COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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October 22, 2012

The Honorable Robert F. McDonnell
Office of the Governor
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

Dear Governor McDonnell:

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 2011-2012. Should you have questions regarding this report, please feel free to contact me or the Director of the Department of Medical Assistance Services, Cynthia B. Jones, at 786-8099.

Sincerely,

Monroe E. Harris, Jr., D.M.D.
Chairman, Board of Medical Assistance Services

MEH/mw
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 2012

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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 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 for four year terms, 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 and vice chair. The terms are staggered and members may not serve more than two consecutive terms.

House Bill 184 (Chapter 137, 2012 Acts of Assembly) requires that at least two members of the Board of Medical Assistance Services be individuals with significant professional experience in the detection, investigation, or prosecution of health care fraud. This means the next two appointments of non-health care providers shall be individuals who meet this requirement. There is currently one vacancy in the non-health care provider group. The current members and past and future meeting dates are listed in Table 1.

During the Board meetings, the Department of Medical Assistance Services' (DMAS) staff briefed the members on changes to the Medicaid/FAMIS program, legislative and budget developments, and DMAS administrative issues. Speakers included the William A. Hazel, Jr., MD, Secretary of Health and Human Resources, Elizabeth McDonald, Legal Counsel who provided Conflict of Interest training and Mike Wirth, Special Advisor of eHHR Integration, Office of the Secretary of Health and Human Resources. 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)	Brian H. Ewald
Joseph W. Boatwright, III, M.D.	Michelle Collins-Robinson
David B. Darden	Kay C. Horney
Karen S. Rheuban, M.D.	Barbara H. Klear
John Mott Robertson, Jr., M.D.	William L. Murray, Ph.D. (Vice Chair)
	Ashley L. Taylor, Jr.
Meeting Dates	
CY 2011	**CY 2012**
March 8, 2011	April 10, 2012
June 14, 2011	June 12, 2012
September 13, 2011	September 18, 2012
December 13, 2011	December 4, 2012

Since September 2010, members of the Board have changed as follows:

Provider members:

- Patsy A. Hobson's term ended on 3/7/11; replaced by David B. Darden who was appointed August 2011 to serve term date 3/8/11 – 3/7/15.
- Michael E. Walker's term ended 3/7/12; replaced by Karen S. Rheuban, M.D., who was appointed July 2012 to serve term date 3/8/12 – 3/7/16.
- Robert D. Voogt, Ph.D., resigned June 2010. Joseph W. Boatwright, III, M.D., was appointed August 2010 to fill an unexpired term for Dr. Voogt through March 2011. Dr. Boatwright was reappointed August 2011 to serve term date 3/8/11 – 3/7/15.

Non-provider members:

- Phyllis L. Cothran's term ended 3/7/11; replaced by Michelle Collins-Robinson who was appointed August 2011 to serve term date 3/8/11 – 3/7/15.
- John C. Napolitano filled an unexpired term for David Sylvester, who resigned March 2010. Mr. Napolitano was appointed August 2010 and resigned April 2012. Brian H. Ewald was appointed October 2012 to serve term date 3/8/12 – 3/7/16 replacing Mr. Napolitano.

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, Newborn Enrollment, the Dual Eligible Financial Alignment Demonstration, and Health Information Technology.

- The Board continued to be active in participating in or attending various DMAS Committees and advisory groups such as the Family Access to Medical Insurance Security (FAMIS)/Children's Health Insurance Advisory Committee, the Pharmacy and Therapeutics Committee, and the Virginia Health Reform Initiative.

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 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. The American Recovery and Reinvestment Act, the Federal Stimulus, resulted in a higher federal match rate for FYs 2009 - 2011, 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.

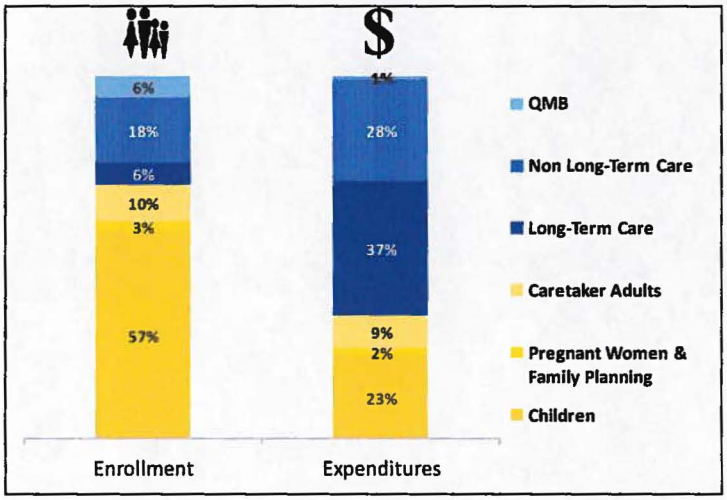
The Virginia Medicaid population in FY 2011 was comprised of 804,186 individuals per month (on average) with annual expenditures of $7.2 billion (approximately 58% from federal funding). Children and adult caregivers make up about 70 percent of the Medicaid beneficiaries, but they account for only 34 percent of Medicaid spending. The elderly and persons with disabilities, while a minority in terms of recipients served (30 percent), account for the majority (66 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 also provides some services at the state's option. These services are listed in Table 2.

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).

