Accelerating Medicaid Innovation
September 22, 2015
Role of Medicaid in the Health System

Health Insurance Coverage
32 million children & 18 million adults in low-income families; 16 million elderly and persons with disabilities

Assistance to Medicare Beneficiaries
9.6 million elderly and disabled — 20% of Medicare beneficiaries

Long-Term Care Assistance
1.6 million institutional residents; 2.9 million community-based residents

Support for Health Care System and Safety-Net
16% of national health spending; 40% of long-term care spending

State Capacity for Health Coverage
FY 2014, FMAPs range from 50% – 73.1%
2014 FMAP for Newly Eligible = 100%

Source: Kaiser Family Foundation, June 2014
According to the Congressional Budget Office, federal spending on major health care programs in 2020 will be $200 Billion lower than predicted in 2010.

Source: Congressional Budget Office; CEA calculations.
Note: The August 2010 GDP estimates have been adjusted for major NIPA revisions in the summer of 2013. Without these revisions, the decline since August 2010 would be larger.
Medicaid & CHIP Enrollees and Expenditures, FY 2011

- Enrollees:
  - Total = 68 Million
  - Children 48%
  - Adults 27%
  - Elderly 9%
  - Disabled 15%

- Expenditures:
  - Total = $397.6 Billion
  - Children 21%
  - Adults 15%
  - Elderly 21%
  - Disabled 42%

SOURCE: KCMU/Urban Institute estimates based on data from FY 2011 MSIS and CMS-64. MSIS FY 2010 data were used for FL, KS, ME, MD, MT, NM, NJ, TX, UT, OK but adjusted to 2011 spending levels.
Better Care, Smarter Spending, Healthier People

Focus Areas

Incentives
- Promote value-based payment systems
  - Test new alternative payment models
  - Increase linkage of Medicaid, Medicare FFS, and other payments to value
- Bring proven payment models to scale

Care Delivery
- Encourage the integration and coordination of services
- Improve population health
- Promote patient engagement through shared decision making

Information
- Create transparency on cost and quality information
- Bring electronic health information to the point of care for meaningful use

Source: Burwell SM. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.
During January 2015, HHS announced goals for value-based payments within the Medicare FFS system.

**GOAL 1:** 30%

Medicare payments are tied to quality or value through alternative payment models where the provider is accountable for quality and total cost of care by the end of 2016, and 50% by the end of 2018.

**GOAL 2:** 85%

Medicare fee-for-service payments are tied to quality or value by the end of 2016, and 90% by the end of 2018.

**NEXT STEPS:**

Testing of new models and expansion of existing models will be critical to reaching incentive goals. Creation of a Health Care Payment Learning and Action Network to align incentives between public and private sector players.
Medicaid Delivery System Reform: Evolving Payment Authorities

• Health homes: 31 programs in 20 states

• Delivery System Reform Incentive Pools: 8 states

• Shared Savings states: 5 states

• Integrated Care Models outside of shared savings: Multiple (primary care case management fees)

• Advancing Medicaid care delivery through Duals Demonstration and State Innovation Models
State Innovation Model Grants have been awarded in two rounds: 38 States and Territories.

Primary objectives include:

- Improving the quality of care delivered
- Improving population health
- Increasing cost efficiency and expand value-based payment

Six round 1 model test states

Eleven round 2 model test states

Twenty one round 2 model design states
Medicaid Innovation Accelerator Program (IAP)

• Advance innovations in Medicaid that will result in improved health, improved health care delivery and lower costs
  – Four-year program to build state capacity and accelerate ongoing innovation in Medicaid through targeted TA
  – Joint Innovation Center-CMCS venture launched in July 2014
  – Support state capacity through by offering targeted technical support in key areas of interest to states
Example of Care Delivery Improvement: Substance Use Disorder

• Guidance identifying approaches to SUD
  – Example: Medication assisted treatment
• Innovation Accelerator Program
  – Working with 15 states to better identify individuals, expand coverage for effective treatment, and enhance practices to effectively treat beneficiaries with an SUD
• Improving SUD coverage through new 1115 demonstrations
  – Develop continuum of care for physical, behavioral, and mental treatment options related to SUD
    • In August, California became the first state to take up this approach
• Recent Rulemaking
  – Mental health parity rule will strengthen states’ ability to provide SUD services to individuals
Modernizing Medicaid Managed Care

• Health care delivery inside and outside of Medicaid has evolved substantially since 2002
• 58 percent of Medicaid beneficiaries are enrolled in capitated, risk-based managed care
• Managed care in Medicaid is growing
  – Serving new populations, including seniors and persons with disabilities who need long-term services and supports
  – Individuals newly eligible for Medicaid
• Managed care growth in Medicare; Marketplace coverage
Managed Care Policy Development Principles

• The proposed rule supports the agency’s mission of *better care, smarter spending, and healthier people*

• Key NPRM Principles
  – Alignment with Other Insurers
  – Delivery System Reform
  – Payment and Accountability Improvements
  – Beneficiary Protections
  – Modernizing Regulatory Requirements and Improving the Quality of Care
Home and Community-Based Services (HCBS) is 49.5% of Long-term Services and Supports (LTSS)

Medicaid Institutional and HCBS Expenditures as a Percentage of Total Medicaid LTSS Expenditures, FFY 1995 - 2012
Uninsured Rate Drops: Adults 18-64

Source: Gallup-Healthways Well-Being Index
Medicaid Expansion
As of September 2015

Current status

- Currently, **29 states + DC** are covering the ACA Medicaid expansion group
Most Recent Expansion: Alaska

- Expansion is being authorized under state plan authority
  - Enrollment started September 1
- Alaska is developing with CMS new approaches to meeting the health needs of AI/AN beneficiaries
  - CMS is updating its policy on the availability of 100% FMAP for services provided by IHS and tribal facilities to AI/AN beneficiaries
  - Emphasis on improving transportation to services, coordination and delivery of care
Arkansas Health Care Independence Program (Private Option)

POPULATION
- New adult eligibility group with some exceptions (medically frail, AI/AN)

DELIVERY SYSTEM
- Access to a qualified health plan (QHP) offered in the Marketplace.
- The state pays premiums and cost sharing reduction payment to the QHP, and uses fee-for-service (FFS)/primary care case management (PCCM) outside of the private option.

BENEFIT PLAN
- Alternative Benefit Plan (ABP) through QHP, as well as non-emergency medical transportation (NEMT) and other benefits.

COST SHARING
- None below 50% FPL and for those above 50%, amounts are consistent with Medicaid requirements
Impacts of Arkansas Private Option

According to the state of Arkansas:

– The number of uninsured patients who visited the ED was reduced by **24 percent**.
– The number of uninsured patients who required hospitalization was reduced by **30 percent**.

Arkansas Hospital Association conducted a survey of Arkansas hospitals:

– The losses responding hospitals incurred caring for low income Arkansans have decreased by **$69 million**.
– Regarding the uninsured specifically, admissions reduced by **46.5 percent**
Medicaid Moving Forward