Senate Finance Committee

Health and Human Resources: Recent Trends and Emerging Medicaid Costs

November 18-19, 2010
Staunton, Virginia

Introduction

- The 2010 General Assembly faced a $4.5 billion shortfall when it put together the 2010-12 biennial budget.

- Reductions totaling $1.0 billion in Health and Human Resources (HHR) addressed 22 percent of the budget gap.

  – Enhanced federal Medicaid funding was expected to mitigate a portion of these cuts.

- Medicaid continues to drive spending in HHR. As a "counter-cyclical" safety net program, costs have risen as enrollment has grown.

- On January 1, 2014, the federally-required expansion of Medicaid will pose additional fiscal challenges, but underlying growth in the current program is more daunting.

- This presentation is designed to:

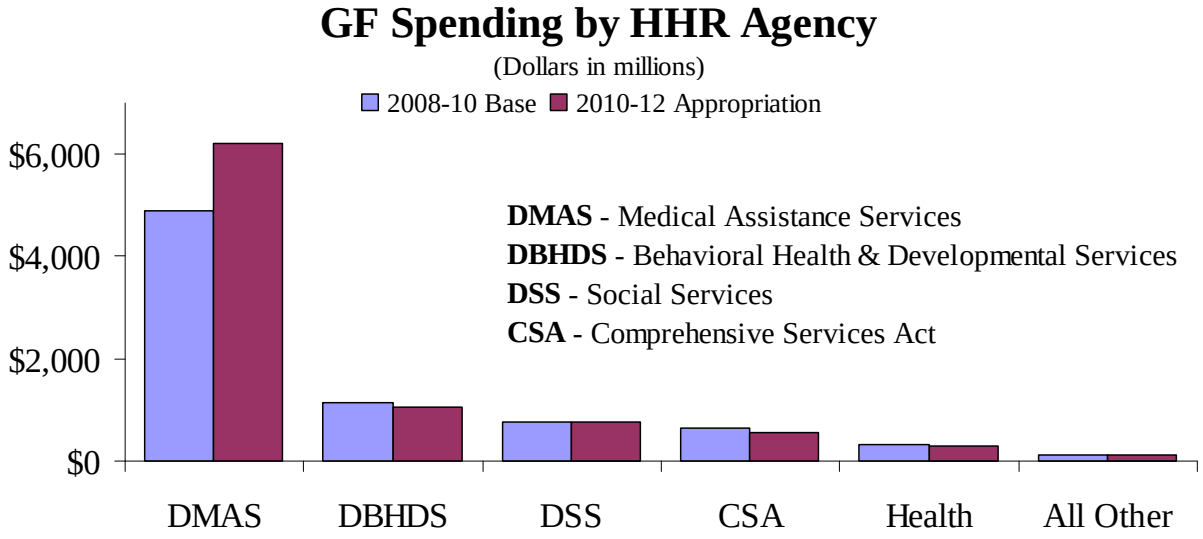
  – Review actions approved by the 2010 General Assembly, including an update on Federal Medical Assistance Percentage (FMAP) funding;

  – Highlight recent trends in Medicaid spending; and

  – Discuss the fiscal implications of federal health care reform on Virginia's Medicaid program.

Summary of 2010 Session Budget Actions

- Net general fund appropriations for HHR programs increased by $1.1 billion during the 2010-12 biennium.

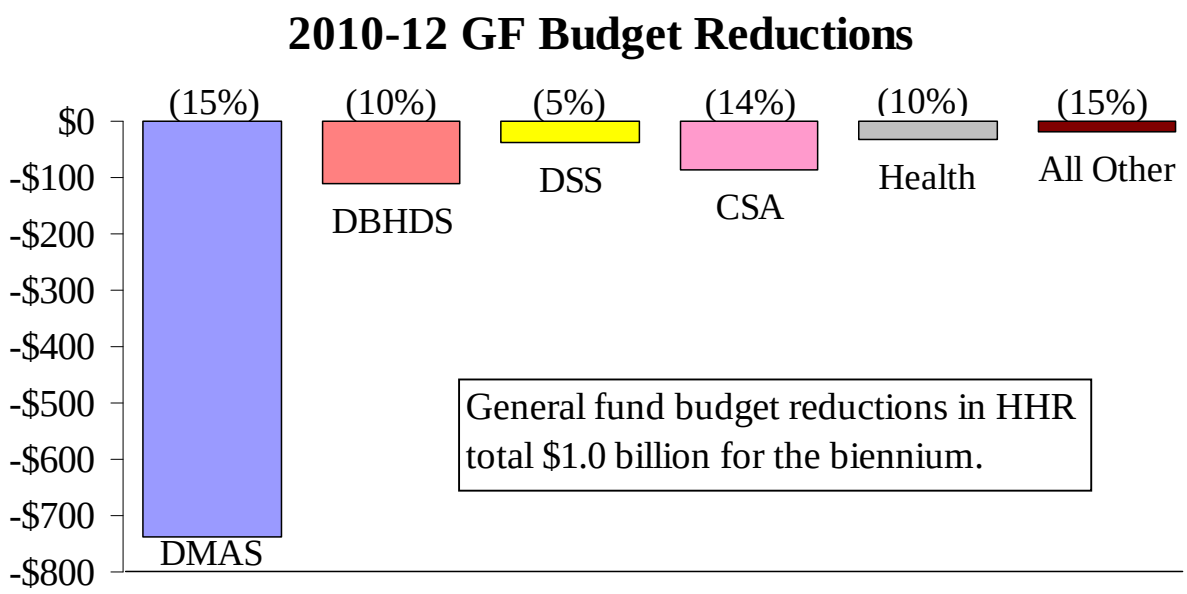


- Mandated or high priority spending required the addition of nearly $2.1 billion, including:
  - $1.2 billion to restore general funds related to the expiration of enhanced federal Medicaid funding;
  - $777.7 million to accommodate rising health and long-term care spending in Medicaid; and
  - $102.5 million to address health care costs for low-income families and shortfalls at state mental health and intellectual disability facilities.
- Discretionary spending in HHR was limited.

Summary of 2010 Budget Reductions

- Not counting mandatory and high priority increases, more than $1.0 billion from the general fund was eliminated from HHR programs.

  – Double-digit budget reductions were the norm.



- The approved budget assumed that Congressional action on six additional months of enhanced Medicaid funding -- through June 30, 2011 -- was imminent.

  – The General Assembly enacted nearly $400 million in general fund budget reductions.

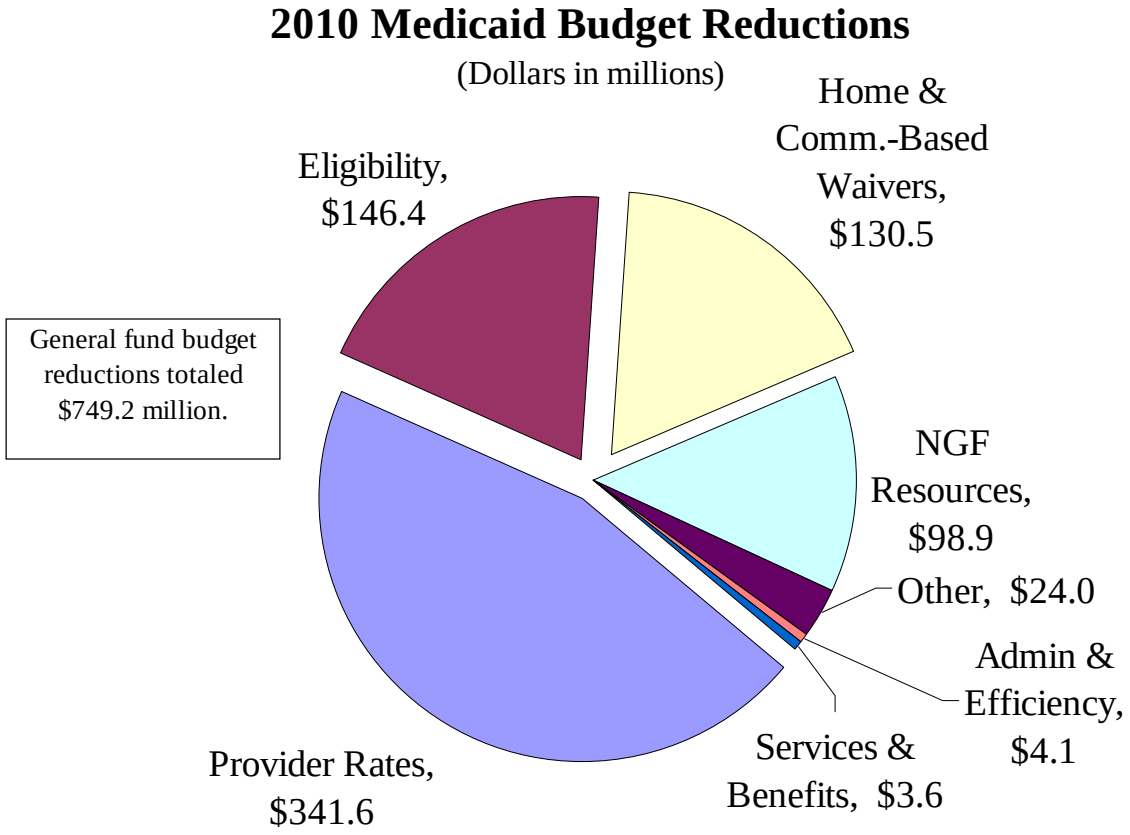
  – The cuts would not go into effect if the federal government extended the temporary boost in funding.

