

SENATE OF VIRGINIA

Senate Finance Committee

Medicaid Overview and DOJ Compliance for 2016

November 20, 2015



Presentation Overview

Topics covered in this presentation:

- Overview of Virginia Medicaid;
- Medicaid Trends and Cost Drivers;
- 2015 Medicaid Forecast and Medicaid Reforms; and
- DOJ Compliance and Medicaid Waiver Redesign.



Overview of Virginia Medicaid

- Medicaid is a shared state/federal program to provide health insurance for certain low-income groups.
- Traditionally, enrollment has been linked to individuals receiving cash assistance.
- Medicaid is essentially four programs:
 - Health insurance for low-income parents and children.
 - Complementary insurance for low-income seniors on Medicare.
 - Health insurance for low-income disabled individuals.
 - Largest payer of nursing home care.
- Medicaid is not Medicare, which is a purely federal program that provides health insurance to all Americans beginning at age 65.



Four Primary Groups are Eligible for Medicaid

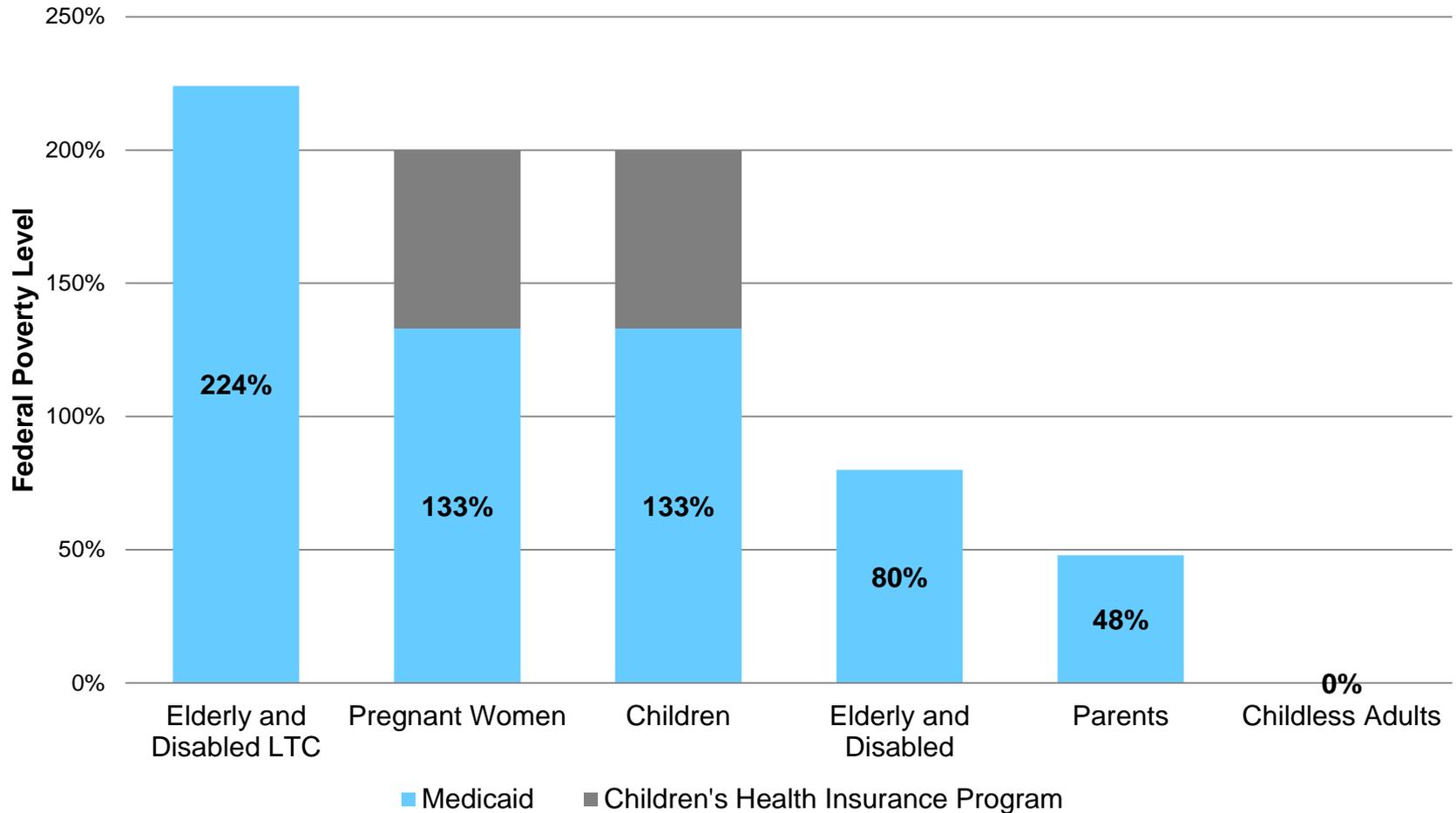
Group	Financial Requirements	Non-Financial	Asset Limits
Children	133% of Poverty	Citizenship and Residency	None
Pregnant Women	133% of Poverty	Citizenship and Residency	None
Aged, Blind or Disabled	80% of Poverty or 300% of SSI for Long-Term Care*	Citizenship and Residency	\$2,000 Individual / \$3,000 Married
Low-Income Parents	24-48% of Poverty	Citizenship and Residency	None

2015 Federal Poverty Limits				
Family Size	80%	100%	133%	200%
1	\$9,416	\$11,770	\$15,654	\$23,540
4	\$19,400	\$24,250	\$32,253	\$48,500

* Supplemental Security Income (SSI) is \$766 per month for an individual.

