HEALTH & HUMAN RESOURCES BUDGET DRIVERS

House Appropriations Committee

November 17, 2015

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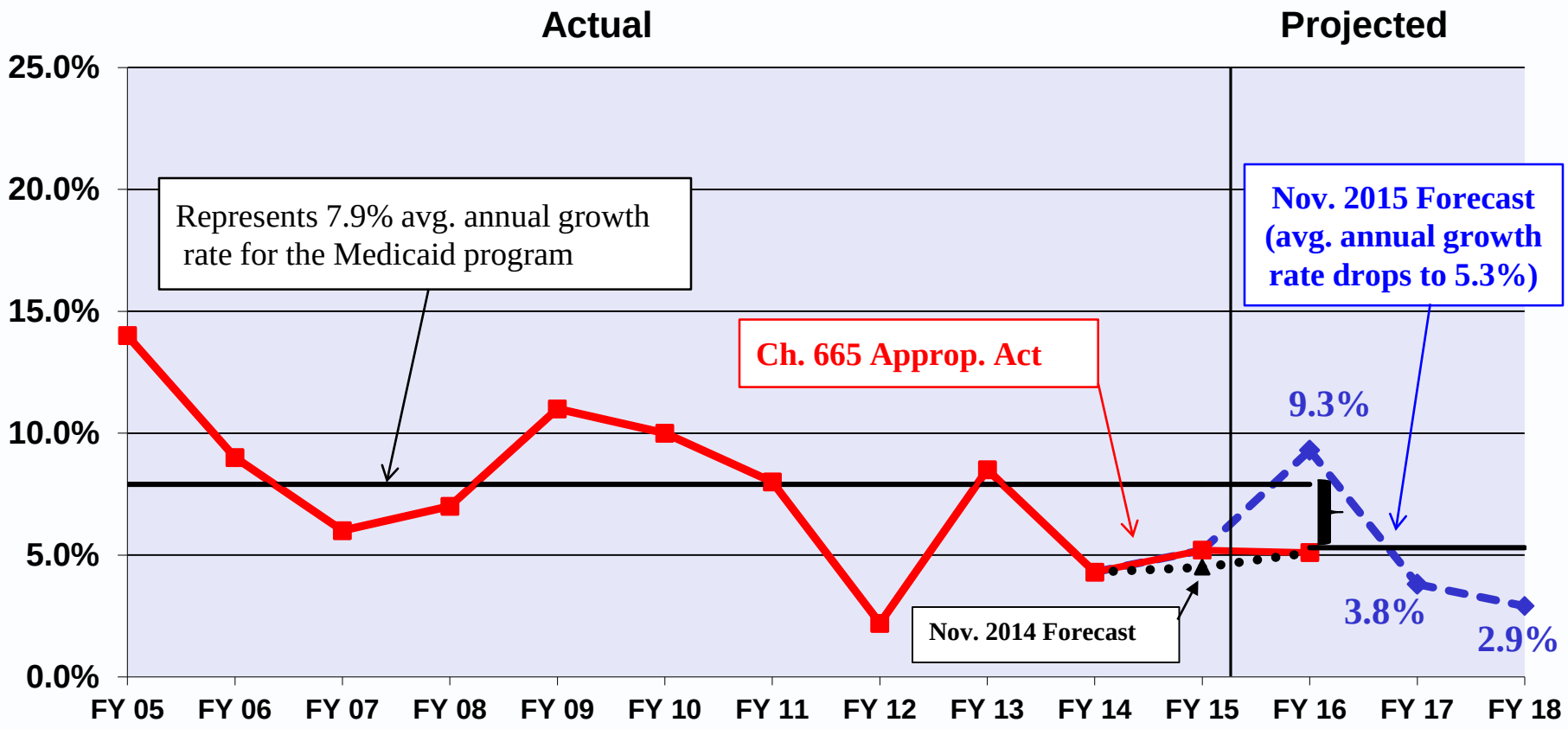
Medicaid Forecast

- Official Medicaid forecast updated every November
- 2015 Official Medicaid forecast updates projected spending for FY 2016 and the 2016-18 biennium
- In addition, Virginia Health Care Fund revenues will influence how much general fund revenue is required to meet the forecast costs of the Medicaid program
  - Revenues in the Fund are used as a portion of the state's match for the Medicaid program
  - Comprised of tobacco taxes, Medicaid recoveries and a portion of the Master Tobacco Settlement Agreement (41.5%)
  - Revenue changes in the Virginia Health Care Fund are not included in Official Medicaid forecast
  - The Fund ended FY 2015 with a cash balance of $8.8 million which will be carried forward into FY 2016

