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Looking ahead in Medicaid: Options for states and the implications for payors and providers

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In a series of papers, McKinsey's Center for US Health System Reform has been exploring major changes to the US health system that may be on the horizon. The first report, *The next imperatives for US healthcare*, discussed the two steps—increasing healthcare-sector productivity and improving healthcare-market functioning—that can better balance the supply of and demand for health services. It also described these steps' potential to produce sufficient savings to lower medical cost inflation to the rate of gross domestic product (GDP) growth.¹ The second report, *Potential impact of individual market reforms*, explored a wide range of changes that have been proposed to stabilize the individual market and the effect some of these proposals could have on claims costs and enrollment by the uninsured.²

This paper, the third in the series, explores opportunities states could consider to improve their Medicaid programs. Recent debates surrounding proposals to transition to new Medicaid funding models have increased focus on those opportunities. Regardless of whether the Affordable Care Act is repealed and replaced, Medicaid will continue to represent a significant budget item for both federal and state governments. Many state leaders are considering options that could potentially bring cost growth in line with economic growth while also promoting other state objectives such as improving access and care quality. Furthermore, many state leaders are considering additional actions to enhance their Medicaid programs to take advantage of the additional flexibility being offered by the federal government.

¹ Singhal S, Coe E. The next imperatives for US healthcare. McKinsey white paper. November 2016.

² Singhal S, Coe E, Finn P. Potential impact of individual market reforms. McKinsey Center for US Health System Reform Intelligence Brief. February 2017.

Financial challenges and opportunities from flexibility

Medicaid, a \$554 billion program³ jointly funded by the federal and state governments, currently provides health and long-term care coverage to more than 70 million low-income children, pregnant women, adults, seniors, and individuals with disabilities.⁴ The federal share of program costs is determined by the Federal Medical Assistance Percentage (FMAP), which varies across states, from a floor of 50% to a high of 74%. On average, the federal government pays more than 62% of total state Medicaid costs.⁵

Eligibility levels vary widely among the states, owing in part to variable adoption of the Medicaid expansion provisions included in the Affordable Care Act (ACA). Thirty-one states and the District of Columbia have chosen to expand coverage for parents and childless adults with incomes up to 138% of the federal poverty level (FPL).⁶ From 2014 to 2016, the ACA offered states 100% of the federal funding needed to cover the cost of serving adults made newly eligible under the Medicaid expansion; the federal share for these populations is beginning to phase down this year and will reach 90% in 2020 and after.⁷

States have the flexibility to choose the system(s) they want to use to deliver Medicaid services; options include a state-run fee-for-service (FFS) system, a primary care case management (PCCM) model, or contracts with comprehensive, risk-based managed care organizations (MCOs). Thirty-nine states (including DC) have contracts with MCOs; nationally, managed Medicaid accounts for approximately 40% of total Medicaid spending and 60% of total Medicaid beneficiaries.⁸

One broadly accepted challenge for the US health system over the past decade has been controlling per-person spending growth. *The next imperatives for US healthcare* highlights that healthcare has not experienced the recent productivity improvements seen in other industries. That paper proposes that using increased productivity and better-functioning healthcare markets to bring healthcare expenditure growth down to approximately the rate of GDP growth (about 2.5% annually from 2010 to 2015) could yield \$284 billion to \$532 billion per year in savings over the next ten years.⁹

From 2010 to 2015, average annual spending growth was higher in Medicaid (6.5%) than in Medicare (4.5%), private health insurance (4.4%), or overall national health

³ Department of Health and Human Services (DHHS). 2016 Actuarial report on the financial outlook for Medicaid. Note: All the references to Medicaid funding in this paper include spending on the Children's Health Insurance Program.

⁴ Centers for Medicare and Medicaid Services (CMS). December 2016 Medicaid and CHIP enrollment data highlights.

⁵ DHHS. 2016 Actuarial report on the financial outlook for Medicaid.

⁶ Kaiser Family Foundation. Current flexibility in Medicaid: An overview of federal standards and state options. January 2017.

⁷ Social Security Administration. Compilation of the Social Security laws.

⁸ Data on the number of beneficiaries is derived from the Medicare Payment Advisory Commission (MedPAC) 2016 analysis of data from the CMS report "Medicaid managed care enrollment and program characteristics, 2014." Data on spending is derived from the Kaiser Family Foundation report "Total Medicaid MCO spending, FY 2015."

