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Manatt on Medicaid:
10 Trends to Watch in 2015

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Introduction

Medicaid is the single largest payer for healthcare services in every state. With nearly 10 million people enrolling in 2014 alone, total enrollment nationally tops 68 million, or one in five Americans.[1] The largest increases in Medicaid enrollment have been in states that expanded their programs under the Affordable Care Act (ACA) – in fact, take-up rates in expansion states far exceeded projections. But states that did not expand likewise saw an uptick in Medicaid, as the publicity surrounding new coverage options and tax credits caused many previously eligible people to enroll.

As predicted, increased Medicaid enrollment, particularly in expansion states, combined with new federal dollars available through State Innovation Model grants and Section 1115 Delivery System Reform Payment Programs, is fueling unprecedented Medicaid transformation efforts in the states. Indeed, it is hard to find a state that is not intent on becoming a smarter purchaser of services for its beneficiaries.

The growth in Medicaid is also reducing the uncompensated care costs of hospitals, providing millions of new enrollees for Medicaid managed care companies, and generating new customers for pharmaceutical manufacturers. Finally, and crucially, Medicaid's growth nationwide is driving down uninsurance rates, connecting millions of Americans to health insurance and healthcare (many for the first time), and providing a solid foundation on which states can begin to tackle the thorny tasks of improving healthcare quality and access while containing costs.

The following ten trends, we predict, will define Medicaid in 2015.

Trend 1
More States Expanding Medicaid: Economics Trump Ideology

Look for more states to expand Medicaid in the year ahead, tempted by the 100% federal matching rate and strong signals from the Administration that it is feeling flexible about granting waivers.

Trend 2
FFM and State Medicaid Programs: High Stakes, Uncertain Future

Unless upset by a dramatic turn in *King v. Burwell*, more states will turn to the increasingly efficient federally facilitated marketplace (FFM) to carry out Medicaid eligibility determinations on their behalf, moving more people to "real time" eligibility.

Trend 3
Medicaid and Marketplaces Continue to Converge

Convergence of Medicaid and Marketplaces will continue as states look for ways to combine the power of the two markets and issuers increasingly seek to "jump the fence" and play in both arenas.

Trend 4
More States Dive Into DSRIP

Additional states will hop on the DSRIP (Delivery System Reform Incentive Payment) Program bandwagon, even as the Centers for Medicare and Medicaid Services (CMS) demands greater accountability and evidence of long-term sustainability.

Trend 5
Thinking Ahead: State Innovation Waivers and Implications for Medicaid

While not in effect until January 1, 2017, planning for State Innovation Waivers will get under way in earnest, as states explore broad flexibility to redesign the coverage continuum.

Trend 6
Long-Term Care Services Remain a High Priority for States and Consumers

Expect reform of Medicaid-driven long-term services and supports (LTSS), with managed LTSS, rebalancing initiatives such as Money Follows the Person, and Duals Demonstrations topping the list of initiatives to watch.

Trend 7
Pharmaceutical Coverage and Costs: Mounting Tensions

Tensions between states and the pharmaceutical industry will intensify in 2015, as Medicaid programs grapple with specialty drugs that offer relief for debilitating conditions but come with a high price tag.

Trend 8
Medicaid Managed Care: A Period of Dynamic Growth

Medicaid managed care will enter a particularly dynamic period in 2015 as Medicaid enrollment surges, more services and populations move into capitated arrangements, states try to marry managed care with other value-based purchasing initiatives, and CMS issues the first new major Medicaid managed care regulation in a decade.

Trend 9
Children's Health Insurance Program (CHIP): The Road to Reauthorization

With funding slated to expire in September 2015, the popular CHIP program will step into the spotlight again. Its funding will almost surely be extended, but it is not yet clear if Congress will want to revisit some of the CHIP provisions in the ACA at the same time or when it will act.

Trend 10
Medicaid Takes the Reins in State Delivery System Transformation

Fueled by multiple federal funding initiatives to catalyze delivery system transformation, Medicaid programs will increasingly drive statewide payment and delivery system reform.

