

Idaho Workgroup on Medicaid Redesign

*Options to provide healthcare services
to low-income Idaho adults*

December 4, 2014

Second Report



Idaho Workgroup on Medicaid Redesign

Richard M. Armstrong, Chair

December 4, 2014

The Honorable C.L. “Butch” Otter
Governor of Idaho
P.O. Box 83720
Boise, Idaho 83720-0034

Dear Governor Otter:

Thank you for the opportunity to help Idaho evaluate possible models for providing comprehensive healthcare coverage for low-income adults. The landscape for designing a uniquely Idaho model has greatly expanded since our 2012 report. With increasing federal flexibility and building on the experiences of other states, along with healthcare system reforms moving forward with the State Healthcare Innovation Plan (SHIP), we are excited about the redesign opportunities available for our state.

The workgroup held three meetings to evaluate models implemented in other states, along with considering new ideas from workgroup members and legislators. The workgroup evaluated savings, costs, benefits and liabilities to the state, counties, businesses, and Idaho citizens. The experience and knowledge of workgroup members was instrumental in evaluating this complex issue.

Workgroup Recommendation: Idaho should expand Medicaid through a hybrid model that utilizes care management and private insurance coverage to provide 103,000 low-income Idahoans with access to health insurance.

This recommendation includes a Direct Primary Care pilot program to cover 1,200 individuals in three types of settings – a direct primary care practice, a community health center and a rural hospital. The specifics for implementing this pilot will require further development.

The opportunity afforded Idaho with this recommendation provides our state with real leverage to transform the overall healthcare system from a volume-based, fee-for-service model to an outcome/value-based system of care focused on care management through medical homes. This recommendation aligns the healthcare coverage for low-income people with the state’s overall vision, utilizing significant federal resources to improve our healthcare system as a whole from the bottom up. By adopting this recommendation, the state will more expediently achieve the healthcare transformation goals envisioned in the SHIP.

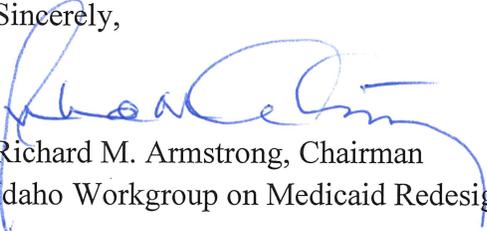
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We are all painfully aware that the current county indigent/state catastrophic healthcare programs are unsustainable, a waste of taxpayer dollars and do nothing to improve our citizens' health. Replacing this very expensive, episodic care with primary and preventive care will keep Idaho's low-income citizens healthier while providing taxpayer relief to both the counties and state. The Care Management/Private Insurance recommendation is estimated to save the state more than \$173 million over the next 10 years.

Learning from the experiences of other states and aligning this recommendation with our state's healthcare transformation vision, we are confident this recommendation is the best path forward for improving the health and well-being of Idaho citizens.

The workgroup is grateful for the opportunity to engage in this study for Idaho.

Sincerely,



Richard M. Armstrong, Chairman
Idaho Workgroup on Medicaid Redesign

RMA/eb

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Redesign*

December 4, 2014

Executive Summary

Governor C.L. "Butch" Otter reconvened the Medicaid Redesign Workgroup during the summer of 2014 to evaluate:

1. Other states' strategies for covering low-income adults.
2. Opportunities from increasing federal flexibility in allowing states to develop unique and accountable Medicaid expansion plans.
3. Options for consideration by government leaders.

The workgroup met three times, beginning in June and ending in November. After thorough evaluation and discussion, the workgroup voted in November to support the following recommendation.

Workgroup Recommendation: Idaho should expand Medicaid through a hybrid model that utilizes care management and private insurance coverage to provide 103,000 low-income Idahoans with access to health insurance.

This recommendation includes a Direct Primary Care pilot program using state funds to cover 1,200 individuals in three types of settings – a direct primary care practice, a community health center and a rural hospital.

The Care Management/Private Insurance option will save the state more than \$173 million during the next 10 years.

Workgroup members noted that expanding Medicaid through this model closely aligns with the goal of Idaho's Statewide Healthcare Improvement Plan (SHIP) to transform Idaho's entire healthcare system from the volume-based, fee-for-service model to an outcome/value-based system of care. Expanding access to healthcare for uninsured through the care management/private insurance options assures that all Idahoans have access to ongoing healthcare which can ultimately result in improved health outcomes for Idahoans and reduced overall healthcare costs for Idaho.

The proposed Care Management/Private Insurance model design includes:

- Care management coverage for adults between 0 to 100 percent of the federal poverty limit, with personal accountability requirements and health incentives to encourage preventive care.
- The purchase of private insurance through Idaho's insurance exchange for people earning 100 to 138 percent of poverty.



Workgroup members strongly supported a model that incorporates personal accountability, coupled with a patient-centered medical home.

Factors supporting the Care Management/Private Insurance recommendation include:

- The recommendation does not expand the existing Medicaid program. Instead, the recommendation aligns with the planned transition of the existing Idaho Medicaid program to care management over next 3 to 5 years.
- A Care Management/Private Insurance option is consistent with legislative direction found in Idaho Code 56-263, Medicaid Managed Care Plan, and with Idaho Code 56-261 which states: ***The Legislature finds that the current healthcare delivery system of payment to Medicaid healthcare providers on a fee-for-service basis does not provide the appropriate incentives and can be improved by incorporating managed care tools, including capitation and selective contracting, with the objective of moving toward an accountable care system that results in improved health outcomes.***
- This hybrid model is supported by the Centers for Medicare and Medicaid Services, which has indicated it will approve Idaho's proposed recommendation.
- The recommendation eliminates the county/state indigent programs that pay for crisis care after the episode occurs, the most costly and inefficient form of healthcare.
- The state can sunset or eliminate coverage at any time. If the federal government increases state costs or mandates changes the state does not agree with, Idaho can opt out.

In this hybrid model, there are benefits specific for both the care management and private insurance populations. For the care management population earning less than 100 percent of poverty, requirements can be built into the contract that:

- Require co-pays for non-emergent use of hospital emergency rooms.
- Shift the payment model from fee-for-service to value, based on improved health outcomes.
- Assign individual members to primary care providers, strengthening the state's patient-centered medical home vision.
- Utilize the maximum allowable cost-sharing for participants to encourage responsible utilization of the healthcare system.
- Offer incentives to empower both participants and providers to work together through health assessments, wellness exams, preventative screenings and other healthy behaviors.
- Provide predictable per-member-per-month rates established from actuarially sound analysis of participants.

For people between 100 to 138 percent of poverty receiving coverage through private insurance, the recommendation provides:

- Continuity with insurance plans they currently are eligible to purchase.
- Support for the state's private insurance model and Idaho's state-based insurance exchange.
- A private market solution, rather than making Medicaid the first coverage option.

The workgroup evaluated a total of five options which are referenced by the option numbers listed below. The Managed Care/Private Insurance option that is recommended is Option 3.5. There is no Option 2; that option was to redesign the current state/county indigent care system which the workgroup decided was not feasible.

The four additional options considered in the 2014 meetings includes:

- **Option 1 Status Quo:** This option does not make any changes to the current system of indigent/catastrophic care that the state and counties provide. This option operates in a volume-based, fee-for-service environment.

The workgroup was in full agreement that the Status Quo option was not a consideration because of the high taxpayer costs for paying for care after the illness or injury occurred. Workgroup members felt the program had been improved over the years as much as an incident-based model of indigent care could, but it continues to be expensive, serving few people while providing no primary care case management to improve outcomes.

- **Option 3 Care Management/State Contract:** Provides care management through a contract that pays a per-member-per-month fee. The contract can be

developed to require the maximum allowable premiums and copays, and can provide incentives to participants for following healthy behaviors and receiving recommended check-ups, screenings and preventive healthcare. Contract components can also include assigning participants to primary care providers, and can charge higher copays for inappropriate use of hospital emergency rooms.

This option had greatest initial administrative costs, but produced the most savings over time. The workgroup supported this option for uninsured adults earning less than 100 percent of poverty, but were reticent to remove people earning more than 100 percent of poverty from the private market. The workgroup voted in August to recommend this option to Governor Otter, but reevaluated as more options became evident. Option 3.5, a hybrid combination of Options 3 and 4, proved a better fit of the workgroup's vision for appropriate coverage.

- **Option 4 Private Insurance/Exchange:** Purchases commercial insurance products on the Idaho insurance exchange for Medicaid-eligible participants with minimal capitation payments for some patient management.

Some workgroup members thought Option 4 was more politically attractive; however, emerging experiences in other states are showing it to be more expensive than originally projected. Concern was also voiced that the premium rates for health plans could be adversely impacted by higher claims' experience if all 103,000 eligible adults enrolled at once. With Option 3.5, many of the eligible adults are already covered in this insurance pool and they will not have an adverse impact on premium rates.

- **Option 5 Direct Primary Care Memberships:** Purchases direct primary care services in which the physician manages the members' physical outpatient healthcare needs for a monthly fee, bypassing traditional insurance coverage with no deductibles or office visit co-pays. Primary care services are provided at a predefined, capitated rate.

Option 5 drew keen interest from the workgroup because it closely mirrors the state's efforts in the State Healthcare Innovation Plan (SHIP) to evolve towards Patient Centered Medical Homes and payment reform. However, members were concerned about the costs and lingering questions about wraparound coverage to pay for hospitalizations and pharmacy. Members voted to support further evaluation of the Direct Primary Care model.

During the August meeting, the workgroup completed a SWOT analysis for each option, which analyzed the strengths, weaknesses, opportunities and threats. From the SWOT analysis, key points are presented below. Option 3.5 was developed after

the August SWOT analysis was conducted, but is included in the chart below for comparison.

Options*	People Covered	Provides Essential Health Benefits?	Personal Accountability Incentives?	Saves State/County Indigent Tax Dollars?	10 year Net Savings to Idaho Taxpayers
Option 1: Status Quo	5,000	No	No	No	\$0
Option 3: Care Management/ State Contract	103,000	Yes	Yes	Yes	\$183.6 Million
Option 3.5: Care Management/ Private Insurance Blend	103,000	Yes	Yes	Yes	\$173.4 Million
Option 4 Private Insurance/ Exchange	103,000	Yes	No	Yes	\$119.7 Million
Option 5: Direct Primary Care Memberships	78,000	Some	No	No	\$0

**Option 2 Redesigning the County Indigent Program and the State Catastrophic Fund, was previously eliminated by the Governor's Workgroup and was not considered in this discussion.*

The August recommendation for Option 3 Managed Care/State Contract was not endorsed by legislative workgroup members at the time. Legislators felt the recommendation was not feasible in the current political environment and encouraged the workgroup to develop an alternate plan.

In November, legislative members agreed the workgroup was moving in the right direction by revising the recommendation to Option 3.5 Managed Care/Private Insurance that includes a Direct Primary Care pilot. Three of the four legislators voted for the recommendation, voicing varying levels of support. The final vote on recommending Option 3.5 Managed Care/Private Insurance was 12 to 1, with all non-legislative members supporting the measure as the best path forward for Idaho.

Workgroup Background

Governor C.L. “Butch” Otter appointed a workgroup on July 13, 2012 to evaluate the advantages and liabilities of expanding health insurance coverage through Medicaid to low-income adults. Many Idaho adults living below poverty have no health insurance options under the Patient Protection and Affordable Care Act (PPACA). The 15-member workgroup, whose members represent both the public and private sectors, was led by Idaho Department of Health and Welfare Director Richard Armstrong.

The workgroup met three times in 2012, submitting a report to Governor Otter in December of that year. The workgroup also met in March 2013. Governor Otter reconvened the workgroup in 2014, with meetings held in June, August and November.

A synopsis on the following pages documents the workgroup’s three 2014 meetings, including the presentations and discussions.

June 18, 2014 Idaho Medicaid Redesign Workgroup Meeting

The workgroup met for the first time since March 2013 at the request of Gov. Otter to address the indigent healthcare system and the lack of healthcare and insurance options for low-income citizens.

The meeting highlights included:

- An independent analysis of other state’s efforts to expand Medicaid, concentrating on six states that are pursuing alternative expansion plans.
- An analysis of the “gap” population, an estimated 78,000 Idaho citizens who earn less than 100 percent of poverty and lack healthcare coverage options.
- An alternative approach to Medicaid expansion that supports community health centers and other community uninsured efforts.
- A comparison of two private option models—Option 3 Care Management/State Contract vs. Option 4 Private Insurance/Exchange -- as possible redesign models.

- An independent actuarial analysis that evaluates the costs and savings of the options being considered by the workgroup.
- A candid discussion focused on the political reality that Medicaid expansion may not be supported by lawmakers in the next legislative session, with emphasis on developing an alternative recommendation for indigent and low-income care/insurance coverage.

Presentations/Key Points:

1. Medicaid Redesign Impact on the State Healthcare Innovation Plan (SHIP), Ted Epperly M.D., Chair of Idaho Healthcare Coalition

- The two most important components to improving people's health are:
 1. A usual source of healthcare in which a patient develops a relationship and trust with a provider.
 2. Insurance coverage that helps pay for care. Without coverage, people live sicker, die younger and cost more.
- SHIP identifies patient centered medical homes as the trusted source of care that focuses on preventive care, managing chronic conditions, and coordinating care with specialists.
- Medicaid redesign and SHIP work in concert with each other: Recommendation to expand coverage to low-income, uninsured people must include healthcare system reforms that strengthen the infrastructure to handle the influx of people.
- Human behaviors account for 40 percent of deaths; providers must have the trust of patients to change their behaviors and hold them accountable for their health.
- SHIP concept moves people from crisis care to prevention, the front end of the healthcare system.
- The SHIP goal is to transform 180 Idaho medical practices to patient centered medical homes over a three-year period
- The state has a unique opportunity to provide 103,000 uninsured people with coverage through a redesigned healthcare system that is sustainable and coordinated.

2. Alternative State Approaches to Medicaid Expansion, Joanne Jee, National Academy for State Health Policy

- Six states are designing alternatives to traditional Medicaid expansion; Arkansas, Indiana, Iowa, Michigan, New Hampshire and Pennsylvania.

- Three alternative models have been fully implemented; however it is too early to analyze data from alternative models to determine performance.

States are designing alternatives to traditional Medicaid expansions					
State program	Premium Assistance	Premiums or Cost Sharing	Benefits Waived	Healthy Behavior Incentives	Work Incentives
AR Private Option	✓	✓			
IA Wellness Plan		✓	✓	✓	
IA Marketplace	✓	✓	✓	✓	
HealthyMI		✓			
HealthyPA (pending)	✓	✓	✓	✓	✓
NH Health Protection Prog (leg. signed)	✓	✓		✓	
IN HIP 2.0 (11/15 in dev.)	ESI	✓	✓	Health plans	✓

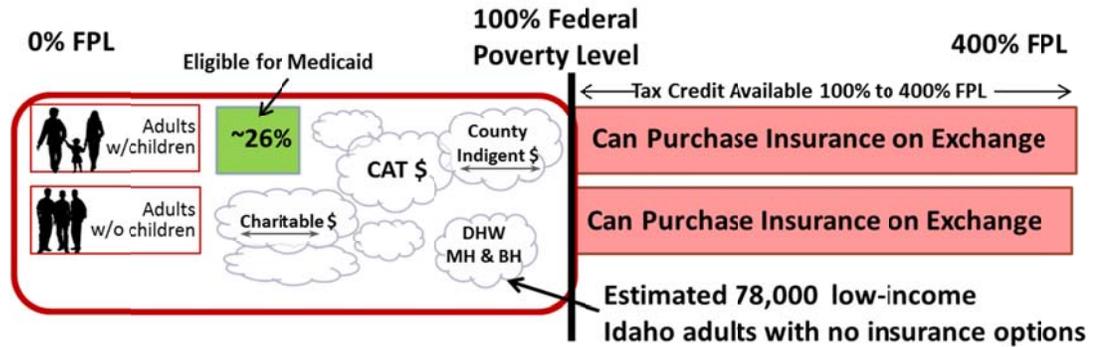
NATIONAL ACADEMY
for STATE HEALTH POLICY

- The Arkansas Private Option and Iowa Marketplace Choice purchase coverage for newly eligible adults from the insurance exchange marketplace; this model is similar to Idaho Option 4, the Private Insurance/Exchange option.

- Other plans incorporate tools that include Care Management efforts, participant premiums and copays, healthy behavior and work incentives; these models are similar to Idaho Option 3, the Care Management/State Contract option.
- The majority of alternative plans include reforms of the healthcare system, such as mandatory provider participation in patient centered medical home initiatives.
- The federal Centers for Medicare and Medicaid Services (CMS) are more negotiable on accountable benefit design to encourage states to expand Medicaid. However, CMS is not flexible on higher levels of cost sharing, mandated wraparound benefits, or partial expansions below 138 percent of poverty.
- CMS may limit the number of alternative demonstrations by states.

3. Medicaid and the “Gap” in Healthcare Coverage, Lori Wolff, Idaho Division of Welfare Administrator

- An estimated 78,000 adults earning between 26 and 100 percent of poverty are not eligible for Medicaid or a tax credit, falling into a “gap” with no coverage options.



- Poorer families cannot afford insurance. If they earn less than the federal poverty limit, they are charged the highest premiums.
- 73 percent of Medicaid applications by parents are denied because they are over income limits; an average of 2,100 applicants per month.
- The Department of Health and Welfare has data on low-income adults who access the Food Stamp Program, which has similar income limits to Medicaid expansion. Data identifies 56,000 adult Food Stamp recipients who do not receive Medicaid; over 60 percent are adults with children. These are adults who are working or taking part in work activities required by the Food Stamp program.
- 68 percent of the gap population lives in households which have at least one full-time worker.

4. Comparing Two Options for Medicaid Expansion: Option 3 Care Managed/State Contract and Option 4 Private Insurance/Exchange, Paul Leary, Idaho Division of Medicaid

- States can receive federal authority to expand Medicaid, which would be required through a State Plan Amendment for Option 3 Care Management/State Contract, or a Section 1115 Demonstration Waiver for the Option 4 Private Insurance/Exchange.
- Section 1115 Demonstration Waivers are usually approved for a three to five-year period and must be budget neutral. The waiver has more frequent

reporting requirements to measure performance, placing an additional administrative burden on the state.

- When the waiver sunsets, CMS will evaluate the performance of the demonstration and decide whether states can incorporate successful components into their state plans.
- Two states are using the waiver for the Private Insurance/Exchange option by purchasing qualified health plans through their state exchanges for the expanded population.
- Option 3 Care Management/State Contract was explored during prior workgroup meetings, in which a framework was developed called the Healthy Idaho Plan. This draft plan would contract with an insurer(s) to provide qualified health plans for the expansion population. The draft included cost sharing and incentives for both participants and providers.

	Option 3 Care Management/State Contract	Option 4 Private Insurance/ Exchange
Cost Sharing	<ul style="list-style-type: none"> • Co-pays on all services up to federal limit • Receipt of services can be conditional on co-pays for participants >100% FPL 	<ul style="list-style-type: none"> • Follows the Qualified Health Plan cost sharing up to federal Medicaid limits • Medicaid pays for cost-sharing in excess of federal limits—at enhanced FMAP rate as long as budget neutrality is maintained
Personal Responsibility Incentives	<ul style="list-style-type: none"> • Can provide incentive for participants to accrue funds to assist with co-pays through prevention/behaviors 	<ul style="list-style-type: none"> • None-unless already included in Qualified Health Plan
Provider Incentives	<ul style="list-style-type: none"> • Providers encourage healthy behavior benefit from co-pay and by achieving improved outcomes 	<ul style="list-style-type: none"> • None-unless already included in Qualified Health Plan

- With either option, the state can eliminate the program and drop coverage on the expansion population at any time.
- Both options utilize the private market to provide coverage to the expansion population; the Private Insurance/Exchange option purchases the coverage through the insurance exchange, while the Care Management/State Contract option contracts for coverage on a per-member-per-month contract with private managed care organizations or insurer(s).

5. An Alternative to Medicaid Expansion, Senator Steve Thayne

- Reform the healthcare system and reduce medical costs by 50 percent by empowering people.
- Third party payers in the form of insurance companies and government control 85 percent of healthcare spending, but neither are concerned about costs because they are not accountable for payment.
- CMS rules are problematic and inflexible, not allowing for an accountable care system.
- Idaho has an opportunity to develop a community health system during the next five to ten years in which the state determines the rules, not the federal government.
- Idaho should build up its community healthcare system.

6. An Update and Actuarial Analysis of State Options, Justin Birrell and Ben Diederich, Milliman actuarial firm

- Updated previous projections with revised census data, woodwork impact on Medicaid that has occurred, and experience gained nationally since the Affordable Care Act became law in January 2014.
- Analyzed three options:
 1. No Expansion
 2. Expansion through Option 3 Care Management/State Contract
 3. Expansion through Option 4 Private Insurance/Exchange
- Based on surveys and experience of other expansion states, the expansion population appears to have greater medical need and acuity than current Medicaid or Temporary Assistance for Needy Families populations. This has increased monthly per-member-per-month costs from last report.
- Option 3 Care Management/State Contract has a per-member-per-month composite rate of \$560; an Option 4 Private Insurance/Exchange has an estimated per-member-per-month composite rate of \$442. However, the cost trend of annual inflation was 7.5 percent for Option 4 Private Insurance/Exchange compared to 2.5 percent for Option 3 Care Management/State Contract.

- Because of higher medical needs of the expansion population, the Option 4 Private Insurance/Exchange rates are projected to be adjusted higher as insurance companies gain claims experience.
- Costs/Savings summary comparison of three options from 2016-2025 that includes the mandatory expansion costs:

1. Option 1 Status Quo:	\$257 Million
2. Option 3 Care Management/State Contract:	\$ 81 Million
3. Option 4 Private Insurance/Exchange:	\$165 Million

6. Next Steps: A Candid Discussion to Set Achievable Parameters

- Legislative members advised the workgroup that Medicaid expansion is not feasible in the Legislature in 2015, recommending the workgroup concentrate on achievable solutions, such as revamping the county/state catastrophic healthcare program.
- Workgroup members felt strongly that the catastrophic/indigent healthcare program cannot be modified into a viable program, even though the Idaho Legislature may prefer to reform the program rather than consider any model that involves Medicaid expansion. This sparked discussion about other options and funding sources that could be explored.
- Several members feel the state should use the federal money to design its own system of care without federal regulations; however, federal funding is only accessible under the Medicaid umbrella.
- Members voiced support to continue evaluating the Private Insurance/Exchange and Care Management/State Contract options, while exploring other possibilities for a third option to provide coverage to the 78,000 people currently without insurance coverage.

August 14, 2014 Idaho Medicaid Redesign Workgroup Meeting

The workgroup reconvened on August 14 and voted to recommend Option 3 Care Management/State Contract to Governor Otter by a vote of 10-3 (two members absent). The Care Management/State Contract option incorporates cost sharing and incentives for both participants and healthcare providers through qualified health plans that are contracted on a per-member-per-month basis with an insurer. A similar Care Management/State Contract option also was the workgroup's recommendation in November 2012.

The August 14 meeting highlights included:

- An overview of recent Medicaid performance showing current care management programs in dental and transportation have helped hold costs down despite increasing enrollments.
- Medicaid administrative costs are less than 3 percent of the total budget, substantially lower than most commercial insurance administrative costs.
- Idaho has the second highest rate of uninsured veterans in the nation, many of whom do not have coverage options due to low income.
- An estimated 41,000 adults Idahoans suffer from serious and persistent mental illnesses; however, only 9,000 qualify for Medicaid due to Idaho's strict eligibility criteria.
- Analysis of county/state medical indigency program cases, reviewed by Idaho Medical Review, LLC, shows that high-cost medical care was required in all cases, with 70 percent of people requiring ongoing specialty care. Primary care availability would have only prevented 10 percent of cases.
- Incident-based indigency program does not address poor behaviors, which account for 70 percent of high-cost claims.
- Option 5 Direct Primary Care model restores the direct relationship between patient and physician in a medical home, reducing hospital emergency room utilization and improving care for members with chronic conditions.
- Options 3 and 4, the Care Management/State Contract and Private Insurance/Exchange options, both serve 102,873 people with 10-year net costs

ranging from \$73.4 million to \$137.3 million. Option 5 Direct Primary Care memberships serves 77,719 people with 10-year costs of \$1.2 billion.

- Premature deaths resulting from not expanding Medicaid are estimated between 76 and 179 early deaths annually.

Presentations/Key Points:

1. The Facts About Medicaid, Lisa Hettinger, Idaho Medicaid Administrator

- Medicaid’s state fiscal year 2015 budget is \$2.033 billion, which includes 67 percent federal funds and 24 percent state general funds.
- 97 percent of Medicaid’s budget pays for medical services primarily to Idaho healthcare providers; only 3 percent is used for program administration.
- Each \$1 of state general funds spent for Medicaid leverages other funding sources to equal \$4.13, which is predominately spent in the Idaho economy.
- People who are elderly or disabled account for 30 percent of Medicaid participants, but more than 70 percent of costs.

Plan	Average Members/Mo. SFY 2014	% of Total Medicaid Members	Monthly Cost/Member
Basic Child	154,854	61.3%	\$184
Basic Adult	26,205	10.4%	\$588
Enhanced Child	30,902	12.2%	\$892
Enhanced Adult	17,080	6.8%	\$2,465
Coordinated	23,445	9.3%	\$1,756

Includes pregnancy

Under 30% of members

Over 70% of cost

- Medicaid care management efforts have helped contain costs. Even though enrollment has been increasing, the costs per member have declined.

2. Medicaid Redesign for Idahoans with Disabilities, Jim Baugh, Executive Director of DisAbility Rights Idaho

- People who apply for disability from the federal Social Security Administration must wait two years after approval to receive Medicare benefits. During the two-year waiting period, few have access to health insurance coverage.

- An estimated 41,000 Idahoans have a severe and persistent mental illness; however, only 9,000 are covered by Medicaid because of strict eligibility criteria for adults.

- Expansion could remedy many of the problems with Idaho's current mental health system by primarily using federal dollars.

- Many people currently receiving adult mental health and substance abuse treatment from the state's Division of Behavioral Health would qualify for the expansion program, saving \$10.2 M. in state general funds annually.

Many Idahoans With Disabilities Are Not Covered

- **Uninsured households with income below 138% of the Federal Poverty Level :**
 - Most adults with severe mental illness
 - Many low income people with disabilities and chronic health conditions
 - People with recent disabilities in the waiting period for Medicare (2years).

- The array of mental health services offered through the Private Insurance/Exchange option does not match those offered through Medicaid and would not be as effective for people with severe and persistent mental illnesses.

- Idaho has an estimated 10,000 uninsured veterans, the second highest rate in the United States. Approximately 3,200 of these earn less than the federal poverty limit.

3. Moving Indigent Care from Incident-based to Systematic Care, Doug Dammrose, M.D., Idaho Medical Review, LLC

- Administration of indigent program varies widely by counties, with inconsistent case approvals.
- Seventy percent of healthcare issues are the result of human behaviors that should be addressed at the primary care level.
- Case reviews of state/county indigent cases exceeding \$50,000 shows:
 - Mean charges per episode = \$130,949.

- 42 percent met Social Security Disability criteria.
- Primary care could have potentially mitigated 10 percent of cases.
- More than 70 percent of recipients required ongoing specialty care.
- No method of care coordination or case management is currently offered.
- Cost shifting to private payers occurs, with increased costs to taxpayers without any federal sharing unless Medicaid expands.

Random Sample

- Out of 1,500 cases reviewed, cases with charges over \$50,000 were selected
 - Cancer – 10%
 - Infection – 22%
 - Cardiovascular – 18%
 - Diabetes – 11%
 - Trauma – 16%
 - Alcohol and Substance Abuse - 11%
 - Liver and Pancreas – 10%
- Mean charges per episode - \$130,949
- 42% of the patients met Social Security criteria for disability

4. Option 5 Direct Primary Care Model, Senator Steven Thayne; Erica Bliss, M.D. with Qliance, a direct primary care organization; and Vicki Wooll, M.D., Family Practice Physician and member of Independent Doctors of Idaho.

