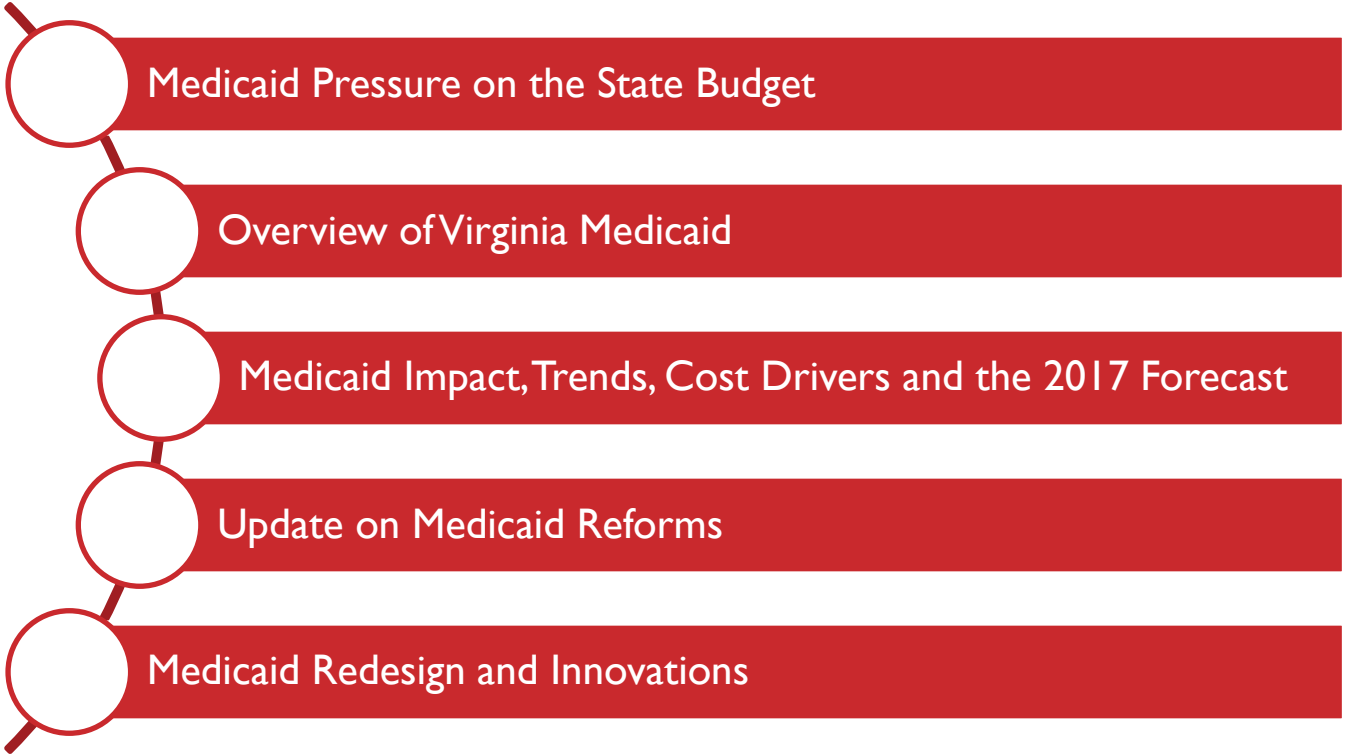
SENATE OF VIRGINIA

Senate Finance Committee

Trends in Virginia Medicaid and Opportunities to Shift the Cost Curve

November 17, 2017

Presentation Overview

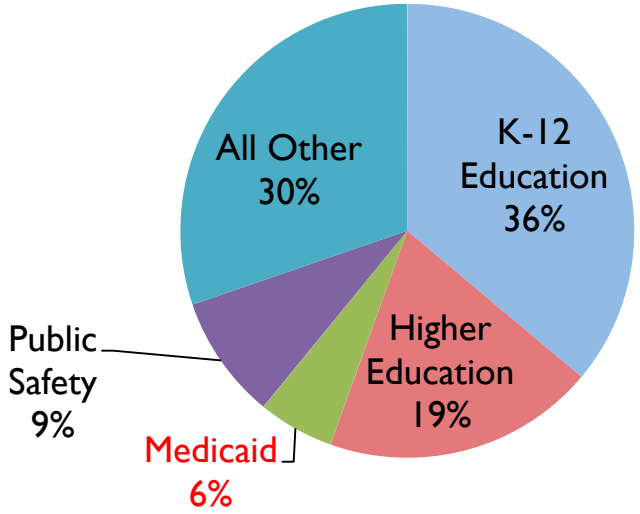


Medicaid Pressure on the State Budget

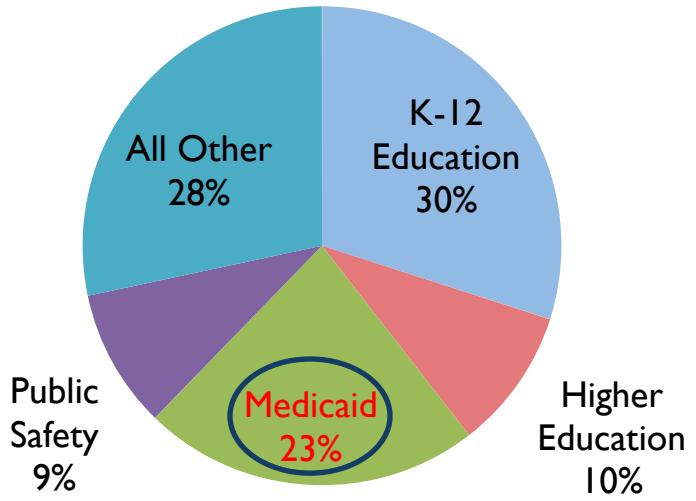
Medicaid's Share of the State Budget Has Grown

Percent of General Budget by Major Area

FY 1985

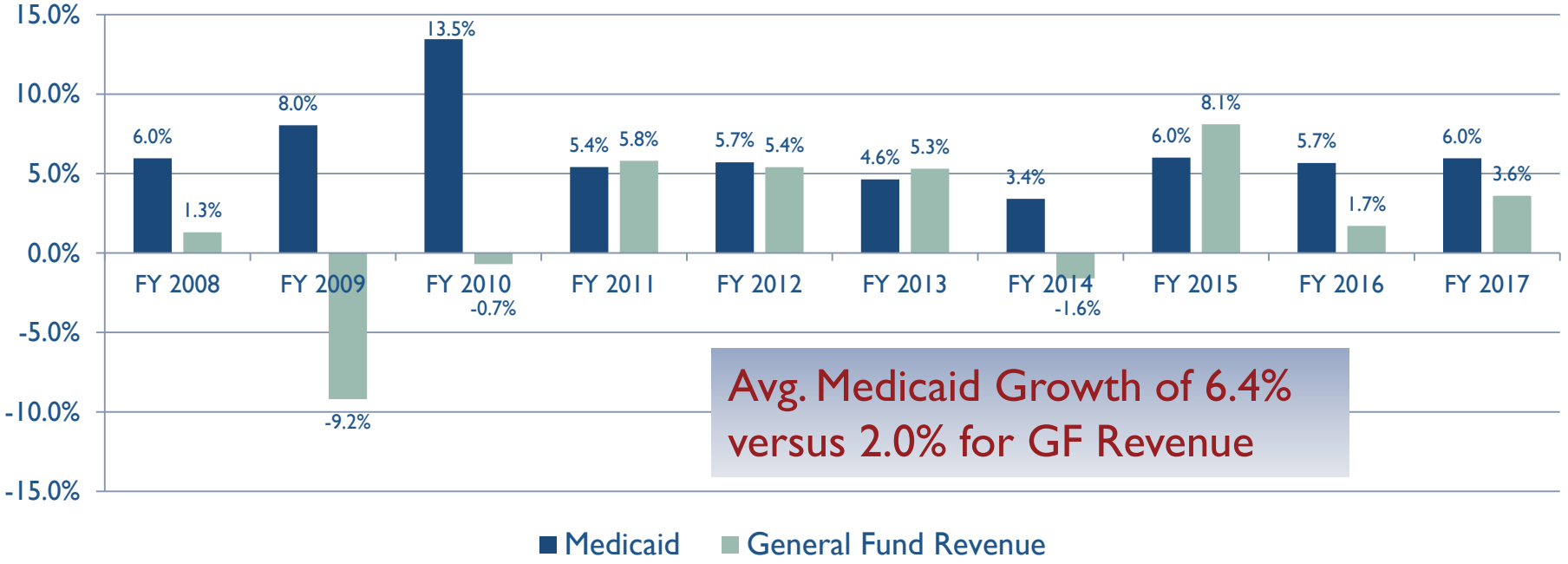


FY 2018



Source: Chapter 221, 1986 Acts of Assembly and Chapter 836, 2017 Acts of Assembly.

