

DATE: 28 February 2018  
TO: John Kitzhaber  
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SUBJECT: MODELING AN ALTERNATE MEDICAID REFORM OPTION BASED ON OREGON'S  
EXPERIENCE WITH TRANSFORMATION

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## Overview

In 2012, Oregon applied for a Medicaid Section 1115 demonstration waiver in order to show that the growth in per enrollee Medicaid spending could be slowed by implementing a new care model—the Coordinated Care Organizations (CCOs)—without reducing eligibility or benefits and meeting rigorous performance metrics. Under this new agreement, Oregon received a one-time investment of federal funds to make the transition to the new care delivery model. After the initial five-year demonstration, the CCOs have performed well on quality and outcome metrics, paid back the initial investment and realized a net cumulative savings of over \$1 billion.

This memo describes how applying key elements of Oregon's approach nationally can serve as an alternative to recent Medicaid reform options proposed in Congress. The goal of this approach is to create a dialogue around Medicaid reform option that could meet bi-partisan goals. Specifically, this model would provide states the levers to ensure broad coverage for low-income Americans, support state-level health system transformation, and reduce program costs for both the federal and state governments in the years ahead.

In exchange for agreeing to curb the overall rate of growth in their programs, states would be offered the option to access upfront federal funding to transform their health care delivery system. Although the transition will require additional spending through an initial investment, this model reveals opportunities for savings to both federal and state budgets. Additionally, states who chose not to expand eligibility to uninsured low-income adults under the Affordable Care Act (ACA) could be provided a new opportunity to access federal funds to increase coverage through this model, while still resulting in over \$700 billion in savings over 10 years.

This memo does not attempt to delineate how states should transform their Medicaid systems, or through what approach they would cover their low-income uninsured population. Rather, the intent of this analysis is to create a dialogue around this model, which has demonstrated its potential to achieve cost savings while ensuring broad access to health coverage.

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## Assumptions

To model the budget impact of the proposed approach, we use data from the CMS Office of the Actuary<sup>12</sup> to create baseline costs and population projections for the Medicaid program. The assumptions were aligned with Oregon’s model, by removing long term care expenditures from the underlying cost estimates<sup>3</sup> and calculating per capita trend rates based on acute care expenditures. To model the proposal impacts, we employed the following assumptions:

- *Constraining program growth:* Average annual per capita growth in Medicaid program spending is reduced by 2 percentage points over the next 10 years (from 5.1% to 3.1%). No changes are assumed to the underlying populations, benefits, or federal medical assistance percentages (FMAP) for the current law Medicaid populations.
- *Transforming state programs:* This approach assumes that federal funding would be provided in the first few years of implementation for states to invest and transition their program to one that is more efficient, cost-effective, and outcome-based. The transformation approaches states take would vary, but would be measured against the lower spending targets and clear access<sup>4</sup>, quality and outcome measures.<sup>5</sup>
- *Filling the coverage gap:* The model assumes that funding is provided to states that have not yet expanded coverage under the ACA low-income adult expansion option. These states would be provided a new opportunity to expand coverage to those currently uncovered up to 138% FPL.<sup>6</sup> The declining federal matching percentages for the ACA expansion are assumed here, but starting at 100% for three years beginning in 2019 and sloping down to 90% by 2025. For simplicity, the per capita cost used to estimate the

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<sup>1</sup> Office of the Actuary, Centers for Medicare and Medicaid Services. 2016 Actuarial Report on the Financial Outlook for Medicaid. US Department of Health and Human Services. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf>

<sup>2</sup> Office of the Actuary, Centers for Medicare and Medicaid Services. National Health Expenditures, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/>

<sup>3</sup> Adding long term care expenditures to this model – that is, curbing growth in long term care expenditures while restructuring and aligning care management, payment and incentives for the “dual eligible” population, and meeting access, quality and outcome goals — would dramatically increase overall net savings.

<sup>4</sup> The addition of access is important because higher provider reimbursement has been found to correlate with more providers accepting Medicaid patients (see Polsky, et. al., February 5, 2015, N. Engl. J. Med. 2015; 372:537-545.) Medicaid reimbursement varies widely from state to state, e.g. 81% of Medicare rates in Oregon; 52% of Medicare rates in California. (Kaiser Family Foundation State Health Facts, Medicaid to Medicare Fee Index, <https://www.kff.org/statedata/>.)

