Preserving Medicaid *and* Reducing the Program's Spending

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The Menges Group

Introduction

- Policymakers' legislation and discourse, broadcast media coverage, and social media postings about Medicaid overwhelmingly reflect positions and opinions from one of two highly polarized camps.
  - One camp is determined to repeal and/or replace "Obamacare," seemingly driven more by a broad political agenda than by specific areas of concern regarding where Medicaid's costs might be excessive.
  - The other camp is staunchly opposed to Medicaid cuts. This group is focused on demonstrating the program's critical importance to those it covers – but makes no mention of areas where excess Medicaid costs might exist.
- This edition of our 5 Slide Series discusses specific areas where Medicaid spending can, and arguably should, be reduced, as well as where doing so will not negatively impact the program's ability to cover those it currently serves.

Medicaid Savings Opportunity #1: Eliminate DSH Payments in Expansion States

- In the Medicaid expansion states, disproportionate share (DSH) payments have continued to occur, collectively growing by 10% from 2012-2016.
- During 2016, Medicaid DSH payments in these states totaled $13.1 billion.
- Medicaid expansion delivers far more revenue to hospitals than DSH. We estimate that Medicaid expansion is yielding $2-3 of revenue for every dollar of DSH.
- Removing DSH altogether in these states would yield annual Medicaid savings of more than $13 billion, and would simply lower the net gain hospitals experienced due to their state adopting Medicaid expansion. This action would not adversely impact beneficiary coverage (neither Medicaid eligibility nor benefits would be reduced).
- Some DSH payments could be preserved for hospitals whose DSH payments exceed their Medicaid expansion revenues.

Medicaid Savings Opportunity #2: Eliminate Excess Prices Medicaid MCOs Pay to Many Providers

- Nationwide, capitation payments represented 48.9% of all Medicaid spending during 2016. Use of this model has increased rapidly – capitation accounted for 27.3% of Medicaid expenditures during 2010. Capitation will be the dominant mode of Medicaid spending from 2017 forward.

- Within Medicaid managed care organization (MCO) capitation contracting programs, providers are paid based on the amounts negotiated with the various health plans. These price negotiation outcomes often far exceed the unit prices Medicaid is paying in the fee-for-service (FFS) setting, as many providers bring significant leverage to these negotiations due to regulatory requirements governing MCO networks and the local market power many providers possess.

- The additional costs to Medicaid that result from these price negotiations are typically hidden and policymakers are generally not aware of their magnitude. That said, states need to look closely at the amounts being paid by their Medicaid MCOs that are above Medicaid FFS pricing levels, then consider regulating price negotiation outcomes that are not serving the program's best interests.

Medicaid Savings Opportunity #2 (continued): Eliminate Excess Prices Medicaid MCOs Pay to Many Providers

- States may often intend for providers to earn payments above Medicaid FFS levels, including when access, quality, and cost objectives are met/exceeded in a value-based contract. However, there are many situations in which large excess costs are locked in due to a provider's negotiating power, and payments several percentage points above Medicaid FFS levels are also a common plan-wide MCO payment policy in their competitive effort to secure a strong delivery network.

- In many states, provider prices paid by MCOs are likely more than ten percent above Medicaid FFS in the aggregate, eliminating any potential for the program to achieve net taxpayer savings relative to the FFS setting. Taxpayer savings are a central objective of Medicaid managed care, and excess Medicaid unit prices that prevent this goal from materializing need to be identified and reigned in.

- On a national aggregate scale, for <u>each</u> percentage point of excess provider pricing that is identified and eliminated within Medicaid MCO contracting, an annual savings of roughly $3 billion will occur. Achieving these savings will not reduce beneficiary coverage. In fact, achieving these savings will help preserve coverage levels.

Summary Observations

- Medicaid costs have not generally been trending at a troubling rate. Across the 10-year timeframe between 2006 and 2016, Medicaid per capita costs increased at an average annual rate of 2.3% – versus 4.0% in the privately insured population.

- Excess cost areas exist in the Medicaid program. It is important to identify and pointedly address these areas, so that available taxpayer funds can achieve optimal health impacts for those living in poverty.
- However, blunt and general reductions in Medicaid spending run a great risk of harming persons when they are both in need and defenseless. While perhaps obvious, it is important for policymaking to accommodate the realities that the population covered by Medicaid is impoverished and that health care is expensive.
  - A MACPAC report estimates that 70% of those newly eligible for the program through Medicaid expansion have incomes below the Federal poverty line
- It is also important not to single out the Medicaid program for cost reductions. For example, large-scale cost savings opportunities also exist in Medicare.

5 Slide Series Overview

Our 5 Slide Series is a monthly publication whereby we briefly discuss/address a selected topic outside the confines of our client engagements.

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