Missouri Healthcare: Past, Present, and Future

October 13th, 2017

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Overview of Presentation

• Background/Context for Missouri
  • Access
    • historical insurance coverage rates in Missouri
    • Missouri’s contribution to the supply of providers
  • Costs
    • Drivers: access issues, inequality, aging population
  • Health status in Missouri

• Moving forward
  • Solutions from other states?
  • Achieving improved access, improving population health, within Missouri’s budget
  • Finding feasible policy solutions
Background/Context

- History of Insurance in Missouri
- Missouri Medicaid History
- Missouri’s Healthcare Providers Trained
- Missourians’ Health
History of Insurance in Missouri

Missouri has tended to be above the national average in terms of the percent of the population obtaining health insurance coverage through an employer. This is still true today, although the numbers have declined steadily since 1999-2000.
Uninsurance rates in Missouri were lower than in the U.S. until 2014, when the U.S. uninsured rate dropped below Missouri’s rate.

Distribution of Uninsured Population in Missouri, by Income, 2016

Missouri Medicaid History

1959: MO limited medical assistance program covering inpatient hospital care with a max reimbursement of $5 per day

1963: MO added a limited drug and dental program for adults

1965: Title XIX of the federal Social Security Act establishes Medicaid

1967: Establishment of the Missouri Medicaid program

1996: The Personal Responsibility Work Opportunity Reconciliation Act creates TANF to replace AFDC

1998: MO creates CHIP program, expanding health coverage to low-income children with family income up to 300% FPL

2005: MO reduces optional Medicaid services provided to adults, excluding pregnant women and blind persons

2007: Missouri Health Improvement Act renames program MO HealthNet to reflect new goals
In 2016, there were 448 new MDs and 413 new DOs trained in Missouri.

Meanwhile, 1699 (11%) of current active MDs are above 65, with another 3192 (20%) between the ages of 55 and 64.

Also, 298 (13%) of current active DOs are above 65, and another 541 (24%) are between ages 55 and 64.
Missourians’ Health

According to America’s Health Rankings 2016 Annual Report:

- In the past year
  - excessive drinking increased 10% from 16.1% to 17.7% of Missouri adults.
  - obesity increased 7% from 30.2% to 32.4% of Missouri adults.
  - HPV immunization among Missouri males aged 13 to 17 years increased 122% from 11.3% to 25.1%.
- In the past eight years
  - preventable hospitalizations decreased 36% from 88.6 to 56.6 discharges per 1,000 Missouri Medicare enrollees.
- In the past two years, diabetes increased 20% from 9.6% to 11.5% of Missouri adults.
Taking all this in, can we find a balance between the ideas of access for everyone and a healthy state budget not dominated by health care costs?
CDC: “86% of nation’s $2.7 trillion annual health care expenditures are for people with chronic and mental health conditions.”
Costs Due to Chronic Conditions

- Chronic disease accounts for approximately 86% of nation's aggregate health care spending, an estimated $8,350 per person in U.S. each year (CDC)

- Treatment of chronic disease captures an even larger of public spending:
  - 96 cents per dollar for Medicare
  - 83 cents per dollar for Medicaid.

- Example: Healthcare costs for a person with diabetes are over $13,000/year; for a person without diabetes, $2,500.
  - For every one point reduction in HbA1c (a measure of blood sugar over time), a 40% reduction in microvascular complications is reported (blindness, kidney disease, nerve damage) and **up to $4,100 can be saved in annual healthcare costs.**
The Role of Rising Inequality

Rising income inequality in US and Missouri has contributed to growth in Medicaid enrollment, even when eligibility standards remain the same.

Workers in low wage jobs are less likely to be offered insurance through employer.

All this is a barrier to preventive care and early detection that can potentially lower overall health care spending over time.