November 2015 Medicaid Forecast



Note: Represents percentage change in all funds, state and federal, adjusted for payment timing changes, cash management, FMAP maximization.
Source: 2014 and 2015 preliminary DPB and DMAS consensus forecast

Preliminary Medicaid Forecast

($ in millions)

	FY 2016		FY 2017		FY 2018	
Medicaid Forecast	**GF**	**All Funds**	**GF**	**All Funds**	**GF**	**All Funds**
November 2015 Forecast	$4,424.8	$8,673.4	$4,585.6	$9,000.6	$4,719.9	$9,260.5
Chapter 665 Funding (Base)	$4,258.2	$8,342.9	$4,258.2	$8,342.9	$4,258.2	$8,342.9
Additional Need	$166.6	$330.5	$327.4	$657.7	$461.7	$917.6

Preliminary Medicaid Forecast: GF Need

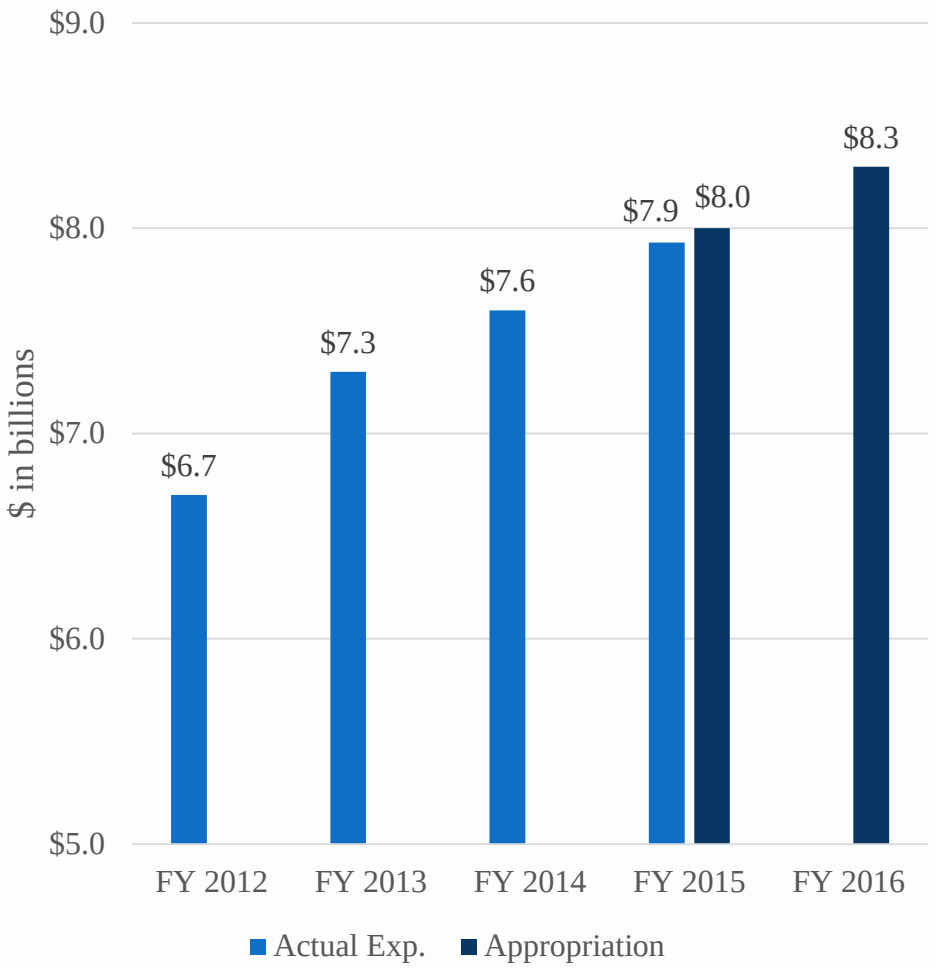
(GF $ in millions)

Medicaid Forecast	FY 2016	FY 2017	FY 2018
Medicaid Expenditures Baseline Forecast	$166.6	$304.9	$396.1
Inflation Adjustment for Hospital Costs		$14.6	$31.7
Inflation Adjustment for Nursing Facility Costs		$7.9	$33.9
Total Change in GF Need	$166.6	$327.4	$461.7

Note: Reflects November 15, 2015 Medicaid consensus expenditure forecast.

