

# ISSUE BRIEF

## PERSPECTIVES FOR THE HEALTHCARE INDUSTRY

### AUTHORS

Robert Herman, M.D.

Anne Jacobs

Patrick Maher

Catherine Srekovich

[navigant.com](http://navigant.com)

#### About Navigant

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## Medicaid Managed Care: Strategic Considerations for States

### THE CHALLENGE: INCREASED ENROLLMENT, INCREASED COSTS

Medicaid is the nation's largest insurance program, covering 68 million individuals including 7.5 million who enrolled last year in the 26 states that expanded their program in sync with the Affordable Care Act.<sup>1</sup> Its growth spans almost four decades covering a broad cross section of lower-income populations. From 1975-2010, the number of children enrolled tripled from 9.6 to 30 million; adults quadrupled from 4.5 to 15.4 million; disabled enrollees tripled from 2.5 to 9.3 million; and those over the age of 65 increased slightly from 3.6 to 4.5 million.<sup>2</sup> According to the Medicaid and CHIP Payment and Access Commission (MACPAC), 37% of all U.S. children are in Medicaid/CHIP along with 10% of non-institutionalized adults between the ages of 19-64.<sup>3</sup>

Due to these enrollment increases, Medicaid costs have increased dramatically. Last year, spending increased 6.7% to \$449.5 billion. In 2014, it is projected to grow 12.8% as the Medicaid expansion population's costs are added. Per the CMS Office of the Actuary, Medicaid spending will grow by 6.7% in 2015, 8.6% in 2016, and 6.8% per year from 2017-2023.<sup>4</sup> Though these costs are shared between states (average 43%) and the federal government (average 57%),<sup>5</sup> based on a complex formula, they are nonetheless problematic, especially in states where sources of income via taxes are limited. In many states, the promise of 100% funding by the federal government for Medicaid expansion through 2016 for the expansion population under the Affordable Care Act is a hard-sell: legislators fear the state's portion, up to 10% of the Medicaid expansion population's costs after 2016, will threaten state fiscal health while still recovering from the economic downturn.

As a result of growing enrollment and its associated costs, states are implementing managed care strategies to control their Medicaid populations' health and costs. In 37 states, subcontracting to private managed care organizations (MCOs) has been the focus; in others, managed care methodologies and programs have been integrated into state oversight. Furthermore, states are increasingly looking toward managed care for Medicaid long-term services and supports. In all of these cases, recognition of Medicaid population distinctives is pivotal to building successful managed care strategies. In this Issue Brief, we offer a summary of those activities and insights about strategies most successful in these efforts.

## FOUR UNIQUE CHALLENGES IN MANAGING THE MEDICAID POPULATION'S HEALTH

Successful Medicaid managed care strategies in states recognize the uniqueness of this population's healthcare needs. Four factors are considered by MCOs and state leaders in structuring their programs and oversight policies.

1. **The complexity of the medical problems in Medicaid populations is high.** Medicaid populations' health problems vary widely by grouping and are often more complicated to treat than those in privately-insured populations who have had access to providers and treatments. To illustrate, consider some of the major distinctions between these four groups of enrollees: children, adults, dual eligible, and disabled. (See *Table 1*)

