State Health Care Spending Trends

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Objectives:

- Provide a long-term look at key indicators related to state fiscal and economic health
- Present a cohesive picture of health care spending
- Help policymakers gain a better understanding of what’s driving costs in specific health care areas
- Highlight policies and practices that may contain costs while maintaining or improving health outcomes
Health Programs Funded by States

- Medicaid & CHIP
- Mental health care
- State Health Care Spending
- Substance use disorder treatment
- State retiree health benefits
- State employee health benefits
- Prison health
States’ Hats

- Insurer: Medicaid & CHIP

- Care Provider for Uninsured and Underinsured: Mental Health Care and Substance Use Disorder Treatment

- Custodian/Enforcer: Prison Health

- Employer: State Employees & Retirees
The Controllable and the Uncontrollable

**Controllable**
- Medicaid expansion or not
- Breadth of benefits & income eligibility levels above floor (Medicaid, BH)
- Criminal justice code
- Provider reimbursement rates
- Incentives (tobacco tax, bike lanes)
- State tax levels

**Uncontrollable**
- Demographics, including of state employees
- Underlying cost of services (i.e., RN salary)
- Vibrancy of private sector ESI (universities, hi-tech)
- Epidemics (AIDS, opioid)
- FMAP
- Must provide services to inmates
- Countercyclical
Overlaps (and Underlaps)

- States fund and provide similar health services through many agencies: clinics, prisons, schools, courts.

- Some individuals are served by many agencies that usually don’t/can’t share information: Medicaid, courts/prisons, SUD providers, housing agencies.

- Many are dually BH diagnosed & physically ill.

- Mentally ill and addicted individuals often cycle between community (EDs) and confinement w/o care handoffs.

- Wide state variation in menu of services offered to whom.
Medicaid’s Reach

• Largest health insurer by enrollment: From 10% in ND & VA - 33% in NM & WV, 2014. But we spend more on Medicare

• Children – 43% covered by Medicaid/CHIP, 2014

• Maternity - 45% of births, 2010. From 25% in Hawaii - 70% in Louisiana

• Nursing Homes - largest payer

• Mental Illness – will be largest payer by 2020

• AIDS – largest payer
Pressure of Health Care Spending on State and Local Budgets Tapers
Total state and local government spending on health care as a share of own-source revenue, 1987-2014

Note: Expenditure data from the National Health Expenditure Accounts were divided by revenue data from the National Income and Product Accounts. Revenue is state and local current receipts minus contributions for government social insurance and federal grants-in-aid.

Sources: Centers for Medicare & Medicaid Services; Bureau of Economic Analysis
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State and local health care expenditures increased by 265 percent from 1987 to 2014 (inflation-adjusted).

Most significant elements: contributions to public employee health insurance premiums and to Medicaid.

State and local spending flat in 2014, the first year of Medicaid expansion. Second smallest change on record.
State Medicaid Spending as a Share of Own-Source Revenue, 2000-15

Federal Action Reduces State Rx Spending for Dual Eligibles

Stimulus Increased Federal Share of Funds

2015: 16.7%

Recession

10%

11%

12%

13%

14%

15%

16%

17%

18%


50-state share

pewtrusts.org/fiscal-health
Change in State Medicaid Spending as a Share of Own-Source Revenue, 2000-15

- Louisiana: 12.8 percentage points
- Alaska: 10.1 percentage points
- California: 8.6 percentage points
- 50-state total: 4.5 percentage points
- Michigan: 1.0 percentage points
- New York: -0.1 percentage points
- North Dakota: -0.9 percentage points
### Change in State Medicaid Spending as a Share of Own-Source Revenue, 2013-15

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<thead>
<tr>
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<th>Expansion states</th>
<th>Non-expansion states</th>
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<tbody>
<tr>
<td><strong>Share rose</strong></td>
<td>12</td>
<td>14</td>
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</table>
| **Share fell** |                  |                      | 17

- Expansion states: 12 states saw their share of Medicaid spending rise.
- Non-expansion states: 14 states saw their share of Medicaid spending rise.
- Non-expansion states: 7 states saw their share of Medicaid spending fall.
- Total states: 33
Interactive Tool for Data Analysis

STATE MEDICAID SPENDING

Medicaid Claims Nearly 17 Cents of Each State Revenue Dollar

The share of states’ own money spent on Medicaid health care coverage for low-income Americans fell slightly in fiscal year 2014, even as enrollment in the program spiked. Still, Medicaid’s claim on state revenue was the third largest in 15 years, consuming 16.8 cents of each state-generated dollar in fiscal 2014—4.6 cents more per dollar than in fiscal 2000. Read more below.

