COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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December 15, 2010

MEMORANDUM

TO: The Honorable Robert F. McDonnell
Governor of Virginia

The Honorable Charles J. Colgan
Chairman, Senate Finance Committee

The Honorable Lacey E. Putney
Chairman, House Appropriations Committee

FROM: Gregg A. Pane, MD, MPA

Subject: Biennial Report of the Board of Medical Assistance Services

Section 32.1-324 of the *Code of Virginia* establishes the Board of Medical Assistance Services and requires the Board to submit a biennial report to the Governor and the General Assembly. Attached is the Board's report for the years 2009-2010. Should you have questions regarding this report, please feel free to contact me at 786-8099.

GAP/
Enclosure

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

Biennial Report of the Board of Medical Assistance Services

Department of Medical Assistance Services

October 2010

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INTRODUCTION

Section 32.1-324 of the *Code of Virginia* requires the Board of Medical Assistance Services (BMAS) to submit a biennial report to the Governor and the General Assembly. This report provides an overview of the Board and the Department of Medical Assistance Services (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 for Medical Assistance* 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. There are currently two vacancies. The current members and past meeting dates are listed in Table 1.

During the Board meetings, the Department of Medical Assistance Services' staff briefed the members on changes to the Medicaid/FAMIS program, legislative and budget developments, and DMAS administrative issues. Speakers included Randall L. Clouse, Director of the Medicaid Fraud Control Unit at the Office of the Attorney General, and Elizabeth McDonald, Legal Counsel who provided Conflict of Interest training. 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. (Chair)	Phyllis L. Cothran
Joseph W. Boatwright, III, M.D.	Kay C. Horney
Patsy Ann Hobson	Barbara H. Klear
J. Mott Robertson, Jr., M.D.	William L. Murray, Ph.D. (Vice Chair)
Michael E. Walker	John C. Napolitano
	Ashley L. Taylor, Jr.
Meeting Dates	
CY 2009	**CY 2010**
March 10, 2009	April 13, 2010
June 9, 2009	June 8, 2010
September 15, 2009	September 14, 2010
December 8, 2009	December 14, 2010

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 provided input into policy and program issues, such as CHIP reauthorization, the Virginia Gold Quality Improvement Program, the Waiver Wait List Reduction Plan, and Health Information Technology.

- 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, and the Managed Care Committee.

OVERVIEW OF THE VIRGINIA MEDICAID PROGRAM

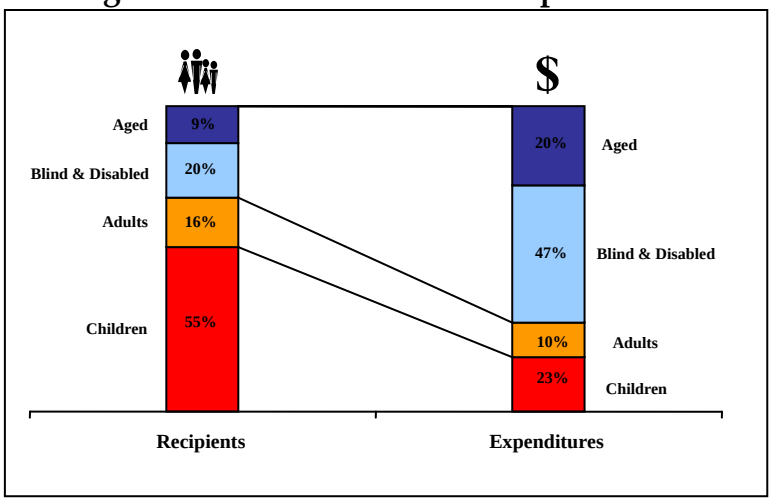
Medicaid is an entitlement program authorized under Title XIX of the Social Security Act that provides coverage of medical services for certain disabled and low-income individuals. Medicaid is financed jointly by the state and federal governments and administered by the states, within guidelines established 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 typically at 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 (currently, the American Recovery and Reinvestment Act, the Federal Stimulus, has resulted in a higher federal match, as will Federal Health Reform for the Medicaid expansion population).

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, elderly, individuals with disabilities, and parents or caregiver relatives of dependent children. Within federal guidelines, states set their own income and asset eligibility criteria for Medicaid. This results in a great variation of eligibility criteria among the states.

