Health Policy 201 – Medicaid/CHIP

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Connecticut Health Policy Project

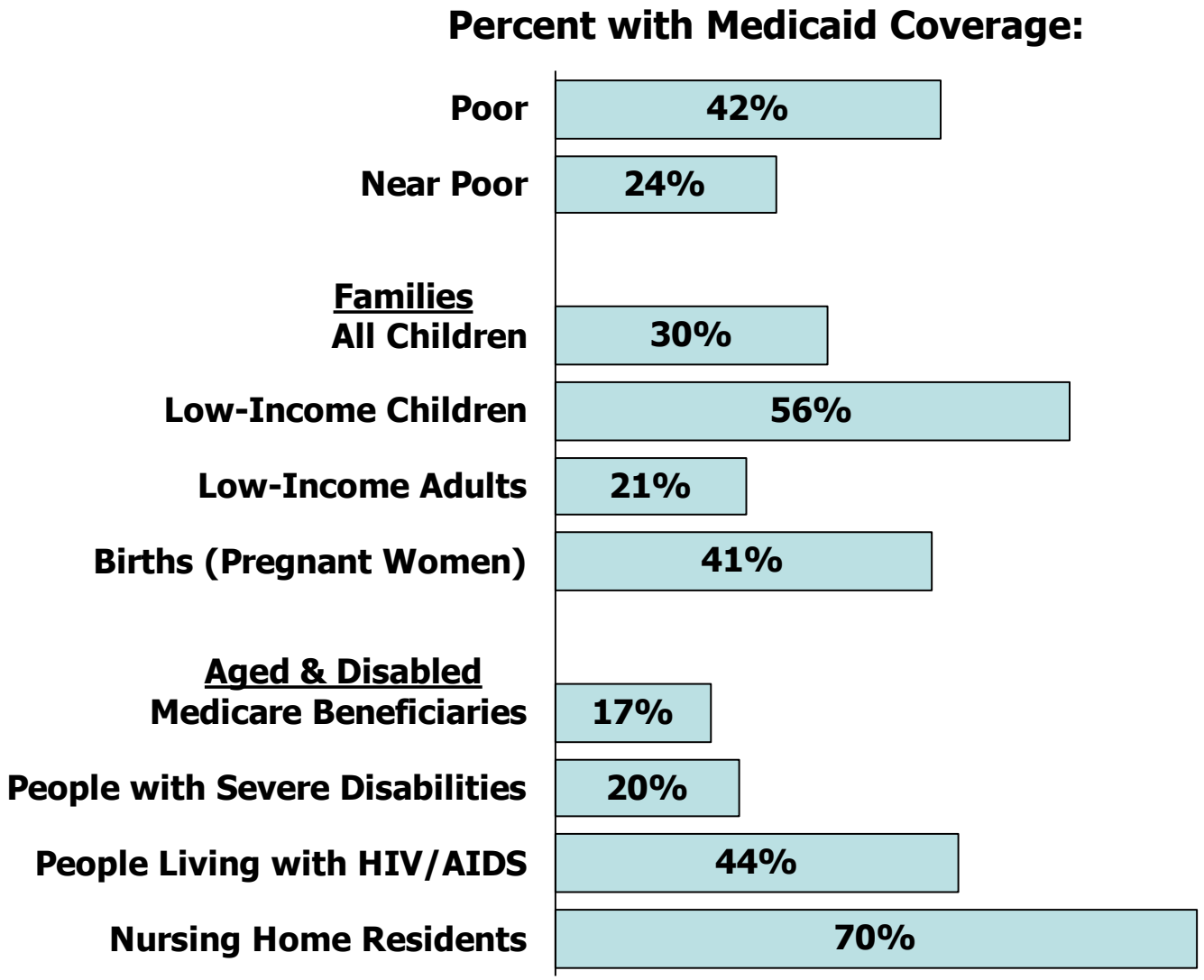
What is Medicaid?

- State/federal partnership program providing care to nearly 60 million low income Americans
- Without Medicaid, most would be uninsured
- Covers mainly
  - Children -- CT covers to 185% FPL
  - Low income parents – CT covers to 185% FPL
  - Pregnant women – CT covers to 250% FPL
  - Elderly – CT covers to 56 or 68% FPL
  - People with disabilities – CT covers to 56 or 68% FPL
  - Childless adults below ~ $500/month income
- Only covers citizens and some legal immigrants

What is Medicaid?

- State/federal partnership
  - Fed.s give general guidance
    - limited oversight
  - States operate programs
    - set eligibility levels
    - provider payment rates
    - hire managed care companies
  - Fed.s reimburse states for half or more of the costs
- Comprehensive benefit package
- Critical safety net support
- Critical state revenue source

Medicaid's Role for Selected Populations



SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of 2009 ASEC Supplement to the CPS; Birth data from *Maternal and Child Health Update: States Increase Eligibility for Children's Health in 2007*, National Governors Association, 2008; Medicare data from USDHHS.

What is CHIP?

- Created in 1997 with bi-partisan support
- Federal program to cover children at higher incomes than Medicaid
  - CT subsidizes up to 300% FPL
  - Families can buy in at full cost above that amount
- Federal subsidies higher than Medicaid – at least 65% match
- States given flexibility in benefit package
  - Could build on Medicaid or use a separate program or both
- States can charge families more than Medicaid
- HUSKY Part B in CT

