2020 Emerging Trends in Public Programs

UnitedHealthcare Community & State

July 2020

United Healthcare®

2020 Emerging Trends

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In 2018, health care spending in the United States reached $3.6 trillion.[1] According to the Centers for Medicare and Medicaid Services (CMS), health care spending is projected to grow at an average annual rate of 5.4% between 2019 and 2028, reaching over $6 trillion in total spend by 2028.[2] Of the over $3.6 trillion spent in 2018, Medicaid's share was 16% or almost $600 billion.[3] As a result, Medicaid accounts for one out of every six dollars spent on health care while covering one in every five Americans (or approximately 72 million people).

Prior to COVID-19, Medicaid enrollment was projected to remain flat through 2020. However, Medicaid spending was slated to increase by about 4% to over $630 billion. This projected increase was due in part to rising drug costs (in particular - specialty drugs), provider rate increases, and the increasing costs associated with caring for the aging population and people with disabilities (costs related to hospitals, nursing facilities, and increased utilization of long-term services and supports).[4] Currently, both Medicaid enrollment and spending are increasing given both the high unemployment rate that has left millions of Americans without access to employer-sponsored health care coverage, and the additional resources required to fight the pandemic.

Given the enrollment and cost pressures that exist in the Medicaid system (and that are being amplified by the public health emergency), states are responding by using their granted autonomy to require continuous adaptation by providers and Managed Care Organizations (MCOs), and to drive increased alignment between the Medicaid and Medicare systems.

The research and analysis for this paper was conducted prior to the outbreak of the COVID-19 pandemic.

Given the public health crisis, the landscape of the entire U.S. health care system, and the entire economy, is shifting. However, the health care policy and practice trends detailed here remain, though they will shift or be amplified due to the pandemic. Additionally, included are new trends that have emerged through the public health emergency that may have long-term implications for state health care agencies, managed care organizations, and the overall health care delivery system.

In this report, we detail the 10 specific actions that states and the federal government are taking in response to these system pressures and begin to outline just five of the trends that we see emerging from the COVID-19 pandemic.

Trend 1: Deregulation and Increasing State Autonomy

Deregulation and increasing state autonomy have been prominent policy goals of the current federal administration. Many states have pursued various waiver authorities and considered policy levers available in the Medicaid system that give them the flexibility to (re)structure their Medicaid programs. Two examples of this trend are the consideration of alternative federal funding mechanisms (e.g., Block Grants) and focus on eligibility verification processes to ensure Medicaid rolls reflect those appropriately eligible for the program.

In January 2020, CMS released a State Medicaid Director Letter detailing a new Block Grant option for states to pursue through Section 1115 Demonstration Waivers. The Healthy Adult Opportunity (HAO) Waiver targets individuals under age 65 that are not disabled or in need of long-term services and supports (LTSS). States that pursue this option will have significant new leeway in designing the benefit package and delivery system supporting these enrollees, while likely tightening spending to meet their allotted federal share.

In 2019, several states instituted new Medicaid eligibility systems or enhanced their eligibility verification and renewal processes. These actions were instituted in part in response to a report from CMS that identified several eligibility components that were driving payment errors, including states not conducting annual redeterminations in a timely manner.[5] Some of the point-in-time redetermination actions taken by states did result in enrollment decreases for both adults and children.

Trend 2: Medicaid Expansion and Consumer Engagement

As of July 2020, 38 states (including the District of Columbia) have adopted Medicaid Expansion.[6] Several states are currently using ballot initiatives to try to expand Medicaid while others are considering legislative action in their states. Nebraska anticipates implementation of Medicaid Expansion in October of this year following its approval in 2018 through a voter-backed ballot initiative.

As the number of states implementing Medicaid Expansion continues to increase, so too does the number of states exploring community engagement requirements (also referred to as “work requirements”). As of July 2020, 10 states have sought and received waiver authority from CMS to implement community engagement requirements (Arkansas, Arizona, Indiana, Kentucky, Michigan, New Hampshire, Ohio, South Carolina, Utah, and Wisconsin).[7] An additional nine states have Section 1115 Waivers pending that include community engagement requirements (Alabama, Georgia, Idaho, Mississippi, Montana, Nebraska, South Dakota, Tennessee, and Virginia).[8] South Carolina, following CMS waiver approval in mid-December, will be the first non-Expansion state to require community engagement requirements for parents of children with incomes under 100% of the Federal Poverty Level (FPL).[9]

While several states are pursuing community engagement requirements, others are pulling back on their efforts given the active court proceedings that are considering the authority of the Department of Health and Human Services (HHS) to allow the implementation of work requirements in Medicaid.

