Manatt on Medicaid

10 Trends to Watch in 2016

May 4, 2016

Bloomberg BNA

manatt

Today's Presenters

Deborah Bachrach
Partner

Patricia Boozang
Senior Managing Director

Melinda Dutton
Partner

Cindy Mann
Partner

Medicaid's Growing Influence in Health Care

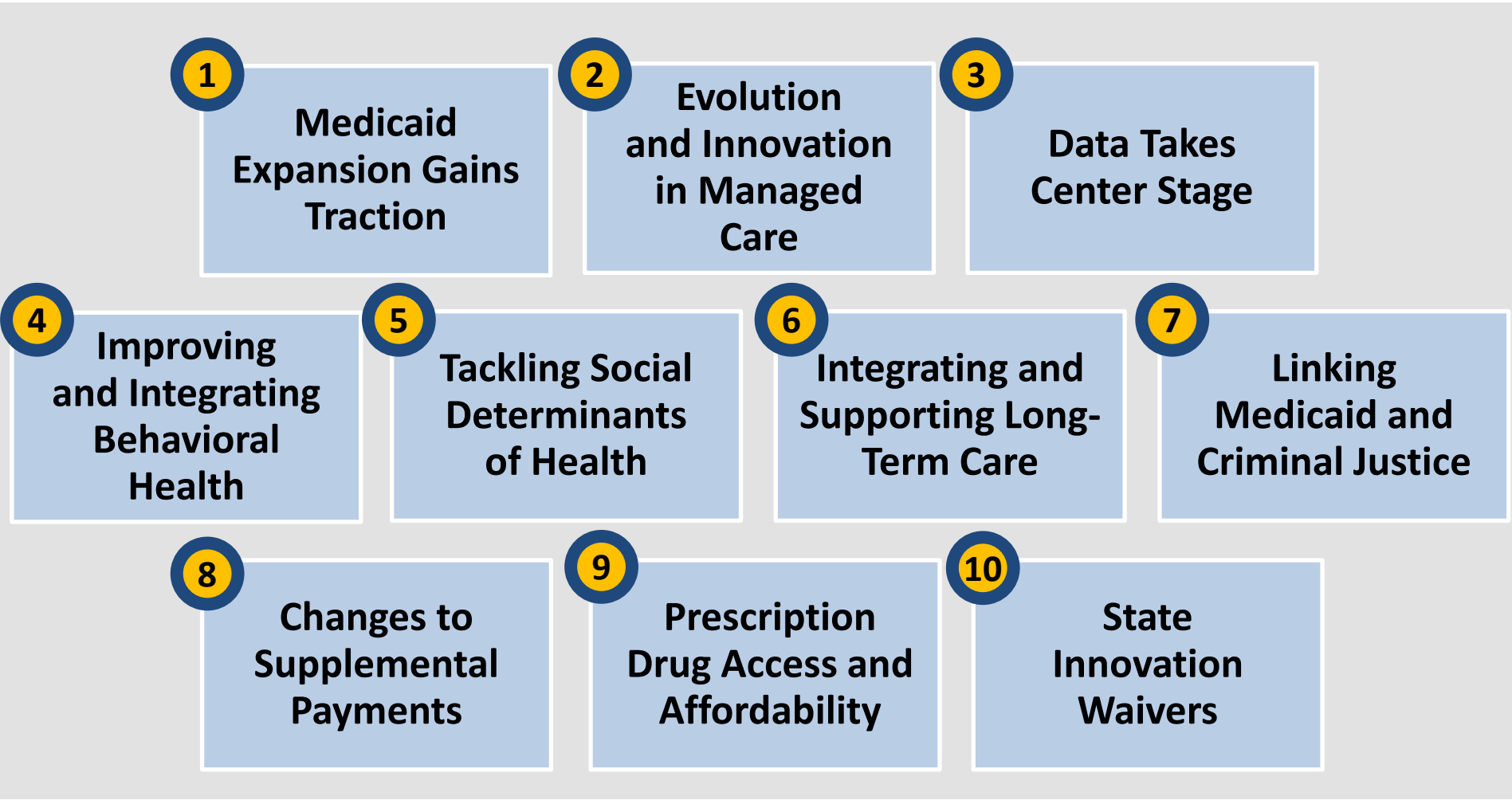
Medicaid is the single largest source of coverage nationwide, and growing…

- ✓ Covers 70 million people annually, 22% of total U.S. population
- ✓ With the ACA, enrollment grew by 13.8% nationally in FY 2015
  - Expansion state enrollment grew by 18% on average
  - Non expansion state enrollment grew by 5% on average
- ✓ $475 billion in total spending annually

Sources: Centers for Medicare & Medicaid Services (CMS). "National Health Expenditures". www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html; CMS. "Medicaid & CHIP December 2015 Enrollment Report". Dec 2015. www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/december-2015-enrollment-report.pdf; Kaiser State Health Facts; Kaiser Family Foundation. "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid". Jan 2016. http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/.

