

Medicaid Redesign: Benefits and Benefits Administration

The cost of administering a State Medicaid program is related to the number of beneficiaries, the services provided and the prices associated with covered services. When budget challenges arise, states have responded by cutting provider rates or covered benefits, as well as by limiting eligibility or access for “optional” expansion populations. While cutting provider fees and benefits appears straightforward, in reality such changes can have unanticipated impacts. Provider underpayment can reduce physicians’ interest in or ability to serve Medicaid patients. A reduction in access to physicians not only reduces access to front-line services, but can also put additional stress on the hospital sector, as consumers are forced to wait for services and end up seeking treatment at more expensive settings of hospitals and emergency rooms in urgent or emergent situations. Eliminating optional Medicaid benefits such as pharmacy can have unanticipated impacts, both negatively affecting beneficiaries’ health and leading to additional service use in other areas. Reducing service access does not reduce need. As with the proverbial balloon, squeezing one end causes a bulge elsewhere.

Alaska has traditionally run a fee-for-service (FFS) Medicaid program. This has started to shift somewhat, and the state is currently working to implement changes to the existing FFS program in order to shift how services are delivered (through the Coordinated Care demonstration projects, for example). Recognizing that the state’s budget situation requires action by state programs and agencies, Alaska can build on the efforts now underway by assessing the potential benefit of new ways of managing covered benefits. One such effort has been used by Oregon’s Medicaid program for over twenty years – the Prioritized List of Health Services.

This section focuses on the Prioritized List rather than on cuts to categories of care, because state experience with the latter type of cut (to Pharmacy, for example) has had significant negative impact on Medicaid beneficiaries and heavy administrative costs that together outweighed the financial benefit.¹ In addition, the elimination of one type of core service often leads consumers to substitute care rather than to forego care entirely.

At present, all states offer at least some optional benefits, including pharmacy, dental, rehabilitative services, and community-based long term care services. Each state defines the optional benefits covered and the extent of that coverage for different beneficiaries. For additional information on optional services, see Appendix 1.

Oregon’s Prioritized List of Health Services

After Oregon conducted a public process to develop policy objectives for the establishment of a method for allocating health care resources in the state, the legislature created the Health Services Commission (HSC) in 1989 and charged it with developing a list of health services prioritized from most important to least important to the entire population to be covered, based the best available medical evidence and

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input from both providers and consumers.² As no attempt to do this work had occurred at the time, Oregon developed its own methodology. The process was not entirely smooth. The initial methodology, which focused on cost and utility, was discarded after the results were at odds with the judgement of all HSC commissioners (both providers and non-providers).³

The current process prioritizes Medicaid spending using a methodology that emphasizes prevention and chronic disease management. The Prioritized List is rooted in the idea that as funds available for Medicaid rise or fall, the state can change the number of lines on the list that are funded, rather than eliminating categories of care or reducing eligibility for one or more populations. The methodology crafts a Medicaid benefit package that provides services necessary to keep a population healthy in order to reduce utilization of high cost “sick care.”

Prioritized List Methodology

The prioritization methodology Oregon established ranks nine broad categories of health care to establish a basic framework for the list (Appendix 2). Each line item (a pairing of a condition and associated treatment) is then assigned to a category. Within each category, a set of criteria are used to sort the line items (Appendix 2). The criteria capture the impact of each condition-treatment pair on the individual’s health and overall population health in order to determine the relative importance of each condition-treatment pair.

The priority given to a line on the List recognizes the item’s Category as well as a number of other factors, because not every service in Category 1 is more important than every service in Category 2. The Category weight is multiplied by the total criteria score for each condition-treatment pair.⁴ Each line gets a total score based on following formula to sort all line items within each of the health care categories:⁵

| | | | | | |
|----------|---|--|---|---------------|------------------|
| Category | X | Impact on Healthy Life | | | |
| Weight | | + Impact on Suffering | X | Effectiveness | X |
| | | + Population Effects | | | Need for Service |
| | | + Vulnerability of Population Affected | | | |
| | | + Tertiary Prevention (categories 6 & 7) | | | |

Once the ranking was conducted, the Commission made adjustments by hand where the ranking failed to reflect the importance of a service. This has occurred in fewer than 5 percent of the line items.

Using this methodology, services near the top of the list include maternity care and newborn services, preventive services found to be effective by the U.S. Preventive Services Task Force, and treatments for

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chronic diseases such as diabetes, major depression, asthma, and hypertension, where ongoing maintenance therapy can prevent exacerbations of the disease that lead to avoidable high-intensity service utilization, morbidity, and death. The Commission does not set the funding/coverage line, but defers to the Legislature to determine what the state can afford. At present, Oregon Medicaid covers line 1 through 475 of the Prioritized List.⁶

Items below the line are evaluated on a case-by case basis to be in compliance with Medicaid regulations on covered benefits. The List overall is used by providers to direct care to those services with the most evidence and greatest impact on the population. Oregon's Public Employee Benefit Board refers to the List to help it structure coverage and cost sharing for state employees' benefit plans.

