

# **DMAS Budget Provisions: Introduced Budget**

*presentation to*

**Senate Finance Committee**

**Subcommittee on Health and Human Resources**

**Scott Crawford**

**Deputy Director, DMAS**

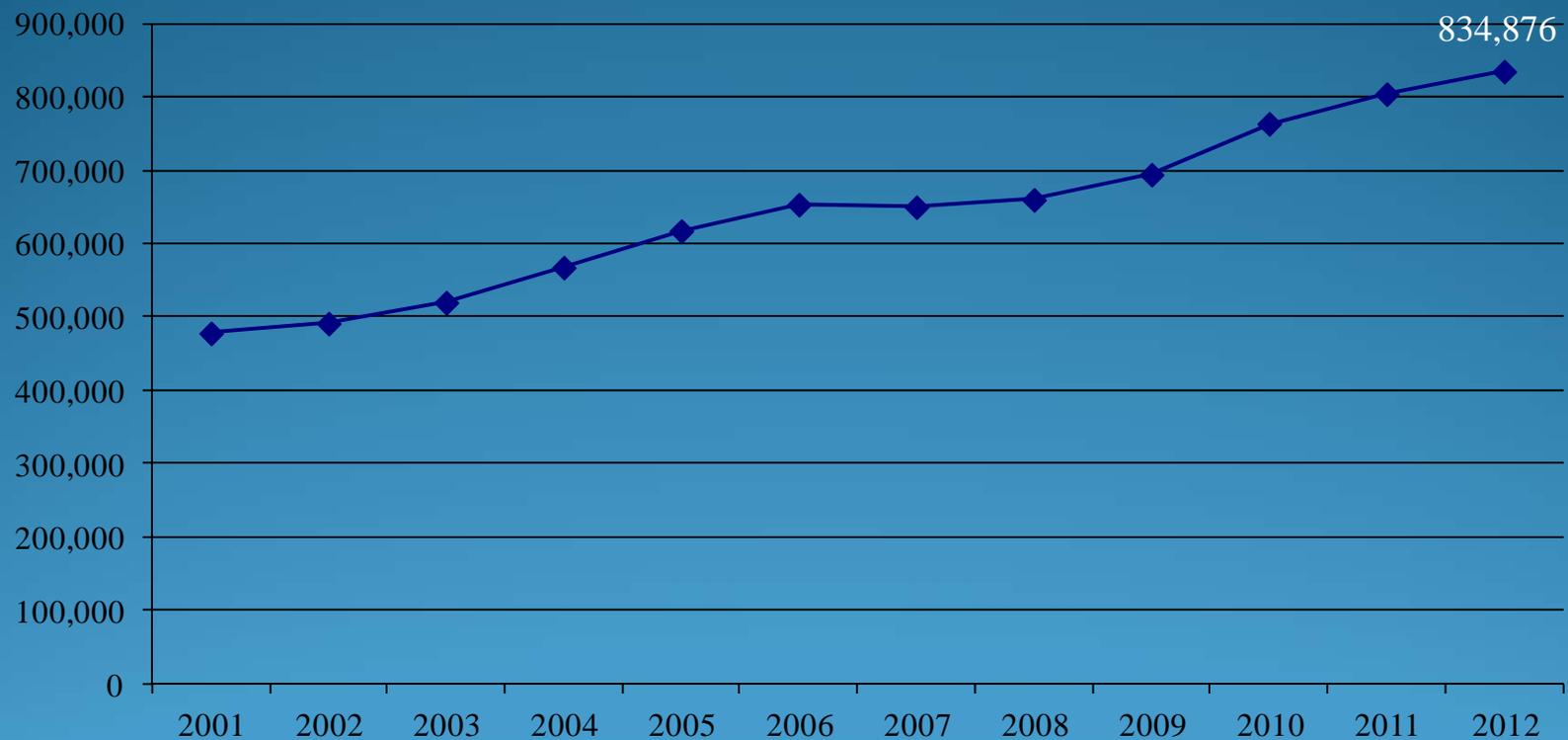


**January 7, 2013**

# Outline

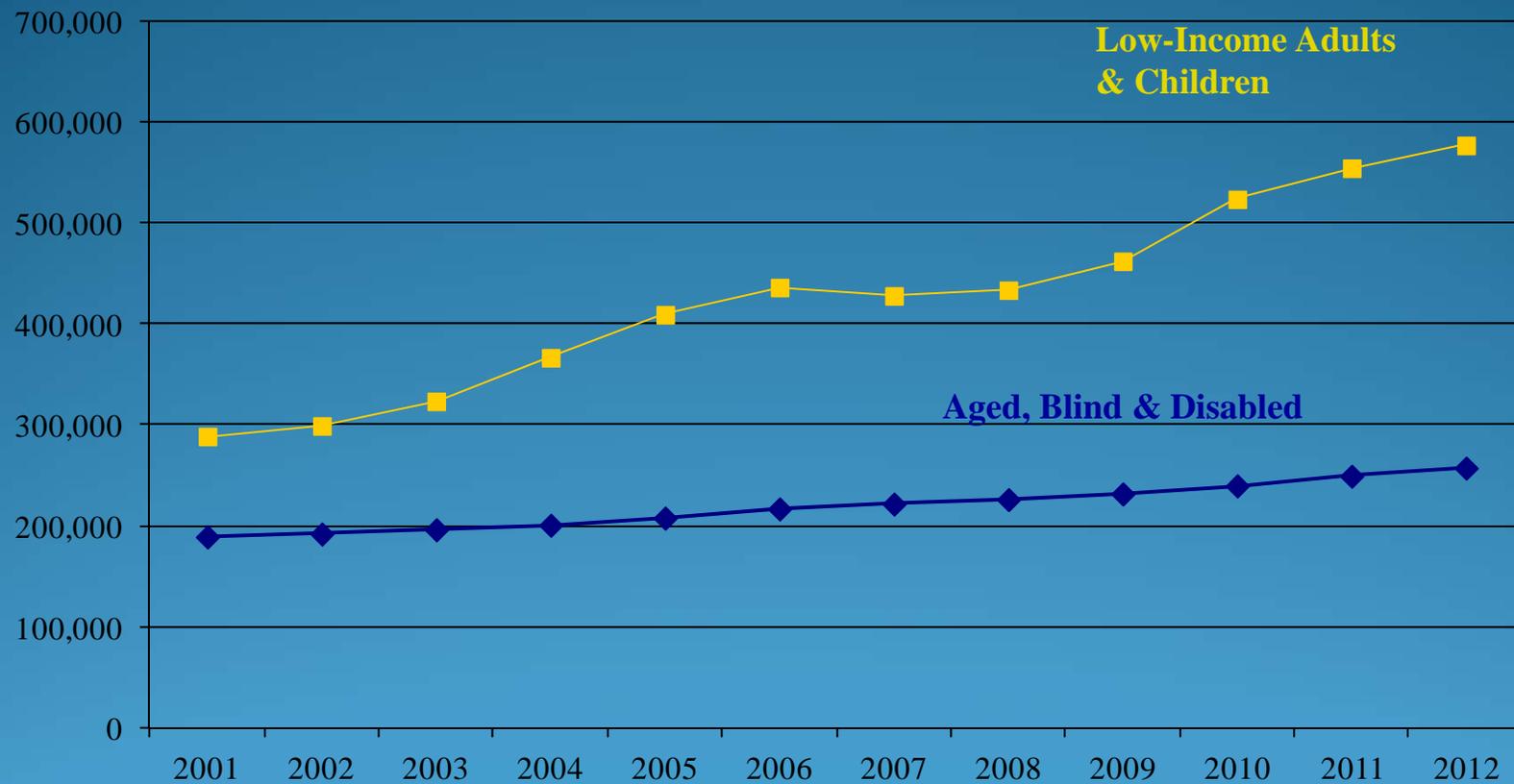
