OVERVIEW OF THE GOVERNOR'S INTRODUCED BUDGET

Presentation to:
House Appropriations Committee
Subcommittee on Health and Human Resources

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Agenda

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

PROGRAM OVERVIEW

Virginians covered by Medicaid/CHIP

1 in 8 Virginians rely on Medicaid

1 in 3 Births covered in Virginia

2 in 3 Nursing facility residents are supported by Medicaid

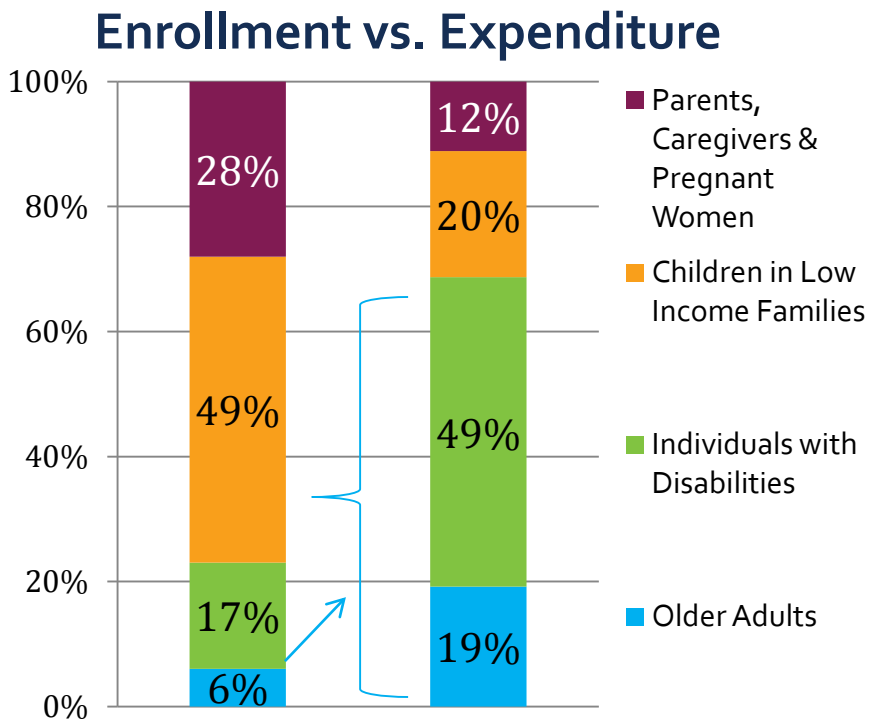
Medicaid is primary payer for Behavioral Health services

50% of Medicaid beneficiaries are children

62% of Long-Term Services & Supports spending is in the community

Virginia Medicaid

Services for Individuals with Disabilities and Older Adults Drive Medicaid Spending



23% of the Medicaid population

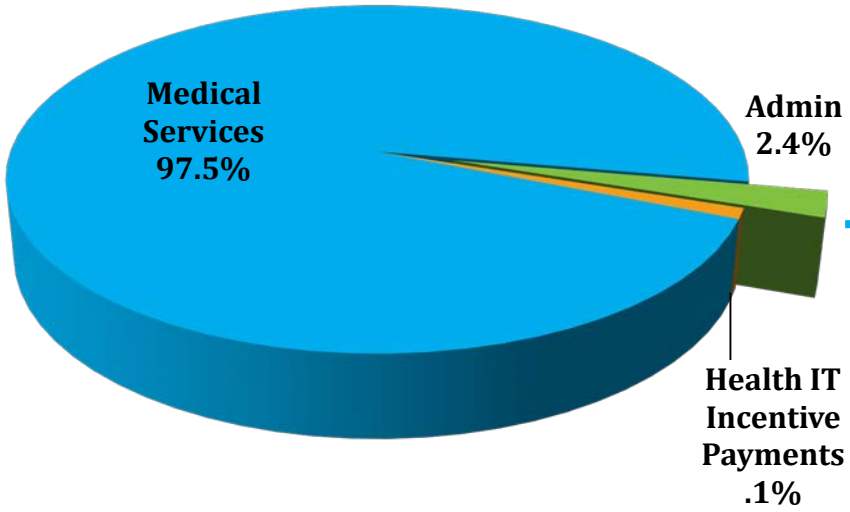
Drives

68% of total expenditures

Medicaid Budget

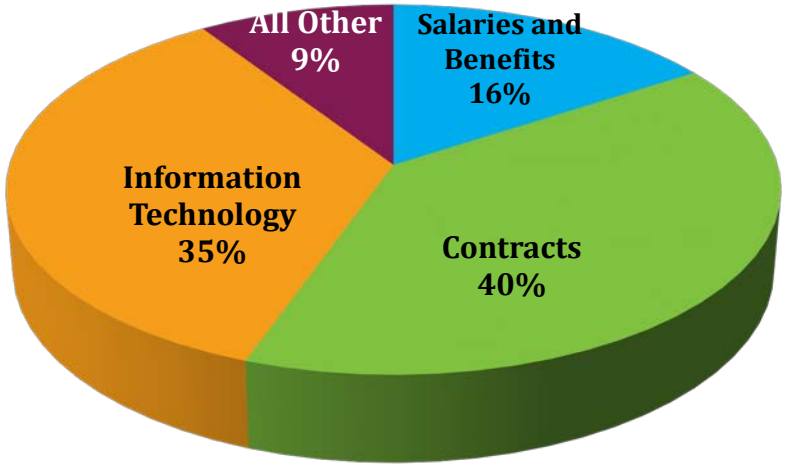
Only 2.4% of the total DMAS budget is for administrative expenses

