

State Health and Value Strategies
Enhancing Value in Health Care

A Robert Wood Johnson Foundation program



Grantmakers in Health: Advancing Mental Health and Addiction Solutions

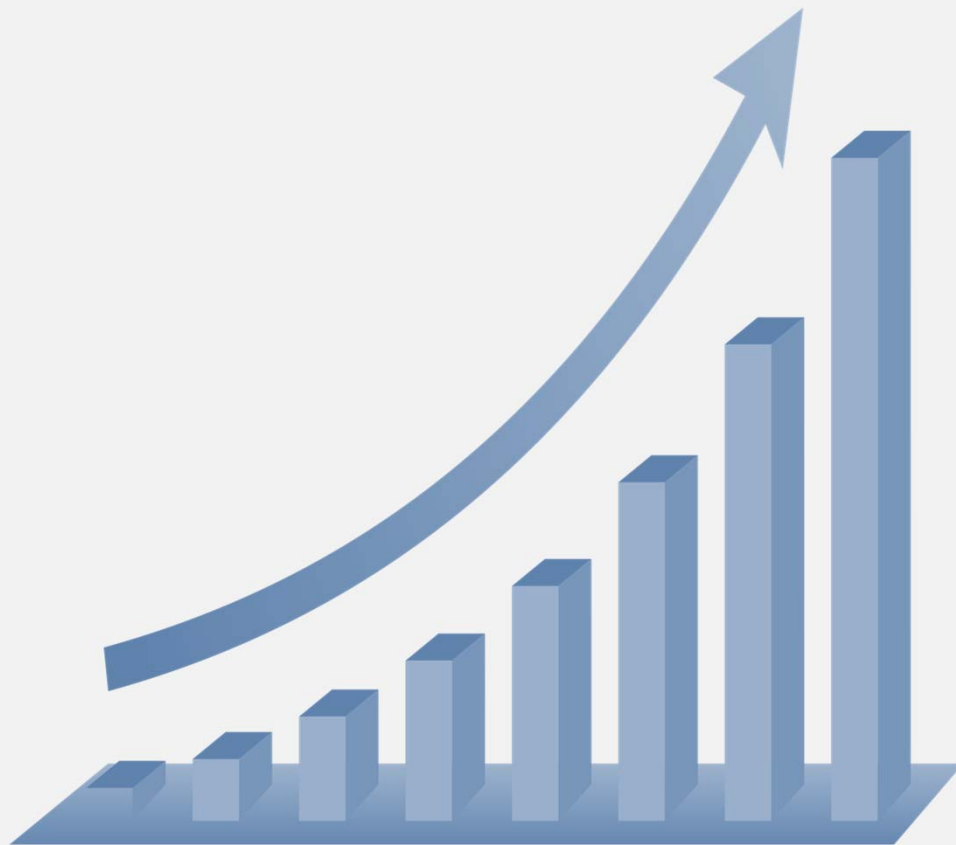
**Overview of Behavioral Health Landscape
February 9, 2017**

Heather Howard

Agenda

- Role of Medicaid in Addressing Behavioral Health
- Dynamic federal policy environment
 - Impact of proposals to repeal and replace the ACA and restructure the federal role in Medicaid

U.S. Opioid Crisis is Rapidly Worsening



THE FACTS

- As of 2014, 1.9 million Americans had an opioid use disorder
- An additional 19.6 million Americans had a non-opioid substance use disorder (SUD)
- Since 1999, the number of opioid overdoses resulting in death has increased by more than threefold for men and fivefold for women

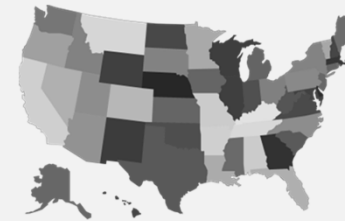
SAMHSA. "Substance Use Disorders." <http://www.samhsa.gov/disorders/substance-use>; SAMHSA, "Mental and Substance Use Disorders." <http://www.samhsa.gov/disorders>.

While Congress Debates, States Can Act



CONGRESS

- In July 2016, the House and Senate passed the Comprehensive Addiction and Recovery Act, which was signed into law by the President.
- The Act **authorized spending of \$905 million** over five years to implement these reforms, **but Congress has not yet appropriated any of this funding.**
- A September 2016 Senate continuing resolution provided \$37 million to fight the opioid epidemic – **far short of the \$1.1 billion** requested by President Obama.



