MCO coverage areas increased to cover Winchester and its surrounding counties; the city of Danville and surrounding counties experienced a second health plan entering the area.

  - The Medicaid managed care program also expanded coverage of the Aged, Blind and Disabled population to those with income at or below 80 percent of the Federal Poverty Level.

Implementation of a Pharmacy Cost Containment Programs

- In January 2004, DMAS implemented its preferred drug list (PDL) program which included the development of the Pharmacy and Therapeutics Committee and the execution of related supplemental rebates.

  - The PDL program in conjunction with other new pharmacy cost savings programs have contributed to a significant decline in the pharmacy expenditure trend; down to only a 2.9 percent increase between fiscal years 2004-2005 compared to increases of 11-15 percent from fiscal years 2000-2003.

  - Cost savings include the invoicing of over $53 million in supplemental rebates (from January 2004 through June 2006) using a unique supplemental rebate model that has outperformed the approaches used by many other states.

  - The PDL was developed and is maintained with substantial support from the provider community and pharmaceutical manufacturers

- DMAS redesigned its Maximum Allowable Cost (MAC) program to reduce overall Medicaid drug expenditures for generic and multi-source drugs while reimbursing pharmacies fairly for these products. This program has been largely successful -- the MAC price is being used for the majority of claims subject to the program, the impact of the new pricing methodology of the pharmacy community has been minimal, and the program has met its savings target. Since the inception of the program in December 2004, there have only been two pricing disputes and these were promptly resolved.

Achieved Significant Progress with the Program of All-Inclusive Care for the Elderly (PACE)

- The Department of Medical Assistance Service has partnered with Sentara Health Care Systems to move forward with the implementation of the first full PACE program in the Commonwealth.

  - This program, designed around an adult day health model, provides for a full spectrum of home-and-community based care at a “one-stop” shop under a capitated system to reduce the cost of care while ensuring the highest quality outcomes for seniors.

  - Open to persons over the age of 55 who qualify for nursing facility care in the catchment area.

  - DMAS will replicate this program throughout the Commonwealth as another way in which to reduce Medicaid long-term care costs and provide quality health outcomes for the elderly.

- Governor Kaine and the 2006 General Assembly made available start-up funding for six additional PACE sites in the Commonwealth. The following areas of the state are developing PACE sites: Hampton Roads, Richmond, Lynchburg, and the far Southwest areas of Virginia.

OTHER ACHIEVEMENTS

Achievement of Full Statutory Compliance Responding to Recipient and Provider Appeals

- The Appeals Division Provider Appeals Unit has continued to maintain 100 percent compliance with all statutory and regulatory time frames governing appeals filed by Medicaid service providers under the Virginia Administrative Process Act.

    - Though the number of filed provider reimbursement appeals annually has grown from 1,127 in 2004 to 1,300 in 2005, the Appeals Division has met the increasing challenge of achieving 100 percent compliance.

- The Appeals Division Client Appeal Unit has seen similar growth from 1,795 appeals in 2004 to 1,973 in 2005. The Client Appeals Unit continues to strive for 100 percent compliance (currently at 98 percent compliance).

Improved Education, Reporting and Approval Process for EPSDT

- The Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) program is a critical prevention and treatment component for children covered by Medicaid. It provides both comprehensive health screenings from birth through adolescence, including immunizations, lead screenings, etc., as well as medically necessary specialized treatment above and beyond the routine Medicaid covered services. DMAS has been working to improve education of families and providers about the availability of these services, improve data reporting to measure progress and clarify and coordinate the pre-authorization process for specialized services.

Implemented a Revisions to the Non-Emergency Transportation Program

- On November 4, 2004, an RFP was issued for transportation brokerage services that made transportation safe, reliable and on-time. Major changes were made with input from consumer groups, advocates and service providers. Changes include more stringent driver training and vehicle requirements; increased use of attendants; service expanded from curb-to-curb only to include both door-to-door and hand-to-hand assistance; a cap on administrative expenses for the broker; as well as a new capitated payment methodology that accounts for enrollment changes. The new transportation brokerage contract was awarded in August 2005 to LogistiCare, Inc.

- In January 2006, DMAS and LogistiCare agreed to work toward increasing the number of trips that would be provided by using fixed-route public transportation, gas reimbursement and volunteer drivers. In 2005, these modes accounted for 9 percent of all non-emergency trips; the goal for 2006 is 12 percent of all trips. This initiative is designed to reduce costs to DMAS and provide greater flexibility and independence for the recipient. The volunteer driver program is used for remote or lengthy trips that are difficult to assign to a provider. Approximately 50 volunteers have been trained throughout the Commonwealth since June 2006. Overall, the trips by alternative transportation modes were just under 11 percent of total trips at the end of October 2006.