- Medicaid Overview
- Medicaid Forecast FY2013-FY2014
- Introduced Budget Provisions

# Medicaid Enrollment Trends: Total Population



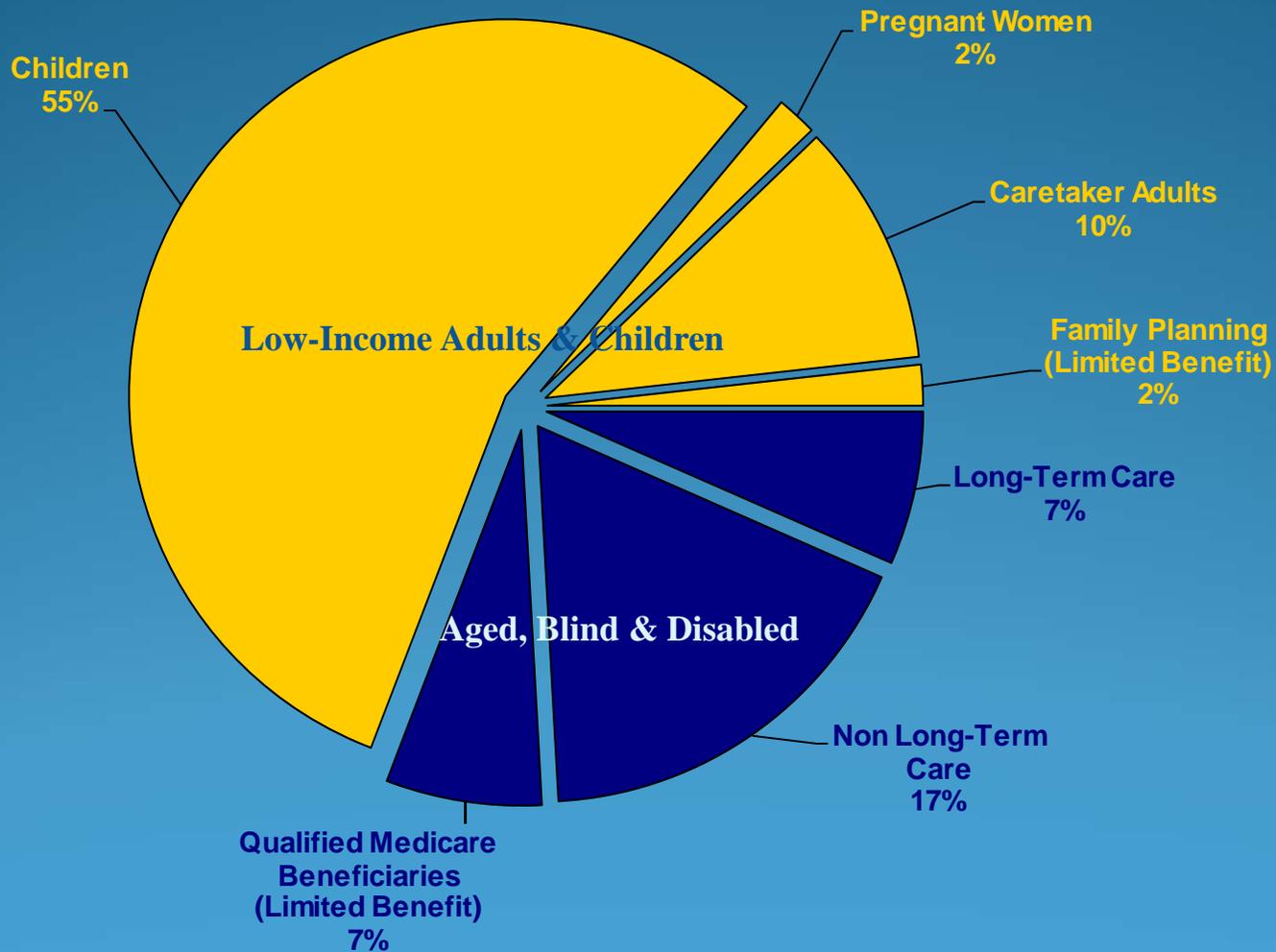
Notes: Average monthly enrollment in the Virginia Medicaid Program, as of the 1<sup>st</sup> of each month