STATES

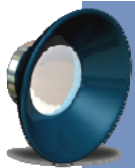
- Medicaid is the largest payer in most states, with total annual spending of nearly \$500 billion nationwide in 2014—including \$47.2 billion for the new adult group
- In 2014, Medicaid spent ~\$60 billion on behavioral health services, including SUD services
- States receive 100% FMAP for expansion adults (decreasing to 95% in 2017); therefore, federal funds pay for **all** SUD services for the expansion population; for previously eligible populations, states receive 50-74.6% FMAP

C. Owens, <https://morningconsult.com/2016/06/07/opioid-bill-include-health-measures-aides-say/>; U.S. Senate Committee on Appropriations, <http://www.appropriations.senate.gov/news/majority/subcommittee-approves-fy2017-labor-hhs-and-education-appropriations-bill>; <http://kff.org/medicaid/issue-brief/medicaid-expansion-spending-and-enrollment-in-context-an-early-look-at-cms-claims-data-for-2014/>; GAO, <http://www.gao.gov/mwg-internal/de5fs23hu73ds/progress?id=0Eg34B33Q-Jdb9-pVEWVJiOojXRnxf5cWNieB0Qdkd0>; CMS, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html>

Medicaid's Imperative to Address the Epidemic



Medicaid is the largest source of coverage and funding for substance use prevention and treatment



Medicaid expansion has amplified Medicaid's role in fighting the epidemic

1.2 million adults with SUD have gained coverage in the 31 Medicaid expansion states.

At least 1.1 million uninsured adults with SUDs live in states that have not expanded Medicaid.*

*These figures includes the states that had expanded as of November 2015.
Since November 2015, Montana and Louisiana have implemented Medicaid expansion.

SAMHSA, http://www.samhsa.gov/data/sites/default/files/report_2073/ShortReport-2073.pdf; Busch et al., <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3672321/>.

Expansion Group May Have Broader SUD Benefits



In expansion states, new adults gain access to comprehensive insurance, including SUD services

- New adults must receive a benefit plan covering the 10 essential health benefits, which include SUD services
- Mental health and SUD services must also be provided in parity with physical health services



For previously eligible adults, SUD coverage is optional

- Some states offer only limited coverage, for example by limiting SUD coverage to pregnant women
- Some states that have expanded are extending the more comprehensive SUD benefits for new adults to these previously eligible populations.

Medicaid Tools to Address the Epidemic



Tailor Medicaid benefits
to bolster SUD prevention and treatment

Implement “Health Homes”
for those with SUD or opioid disorders

Leverage Medicaid’s power in the market
to ensure providers and plans follow best practices

Reform SUD delivery system
to address SUD across physical, behavioral mental dimensions

Tailoring Benefit Design to Bolster SUD Services

Prevention Strategies

- Requiring prior authorization for opioid prescriptions
- Instituting quantity limits for opioid prescriptions
- Strengthening utilization review criteria
- Increasing Medicaid's access to states' Prescription Drug Monitoring Programs



Treatment Strategies

- Promoting use of medication assisted treatment (MAT)
- Adding naloxone to preferred drug lists



**States may amend their Medicaid State Plans to effectuate these changes;
no special approvals are required.**

Implementing Health Homes

The ACA created a State option to implement Health Homes to improve care coordination and care management for targeted high need Medicaid enrollees.

States receive 90% federal match for Health Home coordination services in the first two years of implementation for previously eligible individuals, and 100% federal match (declining to 95% in 2017) for new adults.

Tailoring Health Homes for SUD

States are designing Health Homes targeted to individuals with opioid use disorders and other SUDs.

Program features may include:

- Intensive care management services, including care plan development, patient navigation services, and outreach and enrollment into treatment
- Enhanced provider and workforce education on evidence-based treatment for opioid use disorders

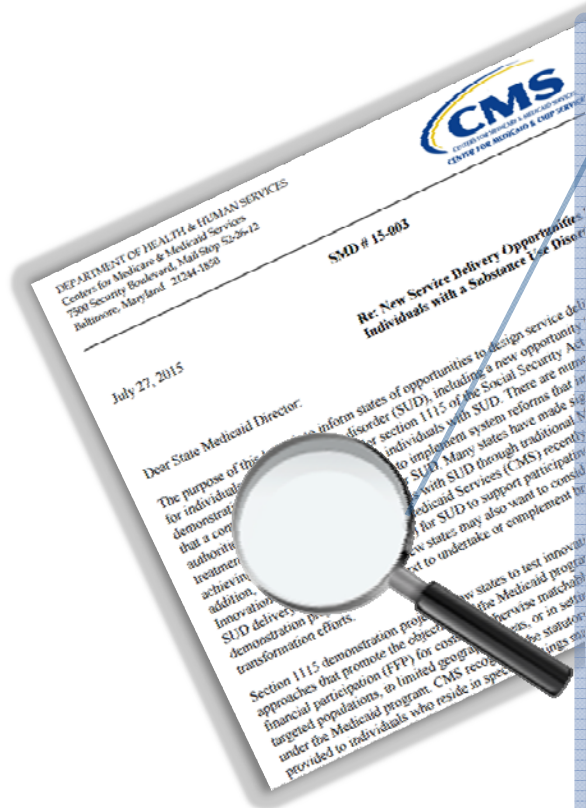


Leveraging Medicaid's Purchasing Power

- Covering case management and home and community based services, targeting the needs of those with SUDs
- Enhancing payment rates for providers meeting best practices in SUD prevention and treatment
- Requiring health plans to contract with certain providers, pay providers more for high-priority services, and provide incentives to plans that meet certain metrics
- Designing special health plans for individuals with serious mental illness and SUD