⁹ Singhal S, Coe E. The next imperatives for US healthcare. McKinsey white paper. November 2016.

expenditures (4.3%). The average annual rise in state Medicaid spending (9.0%) outpaced federal Medicaid spending growth (5.2%) during those years; however, federal growth exceeded state growth from 2012 to 2015 due to eligibility expansion.¹⁰ In comparison, the medical component of the consumer price index (M-CPI) increased about 2.9% annually from 2010 to 2015 and is projected to rise at 3.7% per year between 2017 and 2026.¹¹

The factors that appear to have contributed most to Medicaid spending growth from 2010 to 2015 include:

- Increased enrollment among traditional and new populations (resulting from demographic shifts, increased participation, and state and federal expansions to the aged, disabled, adults, and children)
- Higher per-person spending (due to the addition of new benefits and services and increasing costs among complex populations)
- Cost-shifting (from consumers and uncompensated care)
- Medicaid fee schedule changes
- Enrollment of previously eligible-but-not-enrolled individuals, such as occurred following ACA-related outreach and enrollment support activities

In this paper, we do not examine the relative importance of these factors over the past seven years, nor do we attempt to ascribe a value to what spending growth might have been with a different productivity trajectory. However, given that Medicaid represents a large and growing portion of the nation's healthcare system—in terms of both covered lives and spending—it will need to play a crucial role going forward if overall healthcare productivity is to improve significantly.

Medicaid costs are placing an increasing burden on state budgets. Spending on the program increased from 20.5% of state budgets (including federal and state funding sources) in 2008 to 29.0% in 2016.¹² This increase has created the possibility that over time Medicaid spending could have funding implications for other types of programs, such as elementary and higher education, public assistance, and transportation.

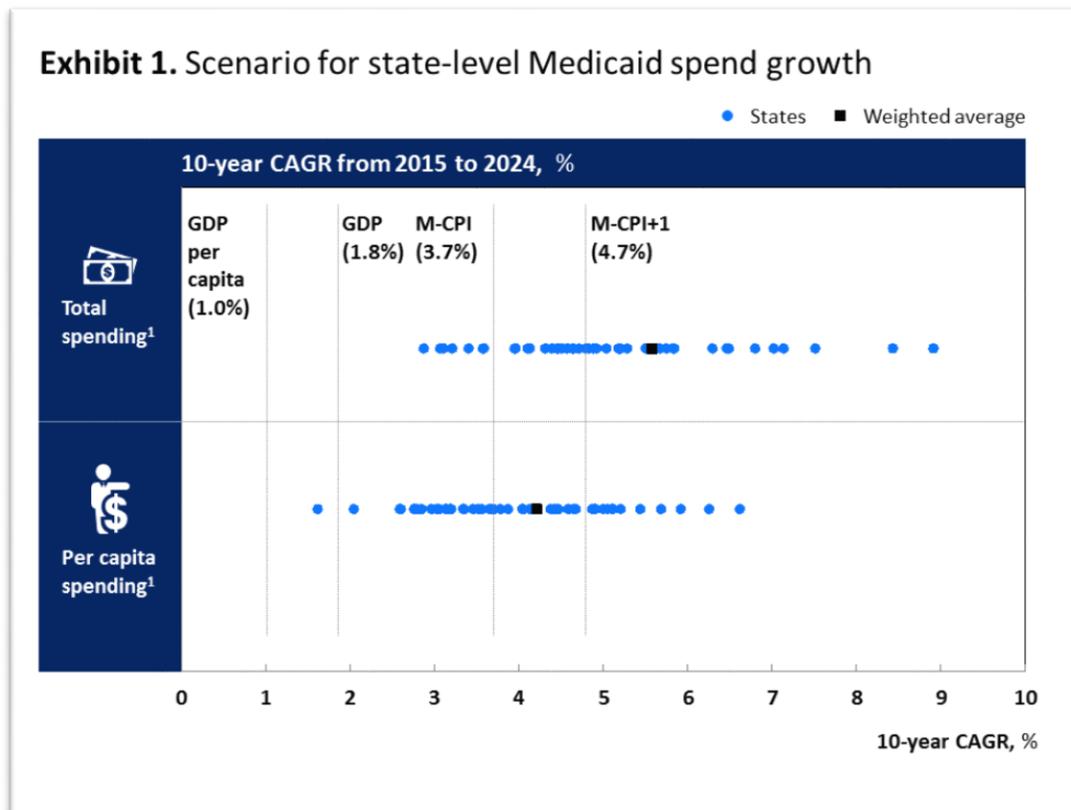
Exhibit 1 shows one possible scenario for state-level Medicaid spending growth over the next ten years. Most states' growth, on both a total and a per capita basis, would in this scenario exceed M-CPI. We developed the scenario using both per-member per-year (PMPY) and enrollment projections. For PMPY figures, we used state-specific, eligibility group (children, adults, disabled, aged, expansion adults)—specific PMPY baselines from the Medicaid and CHIP Payment and Access Commission (MACPAC). We then reconciled those numbers with 2015 total spending from Centers for Medicare and Medicaid Services's (CMS's) Financial Management Reports. To build the future scenario, we also used national data by eligibility group from the Medicaid Actuary's

¹⁰ CMS. Total spend by category, historical NHE fact sheets. 2015.

¹¹ Bureau of Labor Statistics.

¹² In 2016 alone, total Medicaid state expenditures increased by 6.9%, state funding by 6.6%, and federal funding by 7.0%. NASBO. State Expenditure Report Summary. November 2016.

