# Medicaid Trends and their Implications for Securing Revenues for Community Health Centers

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# Why CHCs are Important to Medicaid

- CHCs provide the largest national network of safety net primary care providers
- CHCs have a mission and commitment to serve Medicaid
- Studies show CHCs provide cost-effective care, with savings up to 30 percent
- CHCs provide care to 10 percent of all persons on Medicaid
- CHCs provide services with limited access for Medicaid patients, such as dental
- Services that are important to quality are central to the CHC mission (such as primary care and immunizations)

# Why Medicaid is Important to Health Centers

- Medicaid is one of the better payers, with payment based on reasonable costs
- Medicaid provides a reliable, stable source of funding
- Medicaid is the largest single source of revenue for CHCs
  - 36 percent of all CHC patients have Medicaid coverage
  - 36 percent of all revenues are from Medicaid

# The Context: Medicaid in 2005 – *The Nation's Largest Health Care Program*

- Comprehensive health and long term care coverage for over 58 million in U.S. (Medicare ~ 42 million)

- Medicaid Spending in FY 2005: $316 billion (or more)
  - $134 billion state and local funds
  - $182 billion federal
    - Medicaid accounts for 43% of all federal funds to states

Source: CBO March 2005 Medicaid Baseline; CMS, Office of the Actuary, 2005

# A Lot Is Asked of Medicaid:

- **To Assure Maternal and Child Health**
  - **Comprehensive coverage for 28 million children (more than 1 of 4) and some of their parents**
  - **Prenatal care and delivery for over 1.5 million births annually (37% of U.S. total)**
- **To Provide Chronic and Long Term Care**
  - **Health and Long Term Care coverage for almost 15 million seniors and persons with disabilities**
  - **Home and community-based care for frail elderly and persons with chronic conditions, disabilities, HIV/AIDS**

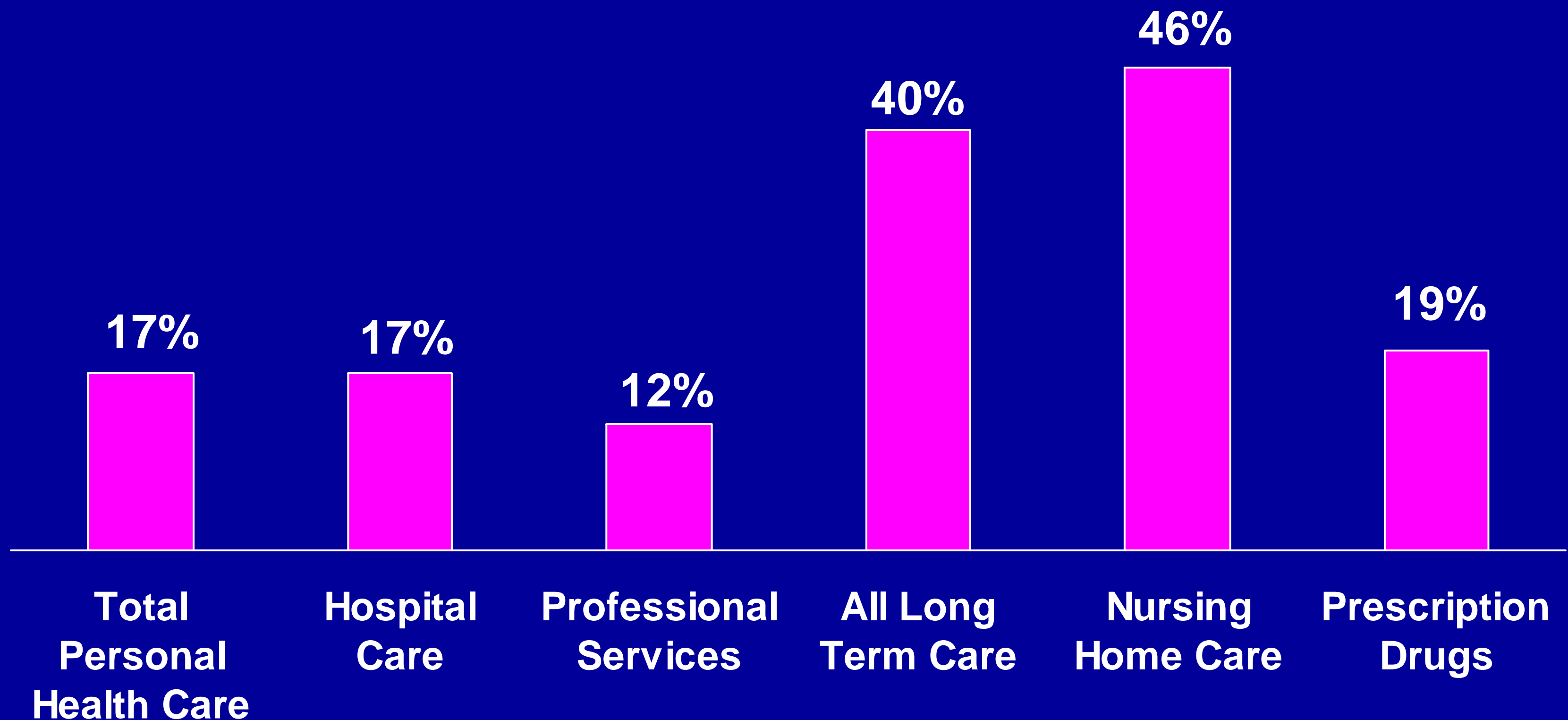
Sources: CBO Medicaid Baseline March 2005, U.S. Census, NGA MCH Update , Kaiser Commission on Medicaid and the Uninsured.

