

State Health Reform Assistance Network

Charting the Road to Coverage

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Medicaid at a Crossroads: What's at Stake for the Nation's Largest Health Insurer

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Since its inception 50 years ago, Medicaid has evolved from a small welfare program into an integral part of the nation's health insurance system, now covering more than one in five low-income children and adults. As Medicaid coverage has expanded and stabilized, states are making strides to improve the cost and quality of the care provided to Medicaid enrollees. And, because Medicaid is the single largest payer in every state, governors are using Medicaid to drive multi-payer reforms, including adoption of value-based payment methodologies and advancement of population health models. In short, Medicaid is an efficient and effective payer and a leader in efforts to improve the quality and efficiency of the nation's health care system.

As Congress and the new administration consider proposals to repeal the Affordable Care Act's (ACA) Medicaid expansion and implement limits on federal Medicaid funding through block grants and per capita caps, it is timely to consider how much states have accomplished to drive value in and through their Medicaid programs over the last 50 years, and most especially over the last five years, and what states stand to lose in terms of progress and innovation in their Medicaid programs and health care delivery systems if federal support for Medicaid is reduced.

Medicaid in context

Today, Medicaid is the nation's largest insurer and the single largest payer in every state, covering more than 20 percent of the total U.S. population.¹ Medicaid is managed by states under overarching federal rules and financed through state funding matched by the federal government at 63 percent on average.² Since 2014, more than 14.5 million people gained coverage in the 31 Medicaid expansion states and the District of Columbia,³ including 11.2 million newly eligible adults. Enrollment and retention of Medicaid-eligible individuals in coverage is enabled by ACA reforms that streamlined eligibility and enrollment processes and by federal investments that allowed states to upgrade their eligibility and enrollment systems and integrate with marketplace coverage.⁴

While there is no doubt that Medicaid stands alongside Medicare and private coverage as an essential part of the health insurance foundation in the U.S., Medicaid is unique. It covers the nation's lowest income and most medically-complex children and adults and the services they require. For example, Medicaid is the largest source of funding nationwide for:

- Mental health services⁵;

ABOUT STATE NETWORK

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- Substance use disorder (SUD) services⁶;
- Long-term services and supports, including both nursing home services and home and community-based care⁷; and
- Maternity care.⁸

Children make up 43 percent of all Medicaid enrollees, but account for just 19 percent of Medicaid spending. Conversely, disabled and elderly people in Medicaid, who constitute 21 percent of all enrollees, generate 48 percent of Medicaid spending (see Figure 1).⁹ In fact, one-third of all Medicaid spending is on low-income individuals who are dually enrolled in Medicaid and Medicare.¹⁰

Despite serving disproportionate numbers of complex patients, Medicaid provides care more efficiently than private insurers and the national health care marketplace overall. For example, Medicaid administrative costs are low, constituting only five percent of total Medicaid spending.¹¹ That compares favorably with commercial insurance where administrative costs are estimated to be 17 percent of revenue.¹² Additionally, from 2000 to 2010, Medicaid spending per enrollee grew only five percent on average compared to 39 percent growth in per capita national health expenditures for the same time period.¹³ Further, Medicaid spending generally has grown more slowly per capita than private insurance and Medicare and is projected to continue doing so through 2023 (see Figure 2).¹⁴

