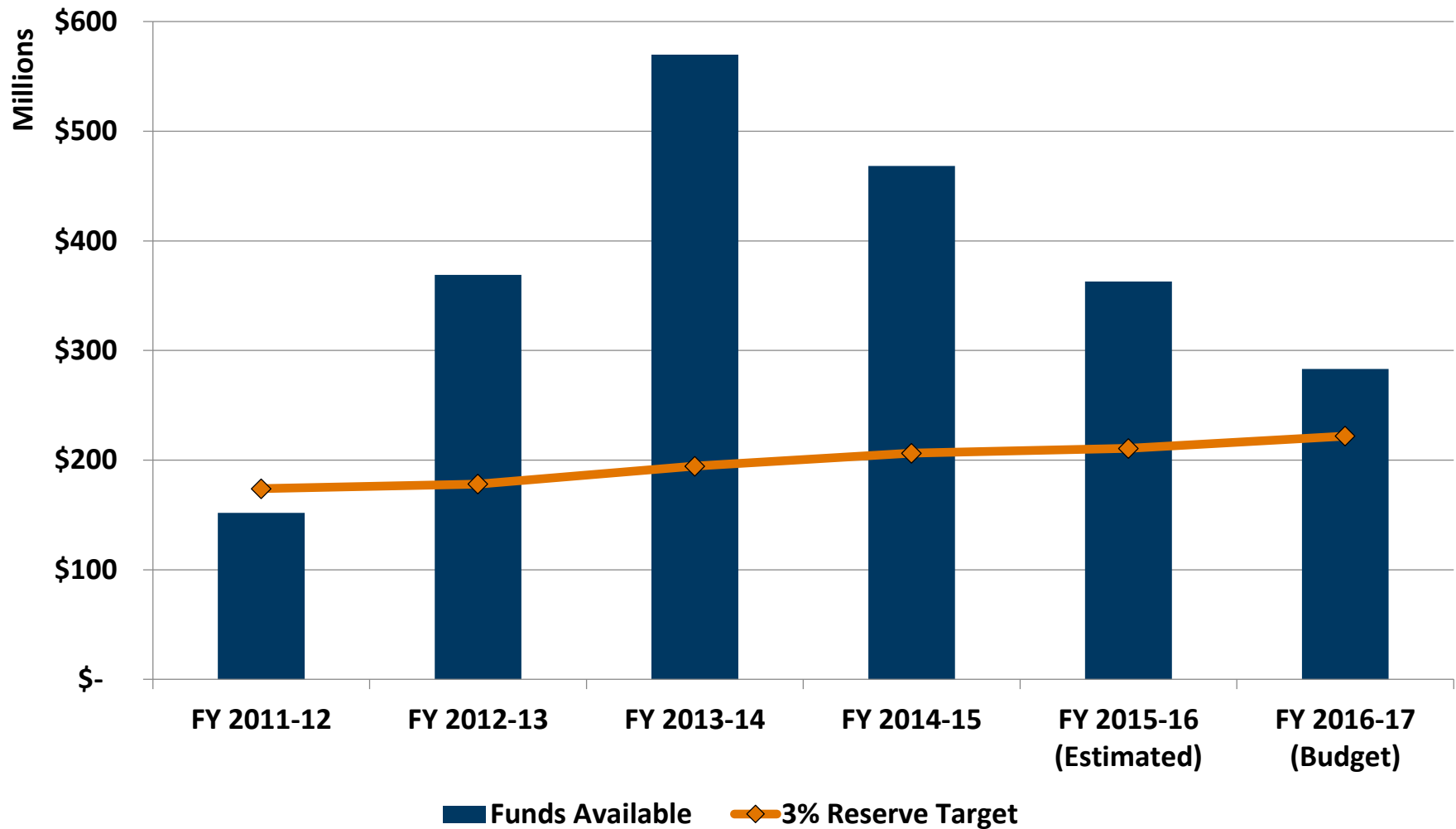# Senate Finance Committee
FY 2016-17 Executive Budget

Christian L. Soura

Director

March 16, 2016

Background: Changes in Fund Balances

Chart: "Funds Available" (bars) and "3% Reserve Target" (line), in Millions, across FY 2011-12 through FY 2016-17 (Budget)

* FY 2016-17 assumes the agency's request is approved as submitted.

