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2019 Emerging Trends in Public Programs

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COMMUNITY & STATE

2019 Emerging Trends in Public Programs

Last year, both Medicaid enrollment and spending rate declined or slowed. The decrease in Medicaid enrollment is a first since passage of the Affordable Care Act (ACA) in 2010. The contraction in the Medicaid growth rate aligns with a reported decrease in overall U.S. health care expenditures. The decrease in both figures last year is also partly attributed to a strengthening economy (including a steadily declining unemployment rate), which slowed caseload growth that, in turn, mitigated spending growth. Enrollment figures were further impacted by a pause in Medicaid expansion and state policies that changed eligibility determinations.

However, Medicaid enrollment and spending are overall on the rise; enrollment in Medicaid is up almost 30 percent since 2013 and Medicaid spending year-to-year continues to increase, topping out at more than $600 billion in 2018.[1] Medicaid is the largest total state expenditure, up almost 10 percent in the last decade.[2] More than 55 million Americans (75 percent of total Medicaid enrollment) now receive Medicaid coverage from a private managed care plan.[3]

There are many factors impacting the increase in spending, including higher costs of prescription drugs, the expansion of long-term services including behavioral health care, targeted provider rate increases, and crises like the opioid epidemic. Factors that impact a rise in enrollment include meeting the needs of an aging population, states carving in more complex populations (who typically also have higher acuity needs), and the expansion system that now includes a population beyond simply being low-income.

States are responding to these system pressures by:

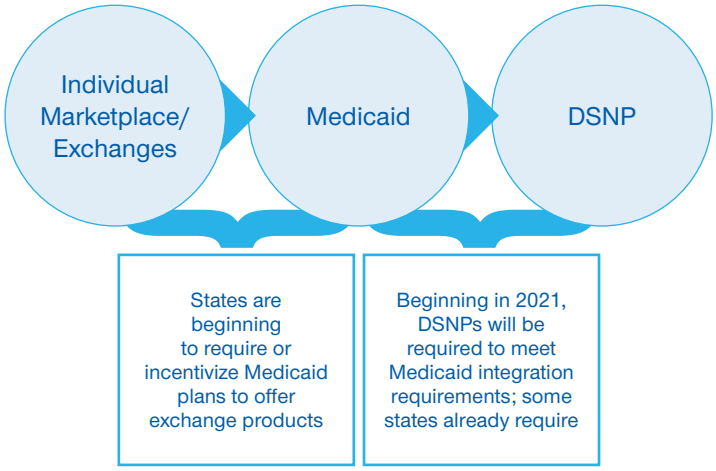
- **Shifting and expanding coverage responsibility** of managed care organizations across the continuum of care;
- **Delegating greater responsibility and risk to managed care organizations and individual providers due to increasing cost pressures** with the goal of identifying inefficiencies and savings while increasing value; and
- **Broadening responsibility for the care** provided to traditional and new Medicaid populations with a particular focus on: pharmaceuticals and drugs, both illicit and prescription; traditionally non-medical or non-clinical services; and the benefit needs of more vulnerable and complex individuals.

We have identified ten unique policy and practice trends to these state system pressure responses.

[1]https://www.medicaidplans.org/_docs/Enduring_State_of_Medicaid.pdf
[2]https://www.nasbo.org/mainsite/reports-data/state-expenditure-report
[3]https://www.medicaidplans.org/_docs/Enduring_State_of_Medicaid.pdf

TREND 1: Continuum of Coverage and System Integration

States are facing challenges regarding affordability, integration, and cost containment across each of the distinct, state-administered programs serving their citizens: Exchange (individual coverage), Medicaid, and State Employees. Simultaneously, states are working to meet federal requirements to integrate Medicaid and Dual Eligible Special Needs Plans (DSNPs). While these dynamics are independent, they are converging to drive a delivery system shift for states. States are moving from managing these populations and programs separately and discreetly to creating a more holistic continuum of coverage through which members may move throughout their lifetime.



