

MassHealth: The Daunting Challenge

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Today's Talk

- Brief overview of MassHealth
- MassHealth Finances In Perspective
- Three of the Biggest Challenges
- Innovative Approaches from Other States to These Challenges
- Takeaways

MassHealth Overview

- Public health insurance program covering over 950,000 Massachusetts residents
 - 15 percent of state's population
- State administered subject to federal rules
 - Mandatory and optional populations
 - Mandatory and optional benefits
- Program costs shared by federal government
 - 50% for MassHealth and 65% for CHIP

The “Workhorse” of the Health Care System

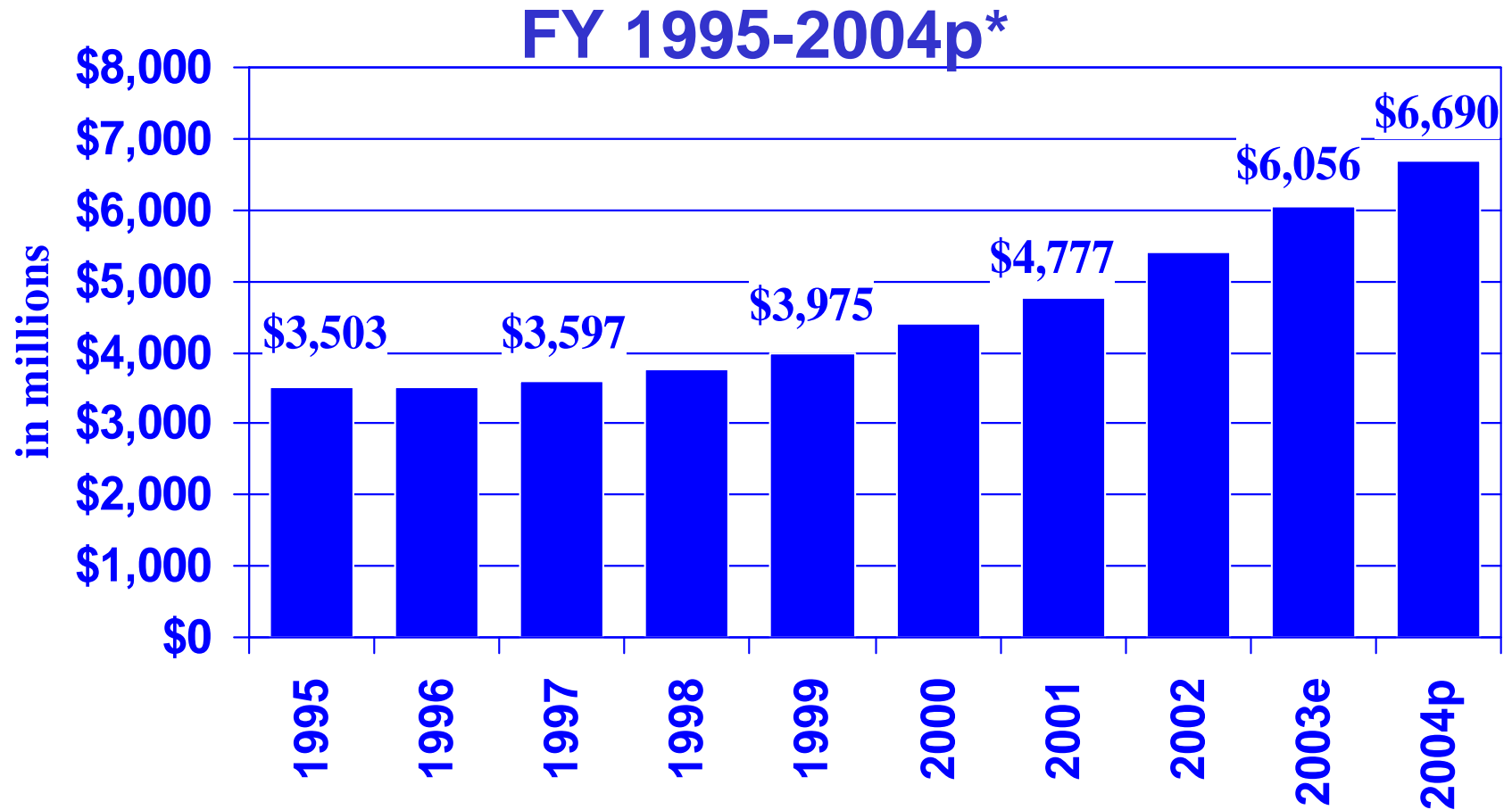
- Covers many of poorest, most vulnerable and highest cost people
 - 27% of children
 - Almost 30% of people with disabilities
 - 50% of people with AIDS; 90% of children with AIDS
 - 7 of 10 people in nursing homes
 - 50% of long-term care expenditures
 - 20% of all prescription drug spending
- Provides protection against the health and financial consequences of being uninsured
 - Eligibility expansions since 1997 have helped Massachusetts maintain low rate of uninsured
 - MA: 7.4% - 9.7% vs. US: 16.3%

MassHealth Policies Affect Private Business

- Covers many low income workers whose employers don't provide insurance or who can't afford it
- Reduces demand on the uncompensated care pool
- Brings in substantial federal matching funds
- Sustains jobs in health care field
 - Economic multiplier = 1.8 - 2.1
 - 8-11 additional Mass. jobs for each 10 new health care jobs
- Cost shifting by providers to private payers when MassHealth reimbursement is inadequate
 - Private payers then shift costs to the business community

MassHealth Finances In Perspective

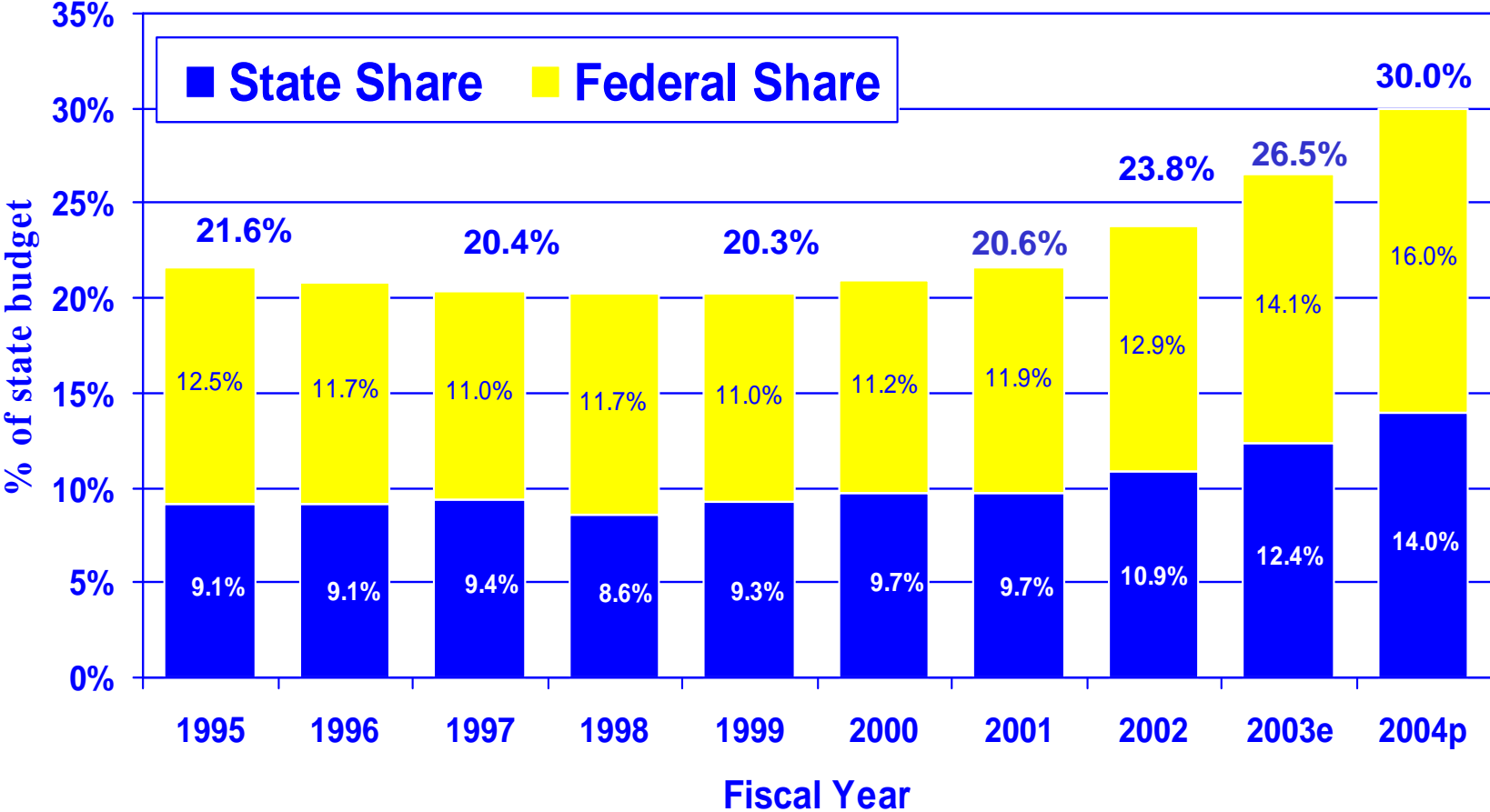
After a Period of Stability, MassHealth Spending is Growing Rapidly



*Excludes disproportionate share hospital payments.