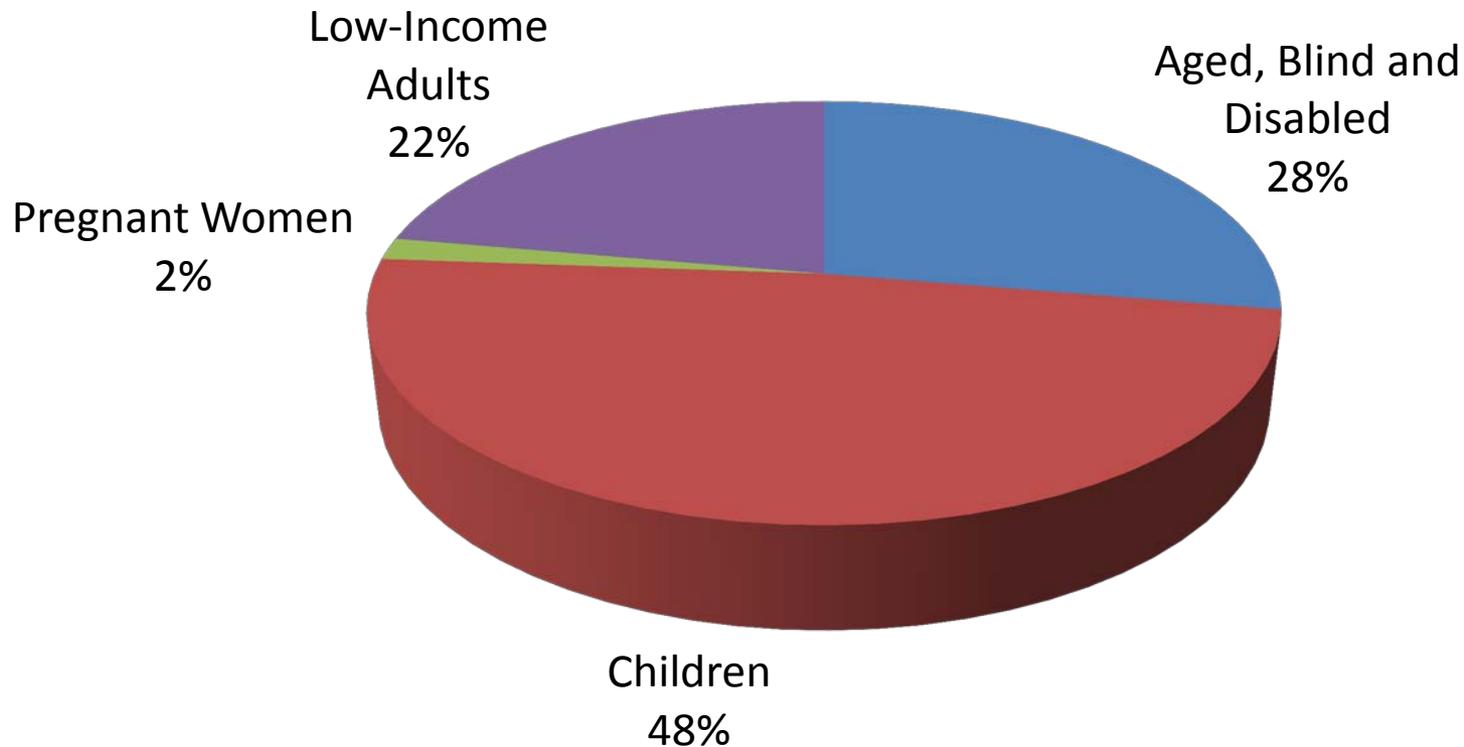


Income Requirements for Medicaid Vary by Group



Current Medicaid Enrollment

November 1, 2015
Enrollment = 992,971



Virginia Medicaid Services

Federally Mandated Services*	Optional Services
Inpatient and Outpatient Hospital	Other Clinics (i.e. ambulatory surgical centers)
Physician	Other Practitioners (i.e. Optometry)
Lab, Imaging and Screening	Dental for Children
Community Health Centers	Rehabilitation Services
Rural Health Clinics	Prescription Drugs
Home Health	Prosthetic Devices
Family Planning	Hospice
Nurse-midwife	Community Mental Health/Clinics/Clinical Psychologist
Nursing Facility	Intellectual Disability Services
Transportation	Inpatient Psychiatric for Children
	Home and Community-Based Waivers

* The Medicare Savings Program is also mandated and requires the state to pay Medicare premiums and deductibles for certain lower-income elderly beneficiaries.



What is a Home and Community-Based Waiver?

- Allows exceptions to normal Medicaid rules, for example, to cap enrollment (which is why we have waiting lists) or limit services to a certain region of a state.
- Virginia has six home and community-based waivers to prevent individuals from entering institutional settings:
 - Nursing facility alternative:
 - Elderly or Disabled
 - Alzheimer's Assisted Living
 - Intermediate Care Facility alternative:
 - Intellectual Disability (ID)
 - Individual and Family Developmental Disabilities and Support (DD)
 - Day Support (provides limited services to individuals on ID waiting list)
 - Hospital alternative:
 - Technology Assisted



Summary of Virginia Medicaid Home and Community – Based Waivers

October 2015 Waiver Enrollment = 44,336

	Elderly and Disabled	Intellectual Disability	Developmental Disability	Technology Assisted	Day Support	Alzheimer's
Approved Slots	No cap	10,717	1,053	513	300	200
Current Enrollment	32,386	10,335	999	287	272	57
Wait List	-	8,123	2,118	-	-	-
Average Cost	\$17,614	\$68,194	\$31,290	\$81,690	\$13,957	\$11,457
FY 2015 Expenditures	\$612.1 million	\$693.8 million	\$28.6 million	\$29.7 million	\$3.8 million	\$0.8 million
Primary Services	Personal Care, Respite Care	Congregate Residential, In-Home Residential Support	Personal Care, In-Home Residential Support	Private Duty Nursing	Day Support	Assisted Living



