Report on the Response of the Department of Medical Assistance Services to the Impact of the Aging of Virginia’s Population

NOVEMBER 14, 2014
Pursuant to Code of Virginia §§ 2.2-5510 and 51.5-136, the Department of Medical Assistance Services submits this report of its progress in addressing the impact of the aging of Virginia’s population.

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Designated agency official responsible for reviewing policy and programs and accommodating the interests of older adults and adults with disabilities under Code of Virginia § 2.2-604.1:

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Official Phone Email
EXECUTIVE SUMMARY

The Medicaid Program is the largest health care financing program for the elderly in the country. Medicaid is financed by state and federal governments and administered by the states. Key long-term care services for the age 65 and over population are nursing facility services and community alternatives. Medicaid offers six home and community-based waivers for persons who meet institutional placement criteria, but choose to reside in the community.

An increased focus has been underway over the last several years to improve community options and integrate systems of care for individuals in order for them to remain in their communities, and afford them more person-centered options that enable individuals to have more control over their health care needs. To strengthen this focus, a Deputy Director of Complex Care and Services was created in 2013 to oversee long-term care and behavioral health services and ensure these issues remain a priority within the Medicaid agency. The increased focus has resulted in the following initiatives/advancements:

**Commonwealth Coordinated Care**

The newest program to provide integrated care is the Commonwealth Coordinated Care (CCC) program, which is a partnership with the Centers for Medicare and Medicaid Services, Virginia, and health plans to blend Medicare and Medicaid services and financing to provide high-quality, person-centered care to Virginians who are dually eligible for Medicare and Medicaid. Under the CCC Program the Medicare/Medicaid Plans, or MMPs, receive a blended capitated rate to provide and coordinate the full continuum of benefits currently provided under Medicare and Medicaid program. This includes primary care, acute care, behavioral health services, nursing facility care, long-term support services through the Elderly or Disabled with Consumer Direction (EDCD) Waiver, and the added benefit of care coordination services for all eligible beneficiaries. MMP’s also have additional benefits that seniors would not previously have access to, such as dental, vision and podiatry services.

The best part of this program is that it gives individuals and their families the peace of mind to know they have one card and one number to call to help them with navigating their needs through both programs.

The CCC Program is voluntary and as of November 2014 it served over 29,000 dually eligible individuals who receive community and nursing home levels services. Individuals who are interested in learning more about the CCC program can visit the following website: [http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx](http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx).

**Programs of All Inclusive Care for the Elderly (PACE)**

Additionally, the Department operates 14 Programs of All Inclusive Care for the Elderly (PACE), which provides another option for coordinated, capitated, case management system in the Commonwealth for those 55 years of age and older designed to retain individuals in the community and address their health and social needs. Over 2,580 individuals have been served since the program’s inception in Virginia in 2007.

The provision of long-term services and supports shifted in FY 2012 to over 50 percent of all
expenditures being provided in the home and community. This is a reflection of the agency’s commitment to ensuring individuals are served in the most integrated setting of their choice, and also demonstrates the shift from institutional care to a more community-based care approach. This is a tremendous accomplishment and Medicaid is continuing to work with its community and state partners to continue in this rebalancing effort. The chart below shows how many people are being served in home and community-based settings, by waiver, as of October 2014;

<table>
<thead>
<tr>
<th>Enrollment/Wait List Summary</th>
<th>EDCD*</th>
<th>ID**</th>
<th>DD+</th>
<th>TECH***</th>
<th>DAY SUPPORT**</th>
<th>ALZ*</th>
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<td>9,984</td>
<td>951</td>
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<td>7597</td>
<td>1634</td>
<td></td>
<td></td>
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</tbody>
</table>

* Sources: Elder and Disabled with Consumer Direction and Alzheimer waivers DMAS Alpha listing; ** Intellectual Disability waiver DBHDS; *** DMAS Tech Waiver database; + DMAS DD Waiver database. Total enrollment and wait lists are point in time counts and subject to frequent changes. MFP Slots are not included.

Other services or programs that DMAS has implemented or plans to implement to address the impact of the aging of Virginia’s population include:

- Managed Care, which will be a fully integrated and coordinated health and long term care services
- Commonwealth Coordinated Care (CCC)
- Health and Acute Care Project (HAP), which is a coordinated medical care only program for many of the home and community based care clients.

The southwestern part of Virginia is considered the most difficult area to obtain services. This is because this section of Virginia is a primarily rural setting. Rural health care disparity, however, is a national problem and is not unique to the Commonwealth.

DMAS has been working to make the Medicaid programs more cost-effective and quality-focused. The primary areas of focus to achieve this outcome revolve around care-coordination, improved business flow with enterprise-based information management, and program integrity.
AGENCY DESCRIPTION

Medicaid is an entitlement program financed by the state and federal governments and administered by the states that is authorized under Title XIX of the Social Security Act. The Virginia Medicaid program is administered by the Department of Medical Assistance Services (DMAS). Federal financial assistance is provided to states for coverage of medical services for specific groups of low-income people. Federal matching payment rates are based on the state’s per capita income. The federal match rate for Virginia is 50 percent for the 2014 federal fiscal year.

Children and parents/caretakers of children make up about 70 percent of the Medicaid beneficiaries in FY 2014, but they account for less than a third of Medicaid spending. Persons who are elderly or who have disabilities, account for the majority of Medicaid spending because of their intensive use of acute and long-term care services.

Medicaid serves five distinct and important healthcare policy roles:

- Ensure access to healthcare for low-income children and women who are pregnant (prenatal care and delivery and comprehensive coverage for children (EPSDT)).
- Provide access to care for low-income adults with children (establishes a set of mandatory and optional benefits).
- Provide for the long-term care needs of the elderly and persons with disabilities (PACE, home and community-based waivers, personal care, nursing facility, personal care, mental health and services for individuals with intellectual disabilities and nursing facilities).
- Finance the safety net for the uninsured who are not Medicaid eligible (Community Health Centers and Disproportionate Share Funding).
- Fill gaps in Medicare coverage for “dual-eligibles” (Medicare premiums, deductibles, nursing facility benefits, and some prescription drug costs).

