Medicaid and Managed Care: A National Perspective and Outlook

Kansas Health Institute

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Vernon K. Smith, PhD
Health Management Associates

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Vsmith@HealthManagement.com
Employer-Sponsored 176 million 48%

Private 26 million 8%

Medicaid 72 million 20%

CHIP 8 million 2%

Uninsured 27 million 8%

Medicare 58 Million 16%

Total 80 Million

Note: Total does not add to 100% due to rounding.

Medicaid: The Largest Single Health Insurer in U.S.
Insurance Status of Americans in 2017
Medicaid and CHIP Enrollment
2000 to 2026 (Projected, under Current Law)

“Non-Expansion” States: Medicaid and CHIP Enrollment Change

Percent Change in Medicaid/CHIP Enrollment
From Pre-ACA (July - Sept. 2013) to May 2017

Average change for 19 Non-Expansion States was +12%
Kansas has 3rd lowest enrollment growth @ 2.3%
May 2017 enrollment = 386,802

Note: Maine data omitted by CMS because comparable data not available.

“Expansion” States: Medicaid and CHIP
Enrollment Change

Percent Change in Medicaid/Chip Enrollment
From Pre-ACA (July – Sept. 2013) to May 2017

Average for 31 Expansion States = 39%

Note: Connecticut excluded because of missing data.

Medicaid Spending Accounts for Over 1/6 of All U.S. Health Care Dollars: Spending by Payer, All Services, in 2017

2017 U.S. Health Spending: $3.5 Trillion

In $Billions

$604 B
17%
Medicaid and CHIP

$719 B
20%
Medicare

$1,209
34%
Private Insurance

$659 B
18%
DOD, VA, IHS, Others

$366 B
11%
Out of Pocket

Note: $587 Billion for Medicaid and $18 Billion for CHIP. Source: HMA estimates, CMS, 2017.
Medicaid: **Total (All Federal and State)** Spending under Current Law, 2000 to 2026 (Projected)

Billions of Dollars
(Includes Federal and State Shares)

- **Post-ACA**
  - Federal Medicaid Spending to States
  - State Share of Medicaid Spending

- **Projected**
  - Total Medicaid Spending

Total U.S. Spending on Medicaid and K–12 Education as % of Total State Spending
Average State Percentages, 2008 – 2016

Source: HMA, based on data in: NASBO, State Expenditure Report, 2016 and Earlier Years.

Kansas:
In 2013, Medicaid was 19.6% of total state budget.
In 2016, Medicaid was 22.5% of total state budget.
Top State Medicaid Priorities for 2017

1. Controlling costs / cost containment
   – Primary focus on pharmacy and long term care

2. Delivery and payment system initiatives
   – Value-based payments
   – Improving health, outcomes, coverage and lower costs
     • Using care coordination, medical homes, managed care, with new focus on social determinants and population health
   – Often using waivers and flexibility under current law

Medicaid Payment and Delivery System Initiatives Are Key Cost Control Strategy: Initiatives in 42 States in 2017

NOTES: Expansions include rollouts of existing initiatives to new areas or groups, and other increases in enrollment or providers.
Medicaid Delivery and Payment System Initiatives, FY 2017

Total Number of States Implementing Selected Initiatives

- PCMH: 32 States
- ACA Health Homes: 26 States
- ACO: 16 States
- Episode of Care: 7 States
- Reforms under DSRIP: 11 States
- Other Initiative: 9 States
- Any Initiative: 42 States

Medicaid has Contracts with MCOs in 39 states; In 28 of these states, at least 75% of all Medicaid beneficiaries are in MCOs.

As of July 2016

- **All Beneficiary Groups**: 39 states
  - Excluded: 2
  - <25%: 9
  - 25-49%: 3
  - 50-74%: 1
  - 75+: 25

- **Children**: 39 states
  - Excluded: 1
  - <25%: 3
  - 25-49%: 1
  - 50-74%: 1
  - 75+: 34

- **ACA Expansion Adults**: 27 states
  - Excluded: 1
  - <25%: 2
  - 25-49%: 1
  - 50-74%: 3
  - 75+: 25

- **All Other Adults**: 39 states
  - Excluded: 1
  - <25%: 2
  - 25-49%: 1
  - 50-74%: 3
  - 75+: 32

- **Elderly and Disabled**: 39 states
  - Excluded: 5
  - <25%: 4
  - 25-49%: 9
  - 50-74%: 13

NOTES: Limited to 39 states with MCOs in place on July 1, 2016. Of 31 ACA expansion states and DC, 27 had MCOs.

Medicaid Reliance on MCOs Is Increasing: Capitated Payments Are Fastest Growing Share of U.S. Medicaid Spending

Long Term Services and Supports: Almost Every State is Expanding HCBS, Increasingly with MCOs: New or Expanded Initiatives in FY 2017

- 24 States Now Use MCOs for Long Term Care
- 18 States Expanded Balancing Incentives in MLTSS
- 18 States Expanded PACE Expansions
- 9 States Expanded Close/Downsize Institution
- 41 States Expanded HCBS Waiver or SPA Expansions
- 47 States Total: States with any HCBS Expansion

NOTES: "HCBS Waiver or SPA Expansion" includes increases to the number of Section 1915(c) waiver slots, serving more people under existing waiver caps, or the addition of Section 1915(i) or Section 1915(k) state plan options to serve more individuals. Source: Vernon Smith, et al., “Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017,” , Kaiser Family Foundation, October 2016. [www.kff.org](http://www.kff.org)
States Increasingly Incorporate LTSS into their Risk-Based Managed Care Programs

- A transformational change has occurred: States have gained confidence that the long term care population can be well served through health plans or managed long term care.

