MEDICAID COST IMPLICATIONS FOR 2012-2014

Susan E. Massart, Fiscal Analyst
House Appropriations Committee Staff
November 16, 2011

- Overview of the Virginia Medicaid Program
- Medicaid Forecast
- Impact of Federal Health Care Reform
- Medicaid Reform Initiatives

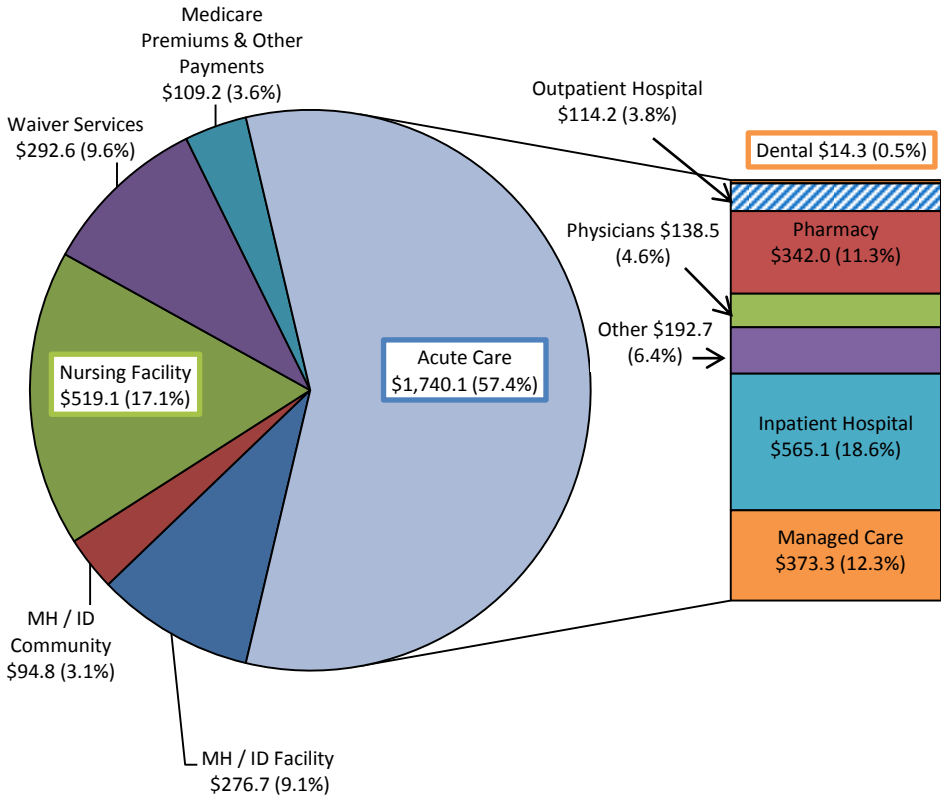
Virginia Medicaid Program

- Largest health care financing program for low-income persons in Virginia
  - Aged, blind or disabled
  - Children
  - Member of a family with children
  - Pregnant women
  - Certain Medicare beneficiaries
- In FY 2011, Medicaid provided payments on behalf of 992,800 recipients at a total program cost of $7.2 billion
- Program costs are shared by the state and federal government
- Virginia's share is 50% in FY 2012 based on per capita income
- ARRA enhanced federal match ended on June 30, 2011

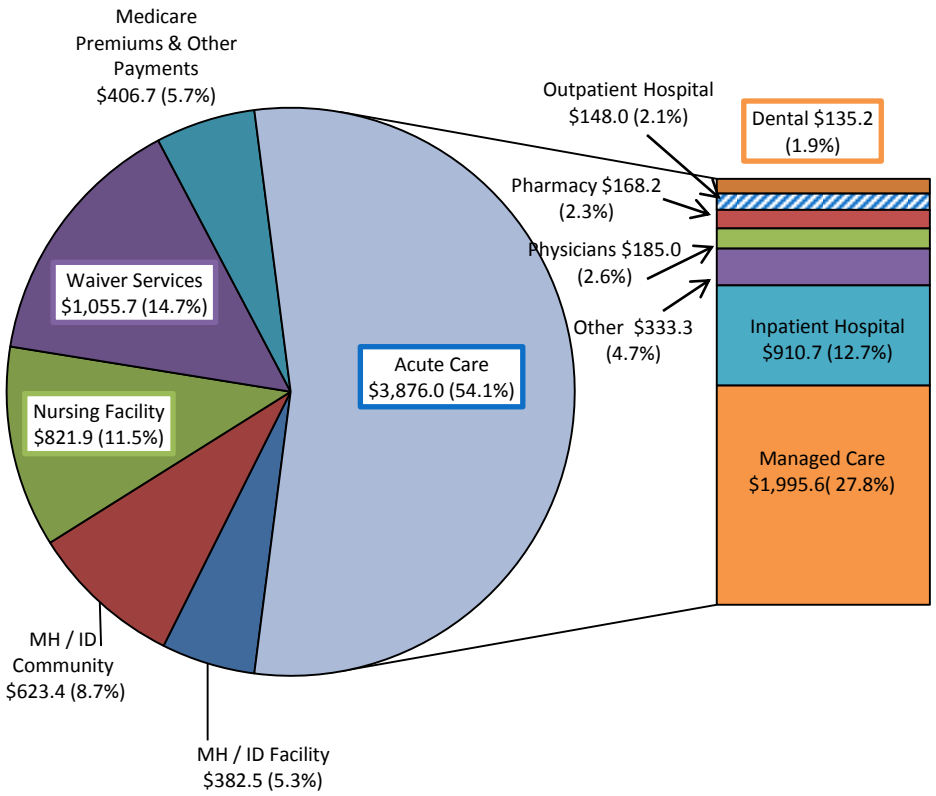
ARRA Enhanced FMAP			Regular FMAP
July 10 – Dec 10	Jan. 11 – March 11	April 11-June 11	FY 2012
61.59%	58.59%	56.59%	50%

