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EFRC QUARTERLY MEETING

JULY 21, 2021

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>> Good morning. We have an aggressive agenda today. I want to make sure we're (Chris Gordon) we're staying on time with everything that's going on.

We'll have the official member roll call of the external financial review council and she'll do that first. As a remind, keep your phone on mute or your microphones on mute. We will mute them for you if it causes interruption. Please be mindful of that.

This is obviously -- this meeting, it is public, therefore, there are members of the public, please keep your questions until the end, there will be be a opportunity at the end for open discussion. For the purposes of the meeting, we will close public discussion for the first part of it.

If you can go ahead, take the role.

>> (Roll call).

We have Dr. Carey.

>> And also Cory is assistant secretary, he's on as well.

>> From DPV do we have Dan, Kenney, mike?

>> Kenney is here.

>> From finance, Joe Flores?

>> (No response).

>> From the money Committee, mike tweety and Susan, I thought I saw both of you.

>> Mike is here.

>> This is Susan. I'm here.

>> From Jlarc, Eric and Stephanie?

>> Eric is here, Stephanie is not.

Okay. Great.

Thanks. Great, everyone. Before we get started, I'll pass it over to ash by Moncure facilitating that Webex for us for some announcements about closed captioning.

>> Good morning, everyone. In the chat, you will find a link to the closed captioning, you can just click the link, it will open up into a new window. There you will be able to see all of the closed captioning for the meeting.

Thank you.

>> Thank you, Ashby. Ellen, Chris, I'll put up the agenda and pass it over to you.

>> Good morning. Good to see and hear you all.

I wanted to kick us off with this EFRC meeting, to express my gratitude to the staff.

We continue to really have -- as you will see today, some of our excellent work, but just wanted to kick this off by giving a thank you to our staff for all of the incredible work that we have done throughout this pandemic. As we get to the recovery phase of it, there is a lot more work to be done. I know that our team is ready to do it, we are tired, but we do it for the reason of our members which is also the reason why all of you are here today to have you demask, to present the State of our program from a financial perspective, but we always keep in our mind that this is the intent here, it is -- even if it is just looking at the dollar, the dollars, they are actually medical services for our members.

We attempt to take a holistic view here and we will go through today where we are in our program and show you all a little bit about that. We look forward to our presentations and the questions.

Chris.

>> Chris: Thank you, Ellen. Just want to jump to the agenda really quick. We have first on the docket an expenditure review presented by our budget director Tanyea and our chief economist, rob Chapman. They'll be speaking a little bit about the year end expenditures and how they compare with the forecasts.

Then we're going to pivot to deputy Roberts, our deputy for programs and operations as well as the deputy

for complex care who will introduce the managed care contracts and also we'll end up with chief deputy Ellen Montz speaking about regulations and other trends in our managed care program. Of course we'll have questions for the public. If members of the council have questions at any time during the presentation, feel free to do that.

If you don't want to interrupt, you want to write items in the chat, feel free as well. Ashby and others will monitor that.

With that, we'll turn it over to our budget director Tanya.

>> Good morning, everyone. (Tanyea Darrisaw: I'm director budget director and joining me is rob Chapman, our chief economist.

>> Rob: Good morning.

>> Tanyea: Next slide.

So just a quick little overview, what we will cover today.

We will speak into our preliminary comparison of our Medicaid forecast to actual expenditures as of the close of state fiscal year 2021. I want to point out that Virginia's state accounting system will close this Saturday. Therefore, we only have preliminary information today and the final forecast will be posted online following July 24th, which is this Saturday.

We will also walk through the fluctuation analysis and speak into the variances and the drivers that are plus or minus 10% and lastly we'll go over our year-over-year forecast fund comparison, comparing FY21 to FY2020.

Many of you who are, you know, able to view our information on the DMSAS website, this is a newest feature that we're providing online which is digitalization of the forecast versus the actuals in comparison when looking at involvement as well as expenditures.

Keeping in mind that our forecast at the time of November, 2020, it did not include the extension through April of this year, which actually, you know, is even more extended as of right now, today.

So you can see that the forecast is definitely lower than actuals for a moment. As it was earlier mentioned, the forecast did not include the extension of the public health emergency. You can also see that our expenditures are just also slightly above what was originally forecasted.

This is for total Medicaid.

All right. So for base Medicaid.

So stepping through the same type of slides, same type

of information, we will look at what is happening with ronnel., as you see, there is a sharper increase in enrollment in comparison to the forecast. And there is definitely a larger increase in the actuals in comparison to the forecast.

We'll see the same. We'll -- next slide, please. Sorry.

For those of you that are familiar with the medicine Medicaid actual report we publish every month, you know there is an upper portion of the spreadsheet that captures our managed care expenditures. So what we did, we have now visualized it a little bit differently for this audience.

The managed care budget represents our forecast, what is in the forecast, and what is now appropriated. The appropriation, for our managed care program, it was 7.55 billion.

So we're using this waterfall concept to kind of walk you through how that 7.55 billion was spent. Of the 7.55 billion, 5.21 billion was spent on the CCC plus program.

Stepping down a little further is the.7 billion that was spent on medallion 4.0.

In addition, we received 340 billion in pharmacy rebates, leaving us with a resulted balance of actually spending more than what was originally appropriated of 20 million.

At the close of -- of June, 2021, many of our members are in managed care and I just want to mention that.

Next slide.

When comparing year-over-year trends of managed care with the process ratio, we can see that there definitely is an increase in profit.

