# Innovative Solutions for Medicaid

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## Introduction

One part of the proposed legislation to "repeal and replace" the Affordable Care Act would implement a so-called "per capita cap" on the Medicaid program. Some Republican legislators have put forward per capita caps as a health system "solution." In fact, caps are not a solution; they create a problem. Caps do not actually reduce the need for care or reduce the cost of care. They only cut the amount of federal money states receive to meet the same health care needs of their residents at the same cost. Less money to meet the same needs is a new problem for states—not a solution. Capping Medicaid is the wrong approach, especially considering that states already have solutions to meet the needs of their residents that will actually reduce costs. These bipartisan solutions should be the focus of legislators, who can learn from the innovations already under way in Medicaid, and the ones that could be expanded or multiplied across the country. This paper is about those real solutions.

## I. Per Capita Caps are Not the Answer

Since 1965, Medicaid has operated as a federal-state partnership where states receive on average 63% of the costs of Medicaid from the federal government.[1] Today, Medicaid pays for health care coverage and services as they are needed. Thus states have the ability to address serious health care problems for older adults, persons with disabilities, pregnant women, and children living in poverty, while paying just 37% of the cost. The federal funds are based on the actual costs of providing Medicaid services in the state. Congress's plan to repeal and replace the Affordable Care Act, called the American Health Care Act (AHCA) proposes to restructure Medicaid by implementing a per capita cap.. Under a per capita cap, the federal government sets an artificial cap on how much funding it gives states, even if the states costs go up. If implemented, this cut will radically reduce available funding for state Medicaid programs over time, resulting in states cutting coverage and services for all enrollees.[2]

The AHCA per capita cap proposal would change federal Medicaid funding from a guarantee to a per person allotment by 2020. The per capita cap would cut the federal contribution per Medicaid enrollee based on a state's 2016 expenditures and is increased annually at an inflation rate that is projected to grow slower than yearly state Medicaid health care costs.[3] Under the AHCA bill that passed out of the House in March, states would receive payments during the year based on their estimated number of people enrolled in their Medicaid program. The amount of the payment would be determined by estimating the average cost per person of providing health care services to specific groups, including children, people with disabilities, older adults, and other adults. Thus, the per capita cap proposal sets an annual upper limit on federal spending per Medicaid enrollee. The federal funding to the state would only increase if enrollment in the state's Medicaid program rises during the year, but would not increase if costs to provide Medicaid services to those enrolled in the program increased or exceeded the federal per person allotment.

Because these caps set an upper limit on spending, they divorce Medicaid financing from people's actual health care needs. While the amount of the cap is based on actual services and costs from the past, it does not account for future changes. For example, if state X was given a cap on spending for adults based on its spending in 2013, and in state X, about 1% of adult enrollees are infected with hepatitis C. For most of 2013, the prevailing treatment for hepatitis C was relatively cheap—about $10-40,000 for a course of treatment, depending on its length.[4] But that treatment regimen was not very effective—it cured only about 40-50% of those treated, caused significant side effects, and took several months to complete.[5] Then, in late 2013, two new "breakthrough" treatments for the disease became available; they cured over 90% of those treated with a 12-week course of treatment, and caused few side effects.[6] But their cost was high—the new drugs were listed at $66,000 and $84,000 per course of treatment.[7] Now the amount provided to State X to provide Medicaid to its adult enrollees in 2014 is based on an assumed cost of about $30,000 per course of treatment for hepatitis C, based on its experience in 2013. But the actual average cost of treating hepatitis C in State X in 2014 is more than twice that amount—about $70,000 per course of treatment. If the infection rate in 2014 increases to 3%, such that more enrollees need treatment, State X's expenditures will increase by 600%. To avoid spending more than the capped amount, State X will either have to withhold the new, highly effective treatments for hepatitis C, or make cuts to other services to make up the difference. In this way, caps become harmful cuts on Medicaid enrollees.

Caps force states to cut services or ration care whenever costs increase beyond the cap—even if the reason for the increase is completely out of the state's control. If a state exceeds the cap, no additional federal funds will be provided to cover those costs. In short, states lose when it comes to a cap – and data shows many states will lose substantially.[8] The states bear all the risk because the cap sets an upper limit on federal spending, but does not allow states

to save or reserve funds if their spending is less than the capped amount. Thus, even if the amount of funding available to states under the cap grew at exactly the rate of average Medicaid spending, total federal support for states would drop substantially, because the federal government would pay most states less but no state would get more.[9]