Total FY16 Expenditures



97.5% of the DMAS budget funds medical expenses

Administrative Budget Breakdown



75% of Administration funds are for IT and Contract expenses

*Note: Health IT Incentive Payments are funded by 100% federal funds.

EXPENDITURE FORECASTS

Forecast Cost Drivers

Higher forecast is driven primarily by three major factors

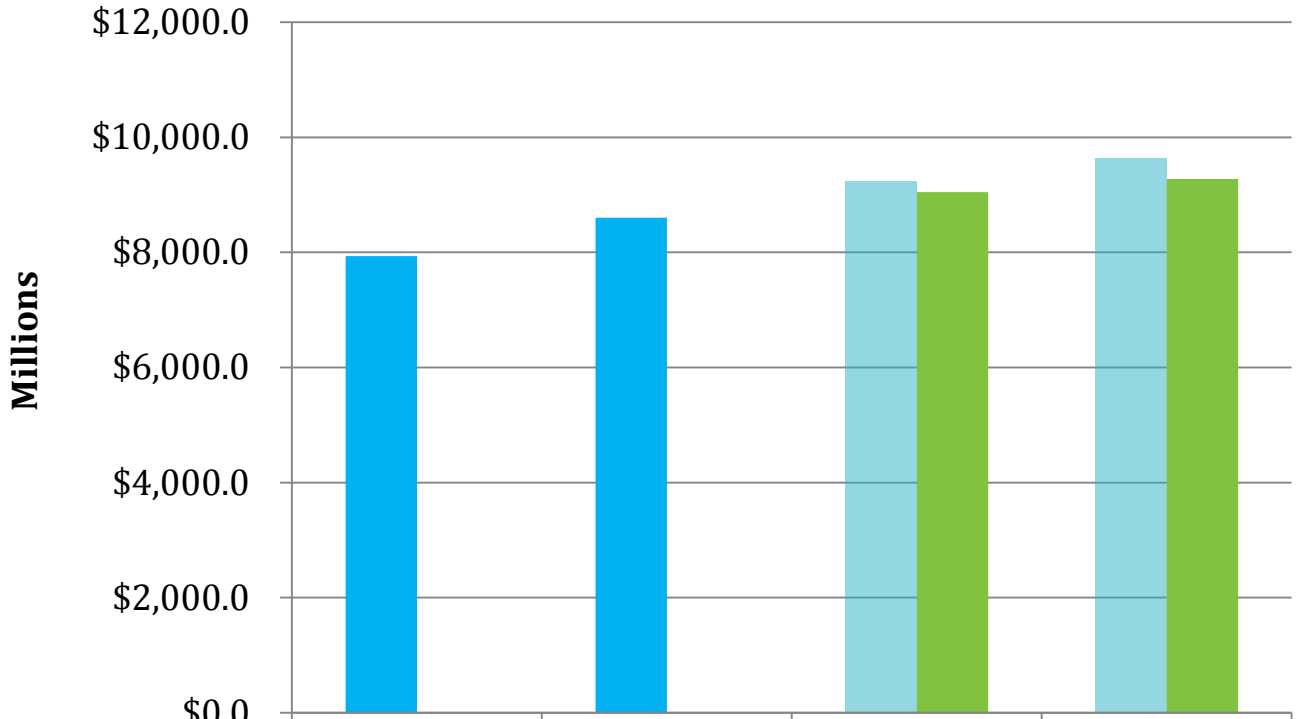
Medicare Part B and Part D Rate Increases

Increases in Costs for Behavioral Health Care

Resume Normal Utilization Trend in Fee-For-Service

New Medicaid Projections

The three major factors are driving a need for $255M GF



	FY15	FY16	FY17	FY18
Medicaid Expenditures/Forecast	$7,934.1	$8,604.5	$9,242.2	$9,637.2
Medicaid Appropriation			$9,048.0	$9,278.1

Impact of Cost Drivers

	Changes in SFY 2017 Forecast		Changes in SFY 2018 Forecast	
	General Fund	Total Fund	General Fund	Total Fund
Medicare Part B and Part D Rate Increases	$16.9M	$20.6M	$46.8M	$58.2M
Increases in Costs for Behavioral Health Care	$31.5M	$63.1M	$54.6M	$109.2M
Resume Normal Utilization Trend in Fee-For-Service	$38.8M	$77.5M	$38.3M	$76.7M
SFY Total of These Factors	**$87.2M**	**$161.2M**	**$139.7M**	**$244.1M**

