

Medicaid Reforms Will Save Money, Making a Good Deal Even Better



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By Massey Whorley and Michael J. Cassidy

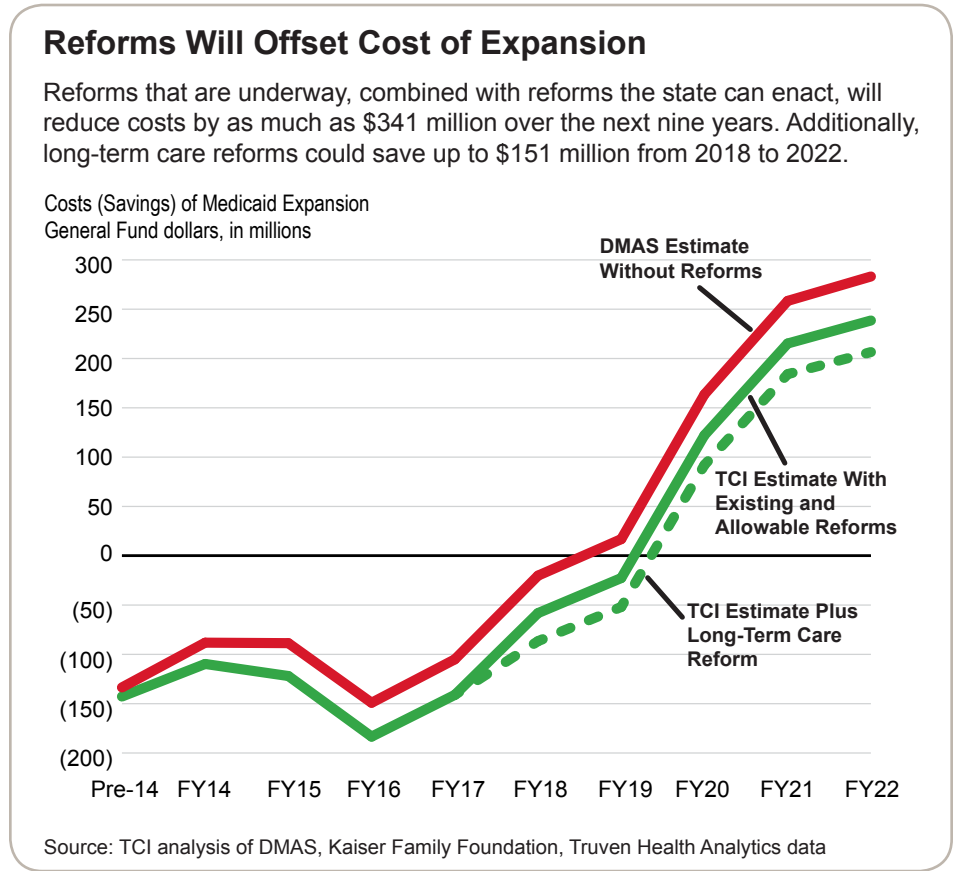
Virginia lawmakers have called for reforms of the state's Medicaid program as part of any move forward to expand health insurance coverage to more low-income Virginians. Some argue that Virginia should delay expansion in order to pursue reforms first.

While efforts to improve health outcomes and cut costs in the health care system are warranted, Medicaid already efficiently provides quality, affordable health coverage to many Virginians. And many Medicaid reforms are in place and underway to accomplish these goals. Delaying expansion would cost the state millions, postpone coverage for thousands of working Virginians, and limit the state's reform options.

This report looks at the set of Medicaid reforms that Virginia policymakers are already pursuing and additional reforms that the state can pursue without special waivers from the federal government. It shows that there is no need to delay expansion since Virginia can already achieve important goals of reducing cost, aligning incentives better within the program, and improving health outcomes among people who have Medicaid coverage through these reforms.

Furthermore, Virginia could pursue additional reforms – based on promising outcomes of recent health care delivery system improvements both here in Virginia and elsewhere – that could help reduce costs over the long-term even more.

Estimates from the state's Medicaid office, the Department of Medical Assistance Services (DMAS), show that Medicaid expansion of health care coverage for up to 400,000 Virginians will cost the state \$137.5 million over the next nine years (2014 to 2022). Savings from the reforms currently underway would completely offset these costs. Moreover, additional health care



delivery system reforms could also achieve significant savings.

Reforms Currently Underway Would More Than Offset Medicaid Expansion Costs

The state is currently implementing several reforms that, based on DMAS estimates, will produce \$325 million in savings from fiscal year 2014 to 2022. These savings more than offset the estimated \$137.5 million cost of Medicaid expansion.