Analysis

Service Costs and Relevant Member Months

Assessing the financial impact of using the Prioritized List in Alaska must take into account that services provided to American Indian and Alaska Native (AI/AN) Medicaid members by Indian Health Service or Tribal providers are funded at 100 percent Federal Match. Any savings associated with the List for these services would accrue to the Federal government. Further, in 2016 Centers for Medicare and Medicaid Services (CMS), in response to a request by Alaska to extend 100 percent federal funding to non-Tribal providers to whom AI/AN members were referred by Tribal providers, permitted all states to allow services by non-Tribal providers to be matched at 100 percent when a care coordination agreement is in place with the referring Tribal provider. While many services for AI/AN members are provided by Tribal or IHS providers, non-Tribal providers also serve AI/AN members. Where care coordination agreements cover these providers, entitling the state to 100% federal match, but other services are provided without such agreements. Where there is no care coordination agreement in place between a Tribal and non-Tribal provider, services are provided at the regular 50% federal match.

Table 1. Medicaid Program Costs for AI/AN and Other Members, State Fiscal Year 2016⁷

| | AI/AN Medicaid Members | Other Medicaid Members | Total Members |
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| Member Months | 730,950 | 1,094,424 | 1,825,374 |
| Per Member Per Month | \$985.65 | \$849.79 | \$904.19 |
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| Total Annual Cost of Services, Tribal Providers (100% Federal for AI/AN recipients) | \$319,088,913 Total Funds \$0 State Funds | \$23,278,398 Total Funds \$11,639,199 State Funds | \$342,367,147 Total Funds \$11,639,199 State Funds |

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The cost of services by Tribal providers are a relatively small proportion of total Medicaid costs in Alaska.⁸ For AI/AN Medicaid members, 44.3 percent of the costs for Medicaid services are from Tribal providers, while that proportion is 2.5 percent of costs for non-AI/AN members.

Estimating Potential Savings

There has not been a definitive study of the financial impact of the Prioritized List on Oregon's Medicaid costs, and estimates vary. An unpublished internal Oregon Department of Human Services analysis conducted in the early 2000s suggested that the Prioritized List saved the program 5 percent. A 1999 article published in *The Journal of Health Politics, Policy and Law* cites a Department estimate that the List saved 2 percent on total program costs in its first five years.⁹

Public reports by the Commission indicate the Prioritized List has modestly impacted per member costs. The State's actuary estimated that costs associated with the funded portion of the List are approximately 90 percent of the cost of funding the entire List. The impact of the List is somewhat blunted by the fact that some high priority items represent a significant expense to the program. Specifically, diagnostic services are effectively considered line "zero" as they are covered in order to diagnose a condition, even if the condition itself is not covered. Diagnostic services can be very expensive, and as technology continues to expand our ability to identify medical issues, continue to expand in costs year over year. On an ongoing basis, the Commission addresses this issue by producing evidence-based clinical guidelines to guide the use of technology and more expensive services, to point providers to optimal approaches for diagnoses and treatments for both quality and cost considerations.

The overall savings from implementing a Prioritized List in Alaska would depend on the extent to which Medicaid recipients are currently receiving items on the non-funded portion of the List. In addition, as services by Tribal or IHS providers for AI/AN Medicaid recipients are funded with 100 percent federal funds and any program savings would only accrue to the federal government. However, some services provided to AI/AN members are provided by non-Tribal providers and thus are reimbursed at the regular federal match of 50 percent. To estimate potential savings from implementing the List, we included all services provided to non-AI/AN Medicaid recipients and services for AI/AN recipients provided by non-Tribal providers. Services by Tribal providers to AI/AN were excluded from the analysis.

To estimate potential savings in Alaska, we quantified 2 – 5 percent reductions using State Fiscal Year 2016 Alaska Medicaid expenditures. Table 2 shows the estimated savings (total, federal and state).

⁸ The PMPM cost for services delivered by Tribal providers was \$187.56 in 2016. The PMPM for services from non-Tribal provider was \$716.63, 80.3 percent of the total PMPM.

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Table 2. Estimated Federal, State Savings to Alaska Medicaid from Prioritized List Implementation*

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*Federal/State splits may not sum to total savings due to rounding.

