SB 180 MEDICAID REFORM (Sen. D. Liljenquist)
PROCEED WITH CAUTION

A Utah Health Policy Position Paper

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SUMMARY

SB180, Medicaid Reform, sponsored Sen. Liljenquist will fundamentally reform the way Medicaid services are paid for and delivered in Utah—and not a moment too soon. The premise for this legislation cannot be disputed: Medicaid spending *is* on an unsustainable trajectory and proven strategies are needed to ensure that beneficiaries and taxpayers are getting good value for the Medicaid dollar. While the overall intent of SB180 is positive, critical details have yet to be seen, and some of the language on spending caps and expectations for consumer behavior sets off alarm bells. Still, payment reforms for Medicaid cannot wait another day, and SB180 may be the best way forward. Advocates and providers will need to be in the driver's seat, at every turn, to make sure beneficiaries come out ahead in a reform process fraught with many unknowns and political frustrations.

THE MEDICAID REFORM FRAMEWORK

Key provisions of SB180 include the creation of Accountable Care Organizations (ACO), a bundled payment system based on a per member/per month spending cap, and a new Medicaid Rainy Day Account as a repository for any savings that may be generated by the proposed payment reforms.

Accountable Care Organizations

This bill will establish ACOs—groups of providers who agree to be accountable for the quality, cost, and overall care of Medicaid beneficiaries. Providers would receive monthly, risk-adjusted, capitated payments based on enrollment, and with those payments provide quality, effective medical care with a focus on promoting health and managing disease. A centerpiece of the ACO model is the "medical home:" Each Medicaid client would have access to a primary care provider who would coordinate the client's use of medical services throughout the ACO network of providers. The medical home coordinates care and disease management, improving quality while controlling cost. If implemented carefully, ACOs have the potential to increase quality of care while limiting cost growth.

Bundled Payment: Per member/Per Month

SB 180 will create a bundled payment system that takes Medicaid away from a fee-for-service payment model, which promotes over-utilization of medical care, to a per member/per month (pm/pm)

Lessons from Other States

Utah is not the first state to undertake ambitious payment reforms for Medicaid. As the state's reform process gets underway this winter, it will be important to consider lessons from other states.

Kentucky has experimented with tying cost sharing to efforts to improve health status, with disappointing results. A legislative audit was not able to document any savings or progress from the program as of 2007: http://www.auditor.ky.gov/Public/Audit_Reports/Archive/2007AMedicaidPerformancereport.pdf.

Vermont created the *Global Commitment to Health*, a Medicaid waiver that capped federal funding at $4.7 billion over 5 years in exchange for flexibility in program design, including the ability to use any savings to cover services not available under Medicaid, explore alternative payment methodologies, and invest in initiatives to improve health outcomes.

Florida's experiment with a new managed care *defined contribution* model (fixed premium paid to providers per plan member rather than a "fixed benefit"), has not been renewed. Florida reforms also established "enhanced benefits accounts:" credits for enrollees who maintain healthy behaviors. These credits were to be used for health care services and medical supply costs not otherwise covered by the plan.

Prepare to Meet HHS' Expectations

Just this week the Federal Department of Health and Human Services invited states to experiment with different payment models in order to control Medicaid spending. Utah should embrace this guidance while drawing lessons from recent state Medicaid reforms. http://www.hhs.gov/news/press/2011pres/01/20110203c.html. This guidance urges states to focus on managing care for dual eligibles; purchasing drug more efficiently; and assuring program integrity.

model. Providers would be paid for packages of services delivered over entire "episodes of illness," rather than for individual services delivered during each patient encounter. The amount paid for each package would be based on risk-based arrangements for similar clients and services. This, if implemented correctly, would reward providers for improving patients' health status.

A New Medicaid Rainy Day Account

Each year Medicaid is allotted a specific amount of money for its operation. During years in which not all the money is spent, the "excess" would be deposited into a "rainy day fund." A problem with such funds in the past is that the money in the fund has not been protected for intended uses—it has been used for programs other than Medicaid. SB180 should include a mechanism to protect the proposed funds, for example a requirement that two-thirds of the Legislature approve any spending beyond the intended purposes.

Other Potential Pitfalls and Points of Concern

Linking Medicaid Spending Growth Targets to the General Fund

SB 180 establishes annual targets for Medicaid spending growth linked to general fund growth, that is, to long-term state revenue growth. When Medicaid's growth is not as high as general fund growth, the excess funds would be deposited into the Medicaid Rainy Day Account. In years when Medicaid growth exceeds general fund growth targets, health benefits would be reduced on a predetermined schedule. This is a dangerous plan based on the faulty assumption that growth within Medicaid could match general fund growth—this means that when Medicaid outgrows the general fund, which is it mostly likely to do, Medicaid recipients would see their benefits shrink.

In any case, this proposed budget management strategy must be approved (in the form of a requested waiver) by CMS (the Centers for Medicare and Medicaid Services). Such a waiver is not likely to pass, as no similar waivers have gone through CMS since federal health reform was passed into law in March of 2010.

Fragmenting Care

The initial implementation of the proposal would exclude large sections of Medicaid recipient programs. Mental health, long-term care, and people living with disabilities would not be included in the initial roll-out of the reform. These are the very populations that cost the most and thus the associated cost centers are most in need of reform. In addition, leaving these populations out could cause significant care and coordination issues for clients as well as providers as their care becomes more, not less, fragmented. In its recent guidance to states hoping to undertake Medicaid reform, CMS asks state Medicaid officials to work closely with the new Federal Coordinated Health Care Office on strategies for managing care of dual eligibles.

Conclusion: Utah Medicaid Reform Train is Leaving the Station

UHPP supports thoughtful, well-planned Medicaid reform that controls cost while increasing quality and access. SB180 seems headed in this direction, though details have yet to be seen. But this train is leaving the station: Now is the time for advocates, providers, and other stakeholders to **get on board**. It will be up to us to draw lessons from other states' experience and to make sure that Medicaid reform goals are aligned with the goals of health system reform.

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