# Medicaid Enrollment Trends: by Category

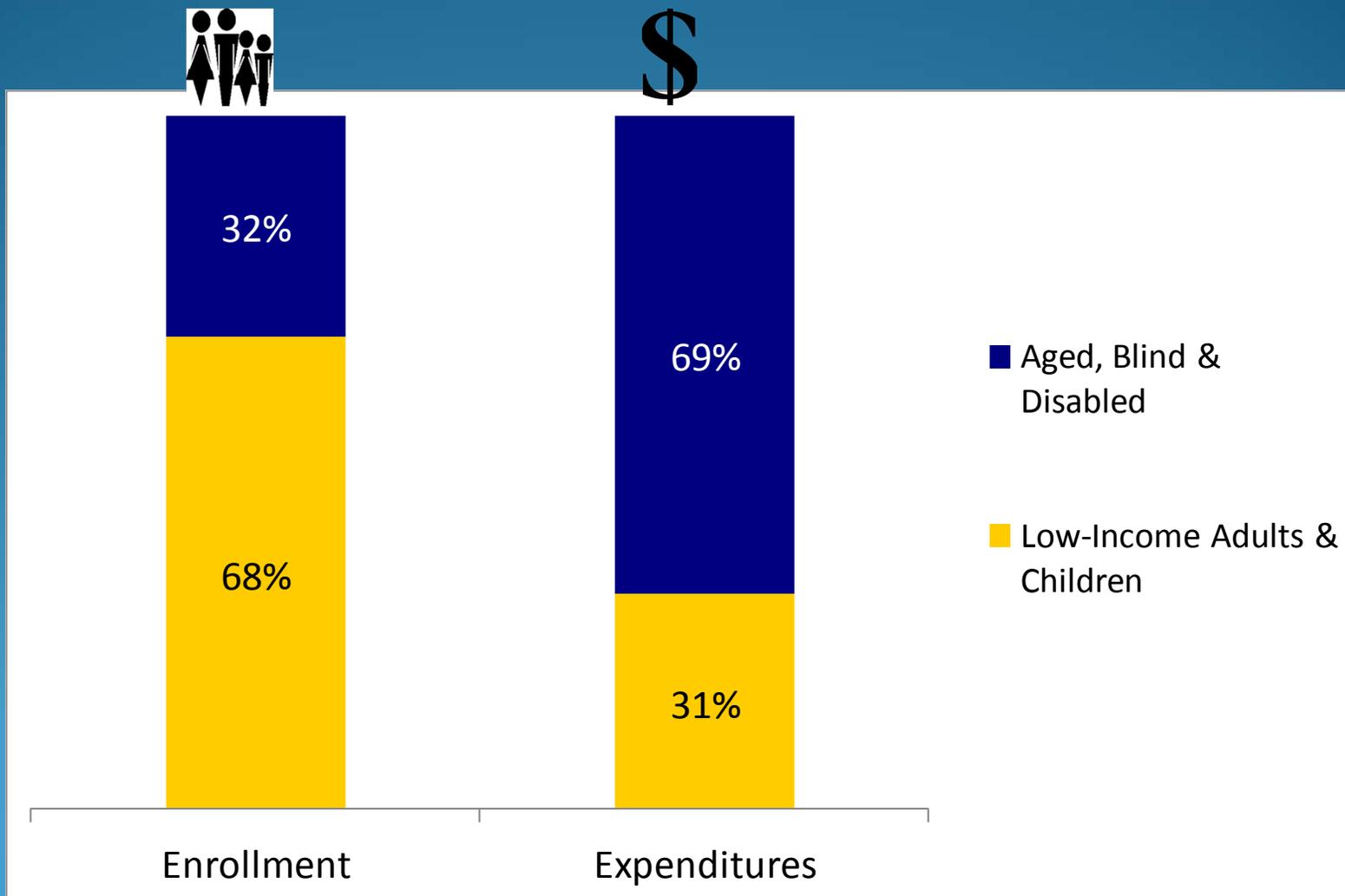


Notes: Average monthly enrollment in the Virginia Medicaid Program, as of the 1<sup>st</sup> of each month

