DIVISION OF HEALTH CARE FINANCING AND POLICY

REPORT TO THE LEGISLATIVE COMMITTEE ON HEALTH CARE

Tuesday, May 6, 2008

STATUS REPORT REGARDING THE MEDICAID PROGRAM IN NEVADA AND IMPACT OF THE BUDGET REDUCTIONS ON CERTAIN PUBLIC HEALTH PROGRAMS IN THE STATE

Presented by
Charles Duarte, DHCFP Administrator
&
Lester Saltzberg, Ph.D., Director of Behavioral Health, First Health Services Corporation

MEDICAID & NEVADA CHECK UP ENROLLMENT, FUNDING AND PROGRAMS

Legislatively Approved Authority versus Revised Authority After 4.5% Reduction and FMAP Change Reduction by Budget Account and SFY

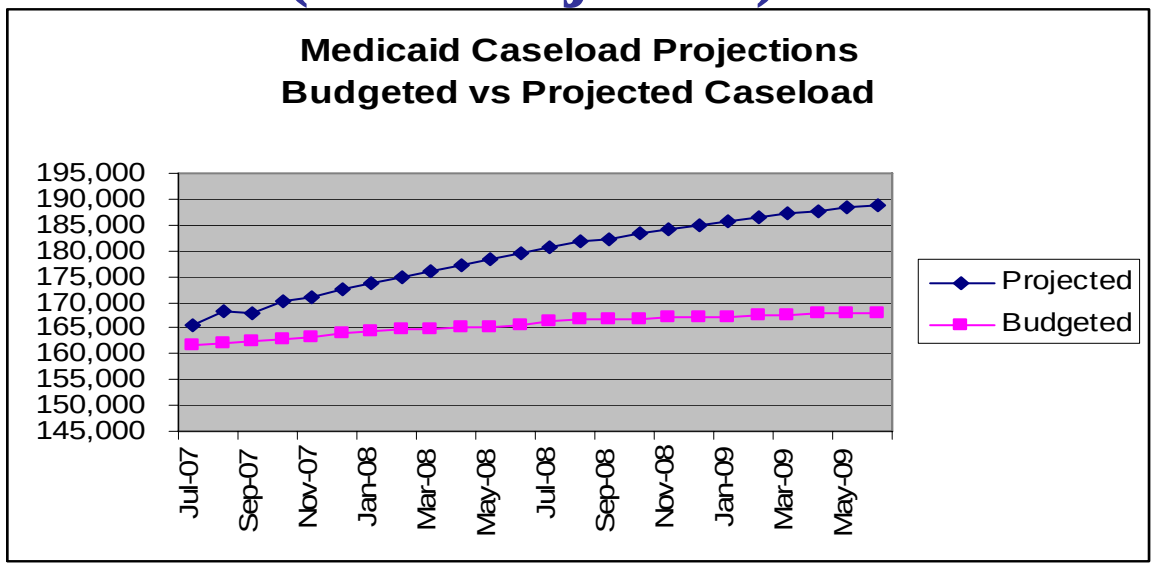
Budget Account	BA Description	FY 2008 Budgeted General Funds	FY 2008 GF Reduction	FY 2008 Loss of Federal Funds	FY 2009 Budgeted General Funds	FY 2009 GF Reduction	FY 09 Loss of Federal Funds
4.5%	**Budget Reduction**						
3155	HIFA Holding Account	2,543,319	2,315,345	2,315,345	4,130,803	3,777,755	3,811,293
3158	Medicaid Administration	1,709,069	619,803	367,069	1,502,672	147,315	147,315
3178	Nevada Check Up	10,899,033	(44,863)	164,165	12,585,449	116,916	(2,950)
3243	Nevada Medicaid	429,004,223	4,731,075	4,258,814	480,536,607	8,000,452	7,787,480
3247	HIFA Medical	1,200,000	1,200,000	8,694,434	-	-	14,314,984
	IGT Transfer		14,261,893				
	Recovery of Overpayment CCDS		5,735,304				
	Reserve for Reversion		634,618				
	Sub-Total	445,355,644	29,453,175	15,799,827	498,755,531	12,042,438	26,058,122
FMAP Changes							
3178	Nevada Check Up					477,100	955,635
3243	Nevada Medicaid					17,771,254	19,579,025
	IGT Transfer					1,446,883	
	Sub-Total					19,695,237	20,534,660
	Total	445,355,644	29,453,175	15,799,827	498,755,531	31,737,675	46,592,782
				45,253,002			78,330,457
							123,583,459