Medicaid's Growth Outpaces GF Revenue Growth Over the Long-Term



Note: Expenditures in FY 2011, FY 2012, FY 2015 and FY 2016 have been adjusted to reflect payment shifts between fiscal years in order to better reflect realistic expenditure patterns in the program.

Medicaid has Largest Share of GF Growth

4 agencies with the highest growth amount in general fund appropriations, FY08-FY17($M)

Agency	FY 2008	FY 2017	GF Growth	GF % Growth	% of Total GF Growth
DMAS	**$2,567.2**	**$4,450.9**	**$1,883.7**	**73%**	**60%**
Treasury Board	405.2	722.1	316.9	78	10
DBHDS	535.7	749.1	213.4	40	7
DOC	961.7	1129.4	167.7	17	5

Source: Adapted from JLARC's Report "State Spending: 2017 Update, October 2017".

The State Budget Issue: Medicaid

- Relative to the overall state budget there are at least three ways to handle the issue:
  1) Increase state revenues to fund other priorities,
  2) Increase economic growth such that GF revenues at least match Medicaid's growth, and
  3) Slow the growth of the Medicaid program.

- Otherwise, Medicaid's share of the general fund budget will continue to grow, further limiting funding for other areas such as education.

- What can Virginia do to limit Medicaid's growth?

Overview of Virginia Medicaid

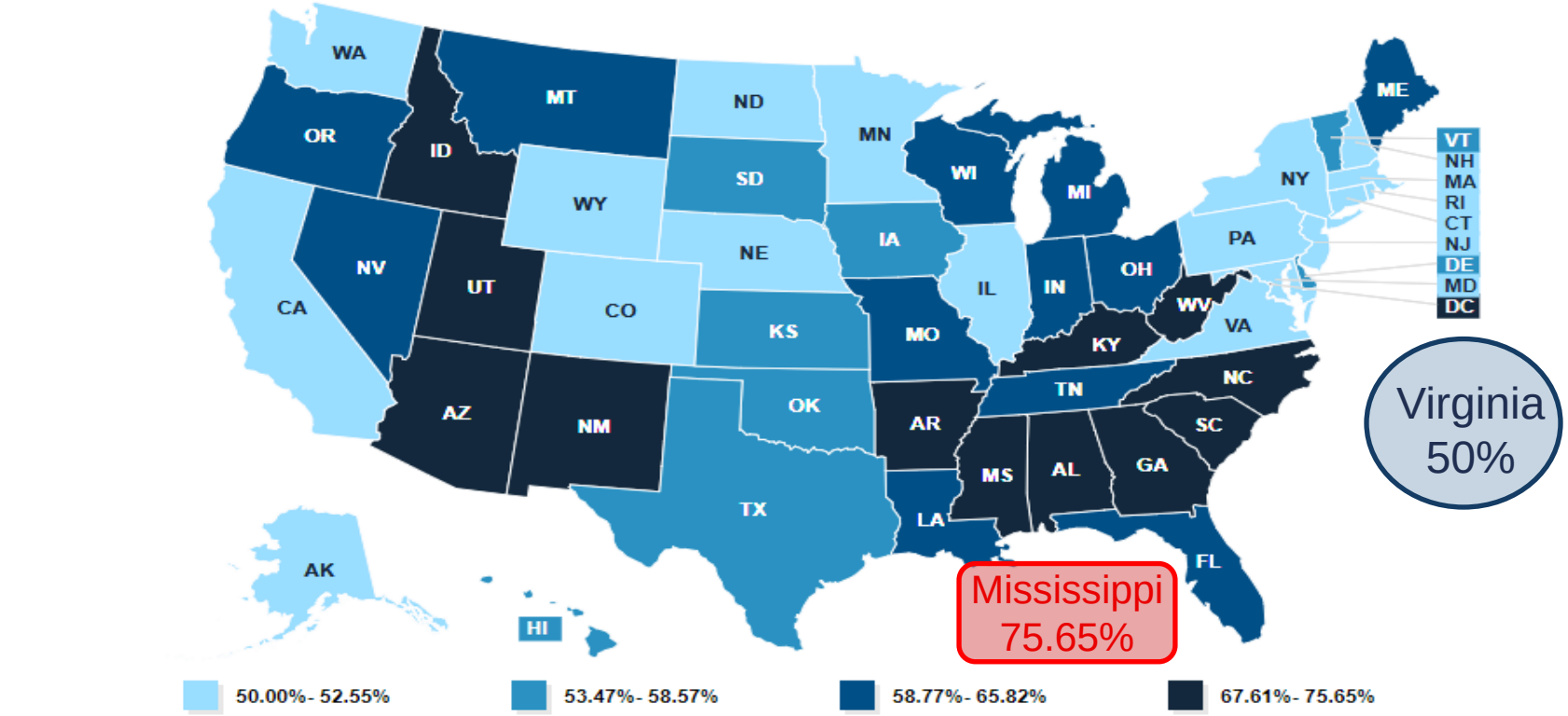
Medicaid is a Safety Net Program

- Medicaid is a **shared** state/federal program to provide health insurance for **certain** low-income groups.

- Medicaid is essentially four programs:
  - Health insurance for low-income parents and children;
  - An insurance supplement for low-income seniors on Medicare;
  - Health insurance for low-income disabled individuals; and
  - A long-term care program for elderly and disabled individuals.

- Federal funds for the program are based on a state's personal income, essentially a state's ability to pay.

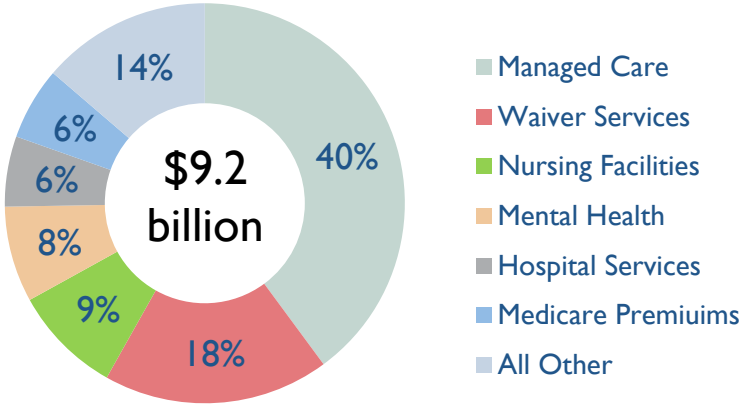
Federal Match Rates Vary From 50% to 75.65%



Source: Kaiser Family Foundation.

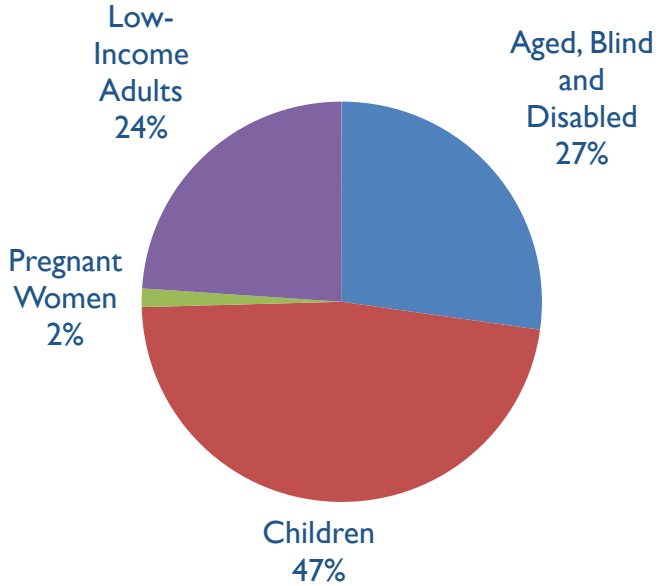
FY 2017 Spending by Service and Enrollment

