Class 8 - Medicaid

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If you only get one thing . . .

Medicare	Medicaid
Run by federal government	Run by states
Funded only by federal government	Funded jointly by states and feds
Covers seniors, people with disabilities	Historically covers children, parents, low-income seniors, people with disabilities
	Now states can cover low income adults without children
No income exclusion	Income qualifications
Coverage set by fed.s	Coverage set by states

What is Medicaid?

- Largest coverage program in US, CT
  - 74.4 million Americans
  - Up 29% from October 2013 due to ObamaCare
  - About 750,000 in CT total
- State/federal partnership
  - Fed.s give general guidance
    - limited oversight
  - States operate programs
    - set eligibility levels
    - provider payment rates
  - Fed.s reimburse states for half or more of the costs
- Comprehensive benefit package
- Critical safety net support
- Critical state revenue source

What is covered?

- Required for states to include:
  - Inpatient and outpatient hospital care
  - Physician, clinic, other practitioner care
  - Labs, X rays
  - EPSDT screening
  - Family planning services
  - Nursing facility and home health care
- Optional:
  - Prescription drugs
  - Dental care
  - DME

CT Medicaid covers

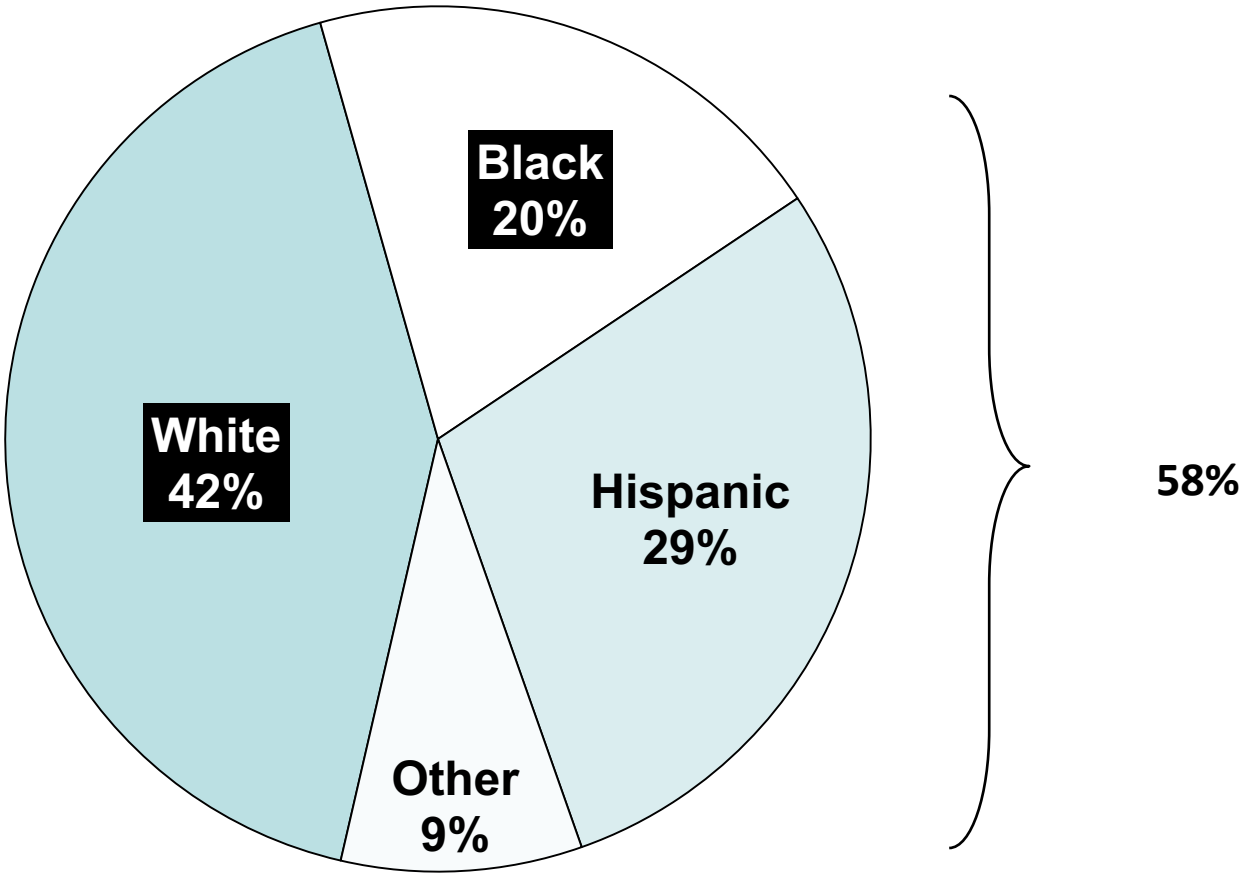
Covers all medically necessary services for children

Hospital care	Outpatient care
Preventive care	Skilled nursing facility
Hospice	Home health care
Transportation	Prescriptions
Family planning	Dental
Vision	Behavioral health

Who is covered?

- Covers mainly – no change with ACA
  - Low income children and their parents
  - Slightly higher income pregnant women
  - Low income elderly – secondary after Medicare
  - Low income people with disabilities
- Really two programs
- Only covers citizens and some legal immigrants
- Before ACA, childless adults covered in state funded SAGA plan but at lower income level
- Now about 750,000 state residents
  - One in five state residents
  - 46% of births in CT

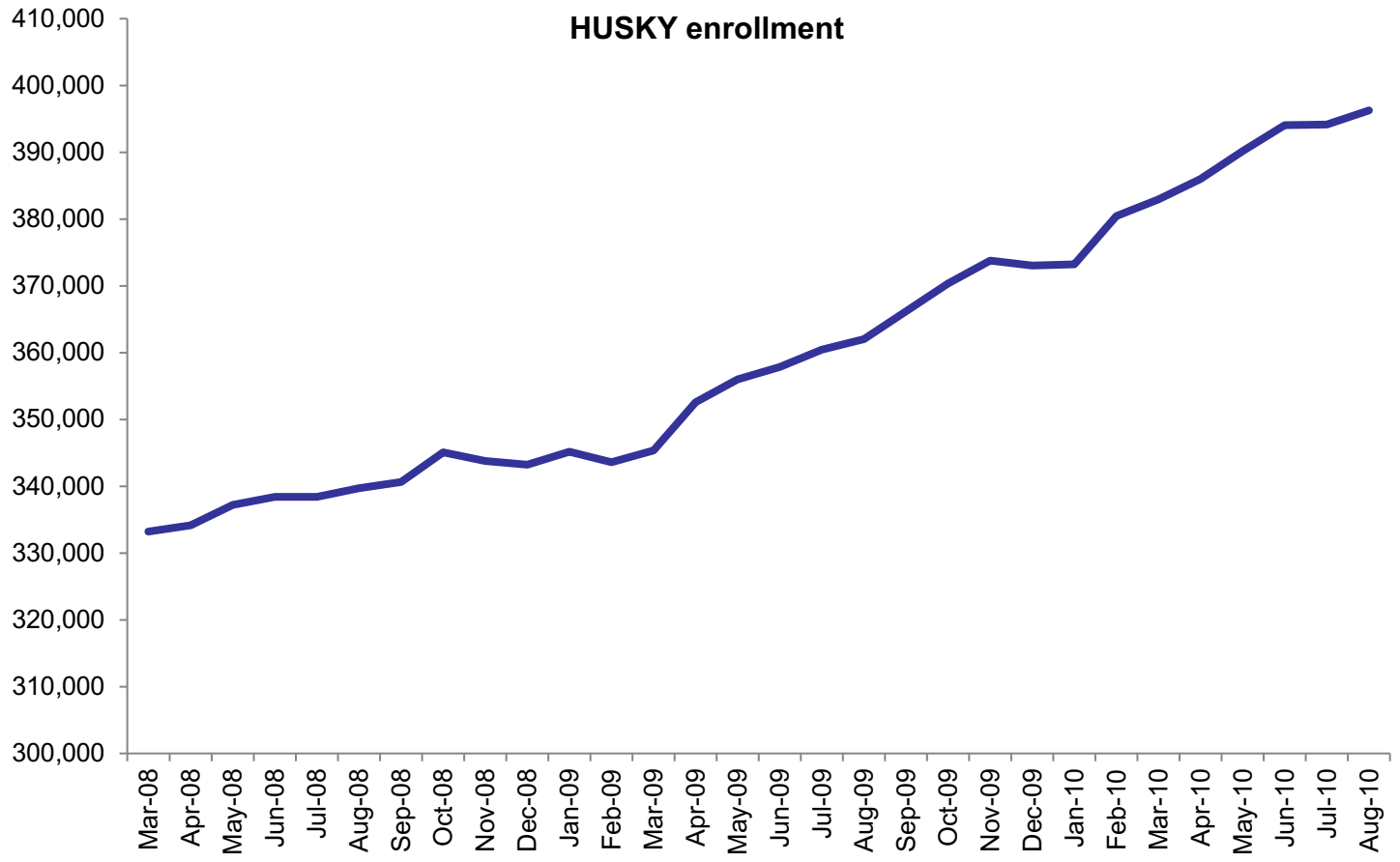
Medicaid Enrollees by Race/ Ethnicity, 2011