Comparison of Expenditures by Service Type FY 2001 and FY 2011

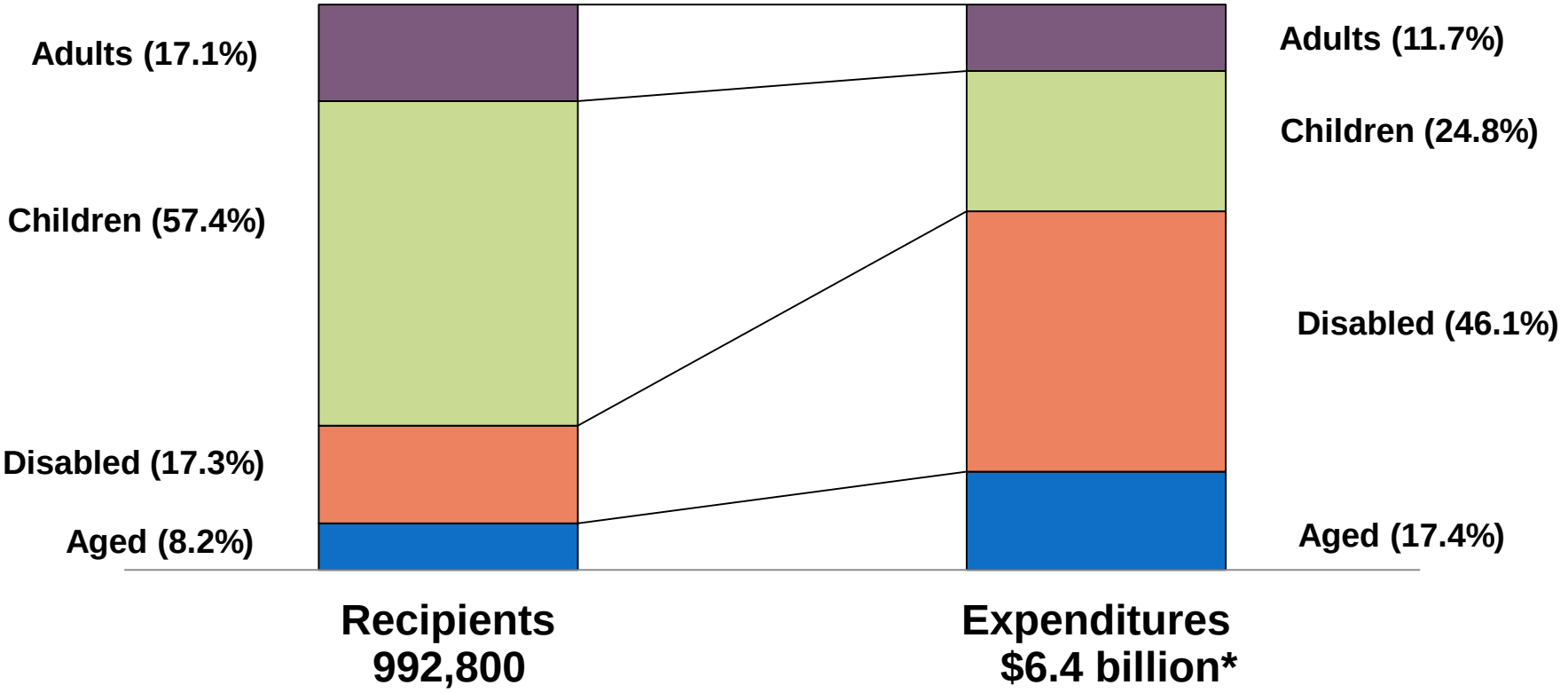
FY 2001 Expenditures = $3.0 billion ($ in millions)



FY 2011 Expenditures = $7.2 billion ($ in millions)



Comparison of Recipient Groups as a Percent of All Recipients and Expenditures (FY 2011)



*Does not include approximately $815 million in lump sum expenditures that cannot be attributable to individual recipients.

