Medicaid Presentation for Montana's Children, Families, Health and Human Services Interim Committee

NATIONAL CONFERENCE *of* STATE LEGISLATURES

The Forum for America's Ideas

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State Medicaid Reform Presentation Outline

- Medicaid Spending
- Medicaid Coverage
- Medicaid in Context
- Medicaid and The Affordable Care Act
- Medicaid Block Grants: What are they and how do they differ from global waivers
- State Actions to Contain Costs
- State Medicaid Research findings
- 2014

Medicaid Has Many Roles In Our Health Care System

Health Insurance Coverage

29.5 million children & 15 million adults in low-income families; 14 million elderly and persons with disabilities

Assistance to Medicare Beneficiaries

8.8 million aged and disabled — 19% of Medicare beneficiaries

Long-Term Care Assistance

1 million nursing home residents; 2.8 million community-based residents

MEDICAID

Support for Health Care System and Safety-net

16% of national health spending; 40% of long-term care services

State Capacity for Health Coverage

Federal share ranges 50% to 76%;

Medicaid Spending

Federal Medical Assistance Percentages (FMAP), FY 2012

NOTE: Rates are rounded to nearest percent. These rates will be in effect Oct. 1, 2011 – Sept. 30, 2012.
SOURCE: Federal Register,, Nov, 10, 2010 (Vol. 75, No. 217), pp. 69082-69083.
http://edocket.access.gpo.gov/2010/pdf/2010-28319.pdf

Medicaid: Budget and Revenue

Medicaid

Elementary & Secondary Education

All Other

	General Funds $656 Billion	Federal Funds $457 Billion	Total Funds $1,547 Billion
Medicaid	15.7%	42.6%	21.1%
Elementary & Secondary Education	35.8%	12.0%	21.7%

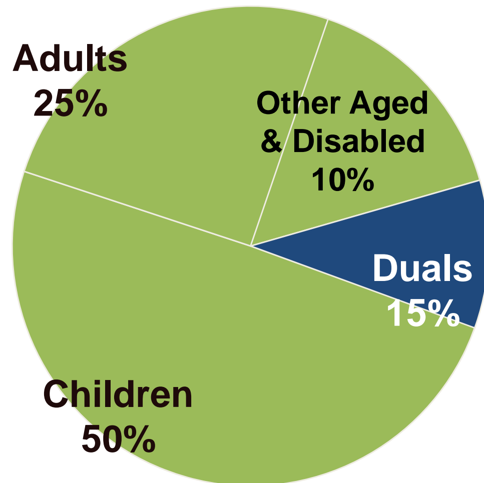
SOURCE: National Association of State Budget Officers, 2009 State Expenditure Report, Dec. 2010

The elderly and disabled account for the majority of Medicaid spending.

SOURCE: KCMU and Urban Institute estimates based on 2007 MSIS and CMS64 data.

