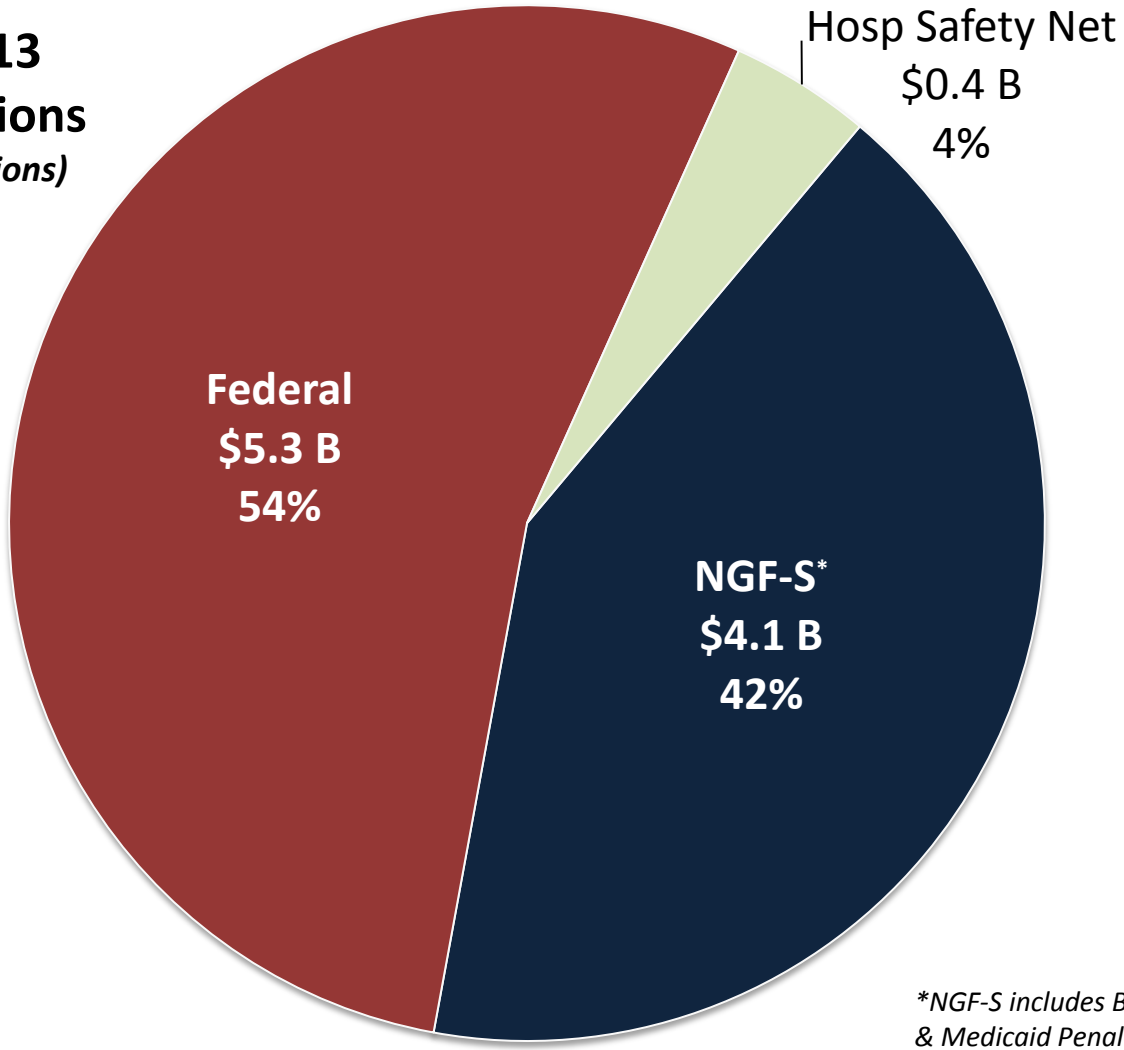
Low-Income Medical Assistance Budget Work Session

Examining trends and how the state incurs costs

Senate Ways and Means Staff Presentation
January 23, 2013

Washington is budgeted to spend $9.9 billion on low-income medical care this biennium with over half coming from federal sources

FY 2011-13 Appropriations
(dollars in millions)