FY 2016-17 Executive Budget

- Guiding principles for the request:
  - Keep reserves above 3% through the planning horizon.
  - Address annualizations primarily in FY 2016-17, with some overhang into FY 2017-18.
  - Cut spending growth to about half of recent levels in ways that minimize the impact on the health system.
  - Increase transparency by reflecting "off-budget" spending within the agency's financials.

- Executive Budget adopted the Department's request.

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FY 2016-17 Budget Request

	General Fund	All Funds
Recurring Requests		
1. Partial Annualization (#7594)	$ 149,416,874	$ 382,491,600
2. Cost Reductions (#7409)	$ (20,261,796)	$ (55,442,868)
3. Personnel Base Realignment (#7372)	$ -	$ -
4. Health Insurance Allocation (#7283)	$ 144,919	$ 399,336
FY 2016-17 Recurring Changes	*$ 129,299,997*	*$ 327,448,068*
Non-Recurring Request		
5. Non-Recurring: MMIS (#7247)	$ 8,474,579	$ 8,474,579

- Net request is for $129 million from the General Fund.
- Still requires using about $79 million from reserves.
- Allows for funds to be shifted off operating lines to hire program integrity staff and eligibility workers.
- No funding requested for new initiatives.

FY 2016-17 Proviso Changes

- **Amend four provisos:**

  - ➤ 33.2 – Long Term Care Facility Reimbursement Rate *(Withdrawn)*
    - ○ *The proviso establishes a formula to update reimbursement rates for long-term care facilities based on a calculated inflation factor.*
    - ○ *The proposed technical amendment addresses the fact that the current language does not explicitly envision the possibility of a negative inflation factor.*

  - ➤ 33.9 – Medicaid Eligibility Transfer *(Not adopted by Ways and Means)*
    - ○ *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.*

  - ➤ 33.15 – SCHIP Enrollment and Recertification
    - ○ *The proviso directs SCDHHS to enroll eligible children in the CHIP program and to share data with other agencies in support of that work.*
    - ○ *The proposed technical amendment updates the names of various programs.*

  - ➤ 33.21 – Medicaid Accountability and Quality Improvement Initiative
    - ○ *The proviso authorizes a variety of programs to support rural and underserved communities and directs various expenditures out of the agency's reserves.*
    - ○ *The proposed amendment steps down some of those allocations as part of the effort to bring revenues and expenditures back into alignment.*

FY 2016-17 Proviso Changes

- **Delete four provisos:**

  - 33.19 – Disproportionate Share DMH
    - *This proviso directed SCDHHS to increase DSH payments to DMH to offset revenue losses experienced by DMH due to federal regulatory changes in 2008. Subsequent changes in 2014 have eliminated the need for this directive. Other language would require that SCDHHS slash DSH payments to all other hospitals if and when the ACA-imposed cuts take effect, which would not be until at least FFY 2018.*

  - 33.24 – Hospital Transformation Plans
    - *This proviso established a hospital transformation program that was funded through a DSH allocation in a single federal fiscal year. The Department announced last year that the program would conclude on June 30, 2016, rendering the proviso unnecessary.*

  - 33.25 – Healthcare Workforce Analysis
    - *This proviso directed the transfer of $200,000 to AHEC, from the Department's reserves. It had not been requested by SCDHHS.*

  - 33.26 – Healthy Connections Prime Participation
    - *This proviso prevented the Department from passively enrolling participants into the "Prime" program until April 1, 2016. That date will have passed by FY 2016-17.*