**Table 1: Differences in Medicaid populations**

	CHILDREN <sup>3,6</sup>	ADULTS <sup>3</sup>	DUAL ELIGIBLES <sup>7,8,9</sup>	DISABLED <sup>3,10,11,12</sup>
<b>Major Diagnoses</b>	<ul style="list-style-type: none"> <li>• Asthma (17%)</li> <li>• ADD/ADHD (11%)</li> <li>• Developmental delay (6%)</li> </ul>	<ul style="list-style-type: none"> <li>• Functional limitation (47%)</li> <li>• Hypertension (30%)</li> <li>• Depression/anxiety (26%)</li> <li>• Arthritis (24%)</li> <li>• Asthma (20%)</li> <li>• Diabetes (12%)</li> <li>• Pregnancy (10%)</li> </ul>	<ul style="list-style-type: none"> <li>• Mental illness (34%)</li> <li>• Heart disease (29%)</li> <li>• COPD/lung disease (25%)</li> <li>• Alzheimer's (6%)</li> <li>• Intellectual disability (6%)</li> <li>• Diabetes (5%)</li> </ul>	<ul style="list-style-type: none"> <li>• Mental illness (47%)</li> <li>• Heart disease (38%)</li> <li>• Central nervous system (28%)</li> <li>• Pulmonary (20%)</li> <li>• Skeletal/connective (18%)</li> <li>• GI (16%)</li> <li>• Diabetes (13%)</li> <li>• Renal (9%)</li> </ul>
<b>Cost Per-Enrollee Per-Year</b>	\$2,854	\$4,368	\$16,460	\$19,031
<b>Environmental Issues</b>	Most children enrolled in Medicaid are from low-income households and many are served by multiple, public programs, putting them at risk for receiving fragmented or inappropriate care	Majority of adults in Medicaid have historically been pregnant women and parents, but ACA expansion will bring in more childless, single adults with different health conditions	41% of duals have a Medicare-qualifying disability; Between 2006 and 2011, the total number of Medicare-Medicaid enrollees increased by 17.7%	Medicaid beneficiaries with disabilities are more likely to have three or more chronic conditions (35%) than non-disabled adults (10%), each additional chronic condition is associated with an average increase of roughly \$8,400 per year
<b>Other Considerations</b>	Less than 10% of children in Medicaid use behavioral healthcare, but this care accounts for 38% of child Medicaid expenditures	Adults are expected to see the highest enrollment and expenditure growth from 2014-2024 due to Medicaid expansion	Significant variation in diagnoses and cost between full-benefit and partial-benefit duals, as well as duals under the age of 65 vs. duals over the age of 65	Disabled beneficiaries have the highest incidence of mental illness, which is nearly universal among the highest-cost, most-frequently hospitalized beneficiaries

This medical complexity is closely associated with prescription drug utilization that is higher than the privately insured population's. While generics are widely used, Medicaid populations use high-cost specialty drugs disproportionately. Consider hepatitis C as an example:

- The minimum treatment time for the new hepatitis C drug Sovaldi is 12 weeks, which may extend to 24 or 48 weeks costing \$1,000 per pill. A 12-week dosage regimen of Sovaldi costs about \$84,000. However, actual treatment will cost more as Sovaldi is taken in combination with other hepatitis C drugs and may extend more than 12 weeks.<sup>13</sup>
- A report by Express Scripts projects states will spend more than \$55.2 billion if they are to provide all of the hepatitis C patients on Medicaid or in the prison system with the latest therapy regimen. According to the 2013 Drug Trend Report, the U.S. will spend 1,800% more on hepatitis C medications in 2016 than it did in 2013. No major therapy class has experienced this high of a spending increase in the 21 years that Express Scripts has measured drug trend data.<sup>14</sup>
- As a result of the high cost, some states and Medicaid MCOs have either not added Sovaldi to the formulary or are limiting access. Some are restricting it to patients who have tried the older drugs, but failed to get satisfactory results. Others will provide it to those in the middle stages of liver damage, but not to those who show little or no signs of damage.

The complexities of medical management for Medicaid populations means higher costs for hospitals, professionals and prescription drugs at a time when states are pressed to fund transportation, education, homeland security and public health programs adequately.

- 2. Socio-economic factors in Medicaid populations make diagnosis and treatment more difficult.** Medicaid enrollees have lower income and literacy rates than the privately-insured population. Access to providers is inconsistent and many experience poor nutrition, unclean air and lack of a family support structure. As a result, interactions with the health system are anecdotal for the majority, especially those newly-enrolled through the Affordable Care Act's provision for expansion: no ongoing physician relationships, no medical records, dependence on emergency rooms and public clinics and so on.

- 3. Many physicians will not accept Medicaid patients.** Medicaid enrollees face obstacles in seeing doctors and health professionals on a regular basis.

- In 2011, 31% of physicians were unwilling to accept new Medicaid patients. Physicians in smaller practices, and those in metropolitan areas, were less likely than others to accept new Medicaid patients. Higher state Medicaid-to-Medicare fee ratios were correlated with greater acceptance of new Medicaid patients – gain sharing programs with providers.<sup>15</sup>
- In a controlled study involving simulated patients who contacted primary care offices seeking new visits, private plan callers were offered an appointment 85% of the time and Medicaid callers only 58% of the time. This suggests significantly higher primary care access barriers for Medicaid patients relative to privately-insured ones.<sup>16</sup>

Many physicians refuse to see Medicaid enrollees because reimbursement rates are lower than privately-insured or Medicare rates; others refuse fearing liability concerns. Reimbursement rates alone are not a reason some physicians limit their accessibility to Medicaid patients. The administrative burden of participating in the Medicaid program, delays in reimbursement, and Medicaid patients' behavior also influence physicians' participation decisions.<sup>17</sup> Some physicians are reluctant based on the possibility that adverse outcomes resulting from treating a Medicaid enrollee with whom the physician had no ongoing relationship would potentially hurt the physician's performance on various publicly accessible report cards. As a result of these myriad factors, in many communities, access to physicians is limited or problematic.