# Medicaid Is Also Asked :

- To Finance the Safety Net
  - Mental health care: over half of publicly financed care
  - Public health and school-based health
  - Health care safety net: $13 billion in DSH for uninsured
  - Community Health Centers: $1.3 billion
- To Fill the gaps in Medicare
  - For "dual eligibles"– the 6.4 million low-income elderly and disabled persons in Medicare and Medicaid account for 42% of all Medicaid spending
  - Medicaid covers premiums, coinsurance and deductibles plus Rx, nursing home care, other services

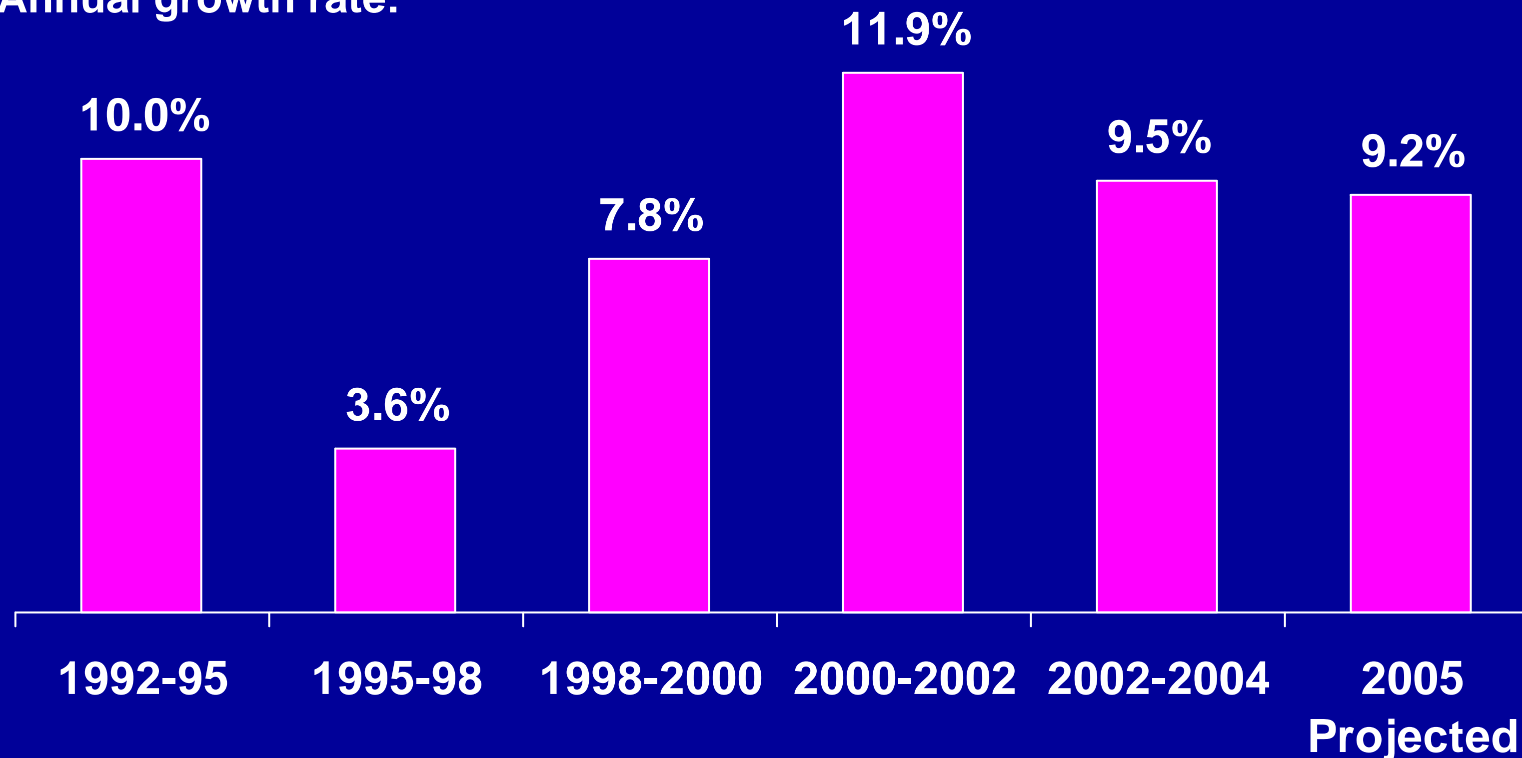
Sources: CBO Medicaid Baseline March 2005, SAMHSA, CMS, and Kaiser Commission on Medicaid and the Uninsured

