



Overview of the Governor's Introduced Budget

Presentation to:

House Appropriations Committee
Subcommittee on Health and Human Resources

Cindi B. Jones, Director
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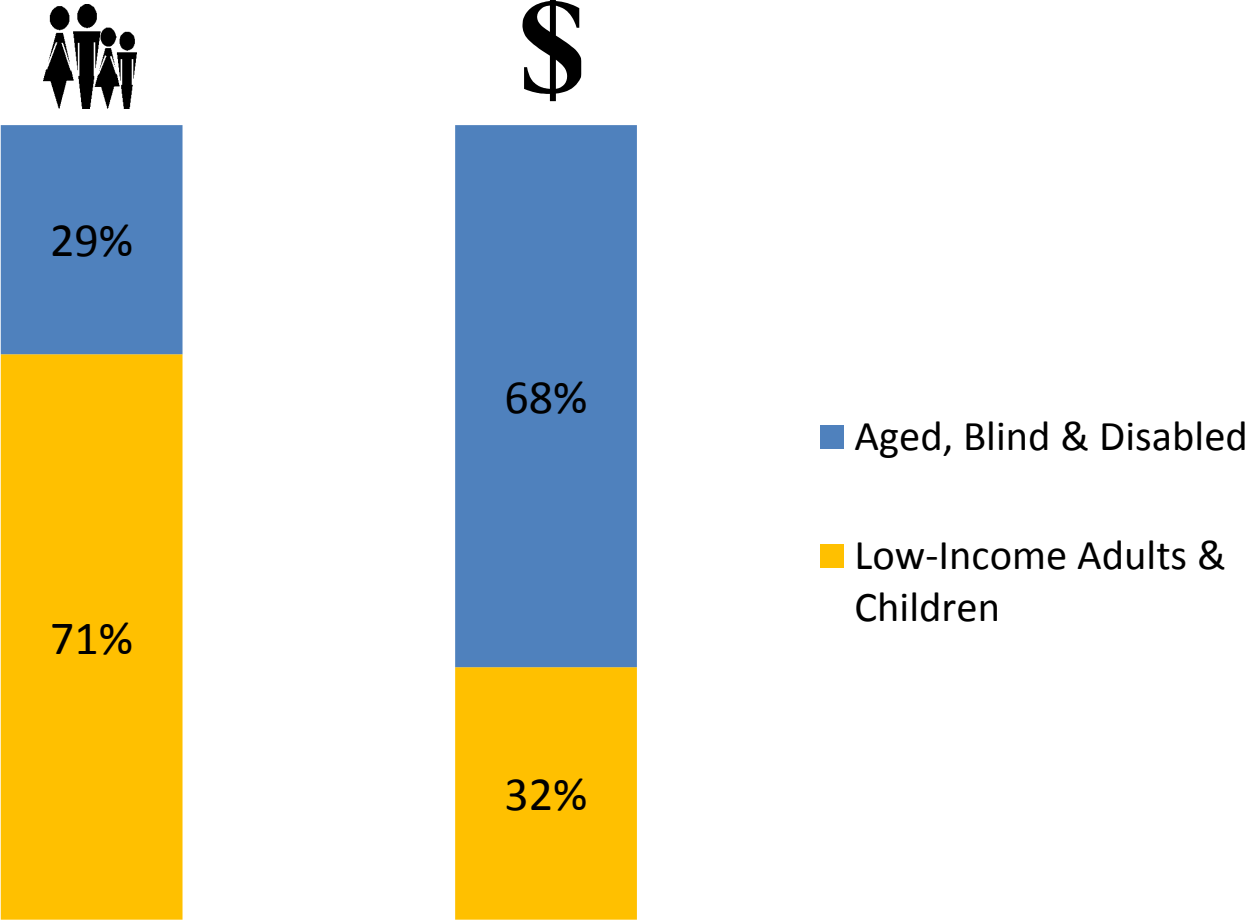
Outline

- ❑ Program Overview
- ❑ Expenditure Forecasts
- ❑ Governor's Budget Amendments
- ❑ Program Updates

In Virginia . . .

- **Medicaid/CHIP covers over 1 million Virginians; 1 in 8 Virginians rely on it**
- **Medicaid/CHIP pays for 1 in 3 births; 50% on Medicaid are children**
- **Medicaid is the primary payer for Long-Term Services and Supports; 2 in 3 nursing facility residents**
- **Medicaid is the primary payer for Behavioral Health Services**