States and the federal government have begun to implement policies and rules in which state-contracted health purchasing is becoming interconnected. Examples of this trend are:

- **States are looking to stabilize individual market premiums** by incentivizing carriers to participate in their Exchanges and have begun to leverage their purchasing power to require or incentivize Managed Care Organizations (MCOs) to offer on the Exchange if providing Medicaid Managed Care or State Employee coverage.
- **Centers for Medicare and Medicaid Services (CMS) and states are requiring DSNPs to integrate** with Medicaid Long-Term Services and Supports (LTSS) and/or Behavioral Health (BH) benefits, in some instances limiting DSNP contracts to Medicaid contractors.

In recent months, several states have introduced proposals to study new programs for individuals above Medicaid eligibility levels to "buy-in" to Medicaid or leverage the Medicaid program to create affordable health plan options for individuals above Medicaid eligibility. Legislation to introduce or study some type of buy-in program for the individual market has been introduced in 16 states in the most recent legislative sessions, including Colorado, Massachusetts, and New Mexico. Colorado, Delaware, Massachusetts, New Mexico, and Oregon have each released or commissioned studies regarding what a Buy-in or Public Option program could look like in their state.[4] The Nevada legislature passed a Medicaid Buy-In program in 2017, but the effort was ultimately vetoed by former Governor Brian Sandoval. Newly elected governors in Connecticut, Illinois, Minnesota, and Wisconsin have expressed interest in the Medicaid Buy-In option.

In addition to connecting Medicaid and the Exchange system, states are increasingly requiring DSNPs to integrate with Medicaid. Beginning in 2021, CMS will require DSNPs to meet increased Medicaid integration and coordination requirements. DSNPs not meeting these federal requirements will face enrollment sanctions and possible contract termination. Many states are also considering increased DSNP requirements beyond what CMS is proposing, and others may pursue new or expanded financial alignment (duals) demonstrations. This trend will only continue to evolve as CMS and states increase integration and alignment requirements for plans serving duals, while simultaneously reducing opportunities to serve this population in non-integrated products.

TREND 2: Medicaid Expansion and Consumer Engagement

Medicaid Expansion remains a forward-looking trend in 2019. Following the 2018 November mid-term election, 37 states have adopted or are poised to adopt Medicaid expansion. Five other states – Idaho, Maine, Nebraska, Virginia, and Utah—are anticipated to expand Medicaid eligibility in 2019 or 2020.

[4]https://www.shvs.org/state-efforts-to-develop-medicaid-buy-in-programs

Georgia, Idaho, and Utah have expressed their desire to "partially" expand Medicaid eligibility to 100 percent of the Federal Poverty Level (FPL), instead of 138 percent. As part of these efforts, states are considering innovative program design inclusive of consumer engagement models.

Consumer engagement models are impacting eligibility of both Expansion and non-Expansion "able bodied" adult populations.[5] The approved and proposed program designs include exemptions for certain populations, most commonly students, caregivers, and those participating in substance abuse treatment programs. In all approved programs, community engagement is defined more broadly than paid employment and can include participation in job training programs as well as volunteering in the community. Several states have received approval of these models, including Arkansas, Arizona, Indiana, Kentucky, Michigan, New Hampshire, Ohio, and Wisconsin. An additional seven states have sought waiver authority.

In addition, states are continuing to look to commercial market tools and consumer engagement strategies that **focus on helping prepare individuals to successfully navigate commercial market coverage.** Kentucky and Virginia's upcoming waiver programs both include member cost sharing (monthly premiums and small co-pays) as well as healthy behavior incentives.

TREND 3: Delivery System Reform

Given cost pressures and the push to focus on the value of the dollars being spent in Medicaid, states are increasingly interested in delivery system reforms that change the way that care is delegated, delivered, and reimbursed, including:

- **Aligning payment and delivery systems** to reward quality and promote more integrated care.
- **Requiring providers to take on additional responsibility** to achieve improved outcomes.
- **Moving away from volume-driven payment** to value-based models.

Direct provider contracting is one such model for increasing quality and decreasing costs. In May 2019, CMS released a Request for Information (RFI) seeking feedback on a direct provider contracting (DPC) model in Medicare Parts A and B, Medicare Advantage, and Medicaid. According to CMS, DPC models "have the potential to enhance the doctor-patient relationship by eliminating administrative burden for clinicians and providing increased flexibility to provide the high-quality care that is most appropriate for their patients, thus improving quality while reducing expenditures."[5]

In addition, several states are encouraging models focused on provider-led care management. Provider-led care management is an approach in which providers are responsible for managing both medical conditions and care coordination activities. Under this approach, MCOs are required to delegate greater responsibility for managing care to providers while still typically maintaining financial risk and actuarial responsibility for the populations that they serve.

