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Medicaid Innovation: The Need for Actuaries in the Medicaid Program

By Chris Bach

You may be asking yourself, “I don’t work on Medicaid, why should I care what’s going on with it?” For me, it’s personal. Years ago I would never have dreamed I would willingly tell people this, but at one point in my life, I desperately needed Medicaid. As the single mom of a young baby who was denied insurance coverage because of his “pre-existing” condition of recurrent ear infections, I was barely getting by financially, working full time, and trying to put myself through school. I could not afford the unexpected, but all too recurrent, medical or pharmacy expenses. I applied for and received Medicaid coverage for my child, which, thankfully, covered the expenses. However, it also came with a public stigma, since it was linked to the welfare program, and offered access only to the limited number of providers who were willing to accept Medicaid patients.

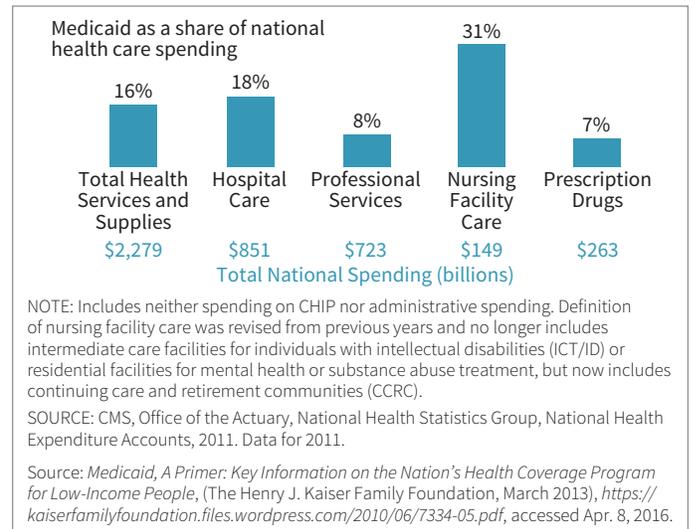
Fast forward 25 or so years to the Medicaid program today. The state-managed health care program for low-income people has been “delinked” from welfare. It has led changes in health care coverage in many ways, including the broad acceptance and use of managed care programs and the beginning of payment reform. There is better public perception of the need for the program and the needs of its recipients, as well as expanded provider access for Medicaid recipients.

Medicaid has come a long way. However, there are still a significant number of challenges in the program, several of which actuaries are highly qualified to address.

First, here is why we all SHOULD care about Medicaid:

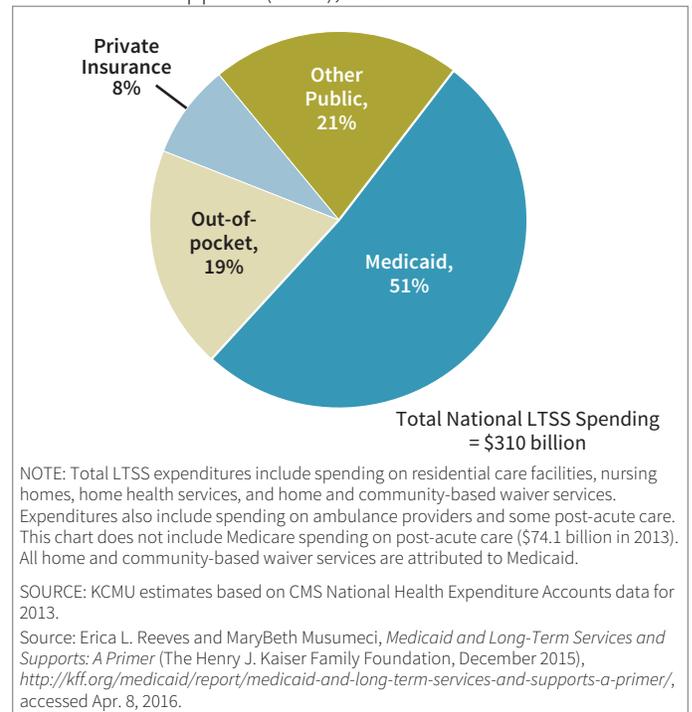
- Medicaid covers an estimated 68 million Americans, more than 1 in every 5.¹ Whether you know it or not, someone you know or love probably receives some type of benefit from Medicaid.
- Medicaid is the primary payer of public health care in the United States, and in 2011 covered 16 percent of all health care services and supplies (see Figure 1).
- Medicaid is the primary payer for long-term services and supports (LTSS), which include nursing home care and other long-term care, covering 51 percent of costs in 2013 (see Figure 2).