Enrollment v. Cost

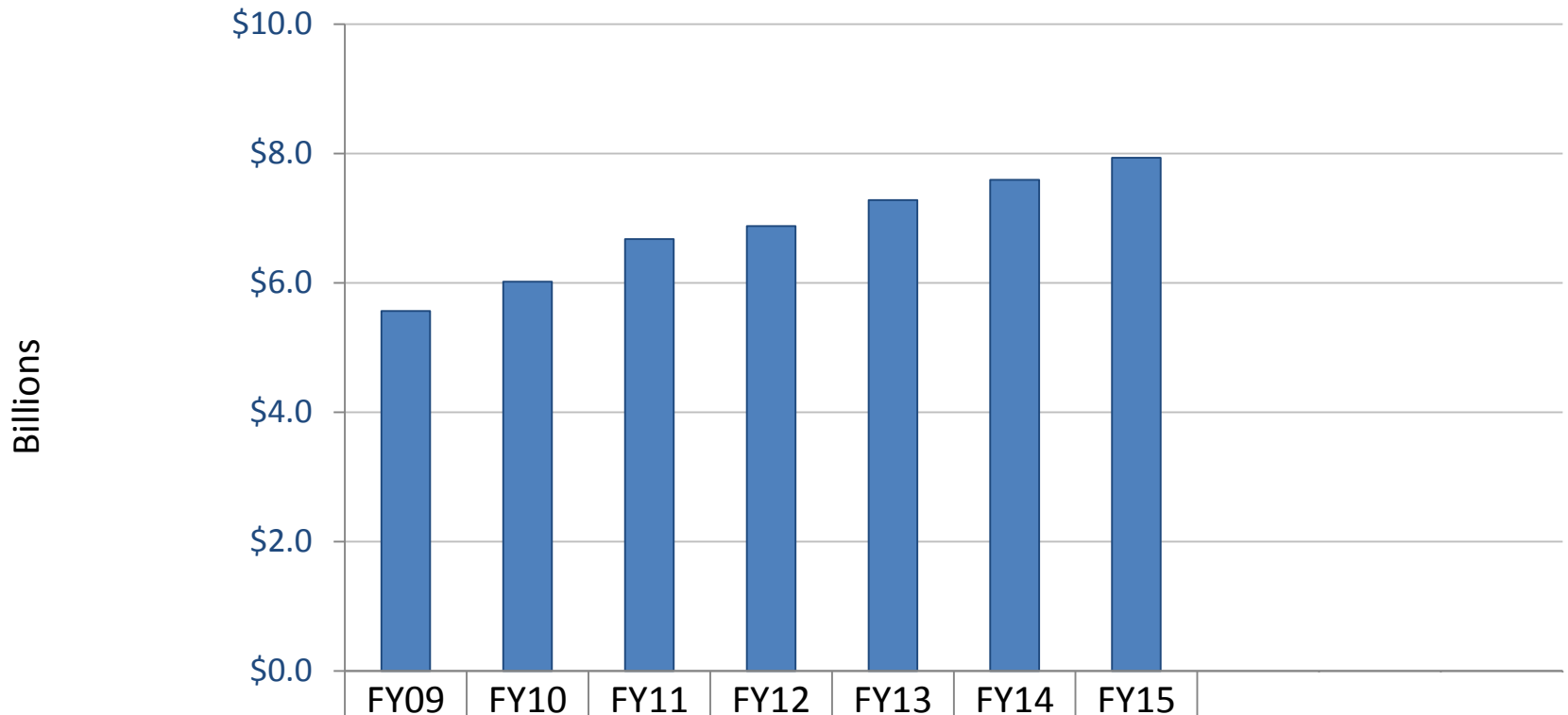


- 30% of Medicaid enrollment is responsible for almost 70% of the expenditures

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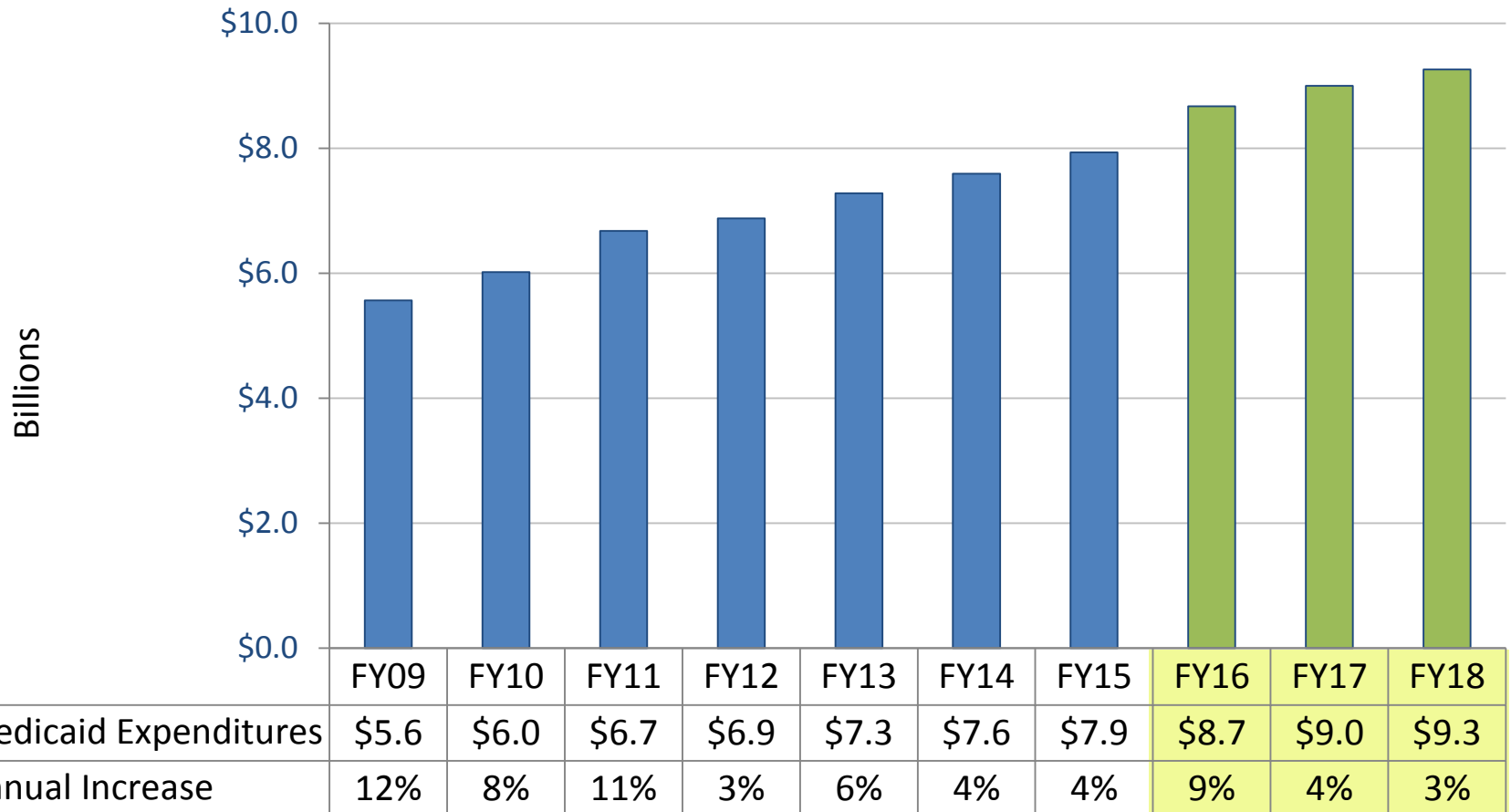
Medicaid Expenditures FY09-FY15



