Medicaid: Bending the Cost Curve

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Medicaid Expenditures Since ACA

- Growth in total (fed + state) Medicaid pending:
  - 17.7% in expansion states*
  - 6.1% non-expansion states
  - Higher costs in pharmacy
  - Higher reimbursement for providers

*Expansion states also report some savings in corrections, uncompensated care, and behavioral health

Medicaid Enrollment and Spending Growth, FY 2015 and 2016; Kaiser Family Foundation.
Medicaid Enrollment – expansion vs non-expansion States
Medicaid Forecast

- Medicaid projected to grow at 5.9% per year
- Increase in % of government funding for health care to 47% of NHE (primarily Medicaid, Medicare)
- Increased acuity/expense per person
  - Aging population + people with disabilities

*National Health Expenditures Projections, 2014-2024*
Cost Drivers: High Cost, High Needs Members

- Most expensive 5 percent of Medicaid members accounted for almost half of the expenditures:
  - Disabled
  - More than 70% have either mental illness or SUD
  - Frequent co-occurring disorders: MH/SUD + asthma, diabetes, HIV

A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures

Major Cost Centers

Varied Spending Patterns Across States:
- Inpatient and outpatient hospital services
- Other support services: rehabilitative services, nursing, targeted case management
- Long-term services and supports - institutional care
How to impact the cost of this care?

- Incentivizing the use of lower-cost, preventive services
- Improving care coordination for people with multiple chronic conditions
- Integrating care for people with MI, SUD
- Keeping people with disabilities at home, in the community
Delivery System Reform + Payment Reform = Improved Care, Reduced Cost... hopefully

Delivery System Reforms:
- Changing the way providers delivery care
- Changing the way providers and systems are configured

Payment Reforms:
- Tying payment to quality
- Increasing flexibility – move away from fee-for-service payment
Promising Models and Practices

- **Patient Centered Medical Homes**
  - Vermont – Expenditures down $482 PMPY
  - Arkansas avoided $34 million in Medicaid costs in 2014

- **Health Homes**
  - Missouri: $15.7 M savings after first 18 months for population with serious mental illness

- **Integrated Care**
  - IMPACT: lowering TCOC through depression treatment
Promising Models and Practices

- Care Coordination
  - Camden Coalition, VT: reduced readmissions for people with complex needs

- Patient activation
  - Better outcomes, reduction in health care costs
  - Washington State: target high-risk Medicaid enrollees

- Supported Employment, Supported Housing
  - Evidence-based practices that can reduce cost, improve outcomes for SMI population
...Supported by payment reform

- Increase in integrated managed care
  - Carved-in MCO models that include BH, PH services
    - Arizona, Tennessee

- Linking payment to measurement
  - ACOs: Maine, Minnesota
  - Pay for Performance: New York’s DSRIP

- Global budgets
  - Accountability for total cost of care: Oregon

- Bundled payments that promote flexibility at the provider level: e.g., Health Homes, PMPM
Caveats

- Complex systems
- Few quick fixes
- Need to look at health care expenditures across silos: schools, corrections, social services
- Multi-payer engagement: Medicare, privates
- Vulnerable populations with highly engaged advocates and providers
Funding Considerations

- Is the initiative data driven?
- Does it target actual cost drivers in your state?
- Is it narrowly focused?
- Does approach support expected change?
- Is there an evaluation? Is it funded?
- Does your state agency have expertise and capacity to manage in new ways?
- Does your state have data analytics capacity?
Thank you