Figure 1
Medicaid’s Role in Financing Health Care



- Medicaid currently covers about 45 percent of all births in the United States and that number continues to grow.²
- Nearly 4 of every 10 children in the United States were covered by Medicaid in 2014.³
- More than 20 percent of all Medicare beneficiaries are also eligible for Medicaid (dual eligible).⁴

Figure 2
Medicaid Is the Primary Payer for Long-Term Services and Supports (LTSS), 2013



Today, the Medicaid program—which is funded by both the state and federal government—is the second-largest expenditure by states on a nationwide basis (behind only elementary and secondary education), and the third-largest federal domestic program (behind Social Security and Medicare).⁵ In short, Medicaid impacts all of us in some way.

MEDICAID PROGRAM HISTORY AND BACKGROUND

Medicaid was established in 1965 by Title XIX of the Social Security Act, the same federal legislation that established Medicare. Medicaid, which is jointly funded by the federal government and each state government, provides health and long-term care coverage for low-income people. Each state must meet a minimum set of requirements, or request a waiver to alter specific requirements, in order to receive federal funding. States are allowed to offer more than the federal benefits, and many choose to do so.

Over the past 50 years, Medicaid has changed to meet the needs of the people it is intended to protect. Various program expansions and additions have been implemented—most recently, many states have expanded their programs as part of the Affordable Care Act—and assorted waiver programs have been implemented. Figure 3 demonstrates the most significant changes since the beginning of the program.

Many times, the Medicaid program changes or initiatives were the first of their kind in the health care industry. Medicaid was an early adopter of electronic claims processing and managed care programs, and has made quality of care a key focus in the past few years. These changes appear to have paid off; Medicaid has experienced the lowest cumulative growth in per capita health spending of all payers over the past several years (see Figure 4).

