

House Ways and Means / Healthcare Subcommittee FY 2017-18 Executive Budget

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Director

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FY 2015-16 Year-End & FY 2016-17 Year-to-Date

FY 2015-16 Year-End

	FY 2015-16		FY 2015-16		Variance	%
	Approp/Authorized		Actual Expend		Over/(Under)	Spent
Medical Assistance	\$	5,773,577,588	\$	5,573,218,804	\$ (200,358,784)	97%
State Agencies & Other Entities	\$	868,974,936	\$	864,566,351	\$ (4,408,585)	99%
Personnel & Benefits *	\$	68,458,064	\$	65,905,317	\$ (2,549,747)	96%
Medical Contracts & Operating	\$	310,805,167	\$	272,260,515	\$ (38,544,652)	88%
TOTAL	\$	7,021,815,755	\$	6,775,953,987	\$ (245,861,768)	97%

- Final FY 2015-16 expenditures were 3% below total appropriation/authorization levels
- Gap closed with \$79 million from reserves, matching the projection from our March 2016 hearing

FY 2016-17 Year-to-Date

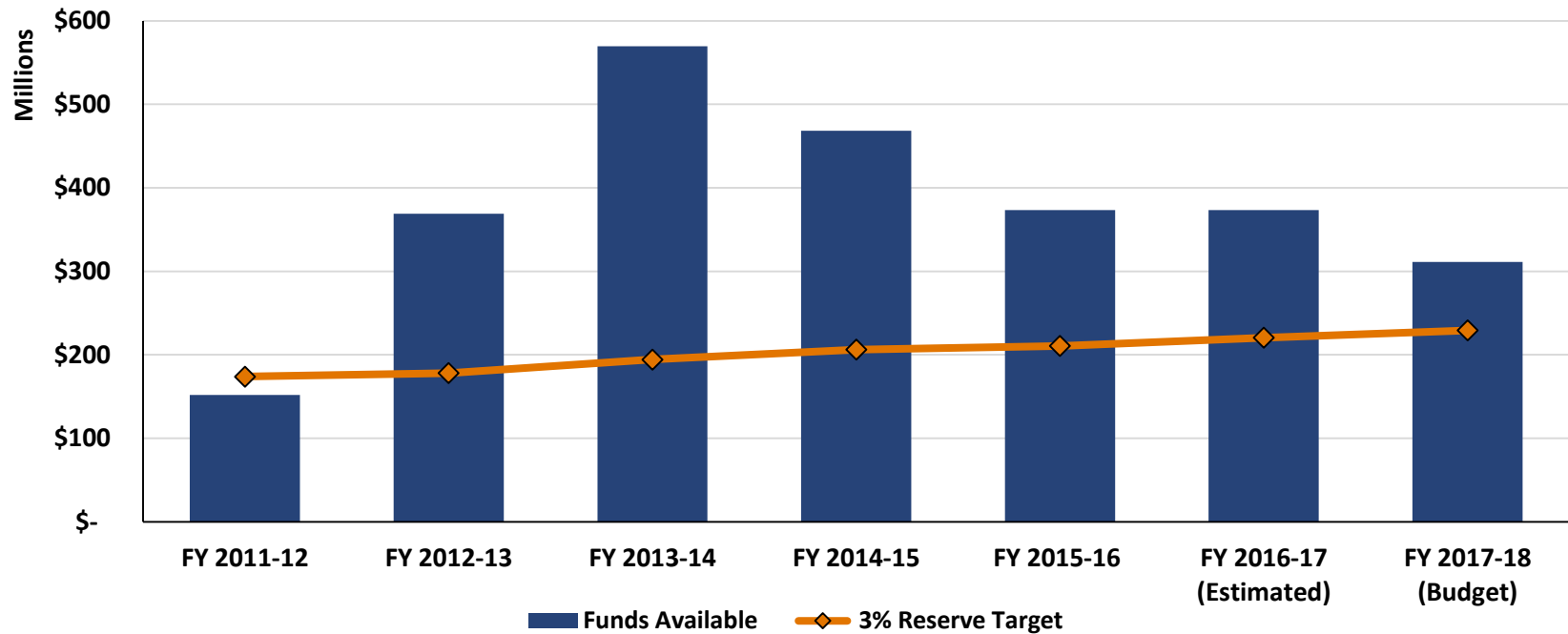
	FY 2016-17 Approp/Authorized	FY 2016-17 YTD (12/31/16)	% Spent
Medical Assistance	\$ 5,953,610,538	\$ 2,996,023,138	50%
State Agencies & Other Entities	\$ 978,462,293	\$ 371,858,122	38%
Personnel & Benefits	\$ 72,885,070	\$ 33,402,245	46%
Medical Contracts & Operating	\$ 349,319,252	\$ 84,668,915	24%
Total	\$ 7,354,277,153	\$ 3,485,952,420	47%