FY 2017 Expenditures (Total Funds)*



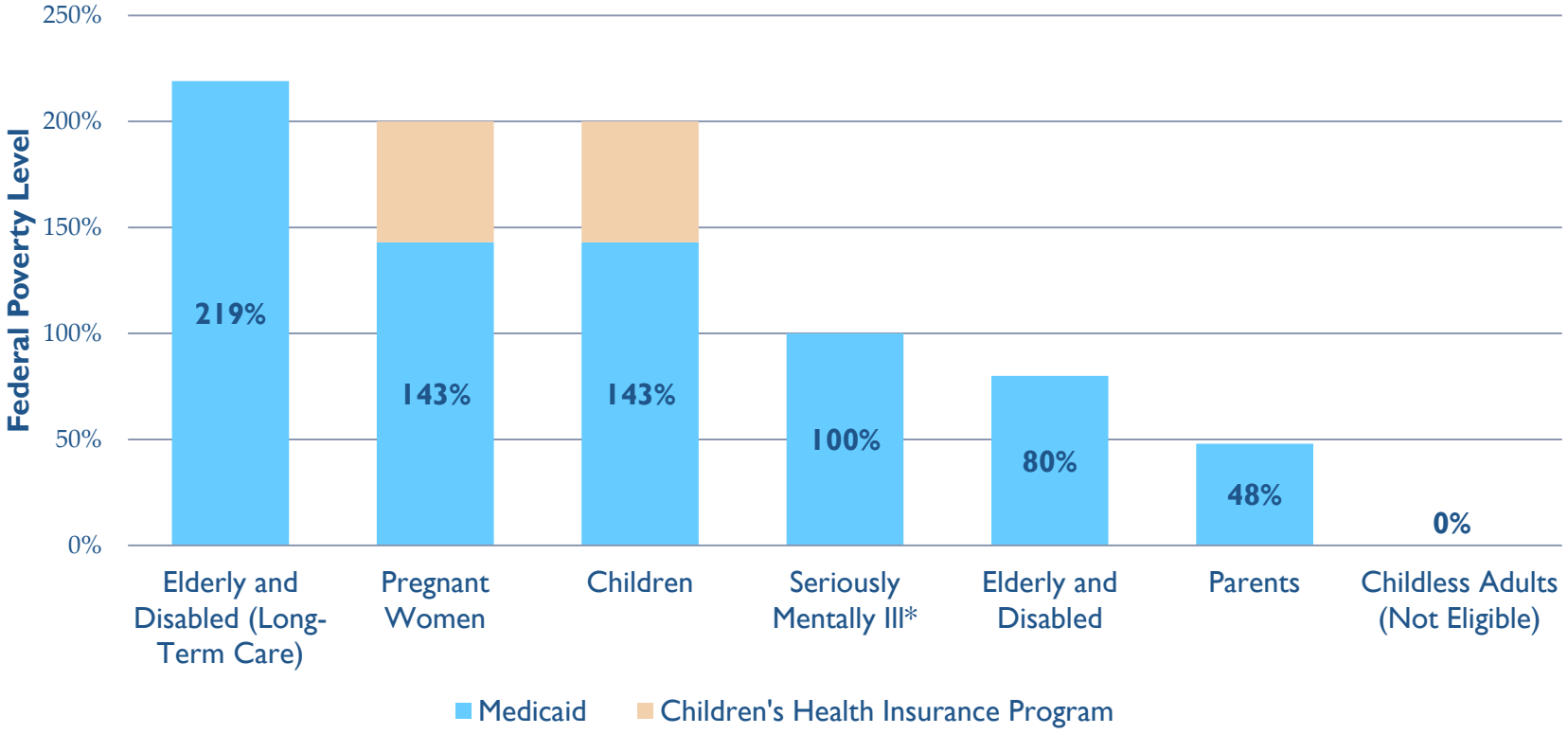
* *Does not include payments to state facilities operated by the Department of Behavioral Health and Developmental Services.*

November 1, 2017 Enrollment = 1,045,465



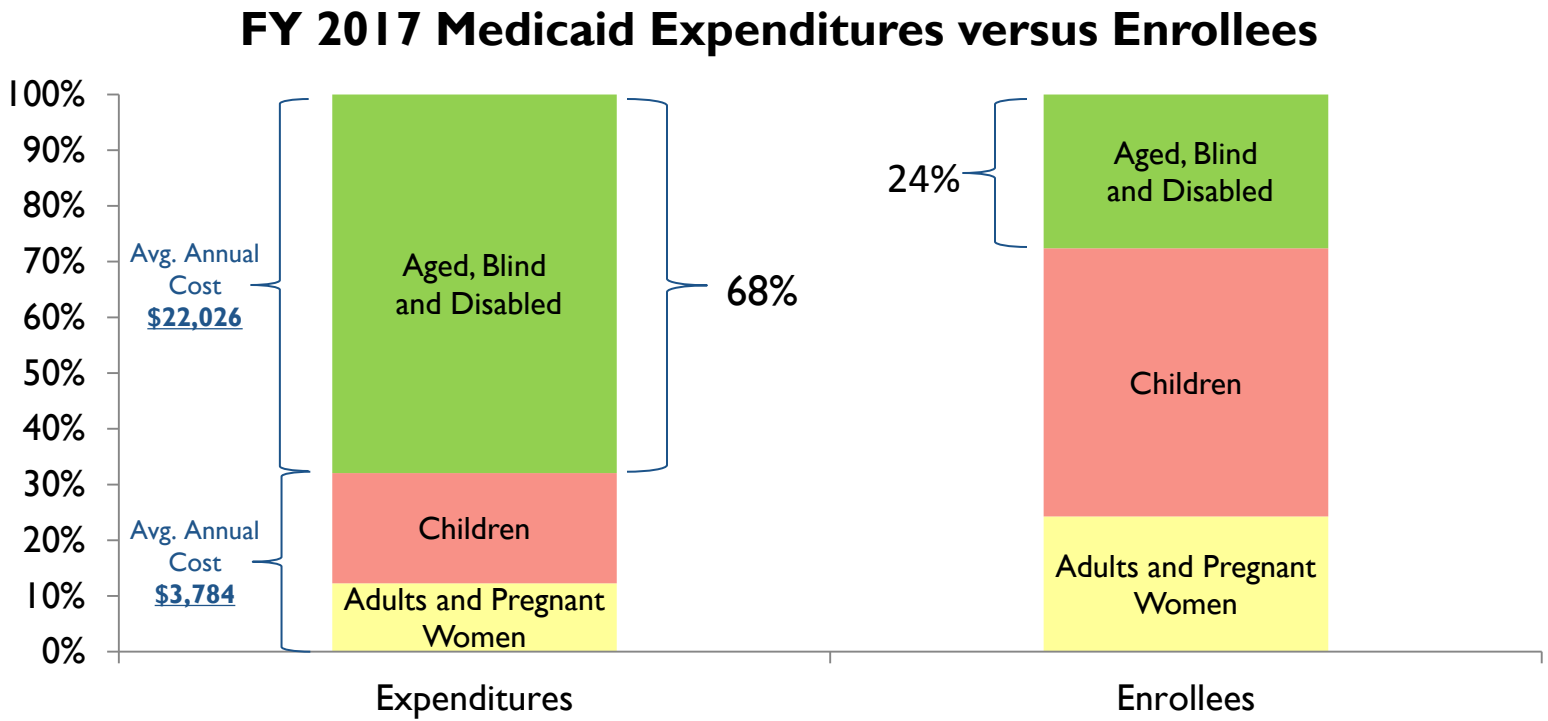
Note: Half of the low-income adults are only eligible for the limited benefit family planning program (Plan First).

Income Thresholds for Medicaid Vary by Group



** Adults with serious mental illness are covered under the GAP waiver, which provides a limited benefit.*

Aged, Blind and Disabled are the Highest Cost



Source: FY 2017 DMAS Databook.

Affordable Care Act Changed Medicaid

- Medicaid is not like **Medicare**, which is a federal program that provides **national health insurance** to all Americans, regardless of income, beginning at age 65.
- The Affordable Care Act (ACA) directed states to expand Medicaid (with an enhanced federal matching rate) to increase health care coverage to lower-income individuals.
- Essentially, the ACA changed the nature of Medicaid to **national health insurance** as opposed to a safety net program for vulnerable populations, which is partly the reason Medicaid Expansion has been debated since the ACA passed.
- The Supreme Court decision resulted in a choice for states. Is the goal of the Medicaid program:
  - Caring for only the neediest citizens, or
  - A broader health insurance program for all low-income individuals.