Reforming the SUD Delivery System

CMS is encouraging states to pursue new SUD-focused 1115 waivers to treat SUD across the continuum of care (including across physical, behavioral and mental dimensions)



CMS issued guidance in July 2015 describing these waivers. Waivers must include the following SUD-specific requirements:

- Appropriate Standards of Care
- Strong Network Development Plan
- Care Coordination Design
- Integration of Physical Health and SUD
- Benefit Management
- Strategies to Address Prescription Drug Abuse
- Strategies to Address Opioid Use Disorder

States implementing SUD delivery system transformation may apply for a waiver of the “Institution for Mental Disease (IMD) exclusion” – this would permit states to receive Medicaid match for services delivered in an IMD, which is not otherwise allowable

Demonstration Waiver Strategies

States are pursuing a variety of innovations to transform the way SUD care is delivered



Creating integrated delivery networks of physical health, behavioral health, and social service providers



Strengthening behavioral health workforce capacity



Implementing new clinical programs targeted towards treating beneficiaries with SUDs



Expanding SUD benefits



Increasing access to care management and care coordination services



California

California is implementing the Drug Medi-Cal Organized Delivery System pilot program, which enables counties to provide an enhanced set of evidence-based benefits to Medicaid beneficiaries with SUDs.



New Hampshire

New Hampshire is implementing a five-year \$150 million DSRIP waiver, under which it will create a series of regional integrated delivery networks with a specific focus on improving behavioral healthcare.

Other States to Watch – New Jersey

- Governor Christie signed an executive order declaring the opioid epidemic a public health crisis
- Legislation currently advancing to place 5-day restriction on opioid prescriptions
 - Several other states have set 7-day restrictions
 - Exemptions for active cancer treatment, hospice or palliative care, and residents of long term care facilities.
- 40% increase in available beds for the treatment of behavioral health and substance abuse disorders (first Certificate of Need (CN) call for new adult psychiatric beds in 20 years)
- Through its 1115 waiver, implementing a Medication Assisted Treatment Initiative, making MAT services available to adults with incomes up to 150% FPL who would otherwise not qualify for Medicaid.
- Significant decreases in uncompensated care for the past two years result in reinvesting charity care savings
 - FY 2017 budget included \$74 million increase in Medicaid rates for SUD services to increase access to treatment.