## II. Caps Stifle Innovation

Reducing overall funds puts pressure on state budgets to be conservative rather than think creatively or expand services through new innovation. After the 2008 recession, at least 31 states plus the District of Columbia cut health care (including cuts to Medicaid and public health), and 29 states plus D.C. cut medical, home care, rehabilitative, or other Medicaid services needed by low-income seniors and people with disabilities.[10] An interview of Medicaid Directors in 2009 found that—faced with rapidly increasing growth in their state Medicaid programs—the Directors' primary goal for the next year's budget was to "maintain as much of the current program coverage and value as possible and to minimize loss of services and erosion of access for individuals."[11] As a result, during the state recession, many state Medicaid programs shifted away from planned delivery reform or innovation projects, and simply gave up on opportunities to improve care *and* reduce costs.[12]

Historically, funding crises have led to regression in innovation, worse outcomes for enrollees, and have often resulted in other unintended consequences. For example, after the 2008 recession, many states cut behavioral health services in particular at a time demand for these services was rising.[13] In Nevada, cuts to mental health services during the recession resulted in multiple lawsuits against the state, and a major hospital losing its accreditation in 2013.[14] Between 2008 and 2013, the state gained infamy for discharging patients from inpatient mental health treatment services with a bus ticket out of state and a few days' worth of medication as a follow-up treatment.[15] Since then, the state has invested in its mental health system, resolved the lawsuits, and worked with the hospital to regain its accreditation in 2015.[16] Nevada has been able to invest in its behavioral health delivery system since 2014 by using Medicaid Expansion funds to provide more integrated behavioral health services to low-income Nevadans. Now more people are getting services and the state has been able to expand its behavioral health workforce.[17] These recent gains could be lost if caps reduce the funds available to the state.

Medicaid caps pose a particular risk to individuals who need the most care. Medicaid enrollees are more likely to have chronic conditions, disabilities, or other special health care needs.[18] Medicaid also covers nearly half of births in the nation.[19] Medicaid programs have invested in effective care management programs that help individuals with the highest need for care "achieve better access to needed care, navigate their way through complex systems, and increase the self-management and self-advocacy skills necessary to function as informed and

'activated' health care consumers."[20] With less money to spend on their Medicaid programs, states could be forced to cut back or even eliminate these innovative and effective programs. For example, one study found that during the 2008 recession, North Carolinian women enrolled in Medicaid were less likely to receive prenatal care after the state cut reimbursement rates to maternity care coordination.[21]

Sometimes innovation requires a major up-front investment, but the funds for that type of investment are less likely to be available if program funding is capped. In recent years, the federal Centers for Medicare & Medicaid Services (CMS) has been leading the charge to use "value-based purchasing," that is, to calculate health care payments in part based on the value of the services received.[22] In 2005, CMS began approving Delivery System Reform Incentive Payment (DSRIP) programs in states. DSRIP programs allows states to channel additional payments to Medicaid providers (such as extra funding for hospitals), but only if the providers make innovative health investments.[23] Currently, eight states have approved DSRIP programs in various stages of implementation. [24] A recent survey of these programs noted that they support major system transformations, while stabilizing the safety net and improving population health.[25] To do this, however, DSRIP programs require a significant investment of resources by all participants, including the federal and state governments, and participating providers.[26] The investment of resources is often front-loaded, as "for process and infrastructure improvements in earlier years, as they are necessary to achieve clinical improvements in later years."[27] Caps will discourage these kind of up-front investments in system improvements that are designed to create long-term savings, making it harder for states to address social determinants of health.

## III. Medicaid is Already a Source of Innovation

Medicaid has a long history of funding new models of care delivery, spurring cutting edge health care treatments, and sparking trends across the health care field.[28] Designed to meet the needs of a low income population, Medicaid has a track record of making investments to address the social determinants of health and health disparities that drive health care costs. In the 1970s, Medicaid made investments to improve infant mortality; in the 1980s, it worked to advance care delivery for people with disabilities; and in the 1990s, it expanded managed care coverage to families enrolled in Medicaid to provide them with better coordinated care.[29]

Medicaid also has a long history of helping states to weather major natural disasters and public health emergencies. For example, after the September 11th terrorist attacks in New York, much of the state's Medicaid computer system was damaged.[30] The state and federal government worked together to establish Disaster Relief Medicaid (DRM) in New York City to respond to this crisis.[31] DRM made the Medicaid application process easier and more streamlined to ensure that people impacted by the attacks had access to needed medical care

without delay.[32] More recently, Medicaid has helped West Virginia to address the opioid addiction crisis that has cost thousands of lives in that state.[33] West Virginia Medicaid has established best practices for prescribing opioid pain medications, and worked with the Board of Medicine in the state to develop continuing education training to ensure that doctors in the state are familiar with those best practices.[34]

