

Priority Medicaid Issues for New State Officials

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The Issue

Medicaid is woven into the fabric of states' health care systems and economies: it covers one in five Americans; is the single largest insurer in every state; and is the largest source of funding for mental health, substance use disorder (SUD), long-term care, and maternity services. Medicaid is also a critical engine in state economies and a significant item in their budgets. Given Medicaid's importance, new state officials will want to evaluate the program, disentangling fact from fiction, identifying challenges and opportunities, and tackling pressing program priorities. This brief highlights priority issues for consideration and potential action.

The Structure of the Medicaid Agency

The Medicaid Director is charged with **stewardship** of the Medicaid program. Where the agency and its leadership "sit" within state government enables or impedes the authority of the Medicaid Director to make critical decisions about program strategy, services, and budget. For example, while Medicaid is the primary funder of behavioral health and long-term-care services—and enrollees requiring these services are among the program's most complex—in some states, responsibility for delivery system and payment policy for these services is vested with agencies that are outside of the purview of the Medicaid Director.

States are increasingly questioning the rationale of this fragmented structure, and consolidating authority for all physical health, behavioral health, and long-term-care services under the Medicaid Director. New state officials should evaluate the structure of the Medicaid Agency and consider changes to strengthen the Medicaid Director's ability to run the program effectively.

Enabling Coverage and Access

Medicaid is first and foremost a health insurance program. Without stable coverage it is difficult for states to design effective care delivery and payment models. When individuals churn on and off coverage, plans and providers are hard-pressed to manage care effectively, and patients themselves are less likely to access "the right care, at the right time, in the right setting." Thus, **a fundamental issue for state policymakers is the state's policies and operating procedures with respect to Medicaid eligibility and enrollment.** A focus on children's coverage is especially critical at this time. For more than a decade, the proportion of children with health insurance has consistently increased year over year; however, in 2017, the rate of insured children declined.¹ **As a first priority, state policymakers should identify any children's coverage loss in their state and determine how this downswing can be reversed.**

Additionally, with the Centers for Medicare and Medicaid Services (CMS) offering states new flexibility in terms of coverage rules—most notably, permitting states to condition coverage on work requirements—coverage policies are under intense scrutiny at this time. Before embracing proposals to add work requirements or any new coverage conditions, state policymakers will want to carefully assess their potential impact on continuous coverage.

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Addressing the Needs of Special Populations

Services for Elderly and Disabled Adults. Medicaid beneficiaries who rely on community and institutional long-term-care services and supports comprise a small percentage of Medicaid beneficiaries—about 6 percent—but consume a disproportionate share of Medicaid resources—over 40 percent.² Accordingly, states are **examining whether care is being delivered in the most appropriate setting**, and **building** the continuum of community-based care. Recognizing the particular importance of care management for these elderly and disabled beneficiaries, states with more mature managed care programs **are increasingly moving these individuals, and the services they require, into the managed care delivery system.**

Behavioral Health Care. Medicaid is the dominant payer for mental health and SUD services nationally. With the expansion of Medicaid, the onset of the opioid epidemic, and an alarming increase in “deaths of despair,” Medicaid has become an especially important **lever** in addressing the most pressing behavioral health needs among Americans. States that have expanded Medicaid are initiating **programs for adults transitioning from prison back into the community, and into Medicaid coverage**, with the goal of improving access to care and reducing mortality and recidivism rates. With strong evidence that physical and behavioral health service integration is essential to effective care delivery, **states are reviewing their payment models and managed care contracts to identify opportunities to support integration, including for people suffering from opioid use disorder.** (See Issue Brief #6 for additional information.)

Buying Value: Quality, Cost-Effective Care

Medicaid agencies are increasingly using their purchasing power to make providers more accountable for total cost of care and quality outcomes through “value-based” or “alternative payment” **initiatives.** **Most Medicaid agencies are abandoning cost-based reimbursement and adopting value-based payment policies.** Through their Medicaid managed care programs, states are requiring or incentivizing their plan contractors to use value-based payment methodologies with providers. States are also **incentivizing plans to meet new quality metrics that link to state priorities**—from reducing avoidable hospital admissions to improving integration of physical and behavioral health care. And, with CMS support, states are **initiating multi-payer purchasing strategies** that align payment approaches and bargaining power across Medicaid, public employee plans, commercial payers, and Medicare.

For more information about Medicaid administration, trends, and coverage for targeted populations, please refer to the resources below.

Additional Resources

Resources on Administration and Structure

- Allison, A. The Role of State Medicaid Directors: A Leadership Imperative. Milbank Memorial Fund. September 2015. www.milbank.org/publications/the-role-of-state-medicaid-directors-a-leadership-imperative/
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- National Association of Medicaid Directors. State Medicaid Operations Survey: Sixth Annual Survey of Medicaid Directors, FY 2017. National Association of Medicaid Directors. September 2018. <https://medicaiddirectors.org/publications/sixth-annual-medicaid-operations-survey/>

Resources on Medicaid Trends

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Resources on Medicaid and Special Populations

- Grady, A., Boozang, P., et al. Medicaid: The Linchpin in State Strategies to Prevent and Address Opioid Use Disorders. Manatt Health. March 2018. www.shvs.org/resource/medicaid-the-linchpin-in-state-strategies-to-prevent-and-address-opioid-use-disorder/
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- Morton, S., Dunn, W., et al. Addressing the Health Needs of Aging America: New Opportunities for Evidence-Based Policy Solutions. University of Pittsburgh: The Stern Center for Evidence-Based Policy. July 2015. www.healthpolicyinstitute.pitt.edu/sites/default/files/SternCtrAddressingNeeds.pdf

