Initial Assessment of Medicaid Expansion and Reform

Presentation to the 29th Alaska State Legislature (2015-2016):
Senate Finance Subcommittee – Medicaid Reform

February 3, 2016

The Menges Group

Overview of our Engagement

- The Menges Group was selected through a competitive procurement process to conduct an independent analysis of Alaska's Medicaid Reform and Expansion legislation and efforts.

- Our client is Alaska's Legislative Budget and Audit Committee
  - The purpose of our contract is to provide the Committee with an independent professional consultant in the area of Medicaid reform and expansion to analyze and evaluate benefits and risks associated with reform proposals and expansion proposals, their financial consequences, and to assist the Alaska State Legislature in understanding and acting upon these proposals.
  - We are interested only in the technical and analytical merits of each issue/option. The following is an excerpt from our proposal:

  "We will analyze each reform option objectively, with a focus on what approaches best serve Alaskans' overall interests. We will not make any recommendation for reform that we do not feel has compelling technical/programmatic merit – regardless of the level of political support it may have."

- We conducted an extensive set of interviews with Alaska stakeholders during late 2015.

Our Objectives in This Report

- Assess Medicaid expansion's costs and benefits
  - Draw upon experience and data now available from the many states that have implemented expansion
  - Estimate fiscal impacts in terms of State funds and for Alaska residents overall
- Review and comment on key provisions of "Medicaid reform" legislation (HB 148, HB 190, SB 78, SB 74, RPL# 06-2016-0056 and 06-2016-0057)
- Identify Medicaid savings opportunities that are:
  a) achievable in near term;
  b) sizable/meaningful;
  c) not impositions of "cuts" to the program; and
  d) minimize DHSS' resource burden to implement and operate the initiative
- Elevate the quantity and quality of information available to help policymakers in their decision-making efforts

Our initial report, completed in mid-January 2016, has covered a wide range of issues. Subsequent reports and project tasks will assess other states' experiences with Medicaid initiatives, State innovation Model grants, and best practices models, including the portability of various programmatic and policy design options including longer range reform efforts to Alaska's program.

Medicaid Expansion

We Assessed Medicaid Expansion From Several Angles

- Medicaid expansion was implemented in Alaska under the premise that no additional State funds would be needed
- Clearly, there are costs associated with the expansion (e.g. 50% state share of administrative costs, and 5% share of medical costs beginning in 2017 climbing to 10% by 2020)
- We looked at the various ways that these costs might be offset by reductions in other State spending and are attributable to Medicaid expansion
- We also looked at ways that Medicaid expansion might trigger new State costs (e.g., woodwork effect whereby more already eligible persons would enroll at 50% State cost)
- Our bottom line on this issue is that Medicaid expansion will impose no net State funds cost during FFY2015 or 2016, but will require an additional $5.7 million in 2017, $10.9 million in 2018, $14.1 million in 2019 and $23.6 million in 2020

Potential Cost Reduction Areas

- Disproportionate Share Payments
  - No reductions yet seen in federal or state disproportionate share payments to hospitals in the expansion states
- Reductions in Non-Medical Behavioral Health Costs
  - We tentatively concur with a $5.8 million reduction in behavioral health treatment and recovery grants, as they will now be converted to the Medicaid program; we trended the savings figures in this area at 3% per year
- Criminal Justice Health Costs
  - We estimate an annual State fund reduction of *$3 million per year* attributable to the implementation of Medicaid expansion
  - Reduced recidivism through better maintenance of this subgroup's behavioral health conditions could yield significant State savings (on corrections and correctional health costs), as well as important community safety benefits

Potential Cost Reduction Areas (cont.)

- Medicaid Spending Reductions
  - Only states that expanded Medicaid prior to 2014 are experiencing reduced state fund outlays within Medicaid (due to an enhanced Federal match on people they were already covering). Alaska will not benefit from this dynamic.
- State Taxation on Increased Provider Revenues
  - Alaska has no sales tax nor an income tax and does not stand to secure a State funds revenue increase by virtue of the influx of Federal Funds created by implementing the Medicaid expansion
- Chronic and Acute Medical Assistance (CAMA) Program
  - The program should be reduced prior to attributing a state savings offset to the implementation of Medicaid expansion. Even full elimination of CAMA would create only a modest offset against the state share of Medicaid expansion costs.