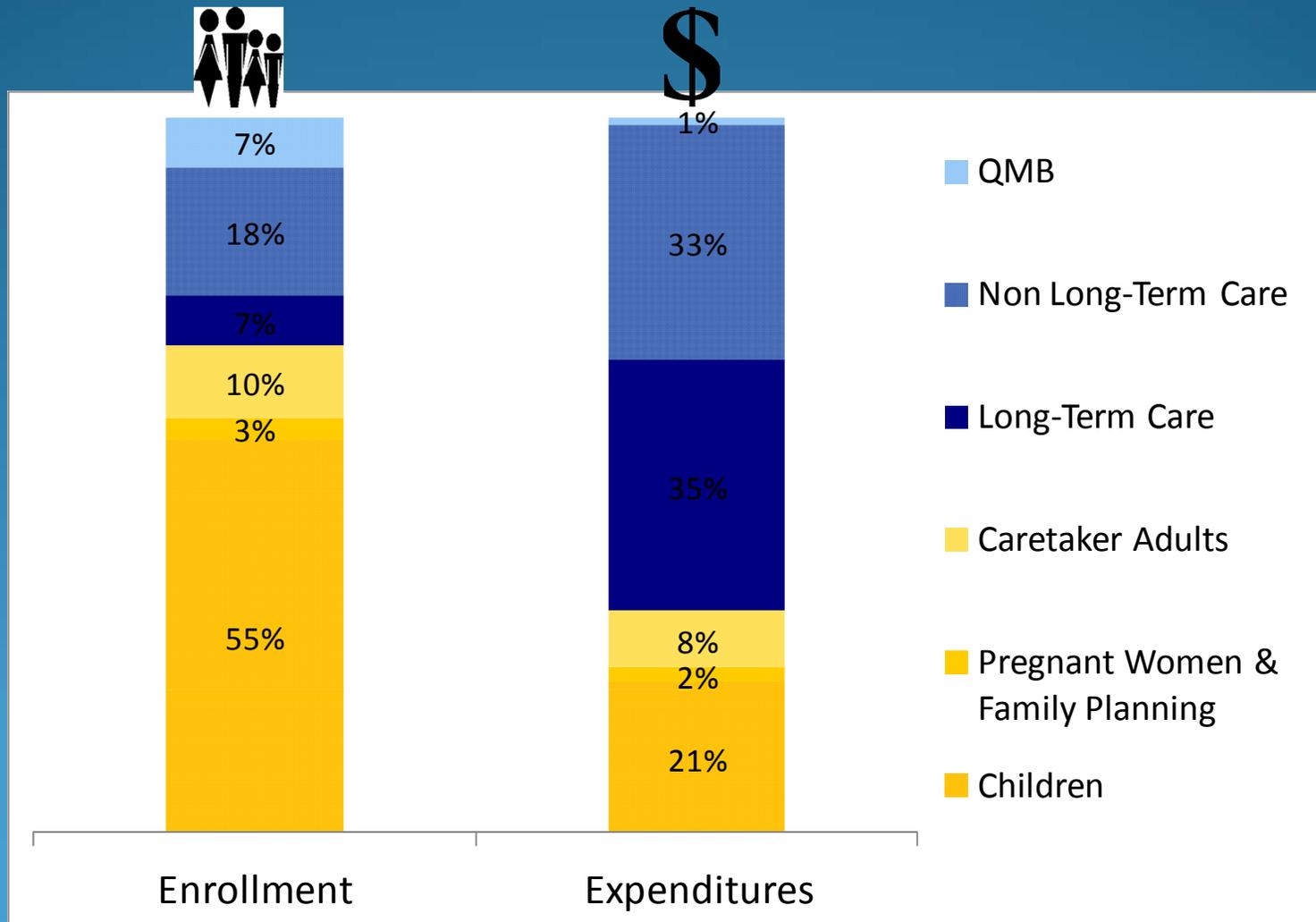
# Medicaid Enrollment Composition – FY12