The MCO had a record breaking year of profits and calendar year 20 and fiscal year 20. Some of the main kind of takeaways, it is that they definitely -- the MCOs made a half billion in profit for the calendar year 20.

With that being said, the MCOs had a windfall profit as I mentioned earlier, managed care medallion 4, it was 109 million and CCC plus has 88 million.

So there is 124 million in revenue from the MCOs of 111 million was actually collected in June and deposited into the healthcare funds to offset general fund utilization.

You want to speak into this a little bit more?

>> I think you covered it. I think (Chris Gordon) again, when we talk about MCO profits what we're looking at, it is calendar year 20, that's an important piece here

and then when we say over half a billion, it was 567 million in profits and again, the rebate, we had and then we have received 111 to date year back, we're working with remaining plans to receive those plans.

Again, I want to point out, this is for base Medicaid.

We have a two-way risk corridor on the medical side with expansion and so we're refine rising that with Mercer and we have expected that to have data and numbers later in the year in September and we'll be able to provide an update to that.

Again, these -- when talking about profit, what we mean, it is LMRs, the loss ratio and underwriting gains as well.

So in terms of MLR, we have three plans that did not meet the 85% and as far as underwriting gain, in Virginia, the way that the contracts are written, pursuant to the appropriation act, it is between 0 and 3%, all of the managed care organizations, they're going to receive 100% of that profit between 3 and 10% they return 50% of it in the state and anything above 10%, 100% is returned to the Commonwealth.

Because FY20 is measuring rebates on a -- it is on a state fiscal year, because of the shut down that occurred at the beginning or at the last six months I should say of FY20, the beginning of calendar year 20, that led to a significant number of the profits. Again, we're expecting return and we have seen 111 so far, what that means, it it is when we receive the funds, they go in the Virginia healthcare fund, the state's share of it in base Medicaid.

Of course during that time period if you recall, we were not receiving the full -- we were not receiving or utilizing the full 50/50 match we have, the federal government was providing a 6.% amount and so of the 114 million that we expect to receive, the state will return 52 million back to the Virginia healthcare fund and the rest will be reported back to the federal government acrider.

Again, based on the current appropriation that we have in the Virginia healthcare fund, that's 10% of the appropriation, the amount retained, the 52 million that we have an appropriation of.

Again, that's a key factor in terms of understanding how we can utilize, and we'll speak to this in a couple of slides, how we utilize the Virginia healthcare fund and how it runs against the ceiling of the appropriation.

Over to you.

>> Tanyea: Thank you.

Next slide.

So likewise, we're going to step through the base Medicaid portion in the next large categorical area on the medication acquisitions report. That's fee for service.

As appropriated, the final appropriation, for state fiscal year, 2021, we had received 4.1, 4.2 billion in appropriation.

This is how the 4.2 billion was spent.

We have the 1.2 billion that was spent on medical expenditures and then we have the .04, which is 4 million spent on behavioral health and rehabilitation, and we have 1.4 billion that was spent on long-term care, long-term services and then we have supplemental payments of 80 million and then we have hospital payments of 47 million and then pharmacy rebates that came in a little bit less at 1 billion.01 billion, 1 million, the fee for service variants, it was .25 million, so 25 million.

We will set up, we will kind of talk through that variant for each of the categorical areas and have that in further slides.

Next slide.

Now we pivot to Medicaid expansion. Likewise, with the other visualization we have published on the website we are now also looking and providing that same information for Medicaid expansion and you can see that the same happened here when comparing the forecast to actuals, that the forecast was lower than the actual enrollment for the remaining part of the year, the last quarter, and likewise, the forecast actually was higher than the expenditures, it was higher than what was expended in state fiscal year 21.

Same thing, providing the same waterfall concept.

Looking at the managed care, there was 3.4 billion that was appropriated for managed care, of which 93 million was spent on CCC +and 2.6 billion was spend on medicate -- well, medallion 4, and then we had the 28 million of pharmacy rebates which left us with around 11 million as variant.

Fees for service, we had 1 million that was appropriated, which you can see the step down, of all expenditure, ranging from medical, which is 30 million, we have behavioral health and rehab, 1 million, we have long-term support services of 3 million and the supplemental payment of 74 billion that was spent and the hospital payment of 6 million and also bringing in an additional 2 million total in pharmacy rebates leaving us with a Fay for service variance of 5 million.

Now we'll actually walk through those grants and

fluctuation analysis of the plus or minus 10%. For base Medicaid, all of the managed care, the mental health case management, the service, the residential service, nursing facility, in patient and outpatient hospital and all other service, all are attributed to the same variant and the reason is lower utilization due to slower fee for service as members remain in managed care due to COVID-19 and the public health emergency.

We have the fee for service pharmacy rebates which is in the same vein as -- in the same vein as all of the other services, in patient, outpatient hospital, also reduced rebates due to lower point of sail pharmacy claims as well as in patient and outpatient hospital, they follow the same type of trend. Lastly, hospital payments, due to the increase growth in Medicaid expansion, it has led to a reduced uncompensated care for hospitals. Hospital payments. Also there was a reduced physician due to lower utilization and included in the forecast, there was payment, however, we did not receive approval in time so therefore those fees, they are no longer qualified for this payment.

On the other side, the greater -- go back on the slides the clinic services, it is greater than 10% variant and that's due to a cost settlement that's occurred in November and likewise, transportation, it is a rate adjustment for data service claims from April to September of 2020 that was paid this past June, just paid this last month in June of 2021 that attribute to the variants of it being greater than 10%.