The Virginia Medicaid population in FY 2009 was comprised of 694,276 individuals per month (on average) with annual expenditures of $5.8 billion (approximately 55% from federal funding). Children and adult caregivers make up about 70 percent of the Medicaid beneficiaries, but they account for only 33 percent of Medicaid spending. The elderly and persons with disabilities, while a minority in terms of recipients served (30

percent), account for the majority (67 percent) of Medicaid spending because of their intensive use of acute and long-term care services (Figure 1, next page).

Figure 1 – 2009 Enrollment & 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 also provides some services at the state's option. These services are listed in Table 2 (next page).

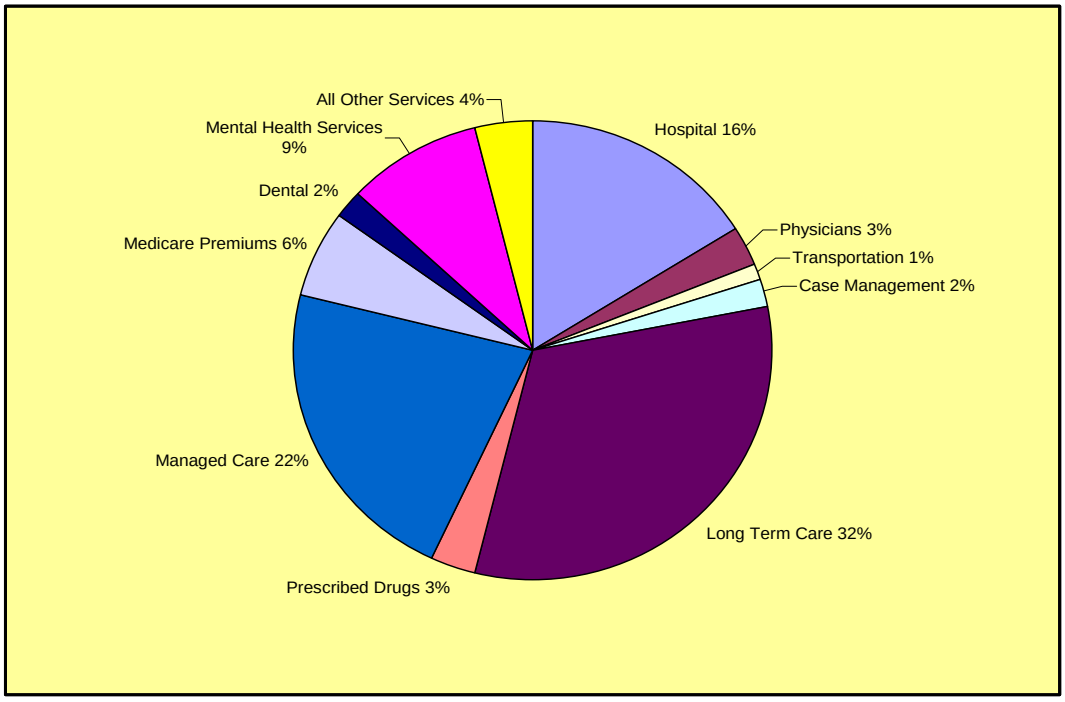
Health care services are provided to Medicaid recipients through two general models: fee-for-service (FFS) - the standard Medicaid program where providers are reimbursed directly from DMAS for services rendered; and managed care - utilizing contracted managed care organizations which pay providers directly (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, therefore, some individuals who are otherwise eligible for managed care are enrolled in a primary care case management program. This program provides managed care through a primary care provider and services are reimbursed under the FFS methodology.

In FY 2009, 62 percent of total Medicaid beneficiaries were enrolled in managed care; 38 percent of total Medicaid beneficiaries were enrolled in the fee-for-service program. Of the 38 percent of fee-for-service enrollees, 18 percent were enrolled in the MEDALLION Program. Figure 2 (next page) presents the proportion of healthcare expenditures by the major service area in FY 2009. 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.

Table 2 – Mandatory and Optional Services Covered by Virginia Medicaid

Mandatory Services	Optional Services
• Inpatient, Outpatient, & Emergency Hospital Services • Nursing Facility Services • Physician Services • 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 Clinic Services • Federally Qualified Health Center Clinic Services • Family Planning Services & Supplies • Transportation Services • Medicare Premiums: Hospital Insurance (Part A) • Medicare Premiums: Supplemental Medical Insurance (Part B) for the Categorically Needy • Optometrist Services	• Prescribed Drugs • Mental Health and Mental Health Clinic Services • Community Mental Retardation Services • Intermediate Care Facilities for the Mentally Retarded Services • Home & Community-Based Care Waiver Services • Skilled Nursing Facility Services for Individuals under age 21 • Dental Services for Individuals under age 21 • Physical Therapy & Related Services • Clinical Psychologist Services • Podiatrist Services • Certified Pediatric Nurse & Family Nurse Practitioner Services • Home Health Services (PT, OT and SLP) • Case Management Services • Prosthetic Devices • Other Clinic Services (rehabilitation agencies, ambulatory surgical centers, renal dialysis clinics and local health departments) • Hospice Services • Medicare Premiums: Supplemental Medical Insurance (Part B) for the Medically Needy)