- Qliance model in Washington State provides direct primary care for a monthly fee of \$59-\$99 month, depending on age. They do not accept insurance and there are no copays. Provides 10 to 30 percent savings.

Qliance Monthly Fees for Individuals		
Ages 0-19	Ages 20-49	Ages 50+
\$59	\$79	\$99

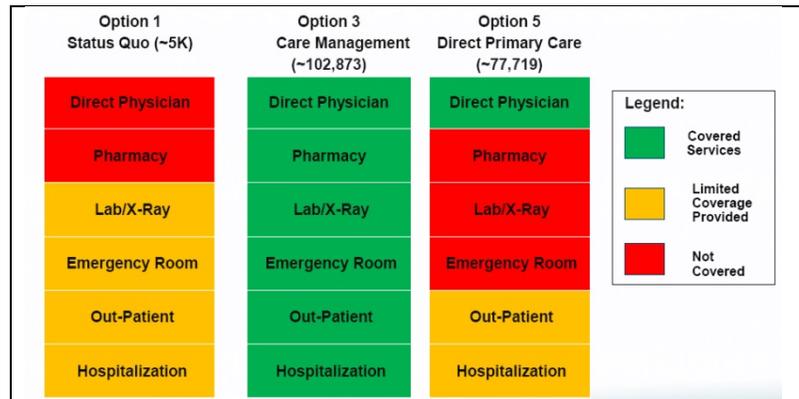
- Restores direct relationship between patient and doctor to improve care and lower costs; the “Marcus Welby” medical practice model.
- Subscribers include individuals, businesses, Washington Medicaid, and state agencies. It can be purchase on the Washington state health insurance exchange.

- Qliance encourages catastrophic healthcare policy to wrap around the primary care services they provide, such as a high deductible policy.
- Primary care physicians in this model carry 800-1,000 patients; this is much lower than most primary care caseload physicians carry today, 2,300-3,500 patients.
- Direct Primary Care Memberships is a good model for people with chronic conditions who require strong case management and have a wrap-around policy for other medical expenses.
- Providers are embracing alternative medical models such as the primary care model due to low Medicaid payments and burdensome administrative paperwork.

5. Idaho Medicaid Expansion: An Actuarial Analysis of State Options; Justin Birrell and Ben Diederich, Milliman actuarial firm

- **Option 1 Status Quo:** No expansion and continuing the state/county indigent care program will cost Idaho taxpayers \$1.17 billion over the next 10 years, serving 5,000 people annually.

- **Option 3 Care Management/State Contract:** When compared to Option 1 Status Quo, expansion using a state plan amendment through care management will produce savings of \$183.6 million over the next 10 years and would serve 103,000 people annually. Monthly premiums are estimated at \$560.



- **Option 4 Private Insurance/Exchange:** Purchasing insurance policies on the Idaho insurance exchange will produce savings of \$119.7 million during next 10 years over Option 1 Status Quo, and serve 103,000 people annually.
- **Option 5 Direct Primary Care Memberships:** Purchases memberships for primary care services using county/state indigent program funds. Ten-year cost is \$1.17 billion, serving 78,000 people annually. Monthly premium for direct primary care membership is estimated at \$65/month. A wrap-around policy for pharmacy, hospital and other services is estimated at \$384/month

for a total cost of \$449/month. No administrative costs have been calculated for this program.

- Option 1 Status Quo and Option 5 Direct Primary Care Memberships are funded by current state/county indigent program funding.
- Option 3 Care Management/State Contract and Option 4 Private Insurance/Exchange are funded by a mix of federal and state dollars, with the federal government paying a minimum of 90 percent of costs.

6. Economic Impacts of Medicaid and Proposed Medicaid Expansion: Steven Peterson, Clinical Assistant Professor of Economics at the University of Idaho

- SFY 2014 Medicaid spending in Idaho totaled \$1.853 billion which includes \$1.32 billion in federal funds.
- Federal \$1.32 billion portion of Medicaid generated gross wages of \$1 billion, supporting 28,342 jobs while also generating \$85.5 million in state and local taxes.

- If Medicaid expansion occurred in 2016, federal Medicaid spending would increase by an estimated \$720.4 million. These additional funds would generate \$548 million in wages, support 14,712 jobs and leverage \$46.5 million state and local tax dollars.

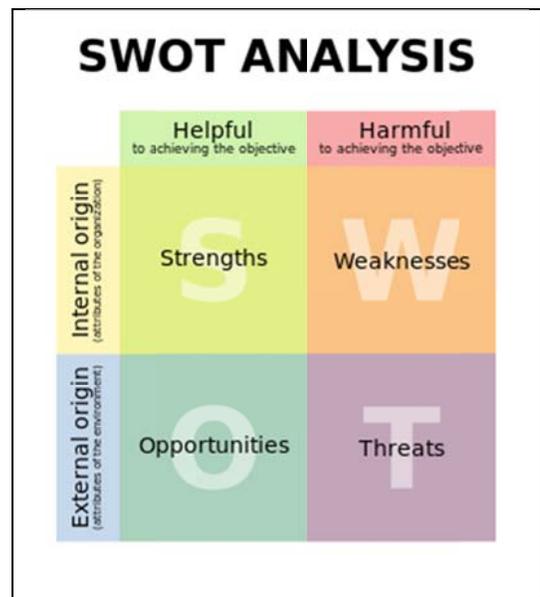


- Existing federal spending in Medicaid plus federal dollars if expansion occurs would equal \$2.04 billion in 2016. This would generate an estimated \$1.56 billion in gross wages, support 43,053 jobs and leverage \$132 million in taxes.
- Medicaid is largely a service industry so new money supports more jobs and wages than other traditional Idaho industries such as grain sales, cattle ranching or mining.

- Absent federal dollars from expansion, healthcare expenditures for people who are uninsured is pulled from other parts of the economy, displacing private spending and reducing overall economic activity in the state.
- Cost shifting results in greater insurance costs to employers and individuals, which reduces consumer spending throughout the economy.
- Uninsured people have higher number of deaths and more sick days with lost productivity than those with insurance.
- Premature annual deaths for uninsured adults are estimated between 76 and 179 if Medicaid is not expanded.
- Any new money has direct impact on the state's economy. If federal money does not come to Idaho, it will go elsewhere.

7. SWOT Analysis: Strengths, Weaknesses, Opportunities and Threats

- Workgroup members analyzed all options under consideration. Option 3 Care Management/State Contract covered the greatest number of people at the lowest state cost over a 10-year period.
- The Affordable Care Act cuts \$500 million in Disproportionate Share Hospital (DSH) payments for Idaho hospitals that treat uninsured people. Option 3 Care Management/State Contract and Option 4 Private Insurance/Exchange would mitigate this negative impact by expanding comprehensive insurance coverage for 103,000 people.



- Option 4 Private Insurance/Exchange minimizes stigma.
- Option 5 Direct Primary Care Memberships is attractive to providers because it streamlines administrative costs.
- If the state chooses Option 3 Care Management/State Contract, approximately 25,000 Idahoans currently purchasing insurance on the exchange would transition from the exchange to the Care Management/State Contract option, reducing state exchange enrollments.
- If the state chooses Option 4 Private Insurance/Exchange, an estimated 78,000 additional people would enroll in the state insurance exchange.

- Option 3 Care Management/State Contract and Option 4 Private Insurance/Exchange would have to meet the Centers for Medicare and Medicaid Services limitations on cost sharing and eligibility.
- Option 5 Direct Primary Care Memberships does not fund mental health services.
- Option 5 Direct Primary Care Memberships continues to use state and local dollars; Option 3 Care Management/State Contract and Option 4 Private Insurance/Exchange are largely (over 90 percent) funded by federal dollars.

8. Next steps: Workgroup votes to recommend Option 3 Care Management/State Contract to Governor Otter.

- Legislators cautioned other workgroup members that sending a recommendation to expand Medicaid through Option 3 Care Management/State Contract would not be successful in the Legislature with the current political climate.
- Workgroup members decided to adhere to the Governor's directive to recommend the best path forward for Idaho, regardless of the political viability.
- All members agreed that an education effort for legislators and the general public is a top priority so informed decisions can be made.
- Workgroup members suggested Option 5 Direct Primary Care model was not a good standalone option, but had merits that could be incorporated into a care management model.
- The workgroup voted 10-3 to recommend Option 3 Care Management/State Contract to the Governor. The three legislative members in attendance at the meeting voted against the proposal and recommended the workgroup develop an option that the Idaho Legislature could give serious consideration to.

November 14, 2014

Idaho Medicaid Redesign Workgroup Meeting

The workgroup approved a recommendation to present to Governor Otter during the August 14 meeting, however, the evolving state and national landscapes in healthcare reform precipitated an additional meeting on November 14th to reassess and improve that recommendation.

The state is in the final phases of obtaining a State Healthcare Innovation Planning (SHIP) grant to reform traditional healthcare. Funding from the grant may allow the state to convert the current fee-for-service model to a patient-centered medical home or direct primary care model that focuses on a primary care physician overseeing a person's healthcare, with reimbursement tied to prevention and improved outcomes.

At the national level, the Centers for Medicare and Medicaid Services is approving increasingly innovative state plans for healthcare coverage for low-income adults, including hybrid plans that blend several options being utilized by different states.

With these evolving changes, the workgroup revisited possible blending of options and finalized a recommendation to Governor Otter that utilizes three options. These include Option 3 Care Management/State Contract; Option 4 Private Insurance/Exchange; and Option 5 Direct Primary Care.

The revised recommendation, referred to as Option 3.5 Care Management/Private Insurance, utilizes the care management option for people earning between 0 to 100 percent of poverty, and private insurance option through the insurance exchange for adults earning between 100 to 138 percent of poverty. As part of this recommendation, the workgroup included an evaluation of the Direct Primary Care model.

The workgroup approved the revised recommendation by a vote of 12 to 1, with one member absent.

Presentations/Key Points:

1. Blending Coverage Options for Low-Income Idaho Adults: Richard Armstrong, Director of the Department of Health and Welfare.

- The workgroup's recommendation should be linked to the state's vision to transform healthcare in Idaho from fee-for-service delivery to a value-based, coordinated, population health delivery system. This road map is outlined in the State Healthcare Innovation Plan (SHIP).

- Current law provides 25,000 Idaho adults with incomes from 100 to 138 percent of poverty the opportunity to purchase insurance coverage on Your Health Idaho, with assistance from premium tax credits. Option 3.5 preserves that coverage.
- Children of families between 100 to 138 percent of poverty receive their insurance from Medicaid through the Children’s Health Insurance Program (CHIP). These children should be allowed to enroll with parents’ private coverage and not be forced onto Medicaid.
- 78,000 adults between 0 to 100 percent of poverty are in a health insurance coverage “gap;” they are not eligible for tax credits or Medicaid.
- Medicaid can help lead the way to healthcare reform by enrolling uninsured adults earning 0 to 100 percent of poverty into a care management program using a patient-centered medical home model. Eventually, all Medicaid coverage should convert to coordinated, care management.



- The Centers for Medicare and Medicaid Services has indicated it will approve a model using care management for the very low income, and private insurance for people slightly above poverty.
- Care management requires personal responsibility of participants; it is not structured like current entitlement programs.

2. Option 5 Direct Primary Care Model: Senator Steven Thayne

- Top-down approach of changing the system will fall short of its goal because it does not empower physicians and patients with choices and resources.
- Expanding Medicaid is based on deficit spending that will result in underpayment to providers and reduce the number of providers who accept Medicaid patients.

- Direct Primary Care model can reduce costs by up to 50 percent and eventually phase out Medicaid.
- Process: Eliminate county indigent and state catastrophic healthcare funds, using this funding to purchase 66,000 Direct Primary Care memberships for uninsured adults who earn less than 100 percent of poverty.

#1 Priority

- To improve outcomes and increase access
- is to invest more \$\$\$ in primary care
- A law that prohibits us from taking common sense, economical, compassionate steps is a corrupt law and needs to be changed.
- The top-down approach suggested by this committee will fall short of its goals of reducing costs – because there is no empowerment of the docs and patients with choices and resources

- First Step: Create a pilot program for 1,200 individuals at a cost of \$900,000 with three types of providers:
 1. Primary care physician
 2. Community health center
 3. Rural Hospital
- FAQs about Direct Primary Care (DPC) Option:
 1. DPC premium levels range from \$50 to \$69/month.
 2. State funds from elimination of catastrophic healthcare program will pay for DPC memberships.
 3. DPC is protected under Affordable Care Act.
 4. DPC does not provide all health benefits and should be accompanied by a wrap-around policy.
- Investing in primary care will do more to provide medical care than any other investment.
- Hospitals could lose up to \$60 million in uncompensated care, which is less than 2 percent of hospital gross revenues. However, hospitals benefit more from tax exempt status.
- Idaho also may want to seek a Medicaid waiver that allows the state to provide primary care and partner with CMS to cover hospitalizations.

3. An Actuarial Analysis of State Options, Justin Birrell and Ben Diederich, Milliman actuarial firm

- Options 3, 3.5 and 4 have local cost offsets and state savings of more than \$900 million over 10 years. Option 5 uses state funding to purchase Direct Primary Care memberships, reducing offsets and savings. The marginal costs of the four options are:

1. Option 3 Managed Care: \$183.6 million savings
2. Option 3.5 Blend of Managed Care/Private Insurance: \$173.4 million savings
3. Option 4 Private Insurance: \$119.7 million savings
4. Option 5 Direct Primary Care: No offsets or savings

- Options 3 and 3.5 have higher initial administrative costs with managed care contracting, but greater savings over a 10 year period.
- There are projected increases in Medicaid costs of \$257 million over 10 years due to required changes of the Affordable Care Act. These expenses will occur regardless of the decision on Medicaid expansion, primarily due to woodwork group claims' costs.

4. Final Discussion

- Workgroup members expressed the importance of a model that incorporates personal accountability coupled with a patient-centered medical home; support for personal responsibility was strongly voiced over expansion of an entitlement program.
- The financing mechanisms of the four options were discussed. Workgroup members felt the slight increase in costs for the hybrid Option 3.5 was validated by purchasing insurance through the exchange for many participants.
- The workgroup discussed the merits of the Direct Primary Care model, which in many aspects mirrors the State Healthcare Innovation Plan objectives. However, members expressed reservations about costs not covered by a DPC model, including hospitalizations and pharmacy.
- The workgroup proposed recommending Option 3.5 Managed Care/Private Insurance with a pilot of the Direct Primary Care option designed within the model. The pilot would cover 1,200 individuals in three types of settings – a direct primary care practice, a community health center and a rural hospital.
- The workgroup approved the recommendation 12 to 1, with one member absent.

Attachment #1

Governor's Letter Reconvening Workgroup

Idaho Workgroup on Medicaid Redesign

December 4, 2014



C.L. "BUTCH" OTTER
GOVERNOR

April 11, 2014

RECEIVED

APR 14 2014

DEPARTMENT OF HEALTH AND WELFARE
OFFICE OF THE DIRECTOR

Richard Armstrong, Director
Department of Health and Welfare
450 W. State St.
Boise, ID 83720

Dear Director Armstrong,

Please accept my sincere thanks for your work last year in leading the Medicaid Redesign Workgroup. The report the workgroup submitted to me provided a good base of information for further discussion.

Idaho is at a policy crossroads in considering how to address our indigent care system, while struggling with the lack of healthcare options for low-income individuals or families.

At this point, I request that you once again gather the members of the workgroup to review current state data and Medicaid redesign options being implemented or considered by other states.

I have asked the Pro Tem and Speaker to provide two legislators from each body to participate in your discussions. Please contact the Pro Tem and Speaker so you can include their designees in your next meeting.

Please provide me with an updated report no later than September 1, 2014. Thank you for supporting my efforts to find reasonable solutions to these complex policy issues.

As Always – Idaho, "Esto Perpetua"

A handwritten signature in black ink that reads "C.L. Butch Otter".

C.L. "Butch" Otter
Governor of Idaho

cc:

The Honorable Brent Hill
The Honorable Scott Bedke

Attachment #2

Workgroup Members

*Idaho Workgroup on Medicaid Redesign
December 4, 2014*

2014 Governor's Workgroup on Medicaid Redesign

Member	Affiliation
Sen. Steven Thayn	Idaho Senate, Emmett (R)
Sen. Lee Heider	Idaho Senate, Twin Falls (R)
Rep. Tom Loertscher	Idaho House, Iona (R)
Rep. Mike Moyle	Idaho House, Star (R)
Dan Chadwick	Idaho Association of Counties
Tom Faulkner	Gooding County Commissioner
Ted Epperly, M.D.	Family Medical Residency of Idaho
Bill Woodhouse, M.D.	Family Medical Residency Program Idaho State University
Lisa Kidder Hrobsky	Idaho Hospital Association
Susie Pouliot	Idaho Medical Association
Drew Forney	Citizen Member
Elizabeth Ambrose Gray	Nurse Practitioner
Tom Fronk	Idaho Primary Care Association
Stephen Weeg	Governor's Health Care Council and Idaho Board of Health and Welfare
Non-Voting Members	
Richard Armstrong	Idaho Dept. of Health and Welfare
Bill Deal	Idaho Dept. of Insurance

Attachment #3

Actuarial Analysis – Milliman Consultants

Idaho Workgroup on Medicaid Redesign

December 4, 2014



**Revised Financial Impact Review of the
Patient Protection and Affordable Care Act
On the Idaho Medicaid Budget Including State and County Cost
Offsets**

Prepared for:
Idaho Department of Health and Welfare

Prepared by:
Milliman, Inc.

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December 3, 2014

This report assumes that the reader is familiar with the state of Idaho's Medicaid program and federal healthcare reform. The report was prepared solely to provide assistance to DHW to model the financial impact of federal healthcare reform provisions. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

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EXHIBITS

Exhibit 1: Impact of the ACA on the Idaho Medicaid Budget

Exhibit 2: Impact of the ACA on the Idaho Medicaid Budget - Savings/Cost Graph

Exhibit 3: Cost Projections by Age/Gender

Exhibit 4: Potential and Projected State and County Cost Offsets

Exhibit 5: Hospital Impact – Projected Loss of Federal Funds due to DSH Reductions

Exhibit 6: Idaho Projected Costs Table and Graph – Status Quo and Expansion (Option 3.5)
Comparisons Including Current Medicaid Costs

Exhibit 7: Idaho Projected Costs Table and Graph – Status Quo and Expansion Blend (Option 3)
Comparisons including Current Medicaid costs

I. SUMMARY OF RESULTS

INTRODUCTION

At the request of the Idaho Department of Health and Welfare (DHW), Milliman has revised their March 7, 2013 report of the Financial Impact of the Patient Protection and Affordable Care Act (ACA) on the Idaho Medicaid Budget. This revision was requested in response to: updated 2012 census data, updated State of Idaho budget, and to price additional coverage options. The reported time period is shorter by a half year, shifting from CY2014-SFY2024 to SFY2016-SFY2025.

Change in estimated number of Medicaid eligible: As a result of the updated 2012 census data the optional Medicaid expansion population decreases from 104,211 to 102,873 adults. These individuals would gain access to coverage in expansion with either options 3, 3.5 or 4 discussed below. Options 1 and 5 do not expand the number of Medicaid eligible adults. For these two options, individuals within the coverage gap, for incomes below the federal poverty limit, would still need to rely on current programs for a portion of their health care costs. Option 1 is a status quo estimate of no expansion, and Option 5 redistributes the state and county offsets to cover the cost of a direct primary care program using state funds.

Change in estimated cost/savings to Medicaid: The state's cost for mandatory expansion over the projection period is \$257.0M; state and county offsets are not realized with mandatory expansion. The ten year savings in state and county funds from optional expansion changes is **(\$173.4M)** assuming Option 3.5 unit cost assumptions.

Optional expansion savings does not offset the mandatory expansion costs for an overall estimated ten year net cost of \$83.5M assuming Option 3.5 unit costs. Note that these figures assume the elimination of the County Indigent/CAT funds.

Throughout this report we refer to state and county offsets. We have assumed that if Idaho expands Medicaid coverage, the state and county taxes supporting these programs will no longer be used to cover these healthcare expenses. The savings from elimination of these programs are the offsets referred to throughout this report.

Description of Options: At the state's request, the expenditures were estimated for the following scenarios.

- Option 1 – Status Quo with No Optional Expansion. For this option we have not projected the unfunded costs for individuals without coverage. It also does not project any offsets for elimination of current programs.
- Option 3 – Expanding Medicaid to 138% of FPL using a Managed Medicaid approach and level of cost assumptions. The updates to the estimates for this option reflect a change in population as well as the shift in time horizon for the projection.
- Option 3.5 – Option 3 and Option 4 blend where 0-100% FPL receives care through Managed Medicaid (Option 3) and 100-138% FPL receives care through the Exchange (Option 4).

- Option 4 – Private Plan models the cost of having the expansion population receive care through the exchange (commercial rates). This model is similar to the approach implemented by Arkansas.
- Option 5 – Direct PCP Program demonstrates redirecting the CAT and Medical Indigent funds to a Direct Primary Care program and Medical Procedures Fund; this option will only cover low income adults under 100% FPL. Outside of the primary care coverage only a small number of individuals would be covered for a limited set of services. This state only program would not be eligible for federal matching funds. Savings from elimination of current state and county programs will be offset by the creation of this new program. This is the only option which unfunded costs are estimated. The proposed program does not provide the comprehensive coverage for all of the essential health benefits addressed by options 3, 3.5 and 4.

The scope of our report is limited to a projection of the financial impact of the ACA on the Idaho Medicaid budget including state and county cost offsets. DHW can use the results of this report, along with its own determination of the potential benefits of expanding Medicaid coverage, as it considers whether or not to expand Medicaid eligibility under the ACA.

SUMMARY OF OPTIONS

In its June 28, 2012 decision, the Supreme Court of the United States upheld most of the ACA, but gave States the flexibility to decide whether to expand Medicaid program eligibility to 133% of FPL. This report evaluates the financial impact of the ACA on the Idaho Medicaid program for five of the six potential ACA Medicaid expansion options:

- > **Option 1 – No Expansion/Continue Indigent Programs as Currently Designed:** Additional enrollment is anticipated from those who are already eligible for Medicaid due to pressure from the individual mandate, referrals from the exchange, or loss of employer coverage. This population is often referred to as the “woodwork effect” population. In addition to the woodwork population we also include pricing for other aspects of the ACA not related to Medicaid expansion. We also refer to this option as the “status quo” option.
- > **Option 2 – No Expansion/Indigent Program Redesign:** Milliman was not asked to perform analysis directly related to this option.
- > **Option 3 – Idaho expands Medicaid to 138% of FPL (Managed Care):** This option includes the cost of Medicaid expansion to 138% of FPL (the full expansion included in the ACA). Note the 133% FPL level specified in the ACA is effectively 138% due to the 5% income disregard. In addition to the increased FPL level of coverage, this population includes changes as a result of the new modified adjusted gross income (MAGI) eligibility guidelines, often referred to within the state as the “Surge” population. In our original report these members were included in Option 1. Guidance from CMS in a letter dated December 28, 2012 to the state Medicaid director indicates that MAGI rules should not “systematically increase or decrease the number of eligible individuals within a given eligibility group”. We have interpreted this to mean that the state would adjust their income considerations eligibility such that when the MAGI rules are applied there is not an aggregate increase or decrease to membership, therefore this “Surge” population has been moved to be part of the optional expansion population.

- > **Option 3.5 – Option 3/Option 4 Blend:** This scenario presents the cost of expansion assuming 0-100% FPL members enroll with Medicaid Managed Care (same assumptions as Option 3) and 100-138% FPL members enroll with plans in the commercial exchange (same assumptions as Option 4). This option assumes that CMS approval would be feasible for Medicaid Expansion¹

On November 14, 2014, Idaho’s Workgroup on Medicaid Redesign voted to recommend Option 3.5 to the Governor as the best path forward for to provide low income adults with an affordable health plan.

- > **Option 4 – Private Pay Option:** This scenario presents the cost of expansion assuming members enroll with plans in the commercial exchange. This option assumes that CMS approval would be feasible for Medicaid Expansion¹.
- > **Option 5 – Direct PCP Program:** This option is based on a model to fund Direct Primary Care and create a Medical Procedure Fund for claims for low income adults under the 100% FPL. The elimination and redirection of the funds from the CAT and Medical Indigent programs will fund this and the program which will not be eligible for federal match. Similar to Option 1, this option does not fund all of the health care cost estimated for the population.

As stated previously, Option 5 assumes both a limited population and set of benefits when compared to Options 3, 3.5, and 4. Please consider figures 1 and 2 below in the evaluation of this option. Note that Options 3, 3.5, and 4 cover the same services and populations but at a different level of reimbursement.

Figure 1 - Comparison of Services offered by Options.

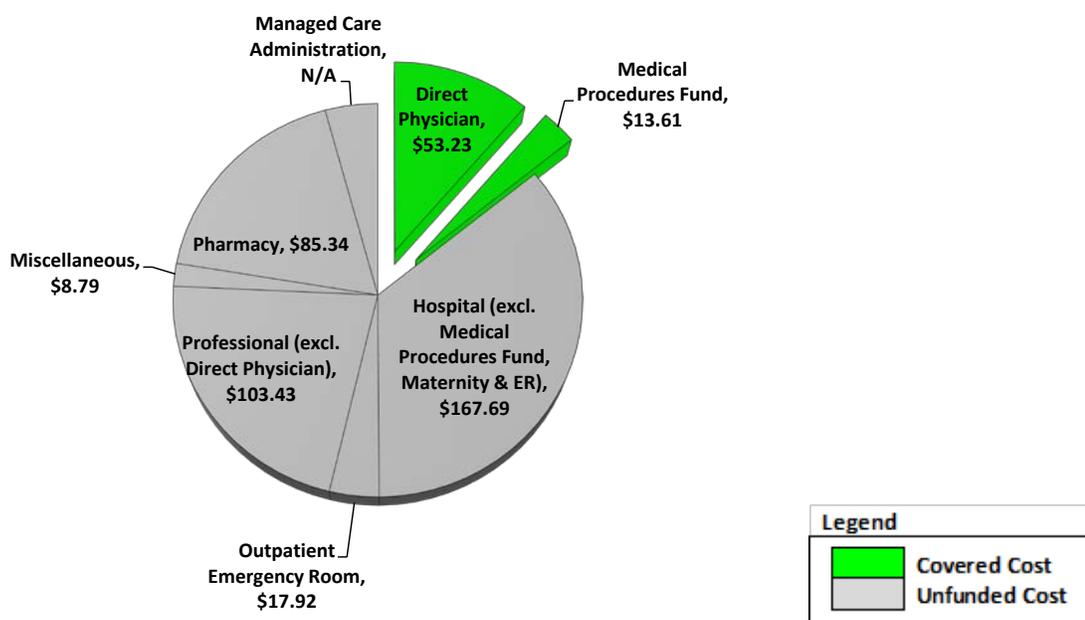
Option 1 Status Quo	Options 3, 3.5 and 4 Managed Care	Option 5 Direct Primary Care
Direct Physician	Direct Physician	Direct Physician
Pharmacy	Pharmacy	Pharmacy
Lab/X-Ray	Lab/X-Ray	Lab/X-Ray
Emergency Room	Emergency Room	Emergency Room
Out-Patient	Out-Patient	Out-Patient
Hospitalization	Hospitalization	Hospitalization

Legend

	Covered Services
	Limited Coverage Provided
	Not Covered

¹ Note August 8, 2014 Letter from the U.S. Government Accountability Office “Medicaid Demonstrations: HHS’s Approval Process for Arkansas’s Medicaid Expansion Waiver Raises Cost Concerns”.

Figure 2 - Option 5 Total Cost Breakdown.



Tables 1a to 1c on the following pages summarize by year total costs including state and county cost offsets as well as total federal costs for Options 1 and 3.5 in Table 1a, Options 3 and 4 Table 1b, and Option 5 in table 1c. Note that the costs identified under Options 3, 3.5, 4 and 5 include only marginal costs, above costs assumed for Option 1. The total at the bottom includes the entire costs, not just marginal costs of each option.

