

What comes next

# Guiding principles for strengthening Iowa's Medicaid program

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Medicaid makes it possible for thousands of low-income Iowa children and adults to get and stay healthy. It allows them to see a doctor when they are sick, get check-ups, buy medications, and go to the hospital without fear of choosing between their health and groceries or paying the rent. It helps parents make sure they can work and take care of their families.

Medicaid has been in the news a lot—in last year's attempts to repeal and replace the Affordable Care Act (ACA), Iowa's transition to and early implementation of managed care, and throughout the campaign season. It's become part of a highly charged political battle.

Now elections are over. Medicaid is too important to be a political football. This brief aims to help Iowans understand the issues at play in our Medicaid program, offer some guiding principles for moving forward and remind us all why it matters that we get it right.

Medicaid is too important to be a political football.

## First, a word about managed care

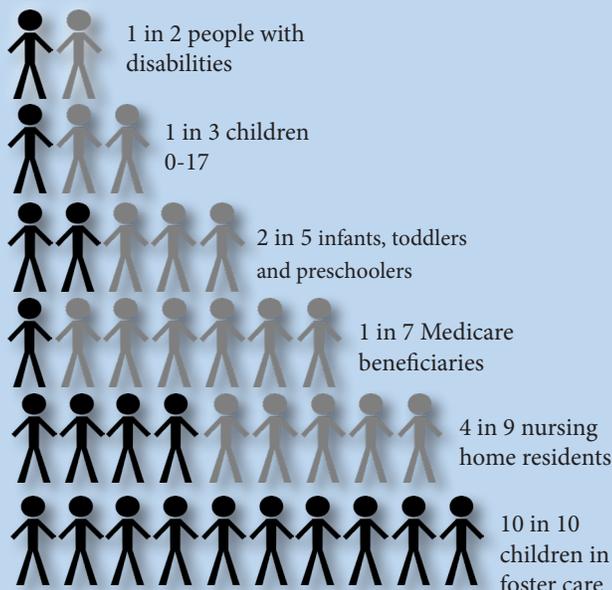
Medicaid managed care is the standard in many states. Of the 37 million U.S. children covered by Medicaid, over two-thirds are enrolled in managed care organizations (MCOs).<sup>1</sup> It has grown in popularity as a delivery strategy because states have seen it both as a potential cost saver and as a tool to offer more innovative health care services.

At its most basic, managed care transfers financial risk for providing covered services from the state to MCOs. The state pays MCOs a fixed amount per member per month (the "capitation rate") based on actuarial analysis.

If an MCO spends more on covered services than it gets from the state, the MCO absorbs the loss; if it spends less, it keeps the difference. That arrangement gives MCOs an economic incentive to manage costs. They can do so in two main ways:

- coordinate care to reduce unnecessary use of high-cost services (for example, promoting preventive care to keep enrollees healthier by preventing avoidable hospitalizations and ER visits);

## Medicaid covers vulnerable Iowans



Sources: Kaiser Family Foundation, "Medicaid in Iowa" Fact Sheet, September 2018, and Georgetown Center for Children and Families, "Iowa Snapshot of Children's Coverage: How Medicaid, CHIP, and the ACA Cover Children."

# How'd we get here?

*A brief history of Medicaid managed care in Iowa*

Iowa started its Medicaid program in **July 1967**, two years after the federal legislation was signed into law by President Lyndon Johnson. For most of its years, Medicaid in Iowa was administered by the state under a “fee for service” arrangement.

In **1995**, Iowa carved out a relatively small managed care component to administer behavioral health services, contracting with a for-profit managed care organization (MCO) later known as Magellan Behavioral Health Services.

In **January 2015**, then-Governor Terry Branstad announced that Iowa would convert its entire \$4 billion Medicaid program to a managed-care delivery model, promising significant cost savings to the state.

Iowa selected four MCOs to administer Medicaid in **August 2015** and went on to sign contracts with three of them.

