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Putting Medicaid in the Larger Budget Context: An In-Depth Look at Three States in FY 2015 and 2016

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Medicaid has long-played an important role in the U.S. healthcare system, accounting for one in every six dollars of all U.S. health care spending while providing health and long-term services and supports coverage to millions of low-income Americans. Medicaid also plays an important role in states budgets as both an expenditure item and the largest source of federal revenue for states.

The years 2015 and 2016 continue a period of significant change and transformation for Medicaid programs. With slow but steady improvements in the economy following the Great Recession, Medicaid programs across the country were focused on implementing a myriad of changes included in the Affordable Care Act (ACA), pursuing innovative delivery and payment system reforms with the goals of assuring access, improving quality and achieving budget certainty, and continuing to administer this increasingly complex program.

However, these changes to Medicaid policy take place in the larger context of states budgets. Unlike the Federal government, states generally have balanced budget requirements, taking into account the amount of revenue coming in from a state's own resources as well as federal revenues. State lawmakers must balance competing priorities across budget expenditure categories. Even in years of economic growth, state lawmakers face this pressure of balancing priorities.

This report provides an in-depth examination of Medicaid program changes in the larger context of state budgets in three states:

- Alaska
- California
- Tennessee

These case studies build on findings from the 15th annual budget survey of Medicaid officials in all 50 states and the District of Columbia conducted by the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA). Additional research on budget activity, economic conditions, and other relevant health policy activity was conducted by KCMU and HMA staff members; each case study was submitted to its respective state for review and comment.

Alaska

Economic and Budget Outlook

Economy

In many ways, Alaska is a unique state, with its vast size, sparse population density and richness in natural beauty and natural resources, on which its economy relies heavily, specifically oil. In 2014, the oil industry was responsible for one-third of all employment and 38 percent of all wages.[1] The federal government also plays a significant role in the state's economy, with an active military presence, a substantial portion of land in the state owned by the federal government, and high per capita federal employment in the state.[2] Due to these influences, Alaska's economy has taken a trajectory different from the one seen at the national level. Going back almost a decade, Alaska's economy was negatively affected by the economic downturn – the unemployment rate increased to 8.0 percent for several months in 2009 and 2010 and the state's GDP declined during this same period – but the impact was comparatively less and shorter in duration, as the economy was bolstered by increased oil production, higher oil prices and increased revenues to support the state budget.

However, the recent decline in oil prices and federal deficit reduction actions have had a negative effect on the state's economy. Oil production in the state fell from 729,000 barrels per day in 2008 to 544,000 per day in 2013,[3] depressing the state GDP.[4] Additionally, job growth slowed, driven in part by declines in federal employment in the state; 2015 was forecast to be the 5th consecutive year of decline in federal employment.[5] These economic forces have presented major challenges to state lawmakers in enacting state budgets.

State Budget

Alaska funds its budget unlike any other state in the nation. It is one of seven states without a personal income tax, one of five states without sales tax, and the only state that has neither. Alaska relies almost entirely on revenues from oil taxes and royalties to fund the state portion of its expenditures – about 88 percent of 2014 general fund revenues were derived from oil revenue.[6] Recent reductions in oil production and prices have negatively affected the state's economy and in turn state revenues; according to a Pew Charitable Trust analysis, 2014 4th quarter revenue in Alaska was over 80 percent lower than the 2008 peak.[7] This has resulted in a state budget crisis.

Alaska has experienced general fund budget deficits since 2013 that have grown each year.[8] In FY 2015, the state ended the year with a deficit of $2.7 billion, which was covered by drawing down funds from the state's Statutory Budget Reserves Fund. The Statutory Budget Reserves Fund was created to build a "rainy day fund," setting aside surplus revenues during earlier periods of economic growth and investing for periods of economic downturn.[9]

When the FY 2016 budget was being developed, the state again faced a multi-billion dollar general fund deficit. The Statutory Budget Reserves Fund had been largely depleted. The Governor's proposal included a series of spending cuts as well as exploring new sources of revenue and tapping into the Constitutional Budget Reserve Fund (a second rainy day fund which requires three-fourths majority approval to use). The Governor, fulfilling a campaign promise, also proposed adopting the ACA Medicaid expansion, highlighting new federal revenue and potential savings within the state budget. (More detail on this is provided in the next section.)

After two special sessions and much debate, the legislature passed a budget that was signed into law by the Governor. For FY 2016, Governor Walker used his line item veto authority to reduce operating appropriations by $200 million for a total annual budget of $4.95 billion. This represents a 19 percent reduction ($1.1 billion) from FY 2015 budget levels. In spite of the reduction, the state expects a spending deficit of $3.7 billion, partially offset by a $1 billion transfer from the Public Education Fund, reserves used for advance funding of school districts. The remaining $2.7 billion will be covered from the Constitutional Budget Reserve Fund.[10]

While the state's reserves can sustain the current expenditure trends until sometime in FY 2018,[11] the state recognizes the need to make fundamental shifts for long-term viability. The spending imbalance has prompted the administration to engage state policymakers in a discussion about strategies to return the state to long-term fiscal stability.