Medicaid has also been on the front lines of new models for long-term services and supports and community-based services for individuals with disabilities for many years, as the largest funder of those cost-saving services.[35] Today, Medicaid provides health coverage to over 16 million older adults and people with disabilities.[36] In fact, Medicaid has paved the way in transitioning people with chronic conditions and disabilities out of institutional settings into community living. In 2005, Congress authorized the "money follows the person" program which provides demonstration grant funding to states to "rebalance" their Medicaid long-term care systems and transition Medicaid enrollees with disabilities from institutions into the community.[37] Nationally, these grants have supported over 50,000 Medicaid beneficiaries in moving out of institutions into the community with a range of supportive services.[38] A recent evaluation of the program found that it has reduced Medicaid spending for the beneficiaries who transition, while allowing beneficiaries to live in the setting of their choice.[39] Unfortunately, some states have not been able to implement these types of innovative programs that improve care and save money over the long-term, because they lack state staffing to design the programs; cuts in Medicaid funding would only worsen this phenomenon. For example, while a report commissioned by the Alaska Division of Senior and Disabilities Services in 2012 recommended that the state take up the federal option to provide more Medicaid home and community-based services for seniors and people with disabilities through a federal funding option, to-date, the state has not been able to implement the proposal.[40]

Medicaid has also helped to set the standard of care women's health care, as a major funder of those services. As described above, Medicaid played a major role in investing in prenatal care that helped to dramatically reduce infant mortality rates in the 1970s.[41] In fact, Medicaid covers a broad range of women's health services for enrollees.[42] In the late 1990s, states worked with CMS to develop innovative family planning expansion programs that now operate in almost 30 states and have helped save millions of dollars and improve health outcomes.[43] Today, Medicaid covers over 20% of women of reproductive age.[44] Medicaid provides three-quarters of all public dollars spent on family planning in the United States.[45] Medicaid's investment allowed women and couples to avoid nearly two million unintended pregnancies in 2014—most of these pregnancies state Medicaid programs would have paid for.[46]

As discussed above, in the last decade, Medicaid has played a crucial role in promoting value-based purchasing in health care. This innovation has helped to advance the "triple aim" of better health, better care, and better cost.[47] For example, Arizona requires Medicaid plans to

make a specific percentage of provider payments through approved value-based purchasing arrangements.[48] The state provides the plans with guidance on the types of arrangements that it considers acceptable value-based purchasing, which include primary care incentives, bundled payments, performance-based contracts, and shared savings; plans must provide the state with examples of its arrangements.[49] Arizona then withholds a portion of its capitation payment to the plan, subject to the plan's meeting the annual value-based purchasing benchmarks.[50] Arizona's investment in this program is on track to bend the cost curve in that state while promoting high value care at both the individual and population level.[51]

In recent years, Medicaid has also invested in patient-centered medical home models. The Affordable Care Act provided states with the option to receive an enhanced federal match when they established patient-centered medical homes in their Medicaid programs.[52] Patient-centered medical homes are intended to focus on the needs and preferences of individual patients with complex health care needs.[53] They are designed to improve access to care, better coordinate care, and advance care quality, while reducing the cost of care.[54] The medical home model uses a team of providers, which is usually led by a physician, and may also include nurses, nutritionists, and mental health providers, to identify and coordinate care that meets a patient's needs.[55] A recent review of the literature on patient-centered medical homes found that the model "drives reductions in health care costs and/or unnecessary utilization, such as emergency department (ED) visits, inpatient hospitalizations and hospital readmissions."[56] By investing in patient-centered medical homes, state Medicaid programs have been able to improve patient outcomes while also reducing costs. For example, Maine was one of the first states to take up the Affordable Care Act health homes option.[57] The first phase of Maine's health homes project focused on Medicaid beneficiaries with two or more chronic conditions or with one chronic condition and were at risk for another.[58] While a full evaluation of the program is still pending, early reports show "promising trends in outcomes, utilization, and costs."[59]

In the past several years, Medicaid has also sparked innovation by providing enhanced funds to states that expanded their programs to include adults who previously were not eligible for the program.[60] The Expansion has allowed states to target services toward adults who were previously largely uninsured, addressing social determinants of health. For example, when it expanded Medicaid, Ohio experienced a reduction in homelessness, while increasing access to behavioral health services, and improving enrollees' ability to secure and maintain employment.[61] Similarly, in 2015 Arizona used Medicaid Expansion funding to bring together two departments in its Medicaid program—one that was responsible for physical health services and another that was responsible for behavioral health services—in order to deliver more integrated care to Medicaid enrollees and increase access to behavioral health services.[62] These innovations are at risk if Ohio and Arizona lose their Medicaid expansion funding.[63]

Medicaid is poised to continue funding and spurring innovation around the country. As described above, recent initiatives have just begun to invest in moving health care purchasing to focus on paying for value, and to address the social determinants of health. Recent Medicaid demonstration waiver proposals have developed innovative concepts to marry value-based purchasing while addressing the particular population health needs of states. For example, West Virginia recently proposed an ambitious waiver project that would allow the state to develop a continuum of care for Medicaid beneficiaries with a substance use disorder.[64] Caps to Medicaid will constrain states flexibility to propose or continue implementation of all of these innovative programs.