Medicaid Impact, Trends, Cost Drivers and 2017 Forecast

Medicaid is a Vital Part of the Safety Net

1 in 8 Virginians rely on Medicaid

Medicaid is the primary payer for **behavioral health** services

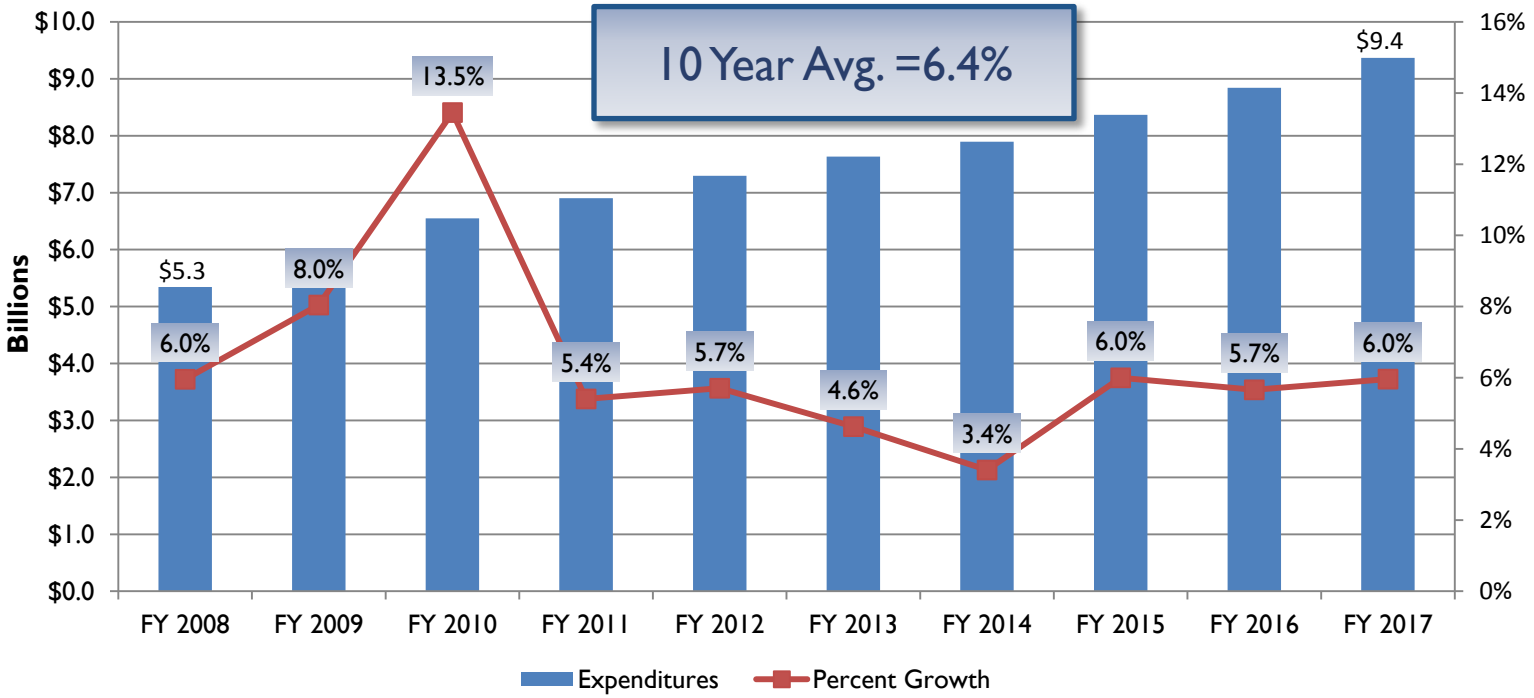
Medicaid covers **1 in 3** births in Virginia

33% of children in Virginia are covered by Medicaid & CHIP

2 in 3 nursing facility residents are supported by Medicaid

62% of long-term services and support spending is in the community

Expenditures Impacted by the Economy



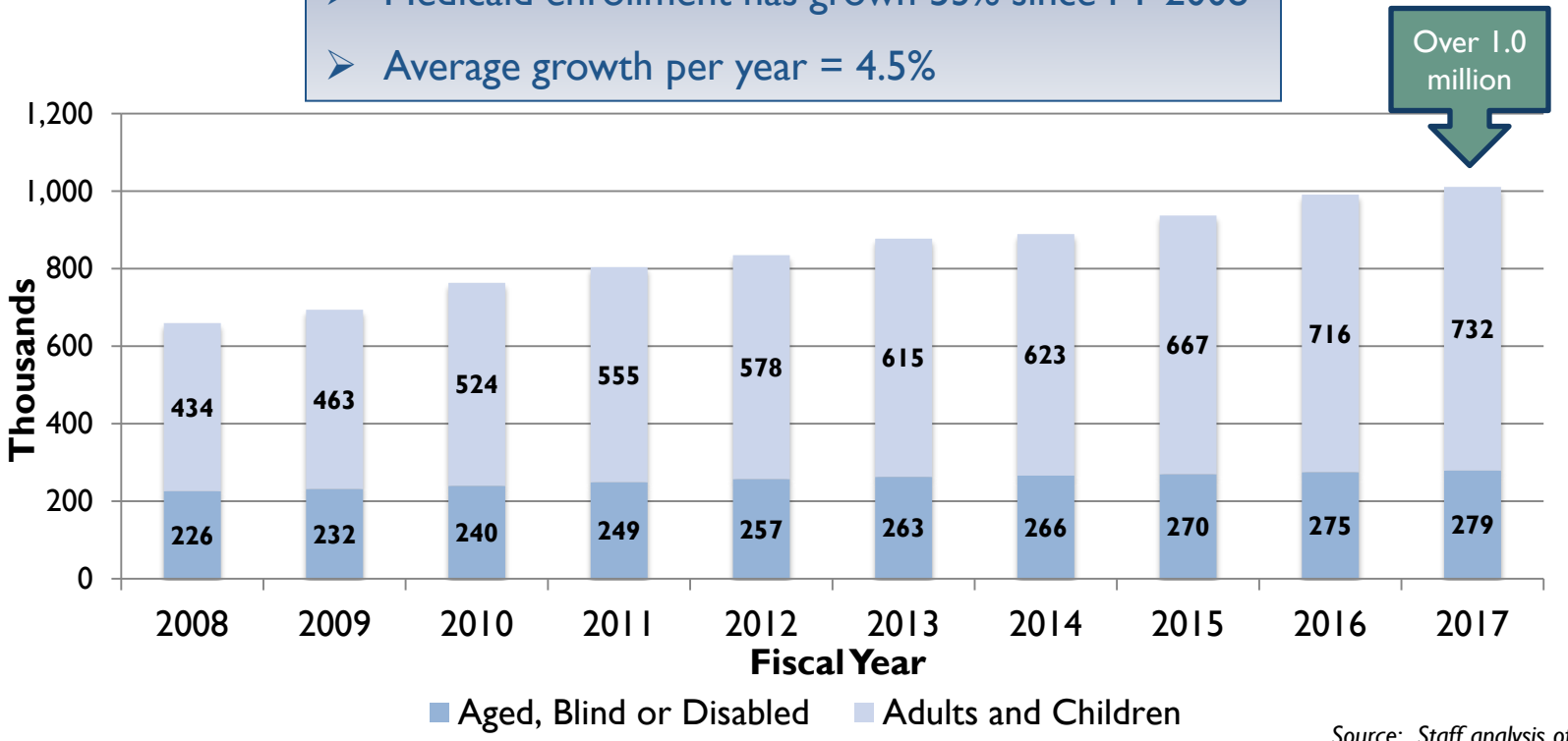
Note: Expenditures in FY 2011, FY 2012, FY 2015 and FY 2016 have been adjusted to reflect payment shifts between fiscal years in order to better reflect realistic expenditure patterns in the program.

Three Primary Drivers of Medicaid

- Enrollment and Utilization
- Inflation
- State and Federal Policy Changes

Medicaid Enrollment Trends

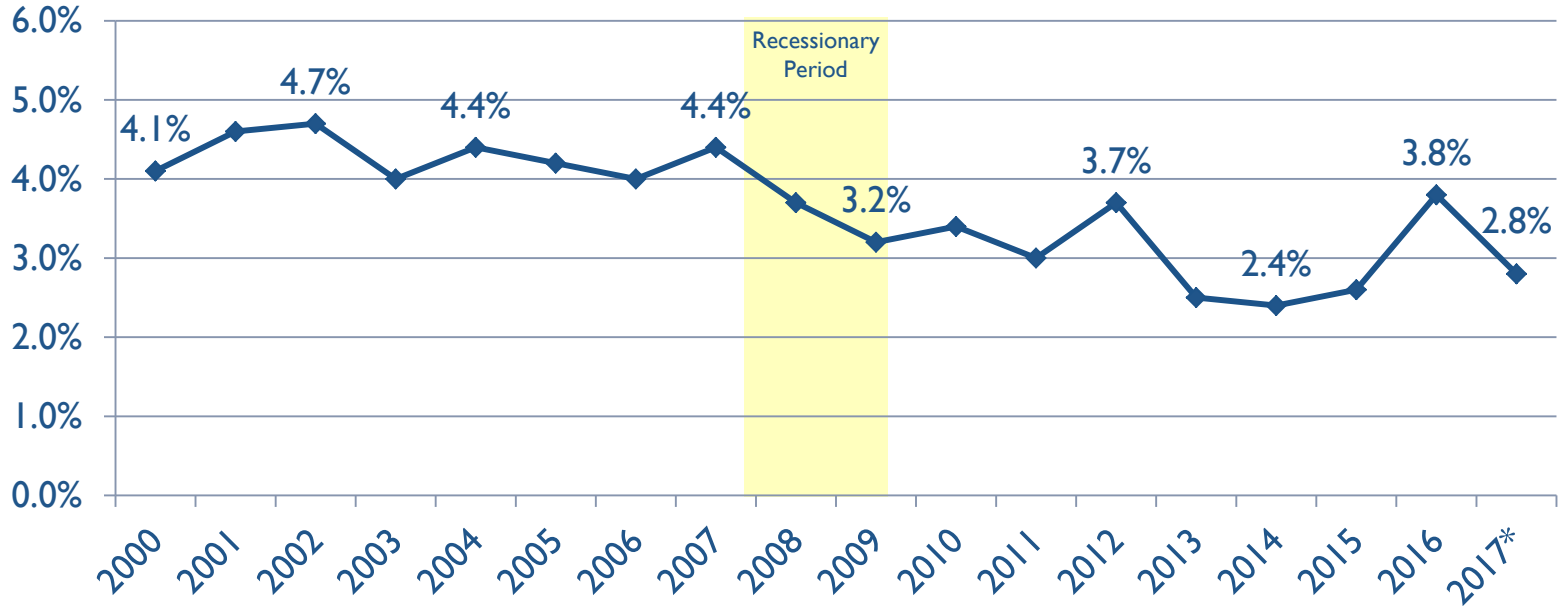
- Medicaid enrollment has grown 53% since FY 2008
- Average growth per year = 4.5%



Source: Staff analysis of DMAS data.

