Biennial Report of the Board of Medical Assistance Services

Department of Medical Assistance Services

November 2008

Table of Contents

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. The current members and past meeting dates are listed in Table 1 (there is currently one vacancy (non-provider) on the Board).

Table 1
Board Members and Meeting Dates

Current Members

Providers	Non-Providers
Robert D. Voogt, Ph.D. (Chair)	Phyllis L. Cothran
Monroe E. Harris, Jr., D.M.D. (Vice Chair)	Kay C. Horney
Patsy Ann Hobson	David Sylvester
Manikoth G. Kurup, M.D.	Barbara H. Klear
Michael Walker	William L. Murray, Ph.D.
	(1 Vacancy)

Meeting Dates

CY 2007	CY 2008
March 13, 2007	June 10, 2008
June 12, 2007	July 29, 2008
September 11 2007	September 9, 2008
December 11, 2007	December 9, 2008

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.

During the past two years, the Board continued to take 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 2007. One change to the bylaws was made so the Secretary no longer needed to be selected by the full board,
- The Board provided input into policy and program issues, such as the integration of acute and long term care, the Governor's Health Care Reform Commission, Nursing Facility Pay for Performance, SCHIP reauthorization, the implementation of tamper resistant prescription drug pads, and the FAMIS teen outreach program,
- The Board received conflict of interest training from Elizabeth McDonald, who acts as Legal Counsel to the Board,
- The Board continued 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, just to name a few.

OVERVIEW OF THE VIRGINIA MEDICAID PROGRAM

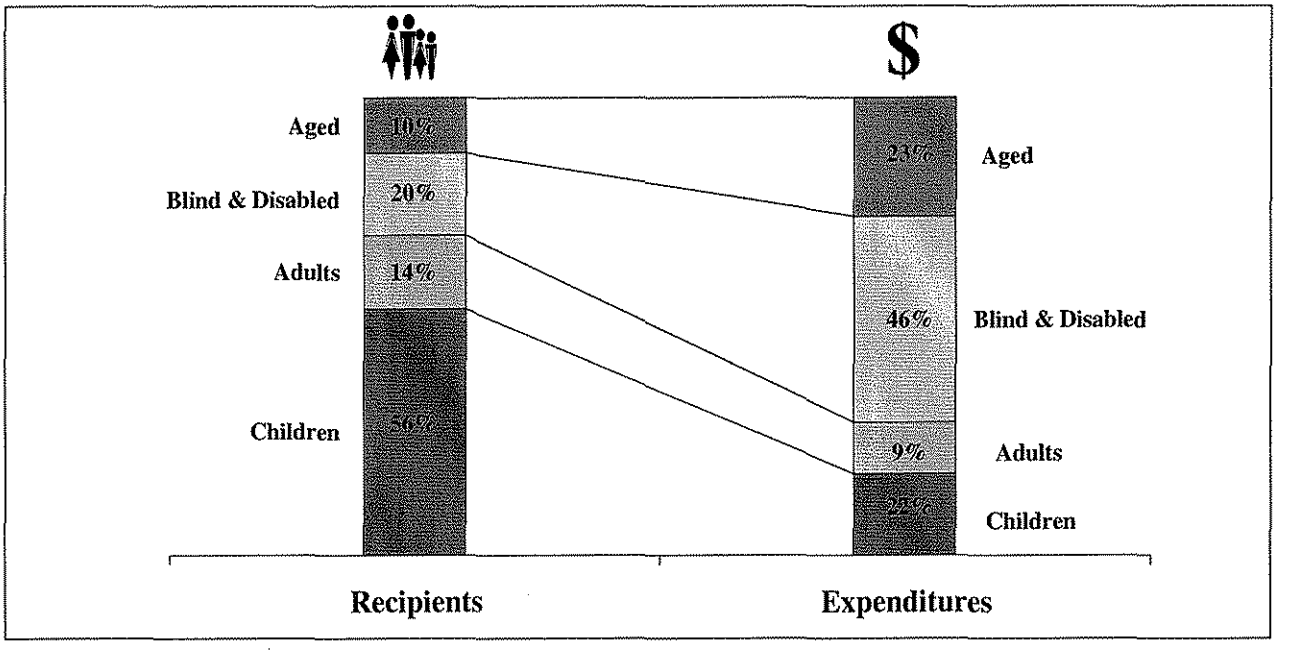
Medicaid is an entitlement program authorized under Title XIX of the Social Security Act that provides coverage of medical services for certain disabled and low income individuals. Medicaid is financed jointly by the state and federal governments and administered by the states, within guidelines established 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 (the federal minimum), 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.

The Virginia Medicaid population in fiscal year 2007 was comprised of 873,978 individuals per month (on average) with annual expenditures of $5 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).

Figure 1 - 2007 Recipients/Expenditures



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.