The costs shown below are only those costs associated with changes due to ACA. We have not included current historical Medicaid costs in these tables. Exhibit 6 later in this report presents projections of costs including the current Medicaid costs under an Option 3.5 scenario, and Exhibit 7 costs under the Option 3 scenario.

Table 1a
Idaho Department of Health and Welfare
Total Projected Additional County, State, and Federal Costs <Savings> (Values in Millions)

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	Cumulative Total
Option # 1: No Optional Expansion (Status Quo)											
State Funds:	\$20.8	\$19.9	\$20.4	\$20.9	\$26.1	\$28.3	\$29.0	\$29.8	\$30.5	\$31.3	\$257.0
Projected State Offsets:	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Projected Impact of State Funds:	\$20.8	\$19.9	\$20.4	\$20.9	\$26.1	\$28.3	\$29.0	\$29.8	\$30.5	\$31.3	\$257.0
Projected County Offsets:	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total State and County Funds:	\$20.8	\$19.9	\$20.4	\$20.9	\$26.1	\$28.3	\$29.0	\$29.8	\$30.5	\$31.3	\$257.0
Federal Funds - Options #1:	\$61.2	\$64.2	\$65.8	\$67.4	\$64.4	\$64.4	\$66.0	\$67.7	\$69.4	\$71.1	\$661.6
Subtotal Option #1:	\$82.0	\$84.1	\$86.2	\$88.3	\$90.5	\$92.8	\$95.1	\$97.4	\$99.9	\$102.3	\$918.6
Option # 3.5: Option 3/Option 4 Blend (Marginal Cost in Excess of Mandatory Expansion)											
State Funds:	\$12.1	\$29.2	\$51.5	\$60.9	\$78.6	\$93.8	\$97.6	\$101.7	\$106.0	\$110.6	\$742.0
Projected State Offsets:	(\$46.0)	(\$47.7)	(\$49.5)	(\$51.4)	(\$53.3)	(\$55.4)	(\$57.6)	(\$59.8)	(\$62.2)	(\$64.7)	(\$547.6)
Projected Impact of State Funds:	(\$33.9)	(\$18.5)	\$2.0	\$9.5	\$25.2	\$38.4	\$40.1	\$41.9	\$43.8	\$45.9	\$194.4
Projected County Offsets:	(\$30.8)	(\$32.0)	(\$33.3)	(\$34.6)	(\$35.9)	(\$37.3)	(\$38.8)	(\$40.3)	(\$41.8)	(\$43.2)	(\$367.8)
Total State and County <Savings>:	(\$64.7)	(\$50.5)	(\$31.2)	(\$25.1)	(\$10.7)	\$1.0	\$1.3	\$1.6	\$2.0	\$2.7	(\$173.4)
Federal Funds - Options #3.5:	\$653.4	\$668.1	\$679.9	\$701.2	\$715.6	\$734.5	\$766.5	\$800.4	\$836.3	\$874.2	\$7,430.2
Subtotal Option #3.5:	\$588.7	\$617.6	\$648.7	\$676.1	\$705.0	\$735.5	\$767.9	\$802.1	\$838.3	\$876.9	\$7,256.8
Total (Including Option #1 Status Quo and Option #3.5 Expansion (138% FPL) including State and County Offsets)											
State Funds <Savings>:	(\$13.1)	\$1.4	\$22.4	\$30.4	\$51.3	\$66.7	\$69.1	\$71.7	\$74.3	\$77.1	\$451.3
County Funds <Savings>:	(\$30.8)	(\$32.0)	(\$33.3)	(\$34.6)	(\$35.9)	(\$37.3)	(\$38.8)	(\$40.3)	(\$41.8)	(\$43.2)	(\$367.8)
Federal Funds:	\$714.6	\$732.3	\$745.7	\$768.6	\$780.1	\$798.9	\$832.6	\$868.1	\$905.6	\$945.3	\$8,091.8
Total:	\$670.8	\$701.7	\$734.9	\$764.4	\$795.5	\$828.3	\$862.9	\$899.5	\$938.2	\$979.3	\$8,175.4

This projection assumes that costs for newly eligible Medicaid members converted from CHIP are reimbursed at current CHIP FMAP rates.
 Does not include costs for historical Medicaid populations.

Table 1b
Idaho Department of Health and Welfare
Total Projected Additional County, State, and Federal Costs <Savings> (Values in Millions)

	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	Cumulative Total
Option # 3: State Plan Option (Managed Care) (Marginal Cost in Excess of Mandatory Expansion)											
State Funds:	\$12.1	\$30.5	\$53.6	\$62.6	\$79.8	\$93.8	\$96.2	\$98.6	\$101.0	\$103.6	\$731.8
Projected State Offsets:	(\$46.0)	(\$47.7)	(\$49.5)	(\$51.4)	(\$53.3)	(\$55.4)	(\$57.6)	(\$59.8)	(\$62.2)	(\$64.7)	(\$547.6)
Projected Impact of State Funds:	(\$33.9)	(\$17.2)	\$4.1	\$11.2	\$26.5	\$38.4	\$38.6	\$38.7	\$38.8	\$38.9	\$184.2
Projected County Offsets:	(\$30.8)	(\$32.0)	(\$33.3)	(\$34.6)	(\$35.9)	(\$37.3)	(\$38.8)	(\$40.3)	(\$41.8)	(\$43.2)	(\$367.8)
Total State and County <Savings>:	(\$64.7)	(\$49.2)	(\$29.1)	(\$23.3)	(\$9.5)	\$1.1	(\$0.2)	(\$1.5)	(\$3.0)	(\$4.3)	(\$183.6)
Federal Funds - Options #3:	\$720.4	\$720.3	\$715.9	\$726.2	\$728.7	\$734.9	\$753.3	\$772.1	\$791.4	\$811.2	\$7,474.6
Subtotal Option #3:	\$655.7	\$671.1	\$686.8	\$702.9	\$719.3	\$736.0	\$753.1	\$770.6	\$788.5	\$807.0	\$7,291.0
Total (Including Option #1 Status Quo and Option #3 Expansion (138% FPL) including State and County Offsets)											
State Funds <Savings>:	(\$13.1)	\$2.7	\$24.5	\$32.1	\$52.6	\$66.8	\$67.6	\$68.5	\$69.3	\$70.1	\$441.2
County Funds <Savings>:	(\$30.8)	(\$32.0)	(\$33.3)	(\$34.6)	(\$35.9)	(\$37.3)	(\$38.8)	(\$40.3)	(\$41.8)	(\$43.2)	(\$367.8)
Federal Funds:	\$781.6	\$784.4	\$781.7	\$793.6	\$793.2	\$799.4	\$819.3	\$839.8	\$860.8	\$882.3	\$8,136.2
Total:	\$737.7	\$755.2	\$773.0	\$791.2	\$809.8	\$828.8	\$848.2	\$868.1	\$888.3	\$909.3	\$8,209.6
Option # 4: Private Option (Marginal Cost in Excess of Mandatory Expansion)											
State Funds:	\$12.1	\$27.7	\$49.6	\$60.2	\$79.8	\$97.8	\$105.0	\$112.7	\$120.9	\$129.8	\$795.7
Projected State Offsets:	(\$46.0)	(\$47.7)	(\$49.5)	(\$51.4)	(\$53.3)	(\$55.4)	(\$57.6)	(\$59.8)	(\$62.2)	(\$64.7)	(\$547.6)
Projected Impact of State Funds:	(\$33.9)	(\$20.0)	\$0.1	\$8.9	\$26.4	\$42.4	\$47.4	\$52.9	\$58.8	\$65.1	\$248.1
Projected County Offsets:	(\$30.8)	(\$32.0)	(\$33.3)	(\$34.6)	(\$35.9)	(\$37.3)	(\$38.8)	(\$40.3)	(\$41.8)	(\$43.2)	(\$367.8)
Total State and County <Savings>:	(\$64.7)	(\$52.0)	(\$33.1)	(\$25.7)	(\$9.5)	\$5.1	\$8.7	\$12.6	\$17.0	\$22.0	(\$119.7)
Federal Funds - Options #4:	\$551.1	\$592.6	\$633.4	\$675.0	\$711.6	\$753.8	\$811.4	\$873.3	\$939.9	\$1,011.4	\$7,553.6
Subtotal Option #4:	\$486.5	\$540.6	\$600.3	\$649.3	\$702.1	\$758.9	\$820.1	\$885.9	\$956.8	\$1,033.4	\$7,433.9
Total (Including Option #1 Status Quo and Option #4 Expansion (138% FPL) including State and County Offsets)											
State Funds <Savings>:	(\$13.1)	(\$0.1)	\$20.5	\$29.8	\$52.5	\$70.8	\$76.5	\$82.6	\$89.3	\$96.4	\$505.1
County Funds <Savings>:	(\$30.8)	(\$32.0)	(\$33.3)	(\$34.6)	(\$35.9)	(\$37.3)	(\$38.8)	(\$40.3)	(\$41.8)	(\$43.2)	(\$367.8)
Federal Funds:	\$612.4	\$656.8	\$699.2	\$742.4	\$776.0	\$818.2	\$877.4	\$941.0	\$1,009.3	\$1,082.5	\$8,215.2
Total:	\$568.5	\$624.7	\$686.4	\$737.6	\$792.6	\$851.7	\$915.2	\$983.4	\$1,056.7	\$1,135.7	\$8,352.4

Table 1c
Idaho Department of Health and Welfare
Total Projected Additional County, State, and Federal Costs <Savings>
State, County and Federal Dollars (Values in Millions)

	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	<u>SFY 2021</u>	<u>SFY 2022</u>	<u>SFY 2023</u>	<u>SFY 2024</u>	<u>SFY 2025</u>	<u>Cumulative Total</u>
Option # 5: Direct PCP Program (Marginal Cost in Excess of Mandatory Expansion)*											
State Funds:	\$66.3	\$69.3	\$72.3	\$75.5	\$78.8	\$82.3	\$85.9	\$89.6	\$93.5	\$97.4	\$810.9
Projected State Offsets:	(\$35.6)	(\$37.3)	(\$39.1)	(\$40.9)	(\$42.9)	(\$45.0)	(\$47.1)	(\$49.4)	(\$51.7)	(\$54.2)	(\$443.1)
Projected County Offsets:	(\$30.8)	(\$32.0)	(\$33.3)	(\$34.6)	(\$35.9)	(\$37.3)	(\$38.8)	(\$40.3)	(\$41.8)	(\$43.2)	(\$367.8)
Total State and County <Savings>:	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Federal Funds - Options #5:	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Subtotal Option #5:	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total (Including Option #1 Status Quo and Option #5 Expansion (100% FPL) including State and County Cost Redistribution)											
State Funds <Savings>:	\$51.6	\$51.9	\$53.7	\$55.5	\$62.0	\$65.7	\$67.8	\$70.0	\$72.3	\$74.4	\$624.8
County Funds <Savings>:	(\$30.8)	(\$32.0)	(\$33.3)	(\$34.6)	(\$35.9)	(\$37.3)	(\$38.8)	(\$40.3)	(\$41.8)	(\$43.2)	(\$367.8)
Federal Funds:	\$61.2	\$64.2	\$65.8	\$67.4	\$64.4	\$64.4	\$66.0	\$67.7	\$69.4	\$71.1	\$661.6
Total:	\$82.0	\$84.1	\$86.2	\$88.3	\$90.5	\$92.8	\$95.1	\$97.4	\$99.9	\$102.3	\$918.6

*Does not include unfunded portion of care

We estimate the total financial impact of Medicaid expansion (Option 3.5) on the state of Idaho, including Medicaid costs and non-Medicaid state and county cost offsets, during state fiscal years 2016 – 2025 to be an approximate cost to the state of \$83.5M. (From Table 1a, the sum of net state funds \$451.3M and county savings (\$367.8M)). For Option 3, during state fiscal years 2016 – 2025 to be an approximate cost to the state of \$73.4M. (From Table 1b, the sum of net state funds \$441.2M and county savings (\$367.8M)).

Although a full economic impact to the state is beyond the scope of this analysis, under Option 3.5, we have projected a total state and federal spending increase in Idaho of nearly \$7.3 billion over state fiscal years 2016 – 2025.

Table 2 shows the enrollment projections by category.

Table 2
Idaho Department of Health and Welfare
Estimated Impact on Projected 1/1/2016 Enrollment

	Total
Mandatory Expansion - Currently Eligible, Not Enrolled	
Children	19,738
Adults, Parents	5,243
Subtotal	24,981
Optional Expansion (138% FPL)	
Adults, Parents*	25,153
Adults, Parents**	35,743
Adults, Non-Caregivers	<u>41,976</u>
Subtotal	102,873
Subtotal Mandatory and Optional	
Children	19,738
Adults	108,116
Medicaid Enrollment Change	
Children (CHIP conversion to Medicaid)***	11,159
Total	139,013

*Eligible due to MAGI eligibility guidelines.

**Eligible due to increased FPL to 138%.

***No net change to costs as FMAP for these members is unchanged.

Note that these projections assume the full impact of expansion. While these population growth figures do not include additional enrollment changes for the eligibility periods of Foster Kids as these members are not new, we have included the costs for additional length of eligibility for these members in our cost projections.

We have not included a migration period for expansion, so for purposes of this analysis we have assumed the full enrollment impact on 7/1/2015. Our experience with Medicaid expansion in other states is that the enrollment has ramped up quickly and a migration period is not a necessity.

Note that we have provided point estimates for both costs and enrollment changes. Actual results will vary from our projections for many reasons, including differences from assumptions regarding take up rates, MAGI impact, projected members by FPL levels, cost trends, enrollment trends, future FMAP rates, and state and county cost offsets, as well as other random and non-random factors. Experience should continue to be monitored on a regular basis, with modifications to projections as necessary.

The attached Exhibits 1 – 7 present the results of our projections in more detail, and Exhibit 6 highlights the cumulative Medicaid spending, including the current Medicaid program, over the horizon of interest:

- > **Exhibit 1:** Impact of the ACA on the Idaho Medicaid Budget
- > **Exhibit 2:** Impact of the ACA on the Idaho Medicaid Budget - Savings/Cost Graph
- > **Exhibit 3:** Cost Projections by Age/Gender
- > **Exhibit 4:** Potential and Projected State and County Cost Offsets
- > **Exhibit 5:** Hospital Impact – Projected Loss of Federal Funds due to DSH Reductions
- > **Exhibit 6:** Idaho Projected State Funds Graph – Status Quo and Expansion Blend (Option 3.5) Comparisons
- > **Exhibit 7:** Idaho Projected State Funds Graph – Status Quo and Expansion (Option 3) Comparisons

The remaining sections of this report document our methodology and assumptions in more detail.

II. UNIQUE ASSUMPTIONS IN THIS ANALYSIS

The scope of our analysis differs from other published studies specific to Idaho in several important areas. These differences may result in confusion, and thus, we felt it necessary to point out key differences in this report. Specifically, we want to point out differences between our findings and those presented in the report by Leavitt Partners dated September 18, 2012, "Idaho's Newly Eligible Medicaid Population: Demographic and Health Condition Information" (Leavitt Report).

Enrollment

The Leavitt Report focused on the expansion of the adult populations and therefore did not address increased enrollment in children due to the woodwork effect or the conversion of some of the CHIP population to Medicaid due to MAGI.

The Leavitt Report projects between 97,066 and 111,525 newly eligible adults. As shown in Table 2 our projection of approximately 102,900 newly eligible adults is very consistent with their projection.

We differ from the Leavitt Report regarding the assumed number of woodwork adults (currently eligible, but not enrolled). The range found in their report is 9,806 – 12,299. We have targeted this population at about 5,200. After discussion with Leavitt Partners we believe that these differences are due to reasonable differences in assumptions.

For purposes of this analysis we have assumed a static distribution of members. We have trended enrollment as a whole but have not attempted to model changing demographics to SFY 2025. Examples of changes which were not modeled include: aging, births/deaths, or changes in income as a percentile of FPL.

The 2012 census data update provided the estimate of percentile of FPL for the population within the gap of coverage from current Medicaid levels up to 100% FPL which is where eligibility for coverage under the exchange begins. This estimate only impacts Option 3.5 and 5.

Cost Projections

The focus of the Leavitt Report was on the potential enrollment and health conditions of expansion members. Milliman's focus was on adding a cost component to this increased enrollment as well as other cost changes for existing members. Costs were projected by age/gender bands based on current Medicaid experience for the Basic population (excluding disabled members).

Per member cost projections exclude costs for member cohorts who we assume are currently receiving care including members with the following aid codes: Pregnant Women, Foster Care, and Breast and Cervical Cancer.

Cost projections by age/gender band are included as Exhibit 3.

III. METHODOLOGY AND KEY ASSUMPTIONS

In the development of these financial impact estimates, we created a model that projected enrollment and healthcare expenditures for the current Medicaid population as well as the expansion population. The following summarizes the cost assumption used for each population:

- > For the current Medicaid and “woodwork” population, we have relied upon State Fiscal Year 2013 Medicaid costs (Basic) as the baseline from which our projection is constructed.
 - Costs are trended at a per member per month annual rate of 2.50% until 2016 and 5.0% beyond that point.
 - Annual enrollment growth rate of 2.05%
- > For the Option 3 expansion population, we based our assumptions on Idaho’s Basic population in addition to experience in other states to proxy the managed care costs.
 - Costs are trended at a per member per month annual rate of 2.50%
 - Annual enrollment growth rate of 2.05%
- > For the Option 3.5 expansion population, the same assumptions were used as Option 3 and Option 4. The assumptions are applied as:
 - For 0-100% FPL members, we used Option 3 assumptions
 - For 100-138% members, we used Option 4 assumptions
- > For the Option 4 expansion population, we based our assumptions on 2014 Idaho Silver Plan Exchange rates to estimate the commercial care costs.
 - Costs are trended at a per member per month annual rate of 7.50% until 2015, 10% for 2016 to 2018, and 7.50% beyond that point.
 - We have assumed that given the projected increased level of morbidity for the expansion population, as this population is integrated into the exchange population there will be increased trends in the early years of transition.
 - Annual enrollment growth rate of 2.05%

Other adjustments included:

- Including Cost sharing subsidies (94% actuarial plan value for the 100-138% FPL population and 100% actuarial plan value for the <100% FPL population.
 - Induced utilization impact from lower cost sharing assumptions.
 - Cost of wraparound services that are excluded by the qualified health plan (QHP), but covered under Medicaid.
- > For the Option 5 the gap population, we based our assumptions on the mix of service categories for a commercial population using the Milliman Health Cost Guidelines to estimate the direct primary care program costs.
 - Costs are trended at a per member per month annual rate of 2.50%
 - Annual enrollment growth rate of 2.05%

MEDICAID EXPANSION SCENARIOS

The fiscal impact associated with the ACA Medicaid expansion includes currently insured and uninsured adults and children who are not currently enrolled in Medicaid. The impact also includes individuals who are currently eligible for Medicaid but not enrolled (the “woodwork effect” population).

We relied on 2012 U.S. Census Bureau data for Idaho to estimate the Medicaid expansion population and the currently eligible but not enrolled population. The U.S. Census Bureau data provided information regarding the number of children, parents, and adults with and without health insurance below a stratified set of federal poverty levels. (FPL)

Idaho’s current Medicaid income eligibility standards are summarized below:

- > Children age under 6: up to 142% of FPL
- > Children age 6 – 18: up to 133% of FPL
- > Pregnant women: up to 133% of FPL
- > Parents: ~20% of FPL
- > Childless adults: not covered
- > CHIP: children up to 185% of FPL not covered under regular Medicaid

Implementation of Options 3, 3.5 or 4 (expansion to 138% FPL) would increase all of the FPL limits listed above to at least 138% of FPL with the exception of CHIP which will remain at 185% FPL. Option 3.5 and Option 4 would cover some or all of the expansion population through the Idaho Health Insurance Exchange.

The ACA reflects the following Federal Medical Assistance Percentages (FMAP) for the expansion populations by calendar year (CY):

- > 100% FMAP in CY 2014, 2015, and 2016
- > 95% FMAP in CY 2017
- > 94% FMAP in CY 2018
- > 93% FMAP in CY 2019
- > 90% FMAP in CY 2020+

Populations currently eligible for Medicaid in Idaho will continue to be subject to the regular FMAP levels. Implementation of Option 5 (state expansion to 100% FPL) would increase the FPL limits listed above to 100% FPL for both Parents and Childless adults.

We anticipate that, during the first one to two years of the program, the new enrollees may have costs that are higher due to pent-up demand, a characteristic of other Medicaid-expansion programs such as the Healthy Indiana Plan.² Because the federal government will be 100% responsible for the cost of the expansion until 1/1/2017, we did not include an explicit amount for pent-up demand.

² Damler, R. (Aug. 26, 2009). Experience under the Healthy Indiana Plan: The short-term cost challenges of expanding coverage to the uninsured. Retrieved Sept. 17, 2014, from <http://publications.milliman.com/research/health-rr/pdfs/experience-under-healthy-indiana.pdf>.

CHIP PROGRAM

The CHIP program is currently funded through September 2015 and authorized through September 2019. The ACA provides additional FMAP of up to 23% beginning on October 1, 2015, and ending September 30, 2019. The additional 23% FMAP will increase Idaho's CHIP program FMAP to 100%. The enhanced FMAP will decrease expenditures for Idaho and increase expenditures for the federal government.

In addition, CHIP members who will qualify for Medicaid coverage under expansion are reimbursed at the current CHIP FMAP rates rather than the enhanced CHIP rates described above.

We have also assumed that the Idaho's CHIP program will continue through SFY 2025.

FOSTER CHILDREN EXPANSION TO AGE 26

The ACA includes coverage for foster children up to age 26 beginning on January 1, 2014. The SFY 2016 total annual expenditures under the program are approximately \$149,000 (state and federal) or \$45,000 (state only). Previously, foster children have coverage up to and including age 17. We estimate that the expansion of Medicaid benefits to age 26 will increase the cost of the foster care program by approximately \$1.5M (state and federal) or \$460,000 (state only).

HEALTH INSURER FEE

The ACA places an \$8 billion annual fee on the health insurance industry starting in CY 2014 for CY 2013 premiums. The health insurer fee grows to \$14.3 billion in CY 2018 and is indexed to the rate of premium growth thereafter. The health insurer fee is considered an excise tax and is nondeductible for income tax purposes. The fee will be allocated to qualifying health insurers based on their respective market share of premium revenue in the previous year (including Medicaid managed care premium).

Taxes are generally considered to be an unavoidable cost of doing business. Since Medicaid managed care capitation rates are required to be actuarially sound, capitation rates for Idaho would have to be increased to cover the cost of the tax, and also a gross-up to cover the additional federal taxes the increase in capitation revenue would generate.

Because the ACA health insurer fee is a federal tax, all tax revenue collected as a result of the fee will accrue to the federal government. Since Medicaid is funded by the state and federal governments, both governments share in funding the premium component that funds the tax. This situation results in the federal government taxing itself and taxing state governments to fund the higher Medicaid managed care premiums required to fund the ACA health insurer fee, with no net financial impact to Medicaid MCOs.

At this point there is minimal impact to the State of Idaho for this fee. If current and expansion members are moved into a managed care plan that is required to pay this fee it will have a greater impact. At this point we have not included funding for this fee in the cost projections.

INCREASED ADMINISTRATIVE EXPENDITURES

In addition to the expenditures associated with providing medical services to the expansion population, the state of Idaho will incur additional ongoing administrative expenditures related to expansion.

We estimated the additional ongoing administrative costs as 3.5% of total expected medical expenditures for the population-based ACA changes under Option 3 (i.e., the ACA expansion population, the woodwork effect population, and the foster care expansion to age 26).

DHW indicated an administrative load of 3.5% of Option 3 medical costs is a reasonable assumption. This figure is consistent with our experience in other states and does not change for the Options 3.5 or 4. We have assumed that these additional administrative costs would have current FMAP rate of 50%.

OTHER ASSUMPTIONS

We used the following key assumptions in our analysis:

FMAP Rates by State Fiscal Year (SFY):

Table 3 Idaho Department of Health and Welfare Assumed FMAP Rate by Year and Population									
FMAP Rates	SFY 2016	SFY 2017	SFY 2018	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
Current Medicaid FMAP	70%	70%	70%	70%	70%	70%	70%	70%	70%
Expansion FMAP	100%	98%	95%	92%	90%	90%	90%	90%	90%
Current CHIP FMAP	80%	80%	80%	80%	80%	80%	80%	80%	80%
Enhanced CHIP FMAP	95%	100%	100%	85%	80%	80%	80%	80%	80%

Note the following regarding the figures in Table 3:

1. We have assumed no changes to FMAP rates after SFY 2021.

Take-Up Rates:

For those newly eligible for Medicaid coverage and the woodwork populations we have assumed an 85% take-up rate for the uninsured population and a 30% take-up rate for the insured members.

State and County Cost Offsets:

The state of Idaho has several state and county programs (not funded by federal dollars) that assist the medical needs of those in the state. We have assumed that Medicaid expansion would replace most of the need for these programs. The largest cost offset or savings with the Medicaid expansion are from the County Medically Indigent and Catastrophic Health Care Cost (CAT) Programs. Based on information provided by DHW we have modeled that all of the County Medically Indigent program and State CAT program would be eliminated under Medicaid expansion on average over the projection period. We have reflected the costs for CAT as a State offset separately from the county offset of the County Medically Indigent programs. The offset includes any associated administrative costs. It is important that the budgets for these programs be monitored separately since the administrative costs may not scale directly with the benefits.

In addition to these primary offsets, DHW also identified several other programs which could have savings under the scenario of Medicaid expansion. We have assumed that all of the savings opportunities for Behavioral Health (DHW) and Public Health (DHW) would be achieved.

These cost offsets or savings were all allocated to the optional expansion population. We have assumed no savings for the currently eligible but not enrolled population, as we understand these members would have been screened for Medicaid eligibility before being enrolled in these programs. Similarly we have not attributed any savings to these programs for the CHIP population shifting to Medicaid.

The State and County Cost Offsets are not a complete economic model; these are programs identified within the state which will be impacted by the decision to expand Medicaid. We reviewed the cost projections for reasonableness but did not modify the values provided by the program, and where necessary, extrapolated the projected growth rate through the end of the modeling horizon.

Direct Primary Care Program:

We relied on the Milliman Health Cost Guidelines to assign the total cost of care for individuals under Option 5 to categories of service for an approximation of the cost of the Direct Primary Care Program. These estimates are based on a commercial population and do not reflect any specific characteristics of the Idaho market. We did not estimate the availability of primary care physicians within the state, nor the adequacy of the coverage to serve the intended population.

A bi-product of the approximation is an estimate of the unfunded care for the population within the coverage gap for this option. These individuals would need to rely on current sources for coverage of all essential health benefits available under the expansion options 3, 3,5 and 4.

Increase in Primary Care Physician Fees to 100% of Medicare:

The federal government will fund an increase in some fees paid to primary care physicians to equal 100% of Medicare reimbursement in CY 2013 and CY 2014. No additional federal funding is available after CY 2014 although CMS may extend the program. Our projections assume that DHW will continue to pay these higher rates pending legislative approval after the additional federal funding had ended because of the implied intent in existing state statutory language.

IV. OTHER IMPACTS NOT MODELED

The following outlines additional financial impacts under the current provisions of the federal legislation. The issues highlighted below **have not** been included in the financial projections shown in our analysis.

- > **Changes to Medicaid Eligibility Levels for Certain Eligibility Categories:** Several states are evaluating whether to reduce eligibility levels for certain Medicaid beneficiaries starting on January 1, 2014, such as pregnant women and breast and cervical cancer program enrollees, due to the availability of subsidized coverage through the health benefit exchange. We assumed that DHW would maintain its current 133% of FPL eligibility level for pregnant women and continue to operate the breast and cervical cancer program.
- > **Reductions in DSH Allotments:** Medicaid Disproportionate Share (DSH) funding will be reduced starting in 2016 depending on the characteristics of each state. Exhibit 5 presents the loss of federal funds to hospitals due to DSH reductions. Changes to DSH funding are not part of our primary state cost exhibits.
- > **Start-up Administrative Costs:** We did not include any additional administrative costs related to reform prior to SFY 2016 or administrative costs related to developing a health insurance exchange. These additional costs could be substantial.
- > **Impact on Other State Agencies:** We did not consider the impact of the ACA on any other Idaho state agencies, except for those programs listed.
- > **Economic Ripple Effect or Multiplier:** We did not consider the multiplied impact of the additional state and federal dollars spent in the state.
- > **Maintenance of Effort:** We did not consider the impact of Maintenance of Effort (MOE) requirements. Our model assumes the federal government will modify or waive current MOE requirements in place for the Department's Behavioral Health and Public Health programs.