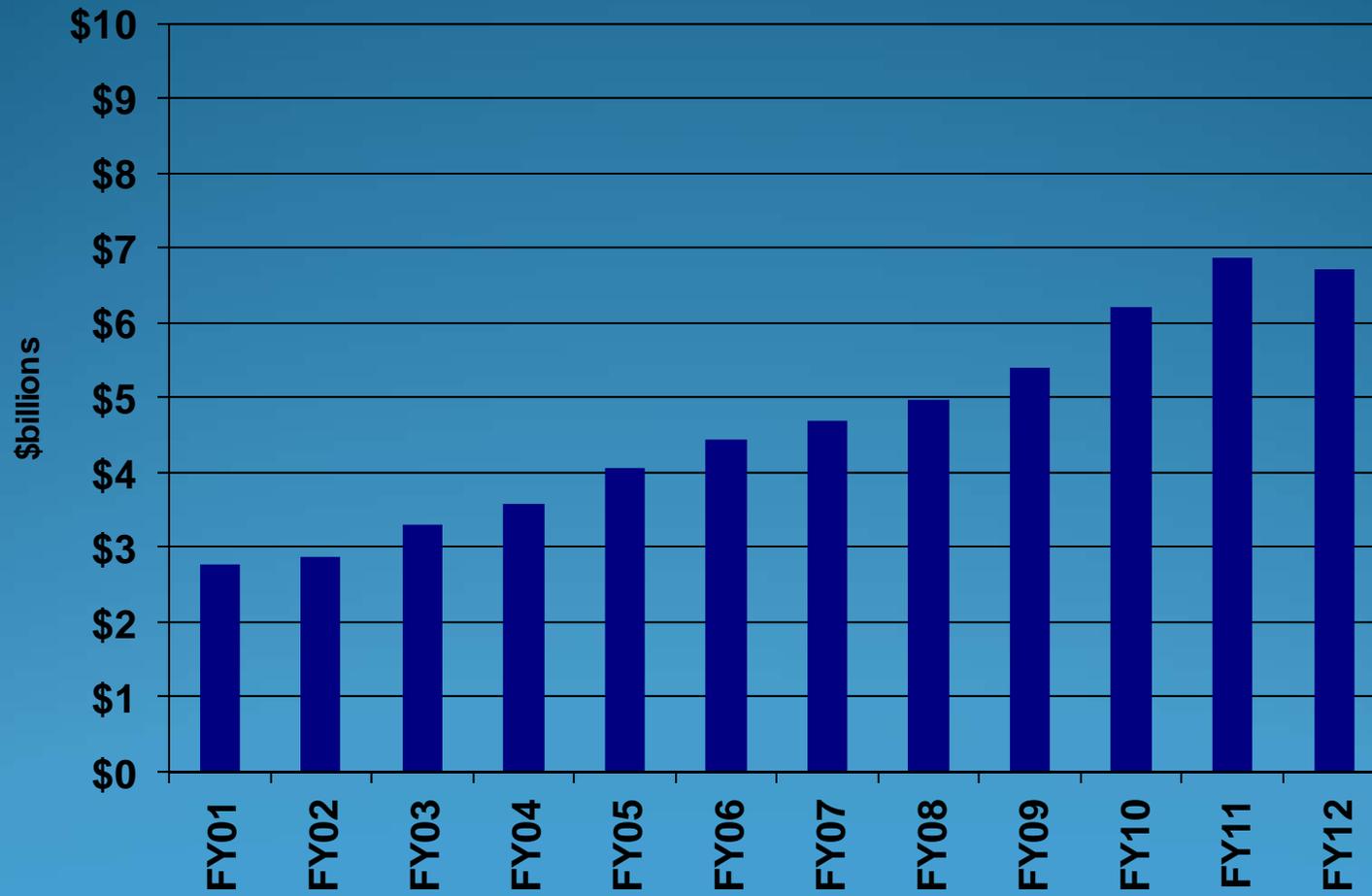
# Medicaid Enrollment vs. Spending



# Medicaid Enrollment vs. Spending

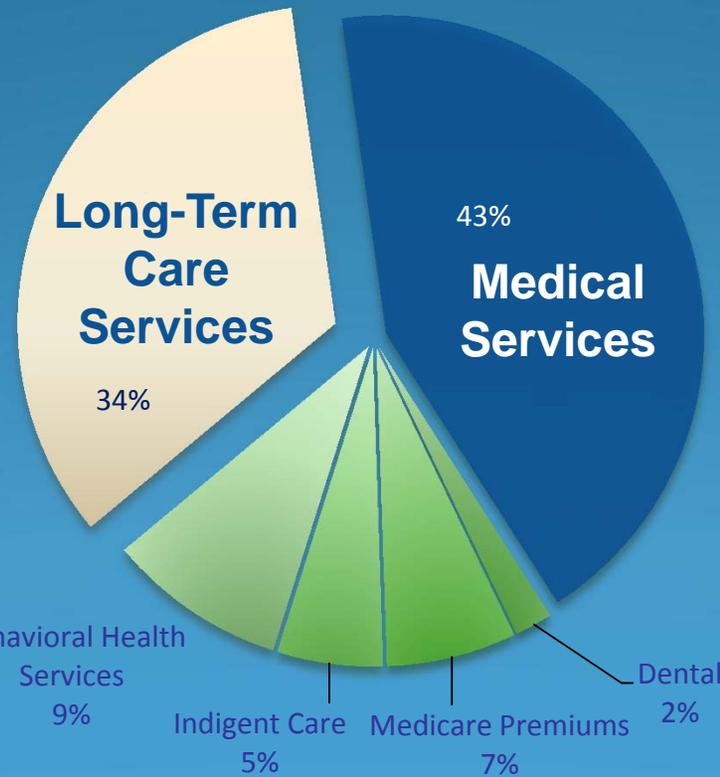
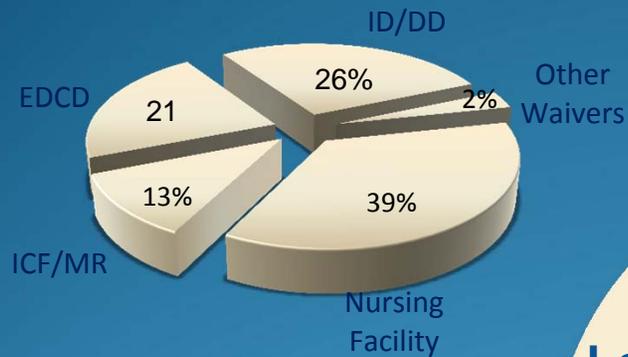


# Medicaid Expenditure Trends

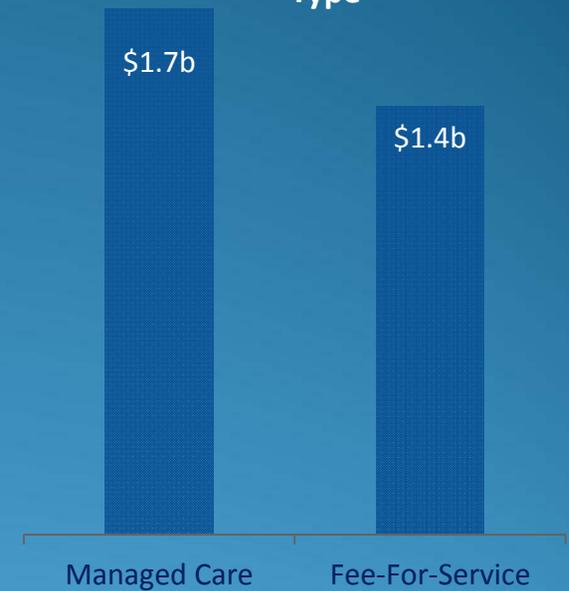


# Medicaid Expenditure Composition

## Long-Term Care Expenditures



## Medical Services by Delivery Type



Notes:

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# Forecasting Process

- Section 32.1-323.1 of the *Code of Virginia* mandates:

“By November 15 of each year, the Department of Planning and Budget, in cooperation with the Department of Medical Assistance Services, shall prepare and submit an estimate of Medicaid expenditures for the current year and a forecast of such expenditures for the next two years to the House Committees on Appropriations and Health, Welfare and Institutions and to the Senate Committees on Finance and Education and Health, and to the Joint Legislative Audit and Review Commission.”