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

Medicaid program eligibility is organized around several mandatory groups. To receive Medicaid, recipients must be categorically eligible and meet the program’s financial test.

- Eligibility Categories:
  - Aged, blind, or disabled (federal categories)
  - Member of a family with children
  - Child under the age of 19
  - Pregnant woman
– Certain Medicare beneficiaries
  • Coverage for persons in these groups is mandatory as long as they meet the financial (income and resource limits) criteria for the program.

Virginia also covers groups that are optional under federal law, including, but not limited to:

  • Medically-needy people who meet a Medicaid covered group and all eligibility requirements, but whose income exceeds established limits;
  • Persons in institutions or Medicaid home- and community-based waivers, (e.g., nursing facilities, intermediate care facilities for the intellectually disabled); and
  • Certain aged, blind, or disabled adults who are not on SSI (federal categories).

The largest programs that support health care for Medicaid seniors and others in their homes and communities and in institutions in FY 2014 are:

  • Preadmission Screening (19,810 individuals were screened at a cost of $2,055,686)
  • Medical Services including hospitals, physicians, pharmacy (385,090 individuals received fee-for-service physician care at the cost of $175,235,122; 63,998 individuals received fee-for-service inpatient hospital care at the cost of $453,326,399; and 208,119 individuals received fee-for-service prescribed drugs at the cost of $129,426,697)
  • Rehabilitation Services (12,883 individuals received services at the cost of $21,026,760)
  • Hospice Services (3,907 individuals received hospice services at the cost of $37,889,264)
  • Home Health Care Services (3,115 individuals received fee-for-service home health services and DMAS spent $5,489,169 on these services.)
  • Nursing Facility Services (27,046 individuals received fee-for-service nursing facility care and DMAS spent $843,580,199 on these services.)

The Virginia Medicaid program covers a broad range of services with nominal cost sharing for some of the beneficiaries as permitted under federal law. The program covers all the federally mandated services:

  • Hospital Inpatient, Outpatient, & Emergency Services
  • Nursing Facility Services
  • Physician Services
  • Medicare Premiums, co-pays and deductibles (Part A and Part B)
  • Certified Pediatric Nurse and Family Nurse Practitioner Services
  • Certain Home Health Services (nurse, nurse aide, supplies and treatment services)
  • Laboratory & X-ray Services
  • Early & Periodic Screening, Diagnostic & Treatment (EPSDT) Services
  • Nurse-Midwife Services
  • Rural Health Clinics
  • Federally Qualified Health Center Clinic Services
  • Family Planning Services & Supplies
  • Transportation
Virginia Medicaid also covers the following allowable, but optional, services:

- Prescribed Drugs
- Mental Health & Mental Retardation Services
- Home & Community-Based Care Waiver Services
- Skilled Nursing Facility Care for Persons under age 21
- Dental Services for Persons under age 21 and in certain emergency circumstances for those over age 21
- Physical Therapy & Related Services
- Clinical Psychologist Services
- Podiatrist Services
- Optometrist Services
- Services provided by Certified Pediatric Nurse and Family Nurse Practitioner
- Home Health Services (PT, OT, and Speech Therapy)
- Case Management Services
- Prosthetic Devices
- Other Clinic Services
- Hospice Services
- Medicare Premiums/co-pays/ deductibles

Medicaid beneficiaries also receive coverage through “waiver” programs. Waivers allow states to develop programs designed to meet the unique medical needs of Medicaid populations who are at risk of institutionalization, including seniors and individuals with a disability. The following waiver programs are available to Medicaid beneficiaries who meet eligibility criteria:

- Alzheimer’s Waiver;
- Day Support for Persons with Intellectually Disabled Waiver;
- Elderly or Disabled with Consumer Direction Waiver;
- Intellectually Disabled Waiver;
- Technology Assisted Waiver; and the
INFORMATION REQUESTED

1. If your agency has undertaken any actions to respond to the current and future impact of an aging population, such as needs assessments, strategic planning, or use of best practices, please briefly describe those actions. Please indicate what assistance from DARS could help your agency as it prepares to serve an aging Virginia population.

In December 2014, DMAS will begin an 18-month project to assess the impact of involuntary relocation on nursing facility residents in Bristol, Virginia. Though closures happen infrequently, the Commonwealth is committed to minimizing consequences for the individuals moved and families involved. This project will be proactive in ensuring health and safety protections and quality outcomes for individuals who experience a closure and relocation in the future. The Department of Medical Assistance Services (DMAS) will subcontract with the Gerontology Center at Virginia Polytechnic Institute and State University (Virginia Tech) to conduct this study.

The goals of the project are to:

1. Assess the impact of involuntary relocation on an estimated 44 individuals relocated or moved due to the Bristol facility closure.
2. Describe resident outcomes resulting from current policies and procedures and the planning, collaboration, and coordination employed by the relocation team (DMAS, DARS, APS and nursing facility) for the Bristol facility closure.
3. Identify risk factors for facilities that are in danger of closing and provide evidence-based suggestions on how such closures may be prevented.
4. Identify “model” relocation practices nationwide that may be replicated in Virginia and other states.

DMAS has asked DARS staff to assist in implementing this project through cooperating with Virginia Tech in the collection data, agreeing to interviews and providing logistical support.

The agency considers the needs of the age 60 and over population as part of it strategic planning, described in the answer to #7.