<sup>5</sup> Approaches to transformation will vary from state to state but under this proposal, would ultimately likely require that providers assume risk and accountability in a coordinated, patient-centered delivery model operating on a global budget that grows at a fixed rate.

<sup>6</sup> Garfield R. & Damico A. “Coverage Gap: Uninsured Poor Adults in States that do not Expand Medicaid.” Kaiser Family Foundation, October 2017. <https://www.kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>

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funding levels is based on the current national average cost of covering low-income adults under states' ACA expansions.<sup>7</sup>

## Findings

- *Constrained spending:* Reducing the average annual per capita Medicaid spending for acute care by 2 percentage points would produce total savings of \$210 billion over five years and \$1 trillion in savings over 10 years.
- *Transformation investment:* The amount of funding allocated for states to transform their Medicaid systems could be dialed up or down depending on funding goals. For this discussion, we assume an initial three-year federal investment of \$24 billion, which is roughly equal to 10 percent of the savings accrued in the first five years of transformation.
- *Filling the coverage gap:* The amount of funding required to cover the uninsured up to 138% of FPL in non-ACA expansion states would be approximately \$110 billion total funds over five years and \$260 billion over ten years.
- *Net Savings:* Taking into account all the assumptions outline above, net savings would be approximately \$100 billion total funds over five years and \$740 billion over ten years. Over ten years, the savings would be split by the federal and state governments \$360 billion and \$380 billion respectively.

## Design Considerations

- *Curbing the cost growth:* Overall national expenditure growth goals could be balanced with state-by-state trend variations, as some states already have lower growth rates or have already agreed to a lower rate of growth. For example, an overall goal of reducing average per capita growth nationally by 2 percentage points could be established, while assuming greater percentage point reductions in faster growing states than slower growing states.
- *Transformation funding:* As mentioned above, the investment amount can be modified to reflect policy goals. One scenario could be to designate a maximum funding amount nationwide with a distribution based on state Medicaid enrollment or another program or state statistic. For example, if non-ACA expansion program enrollment were used as a metric for funding allocation, the \$24 billion in total funding would produce a range from \$3.7 billion for California to \$26 million for Wyoming.<sup>8</sup>

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<sup>7</sup> Medicaid and CHIP Payment and Access Commission (MACPAC). Medicaid Benefit Spending per Full-Year Equivalent Enrollee for Newly Eligible Adult and All Enrollees by State, 2016. <https://www.macpac.gov/publication/medicaid-benefit-spending-per-full-year-equivalent-enrollee-for-newly-eligible-adult-and-all-enrollees-by-state/>

<sup>8</sup> Distribution of \$24 billion based on Medicaid enrollment minus ACA expansion estimates. Source: Kaiser State Health Facts, Medicaid Expansion Enrollment, 2016. <https://www.kff.org/state-category/medicaid-chip/>

Modeling an Alternative Medicaid Reform Proposal (in billions of \$U.S.)

Projected Expenditures with Additional Federal Support (in billions of \$)													
Fiscal Year	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	5-year	10-year
Baseline Medicaid Projections (5.1% average per capita growth)	458.6	495.0	532.0	570.1	613.1	655.6	702.3	750.1	799.0	851.1	906.6	2,865.9	6,874.9
Constrained Medicaid Projections (3.1% average per capita growth)	458.6	500.0	534.9	558.3	575.5	598.6	623.4	648.4	672.6	697.6	723.6	2,767.3	6,133.0
<i>Includes Closing Coverage Gap (Increase coverage to 138% FPL)</i>	-	11.3	23.4	24.3	25.5	26.2	27.3	28.3	29.3	30.3	31.3	110.8	257.2
<i>Includes Federal Transformation Investment Funds</i>	-	8.0	8.0	8.0	-	-	-	-	-	-	-	24.0	24.0
<b>Net Savings</b>	-	5.0	2.9	(11.8)	(37.6)	(57.0)	(78.9)	(101.7)	(126.4)	(153.4)	(182.9)	(98.5)	(741.8)
<i>Federal Share</i>	-	10.6	14.0	5.4	(14.3)	(26.1)	(39.4)	(53.8)	(68.6)	(84.8)	(102.5)	(10.4)	(359.4)
<i>State Share</i>	-	(5.6)	(11.1)	(17.2)	(23.3)	(30.9)	(39.5)	(47.9)	(57.8)	(68.6)	(80.4)	(88.1)	(382.4)

Note: Baseline includes ACA expansion population