# Medicaid is a Significant Share of National Health Care Spending

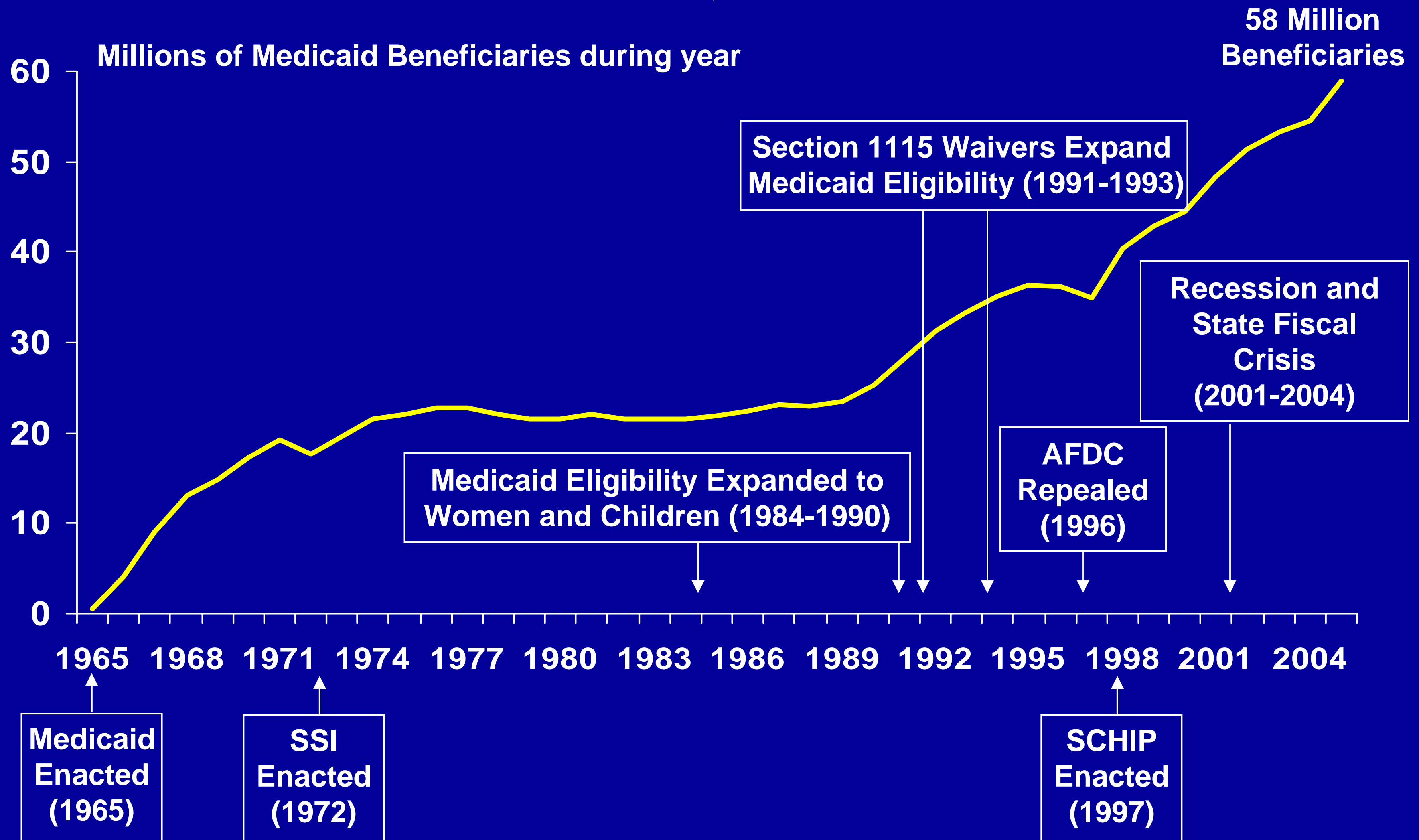



SOURCE: Cynthia Smith, Cathy Cowan, Art Sensenig, Aaron Catlin, and the Health Accounts Team, “Health Spending Slows in 2003,” *Health Affairs*, January/February 2005. Based on National Health Care Expenditure Data, CMS, Office of the Actuary.

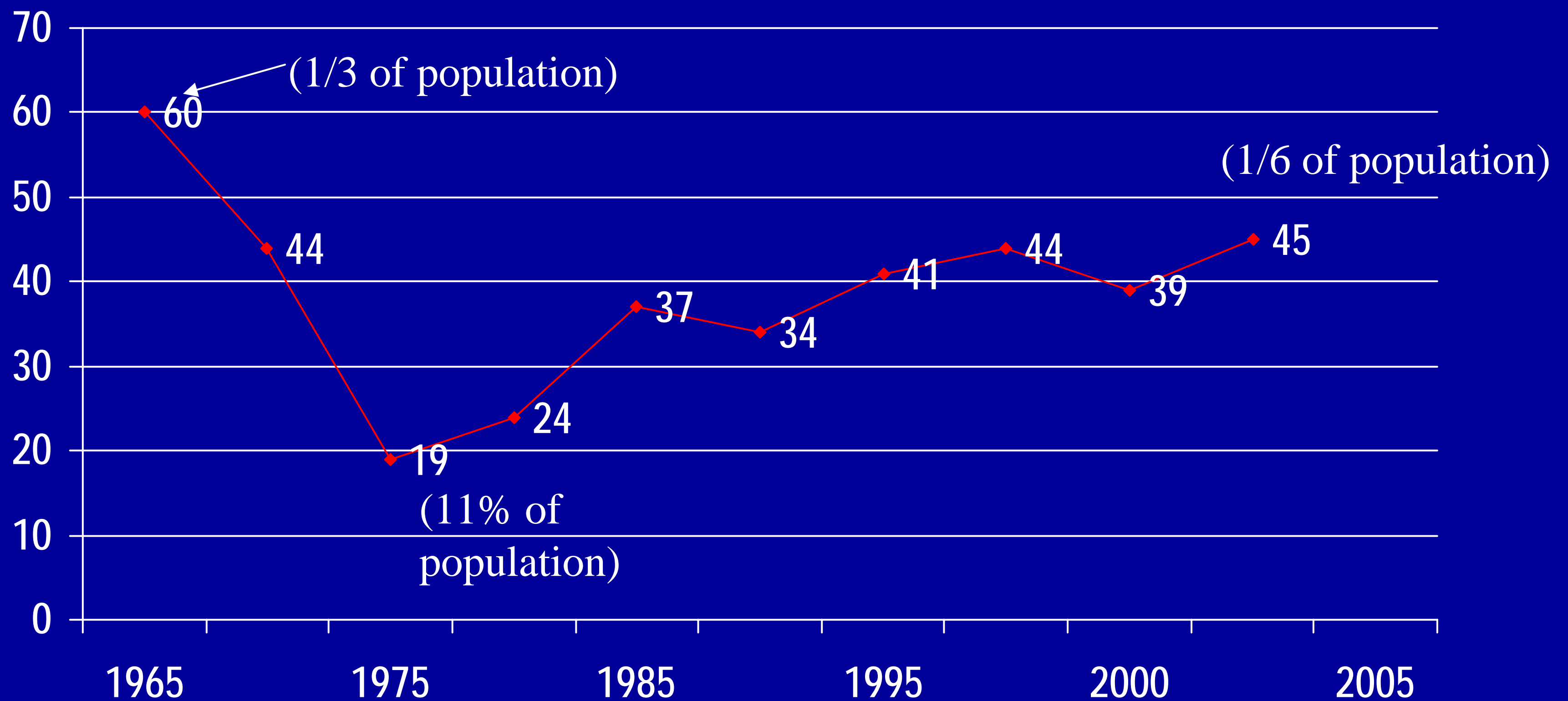
# Average Annual Growth Rates of Total Medicaid Spending




SOURCE: : 1992-2002: Urban Institute estimates for Kaiser Commission on Medicaid and the Uninsured based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64). For 2002 - 2004: Vernon Smith, et al., *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005,* Kaiser Commission on Medicaid and the Uninsured, October 2004. www.kff.org/medicaid/7190.cfm . For 2005: CMS, Office of the Actuary.

