Bending the Health Care Cost Curve in Missouri

Options for Saving Money and Improving Care

Executive Summary

The increase in health care costs over the past several decades has been both a national and a state-specific issue. Despite many efforts, the overall health care cost growth rate has not significantly slowed. These growing cost pressures require a serious, focused effort to fundamentally restructure the delivery of care and associated spending. This report, commissioned by the Missouri Foundation for Health (MFH), is designed to inform a state-level discussion of health care savings opportunities in Missouri.

The full report outlines the estimated impact of six scenarios that could help contain escalating health care costs in Missouri over the next decade while improving health care quality. Billions of dollars in savings are possible. Missouri's health care cost curve can be bent through policy options that better integrate care and yield better health care outcomes. While government would realize much of the savings, in many cases, they also would extend to private employers and households.

Policy Scenarios Designed to Help Contain Costs and Improve Quality of Care

To provide a baseline against which to measure the six scenarios, growth in Missouri health spending was projected through 2021. The Centers for Medicare and Medicaid Services (CMS) projects that national health spending will grow more than 5.9 percent per year over the next decade. Historically, Missouri's growth rate in health spending has averaged about 0.3 percentage points higher than the national average. Based on this trend, health spending in Missouri was projected to equal the national growth rate of 5.9 percent plus 0.3 percent, for an assumed growth rate of 6.2 percent.

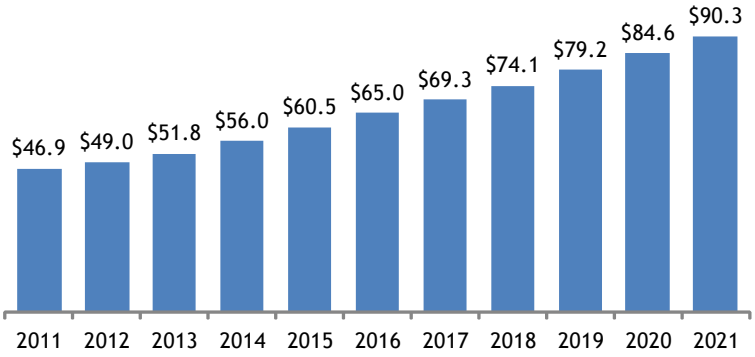
The Patient Protection and Affordable Care Act (ACA) will increase the number of people with health insurance coverage beginning in 2014. Additional spending for the newly insured is estimated to increase health care spending in Missouri by about 4.7 percent once all provisions of the ACA are fully implemented. Using these data, health spending in Missouri was estimated to grow from $46.9 billion in 2011 to $90.3 billion in 2021 (Figure ES -1), resulting in a 10-year baseline of almost $725 billion.

Identification of the six modeled scenarios began with examining a broad variety of policy options. While savings to the state's budget were an important consideration, the approach taken was to examine scenarios that could save health care dollars for all stakeholders. Options focused on approaches that would improve the quality of care provided; catalyze sustainable reductions in cost; and avoid significant disruptions in the health care marketplace for any participant (e.g., costs would not be extracted from, or borne exclusively by, one group or another). The six options selected are not meant to be exhaustive, but rather represent options to address various factors contributing to increasing health care costs and inefficiencies in existing delivery and financing systems. They were selected with the advice of a Technical Advisory Panel (TAP). TAP members came from a broad spectrum of the state health care market, including providers; individuals with knowledge of primary,

acute, and long-term care services; and people with experience in government, private industry, and research.

This analysis also recognizes that the state's ability to influence health care policy is often bounded by its role as a direct purchaser of health care and a regulator of health care providers and insurance companies. As a result, the state has limited ability to influence the actions of Medicare, private insurance, and self-insured organizations. Therefore, when appropriate, scenarios were modeled two ways: projecting "potential savings" if the scenario was universally adopted in Missouri, and "actionable savings" if it was adopted only by MO HealthNet, the Children's Health Insurance Program (CHIP), and state and local employee benefit plans, and as the result of provider or payer regulation by state government.