Woodwork Effect

- Our estimates suggest that states have experienced a “woodwork effect” (growth in their core Medicaid enrollment as more people seek health coverage) due to the ACA overall, but not as a result of implementing the coverage expansion

Medicaid Enrollment Trajectory for Non-Expansion Eligibility Groups

State Group	Non-Expansion Enrollees, Jan ‘14	Non-Expansion Enrollees, Mar ‘15	Percent Increase
22 States Expanding Medicaid	24,385,128	25,120,553	3.0%
22 States Not Expanding Medicaid as of Mar ‘15	21,817,164	23,698,154	8.6%

Provider “Crowd-Out” Assessment

- In Alaska, Medicaid expansion creates hundreds of millions of dollars in revenue for the State’s providers, most of which will be for persons would otherwise remain uninsured and therefore represents additional marginal revenue for the provider community. Medicaid is also a solid payer in Alaska in terms of unit prices, lessening any “crowd-out” concerns.
- In summary, we do not anticipate that Alaska’s providers will become less financially viable due to Medicaid expansion. Our expectation is that the provider community will be made far better off by Medicaid expansion than had the state elected not to expand coverage.

Another Crowd-Out Concern: Will the Dynamic of More Persons Receiving Medicaid Prevent Others (e.g., commercial and Medicare) From Accessing Care?

- Our initial report did not address this issue
- Alaska's Medicaid payments for primary care are 31% above Medicare for any given procedure or office visit code
- To extent the providers take more Medicaid, could this reduce the degree to which they are willing to serve Medicare?
  - This *could* occur, but we envision it is unlikely to materialize on a large scale due to:
    - Additional revenue from Medicaid expansion creates growth – offers a financial means for physicians to increase their delivery capacity
    - Some expansion eligibles have been accessing primary care – either as self-pay or no-pay patients.
    - Provider reluctance to drop existing patients
    - Providing coverage to expansion population does not ensure their access to care to a provider whose patient panel is already full
    - Some providers are averse to taking on new Medicaid patients for non-financial reasons (e.g., relatively high rate of missed appointments)
  - Important to monitor this issue to extent Medicaid expansion remains in place

Estimated Cost Impacts

Estimated Annual Per Capita Medical Costs for Alaska Medicaid Expansion Enrollees

Projections for Alaska Medicaid Expansion Population	
Average Cost Per Expansion Enrollee Across 7 States, FFY 2014	$5,493
Alaska Cost Factor Relative to Other States	1.15
Estimated Cost Per Expansion Enrollee, FFY2014	$6,317
Annual Per Capita Cost Inflation Factor	1.03
Estimated Expansion Cost Per Person, FY2015	$6,506
Estimated Expansion Cost Per Person, FY2016	$6,701
Estimated Expansion Cost Per Person, FY2017	$6,902
Estimated Expansion Cost Per Person, FY2018	$7,110
Estimated Expansion Cost Per Person, FY2019	$7,323
Estimated Expansion Cost Per Person, FY2020	$7,542

Estimated Cost Impacts (cont.)

Estimated Medicaid Expansion Costs

Federal Fiscal Year	Average Expansion Population During Year	Average Annual Medical Costs Per Person	Administrative Costs Per Person (2% of medical assumed)	Total Medical Expenditures	Total Administrative Expenditures	Total Medicaid Expenditures
2015	262	$6,506	$130	$1,703,545	$34,071	$1,737,616
2016	20,000	$6,701	$134	$134,028,094	$2,680,562	$136,708,656
2017	35,000	$6,902	$138	$241,585,639	$4,831,713	$246,417,352
2018	40,000	$7,110	$142	$284,380,810	$5,687,616	$290,068,426
2019	40,000	$7,323	$146	$292,912,234	$5,858,245	$298,770,479
2020	40,000	$7,542	$151	$301,699,601	$6,033,992	$307,733,593

Estimated Cost Impacts (cont.)