Source: Mass. Taxpayers Foundation. Data for 2001 - 04 from June 26, 2003 Bulletin

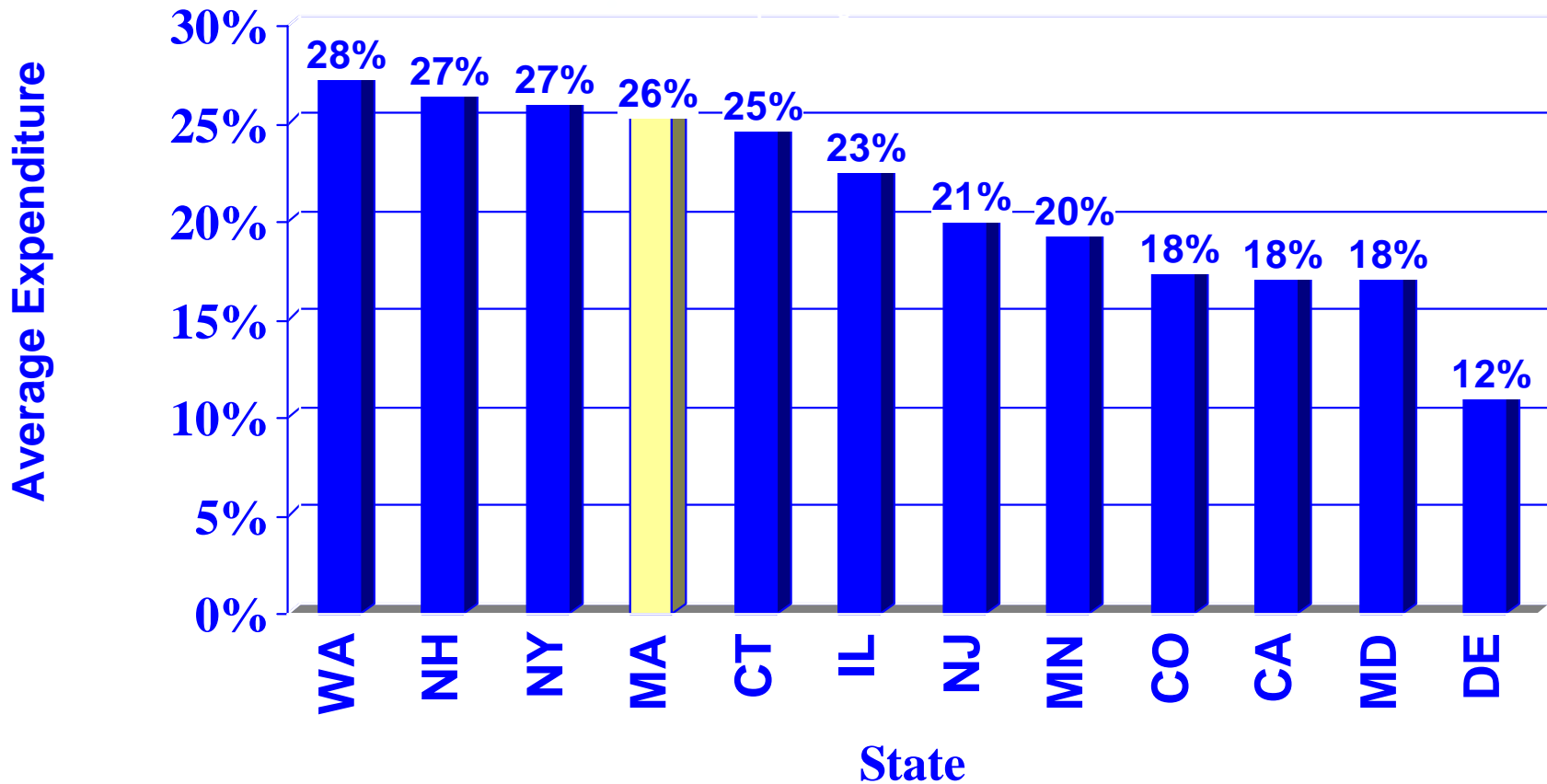
MassHealth Is A Growing Share of the State's Budget, Reflecting Both Increasing MassHealth Spending and Flat Overall State Spending



Source: MTF, 2004p based on House/Senate conference as of 6-26-2003. Assumes state share of 46.6%

Massachusetts Spending Going to the Medicaid Budget is Comparable to Peer States

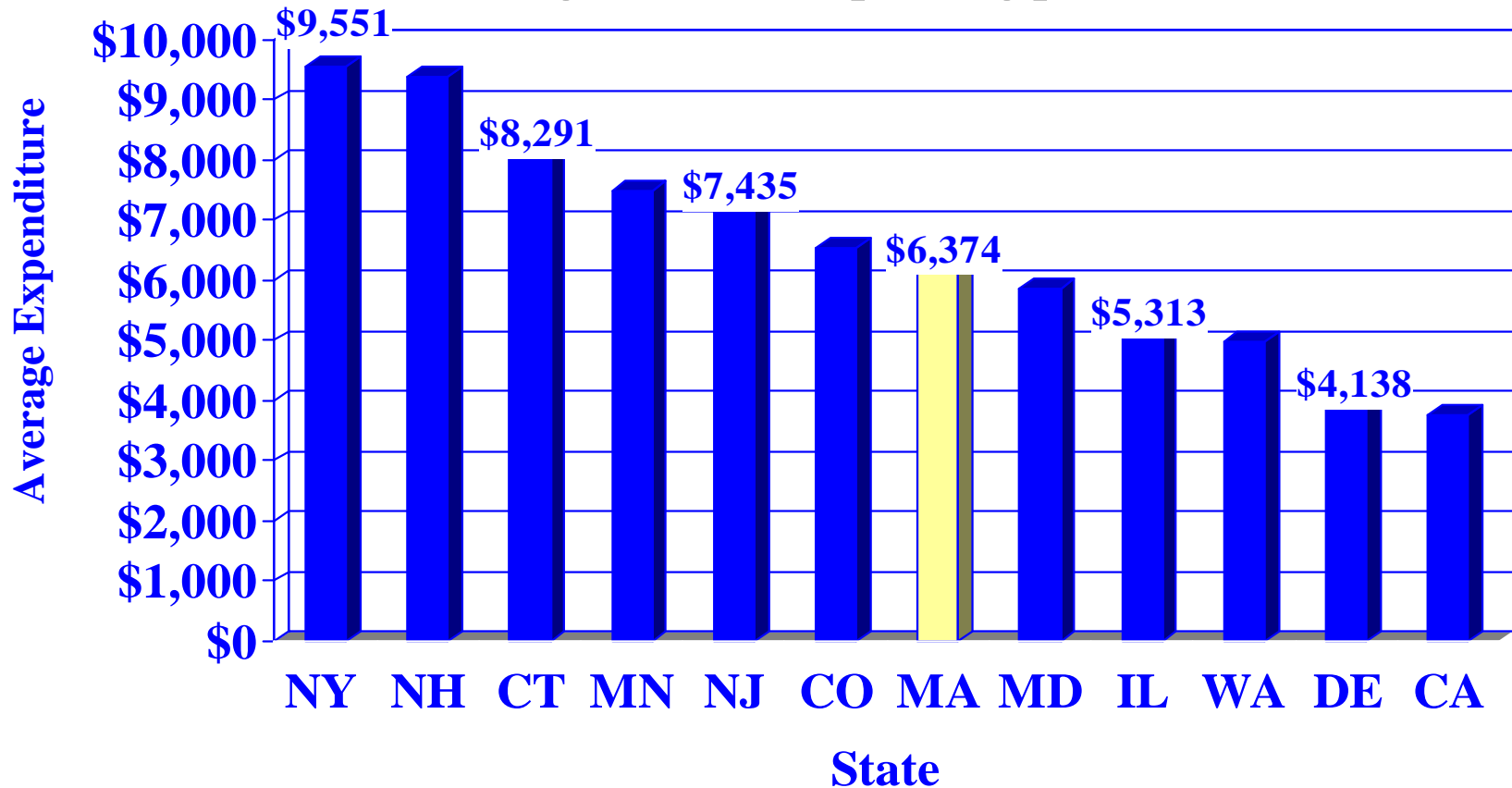
Based on Estimated FY 2003 Expenditures and Tax Revenues



Source: National Association of State Budget Officers, 2002 State expenditure report (preliminary results). Peer states are those with per-capita income similar to Massachusetts

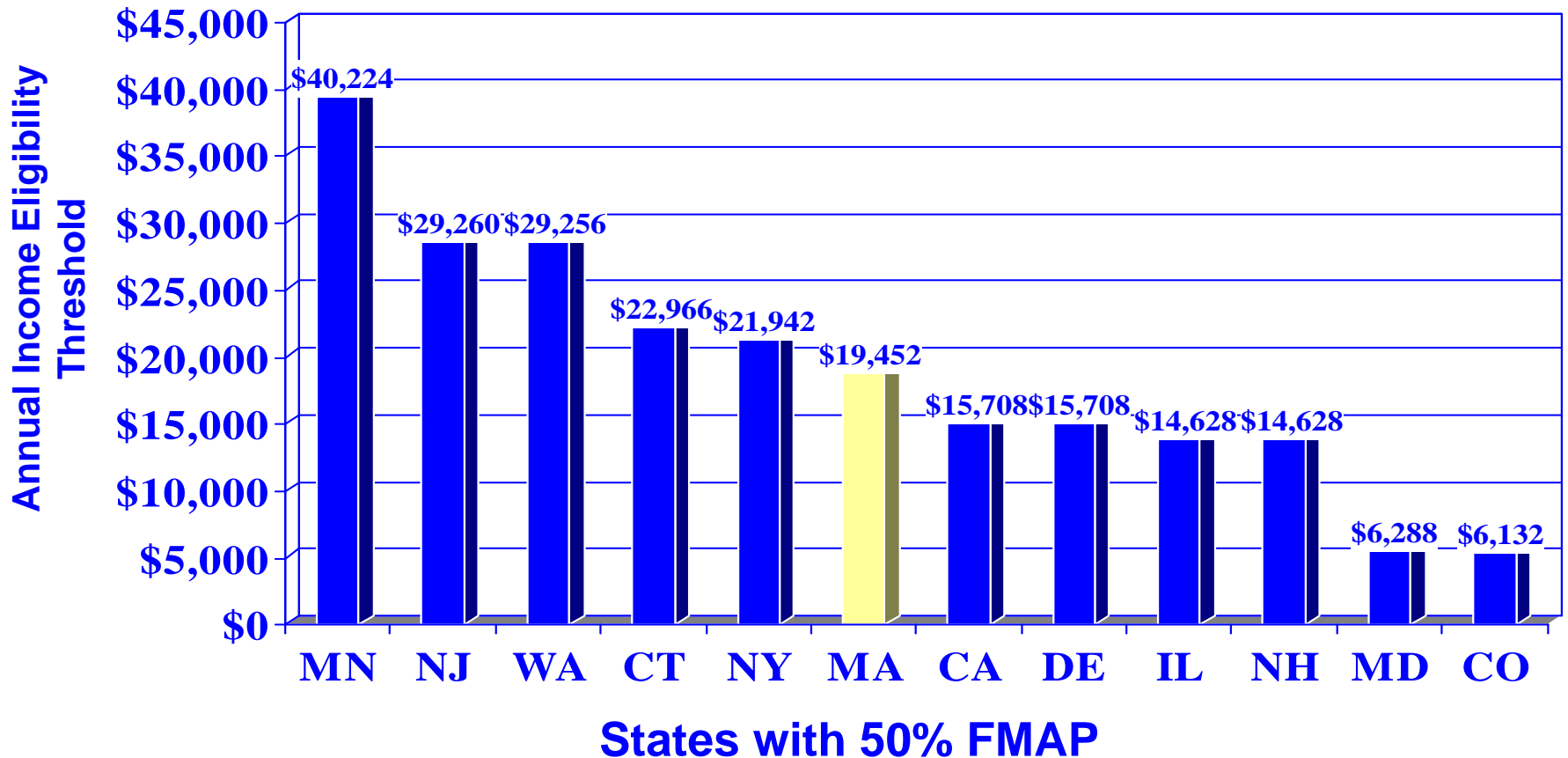
Massachusetts Medicaid Expenditure Per Member Is Average Compared With Peer States

