Medicaid strategies for FY19

KPMG Government Institute

Issue brief | November 2018

The FY17 National Association of Medicaid Directors (NAMD) survey outlines a number of key strategic priority areas that Medicaid Directors have listed for the upcoming year. While Medicaid administrators face a multitude of complex programs on a daily basis, a number of themes are ubiquitous throughout the country. In the sections below, we outline the five most commonly mentioned areas of focus and provide an overview of potential approaches for states to consider. In all of the approaches, we stress the importance of a longer-term view, which we recognize is incredibly difficult to do given the relatively short tenure of many Medicaid administrators combined with an ever-changing regulatory landscape. We also recognize that the five themes covered in this paper are interconnected, and while we address them separately below, to address one requires thinking through the short-, middle-, and longer-term effects on the other four themes.

Delivery system and payment reform
Consider the alignment to MACRA

Behavioral health reform
Carve in vs. carve out

1115 waivers
Align to a multiyear strategy or roadmap

Data systems and IT
Getting MMIS renewals to payment and delivery reform approaches

Program integrity
Using intelligent automation to support your framework

Delivery system reform

Almost half of the Medicaid Directors surveyed by the NAMD named delivery and payment reform as one of their top three strategic priorities for the upcoming year. The Centers for Medicare & Medicaid Services (CMS) has made it clear that they will also continue the drive towards payment reforms and the use of Alternative Payment Models (APMs) in the pursuit of sustainably bending the cost curve while simultaneously improving quality and access to care. The latest CMS Innovation Center model to join the APM family is the Bundled Payment Care Initiative (BPCI) advanced model, covering 29 inpatient clinical and 3 outpatient clinical episodes.[1]

While there are many approaches to payment reform across the country—focus ranging from the formation of Medicaid Accountable Care Organizations to rolling out episodic bundles of care—states should take care to focus on reducing provider burden, keeping the programs manageable, and aligning, where possible, to the CMS APM efforts, thus allowing Medicaid payment models to qualify as Advanced APMs (a subset of APMs that qualify for additional incentive payments).

In order to improve Medicaid to APM alignment, states should take note of three key alignment factors: (1) use of quality measures, (2) use of Certified Electronic Health Record Technology (CEHRT), and (3) appropriate levels of risk sharing.

The current administration is refining quality measures through the CMS Meaningful Measures Initiative to focus on those that meet strict criteria regarding measure reliability, validity, and the supporting evidence base. In addition, the administration is increasingly moving towards the capture of electronic clinical quality measures (eCQM) rather than claims-based measure approaches. As such, an alignment strategy to the APM quality measure set will likely also mean that states need to rethink their approaches to data collection and health information technology (HIT) enablement approaches.

Alignment of payment reform efforts with federal programs will also require increasing levels of sophistication in risk-sharing approaches. The Medicare Access and Children's Health Improvement Program Reauthorization Act (MACRA) Quality Payment Program (QPP) outlines financial risk criteria for Advanced APMs with flexibility for providers.

[1] Centers for Medicare & Medicaid Services. "BPCI Advanced." October 2018. Retrieved from https://innovation.cms.gov/initiatives/bpci-advanced/.

While flexible, a key attribute of the risk criteria in the Advanced APMs is that they subject providers to both upside as well as downside risk. The latter perhaps not featured as often in the Medicaid models.

In order to adequately manage risk, providers looking to manage care across a continuum (whether it be for population health or a specific episode) will inevitably need to increase the focus on data sharing, interoperability, and analytics. As such, the use of CEHRT is a key requirement in advanced APMs, making it another factor for states to consider when designing their own approaches to Medicaid payment reform approaches.

Payment reform is a complex journey, and the right answers are currently far from obvious. But with limited resources and pressure to progress, states need to simultaneously navigate their way through designing a delivery system model that is efficient and serves the needs of their populations while making sure the payment models align to federal developments. States should familiarize themselves with the flexibilities that do exist (e.g., joint data reporting) and, overall, keep an eye on further detail as it emerges to avoid diverging down a path that potentially limits or restricts the future opportunities that payment reform presents.