- Department spent 47% of its annual budget during the first six months of the fiscal year
 - “Medical Contracts & Operating” is typically under budget until late in the year, as contracts take time to issue.
- Unanticipated one-time federal actions have helped this year’s budget
 - Congress suspended the Health Insurer Tax for one year and applied a partial “Part B fix”, saving \$36 million in state match.
 - On course to essentially break-even for the year.



Changes in Fund Balances

Changes in Fund Balances



- The year-end projections for FY 2016-17 and 2017-18 assume:
 - Proposed changes in dental rates occur, even without a funded decision package.
 - Either the DSH cuts do not occur, or if they do, then the “excess” matching funds are used to raise hospital rates.



FY 2017-18 Budget Request

FY 2017-18 Budget Request

Guiding principles for the request:

- Preserves the same general principles as last year
 - Keep reserves above 3% through the planning horizon.
 - Finish addressing prior-year annualizations.
- Reflects changes to the FY 2016-17 baseline
 - One-time benefits from the suspension of the Health Insurer Tax and the partial “Part B fix”.
 - Offsetting costs from the loosening of Hepatitis C coverage policy.
- Limited proposals for targeted rate and process changes

FY 2017-18 Executive Budget

	General Fund	All Funds
Recurring Requests as Funded in the Executive Budget:		
1. Residual Annualization (#11284)	\$ 45,382,209	\$ 261,911,456
2. Adopt Savings Initiatives (#11287)	\$ (3,288,587)	\$ (5,634,871)
3. Transfer Bank Account Monitoring to STO (#11290)	\$ (150,000)	\$ (150,000)
4. Improve Alignment of Adult Vaccine Coverage w/CDC (#11293)	\$ 280,410	\$ 975,000
5. Standardize/Update DME/Home Health Fee Schedule (#11299)	\$ 3,451,200	\$ 12,000,000
6. Allocate Health/Pay Plan Funding (#11302)	\$ 879,007	\$ 879,007
7. Incorporate BabyNet (#11305)	\$ 3,780,000	\$ 11,361,000
<i>FY 2017-18 Recurring Changes</i>	<i>\$ 50,334,239</i>	<i>\$ 281,341,592</i>

Non-Recurring Request:

8. Non-Recurring: MMIS (#11308)	\$ 8,832,619	\$ 8,832,619
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- At \$50.3M, the Executive Budget is \$900k under HHS' request:
 - Does not include a \$4.7M/\$16.5M dental decision package, but does include \$3.8M for BabyNet.
 - \$750k for BabyNet is a transfer from Dept. of Education (VII.D.), not "new".
 - EBO's request for a 3% cut list (\$34.6M GF, \$38.2M State) not in either total.

FY 2017-18 Budget Request

Most funding is for annualizations, but these would be new items:

- Preserve access to dental services (\$4.7M, Not in Executive Budget)
 - Current Medicaid rates are barely above the Southeast regional average for Medicaid programs, but are less than half of the midpoint of usual and customary rates in South Carolina.
 - Proposed increase to 60% of the midpoint for exam, prevention, and oral surgery codes and 50% of the midpoint for ancillary services.
- Standardize and update home health/DME fee schedules (\$3.5M)
 - Current rates are set to varying percentages of the 2009 Medicare schedule.
 - Proposing to reset to a percentage of 2015/16 and also to obtain consulting/pricing services to reduce manual pricing and paper claims.
- Improve alignment with CDC adult vaccination standards (\$280k)
 - Add coverage for Meningococcal B, MMR, and Varicella.