Alaska's Medicaid Expansion

Governor Bill Walker, in keeping with a central campaign promise he made while running for governor as an independent, proposed adopting the Medicaid expansion. In his state of the budget speech, the Governor noted that by expanding Medicaid, the state would be investing in the health of Alaskans and that the expansion would have positive effects on the economy as well as provide additional federal funds and direct general fund savings for budget.[12] The Governor's proposal received support from a number of stakeholders, including the Alaska Chamber of Commerce.[13] However, there was much debate between the Governor and legislature over the Medicaid expansion. The Governor put forward the proposal as part of his budget amendments[14] and as separate legislation.[15] Legislative leaders expressed concerns with expansion related to systems issues as well as a desire to implement additional Medicaid reforms ahead of implementing the expansion.[16] After the two special sessions, the legislature reached a budget compromise in June that funded the budget deficit but did not include the Medicaid expansion. The Governor signed the budget into law in June, avoiding a government shutdown.[17]

In July 2015, Governor Walker moved to expand Medicaid by executive action since Alaska's legislature had not done so. In an attempt to block the Governor's actions, the Alaska Legislative Council comprised of House and Senate legislators, voted to sue the governor for exceeding his executive authority and asked the judge to temporarily halt the expansion pending the outcome of the litigation.[18] On August 28, the Superior Court judge rejected the Council's request, and the Alaska Supreme Court concurred on August 31.[19] The court rulings cleared the path for the "Healthy Alaska Plan" and for enrollment to begin as planned on September 1, 2015.[20]

The Healthy Alaska Plan expands coverage to approximately 42,000 uninsured adults, aged 19 to 64, in families earning up to 138 percent of the federal poverty level.[21] The Healthy Alaska Plan originally put forward by the Governor and the Alaska Department of Health and Social Services in February 2015 estimated that over half (55 percent) of eligible individuals have incomes below 100 percent of the federal poverty level, and thus would not qualify for premium subsidies to purchase health insurance through the ACA Marketplace. It projected that approximately 21,100 would enroll in FY 2016 with enrollment climbing to 26,500 by 2021. [22] In addition, the expansion was expected to provide economic benefit to the state by adding $1.1 billion in new federal revenue, creating 4,000 new jobs; adding $1.2 billion in wages and salaries; and stimulating $2.49 billion in economic activity throughout the state. The Healthy Alaska Plan also noted that the Medicaid expansion was expected to exert downward pressure on the cost of health care and health insurance by

reducing the amount of uncompensated care provided by hospitals.[23] Additionally, the Healthy Alaska Plan noted that the Medicaid expansion would provide additional federal funds that would facilitate reform efforts to increase cost-effectiveness bend the cost-curve and improve value. [24]

Delivery System Reforms

Growth in the state's Medicaid expenditures is reflective of factors affecting the cost of healthcare in general within the state. With 16 percent of the United States' land mass but only 0.2 percent of its population, Alaska's vast size, rural/frontier nature and arctic climate add a unique level of complexity in providing health care services to its state residents. In its 2011 "Findings on Health Care Cost, Pricing and Reimbursement in Alaska," the Alaska Health Care Commission found that physician reimbursement was 60 percent higher than in other highly rural/frontier Western states, commercial reimbursement for private sector hospital services was 37 percent higher, and commercial insurance premiums were roughly 30 percent higher.[25] Higher prices are driven in part by the state's higher cost of living (20-30 percent higher than in the comparison states), higher salaries for health care workers, and by the limited number of providers, particularly in some specialties, resulting in a lack of competition.[26] These structural challenges make it difficult to implement cost-effective ways to deliver coordinated care. In fact, Alaska is one of only three states (along with Wyoming and Connecticut) that does not use a comprehensive managed care delivery system for any of its Medicaid enrollees. However, Alaska has embarked on a number of Medicaid reform initiatives to enhance access to care, improve population health and moderate cost growth.

Alaska Medicaid Coordinated Care Initiative

The state has initiated the Alaska Medicaid Coordinated Care Initiative (AMCCI), a voluntary program providing one-on-one case management services including care coordination, scheduling appointments, addressing barriers, and referrals to specialists and social service supports.[27] The initial focus of the program will be on decreasing the inappropriate use of emergency rooms. "Super utilizers" account for about three percent of Alaska's Medicaid population, but about 22 percent of all Medicaid hospital emergency room expenditures. Around 6,000 enrollees had five or more emergency room visits within a one year period.[28] The state contracted with MedExpert International, Inc. in December 2014 to provide case management services for participants.

Medicaid Redesign Initiative

In July 2015, Alaska's Department of Health and Social Services launched the "Medicaid Redesign" initiative with the goals of developing recommendations for reform, by January 2016, that will optimize enrollee health outcomes, drive increased value in the delivery of services and contain costs in the Alaska Medicaid program.[29] During the recommendation development process, the state is exploring a variety of delivery system and payment reform options (e.g., managed care models, patient centered medical homes, accountable care organizations and other shared savings models).

Tribal Health System Partnership

Work is currently underway with the Tribal Health System on the development of two Section 1115 waiver initiatives. Initially, the Alaska Department of Health and Social Services intended to develop two Section 1115 waiver initiatives. The first, with a target implementation date of July 2016, would develop medically necessary

transportation case management services to facilitate timely and efficient delivery of health care services to Alaska Natives and American Indians (AI/AN) with a 100 percent federal match if the services are coordinated by a Tribal provider. The second waiver, with a target implementation date of July 2018, would expand the scope of Medicaid-reimbursable services available to AI/ANs, and enhance referral coordination.[30] Alaska is seeking approval for 100 percent federal match when a Medicaid beneficiary, who is also an IHS beneficiary, is referred by a Tribal Health Provider to a non-tribal health provider. However, U.S. Secretary of Health and Human Services Burwell recently indicated in a letter to Governor Walker that DHHS is pursuing a policy change and 1115 waivers would not be necessary.[31] Currently, the State is awaiting further policy clarification before implementing these initiatives.

