

SENATE OF VIRGINIA

Senate Finance Committee

Health and Human Resources:

**The Basics of Medicaid,
Recent Growth, and Future
Challenges**

November 17, 2011



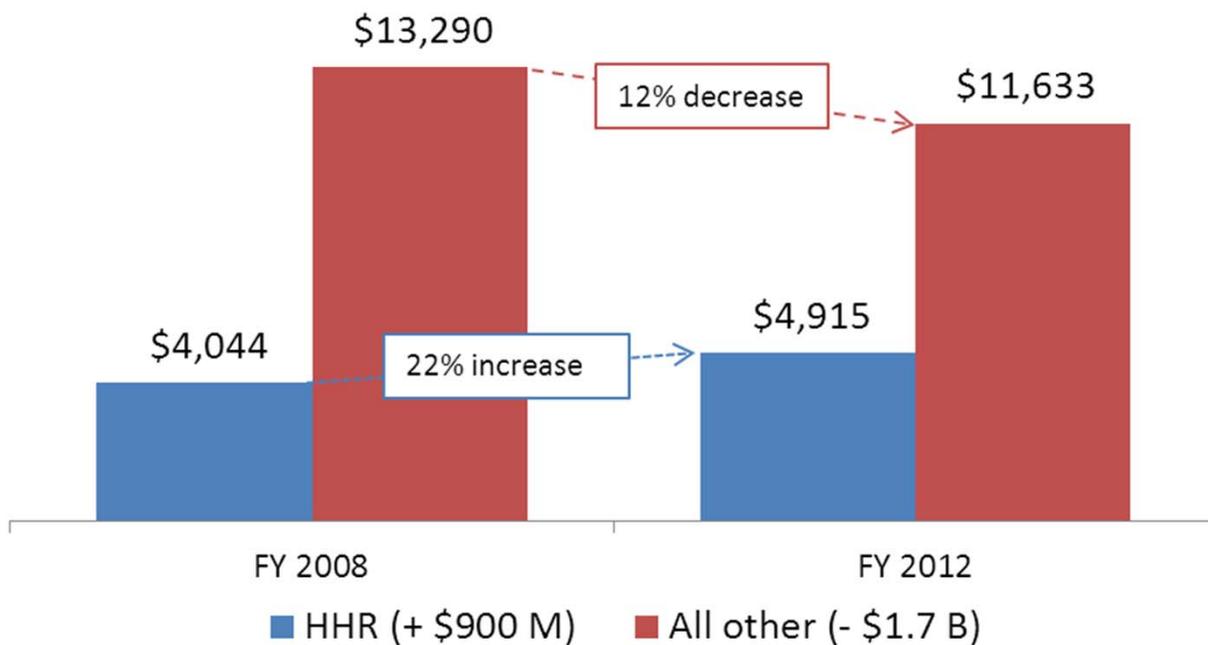
SENATE FINANCE COMMITTEE

Recession Contributing to Growth in HHR

- Demand for “safety-net” services tends to rise during weak economic times.
- Unprecedented demands have been placed on health and human resources programs from food stamps to health care during the Great Recession.

HHR Compared to All Other State Government

(General fund dollars in millions)



HHR Budget Pressures

- In the short-run, Medicaid spending is unlikely to decline significantly, placing increased demands on slow-growing general funds.
- Other budget pressures in HHR include:
 - A pending settlement with the federal Department of Justice related to the treatment and care of individuals with intellectual disabilities (ID);
 - Addressing the “woodwork effect” of expanding Medicaid coverage up to 133 percent of federal poverty guidelines beginning January 1, 2014;
 - Rising caseloads and costs for the Center for Behavioral Rehabilitation, commonly referred to as the Sexually Violent Predator Program; and
 - State agency budgets that have been seen general fund support dwindle at the same time federal funding is being reduced.

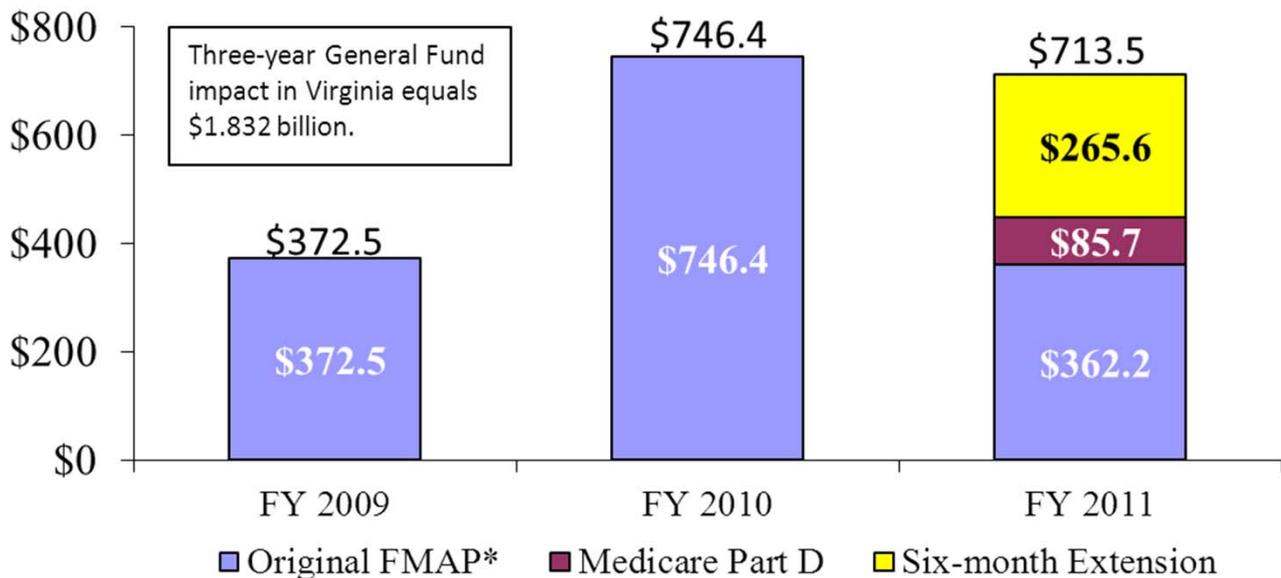


What should we expect from Uncle Sam?

- General fund revenues fell at the same time Medicaid enrollment began to accelerate, prompting the federal government to once again provide relief to state Medicaid programs.
- With Washington's attention turning to the growing federal budget deficit, we need to plan for reductions and not additions in federal funds.
 - The fiscal implications for the Commonwealth remain uncertain but may be significant.

Enhanced Federal Medicaid Funding

(Dollars in millions)



* Federal Medical Assistance Percentage (i.e., Federal share of Medicaid funding).



Overview of HHR Presentation

- In addition to addressing fundamental questions about the Medicaid program such as...
 - How much are we spending?
 - For whom?
 - For what? and
 - How has that changed?
- ...this presentation will detail budget strategies that the Commonwealth and other states have used to restrain the growth of Medicaid spending.
- The presentation will also touch on some of the Medicaid budget reduction strategies currently circulating on Capitol Hill.



What is Medicaid?

- Medicaid is often described as three programs in one:
 - It's a **health care program** for low-income Virginians, primarily children and families and pregnant women, that is similar to commercial health insurance;
 - It's a **long-term care program** for the elderly and disabled for which there are few private payors;
 - Medicaid pays for nursing home care, state intellectual disability training centers, and home- and community-based waivers.
 - It's a **cost-sharing program** for low-income Medicare beneficiaries (i.e., dual eligibles) for which there is no private market.
- In Virginia, Medicaid also:
 - Subsidizes providers that serve a high-volume of low-income recipients; and
 - Funds intensive, community-based mental health services for adults and children.



Who is eligible for Medicaid?

States Participating in Medicaid Must Serve Certain Low-income Populations

Children and family members

Pregnant women

Aged, blind, and disabled

Certain low-income Medicare recipients

- People included within mandated groups must satisfy income and resource criteria to be eligible.