Trend 3: Variations on the Individual Exchange

A continuing trend from last year is state consideration of Medicaid Buy-in or Public Option programs, which leverage Medicaid or other affordable coverage options for individuals who are working and earn too much to qualify for Medicaid, but have difficulty affording coverage on the Individual Exchange. Two states leading this effort are Colorado and Washington.

- **Colorado:** The state's 1332 waiver was approved, and the state drafted a 2021 implementation framework for a Public Option insurance product. It would require insurers that have a certain market share to offer a state option through the Exchange.
- **Washington:** Currently is the only state to have passed Public Option legislation, which was signed by the Governor in May 2019. Plans participating on the Exchange are required to offer at least one "standard" plan at every level. Coverage is available to all Washington residents regardless of income.

Trend 4: Using Procurement Levers

As state Medicaid agencies broaden the size, scope, and complexity of their programs, they are leveraging the procurement process to raise the bar on expectations for their MCO partners to meet. Examples of this trend in action include:

- States are increasingly leveraging MCO contracts and the procurement process to require the deployment of integrated care models and the delivery of **comprehensive behavioral health services.**
- State Medicaid agencies are using Requests for Proposals (RFPs) to transition **care coordination services from MCOs to provider entities** such as health homes, Patient-Centered Medical Homes (PCMHs), or Accountable Care Organizations (ACOs).
- States are increasingly showing signals – both explicitly and implicitly in RFPs – that MCOs are expected to bring together disparate parts of the health delivery system **to improve the health and well-being of entire populations and communities.**
- States are using the Medicaid procurement process to require **alignment of Medicaid and Medicare,** and to influence Medicare Advantage product offerings and program designs.

Trend 5: Access to Care

States are pursuing both policy changes and procurement initiatives to encourage the use of underutilized services and overcome long-time barriers to access by changing the common definitions for who should deliver which health care services, how those are delivered, and in what locations. Additionally, not all populations in Medicaid have equitable access to care (e.g., children, older adults, rural areas, individuals involved in the criminal justice system) and states are looking at innovative strategies to meet their particular needs to live a healthy life. As a result of these trends, MCOs are being expected to leverage new technologies, work with new providers, and cultivate relationships with community-based organizations.

With support from the federal government, **alternative sites of care** that are more accessible and convenient for members, cost effective, and promote improved outcomes are being considered and incentivized by states. State Medicaid programs are also trying to maximize the capacity of current providers to better meet the needs of their members. As a result, more attention is

turning to **allied health professionals, such as community health workers and peer specialists,** who can supplement clinical capacity and work at the intersection of health and community. There is a renewed interest from CMS and state policymakers in innovative solutions specific to **rural areas,** particularly in how care is financed and designed to meet the unique needs of local communities. Interest in the growth and sustainability of **school-based health services** has increased in recent years as communities and state policymakers seek to improve access to health care services for children and adolescents that are tailored to their needs, particularly behavioral health services.[10, 11] Prior to the COVID-19 pandemic, states had primarily established **telehealth** as a requisite strategy for delivering services in underserved areas and maximizing provider capacity when specialty care is scarce, particularly in rural communities. As a result, states were modifying regulations to authorize Medicaid reimbursement for a broader array of services, sites of service, and providers delivering care via telehealth.[12] There are more details in the COVID-19 emerging trends section on how the focus on telehealth has evolved.

Trend 6: Delivery System Reform

Delivery system reform includes a variety of activities designed to change the way care is delivered and to promote more efficient and effective health care. These initiatives are often coupled with payment reforms designed to incentivize quality. Over the last year, there have been a proliferation of new delivery and payment models that are intended to improve the quality of care delivered to patients and reduce unnecessary utilization.

At the federal level, the Center for Medicaid and Medicare Innovation (CMMI) has continued to develop and evaluate new delivery system reform models for different types of providers, patients, and populations. The most recent models are: Direct Contracting models, the Integrated Care for Kids (InCK) and Maternal Opioid Misuse (MOM) models, Primary Care First, and the Emergency Triage, Treat, and Transport (ET3) models. At the state level, Medicaid leaders continue to use their MCO contracts to hasten innovation and accelerate payment reform. **They are increasingly requiring MCOs to use value-based payments (VBP) to address health disparities, improve care delivery for individuals with complex care needs (e.g. dual eligibles, individuals with social needs, and pregnant women/new moms), build partnerships across the delivery system, and engage providers in preparing to take on greater financial accountability for populations.**

Trend 7: Pharmaceuticals

Despite being an "optional" Medicaid benefit, pharmacy spend continues to increase. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), Medicaid spent $64 billion in 2017 on outpatient prescription drugs—a 48.15% increase in gross expenditures compared to 2014.[13] With new blockbuster drugs coming online that have great clinical potential and significant price tags, state Medicaid programs are proactively identifying delivery and budget models that control costs, increase transparency, and support providers, all while ensuring access to needed medications for members. Prevalent policy levers being used by states to achieve these goals are:

- **Alternative Payment Models (APM):** Under these models, a drug manufacturer's reimbursement is tied to an agreed upon outcome, either financial or health-based. Colorado, Michigan, and Oklahoma have all received approval from CMS to use APMs to pay pharmaceutical drug manufacturers based on outcomes.[14]
- **High Cost Drug Management:** As states determine ways to manage the incredible costs of new "specialty" drugs, biologics, and gene therapies, they are looking at partnerships with MCOs to manage these high-cost medications within the pharmacy benefit. Management tools being considered and utilized are risk sharing, risk pools, supplement or kick payments, and medication-specific carve-out from the managed care benefit with claims paid through fee-for-service Medicaid.