In addition, PACE is a care program designed around a day health care model that allows for a full spectrum of medical services at a “one-stop shop” under a capitated system to reduce the cost of care while ensuring the highest quality outcomes for seniors. It is designed to keep individuals in their home and communities. PACE is open to persons aged 55 and over residing in the catchment area who qualify for nursing facility care.

Services include Medicare and Medicaid state plan services, some of which include:

- Adult Day Care, including social work services
- Home Health Care
- Hospital (Acute Care) Services
Eight PACE providers provide services in 14 PACE communities across Virginia. DMAS is expanding this program throughout the Commonwealth as another way in which to coordinate acute and long-term care services while benefitting vulnerable seniors.

Commonwealth Coordinated Care (CCC)

CCC is a program that blends and coordinates Medicare and Medicaid benefits for up to approximately 72,000 eligible Virginians. Virginia launched the program in March 2014 as an innovative approach to providing health care and long-term services and supports to people who often have very complex needs. CCC is Virginia’s response to years of national research that shows the current structure of the two separate health programs results in cost inefficiency and uncoordinated care which can lead to poor health outcomes. Dual eligible individuals typically have the highest and most complex medical needs but are often underserved by the misaligned rules and financial incentives of Medicare and Medicaid. CCC blends all of the benefits currently provided under Medicare and Medicaid into one plan with a designated care manager plus additional benefits offered by the health plan.

CCC commits participating health plans to a new model of care for Medicare/Medicaid beneficiaries that will provide efficiencies and improve the delivery of services to some of the Commonwealth’s most vulnerable citizens. The program also includes provisions for person-centered care planning, interdisciplinary care teams, care coordination services, provider credentialing, access to services, unified appeals and grievances, and closely monitored quality of services.

CCC enrollment is offered to Virginians over age 21 who are eligible for both full Medicare and Medicaid benefits and live in one of the following five regions: Tidewater, Central Virginia, Northern Virginia, Roanoke and Charlottesville. A map of localities included in these regions is provided in Figure 1. CCC enrollment occurs in two phases: The first phase is called “voluntary enrollment” where an individual proactively enrolls in the program. The second phase is called “automatic enrollment” where the individual is automatically enrolled into the CCC if they do not choose to opt out. Enrollees may change MMP’s each month if they choose.
The Virginia Insurance Counseling Assistance Program (VICAP) may provide information and insurance counseling for beneficiaries seeking additional education and support with CCC enrollment.

Behavioral Health Services Administrator-Magellan of Virginia

The Department is approaching the first year of operations of the new care coordination model for its behavioral health programs. This new model was implemented on December 1, 2013 under the directive of our General Assembly and has been accomplished through a Behavioral Health Services Administrator contract with Magellan Behavioral Health of Virginia. This new contract has become a partnership beyond the Department and Magellan but extends to all stakeholders, including members of all ages, providers and multiple community agencies. Within the first year, significant progress has been made toward our goals of improving the coordination of care for individual receiving behavioral health services with acute and primary services and the value of these services.

Some of the value-added services offered through this new program that are making a difference in access to care and quality of services include a 24 hour centralized call center, a crisis line, credentialing of the behavioral health provider network, personalized assistance for members to access care and quality improvement initiatives. Since December 1, 2013, the Magellan call center has received over 39,000 calls, over 15,000 of which are from members and 24,000 from providers. Over 15,000 of these calls were transferred to a licensed mental health professional for personalized assistance and 177 calls were from members in crisis. Magellan coordinates care with the member’s Managed Care Organization when the need medical services are identified. There are over 37,000 credentialed providers in over 6,500 locations.
network is seeing improvement through providers participating in multiple program initiatives and training opportunities. Magellan holds a monthly Governance Board meeting, which is open to the public, to discuss the new program and address any needed areas of improvement.

2. Briefly describe your agency’s services that are used primarily by older Virginians and the funding streams (types and amounts) that support those services. If these particular services or funding streams are provided in conjunction with other state or local agencies or other for profit or nonprofit organizations, please list them.

The Department of Medical Assistance Services (DMAS) provides an extensive array of medical, home-based and long-term care services for qualifying Virginians age 60 and older. Medicaid-funded services receive a federal funding, while other services are paid through state general funds.

Services and their corresponding costs for people age 60 and over are noted below:

Pre-Admission Screenings - DMAS reimburses qualified screening teams for assessments each year using the Uniform Assessment Instrument. 13,715 individuals were screened in 2014 at a cost of $1,427,126 (this figure represents DMAS payments for paid claims).

Home Health Services - Provides reimbursement to home health and home care agencies licensed and/or certified by VDH to provide intermittent nursing or rehabilitation services to individuals in their residences under a plan of treatment written by the patient's attending physicians. In FY 2014, 719 individuals Aged 60+ received Fee-For-Service Home Health Services and DMAS spent $1,359,998 on these services.

Hospice Services - Provides medically-directed services through an interdisciplinary program of palliative care for terminally ill individuals and their families in their homes or (for limited periods of time) in institutional settings. Hospice programs provide nursing, physician, social services, counseling, home health aide and homemaker services with 3,062 individuals aged 60+ received hospice services at the cost of $30,537,578 in 2014.

Rehabilitation Services - Services include physical therapy, occupational therapy, and speech-language pathology services and may include additional therapies and support services available if provided in an inpatient setting. Inpatient and outpatient services are provided by acute care inpatient hospitals, rehabilitation hospitals, outpatient rehabilitation agencies, home health and home care providers. 4,341 individuals aged 60+ received rehabilitation services at the cost of $3,290,879.34 in 2014. This does not include rehabilitation services provided through Managed Care plans or amounts included above in Home Health Services or Nursing Facilities or below in Inpatient Hospital Services.