On **April 1, 2016**, virtually all of Iowa’s 500,000 Medicaid members began receiving services through one of the three MCOs. Almost immediately providers started reporting problems receiving timely payment, and patients started reporting denials of needed services.

MCOs have reported considerable losses in Iowa. Amerigroup CEO Cheryl Harding wrote in a letter to DHS in **June 2017** that the state’s proposed rates “do not support a sustainable Medicaid managed-care program.”<sup>1</sup> Amerigroup exited Iowa’s market in **November 2017** after failing to reach a contract agreement with the state.

Two MCOs remain (with a third to come on board next year). In **late August**, the state finalized contracts with MCOs for the fiscal year that started in July 2018—and for which the legislature set a budget before adjourning in May. The new contracts include a 7.5 percent rate increase, which will cost the state an additional \$103 million.

<sup>1</sup> <https://www.desmoinesregister.com/story/news/investigations/2017/11/02/skepticism-over-iowas-medicaid-math-led-amerihealth-pull-out/819515001/>

- limit access to services and shift the risk to providers (for example, limiting access through use of gatekeepers and preauthorization policies to minimize treatment costs).<sup>2</sup>

In successful Medicaid managed care programs, the state effectively manages both strategies—mitigating the incentives for MCOs to limit services and holding MCOs accountable for coordinating care. There is some evidence from other states that thoughtfully designed and overseen managed care programs can offer improved coordination of services and increased flexibility in benefits.

But overall evidence on the efficacy of managed care is mixed.<sup>3</sup> In fact, in reviewing the evidence, the nonpartisan Medicaid and CHIP Payment and Access Commission (MACPAC), which advises federal officials and agencies on the program, declared that because of the significant

MCOs have an economic incentive to manage costs.

differences in implementation models among states and MCOs, “It is not clear whether managed care provides better or worse access to care than [fee for service].”<sup>4</sup>

In other words, managed care is no magic bullet; it’s how individual states and MCOs implement it that dictates its success or failure.

## Guiding principles

The seven principles here do not represent a specific plan for strengthening our state’s Medicaid program, but rather a framework for thinking through where we go next. They are intended to open the door to ongoing policy conversations and ground the discussion in basic facts about how Medicaid works.

They are applicable to different service delivery methods. But given election results in Iowa, managed care appears likely to stay, at least in some form.

Many of this brief’s examples focus on children, who make up over half of Medicaid members, but its broad themes apply to the entire Medicaid membership.

## Guiding principle 1

### **Build on current public support to act**

It will come as no surprise to anyone who turned on a TV prior to the election that health care generally, and Medicaid specifically, are hot topics. A June 2018 poll found U.S. voters identified health care as the top issue influencing how they would vote in the midterms—above the economy and jobs; guns; taxes and spending; and immigration.<sup>5</sup>

A poll conducted during the 2017 ACA-repeal debate found that 74 percent of respondents had a favorable view of Medicaid. That included 84 percent of Democrats, 76 percent of independents and 61 percent of Republicans.<sup>6</sup> (A similar 2018 poll found sustained support—with the share of Republicans with favorable views actually increasing slightly.<sup>7</sup>) In addition, 7 in 10 Americans report a personal connection to Medicaid: they, their child, or a friend or family member have been covered by the program.<sup>8</sup>

In Iowa, a poll conducted right before the election found that 64 percent of likely voters said Medicaid privatization was a major consideration as they headed to the polls.<sup>9</sup>

The election is over, but Iowans' interest in Medicaid is surely not. Let's harness this public support to act: build on what's working, fix what's not, and make sure Medicaid is meeting the needs of Iowans.