Selected 2011 General Assembly Actions to Contain Medicaid Costs

- Expansion of managed care and care coordination models
- Estimated savings $3.4 million GF in FY 2012
  - Foster care pilot in City of Richmond
  - MCO expansion to Roanoke region
- Additional savings should be realized in the 2012-14 biennium
  - MCO expansion to Southwest Virginia
  - Care coordination for individuals receiving behavioral health services
  - Managed care for acute care services for individuals receiving home and community-based services
  - Care coordination of dually eligible Medicare and Medicaid individuals

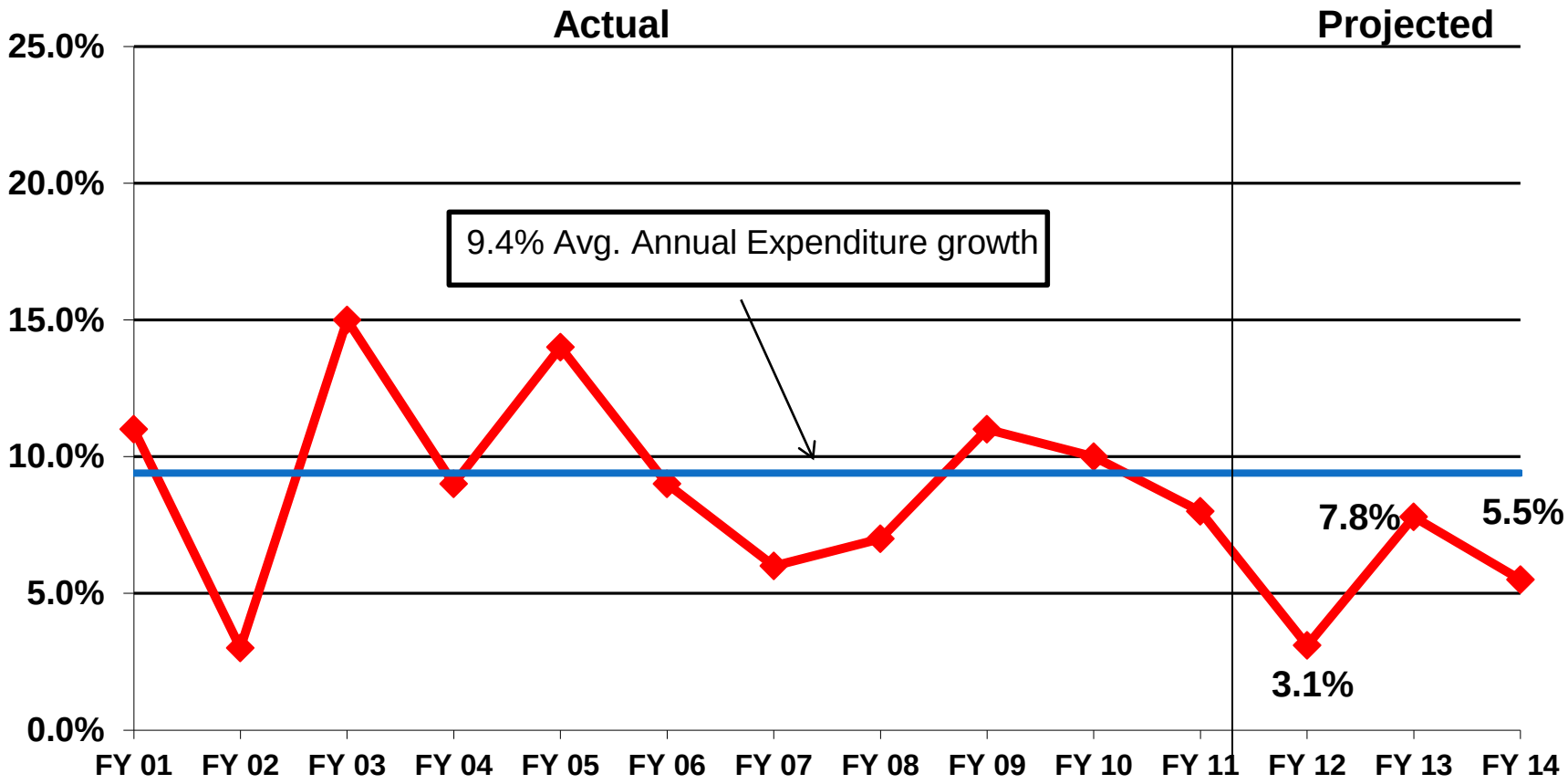
Selected 2011 General Assembly Actions to Contain Medicaid Costs