Trend 1

More States Expanding Medicaid: Economics Trump Ideology

By the end of 2014, 26 states plus the District of Columbia had expanded their Medicaid programs. Many predicted the Republican romp in the 2014 elections would bring an end to additional state expansions, and perhaps even jeopardize some existing expansions. But in the last quarter of 2014 alone, Republican governors in Utah, Wyoming, and Tennessee proposed expansions, joining the ranks of ten additional Republican governors who had expanded their Medicaid programs earlier in 2014. Already this year, Alabama Governor Bentley has indicated that he is now open to expansion. Wyoming's Governor Mead proposed an expansion plan that is being considered by the State's Republican-led Legislature. And, Indiana Governor Pence has received approval from the Centers for Medicare and Medicaid Services (CMS) of the State's expansion waiver, and the newly elected Republican Governor in Arkansas, Asa Hutchinson, announced his intent to extend the State's expansion through 2016, highlighting the benefits to Arkansans, their hospitals and the State itself.

Many factors are bringing states to the table. And it often starts with the money. The federal government is funding 100 percent of state expansion costs through 2016, phasing down to and leveling off at a 90 percent federal match rate in 2020. These new federal Medicaid dollars are a source of relief for state budgets, replacing state funding for such things as the inpatient care of prisoners, mental health and substance abuse services, and uncompensated care. With the 100 percent federal match ending after 2016, states are finding ways to cover the state share, most notably through hospital assessments and trust funds to reserve savings generated in the early expansion years. We expect the economic pressure to expand will ratchet up as states facing 2015/16 budget shortfalls begin to see the economic benefits of the 2014 expansions in neighboring states.

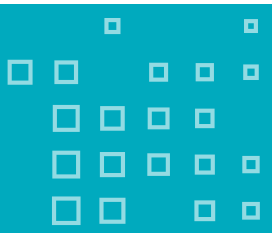
Economics is not the only factor sweetening the Medicaid expansion pot. Equally important is the flexibility to provide coverage to residents through state-designed models that embrace conservative policy priorities. Virtually every state mentioned above has received (or is negotiating) approval from CMS to use some combination of premiums and cost-sharing, incentives for healthy behavior, and/or to establish health savings-like accounts. While states may not condition coverage on work, CMS has permitted states to connect expansion adults to work opportunities and job training. Some states are also requiring or encouraging Medicaid beneficiaries with access to employer-sponsored insurance to enroll in that coverage, with Medicaid subsidizing premiums and cost sharing above Medicaid levels. Several states are building on the Arkansas "Private Option," using Medicaid funds to purchase private coverage for the expansion adults. Finally, the recent approval of Indiana's

expansion waiver with a six-month lockout of adults with incomes above the poverty level and increased co-payments for repeated non-emergency use of the ER serve as an important reminder of CMS's willingness to work with governors in crafting state-specific expansions.

Of course, there are countervailing forces to the growing expansion momentum – political opposition in legislatures has remained strong in many states, and the closer states get to 2017 the more the state share looms. Nevertheless, expect the combination of state budget pressures and alternative expansion models to enable as many as five additional red states to embrace Medicaid expansion in the year ahead.

Trend 2

FFM and State Medicaid Programs: High Stakes, Uncertain Future



With 37 states using the FFM in 2015, the FFM has emerged as a far bigger player in providing eligibility and enrollment services to Americans seeking health insurance, including Medicaid, than had been anticipated. The implementation of the FFM has added a new facet to the Medicaid relationship between state and federal governments: in addition to their traditional regulatory and financial dependencies, Medicaid programs in FFM states now relate to CMS as a partner in determining program eligibility.

The first year of the FFM/state Medicaid relationship was a rocky one. Well-publicized healthcare.gov failures early in 2014 sent frustrated consumers to state application channels, including local Medicaid offices. Behind the scenes, both FFM and state IT functionality to support two-way "account transfer" for consumers who applied at healthcare.gov but were eligible for Medicaid coverage (or vice versa) were fraught with technical errors and operability problems. States and CMS spent much of 2014 hammering out manual workarounds and technical corrections to improve eligibility and enrollment for consumers in FFM states.

Despite these challenges, approximately 4.6 million additional individuals were enrolled in Medicaid and CHIP in FFM states as of October 2014. And the FFM and states have made marked improvements in their application, eligibility determination and account transfer systems and processes. The 2015 open enrollment period has run relatively smoothly despite some persistent challenges. In perhaps the greatest sign of progress, it appears that in "determination states" – those that permit the FFM to make Medicaid eligibility determinations on their behalf, based on state rules – most consumers receive near to real-time Medicaid eligibility determinations.

As the FFM continues to improve its technology and business processes, we anticipate that more states will transition to the determination model, accepting

Medicaid determinations from the FFM with "no touch" required at the state level to effectuate enrollments. If states gain confidence in the FFM's determination model, they could realize administrative efficiencies and savings. In the longer term, as basic FFM eligibility functionality is honed, many states hope the FFM will begin to customize its services and functions for state program features, such as the ability for Medicaid-eligible individuals to shop for and select Medicaid plans through healthcare.gov.

