JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION
OF THE VIRGINIA GENERAL ASSEMBLY

A Review of Selected Programs in the Department of Medical Assistance Services

A Report in a Series on the Virginia Medicaid Program

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Preface

Senate Joint Resolution 441 of the 2001 General Assembly Session directed the Joint Legislative Audit and Review Commission (JLARC) to conduct an evaluation of the development, management, utilization, and funding of the health and mental health services provided through the Department of Medical Assistance Services (DMAS). This resolution reflected legislative concern about the effectiveness and efficiency of DMAS' management of the Medicaid program and other State programs. In FY 2000, DMAS expended $2.7 billion for medical care services to more than 600,000 recipients, including low-income children, pregnant women, and individuals who are aged, blind, or disabled.

This report focuses on four program areas that require immediate review because they are in a period of transition or because of escalating costs. The programs are the child health insurance program, the mental retardation waiver program, the non-emergency transportation program, and the pharmacy program.

Based on the review of the four programs, JLARC staff found that DMAS' management of programs has been hindered to some extent by inconsistent direction from the leadership at DMAS and by the agency's overall lack of clear, consistent, and timely communication with consumers, families, providers, and legislators. This report notes weaknesses in each program area:

- Since the beginning of Virginia's child health insurance program, there has been weak program design, management, and leadership, which has resulted in low enrollment of children in the program and the forfeiture of more than $55 million federal dollars.

- When DMAS assumed management of the mental retardation waiver program, the agency made a series of poor policy decisions, resulting in a lawsuit and an ongoing federal investigation.

- For the non-emergency transportation program, DMAS should have delayed implementation of the new brokerage system until the new contractors were fully operational.

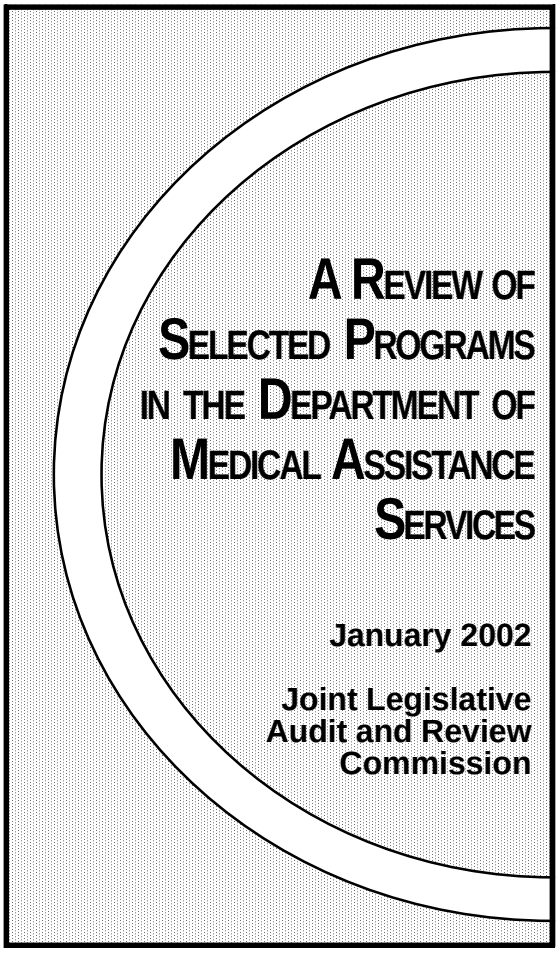
- While DMAS currently has in place most of the common strategies for controlling pharmacy costs, the report identifies three improvements to achieve additional cost savings. One of these recommendations – to lower pharmacy reimbursement rates – was included in the Governor's proposed budget for the 2002-2004 biennium to achieve a savings of $12.7 million.

On behalf of the Commission, I wish to express our appreciation for the assistance and cooperation provided during this review by DMAS staff and contractors, and the provider and consumer representatives.

Philip A. Leone
Director

January 23, 2002

JLARC Report Summary



Senate Joint Resolution (SJR) 441 from the 2001 General Assembly Session directs JLARC to conduct an evaluation of the development, management, utilization, and funding of the health and mental health services provided through the Department of Medical Assistance Services (DMAS). This resolution reflected legislative concern about the effectiveness and efficiency of DMAS' management of the Medicaid program and other State programs.

DMAS administers the State's Medicaid plan, certifies provider eligibility, and makes payments to Medicaid providers for services rendered to individuals eligible for Medicaid. In FY 2000, DMAS expended $2.7 billion for medical care services to more than 600,000 recipients, including low-income children and individuals, pregnant women, and individuals who are aged, blind, or disabled. In addition to administering Medicaid, DMAS administers a number of other State programs, including the Indigent Health Care Trust Fund, the State and Local Hospitalization Program, the Involuntary Mental Commitment Program, the Health Premium Assistance Program for HIV-Positive Individuals, Regular Assisted Living Payments for residents of adult care residences, and the Virginia Family Access to Medical Insurance Security Plan Trust Fund.

This report focuses on four program areas that require immediate review because they are in a period of transition or because of escalating costs. These programs are: the child health insurance program, the mental retardation waiver program, the nonemergency transportation program, and the pharmacy program.

Based on the review of the four programs, JLARC staff found that DMAS' development, implementation, and management of programs have been hindered to some extent by inconsistent direction from the leadership at DMAS and by the agency's overall lack of clear, consistent, and timely communication with consumers, families, providers, and legislators. Since 1997, there have been five different Medicaid directors, and each has had a different view on how programs should be developed. Historically, DMAS has not sought external input to the development or revision of health and mental health policies and services unless directed to do so by outside sources (such as by the General Assembly or the Secretary of Health and Human Resources). This report recommends that DMAS provide a sta-

tus report to the General Assembly on all four programs and how it has implemented the JLARC recommendations prior to the 2003 session.

The primary findings of this report for each of the four programs include:

- Virginia's newly implemented child health insurance program, known as Family Access to Medical Insurance (FAMIS), eliminated some critical obstacles to enrollment associated with the Children's Medical Security Insurance Program (CMSIP), but appears to have created some new program design and operational issues. The key problems are that 4,006 former CMSIP children have dropped from the FAMIS rolls, 2,049 families (representing 3,270 children) are scheduled to lose FAMIS coverage for failure to pay the initial monthly premiums, and 40 percent of families with children enrolled in FAMIS also have children enrolled in Medicaid. Overall, the child health insurance enrollment figures have lagged behind all projections, and the State has forfeited more than $55 million in federal dollars. As of October 2001, DMAS has not spent any of the allotments for FFY 2000 and FFY 2001. Virginia is ranked 40th out of 50 states for expenditures made as a percent of the State's federal allotment.

- The mental retardation waiver program has been in a state of flux for the last year and a half due to legislative and State-level management changes. Contrary to legislative intent, DMAS assumed all policy development and management activities of the waiver, which caused the denial or delay of needed MR waiver services. An underlying problem, however, has been DMAS' poor communication with other State staff, task force members, consumers, and legislators. The management of the MR waiver slots has now been returned to the local level. Recently, the administration announced plans to provide funding for an additional 150 waiver slots, but this is not adequate to address the needs for 1,666 persons on the waiting list who currently need services.

- The new transportation brokerage system appears to be an appropriate model for providing non-emergency transportation for recipients to medical care. It will enable the Commonwealth to avoid cost increases of $56 million dollars over the next two years (based on the difference between projected increases using historical cost data and contract costs). However, the implementation of the new service was problematic because the contractor responsible for a majority of the State did not have enough transportation providers, phone lines, or staff, and routine transportation visits were not scheduled prior to the start-up date. While DMAS should have delayed implementation of this program until the contractors were ready, it is now addressing current concerns with the program.

- DMAS currently has in place most of the common strategies for controlling pharmacy costs, but many are less restrictive than other state's Medicaid programs. Based upon a broad review of how DMAS' strategies compare with other state Medicaid programs, three improvements to achieve additional cost savings were identified: improve the prior authorization process, lower pharmacy reimbursement rates, and improve the recovery of third party payments.

FAMIS Has Design and Operational Issues that May Impact the Enrollment and Retention of Children in the Program

In 1997, both the State and the federal government initiated a child health insurance program to reach uninsured children of low-income families who were not eligible for Medicaid. Virginia's child health insurance program, begun in October 1998, was originally called the Children's Medical Security Insurance Program, or CMSIP. In August 2001, due to low enrollment numbers in CMSIP and the State's desire to implement a health care plan modeled after the private sector, the program was completely overhauled and renamed the Family Access to Medical Insurance Security, or FAMIS.

While Virginia was a forerunner among the states in recognizing the need for improving health insurance for children, its overall track record for insuring children and utilizing the federal funds lags behind most states. As of December 1, 2001, only 34,996 of the expected 63,200 children had been enrolled in the child health insurance program. According to child health advocates, a variety of factors have impacted these low enrollment trends during the CMSIP phase, including poor outreach efforts, cumbersome administrative practices, stringent eligibility criteria, and complicated enrollment processes. It is still too early to determine whether the FAMIS program will be able to meet the enrollment goal.

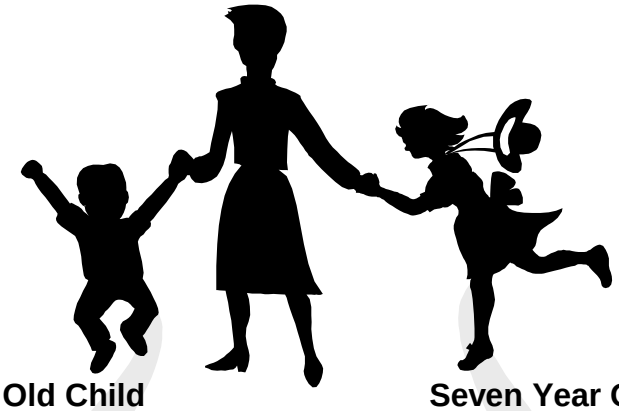
In addition, the State has forfeited more than $55 million in federal child health insurance dollars because it could not spend its federal allotments for 1998 and 1999 in the required three-year time period. As of October 2001, DMAS had not spent any of the allotments for FFY 2000 and FFY 2001. Virginia is ranked 40th out of 50 states for expenditures made as a percent of the State's federal allotments for FFY Year 1998 through FFY 2000.

In August 2001, Virginia implemented FAMIS, which is modeled after private health insurance plans. While this program eliminates some critical obstacles to enrollment associated with CMSIP, it appears to have created new program design and operational issues. Some of these problems must be fixed immediately, and others should be monitored over the next year to gauge how the current approach is impacting the enrollment and retention of children in the program.

One of the special concerns regarding the new FAMIS program is that former CMSIP children appear to be dropping FAMIS health insurance coverage at an alarming rate. In November 2001, 4,000 of these children were dropped from the FAMIS rolls because families did not return the annual applications for re-establishing eligibility (these annual re-applications covered the months of August, September, and October). In December 2001, 2,049 families (representing approximately 3,270 children) were scheduled to lose FAMIS coverage for failure to pay the initial monthly premiums. This report recommends that DMAS determine the extent to which families' non-responses were due to moving, lack of interest in the program, increased income, confusion over administrative requirements, or new program requirements, such as co-payments, monthly premiums, or changes in health care benefits and providers.

Another key concern about the program's design is that, because income limits for Medicaid differ depending on the age of the child, 40 percent of the families with children enrolled in the FAMIS program also have children enrolled in the Medicaid program. Consequently, this means these families have to access and navigate two totally different health insurance programs in order to obtain health care for all of their children (see the figure on the next page, which illustrates a typical family that falls into this category).

Child Health Insurance Benefits Compared: Medicaid *vs.* FAMIS and Effects on Families that Have Children in Both Programs



Five Year Old Child Enrolled in Medicaid	Seven Year Old Child Enrolled in FAMIS
Point of Contact	
Must contact <u>local DSS</u> for eligibility, enrollment, and questions; requires a Medicaid application and verification.	Must contact <u>FAMIS Call Center</u> for eligibility, enrollment and questions; requires a FAMIS application and verification.
Income Rule	
Stepparent's income <u>not</u> counted.	Stepparent's income <u>counted</u>.
Doctor	
Child is taken to Doctor <u>A.</u>	Child is taken to Doctor <u>B.</u>
Transportation	
Transportation services <u>provided</u>.	<u>Only</u> emergency transportation services provided.
Co-Payments	
Co-payments <u>not</u> required.	Co-payments may be <u>required</u>.
Premiums	
Premium <u>not</u> required.	$15 monthly premium may be <u>required</u>.
Services Received	
Receives <u>all</u> Medicaid funded medical care services.	Receives only medical care services available to State employees, which include limits (such as mental health services) and requires partial payment on selected services (such as braces).

Percent of Children Affected

60% of children (20,520) are in families enrolled in FAMIS only. 40% of children (13,773) are in "mixed" families – those with children enrolled in both FAMIS and Medicaid.

The report provides two recommendations to address this problem. First, DMAS should develop formal coordination processes between the FAMIS and the Medicaid programs to help reduce the confusion of participating families regarding who and where to call concerning eligibility and program requirements, health benefits, and service delivery questions. Second, the State should adopt a single eligibility level for Medicaid based on income, not the age of a child.

In addition to these immediate concerns, there are several FAMIS program policies that DMAS needs to monitor over the next year in order to gauge their impact on children, including counting the stepparent's income, addressing fluctuating incomes, requiring a six-month waiting period for insurance, requiring cost-sharing, reducing health benefits, implementing the employer sponsored health insurance, ensuring outreach to uninsured children, and implementing the managed care service delivery system. The report recommends that DMAS provide an update on these issues and how it is implementing the JLARC recommendations as part of its required quarterly reports to the General Assembly.

DMAS' Management of the Mental Retardation Waiver Program Has Been Problematic

The SJR 441 study mandate specifically addressed concerns with the mental retardation (MR) waiver program, due to "strong concerns [that] have been raised by consumers, family members, and providers about the administration of the Medicaid home-and-community-based mental retardation waiver." Virginia has provided Medicaid-funded home-and-community-based care services to eligible persons with mental retardation as an alternative to more costly institutionalization since 1991 (the waiver also allowed the State to maximize federal Medicaid dollars in order to address a statewide budget shortfall). There are a variety of services funded through the MR waiver program. The most utilized services are day support (74 percent) and residential support (60 percent), which are designed to enable the client to acquire, improve, or maintain the health status and functional skills necessary to live in the community. Since 1991, the program has grown from 130 clients and almost $2 million paid to providers in FY 1991 to 4,698 clients and $139 million paid to providers in FY 2000.

The MR waiver program has been in a state of flux for the last year and a half due to legislative and State-level management changes. One of the key legislative changes occurred during the 2000 session of the General Assembly when all of the MR waiver funds were moved from the Department of Mental Health, Mental Retardation, and Substance Abuse Services' (DMHMRSAS) budget to DMAS' budget to streamline the reimbursement process for these services. The legislative intent was that the policy and management for the MR waiver program (to the extent allowable under federal law) would remain at DMHMRSAS because of its agency mission and staff expertise. What occurred instead was that DMAS, with the approval of the Secretary of Health and Human Resources, assumed all policy and decision-making responsibility for this waiver and made a series of mistakes. An underlying problem with the administration of the MR waiver for more than a year has been DMAS' lack of clear, consistent, and timely communication with DMHMRSAS staff, task force members, consumers, and legislators.

This problem started with DMAS' assumption of the management of the waiver, and with subsequent decisions that DMAS made without input from DMHMRSAS or the stakeholders on the impact of these decisions on the health and safety of MR clients. These early problems were associated with DMAS' assessment that the trans-

ferred funds from DMHMRSAS were not sufficient to address the annual expenditures for the clients already on the MR waiver. Based on this conclusion, DMAS began denying requests for enhanced services for persons already on the waiver and admissions to the waiver for persons with emergency needs. DMAS' communication to the families and the service providers concerning these denials were conflicting and slow, leading to a lawsuit and an ongoing investigation by the U.S. Office of Civil Rights.

To address public concerns, the Secretary of Health and Human Resources announced the creation of a task force to develop a new MR waiver. While DMAS spent considerable time and resources on task force meetings and the development of a new MR waiver, it lost credibility when the emergency regulations and the provider manual did not reflect perceived agreements by the task force members. According to the DMAS director, the major accomplishment with the new MR waiver is that the management of the waiver slots was put back at the local level where it belongs. However, the management of the waiver slots was essentially at the local level prior to DMAS' intervention.

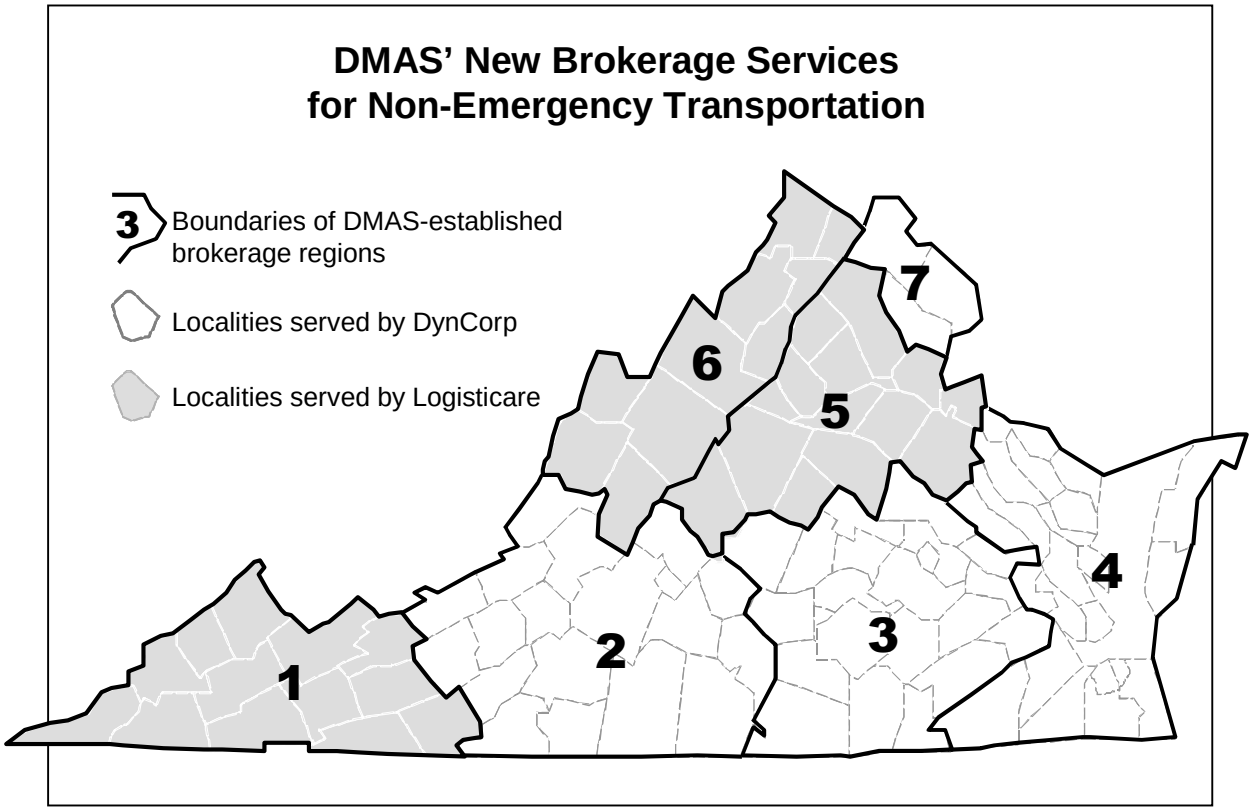
The effectiveness of the transition of day-to-day management of the waiver from DMAS back to the Community Service Boards and DMHMRSAS depends upon how much DMAS continues to micro-manage these activities and whether DMAS improves its communication with these agencies. The overall success of the waiver, however, will depend on how many of the 1,666 persons on waiting lists receive needed services in a timely manner. The administration plans to fund 150 additional waiver slots, but this number will not address those waiting in the community and State facilities for MR waiver services. The report recommends that DMAS provide a status report on the MR waiver activities to the General Assembly prior to the 2003 session.

Both the Secretary of Health and Human Resources and the DMAS director are pleased with the recent accomplishments regarding the administration of the waiver and communication between DMAS staff and major stakeholders. Therefore, they disagree with the JLARC staff findings that some problems remain.

DMAS' New Transportation Brokerage System Appears to Be an Appropriate Model, But Implementation Problems Continue

Transportation services play an important role in ensuring that Medicaid recipients have access to necessary medical care. Historically, however, this Medicaid-funded service has been characterized as a program without adequate State-level oversight and cost containment measures. Consequently, there has been a 20 percent annual increase in costs of the program during the last decade, from about $9.1 million in FY 1990 to $54 million in FY 2000. A key driver of these costs, it is thought, may be a high incidence of fraud and abuse.

To address these concerns, on July 2, 2001, DMAS implemented a new transportation brokerage system for providing non-emergency transportation based upon the success of earlier pilot programs. Contracts were awarded to two companies; one company was awarded the majority of the State (four out of the seven regions) both geographically and in the number of recipients served (see the figure on the next page for the regional breakdown of the state). The purpose of the new system is to use a broker or intermediary to coordinate and monitor transportation services and subsequently control costs, fraud, and abuse. DMAS projects that the transportation brokerage system will enable the Commonwealth to avoid cost increases of $56 million dollars (federal and State funds) over the next two years (based on the difference between pro-



jected increases using historical cost data and contract costs).

However, after the July 2001 start date, recipients, transportation providers, and service providers questioned the ability of the new transportation brokerage model to provide timely and quality transportation services for Medicaid's most vulnerable populations. Most of the complaints were lodged against the contractor that was responsible for the majority of the State. The chief complaints were that there were not enough transportation providers, there were not enough phone lines and staff at the transportation call centers, and there were routine transportation visits left unscheduled prior to the start-up date. Some service providers assert that DMAS should have delayed statewide implementation of the program until proper verification of the critical start-up requirements were conducted.

In spite of initial start-up problems, a brokerage system appears to be an appropriate model for providing transportation services to Medicaid recipients. DMAS is closely monitoring the transportation brokerage system and resolving identified operational problems. The JLARC staff review identified several operational issues that DMAS should address or monitor over the next year to gauge the overall effectiveness of the program, including the quality of the transportation services provided. In addition, DMAS will need to monitor the impact that the statewide expansion of managed care will have on the contracts for transportation brokerage services as more Medicaid recipients move from the fee-for-service program into managed care plans. The report recommends that DMAS provide a status report on the transportation services to the General Assembly prior to the 2003 session.

DMAS Has Several Methods for Controlling Pharmacy Costs, But Additional Savings Can Be Achieved

Prescription drug coverage is an optional Medicaid benefit. However, Virginia's Medicaid program has covered prescription drugs since the beginning of the program in 1969. Pharmacy expenditures are one of the major factors driving increases in the Medicaid budget in recent years. Over the past five years, Virginia Medicaid prescription drug costs have increased 14 percent annually under the fee-for-service program to $341 million in FY 2001 (after drug rebates).

The rapid growth in prescription drug costs is a major concern for both private and state insurance programs. National studies indicate that the main factors for the increase in growth are the discovery of new drug treatments, the increased use of drugs in treatment, the increased advertising by drug manufacturers, and the growth in the elderly and disabled population. Many of these factors impacting expenditure growth are beyond the control of state Medicaid programs. However, state Medicaid programs are attempting to control some expenditure growth through a variety of cost saving alternatives.

This report includes a broad review of Virginia's Medicaid-funded pharmacy services based upon a comparison with other state Medicaid programs. The Virginia Medicaid program currently has most of the common cost alternatives in place, but many are less restrictive than other state Medicaid programs. For example, Virginia's Medicaid program does not have prescription limits (such as the number of days supply or number of prescriptions per month), does not actively utilize a prior authorization system, and pays more to pharmacies than the national average.

DMAS examines additional cost saving measures on an ongoing basis and is currently pursuing the implementation of a tiered co-payment requirement and the expansion of its disease management program. However, more cost savings can be achieved. The report identified three improvements that DMAS should pursue to achieve additional cost savings: (1) improve the prior authorization process so that additional drugs, if warranted, can be added; (2) lower pharmacy reimbursement rates to accurately reflect the current market prices; and (3) improve efforts to recover third-party payments for pharmacy claims.

Table of Contents

I. Introduction

Senate Joint Resolution (SJR) 441 from the 2001 General Assembly Session directed the Joint Legislative Audit and Review Commission (JLARC) to conduct an evaluation of the development, management, utilization, and funding for the health and mental health services provided through the Department of Medical Assistance Services (DMAS). This resolution reflected a variety of concerns about the effectiveness and efficiency of DMAS' management of the Medicaid program and other State programs.

SJR 441 specifically directed JLARC staff to examine: (1) the appropriate role and mission of DMAS in relation to indigent health care policy for the Commonwealth; (2) how the leadership and decision-making processes and internal and external communications of DMAS impact the development, management, and utilization of health and mental health services; (3) the adequacy of current DMAS resources (staff and technology) to develop and manage health and mental health services; (4) the adequacy and appropriateness of how federal and State funds are used for services; and (5) a comparison of Virginia's provision of Medicaid-funded health and mental health services, such as child health, long-term care services and waivers, and mental health services, with other states (see Appendix A for a copy of the resolution).

This report focuses on four program areas, administered by DMAS, which require immediate review. The first three programs require review because they are undergoing major changes. These programs are the child health insurance program, the mental retardation waiver services program, and the non-emergency transportation program. The final program, pharmacy services, was reviewed because it is one of the major factors driving the projected increases in the Medicaid budget.

OVERVIEW OF VIRGINIA'S MEDICAID PROGRAM

The Medicaid program was established in 1965 by Title XIX of the Social Security Act. The program provides three types of health protection: (1) health insurance for low-income families and people with disabilities, (2) long-term care for older Americans and people with disabilities, and (3) Medigap coverage that helps low income elderly fill in the gaps of the limited Medicare benefit. Medicaid is a cooperative venture between the states and the federal government, with the U.S. Government paying a federal matching percentage of between 50 percent and 83 percent of each state's Medicaid expenses. In FY 2002, the federal government will pay 51 percent of the total Medicaid expenditures in Virginia.

Each state administers its own Medicaid program through a central agency. Federal guidance and regulations come from the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration. Within broad federal guidelines, states are permitted to set their own eli-

gibility standards, and to determine the type, amount, duration, and scope of services they will cover. States also have considerable flexibility in setting payment rates for services.

The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid program. DMAS was created in 1985 from the medical assistance services program in the Department of Health. DMAS administers the State's Medicaid plan, certifies provider eligibility, and provides payments to Medicaid providers for services rendered to individuals eligible for Medicaid. In FY 2000, Virginia's Medicaid program provided medical care services to more than 600,000 recipients, including low-income children, pregnant women, and individuals who are aged, blind, or disabled.

In addition to administering Medicaid, DMAS administers a number of other programs. These programs include: the Indigent Health Care Trust Fund, the State and Local Hospitalization Program, the Involuntary Mental Commitment Program, the Health Premium Assistance Program for HIV-Positive Individuals, Regular Assisted Living Payments for residents of adult care residences, and the Virginia Family Access to Medical Insurance Security Plan Trust Fund.

Medicaid Spending Has Increased Significantly

As shown in Figure 1, Medicaid spending has increased substantially during the 1990s. In FY 2000, DMAS spent $2.7 billion to provide Medicaid-funded health and mental health services. The key items driving the Medicaid spending have been increases in overall inflation of medical costs and increases in the Medicaid-eligible population. The major growth areas were nursing facility payments, pharmacy payments, mental health services, implementation of managed care, and general Medicaid spending, which includes a number of categories, such as transportation services. Managed care has reduced the rate of growth in Medicaid spending on acute care service areas, such as hospitals, physicians, and pharmacy costs. Figure 1 also shows the distribution of expenditures by service categories for FY 2000. The services where the largest expenditures occurred were payments made to hospitals and nursing facilities.

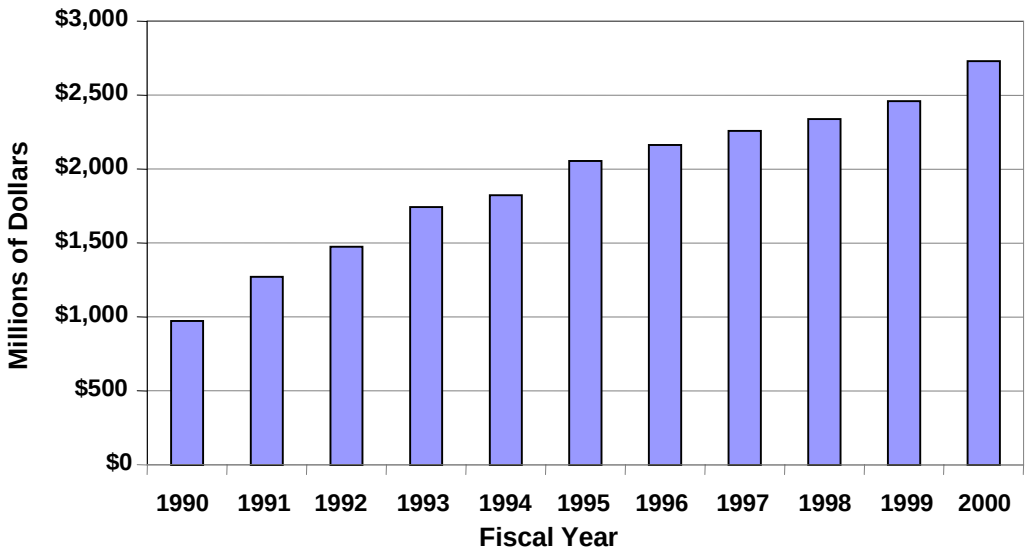
In spite of the fact that expenditures for the Medicaid program continue to grow, Virginia's Medicaid program expenditures per capita are 47th in the country (see Table 1). Historically, Virginia has reported provider reimbursement rates that appear low in comparison with other states.

Medicaid expenditures also depend on the number and types of clients served by the program, as well as on the particular services provided. Different categories of clients have different levels of need and generate widely varying spending levels. For instance, although children represent 50 percent of recipients, only 16 percent of the total annual spending is on their behalf. The blind and disabled category accounts for only 19 percent of the recipients, but 45 percent of the annual spending is used to provide them services.

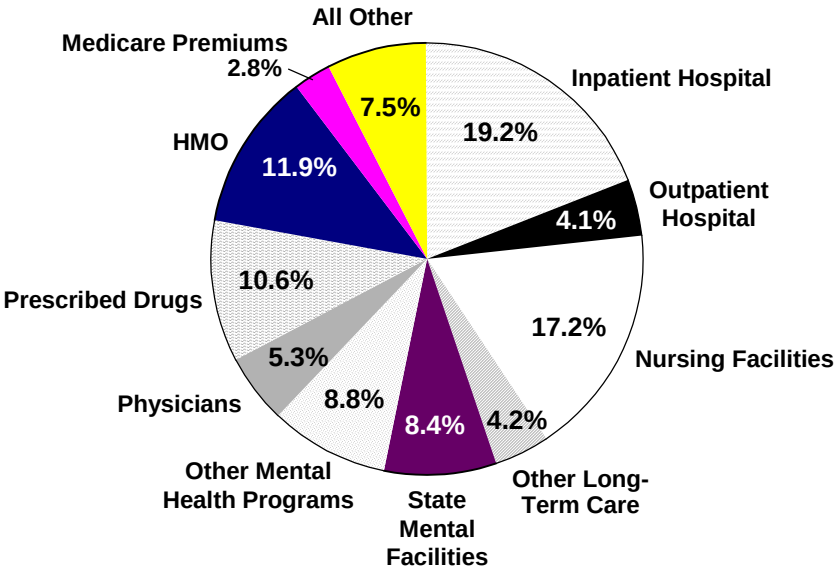
Figure 1

Medicaid Spending

General Medicaid Expenditures



Expenditures by Service Category, FY 2000



Source: DMAS 2000 Statistical Record.