- **Pharmacy Carve-Out:** As states look for ways to manage costs and increase transparency in pharmacy spend, an increasing number are exploring removing or "carving-out" pharmacy as a covered benefit by managed care. This trend is playing out in a variety of states—Florida, New Jersey, New York, and Texas—though activity is different in each and timelines vary. An additional state, Michigan, explored a pharmacy carve-out proposal but ultimately pulled back from the effort and is moving forward with a single, statewide Preferred Drug List.
- **Single, Statewide Preferred Drug List (PDL):** Supporters of a single, statewide PDL cite it as a budget tool to maximize rebate dollars for the state, while providers are supportive due to perceived administrative simplification. Prior to this year, there were 13 states that used MCOs to manage their Medicaid programs utilizing a single, statewide PDL. As of the start of 2020, Arizona, Florida, Kansas, Louisiana, Mississippi, Nebraska, North Carolina, Ohio, Pennsylvania, Texas, Virginia, and Washington have a single, statewide PDL for all Medicaid MCOs, and Michigan is looking to implement later in the year.[15]
- **Pass-Through Pricing:** State contracts and RFPs are increasingly requiring the use of pass-through pricing (in lieu of spread pricing) in order to create more transparency in the reimbursement process. Under a pass-through model, payments for pharmacy claims are completely "passed through" from the MCO to the pharmacy. The MCO then pays an administrative fee to the Pharmacy Benefit Management (PBM) to support base claims and manage activities. For MCOs and/or states that wish to add additional supplemental services for consumers such as medication therapy management, MCOs pay an additional fee to the PBM for these services.

Trend 8: Social Determinants of Health

Across the health care and human services spectrum, organizations continue to research and explore ways to address the negative impacts of social determinants of health (SDOH) that influence health and well-being in order to improve health outcomes and lower costs. This continued and widespread attention on the costs and impacts of SDOH is driving activities among all health care stakeholders, including policymakers, payers, and providers.

State Policy and Procurement Activities

States continue to look to MCOs for innovative solutions through RFPs, contract requirements, or demonstration pilots that focus on the root causes of poor health outcomes. Last year, over three-quarters of states with managed care (35 states) leveraged their MCO contracts to advance at least one strategy to address SDOH. Even in non-MCO states, there are efforts to address SDOH through various initiatives.[16] In many states, policymakers continue to promote SDOH-related initiatives, including housing, education, and employment. In 2019, governors in 10 states released plans to reconfigure their cabinets to better address the conditions that affect health, including proposals for cross-agency and public-private collaborations to leverage state resources and coordinate services more efficiently.[17]

Medicare Supplemental Benefits

While states work to develop new mechanisms to identify and address social determinants in their Medicaid programs, CMS and Congress have moved to allow Medicare Advantage (MA) plans to provide additional supplemental benefits that address health-related social factors. This new flexibility allows for MA plans to include services and supports such as access to healthy food and rides to non-medical locations as part of a benefit package. The expanded supplemental benefits will increase access to functional and social supports for MA consumers across the country, including Dual Special Needs Plan (DSNP) enrollees.

Focus on Screening and Referral Platforms

States and CMS have developed screening tools to identify the social and economic barriers of Medicaid members. At the same time, providers have deployed their own screening tools to meet the immediate needs of their consumers. One example is the PRAPARE (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences) tool used by Federally Qualified Health Centers (FQHCs). However, many of these efforts have been localized to a specific clinic or provider system, with no standard screening questions and only ad hoc referral protocols. Several states are exploring a statewide social determinant screening and referral tool model, like the program launched by North Carolina in 2018 (NCCare360). In addition,

several MCOs have developed partnerships directly with screening and referral tool platform vendors. Once a screening has been conducted, and a SDOH barrier or concern has been identified, states are now not only looking for providers and MCOs to connect members and families to appropriate community-based providers to address the SDOH issue, but also requiring MCOs to develop and/or use tools to support this effort.[18]

Trend 9: Aligning Medicaid and Medicare

Many states and CMS are aggressively pursuing coordination, integration, and alignment between Medicare and Medicaid to improve outcomes and program spending on dual eligibles. Additionally, duals programs are becoming progressively differentiated across each state as states bring local and unique Medicaid elements into Medicare contracts serving duals. These changes range from incremental requirements, such as reporting Medicare quality and compliance information to states, to comprehensive alignment with states eliminating DSNPs without Medicaid contracts, and/or pursuing the Medicare-Medicaid Plan (MMP) program in favor of DSNP. CMS has stated that they intend to continue increasing integration and alignment across Medicare and Medicaid in the coming years.