Figure 2 – FY 2009 Medicaid Services Expenditures



Despite Virginia's relative affluence (8th in the nation in per capita 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 FY 2009.

2009 & 2010 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. The following is a description of some of the key accomplishments:

Ensuring Quality and Integrity of the Medicaid Program

Office of Behavioral Health

The Office of Behavioral Health (OBH) was established in January 2010, and is responsible for developing and implementing policies and administrative processes to support the provision and monitoring of all Medicaid and CHIP funded mental health and substance abuse services. It is the mission of the OBH to ensure the provision of high quality, consumer-focused, and appropriate behavioral health and substance abuse services to Virginia's Medicaid and CHIP beneficiaries.

APA Audit Report for Fiscal Year End 2009

DMAS received the Auditor of Public Accounts (APA) final consolidated Health and Human Resources agencies audit report in January 2010; the report included no audit findings and an unqualified opinion on our FY2009 financial statements. The management and staff of DMAS are to be commended for the Agency's performance on the APA's year end June 30, 2009, annual audit. It is an outstanding achievement for any agency to receive a clean APA audit report, and even more impressive for an agency the size and complexity of DMAS.

Program Integrity Initiatives

The DMAS Program Integrity program continues to have a strong national presence and has implemented cutting edge solutions to battle fraud and abuse, including contracting with multiple private contractors to enhance fraud and waste prevention

programs. Notably, contractors with national expertise in pharmacy, DME, mental health, hospital coding and various other provider types have been engaged.

DMAS continues to work with CMS and other national entities concerning program integrity issues. DMAS has a member serving as the northeastern representative of the CMS fraud technical advisory group (TAG). A DMAS staff member also serves on the regional payment error rate measurement program (PERM) TAG.

In addition, DMAS has been focusing on prepayment review, which has been dramatically enhanced through its prior authorization (PA) contractor KePRO. Over the past two years, multiple new PA requirements for community mental health have been implemented, resulting in a significant reduction of inappropriate utilization.

Current statistics indicate a return on investment of General Funds of over 3:1 for activities managed by the Program Integrity division.

HIPAA Privacy and Security Rules

DMAS is and continues to be in compliance with the HIPAA Privacy and Security Rules and all State requirements (e.g., VITA IS Standard and EO 44 for COOP). In the last two years, DMAS has not had any breaches of PHI and has not had any outstanding security-related audit points. The APA November 2009 Semi-Annual Update Commonwealth Information Security Implementation report ranked DMAS as 'good' for being an agency that has an Information Security (IS) Program that complies with best practices and that follows its IS Program; DMAS has always trained 100% of new workforce members on HIPAA Awareness and all employees are also trained annually for Information Security. The COOP and Agency Preparedness scores DMAS received are above average for the State.

Administrative Efficiencies and Improvements

Managed Care – Maintaining Coverage by Health Plans

Managed care has been one of DMAS' main initiatives for over 10 years and it has become DMAS' goal to offer some type of managed care coverage to all enrollees. Currently, five managed care partners operate Medicaid products across most of the Commonwealth. The partners are: AmeriGroup, Anthem, Optima, Southern Health and Virginia Premier. However, 2009 began with an unprecedented state fiscal crisis that was coupled with a rapid increase in Medicaid and managed care enrollment. In July 2008, MCO membership for Medicaid and FAMIS was approximately 468,000; whereas, currently, the enrollment is approximately 568,000, an increase of over 20% in two years.

Consequently, the MCOs began to re-evaluate their participation in specific geographic areas. As a result, some plans notified DMAS that they would leave selected localities. This prompted DMAS to develop creative solutions to maintain managed care in impacted localities. For example, in October 2009, DMAS began utilizing the "rural exception" option in Culpeper County due to lack of health plan availability within that region. In addition, in May 2010, DMAS brought back the MEDALLION primary care case management (PCCM) program in Warren County to maintain health plan coverage in that area.