Nursing Facility Services - Provides reimbursement for services provided in a nursing facility to individuals who need care on a 24-hour basis. 23,492 individuals aged 60+ received fee-for-service nursing facility care in FY 2014 and DMAS spent $718,251,309 on these services.
Medical Services

Physician Services - Provides reimbursement for services provided to an individual by or under the supervision of a physician within the scope of medicine, osteopathy or psychiatry. 89,993 individuals aged 60+ received fee-for-service physician care at the cost of $39,025,688 in 2014.

Hospital Services - Provides reimbursement for acute care services that are ordinarily furnished to an individual in an inpatient hospital setting for the care and treatment of a condition or disease. 19,829 individuals aged 60+ received fee-for-service inpatient hospital care at the cost of $94,998,361 in 2014.

Pharmacy Services - Provides reimbursement for prescribed substances for the cure, mitigation, or prevention of diseases, or for health maintenance. Drugs must be dispensed by authorized pharmacies or dispensing physicians using a written prescription. 41,951 individuals aged 60+ received fee-for-service prescribed drugs at the cost of $17,618,416 in 2014.

The number of people served in PACE and waiver programs, along with the costs of serving them can be found in fact sheets at http://www.dmas.virginia.gov/Content_pgs/ltc-home.aspx.

LTC routinely collaborates with VDH, VDSS and DBHDS, as described in an overview of LTC that can be found at http://www.dmas.virginia.gov/Content_pgs/ltc-home.aspx.

3. Identify current agency programs specifically designed to serve older Virginians that fall into any of the following eight categories:

- Health Care/Wellness
- Education
- Public Safety (including Adult Abuse Prevention)
- Recreation
- Housing
- Accessibility (including Livable Communities (http://www.vadrs.org/vblc/))
- Financial Security
- Transportation

The primary services provided by DMAS for the age 60 and over population are through home and community-based services and nursing facilities, which are primarily administered by the Division of Long-Term Care (LTC).

In 2014, LTC provided for the protection of the health, safety, and welfare to over 40,000 individuals receiving a Medicaid waiver service from one of the seven current waiver programs. (Note: This number includes both seniors and individuals with a disability.) While all persons aged 65 and over are eligible to receive Medicaid acute care services (such as physician, hospital, pharmacy and labs), many also may receive long-term care services. Individuals seeking Medicaid funded long-term care services are evaluated by preadmission screening teams to determine the medical need for long-term care services and the potential for placement in a community-based care program in lieu of a nursing.
facility. These initiatives offer health care and wellness for seniors in their homes and communities and in institutions, some include transportation services, and ensure accessibility and assistance locating housing.

**Money Follows the Person**

Money Follows the Person (MFP) provides support to individuals so they can successfully transition from institutions to community living.

Individuals must qualify for, and enroll into upon discharge, a Program for All-inclusive Care for the Elderly (PACE) or one of the following waiver programs with services provided in a qualified residence:

- Elderly or Disabled with Consumer-Direction Waiver (EDCD)
- Individual and Family Developmental Disabilities Support Waiver (DD)
- Intellectual Disabilities Waiver (ID)
- Technology Assisted Waiver (TECH)

Participants get $5,000 in one time assistance for transition services. DMAS conducts Quality of Life surveys at the 1-and 2-year marks post transition. This survey establishes the individual’s satisfaction with community living, ensures the individual’s needs are met and necessary services are being provided.

**Housing**

DMAS is active in removing housing obstacles for individuals using Medicaid because it is so critical to the development of community-based services. A cornerstone of this work is the agency’s participation in the Virginia Interagency Housing Committee. This committee, which has representatives from key state agencies such as the Virginia Housing Development Authority, the Virginia Department of Housing and Community Development, the Department of Behavioral Health and Developmental Services, as well as DMAS, was formed as part of the implementation of an interagency Memorandum of Agreement. The goals for the group include:

- expansion of the inventory of affordable and accessible rental units;
- increasing access to rental subsidies;
- building an understanding and awareness of informed choices;
- reviewing potential federal and state policy changes that affect housing options; and
- advancing coordination of actions and resources.

An initial project for the committee has been the full utilization of housing under the Rental Choice Virginia pilot being implemented in Fairfax and Virginia Beach. DMAS programs such MFP, promotes the Rental Choice Virginia program with providers and eligible individuals, and reviews incoming enrollment forms for potential participants.

The Interagency Housing Committee also worked collaboratively to submit an 811 Application to HUD in the spring of 2014. As a part of the application, all involved agencies were required to affirm their commitment to addressing housing problems for low-income individuals living
with intellectual and developmental disabilities and to continue collaboration among the various
agencies. This collaboration includes communication, setting standards and making
recommendations regarding vouchers that become available to the state.

Complimentary to these activities, has been the DMAS MFP program’s commitment and ability
to hire a housing resources specialist. This specialist has been coalescing housing resources,
providing technical assistance, and developing training as well as working with interagency
housing partners. Addressing housing availability is central to the success of MFP, which aims
to transition individuals to community living and integration.

Another activity worth noting is the work of the Olmstead Community Integration
Implementation Team (CIIT). This team works to ensure collaborative efforts to complete and
annually update a comprehensive, cross-governmental strategic plan, designed to assure
continued community integration of Virginians with disabilities. Housing, as well as other
community integration, are part of the strategic plan. The Long-Term Care Division Director at
DMAS serves on the CIIT and ensures that decisions made and actions put forward by the team
are shared and promoted within DMAS. Virginia is being proactive in addressing housing
concerns and DMAS has been an active partner in decision making, policy consideration and
collaborative initiatives.

**Consumer-Directed Waiver Services**

Consumer-directed (CD) is a service delivery model of care. In select waivers, three services
are available through the consumer-directed model or the agency-directed model. These services
are: personal care, respite care, and companion care. Enrolled individuals with a demonstrated
need for these services may elect to receive them through either the CD model of service
delivery, the agency-directed (AD) model of service delivery, or a combination of both. The CD
model differs from AD services by allowing the individual to assume the responsibility for
directly hiring, training, scheduling, and firing staff and monitoring the provision of services
provided. AD services are provided by a Medicaid enrolled provider agency. To receive CD
services, the individual or a designated individual must act as the employer of record (EOR). The
EOR hires, trains, and supervises the attendant(s).