2016 report, allocating growth and variations at the state level using long-term PMPY growth by eligibility group and state from the Kaiser Family Foundation. For enrollment figures, we used state-specific, eligibility group-specific baseline data from MACPAC, reconciled with 2015 total spending from CMS FMR reports and PMPY spending, and built a future scenario using US Census projections for relevant population cohorts, normalizing to match enrollment growth by eligibility group at the national level from the Medicaid Actuary's 2016 report. We assumed that no change would be made to the ACA expansion match rate schedule and that no new states will expand Medicaid. Projections exclude disproportionate share hospital (DSH) and non-DSH supplemental payments.



Spending numbers exclude disproportionate share hospital and supplemental payments.

Source: M-CPI based on Congressional Budget Office (CBO) estimates; GDP based on CBO 2017–27 projection; GDP per capita calculated by removing enrollment trend from GDP

Recent statements from the current administration indicate that states may be given new flexibility to address Medicaid program costs while pursuing goals related to access and quality. Health and Human Services Secretary Tom Price and CMS Administrator Seema Verma, in their first joint action, issued a letter to state governors promoting the

use of 1115 Medicaid demonstration waivers.¹³ In the letter, they declared their objective of accelerating the approval process and outlined priority uses, including:

- Benefit design to encourage consumer-directed care
- Promotion of job training, employment, and independence
- Promotion of enrollment in employer-sponsored insurance

State waivers (1115 waivers and also 1332 state innovation waivers) may therefore gain increased significance and, as states consider actions to improve the individual market via 1332 waivers, they may consider opportunities for coordination across 1115 and 1332 waiver design.

Potential state actions to improve program efficiency

State Medicaid programs have the potential to improve their efficiency and outcomes by using some of the approaches discussed in our November 2016 paper, The next imperatives for US healthcare. These actions include rapid and dramatic productivity improvements in the delivery of health services, improved functioning of healthcare markets, and improved population health.

In this chapter, we describe a range of initiatives state Medicaid programs can consider that focus specifically on the efficiency of care delivery. In the next chapter, we outline what else could potentially be done to improve state Medicaid programs.

States can consider a number of initiatives that hold the potential to increase the efficiency of care delivery and improve overall value. Generally, these initiatives fall into four categories: care delivery and payment innovation; operational improvements; changes to enrollment, benefits, and rates; and personal responsibility benefit design.

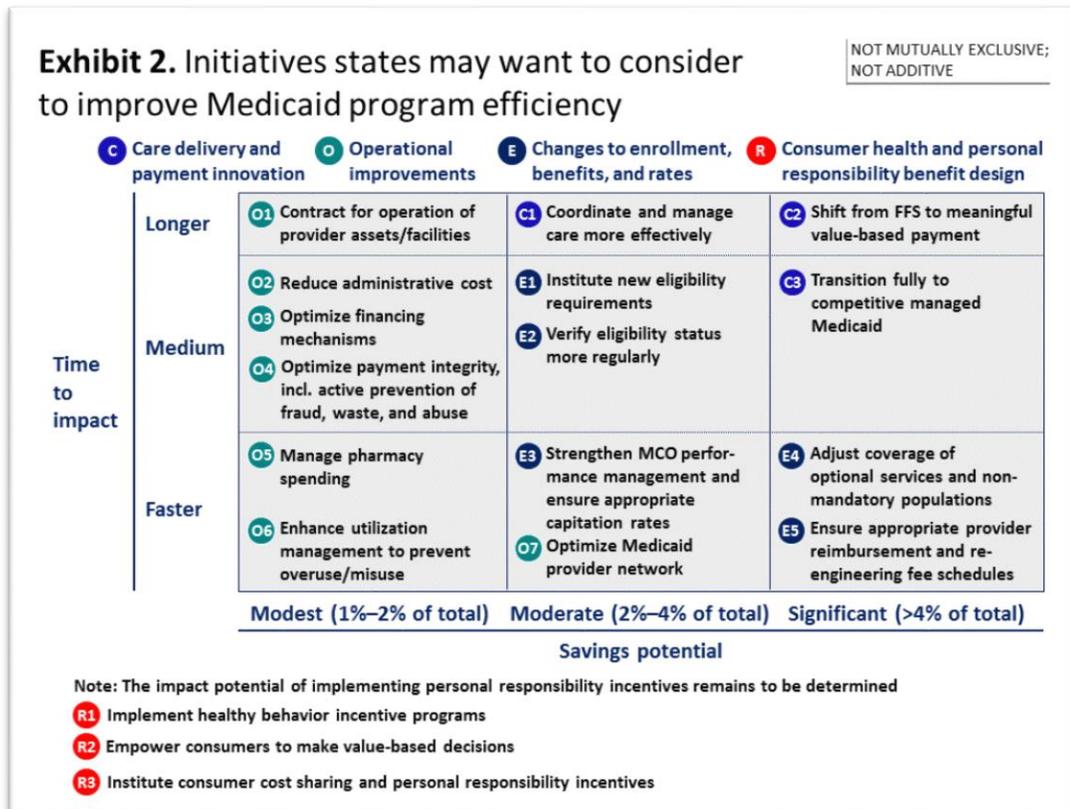
A state's priorities will influence which options it selects and the sequence in which they are pursued. The state's strategy will also be affected by its individual characteristics, including its Medicaid expansion status, current penetration of MCOs, level of and trend in Medicaid spending (total and per member per year), Medicaid reimbursement rates relative to Medicare, and economic and tax revenue outlook—as well as the structure of its current delivery system.