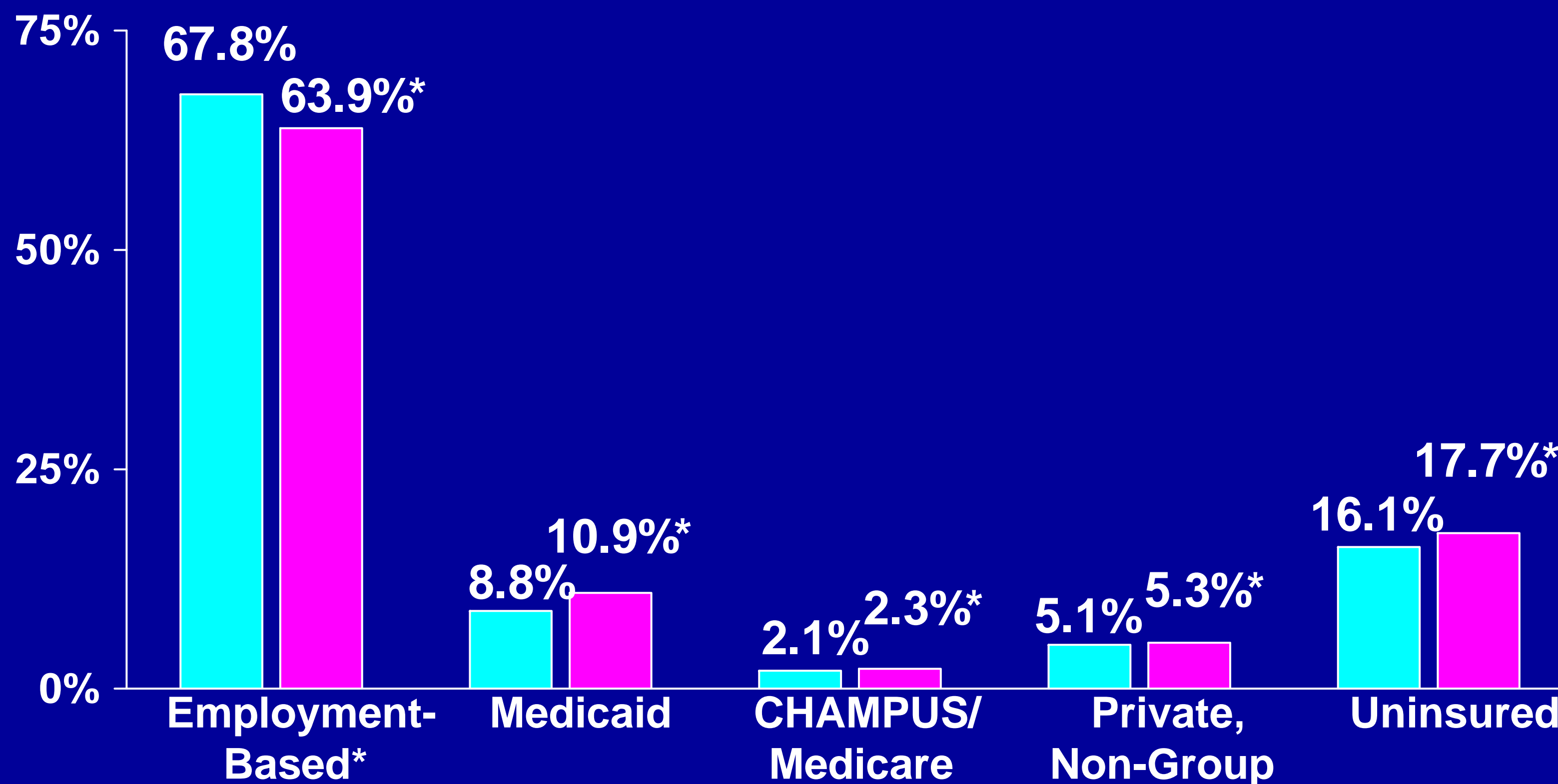

Medicaid Enrollment and Eligibility Milestones, 1965-2005
Millions of Medicaid Beneficiaries during year
58 Million Beneficiaries
60
50
40
30
20
10
0
Section 1115 Waivers Expand Medicaid Eligibility (1991-1993)
Recession and State Fiscal Crisis (2001-2004)
AFDC Repealed (1996)
Medicaid Eligibility Expanded to Women and Children (1984-1990)
1965 1968 1971 1974 1977 1980 1983 1986 1989 1992 1995 1998 2001 2004
Medicaid Enacted (1965)
SSI Enacted (1972)
SCHIP Enacted (1997)
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of data from the Centers for Medicare and Medicaid Services, 2004. CBO March 2005 Medicaid Baseline.
Smith

# Medicaid Reduces the Number of Persons Who Would Be Without Health Coverage




Source: U.S. Census 2004, CPS 2000; *HCFA Review*, 1994.