Converted to the Consolidated Medicare Crossover Claims Processor

- Virginia Medicaid was the first state outside of the pilot program to convert to the CMS mandated consolidated processing for Medicare claims, known as COBA (Coordination of Benefits Agreement).

  - Under the new process, Medicare crossover claims are sent to Virginia Medicaid from a single source, rather than from each carrier and fiscal intermediary. Similarly, DMAS sends a file of dual eligibles to a single processor.

  - Conversion to this process also meant that Crossover claims were sent on the standard 837 claim transactions rather than the old National Standard Formats (NSF).

  - DMAS performed significant parallel testing for several months prior to the implementation to help ensure a smooth transition to the new process in January, 2006.

Implemented Two New Home- and Community-Based Care Waivers

- Implemented a new waiver in 2005 designed to provide support to eligible residents of Assisted Living Facilities who have a diagnosis of Alzheimer's disease or related dementia and provide services in a safe and secure, cost effective environment. Virginia is one of only twelve states offering such a Medicaid program and participants are afforded a higher quality of care as their condition progresses at a lower cost than the alternative institutional placement.

- DMAS implemented a new home-and community-based waiver designed to serve persons with mental retardation who are on the waiting list for the Mental Retardation Waiver. The waiting list for this waiver is over 3,300 persons and the wait for receipt of services may be years. In order to assist persons and their families, a Day Support waiver with 300 slots (all have been filled) was implemented to provide some level of services to persons assessed and needing services and on

the waiting list for the broader spectrum of services offered under the Mental Retardation Waiver.

Achieved Measurable Results with the Real Choice Systems Change Grant

- DMAS closed out its grant from the Centers for Medicare and Medicaid in late 2005. This grant was designed to inform potential Medicaid recipients of the availability of less costly Medicaid waivers that encourage persons to remain in the least restrictive setting (their home and communities) while reducing costs to the Commonwealth for more costly institutional placement.

  The grant resulted in:

  - Production of informational brochures outlining each of the Commonwealth's Medicaid Waivers;
  - Publication of "The Roadmap to Services";
  - Implementation of the Enhanced Care Attendant Training by Virginia Geriatric Education Center;
  - Development and distribution of outreach and educational materials on Consumer-Directed services; and
  - Development of a satisfaction survey for participants of the Elderly and Disabled Waiver.

Awarded a Systems Change Grant for Community Living

- The Department of Medical Assistance Services, in collaboration with other state agencies and key stakeholders, was one of eight states awarded a "Real Choice Systems Change Grant for Community Living" grant in September 2006. The five-year, $2.2 million grant was awarded by the Centers for Medicare and Medicaid Services to assist Virginia with transforming its long-term support system from one that leans toward institutional care, to one that provides easy access to services and supports in the community. The grant will also dramatically enhance the role that individuals have in determining the amount, scope, and providers of their services. Improvements in technology and the use of web-based portals will be pivotal to the success of this project.

Developed New Quality Management Strategies

- In response to new requirements from the Centers for Medicare and Medicaid, the Division of Long Term Care has begun the development and implementation of a comprehensive quality management strategy for the Medicaid Waiver programs.

  - DMAS partnered with Thomson/Medstat for technical assistance to develop this strategy that will enhance the quality of service delivery for all Medicaid Waiver recipients in the Commonwealth. Implementation of these strategies will be instrumental in the integration of managed and long-term care thus assuring quality services while reducing overall Medicaid costs.

Achieved Greater Operational Efficiencies and Enhanced Customer Services

- Successful Implementation of ClaimCheck

  - ClaimCheck was originally implemented in the MMIS in March 2004 but was quickly deactivated as a result of provider concerns with its editing functionality.

  - ClaimCheck was re-implemented by DMAS on January 9, 2006 after a detailed review by DMAS in concert with external provider groups.

  - ClaimCheck is a claims editing software application DMAS uses to identify inappropriate billing of CPT and HCPCS codes by providers.

  - ClaimCheck reviews professional and laboratory claims submitted to the MMIS system and edits them appropriately resulting in corrected payments to providers and often cost savings to the State.

  - Since the re-implementation of ClaimCheck the State has saved over $5.3 million.

- Implemented New Automated Call Distribution System (ACD) for the Provider Helpline in January of 2005

  - The new system enhancements and functionality included more open phone lines for providers and recipients more comprehensive call tracking software, detailed reporting mechanisms, and greater flexibility as changes are identified and/or required.

  - As a result of this implementation DMAS has realized a reduction in calls abandoned (on average a reduction from 35 percent down to 12 percent), reduction in call hold times (down from 5:11 to 3:10), better data and analysis on who and why providers and recipients are calling which allows DMAS to focus ongoing training efforts and resources more appropriately.