Behavioral health reform

Slightly less than half (18 of 45) of the Medicaid Directors surveyed by NAMD indicated the need to work on behavioral health (BH) (both substance use disorder and mental health) reforms as one of their top three strategic priorities. From both a quality as well as a financial point of view, the strategic priority to focus on BH makes sense; while statistics vary by state, studies among Medicaid populations have shown that sometimes as much as 50 percent of the preventable hospital admissions are driven by BH issues.[2]

It appears that a healthy number of Medicaid administrations are "walking the walk" as well as "talking the talk" when it comes to BH reforms. While we cannot verify whether the administrations that indicated BH to be a priority on the survey are the ones that are also making investments through 1115 waivers, it is noticeable that almost half of the states (22 as of November 2017) had an approved or pending section 1115 Medicaid demonstration waiver that focused on one or more BH initiative(s).[3] A large proportion of the BH-focused section 1115 waivers focus on eligibility expansions as well as payment provisions for substance use disorder and mental health treatment. A smaller portion (between three and five depending on whether pending waivers are counted) include a focus on delivery system reforms that integrate physical and BH care and use evidence-based industry standards.

With the focus on integrating primary and behavioral care in practice comes the discussion of whether or not to carve BH into managed care plans, considered the "purest" form of integration, or whether to maintain it as a carve-out. A large number of states with managed care currently maintain a separate carve-out for BH, either operating a vertical carve-out for specific consumers by a specific BH organization (BHO) or keeping it out of managed care altogether. Of the 38 states in late 2017 with managed care, 24 manage at least a portion of BH benefits under a primary carve-out arrangement.[4]

Historically, carve-outs for BH have often been used as a cost containment tool, although arguments can also be made that it helps create specialized focus on BH issues and prevents the redirection of funds away from BH spending in the integrated plan setting. On the other hand, trying to stimulate integration in a carve-out construct through incentives and structures that reward integration can be difficult and costly to manage.[5]

While any form of carve-in is sure to be met with resistance, a number of states have made the transition with varying degrees of success, bringing the management and purchase of both behavioral and physical health under one roof. The latest to make the move is Ohio, which launched its Behavioral Health Redesign program in January and, as of July 1, 2018, now has all BH services integrated into managed care.[6] For states contemplating the move to a BH carve-in, it is important to consider to what degree BH capacity building is necessary, whether managed care organizations (MCOs) or BHOs should be in the lead, and whether it makes sense to create one integrated system or create various models for subsets of beneficiaries with serious mental illness, such as the New York Health and Recovery Plans (HARP).[7]

A discussion that is consistently more intertwined with the discussion of BH and physical health integration is the need to focus on social determinants of health (SDOH) that drive healthcare utilization. Given the direct connections between SDOH and the costs and outcomes of care, it is worth considering how Medicaid can stimulate innovative investments by both plans and healthcare organizations in this space.[8,9] This includes addressing some of the common concerns often cited by plans and healthcare organizations and working together with them to create a smoother glide path to SDOH investments. Common barriers and concerns include:

- Investments in SDOH do not have corresponding billing codes, which means costs are "hidden" from rate setting processes, leading to unwarranted rate cuts to the plans and providers that are spending money on these "hidden" services.
- It is not always clear to organizations what degrees of freedom they have to utilize healthcare dollars for nonmedical spend that, ultimately, leads to a reduction in medical spend and corresponding rise in quality.

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[2] Chakravarty, S. "Behavioral Health Conditions in Hospital Use and Costs," Rutgers The State University of New Jersey, November 2015.

[3] Musumeci, M. "Key Themes in Medicaid Section 1115 Behavioral Health Waivers," Kaiser Family Foundation, November 2017.

[4] Mandros, A. "Understanding the Medicaid Behavioral Health Carve-Out Map – Step One in Health Plan Contracting," Open Minds, April 2017.

[5] Hamblin, A, et. al, "State Options for Integrating Physical and Behavioral Health Care," Centers for Medicare & Medicaid Services, October 2011.

[6] State of Ohio Behavioral Health Redesign. Retrieved from http://bh.medicaid.ohio.gov/.

[7] Ibid.

[8] Sparer, Brown, and Muennig. "(Re) Defining the Health Care Delivery System: The Role of Social Services," February 2016.

[9] Bachrach, D. et. al, "Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment," Manatt Health Solutions, May 2014.