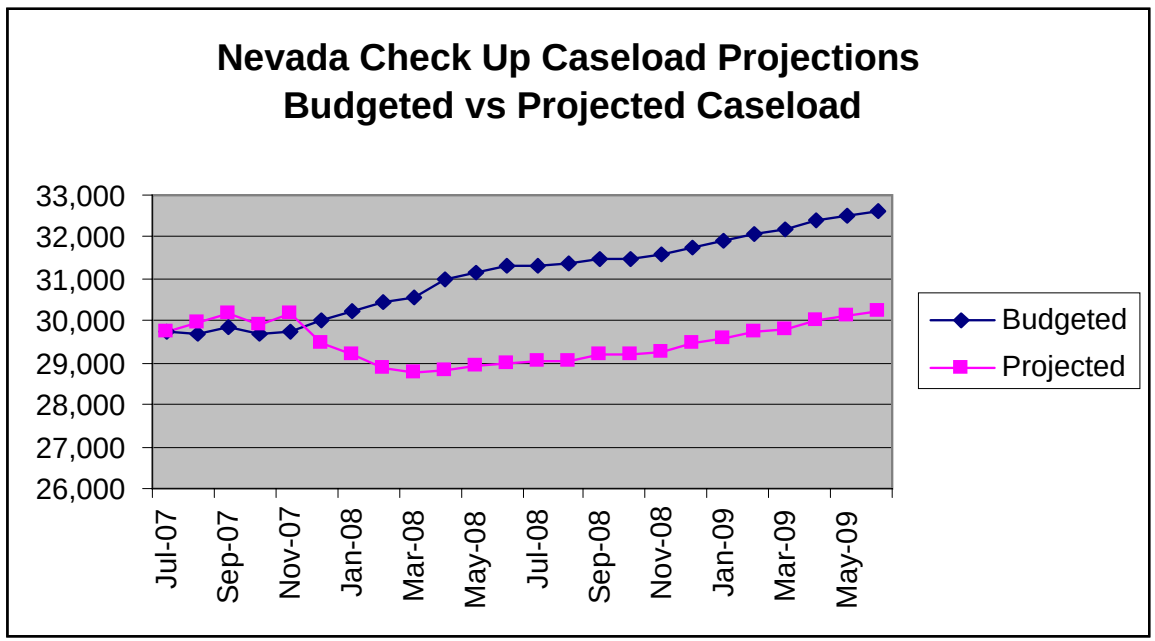
Summary of approved budget reduction initiatives and savings by SFY for 4.5% reduction and FMAP change