The same analysis for Medicaid expansion, the following services fell below that was forecasted by 10% the approval for the payments was captured in time, that we would receive that approval in time, we did not receive that approval in time from CMS and therefore we were and to make the payments in state fiscal year 21. Next, pharmacy point of sale. Due to the global growth, members are in managed care, attributing to the lower than projected spending for pharmacy point of sale claim and likewise, for fee of service, rebates for current year, there is lower utilization of service due to the maintenance of effort from our members remaining in managed care.

There are quite a few services as you see that fall in the above forecast by 10%, clinic service, behavioral health and rehabilitation service, there was overall increased utilization greater than what was forecasted and for the MCO pharmacy rebates, it was based on six quarters of actuals and as we continue to move forward, I believe in

the upcoming forecast we'll sharpen the pharmacy rebates forecast for the upcoming.

The supplemental rate assessment payments, that was based on the increased utilization and the increased enrollment and lastly was transportation.

That was the -- the variance, it was based on the payment made during the year that was not forecasted.

Those items not in the official forecast, those are the payments, the mental health services for CSA, and as you see here, there was 83 million appropriated, of which 69 million was spent and keep in mind this is not included in our forecast. Likewise, for our payments to the facility reimbursement, DBHDS, there was 774 million in the appropriation, of which 57 million was expended. Keeping in mind that the variance here between the 74 million and the 57 million spent was attributed to reduced billing from the loss of CCCA, there are usually about 40 beds that they're able to actual invoice for, and do you to the loss of CSA, they're only billing for 18 beds. There was a loss of revenue due to facility due to COVID attributing to the variants before you.

Of the general fund balance, the general fund balance in DBHDS, that service area, it was 7 million.

All right.

Next, just stepping through --

>> Hey, Tane yea?

>> This is Susan, can I have a question on the last lied. The.

>> CSA, we're not doing Medicaid billings in that facility? I thought we were still going through the process of getting resetter identified.

>> That's the reason why there is a reduction in expenditures this year.

>> Did we not adjust the forecast for that as well? We knew about that last year. It seems like that would have been --

>> Tanyea: We don't forecast -- that's not included in --

>> The appropriation, didn't we adjust the appropriation for that? Sorry.

>> Tanyea: The appropriation, it was adjusted for that.

>> And we still are that much more --

>> Tanyea: Less. Yeah.

>> That's extraordinarily significant.

Part of it, Susan, related to the pandemic, we reached out and I won't speak to DBHDS, when we asked for an

explanation for this, one thing they offered, that you recall, yes, we're not reimbursing for this from a Medicaid perspective but they're utilizing general fund dollars for that., a thing they pointed to, it is in the reduced appropriation, it is not matched by Medicaid and the other thing they related is that the central Virginia training facility, the closing of that facility as well.

Next.

The last part of the summary of all of the Medicaid spending by programs, you can see this is just a visualization of that, the most important thing to point out here is that the healthcare fund we fully executed all of the appropriation, therefore our appropriation balance at the end of the year was 0, our cash balance, as of today, it is approximately 91.7 million and as Chris had indicated, we have seen profits that we have received, the refunds we have received from the managed care profits, approximately 52 million was deposited in the healthcare fund and so our current balance, our current cash balance, it is approximately 91.7 million.

Are there any questions on this slide?

>> Just being stupid, this is Susan again.

If we fully expended the appropriation for the healthcare fund, we got in 52 million from profits, was the rest from pharmacy rebates that came in at the very end of the years or what?

>> Yes. Yes. There was is --

>> Those come in after we sort of cutoff cardinal kinds of activities, is that right?

>> It is the Department of Taxation revenue.

>> Okay.

>> Chris: When it comes to the DOA, the second close you're speaking about, July 24, yes, there is a problem, we fully excluded that appropriation but we have a cash balance that we can't do anything with, we don't have appropriations to do it. In this fiscal year, we can execute that, it doesn't help for FY20. You brought this up in April I believe in our profession.

So the last state fiscal year, they exceeded our expectations. Does that help.

I want to capture that lower part of the Medicaid report, it was just stepping through the forecast versus expenditures for our child health insurance program, as you see on the chart in front of you, the total appropriation for this was 229 million for Famis and the total spend, it was 227 million. This is with us, fully executing of course the famous trust fund and spending that, and the end

of year, of the balance for FAMIS was approximately 700,000 so that was excellent.

So you see the appropriation, it was approximately 218 million, of which 195 million was spent.

It leaves us with an end of year balance of 4.6 million. What's really important to note, it is that the end of year balance, as well as -- the end of year general fund balance, as well as the total 23 million balance of appropriation contributes to the current year pharmacy rebates that were 20 million higher than projected.

The increase pharmacy rebates, it was as a result of improved streamline reclassification processes that of course we will include and reflect in the upcoming forecast.

Next come, just walking through the year-over-year comparison of stays fiscal year 20 to state fiscal year 2021. As you see, the total appropriation for the Medicaid program, it was 14.3 billion, for which 13.7 billion was spent, which is approximately 3.9% below appropriation and the total appropriation for state fiscal year 21 was approximately 16.2 billion, and the spend was 15.9 billion which is approximately 1.8% below appropriation, keeping in mind that this slide does not include CSA, nor does it include the payments.

This means that we're within the 5% strategic area that we wanted to be in pursuant to DPE.

Anything you want to add to this one, Chris?

>> Chris: No.

>> Tanyea: The last slide.

Key takeaways, so our FY21 year end appropriation to actuals were approximately 1.8% below appropriation. When we look at that total Medicaid balance, the balance was 65 million, which again is 1.8% below the appropriation which is in comparison to FY20, that was 3.9%, which is approximately 357 million general fund balance.