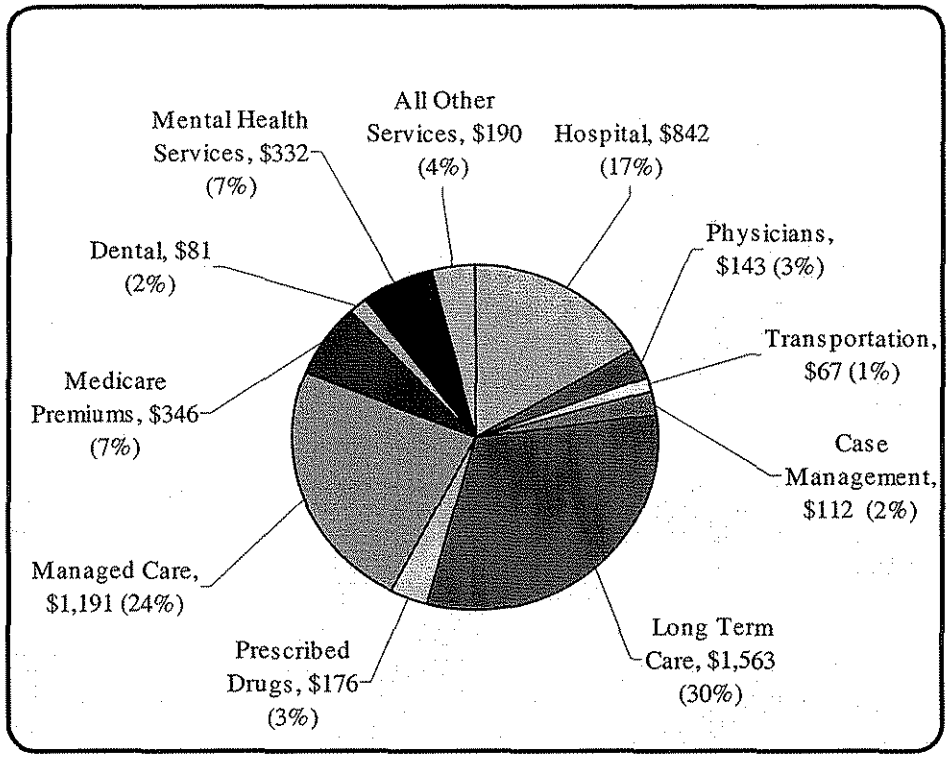
Table 2
Mandatory and Optional Services Covered by Virginia Medicaid

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). 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 are reimbursed under the FFS methodology.

As of December 2007, 64 percent of Medicaid/FAMIS recipients were enrolled in the MCO program, with approximately 36 percent of recipients in the FFS program. Figure 2 presents the proportion of healthcare expenditures by the major service area in FY 2007. 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.

Figure 2 – FY 2007 Medicaid Services Expenditures (Amounts in Millions)



Despite Virginia's relative affluence (9th 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 (48th 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 2 percent of total Medicaid expenditures in 2007.

Appendix B includes a document entitled "Medicaid at a Glance" which provides additional summary information regarding Virginia Medicaid.

2007 & 2008 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, the expansion of the Program for All Inclusive Care for the Elderly (PACE), as well as increased administrative and programmatic efficiencies. The following is a brief description of some of the key accomplishments:

Access Improvements

Expansion and Quality of Managed Care

Effective October 1, 2007, the MCO program expanded into the city of Lynchburg and counties of Amherst, Appomattox and Campbell. This expansion was the third attempt to bring managed care to the Lynchburg region. The three health plans, Southern Health CareNet, Optima Family Care and Virginia Premier, started developing provider networks more than three years ago. During this same time, the Department met with key providers, legislators, advocates, and relevant interested parties to assure that the expansion of these three plans met the agency's objectives. The expansion has been very successful, with 13,000 recipients receiving health care services through a MCO.

In addition, as of December 2007, all five Virginia Medicaid MCOs became accredited by the National Committee for Quality Assurance (NCQA), with four of the five plans having an accreditation status of "Excellent", the highest attainable level. NCQA accreditation validates MCO performance in a number of operational areas. Virginia is one of only a few states to have all of its MCOs accredited. AMERIGROUP was the last MCO to receive its NCQA accreditation as a new health plan in November of 2007. Virginia Premier achieved the status level of "Excellent" from NCQA earlier in 2007. In addition to the accreditations from NCQA, four of Virginia's Medicaid MCOs ranked in the Top 100 of the 2007 U.S. News and World Report's esteemed list of the top 100 Medicaid MCOs in the country: Ranked 22 - Optima Family Care; Ranked 33 - Anthem HealthKeepers Plus; Ranked 41 - CareNet - Southern Health; and Ranked 68 - Virginia Premier Health Plan.

Uninsured Medical Catastrophic Fund (UMCF)

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 apply). Through process and regulatory improvements, the UMCF has now fulfilled its original intent and mission consistently over the past 2 years.

- DMAS met with original authors and advocates, and identified various administrative simplification efforts that would enhance and improve the functionality while maintaining the fund's purpose,

- Regulations were developed, approved, and implemented resulting in significantly more persons receiving financial support,

- A part-time case manager was hired to oversee day-to-day functions of the fund. The case manager is in contact with applicants as well as the contracted providers providing ongoing assistance, case management and liaison duties between providers and recipients,

- The fund spent all appropriated and available resources for the first time since its existence in FY 08. DMAS anticipates full utilization of all funds once again in FY09. To date, the fund has dispersed over $788,000 to those most in need of financial support to pay for their health care costs.

Dental Access Continues to Improve through the "Smiles for Children" Program

On July 1, 2008, ***Smiles For Children*** celebrated its third year anniversary and its success continues to materialize. As a result, more Virginia dentists are willing to join the network and more children in Virginia are receiving necessary oral health services. The program administration is simplified through one dental benefits administrator (Doral Dental, USA) for credentialing and claims filing requirements, which makes provider participation easy. Outreach and personalized member attention has helped members locate appropriate providers and has helped expedite access to all levels of dental care.

More Virginia dentists are enrolling in the dental network. At the start of the program, there were 620 dental providers; there are now 1,128 individual providers in the network. This marks an 82 percent increase and a total of 508 new providers. Providers continue to express satisfaction with program participation and frequently refer their colleagues to join. In July 2008, and in recognition of the three year anniversary, Governor Kaine sent a letter to Virginia dentists thanking them for their participation and encouraging other dentists to join. As a result, additional providers continue to show interest in enrolling in the program.