Other Medicaid Initiatives

DHSS, in collaboration with multiple state agencies, released a request for proposals in July 2015 for assistance with developing a 1915(i) HCBS benefit and 1915(k) Community First Choice Medicaid State Plan option. The initiatives would serve eligible individuals with physical, cognitive, intellectual and behavioral health needs whose income qualifies them for Medicaid and who have functional needs, but who may or may not meet institutional level of care requirements. The state expects the design phase to be completed by July 2016 for implementation in July 2017.[32]

The state is also engaged in a feasibility study to examine various health care provider tax methodologies, and the fiscal and economic impact of such taxes in Alaska. The study is expected to result in recommendations for a specific health care provider tax for implementation, which will be the basis for health care provider tax legislation in the 2016 legislative session.[33]

Alaska Medicaid Policy Changes FY 2015 and FY 2016
Eligibility Changes
• Implemented the ACA Medicaid expansion on September 1, 2015.
Provider Rates and Provider Taxes/Assessments
• Increased rates for inpatient and outpatient hospitals, specialists and nursing facilities in FY 2015. • Froze rates for all providers except specialists in FY 2016. • Continued primary care physician payment levels at or above Medicare rates (state is one of a handful that did so prior to the ACA required primary care increase).
Pharmacy
• Transitioned from using a state Maximum Allowable Cost to using the NADAC as the basis for maximum allowable cost for both brand name and generic drugs in FY 2015. • Reduced the pharmacy ingredient cost reimbursement in FY 2015, with a corresponding increase in dispensing fees.
Delivery System and Payment Reforms
• Implemented Medicaid Coordinated Care Initiative (AMCCI) in FY 2015 with an initial focus on decreasing the inappropriate use of emergency rooms.

California

Economic and Budget Outlook

Economy

California, like many other states, has seen continually improving economic conditions since the Great Recession, during which California experienced record unemployment (peaking at 12.2 percent), major budget shortfalls, and declines across all major industries. California's economy began its recovery from the last recession in June 2009, paralleling the economic recovery for the U.S. After six years of slow growth, the state's economy is now on more solid ground.[34] The state has recovered all of the jobs lost during the recession,[35] and in recent months, job growth in California has outpaced the national average, with notable growth in professional and business services and construction sectors.[36] The state's annual GDP has been growing faster than the national rate for the last few years. As of August 2015, California's unemployment rate had fallen to 6.1 percent, remaining above the national average (5.1 percent) as nearly 1.2 million California residents remain unemployed.[37]

State Budget

California's budget situation has improved in recent years. The state had faced several years of challenging budget conditions that were made more difficult by the Great Recession. At the height of the downturn, the state faced several years of multi-billion dollar budget shortfalls[38] that required a number of policy actions to curb spending and increase revenue, including a temporary increase in personal income tax rates for higher income earners (over $250,000) along with other tax increases approved by California voters through Proposition 30 in November 2012. In 2014, for the first time since 2007, California ended its fiscal year with a positive General Fund balance totaling $1.9 billion, due to much larger than anticipated growth in revenues from personal income taxes and corporate taxes.[39] In 2014 the state also implemented the Medicaid expansion, opened its state-based health insurance Marketplace, and invested in outreach and enrollment efforts.[40]

California's budget processes for FY 2015 and FY 2016 started off with budget surpluses, allowing the state to continue to pay down debt, restore some previous cuts, and make additional investments. The FY 2016 budget, signed by Governor Brown on June 25, 2015, totaled $168 billion. It holds total general fund spending relatively flat (increasing just 0.8 percent over last year) while increasing spending on education, health care, in-home supportive services (IHSS), workforce development, drought assistance, and the judiciary.[41] In addition, the state is expanding full-scope coverage through existing Medi-Cal managed care for undocumented children; this coverage is financed with state-only dollars. The state is also focused on building reserves; the state estimates there will be $4.6 billion in state reserve accounts at fiscal year-end.[42]

Affordable Care Act Coverage Expansion

The 2010 Affordable Care Act (ACA) was designed to expand coverage to a majority of the non-elderly uninsured across the country through the Medicaid expansion and the creation of health insurance Marketplaces in states. These ACA coverage provisions took effect on January 1, 2014. California was one of a several states that opted to expand coverage to low-income adults before 2014.

Early Implementation Efforts: Low-Income Health Program (LIHP)

Since 2010, the state uninsured rate has dropped dramatically. In 2010, out of a total population of 37 million, there were 6.8 million nonelderly uninsured in California.[43] In 2010, well before the major gains in coverage under the ACA, California expanded coverage to uninsured, low-income adults through the creation of the Low-Income Health Program (LIHP) under their "Bridge to Reform" Section 1115 Medicaid Demonstration Waiver.

