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States Are Using Flexibility to Create Successful, Innovative Medicaid Programs

By Hannah Katch

State Medicaid programs across the country are tailoring services and models of care to local needs in ways that streamline health care delivery and improve health. These innovative models demonstrate that current Medicaid rules allow states significant flexibility, and disprove claims by proponents of block-granting Medicaid or imposing a per capita cap, as the House Republican budget plan would do, that current Medicaid rules inhibit state reforms.¹

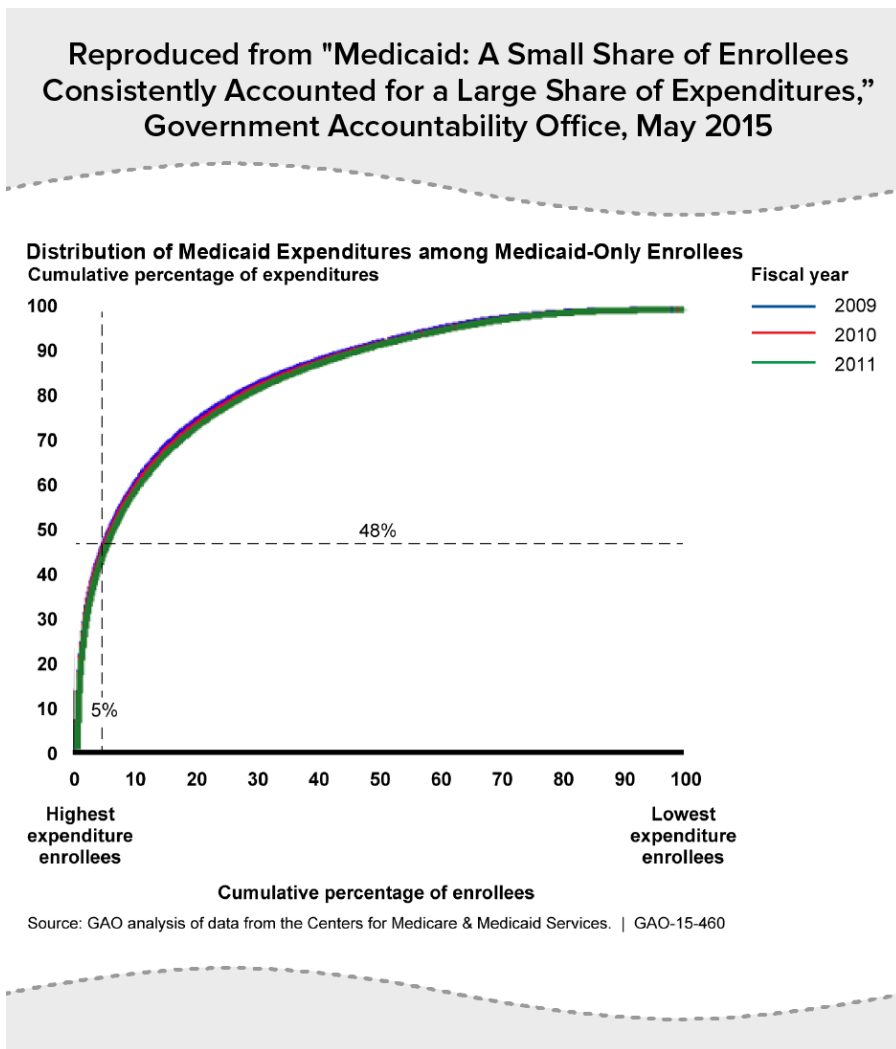
Well before health reform expanded Medicaid coverage for millions of low-income adults, states began changing how they deliver Medicaid services to help ensure that beneficiaries receive appropriate, timely, and cost-effective care. The challenge of meeting the needs of newly covered adults with complex health conditions has reinforced the importance of better organizing the delivery of care, as has research showing that the highest-need beneficiaries drive a large share of Medicaid spending. (Five percent of beneficiaries account for more than half of program costs.²) Improved coordination of care can improve individuals' health outcomes while averting unnecessary costs to the health system.

At the beneficiary level, new programs are beginning to coordinate physical and behavioral health care services as well as social services. At the system level, states are moving to integrate services for their most vulnerable beneficiaries by improving how they communicate and share data across providers and systems, which can ensure that effective health services are provided in a timely way without the need for intensive coordination at the beneficiary level. These coordination and integration efforts are improving health outcomes and making Medicaid more efficient by bridging the gap between health care and other services, such as housing assistance.