	FY 2008 GF Reduction	FY 2008 Loss of Federal and Other Funds	FY 2009 GF Reduction	FY 2009 Loss of Federal and Other Funds	FTE	Ongoing
Staff and Operating						
Hold 15 Positions Vacant	382,210	382,212	524,081	524,081	15.00	No
Additional Salary Savings	275,000	307,265				No
Elimination of New Programs						
Eliminate AB 629	2,110,000	915,792	0	0	1.00	No
Eliminate TBI Waiver Services *			1,008,736	1,111,366	2.00	No
Cap HIFA	2,250,417	11,194,009	3,688,114	18,329,884		Yes
Eliminate HIWA Unearned Income Exemption	215,668	388,614	449,764	554,562		Yes
Limiting Programs/Rate Reductions						
Eliminate Physician Rate Increase *			17,239,618	19,423,294		Yes
Physician Administered Drug Rebates			1,117,188	1,147,076		Yes
Poly Pharmacy Criteria			244,884	255,116		Yes
Direct Impact/Client Services						
Expand TANF/CHAP MCO to 5 counties			4,571,750	4,694,060		Yes
New Revenues/Expense Reductions/Recoveries						
Unbudgeted Pharmacy AWP Settlements	500,000		500,000			No
ESRD recoveries	1,657,600	1,842,400				No
ESRD claim payment methodology changes	710,400	789,600	740,100	759,900		Yes
CCSD Recovery of Negative Balance SFY 05	700,000					No
Increase NCU premiums to $25, $50 from $15, $35	20,065	(20,065)	206,557	(206,557)		Yes
Reserve for Reversion Recovery of Overpayment CCDS	5,735,304					No
Reserve for Reversion	634,618					No
Transfer from IGT *	14,261,893		* 1,446,883			No
TOTAL	**29,453,175**	**15,799,827**	**31,737,675**	**46,592,782**	**18.00**	

*** FMAP reduction initiatives**

Legislatively Approved Caseload versus Actual (and Projected) Caseload





Medicaid Caseload Shortfall Projection: $60,725,608

Biennium Revenues		Leg App Authority	Authority Required	Additional Auth Rqd
2501	General Funds	909,040,830	969,766,438	60,725,608
3511	Fed Title XIX Receipts	1,412,957,277	1,481,728,922	68,771,645
4103	County Reimbursements	47,215,457	50,068,682	2,853,225
Total				132,350,477
Category				
12	TANF/CHAP	684,523,324	735,786,769	51,263,445
14	MAABD	933,990,222	973,123,617	39,133,395
15	Waiver	106,916,326	110,312,476	3,396,150
17	County Match	120,981,206	126,915,808	5,934,602
19	Child Welfare Svcs	116,618,240	150,630,014	34,011,774
86	Reserve	1,388,889	0	(1,388,889)
Total				132,350,477

Factors Driving Shortfall

1 Caseloads Higher than predicted

SFY 08	TANF/CHAP	MAABD	Waiver	County Match	Child Welfare Services	Total
Projected Average Caseload	117,608	42,237	3,748	1,452	7,920	172,965
Budgeted Average Caseload	110,383	41,205	3,551	1,501	7,179	163,818
% Difference Budget vs Actual	6.55%	2.50%	5.55%	-3.21%	10.33%	5.58%

SFY 09	TANF/CHAP	MAABD	Waiver	County Match	Child Welfare Services	Total
Projected Average Caseload	127,164	44,065	3,917	1,457	8,490	185,092
Budgeted Average Caseload	112,015	42,436	3,642	1,508	7,603	167,204
% Difference Budget vs Actual	11.91%	3.70%	7.02%	-3.51%	10.44%	9.66%

2 Child Welfare medical cost per eligible higher than projected

SFY 08	TANF/CHAP	MAABD	Waiver	County Match	Child Welfare Services
Projected Average CPE	216.94	869.58	1,086.42	3,439.70	732.63
Budgeted Average CPE	243.29	905.26	1,191.14	3,172.39	645.37
% Difference Budget vs Actual	-10.83%	-3.94%	-8.79%	8.43%	13.52%

SFY 09	TANF/CHAP	MAABD	Waiver	County Match	Child Welfare Services
Projected Average CPE	261.54	962.13	1,267.03	3,636.71	748.08
Budgeted Average CPE	269.53	944.56	1,284.99	3,394.71	658.98
% Difference Budget vs Actual	-2.96%	1.86%	-1.40%	7.13%	13.52%