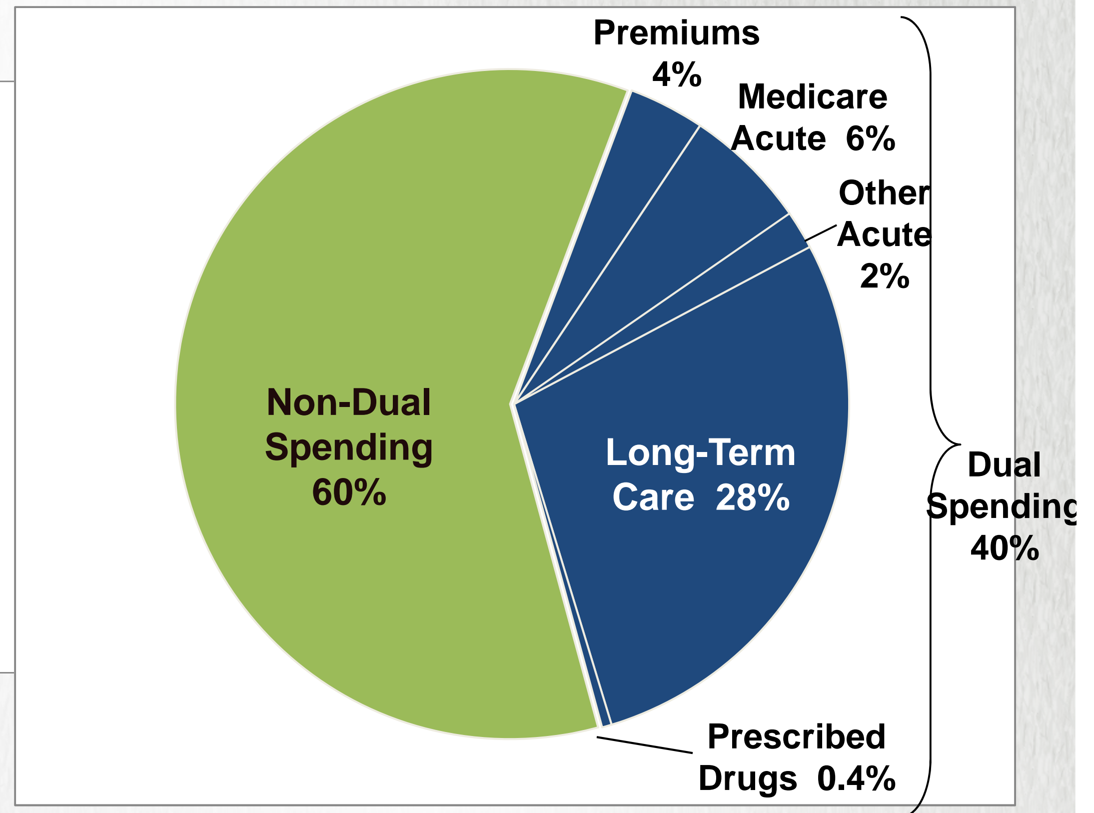
Duals Account for 40% of Medicaid spending.

Medicaid Enrollment



Total = 58 Million

Medicaid Spending



Total = $300 Billion

SOURCE: Urban Institute estimates based on data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2010.

Medicaid Spending Growth Per Enrollee Has Been Slower Than Growth in Private Health Spending

SOURCE: Urban Institute, 2010. Estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64), Medicaid Statistical Information System (MSIS), and KCMU/HMA enrollment data. Expenditures exclude prescription drug spending for dual eligibles to remove the effect of their transition to Medicare Part D in 2006.

Medicaid Enrollment and Eligibility

Since The Start Of The Recession More Than 7 Million More Enrolled in Medicaid

Monthly Enrollment in Millions

	Jun-07	Dec-07	Jun-08	Dec-08	Jun-09	Dec-09	Jun-10
Monthly Enrollment in Millions	42.3	42.7	43.6	44.8	46.9	48.7	50.3

SOURCE: Analysis for KCMU by Health Management Associates, using compiled state Medicaid enrollment reports

State	Enrollment*	Enrollment Growth**	Total Spending FY 2009 (in millions)	Spending as a % of State General Fund (FY 2009)
Montana	**12%**	**18.3%**	**$876**	**8.1%**
Wyoming	15%	15.1%	$526	5.7%
Alaska	18%	21.4%	$1,070	6.1%
Idaho	14%	15.7%	$1,277	12.2%
New Hampshire	11%	15.7%	$1,330	29.3%
North Dakota	11%	19.8%	$572	13.4%
South Dakota	15%	9.2%	$713	20.7%
Vermont	25%	10.5%	$975	15.1 %
West Virginia	22%	9.0%	$2,434	7.9%

***Enrollment as a percentage of total population, 2007**

****Enrollment growth measure as percentage change in enrollment from Dec. 2007 to Dec. 2009**

Medicaid Eligibility for Children

	Ages 0-1	Ages 1-5	Ages 6-19	CHIP
Montana	**133%**	**133%**	**133%**	**250%**
Wyoming	133%	133%	100%	200%
Alaska	150%	150%	150%	NA
Idaho	133%	133%	100%	185%
New Hampshire	185%	185%	185%	300%
North Dakota	133%	133%	100%	160%
South Dakota	133%	133%	100%	200%
Vermont	225%	225%	225%	300%
West Virginia	150%	133%	100%	250%