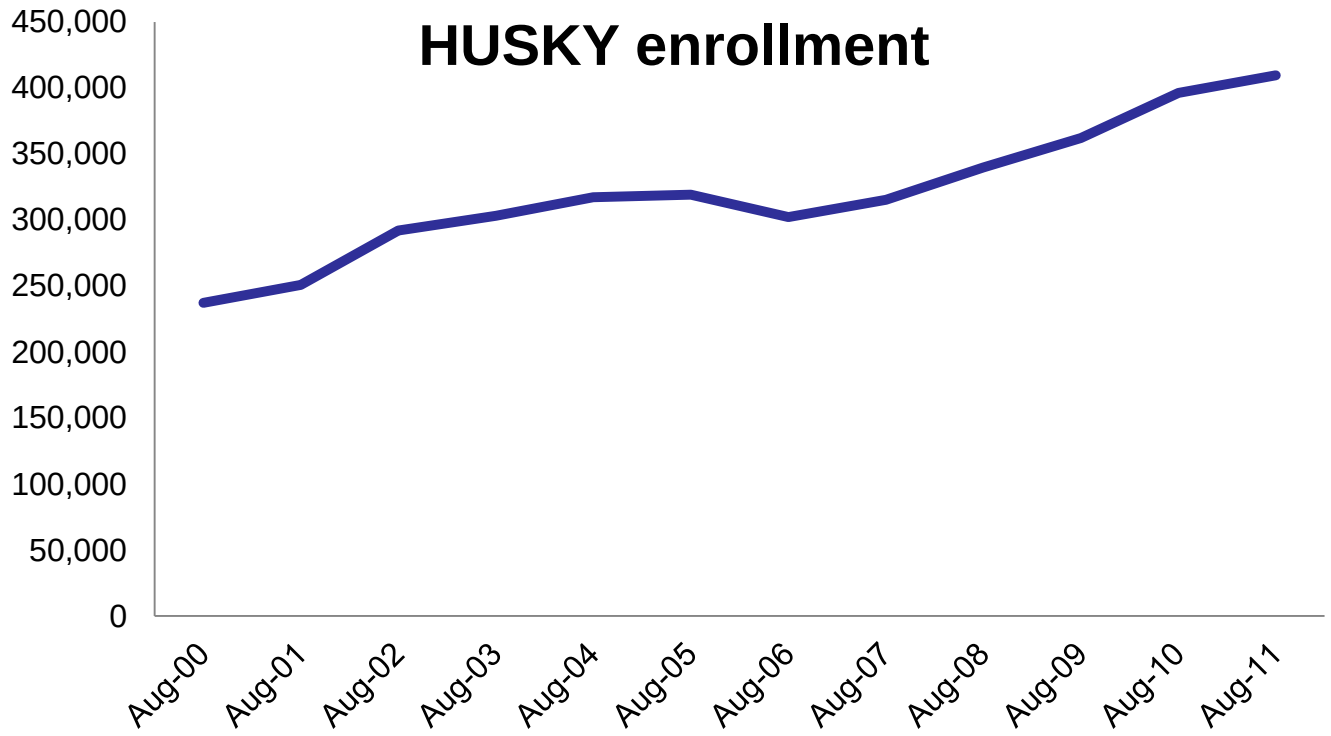
CT Medicaid, CHIP

- Total CT Medicaid = 530,223 (7/2010)
- 12.6% of CT population

HUSKY

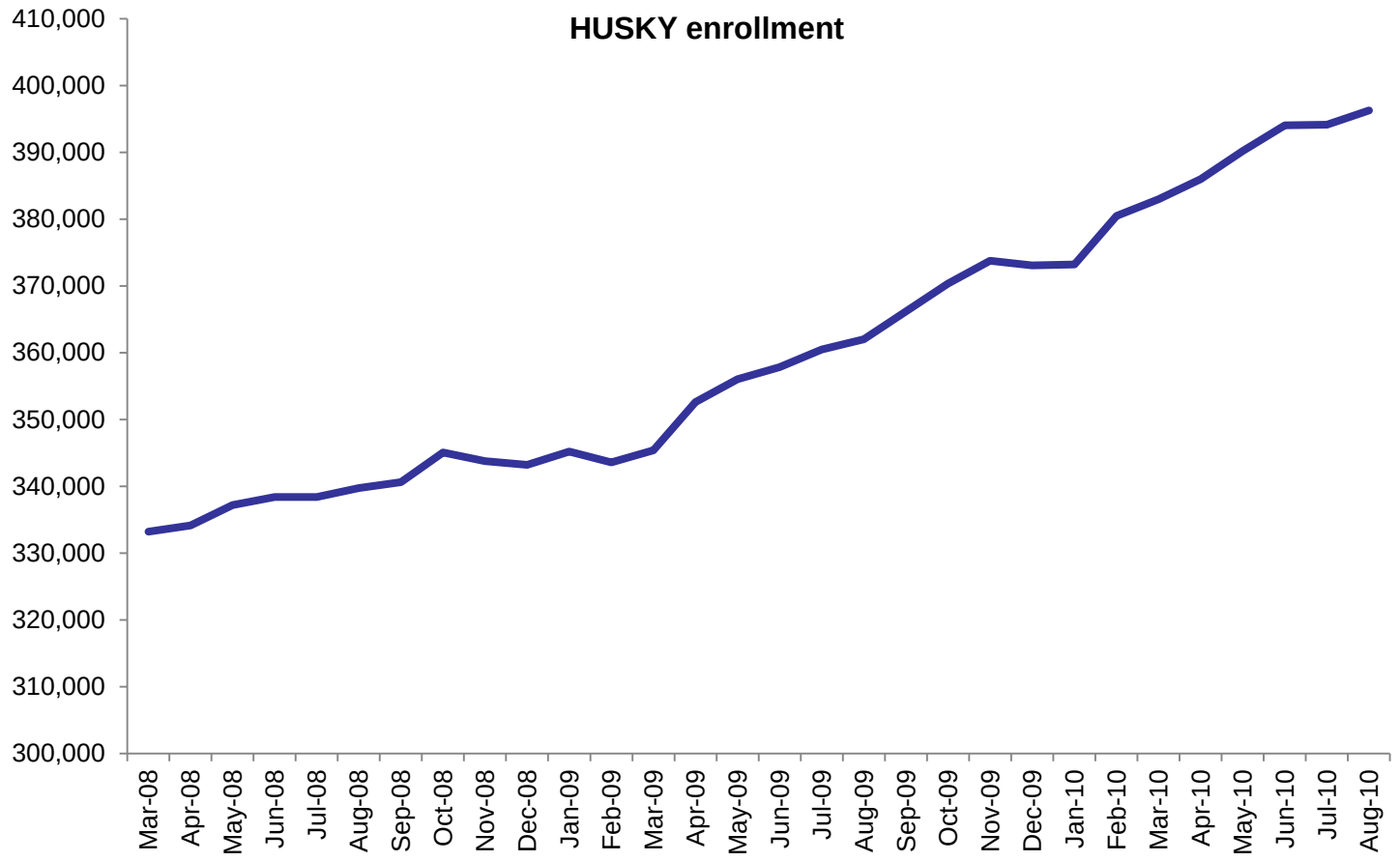
- HUSKY Part A = Medicaid with 394,967 members (10/2010)
  - No cost sharing
  - Up to 185% FPL
  - 250% for pregnant women
  - Children and parents/caregivers
  - Entitlement
- HUSKY Part B = CHIP with 14,954 members (10/2010)
  - Copays to 235% FPL
  - Copays and premiums to 300% FPL
  - No subsidies >300% FPL
  - Only children
  - Capped program, theoretically