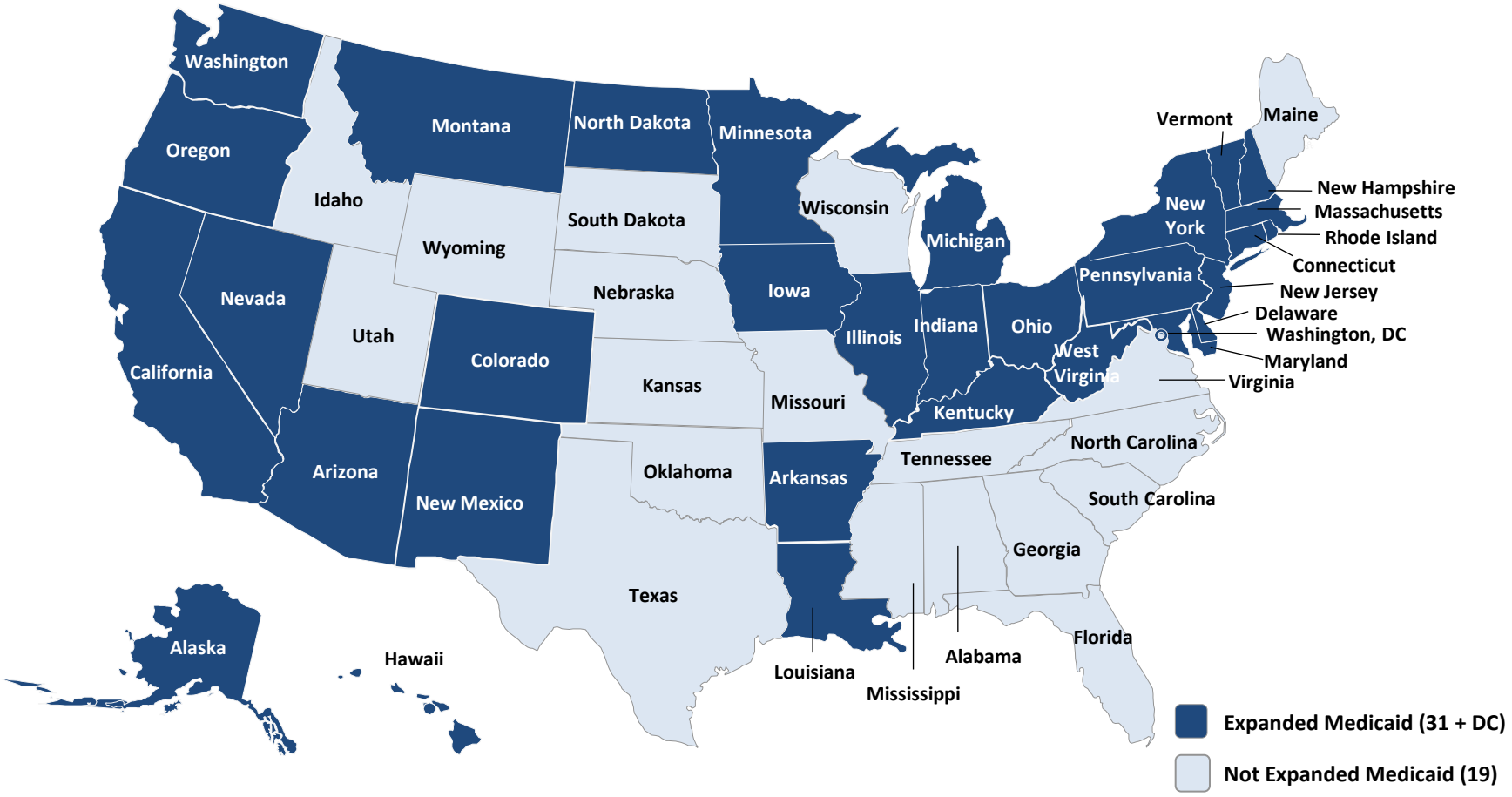
manatt

10 Key Trends in Medicaid



Trend 1
Medicaid Expansion Continues to Gain Traction

31 States and D.C. Have Expanded Medicaid



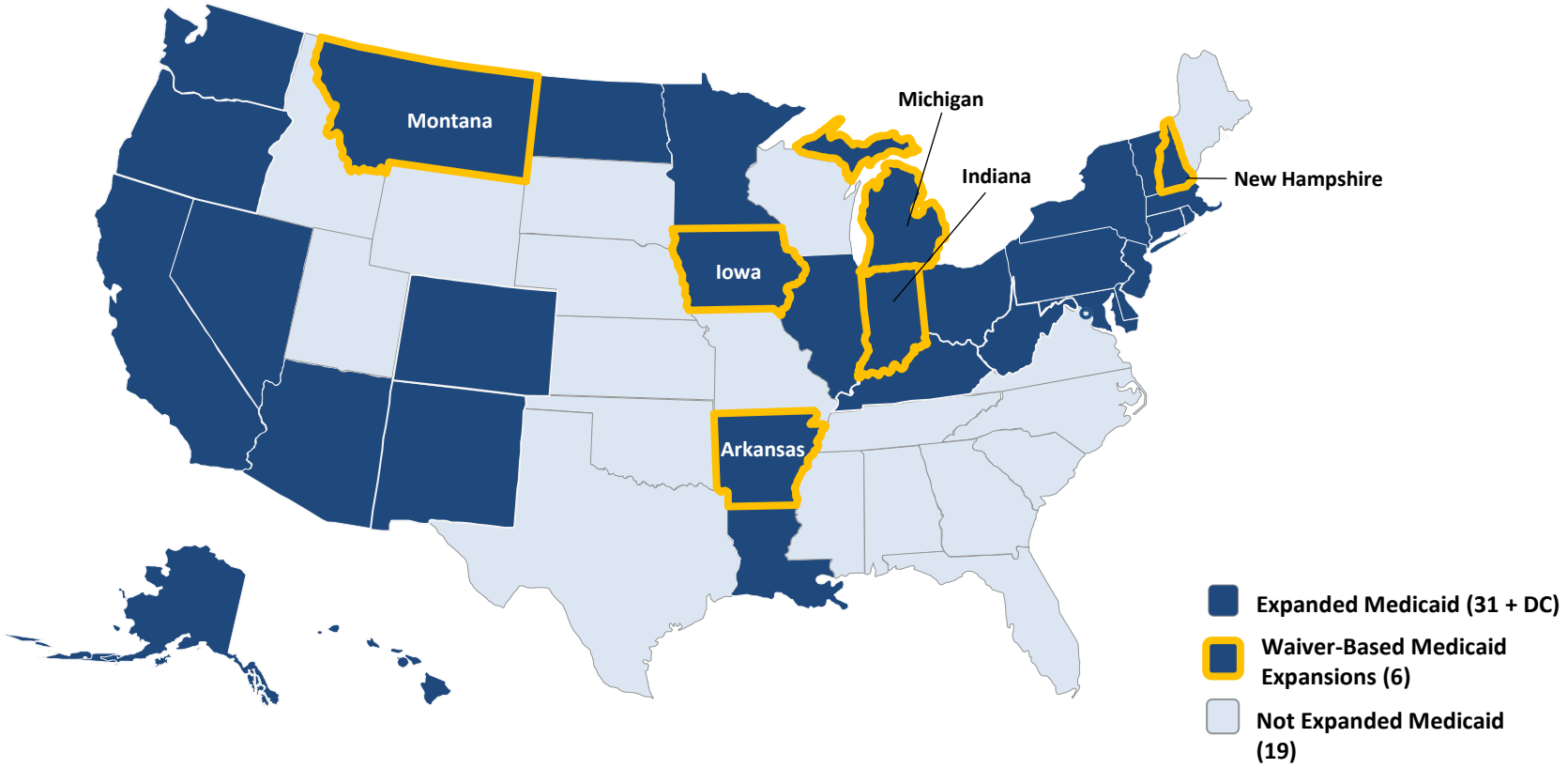
Louisiana's Governor has signed an Executive Order to expand Medicaid by July 1, 2016.

manatt

6 States Are Using 1115 Waivers to Expand Medicaid

States with Alternative Expansions Frequently Use

- Premium assistance
- Premiums
- Healthy behavior incentives
- Co-payments
- Elimination of NEMT