¹ Edwin Park, "Medicaid Spending per Beneficiary Would Shrink by Half Under House Budget's Per Capita Cap Option," Center on Budget and Policy Priorities, April 2016, <http://www.cbpp.org/blog/medicaid-spending-per-beneficiary-would-shrink-by-half-under-house-budgets-per-capita-cap>.

² Julia Paradise, "Medicaid Moving Forward," Kaiser Family Foundation, March 2015, <http://kff.org/health-reform/issue-brief/medicaid-moving-forward/>.

FIGURE 1



Using existing state flexibility under Medicaid, for example:

- Missouri has established “health homes” that coordinate care for beneficiaries with chronic physical health conditions or a diagnosed serious mental illness. Early data from the program show a significant drop in emergency department visits and preventable hospitalizations.
- Tennessee is one of 44 states participating in the Money Follows the Person program, which helps Medicaid beneficiaries safely and successfully transition from nursing facilities to their own homes, the home of a caregiver, or a community-based residential facility. Tennessee’s program has produced significant state savings by reducing unnecessary nursing facility stays.
- A Wisconsin hospital is testing a new way to integrate health services for children with complex medical needs, a rapidly growing group with high health care costs. Participants are significantly more likely to report that their health needs are being met.
- Oregon has established, through a waiver, accountable care organizations — groups of providers and other entities that partner to provide a range of health care services in a

coordinated way — to integrate hospital-based services with primary care, behavioral health care, and other social supports. Oregon has seen emergency department visits and preventable hospital admissions fall significantly, while lowering its growth in Medicaid spending per beneficiary by two percentage points below the levels that are projected in the absence of the waiver.

Even as states experiment with new and effective ways to provide care, some policymakers continue to call for fundamentally restructuring the federal Medicaid financing system in the name of expanding state flexibility, which they claim would allow states to provide improved care to beneficiaries at lower cost. Yet the large and growing cuts that would result from converting Medicaid into a block grant or establishing a per capita cap would force states either to provide considerably more state funding for Medicaid, or, as is more likely, to institute substantial cuts to eligibility, benefits, and/or provider payments. Moreover, the resulting financial squeeze could also halt or reverse progress toward further integrating care and strengthening the health care delivery system for Medicaid beneficiaries by changing Medicaid agencies' focus to making cuts rather than investing in efforts aimed at improving the delivery of care.³

Laboratories of Success: Four Examples of State Medicaid Innovation

During Medicaid's first several decades, beneficiaries had to find their own providers and coordinate their own care, and states reimbursed providers on a fee-for-service basis (that is, for each service they provided). In the 1980s, states began adopting a range of payment and coordination techniques to better organize care.

Many states now rely on managed care plans to develop networks of providers, ensure that beneficiaries have access to primary care providers, and help beneficiaries coordinate their care. Rather than paying providers for each service, which may create an incentive to furnish unnecessary, costly services, states pay a capitated rate, where a plan or provider receives a set amount per beneficiary and is responsible for their care. If payments are set at sound levels, this method can encourage plans and providers to provide the appropriate level of services to keep people healthy while avoiding unnecessary services, which can otherwise drive up costs.

Some states also make capitated payments to groups of providers that coordinate and deliver all the care to their patients while meeting certain quality and cost benchmarks. Other states pay providers for individual services and offer separate care coordination services to help Medicaid beneficiaries navigate the health system.

For most people, who don't have complex health needs and receive all their care from a relatively small number of providers, traditional models of care are a significant improvement over an entirely uncoordinated system. However, people with multiple chronic conditions with an array of providers and needs that go beyond what health care traditionally provides (such as homelessness) still face the burden of coordinating much of their own care even if a group of providers or a managed care plan has an identified care coordinator to help them. Moreover, people receiving care from multiple health and non-health programs may have *several* care coordinators, which can be confusing and inefficient. Recognizing this, many states are moving beyond their initial efforts to coordinate

³ See Park, *op cit*.

physical health care services to coordinate the larger array of physical and behavioral health care and social services that these beneficiaries need to achieve better health.

In addition to helping individuals navigate the various services they need, states are integrating the design of these services to streamline care for their most vulnerable beneficiaries. Providers are improving communication and data-sharing techniques to help beneficiaries access appropriate and timely care across multiple systems. This integration is challenging; many providers communicate and collect data in different ways, both within the health sector and between health and social service providers. But it can significantly improve care for people with complex needs and also improve efficiency.

The following four examples of innovative models, using four different existing areas of opportunity available to state Medicaid programs, testify to Medicaid's current flexibility and its support for state and local innovation.