Other Supporting Materials

FY 2014-15 Year-End

&

FY 2015-16 Year-to-Date

FY 2014-15 Year-End

	FY 2014-15 Approp/Authorized	FY 2014-15 Actual Expend	Variance Over/(Under)	% Spent
Medical Assistance	$ 5,609,214,756	$ 5,592,025,602	$ (17,189,154)	100%
State Agencies & Other Entities	$ 928,876,243	$ 829,842,539	$ (99,033,704)	89%
Personnel & Benefits *	$ 66,911,816	$ 65,095,018	$ (1,816,798)	97%
Medical Contracts & Operating	$ 273,167,948	$ 239,794,349	$ (33,373,599)	88%
TOTAL	**$ 6,878,170,763**	**$ 6,726,757,508**	**$ (151,413,255)**	**98%**

* Reflects the allocation of the 2% FY 2014-15 pay increase.

- Final FY 2014-15 expenditures were 2% below total appropriation/authorization levels.

- Gap closed with over $100 million from reserves.

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FY 2015-16 Year-to-Date

|	FY 2015-16 Approp/Authorized		FY 2015-16 YTD (12/31/15)		% Spent
Medical Assistance	$	5,773,577,588	$	3,644,467,648	63%
State Agencies & Other Entities	$	868,974,936	$	559,139,826	64%
Personnel & Benefits	$	68,458,064	$	44,158,689	65%
Medical Contracts & Operating	$	310,805,167	$	119,823,362	39%
Total	**$**	**7,021,815,755**	**$**	**4,367,589,525**	**62%**

- Department spent 62% of its annual budget during the first eight months of the fiscal year.
  - ➢ Typically under budget until late in the year, as contracts take time to issue.
  - ➢ Department is also withholding certain payments until vendors submit proper documentation.

- Current forecast calls for spending approximately $100 million from reserves.