V. CAVEATS AND LIMITATIONS

This report is intended for the internal use of the Idaho Department of Health and Welfare (DHW) in accordance with its statutory and regulatory requirements. Milliman recognizes that the materials may be public records subject to disclosure to third parties; however, Milliman does not intend to benefit, and assumes no duty or liability to, any third parties who receive this report and related materials. The materials should only be reviewed in their entirety. Any user of this report should possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

In the development of the data and information presented in this report, Milliman has relied upon certain data from the state of Idaho and its vendors. In addition, we have placed significant reliance on census data. To the extent that the data was not complete or accurate, the values presented in the report will need to be reviewed for consistency and revised to meet any revised data. Although we have performed several reasonableness checks we have not audited these data sources. The data and information included in this report has been developed to assist in the analysis of the financial impact of the ACA on state of Idaho Medicaid and related expenditures. The data and information presented may not be appropriate for any other purpose. It should be emphasized that the results presented in this correspondence are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this report.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Justin Birrell and Ben Diederich are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report. This analysis – the assumptions, methodology, and calculations – has been thoroughly peer reviewed by qualified actuaries.

Exhibit 1

Impact of the ACA on the Idaho Medicaid Budget, Including State and County Cost Offsets

Idaho Department of Health and Welfare
Financial Impact Review of the Patient Protection and Affordable Care Act
On the Idaho Medicaid Budget

December 3, 2014

This report assumes that the reader is familiar with the state of Idaho's Medicaid program and federal healthcare reform. The report was prepared solely to provide assistance to DHW to model the financial impact of federal healthcare reform provisions. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Exhibit 1
Idaho Department of Health and Welfare
Health Care Reform Projection - Senate Bill with Reconciliation Act
Total Projected Additional County, and State Costs <Savings> (Values in Millions)

Option # 1: No Optional Expansion	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	Total
Mandatory Expansion Claim Costs:											
Woodwork	\$17.8	\$18.3	\$18.7	\$19.2	\$19.7	\$20.2	\$20.7	\$21.2	\$21.7	\$22.3	\$199.6
Mandatory Expansion	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Foster Care	\$0.04	\$0.05	\$0.05	\$0.05	\$0.05	\$0.04	\$0.04	\$0.04	\$0.03	\$0.03	\$0.4
Physician	\$5.9	\$6.0	\$6.2	\$6.3	\$6.5	\$6.7	\$6.8	\$7.0	\$7.2	\$7.4	\$66.0
CHIP	(\$4.2)	(\$5.8)	(\$5.9)	(\$6.1)	(\$1.6)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	(\$23.5)
Administration (DHW) Costs:	\$1.3	\$1.3	\$1.4	\$1.4	\$1.4	\$1.5	\$1.5	\$1.5	\$1.6	\$1.6	\$14.4
Projected Offsets and Savings											
CAT Program (State)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Medical Indigent (County)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Medical Ind (County Admin)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Behavior Health (DHW)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Public Health (DHW)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total County and State Offset:	\$0.0	\$0.0									
Net State & County (No Expansion)											
Spending <Savings>	\$20.8	\$19.9	\$20.4	\$20.9	\$26.1	\$28.3	\$29.0	\$29.8	\$30.5	\$31.3	\$257.0

Option # 3.5: Option 3/Option 4 Blend	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	Total
Additional Expansion Spending:											
Optional Expansion Claim Costs:	\$0.0	\$16.8	\$38.8	\$47.8	\$65.2	\$80.1	\$83.6	\$87.3	\$91.3	\$95.5	\$606.5
Administration (DHW) Costs*:	\$12.1	\$12.4	\$12.7	\$13.0	\$13.3	\$13.7	\$14.0	\$14.4	\$14.7	\$15.1	\$135.5
Total Additional Expansion Costs	\$12.1	\$29.2	\$51.5	\$60.9	\$78.6	\$93.8	\$97.6	\$101.7	\$106.0	\$110.6	\$742.0
Projected Offsets and Savings											
CAT Program (State)	(\$35.6)	(\$37.3)	(\$39.1)	(\$40.9)	(\$42.9)	(\$45.0)	(\$47.1)	(\$49.4)	(\$51.7)	(\$54.2)	(\$443.1)
Medical Indigent (County)	(\$24.7)	(\$25.7)	(\$26.7)	(\$27.8)	(\$28.9)	(\$30.0)	(\$31.2)	(\$32.5)	(\$33.8)	(\$35.1)	(\$296.5)
Medical Ind (County Admin)	(\$6.1)	(\$6.3)	(\$6.6)	(\$6.8)	(\$7.0)	(\$7.3)	(\$7.5)	(\$7.8)	(\$8.0)	(\$8.0)	(\$71.3)
Behavioral Health (DHW)	(\$9.7)	(\$9.7)	(\$9.7)	(\$9.7)	(\$9.7)	(\$9.7)	(\$9.7)	(\$9.7)	(\$9.7)	(\$9.7)	(\$96.5)
Public Health (DHW)	(\$0.8)	(\$0.8)	(\$0.8)	(\$0.8)	(\$0.8)	(\$0.8)	(\$0.8)	(\$0.8)	(\$0.8)	(\$0.8)	(\$8.0)
Total Local and State Offsets:	(\$76.8)	(\$79.7)	(\$82.8)	(\$86.0)	(\$89.3)	(\$92.7)	(\$96.3)	(\$100.1)	(\$104.0)	(\$107.8)	(\$915.4)
Net State & Local (Expansion Only)											
Spending <Savings>	(\$64.7)	(\$50.5)	(\$31.2)	(\$25.1)	(\$10.7)	\$1.0	\$1.3	\$1.6	\$2.0	\$2.7	(\$173.4)
Net State & Local (Total Costs)											
Spending <Savings>	(\$43.9)	(\$30.6)	(\$10.8)	(\$4.2)	\$15.4	\$29.4	\$30.3	\$31.4	\$32.5	\$34.0	\$83.5

Exhibit 1
Idaho Department of Health and Welfare
Health Care Reform Projection - Senate Bill with Reconciliation Act
Total Projected Additional County, and State Costs <Savings> (Values in Millions)

Option # 3: State Plan Option (Managed Care)	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	Total
<u>Additional Expanding Spending:</u>											
Optional Expansion Claim Costs:	\$0.0	\$18.2	\$40.9	\$49.6	\$66.5	\$80.1	\$82.1	\$84.2	\$86.3	\$88.5	\$596.4
Administration (DHW) Costs*:	\$12.1	\$12.4	\$12.7	\$13.0	\$13.3	\$13.7	\$14.0	\$14.4	\$14.7	\$15.1	\$135.5
Total Additional Expansion Costs	\$12.1	\$30.5	\$53.6	\$62.6	\$79.8	\$93.8	\$96.2	\$98.6	\$101.0	\$103.6	\$731.8
<u>Projected Offsets and Savings</u>											
CAT Program (State)	(\$35.6)	(\$37.3)	(\$39.1)	(\$40.9)	(\$42.9)	(\$45.0)	(\$47.1)	(\$49.4)	(\$51.7)	(\$54.2)	(\$443.1)
Medical Indigent (County)	(\$24.7)	(\$25.7)	(\$26.7)	(\$27.8)	(\$28.9)	(\$30.0)	(\$31.2)	(\$32.5)	(\$33.8)	(\$35.1)	(\$296.5)
Medical Ind (County Admin)	(\$6.1)	(\$6.3)	(\$6.6)	(\$6.8)	(\$7.0)	(\$7.3)	(\$7.5)	(\$7.8)	(\$8.0)	(\$8.0)	(\$71.3)
Behavior Health (DHW)	(\$9.7)	(\$9.7)	(\$9.7)	(\$9.7)	(\$9.7)	(\$9.7)	(\$9.7)	(\$9.7)	(\$9.7)	(\$9.7)	(\$96.5)
Public Health (DHW)	(\$0.8)	(\$0.8)	(\$0.8)	(\$0.8)	(\$0.8)	(\$0.8)	(\$0.8)	(\$0.8)	(\$0.8)	(\$0.8)	(\$8.0)
Total County and State Offset:	(\$76.8)	(\$79.7)	(\$82.8)	(\$86.0)	(\$89.3)	(\$92.7)	(\$96.3)	(\$100.1)	(\$104.0)	(\$107.8)	(\$915.4)
Net State & County (Expansion Only)											
Spending <Savings>	(\$64.7)	(\$49.2)	(\$29.1)	(\$23.3)	(\$9.5)	\$1.1	(\$0.2)	(\$1.5)	(\$3.0)	(\$4.3)	(\$183.6)
Net State & County (Total Costs)											
Spending <Savings>	(\$43.9)	(\$29.3)	(\$8.7)	(\$2.4)	\$16.6	\$29.4	\$28.9	\$28.2	\$27.5	\$27.0	\$73.4

Option # 4: Private Option	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	Total
<u>Additional Expanding Spending:</u>											
Optional Expansion Claim Costs:	\$0.0	\$15.3	\$36.9	\$47.2	\$66.4	\$84.1	\$91.0	\$98.3	\$106.2	\$114.7	\$660.2
Administration (DHW) Costs*:	\$12.1	\$12.4	\$12.7	\$13.0	\$13.3	\$13.7	\$14.0	\$14.4	\$14.7	\$15.1	\$135.5
Total Additional Expansion Costs	\$12.1	\$27.7	\$49.6	\$60.2	\$79.8	\$97.8	\$105.0	\$112.7	\$120.9	\$129.8	\$795.7
<u>Projected Offsets and Savings</u>											
Total County and State Offset:	(\$76.8)	(\$79.7)	(\$82.8)	(\$86.0)	(\$89.3)	(\$92.7)	(\$96.3)	(\$100.1)	(\$104.0)	(\$107.8)	(\$915.4)
Net State & County (Expansion Only)											
Spending <Savings>	(\$64.7)	(\$52.0)	(\$33.1)	(\$25.7)	(\$9.5)	\$5.1	\$8.7	\$12.6	\$17.0	\$22.0	(\$119.7)
Net State & County (Total Costs)											
Spending <Savings>	(\$43.9)	(\$32.1)	(\$12.7)	(\$4.8)	\$16.6	\$33.4	\$37.7	\$42.4	\$47.5	\$53.2	\$137.3

**DHW indicated an administrative load of 3.5% of medical costs is a reasonable assumption. This figure is consistent with our experience in other states. For the purpose of this forecast they have assumed these additional administrative costs would have current FMAP rate of 50%. However, CMS has issued communications that certain administrative costs associated with the expansion population are eligible for an enhanced FMAP rate of 75%. If the state elects to expand its Medicaid coverage, the enhanced federal match will be claimed where allowable. This could result in a lower state fund administrative cost than reflected in this forecast. It should also be noted that even in years where there is a 100% FMAP rate for medical costs for expansion populations there is an increase in the state's costs due to increased administrative costs matched at a lower rate.*

Exhibit 2

Impact of the ACA on the Idaho Medicaid Budget, Including State and County Cost Offsets Savings/Cost Graph

Idaho Department of Health and Welfare
Financial Impact Review of the Patient Protection and Affordable Care Act
On the Idaho Medicaid Budget

December 3, 2014

This report assumes that the reader is familiar with the state of Idaho's Medicaid program and federal healthcare reform. The report was prepared solely to provide assistance to DHW to model the financial impact of federal healthcare reform provisions. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Exhibit 2
Idaho Department of Health and Welfare
Health Care Reform Projection - Senate Bill with Reconciliation Act
State and County Dollars Only (Values in Millions)

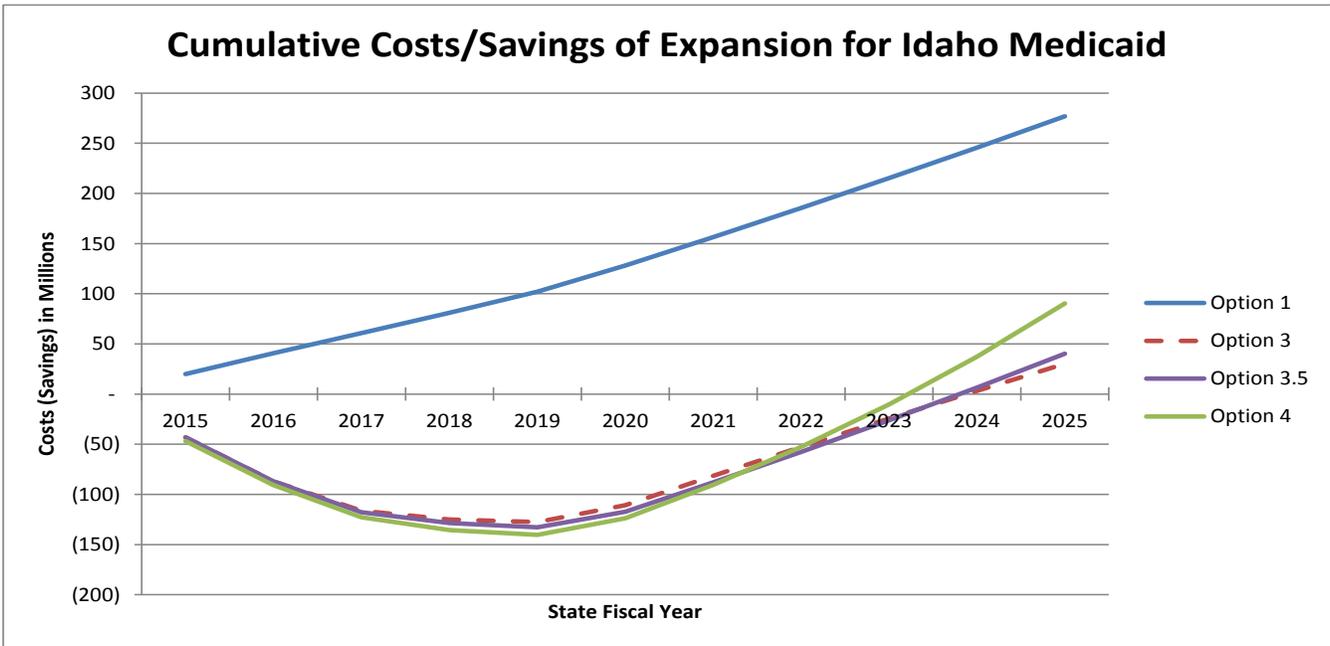
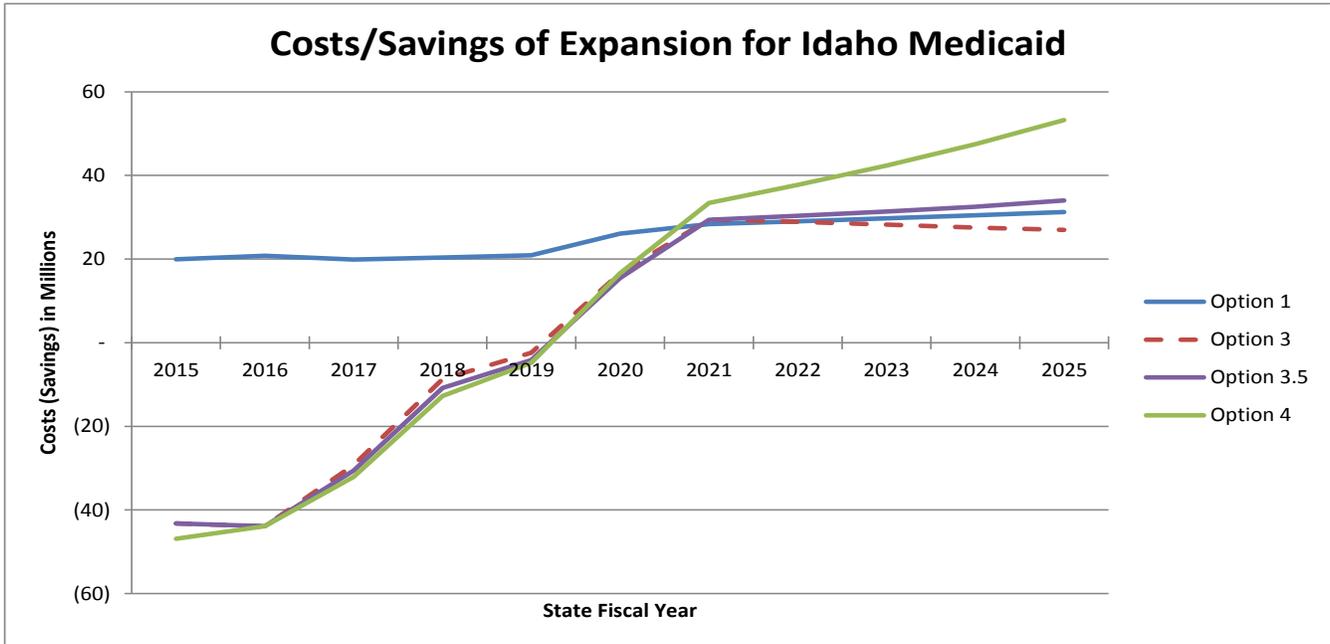


Exhibit 3

Cost Projections by Age/Gender

Idaho Department of Health and Welfare
Financial Impact Review of the Patient Protection and Affordable Care Act
On the Idaho Medicaid Budget

December 3, 2014

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Exhibit 3
Idaho Department of Health and Welfare
SFY 2016 PMPM Costs by Age/Gender Band

Age Band	Managed Care PMPM¹ Cost			Exchange Rates² (2nd Lowest Silver Plan PMPMs)		
	Male	Female	Composite	Male	Female	Composite
18 to 24	\$341.53	\$651.87	\$521.07	\$296.14	\$296.14	\$296.14
25 to 34	\$348.10	\$664.41	\$518.54	\$388.74	\$388.74	\$388.74
35 to 44	\$469.87	\$716.53	\$597.82	\$445.82	\$445.82	\$445.82
45 to 54	\$591.63	\$634.72	\$608.12	\$607.27	\$607.27	\$607.27
55 to 59	\$591.63	\$703.14	\$689.95	\$833.29	\$833.29	\$833.29
60 to 64	\$591.63	\$703.14	\$686.35	\$982.12	\$982.12	\$982.12
Adult	\$417.39	\$676.49	\$561.29	\$423.48	\$457.68	\$442.48

Membership Distribution (Up to 138% FPL)

Age Band	Male	Female	Total
00 to 17	5%	5%	10%
18 to 24	10%	13%	23%
25 to 34	13%	15%	29%
35 to 44	11%	12%	23%
45 to 54	5%	3%	8%
55 to 59	0%	3%	3%
60 to 64	1%	4%	4%
Total	45%	55%	100%

1. Trended 2014 PMPMs for 2 years at 2.5% annual trend
2. Trended 2014 PMPMs for 1 year at 7.5% and trended at 10% for 2015 PMPMs
3. Enrollment trended at 2.1% annually for 3 years (Census data is 2012)

Exhibit 4

Potential and Projected State and County Cost Offsets

Idaho Department of Health and Welfare
Financial Impact Review of the Patient Protection and Affordable Care Act
On the Idaho Medicaid Budget

December 3, 2014

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Exhibit 4
Idaho Department of Health and Welfare
Potential and Projected State and County Cost Offsets (Values in Millions)

<u>Continued Costs:</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	<u>SFY 2021</u>	<u>SFY 2022</u>	<u>SFY 2023</u>	<u>SFY 2024</u>	<u>SFY 2025</u>	<u>Total</u>
CAT Program (State)	\$35.6	\$37.3	\$39.1	\$40.9	\$42.9	\$45.0	\$47.1	\$49.4	\$51.7	\$54.2	\$443.1
Medical Indigent (County)	\$24.7	\$25.7	\$26.7	\$27.8	\$28.9	\$30.0	\$31.2	\$32.5	\$33.8	\$35.1	\$296.5
Medical Ind (County Admin)	\$6.1	\$6.3	\$6.6	\$6.8	\$7.0	\$7.3	\$7.5	\$7.8	\$8.0	\$8.0	\$71.3
Behavior Health (DHW)	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$96.5
Public Health (DHW)	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$8.0
Total County and State Spend:	\$76.8	\$79.7	\$82.8	\$86.0	\$89.3	\$92.7	\$96.3	\$100.1	\$104.0	\$107.8	\$915.4
<u>Continued Costs after Mandatory Expansion Only (note no assumed savings for mandatory expansion):</u>											
CAT Program (State)	\$35.6	\$37.3	\$39.1	\$40.9	\$42.9	\$45.0	\$47.1	\$49.4	\$51.7	\$54.2	\$443.1
Medical Indigent (County)	\$24.7	\$25.7	\$26.7	\$27.8	\$28.9	\$30.0	\$31.2	\$32.5	\$33.8	\$35.1	\$296.5
Medical Ind (County Admin)	\$6.1	\$6.3	\$6.6	\$6.8	\$7.0	\$7.3	\$7.5	\$7.8	\$8.0	\$8.0	\$71.3
Behavior Health (DHW)	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$96.5
Public Health (DHW)	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$8.0
Total County and State Spend:	\$76.8	\$79.7	\$82.8	\$86.0	\$89.3	\$92.7	\$96.3	\$100.1	\$104.0	\$107.8	\$915.4
<u>Continued Costs after Optional Expansion (Option 3, 3.5 and 4):</u>											
CAT Program (State)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Medical Indigent (County)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Medical Ind (County Admin)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Behavior Health (DHW)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Public Health (DHW)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total County and State Spend:	\$0.0	\$0.0									

Exhibit 5

Hospital Impact – Projected Loss of Federal Funds due to DSH Reductions

Idaho Department of Health and Welfare
Financial Impact Review of the Patient Protection and Affordable Care Act
On the Idaho Medicaid Budget

December 3, 2014

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Exhibit 5
Idaho Department of Health and Welfare
Potential Loss of DSH Funding

<u>Other Impacts - Hospitals:</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	<u>SFY 2021</u>	<u>SFY 2022</u>	<u>SFY 2023</u>	<u>SFY 2024</u>	<u>SFY 2025</u>	<u>Cumulative Total</u>
Potential Loss of Federal Funds											
Medicare DSH	\$8.2	\$10.3	\$9.1	\$10.5	\$10.7	\$10.9	\$11.1	\$11.3	\$11.6	\$11.8	\$105.6
Medicaid DSH**	\$0.6	\$1.6	\$4.5	\$5.8	\$4.7	\$4.7	\$4.7	\$4.7	\$4.7	\$4.7	\$40.6
Total Loss of FFs:	\$8.9	\$11.9	\$13.5	\$16.3	\$15.4	\$15.6	\$15.8	\$16.0	\$16.2	\$16.5	\$146.2

** In SFY 2014, Idaho Hospitals received approximately \$24.1 million in federal Medicaid DSH payments; we have applied assumed reductions to this starting amount in annual funding based on national reduction percentages which have been dampened to reflect that Idaho is a low DSH state. Note that these are estimates and many factors will affect final funding reductions. The Affordable Care Act (ACA) reduced disproportionate share hospital (DSH) allotments on the assumption that with the expansion of health care coverage, there would be fewer uninsured and less uncompensated care. Guidance regarding loss of DSH funding was only provided through Federal fiscal year 2020, we have assumed no change in DSH reductions after Federal fiscal year 2020. We do not know the exact impact if a state decides not to participate in the ACA Medicaid eligibility expansion.

Exhibit 6

Idaho Projected Costs Table and Graph – Status Quo and Expansion (Option 3.5) Comparisons including Current Medicaid costs

Idaho Department of Health and Welfare
Financial Impact Review of the Patient Protection and Affordable Care Act
On the Idaho Medicaid Budget

December 3, 2014

This report assumes that the reader is familiar with the state of Idaho's Medicaid program and federal healthcare reform. The report was prepared solely to provide assistance to DHW to model the financial impact of federal healthcare reform provisions. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Exhibit 6a
Idaho Department of Health and Welfare
Option 3.5
Total Projected County, State, and Federal Costs (Values in Millions)

