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VIEWPOINT

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Managing the Future of Medicaid

During the past 50 years, Medicaid has improved health and saved lives among the millions of people in the United States who otherwise would have been uninsured.^{1,2} Given the high level of medical need among the increasing number of people who rely on Medicaid for health care coverage, there is a social responsibility to maximize the value of the available resources.

States have developed strategies to contain Medicaid costs for their enrolled populations; however, these approaches tend to be counterproductive to the goals of providing high-value health care. For example, most states have set physician payment rates for Medicaid below rates paid by private insurers and by Medicare. Low payment rates reduce physicians' participation in Medicaid and undermine beneficiaries' access to care.³

Some states have created administrative barriers to enrollment in Medicaid by requiring individuals to complete complicated forms and to frequently demonstrate that they are eligible for re-enrollment. Barriers to enrollment result in disruptions in coverage, which are associated with subsequent expenses related to increased rates of preventable hospitalizations.⁴

Although these counterproductive, short-term budget-cutting maneuvers have enabled Medicaid to survive over the past 50 years, these approaches are not a sustainable strategy for the program in an environment in which the public and policy makers expect greater demonstrated value. Medicaid's future requires a transformation in how it delivers services to obtain a higher return, measured as health care quality and outcomes, for its investment. Medicaid has enormous assets to make this possible, but they need to be developed to create a health care system that is made more efficient through population health management.

Population health management uses automated and updated information to support the systematic evaluation and addressing of the preventive and chronic care needs of a group of patients. The goal is to maximize these patients' health while minimizing their health care expenditures. This typically means reducing the need for emergency department visits, hospitalizations, and high-cost procedures and imaging studies.

Medicaid faces a challenge in creating an integrated, more efficient delivery system, but it has the advantage of having clinicians who share an interest and often an organizational mission to care for the underserved. Although these values alone are not enough to ensure best practices, they are a valuable starting place for engaging Medicaid clinicians to pursue a shared approach to care. This opportunity requires organizational leadership to establish priorities and expectations for achieving goals. The opportunity is squandered when Medicaid programs offer payment rates that are so far below those of other payers that clinicians are discouraged from participating in the program and are made to feel that their contributions are not valued.

Medicaid has the ability to innovate through state and local variation. State Medicaid programs can use state plan amendments, waivers, and other legal authorities to try new approaches. For example, this is the basis for differences across states in payment approaches and in the availability of optional benefits, such as home- and community-based service programs as an alternative to nursing facility care.

State variation provides an opportunity to learn from natural experiments but is an underdeveloped resource. There has been an insufficient effort to systematically learn from this variation and to develop strategies to rapidly scale up the best ideas across states. Even within states, there are missed opportunities to study innovative practice approaches and to align policies to support and expand successful strategies to have a broader influence. As a result, successes such as the use of care coordination to reduce hospitalizations among high users of emergency services in Camden, New Jersey, are slow to spread among Medicaid clinicians within the state and across state lines.⁵

Data are critical to support this learning process and to support the implementation of the most successful strategies. State Medicaid programs have enrollment, claims, encounter, long-term care assessment, and other data, which could be used for rapid cycle evaluation and to characterize the population's needs to support a process of systematically aligning Medicaid's resources with beneficiaries' needs to maximize efficiency.

While the opportunity exists to use Medicaid's data as the basis of a population management strategy, several steps are needed to turn this potential into a reality. Data collection needs to become comprehensive, timely, and accurate using standards and definitions that are consistent within and across state programs. Medicaid needs to develop reproducible methods for combining its different sources of data and for potentially linking these data with other state and federal data to create robust assessments of its beneficiaries. The integrated data need to be turned into actionable information using standardized performance metrics and disseminated to those who can act based on the information. For example, health information exchange with practitioners, such as those working in emergency departments, could enhance their overall understanding of a beneficiary's needs and support decision making. More efficient sharing of data with researchers and other stakeholders could support rapid cycle evaluation of new programs and potentially lead to discoveries of unrecognized patterns of care, which could become the focus of improvement efforts. This approach of using data to improve care is being used in some integrated delivery systems.⁶

The Centers for Medicare & Medicaid Services (CMS) is investing in a data strategy to pursue these goals, which if successful would allow CMS to help state Medicaid programs to make better use of their own data and to cre-

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ate an ongoing capability to compare health care quality, health outcomes, and costs across states. This effort relies on states to provide data on the characteristics and service use of their individual enrollees, a process that has historically been slow and inconsistent.⁷ CMS is actively engaged in encouraging all states to cooperate but has limited options to force states to comply.