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Changes in Fund Balances

Cigarette Tax Losses Offset General Fund Gains

Annual Cigarette Surcharge Proceeds for SCDHHS
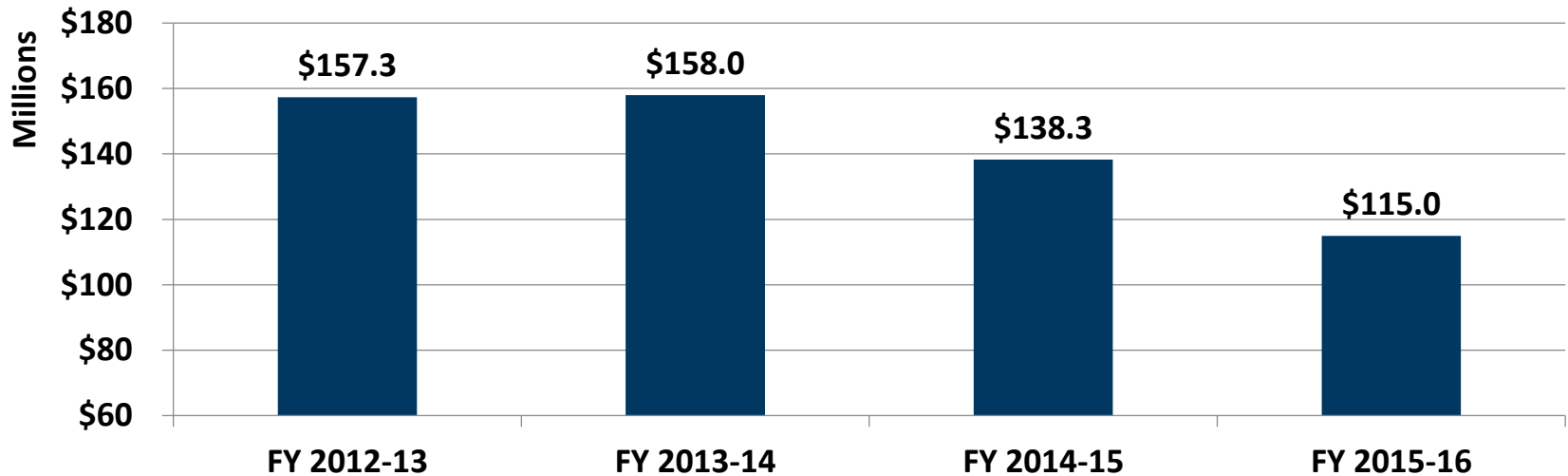
- Between FY 2012-13 and FY 2015-16:
  - General Fund revenues rose by $42.7 million.
  - Cigarette surcharge revenues fell by $42.3 million.
- Annualization problem has been noted each year by OSB/RFA.
- Governor has recommended the necessary recurring funds in each of her budgets.
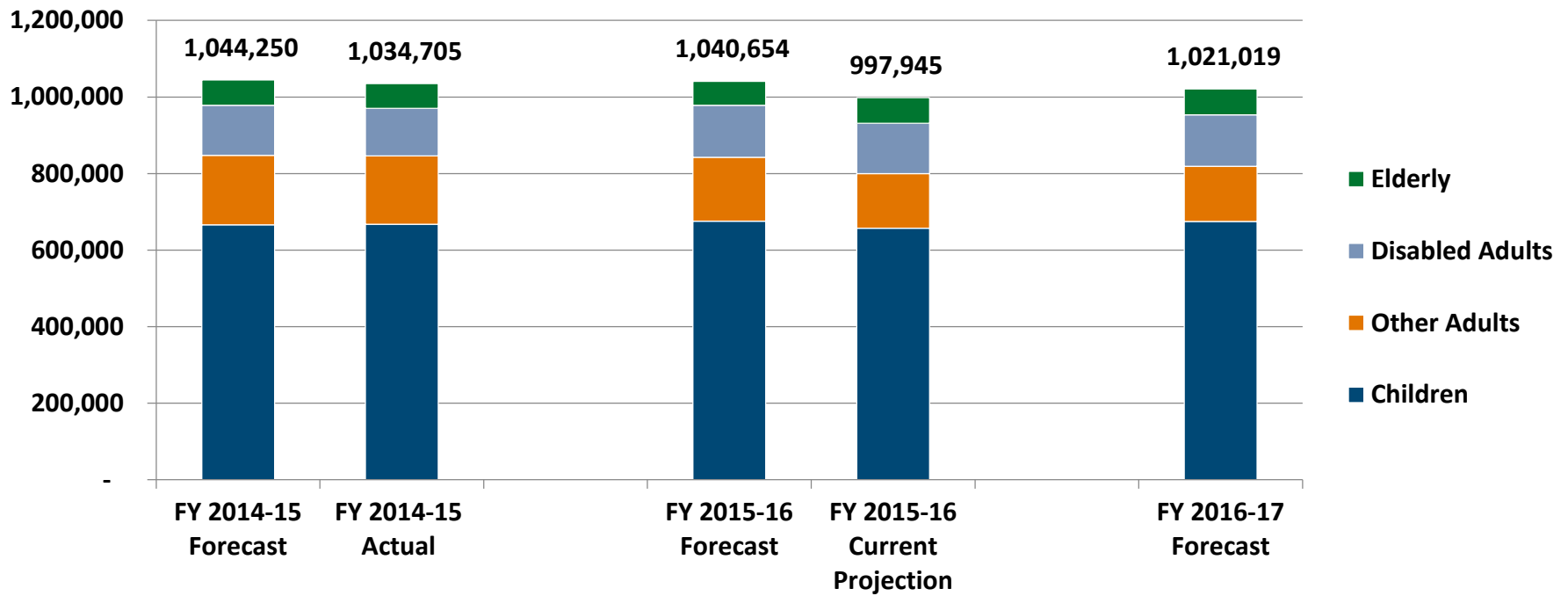
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Changes in Fund Balances

Fund Type	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Estimated	FY 2016-17 Budget
General	$ 62,860,131	$ 232,565,532	$ 280,258,725	$ 174,307,600	$ 68,927,420	$ -
Earmarked	$ 79,031,310	$ 136,493,773	$ 233,205,967	$ 256,412,688	$ 256,412,688	$ 245,644,838
Restricted	$ 10,002,755	$ -	$ 56,266,587	$ 37,601,918	$ 37,601,918	$ 37,601,918
Net Available	*$ 151,894,196*	*$ 369,059,305*	*$ 569,731,279*	*$ 468,322,207*	*$ 362,942,027*	*$ 283,246,756*
3% Reserve Target	$ 173,896,300	$ 178,149,160	$ 194,476,335	$ 206,288,440	$ 210,654,473	$ 221,944,507

- The 3% reserve target is roughly equivalent to six weeks of cash reserves.