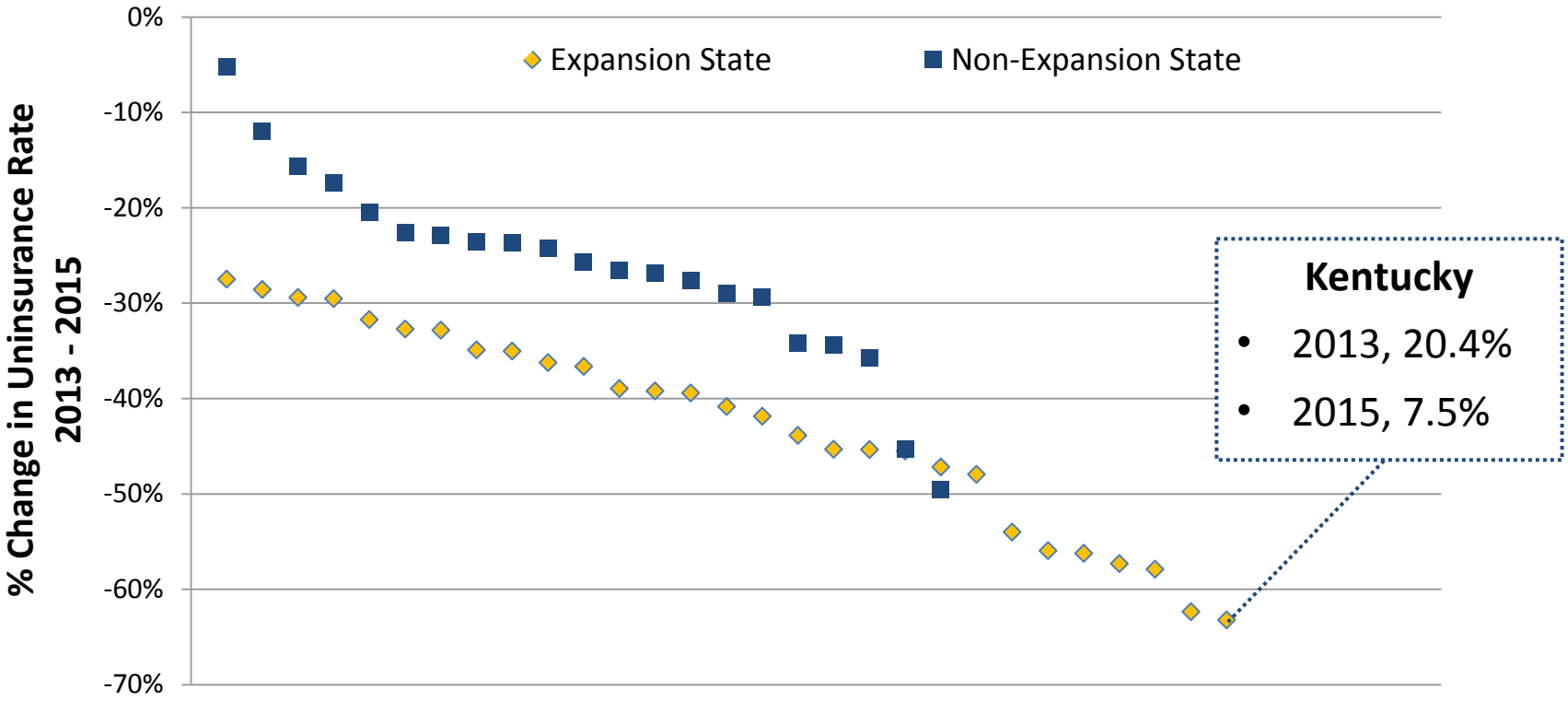


Louisiana's Governor has signed an Executive Order to expand Medicaid by July 1, 2016.

manatt

Expansion Brings Historic Gains in Coverage

Seven expansion states cut their uninsurance rates by > 50% from 2013 to 2015



"Expansion States" includes 29 US States whose expansion was in effect by the end of 2015. Louisiana and Montana are not included.

Source: Manatt Analysis of Gallup-Healthways Well-Being Index (February 2016)

manatt

Early Results from Expansion States

Medicaid expansion improves access to care and health outcomes with positive effects on states' budgets.

Economics

Projected net positive impact on state budgets

- Arkansas $637 million in savings, 2017 – 2021
- Kentucky $820 million in savings, 2014-2021
- New Mexico $300 million surplus for State General Fund, 2014 - 2021

Drop in hospital uncompensated care

- Hospital uncompensated care costs were an estimated $7.4 billion (21%) less in 2014 than they would have been without ACA expansions.
- Ascension hospitals in expansion states saw 40% decrease in uncompensated care in 2014, compared to 6% decrease in non-expansion states

Access

Improved access and clinical outcomes

- Increased use of preventive care and care for chronic conditions
- Decreased use of the emergency department
- Increased medication adherence
- Increased access to breast cancer screenings
- Reduced mortality

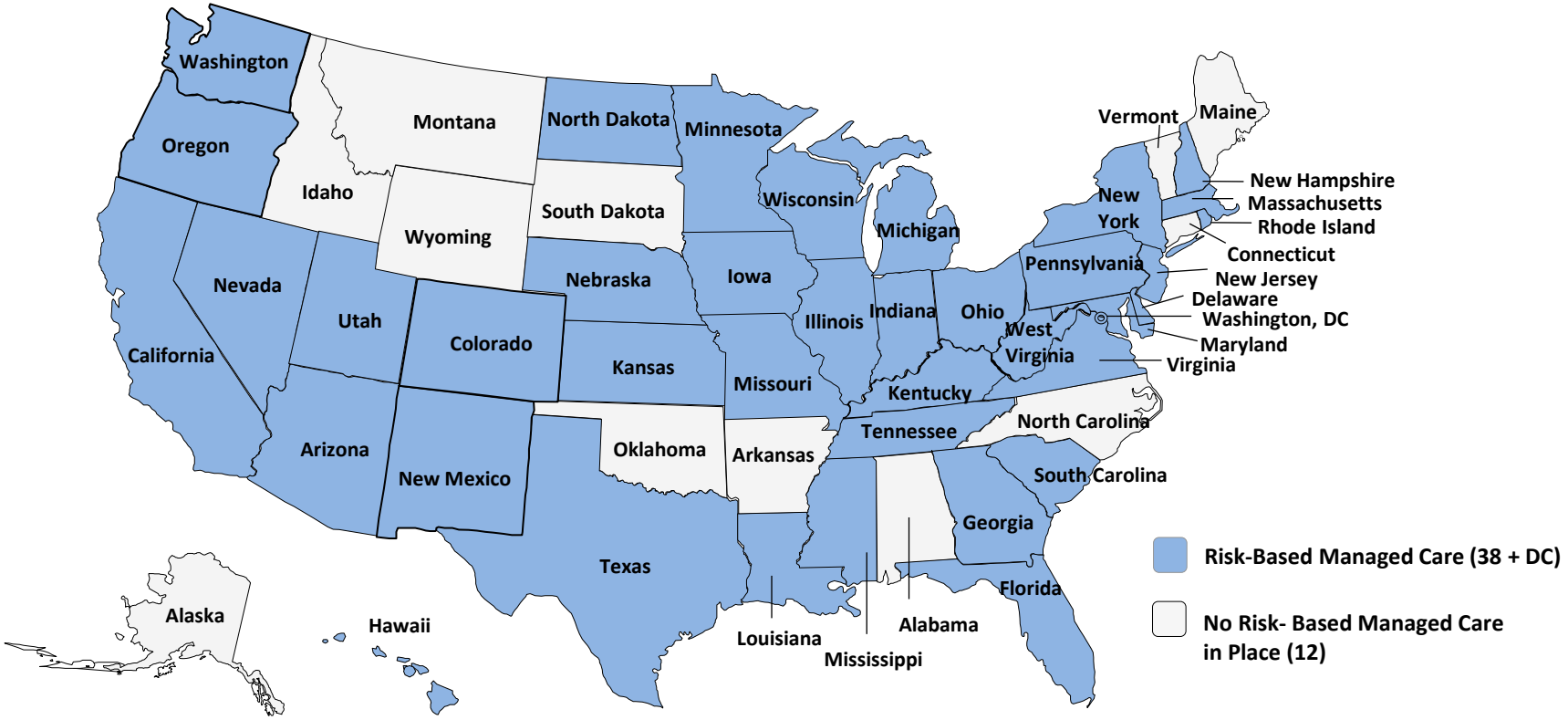
Sources: D Bachrach et al. "States Expanding Medicaid See Significant Budget Savings and Revenue Gains." RWJ State Health Reform Assistance Network. April 2015. statenetwork.org/wp-content/uploads/2015/04/State-Network-Manatt-States-Expanding-Medicaid-See-Significant-Budget-Savings-and-Revenue-Gains-April-20152.pdf; P. Cunningham et al. "How are Hospitals Faring Under the Affordable Care Act? Early Experiences from Ascension Health". Kaiser Family Foundation. April 2015. kff.org/report-section/how-are-hospitals-faring-under-the-affordable-care-act-early-experiences-from-ascension-health-issue-brief/; State Health Reform Assistance Network. "Medicaid Expansion: Just the Facts". RWJ State Health Reform Assistance Network. April 2016. statenetwork.org/wp-content/uploads/2016/03/State-Network-GMMB-Manatt-Medicaid-Expansion-Just-the-Facts-April-2016.pdf

manatt

Trend 2
Continued Evolution and Innovation for Medicaid Managed Care

Managed Care is the Dominant Medicaid Delivery System

38 states and DC contract with comprehensive managed care organizations; 90% of all U.S. Medicaid beneficiaries live in these states.