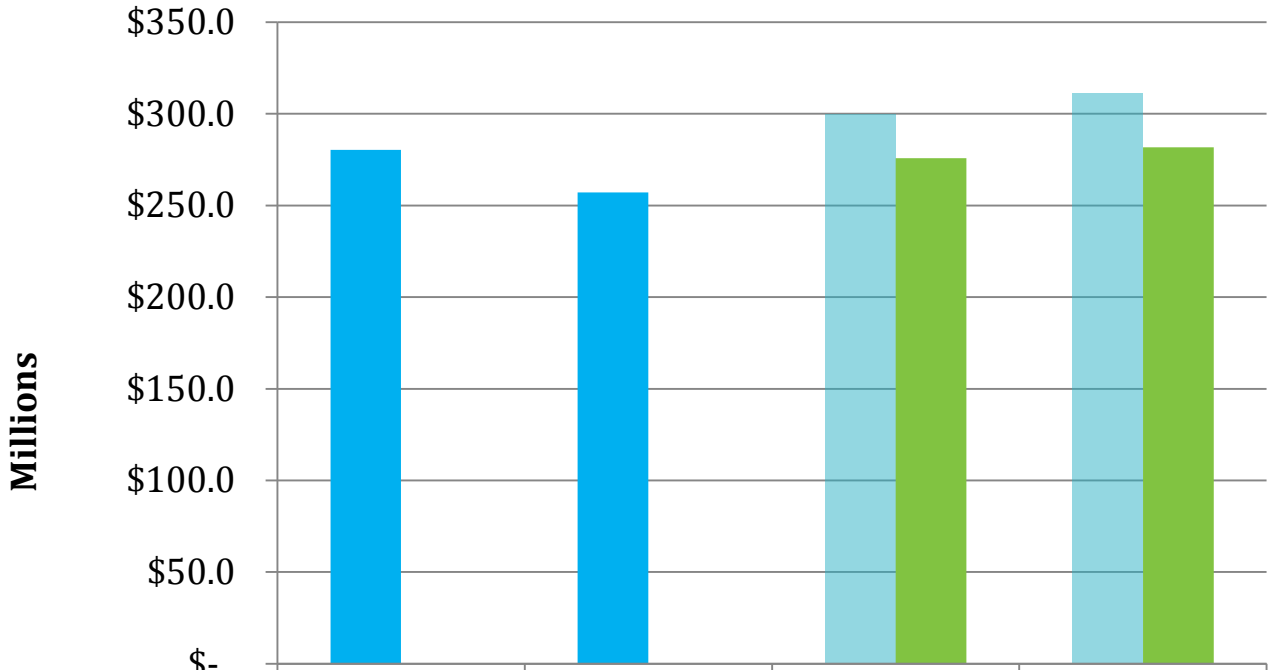
New Medicaid Forecast Results in a $255M GF Need

		Appropriation ($millions)	Consensus Forecast ($millions)	Surplus/(Need) ($millions)
FY 2017	**Total Medicaid**	**$9,048**	**$9,229**	**($180.8)**
	State Funds	$4,609	$4,686	($77.0)
	Federal Funds	$4,439	$4,543	($103.8)
FY 2018	**Total Medicaid**	**$9,278**	**$9,604**	**($325.4)**
	State Funds	$4,728	$4,906	($178.1)
	Federal Funds	$4,550	$4,697	($147.3)