Total Medicaid Enrollees: 47.0 Million

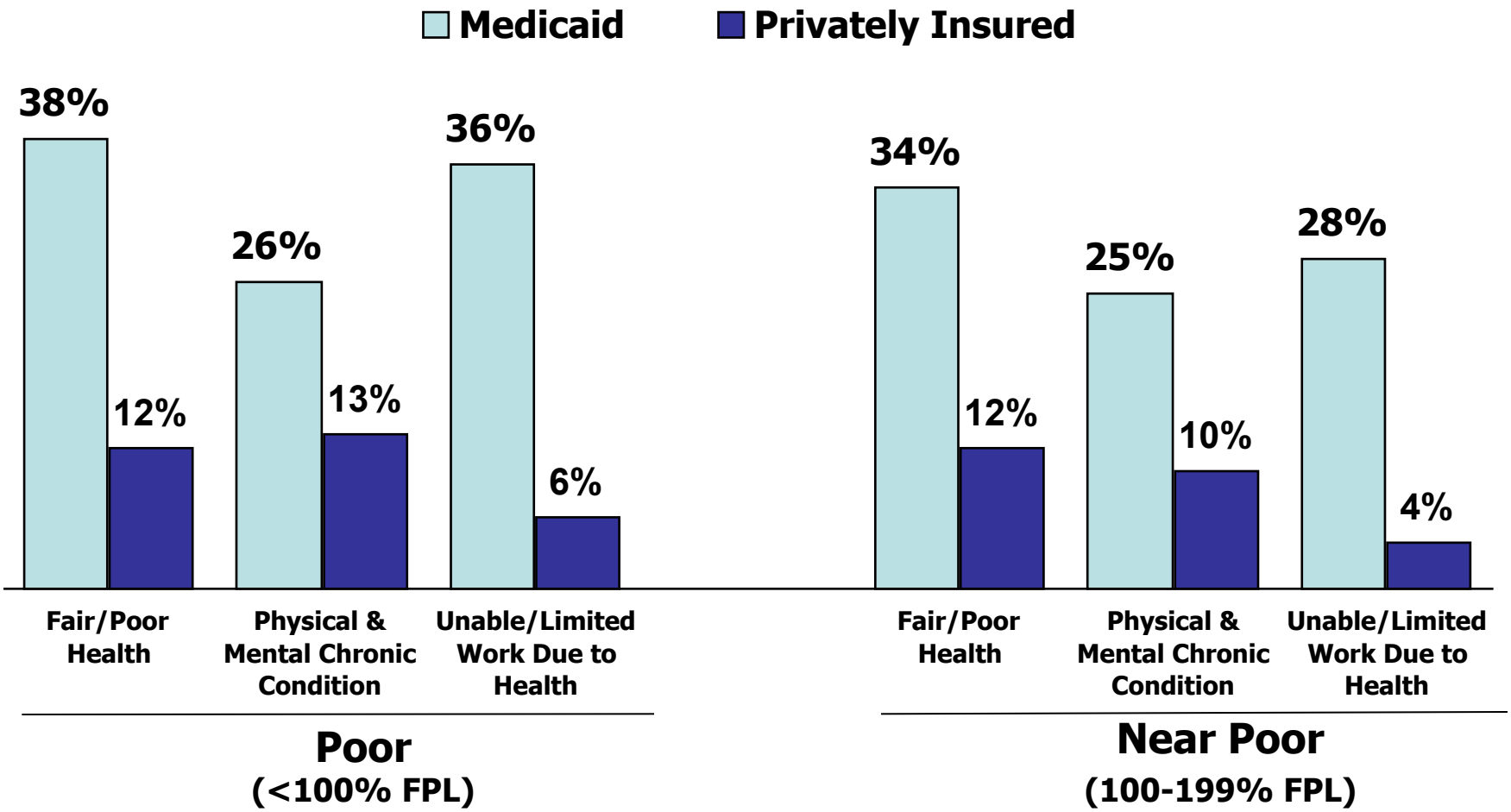
Includes nonelderly individuals 0-64. Other includes Asian/Pacific Islander, American Indian/Alaska Native, and two or more races.
Source: Urban Institute and KCMU estimates based on the Census Bureau's March 2012 Current Population Survey Annual Social and Economic Supplement.