Finally, a Supreme Court decision in favor of the plaintiffs in *King v. Burwell* – which would result in the loss of tax subsidies for Marketplace enrollees in FFM states – could significantly alter the FFM and its level of "business" with states. On the one hand, the volume of healthcare.gov applications would likely plummet as tax credits become unavailable in FFM states, requiring far less interaction between the FFM and state Medicaid programs. On the other hand, the current FFM eligibility determination infrastructure could be leveraged by emerging State-Based Marketplaces, as states seek to preserve tax credits for their citizens without incurring the expense and time required to build new eligibility systems. The combined effect could be increased pressure on CMS to improve FFM functionality and service offerings to states.

The bottom line? Whether due to existing pressures or shifting demands, expect FFM/Medicaid enrollment processes to continue to improve in 2015, offering more timely services to consumers and greater functionality to states.

Trend 3

Medicaid and Marketplaces Continue to Converge

We called it last year and predict more of the same in 2015: look for greater convergence of the coverage offered through Medicaid and Marketplaces in the year ahead. Driven by the more than one-third of low-income adults who churn between Medicaid and Marketplace eligibility over just a six-month period, this emerging trend is likely to include:

- **Playing in Both Medicaid and the Marketplaces.** In the year ahead, more issuers can be expected to "jump the fence" as companies such as Aetna, United and WellPoint continue to move more aggressively into the Medicaid managed care market even as traditional Medicaid managed care companies become bigger players in Marketplaces. More than 40 percent of issuers offer both a Medicaid managed care plan and a Qualified Health Plan (QHP), and this key metric is likely to rise in the year ahead.[2]
- **Buying QHPs for Medicaid Beneficiaries.** More states seeking alternative approaches to Medicaid expansion are likely to pursue the option to use Medicaid funds to purchase QHPs for beneficiaries. Already in effect in Arkansas and Iowa, this "private option" approach is being pursued by New Hampshire and Utah in 2015.
- **Full Convergence.** Especially with State Innovation Waivers visible on the horizon and the Basic Health Plan now a live option, 2015 may be the year when some states begin

to pursue full integration of Medicaid and Marketplace across benefits and cost-sharing structure, provider networks and network adequacy standards, rates, quality and care management requirements, and oversight.

The convergence trend is key for providers and plans as it has the potential to dramatically reshape their relationships with state regulators who will have far greater leverage as Medicaid and Marketplaces merge. Add in purchasing for state employees, and states will have significant influence across plans and providers. From a consumer perspective, convergence promises to ease care transitions and mitigate the effects of churn, providing a more effective coverage continuum on which to build an integrated, quality, cost-effective healthcare system.

Trend 4

More States Diving Into DSRIP

As predicted, more states stepped up in 2014 to propose "Delivery System Reform Incentive Payment" or "DSRIP" waivers, and we anticipate a further acceleration of the trend in 2015. By providing states with the flexibility to make Medicaid-funded incentive payments to providers implementing delivery system reform projects and meeting performance benchmarks, DSRIP waivers are rapidly becoming a key transformation tool for CMS and state Medicaid agencies. States also have SIM grants, health homes, and other initiatives under way, but DSRIP waivers are dominating delivery system reform discussions because of the sheer magnitude of dollars that they can bring to a state and its providers – ranging from hundreds of millions of dollars over the life of a waiver in Kansas, New Jersey, and Massachusetts to billions in states such as New York, Texas and California.

CMS's approach to DSRIP waivers has evolved over the last five years, with increasing emphasis on clear goals, metrics to evaluate state and provider progress, and long-term sustainability. Specifically, expect increasing emphasis on:

- **Statewide Accountability.** It no longer is just providers that must meet performance metrics — in New York, the state as a whole now must meet key measures, including a 25 percent reduction in avoidable hospitalizations by the end of the waiver. The continued flow of funding over the life of the waiver depends on meeting these metrics.
- **Community-Based Approach.** In New York and Texas, partnerships of hospitals, community-based clinics and other providers and social services organizations are eligible for DSRIP payments and responsible for change, not hospitals alone.
- **Sustainability.** CMS is increasingly looking for states to have a plan for converting the DSRIP investments into long-term, sustainable changes to their delivery systems, through Medicaid managed care integration, shifts to value-based payment, and alignment with multi-payer reform initiatives.