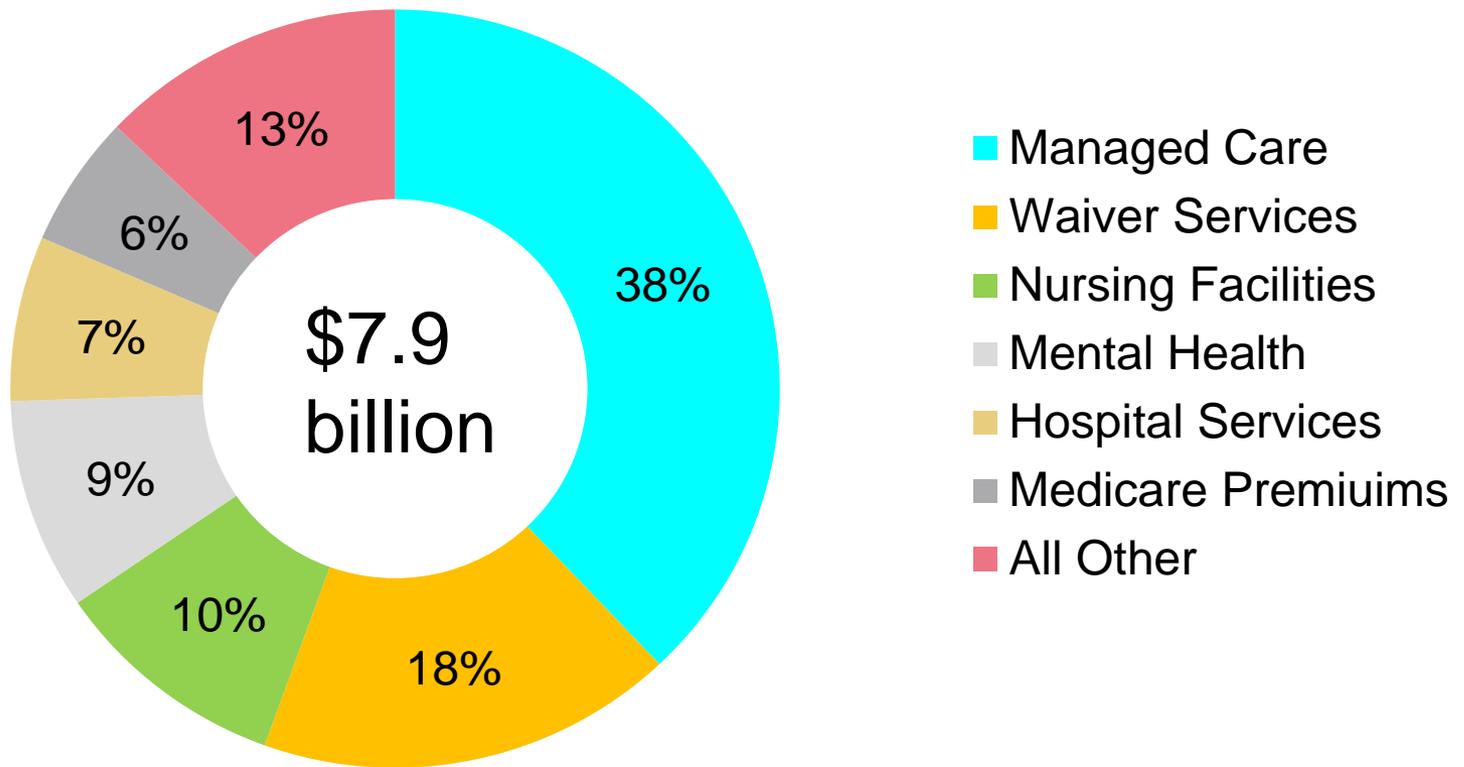
Medicaid Service Delivery System

- As of November 2015, **65%** of Medicaid enrollees are enrolled in managed care.
- Since 1969, when Virginia implemented Medicaid, the state has had a traditional fee-for-service system in which the state receives and pays the claims to providers.
- In 1992, Virginia started the Medallion Program, which was a primary care case management model.
- In 1996, Virginia initiated the managed care model (Medallion II).
- By 2012, Medicaid managed care was available in every locality.
- In 2013, the program became known as Medallion 3.0, to reflect more focus on quality and value-based purchasing.



Virginia Medicaid Spending by Service

FY 2015 Expenditures (Total Funds)*

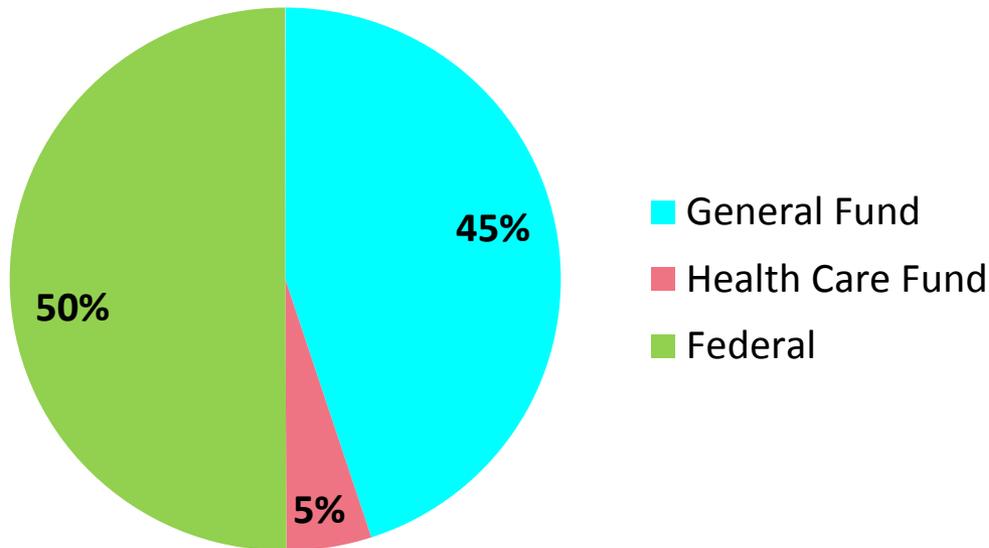


* Does not include payments to state facilities operated by the Department of Behavioral Health and Developmental Services.



Funding Sources for Medicaid

FY 2015 Source of Medicaid Funds



- Virginia's federal match rate is 50%.
- FY 2015 State Funds = \$4.1 billion
- The Health Care Fund includes tobacco taxes, Medicaid recoveries, and 41.5 percent of the revenue from the Master Settlement Agreement with tobacco companies.