HUSKY enrollment in the recession



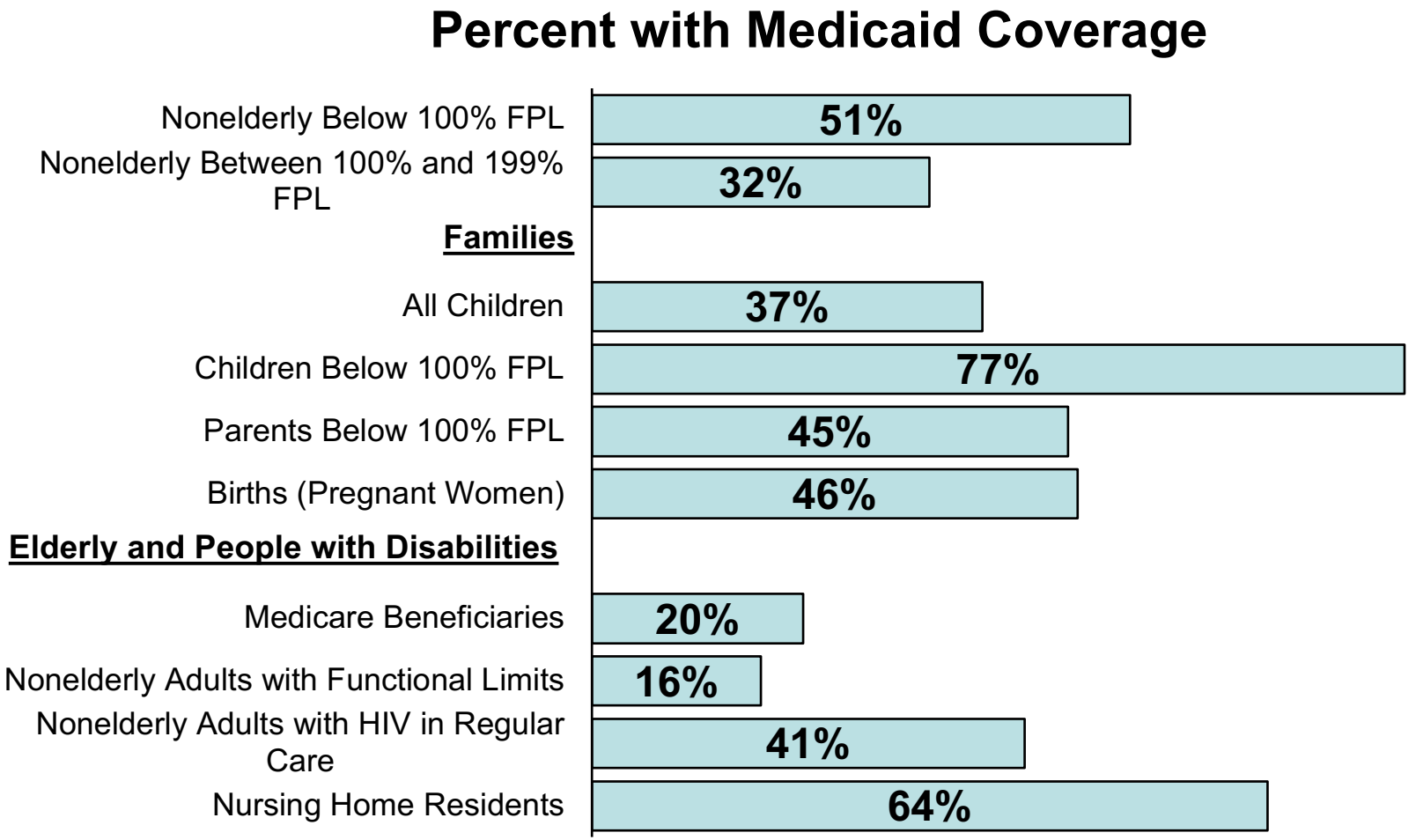
Source: ACS monthly enrollment reports

Medicaid Enrollees are Sicker and More Disabled Than the Privately-Insured



Note: Adults 19-64.
SOURCE: KCMU analysis of MEPS 3-year pooled data, 2004-2006.

Medicaid's role for selected populations.



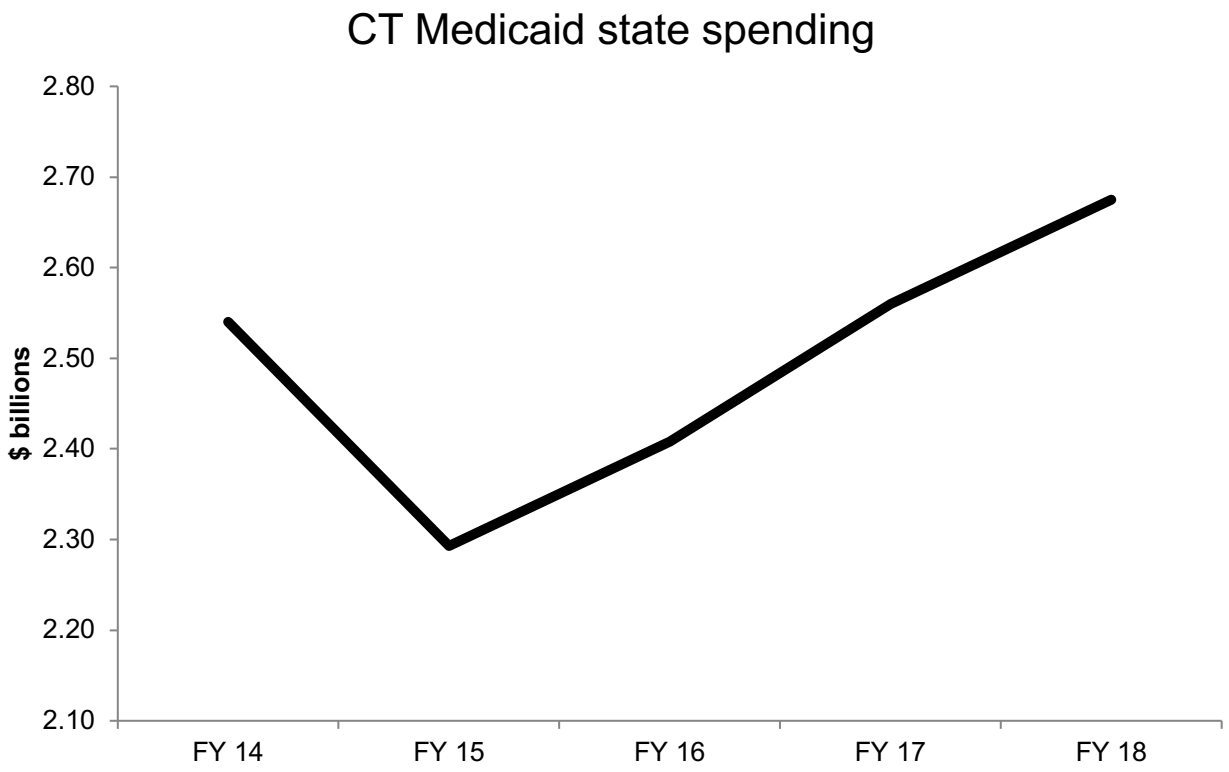
NOTE: FPL-- Federal Poverty Level. The FPL was $19,530 for a family of three in 2013.

SOURCES: Kaiser Commission on Medicaid and the Uninsured (KCMU) and Urban Institute analysis of 2013 CPS/ASEC Supplement; Birth data - Maternal and Child Health Update, National Governors Association, 2012; Medicare data - Medicare Payment Advisory Commission, *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid* (January 2015), 2010 data; Functional Limitations - KCMU Analysis of 2012 NHIS data; Nonelderly with HIV - 2009 CDC MMP; Nursing Home Residents - 2012 OSCAR data.

Funding

- State funds, but reimbursed at 59% by fed.s for CT
  - Other states get more
  - Rate varies by state, over time, always at least 50%
  - ACA gave states 100% funding for new eligibles for first 3 years, now slowly lowering to 90%
  - ACA raised PCP rates to Medicare levels for 3 years, ended in 2015
- Counter cyclical funding
  - Need highest when revenues (taxes) dip
- Spending growth per person stable now in CT
- But less expensive per person than private insurance