Case study: Molina Healthcare Jail Diversion Program[10]

By initiating care management services and outreach to members in jail (prior to them coming back on to Medicaid), Molina is able to improve patient engagement and correspondingly achieve significant reductions to recidivism and healthcare costs. While the investment to do outreach during the period that an individual is still in jail is Molina's own investment, the financial benefits (and the quality of service to the individual) once the individual is released are immediate. Well-engaged individuals after jail release utilize (on average) over $7,000 less per member per month (PMPM) healthcare costs than nonengaged individuals.

1115 waivers

The section 1115 waivers have increasingly become a tool for states to innovate and pursue transformation initiatives that are sensitive to their local state dynamics. While they are perceived as an effective tool to drive change and delivery reform, the NAMD survey also mentioned that the execution of 1115 waiver efforts requires significant time, planning, and resources. The reporting and evaluation requirements alone can present a significant administrative burden. While they are a tool that almost all surveyed Medicaid Directors (38 of the 45 respondents) envisioned utilizing in the next year, the 1115 waiver is only one of many possible tools at a state's disposal to shift funds and support delivery reform projects. As such, it is important for Medicaid programs to consider how the 1115 waiver efforts fit into a broader, multiyear strategic roadmap. While perhaps a straightforward concept, it is not a given that all state Medicaid programs have a comprehensive multiyear strategy laid out that focuses on a select number of measures for health system goals (e.g., cost, access, patient experience, and outcomes) that can then, in turn, be applied to any vehicle used to catalyze reforms, including the 1115 waiver. While states often do have multiyear roadmaps laid out for information technology (IT) efforts as well as parts of the Medicaid program, it is difficult to find examples of states that have operated to a limited number of goals consistently over a longer period of time. A potential reason could be the short tenure of the director position (currently at an average of 26 months) that is not conducive to setting up longer-term plans and maintaining a consistent focus on the same set of themes.

States that have a more consistent longer-term strategy and roadmap are in the advantageous position of being able to structure data collection and analytics mechanisms around the roadmap goals in a more consistent way. As such, they are also in a position to have any new 1115 waiver opportunities feed into the existing data collection and presentation structure rather than needing to shore up a separate measurement mechanism for each new program.

Data systems and information technology

In the coming years, many Medicaid programs around the country will be focusing on a complete modernization and (modular) renewal of their Medicaid Management Information System (MMIS), the federally funded system that verifies eligibility, processes claims, and reimburses providers. Many of the current legacy computer platforms lack the flexibility to respond to changing policies and industry needs. By modernizing their use of systems technology, states have the opportunity to increase efficiencies across programs and reduce program costs.

A key concept for states to keep in mind while seeking modular renewals of the MMIS will be to ensure that the replacement modules are capable of supporting the general movement away from fee-for-service (and associated claims-processing) models to the landscape of value-based and APMs as well as a growing focus on HIT-enabled clinical measure collection. With the business of Medicaid and IT often being managed out of different offices, Medicaid Directors must be particularly vigilant to secure IT implementation plans that are sensitive to the new payment models and delivery approaches that are being supported on the business side of the program. With many states looking to implement multiple IT modernization projects and modules simultaneously, this will not be an easy task.

Program integrity

Program integrity (PI) is consistently on the list of priority topics for Medicaid Directors. While a strong approach to PI has the ability to save the program potentially large amounts of money, perhaps the larger factor is that PI is a core obligation of the Medicaid program.[11] The challenge of executing an effective PI strategy increases with time as healthcare continues to evolve and systems become increasingly integrated and focused on new care and payment models. A read through the last two years of State Program Integrity Review Reports reveals that in most, if not all, states' areas of noncompliance were identified and multiple recommendations for improvements for the PI approaches were delineated.[12] While not specific to Medicaid, a March 2018 survey by the Government Business Council indicated that 64 percent of federal healthcare program leaders felt their PI frameworks were ineffective, that their organizations didn't have a framework in place, or they simply didn't know if a framework existed.[13] The same survey also found a variety of views regarding what the focus of PI efforts should be and who should be responsible for delivery. Perspectives ranged from PI being an enabler for determining strategy, for ensuring program efficiency, and for detecting and preventing fraud, waste, and abuse. Those thought to be responsible ranged from organizational senior leaders to program managers, to compliance officers and others. It is likely that Medicaid administrations grapple with the same issues.