The DSRIP trend will have major implications for states, providers and beneficiaries, as well as for Medicaid managed

care companies grappling with changing provider and member relationships. Companies offering innovative patient engagement strategies, care management tools, and health information exchange solutions can expect new opportunities to support providers in meeting performance benchmarks.

Trend 5

Thinking Ahead: State Innovation Waivers and Implications for Medicaid

Since its passage in 2010, the ACA has fueled a wide range of policy innovations – only a subset of which are highlighted in these trends. But all of these reforms could be overshadowed by State Innovation Waivers.

State Innovation Waivers (also referred to as Section 1332 waivers) permit states to effectively change the coverage terms of the ACA without abandoning its core goals. States can, for example, propose alternative approaches to providing Marketplace coverage, allowing states to receive the aggregate value of the federal funding that would have gone directly to individuals or small businesses for tax subsidies. But there are some limits: State Innovation Waivers must provide coverage that is at least as comprehensive and as affordable to at least the same number of people without contributing to the federal deficit.

States otherwise have wide latitude to modify the requirements of the law, opening the door to broad scale reform, as well as the ability to smooth jagged edges between Marketplace, Medicaid and CHIP coverage. The law permits State Innovation Waivers to be combined with Medicaid, CHIP and Medicare waivers – coordinating approval processes and cost neutrality evaluations, and thereby enabling innovation across the coverage continuum. For example, a state could design a new system of subsidies that extends to all individuals with incomes below 400 percent of the federal poverty level (FPL), minimizing distinctions among subsidy programs and smoothing the premium and cost-sharing cliff for individuals with incomes just above Medicaid levels. (This is precisely what was envisioned by the Basic Health Program (BHP) under Section 1331 of the ACA; however, BHP provides states with only 95 percent of the tax credit and cost-sharing funds and limits its use to individuals with incomes below 200 percent of the FPL.) The ability to combine the cost neutrality evaluation across programs could prove particularly helpful in states like Arkansas, which expanded Medicaid through an 1115 waiver permitting Medicaid beneficiaries to enroll in QHPs: tax credit savings due to increased competition among QHPs could be offset against the costs incurred enrolling Medicaid beneficiaries into QHPs. Combined, State Innovation and 1115 Waivers also could be used to facilitate multi-payer delivery system reform, for example, by aligning performance requirements and/or value-based payment initiatives across the public and private health insurance markets.

While State Innovation Waivers cannot take effect before January 1, 2017, a handful of states have already started to eye their

potential, and we expect interest to build in 2015. With public comment requirements and a six-month federal approval process, expect the first waiver applications to be filed in early 2016. State Innovation Waivers are more likely to emerge as a trickle than a torrent – the law specifically requires state statutory authority to request a waiver, which will mean approval by state legislatures in some states. Early adopters are likely to be Medicaid expansion states with State-Based Marketplaces that are seeking to sidestep specific federal requirements that have created barriers to implementation and broader reform.

However, State Innovation Waivers are also likely to hold appeal for states that, to date, have been resistant to federal reform. Much as 1115 Waivers have created opportunities for states to embrace coverage while rejecting "Medicaid expansion," State Innovation Waivers provide a vehicle for states to craft tailored coverage initiatives – meeting policy imperatives, political optics and market demands of their local environments. The financial stakes are substantial – particularly when combined with enhanced federal Medicaid expansion funds – bringing potential budget relief for cash-strapped states.

Given the dollars at stake, the potential for newly configured coverage paradigms, and the opportunity to transform healthcare delivery, the State Innovation Waiver is a trend to watch in 2015.

Trend 6

Long-Term Care Services Remain a High Priority for States and Consumers

State Medicaid agencies are the largest payer for long-term services and supports (LTSS). With LTSS representing more than a third of Medicaid annual expenditures nationally, and facing growth in both the population eligible for and utilization of services, state Medicaid agencies are highly motivated to manage LTSS costs, and have increasingly emerged as a force for change in the way services are paid for and delivered. Expect the trend toward Medicaid-driven LTSS reform to continue in 2015, with managed LTSS, rebalancing initiatives such as Money Follows the Person, and State Demonstrations to Integrate Care for Dual-Eligible Individuals topping the list of initiatives to watch.