Medicaid Funding: FY 2015

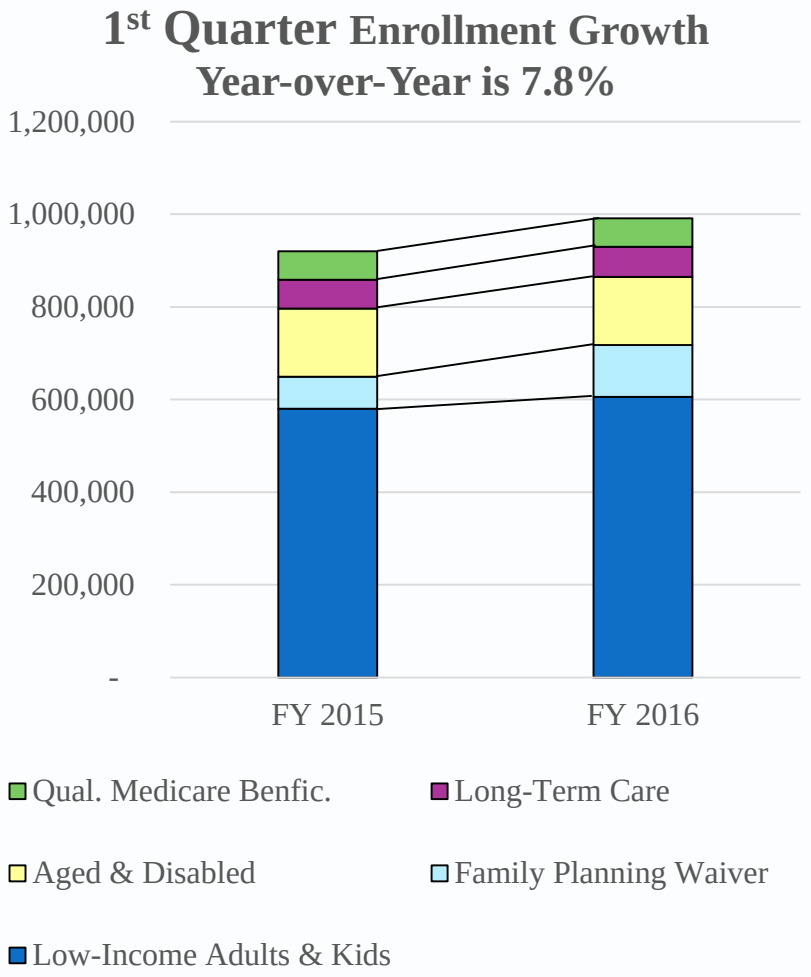
- Final FY 2015 expenditures were $24.5 million GF lower than forecast
- However, unanticipated enrollment growth from the “woodwork” effect of Obamacare resulted in moving two large payments from FY 15 to FY 16
  - $57.5 million GF in 4th qtr. indigent care payments to teaching hospitals
  - $16 million GF for June Medicare Part D payment
- Without these payment delays, Medicaid would have ended the year in the red



Enrollment Growth is Major Cost Factor in FY 2016

- "Woodwork" effect began to show up last 5 months of FY 2015
  - 10,000 added caretaker adults @ $4,500/yr.*
  - 20,000 added low-income children @ $2,500/yr.*
- Slightly higher than estimated enrollment of aged, blind and disabled individuals by end of FY 2015
  - 1,500 aged individuals @ $18,767/yr. *
  - 300 disabled individuals @ $19,754/yr.*
- Lower number of dual eligibles enrolling in the Commonwealth Coordinated Care Program resulting in higher than estimated nursing facility payments
- Enrollment growth for FY 2016 is projected to be 5%

*Based on 2014 Medicaid expenditures.