FY 2017-18 Proviso Changes

- **Amend six provisos:**

- **33.9 – Medicaid Eligibility Transfer**

- *The proviso requires counties to provide office space for local Medicaid eligibility workers.*
- *The proposed amendment directs SCDHHS to produce a report on any ADA-related deficiencies in these county offices.*

- **33.16 – Carry Forward**

- *Two separate carry-forward provisos contain similar reporting requirements, but have different deadlines and recipient lists. Proviso 33.16 focuses on earmarked, restricted, and special accounts, while Proviso 33.22 focuses on the General Fund.*
- *Moving a few words out of 33.22 and into 33.16 would preserve the broader list of recipients and the earlier submission deadline.*

- **33.21 – Medicaid Accountability and Quality Improvement**

- *The proviso authorizes a variety of programs to support rural and underserved communities and directs various expenditures out of the agency's reserves.*
- *Many allocations were cut by 20% in FY 2016-17 (\$7.4M) to help realign revenues and expenditures. In FY 2017-18, the Department is proposing an additional \$2M reduction that would be designed to minimize the impact on the providers who have the most constrained access to other revenue sources (free clinics and 301s).*

FY 2017-18 Proviso Changes

- **Amend (con't):**

- **33.23 – Rural Health Initiative**

- *The Rural Health Initiative promotes rural healthcare and education, supports rural medicine workforce development, and investigates the use of DSH funds to complete transformation plans and/or develop facilities to address access problems for emergency services.*
- *The Department's proposed changes would add new carry-forward language.*

- **113.7 – Political Subdivision Flexibility**

- *The proviso allows political subdivisions to decrease their support for state-mandated services (with exceptions) by the same proportion that the Local Government Fund has been appropriated below the permanent statutory requirement.*
- *The proposed changes would prevent counties from using this proviso to reduce their MIAP payments, since the Department is not permitted to reduce the cost of the program.*

- **117.73 – IMD Operations**

- *In 2006, CMS rejected South Carolina's model of using Medicaid funding to make bundled payments for certain out-of-home placements for children. This proviso requires agencies to keep using the same funds for comparable services and calls for an annual report.*
- *The Department proposes to update the language of this proviso to focus on providing information on out-of-home placements; this information has represented most of the volume of this proviso's reports in recent years. Changes to the RBHS program in 2014 have made it essentially impossible to report under the prior format.*

FY 2017-18 Proviso Changes

- **Delete:**

- **33.22 – Carry Forward**

- *Two separate carry-forward provisos contain similar reporting requirements, but have different deadlines and recipient lists. Proviso 33.16 focuses on earmarked, restricted, and special accounts, while Proviso 33.22 focuses on the General Fund.*
- *Moving a few words out of 33.22 and into 33.16 would preserve the broader list of recipients and the earlier submission deadline. Proviso 33.22 should only be deleted if the requested changes to Proviso 33.16 are made.*

BabyNet Transition

BabyNet – Background

- BabyNet provides early intervention services for children with disabilities, age 0-3
 - Services are designed to identify and meet a child's needs in developmental areas including physical and cognitive development.
 - 4,543 children are receiving services and 1,379 are in eligibility processing.
- Program has been plagued with compliance problems
 - Continuous adverse reports from U.S. Dept. of Education since FY 2002-03.
 - Findings focus on “child find”, parent satisfaction, data quality, etc.
- BabyNet is housed at First Steps, but will move to HHS on July 1st
 - Staff/facilities include a central office, 14 field offices, and four regional work-from-home personnel.
 - Local staff are primarily responsible for intake (45 days) and care planning.