Exhibit 2 outlines the initiatives likely to have the largest impact on program efficiency, organized by both their likely savings potential and the time to achieve full impact. The potential of any initiative will depend on each state's starting point; our calculations of savings reflect the impact a state could realize if it has not yet begun to explore a given option.¹⁴

¹³ Price T, Verma S. Letter to governors. March 14, 2017.

¹⁴ A state that has begun to implement a given initiative may achieve less impact than stated in Exhibit 2 if it has already started to realize savings from the option.

States could decide to implement some of these initiatives on their own; in other cases, however, they might want to work in conjunction with MCOs. Increased state flexibility could make some of the initiatives more attractive or allow new options to emerge.



Source: Literature review, expert interviews

We note three caveats:

- This article offers an overview of the initiatives states may choose to consider; it is not a recommended course of action for any individual state.
- The initiatives are not necessarily additive. In some cases, pursuing one option may reduce the potential impact of another. However, each state could pursue the set of options best suited to its situation, choosing the ones most likely to have a mutually reinforcing effect.
- An initiative's impact on efficiency is only one of the factors states should consider when making choices. Certain actions that have high savings potential and a quicker time to impact (e.g., adjusting the coverage of optional services and non-mandatory populations, reengineering fee schedules) could potentially have a less desirable effect on patient access or provider participation. Each state should therefore take its own priorities into account when considering such trade-offs.

Care delivery and payment innovation

C1) Coordinate and manage care more effectively. Improving the efficacy of care management programs that target specific populations¹⁵ has the potential to lower costs and improve care quality. This approach may produce results more rapidly than full-scale payment and care innovation can, but it may be less effective over time. One approach with potential for impact on cost and quality is coordination and integration between behavioral health and primary care. There may also be opportunity for states to make better use of assessment data to inform care planning and better match an individual patient's needs with level of service and setting of care.

C2) Shift from FFS to meaningful value-based payment. New delivery and payment models that reward providers for delivering high-quality care at lower cost have been shown to improve care quality and reduce costs by 5% to 10% when rolled out across the full spending base.¹⁶ In Arkansas, for example, implementing episodes of care reduced inappropriate antibiotic use by 17% in the first year.¹⁷ An innovative patient-centered medical home network in North Carolina has lowered overall costs by more than 7%.¹⁸ However, some value-based payment programs—most notably, the Medicare Shared Savings Program—have produced mixed early results. States need to work effectively with payors and providers to evolve these models and find suitable approaches for their specific market conditions. The detailed design of the models is critical.

C3) Transition fully to competitive managed Medicaid. Moving the management responsibility for Medicaid costs, access, and compliance to MCOs has often led to a one-time reduction in spending for the targeted population or services. It can also offer the potential for additional savings over time via sustained medical cost management and slowed cost growth. Currently, 12 states do not have managed Medicaid programs.¹⁹ Among the 39 states (including DC) *with* such programs, 11 have 25% or more of their Medicaid beneficiaries (and a larger proportion of total spending) *not* enrolled in managed care.²⁰ States that are already using managed Medicaid programs for nondisabled working-age adults and most services can often achieve additional savings by transitioning other types of beneficiaries (e.g., dual-eligible adults) or services (e.g., pharmacy, behavioral health, long-term services and supports) to managed care. States will likely want to consider what quality-based payment models

¹⁵ Care management programs are often offered by specialized vendors to address the needs of specific groups such as individuals with serious and persistent mental illness, those in need of long-term services and support, those who receive benefits through both the Medicaid and Medicare programs, and those who use a disproportionate amount of healthcare services (especially emergency services).

¹⁶ Examples of such models include patient-centered medical homes, episode-based payments, and accountable care organizations.

¹⁷ Building a Healthier Future for all Arkansans. Statewide tracking report. January 2015.

¹⁸ North Carolina Community Care Networks, Inc. Clinical program analysis. May 2015.

¹⁹ Alabama, Arkansas, Arizona, Connecticut, Idaho, Maine, Montana, North Carolina, Oklahoma, South Dakota, Vermont, and Wyoming.

²⁰ Kaiser Family Foundation. Medicaid reforms to expand coverage, control costs, and improve care: Results from a 50-state Medicaid budget survey for state fiscal years 2015 and 2016. October 15, 2015.

to establish with their Medicaid MCOs. States transitioning to managed care may consider opportunities to evolve the role of their Medicaid agency from primarily a direct FFS payor to an enabler, convener, or policy maker.

Operational improvements

O1) Contract for operation of provider assets and facilities. Some states that have retained state-run medical facilities, mental health facilities, nursing homes, clinics, or other facilities may want to consider contracting private companies to operate the facilities to achieve savings and, potentially, improve quality. The effectiveness of this approach is highly dependent on a state's footprint of provider assets, the current efficiency of its facilities, and the rates negotiated with the private operators.