Despite these challenges, the MCOs remain committed to the program. This is exemplified by the fact that Virginia requires that all its contracted health plans be accredited by the National Committee for Quality Assurance (NCQA) and three of the five MCOs have attained "Excellent" accreditation status, the highest attainable level. Furthermore, based on the rankings published in 2009, nearly all of the MCOs made the *U.S. News and World Report's* esteemed list of top Medicaid MCOs in the country.

Provider Reimbursement

DMAS made numerous improvements to the way it reimburses its providers. During the past two years, DMAS adopted Medicare's policy to not pay for the following "Never Events" as part of its medical necessity criteria: (i) surgery on wrong patient; (ii) surgery on wrong body part; and (iii) wrong surgery on a patient. DMAS also implemented a Hospital Acquired Conditions Reimbursement policy effective January 1, 2010, which excludes selected diagnoses not present on admission from the DRG grouper resulting in lower payments. The selected diagnoses are based on Medicare's policy.

DMAS implemented a new reimbursement methodology for Ambulatory Surgery Centers effective April 5, 2010, using Enhanced Ambulatory Patient Groups. A new methodology was necessary after Medicare changed its methodology which DMAS had been using. DMAS decided to adopt a methodology that was not linked to Medicare's methodology.

DMAS introduced an "Electronic Cost Report" (ECR) in FY09 for multi-level nursing facility providers. This was the final enhancement to DMAS efforts to streamline the cost reporting process. The ECR includes cell limitations, automatic validation checks and warnings to eliminate many errors in cost report submission. The ECR can be uploaded to the DMAS cost reporting database thus eliminating the time and potential errors in manual data entry.

DMAS implemented a prospective rate methodology based on a fee schedule for therapy services furnished by rehabilitation agencies replacing the cost-based reimbursement methodology based on cost reports. Also, DMAS utilized its document management system for cost reports to distribute monthly patient pay reports electronically to nursing facility and ICF-MR providers. (This is part of a larger initiative to put patient pay on the system).

In addition, DMAS began implementation of appropriate site of service differentials for physician/practitioner services by paying more for services furnished in the office than the same service furnished in the hospital (differentials exist only for services that can be performed in either site). The four year transition began on July 1, 2008.

Medicaid Management Information System

DMAS awarded a contract to ACS State Healthcare to replace First Health as DMAS' Medicaid Management Information System (MMIS) fiscal agent. The contract contains a number of service enhancements, including a new provider web portal, online submission of claims, and online provider enrollment. In addition, DMAS migrated all provider and recipient printing and mailing functions from First Health to ACS. DMAS successfully transferred fiscal agent services operations from First Health to ACS on June 28, 2010.

The Information Management Division also had several other notable achievements. The Division implemented GoFileRoom for Nursing Facilities and the Cost Settlement Unit in the Provider Reimbursement Division.

State Medicaid Health Information Technology Project

The Information Management Division, in consultation with operational divisions within the Department, also initiated the federally-mandated State Medicaid Health Information Technology project to support implementation of electronic health records. The project is in the planning phase. An implementation plan for provider incentives for electronic health records is under development with a target completion date of November 2010. In addition, DMAS transitioned support of the Department's information technology infrastructure to the VITA/NG Partnership on July 1, 2010.

Program Operations

DMAS made numerous improvements in program operations during the past two years. Some of the notable accomplishments included reviewing and enhancing the claims process for Medicare Crossover claims; implementing "Never Events" and

"Hospital Acquired Condition" edits for cost avoidance; and fully utilizing the uninsured medical catastrophe fund for 2 consecutive years.

DMAS reduced the customer service call line abandonment rate from 13% in 2008 to 11% in 2009. DMAS also successfully re-enrolled 60,000+ providers to meet the requirements of the national provider identification (NPI) implementation and successfully implemented the enrollment of practitioner billing groups.

Maternal and Child Health Services

Access and Utilization Continues to Improve Through the "Smiles For Children" Program

On July 1, 2010, ***Smiles For Children*** celebrated its fifth anniversary and its success continues to grow. ***Smiles For Children*** operates as a fee-for-service dental health benefit plan. Program administration is simplified through one dental benefits administrator (DentaQuest) for credentialing and claims filing requirements, which makes provider participation easy. Outreach and personalized member attention helps members locate appropriate providers and helps expedite access to all levels of dental care.

