

Governor's Workgroup to Evaluate Medicaid Eligibility Expansion Option

September 27, 2012

Capitol Building, EW-40
700 W. Jefferson Street
Boise, Idaho 83702

Workgroup Purpose: This workgroup was assembled at the Governor's request to discuss Medicaid Expansion, following the Supreme Court's ruling that Medicaid Expansion would be optional for states. Workgroup members were selected from public and official leaders with experience in Medicaid topics. This workgroup, after studying the facts presented, will provide the Governor its recommendations.

During the second workgroup meeting, the workgroup reviewed three options relating to Medicaid Expansion: 1) No Medicaid Expansion/Continue Indigent/CAT Fund Program as Currently Designed; 2) No Medicaid Expansion/Indigent Program Redesigned; and 3) Medicaid Expansion.

Data Review and Analysis of Potential Medicaid Expansion Population: Leavitt Partners presented the final report of its analysis of the newly eligible population in Idaho and its recommendations for possible Medicaid Expansion design options. The final projection for the newly eligible population for Medicaid under expansion is between 97,066 and 111,525 adults.

The last section of the Leavitt report analyzed possible benefit packages, if Idaho does decide to expand Medicaid. The newly eligible group's coverage must meet a Benchmark Benefit Package threshold, as was defined in the Deficit Reduction Act (DRA) from 2005. A Benefit Package must be equal to one of the three available benchmark plans or be coverage approved by the Secretary of the U. S. Department of Health and Human Services (HHS), meet additional Medicaid requirements, and provide all Essential Health Benefits. The DRA allows states to provide different benefits to certain populations, specifies that certain groups are exempt from mandatory enrollment, and details cost-sharing stipulations.

With these guidelines in mind, Leavitt Partners compared four Benchmark Plans: 1) State HMO (Blue Cross of Idaho HMO Blue Plan); 2) State Employee Plan (Blue Cross Traditional Plan for state employees); 3) Standard Blue Cross Blue Shield under the Federal Employee Health Benefits Plan; and 4) HHS Secretary-approved Coverage (Idaho's Basic Benchmark Plan).

If Idaho does expand Medicaid, Leavitt Partners recommends Idaho use Idaho's Basic Benchmark Plan as a framework for coverage. This plan follows the guidelines of the DRA and Affordable Care Act (ACA), allows for administrative ease, and has the framework needed to meet the essential health needs of the majority of the target population. Furthermore, the plan has an existing path to a more comprehensive plan and can be used in new delivery systems Idaho may develop.

Review of Mandatory Medicaid Changes: The Division of Welfare is currently completing Phase 1 of its Medicaid Readiness Initiative (MRI). Phase 1 includes system modernization that follows the Division's strategy to be prepared, but cautious. Medicaid Expansion is Phase 2 of MRI, but the bulk (92%) of the work the Division must undertake in this phase is mandatory, as was laid out in the Supreme Court Decision, *National Federation of Independent Business v Sebelius*. This decision requires the Department of Health and Welfare to create automation, operate with new modified adjusted gross income (MAGI) eligibility guidelines, and connect to a health insurance exchange. If Idaho does not choose to expand Medicaid to the optional population, Medicaid enrollment will still increase by an estimated 37,000 Idahoans. This is due to two factors: the new MAGI eligibility requirements that will go into place regardless of a state's Medicaid Expansion (the surge population) and the anticipated addition of those who are currently eligible for Medicaid but not enrolled at this time (the woodwork population).

Option 1: No Medicaid Expansion/Continue Indigent Programs as Currently Designed

This option will maintain the current Medicaid eligibility criteria, except for the new mandatory requirements, and will maintain the current County Medically Indigent and Catastrophic Health Care Costs (CAT) Programs. Under this option, the Medicaid enrollment forecast, including growth and ACA requirements, is projected to increase from 229,000 participants in 2012 to 332,444 participants in 2020. Costs for the County Medically Indigent Program are projected to increase from \$29.6 million in 2011 to \$39.6 million in 2020. The CAT Program costs are projected to increase from \$39 million in 2012 to \$52.5 million in 2020. Other cost factors include the expiration of the Pre-existing Condition Insurance Program in 2014 (\$6.2 million savings to Idaho's County Medically Indigent Program and State CAT Program in 2012), the expiration of the 5 percent hospital discount for medically indigent programs in 2013, and rising cost of medical inflation, estimated at 6-9 percent. When these amounts are combined, the preliminary estimates of the costs associated with the option of No Medicaid Expansion/Continue Indigent Programs as Currently Designed will increase from \$70 million in 2014 to \$92 million in 2020.