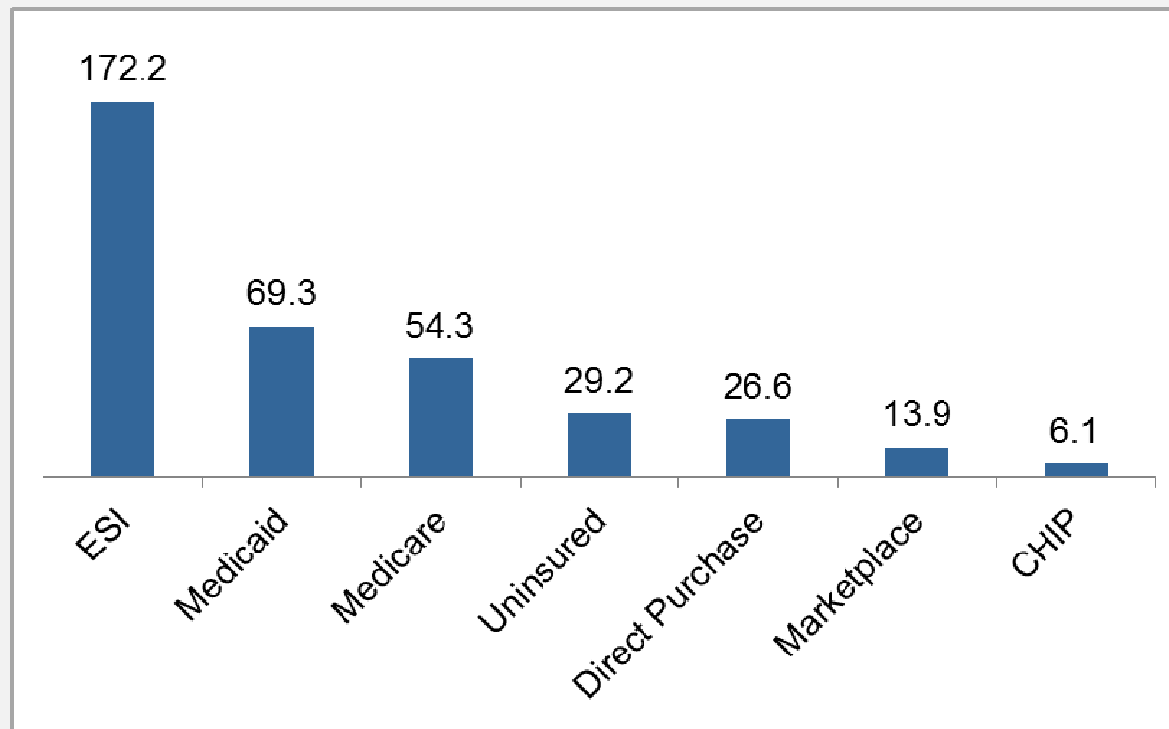
Other States to Watch – Rhode Island

- Rhode Island Governor's Overdose Prevention and Intervention Task Force (November 2015)
- Strategic Plan – Four Strategies
 - Every door is the right one
 - Naloxone as standard of care
 - Safer prescribing and dispensing
 - Expand recovery supports
- Legislation signed in 2016 introduced new limits on initial prescriptions

Medicaid Today

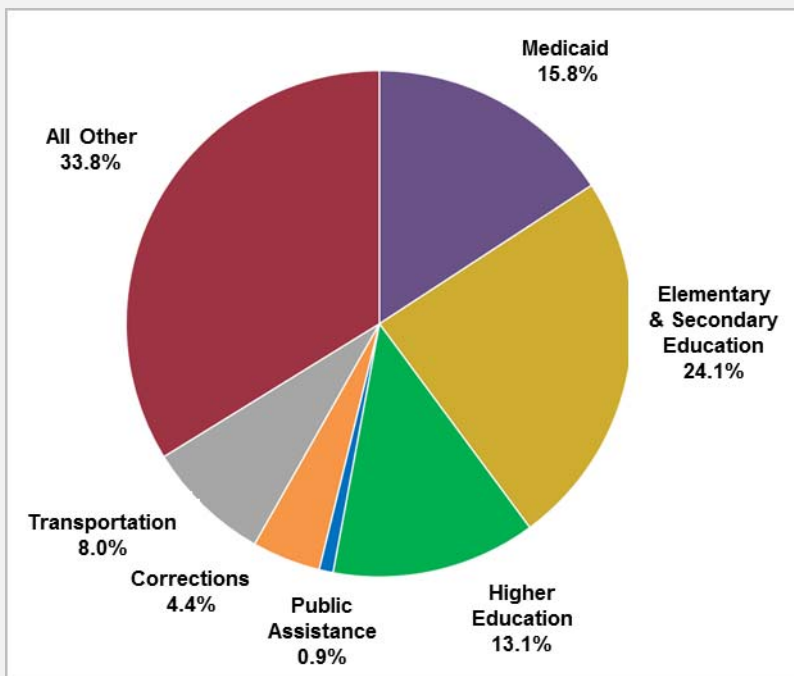
Medicaid is Nation's Largest Single Source of Coverage

U.S. Health Insurance Enrollment by Source, CY 2015 (millions)

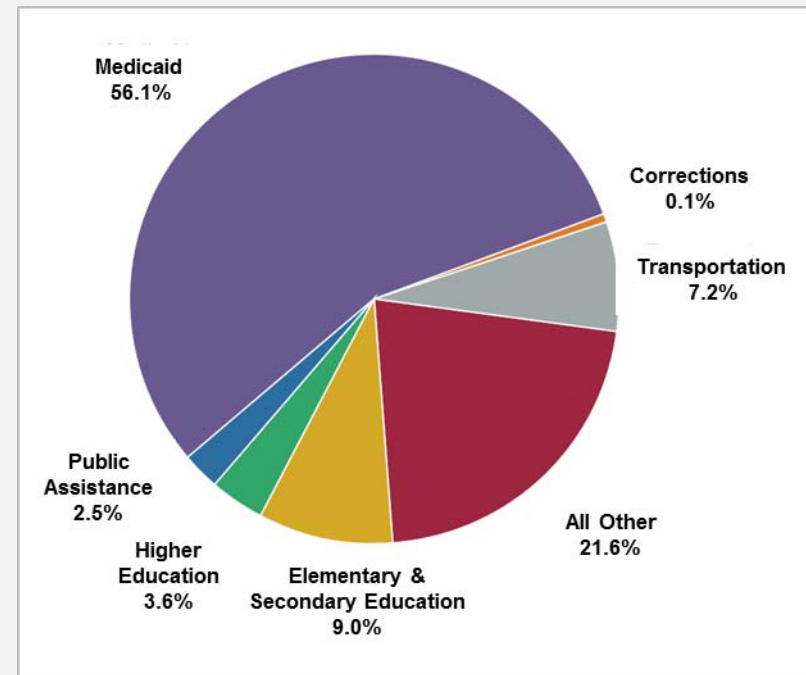


Medicaid is Major State Budget Item and Largest Source of Federal Revenue for States