■ Medicaid Expenditures	\$5.6	\$6.0	\$6.7	\$6.9	\$7.3	\$7.6	\$7.9
Annual Increase	12%	8%	11%	3%	6%	4%	4%

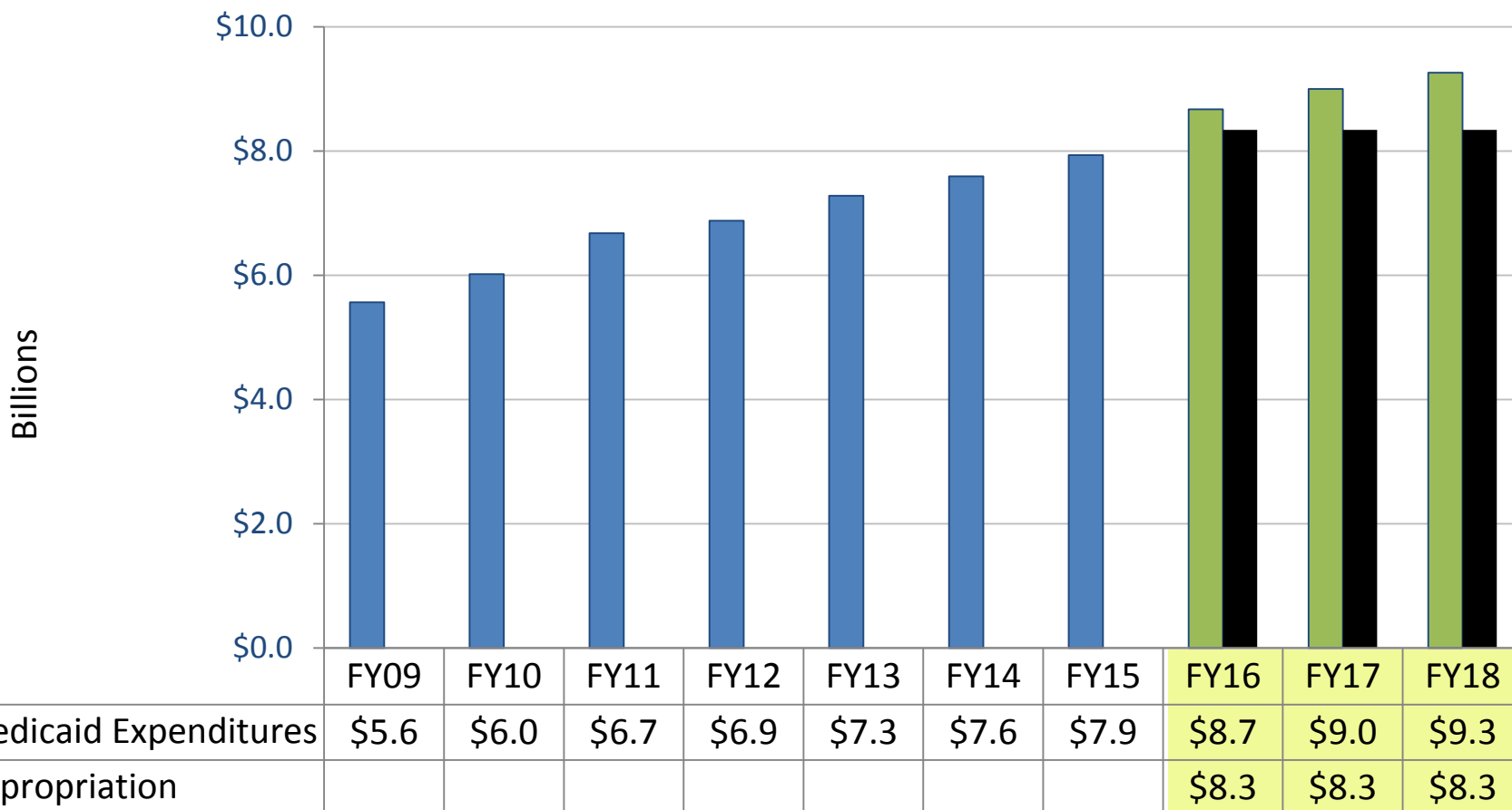
FY09-FY12 expenditures are adjusted to account for cash payment processing changes intended to generate one-time savings (FY09 delay of last weekly remittance cycle) or capture additional federal funds (FY11 payment of 13 MCO capitation payments)

