OVERVIEW OF THE GOVERNOR’S INTRODUCED BUDGET

Presentation to:
Senate Finance Committee
Subcommittee on Health and Human Resources

January 8, 2018
Agenda

- Medicaid Overview
- Expenditure Forecasts
- Governor’s Budget Amendments
- Program Updates
MEDICAID OVERVIEW
Introduction to the DMAS Mission

Ensure Virginia’s Medicaid Enrollees Receive Quality Health Care

- Superior Care
- Cost Effective
- Continuous Improvement
Virginians Covered by Medicaid/CHIP

1 in 8 Virginians rely on Medicaid

Medicaid is the primary payer for behavioral health services

Medicaid covers 1 in 3 births in Virginia

33% of children in Virginia are covered by Medicaid & CHIP

2 in 3 nursing facility residents are supported by Medicaid

62% of long-term services and supports spending is in the community

Medicaid plays a critical role in the lives of over 1.3 million Virginians
Virginia Medicaid: Enrollment & Expenditures

28% of the Medicaid population drives 68% of total expenditures

Expenditures are disproportionate to the population where services for older adults and individuals with disabilities drive a significant portion of Medicaid costs.
Medicaid Budget

Only 2.2% of the total DMAS budget is for administrative expenses.

97.5% of the DMAS budget funds medical expenses.

68% of Administration funds are for IT and contract expenses.

*Note: Health IT Incentive Payments are funded by 100% federal funds.
EXPENDITURE FORECASTS
New Medicaid Forecast Results in a $86.7M GF Need in FY 2018

<table>
<thead>
<tr>
<th>FY 2018</th>
<th>Total Medicaid</th>
<th>Appropriation ($ millions)</th>
<th>Consensus Forecast ($ millions)</th>
<th>Surplus/(Need) ($ millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$9,625</td>
<td>$9,910</td>
<td>($285.1)</td>
</tr>
<tr>
<td>State Funds</td>
<td></td>
<td>$4,917</td>
<td>$5,003</td>
<td>($86.7)</td>
</tr>
<tr>
<td>Federal Funds</td>
<td></td>
<td>$4,709</td>
<td>$4,907</td>
<td>($198.3)</td>
</tr>
</tbody>
</table>

FY17-FY18 Biennium
State Funds Surplus/(Need) ($86.7 GF)

Figures may not add due to rounding
New Medicaid Forecast Results in a $575.8M GF Need in New Biennium (FY19-FY20)

<table>
<thead>
<tr>
<th></th>
<th>FY 2019 Total Medicaid</th>
<th>FY 2020 Total Medicaid</th>
<th>FY19-FY20 Biennium State Funds Surplus/(Need)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Appropriation ($ millions)</td>
<td>Consensus Forecast ($ millions)</td>
<td>Surplus/(Need) ($ millions)</td>
</tr>
<tr>
<td>FY 2019</td>
<td>$9,625</td>
<td>$10,114</td>
<td>($488.9)</td>
</tr>
<tr>
<td>State Funds</td>
<td>$4,917</td>
<td>$5,094</td>
<td>($177.0)</td>
</tr>
<tr>
<td>Federal Funds</td>
<td>$4,709</td>
<td>$5,021</td>
<td>($311.9)</td>
</tr>
<tr>
<td>FY 2020</td>
<td>$9,625</td>
<td>$10,537</td>
<td>($911.3)</td>
</tr>
<tr>
<td>State Funds</td>
<td>$4,917</td>
<td>$5,315</td>
<td>($398.8)</td>
</tr>
<tr>
<td>Federal Funds</td>
<td>$4,709</td>
<td>$5,221</td>
<td>($512.5)</td>
</tr>
</tbody>
</table>

Note: Figures represent the most recent forecast. The official forecast of $583.9M has been decreased by $8M.

Figures may not add due to rounding.
### Drivers of Forecast Changes

<table>
<thead>
<tr>
<th>Category</th>
<th>FY18</th>
<th>FY19-FY20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Payments</strong></td>
<td>Lump sum payments in FY18 delayed from past years</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>Increase in non-GF payments required by the 2017 budget</td>
<td>✔️</td>
</tr>
<tr>
<td><strong>Medicare Premium Changes</strong></td>
<td>Rate increase for Part D (1.22% change) and no increase for Part B (0% change)</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td><strong>More Low Income Adults</strong></td>
<td>Adult population has grown in 2017 as more eligible members remain in Medicaid and are not dis-enrolled</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td><strong>Managed Care</strong></td>
<td>Movement of fee-for-service (FFS) services to managed care resulted in overall savings</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✔️</td>
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</tbody>
</table>
Other Forecast Impacts