There's evidence Iowa Medicaid's program isn't doing as well as it should at meeting their needs. For example, Iowa is falling well below the national average on some key performance measures, such as the share of children receiving recommended well-child visits and immunizations (see chart on page 6).<sup>10</sup>

That can be fixed, and doing so would not be new terrain. Iowans have a history of working together on innovative policies that meet our state's needs. In fact, Iowa was one of the earliest states to adopt the Medicaid expansion option made available by the ACA. Our bipartisan approach was a unique premium assistance model in use by only one other state at the time. A similar pragmatic approach is the way forward now.

Compared with uninsured peers, children covered by Medicaid and CHIP:



Miss fewer days of school



Do better in school



More likely to graduate high school



More likely to attend college



Earn higher wages



Pay more in taxes

Source: Georgetown Center for Children and Families, "Iowa Snapshot of Children's Coverage: How Medicaid, CHIP, and the ACA Cover Children."

## Guiding principle 2

### **Take advantage of Medicaid's flexibility to meet the needs of Iowans**

Medicaid is a federal-state partnership. States operate Medicaid programs within federal standards and a wide range of options, in exchange for federal matching funds.

As a result, each state Medicaid program is unique. For example, Missouri, North Carolina and Vermont have all used Medicaid flexibility to design models that coordinate care for individuals with chronic conditions to improve health service use and outcomes and reduce spending.<sup>11</sup> Iowa has taken advantage of the available flexibility to design one of the more extensive dental benefit packages.

This is an area where the current administration, not often a vigorous Medicaid defender, proclaims its support. Early in the Trump administration, Seema Verma, administrator of the federal Centers for Medicare & Medicaid Services

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(CMS) and then-HHS Sec. Thomas Price wrote to governors: "We wish to empower all states to advance the next wave of innovative solutions. ... States, as administrators of the program, are in the best position to assess the pay unique

needs of their respective Medicaid-eligible populations and to drive reforms that result in better health outcomes.”<sup>12</sup>

Iowa should take advantage of this offer of continued flexibility to look hard at our current program and make necessarily changes.

Guiding principle 3

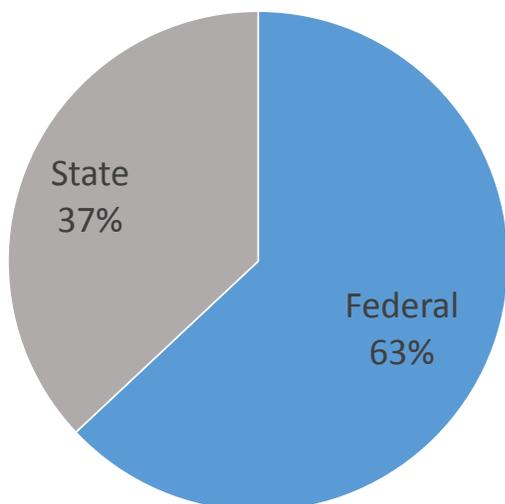
### Be skeptical of promises of cost savings

There’s no doubt Medicaid is a big budget item for states (if not as big as sometimes suggested). In FY 2014 Iowa’s total Medicaid budget was about \$4.2 billion, of which 63 percent was covered by the federal government. The state contributed about \$1.6 billion.<sup>13</sup> That makes Medicaid the state’s second-largest budget item, behind public education.<sup>14</sup>

As such, policymakers often look to cut Medicaid in order to balance state budgets. In fact, Gov. Terry Branstad presented the potential for significant cost savings as one of the major rationales for going to managed care in 2015.<sup>15</sup>

Since then, questions about the degree of cost savings to the state—and how exactly those cost savings are being achieved—continue to proliferate.<sup>16</sup> National analysis has found little evidence that Medicaid managed care models are able to achieve significant cost-savings—at least while

State and federal shares of total Iowa Medicaid spending, FY 2014



The federal contribution—Federal Medical Assistance Percentage, or FMAP—is based on a formula that takes into account the state’s average personal income. It’s calculated annually.

improving, or even maintaining, access and quality.<sup>17</sup>

This is less due to any particular failing of managed care, and more because Medicaid is already a highly cost-effective program. There’s simply not much fat to cut.