Smiles For Children surpassed the 2009 dental provider recruiting goal and, as a result, more children in Virginia are receiving oral health services. The program served over 600,000 Medicaid and CHIP children in 2009. Other highlights include:

- More Virginia dentists, both pediatric and general, are enrolled in the dental network. At the start of the program in July 2005, there were 620 dental providers; as of June 30, 2009, there were 1,247 individual providers in the network. This marks a 101 percent increase and a total of 627 new providers. The number of dental specialists is also increasing.

- More Medicaid and CHIP children are receiving necessary dental care. The percentage of children ages 0-20 receiving at least one dental service increased from 24% in FY 2005 to 40% in FY 2009 (60% increase). Similarly, for children ages 3-20, utilization of at least one dental service increased from 29% in FY 2005 to 48% in FY 2009 (a 65% increase) and continues to increase.

Early Intervention

Early Intervention Services are defined as services provided through Part C of the Individuals with Disabilities Education Act (IDEA) that are designed to meet the developmental needs of each child and the needs of the family, to enhance the child's

development. The Part C program serves children 0-3 years of age and services must be provided in natural environments for the child, such as home and community settings. By law, Part C funds are to be used as "payer of last resort" for direct services to children and families when no other source of payment is available.

Maternal and Child Health staff, in collaboration with the Early Intervention Program at the Department of Behavioral Health and Developmental Services, implemented a new Early Intervention coordination project in October 2009. This effort is designed to change the way funding for Early Intervention Services is utilized by Medicaid and FAMIS beneficiaries and to reduce the overall cost of Virginia's state funding for these services. In addition, by utilizing Medicaid and FAMIS funding appropriately, the program is allowing more of those children who are not Medicaid or FAMIS enrollees to be served using the federal Part C funds. This new Early Intervention initiative helps to effectively provide treatment to children at risk for developmental delay and ensures that the federal Early Intervention or Part C funds are used in accordance with federal policy requirements.

As of May 2010, over 3,000 Medicaid and FAMIS children were enrolled in the Early Intervention Program.

Plan First

On January 1, 2008, DMAS implemented Plan First, the "*new*" family planning program. Plan First provides family planning coverage to men and women who have incomes up to 133% FPL and who are currently uninsured. DMAS submitted an application to the Centers for Medicare and Medicaid Services to request renewal of the program as well as expansion of the income limit for eligibility up to 200% FPL, per a 2007 General Assembly mandate. During FY 2008-2009, approximately 10,000 individuals were served by the Plan First Program.

Text 4 Baby

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

the potential of mobile health technology to address a critical national health priority and reach underserved populations with health information; and decrease the number of premature births among low-income women. DMAS began providing Text4Baby information to pregnant women in our Medicaid and FAMIS MOMS programs in February 2010. Virginia currently has the third highest percentage of women enrolled in Text4Baby in the country.

CHIPRA Implementation

With the signing of the federal Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), a new funding formula resulted in the Commonwealth receiving a significant increase in the FFY 2009 CHIP allotment. Virginia's new FFY 2009 CHIP allotment under CHIPRA was $175.9 million which was an 81% increase over Virginia's original FFY 2009 allotment and provided adequate federal funding for the FAMIS and FAMIS MOMS programs for the remainder of FFY 2009.

The Department is implementing the required CHIPRA provisions affecting both the Medicaid and FAMIS programs. Beginning January 1, 2010, participants in FAMIS and FAMIS MOMS are required to provide documentary evidence of citizenship as part of the eligibility process. Optional CHIPRA provisions that provide cost savings to the Commonwealth have also been implemented. A new provision enables citizenship to be verified by matching applicants' Social Security numbers against the files of the Social Security Administration.

CHIPRA also expands health coverage for children and establishes quality requirements and protections for both health and mental health care services. Individuals enrolled in FAMIS who reside in an area where only one managed care organization (MCO) is available now have the option to disenroll from their MCO and receive care through fee-for-service. Beginning July 1, 2010, FAMIS recipients will no longer be charged co-payments for pregnancy-related services, and coverage limits on mental health and substance abuse treatment services will be brought into parity with medical services. DMAS also worked with CMS to identify how the CHIPRA legislation impacts Virginia's CHIP waiver programs for pregnant women (FAMIS MOMS) and families enrolled in premium assistance (FAMIS *Select*) for the waiver renewal effective July 1, 2010.