Health Homes: Missouri

Health reform includes enhanced federal Medicaid funding for states to provide "health home" services aimed at providing effective, appropriate care to high-cost, high-need beneficiaries with chronic conditions or serious mental illness. These services include comprehensive care management, care coordination, support transitioning between institutions or from an institution to the community, and referral to community and social services.

In 2012, Missouri's Medicaid and mental health agencies established health homes for two groups of beneficiaries: those with multiple chronic conditions and those with a diagnosed serious mental illness. The program supports care coordination for individuals transitioning from one care setting to another, such as from a hospital to a nursing facility. It also integrates behavioral health care with primary care services to reduce avoidable hospital stays. Health home providers are responsible for finding eligible beneficiaries and connecting them with the medical and social services they need.⁴

Every four months, Missouri examines its Medicaid data to identify additional beneficiaries who may be eligible for the health home program and assembles a team of providers (including a care team director, nurse manager, and care coordinator or administrator) to provide needed care.⁵ To ensure that people with physical *and* behavioral health care conditions get needed services, the program ensures that beneficiaries have access to behavioral health and primary care providers, often in the same location.

Missouri also helps health care providers serve beneficiaries more effectively by providing practice coaches, training, technical assistance, and data management. Managed care organizations support

⁴ Kathy Moses and Brianna Ensslin, "Seizing the Opportunity: Early Medicaid Health Home Lessons," Center for Health Care Strategies, March 2014, http://www.chcs.org/media/Seizing_the_Opportunity-Early_Medicaid_Health_Home_Lessons.pdf.

⁵ Barbara Ormond *et al.*, "Health Homes in Medicaid: the Promise and the Challenge," Urban Institute, February 2014, <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/413032-Health-Homes-in-Medicaid-The-Promise-and-the-Challenge.PDF>.

coordination of care by sharing data with the health home providers, and the health homes receive automated notifications when enrollees are admitted to the hospital.⁶

Early data from the program show a significant drop in emergency department visits and preventable hospitalizations for both the physical and behavioral health groups. In addition, Missouri saved about \$52 in monthly Medicaid spending for every participant.⁷

Money Follows the Person: Tennessee

Many people in nursing facilities don't need the level of care the facilities provide but can't return to the community because they lack a home or the support they need to stay in their home. To address this problem, states are rebalancing Medicaid long-term services and supports away from institutional care in favor of home- and community-based services that help people return to or remain in a community setting. Medicaid agencies in 43 states and the District of Columbia participate in the Money Follows the Person program, which Congress authorized in 2005 to provide state Medicaid agencies with funding and flexibility to help beneficiaries safely transition from nursing facilities to their own home, the home of a caregiver, or a community-based residential facility. The Medicaid services provided under Money Follows the Person include many non-traditional services such as home-delivered meals, wheelchair ramps and other home modifications, and support for caregivers.

Tennessee's Money Follows the Person program relies on managed care plans to provide most of these services. Health plan care managers develop care plans and help people transitioning out of nursing facilities arrange for the services they need to live safely in their homes. Once a beneficiary is in the community, the plan monitors the person's needs and care to ensure a successful transition.⁸ The managed care plans receive a set amount per month for their services, which creates an incentive to provide efficient care and avoid unnecessary facility stays. Tennessee also offers an additional financial incentive payment to managed care plans that successfully transition nursing facility residents to the community and help them stay there safely.⁹

Between October 2011 and June 2013, more than 620 beneficiaries transitioned to the community through the program. It has produced significant state savings by reducing unnecessary nursing facility stays. Based on the state's estimates, it costs an average of \$1,969 per month to serve a

⁶ "Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Annual Report – Year Three," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, July 2015, <https://aspe.hhs.gov/pdf-report/evaluation-medicaid-health-home-option-beneficiaries-chronic-conditions-annual-report-year-three>.

⁷ See Moses and Ensslin, *op cit*.

⁸ Molly O'Malley Watts, Erica L. Reaves, and MaryBeth Musumeci, "Tennessee's Money Follows the Person Demonstration: Supporting Rebalancing in a Managed Long-Term Services and Supports Model," Kaiser Commission on Medicaid and the Uninsured, April 2014, <https://kaiserfamilyfoundation.files.wordpress.com/2014/04/8581-tn-tennessee-s-mfp-demonstration-supporting-rebalancing-in-a-mltss-model1.pdf>.