CT Medicaid future funding



Source: OPM, Governor's Budget proposal, 2014

Where the money goes

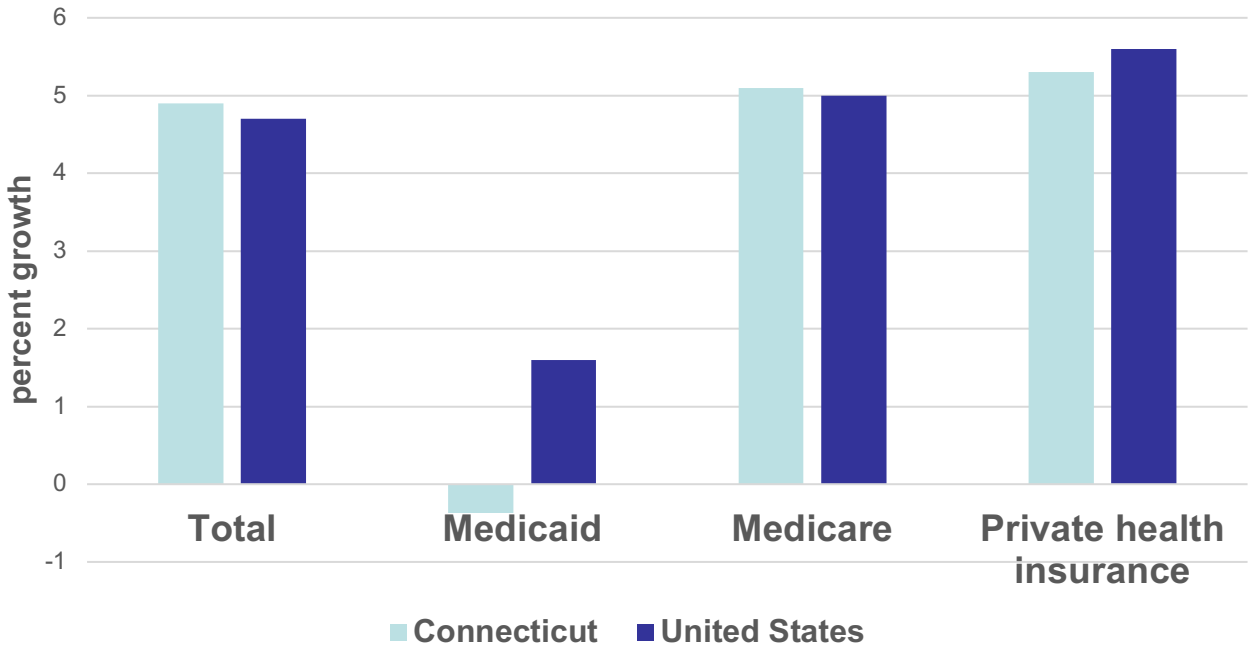
- Medicaid is a large part of the health care market and financing system
  - 16% of all US health care spending
- 71% to acute care, one fourth to long term care
  - 44.4% to long term care in CT, 5th highest in US
- Medicaid is primary payer of nursing home care in US

spending

- Two groups of enrollees vary significantly in spending
- Rates paid to providers low but vary across states
- CT is among more generous states
  - CT provider rates are 76% of Medicare
  - 13th highest rates in US
- Critical funder of safety net services
- Community health centers paid higher rates than private practices

Per capita spending, average annual growth

2001 to 2014



Key Findings

Connecticut Medicaid per person spending from 2001 through 2014 decreased while nationally costs have risen

CT Health Policy Project November 2017

State rank

Per capita – 2014

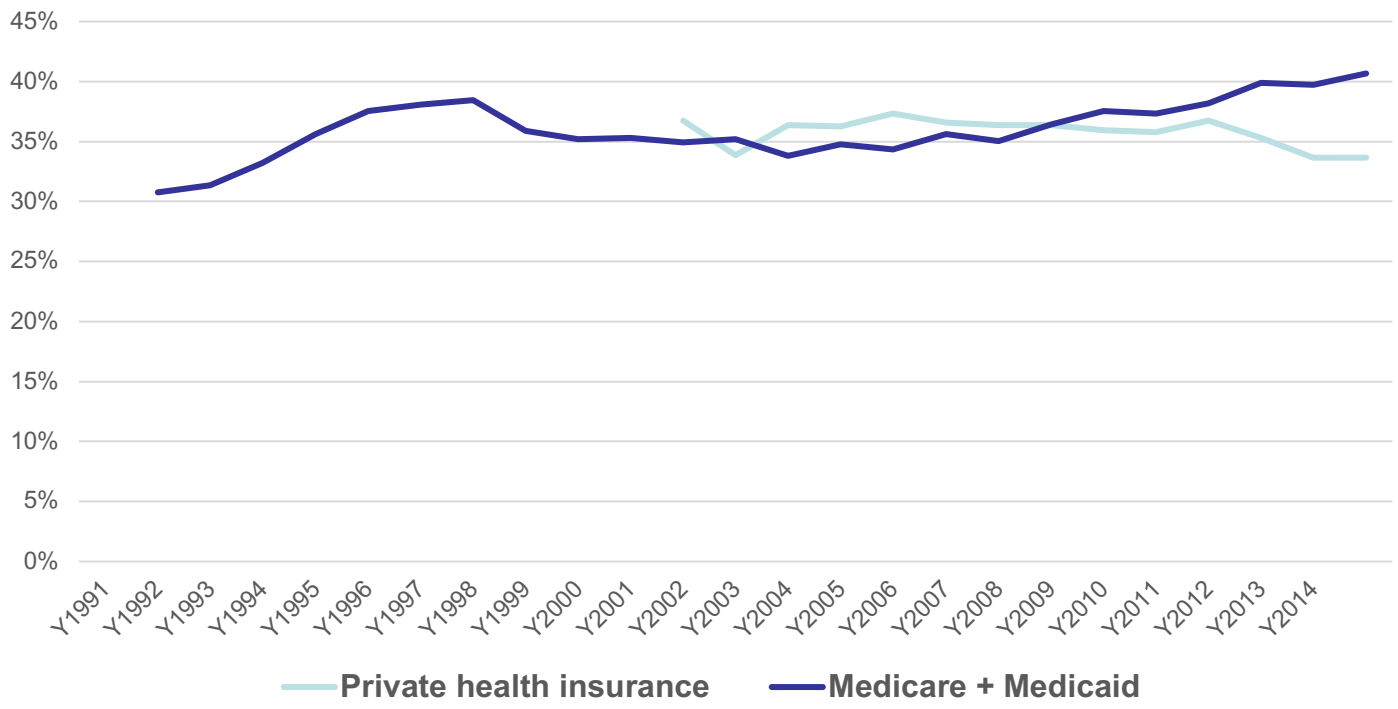
Average annual growth – 1991 to 2014

Key Findings

While Connecticut's relative per capita health care costs are high among states, the rate of growth is much lower, particularly for Medicaid