***Income eligibility limit as a percentage of Federal Poverty Level (FPL), January 2011**

Pregnant Women

State	FPL
Montana	**150%**
Wyoming	133%
Alaska	175%
Idaho	133%
New Hampshire	185%
North Dakota	133%
South Dakota	133%
Vermont	200%
West Virginia	150%

***Income eligibility limit as a percentage of Federal Poverty Level (FPL), January 2011**

Adults

State	Parents	Childless Adults
Montana	56%	NA
Wyoming	52%	NA
Alaska	81%	NA
Idaho	39%	NA
New Hampshire	49%	NA
North Dakota	59%	NA
South Dakota	52%	NA
Vermont	191%	160%
West Virginia	33%	NA

***Income eligibility as a percentage of Federal Poverty Level (FPL), January 2011**

SSI: Aged, Blind, and Disabled

State	Single	Couple
Montana	75%	SSI-based - 83% FPL
Wyoming	75%	83%
Alaska	109%	120%
Idaho	78%	83%
New Hampshire	79%	87%
North Dakota	75%	83%
South Dakota	75%	83%
Vermont**	101%	75%
West Virginia	75%	83%

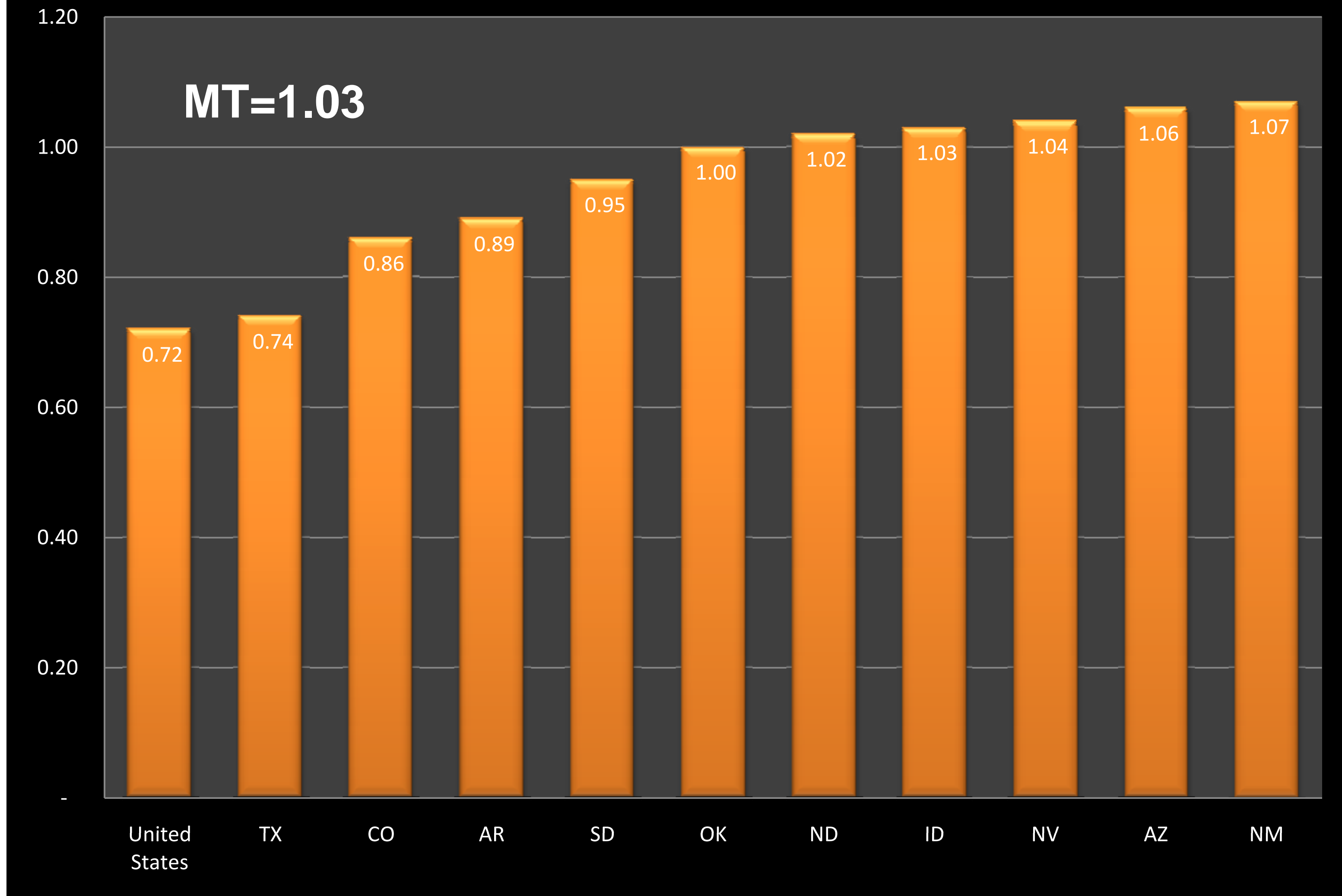
***Income eligibility as a percentage of Federal Poverty Level (FPL) or SSI, 2009**