Summary of Budget Reductions (DMAS)

- As the largest agency within HHR, the Department of Medical Assistance Services was targeted for most of the reductions -- $749.2 million GF for the biennium.

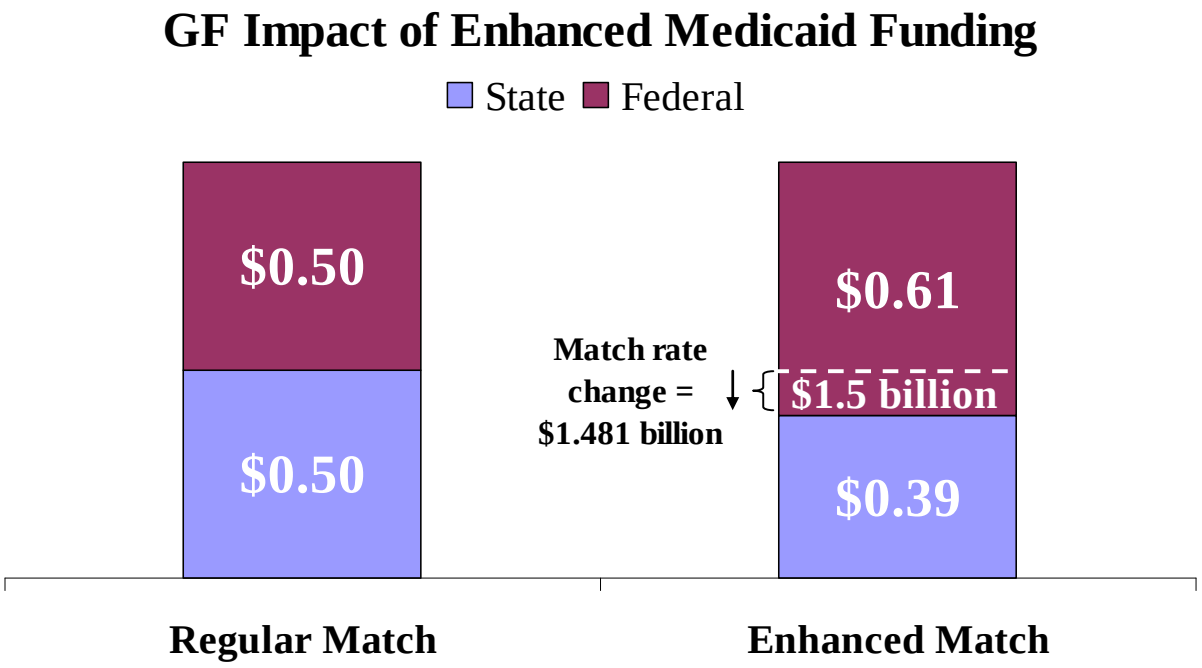
- The three pillars of Medicaid include recipients, benefits, and providers.

- Providers absorbed almost half of Medicaid's budget reductions in the 2010-12 budget, followed by eligibility changes and home- and community-based waiver services.



Federal Funds Helped to Balance Budget

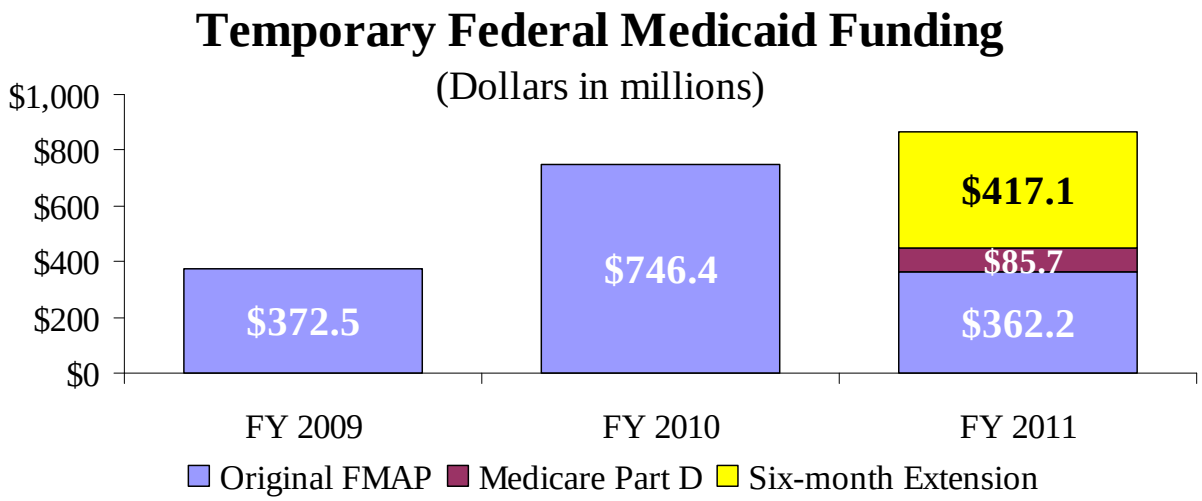
- The temporary infusion of federal Medicaid dollars over a 27-month period (October 1, 2008 through December 31, 2010) helped to mitigate general fund budget reductions.



- The change freed up $1.5 billion in state funds that otherwise would have been spent on Medicaid, allowing the Commonwealth to address other budget issues as general fund revenues declined.

- The federal government increased its share of Medicaid spending for a shorter period of time in 2003, allowing states to reduce their commitment to the program.

Additional Federal Funds Provided in 2011



- The introduced budget anticipated that $362.2 million from the original FMAP increase would be available through December 31, 2010.

- In February 2010, federal guidance related to the Medicare Part D Prescription Drug Program resulted in additional federal funding of $85.7 million.

- The prolonged recession spurred Congress to provide an additional six months of FMAP with revenues to Virginia estimated at $417.1 million.

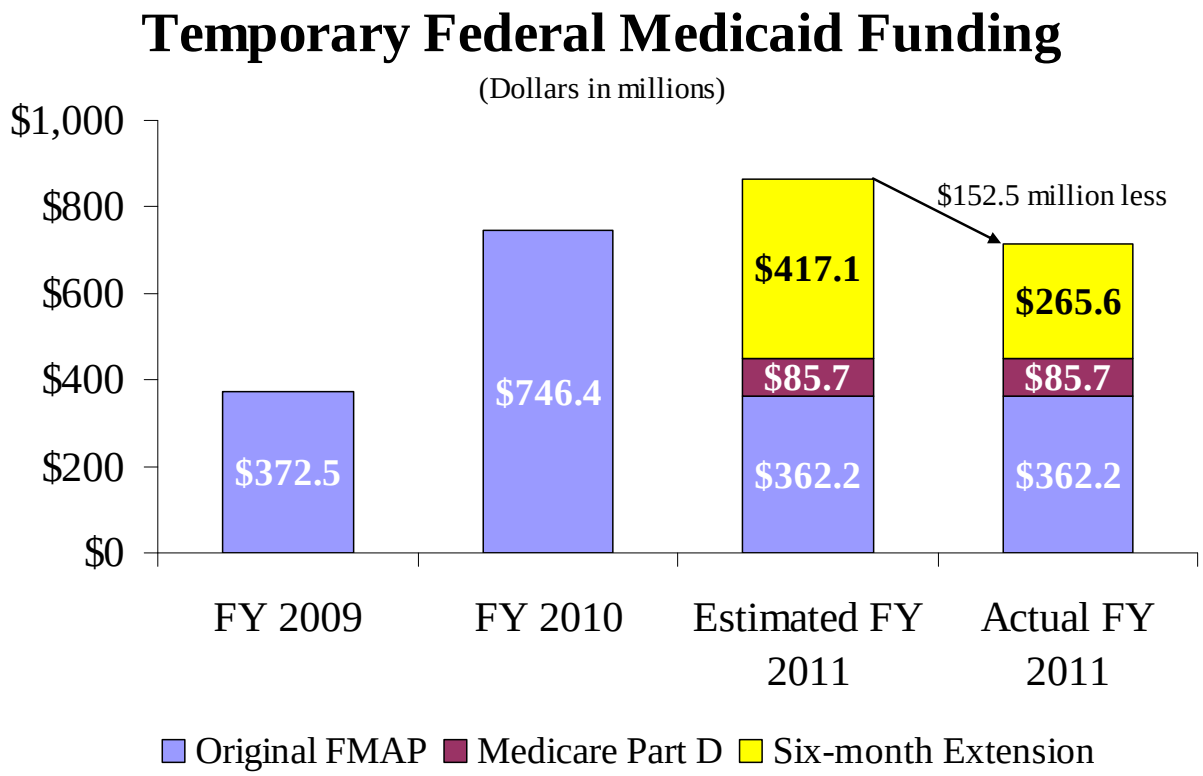
  – The additional federal dollars were appropriated on a contingent basis.