HUSKY enrollment



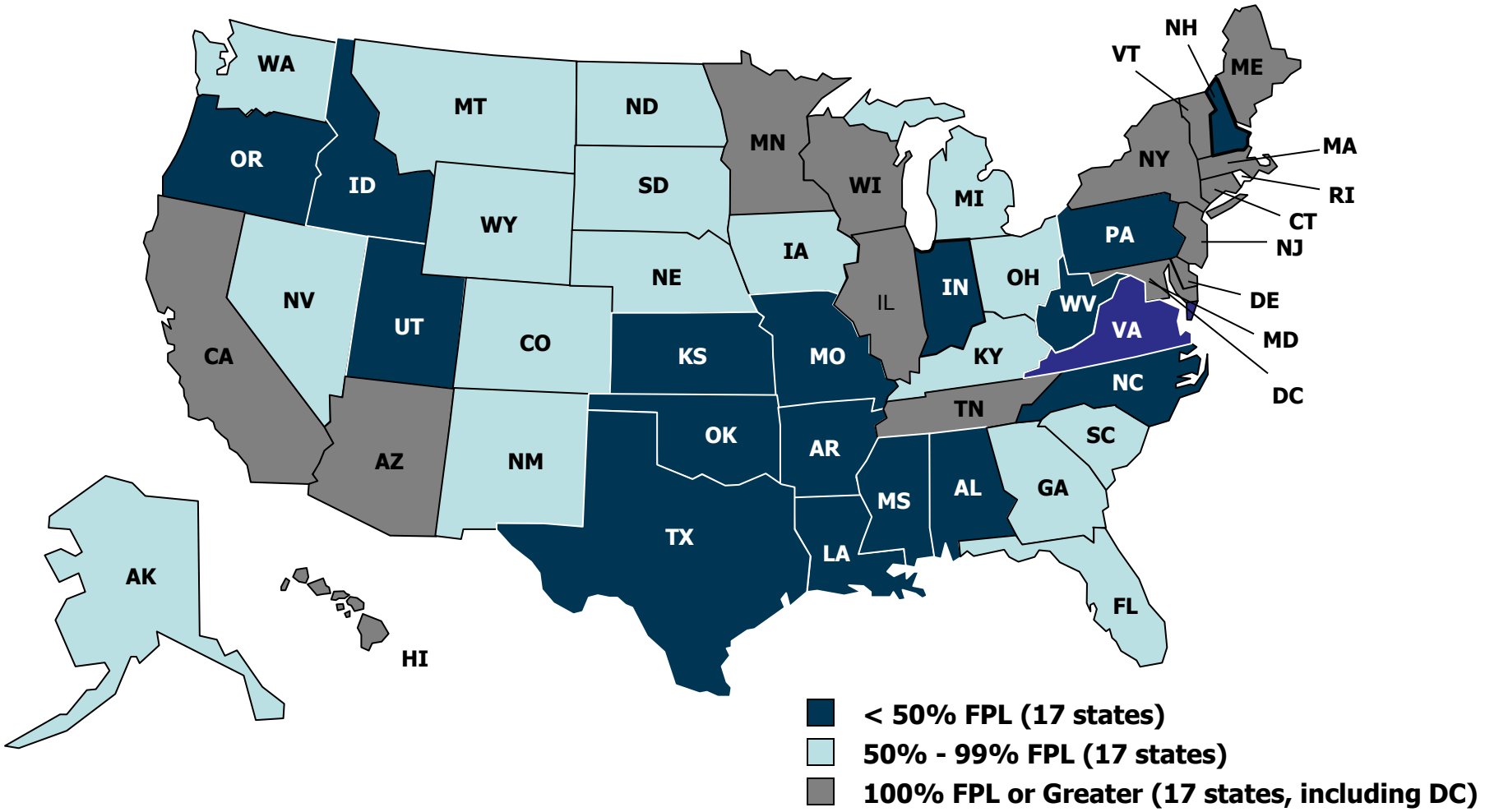
Source: ACS monthly enrollment reports

HUSKY enrollment in the recession



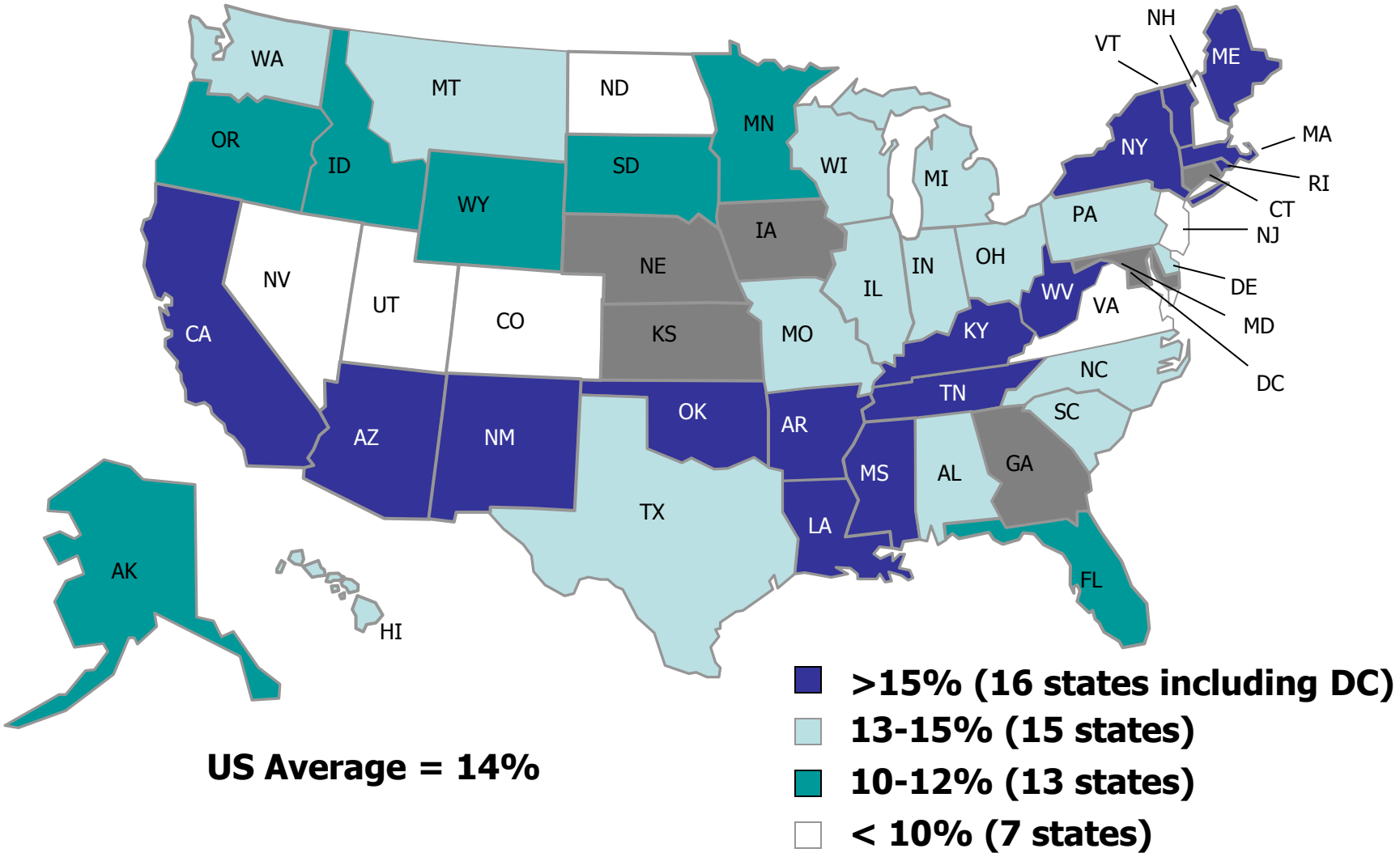
Source: ACS monthly enrollment reports

Medicaid Eligibility for Working Parents by Income, December 2009



Note: The federal poverty line (FPL) for a family of three in 2009 was $18,310 per year.
SOURCE: Based on a national survey conducted by Kaiser Commission on Medicaid and the Uninsured with the Center on Budget and Policy Priorities, 2009.

Percent of Nonelderly Residents Covered by Medicaid, by State, 2007-2008



SOURCE: Urban Institute and KCMU analysis of the March 2006 and 2007 Current Population Survey. Two-year pooled estimates for states and the US (2007-2008).

What is covered?

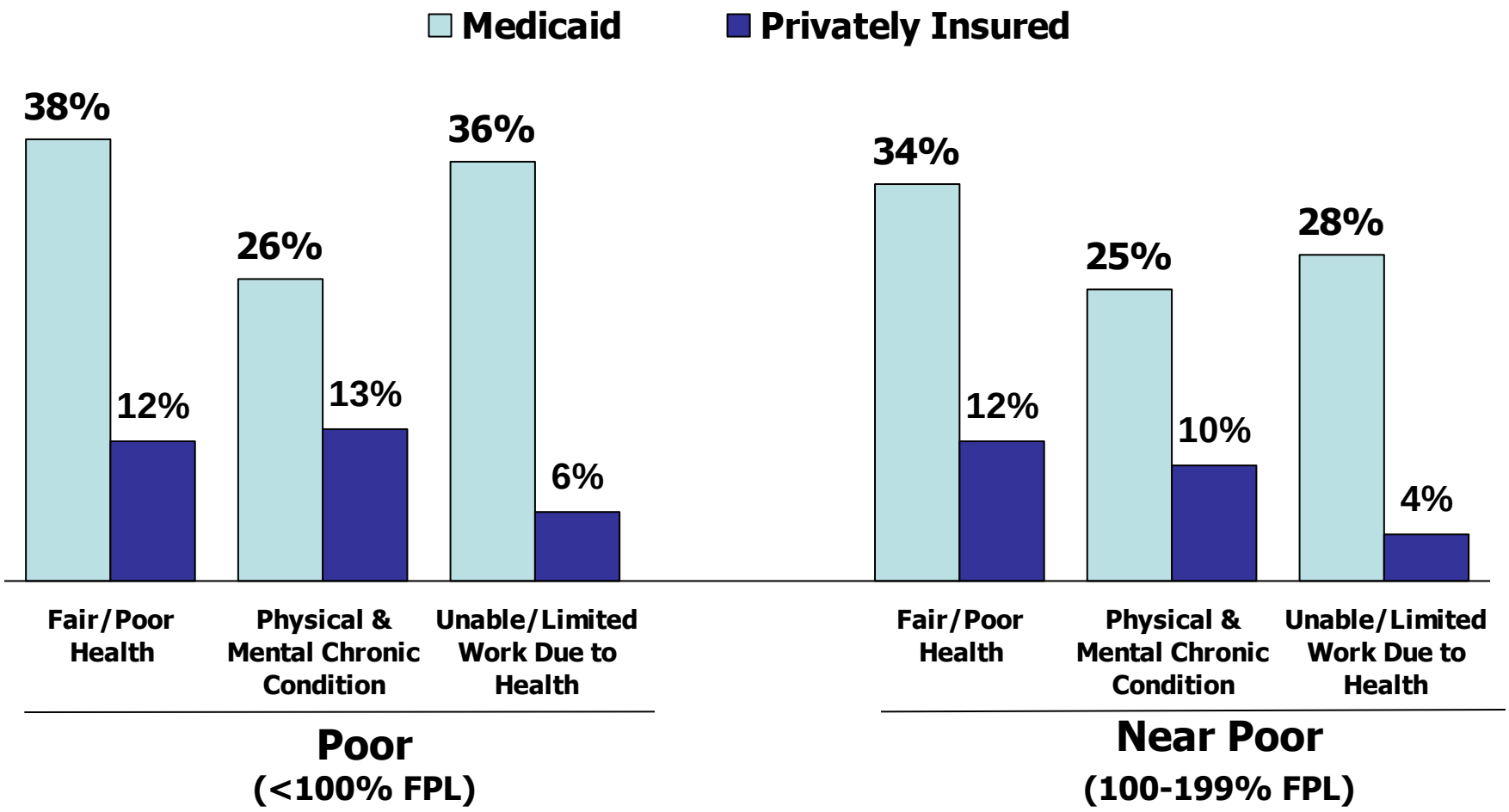
- Required for states to include:
  - Inpatient and outpatient hospital care
  - Physician, clinic, other practitioner care
  - Labs, X rays
  - EPSDT screening
  - Family planning services
  - Nursing facility and home health care
- Optional:
  - Prescription drugs
  - Dental care
  - DME