An individual may be found NOT to be eligible for CD services if:

- It is determined that he or she cannot be the employer, and no one else is able to assume
  this role.
- The individual wants CD services, but health and safety cannot be assured.
- The individual has medication or skilled nursing needs or medical/behavioral conditions
  that cannot be met through CD services.

To facilitate the process of CD services, a fiscal/employer agent, Public Partnerships (PPL), is
the state’s contractor responsible for all fiscal agent services. In the largest waiver, the EDCD,
there are 13,204 people over age 65 and of these, 3,610 people are self-directing their services.

DMAS conducts quality management reviews of the services provided and interviews
individuals for all providers providing services in this waiver to ensure the health and safety of
all individuals.
Managed Care Organizations

In other areas of the agency, the over 60 population is served through managed care organizations (MCOs). Elderly individuals who are eligible for and enrolled in managed care will receive access to preventive and wellness services not available to adults enrolled in fee-for-service. Additionally, elderly member in MCOs have access to disease and case management services if medical conditions warrant that additional, more intensive care management if their conditions warrant. Disease management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.

MCOs provide health education services for its new and continuing members. The MCOs also provide nonemergency transportation services to medical appointments to members who are enrolled in a MCO.” Additional information may be found at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

Transportation

DMAS is responsible for administering Virginia Medicaid's fee for service (FFS) emergency ambulance and nonemergency Medicaid transportation (NEMT) services.

DMAS FFS transportation services include emergency air, emergency ground and NEMT services. The FFS nonemergency Medicaid transportation service (NEMT) is managed and operated by the statewide contracted transportation broker, LogistiCare. LogistiCare takes transportation eligible member's reservations, assigns trips to providers, and pays providers for all nonemergency transportation services. NEMT services include ambulatory, wheel chair, stretcher van, and nonemergency ambulance. NEMT also includes alternative means of transportation which include volunteer drivers, gas reimbursement and bus tickets. More information can be found at http://www.dmas.virginia.gov/Content_pgs/trn-home.aspx.

Program for All-Inclusive Programs for the Elderly (PACE)

PACE was described in reply to question #1 in this report. A full description may be found at http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx.

Commonwealth Coordinated Care (CCC)

Likewise, CCC was described previously. A full description may be found at http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx.

4. Is your agency able to meet all of the service demands of older Virginians for the services listed above? If there are any instances where the demand for services exceeds your agency’s ability to meet the demand, please indicate the service and the extent of the unmet demand. Also, if your agency maintains waiting lists for services, please provide this information, including the waiting list numbers for each service.

Medicaid is the primary payer of nursing facility care for elderly citizens in Virginia and
there is currently no shortage of Medicaid-funded nursing home beds. Some individuals might not be able to pick their first choice for immediate nursing home placement since many nursing homes are at full capacity. While the number of individuals using Medicaid-funded nursing facility services is slowly increasing, it is not anticipated the future need for these services will outstrip the capacity to provide care. This is due to Virginia's aggressive pre-admission screening process, which screens nursing-home eligible individuals and offers community-based services as an alternative to institutional care.

DMAS currently doesn't have a waiting list for the EDCD Waiver, which is the home and community-based waiver that serves primarily elderly individuals. Some waiver recipients, however, have problems accessing services due to the lack of available providers in their service area. DMAS provides services to older Virginians who are eligible to receive them within the restraints of available state and federal funding. There are two waivers for which demand outpaces services, the intellectually and developmentally disabled waivers that are administered through DBHDS with oversight by DMAS.

As of October 2014, there were 7,597 individuals on the waiting list for the ID waiver and 950 for the DD waiver. Not all of these are 60 and older. Some of those on the waiting list eligible for EDCD waiver services are served under that waiver until a slot becomes available.

5. Provide the number of persons, by gender if available, who received services from the agency in each of the past five state fiscal years (FY 2010 through FY 2014) who fell into the following age ranges: 60-64; 65-74; 75-84; and 85 and older. If your agency lacks specific information about the numbers of older Virginians it serves but has other evidence indicating that it is serving more or fewer older Virginians than it has in the past, please describe the basis for that estimation.

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Medicare Premium Data unavailable for State Fiscal Years 2010, 2011 and 2012
### Virginia Department of Medical Assistance Services

#### November 14, 2014

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<th></th>
<th>Expenditures SFY10</th>
<th>Expenditures SFY11</th>
<th>Expenditures SFY12</th>
<th>Expenditures SFY13</th>
<th>Expenditures SFY14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>$1,418,925,802</td>
<td>$1,535,408,251</td>
<td>$1,573,100,697</td>
<td>$1,700,721,838</td>
<td>$1,806,442,816</td>
</tr>
<tr>
<td>60 to 64</td>
<td>$296,241,535</td>
<td>$343,147,083</td>
<td>$357,712,245</td>
<td>$400,925,665</td>
<td>$427,295,377</td>
</tr>
<tr>
<td>65 to 74</td>
<td>$338,239,593</td>
<td>$365,721,202</td>
<td>$381,904,199</td>
<td>$431,082,605</td>
<td>$475,336,825</td>
</tr>
<tr>
<td>75 to 84</td>
<td>$387,088,151</td>
<td>$405,811,393</td>
<td>$406,152,270</td>
<td>$425,264,558</td>
<td>$445,281,218</td>
</tr>
<tr>
<td>85 and Older</td>
<td>$397,356,523</td>
<td>$420,728,673</td>
<td>$427,331,982</td>
<td>$443,449,010</td>
<td>$458,529,397</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Cost per Member SFY10</th>
<th>Cost per Member SFY11</th>
<th>Cost per Member SFY12</th>
<th>Cost per Member SFY13</th>
<th>Cost per Member SFY14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>$13,007</td>
<td>$13,678</td>
<td>$13,859</td>
<td>$14,614</td>
<td>$15,235</td>
</tr>
<tr>
<td>60 to 64</td>
<td>$13,263</td>
<td>$14,484</td>
<td>$14,507</td>
<td>$15,346</td>
<td>$15,726</td>
</tr>
<tr>
<td>65 to 74</td>
<td>$8,635</td>
<td>$9,145</td>
<td>$9,397</td>
<td>$10,227</td>
<td>$10,901</td>
</tr>
<tr>
<td>75 to 84</td>
<td>$11,386</td>
<td>$11,810</td>
<td>$11,985</td>
<td>$12,510</td>
<td>$13,066</td>
</tr>
<tr>
<td>85 and Older</td>
<td>$18,046</td>
<td>$18,536</td>
<td>$18,829</td>
<td>$19,349</td>
<td>$20,025</td>
</tr>
</tbody>
</table>