Share of total Connecticut health spending

Medicare + Medicaid, Private health insurance



CT Health Policy Project November 2017

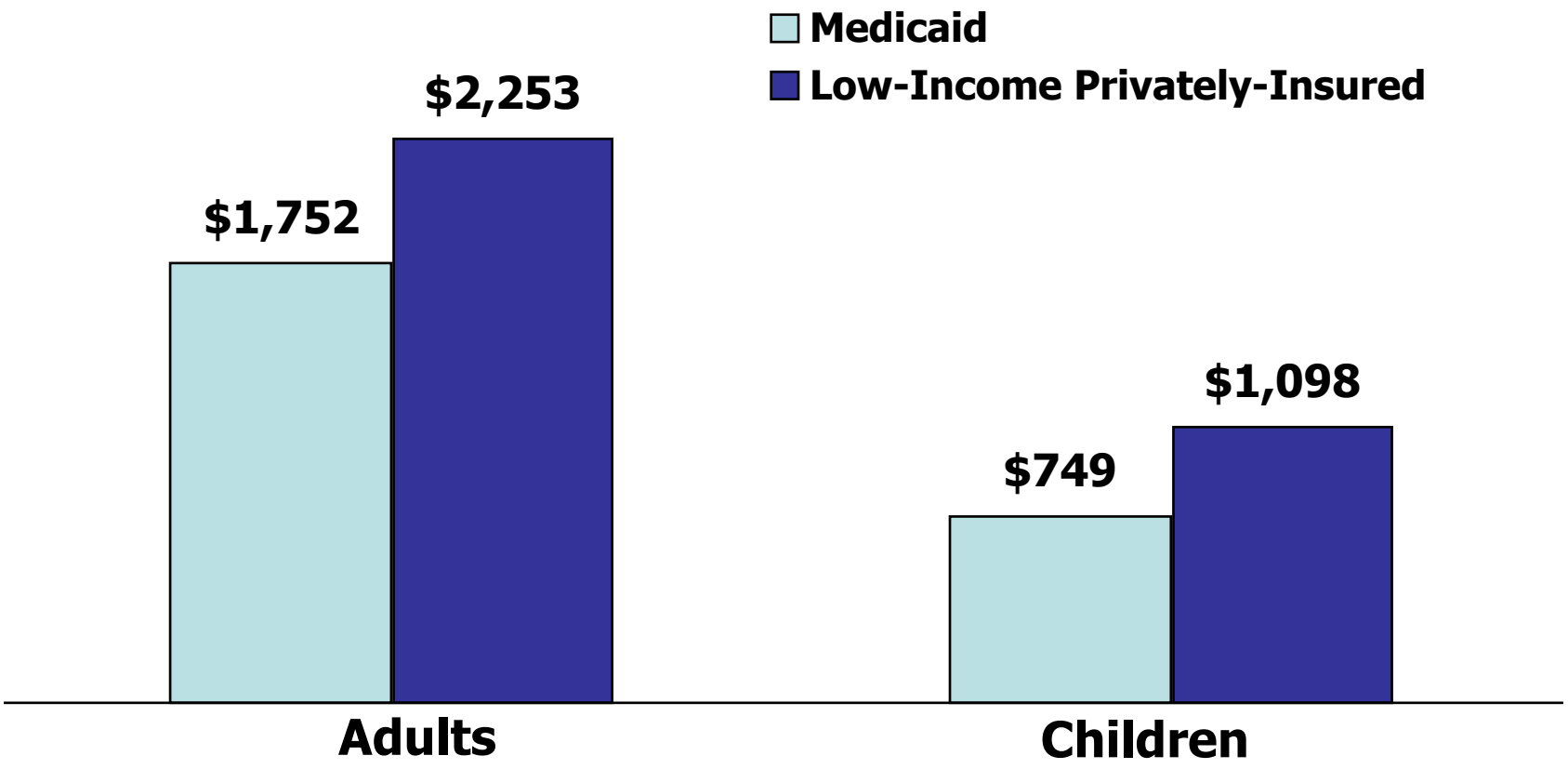
Key Findings

In 2009, public coverage programs' share of total CT health spending began to outpace private insurance

And that gap is growing

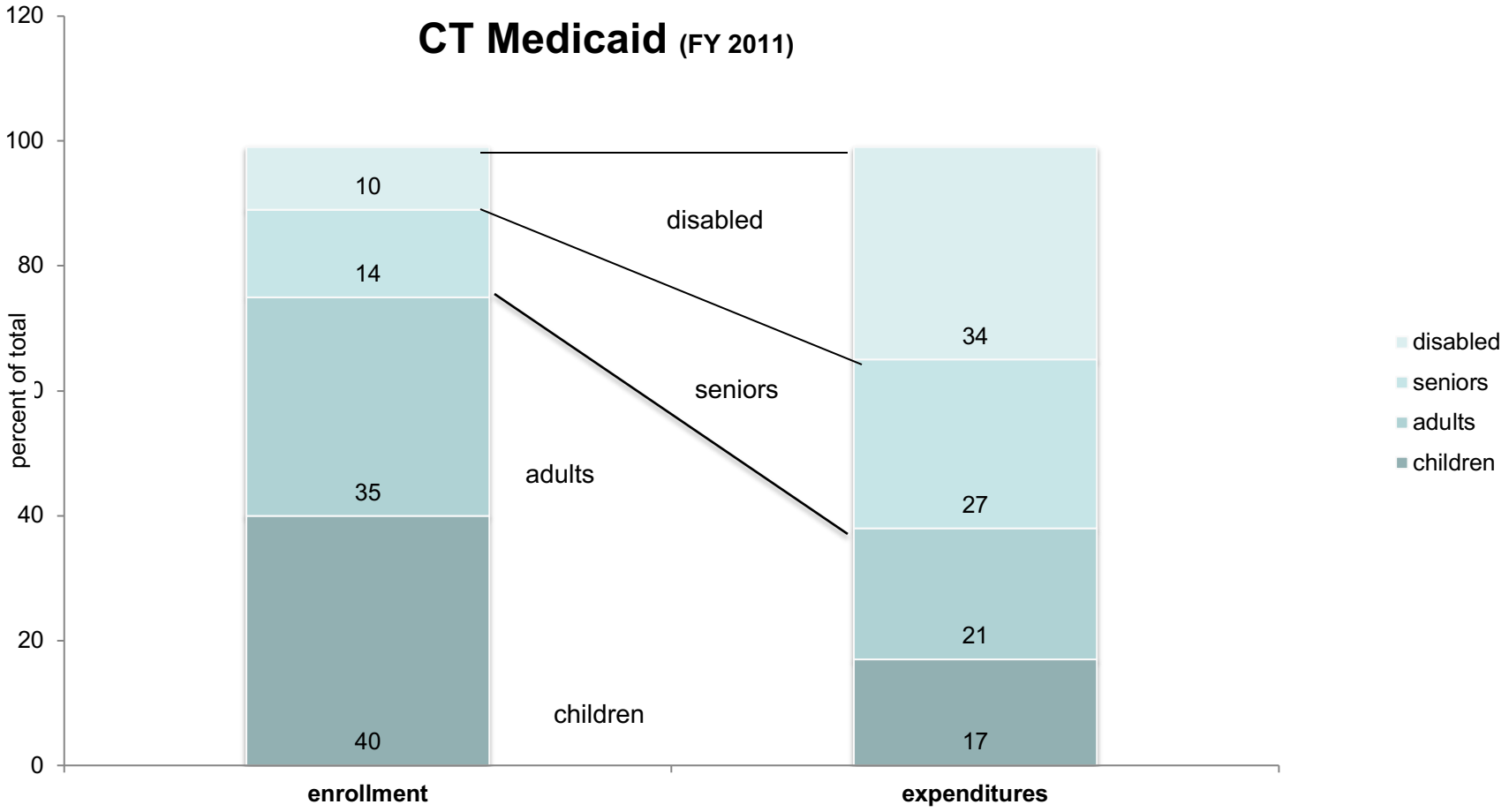
Per Capita Spending For Medicaid Enrollees vs. Low-Income Privately-Insured

Samples adjusted for health differences



SOURCE: Hadley and Holahan, "*Is Health Care Spending Higher under Medicaid or Private Insurance*? " Inquiry, Winter 2003/2004.

Enrollment vs. expenditure



Source: Kaiser State Health Facts Online, 10/2016

HUSKY was a deeply troubled program pre-2012

- Tax break to HMOs on commercial rates to pay them more than CMS allows
- 24% rate increase in 2009
- $50 million overpayments to HMOs
- HUSKY Part B families paying $323 extra each year in profits to HMOs
  - 1,279 children left program in 2009 unable to pay premiums
- HMO medical loss ratios as low as 62%
  - Would not be allowed under federal law now
- Secret shoppers could only get appointments with one in five providers listed in HMO panels
- Very low provider participation, lower than states with worse fee schedules

Few providers participated in CT Medicaid

- Only about half of CT physicians participated before 2012
  - Lower than most states incl states with lower payment rates
- Increase in rates 2008 ⟶ no impact on participation
- Need to improve operations, provider relations, payment processes, communications, information for patients, recruit more physicians, and payment rates
- Recommendations from successful states
- DSS has largely fixed the problems