Figure 3
Medicaid Has Evolved Over Time to Meet Changing Needs

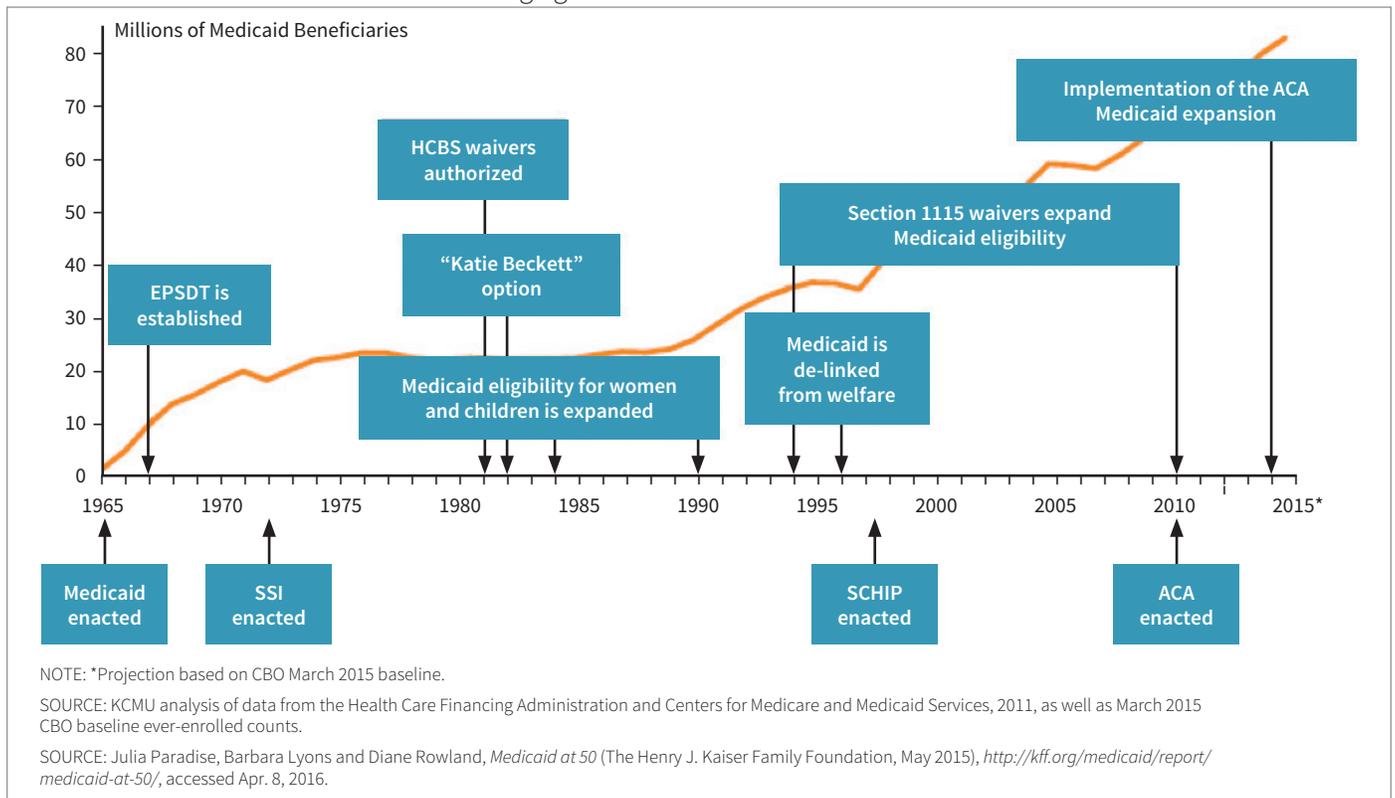
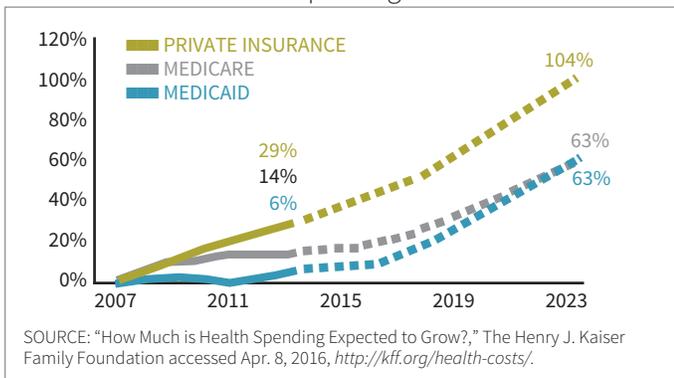


Figure 4
Cumulative Growth in per Capita
Public and Private Health Spending



Given its important role in the U.S. health care system over the past 50 years, it is worth considering what is in store for the future of the program—and how actuaries can help lead the way.

WHAT LIES AHEAD?

The Medicaid program is experiencing a period of growth, innovation and change. Key areas of focus being considered by states include:

- Expanding use of data analytics to drive improvements.
- Improving the quality of care and linking provider reimbursement to the quality of care and health outcomes.
- Moderating increases in cost through payment reform and better delivery systems.
- Providing more efficient care through integration of services and/or programs such as integrating behavioral and physical health care services or integrating Medicare and Medicaid services for beneficiaries eligible for both programs (dual eligible).
- Collaborating across state agencies to consider the impact of social determinants on health care expenses and outcomes and determine which social support programs will drive better health outcomes and/or lower costs.
- Integrating more types of services, such as LTSS, prescription drugs and behavioral health, into existing managed care programs.
- Integrating more populations, such as prisoners and homeless individuals.