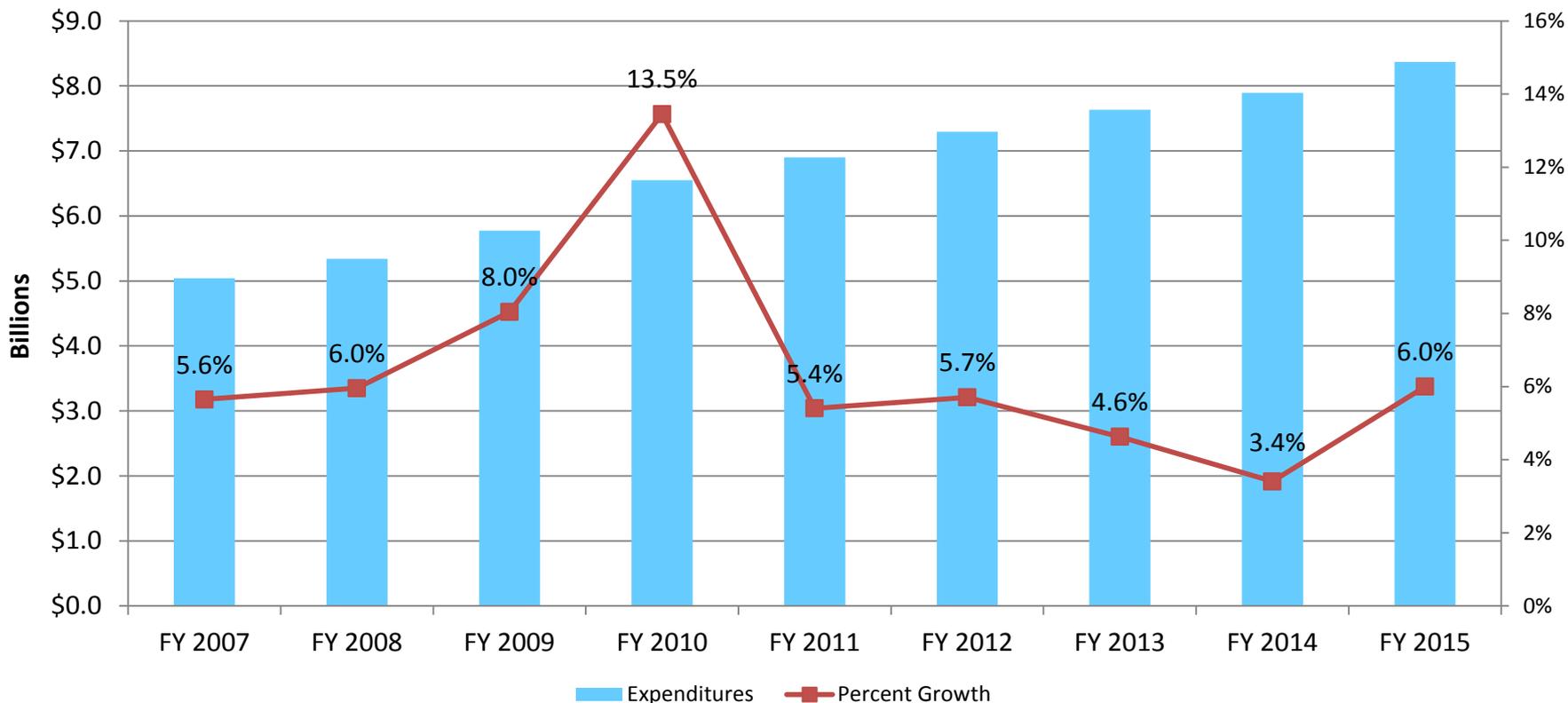
Medicaid Trends and Cost Drivers



Medicaid Expenditure Growth Has Been Modest in Recent Years

Average annual growth since FY 2007 = 6.5%

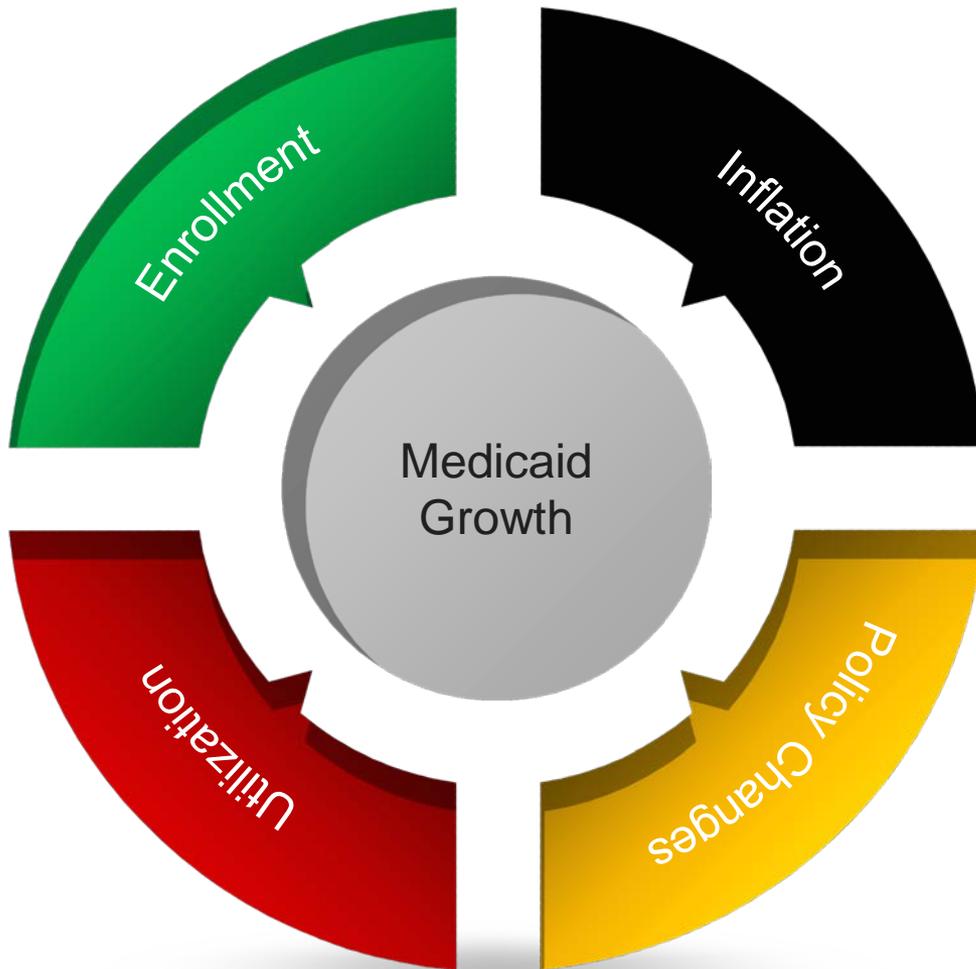
Since FY 2011 = 5.0%



Note: Expenditures in FY 2011, FY 2012, and FY 2015 have been adjusted to reflect payment shifts between fiscal years in order to better reflect realistic expenditure patterns in the program.



What drives costs in Medicaid?



Enrollment

Primary driver of higher costs.

Inflation

Impact of medical inflation.

Policy Changes

Provider rates, benefit changes, additional waiver slots, etc.

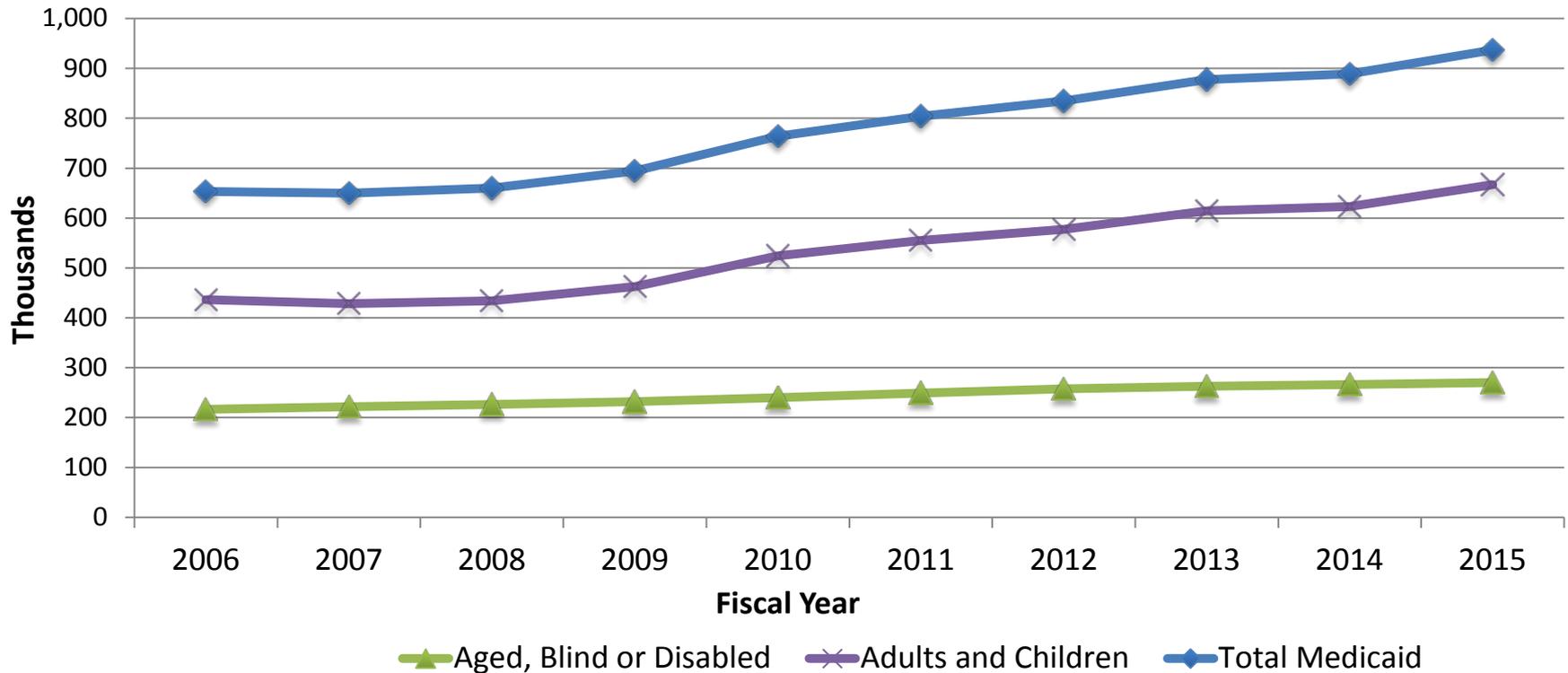
Utilization

Higher use of services.