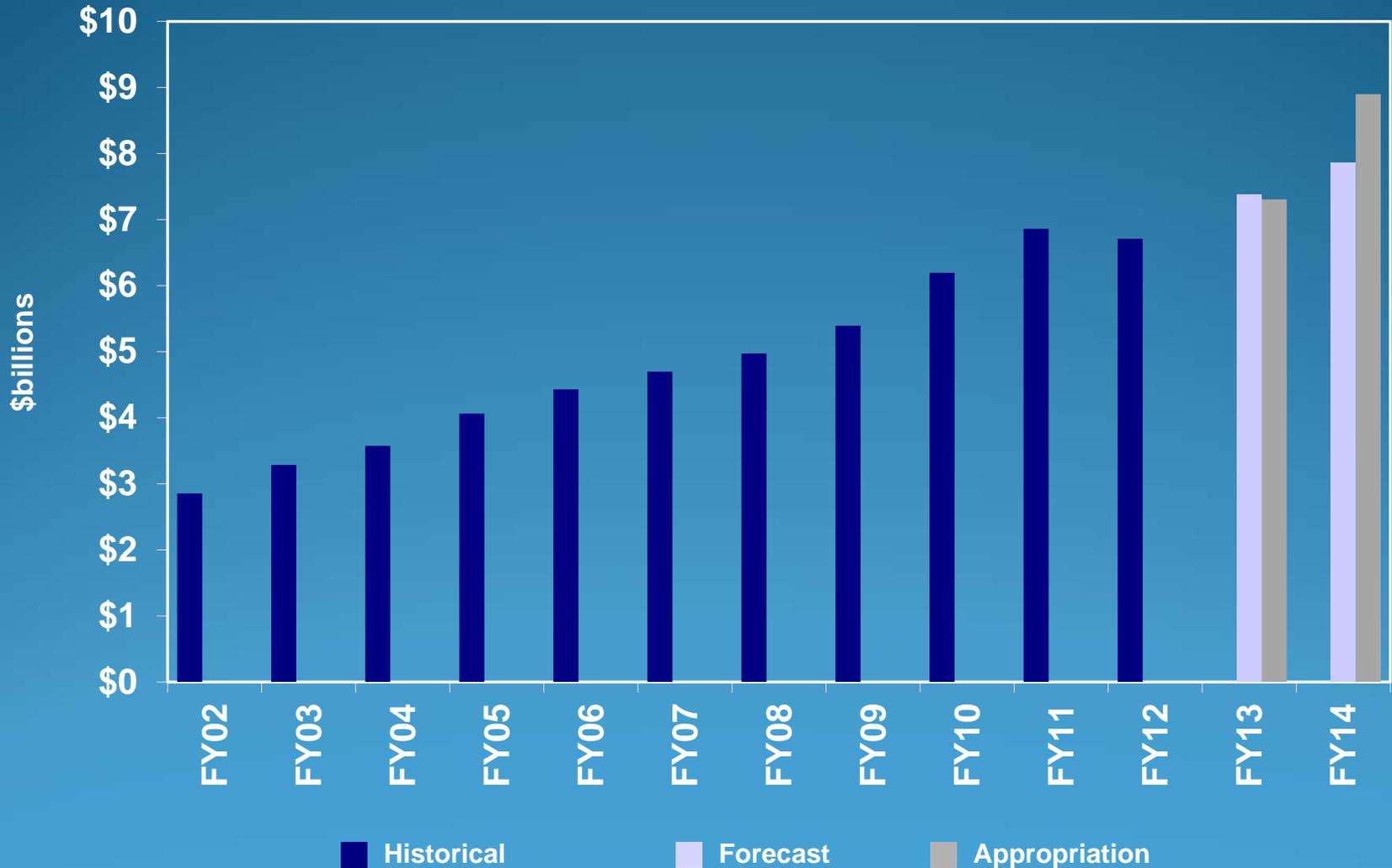
# Forecasting Process

- Due November 15 to Governor and General Assembly
- Projects spending in current and subsequent two years
- Assumes existing program (existing law and regulations)
- Changes are due to:
  - Change in enrollment, utilization, and inflation
  - Application of existing state laws and regulations
  - Application of existing federal laws and regulations

# Forecasting Process

- Each year, DMAS and DPB prepare independent forecasts using monthly level expenditure and utilization data
- The forecast is comprised of over 70 different models that project utilization and cost per unit for each benefit category
- The two agencies meet to compare and evaluate the individual forecasts and an official “Consensus” forecast is adopted

# Official Consensus Medicaid Forecast



# Funding Surplus/(Need) based on Official Consensus Medicaid Forecast

		<b>Appropriation (\$millions)</b>	<b>Consensus Forecast (\$millions)</b>	<b>Surplus/(Need) (\$millions)</b>
<b>FY 2013</b>	<b>Total Medicaid</b>	<b>\$7,304</b>	<b>\$7,379</b>	<b>(\$73.8)</b>
	State Funds	\$3,689	\$3,736	(\$46.2)
	Federal Funds	\$3,615	\$3,643	(\$27.6)
<b>FY 2014</b>	<b>Total Medicaid</b>	<b>\$8,898</b>	<b>\$7,864</b>	<b>\$1,033</b>
	State Funds	\$3,889	\$3,957	(\$68.4)
	Federal Funds	\$5,009	\$3,907	\$1,101

<b>FY13-14</b>	<b>State Funds</b>			<b>(\$114.6)</b>
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Notes: Figures may not add due to rounding

# Medicaid Revenue Forecast

- Medicaid “Revenue Forecast” usually not discussed in budget presentations; normally small amounts; change little over time
- Medicaid “Revenue” comprised of funds recovered due to audits, prior year cost settlements, third party liability settlements, and certain pharmacy rebates
- The large increase in Revenue in 2012, continuing in 2013 and 2014, is a result of a PPACA provision giving Medicaid much bigger Rx rebates, retroactive to March 2010. Some of the Rx revenue is one-time retroactive collection of rebates; will not continue at this level
- The Revenue Forecast for the biennium is \$130 million more than otherwise expected, more than offsetting the \$114.6 million “need” identified in the Medicaid forecast

# MCO Capitation Payments (as paid)

Historical and Projected Expenditures for Managed Care Services  
(\$millions)