- 4. The 'churn factor' adds cost to administering the Medicaid program efficiently and effectively.** Medicaid enrollees enter and exit the program frequently due to changes in eligibility, relocation or other factors. As incomes increase above a state's Medicaid eligibility ceiling, enrollees may jump to health exchanges, or drop coverage altogether. The launch of health exchanges last year adds another dimension to the churn factor: a Health Affairs study found that within six months, 35% of all adults with family incomes below 200% of the federal poverty level will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse; within a year.<sup>18</sup> The churn rate in Medicaid is vexing to state officials and lends to the unique challenge in managing the health of its diverse populations and their costs.

## STATES FACE FUNDING CHALLENGES THAT WILL ONLY GET WORSE

On a per-enrollee basis, funding for Medicaid has not kept pace. Federal funds have become more restrictive, and states have been unable to use provider taxes and other means of raising revenues for the program.

- During FY 2013, states increased the number and size of their Medicaid provider taxes, but at a slower pace than recent years. In FY 2013 there were three new provider taxes and increased rates for 22 existing provider taxes, compared to 2012, when 11 new taxes and 58 provider tax increases were added.<sup>19</sup>
- In 2014, one provider tax was eliminated and two provider taxes were added, while six states reported increases to hospital taxes and five states increased rates for nursing home taxes. Two states plan to add provider taxes in 2015, but two states plan to eliminate hospital taxes. Eight states reported that they plan to increase hospital taxes in 2015 and five states plan to increase nursing home taxes.<sup>20</sup>
- The 2009 American Recovery and Reinvestment Act (ARRA) temporarily increased the federal share of Medicaid costs. The ARRA-enhanced matching rates provided states with over \$100 billion in total funds over 11 quarters, ending in June 2012. The increased federal funds allowed state spending of their own funds on the program to fall, the only declines in state spending on Medicaid in the program's history. The return to regular Federal Medical Assistance Percentage (FMAP) rates in June 2012 meant that states had to finance a higher share of program costs than one year earlier, and state fund costs increased dramatically (on average by 23.6%) relative to FY 2011. Some states adopted policy actions to mitigate the increase in the state cost of Medicaid, which also contributed to the low rate of growth in total Medicaid spending for FY 2012.<sup>18</sup>

Recent studies by Pew,<sup>21</sup> Mercatus (George Mason University),<sup>22</sup> Standard & Poor's,<sup>23</sup> and the Government Accountability Office<sup>24</sup> document the stress in state funding. On a per-Medicaid enrollee-per-month basis, states payments are lower than severity-adjusted payments in Medicare and commercial allocations. Many state legislatures have limited increases in the program in favor of higher-priorities: pension obligations and funding for education, transportation and public services. As a result, controlling costs for Medicaid is a high priority: contracting with private Medicaid managed care plans is widely accepted as a means of controlling costs while implementing innovative population health management methodologies in blue and red states alike.

## CONTRACTING WITH MEDICAID MANAGED CARE ORGANIZATIONS (MCOs) IS BECOMING STANDARD OPERATING PROCEDURE

Managing Medicaid programs through contracts with private MCOs is becoming standard operating procedure. In fact, 37 states already structure Medicaid in this manner. At the end of 2013, 42% of the Medicaid population was enrolled in a managed care plan run by a private operator;<sup>25</sup> and in the first two months of 2014, enrollment increased another 8% per Wells Fargo.<sup>26</sup> Thus, it's understandable that investors are showing interest in the \$140 billion Managed Medicaid business sector and traditional health insurers are making acquisitions:

- Aetna acquired Coventry on May 7, 2013. Purchase price of \$5.6 billion, EBITDA multiple of 7.9.
- Wellpoint acquired Amerigroup on July 9, 2012. Purchase price of \$4.859 billion, EBITDA multiple of 15.3.
- Universal American acquired APS Healthcare on January 11, 2012. Purchase price of \$228 million, EBITDA multiple of 7.3.
- Cigna acquired HealthSpring on January 31, 2012. Purchase price of \$3.8 billion, EBITDA multiple of 6.2.