**NGF-S includes Basic Health Stabilization & Medicaid Penalty Account*

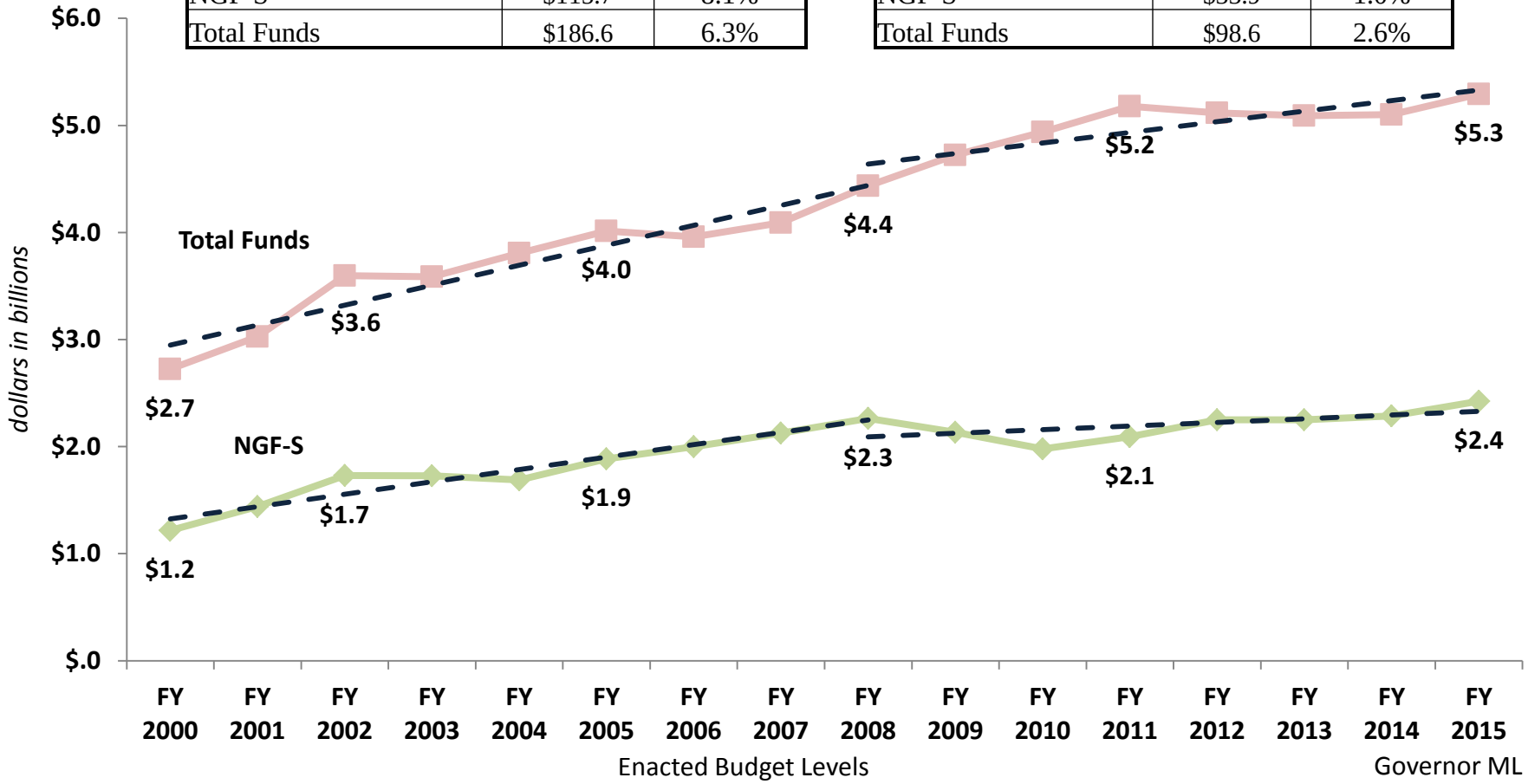
As the majority shareholder and financier of Medicaid, the federal government sets parameters on state actions

- State participation in Medicaid is voluntary both for the current program and under the Affordable Care Act (federal health reform)
- Federal funds are a match, not a grant
  - (50-65% of allowable expenditures) for current program
  - (90-100% of allowable expenditures) for newly Medicaid eligible under Expansion
- Entitlement to individuals and to states
  - All who apply and meet eligibility standards must be served
  - States who incur allowable expenses must receive a federal match
- National minimum eligibility standards, with state option to adopt more generous ones within limits
  - Primary reason why Washington may achieve savings through health reform
- National minimum requirements for covered services, with state option to cover more