Based on the fall 2015 National Association of Medicaid Directors (NAMD) Fourth Annual Medicaid Operations Survey, more than half of all Medicaid directors spent at least half of their time focusing on major payment, delivery system or programmatic reforms in 2015. Of those reform areas, Medicaid directors indicated that delivery system and payment reform initiatives are their top focus.⁶

WHAT IS DELIVERY SYSTEM AND PAYMENT REFORM?

For many years, the Medicaid program paid providers on a fee-for-service (FFS) basis, without regard to quality or outcomes. Over the past 20 years, many states have moved a significant portion of their Medicaid program to managed care, paying managed care organizations (MCOs) to provide all or some of the services for an agreed-upon price. The MCOs then paid providers at contracted rates. This could be considered the first version of payment reform, with the MCOs managing the provider reimbursement rates. Many MCOs are now moving to more risk-based arrangements with providers; a step away from a "pay for volume" approach toward a "pay for performance" approach, reducing or sometimes completely removing the providers' incentive to increase revenue by increasing the volume of services that is inherent in FFS programs.

Many states have recently been moving beyond managed care through the use of delivery system and payment reform initiatives. While there is an underlying assumption that this reform movement will save money in the long run, states have many other purposes in implementing the new programs, including improving beneficiary access to care, improving the quality of care, and improving beneficiary outcomes.

Recent Medicaid delivery system and payment reform initiatives states are considering include Delivery System Reform Incentive Payment (DSRIP) program waivers, accountable care organizations (ACOs), patient-centered medical homes (PCMHs) and health homes (HHs). An overview of each of these is provided here.

- **DSRIP program waivers.** DSRIP waivers are part of the Section 1115 demonstration waiver programs available to states upon approval by the Centers for Medicare and Medicaid Services (CMS). Under a DSRIP waiver, the states develop and implement initiatives that are expected to reduce costs over time. The key component of DSRIP waivers is that payments to providers are tied to meeting specific performance metrics.
- **ACOs.** In general, an ACO is an organization formed by a group of health care providers who are willing to take financial risk and agree to be responsible for the health care delivery and outcomes for a defined population. The ACO is accountable for the quality and cost of care for a defined set of services for their population. If the ACO meets pre-established quality performance standards and achieves savings relative to a pre-determined benchmark, it will share a portion of the savings with the state.
- **PCMHs.** PCMHs are physician-led teams of providers that are responsible for all of the patient's ongoing care. PCMH payments are designed to recognize the added value these

services provide to the patient and are paid either by the state directly or through MCO contracts, often through per-member-per-month (PMPM) fees in addition to regular FFS payments.

- **HH program.** HHs are patient-centered systems of care for individuals with multiple chronic conditions. They are designed to improve the patient’s quality of care and health outcomes by managing and coordinating a wide range of services including physical health services, behavioral health services, LTSS and social service supports. States may design and implement separate HH programs targeting different populations.

These initiatives are just a few of the many new and emerging innovations in Medicaid reform. The design of these programs is continually evolving and improving as emerging experience on the programs and program metrics become available. For further information on Medicaid delivery system and payment reform, visit the Kaiser Family Foundation website at <http://kff.org/medicaid/> or the Medicaid and CHIP Payment and Access Commission (MACPAC) at <https://www.macpac.gov/>.