CMS has tried to support states' data efforts by offering them a 90:10 match for the purchasing and operating of data systems for their Medicaid programs and for the support of health information exchange with Medicaid organizations that furnish Medicaid services. CMS has also established the Innovation Accelerator Program and State Innovation Models Initiative to provide states with data analytic and other technical support to develop, test, evaluate, and bring successful new models of care to scale. The question is whether state Medicaid programs will have the management capacity to leverage these opportunities to transform care.

One of the most promising opportunities for savings is to focus on the small percentage of beneficiaries who use a disproportionate share of the program's resources. For example, the 6.4% of Medicaid beneficiaries who use long-term services and supports account for 45% of the Medicaid program's expenditures.⁸ The development and use of alternative models of care that incorporate enhanced care coordination within acute care and across the spectrum of acute and long-term care could potentially lead to improvements in health outcomes at a lower cost.

Despite increasing recognition of this concept, there is still a shortage of approaches with proven effectiveness. This makes it risky for states to accept financial risk for unproven alternatives. States are likely to outsource management responsibilities and to mitigate their financial risk by sharing it with managed care plans. Medicaid managed care has had mixed success in controlling costs primarily among women and children.⁹ The most recent growth of Medicaid managed care includes older adults and disabled populations, groups that account for greater spending and more complexity. There is also the possibility that the systematic assessment of the Medicaid population could lead to more costs than savings if the process uncovers substantial amounts of previously unmet need.

Capitated payments through managed care raise the potential for withholding necessary care, which could have significant negative consequences for these high-risk populations. States will need to improve their contracting requirements and data systems to ensure that Medicaid's resources are being focused on patient care and not profits. CMS is in the process of reissuing new rules, which are

expected to create a higher standard of accountability for plans in how they use their resources. These rules could affect managed care plans' perceptions of their ability to be profitable and their ongoing willingness to share risk with Medicaid programs.

When Congress passed the Affordable Care Act (ACA), there was the momentary expectation that with a new federal standard for Medicaid eligibility, variation in state Medicaid programs would be reduced. However, the subsequent Supreme Court decision rendering the Medicaid expansion under the ACA as optional has contributed to ongoing state variation. States vary now and are likely to continue to vary for the foreseeable future, not only in terms of whether they expand Medicaid coverage under the ACA, but also in their willingness to step back from short-sighted cost-saving strategies, such as low clinician payments and administrative barriers to enrollment, that undermine their ability to achieve greater value through population management.

Even though the 21 states that have not yet expanded Medicaid coverage will continue to receive pressure from businesses, health care organizations, and clinicians within their state to do so, the financial bar to entry will increase after 2016 when the federal support for the expanded Medicaid population begins to taper to 90% from the current 100%. This small change in financing might also be enough to convince some states to reconsider their coverage of the expanded population and to withdraw or renegotiate their participation using a waiver to set more limited conditions for coverage.

Within limits, the federal government is likely to grant states the flexibility they request to manage their programs, while nudging them toward greater fiscal and performance accountability. Some states, including New York and Oregon, have taken the bold step of placing at risk funds that they might obtain through a Medicaid waiver, based on whether or not they achieve prespecified improvements in health outcomes and reductions in costs. This approach to shared savings could become a model for the federal government to encourage states to redirect their efforts away from destructive cost-saving practices and toward approaches that are beneficial for the patient population. The risk is that if a state fails to meet its performance targets, it will be left with a shortfall of funding to meet the ongoing needs of its Medicaid population, which could result in a decline in the quality of care over time.

The more that is learned from state variation data and experiences that are routinely summarized and publicly disseminated to inform decision making, the better the odds are that the program will continue to play a critical role in improving the health of the country's most vulnerable populations.

ARTICLE INFORMATION

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