Figure ES-1: Projected Total Health Spending in Missouri for 2011 through 2021 ($ in billions)



Source: Lewin Group estimates using CMS spending growth estimates.

The six scenarios are:

- **Implementing Mandatory Managed Care for the Dual-Eligible Population.** Under this model, dual-eligibles would be mandatorily enrolled in a fully integrated coordinated care setting under capitated managed care organizations (MCOs). These MCOs would be at full financial risk for the entire Medicaid and Medicare benefits package for their enrolled dual-eligibles. Requiring a partnership between CMS, which manages these programs at the federal level, and Missouri, it is assumed that Medicare and Medicaid funds for dual-eligibles would be pooled and savings split 50/50 between the federal government and Missouri. This scenario also estimated the savings that would accrue if the state adopted an "opt-out" approach: assigning dual-eligibles to an MCO but allowing them to opt out of a managed care environment and return to fee-for-service. Over 10 years, the mandatory policy is estimated to save $4.8 billion, assuming that 100% of dual-eligibles are enrolled; or $2.7 billion under the opt-out approach.
- **Adopting Bundled Payment Methods.** This scenario would make prospective payments for entire episodes of care, offering global fees otherwise referred to as "bundled payments." It potentially encompasses inpatient care, physician services while hospitalized, and post-acute care services including short-term skilled nursing facility (SNF) and home health care. This model would provide an opportunity for hospitals, physicians, and other health care providers to benefit from reducing complications and hospital readmissions, and increasing flexibility in allocating resources. Based on adopting bundled payments initially for a selected number of conditions, this option has the potential of saving $1.9 billion across all payers during the 10-year period, approximately $0.53 billion of which is actionable through implementing bundled payments for MO HealthNet, CHIP, state and local government health care programs, and insurers participating in the state's health insurance exchange.
- **Enabling a Robust Insurance Exchange.** Under the ACA, Missouri has the option to implement a health insurance exchange addressing its unique needs. States may open exchanges to all insurers meeting minimum standards, or play an active role in selecting carriers, including competitive bidding on the basis of price and quality measures. This scenario estimates the effects of a competitive bidding model, often referred to as the "active purchaser" model, determining which plans may participate on the basis of price, access to providers, and quality of care measures. The decision of which approach to take in Missouri would apply to exchanges for individuals and small employers.

Figure ES-2: Summary of Projected Savings by Policy Scenario, 2012-2021 ($ in billions)

Policy Scenario	Baseline Spending 2012-2021	Cumulative Potential Savings		Cumulative Actionable Savings	
		$	%	$	%
Implementing Mandatory Managed Care for Dual-Eligibles					
Mandatory	$73.5	$4.8	6.6%	$0	0%
Opt-Out	$73.5	$2.7	3.7%	$0	0%
Adopting Bundled Payment Methods	$38.6	$1.9	5%	$0.5	1.4%
Enabling a Robust Insurance Exchange	$38.1	$3.3	6.1%	$3.3	6.1%
Promoting Shared Decision Making and Palliative Care	$360.0	$5.9	1.6%	$4.34	1.2%
Care Coordination and Disease Management					
Mandatory Medical Home	$501.7	$11.9	2.4%	$3.2	0.6%
Voluntary Medical Home	$501.7	$3.1	0.6%	$0.89	0.2%
Advanced Disease Management	$501.7	$1.4	0.3%	$0.2	0.1%
Broadening the Scope of Practice for Primary Care Practitioners	$360.0	$1.6	0.4%	$1.6	0.4%

Over 10 years, using an active purchaser model is estimated to save $3.3 billion, all of which would be actionable by the state.