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[10] KPMG Government Institute, "Investing in social services as a core strategy for healthcare organization," March 2018.

[11] The Government Accountability Office reported that for fiscal year 2016, improper payments were an estimated 10.5 percent of federal Medicaid expenditures nationally.

[12] Centers for Medicare & Medicaid Services, "State Program Integrity Review Reports List." Retrieved from https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/State-Program-Integrity-Review-Reports-List.html

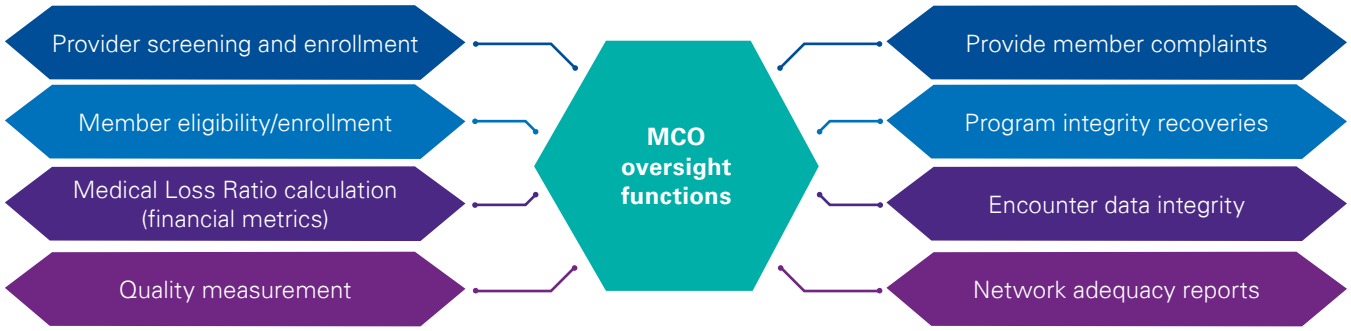
[13] Government Business Council and KPMG. "Maximizing Mission Integrity: A Candid Survey of Program Officers at Federal Healthcare Organizations." https://www.govexec.com/gbc/maximizing-mission-integrity/.

Effective PI requires a sophisticated framework and associated approach that are able to consistently address and measure performance while remaining sensitive to ongoing change. Combined with the common complaint of staff and resource shortages, the time is now to start considering intelligent automation (IA) approaches to PI. Potential areas in which IA could be applied to MCO oversight includes provider contract review, policy management, and provider screening and enrollment. Automation can come in the form of extracting data from contracts to assess compliance, identifying gaps in current policies and assessing the impact of changes, and comparing data across multiple sources to flag discrepancies and update current systems. Leveraging this automation can bring process improvement and increased efficiency to state agencies across the country.

In tandem with investment in data and analytics, better communication and collaboration is an important success factor for PI efforts. "Enhanced collaboration" with a variety of agencies and partners was the focus of one-third of all effective program integrity strategies cited by Medicaid Directors in FY17.[14] Aligned with the Center for Program Integrity's 2018 priority around communication and collaboration, critical to PI is a culture that supports the collaborative management of risk and avoids organizational silos. Given the disparate perspectives apparent in the perceived value of enhanced collaboration versus what healthcare leaders see happening around them, agencies should not rely on historical or myopic perceptions of stakeholder relationships and should regularly challenge the strength and effectiveness of collaboration with key departments and partners.

Figure 1: Overview of an effective PI oversight framework.

An effective oversight framework hinges upon the eight oversight areas shown below.



Conclusion

The strategic priority areas pointed out in the FY17 NAMD survey are, not surprisingly, linked. To address one is often to address (most of) the others. They are also recurring themes that return to the top-five in the NAMD survey on an annual basis. Given the difficulties of maintaining a consistent approach to Medicaid in the face of high staff turnovers and changing leadership, a comprehensive multiyear state plan that weaves together the various strategies may help to create year-over-year consistency.

[14] "State Medicaid Operations Survey," National Association of Medicaid Directors, September 2018.

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