Medicaid Expenditure Forecast



FY09-FY12 expenditures are adjusted to account for cash payment processing changes intended to generate one-time savings (FY09 delay of last weekly remittance cycle) or capture additional federal funds (FY11 payment of 13 MCO capitation payments)

Medicaid Funding Need- (\$956M) GF



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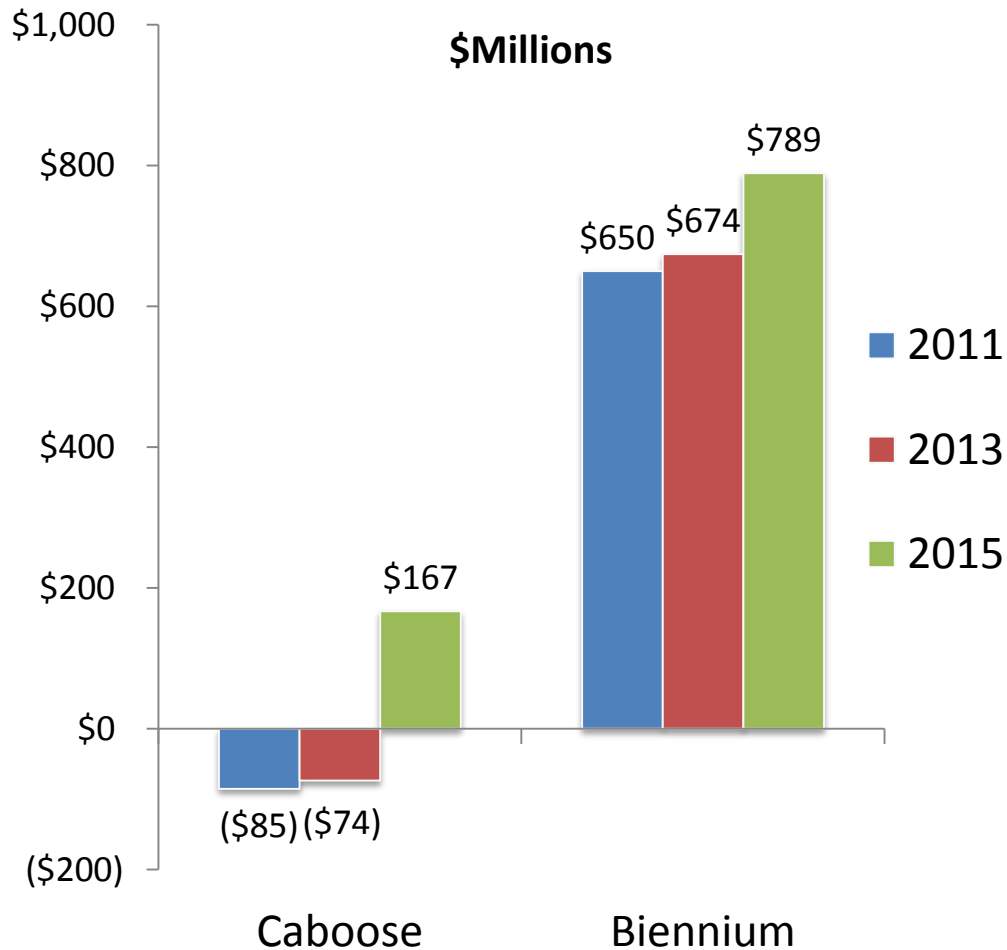
Medicaid Funding Need (\$956M) GF

		Appropriation (\$millions)	Consensus Forecast (\$millions)	Surplus/(Need) (\$millions)
FY 2016	Total Medicaid	\$8,343	\$8,673	(\$330.5)
	State Funds	\$4,258	\$4,425	(\$166.6)
	Federal Funds	\$4,085	\$4,249	(\$163.9)
FY 2017	Total Medicaid	\$8,343	\$9,001	(\$657.8)
	State Funds	\$4,258	\$4,586	(\$327.4)
	Federal Funds	\$4,085	\$4,415	(\$330.4)
FY 2018	Total Medicaid	\$8,343	\$9,261	(\$917.7)
	State Funds	\$4,258	\$4,720	(\$461.7)
	Federal Funds	\$4,085	\$4,541	(\$456.0)

FY16 Caboose	(\$166.6 GF)
FY17-FY18 Biennium	(\$789.1 GF)
Total	(\$955.7 GF)

Figures may not add due to rounding

Explanation of Medicaid Funding Need

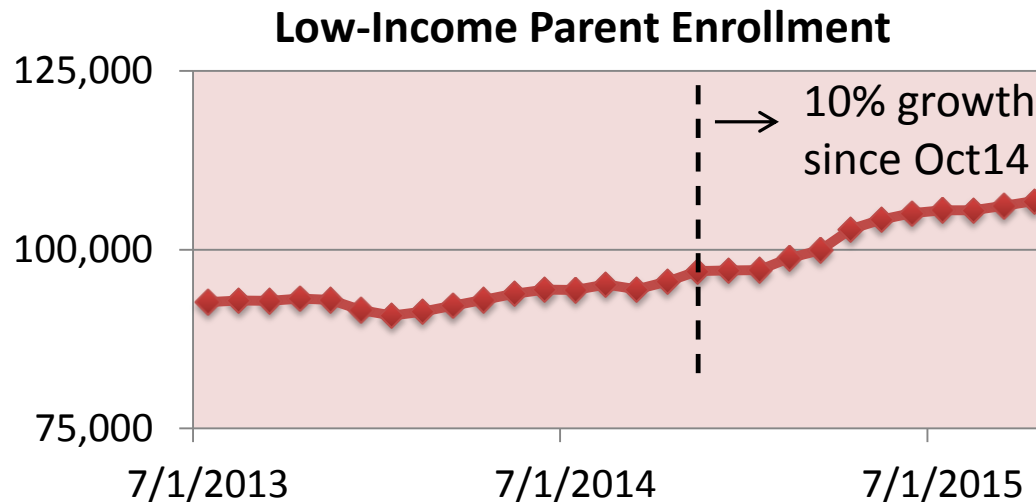


- New Biennium always presents a significant Medicaid funding need:
 - Enrollment growth
 - Increases in health care costs
 - No change in base appropriation