Average Medicaid Spending per Member 2001

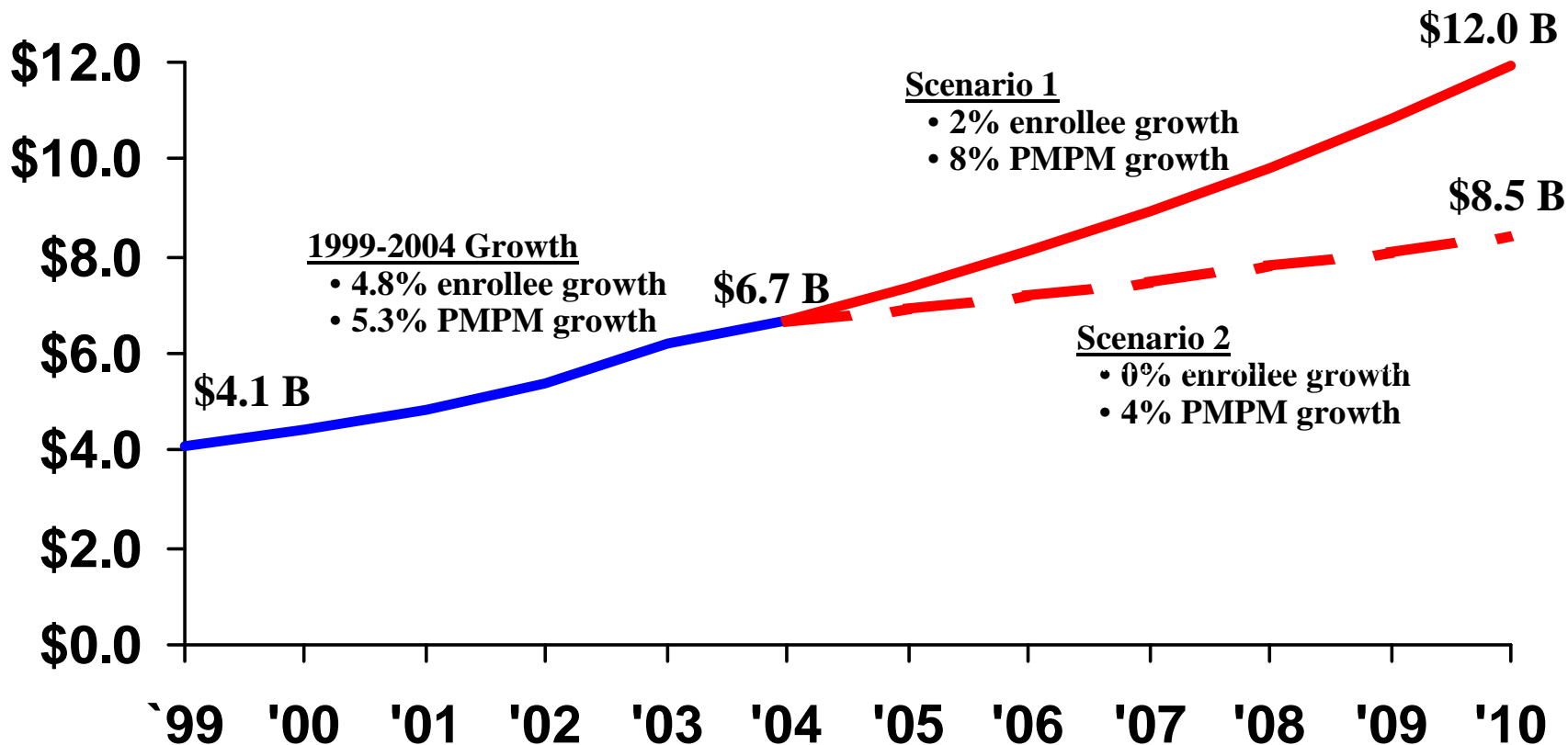


MassHealth Income Standards Are Generally Consistent With those in Peer States

How Much Can A Working Parent with Two Children Earn and Still Be Eligible for Support?



AT CURRENT TRAJECTORY, MEDICAID SPENDING COULD CROSS \$12B BY FY2010



Note: FY 2004 spending projection from Mass Taxpayers Foundation analysis 6-23-03.

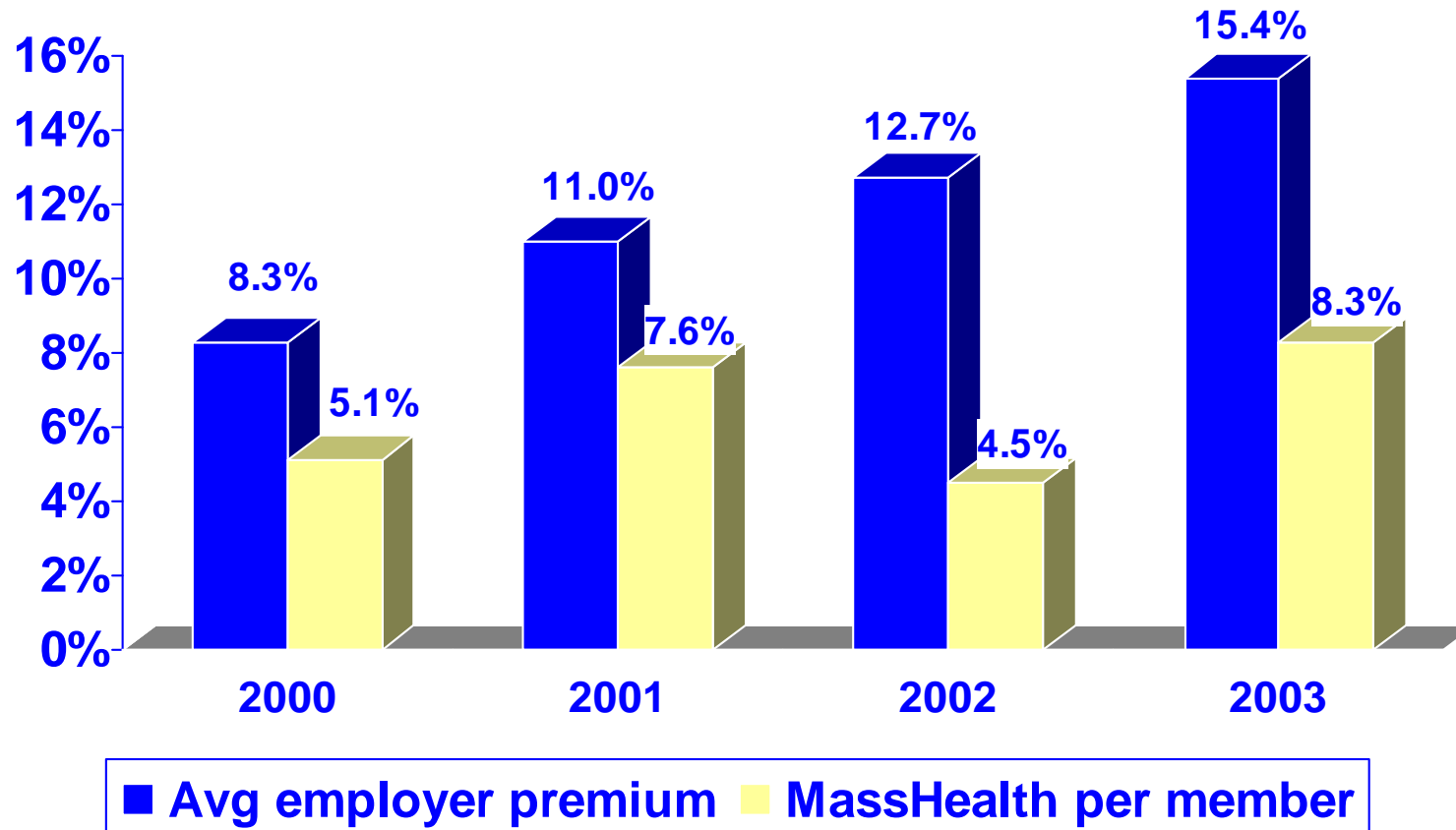
Source: Massachusetts DMA, BCBSF analysis.

What's driving MassHealth Spending?

- Rising health care costs
- Gaps in Medicare coverage
- Eligibility expansions
- Complex and expensive members
- Restructuring other state services to capture federal Medicaid matching funds (\$480 million in federal revenues in past 5 years)
- Care that is too often fragmented, uncoordinated and inappropriate

Recent MassHealth Spending Growth Per Person Rose Slower Than Employer Premiums

Annual Change in Costs per Member 2000 - 2003



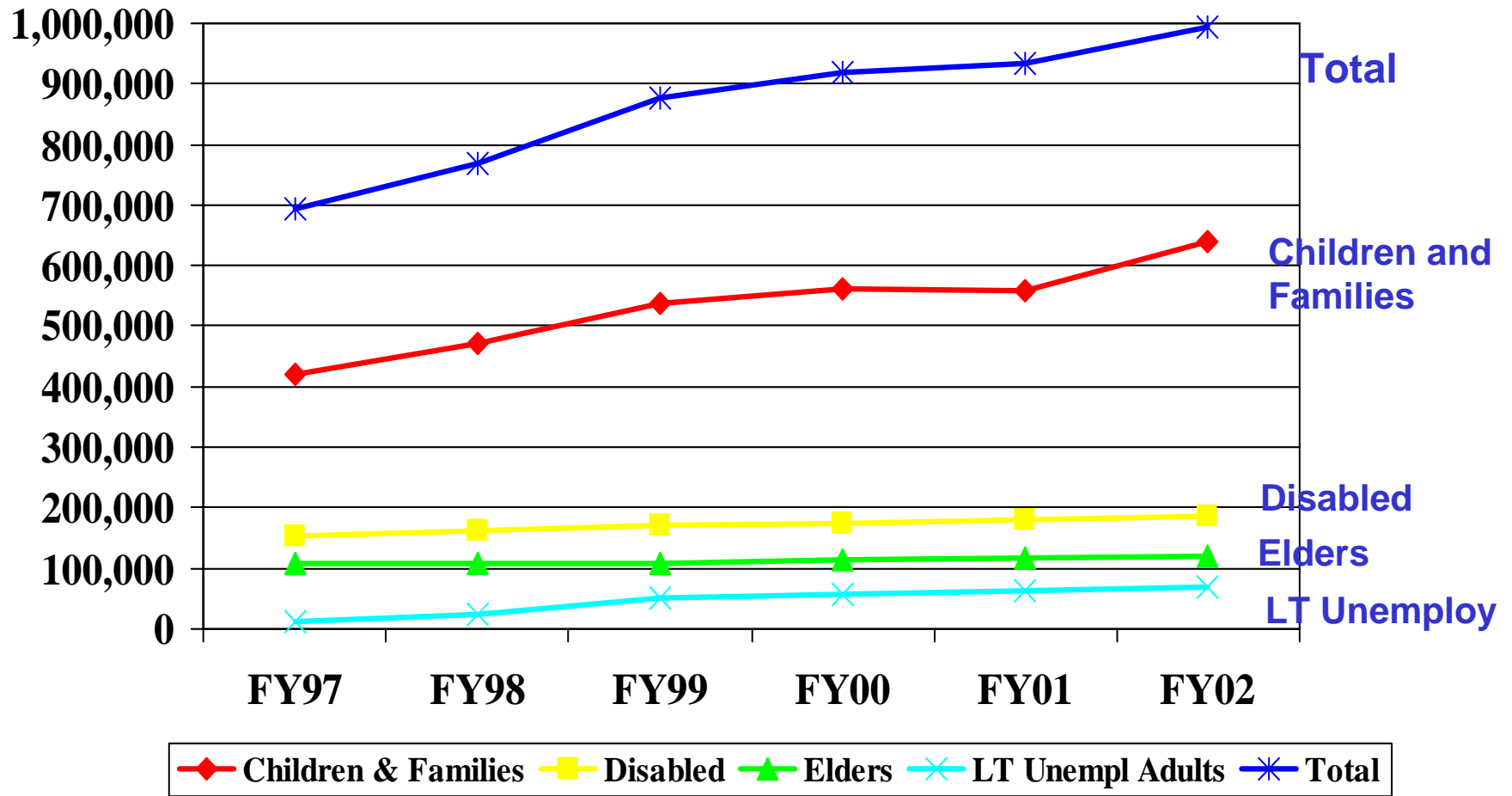
Source: Premium data from Kaiser Family Foundation (national averages). 2003 increase projected by Hewitt Associates. MassHealth figures from DMA and Boston Consulting Group.

