STATE Health & Value STRATEGIES

A Better Way to Manage Medicaid Costs

Many states are experiencing budget shortfalls due to the COVID-19 induced recession.[1] Since Medicaid accounts for a significant portion of states' budgets, states often look to the Medicaid program for savings. In the Great Recession, states frequently cut provider payments and, in some cases, enrollee benefits[2] to generate savings.[3] Although these are not states' preferred policy options because of the negative impact on enrollee access to care, states may turn to these approaches when they need to generate quick savings. Since the Great Recession, states have invested in initiatives that can improve care and also lower costs—such as improving coordination of behavioral health and physical health services, making home and community-based options more available to those who might otherwise go into nursing homes, addressing social drivers of health, and lowering pharmacy costs. Not all of these initiatives can generate short-term savings, but they offer other actions that states facing budget shortfalls may take to achieve savings. The chart below outlines state options to address Medicaid spending without harming enrollee health and provider stability and access to care. While each of the options listed is less of a "quick fix" than a straightforward cut, some have potential for short- and medium-term impacts, and these types of actions are likely to pay off for years to come.

Concept	Overview	Magnitude	Timeline for Potential Savings[4]	Examples
Pharmacy				
Require pass-through pharmacy benefit manager (PBM) pricing	Under many PBM agreements, PBMs profit based on the "spread" or the difference between what the plan pays the PBM and the PBM pays the pharmacies, with the plans unaware of the prices that the PBMs actually pay for the drugs. To ensure that plans are better able to negotiate effectively, states could require that plans only enter into arrangements with PBMs that feature "pass-through pricing," under which the plan pays for exactly what the PBMs pay to the pharmacies plus a negotiated administrative fee. This would eliminate excess profits for PBMs.	Medium	**Short-term.** Available at beginning of next contract year.	Washington, Oregon, Indiana, South Carolina, and others[5]
Require use of single statewide PBM	The PBM market is highly consolidated, with three PBMs covering 71 percent of all Medicaid membership.[6] Health plans, especially in states with large numbers of Medicaid managed care plans, may lack negotiating leverage. A state can save money by procuring a single PBM to serve all plans in the state. The state's contract with the PBM would likely be under a pass-through payment model.	Medium	**Medium-term.** Would require procuring PBM, which would likely take about one year.	Ohio
Increase use of supplemental rebates	States can seek to increase supplemental rebates from manufacturers by, among other tactics, requiring public reporting on drug costs or accounting for supplemental rebates in developing preferred drug lists (so long as decisions are consistent with appropriate clinical guidance). To ensure this leads to savings, states should focus on the total cost of the drug, not just the supplemental rebate, since	Medium	**Medium-term**. Negotiating supplemental rebates may take some time.	New York

[1] State Health and Value Strategies (SHVS), How States Are Managing the COVID-19 Recession and the Implications for State Health Programs, January 28, 2021.
[2] To qualify for the enhanced Federal Medical Assistance Percentages (FMAP) under the American Recovery and Reinvestment Act, states needed to maintain eligibility levels.
[3] Kaiser Family Foundation, Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends, September 2010.
[4] "Short-term" refers to budget savings that would accrue within one year; "medium-term" within one to three years; and "long-term" refers to four or more years to achieve savings.
[5] Center on Budget and Policy Priorities, Options to Reduce State Medicaid Costs: Prescription Drugs, October 14, 2020.
[6] FierceHealthcare, Senate Hearing Puts Spotlight on Debate Over Consolidation in PBM Market, April 11, 2019.

Concept	Overview	Magnitude	Timeline for Potential Savings[4]	Examples
	higher cost drugs may be overall more expensive despite significant supplemental rebates.			
Pursue value-based payment (VBP) models for high-cost drugs	States can adopt outcomes-based payment arrangements, under which supplemental rebates vary based on patients' outcomes. Alternatively, states can enter into "subscription" models for high-cost drugs (e.g., Hepatitis C drugs), under which the state pays a flat fee for an unlimited number of drugs.[7]	Medium	**Medium-term.** Negotiating VBP arrangements may take nearly one year. Savings are not likely to accrue for one or two more years.	Louisiana and Washington
Regulate Markets				
Regulate hospital consolidation	Markets for hospitals are highly consolidated, with one hospital system accounting for more than 50 percent of the discharges in most markets.[8] In some cases, hospital consolidation may be beneficial and help preserve access to care (e.g., consolidation of a rural hospital into a larger health system). Hospital consolidation often leads to higher commercial market prices[9] and may similarly lead to higher prices in Medicaid managed care. States could increase scrutiny of hospital mergers and potentially solicit guarantees on Medicaid pricing as part of the merger review.	Small[10]	**Long-term.** Ramping up antitrust enforcement or other regulatory review is likely to take one to two years, and the impact may take several more years to materialize.	Massachusetts
Limit profits for certain types of providers	For-profit providers—particularly those with significant investment from private equity or similar funding sources—have increased in some sectors, like skilled nursing facilities. There are concerns that these providers may emphasize profitability at the expense of quality patient care. Preliminary evidence, for example, suggests that for-profit nursing homes are performing worse than not-for-profit with respect to COVID-19 infections and deaths.[11] States could cap profits in nursing facilities by applying something like a medical loss ratio (MLR) in Medicaid. In other words, nursing facilities would be required to spend a minimum percentage of their Medicaid dollars on patient care. Those that fall short would be required to refund the excess dollars to the Medicaid program. States could also explore applying this MLR beyond Medicaid.	Small	**Medium-term.** May require legislation and would take at least one year for any reporting and rebates to occur.	New Jersey

