The NEW ENGLAND JOURNAL of MEDICINE

Perspective

JULY 20, 2017

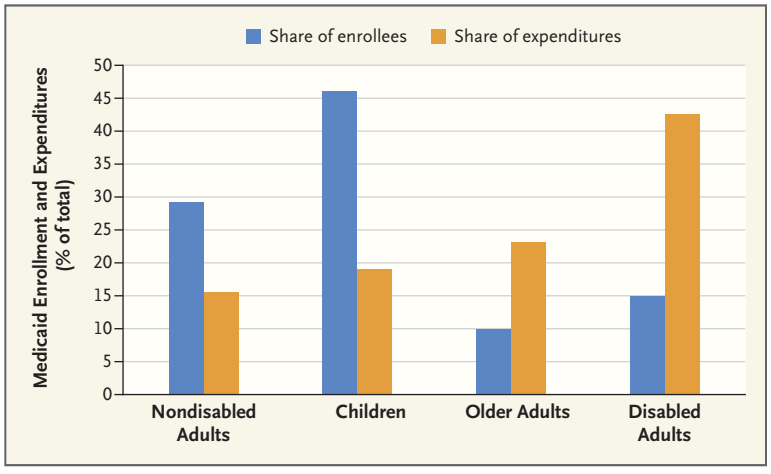
Controlling the Cost of Medicaid

K. John McConnell, Ph.D., and Michael E. Chernew, Ph.D.

The federal–state Medicaid program is facing the possibility of the largest and most consequential changes to its funding since its inception in 1965. The American Health Care Act (AHCA), H.R. 1628, as adopted by the House of Representatives on May 4, would replace the current federal matching program for Medicaid with a per capita cap on federal funds. This cap would limit the growth of these funds to the growth rate of the medical care component of the Consumer Price Index, with an additional 1% growth allowed for older adult and disabled Medicaid enrollees. The Congressional Budget Office has projected that this policy would result in federal funding reductions of more than $800 billion over the next 10 years, equivalent to a 26% reduction in federal support by 2026.[1] These large reductions represent an unprecedented shift of financial risk to the states. Missing from the debate has been consideration of policies that could improve the value of the Medicaid program, controlling Medicaid spending without diminishing coverage or quality.

We believe that any Medicaid-reform proposals should be grounded in the realities of this complex and frequently misunderstood program. Despite a great deal of focus on potential changes affecting "able-bodied" adults, such people represent a minority of Medicaid enrollees and account for a relatively small percentage of total Medicaid spending (see graph). Furthermore, Medicaid has generally been a low-cost means of providing coverage: risk-adjusted expenditures for adult Medicaid beneficiaries are approximately 22% lower than expenditures for adults covered by private insurance,[2] and per capita spending has grown more slowly in Medicaid than in either Medicare or commercial insurance for the past 15 years.[3]

One opportunity for bipartisan compromise in Congress may be in the area of flexibility for states with regard to Medicaid. Traditionally, states have used Social Security Act Section 1115 waivers to experiment with approaches that do not adhere to federal Medicaid rules. In an effort to improve the transparency of the decision-making process regarding such waivers, the Affordable Care Act (ACA) increased procedural requirements for requests and renewals, potentially increasing the administrative and regulatory burden for states. Republicans have signaled an intent to pass reforms that give states more flexibility, with less federal oversight.



Medicaid Enrollment and Expenditures, by Eligibility Group, Fiscal Year 2013.

Data are from MACStats: Medicaid and CHIP Data Book (December 2016) (www.macpac.gov/publication/macstats-medicaid-and-chip-data-book-2).

Although Democrats are unlikely to support flexibility that would, for instance, allow states to implement work requirements for Medicaid eligibility, many states have expressed interest in greater leeway on other fronts, such as alternative payment models that would move Medicaid programs away from fee-for-service approaches. Relaxing some federal requirements could accelerate such efforts and make them more effective. For example, federal regulations impose strict "actuarial soundness" requirements for Medicaid managed-care plans, requiring payment to be closely tied to medical utilization data.[4] Though well intentioned, this focus on the volume of services as a basis for reimbursement limits states' opportunities to pursue alternative payment models. Flexibility that facilitates payment approaches designed to slow overall spending and improve outcomes may be an opportunity for bipartisan efforts that could benefit patients and taxpayers.

In addition, recent discussions about Medicaid have generally overlooked the role of long-term services and supports, yet almost half of Medicaid spending (47% in fiscal year 2013) has been devoted to this area. Historically, the incentives created by the payment system for long-term services have been misaligned with care and spending goals, tending to favor nursing facilities and institutional-based care over home- and community-based services. Conflicting incentives have been particularly problematic for the 11 million dual-eligible beneficiaries covered through Medicare and Medicaid, a group that uses a disproportionate amount of long-term services and supports and must contend with the fragmentation of care that results from coverage provided by two separate programs.