- Reserves peaked two years ago.

- Projections above assume the agency's FY 2016-17 budget is approved as submitted.

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Eligibility and Enrollment Update

Full-Benefit Membership

Chart showing Full-Benefit Membership totals by category (Elderly, Disabled Adults, Other Adults, Children):
- FY 2014-15 Forecast: 1,044,250
- FY 2014-15 Actual: 1,034,705
- FY 2015-16 Forecast: 1,040,654
- FY 2015-16 Current Projection: 997,945
- FY 2016-17 Forecast: 1,021,019

- Full-benefit membership continues to hold around 1 million, even with required restart of annual reviews.
  - ➢ Added an additional month of prior notice of reviews.
  - ➢ Sharing better reports with managed care plans, earlier than in the past.
  - ➢ Authorized plans to outreach to members to complete annual review forms.

Eligibility and Enrollment – Continuing Efforts

- **Systems**
  - Negotiated a three-year extension of the legacy eligibility system with CMS.
  - Planning a phased, careful transition for remaining eligibility categories.
  - Increased data-matching, to send continuation notices instead of review forms.
  - Weekly "data fixes," monthly patches/upgrades, bi-weekly IBM meetings.

- **Staffing**
  - 57% fewer Eligibility Workers/Member in November 2014 than Spring 2011.
  - Restarted annual reviews at the same time as the new eligibility system.
  - Posted 170 eligibility slots since July 1st; also using over 300 state and vendor temps.
  - Created dedicated processing centers, launched 2nd and 3rd shifts at key sites.

- **Policies**
  - Streamlined documentation requirements for long-term care applications.
  - Implemented Business Process Redesign to increase first-touch resolution, cut processing time.

Eligibility and Enrollment – Continuing Efforts

New Processing Centers in 2015-2016

1st Shift: Now Open
- *51 Workers*
- Central Office – Jefferson Square
- Charleston
- Greenville (2 sites)
- Spartanburg

2nd Shift: Now Open
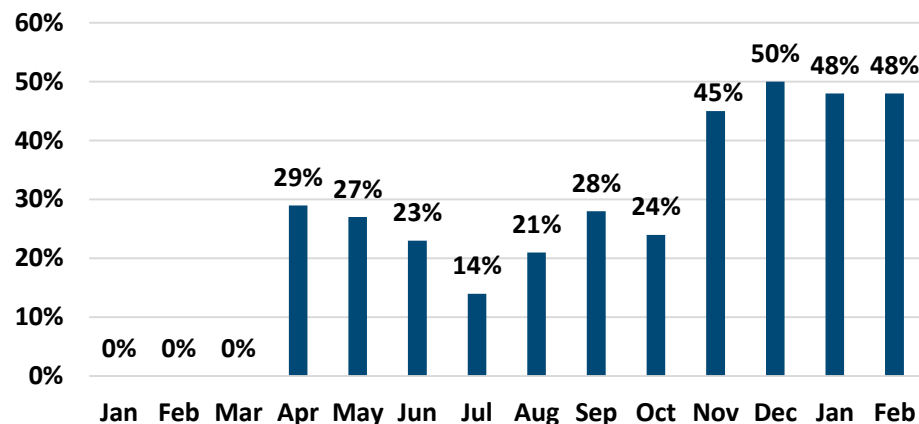- *81 Workers*
- Charleston
- Central Office – Jefferson Square
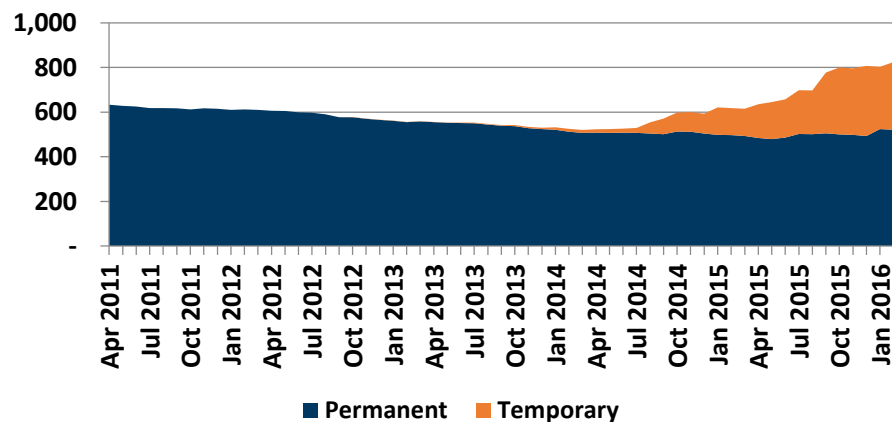- Oconee
- Richland (2 sites)
- Spartanburg