Forecasts by leading, standalone Medicaid managed care plans suggest strong growth is anticipated. (See Table 2)

Table 2: Anticipated growth for standalone Medicaid managed care plans

	2013 EPS	2014 EPS		2015 EPS	2016 EPS
	Actual	Guidance	Consensus	Consensus	Consensus
Centene	\$2.94	\$3.70-\$3.90	\$3.86	\$4.67	\$5.44
Molina	\$1.13	\$1.65-\$2.15	\$1.84	\$2.75	\$3.64
WellCare	\$3.98	\$2.20-\$2.50	\$2.13	\$4.04	\$5.65

Source: Capital IQ

In most states, oversight of MCOs is managed entirely through the Medicaid program; in some, responsibility is shared with the state's Department of Insurance. Approaches to oversight of private Medicaid MCOs vary widely state to state and clear opportunities for improvement exist, but results across the 37 states indicate quality of care has improved in the Medicaid population and a reasonably high level of satisfaction among enrollees has been achieved, particularly in some states and some plans.

From reports filed by states and public reports from the leading investor-owned Medicaid MCOs, there are two broad sets of "best practices" (medical management and administration) that appear most instrumental to achieving better health outcomes for Medicaid populations while constraining costs for states.

## MEDICAL MANAGEMENT BEST PRACTICES

Medicaid MCOs that adopt this best practice use a three-tiered stratification scheme:

- Tier 1 – Patient Centered Medical Homes (PCMH):** The core of medical management opportunity is a comprehensive patient centered medical home to which every enrollee is assigned and through which preventive health includes prophylactic dentistry, mental health, ophthalmic, family medicine (retail clinics), food stamps, pharmacists, nutrition counseling and direct links to public health and school clinics. Funded by the per-member per-month model, PCMH leverages nurse practitioners and mid-level practitioners aggressively. Diversion from hospital emergency rooms is a central Tier 1 focus area, and in some states, annual physical exams are a requirement. *Innovation frontier: Mandatory assignment of every enrollee in a PCMH coupled with an Electronic Health Record (EHR) registry function for each participating provider and online tools for monitoring provider access, treatment options, and medication costs are getting increased attention in lieu of call centers. The focus is health status stability and primary care.*
- Tier 2 – Health coaching in chronic populations:** For the population screened for risk associated with elevated blood pressure, obesity, anxiety/mood disorders diabetes and other risk factors, the mid-tier focus includes educational programs, interventions, and medication management programs specific to each population facilitated by health coaches. Enrollees are screened, and their assignment to an intervention group is determined based on geography and risk factors. Health coaching is customized and sophisticated – adapted to the clinical and social determinants of the enrollee's health to optimize measurable behaviors – medical adherence, physical exercise, confidence and so on. Tier 2 also includes a tight formulary and medication management program for providers and, in some states, waivers of co-pays for enrollees. In Tier 2, a call center staffed by nurses is necessary to interdict behaviors contrary to an optimal care plan and gain early warning signals about non-adherence or churn. *Innovation frontier: Use of online tools and health coaches to modify behaviors, monitor adherence including medication use, physical and mental health exercises. The focus is behavior modification to prevent health status deterioration leading to an acute event.*
- Tier 3 – Case management for high risk populations and dual eligibles:** An individual deemed Tier 3 eligible is assigned a care manager whose panel size may vary from 10-50 enrollees (dependent on complexity and risk assessment) that are the highest-cost, highest-risk populations. The care manager role is to navigate with the patient the system of health services and programs necessary to their wellbeing, to assess treatment plans and make adjustments necessary to optimize adherence by interacting with hospitals, physicians and social workers, to facilitate communication with the patient's family or close circle to enhance connectivity to a "care community," and to measure and monitor outcomes and costs working with program administrators. In Tier 3, narrow networks of specialists, acute- and post-acute providers, tight formulary design, and face-to-face interaction between the enrollee and care manager are essential. And continuity in the patient-care manager relationship is vital. Turnover of care managers is incompatible with optimal health and cost containment. *Innovation frontier: Remote monitoring technologies, care manager compensation plans linked to patient outcomes, and sophisticated treatment strategies for the most severe patient populations are increasingly the focus.*

In each of these tiers, high-performing, private MCOs further stratify these populations by their clinical and social characteristics, use customized formularies, online and telephonic health coaching and narrow networks of accessible providers in each.

