Medicaid Landscape

Council of State Governments
Medicaid Leadership Academy
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The basic foundations of Medicaid are related to the entitlement and the federal-state partnership.

**Entitlement**
- **Eligible Individuals** are entitled to a defined set of benefits
- **States** are entitled to federal matching funds

**Federal**
- Sets core requirements on eligibility and benefits

**State**
- Flexibility to administer the program within federal guidelines

**Partnership**
Figure 2

Medicaid plays a central role in our health care system.

- **Health Insurance Coverage**
  - For 1 in 5 Americans

- **Assistance to 10 million Medicare Beneficiaries**

- **> 50% Long-Term Care Financing**

- **Support for Health Care System and Safety-Net**

- **State Capacity to Address Health Challenges**
Figure 3

Medicaid spending is mostly for the elderly and people with disabilities, FY 2014.

Enrollees
Total = 80.7 Million

Expenditures
Total = $462.8 Billion

NOTE: Totals may not sum to 100% due to rounding.
SOURCE: KFF estimates based on analysis of data from the FFY2014 Medicaid Statistical Information System (MSIS) and CMS-64 reports. Because FFY2014 data was missing some or all quarters for some states, we adjusted the data using secondary data to represent a full fiscal year of enrollment.
Figure 4

Medicaid per enrollee spending is significantly greater for the elderly and individuals with disabilities compared to children and adults.

NOTE: Rounded to nearest $100. Spending may not sum to totals due to rounding.
SOURCE: Kaiser Family Foundation and Urban Institute estimates based on data from FY 2013 MSIS and CMS-64 reports. Due to lack of data, does not include CO, KS, NC, or RI.
Medicaid spending and enrollment growth has slowed after peaks in 2015 due to implementation of the ACA.

Annual Percentage Changes, FY 1998 – FY 2017

- Total Medicaid Spending
- Medicaid Enrollment


NOTE: For FY 1998-2013, enrollment percentage changes are from June to June of each year. FY 2014-2017 reflects growth in average monthly enrollment. Spending growth percentages refer to state fiscal year.

SOURCE: Enrollment growth rates for FY 1998-2013 are as reported in Medicaid Enrollment June 2013 Data Snapshot, KCMU, January 2014. FY 2014-2017 are based on Kaiser Family Foundation (KFF) analysis of CMS, Medicaid & CHIP Monthly Applications, Eligibility Determinations, and Enrollment Reports, accessed September 2017. Historic Medicaid spending growth rates are derived from KFF Analysis of CMS Form 64 Data. FY 2017 data are derived from the KFF survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2017.
For FY 2018, states project that a number of factors will contribute to slowing Medicaid enrollment growth and an uptick in spending growth.

**Slowing Enrollment Growth**
- Stable economy
- Tapering of ACA-related enrollment
- Processing delayed eligibility re-determinations

**Uptick in Spending Growth**
- Targeted provider rate increases
- Rising Rx costs
- Rising long-term care costs

SOURCE: Kaiser Family Foundation survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2017.
Figure 7

Medicaid is a budget item and a revenue item in state budgets.

- Total State Spending (State & Federal Funds): $1.98 Trillion
  - Medicaid: 51.7%
  - Elementary & Secondary Education: 19.6%
  - Other: 28.7%

- State Funds (General & Other Funds): $1.25 Trillion
  - Medicaid: 59.1%
  - Elementary & Secondary Education: 25.3%
  - Other: 15.6%

- Federal Funds: $600.4 Billion
  - Medicaid: 33.7%
  - Elementary & Secondary Education: 8.6%
  - Other: 57.7%

SOURCE: Kaiser Family Foundation estimates based on the NASBO’s November 2017 State Expenditure Report (data for Actual FY 2016.)
Figure 8

Nationally, Medicaid is comparable to private insurance for access to care – the uninsured fare far less well.