3rd Shift: Now Open
- *13 Workers*
- Central Office – Jefferson Square

Cases Continuing - No Review Form

Month	Value
Jan	0%
Feb	0%
Mar	0%
Apr	29%
May	27%
Jun	23%
Jul	14%
Aug	21%
Sep	28%
Oct	24%
Nov	45%
Dec	50%
Jan	48%
Feb	48%

Filled Eligibility Worker Positions

Legend: ■ Permanent ■ Temporary

Program Updates

Healthy Outcome Plans (HOP)

- HOP focuses on high-utilizers of emergency rooms and/or inpatient services
  - HOPs are paid for each enrollee under care plan management
  - 60% of enrollees screened are in high need of further evaluation for behavioral health intervention
  - 8% reduction in preventable ER visits, 11% for those with care plans
  - 9% reduction in chronic disease-related preventable inpatient stays

- Enrollment update, as of January 31, 2016:
  - 13,728 HOP participants against an FY 2015-16 goal of 13,235
  - 89% of enrollees have a developed care plan so far

44 HOPs, including all 56 Medicaid-designated hospitals	
70 primary care safety net providers (FQHC, RHC, Free Clinic)	30 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.

- SCDHHS has been handling service requests through EPSDT while working on policy development, rate-setting, and IT system changes:
  - Multiple events, webinars, etc. to receive and react to public comments.
  - Working with DDSN to provide administrative / authorization services.
  - EPSDT requests are typically resolved within two weeks of receiving a complete document set.

	FY 2014-15	FY 2015-16
Requests Received	**148**	**878**
Approved	148	517
Pending – Awaiting SCDHHS Decision	0	17
Pending – Incomplete Document Set	0	344

Autism

- The interim billing process was established in April 2015 (15-006):
  - ➢ Required the submission of paper-based claims, while new MMIS codes were established and the web tool was developed/tested.
  - ➢ Many claims have been incomplete or have lacked adequate documentation to support the payment request.

- The "Phase II" process was announced in February (16-003):
  - ➢ Claims for autism services may now be submitted electronically.
  - ➢ Paper-based claims will be accepted until March 1st.
  - ➢ Claims initially rejected by MMIS have now been "recycled" and paid.
  - ➢ Training providers on proper billing methods, to reduce future rejections.

- Draft state plan language has been with CMS for review and comment for several months.
  - ➢ Additional discussions with CMS this month.

Waiting List Reduction Efforts

- Collaborative effort with DDSN and providers to reduce waiver waiting lists for state's most vulnerable populations.