## IV. Conclusion: Capping Medicaid will Make Innovation Difficult

Per capita caps hurt these innovative approaches discussed above. Caps to Medicaid funding would constrain the very flexibility that has allowed these innovations to flourish in state Medicaid programs, because they would reduce the amount of funding available to programs. With less money, states will face more pressure to eliminate innovative programs -- or never start them. In addition, many innovations require a major up-front investment, but the funds for that type of investment are unlikely to be available if program funding is capped—even if those innovations could save the state money in the longer term. At the same time, caps mean that states will have less money to spend on those populations who need more care – e.g., people with special health care needs, people with disabilities, pregnant women – which will make it harder to provide them with innovative care. Instead, with less available funding, states are more likely to try to stick to what they know since trying something new may require the state to absorb costs for uncertain outcomes, invest in new systems, and retain state staff to design the programs. Indeed, even if states launch new projects under a capped model, reduced funding will likely scale back or even eliminate their monitoring and measurement efforts, making it more difficult to determine if the projects achieve their intended goals. While caps reduce funding and stifle innovation, state needs and costs will continue to grow. Thus, capping Medicaid does not improve or solve problems in the program. Instead, caps reduce the amount of money available to care for low-income Americans, and force states to cut their Medicaid programs in ways that hurt enrollees and make Medicaid less effective.

## ENDNOTES

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[56] MARCI NIELSEN *ET AL.,* PATIENT CENTERED PRIMARY CARE COLLAB., THE PATIENT-CENTERED MEDICAL HOME'S IMPACT ON COST AND QUALITY: ANNUAL REVIEW OF EVIDENCE 2014-2015 at 4 (2016), https://www.pcpcc.org/sites/default/files/resources/The%20Patient-Centered%20Medical%20Home%27s%20Impact%20on%20Cost%20and%20Quality%2C%20Annual%20Review%20of%20Evidence%2C%202014-2015.pdf.

[57] *See* MICHELLE PROBERT & KITTY PURINGTON, MAINECARE, MAINECARE HEALTH HOMES INITIATIVE 4-5 (2012), https://www.mainequalitycounts.org/image_upload/PCMH%20MaineCare%20Health%20Homes%20Initiative_Michelle%20Probert%20and%20Kitty%20Purington_11.28.12.pdf.

[58] *Id.*at 5.

[59] BRENDA C. SPILLMAN *ET AL.,* U.S. DEP'T HEALTH & HUM. SERVS., EVALUATION OF THE MEDICAID HEALTH HOME OPTION FOR BENEFICIARIES WITH CHRONIC CONDITIONS 30 (2016), https://aspe.hhs.gov/system/files/pdf/224581/HHOption4.pdf.

[60] 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

[61] OHIO DEP'T MEDICAID, OHIO MEDICAID GROUP VIII ASSESSMENT 37, 41 (2017), http://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf.

[62] *See* DEBORAH BACHRACH *ET AL.,* COMMONWEALTH FUND, HOW ARIZONA MEDICAID ACCELERATED THE INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH SERVICES 4, 7 (2017), http://www.commonwealthfund.org/publications/issue-briefs/2017/may/arizona-medicaid-integration-behavioral-health.

[63] *See, e.g., id.* at 7; Noam N. Levey, What Happened When Arizona Cut Medicaid, TRIBUNE NEWS SERV., Dec. 2, 2014 (describing cuts in Arizona's Medicaid program during the 2008 recession), http://www.governing.com/topics/health-human-services/what-happened-when-arizona-cut-medicaid.html.

[64] *See* WEST VIRGINIA DEP'T HEALTH & HUM. SERVS., WEST VIRGINIA PROPOSED MEDICAID SECTION 1115 WAIVER APPLICATION: CREATING A CONTINUUM OF CARE FOR MEDICAID ENROLLEES WITH SUBSTANCE USE DISORDERS (2016), http://www.dhhr.wv.gov/bms/News/Documents/WV%20Proposed%20Medicaid%20SUD%20Waiver%20Application.pdf.