- **Managed Long-Term Services and Supports (MLTSS).** Managed care for seniors and people with disabilities who use LTSS is small, but steadily growing. According to the Kaiser Family Foundation, 19 states had MLTSS waivers as of October 2014 (11 out of the 19 were approved in the last three years), covering seniors and non-elderly adults with physical disabilities; several states also include people with intellectual/developmental disabilities. Most MLTSS programs are statewide, mandatory, and cover comprehensive benefits, including primary and acute care, skilled nursing facilities, behavioral health, and home and community-based services (HCBS).[3] Despite early concerns about the readiness of traditional managed

care providers to manage this high-need population, MLTSS have continued to proliferate and are likely to grow further in 2015, as more states participate and those with existing MLTSS programs expand to cover new populations (such as individuals with intellectual/development disabilities) and services (including institutional care). One key area to watch: performance measurement. While states are required to have a quality strategy in place prior to implementation, an industry consensus has yet to coalesce around the best measures of success.

- **Money Follows the Person (MFP).** Fueled by the opportunity for enhanced federal funding as well as the potential to move high-need/high-cost populations into community-based settings, states will continue to adopt and expand the MFP initiative, as well as other programs targeted at rebalancing LTSS toward home and community-based care and away from institutional care. Rebalancing efforts have been under way in states for more than two decades, but with $450 million per year in additional funding allocated under the ACA[4] and an expanded definition of eligibility, beneficiaries participating in the program have more than quadrupled since 2010, and today all but six states have a program in place. Most participants are elderly or physically disabled, though almost a quarter of program participants have developmental disabilities or mental health issues.[5] Also expect continued efforts to combine MFP with other LTSS initiatives, including the Balancing Incentive Program (BIP), which provides financial incentive to states with low levels of spending on home and community-based care to undergo structural reform. With the current funding allocation for MFP set to expire in 2016, states will be looking to fully leverage available resources to accelerate structural reform efforts – and because "stacking" of federal funding is permissible across MFP, BIP and other programs, states will become increasingly creative in maximizing federal support for these efforts.
- **Duals.** Manatt flagged State Demonstrations to Integrate Care for Dual-Eligible Individuals as a trend to watch in 2014, and unfortunately the implementation challenges identified a year ago continue. As of July 2014, CMS had finalized agreements with 12 states to implement demonstrations.[6] To date, four states have operational dual-eligible demonstrations, and five more are expected to launch this year. An additional eight states have withdrawn applications, and enrollment in existing demonstrations has failed to meet targets. Nevertheless, as the number of participants and participating states continue to grow in 2015 and evaluation of the program gets under way, the duals demonstrations will continue to be a trend worth watching in 2015.

Bottom line, given an aging population and the expense of coverage and care for Medicaid beneficiaries requiring long-term care services, this is an area that will continue to garner the attention of state and federal officials, while providing opportunities and challenges for stakeholders.

Trend 7

Pharmaceutical Coverage and Costs: Mounting Tensions

While states have long wrestled with the pharmaceutical industry over the cost of providing medications to Medicaid beneficiaries, in 2014 the tension between state costs and patient access moved center stage as states grappled with the introduction of specialty drugs that offer relief, if not cures, for debilitating conditions, but come with high price tags that strain state budgets.

Medicaid formulary rules require states to provide access to drugs where manufacturers offer a rebate – 23% or the best price, whichever results in a lower price — unless the drug has no clinically meaningful therapeutic advantage. States may use utilization management (UM) tools, such as prior authorization and reauthorization requirements, generic preferences and step therapy, so long as these tools do not deny medically necessary drugs to Medicaid patients. The standards are clear; the reality far less so. Expect the boundaries to be further tested in 2015.

Notably, these formulary rules do not apply to Medicaid managed care plans that are, for the most part, free to develop their own formularies and UM standards, subject to Medicaid's general medical necessity standard. However, as states increasingly rely on private managed care plans, they are reconsidering whether to require these plans to follow state standards to ensure adequate access for consumers to necessary medications. Specifically, states are increasingly requiring plans to use state formulary rules, to apply certain prior authorization standards, or to offer "transition fills" to ensure access to essential medications when beneficiaries change health plans. Alternatively, states may carve out certain high-cost drugs from their payments to managed care plans or implement "provider prevails" laws, again to ensure access to certain drugs or drug classes.

With many states expanding Medicaid, the issue of how to balance costs with access to necessary medications will become even more pressing. Minimum standards for prescription medications for new adults are linked to the QHP rules. Even so, most states that expanded Medicaid in 2014 maintained the same formularies for new adults as they use for other beneficiaries, rather than opting for the more limited rules applicable to QHPs. However, many states found that the requirement to tie drug coverage to a base benchmark plan did require them to eliminate monthly prescription limits for Medicaid beneficiaries.

Tension between costs and access will likely ratchet up in 2015 engendering further dialog – if not solutions – on how best to ensure patient access to emerging treatments and cures without busting state budgets.