O2) Reduce administrative cost. Lowering the administrative cost to operate existing FFS programs involves a mix of process improvements, technology investments, and optimized outsourcing and vendor management.

O3) Optimize financing mechanisms. Approaches in this area include statewide purchasing of durable medical equipment and optimized drug purchasing programs. States could also optimize Medicaid program financing through federal waivers or grants and streamlined interagency support. To ensure appropriate claims payment, some states are investing in capabilities to coordinate third-party liability and subrogation for Medicaid beneficiaries.

O4) Optimize program integrity, including active prevention of fraud, waste, and abuse. Ensuring the integrity, or correctness, of all provider payments (i.e., that the payments comply with medical policy, appropriately account for coordination of benefits and eligibility, and so forth) and enhancing auditing mechanisms and/or predictive modeling around fraud can, in our experience, reduce overall program cost by 1% to 2%—and sometimes more. To maximize impact, we have found that states often must go beyond standard third-party payment integrity approaches to design and deliver holistic and fully integrated payment integrity efforts; they also typically need to fully partner with MCOs. State Medicaid departments may collaborate with state offices of the inspector general in program integrity efforts.

O5) Manage pharmacy spending. States often consider a combination of actions on pharmacy spending, including more stringent use of preferred drug lists, prior authorizations, formulary revisions, medication management therapy, optimized pharmacy networks, and price negotiation with pharmaceutical companies. Pharmacy programs are an often-discussed potential use of state flexibility.

O6) Enhance utilization management to prevent overuse and misuse. This approach involves ensuring that prior authorizations are at parity with industry standards and appropriately enforced, coupled with more effective utilization management techniques to reduce misuse and overuse of prescription drugs and medical services.

O7) Optimize Medicaid provider network. Allowing a state or its MCOs to optimize high-performance provider networks has the potential to reduce costs through improved rates or reduced utilization, as well as improve care quality. However, optimizing provider networks is less feasible in some areas (e.g., where there are already few providers); thus, careful design is necessary to maintain enrollee access. State Medicaid programs may choose to set clear network adequacy guidelines and allow MCOs flexibility with network design and contracting.

Changes to enrollment, benefits, and rates

E1) Institute new eligibility requirements. To promote appropriate enrollment, states may choose to establish new conditions for eligibility, such as work requirements. Several states, including Arizona, Indiana, Kentucky, and Pennsylvania, attempted to include work requirements as part of their 1115 waivers, but the proposals were denied by CMS under the previous administration.²¹ However, the recent Price/Verma letter to governors expressed interest in waiver applications that promote “training, employment, and independence.”²² In estimating the likely cost impact of such initiatives, we note that 60% of adults on Medicaid hold jobs; about 80% of those adults are members of working families.²³ Many of the remaining adults have barriers to employment (e.g., they are ill or disabled, need to take care of a dependent, are in school, or are retired).

E2) Verify eligibility status more regularly. To ensure that only eligible individuals are on current Medicaid rolls, states can implement more frequent and/or accurate verification procedures. States vary considerably in terms of which data they use to verify eligibility and how often verification takes place.²⁴ Increasing the accuracy of the data sources used, the frequency of verification, and the enabling IT systems can ensure that states are executing on their mission to provide Medicaid to the most vulnerable.

E3) Strengthen MCO performance management and ensure appropriate capitation rates. To set appropriate capitation rates, states must build actuarial calculations on the correct base data, make proper assumptions about trends and efficiencies, and select appropriate point in an actuarially certified rate range. States may also want to improve their capabilities in MCO performance management because clearly defined goals, accountability, and less unnecessary variation have been shown to yield savings.

E4) Adjust coverage of optional services and nonmandatory populations. While states will need to evaluate the impact on overall health outcomes and budget choices, they do have the option of reducing coverage by eliminating services and halting coverage for populations not mandated by the federal government—actions that

²¹ Kaiser Family Foundation. Medicaid and work requirements. March 2017.

²² Price T, Verma S. Letter to governors. March 14, 2017.

²³ Kaiser Family Foundation. Medicaid and work requirements. March 2017.

²⁴ Some states, for example, rely on federal tax returns, but others do not. Some verify income once annually, while others verify two or more times per year.

can yield near-term cost savings proportional to the targeted area(s). However, cutting services could potentially cause longer-term challenges if the levels of uncompensated care rise in the state's health systems and hospitals. It is also possible that a reduction in optional benefits could, in some cases, increase the need for mandatory, often more expensive institutional care.

E5) Ensure appropriate provider reimbursement and re-engineering fee schedules. Some states have reduced provider reimbursement rates, whether directly (via lower state-set per diem rates or FFS schedules) or indirectly (via rates set by MCOs). Currently, the Medicaid physician fee schedule ranges across the states from 38% to roughly 141% of the Medicare schedule, with a national average of 66%.²⁵ Because of the impact on providers and the knock-on implications for commercially insured populations, many states have tried to find other options before taking this course of action.

Emerging actions with potential to improve efficiency: Personal responsibility benefit design

Some states are exploring personal responsibility initiatives through the 1115 waiver program. We have not formally evaluated the impact of these initiatives because many are still nascent. The discussion here is based on preliminary results and findings from similar studies in the commercially insured population.