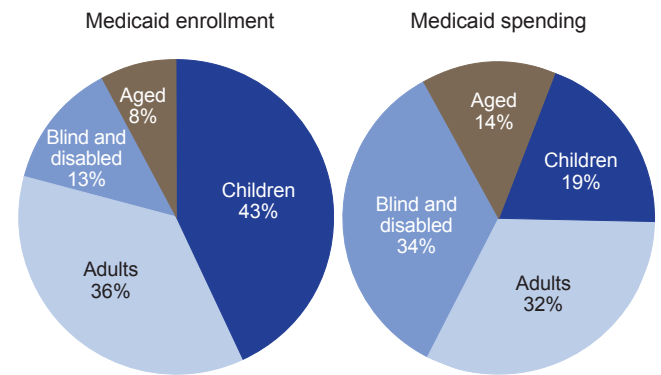
Finally, Medicaid enrollees are generally satisfied with their care and rate it highly. Individuals enrolled in Medicaid get recommended preventive services such as blood pressure and cholesterol checks and are able to access primary care at rates similar to individuals with private coverage.¹⁵ However, Medicaid's historically low reimbursement rates and the relatively long time it takes doctors to receive Medicaid reimbursements have created some barriers to access, particularly for patients seeking timely access to specialists.¹⁶ Given that lack of timely specialty care can result in serious health consequences, as well as potentially higher costs from avoidable emergency department visits and inpatient admissions, states continue to seek solutions to address this challenge. For instance, Indiana—by raising its cigarette tax—increased Medicaid reimbursement rates to incentivize more providers to accept Medicaid. As a result, an additional 335 doctors and more than 600 nurse practitioners and physician assistants began accepting Medicaid patients.¹⁷ Thirteen other states, including New Jersey and Alaska, reported plans to adopt increased Medicaid reimbursement rates for specialists in FY 2016.¹⁸

Given the number of people that Medicaid covers, the increased ability for Medicaid to assure continuous coverage (particularly in those states that have expanded) and Medicaid's responsibility for low-income and high-need individuals of all ages, governors have increasingly sought to leverage Medicaid's power to purchase cost-effective, quality care; improve population health; and drive system-wide reform—assuring that these individuals obtain essential health care in the right setting and at the right price. The benefits flow to all Medicaid stakeholders including federal and state taxpayers, providers, plans, and consumers.

Medicaid as strategic purchaser

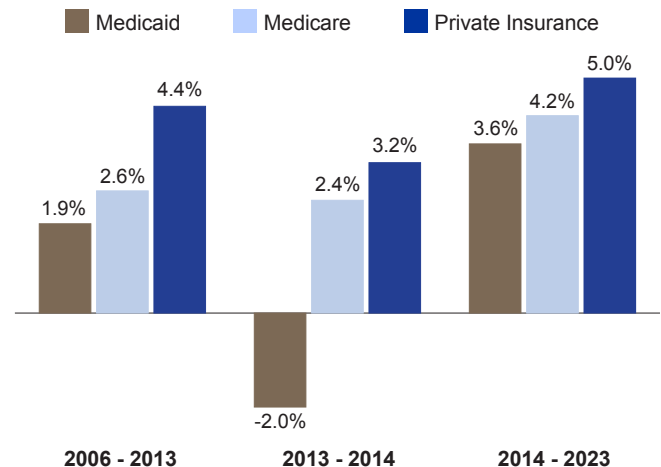
Medicaid modernization and reform is occurring in every state. For states that have expanded Medicaid, the pace of reform is especially significant. If coverage is the foundation of reform (and continuous coverage the gold standard), then Medicaid's ability to cover all low-income adults with incomes below 138 percent of the Federal Poverty Level (FPL) is a game changer. Among those covered through the Medicaid expansion are adults who face the highest disease burden and generate the most significant financial and public health costs to states—the homeless, those with serious mental illnesses, and victims of the opioid epidemic, among others. Expansion states are developing innovative programs to address the needs of these especially

Figure 1. Enrollment and Spending in Medicaid



Source: Spending and enrollment estimates for FY2015 from the Congressional Budget Office's March 2016 Medicaid baseline. Figures may not sum to 100 percent due to rounding.

Figure 2. Average Annual Growth in Per Enrollee Spending



challenging populations (see Spotlight on Medicaid’s Role in Fighting the Opioid Epidemic), while at the same time increasing access to primary and preventive care for all Medicaid enrollees. The immediate impact has been dramatic. In fiscal year 2014 alone, Ohio saved more than \$10 million on inpatient care for inmates.¹⁹ In Arkansas and Kentucky, expansion has been associated with a decreased reliance on the emergency department as a usual source of care, an increased likelihood of having a personal physician, fewer delays obtaining care, fewer skipped prescriptions, and reduced out-of-pocket spending on health care, among other benefits to low-income families.²⁰

Again, while expansion states are especially well-positioned to lead multi-payer reforms, all states are reforming their Medicaid programs and working across payers. The federal government has been a critical partner to states in funding those efforts.