More importantly, the percentage of children eligible for dental services who actually received a service has increased significantly since the start of the program. The percentage of children ages 0-20 receiving care has increased from 24% in FY 2005 to 38% in FY 2008. Similarly, for children ages 3-20, the percentage has increased from 29% in FY 2005 to 48% in FY 2008. These figures represent a 58.3% and 58.6% percent increase respectively.

Continued Enrollment Expansion of Children and Pregnant Women

Enrollment of children in Medicaid or FAMIS has continued to increase. Between July 1, 2006 and July 1, 2008, the net enrollment of children covered by Medicaid and FAMIS increased by 21,646. This increase was largely due to continued aggressive outreach.

Enrollment in FAMIS MOMS continued to grow at a steady rate, with 2,175 women served in FFY 2007. Between July 1, 2006 and July 1, 2008, the net enrollment of pregnant women increased by 300. (In July 2007, FAMIS MOMS eligibility guidelines increased from 166% FPL to 185%. The 2008 General Assembly approved the Governor's recommendation to increase FAMIS MOMS eligibility to 200% FPL to be implemented July 1, 2009.)

Figure 3 and 4 below track the significant enrollment growth of children and pregnant women over the period of January 2006 – 2008. As you can see from the charts, both pregnant women and children grew in enrollment over the two year period.

Figure 3:
Total Children's Enrollment in Medicaid/FAMIS
Jan 2006 - Oct 2008

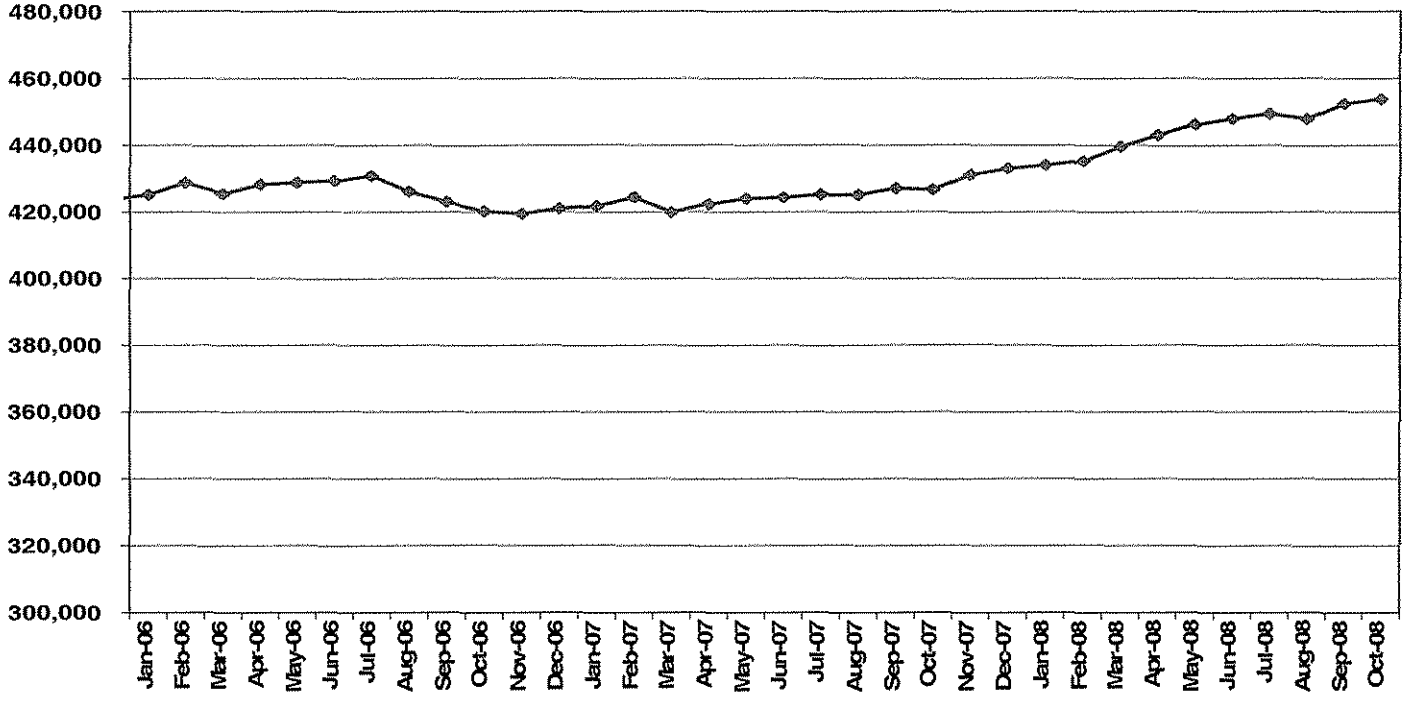
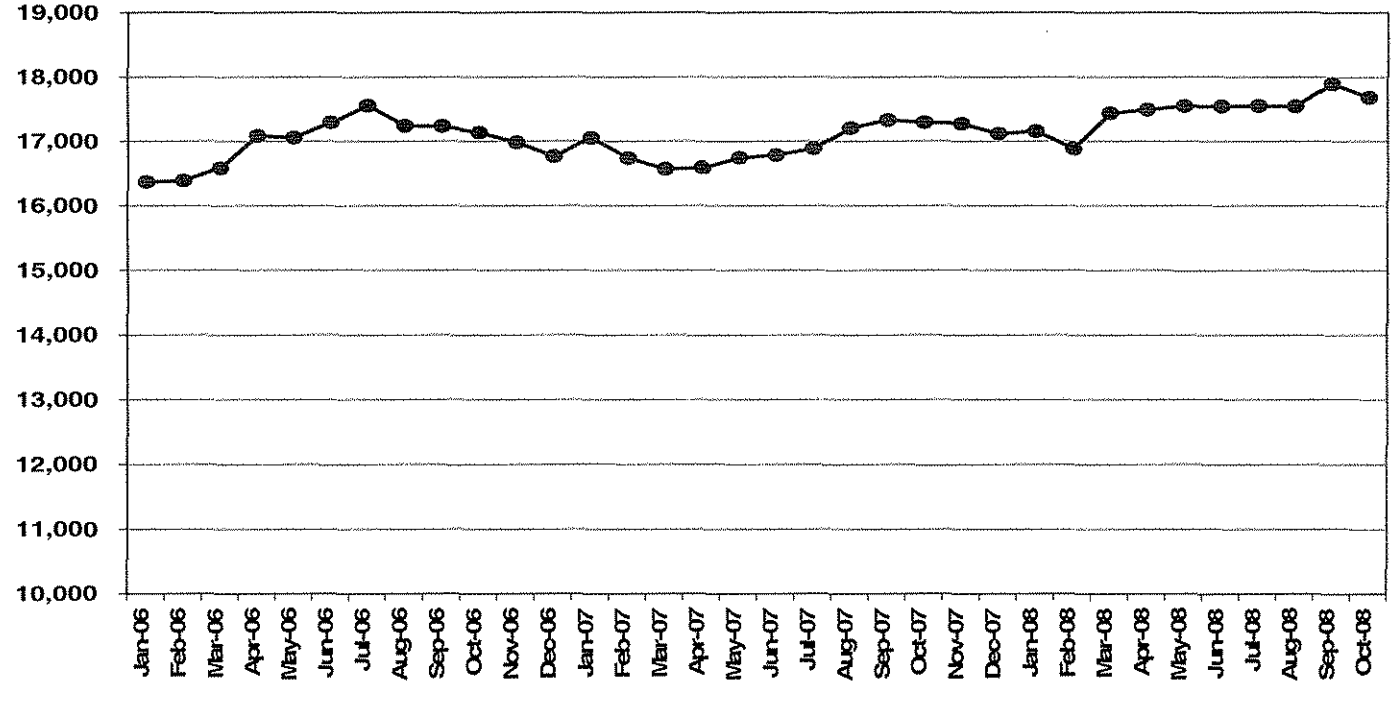