- Required independent assessments by Community Services Boards to manage the care of children in need of community mental health rehabilitation services
  - $9.4 million GF estimated savings in FY 2012
- Adopted “soft” cap on personal care hours in the EDCD waiver program with estimated savings of $8.5 million GF in FY 2012
  - Hours capped at 56 hours per week, 52 weeks per year for a total of 2,920 hours per year
  - Not applied to Intellectual and Developmental Disability waivers
  - Allows for exceptions using criteria based on dependency in activities of daily living, level of care, and risk of institutionalization
- Adopted 5.5% assessment on providers of ICF-MR services
  - $8.5 million GF savings in FY 2012
- Reduced provider rates saving $2.8 million GF in FY 2012
  - Nursing home capital rates
  - Community residential behavioral health services for children
- Increased audits and data mining activities saving $700,000 GF in FY 2012
- Eliminated pharmacy dose fee for nursing homes saving $300,000 GF in FY 2012
- Outsourced provider and recipient call center, reducing 16 positions in FY 2012 and avoiding additional costs to upgrade technology

- Overview of the Virginia Medicaid Program
- Medicaid Forecast
- Impact of Federal Health Care Reform
- Medicaid Reform Initiatives

Annual % Change in Medicaid Expenditures

(Does not include expenditure growth related to federal health care reform)



Note: Represents percentage change in all funds, state and federal, adjusted for payment timing changes, cash management, FMAP maximization.
Source: DPB and DMAS consensus forecast

Preliminary Medicaid Forecast GF Need
(GF $ in millions)

Medicaid Forecast	FY 2012	FY 2013	FY 2014
Medicaid Expenditures Baseline Forecast	($85.4)	$173.0	$363.6
Expenditure Growth from Federal Health Care Reform			$113.9
Total Medicaid Forecast of GF Need	**($85.4)**	**$173.0**	**$477.5**

Note: The GF need for Medicaid expenditure forecast will be adjusted further when the projected revenues for the Virginia Health Care Fund (VHCF) are finalized.

Factors Affecting Medicaid Changes in FY 2012

Factors Reducing Costs

- 3% decline in managed care (MCO) capitation rates
- Additional pharmacy rebates on MCO drugs
- Declines in Medicare Part A & B premiums
- Managed care expansion to Roanoke region

Factors Adding to Costs*

- 2.8% enrollment growth
- 8.6% growth in community mental health expenditures
- 8% growth in dental services expenses
- 5% growth in fee-for-service outpatient expenditures
- 2% growth in waiver expenditures

*Percentage changes in expenditures represent forecasted growth over current appropriations.

Factors Affecting Medicaid Spending Growth in 2012-14 Biennium

- Enrollment Growth
  - Not reflective of new enrollees from federal health care reform
  - 2% growth rate in FY 2013
  - 0.9% growth rate in FY 2014
  - Lower than historical growth rate of 5.4%
    - Substantially lower than recessionary high of 10% in FY 2010
  - Historically enrollment growth has accounted for about one-half of Medicaid expenditure increases

Factors Affecting Medicaid Spending Growth in 2012-14 Biennium

- Forecast includes increases in managed care (MCO) capitation rates
  - Rates required to be actuarially sound by federal government
  - Rates recommended by actuary
- 5% increase in MCO rates in FY 2013
  - Represents $105.7 million total funds
- 3% increase in MCO rates FY 2014
  - Represents $80.3 million total funds

Factors Affecting Medicaid Spending Growth in 2012-14 Biennium

- Forecast includes hospital and nursing home inflationary adjustments and nursing home rebasing
  - Required by regulations
  - Methodology "catches up" payments by inflating costs from a base year for those years in which no inflationary increase was provided
  - Nursing home rebasing would take effect in FY 2013

Impact of Hospital & Nursing Home Inflation and Rebasing			
$ in millions	**FY 2013**	**FY 2014**	**2012-14**
Hospital inflation	$195.0	$114.8	$309.8
Nursing home inflation and rebasing	$50.0	$28.0	$78.0
Nursing home rebasing	$12.0	0	$12.0
All funds (state and federal)	$257.0	$142.8	$399.8
GF Total	**$128.5**	**$71.4**	**$199.9**