Through Section 1115 Delivery System Reform Incentive Payment (DSRIP) waivers, the federal government has provided billions of dollars to states and providers that meet quality and cost metrics and invest in transformation of their Medicaid delivery systems.²¹ The funds are a time-limited investment; state Medicaid agencies must ensure transition to value-based payment policies to ensure long-term sustainability of system improvements. And importantly, states must demonstrate that the federal investment will generate at least an equal amount of federal savings (i.e., the investment must be budget neutral). Additionally, through the State Innovation Model (SIM) initiative, the federal government has provided states with funding and technical assistance to develop and test multi-payer health care payment and service delivery models “to improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) beneficiaries—and for all residents of participating states.”²²

SIM and DSRIP are two examples of targeted federal investment in states’ efforts to reform their health care payment and delivery systems in and beyond Medicaid. Beyond these targeted investments, day-to-day transformation activities in state Medicaid programs—again undertaken in partnership with the federal government—are driving the incremental and long-term evolution of Medicaid as a sophisticated and value-based purchaser. Governors on both sides of the aisle—seeking to lower health care costs while improving access, quality, and overall health of their residents—recognize the value of flexible, state-tailored solutions developed through these new health care transformation models.²³ The literature is replete with examples of state innovations.²⁴

ADVANCING VALUE-BASED PAYMENTS AND MULTI-PAYER ALIGNMENT

Medicaid was late coming to the payment reform table, impeded by its roots in the welfare system, complicated eligibility rules which caused individuals to churn on and off of coverage, antiquated information systems coupled with limited to no data capacity, and perennially tight budgets that left little room for investment in infrastructure to support innovation. Indeed, until recently, Medicaid’s cost containment strategies too often involved reducing eligibility levels, cutting benefits, and slashing provider reimbursement.²⁵ While it has taken decades, today, Medicaid has a seat at every payment reform table—often at the head of the table.

Medicaid is driving value by using alternative payment methodologies to vest providers with accountability for the quality and the cost of the care they provide. New Medicaid payment methods are wide-ranging and include: 1) enhanced payments to providers that meet patient centered medical home (PCMH) standards; 2) bundled payments that hold providers accountable for episodes of care; and 3) total cost of care-based payment models that give providers responsibility for managing Medicaid patients’ overall cost and quality of care.²⁶ Other payment and delivery models target the highest risk, most medically-needy patients through capitated payment to health homes that take on care coordination.²⁷ In some cases, states are extending these payment innovations to all payers. For example, in both Montana and Arkansas, Medicaid and commercial payers offer enhanced rates for providers meeting PCMH standards. As Medicaid has evolved into a strong health insurer, it has become a laboratory for testing a wide range of payment models. These experiments are now being scaled and generating state and federal savings, improving patient satisfaction, and contributing to improved health outcomes.

SPOTLIGHT ON MEDICAID’S ROLE IN FIGHTING THE OPIOID EPIDEMIC

The U.S. is in the midst of an unprecedented opioid epidemic. In 2014, 1.9 million Americans had an opioid use disorder involving prescription medication. State Medicaid agencies have been at the forefront of efforts to combat this devastating and far-reaching epidemic. For example, New Jersey is using savings generated in connection with its Medicaid expansion to increase payment rates to SUD providers as part of an effort to increase access to SUD treatment. Maryland, Rhode Island, and Vermont have Medicaid health homes targeting individuals with opioid dependence, while California is requiring counties to assure coordination across levels of SUD care as part of its 1115 waiver. Several states—Kentucky, Massachusetts, Maryland, Ohio, and West Virginia—have promoted the use of Medication Assisted Treatment (MAT) in the context of their Medicaid expansions to address the opioid overdose crisis. As a result, Medicaid pays for between 35 percent and 50 percent of all MAT in those states.

FEDERAL INVESTMENTS IN MEDICAID TRANSFORMATION

To date, 12 states (including two states with “DSRIP-like” programs) have received over \$37 billion to implement DSRIP programs, and 35 states and Washington, D.C. were awarded more than \$960 million in Round One and Round Two SIM grants. With the exception of Alabama and Kansas, all states that received DSRIP funding also received SIM grants.