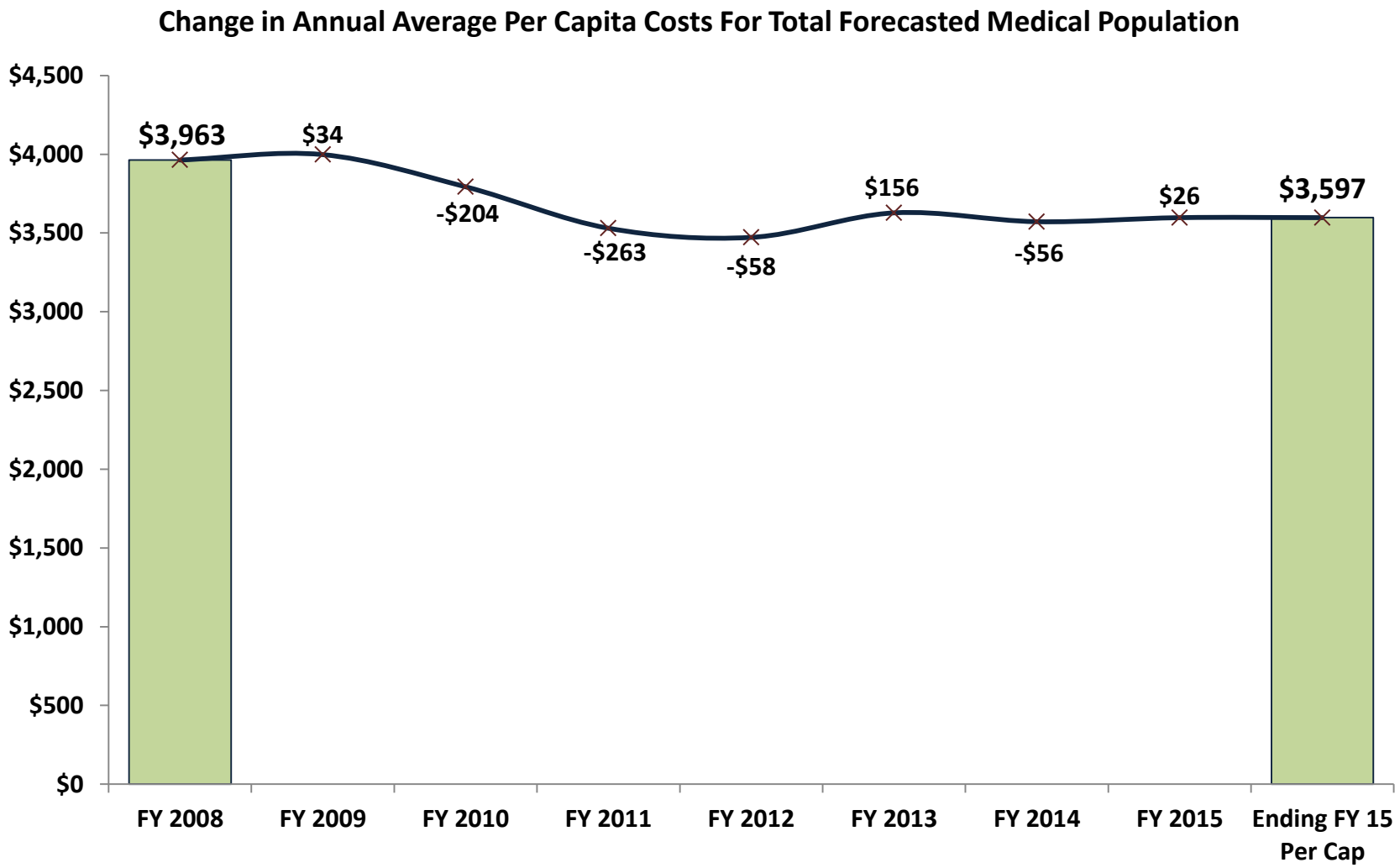
Low income spending is expected to roughly double by the end of FY 2015 from FY 2000 with the strongest growth prior to the recession

Average Annual Growth	2000-2008	
	$ in millions	Percentage
NGF-S	$115.7	8.1%
Total Funds	$186.6	6.3%

