THE HENRY J. KAISER FAMILY FOUNDATION

MEDICAID IN VIRGINIA

January 2017

Medicaid and the Children's Health Insurance Program (CHIP) provide health and long-term care coverage to more than 976,000 low-income children, pregnant women, adults, seniors, and people with disabilities in Virginia. Medicaid is a major source of funding for safety-net hospitals and nursing homes. Federal policy proposals could fundamentally change the scope and financing of the program.

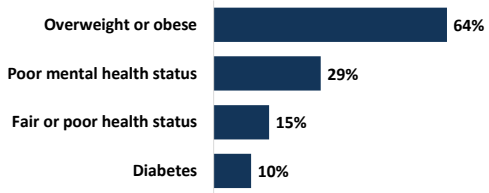
Snapshot of Virginia's population

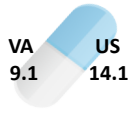
8.2 million people live in VA

28% of VA's population is low-income

Low-income: <200% FPL or $40,320 for a family of 3 in 2016

Adults in VA reporting:





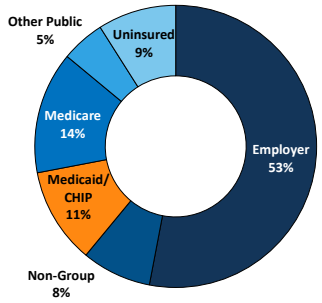
Opioid Deaths

HIV Diagnoses

Per 100,000 population in 2014

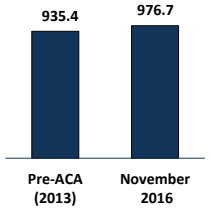
How has Medicaid affected coverage and access?

In 2015, 11% of people in VA were covered by Medicaid/CHIP.



Since implementation of the Affordable Care Act (ACA), Medicaid/ CHIP enrollment has increased in VA.

Monthly Medicaid/CHIP enrollment
(in thousands)

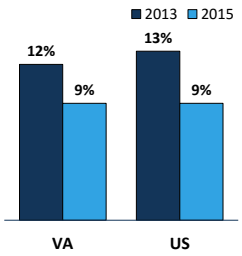


Did VA expand Medicaid through the ACA?

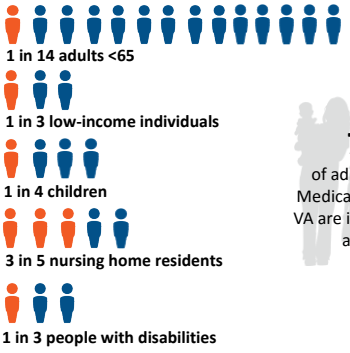
0 adults
in the expansion group in Q1 of 2016

The uninsured rate in VA has decreased.

Uninsured rate



In VA, Medicaid/CHIP covers:



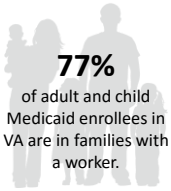
1 in 14 adults <65

1 in 3 low-income individuals

1 in 4 children

3 in 5 nursing home residents

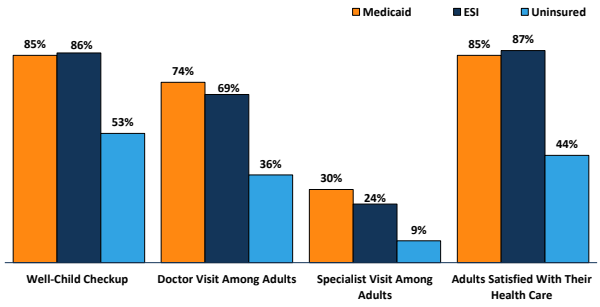
1 in 3 people with disabilities



77%
of adult and child Medicaid enrollees in VA are in families with a worker.

Nationally, Medicaid is comparable to private insurance for access and satisfaction – the uninsured fare far less well.

Percent reporting in the last year:



Medicaid coverage contributes to positive outcomes:

- Declines in infant and child mortality rates
- Long-term health and educational gains for children
- Improvements in health and financial security

And…

>85%
of the public would enroll themselves or a child in Medicaid if uninsured.

How does Medicaid work and who is eligible?