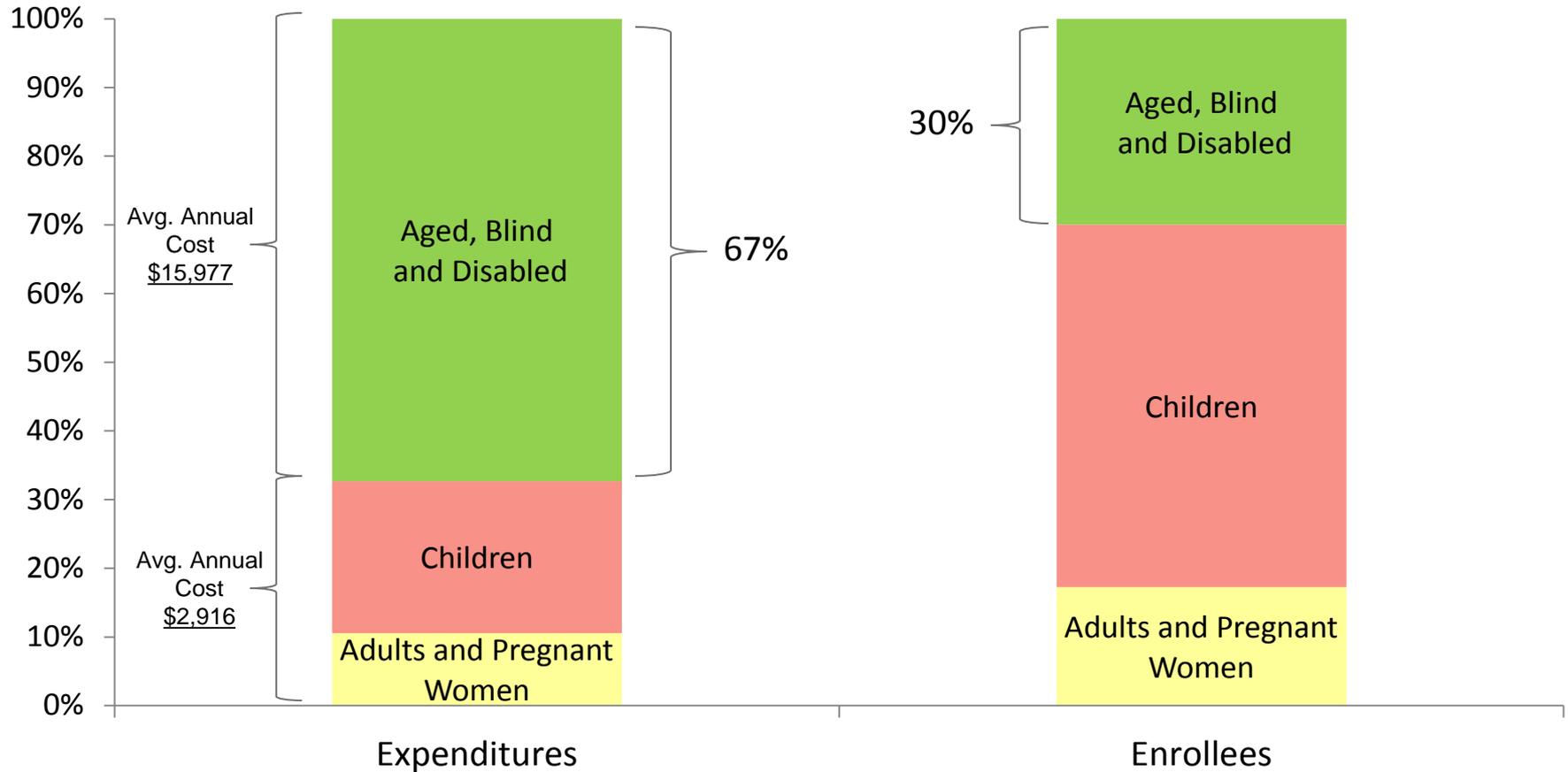
Medicaid Enrollment Trends

- Medicaid enrollment has grown 44% since FY 2006
- Average growth per year = 4.3%
- Adults and Children average was 5.1% versus 2.7% for Aged, Blind and Disabled



Aged, Blind and Disabled are the Most Costly Recipients

Medicaid Expenditures versus Enrollees

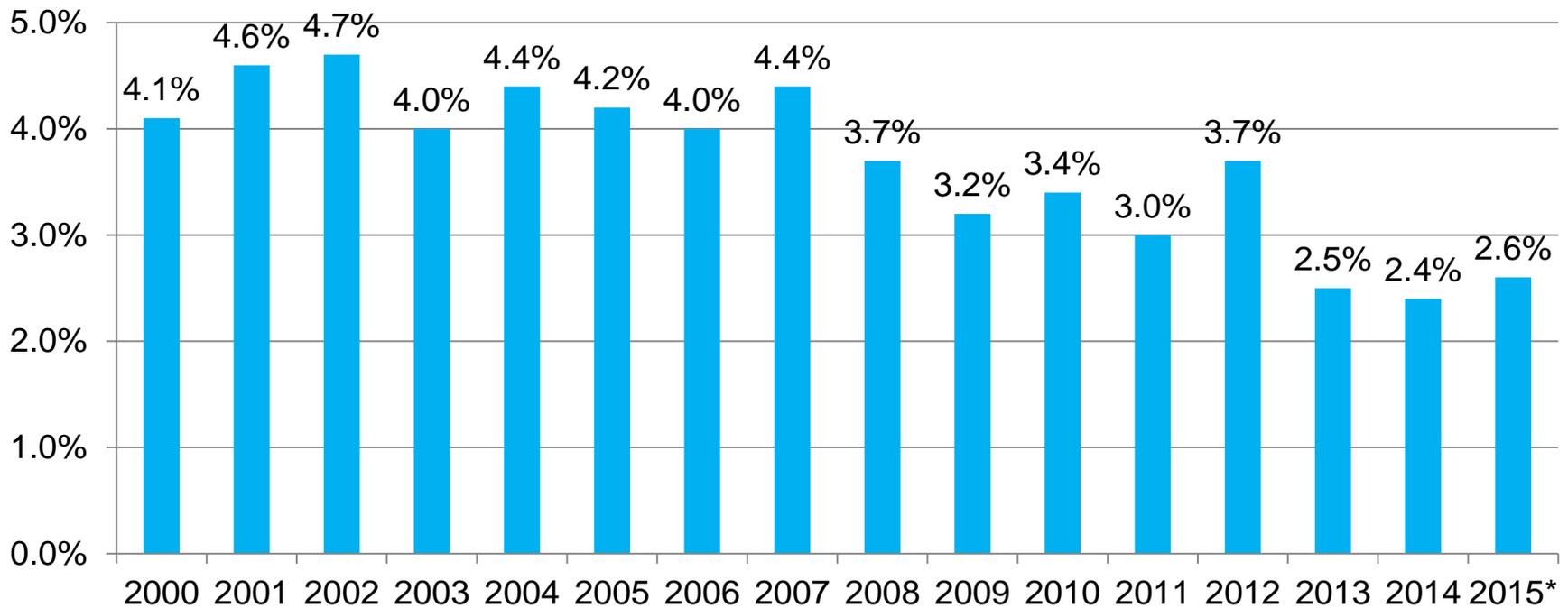


Note: Based on FY 2014 data.



Medical Inflation Has Moderated

- Medical Inflation averaged 4.2 percent prior to 2008 and since then has averaged 3.0 percent.
- Inflation is projected to begin to slowly rise over the next few years.



Source: Bureau of Labor Statistics, CPI – Medical Care.

