Department of Planning and Budget
2018 Fiscal Impact Statement

1. **Bill Number:** SB 915

House of Origin	☐	Introduced	☐	Substitute	☐	Engrossed
Second House	☐	In Committee	☒	Substitute	☐	Enrolled

2. **Patron:** Dunnavant

3. **Committee:** Appropriations

4. **Title:** Priority Needs Access Program; created, report

5. **Summary:** The substitute bill directs the Department of Medical Assistance Services (DMAS) to amend the Medicaid demonstration project (Project Number 11-W-00297/3) to create the Priority Needs Access Program (PNAP) to (i) increase the income eligibility for the program from 100 to 138 percent of the federal poverty level; (ii) include in the benefit package inpatient hospital and emergency room services; (iii) expand program eligibility to individuals with a diagnosis of mental illness, substance use disorder, or a life-threatening or complex chronic medical condition; (iv) include the entire population of the demonstration project in the Commonwealth Coordinated Care Plus managed care program; and (v) limit the number of individuals covered as a result of the expansion of the income eligibility or qualifying conditions to 20,000.

   The bill also does the following:
   - Authorizes new Community Living, Family and Independent Support, and Building Independence waiver slots;
   - Requires the Department of Behavioral Health and Developmental Services (DBHDS) to develop a statewide alternative transportation system for Temporary Detention Orders (TDOs);
   - Directs DMAS to ensure the children covered by Medicaid and FAMIS be screened for adverse childhood experiences; and
   - Directs the Department of Aging and Rehabilitation Services (DARS) to expand services to assist persons with brain injuries in returning to work and community living.

   As amended, the bill's provisions will not become effective unless an appropriation effectuating its purposes is included in the Appropriation Act passed by the 2018 General Assembly.

6. **Budget Amendment Necessary**: Yes. See Item 8. The substitute bill includes an enactment clause that the bill's provisions will not become effective unless an appropriation effectuating its purposes is included in the Appropriation Act passed by the 2018 General Assembly.

7. **Fiscal Impact Estimates:** Preliminary. See Item 8.

8. Fiscal Implications: The substitute bill's expansion of the GAP program and other coverage enhancements could have significant fiscal implications (as outlined below).

Priority Needs Access Program (PNAP)

The fiscal impact estimates for PNAP, as described below, assume that the expansion in SB 915 would become effective on October 1, 2018. This effective date was assumed to maintain consistency in comparing it to the Medicaid expansion proposal contained in the introduced budget that also contains an October 1, 2018, effective date. Further, since this proposal will require extensive negotiations with the federal government to gain waiver approval, an October 1, 2018, effective date is more likely.

The proposal would expand the GAP program in three distinct ways. First, the bill would expand the income criteria for the program from 100 percent of the federal poverty level (FPL) to 138 percent FPL. Second, the bill would include in the benefit package inpatient hospital and emergency room services. Third, the bill would expand the diagnoses that qualify individuals for the GAP program to include substance use disorder (SUD) and mental illness (the GAP program already includes coverage for serious mental illness, or SMI) and anyone in that income bracket with a "life-threatening or complex chronic medical condition." The fiscal implications in this statement reflect an assumption that the newly eligible population would be covered up to 138 percent FPL. SB 915 also limits the number of individuals who can enroll due to the expanded income limits and new qualifying criteria to 20,000. Because of this cap, DMAS allocated enrollment between the new eligibility criteria.

DMAS used data on the number of low-income adults already enrolled in the Medicaid program who also have a diagnosis of mental illness (MI) or substance use disorder (SUD) to extrapolate the number of individuals who would enroll in the program under the provisions of SB 915. DMAS estimated that 4,198 individuals in FY 2019 and 8,268 individuals in FY 2020 would be seek to enroll in the program as a result of a SMI (between 100% and 138% FPL), SUD, or MI diagnosis. However, SB 915 limits the number of individuals who can enroll due to the expanded income limits and new qualifying criteria to 20,000. Because of this cap, DMAS estimates that only 2,863 individuals in FY 2019 and 2,752 individuals in FY 2020 would be able to enroll in the program. The remaining individuals would likely be put on a waitlist until a spot in the program became available.

The bill does not define what would constitute a "life-threatening or complex chronic medical condition." To estimate the number of individuals that might qualify for the program based on this definition, DMAS assumed that any individual in this income bracket with three or more chronic medical conditions would qualify. Based on data from the U.S. Agency for Healthcare Research and Quality (AHRQ), 20.7 percent of Americans have three or more chronic conditions[1]. Using this statistic and a ramp-up factor, DMAS estimated that 19,113 individuals in FY2019 and 52,561 individuals in FY2020 would be seek to enroll the program because of a life-threatening or complex chronic medical condition. However, due

[1] Agency for Healthcare Research and Quality, "Multiple Chronic Conditions Chartbook," p. 4 https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf

to the cap on enrollment, 13,295 individuals in FY 2019 and 17,249 individuals in FY 2020 would actually be able to enroll in the program. The remaining individuals would likely be placed on a waitlist until a slot in the program became available.