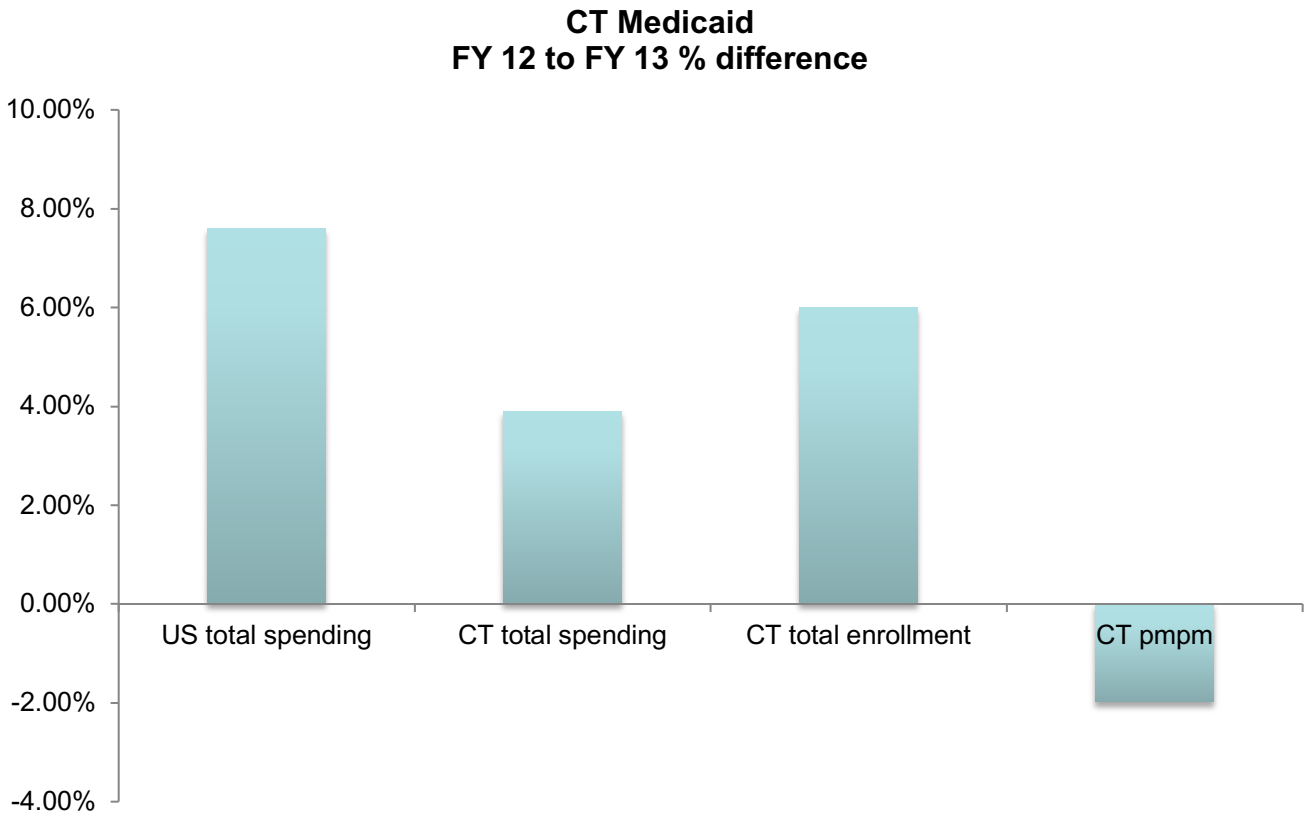
Changed payment model

- CT used capitated insurers to run the program from 1996 to 2012
- New model uses PCMHs administered by an ASO
- Quality up
- 32% more providers participating in first year
  - Still rising, up 7.2% over last year
- Better data for accountability and planning
- Per person costs down 1.9% annually

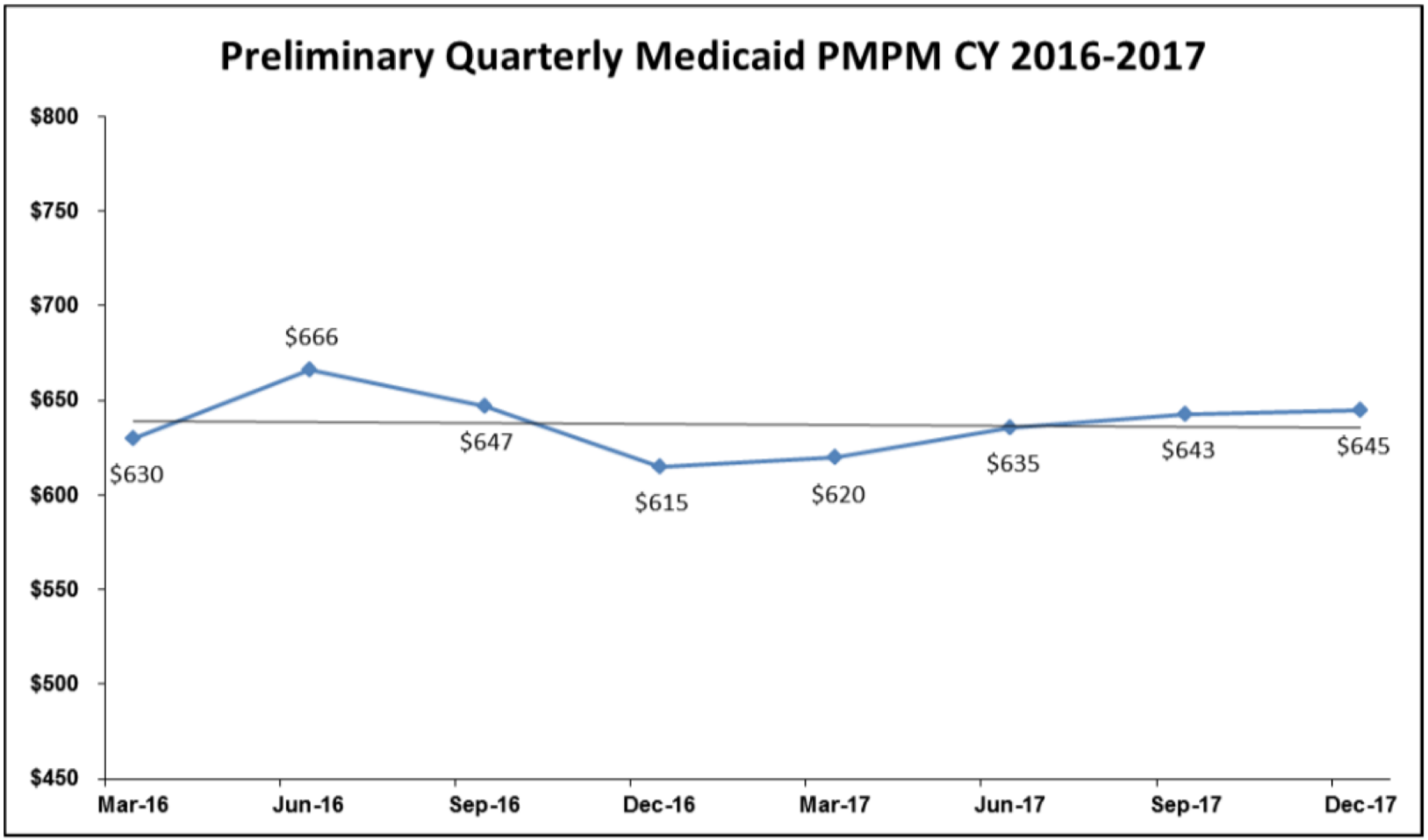
Changed payment model

- 92% of adults and 96% of children can get immediate care when needed
- 93% of adults and 98% of children report positive experiences with the program
- ED visit, hospital admission rates down
- Secret shopper survey – now can get appt with 64% of providers
  - Only 14% told availability based on Medicaid
  - Only 7% felt unwelcome/discouraged from making appt