Source: Kaiser Family Foundation. "Key Findings on Medicaid Managed Care." Dec 2014. http://kff.org/medicaid/report/key-findings-on-medicaid-managed-care-highlights-from-the-medicaid-managed-care-market-tracker/.

manatt

MCOs Increasingly Enrolling Complex Populations

States are increasingly using managed care as a vehicle to cover comprehensive benefits for complex populations

Complex Populations Drive Majority of Costs

- 83% of Medicaid's costliest beneficiaries have at least three chronic conditions
  - Severe mental illness
  - Dual-eligibles
  - HIV/AIDS
  - Developmentally disabled

State Goals

- Addressing physical health, behavioral health, and long-term care silos
- Improving quality and consumer experience mechanisms and oversight capacity
- Transitioning to population health - focusing on the person, not their diagnosis
- Bending the cost curve

Source: Centers for Medicare and Medicaid Services. "CMCS Informational Bulletin". July 2013. www.medicaid.gov/federal-policy-guidance/downloads/cib-07-24-2013.pdf.

Major Overhaul of Medicaid Managed Care Rules

CMS rule align Medicaid managed care with Medicare and Marketplace requirements and promote payment and delivery system reforms in Medicaid's largest and growing delivery models.

Changes to key features of Medicaid managed care programs include:

Network Adequacy

Rate Setting

Value-Based Payment

Medical Loss Ratio Standards

Consumer Transparency

[Updated Medicaid Managed Care Rules were published April 25, 2016.]

States Leveraging MCO Contracts to Promote Reforms

Setting provider value-based payment standards and targets

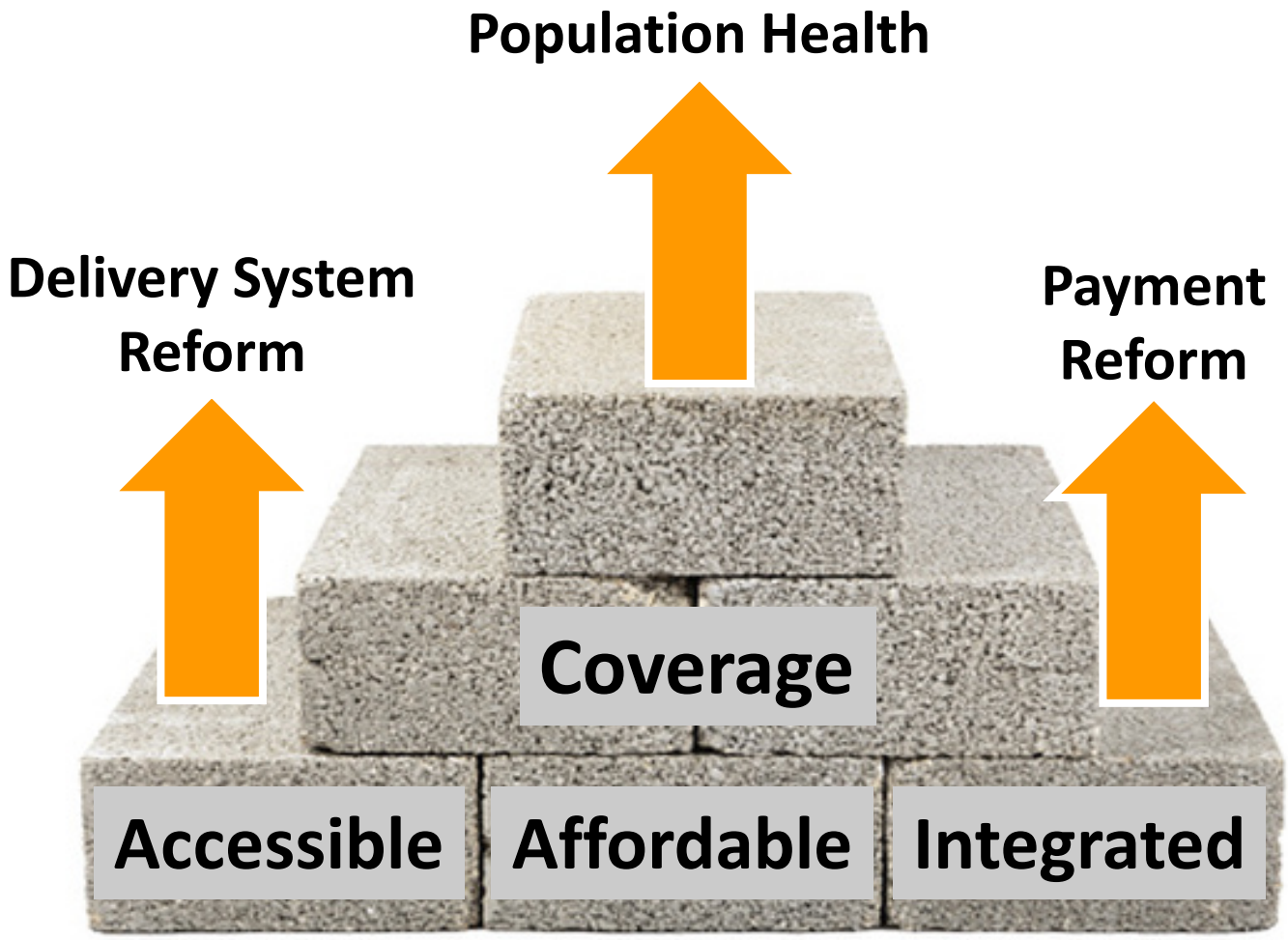
Requiring participation in provider-led reforms (Health Homes, ACOs, PCMHs)

Increasing care integration, care management responsibilities

Focus on population health management and consumer engagement

Trend 3
Data Takes Center Stage in Delivery System Reform

Expanded Coverage is Accelerating Healthcare Transformation



Analytics is Foundational to Population Health Management

Governance and Corporate Structure	Provider Network Management	Financial Management and Payment	Clinical and Care Management
• Business Planning • Contracting • State reporting • Beneficiary member services • Compliance • Antitrust evaluation • Privacy and security protocols	• Network identification • Network management • Provider contracting • Referral protocol development • Credentialing • Management of non-compliant physicians • Provider services	• Reimbursement and distribution structures • Payment metrics definition • Funds flow strategy and structure • Risk assumption and management • Financial analysis and modeling • Managed care contracting • Capital reserves • Partner claim processing	• Clinical protocol and standards development, dissemination and oversight • Care management and coordination capabilities • Ability to link to social determinants of health • Identification of quality targets

Analytics and Informatics

- Metrics development and implementation
- Population analytics
- Utilization monitoring
- High-risk beneficiary identification
- Risk stratification
- Enrollment and claims data analytics

New Investments in Transformation Infrastructure

State Innovation Models (SIM)	CMMI Innovation Grants	DSRIP Demonstration Waivers	Section 1332 Waivers
17 Testing Grants	107 Grants – Round 1	8 State DSRIPs	*Potential new opportunity to integrate Marketplace reforms.*
37 Design Grants	39 Grants – Round 2	Range from $600 million - $11 billion over 5 years	
$960 million	$1.2 billion		

Case Study: New York

New York's Delivery System Reform Incentive Payment (DSRIP) program aims to pay 80-90% of managed care payments to Medicaid providers through value-based methods by 2020.