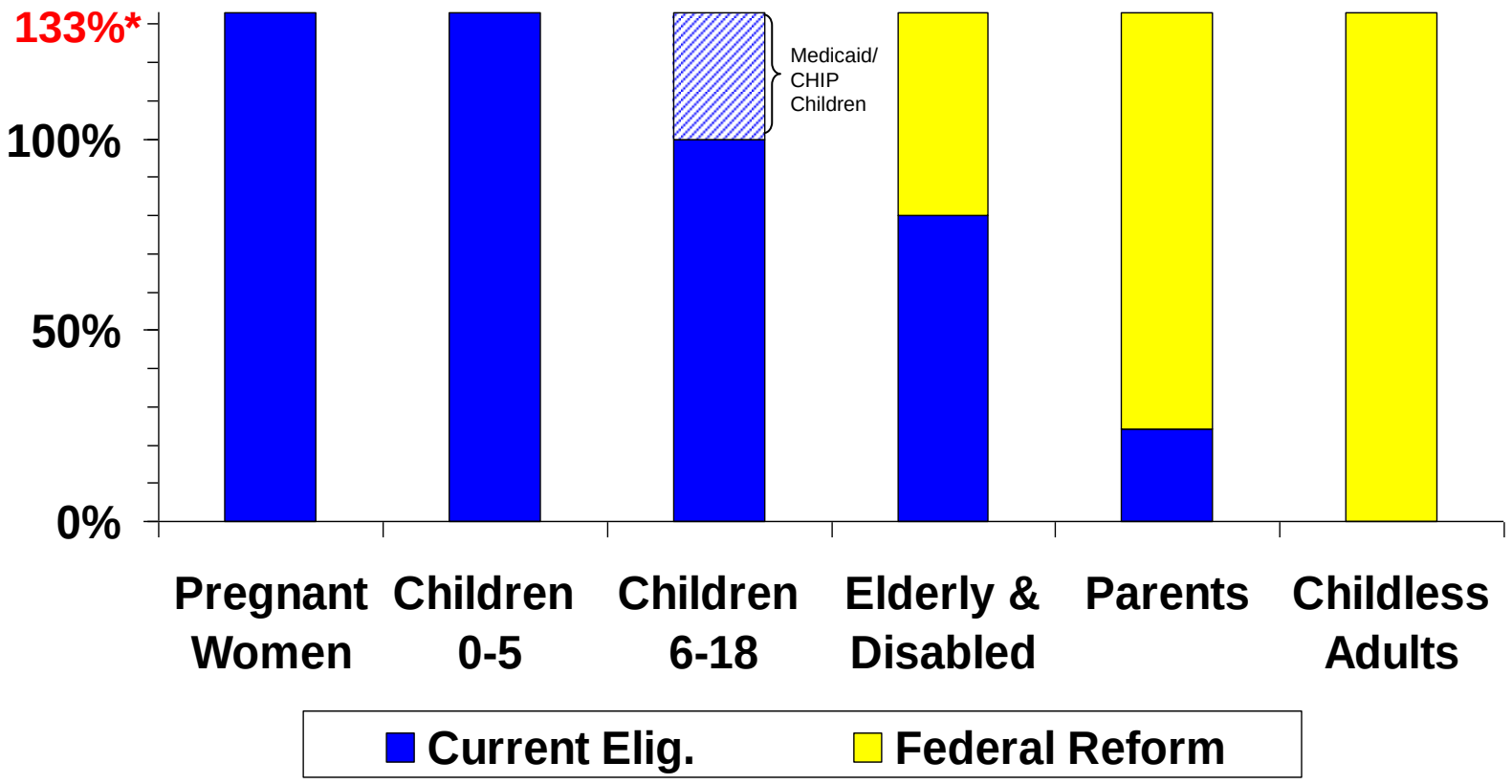
Factors Affecting Medicaid Spending Growth in 2012-14 Biennium

- Continued growth in waiver services
  - 7.4% growth in costs for FY 2013
  - 7.7% growth in costs for FY 2014
  - Rate of growth slowing from 10.6% in FY 2011
- Continued growth in community mental health expenditures
  - 10.3% growth in costs is for FY 2013
  - Includes savings of $20.0 million in FY 2013 from implementing managed behavioral health care
  - 16.7% growth in costs for FY 2014
  - Projected growth is lower than the 25% average annual rate of growth experienced over the past 5 years

	(All funds $ in millions)	
Service	**FY 2013**	**FY 2014**
Waiver Services	$94.1	$97.1
Community MH Services	$59.4	$95.5

- Overview of the Virginia Medicaid Program
- Medicaid Forecast
- Impact of Federal Health Care Reform
- Medicaid Reform Initiatives

2014 Medicaid Expansions Under Federal Health Care Reform Compared to Current Virginia Eligibility Levels



*Does not include 5% income disregard allowed in determining financial eligibility.