Figure 4:
Total Pregnant Women's Enrollment/Medicaid and FAMIS
Jan 2006 – Oct 2008



Continuous Improvement of the Early and Periodic Screening Diagnosis and Treatment (ESPDT) Program

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program has undergone extensive operational development, including the development of necessary policy and procedural guidance for new services resulting in increased service utilization. The EPSDT Nursing benefit experienced a 160% increase in utilization since assuming the program from the Long Term Care Division in February 2007. The EPSDT program has grown to serve the previously unmet needs of Virginia's children by providing services to meet the most complex care needs in the Medicaid program.

Family Planning Program Renewal and Expansion

In 2007, the Family Planning program was evaluated to determine areas for program improvements and enhancements. Total savings to the state over the four year period was more than $9 million. Based on a General Assembly mandate and subsequent CMS approval authorizing DMAS to expand eligibility, on January 1, 2008, DMAS implemented Plan First, the new family planning program which now includes men, as well as those women who have not had a previously covered Medicaid pregnancy.

DMAS hired a part time staff to help with Plan First marketing and outreach and developed a new program logo and brochures to promote enrollment. The General Assembly recently authorized DMAS to increase the income limit for Plan First up to 200% of poverty, while maintaining budget neutrality. The amendment to accomplish this increase was submitted to CMS in March 2008. Staffing issues and concerns about the budget neutrality methodology used by DMAS have led to a delay in approval by CMS. Approval and implementation, however, is expected within several months.

In 2007, there were more than 20,000 individuals served by the Plan First program at some point during the year.

Administrative Efficiencies and Improvements

The Implementation of the National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) required all covered health care providers to obtain and use the NPI in lieu of any other provider identification number(s) for all standard transactions. As a result of this federal mandate, a complete provider re-enrollment campaign of all providers was undertaken as part of the NPI implementation plan.

- In May 2007, an independent verification and validation review was conducted of the DMAS NPI implementation. The Report concluded the project was well planned and successfully managed. The communication campaign undertaken

on the project was cited as impressive. Because the project success was dependent on external (providers) adoption, DMAS implemented an extensive Provider Outreach campaign.

- Various communication channels including mail notification, publications in newsletters, and trailer messages in the voice response systems were employed to encourage providers to re-enroll for NPI. The mail campaign included up to five reminders to providers. This strategy and level of communication was very effective and contributed significantly to the 97% of the actively billing Provider adoption rate as of March 30, 2007.

DMAS Awarded Productivity Investment Fund Grant

DMAS was awarded a Productivity Investment Fund grant for implementation of a web-based provider claims submission system.

- The system will provide small and medium-sized providers an alternative to submission of paper claims.

- Conversion of paper claims to electronic claims will lower costs for claims processing.

- The system is targeted for implementation in early 2009.

Reimbursement-Related Administrative Efficiencies

DMAS implemented a web-based document management product (GoFileRoom) for the submission and settlement of nursing facility cost reports as part of its commitment in an August 2006 Nursing Facility Cost Reporting study to streamline the nursing facility cost reporting process.