CT Medicaid covers

Covers all medically necessary services for children

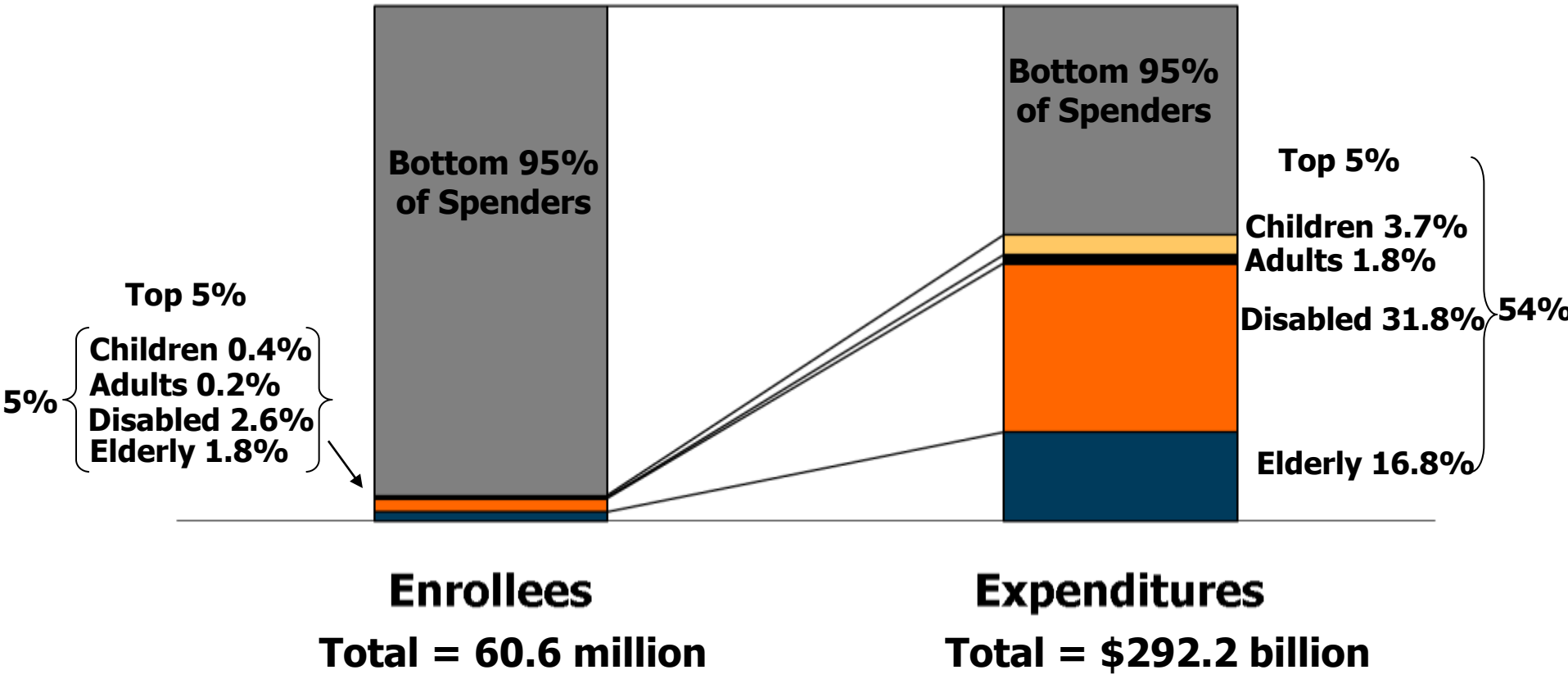
Hospital care	Outpatient care
Preventive care	Skilled nursing facility
Hospice	Home health care
Transportation	Prescriptions
Family planning	Dental
Vision	Behavioral health

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.

Top 5% of Enrollees Accounted for More than Half of Medicaid Spending, FY 2008



SOURCE: Centers for Medicare and Medicaid Services, FY MSIS 2008, FY MSIS 2007 for AZ, NC, ND, HI, UT, VT, WI.

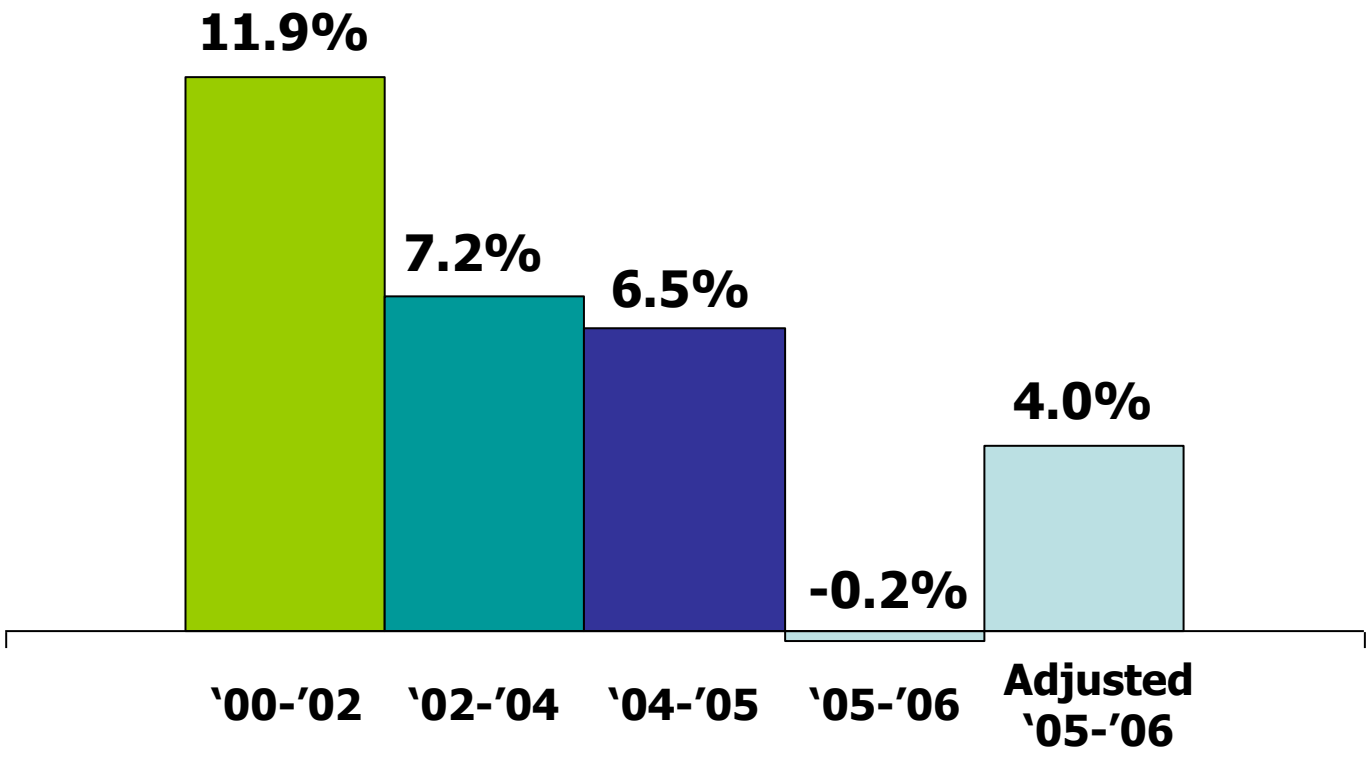
Waivers

- States ask fed.s for permission to break the rules
- Most common requests
  - Different benefit packages for different groups
  - Differences in coverage across the state
  - Enroll members in managed care
  - Cover new groups – ie childless adults
  - Increase federal revenue to states
- Important vehicle to cover the uninsured in progressive states