Because of the 20,000 person cap on new enrollment, DMAS estimates that more individuals will need services and qualify for the program than can be served under the cap in FY 2019 and FY 2020. DMAS assumes that a waitlist for slots in the PNAP program would be established, and that an average of 7,154 individuals would be on that waitlist each month in FY 2019 and an average of 40,829 individuals would be on that waitlist each month of FY 2020.

The table below summarizes how enrollment is estimated to grow as a result of SB 915.

Estimated Average Monthly Membership Under SB 915

	FY 2019	FY 2020
Existing GAP Program (SMI, FPL at or under 100%)	17,074	17,867
Serious Mental Illness (SMI), 100-138% FPL	1,185	1,215
Substance Use Disorder, 0-100% FPL	994	923
Mental Illness, 0 – 100% FPL	684	614
Life-threatening or Complex Chronic Condition, 0 – 100% FPL	13,295	17,249
Estimated Monthly Average Membership	33,231	37,867
Estimated New Enrollment	16,158	20,000

This legislation would provide the current GAP benefits plus inpatient hospital and emergency room services to its enrollees. The benefits that would not be included, or that would be limited, under this package are: medical equipment and supplies, community-based behavioral health services, and transportation services. To estimate the per person spending, DMAS started with comparable rates paid (Medallion 4.0) for a full benefit adult, then applied a 10 percentage point discount factor to the estimated full benefit cost per person to account for limited benefits. Furthermore, in order to account for the fact that individuals with SMI and SUD may have higher cost than an average low-income adult, a 10 percent factor was added to their per person per month rate. Then, to account for the fact that individuals with a life-threatening or chronic condition may have higher spending, a 20 percent factor was added to the per person per month rate for that group.

DMAS estimates that the total funds cost of providing the coverage described in SB 915 would be $138.8 million in FY 2019 and $231.7 million in FY 2020. In addition to the above medical costs, DMAS has identified administrative costs associated with providing call center and enrollment broker services to the population. DMAS estimates that the total cost of these enrollment activities would be $0.8 million in FY 2019 and $0.1 million in FY 2020.

Additional Waiver Slots for Individuals with Development Disabilities

SB 915 provides authorization for DMAS to make additional waiver slots available for individuals with developmental disabilities. The bill provides authorization for an additional 144 Community Living (CL) waivers, 1,847 Family and Individual Support (FIS) waivers, and 305 Building Independence (BI) waivers. The total funds cost of these additional slots would be $71.3 million in FY 2019 and $71.3 million in FY 2020.

Adverse Childhood Experience Screenings

SB 915 requires DMAS to ensure that children in the Medicaid and FAMIS programs are screened for adverse childhood experiences. According to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), adverse childhood experiences (ACEs) are defined as stressful or traumatic events, including abuse and neglect. ACEs tend to be related to development and prevalence of a health problems throughout a person's life. The questionnaire typically used to screen for ACEs asks a number of sensitive questions, including questions related to parental verbal, sexual, physical, and drug abuse. As a result of the sensitive nature of this questionnaire, according to DMAS clinical staff, the questionnaire is inappropriate for use with many children. Therefore, to implement this provision of the legislation, DMAS would contract with consultants with expertise in ACEs and trauma-informed care to develop recommendations regarding screening requirements and screening tools for use with children of all ages. Based on the cost of similar contracts, DMAS estimates that such a contract would cost approximately $250,000 (total funds) in FY 2019.

Assuming that new ACE screening requirements could be implemented on January 1, 2019, DMAS estimates an additional 246,577 children in FY 2019 and 493,152 children in FY 2020 would be screened.[2] DMAS estimates that the total funds cost of ACE screenings for Medicaid and FAMIS enrolled children would be $1,178,638 in FY 2019 and $2,357,267 in FY 2020. The National Survey of Children's Health found that 19 percent of children have experienced two or more ACEs. Of those Medicaid and FAMIS children screened, 46,849 children in FY 2019 and 93,699 children in FY 2020 would likely be identified as having experienced two or more ACEs, and may be referred for additional services and interventions. DMAS has not estimated the cost of those additional services and interventions.

Even though physicians, nurses, and teachers are already mandated to report potential abuse or neglect of children to Child Protective Services (CPS), requiring a standardized assessment instrument to be administered may uncover additional concerns causing a potential increase in the number of CPS referrals to be handled by the child welfare system.