Trend 8

Medicaid Managed Care: A Period of Dynamic Growth

Medicaid managed care is in a dynamic period of change characterized by ACA-driven enrollment increases, shifts in covered benefits and populations, anticipated new federal regulations, and evolving state and federal policies intended to influence the role of managed care in driving value-based payment and broader delivery system reform.

Managed care continues to be the dominant delivery model in state Medicaid programs, and is rapidly growing with the ACA expansion bringing over 8 million new beneficiaries into Medicaid in 2014. Today, 39 states (including DC)[7] enroll beneficiaries in managed care plans (comprehensive managed care organizations) and more than half of all Medicaid beneficiaries are now covered through such plans.[8]

With continued pressure to reduce Medicaid expenditures and better coordinate care for high-need beneficiaries, states are extending Medicaid managed care to high-cost/high-need populations (including the aged, blind and disabled, those with serious mental illness and substance abuse conditions, and waiver populations) and including a broader range of previously carved-out benefits (including pharmacy, behavioral health, and long-term care services).

The growth of Medicaid managed care in all of these areas brings with it increasing federal scrutiny of contracting, provider network adequacy, rate setting, and provider payment arrangements. A September 2014 Office of Inspector General report on access to care in Medicaid managed care programs concluded that federal and state officials have not done enough to ensure that Medicaid beneficiaries have adequate access to physicians, and recommended increased federal oversight on network capacity and access standards in state managed care programs. The regulatory landscape is likely to shift dramatically as CMS is expected to release updated managed Medicaid regulations imminently – rules that haven't been significantly updated in a decade. The new rules are expected to address a sweeping array of issues related to among other things: actuarial soundness of managed care rates, marketing rules, consumer protection, and incorporation and alignment of long-term care payment, Children's Health Insurance Program (CHIP), and ACA guidance.

But perhaps the hottest trend in Medicaid managed care in 2015 (and beyond) will be evolving state and federal policies designed to leverage Medicaid managed care programs in accelerating payment and delivery system reform. State Medicaid programs are increasingly focused on value-based contracting with health plans and providers to help Medicaid achieve the "Triple Aim" of improving patient experience, population health and per capita costs.[9] State Medicaid programs are transitioning away from traditional fee-for-service reimbursement to performance-based payment methods, including pay-for-reporting, pay-for-quality and pay-for-performance-models, and this

is spilling over to Medicaid managed care.

Medicaid managed care states are pursuing payment reform through a variety of mechanisms including requiring their managed care contractors to transition to value-based payment arrangements with their providers and compelling plans to contract with provider-driven delivery systems. Two states on the forefront of this transition are Massachusetts and New York: Massachusetts is implementing alternative payment methods for 80 percent of its members (two-thirds of whom are in some form of managed care) by July 1, 2015; and New York is seeking to transition 90 percent of managed care payments to providers using value-based payment methodologies by 2019. In these and other states, state officials and policymakers are moving to more tightly align and integrate their Medicaid managed care programs and payment reform initiatives. How Medicaid managed care states address myriad, complex issues related to advancing payment reform through managed care and the coexistence of Medicaid managed care and provider-driven delivery systems will be issues to watch in 2015.

Trend 9

Children's Health Insurance Program (CHIP): The Road to Reauthorization

With no new CHIP funding available after September 30, 2015, all eyes are on Congress to see whether it will extend funding for the program. Enacted in 1997, CHIP is a federal-state program providing subsidized coverage to children with family incomes just above a state's Medicaid levels, in most states ranging from 200% to 300% of the FPL. CHIP has grown to be a successful coverage vehicle for more than 8 million low- to moderate-income children.

The ACA requires states to maintain their 2010 CHIP eligibility levels through 2019, a provision known as the "maintenance of effort" (MOE) requirement. If CHIP funding is not extended, states that have expanded CHIP through their Medicaid programs must continue that coverage but at the lower Medicaid federal matching rate. States with separate CHIP programs may limit their CHIP enrollment based on the availability of federal funding, effectively creating an exception to the MOE requirement. In the absence of federal funding, the ACA requires states to enroll children who would otherwise have been enrolled in CHIP into QHPs that have been certified by the Secretary of Health and Human Services as offering coverage "at least comparable" to CHIP covered services and cost-sharing.

Families of CHIP eligible children transitioning to the Marketplace would likely experience substantial increases in out-of-pocket costs, reduced coverage for pediatric dental and vision services and fewer child-specific services. In addition, an estimated 2 million children will not be eligible for subsidies for QHP coverage due to the "family glitch," a provision of the ACA that bases "affordability" on individual rather than family coverage.