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2. Medicaid and CHIP Payment and Access Commission (MACPAC). MACStats: Medicaid and CHIP Data Book. DC: MACPAC; 2018. www.macpac.gov/wp-content/uploads/2018/12/December-2018-MACStats-Data-Book.pdf

Medicaid: The Basics

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The Issue

Since its creation in 1965, Medicaid has evolved from a small welfare program to the nation's single largest health insurer, covering over 66 million people—one in five Americans—in a given month, including one-third of all children and nearly half of all births.¹ The \$565 billion program constitutes 17 percent of health expenditures nationally and serves as the largest single payer for long-term care, behavioral health services, and maternity care in the country.² It is the largest payer and the biggest source of federal revenue in states.³ This brief outlines the basics of the Medicaid program for new state policymakers in order to lay the groundwork for considering the challenges and opportunities that lie ahead.

Medicaid Financing

Medicaid is governed by a unique partnership in which states and the federal government share responsibility for program design, operations, and costs. Each state administers its own Medicaid program according to federal guidelines. In return, federal funds match state dollars to pay for Medicaid-covered services. Generally, the federal matching rate **ranges** from 50 percent to 76 percent.⁴ Certain **programs and services** receive a higher federal match, including: family planning services (90 percent); **Health Home** services (90 percent); care provided in Indian Health Service facilities (100 percent); and care for low-income adults enrolled through state Medicaid expansion programs (93 percent in 2019 and 90 percent in 2020 and beyond).⁵

To pay the nonfederal share of Medicaid costs, states primarily rely on state general funds collected through sales and income taxes.⁶ States also **finance** the program through intergovernmental transfers, using funds transferred within the state or between state and local governments (i.e., by using local tax revenue), and taxes or assessments on health plans and providers. These taxes are capped at six percent of a provider's net patient revenues, and must be levied uniformly on all providers in a class.

Federal Medicaid Rules

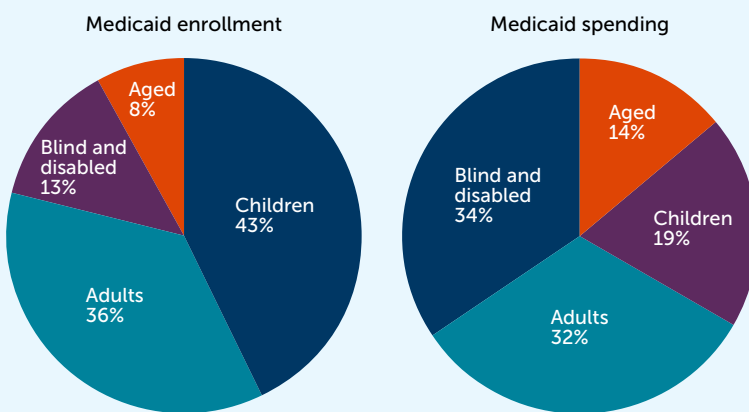
To qualify for federal matching funds, states must operate their Medicaid programs consistent with federal Medicaid law and file a State Plan and State Plan Amendments with the Centers for Medicare and Medicaid Services (CMS) **outlining** state rules and operating protocols for program administration. States seeking to test program features otherwise barred by federal Medicaid law may seek CMS approval to waive the applicable provisions under Section 1115 of the Social Security Act—also known as Section 1115 or Medicaid demonstration waivers. While CMS has broad discretion in approving waivers, it is not limitless: CMS may only approve a waiver if it finds that the waiver would advance the objectives of the Medicaid program. Currently, 46 states have **approved** Section 1115 waivers.⁷ These waivers permit states, among other things, to test new health care delivery models; cover interventions that address social determinants of health; expand coverage for substance use disorder (SUD) treatment; and impose additional conditions on Medicaid coverage, such as premiums.

Medicaid Eligibility and Benefits

Federal rules provide minimum standards for Medicaid eligibility and coverage. All Medicaid programs must cover low-income children, parents, pregnant women, elderly adults, and individuals with disabilities. To date, [37 states](#), including the District of Columbia, have also opted to expand eligibility to include adults with incomes up to 138 percent of the Federal Poverty Level under the Affordable Care Act (ACA). In 2018, Medicaid enrollment included 30 million children, six million seniors, 11 million people with disabilities, as well as 12.6 million adults eligible through Medicaid expansion programs.⁸ Despite making up the smallest share of enrollees, the aged and disabled beneficiaries account for the largest portion—48 percent—of Medicaid costs (Figure 1).⁹

Reflecting the health care needs of the low-income and medically complex people Medicaid covers, federal law requires states to provide a comprehensive benefit package that includes medical services and nonemergency transportation to health care services and appointments.¹⁰ For children under 21, Medicaid’s [Early and Periodic Screening, Diagnostic, and Treatment \(EPSDT\)](#) benefit covers medical, vision, hearing, dental screenings, and any medically necessary treatment services (regardless of whether a state covers such services for

Figure 1. Enrollment and Spending in Medicaid



Source: Spending and enrollment estimates for FY2015 from the Congressional Budget Office's March 2016 Medicaid baseline. Figures may not sum to 100 percent due to rounding.

adults). For adults and children, states may elect to provide additional [optional](#) benefits, such as prescription drugs, case management, personal care, and dental care. Unlike Medicare and most commercial plans, Medicaid also covers [long-term services and supports](#) provided in nursing homes or home and community-based settings.¹¹

Conclusion

Each state Medicaid program is different, reflecting states' diverse health care landscapes and economic, policy, and political priorities. Yet, there are common issues that have implications for state economies, Medicaid beneficiaries, and the future of the program. The briefs that follow in this series call out some of the issues that merit policymakers' immediate attention.