R1) Implement healthy behavior incentive programs. In these programs, beneficiaries are given rewards (e.g., gift cards) for demonstrating healthy behaviors, such as seeking preventative care, filling prescriptions, attending smoking cessation programs, or losing weight. As of December 2015, 15 states had implemented healthy behavior incentive programs for Medicaid beneficiaries as part of either 1115 waivers or specialized ACA grants targeting chronic disease; the majority of the programs focus on smoking, obesity, diabetes, and preventive care.²⁶ A 2016 evaluation of these programs found that incentives positively influence short-term behaviors (e.g., seeking primary care, filling prescriptions) but have little impact on long-term behaviors (e.g., giving up smoking, losing weight).²⁷

R2) Empower consumers to make value-based decisions. To encourage consumers to make value-driven decisions about when and where to seek care, states could work to improve the transparency of cost and care-quality information so that patients can identify and select the highest-value care that would meet their needs.

R3) Institute consumer cost sharing and personal responsibility incentives. In cost-sharing programs, beneficiaries make either small monthly premium contributions or copayments for physician visits, emergency department (ED)

²⁵ Kaiser Family Foundation. Medicaid-to-Medicare fee index, 2014.

²⁶ Medicaid and CHIP Payment and Access Commission (MACPAC). The use of healthy behavior incentives in Medicaid. August 2016.

²⁷ MACPAC. The use of healthy behavior incentives in Medicaid. August 2016.

use, and/or prescriptions.²⁸ Beneficiaries may draw on health savings accounts (HSAs) that are either prefunded or paid into by the beneficiary. Copayments are typically structured to steer beneficiaries toward more responsible use of services. In our experience, in the commercial population it has been possible with appropriate plan design to develop suitable structures without resulting in the adverse effect of individuals foregoing necessary care. For example, it is important that there be no or low copayments for evidence-based preventative care, as well as higher copayments for “inappropriate” use of ED facilities. At present, the evidence is insufficient to definitively assess the impact of cost sharing in Medicaid. One study based on evidence from the Oregon Medicaid program suggested that beneficiaries subject to cost sharing exhibit improved treatment patterns (e.g., decreased ED utilization).²⁹ Another review showed some mixed impact in pharmacy incentives in Medicaid.³⁰ Demonstrations, such as the one in Indiana, continue.³¹

Other ways to enhance state Medicaid programs

Although increasing the efficiency of care delivery to individual Medicaid beneficiaries is an important near-term goal, over the longer term states may want to push their improvement efforts beyond efficiency. Other options states can consider to enhance their Medicaid programs fall into three categories: improve the health of the population, improve the citizen experience, and improve the integration of the markets for healthcare services and health insurance in the state.

Improve the health of the population

Beyond delivering healthcare at an individual level, states have a role to play in understanding the broader needs of their population and key demographic and health trends. States that want to optimize their Medicaid and related public health spending have several options for crafting appropriate, effective interventions in public health.

Maximize return on investments in public health. Although rigorous analytics and transparency can help ensure that public health investments yield maximum impact, many states have not developed a deliberate strategy for managing the return on investment in public health. An explicit prioritization framework that identifies core public health objectives (e.g., obesity reduction, smoking cessation, oral health) and mechanisms for evaluating new investments could aid in this effort.

²⁸ Vulnerable Medicaid populations are currently federally exempted from all out-of-pocket costs and are exempt from cost sharing (See Medicaid.gov. Cost sharing.)

²⁹ Wallace NT et al. How effective are copayments in reducing expenditures for low-income adult Medicaid beneficiaries? Experience from the Oregon Health Plan. *Health Services Research*. 2008;43:515–530.

³⁰ Powell V et al. Cost sharing in Medicaid. *Medical Care Research and Review*. 2015;73:383–409.

³¹ Lewin Group. Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report. July 2016.

Use advanced analytics to respond to public health events. To better target public health needs and prevent public health problems from becoming crises, states could develop the infrastructure to track and identify key demographic and health trends over time. States may need to invest in data collection (e.g., health information exchanges) and transparency tools (e.g., all-payor claims databases) to enable advanced analytics. Using the data to proactively identify challenges before they become larger problems can reduce strain on the healthcare system more broadly. For example, many states are facing the public health, social, and economic costs of the opioid epidemic and are taking steps using their public health infrastructure to address the crisis. However, states might also want to consider using advanced analytics to identify providers who are prescribing opioids at levels well above regional or state averages and then structure interventions to address those providers. Advanced analytics could also help state officials maximize naloxone coverage in areas with high opioid usage rates or study more rigorously the effectiveness of different delivery mechanisms for naloxone (e.g., prescribed concurrently with opioids, given proactively to those at high risk for an overdose). Geospatial analysis could help track overdoses, deaths, and treatment patterns across a state to help officials better evaluate the effectiveness of a range of supply-side and demand-side interventions.