Nevada Check Up SFY08 Shortfall Projection $651,857

Factors Driving Shortfall

Caseloads lower than projected
Cost per eligible higher than projected

SFY 08	Average Caseload	Average CPE
Projected	29,421	112.86
Budgeted	30,281	105.22

SFY 09	Average Caseload	Average CPE
Projected	29,555	119.66
Budgeted	31,894	112.29

Proposed Managed Care Rate Change for Calendar year 2008 is driving up Average CPE

Budgeted HMO Inflation	2.60%
Projected HMO Inflation	16.70%

Check Up Total Medical/Dental

Special Waiver Programs

Nevada HIFA Waiver Update:

In the third quarter of State Fiscal Year 2008 the Nevada HIFA waiver program experienced impact from the State's revenue issues. Initially the two HIFA waiver programs, the pregnancy healthcare coverage program and Nevada Check Up Plus (the employer sponsored insurance-premium subsidy program) were slated to be terminated April 1, 2008, and the programs were closed to application from January 11 – February 19. In February it was determined the HIFA waiver programs would remain in operation, but would have a cap on enrollment. The pregnancy healthcare coverage program has a cap of 200 enrollees and the Nevada Check Up Plus program has a cap of 100 enrollees. A HIFA wavier amendment to authorize the enrollment caps was sent to the Centers for Medicare and Medicaid Services (CMS) in early March. CMS has communicated questions, which have been answered, regarding the capped enrollment. No final approval has yet been received by CMS.

October through March waiver program enrollment was:

Nevada Title XXI HIFA Waiver			
	Pregnant Women	Nevada Check Up Plus	Total
As of 10/31/07	107	5	112
As of 11/30/07	107	5	112
As of 12/31/07	100	5	105
As of 1/31/08	91	5	96
As of 2/29/08	70	5	75
As of 3/31/08	51	5	56

The above data is point in time data and is not reflective of retroactive enrollments in the pregnancy healthcare coverage program. In April, as a result of being over income at their annual program eligibility redetermination, 2 persons were disenrolled from Nevada Check Up Plus, leaving 3 persons enrolled in the program.

Behavioral Health Redesign Update

Children's Fee For Service Medicaid Membership Highlights

- Utilization rate increased from 8.4% to 11% (FY05-CY07)
- Variability in utilization rate between areas (Clark 12%, Washoe 25%, Rural 7%)
- Overall children seen increased 30% (from 3654 to 4746)

Behavioral Health Redesign Update (Continued)

Outpatient/Rehab Services

- Average professional visits per child (CPT codes) down 30% (24.1 vs. 16.8)
- Average Rehab hours per child up 958% (14.1 hrs vs. 134.9 hrs)
- Variability in average hours per child between areas (Clark 103 hrs, Washoe 234 hrs, rural 89 hrs)
- Increase driven by psychosocial rehab and skills training
- Increase primarily driven by treatment homes

Behavioral Health Redesign Update (Continued)

Inpatient and Residential Treatment

- No impact on inpatient and RTC usage
- Inpatient admits and admits/1000 up 6% (758 to 804)
- 30 day readmission rate of 13.5% (up 69%)
- 60 day readmission rate of 19.8% (up 47%)
- Residential admits and admits/1000 up 3% (376 to 386)
- Area (Washoe) with greatest use of rehab services has highest admission rates per 1000 for inpatient and RTC

Behavioral Health Redesign Update (Continued)

Treatment Homes

- Number of children served increased 9% from FY05 to FY07 (1221 children)
- Average length of stay was 176 days (up 7%)
- Treatment homes bill 71% of skills training with 53% of patients
- Treatment homes bill 58% of PSR with 42% of patients
- Provide average of 27 hours a week of PSR and ST (including 2 hour base)
- Five homes averaged between 34 and 50 hours a week per child
- 145 children received over 42 hours a week (only 6 non-treatment home children)
- 12 children averaged over 63 hours a week (highest received 91 hours)