Medical Inflation Remains Historically Low

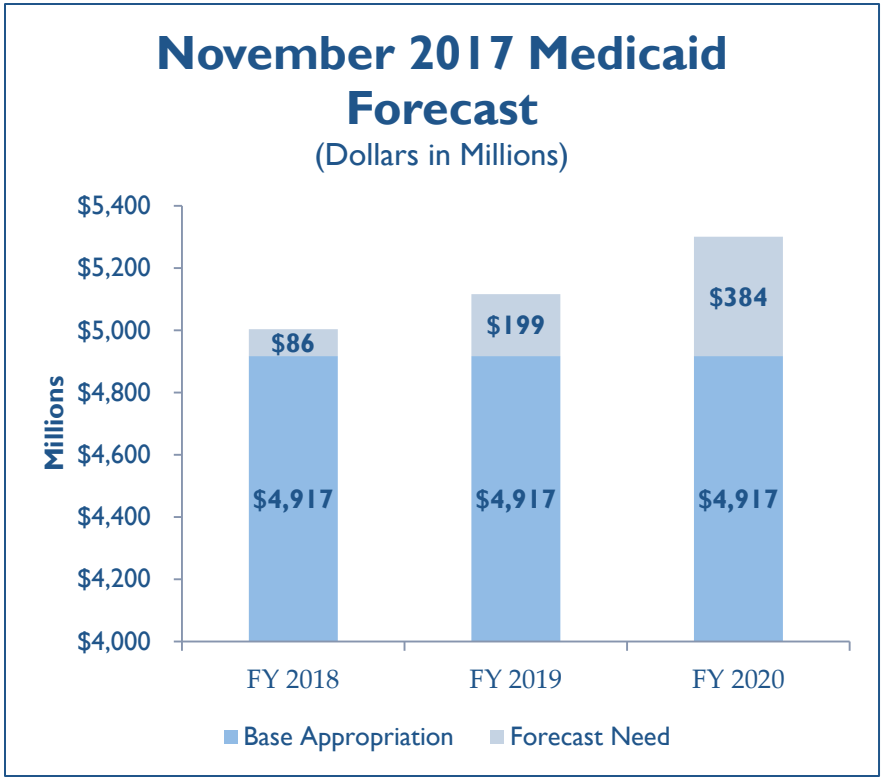
- Medical inflation averaged 4.3 percent prior to 2008 and since then has averaged 3.1 percent.



Source: Bureau of Labor Statistics, CPI – Medical Care. ** 2017 reflects first nine months only.*

2017 Medicaid Forecast Reflects Moderate Growth

- FY 2018 requires additional funding of **$86 million GF.**
- The 2018-20 Biennial GF Forecast Need is **$583 million GF.**
- State spending is projected to increase:
  - 6.5% in FY 2018;
  - 2.3% in FY 2019; and
  - 3.4% in FY 2020.
- Each 1% equals $100 million GF.



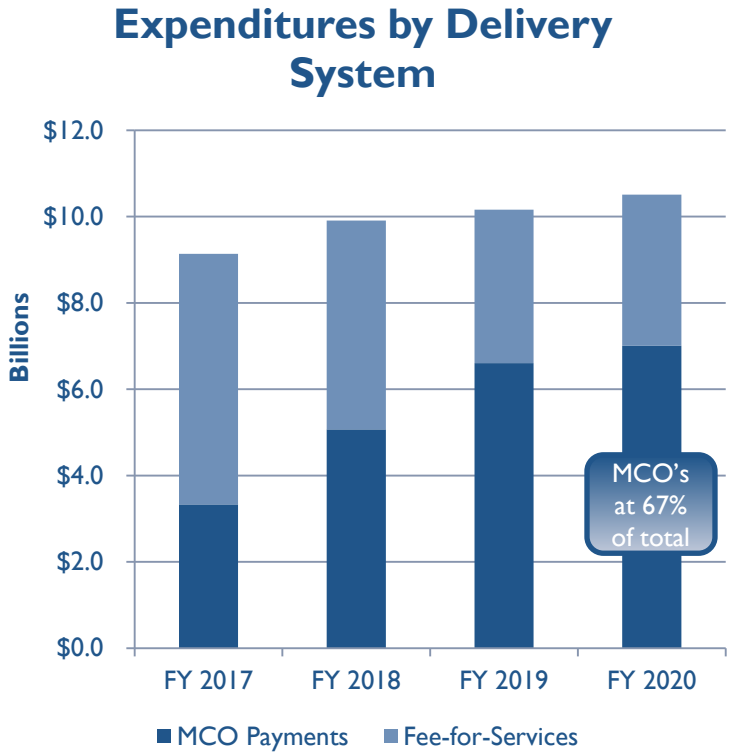
2017 Forecast Drivers

- Enrollment:
  - Aged, blind and disabled are increasing 1.4% while children are at 1.0%.
  - Increase in low-income adults of 7.5% in FY 2018.
- Managed care changes:
  - Savings from the expansion of managed care.
  - Rate increases up to 3.8% across the two managed care programs.
- Hospital and nursing home inflation as required by regulation.

Provider	FY 2019	FY 2020
Inpatient Hospital	2.8% $21.9 million GF	3.0% $48.3 million GF
Nursing Homes	2.9% $10.9 million GF	3.0% $23.4 million GF

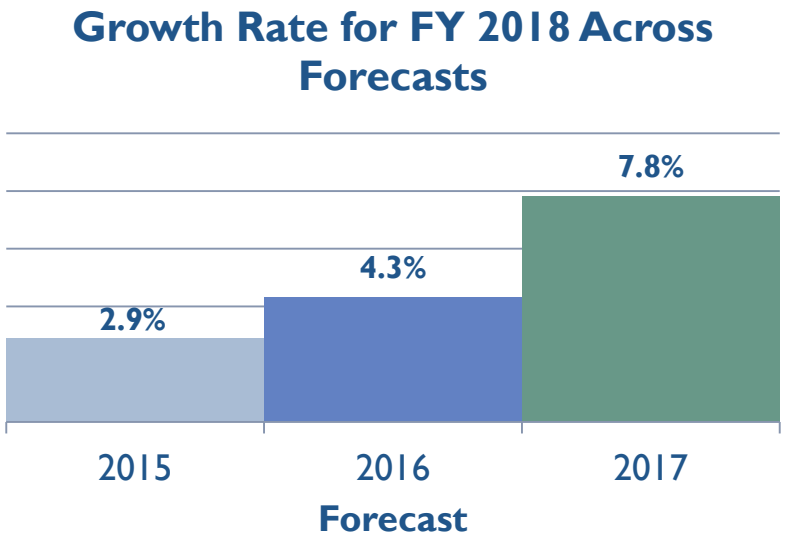
Managed Care Rates Have a Significant Impact

- Adding long-term care and behavioral health services to managed care shifts one-third of total program expenditures by FY 2020.
- Managed care rates assume savings in behavioral health and consumer-directed services.
- **DMAS's actuary has used aggressive savings assumptions which will require close monitoring.**



Out-Years Difficult to Forecast

- Medicaid forecast provides an estimate for 3 years at a time.
- Forecast models tend to taper trends over time.
- The 2017 forecast includes the current fiscal year 2018, and the next biennial budget (FY 2019 and FY 2020).
- Result is typically a funding need in the amended budget.