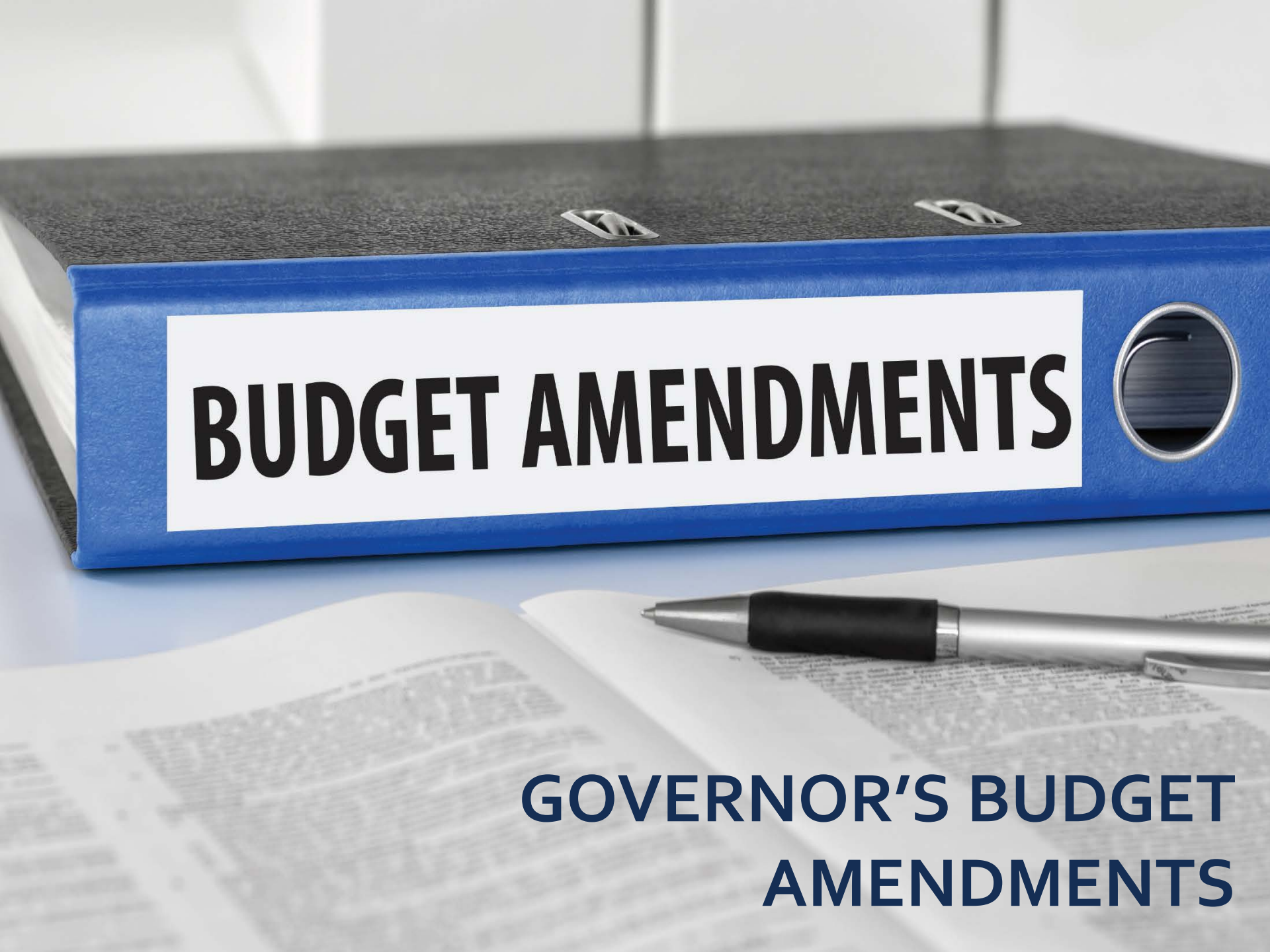
FY17-FY18 Biennium State Funds Surplus/(Need)	**($255 GF)**

Figures may not add due to rounding

New CHIP Forecast Results in a $6.6M GF Need in FY17 and FY18



	FY15	FY16	FY17	FY18
CHIP Expenditures/Forecast	$280.4	$257.1	$299.5	$311.3
Appropriations			$275.8	$281.7



GOVERNOR'S BUDGET AMENDMENTS

FY17 Savings

Administration Savings of **$3M**

	FY17 Savings Strategy	General Funds	Non-General Funds
1	**Audit Contracts** – change to reflect transition from fee-for-service to managed care	($869,176)	($869,176)
2	**Higher Federal Match** – reflect higher federal matching rate for certain information technology costs	($375,000)	$375,000
3	**Contract Costs** – reduce costs associated with certain contracts	($400,000)	($400,000)
4	**Hiring Process** – manage agency hiring process through delays in filling vacancies	($264,113)	($264,113)
5	**Streamlining** – implement administrative streamlining in the Office of the Chief Medical Officer	($45,000)	($45,000)
6	**Return Funds** – return excess IT audit funds	($50,000)	($50,000)
Total FY17 Savings Strategies		**($2,003,289)**	**($1,253,289)**

FY18 Savings

Administration Savings of **almost $5M**

	FY18 Savings Strategy	General Funds	Non-General Funds
1	**Audit Contracts** – change to reflect transition from fee-for-service to managed care	($1,311,446)	($1,311,446)
2	**Higher Federal Match** – reflect higher federal matching rate for certain information technology costs	($375,000)	$375,000
3	**Contract Costs** – reduce costs associated with certain contracts, including Cover Virginia Call Center and Central Processing Unit	($506,237)	($718,711)
4	**Hiring Process** – manage agency hiring process through delays in filling vacancies	($264,113)	($264,113)
5	**Streamlining** – implement administrative efficiencies and streamline	($279,887)	($279,887)
Total FY18 Savings Strategies		**($2,736,683)**	**($2,199,157)**

FY18 Enhancements

Provides $31.6M to enhance services in FY18

	FY18 Enhancements	General Funds	Non-General Funds
1	**Overtime Pay**– allow consumer-directed attendants to receive overtime pay up to 16 hours	$8,535,844	$8,535,844
2	**Same-Day Access** – provide same-day access to evaluation services at CSBs	$1,332,750	$1,332,750
3	**Nursing Facilities** – restore inflation for nursing facilities	$5,454,111	$5,454,111
4	**Readiness Review** – conduct readiness review for new managed care organizations	$67,572	$202,716
5	**Estate Recovery** – enhance estate recovery efforts	($372,318)	$620,530
6	**Substance Abuse** – perform federally required substance abuse (ARTS) waiver evaluation	$150,000	$150,000
7	**Service Access** – comply with federal requirements to perform service access analysis	$75,000	$75,000
Total FY18 Enhancements		**$15,242,959**	**$16,370,951**