[7] Center on Budget and Policy Priorities, Options to Reduce State Medicaid Costs: Prescription Drugs, October 14, 2020.
[8] Medicare Payment Advisory Commission (MEDPAC), Report to the Congress: Medicare Payment Policy, March 13, 2020.
[9] Medicare Payment Advisory Commission (MEDPAC), Report to the Congress: Medicare Payment Policy, March 13, 2020.
[10] Data is more conclusive on the impact of hospital consolidation on the commercial market; it is unclear to what extent hospital mergers increase prices in Medicaid managed care.
[11] Nonprofit Quarterly, Study Finds More COVID Deaths in For-profit Nursing Homes than Nonprofit Ones, August 19, 2020.

Concept	Overview	Magnitude	Timeline for Potential Savings[4]	Examples
Enhance Managed Care Organization (MCO) Oversight				
Create enforceable MLR/increase MLR rebate threshold	States are permitted, but not required, to require rebates from MCOs that fail to meet MLR thresholds.[12] Currently, only 25 states have an MLR rebate requirement.[13] States that do not currently have a rebate requirement could enact one to ensure that plans are not profiting unduly in the Medicaid program, particularly now when utilization of services has sharply declined due to the pandemic. States with a mandatory rebate could explore increasing the MLR threshold to better align with the administrative load built into capitation rates. For example, if a state assumes that 8 percent of the premium is used for administrative costs (including profit), then then MLR should be 90 to 92 percent, rather than 85 percent. States must repay the federal government the federal share of any rebate payments, except that for the expansion population, they may use the non-expansion match rate enabling the state to keep a larger share of the rebates.[14]	Medium	**Medium-term.** Requires amending contracts and then no rebates would be paid until months after the contract year ends.	Virginia, New Mexico, and Nebraska
Establish risk corridors	Like MLR rebates, a risk corridor ensures that MCOs do not reap unexpected profits in the Medicaid program, since any profits in excess of the risk corridor would be returned in whole or in part to the state. Two-sided risk corridors, where the state also agrees to pay additional amounts to MCOs if costs exceed expectations, also enable the state to set rates toward the lower end of any actuarially sound range, since the MCOs have protection against high utilization.	Medium	**Medium-term.** Incorporating a risk corridor into contracts and rates likely must wait for the next contract year. Any repayments would occur more than one year after the contract amendment takes effect to allow for end-of-year claims runout.	Michigan
Extend Coverage				
Expand Medicaid (limited to states that have not yet expanded)	Medicaid expansion generates savings by reducing costs for state-funded services that could otherwise be funded through Medicaid (e.g., behavioral health services), reducing costs for inmates receiving inpatient care in community hospitals, and generating higher matching rates for some Medicaid enrollees (e.g., expansion adults who become pregnant), among other things.[15] The twelve remaining states that have not yet expanded Medicaid could generate significant savings from expansion.	Medium	**Short-term**. Medicaid expansion can be implemented within one year.	39 States (Including Washington D.C.)

[12] 42 C.F.R. § 438.8.
[13] Center on Budget and Policy Priorities, Options to Reduce State Medicaid Costs: Managed Care Medical Loss Ratio, August 31, 2020.
[14] Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) (Pub. L. 115-271, enacted October 24, 2018), § 4001.
[15] SHVS, States Expanding Medicaid See Significant Budget Savings and Revenue Gains, March, 2016.