Children

<table>
<thead>
<tr>
<th>Usual Source of Care</th>
<th>Well-Child Checkup</th>
<th>Specialist Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid/Other Public</td>
<td>95%</td>
<td>85%</td>
</tr>
<tr>
<td>ESI/Other Private</td>
<td>97%</td>
<td>87%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>73%</td>
<td>57%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Usual Source of Care</th>
<th>Specialist Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid/Other Public</td>
<td>14%</td>
</tr>
<tr>
<td>ESI/Other Private</td>
<td>17%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>7%</td>
</tr>
</tbody>
</table>

Nonelderly Adults

<table>
<thead>
<tr>
<th>Usual Source of Care</th>
<th>General Doctor Visit</th>
<th>Specialist Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid/Other Public</td>
<td>88%</td>
<td>72%</td>
</tr>
<tr>
<td>ESI/Other Private</td>
<td>88%</td>
<td>70%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>51%</td>
<td>37%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Usual Source of Care</th>
<th>Specialist Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid/Other Public</td>
<td>29%</td>
</tr>
<tr>
<td>ESI/Other Private</td>
<td>24%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>8%</td>
</tr>
</tbody>
</table>

NOTES: Access measures reflect experience in past 12 months. Respondents who said usual source of care was the emergency room are not counted as having a usual source of care. All estimates are statistically significant from the uninsured group (p<0.05).

SOURCE: Kaiser Family Foundation analysis of the 2016 National Health Interview Survey.
NOTES: Current status for each state is based on KFF tracking and analysis of state activity. *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 expansion waivers. KY’s traditional expansion continues while its expansion waiver is pending with CMS after having been invalidated by a court in June, 2018. UT passed a law directing the state to seek CMS approval to partially expand Medicaid to 100% FPL using the ACA enhanced match, and UT also has a measure on the ballot in November to fully expand to 138% FPL. ID and NE have Medicaid expansion measures on their November 2018 ballots. Expansion is adopted but not yet implemented in VA and ME. (See the link below for more detailed state-specific notes.)

Evidence of the impact of the Medicaid expansion is growing.

- Greater Access to Care
- Improved Self-Reported Health
- Reduced Medical Debt
- Greater Financial Security
- Increased Utilization of Care
- Improved Affordability of Care
Studies show that Medicaid expansion has positive economic effects.

**Figure 11**

- **Federal + State Funds**
- **State Savings**
  - Uncompensated care costs
  - State-funded health programs (e.g. behavioral health and corrections)

- **Increased Economic Activity**
  - General fund revenue and GDP
  - Jobs

States have considerable flexibility under current law to design their Medicaid programs.
Figure 13

Behavioral health and substance use disorder treatment were the most commonly reported benefit enhancements.

**Benefit Enhancements**
- FY 2017: 26 states
- FY 2018: 17 states
  - Most common: BH / SUD services, dental, alternative pain therapies, and telehealth

**Benefit Restrictions**
- FY 2017: 6 states
- FY 2018: 5 states
  - Most common: dental and NEMT

SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2017.
States are newly implementing or expanding pharmacy cost-containment and strategies to address the opioid epidemic.

**Pharmacy Cost-Containment Actions**

Many states reported:

- Utilization controls
- Initiatives to generate greater rebate revenue
- Provider education or profiling initiatives

**Opioid Policies**

Many states reported:

- Adoption of CDC prescribing guidelines
- Adopting pharmacy benefit management strategies (e.g., quantity limits, use of prior authorization)
- Coverage of medication-assisted treatment (MAT) drugs

SOURCE: KFF Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2017.
In 29 states, at least 75% of all Medicaid beneficiaries are in an MCO.

NOTES: Limited to 39 states with MCOs in place on July 1, 2017. Of the 32 states that had implemented the ACA Medicaid expansion as of July 1, 2017, 27 had MCOs in operation.
SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2017.
States are using MCOs to improve quality and incentivize better outcomes.