- FY 2014-15: $13M increase in state funding.
  - All 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: $6.4M increase in state funding.
  - All 1,200 Medicaid slots have been allocated to ID/RD (as of 2/29/16)
  - Net enrollment increase of 544 (as of 2/29/16)

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 was submitted in February 2015 and revised in September 2015 and February 2016, based upon CMS feedback – now in public comment period.
  - ➢ Providers have "self-assessed" their day and residential facilities.
  - ➢ In-depth site visits have started for settings that may be subjected to "heightened scrutiny."

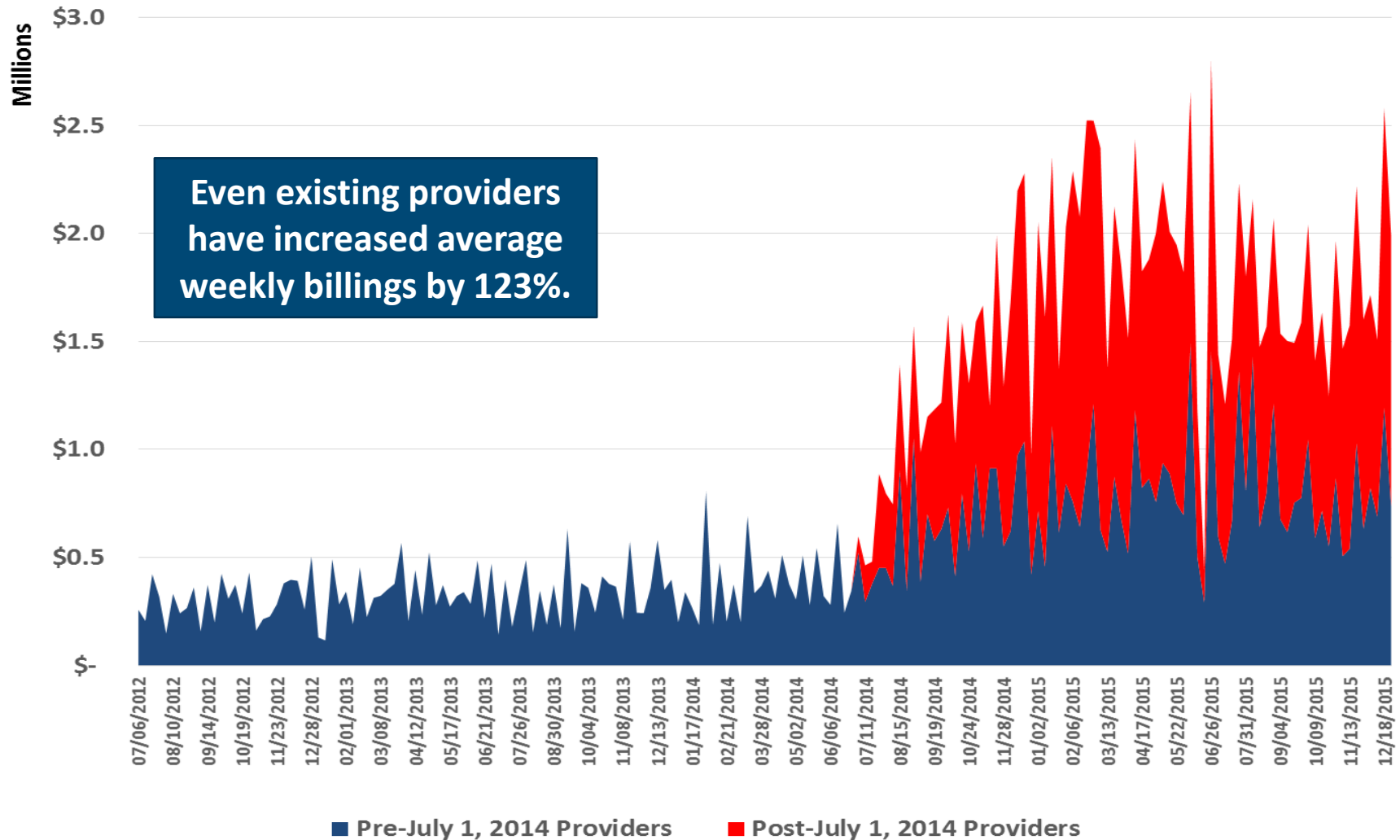| Compliance Status	# of Settings
Fully Compliant with Federal Requirements	198
Modifications Required to Achieve Compliance	921
Subject to Heightened Scrutiny	231
Unable to Meet Requirements	2

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.
  - ➢ Goal was to increase access to services, eliminate the problem that the authorizing agency had been responsible for supplying state match.
  - ➢ Result was a dramatic increase in enrolled providers, beneficiaries, and claims – and fraud.