In fact, Medicaid actually provides more comprehensive benefits than private insurance at significantly lower out-of-pocket cost. Urban Institute researchers found that it costs about 22 percent less to cover an adult with Medicaid than with private insurance.<sup>18</sup> Medicaid’s costs per beneficiary have been growing more slowly than private-employer coverage, according to the MACPAC.<sup>19</sup>

Here are reasons it’s proven difficult to wring significant cost savings out of Medicaid without harming consumers:

- Reimbursement rates and administrative costs were already so low that it is hard to get additional cost savings. Iowa was using cost-containment measures like prior authorization and utilization review even before moving enrollees to managed care and Iowa’s per-member expenditure rate fell far below the national average in that period.
- Because Medicaid covers vulnerable populations, certain federal protections limit the extent to which states can charge premiums and cost-sharing.
- There is a disconnect between many proposed cost-containment strategies and the biggest drivers of Medicaid spending. Many reforms focus on Medicaid populations that are already relatively low-cost users. The largest share of costs in Medicaid are for services for the elderly and disabled, where there’s rightly little appetite for benefit or enrollment cuts (see chart X).<sup>20</sup>

Although we should be realistic about cost savings, that doesn’t mean we shouldn’t explore cost-saving strategies where we can. There’s great interest in strategies that show promise to reduce costs without harming enrollees. Here are several examples from the nonprofit health policy organization Community Catalyst:<sup>21</sup>

- Better leverage the health care workforce. Expanding access to nurse practitioners, community health workers and doulas can help Medicaid increase access to

the health care system—especially primary care that prevents small problems from being bigger problems—at equal quality and lower cost than physicians.

- Help high health care users manage their health more effectively. Focus more on the small percentage of Medicaid enrollees who drive a majority of the costs and provide them with services, skills or education to help more effectively manage their conditions. Doing so requires strengthening the role of care coordination and case management in managed care contracts.
- Tackle prescription drug costs. Although prescription drugs represent a lower share of spending in Medicaid compared with the private market, and Medicaid’s drug rebate program acquires medications at relatively low cost, there is still potential for states to save money by passing laws or applying for waivers that allow them to negotiate additional, supplemental rebates.