* Member counts within age groups do not sum to the total members 60+ due to those who were in different age groups at different times during the year.

### 6. Referring to the services or funding you described in item two, describe any services or funding provided to older Virginians for which the accessibility or availability varies considerably in different parts of the Commonwealth.

Medical and long-term support services are generally available to qualifying elderly Virginians throughout the Commonwealth. However, two areas have some difficulty with service accessibility and availability: southwestern and northern Virginia. Some long-term care services are more difficult to obtain in Northern Virginia because the cost of living is higher for this part of the state than the rest of the state. Some service reimbursement rates do not have an adjusted amount to compensate for the cost difference to provide services in this area.

The southwestern part of Virginia is considered the most difficult area to obtain services. This is because this section of Virginia is a primarily rural setting. Rural health care disparity, however, is a national problem and is not unique to the Commonwealth.

### 7. Over the next five to 10 years, in what ways do you anticipate that an aging population will impact your agency’s services, funding streams, or policies? Consider the impact from an increase in the number of older Virginians and whether the needs of older Virginians will differ from those of today’s older adults. Please include any anticipated impacts upon the cost of services, changes in type of services or the manner of service delivery, or modifications to agency policies, staffing needs, or procedures.

There are a number of ways that the needs of aging Virginians will affect DMAS’ services, funding and policies. DMAS will be challenged to meet their care needs due to:

- A shortage of licensed nurses and direct care service workers (i.e., personal care
aides) to provide necessary services, especially in rural areas;
- Fewer caregivers, which result in a breakdown of natural supports;
- People are living longer and there will be more people with complex, acute care needs;
- Low reimbursement rates that do not cover the costs of providing the service;
- Increased demand for home and community-based services (as a result of the Olmstead decision and the Department of Justice Settlement Agreement with the Commonwealth) and greater numbers of elderly and disabled people in general, will increase the costs of providing services;
- The lack of coordinated care and integrated administrative systems;
- The cost of new breakthroughs in medicine, treatment and technology, e.g., shots to cure Hepatitis C;
- The need to modernize systems and technology to provide services more efficiently and cost-effectively; and
- Federal requirements for new services, delivery mechanisms, care coordination and administrative changes.

One of these federal requirements is the Patient Protection and Affordable Care Act (PPACA). The DMAS strategic plan notes that it will have a significant impact on populations served under the programs administered by DMAS. While now optional, PPACA expansion of coverage would magnify this impact should the Commonwealth decide to expand, irrespective of the decision to expand, the individual mandate for health care coverage is expected to bring additional individuals into agency programs when they decide to seek health coverage for themselves or their families. Furthermore, the availability of subsidized private coverage offered through the Exchange necessitates that DMAS examine the need for current programs offering some level of coverage to individuals in the income range who will be eligible for the subsidized private coverage. Changes to these programs under PPACA reform, may also affect the covered population for DMAS going forward.

DMAS has been working to make the Medicaid programs more cost-effective and quality-focused. The primary areas of focus to achieve this outcome revolve around care-coordination, improved business flow with enterprise-based information management, and program integrity.

Specifically, the Department is working to bring care coordination principles to all populations and services under programs administered at DMAS. These include: 1) the expansion of Medallion 3.0, the capitated MCO program, geographically and to new recipient types (waiver recipients for their acute medical needs); 2) development of care coordination for community mental health services for and adults; 3) the examination and development of care coordination models to improve service delivery for Medicare-Medicaid enrollees.

In addition to care coordination, the Department and its partners across the HHR (Health and Human Resources) Secretariat are taking advantage of unprecedented federal funding to modernize eligibility systems across the HHR spectrum. For DMAS, this will entail a new eligibility determination and enrollment system that will automate, to the extent possible, the eligibility process resulting in real-time determinations of eligibility for certain applicants of Medicaid and FAMIS.

**Future Direction, Expectations, and Priorities**
Virginia’s Medicaid program is very large and complex and has many different components and activities. Several factors impacting Virginia Medicaid are: (i) an aging population, especially those age 65 and older; (ii) an increase in the number of persons with disabilities seeking services; (iii) health care reform and funding, (iv) new technology requirements; such as: electronic prescriptions, and electronic health records, and (iv) continued growth in overall program enrollees and costs. DMAS must find innovative ways to ensure adequate provider/network access as well as strategies to bolster its own administrative capacity to handle a growing and changing client base. To be prepared, DMAS will need to monitor and act proactively by adjusting current activities and implementing new enhancements that provide effective and efficient services to our customers. DMAS will also need to work with Medicaid providers that must adjust to growing caseloads, stagnant or lower reimbursement rates, and new Medicaid population groups that will seriously challenge their ability to fully absorb the financial and operational impact on their practices and businesses.