2017 General Assembly Actions Impacting the Forecast

GAP Eligibility
- Increased from 80% to 100% FPL effective 10/1/2017

New ARTS Services
- Residential treatment services began 4/1/2017
- Peer support services began 7/1/2017

CHKD Rates
- FY18 inflation adjustment restored

CSB Same Day Access (STEP-VA)
- Increased Medicaid utilization at CSBs due to services rendered same day

Other Trends and Assumptions Impacting the Forecast

Waiver Redesign
- New services began in September 2016

Behavioral Health
- Increased growth but moving under managed care

Hospital and Nursing Home Inflation
- Inpatient hospital rates increase by 2.8% in FY19 and 3.0% in FY20
- Nursing home rates increase by 2.9% in FY19 and 3.0% in FY20
New CHIP Forecast Results in a $49.2M GF Need in FY18 and FY19 - FY20 Biennium

Assumes federal matching rate decreases from 88% to 76.5% on 10/1/2019

<table>
<thead>
<tr>
<th></th>
<th>FY16</th>
<th>FY17</th>
<th>FY18</th>
<th>FY19</th>
<th>FY20</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHIP Expenditures</td>
<td>$257.1</td>
<td>$308.9</td>
<td>$339.4</td>
<td>$359.4</td>
<td>$375.1</td>
</tr>
<tr>
<td>Appropriations</td>
<td>$311.3</td>
<td>$311.3</td>
<td>$311.3</td>
<td>$311.3</td>
<td>$311.3</td>
</tr>
</tbody>
</table>
Without any additional Congressional action, 68,495 children and 1,114 pregnant women enrolled in the FAMIS program could lose their coverage on February 28, 2018.

Congress passed a continuing resolution reducing the amount of 2017 left-over funds to be redistributed to Virginia. As a result, Virginia would be short of the full amount needed for January 2018 coverage.

DMAS mailed letters to notify families that the FAMIS programs might end January 31, 2018.

Another continuing resolution passed by Congress provided additional 2018 funds to states for CHIP. Assuming Virginia receives these left-over plus additional funds, Virginia could continue coverage through end of February 2018.

CMS has not yet provided states with guidance on how they will be redistributing 2017 left-over funds in light of the additional 2018 funds.
Expanding Medicaid offers Virginians access to quality, affordable health care while saving millions of dollars.

Nearly 400,000 Virginians could get coverage if Virginia expanded Medicaid.

Expanding Medicaid would save Virginia at least $421.6 million GF over the next biennium.

To-date, Virginia has foregone $10.5 billion in federal funds.
# Medicaid Expansion

## FY19-FY20 total GF savings estimated at $421.6M

<table>
<thead>
<tr>
<th></th>
<th>FY 2019 GF Costs/(Savings)</th>
<th>FY 2020 GF Costs/(Savings)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DMAS Savings</strong></td>
<td>($120.4M)</td>
<td>($221.4M)</td>
</tr>
<tr>
<td>Newly covered populations receive an enhanced federal matching rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DSS Costs</strong></td>
<td>$2.3M</td>
<td>$3.6M</td>
</tr>
<tr>
<td>Additional resources for local workers to handle increased application volume</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Corrections Savings</strong></td>
<td>($17.2M)</td>
<td>($26.9M)</td>
</tr>
<tr>
<td>Federal reimbursement available for inpatient hospital services delivered to incarcerated individuals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CSBs Savings</strong></td>
<td>($16.7M)</td>
<td>($25.0M)</td>
</tr>
<tr>
<td>Federal reimbursement available for substance abuse and mental health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total GF Savings</strong></td>
<td>($151.9M)</td>
<td>($269.7M)</td>
</tr>
</tbody>
</table>

Total GF Savings for FY19 – FY20 estimated at ($421.6M)
Medicaid Expansion (continued)

Total state costs of expansion proposed to be financed by a provider assessment on private acute care hospitals

Estimated Cost of Coverage: FY 2019 = $80.8M (assessment is 0.5%) and FY 2020 = $226.1M (assessment is 1.4%)

Assessment will **cover the full cost of expanded Medicaid coverage** – meaning it will be calculated to equal the amount estimated in the official Medicaid forecast.

**Excluded** from the assessment are: public hospitals, freestanding psychiatric and rehab hospitals, children’s hospitals, long-stay hospitals, long-term acute care hospitals, and critical access hospitals.