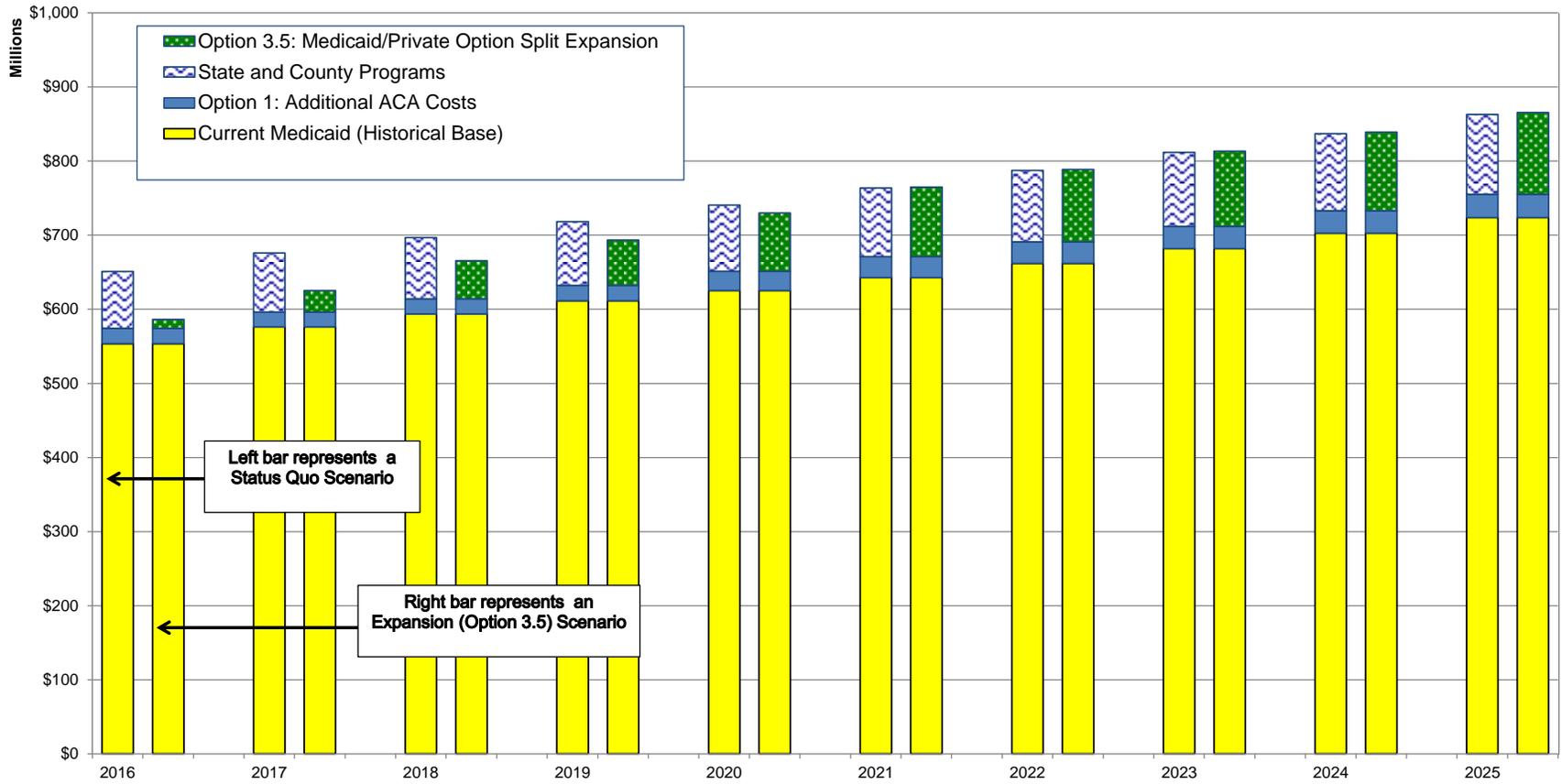
	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	<u>SFY 2021</u>	<u>SFY 2022</u>	<u>SFY 2023</u>	<u>SFY 2024</u>	<u>SFY 2025</u>	<u>Cumulative Total</u>
Current Medicaid (Historical Base) ⁽¹⁾											
State Funds:	\$553.4	\$576.1	\$593.5	\$611.4	\$625.2	\$642.5	\$661.9	\$681.9	\$702.5	\$723.8	\$6,372.2
Federal Funds:	\$1,422.7	\$1,474.5	\$1,519.0	\$1,564.8	\$1,621.3	\$1,673.3	\$1,723.7	\$1,775.6	\$1,829.1	\$1,884.1	\$16,488.0
Subtotal:	\$1,976.1	\$2,050.6	\$2,112.5	\$2,176.2	\$2,246.5	\$2,315.8	\$2,385.6	\$2,457.5	\$2,531.6	\$2,607.9	\$22,860.3
State and County Programs											
CAT Program (State)	\$35.6	\$37.3	\$39.1	\$40.9	\$42.9	\$45.0	\$47.1	\$49.4	\$51.7	\$54.2	\$443.1
Medical Indigent (County)	\$24.7	\$25.7	\$26.7	\$27.8	\$28.9	\$30.0	\$31.2	\$32.5	\$33.8	\$35.1	\$296.5
Medical Ind (County Admin)	\$6.1	\$6.3	\$6.6	\$6.8	\$7.0	\$7.3	\$7.5	\$7.8	\$8.0	\$8.0	\$71.3
Behavior Health (DHW)	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$96.5
Public Health (DHW)	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$8.0
Subtotal:	\$76.8	\$79.7	\$82.8	\$86.0	\$89.3	\$92.7	\$96.3	\$100.1	\$104.0	\$107.8	\$915.4
Option #1: Additional Costs ACA costs - No Expansion											
State Funds:	\$20.8	\$19.9	\$20.4	\$20.9	\$26.1	\$28.3	\$29.0	\$29.8	\$30.5	\$31.3	\$257.0
Federal Funds:	\$61.2	\$64.2	\$65.8	\$67.4	\$64.4	\$64.4	\$66.0	\$67.7	\$69.4	\$71.1	\$661.6
Subtotal:	\$82.0	\$84.1	\$86.2	\$88.3	\$90.5	\$92.8	\$95.1	\$97.4	\$99.9	\$102.3	\$918.6
Option #3.5: Medicaid/Private Plan Expansion Costs											
State Funds:	\$12.1	\$29.2	\$51.5	\$60.9	\$78.6	\$93.8	\$97.6	\$101.7	\$106.0	\$110.6	\$742.0
Federal Funds:	\$653.4	\$668.1	\$679.9	\$701.2	\$715.6	\$734.5	\$766.5	\$800.4	\$836.3	\$874.2	\$7,430.2
Subtotal:	\$665.5	\$697.3	\$731.5	\$762.0	\$794.2	\$828.3	\$864.2	\$902.2	\$942.3	\$984.8	\$8,172.2
Total Costs of Status Quo - No Expansion ⁽²⁾											
County Funds:	\$30.8	\$32.0	\$33.3	\$34.6	\$35.9	\$37.3	\$38.8	\$40.3	\$41.8	\$43.2	\$367.8
State Funds:	\$620.2	\$643.7	\$663.4	\$683.7	\$704.6	\$726.2	\$748.5	\$771.5	\$795.2	\$819.7	\$7,176.8
Federal Funds:	\$1,483.9	\$1,538.7	\$1,584.7	\$1,632.2	\$1,685.7	\$1,737.7	\$1,789.7	\$1,843.3	\$1,898.4	\$1,955.2	\$17,149.6
State, County and Federal Funds	\$2,134.8	\$2,214.4	\$2,281.4	\$2,350.5	\$2,426.3	\$2,501.3	\$2,577.0	\$2,655.0	\$2,735.4	\$2,818.1	\$24,694.3
Total Costs with Expansion ⁽³⁾											
County Funds:	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
State Funds:	\$586.3	\$625.2	\$665.4	\$693.2	\$729.9	\$764.6	\$788.6	\$813.4	\$839.0	\$865.6	\$7,371.2
Federal Funds:	\$2,137.3	\$2,206.8	\$2,264.7	\$2,333.4	\$2,401.4	\$2,472.2	\$2,556.3	\$2,643.7	\$2,734.7	\$2,829.4	\$24,579.9
State, County and Federal Funds	\$2,723.6	\$2,832.0	\$2,930.1	\$3,026.5	\$3,131.2	\$3,236.8	\$3,344.9	\$3,457.1	\$3,573.8	\$3,695.0	\$31,951.1
Total "Swing" Cost <Savings> - No Expansion vs. Expansion											
County Funds:	(\$30.8)	(\$32.0)	(\$33.3)	(\$34.6)	(\$35.9)	(\$37.3)	(\$38.8)	(\$40.3)	(\$41.8)	(\$43.2)	(\$367.8)
State Funds:	(\$33.9)	(\$18.5)	\$2.0	\$9.5	\$25.2	\$38.4	\$40.1	\$41.9	\$43.8	\$45.9	\$194.4
Federal Funds:	\$653.4	\$668.1	\$679.9	\$701.2	\$715.6	\$734.5	\$766.5	\$800.4	\$836.3	\$874.2	\$7,430.2
State, County and Federal Funds	\$588.7	\$617.6	\$648.7	\$676.1	\$705.0	\$735.5	\$767.9	\$802.1	\$838.3	\$876.9	\$7,256.8

⁽¹⁾ This is an expenditure forecast for Idaho's current Medicaid program.

⁽²⁾ Includes Current Medicaid (Historical Base), State and County Programs, and Option #1: Additional ACA costs.

⁽³⁾ Includes Current Medicaid (Historical Base), Option #1: Additional ACA costs, and Option #3.5 Medicaid Expansion Costs.

Exhibit 6b - State and County Funds by Program Graph
Idaho Department of Health and Welfare
Option 3.5



State and County Funds for Status Quo and Expansion Scenarios

Exhibit 6c - State, County, and Federal Funds by Program Graph
 Idaho Department of Health and Welfare
 Option 3.5

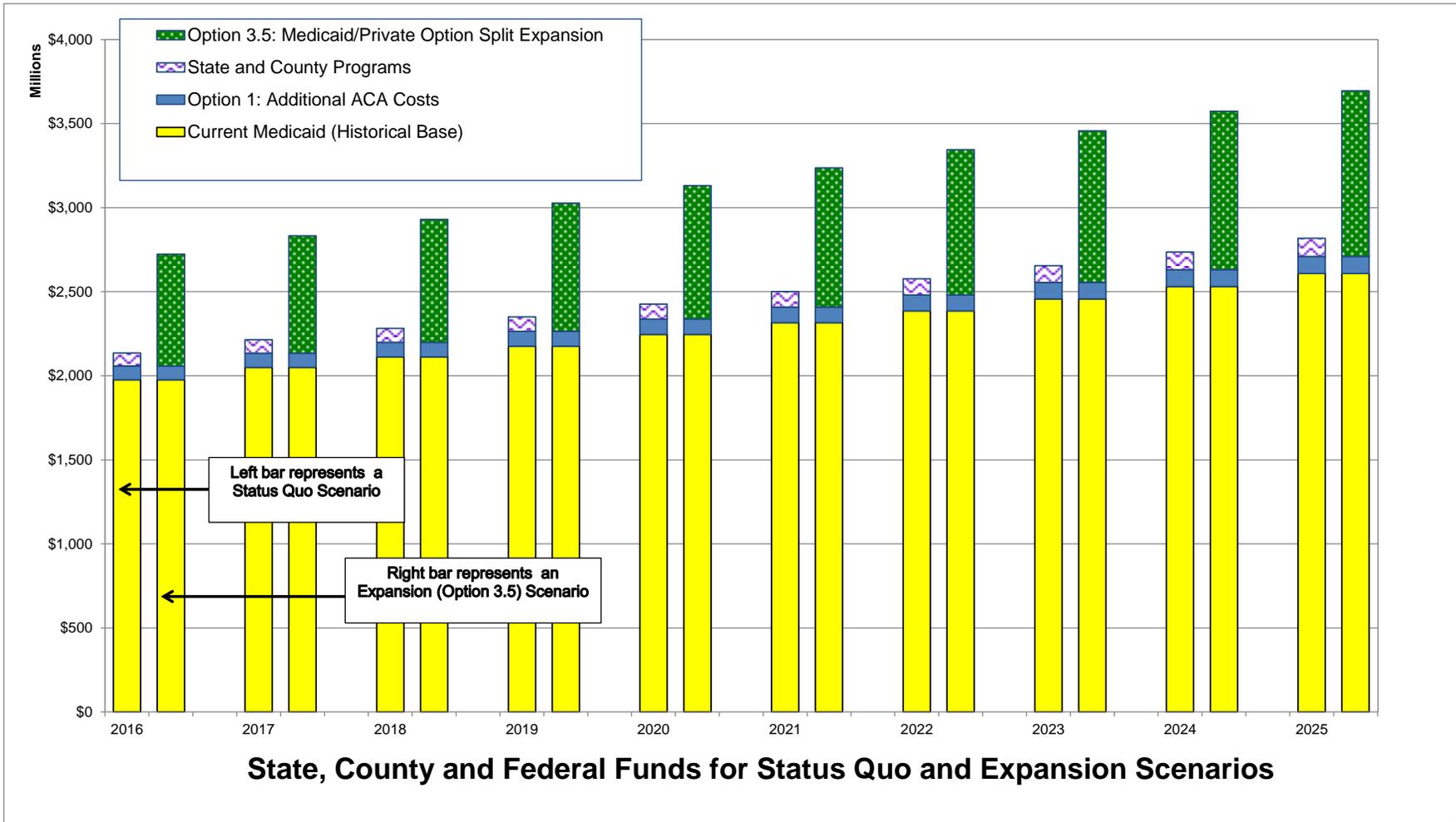


Exhibit 6d - Total State, County, and Federal Funds Graph
 Idaho Department of Health and Welfare
 Option 3.5

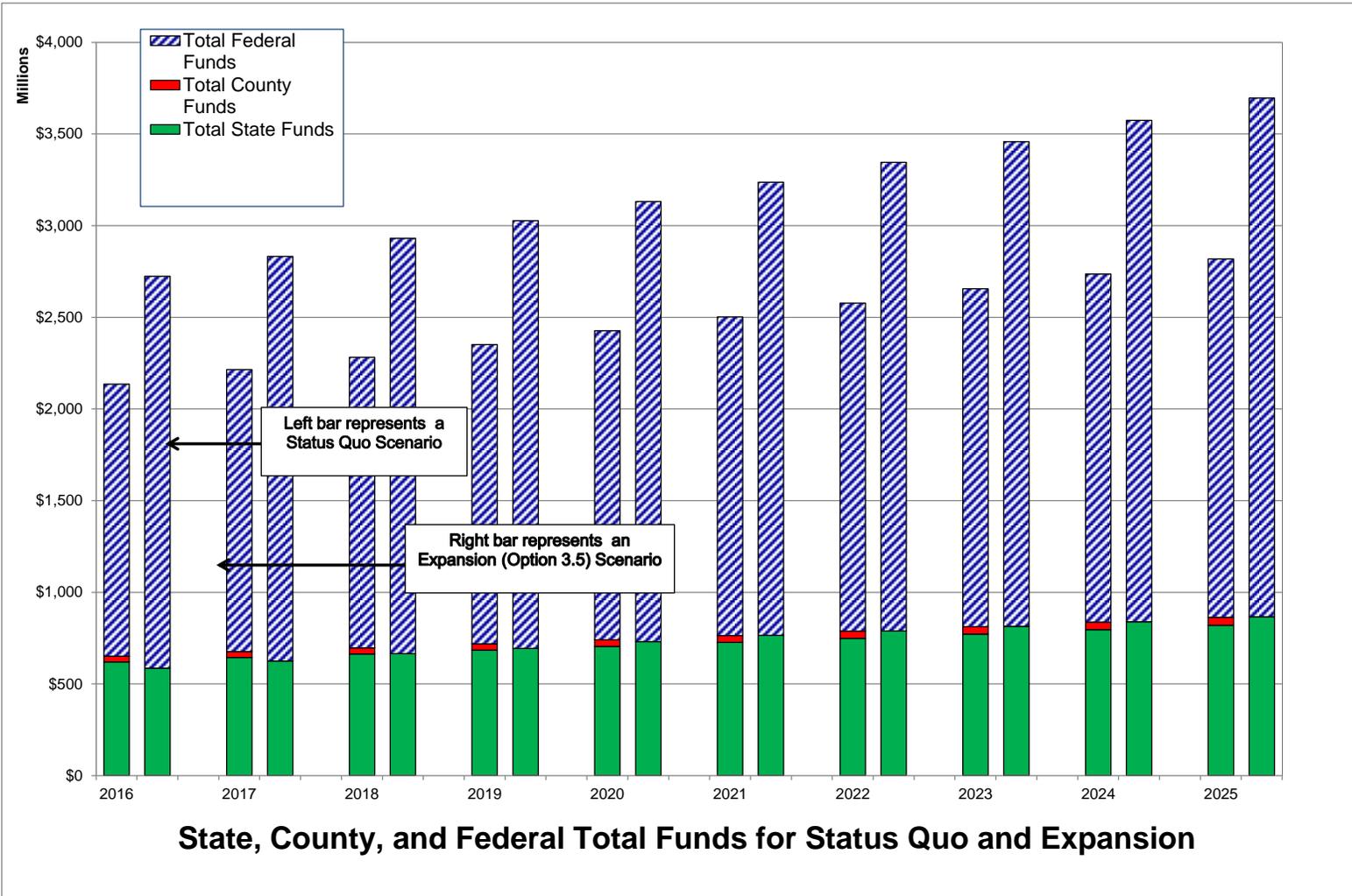


Exhibit 7

Idaho Projected Costs Table and Graph – Status Quo and Expansion Blend (Option 3) Comparisons including Current Medicaid costs

Idaho Department of Health and Welfare
Financial Impact Review of the Patient Protection and Affordable Care Act
On the Idaho Medicaid Budget

December 3, 2014

This report assumes that the reader is familiar with the state of Idaho's Medicaid program and federal healthcare reform. The report was prepared solely to provide assistance to DHW to model the financial impact of federal healthcare reform provisions. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Exhibit 7a
Idaho Department of Health and Welfare
Option 3
Total Projected County, State, and Federal Costs (Values in Millions)

	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>	<u>SFY 2020</u>	<u>SFY 2021</u>	<u>SFY 2022</u>	<u>SFY 2023</u>	<u>SFY 2024</u>	<u>SFY 2025</u>	<u>Cumulative Total</u>
Current Medicaid (Historical Base) ⁽¹⁾											
State Funds:	\$553.4	\$576.1	\$593.5	\$611.4	\$625.2	\$642.5	\$661.9	\$681.9	\$702.5	\$723.8	\$6,372.2
Federal Funds:	\$1,422.7	\$1,474.5	\$1,519.0	\$1,564.8	\$1,621.3	\$1,673.3	\$1,723.7	\$1,775.6	\$1,829.1	\$1,884.1	\$16,488.0
Subtotal:	\$1,976.1	\$2,050.6	\$2,112.5	\$2,176.2	\$2,246.5	\$2,315.8	\$2,385.6	\$2,457.5	\$2,531.6	\$2,607.9	\$22,860.3
State and County Programs											
CAT Program (State)	\$35.6	\$37.3	\$39.1	\$40.9	\$42.9	\$45.0	\$47.1	\$49.4	\$51.7	\$54.2	\$443.1
Medical Indigent (County)	\$24.7	\$25.7	\$26.7	\$27.8	\$28.9	\$30.0	\$31.2	\$32.5	\$33.8	\$35.1	\$296.5
Medical Ind (County Admin)	\$6.1	\$6.3	\$6.6	\$6.8	\$7.0	\$7.3	\$7.5	\$7.8	\$8.0	\$8.0	\$71.3
Behavior Health (DHW)	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$9.7	\$96.5
Public Health (DHW)	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$0.8	\$8.0
Subtotal:	\$76.8	\$79.7	\$82.8	\$86.0	\$89.3	\$92.7	\$96.3	\$100.1	\$104.0	\$107.8	\$915.4
Option #1: Additional Costs ACA costs - No Expansion											
State Funds:	\$20.8	\$19.9	\$20.4	\$20.9	\$26.1	\$28.3	\$29.0	\$29.8	\$30.5	\$31.3	\$257.0
Federal Funds:	\$61.2	\$64.2	\$65.8	\$67.4	\$64.4	\$64.4	\$66.0	\$67.7	\$69.4	\$71.1	\$661.6
Subtotal:	\$82.0	\$84.1	\$86.2	\$88.3	\$90.5	\$92.8	\$95.1	\$97.4	\$99.9	\$102.3	\$918.6
Option #3: Medicaid Expansion Costs											
State Funds:	\$12.1	\$30.5	\$53.6	\$62.6	\$79.8	\$93.8	\$96.2	\$98.6	\$101.0	\$103.6	\$731.8
Federal Funds:	\$720.4	\$720.3	\$715.9	\$726.2	\$728.7	\$734.9	\$753.3	\$772.1	\$791.4	\$811.2	\$7,474.6
Subtotal:	\$732.5	\$750.8	\$769.6	\$788.8	\$808.5	\$828.8	\$849.5	\$870.7	\$892.5	\$914.8	\$8,206.5
Total Costs of Status Quo - No Expansion ⁽²⁾											
County Funds:	\$30.8	\$32.0	\$33.3	\$34.6	\$35.9	\$37.3	\$38.8	\$40.3	\$41.8	\$43.2	\$367.8
State Funds:	\$620.2	\$643.7	\$663.4	\$683.7	\$704.6	\$726.2	\$748.5	\$771.5	\$795.2	\$819.7	\$7,176.8
Federal Funds:	\$1,483.9	\$1,538.7	\$1,584.7	\$1,632.2	\$1,685.7	\$1,737.7	\$1,789.7	\$1,843.3	\$1,898.4	\$1,955.2	\$17,149.6
State, County and Federal Funds	\$2,134.8	\$2,214.4	\$2,281.4	\$2,350.5	\$2,426.3	\$2,501.3	\$2,577.0	\$2,655.0	\$2,735.4	\$2,818.1	\$24,694.3
Total Costs with Expansion ⁽³⁾											
County Funds:	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
State Funds:	\$586.3	\$626.6	\$667.5	\$694.9	\$731.1	\$764.6	\$787.1	\$810.3	\$834.1	\$858.6	\$7,361.1
Federal Funds:	\$2,204.3	\$2,258.9	\$2,300.7	\$2,358.4	\$2,414.5	\$2,472.7	\$2,543.0	\$2,615.4	\$2,689.9	\$2,766.4	\$24,624.3
State, County and Federal Funds	\$2,790.6	\$2,885.5	\$2,968.2	\$3,053.3	\$3,145.5	\$3,237.3	\$3,330.2	\$3,425.7	\$3,523.9	\$3,625.0	\$31,985.3
Total "Swing" Cost <Savings> - No Expansion vs. Expansion											
County Funds:	(\$30.8)	(\$32.0)	(\$33.3)	(\$34.6)	(\$35.9)	(\$37.3)	(\$38.8)	(\$40.3)	(\$41.8)	(\$43.2)	(\$367.8)
State Funds:	(\$33.9)	(\$17.2)	\$4.1	\$11.2	\$26.5	\$38.4	\$38.6	\$38.7	\$38.8	\$38.9	\$184.2
Federal Funds:	\$720.4	\$720.3	\$715.9	\$726.2	\$728.7	\$734.9	\$753.3	\$772.1	\$791.4	\$811.2	\$7,474.6
State, County and Federal Funds	\$655.7	\$671.1	\$686.8	\$702.9	\$719.3	\$736.0	\$753.1	\$770.6	\$788.5	\$807.0	\$7,291.0

⁽¹⁾ This is an expenditure forecast for Idaho's current Medicaid program.

⁽²⁾ Includes Current Medicaid (Historical Base), State and County Programs, and Option #1: Additional ACA costs.

⁽³⁾ Includes Current Medicaid (Historical Base), Option #1: Additional ACA costs, and Option #3 Medicaid Expansion Costs.

Exhibit 7b - State and County Funds by Program Graph
 Idaho Department of Health and Welfare
 Option 3

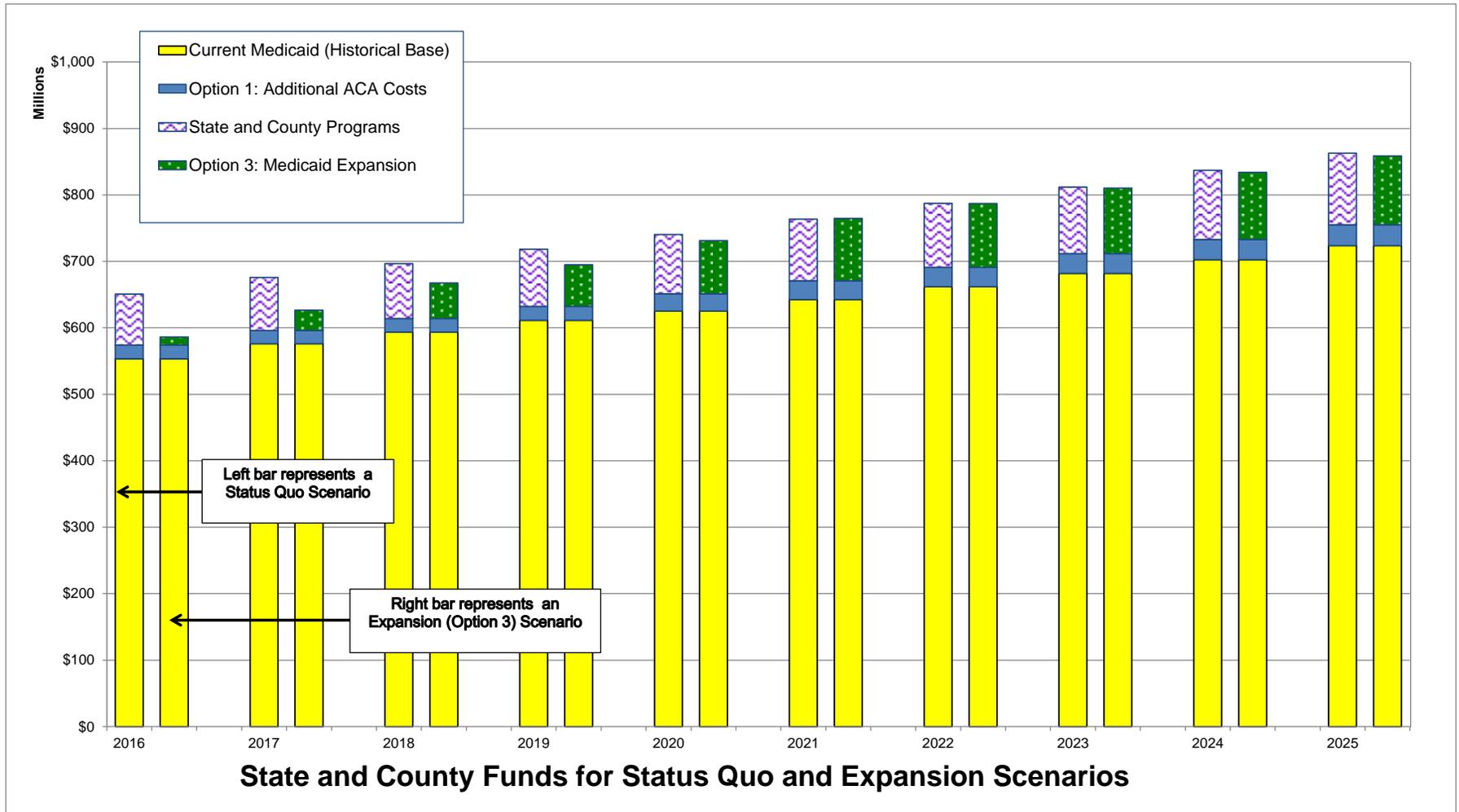
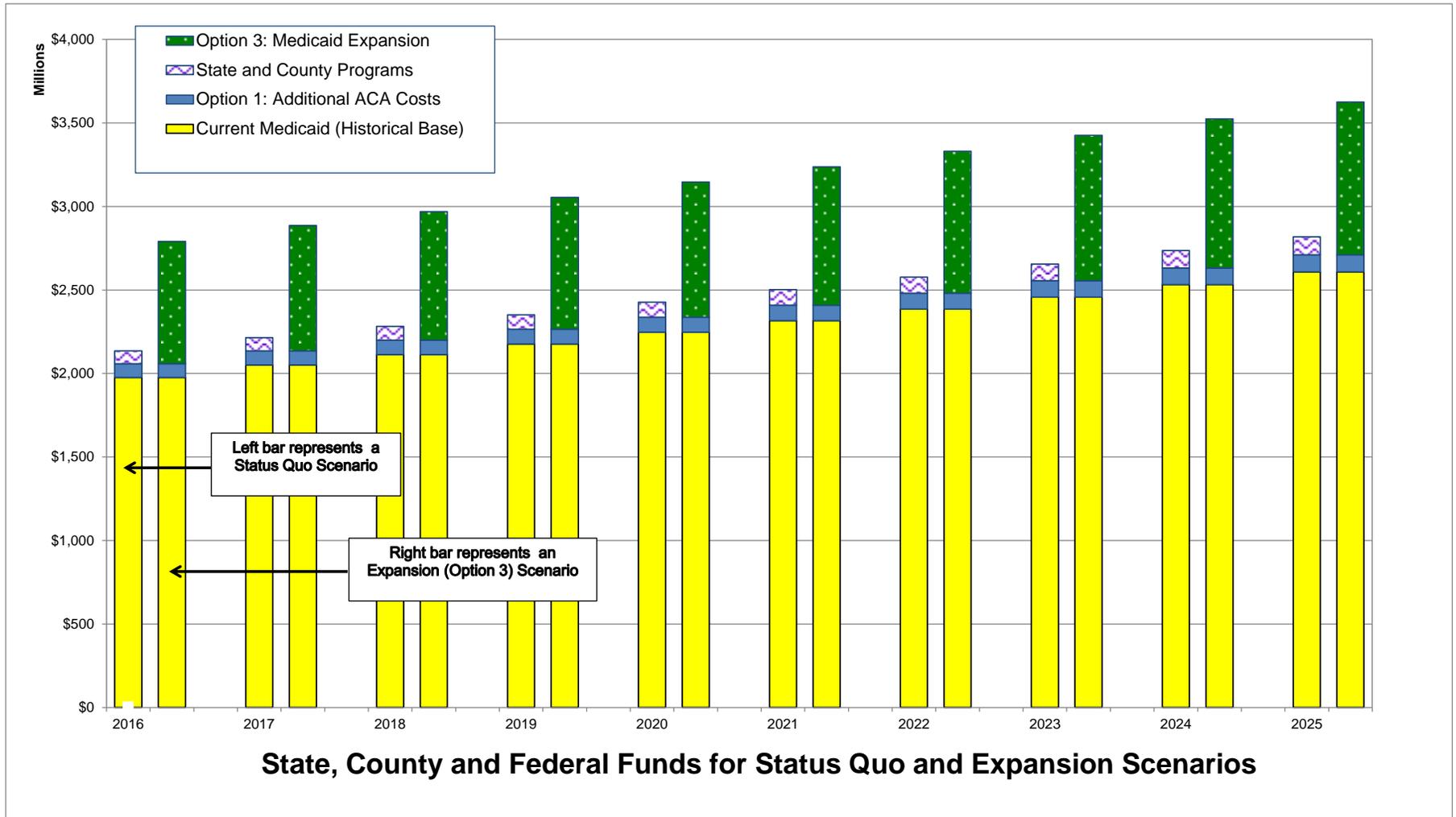
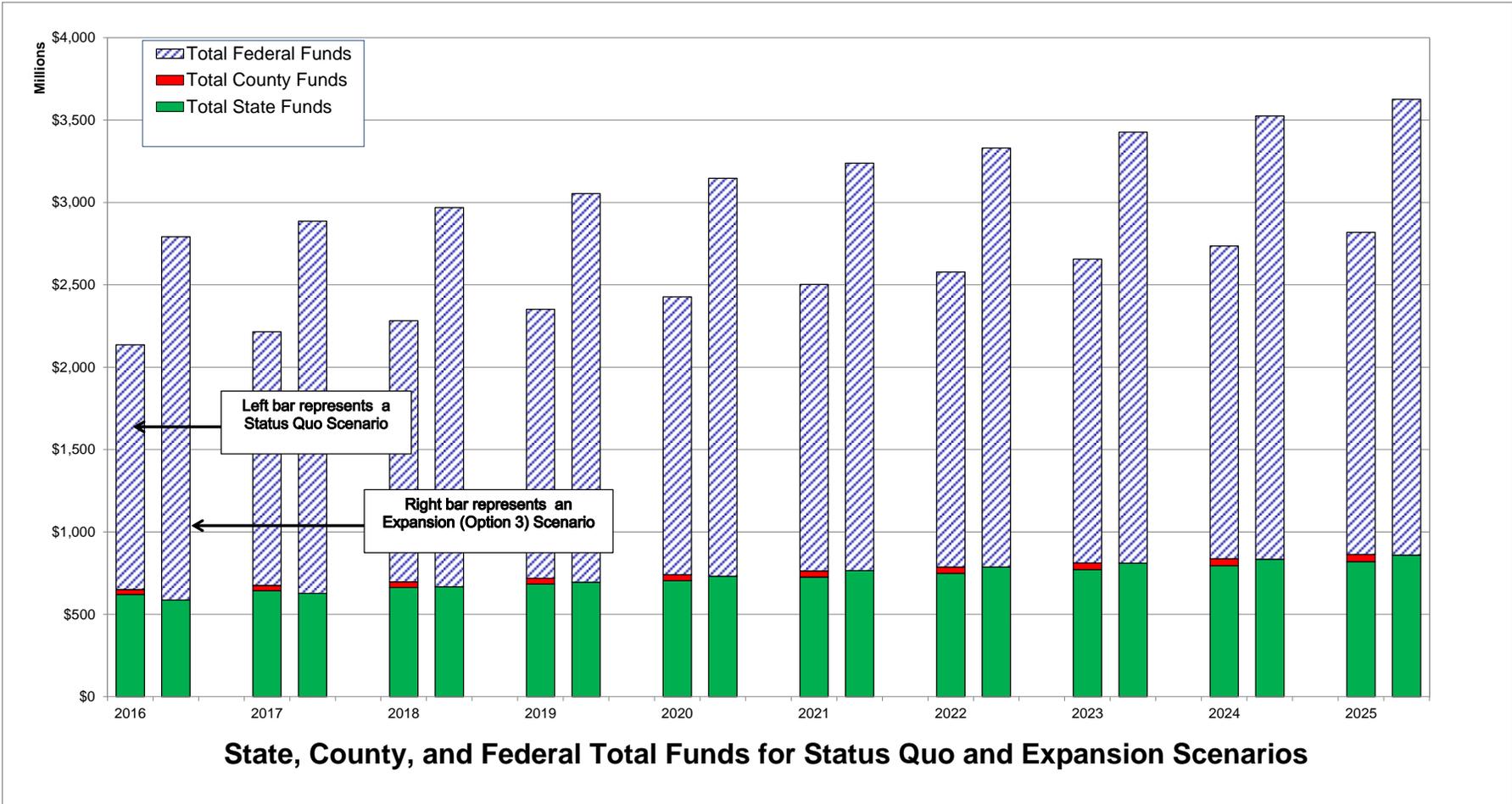


