President Directed HHS Secretary to Convene a Task Force on Health

• “To recommend ways to stabilize and reduce the cost of medical care
• To recommend ways to reduce the costs of drugs, and on the inclusion of prescription drugs in Medicare
• To develop a strategy for improving the delivery of health care for the poor.”

– Confidential “eyes only” memo from White House to Secretary John Gardner, August 21, 1967
“The structure of Medicaid produces serious problems...”

• “Many low income people are not eligible
• Benefits are not uniform and comprehensive
• Long term care benefits are biased toward institutional services
• Payment policies impede access to care
• Health care inflation and general economic conditions undermine Medicaid’s fiscal stability and encourage cutbacks
• Medicaid is complex and difficult to administer.”

– Memo to Secretary Joseph Califona, January 23, 1978
“Medicaid...

• ...has always been under-appreciated, particularly for the role that it plays in the lives of so many Americans.”

  – John Iglehart, Founding Editor, *Health Affairs*
Medicaid Today: America’s Largest Health Program

– Medicaid enrollment of **56 Million** (avg. monthly 2012)
  
  – With turnover, a total of 70 million enrolled during 2012
  
  – Medicare enrollment is **50 million** in 2012

– Medicaid total spending: **$459 billion** (2012)
  
  – Medicaid spending for Hospital, $173 billion; Physicians, $51 billion; Prescription drugs, $21 billion; Home Health, $30 billion; Nursing Facilities and CCRCs, $47 billion; Residential and Personal Care, $77 billion.
  
  – Medicare spending to be $591 billion in 2012

Medicaid Is the Financial Glue Holding Together the Safety Net

- Health insurance for low-income families, persons with disabilities and the elderly
- Assistance to low-income Medicare beneficiaries (40% of Medicaid spending)
- Long-term care, including home and community services
- Support for safety net providers who serve the uninsured - DSH payments to hospitals
- Financial support for other programs such as mental health, school and public health
Medicaid Coverage Improves Medical Care, Financial Security and Health Status

“Randomized controlled trial” study of 2008 Oregon coverage expansion by lottery to 30,000 of 90,000 applicant adults

- **Increased use of health care services**
  - 70% more likely to have “usual place of care”
  - 60% higher use of preventive care like mammograms
  - Spending higher: inpatient +30%; outpatient +35%; Rx +15%

- **Improved financial security**
  - 40% less likely to borrow money to pay medical bills
  - 25% less likely to have bills sent to collection agency

- **Improved self-reported health status**
  - 25% more likely to be in good to excellent health
  - 25% less likely to screen positive for depression.

Medicaid Coverage Associated with Better School Readiness

• “Children with the recommended number of EPSDT well-child visits had a 23% higher likelihood of being ready for school (1st grade), compared with those with fewer visits.”

• EPSDT includes AAP-recommended services, designed to promote normal child development.

• Study examined results for 22,000 children

Medicaid’s Basic Structure:  
A State Administered – Federally Supported “Partnership”

• Medicaid operates under federal law (Title XIX of Social Security Act)
  – Law and regulations define the terms and conditions a state must meet to earn federal matching funds (Federal Financial Participation, or FFP) on qualifying expenditures

• By law, a state is entitled to FFP for all qualifying expenditures

• Qualifying expenditures are defined in the official contract between the state and the federal government, the Medicaid State Plan,
  – The State Plan spells out in detail covered services, qualifying providers, payment methodologies, eligibility, copays, and any waivers for long-term care, managed care or health reform
  – A “Waiver” can allow spending that otherwise wouldn’t qualify to earn FFP
  – Managed care can operate under a State Plan, 1915(b) or 1115 waiver

• Federal matching rate (Federal Medical Assistance Percentage, or FMAP) is recalculated annually for each state
  • Range has been from 50% (statutory minimum) to about 77%, based on state average personal income compared to the national average
1. Federal – State Roles Inevitably Lead to Conflict and Tension

• Federal role is as a regulator, who must prove that all federal funds are spent appropriately.
  – Must show that all conditions are met for qualifying expenditures, in accordance with Congressional intent
  – Audits, oversight, control over waiver approvals

• State role is policy maker and administrator of federal and state funds.
  – Most important decisions are made at state level
  – States called for more flexibility from beginning.
2. Medicaid can be the world’s most effective financing tool

• Much of Medicaid spending growth over time is related to “Medicaid-izing” state health programs.
  – Mental health, public health, substance abuse, school-based health care.
  – Provider taxes now are a major source of financing for Medicaid
    • Hospitals, nursing homes often now participate in financing their provider rate increases.
3. Costs, and how to slow cost growth, has been a constant issue

• Medicaid spending has increased faster than state budgets and revenues
  – Medicaid spending has increased about 7% annually, while revenues increase about 5.5%
  • Medicaid constantly becomes a larger share of budget
  – Medicaid is counter-cyclical, so costs increase more just when states can least afford it.
  – Medicaid has constant focus on cost containment
  – Medicaid operates in the general health care market, with all the medical cost pressures
Governor’s Often Target Medicaid Cost Growth as a Major Issue

“Medicaid growth is simply unsustainable and threatens to consume the core functions of state government.”