So we definitely had a lower balance at the end of this state fiscal year.

Secondly, as Chris had mentioned, and as I mentioned, we fully executed the entire appropriation for the healthcare fund leaving approximately a 91 million cash balance that was unable to be executed to offset general fund revenue this year.

So we received the total revenue that we have received in the healthcare fund, it exceeded the appropriation.

Lastly, we wanted to just kind of compare and look ahead for the upcoming forecast for this upcoming November,

this is definitely considered a big forecast, because we are forecasting and thinking about the upcoming forecast and the impact of the end of the public health emergency, maintenance of effort, redetermination, and that impact on our expenditure backfilling the general fund also with the enhanced replacement, we're looking at definitely a billion as forecasted right now and we haven't completely, you know, finalized the forecast at all.

Just keeping all of that in mind, we're definitely looking at a really big forecast for the upcoming biennium.

Chris, did you want to speak into this a little bit more?

>> Chris: No. Yes. Not -- no. Not -- no explanation but rather just -- we're just telegraphing to people, this is a big two-year biennium obviously. Just level setting expectations with all of the initial programs that we rolled out that were initially pulled back in 20 that we executed in 21 and as we telegraphed in the forecast we just did last November, we're looking at close to almost a billion in potential new spending requirements.

Obviously, we're going to tailor that dine narrow it as we're closer and we started the forecast process.

We want to make it very clear, it is July right now, the forecast preliminary, it comes out October 15 and the final, November 1st. We want to make folks aware early and often that this is the big biennium and as a result you typically see a couple of hundred million increases. That's not going to be the case with this budget, making folks aware of that. Are there any questions either about this piece before we move on to deputy Roberts?

>> This is Susan again.

Just can you state again, what's the 1.8%, what's that translate into in terms of general fund?

>> 65 million-dollar balance.

>> That was compared to 300 and some last year.

>> The 357 million was the general fund balance from fiscal year 2020.

>> Okay.

>> Thank you.

I have another question. Sorry.

So Chris, you said that a billion dollars roughly, you said that for the 20/2022 biennial budget, any speculation on the caboose bill.

Where we'll end up on that?

>> Chris: We just literally started our forecasting process. We had a little internal kickoff meeting with the lead planning group in budget. I think that was a week or

two ago. I can't speak into what the caboose looks like this early. It is only 21 days in the fiscal year.

Obviously some will depend on the special action, if there are things that are not executed, that would potentially effect it as well. I don't -- I'm not aware of any significant impact at this time but I can't commit to a dollar amount.

>> Okay. Thanks.

>> Chris: Thank you. I appreciate that.

The next presentation, it is changes in managed care programs with the managed care organization.

Deputy Roberts, with itlock, I'll turn it over to you.

>> Thank you.

>> Just confirming you can hear me and if so, if you can go to the next slide, (Tammy Whitlock).

As you know, we have had some changes that occurred for 71 in the managed care contracts, but they were strictly based on the directives from the General Assembly and the governor.

Any program, we had some program clarifications and a few operational changes.

None of those had any fiscal impact unless we were explicitly given those funds in the budget process.

Just so everyone remembers -- I'm sure if you reviewed the contract, you do strictly remember reviewing these contracts. The contracts were reviewed by the MCOs, of course, our leadership, many people had reviewed the contracts, our OHE, and of course the Department of Planning and budget.

Then we were able to get all of the contracts and rate pages signed by the MCOs, and director Kim and sent off on time. It was a successful contract year.

Next slide.

>> So a few things, Sheryl and I will split up the responsibility foregoing through some of these contract changes.

Just an example of some of the things that did go in to the contract changes for 7/1, it was any CMS regulatory clarifications, final rule clarifications that we had to put in as a result of CMS sending out any clarifications on their final rules.

Also, everybody is familiar with project bravo, we added three new behavioral health services, I'm going to talk a little bit in more detail about those in a minute.

Smoking cessation, we previously will this covered for pregnant women and now it is covered for all remaining adult members.

Sick leave, consumer the paid benefit for care, respite, companion attendance, effective 7/1, they will start accruing the sick leave. Duel services, this is prenatal, post-partum services provided by licensed doulas, this is going live in spring of 2022.

Telehealth, telemedicine, the telehealth, the telemedicine services to reflect the program changes and GA directives, that occurred in the last session.

I'll send it off to Sheryl.

>> Good morning. Perfect timing for the maternity side.

As you know, we have the unborn child benefit that covers expecting women regardless of citizen status, a week ago we had 142 women that had been enrolled successfully, and we talked to people in northern Virginia, they're doing well in terms of the transition, next month, those women will be in managed care and we'll see that kind of growth.

>> We changed the reimbursement, it is 90% of the service rate. Obviously, we can talk about the vaccine administration for hours for COVID, and we have been actually updating the email for the MCOs to make sure that the payments are going improperly.

One of the things that we are pleased with, it is that we have the 12 months of contraceptive, again, that goes along with the governors plans on maternity and that is consistent. I will spend time in adult dental before we're finished.

As Susan, Mike know, as part of our outreach, our oversight for community mental health, we were instructed to do a report on the determinations and what we decided, Tammy and I, it is that in order to make sure that this report was done not only correctly, but also being able to deal with scrutiny, we contracted with an audit firm to do that report and they have already requested the information from the MCOs and beginning to do that type of analysis.

Last one, basically clarifications.