Change since 2000  Compare state trends  Updated: September 01, 2016

State Medicaid Spending as a Share of Own-Source Revenue, 2000–14
50 States  Alaska  Rhode Island  Iowa

FEDERAL ACTION REDUCES STATE RX SPENDING

STIMULUS INCREASED FEDERAL SHARE OF FUNDS

Alaska  ×
Rhode Island  ×
Iowa  ×

50-state share

pewtrusts.org/fiscal-health
Fiscal 50: State Trends and Analysis

Key Indicators of Fiscal Health

**REVENUE**
- Tax Revenue
- Tax Revenue Volatility
- Federal Share of State Revenue

**SPENDING**
- Change in State Spending

**ECONOMY AND PEOPLE**
- Employment to Population Ratio
- State Medicaid Spending
- State Personal Income

**LONG-TERM COSTS**
- Debt and Unfunded Retirement Costs

**FISCAL POLICY**
- Reserves and Balances
Health Programs Funded by States

- Medicaid & CHIP
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- Employee health benefits
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- Prison health care

State Health Care Spending
Health Programs Funded by States

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State Health Care Spending
Eligible individuals may be enrolled before, during, and after a jail or prison stay.

No federal reimbursement, with one exception: offsite inpatient costs.

HHS: Medicaid enrollment after release can help lower health care costs, hospitalizations and emergency department visits, as well as decrease mortality and recidivism.

Overview
The Centers for Medicare & Medicaid Services (CMS), a unit of the U.S. Department of Health & Human Services (HHS), released new guidance in April 2016 on how states and localities may facilitate access to Medicaid coverage for individuals before, during, and after a correctional institution stay. In announcing these guidelines, HHS noted that Medicaid “connects individuals to the care they need once they are in the community and can help lower health care costs, hospitalizations and emergency department visits, as well as decrease mortality and recidivism for justice-involved individuals.” People under community supervision (e.g., parole) or incarcerated in prisons or jails. This population has disproportionately high rates of physical and behavioral health illnesses.

The guidelines reiterate and elaborate on long-standing policies pertaining to Medicaid coverage of inmates and remove some restrictions on covering certain individuals after release. This analysis, building on previous research conducted by The Pew Charitable Trusts, explains CMS’ latest communication, its practical impact for state and local policymaking, and how some jurisdictions have navigated this terrain.

History of Medicaid coverage for the incarcerated
Jurisdictions have never been precluded by inmates’ incarceration status from enrolling them in Medicaid, the joint federal-state health care program for vulnerable populations. CMS has long held that individuals who meet states’ Medicaid eligibility criteria “may be enrolled in the program before, during, and after the...
Substance Use Disorder Treatment

State and local governments play significant role ($9b in 2009):
- Medicaid
- Substance use disorder agencies

ACA built on longstanding coverage requirements.
Mental Health Care

- State and local governments play significant role ($36b in 2009):
  - Medicaid
  - Mental health agencies

- ACA built on longstanding coverage requirements.

Mix of Public, Private Spending Relatively Consistent
Spending on mental health, 1986–2020
Medicaid Program Integrity Tool

Medicaid Anti-Fraud and Abuse Practices Database

See what measures states are taking to reduce Medicaid fraud and abuse

Billions of state and federal dollars are lost to Medicaid fraud and abuse each year. This first-of-its-kind database compiles and categorizes promising practices states are employing to combat this problem. Using information cited by the Centers for Medicare & Medicaid Services (CMS) in its state reviews, the data presented are current as of June 2013. To learn more about the practices referenced in this tool, read Combating Medicaid Fraud and Abuse.

Using the database

Use the filters below to discover what actions states are taking to fight Medicaid fraud and abuse. Choose a state to view practice type information for that location or compare data across states by selecting “All States” and refining your search by practice type. Note: CMS Noteworthy Picks are practices the agency identifies in its state reviews; all other states should consider implementing.

Select a State

All States

Select a Practice Type

Provider Regulation
- Provider Accountability
- Excluding Problem Providers

Prepayment Review
- Service Verification
- Prior Authorization and Claims Review
- Recipient Lock-In

Post Payment Recovery
- Data Mining
- Detection and Investigation
- Penalties and Recovery

Medicaid Fraud Control Unit Coordination
- Stakeholder Coordination
- Provider Outreach and Education
- Managed Care Oversight
- Targeting High-Risk Providers

Check all

Results

Download resources

Combating Medicaid Fraud and Abuse Full Report

State Health Care Spending on Medicaid Full Report
Upcoming Publications

• Evaluating State Prison Health Care: cost, quality monitoring, reentry care continuity
  – State Prisons and Pharmaceuticals
  – State Prisons and Hospitalization

• Jails: Inadvertent Healthcare Providers