Funding

- State funds, but reimbursed at >50% by fed.s
  - Rate varies by state
  - Was boosted temporarily in 2009 stimulus package
  - CT gets lowest match rate, highest per capita incomes
- Growing proportion of state budgets
  - 21.4% in CT
- Counter cyclical funding
  - Need highest when revenues (taxes) dip
- Spending growth per person similar to private insurance
- Far less expensive per person than private insurance

Overall Average Annual Total Medicaid Spending Growth, 2000-2006

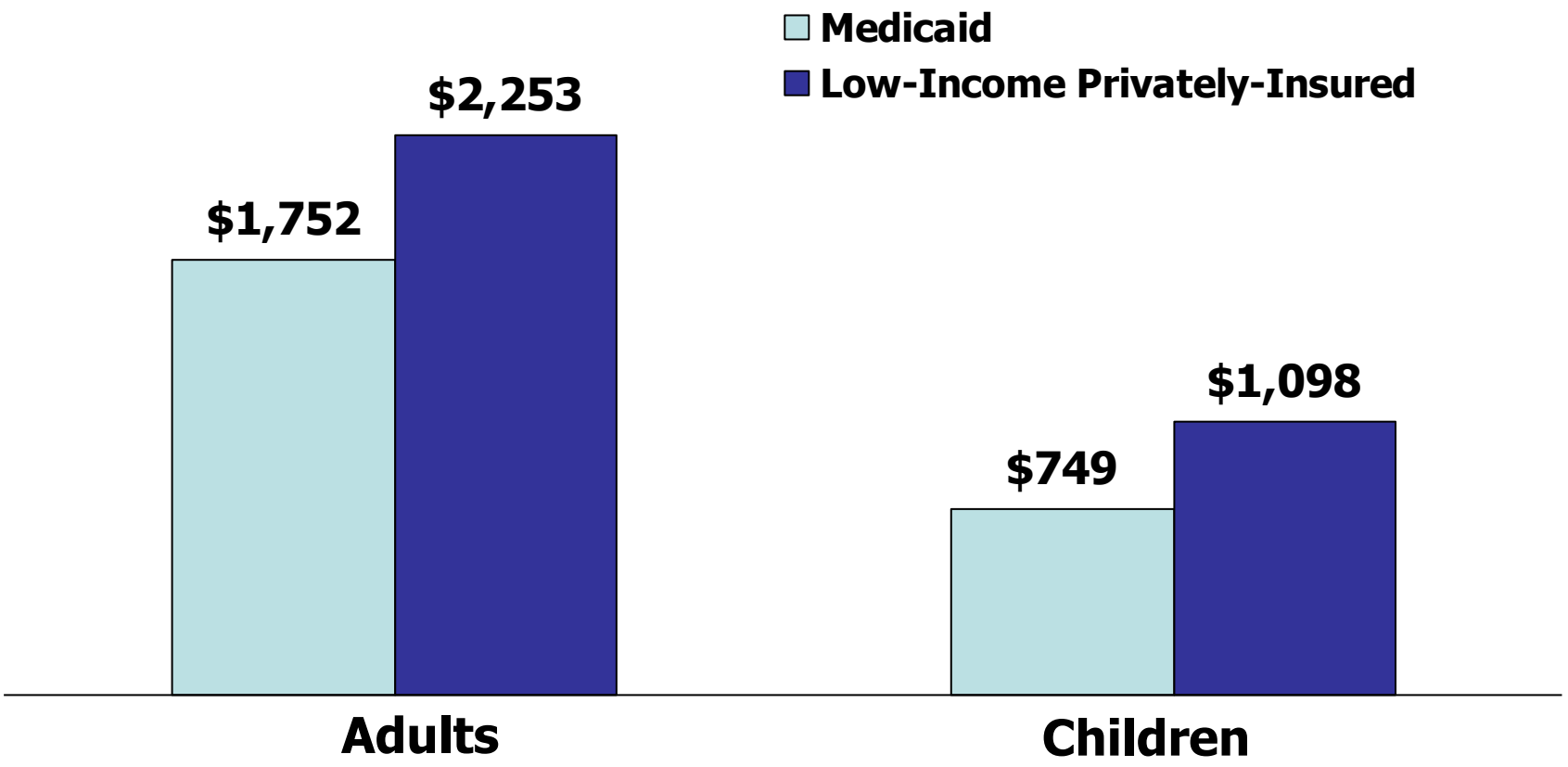


Annual Spending at End of Period (billions)	**$257.3**	**$295.9**	**$315.0**	**$314.5**	**$310.8**

NOTE: Adjusted expenditures exclude all prescription drug spending for dual eligibles to remove the effect of their transition to Medicare Part D in 2006.
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute, 2007; estimates based on data from HCFA Financial Management Reports, 2006 (HCFA-64/CMS-64).

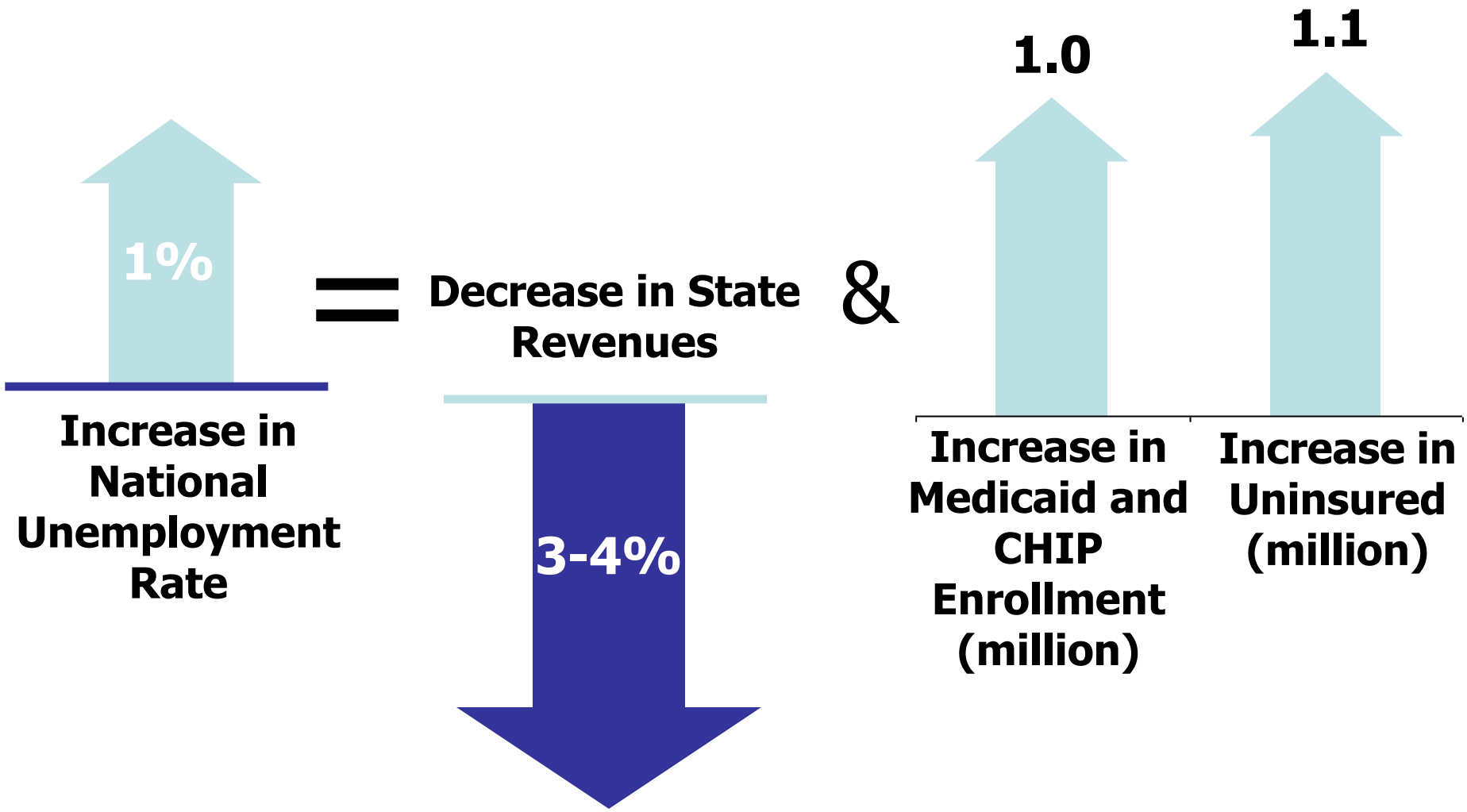
Per Capita Spending For Medicaid Enrollees vs. Low-Income Privately-Insured