Behavioral Health Redesign Update (Continued)

Adult Fee For Service Medicaid Membership Highlights

- Utilization rate increased from 13.6% to 15.7% (FY05-CY07)
- Variability in utilization rate between areas (Clark 14.3%, Washoe 27%, Rural 14.4%)
- Overall adults seen increased 19% (from 4381 to 5214)

Behavioral Health Redesign Update (Continued)

Concerns

- Reduction in higher level therapy services
- Lack of treatment coordination
- Blurring between routine supervision and skills training/psychosocial rehab
- Law of diminishing returns (reasonable amounts of service)
- Services often stay at consistently high level

Behavioral Health Redesign Update (Continued)

Adult Inpatient

- Inpatient admits/1000 initially increased 63% from FY05 to FY07*
- Increase primarily driven by increase in 55-64 year olds hospitalized in community
- Inpatient admits/1000 dropped 15% from FY07 to CY07
- 30 day readmission rate of 8.4% (down 58%)
- 60 day readmission rate of 11.6% (down 43%)

*Only inpatient care provided in the private sector for Medicaid primary individuals.

Behavioral Health Redesign Update (Continued)

Adult Outpatient/Rehab Services

- Average professional visits per adult (CPT codes) down 82% (35.2 vs. 6.2)
- Average Rehab hours per adult up 1293% (4.7 hrs vs. 65.6 hrs)
- Increase driven by BH day treatment and skills training
- Treatment Homes served 99 18-21 year old adults in CY07 (no change since FY05)
- Average length of stay in Treatment Homes was 137 days

PROPOSED STATE PLAN AMENDMENTS AND THE STATUS OF THE FEDERAL REVIEW AND APPROVAL PROCESS

The Division has three state plan amendments (SPAs) that have been held up by CMS because of financial cost reporting concerns. Two of these SPAs (Early Intervention and the Behavioral Health Redesign), having been in review for more than two years. CMS has decided that services previously approved and reimbursed are no longer appropriate for federal financial participation and must be revised in order for the State to continue to receive federal matching funds.

CMS also decided the way the State billed CMS for the federal share was incorrect and has required that we either: 1) transfer Medicaid General Funds in all sister agencies' budgets into our budget account; 2) use the Inter-Governmental Transfer (IGT) process to move the money between budget accounts; or 3) report costs via a Certified Public Expenditure (CPE) process. At this point the Division has ruled out options 1 and 3. We are also waiting for an analysis from the Legislative Counsel Bureau on whether it is appropriate for the Division to use the IGT process to transfer general funds to Medicaid.

CMS has advised us they will grant an extension of the current services through August, 31, 2008. The Division has submitted an extension request and the request is currently at CMS Central Office for approval.

PROPOSED STATE PLAN AMENDMENTS AND THE STATUS OF THE FEDERAL REVIEW AND APPROVAL PROCESS (Continued)

CMS will not allow the coverage of the structured living environment for treatment homes. However, they indicate coverage for individual interventions may be covered. This is outlined in the proposed Rehabilitative regulations. DHCFP has held two public workshops to make the following policy changes:

1. Removal of Treatment Homes as a covered service. The provider may bill the individual services such as Basic Skills Training and/or Psychosocial Rehab in this setting.
2. The Rehab Mental Health Service definitions have been enhanced to clearly define the mental health service and to avoid reimbursement for routine custodial care. The goal is for these services to be adjunct services with other mental health therapies.
3. The utilization management criteria has been modified to establish daily quantity limits based upon the intensity of need for each individual child. The most acute need may receive up to eight hours of Mental Health Rehab Services in a day. Prior authorization is required for all services (except for crisis intervention) and the comprehensive rehabilitation plan is required.
4. Included non-covered services which are consistent with the CMS proposed Rehabilitative regulations.

The proposed policy changes are targeted to be in effect July 1, 2008, in accordance with the CMS proposed Rehabilitative regulations.