Since switch to ASO



Costs stable, enrollment up



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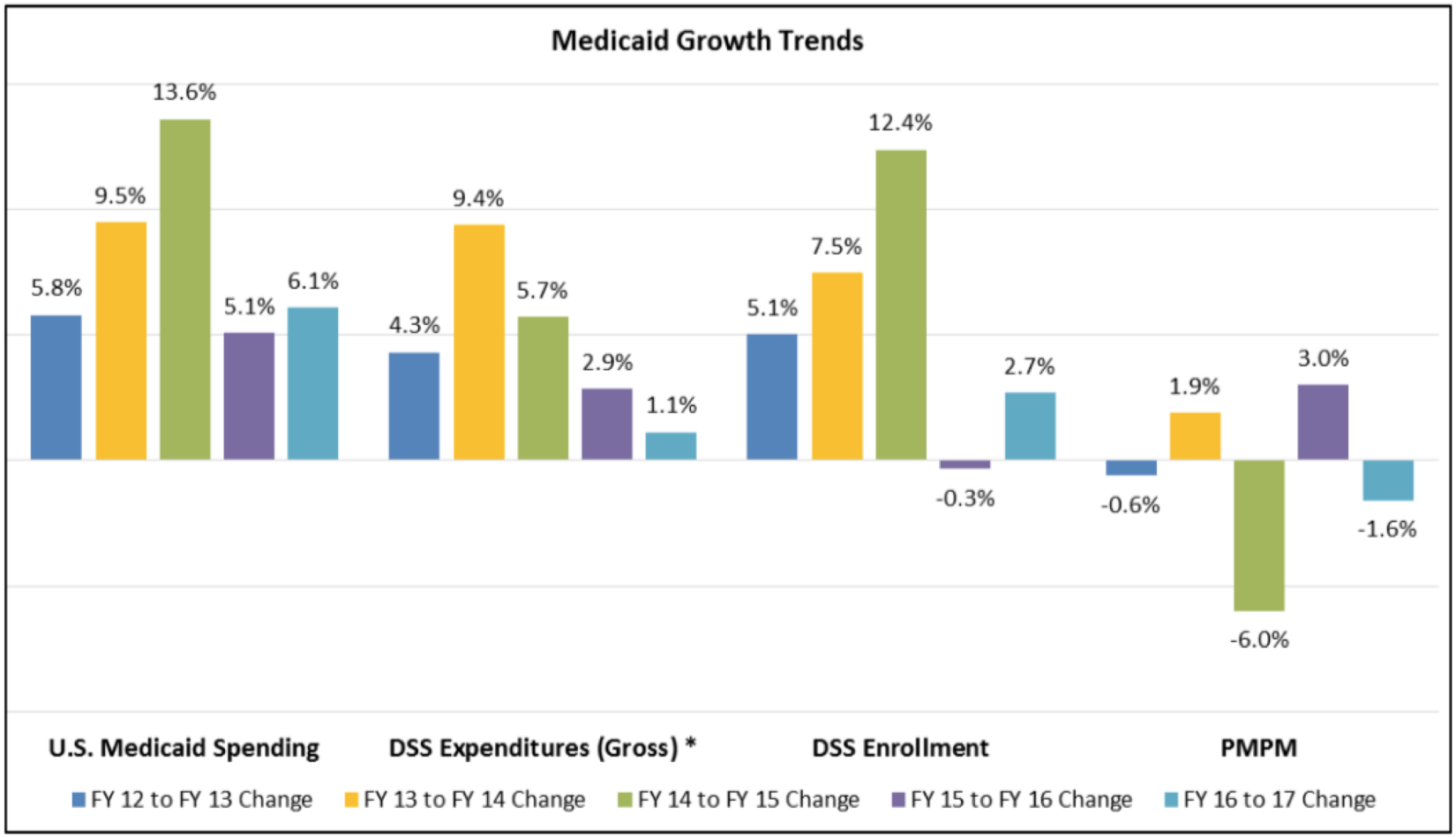


Since switch to ASO

Connecticut Medicaid cost, quality and access to care			
Metric	Performance		Timeframe
Providers participating in Medicaid		Up 5,180 32% increase	Jan 2012 to June 2013
Person centered medical homes (PCMHs) -- providers		Up 243 35% increase	Q3 2012 to Q2 2013
PCMHs – clients in one		205,905 25% increase	Q3 2012 to Q2 2013
Hospital admissions		Down 3.2%	Q1 2012 to Q1 2013
Days in hospital		Down 5.0%	Q1 2012 to Q1 2013
Inpatient costs per member per month		Down 1.8%	Q1 2012 to Q1 2013
Cost per hospital admission		Down 2.7% or $200 each	Q1 2012 to Q1 2013
ED visits		Down 3.2%	Q1 2012 to Q1 2013
Non-urgent ED visit costs		Down 11.7%	Q1 2012 to Q1 2013

Performance now

- Provider participation continues to grow
  - PCPs up 7.5% last year
  - Specialists up 19.3%
- Members largely satisfied with care in the program
  - 91% among adults
  - 96% on behalf of children
- Vast majority able to get immediate access to care when needed
  - 93% of adults
  - 97% of children

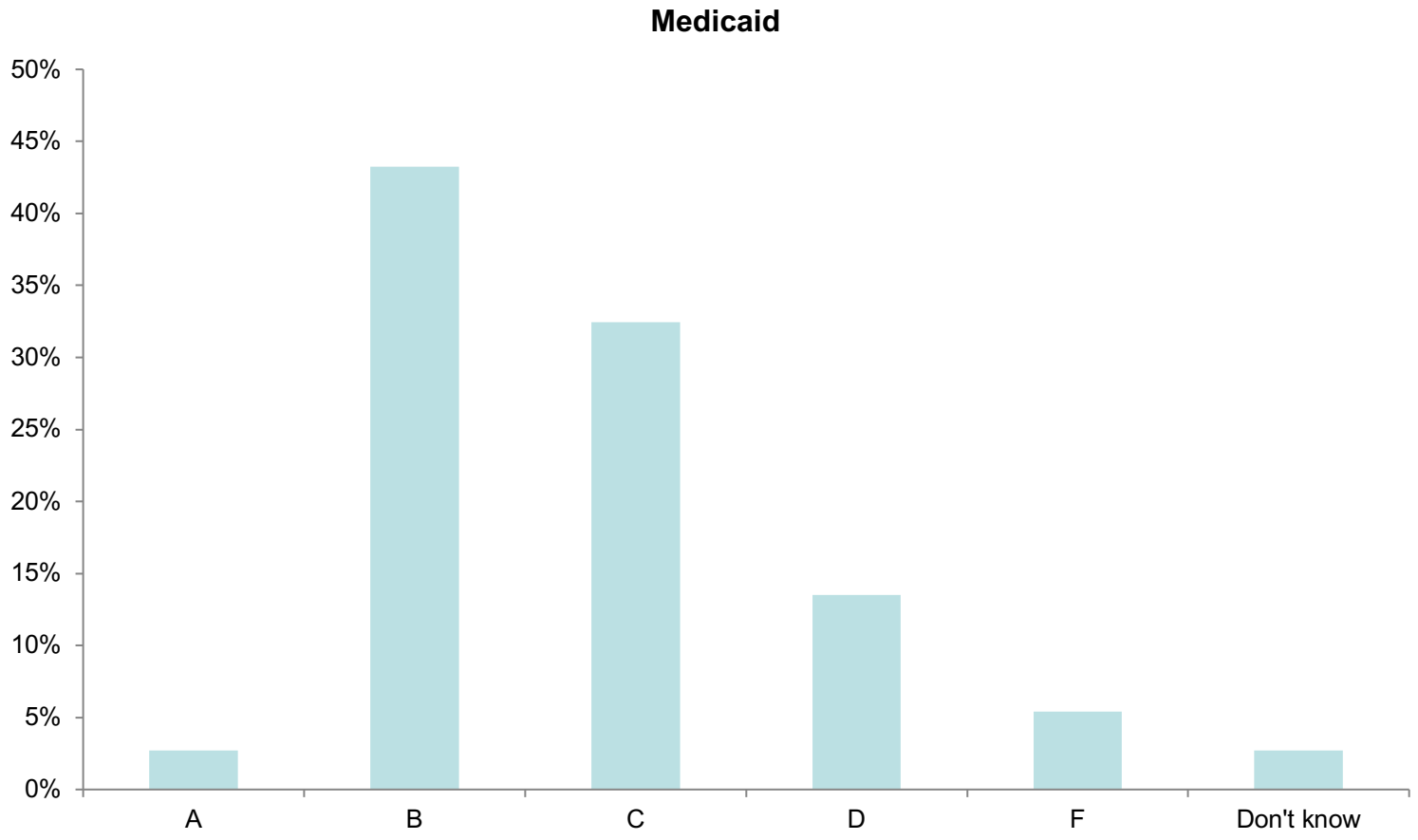
PCMH-focused program

- Based on patient-centered medical home model
- Implemented in 30 other states
- Does not involve HMOs
- Now >100 PCMHs in the program
- Average $141,000 per practice in extra funding