Samples adjusted for health differences



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

Impact of a 1% Point Increase in Unemployment on State Revenues, Medicaid, CHIP & Uninsured

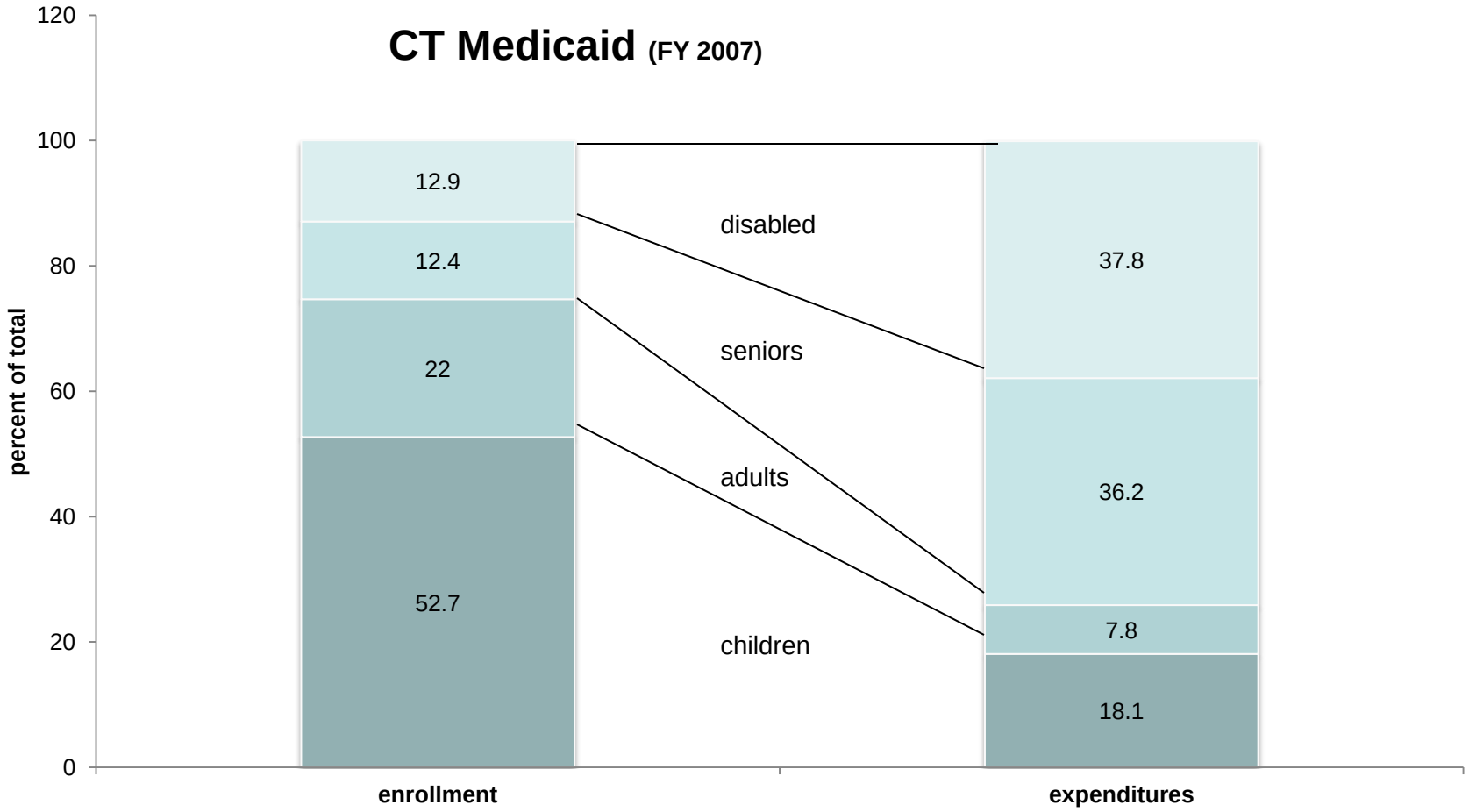


Source: John Holahan and Bowen Garrett, *Rising Unemployment, Medicaid, and the Uninsured*, prepared for the Kaiser Commission on Medicaid and the Uninsured, January 2009.

spending

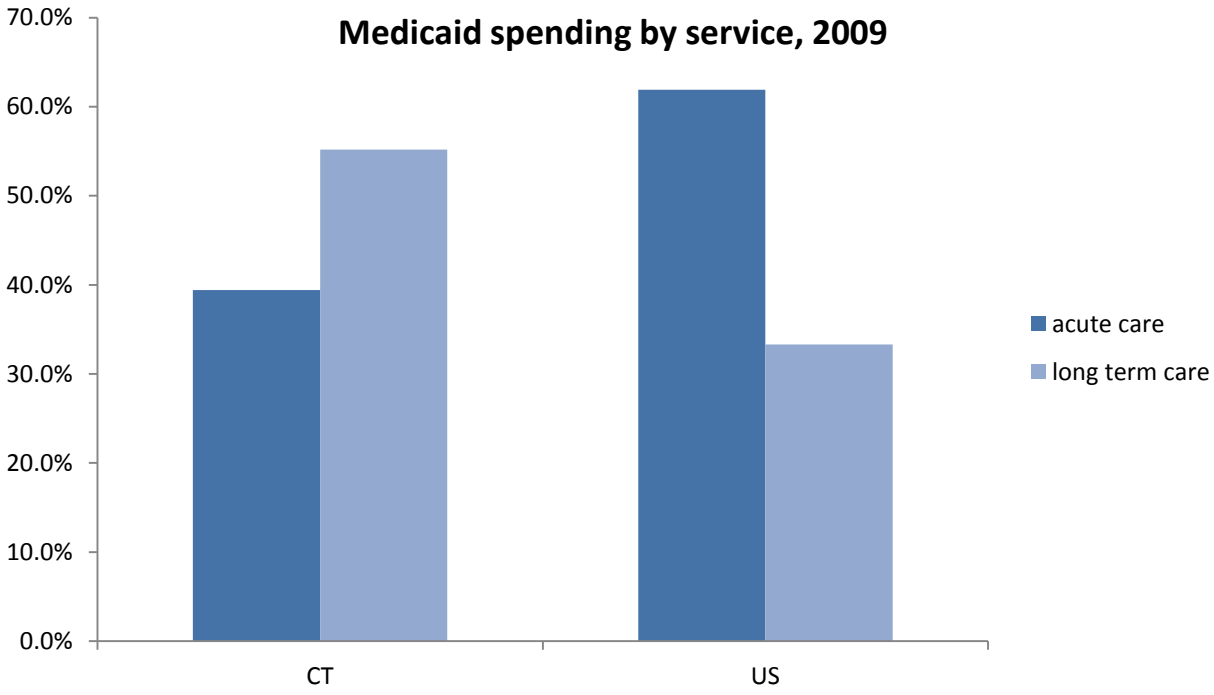
- Two groups of enrollees vary significantly in spending
- Rates paid to providers low but vary across states
- CT is among most generous states
  - CT provider rates are 99% of Medicare
  - 5th highest rates in US,
  - CT managed care plan rates 11% higher than US average
- Critical funder of safety net services