Virginia Has Chosen to Cover These Optional Populations

Individuals with high medical needs (e.g., spenddown)

Persons “at risk” of placement in nursing home or ICF-ID*

Aged, blind or disabled with income under 80% of federal poverty guidelines (FPG)

Nursing home residents with income less than 300% of supplemental security income (221% of FPG)

Children in foster care, private institutions or subsidized adoptions

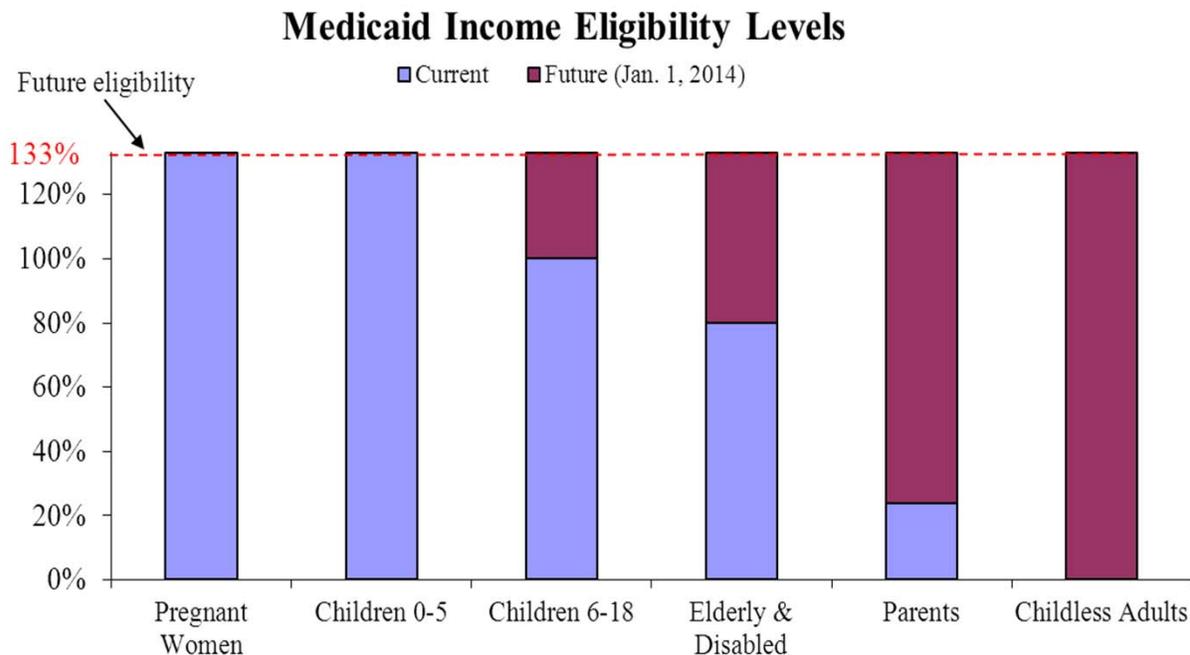
Women screened & diagnosed for breast or cervical cancer

* Intermediate care facility for persons with intellectual disabilities.



Who is eligible for Medicaid after January 1, 2014?

- The Patient Protection and Affordable Care Act creates a floor for Medicaid coverage at 133 percent of poverty (\$29,726 for a family of four).
- An additional 348,489 Virginians are expected to enroll in Medicaid, including 48,724 children who are currently eligible but not enrolled in the program.
 - The state will be financially responsible for the above-mentioned children at the current match rate.
 - The state share of the expansion is zero through FY 2016 and then rises to 10 percent in FY 2021.



What services are provided?

- States participating in Medicaid are **required** to:
 - Pay for acute health care services (e.g., hospital care, physician treatment, and laboratory and x-ray services);
 - Fund certain long-term care services (e.g., nursing homes); and
 - Make premium payments and cost-sharing for low-income Medicare recipients.
- States may choose to provide services not mandated by federal law with prior approval.

Optional Medicaid Services in Virginia

Prescription drugs

Home- and community-based waiver services

Intermediate care for people with intellectual and developmental disabilities

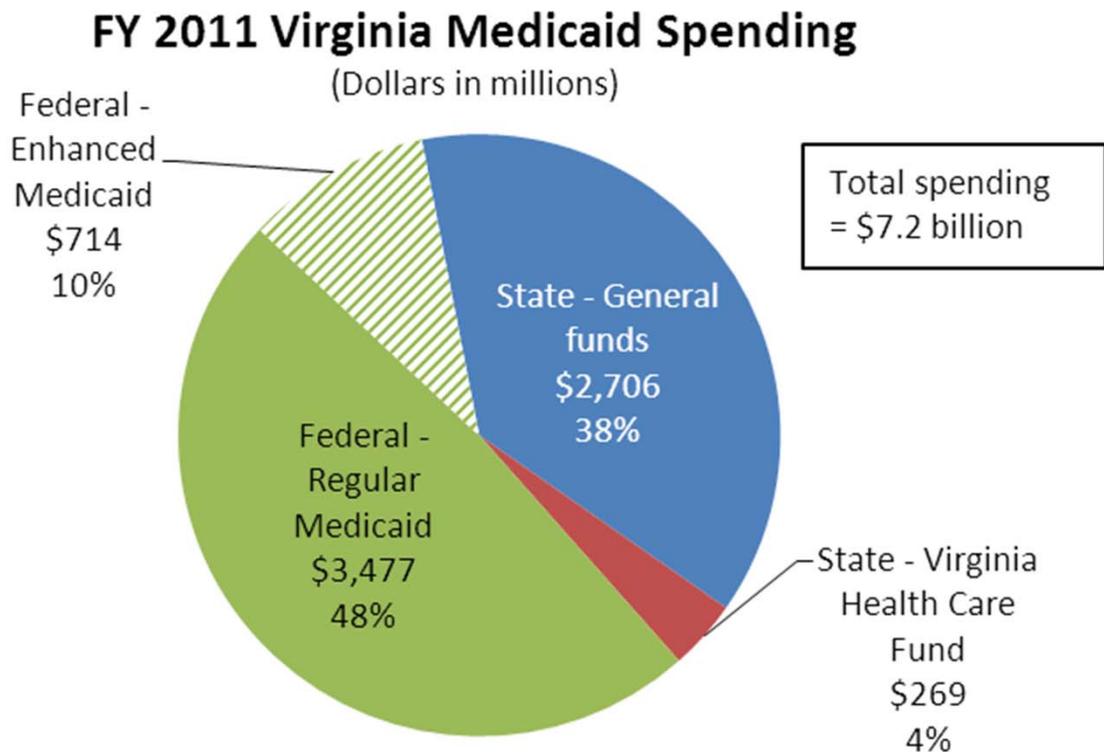
Outpatient mental health services

** Italics denotes fast-growing program or service.*



How much are we currently spending on Medicaid?

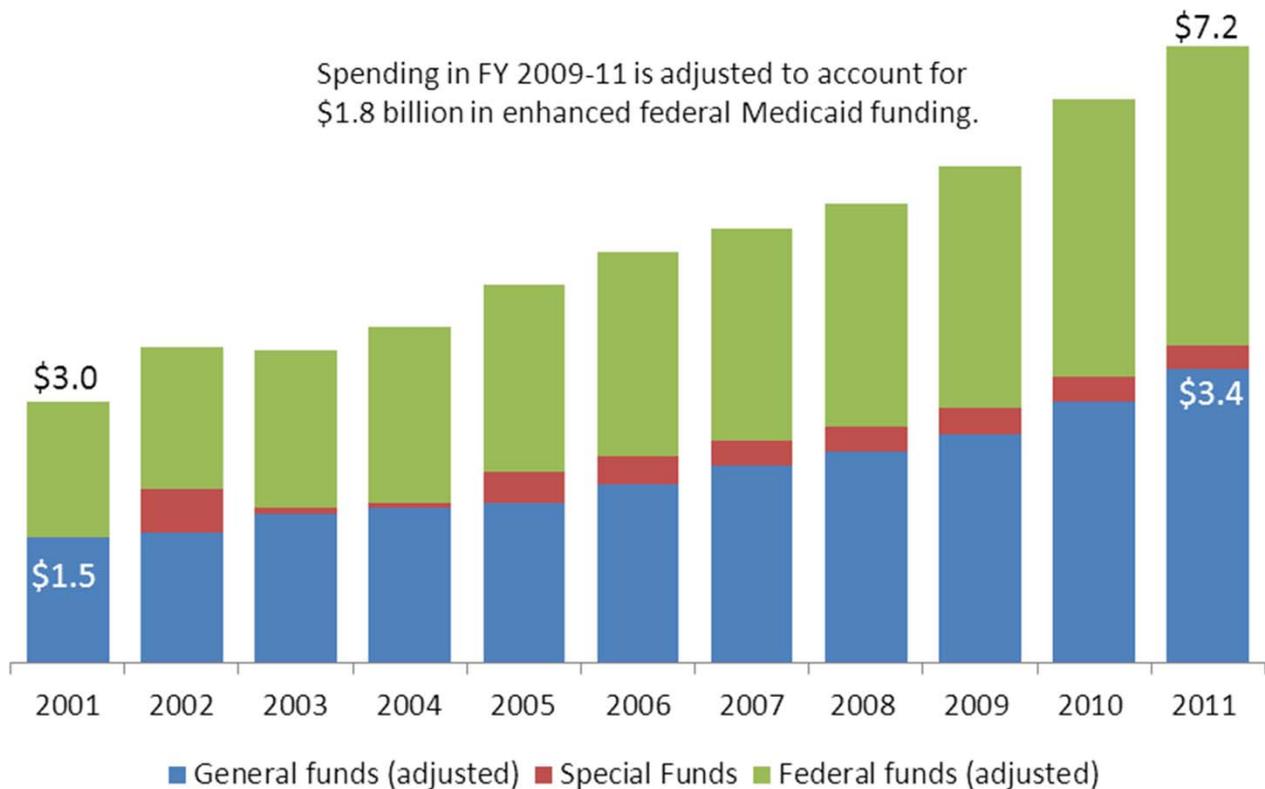
- The federal share of Medicaid ranges from 50 to 75 percent based on a state's per capita income compared to the national average.
- Virginia receives 50 cents from the federal government for each dollar spent in Medicaid.
 - In FY 2011, the federal share was temporarily increased to 59.7 percent, allowing the state to lower its funding commitment to the Medicaid program.