Exhibit 7c - State, County, and Federal Funds by Program Graph
Idaho Department of Health and Welfare
Option 3



**Exhibit 7d - Total State, County, and Federal Funds Graph
Idaho Department of Health and Welfare
Option 3**



Attachment #4

Alternative State Approaches – Joanne Jee

Idaho Workgroup on Medicaid Redesign

December 4, 2014

Alternative State Approaches to Medicaid Expansion

**Joanne Jee
Program Director
National Academy for State Health Policy**

**Idaho Medicaid Redesign
Workgroup Meeting
June 18, 2014**

Overview

- About NASHP
- Key elements of Medicaid expansion
- Status of state Medicaid expansion decisions
- Alternative state approaches to expansions
- Questions

About NASHP

- Non-partisan, non-profit Academy dedicated to helping states achieve excellence in health policy and practice
 - Convene state leaders to solve problems and share solutions
 - Conduct policy analyses and research
 - Disseminate information on state policies and programs
 - Provide technical assistance to states
- State Refor(u)m: www.statereforum.org
 - Online network for health reform implementation
 - More than 9,000 users
 - State specific health reform resources

Key elements of Medicaid expansion

- **Eligibility:** ACA expanded Medicaid eligibility to almost all adults with incomes up to 133% FPL (\$32,913 for a family of 4 in 2014)
- **Benefits:** Provide alternative benefits plan (ABP), which must cover the 10 essential health benefits (EHB)
- **Financing:** Federal share is 100% in 2014-2016, phasing down to 90% by 2020.
- **Deadline for expanding:** None

States are designing alternatives to traditional Medicaid expansions

State program	Premium Assistance	Premiums or Cost Sharing	Benefits Waived	Healthy Behavior Incentives	Work Incentives
AR Private Option	✓	✓			
IA Wellness Plan		✓	✓	✓	
IA Marketplace	✓	✓	✓	✓	
Healthy MI		✓			
Healthy PA (pending)	✓	✓	✓	✓	✓
NH Health Protection Prog (leg. signed)	✓	✓		✓	
IN HIP 2.0 (1115 in dev.)	ESI	✓	✓	Health plans	✓

Snapshot of states with alternative expansion models

	Status	Projected Enrollment	Reported Enrollment
AR Private Option	In effect 9/27/13	225,000 in yr. 1	155,567 (4/21/14)
IA Plan Wellness	In effect 1/1/14	93,968 in year 1	80,564 (5/30/14)
IA Marketplace Choice	In effect 1/1/14	24,891 in year 1	21,966 (5/30/14)
Healthy MI	In effect 4/1/14	300,000 -500,000	287,281 (6/9/14)
Healthy PA	Waiver pending	500,000 newly eligible	—
NH Health Protection Program	Waiver being developed	50,000	—
IN HIP 2.0	Waiver in public comment period	600,000 (includes prior adult group)	—

Two states have approved premium assistance programs

- Arkansas (Private Option) and Iowa (Marketplace Choice) are implementing a premium assistance program using Medicaid funds to purchase coverage for newly eligible adults in the marketplace
 - Arkansas: all newly eligible are mandatorily enrolled in premium assistance
 - Iowa: newly eligible with incomes 100-138% FPL mandatorily enrolled in premium assistance
 - Both have end date of December 31, 2016
- Improve continuity of care?

Non-premium assistance programs

- Iowa Wellness Plan
 - Multiple delivery systems: PCPs, PCPs associated with ACOs, managed care health plans
- Michigan
 - Use existing managed care health plans and prepaid inpatient health plans for behavioral health
- New Hampshire
 - Currently, ESI (HIPP program) or managed care health plan (Bridge program); eventually through Marketplace

Some flexibility on premiums and cost sharing

	Premiums	Cost Sharing	Other
AR-Private Option	State pays premium	<ul style="list-style-type: none"> • <100%FPL – none in year 1 • >100% FPL, per Medicaid rules 	May propose cost sharing for those 50-100% FPL
IA-Wellness Plan	<ul style="list-style-type: none"> • 0-50% FPL, none • 50-100% FPL, \$5/mo. • 90 day grace period • No denial/loss of coverage if unpaid 	\$8 copayment for nonemergent use of ER (had requested \$10)	No premium for medically frail
IA-Marketplace Choice	<ul style="list-style-type: none"> • >100% FPL, \$10/mo. • 90 day grace period • No denial/loss of coverage if unpaid 	\$8 copayment for nonemergent use of ER (had requested \$10)	

Some flexibility on premiums and cost sharing (continued)

	Premiums	Cost Sharing	Other
Healthy MI	<ul style="list-style-type: none"> • <100% FPL, none • >100% FPL, pay into HSA-like acct. =2% of income 	<ul style="list-style-type: none"> • Copay=average of copays in 1st 6 mo. 	<ul style="list-style-type: none"> • Protocols to be dev. • No denial/loss of coverage or service if unpaid
Healthy PA (pending)	<ul style="list-style-type: none"> • Year 1: none • Year 2:<100% FPL, none; >100% FPL \$25 (1 adult), \$35 (>1 adult) 	<ul style="list-style-type: none"> • Year 1: current Medicaid copays apply • Year 2: \$10 copay for nonemergency use of ER 	<ul style="list-style-type: none"> • Premium required for eligibility • Premium Grace period • Denial of service if copay unpaid is ok
IN HIP 2.0 (waiver in devt.)	<ul style="list-style-type: none"> • Monthly payment to HSA-like account 	<ul style="list-style-type: none"> • Only in HIPBasic limited plan • Graduated copays for nonemergency use of ER 	<ul style="list-style-type: none"> • Premium required for eligibility

Healthy behavior incentive programs approved, but few details so far

- Iowa Health and Wellness Program
 - Year 1: Premiums waived for completing health risk assessment (HRA) and wellness exam
 - Year 2: Financial-based award, “evidence based incentive program”
 - Iowa must submit for CMS approval a protocol for implementation in year 1 and subsequent years, including data and monitoring plan
 - State posted RFI on 4/21/14 for Year 2 program
- Healthy Michigan
 - Cost sharing and monthly contribution reductions for adoption of eligible healthy behaviors, including HRA
 - State will submit protocol for CMS approval

Pennsylvania proposes linking work incentives to coverage

- Waiver initially proposed participation in Encouraging Employment as a condition of eligibility for adults working <20 hours per week.
- Reduced cost sharing or premiums for those working >20 hours per week or participating in required job training and related activities.
- On 3/6/14, PA submitted new waiver proposal making Encouraging Employment a voluntary 1-year pilot, with size of cost sharing and premium reductions tied to number of hours worked.

Alternative model states are seeking waivers of some benefits

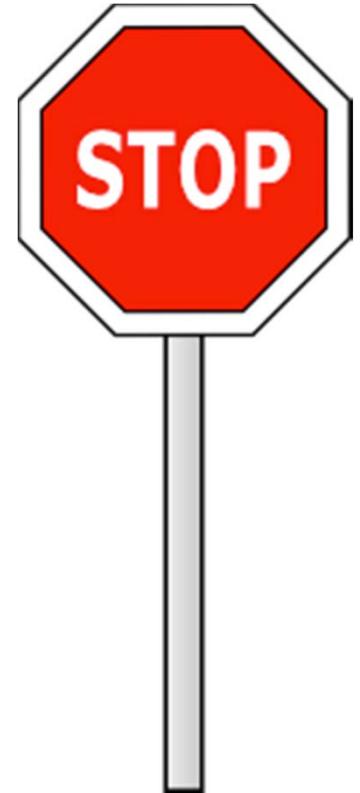
Benefit Waiver Sought	Waiver Granted	Waiver Denied
Non-emergency transportation	<ul style="list-style-type: none"> Iowa (1 year) Indiana 	
Out of network family services		<ul style="list-style-type: none"> Pennsylvania
Early, Periodic, Screening, Diagnosis, and Testing (EPSDT)		<ul style="list-style-type: none"> Iowa
All wrap around services		<ul style="list-style-type: none"> Pennsylvania

State waivers include delivery system changes

- AR: All carriers offering QHPs must participate in a multi-payer initiative to promote patient centered care medical homes; includes episode-based care delivery
- IA: SIM Model Design state, health homes for those with chronic conditions
- PA: SIM Model Design state, priority on Accountable Provider Organization and patient centered medical homes, piloting episodes of care
- NH: improvements to behavioral health delivery system, and systems of those with complex needs.

Some waiver requests have been denied

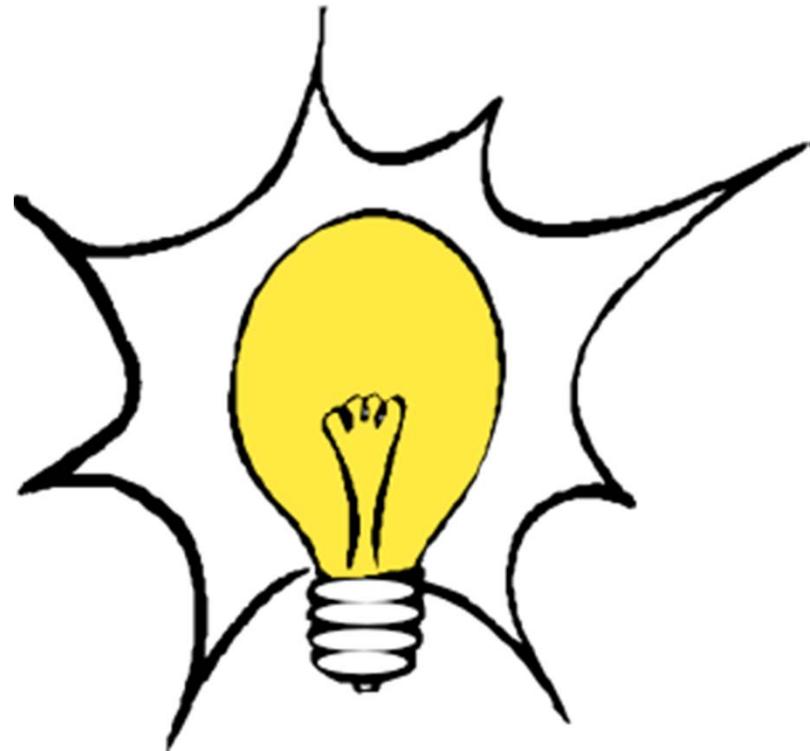
- Cost sharing beyond currently permissible levels
- Certain benefits: EPSDT, out of network family planning
- Partial expansions, below 133% FPL



Adapted from *The ACA and Recent Section 1115 Medicaid Demonstration Waivers, February 2014, Kaiser Commission on Medicaid and the Uninsured*

More state alternatives to Medicaid expansion to come?

- Indiana
- Maine
- Missouri
- New Hampshire
- Utah
- Virginia
- Wisconsin
- Idaho?



Thank you!

Contact information:

Joanne Jee

jjee@nashp.org

www.nashp.org

Attachment #5

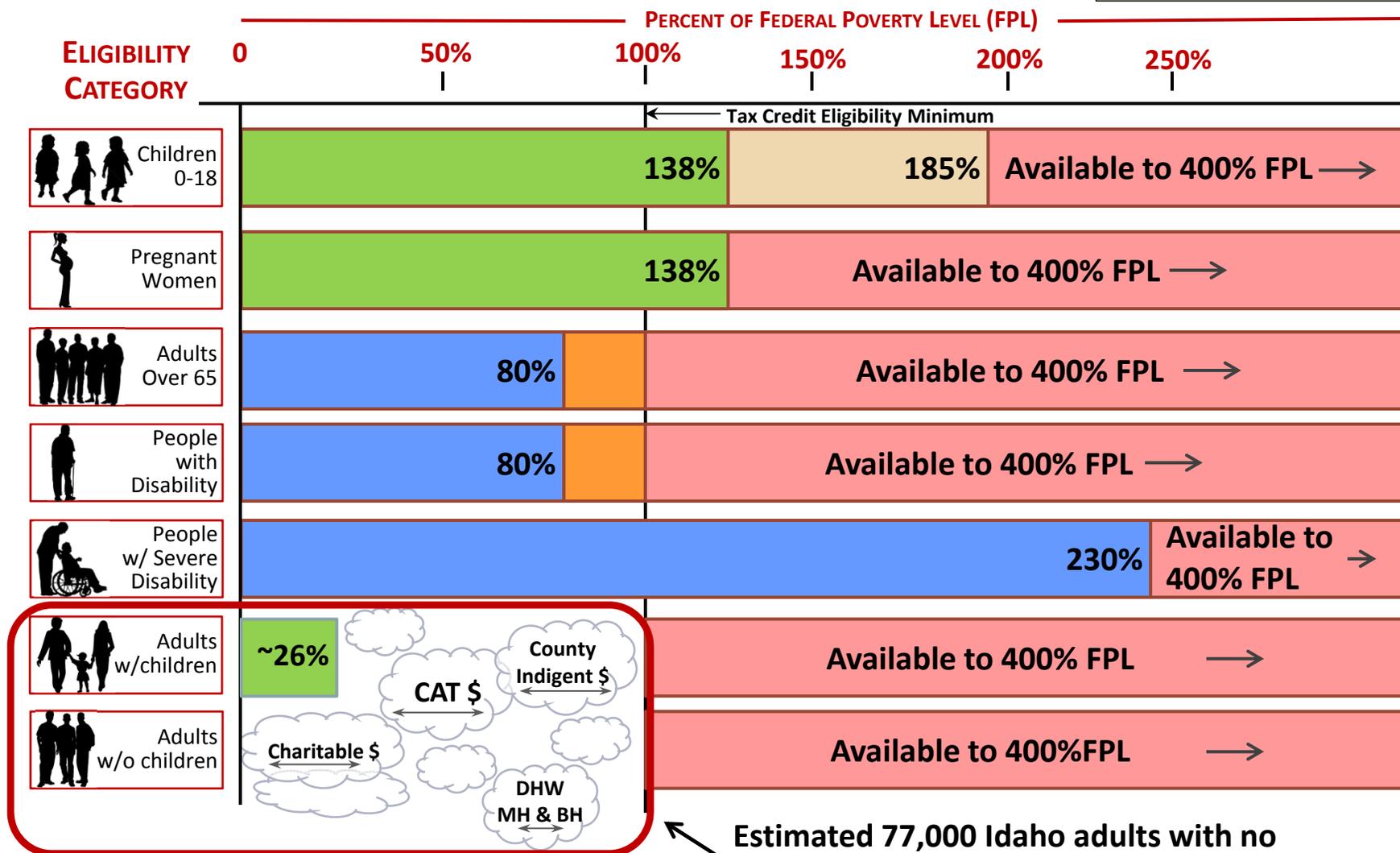
Medicaid Eligibility & GAP Population

Idaho Workgroup on Medicaid Redesign

December 4, 2014

Medicaid/Insurance Exchange Income Eligibility

Medicaid	CHIP
Mandatory	Optional
HIX APTC	Medicare
KEY	Other Coverage



Estimated 77,000 Idaho adults with no insurance options. The "Gap" population.

Attachment #6

**Comparison of Private Insurance/Exchange Option
& Managed Care/State Contract Option – Paul Leary**

*Idaho Workgroup on Medicaid Redesign
December 4, 2014*

MEDICAID EXPANSION

OPTIONS FOR FEDERAL AUTHORITY

- Essentially two options that states are taking to gain federal authority to expand Medicaid.
 - **State Plan Authority** – Authority is gained through amending the current Medical Assistance State Plan (State Plan amendments and if necessary section 1915 Waiver)
 - **Section 1115 Demonstration Waiver** - Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and

MEDICAID EXPANSION

OPTIONS FOR FEDERAL AUTHORITY

-evaluate policy approaches such as:
 - Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible
 - Providing services not typically covered by Medicaid
 - Using innovative service delivery systems that improve care, increase efficiency, and reduce costs
- In general, section 1115 demonstrations for Medicaid expansion are approved for a three-year period and can be renewed, typically for an additional three years. Demonstrations must be "budget neutral" to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the waiver.

MEDICAID EXPANSION OPTIONS FOR FEDERAL AUTHORITY

- Areas not affected by option selected include:
 - State Legislation requirement
 - Eligible population
 - Covered health benefits
 - Medicaid “wrap around” services

MEDICAID EXPANSION

OPTIONS FOR FEDERAL AUTHORITY

- Areas that differ by option selected include:
 - CMS approval, oversight and renewal
 - Use of QHPs vs Medicaid contracted plans (RFP)
 - Provider network
 - Payment to plans
 - Cost Sharing – actual limits are the same
 - Consumer Choice
 - Budget neutrality
 - Personal responsibility and healthy behavior incentives
 - Provider incentives
 - Access to data

Attachment #7

Current Medicaid Status Report

Idaho Workgroup on Medicaid Redesign

December 4, 2014



IDAHO Department of
Health and Welfare

The Facts About Idaho Medicaid

Lisa Hettinger
Medicaid Administrator

August 14, 2014





IDAHO

Department of
Health and Welfare

Idaho Medicaid: Costs & Value

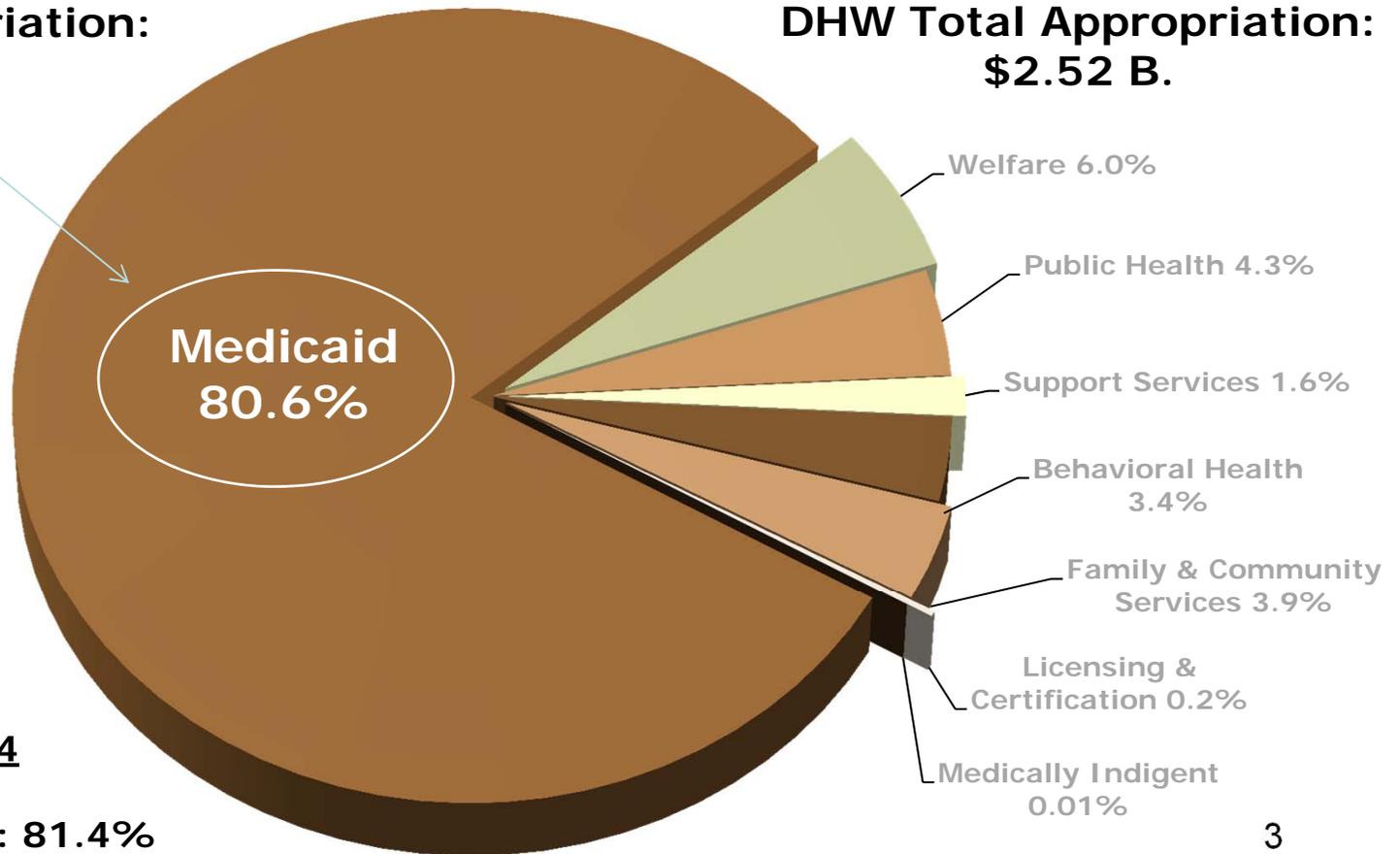
- **What is the cost?**
- **How is the funding used?**
- **Who receives Medicaid services?**
- **How is Idaho Medicaid trending?**
- **What is the relationship between the number of participants and Medicaid spending?**



DHW SFY15 Program Allocations

Medicaid Appropriation:
\$2.033 B.

DHW Total Appropriation:
\$2.52 B.



Medicaid SFY 2014

- \$2.024 B.
- Percent of DHW: 81.4%



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Department of
Health and Welfare

What is the State's Cost?

SFY 2015 Medicaid Budget

➤ Federal funds	\$1.353 B.	(66.6%)
➤ State General Fund	\$ 492 M.	(24.2%)
➤ Dedicated/Receipts	<u>\$ 188 M.</u>	<u>(9.2%)</u>
Total	\$2.033 B.	

- State General Fund dollars are used as matching funds to leverage federal dollars to cover Medicaid expenditures.
- Each \$1 of Medicaid General Fund spending = \$4.13 total spending.
- \$492 M. of Medicaid General Funds = 17% of Idaho State General Fund dollars



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Health and Welfare

How is the Funding Used?



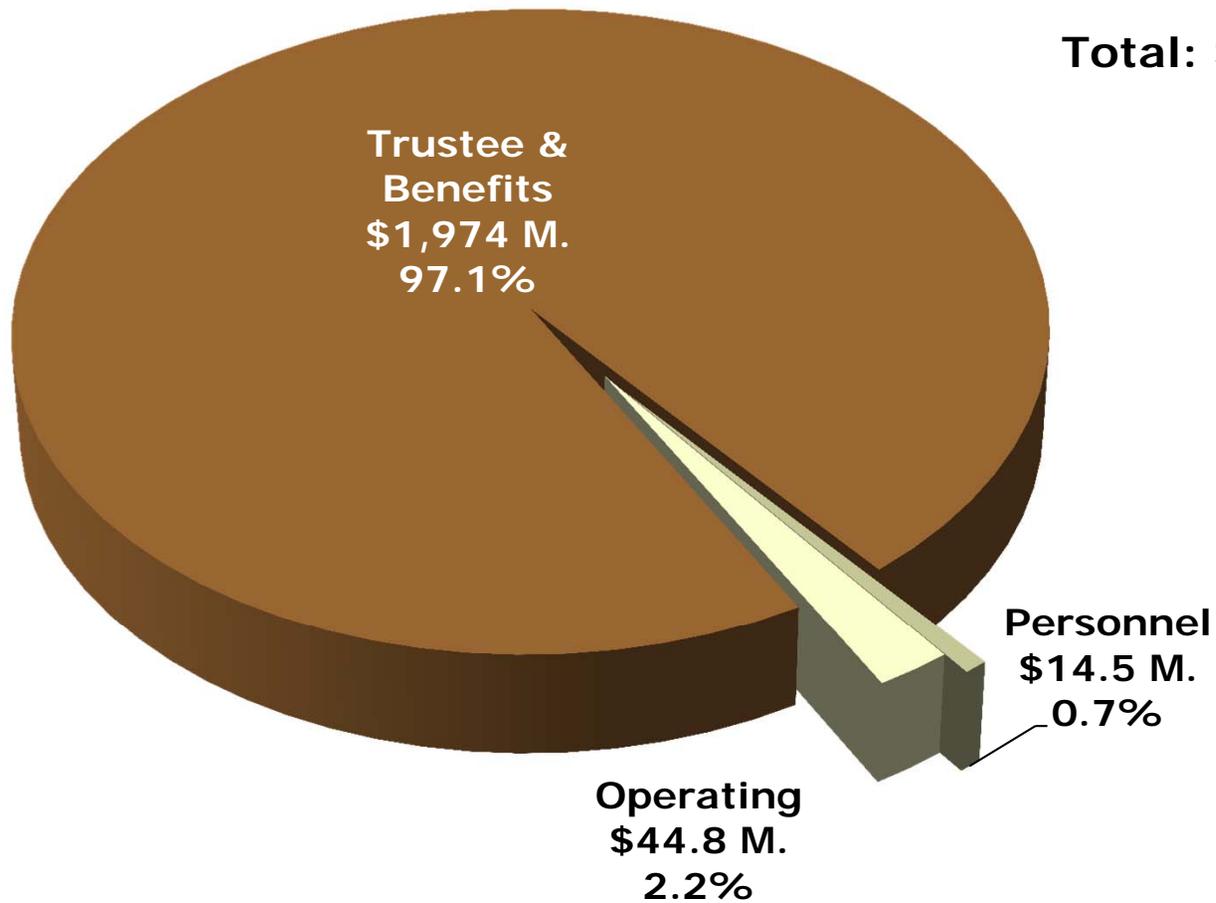
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Department of
Health and Welfare

SFY15 Medicaid by Category

FTP: 210

Total: \$2.033 B.