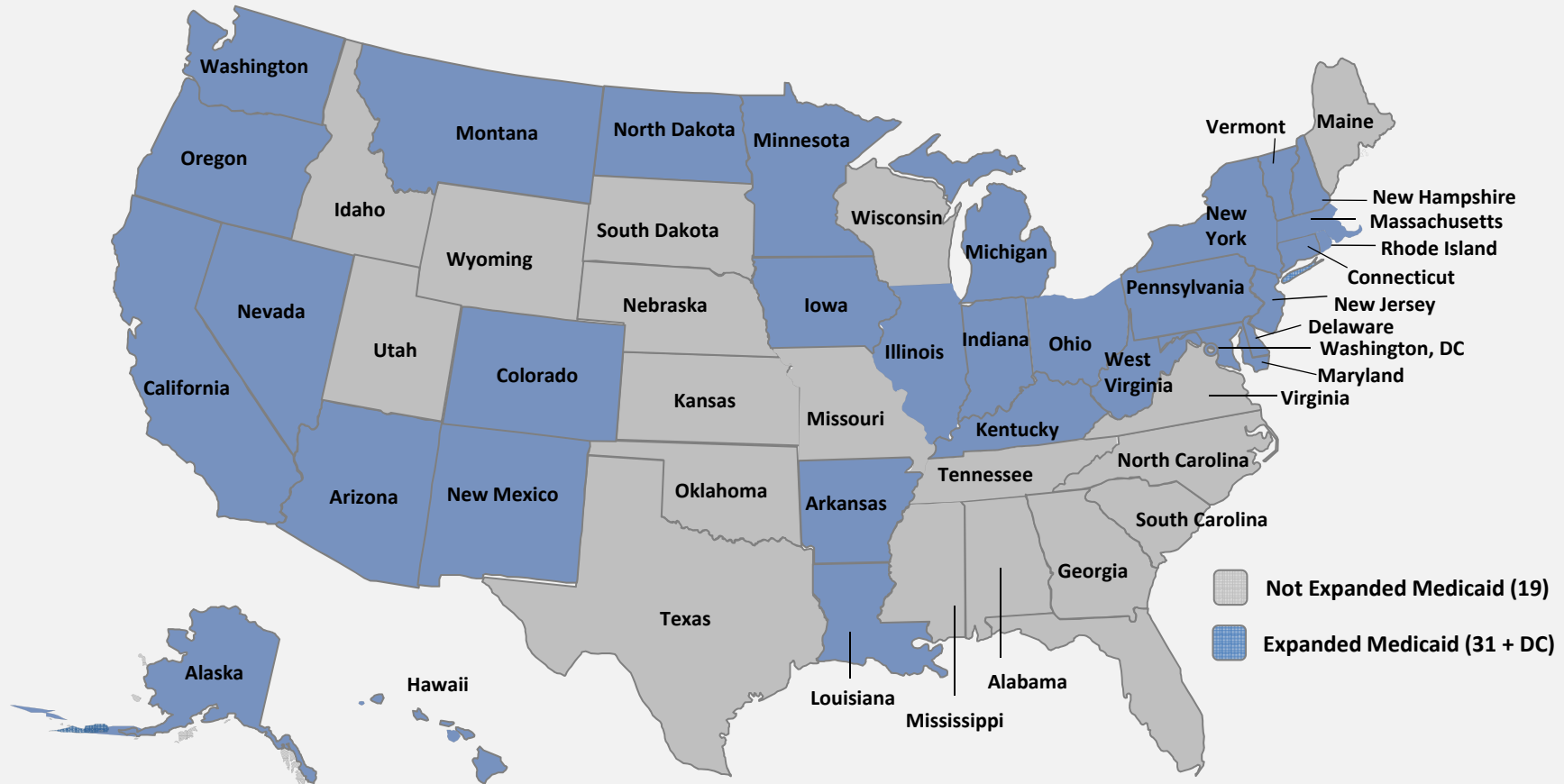
State Medicaid Spending as Share of Budget (State Funds Only), FY 2015



Sources of Federal Funds to States, FY 2015



Recent Growth: 31 States and DC Have Expanded Medicaid



Impact of Medicaid Expansion

Coverage Gains and Federal Funding



14.5 million are covered under Medicaid expansion

- 11.26 million newly eligible adults and 3.25 million adults who would have qualified for Medicaid pre-ACA ¹