Data is crucial to New York's reform efforts

NY Medicaid Analytics Performance Portal

- New statewide resource to support VBP (supports Health Homes and DSRIP)
- Provides dashboard, data warehouse, data management, and analytics for utilization data, claims data, quality and performance metrics

Data Sharing and Tracking

- Providers responsible for improving outcomes and meeting quality milestones
- Quarterly provider reports required
- Data exchange and analytics supported by regional health insurance exchanges

Sources: New York State Department of Health. "MAPP 101 Webinar". June 2015. www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2015-06_mapp_101_webinar.pdf; New York State Department of Health. "DSRIP Performance Data". August 2015. www.health.ny.gov/health_care/medicaid/redesign/dsrip/performance_data/.

manatt

Challenges and Opportunities Ahead

- **Health information exchange infrastructure immature**
- **Funding for transformation capacity limited**
- **Privacy and security policies evolving**
- **Methodological innovation emerging**
- **Increased demand and limited capacity for data analytics professionals**

*Expect **increasing investment** among Medicaid stakeholders at every level **in data analytics and the exchange of health information**, as states seek to ratchet down per capita spending, payers feel increasing pressure to incentivize provider accountability, and providers seek to move further up the payment food chain.*

Trend 4
New Opportunities for Improving and Integrating Behavioral Health

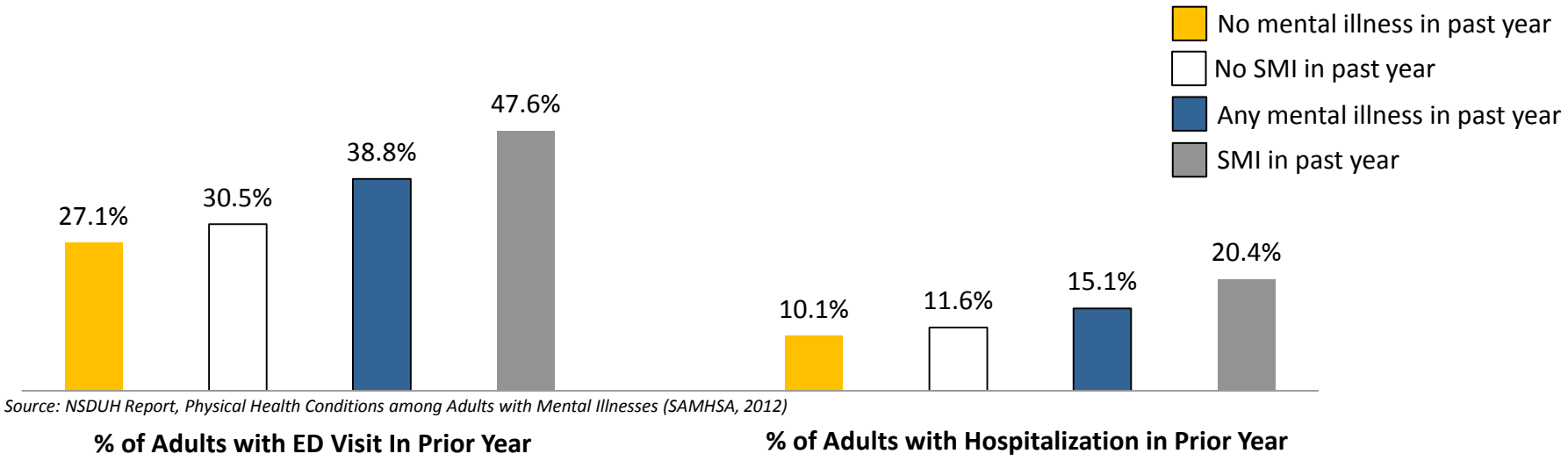
Behavioral Health Care High on States' Agendas

Adults living with serious mental illness (SMI) die on average 25 years earlier than other Americans.

20% of Medicaid beneficiaries have behavioral health diagnoses but account for nearly half of total Medicaid expenditures.

Average Medicaid spending for beneficiaries with schizophrenia is three times that of those without.