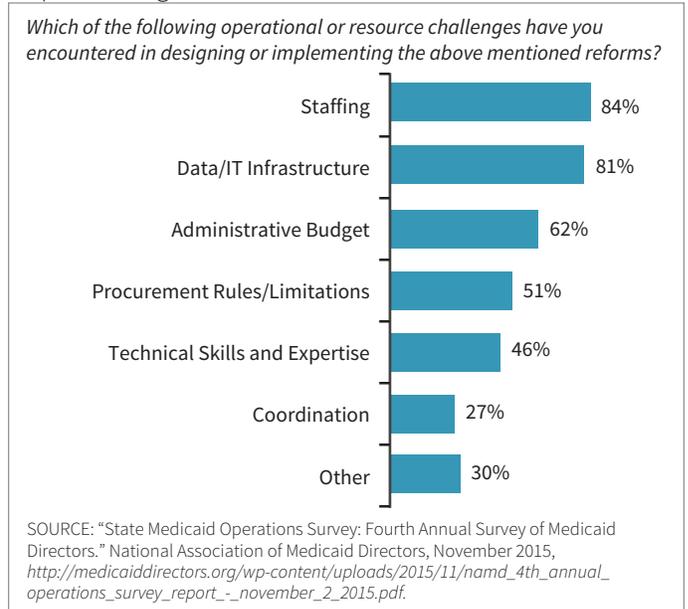
WHAT CAN ACTUARIES DO?

I can honestly say that the Medicaid program helped me get where I am today. Helping vulnerable populations, especially Medicaid populations, has a special place in my heart due, in large part, to my personal experience. As an actuary, I believe we can play an important role in helping position Medicaid for the future.

The movement toward the new Medicaid initiatives has created the need for extensive data analytics resources. In fact, 45 percent or more of the NAMD survey respondents indicated that staffing resources, data/IT needs, and technical skills and expertise are current challenges in designing or implementing the reform initiatives (see Figure 5).

As actuaries we can proactively advocate the significant value our profession can bring to the Medicaid program to help drive change and innovation.

Figure 5
A Wide Range of Barriers Exists to Implementing Medicaid Reforms



How can we, as actuaries, get involved and impact the program in a positive way? Following are some examples of more traditional ways actuaries have worked and can continue to work with states or MCOs on Medicaid issues:

- Establish, analyze or certify managed care capitation rates.
- Develop or analyze risk adjustment programs and/or risk settlements.
- Develop or analyze provider fee schedules and assist in provider contracting.
- Develop or analyze actuarial assumptions in projecting managed care expenses such as trends, incurred but not reported (IBNR) factors, administrative expenses or margin levels.
- Perform feasibility analyses on the impact of moving certain populations or services to a managed care setting.
- Assist in developing and performing impact analyses on the implementation of waiver programs.

There are also innovative and more nontraditional ways actuaries can and do work with states, MCOs, ACOs, advocacy groups, CMS or other Medicaid stakeholders to meet the specific needs of new initiatives in Medicaid. Some examples include:

- Analyze the impact of reform efforts on the sustainability of the program.
- Develop and analyze new value- and quality-based payment models that can be used to drive innovation and improved health outcomes.

- Develop and analyze special needs programs for specific populations or services such as programs to address specific chronic conditions or programs that target certain sectors of Medicaid beneficiaries who may be at high risk.
- Analyze the impact that various social determinants have on health care and consider models that address those social issues.
- Identify areas of unreimbursed care—for example, identify providers with special needs patients who require more time and attention than the average Medicaid patient—and develop models that address reimbursing providers appropriately for those value-added services.

This list may, and likely will, grow to include many other ideas and is only limited by our view of the services actuaries can provide. At the 2015 NAMD Annual Conference, the need for data analytics and strategies to reduce costs while improving outcomes was mentioned in nearly every session I attended. The skill sets and expertise we have developed and strengthened during our actuarial careers place us in the perfect position to meet those needs.

As actuaries we can proactively advocate the significant value our profession can bring to the Medicaid program to help drive change and innovation. ■



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ENDNOTES

- ¹ <http://kff.org/health-reform/issue-brief/medicaid-moving-forward/>
- ² <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/maternal-and-infant-health-care-quality.html>
- ³ <http://kff.org/other/state-indicator/children-0-18/>
- ⁴ *Supra* note 1.
- ⁵ <http://kff.org/other/state-indicator/distribution-of-general-fund-spending/>
- ⁶ <http://medicaiddirectors.org/publications/4th-annual-medicaid-operations-survey-highlights-program-challenges-priorities-for-2016/>



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