Agency priorities include:

- Responding to state and national Medicaid and health care reform issues;
- Coordinating care for all covered individuals and services;
- Implementing an integrated delivery model for Medicare-Medicaid enrollees;
- Improving the effectiveness of home and community-based services for seniors and people with disabilities and increase the number of Program for All Inclusive Care for the Elderly (PACE) sites;
- Enhancing the Department’s capabilities and operations in preventing, identifying, and eliminating fraud and abuse; and
- Implementing efforts to oversee and manage behavioral health services.

The complete strategic plan may be found at https://solutions.virginia.gov/pbreports/rdPage.aspx?rdReport=vp_Agency&rdAgReset=True&Agency=602

8. Please describe the primary steps that should be taken at the federal, state, or local levels to meet the future demands of older Virginians and to make services delivery more effective and efficient.

**Federal** The approval of a 1115 waiver to serve the acutely mentally ill and guidance, support and flexibility in implementing the HCBS and DOL rules.

**State** Streamline and improve service delivery among agencies and service providers.

**Local** Increase the coordination of service delivery among different agencies and services.

9. Identify the extent to which your agency provides “customer-oriented” publications and websites that are designed to be “senior-friendly.” If the information you currently provide is not readily accessible to older Virginians, please identify any steps your agency is taking to improve their access to this information.
**Division of Long-Term Care Website**

The Long-Term Care Division’s website is continuously updated with information about services and programs, with an eye to making it consumer and senior-friendly. Links are shown to additional resources that visitors to the site may find helpful and contact information is listed. http://www.dmas.virginia.gov/Content_pgs/ltc-home.aspx

**Publications**

There are several publications on the website that are particularly helpful to seniors interested in understanding Medicaid and determining if they are eligible for services and what is available:

- Guide for Long-Term Care Services in Virginia
- Virginia Medicaid Program at Glance
- Consumer-Directed Employer Manual
- Fact sheets on programs in LTC and a one-page chart of waiver services.

In addition, there are publications elsewhere on the DMAS website (http://www.dmas.virginia.gov/Content_pgs/rcp-home.aspx) and a search feature for services. These include:

- Medicaid Handbook (Aged, Blind or Disabled)
- Medicaid Handbook (Families and Children)
- Road Map to Services in Virginia

10. Describe any other services or programs that your agency plans to implement in the future to address the impact of the aging of Virginia’s population.

DMAS has a variety of policy changes, services, and programs that are currently underway to addressing the impact of the aging of Virginia’s population.

**Health and Acute Care Project (HAP)**

Those who have complex and acute care needs will be served under a new waiver as part of a joint project between the Divisions of Health Care Services and Long-Term Care Services. The Health and Acute Care Project or HAP, will enroll a projected 2,756 individuals in managed care who are currently receiving primary medical in fee-for-service (FFS) through the EDCD waiver into managed care starting December 2014. There are already 4,680 HCBS waiver individuals enrolled in managed care, which includes the EDCD, ID, DD, Day Support and Alzheimer’s waivers. These members get their acute and primary medical care services through the MCO and their waiver services are carved out and paid for by fee-for-service. This program has the benefit of providing chronic care management and care coordination, where there is a patchwork of services now. The total number in this program will be 7,436, and will increase monthly.

**Commonwealth Coordinated Care (CCC)**

LTC is supporting the agency in its efforts to combine Medicare and Medicaid benefits in one
health plan under Commonwealth Coordinated Care (CCC). As noted in #2, CCC is aimed at reducing duplication of services, better coordinating care and reducing costs of those who are eligible for both programs. As of November 1, 2014, 16,139 participants over age 60 are participating in CCC. Information was included on page 12 and more details may be found at http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx

**A Healthy Virginia**

DMAS is embarking on a multi-prong effort to provide health care to the uninsured, improve access to health care and pursue innovative solutions to all Virginians. Those initiatives that will be of particular benefit to those 60 and over are:

1) Providing medical and behavioral health services for insured people who have a serious mental illness;  
2) Increasing enrollment in the Federal Marketplace through an extensive educational campaign and active assistance;  
3) Becoming a partner with the Veterans Administration to make sure veterans receive quality care in a timely manner; and  
4) Pursuing health homes for individuals with mental illness through a collaborative system of primary, acute, behavioral and long-term services.

A full copy of the report can be found at [https://governor.virginia.gov/media/3096/a-healthy-virginia-report-final.pdf](https://governor.virginia.gov/media/3096/a-healthy-virginia-report-final.pdf)

A new waiver will be created to address the needs of the mentally ill needing acute care services. Details can be found at [http://www.dmas.virginia.gov/Content_pgs/1115.aspx](http://www.dmas.virginia.gov/Content_pgs/1115.aspx)

**11. Please indicate if your agency is experiencing an increase in employees retiring later and describe any actions your agency is taking or plans to take to accommodate its aging workforce with innovative practices.**

The Division of Human Resources anticipates minimal impact of aging upon the DMAS workforce. Recruitment efforts continue to be successful with sufficient applicant pools to fill positions. A similar report was issued in 2007 of the impact of aging upon the DMAS workforce. **Table 1 and Table 2** below provide a review of past retirement experience and how it has impacted DMAS for FY 2008 through FY 2014. During this period, there were 53 retirements.

**Table 2** compares the number of employees who were eligible for full-unreduced retirement to the number who actually retired during FY 08 through FY 14. At the end of FY 14, there were 29 employees (8.01%) eligible for an unreduced retirement. Of that number 12 (or 41.37% of those eligible for unreduced retirement) actually retired.