Improvements to Care for the Elderly and Disabled

The Integration of Acute and Long-Term Care

In 2006, Governor Kaine and the General Assembly directed DMAS to develop a plan to integrate acute and long-term care services to better serve our vulnerable Medicaid clients. As a result of the *Blueprint for the Integration of Acute and Long-Term Care Services*, DMAS is actively engaged in two approaches to better integrate and coordinate the acute and long-term care of the vulnerable Medicaid population in need of both types of services:

Model 1 - Achieved Significant Progress with the Program of All-Inclusive Care for the Elderly (PACE)

- The Program of All-Inclusive Care for the Elderly (PACE) has four sites that are operating across the Commonwealth of Virginia: Sentara Senior Community Care PACE in Virginia Beach, Virginia; Riverside Peninsula PACE in Hampton, Virginia; Mountain Empire PACE in Big Stone Gap, Virginia; and, AllCare for Seniors PACE in Cedar Bluff, Virginia.

- Two additional PACE sites are in their final development stage. Riverside Richmond PACE in Richmond, Virginia, is slated to complete construction soon and will provide a Pharmacy and Pharmacist onsite to handle all medication needs for PACE participants. Centra Health PACE in Lynchburg, Virginia, is on target with the construction of their PACE site and will occupy their building October 2008. Riverside Richmond PACE has a targeted "go live" date of January 1, 2009, and Centra Health PACE has a targeted "go live" date of February 1, 2009.

- DMAS, the State Administering Agency (SAA) for PACE, has approved the development of an expansion PACE site in Western Hampton Roads. Sentara Life Care Corporation will develop a PACE program in the City of Suffolk to provide services to seniors living in the Cities of Chesapeake, Norfolk, Portsmouth and Suffolk. The expansion PACE site is targeted to open in 2009.

- Currently, there are 233 participants enrolled in Virginia PACE programs who receive all Medicaid and Medicare covered services as required by their Plan of Care and authorized by their respective Interdisciplinary Team.

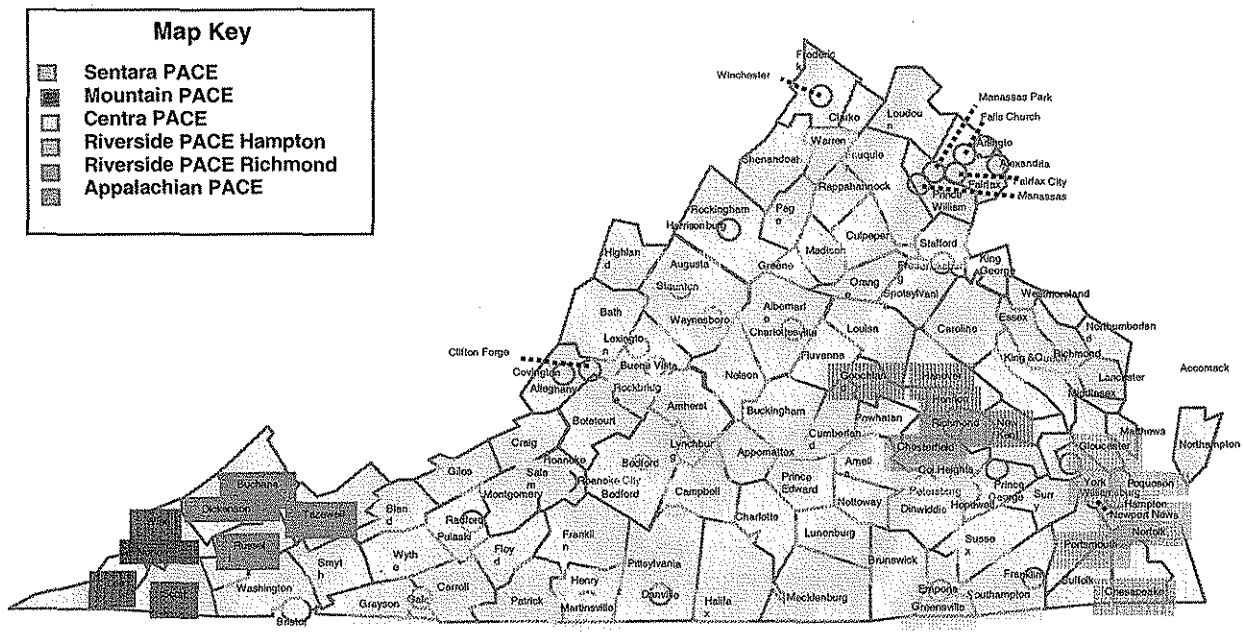
  - This program, designed around an adult day health model, provides for a full spectrum of home-and-community based care at a "one-stop" shop under a capitated system to reduce the cost of care while ensuring the highest quality outcomes for seniors.

  - The PACE Program is open to persons over the age of 55 who qualify for nursing facility care in the catchment area.

  - DMAS has replicated 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.

The map (Figure 5) identifies the PACE sites in the different regions of the state and graphically demonstrates the geographic diversity of the program even at its initial stage of development.

Figure 5 – Map of PACE Sites in the Commonwealth



Model 2 - Acute and Long-Term Care (ALTC) Integration

- In September 2007, the Department implemented its first effort toward streamlining service delivery and improving the coordination of care for participants through Acute and Long-Term Care Integration, Phase I (ALTC Phase I).

  - **ALTC Phase I** enables individuals who are participating in managed care to remain with their MCO if they subsequently become eligible for a home and community-based waiver program. Participants receive primary and acute care through their MCO and receive their waiver services through DMAS fee-for-service. This allows participants to remain with their current providers and receive more oversight and assistance through their MCO.

  - By September 2008, close to 700 participants were benefiting from ALTC Phase I.

- DMAS has also made great strides in **ALTC Phase II**, the development of Virginia Acute and Long-Term Care Integration (VALTC).