Integrate investments across agencies and service types. Medicaid beneficiaries often require complex care to address medical health, behavioral health, and social needs. Significant evidence shows that integration of medical and behavioral health (e.g., via colocation of behavioral health services within a primary care or health home model) can improve both medical and behavioral outcomes for patients.³² In addition, there is growing recognition that social determinants of health play a powerful role in individual health status and behavior.³³ Given that many Medicaid beneficiaries require other social support services (e.g., housing, job training, access to food/nutrition), states could consider strategies to more effectively integrate the provision of those services with healthcare delivery. State health agencies may also want to consider coordinating and co-investing with other relevant state agencies (e.g., housing, education) on areas of shared interest to foster strategic alignment and improve service delivery. The integrated services could be targeted not only at the current Medicaid population but also at individuals with a strong possibility of becoming eligible for the program (e.g., prisoners, opioid users).

Improve the citizen experience

In addition to reducing program costs and improving outcomes, state Medicaid leaders may want to make beneficiaries' interaction with the program and other social support services smoother, easier, and more efficient. A focus on the citizen as a customer may ensure appropriate enrollment levels, enable delivery of more appropriate healthcare

³² Asarnow JR et al. Integrated medical-behavioral care compared with usual primary care for child and adolescent behavioral health: A meta-analysis. *JAMA Pediatrics*. 2015;169:929–37.

³³ Kaiser Family Foundation. Beyond health care: The role of social determinants in promoting health and health equality. November 4, 2015.

performing and worst-performing states.³⁴ Several options could be available to states wishing to maximize citizen participation and long-term engagement.

Improve enrollee journeys. Systems for simplifying the enrollment process and helping beneficiaries who lose eligibility transition to commercial insurance have the potential to facilitate increased access and continuity of care. States can also respond to the heterogeneity of Medicaid enrollees by developing specific journeys to meet different groups' needs and preferences. (The groups could be defined by attitudinal differences or based on demographic factors or health status.) In addition, investments in infrastructure to more carefully track enrollees could help states collect the data they need to make better decisions about several of the healthcare financing and delivery issues discussed earlier in this paper. Finally, states may want to consider addressing individual parts of the customer journey that are currently “pain points,” such as the appeal or cancellation processes. States may also want to expand their definition of the customer journey to include transitions between Medicaid and other types of coverage (e.g., individual coverage or employer-sponsored insurance).

Support choices of healthcare setting. To make certain that Medicaid beneficiaries have access to services appropriate to their needs and preferences, states may want to ensure that individuals have access to a range of treatment options, particularly those based in home- and community-based settings—and that they have the right information and supports available to make those choices together with their families and caregivers. Enabling beneficiaries to receive care in home or community settings may require innovative technology support (e.g., telehealth, remote monitoring, electronic health record integration) and advanced analytics to target the most appropriate options to meet each individual's needs. Many Medicaid MCOs are expanding their offerings and investing in better mechanisms to counsel members during transitions of care to ensure that they are aware of options that promote independence and increase quality of experience.

Empower consumer decision-making. Some Medicaid programs are beginning to follow in the footsteps of commercial insurers by making it easier for beneficiaries to access necessary services digitally and make better-informed care decisions. Digital tools, for example, can help support self-care, give patients information about treatment options, and inform selection of providers. Medicaid MCOs and providers can also focus on health education and literacy to equip patients with the information they need to make both short- and long-term value-driven decisions about care.

Improve integration of the markets for healthcare services and health insurance in the state

Decisions made by state Medicaid leaders can have impact that extends beyond the Medicaid program. Thus, when selecting actions to improve Medicaid programs, these

³⁴ McKinsey Public Sector Journey Pulse Survey. November–December 2016.

leaders may want to consider focusing their efforts on creating value across markets. The leaders could ask themselves the following questions when assessing opportunities:

Market structure. How should the structure of their state's total health insurance market be shaped—not only Medicaid but also the individual exchanges, other commercial insurance, etc.? How should they actively manage across risk pools?

Coordination with other purchasers. How can they coordinate with other state payors (e.g., state employee benefits programs) to leverage scale and create synergies?

Plan design. How can they coordinate plan design across market segments to improve care at points of coverage transition (e.g., through common networks or benefit design)? How can payors be encouraged to create value across market segments?

Provider impact. When developing approaches to program improvement, how can they anticipate the potential impact of these changes on providers? How can providers get the support they need to create additive value across market segments?

Frictional costs. How can Medicaid program processes be simplified so that state leaders are positioned as efficient collaborators for payors and providers?

Considerations for Medicaid MCOs

Given the increasing flexibility becoming available to states, Medicaid MCOs should be prepared to respond to a variety of state actions. Thus, MCOs operating in multiple states will need to develop different strategies based on the set of actions chosen in each state. Because Medicaid MCOs face uncertainty about what states will choose to do, they may benefit from acting now to position themselves as partners in state efforts to improve efficiency, population health, and citizen experience. The areas they need to focus on most are:

Market participation and entry. Medicaid MCOs may need to engage in scenario planning to determine the optimal portfolio of states and covered populations (within and beyond Medicaid). The goals could be to mitigate concentration risk, maintain minimum necessary scale for cost effectiveness, and ensure their ability to serve state customers and beneficiaries in a financially sustainable manner. As states consider accelerating their transition to managed Medicaid, MCOs may need to develop or bolster capabilities (e.g., in market analytics and rapid request-for-proposal response) so they can act quickly when opportunities arise. Given the evolving national situation, Medicaid MCOs will also need to make smart choices about market participation and identify populations and markets where they are well positioned to succeed.