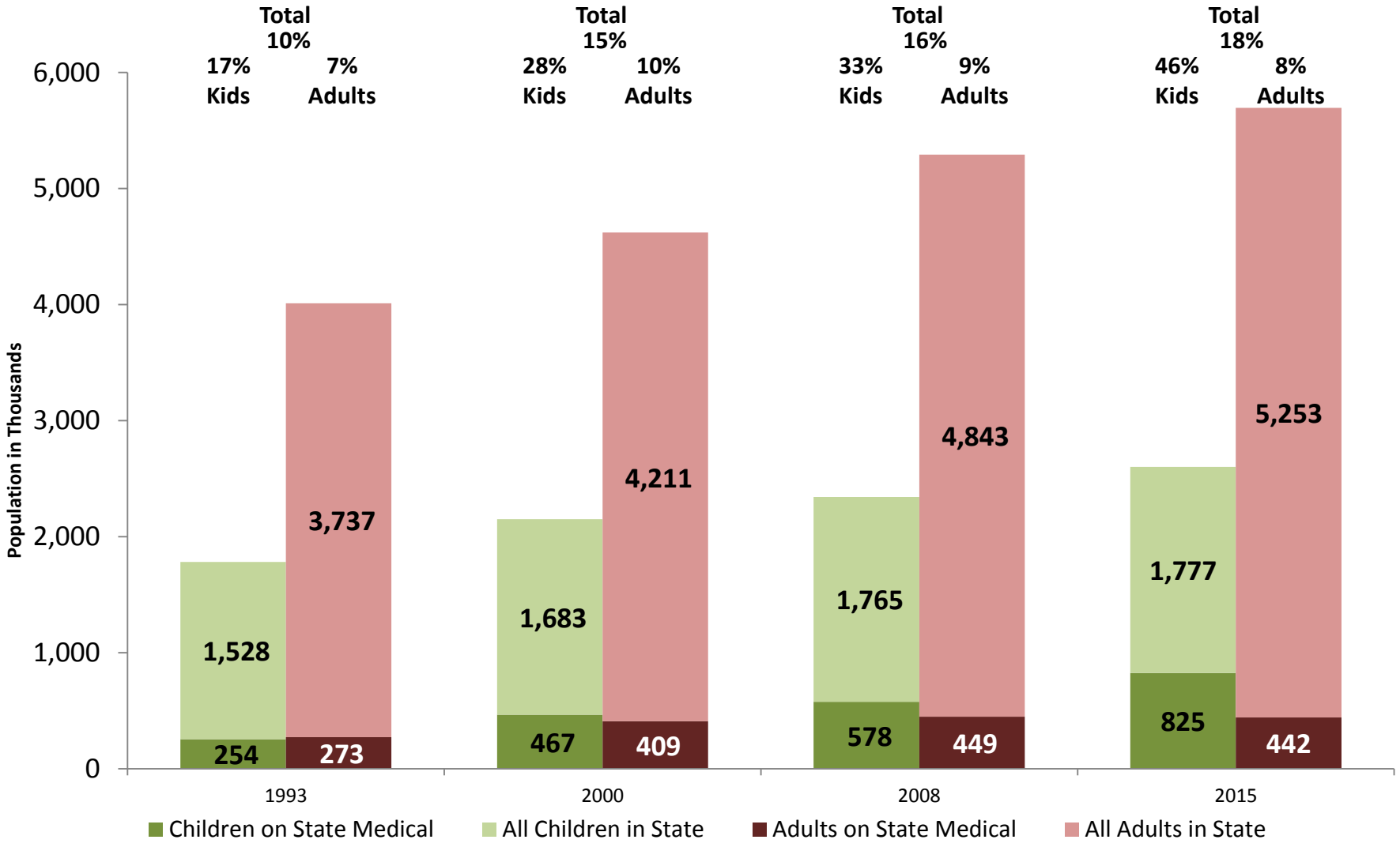
Average Annual Growth	2008-2015	
	$ in millions	Percentage
NGF-S	$33.9	1.0%
Total Funds	$98.6	2.6%



