Medicaid and Managed Care: Missouri and a National Perspective

for MO HealthNet Oversight Committee

April 30, 2015

Vernon K. Smith, PhD
Health Management Associates

© 2015
Vsmith@HealthManagement.com

HEALTH MANAGEMENT ASSOCIATES
Medicaid and Managed Care: Missouri and a National Perspective

• Where Medicaid is now and how it got here – the trends driving the program across states:
  – Growth in health costs, insurance premiums, health insurance coverage, the uninsured

• Medicaid enrollment and spending growth, before and after the ACA.

• State strategies for controlling spending.
  – Why the big Medicaid story of 2015 is delivery and payment system reforms
  – Why states increasingly rely on MCOs.
“Medicaid coverage is ...

“... extremely valuable to the low-income families and individuals who qualify for the services provided by the program.”

“... valuable to society at large, as it enables the least-fortunate members of the population to obtain the health care they need in an orderly way.”

The Value and Impact of Medicaid Is Shown in Many Studies

- Improves access to medically needed care
- Improves health status
- Improves financial security
- Improves school performance and the productivity of current and future workforce
- Benefits medical providers, especially safety net hospitals and community health centers
- Lowers cost of health insurance for business
- Adds economic activity and jobs
- Saves state general funds in mental health, others
- Operates efficiently, very low administrative costs
Insurance Status of Americans, 2015

Medicaid: The Nation’s Largest Single Health Program

- Employer-Sponsored: 172 million (48%)
- Medicare: 54 million (15%)
- Medicaid: 70 million (20%)
- Private: 20 million (6%)
- Uninsured: 28 million (8%)
- CHIP: 6 million (2%)

Source: HMA estimates 2015.
Medicaid is a Significant Payer for Medical Care: U.S. Health Expenditures, by Payer, 2015

In $Billions

- Medicaid and CHIP: 17%
- Medicare: 20%
- Private Insurance: 34%
- DOD, VA, IHS, Others: 19%
- Out of Pocket: 11%

2015 U.S. Health Spending: $3.2 Billion

Note: Medicaid includes $15 billion for CHIP. Source: HMA estimates for 2015.
U.S. Medicaid Spending Trend: 2000 to 2015

$Billions: All State and Federal Funds

$203

$317

$355

$450

$521

$560

Note: Includes Medicaid and CHIP enrollment. Source: HMA, based on CMS, Office of the Actuary, 2015.
General Fund Spending for Medicaid and K-12 Education, as Percent of All GF Spending: All States and Missouri, FY 2014

<table>
<thead>
<tr>
<th></th>
<th>All States</th>
<th>MO</th>
</tr>
</thead>
<tbody>
<tr>
<td>K-12 Education GF</td>
<td>35.0%</td>
<td>34.9%</td>
</tr>
<tr>
<td>Medicaid GF</td>
<td>19.1%</td>
<td>21.9%</td>
</tr>
</tbody>
</table>

Total Spending on Medicaid and K–12 Education as % of Total State Spending
Average State Percentages, 2008 – 2014

Medicaid Spending Now Averages 26% of Total State Budgets

1985 - 2013

Total Medicaid Spending, as % of Total State Spending, Average across all states, And Missouri for 2014.

Source: HMA, based on NASBO, State Expenditure Report, 2014 and earlier years.
What Are the Key Factors Driving Growth In Medicaid Spending?

• *Rising health care and insurance costs*

• *Downward trend in employers offering health insurance*

• *Upward trend in the number of persons uninsured*
Health Insurance Premiums (Reflecting Medical Costs) Have Increased Much Faster than Inflation and Earnings

Cumulative Percent Increases 1999-2014

1999 to 2014:
Avg. Annual Growth
Premiums = 7.9%
CPI = 2.4%

Premiums Up 70% Over Last Decade:
Average Annual Premiums for Single and Family Health Insurance Coverage
1999-2014

- Single Coverage
- Family Coverage

1999
- Single: $2,196
- Family: $5,791

2000
- Single: $2,471
- Family: [VALUE]

2001
- Single: $2,689
- Family: $7,061

2002
- Single: $2,471
- Family: $8,003

2003
- Single: $2,689
- Family: $9,068

2004
- Single: $3,083
- Family: $9,950

2005
- Single: $3,383
- Family: $10,860

2006
- Single: $3,695
- Family: $11,480

2007
- Single: $4,024
- Family: $12,106

2008
- Single: $4,242
- Family: $12,680

2009
- Single: $4,479
- Family: $13,375

2010
- Single: $4,704
- Family: $13,770

2011
- Single: $4,824
- Family: $15,073

2012
- Single: $5,049
- Family: $15,745

2013
- Single: $5,429
- Family: $16,351

2014
- Single: $5,615
- Family: $16,834

- Indicates estimate is statistically different from estimate for the previous year shown.
Missouri Health Insurance Premiums