How much has Medicaid grown?

- Adjusted for one-time federal stimulus dollars in fiscal years 2009 - 2011, general fund spending on Medicaid increased by \$1.9 billion in a decade.
 - Expenditures have increased at an average annual rate of 9.0 percent.

Medicaid Services Expenditures by Fiscal Year
(Dollars in millions)

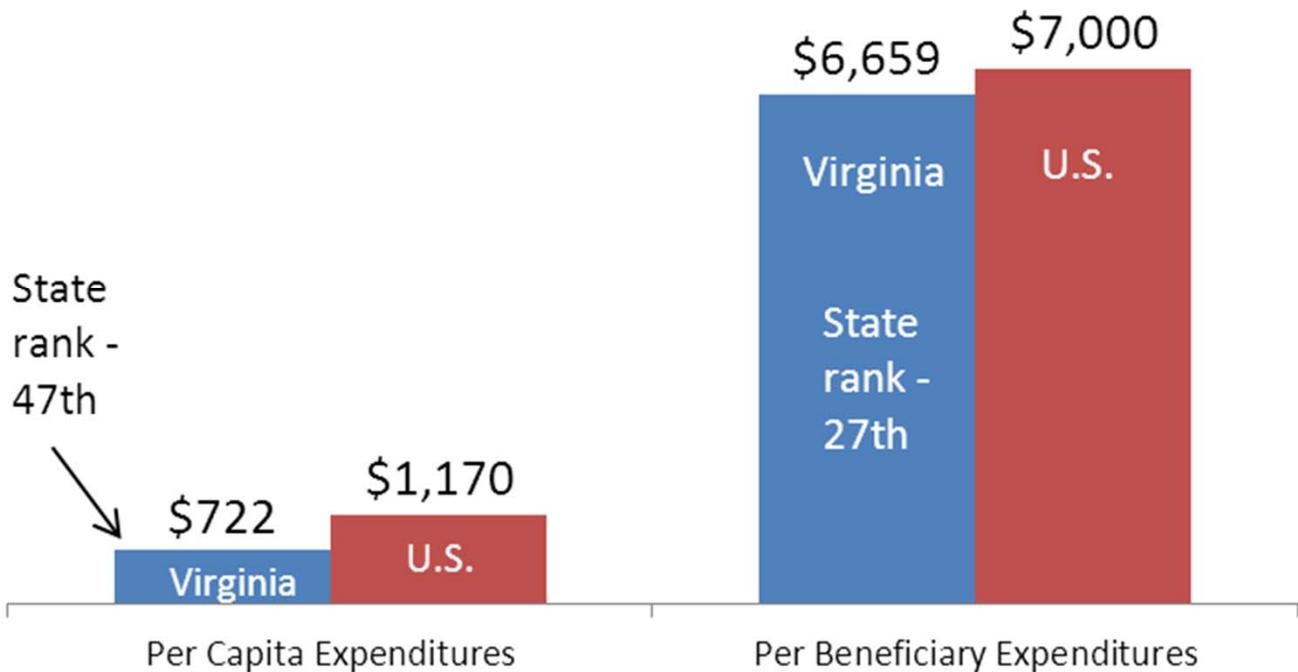


How does Medicaid spending in Virginia compare to other states?

- The Commonwealth ranks among the lowest spending states in terms of per capita Medicaid expenditures.
- Medicaid spending per beneficiary is slightly below the U.S. average.

National Comparison of Medicaid Expenditures

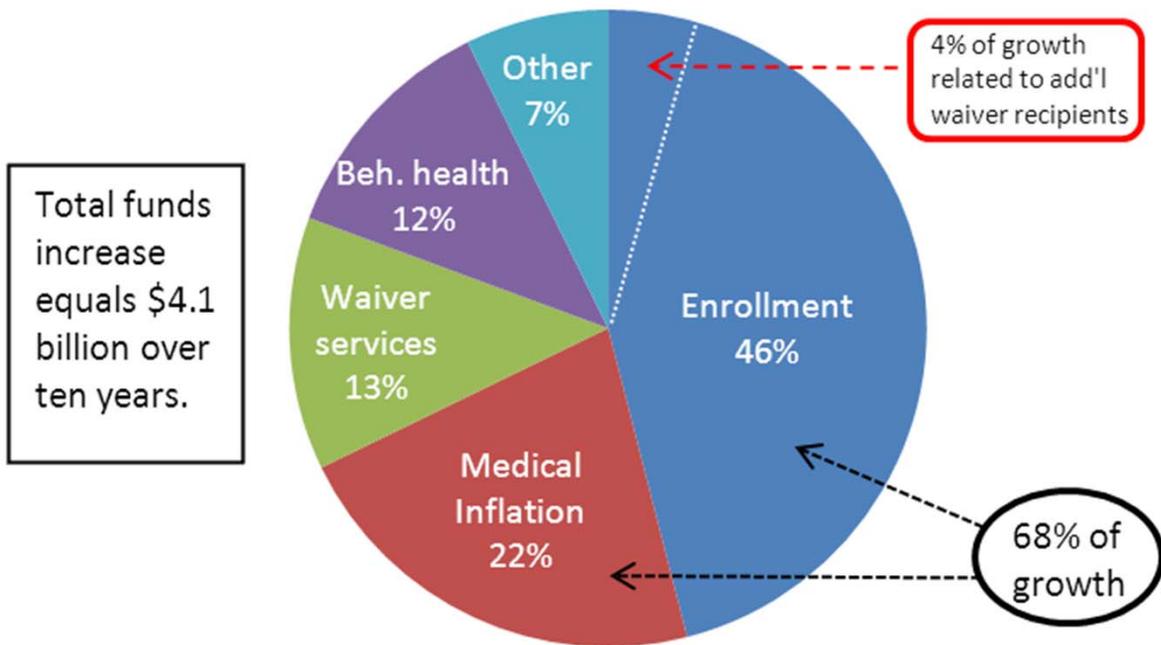
(Based on FY 2009 data)



Why has Medicaid spending grown?

- With the exception of the ID waiver program, eligibility expansions have been minimal.
- Provider rate increases have largely been rolled-back through budget reductions.
- **Enrollment** and **medical inflation** explain 68 percent of the increase in Medicaid.

Explanation of Medicaid Growth Since FY 2001



How has enrollment grown from FY 2001 to FY 2011?

- Enrollment growth accounts for 46 percent (\$1.9 billion in total funds) of the increase in Medicaid spending in the last ten years.
- The average number of children enrolled in Medicaid grew nearly 3.5 times faster than that of the elderly and disabled, but the cost of coverage was virtually identical.