- Massachusetts, Arizona, Minnesota and Wisconsin led the way more than two decades ago.

- Programs generally included Medicaid services only, but programs in Massachusetts, New York, and Wisconsin also included Medicare services.

- At least half of states now include, or have plans to include LTSS in managed care for some populations.

# Recent MLTSS Summary: Selected States

<table>
<thead>
<tr>
<th>Selected States</th>
<th>MLTSS: Integrated or Separate</th>
<th>Brief Description</th>
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<tbody>
<tr>
<td>AZ</td>
<td>Separate</td>
<td>MLTSS since 1989. All Medicaid MCOs must be D-SNPs to optimize integration of Medicaid and Medicare services. One of two states with auto conversion into same plan when Medicaid member turns age 65. ID/DD population in MCOs for acute care, not in MLTSS. Persons with autism in MLTSS MCOs. 73% in HCBS, 5th highest in U.S.</td>
</tr>
<tr>
<td>KS</td>
<td>Integrated</td>
<td>Began in 2013. Includes all Medicaid services for all populations.</td>
</tr>
<tr>
<td>PA</td>
<td>Separate</td>
<td>New. Includes all LTSS and duals. Does not include ID/DD; no current plans to do so. Phase-in begins Jan 2018, SW Region: July 2018 for SE zone; January 2019 rest of state.</td>
</tr>
<tr>
<td>TN</td>
<td>Integrated</td>
<td>All MCOs required to offer D-SNP in all counties to coordinate and integrate care. Includes Duals. ID/DD enrollees prior to July 2016 in HCBS waiver or can voluntarily enroll in MCO; Newer (and previously waitlisted) enrollees are mandatory in MCOs. Focus on VBP, incentives for employment.</td>
</tr>
<tr>
<td>TX</td>
<td>Separate</td>
<td>Star-Plus includes all Duals, Persons with Disabilities. Voluntary pilot for ID/DD adults (400-800 people)</td>
</tr>
<tr>
<td>VA</td>
<td>Separate</td>
<td>Includes all Duals and LTSS. Phasing in by regions beginning July 2017.</td>
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Medicaid Managed Long-term Supports and Services (MLTSS)

Status As of August 2017

Note: ID is largely a FFS Medicaid state, but offers a Medicare Medicaid Coordinated Plan for duals that includes MLTSS
Medicaid Managed Care for People with Intellectual/Developmental Disabilities
As of February 2017

Note: Enrollees in VA's Dual Demonstration, Commonwealth Coordinated Care, are expected to be transitioned to the state’s new MLTSS program starting in 2018.
Nationally, Medicaid LTSS Expenditures Are Now Less than One-Third of Total U.S. Medicaid Spending:
Recent drop due to new spending for Medicaid Expansions

In 2015, Kansas LTSS Was $1.2 Billion of $3.0 Billion Total Kansas Total Medicaid Expenditures, or 40%
Nationally, Medicaid Has Been “Re-Balancing” LTSS for Many Years

Re-Balancing in Action: Nationally, Medicaid HCBS Expenditures Have Exceeded Institutional LTSS since 2013, Facilitated by MLTSS

In 2015, the HCBS Share of All Kansas LTSS Medicaid Spending Was 49%

2015: At 49% HCBS, Kansas ranked 29th among all states.

HCBS as % of all Medicaid LTSS Expenditures, by Group 2015

Note: 2015 expenditures by population group: For U.S.: People with developmental disabilities, $44 billion; Older adults and people with physical disabilities, $98 billion; Behavioral health services, $9 billion. For Kansas: People with Developmental Disabilities, $348 million; Older Adults and people with physical disabilities, $619 million; Behavioral Health and Other Populations, $160 million.

CMS Has Promised States More Flexibility in Program Design in 2017

• States requesting waivers will benefit from broader federal interpretation of what can be approved under “waivers.”
  • Waivers allow Medicaid funding for services and policies that otherwise wouldn’t qualify for Medicaid matching funds.

• Even without Congressional action on the ACA, States have momentum on payment and delivery system initiatives, including social determinants of health.
CMS Key Policy Preferences

• Align Medicaid policies for adults who are not disabled with private insurance
  – Cost sharing, including premiums and emergency room copayments
  – Health savings account features
  – Waivers of non-emergency transportation, presumptive eligibility, and retroactive coverage
  – Encourage employer insurance
• Support state approaches to increase employment
• New tools for Substance Use Disorder (SUD)
• Streamline waiver process for payment and delivery system initiatives
Conclusion

• Kansas enrollment and spending growth has been among the lowest in the nation since 2013.
• Kansas was a leader nationally in developing KanCare.
• The Section 1115 Waiver renewal is an opportunity to assess and improve.
• Medicaid experience across states shows the value of a process of stakeholder engagement and input, as is occurring now, when considering significant changes in policy.