Adult **uninsured rate dropped an average of 8.3 percentage points** in expansion states compared to an average of 5.7 percentage points in non-expansion states, 2013-2015

- Largest decrease of 19.9 percentage points in West Virginia ^{2,3}

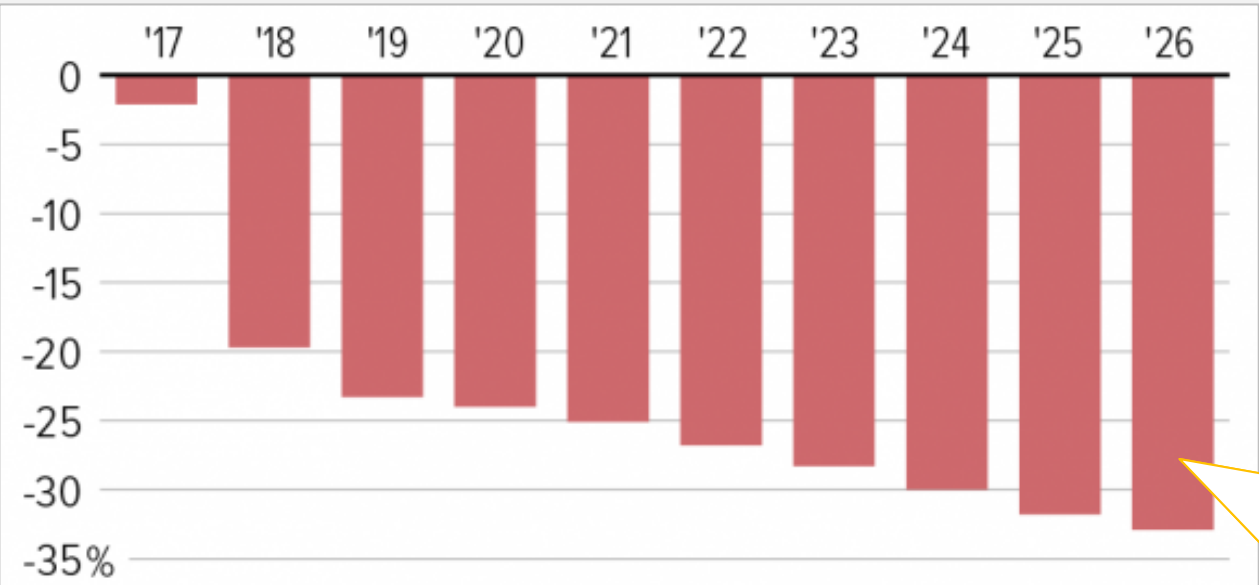


Expansion states received an estimated **\$72.6 billion** in federal funding in 2016 for coverage of newly eligible adults; state share begins in 2017

Alternative Financing Structures

Proposals Sharply Reduce Federal Payments to States

Percent Cut in Federal Medicaid and CHIP Funds
(House FY 2017 Plan Relative to Current Law)



Proposal would cut federal Medicaid funds by \$1 trillion (or 25%) over ten years, resulting in a combined 33% reduction in federal funds for Medicaid and CHIP.

Block Grants

States receive no more than a set amount of federal funds annually

- Amounts typically allocated among states by reference to spending in a base year
- Caps could be frozen (no year-to-year increase), but Medicaid block grant proposals typically allow capped payments to grow based on a national trend rate (e.g., CPI or GDP)
- Provides funding certainty to federal government; shifts risk for enrollment and health care costs to states
- States may or may not have a state spending requirement
- Eligibility and benefit rules set by block grant legislation, generally giving states more flexibility to set eligibility, benefits and other program features; may also impose new obligations on states