Estimated State Fund Costs Attributable to Medicaid Expansion

Federal Fiscal Year	Federal Share of Medical Cost	Federal Share of Admin. Cost	Total Federal Cost	State Share of Medical Cost	State Share of Administrative Cost	Total State Cost	Offset for Behavioral Health Grant Spending Reductions	Offset for Correctional Health Inpatient Savings	Estimated Net State Fund Impact of Medicaid Expansion
2015	100%	50%	$1,720,580	$0	$17,035	$17,035	$0	$0	$17,035
2016	100%	50%	$135,368,375	$0	$1,340,281	$1,340,281	$0	$1,500,000	-$159,719
2017	95%	50%	$231,922,214	$12,079,282	$2,415,856	$14,495,138	$5,779,600	$3,000,000	$5,715,538
2018	94%	50%	$270,161,769	$17,062,849	$2,843,808	$19,906,657	$5,952,988	$3,090,000	$10,863,669
2019	93%	50%	$275,337,500	$20,503,856	$2,929,122	$23,432,979	$6,131,578	$3,182,700	$14,118,701
2020	90%	50%	$274,546,637	$30,169,960	$3,016,996	$33,186,956	$6,315,525	$3,278,181	$23,593,250

The figures in the right hand column represent our estimates of the net State fund impacts of Medicaid expansion. Beginning in FFY2017, a State government infusion is needed to support the expansion.

Medicaid Expansion Is Valuable to Alaska

- Large infusion of Federal revenue into an economy that is struggling
- Reverses current situation where Alaska's taxpayers face roughly a $90 million annual cost by paying for other states' Medicaid expansions – we estimate that the expansion decision turns this into more than a $170 million net gain for Alaska's residents overall (roughly a $250 million annual improvement)
- Significant clinical and peace of mind benefits to those receiving the coverage

Medicaid Expansion's Financial Dynamics From Lens of Residents of Each State

CY2016 Projections	Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
State or Group of States	Projected Additional Persons Covered by Medicaid	Total Expenditures Attributable to Medicaid Expansion	Share of National Gross IRS 2012 Tax Collections	Estimated State Residents' Spending on Own Medicaid Expansion	Estimated State Residents' Spending on Other States' Medicaid Expansion	Net Financial Impact of Medicaid Expansion on State's Residents
States Expanding Medicaid (27)	7,287,000	$46,509,381,935	63.3%	$3,460,349,576	$26,381,134,488	$16,674,890,634
States Not Expanding (23)	-	$0	36.7%	$0	$16,674,890,634	($16,409,933,398)
USA (expansion states only)	**7,287,000**	**$46,509,381,935**	**100.0%**	**$3,460,349,576**	**$43,056,025,122**	**$264,957,236**
Alaska without expanding	**37,000**	**$0**	**0.2%**	**$0**	**$88,548,876**	**-$88,548,875.98**
Alaska with expanding	**37,000**	**$271,950,000**	**0.2%**	**$6,475,000**	**$88,548,876**	**$176,926,124**

Expansion costs based on estimated per person medical expenditures of $6,079 per enrollee in other states ($7,000 in Alaska) and 5% additional costs for administration

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Short Term Program Modifications

Recommendation: Manage Drug Mix Better

- Alaska should modify the preferred drug list and corresponding prior authorization processes to steer volume to the lowest-cost, clinically appropriate medication

Medicaid Cost Per Prescription and Generic Mix, FFY2014

Medicaid Statistic	Alaska	USA	Alaska as % of USA Average	Alaska's Rank Among States
Pre-Rebate Cost Per Prescription	$79.94	$72.40	110%	28th highest
Rebates Per Prescription	$34.76	$35.09	99%	19th highest
Post-Rebate Cost Per Prescription	$45.19	$37.32	121%	9th highest
Generics as % of All Prescriptions	77.7%	80.7%		43rd highest

- Our report identifies the top 25 therapeutic classes where comparative analyses indicate particularly large Medicaid costs savings opportunities exist in Alaska
- We project annual Medicaid savings of more than $5 million by better managing the mix of drugs across these 25 therapeutic classes

Recommendation: Case Management for Persons with Multiple Hospitalizations

- 347 Alaska Medicaid beneficiaries have been hospitalized at least 5 times during the timeframe 2012-2015 (including at least one 2015 admission)
  - This figure excludes maternity/newborn admissions, persons dually eligible for Medicare, and admissions occurring within one day of a discharge
- These persons can be readily identified, as can all emerging beneficiaries reaching any selected threshold of multiple hospitalizations
- These individuals' admissions *after* their 5th hospitalization cost approximately $13 million during 2015

Case Management of Frequently Hospitalized Persons – Savings Estimates

Threshold	# of Persons Reaching This Level	# of Persons with at Least One Hospitalization in 2015	% With at Least One Hospitalization in 2015	Subsequent Admits Above Threshold	Subsequent Admits as % of All Non-Maternity, Non-Newborn Admits	Estimated 2015 Cost of Subsequent Admits	Savings at 50% Reduction	Savings at 25% Reduction
Persons with 3+ Admits	2,136	924	43%	3,220	12.0%	$27,023,305	$13,511,653	$6,755,826
Persons with 5+ Admits	652	347	53%	1,419	5.3%	$13,076,079	$6,538,040	$3,269,020
Persons with 10+ Admits	93	61	66%	364	1.4%	$3,715,425	$1,857,712	$928,856