The next is the work we're doing on provider enrollment in Medicaid. One of the modules we're working on, it is the PRSS, which is the provider portal, but also at the same time, we're doing CARES Act compliance, that change, it is going to be significant to our provider community in terms of both enrollment, screening, the way they handle the managed care, and we did have funds to help us with this process. We hope to have this done in the spring of 22.

The the CCC plus work was done, we're very proud of the work of the care review management system and if you

want to see that action, in terms of what it does in terms of authorization, the work of care management, we'll be happy to have that type of demo for anyone. Precardinal, contract alignment, when we have a new service at this point, you see that compliance, more and more we're aligning in preparation for cardinal.

Last, as part of the ongoing discussions on the partial merger, we want to make sure that we have separation in places, to be in place for contracting to make sure that they keep separate and apart.

Next. First of all, any questions for Tammy and I before we go to the two programs.

Did you hear this enough, that you have memorized them all. We were laughing yesterday saying people have memorized them.

Let's talk about dental.

First of all, I am thrilled, as you know, as well as 700,000 Virginians right now, I went to my own dentist yesterday -- last week, and even though they don't accept Medicaid, they know about this. They said this is wonderful.

I want to say to all of you, if you have not gone to your dentist, this is one of those, you really should, dental care is important and -- go to the next one, I'm sorry.

Yes. There. Thank you.

It help was blood pressure, diabetes, respiratory, it has a whole set. For the Medicaid population, it means not going to the ER, we hope to see ER visits drop.

The big one, not only help but it will engage the workforce, it affects how people get jobs and we'll increase our workforce we're hoping. We are more than happy.

If you have been to the clinic, you know what the clinic was, when you saw 2,000 people standing in line to get dental care, this makes a significant difference in the process and we have heard from the free clinics all around about how grateful they are and the press release that we did, the FQAC dentist, they actually cried that she was finally able to give service, actually cried! I finally can get the services to people that need it so desperately. Thank you all, I know that all of the people on the call worked very, very hard to make this possible.

Next slide.

We covered over 750,000 adults, you see the benefit package, the big things you need to memorize.

Three well visit as year, that's important, three

cleanings a year, why? This is a population that has not been for the dentist, we're working on preventive maintenance and restoration, the goal of the exercise is that people are comfortable with the dentist, the dentist has time to assess them, talk about dental habits as well.

As you know, when you go to the dentist now, it is not just talking about your teeth, you talk about your high blood pressure, you talk about the depression, it is a good answer to have this kind of relationship. We have big stakeholders and the discussions of the stakeholder, then we have independently reviewed to see how it worked and you have no issues now with telephone calls or things like that. Readiness review.

A thing we did is look at target populations, nursing population, other, we need sub dentists who are able to have a flexibility with the population and we have worked with this.

We ensure that the dentists are actually in the network. We're grateful that the governor sent a letter for recruitment, we have worked with the VDA strongly.

However, and by the way, it gets lots of calls, we're getting somewhere between 2 to 4,000 call as week.

It is very popular.

Okay. It has been a popular thing that we see.

Of course, the challenges, Michael, I told you that when you saw me, yes, I'm happy but, so my happy button. One, the easy answer. When we budgeted in the forecast, we budget 32 million, we probably need more money than that, going forward. We'll be talking about that when we do our budgets and budget requests.

Now we realize that's going to be a viable benefit.

The second one, it is recruitment.

We have not had a rate increase for dental since 2005, it was noted in every survey that that is an issue in terms of recruitment for providers both to raise inefficiency and we have that kind of a discussion too as we go forward.

VDA, very much engaged in that discussion, I should say, about recruitment and the rates and so I just wanted to get everyone a heads-up that that is a discussion that we go into the fall with.

The last slide deck, it is just for you all to have, it is with the benefit, what it is. So when people ask what's covered, you have a copy of this, keep it, tell us where you are recovering and why, that will help.

Any additional information, want to speak to a dentist, our staff who helped design this with other dentists would be happy to speak to you.

Thank you.

>> Tammy: A bit of information on Bravo in case you have forgotten, you don't remember, I know you have heard it before, we just want to hit home that this is our vision for behavioral health going forward, all of the services that have been planned for this year, they were planned in line to address the bed crisis. We are hopeful that we can do that, of course, we're in a little bit different intense crisis right now, that was our vision is to have high-quality trauma informed, cost effective services going forward that we can measure the outcomes and really make a difference in peoples' lives that are obtaining the services.

Next slide.

This just gives you a timeline of what we're looking at.

For July 1st, we had mental health, partial hospitalization, mental health intensive outpatient services, and then a community treatment.

Those all went into effect July 1st with the MCOs and on the fee for service side. As Sheryl said, with dental, we did readiness review, we're building capacity as we speak for these provider, we're -- you know, hopeful, it is one of the reasons we didn't take down any services, it is because we knew we were going to have to continue to build capacity over this next year with the services to get people interested in providing them.

The current work that we're doing right now, we have a racial equity work group that our behavioral health team leads. We have in managed care resolutions panel, and this is where all of the behavioral health services, provider, the associations come in and we work with the MCOs side by side to try to figure out and resolve any issues that they're having. We're working with Mercer on an applied behavioral analysis rate study, we are monitoring any of the problems on a daily basis with the first set of services and intervening as we can and, of course, there is a likely hopeful intersection with ARPA for specifically for the crisis piece coming up in December and we have implemented all of our policies for the set of regulations, for services, and we are now working on the regulations for crisis transformation which comes in December.

The second set of services is multitherapy, family function therapy, these are two services that the Department of Justice uses for kids and are very, very, very productive and evidence-based services. The important piece that we are looking forward to, it is mobile crisis

response, the 23 hour beds, the community stabilization, the residential crisis stabilization, these are the services that we're hopeful will assist with the bed crisis as we move forward.