Explanation of Medicaid Funding Need

- Higher than expected enrollment of low-income parents began in FY 2015

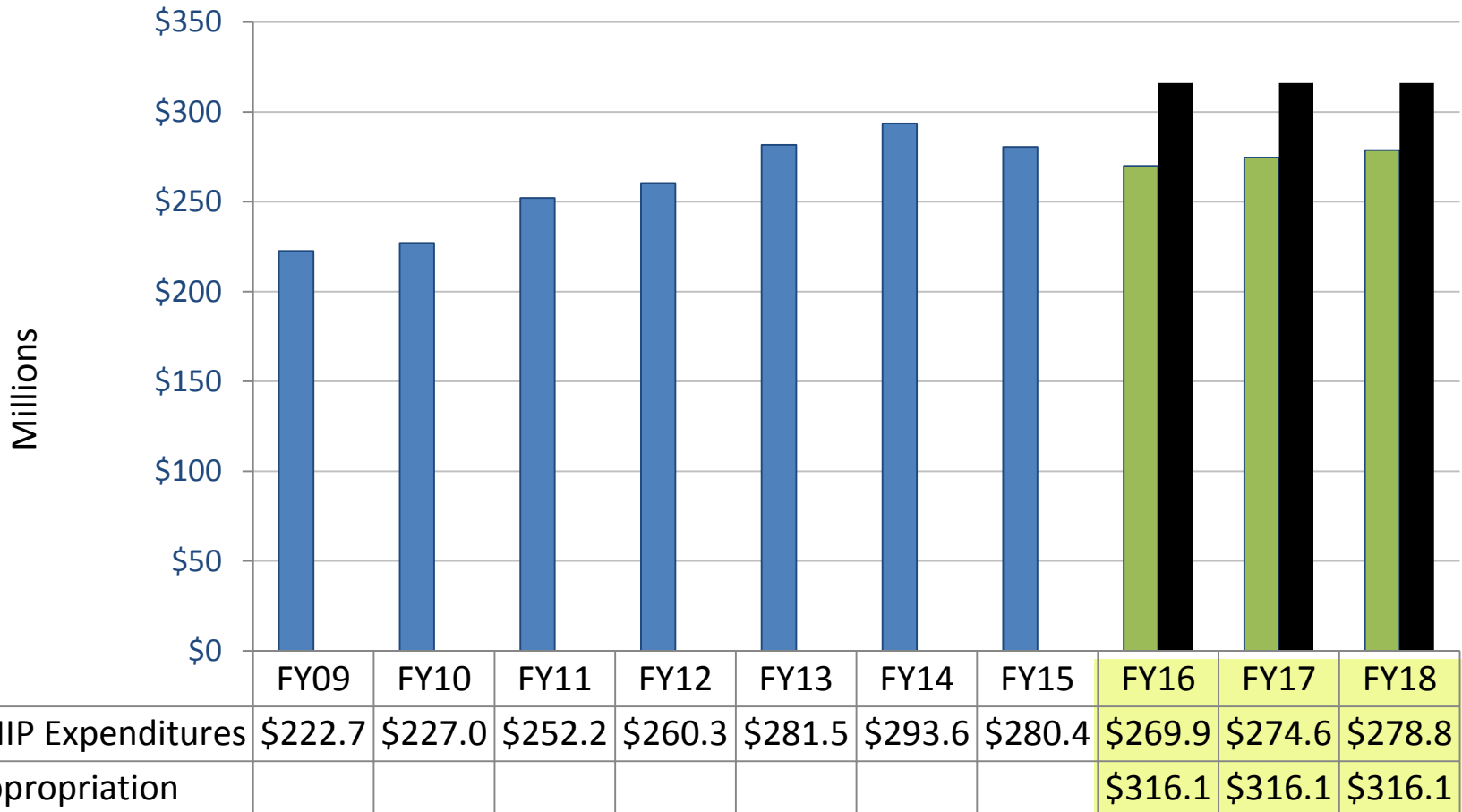
Kaiser 50 State Medicaid Budget Survey Report 2015: “... enrollment and total Medicaid spending grew an average of 5.1 percent and 6.1 percent, respectively, in non-expansion states, with the increase in enrollment **largely due to increased participation of previously eligible parents and children** [emphasis added].”