Figure 1 – 2011 Enrollment & Expenditures



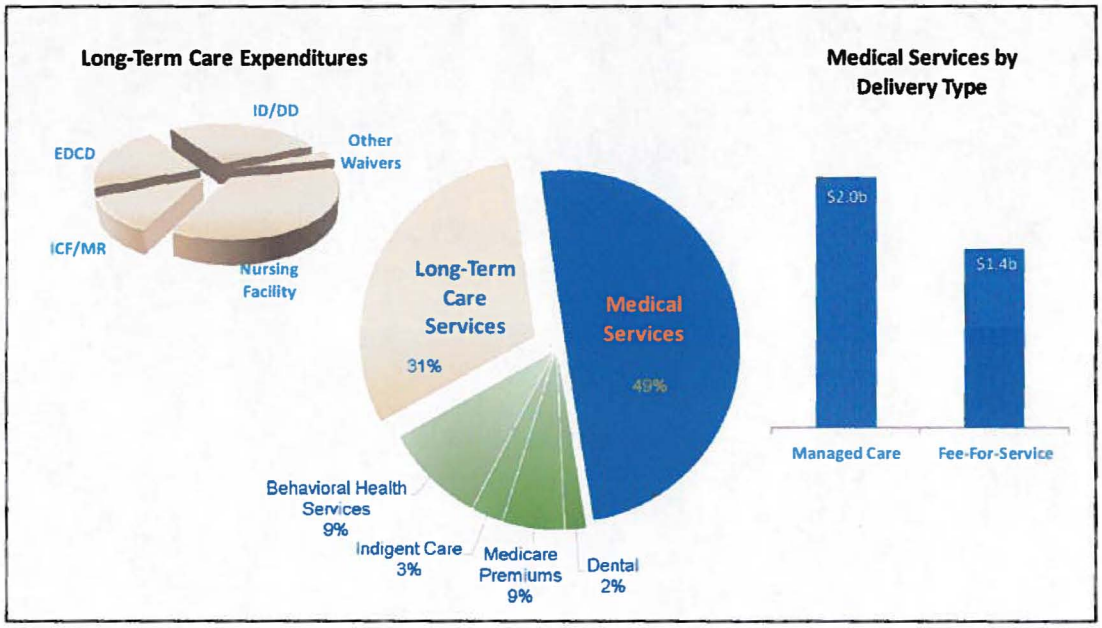
In FY 2011, 62 percent of total Medicaid beneficiaries were enrolled in managed care; 38 percent of total Medicaid beneficiaries were enrolled in the fee-for-service program. Of the 38 percent of fee-for-service enrollees, 13 percent were enrolled in the MEDALLION (Primary Care Case Management) Program. Figure 2 (next page) presents the proportion of healthcare expenditures by the major service area in FY 2011. 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 (6th in the nation in per capita income, 2008-2010), Virginia remains ranked near the bottom among states in terms of the number of Medicaid recipients as a percentage of the population (44th in the nation in 2009). Virginia ranked near the middle in terms of Medicaid expenditures per enrollee (25th in the nation in FY 2009). 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 1.6 percent of total Medicaid budget in FY 2011.

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 2011 Medical Expenditures Composition



2011 & 2012 ACHIEVEMENTS

Ensuring Quality and Integrity of the Medicaid Program

The Department of Medical Assistance Services is strongly committed to improving the quality of services provided to beneficiaries and to ensuring program integrity. The following sections highlight key examples of these initiatives.

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. Beginning in SFY 2010, in response to rising cost and utilization of community mental health services in Virginia Medicaid, the Program Integrity (PI) Division focused its audit efforts as well as those of its contractors on providers of these services which are particularly vulnerable to improper and fraudulent billing. SFY 2011 statistics indicate a return on investment of General Funds of over 4:1 for audit activities managed by the PI Division.

DMAS expanded its efforts to utilize data analysis to identify improper payments. The PI Division recently awarded a contract to analyze and test paid claims data (fee-for-service and encounter) to identify possible improper payments. The project will require the contractor to design and implement data mining and data analytics tests comprising a Medicaid Fraud Waste and Abuse Detection System (MFAD) for DMAS. In addition, there has been an increased focus on claims-based automatic reviews. These reviews are made at the system level using available electronic claim information without the review of a medical record.

As a result of the Affordable Care Act becoming federal law in 2010, States are required to establish programs to utilize Recovery Audit Contractors (RACs) to audit payments to Medicaid providers. RACs are paid on a contingency fee basis, receiving a percentage of the improper overpayments and underpayments they identify and collect from providers. DMAS is currently soliciting proposals from health care auditing firms for RAC services for implementation in fall 2012.

In addition to audit activities, DMAS has been focusing on prepayment review, which has been dramatically enhanced through its service authorization (SA) 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.

The Contract Compliance Unit (CCU) has been created within the PI Division and serves as the agency's fraud and abuse liaison to the MCOs in addition to periodically evaluating the adequacy of MCO program integrity policies, procedures, and outcomes. MCO program integrity staff met with PI Division staff to share innovative practices at quarterly collaborative meetings. In addition to oversight of MCO program integrity, the CCU is also charged with developing a robust audit program for the Recovery Audit Contract and monitoring the current contract auditors including the program integrity efforts of DMAS dental and transportation broker contracts.

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.

DMAS and the Medicaid Fraud Control Unit (MFCU) continue to maintain an effective relationship. In FY 2011, DMAS submitted 63 referrals to MFCU of which four of the referrals resulted in convictions for Medicaid fraud. Many other cases referred to the MFCU are still pending investigation and may result in further prosecutions.

Creation of the Office of Behavioral Health

Since the establishment of the Office of Behavioral Health (OBH) in 2010, DMAS has vigorously worked to improve the quality of behavioral health treatment services to Medicaid/ CHIP beneficiaries and continues to address the significantly increased utilization of behavioral health services.

In 2011, expenditures related to behavioral health care costs reached over $742 million, representing 16% growth since 2009 and nine (9) percent of the total overall expenditures for the Medicaid/CHIP programs. Due to this rapid high growth rate of behavioral health services over the past several years, DMAS implemented several initiatives to curb the growth. These initiatives included:

- Enhancing prior authorization requirements;
- Increasing monthly compliance audits;
- Enforcing rules for marketing services;
- Strengthening staff qualifications; and
- Contracting with the Community Service Boards statewide to perform an independent clinical assessment to support a referral to certain community programs provided to children at risk.

Current utilization data points to these initiatives being successful in improving the efficiency and effectiveness of behavioral health services in Virginia.

Because coordination of care is paramount in continually improving and managing behavioral health services, DMAS was granted the authority through the 2011 Appropriation Act to implement a coordinated care model for individuals in need of behavioral health services that are not currently provided through a managed care organization. DMAS worked collaboratively with the Department of Behavioral Health and Developmental Services, stakeholders and national behavioral health experts to develop the care coordination model blueprint. This blueprint became the outline for a Request for Proposal (RFP) to procure a Behavioral Health Services Administrator (BHSA); DMAS released the RFP on December 16, 2011 and is currently in the procurement process for this vendor.

When implemented, the BHSA vendor will administer a comprehensive care coordination model which is expected to reduce unnecessary expenditures; improve access to quality behavioral health services; and increase the value of behavioral health services purchased by the Commonwealth. The BHSA vendor will join DMAS in its mission to ensure the provision of appropriate, consumer-focused, quality-driven behavioral and substance abuse services, rendering better health outcomes for Virginia's Medicaid and CHIP beneficiaries.