New Covered Groups Under Health Care Reform

- Groups never covered before
  - Childless adults with incomes up to 133% of the federal poverty level (FPL)
  - Former foster care “children” up to age 26 (regardless of income)
- Groups currently covered in Virginia but at lower income levels
  - Parents and caretaker adults from 24% to 133% FPL
  - Disabled adults (not needing long-term care waiver services) from 80% to 133% FPL

Newly Eligible Groups Projected to Cost $1.1 Billion

		$ in millions		
Group	# Eligible	State GF	Federal NGF	All Funds
Newly Eligible (133% FPL)	299,764	0	$1,099.7	$1,099.7

- Cost of newly eligible groups borne by federal government initially
  - FMAP rate of 100% for FY 2014 to FY 2016
  - FMAP stepped down to 90% by FY 2021 (see Appendix B)
- Costs for the new groups may be overstated in FY 2014
  - Assumes newly eligible will enroll and use Medicaid-financed health care services in the first 6 months of FY 2014
  - Assumes current benefit package in Medicaid
    - Federal law allows for use of Medicaid benchmark plan equivalent to the “essential benefit” package with certain requirements
    - Secretary of HHS has not yet defined the “essential benefit” package
    - Benefit package could be less generous than current Medicaid program

Groups Already Covered in Medicaid

- Individual mandate in federal legislation may result in increased enrollment from a "woodwork" effect
  - If upheld by the Supreme Court, Medicaid could see increases in children and low-income families who are eligible under current eligibility standards
  - State will have to cover these individuals at the current Medicaid FMAP rate – 50% for Virginia
- Forecast may be overstated in FY 2014
  - Assumes newly eligible will enroll and use Medicaid-financed services in the first 6 months of FY 2014

		$ in millions		
Eligible Group	**# Eligible**	**State GF**	**Federal NGF**	**All Funds**
Medicaid eligible today but not enrolled – "woodwork" effect	49,537	$90.2	$90.2	$180.4