For more information on the Medicaid program structure, please refer to the resources below.

Additional Resources

Resources on the Basics of Medicaid

- MACPAC. *MACStats: Medicaid and CHIP Data Book*. DC: MACPAC; 2018. www.macpac.gov/wp-content/uploads/2018/12/December-2018-MACStats-Data-Book.pdf.
- Medicaid 101. Medicaid and CHIP Payment and Access Commission (MACPAC) website. www.macpac.gov/medicaid-101.
- Rudowitz, R. 10 Things About Medicaid: Setting the Facts Straight. Henry J. Kaiser Family Foundation. April 2018. <http://files.kff.org/attachment/Issue-Brief-10-Things-to-Know-about-Medicaid-Setting-the-Facts-Straight>.

Resources on Medicaid Authorities and Programs

- Antonisse, L., Garfield, R., Rudowitz, R., Artiga, S. The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review. Henry J. Kaiser Family Foundation. March 2018. www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018.
- Federal Policy Guidance. Center for Medicaid & CHIP Services (CMS) website. www.medicaid.gov/federal-policy-Guidance/index.html.
- State Overviews. CMS Medicaid website. www.medicaid.gov/state-overviews.

Resources on Medicaid State Administration and Financing

- Distribution of State General Fund Expenditures: SFY 2016. Henry J. Kaiser Family Foundation website. www.kff.org/other/state-indicator/distribution-of-general-fund-spending.
- MACPAC. *The Impact of State Approaches to Medicaid Financing on Federal Medicaid Spending*. DC: MACPAC; 2017. www.macpac.gov/wp-content/uploads/2017/07/The-Impact-of-State-Approaches-to-Medicaid-Financing-on-Federal-Medicaid-Spending.pdf.
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Medicaid's Impact on Health Care Access, Outcomes and State Economies

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The Issue

Medicaid has long been an essential source of health insurance coverage for low-income children, parents, elderly, and individuals with disabilities, improving health care access and health outcomes. With the Medicaid expansion under the Affordable Care Act (ACA), authorizing states to extend Medicaid eligibility levels for all adults with incomes up to 138 percent of the federal poverty level (FPL), it is the largest health insurer in the country, covering almost 66 million individuals.¹ Accordingly, Medicaid spending comprises one-sixth of total health care expenditures in the United States, translating to over three percent of GDP.²

Impact on Access to Care and Health Outcomes

Even before Medicaid expansion under the ACA, Medicaid coverage was associated with a range of positive health behaviors and outcomes, including increased access to care;³ improved self-reported health status;⁴ higher rates of preventive health screenings;⁵ lower likelihood of delaying care because of costs;⁶ decreased hospital and emergency department utilization;⁷ and decreased infant, child, and adult mortality rates.⁸ Three states that **expanded** their adult Medicaid eligibility levels prior to the ACA—Arizona, Maine, and New York—thereafter experienced an aggregate 6 percent decrease in all-cause mortality rates for 20 to 64-year-olds, translating to 20 fewer deaths per 100,000 residents than compared to states without expanded Medicaid programs.⁹

While the ACA's Medicaid expansion has only been in effect for five years, there is a growing body of research establishing the impact of Medicaid coverage on health. One recent **study** found that as compared to Texas—which has not expanded Medicaid—low-income individuals in Arkansas and Kentucky who gained insurance coverage during the first three years of Medicaid expansion were 41 percentage points more likely to have a usual source of care and 23 percentage points more likely to self-report being in excellent health.¹⁰ Other **research** demonstrates that expansion states have seen: patients seeking care earlier; increased access to behavioral health services and primary care appointments; increased spending for opioid treatment; and larger decreases in one-year mortality from end-stage renal disease.¹¹ Notably, studies of the expansion population in **Michigan** and **Ohio** have found that the overwhelming majority of enrollees believe that Medicaid coverage has made it easier for them to work (69.4 and 83.5 percent, respectively).¹²

Economic Impact

Medicaid is a fundamental component of states' economies, because of the large role it plays in coverage and care and its design as a federal-state partnership. In all states but one (Wyoming), Medicaid is the largest source of federal grant money that states receive—comprising two-thirds of all federal grants to states, on average—and over the past 10 years, states have seen a 71 percent increase in federal Medicaid funding.¹³

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Medicaid produces economic benefits for both the individuals it covers and society as a whole. Medicaid is responsive to economic downturns, enabling people to access coverage and care in times of financial stress. Among enrollees, Medicaid coverage is associated with improved personal finances; for example, in [Oregon](#), as compared to a control group, individuals who gained Medicaid coverage were 13 percentage points less likely to have medical debt and approximately 80 percent less likely to have experienced catastrophic medical expenses.¹⁴ Of all types of health insurance, Medicaid is the most successful in [reducing](#) poverty rates.¹⁵ On a person-level basis, Medicaid coverage at different points during the lifespan has been tied to economic mobility across generations and higher educational attainment, income, and taxes paid as adults.¹⁶

Studies by states and independent researchers have shown the positive impact of the Medicaid expansion on state budgets and economies, largely driven by increased federal spending in the state as a result of the enhanced federal match for expansion adults (93 percent in 2019 and 90 percent thereafter). States are required to fund the remaining costs of expansion (7 percent in 2019 and 10 percent thereafter). Expansion states have [experienced](#) budget savings, and in many cases, these savings offset at least some of the cost of the state share—as federal Medicaid dollars replace prior state spending—most notably with respect to behavioral health, public health services, and the criminal justice system. Expansion states also reported budget savings as previously covered populations (e.g., waiver populations and pregnant women) become eligible for Medicaid in the adult expansion group where the state receives an enhanced federal match. States have raised revenue for the state share using a variety of strategies, including state general revenue; provider taxes; health plan taxes; tobacco or liquor taxes; and intergovernmental transfers.¹⁷ Some states cite concerns about covering the state share as a reason not to expand.