Table 1

Virginia's Ranking and Medicaid Expenditures Compared to Other States

Measurement	Rank
Population	12
Per-Capita Income	15
Number of Medicaid Recipients	17
Total Medicaid Vendor Payments	23
Number of Medicaid Recipients as a Percent of a Population	43
Expenditure Per Medicaid Recipient	36
Medicaid Expenditure Per Capita	47
Medicaid as Percent of Total State Expenditures	43

Source: U.S. Department of Health and Human Resources, Centers for Medicare and Medicaid Services, preliminary federal fiscal year 1999 data.

Virginia's Medicaid Program Has Been the Focus of Numerous JLARC Studies

As shown in Exhibit 1, since the 1970s, JLARC has completed numerous studies of Virginia's Medicaid program. In 1992 and 1993, JLARC issued a series of reports on DMAS, which included the following programs: ambulatory care, asset transfers and estate recovery, hospital services, long-term care services, and physician and pharmacy services. Primary findings of the reports indicated that at that time, Virginia's program was "not extravagant in the services provided"; eligibility for the program was strict; and the best prospects for long-term cost savings would likely come from reform that controlled health costs for all payers, as opposed to restrictions on the Medicaid program. Most recently, JLARC has conducted a series of reports on nursing facility reimbursement, hospital reimbursement, and Medicaid expenditure forecasting.

Historical Context: DMAS Leadership and Communication

Changes that have occurred at DMAS in recent years form part of the context for this current review of four programs, administered by DMAS. DMAS' development, implementation, and management of programs have been hindered to some extent by inconsistent direction from the leadership at DMAS and by the agency's overall lack of clear, consistent, and timely communication with consumers, families, providers, and legislators. Since 1997, there have been five different Medicaid directors, and each has had a different view on how programs should be developed. Because of this lack of consistent leadership and direction, there have been internal disagreements among senior management staff on key program and policy issues.

Exhibit 1

Past JLARC Reports on Virginia's Medicaid Program: 1978 to the Present

- *Long-Term Care in Virginia* (March 1978)
- *Medical Assistance Programs: An Overview* (June 1978)
- *Inpatient Care in Virginia* (January 1979)
- *Outpatient Care in Virginia* (March 1979)
- *Funding the State and Local Hospitalization Program* (December 1987, S.D. 17)
- *Special Report: Evaluation of a Health Insuring Organization for the Administration of Medicaid in Virginia* (January 1992, H.D. 33)
- *Interim Report: Review of the Virginia Medicaid Program [Ambulatory Care*] (February 1992, S.D. 27)
- *Medicaid Asset Transfers and Estate Recovery* (November 1992, S.D. 10)
- *Medicaid-Financed Hospital Services in Virginia* (November 1992, S.D. 11)
- *Medicaid-Financed Long-Term Care Services in Virginia* (December 1992, S.D. 12)
- *Medicaid-Financed Physician and Pharmacy Services in Virginia* (January 1993, S.D. 29)
- *Review of the Virginia Medicaid Program: Final Summary Report* (February 1993, S.D. 32)
- *Funding of Indigent Hospital Care in Virginia* (March 1993, S.D. 36)
- *Technical Report: Review of the Medicaid Forecasting Methodology* (July 1996, H.D. 5 1997)
- *Technical Status Report: An Overview of Expenditure Forecasting in Four Major State Programs* (August 2000, H.D. 3); this document includes the Medicaid program
- *Virginia's Medicaid Reimbursement to Nursing Facilities* (January 2000, S.D. 28)
- *Review of the Medicaid Inpatient Hospital Reimbursement System* (December 2000)

Historically, DMAS has not sought outside input to the development or revision of health and mental health policies and services unless directed to do so by external sources (such as by the General Assembly or the Secretary of Health and Human Resources). In 1999, concerns about communication between DMAS and service providers and recipients of health care services prompted the General Assembly to add language to the *Code of Virginia*, which requires the director to report to the Governor and members of the General Assembly "the activities of facilitating communication between the Department and providers and recipients of health care services." Concerns about communication between DMAS and consumers, families, providers, and the legislators remain because it tends to be inconsistent.

The leadership and communication problems were present to some degree in three of the four programs reviewed for this report. Since the beginning of Vir-

ginia's child health insurance program, there has been weak program design, management, and leadership. It appears that the State lacked the commitment to find and enroll uninsured children, in spite of continued legislative prodding of the administration. With the mental retardation waiver program, DMAS assumed management of the waiver and made a series of policy decisions without input from other State staff, consumers, and providers. Once problems were identified, DMAS' communication to families and service providers concerning waiver services were conflicting and slow, causing a lawsuit and an ongoing investigation by the U.S. Office of Civil Rights. With the transportation program, DMAS should have delayed implementation of the new brokerage system until the new contractors were fully operational and all routine visits for recipients were scheduled. DMAS' communications to recipients and service providers concerning these changes and implementation problems were not timely and added to the confusion and concern.

JLARC REVIEW

SJR 441 directs the JLARC staff to conduct an evaluation of the development, management, utilization, and funding of health and mental health services provided through DMAS. This report addresses four programs: the child health insurance program, mental retardation waiver services, non-emergency transportation services, and pharmacy services.

In order to meet the requirements of the study mandate, this review of the Department of Medical Assistance Services was designed to address four questions:

1. Is DMAS' revised system for providing health care services to uninsured children developed, managed, and funded in a manner that improves utilization of these services?

2. Is DMAS' development, management, and funding of mental retardation waiver services appropriate and adequate to address the needs of all Virginians eligible for these services?

3. Is DMAS' development, implementation, and management of statewide brokerage services for non-emergency transportation services appropriate and adequate to provide quality transportation in a cost-effective manner?

4. Are there additional improvements that DMAS could make to reduce the growing costs of prescription drugs covered under the Medicaid program?

Research Activities

To review each of the four Medicaid-funded programs, JLARC staff conducted five primary research activities: (1) structured interviews, (2) site visits, (3) a

survey of pharmacy stakeholders, (4) document reviews, and (5) data requests. These methods are described below.

Structured Interviews. Interviews were the key research activity for this review. JLARC staff conducted extensive interviews with the major stakeholders for each study area, including current and former staff from DMAS, the Department of Mental Health Mental Retardation and Substance Abuse Services, the legislature, the federal Centers for Medicare and Medicaid Services, DMAS private contractors, provider associations, State and local departments of social services, and local community service boards, as well as consumers, advocates, and consultants. The study team also attended program meetings, training sessions, task force meetings, and conferences. Discussion topics were targeted to each interviewee, and covered program history, funding, utilization, management, and performance, as well as key problems and concerns.

Site Visits. JLARC staff conducted site visits pertaining to three of the four program areas. For the child health insurance program, JLARC staff visited the new centralized processing unit, which is responsible for determining eligibility and enrolling children into the new Family Access to Medical Insurance Security or FAMIS program. For the mental retardation waiver program, JLARC staff visited a local community service board (CSB) office, a CSB-run group home, and a CSB-run day support program. For the transportation program, JLARC staff visited two area agencies on aging that ran the former pilot programs in Southwest Virginia and the two call centers operated by the new contractors for transportation services. Generally, the purposes of the site visits were to better understand client and provider characteristics, customer satisfaction, services provided, quality control, screening and referral processes, best practices, and differences across various programs.

Survey. As part of the review of pharmacy services, JLARC staff conducted an electronic survey. The survey was sent to DMAS' Pharmacy Liaison Group, the Medical Society of Virginia, and a federal Pharmacy Technical Assistance Group. Each of these groups submitted one answer to the survey. The purpose of this survey was to obtain input on the feasibility of implementing any of the current pharmacy cost containment strategies available to state Medicaid programs, as well as the potential impact on recipients, pharmacies, physicians, drug companies, and the DMAS program administration for each of the alternatives described.

Document Reviews. JLARC staff reviewed various federal and State documents on each of the program areas. The major documents reviewed include: State and federal regulations, the *Code of Virginia*, Medicaid and child health insurance state plans, provider manuals, requests for proposals and contracts, memoranda, minutes from various meetings, legal depositions and settlement papers, and other state or national reports.

Data Requests. In addition to the interviews, surveys, and site visits, JLARC staff requested and reviewed utilization, funding, and program data in all four program areas.

REPORT ORGANIZATION

This report is organized into five chapters, including the introduction, which provides an overview of the Medicaid program and the JLARC staff study. The four remaining chapters provide overviews of each of the program areas evaluated, including a brief review of utilization and funding, a description of recent changes to the program, and a discussion of current concerns with the program. Chapter II presents an assessment of Virginia's child health insurance programs. Chapter III presents a review of DMAS' management of the mental retardation waiver program over the last year and a half. Chapter IV presents a review of DMAS' new transportation brokerage system. Chapter V provides an assessment of DMAS' current cost control mechanisms for pharmacy services.

II. The Child Health Insurance Program

According to the 2001 Virginia Health Access survey, there are likely more than 130,000 children (whose family incomes are at or below 200 percent of the federal poverty line) with no health insurance. In the past, Virginia's only mechanism for covering low-income children has been the traditional Medicaid program, which provides a comprehensive list of preventive health care and medical services to more than 350,000 children (whose family incomes are either below 100 percent or, in the case of younger children, below 133 percent of the federal poverty level). However, both the State and the federal government realized that this program was not sufficient to reach all of the uninsured and underinsured children in the Commonwealth.

In 1997, prior to the federal plan, the Virginia General Assembly established the Virginia Children's Medical Security Insurance Plan to extend health insurance coverage to uninsured children of low-income families who were not eligible for Medicaid. Later that same year, the federal government, through the Balanced Budget Act of 1997, provided federal funds to expand health insurance coverage for children by creating the State Children's Health Insurance Program (Title XXI of the *Social Security Act*). Congress authorized $40 billion in federal matching funds over ten years for states to initiate and expand innovative health insurance programs for uninsured, low-income children. This is the largest single federal investment in health insurance since the establishment of Medicaid and Medicare in 1965. Virginia's portion of the federal funds is $692 million (around $70 million per year) for the ten-year authorization period, which includes an enhanced federal match rate of 66 percent (the current Medicaid match rate is 51 percent).

Virginia's child health insurance program was originally called the Children's Medical Security Insurance Program, or CMSIP, and started in October 1998. In August 2001, due to low enrollment numbers in CMSIP and the State's desire to implement a health care plan modeled after the private sector, the program was completely overhauled and renamed the Family Access to Medical Insurance Security, or FAMIS. The goal of the child health insurance program is to provide health insurance for children whose families earn too much for traditional Medicaid, yet do not have private health insurance coverage. It is designed to increase access to preventive health care and to promote regular immunizations and well-child care. The Department of Medical Assistance Services (DMAS) has the primary responsibility for the development, implementation, and management of the child health insurance program.

While Virginia was a forerunner among the states in recognizing the need for improving health insurance for children, its overall track record for insuring children and utilizing the federal funds lags behind most states. The study mandate for this review, Senate Joint Resolution 441 from the 2001 session of the General Assembly, specifically addressed this concern by stating "Virginia is among the states that for a variety of reasons have been unable to spend millions of federal

matching dollars allocated for the State Children's Health Insurance Program, despite the documented needs among Virginia's uninsured low-income children."

Virginia's child health insurance program has been hindered to some extent by the lack of agreement among State-level policymakers regarding the type of health insurance plan that is best for Virginia's children. As of June 2001, only half of the expected number of children have been enrolled in the child health insurance program, and the State has forfeited more than $55 million in federal child health insurance dollars (Virginia is ranked 40th out of 50 states for expenditures made as a percent of the State's federal allotment). According to consumer groups and child health advocates, a variety of factors have impacted these low enrollment trends, including poor outreach efforts, cumbersome administrative practices, stringent eligibility criteria, and complicated enrollment processes.

In August 2001, Virginia implemented a totally different approach for providing children's health insurance, known as FAMIS. The FAMIS program, which is modeled after private health insurance plans, eliminates some critical obstacles to enrollment associated with the CMSIP program, but appears to have created new program design and operational issues. Some of these problems must be fixed immediately and others should be monitored over the next year to gauge how the current approach is impacting the enrollment and retention of children in the program.

One of the special concerns regarding the new FAMIS program is that former CMSIP children appear to be dropping FAMIS health insurance coverage at an alarming rate. In November 2001, 4,006 of these children were dropped from the FAMIS rolls because families did not return the annual applications for re-establishing eligibility (these annual re-applications covered the months of August, September, and October). In December 2001, 2,049 families (representing 3,270 children) are scheduled to lose FAMIS coverage for failure to pay the initial monthly premiums. In addition, a key concern about the program's design is that 40 percent of the families with children enrolled in the FAMIS program also have children enrolled in the Medicaid program, which means these families have to access and navigate two totally different health insurance programs in order to obtain health care for all of their children.

To address this problem, DMAS needs to develop a close working relationship between the FAMIS and the Medicaid programs to help reduce the confusion of participating families regarding whom and where to call concerning eligibility and program requirements, health benefits, and service delivery questions. Also, the eligibility for child health services through the Medicaid program should be expanded to cover all Medicaid children up to 133 percent of the federal poverty limit. This will ensure that families that are served by both the FAMIS and Medicaid programs are eligible based on the factor of income, not age. In addition to these immediate concerns, there are several FAMIS program policies that DMAS needs to monitor over the next year in order to gauge their impact on children.

OVERVIEW OF VIRGINIA'S CHILD HEALTH INSURANCE PROGRAMS

Congress enacted the State Child Health Insurance Program in 1997 in response to the large number of uninsured children and the impact inadequate health care can have on their well-being. Within broad guidelines, states have considerable flexibility in designing programs to cover low-income children. States can provide coverage through Medicaid, create a separate program, or use a combination of the two.

The major advantage of expanding the Medicaid program to include the new child health insurance is that it builds upon an existing program and service delivery structure. The major disadvantage is that states also have to continue to conform to federal rules, which may be inflexible. For the states that chose a separate program, the key advantage is the ability to design an innovative program with new benefit packages, service delivery arrangements, cost sharing, and simpler eligibility rules and application processes. A separate program can also reduce the welfare stigma associated with Medicaid programs.

Virginia's State-level policy makers have struggled over the advantages and disadvantages of expanding the Medicaid program or creating a separate program since the beginning of the discussions on child health insurance. These struggles have hindered to some extent, the enrollment of children into the child health insurance program, as well as the utilization of millions of dollars in federal funds. The following sections describe the lack of consistent State-level support for this program and how this has impacted the enrollment of uninsured children and the utilization of federal funds.

Virginia Has Lost Valuable Time in Its Development of Two Different Child Health Insurance Programs

It has been almost five years since Virginia's State-level policy makers first formally debated the best way to develop a child health insurance plan for low-income children who are not eligible to receive Medicaid. After three years of implementation of the first child health insurance program, DMAS is only half way to the original enrollment goal of 63,200 children and has forfeited more than $55 million dollars in federal child health insurance allotments. According to the initial proposal, Virginia expected the child health insurance program to be at maturity within three years of implementation, which meant that the enrollment goal would have been met. Instead, the State is starting over with an entirely new program, which may create a new set of problems.

While the design of the children's health insurance program certainly impacts the ability of a State to enroll and retain children, an additional issue for Virginia has been the lack of consistent, State-level support for the program. Virginia's implementation has been slowed by legislative and administrative differences, agency leadership turnover (five Medicaid directors since 1997), and internal differ-

ences among DMAS staff regarding the appropriate way to design and develop a child health insurance program.

Although all members of Virginia's legislature unanimously approved the initial passage of Virginia's child health insurance plan in 1997, program implementation was difficult because of State-level policy differences concerning whether the program should be an expansion of the Medicaid program, a separate program, or a combination of both designs. Exhibit 2 provides a timeline for these struggles. With the implementation of CMSIP in 1998, neither the legislature nor the administra-

Exhibit 2

Timeline for the Implementation of Virginia's Child Health Insurance Programs

Date	Event
March 1997	The 1997 General Assembly establishes the Virginia Children's Medical Security Insurance Plan to extend health insurance coverage to uninsured and underinsured children. This legislation also establishes a trust fund for this program to help fund it.
August 1997	The federal government creates the State Children's Health Insurance Program (Title XXI of the Social Security Act).
March 1998	The 1998 General Assembly determines that Virginia's child health program will be an expansion of the current Medicaid program, including children up to 150 percent of federal poverty guidelines. Other children up to 200 percent of the poverty guidelines would be covered under a Medicaid look-alike program.
June 1998	Pursuant to the administration's direction, DMAS submits the Children's Medical Insurance Program (CMSIP) State Plan to the Health Care Financing Administration (HCFA). The plan creates a separate Medicaid look-alike program, but does not expand the Medicaid program up to 150 percent of the federal poverty guidelines.
October 1998	CMSIP begins after HCFA approves the State Plan Amendment. Local departments of social services begin accepting applications for CMSIP.
March 2000	The 2000 General Assembly makes changes in CMSIP to create the Family Access to Medical Insurance Security (FAMIS) program, which changes the child health program from a Medicaid look-alike program to a program modeled after the private sector.
June 2000	DMAS submits the FAMIS State Plan to HCFA.
December 2000	HCFA approves DMAS' FAMIS State Plan Amendment.
March 2001	The 2001 General Assembly removes restrictive requirements from the child health plan, such as child support and a 12-month waiting period.
January 2001	DMAS publishes a Request for Proposals for a Central Processing Unit (CPU) for FAMIS. DMAS also assumes responsibility for outreach activities from Department of Social Services.
May 2001	DMAS executes a contract with a private contractor to conduct CPU activities.
August 2001	FAMIS emergency regulations become effective. The CPU starts receiving and processing applications.
November 2001	FAMIS cost sharing requirements (monthly premiums and co-payments) begin.
December 2001	FAMIS managed care arrangements to provide revised health benefits begin.

Source: JLARC staff adaptation of various Department of Medical Assistance Services' handouts, program descriptions, and legislative resolutions.

tion were pleased with the design of the program. The legislature was concerned because the Medicaid expansion did not occur as it directed, and the administration was displeased because CMSIP was a Medicaid look-alike program rather than one modeled after the private sector. Consequently, the administration began to advocate for a different child health plan before CMSIP had a chance to be fully implemented. The 2000 General Assembly reversed its 1998 stance and approved a separate program that resembled private health care plans, known as Family Access to Medical Insurance Security, or FAMIS. This plan, negotiated by the Joint Commission on Health Care's Chairman, was a compromise between the administration, legislators, DMAS, and the child health advocates. The advocates supported the compromise because it was the first time it appeared that the program would have consistent State-level support. In addition, a series of legislative changes were introduced during the 2000 and 2001 sessions of the General Assembly, which were designed to address some of the identified shortcomings of Virginia's CMSIP initiative.

Within DMAS itself, there were also difficulties with the development and implementation of CMSIP, and then FAMIS. Since 1997, there have been five Medicaid directors, and each with a different view on how the child health insurance program should be developed. This inconsistent direction from the leadership at DMAS led to internal disagreements on key implementation and program design issues, and to questions from outside observers regarding whether the program was a top priority for the agency. At the present time, it appears that DMAS' leadership and management staff are more supportive of the FAMIS program than they were of the CMSIP program.

Virginia's Child Health Insurance Enrollment Figures Have Lagged Behind All Projections and Performance Goals

According to Virginia's *State Child Health Plan Under Title XXI of the Social Security Act*, the number one strategic objective is "to reduce the number of uninsured children." Three performance goals to address this objective are outlined in the plan: (1) increase the number of Medicaid eligible children enrolled in Medicaid, (2) enroll 63,200 children in the child health insurance plan, and (3) reduce the percentage of uninsured children.

In 1997, DMAS staff, in conjunction with staff from the Joint Commission on Health Care, projected that there would be 135,200 previously uninsured children enrolled in the Medicaid program (72,000 children) or in CMSIP (63,200 children) when the child health insurance program reached maturity in three years. Based upon these projections, DMAS failed to meet all three performance goals under CMSIP. It is still too early in the process to determine whether FAMIS will be able to meet these goals. Each performance goal is discussed in a following section.

DMAS Did Not Track the Enrollment of Medicaid-Eligible Children as a Result of CMSIP Outreach Strategies. In Virginia and nationally, one of the expected outcomes of the outreach strategies for the new child health insurance program is that more children would likely be found eligible and enrolled in the Medicaid program. In fact, it is a federal requirement that children be screened

for Medicaid prior to completing the application for the child health insurance program. Federal reporting requirements also request, but do not require, that states provide the number of children enrolled in Medicaid as a result of the child health insurance program.

According to the National Governor's Association, there is evidence to suggest that for every child enrolled in the child health program, states have enrolled another child in Medicaid. In Virginia, based upon the experience of 12 pilot outreach projects (serving 47 localities), 65 percent of more than 5,500 children assisted by these projects were enrolled in the Medicaid program and the remainder in CMSIP. In Arlington County, one of the State's most successful local departments of social services for enrolling children in CMSIP, 1,248 children were enrolled in CMSIP and 910 additional children were enrolled in Medicaid. This type of tracking of Medicaid enrollees, as the result of CMSIP, was limited to a few outreach projects or local social service agencies.

Because the State and the federal goal is to reduce the number of uninsured children regardless of which program they are enrolled in, DMAS should have tracked new Medicaid enrollees that appeared to be due to CMSIP outreach activities. This critical tracking mechanism was never developed in spite of repeated requests by the legislators and stakeholders for the number of new Medicaid enrollees. If DMAS had captured this data, the Commonwealth's total efforts to enroll uninsured children in insurance programs may have appeared more positive.

At the present time, DMAS does not have a formal mechanism to track the number of children that go through the new FAMIS central processing unit (CPU) and are ultimately enrolled in Medicaid. DMAS is tracking how many children are Medicaid-likely and are referred to either the Medicaid unit located at the FAMIS CPU or to the local departments of social services, but not the final outcome. DMAS should track Medicaid enrollment by conducting a monthly match of Medicaid-likely referrals with the Medicaid Management Information System to determine whether these referrals ultimately are enrolled in Medicaid. The matching of referrals to Medicaid enrollment could be simplified if the applicant's social security number is obtained during the initial application process (the request of this number is allowed by federal state child health insurance program regulations).

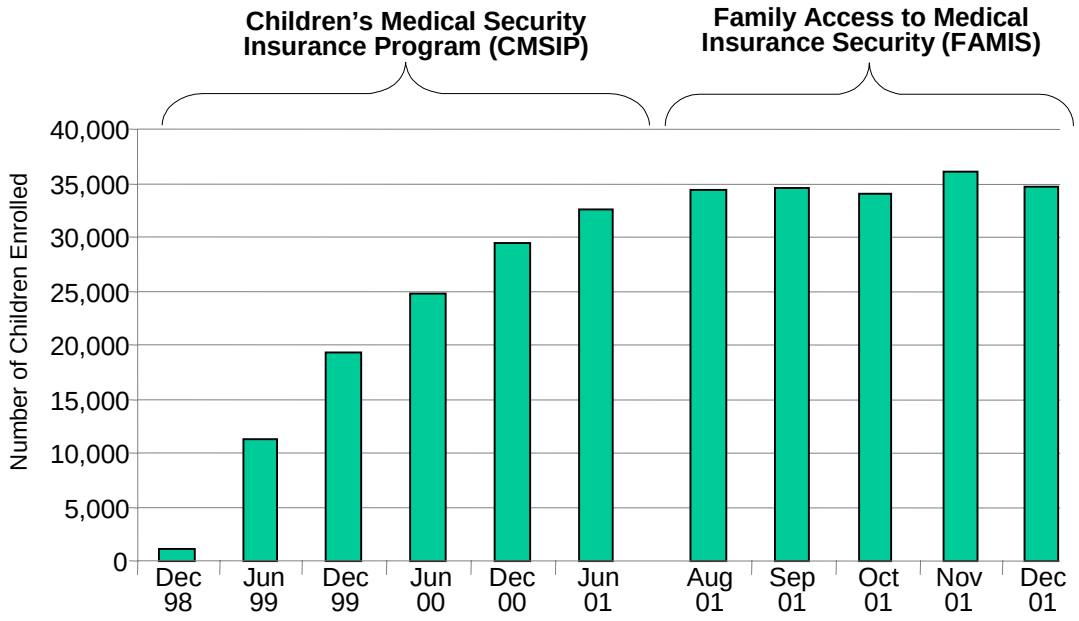
Recommendation (1). **The Department of Medical Assistance Services (DMAS) should track, utilizing the Medicaid Management Information System, the number of Medicaid referrals made by the FAMIS Central Processing Unit (CPU) to the Medicaid unit located within the CPU or to local departments of social services, to determine how many become enrolled in the Medicaid program. The goal of this tracking mechanism is to assess DMAS' overall performance in reducing the number of uninsured children. The Medicaid enrollment data should be reported whenever FAMIS enrollment data is reported.**

DMAS Has Enrolled Only Half of the Projected Number of Children for Health Insurance, and Now Children Are Dropping It at an Alarming Rate. The success of Virginia's child health insurance program is measured not only by the number of children enrolled, but also the number of children that remain in the program over a long period of time. As shown in Figure 2, after CMSIP received federal approval, the enrollment of children in the health insurance program was slow. DMAS indicates, however, that since its inception, CMSIP enrolled over 58,000 unduplicated children. DMAS does not have a clear idea of why children did not remain on CMSIP. The only reason DMAS gave was a "failure to re-establish eligibility in a timely manner at the end of the eligibility period."

As of December 1, 2001, there were 34,996 children in the FAMIS program, for a net increase of 1,220 children since the implementation of the new program in August 2001. Initially, between August and November 2001, it appeared that the net enrollment under the new FAMIS program was slowly increasing due to the increased advertising and outreach activities. However, by the end of November 2001, 4,006 former CMSIP children (or more than ten percent of the children) were dropped off the FAMIS rolls because the families did not return the applications for re-establishing eligibility. This number represents the annual re-applications covering the months of August, September, and October. The FAMIS central processing unit did mail three separate notices (the renewal application, a postcard reminder,

Figure 2

Enrollment in Virginia's Child Health Insurance Plans 12/98 to 12/01



Note: Intervals vary due to data availability.

Source: DMAS' Quarterly Reports on the Status of the Virginia Children's Medical Insurance Program to the General Assembly (October 1998 through June 2001); DMAS data.

and the cancellation letter) to these families, but DMAS does not know why the applications were not returned (the overall response rate to the request for annual reapplications was 50 percent).

In addition, 2,049 families (representing 3,270 children) are scheduled to have their FAMIS insurance cancelled after December 31, 2001 because of failure to pay the monthly premiums (a new FAMIS policy that requires families to participate in cost sharing). This cancellation means that families will have to wait six months before they can reapply for FAMIS.

With the implementation of the FAMIS program, DMAS must examine the reasons why children drop out from the program. Otherwise, former CMSIP children may continue to drop out each month as their annual application to redetermine eligibility becomes due. DMAS needs to determine the extent to which families' non-responses to the annual application requests were due to moving, lack of interest in the program, increased income, confusion over administrative requirements, or new FAMIS program requirements, such as co-payments, monthly premiums, or changes in health care benefits and providers. Through a telephone or mail survey, DMAS should promptly determine why this initial group of families failed to return the required documents and why 2,049 families failed to pay their initial premiums. DMAS has indicated that it is developing a telephone survey to inquire why these initial families are not responding to the FAMIS correspondence. In the future, DMAS should conduct these follow-up surveys on an ongoing basis.

Recommendation (2). **The Department of Medical Assistance Services, in conjunction with the FAMIS Outreach Oversight Committee, should develop a telephone and/or mail survey to track the reasons why children drop out of the FAMIS program. This survey should be conducted on an ongoing basis in order to provide State-level policy makers with the information necessary to determine the impact of the FAMIS program and policies on enrollment and retention of children in its health insurance program. The survey should include questions to determine whether the non-responses were due to moving, lack of interest in the program, increased income, confusion over administrative requirements, or new program requirements, such as co-payments, monthly premiums, or changes in health care benefits and providers.**

DMAS' Child Health Insurance Program Has Not Reduced the Overall Percentage of Uninsured Children in Virginia. According to both the CMSIP and FAMIS State plans, DMAS will utilize the Virginia Health Access Surveys to measure program performance in terms of the goal of reducing the overall percentage of uninsured children across the Commonwealth. In 2001, the Virginia Health Access survey found that the uninsured rate for children with family incomes under 200 percent of the federal poverty limit has steadily increased since the 1996 survey, from 10 percent to 14.1 percent. This increase occurred during the time period of CMSIP. Therefore, DMAS has not met this performance goal; in fact the extent of the problem appears to have worsened, based on the survey.

The 2001 survey also demonstrates the need for DMAS to update its overall projections for Medicaid and FAMIS enrollment. Even though 35,000 children are currently enrolled in FAMIS, the survey found approximately 133,000 uninsured children across the Commonwealth that appear to be eligible to receive health insurance under either the Medicaid or FAMIS programs. Therefore, DMAS' new projections should show this increase over current enrollment figures in order to ensure that the State's enrollment goals are reasonable and reflect the true number of uninsured children.

Recommendation (3). **In order to monitor its performance in reaching uninsured children in Virginia, the Department of Medical Assistance Services should develop an up-to-date projection of the total number of uninsured children in Virginia, the number of potential children eligible for Medicaid, and the number of potential children eligible for FAMIS. Data sources for this projection should include the 2001 Virginia Health Access Survey and the 2000 census data.**

Virginia Has Forfeited $55 Million in Federal Child Health Insurance Dollars

In 1997, through the Balanced Budget Act, the federal government authorized states to receive $40 billion over ten years (from October 1, 1998 through September 30, 2007) to provide coverage under the State Child Health Insurance Program. States receive an allotment each year based upon a formula tied to the number of low-income uninsured children. Under the plan, each state has three years to spend a specific year's allotment and the earliest year's allotment must be spent before a succeeding year's allotment.

Originally, the plan was that any unspent money after three years would be reallocated to states that had used all of their allotments. However, when the first three-year deadline expired on September 30, 2000, for federal fiscal year (FFY) 1998 allotments, 42 out of 50 of the states (including Virginia) had not spent their allocation during the three-year time period (only three percent of the FFY 1998 child health insurance allotments had been spent). Because of this, the federal government allowed the states to retain more than half of their unspent balances.

Another three-year deadline expired on September 30, 2001, for the FFY 1999 allocation. In December 2001, the federal government determined that it would redistribute some of the unspent child health insurance dollars to thirteen states that have successfully spent more than their FFY 1999 allotments and allow the remaining states to retain a portion of their unspent dollars for one more year. Funding for the successful states will be provided from a pool of unspent dollars from other states, including Virginia's unspent dollars.

