Iowa Department of Human Services

Managed Care Savings Summary

Executive Summary

In January 2018, the Department of Human Services (DHS) notified stakeholders that we would be developing a more comprehensive methodology to calculate managed care savings, or 'cost avoidance.' This summary provides an overview of the projected savings for Iowa's managed care program.

Background—Unsustainable Growth

Prior to the implementation of managed care, the cost of the Medicaid program was growing at an unsustainable rate with an average annual growth of 5%.[1] Meanwhile, the average annual growth of state revenue was 3.98%.

- Over the course of ten years (2005 to 2015) the total spend (including federal dollars) for the old Medicaid system, nearly doubled, from **$2.5 billion in 2005** to **$4.9 billion in 2015**.
- In state dollars, the state general fund appropriation increased from **$423 million in 2005 to $1.31 billion in 2015**. The SFY2019 state general fund appropriation is $1.34 billion. (This represents an increase from 9% of the state budget to 19%.)

	Total Spend (state + federal)	State Appropriations (general fund)	Percent of State Budget
2005	$2.5 billion	$423 million	9%
2015	$4.9 billion	$1.31 billion	19%
2019[2]	$5.3 billion	$1.34 billion	18%

Table A: Annual growth rate of Iowa Medicaid program.

The three primary goals of Medicaid Modernization are:

- Improving quality and access to care
- Promoting accountability for patient outcomes
- Creating a more predictable and **sustainable** Medicaid budget

Ensuring we are able to serve Iowa's most vulnerable, now and into the future, requires having a predictable and sustainable budget.

[1] The annual growth, excluding expansion years, was as high as 8.4% (2009). The growth of the program during Medicaid expansion was 9.8% (2014) and 17.3% (2015). **Note**: the growth attributable to Medicaid expansion was **not** included in the 5% average growth figure.

[2] Projections based on 2019 Governor's recommendations

Analysis

The Department's managed care savings analysis compares total projected Medicaid program spending under the current payment model (With MCO) to the estimate of what spending would have been for the same period under the previous Medicaid payment model (Without MCO).

- SFY 2018 Projected Cost (FFS): $5,595,697,354
- SFY 2018 Estimated Annual Cost (Managed Care): $5,184,248,970
- SFY 2018 Difference: $411,448,384
  - Applying the average state match rate (34.25%) results in a projected cost avoidance of **$140.9m**.

		SFY16	SFY17	SFY18
Base "Without MCO" Trend		5.0%	5.0%	5.0%
Cost Containment Adj.		0.0%	0.0%	-2.1%
Revised "Without MCO" Trend		5.0%	5.0%	2.9%
	SFY15	SFY16	SFY17	SFY18
Without MCO	4,936,488,051	5,181,578,396	5,438,837,165	5,595,697,354
With MCO			5,070,561,872	5,184,248,970
Total Savings			368,275,293	411,448,384
State Share			133,217,292	140,939,522

Table B: Cost avoidance calculation comparing the Iowa Medicaid program with and without managed care.

The $140.9m for SFY18 combined with the $133.2m for SFY17 results in more than **$274m** of projected savings.

Methodologies

The annual cost of the Medicaid program is determined by considering total expenditures, including both state and federal dollars.

The projected costs were calculated by looking at a five year period and averaging the growth of the program year-over-year. The actual average annual growth was 5%.

- Under the old system, annual growth, excluding expansion years, was as high as 8.4% (2009). The growth of the program during Medicaid expansion was 9.8% (2014) and 17.3% (2015). The growth attributable to Medicaid expansion was **not** included in the 5% average growth figure.

I. 'Without MCO' Methodology

Base Expenditures

- SFY15 was used as the base expenditure period since it was the last complete year under the previous Medicaid payment model.
- An adjustment was made to base expenditures to include the SFY15 University of Iowa physician upper payment limit (UPL) payment that was not paid until SFY16.

- This UPL payment is included in the “With MCO” expenditure totals. For consistency, it also needed to be included in the “Without MCO” totals.

Expenditure Trend

- SFY15 base period expenditures were trended to SFY18 using a 5 % annual trend rate.
- The trend rate is based on actual Medicaid program trends from SFY11 - SFY15.
- Iowa Health and Wellness Plan expenditures were excluded from the trend calculation as this one-time program expansion is outside of normal trend factors.
- Adjustments were made to the SFY18 trend rate to account for cost containment strategies implemented in that fiscal year.
    - For consistency, the department assumed the cost containment strategies implemented in SFY18 for the current program would have also been implemented under the previous payment model.

II. ‘With MCO’ Methodology

SFY17

- Base expenditures represent final SFY17 expenditures as recorded in the state’s accounting system.
- Adjustments were made to account for SFY17 managed care payment obligations that will not be paid until a future period. This included emerging trend capitation rate adjustments, withhold payments, risk corridor payments, and the health insurer fee reconciliation.

SFY18

- Base expenditures represent the December 2017 estimate of total SFY18 Medicaid program spending.
- Adjustments were made to remove SFY16 and SFY17 managed care payment obligations that will be paid in SFY18.
- Adjustments were made to account for SFY18 managed care payment obligations that will not be paid until a future period. These adjustments are similar to those made in SFY17.

III. Savings Calculation

Total Savings

- Total savings were calculated as the difference between the “Without MCO” (Section I.) expenditure estimate and the “With MCO” (Section II.) expenditure estimate.

State Savings

- State savings were calculated by multiplying total savings by the average state match rate for the applicable fiscal year. The average state match rate

was 36.17 percent in SFY17. The average state match rate is estimated at 34.25 percent in SFY18.

Assumptions

There are many factors which are both unpredictable and fluid that make the calculation of “projected costs” difficult as you consider whether those same factors would have applied, in the same way, in the old model as they do under managed care. Some of those factors are included in Table C. For example, new hemophilia medications have been introduced and are now covered through managed care. These medications have added significant cost to the program. However, these new medications would have increased the cost of the old program as well. This updated methodology does not individually isolate these factors; instead it aims to account for them by looking at total cost.

Factors Considered	
Program Trends	Include, but are not limited to: enrollment trends, new technology and introduction of new pharmaceuticals. Not only are these trends fluid, but some are impacted by managed care in a way that would not have been applicable in a fee for service model.
Cost Containment	Include legislatively mandated changes to the program that impact cost (this is a responsibility of the DHS Council spelled out in Iowa Code).
Risk Corridors	A period of 2-3 years is required to determine payout or recoupment under a risk corridor.
Health Insurance Fee	This fee is an obligation determined by the federal government; while Iowa insurers are required to pay the fee in 2019, it is not required in 2020. This alone has an impact of about $20 million.
Health and Wellness Population	The expansion of Medicaid to the health and wellness population resulted in significant, one-time growth in the Medicaid program.
Administrative Costs	The savings calculation includes administrative costs paid to the MCOs for case management services that were previously not provided.
FMAP	One of the reasons for using *total funds*, rather than state general funds, is the every-changing **Federal Medical Assistance Percentage (FMAP)**; the FMAP is calculated by the federal government and changes on an annual basis based upon each states average per capita income. As a state’s per capita income increases, their FMAP will be adversely impacted. FMAP has varied by more than two percentage points in recent years.

Table C: Factors considered when calculating managed care cost avoidance.