  - Through VALTC, individuals eligible for both Medicaid and Medicare and participants in the Elderly or Disabled with Consumer Direction (EDCD) waiver will be able to receive their health care and long-term care services through a coordinated delivery system.

- These individuals will be enrolled in a new managed care program that will offer ongoing access to quality health and long-term care services, coordinated benefits between Medicare and Medicaid, care coordination, and referrals to appropriate community resources.

- DMAS plans to offer VALTC to adults in the Tidewater area beginning in July 2009.

The Money Follows the Person (MFP) Program Initiative

The Department of Medical Assistance Services (DMAS) applied for and received approval from the Centers for Medicare and Medicaid Services (CMS) to implement the Money Follows the Person (MFP) Program. Money Follows the Person (MFP) is a demonstration project that allows qualified individuals of all ages and all disabilities the option for community living.

The MFP Program began operation on July 1, 2008. For every resident that transitions, Medicaid receives an enhanced Federal match of 75%. Please see Appendix C for information on other grant awards received by DMAS during the past two years.

Medicaid Works Implemented

On January 1, 2007, the Department of Medical Assistance Services (DMAS) implemented *MEDICAID WORKS*, Virginia's Medicaid Buy-In program.

- *MEDICAID WORKS* enables individuals with disabilities to go to work and earn higher income while remaining eligible for Medicaid coverage. The program also allows workers with disabilities to accumulate more savings from their earnings than is allowable under current Medicaid programs.

- *MEDICAID WORKS* helps enrollees gain greater independence from public assistance programs and enables their contribution to the tax base of the community and to its economic growth.

In 2008, a new benefit was added to *MEDICAID WORKS.* Personal assistance services provides for a personal care attendant to a qualifying individual to assist with activities of daily living.

Increased Coordination and Focus in Program Integrity

Achievement of Full Statutory Compliance Responding to Client and Provider Appeals

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

    - the number of filed provider reimbursement appeals annually has grown from 1,601 in 2007 to 2,518 in 2008.

- The Client Appeals Unit continues to strive for 100 percent compliance (currently at 99.5 percent compliance).

    - the Client Appeals Unit has seen annual growth from 1,741 client appeals in 2007 to 2,076 in 2008.

DMAS Program Integrity Division Continues to have a Strong National Presence

- The Department consolidated its program integrity provider review resources across divisions.

- 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 Department has worked with CMS and national entities to develop a strong national PI presence. The Department has had a member appointed to the CMS fraud technical advisory group (TAG), the regional PERM TAG, and has had members attend various national conferences. The Department also hosted the National Association for Medicaid Program Integrity (NAMPI) national conference. This conference is the premiere national Medicaid program integrity conference, and this is the first time that it was held in Virginia. The 2008 NAMPI conference had the highest attendance in NAMPI history with over 40 states represented.

Internal Audit Achieves Significant Successes during Fiscal Year 2007 and 2008

- The Internal Audit Division completed numerous concurrent audit tests identifying a significant number of avoided and questioned costs during fiscal years 2007 and 2008.

- During the latter part of 2006, DMAS IA engaged Richard Tarr, a nationally recognized expert on compliance with the Institute of Internal Auditors International Standards for the Professional Practice of Internal Auditing (IIA

Standards).

The opinion paragraph of the April 2007 report reads:

> "...it is the opinion of the reviewer that the internal audit activity at the Virginia Department of Medical Assistance Services fully complies with the IIA International Standards for the Professional Practice of Internal Auditing."

The DMAS Internal Audit division views this as independent confirmation of the high quality of its work.

Other Achievements

Creation of Diverse External Provider Workgroup

DMAS has established an External Provider Workgroup representing provider types within Hospital, Nursing Facilities, Physicians, Rural Health Clinics, and Community Service Boards. The workgroup meets via conference call on the first Wednesday of each month to collaborate on upcoming challenges, issues and changes affecting DMAS and the provider community at large. In addition, the workgroup discusses general issues from providers related to billing, payments, memos, policy, etc.

- The workgroup has been very instrumental to DMAS in the development of new claims edits, federal regulations reform and a meaningful source of information-sharing related to the clean processing of claims, which has resulted in claims processing efficiencies (decrease of claims pends and denials), streamlined processes, and cost savings to the state.

Innovation in the Children's Mental Health Program

In December 2006, the Department of Medical Assistance Services (DMAS) applied for and was awarded a demonstration grant to design a program that will allow states to offer home and community-based services for children who reside in a Psychiatric Residential Treatment Facility (PRTF) resulting in the development of the Children's Mental Health (CMH) program. The CMH Program is for children under 21 years of age who have been in a PRTF for at least 90 days and who will remain eligible for Medicaid after they leave the PRTF.

This program offers eight critical services to support the individual in their community: respite (consumer-directed and agency-directed), companion care (consumer-directed and agency-directed), In-home residential support services, Family/Caregiver Training, Therapeutic Consultation, Environmental Modifications, Transition Coordination and Service Facilitation. These services are in addition to existing Medicaid mental health services. The CMH Program was implemented on December 1, 2007.

Implementation of the Specialty Drug Maximum Allowable Cost (SMAC) Program

On July 1, 2008, DMAS implemented the Specialty Drug Maximum Allowable Cost (SMAC) program. Specialty drug products are products used to treat chronic, high-cost or rare diseases, including treatments for certain diseases such as Hepatitis-C and Multiple Sclerosis, as well as drugs such as growth hormone agents and interferon. These drugs tend to be higher in cost than standard pharmaceutical products because they typically require tailored patient education for safe and cost-effective use, patient-specific dosing, close patient monitoring, administration via injection, infusion orally, and require refrigeration or other special handling.