Internal Audit

During the two-year period, 2011 through 2012, DMAS Internal Audit (IA) successfully conducted its usual program of concurrent testing, internal control monitoring, and security compliance reviews. During 2011, IA re-emphasized its on-going program of concurrent testing of DMAS business processes; IA began and/or completed 24 concurrent tests encompassing a wide range of agency functions. Additional audit highlights are discussed below.

Completion of Biennial Security Compliance Audit

Internal Audit completed the federally mandated biennial review of the security environment at Xerox/ACS (MMIS Fiscal Agent) and at DMAS' 600 East Broad Street headquarters in June of 2012. The review addressed the following HIPAA Security Rule (45 CFR, Part 164, Subpart C) security standards for the protection of Electronic Protected Health Information: Organizational Requirements, Administrative Safeguards, Physical Safeguards, and Technical Safeguards. IA continues to monitor the completion of corrective action for all security audit findings.

APA Auit Report for Fiscal Year End 2011

DMAS received the Auditor of Public Accounts (APA) final consolidated HHR agencies audit report in January 2012; the report included one audit finding and an unqualified opinion on the FY 2011 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, 2011 annual audit. Comparison to other large agencies in the HHR Secretariat shows that DMAS has very few APA findings.

DMAS Performance Audit

Internal Audit assisted in facilitating and monitoring the DMAS Performance Audit in 2011. In late October 2011, CGI Technologies and Solutions, Inc. (CGI) and DMAS agreed to a Statement of Work that utilized a subcontractor, KPMG, LLP to perform audit work on the DMAS Performance Audit. KPMG developed written observations associated with the corrective action and compliance plans related to prior DMAS audit findings. The written observations were shared and discussed with the division director or manager responsible for the observation. Once observations were finalized with DMAS management, they served as the basis for the audit report. Responsible DMAS managers later prepared corrective action plans to address all of the observations.

HHS, OIG Office of Audit Services – Audit of Medicare Part B Buy-In

Internal Audit facilitated and monitored the HHS, Office of Inspector General (OIG), Office of Audit Services' audit of Virginia's buy-in of Medicare premiums for eligible Medicaid beneficiaries. The objective of the review was to determine whether DMAS claimed Federal share for Medicare premiums it paid on behalf of Medicaid beneficiaries in accordance with Federal requirements. The audit period was from January 1, 2007 through December 31, 2009. The OIG Medicare Buy-In Audit began on March 22, 2010.

The OIG released its draft report for the Medicare Part B Buy-In Audit on March 15, 2012. The report contained one finding regarding improper aid categories claimed for approximately 19 Railroad Retirement beneficiaries. For the audit period (January 1, 2008 through December 31, 2009), the Federal funds to be recovered are less than $16,000, but the OIG recommended that DMAS calculate the amount of additional Federal funds to be recovered from January 1, 2010 forward. IA discussed this with the Director of Program Operations, who indicated that he believes the problem has been corrected since the OIG first brought the issue to his attention. The audit closing conference with the OIG auditors was held on April 9, 2012. DMAS provided its

response to the draft report on April 17th and the final audit report was issued on May 24, 2012.

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 41 (2011) for COOP). DMAS has not had any breaches of PHI and does not have any outstanding security-related audit points. DMAS continues to train 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

Deemed Newborn Enrollment

Approximately 57,500 newborns are deemed eligible for Virginia Medicaid each year. Children born to women enrolled in Medicaid are "deemed" eligible for Medicaid coverage for their first year and are enrolled in Medicaid upon report of the birth. The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 provided for the same automatic eligibility for children born to mothers enrolled in CHIP (i.e., FAMIS & FAMIS MOMS in Virginia). Children born to teen mothers enrolled in FAMIS or to mothers enrolled in FAMIS MOMS are deemed to be eligible for coverage for their first year and are enrolled upon report of the birth. The only information needed for enrollment of the newborn is the child's name, date of birth, race and gender.

There are currently three primary ways for an infant born to a mother enrolled in Medicaid, FAMIS, FAMIS Plus, or FAMIS MOMS to be enrolled in Medicaid or FAMIS:

1. The parent may contact the Local Department of Social Services (LDSS) eligibility worker or the FAMIS Central Processing Unit (CPU) to report the birth and have the baby enrolled;
2. The hospital may report the birth via the paper Newborn Notification Form (DMAS 213) and fax or mail the form to the local DSS or the FAMIS CPU for enrollment; or
3. The mother's Managed Care Organization (MCO) may report the birth via the paper Newborn Notification Form (DMAS 213) and fax or mail the form to the local DSS or the FAMIS CPU for enrollment.

The current process is completed manually and providers as well as the MCOs have reported that this process delays these newborns getting enrolled in coverage as soon as possible. Healthy newborns may have four well baby visits within their first two months of life and babies with special health care needs may exceed four visits with health care providers in this same time period.

DMAS, through the Robert Wood Johnson Foundation's *Maximizing Enrollment* grant, has spent the past three years exploring and implementing best practices for streamlining enrollment and retention of children in CHIP and Medicaid. After discussions with the Virginia Hospital & Healthcare Association (VHHA), DSS staff, participating pediatricians, and learning of the success other states have had with newborn enrollment, DMAS is exploring development of a new secure online newborn enrollment option for hospitals to expedite enrollment. However, DMAS staff is still working through system issues to ensure that any new process will not cause duplicate enrollments or other unintended consequences.

Managed Care

The managed care program continued to expand during the two-year period with the state now contracting with two or more health plans in every locality making the managed care program available statewide. In preparation for the final expansion, DMAS discontinued the MEDALLION Primary Care Case Management program as of April 30, 2012. As of July 1, 2012, Medicaid MCO enrollment was 621,016 out of an overall Medicaid population of 911,109 (68%) while FAMIS MCO enrollment was 61,522 out of an overall FAMIS population of 65,631 (94%).

During this time period, one new health plan contracted with DMAS to participate in the Medicaid/CHIP programs – MajestaCare - A Carilion Health Plan.

Currently, six managed care organizations (MCOs) operate Medicaid products across the Commonwealth. These partners are: AmeriGroup, Anthem, Optima, MajestaCare, Southern Health and Virginia Premier.