**** Vermont uses a higher income standard for Chittenden County: 110% for singles and 82% for couples.**

Many Medicaid enrollees receive care through private managed care.

U.S. Average December 2009 = 72.9%

Note: Unduplicated count. Includes managed care enrollees receiving comprehensive and limited benefits. Percentages are rounded to nearest percent.
SOURCE: Medicaid Managed Care Enrollment as of December 31, 2009. Published by CMS
https://www.cms.gov/MedicaidDataSourcesGenInfo/05_MdManCrPenRateandExpEnrll.asp



Source: Kaiser Family Foundation's, statehealthfacts.org, 2008

Medicaid Block Grants

Medicaid Block Grants

- End the federal matching rate approach to financing Medicaid.
- End federal mandates for eligibility and benefits.
- States would be provided with an annual lump sum of money.
- State would design the Medicaid program to their specifications including eligibility, benefits and delivery model (questionable).
- Funding allotments would/could be subject to annual adjustment.

Existing Medicaid Financing System

- Federal payments are guaranteed to states on an "as-needed" basis. The money follows "eligible people and services provided."
- Program can guarantee coverage to all eligible individuals (with exceptions for waivers.)
- Federal payments to states are based on actual state costs (federal payments increase when state spending increases, ie. Flu outbreak, new and expensive cancer therapy, etc.)
- Requires state spending. States spend money and then they receive federal payments.

Block Grant Financing

- Capped federal financing. The total amount of federal funds is limited to an amount that is predetermined and may be set in federal legislation.
- Federal funding levels can vary from year.
- Funding levels are typically based on a formula. Formulas may not take into account the different and evolving needs in each state.
- Some federal block grant programs have a state spending requirement others do not.

Traditional Block grants*

- A defined amount of funding, often less than traditionally spent in exchange for total flexibility.
- Funds are not tied to amount of services provided.
- Amount can be increased or decreased at any time.
- Historically, once a program converts to a block grant there is no state option to revert back to the traditional financing model.

Global commitment

- A ceiling amount available for reimbursement based on historical expenditure growth.
- Funds based on program expenditures and costs.
- Waiver ceiling increases annually based on 9% inflationary trend.
- Ceiling is permanent for 5 year term of agreement.
- Additional, but limited flexibility to operate program.

Source: Susan Besio, then AHS Director of Planning, Vermont, March 2005.

*We don't know what a Medicaid block grant will look like.

Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration

- Approved on January 16, 2009.
- Capped combined federal and state Medicaid spending at $12.075 billion for the waiver's five-year duration from 2009 to 2013. The federal government would continue to pay a fixed percentage of Rhode Island's Medicaid costs up to the cap.
- Cap was above what the federal government otherwise was expected to spend and gave Rhode Island additional federal Medicaid funding to help pay for services it had previously financed with state-only money.
- RI can terminate global waiver and opt back into regular Medicaid.
- State claims savings from the waiver; speculation that a good percentage of the savings can be attributed to the enhanced FMAP under the Recovery Act.