• Governor Jan Brewer, (R – Arizona), signing request for waiver of “Maintenance of Effort” law in order to cut adults from Medicaid.
Medicaid Was a Driver of State General Fund Spending Growth in FY 2012

Changes in General Fund Spending by Category from FY 2011 to FY 2012

- K-12: $1.3
- Higher Ed: -$3.2
- Public Asst.: -$0.1
- Medicaid: $19.4
- Corrections: $0.6
- Transportation: $0.0

Data is based on comparative levels of enacted spending in FY 2011 and FY 2012
Source: NASBO Fall 2011 Fiscal Survey of States

Health Management Associates
Total Medicaid Spending, as a Percent of Total State Budgets

1985 - 2011

Source: HMA, based on NASBO reports, various years.
Medicaid Cannot Escape Factors that Drive Overall Health Costs

– Technology-driven changes to medical practice
– Higher utilization, including prescription drugs
– Consumer demand, related to incomes, higher expectations
– Aging of population, longer life-spans
– Higher incidence of chronic disease
– Medical liability and defensive medicine
– Administrative costs
Health Insurance Premiums (Reflecting Medical Costs) Have Increased Much Faster than Inflation and Earnings
Cumulative Increases, 1999-2011

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011
Premiums Doubled in Last Decade – And Will Continue to Grow

Family Coverage
2001, 2011 and 2020 Projected

2001: $7,061
2011: $15,073
2020: $23,842

Note: Projection does not reflect impact of health reform.

As Costs Increase, Fewer Firms Offer Coverage: Share of Firms Offering Health Insurance: 2001 and 2011

Uninsured Increased by 13 Million Last Decade
2000 - 2010

Source: HMA, prepared from: Income, Poverty, and Health Insurance Coverage in the United States: 2010
Medicaid Enrollment Increased 58% Over Decade; Wide Variation Across States

2000 to 2010, U.S and Selected States

Note: U.S. growth 2000 to 2010 totaled 19 million, or 58%.
Source: Data compiled by Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured.
“Medicaid Enrollment: December 2010 Data Snapshot,” www.kff.org/medicaid/enrollmentreports.cfm
U.S. Medicaid Enrollment

Note: Enrollment percentage changes from June to June of each year.
Total Medicaid Spending Tracks Enrollment Percent Changes, FY 1998 – FY 2012

NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages for state fiscal year.
http://www.kff.org/medicaid/8248.cfm
States Have Had to Look for New Ways to Slow Medicaid Cost Growth, But ...

- Any easy actions have already been taken
  - States have a perennial focus on cost containment
- Medicaid patients are sicker
  - Compared to low-income adults with private health insurance, over twice as likely to be in fair or poor physical or mental health, or to have chronic health conditions
- Medicaid costs are already lower than other payers’
  - Adjusted for health status, costs per capita are 1/4 less for adults; 1/3 less for children
- Medicaid cost growth has been lower
  - 23% less per capita than for persons with private health insurance

Medicaid and Medicare spending growth per enrollee is lower, compared to private spending.

Per Capita Annual Spending Growth 2000-2010

<table>
<thead>
<tr>
<th></th>
<th>3.0%</th>
<th>4.6%</th>
<th>5.6%</th>
<th>5.1%</th>
<th>6.4%</th>
<th>7.7%</th>
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<tbody>
<tr>
<td>Medicaid LTC per Beneficiary Total</td>
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<tr>
<td>Medicaid Acute Care</td>
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<tr>
<td>Medicare per Beneficiary</td>
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<tr>
<td>NHE Per Capita</td>
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<tr>
<td>Monthly Premiums for Employer Sponsored Coverage</td>
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</tr>
</tbody>
</table>

SOURCE: Urban Institute, 2010. Estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64), Medicaid Statistical Information System (MSIS), and KCMU/HMA enrollment data. Expenditures exclude prescription drug spending for dual eligibles to remove the effect of their transition to Medicare Part D in 2006.
State Medicaid Policy Actions
FY 2011 and Adopted for FY 2012

