Medicaid and CHIP: 2016 and Beyond

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Role of Medicaid in the Health System

Health Insurance Coverage

Assistance to Medicare Beneficiaries

Long-Term Care Assistance

Support for Health Care System and Safety-Net

State Capacity for Health Coverage
Medicaid and CHIP: Coverage Has Lasting Benefits

- Children who enrolled in Medicaid and CHIP in the 80s and 90s were more likely to experience a higher quality of life than those that were uninsured. They attained:
  - Higher wages as adults
  - Higher rates of college attendance
  - Reduced risk of premature death

Medicaid Moving Forward

Delivery System Reform

Coverage Expansion and Simplification

Access to and Quality of Care
Uninsured Rate Down to 8.6%

Source: Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–March 2016
Modernization of Medicaid and CHIP Eligibility and Enrollment

2014’s changes:

- Simplified eligibility rules
- Enrollment on line, by phone, or at a convenient location
- Electronic verification
- Marketplace coordination
- Systems modernization

2016’s results:

- 37 states making MAGI eligibility determinations in real time
- For the states reporting, almost one-third of MAGI applications were processed in under 24 hours
- 15 million more people enrolled (relative to 2013)
- Significant increases in participation rates
Medicaid Expansion
As of September 2016

Currently, **31 states + DC** are covering the ACA Medicaid expansion group
More Progress to Make: Medicaid Expansion Coverage Gap

In states that do not expand Medicaid under the ACA, there will be large gaps in coverage available for adults.

Limited to Specific Low Income Groups

- 0% FPL Childless adults
- 50% FPL $9,900 for parents in a family of three

Median Medicaid Eligibility Limits as of October 2014

NO COVERAGE

MARKETPLACE SUBSIDIES

- 100% FPL $11,670 for an individual
- 400% FPL $46,680 for an individual
Rates of Uninsured Are Lower in Expansion States

Quarterly Uninsured Rate Estimates for Nonelderly Adults (Ages 19 to 64) by Medicaid Expansion Status Using the Gallup-Healthways Well-Being Index, 2012-2016

Medicaid expansion improves:

- **Access**
  - More availability of primary care appointments for Medicaid patients
  - Reduced unmet health care needs
  - Increased rates of diagnosis of people with chronic conditions, and increased regular care and use of prescription drugs

- **Affordability:**
  - Percentage of low-income adults reporting problems paying medical bills declined

- **Quality:**
  - Two-thirds of adults with expansion coverage consider themselves to be better off now than before they had Medicaid

Source: ASPE Issue Brief: Impacts of the Affordable Care Act’s Medicaid Expansion on Insurance Coverage and Access to Care, June 20, 2016
Delivery System Reform and Medicaid

- New all-payer models
- Accountable Care Organizations
- Value-based purchasing, including:
  - Episode-based and population-based payments
- Shared Savings and Integrated Care Models
- Delivery System Reform Incentive Pools
- MACRA’s Quality Payment Program
# CMS DSR Framework Categorizes Payments to Providers

## Description

<table>
<thead>
<tr>
<th>Category 1: Fee for Service – No Link to Value</th>
<th>Category 2: Fee for Service – Link to Value</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery</td>
<td>Some payment is linked to the effective management of a population or an episode of care</td>
<td>Payment is not directly triggered by service delivery so volume is not linked to payment</td>
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<td>Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk</td>
<td>Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., &gt;1 year)</td>
</tr>
<tr>
<td>Limited in Medicare fee-for-service</td>
<td>Hospital value-based purchasing</td>
<td>Accountable care organization</td>
<td>Eligible Pioneer accountable care organizations in years 3-5</td>
</tr>
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<td>Majority of Medicare payments now are linked to quality</td>
<td>Physician Value-Based Modifier</td>
<td>Medical homes</td>
<td>Some Medicare Advantage plan payments to clinicians and organizations</td>
</tr>
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<td>Readmissions / Hospital Acquired Conditions Reduction Program</td>
<td>Bundled payments</td>
<td>Some Medicare-Medicaid (duals) plan payments to clinicians and organizations</td>
</tr>
</tbody>
</table>

## Medicare examples

- Varieties by state
- Primary care care management
- Medicaid Health Homes
- Some managed care provider payments
- Shared savings models
- Episodic-based payments
- Medicaid waivers for delivery reform incentive payments
- Some managed care provider payments
- Some Medicaid demonstrations (DSRIP and others)
- Some Medicaid managed care clinic/organization payments
- Some Medicare-Medicaid (duals) plan payments to clinicians and organizations

## Medicaid examples

- Hospital value-based purchasing
- Physician Value-Based Modifier
- Readmissions / Hospital Acquired Conditions Reduction Program
- Accountable care organization
- Medical homes
- Bundled payments
- Eligible Pioneer accountable care organizations in years 3-5
- Some Medicare Advantage plan payments to clinicians and organizations
- Some Medicare-Medicaid (duals) plan payments to clinicians and organizations

Medicaid Innovation Accelerator Program

- Four year commitment by CMS to build state capacity and support ongoing innovation in Medicaid through targeted technical support
- Supports states’ and HHS delivery system reform efforts
- Key focus areas:
  - Substance use disorder
  - Physical-behavioral health integration
  - Beneficiaries with complex needs
  - Community integration
  - Data analytics
  - Quality measures
States Participating in Medicaid IAP: Direct Program Support

28 States as of September, 2016

- Am. Samoa
- Puerto Rico
- Guam
- Virgin Islands
- No Mariana Islands
Building Blocks: Stronger Quality and Systems of Care

- **Modernizing managed care**
  - Improving managed care to better promote quality, accountability, and delivery system reform

- **Strengthening Access**
  - Increasing data and transparency on access and provider payment

- **Strengthening benefits**
  - Stronger approaches to behavioral health, substance use disorder, and key benefits like home health

- **Supporting Community Integration**
  - Promoting home and community-based settings that support independence and community living

- **Improving Quality**
  - Using quality measures to drive quality improvement for adults and children
The Growing Role of Managed Care in Delivering Care in Medicaid

Number of Beneficiaries Receiving Services Through Capitated Managed Care Plans, 1998

- Managed Care: 18.1m
- Fee-for-Service: 12.6m

Number of Beneficiaries Receiving Services Through Managed Care (includes MCOs, PIHPs, PAHPs, PCCMs), 2013

- Managed Care: 45.9m
- Fee-for-Service: 18.1m
Ensuring Access to Care

• Implementation of new access policies:
  – Allows for better informed, data-driven decisions on proposed changes fee-for-service rates
  – Ensure rates are sufficient to ensure access to services
  – Strengthens CMS review and enforcement capabilities
Home and Community-Based Care is a Majority of Spending on Long Term Services and Supports

Medicaid HCBS and Institutional Expenditures as a Percentage of Total Medicaid LTSS Expenditures, FY 1981–2014

* Data for FY 1987 are excluded
Where Medicaid and CHIP Go From Here: 2016 and Beyond

✓ Continued state coverage gains through Medicaid expansion
✓ State innovation in delivery systems
✓ Building stronger systems of care
✓ Paying for value and quality
✓ Promoting community integration