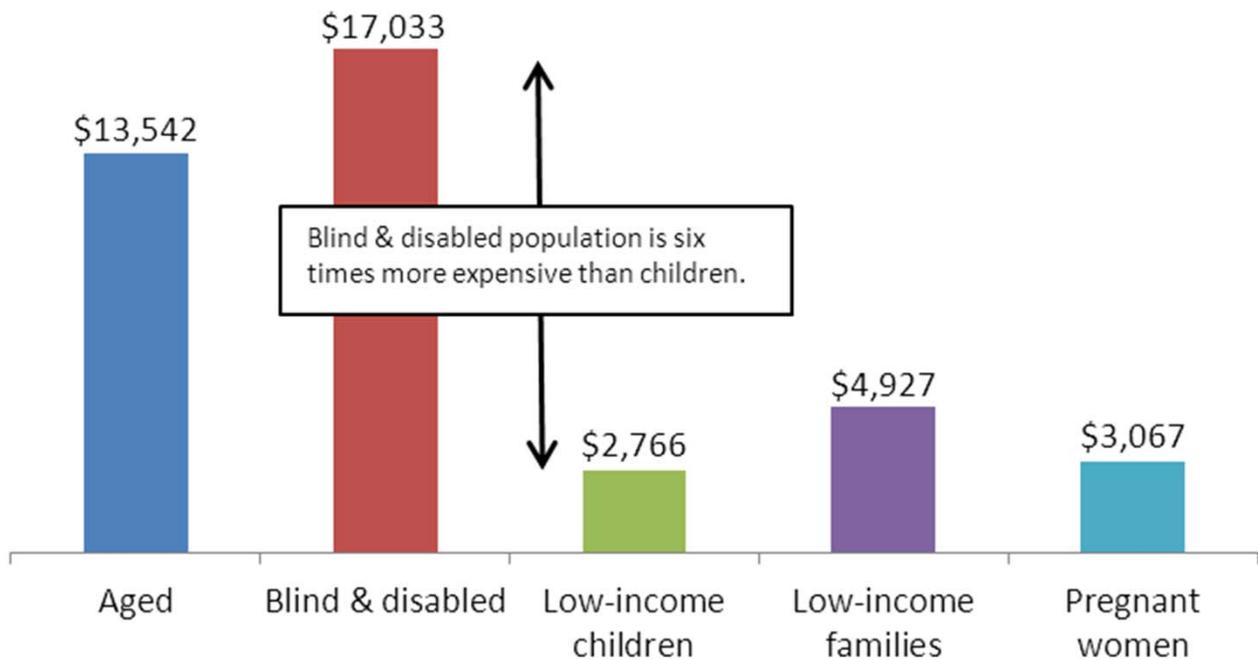
Recent Enrollment Trends in Medicaid			
<u>Population</u>	<u># of enrollees</u>	<u>% of growth</u>	<u>\$ in millions</u>
Children	208,670	64%	\$887.2
Pregnant Women/ Adults	57,490	18%	\$337.6
Elderly & Disabled	60,204	18%	\$880.6
TOTAL	326,364	100%	\$1,863.4



What is cost of serving different Medicaid populations?

- The aged, blind, and disabled have more intensive and expensive health and long-term care needs compared to children and families.
 - Children and families tend to use health care for routine physician visits or emergency room care.

Medicaid Expenditure By Recipient Type (FY 2011)

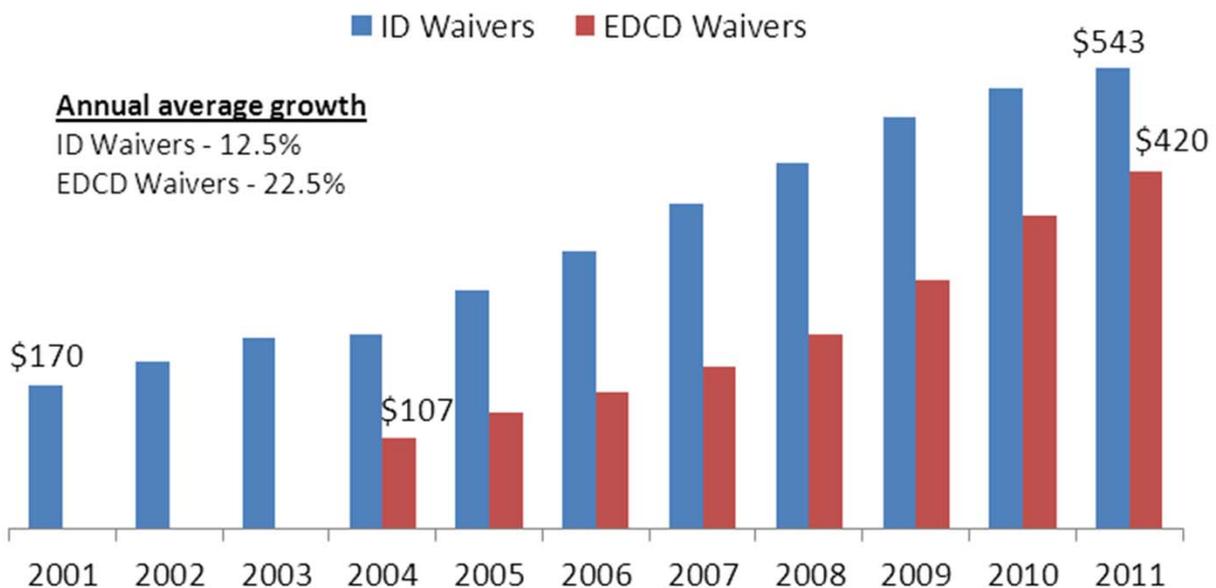


What else is contributing to rising Medicaid costs?

- Enrollment and utilization (i.e., intensity of services) of home- and community-based waiver services added \$890 million in total costs to Medicaid in the past decade.
- Most of the increase can be attributed to the intellectual disability and elderly and disabled with consumer-direction (EDCD) waiver programs.

Home & Community-based Waiver Costs

(Dollars in millions)

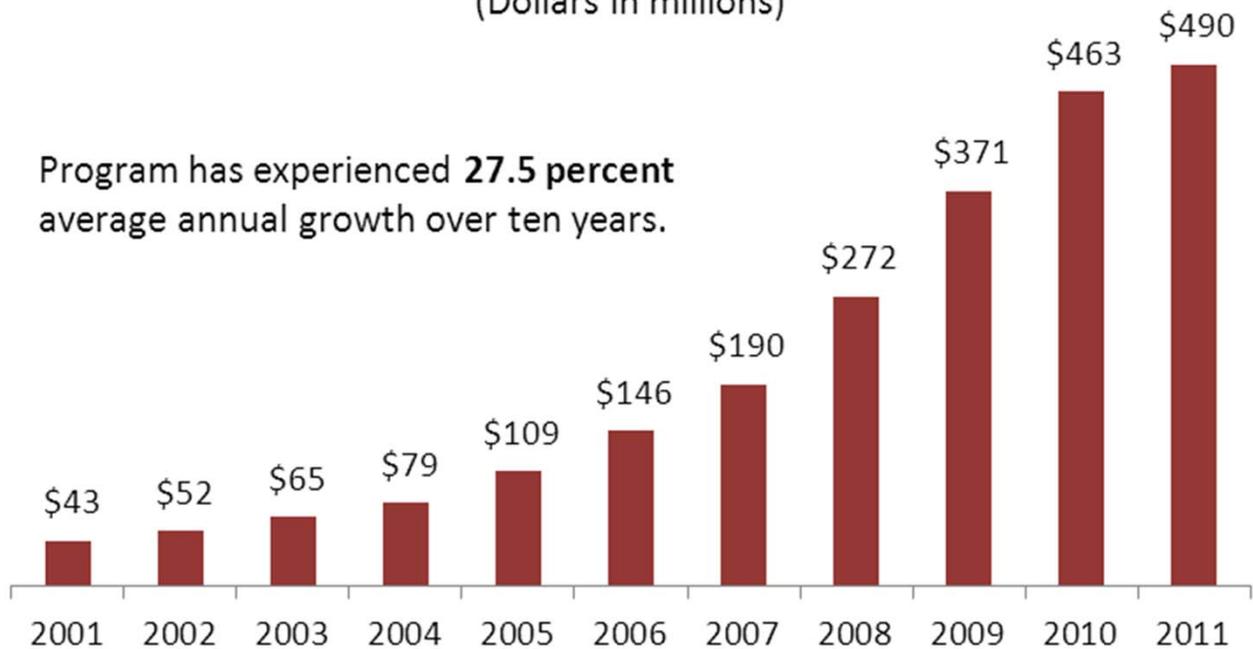


Are there any other areas of Medicaid growth?