Provider Payments | Eligibility | Benefits | Long Term Care
---|---|---|---
35 | 33 | 13 | 32
28 | 22 | 13 | 33
25 | 4 | 18 | 14
39 | 46 | 18 | 11

NOTE: Past survey results indicate not all adopted actions are implemented. Provider payment restrictions include rate cuts for any provider or freezes for nursing facilities or hospitals.

http://www.kff.org/medicaid/8248.cfm
4. Medicaid Has Many Opportunities to Improve Care and Coverage

• Medicaid financing can facilitate state health reform initiatives
  – E.g., Arizona, Tennessee, Oregon, Massachusetts, Vermont, Florida, California, Rhode Island

• Medicaid can be a leader in improving quality

• Managed care has been the vehicle for improving access, quality and controlling costs
Early Medicaid Managed Care Addressed Shortcomings in Medicaid

• “By the early 1980s ensuring access to a medical home had become a major Medicaid concern, as low payment rates contributed to limited provider participation and increasing reliance on emergency departments as a source of primary care.”

Share of Medicaid Enrollees in MCOs and PCCMs, By Plan Type

1991 - 2010


Health Management Associates
Medicaid Managed Care Trend Contrasts with Commercial Health Insurance Market

Percent of all covered employees in each type of plan

With Managed Care, Medicaid Can Be a Leader in Innovation, Quality Improvement and Value

“We are unashamed to use the power of Medicaid to raise the standard of care for all the citizens of our state.” — Craigan Gray, MD, NC Medicaid director

• Better Information for Consumers on Best Practices and Performance
  • Consumer guides and MCO performance report cards, based on HEDIS and CAHPS

• Wide Range of Quality Initiatives
  • Care management programs for high risk / high cost patients
  • Performance improvement projects (e.g., reducing avoidable ER visits)
  • Special initiatives for priority population health (e.g., reducing obesity, disparities)

• Reimbursement Strategies
  • Bonus payments for high performance on HEDIS® or CAHPS® quality performance measures selected annually
  • Penalties for poor performance
  • Higher payment when meet medical home or chronic care management standards
  • Procurements based on quality

Medicaid Can Use Special Initiatives to Improve Quality through Managed Care

- To reduce inappropriate use of ER (43 states)
  - E.g., ER data to PCPs, 24-hour nurse line, beneficiary education, case management for heavy users.

- To reduce obesity, with Medicaid MCOs often playing a leading role (34 states)
  - E.g., weight reduction programs, disease management, health nutrition education, health promotion.

- To reduce racial and ethnic disparities (Almost half the states)
  - E.g., focus on well-child visits, screening for cancers for women; cultural competency; data on race/ethnicity provided to MCOs for analysis of use patterns.

- Other quality initiatives target dental care, depression screening, behavioral health, persons needing care coordination.

Medicaid Increasingly Uses Managed Care for Persons with Complex Health Needs

- Increasingly, states now require populations previously excluded to enroll in some form of managed care, e.g.,
  - children with disabilities receiving SSI
  - children with special health care needs
  - seniors and persons with disabilities.

- 11 states have prepaid Managed Long Term Care programs with total enrollment of over 400,000
  - Programs generally include Medicaid services only, but programs in Massachusetts, New York, and Wisconsin also include Medicare services.

Most Enrollees are Now in Managed Care, but Most Medicaid Spending Is Still FFS

Note: Managed care includes risk- and non-risk based, including MCOs, PCCMs, and limited benefit plans. Data are for 2008. Source: HMA, prepared from data in: MACPAC, Report to Congress: The Evolution of Managed Care in Medicaid, June 2011.
5. The Next Frontier: Coordinated, Integrated Care for Duals and Persons with Disabilities

- Delivery system reform, with vertically integrated care for persons with complex, costly medical needs
- Financial incentives aligned to encourage and reward healthy outcomes
  - Bundled payments, P4P
- Dual eligible initiatives in 26 states
Medicaid Has Turned Long-Term Care from Reliance on Institutions to Home and Community Care

In Billions:

<table>
<thead>
<tr>
<th>Year</th>
<th>Home and Community-Based</th>
<th>Institutional Care</th>
<th>Home and Community-Based %</th>
<th>Institutional Care %</th>
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</thead>
<tbody>
<tr>
<td>1990</td>
<td>$32</td>
<td>$33</td>
<td>87%</td>
<td>13%</td>
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<tr>
<td>1995</td>
<td>$54</td>
<td>$40</td>
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<td>80%</td>
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<tr>
<td>2000</td>
<td>$75</td>
<td>$55</td>
<td>30%</td>
<td>70%</td>
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<td>2002</td>
<td>$92</td>
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<td>68%</td>
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<td>2004</td>
<td>$100</td>
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<td>2006</td>
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<td>59%</td>
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<td>2008</td>
<td>$115</td>
<td>$58</td>
<td>42%</td>
<td>58%</td>
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<tr>
<td>2010 (Prel.)</td>
<td>$125</td>
<td>$55</td>
<td>45%</td>
<td>55%</td>
</tr>
</tbody>
</table>

Note: Home and community-based care includes home health, personal care services and home and community-based service waivers.

Unprecedented New Focus on Coordinated Care for Dual Medicaid – Medicare Eligibles

- Historically, Medicaid and Medicare have been “silo-ed” and prevented from coordinating care
- ACA authorized CMS to create a new “Medicare – Medicaid Coordinated Care Office” in 2010
  - April 2011: CMS awarded contracts to 15 states to design approaches to “coordinate and integrate” care and financing care for dual eligibles.
    - CA, CO, CT, MA, MI, MN, NY, NC, OK, OR, SC, TN, VT, WA, WI
    - July 2011: CMS outlined new opportunities for states to design shared savings initiatives, in managed care or fee-for-service
  - CMS is now working with 26 states on dual eligible initiatives.
    - a point of accountability for care management, measurement of quality and outcomes, quality improvement
Duals Will Rise Dramatically in Importance as U.S. Population Ages
Share of Population Age 65+ Is Increasing Sharply

Source: U.S., Administration on Aging.
Under Health Reform, Medicaid Enrollment Projected to Grow by 1/3 by 2020

Millions of U.S. Medicaid Beneficiaries. Unduplicated, ever-enrolled annually. % Growth by decade.

Projected % Growth in Medicaid Enrollment
Under Health Reform

Selected States, Range Depending on Enrollment Assumptions

U.S. Medicaid Market Projected to More Than Double Over Decade 2010 – 2020

Total Medicaid Spending
With Reform

Total Medicaid Spending
Without Health Reform

SOURCE: HMA, based on CMS, NHE projections, June 2012.
Total Medicaid Spending, Annual Growth Rates, Projected 2013 - 2020

Annual Percentage Changes

<table>
<thead>
<tr>
<th>Year</th>
<th>Growth Rate</th>
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<tr>
<td>2013</td>
<td>7.0</td>
</tr>
<tr>
<td>2014</td>
<td>18.0</td>
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<tr>
<td>2015</td>
<td>7.2</td>
</tr>
<tr>
<td>2016</td>
<td>8.3</td>
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<tr>
<td>2017</td>
<td>7.0</td>
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<tr>
<td>2018</td>
<td>7.0</td>
</tr>
<tr>
<td>2019</td>
<td>7.3</td>
</tr>
<tr>
<td>2020</td>
<td>7.6</td>
</tr>
</tbody>
</table>

Note: Calendar years.

State Share of Medicaid Spending
Annual Percentage Changes, CYs 2013 - 2020

Average Annual Rate of Growth in State Costs
2013 to 2020 = 7.6%

"The primary driver of our national debt is our healthcare programs. There's no one magic bullet — like pass this and it's fixed — but, save the healthcare system and you're saving the country from its debt crisis."

– Congressman Paul Ryan (R – WI)

Source: Modern Healthcare, August 22, 2011.
Federal Medicaid Is 8% of Total Federal Spending

Federal Fiscal Year 2010

Total Federal Spending, FY2010 = $3.5 Trillion

1Amount for Medicare includes offsetting premium receipts. 2Other category includes disaster costs and negative outlays for Troubled Asset Relief Program.

Medicare and Medicaid Are the Primary Drivers of Future Federal Spending Growth and Deficits

Source: CBO.
This is a historic and uncertain time for Medicaid

- Medicaid coverage makes a significant impact on health outcomes
- Medicaid has always been a budget issue for states
  - Challenge is exacerbated by the extended economic downturn, rising health care costs, aging population
- Medicaid can lead improvement in care for persons with disabilities or chronic conditions, dual eligibles, and long term care / services and supports
  - Accountability is a platform for better access, quality, cost savings
- Future is clouded by political and economic uncertainty
  - It is a time of historic change and opportunity, with new tools to address perennial issues