Maximizing Enrollment for Kids Grant

In February of 2009, the Robert Wood Johnson Foundation (RWJF) awarded DMAS one million dollars in funding and support to increase enrollment and retention of eligible children in the FAMIS (CHIP) and FAMIS Plus (children's Medicaid) programs. With approval by CMS, DMAS is able to use grant funding to draw down federal matching

funds thereby increasing our funding to almost $3 million. Virginia was one of eight states selected for the four-year RWJF grant, *Maximizing Enrollment for Kids* (www.MaxEnroll.org). Under the direction of the National Academy for State Health Policy (NASHP), which serves as the national program office for *Maximizing Enrollment for Kids*, a team of national experts are working with Maternal and Child Health staff to identify ways to strengthen systems, policies, and procedures and establish best practices. The program will measure the impact of these changes and will share findings nationally throughout the four-year initiative.

Improvements to Care for the Elderly and Persons with Disabilities

Program of All-Inclusive Care for the Elderly

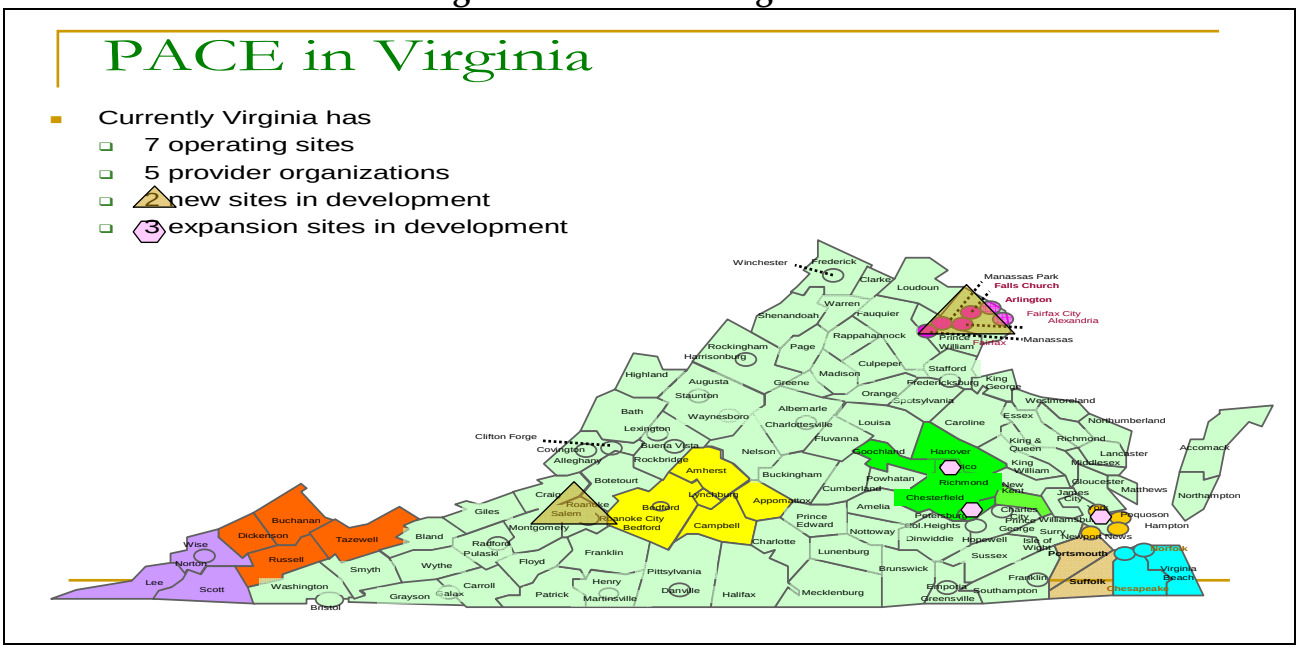
The Program of All-Inclusive Care for the Elderly (PACE) is designed around an adult day health model and provides for a full spectrum of home and community-based care at a "one-stop" shop under a capitated system. This system is designed to reduce the cost of care while ensuring the highest quality 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 is committed to partnering with agencies to develop PACE programs across the Commonwealth to provide comprehensive all-inclusive services to the elderly. DMAS currently has seven sites that are operating across the Commonwealth: Sentara Senior Community Care PACE in Virginia Beach and Portsmouth; Riverside Peninsula PACE in Hampton and Richmond; Mountain Empire PACE in Big Stone Gap; AllCare for Seniors PACE in Cedar Bluff; and Centra PACE in Lynchburg.

Currently, there are 509 participants enrolled in Virginia PACE programs. These individuals receive all Medicaid and Medicare covered services as required by their Plan of Care and authorized by their respective Interdisciplinary Team. The average age of participants is 78 with 79% being female. Participants have an average of six medical conditions and 92% of participants reside in their home or with family in the community.