According to a Kaiser Commission report (a national non-profit independent health care group), state spending on child health insurance has increased rap-

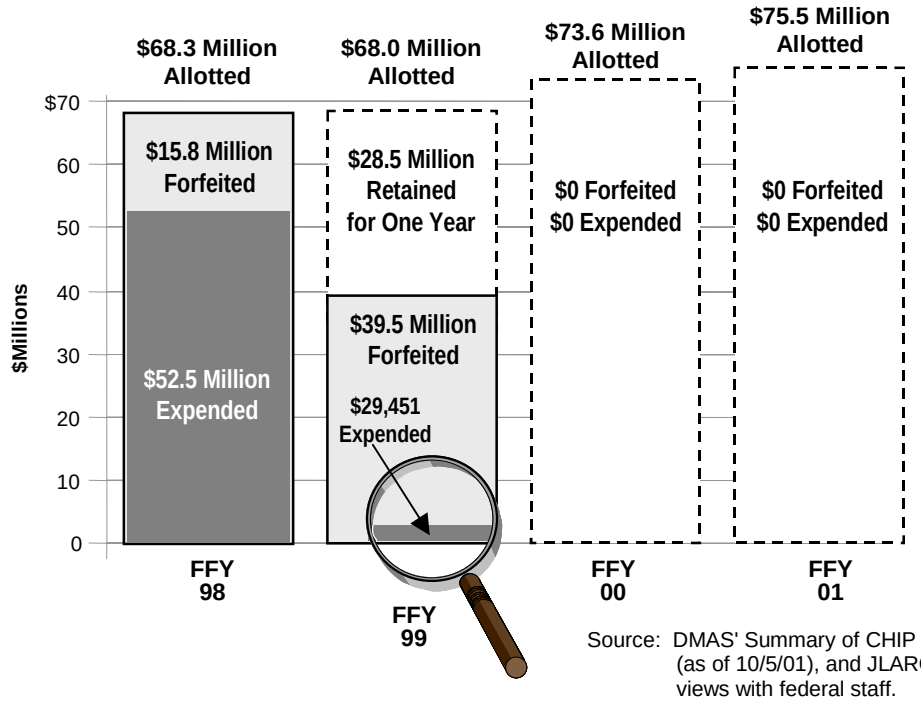
idly. In FFY 1998, the annual expenditures as a share of the annual federal allotment was three percent, in FFY 1999 it was 21 percent, in FFY 2000, it was 45 percent, and in FFY 2001, it is expected to reach 65 percent (these amounts are in additional to unspent funds carried over from previous years). One of the difficulties experienced by states, including Virginia, is that the federal funds have a ten percent cap on administrative funds, based on the state's child health insurance expenditures. This limits the amount of outreach activities that can be conducted and the number of staff that can be hired to implement, manage, and monitor the program.

Virginia's federal allotment is $692 million (around $70 million per year) for the ten-year authorization period, which includes an enhanced federal match rate of 66 percent (the current Medicaid match rate is 51 percent). Virginia must match these funds with a combination of State general funds and FAMIS trust fund dollars (the CMSIP, now FAMIS, trust fund was set up in 1997 by the General Assembly).

Figure 3 illustrates how Virginia has utilized its first four years of federal allotments of $285 million (for July 1, 1998 through September 30, 2001). In FFY 1998, Virginia's allotment was $68.3 million. Of that amount, Virginia spent a total of $52.5 million ($23.5 million over the three years and an additional $28.9 million of reallocated money) and forfeited $15.8 million in federal funds. For FFY 1999, Vir-

Figure 3

Virginia's Child Health Insurance Program: Federal Allotments and Expenditures, Federal FYs 98-01



Source: DMAS' Summary of CHIP Grant Awards (as of 10/5/01), and JLARC staff interviews with federal staff.

ginia's allotment was $68.0 million. DMAS has spent only $29,451 by the end of the three-year period. The federal government recently determined that Virginia could retain $28.5 million of its unspent funds for one more year, thus forfeiting an additional $39.5 million in federal funds.

As of October 2001, DMAS has not spent any of the allotments for FFY 2000 and FFY 2001. Further, DMAS will not be able to spend any of these allotments until the retained $28.5 million of FFY1999 funds has been expended.

According to a Kaiser Commission report, one of the key factors that can affect a state's spending on the child health insurance program is program design choices. For example, each of the following program choices can affect spending: the breadth of the child health insurance program expansion, the State's design of the application and re-enrollment process, the level of premiums the State requires families to pay, and the amount the State invests in outreach efforts. In Virginia, it is likely that several program design choices have impacted the Commonwealth's inability to spend these federal funds.

The bottom line is that Virginia is not utilizing all available federal child health insurance dollars to provide health care to low-income children and its unspent funds are being sent to other more successful states. To date, Virginia has returned $55 million dollars in unused child health insurance money to the federal government. The total amount expended on CMSIP children ($52 million dollars) for medical care is only 18 percent of the total $285 million allocated for the first four years. According to an Urban Institute state comparison of child health insurance expenditures as a percent of the State's allotment for FFY 1998 through FFY 2000, Virginia was ranked low in comparison to other states (40th out of 50 states).

VIRGINIA'S NEW CHILD HEALTH PROGRAM: FAMILY ACCESS TO MEDICAL INSURANCE SECURITY (FAMIS)

During the 2000 session of the General Assembly, legislation was passed that made significant changes to Virginia's child health insurance program, and the name of the program was changed to FAMIS. According to the FAMIS State Plan, CMSIP was being replaced with FAMIS to diminish perceptions of it as a public welfare program, simplify and expedite the eligibility determination and enrollment process, and increase access to a broader array of providers through private-sector health insurance programs. Virginia is one of 35 states that have chosen a child health insurance program that is, to varying degrees, separate from its Medicaid program. The emphasis on making FAMIS similar to health insurance programs and delivery systems found in the private sector builds upon the key advantage of the federal child health insurance initiative, which is to be innovative and not constrained by inflexible Medicaid rules.

There are several key changes between CMSIP and FAMIS, which are designed to make the child health insurance program resemble coverage available in the private sector, and to simplify and expedite the enrollment process. According to

DMAS, the new FAMIS program, which became effective August 1, 2001, has had a successful rollout because FAMIS was implemented on time; a private sector company is managing enrollment, which improves uniformity across Virginia; all children enrolled in CMSIP were automatically enrolled into FAMIS; and the central processing unit has received more than 60,000 telephone calls concerning FAMIS.

Exhibit 3 provides the key differences between the CMSIP and the FAMIS programs. Major changes were made in all aspects of the program design, including its operations, policies (including eligibility requirements), the application process, cost sharing, health benefits and service delivery arrangements, and outreach activities. The FAMIS program addresses two eligibility concerns with the CMSIP program: it reduces the 12-month waiting period for previously insured children to six months, and it eliminates the requirement to provide child support information as a condition of enrollment.

CURRENT CONCERNS WITH THE FAMIS PROGRAM

The new FAMIS program is still in the early implementation phase, so it is too early to determine the overall success of the program. The true measure of success will be the enrollment and retention of children in the FAMIS program and the assurance that they are receiving preventive and necessary health and mental health care. DMAS has been responsive to a variety of start-up concerns, but will need time to work out additional operational and program concerns. One key eligibility policy change that DMAS addressed immediately was to change the effective date for FAMIS coverage to the beginning of the month of application rather than the month that followed the approval.

During the review of the implementation of FAMIS, however, JLARC staff found some additional program design and operational problems that must be addressed. Prior sections in this chapter have already addressed the need for DMAS to track the number of Medicaid recipients that enroll in the program as the result of FAMIS' outreach activities, to determine why former CMSIP children are dropping out of FAMIS, and to develop a current projection on the number of uninsured children in Virginia. DMAS also needs to closely monitor the central processing unit, which is the key entry point to FAMIS, because of implementation problems with call volume and staffing.

One additional program design issue is that 40 percent of the families with children enrolled in the FAMIS program also have children enrolled in the Medicaid program, which means these families have to access and navigate two totally different health insurance programs in order to obtain health care for all their children. In addition to this immediate concern, there are several program policies that DMAS needs to monitor over the next year in order to gauge their impact on children. The concerns about these policies and program design issues are addressed in this section.

Exhibit 3

Key Differences Between Virginia's Child Health Programs: CMSIP and FAMIS

CMSIP	FAMIS
Eligibility Determination	
• Family income less than 185 percent of federal poverty level, using Medicaid income disregards	• Family income less than 200 percent of federal poverty level (such as $35,300 for a family of four), using gross income
• Income does not include stepfather's income	• Income does include stepfather's income
• Child must have been uninsured for 12-months (good cause exceptions may apply)	• Child must have been uninsured for 6-months (good cause exceptions may apply)
• Cooperation with child support enforcement is required	• No cooperation with child support enforcement required
• Enrollment is for up to 12 months as long as the child meets eligibility requirements (changes in family income, employment, address, and availability of health insurance, etc. must be reported); annual redeterminations made at local departments of social services	• Same as CMSIP except that the annual eligibility redeterminations are made through the CPU
Application Process	
• Single application for Medicaid and CMSIP	• Separate application for Medicaid and FAMIS
• Processed by local departments of social services	• Application can be made over the phone at FAMIS call center (application is mailed to recipient for signature)
• Full Medicaid eligibility determination is conducted first prior to eligibility for CMSIP being determined	• Screened for Medicaid eligibility first and Medicaid likely recipients are referred to Medicaid unit at call center or to local department of social services
• Local departments of social services have 45 days to determine eligibility	• Once the signed application is returned to the call center, the center has 10 days to determine eligibility
• Verification requirements are extensive	• Verification requirements are minimal
Cost Sharing	
• Premiums are not required	• Premiums are required for children in families with incomes above 150 percent or poverty--$15 per child with a maximum of $45 per family per month
• Co-payments are not required	• Co-payments are required; yearly co-payment limit per family with income at or below 150 percent or poverty is $180 and the limit per family with income above 150 percent of poverty is $350 (no co-payments are required for well-child and preventive services and families participating in employer sponsored health insurance)

(Exhibit continues on next page)

Exhibit 3 (continued)

Key Differences Between Virginia's Child Health Programs: CMSIP and FAMIS

CMSIP	FAMIS
Health Benefits and Service Delivery Arrangements	
• Same benefits as the Medicaid program	• Benefits similar to those found in the private sector, based on State Employees' Key Advantage Health Benefit Package, with enhancements such as well-child from age six through 18 and therapies for special education students; however, it includes limits on services (such as mental health services) and only provides partial payment on selected services (such as braces)
• Utilizes Medicaid providers or Medicaid managed care entities and their provider networks	• Utilizes FAMIS managed care entities and their provider networks in most localities
Health Benefits and Service Delivery Arrangements, continued	
• Assistance with premiums to utilize employer sponsored health insurance (ESHI) is not available.	• Assistance with premiums to utilize ESHI insurance is available when cost effective; potential outcome is that additional family members may be covered
Outreach Activities	
• Outreach coordinated at the State level by the State Department of Social Services	• Outreach coordinated at the State level by DMAS; FAMIS Outreach Oversight Committee created
• Outreach conducted at the local level by the local department of social services; DMAS provides limited funds for outreach and application assistance	• Outreach no longer conducted by the local departments of social services and DMAS no longer provides funds; however, some localities continue some activities
• Outreach and training also conducted in selected areas of the state by local projects with private funds from Robert Wood Johnson, the Virginia Health Care Foundation, and the Virginia Coalition for Children's Health	• Outreach and training continues to be conducted by local projects with private funds from a Robert Wood Johnson grant, Virginia Health Care Foundation grants, and a Virginia Coalition for Children's Health grants. In addition, DMAS has developed a one-year partnership with, and funding to the Virginia Health Care Foundation ($500,000) and Virginia Coalition for Children's Health to expand those projects (up to $75,000)

Source: JLARC staff adaptation of various Department of Medical Assistance Services' handouts, program descriptions, and *State Child Health Plan Under Title XXI of the Social Security Act.*

The Central Processing Unit for FAMIS Is Experiencing High Call Volume and Staffing Problems

Under CMSIP, the point of contact for eligibility and enrollment into the program was one of 121 local departments of social services. Under FAMIS, the point of contact is a central processing unit (or CPU). In January 2001, DMAS issued a request for proposals (RFP) for a contractor to develop and manage a CPU for the FAMIS program. According to the RFP, the selected company would be "responsible for all aspects of the FAMIS CPU including a telephone call center, applications processing, eligibility determinations, provider and health plan enrollment, premium collections and payments, cost-sharing monitoring, reporting, and multiple electronic interfaces." The purpose for this centralized approach was to simplify eligibility determination and enrollment processes. In May 2001, the $3 million contract for a two-year period was awarded to Benova. Benova also has been DMAS' enrollment broker for Medicaid's managed care program for the past five years.

The CPU became operational on August 1, 2001. According to the contractor, the two main start-up problems have been the unexpected high call volume and the lack of sufficient and trained staff. According to the RFP, the call volume was projected at 2,000 calls a month. Instead, in just three months, the FAMIS call center has received more than 59,000 calls. This unexpected number of calls has put the contractor in the position of having to quickly add staff and computers to address the need. In addition, the call center has experienced turnover of its management and call center staff.

Unfortunately, the high call volume and staff turnover means that potential or current FAMIS families who contact the CPU are likely to communicate with call center staff that have not been adequately trained on the FAMIS program and its operational policies. This has caused many families to receive the wrong information and to be referred to local departments of social services in error. According to 46 local departments of social services staff (of 57 agencies that responded to a JLARC staff question concerning their positive and negative experiences with FAMIS), most of the problems that were brought to their attention centered on the lack of training of the call center staff on eligibility issues, inappropriate Medicaid referrals, and no direct communication with FAMIS staff to resolve issues for their clients. One local department of social services described the following situation for a family that no longer qualified for Medicaid, but should have qualified for FAMIS:

> *The client's Medicaid case was closed at the local department of social services (DSS) due to excess income. She applied for FAMIS and was denied. The FAMIS call center staff told her that her income was within Medicaid guidelines and she needed to go back to the local DSS and apply for Medicaid. She contacted the local DSS worker, who advised her to reapply for FAMIS and include the Medicaid denial letter with the application. She was again denied FAMIS. She brought the FAMIS denial letter, which indicated that the father's income was not included on the application (which was provided to the FAMIS*

worker during the initial call). Therefore, the father's income was added to the application and then re-sent to FAMIS. The client was again denied. The end result is that the client still does not have coverage, her child is in poor health, and she is having to pay for the doctor's appointments out of pocket.

Both DMAS and the contractor are aware of the need to have adequately trained staff to perform the eligibility and enrollment procedures and are addressing these concerns. DMAS staff have held three training sessions for contractor staff covering eligibility, outreach, employment-sponsored health insurance, and questions received by the call center staff. DMAS also has an onsite monitor to serve as a resource. Call center statistics have not been provided because both DMAS and the contractor are continuing to work on defining these statistics to accurately reflect the activities of the call center for enrolling, referring, and tracking clients.

The FAMIS Program Design Is Cumbersome for More than 13,000 Families with Children Enrolled in Both the Medicaid and the FAMIS Programs

According to a recent U.S. General Accounting Office study on how states' enrollment policies can affect children's access to care, close coordination between the Medicaid and the state's child health insurance programs is critical, especially when they are separate programs. This is important because families may have children in both programs or may need to move from one program to another. Virginia is one of 35 states that have child health insurance programs that are separate from the Medicaid program.

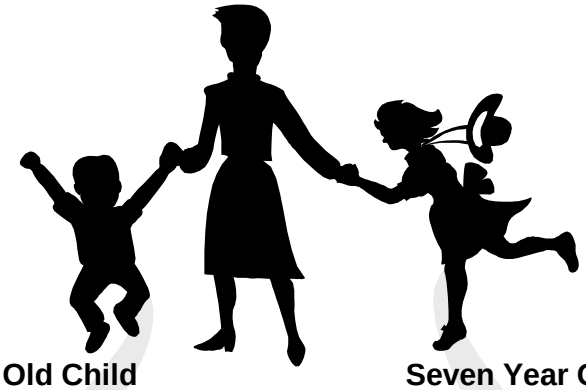
With CMSIP, which was a Medicaid look-alike program, the required coordination with the Medicaid program was inherently present because all administrative processes, enrollment and application procedures, health benefits, and service delivery networks were the same as the Medicaid program and both programs were accessed through the 121 local departments of social services.

With FAMIS, DMAS purposely removed access to the program from the local departments of social services in order to increase enrollment in the program by reducing any problems with welfare stigma and centralizing all enrollment activities. Now, the FAMIS program has separate eligibility criteria, application processes, cost sharing, health benefits, and service delivery arrangements from the Medicaid program. This new division is complicated for any person at the local level trying to assist families, including outreach workers and local departments of social services staff.

In Virginia, 40 percent of the families (or 13,773 of the 34,293 CMSIP children) converted to FAMIS in August 2000 have a child enrolled in FAMIS and another child enrolled Medicaid. Figure 4 illustrates a typical family that falls into this category, which DMAS refers to as a "mixed" family. As shown, a mixed family must deal with two separate points of contact, two different income rules, two different provider networks, two different cost sharing requirements, and two different

Figure 4

Child Health Insurance Benefits Compared: Medicaid *vs.* FAMIS and Effects on Families that Have Children in Both Programs



Five Year Old Child Enrolled in Medicaid	Seven Year Old Child Enrolled in FAMIS
Point of Contact	
Must contact local DSS for eligibility, enrollment, and questions; requires a Medicaid application and verification.	Must contact FAMIS Call Center for eligibility, enrollment and questions; requires a FAMIS application and verification.
Income Rule	
Stepparent's income not counted.	Stepparent's income counted.
Doctor	
Child is taken to Doctor A.	Child is taken to Doctor B.
Transportation	
Transportation services provided.	Only emergency transportation services provided.
Co-Payments	
Co-payments not required.	Co-payments may be required.
Premiums	
Premium not required.	$15 monthly premium may be required.
Services Received	
Receives all Medicaid funded medical care services.	Receives only medical care services available to State employees, which include limits (such as mental health services) and requires partial payment on selected services (such as braces).

Percent of Children Affected

60% of children (20,520) are in families enrolled in FAMIS only. 40% of children (13,773) are in "mixed" families – those with children enrolled in both FAMIS and Medicaid.

Source: DMAS computer conversion data report from CMSIP to FAMIS (August.1, 2001); and JLARC staff analysis of FAMIS documents.

health benefit packages. DMAS does not know how many additional families may switch between the two programs as family income fluctuates.

There are two key reasons why there is a major disconnect between the Medicaid and FAMIS programs: (1) Medicaid eligibility rules are tied to age, in addition to income levels and (2) there is a lack of a formal system for sharing and coordinating information between the FAMIS central processing unit and the local departments of social services. Each of these reasons are discussed below.

DMAS Should Adopt a Single Eligibility Level for Medicaid. One of the key reasons for the mixed family is that Virginia's Medicaid eligibility is tied to both the age of the child and family income. Virginia's Medicaid program covers children from birth to age five with incomes up to 133 percent of the federal poverty level (FPL), and it covers children ages six through 18 with incomes up to 100 percent of the FPL (both of these are minimum federal requirements). Therefore, a Virginia family might have a young child who qualifies for Medicaid and an older child who qualifies for FAMIS. Many children that are enrolled in FAMIS simply "age in" when they have their sixth birthday. In addition to the age factor, a less frequent reason a family may be "mixed" is that the income for the father of one child may be higher than the income from a different father of the second child.

To reduce the impact of the new child health insurance program on the mixed family due to eligibility rules tied to age alone, the initial Virginia proposal (in 1998) recommended removing the age distinction and expanding Medicaid for all children up to 150 percent of poverty. The children whose families had income from 150 percent to 200 percent of the poverty guidelines would be served by the new child health insurance initiative. This expansion or leveling out of the ages was recommended because it could be achieved with the new federal child health insurance dollars (not Medicaid dollars) and therefore, receive the enhanced federal match (which is 66 percent).

Throughout the State-level discussions of Virginia's child health insurance initiatives, however, the administration did not support any expansion of the Medicaid program. The reasons given in an administration position paper on the proposed expansion of the Medicaid program (response to Senate Bill 433/House Bill 1074, the 1998 session of the General Assembly) states that this expansion "deprives children of mainstream health care coverage," "is more likely to displace private insurance," and "requires a vast increase in the welfare bureaucracy."

In order to eliminate families from having to switch their child to a totally different health insurance plan on the child's sixth birthday or having one child in each program simply because of age, a single eligibility rule should be adopted at 133 percent of FPL for all children up to 19 years of age. Under the federal child health insurance program, Virginia can receive an enhanced match for this expansion of the Medicaid. All children whose family income falls between 133 percent and 200 percent of FPL would continue to receive FAMIS.

While DMAS data were not available to determine the impact of this change, it is likely that at least half of the families with children enrolled in FAMIS would return to the Medicaid program with this change. This is based upon data for the current FAMIS program, which shows that 66 percent of all the children enrolled in FAMIS have family incomes at or below 150 percent of the federal poverty level. This change continues to support the State's key objective to reduce the total number of uninsured children. It would also reduce the confusion for families that must negotiate the program guidelines of two completely different health insurance programs.

The long-term goal for the Commonwealth, however, should be to have one health insurance program for all uninsured children. The FAMIS program allows Virginia to be innovative and unconstrained by inflexible Medicaid rules, and to develop a model for how children's health insurance can be provided.

Recommendation (4). **The General Assembly may wish to direct the Department of Medical Assistance Services to amend its Medicaid State Plan and regulations to adopt a single eligibility level of 133 percent of the federal poverty level for all children served in the Medicaid program. In addition, DMAS should be directed to make the necessary changes to the FAMIS State Plan to ensure that federal child health insurance funds (Title XXI) and not Medicaid funds (Title XIX) are utilized to fund this expansion.**

DMAS Should Develop Formal Coordination Processes Between the FAMIS Program and the Medicaid Program. Based upon the language found in the *Code of Virginia*, the *State Child Health Plan Under Title XXI of the Social Security Act*, FAMIS emergency regulations, and DMAS-DSS interagency agreements and memorandums, it appears that DMAS did not want to continue coordination with the local departments of social services when the new FAMIS program was implemented. All of these documents state that the local departments of socials services would no longer have a role in the enrollment of children in the child health insurance program once the transition was made to FAMIS. For example, the State Department of Social Services issued a June 2001 memorandum to the local DSS, stating, "effective with the implementation of FAMIS, local agencies will cease taking applications for CMSIP and will no longer have responsibility for Virginia's children's health insurance program under Title XXI of the Social Security Act." DMAS staff told local agencies during FAMIS training that the best way they could help clients is to refer them to the FAMIS call center.

This exclusion of the local agencies in the enrollment and application process is contrary to the primary finding of the outreach pilot projects for CMSIP. The pilot projects showed that assistance at the local level is critical in helping the clients understand the policies and programs for Medicaid and CMSIP, now FAMIS. In fact, DMAS is currently providing $500,000 to a dozen of these pilot projects to provide this local assistance. During CMSIP, DMAS provided more than $2 million annually to the local departments of social services to assist with eligibility determinations and application assistance. That money is now being used to fund the FAMIS CPU.

There are several additional reasons why this coordination between the Medicaid and FAMIS programs is important: (1) many of the potential FAMIS applicants will be referred to the local departments of social services to determine Medicaid eligibility; (2) there is a high number of families with children in both programs; (3) there is an unknown number of families that will move between these programs as family income fluctuates, and enrollment is not automatic; and (4) poor coordination between these programs may mean that applications that are transferred or incomplete risk being delayed, denied, or becoming missed opportunities. This lack of coordination, and the confusion it causes families could be partially responsible for the 4,006 former CMSIP clients who recently dropped out of the FAMIS program.

One solution is to ensure that the Medicaid staff located at the CPU receive and coordinate all problems for all clients that are being transferred between programs or have a child in both programs. Local departments of social services should be able to call the Medicaid staff directly without going through FAMIS call center staff. Training should be provided to all local departments of social services to explain how these referrals and problems will be handled. The regulations and interagency agreements need to reflect these coordination and collaboration issues.

Recommendation (5). **The Department of Medical Assistance Services, in cooperation with the State Department of Social Services, should immediately develop a detailed plan to improve ongoing communication and coordination between the Medicaid and FAMIS programs. This plan should include provisions for a formal referral and tracking process between the programs, the designation of the roles and responsibilities of both staff for assisting families with enrollment and problem resolution, and dedicated staff within the Medicaid unit at the FAMIS call center that will assist with these coordination efforts.**

FAMIS Needs to Be Monitored to Gauge the Impact of Its Design on Enrolling and Retaining Children

In addition to the previous five recommendations that require immediate attention, there are several other eligibility requirements and program design issues that have raised some concerns. However, it is too early in the process to make major changes to the program design before the State-level policymakers have had the opportunity to address the impact of each policy on the enrollment and retention of children in the FAMIS program. Each of these policy issues should be monitored over the next year to see what changes DMAS makes or what changes may need to be made. These issues and the concerns voiced by stakeholders and child health advocates include:

- **Counting the stepparent's income for eligibility purposes.** This practice is not part of Medicaid eligibility, and it is not in the *Code of Virginia* or in the preliminary draft

of the emergency regulations for FAMIS. DMAS staff indicated that this practice is modeled after private insurance plans whereby stepparents can include their stepchildren on their family policies. DMAS staff state that the practice simplifies the income eligibility process. There are two main concerns with this policy. First, stepparents are not legally responsible for their stepchildren. Second, there are concerns about how the different eligibility standards between the Medicaid and FAMIS program may impact families and their ability to qualify for the FAMIS program once they no longer qualify for Medicaid.

- **Using the best method to address fluctuating income for eligibility.** Because low-income families are likely to change jobs frequently or have jobs with fluctuating income, there is some concern with the manner in which DMAS counts income. DMAS has agreed to look into which method, counting a monthly or annual income, is advantageous to the most people. Many child health advocates feel, however, that a 12-month continuous eligibility for FAMIS would ensure a medical home for a child for a year, reduce the switching back and forth between Medicaid and FAMIS, and eliminate the administrative burden on enrollees and the State for processing income changes. At least 23 states have adopted this policy.

- **Requiring a six-month waiting period for insurance.** The primary reason for the requirement of a six-month lapse in insurance coverage is to ensure that families do not drop existing insurance coverage for FAMIS (the federal regulations require states to develop some mechanism to ensure this does not happen and many states incorporate a six month waiting period). This requirement is a major improvement over CMSIP, which had a 12-month waiting period. There are three good cause exceptions to waive this requirement, including the child being dropped from insurance due to uninsurability, the employer dropping family coverage for all employees, and the person carrying coverage losing or changing jobs. The main concern remaining with this policy is that another good cause should be the parent's inability to continue paying family health care costs (such as when the health insurance exceeds 10 percent of the family's countable family income). Arizona recently reduced the waiting period from six to three months, and eliminated it entirely for chronically ill children.

- **Requiring cost sharing, including monthly premiums and co-payments**. The first letter for the collection of premiums went out in September to the FAMIS families

whose incomes are above 150 percent of the federal poverty guidelines. At the present time, this requirement applies to only 34 percent of the FAMIS children. The cost of the monthly premium is $15 a month per child, not to exceed a maximum of $45 a month. Nonpayment of the premium results in termination of FAMIS coverage for six months. As stated earlier in the report, 1,617 families have not paid the initial premiums and are scheduled to lose coverage for their children on December 31, 2001. Virginia's premium payment requirements are more restrictive than most other states. As of October 31, 2001, DMAS has collected $51,763 in premiums. Co-payments are required of all FAMIS families except if they are participating in an employer sponsored health insurance program or for well-child visits. The main concerns are that the six-month lapse in coverage is punitive, and there is uncertainty regarding the impact these cost-sharing requirements will have on the families and their maintaining the coverage for their children.

- **Reducing health benefits.** In order to resemble private health care insurance plans, the new FAMIS program reduces coverage of important benefits that were available under CMSIP and the Medicaid program, including mental health benefits, vision, hearing aids, dental, orthodonture, and transportation. While these benefits are included, they are subject to limits (such as the amount of mental health services available) and partial payments (such as the purchase of braces). The main concerns are how many children will forego needed medical and mental health care because it is not fully covered under FAMIS, and what impact this will have on other publicly-funded programs, such as indigent health care and the Comprehensive Services Act. Because this program has a 66 percent match and the money is not being spent, the State may want to consider broadening health and mental health coverage.

- **Implementing the Employer Sponsored Health Insurance Program (ESHI)**. This program is a premium assistance program that will reimburse families for part of the cost of covering children on their employer's health insurance. The main requirements are that the family members must be FAMIS eligible, the employer must contribute 40 percent of the cost of family coverage, and the program must be cost effective. At the present time, it is too early to tell how often this program will be utilized because it is voluntary. It is not clear whether employers will be interested and can meet the 40 percent family coverage requirement, whether families will see this as easier than covering the children under FAMIS, or whether plans will

be cost effective once the formula is applied. As of November 1, 2001, 13 ESHI applications have been received by DMAS and two appear to meet the cost-effectiveness requirement.

- **Ensuring outreach to uninsured children.** Under FAMIS, DMAS has made major improvements in conducting outreach to uninsured children, including centralizing the activities at DMAS, establishing an Outreach Oversight Committee, improving the media blitz, developing pamphlets and posters, and developing partnerships with private entities. The major concern with DMAS' early efforts has been the lack of outreach to all the schools across the Commonwealth and ensuring that every child takes FAMIS information home. One local department of social services staff indicated that they were in a school recently that serves low-income children and the school had never heard of the FAMIS program. DMAS attributes the lack of outreach to schools to early implementation problems with the printing and mailing of requested FAMIS pamphlets. The 2001 budget (which was not enacted) also directed DMAS to conduct better outreach with the reduced lunch programs and services through the WIC program. At the present time, these coordination activities have not taken place. All FAMIS outreach activities will continue to be monitored by the FAMIS Outreach Oversight Committee.

- **Implementing the FAMIS managed care service delivery system.** DMAS has successfully contracted with managed care entities in most areas of the State to provide health care benefits to FAMIS children effective December 2001. The letters have recently been sent to the families instructing them to select a provider from the FAMIS network. The implementation of this system will have to be closely monitored to ensure that the families understand how this new program impacts the way health care services will be delivered, especially for the mixed families. In addition, this delivery system will have to be monitored to ensure that enough providers and especially pediatricians are enrolled, to ensure adequate access to quality health care for children. DMAS payment rates to these entities ($107 per month per child for those less than 150 percent of the federal poverty limits and $104 per month per child for those over), however, are even lower than Medicaid payment rates for managed care (which is $230 per month per member). DMAS said the differences are because the FAMIS rates do not include the aged, blind, and disabled population, there are more pregnancies with the Medicaid population, and there are co-pays for FAMIS children.

Since 1998, DMAS has been providing quarterly reports on the status of CMSIP, now FAMIS, to the chairs of several legislative committees. Chapter 464 of the 1998 Virginia Acts of Assembly, in Item 335, and Chapter 824 of the 2000 Virginia Acts of the Assembly, in Section 32.1-351 of the *Code of Virginia*, require this report. The original language requires each report to include a status report on: (1) the number of children enrolled in each component of the program; (2) provisions and impact of the premium and co-payment requirements; (3) outreach efforts undertaken to enroll eligible children in the program; (4) efforts and activities undertaken to involve local children's health care and case management programs in the implementation and ongoing operation of the program; and (5) the expenditure of the funds authorized for the program.

In addition, the 2001 budget (which was not enacted) documented the legislative desire to better understand how the FAMIS program design impacts enrollment and retention of uninsured children. Therefore, DMAS should add several items to these reports, including information on the reasons for enrollment, denials, drop-outs, and shifts between these programs. In addition, DMAS should include how it is implementing the recommendations in this report and the status of monitoring the issues listed in this section.