Then you can see the triangle, the pyramid below, that just talks about all of the projects that are alive right now, bravo, step Virginia, the Marcus alert and the legislation, they combine together to serve as a good purpose for the crisis functioning again to help with the bed crisis.

Then just to remind you N the bottom right about what the budget is for bravo as we sit right now.

Next slide.

I think that's all that we had on the contract changes.

We're happy to answer any questions that you might have.

>> Thank you Sheryl and Tammy for that. The last presentation we have on deck for today, it is Dr. Montz speaking on utilization trends in managed care. Over to you.

>> Ellen.

We'll go to the next slide and get started.

Our first slide we have up here, it is a -- it is a picture of all of our kind of total managed care spend.

By managed care spend, again, when I do this presentation, somebody does this presentation we're looking at actual -- we're not looking at the payments made, we're not talking about accounting and budget, we're talking about expenditures that are related to actual services received through our MCOs. These are our encounters that we're adding up here.

Our first graph, it is tracking our total managed care medical expenditures, and that's how we're trying to differentiate that.

Just to orient folks, to the graph, right, the light blue on the bar graphs here on the bars here, they represent actual spending.

That is already documented through encounters.

The dark blue is our estimate of our incurred, but not reported expenditures in those months and expenditures for services received in those months.

Based on what we have and what else do we think we'll receive in the coming months and so that's the dark blue part of the bar and the maroon, the redline, the purply line, it tracks our per capita spending.

Is what we can see here, and again, this is both CCC

plus and medallion combined, later we'll go through the programs separately.

What we see here, it is -- we obviously can see our little dip due to COVID and it starts in March of 2020.

Then we're seeing that our kind of total expenditures here, they are creeping back up and in the last few months in terms of total, again spending.

They have been hire than they were previously.

Now, that again, and we can -- we can decompose this a little later.

Again, as we know, we have -- gosh, what is it, 300,000, you know, more individuals enrolled in Medicaid since the beginning of the pandemic.

It would -- you know, it would -- it would bare to reason that, right, we would have greater expenditures.

The other thing, per capita spending, it is per month.

Spending within the month.

The other thing, the line to work here, we do see obviously again the dip in per capita spending during the pandemic and it has kind of recovered, but not to prepandemic levels. We will decompose this later but reminder here, that most of our growth that we have seen during the pandemic, it has been in the medallion 4 population, on average it is much cheaper, utilizing fewer and less expensive services than our CCC plus population. Even if we were -- even if each individual, each individual program were spending what we expect them to prepandemic, because we have a greater portion of individuals in medallion 4 and CCC plus, we would expect that our kind of per capita expenditures wouldn't reach the -- wouldn't come back to the prepandemic level, just because of that population distribution.

We'll get into that more later.

Next slide, please.

Before I decompose that top graph we saw on the last slide, I did want to kind of take our -- our team took a look back at really the impact of the pandemic and healthcare utilization and expenditures in the population just to take a step back, to really think about how our Medicaid population experienced the pandemic through their service utilization.

What the next two slides will do, and first it is medallion 4 and the next will be CCC plus, what they will do is compare per capita spending in July to December of 2020 versus July to December of 2019. We are not including the very lowest expenditure months, the March, April, May, but what we're really doing, we're saying, okay, what

are -- how are -- how are our expenditures comparing to what is the impact of the pandemic looking like when the state actually did reopen for elected services, these sort of items. What did it look like. The reason we do this, it is to think about where we will see potentially future impacts, not only on kind of the supply market, the physician market, the nurse market, the community services market, but also on potential impacts to member health health, what services were not received, are they ones that concern us, long-term health? Are they ones that we say, okay, that's probably something that can be explained by lower sickness load or maybe it is okay to skip one.

Here is the graph for medallion 4, the top third, it is all, it is the entire medallion 4 population, the middle component, it is the expansion population, it just brings out the expansion population. The last bottom component, the bottom third there, it is non-expansion medallion for population.

The bars, when they -- I guess there is the -- the X access there.

So we see that with the exception of pharmacy and really we see that that is driven by expansion pharmacy utilization, rather than non-expansion pharmacy utilization, but with the exception of pharmacy we have a pretty -- we had a -- we had a significant decrease in the per capita expenditures and utilization across -- pretty much across the board.

So what we have here, and we have filled this before, the most dramatic decreases in per capita spending, it really shows up in our outpatient and professional expenditures, and these are our -- we have both the hospital outpatient services as well as kind of the other outpatient services that you would receive at a doctor's office, whether it is primary care or a specialist.

Next slide, please.

We do see a different pattern in our CCC plus program and we do see orienting you the entire CCC plus population, the middle is expansion and the bottom is non-expansion CCC plus members.

Overall, we do see that there were lower, there is lower per capita expenditures in the CCC plus program overall.

When you compare the last half of 2020 into the last half of 2019. Again here we have a pretty much different story when it comes to examining the expansion, versus the non-expansion population.

In the expansion population, we had increases in

year -- a half year over half year, but year-over-year within those months and per capita expenditures, one way that -- I have been kind of thinking about this, it is a ramp up of service, particularly the CCC plus expansion member, this is our expansion members who have -- who have conditions that would put them, to make them eligible for CCC plus as services and what we see here, it is that they have a lot of care needs irrespective of a pandemic going on or not. A lot of that we can see, it is kind of ramping up between the beginning of expansion and when you have expansions in full swing.