Goals of the RI Global Waiver

- Goals:
  - To reform publicly-funded long-term care in order to increase home and community-based services and decrease reliance on institutions
  - To further develop the Medicaid medical home model.
  - To implement payment and purchasing strategies that align with the Waiver's programmatic goals and ensure a sustainable, cost-effective program.
  - To ensure that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice.
  - To maximize available service options.
  - To promote accountability and transparency.
  - To encourage and reward health outcomes.
  - To advance efficiencies through interdepartmental cooperation.

Source: RI Global Waiver website

Things to Consider: Medicaid Block Grants

- Untested for Medicaid.
- Provides opportunities for states to design programs that fit their needs with less federal mandates which could lead to innovation.
- Could encourage states to create highly efficient and effective programs with an emphasis on prevention and management of disease
- Will it increase state flexibility adequately? History shows that Congress often adds strings.
- Will the program provide enough "predictability" for state to do their budgeting; the amount of the block grant could change annually.

State Medicaid Reforms

State Medicaid Reforms: Focus on Cost Containment

- Provider rate reductions
- Benefit cuts
- Eligibility changes*
- Pre-authorizations

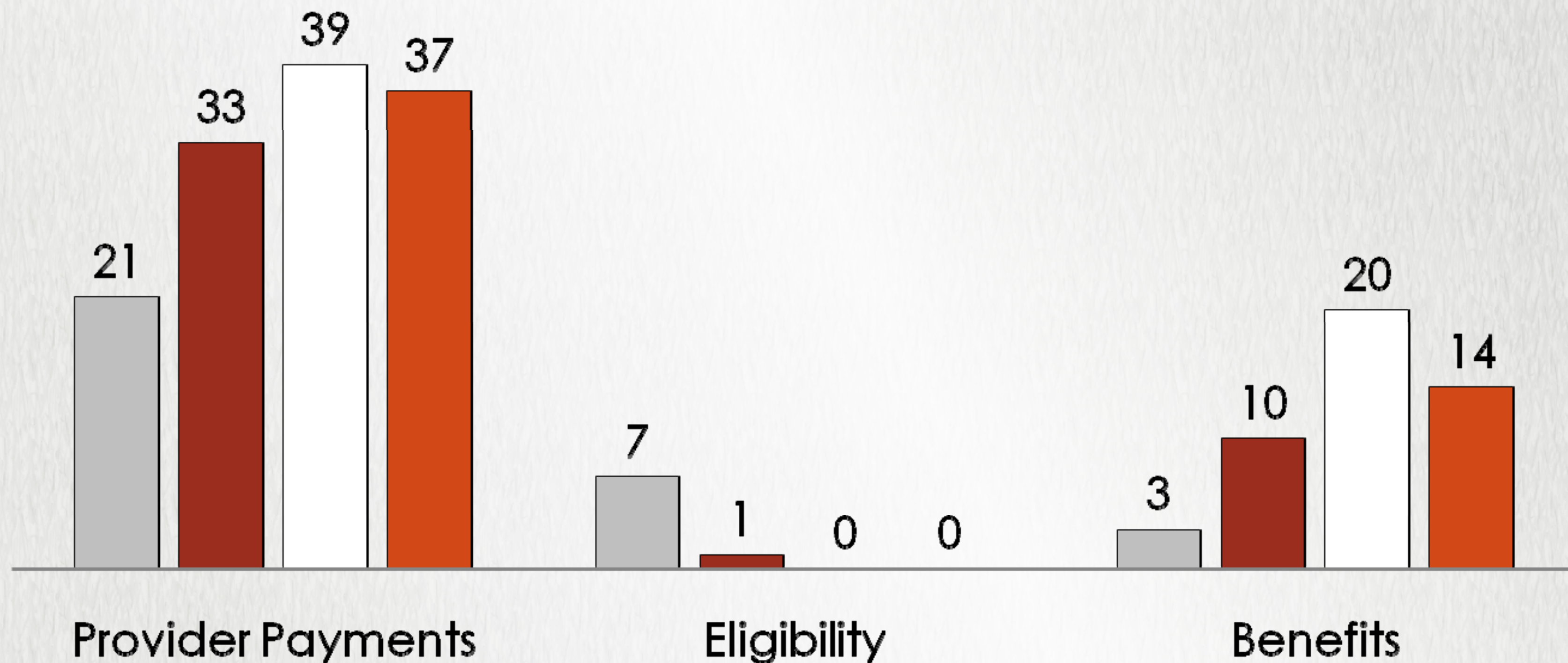
***MOE requirements**

- Waivers expiring before 2014: AZ, HI, IN, MA, MN, OK, RI, and WI.

NCSL Budget Tracking Resources:

- http://www.ncsl.org/default.aspx?TabId=20000

Immediate Cost Containment Measures in Medicaid



Source: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2010.

Note: Past survey results indicate not all adopted actions are implemented. Provider payment restrictions include rate cuts for any provider or freezes for nursing facilities or hospitals. Eligibility includes eligibility and application expansions/restrictions. Benefits includes elimination and utilization controls.

State Medicaid Reforms: Focus on Cost Containment, Cont…

- Increase use of managed care
  - Mandatory or opt-out provisions
  - New populations
  - Increased requirements in contracts: medical homes, disease management

State Medicaid Reforms: Focus on Cost Containment, Cont…

- Long-term Care
  - Move to home-based care
  - Increased use of managed care
  - Focus on dual eligibles

State Medicaid Reforms: Focus on Cost Containment, Cont…