Recommendation (6). **The Department of Medical Assistance Services should expand the quarterly report to the legislature concerning the status of FAMIS to include detailed tracking information on the enrollment and retention of children in FAMIS, the utilization and costs of mental health and health care benefits (those that have been reduced or expanded), how it is implementing the recommendations in this report, and the status of the issues highlighted in this report for ongoing monitoring.**

III. The Mental Retardation Waiver Program

The study mandate for this review, SJR 441 from the 2001 session, directs JLARC to examine how the Department of Medical Assistance Services' leadership, decision-making processes, and communication mechanisms impact the delivery of mental health services. The mandate specifically addressed concerns with the mental retardation waiver program, due to "strong concerns [that] have been raised by consumers, family members, and providers about the administration of the Medicaid home-and-community-based mental retardation waiver."

Under the Medicaid home and community-based service waiver program (Section 1915 (c) of the Social Security Act), Virginia has been able to develop and implement a variety of alternative community-based programs to provide services to individuals at risk of being placed in an institutional setting. These alternatives recognize that individuals (such as the elderly or persons with disabilities including mental retardation) can be cared for in their homes and communities, while preserving their independence and ties to family and friends, at a cost no higher than institutional care. Virginia has provided Medicaid-funded home and community-based care services to eligible persons with mental retardation as an alternative to more costly institutionalization since 1991 (the waiver also allowed the State to maximize federal Medicaid dollars in order to address a statewide budget shortfall). Through this program, for the first time, eligible Medicaid recipients received services in their communities that previously had only been available to those living in an intermediate care facility for the mentally retarded (ICF/MR).

To qualify for the mental retardation (MR) waiver, individuals must be financially eligible for Medicaid services, have a diagnosis of mental retardation or be developmentally at risk if under age six, and need services at the ICF/MR level of care. There are a variety of services funded through the MR waiver. The most utilized services are day support (74 percent) and residential support (60 percent), which are designed to enable the client to acquire, improve, or maintain the health status and functional skills necessary to live in the community. Other available MR waiver services include respite, nursing, therapeutic consultation, crisis stabilization, supported employment, personal assistance, assistive technology, and environmental modification.

The development and management of MR waiver services at the State level has been carried out through a collaborative effort between the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) and the Department of Medical Assistance Services (DMAS). Services at the local level are managed through a network of local agencies called community service boards (CSBs). Some CSBs act as gatekeepers directing consumers to services through private providers, while others act as both gatekeepers and providers by offering services in competition with private providers or where there are no private providers available. There are 40 CSBs and 933 private providers eligible to offer

MR waiver services--providing at least some services in every city and county in the Commonwealth.

The MR waiver program has been in a state of flux for the last year and a half due to legislative and State-level management changes. One of the key legislative changes occurred during the 2000 session of the General Assembly when all of the MR waiver funds were moved from DMHMRSAS' budget to DMAS' budget to streamline the reimbursement process for these services. The legislative intent was that the policy and management for the MR waiver program would remain at DMHMRSAS to the extent allowable under federal law. What occurred instead was that DMAS, with the approval of the Secretary of Health and Human Resources, assumed all policy and decision-making responsibility for this waiver and made a series of mistakes. An underlying problem with the administration of the MR waiver for more than a year has been DMAS' lack of clear and consistent communication with DMHMRSAS staff, task force members, consumers, and legislators.

Initially, the problem started when DMAS assumed management of the waiver, and made decisions without input from DMHMRSAS or the stakeholders on how these decisions would impact the health and safety of MR clients. Once the problems were identified, DMAS' communication to the families and the service providers, concerning decisions regarding requested enhanced and emergency services, were conflicting and slow, causing a lawsuit and an investigation by the U.S. Office of Civil Rights. To address these problems, the Secretary of Health and Human Resources announced the creation of a task force to develop a new waiver and held weekly meetings with DMAS and DMHMRSAS management staff. While DMAS spent considerable time and resources on task force meetings and the development of a new MR waiver, it lost credibility when the emergency regulations and the provider manual did not reflect perceived agreements by the task force members and contained numerous technical errors. In addition, in spite of intervention by the Secretary of Health and Human Resources, communication and cooperation between DMAS and DMHMRSAS management staff remain strained.

According to the DMAS director, the major accomplishment with the new MR waiver is that management of the waiver slots was put back at the local level where it belongs. However, the management of the waiver slots was essentially at the local level prior to DMAS' intervention. The effectiveness of the transition of management from DMAS to the CSBs and DMHMRSAS depends upon how much DMAS continues to micro-manage the activities of DMHMRSAS and the CSBs. Recently, the administration announced plans to provide funding for an additional 150 waiver slots but this is not adequate to address the needs for 1,666 persons on the waiting list who need services now.

OVERVIEW OF MENTAL RETARDATION WAIVER SERVICES

Federal regulations allow states to offer a full range of community-based care services to persons with mental retardation in order to maintain these persons in the community and to avoid the higher costs associated with institutionalization.

In that regard, Virginia's MR waiver has been a success, because the Commonwealth saves more than $50,000 on average a year for each client it serves under the MR waiver, while keeping these clients in the community near families and friends. The Commonwealth has also increased its level of commitment to this waiver through additional funding to address the service needs of persons on waiting lists for waiver services. For more than a year, however, there have been strong concerns raised by legislators, consumers, family members, and providers about the State-level administration of the MR waiver by DMAS.

The following sections describe how the utilization of MR waiver services has grown, legislative actions to improve the funding and the reimbursement streams for the waiver, and the consequences of DMAS' assumption of State-level management of the waiver.

Utilization of Mental Retardation Waiver Services Has Increased Over Its Ten-Year History

Since the beginning of the MR waiver program in 1991, the program has experienced substantial expansion, both in the number of waiver clients and the total payments to service providers (see Figure 5, top two graphs). The program has grown from 130 clients and almost $2 million paid to providers in FY 1991 to 4,698 clients and $139 million paid to providers in FY 2000. From FY 1997 to FY 2000, about 3,000 clients were added to the waiver, and payments to providers increased nearly $72 million (preliminary data for FY 2001 indicate a growth of about 700 new clients and $35 million in increased expenditures). Part of this growth in MR waiver clients is due to two federal changes that required persons who were receiving day health and rehabilitative services as an optional Medicaid service and persons who were enrolled in the Elderly and Disabled waiver to be served under the MR waiver instead.

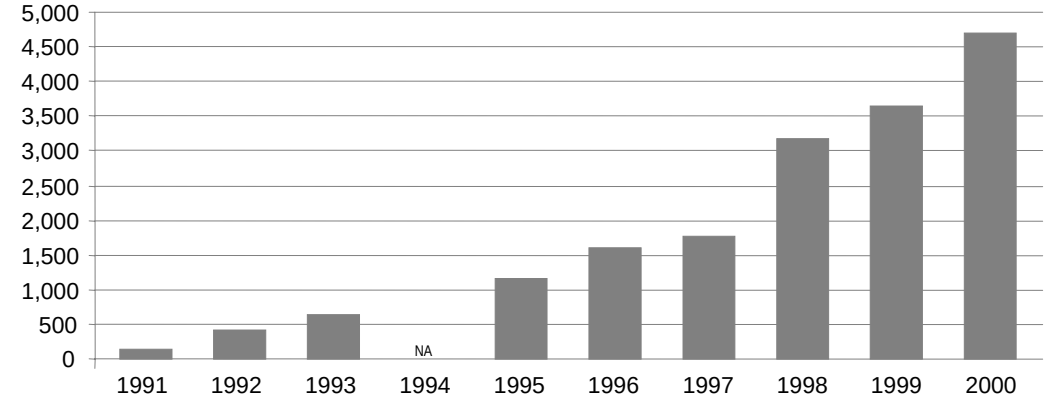
Virginia's MR waiver services have proven cost effective compared to institutionalization (see Figure 5, bottom graph). The average expenditure per recipient of MR waiver services was $29,636 in FY 2000. This is substantially less compared to the average expenditure per recipient in intermediate care facilities for the mentally retarded (ICF-MRs), which was $80,985 during the same year. The average annual savings for each MR community-based placement is approximately $51,349, a 63 percent reduction. If these savings are multiplied by the 4,698 MR waiver recipients served in that year, the estimated program savings for FY 2000 was about $241 million. As shown in the chart, there is a trend of decreasing average costs for waiver services since FY 1997. This is due, in part, to the federal requirement to move some clients who are receiving less costly day health and rehabilitative services to the MR waiver.

In order to control the growth of the waiver, federal regulations allow states to cap enrollment for waiver services, known as waiver slots. Table 2 provides data on the availability of MR waiver slots since the beginning of the waiver program. This table shows two interesting points. First, the number of available slots does not translate to utilization. In some years, the waiver exceeded the allowable

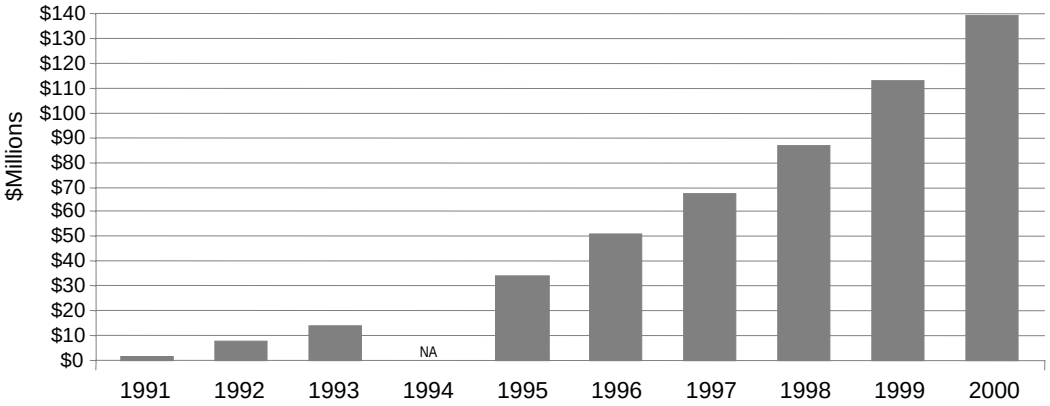
Figure 5

Trends in Mental Retardation Waiver Clients, Payments, and Costs -- FY 1991 to FY 2000

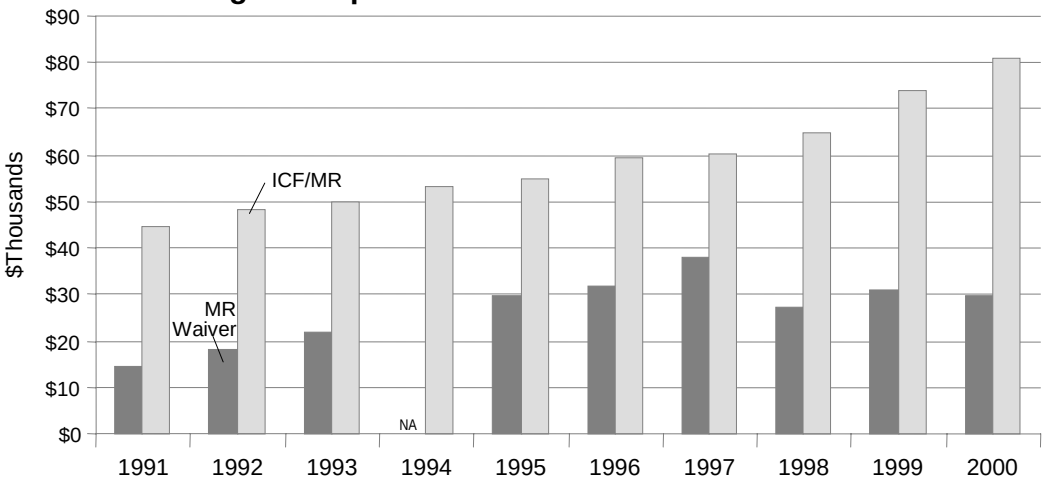
Number of MR Waiver Clients



Total Payments to Providers of MR Waiver Services



Average Cost per Client for MR Waiver and ICF/MR Clients



NA = According to DMAS, FY 1994 data were determined not valid, and therefore the data were not included here.

Source: DMAS' *The Statistical Record of the Virginia Medicaid Program and Other Indigent Health Care Programs*, FY 2000.

Table 2

Comparison of Mental Retardation Waiver Slots: Available Slots to Filled Slots, FY 1991 to FY 2001

State Fiscal Year	Maximum Available Waiver Slots	Filled Waiver Slots
1991	880	130
1992	1,597	412
1993	668	629
1994	NA*	NA*
1995	1,109	1,147
1996	1,453	1,598
1997	2,189	1,768
1998	3,886	3,172
1999	5,386	3,640
2000	5,386	4,698
2001	5,386	5,261**
2002 – projected ***	5,386	---
2003 – projected ***	5,386	---

* NA = According to DMAS, FY 1994 data were determined not valid, and therefore the data were not included here.

** Number of filled slots estimated by JLARC staff.

*** While the administration announced plans for 150 additional waiver slots, as of December 3, 2001, these have not yet been approved.

Source: DMAS' *The Statistical Record of the Virginia Medicaid Program and Other Indigent Health Care Programs, FY 2000,* and letters from the Center for Medicare and Medicaid Services (CMS) provided by DMAS.

number, and in other years (such as in 1995 and 1996), the allowable number far exceeded those enrolled. Second, the number of available slots does not reflect the need for MR waiver services. At the present time, DMAS states that there are 1,666 persons on a waiting list for these services.

The key driver for the number of available MR waiver slots and the utilization of these slots appears to be funding. DMAS sets the number of slots, but it does not have a formal methodology for determining the number of waiver slots based on projected community need or potential discharges from State facilities. In the future, DMAS and DMHMRSAS will have better data to project the number of slots that will be needed due to the recent development of standardized criteria for the statewide waiting list.

In October 2001, due to the fact that the waiver slots had reached capacity and there were no longer any slots to meet emergency needs, the administration announced plans to add 150 slots and $3.5 million dollars to fund these slots. When the new slots are approved, the maximum available slots will be set at 5,536 and will stay at this level until additional slots are funded. However, based on past growth, the annual need for waiver slots will likely exceed this amount.

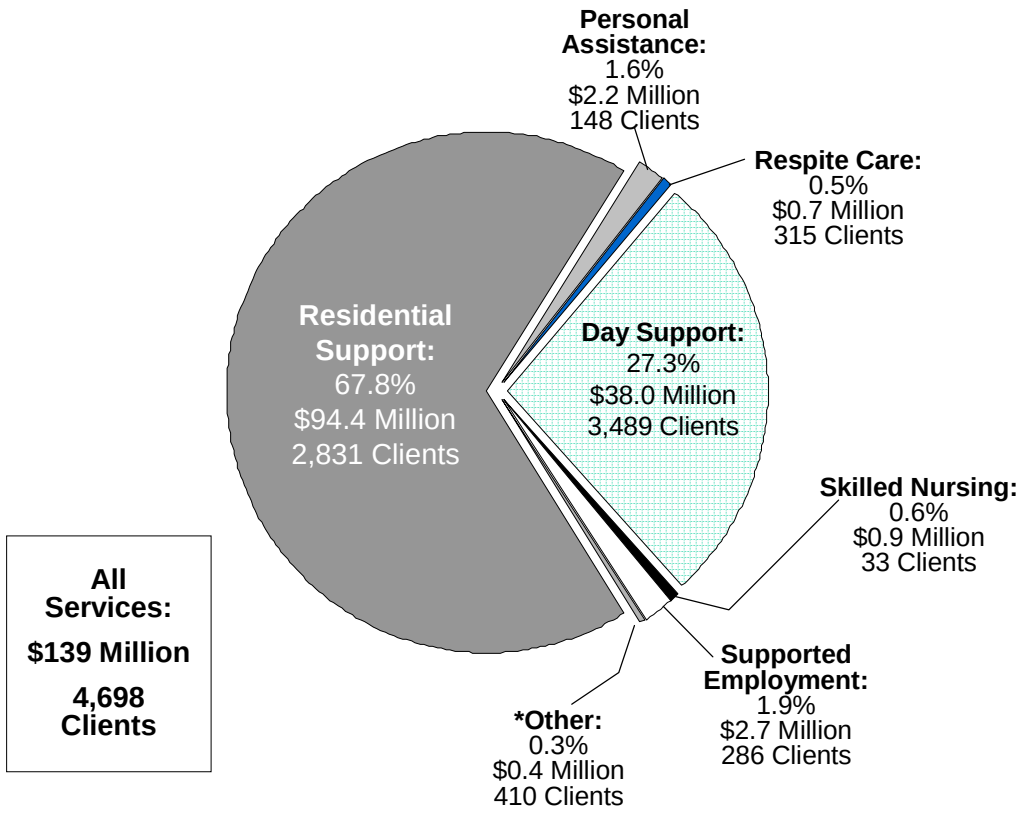
Figure 6 shows that the two most frequently used services, day support and residential support, also comprise the greatest proportion of money paid to providers in FY 2000 (see Appendix B, Exhibit B-1 for a description of each service provided through the MR waiver). Providers were paid about $38 million for day support (27 percent) and about $94 million for residential support (68 percent). However, the most costly services, on an average per-client basis, were residential ($33,355) and skilled nursing ($27,219).

Legislative Actions Provide Funds and Streamline the Reimbursement Process for Mental Retardation Waiver Services

A 1998 legislative report (House Joint Resolution 240) found that MR waiver services should be expanded to support needed policy and treatment ad-

Figure 6

Payments by Service Type for the Mental Retardation Waiver, FY 2000



*Other includes Environmental Modifications, Assistive Technology, and Therapeutic Consultation.

Note: Client counts in this graphic are not unduplicated – a particular client may be receiving more than one service.

Source: DMAS' *The Statistical Record of the Virginia Medicaid Program and Other Indigent Health Care Programs*, FY 2000.

vances. The report also indicated that Medicaid funding for mental retardation services should be maximized, and the reimbursement process for MR waiver services should be streamlined by placing all MR waiver service funds in the Medicaid budget.

In an effort to address the need for adequate funding, the 1999 General Assembly provided about $40 million (in both State and federal funds) for FY 2000 to fund additional Medicaid MR waiver services. The key use for this money was to allow additional community providers to develop needed MR services to serve more people. While all stakeholders and families appreciated the infusion of money, the community providers found it difficult to fully develop the necessary services, such as group homes, in just one year. Consumer groups advise that future funds should be provided incrementally in order to allow time for the community providers to develop the needed services.

To address the need for a streamlined funding mechanism, the 2000 General Assembly directed that while DMHMRSAS should continue to manage the waiver, all of the funds for MR waiver services should be managed by DMAS beginning on July 1, 2000 (for FY 2001). Prior to this direction, the reimbursement mechanism for allocating funds to the CSBs was a complicated stream of funds from both agencies (see Appendix B, Exhibit B-2 for a historical description of the MR waiver funding streams). While DMAS already managed a majority of these funds, DMHMRSAS was directed to transfer all MR waiver funds in their budget to DMAS. This transfer of funds was not as straightforward as envisioned, because there was a disagreement between the two State departments concerning the adequacy of the amount of the transferred MR waiver funds. DMHMRSAS claims that all funds from the State Plan Option Medicaid budget category that were dedicated to the MR waiver were transferred to DMAS immediately and later, additional funds from reconciled accounts were transferred. DMAS claims that the amount of funds transferred was not sufficient to cover the current clients on the MR waiver program for FY 2001.

The major outcome of this budget transfer was that DMAS determined that it was also going to assume the management of the MR waiver from DMHMRSAS. This was clearly not the legislative intent. Based upon DMAS' perception that the MR waiver funds were not enough to serve the current MR waiver clients, DMAS staff stopped all approvals for enhanced services for existing MR waiver clients, and services for new clients from June through mid-August 2000. The crisis this created for the MR waiver clients and their families is discussed in the following section.

DMAS Takes Over Management of the MR Waiver Program and Makes a Series of Missteps

The MR waiver was developed in 1991 to maximize federal Medicaid dollars in order to address a statewide budget shortfall. At that time, it was a clear State-level policy that DMHMRSAS would manage the waiver and DMAS would ensure that federal Medicaid dollars were available to pay for half of the cost of these

services. This was a logical division given each department's staff expertise and mission.

This basic policy has not changed over the years and the arrangement remains acceptable to the federal Centers for Medicare and Medicaid Services or CMS (formerly called the Health Care Financing Administration). CMS recognizes DMAS as the single state agency responsible for the MR waiver and provides certain requirements to which it must adhere. However, CMS also allows a separate agency of the State (such as DMHMRSAS), under the supervision of DMAS, to manage the MR waiver. In fact, the State's basic policy was reemphasized by legislative recommendations made by the HJR 240 joint subcommittee (House Document 77, 1998), which directed "the Secretary of Health and Human Resources, the DMHMRSAS, and the DMAS [to] present a plan to subcontract (carve-out) the administration of Medicaid covered mental health, mental retardation, and substance abuses to DMHMRSAS prior to the 2001 Session of the General Assembly."

However, once the 2000 General Assembly moved all Medicaid-related funds from DMHMRSAS to DMAS to streamline the reimbursement process for these services (which was effective July 2000), DMAS assumed control over the administration of the waiver and made a series of unilateral decisions that negatively impacted the way in which MR services would be prioritized and delivered at the local level. DMAS' early management decisions were based on its assessment that there was inadequate funding for the current MR waiver clients (because of the perceived inadequate funds transferred from DMHMRSAS) even though the State fiscal year had just started. Rather than continue providing services and resolving the funding dispute in the upcoming months, DMAS decided to temporarily stop funding any new admissions to the MR waiver or additional MR waiver services.

Within a month of DMAS assuming financial administration and management of the waiver in July 2000, families, providers, and legislators were voicing serious concerns regarding the impact of DMAS' decisions on services as well as the health and safety of clients. Contrary to federal regulations and the program's history, DMAS began denying requests for increased services by existing clients for lack of funding. In addition, DMAS was not allowing new admissions to the waiver, regardless of the need for MR waiver services. These decisions caused an investigation by the U. S. Office of Civil Rights. The following sections provide a description of these events.

MR Waiver Clients Were Denied Needed Service Enhancements Under DMAS' Management. Once on the MR waiver, clients are entitled to all necessary services, like any other Medicaid recipient. For a variety of reasons, including changes in health, safety, or caregiver situations, clients may need additional services or increases in the number of hours of care. Prior to DMAS' assumption of State-level management of the waiver, some CSBs did not follow this policy and denied clients additional services due to a lack of funds.

Therefore, DMHMRSAS, in coordination with DMAS, conducted training to ensure that CSBs understood the State and federal policies concerning how funds were to be used to meet the need for enhanced services. In addition, DMAS hearing

officers ordered CSBs to provide these service enhancements, regardless of their funding sources. Once all the funds were transferred to DMAS' budget, this was no longer an issue for CSBs because they needed to submit funding requests to DMAS for any additional services for their clients.

After July 2000, just as some CSBs had done in the past, DMAS began denying requests for new services for existing MR waiver clients due to a lack of funding. In a letter to the Director of DMAS, one CSB director stated that the denial of services was hurting hundreds of people statewide and the numbers of people impacted were escalating daily. By late August and early September (2000), complaints by consumers and families reached the media and State legislators, and 32 complaints were filed with the U.S. Office of Civil Rights (discussed further in this section).

In August 2000, DMAS further alarmed consumers and providers when it issued a Medicaid Provider Manual Update stating that DMAS would approve the increased funding for service enhancements according to the extent of available funds. This policy was in clear violation of federal regulations which provided that, once approved for waiver services, clients are entitled to all necessary covered services to ensure their health and safety [42. U.S.C. §1396n(c)(2)(A); 42 CFR §441.302(a)]. Also in August, a Medicaid memorandum outlined emergency criteria, which set a higher standard than previously used, on which DMAS would base decisions on requests for service increases. (See Appendix B, Exhibit B-3 for a historical description of how criteria for the MR waiver were defined).

After the emergency criteria were issued, DMAS received a high volume of requests (137) for service increases in September 2000 (see Appendix B, Table B-1 for monthly detail of service requests, approvals and denials for FY 2001). When interviewed by JLARC staff, DMAS staff stated that they never intended to make it a policy to deny service enhancements for a lack of funding as stated in the August Provider Manual Update. DMAS staff said they met with DMHMRSAS staff in late October (2000) to clarify that increases in services should not be denied for lack of funding. However, the timeline presented below illustrates that this issue was not resolved for several more months:

- In November 2000, DMAS Hearing Officers denied at least two appeals for enhanced services by reiterating the lack of funding (decisions issued November 13 and 21, 2000). DMAS management staff said the hearing officers had not yet been apprised of the correct policy.

- In December 2000, CMS released a draft report on its 1999 routine audit of Virginia's MR waiver that made several recommendations. Based on concerns over denials of entitled services, one CMS recommendation was that Virginia should take responsibility for fully funding the program.

- Also in December 2000, eight MR waiver clients filed suit against DMAS for continued denial of needed, entitled services. While

other clients appealed for and received service enhancements in early 2001, it was several months before the plaintiffs received their requested services. Depositions by staff from both State agencies (DMAS and DMHMRSAS) indicated disagreement about the events of the summer of 2000. Because of this, the case was finally settled out of court in September 2001.

- In January 2001, DMAS Hearing Officers began overturning denial of services. The DMHMRSAS commissioner expressed serious concern in a letter to the DMAS director that the notification letters erroneously stated that DMAS is "overturning the decision of the CSB to deny you services," when in fact it was DMAS that had denied the services.

- In February 2001, a DMAS letter clarified that approval of additional services or service units should be based on health and safety concerns, which is still a higher standard than had been applied previously.

In the end, 786 (or 88 percent) of 891 waiver clients that requested enhanced services in FY 2001 were approved, 63 were denied, and 42 remain outstanding (see Appendix B, Table B-1 for monthly emergency service requests, approvals, and denials for FY 2001).

DMAS' Management of the Waiting Lists Delayed Emergency Services. Concurrently with the denial of enhanced services to those already on the waiver, DMAS also restricted new admissions to the waiver for many persons on the waiting lists. Again, DMAS' reason for these denials was tied to the perceived inadequate transfer of MR waiver funds by DMHMRSAS. In the past, the CSBs locally managed both the MR waiver slots and the waiting lists, and determined who would receive services, which services would be provided, and who would be placed on waiting lists.

According to DMAS, it assumed responsibility for the management of the waiver slots and waiting list because of conditions that jeopardized the federal requirement that the waiver be equally accessible statewide (referred to as statewideness). DMAS staff reported concerns that CSBs had local guidelines for determining who received services that varied among localities, and concerns that CSBs provided individuals with some services but placed them on waiting lists for other services. These conditions led to a lawsuit against DMAS that was later settled based on DMAS' plans to implement statewide criteria for the waiver.

The following are case examples of families waiting for MR waiver services in August 2000:

A 12 year old female is diagnosed with Moderate Mental Retardation, Attention Deficit Hyperactivity disorder, Oppositional Defiant Disorder, Leukoencphalopathy and Seizure Disorder. She lives in a single-parent household and is difficult to man-

age. She poses a risk due to self-injurious behaviors (such as hitting and biting), running away, and aggression towards others. The mother has stated many times that she does not know how much longer she can provide care for her daughter. In absence of waiver services, the mother will not be able to maintain her daughter in the home. (Provided by a CSB)

* * *

A 29-year-old man with mental retardation is eligible for the MR waiver. His mother worked days and the father nights to care for him and a grandparent filled in the gaps. This system fell apart when the grandparent became ill and the father's company moved him to a day shift, leaving a ten-hour gap in care. A program run by The ARC (an association for persons with mental retardation) was providing temporary care. (The Lynchburg News and Advance)

In late August 2000, DMAS released emergency criteria, more restrictive than the previous waiver policy, to prioritize enrollment. While the waiting list policy was under development by DMAS staff, few new clients were added to the waiver for lack of funding. No new clients were enrolled in July 2000 and only 28 were enrolled in August. Overall, there were 713 people added to the waiver in FY 2001, or about 59 a month on average (see Appendix B, Table B-2 for monthly detail of service requests, approvals and denials for FY 2001).

The U.S. Office of Civil Rights (OCR) Received 32 Complaints from Virginia Citizens Regarding the MR Waiver. Because of changes DMAS made upon assuming management of the MR waiver, OCR received complaints from clients who were denied service enhancements, as well as those who were experiencing emergency needs but were denied waiver enrollment for lack of funds. OCR sent DMAS a letter in August 2000 stating that complaints alleged that DMAS was failing "to provide services to people with disabilities in the most integrated setting appropriate, in violation of the American with Disabilities Act (ADA), as clarified by the Supreme Court Decision in *Olmstead vs. L.C."* OCR followed-up with a letter in August 2001, which included three concerns: (1) DMAS' reliance on emergency criteria to address waiting list needs; (2) DMAS' withdrawal of a waiver amendment to add 439 waiver slots over a three-year period; and (3) DMAS' lack of a plan to both move persons from institutional settings to community settings (as encouraged by the Olmstead decision) and to address the waiting list.

When interviewed by JLARC staff, OCR staff reported that Virginia is the only state in its region without a plan to address needs as required by the Olmstead decision. OCR staff stated that since their investigation is in progress, at this point they do not consider Virginia in violation of ADA or the Olmstead decision. However, OCR staff are concerned about this potential problem. DMAS staff state, however, that the waiver is in compliance with the Olmstead rulings and no plan is being developed. On October 31, 2001, DMAS responded to OCR's August 2001 letter. According to DMAS, there are 1,666 people who have requested MR waiver

services by the end of December 2001; 579 of these people have urgent needs. The letter also states that DMAS has recently requested 150 new waiver slots. Since these new slots do not begin to address the current service needs of those on the waiting list, it is likely that OCR's concerns with Virginia's compliance with the Olmstead rulings will continue.

DEVELOPMENT OF A NEW MENTAL RETARDATION WAIVER

In October 2000, in response to concerns voiced by consumers, service providers, and legislators about DMAS' management of the MR waiver program, the Secretary of Health and Human Resources directed DMAS to apply for a new MR waiver. While a new MR waiver was not required, it signaled to the community that DMAS intended to reexamine all aspects of the MR waiver, including its policy development procedures and management of the waiver services.

In order to ensure stakeholder input, to improve communication between DMAS and DMHMRSAS, and to reduce consumer concerns, the Secretary of Health and Human Resources directed DMAS to convene a MR waiver Advisory Task Force. This task force, led by DMAS, included DMHMRSAS staff, families, advocates, and service providers to assist in the development of the new waiver. A similar recommendation to create a task force (House Joint Resolution 218, which failed) had been proposed earlier in the year by the 2000 General Assembly to "improve levels of understanding between the two agencies (DMHMRSAS and DMAS) and to streamline procedures for service authorization and quality monitoring." In order to facilitate communications between DMAS and DMHMRSAS management staff in the development and management of the MR waiver, the Secretary of Health and Human Resources met with agency staff on a weekly basis. In addition, DMAS and DMHMRSAS created an interagency group to review emergency requests by the CSBs.

DMAS, along with the task force members, has been addressing the development and implementation of the MR waiver services in two phases. During Phase I, DMAS developed a new waiver and submitted it to CMS for federal approval in April 2001. The new waiver was implemented on September 17, 2001. Phase II involves examining reimbursement rates for MR waiver services, developing a long-range plan for access to waiver slots, and exploring the need for additional services to be added to the waiver. Originally, Phase II was to be completed by November 2001. Now the completion date is likely to occur sometime in 2002. The progress on the Phase I and Phase II activities, task force comments and concerns, and the transfer of some management of the MR waiver back to DMHMRSAS and the CSBs are described in the following sections.