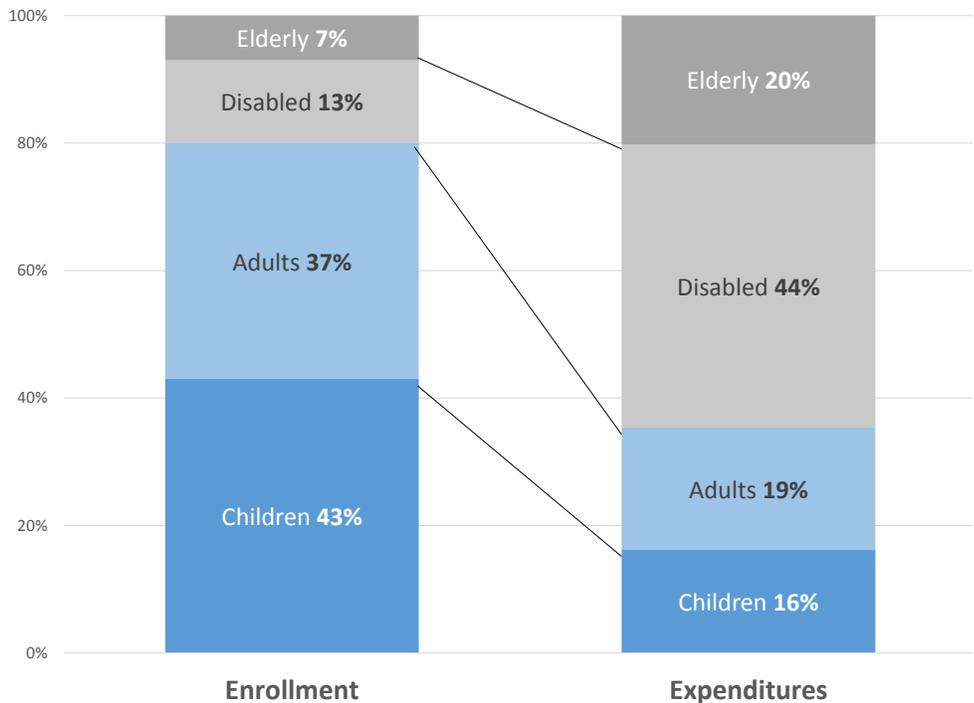
Guiding principle 4

**Think long-term**

Health practice is moving from solely treating disease and managing health conditions to addressing social determinants of health. The shift reflects growing evidence that socioeconomic factors, physical environment and health behaviors drive outcomes even more than medical care.<sup>22</sup>

States can design their Medicaid programs to facilitate this transformation—a long-term approach that is particularly critical for children. The National Association of Medicaid Directors submitted a letter to CMS Administrator Verma last year, arguing that “delivery system and payment reform for the pediatric population must reflect the unique healthcare needs of kids. In particular, social determinants

Iowa Medicaid enrollment and expenditures by population group, FY 2014



In Iowa, children and adults make up 80 percent of Medicaid enrollees but only represent 35 percent of total Medicaid expenditures. The elderly and disabled make up 20 percent of the Medicaid population but constitute 65 percent of total program cost.

of health and adverse childhood events are key cost drivers for children and impact their long-term health as adults.”<sup>23</sup>

The best models use Medicaid financing to provide comprehensive pediatric primary medical care along with other services that contribute to child health and well-being. These include screening for family risk factors like maternal depression, care coordination to identify family strengths and concerns and make referrals to other community resources, and augmented services like home visiting, early intervention and parenting programs.<sup>24</sup>

“Social determinants of health ... are key cost drivers for children and impact their long-term health as adults.”

But doing so in a managed care context requires deliberate choices. The economic incentives for MCOs to manage and coordinate care are best suited to the adult population. The payoff for managing adult chronic health conditions—reduced use of high-cost medical services—is immediate and within the contract period.

Performance on select Medicaid child core quality measures, Iowa and U.S., 2016

Percentage up-to-date on immunizations by age 2

Iowa	U.S.
24%	69%

Percentage receiving six well visits by age 15 months

Iowa	U.S.
50%	61%

Percentage age 0-3 receiving a developmental screening

Iowa	U.S.
12%	36%

Source: Centers for Medicare & Medicaid Services, 2016 Child Health Care Quality Measures

Iowa is falling well below the national average on some key child health performance measures reported annually to the federal government.

But cost savings for setting children on a healthy path to adulthood are only realized far outside the typical three-year contract period.

Although MCOs may well recognize the long-term benefits of this approach, the short-term nature of managed care contracts means it's unlikely to happen unless it's made deliberately. The state must set clear expectations—backed up by explicit fiscal incentives and sanctions—that MCOs meet evidence-informed guidelines for well-child care and that practitioners participate and are sufficiently reimbursed for doing so.

Iowa could consider several strategies to further this goal:

- Convene a Pediatric Advisory Group charged with developing a framework model for how best to improve child health outcomes.
- Move forward with a proposal to require managed care plans to have a Kids Quality Agenda and direct Iowa Medicaid Enterprise to develop a two-year effort to improve managed care plan performance on children and perinatal health care quality measures.
- Adopt a definition of medical necessity—the standard

dictating what services the state must pay for—for children that recognizes that the needs of children differ from those of adults.