Growth Parallels National Trend
2000 - 2013

Family Premiums

<table>
<thead>
<tr>
<th>Year</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000-01</td>
<td>$6,199</td>
</tr>
<tr>
<td>2004-05</td>
<td>$9,580</td>
</tr>
<tr>
<td>2008-09</td>
<td>$11,995</td>
</tr>
<tr>
<td>2012-13</td>
<td>$15,073</td>
</tr>
</tbody>
</table>

As Premiums Increase, Fewer Firms Offer Coverage: Share of U.S. Firms Offering Health Insurance: 2001 and 2013

Missouri Workers with Employer Sponsored Insurance Also Dropping

75% 63%

2000 2011

Uninsured Increased by 13 Million 2000 – 2010, but dropped since 2010, primarily due to ACA

Millions of U.S. Uninsured

2000: 37
2010: 50
2011: 48
2012: 47
2013: 46

Uninsurance Rate for Adults Dropped to Historic Lows Across All States in 2 years, from 2013 to 2015

Figure 1. Trends in Uninsurance for Adults Ages 18 to 64 from Quarter 1 2013 to Quarter 1 2015

“The uninsured rate among U.S. adults declined to a record low since Gallup began tracking it in 2008.”

--Gallup, April 13, 2015.

15 Million adults Gained Coverage Sept. 2013 to March 2015, as Un-Insurance Rate Dropped by 43%

<table>
<thead>
<tr>
<th>Category</th>
<th>Sept. 2013</th>
<th>Mar-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>All States Decrease of 43%</td>
<td>17.6%</td>
<td>10.1%</td>
</tr>
<tr>
<td>States Expanding Medicaid</td>
<td>15.8%</td>
<td>7.5%</td>
</tr>
<tr>
<td>States Not Expanding Medicaid</td>
<td>20.7%</td>
<td>14.4%</td>
</tr>
</tbody>
</table>

U.S. Medicaid Enrollment Trend: 2000 to 2015

Millions of Enrollees

Note: Includes Medicaid and CHIP enrollment.
Source: HMA, based on CMS, Office of the Actuary, 2014 and prior years.
Missouri Medicaid Enrollment Trend
2001 – 2014

Note: Includes only Full-Benefit Medicaid.
Does not include CHIP or Partial Benefit, e.g., Family Planning

Missouri Annual Medicaid Enrollment Growth Has Been Much Lower Than U.S. Average

Annual Percent Changes FY 2002 – FY 2014

NOTE: Enrollment percentage changes from June to June of each year.

“Non-Expansion” States Have Still Seen Growth in Medicaid and CHIP Enrollment

Percent Change in Medicaid/CHIP Enrollment From Pre-ACA (July - Sept. 2013) to January 2015

Missouri = 2.1%
Average of These States = 7.8%

Note: Maine data omitted by CMS because data not comparable to other states.

“Expansion” States: Medicaid and CHIP Enrollment Growth Avg. of 26%

Percent Change in Medicaid/Chip Enrollment From Pre-ACA (July – Sept. 2013) to January 2015

Average = 26.1%

Note: Connecticut excluded because of missing data. Indiana (6.9%) and Pennsylvania (4.5%) excluded due to 2015 implementation.

Millions of Americans

<table>
<thead>
<tr>
<th>Year</th>
<th>Uninsured</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Other</th>
<th>Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>45</td>
<td>51</td>
<td>21</td>
<td>64</td>
<td>169</td>
</tr>
<tr>
<td>2016</td>
<td>23</td>
<td>56</td>
<td>28</td>
<td>81</td>
<td>171</td>
</tr>
<tr>
<td>2020</td>
<td>23</td>
<td>63</td>
<td>32</td>
<td>84</td>
<td>173</td>
</tr>
</tbody>
</table>


Employer – Based Insurance Up Slightly

 Millions of Americans

<table>
<thead>
<tr>
<th>Year</th>
<th>Uninsured</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Other</th>
<th>Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>169</td>
<td>51</td>
<td>64</td>
<td>21</td>
<td>45</td>
</tr>
<tr>
<td>2016</td>
<td>171</td>
<td>56</td>
<td>81</td>
<td>28</td>
<td>23</td>
</tr>
<tr>
<td>2020</td>
<td>173</td>
<td>63</td>
<td>84</td>
<td>32</td>
<td>23</td>
</tr>
</tbody>
</table>