Gaps in Medicare Coverage

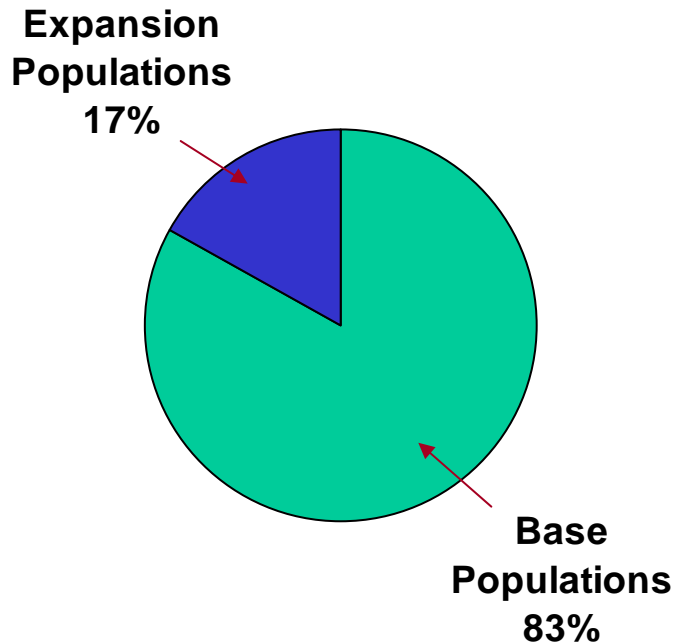
- 40% of total MassHealth spending is on the “dual eligible” population (people with Medicare and Medicaid coverage)
- \$2.2 billion annual cost to MassHealth of benefit gaps in Medicare:

<u>Benefit</u>	<u>Annual MassHealth cost for duals</u>
Outpatient drug coverage	\$500 million
Nursing home care	\$1.25 billion
Community-based LTC	\$250 million
Medicare cost sharing	\$172 million for Medicare co-payments and deductibles

MassHealth Enrollment Has Grown by Over 300,000 since FY97

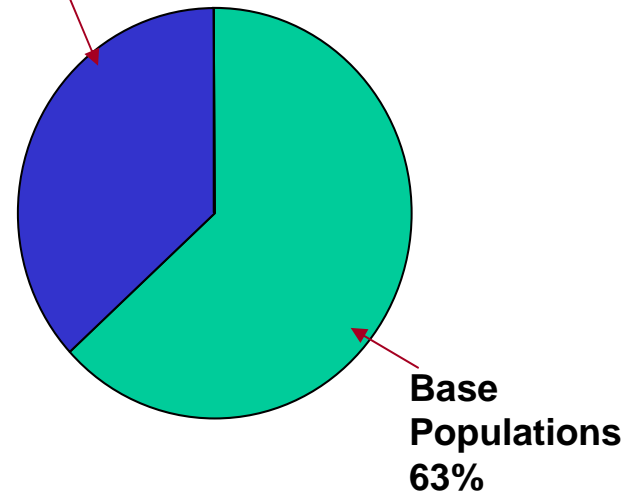


“Expansion” populations account for a relatively small proportion of total MassHealth spending. Expansions accounted for two-thirds of spending growth from 1998-2000 but only about 20% of growth in past 3 years