PROGRAM UPDATES

Program Updates

1. Nursing Home Reimbursement
2. Overtime for CD Attendants
3. Residential Treatment Centers
4. Community Behavioral Health Services
5. JLARC Recommendations
6. Managed Care Updates
7. PPACA Potential Repeal Impact

1 Nursing Home Reimbursement Issues in 2018: Two Methodology Changes Impact Providers

New Prospective Payment System (price-based)

2018 is the 4th and final year of phasing in a new system

Phase-in used because change in methodology results in gain for some, loss for others

Developed through years of work by DMAS and nursing home representatives

Authorized in 2014 Appropriations Act

New Case-Mix Software Assigns Prices to Individual Residents Based on Acuity

New tool is acknowledged to be better than the previous one

Methodology change results in gain for some, loss for others

1

Nursing Home Reimbursement Issues in 2018: Additional Changes Impacting Providers

Required by state regulations to be conducted for 2018

Rebasing

- The required base year is one when state-imposed rate reductions suppressed nursing home spending
- Lower spending in the base year translates to lower rates in the 2018 rebasing
- In this rebasing, rates are 2.3% lower than they would have been if FY17 rates had been increased by inflation

Regulations require use of Medicare wage regions, which have been updated by CMS

Peer group change

- Result is lower rates for five nursing home in the Danville area

2 Overtime for Consumer Direction (CD) Attendants

New DOL rules, effective January 1, 2016 expanded minimum wage and overtime protections to home care workers/attendants

January 1, 2016 – DMAS began paying overtime for attendants working more than 40 hours per week for one consumer

- Live-in attendants were excluded from the overtime payments, in accordance with the DOL rules

2016 Appropriations Act limited attendants to working no more than 40 hours per week for one consumer

- Live-in attendants are exempt from the rule because they are also exempt from the DOL overtime rule

Number of live-in attendants increases from 5,913 in May 2016 to 8,285 in November 2016 – a 40% increase in 6 months

3 Why Are Changes Needed for the Psychiatric Residential Treatment Process?

Medicaid-eligible youth and their families need a timely, simplified process using an independent certification team that is in compliance with federal Medicaid requirements.

The process needs to:

Include a physician and a mental health licensed clinician when determining the youth's level of need for services

Explain community and institutional service options with provider choice so they can make an informed decision

Provide appeal rights

Average length of stay is **260 days** in Residential Treatment. Strengthened discharge planning will appropriately reduce the length of stay

Institutional treatment, where possible, needs to include **family involvement and prompt discharge planning**

3

Needed Changes for Psychiatric Residential Treatment

Single Point of Entry: The IACCT Process

Face to face assessment and IACCT "team" determines the ***appropriate level of care*** based on medical necessity

Ensure services delivered in the ***least restrictive setting***

Focus on including the ***physician*** **and** ***family*** for decision making and throughout the course of treatment

Promote ***improved outcomes*** through intense care coordination

Enforce ***strict turnaround times*** for assessments to ensure timely treatment (community or residential)

Residential Treatment Program Changes

Require ***family engagement*** to promote building and maintaining meaningful relationships with family members (***aligns with DSS/OCS)***

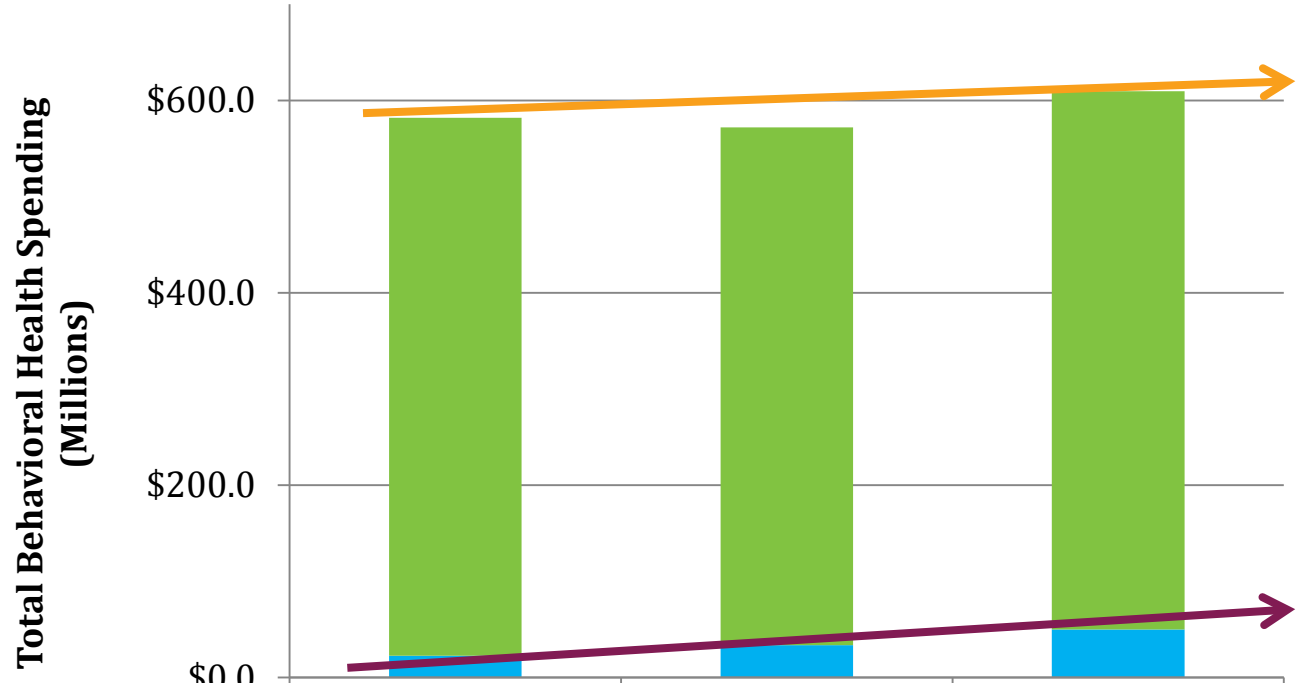
Ensure treatment focuses heavily on ***individualized activities***