Virginia requires that all its contracted health plans be accredited by the National Committee for Quality Assurance (NCQA) and two of the five MCOs have attained "Excellent" accreditation status, the highest attainable level, while three health plans have attained "Commendable" accreditation status.

Each year, NCQA works in partnership with the Consumers Union of America to publish the NCQA's Health Insurance Plan Rankings. Three lists are published, one each for Medicaid, Medicare, and Commercial plans. The rankings are based on each MCO's performance, including consumer satisfaction, prevention, and treatment. This year, all Virginia Medicaid MCOs were rated among the top fifty plans. (MajestaCare, a

newly formed Medicaid MCO, is already setting milestones for attaining NCQA accreditation as soon as possible.)

Making the list of the top fifty is no easy feat. In fact a total of ninety-nine Medicaid MCOs received a ranking with an additional twenty-nine providing "insufficient data" (no ranking); and, another eighty-five Medicaid MCOs that provided no data, which also resulted in no ranking. This amounts to a total of two-hundred and thirteen Medicaid MCOs that were listed by NCQA. Similar to most rankings, one is the most favorable and ninety-nine is the lowest. Congratulations to DMAS' Medicaid MCOs on their rankings and for serving this population so well.

Richmond City Foster Care Pilot

In December 2011, DMAS piloted a project to enroll children, in foster care in Richmond City, into a Medicaid MCO. The budget language contained in the state fiscal year (SFY) 2013 budget builds on this and directs DMAS to expand managed care to children in foster care and adoption assistance statewide. DMAS in partnership with VDSS has begun holding statewide implementation workgroup meetings. The implementation will be rolled out regionally starting with Central Virginia and Tidewater regions in the spring of 2013.

Smiles For Children Program

On July 1, 2012, *Smiles For Children* celebrated its seventh 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 continues to provide increased access to dental services in all areas of the state. Utilization numbers for all ages and network size has increased. The network of dental specialty providers has also continued to increase.

CMS published its report of best practices dental programs and the Virginia *Smiles for Children* program is one of eight in the nation highlighted.

Provider Reimbursement

The following provider reimbursement activities were accomplished over the last two years:

- Provider payment rates were annually updated on July 1 as prescribed in regulation or as directed by the General Assembly. In particular, during the period July 1, 2010 through December 31, 2010, multiple rate adjustments were made for almost all providers, including MCOs, as a result of rate reductions effective July 1, 2010. Most of these reductions were reversed on October 1.

- New Disproportionate Share Hospital (DSH) audits were implemented as required by federal regulations and submitted for years 2005-2008.

- The financial solvency of the PACE organizations were improved to ensure that they met the financial solvency requirements in federal regulations.

- Monthly patient pay reports for nursing facilities and ICF-MRs were distributed to providers through a secure web-based server.

- The Virginia Department of Health is now fully reimbursed for its federal share of its costs for preadmission screening activities.

- A payment rate for Early Intervention case management was developed and implemented.

- The Provider Preventable Conditions policy, which denies full or partial payment to providers for health care acquired conditions, was implemented as a requirement under health care reform.

- Provider Reimbursement re-procured contractors to audit and settle cost reports and provide actuarial services.

- A provider assessment was conducted on ICF-MR providers.

- A study was completed, upon request by the Joint Commission on Health Care (JCHC), on ways to increase reimbursement for medical education for primary care and other specialties that are scarce.

- A study of residential rates for the Intellectual Disabilities Waiver and the Developmental Disabilities Waiver was completed as part of a larger report requested by the General Assembly.

Pharmacy

DMAS collected over $136 million in drug rebates in state fiscal year 2012 for drugs reimbursed by Medicaid MCOs.

DMAS implemented additional pharmacy cost saving measures including a reduction in reimbursement for single source innovator drugs from Average Wholesale Price (AWP) – 10.25% to AWP – 13.1%, and the elimination of the unit dose add-on fee for unit dose dispensing by long-term care pharmacies.

In addition, service authorization requirements were implemented that were recommended by the DMAS Drug Utilization Review Board for Atypical Antipsychotics used for children under six (6) years of age. The service authorization requirements were based on FDA approved indications for new specialty drugs and service authorization requirements based on the American Academy of Pediatrics guidelines for the use of Synagis to treat RSV in premature infants.

Transportation

Fee-for-service ambulance rates were adjusted to 40% of Medicare urban CY2011 rates effective July 1, 2012 with the passing of the Budget Bill by the 2012 Virginia General Assembly.

The Non-Emergency Medical Transportation program developed a new web site for Medicaid members, brokerage contracted transportation providers and Medicaid facilities. Members can go online and find important information such as the Rider Manual, FAQs with answers, and make transportation reservations. Also after appropriate training, facilities can go online and make transportation reservations. The web site address is: http://transportation.dmas.virginia.gov

In addition, a new Non-Emergency Medical Transportation (NEMT) Brokerage Procurement was successful without a protest with the new contract becoming effective October 1, 2011.

Information Technology/Management

Health and Human Resources Information Technology Strategic Plan (HHR ITSP)

The DMAS eHHR team led the initiative to create the first enterprise level HHR Information Technology Strategic Plan (ITSP). Representatives from each Health and Human Resources (HHR) agency (IT departments and business areas), the Virginia

Information Technologies Agency, and other participating agencies were involved in this initiative. The plan contains HHR-level goals, objectives, strategies, milestones, and measures.

Secretarial Committee on Data Sharing (SCDS)

In August 2011, the Secretary of HHR, William A. Hazel, Jr., M.D., and the Secretary of Technology, James D. Duffey, Jr., formed the Secretarial Committee on Data Sharing (SCDS). The SCDS consists of representatives from HHR and other Commonwealth of Virginia agencies, including the Department of Motor Vehicles (DMV), Department of Education (DOE), Auditor of Public Accounts (APA), Virginia Information Technologies Agency (VITA) and Office of the Attorney General (OAG). The DMAS eHHR team was responsible for drafting the committee's report and recommendations. The SCDS mission centers on identifying opportunities and constraints for an enterprise data-sharing model.

Establishing Technical Infrastructure

As part of the eHHR program, DMAS secured federal funding to build a Service Oriented Architecture (SOA) technical environment that will be the basis for interoperability between Federal, State, and local government systems to include Enterprise Data Management for person and organization indices. In addition, in collaboration with DMV, a Commonwealth Authentication Service (CAS) is being designed to address authentication needs for public facing web portals. These technical environments are targeted to initially support the Eligibility and Enrollment system replacement effort being undertaken by the Virginia Department of Social Services and DMAS.