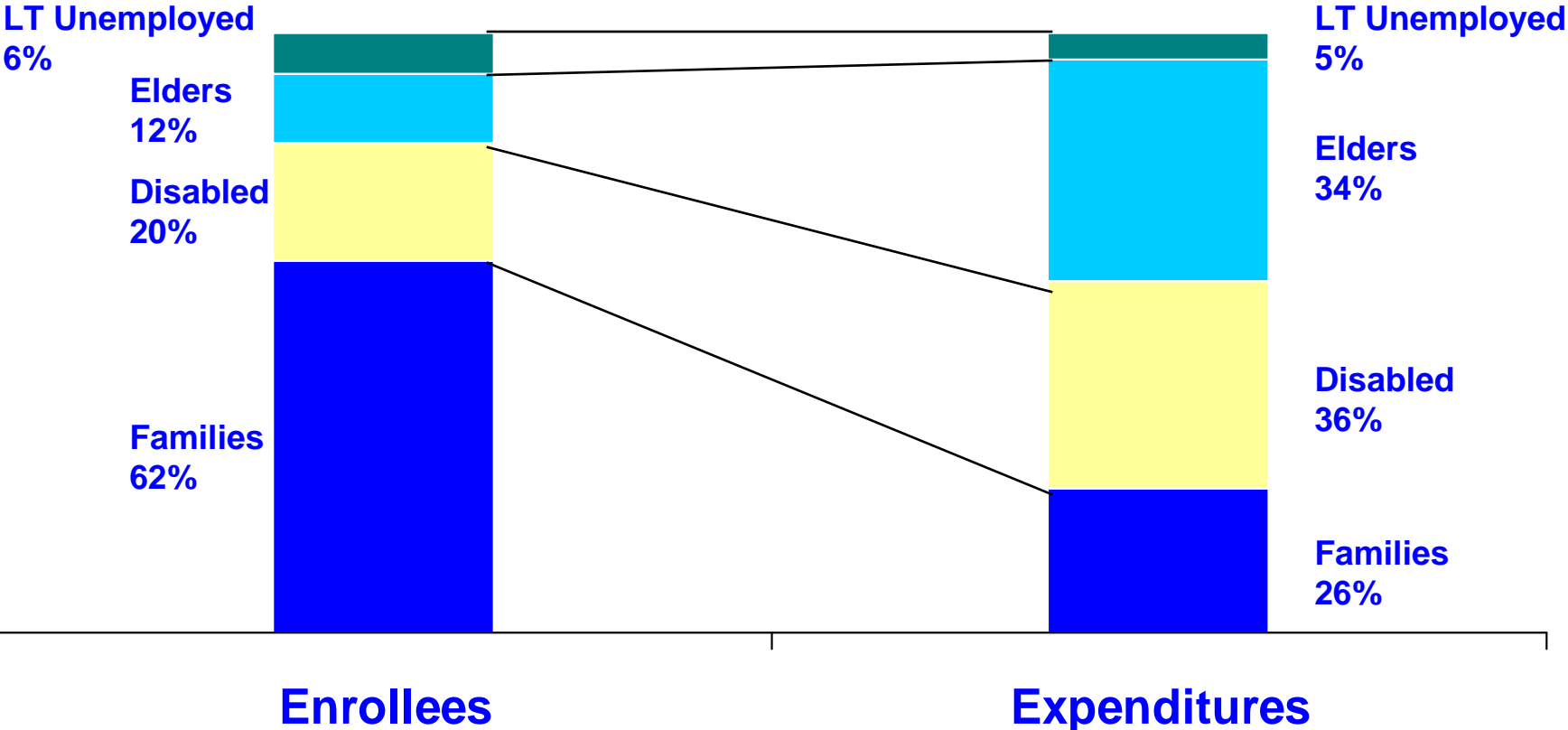
% 2003 Spending

Expansion Populations 37%



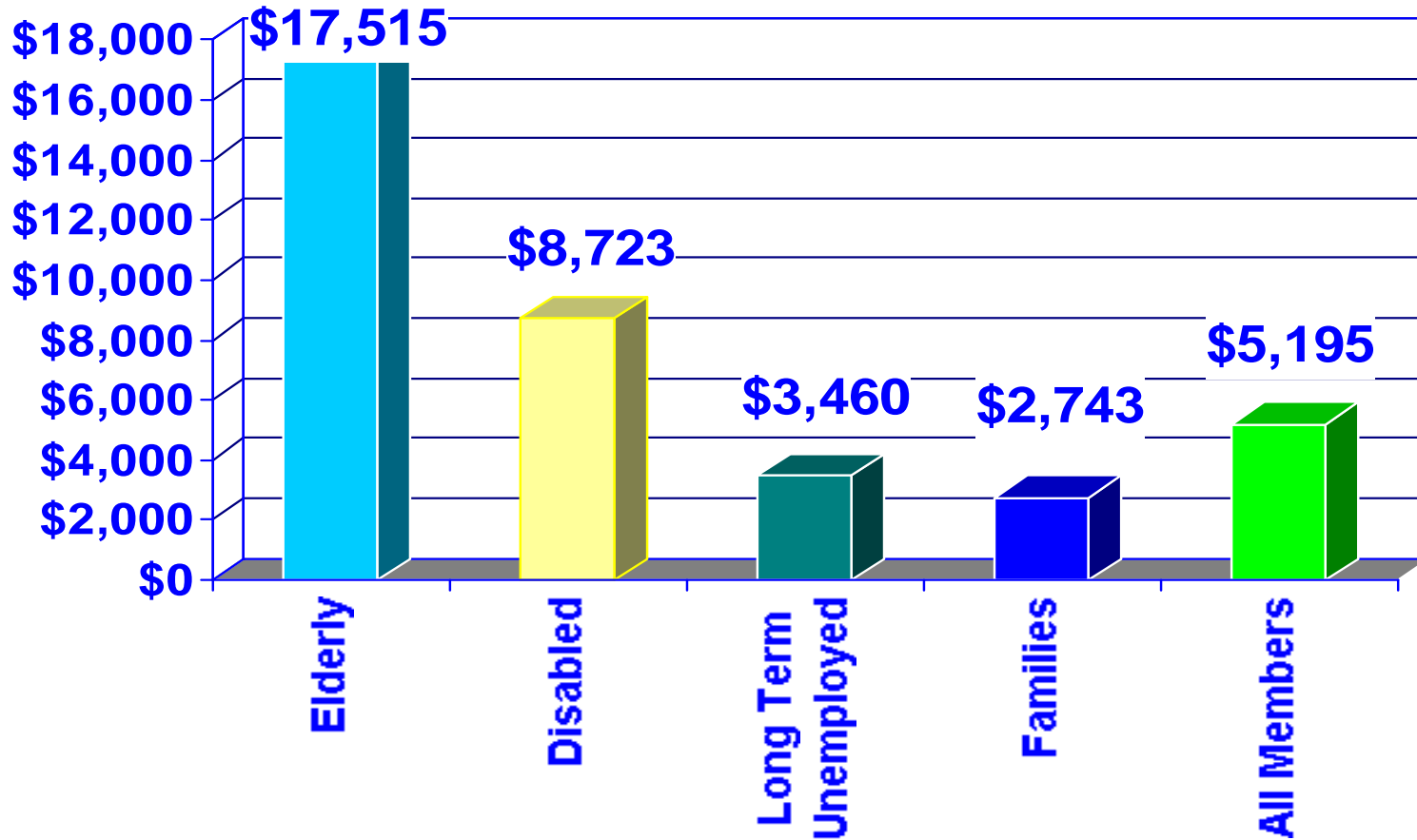
**% Spending Growth
1998-2003**

Most MassHealth Spending Is For Elders and People with Disabilities



Source: Division of Medical Assistance

Services Provided to Elderly and Disabled Members Are Much More Expensive Than Those Provided to Families and Long-Term Unemployed Adults



Expenditures Per Member: FY 2002

What Policy Tools are Available to the State To Deal with Rising Costs?

Short-Term

Policy Tools

- Seek additional federal revenues
- Restrict eligibility
- Reduce benefits
- Increase copayments
- Limit or lower provider payments
- Care management
- Find administrative savings

Potential considerations

- Cost shifting to private payers/business
- Effect on access to care
- Impact on federal matching fund
- Political feasibility
- Need for additional administrative resources
- Conflict with federal requirements

How Can the State Deal with Rising Costs? Longer-Term Options

- Expand and develop new systems of care
- Seek federal support
 - Medicare drug benefit
 - Additional federal match or assumption of responsibility for higher cost populations
- Improve population health

The State Has Already Undertaken Many Savings Initiatives

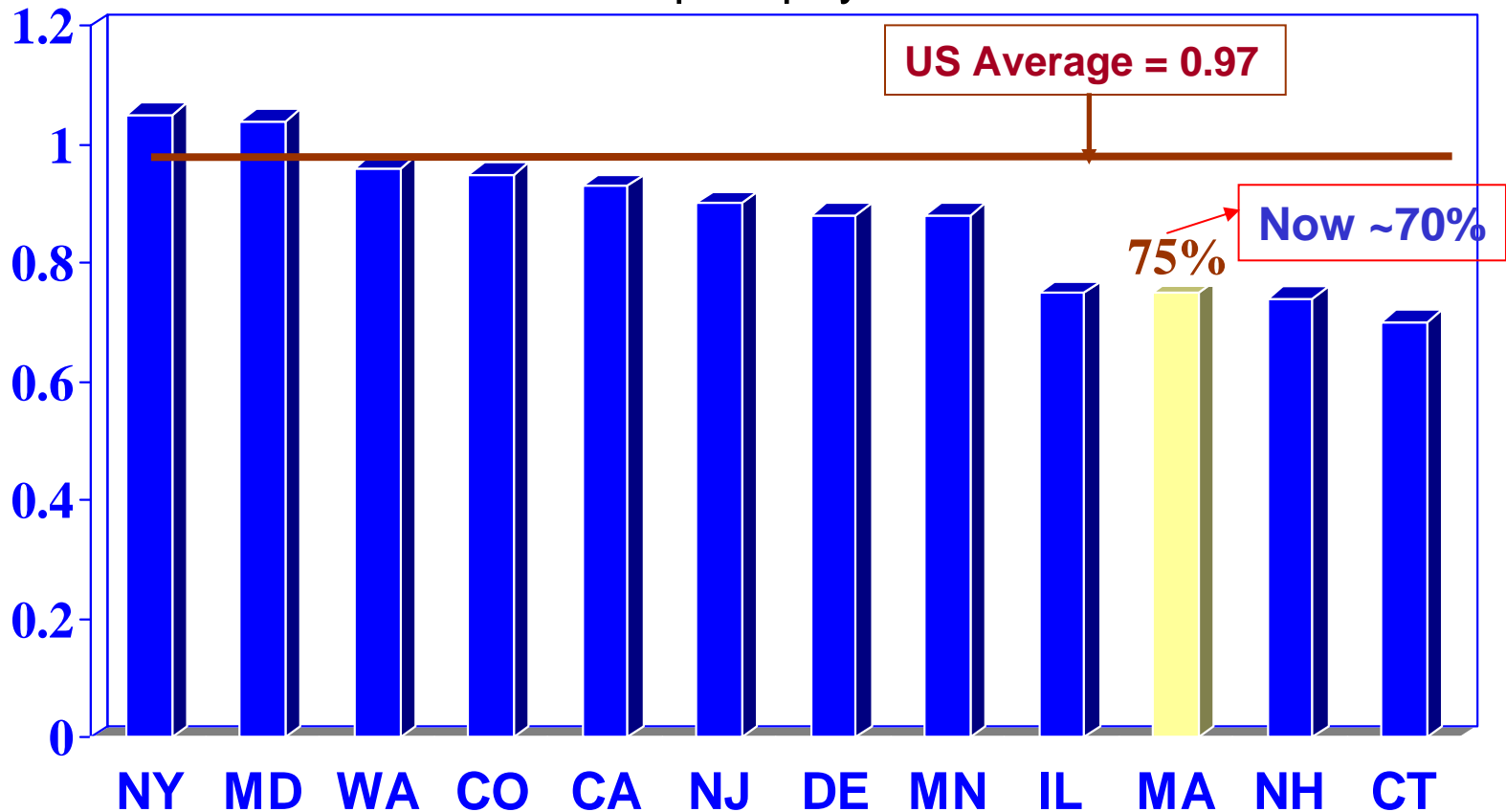
- FY 03 Savings: **\$300 Million**
- FY 04 Projected Savings: **Additional \$500 million**
 - Expand MassHealth drug list and drugs requiring prior authorization
 - Provider rate reductions
 - Tighten nursing home administrative requirements
 - Add new beneficiary premiums and copayments
 - Verify eligibility for employer coverage and Medicare
 - Implement asset tests and expanding estate recovery
 - Identify members for care management
 - Many others

What Are Other States Doing?

- Strengthening controls on drugs 45 states
- Reducing provider payments 37
- Restricting eligibility 27
- Reducing benefits 25
- Instituting/increasing copays 17

MassHealth Hospital Rates are Low Relative to Provider Costs

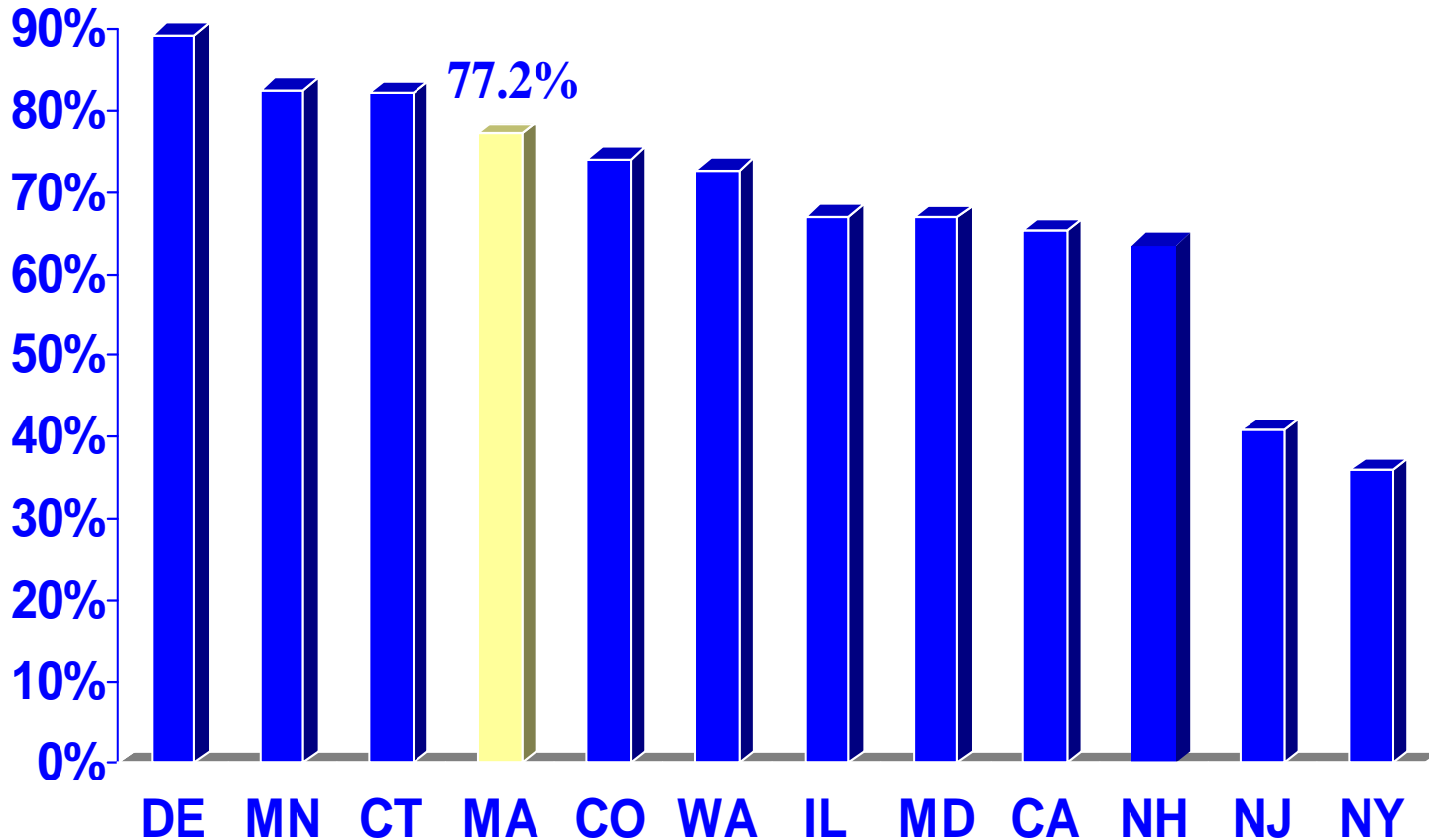
1999 Medicaid hospital payment-to-cost ratio