FY 2016 Forecast Adjustments by Major Category

($ in millions)

Forecast Adjustments	FY 2016 GF $	FY 2016 NGF $	FY 2016 Total
Annualized enrollment growth due to "woodwork" effect of Affordable Care Act	$67.5	$67.5	$135.0
Disproportionate Share Hospital (DSH) payments carried over from FY 2015	$57.5	$57.5	$115.0
15% Medicare Part B premium rate increase	$29.8	$0	$29.8
DSH payment disallowances/deferrals	$26.0	$0	$26.0
Medicare Part D payments carried over from FY 2015	$15.0	$0	$15.0
11.6% increase in Medicare Part D clawback	$9.0	$0	$9.0
US DOL consumer directed attendant overtime rule (does not assume any policy changes capping hours)	$8.0	$8.0	$16.0
Total	**$212.8**	**$133.0**	**$345.8**

Factors Affecting Medicaid Spending Growth in 2016-18 Biennium

- FY 2016 forecast adjustments annualized
- Enrollment growth
  - Projected to continue growth at 5% in FY 2017 and grow by 2.4% in FY 2018
    - Not forecasting large woodwork effect from current Obamacare open enrollment, despite earlier projections
- Rate increases
  - Managed care organization (MCO) capitation rates
    - Rates required to be actuarially sound by federal government
    - Rates recommended by actuary
    - 2.8% in FY 2017 and 3.3% in FY 2018 for low-income children and adults
    - 3.5% each year of the biennium for aged, blind and disabled individuals
    - Represents $85.7 million (all funds) in FY 2017 and $190.4 million (all funds) in FY 2018
  - Hospital and nursing home inflationary adjustments
    - Required by regulations
    - 2.6% in FY 2017 and 2.7% in FY 2018 for hospital inpatient expenditures
    - 0.9% in FY 2017 and 2.9% in FY 2018 for nursing facility services
    - Represents $22.5 million GF in FY 2017 and $65.6 million GF in FY 2018
  - Hospital and nursing home rebasing
    - Expected to take effect in the 2016-18 biennium, however, neither is expected to generate additional costs

Factors Affecting Medicaid Spending Growth in 2016-18 Biennium

- Growth in Medicaid services
  - Home and community based waiver services
    - Growth projected at 6.6% and 2.2% respectively over the biennium
      - Represents an additional $51.6 million GF in FY 2017 and $18.7 million GF in FY 2018
      - Personal care and ID/DD waiver services represent about 65% of the total additional long-term care funds required over the biennium
  - Behavioral health services
    - Continued growth expected in mental health skill building services of 5.5% in FY 2017, leveling off to 0.5% in FY 2018
      - Represents $14.9 million GF in FY 2017 and $4.9 million GF in FY 2018

Other Medicaid Budget Requests

Description (GF $ in millions)	FY 2016	FY 2017	FY 2018
Replace Medicaid Management Info. System		$4.6	$5.8
Commonwealth Coordinated Care Demonstration Program (Dual Eligibles)		$1.5	($6.9)
Increase in Cost of Major Contracts		$2.4	$2.4
Fraud Investigations Using Federal Public Assistance Reporting Information		$1.0	$1.0
ACA mandatory recipient notifications of Medicaid coverage	$1.0	$0.7	$0.7
Total	**$1.0**	**$10.2**	**$3.0**

DOJ Settlement Agreement Costs

(Above $72.2 million GF FY 2016 Base)

Description (GF $ in millions)	FY 2016	FY 2017	FY 2018
Required waiver slots: • 180 ID facility transition slots • 625 ID community slots • 50 DD waiver slots		$13.5	$30.1
100 reserve emergency waiver slots		$1.8	$1.8
Training Center discharges of individuals not eligible for ID/DD waiver		$0.5	$0.5
Transitional funding for individuals leaving training centers		$0.6	$0.5
Guardianship services to 195 ID/DD individuals		$0.5	$1.0
Emergency supports for individuals on waiting list		$0.5	$0.5
Continue rental subsidy to provide on-going support		$0.4	$0.4
Children's crisis services for ID/DD community		$4.7	$5.3
Regional health support networks in SW & Central Virginia		$1.3	$1.3
22 FTEs for DOJ admin. requirements (10 licensing, 5 family support program, 3 regional specialists, 4 other)		$1.9	$2.1
Critical event tracking system		$1.0	$0.3
Increased workload of Independent Reviewer		$0.1	$0.1
Facility closure costs & backfill revenue loss at state mental health hospitals	$7.3	$4.8	$3.9
Medicaid savings from facility closure		($9.8)	($10.9)
Total New Costs	**$7.3**	**$21.8**	**$36.9**