Federal HIPAA Mandate

DMAS completed a major information technology project to bring the agency into compliance with a federal mandate to upgrade to new versions of the standards for electronic healthcare transactions, including eligibility verification, claims submission and claims status.

Provider Incentive Program

DMAS secured federal funding and managed procurements to implement the Provider Incentive Program. Contracts were executed with VHQC and CGI to establish the program. This ARRA funded program encourages providers to adopt, implement, upgrade and meaningfully use certified electronic medical record (EMR) systems. VHQC, as the Regional Extension Center (REC), is providing communications and

outreach services on the incentive program to the provider community as well as technical support to qualifying providers. The program is scheduled to launch in July 2012.

Program Operations

DMAS made numerous business process and program improvements directly affecting members, providers, contractors and staff during the past two years. Some notable accomplishments include:

- Direct Data Entry (DDE) of claims through a new Provider Web Portal was implemented during this reporting period. This no-cost solution to paper submissions has resulted in the processing of more timely and accurate claims, reduced contracting costs and enhanced PR with our participating providers.

- Implementation of Provider Profile Maintenance through the new Provider Web Portal enables providers to make demographic changes (phone, email, address, etc) to their provider file in real time resulting in cost-savings and efficiencies in processing for the state, provider and our Fiscal Agent contractor.

- Blast Email was introduced as an enhanced means of communicating with providers and members in a more cost-efficient and effective manner than more traditional methods. Blast Email allows the agency to send out blanket email messages, official policy changes and/or critical agency communiqués to any provider with a valid email address on file quickly and at a reduced cost than more traditional means.

- The agency's provider and member helpline was outsourced, which resulted in cost-savings in areas of staffing, equipment, and infrastructure while enhancing the quality of our customer services to members and providers.

- The Medical Support Unit and the Health Insurance Premium Assistance Unit (HIPP) both implemented paperless processing within their areas during this reporting period. These changes resulted in improved unit efficiencies, cost-savings to the state and improved workflow metrics and reporting.

- The State mandated 300H legislation was implemented in October 2011. The legislation strongly encourages participating providers to submit claims electronically and receive payments via Electronic Funds Transfer (EFT). Through outreach efforts over 66% of identified providers submitting paper claims have transitioned to electronic claims submissions. Currently, 86% of all claims are received electronically and processed through the system. In October 2011, less than

64% of all providers received EFT. As of July 2012, over 80% of all providers receive EFT representing 97% of all claims payments to participating providers.

Eligibility and Enrollment

DMAS staff began work in November 2011 with the Virginia Department of Social Services to develop and publish a Request for Proposals for a new Eligibility and Enrollment system for use with all public assistance programs. The RFP was issued by Social Services on May 25, 2012 and proposals were due by 2:00 pm on July 31, 2012. A vendor is currently scheduled to begin work in November 2012 with anticipation that the new system will be operational for Medicaid purposes by October 1, 2013.

CGI Eligibility Project

In November 2011, as a result of the JLARC Medicaid Fraud Report, DMAS entered into a contract with CGI to evaluate and make recommendations for improving existing eligibility processes. The scope of this project included an evaluation of short term business process measures available to reduce Medicaid/CHIP eligibility errors at local departments of social services; a gap analysis to determine potential implementation challenges associated with the technology infrastructure project associated with the eHHR project out of the Secretary's office; an analysis of the ACA as it relates to how income, family size and household income are defined in the determination of Medicaid /CHIP eligibility using the new Modified Adjusted Gross Income (MAGI) standard and a review and recommendations on how the eligibility process may work once the new eligibility system is up and running.

Maternal and Child Health Services

Early Intervention

To improve coordination of care for children enrolled in Medicaid or FAMIS who also receive Early Intervention (EI) services, DMAS pursued implementation of Targeted Case Management (TCM). Following a year of intensive meetings with staff from the Department of Behavioral Health and Developmental Services (DBHDS), Community Services Boards (CSBs), Local Lead Agencies, and other stakeholders, EI TCM was implemented on October 1, 2011. The care coordinators are tasked with working with physician's offices to ensure that well-child visits, immunizations, and lead testing for children in the EI program are performed timely. As of December 1, 2011, forty-three EI TCM providers across the Commonwealth provided TCM services for 3,944 children enrolled in both EI and Medicaid or FAMIS. With increased coordination with the

Medicaid and FAMIS MCOs, a more effective transition of services when the children age-out of the EI program (at three years of age), is expected.

Plan First

DMAS successfully moved the Plan First family planning program from a waiver program to the Medicaid State Plan, effective October 1, 2011. Plan First now covers family planning services, drugs and supplies for eligible individuals with family income up to 200 percent of the federal poverty level. DMAS has worked closely with the Virginia Department of Health (VDH) as well as the Virginia Department of Social Services (DSS) this year to increase enrollment in the program in an effort to reduce infant mortality and improve birth outcomes.

EPSDT (Early Periodic Screening Diagnosis and Treatment)

EPSDT is the Medicaid benefit plan for children under the age of 21. The EPSDT program provides preventive care services as well as medically necessary individualized treatment services to correct and ameliorate physical and mental health conditions, when the Medicaid state plan does not offer the needed treatment service. EPSDT defines the non-state plan services as "EPSDT Specialized Services."

The number of members who received an EPSDT Specialized Service has grown significantly during the past several years. In calendar year 2010, 1,020 enrollees were served, whereas in calendar year 2011, 1,461 enrollees were served. The significant increase is due to the provision of Behavioral Therapy services for persons with Autism Spectrum Disorders.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Performance Bonus

Virginia was awarded a Federal Fiscal Year (FFY) 2011 CHIPRA Performance Bonus in December 2011. CHIPRA established "Performance Bonuses" for States to support the enrollment and retention of eligible children in Medicaid and CHIP. Performance bonuses provide additional federal funding for qualifying States that have taken specific steps to simplify Medicaid and Children's Health Insurance Program (CHIP) enrollment and renewal processes by implementing at least five of eight identified processes. In addition, states also have to increase enrollment of children in Medicaid above a baseline level. Virginia's average monthly children's Medicaid enrollment was 535,071, qualifying the state for a Tier 2 bonus of $26.7 million. This was the second highest bonus amount awarded to states for FFY 2011. Virginia was one of 14 states with Administrative Renewals and one of only five states that have implemented the

CHIPRA Premium Assistance Program. The CHIPRA Performance Bonus is available for two more years: FFY 2012 and FFY 2013.