Enrollment vs. expenditure



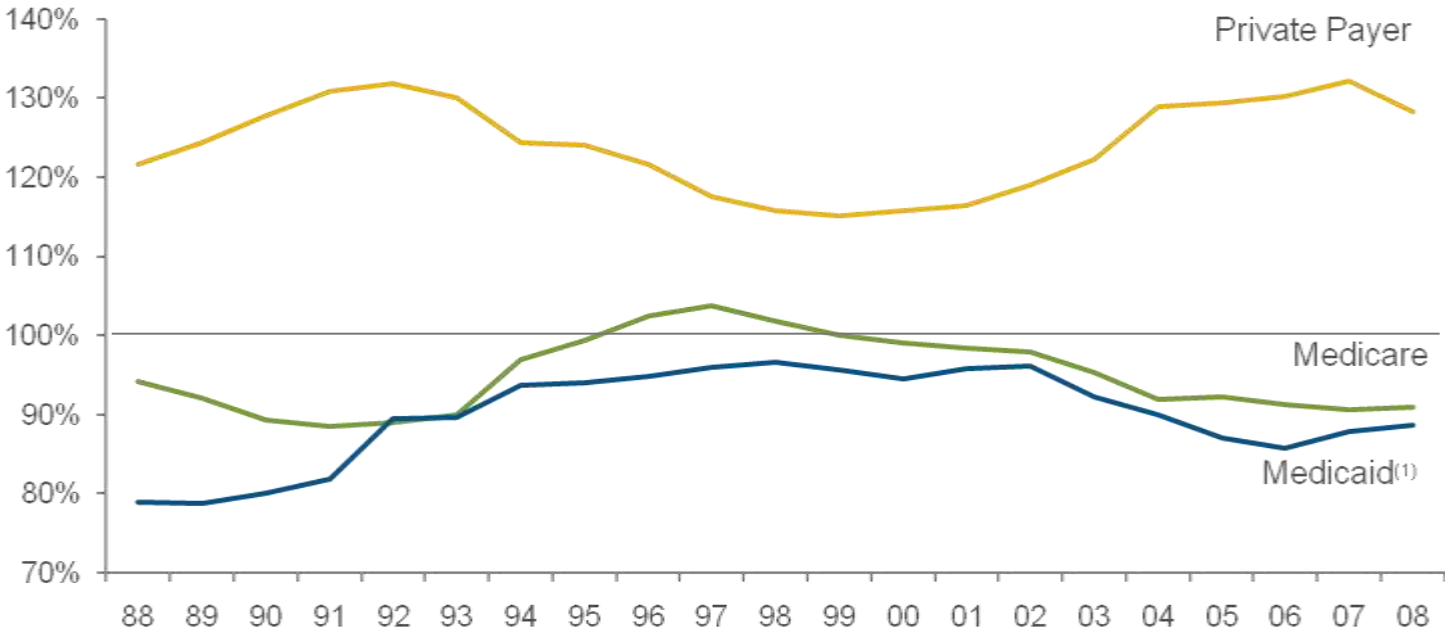
Source: Kaiser State Health Facts Online, 10/19/10

CT spends far more on long term care than other states



Source: Kaiser State Health Facts Online

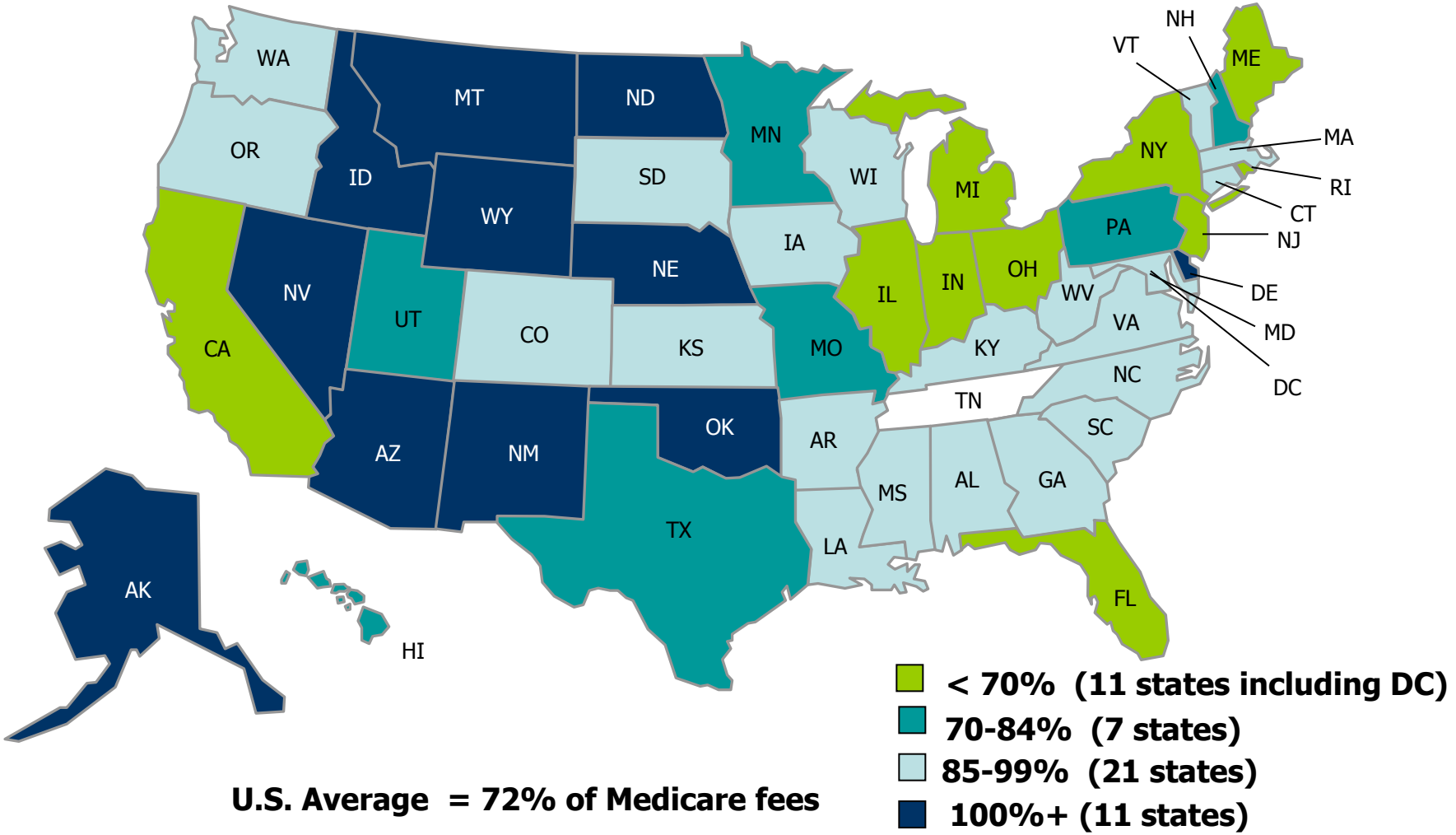
Chart 4.6: Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare, and Medicaid, 1988 – 2008



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2008, for community hospitals.

(1) Includes Medicaid Disproportionate Share payments.