Medical cost and revenue management. Medicaid MCOs are under increasing pressure to deliver high-value coverage by controlling medical costs via effective utilization management, care and/or disease management, high-value benefit design, network innovation, quality and risk adjustment, value-based payment models, or some combination of the above. These organizations may also benefit from reviewing their performance on risk coding and quality metrics. Many Medicaid MCOs are exploring

value-based insurance design to encourage members to use high-value clinical services to promote health outcomes.

Capabilities for specific populations. Medicaid MCOs may need to build new capabilities to manage the care of populations not covered in the past under managed Medicaid.³⁵

Ability to meet quality metrics. As Medicaid MCOs are increasingly being asked to meet standards for quality of care, they may need to build new capabilities in provider engagement, analytics, and reporting.

Flexibility to scale operations up or down and manage administrative costs. Medicaid MCOs will need the agility to scale operations up or down to control administrative costs in the face of changes in the covered populations while maintaining the minimum necessary scale for optimal administrative cost performance, including selective use of vendors.

Enhanced organizational capabilities. Medicaid MCOs may wish to make significant talent upgrades in their retail and consumer-facing functions and technological proficiency, as well as ensure high-performance management of even basic functions to optimize their efficiency and effectiveness. The organizations may also want to adapt to increasing consumerism by building new customer capabilities (e.g., by offering a choice of plans). Regional MCOs that cannot afford to make or acquire advanced capabilities will likely need to develop excellence in joint venture (JV) and alliance design, execution, and management of best-of-breed vendors, as well as ongoing market scanning to identify emerging promising vendor partners.

Considerations for providers

Like Medicaid MCOs, providers should anticipate that Medicaid leaders will take a variety of actions to improve efficiency, population health, and citizen experience. Providers may therefore want to pursue near-term strategies in response to state efficiency improvement efforts while simultaneously developing long-term strategies to better serve Medicaid beneficiaries.

Providers are increasingly recognizing that success in Medicaid may require them to shift the primary site of care away from hospitals and toward community-based and primary care. Such an approach should address the specific medical, behavioral, and social needs of Medicaid subpopulations defined by demographics (e.g., the aged, disabled, children, mothers, adults) or conditions (e.g., medical conditions, behavioral health issues, comorbidity). MCOs may be well positioned to partner with health systems to create an integrated network of service providers, including primary care practitioners, behavioral health professionals, community health workers, and social service partners. By offering access to a broader range of services and shifting away

³⁵ Examples of such populations include those with behavioral health problems, those requiring long-term services and support, and those with other special needs.

from acute care, a partnership of providers and Medicaid MCOs may be able to reduce excess utilization and, potentially, create value for the providers. Some providers and MCOs have already found early success with such models; possible upcoming federal changes and ensuing state changes could prompt more providers to implement Medicaid-specific models at scale.

In the near term, providers should consider improving core capabilities in all coverage segments, including Medicaid. Capabilities that may promote success in all segments include:

Segment and line-of-business strategy. Providers may want to consider balancing their Medicaid business with their higher-margin commercial and Medicare business to support what will likely remain challenging Medicaid reimbursement. This lever may be less valuable to providers for whom Medicaid makes up a significant portion of patient share.

Administrative and delivery cost management. Providers should continue to examine their delivery cost base and attempt to remove waste.

Effective capacity planning. Providers facing future volume uncertainty are likely to benefit from effective capacity planning. Overall, radical rationalization of inpatient capacity—including repurposing existing inpatient facilities and building appropriately—would help ensure that that hospitals can operate with higher utilization, as other high-fixed-cost industries do. Given providers’ existing fixed costs, this lever can have a longer time to impact.

Scale strategies. Many providers are evaluating opportunities to achieve greater scale—including affiliation, mergers and acquisitions, and JVs—in light of general economic pressure from all health insurers (including Medicaid MCOs) and direct state contracting.

Alternate payment streams. Providers can consider entering into value-based payment models with MCOs (by accepting delegated risk) or directly with states (by fully managing risk).

Conclusion

Whether or not major federal changes to the Medicaid program are made in the near term, state Medicaid programs are still at an important crossroads, with states facing increasing fiscal pressure as Medicaid costs absorb a greater proportion of already tight state budgets. Failure to act to control these costs could put pressure on states to make cuts in other important spending areas. The current administration’s signals in favor of greater flexibility suggest that states may have new opportunities to innovate as they try to control the growth in Medicaid spending while improving care delivery for vulnerable populations. The path each state chooses to pursue these objectives will depend heavily on its existing Medicaid system, population needs, and the general healthcare

landscape. Given the likely diversity of state actions, payors and providers would be well served by beginning to build capabilities now.

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