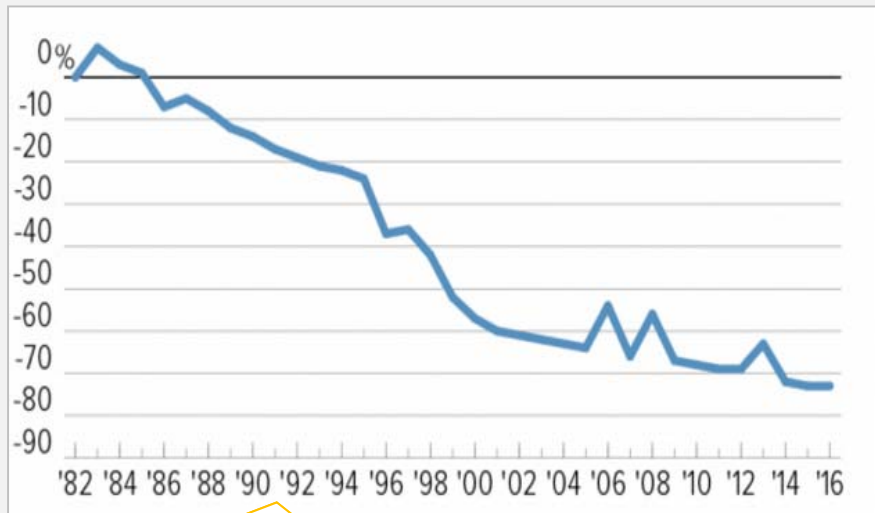
Different Block Grant Designs

- **Some guarantee a set amount - no state spending required**
 - For example, the Social Services Block Grant provides a fixed amount of federal funding, not conditioned on state spending
- **Some guarantee a set amount so long as a state spends a certain amount of state funds**
 - For example, TANF block grant provides federal funding at the capped level so long as the states spends minimum amount of its own dollars on TANF-related initiatives
- **Some guarantee funding *up to* set amount; federal payments are provided as match to state spending up to federal cap (sometimes referred to as capped allotment)**
 - For example, CHIP provides federal funding as a match to state spending up to the federal cap

Federal Funding for TANF and Social Services Block Grants

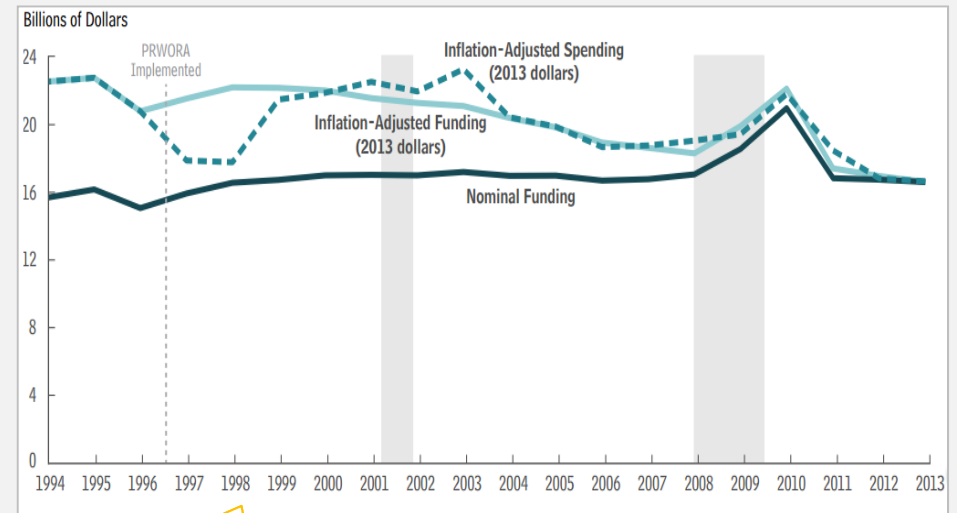
Total dollars of federal funding for TANF and Social Services block grants have declined in value due to inflation

Reductions in Inflation-Adjusted Funding for the Social Services Block Grant



73% reduction in block grant value between 1982 and 2016 due to inflation, funding freezes, budget cuts and sequestration

Total Spending on TANF and Programs That Preceded It



TANF's purchasing power has declined 25% since 1998

Per Capita Caps

States receive fixed amount of federal funds per Medicaid enrollee

- Per capita amount set based on each state's per enrollee spending in base year; amounts typically grow consistent with a national trend rate
- Under the proposals, caps would vary by eligibility category (e.g., disabled, children)
- Shifts risk of higher health care costs, but not enrollment, to states
 - *However*, may be subject to national cap, limiting ability for federal funds to grow with enrollment; in which case, both enrollment and cost risk shifted to state
- State match typically required; federal funds provided to states based on actual expenditures up to the cap

Per Capita Cap Proposals Differ from Caps in 1115 Waivers

States operating under 1115 waivers are subject to per person cap on federal funding to assure “budget neutrality”

- Waiver caps are set to reflect state’s expected medical spend without waiver; they are not designed to achieve savings
- Waivers are optional and features, including per capita caps, are negotiated between CMS and state; scope is limited to aspects of the program subject to the waiver
- Waiver caps can be adjusted to reflect unexpected costs and are not subject to an aggregate cap

Recent Block Grant and Per Cap Proposals

Most proposals are missing key details

Feature	A Better Way (Ryan)	Patient CARE Act (Hatch/Upton/Burr)	FY17 House Budget Comm. (Price)	HAEL Act of 2016 (Sessions/Cassidy)	Heritage Foundation
Type	Per capita cap, with option for block grant	Per capita cap	Block grant	Per capita cap	Per capita cap
State Match Required	✓ (per capita cap) ? (block grant)	?	?	✓	✓
National aggregate cap	✗	✗	✓	✗	✓
Different caps for populations	✓	✓	?	✓	✓
Populations covered	All	All, except acute care of elderly & disabled	All	All	All
Base amount	Average Medicaid spend in state during base year	Nat'l Medicaid spend allocated based on state population with income < 100% FPL	Unclear	Average Federal Medicaid spend during base year	Unclear
Trend rate	Unclear	CPI + 1	Unclear	GDP + 1	Unclear