BabyNet – Initial Focus

- Governor Haley signed Executive Order 2016-20 in September, designating HHS as lead agency. Since then:
 - Initial match of BabyNet providers against Medicaid FFS and MCO network enrollment.
 - Match of BabyNet and Medicaid beneficiary enrollment data.
 - Test of BabyNet enrollment criteria against non-BabyNet Medicaid beneficiaries.
 - HHS review of BabyNet leases, including site visits.
 - Appointment of a quorum for the Interagency Coordinating Council (ICC).
 - Work on the draft FY 2017-18 grant application (for public comment in February or March).
 - Reviewing opportunities for Third-Party Liability (HHS collected \$800k from other insurers for these kids; BRIDGES does not support this capability).

BabyNet Enrollment

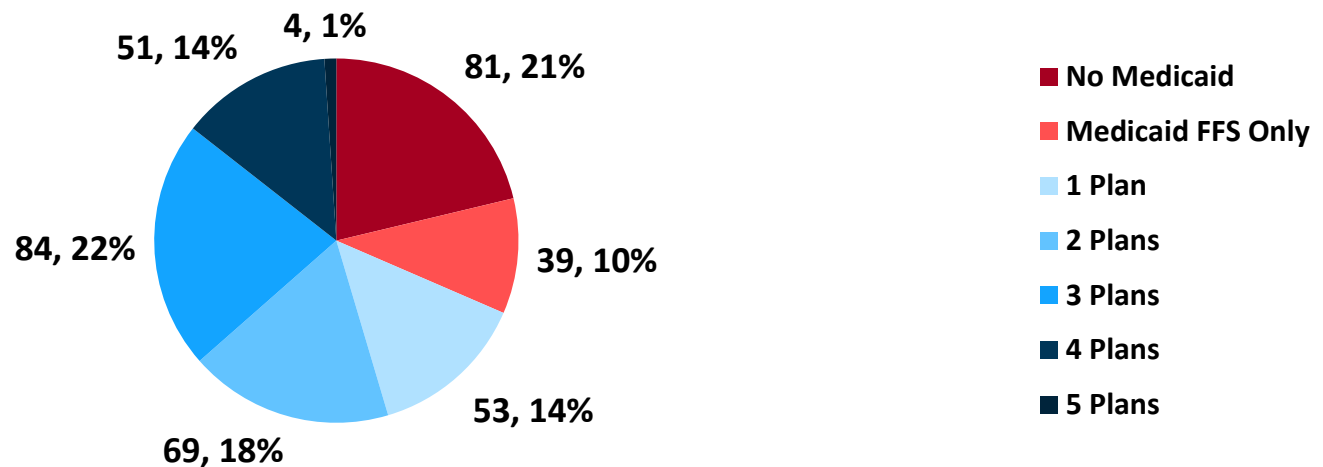
- Most BabyNet beneficiaries are Medicaid eligible:
 - BabyNet records show that 13,166 children have been eligible for BabyNet at some time since 2011.
 - Of these, at least 8,183 (62%) are currently active Medicaid members; even more have historical eligibility.
 - This percentage will rise, as Medicaid IDs for more children are keyed into BRIDGES.
- Children are already enrolled in Medicaid before/if BabyNet finds them:
 - Nearly 9,000 children had Medicaid eligibility prior to their BabyNet eligibility.
 - Only 349 children (2.6%) were enrolled in BabyNet prior to Medicaid.
 - Medicaid is well-positioned for “child find” because we pay for prenatal/delivery.
- BabyNet appears to have missed thousands of other eligible children:
 - Medicaid records identified more than 12,000 children since 2011 who were never enrolled in BabyNet, despite an “established risk” medical diagnosis.
 - More than 2,500 of these children are still under age 3.

BabyNet Provider Network

- The match of BabyNet and Medicaid provider networks revealed significant gaps:
 - About 1/3 of BabyNet providers either have no relationship with Medicaid or else are not enrolled in any MCO networks.
 - Only 1% of BabyNet providers are enrolled in all five MCOs.
 - This confirms that there are additional opportunities to (1) align MCO care plans and Individualized Family Support Plans and (2) increase TPL collections.