Medicaid-To-Medicare Provider Fee Ratios for All Services



U.S. Average = 72% of Medicare fees

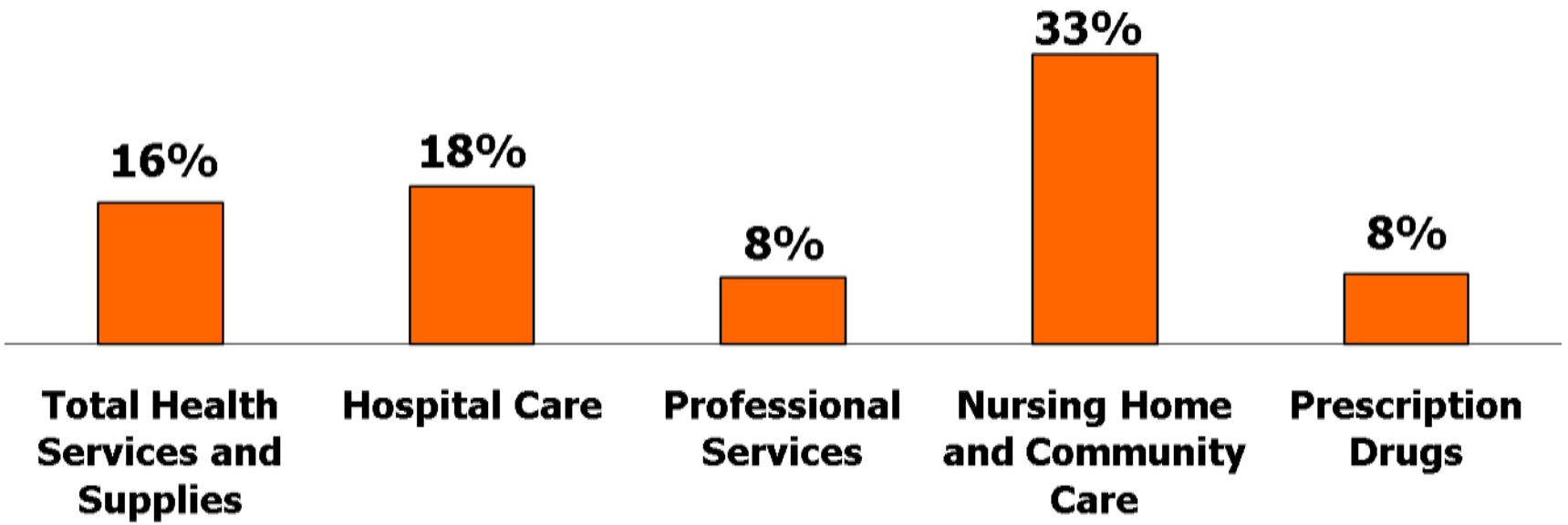
NOTE: Tennessee does not have a fee-for-service component in its Medicaid program
SOURCE: S. Zuckerman, AF Williams, and KE Stockley, "Trends in Medicaid Physician Fees, 2003-2008," *Health Affairs*, 28 April 2009.

Where the money goes

- Medicaid is a large part of the health care market and financing system
  - 16% of all US health care spending
- About two thirds to acute care, one third to long term care
  - Over half to long term care in CT
- Medicaid is primary payer of nursing home care in US

Medicaid in the Health System, 2009

Medicaid as a share of national health care spending:



	Total Health Services and Supplies	Hospital Care	Professional Services	Nursing Home and Community Care	Prescription Drugs
Total National Spending (billions)	**$2,330**	**$759**	**$675**	**$137**	**$250**

Note: Does not include spending on CHIP.
SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, *National Health Expenditure Accounts*, January 2011.

Medicaid managed care

- Most states have moved children and adults into managed care plans, most seniors and disabled still in fee-for-service
- States turned to managed care in 90's to
  - Reduce costs
  - Increase access
- Types of plans
  - PCCM
  - Capitated HMOs
- CT managed care = HUSKY program
  - Low income children and parents now
  - Jan. 1 will be all Medicaid in ASO plan

HUSKY

- Largest purchasing pool in CT
- Managed care for children and families
  - Three HMOs – lots of drama, poor performance
  - PCCM – patient-centered medical home model, pilot originally
  - Now moving to ASO, PCCM/PCMH for everyone
- Capitated, about $200 pmpm
- 24% increase in 2009
- Fighting fiscal accountability
- Transparency issues, FOI
- Few providers participate
- PCCM

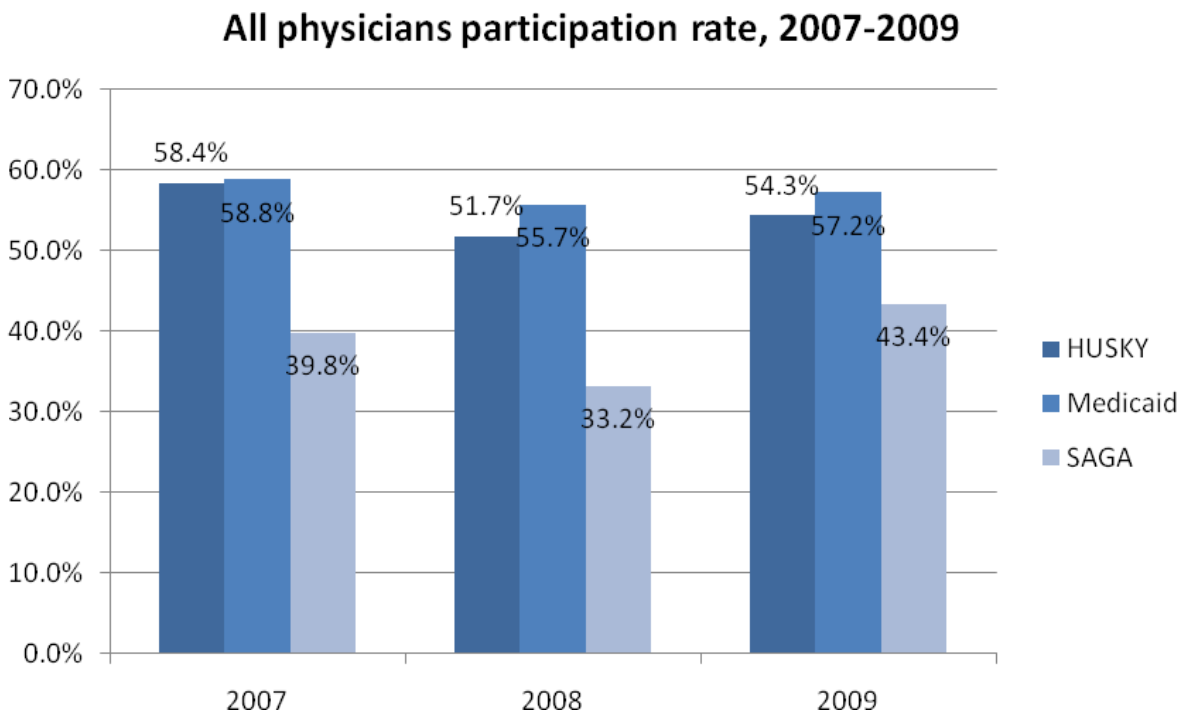
HUSKY deeply troubled program

- 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
- 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 participate in CT Medicaid

- Only about half of CT physicians participate
  - 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 starting to fix problems

Few providers participate in CT Medicaid



Source: Fixing Medicaid, CTHPP, 2011

PCCM

- Based on patient-centered medical home model
- Implemented in 30 other states
- Does not involve HMOs
- OK saved $85.5 m in switch PCCM from HMOs statewide
  - Increased participating providers by 44%
  - Outpatient visits up, ER visits down
- NC saved over $140 m in 2006 with PCCM

Reasons for PCCM in HUSKY

- Policymakers needed an alternative to HMOs
  - In case HMOs leave (or are asked to, again)
  - Transparency
  - Cost
  - Negotiating leverage
  - Competition keeps everyone performing better
- Last PCCM expansion passed both Houses unanimously
- Only implemented in selected communities so far

Reasons for PCCM in HUSKY

- Built on care management
- Less administrative hassle, overhead
- Better access to data
- Better access to specialists
- Empowers providers
  - Better communications with DSS, no HMO in between
- Empowers consumers
  - Take responsibility for their own health
  - Self-management tools and support
- Builds on the patient-provider relationship

How PCCM/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 proposal – enhanced fees, P4P
  - Problem of upfront investment by providers, with payment later
  - Medicaid pays less already

Patient responsibilities

- Contact PCP first with medical problems,
- Not go to ER unless it's a true emergency
- Show up for scheduled appointments
- Get a referral for tests or specialty care
- Collaborate with PCP to develop a realistic care plan
- Take responsibility and manage their own health

Charter Oak Health Plan

- **Have to be uninsured for six months**
  - or paying 33% of income on premiums
- **Run through three HUSKY HMOs**
- **Approximately $300/month**
  - Originally subsidized, but ended in 2009
  - Copays and premiums at all income levels
- **Even fewer providers participate**
- **No dental or vision**
- **Limits on behavioral health care**
- **Has attracted very high cost patients**

Future for CT Medicaid

- ACA brings in 130,000 more members
  - Access is minimal for current 400,000 members
  - Working on problems
  - Basic Health Plan option – 20,000 or more working parents eligibility at risk in 2014
- PCCM/PCMH for everyone
  - Starting slowly Jan. 1st
- Move to self-insurance/ASO Jan. 1st
  - Pay CHN only to administer
  - Removes profit motive
  - One plan will simplify
  - Better analytics for program and providers