⁹ Jenna Libersky, Debra Lipson, and Kristie Liao, "Hand in Hand: Enhancing the Synergy between Money Follows the Person and Managed Long-Term Services and Supports," Mathematica Policy Research, July 2015, <https://www.mathematica-mpr.com/our-publications-and-findings/publications/hand-in-hand-enhancing-the-synergy-between-money-follows-the-person-and-managed-longterm-services>.

Money Follows the Person beneficiary in the community — or about half of the \$3,710 monthly average cost to serve an individual in a nursing facility.¹⁰

Center for Medicare and Medicaid Innovation Grants: Wisconsin

Health reform established the Center for Medicare and Medicaid Innovation (CMMI) to test new health care payment and delivery models. One model offers a new way to provide care for children with complex medical needs, a rapidly growing group who tend to have very high health care costs¹¹ and have hospital readmission rates equal to or higher than seniors who are Medicare beneficiaries.¹² Community-based pediatricians often struggle to meet their needs, and these children and their families often must coordinate care from many different providers — especially when their hospital care is entirely separate from care available in their community.¹³

The Wisconsin Department of Health Services received a CMMI grant to integrate health services for medically complex children enrolled in its Medicaid program. A team of providers and care coordinators works with the children, their families, and their community-based providers. The team provides support for families when the child transitions between settings, such as from the hospital to another facility or home. The program also works with children receiving outpatient care in order to identify children with complex needs and provide them with care coordination and support to avoid unnecessary hospitalizations.¹⁴

An early evaluation of Wisconsin’s model showed that inpatient hospital days and costs decreased by more than 50 percent after children enrolled in the program.¹⁵ Evaluation of this and similar models shows that participants are significantly more likely to report that their children’s health needs were being met, and children were more likely to attend primary care checkups and receive scheduled therapies, mental health care, and respite care.¹⁶

Accountable Care Organizations: Oregon

Accountable care organizations (ACOs) are groups of providers and often other entities such as health plans that partner to provide a range of health care services in a coordinated way. While the use of ACOs in the Medicare program has received considerable attention, state Medicaid programs are also adopting the use of ACOs. One Medicaid ACO model pays providers a capitated rate and

¹⁰ Watts, Reaves, and Musumeci, *op cit*.

¹¹ Jay G. Berry *et al.*, “Children with Medicaid Complexity and Medicaid: Spending and Cost Savings,” *Health Affairs*, December 2014, <http://content.healthaffairs.org/content/33/12/2199.full>.

¹² Jay G. Berry, “What Children with Medical Complexity, Their Families, and Healthcare Providers Deserve from an Ideal Healthcare System,” Lucile Packard Foundation for Children’s Health, December 2015, <http://www.lpfch.org/sites/default/files/field/publications/idealhealthcaresystem.pdf>.

¹³ Jay G. Berry *et al.*, *op cit*.

¹⁴ Center for Medicare and Medicaid Innovation, “Health Care Innovation Awards Round Two Project Profiles,” July 2014, <https://innovation.cms.gov/Files/x/HCIATwoPriProCombined.pdf>.

¹⁵ John B. Gordon *et al.*, “A Tertiary Care-Primary Care Partnership Model for Medically Complex and Fragile Children and Youth with Special Health Care Needs,” *JAMA Pediatrics*, October 2007.

¹⁶ Dennis Z. Kuo *et al.*, “Health Services and Health Care Needs Fulfilled by Structured Clinical Programs for Children with Medical Complexity,” *Journal of Pediatrics*, February 2016, [http://www.jpeds.com/article/S0022-3476\(15\)01169-5/abstract](http://www.jpeds.com/article/S0022-3476(15)01169-5/abstract).

holds them financially responsible for all of their beneficiaries' health care services. ACOs can bridge the gap between clinical care and social service needs by working with other community-based organizations (such as supportive housing providers) to meet the needs of Medicaid beneficiaries. ACOs can also provide limited services to meet non-clinical needs, such as helping someone without stable housing to find or keep a home. By integrating hospital-based services with primary care, behavioral health care, and other social supports, ACOs can provide efficient and effective care far beyond what traditional health care providers usually provide.