TACKLING SERIOUS MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

The imperative to improve access to and quality of mental health and SUD services is a national one, and cuts across all payers—private and public. As the single largest payer of behavioral health services in the U.S., covering more than one-quarter of behavioral health services, Medicaid faces a particularly urgent challenge. In 2011, the approximately 20 percent of Medicaid beneficiaries with a behavioral health diagnosis drove almost half of total Medicaid expenditures (for all service use, not only for behavioral health services).²⁸ Spending for those with a behavioral health diagnosis is nearly four times higher than for those without.²⁹

State Medicaid programs are generating tremendous innovation in using evidence-based practices and payment methods to improve the care, costs, and outcomes for those with serious mental illness and SUDs. Today, state Medicaid agencies are driving consolidation, integration, and coordination at the agency, health plan, and provider levels to identify patients at-risk for SUDs and provide them with comprehensive care management and community-based treatment and recovery services. In just the past two years, Arizona has merged its behavioral health agency into its Medicaid agency, created a fully-integrated managed care plan for individuals with serious mental illness, and increased payments to providers offering integrated care.³⁰ Florida likewise created a specialized managed care plan for those with serious mental illness, and Kansas and Texas carved behavioral health services into their comprehensive managed care programs.³¹ And New Hampshire, with the support of DSRIP funding, is establishing integrated delivery networks of physical health, behavioral health, and social services providers (see New Hampshire's DSRIP).³² Finally, 19 states have established behavioral health “health homes” that facilitate coordination and care across providers and community organizations.³³

Notably, state Medicaid agencies have been at the forefront of efforts to address the opioid epidemic—directly affecting 1.9 million Americans with an opioid use disorder involving a prescription medication and millions more who experience an SUD outside of prescription opioids.³⁴ New York and Massachusetts are among the states using DSRIP waivers to test new models to fight opioid addiction. New Jersey is using its waiver to expand access to Medication Assisted Treatment (MAT) (evidence-based substance use treatment), while California is requiring counties to assure coordination across levels of SUD care. Several states—Kentucky, Massachusetts, Maryland, Ohio, and West Virginia—have promoted the use of MAT in the context of their Medicaid expansions to address the opioid overdose crisis. As a result, Medicaid pays for between 35 percent and 50 percent of all MAT in those states.³⁵ Additionally, state Medicaid programs are implementing strategies to improve access to naloxone (a drug that reverses the effects of an opioid overdose). For example, New Mexico's Medicaid agency reimburses individuals at risk of an opioid overdose for naloxone rescue kits, and California and New York include all injectable forms of naloxone on their Medicaid Preferred Drug Lists.³⁶ To support state efforts to address the opioid epidemic, the Centers for Medicare & Medicaid Services (CMS) has not only approved waivers and provided matched funding, but also has provided technical assistance through the Medicaid Innovation Accelerator Program (IAP).³⁷

LONG-TERM SERVICES AND SUPPORTS

Medicaid is the largest payer for long-term services and supports (LTSS), accounting for more than half of the \$300-plus billion spent on LTSS nationwide annually.³⁸ Americans who rely on these services range from the frail elderly to medically-complex children to physically and developmentally disabled people of all ages. Many are eligible for both Medicare and Medicaid—but it is Medicaid that is the primary funder of LTSS services. Moreover, while people who use LTSS are a small share of Medicaid enrollees (about six percent), their service use accounts for approximately one-third of total Medicaid expenditures.³⁹ Given Medicaid's significant role in covering care for LTSS users—a role that is likely to grow with a rapidly-aging population and advancing medical technologies—Medicaid is developing new payment and delivery strategies to deliver cost-effective and high-quality services to these children, elderly, and disabled individuals whose needs and costs are equally demanding.