TREND 4: Value-Based Purchasing

States are proactively leveraging MCO contracts to accelerate wide-scale value-based purchasing (VBP) adoption. According to research performed by Manatt Health, 30 out of the 39 states with managed care programs mandate or incentivize their contracted MCOs to engage in VBP with providers in their networks.[6] States have been applying this approach to payment reform to areas of health care such as maternity care, LTSS, and substance use. Over the last few months, states have also extended VBP strategies to additional areas of the Medicaid system, including behavioral health, medical devices, and pharmaceuticals.

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[5]Feedback on New Direction Request for Information (RFI) Released, CMS Innovation Center's Market-Driven Reforms to Focus on Patient-Centered Care. Press Release. https://www.cms.gov/newsroom/press-releases/feedback-new-direction-request-information-rfi-released-cms-innovation-centers-market-driven-reforms

[6]Manatt Health, "Leveraging Medicaid Managed Care to Advance Value-Based Payment," Accessed September 26, 2018. https://www.manatt.com/Insights/Newsletters/Manatt-on-Health-Medicaid-Edition/Leveraging-Medicaid-Managed-Care-to-Advance-Value#Article1

[7]The Health Care Payment Learning & Action Network (HCP-LAN) is a public-private partnership established to accelerate transition in the health care system from a fee-for-service payment model to one that pays providers for quality care, improved health, and lower costs. The HCP-LAN alternative payment model framework contains four categories that provide a pathway to increased focus on connecting value to dollars spent.

States are also increasing the required percentage of MCO spend in alternative payment models along with their continued use of the HCP-LAN[7] alternative payment model categories as the framework for their VBP requirements.

TREND 5: Care for Complex Populations

The Medicaid population is becoming more complex and, to date, most states have privatized their Medicaid system. As a result, MCOs are being asked to cover more lives with greater needs and provide services that address both the health and health-related social needs of their members.

Criminal Justice Involved

With the enactment of the ACA and Medicaid expansion, more and more people exiting jail or prison are now eligible for Medicaid. Many of these members have complex health and social needs. States understand they need to design and implement strategies to better connect formerly incarcerated individuals to health care and supports they need to stabilize and successfully re-integrate into the community. States are also increasingly aware and concerned by the financial impact of this care.

Given budget pressures and the interest in reducing recidivism and improving the community transitions for formally incarcerated individuals, states are employing or considering a number of strategies, including:

- States are increasingly deciding to suspend, not terminate, Medicaid when someone is incarcerated.
- States are requiring MCOs to provide care coordination services to enrollees prior to release from incarceration.
- States are encouraging MCOs to have "non-traditional" community-based organizations (CBOs) in their networks.
- States are increasingly asking MCOs to provide comprehensive care models, including physical and behavioral health and coordination of social services.
- States and counties are joining Stepping Up, a national initiative to reduce mental illness in jails and prisons.

Mothers and Children

Pregnant women in the U.S. are increasingly experiencing adverse maternal and birth outcomes. The rate of preterm births continues to rise, particularly among black and Hispanic women, and overall one in ten infants is born preterm. Low birthweight, which affects eight percent of infants, is also on the rise.[8] Infants born preterm or with low birthweight are at an increased risk for experiencing physical disabilities and developmental impairments throughout their lives. With approximately half of births in the U.S. covered by Medicaid[9], state Medicaid programs are acutely impacted by the financial implications of this growing trend.

A particularly difficult trend related to mothers and children is the increasing prevalence of neonatal abstinence syndrome (NAS) among newborns. NAS is a postnatal opioid withdrawal syndrome that can occur in newborns whose mothers were addicted to or treated with opioids while pregnant.[10] Children born with NAS are more likely to experience negative birth outcomes including respiratory and feeding difficulties, low birthweight, and seizures. NAS also puts this vulnerable population at increased risk for admission to the neonatal intensive care unit, birth complications, the need for pharmacologic treatment, and a prolonged hospital stay.[11]