California has a history of county-delivered health care services, as counties have traditionally had broad authority over the provision of health-related services. Building on an existing coverage initiative, LIHP was county-based coverage that was financed with county funds and federal funds at the state's regular matching rate (no dollars from the state General Fund were used).[44] County participation was voluntary. LIHP benefits were more limited than those available to state Medicaid beneficiaries. Counties could use an open fee-for-service (FFS) system or a closed managed care system, or a combination of the two systems. Between July 2011 and December 2013, LIHP coverage was provided through 19 LIHP programs across 53 of the state's 58 counties.[45] By the end of 2013, over 650,000 people were enrolled in the program.[46]

Medicaid Expansion and Marketplace Coverage

In January 2014, California expanded its Medicaid program, known as Medi-Cal, statewide to cover low-income adults at or below 138 percent FPL. Individuals at or below 138 percent FPL who gained coverage under the early LIHP expansion were automatically enrolled in Medi-Cal coverage. As a result, approximately 630,000 LIHP beneficiaries were auto-enrolled in Medi-Cal.[47] Subsidized private coverage became available to adults with moderate incomes (between 139 - 400 percent FPL) through California's state-based health insurance Marketplace, known as "Covered California." An estimated 25,000 LIHP beneficiaries transitioned to Covered California.[48]

In addition to automatically transitioning LIHP beneficiaries to ACA coverage options in 2014, California took several other steps to simplify and streamline enrollment under the ACA including creating a single online portal for Covered California and Medi-Cal applications and adopting the Express Lane Enrollment Project to target and enroll state Supplemental Nutrition Assistance Program (SNAP) beneficiaries in Medi-Cal coverage. The state also invested heavily in outreach and enrollment efforts for both Medi-Cal and Covered California. Covered California established an Assisters Program and worked with community organizations to provide direct assistance to consumers to help them enroll in coverage.

Medi-Cal coverage grew by 30 percent (or 2.8 million people) between the fall of 2013 and the end of 2014.[49] Approximately 1.7 million people applied for and were determined eligible for Covered California health plans between October 2013 and October 2014.[50] From 2013 to 2014, California's uninsured rate declined from 19.1 percent to 13.4 percent.[51]

Despite much success in enrollment, California—like most other states—experienced enrollment and outreach challenges in 2014 including a shortage of in-person assisters, problems with cultural and linguistic resources, and technology/systems issues with the Covered California website. These system issues led to a significant Medi-Cal application backlog. In late 2014 and 2015, the state successfully addressed many of these challenges, largely resolving the backlog issue.[52]

Delivery System And Payment Reform

In addition to coverage expansions, DHCS has increasingly focused on delivery system and payment reform – to expand access for Medi-Cal beneficiaries, to improve care quality and health outcomes, and to reduce costs to create a more sustainable program.

Delivery System Reform Incentive Payment (DSRIP) Initiative

In 2010, California was the first state to secure a DSRIP waiver, effectively establishing the basic framework for future DSRIP waivers – the distribution of funds to safety net providers that agree to meet defined metrics and goals. California pursued a DSRIP initiative to provide financial support and stability to its 21 public hospital systems (referred to as "designated public hospitals") and to "jump start" public hospital system preparation for broader health reform implementation. California's $6.67 billion dollar DSRIP initiative was financed entirely by the state's 21 public hospital systems and the federal government.[53]

Participating public hospitals were required to implement projects in the following areas: infrastructure development (e.g., disease management registries, enhancing performance improvement and reporting capacity); innovation and redesign (e.g., medical homes); population-focused improvement (e.g., diabetes care management and outcomes); and urgent improvement in care (e.g., central line-associated infection prevention). In 2012, the state added the HIV Transition Incentive Program to DSRIP, a new *optional* project, to strengthen public hospital capacity to serve individuals diagnosed with HIV, particularly LIHP enrollees previously served under programs funded by the Ryan White HIV/AIDS Treatment Extension Act of 2009.[54] The state's waiver gave individual hospital systems broad flexibility to determine the specific projects they would pursue and the benchmarks they would attempt to meet – acknowledging hospital systems were at different starting points along the spectrum of delivery system reform. To receive DSRIP funds, participating public hospitals were required to achieve project-specific milestones.

Since each public hospital system developed an individualized implementation plan, it is hard to tell a statewide story involving how much DSRIP has accomplished to date. It is also challenging for the state to assess the impact of DSRIP projects in advancing the state's broader vision for delivery system reform.[55] To address these issues, California proposed a more standardized DSRIP approach in its waiver renewal application (described in more detail below) that includes the use of required core project components and standardized outcome and quality metrics.

In March 2015, California submitted a renewal application for its Bridge to Reform waiver, which was renamed "Medi-Cal 2020." The renewal requests authority for a series of delivery system transformation and alignment programs, including the continuation of DSRIP funding for public hospital systems. The proposed waiver expands the scope of DSRIP-eligible institutions to 42 safety net institutions run by health care districts (referred to as "non-designated public hospitals"). These institutions are predominantly located in rural areas and are often the only hospitals serving their communities. The application requests a funded planning period of up to one year for these safety-net hospitals to build the infrastructure necessary to participate in the program. Proposed DSRIP project domains noted in the Medi-Cal 2020 renewal include:

- system redesign (e.g., improving care transitions, physical and behavioral health integration);
- care coordination for high-risk, high-utilization populations (e.g., health homes, complex care management);

- resource utilization efficiency (e.g., appropriate use of antibiotics, high cost imaging and pharmaceuticals);
- prevention (e.g., obesity, cancer); and
- patient safety in ambulatory care (e.g., medication reconciliation).