- A care coordination team explicitly focused on outreach and care coordination for the 5+ subgroup is projected to have an annual cost of $1.2 million and create a Medicaid inpatient cost savings of approximately $5 million, yielding a net annual savings of approximately $4 million
- Expanding this initiative to the 3+ group would yield much larger net savings

Recommendation: Create Tribal Health Long Term Care Capacity

- Alaska's tribal health delivery system is nearly devoid of long-term care service capacity, and adding this component can yield substantial ongoing State fund savings given the 100% federal financing for tribal health providers' services rendered to Alaska Native Medicaid beneficiaries
  - No State funds will be used when an institutionalized Medicaid beneficiary is served in a tribal facility rather than a non-tribal facility (current State share is 50%)
- With Alaska's nursing home costs per resident being extremely high, we estimate this 50% savings to potentially represent $75,000 per institutionalized enrollee per year
  - If 120 beneficiaries received year-long nursing home care in a tribal health facility, in lieu of a non-tribal facility, annual State fund savings of approximately $10 million would occur

Medicaid Reform: Review of Proposed Legislation

Controlling Expansion Coverage Costs

- Broad-based cost containment initiative applied to all Medicaid populations will have far greater State fund savings value for non-expansion populations
- A 4% reduction in costs for any non-expansion population subgroup will yield a State fund savings of 2.0% at the regular 50% Federal match rate
- A 4% reduction in costs for the expansion population will currently yield no State savings, and at most a 0.4% State savings once Federal match drops to 90%

Increased Use of Tribal Health Services

- Currently, two thirds of the funds spent on Alaska Native health care is paid to private sector providers
- Additional opportunities exist to fill service gaps in Alaska by expanding the tribal health delivery system where a 100% Federal match will occur for care rendered to Alaska Natives who are Medicaid beneficiaries
- We encourage strong exploration of options for putting tribal health skilled nursing facilities into operation. We estimate annual state fund savings of approximately $75,000 per resident will accrue as tribal health nursing home capacity is expanded and Medicaid eligible beneficiaries receive care in these facilities in lieu of a non-tribal nursing home.

Personal Health Savings Accounts

- Medicaid provides first-dollar coverage for a fairly comprehensive benefits package relative to commercial insurance; the costs that an HSA is typically used to cover are largely not applicable in Medicaid
- Alaska's Medicaid population has significant eligibility turnover with only 56% of the persons covered by Medicaid enrolled throughout the year
- We do not believe the administrative complexity involved in shifting to an HSA model is a worthy undertaking at this time given the myriad of other challenges DHSS is facing
- There is no assurance that this type of model will improve the program's cost effectiveness, quality performance, or access performance
- Alaska could implement greater use of beneficiary copayments for various services, but we don't see this to be a successful cost-containment strategy
  - Runs high risk of creating barriers to needed care for poverty population, as well as creating in-effect provider price discounts (when persons fail to pay or providers are uncomfortable seeking collection)

Capitated MCO Model: Alaska's Demographics Don't Fit This Approach Well

- Alaska has only 0.2 Medicaid enrollees per square mile – far below every other state. The remainder of the United States averages 18.6 Medicaid beneficiaries per square mile.
- Even Alaska's most urban areas have highly dispersed populations. The population within Alaska's Metropolitan Statistical Areas (MSAs) is less concentrated than the *total population* in the remaining United States (including MSAs and non-MSAs).

  Persons Per Square Mile: Anchorage MSA: 15.2; Fairbanks MSA: 13.6

  USA Overall: 90.5; USA (non-Alaska): 107.7

- Capitation contracting requires at least two MCOs, to ensure beneficiary choice
  - Many states prefer to ensure that at least three MCOs operate in each area. This assures that no MCO has can unravel the whole program if they terminate their contract.
- The Anchorage and Fairbanks MSAs combined have fewer than 100,000 beneficiaries
- One of the options we currently believe warrants consideration is contracting with a single MCO on a non-risk administrative services only basis to deliver coordinated care services on a program-wide basis

Questions

The Menges Group