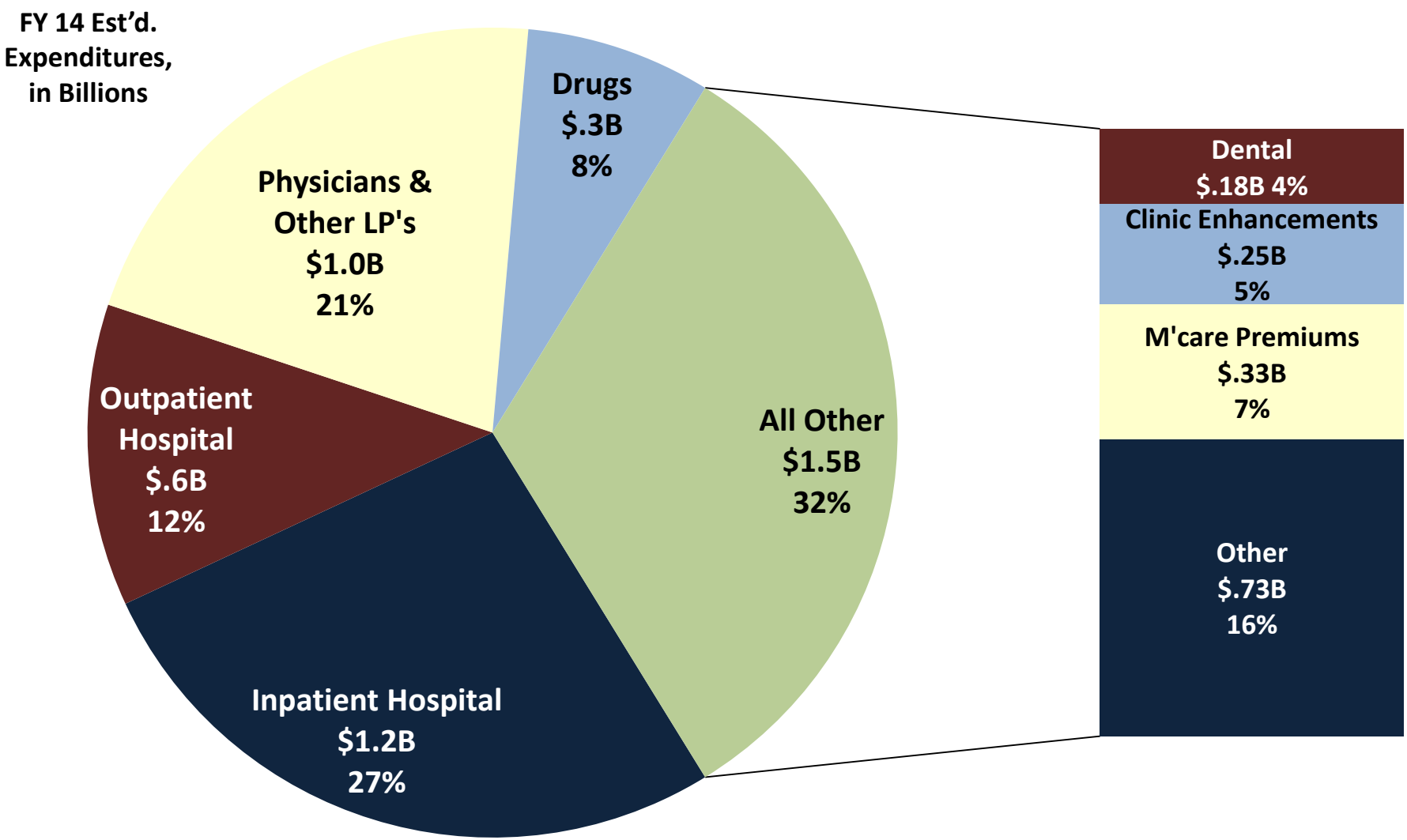
Even though we are seeing small annual growth from 2008 to 2015, the average annual per capita spending is -1.4% over the same period



The total caseload is expected to increase from ~527,000 in 1993 to ~1.2M by the end of next biennium



In terms of dollars, two-thirds of spending on services is for hospitals, physicians, and drugs



The maximum and minimum prices that the state can pay for services are constrained by federal law and court decisions

- Rates must be sufficient to assure patient access comparable to the general population's
  - Federal 9th Circuit interprets as requiring that rates be "reasonably related" to cost
- 9th Circuit requires federal approval of rate reductions before states may implement
  - Can delay savings for 6 – 12 months.
- Rates paid to managed care companies must be "actuarially sound"
- Low-income community clinics ("FQHCs and RHCs") must be paid cost-related rates higher than other providers (extra $119M GF-S/year)

How much the state pays depends on the program being funded and its financing scheme

Program	Description	State/Federal Split
Medicaid – Title XIX	Medical assistance based on categorical eligibility and income	50%/50% (can vary annually)
State Children's Health Insurance Program (SCHIP) – Title XXI	Medical assistance for children and pregnant women with family incomes above 133% FPL	35%/65% (capped annual allotment)
Family Planning	Family planning services provided to low-income clients under a waiver	10%/90%
Disproportionate Share Hospital (DSH)	Grants to hospitals that serve a disproportionate share of indigent patients	50%/50% (capped annual allotment)
Certified Public Expenditures and Intergovernmental Transfers	Funds from local public entities used to match federal funds	0%/50% (local public entities provide the state share)
Assessments	Assessments on providers used to fund payments for services that are matched by federal funds	0%/50%
Administration	Administration of Title XIX and Title XXI programs	50%/50%
Medicaid Management Information System (MMIS)	Replacing the legacy MMIS with a new system (ProviderOne)	25%/75% (for Medicaid-related updates); 10%/90% (for new systems)
State Only/Waiver Populations	DL and ADATSA medical, BHP, undocumented children	100%/0% for state-only groups 50%/50% for waiver groups