Managed Care

California's Department of Health Care Services (DHCS) has a long history with managed care plans.[56] Over time, DHCS has expanded Medicaid managed care to all 58 counties, with each county choosing its own managed care model. As a result, several different managed care models operate across the state. All models include commercial plans and/or county-run plans. In most counties Medi-Cal beneficiaries choose between at least two managed care plans. However, in some less-populated counties beneficiaries have access to only one county-run plan.[57]

At the start of the 2010 Bridge to Reform waiver, 55 percent of Medi-Cal beneficiaries were enrolled in managed care. Today, nearly 80 percent of Medi-Cal beneficiaries, or more than 9 million beneficiaries, are enrolled in managed care. [58]

In addition to the expansion of managed care statewide, in recent years the state has expanded managed care to new Medi-Cal populations, including seniors and persons with disabilities (SPDs). Managed care expansions involving SPDs are described in the next two sections followed by a discussion of managed care systems transformation and improvement strategies outlined in the Medi-Cal 2020 proposal.

Mandatory Managed Care for Seniors and Persons with Disabilities (SPDs)

The Bridge to Reform waiver authorized the expansion of mandatory Medicaid managed care for seniors and persons with disabilities (SPDs) enrolled in fee-for-service (FFS) Medi-Cal.[59] By enrolling SPDs in managed care the state aimed to increase access, improve care coordination, and achieve cost efficiencies.[60] Because of the complex care needs of SPDs, managed care plans had to meet extensive readiness requirements. The state was required to conduct outreach and engagement activities to encourage active plan selection among beneficiaries and to educate beneficiaries about the new delivery system.[61] The state took a phased approach to enrolling Medi-Cal SPDs into managed care over a 12 month period beginning June 2011. During this period, nearly 240,000 FFS SPDs were transitioned to Medicaid managed care plans across 16 counties.[62] Although the state engaged in significant planning efforts to try to ensure the smooth transition of SPDs to managed care, a multitude of challenges arose. Some challenges included beneficiary data sharing delays that hindered health plan and provider readiness; plan difficulty recruiting providers with expertise in complex care; lack of provider training in care coordination; and inadequate/confusing beneficiary outreach materials.[63, 64] The state is using experience gained from this SPD transition to inform similar transitions in an additional 19 (rural) counties[65] and the transition of dually eligible beneficiaries into managed care; both of these latter transitions began in 2014.

Coordinated Care Initiative

California's 2012-2013 state budget established the Coordinated Care Initiative. This initiative was authorized by CMS through an amendment to the Bridge to Reform waiver. Through this initiative, the state aims to transform the Medi-Cal delivery system to better serve seniors and persons with disabilities. The initiative

involves two major components: Cal MediConnect and Managed Medi-Cal Long-Term Services and Supports (MLTSS).

Cal MediConnect is a three year demonstration program for Medicare and Medi-Cal dual eligible beneficiaries. Typically, across states, very little coordination has occurred between Medicare and Medicaid programs. Cal MediConnect seeks to integrate care and improve health outcomes for dual eligible beneficiaries through the alignment of Medicare and Medicaid financing. Under Cal MediConnect, a single health plan is responsible for coordinating medical, behavioral health, long-term institutional, and home- and community-based services for beneficiaries. Enrollment in Cal MediConnect began in April 2014. The demonstration is operating in 7 counties. The state is using a passive enrollment system, where eligible beneficiaries are enrolled into a MediConnect health plan unless they actively "opt-out." Beneficiaries may opt-out or change plans at any time. As of June 2015, enrollment in the demonstration had reached nearly 130,000 beneficiaries.[66] As of July 2015, the opt-out rate, excluding Los Angeles County, was 33 percent. Los Angeles County experienced a higher opt-out rate of 51 percent.[67]

Under the Managed Medi-Cal MLTSS initiative, all Medi-Cal beneficiaries (in demonstration counties), including dual eligible beneficiaries, are required to join a Medi-Cal managed care plan to receive LTSS and other Medicaid-covered benefits. Most people with Medi-Cal only are already enrolled in a Medi-Cal managed care plan, however, now they will also obtain LTSS through their health plan.[68]

Managed Care Systems Transformation & Improvement Programs

The Medi-Cal 2020 proposal outlines payment reform strategies the state believes will promote collaboration and shared accountability across managed care plans and providers. The state believes these strategies will lead to improved care quality and beneficiary health outcomes and reduced costs. Core strategies described in the Medi-Cal 2020 proposal include:

- Shared Savings Incentives with Managed Care Plans – A shared savings incentive for managed care plans based on total cost of care *and* performance on quality metrics. Managed care plans would be required to form partnerships with providers and behavioral health systems, what the state is referring to as "accountable care groups."
- Standardization of Pay-for-Performance programs – The standardization of core elements of managed care plan pay-for-performance (P4P) programs to ease administrative burden on providers and drive quality improvement.
- Physical and Behavioral Health Integration - Incentives to improve coordination between managed care plans and county mental health plans and provider incentives to promote the integration of mental and physical health care services, through coordination or co-location approaches.