The impact of expansion has been shown to reach beyond state budgets. Researchers and states have documented higher GDP, increased state revenue, jobs, and higher growth in health care wages compared to other industries.¹⁸ In [Louisiana](#) alone, Medicaid expansion resulted in \$1.85 billion in new federal funds; \$3.48 billion in business activity; almost 19,200 jobs; and over \$1.1 billion in new personal earnings in state fiscal year 2017.¹⁹ In addition, as compared to states that have not participated in the ACA's Medicaid expansion, expansion states have seen larger decreases in [uncompensated costs](#) and lower rates of hospital [closures](#).²⁰

For more information on Medicaid's impact, please refer to the resources below.

Additional Resources

Resources on Medicaid Expansion and the Economy

- Antonisse, L., Garfield, R., Rudowitz, R, et al. The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review. Henry J. Kaiser Family Foundation. March 2018. <http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Medicaid-Expansion-Under-the-ACA-Updated-Findings-from-a-Literature-Review>
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Resources on State-Specific Studies

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- Manatt Health. Medicaid Expansion: How It Affects Montana's State Budget, Economy, and Residents. Montana Healthcare Foundation. June 2018. <https://mthcf.org/resources/manatt-medex-report/>

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Medicaid's Role in Children's Health

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The Issue

Medicaid and its smaller companion program, the Children's Health Insurance Program (CHIP), cover more than 46 million children, including almost half of all children under the age of six.¹ While medically complex adults drive much of the program's costs, Medicaid plays an outsize role for children, particularly young children and children with special health needs. Through their Medicaid programs, state policymakers have substantial opportunity to affect the health—and future well-being and productivity—of their youngest residents.

Why It's Important

Medicaid pays for nearly half of all births in the country and covers a full range of services for children after birth, from essential screenings to critical treatments and supports for children with special needs. Medicaid also funds health services for children outside the traditional health care system.

Beyond providing access to needed care and services, Medicaid coverage offers long-term health and economic benefits:

- Medicaid is critical in helping to identify and provide treatment for developmental disabilities in children.
- Medicaid enrollment during childhood is associated with better health in adulthood.⁴
- Expanded access to Medicaid leads to lower high school dropout rates, increased college attendance, and more bachelor's degrees.⁵

Considerations for State Policymakers

States are implementing a number of strategies in Medicaid to maximize the health and well-being of children. New state policymakers will want to assess current state policy to determine if these strategies are being or should be pursued.

Ensure Robust Coverage. One of the most effective ways to improve child health is to maximize Medicaid eligibility and coverage. Policies that promote coverage include continuous eligibility, streamlined enrollment and renewal processes, and targeted outreach. Notably, policies that constrain coverage for parents—such as waivers that interrupt or otherwise reduce coverage for adults—can negatively impact the coverage status of their children.

Strengthen Access to Comprehensive Care. States can take meaningful steps to promote children's health and well-being through strengthening care that serves the "whole child."

- **Support interventions to improve birth outcomes**, such as Medicaid-funded [home visitation programs](#) and ["centering" group care initiatives](#) that enhance prenatal, postnatal and infant care, particularly for at-risk families.
- **Implement the comprehensive benefits available to children through Medicaid.** Federal law requires states to provide comprehensive health services for all Medicaid-covered

BY THE NUMBERS: CHILDREN'S COVERAGE

Driven largely by gains in Medicaid and CHIP enrollment, the nationwide children's uninsurance rate has dropped dramatically—from 14% in 1997, the year CHIP was signed into law, to 5% in 2017.

In 2016, 94% of eligible children were enrolled in Medicaid or CHIP.²

In 2017, the number of uninsured children in the U.S. increased for the first time in nearly a decade. Most children who lost coverage in 2017 reside in states that did not expand Medicaid.³

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children, as medically necessary, under a provision known as [Early and Periodic Screening, Diagnostic and Treatment \(EPSDT\)](#). States can set clear requirements for their plans and providers and strengthen their oversight of the delivery of these benefits.

- **Enhance access to specialty pediatric services**, with a focus on vulnerable populations.⁶ States can develop quality metrics on access to specialty pediatric care, set and monitor compliance with strong network adequacy and access standards, and consider payment enhancements, use of telehealth and other initiatives to improve access to specialists.
- **Address the community around the child.** Social and economic factors, such as food insecurity, homelessness and transportation—often referred to as *“social determinants of health”*—play a huge role in children’s health. Medicaid is uniquely positioned to identify nonmedical but health-related needs and link children to services that can address those needs. (See Medicaid Brief #5 for more details on social determinants of health.)

Develop a Health Care Delivery System That Rewards High-Value Care for Children.