Trend 10: Marketplace Evolution

Changing consumer needs and wants, advancing technology, increasing investments by private equity, and a focus on increasing value and cutting costs are the dynamics driving the competition and consolidation that is now commonplace in the health care system. The need to diversify services and approaches to care are increasing competition and lowering barriers to entry. Whether through new entrants, adaptations made by traditional players, or reimagined entities through mergers and acquisitions, the players in health care, and specifically the Medicaid system, are rapidly changing.

Mergers, acquisitions, and newly formed partnerships are a regular occurrence in the health care space as of late and a trend that does not appear to be stalling. Several factors are driving this trend, including declining reimbursement rates, rising costs, evolving consumer needs, and an increasing need to stay competitive. The ability for one entity to serve their consumers end-to-end is a critical factor in these efforts, both to be responsive to changing consumer needs, and also to serve as a differentiating factor when competing for business. Whether through traditional mergers and acquisitions (M&A), vertical integration, or provider partnerships, these actions are meant to drive scale, harness new capabilities, and serve as a response to the external environment, and these policy and procurement actions are changing business strategies and impacting business targets.

Though these broad, system-altering changes are occurring, there are also specific areas of focus where entities are honing their capabilities and targeting their efforts to win business. The value of primary care in addressing both cost and outcomes is increasing efforts to provide access to this level of care.[19] To be responsive to consumer needs, accessible and flexible site of care options are being developed by both new and traditional players.[20] The development and incorporation of technology is rampant across the health care system and there is rapid change occurring in this space to further decrease barriers to access and care for consumers.[21]

COVID-19 Trends

Budget Declines and Medicaid Enrollment Increases

The public health emergency issued by Secretary Azar on January 31 (and subsequently extended in both April and July for an additional 90 days) and the national emergency declared by President Trump on March 31 have had significant impact on state and local budgets. Revenues from state and local taxes plummeted at an unprecedented pace due to the restrictions states and localities have had to place on businesses and residents. By one estimate, states have seen a shortfall in their General Funds of between 30 and 40%.[22] The unemployment rate also reached an all-time high as a result in April. The high unemployment rate has negatively impacted state revenues as well as led to an increase in Medicaid enrollment (ultimately increasing state Medicaid budgets).

Destabilization of Health Care Delivery System

The COVID-19 pandemic dramatically impacted an array of health care safety net providers (e.g. FQHCs, Rural Health Centers, Community Mental Health Centers) due to the shift in utilization of health services that took place among consumers and the resulting decline in revenue. Additionally, the stability of acute system providers was impacted due to their historic reliance on elective procedures for regular cash flow.

Rapid Reliance on Telehealth

Due to the stay-at-home/safe-at-home orders issued across the country, the use of telehealth/telemedicine platforms was quickly embraced by providers and consumers, as well as supported by policymakers. Both CMS and states universally relaxed telehealth policy and payment restrictions. Consumers pivoted to using both video and telephonic platforms in accessing needed health care services, and providers and MCOs looked for ways to integrate digital tools into their care offerings to help reduce the risk of exposure and spread of COVID-19.

Increased Interest in Home-Based Care

Prior to COVID-19, there was an emerging trend around redefining where health care services can be provided, and one's home and neighborhood were being considered as reimagined sites of service. Due in large part to the inability to access care in hospitals or doctor's offices, this trend has accelerated with most health care now accessed and provided in the home.

Shift in Quality Focus

Historic measurements used to assess the impact and quality of health care are now being reassessed for value, and additional measures are being discussed to align with the needs and changes that have emerged from the pandemic. There is a particular focus by states on metrics related to COVID-19 testing and treatment. Additionally, given the rise in telehealth use noted above, additional measures are being considered that measure the efficacy of different digital modalities.

Conclusion

As noted, the first 10 trends were identified prior to the outbreak of the COVID-19 pandemic. However, the market pressures and political realities that were present prior to the announcement of the public health emergency, and that resulted in those trends, still exist. The additional COVID-19 pandemic specific trends are adding a layer of complexity to an already complex system. Working with our public system and provider partners, UnitedHealthcare is advancing initiatives that are responsive to the policy and practice trends that existed prior to the public health emergency and the priorities brought forth by the pandemic to effectively and efficiently address the needs of those we collectively serve in this moment and beyond.

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