- Between November 2014 and November 2015, the following actions were taken:
  - ➢ Terminated 53 providers for failure to demonstrate appropriate accreditation.
  - ➢ Obtained CMS approval to impose a moratorium on enrolling new RBHS providers.
  - ➢ Reinstituted prior authorizations through an external quality improvement organization.
  - ➢ Tightened treatment ratios and increased provider credentialing standards.
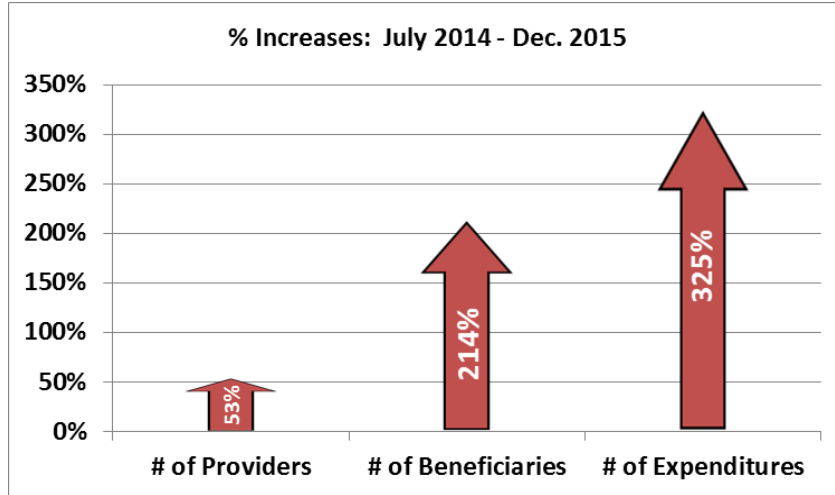
Rehabilitative Behavioral Health Services (RBHS)

- Based upon several rounds of agency/provider comment and on research from independent behavioral health consultants, additional changes are on the way.

- New administrative policies took effect November 1, 2015:
  - More stringent accreditation and credentialing requirements (require SC licenses).
  - Tighter staff training and licensure requirements; background checks.

- New clinical policies took effect January 1, 2016:
  - Revised medical necessity requirements.
  - Parent/Caregiver/Guardian treatment agreement
  - Same Day Service Exclusions (PRS, BMOD, FS)
  - CALOCUS: Changes in frequency, rate and score for medical necessity
  - Non-billable activities clarified
  - Non-billable places of service clarified
  - Additional clinical training requirements required

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Rise and Fall of Weekly Spending on RBHS

Even existing providers have increased average weekly billings by 123%.

Millions

Pre-July 1, 2014 Providers
Post-July 1, 2014 Providers

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Rehabilitative Behavioral Health Services

% Increases: July 2014 - Dec. 2015

Chart showing % increases July 2014 - Dec. 2015:
- # of Providers: 53%
- # of Beneficiaries: 214%
- # of Expenditures: 325%

Program Integrity – Actions Against Providers

- **Investigations: 66**
- **Referrals to the Attorney General: 15**
- **Payment Suspensions: 9**
- **Terminations for failure to provide records: 2**
- **Identified Recoupments: $7.2M**

Average Weekly Expenditures, by Month

Bar chart of average weekly expenditures (in Millions) by month from Jul 2014 to Dec 2015, with a red "Trendline before 3/1/15 policy changes," a green declining trendline, and a black "Historical Baseline" line.

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