DMAS has received recognition from the National PACE Association for Virginia's leadership in developing PACE. Figure 3 (next page) provides information on the geographic location of Virginia PACE sites.

Figure 3 – PACE in Virginia



Consumer-Directed Model of Service Delivery

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

Since 2006, the number of individuals choosing the CD model grew from slightly over 1,000 recipients to over 7,300 as of May 2010. The number of qualifying attendants has grown from approximately 2,500 in 2007 to over 10,000 in 2010. The Consumer Recipient Satisfaction Survey 2009 Annual Report conducted by PPL, documents an overall satisfaction rating of individuals using the CD model to be 3.9 out of a possible 4.0 rating. From the report, 99.7% of those responding indicated "I am satisfied with having the ability to choose who I want as my attendant."

Long-Term Care Partnership

Quality long-term care services can significantly enhance an individual's life during a prolonged illness or after a serious accident. Virginia's Long-Term Care Partnership is an innovative way for Virginians to cover the increasing costs of long-term care services such as in-home support or nursing facility placement, and to protect a portion of their assets. Virginia launched its Long-Term Care (LTC) Partnership on September 1, 2007.

To date, 21 insurance companies offer Partnership policies in Virginia and as of December 31, 2009, 13,448 Virginians have purchased Partnership policies.

The LTC Partnership program enables insurers to offer specially crafted insurance policies that allow individuals to protect their hard-earned life savings if the need for long-term care services arises. For every dollar that a LTC Partnership insurance policy pays out in benefits, an equal amount is protected if the individual eventually applies for Medicaid. In other words, LTC Partnership policyholders who apply for Medicaid coverage are able to maintain some level of assets (equal to the amount of LTC insurance benefits paid) above the $2,000 Medicaid asset limit currently in place for eligibility purposes.

MEDICAID WORKS

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

Money Follows the Person Rebalancing Demonstration Project

Virginia's Money Follows the Person (MFP) Rebalancing Demonstration Project, was awarded to DMAS in May 2007 from the Centers for Medicare and Medicaid Services (CMS). Virginia's MFP Project was developed in collaboration with the Office of Community Integration for People with Disabilities, the Office of the Secretary of Health and Human Resources, numerous state agencies, and other stakeholders. The MFP Project's vision is to create a system of long-term services and supports that enables available funds to "follow the person" by supporting individuals who choose to transition from long-term care institutions into the community. This initiative also complements the efforts of the Systems Transformation Grant, which aims to improve the infrastructure for community-based long-term support services, as well as supports Virginia's implementation of the Olmstead decision. As of June 30, 2010, 136 individuals have transitioned from an institution to the community under the MFP Project with an additional 46 individuals developing their transition plan.

State Profile Tool/National Balancing Indicator Contractor Grant

CMS awarded Virginia the State Profile Tool/National Balancing Indicator Grant in September of 2007. This grant represents an important opportunity for stakeholders to measure Virginia's progress toward balancing its long-term support system. Virginia's State Profile Tool provides a high-level view of the long-term support system, to ensure a uniform understanding of what currently exists in Virginia.

Systems Transformation Grant

The Systems Transformation Grant (STG) is a 5-year, $2.2 million federal grant designed to transform the long-term support system in Virginia. Implementation activities officially began in July of 2007 and are scheduled to continue through September 30, 2011. All activities were designed to have a sustaining impact beyond the life of the grant. The STG has three main goals:

- Development of a One Stop System
- Development/Enhancement of a Self-Directed Service Delivery System
- Modernize IT Systems

Virginia Gold

In 2007, the Virginia General Assembly passed House Bill 2290 directing DMAS to establish a nursing facility quality improvement program. DMAS created a Quality Improvement Program (QIP) Advisory Committee to examine best practices to achieve culture change within nursing facilities to enhance the quality of care for residents. As a result, the *Virginia Gold* project was created to support the enhancement of a supportive workplace with the goal of increasing retention of certified nursing assistants employed by nursing facilities. In the fall of 2009, using Civil Money Penalty (CMP) funds, the *Virginia Gold* project funded five Virginia licensed and certified Medicaid nursing facilities in this endeavor. The five selected nursing facilities include: Trinity Mission (Charlottesville), Autumn Care (Portsmouth), Birmingham Green (Manassas), Dogwood Village (Orange County) and Francis Marion Manor (Marion). An evaluation is being conducted by DMAS staff to determine the effectiveness of this program.