Explanation of Medicaid Funding Need

- Higher than expected enrollment of low-income adults began in FY 2015
 - FY15 costs were higher than projected and \$73M GF in payments had to be delayed until FY16
- Higher than expected increases by federal government for Medicare buy-ins
 - 15% increase in Medicare Part B Premiums effective Jan 2016
 - 11.6% increase in Medicare Part D “Clawback” rate effective Jan 2016
- Implementation of Department of Labor CD-Attendant Overtime Rule Jan 2016
- Primarily one-time increases (“level-shifts”) as opposed to increasing growth trends; higher growth rate in FY16 returning to “normal” growth rate in FY17 and FY18

CHIP/FAMIS Funding Surplus \$54M GF



FY09-FY12 expenditures are adjusted to account for cash payment processing changes intended to generate one-time savings (FY09 delay of last weekly remittance cycle) or capture additional federal funds (FY11 payment of 13 MCO capitation payments)

Explanation of CHIP Funding Surplus

- FY16 managed care capitation rates were significantly lower than projected
- The new ACA MAGI income methodology compressed the income eligibility range for CHIP resulting in a narrower band of eligibility and decreased enrollments in Virginia's FAMIS program
- Time period also reflects the beginning of increased emphasis on processing overdue renewals by DSS, resulting in higher than average coverage cancellations

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Governor's Budget: Savings Strategies

- **Withhold FY2017 and FY2018 inflation from hospitals**

FY 2017	(\$15.0m) GF	(\$14.6m) NGF
FY 2018	(\$32.7m) GF	(\$31.9m) NGF

- **Withhold FY2018 inflation from nursing homes, outpatient rehab facilities, and home health agencies**

FY 2018	(\$12.9m) GF	(\$12.9m) NGF
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- **Limit overtime hours for consumer-directed attendants to 56 hours per week**

FY 2017	(\$5.7m) GF	(\$5.7m) NGF
FY 2018	(\$6.2m) GF	(\$6.2m) NGF

Governor's Budget: Initiatives

- **Provide Health Care Coverage for the Uninsured**

FY 2017	(\$59.2m) GF	\$711.3m NGF
FY 2018	(\$97.7m) GF	\$2.3B NGF

*Figures reflect net savings to all agencies across the Commonwealth including DMAS, DBHDS, DOC and DSS

- Authorizes expansion of Medicaid eligibility for low-income adults to 133% FPL effective 1/1/2017
- Expected to provide access to coverage to over 400,000 uninsured Virginians with an anticipated increase in Medicaid enrollment of over 350,000
- Anticipated to reduce indigent care costs for hospitals across the Commonwealth, especially for rural hospitals
- Expanded coverage would provide substantial resources to strengthen Virginia's mental health and substance abuse disorder treatment system

Governor's Budget: Initiatives

- **Fund comprehensive Medicaid benefit package for substance use disorder (SUD) treatment**
 - Adds new services and increase rates for existing services in order to improve access to SUD treatment options in support of recommendations from the Governor's Taskforce on Prescription Drug and Heroin Abuse
 - Limited access to SUD treatment elevates costs in the criminal justice system. Increasing access to treatment is associated with a decreased likelihood of incarceration for people with SUD
 - Studies have demonstrated that expanding outpatient SUD treatment resulted in a decrease in inpatient hospital and ER costs

FY 2017	\$2.6m GF	\$2.6m NGF
FY 2018	\$8.4m GF	\$8.4m NGF

Governor's Budget: Initiatives

- **Increase rates for private duty nursing (TECH waiver and EPSDT) and personal/respite care services by 2%**
 - Supports access to cost effective community-based long-term care services for the elderly, disabled and children with special needs

FY 2017	\$7.7m GF	\$7.7m NGF
FY 2018	\$8.6m GF	\$8.6m NGF

Governor's Budget: Initiatives

- **Fund replacement of the Medicaid Management Information System (MMIS)**

- State Medicaid programs are required to have a federally-certified system to enroll recipients/providers; process/pay claims; and a decision support system.
- The contract to operate the current VA MMIS expires June 30, 2018 when the current system will be 15 years old
- Virginia is one of 30 states currently in the process of reprocurring their MMIS
- As the primary financier of the costs (90% match rate), CMS is very involved in coordinating states' efforts and assuring cost effective solutions
- Virginia is aggressively working to take advantage of commercial off-the-shelf solutions and decentralizing its systems to obtain the most cost effective solution

FY 2017	\$4.6m GF	\$41.7m NGF
FY 2018	\$5.8m GF	\$52.5m NGF

Governor's Budget: Initiatives

- **Provide funding for implementation of MLTSS**

- DMAS is scheduled to transition over 100,000 recipients into capitated managed care to coordinate their acute, behavioral health and long-term services and supports in Spring 2017
- The introduced budget provides funding for anticipated administrative costs and reflects projected administrative reductions associated with shifts from FFS into managed care

FY 2017	\$0.6m GF	\$2.2m NGF
FY 2018	(\$7.8m) GF	(\$6.9m) NGF

Governor's Budget: Initiatives

- **Fund federally-mandated 1095B notification mailing**
 - DMAS must print and mail proof of coverage (form 1095B) information to approximately 670,000 heads of households to enable those clients to complete their 2015 taxes; in addition the agency is required to provide contact information to handle recipient questions

FY 2016	\$1.0m GF	\$2.5m NGF
FY 2017	\$0.8m GF	\$1.5m NGF
FY 2018	\$0.8m GF	\$1.5m NGF

Governor's Budget: Initiatives

- **Increase support for managed care oversight and compliance**
 - Provides seven positions, and accompanying funding, to handle the increased oversight associated with the complex and growing managed care program

FY 2017	\$360k GF	\$360k NGF
FY 2018	\$360k GF	\$360k NGF

- **Provide funding for increased costs of operational contracts**
 - Three key operational contracts have been or soon will be rebid as required by state procurement law, and more often than not this is when the effect of rising costs of doing business is incurred