Provide family support to ensure ***discharge readiness and successful transition*** back to the community

Support providers with clinical guidance to facilitate family engagement, coordination with DSS/OCS and successful discharge planning

4 Community Based Mental Health Services Utilization

Over 80 percent of these services are delivered by private providers.



	FY14	FY15	FY16
Other Behavioral Health	$559.1	$538.2	$559.5
Multi-Systemic Therapy	$22.8	$33.8	$50.1

4.8% growth in all community behavioral health services spending from FY14 to FY16

120% growth in multi-systemic therapies (which include ABA) from FY14 to FY16

4 Community Based Mental Health Services Utilization *cont.*

Service	Trend	Plan
Crisis Intervention	Slight Decrease	Improve use of these preventative services for at risk members
Intensive Community Treatment	Slight Decrease	Improve use of these preventative services for at risk members
Psychosocial Rehab	Consistent since FY14 with slight increase in Q1 FY17	Magellan monitoring application of medical necessity criteria to ensure appropriate access
Intensive In-Home	Less than 1% increase since FY15 Slight increase in Q1 FY17	Magellan monitoring application of medical necessity criteria to ensure appropriate access and assess utilization trends
Mental Health Skill-Building	8% increase from FY15-16 Overall decrease of 12% since FY14	Possible regulation change to better define qualifying diagnoses, establish discharge criteria, and strengthen service compliance

4 Community Based Mental Health Services Utilization *cont*.

Service	Trend	Plan
Therapeutic Day Treatment	Increasing costs since FY14 13% increase in FY15 Over 3% increase in FY16	• Magellan closely reviewing cases with longer length of stays • Workgroup launch in Spring 2017 to examine potential regulatory changes • Clarifying school, after-school and summer program requirements • DMAS to continue focused audits for regulatory compliance
Crisis Stabilization	Highest growth since end of FY14 23% increase in FY15 19% increase in FY16	• In 2015, changes made to allow easier access to crisis services: prior authorization not required and no longer limit of 8 hours per day • Magellan providing technical assistance and reviewing quality of care for members
Applied Behavioral Analysis	Annual increases of 48% since FY14	• Provider licensing requirements strengthened and expanded through Department of Health Professions • Proposed regulations currently under review • Workgroup launch in early Spring 2017 to explore more requirements on non-ABA therapies

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JLARC: Managing Spending in Virginia's Medicaid Program

Recommendation Category (#)	MLTSS (CCC Plus) Contract & Medallion 4.0 RFP	New Data Warehouse & Improved Data Analytics	Requires Legislative Direction & Authority	May Require Additional Funds	May Require Additional Staff or Contractual Resources
Long-Term Services and Support Screening (#1-6)			✓	✓	✓
Managed Care Oversight and Quality (#8,18-33)	✓	✓		✓	✓
Assess and Report Resources to Implement (#35)			✓		
Eligibility (Option 1)			✓		
Cost Sharing (Option 2)			✓	✓	✓

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JLARC: Managing Spending in Virginia's Medicaid Program *cont.*

Recommendation Category (#)	MLTSS (CCC Plus) Contract & Medallion 4.0 RFP	New Data Warehouse & Improved Data Analytics	Requires Legislative Direction & Authority	May Require Additional Funds	May Require Additional Staff or Contractual Resources
Managed Care Rates: Adjust rates to set community LTSS targets & account for savings initiatives (#7,11)	✓	✓			
Managed Care Rates: Return portion of underwriting gain (#14,34)			✓	✓	
Managed Care Rates: Retain underwriting gain cap (#17)			✓	✓	
Other managed care rate recommendations (#9,10, 12, 13, 15, 16)			✓	✓	✓