Fee-for-Service Transformation

Most services are provided under Medi-Cal managed care plans, although some services are still provided through Medi-Cal's fee-for-service program, namely dental services and maternity care. The state has proposed, in the Medi-Cal 2020 renewal application, to introduce provider incentives to expand access to oral health services and to increase preventive service utilization. The state also proposed a Hospital Incentive Program to promote evidence-based obstetrical care to improve quality and reduce costs.

Increased Access to Housing and Supportive Services Programs

As part of the Medi-Cal 2020 renewal proposal, the state aims to improve care coordination for vulnerable populations including those experiencing homelessness. The state is proposing to include enhanced tenancy support and intensive medical case management services for individuals who are homeless and meet other high-risk criteria. The state also envisions the formation of regional housing partnerships that would be eligible to receive incentive funding to establish and support integrated care partnerships focused on housing. The state would require partnerships to include managed care plans, county health agencies, cities, hospitals, and housing and social service providers.

Additional Areas of Policy Change in FY 2016

Significant adjustments made to the 2015-2016 DHCS budget include: increased Medi-Cal spending due to expected caseload growth (including the expansion of state-funded coverage for children regardless of immigration status); restoration of the 10 percent dental provider rate reduction; increased managed care rates; funding for behavioral health treatment services for individuals with Autism; funding for ACA Section 2703 Health Homes; and funding to restore in-home supportive services (IHSS) hour cuts.

While signing the Budget Act, Governor Brown called for a special legislative session to address Medi-Cal financing issues related to the state's managed care organization (MCO) tax and continued funding for the IHSS restoration. The special session, which began June 19, 2015, is considering the Governor's proposal to restructure the managed care organization tax which is set to expire at the end of this fiscal year. A letter from CMS raised concerns about the current tax structure – noting the tax does not meet the federal requirement to be broad-based.[69] The current tax is estimated to generate $1.1 billion in FY 2016 that can then be used finance care and to draw down federal matching dollars. This special session will also consider how to fund the IHSS restoration in future years.

California Medicaid Policy Changes in FY 2015 and 2016
Eligibility, Application and Renewal Policies
• Expansion to full-scope Medi-Cal coverage for pregnant women between 60-133% FPL in FY 2015. • MAGI based income standards for family planning (Family PACT) eligibility in FY 2015.
Provider Rates and Provider Fees/Taxes
• Increased MCO and Nursing Facility rates in FY 2015. All other rates were held flat. • Plan to increase MCO, Nursing Facility, and Dentists' rates in FY 2016. Plan to hold all other rates flat. • Medicaid MCO tax expires in FY 2016. Legislative plan to make this tax broad-based will be discussed in a special legislative session.
Benefits and Pharmacy
• New behavioral health treatment benefit for children with Autism in FY 2015. • Restoration of previous cuts in In-Home Support Services (IHSS) in FY 2016. • New clinical guidelines for treatment of Hepatitis C will be released in FY 2016.
Managed Care
• HCBS and institutional LTSS added to managed care under the Coordinated Care Initiative in FY 2015. • Substance abuse services moving to an Organized Delivery System operated by counties in FY 2016.[70] • Health plans participating in the Medicare-Medicaid Financial Alignment Demonstration have a quality withhold of 1% in FY 2015 and 2% in FY 2016. • In FY 2016, DHCS will introduce an updated health plan Quality Award.
Delivery System and Payment Reform
• Plan to submit 2703 Health Homes SPA in FY 2016. Health Homes will focus on high utilizers including individuals experiencing homelessness. • Plan to introduce "ACO-like" initiatives (as part of 1115 waiver renewal) in FY 2016. • Plan to continue DSRIP initiative (part of 1115 waiver renewal) in FY 2016. • All-payer claims database initiative led by HHS (not DHCS) in FY 2016.
Long-term Services and Supports Rebalancing
• Plan to expand the number of persons served in HCBS waivers in FY 2016. • Plan to expand the number of persons served under the HCBS State Plan Option 1915(i) in FY 2016. • Plan to build rebalancing incentives into managed care contracts covering LTSS in FY 2016. • Plan to add a new PACE site or increase the number of persons served at PACE sites in FY 2016. • Plan to close/down-size a state institution and transition residents into community settings in FY 2016.

Tennessee

Economic and Budget Outlook

Economy

Tennessee's economy has seen continual improvements in economic conditions since the Great Recession, during which Tennessee experienced record unemployment (peaking at 11.1 percent) as well as steep declines in state revenues. The state has recovered all of the jobs lost during the recession.[71] Nonfarm and manufacturing sectors in the state have outgained national growth.[72] The unemployment rate has steadily declined to 5.7 percent in August 2015, though the state's unemployment rate continues to be slightly above the national average (5.1 percent).[73] State tax revenue collections have also continued to improve since the recession. State revenue collections were up 4.6 percent in the third quarter of 2014, exceeding growth of 3.2 percent in the Southeast Region and 4.4 percent nationally.[74] By the end of FY 2015, the state had collected $605.7 million[75] more than the original budgeted estimate of $12.1 billion (which had assumed 3.17 percent growth[76]).