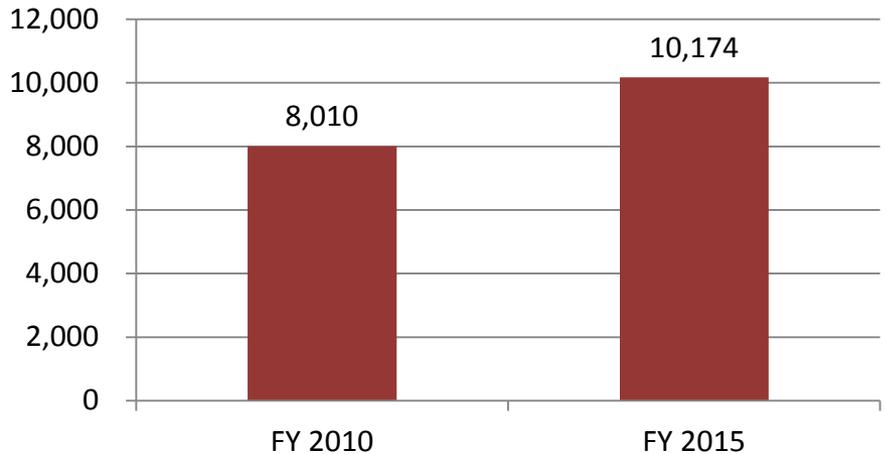
* 2015 reflects first six months only.



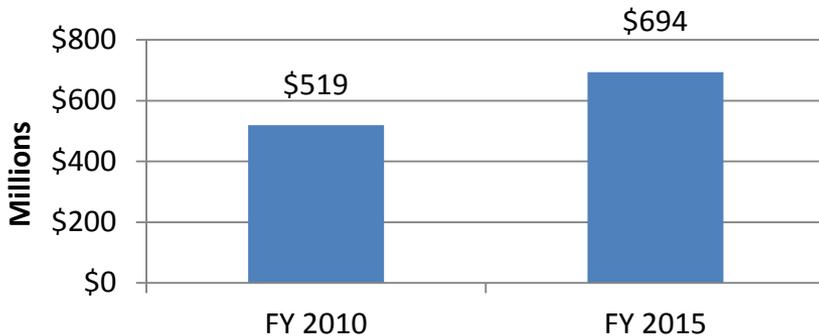
Policy Changes Affect Growth: Intellectual Disability Waivers

- The number of intellectual disability (ID) recipients has increased by 2,164 since FY 2010, a 27 percent increase.
- The General Assembly has approved the new slots to serve more individuals.

Intellectual Disability Waiver Recipients



Intellectual Disability Waiver Expenditures



- ID Waiver spending has increased 34 percent since FY 2010.
- Total spending in FY 2015 for the ID waiver was \$693.8 million (total funds).



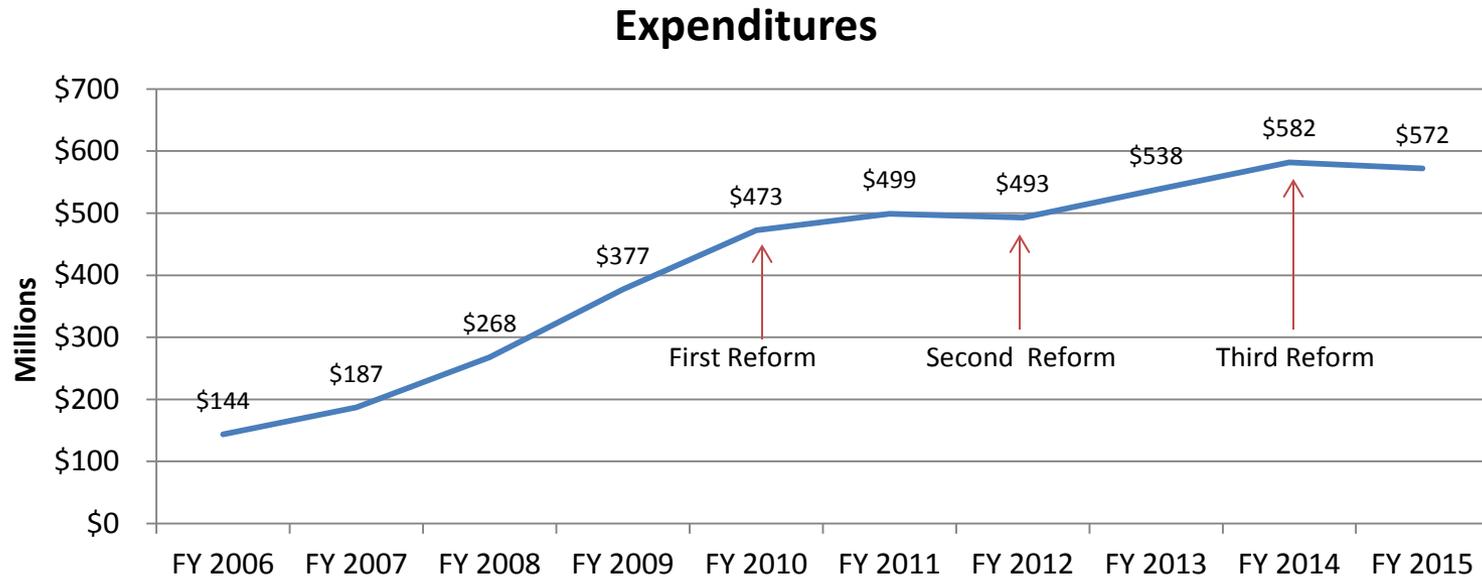
Community Mental Health Rehabilitative Services Drive Costs

- These outpatient services are usually provided in the home or in other community settings.
- Provide behavioral interventions to adults with serious mental illness or to assist children with serious emotional disturbances.
- The goal of these services is to prevent hospitalization or out-of-home placements.
- **Example:** A child has serious behavioral issues with a parent unable to handle the situation, and the child is at risk of an out-of-home placement (i.e. residential treatment facility, foster care, juvenile detention). Intensive in-home services are provided to improve relationships within the family.



Growth in Community Mental Health Rehabilitative Services

- Previous reforms have slowed the growth of these services.
- The November 2015 Medicaid Forecast indicates continued growth in these services.
- Additional strategies to ensure appropriate utilization of these services should be considered.