ID/DD Waiver Redesign

- Virginia began ID/DD Waiver redesign officially in 2011
- Original goals of ID/DD Medicaid waiver redesign were to:
  - Contain costs while adequately funding services
  - Ensure individuals were receiving necessary and appropriate level of services
  - Balance the need for more community slots and the need for increased rates to ensure adequate community providers
  - Remove the diagnostic divisions and integrate the ID and DD services to create “comprehensive” and “supports” waivers
- 2012 DOJ Settlement Agreement delayed the redesign efforts while responding to immediate requirements for facility closures, added ID/DD waiver slots, and other needed improvements
- Redesign efforts were restarted based on General Assembly direction and DBHDS efforts to satisfy DOJ requirements to:
  - Provide integrated community services that support the needs of the target population
  - Support the delivery of community integrated services included in the waivers

Proposed ID/DD Waiver Redesign

- Current ID/DD waiver redesign intended to:
  - Standardize needs assessments, case management, and services levels for ID/DD
  - Employ one waiting list across the disabilities based on needs
  - Restructure rates to ensure adequate number and types of community providers to ensure individuals are receiving appropriate level of care to meet needs
  - Incentivize the use of more integrated living and day services, and add new services to address DOJ Settlement Agreement issues surrounding community integration
- Amends 3 current Medicaid waivers instead of developing a comprehensive waiver
  - One new comprehensive waiver would have subjected Virginia to stringent new federal rules related to community integration immediately instead of allowing a 5-year transition

1. Building Independence replaces Day Support Waiver
   - Targets adults able to live independently in the community. Individuals own, lease, or control their own living arrangements and supports are complemented by non-waiver-funded rent subsidies.
2. Family and Individual Supports Waiver replaces the DD Waiver
   - For individuals living with their families, friends, or in their own homes, including supports for those with some medical or behavioral needs. Designed to meet individual support needs and preferences. Available to both children and adults.
3. Community Living Waiver replaces the ID Waiver
   - 24/7 services and supports for individuals with complex medical and/or behavioral support needs through licensed services. Includes residential supports and a full array of medical, behavioral, and non-medical supports. Available to adults and some children.

ID/DD Waiver Redesign Costs

(GF $ in millions)	FY 2017	FY 2018
New Medicaid waiver rates	$8.4	$16.3
New Medicaid waiver services (e.g., private duty nursing)	$2.9	$4.9
Add 200 waiver slots to mitigate DD waiting list change from chronological to needs based	$3.1	$3.1
Subtotal Medicaid waiver redesign costs	**$14.4**	**$24.3**
DBHDS housing supports (not Medicaid reimbursable)	$2.7	$6.7
Total	**$17.1**	**$31.0**

New Waiver Services

Service	Description of Proposed New Services
Integrated Day	• Activities to acquire, build, or retain skills related to increasing positive social behavior, employability, greater independence and personal choice in the community. Services require a much lower staff to individual ratio than center-based group day services.
Employment	• Ongoing support to a competitively employed individual to maintain stable employment. • Assistance to coordinate benefits to make informed choices about work.
Integrated Array of Residential Supports	• **Shared Living -** Medicaid payment for a portion of the total cost of room and board for an unrelated live-in support person. • **Supported Living -** Residential supports for individuals in a DBHDS licensed apartment setting. • **Independent Living -** Supports for those living in their own apartments, alone or with a roommate.
Medically-Oriented	• **Private Duty Nursing** – Individual and continuous care by a Registered Nurse for individuals with a serious medical condition or complex health care need, necessary to enable an individual to remain at home. • **Adult Dental** – Preventive or basic care up to a capped amount/year.
Behaviorally-Oriented	• Shorter-term crisis prevention, intervention and stabilization to promote community stability instead of higher cost, long-term psychiatric/hospital stays.
Community Access	• Access to employment/community sites via non-medical transportation. • Enable learning about community options from peers.

State Mental Health Geriatric Services

- DBHDS provides inpatient geriatric mental health services at 4 state facilities
- These geriatric patients have severe and persistent symptoms of mental illness and many have complex medical, psychiatric, behavioral and neurologic conditions
  - Some present a significant risk of harm to themselves or others
  - Some may be diagnosed with dementia and are unable to provide for their own basic safety and self-care needs

				FY 2015					
Facility	Location	Geriatric Beds	Average Beds Filled	GF Exp.	NGF Revenue State Medicaid	NGF Revenue Federal Medicaid	NGF Revenue DSH Medicaid	NGF Revenue Medicare /Other	Total NGF Expend.
Hancock Geriatric	ESH in Wmsburg	80	74	**$2.0**	$6.2	$6.2		$1.3	**$13.7**
Piedmont Geriatric	Burkeville	135	115	**$3.0**	$7.6	$7.6	$6.0	$2.2	**$23.4**
Catawba	Catawba	60	55	**$3.3**	$4.5	$4.5	$2.2	$1.4	**$12.6**
SWVMHI	Marion	20	20	**$1.4**	$1.0	$1.0		$1.1	**$3.1**
Total		**295**	**264**	**$9.7**	**$19.3**	**$19.3**	**$8.2**	**$6.0**	**$50.8**