State Budget

Governor Bill Haslam's budget proposal for FY 2016, presented to the Tennessee General Assembly in February 2015, was based on a conservative revenue estimate of 2.53 percent and continued slow growth in the economy. The Governor proposed strategic investments in higher education and in primary and secondary education, including teacher pay, but also proposed cuts in other program areas to stay within projected revenue growth for the year.[77] Health care cuts included downsizing of a state-run facility for individuals with Intellectual and Developmental Disabilities and limiting new eligibility for certain in-home long-term services and supports[78] under the state's Section 1115 Medicaid waiver to only individuals who meet the income and disability standards for SSI.[79] He also proposed and received an increase from 5.5 percent to 6 percent for 2016 in the state's assessment on health maintenance organizations including those that manage benefits for Medicaid beneficiaries through its TennCare program. In addition, the General Assembly passed a bill to increase nursing home assessments FY 2016. The Tennessee General Assembly approved the FY 2016 budget on April 16, 2015 after rejecting attempts to add a provision to authorize an expansion of Medicaid (described further below).[80]

Affordable Care Act Update

Governor Haslam, who was reelected by a wide margin in 2014, proposed an alternative to Medicaid expansion in early 2015 that enjoyed strong support from both business and health care organizations.[81] "Insure Tennessee" would have relied on Section 1115 waiver authority. The plan offered uninsured Tennesseans, ages 19-64, earning less than 138 percent FPL a choice between a defined contribution which could be used to purchase employer-sponsored insurance in the private market or enrollment in a managed care plan with a benefit package identical to Medicaid. The managed care option provided Health Savings Accounts, with incentives for healthy behaviors, and included premiums and copayments for individuals above 100 percent of the federal poverty level. The state's share of expansion costs would have been covered by an increase to an existing hospital assessment on net patient revenue.[82]

The Governor convened a special session of the legislature in February to seek legislative approval to move forward with Insure Tennessee but the proposal was voted down in a Senate committee formed to hear the bill, bringing the special session to a close. Subsequently, the bill was reintroduced by members of the legislature in the regular session and passed out of the Senate General Welfare Committee only later to be voted down in the Senate Commerce Committee. It was not taken up in the House during regular session. Conservative lawmakers who opposed Insure Tennessee expressed concerns over the potential long-term costs to the state and the difficulty the state would face if it were to try to repeal Medicaid expansion in future years.[83]

The state already covers parents to 101 percent of the FPL and pregnant women to 200 percent FPL under the existing TennCare program[84], and reported significant increases in Medicaid enrollment in 2015 for non-elderly, non-disabled adults, pregnant women and children. These increases are thought to reflect more parents seeking required insurance coverage under the Affordable Care Act, including through applications made to the Federally-Facilitated Marketplace (FFM). The state is projecting enrollment growth to slow in 2016.

In 2012, Tennessee contracted with a vendor to redesign the program's eligibility system to enable online applications for eligibility and to reflect other new requirements under the Affordable Care Act, expecting the new system to begin accepting applications by October 2013.[85] However, contractors were unable to meet this and subsequent deadlines. Due to the challenges and delays, individuals were unable to apply for Medicaid through an online portal at the state level. The state instead encouraged TennCare applicants to apply through the federally facilitated marketplace at www.healthcare.gov,[86] and makes computer kiosks available in all county Department of Human Services offices to support this process. Some Tennesseans experienced difficulties in 2014 obtaining timely eligibility decisions through the federally facilitated marketplace. A class action lawsuit was filed against the state in July 2014 on behalf of individuals who claim to have been harmed by delays in enrollment into TennCare.[87] TennCare now offers a "delay hearing" process to individuals who have not received their eligibility determination within 45 days or 90 days, depending on application type.[88] After an independent review of the work completed on the Tennessee Eligibility Determination System (TEDS), the state announced in early 2015 it was bringing in a new vendor to complete the system redesign,[89] and the state now expects to have its new system fully operational in 2018.

Managed Care and Health System Reform in Tennessee

Tennessee initiated the use of capitated managed care arrangements in 1994 with the creation of TennCare under its Section 1115 demonstration waiver. The state has enrolled all Medicaid populations in managed care arrangements since 1994, though the state has continued to innovate in its delivery and financing arrangements to address specific state program goals. Today, most services are provided as part of a comprehensive contract with three statewide managed care organizations (MCOs).[90] In 2010, Tennessee incorporated TennCare CHOICES[91] into the TennCare MCO contracts, thereby including long-term services and supports for older adults and people with physical disabilities in comprehensive managed care. Most outpatient pharmacy services, however, are "carved-out" and paid on a fee for service basis (managed by a pharmacy benefits manager).

The Health Care Finance Administration, within the Tennessee Department of Finance and Administration, administers the TennCare program, working with and through contracted private health plans to achieve

Medicaid program improvement goals. For example, the state's commitment to improving the quality of care for beneficiaries is pursued through a variety of initiatives. TennCare requires MCOs to be NCQA accredited, and plans are required to report a full set of HEDIS and CAHPS measures to the state. The state will pay a performance incentive for high performance in selected HEDIS measures and year-over-year improvement against standards established in annual contracts with the state. Current performance targets include timeliness of prenatal and post-partum care; measures of asthma and diabetes care; follow-up care for children prescribed with ADHD medication; adolescent well-care visits and immunizations; and antidepressant medication management, among others. The 2016 contract year will begin a new three-year cycle for quality improvement. There is also a monthly withhold that must be earned back by plans through meeting state performance expectations. TennCare officials point to achieving improvement in quality scores in the program, even while maintaining low PMPM cost trends.