Oregon established a network of ACOs using a broad federal waiver (known as a section 1115 demonstration) that allows the Department of Health and Human Services to waive statutory requirements to permit testing of innovative state or local models or programs. The Oregon waiver also set goals to improve health care quality and care delivery in several specific areas, including care management, integration of physical and behavioral health care, re-hospitalizations, and perinatal and maternity care. Based on these delivery reforms, the waiver also set a goal of slowing the growth in Medicaid per-beneficiary spending by two percentage points below what was projected in the absence of the waiver.^{17,18}

Oregon's ACOs, known as Coordinated Care Organizations (CCOs), are integrated, community-run organizations responsible for providing all medical, mental health, and dental care services for their members in a specific region of the state.¹⁹ They receive a capitation payment that grows at a fixed rate. CCOs collect and report data on more than 30 different measures of health care quality, and 3 percent of their monthly payments are withheld and redistributed among the CCOs based on their achievement of specified quality goals. Since the waiver's approval in 2011, Oregon has met its spending goal and has seen emergency department visits and preventable hospital admissions fall significantly.²⁰

Oregon's largest CCO, Health Share, provides Medicaid coverage for three counties, including the city of Portland. It is governed by representatives of the entities bearing financial risk, which include health plans, providers, and mental health agencies, along with representatives of local organizations and social service providers. With the Medicaid funds it receives from the state, Health Share pays capitated rates to its contracted health plans and mental health agencies, which are responsible for their members' care. Health Share also provides additional care management services in the home or community for its highest-risk members, such as those who have visited the emergency department six or more times in a year.

¹⁷ State of Oregon, 1115 Waiver Demonstration Renewal, <https://www.oregon.gov/oha/OHPB/Documents/special-terms-conditions-accountability-plan.pdf>

¹⁸ Under the waiver, Oregon received upfront increases in federal funding to develop the ACOs, which would be offset by expected savings as the ACOs were fully implemented. While the state is responsible for reimbursing the federal government if expected savings do not materialize, unlike under a block grant or per capita cap, the state retains financial flexibility for the program to respond to unexpected health care needs, as well as the ability to expand eligibility, add new benefits, and enroll all eligible beneficiaries who apply, as would be the case in the absence of the waiver.

¹⁹ *Ibid.*

²⁰ Jim Lloyd, Rob Houston, and Tricia McGinnis, "Medicaid Accountable Care Organization Programs: State Profiles," Center for Health Care Strategies, October 2015, <http://www.chcs.org/resource/medicaid-accountable-care-organization-programs-state-profiles/>.

In its first year, Health Share cut emergency department visits by 18 percent, enrolled 80 percent of its members in an integrated medical home, and earned 100 percent of its potential payments for meeting quality measures.²¹

Medicaid Innovation Leading the Way to Better Health Care Delivery

A number of states are using Medicaid to connect traditionally siloed systems serving their beneficiaries. States like Missouri have found that providing coordination and care management can both improve health outcomes and reduce unnecessary costs for many of the highest-need Medicaid beneficiaries. Wisconsin and Oregon are going beyond coordination and moving toward a system of care that is more integrated, where various pieces of the safety net fit together so beneficiaries or care coordinators needn't navigate multiple systems.

Many other states have used Medicaid to develop innovative approaches to meeting their beneficiaries' health needs. California's new 1115 Medicaid waiver allows the state to offer a range of substance use disorder services in a coordinated way.²² Minnesota's Medicaid ACO, Hennepin Health, provides integrated care to high-need, high-cost beneficiaries in the state's most populous county.²³ Colorado is working to integrate physical and behavioral health services and using Medicaid services to help beneficiaries find and keep stable housing.²⁴

States have also relied on Medicaid's ability to expand to meet individuals' needs when responding to health crises such as water contamination in Flint, Michigan, the devastation caused by Hurricane Katrina, and the large increase in unemployment, resulting loss of health coverage and greater Medicaid enrollment during the last recession.

In sum, Medicaid gives states financial support and considerable flexibility to respond to crises and develop innovative new models of care.

²¹ Sarah Klein, Douglas McCarthy, and Alexander Cohen, "Health Share of Oregon: A Community-Oriented Approach to Accountable Care for Medicaid Beneficiaries," Commonwealth Fund, October 2014, http://www.commonwealthfund.org/~media/files/publications/case-study/2014/oct/1769_klein_hlt_share_oregon_aco_case_study.pdf.

²² State of California, Medicaid 1115 Demonstration Waiver, http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_FINAL_STC_12-30-15.pdf.

²³ Hennepin Health 2016, <http://www.hennepinhealth.org/about-us/about-hennepin-health>.

²⁴ Corporation for Supportive Housing, "Colorado Crosswalk: Improving Medicaid Financing of Supportive Housing Services," 2015, <http://www.csh.org/wp-content/uploads/2015/09/Colorado-PSH-Medicaid-Crosswalk-Final.pdf>.