Update on Medicaid Reforms

Status of 2013 Medicaid Reforms

Medicaid reforms outlined in the 2013 Appropriation Act:

Results	Medicaid Reforms	Accomplishment
Coordinated Service Delivery	Dual Eligible Demonstration Pilot	Implemented Medicare-Medicaid Enrollee Financial Alignment demonstration (Commonwealth Coordinated Care)
	Foster Care	Implemented inclusion of children enrolled in foster care in managed care
	Behavioral Health	Expedited the tightening of regulatory standards, services limits, provider qualification, and licensure requirements for community behavioral health services
	Commercial-like Benefit Package	Changed services and benefits to be the types of services and benefits provided by commercial insurers in managed care where feasible
	Limited Provider Networks and Medical Homes	Implemented changes to support beneficiaries receipt of higher quality coordinated care through a limited network arrangement in Northern Virginia
	ID/DD Waiver Design	Implementing the redesign of the ID/DD waiver to provide more comprehensive and targeted service options
	All Non-Medicare EDCD Waiver Enrollees in Managed Care for Medical Needs	Implemented changes and EDCD waiver enrollees are covered by health plans for medical needs (HAP) Implementing Commonwealth Coordinated Care Plus (CCC Plus)
	All Inclusive Coordinated Care for Long Term Care Beneficiaries	Implemented Commonwealth Coordinated Care and Initiated transition of all non-dual waiver recipients into managed care Implementing Commonwealth Coordinated Care Plus (CCC Plus)

Status of 2013 Medicaid Reforms (con't)

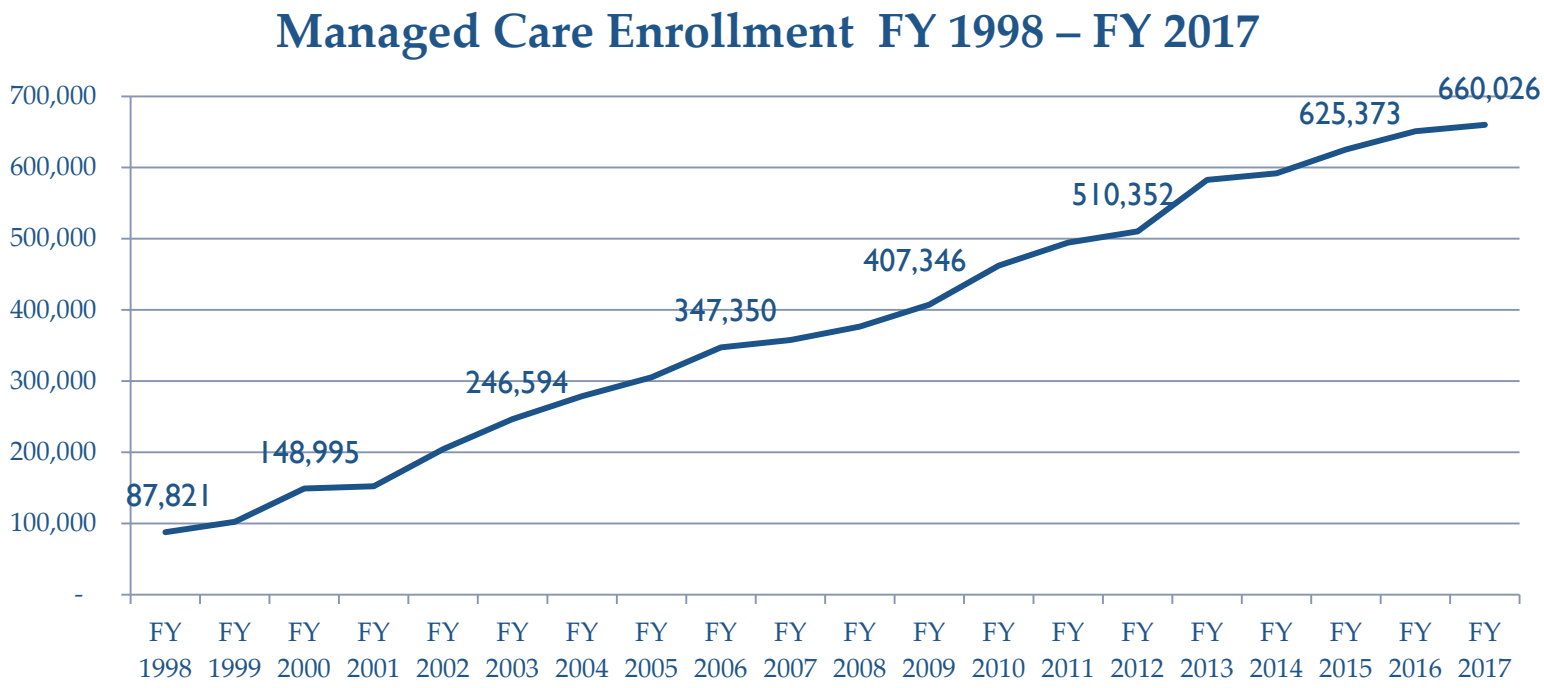
Results	Medicaid Reforms	Accomplishment
 **Efficient Administration**	Enhanced Program Integrity	Enhanced Recovery Audit Contracting (RAC), data mining, service authorization, coordination with Medicaid Fraud Control Unit (MFCU), and Payment Error Rate Measure (PERM)
	eHHR	Implemented new eligibility and enrollment information system for Medicaid and other social services
	Coordinate Behavioral Health	Aligned and coordinated behavioral health services through the behavioral health services administrator (BHSA); implemented behavioral health homes
	Quality Payment Incentives	Implemented financial incentives and high quality outcomes through the Medallion Care System Partnership and alternative payment methods to encourage accountability within the Medicaid provider and MCO program
	Parameters to Test Innovative Models	Implemented over 100 quality measures to evaluate pilot innovations such as behavioral health homes and streamlined care transitions. Payment withhold based on attainment of quality indicators
 **Beneficiary Engagement**	Cost Sharing and Wellness	Developed programs to incent enrollee participation in health and wellness activities to improve health and control costs in managed care; increased patient responsibility by reinstating copayments for FAMIS

JLARC Recommendations are being Implemented

Long-Term Care Needs Assessment Instrument	Recommended efforts to improve reliability for children; training and screening; ensure timely screening; and strengthen oversight of the process.
Managed Care Rates	Adjust rates to account for expected savings; allow negative historical trends to carry forward; rebase administrative rates for enrollment changes and deduct unallowable administrative expenses.
Financial Oversight	Require detailed MCO financial and utilization reporting; control of related party spending; excessive related party spending is not included in capitation; and underwriting gain returns above three percent.
Programs	Administer compliance review and sanctions, report on MCO performance and incentivize MCO performance improvement. Strengthen oversight of behavioral health and LTSS service delivery.
Trend Impact	Monitor MCO spending and utilization trends and analyze what is driving those trends. To include: identifying inefficiencies and adjusting rates and monitoring MCO utilization control methods.
Policy	Submit for CMS review, a proposal requiring cost-sharing based on family income for LTSS eligible individuals eligible through the optional 300 percent of SSI.

Note: These recommendations are from JLARC's December 2016 report "Managing Spending in Virginia's Medicaid Program".

Shift to Managed Care Continues



74% of Current Total Enrollment

Note: Data does not reflect enrollment in the Commonwealth Coordinated Care (CCC) program. *Source: SFC Staff analysis.*

Managed Care Transition Nearly Complete

	CCC Plus	Medallion 4.0
	▪ Serving older adults and disabled ▪ Includes Medicaid-Medicare eligible ▪ 216,000 individuals	▪ Serving infants, children, pregnant women, parents ▪ 760,000 individuals
	▪ Long-term services and supports in the community and facility-based, acute care, pharmacy ▪ Incorporating community mental health	▪ Births, vaccinations, well visits, sick visits, acute care, pharmacy ▪ Incorporating community mental health
	▪ Implementation started Aug 2017 ▪ Implement statewide by Jan 2018	▪ New procurement 2017 ▪ Building on prior experience ▪ Implement statewide 2018
	▪ Contract value approximately $30B over 5 years	▪ Contract value estimated at $10B - $15B over 5 years

Does Managed Care Solve the Budget Problem?