How much Medicaid recipients pay depends on the recipient and or the service provided

- Enforceable cost sharing can only be applied to an individual with a family income above 100% of federal poverty level ($19,090 for family of three)
- Exemptions to this rule include
  - Children <138% FPL, foster children, disabled children, pregnant women, American Indian/Alaskan Native, individuals in institutions or hospice
  - Emergency services, family planning, preventative services or pregnancy related
- Higher co-pays can be applied to non-preferred drugs ($8 instead of $4) and non-emergent use of the emergency room ($8 instead of $0)
- Hospitals are responsible for meeting federal rules determining whether the patient is non-emergent
- Aggregate premiums and copays cannot exceed 5% of family income
  - The 5 percent must be tracked
  - The tracking requirement cannot be the responsibility of the patient

The state pays for low income medical services in two main ways

- **Fee for Service (FFS) :** Provider is paid a fixed rate for each medical product delivered/service performed
  - 19% of current Medicaid enrolled in FFS

- **Managed Care (MC):** Insurance company is paid a fixed monthly "capitation" rate per enrollee within which it is responsible for providing all covered products and services
  - 81% of current Medicaid enrolled in Managed Care

- MC approaches can theoretically result in more effective service delivery than FFS
  - Financial incentives to reduce unnecessary service utilization
  - Financial incentives to keep enrollees well
  - Selecting/limiting participating providers based on price, quality, and cost effectiveness

Potential Budgetary Effects of the Affordable Care Act and Medicaid Expansion

Overview and Governor Gregoire Budget Estimates

On June 28, 2012, the US Supreme Court ruled that states have the option to expand Medicaid eligibility under the Affordable Care Act

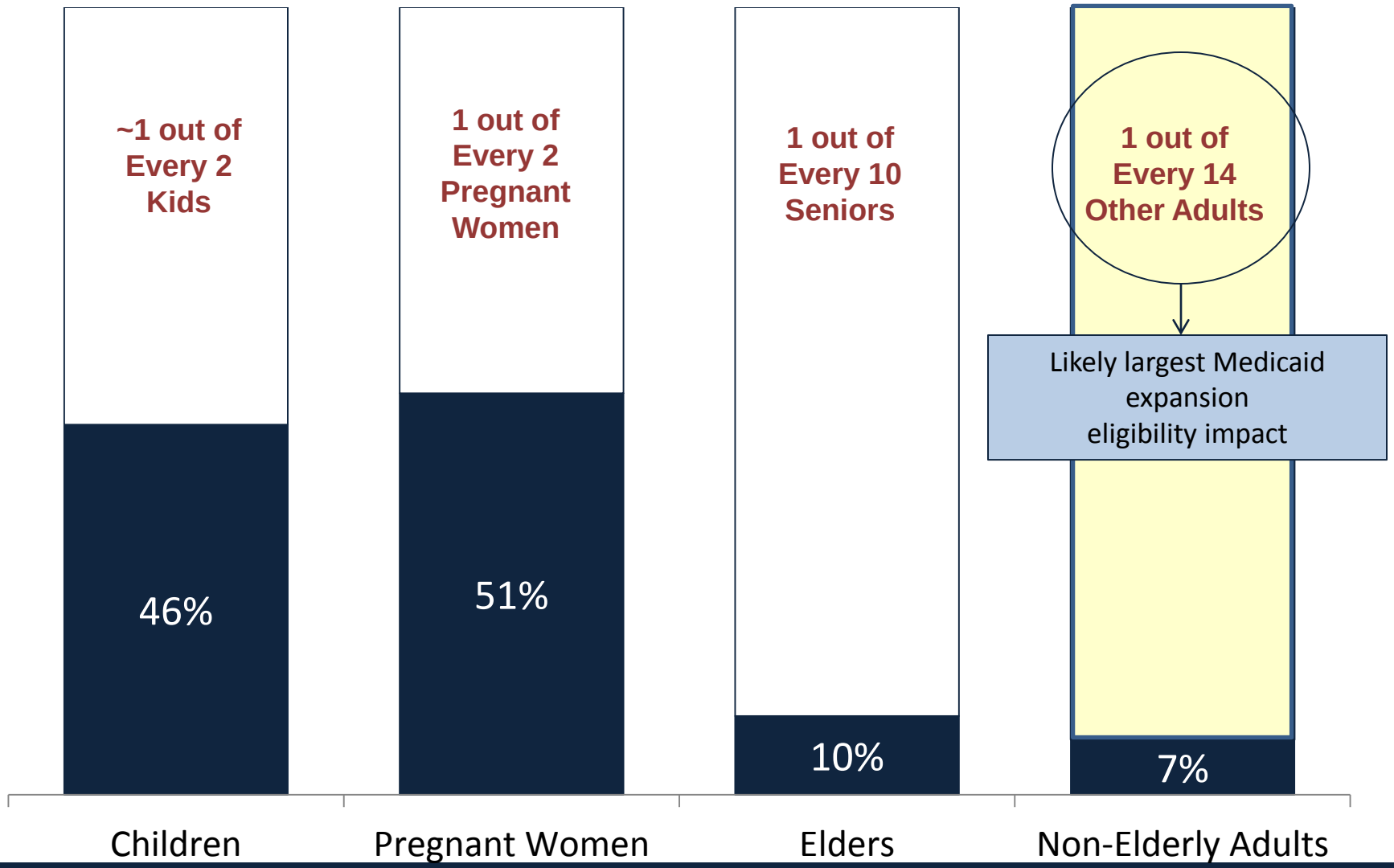
- ✓ As part of this ruling, states are not at risk of losing existing federal matching funds if they do not expand Medicaid eligibility to all residents under 138% of federal poverty