Mental Illness Leads to Greater Likelihood of ER Use and Hospitalization

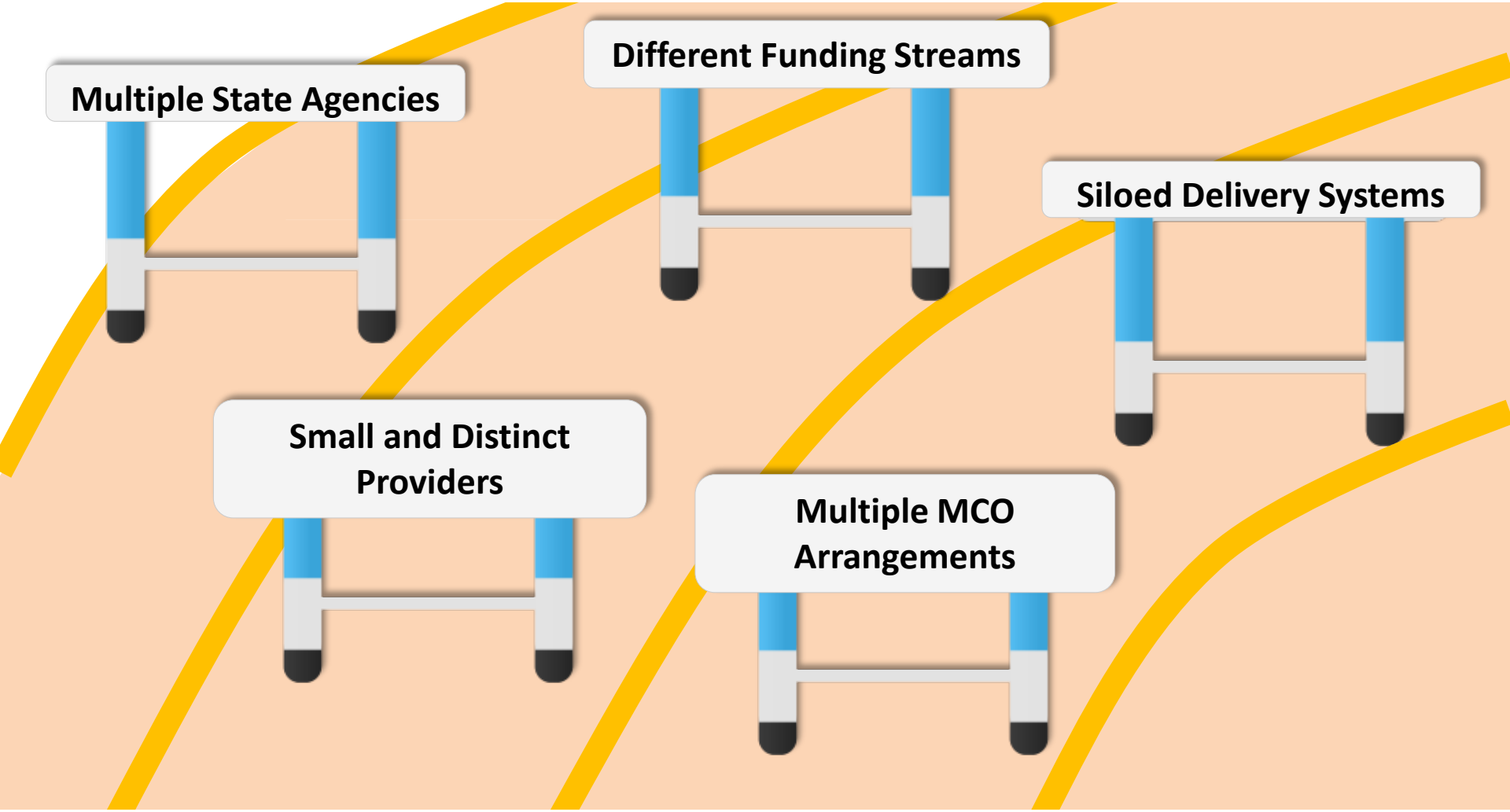


Source: NSDUH Report, Physical Health Conditions among Adults with Mental Illnesses (SAMHSA, 2012)

Sources: Parks, J. et al. "Morbidity and Mortality in People with Serious Mental Illness." National Association of State Mental Health Program Directors (NASHMPD) Medical Directors Council. Oct 2006. www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf; MACPAC. "Report to Congress on Medicaid and CHIP: Behavioral Health in the Medicaid Program". June 2015. www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program%E2%80%94People-Use-and-Expenditures.pdf; Miller, J. & Prewitt, E. . "Reclaiming Lost Decades: The Role of State Behavio Health Agencies in Accelerating the Integration of Behavioral Healthcare and Primary Care". NASHMPD. May 2012. www.nasmhpd.org/sites/default/files/Reclaiming%20Lost%20Decades%20Full%20Report.pdf.

manatt

Historical Hurdles to Integration



Building a Seamless Care Experience

Core attributes of integrated behavioral health care models

Source: Bachrach, D. et al. "State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment". The Commonwealth Fund. August 2014. www.commonwealthfund.org/~/media/files/publications/fund-report/2014/aug/1767_bachrach_state_strategies_integrating_phys_behavioral_hlt_827.pdf.

manatt

Considerations in Addressing Behavioral Health

Federal law can impede or facilitate integration of physical and behavioral health care.

Opportunities

Section 1115 Waivers covering Substance Use Disorder Treatment

- Allow waiver of Institutions for Mental Diseases (IMD) exclusion in the context of broad reform, "guarantee(ing) a full continuum of evidence-based best practices" to meet individuals' needs

New Medicaid Managed Care Rules

- Allows MCOs to cover individuals in IMD if no more than 15 day stay

Challenges

Regulations on Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2)

- Limits information sharing of alcohol or drug abuse treatment information
- Requires detailed patient consent forms listing providers
- SAMHSA proposed changes, but significant consent barriers remain

Sources: Centers for Medicare and Medicaid Services. "New Service Delivery Opportunities for Individuals with a Substance Use Disorder". July 2015. www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf; Belfort, R. et al. "Sharing Behavioral Health Information in Massachusetts: Obstacles and Potentia Solutions". Blue Cross Foundation March 2016. bluecrossfoundation.org/sites/default/files/download/publication/Behavioral_Health_Data_Sharing_FINAL.pdf.

Trend 5
Moving Beyond Medical Services to Tackle the Social Determinants of Health

Social Factors Drive Health Outcomes

Up to 40% of health outcomes are driven by nonmedical factors such as income, education, and occupation.

Food-insecure are 20% more likely to report hypertension

Those who lost a job 83% more likely to develop stress condition such as heart disease or stroke

Especially Critical for Medicaid Populations

Medicaid enrollees are much more likely to report challenges meeting basic needs, such as the ability to afford food, clothing, shelter and medical bills.

Booske, B.C. et al. "Different Perspectives for Assigning Weights to Determinants of Health". University of Wisconsin Population Health Institute. February 2010. uwphi.pophealth.wisc.edu/publications/other/different-perspectives-for-assigning-weights-to-determinants-of-health.pdf; Bachrach, D. et al. "Addressing Patients' Social Needs: An Emerging Case for Provider Investment". Commonwealth Fund. May 2014. www.commonwealthfund.org/~/media/files/publications/fund-report/2014/may/1749_bachrach_addressing_patients_social_needs_v2.pdf.

Addressing Social Determinants: Interventions and Benefits

Interventions

Housing assistance

Food and nutrition aid

Employment supports

Economic supports

Care coordination

Direct and Indirect Benefits

- Savings on health care costs
- Increased provider and patient satisfaction
- Strengthened community health
- Enhanced employee productivity

Targeting Social Determinants in Medicaid

State Plan Amendments

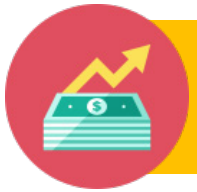
- Targeted case management
- Health homes
- Broaden preventive, rehabilitative, habilitative services

Waivers

- Home & community based waivers
- DSRIP waivers

Capitated Payment Arrangements (e.g. MCOs)

- In lieu of services
- Value-added services



Value-Based Payment

- Shared savings (upside and downside risk)
- Episodic payments
- Global payments

Trend 6
(Re)balancing, Integration, and Workforce Supports– Momentum Builds for Long-Term Services and Supports Reform

Increased Focus on Long Term Services and Supports (LTSS)

Demand

- By 2050, 20% of the U.S. population will be 65+ and 4% will be 85+
- Over 27 million people will need long-term care by 2050

Cost Growth

- LTSS account for over one-third of total Medicaid spending ($140 billion in 2012)
- National LTSS spending, as a share of GDP, is projected to more than double by 2050