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Health and Welfare

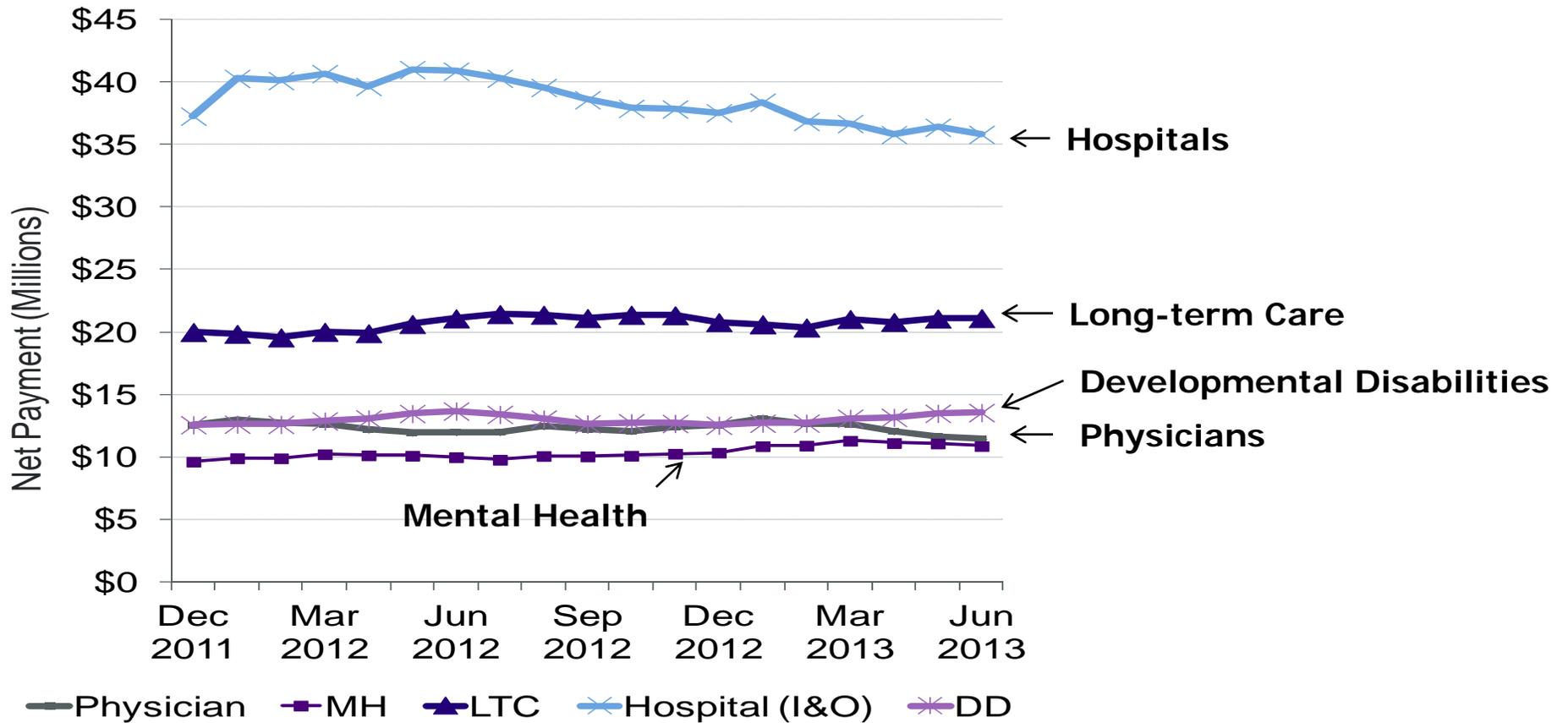
How is the Funding Used?

- **Over 97% pays for health care services provided to Medicaid participants.**
- **Most services are provided by private health care providers who are part of the Idaho health care delivery system.**
- **Impact: For each \$1 of State General Funds allocated to Medicaid = \$4.13 spent predominately in the Idaho economy.**



MMIS Monthly Payouts – Provider Type

Three Month Moving Average





Who Receives Medicaid Services?



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Department of
Health and Welfare

Members and Cost by Plan

Plan	Average Members/Mo. SFY 2014	% of Total Medicaid Members	Monthly Cost/Member	
Basic Child	154,854	61.3%	\$184	
Basic Adult	26,205	10.4%	\$588	Includes pregnancy
Enhanced Child	30,902	12.2%	\$892	Over 70% of cost
Enhanced Adult	17,080	6.8%	\$2,465	
Coordinated	23,445	9.3%	\$1,756	

Under 30% of members

Avg. through 4/30/2014



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Participants in Each Plan

- **Basic Plan – Healthy children and working-aged adults, including pregnant women**
- **Enhanced Plan – People with disabilities and special health care needs**
- **Coordinated Plan – Medicare/Medicaid with majority being elderly with special health care needs**



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Health and Welfare

How is Medicaid Trending?

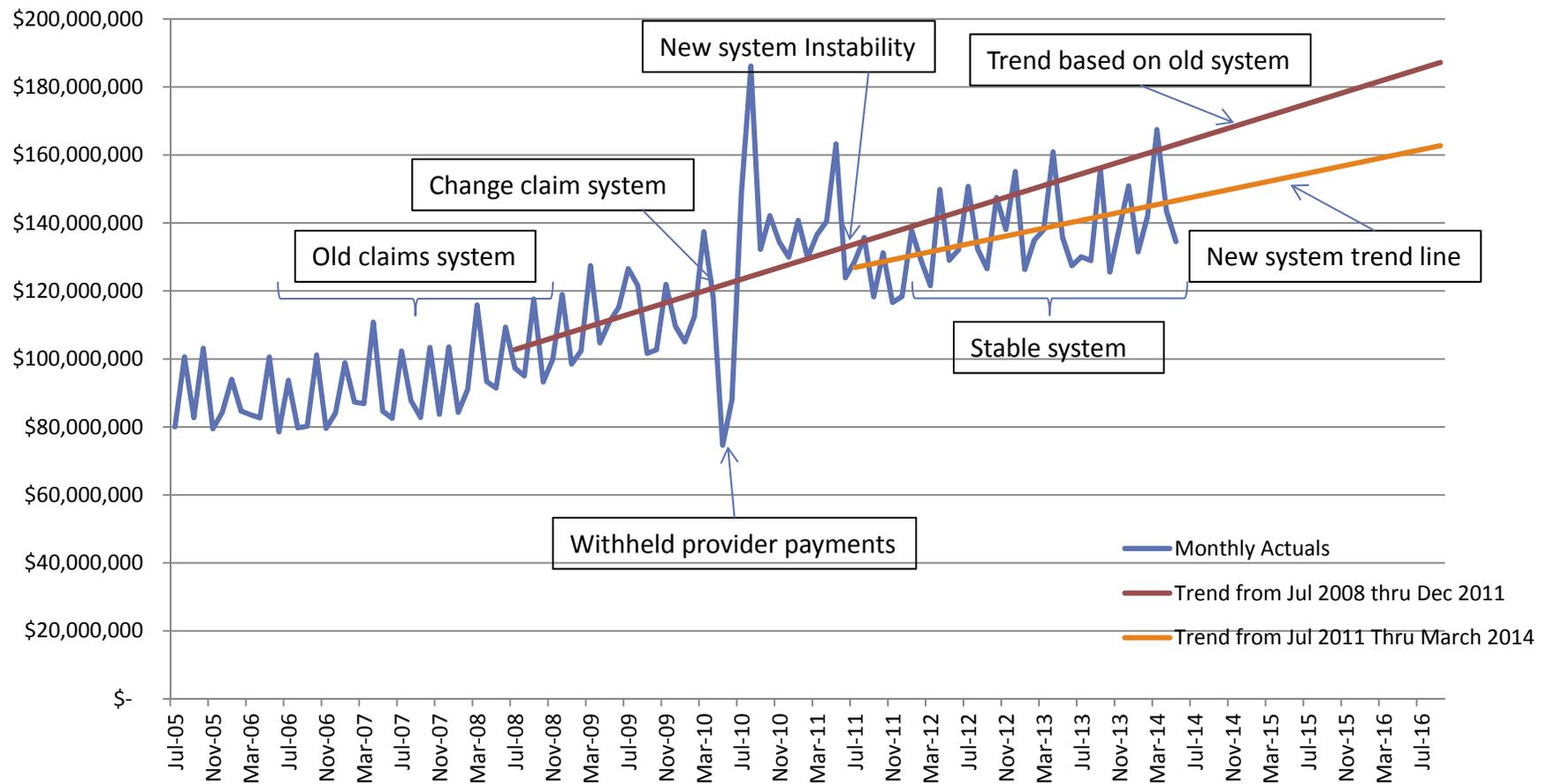


Average Monthly Eligible Participants Percent Change From SFY 2010

	% Growth
SFY '10	
SFY '11	8.7%
SFY '12	5.1%
SFY '13	3.1%
SFY '14	5.5%



Medicaid Expenditure Trends





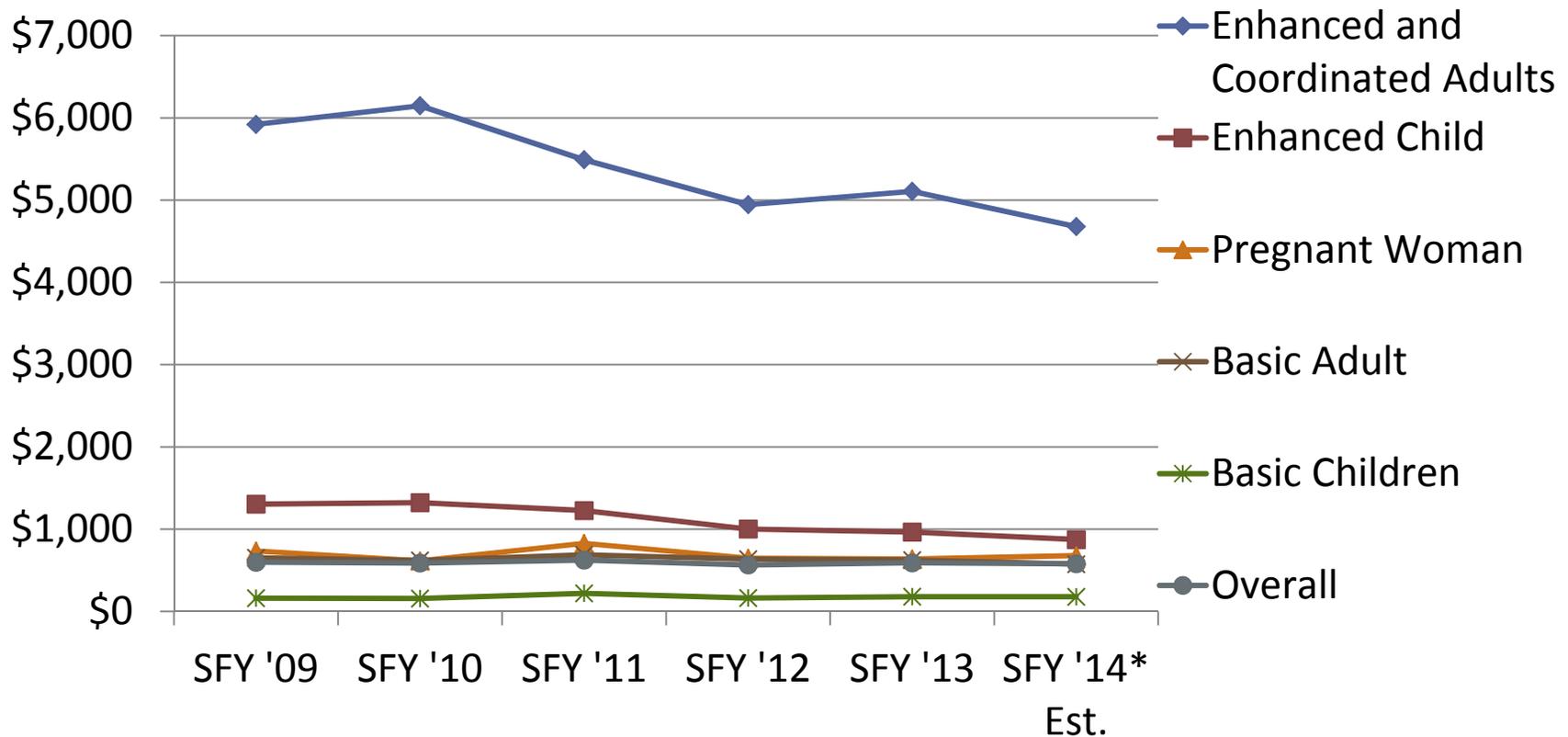
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Health and Welfare

What is the Relationship Between the Number of Medicaid Participants and Medicaid Spending?



Medicaid PMPM by Program





How Have We Bent the Spending Curve?

Reference quarterly Medicaid managed care reports and HB 260 reports to the Idaho Legislature:

- Dental services have seen a decrease in cost and increase in services, mostly because of an increase in preventative services under managed care.
- Non-emergent medical transportation – brokerage has resulted in no change in per member rates since 2008.
- Residential habilitation affiliation – single source contract saves over \$1.2 million annually.
- Behavioral health managed care evolves the old volume-based system to a value-based system of evidenced-based practice.



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How Have We Bent the Spending Curve?

Managed care continued:

- **Integrated managed care for dual eligibles – Will continue to move forward in developing a more coordinated health care approach.**
- **Money Follows the Person – Idaho Home Choice has successfully moved over 180 Medicaid participants who have been in long-term care facilities for at least 90 days back into the community.**
- **Medicaid Health Homes – Patient Centered Medical Homes for participants with asthma or diabetes and an additional co-morbidity or significant mental illness.**
 - **Over 9,500 participants are now in Health Homes.**
 - **Health Homes include 26 different health care organizations operating in over 50 service locations throughout the state.**



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Department of
Health and Welfare

Questions?

Attachment #8

Medicaid Redesign for People with Disabilities
Jim Baugh

Idaho Workgroup on Medicaid Redesign
December 4, 2014

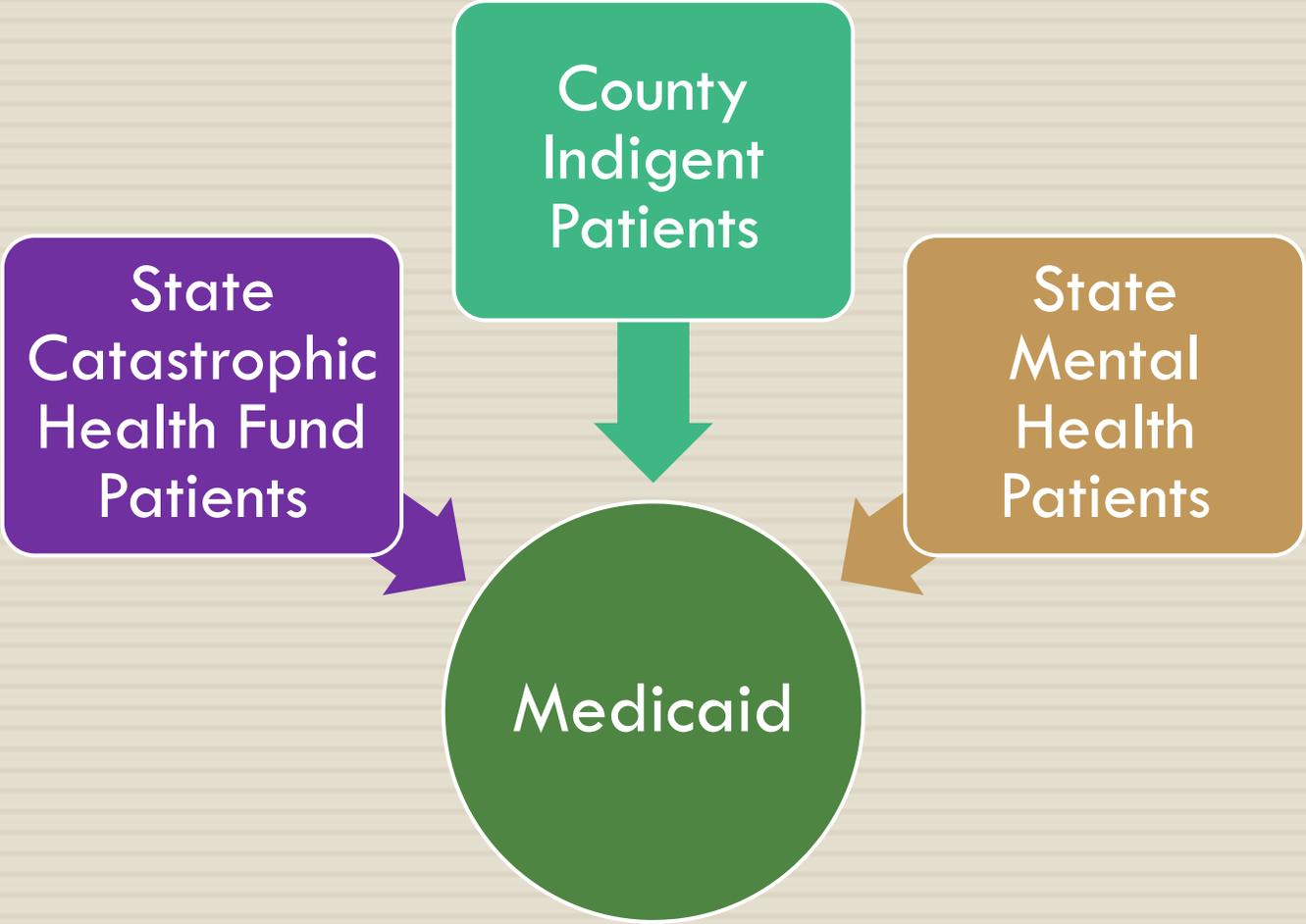
MEDICAID REDESIGN – IDAHO

Presented by:



What it would mean for Idahoans with disabilities.

What is Idaho Medicaid Redesign?



Many Idahoans With Disabilities Are Not Covered

- **Uninsured households with income below 138% of the Federal Poverty Level :**
 - ▣ Most adults with severe mental illness
 - ▣ Many low income people with disabilities and chronic health conditions
 - ▣ People with recent disabilities in the waiting period for Medicare (2years).

People with Serious Mental Illness

- 75,000 Idahoans experienced a serious mental illness in the last year.
- 41,000 have a persistent and recurring serious mental illness that impairs their ability to function in society.
- About 19,000 of these Idahoans receive treatment through the Department of Health and Welfare for these illnesses each year.
- Only about 9,000 of them are currently covered by Medicaid.

Fixing Idaho's Mental Health System

- ❑ Idaho's current mental health system lacks the necessary funding to meet the increasing and critical needs of Idaho citizens.
- ❑ Medicaid redesign would provide a range of community based mental health services to nearly all Idahoans with a serious and persistent mental illness.
- ❑ Medicaid redesign could fix much of what is wrong with Idaho's current mental health system using federal dollars.

Health and Welfare Estimated General Fund Savings

- The majority of adults in the Adult Mental Health (AMH) and Substance Use Disorder (SUD) programs will be a part of the newly eligible population.

This would save about:

- \$6.8 million of the current AMH appropriation.
- \$1.75 million in Substance Abuse Treatment
- \$1.7 million in Community Hospitalization

Total Behavioral Health General Funds Savings =

\$10.25 million per year.

Low income People with Disabilities and Chronic Health Problems

- ❑ Medicaid does not currently cover all low income Idahoans with disabilities .
- ❑ For the majority of people with income over \$754/month, Medicaid is available only for those who meet Nursing Home level of care and other eligibility requirements
- ❑ People with disabilities can be disqualified because of Disability Benefits, part time work etc.

People with recent disabilities in the waiting period for Medicare.

- When people meet the criteria for Social Security Disability Insurance Benefits (SSDI), They must wait 2 years to qualify for Medicare.
- During this time, few people have access to health insurance. If their SSDI payments are more than \$724 / month they cannot get Medicaid.
- This group includes people with cancer, severe arthritis, heart disease, brain injuries, lung diseases etc.

Uninsured Veterans

- Veterans only automatically qualify for Tricare coverage if they retire after 20 years of service.
- Deployed Veterans have 5 years of coverage.
- Extended coverage is available only for “Service Connected” disabilities.

Uninsured Veterans

- 2010 American Community Survey (ACS) data shows that Idaho has about 10,000 uninsured veterans (about 14.8% of non-elderly veterans).
- This is the second highest rate of uninsured veterans in the U.S.
- About 8,000 to 9,000 veteran's family members are uninsured.
- These numbers may have changed as a result of the Insurance exchange, however...

Uninsured Veterans

- If Idaho follows national patterns about 3,200 of these veterans will have households below the poverty level, and unable to take advantage of the insurance subsidies.
- Since Idaho exceeds the national averages for poverty, and number of uninsured veterans, we should expect Idaho to have more than this number of veterans below the poverty level and uninsured.

Who pays for health care now?

- ❑ **Uninsured Families (poor health care options, medical bills, bankruptcy)**
- ❑ **Counties (Indigent Program)**
- ❑ **State (Catastrophic fund, State Mental Health Services)**
- ❑ **Taxpayers (State and County)**
- ❑ **Hospitals (Unpaid Bills)**
- ❑ **Businesses (Increased Premiums)**

Other Ways Idaho Will Save?

- ❑ Lower administrative and legal costs for counties.
- ❑ Improved preventive mental health care reduces costs for local emergency responders, law enforcement, jails and prisons.
- ❑ Lower substance abuse costs and better access to treatment.
- ❑ Fewer unpaid medical bills, resulting in lower health premiums for individuals and businesses.

Attachment #9

**Transitioning Indigent Care from Incident-based to
Systematic Care – Doug Dammrose, M.D.**

*Idaho Workgroup on Medicaid Redesign
December 4, 2014*

August 14, 2014

MEDICAID REDESIGN-IDAHO

Moving Indigent Care from Incident-based to
Systematic Care

Presented by
Doug Dammrose, MD
Idaho Medical Review, LLC
dougdamrose@idahomedicalreview.com

What are the numbers?

- About 5,000 people used the indigent system in FY2014
- Cost of about \$53 Million
- Male 53%/ Female 47%
- Age predominance 21-64

Random Sample

- Out of 1,500 cases reviewed, cases with charges over \$50,000 were selected
 - Cancer – 10%
 - Infection – 22%
 - Cardiovascular – 18%
 - Diabetes – 11%
 - Trauma – 16%
 - Alcohol and Substance Abuse - 11%
 - Liver and Pancreas – 10%
- Mean charges per episode - \$130,949
- 42% of the patients met Social Security criteria for disability

Sample (continued)

- About 10% of the acute/catastrophic cases could have potentially been mitigated by primary care prior to the episode
- All of the care required relatively high cost technical care
 - Neurosurgical/Orthopedic/General Surgery
 - Cardiovascular
 - Oncological
 - High cost pharmacy
- Over 70% would require ongoing specialty care beyond the episode.
- Continued need for predictable pharmacy, laboratory, radiology access

Problems with the current incident based care

- No systematic way to engage the population for preventive care
- Delay in seeking and getting care
- Delayed diagnosis with worse outcomes
- No method of care coordination or case management
- Bankruptcy
- No way to measure impact of interventions or health outcomes

We cannot improve the health of population if we do not have a systematic way to get the data.

Problems with the current incident based care (cont.)

- No consistent method of contracting for reimbursement rates or creating alternative methods of reimbursement that drive provider efficiency
- No consistent method of paying claims using state of the art bundling and editing logic
- Increase cost to taxpayers without federal sharing
- Inconsistent payment to hospitals and physicians that leads to cost-shifting to private payers
- Inconsistent payment methodology for physicians and hospitals makes planning and needs assessment difficult

We cannot control the cost of care that we cannot consistently measure.

Recommendations

- Include management of the indigent population in the “Redesigned Medicaid Model”
- Coverage should be comprehensive, primary care as well as specialty and hospital care to address the high cost, high risk, burden of disease in this population
- Must include seamless pharmaceutical coverage
- Engage systems of care using managed care concepts to drive efficiency (risk models), improved quality, and accountability
- Engage systems of care that allow tracking of cost and outcomes data that allow continued improvement



Questions

Attachment #10

Economic Impacts of Medicaid & Medicaid Expansion

Steven Peterson

Idaho Workgroup on Medicaid Redesign

December 4, 2014

The Economic Impacts of Medicaid and Proposed Medicaid Expansion

Presented to:

The Governor's Workgroup to Evaluate Medicaid
Eligibility Redesign Options

By

Steven Peterson*

Clinical Assistant Professor, Economics

College of Business and Economics

University of Idaho

August 14 2014

- The results and findings of this analysis reflect those of the author, Steven Peterson and do not necessarily represent the University of Idaho or any other organization or individuals.



Who Am I?

- Lifelong Idaho Resident
 - Originally from Lewiston Idaho
 - Affiliated with the University of Idaho for 25 years
 - Worked in health care issues for 10 years
 - Conducted over 100+ economic impact studies in my career
 - ... in virtually every industry in Idaho's economy
- 



Goal of Analysis

- To assess the future impacts of the proposed Medicaid Expansion on Idaho's economy
 - To assess the economic impacts of current Medicaid Spending in Idaho
 - Update of an analysis from 2013
- 



Economic Models

- IMPLAN (Impacts for Planning) model for Idaho
 - Most widely used and accepted input/output modeling system
 - Idaho state model
 - Individual Idaho County models
 - USA model
- 



Economic Base

- ▶ Any economic activity that brings new monies into an economy
 - ▶ National level
 - ▶ State level
 - ▶ County level
 - ▶ Sales of wood products
 - ▶ Sales of agriculture products
 - ▶ Federal spending in Idaho
 - ▶ Tourism
 - ▶ Family-to- family aid
- 



Non-Base

- Any economic activity recirculates existing monies created by export activity
 - Wal-Mart example
 - Instate tuition to Idaho
 - But not to Moscow



FY 2014 Medicaid Spending

- Total Idaho State and Federal Medicaid Spending
 - \$1.853 billion
- Federal Portion \$1.32 billion (71%)
 - New monies to Idaho (Focus of Analysis)
- State Portion \$0.53 billion (29%)



Economic Impacts of 2014 Medicaid Spending Federal Portion only (New Money to Idaho)

- Federal Direct Medicaid Spending \$1.32 billion

- Economic Impacts
- Sales Transactions \$2.25 billion
 - Gross State Product \$1.32 billion
 - Gross Wages \$1.00 billion
 - Total Taxes \$85.50 million
 - Sales/Excise Taxes \$37.2 million
 - Property Taxes \$19.94 million
 - Income Taxes \$28.34 million

- Jobs 28,342

Proposed Medicaid Expansion

- In 2014, the Department of Health and Welfare contracted with Milliman and Associates to re-evaluate the cost and/or savings the Medicaid program is expected to see over the next 10 years. In summary, the report showed:
- Total Medicaid expansion (Managed Care Option) federal expenditures are estimated to increase from \$720.4 million in FY 2016 to \$811.2 million in FY2025.