- Outpatient mental health services including intensive in-home and therapeutic day treatment has increased more than ten-fold.
 - Clarifying federal guidance, the influx of new providers, and the lack of oversight and program controls all contributed to the growth.

Outpatient Mental Health Services Expenditures

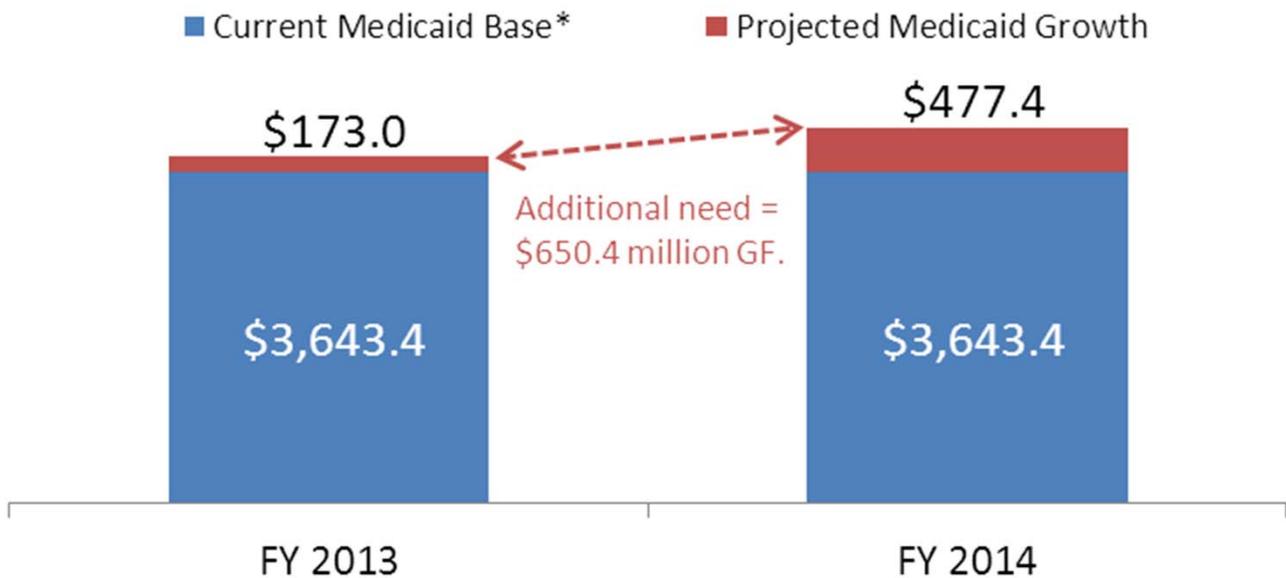
(Dollars in millions)



How much is needed for Medicaid in FY 2012-14?

- The Medicaid forecast projects the estimated cost (or savings) of providing health and long-term care services to eligible recipients based on current law.
 - This forecast does not include funding for 467 intellectual and developmental disability waiver slots each year as required by the *Code of Virginia*.

2011 General Fund Medicaid Forecast



* The Current Medicaid Base includes a base adjustment of \$131.6 million each year to restore general funds for Medicaid that were shifted from FY 2011 to FY 2010.



What accounts for the change in the Medicaid forecast?

- Less funding is needed in FY 2012 (\$85 million savings) due to lower Medicaid managed care payment rates and higher pharmacy rebates.
- An additional \$650.4 million GF will be needed to fully fund projected growth in the program for the 2012-14 biennium.
- Projected **Medicaid increases** are related to:
 - Enrollment (including “woodwork effect”);
 - Utilization and medical inflation;
 - Fast-growing, home- and community-based waiver and behavioral health services; and
 - Restoration of foregone inflation adjustments for nursing facilities and hospital services.
- **Medicaid savings** are estimated for the expansion of managed care to Roanoke, southwest Virginia and behavioral health services.

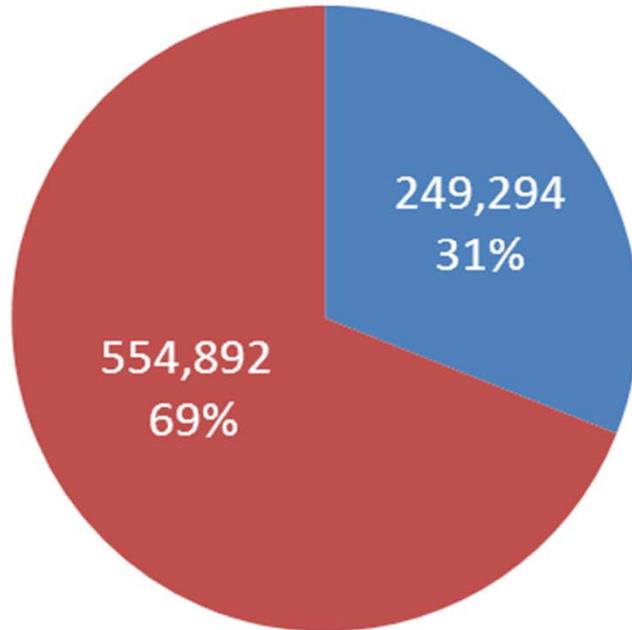


Who is currently enrolled in Medicaid?

- On any given month in FY 2011, 804,000 Virginians were enrolled in Medicaid.
 - More than two-thirds of Medicaid enrollees are low-income adults, pregnant women or children.
 - Thirty-one percent of Medicaid enrollees are individuals who are aged, blind or disabled.

FY 2011 Average Monthly Medicaid Enrollment

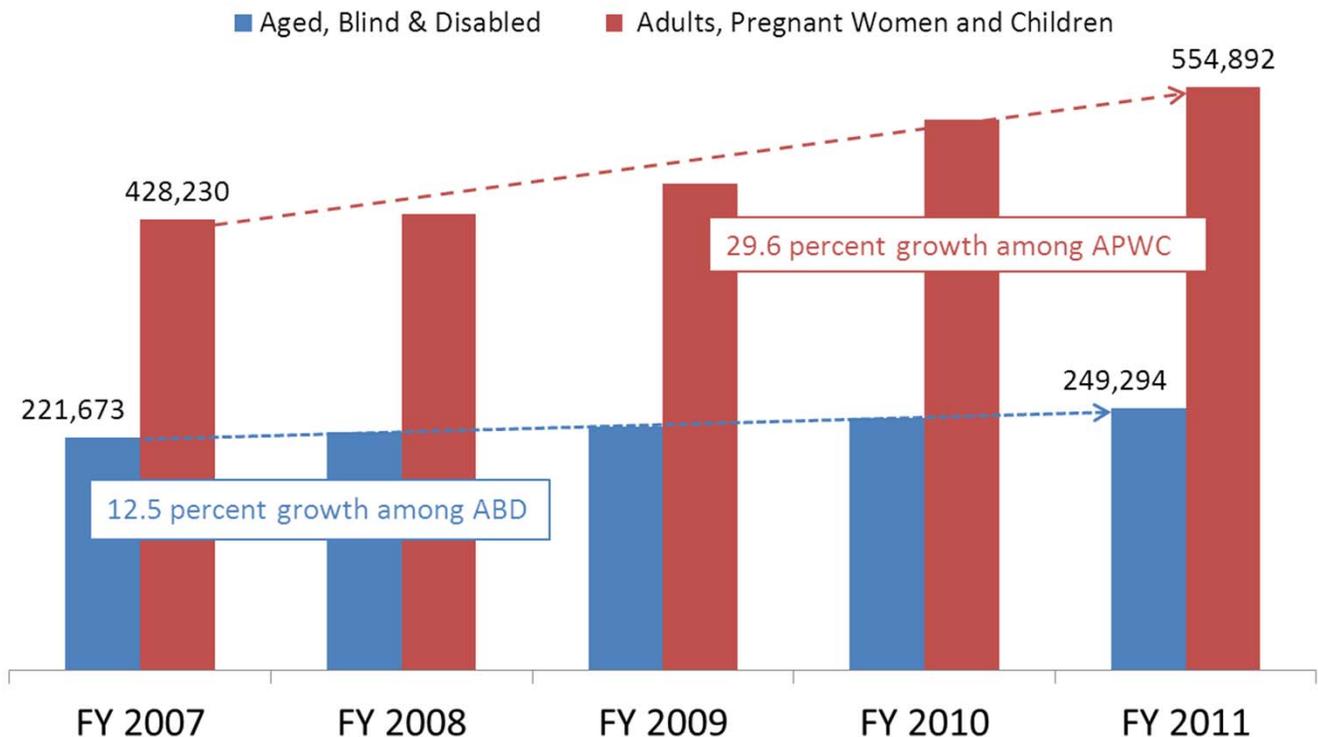
■ Aged, Blind & Disabled ■ Adults, Pregnant Women and Children



How has enrollment changed in recent years?