Workforce

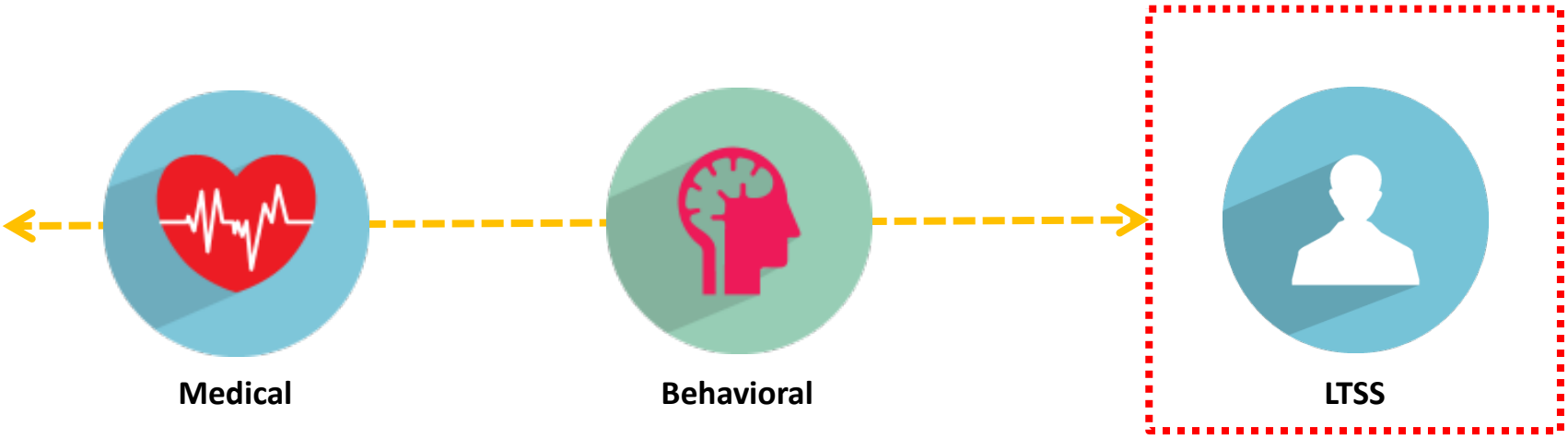
- 1 million+ new LTSS workers needed to meet demand over next decade
- Informal caregivers account for over $500 billion annually

Sources: Center for Disease Control. "Long-Term Care Services in the US." December 2013. www.cdc.gov/nchs/data/nsltcp/long_term_care_services_2013.pdf; Eiken, S. et al. "Medicaid Expenditures for LTSS". CMS. April 2014. www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-2012.pdf; Congressional Budget Office (CBO). "Updated Budget Projections: 2015 to 2025". March 2015. www.cbo.gov/publication/49973; CBO "Rising Demand for LTSS for Elderly People". June 2013. www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44363-LTC.pdf; "Shortage of Caregivers". New York Times. Feb 2014. http://newoldage.blogs.nytimes.com/2014/02/26/a-shortage-of-caregivers/; Reaves, E. et al. "Medicaid and LTSS". Kaiser Family Foundation. Dec. 2015. kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.

manatt

Extending the Trend of Integration

Integration is increasingly focused on behavioral health but typically stops short of including LTSS.



Care continuum improvements between physical health, behavioral health, and LTSS might include:

- Care management protocols
- Strong provider relationships
- Links to social supports
- Improved technology
- Aligned financial incentives
- Connection with behavioral health

Considerations for LTSS Moving Forward

Shifting from Institution to Community

- Rebalancing to home and community-based services (HCBS) remains priority
- 51% of national Medicaid LTSS dollars are in HCBS, up from 18% in 1997

New CMS regulations address LTSS

- New managed care regulations codify best practices
- Qualifying requirements for community-based services

Federal Wage and Hour Rules Impact Home Health Workers

- Department of Labor rule extends minimum wage and overtime protections to home care workers; was recently upheld

State and local legislation impacts caretakers

- Minimum wage requirements
- Paid family leave requirements

Sources: Kaiser Family Foundation. "Medicaid HCBS Programs: 2012 Data Update". Nov 2015. kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2012-data-update/; CMS. "Strengthening the Delivery of Managed LTSS". May 2015. www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/strengthening-the-delivery-mltss-fact-sheet.pdf; CMS. "Regulatory Requirements for Home and Community-Based Settings". www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/requirements-for-home-and-community-settings.pdf; US Department of Labor. "We Count on Home Care". Oct. 2015. www.dol.gov/whd/homecare/litigation.htm; Reaves, E. et al. "Medicaid and LTSS". Kaiser Family Foundation. Dec. 2015. kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.

manatt

Trend 7
Linking Medicaid and the Criminal Justice Systems– Better Health, Reduced Costs, Less Recidivism

Medicaid and Justice-Involved Populations

Key Population

- 1 in 35 US adults are under correctional supervision
- 1 in 110 US adults are incarcerated in prison or jail

Increased Need

- Two thirds of incarcerated individuals meet medical criteria for an alcohol or drug use disorder
- More than half of incarcerated individuals have a mental health problem

Effective Outcomes

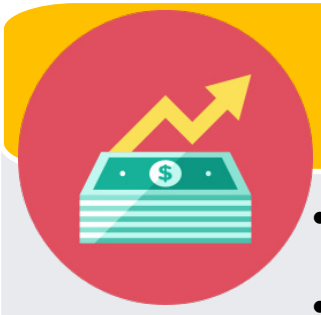
- SUD treatment in and after corrections reduces recidivism and relapse

Sources: Kaeble, D. et al. "Correctional Populations in the United States". US Department of Justice. Revised Jan 2016. www.bjs.gov/content/pub/pdf/cpus13.pdf; US Department of Justice. "Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-2012". Bureau of Justice Statistics. 2015. www.bjs.gov/content/pub/pdf/mpsfpji1112.pdf; National Center on Addiction and Substance Abuse. "Behind Bars II: Substance Abuse and America's Prison Population". 2010. www.casacolumbia.org/addiction-research/reports/substance-abuse-prison-system-2010; CMS. "Coverage and Delivery of Adult Substance Abuse Services in Medicaid Managed Care". May 2014. www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/cms-adult-substance-abuse-services-coverage.pdf.

manatt

Expansion Opportunities Despite the Medicaid Inmate Exclusion

Federal law prohibits Medicaid from paying for medical services provided in prison. However, Medicaid covers inmates when hospitalized in the community.



Medicaid expansion creates new savings opportunity for corrections systems

- With expansion, most inmates will be Medicaid eligible
- While individuals are incarcerated, states will see savings from Medicaid-covered inmate inpatient hospitalization
- Inmates are eligible for full Medicaid coverage upon release

Opportunities to Link to Medicaid Upon Release

States are using Medicaid to coordinate inmate transitions

- ✓ Assist with Medicaid applications or reactivation
- ✓ Require parole and probation officers to follow up on Medicaid eligibility and enrollment
- ✓ Connect beneficiaries with community and social services via Health Homes
- ✓ Maintain continuity of care through Medicaid Managed Care systems

Trend 8
More Change Coming to Supplemental Payments

Use of Supplemental Payments Vary by State

Two types of supplemental payments

Disproportionate Share Hospital (DSH) payments

- Payments to hospitals serving low-income populations, for uncompensated care
- Minimum payments to certain hospitals required by federal law
- Slated to be reduced under ACA

Upper Payment Limit (UPL) funds

- Additional payments to providers comprising the difference between Medicaid FFS payments and the Medicare "upper payment limit"
- Permissible in fee-for-service, but not required by federal law

Supplemental payments made up 10% of total Medicaid spending in FFY 2014

- In some states, over half of all Medicaid payments to hospitals are through some form of a supplemental payment.