Federal CMS Certification Issues

- Certification by the Centers for Medicare and Medicaid (CMS) has been an issue recently, due to a 2014 HHS OIG report
  - OIG found that Piedmont Geriatric and Catawba did not qualify as Acute Care Hospitals
  - Piedmont Geriatric and Catawba Hospitals were certified by Medicare as Acute Care Hospitals and by Medicaid as Long Term Hospitals, thus receiving both Medicare and Medicaid revenues due to this dual designation
  - 2015 General Assembly provided funds to redesignate these hospitals as intermediate care facilities in order to preserve Medicaid funding and replace lost federal Medicare revenue
    - Added $3.8 million GF in FY 15 and $9.1 million GF in FY 16 at DBHDS
    - Reduced $992,476 GF in FY 15 and $4.0 million GF in FY 16 at DMAS reflecting the loss in Medicaid from the designation change
- To date, Piedmont and Catawba have been disenrolled in Medicare (Dec. 2014), but Medicaid reclassification has not yet occurred
  - Facilities continue to receive Medicaid but no Medicare funding
  - Agency proposing to transfer $2.2 million back to DMAS in FY 2016 as state Medicaid match until recertification occurs or an alternative policy decision is made for the facilities
  - Hospitals have spent about $500,000 GF on staffing in preparation for recertification
  - Medicaid DSH reduction is expected but amount uncertain until FY 2015 cost report but could be from $2.5 to $5.5 million
  - Appears there may be some funding unspent ($2-$4 million) depending on the FY 2015 cost settlement with DMAS and the FY 2016 revised DSH estimate
- Continued uncertainty with facility certifications as intermediate care facilities places Commonwealth at financial risk for federal Medicaid payments

Hancock Geriatric Treatment Center (HGTC)

- CMS notified Virginia in March 2015 that HGTC no longer met federal definition of a nursing facility
  - CMS' new interpretation of a nursing facility would have required changes in operational procedures such as:
    - Unlocking interior and exterior doors
    - Allowing patients to keep valuables including sharp objects such as knives, scissors, and razors
  - Virginia had 120 days to substantially comply
  - May 26, 2015, CMS discontinued payment for new admissions
  - August 26, 2015, CMS terminated the provider agreement and all payments ceased 30 days after termination of the provider agreement
- DBHDS Commissioner believes that most of the patients served cannot be quickly or easily discharged into community without compromising their care
- DBHDS plans to continue operating HGTC and supplement regional funding to divert inpatient admissions and assist with discharges if appropriate
- Long-term goal of transitioning 50% of population to community

Budget Request (GF $ in millions)	FY 2016	FY 2017	FY 2018
Continue HGTC operations	$4.4	$5.8	$5.8
Community Inpatient/Discharge Assistance		$2.5	$2.5
Total	**$4.4**	**$8.3**	**$8.3**

Children's Services Act (CSA)

- CSA coordinates local services for emotionally and behaviorally disturbed children
- Localities are mandated to serve eligible children
  - Special education
  - Foster care cases
  - Children requiring mental health services to avoid placement in foster care
  - After several years of decline, CSA is experiencing growth in expenditures
    - Ch. 665 assumed a $9.9 million GF reduction in FY 2016 predicated on anticipated fraud, waste and abuse savings from an expected analytical system, which is not expected to materialize
    - Census grew by 2.4% in FY 2014 to 5% in FY 2015 from 14,628 to 15,726 children
    - Most of this growth was due to an increasing number of children placed in private day treatment through federally mandated Individualized Education Program (IEP) plans
    - Of the 637 additional children in CSA in FY 2015, 41% were placed in private day treatment programs
    - Annual cost of a private day treatment placement was $36,385 in FY 2015 compared with the average annual cost of $22,418 for all CSA services

CSA Budget Request	FY 2016	FY 2017	FY 2018
Expenditure Growth	$6.4	$6.4	$6.4
Backfill Expenditure Reduction	$9.9	$9.9	$9.9
Total	$16.3	$16.3	$16.3

Growth in CSA