![Bar Chart]

**Figure 16**

Any Select Quality Initiatives

<table>
<thead>
<tr>
<th>In Place in 2017</th>
<th>New/Expanded in FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>37</td>
<td>11</td>
</tr>
</tbody>
</table>

Pay for Performance

<table>
<thead>
<tr>
<th>In Place in 2017</th>
<th>New/Expanded in FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>5</td>
</tr>
</tbody>
</table>

Capitation Withhold or Penalty

<table>
<thead>
<tr>
<th>In Place in 2017</th>
<th>New/Expanded in FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>5</td>
</tr>
</tbody>
</table>

Required Data Collection and Reporting

<table>
<thead>
<tr>
<th>In Place in 2017</th>
<th>New/Expanded in FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>8</td>
</tr>
</tbody>
</table>

NOTES: States with MCOs indicated if selected quality initiatives were in place in FY 2017, new or expanded in FY 2018.

SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2017.
Figure 17
Medicaid MCOs using different alternative payment models (APMs).

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any APM</td>
<td>98%</td>
</tr>
<tr>
<td>Incentive/Bonus Payments (P4P)</td>
<td>93%</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>61%</td>
</tr>
<tr>
<td>Global or Capitated Payments to PCPs or IHSs</td>
<td>50%</td>
</tr>
<tr>
<td>Shared Savings and Shared Risk</td>
<td>44%</td>
</tr>
<tr>
<td>Non or Reduced Payment for Patient Safety Issues</td>
<td>43%</td>
</tr>
<tr>
<td>Bundled or Episode Based Payments</td>
<td>38%</td>
</tr>
<tr>
<td>Payment Withholds tied to Performance</td>
<td>22%</td>
</tr>
<tr>
<td>Non or Reduced Payment for Early Elective Deliveries</td>
<td>20%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
</tr>
</tbody>
</table>

### Share of Plans Offering the Following Activities to Promote Health Behaviors:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Share of Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-Child Care</td>
<td>76%</td>
</tr>
<tr>
<td>Timely Postpartum Care</td>
<td>73%</td>
</tr>
<tr>
<td>Prenatal Visits</td>
<td>73%</td>
</tr>
<tr>
<td>Diabetes Management</td>
<td>57%</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>48%</td>
</tr>
<tr>
<td>Adult Primary Care Visits</td>
<td>41%</td>
</tr>
<tr>
<td>Weight Management</td>
<td>39%</td>
</tr>
<tr>
<td>Blood Pressure Control</td>
<td>36%</td>
</tr>
<tr>
<td>Cholesterol Control</td>
<td>25%</td>
</tr>
</tbody>
</table>

NOTES: Plans were asked: “In the Past 12 months, has your Medicaid MCO used any of the following strategies to connect members with social services?” “Other” responses (4% of plans) not shown.
Overall, health care is a relatively small factor in overall health and well-being.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetics</td>
<td>30%</td>
</tr>
<tr>
<td>Individual Behavior</td>
<td>40%</td>
</tr>
<tr>
<td>Social and Environmental Factors</td>
<td>20%</td>
</tr>
<tr>
<td>Health Care</td>
<td>10%</td>
</tr>
</tbody>
</table>

The majority of plans employ various strategies to help connect members to social services.

Share of Plans Responding that Used Any of the Following Strategies to Connect Members to Social Services:

- Link members to social services: 93%
- Assess social needs: 91%
- Maintain social services database: 81%
- Use community health workers: 67%
- Use interdisciplinary community care teams: 66%
- Offer application assistance or counseling referrals: 52%
- Assist justice-involved with community integration: 20%

NOTES: Plans were asked: “In the Past 12 months, has your Medicaid MCO used any of the following strategies to connect members with social services?” “Other” responses (4% of plans) not shown.

In **Oregon**, each Coordinated Care Organization (or “CCO”) is required to establish a community advisory council and develop a community health needs assessment. CCOs receive a global payment for each enrollee, and CCOs offer “health-related services” – which supplement traditional covered Medicaid benefits and may target the social determinants of health.

In **Colorado**, the Regional Collaborative Organizations (RCCOs) are paid a pmpm fee to help connect individuals to community services through referral systems and targeted programs designed to address specific needs identified within the community.