# Erosion of Employer-Sponsored Health Insurance Was Associated with Increases in Medicaid and Uninsured, 2000-2003

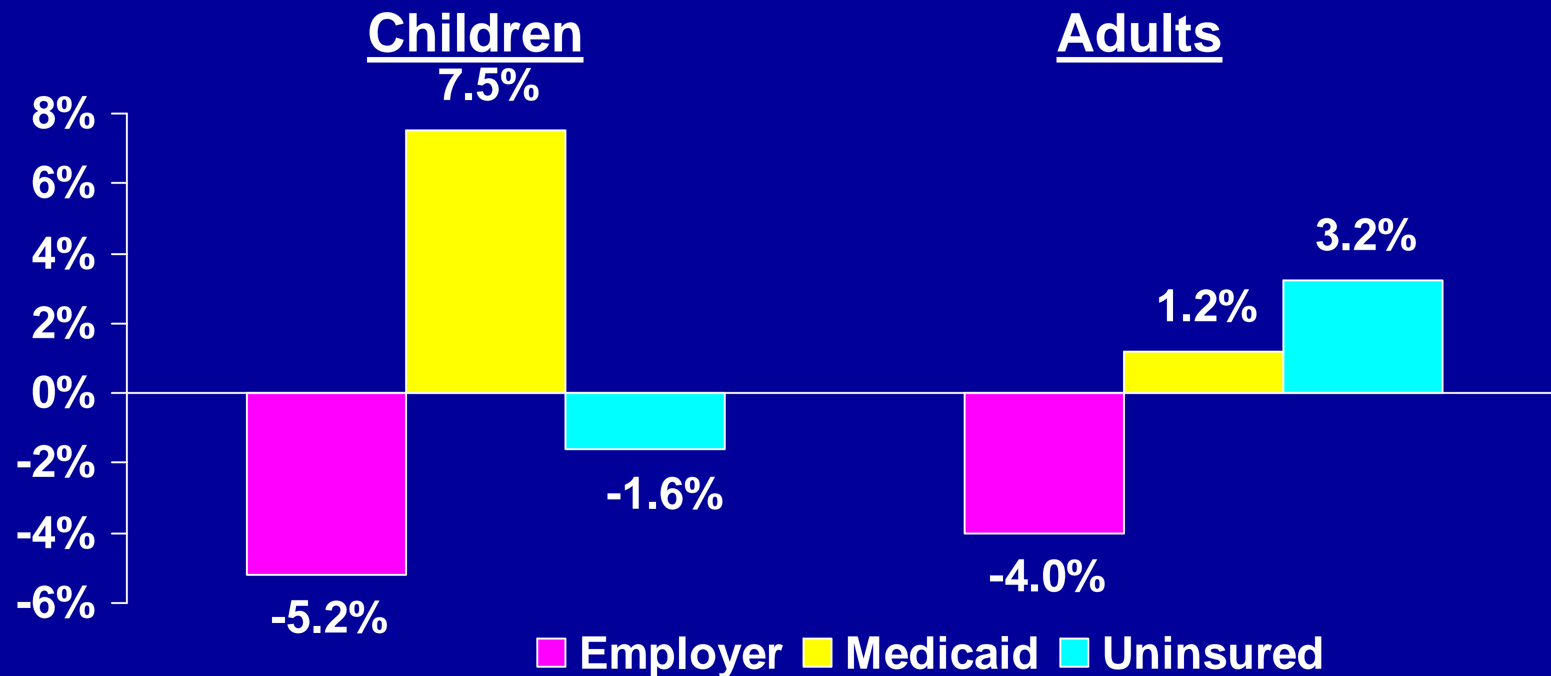



* Statistically significant change between 2000 and 2003 (p<.10)
Medicaid also includes S-CHIP, other state programs.

SOURCE: Urban Institute estimates prepared for Kaiser Commission on Medicaid and the Uninsured.

# Change in Health Coverage for Low-Income Children and Adults, 2000-2003

Percentage Point Changes

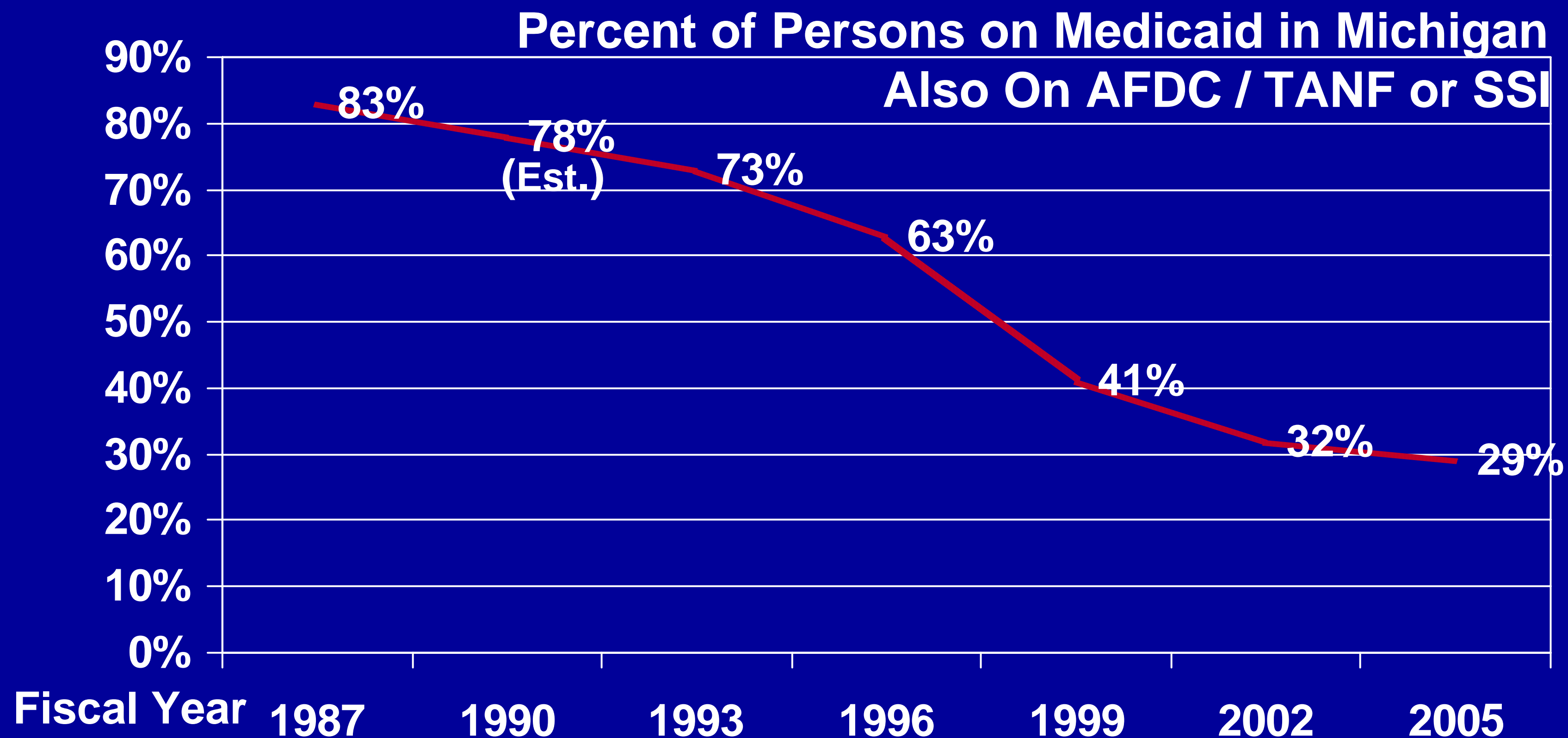



| | Children | Adults |
|---|---|---|
| ***Change in Population*** | ***2.0 Million Children*** | ***5.7 Million Adults*** |
| ***Change in Uninsured*** | ***-0.1 Million Children*** | ***+3.9 Million Adults*** |