  – If FMAP were extended, specific general fund budget reductions would be restored.

FMAP Funding Reduced by Congress

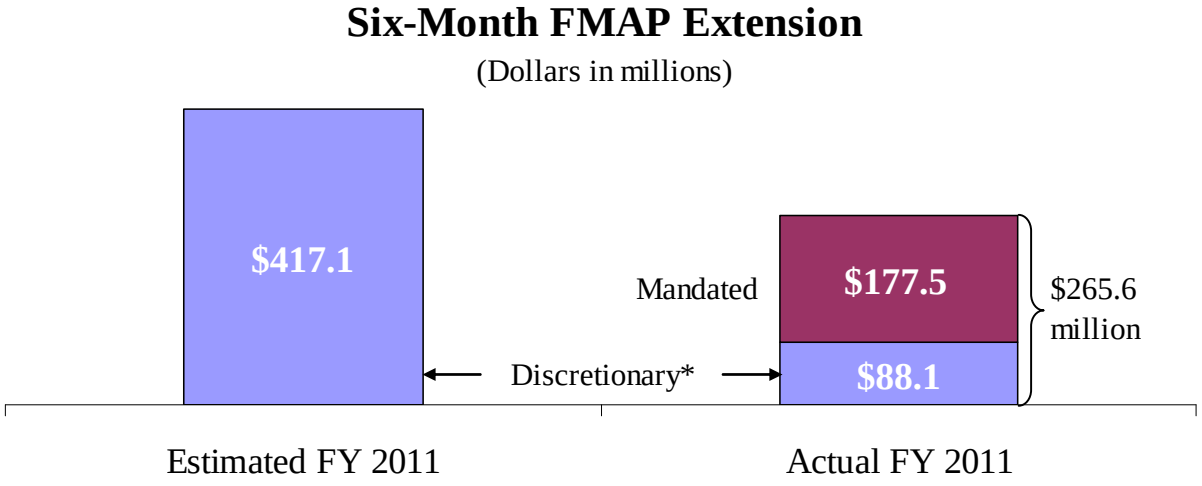
- Concerns about federal spending delayed and then reduced the amount of temporary fiscal relief provided to states by Congress.

- Instead of $417.1 million, the Commonwealth will receive $265.6 million from January 1, 2011 to June 30, 2011 from enhanced federal Medicaid funding.



- Federal funding will not be available to make all the restorations (or additions) that the General Assembly approved during the 2010 Session.

Mandatory FMAP Restorations



* Anticipated maintenance of effort requirements through June 30, 2011.

- Federal maintenance of effort requirements related to FMAP, the passage of federal health care reform and other federal laws require that $177.5 million in general funds be restored.

Budget Reductions That Must Be Restored	FY 2011	FY 2012*	Biennium
Reduce Income Eligibility SSI Population	$14.2	$72.9	$87.1
Reduce Eligibility for Aged, Blind, and Disabled	-	36.2	36.2
Reduce FAMIS and FAMIS Moms from 200 to 175%	-	19.3	19.3
Home and Community-Based Waiver Freeze	3.2	13.3	16.5
Implement ICF-MR Provider Tax	3.5	8.5	12.0
Reduce Auxiliary Grant Rate	-	3.0	3.0
Modify Out-of-State Inpatient Hospital Rates	2.1	-	2.1
Eliminate Optometry Services	0.3	0.4	0.7
Medically Needy Income Limits	-	0.6	0.6
TOTAL	**$23.3**	**$154.2**	**$177.5**

* Amounts restored in FY 2012 with FMAP create a "cliff effect" next biennium.

Discretionary FMAP Restorations

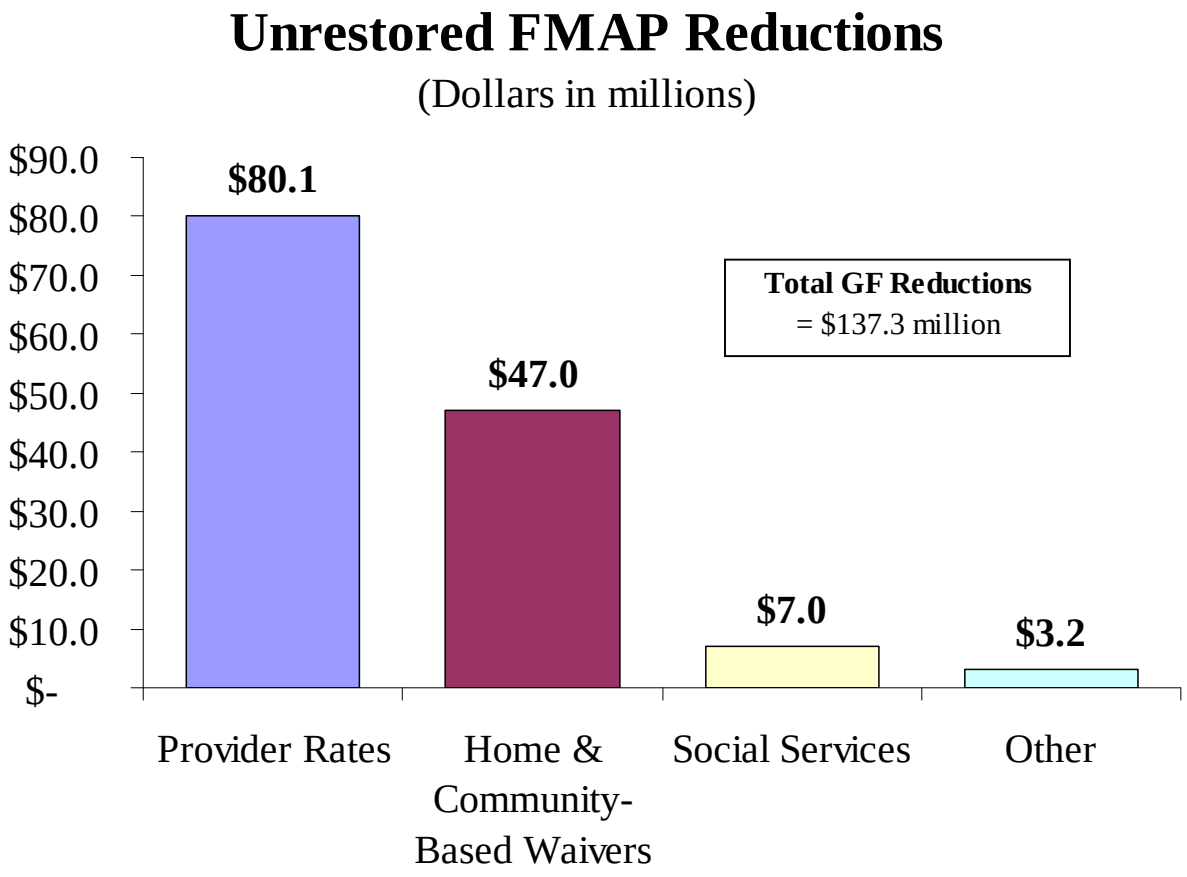
- With the funds remaining after mandated restorations were made, the Governor announced plans to restore those cuts that took effect, or were scheduled to take effect, in FY 2011, at a cost of $71.2 million.

Contingent Restorations or Spending Items	Proposed FY 2011	Unrestored FY 2012
Reduce inpatient hospital rates	$10.1	$24.2
Reduce respite care hours from 720 to 240/year	5.0	21.2
Reduce home and community-based waiver rates	12.6	18.0
Nursing facility operating and capital rates	9.0	16.3
Reduce physician rates	6.1	14.7
Reduce outpatient hospital services	4.8	10.8
Add 250 new Intellectual Disability waiver slots	3.8	7.8
Reduce funding for indigent care at UVA and VCU	4.9	7.1
Reduce funding for child welfare services	2.3	3.0
Reduce reimbursement for hospital capital	1.1	2.6
Reduce funding for general relief	1.8	2.4
Reduce funding for dental services	1.0	2.3
Provide mental health services for children	1.6	2.1
Reduce funding for local departments of social services	1.2	1.6
Reduce funding for pharmacy reimbursement	0.6	1.5
Retain Medicaid School Health Reimbursement	0.0	0.6
Eliminate coverage of podiatry services	0.0	0.5
Reduce mental health therapeutic day treatment rates	1.0	0.0
Reduce funding for Healthy Families	1.0	0.0
Residential psychiatric treatment services	0.9	0.0
Reduce funding for chore and companion services	0.8	0.0
Reduce funding for other purchased services	0.8	0.0
Reduce funding for Centers for Independent Living	0.4	0.0
Reduce long-stay hospital rates	0.3	0.5
Limit Environment Modifications / Assistive Technology	0.2	0.0
Total	**$71.2**	**$137.3**

Consequence of Reduced FMAP Funding

- Significantly less FMAP funding than anticipated will increase the pressure to address budget cuts that are now slated to take effect on July 1, 2011.