FY 2016	\$0.4m GF	\$0.4m NGF
FY 2017	\$2.4m GF	\$2.4m NGF
FY 2018	\$2.4m GF	\$2.4m NGF

Governor's Budget: Initiatives

- **Provide coverage of preventative lung cancer screenings**
 - Currently only covered when symptoms are presenting

FY 2017	\$52k GF	\$52k NGF
FY 2018	\$60k GF	\$60k NGF

- **Provide coverage of Applied Behavioral Analysis (ABA) services for children in FAMIS**
 - Currently this is mandated for commercial coverage and is available to children

FY 2017	\$146k GF	\$675k NGF
FY 2018	\$122k GF	\$893k NGF

Governor's Budget: Initiatives

- **DBHDS Amendments**

- Waiver Redesign
- New ID/DD waiver slots required by DOJ Settlement
- Funds reserve waiver slots
- Training Center funding adjustments

- **Language-Only Amendments**

- Removes language that discontinued the CoverVA Central Processing Unit at the end of SFY 2016
- Provides language authorizing the development of prospective state fiscal year rates for specialized care nursing facilities consistent with the existing cost based methodology

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Program Update: DOL Overtime Rule

Background on Fair Labor Standards Act (FLSA)

- The Department of Labor (DOL) released Home Care Rule (29 CFR, Part 552) that:
 1. Expands FLSA minimum wage and overtime protections to uncovered home care workers/attendants
 2. Redefines companion services which is exempt from FLSA
 3. Requires states that administer consumer directed services to determine if they are “third party or joint ” employers
 - **DMAS has requested an opinion from the Office of the Attorney General.**
- Effective date of 10/13/2015; however DOL issued a time-limited non-enforcement policy ending 12/31/2015 in order to give states additional time to comply
- DMAS began overtime payments to attendants for time worked after 12/31/2015

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Program Update: SUD Delivery System

Incomplete Care Continuum

Limited Coverage: Non-pregnant adults cannot receive residential treatment; instead receive more expensive inpatient detox. Pregnant women lose substance abuse treatment coverage 60 days after delivery.

Fragmented System: SUD treatment services are separated from mental and physical health services

Limited Access to Services

Lack of Providers: Rates for SUD treatment have not been increased since 2007 and don't match the cost of providing care. This severely limits number of providers willing to provide services to Medicaid members. Providers also struggle to understand who to bill for services. Consumers do not know where to seek services.

Current SUD Delivery System is Impacting VA Families: Neglect due to Substance Use Disorders was the #2 reason Virginia children entered foster care in 2013, but over half of mothers with children in foster care have waited more than 12 months for court mandated SUD services (according to the 2013 Title IV B report).

Program Update: SUD Delivery System

Actualizing Change and Progress for Virginia Families

Governor's Task Force on Prescription Drug and Heroin Abuse: Recommendations

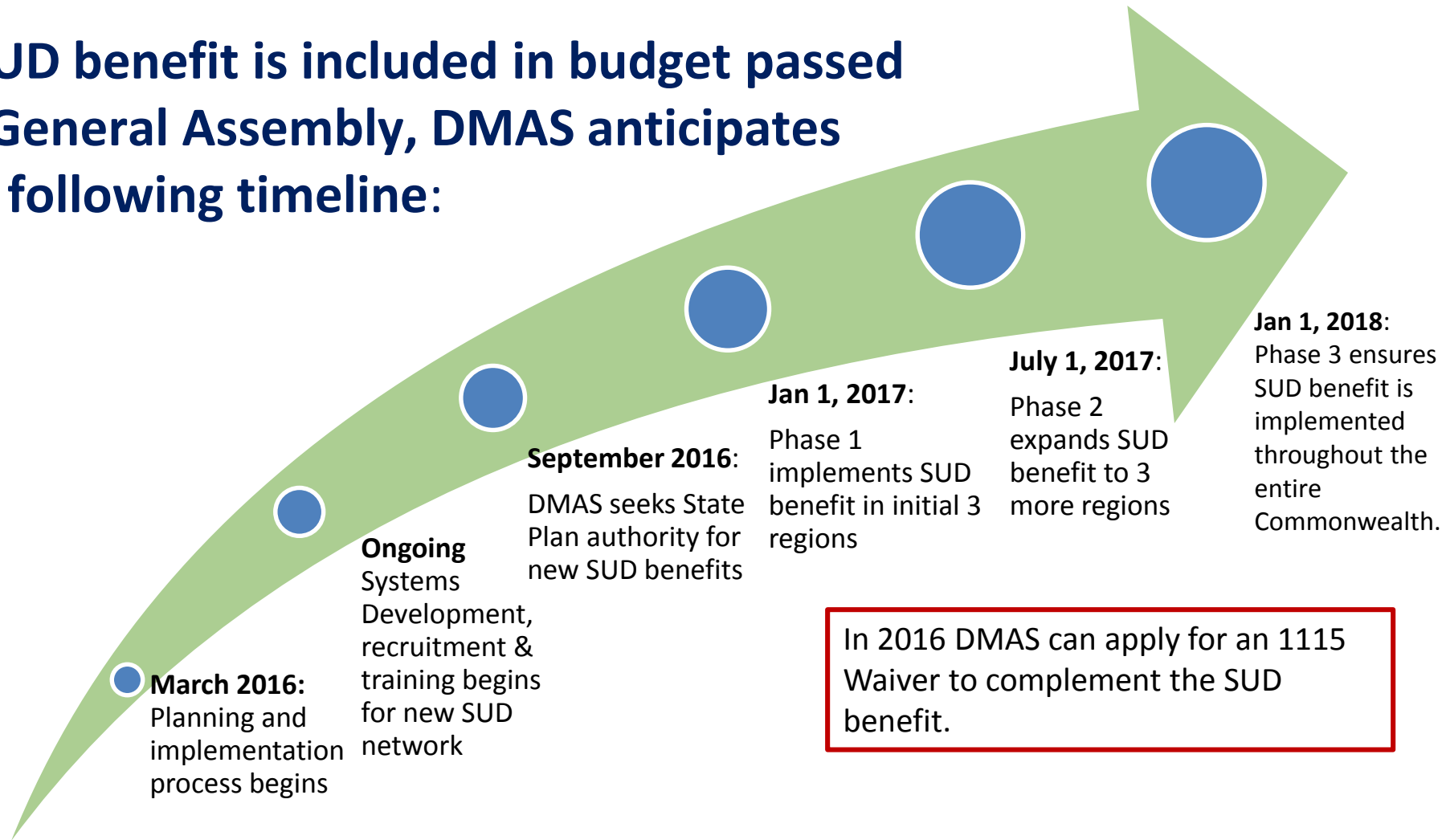
- Examine and enhance Medicaid reimbursement for substance abuse treatment services.
- Ensure health plans are complying with the Mental Health Parity and Addiction Equity Act by providing adequate coverage for treatment, including Medication Assisted Treatment (MAT).
- Explore and expand use of appropriate peer support services, with necessary oversight.