Item 302(JJ) of the 2008 Appropriations Act directed DMAS to implement a specialty drug program. Therefore, effective July 1, 2008, the reimbursement for certain groups of specialty drug classes became subject to a new specialty drug maximum allowable cost (Specialty MAC). This program works in conjunction with the current Virginia Maximum Allowable Cost (MAC) program and the Preferred Drug List (PDL) to ensure recipients receive quality products in a cost-effective manner. This does not affect the Managed Care Organizations (MCOs) because they have their own pharmacy benefits and programs.

Fiscal Division Receives Small, Women-Owned, and Minority Owned (SWaM) Business Award

In October 2007, the DMAS received the Governor's 2007 SWaM Innovator Award for Best Practice. One of DMAS' greatest challenges is getting SWaM-eligible vendors to follow through with the certification process. Therefore, in an effort to reduce the work that vendors would have to do in order to become certified, the agency's SWaM Champion (Fiscal Division Director) implemented a process to assist vendors in becoming SWaM certified. The innovation was to 1) assist vendors in successfully completing the SWaM certification process, and 2) take advantage of on-line resources to gather necessary information, and thereby, reduce the work that vendors have to do in order to become certified.

This effort has significantly increased the number of SWaM certified vendors that are available to meet the agency's contracting needs. This has resulted in higher SWaM scores for the agency, and has made it easier for persons within the agency to find SWaM vendors to meet their needs. Many vendors have appreciated the assistance. They have become certified with less difficulty, and there are many who would not have become certified without the assistance.

For fiscal year ending June 30, 2008, the agency reported spending 51.27% of discretionary expenditures with small, women and minority-owned businesses.

APPENDIX A

Board of Medical Assistance Services
Agenda Items 2007-2008

- Overview of the Appeals Process
- Board Involvement in Key Priorities for 2007-2008
- Budget Update
- Board Bylaws and Amendments
- Managed Care Program Updates
- Money Follows the Person Program
- Long Term Care Partnership
- Medicaid and Long Term Care Reform
- Status of National Provider Identification Implementation
- SCHIP Reauthorization
- Governor's Healthcare Reform Commission
- Integration of Acute and Long Term Care Services
- Tamper Resistant Prescription Pads
- Nursing Facility Pay for Performance
- Medicaid Budget Forecast
- General Assembly Legislative Update
- Federal Medicaid Legislation Changes
- Conflict of Interest Training
- Sentara Health Plan Presentation
- Riverside Program for all Inclusive Care for the Elderly (PACE) presentation
- FAMIS Teen Outreach Program
- Medicaid and Long Term Care Reforms
- Brain Injury Waiver
- PACE Program Update
- Governor's Health Care Reform Commission
- Customer Service and Complaints
- Fraud and Recovery

APPENDIX B

THE VIRGINIA MEDICAID PROGRAM AT A GLANCE

2008

Introduction:

Authorized under Title XIX of the Social Security Act, Medicaid is an entitlement program financed by the state and federal governments and administered by the states. The Virginia Medicaid program is administered by the Department of Medical Assistance Services (DMAS).

Federal financial assistance is provided to states for coverage of medical services for specific groups of low-income people. Federal matching payment rates are based on the state's per capita income. The federal match rate for Virginia is 50% for 2008.

Who Is Covered by Medicaid?

While Medicaid was created to assist persons with low income, coverage is dependent upon other criteria as well. Eligibility is primarily for those persons falling into particular categories such as low income children, pregnant women, the elderly, persons with disabilities, and parents meeting specific income thresholds. Within federal guidelines, states set their own income and asset eligibility criteria for Medicaid, which results in a large variation among the states as to who is eligible. In Virginia, income and resource requirements vary by category.

The Virginia Medicaid population in fiscal year 2007 was comprised of:

- 489, 893 Children
- 123,620 Parents or caretakers of children,
- 94,283 elderly persons, and
- 176,182 persons who are blind or who have disabilities*

Children and parents/caretakers of children make up about 70 percent of the Medicaid beneficiaries, but they account for less than a third of Medicaid spending. Persons who are elderly or who have disabilities account for the majority of Medicaid spending because of their intensive use of acute and long-term care services.

**These totals do not include individuals enrolled in the Family Access to Medical Insurance Security (FAMIS) or Medicaid Expansion Programs.*

What Services Are Covered Under Medicaid?

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 of the federally mandated services:

- Inpatient and outpatient hospital care,
- Physician, nurse midwife, and pediatric and family nurse practitioner services,
- Federally qualified health centers and rural health clinic services,
- Laboratories and x-ray services,
- Transportation services,
- Prenatal care,
- Family planning services,
- Skilled nursing facility and home health care services for persons over age 21, and
- Early and Periodic Screening, diagnosis, and treatment program for children ("EPSDT").

Virginia Medicaid also covers many optional services, including, but not limited to:

- Routine dental care for people under age 21,
- Prescription drugs,
- Rehabilitation services such as occupational, physical, and speech therapy,
- Intermediate care facilities for persons with developmental and intellectual disabilities and related conditions, and
- Mental health services.

Medicaid beneficiaries also receive coverage through "waiver" programs. Waivers allow for programs to be designed to meet the unique medical needs of Medicaid subpopulations. The following waiver programs are available to Medicaid beneficiaries who meet admission criteria:

- AIDS Waiver,
- Alzheimer's Waiver,
- Day Support for Persons with Mental Retardation Waiver,
- Elderly or Disabled with Consumer-Direction Waiver,
- Mental Retardation Waiver,
- Technology Assisted Waiver, and
- Individual and Family Developmental Disabilities Support Waiver.

How Is Care Delivered Under Virginia Medicaid?