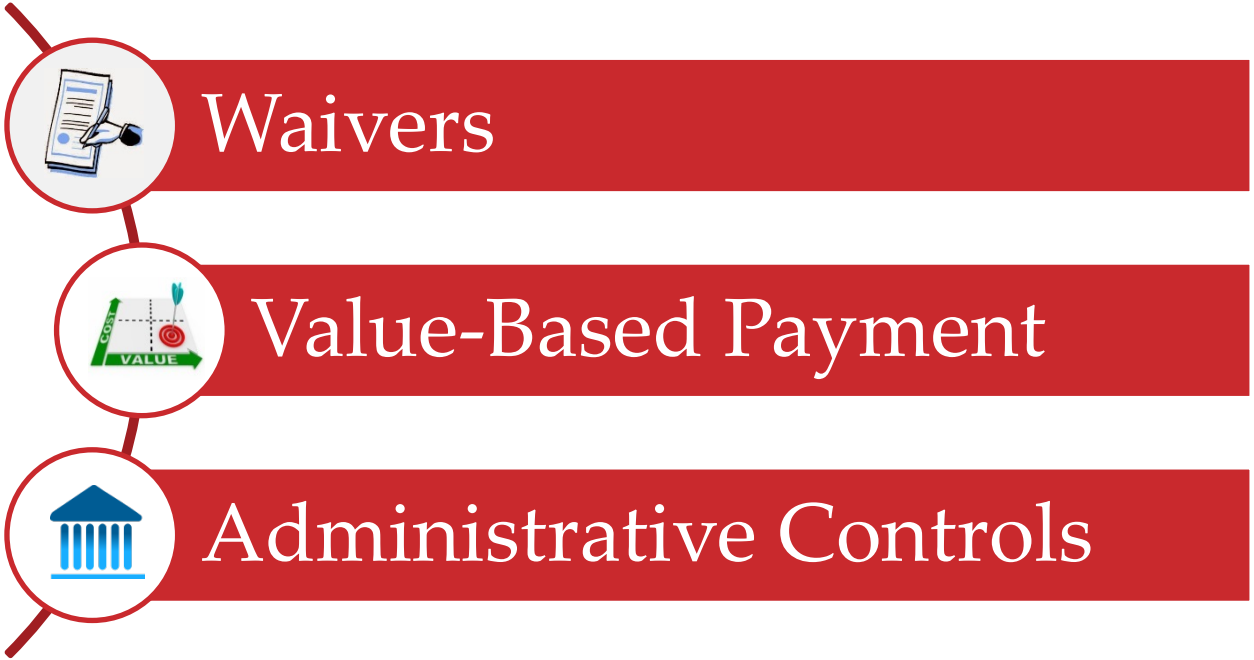
- Provides a more coordinated delivery system.
- Passes some financial risk to private health insurance companies.
- Managed Care is limited by Medicaid's design:
  - Lack of recipient cost sharing;
  - Recipient turnover;
  - Few incentives to promote healthy behaviors; and
  - Difficult to address social determinants of health.

What Control Does the State Have?

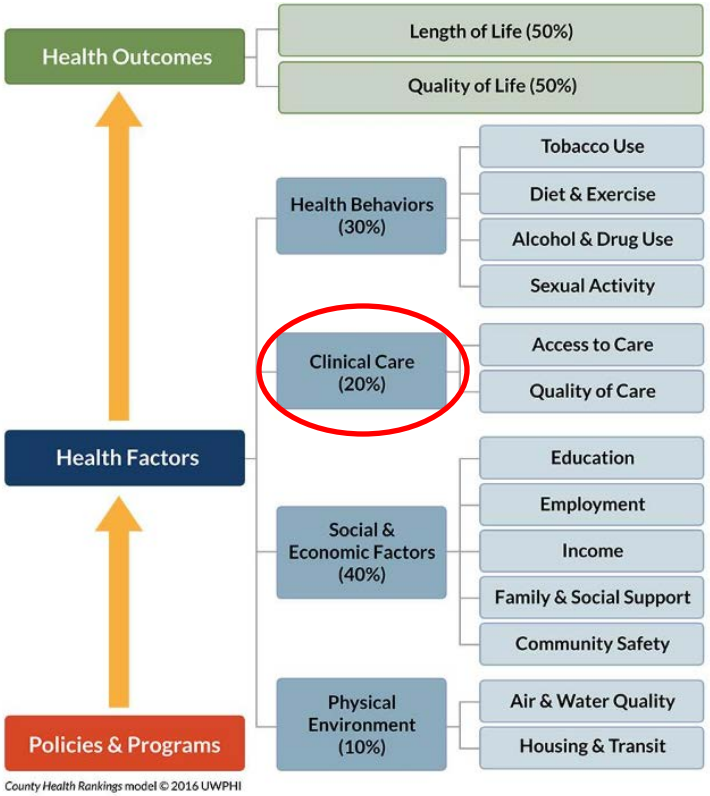
Not in State's Control	State Control
Cost of Services	Provider Reimbursement Rates
Demographics	Program Benefits
Federal Match Rate	Eligibility
	State Revenue

Medicaid Redesign and Innovation

State Options to Consider



Redesign Must be Broader than Clinical Care



Focus must be broader than just medical care

Waivers Provide State Flexibility

- Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to approve demonstrations.
  - Allows a waiver of statutory Medicaid requirements.
  - Must be budget neutral to the federal government.
  - Approval for up to five years.
- Waivers allow states to innovate.

Two States have Global Medicaid Waivers

- Rhode Island was approved in 2009 for a waiver of their entire Medicaid program.
  - Aggregate federal budget cap over five years.

- Vermont was approved in 2005.
  - New payment mechanisms.
  - Non-traditional Medicaid services.
  - Investments in programmatic innovations.

Other Approved State Waiver Provisions

Provision	States
Premium assistance	AR, IA, IN, MI, NH
Premiums / Monthly contributions	AR, AZ, IA, IN, MI, MT
Healthy behavior incentives	AZ, IA, IN, MI
Waive required benefits	IA, IN
Waive reasonable promptness	IN
Waive retroactive eligibility	AR, IN, NH
Co-payments above statutory limits	IN
12-month continuous eligibility	MT

Source: Kaiser Family Foundation Issue Brief (August 2017).

Pending State Waiver Provisions

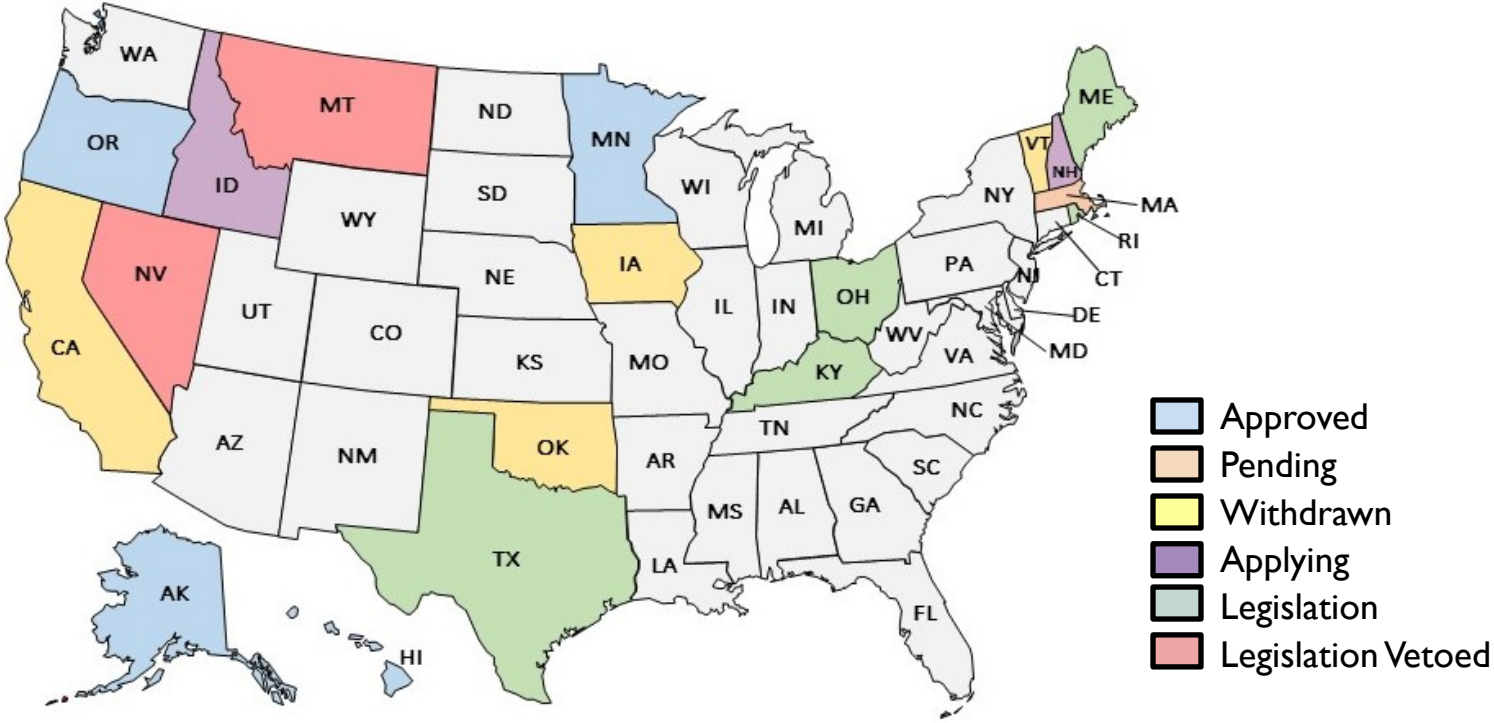
Provision	States
Work requirement	AR, AZ, IN, KY
Time limit on coverage	AZ
Limit expansion eligibility to 100% with enhanced match	AR
Monthly income verification and renewals	AZ
Lock-out for failure to timely renew eligibility	IN, KY
Tobacco surcharge	IN

Source: Kaiser Family Foundation Issue Brief (August 2017).