Missouri Income Data

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>Top 1% of Incomes</th>
<th>Bottom 99% of Incomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cumulative Real Growth</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1979-2007</td>
<td>31.9%</td>
<td>140.5%</td>
<td>20.3%</td>
</tr>
<tr>
<td>2009-2013</td>
<td>0.6%</td>
<td>14.8%</td>
<td>-1.8%</td>
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<tr>
<td><strong>Average Incomes</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2013</td>
<td>$49,653</td>
<td>$833,823</td>
<td>$41,641</td>
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The Role of Aging

The number of people aged 65 and over in Missouri is projected to rise 41% over the next 15 years. Elders face higher health costs and are more likely to be on Medicaid, so this will drive up state spending on Medicaid.
Missouri Medicaid (MOHealthNET) Enrollment

Missouri Medicaid (MOHealthNET) Enrollment

In SFY-2016, seniors and persons with disabilities comprised 25% of enrollees; however, they accounted for 65% of MO HealthNet expenditures.

MO HealthNet SFY-2016

- 16.5% - Persons With Disabilities
- 8.1% - Seniors
- 12.5% - Pregnant Women & Custodial Parents
- 46.7% - Persons With Disabilities ($3,804.0 M)
- 18.2% - Seniors ($1,486.0 M)
- 9.8% - Pregnant Women & Custodial Parents ($797.9M)
- 25.3% - Children ($2,061.7 M)
- 62.9% - Children

Number of People SFY-2016

(Average Monthly)

- Persons With Disabilities: 159,453
- Seniors: 78,124
- Pregnant Women & Custodial Parents: 120,729
- Children: 606,793
- Total: 965,096

Unpacking Growth in Medicaid Spending

- How much of the change in Medicaid spending is attributable to what sources?
- Using the data available to us, we can disentangle these sources of growth, attributing overall spending growth into growth attributable to:
  - Enrollment growth,
  - Spending per enrollee
    - Prices/inflation
    - Utilization per enrollee

- What might account for the rise in “utilization”? Some possibilities:
  - Enrollees are sicker/older and need more services
  - Services are billed more intensively
    - may be a provider response to low reimbursement rates
    - may be due to lack of code options for less intensive services
  - Unnecessary services are provided, through duplication, incomplete recordkeeping, etc.
  - Other possibilities?
Our analysis of CY 2011-2016 data shows many instances in which increased utilization is the driving force in growth of costs.

2015 Blind and Disabled
Enrollment change from last year: 3,888 (2.47%)
Sum of expenditures: $3,813,567,140
Change from 2014: $211,079,388 (5.86%)

Breakdown of Expenditure Change (% contribution to change)
Change due to inflation: $3,813,567 (2%)
Change due to enrollment increase: $92,149,094 (44%)
Change due to higher utilization: $115,116,727 (55%)

(Interactive version available on web resources page.)
Indirect Costs: Uncompensated Care

Missouri Hospital Association reports a **469% increase in uncompensated care cost** at its member hospitals over the past 10 years.

So even if we don’t cover those on Medicaid, demographically similar non-Medicaid eligible population may be adding to the trends we have seen.
Indirect Costs: Productivity Losses

Additional indirect costs come in the form of productivity losses for workers.

- Productivity losses linked to absenteeism cost employers $225.8 billion annually in the United States, or $1,685 per employee (CDC)
- Also, “chronic diseases, a rapidly-aging workforce and factors like stress, fatigue and depression all affect employers’ revenue.”

<table>
<thead>
<tr>
<th>Condition Level</th>
<th>%</th>
<th>Mean Annual Absent Days</th>
<th>Mean Annual Unproductive Days</th>
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<tbody>
<tr>
<td>No conditions</td>
<td>45%</td>
<td>1.4</td>
<td>3.7</td>
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<tr>
<td>1 condition</td>
<td>29%</td>
<td>1.9</td>
<td>7.9</td>
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<tr>
<td>2+ conditions</td>
<td>27%</td>
<td>3</td>
<td>20.1</td>
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<table>
<thead>
<tr>
<th>Risk Level</th>
<th>%</th>
<th>Mean Annual Absent Days</th>
<th>Mean Annual Unproductive Days</th>
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<tbody>
<tr>
<td>Low (0–2 risks)</td>
<td>68%</td>
<td>1.6</td>
<td>5.1</td>
</tr>
<tr>
<td>Medium (3–4 risks)</td>
<td>21%</td>
<td>2.4</td>
<td>12.9</td>
</tr>
<tr>
<td>High (5+ risks)</td>
<td>10%</td>
<td>3.6</td>
<td>28.9</td>
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Solutions?