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JLARC: Eligibility Determination in Virginia's Medicaid Program

Recommendation	DSS System Changes Underway	DMAS Issued Policy Change	Funding Provided to Implement Provisions	DMAS Submitted Report to General Assembly
Automate verification of zero-income reported on Medicaid applications with available resources	✓	✓	✓	
Require eligibility workers to search for unreported assets using all available electronic data	✓	✓		
Develop a plan for a robust Medicaid estate recover program	✓			✓

6

DMAS to Operate Two Managed Care Programs by August 2018

Commonwealth Coordinated Care Plus (MLTSS)	Medallion 4.0
▪ 65 and older ▪ Adults and children with disabilities ▪ Medicare eligible ▪ Those with long-term care needs (community-base and facility) ▪ Integrates medical, behavioral, long term services and support	▪ Pregnant women ▪ Infants ▪ Children ▪ Caregiver adults/parents

213,000 individuals	730,000 individuals

Phasing in 7/1/2017	Phasing in 8/1/2018

6 Addiction and Recovery Treatment Services (ARTS)

- CMS approved ARTS waiver amendment to GAP 1115 waiver – will allow Virginia to obtain federal Medicaid matching $ for addiction treatment in residential facilities with > 16 beds
- Stakeholder Engagement/Provider Training
  - DMAS trained over 800 providers at 12 ARTS 101 sessions
  - Secretary's Summit attended by over 100 hospital, CSB, and FQHC leaders
  - VDH Addiction Disease Management trainings for over 300 physicians, NPs, PAs, and behavioral health providers
- Funds Already Appropriated in 2016 Budget
  - FY17: $2.5 million GF (+$2.5 million in federal match) = $5 million total
  - FY18: $8.3 million GF (+$8.3 million in federal match) = $16.6 million total
- Additional Funds Included in the Governor's Introduced Budget
  - FY18: $150,000 GF (+$150,000 in federal match) = $300,000 total
  - Fund CMS-required independent, external evaluation by VCU researchers to measure the cost savings and outcomes from the ARTS waiver

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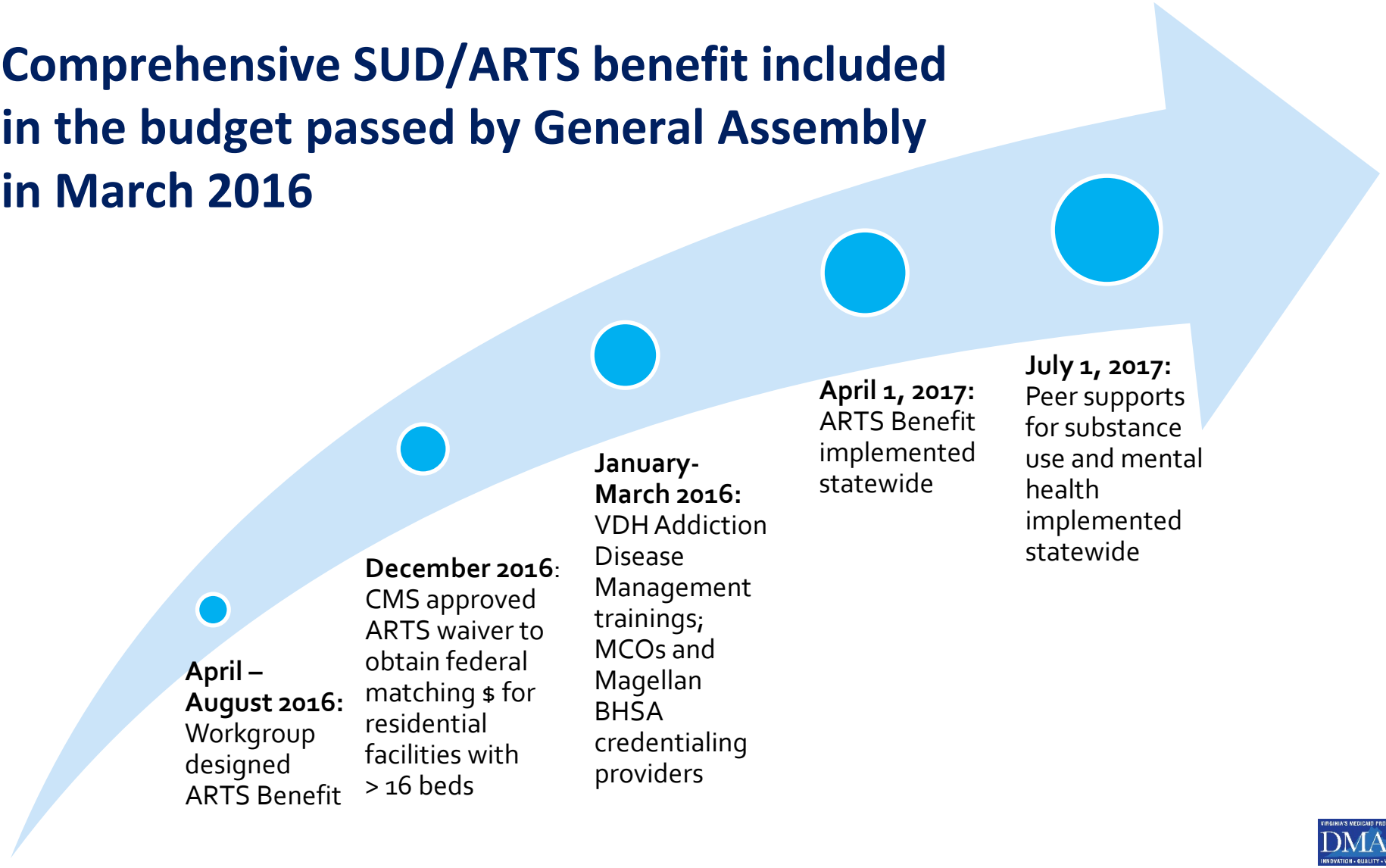
ARTS Implementation Timeline