Implications of Alternative Financing

State Risks

Capping federal funds puts states at risk for costs above cap and limits new investments

- All recent proposals to cap federal Medicaid funding would sharply reduce federal payments to states.
 - FY 2013 House Budget plan: \$1.7 trillion reduction (-38%) from 2013-2022
 - FY 2017 House Budget Plan: \$1 trillion reduction (-25%) from 2017-2026
- Annual growth rates are below estimates
 - FY 2013 House Budget plan included an average 3% growth rate each year, falling short of the estimated 7% annual cost growth
- Capping federal Medicaid dollars locks in funding based on earlier state choices, constraining future state decisions on eligibility, benefits, payment rates and other new investments.

Shifting Risk to States

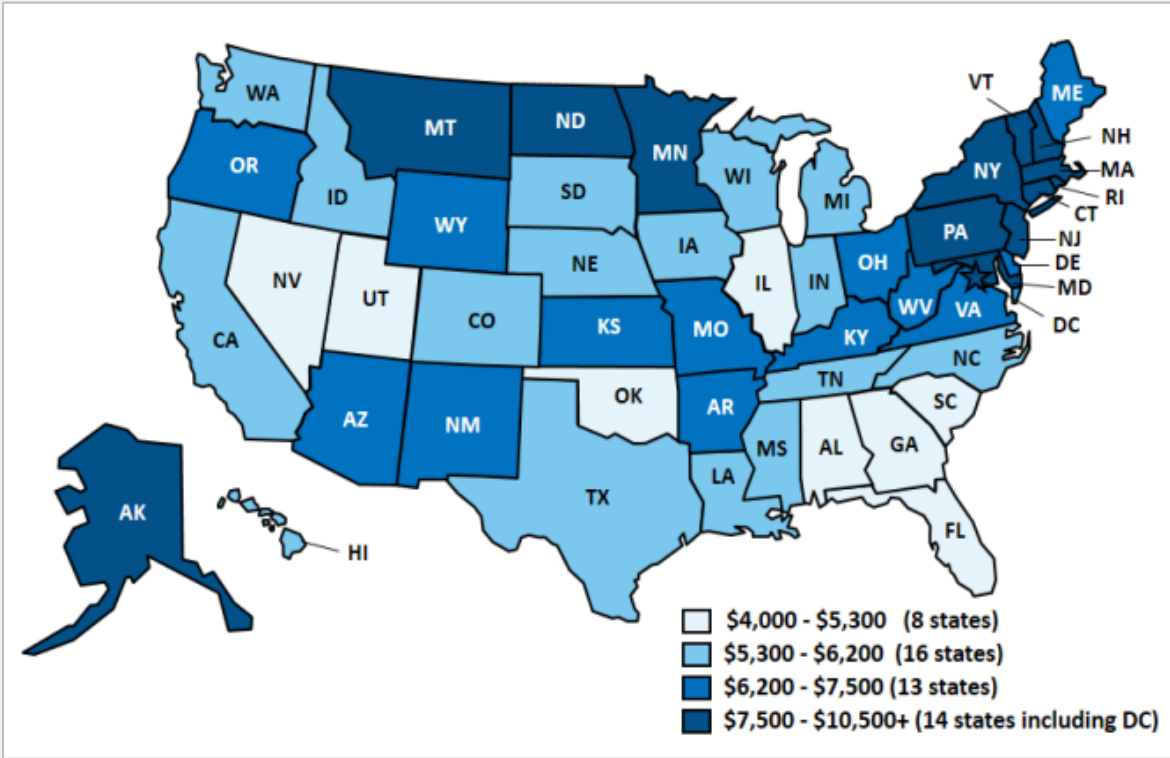
Capped federal funds constrains states' ability to respond to events beyond their control

- Neither block grants nor per capita caps account for:
 - Public health crisis such as HIV/AIDS, Opioid epidemic, Zika
 - New block buster drugs or other medical advances
 - Natural disasters such as Hurricane Katrina
 - Manmade disasters such as 9/11 and lead poisoning
- In addition, block grants do not account for:
 - Economic downturns or other causes of higher-than-anticipated enrollment

Capped Funding: Locks in Disparities Across States

Capped funding freezes in historic differences in spending

Spending Per Full Medicaid Enrollee, FY 2011



How Will the Flexibility Play Out with Reduced, Capped Funding?

- Fewer people served?
- More churning, less continuity of coverage?
- Limited benefits, limited access?
- Greater competition for constrained funding?
- With funding reductions, will new positive programmatic opportunities be more theoretical than real?

Thank you!

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