- Fraud and Abuse
  - New York modified its Medicaid management information system to better identify improperly paid claims.
  - South Carolina is posting Medicaid payment information online.
  - Indiana is modifying long-term care system in multiple ways.

State Medicaid Reforms: Focus on Cost Containment, Cont…

- **Pharmacy utilization or cost control initiatives**
  - Prior authorization
  - Preferred drug list
  - Changing Rx benefits
  - Bulk purchasing
  - Care management

http://www.ncsl.org/default.aspx?tabid=14523#Bills

State Medicaid Reforms: Focus on Cost Containment, Cont…

- Payment reform
- Pilot and demonstration projects: medical homes, chronic disease management
- Establishment of ACOs

State Medicaid Reforms: Focus on Cost Containment, Cont…

- **Medicaid matching revenues**
  - Reallocating tobacco funds
  - hospital assessment or fees

- **Total Medicaid Reforms**
  - Global waivers/block grants/lump-sum payments
  - Proposed as Alternative to ACA

What State Research Suggests

State Recommendations to Improve Care and Contain Costs

- For this presentation, reviewed analytical work done by Medicaid study groups, committees, or analysts in Kansas, Missouri, Nebraska, Ohio, and Utah during past five years.
- Many approaches to institute cost-effective care are multi-year in nature.
- Different issue areas require different approaches.
- There are no magic bullets.

Themes Across States

- Eliminate inefficiencies to reduce costs and improve quality
  - Better management
  - Better delivery of care
  - More appropriate services
  - Improved administration
- Tie pay to performance
  - Make integral part of rate setting
- Create more unity in Medicaid budgeting and management
  - For example, bring together management of Medicaid-funded programs in various agencies

State Recommendations

- Care Management
- Pharmacy
- Finance, Structure and Management
- Long Term Care

"Best Buys" for Medicaid Reform & Cost Containment

- Quality Improvement Strategies
  - Care Management for High-Risk Pregnancy
  - Care Management for High-Risk Asthma
- Systems of Care for Aged, Blind and Disabled Beneficiaries
- Care Management for High-Risk, High-Cost Members with Multiple Chronic Conditions
- Integrated Care for Dual Eligibles

Source: Melanie Bella, Center for Health Care Strategies, Inc.

Preparing for 2014

- Newly enrolled concerns
- "Out of the wood work" concerns

QUESTIONS

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