Governor's Six Budget Items

- Expand short-term SUD inpatient detox to **all Medicaid members**;
- Expand short-term SUD residential treatment to **all Medicaid members**;
- Increase rates for existing Medicaid/FAMIS SUD treatment services;
- Add Peer Support services for individuals with SUD and/or mental health conditions;
- Require SUD Care Coordinators at Medicaid health plans;
- Provide Provider Education, Training, and Recruitment Activities.

Program Update: SUD Delivery System

If SUD benefit is included in budget passed by General Assembly, DMAS anticipates the following timeline:



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Program Update: DSRIP

DMAS is seeking federal waiver authority to further Medicaid innovation. Delivery System Reform Incentive Payment (DSRIP) program will invest in transforming how providers are organized and paid for Medicaid services.

DSRIP is a Medicaid 1115 Waiver focused on Medicaid delivery system innovation.

This is a competitive national program and only seven states have received approval to date:

- CA, NM, TX, KS, NJ, MA, NY

DMAS will submit a waiver application to the federal government in early 2016. Negotiations with CMS will occur throughout 2016 and the earliest the program could start is in 2017. DMAS is in the preliminary stages of developing a potential budget for this program.

Virginia's Medicaid Transformation Drivers

DSRIP presents a strategic opportunity for Virginia's Medicaid program. The transformation priorities are driven by many different factors

Transformation Drivers

Description

Legislative and Judicial Mandates for Reform

CMS Expectation for Value-Based Payment

Lessons Learned and Years of Stakeholder Input

- Mandates for reform to **improve the performance** of Medicaid program
- CMS expects the investment to achieve provider readiness for **value based payment**
- Lessons Learned from other programs and years of stakeholder input point to the need for **provider infrastructure improvements**

Program Update: DSRIP

DSRIP Innovation Focus Areas

Virginia's DSRIP Innovation Areas

Implement Medicaid payment reforms for the Commonwealth by preparing Medicaid providers for Alternative Payment Models

Increase system efficiency and improve care delivery for Medicaid enrollees- especially those with complex needs

Facilitate shared learning projects across the state on alternative payment models and care for complex populations.

Results

Goal 1: Improved Beneficiary Health

Goal 2: Improved Beneficiary Experience

Goal 3: Bend the Cost Curve

Main Components of DSRIP Program

There are three main components of a DSRIP Program. The strength of all three components are important to the success of the application.

Program Design

There are restrictions on the scope of projects within a DSRIP program.

Programs must address:

- Systems Transformation
- Financial Incentive Alignment
- Clinical Improvements

Non-Federal Matching Funds

Select non-federal share options:

- Intergovernmental Transfers (IGTs) – not expecting general fund use
- Designated State Health Programs (DSHPs) – purely an attestation of dollars already allocated and spent on state health programs
- DMAS does **not** plan to seek GF to fund the non-federal share of this program.

Budget Neutrality

DSRIP must be budget neutral. Budget neutrality is a technical calculation.

- Proposed approach includes recognizing the trajectory of savings achieved through significant improvements and savings from home and community based waiver programs

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Program Update: MLTSS

The Department's goal is to develop a coordinated person centered system of care as directed by the General Assembly in the Appropriation Act. The program . . .

- ✓ provides individuals with enhanced opportunities to improve their lives
- ✓ improves community infrastructure and capacity
- ✓ promotes innovation and value based payment
- ✓ provides care coordination and reduces service gaps
- ✓ better manages and reduces expenditures and provides for budget predictability (full-risk, capitated model)



Program Update: MLTSS

Next Steps

- RFP (publish, evaluate, negotiate, readiness, award in 2016)
- Ongoing work
 - CMS authority
 - Regulations
 - Readiness review
 - MCO contracts
- Systems enhancements
- Ongoing stakeholder and member engagement, outreach and education
- Program launch in regional phases
- Ongoing program monitoring and evaluation

Thank you for your support!