FAMIS Enhancements

DMAS has implemented a number of enhancements to the enrollment and renewal processes at the FAMIS Central Processing Unit (CPU) that have made it easier for families to apply for and retain FAMIS coverage. These include:

- **Administrative Renewals** – An administrative renewal process for FAMIS enrollees was implemented in October 2010 in order for the state to qualify for a CHIPRA Performance Bonus. Approximately 60% of FAMIS renewals are completed administratively every month.

- **Verification Submission via the Website** – Over 12,500 verification documents have been uploaded by new and renewing members via the FAMIS website, since implementation in July of 2010.

- **E-Applications** – Electronic submission of new applications via the web and telephone increased from approximately 48% of applications received in July 2010 to 78% of applications received in April 2012. Likewise, electronic submissions of renewal applications, via the web and telephone, also increased over the same time period from under 1% prior to July 2010 to 39% applications received in April 2012.

- **IVR Enhancements** – The FAMIS Interactive voice response (IVR) was enhanced in June 2012 to provide more detailed application and case status information without having to wait to talk to a customer service representative.

In addition, during spring 2011, FAMIS Marketing and Outreach staff worked to completely redesign the FAMIS website. The new website, which went live on June 2, 2011, was widely seen as a great improvement to the previous site and receives approximately 20,000 - 25,000 visits a month.

Grants

Maximizing Enrollment Grant

Through the funding support of the Department's Robert Wood Johnson Foundation *Maximizing Enrollment: Transforming State Health Coverage* grant the following projects and initiatives have taken place:

- A series of focus groups of LDSS eligibility workers and supervisors was completed and a report was developed on the enrollment and renewal process in the spring of 2011.

- Implementation of a data warehouse and reporting tool in August of 2011 that combines data from the Department of Social Services ADAPT eligibility system, the FAMIS Central Processing Unit eligibility system, CHAMPS, with enrollment, claims, and encounter data from the MMIS system.

- The existing Medicaid ex-parte renewal policy was re-written for clarification purposes and distributed in October 2011.

- A new telephone renewal process was added to Medicaid policy in October 2011.

- Utilizing the knowledge that teens are far more likely to be uninsured than younger children, Maternal and Child Health Division staff initiated a statewide 'Teen Health Week' in 2011 and 2012 to promote awareness around health insurance and general health concerns for teens. Working in coordination with the Department of Education and other community partners, staff launched and promoted a FAMIS Facebook page, distributed flyers throughout schools, enhanced the 'Teen' page on the FAMIS website, sent out e-postcards, and attended events. MCH staff plan to make this an annual event and encourage greater support and participation in the coming years from community partners.

- The ***"Focus on Reform: What's Next for Children's Coverage?"*** health reform summit was held on November 9, 2011 at the Glen Allen Cultural Arts Center. The event drew an audience of over 200 LDSS agency staff, outreach project staff, and child health advocates representing 55 localities. The event was recorded and posted on the Virginia Government YouTube Channel.

- Contracted with CGI to complete an Eligibility and Systems Analysis Project. The final phase of the project should be completed by July 2012.

Aetna Health Equity Grant

Virginia was awarded an Aetna Health Equity technical assistance grant in the fall of 2011. MCH staff have worked in cooperation with VDH staff on this project and presented at the Health Equity Summit in May 2012.

HRSA Maternal, Infant, and Child Home Visiting Grant

MCH Division staff continued to work with VDH and other key stakeholders, since July 2010, on the Health Resources and Services Administration (HRSA) Maternal, Infant, and Child Home Visiting grant. HRSA awarded formula grants to the fifty States and six jurisdictions (collectively referred to as "States" in this document), of which $500,000 was unrestricted and available to support the home visiting needs assessment and planning process for a Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. Each of the 56 grantees are required to develop an Updated State Plan for a State Home Visiting Program.

Improvements to Care for the Elderly and Persons with Disabilities

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 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. For calendar years 2010-2012, total funding equaled $1,655,000.

Virginia Gold

Virginia Gold was a two-year pilot grant program, from September 1, 2009 through August 31, 2011, designed to improve certified nursing assistant (CNA) recruitment and retention in Virginia nursing facilities (NF) and to improve the overall quality of consistent care to the residents. Five nursing facilities were awarded civil money penalty funds (CMP) to implement the program. The NF grantees had the flexibility to design programs with the following objectives to meet their unique needs: orientation of new staff, peer mentoring of staff, rewards and recognition of staff, worker empowerment, and training of staff. Most of the five NF grantees have seen an

improvement in the CNA (certified nursing assistant) retention in their facilities. All of the grantees have been successful in introducing peer mentoring, enhanced staff orientation and training, offering CNA rewards and recognition, and improving employee working conditions. Most of the grantees met their initial goal set to reduce the CNA turnover rate. The activities offered during this pilot program have proven to be beneficial to staff morale and staff confidence, have improved the work environment for staff and the living environment for residents, and have created sustainability for the projects that were worthwhile with positive results continuing.

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 case management 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 areas.

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 ten sites that are operating across the Commonwealth: Sentara Senior Community Care PACE in Virginia Beach and Portsmouth; Riverside Peninsula PACE in Hampton and with three sites in Richmond; Mountain Empire PACE in Big Stone Gap; AllCare for Seniors PACE in Cedar Bluff; Centra PACE in Lynchburg, and INOVA Senior Cares PACE in Fairfax.

Currently, there are 765 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 77 with 79% being female. Participants have an average of six medical conditions and 94% 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 provides information on the geographic location of Virginia PACE sites.

Figure 3

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 close to 11,000 as of March 2012. The number of qualifying attendants has grown from approximately 2,500 in 2007 to over 14,000 in March 2012. The Consumer Recipient Satisfaction Survey 2011 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."

Money Follows the Person Rebalancing Demonstration

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 supports Virginia's implementation of the Olmstead decision and complements the efforts of the Aging and Disability Resource Centers (ADRCs) network, which is designed to streamline access to long-term care and integrate the full range of long-term supports and services systems. As of May 2012, 493 individuals have enrolled in the MFP project with 362 individuals having transitioned from an institution to the community.