Source: MedPAC Report to Congress, March 2001
* Mass Private Payer Payment-to-Cost Ratio

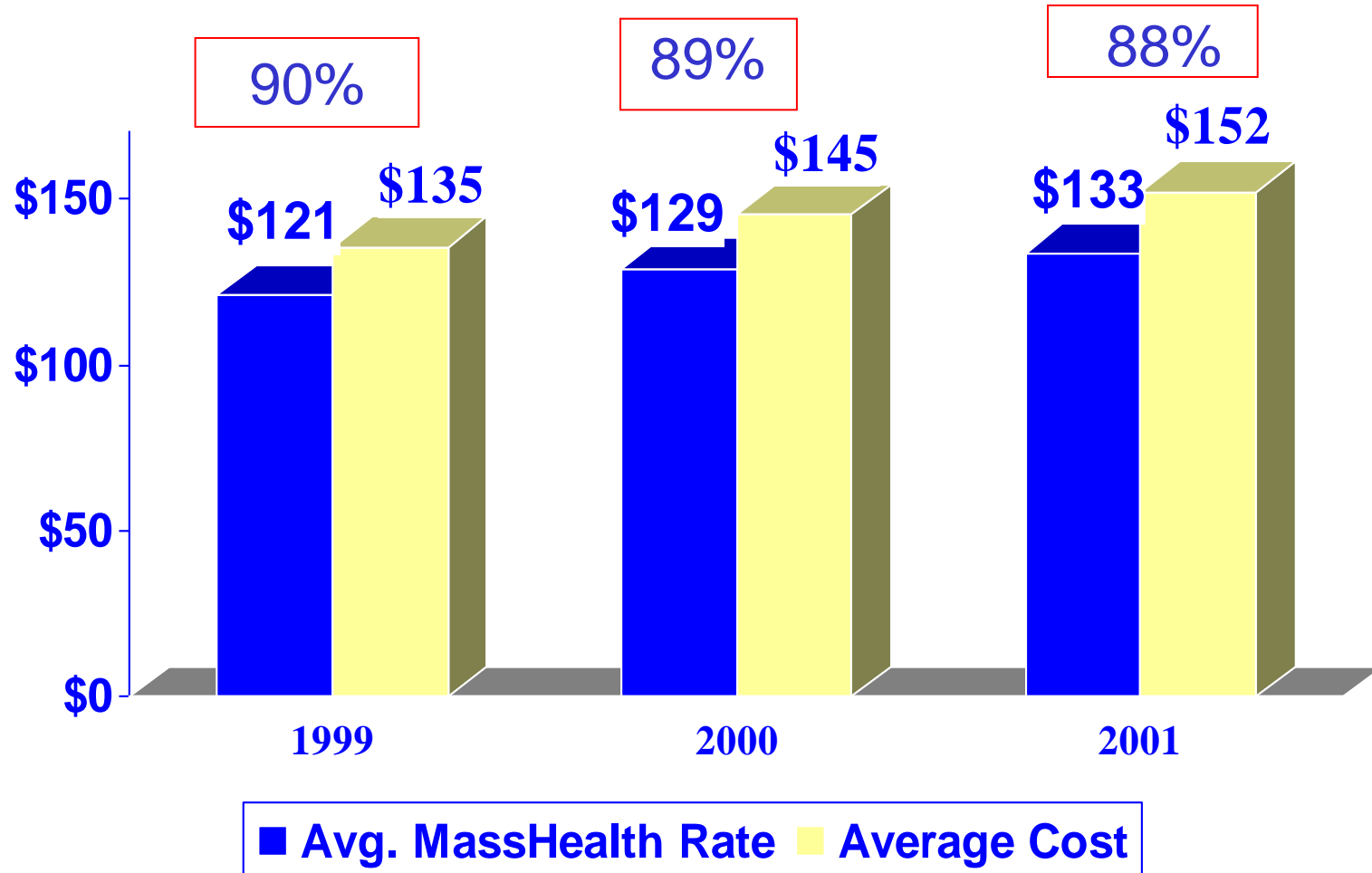
MassHealth Physician Rates are Low Relative to Medicare but Not Other States

Average 2000 Medicaid Fee as Percent of Medicare Allowed Charge



Source: The Lewin Group, Comparing Physician and Dentist Fees Among Medicaid Programs, June 2001. Based on volume weighted average fees for 52 procedures. Adjusted for physician practice expenses in each state.

Average MassHealth Nursing Home Rates Are Below Average Operating Cost



Three of the Biggest Challenges for MassHealth

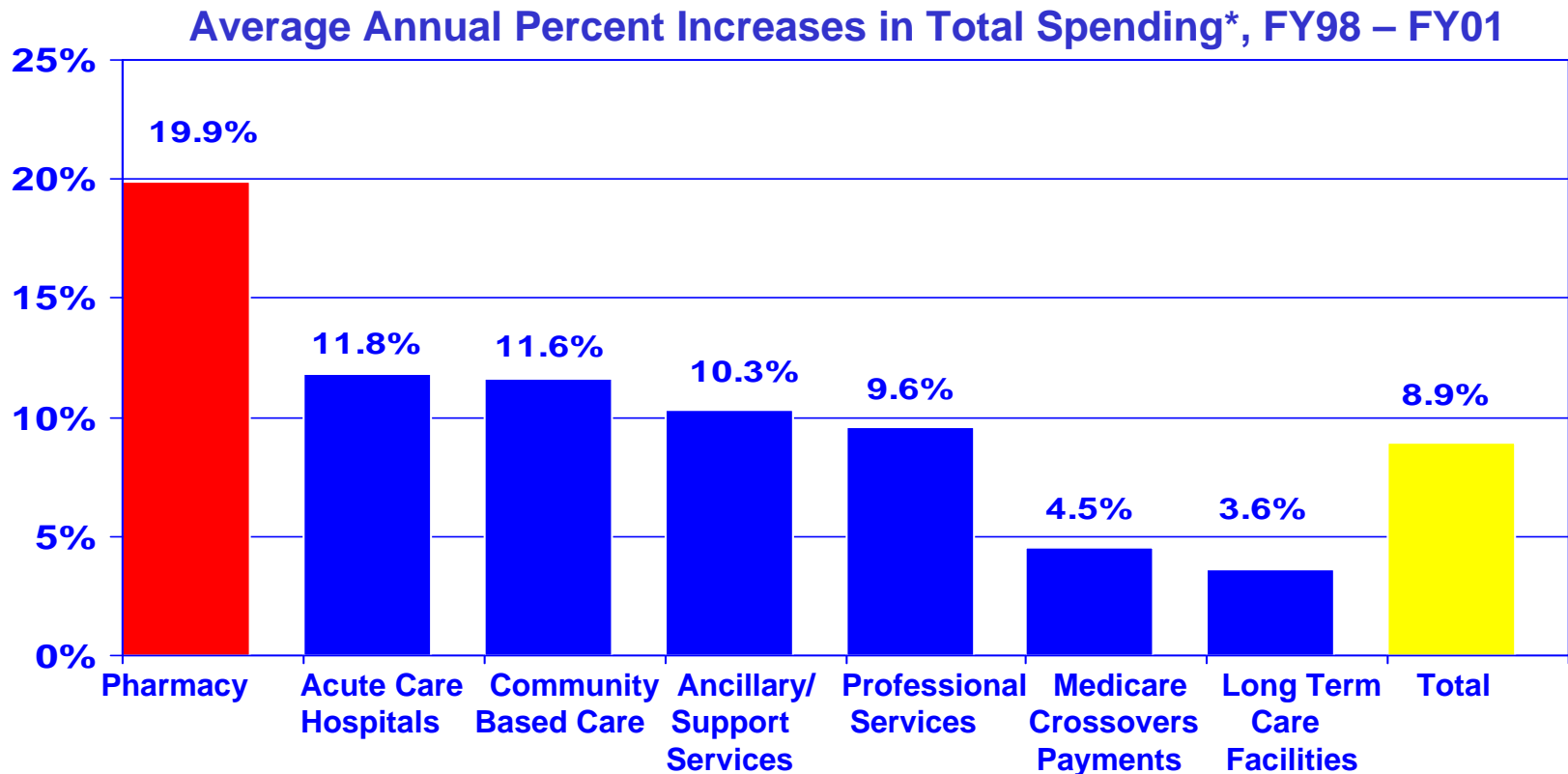
#1: Prescription drug spending

#2: The cost of care for people with disabilities

#3: Expanding cost-effective community alternatives to nursing home care

#1: Total Spending on Pharmacy is Growing Nearly Twice as Fast as Spending for Any Other Service

(Accounts for 28% of total MassHealth spending growth FY97-02)



*Total spending reflect the effect of changes in membership, member mix, utilization and rates of payment