Note: Low-income is defined as less than 200% of poverty ($29,360 for a family of three)

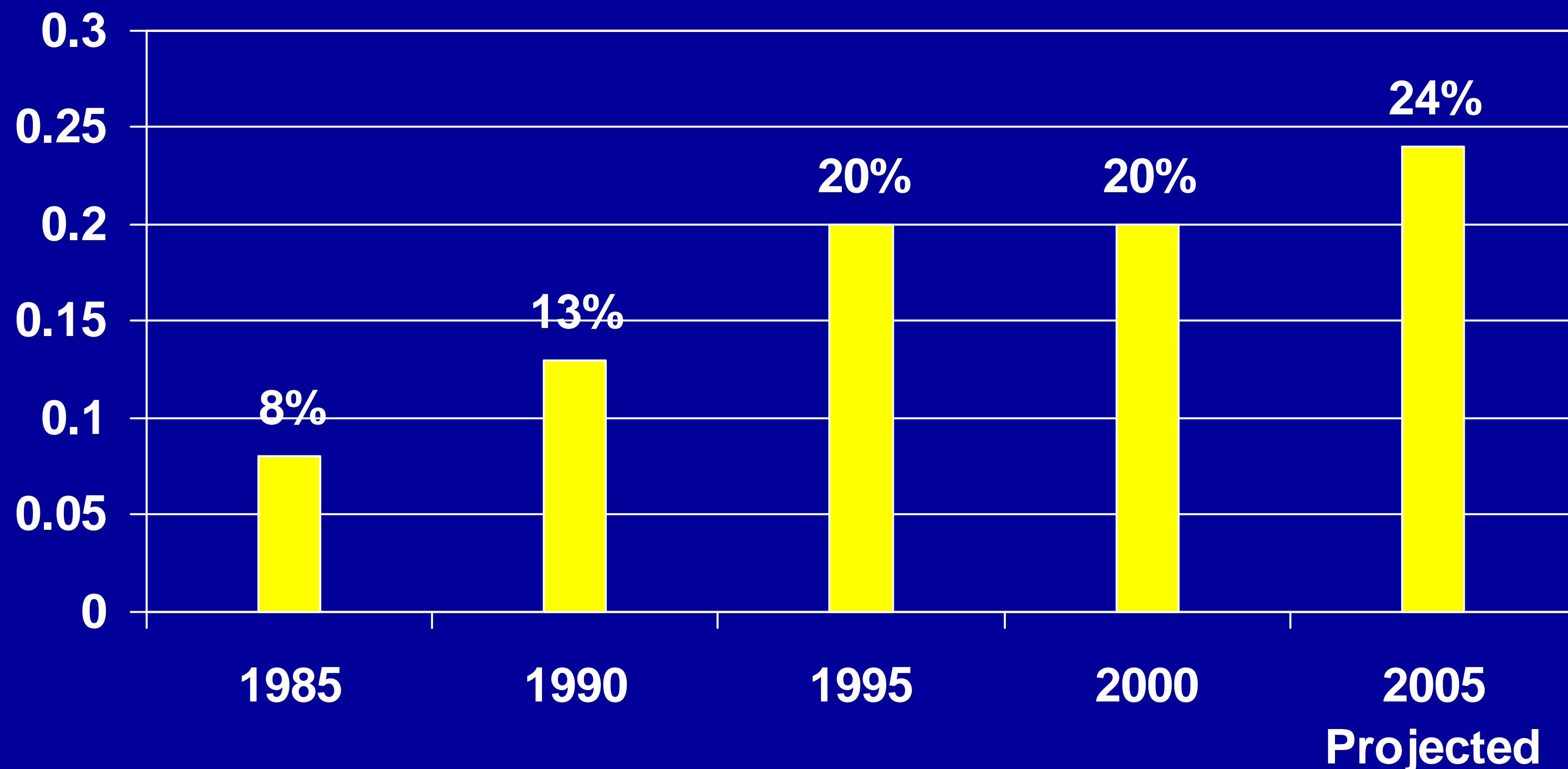
SOURCE: John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs Web Exclusive*, 26 January 2005. Prepared for Kaiser Commission on Medicaid and the Uninsured.

# Medicaid Has Changed Dramatically From Its Welfare Origins to a Health Insurance Program
## (Michigan Example: 1987 - 2004)