Assuming Alaska adopted the Oregon Prioritized List as it stands, the state impact of implementing the Prioritized List would have been \$3.9 million to \$9.7 million in State Fiscal Year 2016. At Alaska's Federal Medical Assistance Percentage of 50 percent, this represents half of the \$19.5 million total savings. The benefit to the federal government would be \$7.4 million - \$18.5 million. For simplicity this estimate assumed no savings from care for AI/AN members, although we recognize that some services for AI/AN members are funded at the 50 percent match rather than the Tribal-specific 100 percent rate.

This estimate is based on the assumption that implementing the List would change service utilization in Alaska in the same way it did in Oregon. This assumption could be undermined by the extent to which much of Alaska is medically underserved. As a significant portion of state residents live in medically underserved areas, access to certain services is already be limited, without un-funding them.¹⁰ In addition, Oregon adopted the Prioritized List along with Medicaid managed care, which together changed the state's Medicaid program in ways the List alone might not achieve. As no other state has established its own Prioritized List, it is challenging to determine how much of the changes to the state's Medicaid program was related to the List and how much was due to other factors. Coordinated Care pilots and case management could enhance the impact of using the List in Alaska, much as the impact of managed care coordination does in Oregon.

Savings Depend on State's Ability to Move Coverage Line

While the idea behind the Prioritized List is that the number of covered Lines can be changed to meet decreases or increases in state resources, in reality Oregon has not made large changes in the number of covered Lines. The barriers are related to federal statute, regulation, and covered populations, as well as years of Medicaid case law. Under its statutory and regulatory purview, CMS exerts significant control over state programs, even those shaped by Medicaid waivers. In Oregon, CMS requires the state to get

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Appendix 2. Oregon Prioritized List of Health Services

Rank Order of Health Care Categories

- 1) Maternity & Newborn Care (100).**⁵⁰ Obstetrical care for pregnancy. Prenatal care; delivery services; postpartum care; newborn care for conditions intrinsic to the pregnancy.
- 2) Primary Prevention and Secondary Prevention (95).** Effective preventive services used prior to the presence of disease and screenings for the detection of diseases at an early stage. Immunizations; fluoride treatment in children; mammograms; pap smears; blood pressure screening; well child visits; routine dental exams.
- 3) Chronic Disease Management (75).** Predominant role of treatment in the presence of an established disease is to prevent an exacerbation or a secondary illness. Medical therapy for diabetes mellitus, asthma, and hypertension; medical/psychotherapy for schizophrenia.
- 4) Reproductive Services (70).** Excludes maternity and infertility services. Contraceptive management; vasectomy; tubal occlusion; tubal ligation.
- 5) Comfort Care (65).** Palliative therapy for conditions in which death is imminent. Hospice care; pain management.
- 6) Fatal Conditions, Where Treatment is Aimed at Disease Modification or Cure (40).** Appendectomy for appendicitis; medical & surgical treatment for treatable cancers; dialysis for end-stage renal disease; medical therapy for stroke; medical/psychotherapy for single episode major depression.
- 7) Nonfatal Conditions, Where Treatment is Aimed at Disease Modification or Cure (20).** Treatment of closed fractures; medical/psychotherapy for obsessive-compulsive disorders; medical therapy for chronic sinusitis.
- 8) Self-limiting Conditions (5).** Treatment expedites recovery for conditions that will resolve on their own whether treated or not. Medical therapy for diaper rash, acute conjunctivitis and acute pharyngitis.
- 9) Inconsequential Care (1).** Services that have little or no impact on health status due to the nature of the condition or the ineffectiveness of the treatment. Repair fingertip avulsion that does not include fingernail; medical therapy for gallstones without cholecystitis, medical therapy for viral warts.

Population and Individual Impact Measures

Impact on Healthy Life. What is the magnitude of the benefit to the patient from the treatment as compared to no treatment for the condition, after factoring in harms associated with the treatment.

- Range of 0 (no impact) to 10 (high impact)

⁵⁰ The numbers are the Category weights, with higher numbers indicating higher priority Categories.

Impact on Suffering. To what degree does the condition result in pain and suffering? Effect on family members (e.g. dealing with a loved one with Alzheimer's disease or needing to care for a person with a life-long disability) is also factored in here.

- Range of 0 (no impact) to 5 (high impact)

Population Effects. The degree to which individuals other than the person with the illness will be affected. Examples include public health concerns due to the spread of untreated tuberculosis or public safety concerns resulting from untreated severe mental illness.

- Range of 0 (no effects) to 5 (widespread effects)

Vulnerability of Population Affected. To what degree does the condition affect vulnerable populations such as those of certain racial/ethnic descent or those afflicted by certain debilitating illnesses such as HIV disease or alcohol & drug dependence? Range of 0 (no vulnerability) to 5 (high vulnerability).