It is anticipated that some retirements will occur over the next several years. **Table 3** provides a review of impact for future years FY 2015 through 2019. Assuming no retirements occur during the next two years, and we keep the same number of classified employees, at the end of this two-year period 15 or 4.14% will be eligible for unreduced retirement.
Table 1

<table>
<thead>
<tr>
<th>Period</th>
<th>Classified Workforce</th>
<th>Number of Retirements</th>
<th>Percentage of Retirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2008</td>
<td>341</td>
<td>7</td>
<td>2.05%</td>
</tr>
<tr>
<td>FY 2009</td>
<td>345</td>
<td>7</td>
<td>2.02%</td>
</tr>
<tr>
<td>FY 2010</td>
<td>345</td>
<td>8</td>
<td>2.31%</td>
</tr>
<tr>
<td>FY 2011</td>
<td>342</td>
<td>8</td>
<td>2.33%</td>
</tr>
<tr>
<td>FY 2012</td>
<td>353</td>
<td>5</td>
<td>1.41%</td>
</tr>
<tr>
<td>FY 2013</td>
<td>357</td>
<td>6</td>
<td>1.68%</td>
</tr>
<tr>
<td>FY 2014</td>
<td>362</td>
<td>12</td>
<td>3.31%</td>
</tr>
</tbody>
</table>

Table 2

<table>
<thead>
<tr>
<th>Period</th>
<th>Classified Workforce</th>
<th>Unreduced Retirement Eligible</th>
<th>Number of Retirements</th>
<th>Percentage of Retirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2008</td>
<td>341</td>
<td>14</td>
<td>7</td>
<td>50.00%</td>
</tr>
<tr>
<td>FY 2009</td>
<td>345</td>
<td>21</td>
<td>7</td>
<td>33.00%</td>
</tr>
<tr>
<td>FY 2010</td>
<td>345</td>
<td>24</td>
<td>8</td>
<td>33.00%</td>
</tr>
<tr>
<td>FY 2011</td>
<td>342</td>
<td>24</td>
<td>8</td>
<td>33.00%</td>
</tr>
<tr>
<td>FY 2012</td>
<td>353</td>
<td>31</td>
<td>5</td>
<td>16.12%</td>
</tr>
<tr>
<td>FY 2013</td>
<td>357</td>
<td>30</td>
<td>6</td>
<td>20.00%</td>
</tr>
<tr>
<td>FY 2014</td>
<td>362</td>
<td>29</td>
<td>12</td>
<td>41.37%</td>
</tr>
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In reviewing the information above there is an obvious difference between the number of employees who were eligible for unreduced retirement and those who actually retired. Using an average of the percentage of those eligible for unreduced retirement who actually retired suggests that approximately 32.36 percent of those eligible for unreduced retirement may retire in each of the next several years. Table 3 reveals these projected numbers of retirements for each of the next several fiscal years.

There is always the possibility of error when estimating the number of retirements since a number of factors may influence when an employee decides to retire and one or more employees may decide to retire who are outside the unreduced eligible group, since they may also retire with reduced benefits. As a conservative measure towards planning for future retirements, using the total number of employees eligible for unreduced benefits may be useful for determining roles at risk.
A review of the types of positions and roles of DMAS may provide some insight on how the potential retirements may impact agency operations. **Table 3** identifies the Equal Employment Opportunity (EEO) code categories that are most at risk for retirements over the next several years.

<table>
<thead>
<tr>
<th>EEO Code</th>
<th>Office or Clerical</th>
<th>Paraprofessional</th>
<th>Professional</th>
<th>Official or Administrator</th>
<th>Number of Projected Retirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2015</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>2</td>
<td>3.23</td>
</tr>
<tr>
<td>FY 2016</td>
<td>0</td>
<td>1</td>
<td>9</td>
<td>5</td>
<td>4.85</td>
</tr>
<tr>
<td>FY 2017</td>
<td>0</td>
<td>2</td>
<td>7</td>
<td>1</td>
<td>3.23</td>
</tr>
<tr>
<td>FY 2018</td>
<td>0</td>
<td>2</td>
<td>10</td>
<td>5</td>
<td>5.50</td>
</tr>
<tr>
<td>FY 2019</td>
<td>0</td>
<td>4</td>
<td>14</td>
<td>3</td>
<td>6.79</td>
</tr>
</tbody>
</table>

A review of **Table 3** reveals the majority of positions at risk are in the professional and official or administrator categories. The professional positions range from providing administrative and technical expertise in program areas to positions in functional support areas such as Information Technology. A number of these incumbents have significant institutional knowledge, technical expertise and are very experienced in the operation of specific agency programs. Particularly significant is the number of middle to senior managerial incumbents in the official or administrator category that may be at risk due to future retirements. The retirement of these incumbents would impact the areas of agency leadership, operational management and resource management.

The loss of professional staff as a result of retirements will be addressed by the recruitment process, internal employee training and succession planning. It is anticipated that the agency will foster cross training opportunities for staff members to develop knowledge, skills and abilities necessary to meet the needs of agency program areas. To date, DMAS is increasing the amount of training opportunities available to employees. Emphasis will continue to be placed on project management, supervisory/leadership, performance management, computer software training and employee health and safety. This type of training is being scheduled for the next several fiscal years. The agency may also consider performing skill gap analysis for key benchmark positions to assist with recruitment and succession planning.

There will be greater use of the Learning Management System (LMS) both internally and with
the programs offered by the Department of Human Resource Management. The LMS is a web-based system designed to present learning and knowledge sharing opportunities to its users. It promotes learning through online course offerings, classroom course registration, and a consolidated transcript of all learning events for individual users. Currently, DMAS is a member of the DHRM LMS Users group and will continue implementing on-line access to the DHRM LMS Knowledge Center.

Given the specific skill sets needed for agency positions and the current internal and external marketplace for qualified candidates, replacing retired employees will not provide significant compensation and employee benefit cost savings to the agency.