Our non-expansion population in CCC plus, it kind of tells us a similar, less dramatic story than our medallion story which is we do see a little bit of an increase in pharmacy A little bit of increase in in patient and I think we haven't done that, but I think that could potentially be driven by COVID but also kind of some needs that potentially arose because of the lack of availability of outpatient services and professional services. That a is conjecture that the point on my part, we have to look at the data to see what diagnosis are driving those admissions.

Right. So overall, a little bit different story, both between the CCC plus and medallion 4 populations and also within the populations when you break them down by expansion versus non-expansion. Importantly, as we move beyond and past the pandemic our plan is really to track outcomes there, are we seeing an impact, and probably by the end of this, you know, this year, more, of lower utilization, and that impacted some populations more than others.

We'll look at the different treatment affects there and then what are the effects on the outcomes moving forward, what should we pay attention to, how should we interact with members and encourage services as a result.

Next slide, please.

If we move back in our minds to the first slide I showed, now we're going back to kind of looking at, here we're just looking -- we're not looking at total expenditures any more, we're looking at per capita expenditures and here it is just in the medallion 4 population.

Those shaded parts of our two graphs here, it is what went into the previous two graphs you saw, comparing the year-over-year six-month period.

Theirs we're looking at, our medallion for CCC plus per capita, the overall expand churrs in the two programs

and going all the way back to July and up to April of 2021 and so that data, it is I think ran sometime in June.

What are we seeing here? We are seeing -- as we -- we're seeing kind of a bounce back.

You will note, this is consistent with what we have red in national data that's been reported, it is that March, March of this year, it has really shown a bit of we're almost back to normal.

As you see, the medallion 4 per capita expenditure, it really even in that March period, that March period, it does look like it is getting us back to our -- you know, to a normal average that we would expect.

And in the CCC+ world we can see over here, you know, in general the effect was never as large as that in medallion 4. You see in the unexpected expenditure thousand lower, now we're seeing them bounce back up.

The team ran the data earlier this week and looked at an added May to this graph, although I didn't have time to update it.

As we're seeing right now, it looks like March is a peek month and that April and May, they kind of level back out at a little lower bit of a number.

We may be seeing kind of a new steady state here which is looking pretty similar, although on average it may be lower than prepandemic levels.

Next slide, please.

As with everything, there is averages, they hide a whole bunch of different and important and interesting stories. Here we have this broken down by a broad service category, we'll start with in-patient, pretty similar stories across both. We have seen a rebound of in-patient services back to just about prepandemic levels.

Next slide, please.

Outpatient.

Importantly, and I say this each time, outpatient here, the expenditures represented here, they're facilities, outpatient facility expenditures, so think of kind of your outpatient hospital services.

This area, also as you see, with professional service, this area is one that's not gained back its prepandemic levels. It is done more so in the CCC+ world than in the medallion 4 world, we're still seeing lower per capita expenditures and utilization in this area nicely we have seen a rebound in March and April and we have seen this rebound, we want to with the exception in there, we don't want to see the rebound in ER utilization for example, and some of the services, with he want to see that spending to

go back up to enroll.

Pharmacy, as I noted, that is a service that didn't really -- with a exception for minor populations, that's a service that didn't really ever see a decrease, there are a lot of hypotheses out there for why that may be. Some tell a nice story, for example, with the prescriptions that a doctor has given, adherence to taking them, so potentially you can avoid, any bad health outcomes that may be from not managing chronic disease for example and a lot of researchers are looking at what it here during the entire pandemic and is that how you describe the pharmacy expenditures and in that case we may expect better health outcomes.

On the other hand, it may be the result of pharmacy utilization, just going up as a result of -- we have the allowance for the refills and throughout the pandemic we allowed the flexibility and we'll continue to allow telehealth, telemedicine, and there you are connected to -- throughout the pandemic to the doctor and you have the necessary prescriptions filled. So we would always expect that those expenditures don't go down as much because access wasn't as limited.

Next and final slide, please.

As I noted on professional service, you can see the drop, it is never as dramatic as that in me Cal done 4 and importantly, we are seeing a return of professional services, we want them to go to the doctors for primary and specialty care to ensure that they don't get a chronic disease or if they have one, they can maintain it and maintain their health. Again, just as I said, we are looking at a rebound, we're seeing a bit of almost to normal is persisting although not increase,.

>> We're going specifically to the panel members, is there specific questions that you may have, either on the presentation or any of the other ones that you have before opening it up for public comments and feedback?

>> Second Carey: Thank you for the detailed presentation from multiple perspectives.

I'm good right now. I'm very much interested in the questions of others and comments from the public it is 11:12, we'll open it up to public comment or questions from folks. I take the silence that you completely understand and agree with everything said here.

Feel free to email us or any of the folks, the presenters directly, are you forecasting the utilization of the services, looking at how you will look at the consumer utilization, there is for access, for network adequacy,

we're seeing enough increase in operating costs in areas such as personnel, personnel due to market shortage, and looking at the stable market salary, so I can speak on to the forecast piece, it looks like it is -- it is -- I'm -- it is related to a bit of behavioral health, if you want to kick that off, then we can go from there.

>> We have within our finalized rates for this year, for the payment rates, those include the general rate setting procedures that have impacts, et cetera, I'm not familiar with the specific behavioral health rates, I know that some of those increased -- was it July 1, Tammy?

>> Yes. For the licensed personnel, yes. Those are in the rates, the fee for service rates as well as managed care rates.

I suppose the other item I would note here, it is that many of our rates are set by the General Assembly and are forward looking. Any future rate impacts would be reflected by a future budget and the like.