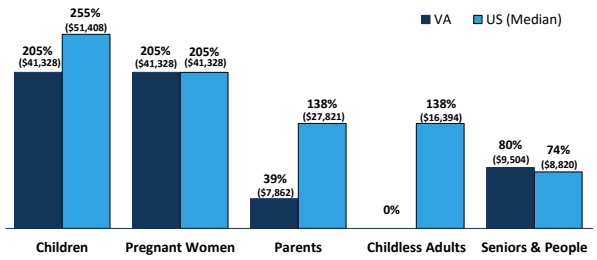
Each Medicaid program is unique:

Federal government sets core requirements, but states have flexibility regarding:

- **Eligibility** - All states have taken up options to expand coverage for children; many have opted to expand coverage for other groups.
- **Benefits** – All states offer optional benefits, including prescription drugs and long-term care in the community.
- **Delivery system & provider payment**– States choose what type of delivery system to use and how they will pay providers; many are testing new payment models to better integrate and coordinate care to improve health outcomes.
- **Long-term care** – States have expanded eligibility for people who need long-term care and are increasingly shifting spending away from institutions and towards community-based care.
- **State health priorities** – States can use Medicaid to address issues such as the opioid epidemic, HIV, Zika, autism, dementia, environmental health emergencies, etc.

Medicaid/CHIP eligibility levels are highest for children and pregnant women.

Eligibility Level as a Percent of FPL, as of January 1, 2017



Eligibility levels are based on the FPL for a family of three for children, pregnant women, and parents, and for an individual for childless adults and seniors & people w/ disabilities. Seniors & people w/ disabilities eligibility may include an asset limit.

How are Medicaid funds spent and how is the program financed?

Medicaid plays a key role in the U.S. health care system, accounting for:

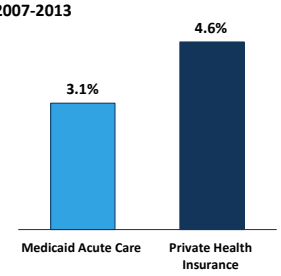
$1 in $6 dollars spent overall in the health care system

More than $1 in $3 dollars provided to safety-net hospitals and health centers

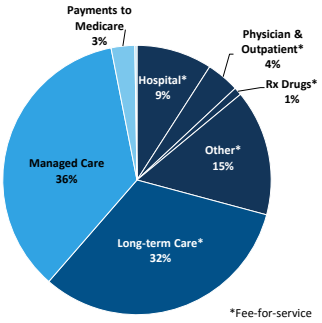
$1 in $2 dollars spent on long-term care

On a per enrollee basis, Medicaid spending growth is slower than private health care spending, in part due to lower provider payments.

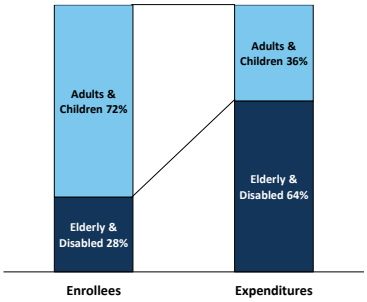
Per enrollee spending growth in the US, 2007-2013



In FY 2015, Medicaid spending in VA was $8.1 billion.



In 2011, most Medicaid beneficiaries in VA were children and adults, but most spending was for the elderly and people with disabilities.



Federal funding to states is guaranteed with no cap and fluctuates depending on program needs.

In VA the federal share (FMAP) is 50%. For every **$1** spent by the state, the Federal government matches **$1**.

Expansion states receive an increased FMAP for the expansion population. VA did not expand Medicaid and did not receive additional federal funds.

0.79
is the Medicaid-to-Medicare physician fee ratio in VA.

55%
of long-term care spending in VA is for home and community-based care.

83%
of beneficiaries in VA are in managed care plans.

191,700
Medicare beneficiaries (16%) in VA rely on Medicaid for assistance with Medicare premiums and cost-sharing and services not covered by Medicare, particularly long-term care.

34%
of Medicaid spending in VA is for Medicare beneficiaries.

22%
of state general fund spending in VA is for Medicaid.

42%
of all federal funds received by VA is for Medicaid.

What are the implications of reduced federal financing in a Medicaid block grant or a per capita cap?

Congress may soon debate proposals to reduce federal Medicaid funding through ACA repeal and federal caps.

The March 2016 Budget Resolution would reduce federal Medicaid spending by **41%** nationally over the 2017-2026 period.

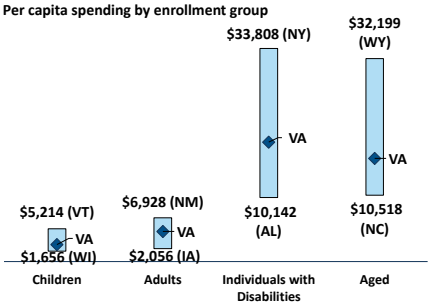
Total reduction in federal funds:
$2.1 trillion

The impact of a block grant or per capita cap will depend on funding levels, but could include:

- Increases in the number of uninsured
- Reduced access and service utilization, decreased provider revenues (to hospitals, nursing homes, etc.), and increased uncompensated care costs
- Increased pressure on state budgets
- Decreased economic activity

A per capita cap could lock in historical state differences or redistribute federal funds across states.

Per capita spending by enrollment group



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