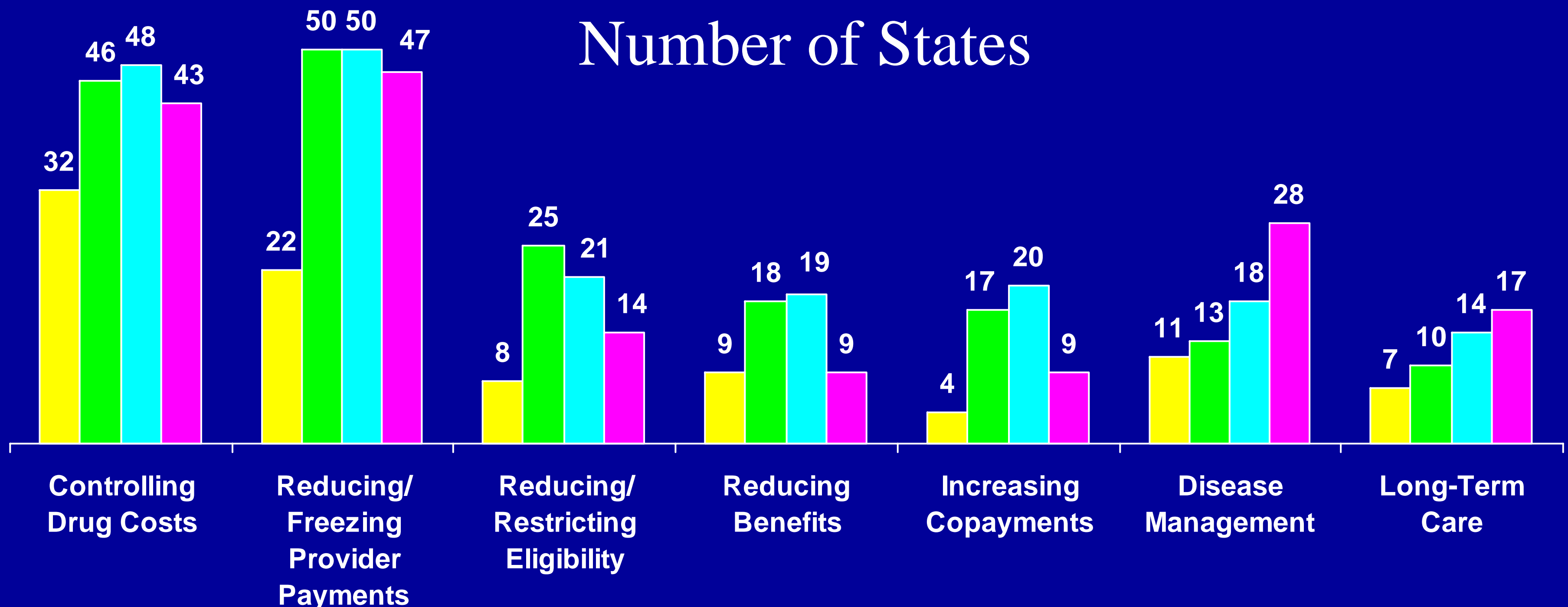

Source: Michigan Department of Human Services,
Michigan Department of Community Health, 2005 projected by HMA.

# Medicaid as a Share of Total State Budgets



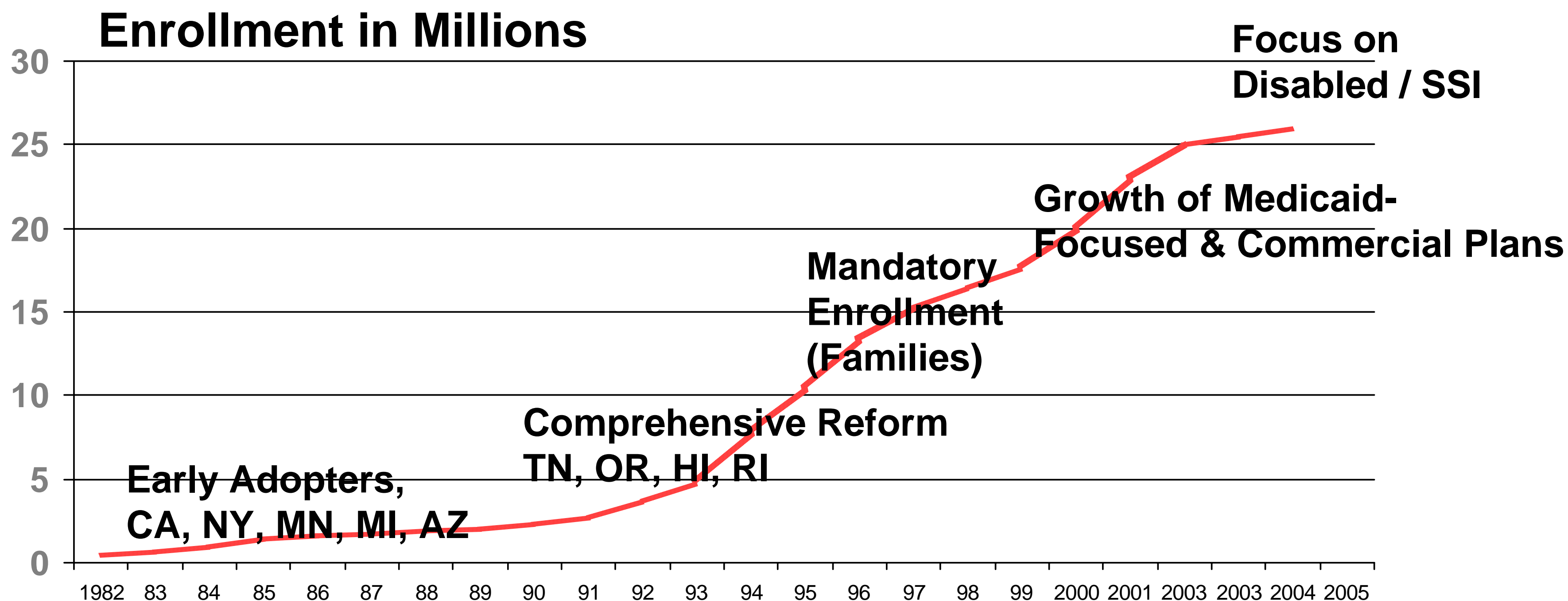

**Note: Medicaid general fund spending was 17 percent of all state general fund spending in 2003.**
Source: National Association of State Budget Officers, various reports.
2005 percentage projected by Health Management Associates