Phase I of the New MR Waiver Is Complete, But Ongoing Implementation Activities Have Delayed Phase II Activities

According to DMAS documents, the new MR waiver was designed to clarify the responsibilities of the CSBs, provide greater consumer control over selected

services (known as consumer-directed services), improve freedom of choice of providers, reduce State-level required paperwork, examine ways to develop provider networks, and enhance the management of psychotropic drugs. It is too early in the implementation phase of the new MR waiver to determine how well the new waiver has accomplished these goals.

During the review and approval process of the waiver, CMS temporarily delayed implementation of the waiver because it had serious concerns about the health and safety of MR waiver recipients living in assisted living facilities (ALFs) that are licensed by the Department of Social Services (DSS). Therefore, DMAS amended the new waiver application to require ALFs, currently licensed by the DSS, to become licensed by DMHMRSAS as mental health residences. For those waiver recipients living in ALFs that opt not to be licensed by DMHMRSAS, the new waiver will require case managers to conduct monthly onsite visits to ensure the residents' health and safety. If the case manager finds a health and safety problem and the facility fails to take corrective action, the MR waiver recipient will have to move to another residential facility or lose MR waiver supportive services. At the present time, it appears that most of the affected assisted living facilities have already applied for DMHMRSAS licensing. It is unclear at this time how many of the ALFs will be able to meet the higher licensing standards.

Phase I was complete with the submission of the new waiver application to CMS in April 2001. However, DMAS and the task force will continue to work on a variety of related issues. These include correcting problems with the regulations for the waiver, completing the provider manual, training CSB and provider staff, and shifting management of the waiver back to DMHMRSAS and the CSBs. With the exception of addressing the issues concerning the regulations, DMAS expects these activities to be complete in January 2002.

Originally planned for completion in November 2001, the remaining Phase II activities have been delayed due to new waiver implementation issues. DMAS, with the task force, have already evaluated the need for increased reimbursement rates and added consumer-directed services to the new waiver this year. Phase II activities will resume in February 2002, and DMAS has projected a completion date in summer 2002. There are three main areas for DMAS, with the task force and stakeholders, to address in Phase II. DMAS plans to: (1) develop a plan to examine the reimbursement rate structure for certain services; (2) develop a long-range plan for access to waiver slots; (3) explore the need for additional services to be added to the waiver (such as dental care) and expand current services to all those who need them.

DMAS Met with Task Force Members, But Agreements Were Not Always Reflected in the Written Documents

DMAS has held at least monthly meetings with the task force members over the past year to receive input on changes and improvements for the new MR waiver. To assess how well DMAS dealt with task force members' concerns, nine members were asked what their concerns were when the task force began versus

what they are now. Common initial concerns were the composition of the task force itself, denial of services, lack of leadership, low reimbursement rates, and lack of funding. Some of these concerns have been addressed, but low rates and funding remain concerns. These are the issues to be addressed in Phase II.

While the task force members interviewed felt that overall the meetings were productive and that DMAS was responsive to their concerns, many at the same time expressed frustration. The main reason members felt the task force had been productive was that the new waiver application had been submitted, approved, and implemented. Many were also pleased that consumer-directed services had been added, which allow the family greater control over who provides care to their relative. A common frustration was dealing with inconsistencies between agreements the task force members made with DMAS during meetings and the written documents produced, including the provider manual and the emergency regulations. Each of these concerns is illustrated briefly below:

- **Concerns with the provider manual**. At one meeting, the task force was given a draft copy of the provider manual with several additions to review over a holiday weekend (the review period was later extended). Some of these additions were in error. At another meeting, which was supposed to be the final review of the manual, members were upset that the manual did not reflect prior agreements made with DMAS. One recent inconsistency between the manual and regulations involved an error in the manual that required prevocational providers (who prepare clients for employment) to be licensed solely by the Department of Rehabilitative Services (DRS); fortunately the regulations correctly allowed for licensing by DRS and DMHMRSAS. The manual is still in progress, and was not completed prior to the effective date of the new waiver services. Because of this delay, provider training and implementation of consumer-directed services have also been delayed.

- **Concerns with the emergency regulations**. Recently approved emergency regulations contained several examples of inappropriate language and some technical errors. One example of inappropriate language that has the potential to impact access to services is the requirement of a nurse to oversee respite care because some providers of respite care are simply sitters hired to give caregivers a break from providing care. Two examples of technical errors include: the use of the term “related conditions” in defining the MR waiver eligible population, and the inclusion of bowel and bladder care under consumer-directed services. Apparently, this language was inappropriately lifted from regulations from other waivers. DMAS is working to address these errors in the next set of regulations.

DMAS Returns Management of the MR Waiver Slots and Waiting List to the Community Service Boards and Pre-Authorizations for Enhancements to DMHMRSAS

The major accomplishment, from the task force members' point of view, is that the State-level management of the MR waiver has been returned to DMHMRSAS, and the management of the MR waiver slots and waiting list has been returned to the CSBs. More than a year later, with some improvements, the waiver is largely back to where it was prior to DMAS' intervention. It is not clear how effective these changes will be since there are indications that DMAS continues to micromanage the waiver. Each of these changes is described in the following sections.

CSBs Regain Control of the Waiver Slots and Waiting Lists. When DMAS implemented new emergency regulations in October 2001, new criteria for enrollment in waiver services waiting lists were established and the management of the waiver slots and waiting list was given to the CSBs. According to the regulations, CSBs will begin management of waiver slots with a base number of slots, equal to the number of waiver clients served when slot management was transferred. New slots will be allocated to a CSB based on its proportion of people on the urgent waiting list. The waiting list meets statewide needs by the rule that, if a CSB has a slot open for 90 days, and another CSB in the same region has an individual on its urgent list, the slot will be re-allocated within that region. The slot may be re-allocated elsewhere in the State until all individuals in urgent need are served, at which point individuals on the non-urgent list may be served. CSBs will notify DMHMRSAS of waiting list updates quarterly. DMAS will ensure urgent criteria are met through the utilization review process.

During discussions with DMAS concerning the official transfer of waiver slots to the CSBs, DMHMRSAS communicated to the task force that the waiver slots had reached capacity (it had in fact exceeded the cap by 13). At that time, there were at least 73 emergencies submitted to DMAS and another 60 emergency submissions pending by CSBs. This meant that the waiver slots were going to be transferred to the CSBs with no ability to serve these emergencies. The CSBs indicated they did not want the management of the waiver slots under these conditions. To avoid additional discontent by consumers and families over the MR waiver, the administration announced in October 2001 plans to allocate $3.5 million and 150 new slots for the MR waiver. Only 110 of these slots are slated for emergencies in the community. The other 40 are to move clients from institutions into the community. DMAS could not document the methodology used to determine how these slots were distributed. As of December 3, 2001, DMAS had not indicated when these potential new slots would be available. This means that since August 2001, only when clients were discharged from the MR waiver have there been slots available to meet the emergency needs of individuals on the waiting list.

DMHMRSAS Resumes Pre-Authorization of Service Enhancements. While DMHMRSAS was previously responsible for pre-authorizing requests for new services for existing MR waiver clients, under DMAS' management of the waiver, DMAS instituted a dual agency review. One positive development is that this pre-authorization process is being returned to DMHMRSAS. DMAS staff also are con-

sidering developing guidelines indicating when certain requests for service enhancements will not require pre-authorization by DMHMRSAS. DMAS does plan, however, to audit 50 percent of the pre-authorizations for enhanced services that are completed by DMHMRSAS. Such an extensive audit plan of a sister agency appears to be duplicative and indicates DMAS' unwillingness to relinquish day-to-day management to DMHMRSAS.

CURRENT CONCERNS FOR THE MENTAL RETARDATION WAIVER

According to the DMAS director, the major accomplishment with the new MR waiver is that management of the waiver slots was put back at the local level where it belongs. DMAS has taken definitive steps to improve the waiver, such as working with the task force to craft a new waiver, making the waiting list statewide, and establishing standardized waiting list criteria.

However, remaining concerns include: the extent of communication DMAS staff will maintain with DMHMRSAS staff, CSB staff, task force members, consumers, and providers in many areas including management of the waiver and the development of program policies and regulations; how the need for additional funds for waiver services will be projected and then distributed to the CSBs and DMHMRSAS; how much DMAS intervenes in the management of the waiver by DMHMRSAS and the CSBs; and, the timing and quality of training for providers on new requirements and for families on accessing the new consumer directed services. DMAS' transfer of responsibilities for waiver slot management and pre-authorizations to CSBs and DMHMRSAS continues to be micro-managed by DMAS. An underlying problem with the MR waiver for more than a year has been DMAS' lack of clear, consistent, and timely communication with DMHMRSAS staff, task force members, consumers, and legislators. The overall success of the waiver, however, will depend on how many of the 1,666 persons on waiting lists receive needed services in a timely manner. The administration recently announced plans to fund 150 additional waiver slots, but these slots are not yet available and will not adequately address those waiting in the community and State facilities for MR waiver services.

To this end, because the implementation and the development of the new MR waiver is still ongoing and undergoing changes, DMAS should provide a status report on MR waiver activities to the General Assembly prior to the 2003 session.

Both the Secretary of Health and Human Resources and the DMAS director are pleased with the recent accomplishments regarding the administration of the waiver and communication between DMAS staff and major stakeholders. Therefore, they disagree with the JLARC staff findings that some problems remain.

Recommendation (7). **The Department of Medical Assistance Services should provide a status report to the Health and Human Resources Subcommittees of the House Appropriations and Senate Finance**

Committees on the mental retardation waiver services by October 1, 2002. This report should address: (1) the status of program funding; (2) the number of available, filled, and planned waiver slots; (3) the development of a slot allocation methodology; (4) the number and characteristics of the clients on the MR waiver and the waiting lists; (5) the status of the CSBs' management of the waiver slots and waiting lists; (6) the status of DMHMRSAS pre-authorization of service enhancements and DMAS' audit of these approvals; (7) the current roles and responsibilities for DMAS, DMHMRSAS, and the CSBs; (8) the training provided to CSBs and other service providers on the MR waiver manual and regulations; (9) an update on Phase II activities, including changes to regulations, a long range plan for access to waiver slots, reimbursement rates, and the need for additional waiver services; and (10) an update on other outstanding concerns by the members of the Mental Retardation Waiver Task Force.

IV. Medicaid-Funded Non-Emergency Transportation Services

Transportation is one Medicaid-funded service that has been characterized as a program without adequate State-level oversight and cost containment measures. There has been a 20 percent annual increase in the cost of this program during the last decade. A key driver of these costs, critics claim, is a high incidence of fraud and abuse.

Transportation services play an important role in ensuring that Medicaid recipients have access to necessary medical care. These services are particularly important to older and/or disabled recipients needing critical services such as dialysis, rehabilitation, physical therapy, chemotherapy, and other important community-based services. Under federal Medicaid regulations, each state is required to provide necessary transportation to and from the nearest qualified provider of Medicaid-covered services.

On July 2, 2001, DMAS implemented a new system for providing non-emergency transportation based upon the success of earlier pilot programs. The purpose of the new system is to use a broker or intermediary to coordinate and monitor transportation services and subsequently control costs, fraud, and abuse. However, after the July start date, recipients, transportation providers, and service providers questioned the ability of the new transportation brokerage model to provide timely and quality transportation services for Medicaid's most vulnerable populations.

Most of the complaints were lodged against the contractor that was responsible for the majority of the State, both geographically and in numbers of recipients served. The chief complaints were: (1) not enough transportation providers, (2) insufficient phone lines and staff at the transportation call centers, and (3) unscheduled, routine transportation visits prior to the start-up date. As a result, transportation providers would arrive hours before or after a scheduled visit or not at all. Recipients could not arrange for transportation services because of busy phone lines. Service providers had clients who did not get picked up for critical medical services (such as dialysis) or day support services. Although the contracted brokerages are essentially responsible for arranging transportation, some service providers assert that DMAS should have delayed statewide implementation of the program until proper verification of the critical start-up requirements were conducted.

In spite of initial start-up problems, a brokerage system appears to be an appropriate model for providing transportation services to Medicaid recipients. DMAS is closely monitoring the transportation brokerage system and resolving identified operational problems. DMAS projects that the transportation brokerage system will enable the Commonwealth to avoid cost increases of $56 million dollars

(federal and State funds) over the next two years (based on the difference between the projected increases using historical cost data and contract costs). However, the State will need to monitor the program to ensure that cost savings are achieved through legitimate efficiencies rather than inappropriate curtailing of services or poor quality services.

The JLARC staff review identified several operational issues that DMAS should address or monitor over the next year to gauge the overall effectiveness of the program, including the quality of the transportation services provided. In addition, DMAS will need to monitor the impact that the statewide expansion of managed care will have on the contracts for transportation brokerage services as more Medicaid recipients move from fee-for-service into managed care plans. This change will likely decrease the number of recipients whose transportation needs will be managed through the brokerage contracts.

OVERVIEW OF VIRGINIA'S MEDICAID TRANSPORTATION SERVICES

Virginia's Medicaid program has provided both emergency and non-emergency transportation services since 1969. Emergency transportation involves the use of ambulances when the individual's transportation to a health care facility is vital. Non-emergency medical transportation is for preventive or non-urgent treatment care, such as a medical appointment. Non-emergency transportation can include the use of bus services, commercial taxicab services, special project vehicles, registered drivers, and local human service agencies (such as community service boards and area agencies on aging). The focus of the JLARC staff review is on non-emergency transportation services.

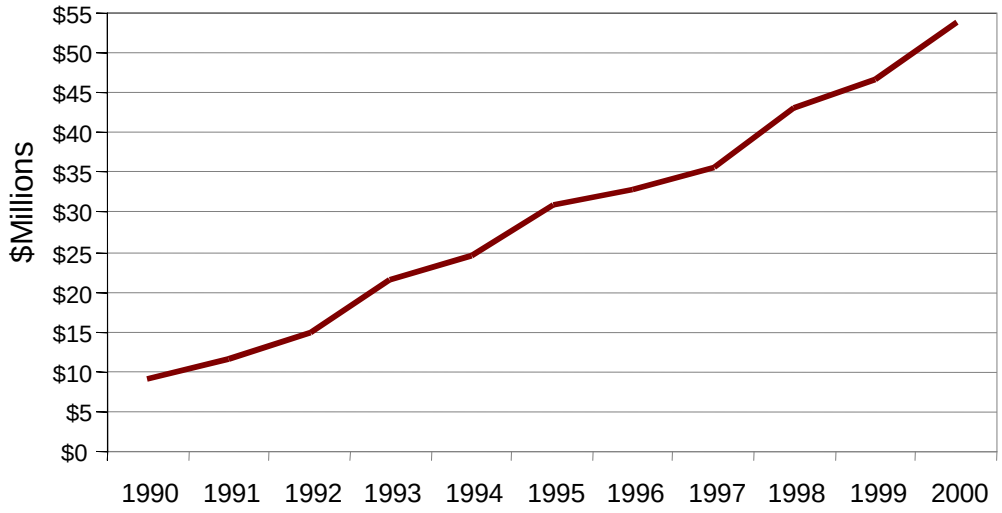
Until 1995, all transportation services were reimbursed on a fee-for-service basis. However, in 1995, Virginia began enrolling fee-for-service Medicaid recipients into health maintenance organizations (HMOs), which include transportation services. Although the number of fee-for-service Medicaid recipients steadily declined with the expansion of the Medicaid HMOs and as a result of welfare reform, total fee-for-service transportation costs continued to increase 20 percent annually, from about $9.1 million in FY 1990 to $54 million in FY 2000 (see Figure 7).

Virginia's Medicaid transportation costs are higher when compared to other states. According to a report by the Community Transportation Association of America (CTAA), in 1999, Virginia's non-emergency transportation program ranked eighth highest in cost per capita compared to other state Medicaid programs. Virginia's transportation costs accounted for two percent of the total Medicaid budget, which was twice the national Medicaid average.

The following section provides some information on how fraud and abuse was detected and monitored under the transportation system prior to the implementation of the brokerage model. DMAS, however, could not provide current or longitudinal data on the magnitude of fraud and abuse in transportation services.

Figure 7

Total Medicaid Transportation Expenditures, FY 1990 – FY 2000



Source: DMAS' *The Statistical Record of the Virginia Medicaid Program and Other Indigent Health Care Programs*, FY 2000.

Fraud and Abuse Contributed to Rising Medicaid Transportation Costs

The *Code of Federal Regulations* defines fraud and abuse in the Medicaid program as the following:

- Fraud is an intentional deception or misrepresentation knowing that the deception will result in an unauthorized benefit.

- Abuse means practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to the Medicaid program.

According to the CTAA, system factors which contribute to a high level of fraud and abuse of Medicaid-funded transportation services are the lack of adequate oversight of transportation services, the use of a large number of transportation providers, and the processing of a high volume of claims. All of these factors were present in Virginia's Medicaid program. According to DMAS, fraud and abuse in the Medicaid transportation program involved a variety of schemes. Some examples of fraud and abuse by a transportation provider included reporting transportation for an ineligible rider, for a trip to a non-covered Medicaid service, for more miles than the actual distance of the trip, for multiple trips where only one trip was necessary, for providing a trip in an ambulance when the recipient did not require this costly service, and for a trip that never occurred.

Prior to the new brokerage system, DMAS identified occurrences of fraud and abuse through the use of computer reviews of unusual transportation services

and discovered that the transportation providers, not the recipients, were the primary abusers of the system. If a case appeared to be accidental abuse, then DMAS provided a warning letter and/or educated the provider on the appropriate provision of Medicaid transportation services. DMAS could not, however, provide any data that suggests the level of fraud and abuse in transportation services and the cost to the Commonwealth over the years. For the majority of the time, DMAS had only one staff person assigned to monitor this program.

DMAS referred cases that appeared to be fraudulent and had the potential for recovery of money to the State Office of the Attorney General's Medicaid Fraud Control Unit to prosecute transportation providers. The Medicaid Fraud Control Unit has prosecuted a number of transportation providers over the years, and has increased its resources devoted to this problem in recent years. Since 1990, the Fraud Unit staff has convicted 38 transportation providers and ordered approximately $2.8 million dollars payable to DMAS. The unit projects an additional $3.3 million to be collected by the end of 2001. One recent case involving a transportation provider from Northern Virginia totaled over $1.4 million in fraudulent claims. However, staff from both of the pilot transportation programs, discussed later in this chapter, stated that referrals to the Medicaid Fraud Control Unit to prosecute cases that were under $100,000 to $250,000 were not investigated.

Due to limited staff devoted to the detection of fraud and abuse at DMAS and the Medicaid Fraud Control Unit, DMAS determined that it must eliminate transportation misuse before it happened through a statewide prior authorization system. DMAS had previously utilized a prior authorization system for transportation services in the early 1980s, but it was stopped due to the administrative burden on local public agencies. More than 15 years later, DMAS returned to this method to control costs by hiring brokers to authorize and manage transportation services.

NEW TRANSPORTATION BROKERAGE SYSTEM

In response to the growing concerns about controlling costs and fraud, DMAS initiated a major change to the way Medicaid-funded transportation services were provided. Based on a 1997 report by the federal Office of the Inspector General (OIG), which recommended the use of brokerage systems to control costs, fraud, and abuse, and to promote the use of the least costly modes of transportation, DMAS implemented a brokerage system through two pilot programs in Southwest Virginia. In 2001, a new transportation program, based upon the successful pilot programs, was implemented statewide. The following sections describe the differences between the fee-for-service model and the brokerage model, provide an overview of the pilot transportation programs, and describe the implementation of a statewide brokerage model for arranging transportation services.

A Transportation Brokerage Model Improves the Management of Transportation Services

A brokerage system differs from a traditional fee-for-service program because it places a gatekeeper or broker between the transportation provider and the recipient. With a fee-for-service system, recipients choose a Medicaid designated transportation provider and arrange their own transportation. With a brokerage system, recipients call a central number and the broker arranges the transportation. One major difference between the two systems is the recipient's freedom to choose a transportation provider. Under the fee-for-service model, federal regulations require that the recipient be given the right to choose between service providers. However, under a brokerage model, federal regulations allow a state to waive the freedom of choice provisions to allow the broker to choose the appropriate non-emergency transportation if the state applies for a special waiver, or if the state bills transportation as an administrative service. Other differences between the fee-for-service and the brokerage system include the method of billing, the responsibility for detecting fraud, the establishment of transportation rates, and the selection of providers. Exhibit 4 is a comparison of the key elements of Virginia's Medicaid fee-for-service transportation system to the brokerage system.

Exhibit 4

Comparison of Non-Emergency Medicaid Transportation Services: a Fee-for-Service System Versus a Brokerage System

	Traditional Fee-for-Service System	Brokerage System
Allowing Freedom of Choice	Medicaid recipients have the freedom to select a transportation provider of their choice	The broker is contractually bound to assign the lowest cost transportation provider. However, if possible, recipient preference is taken into consideration.
Requesting a Ride	Medicaid recipients contact providers directly to arrange transportation	Medicaid recipients must contact the broker in advance to arrange transportation
Billing Services	Medicaid transportation providers bill DMAS for services rendered	Providers bill the broker for trips pre-authorized and arranged by broker
Detecting Fraud	DMAS identifies and investigates fraud issues	Broker identifies and investigates fraud issues
Setting Rates	Established by DMAS	Broker sets or negotiates rates with the provider
Selecting Providers	Transportation providers are selected to provide Medicaid transportation services as long as they meet the requirements of the program and the Commonwealth	Broker contracts with transportation providers to be part of its network based on requirements, which include state Medicaid contract requirements

Source: JLARC staff adaptation of the Virginia Association of Area Agencies on Aging's comparison of Medicaid transportation programs.

Brokerage systems in other states have successfully lowered costs through additional monitoring and increased efficiency. Brokers improve efficiency by maximizing the use of scheduled bus services in certain areas, identifying the appropriate mode of transportation for a recipient, and coordinating multiple trips to the same destination into a single trip. For example, Florida's brokerage model has saved the state over $600,000 in transportation costs each month, and Vermont lowered average trip costs from $6.85 to $3.77 through increased use of public transportation and coordination of multiple trips.

DMAS Initiated Two Pilot Programs to Address the Growing Costs of Transportation Services in Southwest Virginia

From April 1998 to July 2001, two pilot programs conducted a trial of a transportation brokerage system. These pilot programs were managed by two area agencies on aging located in Southwest Virginia (Planning Districts One and Two) where Medicaid transportation costs were historically the highest. The pilots were considered successful because they ensured that only eligible Medicaid recipients received transportation to Medicaid covered services, decreased the number of trips, reduced the length of the trips, guaranteed the appropriate mode of transportation for recipients' medical conditions, and improved efficiency by coordinating multiple trips to the same destination.

The two agencies were paid a total fixed amount of $10.6 million over two years to provide transportation brokerage services. This amount was based on 1997 utilization and cost data for transportation services in their designated planning districts. Based on a JLARC staff forecast of transportation costs, if the State had maintained the fee-for-service system and experienced the same historical rate of growth in these areas, the pilot programs enabled the State to avoid cost increases of $5.1 million (State and federal dollars). In addition, the agencies themselves saved $4.2 million (this does not reflect the pilot programs' administrative costs, which would reduce these savings) because the cost of delivering transportation services was less than their contract amount. The agencies used these additional funds to improve services in other areas of the agency that were otherwise unaffordable, such as capital improvements, equipment upgrades, and added services for the elderly and disabled in their areas.

These cost savings were driven, primarily, by reducing fraud and abuse. The pilot programs achieved this by monitoring transportation providers to ensure that they billed for accurate mileage, billed only for trips they provided, and used the appropriate form of transportation. In addition, the pilot programs identified another area of fraud, which involved transportation providers billing both the Medicaid and Medicare programs for the same trip. Consequently, DMAS staff established regulations to avoid this Medicaid/Medicare double billing.

In addition to cost savings for the pilot programs and for the State, the pilot programs improved the quality of transportation services. They identified transportation providers with vehicles that were not in compliance with American Disabilities Act (ADA) safety standards, identified providers who did not meet Medi-

caid driver requirements, and created a formal complaint process for recipients. One unique characteristic of the pilot programs was that these contractors also served as transportation providers when no other provider was available; this process is known as the provider of last resort. Therefore, the agency could ensure that the recipients received timely transportation services when no other transportation provider was available.

DMAS Implemented a Statewide Brokerage System Based Upon the Success of the Pilot Programs

Based on the positive experience of the two pilot programs, a 1997 report by the federal Office of the Inspector General (OIG), and the best practices of other states, DMAS decided to implement a statewide brokerage transportation program. In the spring of 2000, DMAS issued requests for proposals (RFP) for non-emergency transportation brokerage services for seven regions of Virginia. The brokerage system would cover the 320,000 fee-for-service recipients (or 70 percent of the enrolled Medicaid population) who were not enrolled in Medicaid's capitated managed care plans. Concurrent with this request, DMAS filed a State Plan amendment with the federal government to change transportation from a medical expense to an administrative expense, which allowed DMAS more flexibility in the design of a brokerage system. While this change had relatively no impact on the federal dollars received for this service, it did eliminate the recipients' right to choose their transportation providers. The RFP incorporated many of the best practices from the pilot programs, such as vehicle safety and driver background checks, driver training, and the use of a formal complaint process. DMAS also improved on the pilot programs. In the pilot programs, the agencies had been required to provide services to any recipient with a Medicaid number originating from that area and therefore, had been responsible for providing transportation for recipients who had moved to other areas of the State. In the new system, brokers are only responsible for recipients who reside in their contract area.

As shown in Exhibit 5, three major components of the pilot programs were not built into the new design: (1) dividing the State into smaller planning districts rather than larger regions, (2) allowing the brokers to act as transportation providers of last resort, and (3) requiring the brokers to also reimburse emergency transportation providers. An explanation for why these components were not included follows.

- **Change from smaller planning districts to larger regions:** Each region is approximately three times larger than a planning district. DMAS staff indicated that managing seven regions, instead of a different contract for each of the 22 planning districts, was simpler. Although service providers felt differently, this regional approach to managing transportation is not uncommon. Other states have successfully implemented transportation brokerage systems with one or two providers for the entire state. In addition, utilization of the local area agencies on aging across the State would not have been a viable alternative because not all agen-

Exhibit 5

Best Practices of the Two Pilot Programs Implemented by the New Statewide Transportation Brokerage System

Best Practices Implemented
• Enforcing background driver checks • Using regulations to avoid Medicaid/Medicare double billing • Requiring driver training • Using a central call center to arrange transportation • Using a formal complaint process
Best Practices Not Implemented
• Using smaller planning districts rather than larger regions • Using the broker as a transportation provider of last resort • Managing reimbursement of emergency transportation

Source: JLARC staff analysis based on DMAS transportation request for proposals and interviews with the pilot programs.

cies were qualified or interested in becoming Medicaid transportation brokerage contractors.

- **Elimination of the transportation provider of last resort component:** The program design would not allow the broker to also act as a transportation provider in order to reduce a potential conflict of interest whereby a broker could refer recipients to its own transportation providers in lieu of other willing providers. This was also a recommendation to DMAS staff by Washington State, which operates a brokerage system.

- **Removal of the reimbursement for emergency transportation requirement:** Under the new design, the brokers are only responsible for non-emergency transportation. DMAS was advised, by the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration), to directly manage emergency transportation due to the critical nature of the emergency care. Other state Medicaid programs follow these same guidelines. The pilot programs indicated a concern that removal of this oversight might contribute to a rise in emergency transportation costs. However, DMAS has a medical consultant who will monitor utilization and cost data for emergency transportation services to ensure that service providers and recipients are not utilizing emergency transportation services to bypass the brokers.

DMAS issued two RFPs before the final contracts were awarded. Initially, DMAS granted all seven regions to Logisticare, a company located in Georgia and a broker for medical transportation services in several states including Georgia, Connecticut, California, and Florida. However, another broker, DynCorp, located in Virginia and a broker of transportation services in Arkansas, Connecticut, and Illinois, challenged the award. The RFP was placed out for bid again in October 2000,

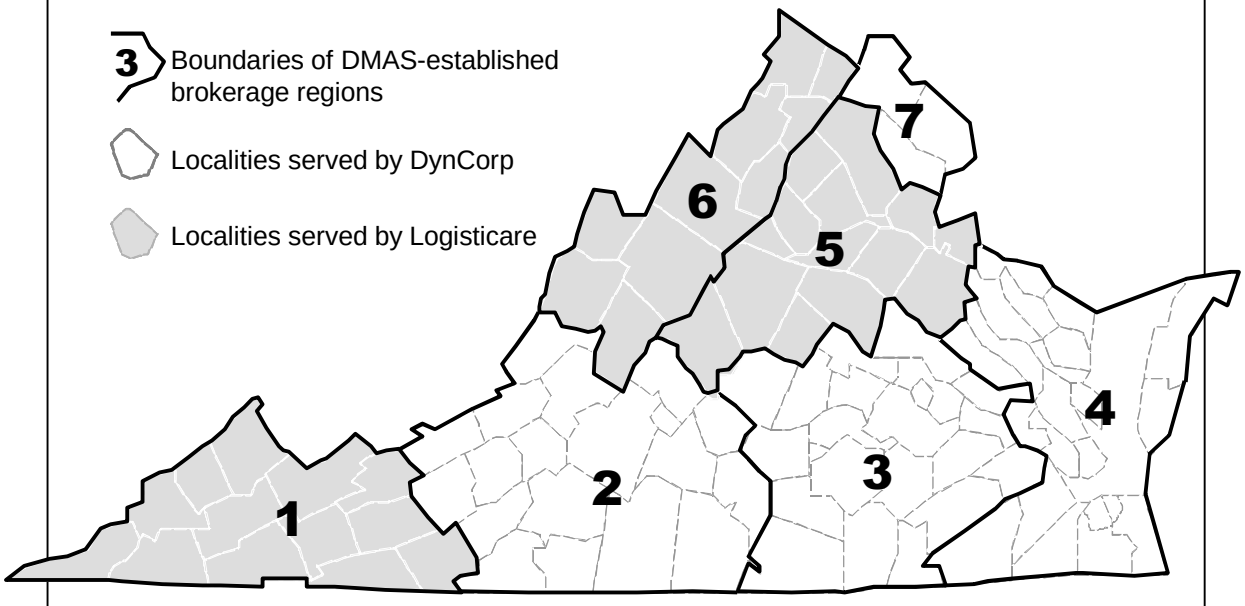
and DMAS awarded four of the seven regions (roughly 70 percent of the total Medicaid population and land area of the State) to DynCorp (see Figure 8 for the regional breakdown of the State).

The two transportation brokers received $73 million as a fixed contract over two years. DMAS estimates that the Commonwealth will avoid cost increases of $56 million ($30 million in federal and $26 million in State funds) for the Virginia Medicaid program for the two-year period (based on the difference between the projected increases using historical cost data and contract costs). The initial contracts are for a two-year period, with four one-year renewal options. During the first two years of the contract, the brokers are allowed to keep any profits. However, after the initial two years, DMAS reserves the right to realize one half of the brokers' transportation profits up to 15 percent of the contract award amount for the year.

The contracts were finally awarded in February 2001. However, the contracts were not signed until April 2001, due to a protest filed by one of the brokers. The brokers spent three to five months following the award of the contract to develop their statewide transportation services for the July 2, 2001 implementation date. Consequently, the notification to recipients, the enrollment of providers, and the provision of transportation services did not occur smoothly, especially in the DynCorp-managed regions of the State.