I will -- I will add into that as part of the rates just mentioned on behavioral health, we did have several items that were COVID related and one in the behavioral health space, it was outpatient utilization as as you -- the quarantining thing from home, the lack of connectivity, obviously, the anticipated behavioral health utilization was expected to be higher, we this is based on input from Tammy and the behavioral health team, we did work with Mercer and we recognized that it would be -- there would be greater utilization, again related to project bravo, so as we're pivoting from institutional rather to outpatient services, there was definitely an impacted forecast there and I'll let Ellen speak into consumer utilization, network adequacy, the last point on the forecast, it is increase operating cost, things like that, again we definitely are aware of that and when we do the forecast, we look at that, we include inflation rates specific for different populations as Ellen mentioned set by the General Assembly, the appropriation act, not all members or providers I should say of our community of our safety net do actually have in inflation requested. When there are incidents like for instance, we direct the actions and increase the rates but aside from that, we follow the inflation criteria and I'll pass it to you to speak about adequacy.

>> You covered the utilization impacts on that forecast.

>> I would add, one factor that is related to rates is the analysis of the minimum wage impact on some services in

DMAS that we would expect to get that report back. Those are some things where we did look at impacts on the minimum wage issuings.

>> We received that final draft from our vender June 30th, two weeks ago, it has been almost a month and what our team has been doing, editing, going back and forth with the vender, trying to finalize that so you have a product.

You have the initial draft on June 30th. It was after when we -- it was the contracts that are required and after our expectation, we're working to get that out and we should have that out by the end of the month.

A follow-up on network adequacy, we have the governor's taskforce on primary care we were working with. You participate fully in that group.

Have we seen primary care providers dropout of the network? Is there evidence that access is being stretched or tested on the primary care or the behavioral health front or on our community-based providers? We have had to close-up, close down the proportion of our practice that's able to care for Medicaid and the Medicaid population members. Any insight into that and how it affected access to services which explained -- any additional information would be great.

>> So -- I'll answer that in a couple of ways. Those relate to how we'll figure out the answer to the questions. The really important question, I think it will be -- we'll approach it in a few ways.

Number one, we know that across the board individuals on average received, went to get, right, fewer services than they otherwise would have during the pandemic.

They did, although the state, they did some really wonderful things to help mitt indicate this impact -- mitigate this impact, as well as the federal government, step in, try and make up for that revenue loss that a lot of providers receive or experienced throughout the pandemic.

Now, that will have kind of a differently impact on providers based on how they're able to weather that pandemic.

What we're tracking, it is -- we're tracking this both in the primary care space and in the behavioral health spaces, all four of those areas pretty intensively is not only looking at service utilization rebounds, but also looking at distinct numbers of MPIs, actually looking at the number of providers that are there. Combining those two things, right. If we see that the service utilization

has rebounded, but we see fewer provider, well, that's less of a concern than if we see that our service utilization hasn't rebounded all the way and we see fewer providers.

I will say that that analysis, it is going on right now.

There is less -- I will say kind of -- there is less concern in the primary care space, although concern, than there is, you know, in our -- frankly, as we're looking at the data, kind of the DD waver, the HCBS space, in terms of the provider resilience I will say.

We're specifically looking at that and we should have results that could be great to present if folks would like to see that. I think that's the right question that we have to ask about have we come out of this with the market that we need to deliver our services to our members.

>> Great. Thank you so much.

>> If I could add one statement to that, just to -- what we're hearing, it is that -- we have got the group of providers, our behavioral health provider, our art providers, our personal care providers who -- this is the group that never stopped during the pandemic, they continue to go in, providing services, some of them through telehealth, but many, many, many of them hands on through the pandemic.

We are hearing that not only are providers closing because they have not been able to bill but the burnout in our provider staffing, the workforce, it is becoming really apparent and extensive.

It is a lot on the community -- in the behavioral health side with outpatient, you know, the licensed individuals as well as some of the intensive in-home, those are the services that really kept going and then of course, on the personal care, we have done a lot for the personal care groups, that behavioral health group that never stopped during the pandemic, that's the piece that we are really concerned about that we're going to lose a great deal of those workforce because we're hearing that they're actually going to the DD side, because of the stress.

Throwing that out there, just to share what we have heard from the field.

>> I don't see any more comments in the chat, I believe we have addressed that. Thank you for the response and dedication to making Virginia the greatest state. Definitely appreciate that feedback.

You can certainly tell where the answers and responses to that, obviously, the member, they're making sure that they have the adequate safety nets that we need in order to

make sure that we continue service for them.

Are there any other questions from anyone else? I see a head shaking.

We're done then.

Ellen, did you want to close it out with any comments?

>> Thank you, everyone.

>> Thank you. Yeah. I would simply, again, thank you, to add to what Ellen said (Daniel Carey) this forum I look forward to every quarter, a key element is transparency, folks were able to ask very indepth questions and receive very indepth data in addition to the monthly updates that we get and give to the General Assembly.

I complement the preparation that clearly goes into the forums and I think it is a tremendous aid to the collaboration with other parts of government, whether the General Assembly, other, multiple stakeholder, and really appreciate this and I think it is having the intent, if not, please let us know.

We care deeply about reliability, transparency, and commitment to not only providing great service for our member, but doing so in an economically sustainable way and very transparent way.

My complements to the leadership and to all of the teams that the folks represent.

Thank you so very much.

>> Thank you, Ellen, thank you, Chris. Thank you for all of your hard work.

Appreciate it.

>> Thank you.

>> Have a great day.