- Trend is distorted by variation in the number of MCO capitation payments per year

- The 2011 forecast for FY14 assumed the Medicaid Expansion under ACA which is now optional

	2006	2007	2008	2009	2010	2011	2012	2013	2014
◆ 2011 Forecast	\$1,091	\$1,191	\$1,226	\$1,272	\$1,590	\$1,972	\$1,553	\$2,097	\$3,389
◆ 2012 Forecast	\$1,091	\$1,191	\$1,226	\$1,272	\$1,590	\$1,972	\$1,698	\$2,218	\$2,450
	13.2%	9.2%	3.0%	3.7%	25.0%	24.0%	(14.0%)	30.6%	10.5%

# MCO Capitation Payments (as incurred)

Historical and Projected Expenditures for Managed Care Services  
(\$millions)



- Adjusting for the variation in the number of annual MCO capitation payments shows true annual growth rates
- Reduction in FY12 reflects decrease in average PMPM rates
- Increase in FY13 reflects increase in average PMPM rates as well as the expansion into Southwest Virginia

	2006	2007	2008	2009	2010	2011	2012	2013	2014
◆ 2011 Forecast	\$1,091	\$1,191	\$1,226	\$1,393	\$1,590	\$1,825	\$1,710	\$2,097	\$3,389
◆ 2012 Forecast	\$1,091	\$1,191	\$1,226	\$1,393	\$1,590	\$1,825	\$1,845	\$2,218	\$2,450
	13.2%	9.2%	3.0%	13.6%	14.1%	14.8%	1.1%	20.2%	10.5%

# Inpatient Hospital Expenditures

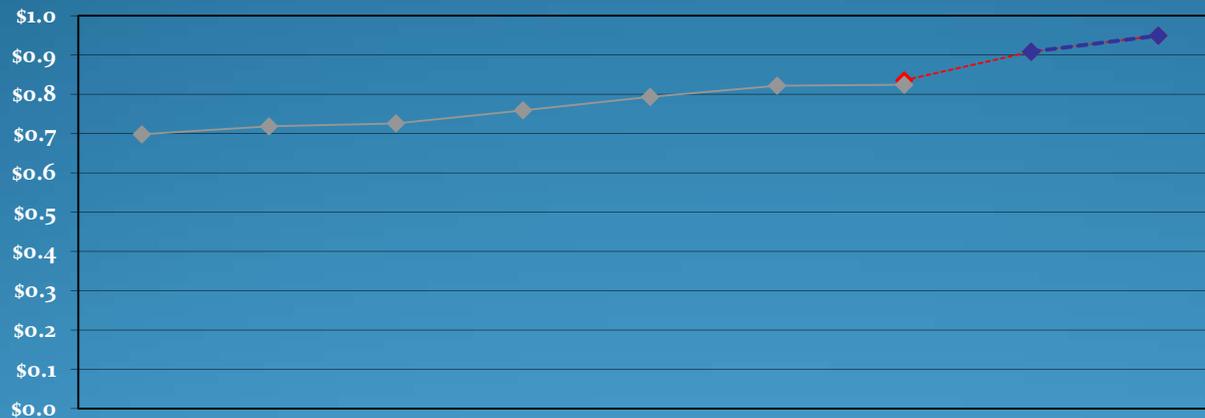
Historical and Projected Expenditures for FFS Inpatient Hospital Services  
(\$millions)



- Again, payment timing issues related to cost savings initiatives, year-end cash management and federal match rate maximization efforts distort the true annual growth trends
- FY13 reflects the provision of 2.6% inflation for operating rates
- FY14 reflects the rebasing of operating rates and DSH payments, which costs approx \$160 million

# Nursing Facility Expenditures

Historical and Projected Expenditures for Nursing Facility Services  
(\$millions)

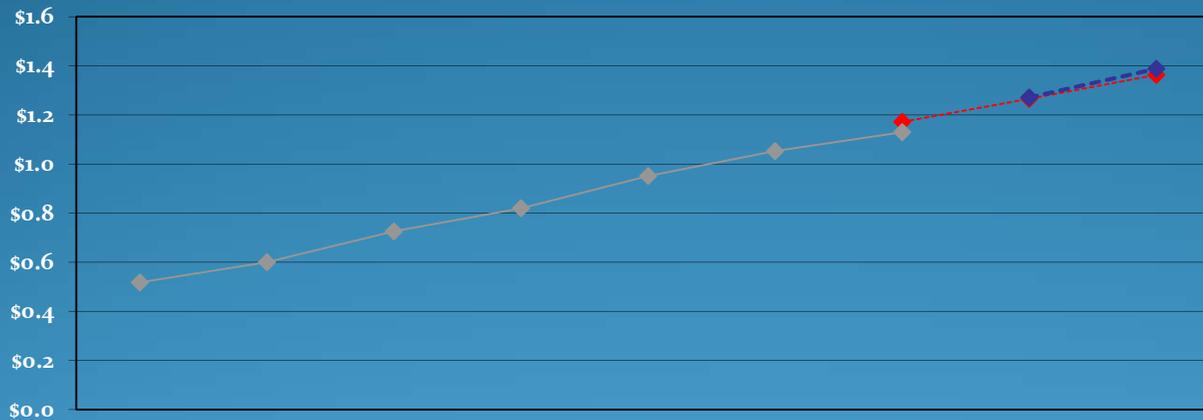


- FY13 reflects the provision of 2.2% inflation in rates followed by an additional 2.2% increase in FY14

	2006	2007	2008	2009	2010	2011	2012	2013	2014
◆ 2011 Forecast	\$698.0	\$718.4	\$725.8	\$759.0	\$793.4	\$821.9	\$835.5	\$908.5	\$949.4
◆ 2012 Forecast	\$698.0	\$718.4	\$725.8	\$759.0	\$793.4	\$821.9	\$824.2	\$830.5	\$837.9
	8.0%	2.9%	1.0%	4.6%	4.5%	3.6%	0.3%	0.8%	0.9%