- **Narrow networks:** MCOs routinely use narrow networks for reference labs, post-acute care and in medical specialties including adult mental health, orthopedics, cardiology, and OB-GYN. In Tier 1, primary care is typically contracted to providers that make optimum use of nurse practitioners and allied health professionals in their practices. Hospitals “in network” are those that offer a full range of acute and outpatient services and agree to MCO contracts that are negotiated annually. A key element in these contracts is emergency room coverage: Medicaid MCOs prefer hospitals that operate off-site urgent care clinics accessible to Medicaid enrollees to offset costs and congestion in traditional adult and children’s emergency departments.

In narrow network contracting, thresholds of quality and access are important to Medicaid MCO operators. Renewals are contingent on performance around quality, access, safety and cost. A reality in Medicaid managed care is that provider panels are dynamic because capitated or fee-based payments are low relative to commercial payments, private Medicaid MCOs affiliated with larger commercial plans sell providers on higher volumes and preferred positioning “in network” in their contracting.

- **Restrictive formulary for specialty drugs:** 28 states include pharmacy benefits in their contracts with MCOs while nine states carve out their pharmacy benefit. Most states (22) do not require their MCOs to align their individual plans’ preferred drug lists (PDLs) with the State-approved Medicaid fee-for-service PDL. Thirty-five states require prior authorization for Sovaldi. Several states additionally require treatment candidates to meet a set of clinical or clinical-related criteria for prior authorization. Some states have implemented a “once in a lifetime” rule that allows Medicaid patients only one chance at treatment with Sovaldi.<sup>27</sup>

- **Nominal co-payments:** States have found private MCO efforts in capturing nominal co-payments for branded drugs where a generic is suitable, and co-payments for use of hospital emergency rooms where an urgent care center alternative is an option. Private MCOs are also using retail clinics in lieu of primary care practitioners for simple, uncomplicated tests and diagnoses, usually in Tier 1 populations. Increasingly, private MCOs are using modest out-of-pocket requirements to channel enrollees to appropriate settings and providers.

## ADMINISTRATIVE BEST PRACTICE

The operating margins to manage a Medicaid life in the “average” state is 2.5% for MCOs vs. 6% to 7% for commercially-insured lives, so margins are lower and risks higher. Therefore, Medicaid MCOs are keen to manage efficiently, leveraging technologies and outsourcing to the max.

In each function, the highest-performing MCOs have dedicated capital to state-of-the-art information systems and programmatic design to keep fixed and per-enrollee per-month variable costs low. (See *Table 3*)

Most states allow private MCOs maximum flexibility in staffing, provided terms of contract compliance are met. Therefore, outsourcing and offshoring are prominent in administrative processes used by private MCOs.

**Table 3: Managed Care Organization Functions and Key Indicators**

MCO FUNCTIONS	KEY INDICATORS
Enrollment and Eligibility	<ul style="list-style-type: none"> <li>Identify verification</li> <li>Public program eligibility matching (e.g. Supplemental Nutrition Assistance program (SNAP))</li> <li>Churn analysis and surveillance</li> </ul>
Network Administration: Physicians, Allied Health, Acute, Post-Acute, Community Services, Retail Health	<ul style="list-style-type: none"> <li>Credentialing</li> <li>Adequacy/access</li> <li>Provider payments, incentives</li> <li>Provider satisfaction</li> </ul>
Funding Procurement and Financial Reporting	<ul style="list-style-type: none"> <li>FMAP &amp; state (direct funding including Disproportionate Share Hospital (DSH))</li> <li>Provider taxes</li> <li>Grants</li> <li>Gifts/philanthropy</li> </ul>
Clinical Outcome Measurement	<ul style="list-style-type: none"> <li>Safety (errors)</li> <li>Efficacy (processes of care)</li> <li>Effectiveness (outcomes)</li> <li>Access (scheduling)</li> <li>Real-time or close-to-real-time measurement</li> </ul>
Contract Compliance	<ul style="list-style-type: none"> <li>Reserve and fiscal stability</li> <li>Network stability</li> </ul>
Risk Management	<ul style="list-style-type: none"> <li>Adherence to medical necessity</li> <li>Fraud</li> </ul>
Enrollee Education and Adherence	<ul style="list-style-type: none"> <li>Online and social media</li> <li>Health coaching</li> <li>Provider Continuing Medical Education (CME)</li> </ul>