Figure 8

DMAS' New Brokerage Services for Non-Emergency Transportation



Source: JLARC staff analysis of DMAS' Request for Proposals and the two awarded contracts.

CONCERNS REGARDING THE IMPLEMENTATION OF THE NEW TRANSPORTATION BROKERAGE SYSTEM

Beginning on the day the new system was in effect, numerous complaints arose from transportation providers, recipients, and service providers regarding the adequacy of transportation services by the brokers, especially in the DynCorp regions. Transportation providers complained about contract concerns, which appeared to be burdensome and restrictive. Recipients complained that they could not get through on the brokers' central phone line, or they had to wait long periods of time on the phone to arrange transportation. Service providers, such as hospitals, dialysis centers, and nursing facilities, complained that their clients were not being transported to critical medical services.

The following sections describe how DMAS should have identified problems prior to implementation, DMAS' actions to remedy the problems, and the concerns of the service providers, recipients, and transportation providers. The final section summarizes additional issues that DMAS should monitor over the next year.

Although DMAS' Design of the New Brokerage Program Appears Appropriate, DMAS Did Not Effectively Review the Readiness of the Brokerage Operations

Even though DMAS sufficiently designed the brokerage system by incorporating the best practices of the pilot programs and other state Medicaid programs into the RFP, DMAS did not ensure that the brokers were fully prepared to implement the new system prior to the July 2, 2001, implementation date. While the broker is primarily responsible for fulfilling contract requirements, DMAS should have recognized and corrected potential problems during the readiness review of the program two weeks before the start-up date. These problems involved the basic start-up requirements that a transportation brokerage system should have ready before implementation: adequate phone lines and staff, adequate numbers of transportation providers, and all routine transportation trips scheduled. In addition, DMAS failed to ensure that one brokerage firm had a local office in each region, which was required in the contract. Unfortunately, because of its failure to identify these basic problems in advance, DMAS was forced to respond to these problems immediately after the implementation date.

The problems centered primarily on one contractor, DynCorp, which was awarded a contract to serve the majority of the State. The other contractor, Logisticare, has a smaller area of the State, which includes the former pilot programs and it is in mostly rural localities. Logisticare had the basic requirements completed prior to the implementation date.

Each of the major start-up problems with DynCorp is described briefly below:

- **DMAS did not adequately review the phone line and staffing capacity of the call centers.** Initial complaints focused primarily on busy phone lines, calls left unanswered, and long wait times to arrange transportation through the call centers. This was primarily due to the lack of high-speed phone lines (called T1 lines) and staff. According to a DMAS letter, DynCorp had one T1 line per 11,846 transportation users, while Logisticare had one T1 line per 3,197 transportation users. In addition, during high call volumes, DynCorp's proposal stated that calls would be transferred to a Missouri call center; this call center was not prepared to take Virginia calls.

- **DMAS did not take appropriate action to ensure that there were an adequate number of transportation providers to take recipients where they needed to go.** DynCorp did not have sufficient transportation providers on the start date. Although DMAS expressed concern about the lack of transportation providers in Region Three during the review, DMAS allowed DynCorp to begin operations in that region.

- **DMAS did not ensure that DynCorp had all routine visits scheduled and in the computer system.** Both the pilot programs and the brokerages claim that the majority of Medicaid transportation is for routine trips to service providers, such as dialysis centers and other community based providers. Once these trips are scheduled, the non-routine trips to a medical service are easy to manage. However, DynCorp did not have all of the routine trips scheduled and in the computer system prior to implementation. DynCorp stated that its problems were because it double-entered trip information and service providers did not provide the required information in a timely manner. In spite of this, DMAS should have ensured the routine visits were scheduled prior to implementation. The community service boards (CSBs) in the DynCorp area knew this trip scheduling had not occurred and tried to prepare for the lack of transportation services for their mentally ill and retarded clients.

- **DMAS allowed DynCorp to implement the program even though the company was not in contract compliance with the regional offices.** The DMAS contract requires that the broker set up offices in each of the regions contracted for services. The offices are responsible for working with and enrolling transportation providers. If DynCorp had all its regional offices in place, these offices could have increased the number of enrolled transportation providers before the start date.

According to the brokerage firms, DMAS could have avoided the initial high telephone volume at the call centers by initially informing only current recipi-

ents of transportation services about the change to the new transportation brokerage system. Instead, DMAS' memorandum concerning the change went to all Medicaid recipients, including those that have never utilized transportation services. This caused both brokerages to receive a large volume of telephone calls from recipients who wanted to know about Medicaid-funded transportation services. According to DMAS, due to the amount of inappropriate transportation, which it believes occurred historically, existing transportation claims data was of limited use in projecting the need for brokered services.

Once DMAS Realized the Magnitude of the Problems with the New Transportation System, Staff Responded Quickly

On the first day the new system was in effect, numerous complaints arose from transportation providers, Medicaid recipients, and Medicaid service providers regarding the adequacy of transportation services by the new transportation brokers, especially DynCorp. The CSBs, which provide services to mentally ill and mentally retarded clients, were especially concerned for the safety of clients who were totally dependent upon routine transportation services to attend their community-based services. Other providers, such as hospitals, dialysis centers, and nursing facilities also complained that their clients were not being transported to critical medical services.

While some complaints were expected due to the change of the program from a fee-for-service to a brokerage system, the level and the nature of the complaints highlighted serious operational issues that needed to be resolved immediately. While many of these problems should have been avoided, DMAS did respond quickly to legislative, provider, and consumer concerns. The following is a list of DMAS actions taken to improve the brokerage system:

- Issued a letter to Medicaid recipients residing in the DynCorp areas, which allowed them to revert back to the fee-for-service transportation system until September 1, 2001.

- Issued a warning letter to DynCorp citing contract deficiencies with inadequate phone lines, lack of staff, insufficient transportation providers, lack of scheduled routine visits in the computers, and inadequate regional offices. DMAS requested a corrective action plan for each deficiency.

- Conducted daily telephone conference calls with DynCorp and Logisticare staff to discuss problems with the brokers and plans of action to improve the system.

- Traveled to the Logisticare and DynCorp call center operations to meet with staff, to answer questions about Medicaid coverage, and to discuss how to handle unusual circumstances.

- Attended meetings with service providers and DynCorp to ensure provider concerns were resolved.

In spite of these efforts, DMAS did not adequately communicate its actions to fix the problem to service providers and recipients. This further exacerbated the problems and concerns about the new transportation system. For example, an initial July 3rd letter, which allowed recipients to revert back to the old transportation system, was posted on the DMAS website, but was not mailed to providers and recipients until July 24. This meant that some recipients were unaware of the important change until three weeks later. In addition, letters to recipients and service providers about the September 1st re-start date in the DynCorp regions were not sent out until August 24th, leaving service providers a short amount of time to prepare for the change. At that time, service providers were not certain whether DMAS was going forth with the new start-up date of September 1, 2001.

Complaints from Transportation Providers, Medical and Community Service Providers, and Recipients Reflect Contract and Operational Problems

While installing new phone lines and hiring more staff were immediate responses to start-up problems, ensuring an adequate number of transportation providers and scheduling routine visits for Medicaid clients took longer for the brokerage firms to achieve. Several contract and operational problems remain. These concerns are described in the following sections.

Contract Problems with Transportation Providers. The initial contract problems with DynCorp involved DMAS' requirements that transportation providers carry an additional $500,000 general commercial insurance, increase the automobile insurance to $500,000 from existing insurance requirements, and use drivers who are a minimum age of 20 years. Some providers did not agree with or could not afford these new requirements. DMAS addressed these problems by lowering the automobile insurance rates to State and local requirements, and by lowering the minimum age to 18 years. Another contract problem dealt with DynCorp's complicated reimbursement methodology, which differed from the former flat mileage rate system set by DMAS and the methodology used to set rates by Logisticare. One group of providers in a DynCorp region initially filed suit against the company regarding the contract requirements. While these providers have since dropped their lawsuit, they remain concerned that DynCorp is not honoring recently negotiated commitments.

Problems in the Logisticare area focused on high penalties imposed if transportation providers did not meet specific requirements. For example, if a provider was late for a pickup, Logisticare would reduce its reimbursement by a certain percentage, regardless of the reason for the delay. As a result of these complaints, many providers did not sign on with the new brokerages, which created a lack of providers.

Complaints from Medical and Service Providers. The primary concern of the service providers was the reliability of the transportation brokerage sys-

tem for getting recipients where they needed to go safely. Initially, hospitals reported that recipients sometimes had to stay overnight in the facility because transportation could not be arranged. Dialysis centers complained that recipients needing critical services were not being picked up. One newspaper article reported that a recipient had to walk 12 blocks to receive dialysis after a provider did not show up. One CSB reported that a transportation provider left a mentally retarded client unsupervised in the parking lot of a facility, more than 30 minutes before his scheduled appointment. Both brokerage companies have improved and continue to work on earlier problems with scheduling routine visits and poor transportation services by designating specific call center staff to work closely with service providers and transportation providers.

Another concern unique to the CSBs is the potential limits being placed by the transportation brokers on the types of Medicaid covered services that are considered valid for transportation services. For example, some CSBs have routinely billed DMAS for not only the round-trip to get the Medicaid recipient with mental retardation to a day support program (which is a Medicaid-covered service), but also the trips that are taken during the day as a part of socialization and community integration activities (such as trips to the shopping mall or the beach). One broker wants to deny transportation services for these socialization services, claiming that the trips are not for Medicaid-covered services. CSBs do not think a transportation broker should or is qualified to make determinations of what services on a client's care plan should be covered.

DMAS' contract simply indicates that the broker should provide transportation only to a Medicaid-covered service. At the present time, DMAS has not clearly defined what transportation services the brokers should cover. In the meantime, trip discrepancies between the brokers and the CSBs are handled by DMAS. It is important to note, however, that not all CSBs billed DMAS for these additional transportation services in the past. If more begin to do so, the increased costs will be borne by the broker and not DMAS. In an interview with JLARC staff, federal officials indicated that they support the use of Medicaid funds to transport persons with mental retardation to these non-traditional socialization activities.

Complaints Regarding Poor Transportation Services For Recipients. Recipients continue to lodge complaints about transportation providers who are late or do not provide a trip. However, the magnitude of the problem is unclear because there is no comparative complaint data from the fee-for-service system because no formal complaint process was in place. Initial data from the two brokers, however, indicate they are operating with less than a half-of-one percent complaint rate. In September 2001, DynCorp logged 946 complaints for 194,332 completed trips and Logisticare logged 143 complaints for 52,057 completed trips.

Although numerous complaints arose regarding the statewide brokerage system, the pilot programs encountered some similar implementation problems. During interviews with the staff of pilot programs, they cited problems with heavy call volumes and additional staffing requirements during the first two weeks of implementation, and transportation providers who would not sign contracts. One pilot program stated that transportation providers picketed outside one of the call center

offices. Exhibit 6 provides a comparison of implementation problems between the two programs. However, the program scope and the magnitude of the problems of the statewide brokerage system exceeded the program scope and the problems of the pilot programs.

Exhibit 6

Comparison of Implementation Issues between the Pilot Programs and the Statewide Brokerage of Medicaid Transportation Services

Implementation Issue	Pilot Program	Statewide Brokerage
• Transportation providers resistant to new system	√	√
• Large call volume during initial startup	√	√
• Extra staffing requirements during initial startup	√	√
• Complaints about the brokerage inappropriately denying transportation services	√	√
• Lack of transportation providers at start-up	N/A	√
• High percentage of complaints of transportation providers showing up late or not at all to pick up recipients	N/A	√

Note: N/A = not applicable.

Source: JLARC staff analysis of DMAS contracts with the pilot programs and the two brokerage companies, and interviews with staff from DMAS, the two pilot programs, and the two brokerages.

DMAS Plans to Continue Monitoring the Transportation Brokerage System

Virginia's Medicaid transportation brokerage system is still in the early implementation phase, so it is too early to determine the overall success of the program, though some improvements have been made. However, complaints about poor transportation in both brokers' regions remain a problem. DMAS plans to continue monitoring the brokerage system for contract and operational deficiencies to improve transportation services. As of October 30, 2001, DMAS monitoring has identified that DynCorp has not met all contract requirements including:

- lack of adequate management staff and appropriate local staff for regional offices,
- lack of appropriate transportation providers,
- non-compliant transportation vehicles,
- lack of appropriate reporting to DMAS and response to recipient complaints, and

- lack of education to recipients regarding the availability of non-emergency transportation services.

In addition to the ongoing monitoring of the contract and outstanding concerns, DMAS will need to closely monitor the impact of these additional issues:

- In December 2001, DMAS is expanding Medicaid HMOs statewide, which has the potential to move 81,800 fee-for-service recipients into these plans. It is unclear at this time what impact this will have on the transportation brokerage contracts, since the number of recipients and trips required are likely to decrease.

- In the spring of 2002, DMAS will have the results of the first recipient satisfaction survey, which will provide the first systematic indication of the quality of transportation services provided.

- With the implementation of prior authorization for non-emergency services, the pilot project staff stated that DMAS might see increased utilization and costs of emergency transportation services to avoid the intervention of the brokerage.

Because the implementation and development of the new transportation brokerage system is still ongoing and undergoing changes, DMAS should provide a status report to the General Assembly prior to the 2003 session.

Recommendation (8). **The Department of Medical Assistance Services should provide a status report to the Health and Human Resources Subcommittees of the House Appropriations and Senate Finance Committees on Medicaid-funded non-emergency transportation services by October 1, 2002. This report should address: (1) contract compliance by the two brokerage firms (including call center statistics, staffing, telephone lines, numbers of routine and non-routine trips scheduled, and the number of transportation providers); (2) the fiscal and program impact of the conversion of fee-for-service clients into managed care; (3) the results of recipient satisfaction surveys; (4) identified concerns of the recipients, transportation providers, and service providers, and how the concerns were addressed; (5) the impact the prior authorization for non-emergency transportation services has on the utilization and costs of emergency transportation services; and (6) the incidence of fraud and abuse for transportation services, including incidents found by the brokerage firms and those prosecuted through the Medicaid Fraud Unit.**

V. Medicaid-Funded Pharmacy Services

Another major factor driving increases in the Medicaid budget in recent years is pharmacy expenditures. Prescription drug coverage is an optional Medicaid benefit. However, all state programs provide this coverage for their Medicaid recipients. Virginia has covered prescription drugs since 1969. Medicaid policy for coverage of prescription drugs is set by individual states within broad federal guidelines. For example, federal guidelines require states to cover all drugs sold by manufacturers that have rebate agreements with Medicaid. States do have the ability to restrict access to these drugs, however, through prior authorization requirements and prescription limits.

The focus of the JLARC staff review is on prescription drug services for Medicaid recipients under the fee-for-service program. The recipients of these services reside in areas of the State that currently do not offer a Medicaid Health Maintenance Organization (HMO) plan or are exempted from inclusion in Medicaid HMO plans (such as persons in nursing homes, community-based waiver programs, and foster care).

Over the past five years, Virginia Medicaid prescription drug costs have increased 14 percent annually under the fee-for-service program to $341 million in FY 2001 (after drug rebates). Prescription drugs were the third fastest growing expenditure, behind Medicaid managed care coverage and mental health services, and accounted for 11 percent of the Virginia Medicaid budget in FY 2000. The rapid growth in prescription drug costs is a major concern for both private and state insurance programs. National studies indicate that the main factors for the increase in growth are the discovery of new drug treatments, the increased use of drugs in treatment, the increased advertising by drug manufacturers, and the growth in the elderly and disabled population. Many of these factors for expenditure growth are beyond the control of state Medicaid programs. However, states are attempting to control some expenditure growth through a variety of cost-saving alternatives.

The JLARC staff review of Virginia Medicaid-funded pharmacy services is a broad review of potential cost saving measures based upon a comparison of Virginia's Medicaid program with other state Medicaid programs. The Virginia Medicaid program currently has most of the common cost saving alternatives in place, but many are less restrictive than other state Medicaid programs. DMAS examines additional cost-saving measures on an ongoing basis and is currently pursuing the implementation of a tiered co-payment requirement and the expansion of its disease management program. However, more costs savings can be achieved. All of these cost alternatives, however, should be weighed against the impact that any restriction will have on overall health care costs and access to drugs for Medicaid recipients. For example, limiting access to some high cost drugs for conditions such as asthma, depression, or diabetes may only increase visits to the emergency room or to doctors. The JLARC staff review identified three improvements that DMAS should pursue: (1) improving the prior authorization process so that additional drugs, if

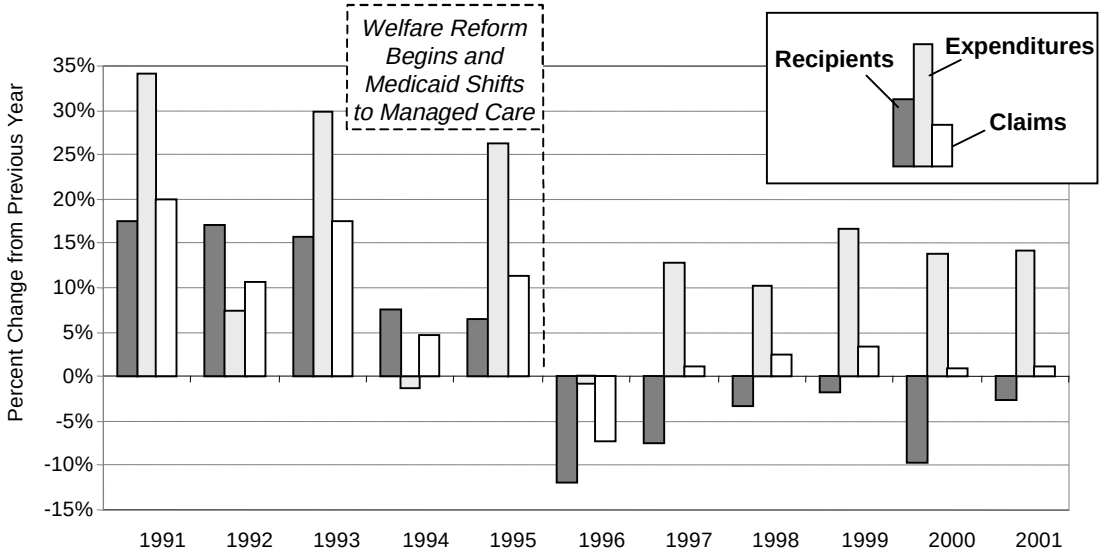
warranted, can be added; (2) lowering pharmacy reimbursement rates to accurately reflect current market prices; and (3) improving efforts to recover third-party payments for pharmacy claims.

UTILIZATION AND EXPENDITURE GROWTH IN MEDICAID-FUNDED PHARMACY SERVICES

For this review, trends examined for the utilization and expenditure growth in Medicaid-funded pharmacy services are limited to payments for fee-for-service recipients. Prior to December 1, 2001, fee-for-service recipients comprised approximately 70 percent of the enrolled Medicaid population. The remaining 30 percent of the Medicaid population receive pharmacy services under Medicaid health maintenance organizations (or HMOs). Despite the steady decline in the number of fee-for-service recipients with the expansion of managed care and as the result of welfare reform (both of which began in 1995), pharmacy expenditures and the number of pharmacy claims continue to increase at rates higher than the rate of inflation for pharmacy and medical services as measured by the consumer price index (CPI) for urban consumers (see Figure 9). In FY 2001, Virginia Medicaid pharmacy expenditures increased 14 percent to $341 million.

Figure 9

Comparison of Annual Changes in Virginia's Medicaid Pharmacy Recipients, Expenditures, and Claims FY 1991 - FY 2001



Note: Expenditure growth includes drug manufacturer rebates.

Source: DMAS' *The Statistical Record of the Virginia Medicaid Program and Other Indigent Health Care Programs*, FY 2000.

One change, which may affect pharmacy expenditures in the coming year, is the expansion of Medicaid HMO services statewide, effective December 2001. However, it is not clear what impact this will have because many elderly and disabled clients with long-term care service needs will be excluded from managed care.

Recent national studies have found that both increased prescription drug use and rising drug prices contribute to growing pharmaceutical costs. The following sections discuss the main factors influencing drug cost increases, such as the introduction and growth in new treatments, increased advertising, and a shift in demographics. Unfortunately, many of these factors are beyond the control of state Medicaid programs.

Medical Advances in Research and Technology Have Created New Drug Treatments and Increased Demand

Advances in technology have improved diagnosis rates, increased awareness, and created new drug treatments for diseases. From FY 1996 to FY 2001, the average annual number of prescriptions per Virginia Medicaid fee-for-service pharmacy recipient rose from 18.5 to 26 prescriptions. The demand for prescription drugs has increased as new drugs for previously ineffective treatments or untreatable diseases enter the market. For example, people are demanding drugs, such as Celexa® for depression, Claritin® for allergy relief, and Prilosec® for acid reflux, that provide an alternative to previously ineffective therapy. In addition, diseases such as AIDS, cancer, and rheumatoid arthritis, in many cases, now have multiple drug regimens in comparison to previous single drug regimens.

Unfortunately, the development of new drug treatments comes at a higher price than older treatments. In FY 2001, Virginia Medicaid pharmacy expenditures increased from the prior year ten times more than the pharmacy claims increased. This disproportionate change indicates a shift to higher priced drugs. New drugs are patented, which allow the manufacturer to have a monopoly on the supply and price of the drug for an average of 10 years. During this time, the price of the drug is considerably higher to allow the manufacturer to recoup the initial investment costs to develop the drug. Once the patent has expired, other manufacturers are allowed to compete and produce a similar product or generic form of the drug, which lowers the price. As more recipients take newer drug treatments with higher costs, pharmacy expenditures increase.

Advertising by Drug Manufacturers Has Increased Demand for Drug Treatments

Between FY 1996 and FY 2001, the average price per prescription (after rebates) for Virginia Medicaid recipients increased from $22.40 to $39.19. Another driving force in increased utilization and expenditures is the rising demand for newer drugs from increased advertising. In 1997, Food and Drug Administration (FDA) regulation changes in advertising allowed drug manufacturers to market their drugs in the media. Advertising directly to the consumer through television, radio, or magazines, creates an awareness of the new drug treatments available.

Subsequently, consumers demand these advertised drugs by name. An FDA study of the effects of increased advertising reported that 27 percent of respondents in a survey asked their doctor about a condition they had not been treated for before. Another survey by a leading health magazine found that doctors reported a 53 percent increase in the demand for brand name drugs advertised.

The Elderly and Disabled Groups Will Continue to Grow, Accounting for a Majority of the Pharmacy Expenditures

The average American is living longer due to advances in technology and medicine. According to the U.S. Census Bureau, the average life expectancy increased from 78.8 to 79.5 in the last 10 years. The number of older Americans will also increase in the coming years as the baby boomer generation ages. As the population lives longer, pharmaceutical expenditures, specifically in the elderly and disabled category, will continue to climb. A recent health policy report indicates that 45 percent of Americans live with at least one chronic illness and spend a disproportionate share of total medical costs to treat their illnesses.

In FY 2001, Virginia Medicaid's elderly and disabled population accounted for 43 percent of the pharmacy recipients, but they expended 87 percent of total pharmacy costs to treat their illnesses (see Figure 10). In particular, pharmaceutical expenditures for Virginia Medicaid recipients receiving prescription drugs were considerably higher for the elderly and disabled at $2,193 and $2,695 per recipient, respectively, than per indigent child or adult (at $291) in FY 2001 (see Figure 11). Consequently, the pharmacy cost to enroll each additional aged person is seven times more than the pharmacy cost to enroll an additional indigent child or adult.

VIRGINIA'S MEDICAID REIMBURSEMENT SYSTEM FOR PHARMACY SERVICES

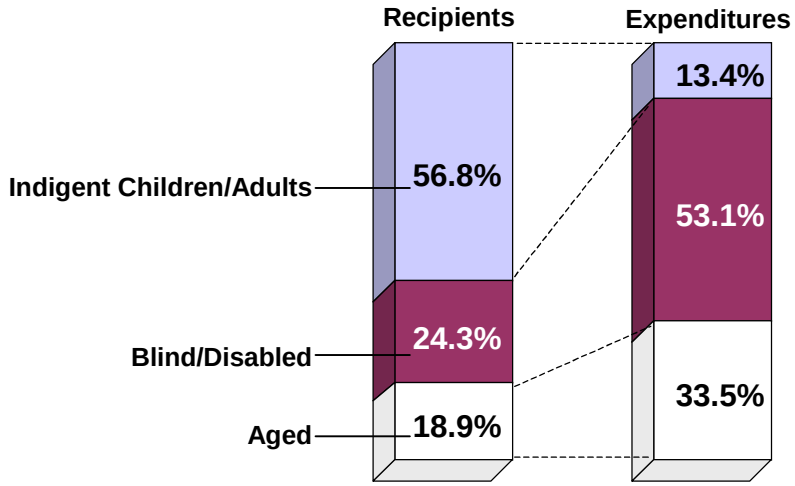
State Medicaid programs and private insurers reimburse pharmacies based on an acquisition cost and a dispensing fee. Each state sets its own acquisition cost and dispensing fee rates for the Medicaid program. States also receive a refund or rebate on their drug purchases based on an agreement with federal Medicaid and drug manufacturers. The following sections describe Virginia Medicaid's pharmacy reimbursement rates and drug manufacturer rebates.

Pharmacy Payments Include Acquisition Costs and Dispensing Fees

Acquisition costs are estimated by the state Medicaid program and cover the price paid by the pharmacy to the wholesaler. Dispensing fees cover the pharmacy's costs required to fill the prescription. Acquisition costs are determined by whether or not the drug is a single source (brand name with no equivalents) or a multiple source (a drug with generic equivalents). For example, Celebrex® is a brand name drug with no generic equivalent, while Motrin® is a multiple source

Figure 10

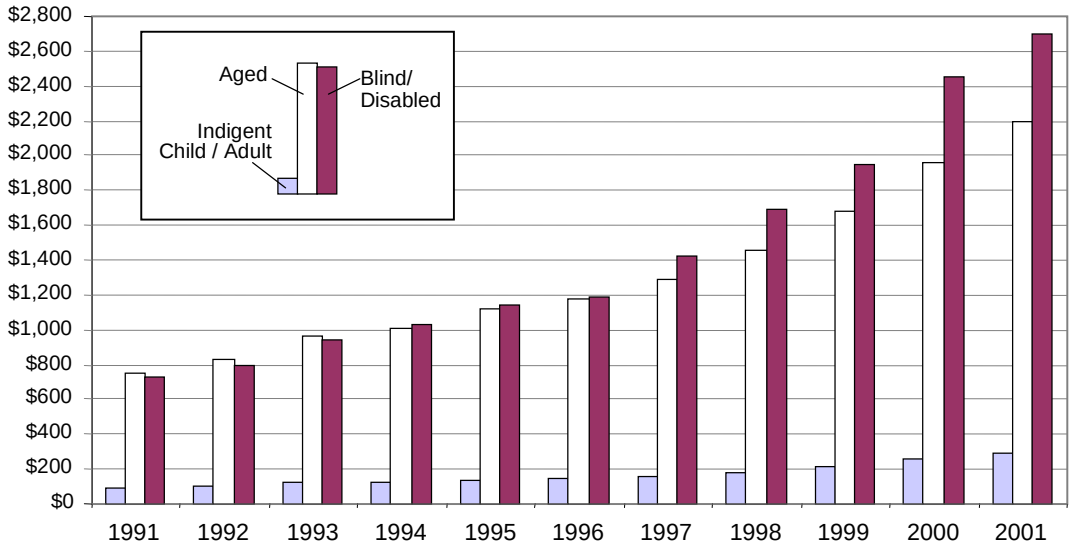
Comparison of Medicaid Pharmacy Expenditures and Recipients by Eligibility Group, FY 2001



Source: DMAS' *The Statistical Record of the Virginia Medicaid Program and Other Indigent Health Care Programs*, FY 2000.

Figure 11

Medicaid Pharmaceutical Expenditures Per Recipient by Eligibility Group, FY 1991 - FY 2001



Note: Estimates based on total expenditures (without drug manufacturer rebates) per pharmacy recipient.

Source: DMAS' *The Statistical Record of the Virginia Medicaid Program and Other Indigent Health Care Programs*, FY 2000.

drug, with several generic equivalents that use the active ingredient, Ibuprofen**.** DMAS determines the acquisition costs of a drug through the lower of the four prices listed:

- **Average Wholesale Price (AWP) minus nine percent**: AWP is the drug manufacturer's sticker price for a product. However, the sticker price is routinely discounted to pharmacies. In order to share in the additional savings the pharmacies gain between the sticker price and the discounted price, state Medicaid programs, HMOs, and state health programs reimburse pharmacies at AWP less a specific percentage. In Virginia, the percentage is nine percent.

- **Federal Upper Limits (FUL)**: FUL prices are for multiple source drugs that have at least three sources of supply. In general, the FUL price is 150 percent of the lowest price available nationally for a drug.

- **Virginia Maximum Allowable Cost (VMAC)**: VMAC applies to generic or multiple-source prescription drugs that have two sources of supply and are therapeutically and chemically interchangeable.

- **Usual and Customary Costs (U&C):** Virginia's U&C costs are determined by the price a cash-paying customer would pay at a pharmacy.

The use of FUL and VMAC require the use of generic drugs when available through federal and State guidelines. For example, if a pharmacist fills a brand name prescription that has a generic equivalent without a physician's handwritten "Brand Necessary" on the prescription, then the pharmacy will only be reimbursed at the generic rate. Exhibit 7 is an illustration of how pharmacy payments are determined based upon whether the drug is brand name (single source) or generic equivalent (multi-source) and the Virginia dispensing fee.

Dispensing fees account for approximately 10 percent of pharmacy payments and acquisition costs account for the remaining 90 percent. Nursing facility pharmacy payments are determined by the same formula described with the exception of unit-dose delivery. Nursing facilities may have a 24-hour single dose medication dispensing system for patients. In this case, separate packaging and handling charges are allowed. Only one dispensing fee is paid to the pharmacy per month for any specific product.

Manufacturer's Rebates Decrease Medicaid Pharmacy Costs

One major way that state Medicaid programs lower their acquisition costs is through drug manufacturer rebates (required as part of the Omnibus Budget and Reconciliation Act (OBRA) of 1990). OBRA '90 requires drug manufacturers to have a national rebate agreement with the federal government to receive federal funds for

Exhibit 7

Virginia Medicaid Pharmacy Payments: Acquisition Costs Plus the Dispensing Fees

Generic Equivalent/ Multi-Source Drug	Lower of • Federal Upper Limits (FUL) + $4.25 dispensing fee • Virginia Maximum Allowable Cost (VMAC) + $4.25 dispensing fee • Usual and Customary Costs (U&C) • Average Wholesale Price-9% (AWP-9%) + $4.25 dispensing fee
Brand Name/ Single Source Drug	Lower of • AWP-9% + $4.25 dispensing fee • U&C

Source: DMAS staff definitions.

drugs provided to Medicaid recipients. Under these agreements, state Medicaid programs receive rebates based on the difference between the average manufacturers' price and the best price offered to any wholesaler for each drug. In turn, states must include almost all drugs made by these manufacturers in their drug formularies. Rebates are allocated to federal and state governments according to federal participation rates (currently 51 percent in Virginia). Some states also have rebate agreements with drug manufacturers separate from the federal rebates. Virginia's total drug rebates average about 18 percent of the total pharmacy costs annually (all rebates revert back to the State general fund and do not directly reduce DMAS pharmacy costs). Virginia Medicaid pharmacy rebates reduced the totaled pharmacy payments by $72 million in FY 2001 from $413 million to $341 million.