Increasingly, Medicaid spending on LTSS has moved out of nursing homes and other institutional settings and into the community, reflecting the preference of people receiving LTSS (as well as legal mandates) to age at home and receive care in the least restrictive setting possible. Today, virtually every state is providing Home and Community-Based Services through its Medicaid program, often with enhanced federal matching dollars made available through the ACA. To ensure that these services are integrated into comprehensive care models, 19 states have implemented managed long-term care programs.⁴⁰ These and other states also are integrating care for dually-eligible beneficiaries through Medicare Advantage Dual Eligible Special Needs Plans

NEW HAMPSHIRE'S DSRIP

In January 2016, New Hampshire was awarded \$150 million over five years for its 1115 DSRIP waiver targeted at transforming the state's delivery system for Medicaid beneficiaries with mental health and substance use disorders. Through networks of regionally-based, integrated providers, the state is implementing projects to strengthen community-based mental health services and combat the opioid crisis.

“We have spent a billion dollars on [Ohio's opiate and heroin epidemic]. A billion dollars...thank God we expanded Medicaid, because that Medicaid money is helping to rehab people.”

- Ohio Governor John Kasich's remarks at the signing of Ohio Senate Bill 319 on January 4, 2017.

(D-SNP) (Arizona, New Jersey, and Tennessee) and through the Financial Alignment Initiative (California, Texas, Massachusetts, New York, and Virginia). Finally, several states, including Tennessee and Minnesota, have implemented alternative payment methodologies for LTSS.⁴¹

INTEGRATING INTERVENTIONS THAT ADDRESS THE SOCIAL DETERMINANTS OF HEALTH

Extensive research demonstrates the impact of social factors—such as income, access to food and housing, and employment status—on the health and health outcomes of Americans, particularly lower-income populations. In fact, nonmedical factors account for as much as 40 percent of health outcomes, and 80 percent of physicians believe that addressing social needs is as critical to improving patients' health and outcomes as addressing their medical conditions.⁴² Given the compelling data, many Medicaid directors are looking to implement strategies to integrate social interventions into their coverage, delivery, and payment models (see State Strategies to Integrate Social Services and Health Care Delivery).⁴³ States have significant flexibility under Medicaid law and regulations⁴⁴ and are taking full advantage to assure that their Medicaid spending is targeted to the services—both medical and social—that have been shown to influence patient health and health outcomes, while also achieving cost-savings for states' Medicaid programs as a result of reduced emergency department use, inpatient admissions, and readmissions.⁴⁵

For example, Oregon has employed a joint accountability approach to improve population health by aligning goals across its health and education systems (e.g., kindergarten readiness) and promoting cross-sector leadership.⁴⁶ To support this approach, the state makes monthly capitation payments to regional Coordinated Care Organizations (CCOs) that are authorized and expected to deploy those funds to address social factors that impact the health of their Medicaid enrollees. Multiple states are implementing health homes to provide care coordination and linkages to social and community supports to address non-clinical needs that influence health.

Early reports show financial savings as a result of health home implementation; in Missouri, health homes decreased both hospital admissions and emergency room use and saved nearly \$1,000 per member in total Medicaid costs, while in New York, utilization and spending on inpatient services decreased approximately 30 percent for a subset of health home enrollees.⁴⁷ Importantly, the ACA incentivized health home development by providing enhanced matching to states for all health home services in the first eight fiscal quarters of a state's health home implementation.⁴⁸

EMBRACING MEDICAID MANAGED CARE

Managed care is the dominant delivery model in state Medicaid programs. Across 38 states and Washington, D.C., approximately three in five Medicaid beneficiaries are enrolled in comprehensive managed care organizations. Nine of the 12 remaining states without comprehensive managed care programs operate primary care case management (PCCM) systems, through which Medicaid beneficiaries receive coordinated primary care. The shift to managed care has accelerated rapidly—from 2013 to 2014 alone, enrollment increased 24 percent.⁴⁹