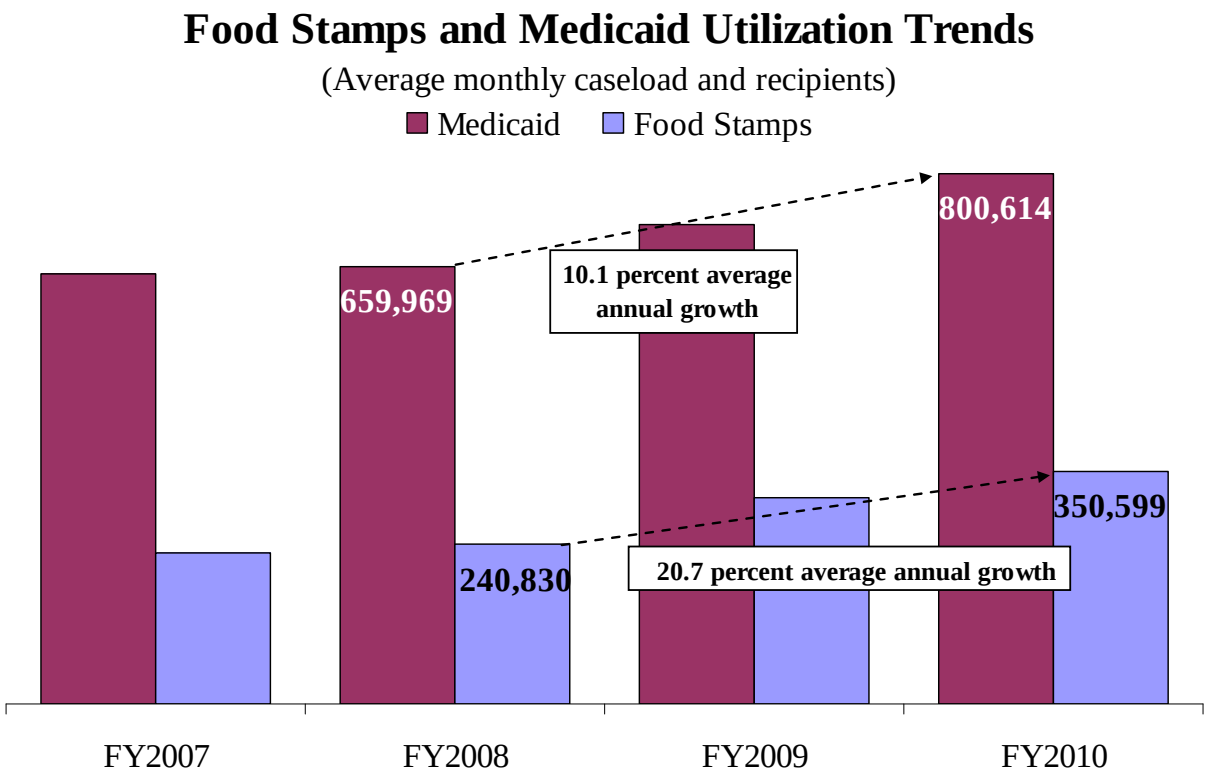
- Medicaid providers, community-based waiver services and services delivered through local Departments of Social Services face $137.3 million in general fund reductions in FY 2012.



Recent Trends in Medicaid Spending

Demand for Services Continues to Grow

- The lingering effects of the current economic recession are placing unprecedented demands on local Departments of Social Services (DSS).



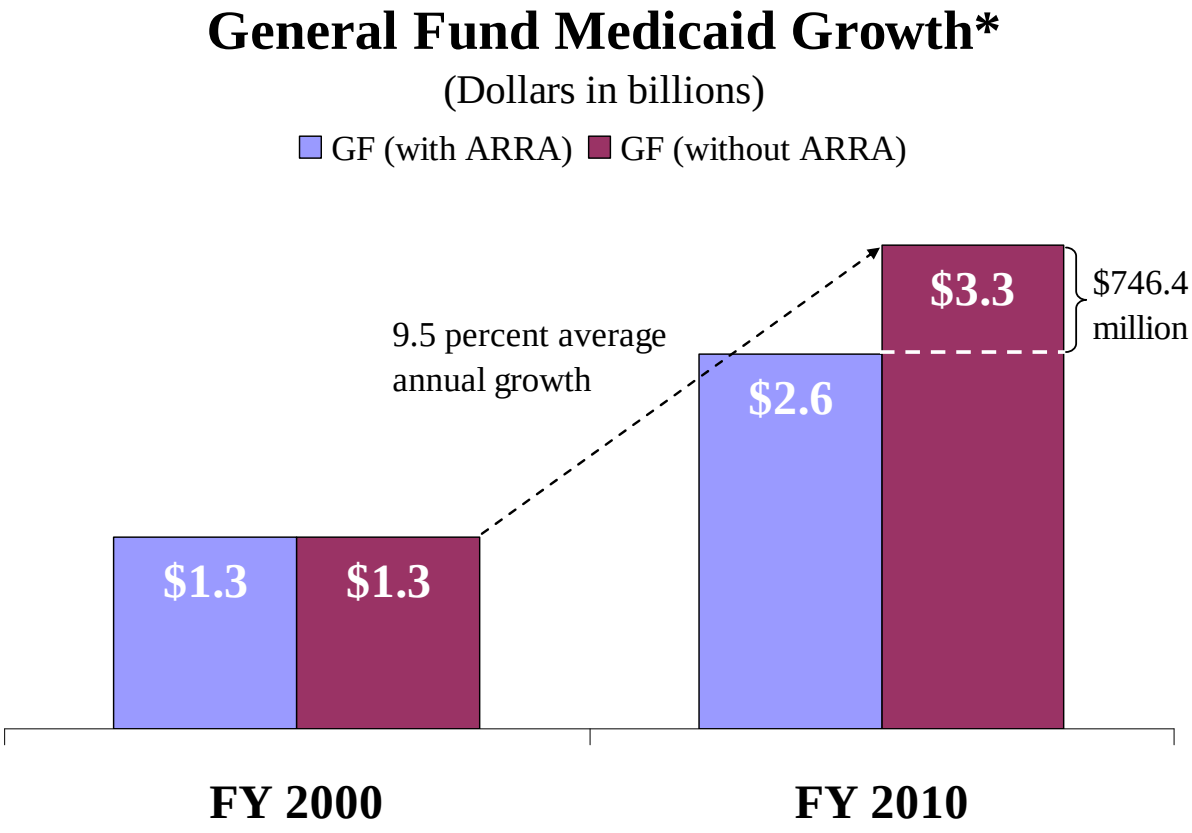
- Caseloads managed by local DSS offices have increased significantly in the past two years. Average annual growth is:

  – 20.7 percent for food stamps caseloads; and

  – 10.1 percent for Medicaid recipients.

Medicaid Growth Since FY 2000

- General fund spending on Medicaid more than doubled during the past decade.



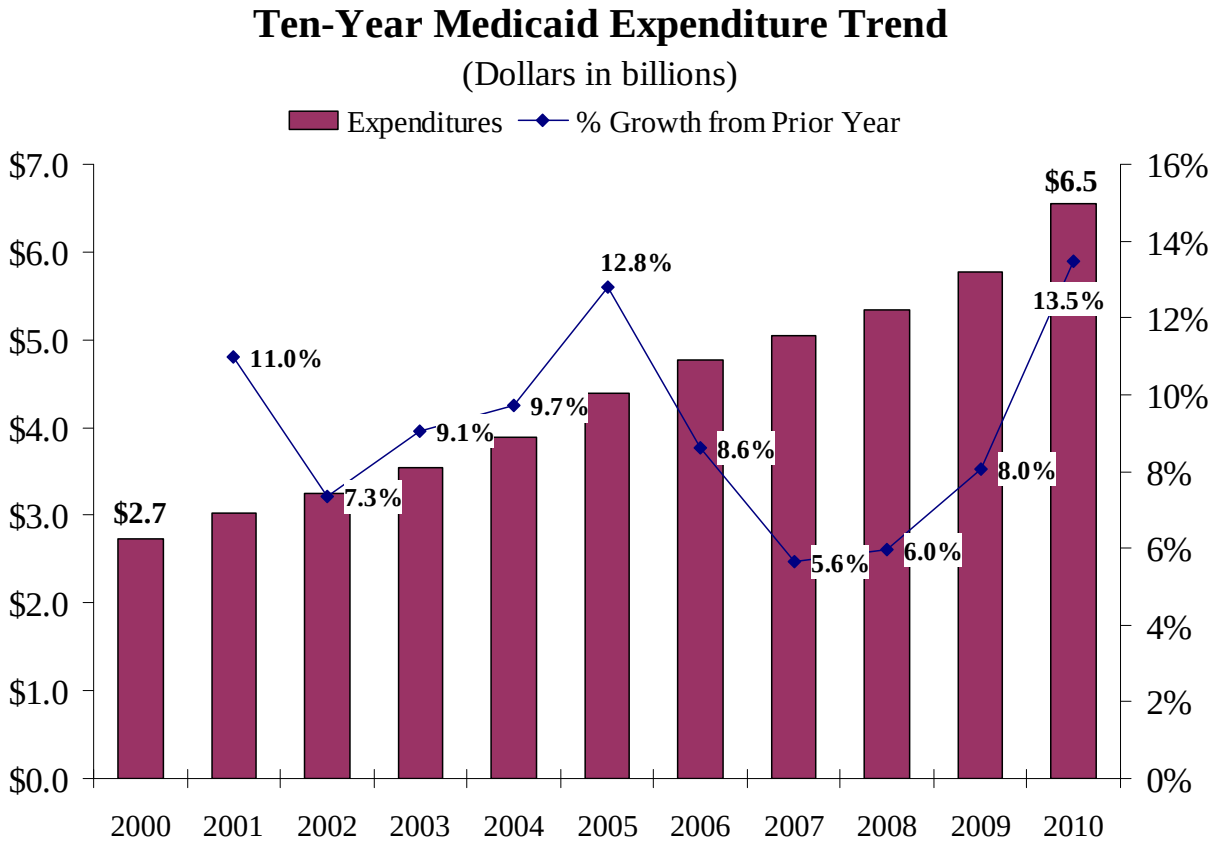
* Includes state match from Virginia Health Care Fund.