# Home & Community-Based Care Waiver Expenditures

Historical and Projected Expenditures for Home & Community-Based Care Waiver Services (\$millions)



- **Utilization of personal care and respite services has been increasing significantly; initiatives were implemented in FY12 to cap personal care hours and reduce the number of allowed respite hours per year**

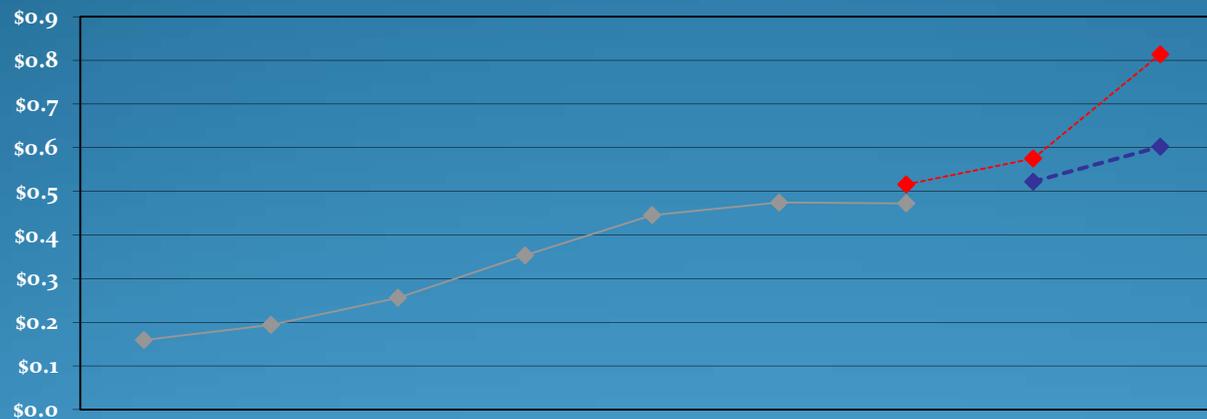
	2006	2007	2008	2009	2010	2011	2012	2013	2014
◆ 2011 Forecast	\$517.8	\$600.2	\$725.8	\$819.8	\$951.3	\$1,052	\$1,172	\$1,266	\$1,363
◆ 2012 Forecast	\$517.8	\$600.2	\$725.8	\$819.8	\$951.3	\$1,052	\$1,130	\$1,271	\$1,388
	15.9%	15.9%	20.9%	12.9%	16.0%	12.7%	7.3%	12.5%	9.2%

# Virginia's Dual Eligible Demonstration

- Virginia is one of 25 states interested in participating in a federal three-year demonstration to integrate Medicare and Medicaid acute, primary, behavioral and long-term care services for individuals who are eligible for both Medicare and Medicaid (dual eligibles)
- Demonstration would start in January 2014 and cover five regions of the state (Tidewater, Central, Northern, Charlottesville, and Roanoke)
- Delivery of care in a capitated, risk adjusted arrangement provided by Managed Care Organizations in each region
- 65,415 individuals eligible for enrollment in the first year (adult, full benefit duals, including individuals enrolled in the Elderly and Disabled with Consumer Direction waiver and individuals in nursing facilities)
- Enrollment will be optional for Demonstration participants

# Behavioral Health Expenditures

Historical and Projected Expenditures for Behavioral Health Services (\$millions)



	2006	2007	2008	2009	2010	2011	2012	2013	2014
◆ 2011 Forecast	\$159.5	\$194.0	\$256.0	\$353.2	\$445.3	\$474.4	\$515.8	\$575.3	\$813.9
◆ 2012 Forecast	\$159.5	\$194.0	\$256.0	\$353.2	\$445.3	\$474.4	\$472.3	\$521.9	\$602.3
		21.6%	31.9	38.0%	26.1%	6.5%	(0.5%)	10.5%	15.4%

- Utilization of behavioral health services has been experiencing high growth rates over the past several years, however several initiatives implemented have curbed the growth
- The 2011 forecast for FY14 assumed expenditures associated with the enrollment of new populations under Federal health care reform, which is now optional

# Controlling Growth of Behavioral Health Services

- In the last three fiscal years, there has been a \$102 million increase in the cost of Mental Health Support Services
  - DMAS is working with stakeholders to make regulatory changes that change eligibility criteria and limit the number of hours allowed each day
  - Regulatory changes to occur this year
- Implemented an Independent Clinical Assessment requirement for children in need of Intensive In Home, Therapeutic Day Treatment and Mental Health Support Services in July 2011
  - Reduction has been realized in Intensive In Home and Therapeutic Day Treatment services

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# Amendments in Introduced Budget - Program Initiatives

	FY 2013 Total Funds	FY 2014 Total Funds
Maintain DSH payments at FY2013 funding level	\$0	(\$43,492,318)
Correct FY14 funding error for state teaching hospitals	\$0	\$11,257,011
Modify minimum occupancy requirement for NFs from 90 to 88%	\$0	\$1,833,248
Medicaid enrollment of eligible DOC prisoners for inpatient hospital services	\$0	\$2,775,770
Provide exceptional rates for qualifying community placements	\$0	\$0
Authorizes elimination of state funded health care programs that duplicate coverage provided through health benefits	\$0	\$0

# Amendments in Introduced Budget - Administrative Initiatives

	FY 2013 Total Funds	FY 2014 Total Funds
Fund Dual Eligible Financial Alignment Demonstration	\$0	\$2,501,675
Capture savings from lower cost of PERM eligibility review contract	\$0	(\$2,221,974)
Maximize federal cost allocation	\$0	\$0
Reduce personnel costs	\$0	(\$712,962)

Questions?