States are using their managed care plans to advance their purchasing goals, requiring plans to use value-based payment methodologies with network providers and participate in multi-payer reforms, enrolling the most complex populations in plans, and moving most or all Medicaid benefits under plan management to achieve integration and better management of total cost of care. For example, Ohio requires plans to submit to a strategy for ensuring that 50 percent of their payments to providers are value-oriented by 2020 (see Ohio's Use of Managed Care to Drive to Value-Oriented Payments).⁵⁰ New York is requiring that at least 80 percent of plan payments be made through value-based payments by 2020.⁵¹ Texas requires its plans, in collaboration with network physicians and hospitals, to conduct gain-sharing pilots aimed at reducing inappropriate inpatient admissions and readmissions.⁵² The recently overhauled Medicaid managed care final regulations issued in April 2016 track and reinforce these trends by promoting value-based purchasing in states' Medicaid managed care quality strategies, states' payments to managed care plans, and managed care plans' payments to network providers.⁵³

STATE STRATEGIES TO INTEGRATE SOCIAL SERVICES AND HEALTH CARE DELIVERY

1. Shared Governance
2. Financing and Payment Models
3. Integrated Assessments and Care Teams
4. Data Linkages
5. Procurement and Grant Funding Efforts
6. Performance and Quality Metrics

OHIO'S USE OF MANAGED CARE TO DRIVE TO VALUE-ORIENTED PAYMENTS

Ohio requires its managed care plans to ensure that 50 percent of its payments to providers are "value-oriented" by 2020. Value-oriented payments are defined as payments designed to cut waste by reducing unnecessary payment and care or reflect value by tying payment to provider performance on the quality and cost of care.

Medicaid in the future

Within and beyond the areas discussed above, Medicaid is now a recognized leader in efforts to reform the nation's health care system, continuously working to improve coverage, access, payment, and delivery of care. The foundation for these reforms is stable coverage, which provides an opportunity for states to build on existing reforms and adopt innovations that other states have successfully tested and deployed. The examples here scratch the surface of the innovations that are being actively advanced by states today to ensure that Medicaid dollars are being spent wisely on cost-effective, quality care that is improving the health of the nation's most vulnerable residents and the communities in which they reside. The progress has taken decades, and has been significantly accelerated by federal financial support through Medicaid's federal matching policies—using enhanced match to enable and incentivize coverage expansions, systems upgrades, and new delivery models—and through the federal commitment to fund delivery system transformation in the last decade. This progress also has been enhanced by the federal government's commitment to supporting cross-state learning collaboratives and other technical assistance to ensure that all states are aware of the activities and best practices occurring in other states.

Medicaid's progress is intertwined with its critical place in the health care system. If the federal government pulls back its support for Medicaid by withholding funds for coverage expansions or reducing and limiting federal funding regardless of enrollment and costs, states will have no choice but to resort to the same detrimental cost-cutting strategies that were common before the ACA—cutting eligibility, benefits, or both, and slashing rates to providers and plans. Gains in coverage, access, and quality along with the cost-savings will dissipate. And, without sufficient funding to cover the basic health care needs of their residents, states will be unable to invest in the infrastructure and system improvements that have made Medicaid an efficient and effective health insurer. These impacts will be felt beyond Medicaid; they will ripple through the nation's health care delivery system writ large.

Endnotes

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- ²² The following states and the District of Columbia received SIM grants: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Idaho, Illinois, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin (See State Innovation Models Initiative: General Information, <https://innovation.cms.gov/initiatives/state-innovations>).
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- ²⁶ In state fiscal year 2016, 29 states served at least some of their Medicaid beneficiaries through PCMH: Alabama, Arkansas, Colorado, Connecticut, Florida, Idaho, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Wisconsin and Wyoming (Kaiser Family Foundation. "States that Reported Expanding Patient Centered Medical Homes." <http://kff.org/medicaid/state-indicator/states-that-reported-expanding-patient-centered-medical-homes/?currentTimeframe=0>). As of April 2016, Arkansas, Ohio, and Tennessee had begun to implement bundled episode-of-care payments, New York was actively developing a state-wide program, and Connecticut, Oklahoma, and South Carolina were considering implementation of such a model (National Association of Medicaid Directors and Bailit Health, 2016). Other states are implementing population-based payment models, including California, Colorado, Maine, Massachusetts, Minnesota, Oklahoma, Oregon, Rhode Island, and Vermont. Among these states, Colorado, Oklahoma, and Oregon have adopted full-risk capitation models (National Association of Medicaid Directors and Bailit Health, 2016).
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