- Excluding federal funding provided in FY 2010, growth averaged 9.5 percent during the past decade.
  - Prior to the current economic recession, Medicaid spending was increasing at a rate of six percent annually.

Inflation and Enrollment Drive Medicaid Growth

- Enrollment changes and medical inflation account for most of the recent growth in Medicaid spending.

- Medical inflation, the price of medical care and health services, accounts for 43 percent of growth over the past ten years.



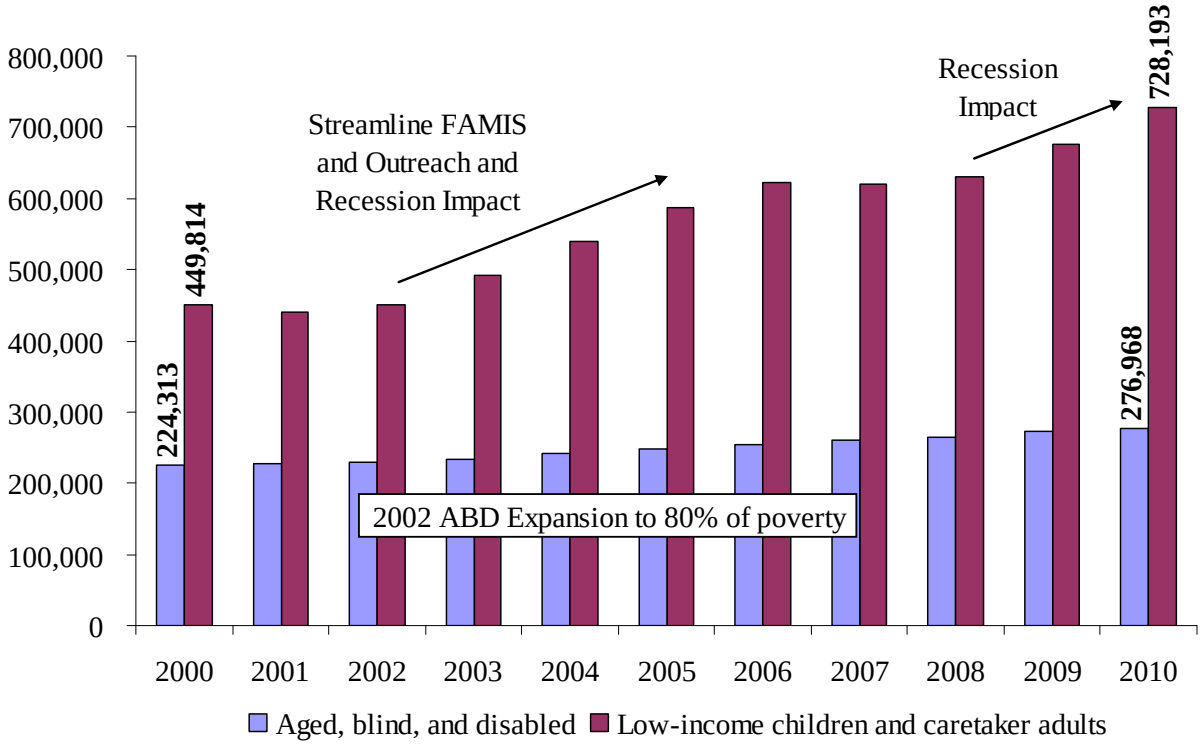
- Annual growth rates in FY 2009 and FY 2010 are distorted by delayed payments to managed care organizations, hospitals, and other providers approved at the 2009 Session.

Medicaid Enrollment Contributes to Growth

- Enrollment accounted for 45 percent of expenditure growth in the past ten years.

- Efforts to expand access to FAMIS through programmatic changes and outreach as well as the 2003 and current economic recession explain most of the caseload growth among low-income Virginians.

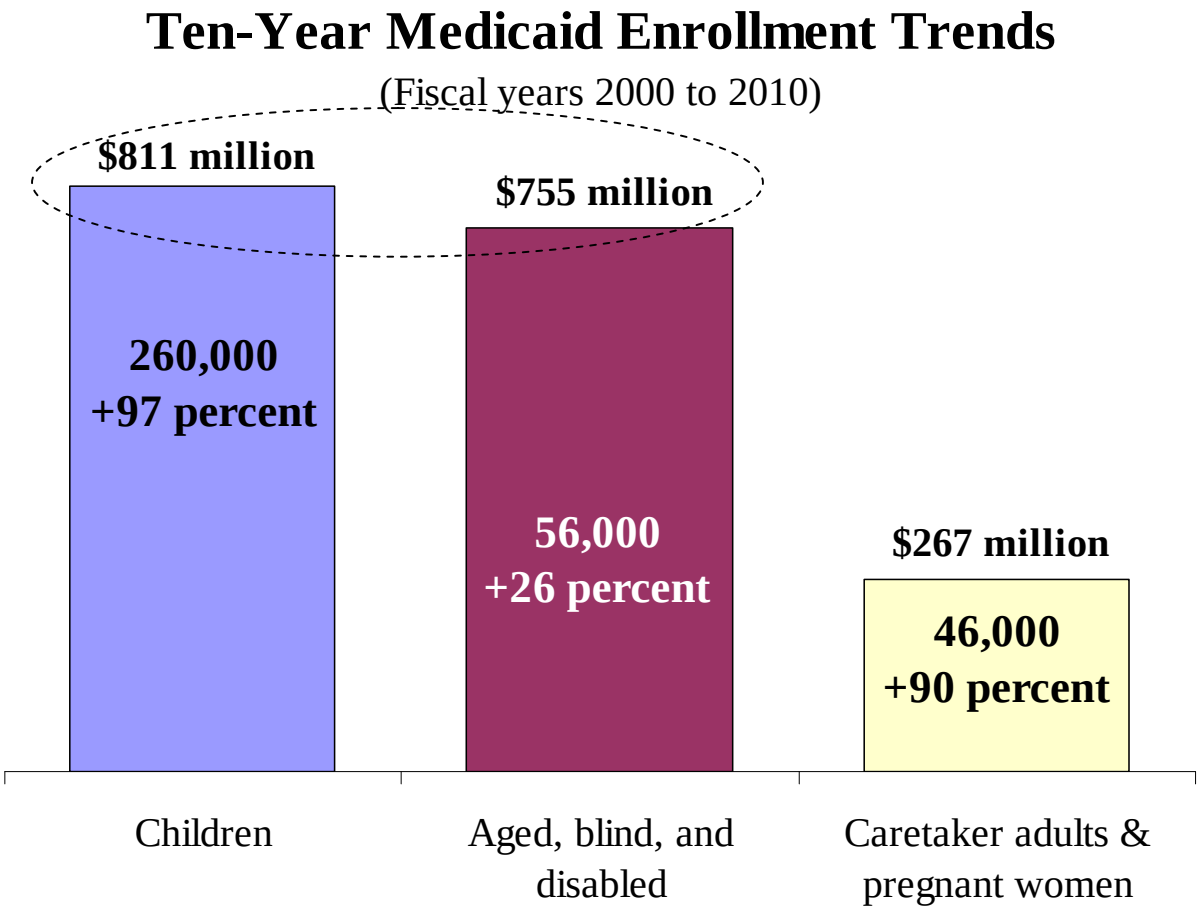
Ten-Year Trend In Medicaid Enrollment



- Annual enrollment growth among low-income families with children and caretaker adults accelerated from 2 percent in FY 2008 to 13 percent in FY 2010.