- **Promoting Shared Decision Making and Palliative Care.** Requiring providers to use patient decision aids in all health care programs, and requiring hospitals to establish palliative care programs, promotes better coordinated, higher value care where appropriate. Palliative care programs have been shown to improve physical and psychological symptom management, caregiver well-being, and family satisfaction. Studies have shown that when given the choice, patients nearing the end of life often will decline costly and invasive treatments that hospitals may be inclined to provide. Studies also have shown patients report more comfort and satisfaction with their treatment after using a decision aid, and report more realistic expectations of treatment outcomes. Patient aids also can reduce waste associated with defensive medicine. Savings are estimated at $5.9 billion over 10 years, of which approximately $4.3 billion is actionable.
- **Care Coordination and Disease Management.** Implementing a medical home or advanced disease management program would improve care coordination, particularly for individuals with complex, chronic diseases. Designed to coordinate the care provided, this model includes a team of professionals led by a primary care provider, and programs designed to ensure that patients with chronic health conditions are treated according to evidence-based guidelines. Adoption of a mandatory or voluntary medical home program or an advanced disease management model could result in potential savings of $11.9 billion, $3.14 billion, or $1.35 billion, respectively, over the next 10 years. Implementing only those program changes over which the state has management control would result in lower savings ($3.2 billion, $860 million, and $23 million, respectively).
- **Broadening the Scope of Practice of Primary Care Practitioners.** Missouri's current scope of practice for physician assistants and nurse practitioners is limited compared to many other states. For example, these trained professionals are often unable to write prescriptions or practice when they are not under the direct supervision of a physician. Expanding their scope of practice will improve access to primary care, for which there is significant unmet need in Missouri, and will reduce the overall costs of care while continuing to provide high quality care. Over 10 years, modeling of this scenario demonstrates that health care costs would be reduced by $1.6 billion, all of which is actionable by the state.

Additional Considerations

There are a number of additional considerations regarding these scenarios and savings.

Results are not additive. A number of these scenarios have overlapping impacts and thus, savings estimates are not additive.

Results include potential and actionable savings. These estimates reflect the total estimated "potential" savings that could result from each scenario, and "actionable" savings that the state can independently achieve. Actionable savings are limited when an entity such as the federal government, an insurance company, or provider has authority to choose whether to implement the proposed change.

Federal health care reform initiatives provide new opportunities. With the recent passage of the ACA, the federal government has taken steps that have the potential to slow the rate of growth in health care spending or enhance the impact of some of the options discussed here. While some of these changes have been incorporated, the impact of many of them is not yet known.

Intrastate differences exist. While the scenarios were modeled for statewide impact, Missouri's "I-70 corridor" clearly differs from the rest of the state. Policymakers may want to consider such differences during implementation.

Effective design and phased implementation are assumed. For the purposes of this paper, savings are presented on a consistent 10-year timeframe (2012–2021) to permit comparison; however, realistic timeframes to implement these options vary. This report assumes effective implementation and phased-in savings estimates, where appropriate. The impact of these cost-savings scenarios on provider taxes, which contribute to the funding of MO HealthNet, was beyond the scope of this report and should be taken into consideration as implementation plans and phase-in periods are determined.

Realizing savings assumes that costs are not shifted elsewhere. Savings to providers or insurers are not savings to consumers unless passed back as lower prices and/or lower premiums. We assume here that savings would come as a reduction in the rate of growth in health spending, but note that if those savings are retained by insurers or providers as income, they would not represent a net reduction in health spending and premiums.

Conclusions

Health care costs nationwide and in Missouri continue to escalate and squeeze government, employers, and households. In the wake of sizable state budget deficits, rising health insurance premiums and expanding public insurance enrollment, it is important to start addressing health care costs now. Federal health care reform will further increase the number of Missourians accessing the health care system, increasing cost pressures and the need to find more efficient, higher value approaches to health care delivery.

This report shows Missouri has the ability to trim health care cost growth by billions of dollars using a wide range of policy options available to the state. Implementing these changes would slow spending growth in Missouri without destabilizing the foundations of the delivery system. Rather, each scenario would improve the manner in which care is delivered or structured, resulting in a more efficient, integrated, patient-centered, and quality-oriented system.