State Innovation Waivers (Section 1332)

- Waiver of Affordable Care Act Provisions:
  - Not a Medicaid waiver;
  - Began January 1, 2017;
  - State can waive essential benefits, cost sharing, and eliminate the employer and individual mandates;
  - Waiver must cover similar number of residents, similar level of benefits, and be at least as affordable; and
  - Cannot increase the federal deficit.

State Activity on Section 1332 Waivers



Source: Robert Wood Johnson Foundation

Status of Section 1332 Waivers

States have focused on stabilizing the exchange market

State	Proposal	Status
Alaska	Use federal pass through funding for state's reinsurance program.	Approved
California	Allow undocumented immigrants to purchase coverage through the state's marketplace without premium subsidies.	Withdrawn
Hawaii	Retain the employer coverage provisions currently in place through the state's Prepaid Health Care Act, which was enacted in 1974.	Approved
Iowa	Create a Proposed Stopgap Measure plan that would be the only plan offered in the marketplace.	Withdrawn
Minnesota	Create a new state reinsurance program.	Approved
Oklahoma	Create a new state reinsurance program.	Withdrawn
Oregon	Create a new state reinsurance program.	Approved

Source: State Health Reform Assistance Network, Robert Wood Johnson Foundation.

Combining the 1115 and 1332 Waivers

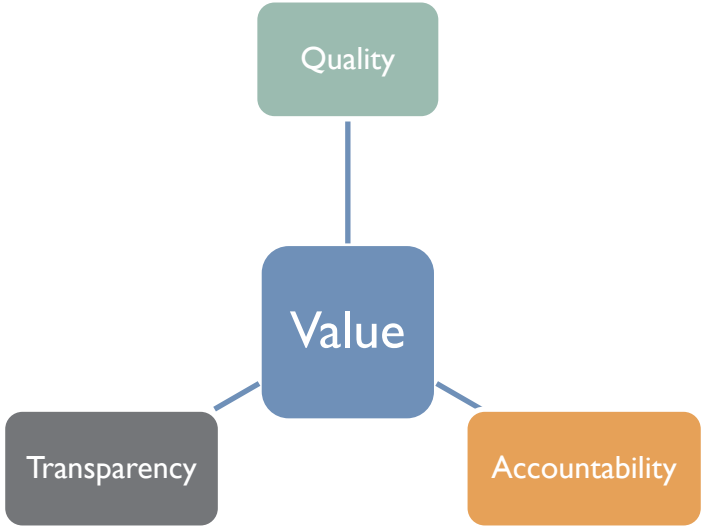
- Referred to as the "Super Waiver".
- A combined Affordable Care Act and Medicaid waiver could:
  - Improve coordination of health insurance across programs;
  - Improve premium subsidies and cost sharing; and
  - Better align eligibility rules across programs.

Redesign of Virginia's Medicaid Program

- Virginia should consider establishing a Medicaid Redesign Initiative.
  - Overseen by a team from the executive and legislative branches which includes health policy experts.
  - Evaluate opportunities for a Global waiver or other 1115 Waivers.
  - Consider enhancements to the GAP waiver as a vehicle for broader redesign of the program.
  - Focus redesign on integration of medical and behavioral health.
  - Explore opportunities to fund initiatives to address the **social determinants of health** and improve the overall health of the Medicaid population.

Other Options: Moving Toward Value-Based Payment

- Not based on volume.
- Use of quality measures.
- Data and analytics are critical.
- Virginia should promote new value-based payment models through Managed Care contracts.



Use of Administrative Fiscal Controls

- **Legislative Oversight Committee:**
  - Ohio legislature's response to Governor's expansion of Medicaid.
  - Uses an actuary to establish a limit on the growth in per member per month costs.
  - Governor must observe limits in his/her proposed budget.
- **Global Spending Cap:**
  - New York implemented in 2012.
  - Limits Medicaid spending to 10-year rolling average of medical inflation.
  - Monthly monitoring to intervene, if spending is on track to exceed cap.

Other Options: Improving Administrative Controls

- Virginia should consider developing target spending levels for Medicaid.
  - Monthly monitoring of Medicaid spending.
  - Early warning assessment of higher than expected growth.
  - Development of proposals to address higher growth.
- Oversight of the Medicaid forecasting and Managed Care rate setting processes should increase.
  - Enhance capabilities of agencies in consensus forecasting process.
  - Use an independent actuary to evaluate assumptions and rates.

Key Takeaways

- Medicaid's share of the budget will continue to grow absent changes to the current program.
- Managed Care is a major improvement.
- Waivers provide more flexibility to redesign Medicaid.
- Virginia needs to place a greater focus on health outcomes in the program.
- Oversight and monitoring are essential to managing the growth of the program.

Appendix

Four Primary Groups are Eligible for Medicaid

Group	Financial Requirements	Non-Financial	Asset Limits
Children	143% of Poverty	Citizenship and Residency	None
Pregnant Women	143% 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

2017 Federal Poverty Limits				
Family Size	**80%**	**100%**	**133%**	**200%**
1	$9,648	$12,060	$16,040	$24,120
4	$19,680	$24,600	$32,712	$49,200

* Supplemental Security Income (SSI) is $733 per month for an individual.

Source: SFC staff analysis.

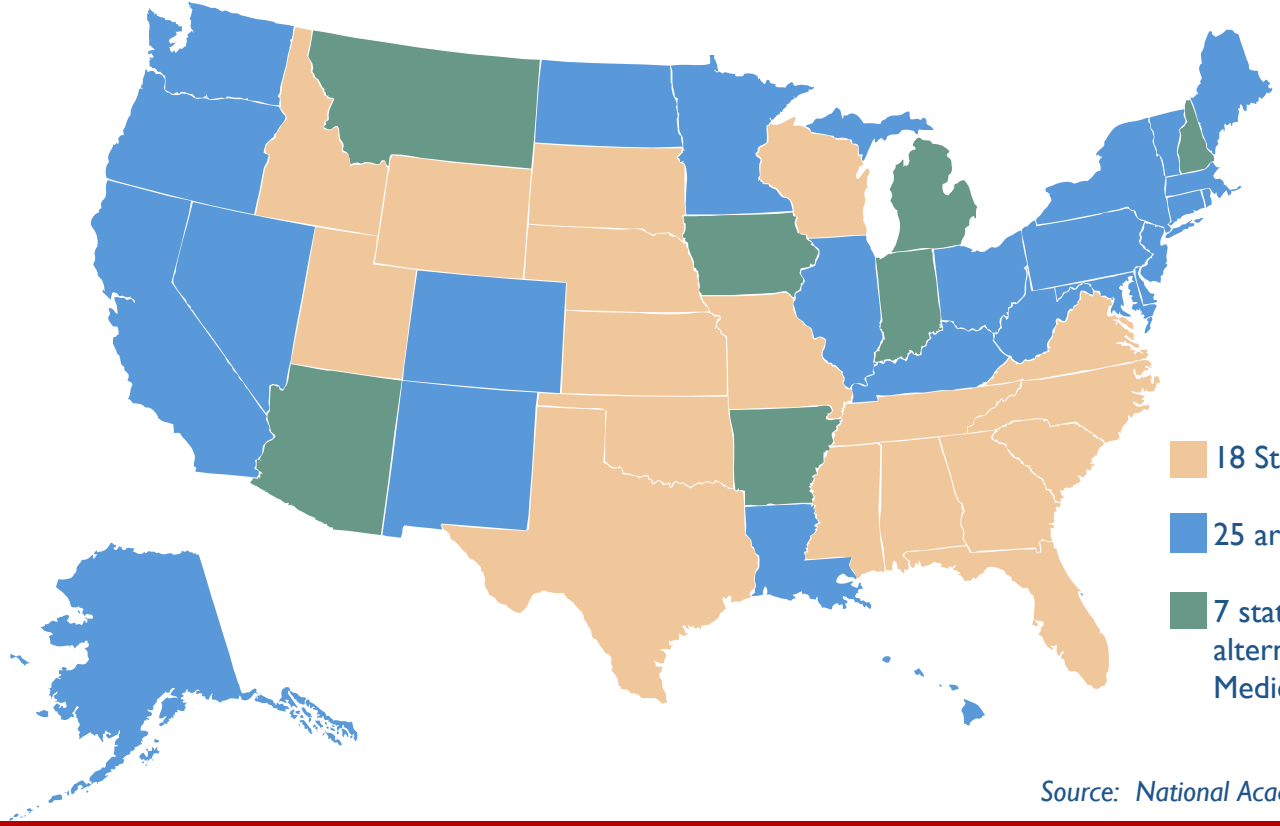
Virginia Medicaid Services

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.*

Source: SFC staff analysis.

Status of State Medicaid Expansion Decisions



Source: National Academy for State Health Policy.