Tertiary Prevention. In considering the ranking of services within categories 6 and 7, the degree to which early treatment prevents complications of the disease (not including death).

- Range of 0 (doesn't prevent complications) to 5 (prevents severe complications)

Effectiveness The degree to which the treatment achieves its intended purpose.

- Range of 0 (no effectiveness) to 5 (high effectiveness)

Need for Medical Services. The percentage of time in which medical services would be required after the diagnosis has been established.

- Percentage from 0 (services never required) to 1 (services always required)

Net Cost. The cost of treatment for the typical case (including lifetime costs associated with chronic diseases) minus the expected costs if treatment is not provided -- including costs incurred through safety net providers (e.g., emergency departments) for urgent or emergent care related to the injury/illness or resulting complications.

- Range of 0 (high net cost) to 5 (cost saving)

Appendix 2. Oregon Prioritized List of Health Services

Rank Order of Health Care Categories

- 1) Maternity & Newborn Care (100).**⁵⁰ Obstetrical care for pregnancy. Prenatal care; delivery services; postpartum care; newborn care for conditions intrinsic to the pregnancy.
- 2) Primary Prevention and Secondary Prevention (95).** Effective preventive services used prior to the presence of disease and screenings for the detection of diseases at an early stage. Immunizations; fluoride treatment in children; mammograms; pap smears; blood pressure screening; well child visits; routine dental exams.
- 3) Chronic Disease Management (75).** Predominant role of treatment in the presence of an established disease is to prevent an exacerbation or a secondary illness. Medical therapy for diabetes mellitus, asthma, and hypertension; medical/psychotherapy for schizophrenia.
- 4) Reproductive Services (70).** Excludes maternity and infertility services. Contraceptive management; vasectomy; tubal occlusion; tubal ligation.
- 5) Comfort Care (65).** Palliative therapy for conditions in which death is imminent. Hospice care; pain management.
- 6) Fatal Conditions, Where Treatment is Aimed at Disease Modification or Cure (40).** Appendectomy for appendicitis; medical & surgical treatment for treatable cancers; dialysis for end-stage renal disease; medical therapy for stroke; medical/psychotherapy for single episode major depression.
- 7) Nonfatal Conditions, Where Treatment is Aimed at Disease Modification or Cure (20).** Treatment of closed fractures; medical/psychotherapy for obsessive-compulsive disorders; medical therapy for chronic sinusitis.
- 8) Self-limiting Conditions (5).** Treatment expedites recovery for conditions that will resolve on their own whether treated or not. Medical therapy for diaper rash, acute conjunctivitis and acute pharyngitis.
- 9) Inconsequential Care (1).** Services that have little or no impact on health status due to the nature of the condition or the ineffectiveness of the treatment. Repair fingertip avulsion that does not include fingernail; medical therapy for gallstones without cholecystitis, medical therapy for viral warts.

Population and Individual Impact Measures

Impact on Healthy Life. What is the magnitude of the benefit to the patient from the treatment as compared to no treatment for the condition, after factoring in harms associated with the treatment.

- Range of 0 (no impact) to 10 (high impact)

⁵⁰ The numbers are the Category weights, with higher numbers indicating higher priority Categories.

Impact on Suffering. To what degree does the condition result in pain and suffering? Effect on family members (e.g. dealing with a loved one with Alzheimer's disease or needing to care for a person with a life-long disability) is also factored in here.

- Range of 0 (no impact) to 5 (high impact)

Population Effects. The degree to which individuals other than the person with the illness will be affected. Examples include public health concerns due to the spread of untreated tuberculosis or public safety concerns resulting from untreated severe mental illness.

- Range of 0 (no effects) to 5 (widespread effects)

Vulnerability of Population Affected. To what degree does the condition affect vulnerable populations such as those of certain racial/ethnic descent or those afflicted by certain debilitating illnesses such as HIV disease or alcohol & drug dependence? Range of 0 (no vulnerability) to 5 (high vulnerability).

Tertiary Prevention. In considering the ranking of services within categories 6 and 7, the degree to which early treatment prevents complications of the disease (not including death).

- Range of 0 (doesn't prevent complications) to 5 (prevents severe complications)

Effectiveness The degree to which the treatment achieves its intended purpose.

- Range of 0 (no effectiveness) to 5 (high effectiveness)

Need for Medical Services. The percentage of time in which medical services would be required after the diagnosis has been established.

- Percentage from 0 (services never required) to 1 (services always required)

Net Cost. The cost of treatment for the typical case (including lifetime costs associated with chronic diseases) minus the expected costs if treatment is not provided -- including costs incurred through safety net providers (e.g., emergency departments) for urgent or emergent care related to the injury/illness or resulting complications.

- Range of 0 (high net cost) to 5 (cost saving)