- Enrollment among populations that are more sensitive to economic conditions (i.e., low-income adults, pregnant women and children) began to accelerate in FY 2009.
- Growth among the aged, blind and disabled was less pronounced in the past four years.

Recent Medicaid Enrollment

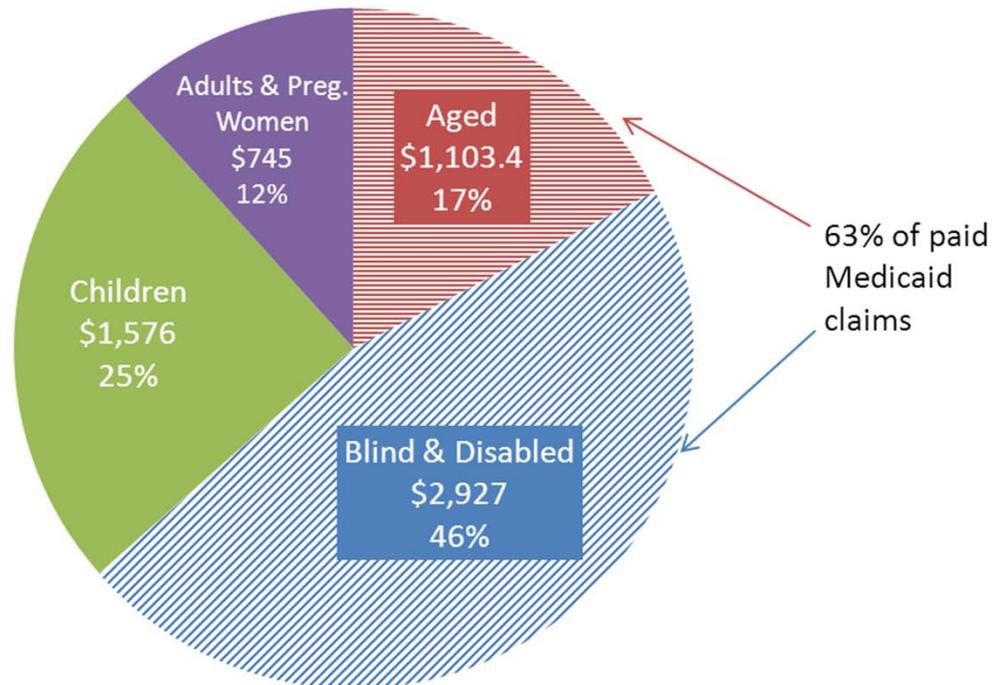


How much do we spend on Medicaid recipients?

- In 2011, 63 percent of Medicaid claims were paid on behalf of recipients who were aged, blind or disabled.

FY 2011 Medical Claims by Population (*)

(Total dollars in millions)



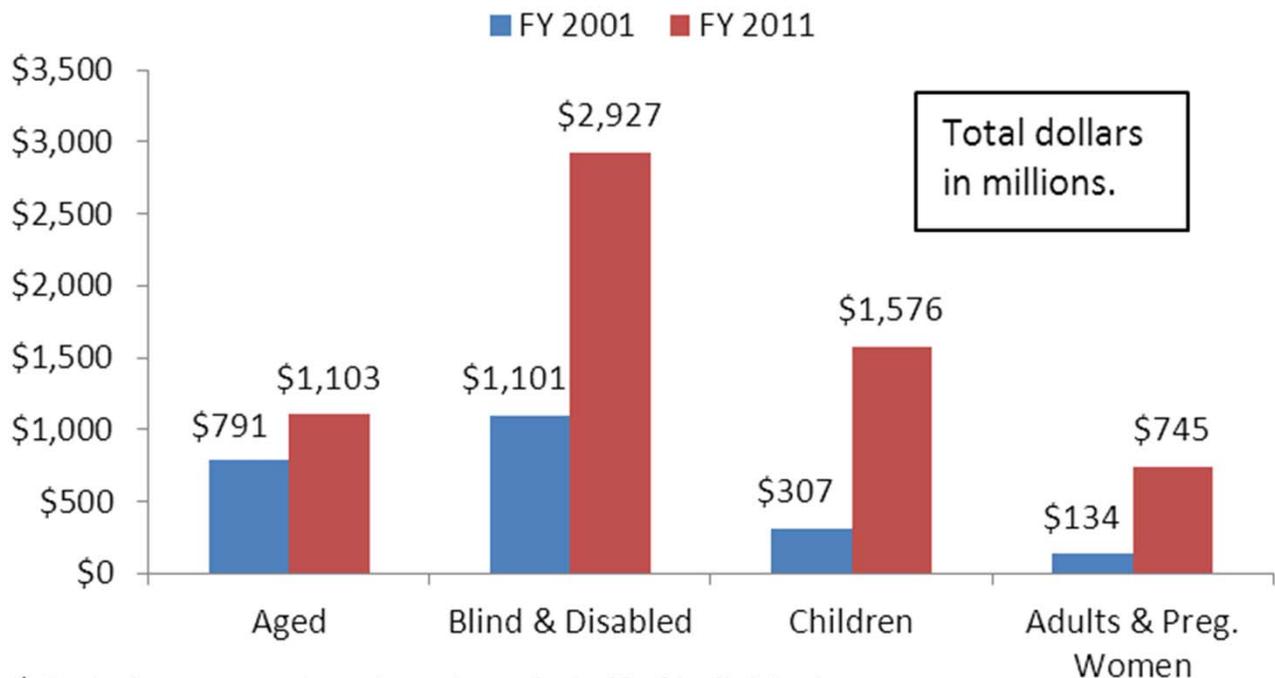
* Excludes Medicaid claim payments not attributable to individual recipients.



How has spending on Medicaid recipients changed?

- Spending on the blind and disabled, including home- and community-based waiver services, increased by \$1.8 billion in a decade.
 - Children’s services expenditures also grew at a healthy rate over this period, reflecting in part the growth of mental health treatment.

Change in Medicaid Expenditures by Population*

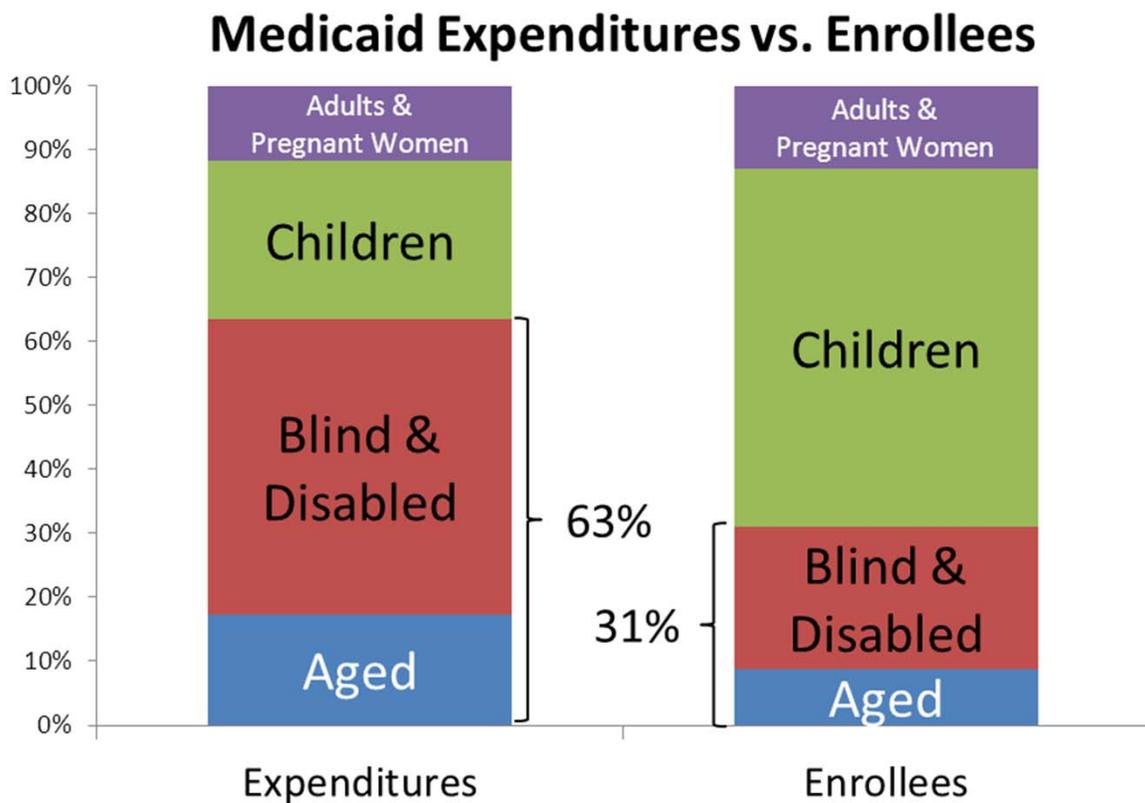


* Excludes payments not made on behalf of individuals.