As a result of these issues, a consensus is emerging that CHIP funding should be extended. The National Governors Association has called for an extension, as have 36 out of 41 states that responded to a congressional inquiry. The nation's governors have been joined by a cadre of advocacy groups on the left and some right-leaning organizations, such as the American Action Forum. In June 2014, Congress's advisory body on Medicaid and CHIP, the federal Medicaid and CHIP Payment and Access Commission (MACPAC), recommended that CHIP be extended for at least two years.

Given this emerging consensus, it is very likely that Congress will extend CHIP funding, but in what form and for how long remains to be seen. MACPAC has recommended extension for two years, though CHIP supporters are likely to push for 2019, when the MOE expires. Republican members, now in the majority in both houses of Congress, may want to revisit some of the issues that arose during the ACA debate over the future of CHIP, such as whether the MOE should be maintained.

The enhanced federal matching rate (FMAP) for CHIP is also an issue to watch – reductions would decrease the federal cost of extension, but also stoke state fears about the continued availability of enhanced FMAP under Medicaid. Finally, Congress has a history of going "down to the wire" when it comes to CHIP funding extensions; so, while there are increasing signs that Congress may tackle the funding extension this spring, it is possible that the future of the program will not be known until later in 2015.

Trend 10

Medicaid Takes the Reins in State Delivery System Transformation

Fueled by multiple federal funding initiatives to catalyze delivery system transformation, Medicaid programs are increasingly driving statewide payment and delivery system reform. The scale and scope of current federal and state initiatives are unprecedented. A second round of Health Care Innovation Awards were awarded in 2014, providing $360 million to improve care and lower costs to people enrolled in Medicare, Medicaid and CHIP.

An additional $900 million in State Innovation Models (SIM) grants have been announced to support the development of multi-payer payment and delivery system transformation. Despite a bumpy launch, Dual Demonstrations continue to move ahead in eighteen states; more than a dozen states have State Plan Amendments authorizing Medicaid health home initiatives;[10] and eighteen states are leading or participating in accountable care models that include Medicaid and the CHIP.[11] These initiatives supplement DSRIP waivers and new value-based contracting requirements for Medicaid managed care organizations described elsewhere in this document.

While state reform efforts are diverse – targeting different populations, deploying varied clinical interventions, and relying on separate funding streams – common themes are emerging.

- **Greater accountability at the site of care.** Increasingly, states are pushing performance accountability, care management responsibility and financial risk to the site of care. Provider-led care management initiatives are emerging both in states with robust Medicaid managed care programs – including New York and Massachusetts – and in states where provider-led initiatives provide an alternative to traditional managed care – including Colorado, Oregon and Alabama.
- **Focus on integration of physical and behavioral health.** Medicaid finances more than a quarter of the nation's spending for behavioral healthcare and populations with co-occurring physical and behavioral health needs are among Medicaid's highest cost and highest need patients. Mounting evidence illustrates that siloed care and inadequate access are contributing to poor outcomes and high cost, and it is therefore not surprising that nearly every major reform initiative is targeting the integration of physical and behavioral health.
- **Value based payment.** As in DSRIP, state and federal reform efforts are making payment contingent on increasingly rigorous metrics, ratcheting up from pay-for-reporting to pay-for-performance, and ultimately, payment for outcomes.
- **Focus on community health.** Defined by geographic/regional boundaries, focused on population health, and looking beyond the clinical encounter to focus on social determinants of health and the services outside the clinical setting required to address these needs, reform efforts are increasingly moving beyond the hospital board room to seek a shared community commitment to wellness.

Not surprisingly, these initiatives have to overcome some hurdles. Marked progress in recent years in electronic health record adoption, health information exchange, and state-led data aggregation and dissemination efforts have yet to fill the data gap. The scope and scale of workforce shortages are posing a serious threat to reform while escalating efforts to expand the role of physician alternatives and implement new models of team-based care. And states are taking a fresh look at legal requirements –from antitrust, to patient consent, to siloed operational and payment requirements that interfere with co-location of physical and behavioral health – all with an eye to eliminating barriers to transforming care delivery.

Despite the challenges, reform momentum is building and early results are positive. In the year ahead expect states leading the transformation curve to become increasingly sophisticated in changing the payment paradigm from volume to value, and reorganizing systems of care.