Rising NAS rates are prompting targeted intervention efforts. States are shifting to evidence-based approaches including connection to care before and after delivery and better coordination between systems.[12] Public health measures to prevent and treat opioid dependence before and during pregnancy are also essential to reducing the incidence of NAS and its related health care burden. Strategies include promoting responsible opioid prescribing, decreasing unplanned pregnancies among women who abuse opioids, screening and treatment during pregnancy, and standardizing postnatal treatment for infants with NAS.[13]

[8]https://www.marchofdimes.org/complications/low-birthweight.aspx
[9]https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[10]https://www.nejm.org/doi/full/10.1056/NEJMra1600879
[11]https://www.nejm.org/doi/full/10.1056/NEJMra1600879
[12]https://pediatricsnationwide.org/2018/10/22/neonatal-abstinence-syndrome-transforming-care-for-newborns-and-their-families/
[13]https://www.cdc.gov/mmwr/volumes/66/wr/mm6609a2.htm

TREND 6: Evolving Opioid Crisis

The cycle of addiction and drug trends continue to evolve in the U.S. Though abuse of prescription opioids are still of significant concern, opioid misuse has now progressed into sharp increases in the use of heroin, fentanyl, and other deadly drugs such as cocaine and methamphetamine. Approximately 19.7 million Americans are now classified as having a substance use disorder (SUD), including 2.1 million Americans who have an opioid use disorder (OUD).[14] More than 115 people in the U.S. die each day from an opioid-related overdose, making this the leading cause of accidental death in the U.S.[15] With the increases in heroin, fentanyl, and other drugs, the prevalence of polysubstance use (consumption of more than one drug at once) has made this epidemic and the response to it even more complex.[16]

As the nature of the epidemic has spread, so has its impact on multiple systems. States have seen a significant increase in the number of children entering the child welfare system due to the opioid epidemic. Between 2012 and 2016, the number of children in foster care nationally rose by 10 percent, from 397,600 to 437,500 and more than two-thirds (36 states) experienced caseload increases.[17]

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A growing number of states and local communities are recognizing the importance of Medicaid-covered treatment programs as a cost-effective alternative to incarceration for justice-involved individuals. Local jails are working to close health coverage gaps by suspending, rather than terminating, Medicaid coverage for individuals who are incarcerated.

The opioid crisis also has broad consequences on public health including an increase in an individual's susceptibility to contract an infectious disease, including sexually transmitted diseases and blood borne illnesses such as the hepatitis B and hepatitis C viruses.

As this crisis continues to evolve, Medicaid's role in supporting a full continuum of care for SUD and OUD spanning prevention, treatment, and recovery support services is even more critical. State policy and practice reform trends that are influencing Medicaid's role in this effort include:

- **Preventing prescription drug misuse and overdose deaths** through the use of technology to help promote safer prescribing practices (in accordance with CMS recommendations)[18] and through state laws that simplify the process of obtaining naloxone and/or expanding distributors beyond pharmacists to include first responders (e.g., emergency medical technicians, law enforcement officers, harm reduction staff, family, and friends) thereby helping to prevent more overdose deaths.[19]
- **Expanding access to medication assisted treatment (MAT)** through changes in prior authorization policies, increases in the number of qualified physicians, and expansion in access to and capacity of providers, including Federally Qualified Health Centers (FQHCs).
- **Expanding access to SUD inpatient treatment** through use of 1115 waivers to pay for SUD residential services in an Institution for Mental Diseases (IMD) facility.[20]
- **Encouraging alternatives to opioids** that include chiropractic services and acupuncture.
- **Focusing on special populations** including pregnant moms with substance use disorders, criminal justice involved population, those with co-occurring hepatitis C and SUD, and foster youth.
- **Ensuring timely, actionable, and localized data** to identify specific areas of need, focus resources, drive progress, and evaluate outcomes.

[14]https://www.samhsa.gov/data/report/2017-nsduh-annual-national-report
[15]https://www.ndhi.org/files/7415/2907/4391/Opioid_Roadmap_FINAL.pdf
[16]https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_09-508.pdf
[17]https://aspe.hhs.gov/system/files/pdf/258836/SubstanceUseChildWelfareOverview.pdf
[18]https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf
[19]https://www.samhsa.gov/capt/sites/default/files/resources/naloxone-access-laws-tool.pdf
[20]https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table5

TREND 7: Pharmaceuticals

Rising prescription drug prices impact the entire health care system including state Medicaid programs, resulting in budget predictability and sustainability concerns. In 2017, overall spending on prescription drugs in the U.S. was $425 billion, representing one out of every ten health care dollars spent.[21] States and the federal government are utilizing different levers in an attempt to lower pharmacy costs, including greater oversight and control. The emergence of new, high-cost drugs and other market disruptions intensifies the need to employ innovative practices that drive value, competition, and market stability.