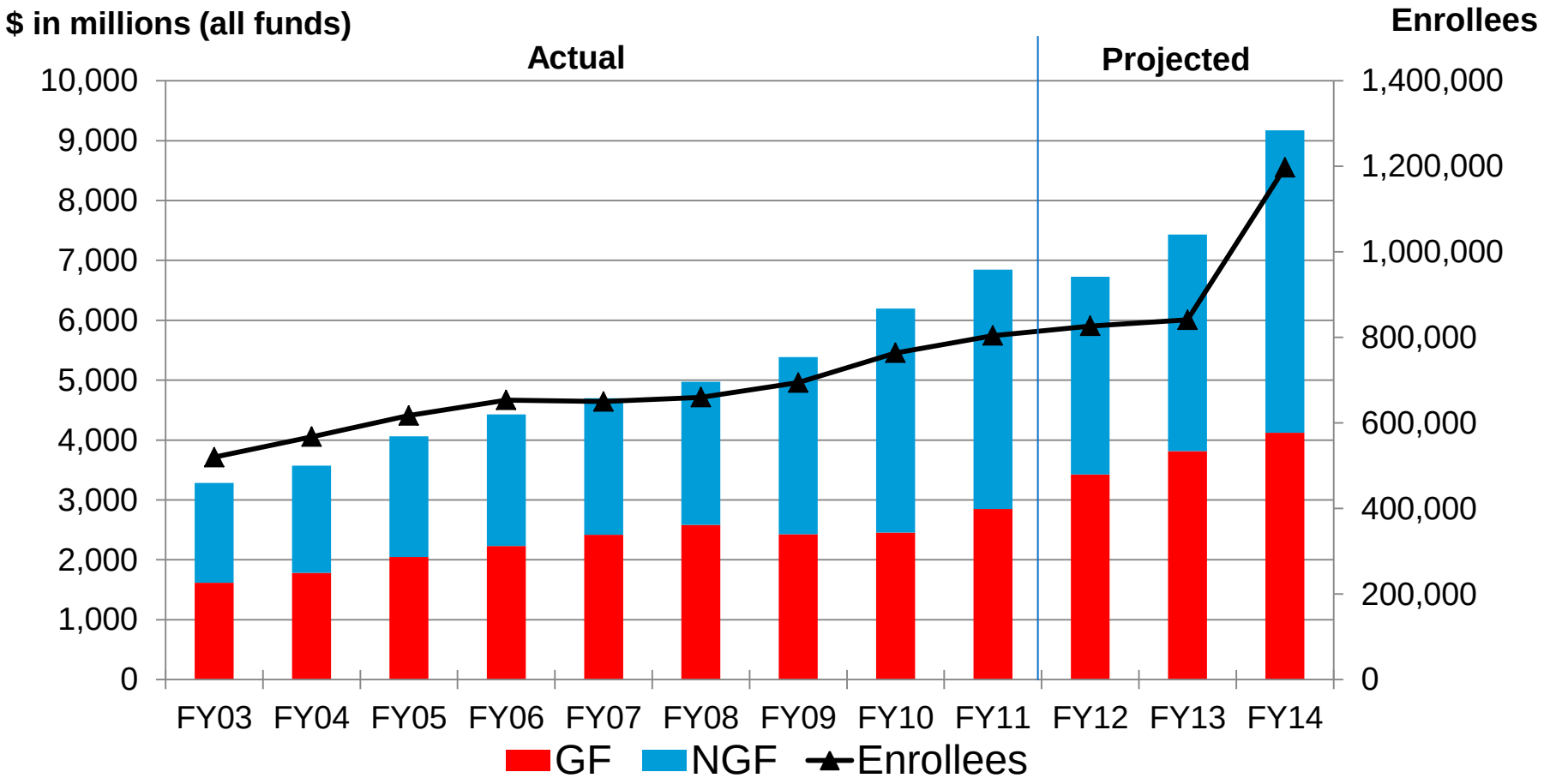
Groups Already Covered in Medicaid

- Medicaid children ages 6 to 18 in families with incomes between 100% to 133% FPL
  - Currently covered under Medicaid program
  - State receives more favorable FAMIS match rate of 65% under federal children's health insurance program (CHIP)
- Federal legislation reverts match rate to Medicaid FMAP
  - 50% for Virginia

		$ in millions	
Eligible Group	**# Eligible**	**State GF**	**Federal NGF**
FAMIS/CHIP children ages 6 to 18 with family income between 100%-133% FPL - incremental cost	48,530	$7.6	($7.6)

Note: The full cost of covering this group is $25.2 million GF and $25.2 million NGF in the Medicaid program; however, the cost would have been $17.6 million GF and $32.8 million NGF if the state were able to continue receiving the CHIP FMAP rate of 65%. Thus, the incremental cost to the state of $7.6 million GF represents the difference in the FMAP rates.

Impact of Federal Health Care Reform on Medicaid Forecasted Growth



Note: FY 10 expenditure growth is artificially high as it reflects Medicaid provider payments that were lagged from June of FY 2009 into July 2010. FY 11 expenditure growth reflects provider payments that would have been paid in FY 2012 based on prior budget actions to lag payments. FY 14 expenditure projections include estimates of expenses for new enrollees, the woodwork effect and the changes to the FMAP rate for Medicaid/CHIP children under federal health care reform.

Additional Federal Health Care Reform Changes Not Included in the Expenditure Forecast

Primary Care Rate Increase

- Federal law requires state Medicaid programs to increase payments for primary care services up to the Medicare reimbursement level
- Virginia Medicaid currently reimburses primary care services at 85% of the Medicare level
- 100% federal reimbursement in effect 2 years (2013 and 2014)
  - 100% FMAP rate ceases after this period
  - States could opt to continue at regular FMAP rate
- Estimated cost to increase rate:
  - $35.3 million NGF in FY 2013
  - $75.3 million NGF in FY 2014
- DMAS will need additional authority to modify rate structure for this period

DSH Reductions

- Forecast does not reflect any reductions in Disproportionate Share Hospital payments in FY 2014
  - DSH reduction scheduled to take effect federal FY 2014 (October 1, 2013)
  - Secretary of HHS has not yet defined how this will be implemented

- Overview of the Virginia Medicaid Program
- Medicaid Forecast
- Impact of Federal Health Care Reform
- Medicaid Reform Initiatives

Potential Federal Changes in Financing Medicaid to Address Deficit

- Medicaid exempt from across-the-board cuts under Budget Control Act
- Joint Committee can propose Medicaid reductions to address deficit
- Proposals being discussed to contain Medicaid costs
  - Limits on provider taxes
  - Blended / lower match rates
    - President has proposal blending Medicaid and CHIP match rates beginning in 2017
  - Repeal or modify provisions of the health care reform legislation
    - House of Representatives passed legislation in October to amend the modified adjusted gross income (MAGI) definition that will be used to determine eligibility for Medicaid under health care reform
    - MAGI excludes the non-taxable portion of Social Security benefits in determining eligibility

Potential Federal Changes in Financing Medicaid to Address Deficit

- Medicaid Block Grant
  - Conversion from open-ended entitlement financing to program with annual caps on expenditures
  - Funding distributed based on a formula
  - Controlled growth using annual changes in population and inflation or GDP
  - State flexibility to design and manage their Medicaid programs
  - Question on how this would or could work if federal health care reform is not repealed
  - Preliminary estimates of Congressional proposals to implement a Medicaid block grant indicates states would experience a 22% reduction in federal Medicaid spending (assuming the repeal of federal health care reform)

Rhode Island's "Block Grant"