# State Medicaid Cost Containment Strategies: New Initiatives by Year FY 2002 – FY 2005



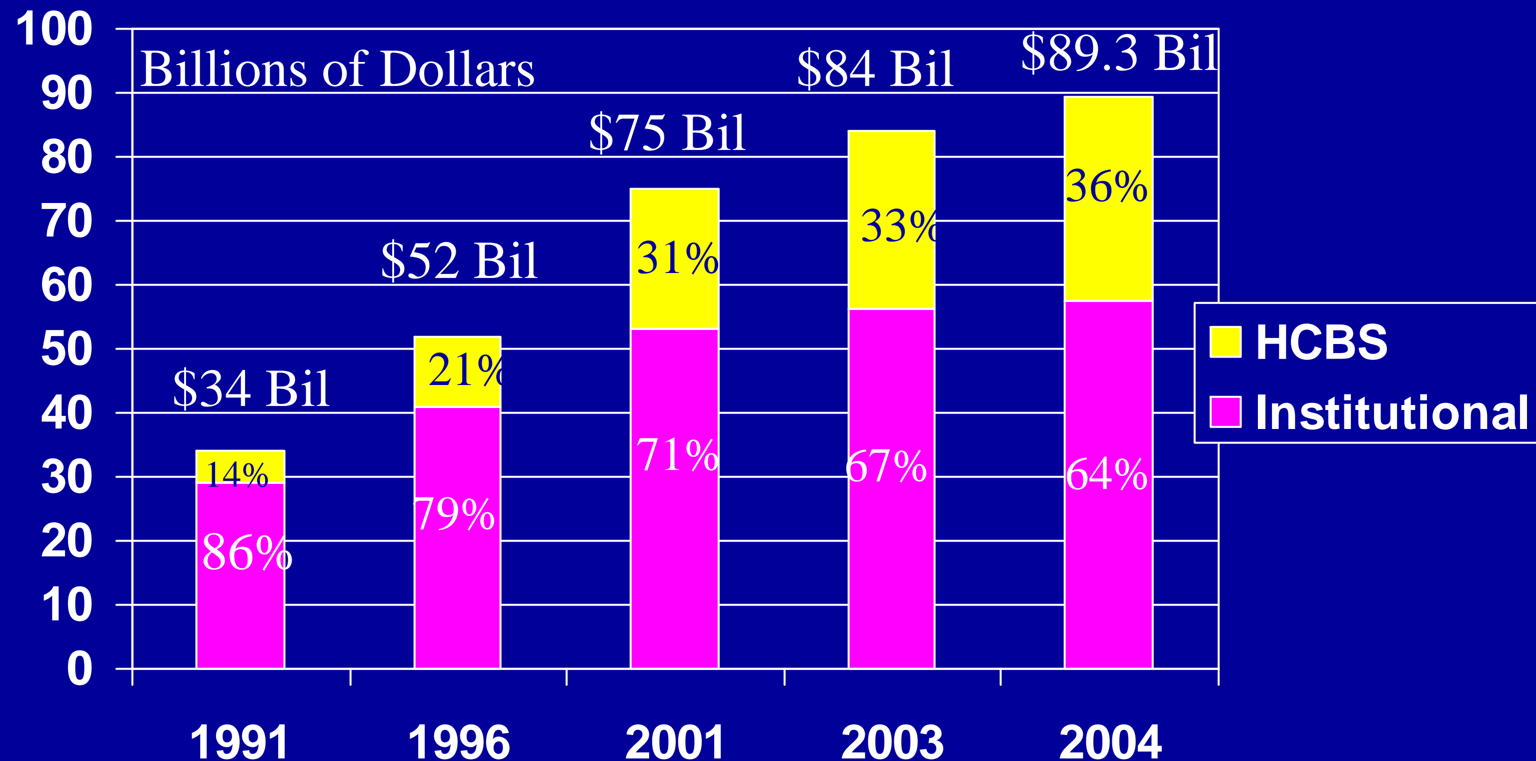

SOURCE: Vernon Smith, Rekha Ramesh, Kathy Gifford, Eileen Ellis, Robin Rudowitz and Molly O'Malley, *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005*, Kaiser Commission on Medicaid and the Uninsured, October 2004.

# Managed Care Remains a Medicaid Cost Containment Strategy: New Focus on SSI




Source: CMS 2004, Robert Hurley

# Medicaid Long Term Care: Trend Continues Toward Home and Community Care Selected Years 1991 - 2004




Source: Brian Burwell, Kate Sredl and Steve Eiken, Thomson Medstat, 2005.

## Each of These Trends Affect the Possibility for Medicaid Reimbursement?

- Increasing focus on cost containment
- New focus of Medicaid managed care
- Limits or elimination of covered benefits such as dental
- Restrictions on eligibility
- Focus on disabled, persons with chronic conditions and long term care

# Basic Strategies for Medicaid Reimbursement

- Take advantage of opportunities to learn Medicaid billing requirements and billing codes
- Know when certain services (like dental, outreach or transportation) can be billed separately
- Know Medicaid policies for eligibility, and how you can help an uninsured patient become enrolled in Medicaid
- Know Medicaid reimbursement policies for managed care, mental health, school-based services, services for migrants

## Strategies When Medicaid Limits Dental and Other Medicaid "Optional" Services

- Be sure policy makers know how cuts affect CHCs, who may become the only source of care for an eliminated service like dental, or for individuals who lose eligibility
- "The recourse will be that we'll either convince the Family Health Center to see these patients or they'll use the ER."
  - Steve Hollis, Social Services Supervisor, Boone County Health Department, commenting on the impact of Missouri's plan to cut 100,000 of one million from Medicaid in July 2005. Quoted in *The Missourian*, Columbia, MO, June 12, 2005
- Explore the option of including an eliminated service within the CHC scope with Medicaid reimbursement reflecting its inclusion

# Medicaid Managed Care

- Be sure to participate as a qualified PCP in managed care networks
- Work with state Medicaid toward policies that ensure a patient base for health centers
  - CHCs can be a "preferred" PCP for auto-assignment
  - Look for ways to encourage patients to choose you

# Strategies for Reimbursement for Behavioral Health Services

- Know who is responsible for payment:
  - E.g., managed care plan, behavioral health plan, Medicaid fee-for-service, community mental health clinic
- Know how Medicaid payment requirements differ from Medicare or other third-party payers
- Work to create partnerships with community mental health agencies

# Strategies for Special Populations

- Health services for migrants or homeless
  - Know how (or if) the state identifies migrants or homeless persons in its systems
  - Know the state policies where migrants or homeless may be required (or have the option) to enroll in managed care
  - Know how to handle “out-of-network” billings
  - Work with your state Medicaid program when special policies are needed to assure payment

# Home and Community Based / Long Term Care Issues

- States are increasingly looking for ways to serve the elderly and disabled in their home or community
- CHCs may find new opportunities in working with aging agencies and other organizations that focus on community-based care

# Conclusion

- Current spending and demographic trends create new pressures for change, control and quality improvement in Medicaid
- Medicaid is likely to become a more significant source of revenue for health centers
- Federal and state Medicaid reform can be expected to create new issues, as Medicaid evolves into the future