Comprehensive SUD/ARTS benefit included in the budget passed by General Assembly in March 2016



7 Potential Impact of Repealing the ACA

Repealing the ACA could have major impacts on Medicaid, depending on what portions of the law are repealed

Potential Impact	FY18 Estimated GF Impact	FY19 Estimated GF Impact
Lose managed care drug rebates	$80.7M	$157.2M
Lose enhanced match for CHIP	$48.8M	$65.0M
Reverse reductions in indigent care	$19.2M	$29.5M
Eliminate ACA insurance tax	$0	($19.9M)
Eliminate GAP program	($21.8M)	($35.4M)
Other impacts (former foster care youth, Plan First, reporting requirements)	($3.5M)	($5.2M)
Total Cost/(Reduction in Cost)	**$123.2M**	**$191.2M**

VISION FOR SUCCESS

New Divisions Created

- ✓ Office of the Chief Medical Officer
- ✓ Office of Innovation and Strategy
- ✓ Division of Procurement and Contracts
- ✓ Office of Data Analytics

Virginia's Vision

Everyone is paid for consistently doing the right thing

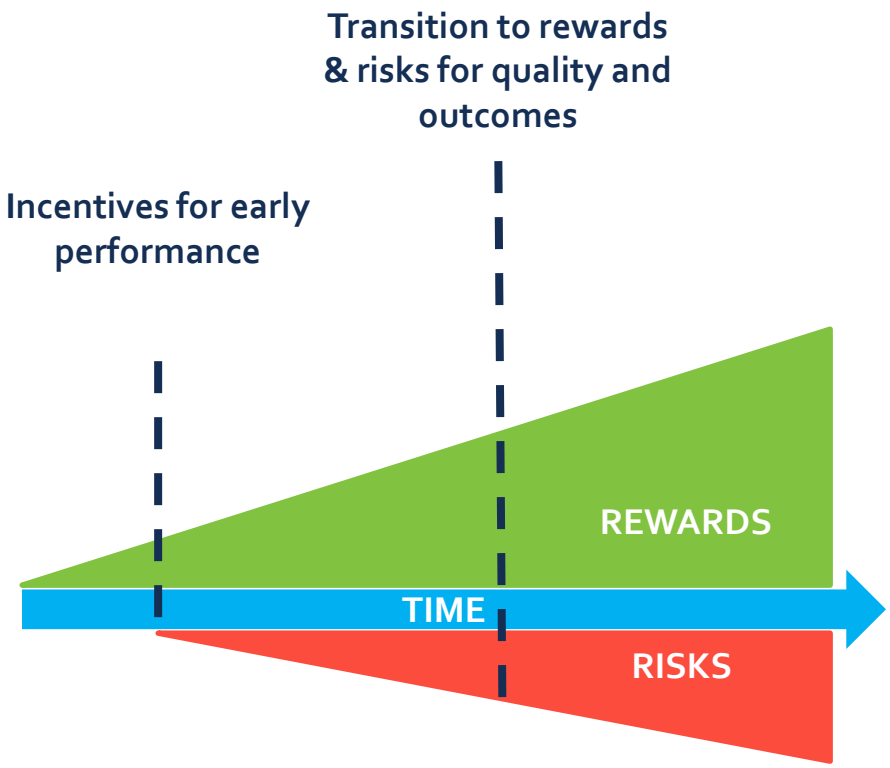
Virginia Medicaid will…

Incentivize patient-centered care that achieves quality outcomes	Balance and align penalties and rewards	Create efficiencies and bend the cost curve

Guiding Principles

Support providers to have the tools and information they need	Structure incentives to achieve defined quality outcomes	Plan and implement change incrementally and consistently

Looking Ahead



Performance Based Payments Increase with Time

Examples of High Priority Areas

- Utilization and Cost of Care
- Patient and Provider Satisfaction
- Percent of LTSS in the community
- Percent of Payments in Value-Based Payments
- Increased Transparency
- Enhanced Care Quality and Access