Some states are considering requiring MCOs to transition their Pharmaceutical Benefit Manager (PBM) contracts from the traditional or spread pricing model to pass-through or transparent pricing model. In 2019, a total of 113 bills have been introduced in state legislatures to require greater oversight of PBMs and 53 bills on drug pricing transparency.[22] While many of these bills will not survive the legislative process, it demonstrates the intensity by which policymakers are attempting to use legislation to address the perceived price gouging within the drug supply chain. The political pressure has also renewed states' interest in exploring a pharmacy carve out from Medicaid managed care. For example, in states such as California, Nevada, and Texas a complete carve out of the pharmacy benefit is under consideration.

States may also impose additional limitations on benefit management. One example of this is the consideration by some states to move toward implementation of a single state-run Preferred Drug List (PDL). Single state-run PDLs can block levers used by MCOs that drive value for a state. In addition, some states are implementing or considering limits on prior authorizations or step therapy measures.

A small number of states are moving towards value-based payments for drugs. CMS has approved waivers for Colorado, Michigan, and Oklahoma that allow outcome-based contract arrangements with drug manufacturers.[23,24] States are also seeking ways to leverage purchasing power by asking for flexibility when determining formularies.[25] Massachusetts submitted a waiver request to utilize a closed formulary and exclude certain high-cost drugs. CMS denied the waiver citing issues with rebate collection and the broad ranging impact of the proposal but offered technical assistance on a smaller and edited demonstration proposal.[26] Most recently, Louisiana and Washington State have received approval to implement an alternative subscription based "Netflix model" for costly hepatitis C drugs.[27]

TREND 8: Social Determinants of Health

With the increase in state Medicaid populations and the corresponding rise in state spending to support the health care cost of these individuals, states are increasingly requesting solutions in Requests for Proposals, incorporating contract requirements, or implementing new initiatives or demonstration pilots focused on the root causes of poor health outcomes. Addressing the root health-related social factors or social determinants of health (SDOH) is viewed by MCOs, providers, and policymakers alike as a real opportunity to achieve the triple aim of improving patient experience, managing health care costs, and improving overall health and well-being.

When state Medicaid programs prioritize SDOHs, they tend to focus on key areas or domains including housing, nutrition, transportation, employment, and interpersonal violence that hinder an individual's and/or family's ability to achieve optimal health and well-being. Because of the breadth of these domains, most are further divided to allow MCOs, care coordinators, and providers to better understand the nature of the SDOH barrier and possible ways to mitigate the issue.

[21]https://nashp.org/rx-legislative-tracker-2019/
[22]https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MI/MI-18-0009.pdf
[23]https://www.healthcaredive.com/news/cms-clears-medicaid-value-based-drug-state-plan-denies-closed-formulary/526712/
[24]http://www.governing.com/topics/health-human-services/gov-state-control-drug-prices.html
[25]https://www.modernhealthcare.com/article/20180627/NEWS/180629925
[26]https://www.washingtonpost.com/health/2019/01/10/louisiana-adopts-netflix-model-pay-hepatitis-c-drugs/?utm_term=.ab7e0d479e2f
[27]https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf

States are taking different approaches to addressing SDOHs based on their populations and the demand for traditionally non-covered services. Most commonly, states are using MCO contracts or 1115 demonstration waiver authorities to identify specific requirements and incentives that will improve outcomes and lower costs.[28] SDOH activities being required or incentivized include the following:

- **Screening & referrals.** States and CMS are developing screening tools to identify the social and economic barriers of Medicaid members. At the same time, providers have deployed their own screening tools (e.g. use of the PRAPARE[29] tool for FQHCs) to meet the immediate needs of their members. Once a screening has been conducted, and a SDOH barrier or concern has been identified, states are not only looking for providers and plans to connect members and families to appropriate community-based providers to address the SDOH issue but also requiring MCOs to develop and/or use tools to support this effort. Of the soon to be 40 states that provide Medicaid services through risk-based managed care plans, 35 include SDOH activities related to screening and/or referrals in their MCO contracts.
- **Services & funding.** Medicaid has historically focused mainly on paying for hospital and doctor visits. Many states have used their 1115 waiver authority to cover specific SDOH related services traditionally not covered by Medicaid. Over 20 current MCO contracts contain some reference to the provision of additional services related to SDOH.
- **Value-based purchasing (VBP).** States are starting to require MCOs to consider SDOH in the context of their VBP initiatives. Typically at the provider level, these arrangements provide incentives and/or tie penalties to the provision of higher quality and more efficient care by encouraging providers to engage with non-health care CBOs and using dollars from VBP contracts to pay for services like food, housing supports, legal aid, and transportation services.
- **Community reinvestment.** As many states explore the alignment of health care and social services, they are including explicit or implied performance requirements for reinvestment in communities. At the far end of the reinvestment spectrum are explicit requirements to reinvest a percentage of profits back into communities. On the other end, requirements for contracting or coordinating with CBOs produces implied requirements for community reinvestment.
- **Quality assurance & performance improvement.** As a core part of all MCO contracts, quality assurance and performance improvement requirements are designed to focus on achieving significant improvement in health outcomes and member satisfaction. Currently, 13 states use their quality assurance and performance improvement contract requirement to encourage MCOs to address SDOH.

While states work to develop new mechanisms to identify and address social determinants in their Medicaid programs, CMS and Congress have moved to allow Medicare Advantage (MA) plans to provide additional supplemental benefits that address LTSS and health related social factors. This new flexibility allows for MA plans to include new services and supports like access to healthy food and rides to physician's offices as part of a benefit package. The expanded supplemental benefits will increase access to functional and social supports for MA members across the country, including DSNP enrollees.

TREND 9: System Convergence

System convergence is a trend, supported by federal and state policy, and regulation that requires the management of an individual's health care needs holistically to increase value and manage costs. Related to the social determinants of health trend, this trend is about the broader push to integrate the two systems (i.e. health care and social services) across benefits, financing, populations, and providers. Critical to this trend is the need to both formally or informally partner with human services/community-based organizations, considered non-traditional providers in the Medicaid space.

[28]https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf
[29]http://www.nachc.org/research-and-data/prapare/

TREND 10: Mergers, Partnerships, and New Entrants

With the push towards greater efficiency, lower cost, and higher value, a transformation or realigning of the health care system is taking place. In addition to new players in the health care space, there has been an increasing number of mergers or partnerships between current health care players.

According to a PwC Health Research Institute report, 84 percent of all Fortune 50 companies are now involved in health care.[30] The BDO Center for Healthcare Excellence & Innovation surveyed health care leaders on the question of the impact of recent mergers and acquisitions. Over 80 percent of executives, clinical leaders, and clinicians expect disruptive mergers to continue impacting the industry in the next three years.[31] Some believe that these shifts will improve efficiencies, cut costs, and improve care. Others have expressed concern about the impact on individuals given narrowing networks and to current health systems and insurers given increasing competition.

In 2018, there were examples of industry leading organizations, but from sectors other than health care, entering or signaling entry into the health care arena through investment activity, creation of new business lines, or through the hiring of health care experts onto their management teams. Additionally, realignment and a reimagining of roles and responsibilities in health care is taking place through the addition of on-site health care services by retail stores and official mergers or formal partnerships between health insurers and pharmaceutical companies, providers, or other MCOs.

Conclusion

While policy uncertainty exists around the future of the Medicaid program, the conversation is largely shifting to one of how to strengthen and enhance Medicaid's long-term viability as the safety net public medical assistance program it was originally envisioned to be. Working with our state and federal partners, UnitedHealthcare is responding to these system pressure related trends in order to advance the efficient and high value system we all want.

[30]https://www.pwc.com/us/en/industries/health-services/pdf/pwc-us-healthcare-top-health-industry-issues-2019.pdf
[31]https://www.bdo.com/blogs/health-and-life-sciences/january-2018/consumers,-healthcare-orgs-unaligned-on-pricing

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