Health Care Reform

Changes Implemented in Virginia in Response to the Affordable Care Act

The Affordable Care Act (ACA) became law on March 23, 2010. Perhaps the largest provisions of this law, the Medicaid expansion to all individuals up to 133 percent of the federal poverty level, and the implementation of the health insurance exchanges for subsidized health insurance coverage will not become effective until 2014. The recent Supreme Court of the United States decision, which upheld the individual mandate but made the Medicaid expansion optional to states, is still under review by this Administration and Members of the Virginia General Assembly. Because Medicaid expansion is now optional, DMAS must first obtain authority through the Governor and the General Assembly in order to implement this change.

Regardless of the decisions the Commonwealth needs to make regarding Medicaid expansion and health insurance exchanges, the Affordable Care Act required States to implement various Medicaid-related provisions almost immediately. The Department has been working to ensure that Virginia is in compliance with these new requirements which range from the addition of new services to measures designed to reduce waste, fraud and abuse. A considerable amount of effort has gone into implementing the changes, many of which have required amendments to the Medicaid State Plan and the promulgation of State regulations. In addition, even though the major ACA provisions do not become effective until 2014, preliminary planning is underway on the implementation of the Medicaid expansion and the health insurance exchanges. Some of the changes DMAS is working on are summarized below.

Measures Designed to Reduce Fraud and Abuse

- One of the biggest ACA-related changes DMAS is working on includes the new requirements for provider screenings which are supposed to be in effect now,

although CMS has provided States with some leeway as long as they are demonstrating progress towards compliance with the new requirements.

- Providers are divided into low, medium, and high risk groups based on the perceived risk of fraud. The level of screening varies by risk category, with the highest risk category requiring site visits, fingerprints, and criminal background checks. All providers, those newly-enrolling as well as currently enrolled providers must comply with the new screening provisions. Even prescribing and referring providers must enroll in the Medicaid program. DMAS will have to be ready to impose temporary enrollment moratoria for the Medicaid program should CMS or local circumstances require it.

- DMAS staff has been working with CMS and other States to understand the full impact of these requirements on our operations and is actively planning for the changes that will need to be made to information systems, provider contracts, and the way individuals access services.

- ACA required States to establish programs to contract with a Recovery Audit Contractor (RAC). The state has contracted with an entity on a contingency basis for indentifying and collecting Medicaid overpayment to providers and suppliers.

Pharmacy-Related Provisions

- ACA required pharmaceutical manufacturers to increase the amount of rebates provided to the managed care organizations (MCOs) in the Medicaid program for outpatient single source and innovator multiple source prescription drugs. To date, DMAS has collected over $154 million in additional rebates as a result of the new ACA requirement. In addition, DMAS worked with its fee-for-service drug program contractor to collect the rebates for drugs provided in the Medicaid fee-for-service system, which to date has totaled $11.7 million.

- DMAS has begun providing certain drugs from the list of excluded drugs (e.g., certain smoking cessation drugs) which were previously not covered.

- DMAS has implemented certain changes to pharmacy reimbursement limits.

- ACA expanded enrollment in the 340B Drug Pricing program for safety net providers who became newly eligible for this program. This provision makes discounted drugs available to children's hospitals, free-standing cancer centers, critical access hospitals, rural referral centers, and sole community hospitals.

Financing and Payment Changes

- ACA extended the period for collection of overpayments to providers from 60 days to one year and DMAS has implemented this provision.

- ACA prohibits Medicaid payments for preventable health care acquired conditions. DMAS already denied payment for preventable hospital acquired conditions, but has put additional measures in place to ensure compliance with ACA. These measures are expected to further reduce costs and improve the quality of care for Medicaid patients.

- ACA provides for a temporary two year increase in Medicaid payments for primary care services. DMAS has responded to CMS with suggestions on how to improve their proposed rule implementing these increased primary care payments. Preliminary planning to implement this provision is underway, although final preparations will have to wait until the final rule is released by CMS.

- ACA provided an extension of funding for programs such the Money Follows the Person program, allowing DMAS to continue operating these programs.

General Changes to Services

- ACA required State Medicaid programs to cover all medically necessary care to children receiving hospice care. Prior to this, if families chose hospice services for their child, the child was not eligible for any other services outside of hospice care.

- DMAS started providing face-to-face tobacco cessation counseling services to pregnant women following the new requirements in ACA. (DMAS already provided tobacco cessation pharmacotherapy services to all Medicaid individuals.)

CMS/RAND Modified Adjusted Gross Income Project

In late 2011, CMS selected 10 states to test the different methodologies of determining federal medical assistance payments (FMAP) for the newly eligible Medicaid beneficiaries under the Affordable Care Act.

The study states are: Arizona, California, Indiana, Nebraska, New Hampshire, New York, Oregon, Tennessee, Virginia, and West Virginia. CMS contracted with RAND to

lead the project. CMS' proposed regulation on Medicaid eligibility had suggested three options for determining the applicable federal matching rate for the newly eligible Medicaid beneficiaries.

Other Achievements and Initiatives

Client and Provider Appeals

The Agency's Appeals Division is court-mandated to maintain a 97% compliance rate in timely resolution of appeals filed by recipients of services administered by the Agency. The Appeals Division is mandated by statute and regulation to maintain a 100% compliance rate for timely resolution of appeals filed by Medicaid Service Providers.

As enrollment eligibility statistics and the number of offered programs increase, the number of appeals has increased, as well. For example, looking just to the past three years, the Appeals Division processed 3,408 client appeals in 2011, up from 2,537 just three years ago. Appeals by Medicaid service providers have increased to 3,316 appeals this past calendar year compared to 1,912 three years ago.

In the remainder of this calendar year and into the next, the Appeals Division will have new factors, such as new contract audits, new federally mandated audits and continued increased enrollment and client services, all adding to the number of incoming appeals. To stay abreast of the challenge and to fulfill the duty to provide a timely process for granting a due process review to all of our clients and providers, the Appeals Division has reorganized staff and has continued to take advantage of emerging technologies to increase efficiencies. Appeals Division management has used focused teams of staff in dual roles to target intake backlogs and assist in the most complex cases. The use of electronic scanning to reduce boxes of hard-copy evidence to a single CD-ROM disc and the use of electronic transfer technologies are all implemented or currently being implemented.