DMAS provides Medicaid to individuals through two general care delivery models: a model utilizing contracted managed care organizations (MCO) to coordinate care; and a Fee-for-Service (FFS) model, the standard Medicaid program whereby service providers are reimbursed directly by DMAS.

The MCO program, started in 1996, is available in certain regions of the state. As of December 2007, 424,786 Medicaid beneficiaries were enrolled in managed care (64 percent of total beneficiaries), with 235,233 beneficiaries enrolled in the fee-for-service program (36 percent of total beneficiaries).

MCO program expansions will continue in 2008 with the development of an integrated acute and long term care program for beneficiaries who are currently exempt from the managed care program.

As an additional option for long-term care recipients, DMAS is also expanding the Program for All-Inclusive Care for the Elderly (PACE) to multiple sites across the Commonwealth. PACE is designed to allow Medicaid eligible individuals aged 55 or older who have been assessed as meeting nursing facility level of care to avoid more costly institutionalization by providing coordinated care in their homes and communities.

Medicaid Expenditures and Enrollees

Over the past ten years, the number of people enrolled in the Virginia Medicaid program has increased by 21%. The overall increase has been driven primarily by increases in persons who are blind or otherwise disabled, as well as increases in children enrolled (largely in response to significant outreach and education efforts regarding the need for childhood health coverage).

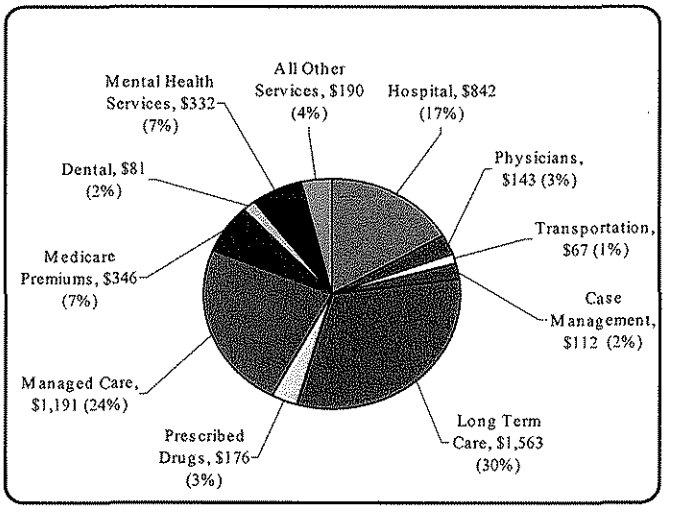
Group	1997	2007	% Change
Aged	92,531	84,283	-9%
Blind and Disabled	116,797	176,182	51%
Children	393,919	489,893	24%
Adults	121,357	123,620	2%
Total	724,604	873,978	21%

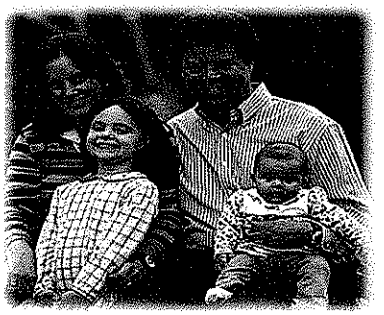
Despite this enrollment growth over the 10 year period, Virginia's eligibility criteria remain among the strictest in the nation. With population ranking Virginia as the 12th largest state (2006), we are 22nd in the number of Medicaid recipients served, and are the 47th lowest state in the nation in terms of Medicaid recipients as a percent of the total population (both rankings from 2005)

In addition to population increases, expenditures have increased as well, albeit consistent with those of other states. Virginia's 7.1% projected increase from 2007 to 2008 compares to 7.8% for all states. Expenditure levels are affected by population and economic change, such as health care cost inflation, as well as by advances in health care delivery and program changes directed by federal and state decision makers.

Though Virginia's rate of growth in expenditures is comparable, the absolute level of spending remains low relative to other states. While Virginia enjoys higher than average per capita income (ranked 9th in 2006), Medicaid spending per recipient ranks 31st (2005) with spending per capita ranked near the lowest levels nationally at 48th (2006).

DMAS FY2007 Medical Services Expenditures
(Amounts in Millions)





In FY 2007, 2.1% of the total DMAS budget was allocated toward administration.

DMAS strives to provide a system of high quality comprehensive health services to qualifying Virginians and their families.

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APPENDIX C

Listing of Grants and Awards during the 2007-2008 Time Period

Large Grants - Federal Fiscal Year 2008

GRANT NAME	AMOUNT FY 2008
Medicaid – Medical Assistance Payments	2,727,945,000
Medicaid – Administrative Payments	161,650
FAMIS – State Children's Health	90,338,630

Small Grants - Awarded During the Period 2006-2008

GRANT NAME	AMOUNT	Beginning	Ending
Competitive Employment Grant YEAR 1	500,000.00	1/1/2008	12/31/2008
Competitive Employment YEAR 2	500,000.00	1/1/2009	12/31/2009
Competitive Employment YEAR 3	500,000.00	1/1/2010	12/31/2010
Competitive Employment Grant YEAR 4	500,000.00	1/1/2011	12/31/2011
STG-Systems Transformation Grant	2,245,258.00	9/30/2006	9/31/2011
PRTF- Psychiatric Residential Treatment Facilities Demonstration Grant	3,172,117.00	12/20/2006	12/19/2011
MFP - Money Follow the Person	1,571,143.00	5/30/2007	9/30/2011
STATE PROFILE TOOL GRANT	409,500.00	9/30/2007	9/29/2010
Private Grants:			
Quality Summit Innovation Grant *(private donation)*	30,000.00	7/1/2007	