Most Medicaid resources are consumed by a few recipients

- While the aged, blind and disabled make up 63 percent of spending they represent only 31 percent of Medicaid enrollees.
- National data suggests that 50 percent of Medicaid spending is made on behalf of 5 percent of Medicaid recipients.
- These facts present challenges and opportunities.

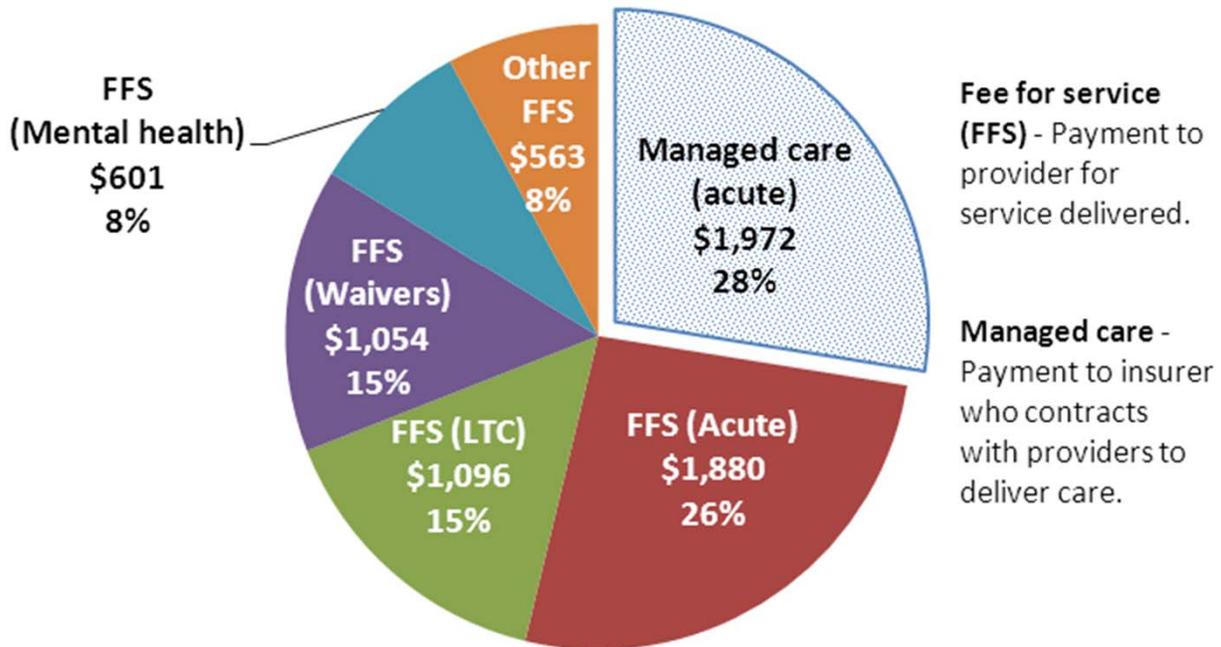


Where is the opportunity among high-cost Medicaid populations?

- Seventy-two percent of Medicaid services are paid for through fee-for-service arrangements.
- The coordination of acute and long-term care services for Medicaid recipients who are elderly, disabled or chronically ill may improve quality and slow rising costs.

Medicaid Managed Care and Fee For Service

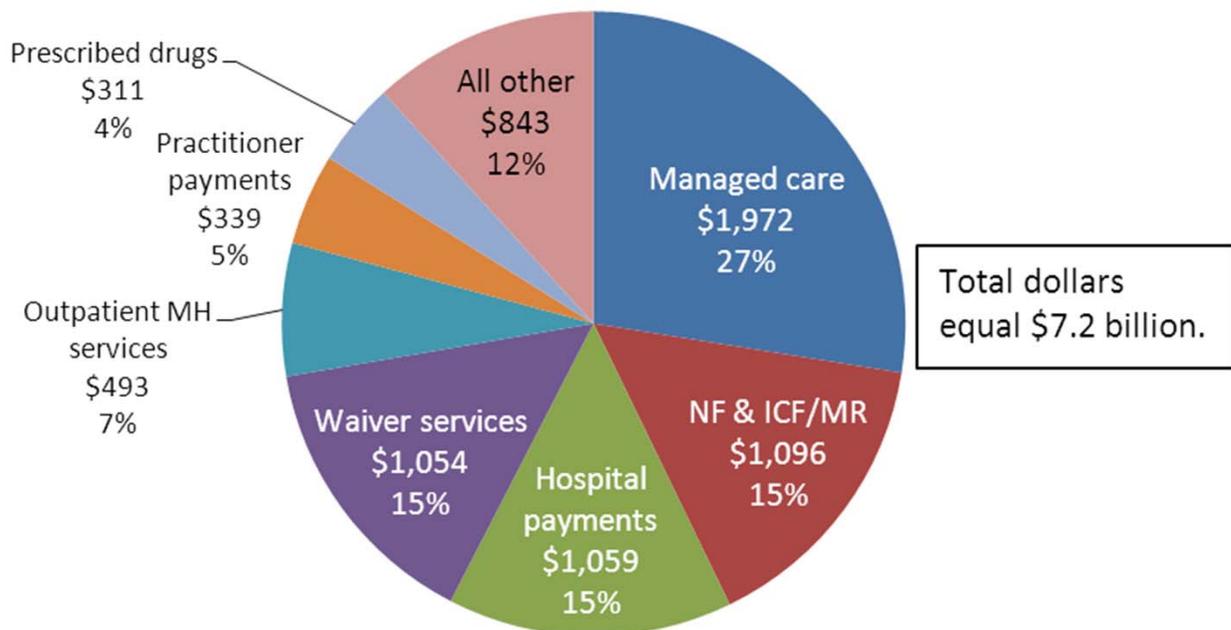
(Dollars in millions)



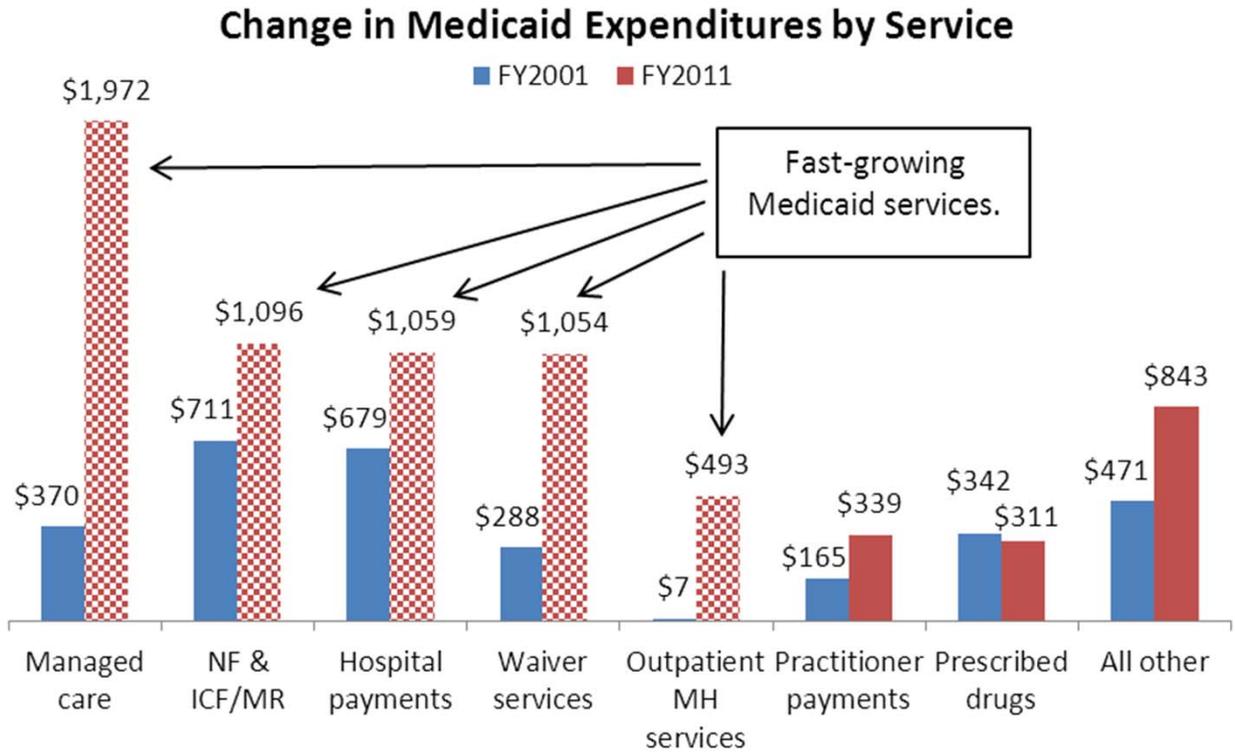
How much do we currently spend on Medicaid services?