BabyNet Providers - Enrollment in Medicaid

(#, % of BabyNet Providers)



FY 2017-18 BabyNet Funding

	First Steps Request	Executive Budget
Recurring Request:		
1. BabyNet Service Funds (#11439)	\$ 1,200,000	\$ 1,500,000
2. Local Partnerships Home Visitation Services (#11377)	\$ 2,180,000	Not BabyNet
3. Early Childhood Data System (#11463)	\$ 142,448	X
4. BabyNet Service Coordination (#11466)	\$ 1,250,000	\$ 1,530,000
5. BabyNet Rural Provider Mileage (#11380)	\$ 300,000	--
6. BabyNet Centralized Patient Referral System (#11374)	\$ 100,000	--
7. BabyNet Federal Compliance (#11469)	\$ 462,000	--
FY 2017-18 Recurring Changes	\$ 5,634,448	\$ 3,030,000
* These values do not include \$750,000 transferred from the Department of Education (VII.D.)		

- The Executive Budget's treatment of BabyNet is based upon First Steps' initial recommendations, plus some additional changes:
 - Positions associated with BabyNet work would move to HHS.
 - Some BabyNet funding would remain in the EIA under "Partnerships".
 - HHS did not request funding for systems such as BRIDGES that are still under evaluation.
 - After submitting its FY 2017-18 budget request, HHS recommended an additional proviso that would direct EBO to help develop a comprehensive BabyNet budget for FY 2018-19.

FY 2017-18 BabyNet Proviso Changes

- **Amend one proviso:**

- **117.98 – First Steps - BabyNet**

- *This proviso has given various agencies reporting responsibilities while First Steps worked toward bringing BabyNet into federal compliance. The proviso would be amended to preserve existing reporting requirements with a new lead agency.*

- **Add two new provisos:**

- **33.NEW – BabyNet Compliance**

- *This proviso would direct HHS to provide an annual report on its efforts to bring BabyNet into federal compliance. It largely replaces Proviso 1.74.*

- **33.NEW – BabyNet (Not in Executive Budget)**

- *“From funds available in the current fiscal year for budgetary analysis and oversight, the Executive Budget Office shall conduct an inventory of all BabyNet-related spending, which shall be presented to the Governor, the Chairman of the Senate Finance Committee, and the Chairman of the House Ways and Means Committee no later than July 15, 2017. All affected agencies shall support the Executive Budget Office in this effort by providing information upon request, so that the first recommendation of the Legislative Audit Council’s 2011 report on BabyNet may be implemented.”*

FY 2017-18 BabyNet Proviso Changes

- **Delete three provisos:**

- **1.74 – First Steps Accountability**

- *The Department proposes to delete this proviso and replace it with an amended version in the HHS section.*