DMAS will be responsible for assessing and collecting the assessment which will be **calculated as a percentage of net patient revenue**.
Budget Highlights

Provides $3.2M GF over the biennium to improve access to health care

<table>
<thead>
<tr>
<th>FY19-FY20 Enhancements</th>
<th>FY19</th>
<th>FY20</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Eye Care Services for Children – Funds vision exams and glasses for school age children in Title I schools</td>
<td>GF = $0</td>
<td>NGF = $336K</td>
</tr>
<tr>
<td>2  CSB Same Day Access (STEP-VA) – Covers the Medicaid costs associated with providing same day access at all CSBs by 7/1/2019</td>
<td>GF = $1.6M</td>
<td>NGF = $1.6M</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total FY19-FY20 for improving health care access</td>
<td>GF = $1.6M</td>
<td>NGF = $1.9M</td>
</tr>
</tbody>
</table>

Total GF FY19-FY20
$3.2M
Provides $1.0M GF over the biennium to comply with federal requirements and ensure program quality

<table>
<thead>
<tr>
<th>FY19-FY20 Enhancements</th>
<th>FY19</th>
<th>FY20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3 Independent Quality Review</strong> – Provides funds for a federally required independent review of the MCOs to ensure quality and access</td>
<td>GF = $302K</td>
<td>GF = $570K</td>
</tr>
<tr>
<td></td>
<td>NGF = $905K</td>
<td>NGF = $1.7M</td>
</tr>
<tr>
<td><strong>4 Evaluation of Governor Access Program (GAP) Impact</strong> – Provides funds for a federally required evaluation of the impact of the GAP program</td>
<td>GF = $85K</td>
<td>GF = $85K</td>
</tr>
<tr>
<td></td>
<td>NGF = $85K</td>
<td>NGF = $85K</td>
</tr>
<tr>
<td><strong>Total FY19-FY20 for complying with federal requirements</strong></td>
<td>GF = $387K</td>
<td>GF = $655K</td>
</tr>
<tr>
<td></td>
<td>NGF = $990K</td>
<td>NGF = $1.8M</td>
</tr>
</tbody>
</table>

Total GF FY19-FY20 $1.0M
Provides $47.7M GF over the biennium for new waiver slots

<table>
<thead>
<tr>
<th>FY19-FY20 Enhancements</th>
<th>FY19</th>
<th>FY20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5 New Waiver Slots</strong> – 825 new slots in the Community Living (CL) and Family and Individual Supports (FIS) waivers over the biennium</td>
<td>GF = $14.5M</td>
<td>NGF = $14.5M</td>
</tr>
<tr>
<td><strong>6 Reserve Waiver Slots</strong> – 50 CL waivers slots over the biennium to be held as reserve capacity to address emergency situations</td>
<td>GF = $937K</td>
<td>NGF = $937K</td>
</tr>
<tr>
<td><strong>Total FY19-FY20 for new waiver slots</strong></td>
<td>GF = $15.4M</td>
<td>NGF = $15.4M</td>
</tr>
</tbody>
</table>

Total GF FY19-FY20 $47.7M
Budget Highlights (continued)

Provides $19.5M GF over the biennium to improve reimbursement for consumer directed home and community based services

<table>
<thead>
<tr>
<th>FY19-FY20 Enhancements</th>
<th>FY19</th>
<th>FY20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7 Overtime Pay</strong> – Beginning 7/1/2019, allow for up to 16 hours per week of overtime for consumer directed (CD) attendants</td>
<td>GF = $0</td>
<td>NGF = $0</td>
</tr>
<tr>
<td><strong>8 Rate Increase</strong> – Increase rates by 2% for consumer directed personal care, respite, and companion services</td>
<td>GF = $4.8M</td>
<td>NGF = $4.8M</td>
</tr>
</tbody>
</table>

Total FY19-FY20 for improving consumer directed home and community based services

<table>
<thead>
<tr>
<th>FY19</th>
<th>FY20</th>
</tr>
</thead>
<tbody>
<tr>
<td>GF = $4.8M</td>
<td>NGF = $4.8M</td>
</tr>
<tr>
<td>GF = $14.7M</td>
<td>NGF = $14.7M</td>
</tr>
</tbody>
</table>

Total GF FY19-FY20 $19.5M
Budget Highlights (continued)