In recent years, the state has required its health plans to undertake initiatives to reduce the rate of early elective deliveries; for example, since 2011, plans can pay no more for C-sections than for vaginal deliveries.[92] TennCare has also implemented Patient-Centered Medical Homes (PCMHs) through its MCOs and is working now to align these programs across plans. Further, under its State Innovations Models (SIM) grant from the Center for Medicare & Medicaid Innovation (CMMI), Tennessee is pursuing a multi-payer approach to PCMHs, beginning with 12 sites in 2016. The goal is to improve prevention and management of chronic disease, increased coordination and integration across multidisciplinary provider teams, and improved wellness and preventive care within the state. As part of this broader initiative, Tennessee plans to create a statewide TennCare Health Homes initiative in 2016 for individuals with Severe and Persistent Mental Illness, to further promote effective integration of physical health care, behavioral health care, and long-term services and supports within the state.

The state's SIM grant is supporting a wide array of reform initiatives that the state anticipates will help providers build capacity in their practices to transition to value-based payment and delivery models. The state established a goal to introduce 75 Episodes of Care (EOC) payments over five years; the first three EOCs for acute asthma exacerbation, perinatal and total joint replacement (hip and knee) are fully implemented, design has been completed for another five episodes and design is underway for 12 additional episodes.[93] The SIM grant will also be used to develop quality and acuity-based payments for long-term services and supports.

In addition, the state's SIM grant is supporting the Department of Health in development of a statewide stakeholder process to develop a plan for improved population health. This will include the use of economic analysis and forecasting during the development of the State Health Plan to identify health disparities and "hot spot" populations accounting for a disproportionate share of health care costs. The Department of Health will also use grant awards to Tennessee academic public health programs to address five population health priority topics: obesity, diabetes, tobacco use, child health, and perinatal health.

Pharmacy

TennCare officials report that pharmacy costs are a significant upward pressure on expenditures in the program, fueled by the cost of new Hepatitis C treatments, generic drug price increases, and especially the cost of biosimilars and certain specialty agents (e.g., for cystic fibrosis and cholesterol lowering treatments). The state, which has managed the pharmacy benefit closely through its single statewide pharmacy benefits manager

(PBM) for many years, implemented policy changes in 2015 and plans additional changes in 2016 to counter this pressure.

After reporting growth in pharmacy expenditures of 23 percent in FY 2014 over FY 2013, TennCare implemented pharmacy ingredient cost reductions as it moved to AWP-15% for brand name drugs in 2015, and also implemented tighter management of specialty agents. For example, oncology agents are limited to a 14 day supply on initial fill, the state has introduced edits to identify late refills for Hepatitis C treatment to better ensure medication compliance, and select specialty agents have been designated as “MCO-reimbursed only” when administration should only be performed in a healthcare facility. The state also introduced new prior authorization requirements for ADHD stimulant agents prescribed for adults and on the use of compounded prescription medications to ensure that all compounded prescriptions are medically necessary and FDA-approved or otherwise supported by CMS-recognized compendia.[94]

Additional planned reductions for 2016 include a 2 year lifetime limit for individuals being treated for opioid addiction with Buprenorphine-containing medications.[95] TennCare implemented a “New Drug” Review Policy that will implement clinically relevant prior authorization criteria and point-of-sale rejections until new agents are appropriately review by the state’s Pharmacy and Technology committee. The state also plans to transition to Guaranteed Net Unit Price (GNUP) contracting with pharmaceutical manufacturers.

Tennessee Medicaid (TennCare) Policy Changes FY 2015-2016
Eligibility, Application and Renewal Policies
• Limiting new LTSS enrollment into a 1915(i)-like group (CHOICES III, offered under 1115 authority) to SSI eligibles only in FY 2016. People already enrolled in the group under institutional income standards will be grandfathered. • Implemented new policy to suspend Medicaid eligibility upon incarceration (rather than terminate[96]).
Delivery System and Payment Reforms
• Continuing to expand the use of Episodes of Care. (FYs 2015 and2016) • Expanding the use of PCMHs. (FYs 2015 and 2016) • Planning to implement of health homes for those with severe and persistent mental illness. (FY 2016) • Implemented individual cost cap in one 1915(c) waiver for individuals with intellectual disabilities in FY 2015. (People whose services exceeded the cap were transitioned to another waiver with an aggregate cost cap, such that their services were not reduced.)
Provider Rates and Provider Fees/Taxes
• Across the board 1% rate cuts for MCOs and many ancillary providers in FY 2015 which were continued in FY 2016. • Increase nursing facility assessment in 2015 and 2016 and TennCare MCO tax in 2016 (from 5.5% to 6%)
Benefits and Pharmacy
• Reducing pharmacy ingredient cost reimbursement (no change in the dispensing fee). • Adjusting the state's PDL to add new prior authorization for ADHD stimulant agents for adults. (2015) • Planning to transition supplemental rebates to Guaranteed Net Unit Price (GNUP) contracting with pharmaceutical manufacturers. (October 2015) • Implementing new pharmacy cost-containment measures targeted to specialty drugs, such as new prior authorization requirements and edits on specialty agents. (FYs 2015 and 2016) • Implementing additional pharmacy cost-containment measures such as management of compound drugs (2015) and instituting a 2-year life-time limit on use of Buprenorphine-containing medications for opioid addiction treatment (2016).

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[96] Incarcerated individuals in a suspended status are eligible for inpatient hospitalizations to be reimbursed by TennCare and not billed to the correctional facility.