Additionally, the Appeals Division is developing, in conjunction with DMAS Information Management, an updated database software program and a workflow processing software program to track and process appeals without the need for multiple and repetitive handling of documentation. DMAS is pleased to consistently meet and surpass the court mandates and statutory requirements. The compliance rate for meeting all statutory, regulatory and court-imposed deadlines exceeds the court-ordered requirements and stands at 99.6% for client appeals and 100% for provider appeals.

Human Resources

DMAS has had numerous achievements in this area over the past two years including:

- Launched the federally required E-Verify System for review and attestation of employment eligibility and identity documents to comply with federal I-9 requirements.

- Developed and implemented a formal interactive/reasonable accommodation process to ensure full compliance with the Americans With Disabilities Act Amendments Act.

- Increased participation in 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 66%.

- Increased employee teleworking, in line with the Governor's objectives, to 33%. DMAS continues to promote teleworking.

- Updated key HR policies to ensure legal compliance and fair, equitable administration of HR Programs. Policies included: Business Conduct and Ethics, the EEO Statement, Physical Access Control, Visitor Access Control, and Outside Employment.

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 2011, DMAS' utilization percentage was 53%, exceeding the Governor's goal of 40% SWaM participation. DMAS will continue to explore new and creative ways to increase procurement of SWaM businesses by identifying opportunities and existing obstacles.

Financial Alignment Demonstration

In August of 2011, the Centers for Medicare and Medicaid Services (CMS) Office of Medicare and Medicaid Integration offered an opportunity for states to participate in the Financial Alignment Demonstration. The Demonstration seeks to test models to integrate Medicare and Medicaid services, rules and payments under one delivery system for individuals who are eligible for both Medicare and Medicaid (*dual eligible individuals).* A high proportion of dual eligible individuals have chronic health conditions and functional impairments and receive services through two separate but overlapping programs that are uncoordinated and result in fragmented, sub-optimal

care and outcomes. The Demonstration seeks to test programs that align the two systems under a unified delivery model.

As proposed, the Demonstration allows for a capitated model and a managed fee-for-service model. Virginia has submitted a proposal to participate under the capitated model. Under the capitated model, managed care organizations will provide all Medicare Part A, B and D benefits (Inpatient, Outpatient and Professional, and Prescription Drugs, respectively) and the great majority of Medicaid benefits to demonstration enrollees, including medical services, behavioral health services and both institutional and community-based long term care services and supports (including consumer direction).

The Demonstration will operate for three years beginning January 1, 2014. Individuals over the age of twenty-one years who are eligible for Medicare and full Medicaid benefits will be eligible to participate in the Virginia Demonstration. The Demonstration allows for passive enrollment with an 'opt out' option. Under this method, individuals are provided information during an open enrollment period on the program options available to them under Medicare (e.g., fee-for-service, PACE, Medicare Advantage Plans, and the Demonstration). If no selection is made, the individual may be passively enrolled in the Demonstration but will be able to opt out of the Demonstration at any time.

The Demonstration is planned to be implemented in four regions in the first year (Central Virginia, Northern Virginia, Tidewater and the Charlottesville/West regions) and expand to the Roanoke region in the second year, pending approval from CMS. The goals of the Demonstration include: reducing fragmentation; providing high-quality and coordinated care; improving the health and lives of enrolled individuals; reducing the need for avoidable services, such as hospitalization and emergency room use; encouraging individual participation in treatment decisions; and supporting the goal of providing treatment in the least restrictive, most integrated setting.

The model will include a strong, person-centered service coordination/case management component, rigorous quality monitoring and ongoing stakeholder participation in program design and ongoing implementation. Participating health plans will receive a blended, capitated premium payment that will take into account expected savings and quality withholds that can be earned back by meeting performance goals. DMAS submitted a proposal to CMS on May 31, 2012 and expects a decision on whether or not it will be accepted in the first quarter of 2013.

APPENDIX A

Board of Medical Assistance Services
Agenda Items 2010-2012

2010 (June – Dec)

- Update DMAS Budget Reductions and Stimulus
- Conflict of Interest Training: Elizabeth McDonald, Legal Counsel
- National Health Care Reform Update – Impact on Medicaid and Virginia
- Smiles for Children Update
- Maximizing Enrollment Grant – Overview and Updates
- Program of All-Inclusive Care for the Elderly (PACE)
- Early Intervention Medicaid Initiative
- Medicaid Forecast
- Regulation Update

2011

- DMAS Budget/Budget Reductions
- General Assembly Update
- Report on the Virginia Health Reform Initiative
- Transition from First Health Services to ACS
- Regulation Update
- Riverside PACE/Tour of Riverside PACE: Craig Connors, Vice President, Home and Community Based Services – Riverside Health System
- 2011 Plans for the Virginia Health Reform Initiative
- Early Intervention Targeted Case Management
- Plan First: Virginia's Family Planning Program
- DMAS Pharmacy Programs
- Care Coordination
- Medicaid Forecast
- Newborn Enrollment

2012 (January – June)

- General Assembly Update
- Electronic Health Records
- Director's Report and Status of Key Projects
- Eligibility Enrollment Project: Mike Wirth, Special Advisor of eHHR Integration, Office of the Secretary of Health and Human Resources
- Medicare and Medicaid Financial Alignment Demonstration (Duals Demonstration)
- DMAS Budget/Budget Reductions
- Regulation Update

APPENDIX B

Grants/Demonstrations and Awards during the 2011-2012 Time Period

Large Grants – Awarded during 2011-12 time frame

GRANT NAME	SFY 2011	SFY 2012
Medicaid – Medical Assistance Payments	3,477,996,000	3,563,143,000
Medicaid – ARRA	689,197,000	0
Medicaid – Administrative Payments	147,484,000	162,317,000
Medicaid – Health Information Technology	32,000	15,954,411
CHIP – State Children's Health (FAMIS)	175,234,257	175,234,257
CHIP – CHIPRA Enrollment Bonus	0	26,729,489

Small Grants/Demonstrations – Awarded during 2011-12 time frame

GRANT NAME	SFY 2011	SFY 2012
Competitive Employment Grant	0	750,000
PRTF – Psychiatric Residential Treatment Facilities Demonstration Grant (Demonstration)	0	2,408,803
MFP – Money Follows the Person Demonstration	6,906,403	11,797,802
State Planning & Establishment Grant for the Affordable Care Act's Exchanges	1,000,000	0
Private Grants:		
Robert Wood Johnson Foundation	0	150,000