2015 Medicaid Forecast and Medicaid Reforms



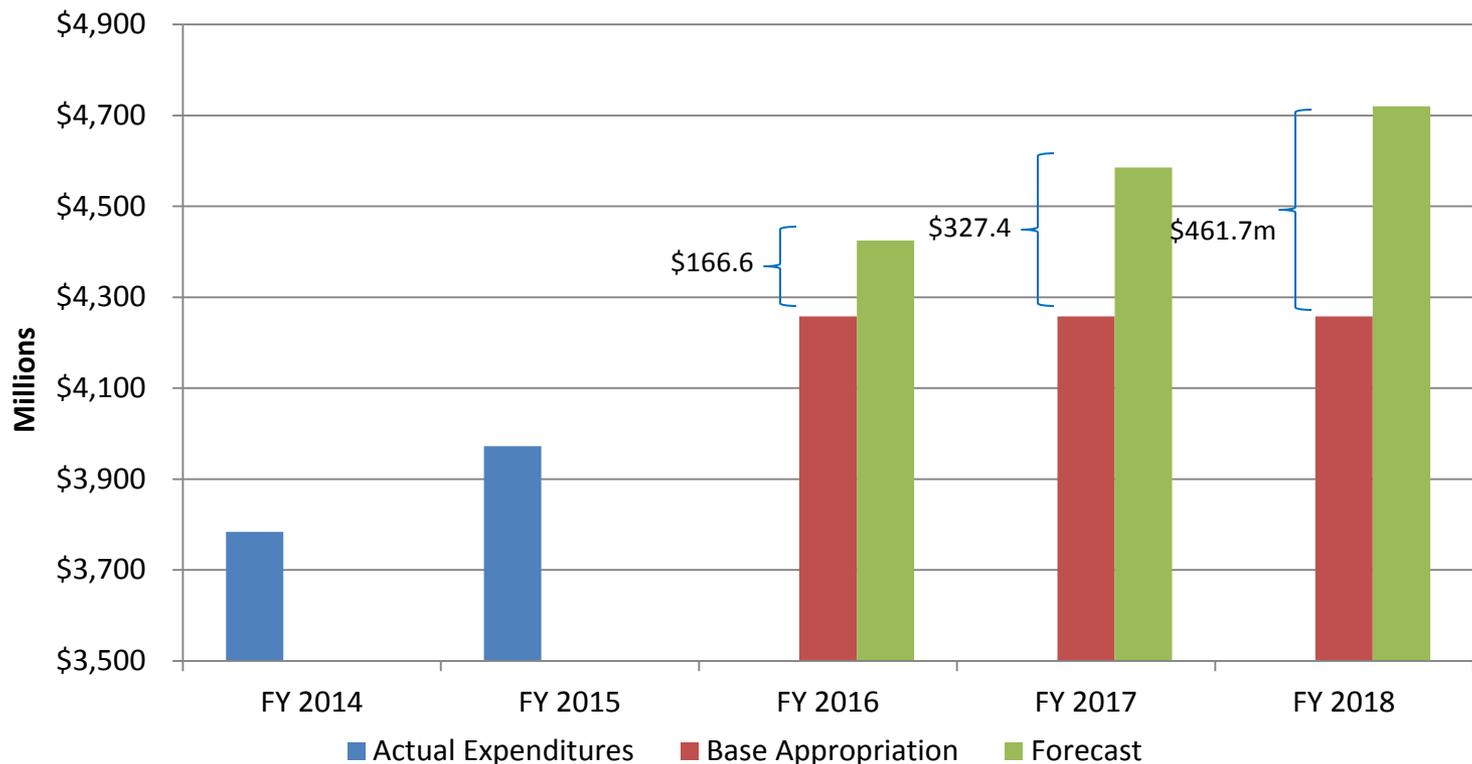
Medicaid Forecast: FY 2016

- In the 2015 Session, the Medicaid budget was adjusted to reflect savings of \$193 million GF for FY 2016.
 - Mainly due to savings from reforms in behavioral health.
- The revised forecast for FY 2016 requires **\$166.6 million GF**.
 - Partly due to a shortage of funding in FY 2015 that delayed \$74 million in payments into FY 2016.
 - Growth is now projected at 9.3%, but this amount is inflated due to the shift in expenditures from FY 2015.
 - The FY 2015 shortfall was mainly due to higher enrollment of 11,000 low-income parents (an unexpected woodwork effect). The FY 2016 cost impact of this higher enrollment is \$68 million GF.



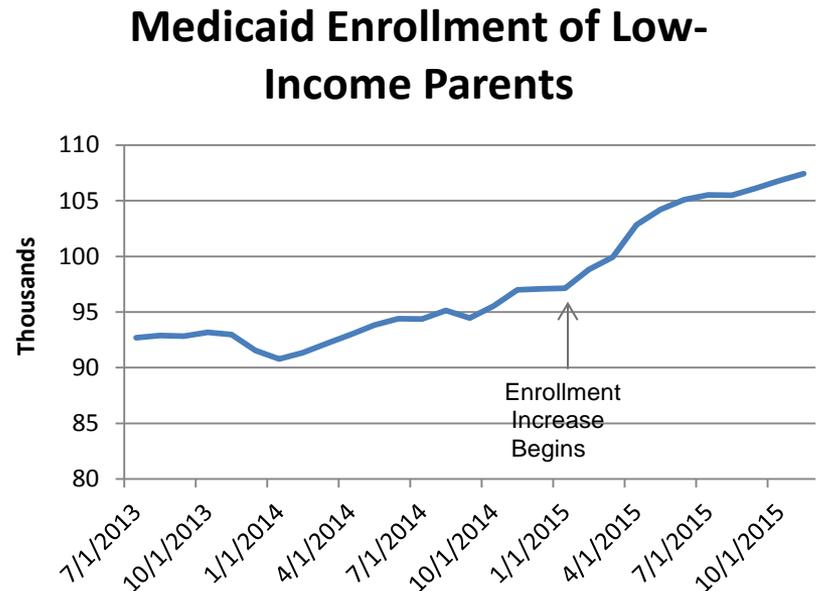
Medicaid Forecast: FY 2017 and FY 2018

- Projected funding need of \$327.4 million GF in FY 2017 and \$461.7 million in FY 2018. (Total biennial need of \$789.1 million GF)
 - Expected growth is 3.8% in FY 2017 and 2.9% in FY 2018.



Medicaid Forecast Continues Modest Growth Trend

- The forecast does not reflect any underlying significant change in growth trends for the program.
- Typical cost increases such as inflation for hospitals, nursing homes and increased managed care rates are reflected (inflation adjustments equal \$22.5 million GF in FY 2017 and \$65.6 million GF in FY 2018).
- The cost of the enrollment of 11,000 low-income parents in FY 2015 ripples through FY 2017 and FY 2018, since last year's forecast did not anticipate those costs and are not reflected in the FY 2016 appropriation.
- Enrollment is projected to increase 5.0 percent in FY 2017 and 2.4 percent in FY 2018.



Update on Medicaid Reforms

- Recent Major Reforms:
 - Behavioral health services
 - Behavioral Health Administrator to oversee these services, including the provider network.
 - Modified regulations to better define services and criteria for access.
 - Commonwealth Coordinated Care program
 - Implemented in March 2014, to provide more coordinated care for individuals eligible for both Medicare and Medicaid.
 - A federal initiative to better coordinate the acute care provided by Medicare with long-term care services provided by Medicaid.
 - Projected savings has not really been achieved due to high opt-out rates and Medicare's freedom of choice requirements.
- Next Major Reform: **Managed Long-Term Services and Supports**
 - Moves Medicaid/Medicare dual eligible and other long-term care recipients into mandatory managed care.
 - Planned implementation date of July 1, 2017.



Status of JLARC's Medicaid Study

- Phase 1: Eligibility determination and non-emergency transportation
 - In December, the Joint Legislative Audit and Review Commission (JLARC) will report on their review of Medicaid non-emergency transportation services.
 - JLARC has completed their review of the Medicaid eligibility system. They had 16 recommendations.

Summary of Key Recommendations

Improve asset verification process

Require electronic verification when zero income is reported

Fund efforts to reduce current backlog of Medicaid renewals

- Phase 2: Cost drivers and best practices
 - JLARC is hiring a consultant, and over the next year will evaluate the cost drivers in Medicaid and develop actionable recommendations.
 - The focus is on managed care, disabled and other high cost recipients, long-term care services, and community-based behavioral health services.