Sources: Social Security Act § 1902 (a)(13)(A)(IV) and 1923; 42 CFR § 447.257-272, .300-.362, .512-518; 57 Fed. Reg. 28141; 66 Fed. Reg 3175; 67 Fed Reg 41103; Total supplemental payments from MACPAC, Exhibit 23 & 24, MACStats Medicaid and CHIP Data Book, December 2015. Available at: www.macpac.gov/publication/macstats-medicaid-and-chip-data-book-2/; Share of total Medicaid spending from Manatt analysis of FY 2014 CMS-64 expenditure data.

manatt

UPL Payments Important, But Concerns Remain

Purposes

- Support to safety net hospitals
- Addresses shortfalls in Medicaid payments

Concerns

- Lack of transparency and accountability
- Generally not tied to value-based purchasing strategies
- Payment often driven by source of nonfederal share
- Calculation is based on a shrinking FFS base

New CMS regulations prohibit supplemental payments that are "passed through" managed care plans.

Redeploying Supplemental Payments

Strategies and Considerations

- **To promote VBP strategies, payments can be folded into FFS or MCO rates**
  - Can target safety net institutions
- **Tie payments to quality metrics/outcomes**
- **Phase-in/transition permitted by new managed care regulations**
- **Changes in how nonfederal share is raised or used might be needed**

Trend 9
Access and Affordability Tensions Continue for Prescription Drugs

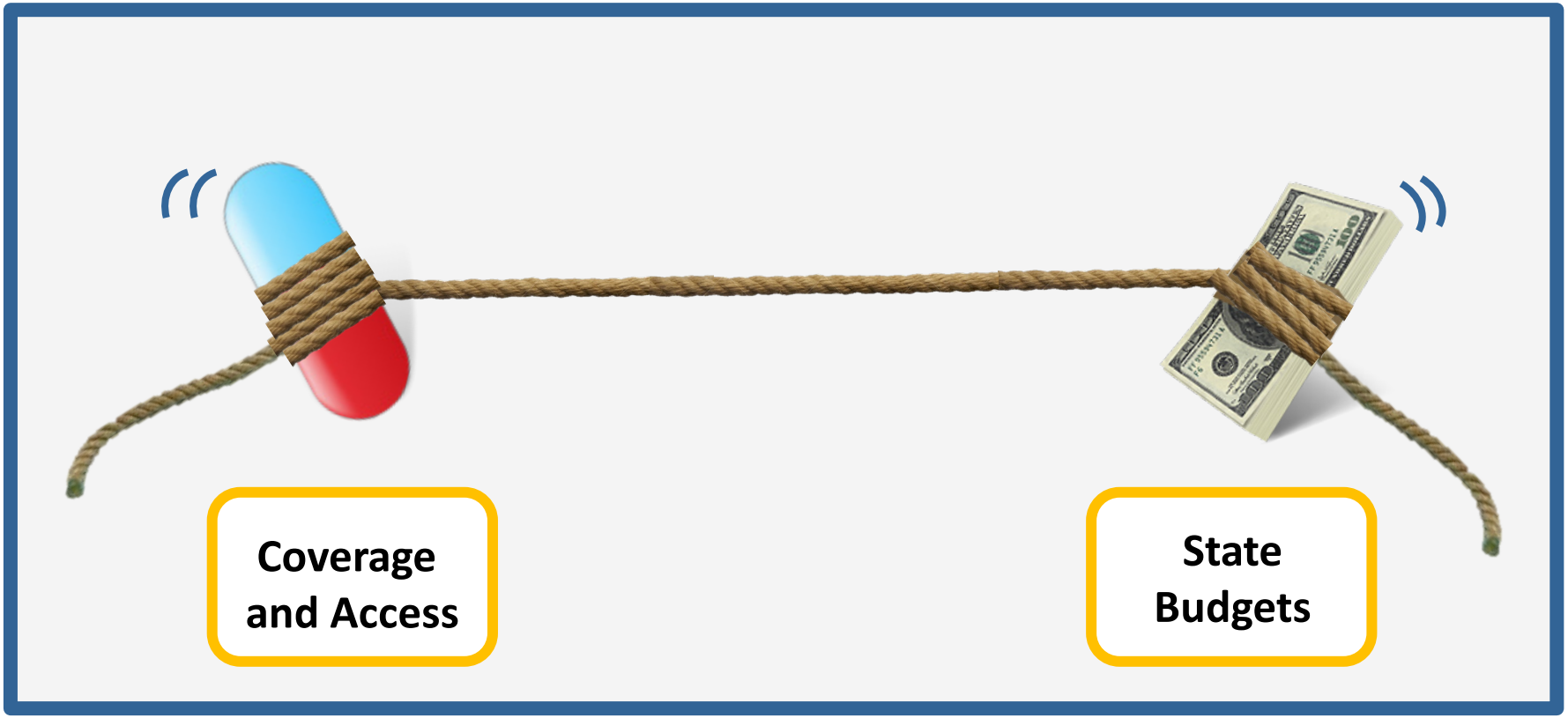
Medicaid Formulary Rules

Section 1927 of the Social Security Act requires state Medicaid agencies to include on their formularies, or through prior authorization, drugs for which the manufacturer provides a rebate.

- ✓ States may apply "clinically appropriate" and "medical necessity" criteria
- ✓ Section 1927 applies to drugs covered under state Medicaid managed care contracts; drugs not covered by the contract must be available through Medicaid fee-for-service

Sources: Social Security Act § 1927(d)(4)(B); SSA § 1927(d)(4)(C).

Tension Remains



Efforts to Resolve the Tension

Statute

Regulations

Guidance

Negotiation

Litigation

Trend 10
State Innovation Waivers Provide a New Angle in the Coverage Expansion Debate

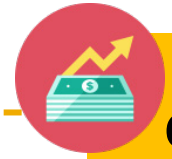
1332 Waivers Provide New Opportunities for States

States may request waivers of certain ACA requirements related to Marketplace coverage, subsidies, and insurance mandates starting in 2017; Section 1332 is *not* a vehicle to waive Medicaid requirements.

Statute anticipates coordination between 1332 waivers and other waiver authorities in Medicaid and Medicare.

Align Policies Across Coverage Continuum

- **Eligibility Rules**
- **Benefits**
- **Plan Design**



Smooth Affordability Cliffs Between Programs

- **Subsidy Scale**
- **Subsidy Eligibility**
- **Cost Sharing**

New Guidance Limits Scope

HHS and Treasury joint guidance issued in December, 2015 provides conditions for waiver approval.

Strict Interpretation of Guardrails

- Minimum Essential Coverage
- Affordability
- Benefit Comprehensiveness
- Budget Neutral – not counting savings from other programs
- Federal Pass-Through Funding

Operational Limitations

- CMS unable to customize Healthcare.gov
- IRS cannot support state-by-state modifications to tax administration

1332 Considerations for States

State 1332 initiatives address a variety of goals.

Several States Seeking to Preserve Pre-ACA Programs

- Employer mandates
- Elements of individual and small group markets
- Direct health enrollment for small employers

Hawai'i, Massachusetts, Vermont

Some States Using Rest of 2016 to Plan for Broader Waivers

- Convene stakeholders to identify opportunities to improve health coverage and financing
- Analyze affordability and access challenges and options
- Prepare for next Administration

California, Minnesota

Opportunity for Medicaid alignment

Much Could Change…





Questions?

Presentation developed by

manatt

Thank You!

Deborah Bachrach| Partner

dbachrach@manatt.com

Melinda Dutton| Partner

mdutton@manatt.com

Cindy Mann | Partner

cmann@manatt.com

Patricia Boozang | Senior Managing Director

pboozang@manatt.com