Delivery and payment systems serving children should align with children’s social, emotional, physical, and mental health needs, rather than rely on systems designed for adults. Children with special needs require intense care coordination and case management across child-serving systems.

- **Deploy a “medical home” model focused on children** that includes well child visits and primary care services, care coordination, case management, and other needed services—such as effective linkages to services that address children’s social needs.
- **Tailor financing and payment models and risk adjustment programs** so they are designed to address the longer-term “return on investment” of pediatric interventions.
- **Pursue two-generation approaches** that shift the traditionally singular focus on children’s health care needs to children and parental health.
- **Leverage federal opportunities to reform delivery systems serving children**, such as the Center for Medicare and Medicaid Innovation [Integrated Care for Kids \(InCK\)](#) Model.⁷

For more information on Medicaid’s role and examples of strategies discussed above, please refer to the resources below.

Additional Resources

Ensure Robust Coverage

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Strengthen Access to Comprehensive Care

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Develop a Health Care Delivery System That Rewards High-Value Care for Children

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- Johnson K., Bruner C. A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health. Child & Family

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Case Studies and Example Initiatives

- Brundage, S. Seizing the Moment: Strengthening Children's Primary Care in New York. United Hospital Fund. January 2016. <https://uhfnyc.org/publications/publication/seizing-the-moment-strengthening-childrens-primary-care-in-new-york/>
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- Colorado Children's Healthcare Access Program website. <https://cchap.org/>. Note: Colorado's Medical Homes for Children
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- Help Me Grow National Center website. <https://helpmegrownational.org/>. Note: System designed to help states leverage existing resources to identify vulnerable children, link families to community-based services, and empower families to support child development.
- Project DULCE website. <https://dulcenational.org/>. Note: Medical-Legal partnership model focused on child's first 6 months of life.
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Endnotes

1. In federal fiscal year (FY) 2017, Medicaid and CHIP financed coverage for 36.9 million and 9.5 million children respectively. Most CHIP-funded children are enrolled in their state's Medicaid program, rather than in a separate CHIP program. Because of the close connections between the two programs, the impacts and opportunities described here generally apply to Medicaid and CHIP together. Sources: Centers for Medicare & Medicaid Services (CMS). 2017 Number of Children Ever Enrolled Report. DC: Department of Health and Human Services; 2018. www.medicaid.gov/chip/reports-and-evaluations/index.html; Medicaid's Role for Young Children. Georgetown University Health Policy Institute Center for Children and Families. December 2016. <https://ccf.georgetown.edu/wp-content/uploads/2017/02/MedicaidYoungChildren.pdf>
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6. Vulnerable populations may include children in foster care; children with disabilities or medically complex conditions; children with serious emotional disturbance; youth with substance use disorder; and victims of trauma.
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Medicaid’s Role in Addressing Social Determinants of Health

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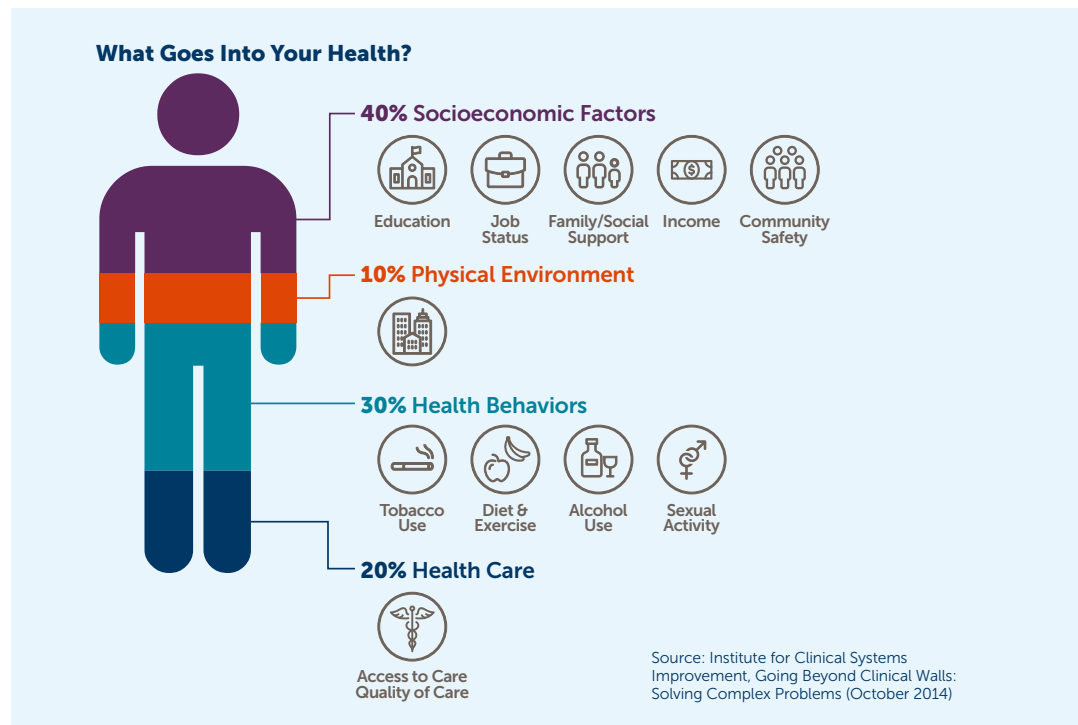
The Issue

Policymakers are increasingly recognizing the important role that social and economic factors, such as housing, healthy food, and income play in a “whole person” approach to health care, especially among Medicaid’s low-income enrollees. Often referred to as “social determinants of health” (SDOH), these factors can drive as much as 80 percent of health outcomes.¹ States have a significant opportunity to cover some nonmedical services that directly impact health, as well as to connect people to housing and other social services not covered by Medicaid.