VIRGINIA'S CURRENT COST CONTROL ALTERNATIVES FOR MEDICAID-FUNDED PHARMACY SERVICES

Experts predict that pharmacy cost increases will continue at a steady rate because many of the factors influencing the rising costs, such as the growing elderly and disabled population and the development of new drug treatments, are beyond the control of state Medicaid programs. However, several alternatives exist, and state Medicaid programs are using these alternatives to control some of the costs. Alternatives include obtaining additional discounts with manufacturers, limiting access to less cost-effective drugs through prior authorization and prescription limits, and monitoring patient usage with drug utilization review (DUR) procedures. The following section describes the common methods to control pharmacy costs, Virginia's current cost control practices, and the practices of other state Medicaid programs.

Virginia's Medicaid Program Utilizes Several Cost Control Alternatives for Pharmacy Services

DMAS has incorporated a variety of cost control methods over the years, including lowering acquisition costs and dispensing fee rates, enhancing DUR, and implementing a management program for specific high cost diseases (known as disease management). Exhibit 8, which begins below and continues over several pages, provides a description of the most common cost alternatives utilized by state Medicaid programs for pharmacy expenditures, a brief description of DMAS' current cost control methods, and the practices of other state Medicaid programs.

DMAS also has an advisory task force, known as the Pharmacy Liaison Committee. The General Assembly created this task force, consisting of representatives from community, chain, and nursing facility pharmacies, in 1996. The purpose of the task force is to assist DMAS in developing and implementing cost-saving initiatives for prescription drugs. DMAS meets with this group on a quarterly basis.

DMAS Plans to Implement Additional Cost Control Methods

DMAS continues to look at cost controlling methods and plans to implement two additional alternatives within the next year: implementation of a co-payment requirement and expansion of its disease management program. Each of these programs is described in the following sections.

Exhibit 8

Prescription Cost Control Alternatives, Current Practices of the Virginia Medicaid Program, and Comparisons with Other State Medicaid Programs

Cost Control Alternatives	Virginia's Medicaid Program	Other State Medicaid Programs*
Prescription Limits: Prescription limits can be placed on the number of day's supply, the prescriptions per month, and the refills per prescription.	• There is a prescription limit of 4 tablets in 30 days only on Viagra®. • A 34-day limit supply was included in 2001 budget • language, which did not pass. DMAS has not submitted it for incorporation into the Governor's 2002 budget.	• 27 states limit the number of day's supply from 30 to 100 days. • 11 states limit the number of prescriptions per month ranging from 3-10 prescriptions. • 14 states limit the number or refills per prescription. • 8 states (including Virginia) have no general prescription limits.

Exhibit continues on next page.

Exhibit 8 (continued)

Cost Control Alternatives	Virginia's Medicaid Program	Other State Medicaid Programs*
Drug Utilization Review (DUR): Retrospective and prospective DUR allows Medicaid to monitor medication use for safety purposes. DUR may be patient focused or through provider profiling. DUR can also serve as a cost containment tool to help further manage the use of expensive drug and drugs with the potential for misuse and abuse.	• DMAS operates DUR within federal requirements and has enhanced the program to evaluate recipient drug use and compare provider prescription practices. • Criteria set by the DUR Board include early refill and therapeutic duplication alerts in the Prospective DUR system used with the Point-of-Service on-line claims system. • Significant savings and cost deferrals have been experienced by judicious use of over-rideable denials on-line by pharmacists.	• As required by federal law, all states must have a DUR. • Information on the utilization of enhanced DUR in other states is unavailable.
Increased Patient Cost Sharing: This refers to co-payments required of recipients when receiving prescriptions.	• Co-payment is $1.00 for each prescription. Exceptions are for family planning drugs or drugs used for pregnancy related conditions, persons under age 21, or patients residing in a nursing home. • DMAS is considering tiered co-payments based on $1.00 for generic and $2.00 for brand name drugs. The proposal is in the regulatory process.	• 30 states use a co-payment where applicable. • 17 states use a tiered co-payment for brand and generic drugs. • Co-payments range from $0.50 to $2.00 (with the exception of Utah, which has a $5.00 co-payment).
Prior Authorization (PA): Whether or not a drug is on a drug list (or formulary), states may require physicians to request and receive official permission before a particular product can be dispensed. If a state requires prior authorization, it must respond to the request within 24 hours and provide a 72-hour supply in the case of an emergency.	• In 1993, the General Assembly created a PA Committee (PAC) and a process for including drugs in the PA program. No PA requirement was enacted by the PAC, which has not met in several years. • Prior authorization is required for drugs when used for weight loss as required by the legislature in the 1999 session of the General Assembly.	• 32 states are actively using a prior authorization system. • In 2000, states reported the number of PA requests ranged from 50 to 1.2 million and approvals ranged from 70-99 percent of the requests. • Some drugs requiring prior authorization include non-steroidal anti-inflammatories (NSAIDS), anti-ulcer, antipsychotics, antihistamines, hemophilia medications, and single source drugs.

Exhibit continues on next page

Exhibit 8 (continued)

Cost Control Alternatives	Virginia's Medicaid Program	Other State Medicaid Programs*
Drug Formulary: A formulary is a list of covered drugs. Almost all prescription drugs sold by a manufacturer with a drug rebate agreement are included on the Medicaid list or *open formulary*. However states can limit access to some drugs through prior authorization and drug limits, referred to as a *restricted formulary*.	• DMAS maintains an open formulary with few restrictions outside of federal regulations. • In 1996, the Governor proposed a restricted formulary but the General Assembly substituted an enhanced DUR.	• 46 states maintain an open formulary within federal guidelines. But access is restricted in 32 states through prior authorization of some drugs. • Two states, Florida and California have a unique *restricted formulary* that is limited to manufacturers who provide additional rebates to the mandatory federal rebates. Florida recently introduced this formulary. However, there is a lawsuit challenging its legality.
Disease Management: Disease management involves monitoring patients' drug therapy and medical services utilization with the goal of helping patients, typically with chronic diseases, to improve their health. This program can actually increase prescription costs, but has proven to lower overall health care costs.	• DMAS implemented disease management in 1996. • Program focuses on physician and pharmacist intervention for asthma/chronic obstructive pulmonary disease, hypertension/ congestive heart failure, depression, diabetes, and gastro-esophageal reflux disease/peptic ulcer disease • Preliminary estimates for disease management indicate net savings for the program. Cost avoidance in medical utilization ($1.29 million) offset by increased pharmacy expenditures ($209,909) and direct costs of quarterly interventions ($616,674) result in a 1.75:1 return on investment • A new plan is under development and may expand the range of diseases/intervention initiatives in mid 2002.	• 10 states operate a disease management program. • The number of diseases include in disease management varies among states. • Disease management programs exists for AIDS, asthma diabetes, congestive heart failure, hemophilia, hypertension, cancer, sickle cell anemia, diabetes, cerebral palsy, and liver disease. • Program designs vary. For example, some focus on educating the physician and others reimburse pharmacists for additional patient counseling.

Exhibit continues on next page

Exhibit 8 (continued)

Cost Control Alternatives	Virginia's Medicaid Program	Other State Medicaid Programs*
Lower Pharmacy Dispensing Fees: Dispensing fees are paid to cover the pharmacist's cost of dispensing a drug.	• In 1996, DMAS lowered the dispensing fee from $4.40 to $4.25.	• The average Medicaid dispensing fee is $4.32. • Some states vary dispensing fees depending upon the type of drug sold (brand or generic) or on the type of pharmacy (retail/nursing home, rural/urban, large/small).
Lower Acquisition Costs: Acquisition costs are determined by the estimated price paid by the pharmacist to the wholesaler. States estimate these costs based on a variety of formulas.	• DMAS reimburses pharmacies for acquisition costs based on the lower of (1) Average Wholesale Price (AWP) minus 9 percent (2) Federal Upper Limits (FUL) (3) Virginia Maximum Allowable Cost (VMAC) or (4) Usual and Customary rate (U&C). • In 1990, DMAS lowered the reimbursement rate from AWP only to AWP minus 9 percent based on a recommendation from an Office of the Inspector General report.	• Average AWP for other states is AWP less 10 percent. • Over 50 percent of the states use AWP as a determination of brand reimbursement rates. • 6 states include wholesale acquisition cost (WAC) plus a percentage, which is reported to be a more accurate determination of actual cost. • 4 states define the Usual and Customary charge (U&C) as the lowest price paid, which includes a private insurer.
Increased Monitoring of Fraud and Abuse: All state Medicaid programs are responsible for monitoring fraud and abuse.	• Increased emphasis on monitoring fraud and abuse among providers and recipients under Virginia Medicaid is handled through Provider or Recipient Review Units. Potential problems identified through other programs within Medicaid are referred to the appropriate section for action. • Suspected provider fraud is referred to the Medicaid Fraud Control Unit at the Office of the Attorney General, as required by Virginia Code.	• Utah reported $300,000 in savings through aggressive use of computer analysis to track patient and physician abuse of pharmacy services.

Exhibit continues on next page

Exhibit 8 (continued)

Cost Control Alternatives	Virginia's Medicaid Program	Other State Medicaid Programs*
Pooling Drug Purchases: A relatively new alternative, where states pool drug purchases to buy drugs at a discount and reduce costs.	• DMAS does not participate in cost pooling.	• Maine, Vermont, New Hampshire entered into an agreement to pool drugs purchases. • Six other states have met and agreed to bulk purchase drugs. • Both programs are very new and remain in the development and implementation phase.
Pharmacy Benefit Manager (PBM): Similar to a primary care physician for health care, a PBM administers the prescription drug portion of the health care insurance. PBMs are more common with managed care plans than with Medicaid plans.	• Most DMAS managed care plans have PBMs. However, there is no PBM in the fee-for-service pharmacy program.	• No states currently have a PBM for pharmacy services. However drug pooling among states may act as a PBM.

*Note: Comparisons exclude Tennessee and Arizona which use individual managed care and pharmacy benefit management organizations to make formulary/drug decisions.

Source: JLARC staff analysis based on DMAS staff interviews, a survey by the National Pharmaceutical Council of state Medicaid programs in 2000, and a JLARC staff literature review.

DMAS' Efforts to Introduce a Two-Tiered Co-Payment Requirement Should Reduce Pharmacy Costs. Patient cost sharing or co-payments require that the patient pay a nominal fee to receive the prescription. The main purpose of co-payments is to have the recipient share in some of the costs of prescription drugs. Co-payments also may discourage unnecessary utilization by recipients, thereby reducing overall Medicaid pharmacy expenditures. DMAS currently charges certain Medicaid recipients (with the federally mandated exception of children under the age of 21, recipients in nursing homes, or recipients receiving emergency services, pregnancy-related services or family planning services) a $1.00 co-payment for prescription drugs. The new plan is for a two-tiered co-payment system, which will require Medicaid fee-for-service recipients to pay $1.00 for generic and $2.00 for brand name drugs. The use of a two-tiered co-payment is currently in the regulatory process and should be implemented in early 2002. The projected Medicaid savings from this new co-payment requirement is $2 million (federal and State funds) per year.

Currently, 30 state Medicaid programs require some level of co-payment; 17 states have a similar tiered co-payment requirement. Virginia pharmacies oppose the change in the co-payment requirement for three reasons: (1) pharmacies may bear more of the financial burden of the increase than the recipients because

services cannot be denied if the recipient refuses to pay; (2) retail pharmacies that are located in areas with a high concentration of Medicaid clients may bear a higher financial burden due to a higher incidence of unpaid co-payments; and (3) it may reduce utilization of newer, more effective medications.

DMAS' Expansion of a Disease Management Program Should Improve the Overall Health Care of Medicaid Recipients. Disease management involves monitoring patients' drug therapy and utilization of medical services with the goal of helping chronically ill recipients improve their overall health. These programs manage chronic and high cost disease states through case management, and recipient and physician education. Although disease management programs tend to increase pharmaceutical expenditures, they have been proven to reduce overall health care costs by reducing unnecessary trips to the emergency room and the doctor.

In 1996, Virginia initiated a disease management program for asthma patients, resulting in a reduction of overall health care spending by $257,000 during a 20-month period. In 1999, DMAS expanded the program into other areas, including patients with diabetes, depression, hypertension/congestive heart failure, and gastroesophageal reflux disease/peptic ulcer disease. Preliminary DMAS data indicate a $500,000 savings (including administrative costs) in overall health costs over a two-year period. DMAS plans to further expand this program in early 2002 into other high cost areas. Some disease states under consideration include hemophilia, cystic fibrosis, AIDS, and HIV.

Currently ten states operate a disease management program to ensure that chronically ill patients' overall health care needs are closely monitored. The number of diseases included in these programs varies, as well as the design of the program. For example, some state programs focus on physician education and others focus on pharmacists counseling patients. Disease management can be an effective tool to reduce overall health care costs. However, states must maintain a good tracking system to monitor costs in other medical expenditure categories in order to measure whether there are actual cost savings.

POTENTIAL COST CONTROL ALTERNATIVES FOR VIRGINIA'S MEDICAID-FUNDED PHARMACY SERVICES

While DMAS has implemented a variety of cost control measures, its pharmacy coverage is less restrictive than other state Medicaid programs. For example, Virginia's Medicaid program does not have prescription limits (except for Viagra), does not actively utilize a prior authorization system, and pays more to pharmacies than the national average. In addition, DMAS is not collecting all of the third party payments it is due.

Each of these issues, except prescription limits, will be discussed in the following sections. JLARC staff did not address prescription limits in this study because simple limits, such as on the number of day's supplies, the number of prescrip-

tions per month, or the number of refills per prescription may not address the overall health care needs of the recipient over the long term.

In order to receive input from the major stakeholders on the advantages and disadvantages of all the cost containment measures, JLARC staff conducted a survey of selected groups. The groups that responded to the survey included DMAS' Pharmacy Liaison Committee, the Virginia Medical Society, and the federal Medicaid Pharmacy Technical Advisory Group. Each group was asked to provide the potential advantages and disadvantages for each the common cost containment alternative (shown previously in Exhibit 8 on pages 115-118). In addition, each group was asked to provide the potential impact of this alternative on physicians, recipients, pharmacies, and the DMAS administration of the program. JLARC staff also reviewed various national studies and reports on standard pharmacy cost containment methods. The input from these groups was utilized by JLARC staff, when appropriate, in the development of further improvements for pharmacy services provided under the Virginia Medicaid program.

The following sections address potential improvements DMAS can make in the prior authorization process, reimbursements to pharmacies and recovery of third party payments for pharmacy services.

The Current Prior Authorization Committee Is Ineffective and Should Be Redesigned

Prior authorization requires the physician to receive special permission from a State Medicaid staff member, or a DMAS contractor, before a particular drug can be dispensed. Under federal Medicaid regulations, states are allowed to implement prior authorization procedures. However, states must provide a response within 24 hours of a request for prior authorization and provide for the dispensing of at least a 72-hour supply in an emergency situation.

Virginia's Medicaid program currently limits only weight loss drugs through prior authorization, which was implemented at the direction of the General Assembly. Thirty-five states have active prior authorization programs, which range from selected brand name drugs to whole drug classes such as anti-ulcer medications. Some prior authorization procedures incorporate a "fail first" policy where patients first must prove the ineffectiveness of a less expensive drug before they can try using a more expensive alternative.

Prior authorization programs can reduce the use of high-cost potentially abusive drugs and ensure that the doctor justifies the medical necessity of the drug rather than bending to a patient's request for a specific drug. However, there are several disadvantages to a prior authorization program. For example, prior authorization requires additional administrative costs, which may outweigh the cost savings; it may restrict access to needed prescription drugs, which could result in higher costs in other healthcare areas; and it may deter the physician from using the appropriate medicine. Some critics question the cost effectiveness of prior authorization programs when most states end up approving 70 to 99 percent of the requests

for prior authorization (this does not take into account, however, the requests that are not made due to the prior authorization requirement).

However, other studies of state Medicaid programs have shown that prior authorization programs can be cost-effective. For example, Georgia's prior authorization for brand name non-steroid anti-inflammatories (NSAIDs) resulted in a projected annual savings of $7 million, and found no increase in the use or cost of physician or hospital services seven months after program implementation.

In 1993, the General Assembly directed DMAS to implement a prior authorization program for high cost drugs. The legislation established an advisory panel (called the Prior Authorization Committee) to determine and recommend certain drugs for prior authorization. However, DMAS has found the language that describes the prior authorization process to be burdensome and unnecessary. For example, Section 32.1-331 of the C*ode of Virginia* requires the committee to conduct public hearings and notify any manufacturer of the drug whose product is being reviewed before it can begin the process to recommend a drug for prior authorization to the Board of Medical Assistance Services (BMAS). If the recommendation is accepted by BMAS, then it must still go through the full Administrative Process Act (APA), which requires additional public comment.

DMAS staff commented that this dual public comment process can take up to two years. DMAS staff indicated that this public comment requirement, in addition to the APA, is an unnecessary burden, which has blocked DMAS from prior-authorizing any drug--even ones that could be deemed appropriate. No other Medicaid-funded service is required to go through such an onerous review process prior to making changes to the service. Instead, the Committee indicated that less burdensome options should be tried before administering an extensive prior authorization process. For example, an enhanced prospective drug utilization review (ProDUR) was recommended and later implemented by DMAS. Consequently, the committee has not met in several years and no drugs have been approved through this prior authorization process.

In order to allow the Prior Authorization Committee to select high cost or specialized drugs for prior authorization, the sections in the *Code of Virginia (*and the associated Medicaid State Plan and regulations) that mandates the process for prior authorization, should be streamlined. This should include, at a minimum, the removal of any public comment process before the APA process. The APA process is sufficient for a review of which drugs should be prior authorized. Language concerning the membership of the committee should be changed to include members from DMAS' Drug Utilization Review board. These members include physicians and pharmacists who could determine what drugs to recommend for prior authorization. In addition to the prior authorization committee, DMAS staff should be able to recommend potential drugs for prior authorization. DMAS staff have the expertise and the direct access to pharmacy and medical care claims to conduct a cost-benefit analysis and to determine the impact of the overall health of the recipient for any drugs they would recommend.

Recommendation (9). **The General Assembly may wish to amend Section 32.1-331.13-14 of the C*ode of Virginia* to facilitate the creation and operation of a prior authorization program for selected drugs, including but not limited to: (1) the removal of the public hearing requirement and special notice to drug manufacturers, (2) the addition of members from the Drug Utilization Review board to the Prior Authorization Committee, and (3) the addition of a provision stating that the Department of Medical Assistance Services staff should be able to recommend potential drugs for the committee to review. In addition, the General Assembly may wish to review and amend the committee membership requirements to ensure representation from all stakeholders.**

Recommendation (10). **The Department of Medical Assistance Services should annually develop a list of potential drugs for prior authorization by the Prior Authorization Committee. This list should be based on a thorough review of Medicaid pharmacy and other medical care claims in order to ensure that prior authorization will not inappropriately reduce access to this drug by recipients or increase their overall health and mental health care costs. In addition, a cost-benefit analysis and potential impact statement on the overall health of the recipient should be completed for each drug recommended for prior authorization.**

DMAS Should Reduce Reimbursements to Pharmacies to Reflect the National Average

Based on a comparison with other states' Medicaid programs and to private insurers, Virginia Medicaid reimbursement rates to pharmacies appear high. The reimbursement rate for pharmacists is one area in which DMAS does have some control over the costs of drugs. As previously discussed, DMAS determines the acquisition cost of a generic equivalent drug from the lower of: (1) Federal Upper Payment Limits, (2) Virginia Maximum Allowable Costs, (3) Usual and Customary rates, or (4) Average Wholesale Price minus nine percent. For brand name drugs, the acquisition cost is the lower of (1) Average Wholesale Price minus nine percent or (2) Usual and Customary rates. In addition to the acquisition cost, DMAS reimburses pharmacies a dispensing fee of $4.25.

Two of these pricing mechanisms, the Federal Upper Payment Limits and the Virginia Maximum Allowable Costs, are not subject to state adjustment because they are set by federal guidelines or reflect current market rates. On the other hand, the discount rate for the Average Wholesale Price (AWP) and the definition of the Usual and Customary (U&C) cost are set by the states and can be adjusted to achieve cost savings. JLARC staff found that these two reimbursement rates are more generous than other state Medicaid programs or prices paid by private insurers and should be reduced.

Cost Savings May Be Achieved by Changing the Average Wholesale Price (AWP) Rates. In 1990, DMAS reduced the pharmacy acquisition cost rate

from AWP only to AWP minus nine percent, with a dispensing fee of $4.25. However, a comparison of Virginia's AWP rate to other state Medicaid programs and private insurers indicates that DMAS pays a higher acquisition cost rate for brand name drugs. According to a National Pharmaceutical Council survey of state Medicaid programs in 2000, the average state Medicaid rate is AWP minus 10 percent with a $4.32 dispensing fee. Table 3 is a comparison of Virginia's dispensing fees and reimbursement rates to neighboring states. It is important to examine both dispensing fees and reimbursement fees because some states compensate for lower acquisition reimbursement rates with higher dispensing fees. Virginia's AWP reimbursement rate is higher than neighboring states.

Table 3

Medicaid Pharmacy Payment Rates for Virginia and Neighboring States

State	Dispensing Fees	Reimbursement rates
Kentucky	$4.75 (outpatient) $5.75 (long-term care)	AWP minus 10 percent
Maryland	$4.21	AWP minus 10 percent
North Carolina	$5.60	AWP minus 10 percent
South Carolina	$4.05	AWP minus 10 percent
Virginia	$4.25	AWP minus 9 percent
West Virginia	$3.90 (plus extra fees for compounding)	AWP minus 12 percent

AWP=Average Wholesale Price

Note: Tennessee has individual managed care and pharmacy benefit management organizations that make drug decisions.

Source: National Pharmaceutical Council Survey 2000.

In addition, a leading drug manufacturer's report on health care trends indicates that in 1999, the HMO average reimbursement rate was AWP minus 14 percent, and a survey by an on-line newsmagazine for pharmacists reported a similar reimbursement for community pharmacies at AWP minus 13 percent. These comparisons indicate that Virginia Medicaid's reimbursement rates are higher than other states' Medicaid programs and private managed care rates.

According to responses to the JLARC staff survey, pharmacy groups are concerned that if Medicaid reimbursement rates were adjusted, some pharmacies would be forced out of business, particularly rural and community pharmacies, thereby restricting access to drugs for the Medicaid population. According to DMAS staff, before any adjustments are made, the agency is required to conduct a survey to accurately determine this and appropriately adjust the AWP rate. To address the pharmacy group concerns, DMAS should determine whether reimbursement rates need to reflect cost differences based on geographic location, size, and type of pharmacy provider to ensure access to services by all Medicaid recipients (as practiced in five other states and recommended in a 1993 JLARC study on pharmacy costs).

JLARC staff estimate that the costs savings for increasing the AWP discount from nine percent to a range of ten percent to 14 percent, which reflects the average state Medicaid program and private insurer rates, to be from $4.5 million to $22.7 million (both State and federal funds). Estimated savings do not include the possible fee-for-service expenditure reduction in pharmacy claims that may occur with the statewide expansion to managed care in December 2001. However, highest cost users, the elderly and disabled are not expected to move into managed care plans. The potential cost savings are summarized in Table 4.

Table 4

Potential Cost Savings of Changing the Average Wholesale Price (AWP) Paid to Pharmacies for FY 2002

Options	Potential Savings
AWP minus 10 percent	$4,551,407.67
AWP minus 11 percent	$9,102,815.34
AWP minus 12 percent	$13,654,223.01
AWP minus 13 percent	$18,205,630.68
AWP minus 14 percent	$22,757,038.35

Note: Cost savings (both State and federal funds) are forecasted with annual 25 percent increases based on single source and brand name expenditures between 1997 and 1999. Estimated savings do not include the possible fee-for-service expenditure reduction in pharmacy claims that may occur with the statewide expansion to managed care in December 2001. Estimates assume that the dispensing fee remains at $4.25.

Source: JLARC staff analysis based on Department of Medical Assistance Services claims data for single source and brand name drugs from 1997-1999.

Although the majority of state Medicaid programs reimburse brand name drugs at the AWP rate, some state programs have started to use another method to determine acquisition costs, the Wholesale Acquisition Cost (WAC) plus a specific percentage. Unlike the AWP rate, which is based on the suggested retail price or the sticker price by the drug manufacturer, WAC is determined by the actual price paid to the wholesaler. With the WAC rate, states add on a percentage to allow pharmacies to incorporate shipping and handling costs. For example, some states reimburse at WAC plus seven percent. Currently, six state Medicaid programs use the WAC pricing system rather than the AWP or in addition to AWP as part of determining the best method for achieving the lowest acquisition costs. Use of WAC as part of the acquisition cost determination would likely capture additional discounts the pharmacy may receive and provide additional savings to the Medicaid program. The cost savings for this acquisition rate is unknown, but is likely to be equal to or better than the savings attributed to changing just the AWP rate alone. Therefore, DMAS should examine both of these pricing mechanisms to determine which provides the Commonwealth the best overall savings and still provides appropriate access for Medicaid recipients.

Recommendation (11). **The General Assembly may wish to direct the Department of Medical Assistance Services (DMAS) to conduct a survey to determine the Average Wholesale Price (AWP) and the Wholesale Acquisition Cost (WAC). Based upon the survey results, DMAS should develop and implement a plan by July 1, 2002 to: (1) increase the AWP discount rate to more accurately reflect national averages and (2) determine whether to incorporate or replace the AWP with the use of the Wholesale Acquisition Cost (WAC) plus a percentage.**

Change the Definition of the Usual and Customary (U&C) Rate. The second change to the acquisition cost that may provide additional cost savings to the Commonwealth is to change the definition for the Usual and Customary (U&C) rate. Virginia Medicaid defines U&C as the price paid by a cash-paying customer. However, some state Medicaid programs define U&C differently. For example, Georgia defines the U&C as the lowest or best price a pharmacist charges to any other payer (including HMO customers, who are usually charged the lowest price). Maine, North Carolina, Massachusetts, and Rhode Island also have this "best price" definition in their state Medicaid regulations. DMAS should define the U&C rate as the best price paid by any other payer in order to ensure that Medicaid reimbursements accurately reflect the average price paid by health insurers. In addition, DMAS should determine the potential cost savings as the result of this change.

Recommendation (12). **The General Assembly may wish to direct the Department of Medical Assistance to promulgate regulations by July 1, 2002 to change the definition for its Usual and Customary reimbursement rate to the lowest price a pharmacist charges to any other payer.**

DMAS Is Not Collecting $10 Million Annually in Third Party Pharmacy Payments

Many Virginia Medicaid recipients have other pharmacy coverage through private health insurance or other State and federal programs, such as workmen's compensation or Medicare. Since Medicaid is a payer of last resort, other insurance providers or "third parties" are liable for claims that providers send to Medicaid. When claims involve a liable third party, state Medicaid programs can either use a cost-avoidance system or a "pay and chase" system. Under the cost avoidance system, which is the traditional method employed for most types of third party claims, Medicaid programs return the claims to the pharmacies to bill the third parties first. Under the "pay and chase" system, the Medicaid programs assume responsibility for getting the third party payment by paying pharmacies for the claims first and then recovering these payments from third party companies. The latter payment method is only available to states that have obtained a waiver from the federal government and have proven the "pay and chase" method to be cost-effective.

Thirty-five states, including Virginia, use the pay-and-chase method for pharmacy claims. The primary reason states utilize this method is to reduce the

administrative and financial burden on pharmacies associated with billing third party payers prior to billing the Medicaid program so they will continue to serve Medicaid recipients. According to a recent report by the federal Office of the Inspector General (OIG), some pharmacies do not have billing systems that allow them to bill two payers at the same time, and some third parties pay the policy holder directly and not the pharmacy.

According to the OIG report, over 30 of the "pay and chase" states, including Virginia, lost more than 80 percent of the Medicaid payments they tried to recover from third party payers. In 1999, Virginia Medicaid paid and chased $11.9 million to third party payers, yet only recovered $1.5 million for a loss of more than $10 million dollars. The OIG report indicates that state Medicaid programs have difficulty recovering these third party payments for the following reasons: denials due to incompatible claim formats, unreasonable filing time limits, unprocessed claims with no explanation, vague denials, and the inability to identify the liable payer or claims processing entity. Many of the problems occurred with the third parties' pharmacy benefit management (PBM) company who acts as a gatekeeper for the insurer.

The OIG report provides a list of best practices to improve recovery of third party payments. These practices include moving to a cost-avoidance system, sharing information with third parties to keep beneficiary coverage updated, billing the insurance provider directly and avoiding the PBM, improving system compatibility and claim formats with third parties, and taking legal action with third party payers.

DMAS staff should review the best practices described in the OIG report to improve its methods for recovering third party payments and develop a plan for doing so. DMAS also needs to reexamine the advantages and disadvantages for moving to a cost avoidance approach (as 12 of the 35 other "pay and chase" states are considering). DMAS should consider the impact this change will have on Medicaid recipients and pharmacies.

Recommendation (13). **The General Assembly may wish to direct the Department of Medical Assistance Services (DMAS) to examine its current method for recovering third party payments for pharmacy claims, including the cost feasibility for moving to a cost avoidance system. Based upon this review, DMAS should develop and implement a plan for improving third party payment recovery for pharmacy claims, to become effective by July 1, 2002.**

Appendixes

Appendix A

Study Mandate

Senate Joint Resolution No. 441
2001 Session

Directing the Joint Legislative Audit and Review Commission to conduct an evaluation of the development, management, utilization, and funding of health and mental health services provided through the Department of Medical Assistance Services.