- ✓ The court did uphold the individual mandate requirement for all individuals to have qualifying health coverage or pay a tax penalty

The 2013 legislature will decide whether to expand Medicaid or not for a January 1, 2014 implementation date

The state will incur additional costs as a result of ACA regardless of the decision to expand Medicaid eligibility

Non-elderly adults, who are largely ineligible for Medicaid now, will see the largest impact under federal health reform

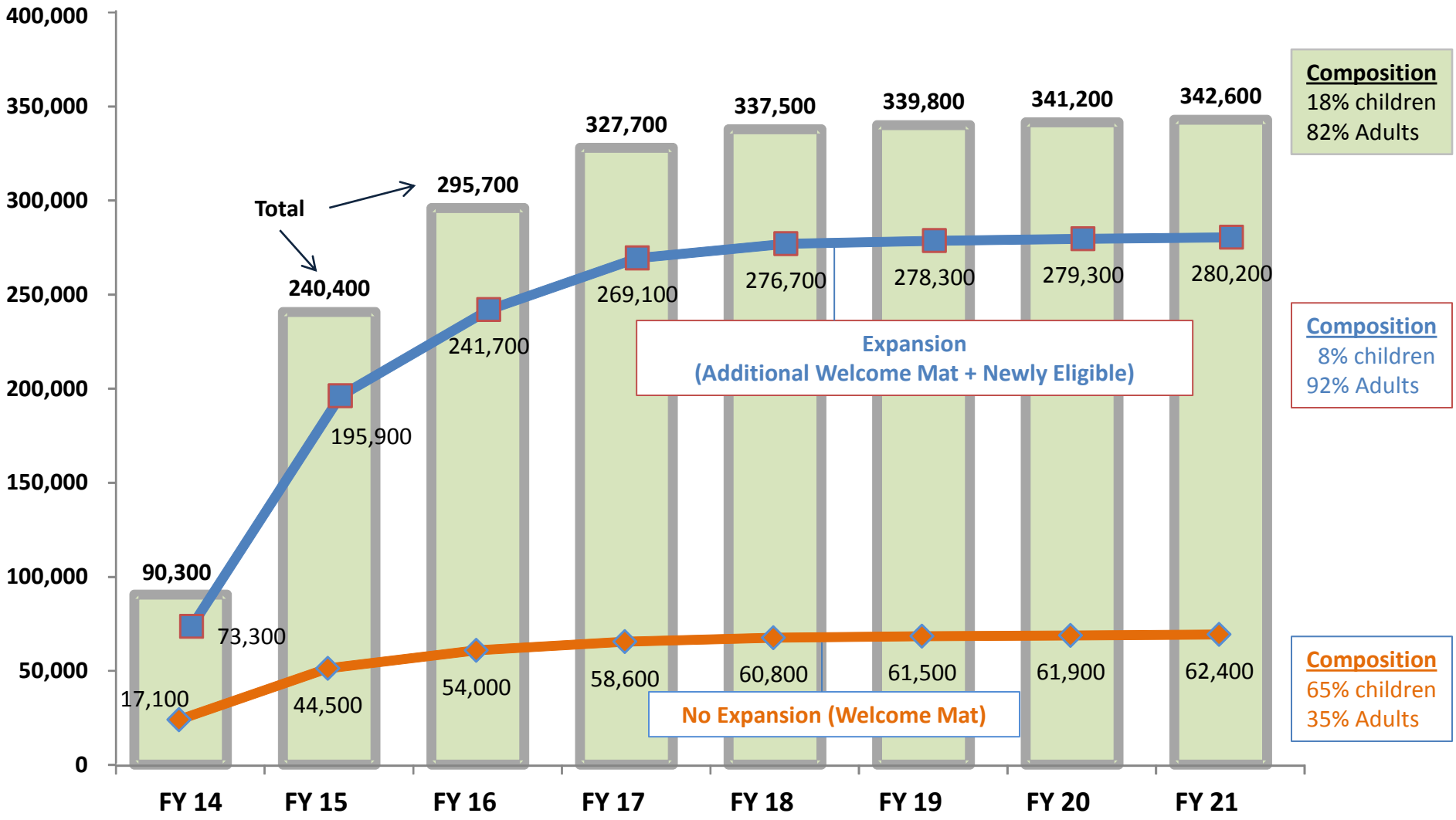


ACA medical eligibility can take four large pathways – each with different impacts on state financing and flexibility

Welcome Mat

Pathway / Coverage	Eligibility	Optional Under ACA?	State Finance Share
Currently Medicaid Eligible	• > 65 years of age • < Receiving Medicare • Eligible for an existing Medicaid category (pregnant, children, etc.)	Yes and No (adult MOE expires)	2014: 50% 2020: 50%
Children's Health Insurance Program	• Maintain current levels to 2019 • < 19 years old children • Living in families at or below 300% FPL	No	2014: 35% 2020: 12%
Newly Medicaid Eligible	• Childless adults with adjusted incomes up to 138% FPL • Parents with incomes between ~40% and 138% FPL	Yes	2014: 0% 2020: 10%
Subsidy Eligible (Exchange)	• Individuals or families with incomes between 138% and 400% FPL	No	2014: 0% 2020: 0%

Depending on whether the state elects to expand Medicaid coverage, an additional 62,000 to 343,000 people could be enrolled



Pending federal guidance, budget assumptions and future legislative decisions will shift cost and savings estimates