- Rhode Island's Medicaid program is richer in benefits and more generous in eligibility than Virginia
  - In 2008, Rhode Island's spending per Medicaid enrollee was 42% higher than Virginia's
- Heavy reliance on institutional care, particularly nursing home care
  - Lower acuity levels than Virginia
- Prior to changes, Medicaid accounted for 25% of the state GF budget
- Rhode Island's program is not a true block grant it is a global waiver
  - Combined ten separate waivers into one statewide demonstration waiver
- Total expenditures are capped over a 5-year period, state assumes risk for exceeding the cap
  - State negotiated spending ceiling cap of $12.075 billion over this period, well below the amount they believed they would actually spend
  - Certain items not subject to ceiling
  - Retains state and federal cost sharing for Medicaid expenses
- State subject to eligibility MOE requirements under federal health care reform
- Significant benefit was federal approval to obtain Medicaid reimbursement for certain services not otherwise matchable under the program

Lessons from Rhode Island's Experience

- Most of Rhode Island's changes could have been achieved under existing waivers according to legislative and executive branch staff
- Report on cost savings of program has not yet been released, but should be available soon
- Early reports of $69 million in annual savings, of which $20-$22 million results from the diversion of individuals from higher cost institutional settings to community based services
- Preliminary estimates of $20-$30 million in annual state savings by allowing the use of Medicaid to fund costs not otherwise matchable
  - Rehabilitative services, behavioral health services, child welfare services, aging preventive services
  - Not likely to be repeated with other states
- Expenditure cap was negotiated based on a complicated formula which factored in Medicaid enrollment growth, utilization and demographic factors
  - Program would have to grow substantially and not achieve any savings in order to hit expenditure cap
- Program staff believe that a research and demonstration waiver may provide more flexibility for selective contracting of services

How Does Virginia Stack Up?

- Virginia eligibility more restrictive eligibility than Rhode Island
  - 1 in 7 Virginians enrolled in Medicaid compared to 1 in 5 Rhode Islanders
- Virginia Medicaid cost per Medicaid enrollee lower than Rhode Island
- Virginia per capita Medicaid expenditures lower
  - In 2009 Virginia ranked 27 in per capita Medicaid, Rhode Island ranked 10
- 68% of Virginia Medicaid recipients are currently enrolled in managed care
  - Mostly low-income children and adults (90% of those enrolled)
  - 810 recipients enrolled in Programs of All-Inclusive Care for the Elderly (PACE)
  - Plans underway to enroll almost all in MCO or coordinated care arrangement
- Virginia has had a preadmission screening program in place since 1977 for individuals entering nursing facilities and the waivers
  - Mandated by Code of Virginia § 32.1-330
  - Historically, Virginia has one of the highest acuity levels in nursing facilities
- Virginia operates 7 home and community-based waivers to divert people from institutional care
  - Must meet same program criteria that is used for admission to institution
  - DMAS conducts quality management reviews and provider audits to insure health, safety and welfare and appropriate use of Medicaid funds
  - Level of care reviews performed at least annually
  - Instituted cap on personal care and respite care hours – seems to be lowering growth

Opportunities for Future Medicaid Cost Containment

- Acute Care
  - Strengthening provisions in managed care and care coordination strategies to ensure the use of best practices and outcome-based measures
  - Re-examining requirements for reporting encounter data to ensure information can help policymakers track performance, outcomes and cost effectiveness
- Long-term Care
  - Re-examining service limits to achieve cost savings and appropriate utilization
  - Use of health care spending accounts for consumer directed waiver services to better meet needs, control utilization and control cost of services
  - Re-examining the service authorization process to see if it can be improved to be more cost effective and ensure better outcomes
  - Re-examining efforts to better manage high cost, high need recipients
  - Expanding integration of acute and long-term care services
- Mental Health Services
  - Re-examining utilization of children's mental health services as well as adults
  - Will managed behavioral health care address inappropriate utilization?
  - Can additional savings be realized by integrating acute and behavioral health services?
- Eligibility Processing
  - Ensuring technology solutions are cost effective and address the most common types of errors

Appendix A
Federal Poverty Income Levels

2011 Federal Poverty Level (FPL) Guidelines

Persons in Family	48 Contiguous States and D.C.	Alaska	Hawaii
1	$10,890	$13,600	$12,540
2	14,710	18,380	16,930
3	18,530	23,160	21,320
4	22,350	27,940	25,710
5	26,170	32,720	30,100
6	29,990	37,500	34,490
7	33,810	42,280	38,880
8	37,630	47,060	43,270
For each additional person, add	3,820	4,780	4,390

SOURCE: ***Federal Register*, Vol. 76, No. 13, January 20, 2011, pp. 3637-3638**

Appendix B
Federal Match Rates for Newly Eligible Groups Under Federal Health Care Reform

Federal Match Rates for Newly Covered Groups

State Fiscal Year	Medicaid Match Rate	
	Federal	State
2014	100%	0%
2015	100%	0%
2016	100%	0%
2017	97.5%	2.5%
2018	94.5%	5.5%
2019	93.5%	6.5%
2020	91.5%	8.5%
2021-beyond	90%	10%