Source: DMA

BCG's Recent Recommendations

The right efforts are underway already; accelerate the pace where possible

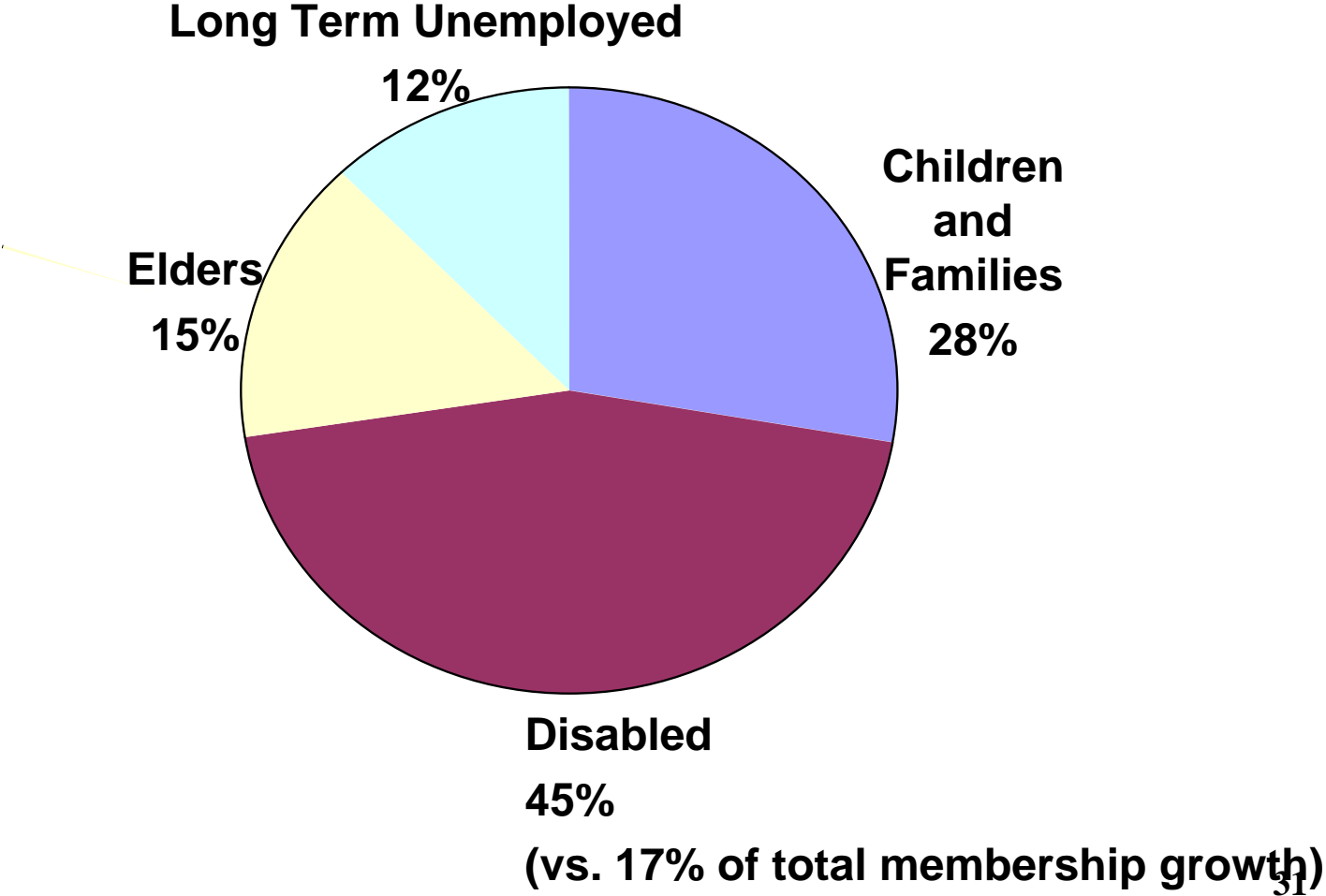
Also consider:

- Adopt stricter preferred drug list
- Negotiate supplemental rebates with manufacturers
- Coordinate purchasing across state agencies
- Explore multi-state drug purchasing cooperative

Drug Innovations in Other States

- Michigan
 - Very strict Preferred Drug List (29 of the top 100 drugs require prior authorization)
 - Aggressive supplemental rebates
 - \$43 million savings (7%) in FY 2002
 - Projected annual savings of \$100+ million when fully implemented
- Maine
 - Maine RxPlus: Medicaid drug discounts available to uninsured persons
- Florida “Healthy State” Program
 - Partnership with Pfizer for disease management for certain members with targeted chronic conditions
 - Very controversial program; savings unclear

#2: Disabled Members Accounted for 45% of MassHealth Expenditure Growth Between FY1997 and FY2002



Source: MassHealth Claims Data

Why is Spending for Individuals with Disabilities Growing So Fast?

- 25% increase in number of members with disabilities since 1997
 - Medical advances that improve life expectancy
 - Shifting of state programs for disabled to Medicaid to get federal matching funds
 - More generous eligibility guidelines for people with disabilities than many other states
 - State initiatives to reduce number of people with disabilities who are uninsured and not employed
- 44% increase in spending per disabled member
- Cuts in eligibility likely to produce significant cost shifting to business

Approaches to Moderating Spending Increases for Disabilities

- Control rising prescription drug costs
 - More than half of MassHealth pharmacy spending is for disabled members
- Develop new models of care
 - Care coordination and disease management
 - Specialized managed care programs

Center for Health Care Strategies:

Improving Care for Adults with Chronic Illness and Disabilities Initiative

- Workgroup of 12 Medicaid health plans (one from Massachusetts) piloting managed care best practices for adults with chronic illnesses and disabilities:
 - Improve diabetes management for members with chronic behavioral health disorders
 - Reducing hospital admissions for secondary complications of disability (pneumonia, UTI, bowel obstruction)
 - Improve self management of medical conditions in patients with dual diagnoses (physical and mental health needs)
 - Improve pain management of members with chronic disabilities
 - Implement harm reduction plans for members with substance abuse problems

“Cash and Counseling” Demonstration: Arkansas, Florida, New Jersey

- Consumer-directed model for purchasing supportive services
- Frail elders and adults with disabilities given monthly cash allowance to purchase personal assistance services instead of relying on state-contracted agencies
- Aim is to enhance control and autonomy, reduce unmet needs, improve quality
- Results from Arkansas “Independent Choices” evaluation for 1,800 enrollees impressive on all dimensions:
 - Much higher satisfaction and much lower unmet needs
 - Data on cost impact not yet available

Community Medical Alliance, Massachusetts

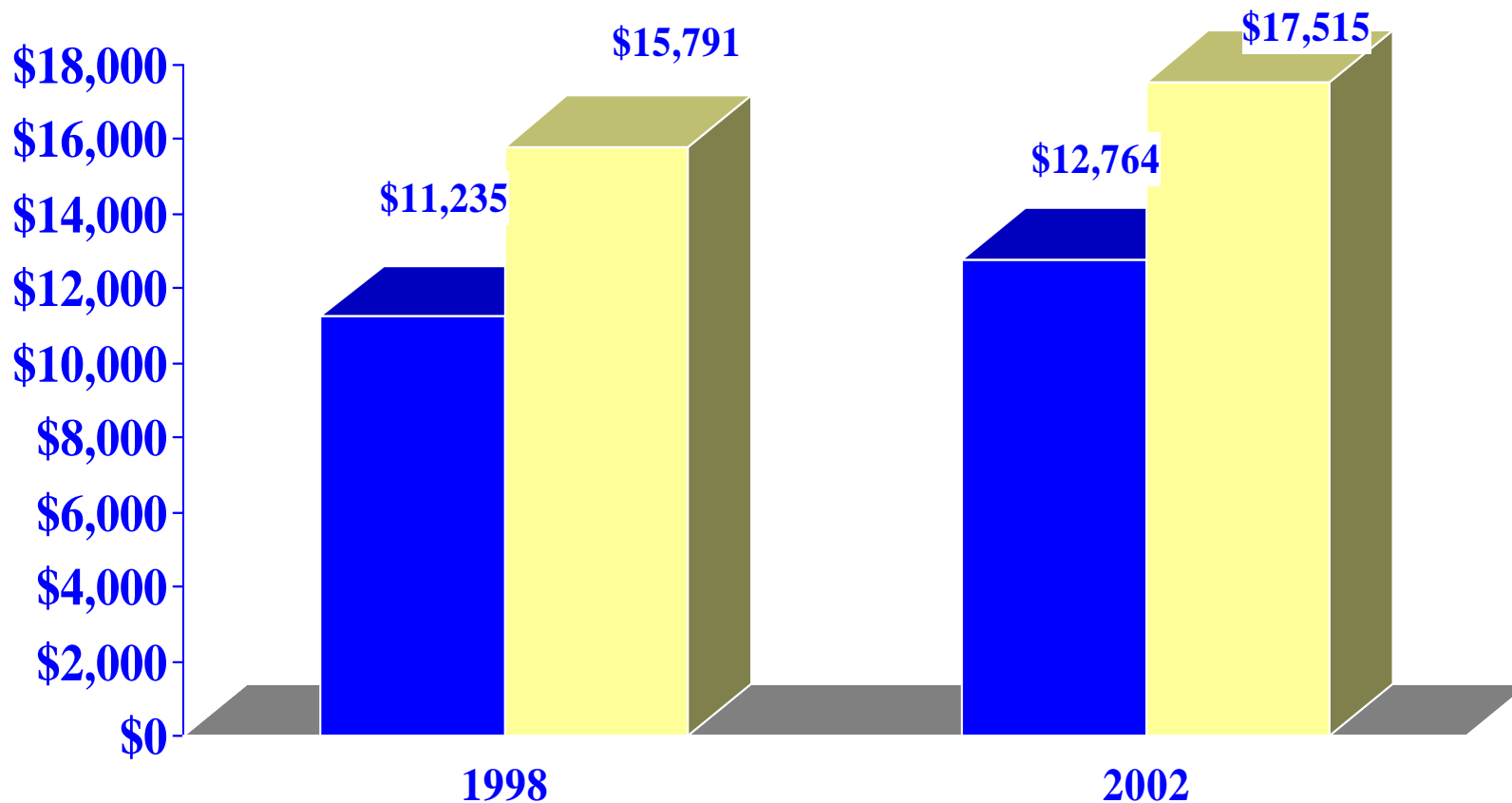
- MassHealth Managed Care Program That Focuses on High Cost Members (Severely Disabled Adults, People with AIDS and Technology-Dependent Kids)
 - Prepaid risk-adjusted premiums
 - Flexible benefit model
 - MD/RN/NP team coordinates all aspects of care
- Results for severely disabled
 - Overall costs per member reduced by 40%
 - Hospitalization costs reduced by 80%
- Results for AIDS patients
 - Mortality rate declined from 60% to 12%
 - Hospital days declined by 65%
- Results for SSI-eligible disabled individuals
 - Overall costs per member reduced by 27%
 - Hospitalization costs reduced by 50+%

#3: Expanding Cost-Effective Community Alternatives to Nursing Home Care

- 25% of **total** Massachusetts Medicaid spending is for nursing home care (~\$1.6 billion)
- **3%** of Massachusetts Medicaid members are in nursing homes (~36,000 people)