Guiding principle 5

**Adopt evidence-based and -informed strategies and promising practices**

The striking fact made clear when reviewing the literature on Medicaid interventions is that there is a remarkably scant evidence base for many of the Medicaid reforms states pursue.<sup>25</sup> The evidence base for pediatric-specific interventions is even more limited because most practices are tested on the adult population.<sup>26</sup>

The state should adopt and expand strategies with a track record when it can. Iowa has tested evidence-based interventions in parts of the state like the Pediatric Integrated Health Homes for children. We know they improve physical and mental health outcomes for children. Iowa also has four pilot sites for the Centering Pregnancy group-based model of prenatal care, which has shown dramatic improvements in birth-related outcomes among Medicaid patients in communities with the poorest birth outcomes.

We should also learn from other states testing promising strategies. New York has created a broad-based First 1,000 Days on Medicaid Initiative based on the understanding that a child's first three years are the most crucial years of development. The effort is identifying ways to improve outcomes for young children and their families, working with health, education and other stakeholders to maximize outcomes for the children Medicaid serves.<sup>27</sup>

Iowa should test more of these innovative approaches in Medicaid and expand the ones that show results.

Guiding principle 6

**Embrace engagement, accountability and oversight**

Effective Medicaid programs create a seat at the table for Medicaid members and their families—making sure their voices are heard in design, implementation and oversight. Authentic member engagement is a powerful way to shape decisions and practices so they work well on the ground.

Iowa has great starting points. There's consumer representation on the Department of Human Services' Medical Assistance Advisory Council (MAAC)<sup>28</sup> and each of Iowa's MCOs includes members on some advisory boards.

"If you can't measure it, you can't improve it."

But more could be done. For example, Iowa could establish a state-level stakeholder planning and oversight committee with at least 50 percent of membership made up of Medicaid members

or require MCOs to have written plans on how they will ensure meaningful consumer engagement.

These structures can prove beneficial not only for consumers, but for MCOs, who get proactive real-time suggestions from members, instead of only hearing about grievances or problems after the fact.

Accountability also requires data. Right now, much of what the Iowa public knows about Medicaid's performance is based on anecdote. Those stories are powerful, but we need to know more. Iowa's Medicaid program must do a better job collecting, analyzing and disseminating a wide range of outcome data, including by race and ethnicity.

As management gurus say, "If you can't measure it, you can't improve it." Right now we cannot measure how well we are serving children of color in our state. A data request several years ago found DHS had enrollment data by race and ethnicity for just about 40 percent of children on Medicaid (and about 30 percent of children on hawk-i). Without that data, there is simply no way to know if we are equitably serving every Iowa child.

This is important, because across indicators, children of color in Iowa fare worse than white peers, and the gaps in outcomes are worse than in many other states.<sup>29</sup>

We must pair accountability with oversight. IME publishes extensive data in their quarterly reports but we must ensure that this oversight translates into data-informed action.

## Guiding principle 7

### Protect coverage gains

Iowa has seen substantial reductions in the share of uninsured children and adults in recent years thanks to Medicaid. Today, 97 percent of Iowa kids are covered.<sup>30</sup> The share of low-income Iowa adults without insurance went down about 13 percentage points between 2008-09 and 2015-16, periods before and after Iowa expanded its Medicaid.<sup>31</sup>

We must make sure any Medicaid reforms don't result in backsliding. We have seen from other states that barriers like work requirements, lockout periods and time limits have been used to reduce enrollments and cut costs.<sup>32</sup> For example, since August, 12,000 Medicaid beneficiaries in Arkansas have lost coverage for not complying with the state's work requirements. Similar requirements in Kentucky have tied the state up in costly and ongoing litigation. Neither example is one Iowa should follow.



The relatively low level of uninsured Iowans is a reflection of the policy and programmatic decisions our state leaders have made to expand coverage for Iowa's children and families. It reflects the system we created based on shared belief that kids and their families should have access to health care. It's a true success story.

Medicaid exists to connect families to the care they need, not to add barriers to getting and staying healthy. So let's not backtrack on recent coverage gains.

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