WHEREAS, the Department of Medical Assistance Services (DMAS) and the Board of Medical Assistance Services were established by Chapter 781 of the 1984 Acts of Assembly to perform certain functions that were previously performed by the Department of Health and the Board of Health; and

WHEREAS, § 32.1-325 authorizes the "Board, subject to the approval of the Governor...to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto"; and

WHEREAS, the primary responsibility of DMAS is to administer the state plan for medical assistance services (Medicaid) as approved by the Secretary of the United States Department of Health and Human Services by developing regulations to implement federal and State laws governing Medicaid and by processing Medicaid payments; and

WHEREAS, in addition to Medicaid, DMAS administers a number of other programs, including the Indigent Health Care Trust Fund, the State/Local Hospitalization Program, health insurance premium assistance for HIV-positive individuals, and the Family Access to Medical Insurance Security Plan (FAMIS); and

WHEREAS, the appropriation for DMAS has grown from $597 million in fiscal year 1986 to $3.2 billion as proposed by the Governor for fiscal year 2002; and

WHEREAS, the number of DMAS employees has grown from 183 full-time equivalent positions (FTEs) in fiscal year 1986 to 312 FTEs as proposed by the Governor for fiscal year 2002; and

WHEREAS, the DMAS appropriation proposed by the Governor for fiscal year 2002 is almost 54 percent of all funds and 60 percent of general funds proposed for the Office of Health and Human Resources; and

WHEREAS, by using Medicaid to meet the costs of some state programs, the Commonwealth has been able to shift some of the cost burden of health and mental health care to federal trust funds; and

WHEREAS, shifting the cost burden to federal trust funds means that a greater share of services delivered by the affected state programs is subject to decision-making by DMAS and federal laws and regulations that govern Medicaid; and

WHEREAS, the continuous growth in Medicaid expenditures and the degree to which indigent persons and people with disabilities now rely on Medicaid to fund basic health and mental health services make it incumbent upon the Commonwealth to ensure the most efficient and effective administration of the Medicaid program; and

WHEREAS, concerns about communication between DMAS and providers and recipients of health care services prompted the 1999 Session of the General Assembly to add § 32.1-324.2 to the Code of Virginia, which requires the Director to report to the Governor and members of the General Assembly "the activities of facilitating communication between the Department and providers and recipients of health care services"; and

WHEREAS, in March 2000, the federal Health Care Financing Administration declined to renew the Medicaid Intensive Assisted Living Waiver, which had been used as a Medicaid-funding alternative to nursing facility placement; and

WHEREAS, strong concerns have been raised by consumers, family members, and providers about the administration of the Medicaid home- and community-based mental retardation waiver; and

WHEREAS, Virginia is among the states that for a variety of reasons have been unable to spend millions of federal matching dollars allocated for the State Children's Health Insurance Program, despite the documented needs among Virginia's uninsured low-income children; and

WHEREAS, during the last decade, the Joint Legislative Audit and Review Commission (JLARC) has reviewed various components of the Medicaid Program, including hospital services, long-term care, physician and pharmacy services, asset transfers and estate recovery, reimbursement to hospitals and nursing facilities, and expenditure forecasting; and

WHEREAS, JLARC has not been asked to conduct a comprehensive evaluation of the health and mental services funded by DMAS, including how the agency's mission and responsibilities, leadership and decision-making, staffing, communication, and technology impact the development, management, utilization, and funding of the services provided; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Legislative Audit and Review Commission be directed to conduct an evaluation of the development, management, utilization, and funding of health and mental health services provided through the Department of Medical Assistance Services. JLARC

shall examine, but is not limited to, (i) the appropriate role and mission of DMAS in relation to indigent health care policy for the Commonwealth; (ii) how the leadership and decision-making processes and internal and external communications impact the development, management, and utilization of health and mental health services; (iii) the adequacy of current resources (staff and technology) to develop and manage health and mental health services; (iv) the adequacy and appropriate use of federal and state funds for services; and (v) a comparison of Virginia's provision of Medicaid-funded health and mental health services, such as child health, long-term care services and waivers, and mental health services, with other states.

All agencies of the Commonwealth shall provide assistance to the Joint Legislative Audit and Review Commission for this study, upon request.

The Joint Legislative Audit and Review Commission shall complete its work in time to submit its findings and recommendations by November 30, 2002, to the Governor and the 2003 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix B

Mental Retardation Services, Funding Streams, Eligibility Criteria, and Emergency Requests

Exhibit B-1

Description of Services Provided by the Mental Retardation Waiver

Residential Support Services: These consist of training and support provided primarily in a consumer's home or in a licensed/certified residence considered to be his or her home. They are designed to enable a consumer to acquire, improve, or maintain the health status and functional skills necessary to live in a community setting. Settings may be congregate or in-home/supported living. This may include specialized supervision or support needed by a consumer with challenging behavior. Emphasis is on a person-centered approach that empowers and supports each individual in developing his or her own lifestyle. It may not include room and board.

Personal Assistance Services: These are available to consumers who do not receive Residential Support Services and for whom training and skills development are not primary objectives or are received in another service or program. These services include assistance with personal care, activities of daily living, and medication or other medical needs; access to community resources; and, monitoring of health status. It may include supervision to ensure a consumer's safety. These services may be provided in residential and/or non-residential settings to enable a consumer to maintain the health status and functional skills necessary to live in the community and participate in community activities.

Respite Care: This provides temporary, substitute care normally provided by family or other caregivers. It is provided on a short-term basis because of the emergency absence of or the need for relief by those persons who normally provide care. It is provided in a consumer's home or other community residence, or in an alternative community respite site.

Nursing Services: This is for persons with serious medical conditions and complex health care needs that require specific skilled nursing services ordered by a physician, which are not available under the Medicaid State Plan. It is necessary to enable a consumer to live in a non-institutionalized setting in the community and cannot be provided by non-nursing personnel. It is provided in a consumer's home and/or other community setting on a regularly scheduled or intermittent need basis.

Environmental Modifications: This includes structural modifications to homes, work sites, or family vehicles. Modifications are provided as needed only for situations of direct medical or remedial benefit to the consumer. These are provided primarily in a consumer's home or other community residence. Modifications may not be used to bring a substandard dwelling up to minimum standards.

Assistive Technology: This includes adaptive devices, appliances, and/or controls that enable a consumer to be more independent in personal care, activities of daily living, and communication.

Day Support Services: These are provided primarily in non-residential settings, separate from the home or other community residence, to enable a consumer to acquire, improve, and maintain maximum functional abilities. This service includes a variety of training, support, and supervision offered in a setting that allows peer interactions and an opportunity for community and social integration. These services may be provided in the community or in a center-based program.

Exhibit continues on next page.

Exhibit B-1, continued

Description of Services Provided by the Mental Retardation Waiver

Supported Employment: This is paid employment for persons with mental retardation for whom competitive employment at or above the minimum wage is unlikely and who, because of the disability, need intensive ongoing support, including supervision, training, and transportation to perform in a work setting. Supported employment is conducted in a variety of community work sites where non-disabled persons are employed.

Therapeutic Consultation: Therapeutic Consultation is consultative services provided by members of the psychology, therapeutic recreation, speech therapy, occupational therapy, physical therapy or behavioral disciplines to assist the individual, parent/family members, residential support providers and day support providers in implementing an individual service plan.

Crisis Stabilization: This is direct time-limited intervention to persons with mental retardation who are experiencing serious psychiatric or behavioral problems which jeopardize their current community living situation. This service provides temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional admission or to prevent other out of home placement.

Personal Emergency Response Systems (PERS): This is an electronic device that enables individuals, who are alone for significant parts of the day, to secure help in an emergency. The system is connected to the phone and programmed to signal a response center once a help button is pressed.

*** Adult Companion Services:** Companions may assist or supervise the individual with such tasks as meal preparation, community access, laundry and shopping, but do not perform these as discrete services. These services do not include hands-on nursing care.

*** Consumer Directed Services:** This option affords clients and family caregivers direct control over who, how and when services are provided and is available for personal assistance, respite care, and adult companion services.

* Adult Companion Services and Consumer Directed Services are the new services offered through the new MR waiver. However, Consumer Directed Services are merely new ways for consumers and families to obtain previously available services.

Source: DMAS new mental retardation waiver application, September 2001.

Exhibit B-2

Past and Current Funding Streams for Mental Retardation Waiver Services

Prior to July 1, 1999

State general funds were allocated to the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) for existing and new Medicaid MR community services. DMHMRSAS allocated these funds according to a formula to Community Service Boards (CSBs) to spend at their discretion on new Medicaid MR waiver or MR State Plan Option services. CSBs would return a portion of these funds to DMHMRSAS for new MR Waiver services. DMHMRSAS would transfer state general funds to the Department of Medical Assistance Services (DMAS) for both new and existing services to draw the federal match. All federal matching funds were filtered through DMAS' budget.

From July 1, 1999 to July 1, 2000

Base funding was allocated as explained above.

The additional allocation of about $20 million for MR Waiver services was distributed based on each CSB's proportion of the waiting list for new services. CSBs would report to DMHMRSAS when they spent a portion of their allocation for new services. The rest of the process is the same: DMHMRSAS would transfer these funds to DMAS to draw the federal match. All federal matching funds were filtered through DMAS' budget.

July 1, 2000 to Present

The MR Waiver budget was transferred to DMAS effective July 1, 2000. All federal and state general funds are now filtered through the DMAS budget, and the tracking system switched from money-based to slot-based. While CSBs continue to submit requests to increase services and add new clients, DMAS tracks program funding and handles paying providers.

Source: JLARC staff interviews with DMAS and DMHMRSAS staff, summer 2001.

Exhibit B-3

Past and Current Versions of Eligibility Criteria for Mental Retardation Waiver Services from June 1999 to Present

June 1999 to August 2000

Priority Category

The individual must meet one of the eligibility criteria below and one of the following criteria:

- Caregivers have become unable to provide care for reasons such as illness, age, or infirmity;
- the individual is aging out of foster care, Comprehensive Services Act (CSA), or special education;
- caregivers need supports to enable them to work outside the home;
- the family situation involves real or potential abuse or neglect; or
- other critical emergency situations apply that, without MR Waiver services, would cause the individual to not be able to remain in his or her home.

Eligibility Criteria for Admission to the MR Waiver

The individual must meet all of the following basic criteria:

- The individual is Medicaid-eligible;
- The individual must have a diagnosis of mental retardation, or if under age six, be at risk for development delay; and,
- the individual must meet at least two of the Level of Functioning criteria for admission to an ICF/MR facility.

August 2000 to October 2001

Emergency Category*

The individual must meet the eligibility criteria below and one of the following criteria:

- The primary caregiver has a serious illness, has been hospitalized, or has died;
- the individual has been determined by the Department of Social Services to have been abused or neglected and needs immediate services;
- the individual has behaviors which present risk to personal or public safety;
- the Individual presents extreme physical, emotional, or financial burden at home and the family/caregiver is unable to provide care; or
- the individual is aging out of publicly funded residential placements or otherwise becoming homeless.

Eligibility Criteria for Admission to the MR Waiver

The individual must meet all of the following criteria:

- The individual must have a diagnosis of mental retardation, or if under age six, be at risk for development delay;
- the individual must meet at least two of the Level of Functioning criteria for admission to an ICF/MR facility; and
- there must be a reasonable indication that the individual might need ICF/MR services in 30 days or less.

October 2001 to present

Urgent Category

The individual must meet the eligibility criteria below and one of the following criteria:

- Both of the birth or adoptive parents are 55 years or older;
- the individual is living with a person other than the birth or adoptive parents who is providing the service voluntarily and without pay, and the person who has been providing the care indicates that he or she can no longer care for the person with mental retardation;
- there is a clear risk of abuse, neglect, or exploitation;
- either of the birth or adoptive parents has a chronic and/or long term physical or psychiatric conditions(s) which limits significantly his or her ability to care for the person with mental retardation;
- the individual is aging out of publicly funded residential placement or otherwise becoming homeless; or
- the individual lives with the birth or adoptive parents and there is a risk to the health or safety of the individual, parent, or other individual living in the home due to either of the following conditions: (1) the individual's behavior(s) presents a risk to self or others which cannot be effectively managed by the parents, even with generic or specialized support arranged or provided by the CSB; or (2) there are physical care needs (such as lifting or bathing) or medical needs, which cannot be managed by the parents, even with the generic or specialized supports arranged or provided by the CSB.

Exhibit continues on next page.

Exhibit 3, continued

Recent Past and Current Versions of Eligibility Criteria for Mental Retardation Waiver Services from June 1999 to Present

October 2001 to present, continued

Eligibility Criteria for Admission to the MR Waiver

The individual must meet all of the following criteria:

- The individual must have a diagnosis of mental retardation, or if under age six, be at risk for development delay;
- the individual must meet at least two of the Level of Functioning criteria for admission to an ICF/MR facility; and
- there must be a reasonable indication that the individual might need ICF/MR services in 30 days or less.

Planning Category

In the past DMHMRSAS has planned separately for individuals expected to age out of Comprehensive Services Act, foster care, and special education programs in the near future and those ready for discharge from institutions. DMHMRSAS has not defined this yet.

* These emergency criteria were originally applied to services for new clients and service enhancements for existing clients. Criteria for service enhancements were changed officially in February 2001 to meet clients' health and safety needs.

Source: Letters and memos provided by DMAS and new MR waiver regulations.

Table B-1

Emergency Requests for Mental Retardation Waiver Service Enhancements from August 2000 through July 2001

Month	Number of Requests	Number Approved	Number Denied
August 2000*	12	12	0
September 2000	137	107	29
October 2000	61	44	16
November 2000	12	12	0
December 2000	40	39	0
January 2001	51	51	0
February 2001	59	59	0
March 2001	88	85	3
April 2001	111	106	4
May 2001	79	79	0
June 2001	121	101	9
July 2001	120	91	2
Total**	**891**	**786**	**63**
Monthly Average	**74**	**66**	**5**

* DMAS did not begin collecting data for August 2000 until August 23, 2000.

** The sum of the requests approved and denied does not equal the total number of requests because 42 requests were pending further information.

Source: DMAS internal report.

Table B-2

Emergency Requests for Mental Retardation Waiver Slots from August 2000 through July 2001

Month	Number of Requests	Number Approved	Number Denied
August 2000*	30	28	2
September 2000	198	122	77
October 2000	96	70	25
November 2000	58	51	7
December 2000	5	3	1
January 2001	49	39	4
February 2001	59	42	9
March 2001	87	79	5
April 2001	93	68	11
May 2001	79	70	8
June 2001	168	87	50
July 2001	88	54	22
Total**	**1010**	**713**	**221**
Monthly Average	**84**	**59**	**18**

* DMAS did not begin collecting data for August 2000 until August 23, 2000.

** The sum of the requests approved and denied does not equal the total number of requests because 76 requests were pending further information.

Source: DMAS internal report.

Appendix C

Agency Response

As part of an extensive data validation process, the major entities involved in a JLARC assessment effort are given an opportunity to comment on an exposure draft of the report. Appropriate technical corrections resulting from the written comments have been made in this revision of the report. This appendix contains the written response of the Department of Medical Assistance Services.

DEC 7 - 2001

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

ERIC S. BELL
DIRECTOR

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December 7, 2001

Mr. Philip A. Leone
Director
Commonwealth of Virginia
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Capitol Square
Richmond, Virginia 23219

Dear Mr. Leone:

Enclosed please find the DMAS' response to your draft of the *Interim Report: Review of the Virginia Medicaid Program.* We appreciate the opportunity of providing you with our comments.

Should you have any questions, please do not hesitate to call.

Sincerely,

Eric S. Bell
Director

ESB/bws

Enclosure

Department of Medical Assistance Services Response to

The *Interim Report: Review of the Virginia Medicaid Program*

Virginia's Department of Medical Assistance Services (DMAS) is in receipt of your draft report entitled *Interim Report: Review of the Department of Medical Assistance Services*. Please consider this letter as a formal response to your report. DMAS greatly appreciates the opportunity to respond to several issues in the report and hopes these comments will be incorporated into the report's final version.

Within the body of this letter DMAS will outline its comments in four sections based upon the structure of your report. The sections reviewed include: The Child Health Insurance Program; The Mental Retardation Waiver Program; Medicaid-Funded Non-Emergency Transportation Services; and Medicaid-Funded Pharmacy Services. DMAS is basing its comments on the following criteria; factual errors, errors of omission, balance or objectivity, and recommendations. Given the limited time line offered by JLARC of two business days to respond to the interim report's draft findings, DMAS was only able to offer comments and feedback that were readily apparent. DMAS was not able to investigate all issues that are highlighted in the report.

DMAS' initial review of the draft report produced one hundred and thirty nine points of clarification and/or error. Subsequently, JLARC agreed to change or clarify approximately forty percent of the items. However, DMAS would point out that the report contains some questionable information that presents a distorted view of this agency's performance. In addition, the agency was unable to fully review and comment on the entire document due to the

limited review time. It should be noted, however, that JLARC has agreed to consider additional clarifications and comments after December 10, 2001.

DMAS' overall satisfaction with the report is weighed against the criteria already mentioned. DMAS' position is that the Medicaid-Funded Pharmacy Services and Medicaid-Funded Non-Emergency Transportation Services sections are factually correct and present the facts in a balanced and objective way. DMAS' position on the Child Health Insurance Program section is that JLARC is advocating positions that are beyond the scope of DMAS' authority. It does not accurately reflect the significant and positive changes the agency was allowed and continues to perform with the FAMIS program. One example is the JLARC position that DMAS should expand the Medicaid program. This clearly was not the legislative intent of FAMIS and DMAS should not be faulted for the perception of non-compliance. Lastly, DMAS disagrees with the tone and objectivity of the Mental Retardation (MR) Waiver Program section. Clearly there was concern and issues as to the proper management of the MR Waiver before January 1, 2001. However, the section does not accurately reflect the significant strides DMAS has accomplished with the help of the Secretary of Health and Human Services, the Department of Mental Health, Mental Retardation, Substance and Abuse Services (DMHMRSAS), advocates, and the MR Waiver task force. JLARC's position that DMAS continues to "micro-manage" the waiver and continues to be adversarial to advocates and/or other state agencies is without merit and is not supported by fact.

The following commentary is to clarify the department's position on some of the audit findings we find questionable.

Child Health Insurance Program

The Family Access to Medical Insurance Security plan (FAMIS) passed by the General Assembly in 2000 was a compromise negotiated among administration, legislators, and child health advocates. Although all parties supported the compromise, advocates continued to press for amendments to the plan even before the program was implemented. Many of the concerns identified in this report comprise their criticisms and list their desired structural, administrative, and service elements that were not included in the initial compromise or in the amendments made in the 2001 General Assembly Session.

One of the items discussed in JLARC's Interim Report is that former CMSIP recipients appear to be dropping FAMIS health insurance at a high rate. However, annual re-determination of eligibility for health coverage is a federal requirement both in FAMIS and Medicaid programs. Benova, the third party administration for the FAMIS program encourages compliance by mailing three written contacts to all enrollees prior to discontinuation of coverage. This process is improved from that utilized in the CMSIP program. Contact with non-respondents will give DMAS evidence of the reasons for failure to complete the re-determinations that can be used to amend processes and procedures to encourage retention. The current termination rate for FAMIS is comparable to the historical monthly termination rate for the Medicaid program.

Because of the various methods an individual can access FAMIS, there is no clear-cut way of tracking the activities generated as a result of a particular intervention, visit, inquiry, or call. DMAS will be tracking the number of new Medicaid enrollees by receiving the names of Medicaid possible referrals and matching those referrals to the Medicaid enrollee database periodically. Referral names will be captured and matched for up to six months following

referral to match to Medicaid enrollees. This will capture new enrollees added by on-site Medicaid workers as well as those added by local departments of social services. Additionally, DMAS and DSS have designed and will implement a formal communication document to ensure that information is exchanged between Medicaid and FAMIS when appropriate and in accordance with confidentiality laws.

Another element discussed at length in the JLARC report is raising the income limit under Medicaid to 133% of the federal poverty level for all children to age 19. The report notes that this can be done through directive of the General Assembly to amend the State Plan. However, another crucial difference is that the benefit packages are different between the two programs, and Medicaid is an entitlement program while FAMIS is not. Therefore, this change could have a cost impact.

As the JLARC report discusses, major changes made in the structure and delivery of medical benefits to low-income uninsured children. These changes are still being implemented. Managed care assignment in a number of regions across the state just became effective December 1, 2001. Benova now employs three times the number of line staff originally anticipated for operation of the central processing unit. Other operational and reporting mechanisms are in development. DMAS will be assessing the changes over upcoming months to ensure the goals of the FAMIS program are being met.

FAMIS Recommendations

JLARC recommended several modifications to FAMIS such as specific methods for tracking FAMIC recipients. There are currently procedures in place to track FAMIS applicants who are referred to the Medicaid co-located staff at the Central Processing Unit and whose eligibility is determined at the CPU. A process will be developed to also track applicants who

are enrolled with local Departments of Social Services. This will be accomplished by comparing on a monthly basis eligibility data on the Medicaid Management Information System with the Medicaid referrals from Benova. This information will be reported on a monthly basis.

DMAS is currently contacting families whose children have dropped out of the FAMIS program. These families are not only being surveyed as to why they did not renew in the program, but also they will be encouraged to re-enroll in FAMIS and will be sent another pre-filled application upon request. The Department is working with the FAMIS Outreach Oversight Committee to determine the feasibility of outsourcing the process of regularly surveying FAMIS enrollees.

The JLARC report discusses the need for updated projections of potential eligible children in both FAMIS and Medicaid. DMAS will update its projection of the total number of potential children eligible for Medicaid and FAMIS. DMAS will utilize the 2000 Census data, as well as other data sources as may be appropriate to gather such information.

JLARC also made the assertion that a clear process is needed to ensure coordination between FAMIS and Medicaid. DMAS has been working with and will continue to work with the Department of Social Services in improving ongoing communication between the Medicaid and FAMIS programs. Staff from DMAS and DSS has developed a tracking form to be used by local DSS offices and the Central Processing Unit to communicate eligibility issues regarding FAMIS enrollees. Enrollment coordination is being handled collectively by the three (3) Medicaid eligibility workers on site who receive and process referrals from FAMIS applications.

The FAMIS quarterly report already includes enrollment information and will be expanded to include retention of children in FAMIS. Also, DMAS plans to include in the FAMIS report the status of implementing the recommendations and other issues highlighted in

the JLARC report. The utilization and costs of mental health and health care benefits will also be included in the DMAS quarterly report.

The Mental Retardation Waiver Program

Many of JLARC's statements about the management of the waiver stem from the interpretation of single state agency authority. The Department of Medical Assistance Services, as the single state Medicaid agency, has certain mandates to which it must adhere. Specifically, "the agency must not delegate to other than it's own officials, authority to exercise administrative discretion in the administration or supervision of the plan or issue policies, rules, and regulations on program matters. If other state or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgement of that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency." 42 CFR Section 431.10 (e).

JLARC reports that there was a clear state-level policy that DMHMRSAS would manage the waiver and DMAS would ensure that federal Medicaid dollars were available to pay for services. State-level policy as evidenced by House Bill 30, 2000 Reconvened Session, Section 319, Y. 1. states "...The agreements shall also specify the Department of Mental Health, Mental Retardation and Substance Abuse Services responsibility for participation in policy and regulatory development for the above-listed services as described in the report of the Joint Committee Studying the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services, *subject to the Department of Medical Assistance Services oversight and approval with respect to compliance with federal law"* (emphasis added). As noted above, federal law does not allow DMAS to abrogate its policy-making authority, nor does

it allow other agencies to substitute their judgment for that of DMAS with respect of the application of that policy.

DMAS transferred as much authority to DMHMRSAS as was allowed by federal law. The Waiver application pre-print offers three choices of who will operate the waiver: "(1) directly by the Medicaid agency; (2) operated by a separate agency of the State under the supervision of the Medicaid agency; or (3) operated by a separate division within the Medicaid agency. If the Waiver is not operated directly by the Medicaid agency, the Medicaid agency must assure CMS that it exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules, and regulations related to the Waiver." DMAS chose the broadest possible plan, which was to have the Waiver operated by a separate state agency. In addition, the only responsibilities that were not with DMHMRSAS, and that could be delegated to DMHRMSAS, were statewide waiting list maintenance, slot management, and utilization review. Responsibility for the waiting list was transferred to DMHMRSAS in October 2001; DMHMRSAS requested that utilization review be transferred from DMHMRSAS to DMAS in November 2000; and management of the slots, with DMHMRSAS oversight, was transferred to the CSBs in October 2001.

Communication with Task Force and DMHMRSAS

DMAS has consistently communicated with DMHMRSAS staff, task force members, and consumers. DMAS felt it was important to include consumers as members of the task force. DMAS also communicated with legislators and other state officials regarding the MR Waiver. Cooperation and communication between DMAS and DMHMRSAS management staff have been both consistent and productive. Since 1999, there have been consistent meetings between DMAS and DMHMRSAS staff and collaboration and communication have increased

dramatically. In addition, DMAS acknowledges that there was concern initially about communications with CSBs, advocates, and consumers, but DMAS is not aware of concerns of this nature since January 2001.

JLARC indicates that the emergency regulations and the draft provider manual did not reflect perceived agreements by the task force members and contained numerous technical errors. Part of this issue is that some Task Force members were reading the regulations incorrectly. The Centers for Medicare and Medicaid services (CMS) mandated that DMAS keep the "old" waiver in effect for individuals living in the assisted living facilities (ALFs) who would later have to transfer to DMHMRSAS group homes. This confused some task force members as they misinterpreted that these "old" regulations applied to the new waiver. DMAS and DMHMRSAS staff met with the task force and this erroneous assumption was corrected. There were some technical errors in the emergency regulations that have since been corrected through the errata process. These corrections are effective in the emergency regulations. DMAS and DMHMRSAS are currently meeting with the Task Force to review the final regulations that replaced the emergency regulations as of October 17, 2002.

The MR Waiver Manual being reviewed by the Task Force members is a draft and the reason for review is to correct errors. Initially, the manual was sent out for review and given a short turnaround time because DMHMRSAS had already scheduled provider training. The Task Force initially requested an additional 30 days for review of the manual, that was granted. However, the Task Force determined that the review of the manual could not be completed in that time frame. Therefore, with the approval of the Task Force, the provider training was rescheduled for January and February 2002. The Task Force is scheduled to complete their review of the draft manual on December 12, 2001.

Lawsuits

Because Community Services Boards (CSBs) were not providing services on a statewide basis, DMAS was sued in the United States District Court, Western Division on October 11, 2000 (*Lewis Johnson v. Smith*). This lawsuit was settled because of DMAS' statewide criteria for the waiver.

The *Quibuyen v. Rossiter* lawsuit was settled because all plaintiffs, as of the date of the settlement, had received the services for which they qualified. The Commonwealth had already determined in October 2000 that needed increases in plans of care should be granted without going through the emergency process. The lawsuit was not filed until December 19, 2000. Therefore, with nothing left to litigate the Attorney General's Office recommended settlement. In addition, every time there was a ruling on this case, the ruling was in favor of the Commonwealth. The plaintiffs' motion for summary judgment was denied and the plaintiffs' request for class certification was denied.

Additional Issues

1. Approval of emergencies was unprecedented. There had not previously been a provision of approvals for emergencies for this Waiver. The emergency criteria that were used to approve individuals for the Waiver were developed collaboratively between DMHMRSAS, advocates, consumers, private providers, and other state agencies. Although it was not necessary to get CMS approval, CMS reviewed and approved of the criteria. The Governor approved funding to add additional individuals to the MR Waiver that brought Virginia to capacity for the number of MR Waiver slots approved by CMS.

2. JLARC reports that DMAS withdrew a waiver amendment to add 439 waiver slots over a 3-year period. DMAS did not withdraw this amendment. This number was incorrect in a draft document and was corrected prior to approval.
3. JLARC reports that the allocation of 150 additional MR Waiver slots was an effort to avoid additional discontent by consumers and families. This was a generous allocation by the Governor to provide services to those needing MR Waiver services.
4. JLARC questions the extent of audit plan for the waiver. CMS questioned why DMAS was not conducting a 100% review. Furthermore, in order to have a Home and Community Based Waiver approved by CMS, plans of care must be subject to approval by the Medicaid agency. 42 CFR§ 441.301 (i).
5. JLARC notes that DMAS has not indicated when the potential new slots will be available. Oversight for management of the sots was transferred to DMHMRSAS in October 2001. DMHMRSAS would provide this information.
6. Recommendations: Since DMHMRSAS had day-to-day operational authority for the waiver, the recommendations should be revised to say that DMAS and DMHMRSAS should provide the report. DMAS is happy to provide any updates requested by the General Assembly; however, we question that the General Assembly would want to know the details of the status of DMAS' audits of DMHMRSAS approvals of service enhancements (Recommendation 7(6). Number 10 should be deleted as too broad or the concerns should be listed so we can be sure that the concerns are addressed.

Medicaid-Funded Non-Emergency Transportation Services

JLARC reported on DMAS transportation brokerage system and evaluated whether a brokerage mode was appropriate. In a separate communication to JLARC staff, DMAS has

provided technical corrections regarding this chapter. DMAS views the report in general as balanced and without significant flaws.

DMAS appreciates the recognition by JLARC staff that the brokerage model is appropriate for the management of transportation services for Virginia Medicaid recipients. DMAS also appreciates the recognition by JLARC staff that the brokerage system is in the "early implementation phase". DMAS continues to closely monitor the implementation and address issues that arise promptly and thoroughly. Through November, the brokers coordinated about 13,000 trips a day. DMAS and the brokers are committed to seeing that each trip delivered is done so in a safe, timely, and appropriate manner.

The introduction of the transportation brokerage system in July 2001 represented the single largest change in DMAS transportation coverage, since the inception of the coverage in 1969. Unquestionably, some recipients, transportation providers, and medical providers would have preferred DMAS had not implemented the brokerage system. However, given the significant rise in DMAS transportation expenditures over the past decade, reports of inappropriate transportation, and DMAS interest in improving the quality of transportation services, the decision to move to a brokerage system is warranted. DMAS continues to assist the Office of the Attorney General and the United States Attorney's office with investigations of Medicaid transportation fraud. Two transportation providers were recently convicted which resulted in imprisonment, a fine of $449,000, and restitution of $448,000.

DMAS has no objections to the JLARC recommendation regarding a status report on the brokerage system as described in the report.

Medicaid-Funded Pharmacy Services

The JLARC report also provides an overview of the Virginia Medicaid pharmacy program and attempts to broadly describe pharmacy utilization and expenditures, reasons for pharmacy expenditure growth, and how the program pays for pharmaceuticals. It identifies cost savings components of the program and recommends enhancements as well as several new initiatives for reducing overall expenditures. There is only minimal recognition that many of the program components identified for change are operated as directed by the Virginia legislature, not at the behest of DMAS administration. DMAS would welcome action by the General Assembly on several of the JLARC recommendations as referenced below, which would increase operational efficiencies and cost effectiveness of the program.

The actual savings resulting from potential cost control alternatives identified in the report should be reconsidered based on the fact that only about 45% of Medicaid recipients remain in fee-for-service programs after December 1, 2001. The projections highlighted in the report are overstated if based on program enrollment before the managed care expansion implemented on that date.

DMAS offers the following comments on the recommendations put forth in the report:

- **Recommendation (9)** to the General Assembly to amend the prior authorization program is a step in the right direction. Removal of the separate public hearing requirement and special notice to drug manufacturers would lessen the administrative burden for DMAS. However, as noted previously, the APA process is lengthy and burdensome for determining whether new pharmaceutical products should be considered for prior authorization. Prior Authorization Committee decisions on products should receive public comment but should also be implemented in a timely manner. Delays for

extended periods of time would reduce the overall effectiveness of the program as well as its potential cost savings. DMAS recommends removal of the APA requirement from the Medicaid PA program.

- **Recommendation (10)** to have DMAS annually develop a list of potential drugs for prior authorization consideration by the Committee is acceptable to DMAS with the reconfiguration outlined in **(9).**
- **Recommendation (11)** to the General Assembly to direct DMAS to conduct a pharmacy survey regarding AWP and WAC pricing and making changes based on the findings is currently under consideration by DMAS.
- **Recommendation (12)** to the General Assembly to direct DMAS to change the definition for Usual and Customary reimbursement to enable "most favored nation" status is acceptable to DMAS.
- **Recommendation (13)** to the General Assembly to direct DMAS to examine its method of recovery for TPL is currently under review by DMAS.

In summary, we appreciate the opportunity to submit our position and comments on your report. As we have indicated, DMAS is pleased with the objectivity and balance of two of the sections of the report. However, in our opinion the Children's Health section needs ongoing analysis and clarification. In addition, the current DMAS administration respectfully disagrees with the report findings regarding the MR Waiver.

It is certainly the intent of DMAS' current administration to listen to the MR Waiver Community through the MR Waiver Task Force and work with DMHMRSAS as well as special interest groups such as the ARC of Virginia in order to ensure that the needs of the mental retardation community are met within available resources.

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