Improved Coordination Efforts with the Department of Social Services

- DMAS made some significant improvements towards improving the oversight, training and coordination with State DSS in support of the ongoing administration of the Medicaid program.
    - DMAS developed a new online Users manual for all state and local DSS workers to use when enrolling or editing information on recipients in the new MMIS system.
    - DMAS developed a dedicated training environment for DSS and their contractor VISSTA to utilize to enhance and improve training for eligibility workers at the local level.
    - Regular weekly status calls are used to coordinate system projects and monthly high level management meetings are held to address challenges and barriers associated with the two agencies.
    - A more comprehensive Memorandum of Understanding (MOU) is currently under review by both agencies.

Made Significant Claims Processing Improvements

- DMAS has made significant improvements in its claims adjudication during the past 2 years.
    - On average clean claims are processing within five days of receipt.
    - The average number of claims pending for review was reduced from 70,279 to 18,194 over the past 24 months.
    - The percent of ER claims processed within time standard is currently 100 percent and has remained constant for last 2 years.

Revamped the Uninsured Medical Catastrophic Fund (UMCF) to Fulfill its Original Mission

- The UMCF is a fund dedicated to individuals with life threatening ailments that are uninsured and have no means of financial support available to pay for necessary treatment for their condition (other eligibility criteria also applies).
    - DMAS met with original authors and advocates and identified various administrative simplification efforts that would enhance and improve the functionality while maintaining the funds purpose.

- Regulations were developed, approved, and implemented resulting in more persons receiving financial support than in the funds previous entire history since September 2002.

- The fund continues to be funded primarily through private contribution and some General Fund expenditures.

Improved Compliance with Accounting Principles

- The Fiscal division of DMAS has updated its internal procedures and the procedures for the agency's fiscal agent for key financial functions to assure compliance to accounting principles. These procedures include:

  - Void and stop payment checks
  - Manual checks
  - Advance payments to providers
  - Repayment Agreements
  - 60-day reporting
  - Monitoring of negative balances

Improved Prior Authorization Services for Fee For Service Providers

- This year (2006), DMAS awarded the contract for prior authorization and utilization review (PAUR) of the fee-for-service program to Keystone Peer Review Organization (KePRO). KePRO won the competitive bidding process for PAUR services based on its ability to implement interactive web-based technology (iExchange) and to move the PAUR process from a primarily fax and paper-based process to a speedier, provider-friendly paperless process. The contract covers sixteen core services from inpatient hospital services to home and community based waivers. The implementation and transition from the previous vendor was completed in the summer of 2006. The contractor processes about 16,000 prior authorizations per month with a 3% denial rate.

- The implementation and transition process lead to several innovations for the agency in terms of training and education including:

  - the use of web-based training technology,
  - collaboration with various associations for information dissemination,
  - creation of Prior Authorization Advisory Group,

- targeted beta site testing and training with major health systems and providers,
- revision of manuals and workflows, and
- development of an appeals training program.

State Policymakers Increased Reimbursement Rates for Many Providers

- Certain key physician, hospital, nursing home and Home and Community Based Care rates were increased to improve access to care. Of particular note, rates paid for obstetrical and gynecological (OBGYN) services were increased initially by 34 percent in September 2004 in response to the work of Governor Warner's Executive Directive 2 Workgroup (OBGYN services have had additional modest increases since this initial increase). Also, as mentioned above, the rates paid to dental providers have also experienced a significant rate increase during the past two years (an initial increase of 28 percent, on average, in July 2005). Finally, payment rates for pediatric services have had substantial increases with more scheduled to occur in the future.

APPENDIX A

Board of Medical Assistance Services
Agenda Items 2005-2006

- Bariatric Surgery Centers of Excellence Program
- Board Involvement in Key Priorities for 2006
- Budget Update
- Budget/Forecasting the Medicaid Program
- Budget—State and Federal
- Bylaws Amendment
- Citizenship Requirements of the Deficit Reduction Act
- Conflict of Interest Training
- Dental
- FAMIS
- Fraud & Recovery
- General Assembly Legislative Update
- Health Care Fund
- Healthy Returns, A New Disease Management Program
- Hurricane Katrina Response
- Integration of Acute and Long Term Care
- Long Term Care Medicaid Screening
- Managed Care Program
- Medicaid Coverage of Erectile Dysfunction Drugs
- Medicaid Reform
- Medicaid Revitalization Committee and Massachusetts Health Care Reform
- Medicare Part D
- Medicare Part D and Federal Medicaid Reform
- Role of the Board
- Transportation
- Transportation—Fuel Supplement
- Web X