About Manatt

Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is a fully integrated, multidisciplinary legal, regulatory, advocacy and strategic business advisory healthcare practice. Manatt Health's extensive experience spans the major issues reinventing healthcare, including payment and delivery system transformation; health IT strategy; health reform implementation; Medicaid expansion, redesign and innovation; healthcare mergers and acquisitions; regulatory compliance; privacy and security; corporate governance and restructuring; pharmaceutical market access, coverage and reimbursement; and game-changing litigation shaping emerging law. With 80 professionals dedicated to healthcare—including attorneys, consultants, analysts and policy advisors—Manatt Health has offices on both coasts and projects in more than 20 states. For more information about Manatt Health, contact www.manatt.com/HealthcareIndustry.aspx.

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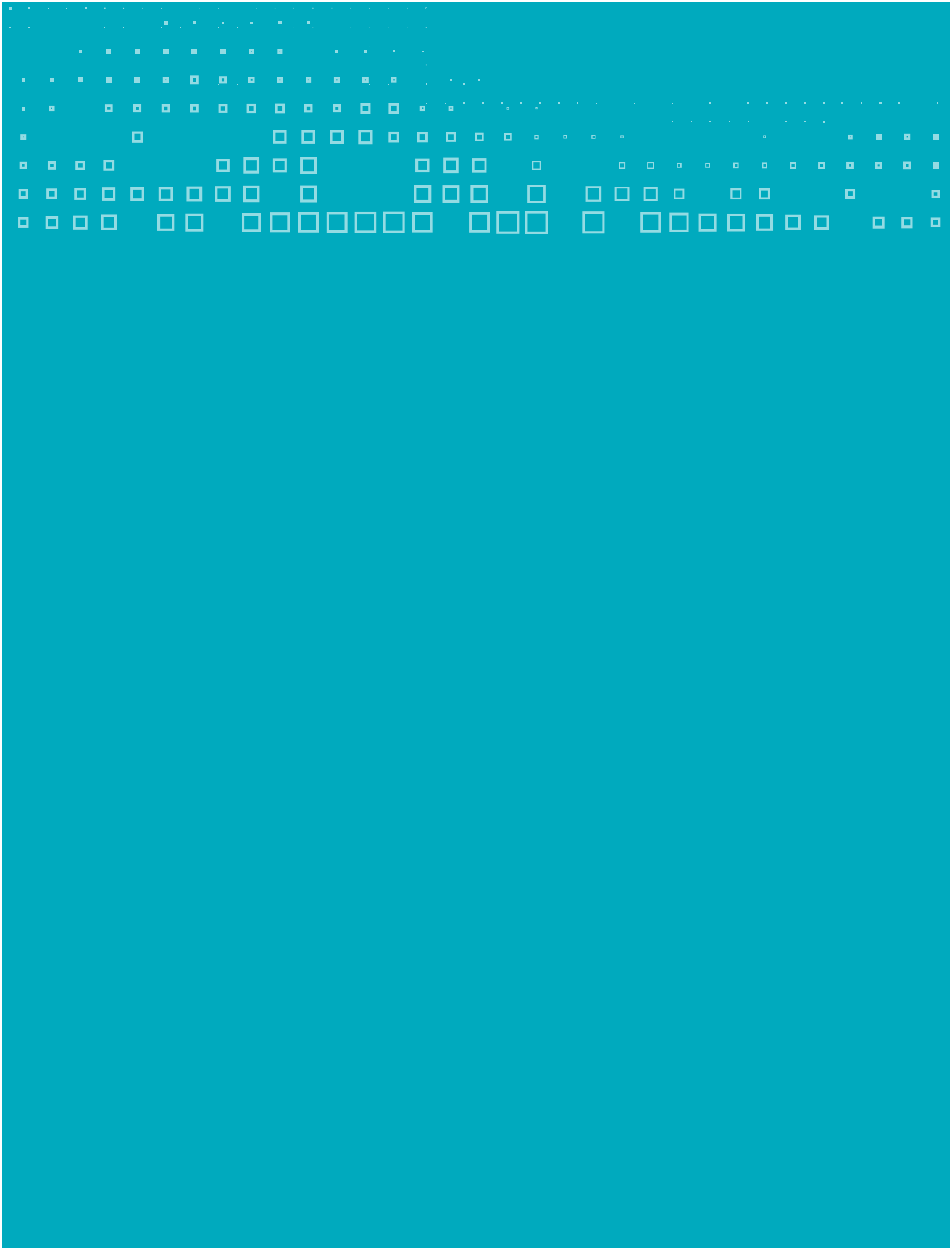

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