Option 2: No Medicaid Expansion/Indigent Program Redesign

This option will maintain the current Medicaid eligibility criteria, except for the mandatory requirements, and will redesign the County Indigent and Catastrophic Health Care Cost (CAT) Programs. The Medically Indigent Program was created by the counties in the 1980s and expanded to the state level in the 1990s. Unlike traditional medical insurance plans, the County Medically Indigent Program and CAT Program are not eligibility based. They are an incident-based, based on an applicant's ability to pay a medical bill over a five-year period. Upon application for financial assistance an automatic lien is attached to all real and personal property of the applicant. A program redesign would include uniformity and standardization in claims processing, forms, electronic vs. paper, policies, and an expansion of utilization management and medical review. Costs for third party administration (TPA) implementation are projected to be \$1.5 to \$3.5 million and annual operating costs are projected to be \$1.2 to \$3.4 million. Savings for the redesign are estimated at 2 percent as increased claim processing efficiencies are realized. The costs associated with the option of No Medicaid Expansion/Indigent Program Redesign are projected to increase at about the same level as Option 1, from \$70 million in 2014 to \$92 million in 2020.

Option 3: Medicaid Expansion

This option will increase the Medicaid eligibility income threshold to 138 percent of the federal poverty level, expanding the program by between 97,066 and 111,525 newly eligible participants. This option will increase the current number of program applicants from 229,000 in 2012 to 453,000 (including Woodwork and Surge) in 2020. This new population, as described by Leavitt Partners will include both younger, relatively healthy adults, and older adults with chronic conditions.

Costs have not been projected for this increase, but the Medicaid Expansion population will be funded through the Federal government at 100 percent from 2014-2016 and federally matched at 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and beyond. Additional state administrative costs will be matched at 50 percent.

Additional assumptions relating to the costs of Medicaid Expansion include:

- *Pent-up Need.* There is anticipated pent-up need for health care for this new population that is projected to be costly immediately following expansion, but would gradually taper as the new population transitions into regular health care.
- *Cost-shifting.* An estimated 90 percent of applicants served through the County Medically Indigent and CAT Programs would now be eligible for Medicaid, providing a cost-shift from those programs. Also, an estimated 94 percent of current adult behavioral health clients would now be eligible for Medicaid, decreasing the need for state general funds in the Division of Behavioral Health.
- *Time-appropriate Care.* Cost-savings are forecasted when health care is received efficiently (preventive and early treatment in a primary care setting rather than critical treatment at an emergency room).

Guiding Principles: Following the presentation of the three options workgroup members identified several principles/critical issues to guide their deliberations. These principles are grouped by the type of issue they address, including: overall system costs, economic impact to the state, benefit design, service delivery system design, populations to be served, and messaging:

Costs

- The current county costs for health care are unsustainable. Increased property taxes put pressure on the counties with no predictability related to growth.
- Idaho should commit to Medicaid Expansion sooner (2014) to take advantage of the 100 percent federal support for as long as possible.
- Current provider administrative costs are too high. Must simplify the system for billing.

Economic Impact on Idaho

- We should explore the business case for bringing new business to Idaho. New businesses will not want to come to states that have not committed to Medicaid expansion.
- Acknowledge there is a fear of dependency and fear of creating a larger entitlement program in Idaho. Any argument for expansion must be presented as a growth opportunity for the economy of the state, not as creating greater dependency.

- Better health care for Idahoans will help the economy, as more businesses come to Idaho because they know there is a health care system in place for low-income Idahoans.

Benefit Design

- We should look to creating a benefit structure that increases personal accountability. This is better for patients' health and will decrease overall system costs.
- Encourage/require prevention strategies.
- Cover/encourage evidenced-based benefits that are known to add value.
- Provide medical consumerism classes so that people are informed about their medical decisions and understand the implications.
- Require end-of-life discussions and documentation, such as Physician Orders for Scope of Treatment (POST), to receive benefits. We know that a large part of health care dollars are spent in the last weeks to months of life, so we need to do a better job of discussing a plan.

Service Delivery System Design

- Health care in Idaho needs to move away from fee-for-service, prepaid benefits and cost shifting, or the system will become unaffordable.
- The Idaho Medical Association has taken a position in support of Medicaid expansion as part of a larger model-of-care transformation, including movement toward the medical home model of care and community care networks.
- The Community Care Network model should be developed for the expanded population as well as for the current Medicaid population.
- There is an opportunity to transform care delivery in Idaho to a coordinated managed-care system.
- Change the way of paying for services by shifting provider incentives from volume-of-visits to value-of-care in keeping people healthy.

Consider Populations to be Served

- The state wants to plateau Department of Correction (DOC) growth and strengthen DOC relationships with counties. Inmate re-entry to the community is critical to efforts to keep individuals from re-offending. A broader Medicaid program offering basic health care and behavioral health services is essential.
- For behavioral health patients, consider a model that offers peer support from and to behavioral health patients.
- The workgroup must commit to look past the numbers to see the individuals and consider improving health care access to the working poor.

Messaging

- The workgroup needs a simple, concise graphical representation of the costs over 10 years for Options 1, 2, and 3.
- We need to do a better job of explaining costs with and without Medicaid Expansion and the phases of the ACA to the public.

Next Steps: The Department of Health and Welfare will develop a document that shows the costs associated with Medicaid Expansion and share this at the next workgroup meeting.