Concept	Overview	Magnitude	Timeline for Potential Savings[4]	Examples
Expand coverage in the postpartum period	Currently, Medicaid eligibility for pregnant women extends only 60 days postpartum. By extending coverage for 12 months, consistent with current evidence of postpartum health risks—women are more likely to get the cost-effective care that they need to: (1) manage any postpartum complications; and (2) identify and address underlying health conditions that may otherwise result in increased morbidity in the medium- and long-term. Several states are currently seeking Section 1115 waivers to extend postpartum coverage beyond 60 days.	Unknown	**Medium- to Long-term.** Savings (e.g., from identifying and addressing health conditions early, better birth outcomes, birth spacing, reductions in churn) may take several years to materialize.	Illinois and New Jersey[16]
Focus on individuals at risk of needing institutional level of care	Many individuals become eligible for Medicaid only when they need nursing facility levels of care. That means individuals must wait until their health worsens to qualify for Medicaid. By providing Medicaid funded services to individuals "at risk" of needing nursing facility levels, states may be able to help them stay healthier and in the community by delaying the need for more intensive care.	Medium	**Long-term.** States must seek a Section 1115 waiver to cover these populations, and securing such a waiver may take one year or more. Significant savings may take a few years to materialize after program launch.	Vermont and Washington[17]
Explore converting state-funded behavioral health services to Medicaid	Many states cover a broad range of behavioral health services outside of the Medicaid program.[18] States could explore whether some of those services might qualify as Medicaid services, and, if so, incorporate those services into the Medicaid benefit package for Medicaid-enrolled individuals.[19] By doing so, states can reduce the cost of the behavioral health services on their state budgets.	Low-Medium, depending on extent of state-funded behavioral health services	**Short-term**. After analyzing their state-funded benefits, states would submit a State Plan Amendment (SPA) to include these services in the benefit package. States would begin receiving federal dollars effective as early as the first day of the quarter in which the SPA is submitted.	Many States
Telehealth				
Expand access to telehealth, potentially including offering	During the COVID-19 pandemic, use of telehealth has dramatically increased.[20] Preliminary analyses suggest that telehealth is used as a substitute for more expensive urgent care or emergency department utilization for many conditions. In	Medium	**Short-term**. The COVID-19 pandemic demonstrated that states can quickly expand access to telehealth services.	North Carolina and Michigan

[16] Both states are seeking Section 1115 waivers to extend postpartum coverage for women with incomes above 138 percent of the federal poverty level (FPL). Kaiser Family Foundation, Expanding Postpartum Medicaid Coverage, December 21, 2020.

[17] While Washington State's Tailored Supports for Older Adults (TSOA) program does not make individuals who are "at risk" of needing nursing facility levels of care eligible for Medicaid, it does provide a limited set of services to individuals "at risk" of needing long-term services and supports (LTSS). Washington State Health Care Authority, TSOA, July 16, 2019.

[18] Milbank Memorial Fund, State Options for Medicaid Coverage of Inpatient Behavioral Health Services, November 6, 2019; and The Commonwealth Fund, The Impact of Medicaid Expansion on States' Budgets, May 5, 2020.

[19] States do not need to do this for all adult enrollees if they use an alternative benefit plan. Instead, they could limit it to the expansion population.

[20] Manatt Health, Executive Summary: Tracking Telehealth Changes State-by-State in Response to COVID-19, January 28, 2021.

Concept	Overview	Magnitude	Timeline for Potential Savings[4]	Examples
financial support to providers to purchase equipment needed for telehealth	the case of behavioral health services, telehealth has increased utilization of services above the pre-pandemic baseline. It is unclear whether utilization has increased because of an uptick in mental distress due to the pandemic or because improved access to services has led more people to seek treatment for pre-existing conditions. Either way, expanded access to telehealth for behavioral health may improve treatment of behavioral health conditions and avoid either emergency department utilization for enrollees in crisis or worsening of physical health conditions.			
Financing				
Implement new/increased provider fees	Nearly all states use provider fees or taxes—most commonly on hospitals and skilled nursing facilities—to fund a portion of their Medicaid programs.[21] States could implement new provider taxes or increase existing ones to maintain current funding levels or enhance them. Taxes take a toll on providers by reducing the net payments they receive (unless the tax is paired with enhanced rates), but because payments and services remain intact, the impact is less severe.	Small, Medium, or Large depending on current level of taxes	**Short-term.** Available shortly after legislative enactment.	Alabama, Illinois, and New Jersey[22]

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[21] SHVS, Provider Donations and Assessments: Options for Funding State Costs of Medicaid Expansion, March 2016; and SHVS, Finishing the Job of Medicaid Expansion, January, 26, 2021.

[22] These are examples of states that raised or created new provider taxes in 2019. National Conference of State Legislatures, State Tax Actions Database, February 2, 2021.

ABOUT MANATT HEALTH

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