- **1A.56 – BabyNet Early Intervention Autism Therapy**

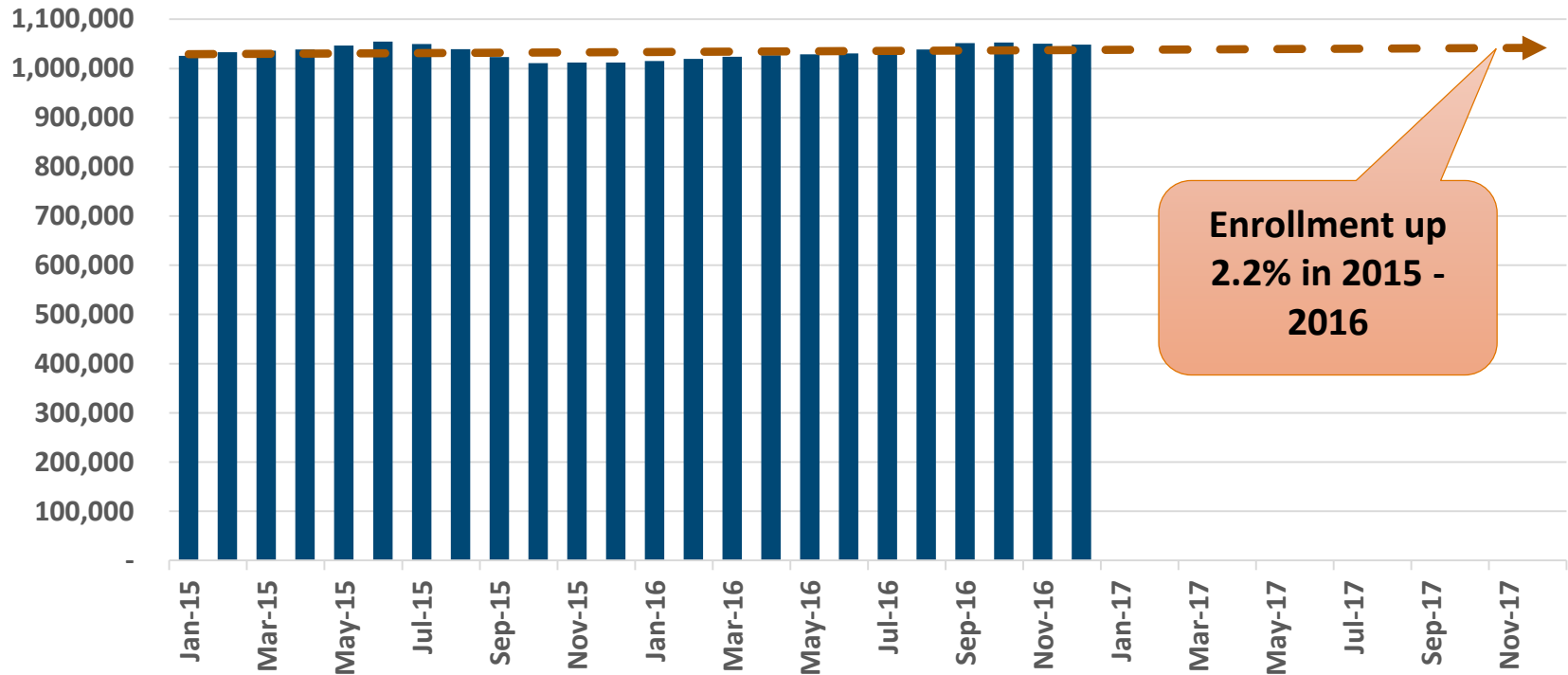
- *The Department proposes to delete this proviso because BabyNet will no longer be managed by First Steps and because the Department intends to align the BabyNet provider network and billing rates with Medicaid's.*

- **1A.77 – BabyNet Financial Audit Reimbursement**

- *The Department proposes to delete this proviso because the audit and associated reimbursement were a one-time event in FY 2016-17.*

Eligibility and Enrollment Update

Full-Benefit Membership



- Full-benefit membership continues to hold around 1 million, rising slowly but steadily.

Eligibility and Enrollment – Continuing Efforts

- **Systems**

- Planning a phased, careful transition for remaining eligibility categories; implementation work is delayed by months-long procurement protest.
- Increased data-matching, to send continuation notices instead of review forms.
- Redesigned assignment queues to prioritize the most important work.

- **Staffing**

- Continuously hiring new eligibility workers – increased “bounties” for referrals.
- Approved a new “Senior Eligibility Worker” career ladder to improve retention.
- Created dedicated processing centers, launched 2nd and 3rd shifts at key sites.
- Central Processing Center opens on Browning Road shortly, with capacity for another 92 workers – no interruptions from walk-ins or inbound calls.

- **Policies**

- Built an Escalation Team to handle complex and/or emergent cases.
- Streamlined documentation requirements for long-term care applications.
- Implemented Business Process Redesign to increase first-touch resolution.