Why It’s Important

Medicaid enrollees—low-income by definition—are particularly likely to struggle with basic needs, including food, clothing, and shelter. With state Medicaid programs increasingly looking to pay for health outcomes—not simply the volume of health care services delivered—there is an increased focus on strategies to address social needs that contribute to outcomes. To date, the evidence base for the cost-effectiveness of addressing social need is strongest for high-need populations. For example:

- Providing supportive housing to a seriously mentally ill person who otherwise would be homeless can significantly reduce medical expenditures on emergency department visits and inpatient care.²



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- Connecting low-income older adults with chronic conditions to the Supplemental Nutrition Assistance Program (SNAP) or providing home meal delivery can reduce health care costs and utilization.³

Considerations for State Policymakers

States are implementing a number of [strategies](#) to address SDOH and to integrate such efforts into the delivery of health care. New state officials will want to consider assessing current state policy to determine if these strategies are being or should be pursued, recognizing that ensuring access to physical and behavioral health care services is most essential, but that a whole person approach to health care delivery may well include addressing social issues through evidence-based interventions.

Covering Selected Nonmedical Services. States have the option to classify some community-based services as covered benefits in Medicaid, allowing them to receive federal Medicaid matching funds for these services. For example, Medicaid can [cover](#) the cost of helping people sign up for other social service programs (e.g., SNAP, housing vouchers) as part of “case management” services, an optional benefit in Medicaid. If a state pursues a Medicaid Section 1115 waiver, it can also potentially provide a broader array of nonmedical services.

Integrating Social Supports Into Health Plan Care Management. If they operate a Medicaid managed care program, states can [require](#) Medicaid managed care organizations (MCOs) to connect beneficiaries to social supports as part of their care management obligations. Twenty-four states now require MCOs to screen beneficiaries for unmet social needs and help them to address those needs.⁴ In North Carolina, for example, MCOs are obligated to refer people to food, housing, transportation, domestic violence resources, and to track the outcome of their referrals. For high-need beneficiaries, the state requires that the MCO offer in-person help filling out social service applications and hire a specialist who can offer housing expertise.

Using Value-Based Payments to Support Social Interventions. States cannot use Medicaid to directly finance the cost of providing housing, and a number of other social services, but they can offer and encourage their providers to make such expenditures. Value-based payments reimburse providers for achieving specified outcomes and containing costs, rather than the volume of services that they provide. When reimbursed on this basis, a state [can](#) essentially “free” a provider to give a beneficiary whatever services are required—regardless of whether they are medical or nonmedical—to achieve the necessary outcomes. Arizona, for example, requires its MCOs to make 50 percent of their reimbursement to providers through value-based payments.⁵ This has allowed providers to offer housing to homeless beneficiaries instead of paying for the medical bills they would have incurred if they continued to live on the streets.⁶

Evaluating the Impact of SDOH Interventions. With evidence of the impact of addressing SDOH still emerging, states should systematically evaluate the effectiveness of their SDOH initiatives. In particular, it is important to assess whether SDOH interventions work outside of high-need and high-cost populations. If a state uses a Medicaid waiver as the basis for their SDOH strategy, CMS will require such evaluations as part of the waiver. States that rely on managed care-based strategies can also conduct evaluations. Michigan, for example, requires MCOs to develop and submit a multiyear SDOH plan. As part of this plan, MCOs must articulate how they will use data to support their efforts and what SDOH-related measures they will report.

Conclusion

The interest in addressing SDOH via Medicaid continues to rise, reflecting the growing focus among states on paying for improving health outcomes and containing costs. While none of the tools at states’ disposal can single-handedly resolve underlying gaps in the social safety net, they provide important opportunities to offer social support that will have direct impact. For more information on Medicaid’s role in SDOH, please refer to the resources below.

Additional Resources

Resources for Social Determinants and Medicaid Managed Care

- Bachrach, D., Guyer, J., Meier, S., et al. Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools. The Commonwealth Fund. January 2018. www.commonwealthfund.org/publications/fund-reports/2018/jan/enabling-sustainable-investment-social-interventions-review
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- McGinnis, T., Crumley, D., Chang, D. Implementing Social Determinants of Health Interventions in Medicaid Managed Care: How to Leverage Existing Authorities and Shift to Value-Based Purchasing. Academy Health. February 2018. www.academyhealth.org/sites/default/files/implementing_sdohealth_medicaid_managed_care_may2018.pdf

Resources for State Medicaid Options for Addressing Social Determinants

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Medicaid's Role in Fighting the Opioid Epidemic