Provides $5.1M GF over the biennium to enhance agency operations

<table>
<thead>
<tr>
<th>FY19-FY20 Enhancements</th>
<th>FY19</th>
<th>FY20</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 Third Party Liability (TPL) verifications — Cover increased contract costs of TPL verifications and increase the number of verification conducted annually</td>
<td>GF = $104K</td>
<td>NGF = $104K</td>
</tr>
<tr>
<td>10 CoverVA Call Center — Funds anticipated increased costs for reprocuring the CoverVA Call Center</td>
<td>GF = $3.8M</td>
<td>NGF = $6.3M</td>
</tr>
<tr>
<td>Total FY19-FY20 for enhancing agency operations</td>
<td>GF = $3.9M</td>
<td>NGF = $6.4M</td>
</tr>
</tbody>
</table>

Total GF FY19-FY20 $5.1M

Introduced Budget language in FY19 and FY20 to enhance and improve services

| 11 Medical Residencies Awards — Specify which hospitals have been awarded the remaining 10 graduate medical residency slots from the initial cohort funded |
PROGRAM UPDATES
Overview of Program Updates

- Evolving Managed Care (CCC Plus and Medallion)
- Governor’s Access Plan (GAP)
- Addiction Recovery Treatment Services (ARTS)
Recognizing the value of managed care for the Commonwealth and Medicaid enrollees, DMAS extended managed care to 95% of the Medicaid population through two managed care programs: Commonwealth Coordinated Care (CCC) Plus and Medallion 4.0.
## Strategic Transition to Managed Care

### Two managed care programs

<table>
<thead>
<tr>
<th>CCC Plus</th>
<th>Medallion 4.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Serving older adults and disabled</td>
<td>▪ Serving infants, children, pregnant women, parents</td>
</tr>
<tr>
<td>▪ Includes Medicaid-Medicare eligible</td>
<td>▪ 760,000 individuals</td>
</tr>
<tr>
<td>▪ 216,000 individuals</td>
<td></td>
</tr>
<tr>
<td>▪ Long-term services and supports in the community and facility-based, acute care, pharmacy</td>
<td>▪ Births, vaccinations, well visits, sick visits, acute care, pharmacy</td>
</tr>
<tr>
<td>▪ Incorporating community mental health</td>
<td>▪ Incorporating community mental health</td>
</tr>
<tr>
<td>▪ Implementation started Aug 2017</td>
<td>▪ Implementation statewide August 2018</td>
</tr>
<tr>
<td>▪ Implement statewide by Jan 2018</td>
<td>▪ Building on two decades of managed care experience</td>
</tr>
<tr>
<td>▪ Approximately $30B over 5 years</td>
<td>▪ Estimated $10B - $15B over 5 years</td>
</tr>
</tbody>
</table>

- Long-term services and supports in the community and facility-based, acute care, pharmacy
- Incorporating community mental health
- Implementation started Aug 2017
- Implement statewide by Jan 2018
- Approximately $30B over 5 years
Managed Care Alignment

Managed Care Alignment

- Regions
- Services (where possible)
- Integrated behavioral health models
- Common core formulary
- Care management (when appropriate)
- Provider and member engagement
- Innovation in managed care practices (including VBP)
- Quality, data and outcomes (when appropriate)
- Strong compliance and reporting
- Streamlined processes and shared services
- Emergency Department Care Coordination

CCC Plus and Medallion 4.0 managed care programs are aligned in many ways
CCC Plus Program Update

CCC Plus offers an integrated delivery model that includes:

- Medical, behavioral health and long-term services and supports
- Very few carved-out services (e.g., dental, community mental health until 1/1/2018, and DD Waiver services)
- Care coordination for all CCC Plus enrollees

Care Coordination is a key benefit offered through CCC Plus

- **Assess**
  - Identify barriers to optimal health

- **Plan**
  - Support person-centered, individualized care planning that includes the social determinants of health

- **Communicate**
  - Establish collaborative relationships that connect the enrollee, MCO, and providers

- **Coordinate**
  - Support care transitions and help enrollees navigate the health care system

- **Monitor**
  - Track progress towards goals and ensure ongoing continuity of care

Care Coordination supports individualized service delivery and provides long-term benefits to enrollees and their families
Finalizing CCC Plus Implementation

CCC Plus phased in regionally August 2017 – January 2018

- Tidewater
- Central
- Charlottesville
- Roanoke Alleghany & Southwest
- Northern & Winchester
- CCC & Remaining ABD

As of January 1, 2018, approximately 216,000 enrollees successfully transitioned to CCC Plus

- Management of behavioral health services transitioned from Magellan to the CCC Plus health plans
- Over 77,000 individuals transitioned from the Medallion 3.0 Medicaid managed care program
- Approximately 25,000 individuals transitioned from the Commonwealth Coordinated Care Medicare-Medicaid alignment demonstration

DMAS worked with stakeholders to resolve implementation concerns such as provider payments, coordination with Medicare, and continuity of care
Medallion 4.0 will keep the best of Medallion 3.0 and enhance MCO compliance and performance evaluations, evolve value-based purchasing, and innovate care delivery.