Among the reforms is the Medicare-Medicaid “dual eligible” demonstration project that is scheduled to begin January 1, 2014, and is predicted to save an average of \$21 million per year. “Dual eligibles” are low-income seniors and people with disabilities who are enrolled in both the Medicaid and Medicare programs. They represent some of the most vulnerable members of our community, and because

of their poorer health status, they make greater use of medical and support services. Many are unnecessarily admitted to hospitals or placed in nursing homes. Complicating matters is the need for them to navigate two health insurance programs with different sets of rules and requirements that can often result in inadequate coordination of services and fragmented care.

While the demonstration project would only be authorized to run initially for three years, it could be extended especially if promising outcomes result. Since these reforms are consistent with the federal government's approach to help states improve quality and will reduce federal costs, effective practices would be expected to continue.

Creating savings through improving and integrating medical care and support

services for this population is a key goal for Virginia health policymakers. If successful, this pilot could be expanded to other segments of the long-term care population in our Medicaid program, which could yield additional savings.

In addition, the recently completed statewide expansion of managed care will save on average \$7 million annually. And other reforms currently in place, like enhanced program integrity efforts, are forecast to save the state a total of \$5 million per year.

Additional Reforms Could Produce More Savings

Several additional Medicaid reforms could also produce savings and are fully within Virginia's control to implement now. Reforms such as having Medicaid adopt a more commercial-like benefit package, placing reasonable limits on non-essential benefits, and imposing nominal cost-sharing can all be enacted through amendments to our state plan for Medicaid. Conservatively, these reforms could save the state \$1 million to \$2 million per year.

These reforms could be accomplished by several means. Virginia could more closely align Medicaid benefits for the expansion population with commercially available insurance plans by placing limits on services such as physical, occupational, and speech therapies. Virginia does not currently limit these benefits. The state could also place reasonable limitations on non-essential benefits, like non-emergency transportation services.

Proposed new rules from the federal government also allow the state to increase the use of co-pays among people covered by Medicaid. For the expansion population, the state could impose a co-pay of \$4 for outpatient visits for individuals under 100 percent of the poverty level. For individuals above that level, the state could require a co-pay of as much as 10 percent of the state's costs, not to exceed five percent of their family income. The state could

also implement a co-pay of \$8 for non-emergency use of an emergency room to discourage this practice. Such cost sharing could reduce overall Medicaid costs because recipients would have incentives to avoid unnecessary care and access the health system more efficiently. The state would also be able to reduce payments to health care providers by the co-pay amount, since providers would be responsible for collecting the co-pay from Medicaid recipients.

Delivery System Reforms Hold Promise of Improved Outcomes and Reduced Costs

Major drivers of Medicaid spending, such as long-term care and unmanaged chronic illnesses, could be addressed through more systematic health care delivery system reforms. While this would require more stakeholder engagement to identify which reforms hold the most promise in Virginia and may require applying for special federal waivers in order to implement, the cost savings could be significant.

Long-term care comprises 35 percent of all Virginia Medicaid expenditures, despite the fact that only seven percent of recipients receive long-term care. While the Medicare-Medicaid dual eligible demonstration project will address a portion of this population, many Medicaid recipients in long-term care are not dual eligibles. These individuals receive care that is not comprehensively managed. DMAS estimates that employing managed care principles to long-term care in Virginia could reduce expenditures by five percent per year. While reforms in this area would require further federal waivers, and would likely take four to five years to implement, the state could expect average annual savings of \$30 million per year starting in 2018.

Coordinated care principles could also be applied to the prevention and management of chronic disease within the overall Medicaid population. A recent study at Virginia Commonwealth University illustrated that community-based, coordinated care can reduce health care costs by as much as 48 percent. Similar

Coordinated Care Saves

Delivery system reforms that coordinate care have been shown to control costs and reduce the need for acute care.



48%
decrease in average
health care costs per year

Results compare people without health insurance who gained coverage through a VCU program for 1 year versus 3 years.



33%
relative reduction in
hospitalizations

Results compare the hospitalizations of Medicare beneficiaries participating in Pennsylvania coordinated care demonstration project.

Source: Health Affairs

findings emerged from a coordinated care model in Pennsylvania that focused on the prevention of chronic disease among older patients. This study found that by addressing the root causes of chronic diseases, coordinated care models can reduce hospitalization by 33 percent.

The bottom line: Reforms can be done under current rules and are well within Virginia's power to implement. There is no need to wait to expand Medicaid.

804-396-2051
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