DOJ Settlement Agreement and Medicaid Waiver Redesign



DOJ Settlement Agreement

- The Commonwealth entered into a settlement agreement with the U.S. Department of Justice (DOJ) on August 23, 2012.
- The agreement was in response to a complaint that the Commonwealth had violated the Americans with Disabilities Act in the state training centers.
- The settlement agreement requires:
 - Creation of 4,170 Medicaid waiver slots over 10 years;
 - Modifications to the service system to be more community focused;
 - Improvement in the quality of services; and
 - Providing more integrated housing, day and employment opportunities.
- The agreement does **NOT** require:
 - The closure of the state training centers (although this is necessary to fund the Commonwealth's plan); or
 - Redesign of the Medicaid Intellectual or Developmental Disability Waivers.



Waiver Redesign Helps Achieve DOJ Compliance

- The three Medicaid waivers serving individuals with intellectual and developmental disabilities have changed little since the 1990's.
- Redesign of the waivers has been an integral part of the Commonwealth's plan to comply with the DOJ settlement agreement.
- The redesign helps the Commonwealth comply because:
 - It modifies the waiver services to provide more integrated community services; and
 - Restructures the waiver rates to support integrated services in the community for individuals with more intensive needs.
- At the October 23, 2015 court hearing before Judge Gibney, the Commonwealth reasserted that redesign of the waivers will help achieve compliance.
- The judge indicated that any further delay in implementation of the waiver redesign will result in the **court taking action** in the spring.

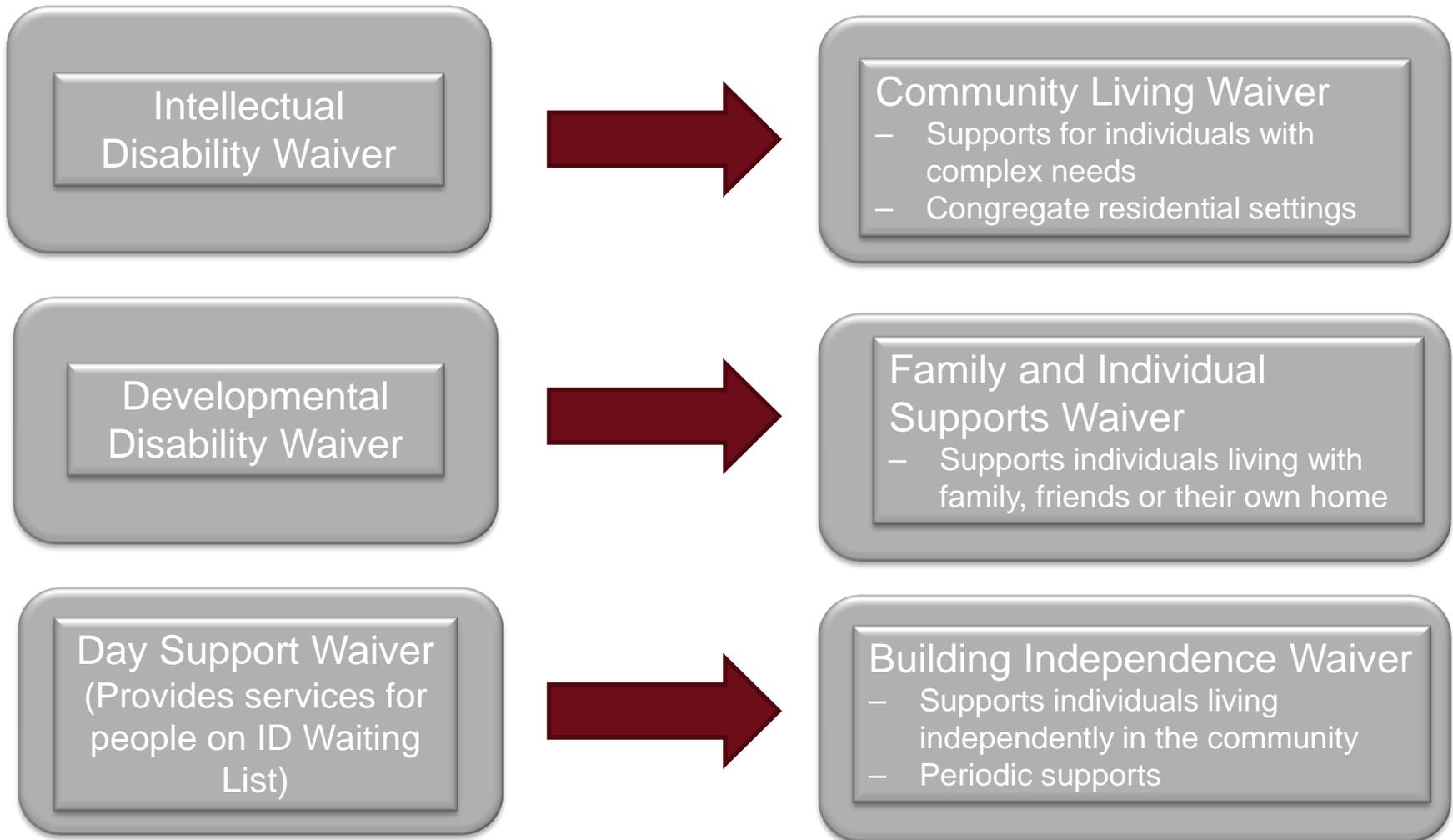


How will the waivers change?

- The waivers will no longer be differentiated by diagnosis.
 - Intellectual disability versus developmental disability
- New waivers will be differentiated mainly by the type of living arrangement and the level of support needs for each individual.
- New services will be added, current ones will be modified and the rates paid to providers for these services will be increased based on an actual study of the costs to provide the services.
- The separate waiting lists for the intellectual and developmental disability waivers will be combined and based on need. *(The developmental disability waiver's waiting list has been based on the order of when the individual was added to the list.)*



Overview of Waiver Redesign



DOJ Funding Need for FYs 2017-2018

Budget Item	FY 2017 (GF in millions)	FY 2018 (GF in millions)
Required Waiver Slots (855 Slots)	\$13.5	\$30.1
Reserve Waiver Slots (100 Slots)	\$1.8	\$1.8
Private Duty Nursing Rates	\$11.3	\$13.1
Waiver Redesign	\$11.3	\$21.2
Crisis Funds	\$4.7	\$5.3
Rebase Facility Funding	-\$5.0	-\$7.0
Additional Administrative Positions	\$1.9	\$2.1
Other DOJ Related Costs	\$4.6	\$3.8
Total	\$44.1	\$70.4

Note: In FY 2016, there is a GF need of \$7.3 million to reflect the latest closure schedule for the training centers.



Conclusions

- Medicaid spending continues the recent trend of modest growth as compared to the historical average of around eight percent.
- Despite the slower growth, the program's size still requires an additional \$955 million GF in the current budget cycle.
- The November 2015 forecast does not reflect any significant increasing growth trends.
 - The only unexpected enrollment growth was in FY 2015 in low-income parents due to open enrollment in the federal exchange.
- In 2017, the next major phase of Medicaid reform will begin with the move of long-term care recipients into managed care.
- Funding the redesign of the intellectual and developmental disability waivers is **critical** to compliance with the DOJ settlement agreement.