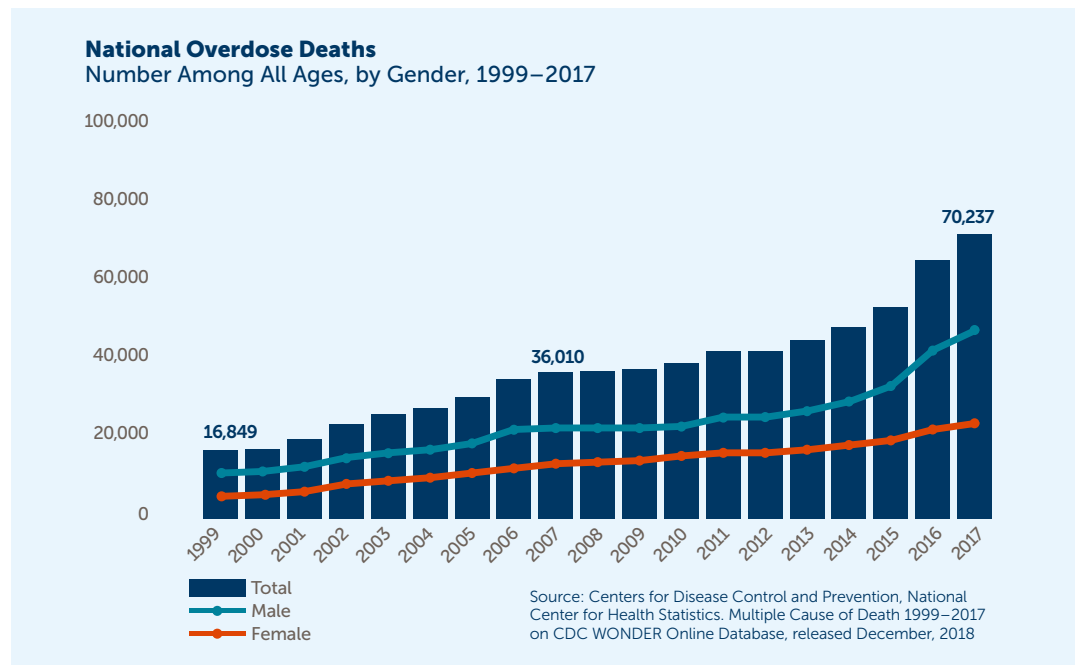
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The Issue

In 2017, deaths due to opioid-related overdoses totaled nearly 50,000, surpassing other leading causes of accidental deaths, and even deaths due to HIV/AIDS at its peak in 1995.¹ While opioid addiction and death rates vary state to state, the opioid mortality rate continues to climb in most states.² The profound health, economic and social consequences of substance use disorders (SUDs), including opioid use disorders (OUDs), require significant, sustained investment in coverage and treatment—and **Medicaid is the key platform from which states are tackling the SUD crisis.**

Why It's Important

Medicaid is the largest source of coverage and funding for substance use prevention and treatment nationally. Medicaid covers nearly 40 percent of adults with an OUD and 17 percent of adults experiencing any type of SUD. Even before the Affordable Care Act's Medicaid expansion, **Medicaid spent three times more (\$9.4 billion) on services for people with OUD than SAMHSA's 2017 budget for SUD overall (\$2.9 billion).** Medicaid's substantial dollars provide access to prevention, treatment and recovery services for those with addiction, and just as important, fund comprehensive coverage for a broad spectrum of physical and behavioral health services to treat co-occurring conditions for people with addiction disorders. States have significant opportunity to strengthen their responses to the substance use crisis by leveraging their Medicaid programs.



Considerations for State Policymakers

States are implementing a number of Medicaid strategies to prevent and treat SUD, and support long-term recovery.³ New state policymakers should assess current state policy to determine if these strategies are being or should be pursued:

Pursue Relief From the Institutions for Mental Diseases (IMD) Exclusion for SUD Treatment.

In July 2015 and November 2017, CMS [issued](#) guidance inviting states to apply for 1115 demonstrations that would waive the IMD exclusion—the historical prohibition on using federal Medicaid funds to pay for treatment delivered to individuals ages 21 to 64 residing in institutions with 16 or more beds—for individuals receiving SUD services. This policy is intended to expand access to residential treatment and withdrawal management services and states can consider pursuing this strategy to provide the full continuum of SUD care. To date, 17 states have obtained IMD exclusion waivers. A provision in October 2018 federal opioid legislation, the [SUPPORT Act](#), permits states to pursue a Medicaid State Plan option to obtain federal Medicaid funds for SUD services provided in an IMD up to 30 days per year.⁴

Expand Medication-Assisted Therapy (MAT). MAT is an evidence-based, highly effective treatment option for individuals with OUDs and many states are seeking to expand it through strategies like encouraging physicians and extenders to obtain Drug Addiction Treatment Act of 2000 ([DATA 2000](#)) waivers to prescribe medications used for MAT outside of designated opioid treatment programs. The SUPPORT Act increases flexibility for MAT by increasing the number of patients for whom qualified providers can prescribe or dispense MAT; eliminating existing time limits for physician extenders to become qualifying prescribers; and authorizing additional providers to become waived. States can also improve MAT access in other ways, including enhanced reimbursement to physicians who provide the service.⁵

Leverage Medicaid Managed Care Contract Requirements. States with Medicaid managed care delivery systems can require their health plan contractors to implement strategies and practices that address SUD/OUD (see Medicaid Brief #7 for more information). Some of these strategies are now mandates under the SUPPORT Act, including requiring managed care organizations to:

- Provide a full continuum of behavioral health services;
- Ease or eliminate prior authorization requirements for MAT and other services;
- Ensure providers comply with Prescription Drug Monitoring Program requirements and opioid prescription limits; and
- Require plans to offer non-opioid alternatives to pain management.

Innovate (Including by Appropriating Other State Innovations). States are using their Medicaid State Plan authority, 1115 waivers, and managed care contracts to pursue other innovative reforms. Notable examples include:

- Vermont’s [Hub and Spoke Model](#), in which opioid treatment “Hub” programs offer all elements of MAT and “Spoke” primary care or family medicine providers provide less intensive types of team-based treatment, counseling, and care management.
- West Virginia’s Neonatal Abstinence [State Plan Amendment](#) program, which funds withdrawal symptom treatment in babies exposed to opioids before birth.
- Ohio’s [Pre-release Care Coordination Program](#), to provide care management during the discharge process for incarcerated people with high health needs, including SUD.