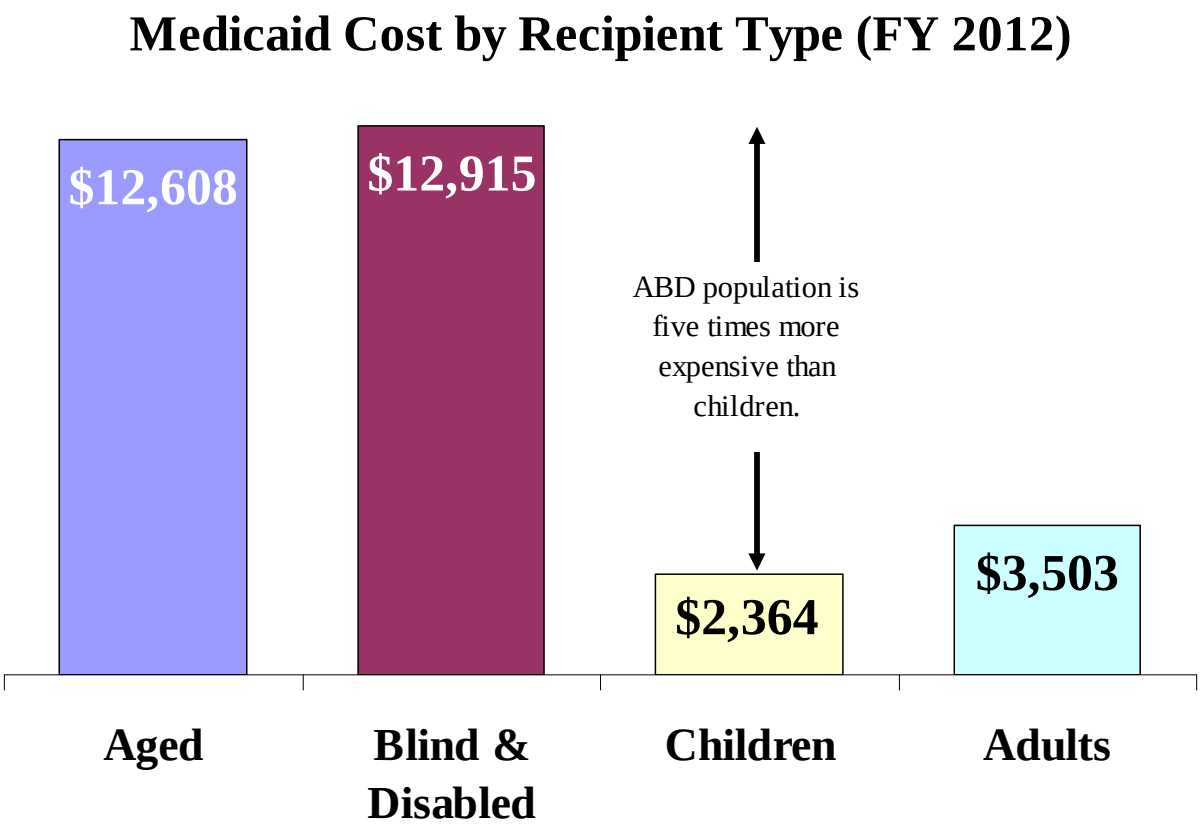
Trends in Medicaid Enrollment

- The number of children enrolled in Medicaid nearly doubled over the past ten years.
  - The additional cost of serving this population was $811 million (all funds).
- Enrollment among the aged, blind, and disabled increased by 26 percent at a cost of $755 million.



Medicaid Cost by Recipient Type

- Spending on Medicaid recipients who are aged, blind, and disabled is more than five times that of children.

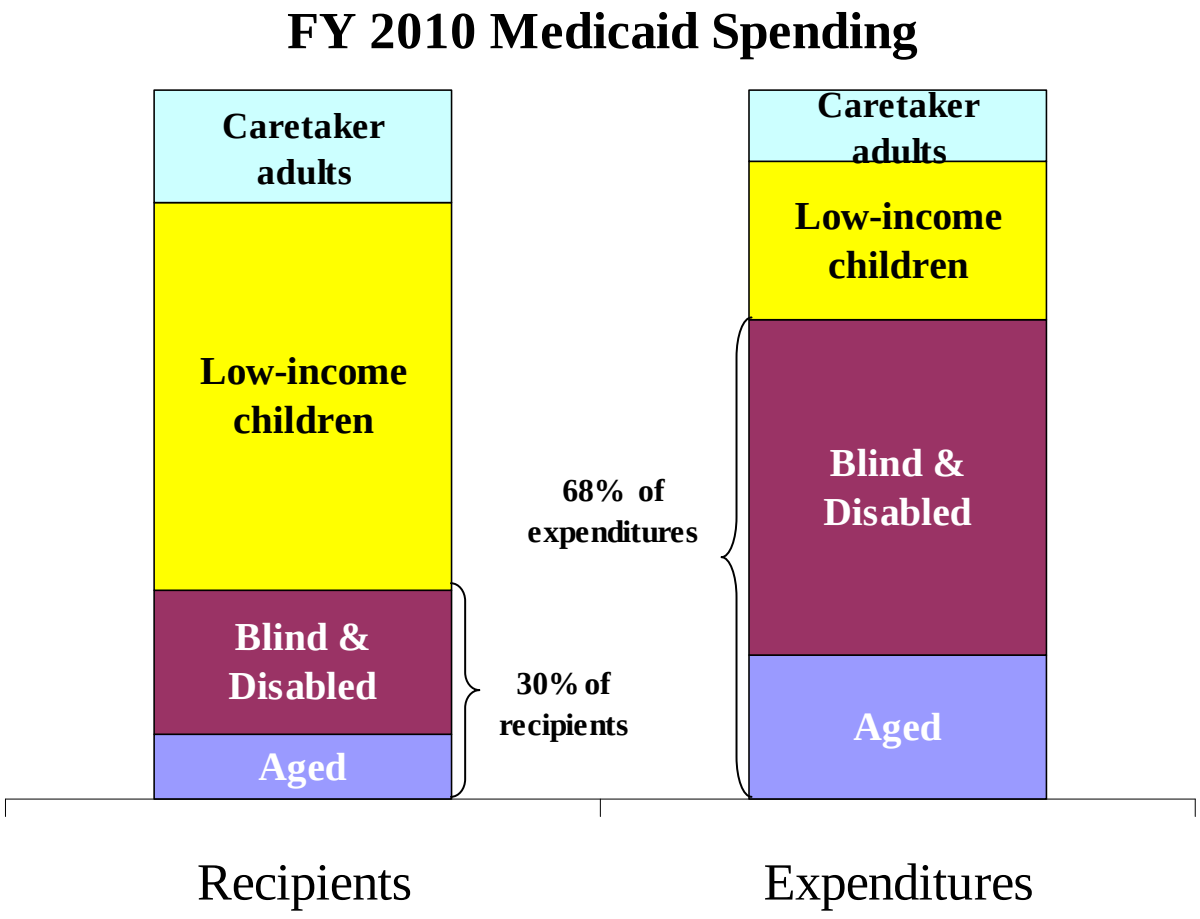


- The aged, blind, and disabled are the primary consumers of long-term care services provided by nursing homes or intermediate care facilities but are also heavy users of hospital, physician and pharmacy services.

- Low-income families with children tend to receive acute health care services provided on a temporary basis when an illness arises or an accident occurs.

The Aged, Blind, and Disabled Account for A Disproportionate Share of Spending

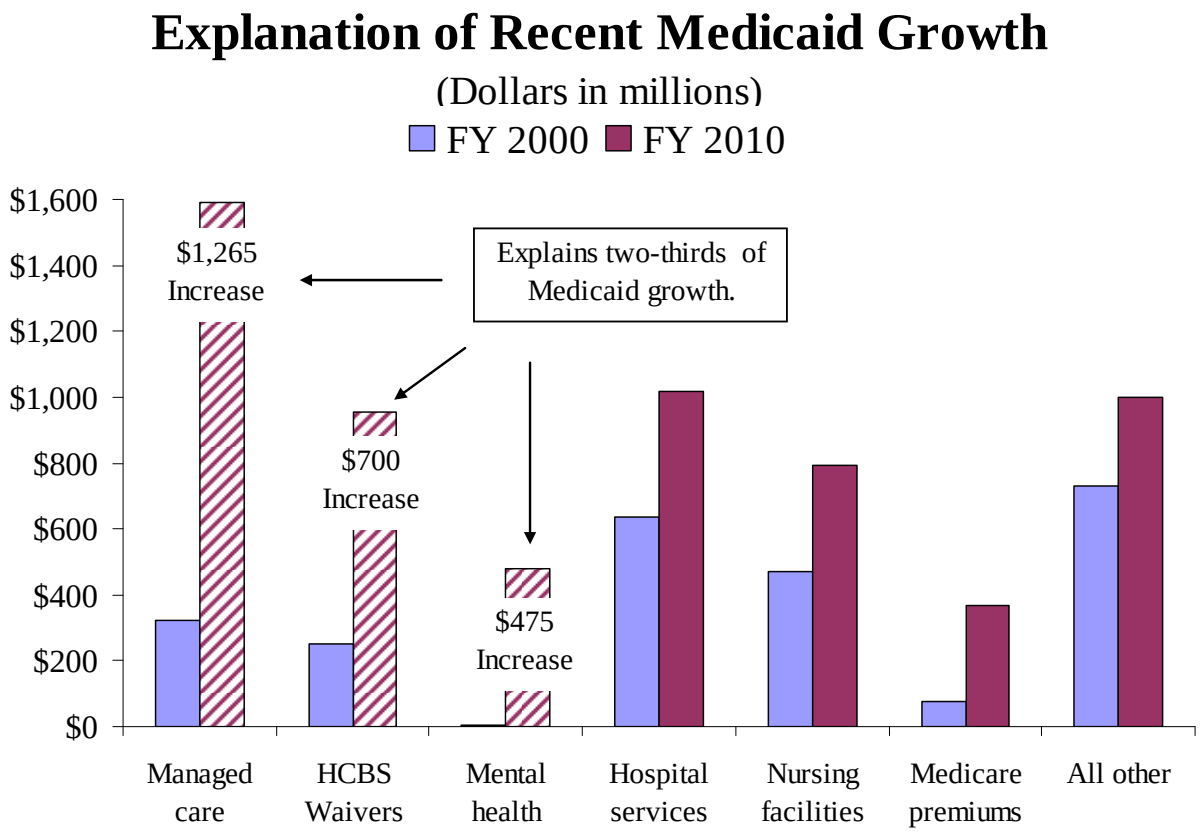
- Thirty percent of Medicaid recipients -- the aged, blind, and disabled -- account for two-thirds of Medicaid spending due to their chronic health and long-term care needs.