It is unknown how many new CPS assessments and/or investigations will be necessary as a result of having the ACE Questionnaire administered. However, the Department has shown a cost estimate based on a one percent increase in referrals and the corresponding assessments or investigations.

[2] Some Medicaid and FAMIS enrolled children are already receiving ACE screenings when certain risk factors are identified or when children receive certain services. In FY 2017, 31,202 children in Medicaid and FAMIS received these ACE screenings. The estimates in this fiscal impact statement assume that these screenings would continue and that these children would not receive another ACE screening as a result of this provision.

For every one percent increase in referrals due to this bill, approximately 391 new CPS assessments/investigations will be needed annually. This would require the equivalent of 13 additional local departments of social services (LDSS) positions. The total annual estimated cost is $1,083,847 funded through general fund dollars ($915,851) and local match ($167,996). There are no unobligated federal funding sources available to the Department for CPS activities.

During FY 2017, the Department received 83,145 CPS referrals of which 39,105 or 47 percent (39,105/83,145) were investigated. Assuming the number of CPS referrals increases by one percent due to the legislation, it is estimated that LDSS will receive 831 (83,145 x 1%) new referral/reports. Since 47 percent of referrals resulted in either a Family Assessment or CPS investigation, 391 (831 x 47%) new assessments or investigations are also projected.

Considering all of the requirements to respond to a valid referral, the Department of Social Services estimates that each CPS assessment or investigation requires an average of 50 hours to respond. Based on this, 19,542 (391 cases x 50 hours per case) additional local staff hours will be required to validate these reports. Given 1,500 productive hours per local staff annually, the equivalent of 13 (19,542/1,500) additional local department staff is required. The average annual cost, including salary, benefits, and nonpersonal services of employing a local CPS worker used for this analysis is $88,535 for a total estimated cost of $1,150,953 (13 x $88,535) for the first year and $1,083,847 each year thereafter. One-time costs of $67,106 for new employee on-boarding are included in the first year totals. General fund of $972,555 in FY 2019 and $915,851 in FY 2020 and each year thereafter are needed for a one percent estimated increase in referrals due to this legislation. Local match requirements at 15.5 percent equal $178,398 in FY 2019 and $167,996 in FY 2020.

Alternative TDO Transportation System

SB 915 requires the Department of Behavioral Health and Developmental Services (DBHDS) to establish and operate a statewide alternative transportation system for adults and children subject to a TDO. The agency estimates the cost of operating such an alternative transportation system to be between $5 million and $10 million per year. Last year, DBHDS issued a request for information (RFI) to seek information on potential providers and their cost estimates. Over the 30 days the RFI was posted, two viable providers responded and estimated statewide costs between $5-6 million. This lower cost would be based on economy of scale as the providers already provide this service and have the infrastructure in place and variations in their model of providing this service. However, based on the results of a pilot program in the Mount Rogers area, DBHDS projects a significantly higher cost of $10.3 million, including a central office position to manage the program. Approximately 25,000 TDOs are executed each year of which about 50 percent (12,879) require law enforcement transportation. This comes to approximately 35 cases statewide that could be handled by a vendor each day. The Mt. Rogers pilot found that, on average, 50 percent of TDOs were still transported by law enforcement for a variety of reasons, including safety, and in most cases the destination was close enough that it was easier for law enforcement to just transport the individual as opposed to wait for alternative transport. The DBHDS estimate assumes that 36 teams of three drivers (two day shifts, one night shift) will be needed across the state to provide full, 24/7 coverage, at a daily cost of approximately $734 per day per team ($9.7

million). The number of teams would vary by region, and a 15 percent cost of living adjustment would be given to those drivers in the Northern Virginia region. The costs would also include a mileage component, which the agency estimates at $550,000. In addition, DBHDS would require one central office position to manage the alternative transportation program, as this is not a function the agency currently coordinates.

Expand Neurobehavioral Services

SB 915 requires the Department of Aging and Rehabilitation Services (DARS) to expand neurobehavioral services used to assist persons with brain injuries in returning to work and community living. There is not sufficient direction in the bill to estimate a specific fiscal impact. Any additional effort by DARS to increase neurobehavioral services could be construed to meet the minimum requirements of the bill. For reference purposes, DARS estimates that the agency may be able to serve approximately ten residential stays (varying from three to 24 months) at a cost of approximately $1.0 million. Similarly, $1.0 million could be used to establish a network of 12 specialized services that would serve approximately 300 individuals. Any expansion would require some administrative funding for the agency ($100,000). General fund support would be necessary for any expansion by DARS.

9. Specific Agency or Political Subdivisions Affected:

Department of Medical Assistance Services
Community Service Boards
Department of Corrections
Department of Social Services
Department of Behavioral Health and Developmental Services
Department of Aging and Rehabilitative Services

10. Technical Amendment Necessary: No

11. Other Comments: None