Conclusion

State Medicaid programs are the bedrock of state efforts to fight the still-raging opioid epidemic, and the substance use crisis overall. Examples of impactful state strategies that use Medicaid’s funding and infrastructure abound and are becoming models for all-payer efforts to combat addiction. For more information on Medicaid’s role, please refer to the resources below.

Additional Resources

Resources on Legislation and Administrative Guidance

- 1115 Substance Use Disorder Demonstrations. Centers for Medicare & Medicaid Services website. www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/reducing-substance-use-disorders/1115-sud-demonstrations/index.html. Accessed December 11, 2018.
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- SUPPORT for Patients and Communities Act, H.R. 6, 115th Congress (2018). www.congress.gov/bill/115th-congress/house-bill/6

Resources on Strategies and Best Practices for Medicaid's Role in the Opioid Epidemic

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Medicaid Managed Care: Increasing Expectations and Accountability

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The Issue

Over the past two decades, state Medicaid programs have been on a steady march away from fee-for-service toward payment and delivery systems designed to bring greater budget predictability, quality, and accountability. For most states, this has meant increasing reliance on Medicaid managed care. Today, managed care is the primary delivery system for Medicaid nationally, with more than 8 in 10 beneficiaries enrolled in some type of managed care across 48 states plus the District of Columbia.¹ With this growth has come similar growth in expectations. States are covering a broader array of services for more high-need enrollees, bringing more rigor to their contracting, oversight, and payment processes, and holding managed care plans accountable for achieving targeted goals. For new state officials, this begs a critical question: **Is my state getting enough value from our Medicaid managed care program?**

Why It's Important

A well-managed Medicaid managed care program has the potential to help states bring more predictability to program costs while enhancing efficiency and outcomes. But managed care is no panacea. [Evaluations](#) over time have documented mixed results, ranging from measurable improvements in access, quality, and efficiency, to headline-grabbing horror stories of care disruption and cost overruns.² With this in mind, states with managed care are increasingly focused on getting more value from plans and explicitly building [state priorities](#) into contractual requirements. New state policymakers should consider assessing their current managed care programs and exploring strategies for advancing cost, quality, and accountability goals.

Considerations for State Policymakers

Consider Integrating the Full Service Array Into Managed Care. Early on, Medicaid managed care was mostly reserved for relatively healthy populations and a core subset of mostly physical health services. As managed care has taken root, states have begun to include a broader range of services—including behavioral health, prescription drugs, and even long-term care—into integrated risk arrangements. These efforts generally have been met with success, aligning financial incentives and enabling better coordination of care across the care continuum.³ Yet most states have a long way to go to realize the full value of integration. For example, while mounting [evidence](#) indicates that integration of physical and behavioral health is a best practice, only a minority of states currently do so.⁴

Exercise Caution With High-Need Populations. States have increasingly enrolled more vulnerable populations in managed care. For example, one-fourth of managed care states enroll individuals with intellectual/developmental disabilities (I/DD) into managed care.⁵ Twenty-four states operate some form of managed care to provide long-term services and supports (LTSS) to older adults and those with physical disabilities. States design managed

care products for high-need individuals differently—sometimes adding subpopulations and new services into comprehensive plans that serve the majority of Medicaid enrollees, and sometimes developing “specialty” plans for targeted higher-need members. High-need individuals are far more likely to have complex care relationships with multiple providers and informal caregivers; manage more chronic conditions and medications; and be highly vulnerable to care disruptions. Enrolling these populations requires time and thoughtful planning, including consultation and partnership with beneficiaries, their families, their providers, and communities, and is best attempted in mature managed care environments.

Create Accountability for State Priorities. While wide variation exists among states’ managed care programs, states are increasingly including contractual mandates designed to hold plans accountable for specific policy, operational, and financial priorities. Many states include operational provisions tied to withholds and incentives designed to, for example, minimize administrative burden on providers, create rate floors for essential providers, or mandate a certain medical loss ratio. A smaller but growing number of states are going further—using their contracts to drive innovation and test new ways to achieve state health care priorities.

- **Targeting vulnerable populations.** Many states have begun requiring plans to identify and address needs for targeted subpopulations, including [children](#) with neonatal abstinence syndrome and individuals transitioning out of incarceration.⁶
- **Addressing social determinants of health (SDOH).** States are [beginning](#) to include SDOH-related provisions in their managed care contracts that, for example, require screenings for social needs and ensure enrollees are connected to community-based resources. (See Medicaid Policy Brief #5 for details.)
- **Shaping care management.** States are [demanding](#) more, in terms of how and where care management is delivered, including mandating coordination with health homes⁷ and requiring locally based care management.⁸
- **Accelerating value-based payment.** States are [increasingly](#) looking to enhance accountability through upside and downside risk arrangements between plans and providers, including requiring plans to expand their deployment of meaningful value-based payment with provider networks and setting targets for the proportion of plan payments that are value-based.⁹

For additional information on how states can get the most out of their Medicaid managed care programs, please refer to the resources below.

Additional Resources

Resources on Managed Care and Payment Reform

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Resources on Medicaid and Behavioral Health

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Resources on Medicaid and Social Determinants of Health

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7. Example states include: Minnesota, Missouri and New York.
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