MassHealth Spending for Elders is ~40% Higher Than US Average

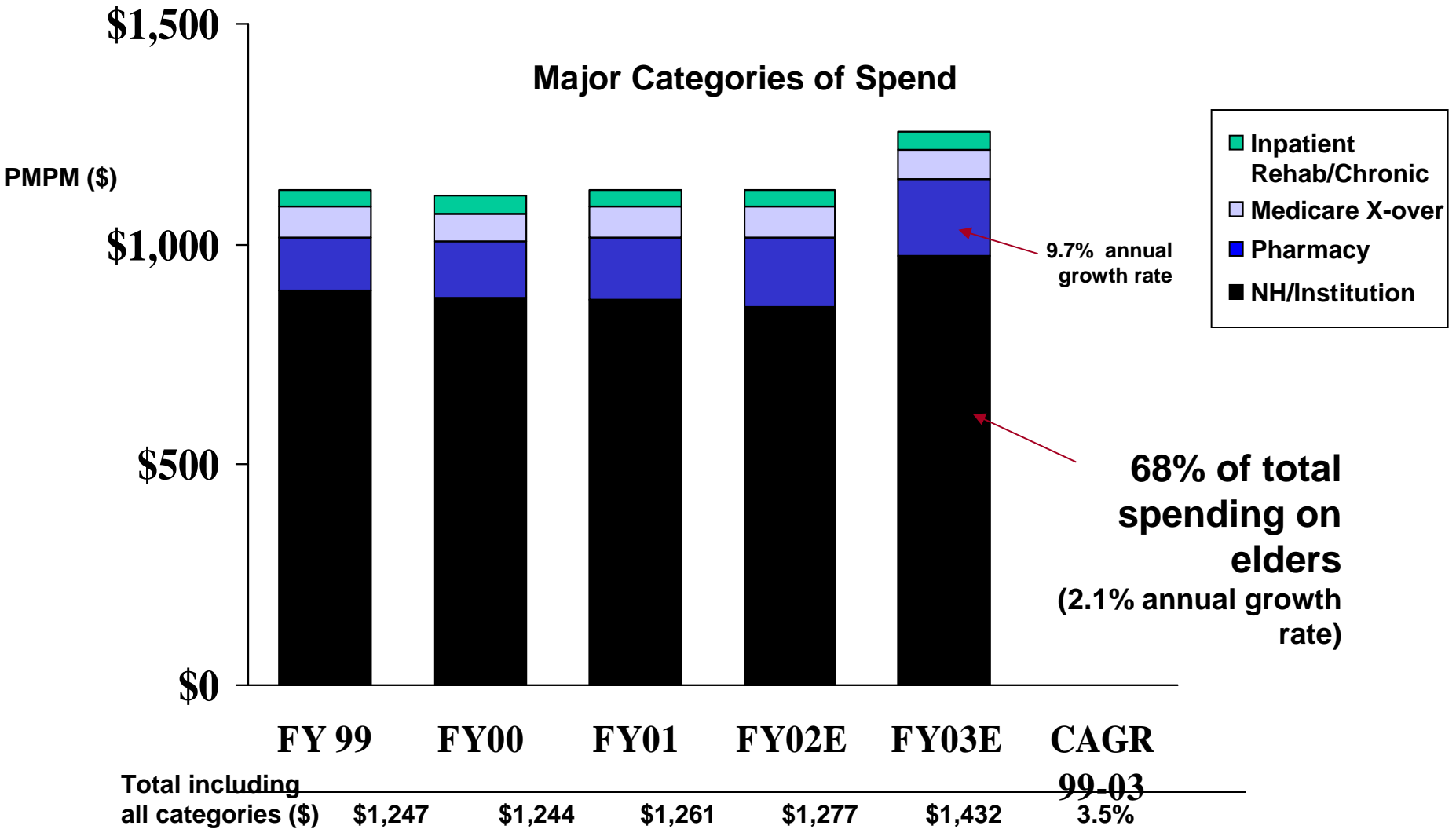
Medicaid Spending Per Elder Beneficiary: US vs. MA



Source: Kaiser Family Foundation ■ United States ■ Massachusetts

AS IN MOST STATES, MASSHEALTH SPENDING FOR ELDERS IS OVERWHELMINGLY CONCENTRATED IN NURSING HOMES

Major Categories of Spend



Massachusetts versus States With Innovative Long Term Care Policies

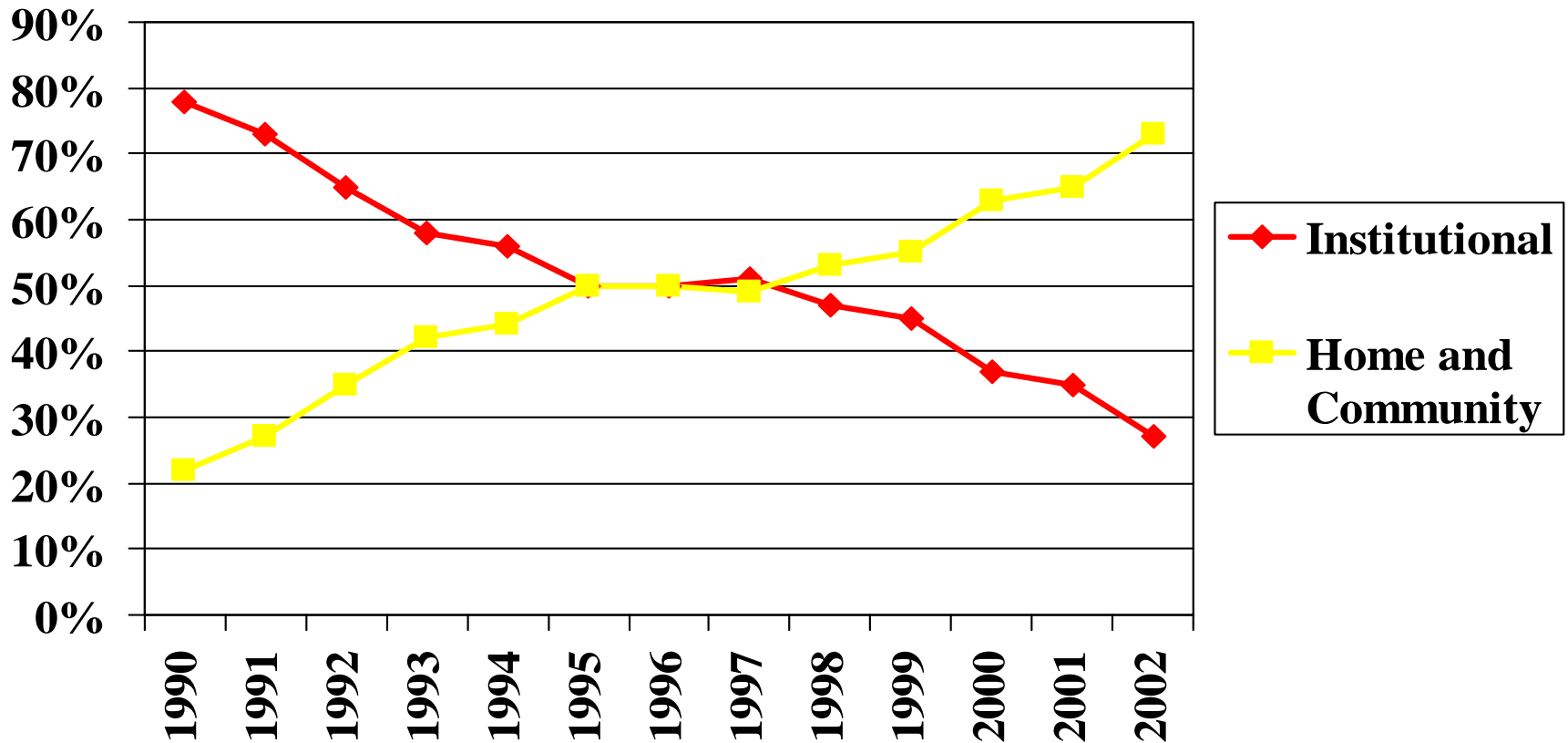
	Beds Per 1000 85+	NH Residents per 1,000 85+	Per Capita LTC: 1998	Medicaid Per Capita LTC 2000
MA	479.0	427.0	\$740	\$370
NJ	384.0	337.0	\$514	\$299
OR	237.0	174.0	\$299	\$203
AZ	235.0	193.0	\$242	NA
US	423.0	349.0	\$433	\$240

Oregon Home and Community Based Services Initiative

- Medicaid long term care cost 20% below US average
- Successful shift from institutional to home based care
 - ~30% of LTC for nursing homes vs. 57% US average
- Success Factors
 - Federal waiver with overall spending cap but allowing flexibility in total number of persons served
 - Consolidated administrative structure for elders with tight pre-admission screening and case management
 - Two-thirds of home and community-based service clients served in home. State actively promotes development of alternative living arrangements
 - Low nursing home bed supply and tight state controls over further development

Oregon's Long-Term Care System

Institutional, Home & Community-Based Services Spending as a % of Medicaid Long-Term Care Spending, Oregon, 1990-2002



Sources: Congressional Research Service (CRS) calculations based on CMS/HCFA 64 data provided by The Medstat Group, Inc.; KFF

Trends in Oregon and US Medicaid Long Term Care Spending Average annual increase 1990 - 2000

	Oregon	US
Institutional Care	2.3%	12.4%
Home and Community	21.8 %	17.4%
Total Medicaid	9.8%	13.6%

Massachusetts Has Taken Steps to Develop Alternatives to Nursing Home Care

- Program of All Inclusive Care for Elders (PACE)
 - Capitated managed care program for frail elders, blends Medicaid and Medicare
 - Reduces costs by substituting preventive and supportive services for hospital and nursing home care
- Senior Care Options demonstration waiver
 - Integrated Medicare/Medicaid funding
 - First state to incorporate the aging network into the SCO model, improving on Minnesota and Wisconsin models.
- EOHHS reorganization places all elder services under single entity

Substantial challenges to LTC reform

- Small scale and voluntary nature of existing innovative programs
- High nursing home bed capacity and difficulty of closing existing facilities
- High real estate costs limit community-based housing alternatives
- Need for new state screening and tracking systems

Other Strategies To Contain MassHealth Spending

- Additional resources for program management and innovation
 - Analysis, IT, and new program development
- Other new care management programs
 - Predictive modeling, disease management
- Selective contracting for certain services
- Investments in expanding community health center infrastructure
- Targeted public health improvement programs in areas with high concentrations of MassHealth recipients

Session Take Aways

MassHealth Takeaways (1)

- Critical program for state's most vulnerable residents
- Rising health care costs are the major reason for rising spending
- Current rates of increase are not sustainable within existing resources
- MassHealth cuts will affect the economy
 - Loss of federal funds
 - Shifts costs to private employers
 - Impact on uncompensated care pool
 - Financial impact on health care delivery system
 - Impact on community health and productivity

MassHealth Takeaways (2)

- No silver bullets
- Many initiatives already underway
- Must focus aggressively on:
 - Prescription drug spending
 - Care management for high cost members
 - Cost-effective alternatives to nursing home care
- Development and expansion of new delivery models and approaches is critical
 - Requires political support and resolve
 - Requires multi-year commitment

The Top Three Things The Business Community Can Do Now

#1: Advocate for additional federal financing

- At least another year of federal emergency relief
- Medicare drug benefit and greater federal financial role for dual eligibles

#2: Support the state's efforts to better coordinate and manage care

- “The status quo has many constituencies”
- Additional administrative resources are a necessary investment

The Top Three Things The Business Community Can Do Now

#3: Help re-frame the MassHealth discussion

- Not just a budget problem but a community challenge
- Social protections and economic well being are not separate but are both public values that can and must work together