**The District of Columbia** encourages MCOs to refer beneficiaries with three or more chronic conditions to the “My Health GPS” Health Home program for care coordination and case management services, including a biopsychosocial needs assessment and referral to community and social support services.

**Louisiana** requires screening for problem gaming and tobacco usage and requires referrals to Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and the Louisiana Permanent Supportive Housing program when appropriate.

**Nebraska** requires MCOs to have staff trained on social determinants of health and be familiar with community resources; plans are also required to have policies to address members with multiple biopsychosocial needs.

**California, Massachusetts, New York and Texas** are using DSRIP initiatives through 1115 Waivers to address social determinants of health.
Medicaid can work with public health and criminal justice systems to address broader health issues.

Key Issues:
- Mental Health
- HIV
- Opioids
- Health Disparities
The HHS Secretary can waive state compliance with certain Medicaid provisions that are:

- “Experimental, pilot or demonstration projects”
- “Likely to assist in promoting the objectives of the Medicaid program”
- Budget neutral to the federal government
- Subject to state and federal public notice and comment periods

The Trump Administration has issued waiver guidance:

- New waiver approval criteria in Nov. 2017, which no longer include increased coverage
- New guidance on work requirement / community engagement waivers in Jan. 2018

Each Administration has some discretion over which waivers to approve and encourage; however, that discretion is not unlimited.

- DC federal district court invalidated Secretary’s approval of Kentucky’s waiver in June, 2018, citing failure to consider impact on providing affordable coverage.
NOTES: Some states have multiple approved and/or multiple pending waivers, and many waivers are comprehensive and may fall into a few different areas. Therefore, the total number of pending or approved waivers across states cannot be calculated by summing counts of waivers in each category. For more detailed information on each Section 1115 waiver, download the detailed approved and pending waiver tables posted on the tracker page. “MLTSS” = Managed long-term services and supports. On June 29, 2018, the DC federal district court issued a decision in Stewart v. Azar. The court invalidated the waiver approval and sent it back to HHS to reconsider the Kentucky HEALTH Section 1115 waiver program. The separate “institution for mental disease” substance use disorder payment waiver continues.
Complex policies in recent waivers run counter to simplified ACA eligibility and enrollment rules.

Pre-ACA
- Apply in person
- Paperwork and asset test requirements
- Wait for eligibility determination
- Frequent renewals requiring paperwork and documentation

Post-ACA
- Multiple options to apply
- Electronic verification and no asset tests
- Real-time determination
- Annual automated renewals

Future?
- More documentation (e.g. work)
- Premiums
- Frequent reporting and documentation
- Lock-out periods

Figure 26

Large shares of the public across parties say they have a favorable opinion of Medicaid.

*In general, do you have a favorable or an unfavorable opinion of Medicaid?*

- **Very favorable**
- **Somewhat favorable**
- **Somewhat unfavorable**
- **Very unfavorable**

**Total**

- 40% Very favorable
- 34% Somewhat favorable
- 13% Somewhat unfavorable
- 8% Very unfavorable

**By Political Party ID**

- **Democrats**
  - 56% Very favorable
  - 26% Somewhat favorable
  - 8% Somewhat unfavorable
  - 5% Very unfavorable

- **Independents**
  - 38% Very favorable
  - 36% Somewhat favorable
  - 13% Somewhat unfavorable
  - 8% Very unfavorable

- **Republicans**
  - 24% Very favorable
  - 41% Somewhat favorable
  - 17% Somewhat unfavorable
  - 12% Very unfavorable

*NOTE: Don’t know/Refused responses not shown.*

*SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted February 15-20, 2018)*
What to watch

• Elections
  – Midterms
  – 36 Gubernatorial races
  – Medicaid expansion ballot initiatives

• Waivers
  – Outcome of litigation (KY, AR)
  – Work waivers in non-expansion states
  – Other waivers that limit coverage

• Revised MCO regulations

• Other state priorities
  – Focus on opioids and behavioral health
  – Social determinants of health