Several programs have attempted to correct these incentives. For example, the Money Follows the Person demonstration program provides enhanced federal funds to help transition Medicaid beneficiaries from institutional settings to home- or community-based services. The Program of All-Inclusive Care for the Elderly (PACE) pools Medicare and Medicaid funding into a single capitated payment, allowing beneficiaries to receive a high level of care but remain in their communities. Other efforts — including waivers for home- and community-based services, managed long-term services and supports, and the ACA's dual demonstration projects, which aim to integrate care, financing, and administration for dual-eligible beneficiaries — offer various mechanisms for improving payment and coordination among these services. Many of these efforts are too new to have been rigorously evaluated, and the evidence of substantial cost savings is not robust, in part because the programs have not been widely implemented. Nonetheless, addressing patients' needs for long-term services will probably require a variety of strategies to support patient choice and meet the complex needs of populations in various settings, so continued innovation is crucial.

Unfortunately, proposed Medicaid cuts have the potential to exacerbate existing inefficiencies in the long-term services market.[5] In particular, since home- and community-based services are generally classified as "optional" benefits, states may opt to cut these services when faced with reductions in federal support. Given the significance of long-term services to Medicaid spending and the vulnerable populations that rely on them, we believe that both political parties should support policies that focus on incentives as a mechanism for improving and sustaining their value.

Democrats and Republicans may also find common ground in continued efforts to improve the

integration of physical and behavioral health care. Integrated care models, which allow patients to receive primary care and treatment for behavioral health conditions in the same setting, have been associated with improved patient outcomes and, according to some studies, lower health care spending. These programs are particularly salient for the Medicaid population, which has a higher prevalence of mental health and substance abuse conditions than the general population. Bipartisan support is needed to clarify and simplify licensing and scope-of-practice requirements for various health care professionals that currently impede the spread of integrated care models.

Both parties should be able to support policies that address the high cost of prescription drugs. Drugs have been an important driver of health care costs in recent years, with Medicaid spending on prescription drugs increasing by 24% in 2014, for example.[5] The Medicaid Drug Rebate Program, designed to guarantee Medicaid a "best price" for prescription drugs, has left states vulnerable to the high costs of brand-name drugs with little competition. In particular, the rebate program limits states' flexibility to exclude low-value drugs from formularies (potentially restricting opportunities for favoring high-value therapies) and provides no mechanism for states to negotiate lower prices.

Bipartisan efforts to modify the rebate program may open up new avenues for addressing drug spending. For example, the implementation of value-based purchasing for high-cost specialty drugs has been hampered by requirements imposed by the rebate program as well as by a lack of clarity about the criteria that could justify targeted coverage policies for certain drugs. With bipartisan support for implementing value-based purchasing, states could be given greater flexibility in determining coverage guidelines or be granted waivers that address aspects of the rebate program that impede value-based purchasing. In addition, the federal government could consider providing greater support for volume purchasing by multiple states or revising the drug rebate program to create a federal–state negotiating pool, which might provide pricing and rebate options that are beyond the current reach of most single-state or multistate approaches.

A dynamic policy environment and the increased role of the Medicaid program may stimulate a variety of policy proposals in the near future. The greatest benefits to public health and the largest returns on the taxpayer dollar will come from an honest acknowledgment of the program's successes and weaknesses and the pursuit of policies tailored to the realities of Medicaid and the populations it covers.

Disclosure forms provided by the authors are available at NEJM.org.

From the Center for Health Systems Effectiveness and Department of Emergency Medicine, Oregon Health and Science University, Portland (K.J.M.); and the Department of Health Care Policy, Harvard Medical School, Boston (M.E.C.).

This article was published on June 14, 2017, at NEJM.org.

1. Smith VK. Can states survive the per capita Medicaid caps in the AHCA? Health Affairs Blog. May 17, 2017 (http://healthaffairs.org/blog/2017/05/17/can-states-survive-the-per-capita-medicaid-caps-in-the-ahca/).
2. Coughlin TA, Long SK, Clemans-Cope L, Resnick D. What difference does Medicaid make? Menlo Park, CA: Kaiser Family Foundation, 2013 (https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf).
3. Report to Congress on Medicaid and CHIP. Washington, DC: Medicaid and CHIP Payment and Access Commission, June 2016 (https://www.macpac.gov/wp-content/uploads/2016/06/June-2016-Report-to-Congress-on-Medicaid-and-CHIP.pdf).
4. Mendelson A, Goldberg B, McConnell KJ. New rules for Medicaid managed care — do they undermine payment reform? Healthc (Amst) 2016;4:274-6.
5. Solomon J, Schubel J. Medicaid cuts in House ACA repeal bill would limit availability of home- and community-based services. Washington, DC: Center on Budget and Policy Priorities, May 18, 2017 (http://www.cbpp.org/research/health/medicaid-cuts-in-house-aca-repeal-bill-would-limit-availability-of-home-and).

DOI: 10.1056/NEJMp1705487

Active Surveillance for Low-Risk Cancers — A Viable Solution to Overtreatment?

Megan R. Haymart, M.D., David C. Miller, M.D., and Sarah T. Hawley, Ph.D.

There is wide variation in the intensity of treatment for low-risk cancers, and many patients are at risk for overtreatment. Despite 5-year survival rates that approach 100% among patients with low-risk differentiated thyroid cancer, prostate cancer, and ductal carcinoma in situ (DCIS) of