Other Achievements

Client and Provider Appeals

The Agency's Appeals Division is court-mandated to maintain a 97% compliance rate in timely resolution of client appeals. As enrollment and programs increased, the number

of appeals filed has followed. The Appeals Division processed 2,214 appeals in calendar year 2008 as compared to 2,889 in calendar year 2009. To accomplish this with virtually no increase in staff size, Appeals Division management has used focused teams and staff in dual roles to target intake backlogs and assist in the most complex cases. DMAS is proud to consistently meet and surpass the court mandate. The current compliance rate stands, as of May 2010, at 98.5%.

Human Resources

DMAS' Human Resources (HR) Division has had numerous achievements over the past two years. DMAS has:

- Exceeded Governor Kaine's challenge to reach a goal of 20% of eligible employees who are teleworking. DMAS continues to promote teleworking and developed and implemented an HR Policy on Teleworking to ensure fair and equitable administration. Percentage of eligible positions/employees teleworking is 26%.

- Reached goal of 100% Direct Deposit of pay for all employees. This cost containment effort resulted in 100% paperless checks and pay statements and boosted DMAS' Go Green initiative.

- Launched DMAS Knowledge Center (part of the Virginia Learning Management System) an educational system accessible to all employees. The "Unlock the Knowledge" program was designed and presented by the DMAS Training Manager.

- Developed and implemented new supervisory training on HR Compliance & Processes designed to reduce costly employee relations issues, EEOC charges and litigation.

- Promoted the DMAS Alternate/Flexible Work Schedule Request program to enable employees to work varying schedules and reduce commuting costs, car emissions, etc. Current participation rate is 51%.

- Developed internal communication tool "HR Infoshare" to ensure employees receive timely, regular and accurate information on HR programs/policies/procedures, as well as benefits and retirement information.

- Launched agency-wide ongoing food collection program for the Central Virginia Food Bank. Food goods are distributed to the Food Bank every other week.

- Developed and implemented a Physical Access Control Policy and Visitor Access Control Policy to ensure meeting safety and security standards at DMAS.

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

DMAS remains committed to its efforts to provide opportunities to small, women and minority-owned (SWaM) businesses throughout the Commonwealth. For FY 2010, DMAS' utilization percentages exceeded the Governor's goal of 40% SWaM participation. DMAS is excited about the achievements thus far and are optimistic that the Department's quest to explore new and creative opportunities in this area will improve SWaM percentages for the agency and the Commonwealth.

APPENDIX A

Board of Medical Assistance Services
Agenda Items 2009-2010

2009

- CHIPRA 2009 Highlights: SCHIP Reauthorization Legislation
- American Recovery and Reinvestment Act
- Overview of 2009 General Assembly Actions and Amendments to 2009 – 2010 Budget
- Medicaid Fraud
- Medicaid Forecast/Budget Update
- Medicaid National Perspective
- Key Activities by Division
- Federal Health Care Reform: Summary of Proposals to Date
- Update on the FMAP Increase Under the Federal Stimulus
- Virginia Gold Quality Improvement Program
- Waiver Wait List Reduction Plan
- Federal Health Care Reform Update
- Medicaid Budget and Forecast FY 2010 – FY 2012
- Health Information Technology Update
- Regulation Updates

2010

- DMAS Budget/Budget Reductions
- General Assembly Update/National Health Care Reform Update – Impact on Medicaid and Virginia
- Health Information Technology Advisory Commission (HITAC) Update
- Conflict of Interest Training
- Regulation Updates

APPENDIX B

Grants and Awards during the 2009-2010 Time Period

Large Grants - Federal Fiscal Year 2008

GRANT NAME	AMOUNT FY 2010
Medicaid – Medical Assistance Payments	3,318,924,000
Medicaid –ARRA	715,930,000
Medicaid – Administrative Payments	164,732,000
FAMIS – State Children's Health	184,484,740

Small Grants - Awarded During the Period 2008-2010

GRANT NAME	AMOUNT	Beginning	Ending
Competitive Employment Grant	2,250,000	1/1/2008	12/31/2011
STG – Systems Transformation Grant	2,245,258	9/30/2006	9/31/2011
PRTF – Psychiatric Residential Treatment Facilities Demonstration Grant	3,172,117	12/20/2006	12/19/2011
MFP – Money Follows the Person	7,274,060	5/30/2007	9/30/2011
State Profile Tool Grant	409,500	9/30/2007	9/29/2010
Private Grants:			
Robert Wood Johnson Foundation	150,110	2/15/2009	2/14/2013