**Enhancing Care Delivery**
- Medallion 4.0 will begin covering and coordinating services that were previously “carved out” and paid through traditional fee for service Medicaid
- Early Intervention
- Third-Party Liability (TPL)
- Non-traditional behavioral health services
- Enhanced services

**Advancing Care Delivery Innovations**
- Medallion 4.0 will focus on innovations that follow a person-centered approach to improve health outcomes while lowering the total cost of care
- Maternal and child health focus
- Value-based Payment
- Performance Incentive Award (PIA)
- Telehealth
- New member engagement strategies: (smartphone apps and social media)
- Social determinants of health
- New innovations
DMAS began Medallion 4.0 procurement in 2017 and will phase-in program implementation regionally in 2018

- In 2017, DMAS issued MCO procurement and announced notice of intent to award 6 health plans with Medallion 4.0 contracts
- DMAS will concurrently operate and Medallion 3.0 and Medallion 4.0 programs during implementation phase-in
- Regional implementation will begin in August 2018

### Medallion 4.0 Regional Phase-in

<table>
<thead>
<tr>
<th>Region</th>
<th>Phase-in</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tidewater</td>
<td>August</td>
</tr>
<tr>
<td>Central</td>
<td>September</td>
</tr>
<tr>
<td>Northern/Winchester</td>
<td>October</td>
</tr>
<tr>
<td>Charlottesville/Western</td>
<td>November</td>
</tr>
<tr>
<td>Roanoke/Alleghany/Southwest</td>
<td>December</td>
</tr>
</tbody>
</table>

32
The Governor’s Access Plan (GAP)

GAP improves access to care for Virginians with serious mental illness (SMI)

GAP offers basic medical and behavioral health care services for Virginians who would otherwise not have health care coverage including:

- Prescription drugs
- Primary care
- Counseling & Peer Support Services
- Behavioral health support for complex diagnoses such as depression, bipolar disorder, schizophrenia, and post-traumatic stress disorder

I would be in the hospital without GAP. Now I have hope that life will continue to get better.

GAP services help prevent the hospitalization, unemployment, incarceration, homelessness, and social isolation that often occurs from untreated SMI.
As of December 10, 2017 there are 13,560 Virginians enrolled in GAP.

Since January 2015, GAP has improved access to care for more than 17,000 Virginians.
DMAS launched the ARTS benefit on April 1, 2017

- Addiction and Recovery Treatment Services (ARTS) is an enhanced substance use disorder treatment benefit Medicaid member across the Commonwealth experiencing substance use disorders (SUD)
- The ARTS benefit expands access to a comprehensive continuum of addiction treatment services for all enrolled members in Medicaid, FAMIS, FAMIS MOMS and the Governor’s Access Plan (GAP)

Since April 2017, there has been an increase in SUD benefit utilization

- 13,903 Medicaid members used a SUD service – a **40% increase**
- Number of members using Opioid Use Disorder services **increased by 49%**

*Results based on a VCU evaluation of April-August 2017*
ARTS: Decreasing ED Utilization

Substance use-related emergency department visits also declined in the first five months of implementing the opioid benefit

- All Substance Use Disorder related visits declined by **31%**
- Opioid Use Disorder related visits decreased by **39%**
- Alcohol Use Disorder related visits were down **36%**
Implementing Prescribing Guidelines

In response to the opioid crisis, DMAS implemented CDC opioid prescribing guidelines

- Aligned with Board of Medicine Emergency Opioid Prescribing Regulations
- Reduced opioid prescription expenses and quantities in just 6 months (across Medicaid Fee-for-Service and Managed Care reduced)\(^1\)

Reduced opioid Expenses by 42.4% or $3.5 Million
- Jul to Dec 2016 = $8.25 Million
- Jul to Dec 2017 (projected) = $4.75 Million

Reduced opioid Quantity by 39.2% or 5.75 Million doses
- Jul to Dec 2016 = 14.65 Million
- Jul to Dec 2017 (projected) = 8.90 Million

- Average unique members receiving opioids decreased by 5.4%

\(^1\)Comparison period: July – Dec (2016 actual vs 2017 projected)
Our Mission Remains Unchanged

Ensure Virginia’s Medicaid Enrollees Receive Quality Health Care

Superior Care

Cost Effective

Continuous Improvement

As DMAS drives improvement and innovation, our mission remains the same