- In 2005 low-income Medicare beneficiaries who are elderly and disabled – "dual eligibles" – accounted for 18 percent of Medicaid enrollees but nearly half (46 percent) of Medicaid expenditures.

Where Has Medicaid Spending Grown?

- Most Medicaid resources are spent on **a) acute care** provided by managed care companies and hospitals and **b) long-term care** delivered through home and community-based waiver services and nursing homes.



- The expansion of managed care and enrollment growth explains most new Medicaid spending.

- Additional Intellectual Disability waiver slots as well as the provision of community-based mental health services have also contributed to rising costs.

2010 Session Efforts to Slow Spending

- Multiple budget strategies were enacted to reduce the growth of spending in three of the service areas contributing the most to recent growth.

Managed care	LTC waiver	Mental health
Provider rate reductions (pass-through)	5% provider rate reduction	Reduce provider rates
	Freeze enrollment	Increase prior authorization
	Reduce respite care	Increase provider audits

- Provider rate reductions have consequences.

- Most experts seem to agree that any hope of achieving sustainable cost savings must come from fundamental changes to the Medicaid program including:

  - Reexamining our payment systems;
  - Unifying standards for health information technology;
  - Evaluating the cost-effectiveness of new treatments;
  - Exploring new models of delivering care; and
  - Embracing care coordination and managed care principles in long-term care.

- None of these changes will be easy and many of them are unproven … there are no magic bullets!

Virginia Health Reform Initiative (VHRI)

- In August, the Governor announced the creation of the VHRI Advisory Council to develop a "comprehensive strategy for implementing health reform", as well as ensuring affordable access to health care.

- Despite the Commonwealth's legal challenges to the federal Patient Protection and Affordable Care Act (ACA), the VHRI is focusing its attention on key areas that may result in substantive changes to our health care system.

VHRI Key Issue Areas		
Insurance Reform	Medicaid Reform	Technology
Delivery & Payment Reform	Purchasers	Capacity

- Presentations to the VHRI suggest that the current system of health care is unsustainable and not conducive to economic growth.

  – Reforms will not happen overnight.

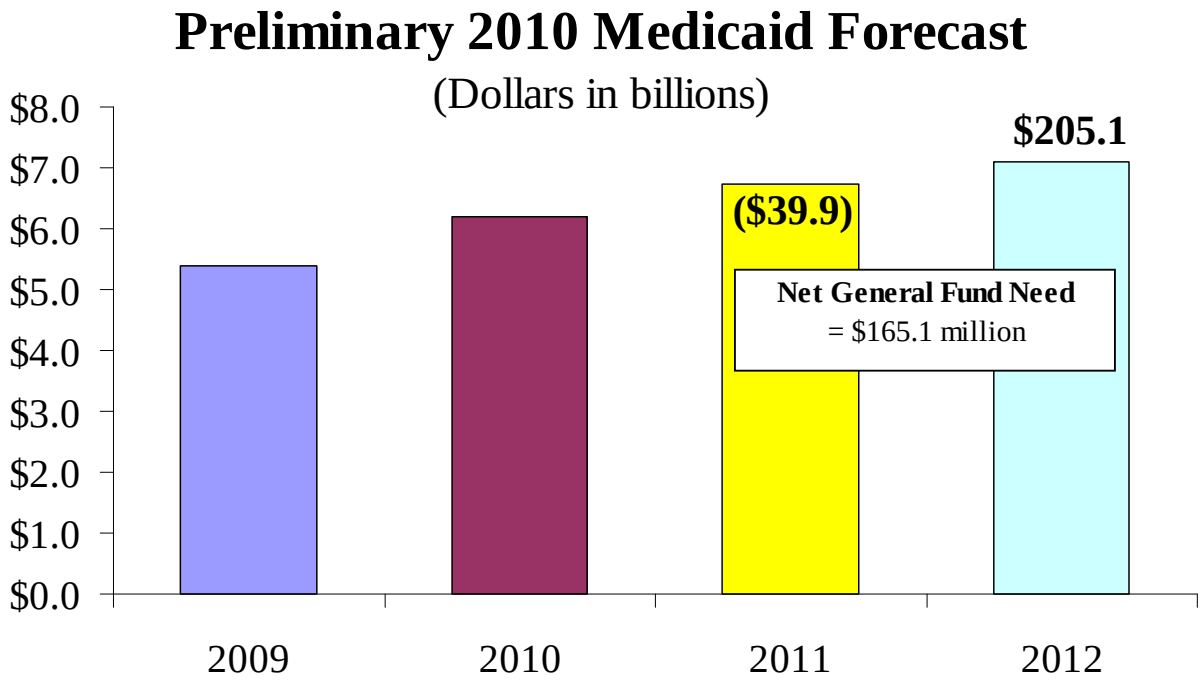
- Preliminary recommendations are likely to be presented to the Governor in mid-December.

- A thorough examination of our health and long-term care systems is certainly warranted.

2010 Medicaid Forecast and Possible General Fund Impact of the Patient Protection and Affordable Care Act of 2010

2010 November Medicaid Forecast

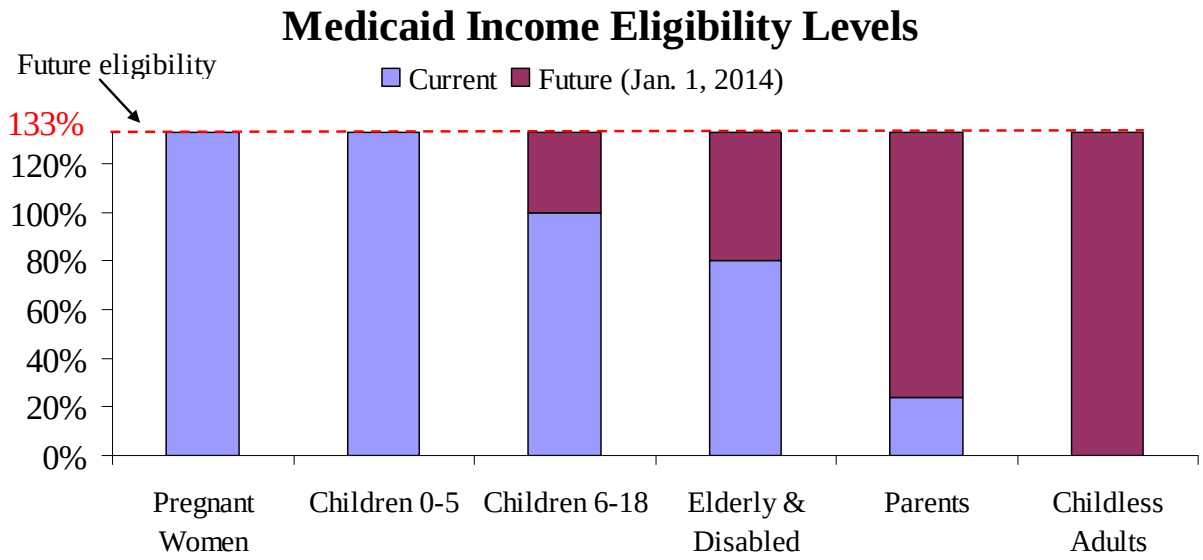
- Preliminary estimates indicate that $165.1 million will be needed to fully fund the program in FY 2010-12.



- Three factors account for most of the change in the recent Medicaid forecast:
  - The receipt of $265.6 million of enhanced FMAP funding explains the "excess" in FY 2011.
  - Average monthly enrollment growth is slowing and health care costs are less than expected.
  - The cost of long-term care services, primarily home and community-based waiver services, continues to experience steady growth.