### KEY TAKEAWAYS FOR STATES

For states, private MCOs are an important partner in managing their growing Medicaid population while reducing the financial risk in its management. Not every MCO is capable. Many are hard pressed to provide the full scope of services necessary for addressing the complexity of the tasks, especially in states where funding is relatively low. The evidence suggests private Medicaid MCOs have been successful in improving health and containing Medicaid costs, so Medicaid MCOs are likely to play an expanded role for states as enrollments increase. Therefore, as their overseers, state officials should consider:

- Evaluating, auditing enrollment, eligibility, churn and fraud detection methodologies used by MCOs contracted by the state.
- Reviewing, auditing the clinical algorithms and provider incentive programs used by private MCOs in their clinical operations.
- Using rapid cycle feedback and leading indicators to evaluate performance as close to real-time as possible.
- Assessing methodologies used by MCOs to assess provider quality, access, safety along with methodologies used to collect co-payments.
- Testing creative shared risk arrangements with MCOs to bend the cost curve in Tier 1 and Tier 2 patient populations (in Tier 3, savings are generally quicker to achieve).
- Facilitating expanded scope of practice for nurse practitioners and advanced practice nursing to increase access to primary care services.

- Funding innovative models for training and equipping care managers and health coaches to sustain longer-term patient-coach relationships and reduce churn.
- Mandating assignment of Medicaid enrollees to patient centered medical homes.
- Assessing ways and means of integrating social services programs with Medicaid services (connecting health and human services) e.g. SNAP, and others.
- Evaluating approaches of integrating physical and behavioral health services to enable effective care management and health coaching.
- Creating innovation awards for MCOs that deliver enhanced outcomes/cost efficiencies.

Medicaid MCOs are an important and growing sector in the economy of most states. Improvements in their performance should be rewarded by states, and vigilance in their oversight a key focus.

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## AUTHORS

**Roberta Herman, M.D., Director**  
*Navigant Healthcare and National Co-Practice Leader, Value Transformation*

Roberta is a Director in Navigant's Healthcare Practice. Her current portfolio includes strategic planning, operational assessments and analytics for providers and payers. Dr. Herman is an internist who trained in medicine, epidemiology and biostatistics at McGill University in Montreal, Canada. Prior to joining Navigant, she had been a Chief of Internal Medicine at Harvard Community Health Plan's Cambridge Center and served as Chief Medical Officer and then Chief Operating Officer at Harvard Pilgrim Health Care in Wellesley, Mass. Contact her at roberta.herman@navigant.com or 617.748.8309.

**Anne Jacobs, Managing Director**  
*Navigant Healthcare and National Practice Leader, Federal Government Health Solutions*

Anne is a Managing Director in the Healthcare practice and the national practice leader for the Federal Government Health Solutions segment. She specializes in managed care and oversight of healthcare payers and providers, and in the design, implementation, ongoing operation, monitoring and evaluation of Medicaid managed care programs. She also specializes in assisting payers, particularly managed care organizations, to identify opportunities to improve their operations, to implement such improvements and to develop and execute market entry and exit strategies. Contact her at anne.jacobs@navigant.com or 202.973.3124.

**Patrick Maher, Managing Director**  
*Navigant Healthcare*

Patrick is a Managing Director with Navigant's Healthcare Strategy Practice. Over the past twenty-five years, Patrick has worked in management consulting, banking and private equity with a heavy focus on healthcare. With direct experience in U.S. and European health systems, Patrick's insight into a variety of healthcare systems has helped shape his transformation passion for a more efficient and effective U.S. healthcare system. Contact him at patrick.maher@navigant.com or 415.356.7163.

**Catherine Sreckovich, Managing Director**  
*Navigant Healthcare and National Practice Leader, Government Health Solutions*

Catherine is a Managing Director in the Healthcare practice and the practice leader for the Government Health Solutions segment. With more than 30 years of experience in the healthcare and insurance industry, she is adept at working with commercial health plans, administrative services organizations, third-party administrators, managed care programs, Medicare contractors, and agencies in the public sector. Contact her at csreckovich@navigant.com or 312.583.5747.