Medicaid to Increase by 20 million by 2020

Millions of Americans

<table>
<thead>
<tr>
<th>Year</th>
<th>Uninsured</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Other</th>
<th>Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>45</td>
<td>51</td>
<td>21</td>
<td>64</td>
<td>169</td>
</tr>
<tr>
<td>2016</td>
<td>23</td>
<td>56</td>
<td>28</td>
<td>81</td>
<td>171</td>
</tr>
<tr>
<td>2020</td>
<td>23</td>
<td>63</td>
<td>32</td>
<td>84</td>
<td>173</td>
</tr>
</tbody>
</table>


Health Management Associates
How Are States Responding to Need to Control Medicaid Spending?

• **A Focus on Improving Quality, Controlling Costs and Increasing Value**
  
  – *Focus on high-need, high cost populations*, including persons with chronic conditions, disabilities, in LTC and on both Medicaid and Medicare (dual eligibles)
  
  – *Quality improvement*: strengthening contract requirements for health plans, pay-for-performance, special initiatives e.g., on non-emergency ER use.
  
  – *Cost savings* through managed care, delivery system and payment reforms, payment restrictions.

Missouri Medicaid Has Used Several Strategies to Improve Care, Control Cost

Cost and enrollment growth are well below national trends

- Controls on benefits and eligibility
- Focus on program integrity
- National model for Health Homes
- Increasing use of managed care, with new contract requirements for MCOs and patient incentives
Nationally, Delivery System and Payment Reforms are a Priority for Medicaid in 2015

— *Focus on improving care, cost and outcomes for high-need, high cost populations*

- Managed care, care management, coordinated and integrated care, often using State Innovation Model (SIM) grants or Delivery System Reform Incentive Payment (DSRIP) waivers.

- Payers are strengthening contractual requirements for health plans, with Pay-for-Performance, withhold incentives based on performance, auto-assignment algorithms, other initiatives, e.g., non-emergency ER use.

Delivery System Reforms to Coordinate Care and Control Costs Are in Most States in 2014 - 2015

NOTE: Expansions of existing initiatives include rollouts of existing initiatives to new areas or groups and significant increases in enrollment or providers. Dual Eligible Initiatives include those through and outside CMS financial alignment demonstration.
The Need for Effective Systems of Care for an Aging Population Is Seen in Increasing Share of Population Age 65+

Compared to health costs for a 40-year-old:
- Ages 65-74, are 3X higher
- Ages 75+, are 5.65X higher

Source: U.S., Administration on Aging.
In FY 2015, States Continue to Expand and Improve Managed Care.

**Actions to Expand Managed Care**

<table>
<thead>
<tr>
<th>Category</th>
<th>FY 2014</th>
<th>FY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographic Expansions</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Eligibility Group Expansions</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>New Mandatory Enrollment</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Any Managed Care Expansions</td>
<td>22</td>
<td>23</td>
</tr>
</tbody>
</table>

**Policy Changes in Either Year**

<table>
<thead>
<tr>
<th>Category</th>
<th>FY 2014</th>
<th>FY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care Expansions</td>
<td>33</td>
<td>34</td>
</tr>
<tr>
<td>Quality Initiatives</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In 2011, Half of U.S. Enrollees Were in MCOs, but Most Dollars Were Not
Share of Medicaid Enrollees and Dollars in Managed Care: (LTC and Dual Eligibles Account for Large Share of FFS Dollars)

**U.S.**

- **Enrollees:** 50%
- **Dollars:** 24%

**Missouri**

- **Enrollees:** 45%
- **Dollars:** 14%

Note: Managed care includes risk- and non-risk based, including MCOs, PCCMs, and limited benefit plans. Data are for 2011.
Share of Missouri Medicaid Dollars in Managed Care, by Eligibility Group, 2011

- All MO $$: 14%
- Children: 47%
- Adults: 43%
- Disabled: 0.2%
- Aged: [VALUE]

Note: Managed care includes risk-based MCOs. Data are for 2011.
Conclusion: Significant Changes Are Occurring in Medicaid

• Innovations with payment and delivery system initiatives, greater use of managed care and care management, to achieve greater value for state tax dollars.

• Managed care is the platform for accountability for better care, access, quality and health outcomes, and for saving costs.
  – Priorities involve care for all Medicaid groups, including persons with disabilities and chronic conditions, long term care, and dual eligibles.
Medicaid Can Make a Significant Difference

“We are unashamed to use the power of Medicaid to raise the standard of care for all the citizens of our state.”

-- State Medicaid director, describing initiatives in his state.