Federal Health Care Reform and Medicaid

- The full fiscal impact of federal health care reform will not begin to be felt in Medicaid until January 1, 2014.

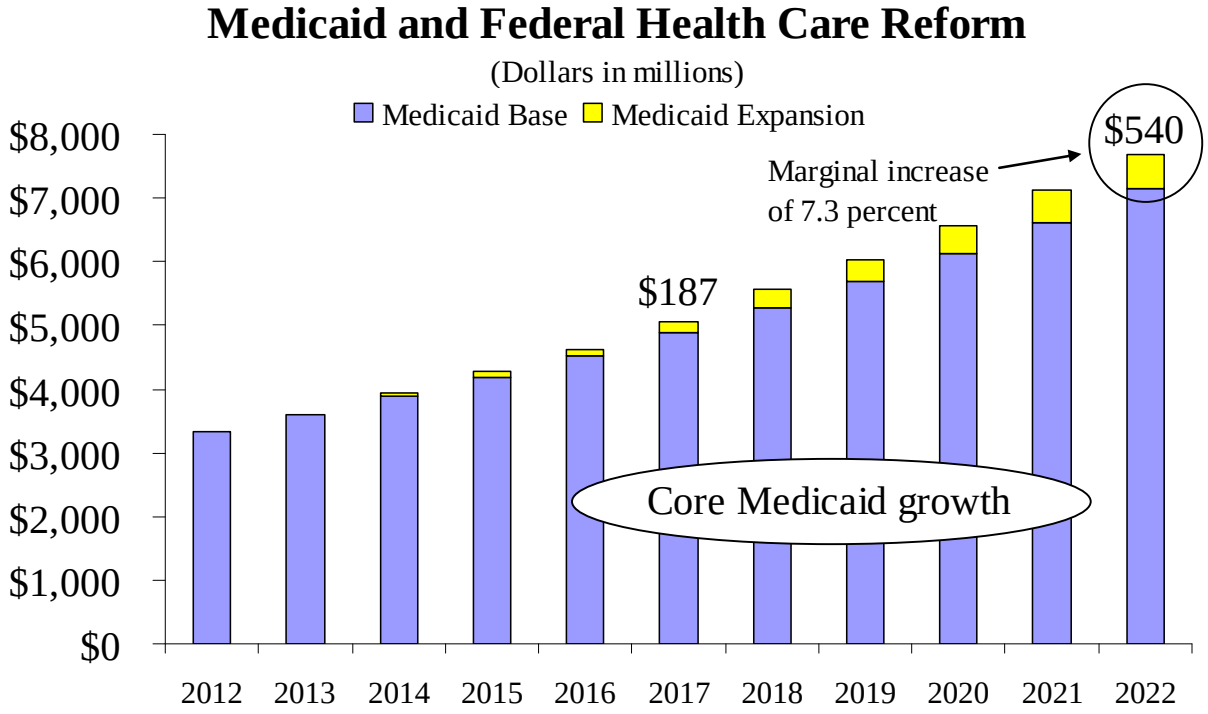


- The expansion of Medicaid to all individuals under age 65 with income under 133 percent of poverty ($29,300 for a family of four) is expected to significantly reduce the level of uninsured in Virginia.
  - One in seven individuals lack insurance in the Commonwealth equating to more than 1.1 million Virginians.
- DMAS estimates that an additional 271,000 to 426,000 individuals may receive services when eligibility is expanded, including 50,000 children who are currently eligible but not enrolled in Medicaid.

Estimated GF Impact of Medicaid Expansion

- Depending upon actual enrollment, DMAS projects the net general fund impact of the Medicaid expansion to range from $1.5 to $2.2 billion through FY 2022.

- Assuming enrollment increases by 426,000 Virginians (upper estimate) projected spending may rise by $540 million GF or 7.3 percent in FY 2022.



- Underlying growth of current Medicaid spending will be more challenging than addressing the incremental cost of expanding coverage to low-income Virginians.

Costs of Uninsured in Virginia

- The general fund impact of expanding Medicaid to the uninsured is significant, but there are costs that the Commonwealth is currently incurring that can be reduced or eliminated in future years.

- Over the last ten years, VCU and UVA Health Systems received more than $1.0 billion from the general fund for indigent health care costs.

  – *Will a general fund subsidy of $104 million each year still be necessary after January 1, 2014?*

- In 2009, hospitals provided $491 million in charity care to uninsured and underinsured Virginians.

  – It is estimated that these uncompensated care costs will fall by 75 percent, reducing pressure on hospitals to shift costs to private insurance plans.

  – *Will rising premiums for the State Employees Insurance Plan begin to slow?*

- Thirty-two percent of the individuals seen by community services boards are uninsured.

  – *Will the current level of general fund support for CSBs still be necessary when these individuals begin receiving coverage through Medicaid?*

Health & Human Resources Subcommittee

- The Senate Finance Committee's Subcommittee on HHR met five times this interim to solicit input on the possible implications of federal health care reform.

2010 HHR Subcommittee Meeting Dates and Locations
June – Norfolk – Children's Hospital of the King's Daughters
July – Manassas – Prince William Hospital
August – Richmond – VCU Health System
September – Charlottesville – UVA Medical Center
October – Marion – Smyth County Community Hospital

- Conflicting set of themes emerged from the hearings.

Expansion – How many uninsured Virginians will gain access to health care coverage?
Workforce – Are sufficient providers available to serve the volume of new recipients?
Opportunity – Will new models of care, delivery systems, and payment models result in cost-savings?

- Primary concerns revolve around **funding** and **uncertainty**.
  - How many individuals will show up and when?
  - When will the relevant regulations be finalized?
  - What changes will be made by Congress?

Conclusion

- The restoration of general funds for Medicaid, higher Medicaid enrollment, and other high priority spending items required the addition of $2.1 billion in HHR in the 2010-12 biennium.
  - New general fund spending was offset by $1.0 billion in reductions to HHR programs.
- Similar to the 2009 Session, additional federal dollars helped to soften the blow.
  - Less-than-anticipated FMAP will likely motivate affected groups to advocate for restoration of funding cuts slated to take effect on July 1, 2011.
- The rising cost of health and long-term care spending, made worse by the current recession, is an immediate problem for the Commonwealth.
  - Efforts to fundamentally change the current program, including realigning payment incentives and delivery systems, are necessary.
- The expansion of Medicaid funding under federal health care reform on January 1, 2014, will substantially increase enrollment in the program.

Appendix I

Mandatory Population Groups
Aged, blind, or disabled
Member of a family with children
Low-income children and pregnant women
Certain Medicare beneficiaries with incomes less than 135 percent of federal poverty guidelines (FPG)

- Mandatory groups must also meet financial criteria (e.g., income and resource) to be eligible for Medicaid.

- States that choose to expand coverage beyond "mandatory population groups" are eligible for federal Medicaid matching funds.

Optional Population Groups
"Medically needy" individuals whose income exceeds Medicaid limits but who are impoverished by medical bills
Individuals who are at-risk of needing nursing home or an ICF-MR level of care without home- and community-based waiver services
Aged, blind, or disabled with income under 80 percent of FPG
Nursing home residents with income under 300 percent of SSI (221 percent of FPG)
Children under 21 in foster homes, private institutions, or subsidized adoptions
Women screened and diagnosed with breast or cervical cancer

Appendix II

Mandatory Medicaid Services
Hospital services (BOLD denotes high cost services)
Nursing facility services
Physician services
Medicare premiums, copays, and deductibles (Part A and B)
Certified Pediatric Nurse & Family Nurse Practitioner Services
Early & periodic screening, diagnostic, and treatment (EPSDT)
Certain home health services (nurse, aide, supplies and treatment services)
Laboratory and X-ray services
Nurse midwife services
Rural health clinics and federal qualified health center clinic
Family planning services and supplies
Transportation
Optional Medicaid Services
Prescribed drugs
Mental health and mental retardation services
Home & community-based waivers
Medicare premiums, copays, and deductibles (Part B – medically needy)
Dental and skilled nursing facility care for persons under age 21
Clinical psychologist
Services provided by certified pediatric nurse and family nurse practitioner
Intermediate Care Facilities for the Mentally Retarded (ICF/MRs)
Optometry, podiatry, and home health services (PT, OT, and speech therapy)
Certified pediatric nurse and family nurse practitioner services
Case management services
Prosthetic devices
Other clinic services
Substance abuse treatment
Hospice

Appendix III

- Other noteworthy Medicaid Provisions from the federal Patient Protection and Affordable Care Act include:

  – Increasing the Medicaid reimbursement rate for primary care services to Medicare levels in FY 2013 and FY 2014 with 100 percent federal funding.

  – Creating optional demonstration program for bundled or global payment methodologies for safety net hospitals.

  – Requiring coverage of services provided by freestanding birth centers.

  – Increasing FMAP (one percentage point) for certain optional preventive services and adult immunizations.

  – Increasing FMAP for long-term care rebalancing efforts between community care and institutional care.

  – Extending the Money Follows the Person Grant through September 30, 2016.