States are still waiting for key federal guidance:

- Federal methodology for streamlining and applying new Federal Medical Assistance Percentages (FMAP)
- The benefit package for newly Medicaid eligible not defined
- Uncompensated care reductions are still unknown
- Federal "fiscal cliff" constraints and impacts are unknown

The reliability and accuracy of cost estimates

The potential ability to offset current state costs

The impacts on other programs

- Aged, Blind, and Disabled cash program and Housing Essential Needs
- Revenue impacts, financial hardship cases, and immigration status

Governor Gregoire chose to expand Medicaid in her budget to achieve a net savings of $156 million in 2013-15. Her budget achieves savings through elimination of duplicative programs and refinancing

Governor Gregoire Affordable Care Act Budget			
Summary of Costs and Savings	FY 2013-15		
	GFS	Other	Total
BASELINE COSTS/SAVINGS REGARDLESS OF EXPANSION			
1. Total costs regardless of expansion	**$85.6**	**$145.6**	**$231.2**
TOTAL COSTS/(SAVINGS) FROM EXPANSION			
2. Increased costs from expansion	$51.7	$754.4	$806.1
3. Basic Health, Disability Lifeline, and ADATSA Medical	($101.3)	$140.0	$38.7
4. Presumptive SSI and Medically Needy Blind Disabled	($135.5)	$139.8	$4.3
5. Take Charge; HIV Services; Breast, Cervical, Colon Cancer Screening and Treatment	($15.6)	($29.1)	($44.7)
6. All Other	($41.7)	$35.6	($6.1)
7. Total Cost/ (Savings)	**($242.4)**	**$1,040.7**	**$798.3**
NET COSTS/SAVINGS FROM BASELINE			
8. Net Costs/Savings From Baseline	**($156.8)**	**$1,186.3**	**$1,029.5**