Program Updates

Healthy Outcome Plans (HOP)

- HOP focuses on care management of emergency room and/or inpatient high-utilizers
 - HOPs are paid for each enrollee under care plan management.
 - Fewer enrollees scored at high need for further behavioral health evaluation down from 65.7% to 61.3%.
 - Mean ED visits for HOP enrollees fell from 3.82 (FFY14) to 2.16 (FFY16).
- Enrollment update, as of November 30, 2016:
 - Exactly 15,000 HOP participants against an FY 2016-17 goal of 13,897.
 - 96% of enrollees have a developed care plan.

44 HOPs, including all 56 Medicaid-designated hospitals

71 primary care safety net providers
(FQHC, RHC, Free Clinic)

33 participating behavioral health clinics
(DMH, DAODAS)

Autism

- In July 2014, CMS directed states to offer Autism Spectrum Disorder (ASD) services through EPSDT authority or the State Plan
 - We have been compliant with this requirement since December 2014.
 - So far, 495 recipients are receiving services through EPSDT authority.
 - Consider this against the ~650 that were historically enrolled in the PDD waiver.
- New State Plan ASD services take effect July 1, 2017
 - Substantial rate increase for lead and line therapy, with RBT (Registered Behavior Technician) certification required for Line Therapists.
 - Services included in the managed care benefit for MCO enrollees.
 - PDD waiver to sunset as required by CMS based on their approved schedule.

ASD-Related EPSDT Requests	
<u>Requests Received</u>	<u>1,454</u>
<i>Approved</i>	1,066
<i>Pending – Awaiting SCDHHS Decision</i>	0
<i>Pending – Incomplete Document Set</i>	388

Waiting List Reduction Efforts

- Collaborative effort with DDSN and providers to reduce waiver waiting lists for state's most vulnerable populations
- FY 2014-15: \$13 million increase in state funding
 - 1,400 slots allocated to Intellectual & Related Disabilities (ID/RD) and Community Supports (CS) Waivers – 725 ID/RD, 675 CS
 - Net enrollment increase of 883 (as of 6/30/15).
- FY 2015-16: \$6.4 million increase in state funding
 - 1,200 Medicaid slots allocated to ID/RD Waiver.
 - Net enrollment increase of 854 (as of 6/30/16).
- FY 2016-17: \$6.6 million increase in state funding
 - 750 slots allocated to CS Waiver (as of 1/5/17).
 - 63 additional residential slots allocated (as of 1/5/17).
 - Net enrollment increase of 291 (as of 1/5/17).

Home & Community Based Services – Final Rule

- CMS established new standards for waiver services and settings in a 2014 “final rule” – compliance is required by March 2019
- Our Statewide Transition Plan received Initial Approval from CMS in November, making us one of the first states to receive approval
 - Policy changes required for compliance are close to completion.
 - Site visits for Adult Day Health Care facilities approximately 30% completed.
 - Site visits for day programs and residential settings begin in March 2017.
 - Final approval should occur after site visits are completed.

<i>Setting Type</i>	<i># to Assess</i>
Adult Day Health Care	83
Day Program	85
Residential	1,115

Rehabilitative Behavioral Health Services (RBHS)

- In July 2014, the Department eliminated prior authorizations for RBHS and assumed responsibility for supplying state match in most cases
- On July 1, 2016, the Department carved RBHS services into the managed care service array
 - The moratorium on enrolling new providers is still in place pending analysis of post carve-in utilization data.
- Actions against RBHS practices are continuing:
 - 85 investigations so far.
 - 33 referrals to the Attorney General's Office.
 - \$12 million in identified recoupments.

Rural Health Initiative

- Finalizing contract with USC School of Medicine for creation of a Center of Excellence
 - For “programs and collaborations delivering rural health research, the ICARED program, workforce development scholarships and recruitment, rural fellowships, health education development, and/or rural practice support and education.”
- Released a “Request for Expression of Interest” for Graduate Medical Education expansion and/or rural training programs
 - Approved two proposals for rural rotation programs.
 - Invited two applicants to submit full proposals for new residency slots.
- Approved six hospital transformation proposals so far
 - Ongoing negotiations with three additional applicants.