STATE OF IDAHO												
Division of Medicaid												
Health Care Reform Projection - Senate Bill with Reconciliation Act												
State and Federal Funds Dollars (Values in Millions)												
	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	Total	
Option # 3: State Plan Option (Managed Care)												
State	\$12.1	\$30.5	\$53.6	\$62.6	\$79.8	\$93.8	\$96.2	\$98.6	\$101.0	\$103.6	\$731.8	
Federal	\$720.4	\$720.3	\$715.9	\$726.2	\$728.7	\$734.9	\$753.3	\$772.1	\$791.4	\$811.2	\$7,474.6	
Total	\$732.5	\$750.8	\$769.6	\$788.8	\$808.5	\$828.8	\$849.5	\$870.7	\$892.5	\$914.8	\$8,206.5	



Economic Impacts of 2016 Projected Medicaid Expansion Federal Portion only (New Money to Idaho)

- ▶ Federal Direct Medicaid Spending \$720.4 million

- ▶ Economic Impacts

- ▶ Sales Transactions \$1.22 billion

- ▶ Gross State Product \$0.717 billion

- ▶ Gross Wages \$0.548 billion

- ▶ Total Taxes \$46.51 million

- ▶ Sales/Excise Taxes \$20.25 million

- ▶ Property Taxes \$10.84 million

- ▶ Income Taxes \$15.41 million

- ▶ Jobs 14,712

Economic Impacts of Medicaid Expansion Spending Federal Portion only (New Money to Idaho)

Figure 1: (New) Mandatory + Optional Expansion Federal Portion - FY2014-2025 (Option One + Three Milliman Study)

FY	Nominal Federal	Sales Transactions	GSP	Total		Idaho Taxes			
				Compensation	Jobs	Sales/Excise	Property	Income	Total
2016	\$720,405,610	1,222,520,381	\$716,520,815	\$547,900,023	14,712	\$20,248,134	\$10,844,987	\$15,413,834	\$46,506,956
2017	\$720,265,254	1,222,282,198	\$716,381,216	\$547,793,276	14,420	\$20,244,189	\$10,842,874	\$15,410,831	\$46,497,895
2018	\$715,946,775	1,214,953,787	\$712,086,025	\$544,508,884	14,023	\$20,122,812	\$10,777,863	\$15,318,433	\$46,219,108
2019	\$726,217,698	1,232,383,430	\$722,301,562	\$552,320,371	13,893	\$20,411,492	\$10,932,482	\$15,538,190	\$46,882,164
2020	\$728,736,261	1,236,657,404	\$724,806,544	\$554,235,848	13,621	\$20,482,280	\$10,970,396	\$15,592,078	\$47,044,754
2022	\$734,933,817	1,247,174,587	\$730,970,679	\$558,949,360	13,426	\$20,656,473	\$11,063,694	\$15,724,681	\$47,444,848
2022	\$753,307,162	1,278,353,952	\$749,244,946	\$572,923,094	13,451	\$21,172,884	\$11,340,287	\$16,117,798	\$48,630,969
2023	\$772,139,841	1,310,312,801	\$767,976,069	\$587,246,172	13,475	\$21,702,206	\$11,623,794	\$16,520,743	\$49,846,743
2024	\$791,443,337	1,343,070,621	\$787,175,471	\$601,927,326	13,541	\$22,244,762	\$11,914,389	\$16,933,761	\$51,092,912
2025	\$811,229,420	1,376,647,386	\$806,854,858	\$616,975,509	13,607	\$22,800,881	\$12,212,248	\$17,357,105	\$52,370,234



Economic Impacts of 2016 Medicaid Expansion Spending and Existing Medicaid Spending Federal Portion only (New Money to Idaho)

- Federal Direct Medicaid Spending \$2.04 billion

- Economic Impacts
- Sales Transactions \$3.47 billion
 - Gross State Product \$2.03 billion
 - Gross Wages \$1.56 billion
 - Total Taxes \$132.0 million
 - Sales/Excise Taxes \$57.47million
 - Property Taxes \$30.78 million
 - Income Taxes \$43.75 million

- Jobs 43,053

Economic Impacts of Medicaid Expansion Spending and Existing Medicaid Spending Federal Portion only (New Money to Idaho)

Figure 2: (New) Total Economic Impacts of the Federal Portion of Medicaid (FY2014) Plus Optional and Mandatory Portions

	Nominal	Sales	Total			Idaho Taxes			
	Federal	Transactions	GSP	Compensation	Jobs	Sales/Excise	Property	Income	Total
2014	\$1,324,466,454	\$2,247,609,977	\$1,317,324,256	\$1,007,314,756	24,778	\$37,226,216	\$19,938,519	\$28,338,351	\$85,503,086
2016	\$2,044,872,064	\$3,470,125,357	\$2,033,845,071	\$1,555,214,778	43,053	\$57,474,350	\$30,783,506	\$43,752,185	\$132,010,041
2017	\$2,044,731,708	\$3,469,887,175	\$2,033,705,472	\$1,555,108,032	42,762	\$57,470,405	\$30,781,393	\$43,749,182	\$132,000,980
2018	\$2,040,413,229	\$3,462,558,763	\$2,029,410,281	\$1,551,823,639	42,364	\$57,349,028	\$30,716,383	\$43,656,784	\$131,722,194
2019	\$2,050,684,153	\$3,479,988,407	\$2,039,625,818	\$1,559,635,126	42,235	\$57,637,708	\$30,871,001	\$43,876,541	\$132,385,250
2020	\$2,053,202,716	\$3,484,262,381	\$2,042,130,800	\$1,561,550,604	41,963	\$57,708,496	\$30,908,915	\$43,930,428	\$132,547,840
2022	\$2,059,400,271	\$3,494,779,564	\$2,048,294,935	\$1,566,264,116	41,768	\$57,882,688	\$31,002,213	\$44,063,031	\$132,947,933
2022	\$2,077,773,616	\$3,525,958,929	\$2,066,569,202	\$1,580,237,850	41,792	\$58,399,100	\$31,278,806	\$44,456,148	\$134,134,054
2023	\$2,096,606,295	\$3,557,917,777	\$2,085,300,325	\$1,594,560,927	41,816	\$58,928,422	\$31,562,313	\$44,859,093	\$135,349,829
2024	\$2,115,909,791	\$3,590,675,598	\$2,104,499,727	\$1,609,242,082	41,882	\$59,470,977	\$31,852,908	\$45,272,112	\$136,595,997
2025	\$2,135,695,875	\$3,624,252,363	\$2,124,179,114	\$1,624,290,265	41,949	\$60,027,097	\$32,150,768	\$45,695,456	\$137,873,320



How does Medicaid compare to equivalent (out-of-state) sales (\$720.4 million) in other industries? (Including the multiplier effects)

➤ Grain Sales	Jobs 10,523	Gross Wages \$247 Million
➤ Gold Mining Sales	Jobs 2,988	Gross Wages \$179 Million
➤ Sawmill Sales	Jobs 7,309	Gross Wages \$323 Million
➤ Cattle Ranching Sales	Jobs 7,582	Gross Wages \$221 Million
➤ Professional Services	Jobs 8,901	Gross Wages \$555 Million
➤ Medicaid Expansion	Jobs 14,712	Gross Wages \$548 Million



How of Interpret the Previous Results?

- Not meant to compare one industry to another...
- ...rather to illustrate the point that any economic activity that brings new money into Idaho creates jobs, income, and tax payments.



(Near Term) Federal dollars represent new non-substitutable monies coming into Idaho's economy

- ▶ A one dollar reduction in federal these federal dollars will result in a one dollar reduction in economic activity in Idaho.
- ▶ In the absence of the federal dollars, these health care expenditures will be pulled from elsewhere in Idaho's economy displacing private spending, and reducing economic activity elsewhere in the state.
- ▶ Untreated health care does cause greater cost shifting to employers and individuals with private health care plans, increasing their premiums which, in turn, reduces consumer spending throughout Idaho's economy.



Results similar in magnitude to other studies

- ▶ *If they expand Medicaid, nonexpanding states would obtain more than \$400 billion in federal funding over ten years, creating...*
- ▶ *172,400 jobs during 2015, according to the Council of Economic Advisers. Their hospitals would receive \$168 billion in new revenue...*
- ▶ *Source: What Is the Result of States Not Expanding Medicaid? Stan Dorn, Megan McGrath, John Holahan. Urban Institute Robert Wood Johnson Foundation*

http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414946

Longer Term Impacts of No Expansion

- ▶ *Estimated annual deaths in Idaho*
 - ▶ *Low 76*
 - ▶ *High 179*
- ▶ *Statistical Value of a Human Life \$7 million to \$9.1 million (EPA)*
 - ▶ *Low 76---- \$ 691,600,000*
 - ▶ *High 179--- \$1,628,900,000*
- ▶ *Does not include lost productivity effects*

Source: Health Affairs Blog - <http://healthaffairs.org/blog> - Opting Out Of Medicaid Expansion: The Health And Financial Impacts. Posted By [Sam Dickman](#), [David Himmelstein](#), [Danny McCormick](#), and [Steffie Woolhandler](#) On January 30, 2014 @ 10:00 am In [All Categories](#), [Coverage](#), [Disparities](#), [Health Reform](#), [Medicaid](#), [States](#).

Any Questions?



Attachment #11

SWOT Analysis

Idaho Workgroup on Medicaid Redesign

December 4, 2014

Options for Coverage of Gap Population Earning <100% FPL

	Option 1: Status Quo	Option 3: Private Managed Care Option	Option 4: Private Insurance Exchange Option	Option 5: Direct Primary Care Memberships
Description	<ul style="list-style-type: none"> Utilizes state/county tax dollars to fund incident-based health care costs No primary care No wellness focus Administered by counties and state CAT fund 10 year state and local net cost of \$1.2B (no offsets) SFY 2016 state and local net cost of \$97.6 M. Covers 5,000 people \$500 M. loss to hospitals for Disproportionate Share Hospital payments beginning soon 	<ul style="list-style-type: none"> Utilizes primarily federal tax dollars with state share increasing from 0 to 10% by 2020 Focus on Primary Care/Prevention/PCMH Integrated, market-based approach Uses contracted health plans equivalent to Qualified Health Plan coverage on the health insurance exchange. Uses newly developed benefit design utilizing healthy behavior incentives, copays and other evidence based tools to engage enrollees in health decisions. Provides essential health benefits for 102,873 Idahoans 10 year state and local net cost of \$73.4 M. SFY 2016 state and local net savings of \$43.9 M. \$500 M. loss to hospitals for Disproportionate Share Hospital payments beginning soon 	<ul style="list-style-type: none"> Utilizes primarily federal tax dollars with state share increasing from 0 to 10% by 2020 Integrated, market-based approach Uses private QHP coverage via the health insurance exchange (silver level plan) Federal/state dollars would fund premiums/cost sharing outside of what is allowable to charge enrollees per CMS criteria Provides essential health benefits for 102,873 Idahoans 10 year state and local net cost of \$137.3 M. SFY 2016 state and local net savings of \$43.9 M. \$500 M. loss to hospitals for Disproportionate Share Hospital payments beginning soon 	<ul style="list-style-type: none"> Utilizes state/county tax dollars to fund direct primary care memberships (\$49 M) and Medical Procedures Fund (\$10.8 M) Focus on Primary Care/Prevention/PCMH Provides direct primary care services to 77,719 Idahoans 10 year state and local net cost of \$1.2 B. (no offsets) SFY 2016 state and local net cost of \$97.6 M. \$500 M. loss to hospitals for Disproportionate Share Hospital payments beginning soon
Strengths	<ul style="list-style-type: none"> Does not require legislative change Infrastructure currently in place 	<ul style="list-style-type: none"> Federal waiver allows for immediate discontinuation if program is not functioning as desired. Elimination of county and state indigent programs and related taxation Leverages federal tax funds back to Idaho to finance healthcare for working poor Cost savings to state and counties Comprehensive coverage including 10 essential health benefits Proactively invests in primary care to keep individuals healthy Incorporates healthy behavior incentives and personal accountability State infrastructure support is already in place Uses private industry and promotes competition & choice Copays allowed for all participants on all services, within CMS limitations 	<ul style="list-style-type: none"> 3-year demonstration waiver allows for sunset if program is not functioning as desired Elimination of county and state indigent programs and related taxation Leverages federal tax funds back to Idaho to finance healthcare for working poor Cost savings to state and counties Comprehensive coverage including 10 essential health benefits Uses private industry and promotes competition & choice Minimizes churn Minimizes stigma Increased enrollment (77,000) in Your Health Idaho insurance exchange 	<ul style="list-style-type: none"> No federal waiver needed State control of eligibility, benefits, cost-sharing Minimizes dependence on federal funds Proactively invests in primary care to keep individuals healthy Streamlined administrative costs to providers

	Option 1: Status Quo	Option 3: Private Managed Care Option	Option 4: Private Insurance Exchange Option	Option 5: Direct Primary Care Memberships
Strengths (continued)		<ul style="list-style-type: none"> Providers can make receipt of services conditional on payment of co-pay for those over 100% FPL Minimizes churn Low administrative costs (3%) Provides funding for critically needed mental health services 		
Weaknesses	<ul style="list-style-type: none"> State of Idaho would assume expenses of increasing health care costs Double taxation continues Administratively burdensome and inconsistent county/state indigent processes with associated litigation No focus on wellness/prevention or primary care Loss of life No economic gain A reactive incident based care system Increased medical bankruptcy for individuals Over 70,000 Idahoans don't have coverage Underpayment to providers (less than Option 4) Concern about lack of data on outcomes and cost No funding for community mental health services 	<ul style="list-style-type: none"> CMS limitations on cost sharing and eligibility Underpayment to providers (less than Option 4) Expansion of Medicaid is a direct link to a negative perception of Obamacare Reduction in enrollment (25,000) in Your Health Idaho insurance exchange 	<ul style="list-style-type: none"> Possible adverse selection in QHPs driving up annual rate increase CMS limitations on cost sharing and eligibility Budget neutrality requirement Medicaid responsible for cost sharing in excess of federal limits Uncertainty of long term viability with 3-year waiver Increased administrative costs Inconsistency with personal responsibility components Administrative complexity for physician practices 	<ul style="list-style-type: none"> State of Idaho would assume expenses for increasing health care costs Double taxation continues Requires establishing new state/county infrastructure to administer program Requires negotiating primary care membership terms with providers Undefined personal responsibility or healthy behavior drivers Access limitations Would also require a wraparound coverage Delay in implementation as plan is developed Unknown costs to counties Extensive legislative changes required Scalability and lack of DPC clinics Regional Contracting Disparities Cost shifting Increased medical bankruptcy Inadequate data to support effectiveness in those in poverty Concern about lack of data on outcomes and cost No funding for mental health services
Opportunities	<ul style="list-style-type: none"> (None identified) 	<ul style="list-style-type: none"> Connect newly covered Idahoans with medical homes to mitigate increase in ER utilization Build in a sunset clause to end program if Congress decreases match rate End double taxation: "Funded opportunity rather than unfunded mandate" Cover people quickly once approved Could further payment reform conversations Can take advantage of economic benefits 	<ul style="list-style-type: none"> Connect newly covered Idahoans with medical homes to mitigate increase in ER utilization Build in a sunset clause to end program if Congress decreases match rate End double taxation: "Funded opportunity rather than unfunded mandate" Cover people quickly once approved Can take advantage of economic benefits Increase options for consumers Transition out of plans would be more 	<ul style="list-style-type: none"> Could design something unique that no other state has tested Eligibility determined through State Medicaid eligibility screening Potential growth of Direct Primary Care throughout Idaho Enhance innovative modeling

	Option 1: Status Quo	Option 3: Private Managed Care Option	Option 4: Private Insurance Exchange Option	Option 5: Direct Primary Care Memberships
Opportunities (continued)		<ul style="list-style-type: none"> Directing care to in-state providers Could use innovative models (Direct Primary Care memberships) Single conversation around redesign for existing population Enhance efficiencies within existing Medicaid Cost cutting by virtue of volume Eligibility determined through State Medicaid eligibility screening 	<ul style="list-style-type: none"> seamless Increased opportunity for competition Eligibility determined through State Medicaid eligibility screening 	
Threats	<ul style="list-style-type: none"> Rising percentage of county/state budgets dedicated to indigent care costs Continued litigation of claims Coverage gap population gets sicker, less productive Disapproved claims contribute to rising uncompensated care, which drives up premium costs for insured population Rising ER and corrections' costs due to untreated mental illness Could be subject to legislative elimination or underfunding 	<ul style="list-style-type: none"> Congress could decrease matching rate (FMAP) in the future Legislative and gubernatorial reluctance Rate setting may be difficult Lower return on investment by delaying the length of time to make a decision 	<ul style="list-style-type: none"> Inability to renew waiver after 3 year demo period Congress could decrease matching rate (FMAP) in the future Legislative and gubernatorial reluctance Lower return on investment by delaying the length of time to make a decision Achieving budget neutrality Uncertainty about payer participation Potential negative impact on Qualified Health Plan rates 	<ul style="list-style-type: none"> Significant delay in implementing due to extensive legislative and rule changes, as well as infrastructure/process development Continued indigent program cost burden until transition occurs Possible lack of provider participation depending on membership terms Rising uncompensated care costs due to insufficient funding to support necessary hospitalizations & treatment not prevented by primary care focus (\$10.8 M. for medical procedures fund) Costs to administer program unknown Healthcare conditions could be exacerbated due to service gaps Physicians might not choose to participate Difficult to implement in rural communities

NOTE: Option 2—Redesigning the County Indigent and State Catastrophic programs was eliminated from consideration by the Governor’s Medicaid Redesign Workgroup in 2012.

Attachment #12

**Option 3.5: Blending Care Management and
Private Insurance Models – Richard Armstrong**

*Idaho Workgroup on Medicaid Redesign
December 4, 2014*

MEDICAID REDESIGN WORKGROUP

November 14, 2014

Richard M. Armstrong
Director
Department of Health and Welfare



State Healthcare Innovation (SHIP) Goal

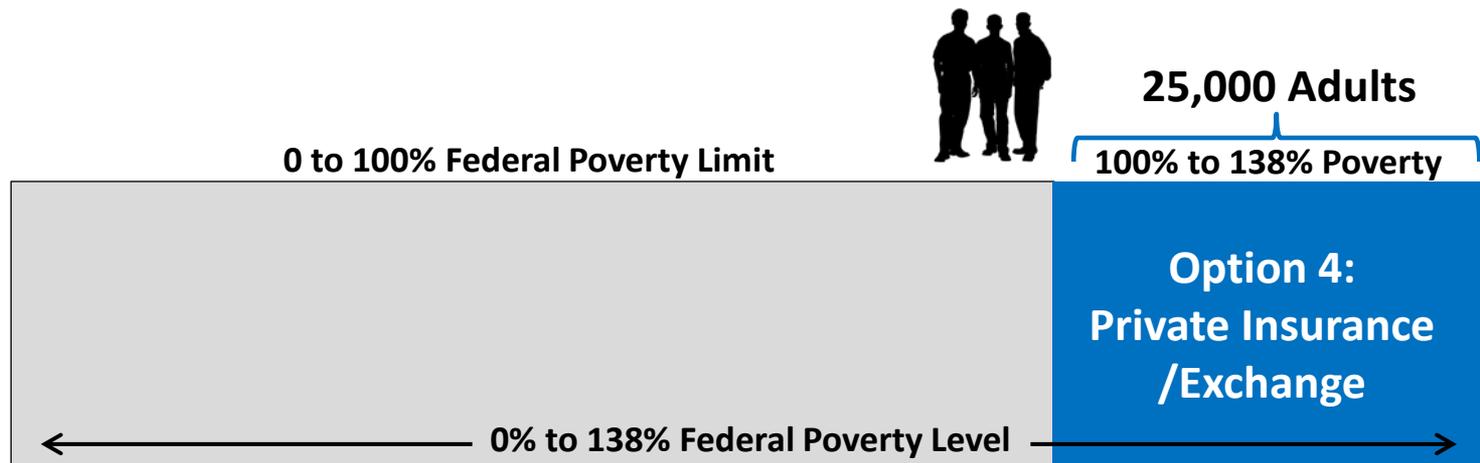
Redesign Idaho's healthcare delivery system to.....

...Evolve from a fee-for-service, volume-based system...



...To a value-based system of care based on improved health outcomes.

Blending Coverage Options for Low-Income Idaho Adults 100% to 138% of Poverty

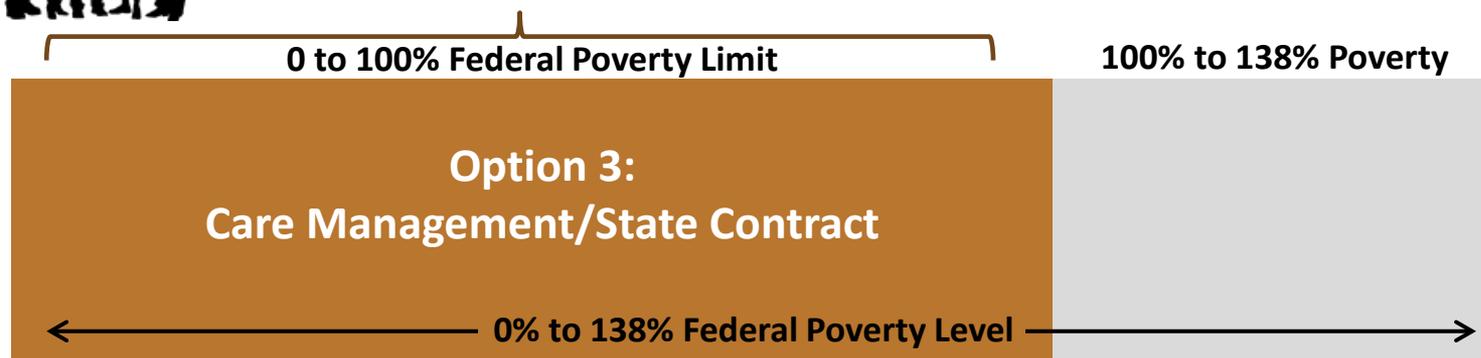


- Purchases premiums for adults between 100% - 138% FPL on the state insurance exchange, providing continuity with the insurance plans they are already eligible to purchase.
- Supports the private insurance model and Idaho's state-based insurance exchange.

Blending Coverage Options for Low-Income Idaho Adults 0% to 100% of Poverty

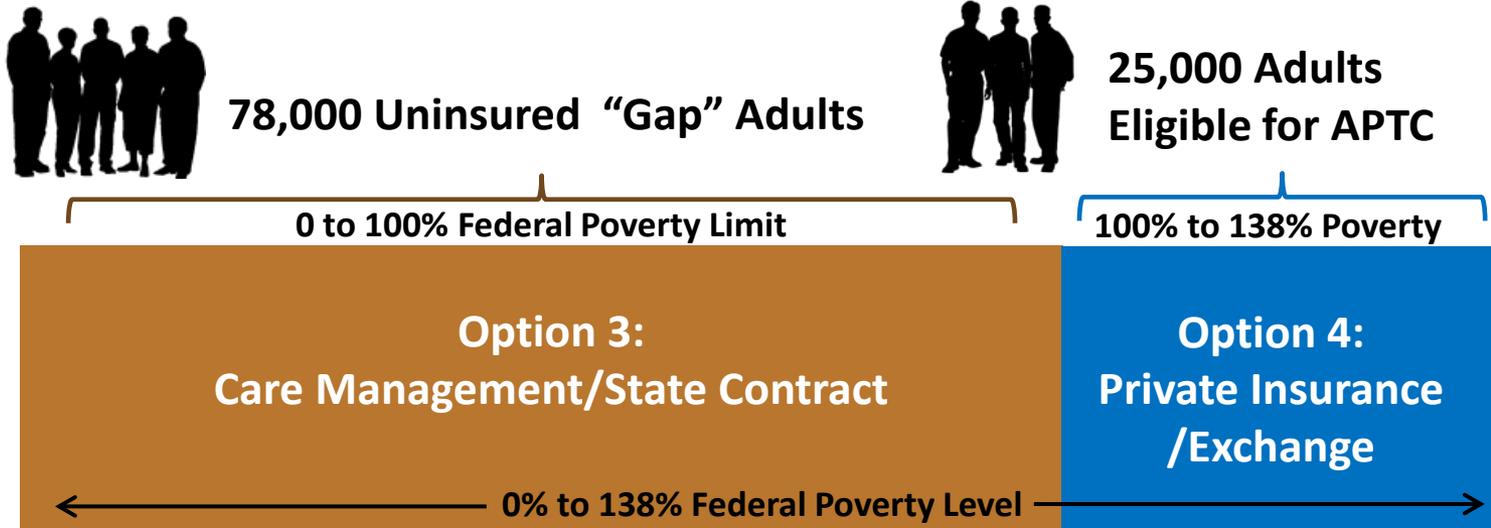


78,000 Uninsured "Gap" Adults



- Promotes the patient centered medical home (PCMH) model.
- Builds requirements into care management contracts to:
 - Assign individuals to a primary care physician or direct primary care provider
 - Shift the payment model towards paying for value, based on health outcomes, rather than paying for volume through fee-for-service model
 - Incentivize personal responsibility and accountability through healthy behavior incentives
 - Require co-pays for non-emergent ER utilization
- Develop an RFP that is open to a variety of care management structures to improve outcomes.

Option 3.5: A Blend of Managed Care/Private Insurance



- Saves Idaho taxpayers more than \$1 Billion during the next 10 years.
- Provides 103,000 people with access to healthcare coverage
- Supported by CMS

Attachment #13

Option 5: Direct Primary Care Model
Sen. Steven Thayn

Idaho Workgroup on Medicaid Redesign
December 4, 2014

Medicaid Redesign

Nov. 14, 2014

My Approach

- First, create a system that provides more access and better outcomes at reduced costs.
- Then, secondarily, see if it fits within federal and state law.

#1 Priority

- To improve outcomes and increase access
- is to invest more \$\$\$ in primary care
- A law that prohibits us from taking common sense, economical, compassionate steps is a corrupt law and needs to be changed.
- The top-down approach suggested by this committee will fall short of its goals of reducing costs – because there is no empowerment of the docs and patients with choices and resources

Medicaid Expansion

- Will not improve access – fewer docs taking Medicaid patients
- Underpays providers – form of slavery
- Codifies the states junior position to the federal government
- Based upon eternal deficit spending
- Short-term solution, at best

Need another choice

- Maintains state sovereignty
- Stable economic base
- Empowers docs and patients
- Opens door to reduce costs by 50%
- And, eventual phase out of Medicaid

Process

- Eliminate county indigent fund
- Eliminate CAT fund - \$40 million
- Buy 66,000 DPC memberships for the expansion population

First Step

- Create a pilot program this year for 1,200 individuals at a cost of \$900,000
- Primary care to be offered at three types of providers
 - DPC doc's office
 - CHC such as at the new Terry Reilly in Nampa
 - Rural hospital
 - Rural hospitals are dying under the ACA

FAQ

- Don't have a DPC network.
 - CHCs now provide care to 10% of the state or 150,000.
- What would the appropriate reimbursement level be?
 - Qliance's level is \$69 per month, locally, one DPC provider charges \$50 per month.
- How would DPC memberships be paid?
 - Not using insurance.
 - State Funds only

FAQ 2

- Doesn't fit in federal law.
- DPC is protected under the ACA section 1301 (3) and can be sold on the exchange.
- (3) TREATMENT OF QUALIFIED DIRECT PRIMARY CARE MEDICAL HOME PLANS.—The Secretary of Health and Human Services shall permit a qualified health plan to provide coverage through a qualified **direct primary care medical home** plan that meets criteria established by the Secretary, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are coordinated with the entity offering the qualified health plan.
- Doesn't provide essential Benefits.
 - Doesn't have to provide all benefits. It is suppose to be accompanied with a wraparound policy.

Hospitals will lose \$60 million

- An increase investment in primary care will do more to help provide medical care to citizens of Idaho than any other investment.
- \$60 million less than 2% of the \$3.4 billion of the hospital gross revenue in Idaho
- More primary care will reduce uncompensated care
- Hospitals – tax exempt status

Wavier

- Another possibility is to seek a waiver
- Idaho uses state money to pay for primary care as described
- Partner with CMS to cover hospitalizations
- New Congress may be willing to consider innovative solutions; as far as I know, there are no other options on the table; if this committee suggested an innovative solution, it may actually happen.