How PCMH works

- PCP expected to provide all primary care services needed, plus
  - Referrals to specialists and tests, collect results and follow up with patient
  - Initial risk assessment and develop care plan with patient
  - Provide patient education and support to manage their own care
- PCPs can choose how many patients they will take responsibility for
- PCPs must be certified by NCQA
- Current payment – enhanced fees + P4P/quality

CT thoughtleaders on Medicaid



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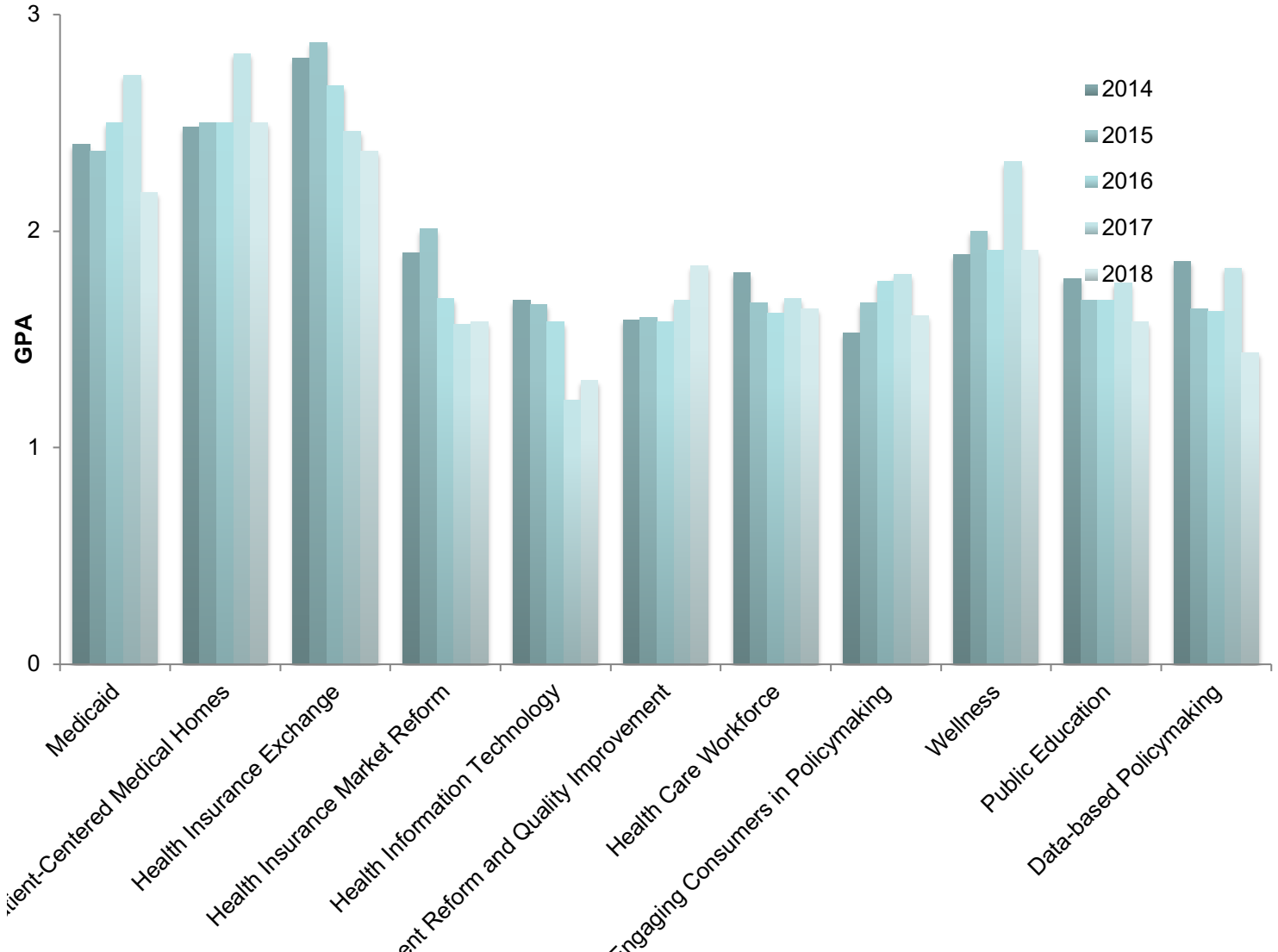

Changing again, why?

- Very controversial
- Politics, shiny new toys
- Quality does need improving, especially at community health centers and hospitals
- Moving to Shared Savings model – PCMH Plus/+
  - Networks of providers
  - If can save $$ on total cost of care, they get half of that back
  - Large investments necessary
- Problems
  - We are making progress, fragile but moving ahead

BIG Problems

- No evaluation – will add 200,000 more before have info on underservice or rising costs of first 100,000
- Consumer notice changed at last minute to accommodate ACOs
  - Now need a college education to read it
  - Surprise – very few opt-outs – used to justify program
- Implementation troubling – no tracking ACOs
- Lots on our plates to continue implementation and address higher enrollment
- **Very Very** political decision, not based on evidence or needs

BIG Problems

- Serious concerns about underservice – esp in Medicaid
- Medicaid pays less, how to generate savings?
- Serious investment by providers required
  - No promises of sustainabilty
- This model ended up costing more in Medicare for many years, esp in CT
  - These ”savings” payments are supposed to fund the program
- Quality monitoring is deeply inadequate and selective public reporting
- Secrecy -- not sharing data, secret meetings to implement
- Changed consumer notice so it’s unreadable, no knowledge about right to opt-out

What is CHIP?

- Created in 1997 with bi-partisan support
- Federal program to cover children at higher incomes than Medicaid
  - Subsidized premiums and cost sharing
  - Up to 300% FPL
- Federal subsidies higher than Medicaid
  - Varies by state
  - CT now getting >80% match
- States given flexibility in benefit package
  - CT used private plan, less generous than Medicaid
- States can charge families more than Medicaid
- HUSKY Part B in CT
- Congress has to reauthorize the program

Federal Medicaid trend

- ??????
- Pushing work requirements
- Easing network adequacy standards
- Attempts to cap funding lost steam but still talking
  - Shifts costs onto states
  - Flexibility but with grossly inadequate funding
- Cuts to Prevention and Public Health Fund, Planned Parenthood, cost saving “innovations”, ...
- CHIP reauthorization lapsed at the end of September, but finally passed
  - 17,331 children in CT

Trends

- State budget pressures led to cut 18,000 working parents last year, another 10,000 will lose it Jan. 1, 2019
- Provider rate cuts
- Medicaid enrollment stable (absent cuts) after sharp growth
  - Employer coverage dropping
  - Recession, lower incomes, more people qualify
- Medicaid finances – optimistic trend
  - Federal reimbursement unknown
  - Reforms working
- Quality improvements working, expanding
- HUGE elephants in the room – Federal action/cuts, CT's experimental payment reform plan