- Missouri Waivers
- Solutions from Other States?
- Charge for Today
Missouri Waivers

Through Section 2176 of PL97-35 of the Social Security Act, certain statutory limitations have been waived in order to give states, with approval from the HHS, the opportunity for innovation. Currently, Missouri has approval to provide services under the following waivers:

**1115 Demonstration Waivers:** experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs, giving states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches. MO HealthNet and Department of Mental Health Waivers

- **1115 Women’s Health Services Program**
- **Gateway to Better Health Waiver**
- **Mental Health Crisis Prevention Project**

**1915(c) Home & Community Based Waivers:** under a waiver, certain services that could not otherwise be reimbursed under Title XIX may be provided to a select group of participants, in order to provide an alternative to institutional care.

**Department of Health & Senior Services Waivers**
- Adult Day Care Waiver
- Aged and Disabled Waiver
- AIDS Waiver
- Independent Living Waiver
- Medically Fragile Adult Waiver

**Department of Mental Health Waivers**
- MO Children with Developmental Disabilities (MOCDD) Waiver
- Autism Waiver
- Comprehensive Waiver
- Community Support Waiver
- Partnership for Hope Waiver
Solutions from Other States? Waivers

States have flexibility to alter some of the requirements of Medicaid law

**1932(a) State Plan:** Managed care delivery system by getting a state plan amendment approved by CMS.

**1915(a) Waiver:** voluntary managed care program simply by executing a contract with companies that the state has procured using a competitive procurement process. 13 states (and Puerto Rico) use 1915(a) contracts to administer 24 voluntary managed care programs.

**1915 (b) Waiver:** managed care delivery system using waiver authority under 1915(b). Uses Freedom of Choice, Enrollment Broker, Non-Medicaid Services Waiver, Selective Contracting Waiver

**1115 Demonstrations:** experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. Gives states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible
- Providing services not typically covered by Medicaid
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.
Solutions from Other States?

Sections 1115 of the Social Security Act gives Secretary of HHS authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:

- **Expanding eligibility** to individuals who are not otherwise Medicaid or CHIP eligible;
- Providing **services not typically covered** by Medicaid; or
- Using **innovative service delivery systems** that improve care, increase efficiency, and reduce costs.

There are currently 29 approved and 37 pending waivers across these three goal areas.
Some states have turned to waivers for coverage expansions

- At least 9 states have Section 1115 waiver proposals for coverage expansions undergoing public comment or CMS review

- Common elements to most proposals include
  - charging premiums,
  - cost sharing,
  - healthy behavior incentives,
  - work-related provisions.

- Some states:
  - time limits and health savings accounts.
  - Two states propose “partial expansion”.

- Key requirement: budget neutrality, cannot reduce coverage (until now).
Solutions from Other States?

Other states are trying **Delivery System Reform Incentive Payment (DSRIP) Waivers** (CA, MA, NH, NJ, NY, RI, TX, WA as of 2017)

Early findings/lessons learned, according to Kaiser Family Foundation (2015), on DSRIP in CA, MA, NY, and TX:

- DSRIP is changing the way care is delivered by promoting collaboration, supporting innovation, and focusing on social services.
- It is critical, but challenging, to design appropriate measures of the impact of DSRIP
- DSRIP’s role in broader delivery system reform and Medicaid managed care remains unclear
- The financing structure underpinning DSRIP waivers can dramatically affect how they are used
Charge for Today

Throughout the day, we challenge audience to be mindful of the issues discussed here, in the other talks and discussions, and think about the following question:

**How do we balance the competing goals of healthcare access for everyone and ensuring a healthy state budget over time?**

- Are there innovative ways to pay that emphasize population health?
- Are there “easy” policy solutions in the short term that improve efficiency while also improving outcomes?
- Can we broaden our perspective beyond the short-term to look at ideas for investing now and obtaining the dividends in the medium- and long-term?
Questions?

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https://publichealth.wustl.edu/centers/health-economics/