- Four payment categories accounted for 72 percent of Medicaid expenditures in FY 2011.
- Managed care payments are distributed across acute health care categories like hospital services, physician payments and prescribed drugs.

FY 2011 Medicaid Expenditures by Service



How has spending changed in the past decade?



Explanation of Fast-Growing Medicaid Services

Service	State Policy decision	Enrollment	Utilization
Managed care	X	X	X
Nursing facility & ICF/MR			X
Hospital payments		X	X
Waiver services	X	X	X
Outpatient mental health		X	X

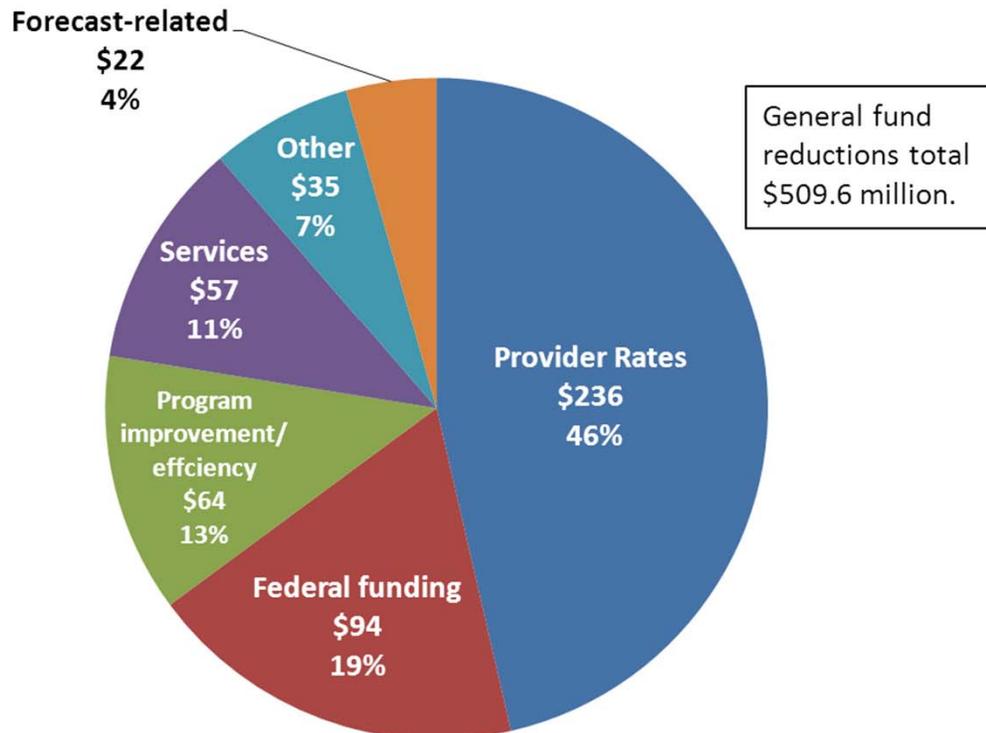


What has been done to control rising Medicaid costs?

- While general fund spending on Medicaid has increased, numerous budget reductions strategies have been employed to reduce \$509.6 million GF from the program this biennium.
 - Reductions to provider rates account for 46 percent of Medicaid reductions in 2010-12.

2010-12 Medicaid Budget Reductions

(Dollars in millions)



Primary Medicaid budget reduction strategy is probably temporary

- Reducing provider rates is best viewed as a short-term budget strategy.
 - There may be adverse consequences from continuously underpaying Medicaid providers.

Consequences of Sustained Provider Rate Reductions

Quality providers may walk away

Access to care may be denied

Recipients may choose more expensive care options

- Some providers such as nursing homes and home- and community-based waiver operators are more reliant upon Medicaid.
 - There is limited private funding for these services.
- Providers will be needed to deliver services to the new Medicaid expansion population.



What budget reduction strategies may bend the cost-curve?

- Managed care, which is based on paying an insurer a fixed monthly payment to deliver benefits to eligible enrollees, is expanding:
 - To the last regions of the Commonwealth that are paid on a “fee-for-service” basis; and
 - To populations that have not traditionally been enrolled in managed care.

New Care Coordination Populations

Children in foster care (City of Richmond pilot)

Home and community-based waiver recipients (acute and medical care only)

Low-income Medicare recipients (i.e., dual eligibles)

Individuals receiving behavioral health services

- Improving oversight of high-growth budget areas such as community-based mental health services where “independent clinical assessments” are now required before services are provided.



How have other states reduced Medicaid spending?

- States are using multiple strategies to slow the growth of Medicaid spending.

State Medicaid Budget Reduction Strategies in Recent Years	FY 2011	FY 2012	VA
Reduced provider rates	39	46	Yes
Imposed or increased provider taxes to generate federal revenue	17	26	Yes
Eliminated, reduced or restricted Medicaid benefits	18	18	Yes
Established specialty drug programs	7	19	Yes
Imposed or raised copayment requirements incl. pharmacy and ER visits	5	14	No
Utilization controls and service limits for home and community-based services and institutional services	14	11	Yes
Source: 2011 Survey of State Medicaid Directors			



What will Supercommittee decide to do on Medicaid?

- There is considerable uncertainty and very little detail about federal Medicaid budget proposals.
 - A one percent reduction in the federal Medicaid match rate translates into a two percent general fund impact or \$72 million (i.e., **cost shift**).
 - A one percent reduction in Medicaid spending translates into **cost savings** of \$36 million GF.

Proposal	Pros	Cons
Blended match rate	Combined match rate/enhanced rate during recessions	Probable lower match rate for state
Limit provider taxes	None to the state	Less revenue to state
Repeal federal health care reform	- No cost for expanded coverage	- No coverage for uninsured
Convert Medicaid to a block grant	- State determines covered services and populations - Predictable funding	- State determines covered services and populations - Funding may not be enough to address cost trends



Conclusion

- While Medicaid enrollment appears to be slowing, spending will remain steady through the next biennium.
- Medicaid is three programs in one that requires participating states to cover certain populations and deliver specific services.
- Enrollment growth and medical inflation are driving spending in Medicaid.
- The intellectual disability waiver program and outpatient mental health services are among the fastest growing areas of Medicaid.
- Provider rate reductions account for almost half of recent Medicaid savings.
- Newer models to better manage the care of certain populations hold promise for “bending the cost curve.”
- While federal budget reductions to Medicaid remain unknown they are likely to be significant.



Appendix I: Mandatory Services

Mandatory Medicaid Services

Inpatient, outpatient and emergency hospital

Physician and nurse midwife

Federal qualified health centers/rural health clinic

Laboratory and x-ray

Transportation

Family planning and supplies

Nursing facility

Home health (e.g., nurse, aide)

Early and Periodic Screening, Diagnosis, and Treatment program for children (EPSDT)



Appendix II: Optional Services

Optional Medicaid Services in Virginia

Certified pediatric nurse and family nurse practitioner

Routine dental care for persons under age 21

Prescription drugs

Rehabilitative Services (i.e., PT, OT, and SLP)

Home health (e.g., PT, OT, and SLP)

Hospice

Mental health services

Substance abuse services

Intermediate care facilities for persons with DD/ID and related conditions

